FDI closes Annual World Dental Congress in Singapore
World Dental Federation appoints new president and invites to Brazil

Singapore: Singapore has a long and successful relationship with the dental profession. Not only does the city state host the oldest running dental school in Asia; first implants were placed here by Dr Henry Lee almost 20 years ago. Nowadays, the island boosts a workforce of 1000 dentists that are both educated internationally and make use of the latest state-of-the-art equipment.

Large international manufacturers such as 3M ESPE and Straumann have taken advantage of Singapore's position as a trading hub and serve most of their customers in the Asia Pacific region from here. With IDEM Singapore, the city also hosts a dental congress that did not only feature popular topics such as implants, aesthetics, and periodontics, but also gave insight into new challenges and developments in dentistry. Among others, the prevalence of oral cancer, salivary biomarkers as well as the therapeutic potential of dental stem cells and tissue engineering were discussed. Limited Attendance Courses were expended to give participants the chance to learn in a more intensive and intensive environment. Auxiliaries and office personnel had the chance to get their hands on the New Patient Experience in a special full day programme. As one participant put it: “What strikes me about this congress is how it brings together so many different specialist areas in dentistry, all under the same roof.”

Though official numbers have not yet been released, exhibitors speaking to Dental Tribune Asia Pacific said that visitor's numbers clearly did not meet their expectations. In spite of this, most exhibitors also reported increased numbers in sales and business deals. Plenty of new products and processes were introduced, for example, surgical instruments and handpieces that now come with built-in and long-lasting LED lights. Nobel Biocare introduced their newest product NobelProcera for the first time to Singaporean dentists during an official launch dinner held at the Charilton Hotel. The system aims to combine industrialised production processes with versatile and individually aesthetic dental restorations.

In addition, continuing education was offered to trade show visitors through Dental Tribune in collaboration with the DT Study Club, who held their first online symposia outside the United States.

Members of the 2010 Local Organising Committee invited to next year’s congress in Salvador da Bahia in Brazil, home country of the newly appointed FDI president Dr Roberto Vianna. Dr Vianna, who took over the presidency from Dr Burton Conrod, Canada, received his DDS from the Federal University of Rio de Janeiro in 1965. Since then, he has been serving for many national and international health organisations, including the World Health Organization and the Latin America Association of Dental Schools.

“I am very happy to lead the FDI as president over the next two years. The organisation is of course, the voice of dentistry, but more so, it is a means of empowering dentists to think about oral health on another level, for the benefit of the greater population,” Dr Vianna said. “I would like to contribute and help spread the FDI message; to advocate for the general public.”

Speaking about the 2010 FDI Annual World Dental Congress in his home country Brazil, Dr Vianna borrowed a phrase from France's national anthem, “Je m'engage à vous sauver” (now is our glorious day); “I am very excited to see the AWDC in the future. It will be a landmark publication that will strengthen the FDI’s position as a world leader for the promotion of oral health information by demonstrating the state of world oral health in easy language, for everybody.”

“I'd like to see us focus on developing our relationships and networks, both across the organisation and with FDI in the long-term goal of eradicating dental caries. In July 2009, the Rio Caries Conference was held in Brazil to launch the initiative and a series of follow-up events are expected over the next ten years. Dr Vianna also announced that he will support the GCI throughout his term as president.

Another important advocacy tool during his term will be the new Oral Health Atlas, which was launched at the FDI Pavilion in Singapore and will be available at Amazon UK after the FDI congress. According to Dr Vianna, this will be a landmark publication that will strengthen the FDI’s position as a world leader for the promotion of oral health information by demonstrating the state of world oral health in easy language, for everybody (from dentists to government delegates to the general public).
Change to complaints procedure triggers more queries

The new two-stage NHS complaints procedure has led to more dental professionals seeking advice from the Dental Defence Union on how best to respond to patients’ complaints.

The Dental Defence Union (DDU) saw a 20 per cent increase in members notifying them of patients’ complaints in 2008.

