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LEADING FROM THE FRONT

Professor Richard Ibbetson on how he plans to uncover Aberdeen's hidden potential

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Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
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LIGHT AT THE END OF THE TUNNEL

New Aberdeen dean sets out his vision for under-fire school

In March last year, on this very page I asked "What now for the crisis-hit Aberdeen Dental School?" A damning GDC report had just been followed up by former BDA president John Drummond calling for the school's closure saying that the school had never been a success and has "sucked" resources from Glasgow and Dundee.

Nearly a year later and there is significant light at the end of the tunnel. The much respected figure of Professor Richard Ibbetson has taken the helm and a new sense of optimism is starting to prevail.

Professor Ibbetson is not one to shirk a challenge, he was brought on board to develop the fledgling Edinburgh Postgraduate Dental Institute and he has held senior positions at the Royal College of Surgeons of Edinburgh, the University of Central Lancashire and the Eastman Dental Institute during an impressive career.

Restoring and repairing the reputation of Aberdeen Dental School is undoubtedly his biggest challenge to date but don't be fooled by his calm and unassuming demeanour. As David Cameron describes during his interview on page 24, he has clearly managed to retain the energy and enthusiasm to drive this school forward.

He acknowledges that it is not going to be a quick fix but there are signs already that the school is on the right tracks. The latest GDC report was a big improvement and Prof Ibbetson has declared himself very impressed with the attitude and outlooks of the staff and students at the school, despite all the criticism that has come their way in the last year.

There are still a number of senior positions that need to be filled and the new dean is refreshingly honest and open about these challenges. However, he is confident that the key positions will be filled and that the current staff have the potential to develop and help him drive the school forward.

Elsewhere in the magazine we have a special feature on an innovative training programme that has seen Dundee Dental School staff travel to Cairo to teach students from across north Africa. Professor David Bearn tells Richard Goslan how the students have benefitted from face-to-face teaching and it has been such a success that there are even plans in place to expand.

We also have the latest Scottish Dental Round Table that, this issue, is focusing on the future of NHS dentistry in Scotland. Chairman Robert Donald leads a panel discussion featuring both NHS and private dentists looking to the future and debating what needs to be done to make sure NHS dentistry stays a part of Scottish practice life.

Restoring and repairing the reputation of Aberdeen Dental School is undoubtedly his biggest challenge to date

As ever, if you want to respond or comment on any of the issues or stories reported in *Scottish Dental* magazine, please don't hesitate to join in the discussion online at SDmag.co.uk or by contacting me direct on the email address above or by phone on 0141 560 3050.

WE COULDN'T HAVE DONE IT WITHOUT...

1

RICHARD IBBETSON
(ON ABERDEEN DENTAL SCHOOL)
Professor Rochard Ibbetson was the first director of the Edinburgh Postgraduate Dental Institute and a past dean of the RCSEd.

2

ROBERT DONALD
(ON THE FUTURE OF NHS DENTISTRY)
A GDP in mixed practice in Nairn, Robert Donald is also chairman of the Scottish Dental Practice Committee and a non-executive director of MDDUS.

3

IRENE BLACK
(ON DECONTAMINATION)
Irene Black is an assistant director for NHS Education for Scotland with the remit for infection control and decontamination.

4

EMMA FINNEGAN
(ON PAIN MANAGEMENT)
Glasgow graduate Emma Finnegan is a core trainee at Glasgow Dental Hospital and School with a special interest in oral medicine.

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HAVING HIS SAY →
Arthur Dent is a practising NHS dentist in Scotland
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IS YOUR CPD UP TO SCRATCH?

Arthur Dent reports on the importance of face-to-face learning compared with only distance or journal related CPD

Time has rolled round again to the end of yet another year of verifiable and non-verifiable CPD. The audit cycle finishes in July 2016 and I wonder how many people can honestly say their dentistry has improved because of either?

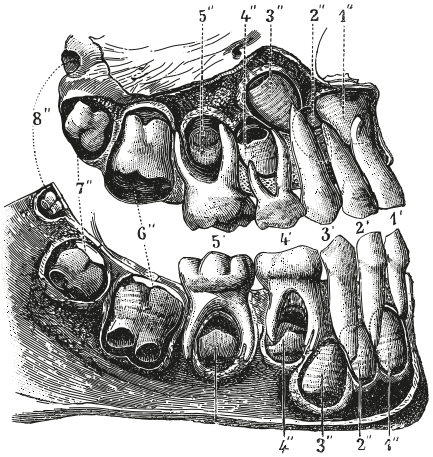
We know the General Dental Council view dimly registrants who have only distance or journal related CPD and not face-to-face learning.

It's worth considering who provides the CPD. Twenty years ago, one received the booklet of (free) Section 63 courses in August, and there was a rush to get booked on the hands-on courses, which often sold out on the day of issue. After a few years, no new courses were available, and the desire to learn waned.

Now courses are released sporadically, and they are no longer free. However, the quality and variety of courses has become rather reduced. There are no longer hands-on courses on four handed dentistry or the application of rubber dam – even though the indications for the latter's use have increased. Lots of the courses are now to do with bureaucracy and fear – how to avoid complaints, how to use the SDR, IRMER – and how is patient care improved by any of these?

Many courses are now aimed at the dental team, which is often a good thing, but where are the courses using butcher meat to help practitioners improve their oral surgery skills? Courses work best when they are tailored to the audience – and often we require different teaching from the rest of our team.

There has been a dramatic rise in recent years of very expensive postgraduate



ABOVE: **The quality and variety has reduced with hands-on courses no longer available**

courses, which are heavily advertised in the back of the BDJ as well as more illustrious periodicals such as *Scottish Dental* magazine. These range from a weekend course to much longer commitments, and sometimes result in a postgraduate qualification. The quality of these courses is extremely variable, and can seem like a simple way to make very large sums of money, with fees of £500 per day being charged.

The popularity of these courses is partly due to the poor levels of experience gained by undergraduates. This has sadly lead to many courses being taught at an undergraduate rather than postgraduate level, leaving experienced practitioners feeling they have wasted their time and money. A very poor course that was recently attended managed to have completely redundant feedback – the lecturer informed attendees he had already been booked for the next year.

Twenty years ago, one received the booklet of Section 63 courses, and there was a rush to get booked on the hands-on courses, which often sold out on the day of issue. After a few years the desire to learn waned

There has also been a rise due to the feeling of fear conjured by PSD, health boards and the GDC. We are no longer being judged by what the average general dental practitioner would do, but by what a specialist would do. We expect to be taught by those at the top of our profession, but these speakers rarely have an understanding of life in an NHS general dental practice.

Recently, a specialist speaker, who is an expert witness at the GDC, informed attendees that a written treatment detailing EVERY possible treatment option and treatment plan should be given to every patient as failure to do so contravened GDC guidelines. Any patient attending with a lost MOD restoration would fall into this category – where would we find the time and money to do this? And is this what patients want?

Each time a specialist makes these pronouncements, it has a detrimental effect on the entire profession. Something an expert does in a private specialist practice becomes normalised in the eyes of the GDC. We must not let this happen.

SCOTTISH DENTAL SHOW 2016

WITH SOME OF THE COUNTRY'S TOP EXPERTS ON THE STAGE, ACCOLADES FOR THE INDUSTRY'S STARS AND NUMEROUS TRAINING OPPORTUNITIES, THIS YEAR'S EVENT IS ONE NOT TO BE MISSED

13-14 MAY 2016 **WWW.SDSHOW.CO.UK**

With 30 years of experience in the field of mouth cancer, Cardiff dental dean Professor Mike Lewis is one of the foremost experts on the subject.

And on 13 and 14 May, the Dundee graduate and former Glasgow Dental School lecturer will be heading back up to Scotland to open the 2016 Scottish Dental Show at Braehead Arena with two lectures entitled 'Mouth Cancer – How to beat it!'

Professor Lewis explained that he remembers a time when clinicians could quite reasonably expect to go through their whole careers without seeing a single case of mouth cancer in their practice. However, since 2000, there has been a 30 per cent increase in the number of cases in the UK, meaning practice teams now have no excuse not to be completely up to date on the subject.

A CORE CPD topic since 2012, Professor Lewis explained that his two one-hour lectures on 13 May will deliver a highly illustrated and practical update on the presentation, detection and prevention of mouth cancer that has relevance for all members of the dental team.

He said: "My talk this year will provide an opportunity for individuals to assess just how good they are at detecting mouth cancer. The presentations will also include many clinical cases to illustrate how the likelihood of detection can be improved and how this can subsequently save a patient's life."

Professor Mike Lewis

Professor Brian Millar

Professor Tim Newton

Professor Lewis also explained how much he enjoys coming back to Scotland to lecture. He said: "It is an absolute delight to visit Scotland to attend professional meetings. It is always like a homecoming for me, as I spent 17 years of my life undertaking my dental and oral medicine training in Dundee and Glasgow.

"In December 2015, I spoke at the Glasgow Odontological Society and was overwhelmed by the fact that the lecture theatre was full and that so many professional colleagues, both retired and those still working, came to hear me talk."

And for those dental professionals who haven't registered for their free ticket to the Scottish Dental Show, Prof Lewis said: "Events such as the Scottish Dental Show are an essential part of being a dental professional, as it provides the only CPD environment where there is an opportunity to meet the 'experts' and discuss issues with fellow professionals face to face in a relaxed setting."

CREATIVE COMPOSITES

Another familiar face for Scottish clinicians is King's College London Professor of blended learning Brian Millar, who will be returning to Scotland to give a lecture on non-invasive aesthetics.

Also a Dundee graduate, Professor Millar will be presenting 'Advanced anterior aesthetics, being creative with composite when managing tooth wear' on 13 May at 9am, as well as a hands-on workshop later in the day.

When asked what delegates can expect from his appearance at Breahead, he said: "My presentation will update delegates on the use of diagnostic techniques, smile design using digital and mock-up

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techniques, guidelines for success, parameters of smile design and planning with your patient to deliver an outcome that both you and your patient are seeking.

"The hands-on sessions will give delegates an opportunity to carry out the smile design planning and restorative procedures on models."

STRESS MANAGEMENT

A recent survey by the Scottish Association of Local Dental Committees in November 2015 found that nearly 90 per cent of dentists in Scotland are 'adversely stressed'.

Against this background, Professor Tim Newton's lecture, 'Identifying and managing the stress of dental practice', could not be more timely or relevant.

Taking place on 13 May at 1.30pm, Professor Newton explained that he wants to encourage delegates to take a realistic look at their practice life.

He said: "I want delegates to start to think about ways in which they can change their dental practice in order to address the stress and strain of dental practice.

"I don't expect delegates to learn anything from my talk, as such – I want them to be challenged about how they currently think about their working lives, and to leave with a plan to make one small change and see how that goes."

MORE INFO
To see the full lecture line-up, visit ww.sdshow.co.uk

SCOTTISH DENTAL AWARDS 2016 CATEGORIES

Scottish Dental Lifetime Achievement Award
Last year's recipient: Elizabeth Saunders

Young Dentist Award
Last year's winner: Jonathan Dougherty – Kilmarnock Dental Care

Employer of the Year
Last year's winner: Morven Gordon-Duff – Huntly Dental Practice

Website of the Year – NEW FOR 2016
Last year's (Digital Strategy category) winner: Dental Studios Scotland

Practice of the Year
Last year's winner: G1 dental, Glasgow

Dentist of the Year
Last year's winner: Samuel Barry Lemon – Bluewater Dental, Lochwinnoch

Laboratory of the Year
Last year's winner: Leca Dental Laboratory

Dental Team Award
Last year's winner: Crown Dental Group

Unsung Hero
Last year's winner: Dr Jon Victor

DCP Star
Last year's winner: Kirsty Rodger – Huntly Dental Practice

Business Manager/ Administrator of the Year
Last year's winner: Liz Alexander – Southwest Smile Care Centre

The Community Award
Last year's winner: Linsey Paton – Tryst Dental

The Style Award
Last year's winner: Glasgow Southside Orthodontics

Scottish Dental Representative Award 2015
Last year's winner: Donna Morrison – The Dental Directory

SCOTTISH DENTAL AWARDS

Dentists, dental teams and dental businesses have until 31 March to get their nominations in for the 2016 Scottish Dental Awards.

There are 15 categories up for grabs, culminating with the prestigious Scottish Dental Lifetime Achievement Award.

For 2016, the Digital Strategy Award has been renamed Website of the Year, and we have a brand new category, the Business Excellence Award, to celebrate the outstanding dental businesses operating in Scotland. The new award is open to any dental business, from dental practices to groups, suppliers, manufacturers and any associated companies who have an office or representation in Scotland.

The 2016 Scottish Dental Awards ceremony and dinner will be held at the five-star Glasgow Hilton, with television personality Carol Smillie hosting on the evening. Music will again be provided by the Lost Angels, meaning it will be one of the highlights in the 2016 dental calendar.

MORE INFO
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DEFACTO

GDC DEFENDS NO CASE TO ANSWER INCREASE

With 10 Fitness to Practice cases thrown out last year, costing registrants an estimated £780,000, the GDC has revealed that a more streamlined complaints system will be introduced

The number of GDC Fitness to Practise (FtP) cases that are thrown out with 'no case to answer' increased from just two in 2014 to 10 last year, costing registrants an estimated £780,000.

Glasgow dentist Arshad Ali was one of those registrants summoned to Wimpole Street in November but the expected five-day hearing was cut-short on the second day after all the charges against him were found to be not proven and it was declared there was no case to answer. Mr Ali, who has been advised not to comment on the specifics, explained to *Scottish Dental* magazine that the whole process took just under a year from first letter to the hearing itself. He said that the process put him, his family and staff through "major stress" before and during the hearing, involving cancelled clinics and time away from his practice for meetings and the hearing itself.

According to the GDC's own figures, the cost of an average FtP case reaching a hearing in 2013 was £78,000. However, a spokesman for the GDC played down this number, saying that the average hearing is now just under four days in duration and costs in the region of £23,000.

Jonathan Green, director of FtP at the regulator, said that the "slight increase" in no cases to answer between 2014 and 2015 had to be put into context in that there were 286 hearings in 2015 compared to 194 in 2014.

He said: "Later this year the introduction of case examiners will lead to a more streamlined complaints system with powers to agree undertakings on less serious cases. This will reduce the number of cases goings as far as

Practice Committee hearings.

"There is a likelihood there will always be some no cases to answer as this is often due to the complexities of cases and evidence put in front of Panel members. The Panel is independent of the GDC and ultimately make the final decision on whether it is the treatment offered by the practitioner or their conduct which falls below the standards expected."

CALLS TO END SCOTS' 'ADDICTION TO SUGAR'

Scottish dentists have given their support to a new report that claims there is an urgent need to curb Scotland's "addiction to sugar".

Food Standards Scotland's report 'The Scottish Diet: It needs to change', highlights the health risks of consuming too many calorific foods with little or no nutritional value. It also notes that nearly a quarter of the nation's sugar intake comes from sugary drinks and 50 per cent from unhealthy foods that are heavily promoted in supermarkets.

Colwyn Jones, consultant in dental public health and member of the BDA's Scottish Council, said: "Scotland, like the rest of Britain, is addicted to sugar, and we are all paying the price. Tooth decay is the leading cause of hospital admissions among young children. The BDA believes the government has a clear duty to send the strongest possible signal to retailers and the food industry in general, that while added sugar might be helping their sales, it is hurting their customers. The new report provides us with yet another reminder of how our diets are making us ill, and how consuming sugary and high-fat foods has become the norm rather than an occasional treat."The urge to resist change may be strong, but solutions can be found when consumers, the food and drink industry, media and government all work together."

DID YOU KNOW?

50%

FACT

Half of UK dentists wouldn't recommend their career to friends and family

* 2015 Censuswide survey on behalf of Wesleyan

GDC APPOINT NEW CHIEF EXECUTIVE

The General Dental Council has announced that Ian Brack will replace under fire chief executive and registrar, Evlynne Gilvarry, when she steps down at the end of January.

Gilvarry, who has come under intense criticism in recent times, not least for last year's controversial ARF increase, announced she was standing down in November.

GDC chairman, Dr William Moyes, said: "I am delighted to welcome Ian to the team and I am very confident he will make a telling contribution to the work of the GDC. Having been at Office for Legal Complaints and the Olympic Lottery Distributor, he is used to leading complex organisations. Ian brings with him a wealth of experience as well as a commitment to making sure we continue to put patient and public protection at the heart of what we do.

"While I welcome Ian's appointment, I would like to pay tribute to Evlynne Gilvarry for her immense commitment and leadership during the past five years."

CBE FOR SCOTLAND'S CHIEF DENTAL OFFICER

Margie Taylor was awarded the prestigious accolade in the Queen's New Year's Honours and was keen to praise her colleagues and staff for all their work over the years

Scotland's Chief Dental Officer (CDO), Margie Taylor, has paid tribute to her colleagues and staff after it was announced she was to receive a CBE in the Queen's New Year's Honours.

The CDO, who was appointed in 2007, said: "I feel enormously privileged to receive the CBE but recognise that many others have contributed to the improvement of oral health over the years and therefore have helped me gain this recognition.

"I would especially like to thank the team of nursery school nurses, primary school teachers and obviously the parents for recognising that tooth decay isn't inevitable and have joined with the dental and public health nurses team, from many disciplines, to help reduce it."

She explained that the achievement she is most proud of is the improvement in child dental health.

She said: "As a young dentist I spent a lot of time extracting baby teeth from very young children. When you know that dental decay is almost totally preventable I thought that it was an awful trauma for, not only the children, but the parents as well.

"So, when I was appointed as CDO I thought that if I can achieve anything in the role it had to be to try and prevent this disease."

She also explained that she is encouraged by what the Scottish Government's 'A Stronger Scotland' document says about dentistry.

She said: "This document has given us the way forward, which is to see if we can address the outdated system. The current system was devised when there was a lot of dental decay and a lot of people needed fillings and extractions and we have seen that pattern changing in recent years."

Chief Dental Officer Margie Taylor

STUDENTS GO THROUGH THE LOOKING GLASS

Staff and students at Glasgow Dental School got in the panto spirit before Christmas to raise nearly £3,000 for charity.

The annual Glasgow Dental Student Society pantomime took place at the end of November in the Glasgow University Union Debates Hall and raised £2,826.47 for two charities, the Beatson Cancer Charity and the Scottish Association for Mental Health.

Final year students Sam Poole and Graeme Ker wrote the panto entitled 'Alice in Gumderland' which was performed in front of a packed audience of friends, family, staff and fellow students at Glasgow University. Even the staff got in on the act as some prominent members of the teaching department performed a half -time show in the form of a James Bond medley.

Sam said: "Although it is the final year that put the panto on, it really is a dental school pantomime. You have got so many people involved, like the band and all the cast and crew. I loved the fact that everyone came together for the show. Everyone had a great time."

And Graeme said: "It is a real asset to the dental school and to our learning experience. As fifth years we are about to go out into the big bad world and it brings us closer together, solidifies relationships with staff and it inspires younger years to get involved. And, on top of all that, it raises lots of money for charity, it's just a brilliant event."

MDDUS ANNUAL REPORT SHOWS A RISE IN CLAIMS

Indemnity organisation MDDUS has reported a 19 per cent increase in claims against GDPs and hospital dentists in 2014, compared with the previous year.

The defence body also saw an increase in the number of members that were subject to investigation by the GDC, which was up 37 per cent on 2013.

MDDUS head of Dental Division, Aubrey Craig, said: "The threat of regulatory action can destroy careers and reputations but we have the experience and expertise to assist our members and we continue to engage robustly with the GDC on behalf of our members."

The figures were released as part of the MDDUS' annual report, which also showed a significant growth in membership numbers, with a 10 per cent increase in new members from outside Scotland during 2014.

The defence body also saw a 9.4 per cent increase in total memberships, with approximately 35,000 members as of September 2015.

MDDUS dental advisory team reported an increase of 13 per cent in telephone calls for advice in 2014, while email contacts also increased by 12 per cent.

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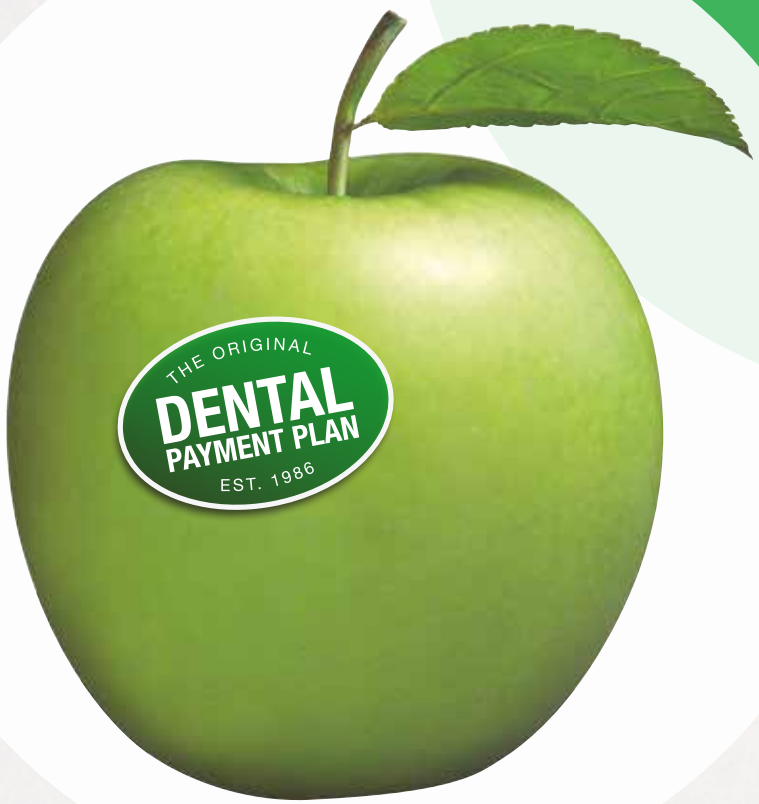

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AUDIT REVEALS FAILINGS

Scottish health board fails to monitor grant conditions for 20 practices awarded nearly £3 million through the Scottish Dental Access Initiative

An internal audit of 20 grant-aided practices in NHS Grampian (NHSG) has identified significant failings by the health board in how it monitored grant conditions.

The audit, compiled by accountants PricewaterhouseCoopers, found that of the 20 practices awarded funds from the Scottish Dental Access Initiative (SDAI), all but one had not been subjected to annual monitoring to confirm they were complying with the grant conditions.

It also revealed that, while NHSG is required to submit a letter to Scottish Government confirming appropriate procedures were in place, the board's processes at the time meant that the board "only partly complied with the declaration". The report stated that for 14 of the 20 practices, although documented procedures were in existence, annual monitoring had not been completed during 2013 and 2014.

A total of £2,975,000 has been awarded in Grampian since 2008, with the average grant being approximately £130,000. The report said that of the practices benefitting from a grant, all but two have a list size in excess of their target registration levels.

Aberdeen dentist Ross McLelland, who has been raising awareness of the problems with the SDAI grants awarded in the region for the last few years, said: "The findings in this report don't surprise me. A catalogue of SDAI issues has been highlighted to NHSG over the last few years, with little action being taken. Ray Watkins, former CDO for Scotland, was consultant to NHSG in 2012 and personally reassured me that all scrutiny and monitoring of SDAI grants in the region was robust. This report proves that this statement was false.

"Remember that this is the health board that awarded a £250,000 SDAI grant to a practice that was not eligible under the contract terms at that time.

