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Scottish Dental

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On the critical list

NHS dentistry is 'broken' and 'real reform won't wait', warn practitioners

The statistics came thick and fast in the first month of this year.

An eight per cent fall in the number of NHS practitioners since the outbreak of COVID, with 11 of the country's 14 regional health boards reporting a decline. NHS dental activity is down 43 per cent. Four in five practices are not accepting new NHS patients.

Patients seeking hospital dental treatment on the NHS have, in some cases, been waiting for between two and three years. In NHS Lanarkshire, the average waiting time for inpatient or day case treatment through the Public Dental Service was 41 weeks last year – compared with four weeks in 2019.

Barely half (50.4 per cent) of NHS registered patients have seen a dentist in the past two years, compared with 65.1 per cent in 2020. The gap in child participation, between the most and least deprived areas in Scotland, now stands at 20 percentage points – compared with three in 2008.

The Scottish Government responded with numbers of its own: "A record number of people are registered with an NHS dentist, covering more than 95 per cent of the population of Scotland, and across key treatments NHS dental services are at comparable levels of activity to levels last seen before pandemic restrictions were introduced," said a spokesperson.

"Dentistry is an important part of our NHS Recovery Plan. More than 1.5 million NHS examination appointments were completed between April and October, with an average of more than 300,000 courses of treatment per month, meaning we are on course for more than 3.5m contacts in the 2022/23 financial year. In total, the Scottish Government has provided over £150 million to date in additional support to maintain the capacity and capability of the sector."

But, as David McColl, Chair British Dental Association's Scottish Dental Practice Committee, commented: "Patients in Scotland's poorest communities are paying the price for the crisis in dentistry. The Scottish Government must not try to hide behind positive sounding registration figures. The reality is patient participation remains on the floor, and inequalities are set to widen. Dentists are reconsidering their futures working in a broken system. NHS dentistry is on the critical list, and real reform won't wait."

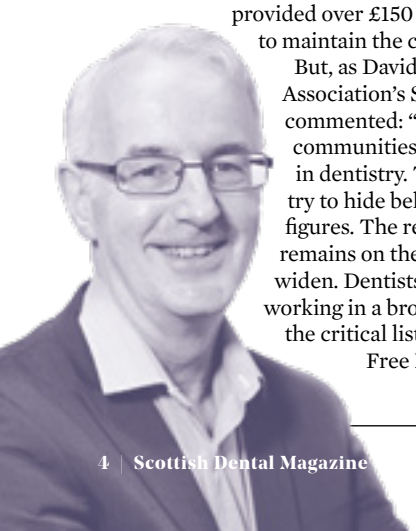
Free NHS dental for all remains a key Scottish Government policy. Rightly, the BDA in Scotland continues to warn that a return to a 'business as usual model' – what it describes as 'low margin and high volume' – will put practices under unsustainable financial pressure, with soaring running costs raising the risk of closure or a move to the private sector. It has urged the Government to continue with its additional financial support for practices – which is set to end on 1 April – to support dentists and their teams as they work through the historic backlog of dental care and until a new, sustainable funding arrangement for NHS dentistry is in place.

But the reality is that the exceptional support will, indeed, come to an end; over a period of two months in the run-up to Christmas, Scotland's Chief Dental Officer, his team, and an advisory group comprising general dental practitioners, dental care professionals and specialists, held a series of workshops to discuss the treatment items that should be available in a revised Determination 1 (though not funding – that, as the Group's remit noted "is a matter for discussion between government and trade union representatives").

They considered the elements of an oral health examination, diagnosis and treatment, preventative and periodontal care, and restorative and surgical treatment. At its final meeting in December, concerns were raised regarding the effect that a revised Determination 1 may have on the mixed practice model – and how the changes will be communicated to dentists.

As we acknowledged in the last edition, the founding of the group (and the commissioning of a sectoral survey that preceded it) were positive steps on the part of the Government's Dentistry and Optometry Division. But revisions to the existing – and outmoded – model of NHS dentistry are unlikely to stem the tide of negative statistics that ushered in the new year.

> "REVISIONS TO AN OUTMODED MODEL ARE UNLIKELY TO STEM THE TIDE OF NEGATIVE STATISTICS THAT USHERED IN THE NEW YEAR"



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Arthur Dent is a practising NHS dentist in Scotland
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New Year: New SDR?

Questions abound. What will the fee structure look like? 'New Determination 1': what about the rest? The devil will be in the detail

Will Determination 1 v2 be workable? Will it be any good? From what I can see from the notes on ScottishDental.org[1], there are certainly fewer items. Fundamentally, this is what people have been calling for – for years. However, being that Item of Service (IOS) is the primary payment method, it has to be suitable. Can it reflect the complexity of the work in a fraction of the codes? Will we end up with a huge discretionary fee list because it's unsuitable?

I feel the most important factor for the Scottish Government is that dentists are prepared to accept an aggregate fee structure. I mean not all fees may make money but, overall, the money we earn will be enough, or the same, or better. This is a very difficult balance to achieve. Dentists have always struggled with any code which is not income generating. Look at the classic argument that molar endo, chrome, and gold crown fees simply don't compensate for the time or costs involved.

I understand the aggregate argument. We have to look at the overall balance of fees, CC&C and allowances to enable a reasonable living and businesses to be profitable. The Scottish Government does have an understanding of this – however, not a good understanding. One complexity is business owners, be they private or corporate, have different income streams to associates. This puts each group at odds with the other and the Scottish Dental Practice Committee (SDPC) and the Scottish Government have to strike a balance which allows both groups to be happy. Look at the strikes we are currently plagued by in healthcare and elsewhere. There are huge variations in what's on offer and within the deals themselves: often offering larger percentages or flat rates to those in lower levels of responsibility. Could associates end up being more rewarded than owners?

This should be done with great care. Back in the late nineties and early 2000s, associates were in short supply (cf the 200 or so empty associate positions in Scotland just now) and percentages were increased. This led to a real lack of impetus to buy practices. In turn, this forced the 2005 Action Plan to redress the balance towards ownership. If the Scottish Government and SDPC are not careful, and the workforce planning isn't addressed quickly, there will be a very similar situation again. The fee structure in any new SDR will have to reflect that.

So, what will make it work? I believe there must be a little (and I mean a very little) more emphasis on the CC&C. This will give comfort to dentists that some fluctuation in IOS fees will be flattened out and we can expect that 'background income', which pays for holidays and illness and guarantees viability, to tick along. Dentists need to accept the loss of 'Christmas Tree Codes' like sensitive cementum, stone and smooth etc., and take responsibility for preventive advice and minimal items within that CC&C.

Once the new 'Det 1' fees are set, they must be trialled and proven to result in, at the very least, a 'net zero' situation. A pilot would test this (I've already called for this) and would give comfort to dentists and those paying the bill, that all will be satisfied and no one disadvantaged. This should be at least six months. It would also allow codes to be refined, dropped or amended and some added, if proven necessary. There should be no 'magic number' of codes to achieve; simply a workable document.

The desire for less administration, I think would benefit everyone. The Practitioner Services Division (PSD) would get greater efficiency with less funding. However, that will only work if the codes are workable. Fewer fees will create more requests for clarity, more difficult prior approval and backfire for PSD. Practice management systems take care of EDI claims and, as long as we code properly, it doesn't matter whether there's 30 or 3000 codes. More codes equal fewer provisos and fewer queries from dentist or PSD. Fewer codes mean more provisos to include or rule out instances when the code is the correct one; does that equal more opportunity for confusion and create a greater burden on the people involved to answer queries in either direction? That is more complicated, not less.

Prior approval needs an overhaul. Items, like soft splints, take longer to complete the PA for than the treatment itself. The PA cost is too low. It takes far too long and is too subjective to be reasonable. It's an enormous barrier to proper care.

Finally, and most importantly, the other allowances need to be sorted. Generally, I feel they are appropriate. They need some tidying up:

- Rent shouldn't be paid to practices; it should only be paid where a proper lease agreement is in place. This would force practices to move their property into a separate entity; there is some tax benefit in this. The main point is it then makes practices comparable in terms of profitability.
- GDPA has already had a little tickle, post-COVID. The cap must go. There is absolutely no evidence for it. One surgery or ten have comparable costs in terms of staff, utilities, equipment and materials. With every fee increase, more practices are affected; this is a de-facto, year-on-year cut in practice funding, especially in poorer areas.
- SDAI funding should be re-introduced across Scotland to fund improvements and expansion (where a properly assessed business case is made). This would improve the dental property portfolio but keep that funding in dentists' hands: not landlords, if rent is amended.

These are the allowances which make practice ownership viable, and the only way NHS dentistry survives in Scotland is with practice ownership, especially non-corporate ownership, being incentivised. Much work to do.

[1] *www.scottishdental.org/wp-content/uploads/2022/12/CDO-Advisory-Group-Note-of-Workshop-3-24-November-2022.pdf*

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Figures reveal depth of Scotland's access crisis

Gap between the most and least deprived areas in Scotland continues to grow

THE British Dental Association (BDA) has called on the Scottish Government to "fix the broken system underpinning NHS dentistry", as new data[1] reveals little sign of a recovery in attendance and ever-widening health inequalities.

Figures from Public Health Scotland show participation rates – contact with a dentist within the past two years – continued to fall. On 30 September 2022, just 50.4 per cent of all registered patients had seen an NHS dentist within the last two years, still down on the 52.6 per cent seen in 2021, and a considerable reduction from almost two-thirds (65.1 per cent) in 2020. The participation rate among registered children was higher than for adults (65.7 per cent compared with 47.2 per cent).

The gap between the most and least deprived areas in Scotland continues to grow, with the new data showing record inequalities in participation rates. In September 2008, the gap in child participation between the most and least deprived areas was three percentage points; this had increased to seven percentage points by 2010, eighteen percentage points (55.3 per cent compared to 73.1 per cent) in September 2021. The figure now stands at twenty percentage points (55.9 per cent compared with 75.8 per cent).

The BDA has warned that lower levels of participation will inevitably translate into a higher dental disease burden, with deep oral health inequalities expected to widen even further given the cumulative impact of limited access to services, the temporary suspension of public health programmes, and the impact of lockdown diets. Lower participation will reduce the chance of picking up early signs of decay and oral cancers at routine check-ups, and delays in treatment will mean higher costs to the NHS and worse outcomes for patients.

Registration rates remain high due to lifetime registration; more than 95.4 per cent of the Scottish population were registered with an NHS dentist in September 2022 – but the percentage of children registered fell marginally.

Free NHS dental for all remains a key Scottish Government policy. BDA Scotland has long warned that a return to 'business as usual' – a low margin and high-volume model – will put practices under unsustainable financial pressure, with soaring running costs raising the risk of closure or movement to the private sector.

The BDA Scotland stressed that government ministers must continue with additional financial support for practices – set to end on 1 April to support dentists – and their teams as they work through the historic backlog of dental care and until a new, sustainable funding arrangement for NHS dentistry is in place.

This data follows recent reports of a growing exodus of dentists from the NHS (see story, this page). David McColl, Chair of the BDA's Scottish Dental Practice Committee, said: "Patients in Scotland's poorest communities are paying the price for the crisis in dentistry.

The Scottish Government must not try to hide behind positive sounding registration figures. The reality is patient participation remains on the floor, and inequalities are set to widen. Dentists are reconsidering their futures working in a broken system. NHS dentistry is on the critical list, and real reform won't wait."

[1]tinyurl.com/2hdbjmfk

Profession warns of 'exodus'

DENTISTS have warned there could be a "wholescale exodus" of the profession from the NHS if ministers fail to make a "serious long-term commitment" to the sector. Data covering eight months from 2022 to 2023 reveals that Scotland had 3,155 dentists carrying out work on the NHS, compared with 3,407 in 2019-20.

"The Scottish Government needs to make a serious long-term commitment to prevent a wholesale exodus from the NHS," said Robert Donald, Chair of the British Dental Association's Scottish council. "Ministers need to understand that Scotland can't have NHS dentistry without NHS dentists."

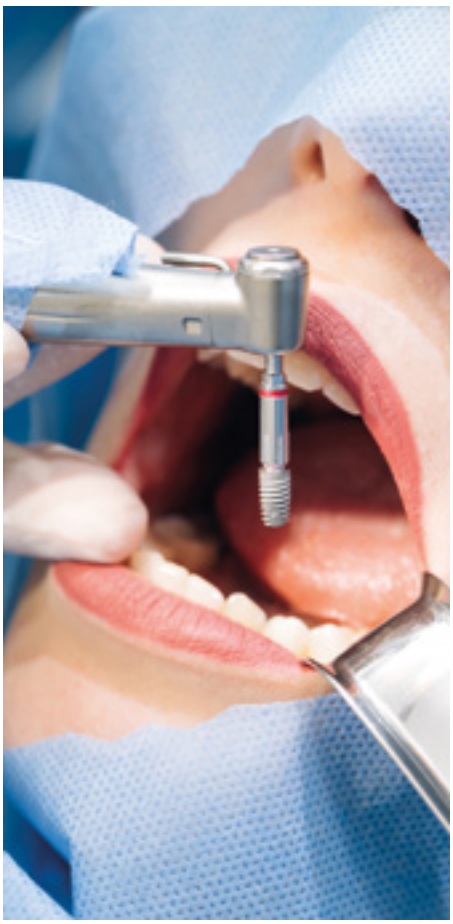
Mr Donald said that dentists in the NHS have "little sense of what the future will bring when the last pandemic support is pulled away". But he added: "What they do know is this service hasn't bounced back, and that some NHS treatments are now being delivered at a loss."

His comments came as the Scottish Liberal Democrats accused the Government of an "unacceptable failure" to support dentists. Figures released to the Liberal Democrats by Public Health Scotland found 11 of the country's regional health boards now have fewer NHS dentists than they did in 2019-20. Scotland's largest health board, NHS Greater Glasgow and Clyde, has 59 fewer, while NHS Lothian has seen a reduction of 54.

Alex Cole-Hamilton, Scottish Liberal Democrat leader, said: "[The] figures point to this Government's unacceptable failure to support NHS dentistry in Scotland." He said dentists are no longer prepared to work for the NHS because of the low rates they receive and "the barriers thrown in their way by ministers". Mr Cole-Hamilton added: "For many of them, the pandemic was the last straw. They have decided it is simply less hassle to work privately."

A Scottish Government spokesperson said: "Dentistry is an important part of our NHS Recovery Plan. More than 1.5 million NHS examination appointments were completed between April and October. In total, the Scottish Government has provided over £150 million to date in additional support to maintain the capacity and capability of the sector."

Funding for dental reform announced, see page 14



Strontium may improve implant recovery

Scaffolds loaded with the metallic element stimulate wound healing, say researchers

RESEARCHERS have developed a strontium-loaded scaffold that can be personalised to fit any size of dental implant and could help improve healing and tissue attachment in patients.

The success of dental implants is dependent on the growth and adhesion of soft tissues to the implant surface. Previous research by the team at the University of Buffalo in New York found that strontium, a bone-seeking element that improves bone density and strength, also supports soft tissue function. Strontium, they discovered, can promote the function of fibroblasts – a type of cell that forms connective tissues and plays a critical role in wound healing.

The new study, published earlier this year in the *Journal of Biomedical Materials Research*[1], found that scaffolds loaded with strontium – even at low concentrations – promoted wound healing by stimulating gingival fibroblast activity.

"Scaffold materials have been explored to promote bone and skin wound healing, but adaptations for the oral cavity are limited," said lead investigator, Michelle Visser, PhD, Associate Professor of oral biology in the university's School of Dental Medicine. "These novel scaffolds represent a system for effective strontium release in the oral cavity."

To produce the scaffolds – which are porous structures that promote and guide cell growth – the researchers developed reusable, ring-shaped templates and molds. The flexible hydrogel scaffolds are infused with a range of strontium concentrations that are released in an initial burst over 24 hours, followed by a sustained dosage over four days with minimal toxicity.

Tested in the laboratory, the strontium-loaded scaffolds increased the cellular activity of isolated gingival fibroblasts cells, while the hydrogel scaffold alone had little effect on the cells.

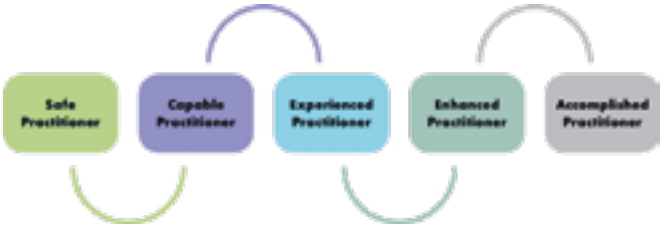
[1]*https://onlinelibrary.wiley.com/doi/full/10.1002/jbm.a.37439*

CGDent launches new membership scheme

THE College of General Dentistry has launched Certified Membership, a new, enhanced membership scheme offering elevated professional recognition and ongoing one-to-one career support.

Last June, the College published Career Pathways in Dentistry: Professional Framework[1], which set out the attributes which define each of five career stages – safe, capable, experienced, enhanced and accomplished – for each role in the primary dental care team, and for each of five domains within each stage – clinical and technical, professionalism, reflection, development and agency.

Using the Professional Framework, Certified Membership offers structured support for individuals to map out their career journey, working with a trained facilitator to plan and document the staged acquisition of the skills, knowledge, experience and behaviours necessary to enable them to fulfil their professional ambitions.



With flexible scheduling of support, it will enable dental practitioners to make the right investment in training, build confidence in their practice, and maintain momentum in their career, all while carrying on with their jobs and busy lives.

Their Certified Membership status will aid them in their journey, offering formal recognition of their capability at each career stage, demonstrating their commitment to professionalism and high standards of practice, and signifying their dedication to further professional development.

Phase 1 of the programme, with a limit of 50 places, is now open to dentists. For details of how to enrol, visit: cgdent.uk/certified-membership

[1]*https://tinyurl.com/5h74mdum*

BASCD presents awards at ASM

Encouraging researchers in the field of population oral health

THE British Association for the Study of Community Dentistry (BASCD) is keen to encourage researchers in the field of population oral health – and to support this it offers four awards, including the Keith Woods Essay Competition and the BASCD-Borrow Foundation Early Career Poster Award.

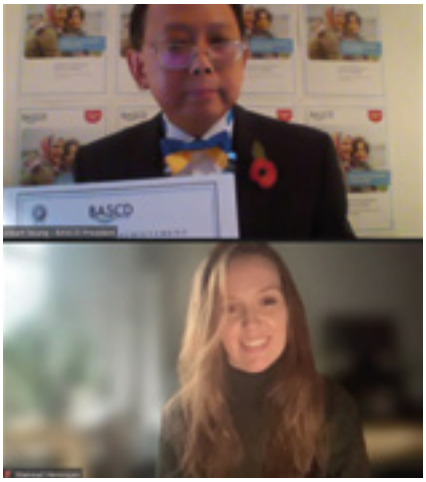
The essay competition is designed to foster the interest of the next generation of dental professionals in public health dentistry. For 2022, the title was *'The oral health of refugees and the mobilisation of oral health care services to meet their needs'*.