Rupert Hoppenbrouwers, head of the DDU said: “We don’t believe that the increase reflects a decline in standards but that members are sensibly contacting us for advice about the new two-stage NHS complaints procedure which came into effect on 1 April 2009 in order to ensure they meet its requirements.

“In addition, our experience is that members want to respond appropriately to a complaint in order to maintain a good professional relationship with the patient, because it is their ethical duty and to prevent the complaint from escalating into a General Dental Council (GDC) complaint or a claim for compensation.”

He added: “As I explain in my Dental Review in the 2008 MDU Annual Report, the emphasis of the new NHS procedure is local resolution, and we are encouraging members to comply closely with regulations that require careful planning of investigations and responses, as well as evidence for complainants that, if appropriate, lessons have been learned and changes made.”

The DDU has extensive experience of assisting members with complaints. It can help members draft initial responses to complaints and, on the rare occasions that complaints are referred to the Ombudsman or the Dental Complaints Service, it can also support members with this procedure.

The DDU’s Continuing Professional Development courses also provide specific practical advice on complaints handling.

Scottish dental centre up for design award

Dumfries Dental Centre in Scotland has been nominated for the Roses Design Awards.

The £2.7m Dumfries Dental Centre and Outreach Teaching Facility in Dumfries is a multi-functional dental centre incorporating eight general practitioner surgeries, six outreach training surgeries and four primary care dentistry training surgeries.

The centre is situated within the grounds of Dumfries Royal Infirmary located between the infirmary campus and the Crichton campus.

The building, designed by Archial Architects is long and linear in plan, culminating in a semi-circular form at its southern point.

A spokesman for the centre said: “A palette of bright, bold colours has been used to enliven the internal environment and make it visually stimulating. It is hoped that this has the benefit of helping dentally anxious patients by making the visit to the dentist less daunting.

“Views over the Nith Valley towards the Dumfriesshire hills have been exploited by maximising glazed areas to the waiting area and from the dental surgeries on the Southern and Western facades.”

The Roses Awards is an annual competition open to design and architecture companies outside the M25 boundary. The results of the 2009 Roses Design Awards will be announced at the awards ceremony which is taking place on Friday 23 October in Nottingham.

Dumfries Dental Centre won the NHS Scotland Environment, Estates and Facilities Annual Design Award in 2007.
Dental Access contract – read the small print

By Tony Jacobs BDS

The name of Dr Mike Warbuton, a medical practitioner working for the Department of Health was one which had been coming up more frequently, and over the summer there was talk of the development of a new contract for dentistry, devised and pushed forward by this man and his team. Rumours were transmitted which suggested this contract would include some of the components from the Steele Review, which had been warmly received, but minus the piloting aspect that Steele had insisted upon. In fact Prof Steele had insisted on a long pilot with proper evaluation, and events now show us this “Warbuton” contract was being pushed to the front without any semblance of piloting. Dr Warbuton headed a “dental access team” and used the expertise of the DH’s commercial division in composing this complex document.

Through GDPUK, more whispers emerged, and a copy of this document arrived mysteriously in my inbox. More whispers followed and it transpired one of the large corporate dental companies, who are very experienced in negotiating dental contracts, had walked away from any further discussions with Dr Warbuton. Furthermore, it also emerged that the BDA had been discussing this contract simultaneously, and they too had a showdown meeting with the DH, and were also poised to cease discussions too.

GDPUK.com was able to publish this draft contract and a spreadsheet showing the application of the targets in the contract, and their bearing on the contract value, this is available to download at www.gdpuk.com/news and makes interesting reading for dentists concerned about the future of NHS dental contracting.

The contract is weighted differently to the present one by virtue alone. This means there is not base all the payments on achievement of UDAs, merely 51 per cent. This might sound like a good starting premise, but the remaining part of the contract value can be achieved by reaching other targets. 10 per cent of the contract value is made up of giving value for money plus good response from patient questionnaires about waiting times, the practice and treatment received, plus a further 50 per cent is based on reaching Key Performance Indicators, which are outlined in the spreadsheet named above.