Aberdeen dentist Ross McLelland

"This all amounts to a serious mismanagement of public funds in Grampian, and I wonder if it's any better in other health boards. Perhaps it's time for all health boards and all national SDAI awards to be scrutinised."

An NHS Grampian spokesperson said: "We fully accept the findings of this report and have already put measures in place to address the issues raised. These are fully detailed in the report."



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BDA CALLS FOR GDC CHAIR TO RESIGN

Latest PSA report highlights concerns raised by whistleblower

Right: British Dental Association chair Mick Armstrong

The British Dental Association has again called for the head of the GDC to resign after the latest damning report by the Professional Standards Authority (PSA).

The report, which runs to 306 pages, lists the findings of an investigation into concerns raised by an unnamed whistleblower surrounding the regulator's Investigating Committee. The report highlights a number of "objectionable practices" which it says jeopardised the independence of the GDC committee during 2013.

It also highlighted a number of organisational and personal failings in senior positions at the GDC, singling the current council chair, Dr William Moyes, for a series of failures and "inappropriate decisions".

BDA chair Mick Armstrong said: "The BDA has consistently argued that the GDC is out of control and unaccountable. Once again, we can see why. The chair doesn't understand dentistry and has failed to grasp that a fundamental prerequisite for good regulation is accountability and transparency. As this report shows, he has a disregard for his peers and is not open to scrutiny by the Council. This is a disservice to both the profession and the public.

"This only further reinforces the grave concerns and the massive loss of confidence the profession has in this hugely overpriced and underachieving regulator.

"Well enough is now more than enough. Dr Moyes must go."

Speaking jointly on behalf of the GDC, chair William Moyes and chief executive and registrar Evlynne Gilvarry said: "We're grateful to the Professional Standards Authority for the additional learning it has provided through this investigation and report, building on our own work since the issues first came to light in 2013. We are continuing to apply ourselves in full to the lessons contained in the report's recommendations and other findings. We will be publishing our full response in due course."

PRACTICE IS BEAMING

A Dundee orthodontic practice has picked up a major regional award for its customer-centric approach to patient care.

Beam Specialist Orthodontic Practice was named Services Business of the Year at The Courier Business Awards, held at the Fairmont Hotel in St Andrews and attended by almost 600 business leaders from across east central Scotland.

The practice was opened in 2007 and is owned by specialist orthodontist Ruaridh McKelvy and his wife, dentist Jane Adams. Speaking about the award, Ruaridh said: "We are proud to have won several dental awards over the years but this particular award saw us competing against other local businesses, in a huge range of sectors. Of course, the fact that we won the most hotly contested category, as well as being up against other dental practitioners, added to the thrill and sense of achievement.

"A huge part of our success can be attributed to our team who, due to our investment in them, enable us to innovate, develop and give our patients expert, friendly service. The customer experience is at the centre of our thinking, with 96 per cent of our patients being 'delighted' at the end of their treatment and, with this new award, we are further motivated to improve their experience."

SCOTTISH DENTISTS TO RECEIVE TOP HONOURS

Two Scottish dentists have been recognised for their hard work and commitment to their profession in the annual BDA Honours and Awards.

Hamilton dentist Graham McKirdy, who retired late last year, has been given Fellowship of the Association and community dentist Robert Hamilton has been awarded BDA Life Membership. The honours and awards will be officially presented at a special dinner and ceremony at the British Dental Conference and Exhibition on Saturday 28 May in Manchester.

Graham McKirdy worked as a GDP for more than 30 years and is a former chair of both the BDA's Scottish Council and UK council, as well as being a member of the General Dental Practice Committee and the Scottish Dental Practice Committee.

He said: "I think it's a great privilege to be recognised by the BDA and also by the west of Scotland branch for nominating me. It has been a privilege to represent general dental practitioners and dentists in general, over many years. I would like to think I have played a small part in improving dentistry in the practice and overall the delivery of dentistry for patients."

Robert Hamilton, who is now also retired, is a former chair of the BDA's Scottish Salaried Dentists Committee and was the lead dentist in negotiations for new terms and conditions which led to the new Public Dental Service in Scotland. He worked in the community service in Aberdeen and the surrounding areas for more than 30 years.

He said: "It is a great honour to be given life membership. It is a recognition from colleagues that I must have done something right. Being elected in the first place and then to be trusted to chair the committee, or hold some other office, is a privilege in itself.

"Over the years I have always worked with a very supportive group of committee members and exceptional BDA staff members who have made life much easier than it might have been."

ABOVE: Graham McKirdy, top, and Robert Hamilton, bottom

IMPROVEMENTS FOR DENTAL CARE ASSISTANT STUDENTS

The first cohort of students on a new course aimed at widening access to the dental industry have completed their studies at Edinburgh College.

The new Dental Care Assistant course, which is the first of its kind in the east of Scotland, offers an introductory course for those students who may not have any formal qualifications to apply for the SVQ level 3 course, or to those mature applicants returning to further education. The first cohort started in August and the college is anticipating a high pass rate for their first group of students.

Many of the students leaving the course will go on to study on the college's SVQ Level 3 Dental Nursing course or further study while in practice. As the students complete a prevention of infection unit during their studies, as well as completing their PVG checks and getting their hepatitis B vaccinations, they are ready for trainee roles in dental practice straightaway.

Tom MacGregor, curriculum manager for health and veterinary at Edinburgh College, said: "Many of our Dental Care Assistant students joined the course with a lack of confidence and found teamwork and interacting with others a challenge. This course has developed them into confident individuals who can make positive contributions to their team, and work independently. They now show self belief, have more job ready skills and feel comfortable presenting themselves and their work."

DENTAL PROTECTION CHIEF TO STAND DOWN

After 18 years as Dental Protection's dental director, Kevin Lewis has announced he is stepping down from the role in the summer.

Kevin was a member of the original board of directors when Dental Protection Limited was created as a separate company within the Medical Protection Society (MPS) group back in 1989. He became a dentolegal adviser in 1992 and became dental director in 1998.

He said: "It has been a huge privilege not only to work in this fascinating field over so many years, but also to work with such phenomenally good people. There is something very special about being in a position to help your professional colleagues through times of difficulty, and one of the pleasures of the job is seeing that commitment and passion running right through the Dental Protection team. Our members can be assured that this commitment will remain undiminished."

Kevin explained that he will still be involved in dentistry saying he will look forward to having more time to spend on his writing and lecturing commitments.

Dr Howard Farran, DDS, MBA
(Founder & CEO of Dentaltown, Orthotown & Hygienetown)

"Uncomplicate Business"

In this seminar, Dr. Farran shares his proven techniques with you and your staff to increase your productivity and build your business.

Dr. Howard Farran is one of the most forward-thinking, cutting-edge dentists in the world. You will enjoy his fast-paced, straight-from-the-hip, politically incorrect, exhilarating style while you learn more in one lecture than you ever thought possible. Dr. Farran's seminar focuses on the business of running a dental office –things that every business needs to do during this economic environment, and what every business needs to make its products and services more efficient. The things that can realistically be managed and what functions your business should have. This seminar is perfect and the timing couldn't be better!

Howard's topics may include:

- Learn how to apply time-tested MBA-level management to your office.
- Learn how to build a winning team without any hype, fluff, or wishful thinking.
- Learn how to get twice as much done in half the time while reducing your stress.
- Understand how to learn and commit to operations and logistics, instead of chaos and guesswork.
- Learn to focus your practice: market differentiation, cost leadership, and niche market.
- Learn which sectors in dentistry are growing faster with higher net income so you can focus your practice for profitability.
- Learn how to develop a relationship-based practice instead of a product-based practice.
- Increase treatment plan acceptance by understanding market segmentation and price elasticity.
- See how going digital can dramatically increase your case acceptance.
- Learn the real reasons patients put off dental treatment.
- Learn the first and second laws of customer satisfaction.
- Learn about the only three things you manage – people, time, and money.
- Learn about the three functions of business – to make something, sell something, and watch the numbers.

Dr Mike Gow
BDS (Gla) MFDS RCPS (Gla) MSc Hyp (Lon), PGCert (Edin)

"A masterclass on rapid rapport, language and communication"

In this seminar, Dr. Gow shares many of the secrets in rapport, communication and language that he has learned following years of studying hypnosis and Neurolinguistic Programming.

Dr. Mike Gow is well known for his work with hypnosis and has even appeared several times on television demonstrating it. He has trained to an advanced level in hypnosis, and regularly teaches on the topic with enthusiasm and energy. His hypnosis talks usually include brief teachings on rapport, language and communication, and often delegates having found great value in learning these, have asked for a standalone workshop on the topic. So here it is and no previous experience is required!
The seminar will focus on the essential topics of rapport, language and communication and how with effective use of these you can experience more predictable outcomes in your interactions with others in both your professional and personal life.

Mike's topics may include:

- Learn how to establish rapid rapport with a few simple techniques.
- Understand verbal and non-verbal communication
- Be able to use effective suggestions and embedded suggestions.
- Understand the importance of positive language and be able to apply it.
- Understand the importance of avoiding emotive language.
- Be able to recognise and avoid 'verbal eraser' words.
- Be able to effectively use 'binds and double binds'
- Understand and be able to use 'yes sets'.
- Learn how to use 'anchoring'.
- Understand how to apply these techniques ethically.
- Learn how to use your voice effectively.
- Be able to use basic relaxation techniques.

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Workshop details:

London:
Thurs 16th June (Dr Mike Gow) £345 (£295 if booked before 14th May)
Fri 17th June (Dr Howard Farran) £345 (£295 if booked before 14th May)
Book both days for £645 (£545 if booked before 14th May)

Glasgow:
Fri 24th June (Dr Howard Farran) £345 (£295 if booked before 14th May)
Sat 25th June (Dr Mike Gow) £345 (£295 if booked before 14th May)
Book both days for £645 (£545 if booked before 14th May)

Contact Janet at MacScotland for more information or to register: **macscotland@outlook.com**

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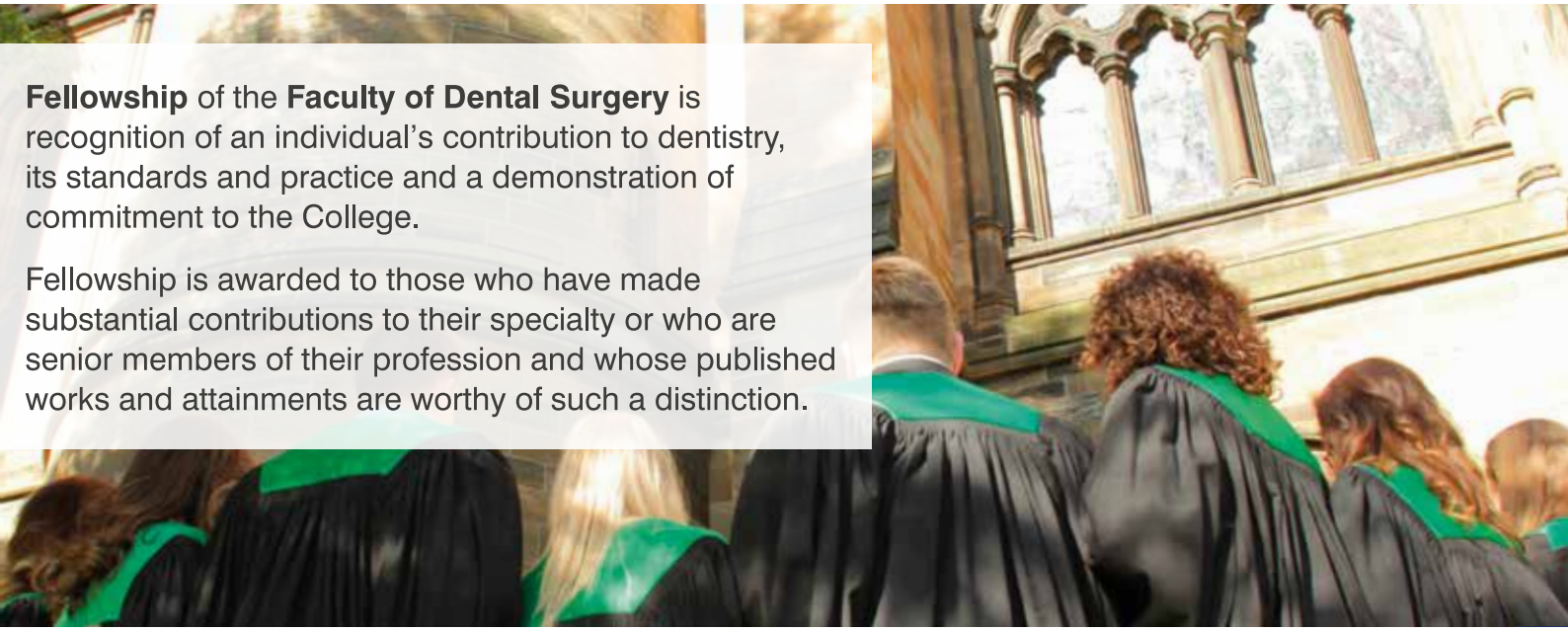

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ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

FACE-TO-FACE

DUNDEE STAFF TAKE INNOVATIVE PROGRAMME TO AFRICA

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A NEW BEGINNING

ABERDEEN DENTAL SCHOOL HAS NOT HAD ITS TROUBLES TO SEEK IN RECENT TIMES BUT, ACCORDING TO ITS NEW HEAD RICHARD IBBETSON, THE POTENTIAL IS THERE FOR IT TO BE A QUALITY CENTRE OF EDUCATION IN THE NORTH EAST

DAVID CAMERON KATE SUTHERLAND

The first thing that strikes you about Richard Ibbetson is his air of calm, assured professionalism and command. When it's mixed with an almost youthful enthusiasm, it leaves the impression that this is not only a man with the knowledge, skill and experience to get a job done, but of someone who retains the energy and enthusiasm to drive any project put in front of him through to a successful outcome.

For the task he has ahead of him, he's going to need both, in spades. Professor Ibbetson is the new head of the Aberdeen Dental School and the man who has chosen to accept the chalice – it has yet to be seen how poisoned it is – that contains a school which, over the past few years, has been mired in controversy as the General Dental Council (GDC) ripped it to shreds over, among other things, its teaching standards, injuries to patients, and a virtual revolt by students.

As the country, never mind the profession, saw the school's dirty washing hung out in public through last year's GDC report into its performance, it made for torrid reading. And that was to say nothing of the underlying simmering political debate as dental professionals and politicians slugged it out over what many claimed was nothing more than a vanity legacy the former First Minister Alex Salmond wished to leave behind to his beloved north east. Why, the critics cried, is it there at all when the centres of excellence that are Glasgow and Dundee already exist?

Richard Ibbetson's answer is as concise as it is sharp: "Do I worry about what anyone might say about this place in Glasgow or Dundee? No, frankly, I don't. If I were there, I might be saying the same thing. But 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!"

> "DO I WORRY ABOUT WHAT ANYONE MIGHT SAY ABOUT THIS PLACE IN GLASGOW OR DUNDEE? NO, FRANKLY, I DON'T"
>
> RICHARD IBBETSON, HEAD OF ABERDEEN DENTAL SCHOOL

It appears that an excellent start has already been made. The most recent GDC inspection report is a night and day improvement on the previous year and has ticked virtually all the boxes within the educational and clinical training arenas.

Only the examination processes themselves have been left with work to do and that is something that Ibbetson argues will, as he would expect, take time and effort to sort, neither of which the staff at Aberdeen have shirked away from in turning things around over the past 18 months or so.

Indeed, when he arrived in post earlier this year, the professor was pleasantly surprised and pleased by what he found among the people who, by the very nature of what had gone before, must have been at a fairly low ebb in terms of morale.

"I wouldn't have come here if I thought I couldn't see the positive way ahead. In the past year, there has been an enormous amount of work that has gone into first of all managing the requirements of the GDC, which I fully recognise is necessary, important and can't be escaped.

"However, what I found was a group of staff who, despite everything that had gone

before, were actually very keen and very dedicated to what they were trying to do. This was very impressive.

"What I also found were cohorts of students whose qualities have shone through. They are good, mature individuals who have achieved degrees before, work very hard here and have a great attitude. That has been a great help to the school."

However, what of the elephant in the room? Ibbetson himself has a formidable – and admirable – reputation. Colleagues around the country speak in glowing terms of his abilities as a clinician, academic and leader. However, he simply can't turn Aberdeen around on his own and, so far, the senior academic posts at the school remain mainly unfilled. Surely lack of such senior guidance will hold him back?

"There is no doubt that what the school perceives it needs is more senior academics. This creates an interesting challenge, of course. Because if you were a senior academic, you have to ask if you would consider moving to Aberdeen and there are multiple reasons for that. Location, cost – Aberdeen is an expensive city – and, of course, you also have to say that if I was an aspiring young academic or someone who was pretty senior looking for a promotion, if I'm any good, my own dental school would want to keep me because there is a shortage of clinical academics just now.

"I was asked the question, how will you attract high-level academics? There are three answers to that: First, I'm confident that we will attract one or two: I have ongoing discussions with a number of senior academics as we try to work out a way of bringing them here.

"The second element in this is to bring in experienced, upskilled GDPs – which we have done – who have the necessary additional qualifications that make them ideal teachers.

"And third, because of the issues that have been here, the existing staff really have had to stand up and upskill themselves and, to some extent, they have been proofed in fire and gained an enormous amount of knowledge and skill that they don't actually realise they have. There is a very good team of people here right now who can deliver.

"I will recruit, but the other 50 per cent of the direction of the school will come from developing its own. It's about career paths for people who are already here. They are very talented and need the opportunity to grow and develop – I have to give them the space to do that and that's what I intend to do."

The major issue then in moving forward is not so much in the teaching resource, but in the question of achieving the holy grail of sufficiency.

The GDC report in 2015 made it clear that the inspectors will be back again in 2016, but this time their focus will almost certainly be on exam process rather than teaching and the clinical capabilities of the students.

If, or rather when, Ibbetson makes sure that particular box is ticked, then he and the team can kick on into a different gear. Yes, there are hurdles that will have to be overcome, and they will not be without their challenges, but on the other side of that, a vision is already being formulated.

Ibbetson is committed to making Aberdeen Dental School much more than simply a teaching centre for dental undergraduates. It has to deliver in terms of patient care, education and professional development of practitioners in the north east.

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PROFILE

Professor Richard Ibbetson graduated from Guy's Hospital Dental School, University of London, in 1974 and completed an MSc in Conservative Dentistry at the Eastman Dental Institute in 1979.

He then spent 20 years on the staff of the Institute and later was head of the Department of Conservative Dentistry before developing a new Department of Continuing Education. In 1999, he was appointed chair of Primary Dental Care at the University of Edinburgh and director of the new Edinburgh Postgraduate Dental Institute with a particular remit to develop postgraduate dental education and education for the dental team.

He was then appointed as professor of Restorative Dentistry at Barts and the London School of Medicine and Dentistry. He is a past dean of the Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh and holds an Honorary Professorship at the University of Edinburgh.

In March 2014, he was appointed director of the graduate entry dentistry programme (BDS) at the University of Central Lancashire (UCLan).

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Key to this has been the work that has already been done in forging a much closer and more effective working relationship between the school and NHS Grampian. The improved sharing of resources in terms of knowledge, both clinical and administrative, and in the way patients are managed is already proving beneficial to both parties.

The upskilling of GDPs to be able to tackle clinical challenges that they would otherwise not have been able to do is central to building the skills networks that are becoming increasingly more prevalent around the country and that benefit not just the practitioners, but also the wider community.

"I want to start two post-graduate programmes. One will be in restorative dentistry and the other will be in special care dentistry," says Ibbetson.

"These are important because of changes in the way that dental health care is delivered, in practice or outside, because patient expectations continue to increase, demands on hospital services and specialists continues to increase and at present we can't really meet them.

"England is moving more and more towards the idea that you have to have upskilled intermediate practitioners who can deal with the work that might be too difficult for the GDP, but not too difficult for the GDP who has had additional training. Managed clinical networks are coming and we want to be a part of that. We are already exploring how we might bring forward an endodontic network.

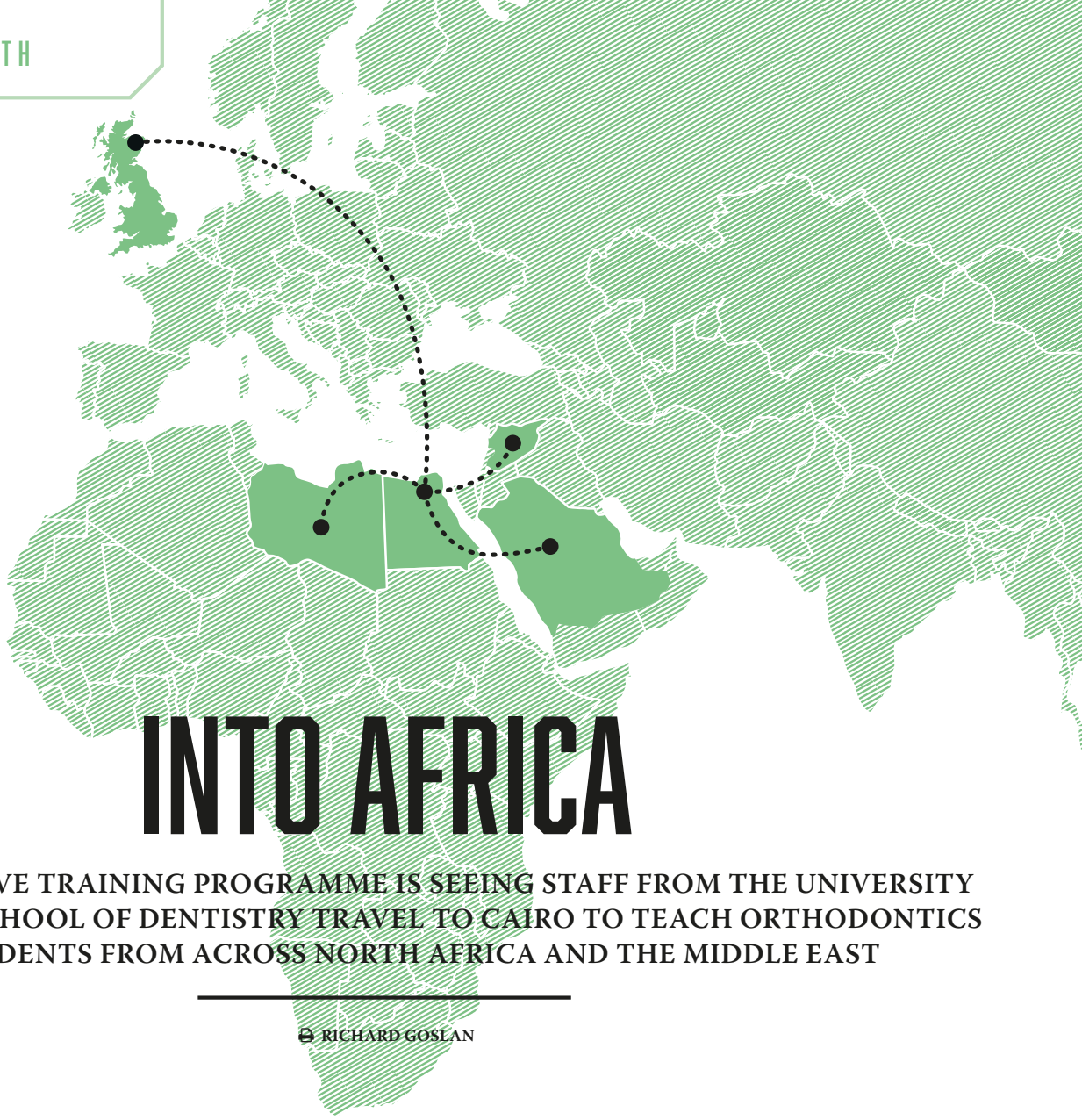
"Through the school and with the co-operation of our secondary care NHS colleagues in restorative care and the like, we are going to train people. So we can then help NHS provision in the north on a much wider basis."

