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Scottish Dental

FEBRUARY 2020

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As a new decade starts, we look back on
ten years of Scottish Dental magazine

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A plea for clarity when it comes to pay

In his annual report published last November, Hew Mathewson, the outgoing chair of the Scottish Dental Practice Board (SDPB) expressed concern over plans to replace the organisation. “We must accept that SDPB is an anachronism dating back to the beginnings of the NHS and that its equivalents in the rest of healthcare are long gone,” he wrote. “However, reflecting on the work of SDPB, and that of my predecessors, I can’t help but be impressed with how the members unfailingly put Primary Care Dentistry and our patients at the heart of all its work. Currently, while Practitioner Services is not directly accountable to SDPB, it does actively engage with it and formal SDPB approval is required for changes of policy etc. A Board which properly understands, and is empathetic to, what is happening in practice is unlikely in my view to be matched in this respect at least by its successor which will inevitably have its roots in, and first loyalty to, ‘the administration’.”

As we detail on page 46, the process of replacing the SDPB – an intention signalled by the Scottish Government in its Oral Health Improvement Plan published in January 2018 – is now in its advanced stages. Putting aside debate over the merits or otherwise of such a change, the process is in itself a challenge; the SDPB is a statutory body and any formal adoption of its functions is contingent on legislative

change. However, the chair of the putative governing body, Paul Cushley, has emphasised its intention to be open and engaged with the profession. “Reinvigoration of the governance arrangements gives NSS an opportunity to address many of the criticisms outlined in the Oral Health Improvement Plan,” he told *Scottish Dental*. “Previous structures have served us well in the past, but the review and changes are required to ensure that structures and processes are fit for the 21st century and are able to adapt to the new model of care and the new SDR going forward.

Transparency, collaboration and consultation are intrinsic to the development of these structures.”

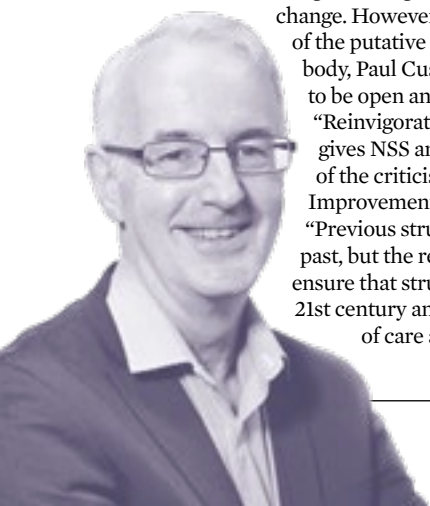
While governance may strike many practitioners as a rather dry subject, divorced from the realities of everyday practice, its impact on their work, their livelihoods, and their wellbeing can be significant. Take the case of Hugh Taggart, for example. He has been embroiled in nearly-decade long dispute with Practitioner Services over their belief that he was an “outlier” in the use of a particular procedure. We detail the case, and the issues stemming from it, in our news story on page 9 and a background feature on page 44. It is a byzantine story which would have played out in a public forum had it not been for the decision by Practitioner

Services to ‘walk away’ from a court case it had brought against Taggart. For his part, Taggart was frustrated by their climbdown; there were policies, procedures, and decisions that he would have welcomed being subject to scrutiny. The Glasgow-based dentist, who was compelled to sell his two practices, had to cash in pensions, and feared he would have to sell his home during his ordeal, may still get his wish; he has made a referral to the General Dental Council.

The reason for linking these apparently very different stories – one bureaucratic, the other bruising – is that the system of remunerating practitioners strikes this observer as being spectacularly unwieldy and prone to heap yet more worries on an already pressured profession. As the SDPB recedes from view and the National Dental Governance Committee, as it is called, comes to prominence the issue

of payments to dentists, and how they are verified, will no doubt be on the agenda again. Perhaps more significantly, this year will see a wider discussion of the proposed New Model of Care which, if implemented, will have profound implications for how dentists treat patients on the NHS, how they are paid, and how those payments are verified. As Hew Mathewson also noted in his report: “The concern that practitioners can be under scrutiny or in some cases formal investigation for several years, to the detriment of their own health, remains an issue.” Particularly when an investigation is abandoned before it can be tested in court.

“
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BEING UNWIELDY”**



Let's not be viewed as nay-sayers

Starting a lively debate is the only way change can work well for all stakeholders

Sitting down to write this article, I wanted to embrace the positivity of the New Year. However, I am filled with concern for the future. The Scottish Government is proposing potentially revolutionary change in terms of new models of care, finance and, possibly, information technology. I have doubts about where that will end and how dentistry will move forward. I have aired other concerns in articles previously but I am going to try to stay positive and encourage debate over what our future profession will look like.

I have no post-grad qualifications, but I have a great deal of clinical and practice owner experience. I think about the future and wider issues in dentistry regularly. In my view, we have to set a baseline of what the profession wishes to achieve and how we want to achieve it. We must take into account the working patterns that younger practitioners want. We should take heed of the problems our medical colleagues have in recruitment and retention of GMPs. A quick look online demonstrates many vacant associate positions. We already have a problem and the desire to work fewer days will add to this tension. The counter to this is the need to service the demand for early morning, late night and weekend appointments.

Most practices in Scotland are mixed so we should all add to the consensus between NHS and private care. As corporates increasingly buy-up practices, they should have a fair say on how the profession moves forward. However, it is contingent on the Government to ensure that public money is not being stripped from the service to create profits for distant owners or investors with deep pockets. But by the same token, there has to be enough profit in dentistry to ensure continued purchase and development of practices. Without an economic benefit, dentistry (in particular NHS dentistry) is seriously at risk.

Where's the positivity? Well, here goes. I would like to see the Government reduce their input in dentistry to include only policy, payment and monitoring. I would strip out the individual health boards' input and raise these elements to a national level, thereby reducing administration levels. Strip out all the extraneous costs, like Denpro, which can be achieved through individual negotiation by practices. Take the savings and add to them to develop the quality agenda.

If we are serious about improving quality, it needs to be funded. It starts with improvement of facilities. Grants should be reinstated to continue a move to larger centres with more dentists and greater skills-mix involving special interests

which are driven by patient need. I don't believe this can be done in smaller practices – larger, more professionally run and developed practices must be beneficial for patients and dentists alike. Audit facilitators and educators should develop practices and practitioners using evidence gathered in practice. Dentists should be happy to embrace the potential benefits for their patients and the Government has to accept that this will lead to more options, many unavailable on the NHS. There should be an open discussion about what can and should be available through the NHS.

I would like an expansion of specialist input available through the Public Dental Service (PDS). Its role needs to shift. Its property portfolio is too large. The dental schools are overrun by referral patients that can't be seen within reasonable timeframes and younger practitioners are more inclined to want to specialise. If the PDS was utilised like a local extension of the schools, with demand-based specialists then treatment plans and better care could be delivered locally. Once again, this needs to be funded – not just the posts but the facilities and training.

I would dearly like to avoid a 'core service'. I believe in NHS dentistry and I feel that reducing the availability of provision will be bad for the public. I believe it will be a public relations nightmare and that it will sit at the feet of the profession, not the Government. I think that there is room for private dentistry but that it shouldn't rely on running down the NHS and limiting the options for people who can't afford it – and the reality is, in Scotland, there are a lot of people in that category.

I haven't even touched on many other thoughts I have about how things could or should be. There are many risks and opportunities which must be explored. However, I am very much of the opinion that we should be leading this debate. Not waiting for committees of academics to tell us what will happen without any idea of the real needs of patients, the real caries rate, the difficulties of practice, and the economic realities and drives which prompt people to risk their future on buying and running practices.

I don't pretend to have all the answers but if we don't start driving this in the media, we will miss the opportunity to shape the future. We will not get patients involved or on our side.

We may end up looking like the nay-sayers and reactionary professionals concerned about ourselves or worse, our profits, rather than visionaries concerned with the best interests of our patients and the future of their care. We should be the masters of our own destiny and starting a lively debate is the only way I can see this working well for all stakeholders. Positive?



Fees reclaimed from dentists amid 'climate of fear'

Regulator to investigate activities of Practitioner Services

THE recovery of fees paid to dentists by NHS NSS Practitioner Services Division (PSD) is under scrutiny as the result of a referral to the General Dental Council (GDC).

The referral will centre on the activities of the PSD, Scottish Government policy regarding the funding of fees paid to dentists, and the conduct of two dentists in the division in helping to recover millions of pounds from practitioners over the past 15 years. The activities are claimed to include:

- The PSD working to a minimum recovery target of £200,000 a year
- The use of sampling, whereby a decision on the validity of thousands of treatments carried out over many years is based on the result of checking a very small number of patient records
- Dentists being threatened with referral to the GDC if they did not cooperate with the PSD and agree to repay fees
- The PSD's handling of the 80 per cent 'patient contribution' portion of recovered fees, amounting to several hundred thousand pounds, which should have been returned to patients.

Now, two officials who work and have worked at the PSD have been referred to the GDC by Glasgow-based dentist Hugh Taggart. The move follows the PSD 'walking away' from a case, due to be heard at Edinburgh Sheriff Court in October last year, in which they were attempting to recover fees paid to Taggart, and the loss by the PSD of another case, at the Court of Session two years ago, involving disputed recoveries from an Edinburgh-based dentist.

Investigators at the GDC are likely to examine the email exchanges, public statements, and legal submissions of the PSD officials which form the basis of their referral to the GDC, so they can investigate the veracity of Taggart's allegations and rule on the officials' conduct.

The minutes of the Scottish Dental Practice Board, in which the activities of the PSD in recovering payments are detailed, will also be scrutinised.

Dentists contacted by this magazine have spoken of a "climate of fear" being created by PSD during their interactions with the division over contested payments. A spokesperson for the PSD said that

the division did not work to a target or a minimum recovery amount. "This is a clear misunderstanding of how the system works," he said. "The figure [of £200,000] is an expected outcome in a system in which it is accepted by all stakeholders that overpayments can occur. It represents less than 0.02 per cent of payments made.

"The Regulations [enacted by legislation in 2010] and the Payment Verification Protocol published by the Scottish Government accept that overpayments can occur and when they do, they should be recovered to the public purse. Practitioner Services would want the actual recovery figure to be zero, since it would mean all claims complied with the rules. This is not achievable, so some figure needs to be assessed so that we can report actual recoveries and whether they are within the expected levels."

The spokesperson added that the Court of Session judgment "made clear that a robust system of sampling and extrapolation is a rational basis for recovering overpayments". He said that in the case of Hugh Taggart, there was "no evidence" to support the claim that the dentist had been threatened with referral to the GDC if he did not cooperate with demands for repayment. A complaint was investigated at the time, he said, and not upheld.

He disputed the contention that demands for the return of fees paid more than five years previously was invalid under Scottish law. "Payments made under the Regulations are not subject to the five-year short prescription period. NSS has multiple opinions from senior QCs which advise that this is the case."

It is understood, however, that in his referral to the GDC Taggart will point to the PSD's initial attempt to examine 20 years' worth of payments and, when challenged, the PSD subsequently restricted the contested period to five years – and agreed to repay fees it had reclaimed going back further than five years.

Regarding the 80 per cent patients' portion of fees recovered, the spokesperson said: "We have a protocol for this and normally reach agreement with the dentist on how patient charges will be returned. In this particular case,



we did not get as far as needing to invoke the protocol since we did not recover any patient contributions either in the court proceedings or otherwise."

The spokesperson said that the two court cases involving contested fee recoveries should not be conflated. "The cases are not similar and decisions made in the Sheriff Court case were based on counsel advice and the Scottish Public Finance Manual, since the irrecoverable cost of the court case would be more than the value pursued in court."

However, he added that as the result of the Court of Session judgment, the PSD is "updating [its] processes and expects to publish a new protocol by July".

GDC to probe Practitioner Services, page 44

Call to action on practitioner burnout

Half of UK dentists have considered leaving the profession for their personal wellbeing

THE dental community must act to prevent burnout among dentists, so they stay in practice rather than quit the profession, according to the indemnity provider Dental Protection.

A survey of dentists in the UK reveals increasing levels of burnout among the profession, it said. Half of the respondents (50 per cent) indicated that they have considered leaving the profession for reasons of personal wellbeing. The same proportion (50 per cent) are dissatisfied with their work/life balance and 60 per cent said they found it difficult to take a short break.

In its new report *Breaking the Burnout Cycle*, Dental Protection says burnout creates problems not just for the dentist involved but can impact patients and the wider dental team.

It calls on dental organisations to consider establishing a 'wellbeing guardian' so that dentists have access to a named person who has undergone the required training to recognise burnout and offer the necessary support. It also calls for dentists' wellbeing to be included among other key performance indicators.

One Dental Protection member said: "The bureaucracy with CQC, GDC, NHS, and the constant fear of litigation are making this profession difficult to perform and add to the burnout feeling."

Raj Rattan, Dental Director at Dental Protection, commented: "Dentistry can be a very rewarding profession – being able to play an important part in the health and quality of life of the public gives a sense of pride. However, when I talk to dentists, it



is evident that there is an increased incidence and risk of burnout.

"The sense of disillusionment, which is a feature of burnout, is demotivating for the dental team and potentially puts patients at risk from sub-optimal care. In contrast, dentists who are motivated, enthused and engaged show high levels of empathy, are more compassionate and provide safer patient care.

"I am proud of the work Dental Protection does to support those dealing with burnout. But while this support is invaluable, it is only a part of the solution. The environment within which a dentist works is key – it is crucial to their wellbeing and their ability to thrive in the clinical setting. This is why we at Dental Protection, alongside other organisations, campaign tirelessly for reforms to help improve everyday working conditions for dentists and their teams.

In our report on burnout we recommend some potential steps that both large and small dental organisations can consider. We believe that change at organisational level is a significant root cause of burnout and this must be addressed effectively if we want to support dentists to remain in the profession."

Meanwhile, national data from the Association of Charitable Organisations shows the number of people seeking help from charities and benevolent funds because they have nowhere else to turn following an unexpected change in circumstances has risen over the last four years.

One charity, the BDA Benevolent Fund, said it had received more applications in 2019 than in any year, a 10 per cent increase on 2018.

More info: bdabenevolentfund.org.uk/request-help

Addressing inequalities, celebrating improvement

THE THEME of the British Association for the Study of Community Dentistry's (BASCD) Spring and Autumn conferences this year is *Addressing Inequalities, Celebrating Improvement* and considers the evidence on how best to further improve oral health of vulnerable groups.

The Spring conference places the spotlight on children, while the Autumn conference centres on vulnerable older adults.

Maria Morgan, senior lecturer in Dental Public Health

at Cardiff University and honorary specialist in Public Health (Dental) at Public Health Wales, becomes President of the BASCD in April.

Morgan, who has worked in dental public health in Wales for more than 20 years, leading the work of the Welsh Oral Health Information Unit – including overseeing the national epidemiology programme, monitoring Designed to Smile and Gwen Am Byth – is the first non-clinical public health specialist

to be nominated as BASCD President. She is also registered as a specialist with the UK Public Health Register (UKPHR) and a fellow of the Faculty of Public Health and during her presidency she hopes that there will be closer collaboration between these organisations and BASCD.

"These conferences reflect much of my career in dental public health and celebrate the benefits of the reality, not the rhetoric, of multi-agency working to affect the wider

determinants of health," said Morgan, "after all we are stronger together."

Morgan's presidential conference, on 2-3 April, 2020 in Cardiff's City Hall, will mark the success of Wales's flagship 'Designed to Smile' programme, as well as initiatives operating in the rest of the United Kingdom. It will also consider best practice to further improve children's oral health.

More info: bascd.org/conferences-and-events

GDC publishes corporate plan

'Promotes relationship between activity and fees', says regulator

AS PART of the General Dental Council's new approach to strategic planning, and in the wake of releasing its three-year corporate strategy, *Right Time, Right Place, Right Touch*, the regulator has published its costed corporate plan for 2020.

The GDC said the plan "promotes greater understanding of the relationship between... regulatory activity and the fees charged".

Ian Brack, chief executive, said: "The plan is an essential tool which will enable the GDC to manage its resources, in circumstances which will undoubtedly change over time, so it can deliver an effective, timely and proportionate service for the public while providing registrants with a far higher degree of certainty regarding the annual retention fee for the next three years."

The GDC says this programme of work included in the plan further progresses the GDC's aim of being a "fair and cost-effective regulator that intervenes at the right time, in the right place and with the right touch". In a foreword to the plan, Brack wrote: "The GDC exists to protect patients and maintain the high levels of public confidence in dentistry and oral health services. While we believe that we have met our responsibilities in these areas, we recognise that we have been less effective in sustaining the confidence of the professions in their regulator."

"Too much of our time and effort was being directed toward enforcement, rather than on prevention. A focus on the prevention of harm benefits the public and dental professionals. *Shifting the balance: a better, fairer system of dental regulation* set out our proposal for change and addressed the need to provide clarity and timeliness in addressing patient concerns, to secure the support of the professionals we regulate, and to be more flexible and proportionate by adopting a more preventative approach."

In parallel, said Brack, the regulator has taken steps to improve cost effectiveness and financial management. Operations have

been moved to Birmingham, yielding "significant long-term savings". An estates refurbishment programme completed last year, means that all hearings will be held in its London office, "at a considerably reduced cost" which in turn will have a direct impact on the annual retention fee. Brack added: "We have made decisive moves to address the issue of fees, updating and further refining our costs analysis and introducing fees for first registration."

He continued: "We want the system of dental regulation to promote professionalism and we have been facilitating conversations with members of the public and the professions to develop a set of principles that will protect patients and be fair to professionals. [This] will also help to promote high-quality education and lifelong learning, focusing our resources on ensuring high standards of care and professional conduct."

"However, there is also further work needed to ensure that patient concerns and complaints are routed to the right place (which may not be the GDC) and, when they come to us, are being dealt with quickly and effectively. The [corporate plan] is fundamental to sustaining these changes and continuing the improvement of the GDC."

More information: tinyurl.com/tmwmcr7



“TOO MUCH OF OUR TIME AND EFFORT WAS BEING DIRECTED TOWARD ENFORCEMENT, RATHER THAN ON PREVENTION”

Attendance gap 'shows no sign of closing'

BDA Scotland has called for a concerted effort to get low-income patients to attend their dentist as new data shows the attendance gap between Scotland's most and least deprived communities continues to grow.

While registration in Scotland continues to break records (up from 94.2 per cent in 2018 to 95.7 per cent in 2019), data from the NHS Scotland Information Services Division shows the overall attendance rate has continued to fall from around 98 per cent between September 2006 and March 2008, to a record low of around 69 per cent in September 2019.

