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> If you make wrong choices about materials and their application, you get in to trouble, so it's actually very, very important
>
> **PROFESSOR GRAHAM CHADWICK**

24

CONTACT DETAILS

Managing editor: David Cameron
david@connectcommunications.co.uk
Editor: Bruce Oxley
Tel: 0141 560 3050
bruce@sdmag.co.uk
Advertising sales manager: Ann Craib
Tel: 0141 560 3021
ann@connectcommunications.co.uk
Design: Renny Hutchison, Raymond Francis, Katherine Pentney
Sub-editor: Wendy Fenemore
Subscriptions: Lauren Adger
Tel: 0141 561 0300
info@sdmag.co.uk

42

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Specialist in Endodontics, GDC No. 62862

Dr P Coli DDS, PhD,
Specialist in Periodontics and Prosthodontics, GDC No. 104397

Dr F Veldhuizen BDS, MFDS RCS(Ed), MClinDent, MRD RCS(Ed),
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Dr P Hodge BDS, PhD, FDS RCS(Ed)
Specialist in Periodontics, GDC No. 56503

Mr M Paley BDS, MB ChB, FFDRCSI, FRCS, FRCS(Ed)(OMFS),
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Dr G Ainsworth BDS FCS RCPS Glasg, MSc (Ed), MSurgDent RCS(Ed
Specialist Oral Surgeon, GDC No. 71932

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Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
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THE BIGGEST AND BEST SHOW YET

2016 Scottish Dental Show breaks all records, again...

Another year, another Scottish Dental Show and this year was, without doubt, the biggest and the best yet. We saw nearly 2,000 people come through the doors at Braehead Arena to take in a world-class field of lectures and workshops as well as the busiest trade show we have ever hosted.

There were nine hours of verifiable CPD available including 10 sessions of core CPD over the two days and the lectures broke all records as well. We had two sessions that saw more than 300 delegates attend, five with more than 200 and three with more than 100.

If you attended, your CPD certificates are now ready online so please click on the link in your registration email to download. You will also have been sent the link in a separate email that also includes the feedback questionnaire and a link to the GP214 form for you to claim CPDA for the show.

Hundreds of you have already completed the feedback survey, but if you haven't already, please take five minutes to let us know what you thought of the show. It is only through honest feedback that we can continue to improve and bring you a show that is both relevant and interesting.

We also need feedback on the speaker sessions and workshops that you attended in order to satisfy the GDC's requirements on CPD, so don't forget to fill that section in as well.

The planning for 2017 has begun and, amazingly, 83 stands have already been sold as the dental trade again puts its weight behind the biggest event of its kind in Scotland. Turn to page 28 for our special feature on the 2016 show.

The 2016 Scottish Dental Awards was also a great success with nearly 450 in attendance at the Awards Dinner at the Glasgow Hilton on 13 May. Hosted by Carol Smillie, the event saw 15 awards handed out, culminating with Hugh Harvie being awarded the 2016 Scottish Dental Lifetime Achievement Award.

Hugh received a standing ovation as he took to the stage and it was clear that he was a very popular winner. I've met Hugh on a number of occasions and was fortunate to be sitting next to him at the dinner itself. I'm sure we could not have chosen a more worthy and gracious recipient.

All the winners are featured in our picture special starting on page 36. A massive congratulations to all the winners and shortlisted individuals and practices and a huge thank you to everyone who nominated, provided a testimonial, or who just came along to enjoy the party.

I'm sure we could not have chosen a more worthy and gracious recipient

Nominations for the 2017 awards will open, along with registrations for the 2017 show, later on this summer. So get your thinking caps on and get your nominations in nice and early!

WE COULDN'T HAVE DONE IT WITHOUT...

1

PROFESSOR GRAHAM CHADWICK (ON HIS 26 YEARS AT DUNDEE)
Professor Geaham Chadwick is professor of operative dentistry and dental material science at Dundee Dental School.

2

MARGARET ROSS (ON DIRECT ACCESS)
Margaret Ross is senior lecturer for DCPs and programme director of the BSc (Hons) oral health sciences degree at the University of Edinburgh.

3

DR ROBBIE LAWSON (ON LINGUAL ORTHODONTICS)
Dundee graduate Robbie Lawson is a partner at Edinburgh Orthodontics and a member of the Worldwide Incognito Lingual Appliance Advisory Board.

4

DR ADITI DESAI (ON INTEGRATING DSM)
Dr Aditi Desai is the current president of the British Society of Dental Sleep Medicine. She works in Harley Street and London Bridge Hospital.

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Insider

HAVING HIS SAY →
Arthur Dent is a practising NHS dentist in Scotland
arthurdent@sdmag.co.uk

WHEN MR MOYES CAME TO TOWN

GDC chair put in an appearance at the Scottish LDC and received a less than luke-warm reception...

This column has visited many topics over the years, and I have no shame in returning to a well-worn one: the GDC is failing the profession. Following some welcome correspondence, and also the appearance of Bill Moyes at the Scottish Local Dental Committee Conference in Stirling, I think more can be added to this.

When I graduated, it was clear that while a Fitness to Practise hearing could happen, it would only be following failure of local resolution, or when something very dire had occurred. This is no longer the case.

The last dental chair of the GDC was Alison Lockyer, who was well liked and well respected by the profession. She resigned in May 2011, having made a number of allegations (source: http://www.publications.parliament.uk/pa/ld201516/ldhansrd/text/160118-gc0001.htm). The Professional Standards Authority published a report as a result of this in February 2013. It did not find that the GDC was failing, but it identified some general learning which could be gained from the experiences of the GDC. In July 2013, a member of the investigation committee raised concerns under the GDC's whistleblower policy that certain processes were compromising the independence of the investigating committee's decision-making. The GDC also commissioned an independent review into the concerns of the whistleblower, which was published in 2014, but in April 2014 the PSA started its own investigation, which was published in December 2015.