The school, he argues, must also have a role to play in research. Ibbetson believes there are several members of staff whose potential contributions to research have been thwarted to a degree by being deflected by issues highlighted, and contributed to, by the GDC.

And, he says, the school has a central role to play in the wider community of Aberdeen and the north east. Already, the closer working relationship with NHS Grampian is paying dividends and the flow of patients to the school, which had been a significant problem in recent years, has improved. This has meant that students have more patients to train on – under proper supervision – and that there is an improved service to the community.

There has even been an open day held at the school in which local people could come and see for themselves the superb facilities that are available to them.

The journey that Ibbetson and his team have ahead of them is not going to be without its turbulent twists and turns and there will undoubtedly be many difficult challenges to be faced and overcome. But with Professor Ibbetson at the helm, it would appear that the school is very much set on a healthy new course.



INTO AFRICA

AN INNOVATIVE TRAINING PROGRAMME IS SEEING STAFF FROM THE UNIVERSITY OF DUNDEE SCHOOL OF DENTISTRY TRAVEL TO CAIRO TO TEACH ORTHODONTICS TO STUDENTS FROM ACROSS NORTH AFRICA AND THE MIDDLE EAST

RICHARD GOSLAN

This summer, a group of dentists will graduate from the University of Dundee School of Dentistry. Nothing unusual in that, you might think. But these students come from various locations across Northern Africa and the Middle East. They are also the first to gain an MSc in Orthodontics from training received entirely in Egypt, by teachers who have travelled from the UK.

The international programme launched in Cairo at the start of 2013, having been established by David Bearn, professor of orthodontics and associate dean for internationalisation at the School of Dentistry in Dundee.

Professor Bearn had arrived in Scotland from the University of Manchester in 2007, and discovered there was no international orthodontics programme on offer. When he found out it was more to do with capacity at the School of Dentistry than through any lack of will, he decided to take a different approach.

"We had shelved the idea of international students coming here to do an MSc in orthodontics, but then I got into discussions with a contact in Cairo who was looking for someone to partner with to provide programmes there," says Professor Bearn.

"We had the academic willpower and the desire to take our knowledge and skills and share them, so we entered into discussions about working in partnership. As a result, we enrolled our first group of students into our masters programme in orthodontics in Cairo in January three years ago, and I'm very pleased to say that group is now ready to graduate."

FACE-TO-FACE TEACHING

The MSc is aimed at qualified dentists from not only Egypt, but also around the Middle East and Northern Africa who wish to specialise in orthodontics, as well as work in general practice.

The teaching takes place in Cairo using the facilities of the Arab Society for Continuous Dental Education (ASCDE), and the programme runs alongside a complementary three-year programme in clinical orthodontic skills, delivered and assessed by the ASCDE.

Instead of having a day a week of seminars and study time, the students receive the equivalent hours in one concentrated monthly period of face-to-face teaching. Faculty staff from Dundee, as well as colleagues from other dental schools in the UK, travel regularly to Cairo to work with the dentists there.

"The students in Cairo receive three days or so of intensive teaching, then they have three weeks to digest that, work through it, complete their given tasks and prepare for the next intensive period," says Professor Bearn.

ABSOLUTE COMMITMENT

The MSc students include not only Egyptians, but also others from Saudi Arabia, Libya and even those escaping war-torn Syria.

"One of our intake in the second cohort had started his postgraduate training in Syria, and had almost completed it when the country completely fell apart," says Professor Bearn.

"He had to leave before he could graduate, and start all over again. But what we see is the absolute commitment of these people to push on under circumstances that we can hardly imagine. That inspires me, the sense that we are not just doing orthodontics and postgraduate education, we are opening up opportunities for

people that would not otherwise be available to them."

The students also experience a personalised and interactive teaching environment they have never had the chance to experience before, with the intake restricted to 16 in each cohort.

"When they come into our programme, it's a completely new way of learning for them, to have that access to the faculty, that interactivity and the possibility of working in small groups and discussing procedures. It blows them away and it's great to see them loving learning in that way," says Professor Bearn.

"Most of the students will have completed their dental degree at a large public university. Cairo University, for example, has over 150,000 students, more than the population of Dundee, so you can imagine when you're dealing with that many students, there are very few opportunities for small group teaching and interactivity – it's all about massive lectures with the professor standing at the front."

A CHANCE TO FLOURISH

Professor Bearn says the difference in approach can be transforming for students who have previously been lost in the crowd.

"We see students flourishing in this different environment and atmosphere," he says. "There was one guy, Khaled, who when he came to us was clearly very intelligent, but his self confidence was low. After his first assignment I told him: 'You know, Khaled, this was a very good piece of work. If you do a bit here, you'll be up to an A grade'. He said: 'No one has ever told me before that I've done a good piece of work'.

"Watching him over the next 18 months, he's really grown and gained confidence. So it's not just about acquiring knowledge and skills, it's about gaining a greater belief in themselves."

The expectation for graduates such as Khaled is that they take this knowledge – and confidence – and apply it in their home country.

"That is absolutely the ethos of our programme," says Professor Bearn. "We make it clear that the MSc is not aimed at students who want to come and do orthodontics in the UK. We select people who have their roots in their home country, whether that's Egypt, Sudan, Syria or Libya, and we say to them, we're training you to go back and, where possible, be an orthodontist in your home country."

COPING WITH CHALLENGES

Working in the Middle East is not without its challenges – especially when you find Egypt in the middle of mass protests to mark a year since the inauguration of Mohamed Morsi as president.

"During that first year in 2013, there were about three months we couldn't travel to Egypt at all. For the next three months, we flew out, but instead of going to our normal teaching location in Cairo, the students came to us at an airport hotel," says Professor Bearn.

"But then everything calmed down and we were able to go back to our previous pattern. Ultimately, I think we showed a degree of resilience and our colleagues and the students in Egypt appreciated the fact that we didn't just say it was too difficult and walk away; we showed a commitment to the students and the project."

Safety for travelling staff is a priority, with strict guidelines about how they move around the city, but Professor Bearn points

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out the satisfaction his colleagues get from their involvement in the project.

"All of our people who travel to Cairo are keen to go and once they've been, most of them ask when they can return," says Professor Bearn. "They get to see dentistry in a different cultural setting, and it can blow their minds to witness the situation the local dentists have to work in.

"But what keeps people going back is that sense of making a difference, that sense of reward; for those of us in education, there is nothing quite like the thrill of seeing a student who 'gets it', and for students out there, this course can be such a transformational experience."

"WHAT KEEPS PEOPLE GOING BACK IS THAT SENSE OF MAKING A DIFFERENCE"

PROFESSOR DAVID BEARN

EXPANSION PLANS

Indeed, the MSc has been such a success that Professor Bearn is now looking at the possibility of establishing a similar programme in a different region, with India and Kazakhstan already mentioned as candidates. There is also scope for the dental project to expand within Cairo to incorporate other areas of expertise from the University of Dundee, such as infection prevention and control from the School of Nursing and Health Sciences.

In the meantime, Professor Bearn's first Cairo graduates are preparing to move on – but not lose touch.

"We've had all sorts of interesting ideas, but obviously we want to keep an alumni group together," he says. "For the very brightest students who want to do it, there may be opportunities to come to Dundee to pursue a full-time PhD. We're also hoping that quite a few of our students return as trainers for future cohorts.

"But, wherever they end up, we want to be alongside them and share their experiences as they continue their journeys."

NHS DENTISTRY IN THE SPOTLIGHT

ROUND TABLE LOOKS AT THE FUTURE OF THE NHS

BRUCE OXLEY MARK K JACKSON

It's not often that Robert Burns is brought up in a discussion about dentistry but, in opening the latest Scottish Dental Round Table, chairman Robert Donald quoted the following line from Scotland's great poet: "facts are chiels that winna ding". For those not familiar with Burns' 1786 poem *A Dream*, it basically means you cannot argue with the facts, and the chair of this particular discussion had a few choice ones of his own to share with the group.

He said: "The reports on morale and motivation show a direct zcorrelation between net profit and low morale. So, if you're a higher NHS-committed dentist, you actually have lower morale and motivation compared with your colleagues in mixed practice and there's also a direct correlation between working longer hours to keep businesses afloat, which is also associated with lower morale and motivation.

"We know that the real net profit for practice owners in Scotland is down by 29 per cent in the last five years, we also know that the real net profit for associates in Scotland is down by 31 per cent between 2008/9 and 2013/14. These are the government's own statistics and I think they're quite damning of government policy.

"Scottish practices have the highest expenses to earnings ratio at 70 per cent. We also have the lowest turnover of all dentists in the UK. How do you feel we can actually keep NHS dentistry in Scotland with statistics like that?"

Retired Glasgow dentist Gerald Edwards revealed that the stress and pressure of NHS dentistry contributed to his retirement. He explained that not having enough time for patients, keeping on top of your notes, the pressure to make money allied with all the rules and regulations make it an impossible situation.

He said: "It's an impossible situation to be working in. It's just not on. So, you're going to have low morale of staff, you're going to have low recruitment. I don't want to put politics in to it too much, but the NHS and the Scottish Government up here haven't done a good job."

Laura Milby, who runs a practice in Kilsyth, asked if the table thought that part of the problem is that NHS dentistry is trying to be all things to all people. She said: "It can't be all things to all people. I think that brings you round to the SDR. If we're going to keep NHS dentistry to treat patients and maintain good patient care, then we can't provide all these things that are currently on the SDR."

Jonathan Dougherty felt that he saw NHS dentistry becoming more of a core service. To which Laura Milby replied: "I don't even think just about dealing with patients in pain, I think it should be a basic service. I know they don't like the expression 'core service' but to my mind, on the NHS, there is no need for patients to have six veneers for example, I'm sorry but I just don't think that's NHS treatment.

"There's a limited budget, we all know this, so if that's the case we all have to spend that money wisely."

Mydentist clinical director and Battlefield dentist Sharon Letters argued that it is "hugely important" to keep NHS dentistry but said that perhaps the answer is a core service with a greater focus on prevention. She said: "If you look at low socioeconomic groups, there's still a huge variation between both the treatments that they get and the prevention that they get compared with other groups.

"I think we really have to look at a more preventative service for the NHS rather than just fire-fighting and picking up the pieces when things go wrong."

Jamie Kinnell, an associate in Glasgow, said that he thinks it is very important for patients to have access to NHS dentistry but that patients often think it is an all-encompassing service, which budget constraints simply don't allow for.

He said: "When patients require more complex treatments, the fee is simply not appropriate for the dentist to meet their obligations with the GDC. In terms of prevention, it comes down to the fee the dentist is getting and there needs to be an adjustment with fee per item and the SDR.

"You're not encouraging prevention, there needs to be a higher examination fee which allows time for prevention as well record keeping and consent, given the standards the GDC expects of us."

Arfan Ahmed, managing partner in the L&T Dental group, said he definitely felt it is important to have an NHS dentistry service similar to how it was 20 years ago. However, he argued that many dentists might be happy with the way the SDR is structured because it has allowed them to do more private work. He said: "I think it's an absolute fact that very few governments in the world can afford to subsidise high quality private dentistry – it's too expensive."

Sharon responded by saying: "I think we're maybe doing some of our colleagues a disservice here because I think that a lot of our colleagues are actually providing very high quality NHS dentistry under the NHS constraints."

Gerald then said: "I think Sharon's right but this is the government hiding behind the GDPs. We're taking the stress. The government are getting away with murder because they're not providing enough money for the service but dentists are doing more than they have to because they're decent people."

And Robert said: "The feedback I get from a lot of dentists is that they are providing high quality work in spite of the NHS and in some ways they are actually subsidising that treatment themselves every day."

Jamie said that he knew of many dentists who are providing a far higher service than the NHS is paying them for but asked if that was sustainable. "I'm actually quite impressed a lot of the time that someone has provided that level of treatment within the fee structure of the NHS but it can't be sustainable. If it's not sustainable then a few years down the line, unfortunately for those patients, it won't be there. Patients should have access to those range of treatments and not just a core service."

The discussion then moved on to what needs to change to make NHS dentistry more sustainable.

"They have to reduce the amount of items that are covered," said Gerald. "I mean molar root treatments, anything cosmetic, metal dentures, all these things, they're not viable anymore.

"The trouble is the government doesn't care and it doesn't value NHS dentistry. But the GDC will be down on your back if you don't do all this wonderful stuff. You're meat in the sandwich, you're being crushed from both sides."

Laura said: "I had a patient a couple of weeks ago and I thought the best treatment for this tooth is a gold inlay. The lab fees for the inlay cost more than I got on the NHS fee scale to do it. Would I do it again? Yes, I probably would, because that patient has been coming to me for a long time and that was the best treatment for that tooth. I don't think I'm alone in that – you just take the hit."

Robert then asked how the dentists around the table would like to see the SDR changed to introduce prevention and not destabilise the system.

Jonathan took up the discussion by saying: "I would increase reward. I think you should get paid more for having to do less treatment. I know that sounds a bit silly but, if you're trying to focus on prevention and your preventative advice is good, the patients will need less treatment. Right now we're not getting that reward for providing preventative advice. We are getting rewarded for the more treatment we do. Therefore where is the incentive for promoting better oral health."

To which Robert replied: "It's almost like an obscene incentive isn't it? If they want

CONTINUED OVERLEAF>

THE PANEL

Robert Donald is a GDP in a mixed practice in Nairn. He is chairman of the Scottish Dental Practice Committee and also a non-executive director of the Medical and Dental Defence Union of Scotland.

Sharon Letters is the clinical director for {my}dentist covering Scotland and the North East of England. She also works as an NHS dentist in Battlefield, Glasgow.

Gerald Edwards is a retired NHS dentist who ran a single-handed practice in Stonehouse, South Lanarkshire, for 25 years. He also worked as an associate in East Kilbride, Pollok and Queen's Park, Glasgow.

Arfan Ahmed is the managing partner of the L&T Dental Group. He has worked in mixed NHS and private practices during his career and he is also a non-executive director of a pharmaceutical company.

Jamie Kinnell works in private practice at Dentistry on the Square in Glasgow. He is currently studying towards his MSc in restorative dentistry.

Jonathan Dougherty works in Kilmarnock Dental Care, and Philip Friel Advanced Dentistry. He graduated in 2010 and is just in the process of finalising his diploma in restorative dentistry with the Royal College of Surgeons England.

Laura Milby qualified in 1984 and has a practice in Kilsyth in Lanarkshire. She got involved late in to dental politics around 15 years ago and also works as a practice inspector.

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us to do more prevention, we have to take the foot off the treatment and the treatment pays the grants because it's based on your turnover. So, the more work you do, the more money you get in your grant. The less work you do, if you did more prevention you would get less money for that."

Jamie then argued that practices could be paid preventive fees based on a percentage of their previous year's gross, and then the practice's performance is monitored going forward. He said: "The incentive then is immediately for them to focus on prevention because, in the long term, the better the preventative approach and the quality of their work is, then the amount of work they'll need to do should reduce which is beneficial for them. The fee that they're getting can then be reviewed if items of service don't reduce, but that immediately allows those practitioners to focus on a preventative approach."

However, Gerald explained that the government is unlikely to see it that way. He said: "The problem with that is the politicians' love of statistics. When you do a filling it's a statistic, when you do nothing it's not a statistic. If you've got prevention you can't prove that it's either prevention or it's just neglect. You won't know for 10 years and the politicians won't go for that."

Robert then argued that the government needs to change its mindset away from measuring treatments to measuring outcomes. "A successful outcome for dentists is not having to do any treatment whereas in their eyes a good outcome is 'well we did record numbers of fillings this year or record numbers of extractions."

"I THINK THAT A LOT OF OUR COLLEAGUES ARE ACTUALLY PROVIDING VERY HIGH QUALITY NHS DENTISTRY UNDER THE NHS CONSTRAINTS"

SHARON LETTERS

Arfan said that there are "some very simple changes that can be made to the SDR," by focusing on what the evidence base is saying. He cited the example of over preparation of teeth to accommodate amalgam fillings for certain restorations. "The option of providing composite restorations that are remunerated appropriately should be considered," he said.

Robert then asked the group whether they felt the current SDR encourages good record keeping. He said: "We work under a system where, instead of being judged by the quality of the treatment, in many cases it's the records that we're gauged on as to the quality of the treatment. The fact is the system does not properly fund or reward that level of record keeping."

The feeling around the table was that the fee for an examination doesn't allow for enough time to do everything and needs addressed. Jonathan described the pressure he feels to get notes done between patients. He said: "My notes are literally done between when the patient leaves and the nurse is quickly cleaning up before the next patient. You're under pressure to get them finished because there's another patient waiting."

Jamie suggested multiple examination fees with guideline times so the dentist can choose the appropriate one. He said: "The examination price has to be dramatically increased, guidelines put in place for what's included and then if they want to take other things off that's fine. I think everybody would be much happier if they just had higher examination fees to cover the care that's been provided to patients and also their record keeping obligations, consent, IRMER, GDC and so on."

The table unanimously agreed that a change to the exam fee was essential and would improve the daily lives of NHS dentists, despite reservations from some members of the discussion that it would never happen due to ongoing budget restraints.

The conversation then moved on to the differences between NHS and private, with Robert asking: "Do you feel you work harder on the NHS compared to private? Can you compare the two?"

Arfan was the first to answer: "I think working within NHS dentistry can be extremely stressful. I qualified in 2008, completed my VT year and soon after virtually gave up NHS dentistry, because I found it quite stressful.

"I very consciously made the decision that I want to spend at least 30 to 45 minutes talking to my patients when they come in, really understanding what their needs are and spending time providing good quality dentistry. I'm not saying that NHS dentists don't do good quality dentistry, but how many NHS dentists spend half an hour or 45 minutes doing an examination?"

Robert then asked Gerald if he had his time again, if he would still work under the NHS. He said: "I liked the NHS system

but when I started it was a lot different. It was less stressful, hugely less stressful. Nowadays with the NHS you've got so many things you're supposed to do.

"It became more and more onerous, more and more responsibilities – you get paid less and there is more aggravation."

But Laura revealed that the reason she works in the NHS and will continue to work in the NHS is because she wants to care for the people that can't afford to pay for private treatment. And, in order to do that, she has to supplement her NHS income with more private treatment.

Arfan said, with regards to affordability, it comes down to the type of dentistry you wish to do. He said: "You should not compromise on quality. You have your core principals and beliefs and that's the quality you work to. It's like doing half of a heart operation, it doesn't make sense, but in dentistry you do half an examination and that's okay. I find this mindset difficult to contend with."

For Jamie, it is also about being paid appropriately for his time. He said: "I have moved from NHS to private over the last four years. The difference is time and I'm paid appropriately for my time. There's some NHS practitioners, in terms of the fees coming in to the practice, they may not be that much different, but what they're doing is they're forcing themselves to work to a limited time. That's where the stress is. It's a constant grind. You ask anyone why it's stressful, it's a never-ending assembly line, it's constant, there is no let-up."

Robert then asked the dentists around the table to get their crystal balls out and predict what the future holds for NHS dentistry. Arfan said: "I think, despite people's best intentions and people wanting to do the best for their patient, there is a risk the quality of NHS dentistry may deteriorate due to the significant burdens now placed upon associates and practice owners." He also argued that there should be some form of licensing to limit new NHS practices opening up where there is already adequate provision. "I think this would have a positive impact on the long-term sustainability of NHS practices," he said.

Despite graduating in 2010, Jonathan said he feels his time in the NHS could be coming towards an end. He said: "I think if the service continues going the way it's going, I don't know if I could continue working within the NHS. I think the stress created by working on the NHS is not only physically, but emotionally draining. I think the public's view of NHS dentistry needs to change and I feel the government need to be honest with the public regarding this. We all know within the profession that it cannot continue the way it is currently going and the greater powers need to come forward and be honest about this."

Laura explained that she thinks she will always be mainly NHS but she is realistic in that she will have to do more private work to "balance things out". However, she said the big thing for the profession and the government to focus on is prevention for both the young and old. "We need a big push on education, I think the government has a lot of responsibility for the education of patients," she said.

For Sharon, she believes a lot of dentistry will be patient driven as they use various technologies to research the private options open to them. She also argued that the rise of corporate dentistry will play its part. She said: "I think there will be more corporate dentistry in the future. The advantage of that is that it does take away some of those stresses that are on practitioners from day to day. Corporates provide support for clinicians, ensuring they remain compliant and can focus on the dentistry, both NHS and private.

"I also think probably some of the secondary care services that we've got at the moment will be pushed back in to primary care, I think that's probably how I see it in the future."

Jamie Kinnell echoed Jonathan's worries about the stresses on dentists. He said: "I think practitioners that continue to work in the NHS as it is are going to burn themselves out. They will either leave the profession or go abroad. and again it's the patients who rely on the NHS who will lose out."

The last word was given to Gerald who said that he felt a core service is inevitable. He said: "Let's face it, the government doesn't like to spend money so what it should be doing is this dreadful phrase "core service". It's going to come. It will take out all the fancy stuff, bring in a longer examination period where you get paid a wee bit extra for the examination, you will get pain fixed, you'll get the very basics fixed and if you want anything else it's private. I think that is the fairest and most sensible thing to do, I think that's the obvious solution.

"So eventually, you'll have a two-tier system, I don't think there's anything wrong with that and I think that solves all the problems." ◤

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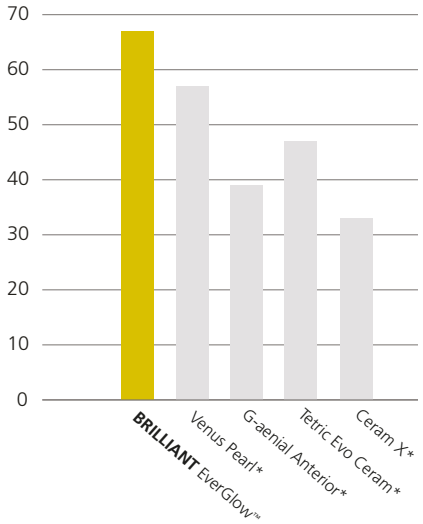

Even after loading for 6,000 cycles in a toothbrush simulator, BRILLIANT EverGlow retains its initial gloss and performs very well.