The winner was Ellie Macintosh, a recent graduate of dental therapy and hygiene from the Peninsula Dental School. Commendation went to Yasmin Aziz, a recent dental graduate from the Cardiff Dental School.

The BASCD-Borrow Foundation Early Career Poster Award is sponsored by The Borrow Foundation which is actively engaged in promoting oral health and disease prevention.

The 1st prize award winner K. Julia Hurry, of Queen Mary University of London, (topic: *'Barriers and Dental Care Pathways for Children Looked After in the UK'*) received a certificate, £200 and financial support to participate at the congress of the European Association of Dental Public Health being held this year.

A certificate and prize of £50 were awarded to both the 2nd and 3rd prize winners; Sarah Kaddour, of NHS England (topic: *'Stay Smiling: Co-producing an oral health training programme for care homes'*) and Mairead Hennigan, of NHS Lothian (topic: *'Service evaluation of a new unscheduled paediatric dental service in NHS Lothian'*).



Mairead Hennigan, of NHS Lothian, receiving her prize at a virtual ASM from BASCD President Albert Yeung

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A root canal treatment alternative? GDPs wanted for important research study

Researchers look at alternative procedure for tackling irreversible pulpitis

AN alternative to root canal treatment, the favoured procedure for saving teeth damaged by advanced decay, is being explored by researchers.

The 'Pulpotomy for the management of Irreversible Pulpitis in mature teeth' (PIP) Study is looking at the clinical and cost effectiveness of root canal treatment compared with full pulpotomy.

Treating decay is estimated to cost the NHS £3.4 billion a year. Using pulpotomy would potentially be less time-consuming and cheaper.

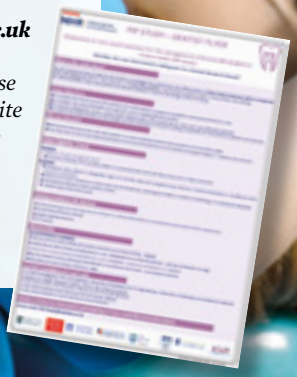
A team based at Dundee University's School of Dentistry aims to recruit 530 patient participants from 50 dental practices across Scotland and England to take part in the year-long study.

"Research has already been conducted in children's teeth that supports using pulpotomy instead of root canal treatment," said Professor Jan Clarkson, one of the study leads. "However, there are gaps in our knowledge about using pulpotomy in adult's teeth."

The study will consider the pain experienced by patients, the impact of treatment on their lives, whether further treatment is needed due to infection and the time and financial costs incurred.

*If you would like further information, please contact – **PIP-Study@dundee.ac.uk***

If you are interested in being involved in this primary care research study, please complete the following Site Initiation Questionnaire by scanning the QR Code – this will take no more than 10 minutes to complete.



Exploring 'perio-ortho synergy'

INTERACTION, cooperation and common ground between periodontology and orthodontics will be the focus of the Perio Master Clinic 2023[1], in Antwerp on 3-4 March, organised by the European Federation of Periodontology.

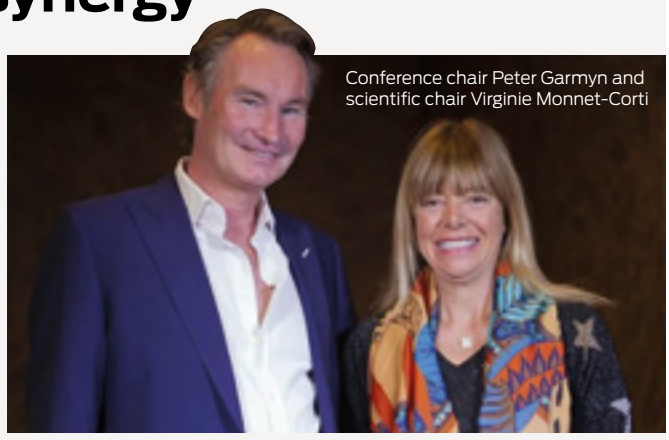
Perio Master Clinic is a triennial, hands-on conference which aims to upskill and update the technique and practical mastery of dental practitioners, so that they can take better care of their patients' oral health but also so that they can treat the sequelae of periodontitis efficiently and aesthetically.

Under the theme 'perio-ortho synergy', this edition of the conference will shed light on a combined periodontal and orthodontic treatment approach, and on management with the additional use of implant dentistry. The event will be led by conference chair Peter Garmyn, from Belgium, and scientific chair Virginie Monnet-Corti, from France.

Multidisciplinary collaboration between periodontists and orthodontists is key for the treatment of periodontitis in its advanced stages. Most severe periodontitis patients need orthodontic treatment, but orthodontists are sometimes afraid to treat them, which results in frustration when successfully treated periodontitis patients cannot complete their rehabilitation as implants cannot be placed without previous orthodontic treatment.

"Today most orthodontists would not treat stage IV periodontitis cases," said Dr Garmyn. "That is why it is essential to reach a common understanding among perio and ortho professionals, which is what we hope to achieve with Perio Master Clinic 2023.

"It is about more than exchanging tips, tricks and techniques – our purpose is also sharing visions, challenging traditional boundaries, and finding synergies between both specialties, for the benefit of patients."



Conference chair Peter Garmyn and scientific chair Virginie Monnet-Corti

Professor Monnet-Corti added: "The treatment of complex cases of advanced periodontitis - right at the crossroads of perio and ortho - is one of the most exciting areas of dentistry today, and we will show that practitioners can still expect predictable, biological and aesthetic, long-lasting treatment outcomes in these periodontal patients."

The EFP is a non-profit organisation dedicated to promoting awareness of periodontal science and the importance of gum health for oral health professionals and the public.

[1] *www.efp.org/news-events/perio-master-clinic-2023-antwerp*

Funding for dental reform announced

Allocation included in £19 billion spend on health and social care

MORE than £2 billion has been allocated to deliver and improve primary health care services, the Scottish Government has announced, "enabling dental reform and supporting GP services through investment in multi-disciplinary teams and targeted assistance".

The Government said health and social care services will receive the highest ever budget settlement over the next year "paving the way for sustainable public services in Scotland". The overall £19 billion package will "help tackle the immediate pressures caused by the pandemic and a tough winter, while supporting the delivery of health and care services that are fit for the future," it said in a statement.

It added: "The Scottish Government has surpassed its commitment to ensure every extra penny it receives from the UK Government is spent on health and social care. This means an extra £1 billion will be available to improve front line services and help fund the NHS pay deal for 2022/23."

Health Boards across Scotland will receive a six per cent boost in funding as part of the Budget – bringing their total budget to £13.7 billion, which includes more than £9 billion to give staff a fair wage.

Humza Yousaf, the Health Secretary, said: "Frontline workers are the foundation of our health and care services, and I am extremely grateful for them for getting us through the pandemic and facing down one of the toughest winters in NHS history.

"This historic settlement took some difficult decisions, but we are steadfast in efforts to address the immediate pressures on health and social care services and support fair work and pay.

"I want health and care services that are fit for the future – a future where Scotland continues to be the best place for health and care workers and where everyone gets the care that they need, where and when they need it."

'Unbeatable' take-home whitening experience

SDI has long been at the forefront of advanced professional tooth whitening with an excellent reputation for its award-winning Pola whitening gels for use in-practice, at home or on the go.

Launched in the UK in April 2021, SDI has changed the game again with Pola Light, an advanced, fast-acting take-home whitening system using Pola Day 6% hydrogen peroxide gel coupled with a comfortable LED mouthpiece that helps accelerate the whitening process.

Proving that not all whitening treatments are the same, Pola Light is ready to use straight from the box with no impressions or custom trays required.

Features include:

› Just two 10- or 15-minute treatments a day
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› Unique blend of soothers, conditioners and high-water content minimises sensitivity
› No mess high viscosity gel that does not leak from the trays
› Instruction guide and shade guide included
› Visibly whiter teeth in just five days

Dr Linda Greenwall, a specialist in restorative dentistry and prosthodontics, with a special interest in cosmetic dentistry, said: "Pola Light brings something different to the whitening market, allowing our patients to experience professional whitening at their convenience and at a more affordable cost, delivering whiter teeth in as little as five days."

Its makers say that Pola Light offers patients an exciting, motivational whitening treatment for a brighter, more confident smile in a simple and manageable way. "It's the ideal choice for whitening teeth quickly and safely at home as well as for future top up treatments," said a spokesperson.

For more information visit sdipola.co.uk/products/pola-light

College of General Dentistry forms '1992 Circle'

THE College of General Dentistry is establishing the '1992 Circle' as a social forum for retired Fellows.

The new group is named in honour of the year the Faculty of General Dental Practitioners was founded, a key moment which brought together the members of the College of General Dental Practitioners (UK) and of the former RCS Advisory Board in General Dental Practice, with the shared ambition to create an independent College over time.

Thirty years on, the 1992 Circle aims to bring together and recognise those whose vision put the general dental profession in the UK on a journey towards independent collegiate status, and those whose ongoing commitment carried this through to the establishment of the College of General Dentistry.

The group will gather periodically for social events, typically linked to the College's main activities. An inaugural gathering took place last month at Elizabeth Gaskell's House in Manchester.

There is no charge to become a member of the '1992 Circle' or to attend the inaugural gathering. Eligible individuals wishing to attend should email **contact@cgdent.uk**, using the subject line '1992 Circle'.

> "THE GROUP WILL GATHER PERIODICALLY FOR SOCIAL EVENTS LINKED TO THE COLLEGE'S MAIN ACTIVITIES."

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Cyber security resources unveiled

Designed to help NHS organisations run their own awareness campaigns

NHS practices are being invited to take advantage of new cyber security resources designed to raise awareness of the threat of ransomware.

The new information packs have been made available on the NHS Digital website[1] as part of the existing 'Keep I.T. Confidential' online cyber security awareness toolkit.

Two sets of campaign materials have been published; one aimed at staff based in clinical settings and another for those who work in the adult social care sector.

Launched by NHS Digital's Data Security Centre, the free materials have been designed to help NHS organisations run their own cyber security awareness campaigns at a time and in a way that suits them.

The aim is to help improve staff knowledge of cyber security concerns such as phishing, unauthorised data sharing, unlocked screens and weak passwords.

Assets included in the toolkit are:

- Screensavers
- Digital banners
- Sticky notes
- Social media graphics – Facebook, Instagram, Twitter, LinkedIn
- An animation

Mike Fell, NHS Digital's Executive Director of Cyber Operations, said: "Good security practices are our shared responsibility and being cyber aware can significantly reduce the chance of cyber events affecting people's care.

"We know how busy staff are, but we encourage everyone to prioritise reducing security risks as much as they can to protect the NHS and social care against vulnerabilities.

"Taking small, simple steps and considering security in your day-to-day work can make a huge difference and we hope that these resources can really play a part in helping to drive that change."

[1]*https://tinyurl.com/mukeepsp*

National digital platform launched

Laying the foundation for a 'health and social care revolution'

A NEW National Digital Platform (NDP) for Scotland is set to transform the range of digital services that are on offer to help people manage their care and live healthier lives. The platform is a collaborative effort, designed and delivered by NHS Education for Scotland (NES) along with multiple partners from across health and social care.

The NDP offers the technical capability for health services, including dentistry, to deploy, design and maintain digital and data products.

The platform will allow individuals better access and control over their health and social care data, so they can make informed decisions about their own health. With better access to data, staff will be able to make better decisions about care – and planners and researchers will be able to improve the efficiency of that care. It also means that potential developers have a standard approach to digital infrastructure and can access components and services to speed up developments.

Humza Yousaf, Cabinet Secretary for Health and Social Care, Scottish Government, said: "Within our health and social care system, services are steadily becoming available on digital platforms for those who wish to use them. It is important that these digital platforms work seamlessly together to ensure that people are able to access the right care, at the right place, at the right time."

Digital services will become the first contact with health and care services for many people in the coming years. This requires systems that can 'talk to each other', and can store and share information appropriately and effectively. The NDP will enable this interaction and make it easier for citizens to access services digitally.

NHS partners have created a standard platform that other services and apps can be built upon, in the same way that mobile phones use an Android or iOS platform.

Karen Reid, NES Chief Executive, said: "This project should have massive benefits for the people of Scotland. Already there are a handful of services using the platform, but this is just the start. As an open platform just like you'd get on your phone, we're making it possible for developers everywhere to come up with innovative apps to help us all. Ultimately, the platform will make it simpler to deliver technology that improves the care and wellbeing of people in Scotland."

Services already using the Platform include:

› Covid Vaccination Management tool
› Open Eyes (ophthalmic electronic patient record)
› Stroke Assessments tool
› ReSPECT emergency care patient summaries

More information about the platform, and case studies about how it is already helping, can be found at ***www.nationaldigitalplatform.scot***

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Image: Diana Polekhina on Unsplash

Perils of 'Instagram smile'

Dentists warn of permanent damage from clear braces ordered online

THE demand for 'Instagram smiles' has left people with damage from wearing clear braces or "aligners" ordered online, according to a report[1] by the BBC.

The British Orthodontic Society (BOS) welcomed the report, warning of the dangers of permanent damage from clear braces ordered online, that appeared on the BBC website. The report was picked up by other media organisations, including *The Times, Daily Mirror, BBC Radio 1* and LBC.

It supported the position of the BOS – and 31 professional dental and orthodontic societies, associations, and institutions from 25 countries across Europe[2] that any self-administered and remote treatment "cannot be justified from a professional medical perspective" and thus represents a "serious violation of ethical, medical and dental standards".

Dr Anjli Patel, Director of External Relations at the BOS, said: "We are delighted that the message is getting out to patients of the potential harm that can be caused by aligners if not assessed by a dentist in person. All dental treatment should be carried out by a suitably qualified clinician. This means treatment will be as safe and effective as possible.

"It is important that patients are able to distinguish between the delivery of patient care which is clinician led and follows GDC standards versus the delivery of aligners which is what most Direct to Consumer companies provide."

The BOS advises those who are considering orthodontic treatment to arrange a consultation with a dentist or orthodontist to minimise the risks associated with potential treatment.

[1]www.bbc.co.uk/news/uk-58038752
[2]tinyurl.com/bdd75f3k

> **"DENTAL TREATMENT SHOULD BE CARRIED OUT BY A SUITABLY QUALIFIED CLINICIAN."**

DATES FOR YOUR DIARY

2023

25 FEBRUARY
25th Annual Conference for Dental Care Professionals
Edinburgh
www.rcsed.ac.uk/events-courses/25th-annual-conference-for-dental-care-professionals

14-18 MARCH
IDS 2023
Cologne
www.ids-cologne.de/die-messe/ids

24-25 MARCH
BDIA Dental Showcase
London
www.dentalshowcase.com

24-25 MARCH
Excellence for the Dental Team
London
tinyurl.com/3kkp58ms

17-29 APRIL
International Osteology Symposium
Barcelona
www.osteology-barcelona.org

4-6 MAY
ADI Team Congress 2023
Birmingham
www.adi.org.uk/association_dental_implantology_congress

11-13 MAY
European Aligner Society 4th Congress
Turin
www.eas-aligners.com/4th-eas-congress

12-13 MAY
British Dental Conference & Dentistry Show
Birmingham
birmingham.dentistryshow.co.uk

18-20 MAY
Oral Reconstruction Global Symposium
Rome
symposium2023.orfoundation.org

19-20 MAY
Scottish Dental Show
Glasgow
www.sdshow.co.uk

Note: Where possible this list includes rescheduled events, but some dates may still be subject to change.

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Specialist Periodontist
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- GDC NO 63897

ADRIAN PACE-BALZAN
Specilaist Endodontist
BChD MFDS RCPS (Glasg)
MPhil MClinDent (Prosthodontics)
FDS(Rest Dent)
RCS (Glasg)
- GDC NO: 83943

LORNA HARLEY
Specialist Endodontist
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MRD (ENDO)
RCS (ED)
- GDC NO 79246

KATHY HARLEY
Specialist in Paediatrics
BDS MSc FDSRCS (ED)
FDSRCS (England)
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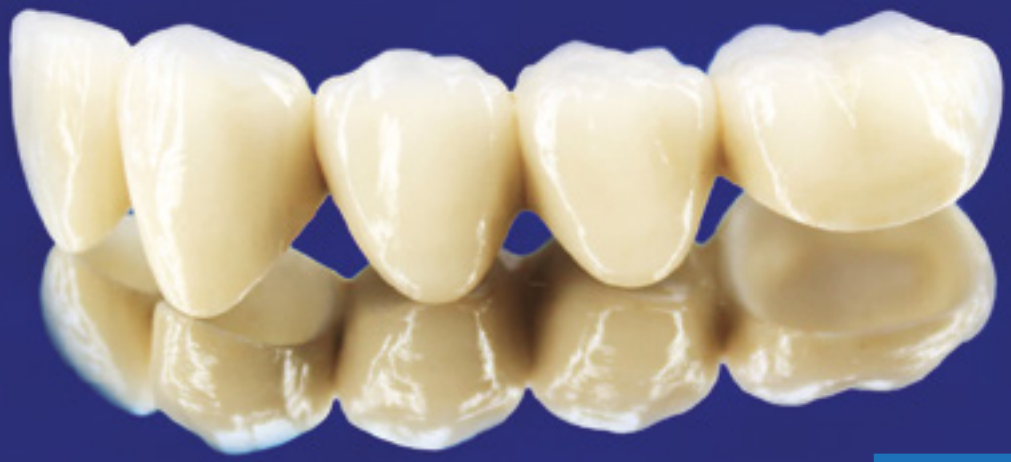

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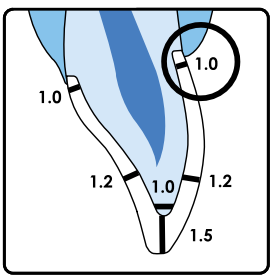
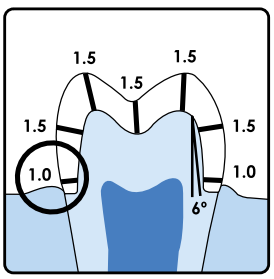
PREPARATION GUIDE

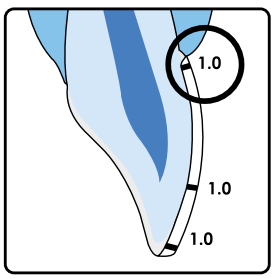
Anterior crown



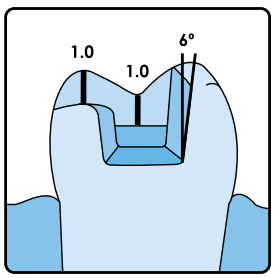
Posterior crown



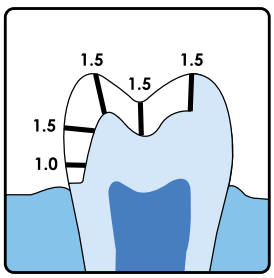
Veneers



Onlay / Inlay



Partial crown



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Scottish Dental SHOW 2023

See you there!

The Scottish Dental Show is a great opportunity for professional development, to meet colleagues and to engage with suppliers and advisers

On 19-20 May, Glasgow is hosting the Scottish Dental Show; a chance to catch up with colleagues and meet the suppliers and advisers supporting the profession, as well as a great opportunity for continuing professional development.