The percentage of children visiting the dentist in a two-year period fell from 97 per cent in 2007 to 83.7 per cent in 2019. For adults, attendance fell from 98.7 per cent to 65.4 per cent between 2007 and 2019.

The BDA said it was also concerned that the difference in attendance rates between the most and least deprived areas has reached an all-time high for both adults and children. At September 2019, 60.8 per cent of adults in Scotland's poorest areas saw their dentist in the last two years, compared with 71.5 per cent of those in the most affluent neighbourhoods. Among children, the figures were 79 per cent and 88.8 per cent.

Joe Fitzpatrick, the Public Health Minister, said: "It is very encouraging to see that a record number of people in Scotland are registered with an NHS dentist."

However, Robert Donald, chair of the BDA's Scottish Council, said: "Being on the register is meaningless if patients aren't making it to their dentist."

"Behind the spin is a large and growing gulf in attendance between rich and poor... yet there is little energy to bridge this divide. When patients bottle up problems, we all pay the price."

"The Scottish Government could save patients pain and our NHS a fortune by encouraging regular check-ups."

FGDP urges Botox ad compliance

THE Faculty of General Dental Practice (FGDP(UK)) is encouraging dentists and dental practices offering botulinum toxin injections to ensure their marketing is legally compliant.

Advertising prescription-only medicines to the public breaches the Human Medicines Regulations 2012 as well as the Committee of Advertising Practice (CAP) Code, even when they are to be administered by a registered healthcare professional.

The CAP and Advertising Standards Agency have announced that from 1 February 2020, they will use automated technology to identify noncompliant social media posts, which if not removed could result in referral to the Medicines and Healthcare products Regulatory Agency (MHRA) and/or statutory professional regulators such as the GDC.

To aid compliance, the MHRA and CAP have issued new guidance which applies to all social media promotion of Botox, which includes paid-for ads, non-paid-for marketing posts and influencer marketing.

The guidance says there can be no direct



references to a prescription-only medicine or treatment, whether via a brand name, brand-like name or in the generic, including in images and hashtags or in promotions such as sale packages and competition prizes. Indirect references such as 'anti-wrinkle injections' are also banned.

The organisations instead advise promoting professional consultative services and suggest that advertising "a consultation for the treatment of lines and wrinkles" may be acceptable. Dermal fillers and other non-prescription-only medicines are not covered

by the enforcement action or guidance and can still be advertised provided there is no implication that a prescription only medicine is also available.

"Increasing numbers of dental practices offer injectable cosmetic treatments, and patient demand continues to rise, but many may not be aware of the regulations restricting the advertisement of prescription-only medicines and treatments," said Professor Mike Mulcahy, FGDP(UK)'s lead on nonsurgical facial aesthetics. "To avoid the possibility of facing regulatory action, I strongly advise all dentists who administer Botox to read the new guidance and immediately review and, if necessary, adapt their social media, websites, and other marketing to ensure compliance."

In a separate development, the Scottish Government is proposing to legislate on nonsurgical services so that people who are not healthcare professionals will need a licence to carry out cosmetic procedures such as dermal fillers or lip enhancements.

More information at tinyurl.com/tmyt2vs and tinyurl.com/sghdsv9

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(*as per
NHS Greater
Glasgow
guidelines)

SHOP WHERE SERVICE AND VALUE COUNT

Larkhall Dental secures future success

A DENTAL practice serving more than 5,000 patients at the heart of a South Lanarkshire community has secured an important buy-out. Larkhall Dental Institute has joined Scotland's largest dental group, Clyde Munro, which now has 38 practices across the country, 21 of which were acquired during 2019.

Founded eight years ago, Larkhall is a forward-thinking practice offering the community NHS, private and cosmetic treatments. It caught the eye of Jim Hall, founder and chief executive of Clyde Munro, as being a perfect fit for its network of family practices.

It was previously owned and operated by husband and wife team Callum and Heather Graham, who have driven the practice to success after starting from scratch and

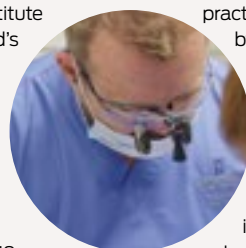
without a client base in 2012. After opening with just one chair in operation, it is now introducing its third surgical room. It is one of three

practices owned and run by the Grahams, the other two of which were sold separately.

"We are happy that Callum is continuing to stay involved by running day-to-day operations

at Larkhall," said Jim Hall. "His hard work and dedication are very much embedded at the heart of the business."

Since its foundation in 2015, Clyde Munro has enjoyed rapid growth and now treats more than 300,000 patients across the country. Its ambition is to become Scotland's "local dentist, operating an expanding network of family dentists across Scotland, with each devoted to providing the best dental care".



Better patient care through collaboration

AESCULAP Academia has announced a collaboration between the BSRD, BSSPD, RD-UK and SRRDG; the 1st Joint UK Restorative Dentistry & Prosthodontic Conference. The theme of the conference, which is to be held at the Crowne Plaza Hotel, Glasgow on 25-27 March, is 'Better Patient Care through Collaboration'.

Day One is focussed on treatment of patients with cleft lip and palate, providing perspectives on team-based care by surgeons, restorative dentistry consultants and a clinical psychologist.

Day Two will cover updates on the latest developments in head and neck cancer treatment, with input from leading oncologists and surgeons including discussion of a digital, team-based approach to implant rehabilitation.

Day Three will cover tooth wear. The day will explore how patient care pathways can be improved by working together with psychiatrists, gastroenterologists, general dental practitioners and restorative specialists.

The speakers include experts within these fields, along with Peter Brennan, Consultant OMFS, who will

cover 'Human factors in a clinical practice – Staying safe and avoiding burnout' – a highly relevant topic today.

There will be a panel-based discussion of clinical tooth wear cases with audience participation. In addition, discussion of barriers to optimal care for these patients both in hospital and general practice will take place. The aim will be to improve understanding of the challenges faced in both settings and to explore options to overcome these. There will also be discussion around managed clinical networks and new models of care. The tooth wear day is aimed at specialists, GDPs, specialist registrars, VTs and DCTs. Aesculap Academia invites all to attend this exciting joint conference!

For more information regarding the programme, drinks reception at the City Chambers, and gala dinner at Òran Mór, please visit the website - rdpduk2020.eventbritestudio.com



REGISTRATION
OPEN IN
DECEMBER

THE 1ST UK RESTORATIVE DENTISTRY & PROSTHODONTIC CONFERENCE – BETTER PATIENT CARE THROUGH COLLABORATION

Wednesday 25th – Friday 27th March 2020, Crowne Plaza Glasgow

WEDNESDAY

Theme: Cleft lip and palate

Topics: Perspectives on team-based care by surgeons, restorative dentistry consultants and clinical psychologist.

Social Programme:

Welcome civic reception hosted by The Lord Provost at Glasgow City Chambers

THURSDAY

Theme: Head and neck cancer

Topics: Update on latest developments in head and neck cancer treatment from leading oncologists and surgeons.

Digital, team-based approach to implant rehabilitation.

Award of BSSPD Schottlander research prize.

Social Programme:

Black tie gala dinner at Òran Mór

FRIDAY

Theme: Tooth wear

Topics: Collaboration of consultants in psychiatry, gastroenterology and restorative dentistry with GDPs to improve patient care. Panel discussion Collaboration of GDPs, consultants and service managers to consider new models of patient care.

Award of BSRD Gary Pollock oral clinical case presentation prize.

FOR FURTHER DETAILS AND TO REGISTER:

<https://rdpduk2020.eventbritestudio.com> | 0114 225 9143/9135 | @academia_UK



PEOPLE
NEWS

Survey looks into attitudes to prescribing antimicrobials

National dental organisations are encouraging participation in a survey which aims to build an understanding of dentists' knowledge of, and attitudes to, the prescribing of antimicrobials. The survey, which is open to all practising dentists, as well as trainees and students, is available online at tinyurl.com/top6bgv until 31 May. People who take part in it are awarded a certificate for one hour's CPD.

Registration application fee

The GDC announced in December that registration application fees would be introduced from 1 January this year. It said the fees are being brought in to cover the costs relating to applications, which are currently met by existing registered dental professionals. Registration fees range between £22.95 (for a UK qualified dentist or DCP) and £685.35 (for registration as a dentist requiring individual assessment).



Peter Mossey

Latest appointments

The General Dental Council has named Gordon Matheson, the former Glasgow City Council leader, as its new Head of Scottish Affairs. Global children's charity Smile Train has appointed Dr Peter Mossey, Associate Dean at the Dundee Dental School, as one of four new Medical Advisory Board members. Robert Kirschen is the new honorary patron of the British Orthodontic Society.

'Rule 4' report published

The GDC has published its report on last year's consultation relating to the 'Rule 4' process in fitness to practise. The process provides dental professionals with an opportunity to submit their comments about concerns that have been raised. A pilot will now run until the end of October to test the need for a 14-day extension to the Rule 4 time limit. More information at tinyurl.com/ro7udoh

Increase in public CPR

Bystanders performed CPR on 64 per cent of people who suffered cardiac arrest outside of a hospital setting last year, an increase on the 41 per cent figure in 2015 when Scotland's strategy for out-of-hospital-cardiac-arrest was launched.



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BDS (Glasgow 1983),
FDS, MSc, MDO, RCPS



Justine Weir
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BDS (Glasgow 2001),
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Sheena Macfarlane
GDC No. 53199
BDS (Glasgow 1979), BSc



Paul Mooney
GDC No. 178517
BDS (Glasgow 2009),
MFDS, MSc, M.Orth, RCS

DATES FOR YOUR DIARY

15 FEBRUARY

SmileFast Direct Activation Course

London
www.smilefast.com/course

17-18 FEBRUARY

Dental Cone Beam 2A

RCPSG, Glasgow
www.tinyurl.com/rj4vyr9

2-3 MARCH

28th Euro Dentistry Congress

Edinburgh
dentistry.cmesociety.com

7 MARCH

24th Annual Conference for Dental Care Professionals

RCSEd, Edinburgh
www.tinyurl.com/sdqj5n4

11-13 MARCH

Standard Edgewise Technique Course

Edinburgh Dental Institute
www.tinyurl.com/vkbvcjz

13 MARCH

Preparing for retirement

BDA, York
www.tinyurl.com/ts6543b

14 MARCH

SmileFast Direct Activation Course

Birmingham
www.smilefast.com/course

27 MARCH

Aesthetic management of the missing dentition

BDA, London
www.tinyurl.com/uhzettl

25-27 MARCH

The 1st UK Restorative Dentistry & Prosthodontic Conference

BSSPD, Glasgow
www.tinyurl.com/t2e3vkj

4 APRIL

SmileFast Direct Activation Course

Edinburgh
www.smilefast.com/course

24-25 APRIL

Scottish Dental Show

Braehead Arena
www.sdshow.co.uk

30 APRIL-1 MAY

Dental Education Conference

EICC, Edinburgh
www.tinyurl.com/t2bk4cx

30 JULY

Career Yearnings, Earnings & Learnings

FGDP(UK), London
www.tinyurl.com/w3r978x

28 AUGUST

Dental Cone Beam 2B Certification

Royal College of Surgeons and Physicians Glasgow
www.rcpsg.ac.uk/events/conebeam2

14-15 SEPTEMBER

Euroscicon Expo on Dentistry & Oral Hygiene

Edinburgh
www.dentistry.euroscicon.com

11 NOVEMBER

Scottish Dental Awards 2020

Hilton Glasgow, William Street
www.sdshow.co.uk/awards

12-14 NOVEMBER

BACD Annual Conference

EICC, Edinburgh
www.tinyurl.com/rvc6yzf

27-28 NOVEMBER

BSDHT Oral Health Conference

SEC, Glasgow
www.bsdht.org.uk



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egistration is now open for the Scottish Dental Show 2020 (sdshow.co.uk). Voted a huge success in 2019 by visitors and exhibitors alike, the show promises to be even bigger and better in 2020. You can register at scottishdental20-visitor.reg.buzz now.

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. By the end of last month, registrations were already up by 50 per cent on last year.

With more than 130 exhibitors demonstrating the latest technology and developments in dentistry, and more than 60 lectures and workshops from professionals

covering a multitude of topics, attendees will have plenty to see and do. With delegates from Angus, Aberdeenshire, Dumfries & Galloway, Edinburgh, Stirling and further afield, the Scottish Dental Show is a must-attend event for the entire industry.

For the first time in the show's history, you can now earn up to 10 hours of continual professional development. The show's Education Programme, validated by NHS Education for Scotland, will feature eCPD, Clinical Skills, and Business & Management sessions, and those eligible can also claim CPD Allowance (CPDa).

This year's speakers include leading Consultant Oral and Maxillofacial Surgeons Professor Roger Currie and Professor Stuart Clark; the Director of Edinburgh Dental Institute, Professor Angus Walls; Consultant in Special Care Dentistry, Helen Patterson; The Confident Dentist, Dr Barry Oulton; Dental Sales Trainer, Ashley Latter; and award-winning aesthetic dentist Dr Monik Vasant, plus many others. 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 Hilton Glasgow). 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.

During the two-day event, the Scottish Dental Show stand will preview the awards, provide all the information you need to enter and nominate, and provide an early opportunity for you to help recognise and celebrate the best in the profession and industry.

Ann Craib, Sales and Events Manager, 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 90 per cent of exhibition stands are already booked for 2020, and we're gearing up for a fantastic two days of engagement and learning in April."

Ann added: "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."

“

WE'RE GEARING UP FOR A FANTASTIC TWO DAYS OF ENGAGEMENT AND LEARNING IN APRIL

ANN CRAIB

2020 SPEAKERS

Jennifer Alexander | Specialist Orthodontic/ Prosthodontic Technologist

James Baker | Specialist Prosthodontist

Phillip Barker | Director, Mediholdings

Tariq Bashir | Cosmetic Dentist

Fadi Barrak | Oral Surgeon

Martyn Bradshaw | Practice Sales Director, PFM Dental

Richard Charon | Inhalation Sedation Trainer

Stuart Clark | Consultant Oral and Maxillofacial Surgeon

Andrew Culbard | Cosmetic Dentist

Roger Currie | Consultant Oral and Maxillofacial Surgeon

Kirstyn Donaldson | Honorary Senior Clinical Lecturer in Dental and Maxillofacial Radiology

Matt Everatt | Technical Director, S4S

Phillip Friel | Implant Dentist

Mike Gow | Phobia and Anxiety Management Dentist

Louise Grant | Healthcare Accountant, EQ Accountants

Angela Harkins | Clinical Teaching Fellow

Helen Kaney | Lead Dento-legal Consultant and Head of Dental Services Scotland, MPS

Michael Kelly | Partner, MacRoberts

Simon Knox | Dental Business Coach

Ashley Latter | Selling Coach

Sarah Manton | Director, Faculty of Dental Trainers

Lucy Mitchell | QIIP Team Member, NHS Scotland

Peter Ommer | Director of Dentistry, NHS Ayrshire & Arran

Barry Oulton | The Confident Dentist

Christine Park | Senior Clinical University Lecturer/ Honorary Consultant in Paediatric Dentistry

Helen Patterson | Consultant in Special Care Dentistry

Ross Scales | Quality Assurance Operations Manager, General Dental Council

Clive Schmulian | Disruptive Dentist

Ian Simms | Practice Valuation Manager, Mediholdings

Michael Royden | Partner, Thorntons Law LLP

Harry Singh | Dentist/Facial Aesthetician

Craig Stirling | Partner, Davidson Chalmers Stewart

Monik Vassant | Aesthetic Dentist

Liz Webster | Dental Nurse Team Leader and Medical Emergency and Basic Life Support Trainer

Lezley Ann Walker | Dental Team Tutor, and Medical Emergency and Basic Life Support Trainer

Angus Walls | Director, Edinburgh Dental Institute

+ plus many more.



An exhilarating journey

As a new decade starts, we look back on 10 years of Scottish Dental magazine

WORDS
STEWART
MCROBERT

When Iceland's Mount Eyjafjallajökull erupted ten years ago it unleashed volcanic ash that caused major disruption of air traffic across northern Europe.

Fortunately, it didn't cause the grounding of Edition 1 of the new incarnation of *Scottish Dental*, which had taken flight a couple of weeks earlier and was still dropping through practice letterboxes when the mountain was causing maximum mayhem.

While we don't mind provoking a little disruption every now and again, our aim is to bring clarity rather than confusion. And, as a new decade starts, it seems apt to look back on some of the multifarious topics that have been illuminated, explained, debated and discussed in these pages over the magazine's initial ten years.

Children first

Appropriately enough, Edition 1 included a feature on what has turned out to be one of Scotland's most passionately discussed policy initiatives; Childsmile.

Back then, the programme had already been in existence for five years

on a trial basis but was about to be implemented across the country.

As Lynn Brewster, at that time Childsmile's West of Scotland programme manager, explained, the focus in 2010 was on integration and consolidation.

She told the magazine: "Childsmile is currently in an interim demonstration phase prior to being mainstreamed into routine dental services. During this time, 2009-11, a fully integrated programme encompassing Childsmile Core, Practice, Nursery and School will be embedded within Scotland's 14 NHS boards. Members of the Childsmile board are currently working to embed the evolving dental care pathway within the child health system, to ensure programme delivery by an appropriately trained and skilled workforce and that it is supported by national payment systems and IT facilities."

The programme has become an established part of public dental policy. While its merits have been argued over there have been some indications of its impact. In December 2013 researchers from Glasgow University reported Childsmile had saved more than £6 million since it began with fewer children needing extractions,

fillings or general anaesthetic.

Challenging

If *Scottish Dental* has a main purpose it is to reflect the concerns of the country's dental professionals by challenging Scotland's Chief Dental Officer. In June 2010 the since retired Margie Taylor made the first of many appearances in the magazine. This time around she answered questions on, among other things, decontamination, NHS remuneration, continuous registration, salaries, recruitment and retention, and Scotland's poor oral health record.

Initiative

Dental professionals' initiative and willingness to try new ideas always impresses. In November 2010, a perfect example of this was featured.

After spending thousands of hours treating victims of facial trauma, three surgeons from Glasgow had decided enough was enough.

Oral surgeon Christine Goodall had seen thousands of young men injured as a result of 'recreational violence'. The cumulative effect of this led Christine and two colleagues at Glasgow Dental Hospital – maxillo-facial surgeons Mark Devlin and David Koppel – to set up an innovative



charity to try and stop violence before it happens. Medics Against Violence (MAV) was founded in 2008, becoming a registered charity the following year. Over the years they have helped reduce violent injuries, especially among the young.