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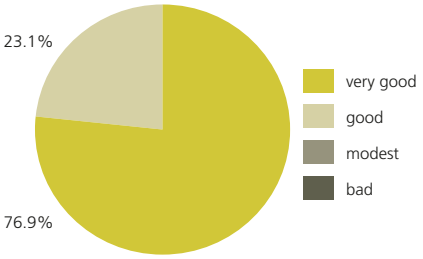
EVALUATION OF POLISHABILITY



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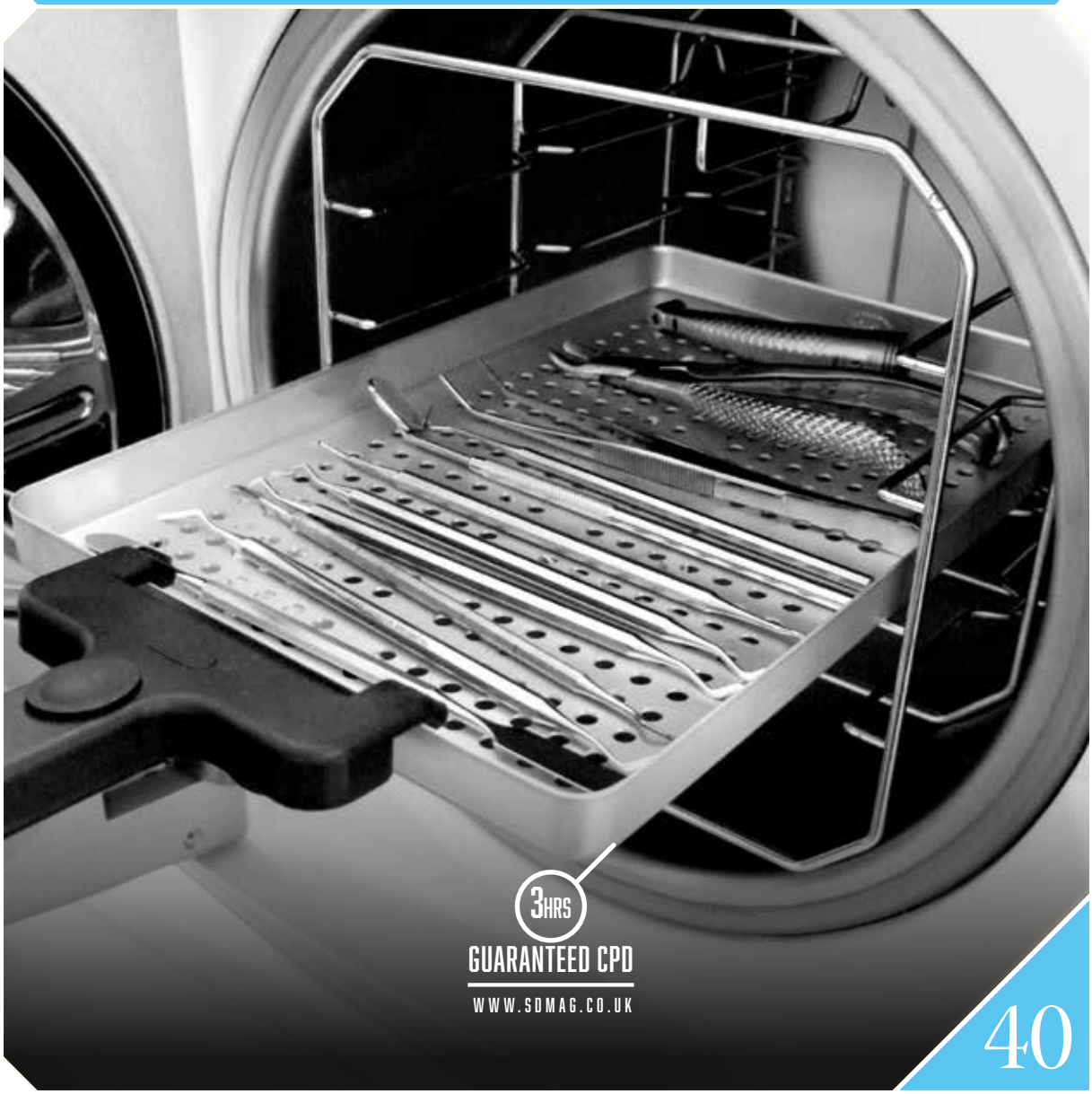


DECONTAMINATION – WHERE ARE WE NOW?

HYGIENE

The decontamination of dental instruments is a vital element of any general dental practice. Irene Black gives an update on the current situation

IRENE BLACK

Like most topics, decontamination has gone through phases of being high profile and then seemingly disappears off the radar. Recently, when decontamination does re-emerge, it is often when errors or omissions have been identified. It is still undoubtedly an extremely emotive issue, particularly when things go wrong. It is also a critical element as far as patient safety is concerned.

Dental practices and their teams have come a long way in the last five years as far as decontamination is concerned. We have been in a period of consolidation as far as guidance and requirements are concerned but, in my experience, we occasionally slip back into old habits. Reviewing and refreshing our knowledge and skills is essential to ensure we are following the requirements and able to show we are doing the right things to the best of our ability.

The decontamination cycle (Fig 1)

Decontamination is the process by which reusable items are rendered safe for further use on patients and safe for staff to handle. The process is complex and involves several stages, with potential for error throughout.

The decontamination cycle begins in the surgery with segregation of reusable items and disposal of single-use items and other materials in appropriate waste containers. Items to be processed for reuse must be transported safely to the Local Decontamination Unit (LDU) as soon as possible. The transport boxes should be rigid, lidded, and easy to clean. These transport boxes must be easily identifiable as containing either 'dirty' or 'clean' items to avoid any potential confusion. Colour coded boxes are often the simplest way to ensure this. Using marker pens or labelling only the lids still leaves potential for error.

The next stages of the cycle are cleaning, inspection, sterilisation packing and storage.

Local Decontamination Units (LDU)

Dental practices today – space, the first frontier

Today, those considering setting up new dental practices need to make sure they have enough space to meet current requirements and ensure they are future proofing their setting. Recently, the number of dental professionals looking to set up new practices has been increasing. The settings of choice tend to be small commercial units in shopping areas where there is potential for patient footfall. I do have some concerns that, in the drive for financial viability, they are starting out with a limited area and will find they run out of space in a short time.

Despite advances in new technology, implying that practices should become more streamlined, the reality is we have many more items to house. In my experience, our need for storage capacity has not decreased despite the drive towards paperless systems and digital advances. Lack of space can result in cluttered, chaotic and disorganised settings with less potential to create a good impression and more potential for error, particularly in relation to good infection control and decontamination.

LDU compliance

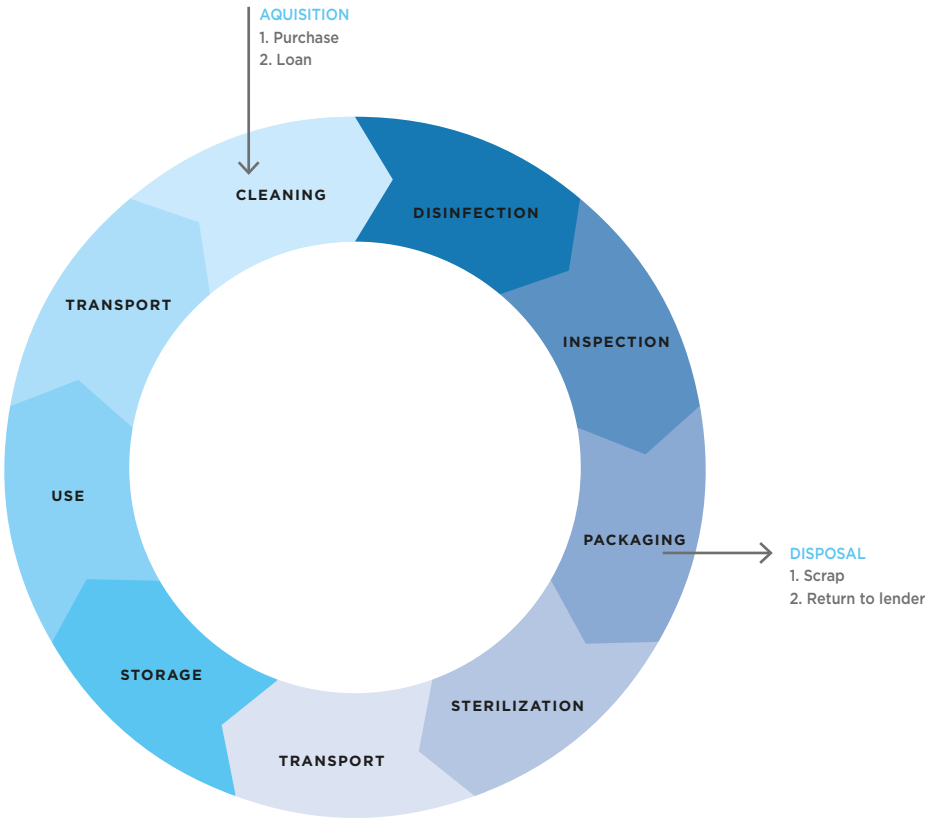
Current guidance states an LDU compliant with SHPN13 is essential for primary care dental practices (Compliant Dental Local Decontamination Units in Scotland (Primary Care) (2013)).

Key points

General requirements for LDUs:

- Away from the clinical area and no activity other than decontamination undertaken
- Dirty and clean areas clearly demarcated
- Instrument flow from dirty to clean
- Smooth cleanable surfaces

FIGURE 1
The decontamination cycle



Dental practices and their teams have come a long way in the last five years as far as decontamination is concerned

- Well lit with ventilation
- Enough space for equipment and set-down areas.

Essential components

- Hand wash sink and Personal Protective Equipment (PPE)
- Set-down areas
- Washing sink and rinsing sink
- Washer disinfector
- Inspection areas
- Sterilisers
- Packing area.

Every dental practice in Scotland now has a room dedicated to the decontamination of dental instruments. Having an LDU is the accepted norm and is an essential requirement for the Combined Practice Inspection. These LDUs can undoubtedly vary in shape and size, but the general lay out should be in line with the single room model as stipulated in Scottish Health Planning Note 13 (SHPN13). There are sometimes some minor variations in the configuration and they may not all follow the exact requirements of SHPN13.

The design differences often relate to limited space available or build decisions determined by a contractor. Limitations such as plumbing, or other seemingly insurmountable building difficulties, have often been identified as the cause. In some cases, health boards may have agreed to minor deviations from the guidance to ensure continuance of a service when there appeared to be no other option available.

Some LDUs are undoubtedly smaller than the preferred option and space constraints are not ideal. In these circumstances, it is essential that the correct process is applied to the letter every time to avoid errors. These errors are often due to insufficient set-down space. All staff must be trained accordingly to ensure everyone knows and follows the exact procedures in place for that setting.

Other difficulties relate to using the dedicated LDU for other purposes. Again, this usually comes about due to overall space limitations in the practice. These other activities have ranged from housing X-ray developers to tea and even food preparation, neither of which is acceptable either for staff or patients. Hopefully, that message has been heard loud and clear and common sense now dictates that this is not acceptable.

LDUs are now in use across Scotland. Staff have accommodated remarkably well. I don't believe many would wish to go back to carrying out decontamination in the clinical area. The constant background activity of washing up, while an ultrasonic rattled incessantly and autoclaves generated sauna-like conditions, was not exactly conducive to the provision of good quality patient care.

Single-use items

The guidance stipulates that the use of single-use items should be the option of choice where possible as long they are viable and work effectively for the purpose required. All items carrying the single-use symbol (Fig 3) should not be re-used or reprocessed. If this symbol appears on an item this is part of the manufacturer's instructions. Compliance with manufacturer's instructions is accepted as the legal

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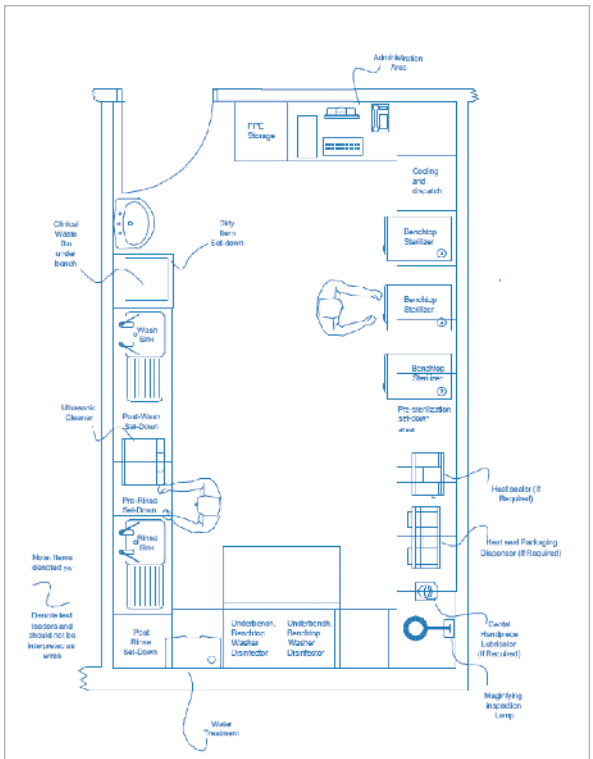

The option appraisal will determine the type and number of each type of equipment. Other areas or rooms not shown are required to support this model, e.g. device storage, domestic services and trolley parking

FIGURE 2A
SHPN 13 part 2 Dedicated separate Room/rooms

FIGURE 2B
Washer disinfector in LDU

FIGURE 3
single-use symbol

FIGURE 4
clip trays

FROM PREVIOUS PAGE>

requirement for all equipment.

Specific single-use items that have presented difficulties include:

- **Three-in-one tips**. Reusable metal tips are unacceptable as they are extremely difficult to clean and there are good disposable alternatives. The requirement for single use three-in-one tips is part of the practice inspection.
- **Endodontic files**. This has been a requirement in Scotland since 2004 and has not changed. (The situation in England is different in that they allow for re-use on the same patient. The issue with this is the exacting requirement for reprocessing and the potential for error as far as identification and storage are concerned.)
- **Plastic impression trays** are single-use despite the fact labs return them to practices for disposal. The effort required to clean and re-use most certainly outstrips any benefit gained considering the time and energy expended on trying to clean and prepare these for re-use.
- **Matrix bands**. There is evidence to show that these items, which are often heavily contaminated with blood, cannot be cleaned effectively and present a risk to staff and patients. These must be dismantled with care and disposed of in appropriate waste containers for sharps. The holder must then be cleaned and sterilised. There are single-use alternatives.

The decontamination process

The decontamination process is about the application of knowledge and skills and is dependent on what individuals do in their own settings. The decontamination process in the LDU includes cleaning, inspection, sterilisation and packing for storage.

The general principles of the process are:

- All items should be processed according to manufacturer's instructions. The problem with this can be that the instruction provided may not be clear or explicit. In that case, you are entitled to request information from the manufacturer or via the supplier.
- The flow of the instruments in the decontamination process is always from the dirty to clean area and never goes back in the process. The only exception would be if visible soil is picked up through inspection and the item is returned to the start of the cycle to repeat the full process.
- Using an automated cleaning process is required and washer disinfectors are essential for cleaning dental instruments.
- All re-usable items must be at least sterilised if not sterile at the point of use.
- Policies and procedures must be in place for all aspects of decontamination. All staff must have read these and can access them for easy reference.

Cleaning

Washer disinfectors – the final hurdle for compliance?

"Use of a washer disinfector (WD) is a requirement for compliant reprocessing of dental instruments" (Compliant Dental Local Decontamination Units in Scotland (Primary

Care) (2013)). Using a washer disinfector is the preferred method for cleaning dental instruments because it offers the best option for the control and reproducibility of cleaning. This means the cleaning process can be validated. WDs are used to carry out the processes of cleaning and disinfection consecutively.

A typical WD cycle for instruments includes the following five stages:

- **Flush** – Removes gross contamination. Latest standards indicate that a water temperature of <45°C is used to prevent protein coagulation and fixing of soil to the instrument
- **Wash** – Removes any remaining soil. Detergents used in this process must be specified by the manufacturer as suitable for use in a WD
- **Rinse** – Removes detergent used during the cleaning process.
- **Thermal disinfection** – The temperature of the load is raised and held at the pre-set disinfection temperature for the required disinfection holding time: for example, 80˚C for 10 minutes, or 90˚C for one minute
- **Drying** – heated air removes residual moisture.

Some manufacturers have worked on this in an effort to reduce cycle times as this was a significant barrier to their use. They have endeavoured to reduce the cycle times to improve efficiency for use in practice and while still demonstrating effective cleaning efficacy as per testing requirements.

What have the problems been?

It is safe to say that the dental profession in Scotland has been slow to adopt this piece of equipment as a 'must have' as they strive towards best practice in decontamination.

The reasons for this are varied and complex. The reputation of these items have been somewhat tarnished often through anecdote and bad press. Admittedly, this was not helped by some genuine technical problems related to specific machines resulting in some practitioners experiencing difficulties despite their best efforts. Negotiations with suppliers and manufacturers have been ongoing in an effort to resolve specific cases. From the outset, some practitioners heard about these problems and simply decided not to try for themselves.

Another difficulty with washer disinfectors was that they didn't fit naturally and seamlessly into our existing processes. We had to change aspects of what we did to make them work efficiently and effectively for us. Change is difficult and it takes time. The early abandoners ran out of patience and gave up quite quickly. Some of the more tenacious teams persevered and have become converts. Recently, I have had some surprisingly positive feedback from some of the more strident early objectors.

The fact is, these machines are an essential requirement in Scotland to ensure our reusable instruments are clean and able to be sterilised effectively.

To utilise a washer disinfector efficiently and effectively, in my opinion, we need several things. First of all, you need have done a capacity calculation to work out which washer disinfector suits the needs of your practice. The overarching aim is ultimately to run the washer disinfector a minimum number of times a day and only put it on when it's at or close to its full capacity. To work that out, you need to look at:

- How many items are used in the practice in an average session?
- What does the WD hold?
- Could the internal set-up be improved to hold more?
- How long will it usually take to get the WD to capacity?
- How long does the full decontamination cycle take?
- Do you have enough stock of instruments to avoid shortages at busy times?

In my opinion, using clip trays (Fig 4) for cons kits are essential to allow the WD to work efficiently for you. The initial capital outlay will save running cost in the longer term. It also reduces risks for staff having to spend time dismantling open trays, which need to cleaned separately and then reassembled before storage.

Members of the dental team who work in the LDU are best placed to work this out and establish a routine that suits the way the practice works and use the WD efficiently and effectively.

Ultrasonic cleaners

Compliant ultrasonic cleaners are also an automated cleaning method. They are useful as a back-up cleaning method. They are no longer an essential requirement as far as the practice inspection is concerned as washer disinfectors are the first line cleaning method and an essential requirement.

Ultrasonic cleaners can be utilised to pre-clean particularly heavily soiled instruments before processing in the washer disinfector. This is useful if there is a delay before the washer disinfector is at capacity and heavily contaminated surgical kits would become difficult to clean if left to dry out. Pre-cleaning is advisable in that situation.

Using an ultrasonic cleaner if the washer disinfector is down for short periods is acceptable. The ultrasonic cleaner will have to be validated and tested as per manufacturers' instructions to ensure it is functioning effectively if it has to be brought back into use. In a busy practice, an ultrasonic alone may not provide the capacity required to ensure throughput and it may be necessary to revert to full manual cleaning as well.

Reverting to full manual cleaning utilises significant volumes of hot water, detergent and staff time. It also puts your staff at risk of injury. Using manual cleaning should only be adopted as a last resort for cleaning dental instruments. When service and maintenance contracts for washer disinfectors are being arranged some assurance from the supplier as to their response time and contingency plans, if the washer disinfector fails, should be sought. Details of full manual cleaning process can be found in The SCDCEP guidance document – *Cleaning Dental Instruments*, can be accessed at www.sdcep.org.uk/published-guidance/decontamination/

Handpieces and washer disinfectors

Cleaning handpieces effectively due to the extremely narrow lumens is a difficulty. As far as I am aware, there has been little progress on effective handpiece cleaning in washer disinfectors. Some practices are processing handpieces in their washer disinfectors without detriment to their equipment. Most practices are understandably tentative about putting these delicate, expensive items in their washer disinfector. There is no specific guidance that stipulates this is a requirement. If you plan to process handpieces in a washer disinfector, make sure you have written instructions and an assurance of compatibility from both the handpiece and the washer disinfector manufacturer.

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Tray of instruments loaded correctly for optimal processing in a non-vacuum steriliser

Print-out showing the parameters reached during the sterilisation cycle

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Decontamination process – sterilisation

All reusable items must be sterilised. From time to time we come across situations where there is some confusion as to what type of autoclave is in use or which cycle is being used. It is imperative that the whole dental team understands the difference between vacuum and non-vacuum cycles in benchtop sterilisers to ensure these are used safely and effectively.

- A non-vacuum cycle can only be used for unwrapped items. When the cycle is complete, the items will have been sterilised.
- It is essential that any steam steriliser is not overloaded.
- If a vacuum cycle is used, items can be wrapped or bagged before sterilisation. When this cycle is complete, the items will be sterile as long as the packaging is intact.

Please note, if items are wrapped before being placed in a non-vacuum cycle. they will not have been sterilised. If these items were subsequently used. this presents a significant risk to patient safety. This is a serious event and must be reported.

Maintenance, testing and validation of all decontamination equipment

There tends to be some confusion as to what is required as far as testing and validation of equipment is concerned and what your engineer, supplier or manufacturer provides as part of contractual arrangements.

Maintenance contracts for your decontamination equipment are required to make sure the equipment is in good mechanical working order. You may have options as far as the cover you choose. Make sure you are certain which cover you are paying for and exactly what it includes. Testing and validation are not the same as general maintenance. Your engineer may do this at the same visit as part of the contract. Always make sure you know exactly what they have carried out and retain all paperwork as evidence.

Validation is a documented procedure used to show that the decontamination process will repeatedly and consistently take place to a satisfactory standard when defined operating conditions are used. Validation checks and tests are carried out at least annually, which is referred to as revalidation. Some manufacturers may refer to this as annual testing rather than revalidation.

Periodic testing is required to ensure that WDs perform consistently as specified at validation.

Tests and testing intervals will be stipulated in manufacturer's instructions. Some of these tests will be carried out by practice personnel and provide regular checks to evidence that equipment is operating as per the parameters determined at validation.

A test person (engineer) will carry out periodic testing/revalidation as specified in the manufacturer's instructions. This will be required at least annually. Always check with your engineer and make sure you know what is being carried out at each visit.

Testing carried out by practice teams include:

- Automatic control tests. These are required for washer disinfectors, ultrasonic baths and autoclaves. Details on how to perform automatic control tests can be found in the SDCEP decontamination guidance: www.sdcep.org.uk/published-guidance/decontamination/
- Cleaning efficacy tests are used to demonstrate the ability of washer disinfectors and ultrasonic baths to remove soil and contamination. Consult your manufacturer to see which tests are recommended and how often these should be done.

Storage

As far as storage of dental instruments after sterilisation is concerned, the general principle for all reusable items is to ensure that the potential for re-contamination through direct contact or aerosol production is eliminated.

Aerosol production during clinical procedures presents a risk of contamination of surfaces and items within the

area. Aerosols contain blood, saliva and significant levels of associated micro-organisms. This can constitute a risk of transmission of infection as many of these micro-organisms can survive on surfaces for variable periods of time. Thorough environmental cleaning and closed storage must be applied to avoid potential risk of transmission of infection.

The practice of bulk storage of items for intraoral use should be discontinued. Using drawer inserts to store loose mirrors and probes is not acceptable as far as avoiding possible contamination is concerned. Storage options include the bagging of examination and other kits. Bagging of forceps and other items for oral surgery has been accepted as the norm for some time. Conservation kits in clip trays should be stored covered with a lid or bagged and can be placed in cupboards in racks or drawers either in the clinical area or in a central storage area.

All items for clinical procedures should be set out for use on each patient immediately before the treatment episode. During clinical procedure, when extra items stored in drawers or cupboards are required, good local systems for retrieval to avoid potential contamination of other items must be in place. This may involve glove removal and use of clean tweezers to ensure efficient safe practice.

Practices may have adopted different ways of fulfilling the requirements for storage related to their specific storage spaces and practice layout. Avoiding the potential for recontamination is essential and should be considered fully to ensure there are safeguards to ensure the risk of this is eliminated as far as possible.