Alongside a fantastic exhibition, the show features a wide-ranging education programme comprising lectures and workshops. GDC 'highly recommended' topics (medical emergencies, disinfection & decontamination and radiography & radiation protection) and GDC 'recommended topics' (legal & ethical issues, complaints handling, oral cancer early detection, safeguarding children and young people and safeguarding vulnerable adults) feature on both days.

Among the speakers in 2023 are:

- Mark Worrall, Head of Department, Medical Physics, University of Dundee (Radiography)
- Stacy O'Donoghue, Dental Tutor, NHS Education Scotland (Infection Control and Decontamination)
- Mike Lewis, Professor of Oral Medicine, University of Cardiff (Oral Cancer)
- Stuart Clark, Oral and Maxillofacial Consultant, NHS Manchester (Medical Emergencies)
- Mark Greenwood, Consultant/ Honorary Clinical Professor of Medical Education in Dentistry, University of Newcastle (Medical Emergencies)
- Emma Riley, Chair of the Society of British Dental Nurses and Ambassador for the Mouth Cancer Foundation (Oral cancer and the Role of the Dental Nurse)
- James Green, Maxillofacial and Dental Laboratory Manager, Great Ormond Street Hospital for Children (Medical Devices Regulation)
- Christine Park, Honorary Consultant in Paediatric Dentistry, Glasgow Dental School (Safeguarding Children and Young People)
- Nicholas Beacher, Honorary Consultant in Special Care Dentistry, Glasgow Dental School (Safeguarding Vulnerable Adults)
- Mike Gow, Clinical Director, The Berkeley Clinic
- Tariq Ali, Principal, Centre for Implant Dentistry
- Tariq Bashir, Principal Dentist, Excellence In Dentistry
- Arshad Ali, Clinical Director, Scottish Centre for Excellence in Dentistry
- Lisa Currie, Clinical Director, The Orthodontic Clinic
- Peter Ommer, Director of Dentistry, NHS Ayrshire and Arran
- Jeremy Cooper, founder, Confidental
- Clement Seeballuck, Clinical Lecturer in Paediatric Dentistry, University of Dundee
- Siobhan Kelleher, Dental Coach
- Lauren Long, Dental Therapist
- Paula Mann, Trainer, Aesthetic Training Academy
- Caroline Henderson, Trainer, Aesthetic Training Academy

WORDS
WILL PEAKIN

Check the Scottish Dental Show 2023 website for updates and for when free registration opens: **www.sdshow.co.uk**

The show also features a wide-ranging education programme

A chance to meet suppliers and advisers supporting the profession

DENTISTRY IN war-torn Ukraine

Operating during blackouts, extracting teeth on a battlefield, bombed laboratories; the Ukrainian dental profession confronts terrible odds

WORDS
ANNA
FILONENKO

"It's our people's war," say Ukrainians, precisely defining their attitude towards the Russian invasion. People from all backgrounds have enlisted in the military. Dental professionals were among them, expanding their scopes of practice to become servicemen, volunteer clinicians, builders and translators - turning community outreach into a moral obligation; joining the front in the nation's bid for victory against the aggressors.

The figure of speech 'armed to the teeth' acquires a literal meaning in Ukraine. Since joining the army or local territorial defence, dental professionals have had to learn new skills, of combat. But, after the first months of military service, dentists, oral surgeons and lab technicians are once again needed in their profession; performing medical interventions, even in the war zone.

"We have to extract severely decayed teeth right on a battlefield. It's sad, but the amount of the wounded and dead does not permit us to allocate time for routine dental treatments," said Kostiantyn Abramovych, an army captain, who was previously a civilian dentist. He joined the army in 2014, heading a branch of its medical service. After Russia's full-scale Russian invasion last year, he became commander of a rapidly expanded medical unit. Resources and expertise are drawn from wherever they are available. "Our battalion's oral surgeon-soldier has joined the ranks with his own surgical instruments," said Dmytro Ivanyuk, a former dental lab technician and now an army division commander. "A dentist from a nearby village has lent a dental unit and autoclave. People have donated money to purchase necessities required. This collaboration is so successful that we have an ambition to treat not only acute dental pain, but also to start implantology soon."

Despite the risks, such teamwork of the military and civilian dental professionals attracts many dental volunteers to the war zone. Where army clinicians reach the limit of their capacity, dental volunteers uphold new standards of care to keep Ukrainian soldiers healthy – and alive.

> "THE FIGURE OF SPEECH 'ARMED TO THE TEETH' ACQUIRES A LITERAL MEANING IN UKRAINE"

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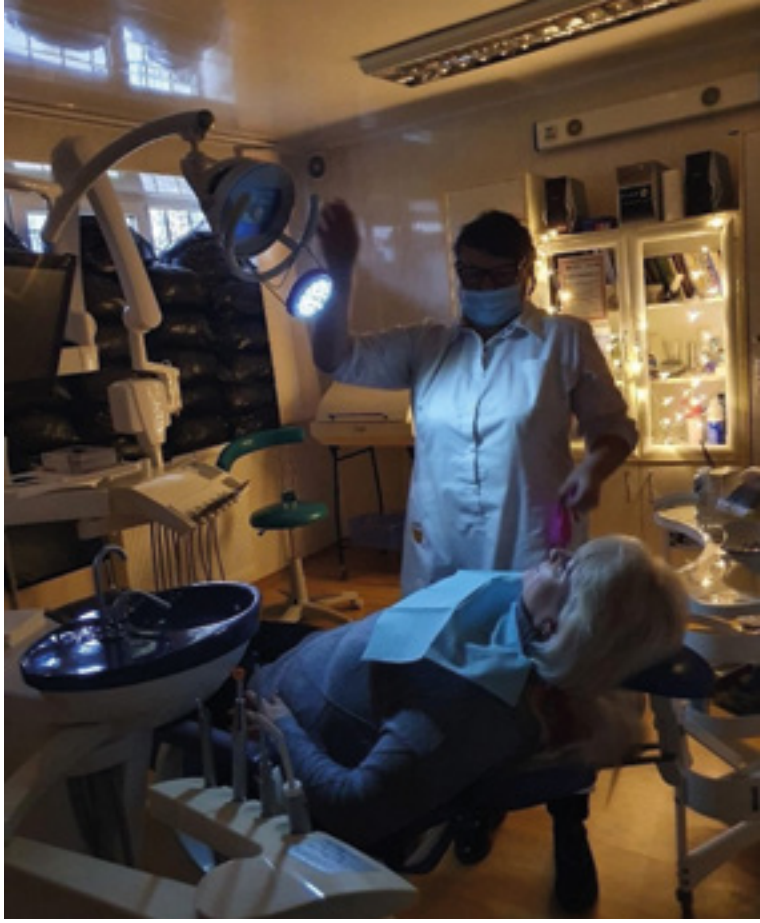

Dr Maryna Pidgoretska treating a patient during a blackout

"According to our statistics, five Ukrainian soldiers have perished due to dental pain. Those five deaths were indirect – being in excruciating pain, they could not concentrate on their tasks and were killed by the Russian military," said Dr Valery Horbenko, a volunteer dentist for the dental society, Tryzub Dental.

It operates on a rotational basis; clinicians and assistants work for a week in a mobile clinic, switching the specialties, so every dental need of soldiers can be met. They drive near the frontline and treat them near battlefields. They themselves are targets for the Russians, with their vehicles destroyed in battles near Mariupol.

"During the first weeks of the invasion, when Kyiv was very close to the occupation, we used our office as an air raid shelter," said Dr Anton Reznikov, owner of TDC Clinic in the capital. "Our dental team members and their families lived and worked here, helping military personnel and even foreign diplomats – repairing their teeth, when practically all dental clinics were closed. That was our service to the country."

"Being a native Jordanian, I had an opportunity to flee the war," said Dr Fadi Al Tarifi, owner of New Dent Clinic in Ivano-Frankivsk, a city in Western Ukraine. "But, like many other immigrants from Arabic or African countries, I stayed to support our current homeland. I envy the Ukrainians' unity and perseverance. I envy in a good way, because it's unprecedented to me to witness such unanimous altruism of the whole nation. I cannot stay aside. Since 2014, I have offered free dental service to the Ukrainian military, police, and families of our fallen heroes."

Dr Fadi Al Tarifi, seen here wearing a Vyshyvanka, the traditional Ukrainian embroidered shirt, who received an award from the Ukrainian governor in Ivano-Frankivsk

Dr Maryna Pidgoretska from Nikopol, a city in central Ukraine, said: "Even blackouts don't stop us from providing health care to our patients. We have learnt how to do dentistry without electricity and water supplies. During network outages, generators, flashlights, and water reservoirs have become essential. We cover our windows with sandbags to protect against air strikes and shelling. Despite everything, we are pretty successful in outwitting the terrible odds."

Besides the provision of dental care, Ukrainian oral health specialists have proved themselves versatile volunteers where needed. Ihor Vovk, a former dental lab owner and currently a volunteer for the Seventh-day Adventist Church, said: "I lost my business – my dental lab in Irpin. The Russians burned all my equipment and even invaluable antique instruments from my museum collection. But I grieve for nothing compared with my neighbours – people mourn their children after the massacres in Irpin and Bucha." Ihor is helping rebuild villages after the battle of Ivankiv, a key crossing over the river Teteriv.

Ihor Vovk's burnt dental lab in Irpin

Dr Maksym Bondar is working as a translator for the foreign military

Dr Maksym Bondar, from Mykolaiv, a city on the Black Sea, didn't accept his rejection for military service – volunteering his services as a translator for visiting foreign military personnel. "It's terrible and terrifying in Mykolaiv. I am so accustomed to the air attacks, that I can distinguish the sounds of different missiles. BM-21 Grad is like a firework nearby.

"On the other hand, C-300 is very scary, felt from far away, up to 1,000 metres. Exploded within 500 metres, it yields a massive wave of pressure on the chest, several in a second. The BM-27 Uragan can blow up an apartment, the C-300 can destroy two floors of a building.

"I am glad my English, German and Polish are good enough to connect Ukraine's helpers, fight off the aggression and bring us to victory. I am happy that dentists can be civilian warriors to do something small but invaluable."

Unfortunately, the reality of war leads such moral call-ups to tragedy. Back in 2016, Zevri Abseitov a dentist from Crimea, was imprisoned for eight years after a show trial. His name was added to a list of political prisoners of war. His wife Fatima visited him in jail recently. She said he is holding up well, despite deteriorating health. He is more concerned about his family than himself, she said, and very proud of his son, who was awarded a grant to study dentistry in Turkey.

The dangers for Ukrainian dentists, victims of Russian aggression, is not limited to forced labour or imprisonment. Hanna Beliaeva, from Kharkiv, jointed the Army in the spring of last year and was killed in July defending her home city. The tragedy in Dnipro at the beginning of this year took the lives of two dentists, Olga Usova and Iryna Salamatenko – best friends and volunteers for Tryzub Dental. They were among 46 people killed when a Russian missile hit their apartment building.

The Ukrainian dental community regards the invasion as a terrorist attack on their country and has called on colleagues around the world to boycott of Russia. They have created a registry – dentalboycott.com – listing companies who have boycotted Russia or, they say, have so far refused.

Dramatic military operations go toe-to-toe with philanthropic civilian gestures. The Ukrainian dental community has quickly turned dental medicine into medical volunteerism.

In the military and civilian settings, risking their lives, they raise standards of care, offer fee-free treatments, evolve mobile dentistry, and render a multitude of support in towns. Ukrainian dentists have discovered their new characteristics, skills and motifs for the future of their land.

The war will end – those achievements must not.

Anna Filonenko is a former journalist from Ukraine now working as a dental hygienist in the USA.

> **"I AM SO ACCUSTOMED TO THE AIR ATTACKS, THAT I CAN DISTINGUISH THE SOUNDS OF DIFFERENT MISSILES"**
>
> – DR MAKSYM BONDAR

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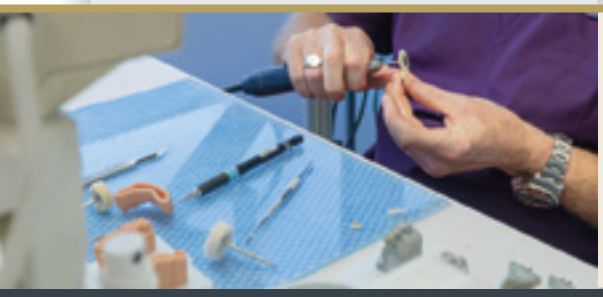

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Less pulpectomy, more pulpotomy

Minimally invasive trends in endodontology are an increasing focus for practitioners

WORDS
WILL PEAKIN

With endodontic files becoming more flexible and more resistant to breaking, there is a shift in concepts and methods around practise where the tooth structure can be spared more frequently. The art lies in achieving the right balance; less taken away in the coronal area, yet sufficient space is created in the apical region to allow for effective rinsing.

However, this method does restrict the view in comparison with a more invasive preparation. This can be offset by using a bright dental microscope. This conservative approach gives the practitioner the reassurance that, if further treatment is necessary, there is sufficient substance left to enable a safe post-endodontic treatment. This year's IDS in Cologne will showcase the files, microscopes and magnifying glasses that are most suitable.

Today, the chosen therapy for inflamed pulp can be a less invasive method; less often pulpectomy, more frequently pulpotomy. This approach is established in the treatment of milk teeth, where it is used to support space retainer function, but pulpotomy can also be successful even after the root growth has finished. In this case, the wound that arises after the vital amputation is treated using a suitable material, such as mineral trioxide aggregate (MTA). MTA-based bioceramic sealers are also becoming more popular.

A range of digital tools are available for endodontic planning, from 3D X-rays through to drilling templates. This helps the person carrying out the treatment to maintain the ideal angle for the introduction of files. The specialist can carry out the planning and either complete the treatment themselves or refer the patient back to the family dentist to carry out the treatment using the digital documents supplied. IDS 2023 will present suitable software for endodontic planning and smooth communication between practices.

"Enhancements and alternatives to recognised endodontic treatment routines have repeatedly been presented at IDS," said Mark Stephen Pace, chairman of the Association of German Dental Manufacturers).

"That was the case at the very first trade fair of its kind in the year 1923; for example, in its era among others the development of the Walkhoff paste was considered to be a novel bacteria-eliminating root filling material. The same will also be true this year when we celebrate the 100th anniversary of IDS.

"Digital methods arrived on the endodontics scene a little later than in the area of prosthetics, but now I am observing that they are also creating new scope for family dentists and specialists. The thing that impresses me most is how much the opportunity for maintaining natural teeth can be increased thanks to new methods of tooth preservation and regeneration of the pulp."

IDS takes place in Cologne every two years and is organised by the GFDI Gesellschaft zur Förderung der Dental-Industrie mbH, the commercial enterprise of the Association of German Dental Manufacturers (VDDI). It is staged by the Koelnmesse GmbH, Cologne.

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Digital methods are creating new scope for family dentists and specialists

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Local, national and international collaborations can yield outcomes that exceed expectations

WORDS
THE MALDENT PROJECT TEAM

It was a great honour for a team involved in the MalDent Project to be invited to deliver the Caldwell Memorial Lecture at the 2022 College of General Dentistry Scottish Study Day, held at Glasgow Science Centre in December. The title of the jointly delivered presentation was *The MalDent Project: Progress through Partnerships*.

As well as updating delegates on the status of the project, the team's aim with their presentation was to show how local, national and international collaborations, based on mutual trust and respect, can yield outcomes that exceed expectations.

Professor Jeremy Bagg began by describing the background to the MalDent Project. The two initial principal partners were the University of Glasgow and the University of Malawi College of Medicine (now Kamuzu University of Health Sciences).

In 2018 they were jointly awarded a Scottish Government International Development grant of £1.3 million over four-and-a-half years. Their principal objectives were to establish a BDS degree programme, the first in Malawi, and to develop an Oral Health Strategy for Malawi through close working with the Ministry of Health and other key stakeholders, including the World Health Organization.

These were ambitious objectives and from the outset there were multiple partners across the academic, healthcare, charitable and commercial sectors.

The presentation focused on the role played by three UK charities – Bridge2Aid, Dentaid and Smileawi – and the dental supply company Henry Schein, working in collaboration with the two university partners. Dentaid covers multiple functions, both national and overseas, in its portfolio of activities. One of these is the servicing and installation of donated dental equipment and it is this particular skill that it has brought to bear on the MalDent Project.

Stuart Bassham, Dentaid's Workshop and Engineering Manager, flew up to the Study Day from Southampton to tell delegates about the work he and his team had carried out, replacing 22 dental chairs and installing 12 A-dec phantom head units in the Dental Department at Kamuzu Central Hospital.

During both installation visits to Malawi, Henry Schein provided an engineer, free of charge – Jonathan Langley in 2018 and Chris Cox in 2022.

The result of all this work was a transformation of the Dental Department with upgraded equipment, providing a suitable clinical teaching environment for the BDS students, improved working conditions for staff and an enhanced patient experience.

The work to develop a National Oral Health Policy for Malawi took place following the establishment of a policy taskforce in February 2020, culminating in launch of the policy on 14 April 2022.

Some 22 meetings were held online, with a small number of face-to-face meetings among the Malawian taskforce members. Attention has now turned to implementation of the policy and the Study Day was

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a wonderful opportunity for Nigel and Vicky Milne, the Scottish founders of the charity Smileawi, to tell the audience about the wide variety of activities their organisation undertakes in Malawi in the context of the policy.

As a small Scottish charity with a main aim of helping to improve oral health services in Malawi, much of Smileawi's work aligns very closely with the seven pillars of the Oral Health Policy.

Key to their operation is providing very important support for the dental therapists and funding student therapists at the Malawi College of Health Sciences.

This vital sector of the dental workforce will grow in strength and confidence and be equipped to play a major role in the Oral Health Policy implementation.

The joint work of Smileawi andBridge2Aid, described by the next speaker, was another example of engagement with dental therapists to strengthen oral disease prevention –a key policy objective.

Bridge2Aid is a key charity partner of the MalDent Project. Andrew Paterson, one of the charity's trustees, has been involved as a clinician with the successful emergency dentistry task-shifting programme that Bridge2Aid has delivered in Tanzania for more than 15 years.

A similar model is planned in Malawi. However, Bridge2Aid, together with Smileawi and other UK and Malawian partners, has also embarked on a programme of community Oral Health Promoter training in Northern Malawi, which again maps onto the Oral Health Policy implementation plan.

Andrew described how phase one was a modular course delivered remotely to Northern Malawi dental therapists, using the ProDental CPD platform, to upskill their oral health knowledge and give them teaching skills, so they could share key oral health messages to remote and rural areas and disadvantaged groups.

Working with the Malawian Ministry of Health and the Dental Association of Malawi ensured messages were culturally appropriate and community led.

Phase two empowered the therapists to use newly acquired teaching skills to train rural Oral Health Promoter volunteers who are actively engaged in promoting oral health in schools, churches and other community settings rurally.

The course will be run in Central Malawi this year and thereafter in Southern Malawi, to create a national network of rural Oral Health Promoters.