Emphasis on stress

A recurring theme across the years has been the levels of stress endured by the country's dental professionals. It was an issue first raised in the magazine in December 2010 when a report of UK workplaces undertaken by Professor Garry Cooper revealed that dentistry was one of the 10 most stressful professions in the UK, alongside firefighting, police work, social work, mining and medicine.

Despite initiatives like The Dentists' Health Support Programme dental professionals were subject to higher than average levels of anxiety, addiction and both attempted and successful suicide. Mental health problems and addiction were by far the main reasons why a dentist might come before the General Dental Council.

Sadly, this issue has persisted. So much so that when the magazine underwent a radical redesign in August 2018 the first edition with

the new look focused heavily on a profession in crisis thanks to the crushing effects of stress.

Structure and safety

The structure of healthcare scrutiny underwent a change in 2011 when Healthcare Improvement Scotland (HIS) took over from the Care Commission. The Scottish Government decided to have a new single body to scrutinise health services, with another separate body regulating care services and social work. HIS brought together a variety of functions, including the scrutiny of independent healthcare, which was the original remit of the Care Commission.

As featured in June 2011, there was a significant step forward for safety in the industry when Trading Standards withdrew its 'blind eye' policy on tooth whitening products. This resulted in one of the major suppliers of whitening products, The Dental Directory, ceasing sales of all products with immediate effect.

Good Show

Recognising the growing need for a serious and substantial annual convention the magazine made its own major contribution to the

profession's development by launching the Scottish Dental Show. Announced in October 2011, the first show was lined up for 24 and 25 May 2012.

Promising to be much more than a trade show, from the start it included an extensive programme of speakers and workshops that offered a significant volume of verifiable CPD.

The Show has become a 'must-attend' event for dental professionals across the country, and the latest, which will take place on 24 and 25 April at Braehead, promises to be as pioneering and forward-thinking as the first.

One benefit of creating the Show was the opportunity to give due recognition to people, practices and organisations across the sector who had developed new standards, services, ideas and technologies.

Most notable was the presentation



“WELL DONE AND CONGRATULATIONS ON YOUR ANNIVERSARY”

JANET PICKLES, RA MEDICAL

(Pictured)
Launched in 2011,
Childsmile has
become an
established part
of public dental
policy



of the first ever Scottish Dental Lifetime Achievement Award. The inaugural recipient was Professor William Saunders, former dean of Dundee Dental School, who received membership of the Scotch Malt Whisky Society as well as a crystal trophy. A surprised but delighted Professor Saunders said: "I was completely overcome. In fact, my wife Jenny was very worried about me because I was so surprised. It is so unusual for a clinical academic to be awarded such a prestigious accolade over high profile general dental practitioners."

Independent viewpoint

It might seem like a generation ago to some, but 2014 saw a rather important referendum take place on the matter of Scotland's place in the UK. On



Saturday 10 May, the Scottish Dental Show hosted an independence and dentistry debate at Braehead Arena. The debate, chaired by former GDC President and Edinburgh GDP Hew Mathewson, centred on the motion 'Scottish general dental practice will be better for patients and dentists in an independent Scotland'. There were thoughtful contributions from

panellists Clive Schmulian, Anas Sarwar MP, Gerard Boyle and Dr Willie Wilson. After recent events there could well be a rerun of this discussion in the near future.

Northern light

While the magazine was busy being born so was Aberdeen Dental School. The first edition included news of the £17.7 million School's official opening.

However, the institution endured one of the darker periods of its chequered history in early 2015 when a 52-page GDC report catalogued a long and damning list of errors and deficiencies. The report was the third consecutive critical inspection of the school to reveal significant issues.

Thankfully, better times were



CONGRATULATIONS SCOTTISH DENTAL MAGAZINE ON THE 10 YEARS OF TRADING AT CONNECT! A REAL ACHIEVEMENT"

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CONGRATULATIONS ON YOUR ANNIVERSARY ANN AND SCOTTISH DENTAL MAGAZINE”

**IVIN S.Y. TAN AND DR LISA
CURRIE, THE ORTHODONTIC
CLINIC**



ahead. In January 2016, the magazine highlighted its re-birth under a new Head, Richard Ibbetson. He was determined to realise the School’s potential to be a quality centre of education. As he said: “Aberdeen’s here; it might be small, but it’s going to stay. It might take five years, but it’s going to be very, very good!”

The ‘B’ word

The United Kingdom’s latest constitutional rammy, Brexit, was wryly observed by the magazine’s insider columnist, Arthur Dent, in July 2016. He (or was it she?) showed incredible foresight when noting “...nothing is going to happen very soon. The government must trigger Article 50 by officially notifying the EU of its intention to leave. Once triggered, there is a two-year period in which the terms of the leaver’s exit are negotiated. At the time of

writing, there is no timescale for this to happen, leading to a longer period of uncertainty.”

Having got Brexit out of the way temporarily, a more immediately significant revolution for Scotland’s dental profession then raised its head.

OHIP

In September 2016, it was announced that Scotland’s new Oral Health Improvement Plan (OHIP) would be put out to consultation for 12 weeks. Promising a radical rethink of how patients are treated, and dentists are remunerated, the document also set out plans to introduce a new preventive care pathway, with the aim of moving dental services away from a restorative approach. Also, in prospect, was a review of the SDR and introduction of an Oral Health Risk Assessment (OHRA) for all patients at 18 years of age and at regular intervals.

The Plan was subsequently launched with much fanfare in early 2018. At the time Health Secretary Shona Robison said: “The Oral Health Improvement Plan will support the profession to spend more time on what they do best – providing excellent care for the patients who need it most. We will continue to work closely with them as the

recommendations are implemented. It will ensure people get the personalised care they need, when and where they need it.”

It wasn’t too long before questions were being asked. In August 2018, we reported that Scotland’s dentists had deep concerns about implementation of the OHIP given the absence of new investment to make the plan a reality. BDA Scotland said it agreed with the principles at the heart of the plan, but the lack of detail on vital issues including funding and timescales, as well as lack of involvement from the profession in implementation, could put NHS services at risk.

Complex topics

Scottish Dental has always been ready to take an in-depth look at complex topics. In October 2018, we examined the issue of consent as influenced by the Montgomery case of 2015.

As the requirements, legalities and practices around obtaining informed consent are a major part of the teaching in dental schools, it seemed appropriate to consider a lack of clarity in the profession as to how much Montgomery should affect existing practices and relationships with patients, if at all.

With the support of the Royal

Recently *Scottish Dental*, profiled the , above, of a firm which has created a technology to remineralise teeth ‘on the go’



CONGRATULATIONS TO SCOTTISH DENTAL ON YOUR ANNIVERSARY”

FARID AHMED, ADVANCED DENTAL EQUIPMENT LTD

“Bien-Air would like to congratulate Scottish Dental on their **10th anniversary**. Great team and great publication.”



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Martin Aitken would like to wish the Scottish Dental team a very Happy 10th Anniversary.



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College of Physicians and Surgeons of Glasgow who had been looking into the issue in detail, we brought together a group from across the dental world in a round-table discussion on what consent meant in a post-Montgomery world.

Another concern for everyone involved in healthcare is the impact of Scotland's ageing population. With more people living longer, the healthcare system is under increasing pressure, especially the dental services for those living in care homes

In February 2019, the magazine talked to some of those with expertise in this field. They outlined the challenges involved in providing efficient dental care to people who are living into their 80s, 90s and beyond, taking a plethora of medications, have more of their own teeth and have undergone a variety of procedures such as root treatment and have had implants fitted. The profession still has to get its head round this problem.

Technology rules

New, ground-breaking technology invariably creates interest among dental professionals and the public alike. In August 2019, we showed how Artificial Intelligence (AI) could affect the future of dental care, not least the development of a toothbrush that detects wider health issues. It seems the boffins at Procter & Gamble have been busy creating the Genius X, a toothbrush that boasts AI as a key feature.

In a similar vein, the October 2019 edition reported how Dundee University had taken what it believed to be a radical step in modernising the way dental students learn. Dr Andrew Mason, Clinical Senior Lecturer at Dundee University's School of Dentistry explained: "At its heart, the curriculum integrates clinical science with clinical



More recently, the magazine reported on how Dundee University's radical step in modernising the way dental students learn

practice. That means, at Dundee, a dental student will carry out clinical practice from week one; that's huge."

Then, in December 2019, the innovation theme continued. We reported how Scottish biotech firm Dentherapy had produced Toothboost, a technology designed to remineralise teeth 'on the go'.

Last word...?

It's been an ever-present in our lives since June 2016, but our final edition of 2019 reflected on 'Lessons from history' and the effects Brexit will have on the profession. Michael Donaldson, Consultant in Dental Public Health and Head of Dentistry at the Northern Ireland Health and Social Care Board, has spent time trying to predict the outcomes. His summary?

"The consequences for the UK and Ireland are likely to be significant – though not wholly negative."

As we enter a new decade, here's hoping for even more topics that will rile and rouse our readers... and a journey that's not always turbulence free.



Christine Goodall and two colleagues at Glasgow Dental Hospital set up an innovative violence prevention charity

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Sending best wishes to the Scottish Dental team on their 10th Anniversary at Connect. Great team and Superb magazine.



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Wishing the Scottish Dental team Happy 10th Anniversary. Here's to the next ten

The art of dentistry...

a search for identity

How creativity could improve wellbeing, clinical practice and public health

WORDS
WILL
PEAKIN

Rachel Jackson was six months into a four-year BDS programme at the Aberdeen Institute of Dentistry and, “I thought I was going to walk out the door.”

Partly, at the age of 34, it was “being a student again”. She was also juggling being a mum; away from home during the week, with an overwhelming workload.

“I couldn’t find myself, my creativity; I was lost to science. How could I get that back, and manage this volume of information? I had to approach my learning differently. So, I reflected back to my time as a medical illustrator and decided to illustrate what I was learning.”

At school, Rachel’s interest in the convergence of art and the sciences had led her to study Medical Illustration at Glasgow Caledonian University and from there a job at Monklands Hospital; part of a team working with surgeons to depict

medical concepts or procedures. Photography was in her remit, also, for patient information leaflets or publicity pictures. There was a more challenging side to the photography; documenting injuries sustained as the result of serious crimes.

“It was a steep learning curve,” Rachel recalled. “But I had very experienced and supportive colleagues. My approach was to do the job to the best of my ability; it would be disrespectful to the patient if I didn’t do that.”



In her early twenties, now with a baby girl, Rachel decided to move with her partner back to Inverness – “back home” – to be closer to family, and she got a job as a dental nurse. It was part-time and involved patient care in a clinical setting; all things that suited her. By 2013, she had also gained a degree in Oral Health Science from the University of the Highlands and Islands and was working as a therapist in the Public Dental Health Service and independent practice.

“I’m quite a reflective learner,” she said, “constantly wanting to move forward.” Rachel became a part-time tutor, using her photographic skills to teach vocational trainees in clinical photography. This led to

Majestic structures - ceramic on canvas

From the collection ‘The Beauty Within’, my study of histological sections, patterns and formations seen during tooth development have been transcribed and represented using a medium that I hope captures the essence of a tooth’s inner beauty. I chose to take inspiration from ground sections mainly due to the colours, tones, and textures – reminding me of the gemstone ‘Tiger’s Eye’, used in jewellery. The mesmerising unruly flow of dentine, dammed by a wall of enamel, offers unremarkable beauty. Nature that we respect and very skilfully recreate but, in the process are often reminded of the insubordinate character of the various constituents.



Facial Nerve
- pencil on paper

Out of all the cranial nerves, the facial nerve is my favourite; its delicately woven path reminds me of a leaf skeleton. I sketched this specimen as I watched a medical surgeon dissect its path through the parotid gland; considering how best to approach tumour removal. We chatted about what an honour it was to be there, to have these incredible moments and how grateful we both were to those who donate their bodies to education.



a full-time post on the Oral Health Science course from which she had graduated. “I gained so many transferable skills working within an inspirational team using the most up-to-date teaching methods and it was incredibly rewarding seeing new students blossom,” she remembers.

A full-time teaching position became available, but Rachel had a taste for restorative dentistry and opted to develop her clinical skills. As a therapist, she had referrals from 10 to 15 dentists a week. “This was a significant form of peer review and reflective practice. I could learn from patients’ medical conditions, the approaches to treatment planning, what worked and what didn’t,” she said.

“I was like a sponge soaking up all this information and quickly outgrew my remit. I was at a crossroads. I enjoy clinical work and contact with the patient. In years to come, I could combine teaching again – but in a different role. So, I thought: ‘Let’s see what happens if I get into Aberdeen [Institute of Dentistry].’”

Friends cautioned that she would face hurdles; financially and in balancing family life. She wasn’t quite prepared for the information overload. “The volume of work within a condensed post-graduate BDS course is unbelievable.

“To decide at the age of 34 to turn a stable life upside down to study dentistry, to work, be a mum, and travel – I had to approach my new path a little differently,” said Rachel.

“I had an opportunity; to carve a new identity in dentistry, one that embraced the new but allowed me to keep important elements of who I was before. At the time my priority was to stay connected with my daughter.

“So, I decided to illustrate what I was learning because that’s what I did as a medical illustrator; remove the noise from a procedure so that information could be conveyed concisely. In the process, I could bring these illustrations home to my daughter. I could bridge home and university life, educate my daughter and give her a window on mum’s time

at university. It was a vital lifeline for both of us.”

As the course progressed, the number of illustrations began to build. At the end of the second year she took them to Professor John Gibson, the Institute’s director. “I asked him: ‘What do you think? Is there anything I can do with this?’. I explained that my ability in clinical skills was enhanced by my artwork and vice-versa. It was a bit like going into *Dragons’ Den*, pitching the idea!

“He listened to my perspective on the profession’s health and wellbeing, teaching methods, my journey in search of an identity and how artwork could be used to connect with patients – just as it had done with my daughter. Professor Gibson took no convincing and has fully supported me ever since in further finding connectedness in the art and science of my chosen profession.”

As well as helping in her learning and improving her mental wellbeing, Rachel began to see the possibilities of dental art in communicating with patients and the public more widely: “Representing dentistry in a different way, with people being able to see the beauty of the structures and, in turn, value their health more.”

Last November, the British Academy of Cosmetic Dentistry’s annual conference in London hosted an exhibition of Rachel’s work. This spring a permanent installation will be housed at The Campbell Clinic in Nottingham. Rachel is also working on commissions from dentists.

Her next focus is on how the dental curriculum can be enhanced by the arts, whether it’s through using painting to improve fine motor skills or in a wider sense, such as by depicting pain through art to increase empathy with the patient.

There is also a place, she said, for art therapy in dental schools. “For me, the ultimate goal is the acceptance of the arts within dentistry and a shift in the public’s perception of dentistry with creativity – forming a platform to improve the health and wellbeing of the profession as a whole.”

See more at www.medink.co.uk



Rachel's home studio



THE VOLUME OF WORK WITHIN A CONDENSED POST-GRADUATE BDS COURSE IS UNBELIEVABLE. I HAD TO APPROACH MY NEW PATH A LITTLE DIFFERENTLY”

RACHEL JACKSON



In Fashion - mixed media on canvas

Love it or hate it; this painting looks to depict how dentistry is largely represented within today's society, particularly on social media. Is this today's definition of beauty? Society appears to say so, particularly the younger generation. Today, an area of dentistry is identified rightly or wrongly with fashionable trends; a luxury buy, a priority before health. It took me quite some time to finish this as it played on my own professional values for some time during the process.



Endo Jelly – pencil on paper

After studying endodontics, I soon realised that treatment was as much about connecting with the tooth itself, visually and using 'soft skills', as it was about following a protocol. Endodontics was the first time that I had truly connected the science and art of dentistry. The importance of spatial awareness, tactile senses, and analysis are represented here using the jellyfish – its transparency represents the need to understand morphology, respect canal systems, and connect to the tooth. The jellyfish; enticingly fluid but can yield an unpredictable sting.





Clinical techniques

Prominent UK dentists and experts in leadership share their insights showcased

M

embers of the Faculty of General Dental Practitioners Scotland celebrated ten years of hosting their annual Study Day at the Glasgow Science Centre in December. Nearly 400 delegates gathered to hear presentations from Professor Avijit Banerjee and Professor Tara Renton, of King's College London, as well as talks on leadership, and to network and socialise.

The FGDP(UK) Scotland Study Day has been held every year since 1992 and is now one of the leading events in Scotland's dental calendar. At the latest gathering, dentists who graduated from Glasgow in 1984 and 1989 joined their colleagues during the day before an evening reunion meal.

At the same time, the full cohort of BDS5 students from Glasgow Dental School and the majority of their predecessors in VT (Foundation Year) joined a group of established dentists and recent MJDF graduates to represent the full spectrum of the dental community. Avijit Banerjee's talks outlined the

modern management concepts for treating the deep carious lesion in an adult. He described the use of some of the clinical operative techniques and bio-interactive materials available to restore teeth and provided appropriate clinical tips.

In Tara Renton's presentation on non-odontogenic pain, delegates were encouraged to consider patients holistically.

Her second talk was a thorough review of the evidence and techniques for local anaesthesia providing a compelling case for infiltration dentistry whilst avoiding systemic and localised complications.

The presentations concluded with the Caldwell Memorial Lecture on Leadership with Faculty board member, Sami Stagnell; NHS Lanarkshire's clinical director of general dental services, Laura Milby; and Major General Ewan Carmichael, founder of the Air Assault Medical Regiment, each providing their take on the subject.

This year's Study Day is on Friday 4 December at the Science Centre and features Professor Iain Chapple, Head of the School of Dentistry at Birmingham University; Professor John Whitworth, of the School of Dental Sciences at Newcastle University; and Steve Bonsor, Senior Clinical Lecturer at Aberdeen University's Institute of Dentistry, who will deliver the Caldwell Memorial Lecture.

More information: fgdpScotland.org.uk/glasgow-study-day



Delivering the best software

Expanding the modernisation of NHS claiming and payments from general dentistry into orthodontics

2019 was an eventful year for orthodontics in Scotland. As previously reported in this publication, NHS National Services Scotland expanded its modernisation of NHS claiming and payments from general dentistry into orthodontics, enabling and requiring electronic submission of GP17 Orthodontic claims for the first time.

From 1 January this year, all new orthodontic claims for prior approval or payments had to be submitted electronically. According to the NSS website on orthodontic system supplier details, there are four suppliers accredited for the submission of GP17(O) claims. They are Systems for Dentists (SfD), Software of Excellence (SoE), Dentally, and Carestream R4.

Historically, there were two major orthodontic software suppliers in Scotland. However, these companies have not opted to develop their solutions for eOrtho at this time, forcing their clients to seek other solutions.