In general:

- No unnecessary items intended for clinical use should be set out on work surfaces during clinical procedures. Reduced clutter means easier cleaning.
- Items set out for a specific patient treatment and not used must be fully reprocessed or disposed of if single use.
- Sterilised items even in closed storage such as cupboards or drawers should be covered.

There is no specific guidance in Scotland as far as the timescale for safe storage of non-sterile or sterile items. HTM 0105, the guidance applied in other areas of the UK apart from Scotland, stipulates more exacting requirements for storage (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170689/HTM_01-05_2013.pdf)

Training

The need for suitable training enabling the application of good infection control and decontamination, in line with Scottish guidance, is essential for the whole dental team. Another essential requirement is quality assurance. Audit is the accepted method of choice. This is essential, not only for infection control purposes, but also to fulfil NHS terms of service.

NHS Education for Scotland can provide both and help to avoid the pitfalls.

Our national infection control support team is made up of dental nurses with extensive experience both in practice and as trainers. They have been trained specifically to Scottish infection control and decontamination guidance requirements. They have a wealth of knowledge and are fully aware of the differences in guidance in others parts of the UK. Our team can tailor sessions to meet any needs the practice feel they have. For example. if you are struggling to integrate your washer disinfector into your usual process. our team can help.

The training does provide knowledge, but the real focus is on practical application. In a busy practice, knowing what to do doesn't mean we all do it every time. Our sessions are designed to identify what makes the application of that knowledge challenging and what might help to make that change. Providing the practice with an action plan is an essential element to enable these changes. This plan will be supported and followed up. We also have two short e-learning programmes that are useful for updates or induction for new staff. These can be accessed though the NHS Education Portal (https://portal.scot.nhs.uk/)

On request, in conjunction with booking a training session, dentists can access four pre-populated audits via the NES Portal covering four areas of infection control and decontamination. Our team can review data collection and provide feedback on audit reports. After submission of a satisfactory report, dentists will have evidence of quality assurance in their practice and be eligible for audit hours and allowance.

NHS Education for Scotland has worked hard over the last years to ensure a consistent message based on Scottish guidance requirements has been delivered to the whole dental team in every practice in Scotland. NES has delivered 2,313 in practice training sessions to 6,511 dentists and 1,335 DCPs.

The message is out there. If you feel your team could benefit from our training, please contact Natalya.Zhernakova@nes.scot.nhs.uk or call 0141 352 2642.

ABOUT THE AUTHOR

Irene Black graduated from Glasgow University in 1980, gained her Membership of the Faculty of General Dental Practitioners in 1999 and the Certificate in Effective Dental Management in 2005.

Along with her husband, she owned an NHS dental practice in Eaglesham for 27 years where she continues to work on a part-time basis.

Irene has been a dental practice adviser in Greater Glasgow and Clyde health board for 14 years and her interest in education developed during nine years spent as a vocational trainer.

She has worked as an assistant director for NHS Education with the remit for infection control and decontamination for the last eight years. This has included developing both in-practice and other training packages for the dental team. As part of this role, she has worked with Scottish Government and other NHS organisations in an effort to determine how the difficulties related to decontamination in dental services might be resolved.

Irene also works with the Scottish Dental Clinical Effectiveness Programme in guidance development and research.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- This article reviews the general principles of decontamination and highlights some aspects that have been challenging for dental practices and their teams.

LEARNING OUTCOMES:

After reading this article you should be able to:

- Plan the general layout of a single room local decontamination unit.
- Describe each stage of the decontamination cycle.
- Demonstrate the decontamination process in your own setting
- Discuss the testing requirements for decontamination equipment.
- Identify the relevant guidance documents for decontamination in Scotland.

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REFERENCES

Scottish Health Planning Note 13 Part 2, Local Decontamination Units (www.hfs.scot.nhs.uk/online-services/publications/decontamination/)

Local Decontamination Units: Guidance on the Requirements for Equipment, Facilities and Management (www.documents.hps.scot.nhs.uk/hai/decontamination/publications/ldu-001-02-v1-2.pdf)

Compliant Dental Local Decontamination Units in Scotland (Primary Care) (2013) (http://www.hfs.scot.nhs.uk/publications-1/decontamination/)

PREFABRICATED CROWNS FOR PRIMARY MOLARS

RESTORATIVE

How to achieve full coronal coverage in primary molar restorations

ANNE C. O'CONNELL, EVELINA KRATUNOVA

In children, the goal is to restore the tooth once for the lifetime of that tooth, yet full coverage restorations for primary teeth are underutilised in general practice.

The function of a crown is to protect existing tooth structure and to retain the tooth in function. Numerous clinical situations require full coverage restorations in primary molars in order to provide the most durable restoration (Table 1). Primary teeth with extensive caries can be restored most successfully with crowns. Enamel hypoplasia of the primary molars may require replacement of cusp anatomy which is also best achieved by full coverage restoration.

Crowns also provide an optimal coronal seal for pulpally treated primary molars; research shows that indirect pulp therapy, pulpotomy and pulpectomy procedures have better outcomes as clinical success depends on protecting the tooth from the oral environment. Protection of the dentinal-pulpal complex from contamination of the oral environment also promotes healing and protects the vitality of reversibly inflamed pulp, eliminating the need for pulp therapy.

Crowns are also indicated for developmental defects of the tooth structure; teeth with extensive tooth surface loss due to attrition, abrasion, or erosion; fractured primary molars; and infra-occluded primary molars to maintain mesio-distal space (Seale and Randall 2015).

Classification of prefabricated crowns for primary molars

All prefabricated crowns for primary molars are available in varying sizes for each primary tooth type. The manufacturers seeks to replicate the height, mesio-distal width, contour and anatomy of the natural primary teeth, specifically to accommodate the convexity of the cervical margins and the exaggerated mesio-buccal bulge on primary first molars.

Stainless steel crowns (SSCs) or preformed metal crowns (PMCs) are widely recognised for their strength and longevity; however, due to the metallic colour, they lack aesthetics (Fig 1) (Seale and Randall 2015). Chair-side techniques for direct veneering and open-facing have been used to mask the metal colour. Over the years, alternative tooth coloured full coverage restorations have been tested using different types of dental materials and techniques with varied levels of success. Commercially fabricated preveneered SSCs combine durability and aesthetics (Leith and O'Connell, 2011; Kratunova and O'Connell, 2014; O'Connell et al. 2013). Prefabricated crowns made from composite resin, high density polymers, polycarbonate and zirconia offer a tooth coloured alternatives (Fig 2).

Conventional stainless steel crowns

Stainless steel crowns (SSCs) are prefabricated extra-coronal restorations which can be adapted to individual teeth and cemented in place to provide a definitive restoration (Kindelan et. al. 2008). The SSC is a durable, cost effective, minimally technique sensitive restorative option that offers the advantage of full coverage and accommodates the majority of treatment indications for primary posterior teeth (Seale and Randall 2015).

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SSCs were popularised as a restorative method for primary molars in the 1950s (Humphrey 1950; Engel 1950). Over time, SSCs have been modified to improve the anatomical form and the alloy composition (9-12 per cent nickel; chromium 12-30 percent) (Randall 2002). The conventional SSCs are pre-trimmed, pre-contoured and crimped and usually need no or minimal adjustment by the operator. The conventional tooth preparation requires local anaesthesia and the tooth is prepared with 1-1.5mm

FIGURE 1
Restored primary molars showing the poor aesthetics of the stainless steel crowns in the smile.

FIGURE 2
Prefabricated full coverage restorations currently available for primary molars in order: stainless steel crown, crown former for composite posterior strip crown, Nusmile veneered SSC, KinderKrown VSSC and a zirconia crown.

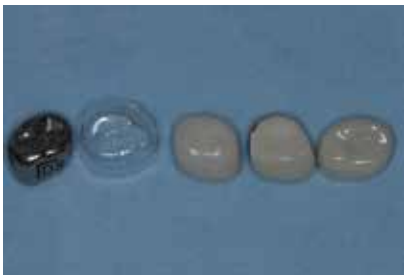

TABLE 1

INDICATIONS FOR FULL COVERAGE RESTORATIONS
Extensive tooth destruction – caries, erosion, developmental defects
Caries with > two surface involvement
Post pulp therapy
Fractured molars
Infra-occluding molars: to maintain mesio-distal space
Patients with high caries susceptibility/OH impairment /special needs
Caries lesions restored under general anaesthesia

TABLE 2

Armamentarium required for placement of conventional stainless steel

BURS	Occlusal reduction - Football Proximal reduction - Flame	
SSC INSTRUMENTS	Crimping Pliers Gordon Contouring Pliers Johnsons contouring Pliers Howe Pliers Bee Bee Curved Crown scissors Band seater	
SSC KITS	Available from the major manufacturers either retrimmed, crimped and contoured, or pretrimmed with paralled walls	

occlusal reduction and minimal proximal reduction of the primary molar to allow for the crown thickness (0.2mm). The armamentarium required for placement of a SSC is outlined in Table 2.

The finish line should be a smooth feather edge at or below the gingival margin with no step or shoulder. A snap fit is achieved when the flexible metal margin passes over the buccal bulbous area and fits into the cervical constriction of the molar. SSC margins can be well adapted into the undercut areas with the help of contouring and crimping pliers (Randall 2002). SSCs cannot be used in children with nickel sensitivity. Any self-curing luting cement can be used to secure these crowns, with glass ionomer being the most popular material.

Stainless steel crowns using Hall technique

There is growing evidence that a biological approach to management of caries is effective (Kidd 2004; Ricketts et al. 2006; Thompson et al. 2008) and the technique is now gaining popularity worldwide. Isolating the caries in the tooth using a crown (sealing in caries) isolates the microflora from their nutrients reducing/eliminating their ability to cause demineralisation. The dentinal-pulpal complex is also protected from the oral environment arresting the caries process, and maintaining of the vitality of reversibly inflamed pulp.

Placement of a SSC on carious primary molars without any prior tooth preparation, decay removal, or local anaesthesia is known as the 'Hall Technique', named after Dr Norna Hall who had used this novel method in her clinical practice since the 1980s. The indications for Hall crowns are the same as those of conventional SSCs but cannot be used where there is a diagnosis of irreversible pulpitis or dental sepsis (Innes et al. 2009, 2011).

Success of the Hall technique relies on correct pulpal diagnosis. There is no need for local anaesthesia as there is no reduction of tooth structure and no caries is removed. The crown is filled with a glass ionomer cement and pushed onto the tooth thereby sealing the caries lesion from the oral environment. Sometimes, it is necessary to use orthodontic

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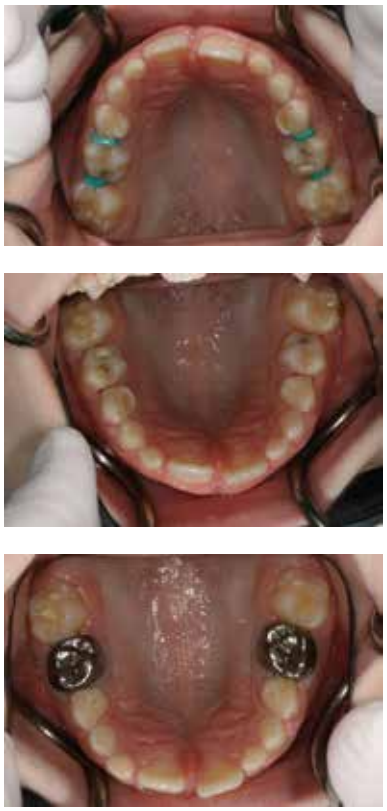

FIGURE 3
Provision of a full coverage restoration using the Hall technique. No local anaesthesia or tooth preparation.
A. placement of orthodontic separators
B. space provided after 1 week
C. Cementation of SSC

FIGURE 4
Life-like aesthetics of pre-veneered SSC (VSSC) placed on the lower first primary molars
A. the smile line and
B. intraorally

FIGURE 5
A. The internal surface and
B. external surface demonstrating differences between the various commercial brands of VSSC

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separators and a band seater to allow easier seating (Fig 3). Evidence of the clinical success of this technique after five years is very promising (Innes et al. 2011).

The crown is cemented onto an unprepared tooth causing a premature contact on that tooth. This increase in the vertical dimension of occlusion seems to be of little consequence in children, as occlusal equilibrium is re-established within two to four weeks, without any symptoms (Gallagher et al. 2014).

Preveneered stainless steel crowns

The increasing demand for a more natural appearance of primary tooth restorations led to the introduction of the commercially produced aesthetic preveneered stainless steel crowns (VSSCs) for paediatric dental patients. Recent developments in dental materials result in thermoplastic, composite or epoxy resin veneers to be bonded successfully to base metal using mechanical retention and/or chemical bonding (Hosoya et al. 2002).

The VSSCs were developed to combine the strength and durability of the conventional SSCs with the aesthetically pleasing appearance of the white veneer facing (Figure 4a, 4b). The exact specifications of the attachment, thickness and pattern of the veneer remains proprietary to the individual manufacturer. However, the makers of the current leading brands VSSCs (Nusmile, www.nusmilecrowns.com – and Kinderkrowns – www.kinderkrowns.com) have disclosed that the veneer is a composite resin material which is attached either through an intermediate bonding agent to the pre-prepared (e.g. alumina blasted) metal surface or is bonded and additionally mechanically retained to a fenestrated stainless steel core in different patterns (Fig 5).

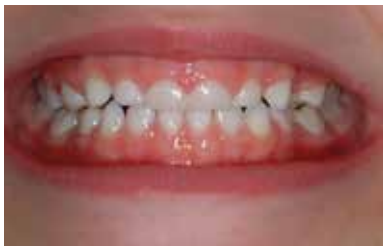
The composite facing material requires adequate thickness for mechanical strength and ability to withstand occlusal masticatory forces. Therefore, the tooth preparation for a VSSC has to be modified to allow for this increased bulk in the occlusal and buccal surface. Greater buccal reduction is required. Local anaesthesia is required for tooth preparation with 1.5mm occlusal reduction.

Circumferential reduction is required to remove any cervical undercuts as the crown must fit passively onto the tooth. The finish line is 1mm below the gingival margin. This reduction of tooth structure is much greater than conventional SSC crown preparation but does not result in exposure of the pulp. Pulp therapy will be dictated by the extent of caries. VSSCs cannot be crimped in the areas of the facing so that limited crimping is advised only on the metal margins.

Manufacturers also warn that the metal substructure flexes from pressure during crimping, fitting or seating and this could introduce micro-fractures to the facing which subsequently can progress to veneer loss. Veneer wear or fracture may occur but the restoration will not need to be replaced as the tooth remains protected by the metal substructure (O'Connell and Kratunova 2014). Heat sterilisation may cause discolouration of the facing material and the manufacturers advise chemical sterilisation for colour stability.

Prefabricated paediatric zirconia crowns

Zirconia has become increasingly popular as a restorative material due to its exceptional properties combining high aesthetic value and excellent mechanical characteristics (Zarone et al. 2010). Prefabricated paediatric zirconia crowns were first manufactured for clinical use in 2007. The solid



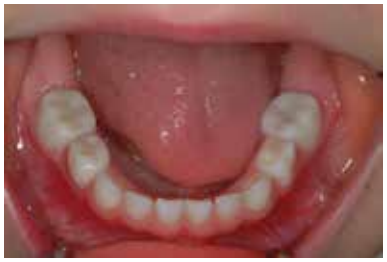


FIGURE 6
Primary molar zirconia crowns
A. Excellent aesthetics in the smile
B. Intra-oral view of same child

FIGURE 7
Variations in the size, contour and anatomy of the various manufacturers of prefabricated zirconia crowns currently available requiring modifications in tooth preparation.

zirconia construction offers high strength and durability along with superior aesthetics due to realistic anatomy and shade of the crowns (Fig 6a, 6b). It has been demonstrated that zirconia does not enhance bacterial adhesion and growth (Scarano et al. 2004) so that the surface biocompatibility and thin gingival margins of the crowns do not compromise gingival health. The colour of zirconia crowns is stable and fracture of the ceramic is unlikely given the high flexural strength and fracture toughness of the material. These crowns can be used in nickel-sensitive patients.

Zirconia is rigid and must fit passively on the tooth, therefore clinical skill is required to allow for appropriate (but not excessive) tooth preparation. The tooth preparation is critical as no crimping is possible in the zirconia crowns and adjustment of zirconia is not advised. In addition, each manufacturer of zirconia crowns emphasises different anatomical features that will necessitate alteration of the tooth preparation for maximum success (Fig 7).

Local anaesthesia is required for the tooth preparation with occlusal reduction of 1.5 - 2mm. Circumferentially, the primary tooth is reduced uniformly 1.5mm with a subgingival margin extension of 1-2mm. The zirconia crown should have a passive fit without any friction on tooth structure and no bulging of the gingival tissue. Paediatric zirconia crown kits are now commercially available in the EU and are very attractive for patients/parents and clinicians.

There are no published prospective clinical trials published so far reporting on the performance of zirconia posterior crowns, but data on anterior primary teeth shows that they perform well over time.

The general dental practitioner should use full coverage restorations routinely, especially for children with cavitated proximal lesions and in children assessed as high risk for caries. There have been significant advances in restorative paediatric dentistry and the newer options exist to provide aesthetic restorations for children.

The use of Class 2 restorations using composite, compomer, or glass ionomer should be restricted to small proximal lesions in children at low caries risk, or as a temporary solution. Selection of the most appropriate restoration must be based on the individual case and additional training will be required for clinicians to become competent in these techniques.

All these options however are valuable as part of the clinicians' armamentarium providing restorative choice in the contemporary paediatric dental practice.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To introduce the concept of aesthetic dentistry for children
- To explain the various options for prefabricated crowns for primary molars
- To describe the differences between the types of crowns
- To encourage general dental practitioners to use prefabricated crowns.

LEARNING OUTCOMES:

- To understand the variety of alternative restorations that increase the scope of their professional practice
- Understand the options available for restoration of primary molars
- To become familiar with the essential steps for tooth preparation.

EXAMPLE QUESTION:

The correct position of the crown margin in a primary molar is:
A. At the gingival margin
B. Sub gingival
C. Supragingival
D. Location dictated by extent of caries.

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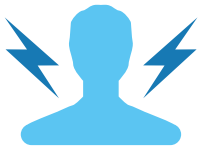
I FEEL YOUR PAIN

PAIN MANAGEMENT

A guide to managing common non-dental orofacial pain in primary dental care



EMMA FINNEGAN, ALEXANDER CRIGHTON

The patient presenting with non-dental orofacial pain can be one of the most challenging aspects of primary dental care and appears to be more prevalent than previously thought. Although a small part of everyday dentistry, dentists are often the first point of call for patients with orofacial pain, usually before the GP, and pain consultations can be among the most difficult to manage.

Time constraints and lack of experience in managing non-dental pain disorders are just some of the challenges faced, but a good history, along with a few simple investigations, can improve the consultation outcome, therapeutic options and, where needed, the quality of pain referrals. This article aims to help clarify some of the most common orofacial pain disorders and, where appropriate, give guidance on investigations and treatment that may be carried on in a primary care setting.

Before considering the following diagnoses, other dental and pathological sources of pain must be excluded through appropriate clinical examination and imaging. The more common non-dental orofacial pain conditions that may present to the dentist include:

- TMD
- Burning Mouth Syndrome
- Sinusitis
- Trigeminal neuralgia.

The acronym SOCRATES (Site, Onset, Character, Radiation, Associated Factors, Timing, Exacerbating/Relieving Factors and Severity) is a standardised tool for pain history and assessment endorsed by many medical and dental schools across the UK and provides a thorough and logical approach to history taking. This is as applicable to the dental practice setting as to the specialist pain clinic. Each of these features should be asked about and the response noted. Remember that the 'absence' of a finding can be as important as a 'positive' response where pain and its associated features are concerned – both must be recorded in the notes.

Temporomandibular joint dysfunction (TMD)

Background

This is the most frequently seen non-dental pain condition presenting to the dentist. It is also one of the most varied orofacial pain disorders as it can appear in many different ways. Always consider TMD in the differential diagnosis of orofacial pain, even if the symptoms do not seem exactly to fit. This is particularly the case where the pain reported is bilateral. It is easy for the practitioner to treat in primary care and will respond promptly to the correct treatments.

Remember that for TMD:

- Clicking of the jaw in the absence of pain and locking does not require referral or treatment
- Bite splints DO work and should be tried where TMD cannot be excluded. These are now available on the NHS without prior approval. They are not effective alone for every patient, but are used together with other medical and physical therapies to good effect.

Where locking of the TMJ is the main problem, the issue is usually related to the joint itself and these patients should be referred to the local maxillofacial surgery service for assessment.

Aetiology

Parafunctional habits, such as clenching and grinding, are frequently seen in patients with TMD, although many patients also have similar habits without problems. Where pain is present, habits such as chewing gum seem to be an important trigger of pain. Unilateral chewing especially appears to be a risk factor.

Evidence of clenching can be seen from the oral soft tissues with crenulation of the tongue edge and a buccal mucosa occlusal line being common findings. Stress and emotional burden are very often cited, but will not always

FIG 1

SOCRATES in TMD

SITE	TMJ, ears, cheeks, temple, teeth, sublingual region Unilateral or Bilateral
ONSET	**Acute**: This is less common. May be following trauma to joint/face, joint dislocation, or muscle spasm.. **Chronic**: Gradual onset- weeks/ months
CHARACTER	Dull ache Throbbing Sharp (with wide opening/ muscle spasm). Less common N.B. Pain is not pulsatile
RADIATION	Neck, head (headache), face, upper and lower jaws
ASSOCIATED FACTORS	Trismus Clicking or crepitus in TMJ (more common in older age group) Mandibular fatigue and stiffness of the jaw Extra-oral swelling caused by muscle hypertrophy Soft tissue features: linea alba and tongue scalloping
TIMING	Morning, during night, during stressful activities e.g. driving
EXACERBATING/ RELIEVING FACTORS	Chewing Yawning Playing a wind musical instrument
SEVERITY	Range: mild to severe

feature in the history unless specifically asked about by the dentist.

Occlusal factors themselves seem to play a very small role in chronic TMD, although acute changes may be found after placement of a restoration that disrupts the normal intercuspal position. However, looking at the occlusion for triggers in chronic TMD is rarely helpful and often results in destruction of dental hard tissue unnecessarily. TMD itself may in fact cause occlusal changes, as pain-induced muscle dysfunction around the joint results in altered closing patterns of the mandible and a secondary occlusal change.

There is certainly no link with orthodontics in either the origin or resolution of TMJ dysfunctions. Hypermobility of the joints, however, does show an increased probability of developing problems. This is demonstrated in studies on patients with Ehlers-Danlos syndrome, where all patients in the study experienced TMD and multiple joint dislocations.

Who is affected?

As a condition which affects 5-12 per cent of the population, these patients frequently present in dental practice. More women than men are affected by the disorder (quoted up to 4:15) and unlike other types of orofacial pain, its prevalence is higher in a younger age group, with up to 7 per cent of 12-18 year olds diagnosed with mandibular pain dysfunction. However, children and older adults are also affected, commonly with stressful life events being key precipitators.

Interestingly, women taking oral contraceptives or on supplemental oestrogen are also more likely to both suffer from TMD and to seek treatment for the condition. This is thought to be due to the presence of oestrogen receptors in the TM joints, which modify metabolic activity, affecting ligament laxity and also due to the effects of oestrogen on pain experience. There appears to be no genetic predisposition and no influence from the family environment, although many patients citing 'stress' as a trigger have home issues!