The presentation finished with a summary by Professor Bagg of three ongoing workstreams – the design and construction of a dental clinical teaching facility on the Blantyre campus of Kamuzu University of Health Sciences, the development of a Malawian version of the Scottish Childsmile programme that would be applicable to the local environment, and a National Child Oral Health Survey planned for this year.

He also stressed how important multi-sectoral collaborations have been to the progress of the project.

To learn more about the MalDent Project, please visit **themaldentproject.com**

> "WORKING WITH THE MALAWIAN MINISTRY OF HEALTH AND THE DENTAL ASSOCIATION OF MALAWI ENSURED MESSAGES WERE CULTURALLY APPROPRIATE AND COMMUNITY LED"

Scots dentists Vicky and Nigel Milne, founders of the Smileawi charity, help teach a class at Malawi's Embangweni School for the Hard of Hearing

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Raising awareness

Dental students are working with a Scotland-based charity to share good practise

WORDS
MATTHEW FANCOURT

During Mouth Cancer Awareness Month, the Dundee Dental Student Society worked in partnership with the charity Let's Talk About Mouth Cancer to help raise awareness within the Dundee University community of oral cavity cancer.

Head and neck cancer (HNC) incidence is growing – increasing by 83 per cent in the UK since the late 70s, with global cases predicted to rise by 1.08million cases annually[1,2]. HNC is now the eighth most common cancer[3], with 12,400 cases diagnosed in the UK every year[1]. Health promotion is at the forefront of the battle against this disease; however, it has a long way to go as many are still unaware of the risks and causes of this potentially life changing cancer.

The Dental Society has always worked closely with Let's Talk About Mouth Cancer, a Scotland-based charity founded in 2014, with some of its members being Dundee University graduates. Its core aims are to improve the prognosis of patients diagnosed with oral cancer through early detection, support research into diagnostic tools, raise awareness of mouth cancer within the public and to share knowledge of good practise amongst healthcare professionals[4].

The charity had humble beginnings, with early events involving volunteer dentists providing free mouth cancer screening in public places[5]. It has since grown in size, with the addition of their patient champion Barbara in 2020, a tongue cancer survivor who has helped raise awareness of the disease and funds for the charity[6]. The charity provides teaching around oral cancer detection to final year dental students, vocational dental practitioners, and newly qualified dental hygiene therapists, helping to prepare them for what can be a daunting time as newly qualified dentists/dental care professionals.

The society runs a health promotion stall outside the university student union, where we educate both students and staff about risk factors, oral manifestations of the disease, and how to perform a mouth cancer self-examination. Many of those we spoke to were unsure on what to look for, and where to go if they did spot anything unusual.

Some people we spoke to were shocked to hear that alcohol was a main risk factor of oral cancer, and with the associated 'drinking culture' of many people's university experience, it is vital that young people, in particular, are made aware of this link and the risks involved. Young people must understand that habits and lifestyle choices they make in their early adulthood can shape their future health, with this cancer in particular having the potential to cause significant alterations to speech, swallowing and appearance at an early age.

Let's Talk About Mouth Cancer provided us with their 'five simple steps for self-examination' leaflet which we distributed to those we spoke to. This is a simple, systematic approach anyone can carry out at home to aid in early detection of potential oral cancers.

The week culminated with our annual 'Acoustic Night' – an open mic fundraiser event attended by both staff and students where all are invited to showcase their musical talents. The night was rounded off by our teaching lab technician Chris and his student band, performing dentistry-based parodies on popular songs to get the crowd on their feet and up dancing. The event was a huge success, and after a long and, at times, stressful semester it was a brilliant chance to socialise with friends and dental school staff.

A grand total of £1,587 was raised for Let's Talk About Mouth Cancer via a raffle, with thanks to staff, students, society sponsors and local businesses who donated a variety of fabulous prizes.

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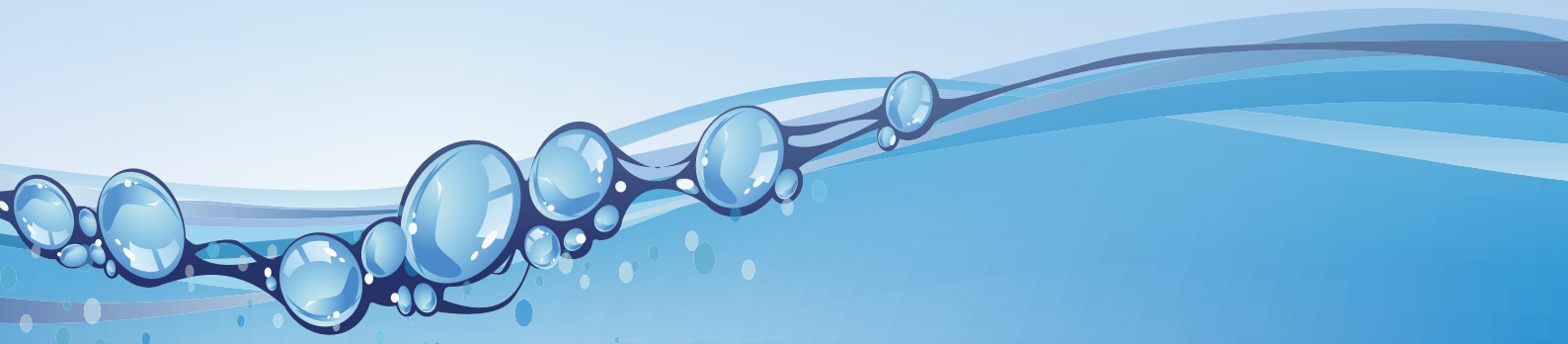
Study sheds new light on benefits to children



Researchers say that targeted approaches to caries reduction should be evaluated

WORDS
WILL PEAKIN

In 1894, Fluoridation of the water supply may confer a modest benefit to the dental health of children, a seven-year-study led by University of Manchester researchers has concluded1. However, the benefits are smaller than shown in previous studies – carried out 50 years ago – when fluoride toothpaste was less widely available in the UK.

The CATFISH study, funded by the National Institute for Health and Care Research, was published in the journal Public Health Research. The research was led by a team from the University's Division of Dentistry and is the first contemporary study of the effects of initiation of a water fluoridation scheme in the UK since fluoride toothpaste became widely available in the 1970s. The study also showed it was likely that water fluoridation was a cost-effective way to help reduce some of the £1.7 billion a year the NHS spends on dental caries.

Other collaborators on the study included Cambridge University, Kings College London, Salford Royal Foundation Trust and the specialist dental services at North Cumbria Integrated Care NHS Foundation Trust.

The study assessed the dental health of two cohorts of young children over a six-year period in West Cumbria - where water fluoridation was reintroduced in 2013, and the rest of Cumbria, which remains fluoride free.

In West Cumbria, the younger cohort were born after water fluoridation was introduced (this meant they had the full effect of water fluoridation). The older cohort was aged around five when fluoride was reintroduced into the water supply – which meant they mainly received the benefit for those teeth already in the mouth. At the end of the study, 1,444 five-year-olds who were part of the younger cohort and 1,192 eleven-year-olds who were part of the older cohort had taken part.

Dental teams carried out examinations on the children at regular intervals and took images of their teeth which were blinded to the fluoridation status of each participant to remove bias. They also collected information about the children's diet, brushing habits and dental attendance.

In the younger cohort, 17.4 per cent of the children in fluoridated areas had decayed, filled or missing milk teeth; the number was 21.4 per cent for children in non-fluoridated areas, amounting to a modest 4 per cent reduction in incidence of caries. In the older cohort, 19.1 per cent of the children in fluoridated areas had decayed, filled or missing permanent teeth; the number was 21.9 per cent for children in non-fluoridated areas. There was insufficient evidence as to whether water fluoridation prevents decay in older children with a difference of 2.8 per cent.

Over the last 40 years the proportion of children affected by decay has fallen dramatically. But because tooth decay falls disproportionately on more disadvantaged groups, fluoridation should be considered alongside measures targeted at vulnerable populations, the team argue.

Professor Mike Kelly, senior member of the research team from The University of Cambridge said: "Health inequalities are a feature of all societies, including the UK. The poor dental health of children from the most disadvantaged communities and the excess number of children having general anaesthetics each year still needs

Water fluoridation is also a highly contentious issue

to be addressed. We need to continually look at measures which can help prevent the unnecessary burden of pain and suffering".

Dr Michaela Goodwin, from the University of Manchester and senior investigator on the project, said: "While water fluoridation is likely to be cost effective and has demonstrated an improvement in oral health it should be carefully considered along with other options, particularly as the disease becomes concentrated in particular groups. Tooth decay is a non-trivial disease which is why measures to tackle it are so important.

"The extraction of children's teeth under general anaesthetic is risky to the child and is the most common reason for children between the ages of five and nine to have a general anaesthetic. Decayed teeth are painful and can impact on sleep patterns, learning, attention and many aspects of general health. But more questions remain, and we hope to follow up on these children in the long term."

The addition of fluoride to community drinking water supplies has been a long-standing public health intervention to improve dental health and was introduced in the UK during the 1960/70s against a background of high population prevalence of dental decay. Following widespread use of fluoride toothpastes in the mid-1970s, the prevalence and severity of decay have dramatically fallen, leading to questions regarding the cost-effectiveness of water fluoridation (WF) in contemporary populations. These questions were raised by a number of systematic reviews that queried the scientific rigour of early studies.

Water fluoridation is also a highly contentious issue, with both pro-fluoridationists and anti-fluoridationists arguing vociferously for their point of view, and in often heated and politically charged debates. There have been no new WF schemes in the UK since the late 1970s and some schemes have been withdrawn. Less than 10 per cent of the UK population receive fluoridated water, a figure that often surprises both lay and professional groups. Against this background, there is considered to be a need to redress two major elements of the fluoride scientific debate:

1. the impact of low caries levels in the UK population and the segmentation of the disease into the most disadvantaged groups

2. the identified weaknesses of early works.

The prolonged interruption of fluoride dosing at two schemes established in the late 60s/early 70s in Cumbria, Cornhow and Ennerdale, followed by the resumption of dosing, offered a unique opportunity to undertake an assessment of what was, from a biological perspective, a new scheme. This met an important requirement of the Medical Research Council criteria for a high-quality study and, hence, the CATFISH (Cumbrian Assessment of Teeth a Fluoride Intervention Study for Health) study was undertaken.

The CATFISH study aimed to:

- **Assess the impact of WF** on oral health (dental caries) in two separate cohorts of children exposed to WF in utero and from five-years old over a five-year follow-up period
- **Assess whether or not** fluoridating water is a cost-effective strategy in these cohorts
- **Determine if WF** reduced health inequalities in these cohorts.

The objectives were to:

- **Recruit children into two cohorts**, that is, a birth cohort and a cohort of children entering their first year of primary school (i.e., aged five years)
- **Assess children's dental health** by clinical examination at set intervals
- **Use the Index of Multiple Deprivation** (IMD) as a measure of deprivation in their assessment of the impact of WF on health inequalities
- **Assess the cost-effectiveness of WF** using a formal health economic evaluation
- **Measure potential effect modifiers** that may explain any differences in the groups using questionnaire data
- **Meet the requirements** of a high-quality evaluation by considering the weaknesses identified in previous WF studies
- **Account for bias** due to lack of blinding in clinical examinations by supplementing this with remote photographic scoring.

A prospective longitudinal cohort design was employed with two distinct populations. From September 2014 to September 2015, children were recruited at birth. These children had a 'full effect' of WF, as they received both systemic exposure to WF (from in utero), resulting in incorporation of fluoride into the enamel as it develops, and topical exposure to WF in the form of exposure to fluoride in drinking water, which acts once a tooth has erupted by creating an environment at the tooth surface that favours remineralisation. Children had a dental examination at three and five years of age, and questionnaire data were collected throughout their participation in the study. A census approach was taken to recruitment based on births in two hospital sites, West Cumberland Hospital in Whitehaven, and Cumberland Infirmary in Carlisle.

Children were recruited in their first year of school, from September 2013. These children had predominantly topical exposure to WF and, therefore, the preventative effect would come from creating an environment that would encourage remineralisation of enamel and inhibit bacterial metabolism. This group enabled comparison of effect size with children who have systemic and topical exposure as the cohorts age. Children had a dental examination at 5, 7 and 11 years of age, and questionnaire data were collected throughout their participation in the study. Children in primary schools in Cumbria were invited to participate.

Control participants lived in the east of Cumbria, whereas the intervention group lived

> "WE NEED TO CONTINUALLY LOOK AT MEASURES WHICH CAN HELP PREVENT THE UNNECESSARY BURDEN OF PAIN AND SUFFERING"

in the west of Cumbria, receiving drinking water from either Ennerdale or Cornhow water treatment plants. The intervention was implemented by United Utilities (Warrington, UK) who were responsible for regulating the dose at 1 part per million (ppm) fluoride in the drinking water. The control was defined as children receiving drinking water from treatment plants where fluoride had not been added.

A sample size calculation was conducted before the study began, based on previous research. The proportions of 0.47 of 'non-exposed' children developing caries and of 0.37 of 'exposed' children developing caries were used to detect a risk difference of 0.1 (risk ratio 0.8) at a significance level of 0.05 and with 90 per cent power, resulting in a total sample size of 1044 children.

Clinical examinations were undertaken by trained and calibrated dental examiners, using caries into dentine as the threshold for diagnosis. In addition, clinical intraoral photographs were taken and remotely scored by an additional examiner without knowledge of the fluoridation status of the participant. The primary outcome was the prop 0ortion of children who had the presence or absence of clinical evidence of caries into dentine in their primary teeth (birth cohort) and permanent teeth (older school cohort). In addition, the team collected data from the NHS Business Services Authority relating to dental activity and the number of dental extractions undertaken with dental general anaesthetic (DGA) in hospitals for each cohort. Relative deprivation was measured using the IMD (from 2010) and participants' postcodes. The eruption times of primary teeth were also recorded to determine if this could influence caries outcomes.

Questionnaire data concerning a range of potential behaviours and practices that could affect the outcome, for example weaning, diet, toothbrushing and other fluoride sources, were collected directly from both parents and older children.

Statistical analysis for the primary outcome was performed using generalised linear models with fixed effects for group for the unadjusted effect estimate and, additionally, area deprivation quintile, age and sex for the adjusted effect estimate. The team calculated the mean number of decayed, missing and filled teeth (in primary teeth in the birth cohort and in permanent teeth in the older school cohort), with an assumption of caries as the underlying cause, to compare the caries increment in each group. This was assessed using a negative binomial regression, including area deprivation quintile, age and sex as covariates and number of erupted teeth as an offset.

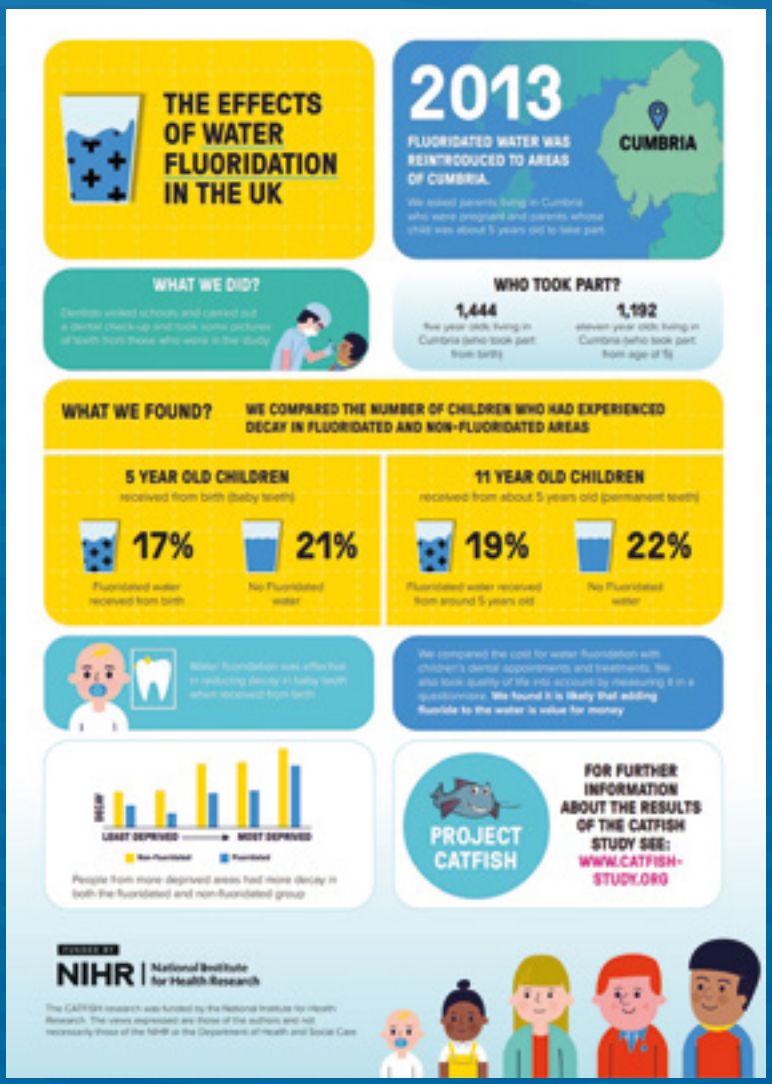
Analysis of DGA data also utilised generalised linear models, with fixed effects for group for the unadjusted effect estimate, and area, deprivation quintile and sex for the adjusted effect estimate. Secondary outcomes (e.g., behaviours that could affect dental health) were analysed using generalised estimating equations to allow for repeated measures within participants. Health disparities were investigated in both cohorts by comparing decayed, missing or filled teeth (primary) (dmft) and decayed, missing or filled teeth (permanent) (DMFT) across exposed and non-exposed groups by quintile of deprivation. Generalised linear models with the appropriate link function and including an exposure by deprivation interaction term were undertaken to determine the effects at different levels of deprivation.

Cost-effectiveness analyses took an NHS and local authority perspective. Costs included the capital and running costs of WF, and NHS dental activity. The measure of health benefit was quality-adjusted life-years (QALYs). QALYs gained from baseline to end of follow-up were estimated as the number of days multiplied by utility scores for health-related quality of life. The utility values were estimated from the Child Health Utility 9-Dimensions questionnaire. Cost-effectiveness was summarised using incremental cost-effectiveness ratios (i.e., cost per QALY gained).

Estimates of net costs and outcomes were bootstrapped (i.e., a form of random sampling with replacement) (10,000 bootstraps) to generate cost-effectiveness acceptability curves that provided the probability of cost-effectiveness for a range of thresholds for willingness to pay for a QALY. Sensitivity analyses included alternative specifications where missing data were imputed, where costs of WF were apportioned to only children aged 0–12 years and for the clinical outcome measures of presence of no decay and mean number of decayed, missing and filled teeth avoided.

Results

In the birth cohort, 2035 participants consented out of a potential 3138 infants born in Cumbria. The final clinical examination involved 1444 participants. Questionnaire response varied throughout the study. A total of 516 parents completed the questionnaire in the final round of questionnaires. In the older school cohort, 1662



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The study is the first in the UK since fluoride toothpaste became widely available in the 1970s

participants consented out of a potential 3,077 children invited to participate. The final clinical examination involved 1,192 participants and 1,185 children completed the final child questionnaire.