More than 90% of specialist orthodontic practices chose Systems for Dentists (SfD) as their new practice management software supplier. This overwhelming majority shows an unprecedented confidence across the profession for the company.

Ryszard Jurowski, SfD's managing director, said: "The confidence and faith that the Scottish orthodontic

community has placed in us has been humbling. We are working hard to ensure that we engage directly with all stakeholders, allowing us to continue offering the outstanding service levels we are known for."

It is always good to see a company choose to put the client journey ahead of the bottom line. In this case, Systems for Dentists has ensured that its costs are competitive and continue to give back to their clients.

Friday 17 January marked this year's Scottish Orthodontic Conference at the Royal College of Physicians and Surgeons of Glasgow. During the course of the day, the orthodontic community was treated to a series of talks including modern cleft care as well as an update from SfD on current progress and plans for 2020. This event formed part of the direct engagement that SfD is planning with its orthodontic clients and provided an ideal forum for feedback and functional enhancements.

Adam Vernon, operations manager, commented: "I enjoyed presenting to the professions and was delighted to see how well they received our new features such as the common information screen. Overall, the team was impressed with how well the clientbase is utilising our software and engaging with us to ensure we are able to deliver the best possible software for orthodontics – both NHS and private – across the UK."

Moving forward, SfD will continue its significant investment in the orthodontic market. The company has developed some key relationships in the field and is working to deliver close integration with some key additional systems.

During his presentation at the Scottish Orthodontic Conference, Adam said: "There is no excuse of having to manually duplicate patient demographic information between systems. Where we find such waste we always try to integrate to mitigate human error and also ensure no time is wasted."

The company is already proving this with its current integration with virtually all digital imaging systems within the dental market and the team is taking this further with a focus on additional third-party software suppliers within the orthodontic field.

“

WE ARE WORKING HARD TO ENSURE THAT WE CONTINUE OFFERING THE OUTSTANDING SERVICE LEVELS WE ARE KNOWN FOR”

RYSZARD JUROWSKI

Top tips for submission

eDental programme aims to modernise payment and prior approval processes

NHS NSS Practitioner Services Division (PSD) continued to implement its eDental programme throughout last year and made it clear that the deadline of 1 January this year would not be deferred again.

The eDental programme aims to modernise payment and prior approval processes for dental practices. By last summer, mandatory electronic payment claims for all general treatment were complete and all practices had access to electronic payment reports through PSD's e-Schedules service.

Specifications for the eOrtho payments/interim payments and prior approval were originally issued to the two specialist orthodontic system suppliers and all the general practice system suppliers in October 2017.

The original plan was that all orthodontic cases, whether payment or prior approval, were to be submitted electronically by 1 January last year. However, due to a lack of progress by the specialist suppliers, and following concerns raised by the BDA, the implementation date was deferred until 1 January this year.

The PSD had completed development work on its internal system towards the end of 2018 and went live with the system in March last year. It held orthodontic specialist practices events during 2019 to support dentists.

The first PMS supplier went live in May last year and other practice management system (PMS) suppliers continued development work to update their software and implement electronic services. For the current position of each supplier, visit: tinyurl.com/w8mevzh.

PMS supplier testing has been undertaken in two parts. 'Fit for purpose' tested the technical connections and communication channels between the PMS and PSD (which could only take place once a PMS provider had completed its own development and own in-house testing and declared themselves ready testing). Following the 'fit for purpose' process, accreditation took place

in which the PSD tested a set of valid business scenarios.

Last October, NHS NSS reminded practices that there is no web form solution available for orthodontics and therefore, if undertaking orthodontic activity, they should ensure they have a PMS which has been accredited for electronic orthodontic payment and approvals in order to be able to submit from 1 January.

From the practices who had transitioned across already for eOrtho, NHS NSS passed on some top tips that will help practices avoid any delays in processing:

1

When submitting physical evidence, mark on the box submitted, "eOrtho"

2

Only send the updated electronic submission request when the physical evidence has been sent

3

If a practice receives a response requesting evidence for an IOTN 5 case, ensure you supply all relevant photographs and radiographs

4

If using discretionary code 3999 01, practices must add observations

5

If you are submitting electronically, do not submit the paper GP17-O as duplicate

The way in which dentists communicate with their patients is fundamental to the delivery of care, patient adherence, positive clinical outcomes and to the notion of person-centred care. In line with General Dental Council guidelines, the provision of person-centred care has become central to the undergraduate dental curriculum and to dental practice more widely.

Research suggests that the power dynamic that exists when a patient enters the dental surgery means that, for some patients, they are unlikely to feel able to participate fully in a patient-centred consultation and to engage in shared decision making.

One of the challenges that researchers and academics face when teaching the next generation of dentists is to demonstrate how the power inequalities within the dentist/patient relationship can be reflected and reinforced through particular speech patterns and vocabulary. This is essential if students (and practising dentists) are to become more aware of how they might adapt their speech to make the dynamic between the patient and dentist more equal and balanced.

There has been limited research undertaken into person-centred communication within a dental setting, although communication in healthcare settings more widely has received significant attention. Psychologists suggest that it is not just what is said but the way that it is said that is important; termed paralinguistic communication.

Gestures, posture, pitch, eye contact or lack of it, proximity, facial expression and the like can all help people interpret what is being communicated. Current methods for looking at communication in clinical settings focus on verbal and non-verbal communication but little attention is paid to paralinguistic aspects of communication. There has been no work undertaken, to date, on the speech dynamics that exist between dentists and their patients.

With this in mind, the aim of our project* was to develop a methodology or process that would enable the visual and audio re-presentation of speech patterns and rhythms present in dental interactions. The theory of communicative musicality provided a starting point to explore rhythm and pitch in dental consultations.

Communicative musicality

Communicative musicality is the theory that human interaction is intrinsically musical in nature. The term was developed through research on mother/infant communication to

Communicative musicality in dentistry

Understanding how a mother interacts with her baby could improve care

describe the way in which emotions are communicated through a series of rhythmic exchanges. Acoustic analysis on the vocalisations of mothers/baby dyads in this study showed noticeable patterns of timing, pulse, voice, timbre, and narrative. This follows many of the rules of musical performance and led to the term communicative musicality. The theory of communicative musicality has been used to look at the impact of rhythmic exchanges on hospitalised infants through the use of live music therapy. The study found that infants who received music therapy were less irritable and cried less when interacting with adults. Using a similar methodology, a study (Robb L., 1999) also found that depression changed the rhythm and pitch of communications between a mother and her infant with postnatal depression resulting in vocalisations that were lower-pitched and quieter with longer pauses between sounds. This illustrates the potential importance of pitch and rhythm in communication in clinical settings.

Method

This proof of concept study drew on an analytical mixed method approach to compare traditional thematic analysis of qualitative interviews with dentists to a paralingual analysis of the rhythms and pitch of the speech. Five dentists working in Special Care Dentistry and/or with anxious patients in primary and secondary

care settings were interviewed by an experienced qualitative researcher. The dentists were asked about whether patients could be classified as 'easy' or 'challenging' to work with and what makes a patient 'easy' or 'challenging'. This notion drew on research regarding patient/clinician interactions and good/bad patients and was picked to provide the potential for positive and negative speech within the interviews. The recordings of dentists talking about their work and the content of the speech were then analysed separately and independently in two ways. A thematic analysis of the recording was undertaken using a framework developed around the hierarchy of the PCC in dentistry model.

Concurrently, a rhythmic analysis was undertaken to map key dynamic distinctions such as power, authority and empathy and the rhythmic patterns within the speech. The first analysis focused on the language used and the second focused on the rhythms rather than the words.

Thematic analysis

Each interview was coded using a framework derived from the 'hierarchy of PCC in dentistry' model. This model incorporates different styles and contents of communication in a dental consultation. The foundational components of the model are: context, a holistic approach, the ethos of the relationship and shared

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responsibility. The provision of information, choice and control then build from these foundations. Each interview was mapped to the model. Narrative accounts of each interview were also created and, along with the coding and mapping, this enabled us to rank the five interviews in relation to their level of person-centredness.

Concurrently with this analysis a rhythmic analysis was also being undertaken.

Rhythmic analysis

For this analysis the interview recordings were mapped to determine distinctions, differences and speech qualities. The purpose of this was to see whether the specific dynamics of speech can be heard rhythmically. Once the interviews were recorded, the rhythmic patterns within the speech patterns could be considered in isolation, regardless of the language content of the interviews. To facilitate this, the interviews were sped up by 35% so that the patterns, rhythm, and pitch could be easily heard. The central section of each interview was selected as it had the least amount of peaks and troughs, hence giving a more comprehensive perspective of the speech patterns.

Initially a visual image of sound waves for each interview was created. This gave an insight into the variation of each speech pattern. Within these images the pitch and tone were clearly displayed and the density of the patterns revealed the rhythm and the way in which this fluctuated throughout the sections selected.

Dance theorist Gabrielle Roth's 5Rhythms were combined with the five elements of Chinese philosophy (Flowing/Water, Staccato/Wood, Chaos/Fire, Lyrical/Earth, Stillness/Metal) and were used to map the interviews. Each element was further divided into Yin and Yang, which stand respectively for the patriarchal, nurturing and patient-led model of health care and the patriarchal, authoritative and bio-medical led model. Key words were used for each element and each quality.

The dynamics within each interview were also considered. In order to make this explicit, a set of notations was drawn up, using five stanzas to categorise and mark where the speech patterns were distinctive and exceptional. By careful listening, it was possible to mark the distinctions within each speech pattern and to respond accordingly. This mapping process was undertaken three times, in order to triangulate the results and see whether the process was effective. The response consisted of coding the

dynamics, using the elements, and additionally categorising them as Yin or Yang: masculine or feminine.

The words used were mapped to the notation and the two analyses came together. When listening to the interviews, it was evident that the rhythmic patterns changed according to what was being said; for example, when discussing types of patients, most interviewees spoke more distinctly and rapidly. It was interesting to hear the silences and to note there were different types of silence, i.e. interviewees were silent when thinking about how to respond to a question, and again when they had said something specific, as if to let the weight of what they had said settle.

Results/Evaluation

The final stage of the process was to evaluate the rhythmic analysis and see if the rhythm rankings matched the thematic analysis for person-centredness. The abstract nature of the re-presentations encouraged an intuitive response. The visual re-presentations were presented to a mixed audience of 42 artists, dentists, academics, and members of the public. Alongside each set of visual re-presentations, the rhythmic analysis was performed by Dr Christina Lovey in the form of tap dance. The audience was asked to listen to the rhythms and fill in an evaluation form, which included three questions:

1. Which of the dentists do you find most pleasing in terms of their re-presentation?
2. Which of the dentists would you most like to visit for a consultation?
3. Which dentist would you choose to make an appointment with for a vulnerable family member?

Discussion

The evaluation of our rhythmic and visual re-presentations of dentists' speech suggests that there may be some correlation between the person-centredness of the dentist and the perception of their paralinguistic speech patterns. This suggests that the theory of communicative musicality may provide an alternative way of getting dentists and dental students to think about not just the content of the speech in consultations but also the

ways in which they speak.

This method has the potential to enable us to use communicative musicality as a way of better understanding dentist/patient interactions in a number of ways. In the short term we have developed a method to enable the use of visual and audio formats to re-present elements of speech dynamics in patient/clinician communications. This can be used to supplement existing teaching in the undergraduate dental curriculum around communication and the provision of person-centred dentistry. It can also be used as a way of representing communication through alternative (non-written or spoken) modes to dental professionals more widely. Analysis of the communications between dentists and their patients would also allow us to compare both the content and the rhythms of speech of the different participants in the consultation and create a visual/audio representation of the interaction. We could then look for rhythmic, pitch and tonal indications of power, empathy, consensus and the other aspects we might expect to find in a consultation. Further research is needed to explore the impact of gender and accent on the rhythmic presentations.

Conclusion

The conceptual work we have undertaken has the potential to be impactful in several ways. It could be used as a demonstration within a teaching context to raise awareness of the importance of speech patterns. It could be used to provide examples of how to better communicate with patients or of contrasting approaches that currently exist within dentistry. It could also help aid discussions about power in dental consultations and consideration of the patriarchal model of health care and the alternative patriarchal perspective.

* kcl.ac.uk/cultural/projects/2018/communicative-musicality

Full article – with tables, pictures, and references
– available at www.irelandsdentalmag.ie/communicative-musicality-in-dentistry



ALONGSIDE EACH SET OF VISUAL RE-PRESENTATIONS,
THE RHYTHMIC ANALYSIS WAS PERFORMED IN TAP DANCE

GDC probes Practitioner Services

Regulator to investigate allegations that dentists were forced to repay fees ‘under duress’

As outlined in our news story on page 9 of this edition, the recovery of fees paid to dentists by NHS NSS Practitioner Services Division (PSD) is under scrutiny as the result of a referral to the General Dental Council (GDC). The case centres on the activities of the PSD and the conduct of two dentists in the division in helping to recover millions of pounds from practitioners over the past 15 years.

The activities are claimed to include:

- The PSD working to a minimum recovery target of £200,000 a year
- The use of sampling, whereby a decision on the validity of thousands of treatments carried out over many years is based on the result of checking a very small number of patient records
- Dentists being threatened with referral to the GDC if they did not cooperate with the PSD and agree to repay fees
- Demands for the return of fees paid more than five years previously; an invalid claim under Scottish law
- Repayment of contested treatment fees being taken from current earnings, without consent; which is not permitted under Scottish law
- PSD's handling of the 80% 'patient contribution' portion of recovered fees, amounting to several hundred thousand pounds, which should have been returned to patients
- Historical attempts by the Scottish Government to part-fund an increase in fees paid to dentists in 2015-16 using money previously recovered.

Publicly available details of PSD's recovery activities go back as far as 2010. The annual report of the Scottish Dental Practitioners' Board (SDPB) for 2010/11 notes: "Throughout the year, PSD – working to the policies of the SDPB – has challenged or declined prior approval requests of some £5m and recovered circa £900,000 from practitioners."

Minutes from a meeting of the SDPB in August 2016 record the recovery of more than £500,000 from dentists over the previous year. In November 2017, committee members were informed: "Historically PSD had been

baseline funded to recover £200k [a year]". In May 2018, the minutes noted: "A baseline recoveries value of £200,000 had been agreed with the Scottish Government."

Dentists contacted by this magazine have spoken of a "climate of fear" created by PSD during their interactions. "I felt that I was only agreeing to repay fees under duress," said one. "It was a case of 'co-operate, or we'll start digging deeper'. Worse still, there was the constant threat of being referred to the GDC and possibly losing my livelihood."

Now, two officials who work and have worked at the PSD have themselves been referred to the GDC. The move follows the loss by the PSD of a case at the Court of Session two years ago involving disputed recoveries and the PSD's 'walking away' from another similar case at Edinburgh Sheriff Court in October last year.

In 2018, after a four-year dispute, Edinburgh dentist Joanna Adamczak-Gawrychowska successfully challenged the PSD's attempt to recover more than £70,000. Following a Judicial Review at the Court of Session, Lord Arthurson described the case against her as "irrational and unfair" and based on a "miniscule sampling" of 33 patient record cards. By the time she launched proceedings, PSD had recovered £48,000 from Ms Adamczak-Gawrychowska.

Last October, the PSD walked away from a scheduled hearing at Edinburgh Sheriff Court at which they were attempting to recover £16,000 from Glasgow dentist Hugh Taggart. It was the culmination of an eight-year dispute in which Taggart was forced to sell two practices he owned, cash in pensions, and feared he would need to sell his home.

At one point during the dispute, PSD said that he was liable to repay more than £53,000 after initially being identified in 2011 as an "outlier" concerning the use of a particular treatment (the provision of acrylic occlusal splints). At the time, he provided 11 patient records cards, as requested by the PSD, but heard nothing until 2014 – when he was told that he had again been identified as an outlier.

On this second occasion, he was given 14 days to go through 20 years' worth of patient record cards and submit each one involving the disputed treatment. Taggart challenged the demand and the PSD responded by asking

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for just 20 cards instead.

At the beginning of 2015, he attended two meetings at the PSD in Edinburgh where he had expected to go through the cards and discuss the validity of the treatment. Instead, he said, he was threatened with a wider investigation by the PSD – and referral to the GDC – if he did not repay the £50,000-plus sum demanded.

Without his consent, the PSD began deducting between £1,200 and £2,100 a month from future fee payments. Taggart lodged a writ at Edinburgh Sheriff Court challenging the deductions and they stopped. But the PSD's legal team told Taggart's lawyer that, while they believed his claims for payment were neither fraudulent nor inappropriate, he had not complied with "the spirit of the rules and regulations"; a claim which Taggart said would have been contested by an expert witness prepared to give evidence on his behalf.

Taggart was told that he would be reimbursed – but that legal action would then be taken to recover the sum all over again. His lawyer countered by arguing that the PSD had unlawfully taken money off future earnings without his consent and had breached the five-year limit on reclaiming a debt, by seeking money going back 20 years. The PSD backed down and agreed to repay Taggart, including interest, a sum of £27,000.

Bizarrely, the PSD continued with its counterclaim to recover the money. On three occasions a hearing date was set, but each time the PSD delayed proceedings. Finally, a four-day hearing was scheduled for 21 October last year, by which time the amount the PSD was seeking had fallen to £16,000.

A few days before the case was due to start, the PSD walked away – stating that there was no "public interest" in pursuing Taggart for such a small amount. It also agreed to pay him £18,000 in expenses. Investigators at the GDC are

now likely to examine closely the email exchanges, public statements, and legal submissions of the PSD officials which form the basis of the referral to the GDC, in order that they can investigate the veracity of Taggart's allegations and rule on the officials' conduct.

The minutes of the Scottish Dental Practice Board will also be scrutinised. They detail discussions about:

- The practice of the PSD recovering patient contributions at the same time as expecting dentists to refund patients directly. In Taggart's case the PSD was reclaiming around £2,700 in patient contributions before he issued his writ
- The linking of recoveries to the future funding of dentists' fees
- The failure of the PSD to publish "plain English" guidance for dentists to reduce "mis-claiming and the need for recoveries".

In his referral to the GDC, Taggart states: "The public has an expectation that dentists who are employed in a managerial position will act in accordance with the rules and regulations which all dental professionals are expected to adhere to and in addition will act to safeguard them.

"I feel that their conduct towards the general public and the dental profession, as illustrated in the minutes of the SDPB, and their conduct towards me is redolent of individuals who, on having had a public office conferred on them, abuse the authority that attends to the office."