Examination

Palpate the muscles of mastication for evidence of pain or hypertrophy. Use forced movements of the mandible against pressure to look for pain in the medial and lateral pterygoid muscles. Palpate the TMJs in static and dynamic movements – this may elicit pain, clicking and crepitus, all of which should be noted. Measure mouth opening inter-incisally – as a single measure, this does not contribute much, but can be measured serially to look for improvements as treatment progresses.

Soft tissue features, including evidence of parafunctional clenching and tooth wear, should also be noted. If neck or shoulder pain is also present, palpate the trapezius and sterno-mastoid muscles, looking for areas of focal tenderness which might indicate referred pain from the neck to the face.

Treatment

Conservative management remains the most successful treatment for TMD and should always be tried in primary care before considering a referral. Patients must be aware of the self-limiting nature of the condition and they must understand that their role in the treatment is paramount. The success of treatment will depend upon the patient following a standardised regime:

- Medications: NSAIDs (*TDS for first two weeks and as needed thereafter*)
- Soft diet (*liquid for first two weeks and avoidance of hard/ chewy foods after*)
- Localised heat (*apply to affected side for five minutes TDS in evening with five minute breaks intermittent between for two weeks and as needed thereafter*)
- Yawning support/avoid wide opening
- Avoidance of chewing gum/habits (*e.g. nail/pen biting*) and playing wind instruments.

If these simple measures fail to produce an improvement within a month, a Bite Raising Appliance (BRA) should be made and fitted. There is evidence to support the use of both soft and hard BRAs, but neither is clearly better. A soft appliance may be useful in the first instance, as is more comfortable to wear and easier to construct and fit. Some patients will find these encourage clenching; however, this does not seem to affect the success. The patient should be advised to expect this at the beginning of treatment and even some initial increase in discomfort.

Most patients will have seen a good improvement in two months of night use of a splint. In acute cases, a small dose of diazepam (2-5mg up to TDS) can be useful in conjunction with the treatments suggested above remembering to assess the impact this may have on the patient's life and warning the patient about drowsiness and sedation from the treatment.

If there is no good improvement in this time, a referral for specialist assessment should be arranged.

Specialist referral

Onward referral to oral medicine should be made if symptoms are not improving or the symptoms are increasing despite conservative management AND provision of a BRA.

Investigations and treatment that can be carried out in specialist centre, include ultrasounds and MRI scanning to give evidence of disc displacement and Cone Beam CT to demonstrate

CONTINUED OVERLEAF>

ABOUT THE AUTHORS

Emma Finnegan graduated in Dentistry from the University of Glasgow and has a special interest in oral medicine. She currently working as a core trainee in Glasgow Dental Hospital and School.

Dr Alexander Crighton is a consultant in oral medicine and honorary senior lecturer in medicine in relation to dentistry at Glasgow Dental Hospital and School.

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joint degeneration. Medication, commonly a tricyclic antidepressant such as Nortriptyline, can be used at night to help with sleep, relaxation and improve pain in conjunction with conservative measures. SSRIs often exacerbate TMD pain and where patients present taking these, discussion with the GP with a view to changing the SSRI to an alternative antidepressant therapy can help treatment.

Burning Mouth Syndrome (BMS)

Background

This name encompasses a number of disorders, which include burning/pain (often of the tongue, lips and buccal mucosa) in the absence of soft tissue abnormalities, as well as a bad taste (dysgeusia), perceived dry mouth (xerostomia) with plenty of saliva present, or a feeling of paraesthesia. For this reason, the term oral dysaesthesia is often preferred. Glossodynia is another term for the same condition.

BMS is a diagnosis of exclusion and true BMS has no identifiable cause. It is a neuropathic pain in which there is either a disturbance in the way in which information is passed from the oropharynx to the brain, or the understanding of that information by the brain.

Aetiology

This is unknown. In some cases it behaves like a neuropathic pain and in others as an abnormal perception. In some patients, testing of vitamin B12, folate or iron reveals deficiencies; others have diabetes as an undiagnosed cause of dryness or neuropathy and in a few candida has been shown to be responsible for the burning. The most common finding in patients with BMS or other forms of dysaesthesia is a generalised tendency to anxiety.

Who is affected?

It is a condition which affects between 1-15 per cent of the population at some point and occurs more commonly in females particularly of peri-menopausal (as high as 40 per cent of this group), but these figures seem higher than seen in clinical practice in Scotland. Although any age can be affected, it occurs rarely in women below 30 years and men below 40 years.

Investigations

It is important to exclude lichen planus, haematinic deficiencies, diabetes and invasive candidiasis before concluding that there is an oral dysaesthesia. Gastro-oesophageal Reflux Disease (GORD) has been suggested as a trigger where taste is involved and a trial of a proton pump inhibitor is often given. Referral to the GP for exclusion of nutritional deficiencies and diabetes is sensible and, where oral dryness is the main complaint, a review of the patient's medication to see if any medicines with antimuscarinic side effects can be eliminated.

Treatment

A lower soft acrylic bite splint can be helpful to avoid irritation from teeth if a parafuctional habit is present. This is particularly the case where the symptoms are predominantly present around the edge of the tongue. Chewing gum is a useful distraction from symptoms and Gelclair or similar products can be helpful to soothe and distract from the sensation. Alphalipoic acid has shown to be helpful to some patients- this can be purchased at health food shops.

Relaxation/stress reduction exercises and hypnotherapy can be useful where patients are not keen for medication but the use of a tricyclic antidepressant such as Nortriptyline for up to six months can give a good reduction in symptoms.

FIG 2

SOCRATES in BMS

SITE	Anterior 2/3 tongue, anterior hard palate and lower lip most common sites
ONSET	Often spontaneous onset – patients often attribute to recent dental treatment, illness or medication persisting for months or years In many cases, symptoms will eventually resolve – patients are reassured by this
CHARACTER	Burning, scalding, tingling, metallic or foul taste Present each day, but can become intermittent as it resolves
ASSOCIATED FACTORS	Anxiety a very common finding Poorly fitting dentures ACE inhibitors may be linked to cause and cessation may resolve In men, adultery is an associated factor that has been seen due to guilt and associated stress
TIMING	Not present on waking Symptoms often become more severe as day progresses – most severe in evening Does not affect sleep
EXACERBATING/ RELIEVING FACTORS	Talking, eating spicy food, stressful events all make worse Relieved by eating, chewing gum and 'being busy'
SEVERITY	Varies: mild to severe

Sometimes patients seek reassurance of the absence of pathology and have comfort in knowing their diagnosis and require no further treatment. Many have suspected that they have cancer and the dentist should always make clear to the patient that this is not the case.

Specialist referral

In many circumstances the patient can be managed in primary care by the dentist and the doctor, but where there is doubt as to the diagnosis or the patient's symptoms fail to respond to the treatments outlined above, referral to an oral medicine specialist is needed.

Maxillary sinusitis

Background

Acute maxillary sinusitis produces unilateral midface pain which can be very similar in character to pulpal or periapical pain in the upper molar teeth. It should be suspected where a dental cause does not seem likely after clinical and radiographic examination of the teeth and sensibility testing. It can also be confused with TMD pain.

Who is affected?

Sinusitis rarely affects children below the age of nine years as the maxillary sinuses do not develop properly until puberty. Elderly people are at higher risk due to both a more compromised immune system and also a combination of anatomical and physiological factors such as dry nasal mucosa, weaker cartilage causing airflow changes and a diminished cough/weakened gag reflex. Atopic individuals show a particular high risk for developing chronic sinusitis.

Aetiology

Most are viral infections. Chronic sinusitis is not painful, only acute exacerbations. There may be local nasal and sinus

abnormalities contributing to the aetiology, such as polyps in the nose or sinus, septal deviation or obstruction to the meatus of the sinus in the nose. There may have been a precipitating event such as an upper molar extraction where the roots have been close to the sinus floor.

Character
Constant throbbing pain which may vary in intensity.

Associated features
There will often be a history of sinusitis and frequently an awareness of a bad taste or halitosis. This is often worse in the morning and due to pus running into the oropharynx from the nasal floor (post nasal drip). Many patients get tenderness to pressure of the cheek over the affected sinus and discomfort on pressure on the alveolar ridge between the roots of the first and second premolar teeth. The patient may report the pain as being more severe on bending forward or lying down.

Management
If maxillary sinusitis is suspected, the patient should be referred to their GP for appropriate treatment. If the dentist wishes to give temporary supportive therapy, this can be with spray or drop nasal decongestants and not antibiotics, which are ineffective in viral infections.

Trigeminal neuralgia (TN)

Background
TN is usually a straightforward diagnosis due to the character of the pain experienced. The sudden intense and short duration of the pain means that the dental pains which can be confused with TN are acute dentine sensitivity and cracked cusp syndrome. Both of these can give similar histories in some patients where the trigger for trigeminal neuralgia is intraoral. The dentist should look carefully for evidence of these, trying agents to reduce sensitivity, testing the cusps of the premolar and molar teeth in the area of the pain.

Aetiology
The cause of TN is often unknown. Demyelination of the trigeminal nerve is a common factor, however, and this may be due to pressure from an adjacent blood vessel, or, less commonly, a tumour or other intracranial mass (2 per cent of patients) or multiple sclerosis. Diagnosis is by clinical assessment and exclusion of other causes of pain.

Who is affected?
Trigeminal neuralgia is a rare condition traditionally affecting an older age group, typically individuals over 50. However, many more patients now are seen in a younger age group and the diagnosis should be considered in any patient with the characteristic pain history. More women are affected than men and the overall prevalence varies in the literature, but has been quoted at between 0.16 per cent and 0.3 per cent.

Character
The key feature of trigeminal neuralgia is the short intense pain experienced on one branch of the trigeminal nerve. This may be triggered by touch, washing, eating or a change in ambient temperature. The patient often describes the pain as being "like an electric shock" and stops them in their tracks.

However, between these, the patient is pain free, although some describe a burning feeling in the trigger area. Trigeminal neuralgia often first presents in the autumn and is frequently worse over the winter months.

Associated features
Rarely, patients will report swelling and redness in the area of their trigger.

Management
Trigeminal neuralgia requires specialist assessment and management at the beginning. Once the treatment is stabilised, the care can be continued in primary care. Primarily, this should be through the GP. A dentist suspecting TN should liaise with the patient's GP for a referral to oral medicine or neurology and to start the patient on an appropriate medicine, usually carbamazepine whist the referral process progresses.

Although this drug is in the dental formulary, it should only be started by a dentist on the instruction of a specialist, particularly because the patient needs to have blood tests before and during treatment with this drug.

Conclusions

Although many of the pain conditions covered in this article would traditionally be referred to a specialist unit, a good history, careful examination and appropriate investigation can help establish an accurate diagnosis, which can facilitate initial management in a practice setting. This can be much more convenient for the patient and allow a much quicker start to treatment and relief of symptoms.

The simple strategies outlined above are frequently effective, making for a happy patient and dentist. They are often the first things tried by a specialist and having this initiated in primary care means that patients subsequently passed to a specialist get quickly on to the more complex treatments where needed. Patients often have to travel significant distances for specialist care, especially in oral medicine and are often grateful for management locally. Additionally, limiting the pressures on tertiary care centres allows the patients needing this level of care to be seen more promptly.

Always try to have the same methodical process for pain history taking using SOCRATES – this will help form a logical thought process for forming a diagnosis. Employ all means of investigation prior to referral. Radiographs in particular are critical to eliminating dental sources of pain. Liaison between dentists and general medical practitioners is underutilised and is of immense benefit for complete patient care, from simple investigations to appropriate prescribing or onward referral to specialist medical services.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:
- Review the common non-dental oral pain conditions seen in dental practice
- Outline the investigations that the dentist can arrange with the patient's GP to help with the diagnosis and treatment
- Give simple management strategies that the dentist can use before a hospital referral is needed.

LEARNING OUTCOMES:
After reading, the dentist should be familiar with:
- The common non-dental facial pain conditions
- The structure needed for history taking in chronic pain
- The role of the primary care team in assessing and managing non-dental facial pain.

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MARCOS WHITE

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And BioHorizons isn't just about getting dentists to use their products. I've found that they are really committed to education. I was recently fortunate enough to be invited to one of their international training programmes and was truly blown away on all fronts. The training was to a high level and well-tailored to all delegates. BioHorizons' staff attending were approachable, generous and open to feedback. All in all, it was really humbling to see a company with a focus truly on engaging with – and supporting – their customers.

Indeed, the longer I have spent as a BioHorizons partner the more staff I have met and the more of the 'family' approach I have seen in action. Whether it is the reps, the marketing team, or research and development, they are all totally approachable, generous with their time and assistance, and nothing is ever too much trouble. I think this aspect is a real credit to the BioHorizons brand and they have done incredibly well to engender this.

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ABOUT THE AUTHOR
Marcos White is the principal dentist at The Courtyard, an award-winning practice in Huddersfield. Marcos enjoys caring for his loyal patient base and having the confidence to provide solutions to whatever restorative issue he is presented with.

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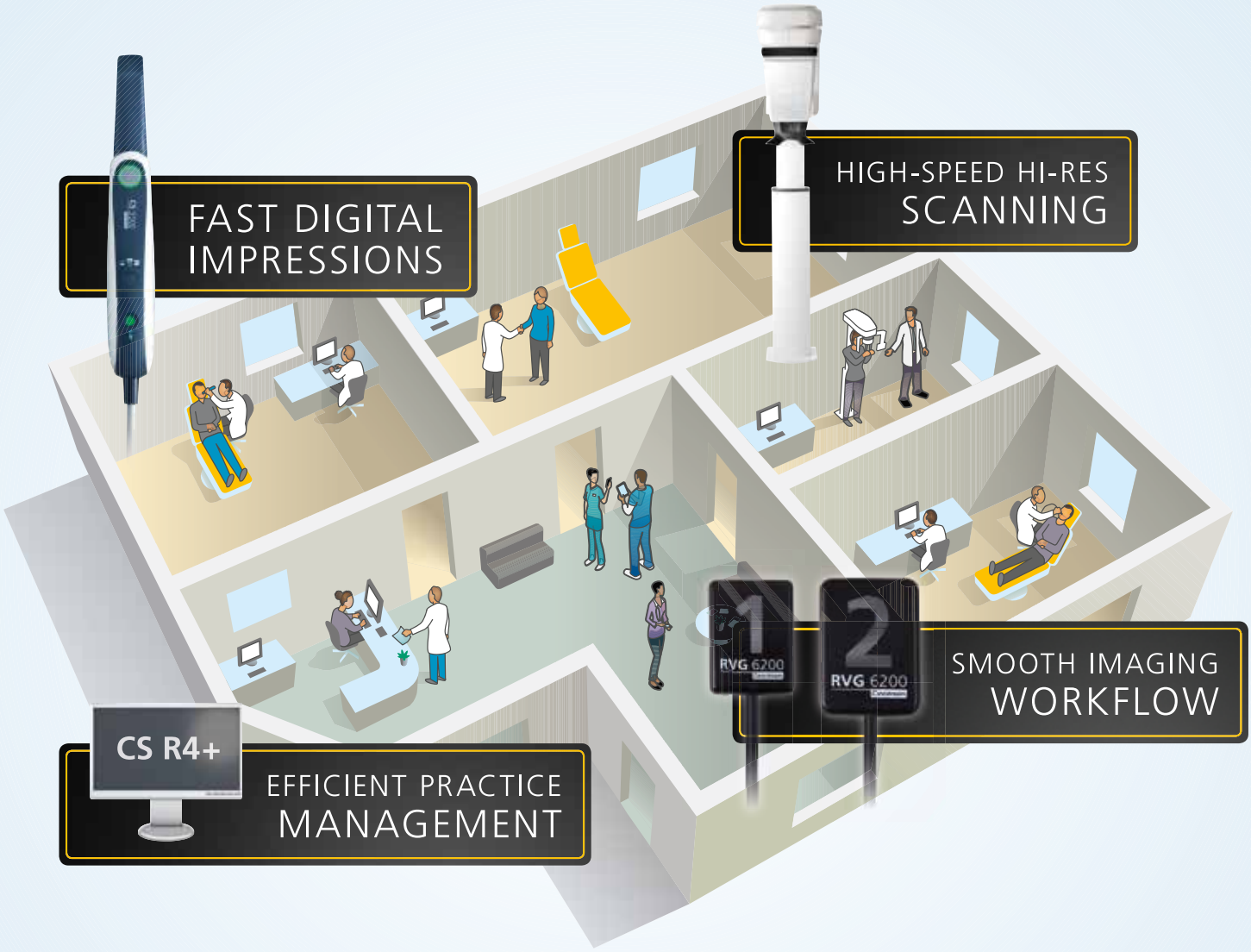

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PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

INNER CIRCLE

DO YOU HAVE THE RIGHT PEOPLE AROUND YOU?

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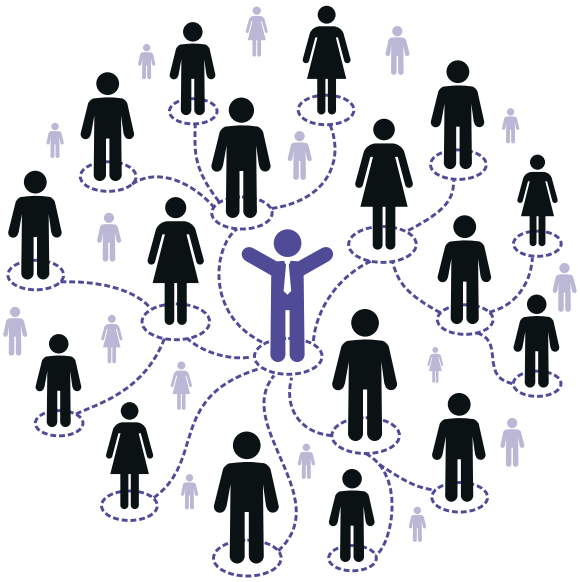

THE INNER CIRCLE

SETTING UP A NETWORK OF LIKE-MINDED COLLEAGUES CAN PAY DIVIDENDS WHEN IT COMES TO ADVICE AND SUPPORT IN MANAGING YOUR BUSINESS

ADAM MORGAN

It is well known, that it is incredibly rare to find success alone, without anyone's help or guidance along the way. The same is true in dentistry – and in any profession for that matter. So many great people have all the right ingredients for success and yet never achieve their own goals or ambitions – and it isn't for their lack of hard work, drive or intellect. I have found that the number one reason people do not reach the levels of success they aspire to is because of their 'inner circle.'

This inner circle, is a well thought out, hand crafted group of individuals that you surround yourself with. They are not friends – not initially. Nor are they people you necessarily like to spend great amounts of time with. They are agitators – people who disrupt your thinking and challenge you to go beyond yourself. They are there to pull you up after a set-back or to give you the 'tough talk' that no one close to you could ever give. They are also highly skilled at something that you are not – for example, if you are not an expert in business, they should be.

Pick people for your inner circle that have very different skills than you do. Never meet together in a group, always one on one and take questions to them that you want answers to. Be eager to learn and be challenged to think differently by these people – they are your direct route to skills and knowledge that you do not have time to acquire for yourself – because as we all know, expert experience is worth its weight in gold and is something only time and skill combined can produce.

When looking for people to be in your inner circle, start by making a list of five to 10 people you most admire. These people should have a reputation for success and being skilled at what they do. Then search for these people on LinkedIn. You may find that you have a friend in common, if so, ask for an introduction from this person and if you do not have anyone in common, write a well thought out message introducing yourself.

The goal here is to set a telephone appointment or informal meeting together. When you meet, explain why you want to have a small amount of their time and help and then get to know their story. What did they do to be where they are? What advice would they have for their younger self?

When you meet or speak with people in your inner circle, it is important that there is always a value or reason for you to speak together. The ownership for this lies with you to be prepared with questions to ask or topics that you want advice or guidance on. Never go unprepared – no one likes spending time with time wasters. Meet or speak as little or often as you both are willing and able to, some people you will speak to more than others, but always, always go with an open mind, eager for answers and make it very clear that you want to grow and learn from their wisdom and advice.

I personally have a handful of people that I speak with a few times throughout the year, some more than others – and they teach me more than I could ever learn from going to a class, reading a book or listening to a podcast. They are my handpicked inner circle, with each person adding tremendous value to my life. I have found that many successful people are more than happy to share their wisdom and skill – but very few people earnestly seek it out and ask for it.

So my question to you is: Do I have the right people around me?

BE INFORMED AND BE PREPARED

DISCOVER SOME KEY ADVICE FOR NEW DENTAL ASSOCIATES IN 2016

JAYNE CLIFFORD, ALASDAIR MACDOUGALL

If you are in the process of securing your first dental associate post, or you have already started your self-employed career, then the following accounting, tax and financial suggestions and recommendations will be relevant for you.

REGISTER AS SELF-EMPLOYED

You should register as self-employed with HM Revenue & Customs (HMRC) within three months of becoming self-employed to ensure you pay the correct income tax and National Insurance.

HOW DO I PAY TAX AND HOW MUCH SHOULD I SET ASIDE EACH MONTH?

You should pay HMRC direct. Tax payments are due at the end of January and July each year. If you become self-employed in August 2016 you may not have to pay your first tax bill until January 2018. It is good practice to set aside 30 per cent of your annual income for tax. Don't forget that you will also have to pay Class 2 and Class 4 National Insurance through self-assessment and some of you may well have student loans to repay.

DO I NEED AN ACCOUNTANT?

An accountant will act as your business and tax adviser, this will involve keeping you compliant with the law and tax regulations – submitting your annual tax return and preparing your annual accounts and providing you with advice on offsetting your taxable income with business expenditure. So do keep your receipts and make good records of your expenditure, including any business or professional courses you attend. Your accountant should have good working knowledge of the dental sector and be aware of the nuances that only exist for those working in the NHS. We would also recommend that your accountant is a member of the Institute of Chartered Accountants of Scotland.

If you are thinking about buying a practice, then your accountant will help you with sourcing funding, creating financial projections in terms of your business income and meeting your liabilities as they fall due. They will also help you to structure the business to minimise your future tax bills. Lenders will look for at least five years post-qualifying experience and a deposit of between 10 per cent to 25 per cent of the purchase price.

WHERE CAN I GET ADVICE?

Martin Aitken & Co run financial and tax awareness sessions in association with dental schools for those beginning their dental careers. We also regularly attend the Scottish Dental Show at Braehead (13 and 14 May), the FGDP (UK) Scotland Study Day in December and we will be attending the BDS Undergraduate Conference in March. If you can't wait until then, send Jayne Clifford (jfc@maco.co.uk) an email with your queries.

TURNING TO YOUR PERSONAL FINANCES: MORTGAGES, SAVINGS AND PROTECTION

To get a mortgage, most lenders will require you to have two years of self-employed accounts as evidence of your income and your ability to repay the debt. The new Help-to-Buy Individual Savings Account (ISA) is worth checking out as you save towards your deposit. Cash ISAs are always a good option for those early in their dental careers.

You can currently save up to £15,240 per tax year and you won't pay any tax on the interest or have to declare it on your annual tax return. For longer-term savings, Stocks & Shares ISAs are also worth considering as part of your investment strategy as both capital gains and income will be tax free.

If you arranged an income protection policy while still at university, or at the start of your VT year, you should review this policy to ensure the cover is still adequate. You should also make a will and set up a Powers of Attorney. No one likes to think about dying, however, dying without a will can leave those you leave behind with significant financial uncertainty. Scottish intestacy law is complex, archaic and can be unfair. So, don't leave others to deal with your finances if you are no longer around or if you are unable to deal with them yourself.

ABOUT THE AUTHORS
Jayne Clifford is a director at Martin Aitken & Co. Alasdair MacDougall is a director of Martin Aitken Financial Services.