An example is the prescribing of antibiotics, and if a practitioner prescribes these at a rate lower than the average for the local PCT, then this reaches the target for that KPI. Inevitably this number would therefore fall each year, making a serious effect on practitioners’ prescribing patterns, and clearly affecting so-called “clinical freedom.” Other targets include reducing the number of regular patients seen each quarter, and gives more pay for seeing them yearly. Each of these requirements is listed and weighted, but not all of them is necessary to earn that 50 per cent of the contract value.

An example in the value for money category is to reduce the number of patients who have more than 24 UDAs of treatment in a 12-month rolling period. In other words, having the contract will be squashed, and genuine patients who need antibiotics, or who genuinely break teeth three times in 12 months will find it difficult to have a third lab item if the dentist is not meeting targets. The figures in the example of the DH trying to ensure that previous suspected gaming by practitioners is not unpunished.

The KPIs are split into three weighted 10 per cent categories, across, effective care and health promotion. Under the contract, every patient must be asked about smoking, and then 90 per cent are to be “signpost” to cessation services to meet the next target. This might help oral health, but is not what has been seen as dentistry. This is only a selective summary and the detail is available to download.

In addition, the contract is composed of many schedules. When schedules, it seems to give ownership of the practice to the PCT in the event of termination of the contract, imposes many requirements on the contractor on terms of who is employed and how, and more akin to a contract of employment than one between an independent contractor and a health commissioner.

Publication of the draft produced a cascade of responses. The following day, the BDA issued a press release, and wrote to GDPC members. The BDA’s summary was clear, they saw the contract as initiating micromanagement of dental practices, with a vast array of detailed requirements. The contract would be understood during family practices, and would leave them at constant risk of breach if they did take it on. GDPC had met with the DH on this matter, but had made no progress in making it even slightly suitable. The GDPC Executive had decided to continue with discussions rather than walking away. Their advice went on to tell members about the possibility of the contract as it is unsuitable, and open to lengthy and complex litigation. They went on to say things moving towards something based on the Steele recommendations remains the present aim of the GDPC.

Dental colleagues commenting on this in the GDPUK forum, having been able to read the contract and spreadsheet made a number of salient points, they felt this was going to be a big boost for Denplan. A practitioner could take this on and perhaps use that as a springboard for control of the practice, like the absence or lack of response to patient questionnaires. Comments were made looking back to items of service with nostalgia. In addition, further analysis showed the weighting of the KPIs was not evidence based, just invented to fit in with the spreadsheet.

Advice from all sides is not keen to enter this arrangement – the corporate companies had led the way with their commercial nous – if they will not attempt to make this work, it has to be a powerful challenge for any practitioner.

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About the author

Tony Jacobs, BDS, is a GDP in the suburbs of Manchester. He has had a family dental contract since June 1998. He was also a GDP at St Peter’s Healthcare, Salford since 2003. Tony is a GDP at the Longley Dental Centre in Manchester. He is a GP dental consultant, and has published a number of articles in the Dental Protection Journal. He currently acts as a GDP consultant, and has written and edited for Dental Protection.
Dental Tribune spoke to CDO Dr Barry Cockcroft about the Dental Access Contract

The thing to remember about the Access Contract is that it is only linked to the work that Mike Warburton’s team is doing; it is focussed on the access programme, working with PCTs, to develop around 150 brand new practices across the country.

The draft of the access contract that has been released was an early draft that the team shared with the NHS to get their feedback. The team also shared it with the British Dental Association (BDA); we agree with the BDA that this is a work in progress. The access team has met with the BDA several times and there are more meetings planned.

The contract does include some suggestions that Jimmy offered in the Steele review but then again the access programme pre-dated the Steele review so it would have been silly to ignore the work that Jimmy was doing.

The most significant work relating to Steele will be piloting with existing practices. We are committed to getting them running as soon as possible, but we need to agree what we are going to pilot, where, when are we going to pilot, how long are we going to pilot for and how we are going to evaluate them. The intention is certainly to have Steele review pilots up and running by the Spring.