In addition to the responses to claims outlined in our news story, a spokesperson for the PSD said that, while publication of a guide for dentists had been discussed by the SDPB, it had been "agreed with the BDA/SDPC that a face to face approach would be more effective. Since then, we have run nine evening roadshows, 12 mandatory training sessions for dentists coming to Scotland, and increased engagement with vocational trainees."

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Replacing the Dental Practice Board

A new national dental governance structure is taking shape



“ *The role of the Scottish Dental Practice Board (SDPB) has been poorly understood by the profession and a clearer remit and individual accountability might be a good idea.”*

“ *I have been a practice owner in Scotland for 30 years and have little notion as to the function of the SDPB, save what I read on the internet.”*

“ *The dental community confuses the SDPB with Practitioner Services.”*

“ *Never been a fan of the SDPB. Vested interests abound.”*

“ *You would be hard pushed to find a practising dentist who doesn't feel that SDPB treat all of us as though we are fraudulent.”*

When the Scottish Government published the results of a consultation

on its proposed Oral Health Improvement Plan (OHIP) in 2017, the perception conveyed of the Scottish Dental Practice Board was, to say the least, not positive. Even the Board itself recognised that change was needed: “Of the options listed in the consultation document, SDPB believes the ‘do nothing’ one is the least appropriate,” it said in its own response.

The Board's role is defined in statute, dating back to 1997 and updated in 2010, and its main responsibility is the authorisation of payment of fees to dentists in accordance with regulations. But, the Board noted, “the developments in primary care dentistry over the last couple of decades have moved us well beyond a focus on payments, towards a far wider spectrum. Even the payment system itself is far more extensive than it was, and the Board's formal interest relates only to the ‘traditional’ elements.

“In addition, the management arrangements for delivering the operational functions on behalf of the Board ... changed with the creation of Practitioner Services in the 1990s; and its place within NSS [NHS National Services Scotland] has also changed over the years. All of this is effectively recognised in the consultation document. The value of our current limited role is, therefore, correctly challenged in the consultation. This then leads us to consider another option – to simply

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dispense with the Board.”

Scroll forward three years, and the SDPB is still in existence. When the Government published its OHIP in 2018, one of the proposed actions was to “consider how the functions of the SDPB can be subsumed within NHS NSS (National Services Scotland)”. While legislation would be required to formally dispense with the SDPB, that process of transferring responsibilities is now well under way.

The functions of the SDPB continue to be protected by legislation and any formal adoption of its functions is contingent on legislative change. However, two preliminary meetings of its effective replacement, the National Dental Governance Committee (NDGC), have been held so far; at the end of last year and last month. Any decisions made by the NDGC will still have to be endorsed by the SDPB.

Subject to formal approval by the Government, the NDGC will be a sub-committee of the NSS Clinical Governance Committee, “reflecting

“

TRANSPARENCY, COLLABORATION AND CONSULTATION ARE INTRINSIC TO THE DEVELOPMENT OF THESE STRUCTURES”

PAUL CUSHLEY



A recent preliminary meeting of the National Dental Governance Committee

NSS's unique position within NHS dentistry in Scotland, where NSS provides a number of services on behalf of all the territorial NHS Boards". NSS makes payments to NHS dentists on behalf of the Health Boards for the provision of NHS dental care throughout Scotland.

It ensures that treatment and payment is in accordance with NHS regulations. NSS is also the only source of clinical reassurance on the quality and appropriateness for NHS Boards of the NHS dental treatment provided or intended by dentists through NSS hosting the Scottish Dental Reference Services (SDRS).

Under the proposals, the NDGC will meet and report quarterly and publish an annual report. The agenda and minutes will be published online, and meetings will be open to the public. The committee will include a 'Stakeholder Council', comprising representatives from NHS Education for Scotland, the British Dental Association, Scotland's Dental Directors, the Scottish Dental Practice Adviser Group, and the Health Boards' dental services administration staff.

The committee will be chaired by the NSS Dental Director, currently Paul Cushley. Two representatives from Practitioner and Counter Fraud Services, including the Senior Dental Adviser, and a representative from the office of the Chief Dental Officer will also attend.

The new governance structure

will also more accurately reflect the contribution that NHS Education Scotland makes in developing and maintaining skills and knowledge in the workforce and how this positively impacts on performance. While the increasing role of Health Care Improvement Scotland in Quality Improvement is not currently reflected in the membership of the stakeholder council, representation is being actively considered.

Responsibility for the strategic direction of the Scottish Dental Reference Service will sit with the NDGC, while Practitioner Services will retain the day-to-day management of the service. A separate project is under way with NSS to standardise payment verification across Scotland's 14 health boards. The NDGC, it is understood, will use "high level strategic information around performance to allow comparison and challenge performance".

Paul Cushley said: "The reinvigoration of the governance arrangements gives NSS an opportunity to address many of the criticisms outlined in the Oral Health Improvement Plan. Previous structures have served us well in the past, but the review and changes are required to ensure that structures and processes are fit for the 21st century and are able to adapt to the new model of care and the new SDR going forward. Transparency, collaboration and consultation are intrinsic to the development of these structures."

Functions of the National Dental Governance Committee

- › Where relevant, the NDGC may consult other bodies with an interest in clinical governance in NSS.
- › Engage with all other organisations involved in the delivery of dental services to develop the provision of General Dental Services in Scotland.
- › Establish and foster formal links with all other regulators operating in the dental domain in Scotland to aid consistent regulatory compliance and improve quality assurance.
- › Determine the priorities and authorise the strategy and policy of the Scottish Dental Reference Service (SDRS) with regards to clinical assurance.
- › Set the operational targets for the Scottish Dental Reference Service and scrutinise the performance of the Scottish Dental Reference Service with regard to these targets.
- › Establish a mechanism to deliver, on behalf of the territorial Boards, a consistent national appeals mechanism for orthodontic decisions made by PSD.
- › Review the Payment Verification process (with particular regards to the part 2 clinical governance information) to establish mechanisms to maximize the value of and use the high-level data to help improve Boards' performance.

A DIGITAL DECADE IN DENTISTRY

We are continually moving forward, gaining experience from technology; even from tech that will be rightly consigned to history

[WORDS: SUSIE ANDERSON SHARKEY]

AS I AM WRITING THIS, WE HAVE entered into, not just a new year but also a new decade. New Year is a time traditionally for both reflection on the past year(s) and a look forward to what lies ahead. It's fair to say that as we look back on the last decade in the dental industry that a lot has happened. Perhaps one of the biggest changes has been the use of 21st century digital technology in every part of the workplace.

In reception over the past few years we have seen the rise of using a tablet that enables patients to fill in and/or update their personal information. This not only saves time at reception but also enables the patient to fill in private details without having to be taken into a different room for a confidential chat. Any information that is filled in by the patient is automatically stored into their patient records online and eliminates the use of filling in a form by hand, the receptionist scanning it into the patient records and then shredding the document. Any changes recorded by the patient can be discussed with the dentist privately in the surgery. We have been using the Clinipad in our dental practice for about four years now and, overall, it has been well received. However, we do still keep a blank paper medical history for our elderly patients who have never used a tablet. Patients can sometimes be wary of change and it's important that adequate training in the whys and wherefores of new technology is made available to front of house staff.

Another change at reception we have seen over the past few years is the ability for patients to choose their appointment times and dates online without having to call the surgery. This puts the patient in control of their appointment, not to mention the actual time of making the appointment, which can of course be anytime day or night as there is a 24-hour access to the appointment-making system.

In the surgery there have been huge leaps and bounds in the past decade regarding the digital aspect of practice. Many practices

now use a digital scanner for the scanning of impressions which takes away the need for the use of alginate, patient gagging, inaccurate impressions, longer waiting times; the list is endless. Anyone who has used, or is using a digital impression scanner, will know exactly the benefits to the practice and patients. Alongside the use of the digital impression scanner is the use of CAD/CAM technology which enables the dentist to fabricate the crowns, inlays, onlays and/or veneers chairside, thus enabling a single visit prep and fit which busy patients value. Obviously, there are outlay implications regarding the use of digital workflow but speaking to one of the well-trained reps should produce a solution which will enable the dentist to offer this as a desirable option of patient choice. And if there is one thing we are well aware of, the patients do have a choice of when, where and how they will spend their hard-earned cash.

The use of digital x-rays, although this has been around for more than 10 years, has come on immensely in the past decade as has the use of CT scanning. We have also seen in more recent years the use

of dental 3D printing and I have used a digital printer on a number of occasions to print out models for teeth whitening. It is a fairly straightforward technique, the huge benefits being of course precision, accuracy and productivity. 3D printing is easily incorporated into the digital workflow and is useful not merely for teeth

whitening but for producing for example prosthetic models for crowns and bridges, removable partial dentures, surgical guides, again the list is (almost) endless. 3D printing is probably one of the newer kids on the block and it remains to be seen how the industry will embrace this technology.

So that, my dental colleagues, is a brief overview of a very few technological advances that have emerged in our industry in the past decade. There are of course many more, but space does not permit me to include everything. In looking into the next decade, what can we expect from an industry where there is still much room for advancement and improvement? As must be, we are continually moving on, moving forward, gaining experience from technology that has worked, and also from technology that perhaps will be rightly consigned to history. As human beings, we are very inquisitive (some may say nosey) creatures and this has led to great development and introduction of new technologies in every age. I'm hoping that this new decade will prove to be no less the case and we can look forward to some exciting advances in our industry in the next decade.



WE HAVE BEEN USING THE CLINIPAD IN OUR DENTAL PRACTICE FOR ABOUT FOUR YEARS NOW"

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

JUST BECAUSE THE DOOR CAN OPEN, DOESN'T MEAN YOU HAVE TO WALK THROUGH

The new way of health and beauty brings great opportunities, but also significant risks

[WORDS: ALUN K REES]

EVERY DENTIST HAS EXPERIENCED that elated feeling of pushing at an open door. It often comes after a period where it feels as if every patient has rejected, declined, or even demeaned your suggested treatment plans. You have come to feel as if every patient you see has been inoculated to say: "If it ain't broke, don't fix it, doc". Your self-esteem is wobbling, and you start to doubt the wisdom of learning all those advanced techniques, taught on expensive courses, which you justified as an investment that would repay itself many times over.

Then one day a new patient asks before you start your examination if you could do something about the position of their teeth; and their colour; and the size; and their shape.

"Yes!", you think – as the door inches opens in front of you.

"Of course, no problem," you respond, and reach for the camera.

Eighteen months later, as you are struggling to complete the "short-term" orthodontics, having already whitened the teeth beyond B1, the patient asks when are you going to make a start on changing the shape and colour of the teeth? Then, the killer punch; will everything be finished for their wedding, next month.

You make a mental calculation of surgery

time plus laboratory fees and realise that any profit has gone, and your pre-treatment assessment could have been better.

Dental caries, we are told, is a disease that is on the wane. The 80/20 rule, first described by Pareto applies, 80% of the disease occurs in 20% of the people and social status reflects incidence. Prevention works. Periodontal disease is widespread but treatable and is hardly going to employ a dentist full time.

It appears as if the future for dentistry is as part of the health and beauty industry where procedures will be largely elective. Certainly, the trilogy of drill/fill/bill, recall and do it again has changed over the past 30 years. Of course, there are still areas of deprivation with high needs, but they are the exception rather than the rule.

What is a dentist to do? You have built your practice on a cornerstone of prevention and health. The ear-to-ear restorations of the past are being superseded as members of the still dentate, baby boomers/heavy metal generation are moving towards the end of their lives – albeit bringing different challenges as their large restorations start to fail.

In the absence, or reduction, of disease dentists still have great skills, which can be used in different ways. The change in mindset from reactive to proactive prescribing



can be something of a quantum leap, after several generations of “check-up, prescribe, accept, treat”.

The new way of health and beauty brings great opportunities but also significant risks. For every individual adult who has slipped through the net as a teenager and been left with crooked teeth which look unappealing, are difficult to clean, and don't function well, there are those who will pay for treatment they believe to be a psychological magic wand. What we know is that you can't get on a BDS course at Hogwarts and there are no dental magic wands. Before

“

**BEFORE EMBARKING ON
LARGE TREATMENTS NON-
CLINICAL ASSESSMENTS,
AS WELL AS CLINICAL,
NEED TO BE EXEMPLARY”**

embarking on large treatments non-clinical assessments, as well as clinical, need to be exemplary. Much is written about educating patients and increasing their “dental IQ” and this is desirable and necessary when helping patients to change attitudes to focus on health and self-care.

However, the improvement in awareness can also bring dental consumerism – with greater expectations leading to a rise in potential complaints, which take time and skills to manage.

The old rules still apply but must be adapted and improved for different times.

- Know yourself, know your patient, and get the best for both
- Under promise and over deliver
- Never want to deliver the treatment more than the patient wants to receive it – and be prepared to say no
- Be clear about your limits and be prepared to refer early rather than late
- Beware of deadlines that are imposed by the patient. Only bleeders come first - elective means delivering at the chosen time, the right time for success
- Body dysmorphia is real, and on the rise especially in the young; fuelled by social media and its use of images
- Know that just because the door can open, does not mean that you have to walk through it.

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

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GETTING PAST THE DUE DILIGENCE STAGE – IT REALLY DOESN'T NEED TO BE THAT PAINFUL!

The list of questions to be answered when selling a practice can run to more than 40 pages; some thoughts on making completion easier

[WORDS: RICHARD PEARCE]

DD, DUE DIL, CALL IT WHAT YOU

will, refers to the vendor providing detailed information about the business (Practice), to the potential buyer. It happens after an agreement in principle has been reached for the sale or purchase (often called Heads of Terms or HoT's) and precedes the preparation of the Business Purchase Agreement (BPA) or Share Purchase Agreement (SPA).

Note: A BPA refers to a sale of goodwill and assets (normal in a single practice sale). A SPA would be used in a share sale or purchase (more likely in a group of practices operated as a limited company).

Due diligence is where you are asked (as the vendor) to answer an extensive list of questions and where it exists, provide the evidence to support your answer. Hopefully the questions are sensibly grouped into subject areas (and a template table provided where applicable), so you might have:

Financial

- Last three years' accounts (and management accounts for current financial year)
- Asset register (make and model of each equipment item, date purchased, estimated value)
- Details of all service contracts.

HR

- Associate and self-employed persons information (name, start date, specialisms, clinical hours or weeks, monthly gross for last three months, commission percentages)
- Employed staff information (name, position, DoB, annual salary, start date, any disciplinarys)
- Organisation chart.

Patients

- Numbers by category (Membership Plan, NHS, Med Card, PAYG etc.), who

have attended in the last 18 months. This list could run to 40 pages and this can be daunting to some vendors. So, here are some thoughts on completing the DD.

On receipt of the DD enquiries the ball is now in your court, as the vendor, as to how you will speed up or slow down the sale process. The DD enquiries are likely to come from the buyer's solicitor direct to you or via your solicitor. However, there is nothing to stop you, as the vendor, having prepared a set of answers to a standard dental practice DD, updating them where necessary and then forwarding them, as soon as HoTs have been agreed. It is only then you will get a sense of how quickly the purchasers solicitor operates and how much detail they are looking for. You will know this from the subsidiary questions they ask you. If you are selling to a corporate, their approach to the conveyancing process will be, as you would expect, formulaic. After all, they have done



it many times before and probably the same solicitor will have acted for them many times.

In practical terms, a laptop is required (a word on why a laptop, later) and a digital folder for each set of questions. Label each document starting with the number of the question you are answering (or providing evidence for) e.g. C8 – Asset Register. You will also need a scanner for registrations and registration certificates, contracts etc. Label these scans in the same way. You can then send an email for each section of the DD; and your subject line will, of course, start with your practice name.

A laptop is suggested due to the likelihood that you will want to keep the sales process confidential until completion. Hence, your laptop can be kept secure (physical and access) with all information kept off network. It may be that you bring your Practice Manager into the ‘circle of trust’

“DON'T BE DAUNTED BY DUE DILLIGENCE - IF YOU GET ORGANISED, LIKE MOST ELEMENTS OF BUSINESS ADMINISTRATION, IT CAN BE COMPLETED PAINLESSLY”

but many vendors do not as knowledge of an imminent sale can be very de-stabilising for staff. If you have a business manager, then delegate the whole process to them. This is just business, after all, and they should have all the required information at their fingertips and will have bought and sold businesses before.

Don't be daunted by DD – and if you get organised, like most elements of business administration, it can be completed painlessly.

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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A major haemorrhage following the routine removal of a lower first permanent molar: a case report

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Introduction

Arteriovenous malformations (AVM) are rare vascular lesions defined by the presence of abnormal arterial and venous channels connected without an intervening capillary bed. AVMs occur as a result of errors in embryogenesis and are present at birth but may manifest at any time^{1,2}. AVMs can be divided into slow or fast flow malformations depending on the blood flow through the lesion³. Vascular malformations rarely affect bone however 50% of lesions affecting bone occur in the skull and maxillofacial region and are termed intra-osseous^{4,5}. Despite the fact AVMs of the mandible are uncommon, there are a number of case reports in the literature highlighting these vascular malformations as a cause of major haemorrhage following exodontia^{6-12,15}. These case reports demonstrate how a simple extraction can turn into a life-threatening emergency. We report such a case of a 13-year-old female who suffered from a major haemorrhage following the removal of a carious lower right first permanent molar (46).

Case description

A 13-year-old female presented to her General Dental Practitioner with a grossly carious 46 (See fig 1) that required extraction. She had an unremarkable medical history and took no routine medication. Immediately, following an uncomplicated extraction of the 46, there was a significant bleed from the socket. An ambulance was called. The patient was taken to the Accident and Emergency department at the Queen Elizabeth University Hospital, Glasgow. The Oral and Maxillofacial team took a lead in the patient's care.

On arrival, the patient was biting on gauze inserted into the extraction socket by the General Dental Practitioner. The haemorrhage was controlled. On removal, there was immediate high flow bleeding from the

socket. The patient was in hypovolemic shock and required resuscitation with IV fluids and group specific blood. An urgent contrast CT angiogram of the head and neck was conducted.

This demonstrated an intraosseous lesion within the right mandible, supplied by an enlarged and tortuous inferior alveolar artery which entered a widened mandibular foramen and a larger vascular structure within the right mandibular ramus, which coursed anteriorly to the inferior alveolar artery. The two vascular structures were noted to be inseparable around the angle of the mandible (See fig 2 and 3). With this clinical presentation and radiological findings an intraosseous AVM was diagnosed.