In the birth cohort, 17.4 per cent of children in the intervention group had decayed, missing or filled teeth, compared with 21.4 per cent of children in the control group [unadjusted odds ratio (OR) 0.77, 95 per cent confidence interval (CI) 0.59 to 1.01]. However, there was evidence of a significant association between fluoridation and the presence of decay when important confounders [i.e., deprivation (reference IMD quintile 1), age and sex (reference male)] were adjusted for (adjusted OR 0.74, 95 per cent CI 0.56 to 0.98).

For the older school cohort, although a similar difference was seen, with 19.1 per cent of children in the intervention group and 21.9 per cent of children in the control group having decayed, missing or filled teeth, the estimated effect was smaller in the older school cohort and there was insufficient evidence of an effect, with an unadjusted OR of 0.84 (95 per cent CI 0.64 to 1.12) and an OR adjusted for deprivation (reference IMD quintile 1), age, dmft at baseline and sex (reference male) of 0.80 (95 per cent CI 0.58 to 1.09).

Mean dmft count in the birth cohort was 0.49 in the intervention group and 0.69 in the control group. For the older school cohort, the mean DMFT count was 0.32 in the intervention group and 0.40 in the control group. For the adjusted analysis, the incidence rate ratio (IRR) for the birth cohort dmft rate was 0.61 (95 per cent CI 0.44 to 0.86) in the intervention group compared with the control, and for the older school cohort the IRRDMFT rate was 0.69 (95 per cent CI 0.52 to 0.93). Both the birth and older school cohorts represent statistically significant lower rates of decay in the intervention groups after adjusting for confounders.

The remainder of their secondary outcomes, including, for example, number of DGAs for dental extractions, self-reported health outcomes and eruption timing (in the birth cohort only), demonstrated no significant differences between the intervention and control groups.

There is a clear social gradient in caries experience, with more deprived areas having lower proportions of caries-free children and children with higher mean dmft/DMFT scores. There was no significant difference in the performance of WF on caries experience across deprivation quintiles (according to analysis where an interaction term was added to the model).

In both the birth cohort and older school cohort there was evidence that WF resulted in small positive gains in QALYs, as well as reductions in NHS dental service costs associated with WF that exceeded the costs of fluoridation. For both cohorts, WF was likely to be cost-effective at a willingness-to-pay threshold of £20,000 per QALY (probabilities >0.62). The figure of £20,000 was chosen as this is the standard threshold used to determine whether or not interventions constitute good value for money for the NHS.

Water fluoridation represented a small proportion of total NHS dental and WF costs, at £14.14 per capita (£105.63 when apportioned to each child aged up to 12). NHS dental services cost more than 10 times this amount for the birth cohort and more than three times this amount for the older school cohort.

Conclusions

The impact of WF in the birth cohort, although statistically significant once adjusted for important confounders, is much smaller than previous studies have reported. The intervention was cost-effective in this group. However, the clinical and public health significance of the modest reduction in caries status needs to be compared with the effect of other dental health preventative measures.

Although a similar clinical difference was seen for children in the older school cohort, who had topical exposure, there was insufficient evidence of an effect. However, the intervention was still cost-effective for this group. Although this may suggest that WF acts either mainly via the systemic route or in combination with topical effects, the follow-up period for the permanent teeth was short and may not have provided sufficient time for caries to develop to produce a measurable difference between groups.

In both cohorts, the team could find no strong evidence that WF reduces dental health inequalities. Caries prevalence was lower than expected (ffi 20 per cent in both cohorts at the end of the study period) but was in line with other national surveys, with the 2019 oral health survey of five-year-olds indicating that, on average, 23.4 per cent of children in England had experience of dental decay and 24.2 per cent of children across areas examined in Cumbria had a dmft greater than zero. This prevalence demonstrates that the decline in caries continues, and prevalence levels should be considered when deciding on population versus targeted prevention strategies.

Further research

This study examined the potential benefits of community WF; that is, a reduction in dental caries. However, it has not considered the potential risks. Most authorities believe that dental fluorosis is the only proven side effect of the consumption of water that has been fluoridated to the target 1 part per million. The team was not able to assess the impact of fluorosis on the birth cohort, as children in this cohort were not old enough to demonstrate the presence of fluorotic lesions on permanent teeth at the end of the follow-up period, and, as a systemic artefact, fluorosis could not be assessed in the older school cohort. To complete the picture of balanced risk and benefit, the birth cohort should be assessed for fluorosis when they are 11 years old.

The study has suggested a modest oral health benefit in the birth cohort. However, the clinical findings are restricted to the primary dentition only and, therefore, it is important to determine if benefits are seen as the permanent dentition erupts (i.e., do children in the birth cohort carry the benefit as they get older?).

The use of a population-wide intervention for a disease that is concentrated in identifiable groups of individuals against a picture of falling disease prevalence has been challenged, and the results of this study confirm that most children are caries free, irrespective of their WF status. Consideration should be given to evaluation of targeted approaches to caries reduction that could be compared with the results of the current work as a contemporary evaluation of water fluoride effectiveness in a UK population.

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She's worked as an orthodontist in a paediatric hospital in Genova, teaching undergraduates and has been involved in clinical research to identify new therapeutic approaches for patients affected by rare genetic syndromes. Giulia has published several articles in international journals, collaborating with Seton Hill University, USA. She moved to the UK in 2015 and worked in Edinburgh and London practices. She's now settled in Edinburgh with her family.

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Quality is in demand

Future-proofed practices will attract premium prices as demand for the best assets exceeds supply

WORDS
WILL PEAKIN

Specialist business property adviser Christie & Co launched its *Business Outlook 2023: Finding Clarity* report last month, which reflected on the themes, activity and challenges of 2022 – and forecasted what 2023 might bring across the industries in which Christie & Co operates, including the dental sector.

The business reported that its dental team had its strongest year of performance on record. Demand from buyers continues to outstrip current supply and, as such, the broker anticipates that this favourable ratio will remain.

Dental business completion volumes at Christie & Co rose by 23 per cent from 2021 to 2022, and 124 per cent from 2018 to 2022 – illustrating the increasing demand for quality practices. In 2022, 150 offers were formally accepted, reflecting a 50 per cent increase on 2021, and the aggregate offer value received rose by 48 per cent to over £930m. Bank valuation instructions also hit an all-time high, with a significant increase in instructions, which is anticipated to continue.

Pricing was competitive last year, with deals completing well in excess of the asking price. Christie & Co reported a positive dental price index of +8.6 per cent in 2021, and this trend continued throughout 2022, with a positive price index movement of +2.2 per cent, which is reflective of the core market activity and continued growth and demand within the private sector and is offset against a cooling within the NHS market.

Sentiment survey

The business property adviser anonymously surveyed dental professionals across the UK to gather their views on the year ahead. Almost half (48 per cent) said they felt positive going into 2023, while 26 per cent felt neutral and negative in equal measure. When asked about their sale and acquisition plans in the year ahead, 57 per cent of respondents said they are considering buying and/or selling in 2023.

The funding landscape

In a segment on funding, Christie Finance (part of the Christie & Co Network) noted the strength of private dentistry, to the extent that lenders are now putting much less emphasis on NHS/private split. The exit of some specialist banks in 2022 allowed other healthcare lending specialists to step into the spotlight, and there is a demand for the sector as they are offering excellent terms for the right practice and owner, if positioned correctly. But, said the company, it was important to note that under the strain of the current economic market and an ongoing recruitment struggle in the sector, lenders are generally taking a more cautious approach, so are favouring more robust practices that can withstand a stressed interest rate.

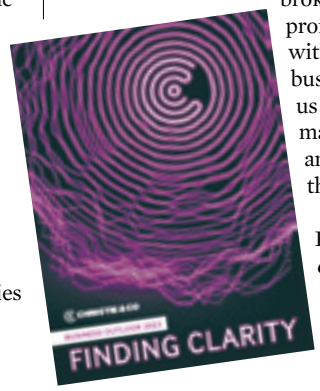
Market predictions

In the year ahead, Christie & Co expects:

- High demand for private practices will remain, as private dentistry continues to benefit from growing waiting lists for NHS appointments
- The market will become more quality-driven and practices which are future-proofed will continue to attract premium prices as demand exceeds supply for the best assets
- Practices with NHS contracts will be subject to more scrutiny by purchasers and lenders in terms of Unit of Dental Activity (UDA) delivery and practice economics. Demand will continue to be strong for those with higher UDA rates and a good track record of delivery
- Corporate operators and other dental groups will continue to seek specialist practices to drive internal referral income
- Any tightening of consumer spending is likely to affect cosmetic and aesthetic revenues more than general treatments
- Further reforms in NHS dentistry are crucial to combat the shift towards private and the loss of dentists in the NHS. There is likely to be a rise in practices either rebasing or handing back their NHS contracts as practices convert partly to private/plan
- Demand for platform opportunities from new investors will remain strong. Group opportunities where NHS income is the smaller revenue stream will remain in high demand, particularly those that are fully integrated with a functioning head office structure
- The continued shortage of Associates and DCPs will inflate wage costs, impacting profit margins and forcing some owners to review their future strategy
- Buyers will remain active and continue to acquire, but with a more microscopic approach to viability and performance of the opportunity
- High street banks will continue to lend in the sector. Funding is being stress tested at the highest rate seen in over a decade, so a deal that worked before the interest base rises will continue to be viable for robust practices with a financially secure buyer
- Global technology companies will use virtual reality, Artificial Intelligence (AI), and 3D printing to accelerate efficiencies in the sector, especially in cosmetic and private dentistry.

Paul Graham, Head of Dental at Christie & Co, said: "The UK economy has been struggling under the weight of high inflation and rising borrowing costs. Pair this with operational hurdles within the dental sector including reduced personnel and an NHS at breaking point, then it wouldn't have been a surprise to see a subdued or static performance last year.

"However, our transactional activity in the dental sector has defied these challenges and we've just achieved our strongest ever year on record. There is no doubt that the sector is recalibrating, but it's far from doom and gloom. At Christie & Co, we have the largest team of brokers, RICS valuers and advisory professionals in the dental sector, with market-leading data and business intelligence which allows us to be agile, proactive with market predictions and trends, and wise on how to overcome the headwinds."



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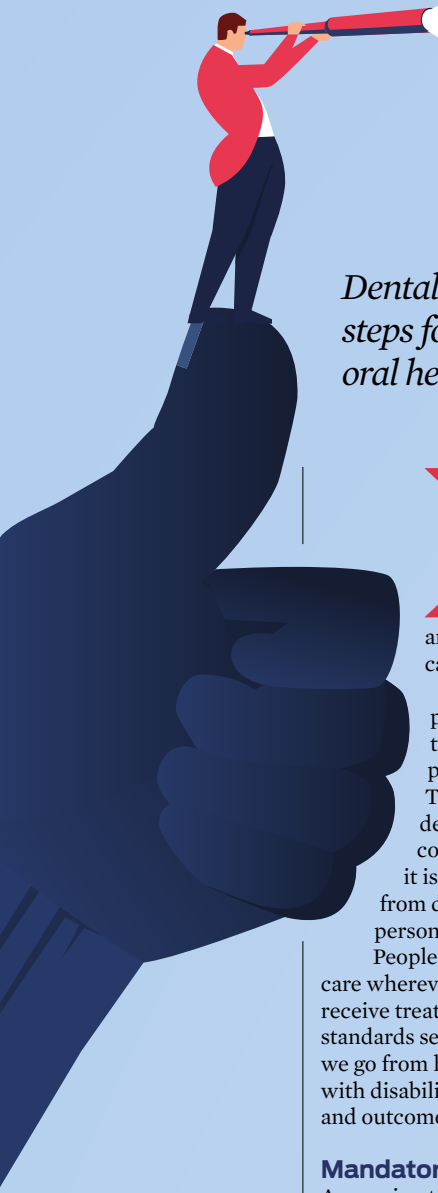

Dental health for all: Critical steps for reducing inequalities in oral health for people with disabilities

In 2012, the International Association for Disability & Oral Health (iADH) took a big leap forward in addressing the oral health inequalities faced by people with disabilities by launching guidance for designing an undergraduate curriculum in special care dentistry.

Ten years on, we have seen plenty of progress in the attitudes towards better treatment for this diverse population of patients, but there is still a long way to go. The experience students gain in special care dentistry during undergraduate training continues to be incredibly ad hoc. Even today, it is still very possible for a student to graduate from dental training without having treated one person with a disability.

People with disabilities have problems accessing care wherever they live in the world. When they do receive treatment, the outcomes often fail to meet the standards seen for the general population. So, where do we go from here? How do we ensure that people living with disabilities have access to quality oral health care and outcomes?

Mandatory training

Approximately one in five people are living with a disability.[1] Training needs to reflect the world we live in so that students are able to provide care for their whole community following graduation and are equipped with the skills and confidence to do so.

To truly improve outcomes for people with disabilities, we need to elevate the importance of special care dentistry within both clinical practice and dental team training. Exposure to people with disabilities should be seen as an essential part of professional training, not just "nice to have". This means mandatory inclusion of special care dentistry in all undergraduate programmes, with structured training and assessments, including logbooks showing diverse patients during clinical training – the same as any other dental discipline.

This isn't the case currently. In the United Kingdom and Ireland, we see vastly different scenarios between institutions, ranging from ad hoc exposure to exemplary programmes that include special care dentistry as a clinical speciality with associated academic departments. In some dental hospitals, exposure depends entirely on whether a person with a disability visits the hospital for treatment – and even then, there is no guarantee that there is a trained expert on hand that can guide the student on how to provide quality care to that individual. This type of scenario just wouldn't happen in endodontics or oral surgery training.

Gradual exposure

Many students will have had no exposure to people with disabilities growing up, so it can be very daunting to work with someone with special healthcare needs. When it comes to special care dentistry, it's necessary for students to learn how to make reasonable adjustments to their typical approach. It's all about learning to problem-solve, work together, make adjustments and find a path forward for each individual patient that truly demonstrates a student's understanding of patient-centred care.

Training needs to promote an inclusive model of disability that recognises that no two patients are the same, even if they share the same diagnosis. It should also embrace the International Classification of Functioning, Disability and Health (ICF) – recognising that we are all on a spectrum of ability and disability. Students should spend time with people with disabilities in non-dental environments, through community projects, to encourage them to question their pre-existing beliefs. As students start to become familiar with different types of diversity, they can start to focus on providing personalised, precision care for everybody.

It's also important for students to have time for reflection. What did they learn? What did they find easier or harder than expected? Where may unconscious bias be setting in? It's all a learning curve and students should be given the chance to build confidence over time, rather than being thrown in at the deep end. They can start with prevention and communication, then work up to doing simple treatments within their clinical competency.

A change in mindset

Dentists often think that people with disabilities can't achieve good oral hygiene, which is not the case at all. It's just that they need the right equipment, the right level of assistance, and creative and innovative solutions. A big part of educating students and dental professionals about working with people with disabilities involves getting them to rethink their assumptions and question unconscious bias. Providing quality care to people with

WORDS
PROFESSOR ALISON DOUGALL

disabilities isn't solely about getting them through the door, it means ensuring that treatment outcomes are equitable as well.

Longitudinal ageing studies show that people with disabilities struggle to access preventative care, as well as periodontal, restorative and functional treatment.[2] One study in Ireland found that the more often people with intellectual disabilities visited the dentist, the fewer teeth they had – due to the increased likelihood of undergoing extractions compared to able-bodied peers.[3]

Equitable care requires a mindset shift, with dentists thinking about how to facilitate the right care for each person. Finding strategies to restore rather than extract teeth to maintain function should be easier nowadays due to technological advances such as rotary endodontics. For patients with physical disabilities, a whole range of aids are available to assist with brushing and maintaining good oral hygiene. Disability does not equal poor oral health, yet this has been written into textbooks over the years – so it will take time to change the mindset and attitudes of trainers and students alike.

Mainstream acceptance and support

Just like sustainability, special care dentistry should be embedded into the whole curriculum, not taught in a silo or added as an afterthought. For example, if students are studying communication, they should be taught how to communicate with people with hearing impairments or aphasia as part of that module. If they are learning about consent, they should learn how to assure autonomy for those with disabilities as well as assisted decision-making processes for individuals without the capacity to make their own decisions. The skills students learn from working with diverse patients are transferable skills for the whole population. Communication, teamwork, planning, problem-solving, patient centricity – these skills are at the heart of quality care and are valuable for treating all patients with dignity.

This also needs to carry through to general practice. While some people with disabilities require specialist care at designated clinics with highly trained teams, 85% of people with disabilities can and should be treated within general practice.[4] We have seen amazing technological advancements that can make care so much better for all kinds of patients. Think about how much easier treatment has become with digital solutions like CAD/CAM compared to traditional impressions. We have the tools available to make life easier for patients and scales to measure the complexity and skills needed to take on a certain case.

Just as we need specialist oral surgeons to take on difficult wisdom teeth removals, there is always going to be a subset of patients with disabilities that require specialist care. That's where postgraduate education comes into play. But, in the end, it's not about whether someone is a specialist or not. It's about whether they have the skills, training and equipment to treat someone – plus the willingness to do so.

Looking to the future

There is still a lot of work to be done to address the oral health inequality experienced by people with disabilities, but we know the steps we need to take on the path ahead. This year, the World Health Organization adopted a landmark global strategy on oral health, setting a bold but essential vision for universal oral health coverage by 2030. It's a significant step in the right direction, but it will take time. Change also needs to be built from the ground up, by training the next generation of dental professionals.

My dream is for special care dentistry to be seen as something that is cutting edge and allows diverse individuals to achieve their personal best health, not a sub-standard compromise. Something that is included in every dentistry conference, the focus of long-term research, and driven by specialist postgraduate training. A discipline that showcases precision care at its finest and is inclusive of all members of our community. Because good oral health isn't a luxury, it's a human right.

This article was based on a presentation by Professor Alison Dougall for the digital event 'Special Care Dentistry: Reducing Inequalities – Bridging the Gap', organised by Dentsply Sirona International Special Clinic Solutions on 15 November 2022. Dentsply Sirona is committed to supporting clinicians to go beyond and help build a dental industry that is fairer, more inclusive and ensures the highest standards of ethics and responsibility. For a recording of this training event, contact salzburgaut-clinicsolutions@dentsplysirona.com. Professor Alison Dougall is Head of Child and Dental Public Health at Trinity College Dublin and Director of the Doctorate Training Programme in Social Care Dentistry. She is the past president of the International Association for Disability & Oral Health (iADH) and led the International Task Force that produced consensus guidelines for developing a curriculum on special care dentistry. She was the Health Leader in Ireland in 2018 and 2021 won the John Tomes Medal for the international impact of her body of work. Professor Dougall is a clinical consultant providing comprehensive care for people with complex healthcare needs. In addition to writing a clinical guide to special care dentistry, she has more than 45 articles published in peer-reviewed journals.