ASDP

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THE PROFESSIONALS

FORMER ROYAL NAVY DENTAL OFFICER GILLIAN LESLIE TURNED TO THE ASDP TO HELP HER OPEN HER OWN PRACTICE

RICHARD CROASDALE

When dentist Gillian Leslie decided to open her own practice in 2013, she turned to the Association of Scottish Dental Professionals (ASDP) – an alliance of businesses serving the dental profession, founded by Ian Main of Stark Main & Co Dental Chartered Accountants – to help her plan, finance and develop the new business.

Gillian's professional career to date had been far from conventional: having graduated from the University of Glasgow in 1998, she immediately joined the Royal Navy as a dental officer. She spent 13 years serving in various establishments around the world and was the task group dentist for a fleet of ships engaged in a global tour in 2000.

She then joined the Royal Marines at the Commando Logistics Regiment and served with them during the first six months of the second Gulf War, treating dental and medical emergencies.

Following this, she was sent to the USA to join the US Navy for a course in exodontia, before returning to the UK and completing her membership with the Royal College of Surgeons of England, with a year at the QA Hospital Maxillofacial department in Portsmouth.

After various other appointments and a year in Brunei, she decided to leave military service following the birth of her daughter.

"I completed two years in general practice to learn the 'civvie' ropes, but decided to try to buy my own practice after realising that I was used to running my own show," she recalled.

Gillian contacted ASDP after finding them on Google, and met with representative Trisha Munro (Strictly Confidental) in early 2013 to register as a client.

"Trisha was very understanding of my need for confidentiality, and was extremely patient about when I could and couldn't be contacted," said Gillian.

Trisha quickly identified a practice that had just come on the market close to Gillian's home town. It was in need of a great deal of work, but Trisha saw real potential and was keen for Gillian to see it for herself.

"Initially when I saw it, I thought there's absolutely no way can I do this, but she was fantastic at painting the picture of how it

CONTINUED OVERLEAF>

Ian Main

Trisha Munro

Craig Stirling

FROM PREVIOUS PAGE>

could be and giving me confidence that I could in fact, with her help, do it. We had to move very quickly, as my relationship with my existing principal had started to deteriorate and I was keen to move ASAP," Gillian said.

Trisha contacted two big high street lenders and decided to go with the Bank of Scotland – an ASDP member – and account manager Julie McLaren.

While the bank's rates were competitive, Trisha says it was Julie's "can do attitude" that convinced her that she would do everything in her power to help get the business off the ground.

On Julie's advice, Trisha then got in touch with Ian Main of Stark Main & Co Dental Chartered Accountants, to help her work up a business plan with robust cash-flow projections.

"Ian and Julie met me within the week and both gave me invaluable advice on how to proceed.

"Julie, Ian and Trisha worked as a trio at this point to help me formulate my business plan. Julie gave me advice on the kind of things the bank were looking for, such as local population, competition, and where I saw my business going and growing.

"Ian worked hard to produce a fantastic set of projections, giving more confidence about the viability of the vision, and Trisha helped organise surveys via dental specialist surveyors DM Hall and quotations for dental equipment and consumables.

"After careful review, I selected leading practice management software Exact from Software of Excellence.

"I had my business plan within a couple of weeks and was able to go to the bank with a plan of about 130 pages."

The end of May saw Gillian facing a major setback – despite all her hard work, the bank declined her application. "I was devastated," she recalled. "But we didn't give up and Ian came up with a creative new deal structure for the plan, which they eventually agreed to.

"Trisha had advised me to contact Craig Stirling at Davidson Chalmers at this point, who formally proceeded with the offer. There were a few obstacles in relation to the acquisition that needed to be surmounted, but Craig was a consummate professional and a genuine dental specialist and managed to deal with everything that was flung at him.

"He was very approachable and would answer emails the day I sent them. I think most people have the idea that a solicitor keeps you at arm's length, but I really felt Craig went out of his way to keep me up to date."

Gillian finally moved into the practice in June as an associate, then officially bought the practice at the end of July. She started renovations as soon she could, closing the practice for two weeks, during which time Trisha helped identify suppliers of equipment and consumables.

With a lot of hard work against some tough deadlines, the business opened after two weeks and had its inspection within three.

"I cannot speak highly enough of Ian Main and the rest of the team at ASDP," said Gillian. "There were a lot of sleepless nights and moments of panic, but they all held my hand throughout it all without stepping on my ideas. I feel my practice is the fruit of my own labour, but without ASDP, I would have really struggled and I doubt I would be where I am today."

New Year – new start?

TAKE SOME TIME OVER THE FESTIVE PERIOD TO CONDUCT A HEALTH CHECK AND SHINE THE LIGHT IN THE EYES OF YOUR PRACTICE. IAN MAIN OFFERS SOME HELPFUL HINTS AND AREAS TO LOOK AT

IAN MAIN

At the time of writing, we are almost into 2016. I sincerely hope that 2015 has been a successful period for you and your practice.

Traditionally, a New Year can be a time for reflection and goal planning. I suggest practice owners should take the opportunity between mulled wine and turkey to think about the year ahead.

When was the last time you 'shined the light in the eyes' of your practice performance? There is no doubt that you are trading in a period of unprecedented change and challenge so without question any incremental gains available, however small, should be grasped by reviewing where you could improve.

There are lots of ways to review your practice, and regular readers of my column will know I am a strong advocate of ensuring you track performance using carefully designed and targeted key performance indicators (KPI's.) Other ways to run the rule over your practice can range from financial benchmarking, mystery shopping, patient surveys, team surveys etc. All of which have some really valuable potential insights into your operations and should be considered on a periodic and systematic basis without doubt. However, if you are 'time poor' and unsure where to start with your focus in the New Year, it may be time to undertake a 'health check' on your practice.

With our years of in-depth experience, gained from working with high performing practices and transforming some underperformers, we have developed our own 'Dental Business Success Checklist'. This checklist contains 56 carefully designed yes/no answer questions on your confidence levels to assess whether you are adopting best practice in the critical areas of your leadership, financials, operations, marketing, sales and team. In the space of the time it takes to drink a coffee, it will identify some areas of potential improvement in your practice and has assisted our clients to improve performance exponentially. So if you over indulged during the festive period is it time for a practice detox?

I would love to share a copy of the checklist with you free of charge, please do get in touch if you'd like to work through it. Good luck in 2016.

MORE INFO
To get in touch with Ian, call 0131 248 2570, or email ian@starkmaindental.co.uk

Beware the seven-year itch

STEVE MITCHELL

Recent commentary in the press about practices being investigated by The Scottish Dental Access Initiative (SDAI) could have been prevented, in some cases, if those practices had better visibility of their finances.

SDAI provides funding to set up new practices, one of the conditions being that 80 per cent of the business comes from NHS patients for seven years. Undoubtedly, some practices are falling foul of the seven-year rule due to poor record keeping, and investigators are now asking for access to the practices' accounts.

Practice owners can struggle to keep on top of their accounts for a variety of different reasons; lack of time, outdated or too complex software. As dentists, you have the right tools to look after your patients but equally, without the right tools to look after your finances, long-term issues can arise for the practice and its owners.

AAB can provide you with the right tools to make it easy to understand your business finances, visible 24 hours a day from anywhere. Our cloud bookkeeping platform for dentists can take the hard work out of keeping your accounts and allow you to monitor finances in real time, easily run reports to check on practice profitability by partner or associate and monitor the level of your NHS income to overall income.

The combination of direct links between practice bank accounts, our bookkeeping platform and automated bank reconciliations, means your accounts are always kept up to date. For practice owners who are time constrained, this can free up their time so they can spend more time generating practice income. The platform provides multi-user access to the same live data, making a partial or full outsourced bookkeeping service much more practical so, you can choose to do as little or as much of the bookkeeping as you want but still have visibility of the practice finances.

MORE INFO
Steve Mitchell is accounting services director at Anderson Anderson & Brown LLP

It's not about you!

THE MOST IMPORTANT ELEMENT OF YOUR BUSINESS ARE YOUR PATIENTS – AND IF YOU DON'T GIVE THEM THE SERVICE THEY DESERVE, YOUR COMPETITORS WILL, SAYS ADAM MORGAN

ADAM MORGAN

I was sitting in a waiting room recently and, as I usually do, started to chat to the person across from me. We exchanged pleasantries and I asked who they were due to see.

This person began to share a little bit of what treatment they were expecting to have done and that they were unsure of what it involved and that they just hoped it would be over as quickly as possible.

I then asked: "What is it that you like most about coming to this practice?" The response I got made me feel so sad – she said: "I only come here because it is close to where I work. If I could see the dentist near to where I live, I would go there in a heartbeat."

I, of course, had to then ask why. She replied: "Because I'm just a number in here – no one seems to remember me even though I have been coming here for a few years now and I feel like everyone is too busy rushing around all the time – I don't matter to them".

Wow – what a statement.

How many of us are guilty of being too busy, not taking the time to build relationships with our patients and rushing from one appointment to the next?

In today's world – where the customer is king – do you truly make time to talk and make people feel welcome? Taking one minute extra with each person to look them in the eye and have a meaningful conversation is so important, regardless of where you work or what your position is.

I usually hear people say: "I don't have time." The reality is you can't afford to not have time for people. If the only reason people come to see you is because of convenience, then you are on thin ice that is rapidly melting beneath your feet. Someone will open their doors, somewhere that is more convenient and bang – off they go like a bullet from a gun.

If you want to build a loyal, rewarding patient list, start by looking hard at the way you make people feel when they are with you. Great service is created – it doesn't happen without well-crafted processes and training.

Remember, when the patient is there, it is not about you – it is always about them... always.

MORE INFO

Adam Morgan is an award-winning training specialist who teaches businesses and individuals how to create greatness in their marketplace. He works with practices across the UK and helps dental teams to achieve their goals and vision. To get in touch with Adam, call 07557 763 785, or email hello@adammorgancompany.com

The Scottish dental market saw high demand in 2015

PAUL GRAHAM

Market activity shows no signs of abating as we head into 2016. Last year was marked by high demand from private multiple practice owners. This buyer profile is dominating the market just now. We have also seen an upturn from first-time entrants and that is crucial, as it fuels activity at the lower end of the market, with one and two surgery practices in high demand.

Another very interesting feature is the increase in enquiries from private equity and other investors, who are attracted by the solidity of the sector and are looking for larger practices. They have a similar appetite to the acquisitive private multiple practice owners. The scalability of a practice comes high on their list of priorities, with four or more surgeries and principals staying on post-sale being of particular interest. In 2015, we completed on a number of these types of sales, where not only the price achieved was well in excess of market value, but terms in favour of the seller were also delivered. Too often we see sellers who have been dealing directly with a buyer, receiving unfavourable and unrealistic conditions attached to a mediocre offer.

In recognition of the different needs and demands of these buyer profiles, Christie & Co offers a bespoke service tailored specifically for our client, the seller. Unlike many agents who agree to take fees from both buyer and seller, we view this as a conflict of interest. Taking a confidential 'whole market approach' to selling, we have the expertise to deliver your objectives in a fair market place.

As the only national firm undertaking formal, accredited Royal Institution of Chartered Surveyors (RICS) valuations and also selling dental practices, we have unique insight into prices that are actually achieved. The dental market remains strong and confidence from buyers is high. Over the last 12 months, Christie & Co have sold more than £28 million of dental practices and a further £112 million of practices valued for loan security purposes.

At this time of year, many will consider a change of direction and if you are considering this pathway within the next five years, then it is important to begin the process now. To some this may seem too far down the line but it is imperative to do so, should you wish to maximise the result.

To confidentially discuss how Christie & Co might help you achieve your future plans, please don't hesitate to contact me.

MORE INFO
Paul Graham is an associate director at Christie & Co. To contact him, call 0131 524 3416, 07739 876 621 or email paul.graham@christie.com

DENTAL LEGAL STUDY DAY

MULTAY EVENTS HAS THE EXPERIENCE AND SKILLS TO PROMOTE YOUR BUSINESS, CREATING PROFESSIONAL MARKET-LEADING EVENTS

Multay Events Ltd is a new events management team set up in Scotland to assist with any event, sponsorship and the delivery of first-class conferences. The team is headed up by Anne Marie Taylor and Liz Mulgrew, who have vast experience of the media, events and personal assistant skills.

An exceptional business for exceptional events, Multay Events is founded by an experienced events team with multiple contacts in venue identification and sourcing of support teams. We have the experience, skills and knowledge to ensure any event, no matter how large or small, fulfils its ultimate potential. We are flexible, fast, responsive and reliable.

No matter what stage of planning you are at, we would welcome the opportunity to help you make your event the best it can be.

Multay Events strives to be the best-running event management company in Scotland, producing the highest-quality events that set the standard for professional events. We believe that each event is unique, with its own objectives and challenges. We understand you require an event partner that understands your business.

The first dental event is Legal Essentials for Dentists and Trade Show. The event is sponsored by Taylor Defence Services Ltd, the indemnifier of choice for Scottish dentists.

This event is designed to educate and teach general dental professionals to maintain their registration and ease the pressures that dental professionals are under while putting together an informative and educational day. This event is directly relevant to delegates who want to know assistance is readily available.

With five hours of CPDA, a three-course lunch and free drinks reception, this event will be the premier event for dentists to attend this year.

Exhibitor times are set throughout the day in a well-proportioned event, allowing you sufficient time to discuss your needs with companies who are there to help you. Register early to avoid disappointment as there are limited spaces available.

MORE INFORMATION
To find out more and to book your space, visit www.multayevents.co.uk

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Ray Ross, Edinburgh

"The service has been fantastic and you truly provided a hand holding service throughout. A must for anyone selling to a Corporate."

Adelle McElrath, Kilmarnock

CONTACT US TO DISCUSS THE SALE OF YOUR PRACTICE

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

PEOPLE BEHIND THE TECHNOLOGY

DESPITE ALL THE TECHNOLOGICAL ADVANCES IN THE SECTOR, SOMETIMES THERE IS NO SUBSTITUTE FOR THE HUMAN TOUCH

Rapid technological change is part and parcel of modern life and this is as true in the dental laboratory sector as it is elsewhere.

And, if you don't keep up-to-date with all the developments in your industry you run the very real risk of being left behind. Fortunately, in Scotland and the UK we are fortunate to have some of the very best technicians and some of the most forward-thinking laboratories out there.

From digital milling machines and 3D printers, to digital communication and interaction with clinicians, the modern dental laboratory is embracing a whole raft of new technologies.

However, despite this technological revolution, there will always be a need for highly trained and GDC-registered dental technicians and clinical dental technicians to provide the all-important human touch when dealing with customers, dentists and patients, not to mention producing hand-crafted restorations and finishes that can't be replicated by machines.

On top of all this technology, producing the best quality work that gives the patient the best clinical outcome is paramount to any dental lab and dentist worth their salt. To this end, great communication and cooperation must be in place between lab and practice – digital communications and technologies can aid this, but it is the people behind the technology that make the real difference.

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CHALLENGES OF THE CHANGING MARKET

NICK LECA LOOKS BACK ON A YEAR OF CHANGE FOR THE HILLINGTON-BASED LABORATORY

It has been a year of business transformation for Leca Dental Ltd. Over the past year, we have worked very hard to create a completely new physical work environment, while further developing our manufacturing capabilities.

The demands of the industry and our customers are changing; we are now in a very competitive situation and the need to maintain focus is critical. During this year, our management team held various strategy meetings and discussed where we would focus and how we could continue to evolve as a business to ultimately meet these challenges and to continue to build a solid foundation for business success for the future. The critical success factor for any business can be easily demonstrated by the diagram below.

By focusing on the Key Performance Indicators (KPIs) within our business we are addressing the key aspects for retaining and growing our customers.

Each department within our laboratory has a direct impact on our performance and, to reflect this, we hold a daily meeting with department heads to discuss the previous day's performance and the improvements that we need to make.

Currently, our on-time delivery performance averages 99.2 per cent and our remake (quality) level is below 0.05 per cent. We are constantly challenging these numbers to provide the best service we can. Cost is also a critical element – we are now competing with a global market. Dental appliances can be procured from the Asian market with a lower price point. We have acknowledged that we will never compete with this market on price, therefore we need to create a business which offers unbeatable customer service.

Another area for key focus throughout this year has been on materials. Digital dentistry is now fully integrated within our laboratory. We now have the ability to offer a full digital solution, from receiving intra oral scans and producing digital restorations to the milling and supply of the final quality product. We have had to embrace this head on.

Materials are constantly changing and we need to have a clear technology roadmap to ensure that we are moving in the same direction as our clients and the market. Within our purchasing teams, we need to build strong relationships with the material suppliers and the key innovators within our sector. By forging these partnerships, we can offer a win/win solution by ensuring that we can offer the latest technologies to our customers.

All of the above would not be possible without a highly motivated and focused workforce. We are in the process of completing an organisational development review with some external consultants. We need to grow and retain our people to ensure that we can execute on all the KPIs effectively.

A Dental Laboratory with a difference

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Thomas, Martin and Nick Leca run this family business with precision and efficiency. 2015 has seen the laboratory moving to larger purpose built premises to ensure that the team of 60 provides the service to clients that excels their expectations. Our departments of Crown and Bridge, Chrome, Orthodontics, Prosthetics, Implants and lab-to-lab services are all available to clients.

Continuing Investment

Our new 10,000sq ft. premises have been equipped with the very latest of equipment. This has been a considerable investment but one that has made us a premier dental laboratory ensuring we offer the very best in dental restorations. We have also built an in-lab surgery allowing our partners to utilize this area for patient support.

COME AND VISIT US TO SEE FOR YOURSELF

Our Expertise

Our experience and expertise starts with the combined 75 years experience of the Leca family. All of our technicians are highly skilled and are continually updating their knowledge. A driven and efficient team of support staff, who ensure that deadlines are met and all areas of admin and delivery run smoothly, complements the technicians.

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Piezoelectric Surgery Techniques with Dr Colin Burns

- BDS Glasgow 1990, MFDS RCS 2005, GDC Number 65349
- Masters Degree with Merit (MSc) in Implant Dentistry from Warwick University 2012.
- Fellow of the International Team for Implantology.
- Registered ITI speaker.
- Lectures on postgraduate courses to Dentists, Dental Therapists and Hygienists, and Dental Nurses on Implant Dentistry.
- Mentor for Dentists undergoing implant training.
- Member of the Association of Dental Implantology.

One of the major criticisms of ultrasonic surgery is that it takes more time, thus prolonging surgical procedures. Ultrasonic surgery requires a learning curve similar to any new surgical method.

Piezoelectric technology for pre-implant procedures makes surgery more precise and is significantly less traumatic to both hard and soft tissue. This in turn means dramatically less post-operative discomfort and swelling. This lecture followed by hands on training will cover:

- Bone Augmentation
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Dr Colin Kane
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If you require any further information please feel free to contact Andrea Cooke, Practice Manageress, at **ac@smilescene.co.uk** or by calling now.

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BDA British Dental Association

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The dental team at Smilescene, led by Principal Kevin Clark, has been providing a fully comprehensive range of NHS and private dental care to patients across Lanarkshire and Glasgow since 1991.

We pride ourselves on maintaining the highest standard of patient care and, as such, we aim to make patients visits as comfortable and pleasant as possible.

As many of you will be aware, the Public Dental Service has recently issued a letter concerning the provision of sedation services in Lanarkshire, stating that their current waiting list is 10 months, with anticipation that this will rise.

As one of the few accredited dental sedation practices in the area, Smilescene are pleased to announce that we would be delighted to accept referrals to our sedation clinics from other dental practices. If you have a patient you feel would benefit from our expertise, please do not hesitate to contact us for further information.

We are able to accept referrals from fellow practices for all manner of treatments, from periodontal scaling to surgical extractions. Our aim would be to see your patient and provide them with the treatment they require within a short period of time. As we have short waiting times, this is possible for us to do.

On completion of treatment, our team will return the patient to your care. Smilescene Hamilton is also able to receive oral surgery referrals.

MORE INFORMATION

If you would like to know more or would like to know how to refer to us, please contact us on referrals@smilescene.co.uk Alternatively, why not visit us at www.smilescene.co.uk, where you can see our full range of treatments?

PATIENTS, PASSION AND AMBITION

GLASGOW SOUTHSIDE ORTHODONTICS EXPERIENCE SIX YEARS OF GROWTH

STEWART MCROBERT

"To create a specialist orthodontic practice that has an exceptional working relationship with referring dentists and provides the very best treatment to patients" – this mission statement was simple and honourable when Fern Stewart and Nadia Hajjaj set up Glasgow Southside Orthodontics (GSO) in 2009.

The opening of GSO was prompted by practicalities as well as the passion to create a distinctive service. At the time, Fern was working independently in a local surgery where her waiting list had grown beyond manageable proportions. It had become clear bigger premises were required.

Nadia, who had spent seven years as an associate orthodontist in Scotland, was keen to act on a desire to run her own business. She explained: "It was time to have more freedom and options. Meeting Fern provided the opportunity to move on."

Fern explained: "Our goal was to have a practice where we could implement and follow through on our own ideas and observe an ethos that emphasised close co-operation with dentists and to deliver a service that is fully focused on patients."

The pair found an ideal spot in Thornliebank that gave them the chance to set up premises suited to their ambitions and ideals, a bespoke orthodontic practice replete with all the necessary equipment and software. Six years and more than 7,000 patients later, the team at GSO are looking forward to welcoming the next generation of new referrals.

Initially GSO operated two full-time surgeries. However, around three years ago, a third was added and that has now become fully functional. This development allowed Lindsey Church to join the practice in July 2013. She was followed more recently by Nadia Gardner, who came on-board as an associate in October 2015. This has allowed the practice to respond promptly and more effectively to new referrals.

SPECIALIST

"It's important to stress that we are solely a specialist orthodontic practice" said Fern. All four orthodontists are registered on the GDC specialist list. To ensure continuity of care, every patient is allocated a specific orthodontist who provides the entire course of treatment.

While all four orthodontists keep up-to-date with the most recent developments in the speciality, what helps to create high levels of patient satisfaction is the attitude and approach of the team at GSO. Nadia said: "It's important to recognise that our staff are a vital part of what we have achieved at GSO. They are part of the family

CONTINUED OVERLEAF>

glasgow southside orthodontics

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"I was a bit nervous when I went to the orthodontist for the first time but Fern and her staff were so friendly it made it all very easy. She gave me really good tips for looking after my teeth while they have been improving and though I'm not quite finished yet, I am so pleased with the results so far. Thanks for looking after me so well"

Ms Lindsay Kerr, Newton Mearns

Fern Stewart with patient

Nadia Gardner

Lindsey Church

"OUR FIRST CHOICE"

Content patients are the be all and end all for the vast majority of dental practices, and that's true at GSO.

However, equally important is the satisfaction of referring dentists. Two of those who have sent patients to GSO took time to give their views:

Gerard Boyle of Shawlands Dental Practice said: "Glasgow Southside Orthodontics has been our first choice place of referral since the day it opened, for all five dentists at Shawlands Dental Practice.

"We've known Fern and Nadia a long time, and have total confidence in them and their staff when we entrust them with the care of our patients. Communication from the practice is clear and prompt, and our patients are always delighted with the service they receive. When required, the orthodontists are always happy to discuss a case over the phone."

Recently retired dentist Alan Caplan observed: "Fern has been my preferred orthodontist for more than 20 years. From her days at Giffnock, then Orchard Park, and finally with Nadia in GSO, she has provided an excellent level of service to me and my patients. Good communication about patients and ease of online referring combine to make a referring GDP enjoy a clear mind that all is in place. My patients report a confident, friendly relationship with Fern and Nadia, and often request one by name for younger sibling referrals."