Following the CT scan, the patient was transferred to the interventional radiology suite and underwent fluoroscopic guided embolisation and coiling to occlude the distal portion of the artery (See fig 4 and 5). Post embolisation the extraction socket was surgically explored and despite the radiological intervention there was immediate bleeding on removal of the haemostatic pack from the socket. The socket was repacked and Tisseel applied to the socket and buccal bone. An advancement mucoperiosteal flap was raised to cover the socket. Haemostasis was achieved. During the procedure the patient required packed red cells and vasopressors to maintain an adequate blood pressure. The patient remained ventilated in ICU overnight and extubated without incident the following morning. There was no further bleeding during a four-night period as an inpatient. The socket healed well (See fig 6) and there have been no further episodes of bleeding since discharge.

Discussion

Despite cases such as this being an extremely rare occurrence it is certainly not unique as demonstrated by the numerous case reports cited

in this article. As dental practitioners, it is important to be aware of clinical and radiographic signs of AVMs in the maxilla and mandible as the detection of such malformations is sometimes possible and could avoid creating an emergency in a dental setting^{13,14}. Clinical signs can include pericoronal bleeding^{6,7,13,15}, tooth mobility¹⁶, occlusal abnormalities, soft tissue swelling^{7,15,17}, mental nerve paraesthesia^{14,18,19} and local pulsation¹⁷ which may be visible or palpable. AVMs of the jaws show intraosseous osteolytic expansion on a CT scan but can have a variable appearance on plain-film radiographs²⁰. Such radiographic findings have been reported as a poorly defined radiolucency and can have a honeycomb or soap bubble appearance²⁰. These signs and examination findings are not specific to AVMs and indeed their radiographic features are variable and may mimic simple odontogenic cysts¹⁹. The non-specific nature of such clinical and radiological findings in association with the rare nature of such lesions makes diagnosis on a purely clinical basis challenging, particularly in the dental practice setting.

Conclusion

With this paper we hope to raise awareness of arteriovenous malformations within the dental community. Given the challenges in diagnosing such lesions there is the potential for such emergencies to occur in the dental setting. In presenting this case, we hope it will provide some reassurance to General Dental Practitioners that even in this worst-case scenario, simple measures such as packing a socket and applying pressure can arrest a haemorrhage. This case also highlights the importance of achieving such pre-hospital haemostasis as despite the fact it was achieved, the patient still required transfusions, inotropic support and a period in intensive care.



Figure 1 Pre-operative periapical radiograph of the 46



Figure 2 CT face with contrast

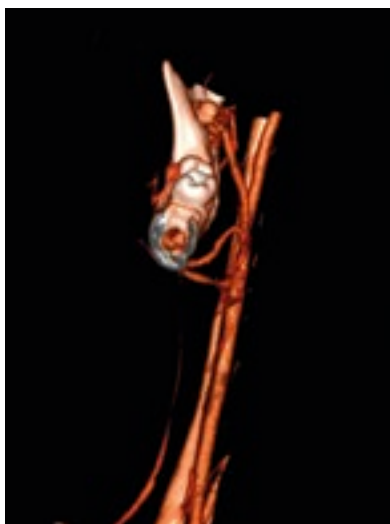


Figure 3 3D reconstruction of CT scan: vessels supplying right mandible

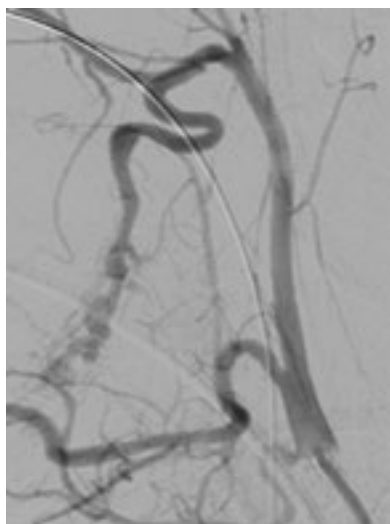


Figure 4 Fluoroscopic guided embolisation. Shows dilated and tortuous inferior alveolar artery pre embolisation.

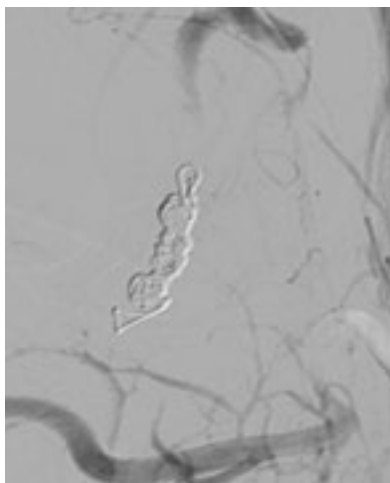


Figure 5 Fluoroscopic guided embolisation. Post embolisation.



Figure 6 Lower right first molar socket post-surgical intervention

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A successful autotransplantation using a technique pioneered at Glasgow Dental Hospital

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Figure 1: Clinical presentation of patient showing missing UR1 due to avulsion and supplemental lateral incisor distal to UL2



Figure 2: Acrylic Partial Denture in situ

Introduction

Autotransplantation of teeth in children is a recognised treatment option for carefully selected cases, such as repositioning an ectopic tooth or the replacement of an unrestorable or avulsed tooth with another tooth from the patient's dentition. It involves the transplantation of a tooth from one site into an extraction site or surgically prepared socket in the same patient. Autotransplantation survival rates range between 59.6% and 94% after 10 years.^{1,2,3} We present a case report of a successful autotransplantation using a technique pioneered at Glasgow Dental Hospital.²² The clinical and radiographic findings were supplemented with CBCT to plan the autotransplantation procedure.

A fit and well seven-year-old girl was referred by her GDP having avulsed her

upper right central incisor two weeks previously. The tooth was not found at the time of injury; therefore, it was not reimplanted. Examination revealed the patient to be in the mixed dentition with missing UR1 and a supplemental lateral incisor erupting distal to the UL2 (Figure 1). Sensibility testing of the remaining upper incisors was undertaken, and all teeth responded positively to ethyl chloride and electric pulp testing.

The UR1 space measured 8mm in width and the supplemental lateral incisor measured 6mm mesio-distally.

A cone beam CT scan to further evaluate the morphology of both the lateral incisors in the upper left anterior region and the available bone in the UR1 region showed:

- Absence of UR1 with no evidence of infection or retained root elements

- Supplemental incisal tooth with an open apex, normal root morphology and measuring 14mm in length from crown to root end.

For the purposes of space maintenance and aesthetics, an upper removable appliance was designed to replace the UR1. The patient was highly anxious and only managed a sectional impression, thus an acrylic-only denture was constructed and fitted (Figure 2).

The upper left supplemental incisor tooth was planned for autotransplantation into the UR1 socket under GA. Further eruption of the upper lateral incisors was encouraged to minimise potential surgical trauma during autotransplantation. The most distal upper left lateral incisor was extracted atraumatically (taking care not to damage the root surface) and transplanted under general anaesthetic into the UR1 site following socket preparation using couplands elevator and chisel.

Figure 3 shows the donor tooth after transplantation.

The gingival margin was sutured to stabilise the autotransplanted tooth and a flexible wire and composite splint was bonded to the transplanted tooth and one tooth either side. The patient was reviewed two weeks later, and a periapical radiograph was taken as a post-operative baseline of the stage of root development of the tooth and to confirm a satisfactory position post-operatively (Figure 4).

The splint was removed at four weeks post-surgery and at that visit, all teeth were responding positively to sensibility testing (Figure 5).

The patient was seen at regular intervals for review and sensibility testing. A periapical radiograph taken one-year post operatively (Figure 6) shows continued root development and pulp canal sclerosis of the transplanted tooth, demonstrating that it remained vital.

A sectional fixed appliance was placed on the upper anterior teeth (URC to ULC) for ten weeks to correct the midline shift and to create space for a composite build-



Figure 3: Donor tooth in situ after transplantation into the prepared URI socket



Figure 4: Periapical radiograph of transplanted tooth two weeks post-op

up of the transplanted lateral incisor to resemble a central incisor (Figure 7).

Following the eruption of her permanent dentition she underwent a comprehensive course of orthodontic treatment on a non-extraction basis (Figure 8). Her transplanted tooth remained vital throughout the treatment and a good aesthetic result was obtained (Figure 9). The patient is now wearing night-time retainers and the prognosis for her transplanted tooth remains excellent.

Discussion

Autotransplantation of teeth is a recognised treatment option in children with suitable clinical presentations. The main advantage is that it avoids the need for a prosthetic tooth replacement and uses autologous tissue – in the form of a tooth from the patient's own dentition – to preserve the periodontal ligament and facilitate favourable aesthetic outcomes.⁹ Implants are contraindicated in children as the implant will not erupt alongside adjacent teeth as the child grows.²² The literature demonstrates varying surgical success rates of autotransplantation, from 79% to 100%^{14,23} and thanks to a selection of studies and case series, we are able to identify factors which can improve the outcome for patients.

Autotransplantation ensures maintenance of the alveolar bone level by physiological stimulation of the periodontal ligament. Damage to the periodontal structures and root surfaces may induce ankylosis and external root resorption, which can lead to unfavourable results.⁵ Care must thus be taken to ensure the atraumatic extraction of the donor tooth and to minimise the extra-oral dry time.²² Another factor determining the success of the technique is the size of the recipient socket, which should be larger than the donor tooth to ensure minimal trauma to the periodontal ligament and root surface.⁹ For this reason, it is often necessary to carry out augmentation of the socket. In some

Figure 5: Clinical presentation after splint removal



Figure 6: Periapical radiograph showing continued root development and secondary dentine deposition in root canal of the transplanted tooth



Figure 7: Patient in the permanent dentition with successfully transplanted supplemental tooth replacing her URI



Figure 8: Comprehensive orthodontic treatment





cases, autotransplantations to existing sockets have been reported to have higher success and survival rates compared with transplantations to augmented sockets.^{10,11}

Recent developments in three-dimensional imaging and printing allow more detailed surgical planning including the construction of a surgical template of the donor tooth to contour the recipient surgical site, thus minimising damage to the donor tooth itself.^{22,23}

Root canal treatment of the donor tooth was not necessary after autotransplantation because the tooth showed evidence of continued vitality and root development. It is widely accepted that to achieve revascularisation of the pulp and successful periodontal healing in transplanted teeth, the ideal root development should be three quarters of the full root length.⁴ Success rates for the autotransplantation of developing premolars are reported to be over 80% when donor tooth root formation was between two-thirds and four-fifths of the total root length.^{3,10,12-18} Root canal treatment is necessary in fully developed teeth to halt the development of infection-related root resorption.⁴

There is no clear consensus about the method or time of splinting donor teeth after autotransplantation, however rigid fixation over a long period of time is unnecessary and may increase the risk of dentolavicular ankylosis.^{6,7,8}

This case required a short course of fixed orthodontic therapy. No root resorption was noted, despite it being a known risk of applying orthodontic forces to teeth. The influence of orthodontic movement on transplanted teeth in the literature is variable.¹⁹ Some studies state that the application of orthodontic forces did not affect root development² or influence the long-term prognosis²⁰ whereas others report slight surface resorption and shortening of the root in teeth that had undergone orthodontic rotation.²¹ Despite autotransplantation being a well-recognised technique, the amount of robust evidence in this specialist area of surgery is limited, with no randomised controlled trials reported in the literature. There is also a lack of studies with long-term follow-up of patients, with the average follow-up time in the literature being five to six years.^{19,23,24,25}

Conclusion

This case demonstrates that autotransplantation is a viable treatment option for a socket following avulsion. It details the stages involved in the treatment and planning of autotransplantation in suitable cases with appropriate donor teeth. Further follow up is required in these cases to determine long-term success.



Figure 9: Final occlusion following completion of orthodontic treatment

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Introduction of patient fees for removable retainers: an audit

Ritchie, C; Loh, PJ; Ngiam, C; Carney, A; Mossey, PA Dundee Dental Hospital and School

Background and rationale

Anecdotal evidence in Dundee Dental Hospital and School (DDH&S) suggested patients were receiving multiple vacuum formed retainers (VFRs) for non-clinical reasons, such as loss, breakage and poor fit due to non-compliance, with a detrimental impact on both clinical outcomes and resources. To investigate this and identify areas for improvement, an audit was conducted.

Objective

To determine the impact on retainer provision and patient compliance when introducing patient fees for VFRs on a non-profit basis.

Design, setting and intervention

A two-cycle retrospective audit was conducted within the orthodontic department in May 2018 and April 2019. A new Standard Operating Procedure (SOP) for retainer payment by patients was implemented within the department after Cycle 1.

Gold Standard

NHS Tayside health board and orthodontic consultants agreed that 100% of patients planned for VFRs should receive the first set free at debond, and thereafter a fee would be incurred for any replacements for non-clinical reasons.

Methodology

Following Caldicott approval, n=50 patients undergoing post-fixed appliance review between February 2016 and November 2017 were consecutively identified from laboratory records. Relevant information was extracted from patient notes and payment records by two investigators independently, in accordance with an agreed protocol, which was initially tested by a pilot study to validate the methodology. Inclusion and exclusion criteria were adhered to.

To check compliance with the new SOP, and examine its impact on retainer provision, a methodologically identical second cycle was conducted with n=52 review patients between December 2017 and April 2019.

Outcome measures, results and discussion

The primary outcome measures were a) the number of VFR replacement sets (defined as upper/lower/or both) received, and b) if a cost of £30 was incurred per replacement

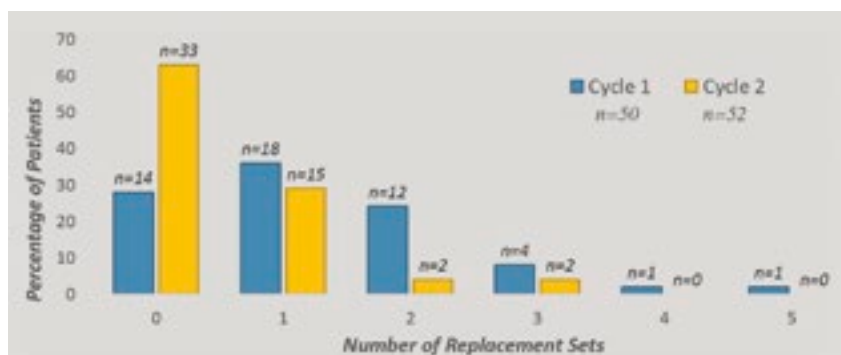


Figure 1

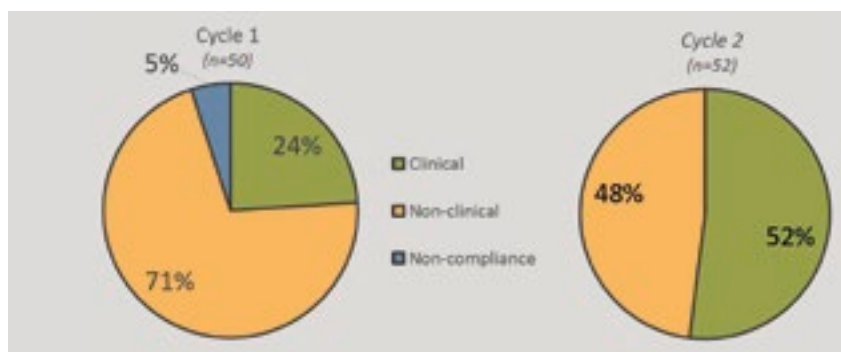


Figure 2

VFR for non-clinical reasons. The secondary outcome measures were a) the reasons for replacement VFRs, b) if patients were informed of the replacement fees in advance and c) retainer type.

Figure 1: Percentage of patients receiving replacement VFR sets

Figure 1 shows that the number of patients receiving replacement VFR sets decreased by 47%, from n=36 (18+12+4+1+1) in Cycle 1 to n=19 (15+2+2) in Cycle 2, following the implementation of the SOP. The maximum number of replacement sets per patient in Cycle 2 was three, in contrast to five sets in Cycle 1. Our results demonstrate 96% compliance with the agreed standard in that a patient received a set of VFR's at debond free of charge, and those patients receiving any replacement sets thereafter, for non-clinical reasons, incurred a fee.

Figure 2: Reason for Replacement VFR (% of replacement retainer sets)

Figure 2 indicates that 76% of VFR sets issued in Cycle 1 were due to non-clinical/non-compliance reasons. Only 24% of the replacement VFR sets were given due

to clinical indications such as bruxism wear or restorative input. After the new SOP implementation, replacements for non-clinical reasons decreased from 71% to 48%, and non-compliance was 0%. In only 52% of the patients was there a recorded note of having been informed at debond of the newly introduced charges for replacement retainers. Department compliance with the newly introduced payment SOP was incomplete with 33% (n=4) of retainers being replaced for non-clinical reasons without incurring a cost. It was also noted that 92% and 79% of patients received VFRs at debond in Cycle 1 and Cycle 2, respectively. When the new SOP is embedded in orthodontic clinical practice, even better compliance would be expected.

Take-home message

The introduction of patient fees for VFRs on a non-profit basis can reduce the number of patients receiving replacement retainers for non-clinical reasons. Retainer payments potentially could have played a role in changing patient attitudes to, and compliance with, retainer care. This could have beneficial impacts on clinical outcomes, financial resources and the

MDDUS CASE STUDY:

CHARGED AFTER A LATE-NIGHT STRAMASH

Remember, the GDC holds dentists to a higher standard of behaviour than is expected of the general public

[WORDS: AUBREY CRAIG]

DAY ONE

Ms D, a final year dental student, is out with friends for drinks in a busy city centre. Just before 11.30pm Ms D and two friends leave to catch the last train home. One of the friends cannot find her ticket and the station guard refuses to let her through the turnstile. An argument breaks out attracting the attention of two police officers. The station guard then accuses the three women of intimidation and racist abuse. All three are arrested and charged.

ONE WEEK LATER

An MDDUS lawyer replies to the GDC on Ms D's behalf, arguing that the decision not to register her is disproportionate. The letter makes the point that the charges at this stage are only alleged and that had the incident occurred when Ms D was already a registrant it would be highly unlikely that she would have been removed from the register even after an appropriate GDC investigation of the facts. Enclosed with the letter is proof of the offer to Ms D of vocational training conditional on her registration with the GDC. In addition are eight character references including one from the head of the dental school and another from a VDP trainer.

TWO WEEKS LATER

The GDC replies with a letter recommending that Ms D withdraw her application until after the criminal proceedings against her have been concluded. It advises her to obtain legal and/or professional advice before replying to the letter. Ms D is very upset and contacts MDDUS. She meets with a dental adviser and a lawyer to discuss the case and formulate a plan.

ONE MONTH LATER

The GDC responds to the letter refusing to approve Ms D's application on the grounds that she has failed to fulfil the "requirement of good character necessary for registration at this time". MDDUS immediately appeals

this decision. A hearing is held three months later before a registration appeal committee. The committee considers oral and documentary evidence, including reflective learning logs and CPD undertaken by Ms D since the registrar's decision. One of Ms D's professors attends to testify to her character and excellent academic and clinical ability.