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Equitable care requires a mindset shift, with dentists thinking about how to facilitate the right care for each person

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TWELVE HABITS FOR DENTAL SUCCESS

From 'mise en place' to going against the flow

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

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I HAVE recently reread a piece in the *FT Weekend* by one of my favourite columnists, Gillian Tett. An anthropologist by training, she is an insightful analyst of people and their behaviours. Her column from the weekend of 8-9 October 2022 described the experience of sitting next to Retired Admiral William H McRaven. He was a US Navy Seal for 37 years and, as head of the US Special Forces, ran the operation that killed Osama bin Laden in 2011.

In 2014, he made a now famous commencement address at the University of Texas (available on YouTube). He encouraged the graduating students, that if they wanted to change the world, to start their day by making their bed, saying: "At least you know that you have done one thing right that day and also you will be getting into a tidy bed."

The Admiral went on to give nine more lessons in how they might change the world. They were all simple because: "The little things in life matter. If you cannot do the little things in life right, you cannot do the big things right."

It got me thinking, once again, about how we like to complicate life, making things easier to get wrong and how habits, especially bad ones, once established can be so difficult to change.

So, here are my suggestions for Twelve Habits for Dental Success. They apply to everyone from cleaners to Principals. Influences come from my own dental practice teams over a 25-year span, the teams I have coached, worked with and learned much and, not forgetting, Dr Paddi Lund's Courtesy System.

1) THE FIRST IS NOT TOO FAR AWAY FROM MAKING YOUR OWN BED. Become familiar with the concept of 'mis en place'. This translates as "to put in place" or "to gather". It refers to the set-up required before cooking and is used in professional kitchens to describe the organising and arranging of the ingredients that a cook will require for the items on a menu that are expected to be prepared during a shift. The philosophy is easily transferable to dentistry to ensure that a day not only starts well, but also continues well.

2) THE PS TO 'MIS EN PLACE' IS TO ALWAYS LEAVE YOUR WORKROOM AS YOU WOULD WISH TO FIND IT, to prepare for the next day. The New Zealand All Blacks have a tradition of 'Sweeping the Sheds', or dressing rooms, with two senior players ensuring their dressing room is left clean after every match. The All Blacks look after themselves and don't expect anyone to do such jobs for them.

3) KNOW YOUR STRENGTHS AND ACKNOWLEDGE YOUR WEAKNESSES and audit both regularly. Share your knowledge and encourage others to share theirs. Focus on constant improvement. Never stop learning about your speciality, about your fellow human beings and about yourself.

4) EVERYBODY'S TIME IS IMPORTANT TO THEM, SHOW RESPECT FOR IT. Poor time management is a huge stressor for both dental teams and patients. Start on time, stay on time and finish on time. If you don't respect others' time, then how can you expect them to show respect for yours?

5) STUFF HAPPENS. Things will go wrong. Mistakes will be made. Accept the mistakes and learn from them. When you lose, don't lose the lesson. When things don't work, admit it and don't be afraid to change. Acknowledge any mistakes, don't look to apportion blame, and move on.

6) ESTABLISH A 'STILL-POINT' IN YOUR DAY. Put aside 10-15 minutes at the start, middle or end of the day. Look backwards by 24 hours, what have you learned? Look forward a day, what can you anticipate? What problems are looming and how will you deal with them? Do this as an individual and with a team. Whether it's a morning huddle, a daily wash-up, or meet and talk.

7) DENTISTS SHOULD ONLY DO WHAT DENTISTS CAN DO; THE REST SHOULD BE DELEGATED. If you are a team leader, lead properly and ensure that you are delegating as much as possible.

8) LEAVE THINGS BEHIND and mentally wipe your feet when you leave. Don't bring work home – if you can't finish things at work then change the way you work and delegate more.

9) IN YOUR DEALINGS WITH OTHERS, ALWAYS TELL THE TRUTH and speak in private if necessary. Make eye contact and smile. Say thank you routinely and regularly – and mean it.

10) ALWAYS BE MARKETING. From the postman to the prime minister, be proud of what you and your team can do to help patients. Don't be afraid to talk about dentistry to friends and other professionals; the value of your network is beyond measure.

11) ALWAYS BE RECRUITING. Examine all interactions in places where you are served. What could that person bring to your dental business?

12) FINALLY, DON'T BE AFRAID TO GO AGAINST THE FLOW SOMETIMES. Be guided by your values and not fashion or trends. Know yourself, know your patients and get the best for both.

Injection moulding technique with injectable composites: quick fix or long-lasting solution?

Professor Marleen Peumans, Dr David Geštakovski, Dr Jacopo Mattiussi, and Dr. Kostas Karagiannopoulos

Introduction

The injection moulding technique with injectable composites, which became known to dentists worldwide due to the work of Dr Douglas Terry,[1-3] has become increasingly popular in the latest years. It is a relatively simple procedure that makes it possible to obtain a predicable end result, even in complex situations, because the morphology can be determined in advance. It is in part because of the development of suitable, high-quality materials, such as G-ænial Universal Injectable and EXACLEAR, that injection moulding is a reliable procedure. G-ænial Universal Injectable has the ideal consistency and mechanical properties and thus it is widely used for this technique. Combined with the highly transparent EXACLEAR silicone, the technique has become approachable and easy to conduct. In the following overview, it is shown how the restorations that were made with this technique can stand the test of time.

Case 1: Restored occlusion after severe general wear by Professor Marleen Peumans, Belgium

Because of its high wear resistance, G-ænial Universal Injectable can also be used to restore occlusal surfaces. This is particularly useful in case of abrasion/erosions in the molar area and has the advantage that it can be used in a minimally invasive way. In these cases, careful planning is imperative to restore the function in a correct manner. Injection moulding is a valuable method for a correct restoration of a physiologic occlusion with the aid of digital modelling techniques. Two models were printed: one with every second tooth restored and another one with all teeth restored. Based on those, two transparent silicon indices were made (Exaclear, GC). Working with two silicone indices has the advantage that the intraoral seating is more stable, there is greater control of excess material on adjacent teeth and a better emergence profile can be created.

Four models were made in total (two per jaw). One year after treatment, the surfaces still look smooth and shiny, without obvious occlusal wear facets.

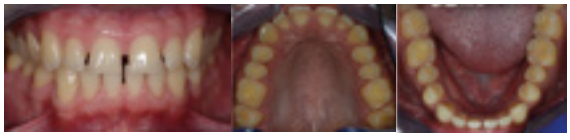

Fig. 1A: Worn occlusal surfaces and maxillary diastema before treatment. The colour of the teeth discloses the loss of surface enamel, with the colour of the dentine clearly showing through.

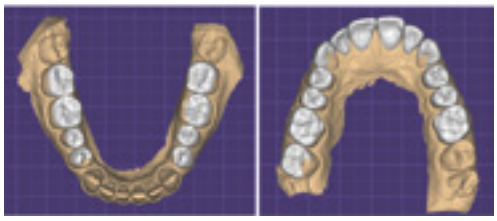

Fig. 1B: Computer-aided design of the restored occlusion. The diastemata between the maxillary incisors were restored as well.

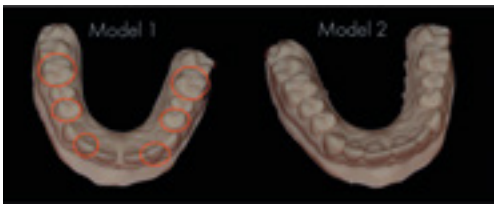

Fig. 1C: The two 3D-printed models of the maxilla; in Model 1, every other tooth was restored, while in Model 2, all teeth were restored.

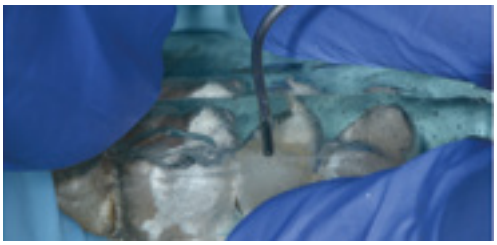

Fig. 1D: Injection moulding with G-ænial Universal Injectable in a transparent mould.

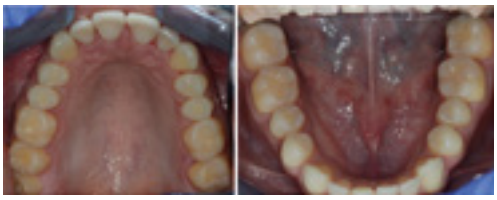

Fig 1E: Restored dentition after treatment.

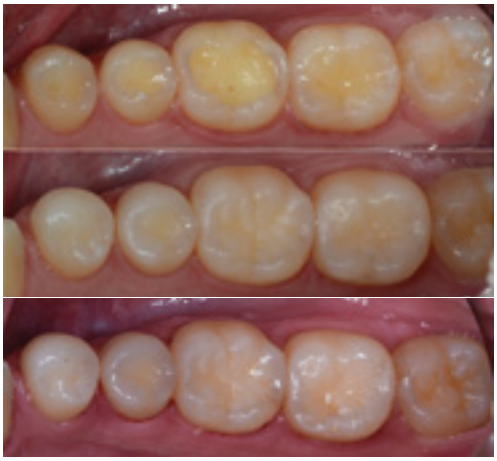

Fig. 1F: Close-up of the fourth quadrant. Top: before treatment; Middle: at baseline (after restoration); Bottom: one year after treatment.

Case 2: Cost-effective aesthetic rehabilitation by Dr David Geštakovski, Croatia

In the presented case, six composite veneers were made on the upper incisors and canines with the injectable moulding technique. After facial analysis, teeth were scanned and a digital 'wax up' was made. Based on the wax up, an intraoral mock-up was done to check guidance, functional parameters, aesthetics, and phonics. To get long lasting results, function needs to be planned in a correct way. Therefore, canines were included to obtain canine guidance in order to avoid potentially harmful contacts and forces on incisors, which may cause chipping of the restorations. Because of the low lip line the patient's gingiva was not visible in the forced smile so the asymmetry in the soft tissue around the central incisors was left as before. In this case, the silicone indices (EXACLEAR) were again based on two different 3D-printed models, for the same reasons as mentioned in Case 1 (vide supra).

Teeth were cleaned and etched, retraction cords were packed in the sulci to prevent crevicular fluid from flowing in field of work and to avoid subgingival flow of the injectable composite. Adjacent teeth were isolated with Teflon tape and after the adhesive protocol (G-Premio BOND, GC), G-aenial Universal Injectable (GC) was injected and polymerized directly onto the teeth. A1 shade was used for the incisors, while the canines were done with A2. For finishing and polishing, a scalpel nº 12, Epitex strips (GC), a fine diamond polishing bur and silicone spirals were used.

Two years later, the restorations maintained high aesthetic quality, without chipping or marginal discolorations. The beauty of this technique is its predictability and possibility to achieve great symmetry and marvellous primary, secondary, and tertiary morphology.

Case 3: Interceptive restorative treatment of a full mandibular arch by Dr Jacopo Mattiussi, Italy

In this case, G-ænial Universal Injectable was used to offer the patient a long-term temporary solution that did not hinder a more complex full-mouth rehabilitation in the future because the economic situation of the patient did not allow such treatment at the moment. In contrast to the previous cases, no CAD/CAM technique was used to make the design, but a traditional wax-up and bite registration were done. The vertical dimension was slightly increased and occlusal planes and curves were regularised as much as the pre-existing situation allowed it. Here, only one clear silicone key was used to restore the entire lower arch was restored in a single session. The result impresses in terms of aesthetics and the patient was very satisfied. It was ensured that the patient could clean all interdental spaces and at follow-up, healthy gingival tissues could be seen.

Case 4: Treatment of localised wear of anterior teeth by Dr Kostas Karagiannopoulos, United Kingdom

A 45-year-old man presented complaining of the appearance of his front teeth. Severe localised tooth

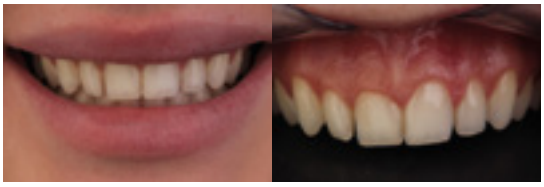

Fig. 2A: Initial situation.

Fig. 2B: Checking the size of the injection holes in the silicon index (EXACLEAR, GC) on the first 3D-printed model.

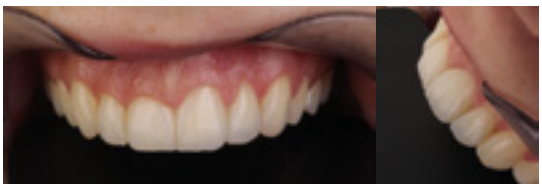

Fig 2C: Result directly after treatment, showing nice shape and morphology. The gingival line was not modified since it was not visible during smiling.

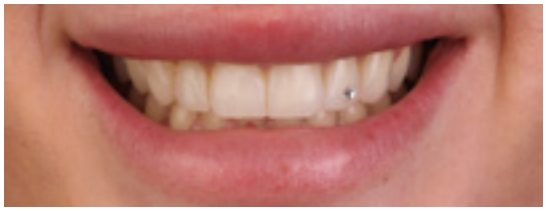

Fig. 2D: Result after two years. The shape of the restorations was maintained, without chipping or marginal staining.

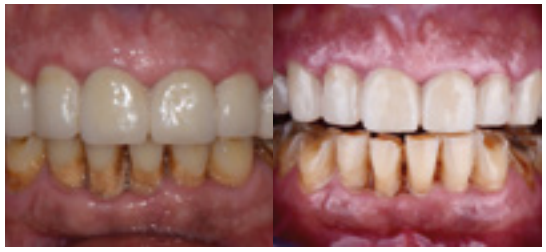

Fig. 3A: Initial situation. The upper jaw was restored three years ago by means of a voluminous zirconia full-arch restoration of which the patient was not very satisfied. The lower jaw was highly chromatic in comparison, with a considerable amount of tartar, extensive destruction of the hard tissues and periodontal attachment loss.

Fig. 3B: Impression taking and facebow registration. The wax-up was made with the aim of increasing the DVO just enough to regularise the occlusal planes and curves, with obvious limitations dictated by the morphology of the upper maxillary rehabilitation.

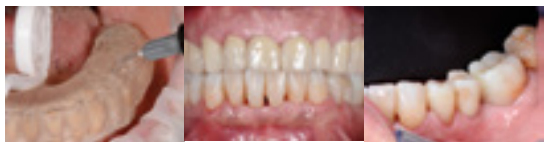

Fig. 3C: The lower are was restored per sextant. Old restorations were removed, cavity edges rounded and their surfaces sandblasted. The enamel was selectively etched before application of G-Premio BOND (GC).

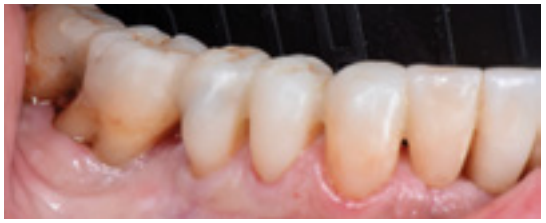

Fig. 3D: Images taken two and a half months after treatment. Harmonised aesthetics, a normalised vertical dimension and excellent health of the soft tissues are evident from the observation.

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Phil is the Principal Dentist at our Advanced Dentistry clinic in Glasgow and has vast experience in all aspects of Dental Implantology, including bone grafting, immediate implant placement and loading together with soft tissue surgery. Phil accepts referral appointments at our Advanced Dentistry clinic in Glasgow, as well as our clinics in Oban, Edinburgh and Inverness.

DR. KEVIN LEEMING

MF GDP (UK) 2006 I BDS

DENTAL IMPLANTS

Kevin is the Principal Dentist at our Advanced Dentistry clinic in Inverness. Since passing his MFGDP diploma in 2005, achieving his MJDF qualification in 2007 and his DPDS in 2008, Kevin has focused on general dentistry with a special interest in Dental Implantology. Kevin accepts referral appointments at our Advanced Dentistry clinic in Inverness.

DR. MAIRI HENDERSON

BDS Dip.MJDF MFDS RCS Eng MCGDent PG Cert Imp

PERIODONTICS & DENTAL IMPLANTS

Mairi has committed her professional development and training to the disciplines of Periodontology and Implantology. Mairi accepts referral appointments at our Advanced Dentistry clinic in Glasgow, as well as our clinics in Linlithgow and Edinburgh.

DR. CHRIS DALL

BDS

DENTAL IMPLANTS

Chris enjoys all aspects of general and cosmetic dentistry and has developed a special interest in Dental Implantology. Chris accepts referral appointments at our Advanced Dentistry clinic in Inverness.

DR. STUART MCLAREN

MBChB BDS MFDS RCSEd MRCEM

DENTAL IMPLANTS & SEDATION

Dr Stuart McLaren is a qualified Medical Doctor and Dentist with a special interest in Dental Implantology. Stuart accepts referral appointments at our clinic in Dumfries.

DR. MARTIN MACEACHEN

BDS MFDS RCPSG MCGDent

RESTORATIVE DENTISTRY & DENTAL IMPLANTS

Martin's particular focus is on restorative dentistry, especially crown, implant, and bridge work in both basic and advanced cases. Martin accepts referral appointments at our Advanced Dentistry clinic in Glasgow, as well as our clinic in Oban.

DR. MEHDI SHAMS

BDS MSc MFGDP (UK)

DENTAL IMPLANTS

Mehdi is the Principal Dentist at our Grandholm Clinic in Aberdeen. He has a special interest in Dental Implantology and teaching as a VT Trainer. Mehdi accepts referral appointments at our Aberdeen clinics.

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surface loss of multifactorial origin led to short clinical crowns. Worn teeth in occlusion due to dentoalveolar compensation have the restorative disadvantage of lack of interocclusal space. It was decided to proceed with additive composite restorations to restore the affected teeth using the Dahl concept: this is a method of treating the localised wear of anterior teeth, without having to treat the posterior teeth. The latter are discluded and allowed to re-establish themselves over time. All primary disease was controlled prior to the restorative phase, including the intrinsic acid erosion.

The alternate tooth technique was used to carry out the injection moulding technique. Once proximal and gingival excess was removed on all six restorations there was minimal finishing as the anatomy was wax-up driven and not freehand. The final result exhibited good surface texture and lustre while anterior guidance was maintained.

At a follow-up appointment after 20 months, no chips, fractures or debondings were observed. The patient is a heavy smoker and sees the hygienist regularly. Occlusal contacts were re-established on the posterior teeth after completion of the Dahl movements and the patient is now wearing an occlusal appliance at nights. Of note is the

Fig. 4A: Pre-operative photographs.

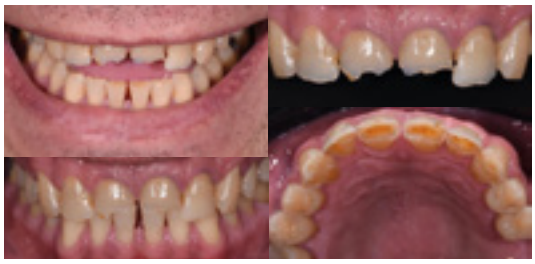
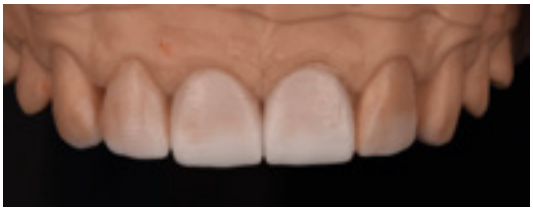
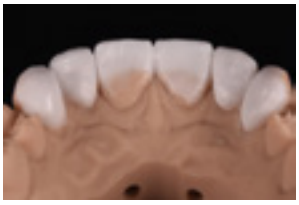


Fig. 4B: Diagnostic wax-up on printed models.