There have been many reports on dentistry in the past and we have a long history of not implementing them. What the Secretary of State Andy Burnham said at the press conference when we launched the Steele review was that we have to make sure we implement these recommendations. I am committed to doing just that — we will have an implementation board to make sure we implement it and, like the review itself that will have considerable engagement with stakeholders.

Going it alone
Trading as a limited company can hold benefits for dentists. Michael Lansdell explains

"Going limited" might not be suitable for everyone, for dental professionals to decide whether their circumstances would benefit from incorporation, it is vital that they fully understand the role of each specialist. Just as members of the dental team work well together and complement each other through their specific strengths, so accountants, brokers and solicitors make up a synergistic team when dealing in their own area of expertise. Although multiskilling to a certain extent can be helpful, the intricate balance between all parties is at its optimum when roles are kept separate.

The next step
The role of the specialist accountant is to completely evaluate a dentist’s business and personal circumstances to work out whether incorporation is the best step forward. Skilled at identifying tax savings and other benefits to the client, a good accountant should provide a balanced view on incorporation, detailing what the dentist can expect after becoming a limited company. Taking into account the ultimate sale value to third party and if the total net benefit is worth the process, the accountant will then create a unique incorporation blueprint for the practice.

Brokers who have considerable experience in gaining the proper valuation of a business, as well as providing a goodwill valuation well supported by comparable sales of similar practices should be approached when ‘going limited’. Gaining such a valuation is key in the event that the transaction is examined by HM Revenue and Customs, ensuring the dentist has a justified explanation of methodology and methodology explaining a valuation to support the true practice value.

Solicitors assist in the sale of the business agreement from sole trader to limited company; their skills are needed to set out a legally enforceable sale agreement that is appropriate for everyone’s needs. Flexible enough to not create any restrictions pertaining to the agreement by taking into account the close association between vendor and purchaser, the solicitor will protect the interests of both parties. Dentists can also benefit from the solicitor aiding any possible conveyancing process, for example, property sale and rental agreements back to the limited company.

Ask for advice
Consulting an Independent Financial Adviser (IFA) is useful when assessing whether the rules will allow the transfer of a freehold property into a Self Invested Personal Pension (SIPP).

They will also give advice on pension investments, and deal with additional contributions from savings generated by incorporation, to increase the size of pension pots. This kind of expert team will guide a dental professional through successful incorporation, provided each member works to its strengths, as there are potential problems that might occur if specialist’s roles are confused.

Although trained in valuation techniques, accountants are not open to the same information on comparable practice sales and prices as brokers. Brokers will be able to provide an accurate, justified goodwill value that will be sustainable under HMRC scrutiny.

Accountants are involved in liaising with the solicitor and coordinating the incorporation, however they should avoid attempting legal advice such as negotiating with a contractor for contract as it might cause problems. A solicitor should always be involved when documenting the terms of sale between the sole trader and limited company in a genuine arm’s length sale.

Defining roles
Keeping roles clarified throughout the incorporation process will ensure the dentist receives advice tailored to his specific circumstances. Approaching a solicitor for accounting tax advice on incorporation might prove problematic, a conclusive answer will be provided by an accountant skilled in calculating whether becoming limited would be a net benefit or net cost to the dentist. By assessing the potential savings against financial downsides, incorporating fees and potential risks, the accountant will advise whether the business will be strengthened by incorporation.

For the right practitioner, there are numerous advantages to becoming a limited company, and with expert advisers, it can be an uncomplicated course to take. Working with an interdisciplinary team that knows their strengths and limits can make the incorporation process effortless, and with clear boundaries of responsibility dental professionals will know what to expect from their respective advisers.

About the author
Michael Lansdell was brought up in South Africa, receiving his honours degree there in 1991. He completed his training with international accounting firm Deloitte in 1994, and went on to become a founding partner at Lansdell & Rose Chartered Accountants a year later. Based in Kensington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner-managed clients, generally dentists and doctors, and specialising in the incorporation of dental practices. To contact Lansdell & Rose, call 020 7376 9333.