A barrister instructed by MDDUS to represent Ms D submits that the registrar has given insufficient reasons for the decision and failed to take due regard of the fact that Ms D has only been charged with an offence and has denied it from the outset.

The criminal allegations remain unproven and are not material in assessing the issue of good character. Guidance from both the Professional Standards Authority and the GDC on the impact of criminal convictions does not refer to unproven allegations.

Ms D's barrister contends that the decision not to register her has had a punitive effect, resulting in the loss of her vocational training place, which was difficult to obtain given the very limited number of placements available. This has prevented

her from practising dentistry and presents the risk of Ms D becoming deskilled. The registration committee decides that the ongoing criminal proceedings are indeed relevant in judging whether Ms D is of "good character" but that the reasoning applied by the registrar is obscure and inconsistent given the character references submitted in the case. Taking account of all the evidence on balance, the committee decides that the appeal is upheld and the decision of the registrar is quashed.

Ms D is subsequently entered on to the GDC register – and she takes up her vocational training six months later.



FOUR MONTHS LATER

Ms D is on course to graduate and has secured a place on a vocational dental practitioner scheme starting in the summer. She has applied to register with the General Dental Council and, as required, declared that she is subject to criminal proceedings.

She receives a letter from the GDC to say that her application for registration is on hold pending further information on the outcome of her criminal trial, but the trial is scheduled for two months after Ms D's VDP start date. Ms D replies to the GDC stating that she has pleaded "Not guilty" to the charges and denies making racist remarks. She was only trying to calm down her friend who was angry and inebriated.

KEY POINTS

- Contact MDDUS immediately before making any representation to the GDC in regard to criminal charges or a potential complaint
- Be aware that the GDC holds dentists to a higher standard of behaviour than is expected of the general public.

“
CONTACT MDDUS
IMMEDIATELY BEFORE
MAKING REPRESENTATION
TO THE GDC

Aubrey Craig is head of dental division at MDDUS



A LANDSCAPE TRANSFORMED

Dargavel Dental Care is at the heart of a new and thriving community in the west of Scotland

Around 15 miles west of Glasgow, an extraordinary transformation of the Scottish landscape is under way. Where there was once a Royal Ordnance Factory, spread over 2,400 acres, there is now a growing community. Dargavel Village is an award-winning, multi-million pound development being built on the former munitions site and is one of the UK's largest, privately funded brownfield regeneration projects.

When complete in 2034, it will be home to 4,000 new houses, a business park, new primary school, community centre, retail and commercial units, leisure facilities and a community woodland park.

Since the factory ceased operations in 2008, the site's owners





BAE Systems, has been working closely with Renfrewshire Council, the Scottish Environment Protection Agency, and Scottish Natural Heritage to transform the site. Dargavel Village gets its name from Dargavel House, a Grade B listed 'Tower House' building situated within the grounds of the complex and dating back to 1514.

After three years of land remediation, construction began on the site in January 2013. Now, more than six years into the transformation, more than 1,000 households are enjoying the benefits of the development.

BAE's vision for Dargavel Village is to create an aspirational place for people to live and work and, in 2018, it won the 'Place' category of the Scottish Awards for Quality in Planning and a winner of the 'Excellence in Planning for Homes – Large Schemes' category at the prestigious Royal Town Planning Institute (RTPI) Awards for Planning Excellence 2019.

Last year saw the completion of further supporting infrastructure and the opening of the first phase of the retail park in the village centre. It is here that Dr Philip Byrne, owner of Erskine Dental Care, has opened his latest practice, Dargavel Dental Care. "It's a tremendous opportunity to be part of a thriving community," said Philip, who qualified from Glasgow University in 2002 and completed a Diploma in Implant Dentistry from Newcastle University in 2017.

At Erskine, Philip is responsible for implant and CT scan referrals and mentors referral practices in implant restoration. Dr Arlene McGuire, owner of Linwood Dental Care, who qualified from Glasgow University in 2010, also provides facial aesthetics for all three practices. Arlene is currently studying for an MSc in professional non-surgical aesthetic medicine at Newcastle University, having passed her first year with distinction.

Dargavel has two fully equipped surgeries, providing mainly NHS care; though there is a variety of private options available should patients choose. The practice comprises Dr Katie Crawford, who has a special interest in restorative dentistry and is active in charitable work (visiting Malawi and completing a dental project in Sydney), Dr Pamela Dickson, who completed her MJDF examinations in London last year, Dr Matthew Doswell, who is completing sedation training in London, and Dr Ryan Jenkins, currently studying towards his Post Graduate Clinical Diploma in Orthodontics.

"Philip and Arlene are amazing



WE ARE SO LUCKY TO BE PART OF THIS MASSIVE PROJECT WHICH IS TRANSFORMING THE AREA AND WE REALLY WANT TO BE AT THE HEART OF THE COMMUNITY" – LAURA PATERSON



employers sending staff on various courses," said Laura Paterson, practice manager at Dargavel, "including, Scottish Enterprise leadership and management, dental sedation, dental radiography, implant training, trainee dental nursing, and SVQ business administration at SCQF Level 6. As manager, I want all my staff to be fulfilled in their job roles; able to progress their skills and have new opportunities throughout their career."

Work to fit out the location at Dargavel began last summer, and the practice has been open since October. The team has benefitted from fantastic support and services provided by pckwikfix, the Glasgow-





based IT consultancy, SDI, the specialist dental materials supplier, Acteon, the dental equipment and products group, Belmont, the dental chair maker, and Dental Sky, the dental supply company.

"It's been a massive undertaking opening a new practice with no patients. However, with some marketing, social media, and word of mouth we are already seeing a bright future," said Laura.

"We are aiming for family centred NHS care, providing high quality dentistry that our patients can rely on at all times. We want to help each of our valued patients look after and make the most of their smile through general and cosmetic dental treatments in a safe, clean and comfortable environment.

"We want to be the local NHS dentist that the residents know and look forward to coming back to see. It's a beautiful village with the nicest patients. We are so lucky to be part of this massive project which is transforming the area and we really want to be at the heart of the community."

dargaveldentalcare.co.uk
erskindentalcare.com
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THE CUBE: AN AMAZING MULTIFUNCTIONAL SURGICAL DEVICE

My name is Adam Stokes and I cover the North East and Scotland for Acteon UK. Acteon specialise in the manufacture and supply of minimally invasive innovative technologies for dentists and dental professionals, which have been designed to diagnose, treat and educate patients with greater efficiency.

One of these is the Piezotome Cube, an amazing multifunctional surgical device. Although it is indicated for use with Sinus Lift, Intra Lift, Bone Surgery, Crest Splitting and Crown Extension, it is changing the way the profession views extractions.

We know that extractions are often unpredictable. Problems may arise if it's a molar or premolar with twisted or curved roots, a difficult location, a fractured root, ankylosed teeth or impacted teeth. We also need to remove the whole tooth and leave as much bone behind as possible,



especially when many more patients nowadays have implants.

Perhaps it's time for a re-think? Extractions with a rotary instrument lead to immediate destruction of bone while the Cube allows full socket preservation. With a rotary instrument there is a mandatory flap, a risk of damaging soft tissues, post-operative pain for up to two days.

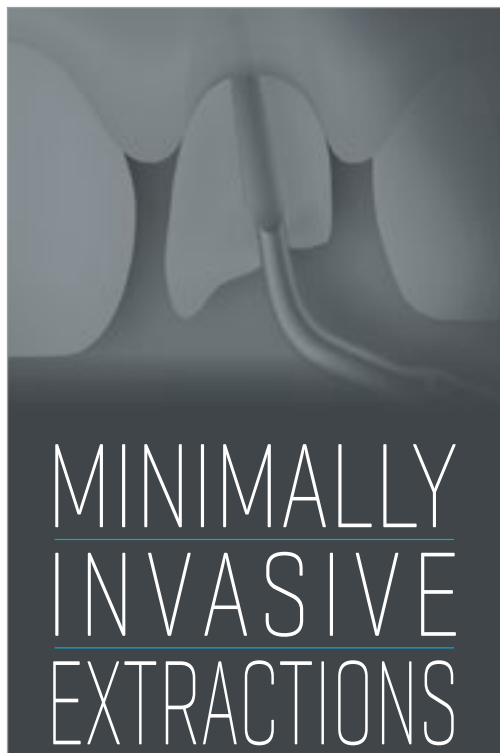
In addition, the procedure is physically

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taxing and dreaded by patients. However, when using the Cube there can be immediate implant placement, it is safer for soft tissues, there is up to 50% less pain and swelling, 98% less analgesics are used, and no force is needed. For the first time, Piezo surgery is powerful enough to carry out extractions in the same timeframe as using a rotary instrument.

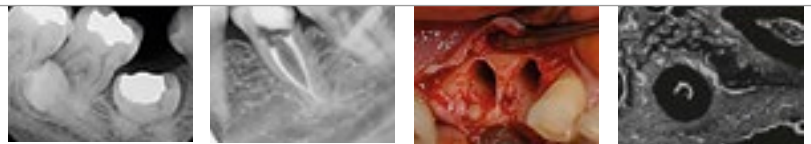
If this doesn't convince you, why not have a demonstration at your practice. I am always happy to pop in and chat about our great products, from Pure Reflect Mouth Mirrors, Piezotome Cube, Ultrasonic Newtron Scalers, to our CBCT Triums.

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CUBE



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INVASIVE
EXTRACTIONS

MADE PREDICTABLE WITH
PIEZOTOME
CUBE



Rotary Instrument vs. Piezotome Cube

- | | |
|--------------------------------------|----------------------------------|
| Immediate destruction of bone | > Full socket preservation |
| Mandatory flap | > Immediate implant placement |
| Damage to soft tissues | > Safer for soft tissues |
| Post-operative pain for up to 2 days | > Up to 50% less pain & swelling |
| Procedure is physically taxing | > No force is needed |
| Dreaded by patients | > 98% less analgesics are used |



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BUYING A PRACTICE – YOUR DREAM AND HOW TO AVOID IT BECOMING YOUR WORST NIGHTMARE

For many young dentists, from an early stage of their careers, one of their key aspirations is to buy their own practice. It is the chance to be their own boss, and to build a solid financial base for their future. It isn't for everyone, but a large proportion of associates see this as the way forward for them.

That is a very admirable aim in life, and with the right level of planning, can bring the anticipated rewards over time. But what is involved in taking that big step?

Rather obviously, the first step is to find the right practice. Looking closest to home, that might be buying the practice in which you currently work (or buying into it as a partner). In years gone by, that was by far the most common route to ownership and was viewed as a natural progression.

These days it is, however, much more common for an associate to buy a different practice to the one in which they work. It gives them a fresh start as a principal in a new setting which they can mould to their own plans.

Many practices are marketed by sales agents, and it is therefore a good idea to register with all of the main agents so that you will receive details as practices come to the market. That will ensure that you can track the practices which are available. The market is very buoyant, with lots of buyers out there, and so it is important to act quickly as practices are put up for sale, otherwise you are likely to miss opportunities.

You will have thought about what type of practice would suit you. Some of the key aspects to consider here are:

- Location – where do you want to work (and possibly live)?
- Size – are you keen to own a small practice or one with a larger number of surgeries?
- Type of practice – do you prefer NHS, private, mixed, practices which do specialist treatments, etc?
- Expansion opportunities – are you looking for a practice where you can add value, eg by adding surgeries?
- Price – last, but by no means least, how much can you afford to pay?

That leads us on to the all-important question of finance. Where is the money coming from to buy the practice? It may be that you are fortunate enough to have built up capital to use towards the purchase, or you may have friendly relatives who are happy to gift or lend money to you. In most cases, buyers need to turn to banks for loan finance.

The first point to make is that banks are generally very happy to lend to dentists. They see the profession as a very safe area of business and will go further in terms of lending than they would for many other business owners. They will of course require to be satisfied that all of the finances of the practice stack up, and ultimately that the bank don't see a risk that they won't be repaid.

They will also look at you as a borrower and gauge your ability to make the practice work. This is particularly true for an associate buying their first practice, and without a proven track record of running a practice. In this regard, the bank will be interested in your plans for the practice, their perception



Michael Royden,
Partner,
Thorntons Law LLP
mroyden@
thorntons-law.co.uk

of your abilities as a manager of people, etc. At Thorntons, we are very fortunate to have contacts with the Healthcare teams within all of the major banks, and so can make introductions for our buying clients when required.

In buying a practice, one of the key areas is diligence. This is the process of checking various aspects of the practice from a financial and a legal perspective. This is a whole subject in its own right, but having experienced lawyers and accountants (who regularly deal with dental practices) on your side will be a significant benefit to you in terms of ensuring that all is as you would expect with the practice.

Finally, and hopefully something which most buyers would consider at an early stage, do you feel ready to own and manage a practice? There is sometimes an assumption made by associates that they need to get on to the practice ladder as early as possible, and there are good reasons for that. However, making the transition to principal brings with it a wide range of responsibilities and challenges, and not everyone is fully equipped to take that leap. Knowing whether you have the necessary skills to make a success of a practice may be difficult to assess, but speaking to peers who have bought practices, or to your current principal, should help.

In the end, buying a practice is a very exciting venture, and if you go into the process well prepared and advised, that should make the whole experience much more straightforward and successful.



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The Dental Law team at Thorntons have years of experience providing specialist advice to dentists throughout Scotland.

“Michael Royden represented my interests in the practice sale highly competently, very efficiently, and with great judgement. He was diligent in seeking my views and consent at each key part of the negotiations. Thorntons were proactive, courteous, reliable, trustworthy and a pleasure to work with.”

- Michael Hopf

- ▶ Buying or selling a practice
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WHAT IS CONSIDERED 'NHS EARNINGS' FOR THE PURPOSES OF THE GP234 FORM?

The 28 February 2020 deadline is fast approaching! If you are eligible to claim for the rental reimbursements from the NHS, the Practitioner Services must receive this completed form by that looming date.

Part of the form requires the dental professional to assess the NHS earnings as a percentage of total earnings received by the dental practice and/or dental bodies corporate. However, in recent years many dental professionals have sought clarification of what is considered 'NHS Earnings' for the purposes of the GP234 form.

The definition of NHS Earnings, which is

required to be used for the GP234 form, is the proportion of income derived from General Dental Services (GDS) work only and reference should be made to the Statement of Dental Remuneration (SDR) where the interpretation of NHS Earnings is defined under 'Determination XV Reimbursement of Practice Expenses'.

In paragraph 2(2)(g): "NHS Earnings" means the dentist's gross earnings from the provision by him in person of general dental services under the National Health Service (Scotland) Act 1978. And in paragraph 1(1): "gross earnings" means in relation to reimbursement of practice rental costs,



If you have any questions in relation to the GP234 form, please contact Louise Grant (louise.grant@eqaccountants.co.uk) or call 01382 312100

excluding any remuneration by way of salary, from all the dentists within the practice from the provision, or assistance in the provision, by each dentist in person of general dental services under the NHS(Scotland) Act 1978.

It is very important to note that all private income, including private treatment which is an entire course or part of a mixed course of treatment, must be excluded from NHS earnings.

Any reference to NHS earnings defined for SDAI is not relevant for the purpose of reimbursement of practice rent and practices must comply with the definition quoted above.

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CONTINUED CONSOLIDATION

Practice owners with three or more sites will be acquisition targets for larger companies

It was a strong year for the dental sector in Scotland throughout 2019, with transactional activity increasing by 22% against the prior year. Expansion was a key focus for medium sized and corporate groups. Christie & Co observed continued demand across the country for all types of dental practices, although there was a steep increase in demand for private practices, with prominently located mixed practices continuing to sell for premium prices. Overall, the buyer pool remains active with first time buyers, single site operators and multiple operators fuelling activity.

One of the evolving features has been the growth in the number of multiple practice owners with three or more sites. Many of these will be acquisition targets for larger

companies, fuelling the continued consolidation that has become a feature of the market. We are seeing an increase in prices being paid, driven by higher multiples of EBITDA to reflect the shortage of such opportunities. Those that have high quality integrated portfolios with competent management teams are attracting significant premiums.

The shortage of associates remains a key challenge and shapes the expansion strategies of many corporates and multiple practice owners. This has led to buyers becoming more discerning in terms of location and practice type which has polarised demand for larger, better-quality practices in both NHS and private segments. Across the market we noted an increase in



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

average sale price of 5.4%, with larger practices operating in the private sector growing at a faster rate than their NHS counterparts.

Our market presence and transactional activity has notably increased over the last five years and our regional network assures an in-depth knowledge of the local markets within which we work. Analysis of buyer trends reveals that some 85% of independent purchasers acquire a practice within 50 miles of where they live, rather than relocating.

We believe that the market will continue to perform well in 2020 with demand from both the independent and corporate sectors. Traditional lenders will support buyers and a number of new challenger banks will enter the market.

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- A two-day CBCT course which fulfils your UK requirements – no need to attend a separate course
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- Academic modules and research project take place online from your home
- Course fees are all-inclusive. No hidden costs
- Achieve an MSc in two years instead of the usual three.

Places are limited and already filling up.

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2 years, part-time | Glasgow | October 2020

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17 Oct 2020: Treatment planning and case selection.

14 Nov 2020: Basic sciences for implant dentistry.

5 Dec 2020: Surgical skills for implant dentistry.

16 Jan 2021: Implant Design, biomechanics and overdentures.

6 Feb 2021: Restoring implants.

13 March 2021: Occlusion.

17 April 2021: Digital workflow in implant dentistry.

8 May 2021: Bone defects and their management; case presentations.

22 May 2021: Cadaver course.

5 June 2021: Complications and revision.

CBCT Masterclasses: Choose a date near you, to be completed by 5 June 2021.

Module DX4017: Utilising the evidence base – completed online

Module DX4016: End of year Assessment – date TBC

Complete 5 Clinical days - supervised clinical practice

You will assess and plan appropriate treatment for patients. Includes: case assessment and treatment planning, including use of radiographic stents and CBCT.

Introductory dinner - 16 October 2020

End of Year 1 dinner - 5 June 2021

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Complete 10 Clinical days - supervised clinical practice

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Prepare and submit a 8,000-word clinically orientated research project, which may take the form of a minisystematic review.

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BUYING OR SELLING: YOUR QUESTIONS ANSWERED

Martyn Bradshaw, an expert in valuations and sales of dental practices, addresses the key posers raised on both sides of the property purchase

IS THERE STILL AN ACTIVE MARKET FOR DENTAL PRACTICE SALES?