FROM PREVIOUS PAGE>

and they make the practice tick. We are very lucky – our staff are very motivated, and they are wonderful with the patients. We appreciate everything they do."

According to Nadia, a distinguishing feature is the personal approach that is taken at GSO. Everyone at GSO takes time to focus on patients as individuals. "For us, the greatest satisfaction is to see patients happy when they are finished with their treatment," she said.

REFERRALS

Although there are some patients who self-refer, the majority of the work that comes to GSO is channelled through GDPs with whom they have set-up close working relationships. Fern's long experience – she has specialised in orthodontics for over 21 years – and GSO's well-earned reputation allow it to generate referrals from existing and new sources.

She said: "Dentists identify patients who need orthodontic assessment and treatment and refer them to us. We believe strongly in keeping our referring practitioners fully informed and up to date with the treatment to be provided. At the end of the day, it is important that orthodontist, and dentists work together for the benefit of the patient."

Most referrals come from around the Glasgow area, but the practice treats patients from further afield including Lanarkshire, Edinburgh and Helensburgh; there is even one individual who travels from Islay for treatment!

> "IT IS IMPORTANT TO KEEP CONTROL OF OUR STANDARDS. IT CAN BE EASY TO GET OVERLOADED IF YOU TAKE TOO MUCH ON"

NHS and private referrals for both children and adults are always welcome at GSO.

"With the recent introduction of funding restrictions using IOTN scoring there are some patients who are no longer eligible for NHS funding," said Nadia. "However, we provide a self-funding option for these patients through an affordable payment package."

GSO offers a wide range of treatments. This includes removable, functional and fixed appliances using stainless steel and aesthetic brackets. Also available is the Damon self-ligating system, Insignia Advanced Smile Design and Invisalign.

Referrals can be made online via our website or SCI Gateway. You can also contact the practice by telephone or fill in a referral form. Please contact the practice if you would like to receive a referral pad.

SATISFACTION

Confident that the demand for specialist orthodontic treatment will continue to grow, Nadia and Fern confirmed that they are content with the size that GSO has reached – there are no plans to extend the practice. "It is important to keep control of our standards. It can be easy to get overloaded if you take too much on. We want to maintain the excellent standard of treatment that we give to patients, their families and the referring practitioner.

"We like to think that we do good work here and do so in a happy environment."

Despite the success that has been achieved so far, there is no sense of complacency. Fern and Nadia encourage and are keen to receive feedback. They assess their success with dentists in terms of continual referrals; if dentists keep sending their patients to GSO it is a sign that the practice is providing a good service to them.

In a similar way, families of existing and former patients often bring along younger brothers and sisters for treatment.

The progress made by GSO suggests that the aspirations set out by Fern and Nadia in 2009 have more than been fulfilled.

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FAMILY AFFAIR

GENERATIONS OF LOCAL PEOPLE HAVE BEEN ATTENDING STATION DENTAL SINCE 1971, TESTAMENT TO ITS ROLE AT THE HEART OF THE COMMUNITY

RICHARD CROASDALE

Lorraine Taylor joined Station Dental in Uddingston (established 1971) for a vocational traineeship in 1990, having qualified from the University of Glasgow. When the practice founder announced his plans to retire in 2006, Lorraine took her opportunity to take over as principal.

She said the loyalty and sense of community you experience in a well-established small-town practice is what's kept her there for all those years. Indeed, the practice's core ethos is to encourage families to come together for regular care, in a relaxed atmosphere, without any pressure to opt for a particular treatment.

"Being a dentist in a small community gives you chance to build up relationships, and it's great to see generations of the same family coming back to us, even if it does make you feel a bit old," said Lorraine. "I can remember kids coming in for their first days at school, and now they're coming in with their children. It makes you realise you must be doing something right if they've still got their teeth after 25 years of treating them!"

The vast majority of Station's patients are still NHS, but Lorraine confirmed that much else has changed during her 25 years, principally in terms of patients' awareness of oral hygiene.

"Patients increasingly want white fillings and more cosmetic treatments," she said. "People in general are much better at brushing their teeth and more aware of the importance of things like interdental cleaning. People are also much keener to keep their teeth, whereas in the past they'd reach a stage where they just wanted them all out. They expect a higher standard of cosmetic treatment because they're much more aware."

Taking time out for CPD has become increasingly important as patients have shown interest in a greater range of treatments. But not all changes have been so positive, explained Lorraine, with practice administration taking an ever-greater chunk of patient-facing time.

"There's a lot more time spent in admin, including staff meetings and routine paperwork. That's been a source of increasing frustration, because the more time the paperwork takes up, the less time you have to actually see patients. Check-ups take longer because you have to put so much more details into notes, for example. But you've got to go with the flow, and that's just the way things are now."

In November 2015, Station Dental Surgery moved into new premises 500 metres down the road. Lorraine explained that leaving the practice's home of 45 years was long overdue.

"We had been in what was basically a converted two-bedroom tenement flat. So we didn't have space for a decontamination room and, perhaps more importantly, being at the top of a long flight of stairs meant we didn't have any disabled access. We were bursting at the seams."

The new practice had previously been occupied by a doctor's surgery, which was itself looking for larger premises, so the fabric of the building was ideally suited to Station Dental's needs.

"I'd been on the health board's priority list to move, because of the lack of disability access and decontamination room," said Lorraine. "They were keen for us to see the doctor's surgery and, although we thought it was a little bit big, we pursued it. The health board applied for a grant on my behalf and it was successful, so the majority of the cost of the move was covered.

"The rooms were all the right size and access was great. It was still a three-month refurbishment though; we basically stripped it right back to the walls, installed everything we needed under floors to accommodate dental equipment, including A-Dec chairs, put in new windows, then painted and decorated. We probably did more than we needed to for our current needs, but it gives us the scope to grow."

And growth is definitely part of the plan. Having gone from a two-surgery practice to four surgeries, Lorraine plans to take on more staff and double patient numbers over the next couple of years.

"We took on another dentist at the end of 2015 and she has already increased from one day a week to two. Then we have a hygiene therapist who works with us on a part-time basis too.

"We have two spare treatment rooms at the moment that we're not doing anything with, so in the future, we plan to offer an orthodontist in there, or something along those lines. For the moment though, we're focused on settling in ourselves, getting used to having more space and new computer systems.

"Ian Wilson at IW Technology Services was a great help in installing the new IT systems and making sure all our records were safely transferred across from the old practice.

"It's been a long process all in all, but well worth it now that we are in and our staff and patients all seem very happy."

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AN EYE ON PERFORMANCE

BEN FLEWETT, MANAGING DIRECTOR AT SOFTWARE OF EXCELLENCE, DISCUSSES THE VALUE OF MEASURING PERFORMANCE DATA IN DENTAL PRACTICES

The acknowledgement of dental practices as businesses has been largely driven by the increasingly competitive nature of the market and the growing influence and market penetration being enjoyed by dental corporates, both large and small. Alongside these factors, the business approach of practices is also changing, with the monitoring of performance becoming a key area now recognised as providing valuable data for business managers.

Measuring performance data allows business owners and managers to plan a clear direction for the future and provides a solid foundation for decision-making. On a micro level, monitoring the performance levels of each member of the practice team allows managers to assess and encourage individuals' contribution as part of a practice's overall success, and take immediate steps where necessary, should performance shortfalls become apparent.

However, despite an increasing awareness among practice owners and managers of the importance of KPIs (Key Performance Indicators), a significant number are still failing to measure practice performance. There can be many and varied reasons for this behaviour, but it appears that a lack of understanding about how and where to access relevant performance data plays a major part in this ambivalence.

Dentistry is somewhat unique in business terms, and recent research undertaken by Software of Excellence has provided clear evidence that there are overwhelmingly large numbers of practice principals, around 80 per cent, who admit to not knowing enough about their business performance. This figure becomes even more concerning when you consider that almost half of dentists claim they are not concerned about how their practice is performing.

We know from our research that just 35 per cent of respondents are currently measuring KPIs, whilst only 12 per cent are benchmarking their performance against other practices. Those who are doing so are far more inclined to seek out a third party to help them with the benchmarking process, which in my view is a positive move as such external support can be a valuable asset when trying to understand and analyse performance data, often providing an objective view that challenges the beliefs of those within the practice as to what is possible.

In order to become more efficient and productive, a business needs to identify and routinely measure its most important KPIs to build a clear picture of its performance and identify the biggest opportunities for growth. This method is not solely about making wholesale changes to the way a practice operates, it has also been proven that even relatively minor alterations to existing processes can translate into substantial bottom line impact.

Even something as simple as a "daily huddle", used as to focus attention around daily performance targets, encourages "buy-in" and has a tangible impact on business outcomes.

There are no real excuses for today's dental businesses to avoid routinely measuring practice performance on a weekly or monthly basis. Generating reports is easy to achieve from a suitable practice management system and since the reports produced use only the data input into the system, they provide a reliable overview of KPIs such as chairtime utilisation, revenue, recall success and the like.

Taking this information and benchmarking practice performance to industry standards can help to identify where shortfalls in performance may be relative to similar types of practices in the local area and allow remedial action to be taken and performance targets to be set.

Aside from the monitoring of internal performance, it is easy to overlook the importance of patient satisfaction and how this can benefit all practices. Our research showed that fewer than 40 per cent of respondents carry out patient surveys on an annual basis and for a variety of reasons this figure needs to rise.

Logically, taking the time to listen to and understand what patients expect from your practice gives important feedback, which will help you improve levels of care and service by putting patients' priorities ahead of what dentists often perceive them to be.

Combining an understanding of what your practice data is telling you, your patients' feedback and focusing on those areas where performance can be increased or improved allows targets to be set and staff to be motivated around common objectives.

Don't forget this most important point: great people like to be noticed. Chances are you already have a great team producing good results. By consistently and frequently focusing on the performance of a receptionist or associate, you are inherently implying that what they do really matters to you. It gives you many opportunities to say "good job!"

HELP IS AT HAND

It is clear that performance monitoring is now a vital component of practice success, but it remains a relatively new concept for many practice owners and managers. For those unsure about taking the next step, I would advise them to seek third party assistance to help implement monitoring and reporting procedures.

Acknowledging the importance of practice data and its role in improving practice performance is an important first step in embedding these processes within routine practice management, and gives principals and managers a deeper insight into their business than they have ever had before.

MORE INFO

Performance Monitoring – a gateway to sustained practice growth is a Software of Excellence Whitepaper, available for download softwareofexcellence.com/uk/whitepapers

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To some, this partnership is the delivery of a completed case, without any involvement in the surgical or restorative phase. To others it is a journey of clinical development through our mentoring

and training programs which equip our referring dentists with the skills to be involved in implant restorations.

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

"I have benefited greatly from the Care Dental Implant Clinic three-year programme of education I am currently participating in with Bruce and Dr Paul Tipton. This course not only increases my knowledge and understanding of implants, it has also enabled me to confidently undertake advanced restorative dentistry on my own patients, during the restorative phase."

MORE INFORMATION

The clinic accepts a whole range of referrals; for single implant placements to full mouth rehabilitation cases with bone reconstruction. To discuss partnering with Care Dental Implant Clinic please call 01764 - 655745 or email referrals@care-dental.co.uk

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The centre also has the most up-to-date diagnostic and precision equipment that ensures patients are given the best treatment and care that they deserve.

The centre also welcomes dentists to accompany their patients when they come in for treatment.

Referring dentists can enjoy FREE update seminars at the centre, ranging from refer and restore through to endodontics and treatment planning.

There is also the opportunity to have in-practice complimentary lunch and learns, which are very popular.

Other courses, including masterclasses, are held at prestigious locations throughout the year.

Referring dentists will also receive a monthly e-newsletter update that keeps everyone fully informed.

Scottish Centre for Excellence in Dentistry really does go that extra mile on all levels of service and care – working alongside them would be a great addition to your own practice and the treatments you can offer your patients.

Please also be assured that any patient referred to Scottish Centre for Excellence in Dentistry will be returned to you for continuing care.

MORE INFORMATION

If you would like to refer your patients for any of the referral services listed below please contact the practice and speak to Yvonne Muir or email her on yvonnemuir@scottishdentistry.com

TREATING ANXIOUS PATIENTS

Complete Dental Care was opened in Cambuslang in 2011 by Hassan Ali and Omar Iqbal, who studied together at the University of Glasgow and graduated in 2005.

They have both completed further education, attaining the MFDS. Hassan has since completed a masters degree in restorative dentistry from Kings College, London, while Omar has completed the 1-2-1 dental implant course in Sheffield in 2013. He is also currently working towards a masters degree in dental implantology with the University of Bristol.

The practice was started as a single surgery squat and has now grown to a four-surgery practice, with Alyson Lovie and Andrew Hannah joining the team over the years. The main focus of the practice has always been NHS dentistry and from the outset we have strived to provide high-quality care.

More recently, there has been a focus in the practice in the treatment of anxious patients. In 2013, Omar was among the first group of Scottish dentists to complete IV sedation training through the Glasgow Dental Hospital postgraduate centre, which was organised and run by NES.

Since then, Omar has provided IV sedation for hundreds of dental patients and has been accepting referrals from colleagues. Alyson Lovie completed the course in 2015 and Andrew Hannah is due to start the course this year.

Our dental nurses have also trained on the NES sedation course alongside the dentists, to make sure the full team is geared towards providing IV sedation in a safe environment.

We are happy to accept referrals from our dental colleagues for all types of treatments, from simple NHS restorative care to surgical extractions including lower wisdom teeth. You can rest assured that your patients will receive high quality dental care from us.

MORE INFORMATION

To find out more, contact Complete Dental Care Cambuslang on 0141 641 2107 or visit www.glasgowdentalcare.co.uk

LOOKING AFTER YOUR PATIENTS

SINCLAIR DRIVE DENTAL CARE IS NOW ACCEPTING REFERRALS FROM OTHER PRACTICES FOR PATIENTS WHO REQUIRE INTRAVENOUS SEDATION

The team at Sinclair Drive Dental Care is continuing to provide intravenous sedation and we would like to extend this facility to other dental practices in the surrounding areas.

The practice aims to see all referrals within one week for consultation and within two weeks for treatment. This allows us to have no waiting list, ensuring your patients are seen quickly and efficiently.

It is practice policy that no patient who is referred to the clinic will be allowed to register as a patient and that all patients are discharged back in to the care of their referring GDP, with a letter detailing the treatment that was carried out.

We would like to introduce our two dental practitioners who will be seeing patients who are referred to the clinic.

Our sedationist Dr Gordon Meek has been a qualified dentist since 1972 and has a wealth of experience in the field. He worked full time at the Glasgow Dental Hospital from 1972 till 1976 and has worked in general practice ever since.

Until 2010, Gordon taught periodontal and restorative treatments in Glasgow Dental Hospital. He brings more than 40 years of experience to our south-side clinic and has a special interest in all aspects of dentistry, including aesthetics, endodontics, periodontics and even dental implants.

Our associate dentist, Dr Sunita Lagoo, has proved herself to be very popular with the patients because of her gentle touch and manner. Sunita graduated in 2001 and has worked in a variety of hospitals gaining experience of very high standard.

We would like to take this opportunity to thank you for any referrals received or any that you may send in the future.

MORE INFORMATION
For queries or a referral pack, please contact the surgery on 0141 632 2512.

2016

HAPPY NEW YEAR!

SCOTTISH DENTAL MAGAZINE AND OUR FRIENDS IN THE DENTAL COMMUNITY WOULD LIKE TO WISH YOU ALL A HAPPY NEW YEAR AND ALL THE BEST FOR 2016

SCHÜLKE

Schülke UK provides an extensive range of infection prevention and control products to meet the highest standards of hygiene and care in dental practices. The range includes a biofilm removal and protection system for dental unit waterlines, surface cleaning wipes, disinfectants, instrument decontamination products and hand hygiene and disinfectant products. Schülke also provides in-practice verifiable CPD training in infection control.

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*Contact **Allan Wright, Senior Regional Consultant on 07976 513 439**, or email allan.wright@schuelke.com*

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Coltene would like to wish all its customers a very happy and prosperous 2016. As always, Coltene is committed to offering the highest standards in both its wide range of dental products and its customer care.

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*Contact your Coltene Scottish representative **Helen Wilson on 07788 146 109** and she will be pleased to arrange a visit to your practice to demonstrate BRILLIANT EverGlow or any of the other materials in Coltene's wide portfolio, visit www.coltene.com*

NEW YEAR PENNY SALE

Kemdent is celebrating the New Year with a penny sale, buy one 5L disinfectant and get another for just one penny! The offer applies to PracticeSafe Alcohol Based Disinfectant, ChairSafe Alcohol Free Disinfectant and InstrumentSafe Alcohol Free Disinfectant

If you are looking for alcohol based disinfectants for the effective cleaning of your practice, try PracticeSafe.

Are you looking for an alcohol free disinfectant that is specially formulated to clean sensitive surfaces and equipment? ChairSafe is ideal and available in 200ml foam, 500ml spray or 1L refill, 5L refill and 10L refill plus disinfectant wipes. InstrumentSafe is a pre-sterilisation concentrate perfect for dental medical instruments, including rotary hand-pieces. It has a broad spectrum of activity, fast and efficient (five minutes in an ultrasonic bath) and kills MRSA.

Find the disinfectant to suit your needs and view all the offers on the Kemdents' website www.kemdent.co.uk

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For all dental professionals, education is key. But for young dentists, it's imperative for success.

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For more information visit www.quintessdenta.com, email info@quintessdenta.com or call 028 6862 8966

'RICHARD OF YORK GAVE BATTLE IN VAIN'

We all remember the mnemonic for remembering the colours of the rainbow, but the choice of colours in which Belmont chairs are available would be impossible to remember! Furthermore, four new colours have been added to the palette: Sonora, Silver Pearl, Salmon and Mandarin.

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From the most popular pastel Light Blue (Standard CG19) to the second best-seller- always stylish - Black (Ultraleather Raven Wing), Belmont offer a diverse colour range of seamless and luxury fabrics to ensure you get just the right shade to complement your practice's personality.

Is it time that your surgery underwent a bit of a revamp?

For more information, call 020 7515 0333.

EXPERIENCE NOT ESSENTIAL

Durr Dental's panoramic device is so easy to use that user experience is almost negligible. The intuitive 7"-touch display on their VistaPano enables users to quickly and clearly view all settings, facilitating speedy and smooth processing. Face-to-face positioning reduces patient anxiety.

VistaPano employs S-Pan technology that results in an image of impressive clarity. Since the reconstruction is geared at the actual position of the bite, incorrect positioning is, within reasonable limits, eliminated.

Radiation safety is also optimised. The VistaPano S can take a panoramic image in just seven seconds, meaning patients are exposed to the lowest possible radiation dose.

The equipment is also highly intuitive and adapts the dosage according to which of the 17 different programmes is selected.

A NEW VOYAGE(R)

Like buying a car, your chair is likely to be with you for a long time, so you need to ensure both functionality and aesthetics are considered when committing to a purchase. The new Voyager III is a versatile and compact treatment centre, designed and built for the most demanding working environments.

It is a significant upgrade from the previous model. Improvements include better vacuum air-flow, the chair base and delivery arm have been redesigned and the chair's ergonomics and comfort have been improved. It also comes with touchless sensor as standard. As with the previous model, the Voyager III can be moved from left to right-handed use in a couple of simple steps. Moreover, the clever 'Below-The-Patient' engineering ensures that neither left nor right-handed use is compromised.

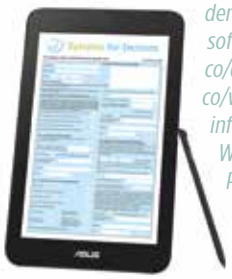
To find out more about the Voyager III or the benefits of below-the-patient treatment centres, visit www.belmontdental.co.uk or call 020 7515 0333.

PAPERLESS SOLUTIONS FOR SCOTLAND IN 2016

In the run up to the Scottish Dental Show on 13 and 14 May 2016, one of the UK's leading dental practice management software solutions specialists, Systems for Dentists, is looking forward to demonstrating how it can revolutionise the way to a paperless dental practice.

And one of its most popular products, Wireless Signature Pads, reduces admin, and saves time and money.

And the up and coming availability of this fabulous wireless technology is set to create a buzz among dentists keen on allowing patients to read and sign all mandatory documentation electronically.



Download a full demonstration of the software at www.sfd.co/demo, visit www.sfd.co/wsp.html for further information on the Wireless Signature Pad, or call 0845 643 2828 to arrange an appointment. Quote SDMwinter.

BE FLEXIBLE

Do you wish you had the technology to allow a flexible workflow, while providing outstanding clinical results for patients?

If so, then you need look no further than CS Solutions from Carestream Dental. Available as a fully integrated package or as individual technologies, CS Solutions consists of: CS 3500 intraoral scanner, CS 9300 or CS 9000 3D CBCT impressioning scanner, CS 3000 milling machine, CS Restore software and CS Connect communication portal.

The innovative system provides the opportunity to scan, design, mill and place restorations chairside if you wish, or you can send your digital scans in an open STL file to a laboratory of your choice for manufacture. It also boasts easy portability, efficiency and high quality images, ensuring streamlined diagnostics and treatment planning for optimum clinical results and patient satisfaction.

Contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

BREAK FREE FROM CONVENTIONS

Essentia is GC's new light-cured radiopaque universal composite, that enables clinicians to break free from conventions and eyematch intuitively.

Designed by dentists for dentists, because of its innovative and bold shade concept, GC's Essentia introduces a paradigm shift in restorative dentistry. Essentia represents the pure essence of composite layering, eliminating the need for shade guides. With just seven shades clinicians can create perfect aesthetic solutions for all their restorations.

Essentia's new shade concept employs just seven shades to solve every clinical situation, with all the shades being of regular use to save on costs and inventory.

Essentia features optimal handling and optical properties. It also simplifies the polishing procedure, delivering a perfect surface finish in a few steps.

For further information, please contact GC UK Ltd on 01908 218 999, e-mail info@gcukltd.co.uk or visit www.gceurope.com

FREE EQUIA FORTE SAMPLE

EQUIA Forte is the latest innovation in GC's glass ionomer and resin technology range, two innovative systems working in synergy to build a stronger, superior bulk fill material for Class I & II restorations.

EQUIA Forte Fil is the fast setting, aesthetic restorative with an innovative hybrid glass technology offering greater fracture toughness, wear resistance and fluoride release. No need for conditioning or bonding, with its built-in universal adhesive technology.

EQUIA Forte Coat is a thin film-thickness lustre coating which enables clinicians to save on polishing time and improve the translucency and aesthetics quickly and easily.

To claim your free EQUIA Forte sample pack please contact your local GC Representative or e-mail info@gcukltd.co.uk with your name, practice address and phone number.

For further information contact GC UK Ltd on 01908 218999, e-mail info@gcukltd.co.uk or visit www.gceurope.com

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USER-FRIENDLY SOFTWARE

Principal of Stradbrook Implants in Tonbridge and renowned lecturer in the field of dental implants, Mark Haswell has been working with leading solutions from Nobel Biocare for several years now.

"The recent Nobel Biocare Team Conference was very good.

"I attended a full workshop with Peter Wöhrle and Pascal Kunz focusing on the integrated treatment workflow achievable with NobelClinician. The workshop delivered all the information I needed, and we have since installed the software in my practice. It is my hope that this software will help us streamline our daily processes."

Designed to enhance diagnostics, treatment planning and patient communication, NobelClinician is an intuitive software programme suitable for all practitioners.

Contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com

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