> AT A FOLLOW-UP APPOINTMENT AFTER 20 MONTHS, NO CHIPS, FRACTURES OR DEBONDINGS WERE OBSERVED"

high-gloss retention of the six direct composite restorations. No further polishing was carried out on the facial surfaces during that 20-month period.

Conclusion

Injection moulding has a wide range of indications, from anterior to posterior, from interceptive to final restorations, for aesthetic as well as functional rehabilitations, without excessive requirements in terms of clinical skills. The excellent strength and gloss retention of G-ænial Universal Injectable contribute to a maximum longevity for this type of treatment.

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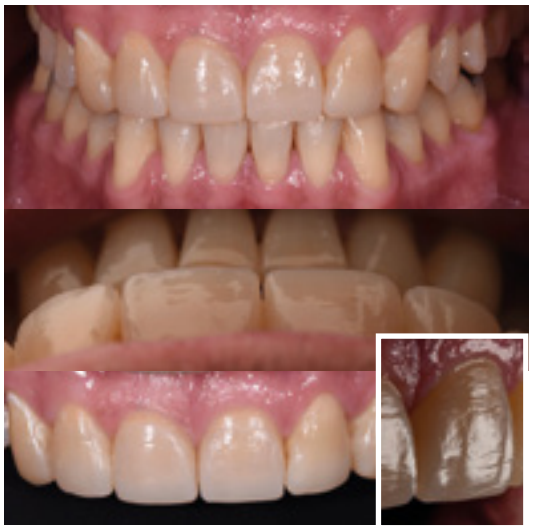
[1]Terry, DA. Restoring with Flowables. Quintessenz Publishing. 1st Edition 2017.

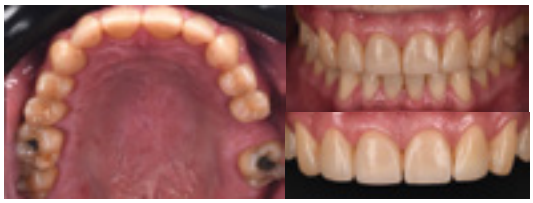
[2]Terry DA, Powers JM. A predictable resin composite injection technique, Part I. Dent Today. 2014 Apr;33(4):96, 98-101.

[3]Terry DA, Powers JM, Mehta D, Babu V. A predictable resin composite injection technique, part 2. Dent Today. 2014 Aug;33(8):12.

Fig. 4C: Immediate treatment result. The ability to replicate anatomic details and microtexture on the facial surface with the injection moulding technique combined with a fairly rigid stent exceeds that of all other direct composite techniques. Note the slight disclusion in the posterior area.

Fig. 4D: At the 20-month follow-up, the occlusion was fully re-established. The high-gloss retention of the six direct composite restorations was noteworthy, eliminating the need for repolishing.





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Course delivery - This course is made up of virtual classrooms, live webinars and contact days that take place mostly on Saturdays in Glasgow. Clinical supervision days take place at our Regional Training Centres throughout Scotland and Northern Ireland.

Course Overview

Module DX4016 Clinical Implantology Year 1.

MSc course introduction followed by 13 days of lectures and hands-on tutorials:

7th & 8th Sep 2023:	MSc Course Induction. Preston Campus or remote (TBC).
7th Oct 2023:	Treatment planning and case selection. Face to face contact day with hands-on workshops. Glasgow.
28th Oct 2023:	Basic sciences for Implant dentistry. End of Module Assessment. Pre-recorded lectures; live webinar discussions.
11th Nov 2023:	Implant Design. Pre-recorded lectures; live webinar discussions. End of Module Assessment.
2nd Dec 2023:	Surgical skills for Implant dentistry. Face to face contact day with hands-on workshops. Glasgow.
13th Jan 2024:	Occlusion. Pre-recorded lectures; live webinar discussions. End of Module Assessment.
3rd Feb 2024:	Restoring Implants. Pre-recorded lectures; face to face contact day with hands-on workshops. Glasgow.
24th March 2024:	Digital Workflow in Implant Dentistry. Pre-recorded lectures; face to face contact day with hands-on workshops.
16th March 2024:	Bone Defects. Pre-recorded lectures; live webinar discussions; end of module assessment.
20th April 2024:	Complications and their management & revision. Pre-recorded lectures; live webinar discussions. End of Module Assessment.
TBC April 2024	Formative Written Exam. On-Line using Maxinity.
May 2024:	Case reports. Case Report Presentations covering Case selection & treatment planning – each delegate to present one case.
11th May 2024:	Cadaver course. Face to face contact day with hands-on surgical skills workshops. West Midlands Surgical Training Centre Coventry.
TBC June 2024:	End of Year Exam. Written Exam and Unseen Case Oral Exam.
TBC July 2024:	Written Exam and Unseen Case Oral Exam - Resits.
To be completed before 28th Feb 2024:	CBCT Masterclass. 2 days, consecutive. Day One: On-line Module; Day two: Contact day. Choose from a selection of dates.

Module DX4017 Utilising the evidence base – completed online

Module DX4016 End of year Assessment
Date TBC.

Complete 5 Clinical days - supervised clinical practice.
You will assess and plan appropriate treatment for patients. Includes: case assessment and treatment planning, including use of radiographic stents and CBCT.

Module DX4026 Clinical Implantology Year 2.

Complete 10 Clinical days - supervised clinical practice. Includes: case consultation, implant placement, GBR procedures, restoration, follow up.

Module DX4027 Research Strategy. Prepare and submit a 8,000-word clinically orientated research project, which may take the form of a mini systematic review.

Final examinations.

PLEASE NOTE that all webinars are preceded by recorded lectures and long questions for discussion.

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Your reps across Scotland

Whether in-person or on a video call, there may be some familiar faces in the next few pages of our special feature on dental business representatives. Some may be new to you, but they all represent the best dental supply companies in the industry, providing world-class products. They encompass the whole spectrum of dental equipment, dental materials and supplies, and dental plans, and come with years of experience in their respective fields.

This special feature aims to give you some insight into who you and your practice managers will be speaking to, their industry background and the services they provide, helping you to maintain leading standards of patient care. These dental representatives can be a tremendous resource to dentists and their teams, helping to explore the best options for choosing equipment, dental materials, consumables or services to improve the efficiency and cost-effectiveness of the dental practice.

It is difficult for dental practices to keep up with all the developments in the dental marketplace, particularly in the post-COVID era, so dental representatives can provide a valuable service by sharing what is new in the industry, and to offer advice on what could help dental teams and their practices going forward.

Dental representatives are keen to develop strong relationships with individual dental practices, so the better they know each dental team the more they can tailor their advice and services to meet the aims of each practice.

They have wide experience in their respective fields and are ideally suited to provide valuable advice on solutions to dental practice issues, as well as training and after-sales support, when applicable, to make the most of dental practice investments. Read more about the leading business representatives and their excellent products and services on pages 63-65.

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BRINGING A WEALTH OF EXPERIENCE

COLIN HOGG recently joined the Southern Implants UK & Ireland team and will be looking after the West of Scotland.

Colin has been involved with implant dentistry since 1999. He is a GDC registered Dental Technician and has worked in the industry as a sales specialist and technical trainer delivering a number of courses for the DCP team.

Colin has a keen interest in technical, restorative and digital dentistry and brings a wealth of experience to the Southern family.

Colin Hogg,
West of Scotland Representative
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LOUISE GRANT • EQ ACCOUNTANTS

HERE TO HELP YOUR PRACTICE GROW

EQ ACCOUNTANTS' Healthcare team offers specific accountancy, taxation and business advisory services to each of the healthcare professions, particularly within the dental sector. Louise Grant, Anna Coff and Samantha Turkington attend and deliver talks at various dental events, including the Scottish Dental Show. If you would like more information on the services and support we can offer you and your dental practice, contact our EQ Healthcare team.

Louise Grant, Partner in our Dundee office and head of EQ Healthcare, enjoys being seen as part of her client's team, helping them to grow, develop and realise their personal ambitions. Louise specialises in corporate finance and has assisted many dental professionals to fulfil their dream of owning their own practice, either on their own or with other business partners.

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ANNA COFF • EQ ACCOUNTANTS

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ANNA COFF, a Manager in our Forfar office and member of EQ Healthcare, acts for numerous dental practices of all shapes and sizes across Scotland. Anna supports her clients with accounting and taxation issues, allowing them to focus on running a successful practice.

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SAMANTHA TURKINGTON • EQ ACCOUNTANTS

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SAMANTHA TURKINGTON, a Senior in our Forfar office and member of EQ Healthcare, acts for a number of dental clients, providing them with accounting, tax and compliance support. Samantha also keeps up to date with topical issues affecting her clients, writing various articles for the *Scottish Dental* magazine.

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BRIAN RHONEY • ACTEON

EXTENSIVE KNOWLEDGE

BRIAN RHONEY has more than 22 years' of dental sales experience, having started with the well-known dental laboratory supplier John Winter and Company back in 1999. Brian started as a technical sales representative and later progressed to Sales Manager before moving into dental surgery sales, having had spells with Dentsply Sirona and Straumann. He is probably best recognised for his time as Surgical Product Manager for Henry Schein, where he spent eight years covering Scotland, Northern Ireland and the North of England. Having sold general consumables and equipment for laboratories and practices, CAD/CAM systems, biomaterials and implants, Brian has an extensive knowledge base across dentistry, particularly in the surgical field. He is now delighted to be able to bring that knowledge to his new role as Northern & Scotland Territory Manager with Acteon UK Ltd. Brian says: "I am very excited to have been given the opportunity to join Acteon and really looking forward to being back out in the field meeting all our distributors and end users again and promoting such great products."

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ALLAN WRIGHT • A-DEC

SUPPORTING PRACTICES ACROSS SCOTLAND

AS one of the largest dental equipment manufacturers in the world, A-dec UK designs and builds much of what you see in the dental treatment room.

A-dec's primary focus is to create innovations, simple solutions and superior services that help dental professionals perform healthier, more efficient dentistry. Each piece of dental equipment is designed and tested to withstand the unique demands of a dental practice.

Allan Wright is A-dec's Territory Manager for Scotland, based in Stirling. He has worked in the dental industry for more than 17 years, supporting practices all over Scotland. Allan has an in-depth knowledge of infection control within dentistry and, as an ergonomics assessor, can help ensure dentists have a lasting career in dentistry.

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KYM PENFOLD • DENTAL SKY

MEET KYM FROM DENTAL SKY!

INTRODUCING Dental Sky's Sales Specialist Kym Penfold! Kym will be showcasing the brilliant Wand STA, the state-of-the-art digital platform for local anaesthesia which builds practices by greatly improving patient satisfaction, driving increased loyalty and referrals, and differentiating the dental practice.

Kym will be on-hand to demonstrate how the fantastic Wand STA can painlessly perform all traditional dental injections under the patient's pain threshold with no numbness to the lips or face and deliver single tooth anaesthesia! The team will also be showcasing a range of other brilliant products Dental Sky has to offer! Come to stand H13 at The Scottish Dental Show to learn more and meet the friendly Dental Sky team!

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DAN NULTY • PATIENT PLAN DIRECT

DENTAL PLAN PROVIDER EXPERTS

TRUSTED by hundreds of practices across the UK, Patient Plan Direct understands dental practices' challenges and have developed our solution, transparent fee structure and support to meet your needs. Our expert advice and support can help you to achieve your plan objectives and retain more of your plan income. Our admin fees are often two to three times less than other major plan providers, meaning that a significant cost saving can be achieved when switching from an existing plan provider to Patient Plan Direct.

We are also helping more practices than ever before create less reliance on the Scottish NHS contract, growing a healthy private membership base.

Our people play a huge role in delivering excellent service. From the support of a dedicated Business Development Manager to our highly responsive Client Services team, we've got you covered every step of the way. Want to know how we can make your practice more profitable? Get in touch with Dan today.

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Facebook: facebook.com/PatientPlanDirect
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TONY CANNAVAN • STRAUMANN

THIS IS US

THE Straumann Group endeavours to be the first partner that professionals choose to do business with, to help them find genuine solutions, and turn ideas into reality. Empower your business with our innovative solutions and benefit from our dedicated local infrastructure.

The Straumann Group is one of the very few organisations in the dental industry with both an office and a warehouse in the United Kingdom. Our infrastructure allows us to provide complete support to our customers with quality assurance and agility.

Your business and patients will be supported with a nationwide sales force and support team – including an eShop; customer service and technical first-level support; a complete logistics operation with local warehouse, returns processing and next day deliveries; as well as our digital experience showroom and education centre.

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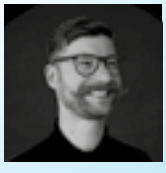

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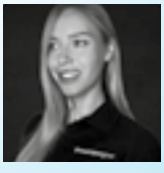

ZOE ELLIS • STRAUMANN

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martin aitken
accounting | tax | finance

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

Preparing for life as a new self-employed dental associate

WORDS
JAYNE CLIFFORD

Jayne Clifford, Director, Martin Aitken, and member of the National Association of Specialist Dental Accoutants & Lawyers (NASDAL).
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Register as self employed

You should register as self-employed with 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 directly. Tax payments are due at the end of January and July each year. If, for example, you become self-employed in August, you may not have to pay your first tax bill until the January after next – a full 17 months later. 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 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, 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, and 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 and 24 per cent of the purchase price.

Turning to your personal finances: mortgages, savings, and protection

To obtain 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 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 – see our tax rate card at maco.co.uk for the current annual maximum savings limits. You won't pay any tax on the interest you receive from your ISA, nor will you 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 tax will be free. They are not suitable for everyone though, so do speak to us before investing.

If you arranged an income protection policy whilst 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 up a Will and set up a Power 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.

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 CGDent Faculty Day in December and the Scottish Dental Show each spring, as well as other BDS Undergraduate events throughout the year. If you would rather have a private chat, you can email me at jfc@maco.co.uk with your query and I'd be more than happy to arrange a time to meet with you.

**As a mortgage is secured against your home, it could be repossessed if you do not keep up with the mortgage payments.*

WHEN BUYING, PLAN AHEAD

Be clear on what steps are required to reach the promised land of practice ownership, says Michael Royden

Many dentists aspire to be their own boss and to become a practice principal. That might involve entering into partnership with other dentists, either in the practice that they work as an associate or in a new practice. However, in many cases they look to acquire a practice and become a sole principal, which allows them to run the business without having other co-owners to consult on business decisions.

Going down this route isn't for everyone, but for those who choose to take the purchase path, it is useful to plan ahead and to be clear on what steps are required to reach the promised land of practice ownership.

FINDING THE PRACTICE

Once you know what type of practice you want to buy (NHS, private or mixed) and have a geographical location in mind, you can start your search. Some find a practice through word of mouth and professional connections, but most common is to find a practice being marketed by one of the dental agents. We would tend to recommend that you register as a potential purchaser with all of the agents, so that they will let you know if a suitable practice comes to the market.

You should also think about whether you want a practice with a property which is owned (in which case the total value will be higher) or leased.

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GETTING INTO POLE POSITION

Finding a suitable practice is the first step, having an offer accepted is another. In recent years, in particular, competition for practices has been significant. This has even led to some practices being sold via a closing date, similar to when some houses are sold. That, and the presence of corporates keen to buy increasing numbers of practices, has certainly had an upwards impact on goodwill prices, which isn't helpful to potential buyers. However, there are individual buyers who are successful, so don't be put off by that.

FUNDING

Once you have found the ideal practice, the next step is to secure the necessary funds to achieve your dream. You should ideally have looked at finance, in principle, prior to your practice search so that you can have some confidence that the money will be available.

You may be lucky enough to have some capital behind you by way of savings, or perhaps another source of finance, such as from family members. If so, that is great, and will certainly help. Most purchasers need to look to banks for purchase finance. The Thorntons Dental Team has contacts with all of the healthcare teams within the banks and are happy to make introductions where required. Alternatively, some use finance brokers who can search for suitable finance for any given purchaser.

Banks continue to be keen to fund the right practice and the right purchaser, and so hopefully you should be able to secure the necessary funds.

GETTING THE RIGHT ADVICE

Once you have the practice and the finance, you can start to progress the purchase along with your professional advisers. The timescale from start to finish will vary from one practice to another, but in most cases it will take three or four months to reach the completion date. There are a number of legal and other steps in this process, a subject in its own right, and one which we will cover in future articles.

One very important point is that you will need accountancy and legal advice on the acquisition, and ideally you will consult advisers who have experience in buying dental practices. That should make the deal as smooth as it can be.

ACHIEVING YOUR DREAM

Having gone through all of these essential steps, you should at the end of the road reach the stage where completion can take place and you can start to run your own practice, making your own decisions and benefitting from the value which the practice as a whole generates.

The effort involved in buying a practice shouldn't be underestimated, but with the right advice and good preparation, it should be possible to achieve your dream of becoming your own boss, and take the first steps on your journey as a practice principal.

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Over 40 practice sales & acquisitions completed in 2022

NASDAL
National Association of Specialist Dental Accountants & Lawyers

aspd

Professional Adviser
Dental Awards 2019
I'm a Winner
Michael Hayden

We're here **for you** and **your business** with in-depth knowledge of the dental sector:

- Buying or selling a practice
- Buying, selling & leasing premises
- Practice Incorporation
- Partnership Agreements
- Associate Agreements
- Employment Contracts

Contact Us

03330 430350

thorntons-law.co.uk

Thorntons is a trading name of Thorntons Law LLP

NEW YEAR CLEAR OUT...

...what you shouldn't get rid of

The start of a new year is often a great opportunity to clear your home and office of things you may no longer need. However, when running your own business, there are items you shouldn't dispose of.

If you are an associate who prepares a tax return each year, your records should be kept for 22 months after the end of the tax year the return is for. For example, information used to complete your 2021/22 tax return which was filed on 31 January 2023 should be kept until at least the end of January 2025.

If you trade as a partnership or sole trader, records are required to be kept for five years after the filing deadline. For example, with partnership accounts prepared until 30 September 2022 and recorded on the partnership tax return on 31 January 2023, these records must be kept until 31 January 2028.

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If you trade as a limited company, you must keep your accounting records for at least six years after the financial year which they relate to. Let's say you have prepared your last set of accounts for the year ended 31 March 2022, then the information required to complete the accounts must be kept until 31 March 2028.

Limited companies have extra regulatory requirements through the upkeep of their statutory books. These books contain information regarding the formation of the company, its shareholders and directors, and are to be kept for at least seven years after the company is struck off.

At EQ, part of our compliance process can include keeping and maintaining these records for you. For more information, please get in touch with Samantha.