Absolutely, we have never been busier. There are thousands of dentists looking for practices to purchase, whether they are seeking their first practice to work in, an existing owner looking for an additional site, or a corporate.

In 2019, 46% of our practices sold to individuals and of the 'corporate' sales we dealt with, 41% were to dentists who bought multiple practices, showing that acquisitions are not just limited to the big names.

CAN YOU EXPLAIN THE TERM 'EBITDA'?

EBITDA stands for 'earnings before interest, tax, depreciation and amortisation'.

Amortisation – the depreciation of the goodwill asset – will only be applicable for those with limited companies. Put simply, when we as valuers are calculating EBITDA, we are looking at adjusted profit of the practice after adding back personal items (loan interest, personal insurances, spouse's wage, motor expenses) and tax reducers such as the depreciation.

It is then a multiple of this profit that is used to calculate the value of the practice.

ARE PRACTICES NOT VALUED ON TURNOVER ANY MORE?

No, whenever possible we will use a multiple

of profit (EBITDA). This is a far better calculation as the value is determined by the profit, and as such should always be affordable when the purchasers are looking for finance with the banks. If a practice is valued on turnover, it has no correlation with the profit.

Interestingly, we reviewed all of the previous year's sales (2019) and 2% of our sales were actually based on a value derived from turnover. However, the reason we used this was due to those practices being unprofitable, so we knew that the value we could achieve would be higher than multiplying the profit.

IS FINANCE READILY AVAILABLE FOR DENTISTS LOOKING TO BUY?

Absolutely, numerous banks offer finance and have specialist healthcare departments. Some banks offer 100% finance (no deposit), although you open yourself up to more banks where a 10% deposit can be found. The rates are also very competitive, and we have recently arranged finance for a number of clients at a rate of 2.4%+ Bank of England base rate, so affordability for buyers is good.

WHAT ADVICE WOULD YOU GIVE A BUYER?

You need to look at the practice carefully and determine that it is right for what you



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

want to do going forward. I have seen several dentists who are looking for a second practice, and don't really understanding that they need to purchase an 'associate led' practice, meaning that the practice operates with them not working on the premises. They cannot be in two places at once, and acquisitions made on that basis often end up being financial disasters.

For any practice, prospective buyers should look at how the practice would work under their ownership and determine the profitability on that basis.

IF I AM SELLING MY PRACTICE, WHAT DO I NEED TO KNOW?

I would recommend that all sellers use a dental agent. This means you should not only get the maximum number of buyers – therefore maximising the price – but you will also get expert advice. Selling a practice – or any business – is complicated and should not be underestimated.

Where a seller does not wish to use an agent, for example if they are selling to an associate, then I suggest that they still at least get a valuation.

Our company undertakes a large number of valuations for this type of situation, supplying the valuation as a stand-alone service, so you should be able to get the relevant assistance.

Selling your practice is a big deal

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“Having spent years building the practice, it was important to us we found someone to take good care of our team and patients. PFM Dental took the time to understand who we were looking for and helped us market accordingly.”

– Mark Woodger, former practice owner

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Practice Sales & Valuations

Wealth Management

AVOIDING 'TAX TIME' STRESS

Spread payment of your HMRC demand with affordable monthly payments

Aileen Boyle shares her insight on a tax funding option developed by Braemar Finance's in-house specialists which is designed to help professionals take the pain out of the process and spread the cost of tax liability.

HOW CAN YOU HELP DENTAL FIRMS WITH PAYING THEIR TAX?

Every tax season brings its own challenges, but fortunately there are finance options available to both individuals and businesses to help spread the cost of any tax liability.

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Popular with many professionals,

our unsecured tax loans give you the option of spreading the cost of your tax demand into more affordable monthly payments. We have found that 'tax time' can be incredibly stressful for business owners because no one enjoys the thought of having to deal with the impact that paying out a lump sum to HMRC has on a firm's cash flow.

We introduced the Braemar Finance tax loan to help business owners avoid any HMRC penalties and daily interest charges for late submission.

We fund personal, business, corporation, capital gains, and crossover tax demands and will consider consolidation of existing agreements. With flexible repayment terms and fixed monthly payments, the payment can be made directly to HMRC or your bank account.



Aileen Boyle is Managing Director of Braemar Finance, helping businesses in the dental sector for more than 25 years. Call 01563 897545 or visit www.braemarfinance.co.uk

The application process is very simple – just tell us the amount of your tax bill and the term you would prefer and our in-house specialist underwriters will provide a quick decision.

We will then tailor the tax loan to suit your circumstances, with fixed payments over the agreed repayment period.

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FILPIN – The perfect product for all dentine retention pulpal pin requirements that provides maximum advantages without compromising safety, dentine integrity or retention. It is 99.8% pure titanium, more flexible, biocompatible and compatible with all dental materials. The self-threading, self-aligning pin speeds and eases placement for self-shearing first time, every time once optimum depth is reached. Its unique thread design maximises retention strength. After insertion FILPIN can be easily bent to suit the restoration without breaking it or the tooth. If minimal tooth structure is present pins are recommended to enhance chemical bonding provided by adhesives and when core build-up is used with less than one half of coronal tooth structure remaining. Bonding alone is not sufficient in many situations where minimal tooth structure is present. Pins provide anti-rotational benefit when a single post is used.

Filpin shanks are autoclavable and may be reloaded many times with Filpin Spare Pin inserts.

FILPOST - is the only prefabricated post system that can be customised to suit the restoration for root post and core build up. It can be bent and shortened without risk of fracture, enabling easy insertion of multiple posts into converging canals. It is engineered to be easier to place, even in difficult cases, in a faster, safer manner. There is more preserving of healthy tooth structure and it is stronger in use via its unique passive 'interlocking' system. It's 99.8% titanium, biocompatible and compatible with all dental materials. Save time by using FILPOST as no drilling is required during placement thus avoiding risk of perforation. Its anatomical shape minimises dentine removal.



Better by design

Restoration Retention System

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- Unique 'retentive' thread
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FILPOST

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MAKING THE RIGHT CHOICE FOR YOU

Strictly Confidential's Patricia Munro and Gillian Wylie share their advice on how to choose a trusted partner to help buy or sell your dental practice

Trust. That belief in someone. Often someone you've not met before. And we all have a sixth sense about it – whether we can work with a person, whether they'll do what they say they will, if they've got your best interests at heart. When you're thinking of taking that all-important step to buy your first practice, expanding or wanting to get the best outcome for retirement, at the heart of the matter sits trust. After all, your hopes and dreams are resting on them.

SO, WHAT ELSE SHOULD YOU BE CONSIDERING WHEN MAKING THE RIGHT CHOICE?

- 1. Market knowledge:** think about the geographic area you're looking at and find someone who knows that locality really well, whether you're thinking Scotland-wide or just a few postcodes. And market knowledge isn't just about location. Knowing which practices match your requirements, which may be coming on to the market or who is looking to buy can dramatically cut the time involving in your search
- 2. A specialist knowledge of dentistry:** Having an in-depth knowledge of dentistry

is massively important, to understand how your practice operates, how best to value it, the technology and processes that you use. You may also want someone to bounce ideas off as you fine-tune your requirements – do you want room to expand? Is parking essential? Are you planning to offer facial aesthetics now or in the future?

3. Experience: there's no substitute for experience. Having an experienced adviser helps anticipate the bumps in the road that will doubtless occur, reassure you that things are progressing on track and, quite frankly, keep you calm through what can be a daunting period and ensure you get the best deal for you

4. Valuation skills: we all know that in dentistry, a seemingly innocuous bit of plastic can potentially be worth thousands! Look for someone with the knowledge to accurately value your dental equipment, fixtures and fittings, goodwill and stock. It all adds up and whether you're buying or selling, you need a comprehensive assessment

5. Confidentiality: sometimes you may not want staff, friends or family knowing that you're considering buying or selling your practice. It may just be about keeping the

value of the business confidential, but this also comes into play when you need to ensure staff don't get cold feet and leave or that patients become nervous, both of which can affect your valuation

6. A wider support network: it would be great if just one person could help you with your sale or purchase. But in reality, you may find you need a financial adviser, accountant, solicitor, HR support - even help with recruitment or recommendations for new dental equipment and practice refurbishment in the future. It can take away a whole heap of pain if you've appointed someone very well networked to help you

Strictly Confidential has been operating for more than 18 years in the dental industry in Scotland, offering support for dental practice sales, valuations, purchases and recruitment across the whole of Scotland. We provide a valuable and discreet service to our clients because we understand the importance of confidentiality when either buying or selling a dental practice.

All of our valuations and meetings are held out of hours and on weekends, to ensure a confidential service is provided. Meetings can be held at the practice or at another suitable location.

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www.strictlyconfidential.co.uk

LEARNING, NETWORKING AND SUPPORT FROM THE ADI

Having colleagues to turn to for support can make a huge difference to your job satisfaction – and the quality of your implant dentistry

The Association of Dental Implantology (ADI) is the go-to organisation for all dental professionals interested in, or involved with, dental implants. With more than 2,400 active members, it has become a thriving community of like-minded individuals who all share the same passion for excellent dentistry.

As such, there are many advantages to membership with the ADI. Not least because learning and networking opportunities are available throughout the year – both of which are essential for a long and successful career in dental implantology.

EVENTS

ADI Focus Meeting

This year's ADI Focus Meeting will be held on 14 March 2020 at the IET London, Savoy Place. Entitled "Medicolegal and Human Factors in Dental Implantology", it has been designed to inspire dentists and their teams to learn from mistakes. The programme will consider how to minimise the risk of complaints and how to manage any situations that do occur. Visit the website to register.

ADI Study Clubs

Held throughout the year and at different locations across the country, the ADI Study Clubs offer a more intimate learning experience for dental professionals to hear from experts in their relevant fields. Upcoming sessions will offer a wealth of information and advice on how to maintain dental implants in the long term, as well as digital smile design and its benefits in improving treatment acceptance, planning and surgical placement.

Delegates will also find out more about the progression of the field over the past ten years and discover how to optimise the business aspects of offering dental implant therapy. All ADI Study Clubs are held in evenings and offer verifiable CPD. The full list is available on the ADI website.

ADI Team Congress

This highly anticipated biennial event offers a comprehensive educational programme for all members of the dental team, including dentists, dental nurses, dental hygienists and therapists, practice managers and dental technicians. It presents an array of leading speakers from the UK and abroad, providing



Learning and networking opportunities are available throughout the year

information and inspiration from globally renowned professionals. There is also a trade exhibition hosting manufacturers and suppliers of dental implant-related products and technologies for delegates to browse. The next event will be held in 2021, so be sure to look out for information when it is announced.

All these educational events also have a social aspect to ensure you have time to catch up with friends and meet new people.

LEARNING RESOURCES

Another invaluable resource for ADI Clinician and First Five Years members is free premium membership to Dental Tubules. This platform offers more than 750 hours of learning, with almost 1,500 videos covering a spectrum of subjects to suit all interests and experience levels. The intelligent Personal Development Plan (iPDP) also facilitates smart CPD planning and fulfilment.

While the benefits of face-to-face interaction are many, the ADI understands the time pressures dentists and their teams face in the modern industry. As such, it has made webinars available on key topics that can be watched between events to keep you up-to-date in an easy and convenient way. Seven webinars are currently available to members to access at any time, so you can fit your learning around your busy schedule with ease.

In addition to all this, the ADI also provides members with access to prestigious research journals that feature an array of the

For more information or to join the ADI, please visit www.adi.org.uk

latest studies and concepts in the dental implant arena. The *Clinical Oral Implants Research (COIR) Journal* and *EDI Journal* are both highly respected publications that will help dental professionals remain at the cutting edge of implant dentistry.

NETWORK OF SUPPORT

Perhaps one of the biggest benefits of joining the ADI community is the support that becomes available to you.

As part of a group of like-minded professionals, you will be able to share ideas, gain inspiration and seek advice on everything from specific cases to postgraduate qualifications.

The ADI members-only Facebook group is perfect for this, enabling individuals to post queries and see how others have overcome similar challenges. This is a great place to find possible mentors or to pass on your own knowledge and expertise, helping colleagues grow and raising standards across the board.

Ultimately, knowing you're not alone and having colleagues to turn to for support can make a huge difference to the quality of your implant dentistry and your job satisfaction. Regardless of whether you are just getting into dental implantology or have been offering treatment for many years, you will certainly gain from joining the ADI.



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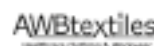
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BRITAIN IN 'STATE OF DECAY' AS TWO THIRDS OF CHILDREN REGULARLY REFUSE TO BRUSH THEIR TEETH

- Research from Oral-B reveals British kids brush their teeth just nine times a week
- 46% of children have already had a filling or cavity as a result of tooth decay
- Oral-B launches #strongteethstrongkids campaign to support parents and encourage them to take part in their #bedtimebrushchallenge to improve children's oral health.

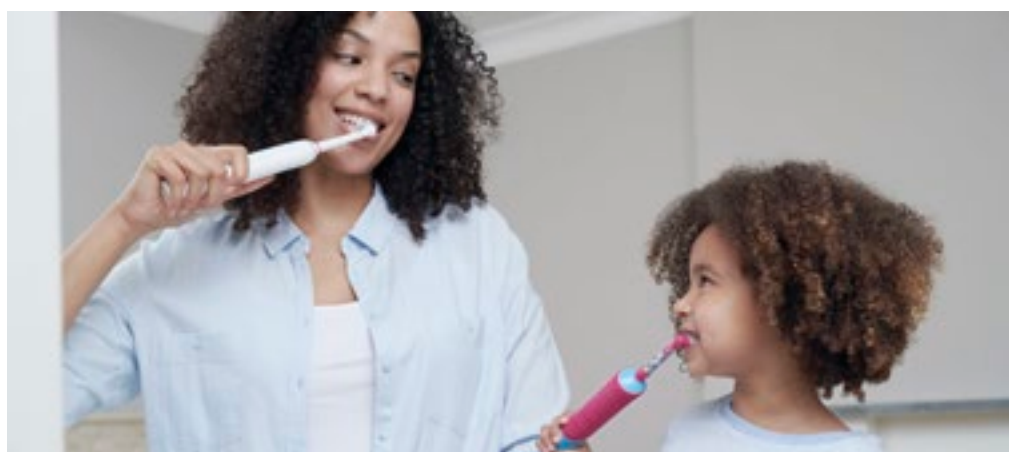
UK parents are being pushed to the brink as they try to get their kids to take dental hygiene seriously. Research from Oral-B has shown that 70% of parents say ensuring their children regularly pick up a toothbrush is the most stressful element of modern parenting.

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' SUGAR INTAKE EVERY WEEK:

1. Pieces of fruit: **8**
2. Biscuits: **6**
3. Chocolate bars: **4**
4. Packets of sweets: **3**
5. Fizzy drinks: **3**
6. Pieces of cake: **3**
7. Smoothies: **2**

Follow and get involved in the campaign on Instagram via @oralb_uk and #strongteethstrongkids #BedtimeBrushChallenge



British kids are brushing their teeth on average just NINE times a week, skipping on at least 20 occasions every month.

The research has been discovered 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, with tips from experts and parenting influencers.

The study found that 70% of parents admit that the flashpoint of brushing can cause tantrums. So, it is no surprise that 71% admit they sometimes give up and let teeth-brushing slide to avoid a major meltdown.

If their children were left to their own devices, only 22% of parents reckon that they would do any brushing at all. This is despite the fact that the average British child consumes three fizzy drinks, three packs of sweets, and a staggering four chocolate bars every week, according to the research.

A whopping 86% of British parents admit that their child eats too much sugar, which is one reason why 46% of kids have had a filling or a cavity.

Problems with brushing causes parents some social anxiety too, with 7% of parents admitting they are ashamed of the state of their kids' teeth and 30%

saying they constantly worry about their kids' teeth.

"This research shows just how hard it can be for parents to encourage their kids to brush their teeth well every day. We're on a mission to improve the oral health of kids in the UK by helping parents make brushing fun. We launched the #bedtimebrushchallenge to support parents in educating children from a young age about the importance of oral health whilst giving people the chance to win brushing bundles for the whole family. We believe that strong teeth make strong kids and we're excited to see how many people take part in our challenge," said Adam Parker, Northern Europe Marketing Manager, Oral-B.

The study found that only 18% of parents say they are proud of their own dental health, 15% admit to having bad teeth and 19% say they wish their own parents had forced them to brush more. A staggering 96% of parents wish that dental hygiene was taught in school, perhaps as it might make enforcing an oral health routine at home easier.

When it comes to routines, 62% of kids brush their teeth every morning, 58% every night, 55% use a good toothbrush and just 51% go to the dentist every six months. Only a third use a fluoride-rich toothpaste and just a quarter manage to have any sugar-free days at all.

Stoke on Trent is the brushing capital of the UK, where kids brush 11 times a

week – and for around 90 seconds, compared to Leicester where they only brush eight times a week and for 60 seconds.

Dr. Roksolana Mykhalus, founder of children's dentistry practice Happy Kids Dental, said "We've seen first-hand just how poor oral health in children can be – and this research shows just what a struggle it can be to get kids to brush their teeth. Most of these problems could be avoided if children had a regular oral care routine at home, and ate a healthy, balanced diet. We always recommend that children should brush their teeth twice a day for two minutes (ideally with an electric toothbrush from aged 3 upwards), accompanied by a fluoride toothpaste. When kids have strong healthy teeth the difference in their general wellbeing is really noticeable, they tend to be much happier and more confident vs those with poor oral health."



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>

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Chairs need to be wiped down between patients and for such regular use you need a fast-acting upholstery cleaner that will not damage artificial leather; B300 does just that. It has reduced levels of alcohol so that over time it will prevent brittle, cracked surfaces. However, it is bactericidal (even killing TB), yeasticidal and has limited virucidal impact, being effective against non-enveloped viruses, including norovirus.

The perfect adjunct to this is B100, an intensive cleaner designed for occasional use, to remove stains of all kinds as well as discolouration. Despite its rigorous cleaning action, it will not damage your upholstery.

The daily care of your waterlines is another routine hygiene task that must be carried out. B700 is a tried and tested maintenance solution for waterlines. It maintains the water flowing through your unit and will minimise the potential for biofilm formation. B700 is supplied in a single-dose sachet. B700 is also non-effervescent, which means it can be used instantly.

Before you start using B700 it is essential that you test and 'shock' your system using the B900 kit. This will remove any existing biofilm.

Thereafter, you're advised to perform this quarterly to prevent the build-up of future biofilm. The B900 kit contains a box of five shock bottles, tester strips and 10 dipstick slides for 'before' and 'after' evaluation.