LATEST CHRISTIE & CO BUSINESS OUTLOOK

Joel Mannix reports on the positive sentiment for the dental market in 2023

Despite some significant headwinds – not least rising interest rates, geopolitical and economic uncertainty, and increasing workforce challenges within the profession – it is far from doom-and-gloom in the current dental market, and we expect another busy year for practice sales.

As reported in our recent *Business Outlook* publication, our completion volumes rose by 23 per cent from 2021 to 2022, and a staggering 124 per cent from 2018 to 2022, illustrating the increasing demand for quality practices. In 2022, 150 offers were formally accepted, reflecting a 50 per cent increase on 2021, and the aggregate offer value we received rose by 48 per cent to more than £930 million. Bank valuation instructions also hit an all-time high, with a significant increase in instructions, which we anticipate continuing. Pricing was competitive in 2022, with deals completing well in excess of the asking price. We previously reported a positive dental price index of +8.6 per cent for practices sold through us in 2021. This trend continued throughout 2022, with a dental price index of +2.2 per cent.

THE YEAR AHEAD

We recently surveyed dental professionals across the UK to gather their views on the year ahead. Almost half (48 per cent) said they felt positive going into 2023, and 57 per cent said they are considering buying and/or selling in 2023.

What we can expect in 2023:

- Institutional investors will continue to deploy capital in healthcare and needs-based sectors
- Corporate consolidation will not mean practices are in less demand or result in lower multiples of EBITDA being paid, as new and more aggressive buyers enter the market
- First-time buyers may be more price sensitive due to rising interest rates
- Economic factors and the rising cost of living will impact what consumers are willing to pay for costly private dental treatments
- Larger portfolios and dental groups will enter a sales process in 2023

For more on the dental market, read Christie & Co's Business Outlook 2023 report: christie.com/business-outlook-2023

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We asked dentists we've helped make a successful move from NHS to private practice to sum up how they feel now they've made the move, in **just three words...**

POSITIVE EXCITED CALM

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Craig Walsh : Principal Dentist
and Owner, Buxton Dental Practice

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NEW YEAR, NEW YOU?

Take proactive steps to understand and enhance your practice performance, says Victoria Forbes

I am writing this as we nudge from 2022 into 2023 and it is fair to say that the last two years have been tumultuous for the Scottish dental sector.

We have seen unprecedented challenges emerge to test the resolve of the profession and the levels of stress felt by practice owners have been at all time highs. That said, there are a lot of positives to accompany the challenges and at Dental Accountants Scotland we always advocate gratitude and a positive attitude.

As practice leaders, your team is looking to you in 2023 to provide strength, positivity and leadership. The impact of a whole team positive attitude is proven to be massively dynamic and provides both financial and morale improvements. Let's stand together and drive forward the Scottish dental profession in 2023 and take proactive steps to understand and enhance your practice performance.

Victoria Forbes
Director, Dental Accountants Scotland
E: victoria@dentalaccountantsscotland.co.uk

If you would like to explore how you can improve your practice performance and quality of life in 2023 please do give us a call and we will be delighted to provide you with a fun and positive approach while reviewing your current results. With our expert analysis and knowledge of the sector we are able to translate this to being your best year of ownership so far.

We look forward to hearing from you and wish you all the best for the year ahead. Good luck.

TRANSFORM YOUR PRACTICE

Patients can instantly see full 3D images

Follow the example of a group of Scottish practices investing in 3D scanning

Five Tayside dental practices have made a £250,000 investment that will see them become some of the most digitised surgeries in Scotland. Two dental practices in Dundee and surgeries in Forfar, Newburgh and Kinross will bring the latest 3D digital intraoral scanning technology to patients.

Dundee firm First Alba Healthcare, run by husband-and-wife team Dr Rami Sarraf and Dr Ewa Plewa Sarraf, owns the practices. Together they employ a team of 45 staff and associates. The business, which began in 2009 with 1,600 registered patients, now has around 40,000 patients in total: a mix of NHS and private.

First Alba purchased the Medit i700 intraoral scanner – a cutting-edge scanner with powerful hardware and intelligent software, that will make the scanning experience a comfortable one for both dentist and patient – from MediMatch, whose team have also been training staff in its use.

The state-of-the-art equipment – used to create braces, retainers, bridges, crowns and other dental appliances – brings with it many significant benefits to patients, including a quicker, more comfortable experience when having appliances made, by removing the need to use moulding material, plus the opportunity for the patient to instantly see a full 3D image of their mouth on the monitor.

This can lead to a greater understanding by the patient of what is being done to their teeth and gums, considerably aiding communication between them and the dentist in moving forward with future dental care. Unlike most scanners on the market, the Medit i700 can be directly connected to the computer using a power delivery cable without a power hub and extra cables. This new feature of Medit i700 improves mobility and maintenance.

The new scanning technology also carries a lower carbon footprint. Appliances can be made on site, rather than transported back and forth to external labs. The amount of clinical waste generated in making appliances is also greatly reduced.

With the new equipment at hand, Dr Sarraf has undertaken a staff training programme. "We had planned to introduce the technology at each of our five surgeries before COVID struck," he said. "We are now able to continue with the full plan to make the business the most digitised dental surgeries in Scotland.

"The technology has been introduced as a result of painstaking research by myself and my wife as to the best equipment to buy for our purposes. Patients want a fast and reliable service without the need for impressions which are not only unpleasant for the patient, but very time consuming to make.

"This significant investment in new technology will revolutionise the service we are able to provide to patients needing specialist made-to-measure appliances"

For more information about the Medit i700 visit medimatch.co.uk/medit-digital-intraoral-dental-scanner

First Alba Healthcare staff during a training session

SEE BETTER, FEEL BETTER!

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At Optergo UK we have assembled a team with over 30 years' experience servicing the UK and European Dentists with custom-made precision loupes. Our team's experience is paired with the highest quality Dental Loupes manufactured in Sweden. With 7 measurement points taken at every fitting which are backed by a qualified Optometrist, we aim to ensure the best fit first time round.

No neck bending – The Pentaroof Patented Prism system of Optergo's Vinkep Loupes shifts the magnified image up and forward by 15 degrees for a natural position without obstructing the clinician's peripheral version. Providing strong magnification and a large field of vision together with an edge-to-edge accurate image the relatively small telescopes are extremely light-weight and comfortable.

6 GET YOUR LOUPES IN WEEKS OR YOUR MONEY BACK*

*T&C'S APPLY

For enquiries or to make an appointment to see our outstanding range and learn about optimum ergonomic posture when wearing loupes, please call me on 07539 071949 or email me at jane@optergouk.com

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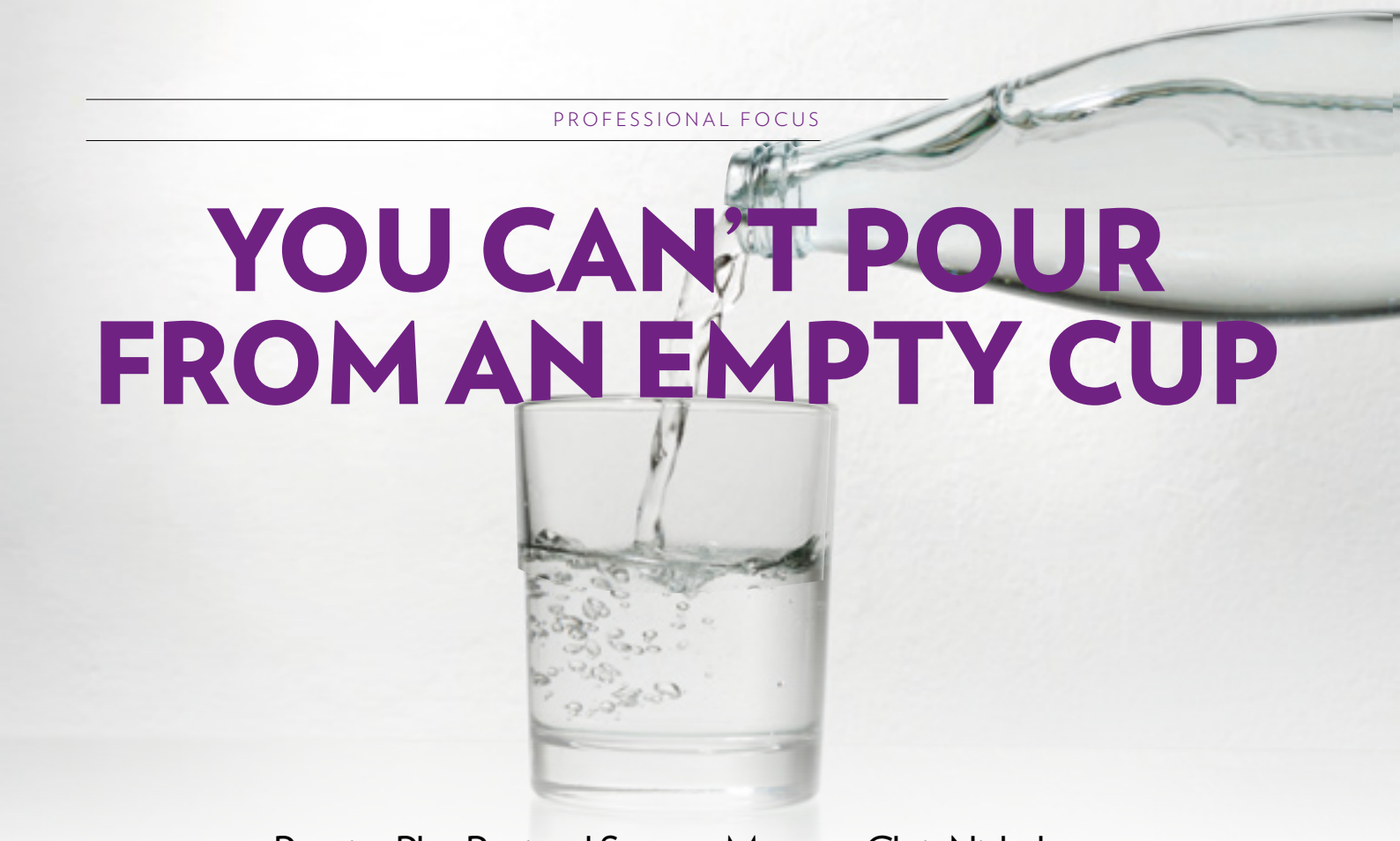

YOU CAN'T POUR FROM AN EMPTY CUP

Practice Plan Regional Support Manager Chris Nicholson shares his suggestions for ways practices can make sure everyone on the team is pouring from a full cup

Although I have spent the past 10 years working in dentistry and the healthcare sector, I started my career in retail with Asda. Retail management is a notoriously demanding career as, along with long and often unsociable hours, there can be a lot of travel involved, so you need to be able to learn how to become resilient. As I look after quite a number of dental practices, I can see how some of them are really struggling at the moment.

There are a lot of principals, practice managers, dental nurses and other team members who are exhausted because of the demands placed on them over the pandemic, and due to the recruitment and retention crisis. There's a chronic shortage of qualified or experienced dental staff at the moment. If they have a vacancy, practices can't find people to fill it for love nor money, which has an effect on the people still working there who have to cover the extra workload caused by being a team member down. Even if they've managed to avoid catching COVID themselves, their colleagues are likely to have caught it, or at least the Omicron variant, so they've had to cover for people off ill too. And then there's still the backlog of appointments to clear from lockdown. If they haven't reached it already, people are close to burnout.

Although a lot of my job is about supporting practices with business processes, I also feel it's important for me to support them with building resilience within their teams. When I worked in retail, I spent time going around the country opening new stores, which was quite stressful at times. There were often last-minute glitches to overcome and challenging deadlines to meet. I always had one eye on how my team members were coping with the pressure, but I also had to keep an eye on my own wellbeing too. If I wasn't at my best, then I wouldn't have been able to support them properly, so I learned to prioritise myself and my own wellbeing.

That's one of the messages I'm trying to pass on to my practices. You have to look after your wellbeing if you want to be able to help others. I think people who work in caring professions and environments struggle a bit with that concept. They're so used to caring for everyone else that they almost feel it's selfish to prioritise themselves. It's not selfishness, it's self-care and it's important for everyone. There's a good reason the instruction in a pre-flight safety talk on an aeroplane is to make sure you put on your own oxygen mask before you start to help anyone else. If you aren't OK, then you can't help anyone else.

There are lots of things you could do that count as self-care, but one of the simplest and easiest things to do is to take a break. It may seem as if there aren't enough hours in the day to be able to take a break, but not prioritising time to step away from things and stop for a while is a false economy.

Breaks are essential for making sure people can still perform at their best. Without breaks, people lose focus and that's when mistakes happen. If you do manage to take a break, then going for a walk and getting some fresh air will increase the benefits. Exercise releases feel good hormones and cortisol, which helps us deal with stress. Even a 10-minute walk can be enough to improve your mood and clear your head so you're ready to get back to work with more focus.

Of course, eating healthily, drinking plenty of water and getting a good night's sleep are things we should be doing whether we're stressed or not. Fuelling your body with the right food, rather than relying on sugary or fatty snacks, will help you avoid some of the energy dips you may experience as will making sure you're taking in enough fluids.

None of these things are rocket science, really. But when I talk to teams about self-care and remind them that they need to take care of themselves to be able to take care of their patients, they seem to understand that putting your own wellbeing first is not a selfish thing to do.

Chris Nicholson

Chris Nicholson is a Regional Support Manager at Practice Plan and has more than 15 years' experience in the healthcare industry, including five in dental practice. Practice Plan is the UK's leading provider of practice-branded patient membership plans, partnering with more than 1,800 dental practices and offering a wide range of business support services. For more information visit the Practice Plan website: www.practiceplan.co.uk

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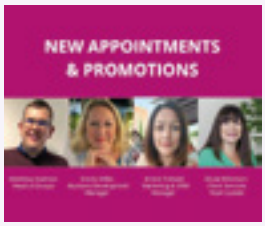
› PATIENT PLAN DIRECT

GROWTH LEADS TO NEW HIRES AND PROMOTIONS



Patient Plan Direct has expanded its team with the appointment of three new staff, as well as promotions for existing team members, in line with significant business growth. With 2022 being a record-breaking year for the dental plan provider, Patient Plan Direct now in its 14th year, has invested in three new appointments:

Matthew Hadman, formerly the Practice Manager of a dental practice with more than 3,000 plan patients, has joined Patient Plan Direct after three years as a Regional Support Manager at Practice Plan. The unique experience of working within a practice and also selling dental membership plans, brings a breadth of knowledge and insight into the team. This has resulted in Matt making a huge impact very quickly, resulting in a promotion to Head of Groups within six months of joining the business.

Emma Wilks joined Patient Plan Direct in October and has already made waves in the Midlands and Greater London area. Based in Essex, her 10 years within the dental industry has included working at a dental manufacturing company, a dental dealership and time at DPAS, before joining Patient Plan Direct. With her specialist knowledge in dental plan memberships, Emma is steadily growing the business in her region, whilst quickly forming strong relationships with our existing clients.

Kristin Fretwell has taken up the new role of Marketing and CRM Manager. A highly experienced marketing professional, she has more than 18 years' experience across several industries. While developing an enhanced marketing support to existing clients, she will also contribute to driving business growth with a focus on marketing spend effectiveness.

Existing team member, **Shula Wilkinson**, has also been promoted to a team leader role in the client services department, to support existing team members and recent new hires. Shula has been with the company for more than four years and has been key in creating a highly responsive client services team.

For further information please contact: info@patientplandirect.co.uk

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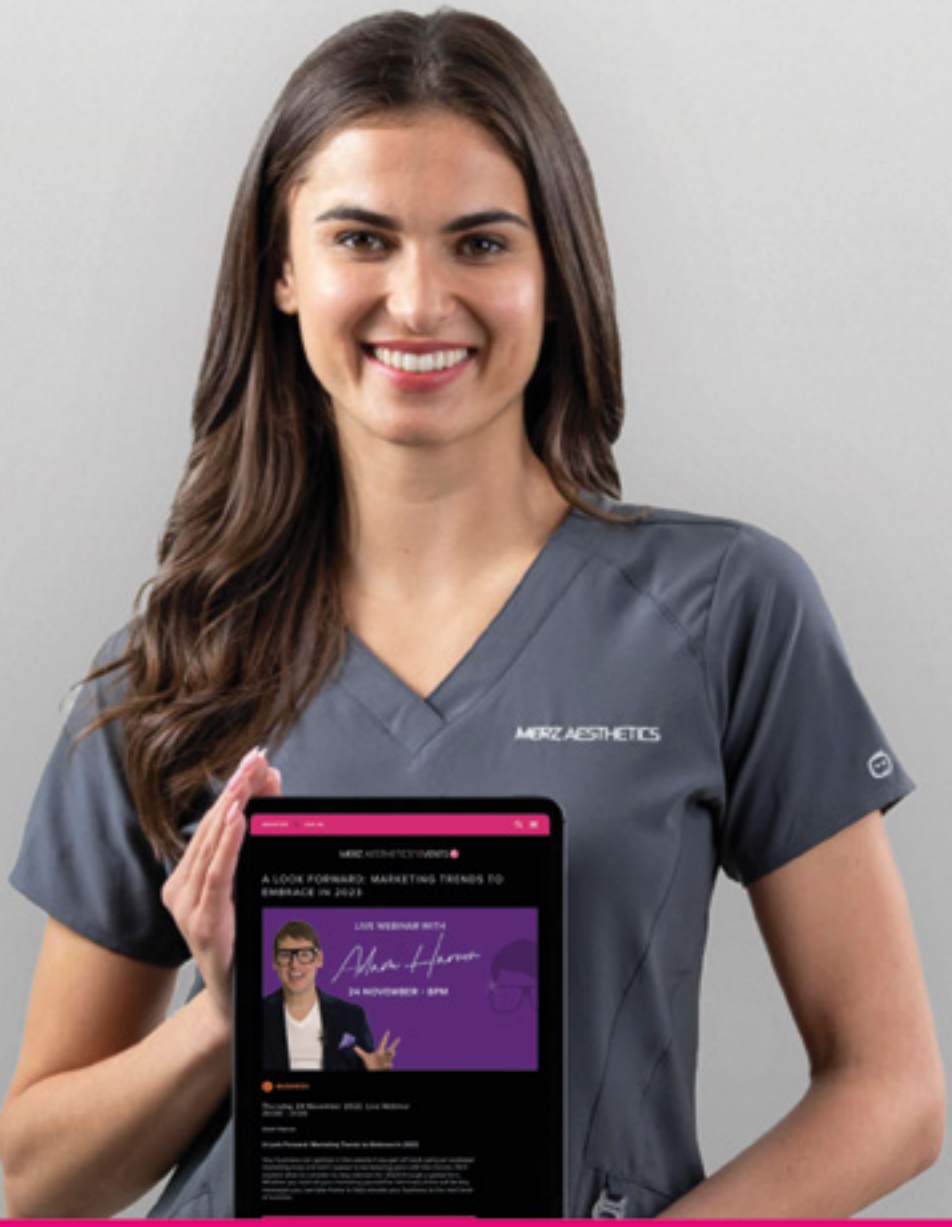

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