The BDA has rightly described the GDC as "Britain's most expensive healthcare regulator" and it "is also the least efficient, most troubled and enjoys little confidence among dentists or the Professional Standards Authority". It states that the GDC failed to meet eight out of 24 of the PSA standards of good regulation in its 2014-15 performance review and, crucially, fully met only one of the 10 standards relating to FtP processes, representing what the PSA describes as "a significant decline in its performance compared to the assessment of the year before".

The BDA points out that, in comparison, last year the GMC met every one of the 24 standards while charging its members less than half the fee that the GDC charges.

During a Parliamentary debate in January, Lord Hunt of Kings Heath said: "It is also clear from reading between the lines of the report and the careful way it has been put together that the PSA lacks confidence in the performance of the GDC. Frankly, I would have expected the entire board of the GDC to resign in the light of that report just before Christmas. I understand that the chief executive has resigned but no one else on the board seems prepared to take responsibility for a culture that has clearly lasted over a good many years. That is not acceptable. Can there be any confidence that this organisation is fit for purpose?

"I now understand the concerns that the profession has about the GDC. I had not realised until I went through this information just why there was so much angst within the profession. It is absolutely justified. I would be doubtful of putting any order through in relation to the GDC unless we were absolutely certain that it is able to carry out its job properly."

The GDC chair, Bill Moyes (who is not a dentist), agreed to address the Conference of Scottish Local Dental Committees on 22 April. He mentioned that complaints have risen by 110 per cent since 2010, but claimed not to know why this increase had occurred. Mr Moyes iterated this point on many occasions.

The GDC website does not make it apparent to a patient that the first port of call would be to complain to their own practice. Mr Moyes told delegates that any complaint made directly to the GDC is automatically treated as an FtP hearing. He claimed that a change in the law would be required to stop this from happening. Nothing is preventing the GDC from changing the advice on their website.

A member of GG&C LDC, who works for a defence organisation, correctly stated that local resolution is better for patients, not just for dentists. Mr Moyes's response was to say it was our job to "keep what things we can away from the GDC", and described his own dental practice as having "a curling dog-eared complaints policy hiding behind a pot plant" and that we failed to invite comment from our patients. He would be unaware, then, of the Combined Practice Inspection document which rightly demands that the complaints procedure is well displayed, and that we invite comments. He could also consider the GDC's own insistence that dental websites include the complaints procedure. Mr Moyes clearly does not want to accept responsibility for the complaints – it is our fault and not that of the GDC.

He claimed that the infamous advert in *the Telegraph* was in no way responsible for the increase in complaints.

Robert Donald, chair of SDPC, asked why Mr Moyes had refused to meet him, and was told that he would meet with them "when they had something serious to contribute". Mr Moyes said this several times, and it showed the scant regard he holds for Scottish dentists in that he thinks SDPC would not be serious.

Mr Moyes was then asked by the vice-chair of SDPC, David McColl, why he thought dentists were twice as likely as medics to be in front of an FtP hearing. Apparently he "does not know". Mr McColl then asked whether he thought the financial aspect of dentistry had any impact upon this. Mr Moyes once again "did not know".

A further question from Robert Sweeney reminded Mr Moyes that Lord Hunt had suggested he should resign. Mr Moyes then claimed that he was "part of the solution, not part of the problem" (this was rather unprofessionally, but certainly understandably, met with guffaws from the floor). He said categorically: "I will not resign." Mr Sweeney correctly stated that the GDC should only deal with the most serious cases, and that lives and careers were being ruined.

Henrik Overgaard Neilson, chair of GDPC, said that the GDC had failed to gain the confidence of the profession. Mr Moyes claimed there was a lack of enthusiasm "outside of this room" and cited legal issues that compelled the GDC to start FtP proceedings rather than referring patients back.

Mr Moyes then claimed "we don't go advertising for it" and refused to take further questions. The arrogance and lack of insight, as well as lack of empathy for our profession, was staggering.

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Professor Lorna Macpherson, co-director of Childsmile, speaking at the meeting of paediatric dentists

CHILDSMILE SHOWS WAY FORWARD FOR ENGLISH KIDS' ORAL HEALTH

A recent meeting of paediatric dentists in London focused on the achievements of the Childsmile programme in Scotland and how English dentistry could learn from the successful initiative.

Professor Lorna Macpherson, co-director and evaluation lead for the programme, presented to the meeting of the British Society of Paediatric Dentistry on the topic "Learning from Childsmile".

At the meeting, Prof Macpherson remarked on what she felt was a great enthusiasm for change in the room and likened it to how the profession in Scotland had felt when they embarked on a stakeholders meeting at the turn of the century before Childsmile was launched.

The aim of the meeting was to look at ways of breaking down barriers to improve the oral health of children in England.

One of the major successes highlighted by Prof Macpherson was seeing dentistry integrating with other aspects of healthcare as well as the reduction by a third of the number of general anaesthetics carried out for multiple extractions of teeth in children.

Claire Stevens, spokesperson for BSPD, said after the meeting that one of the society's aims was to see a programme like Scotland's Childsmile implemented in England.

LDC CONFERENCE DEBATES THE ISSUES

Unannounced inspections and the recent DenPro launch were among the subjects debated and voted on at the recent Scottish Conference of LDCs recently.

Lothian LDC proposed a motion on the Scottish Government's "failure to consult fully with the profession" over unannounced visits and called for ministers to "engage fully with SDPC when considering issues of similar importance and in doing so, allow all parties adequate time for proper consideration of the matter". The motion was passed by majority.

On the launch of the DenPro procurement scheme, Kenneth McDonald, from Greater Glasgow and Clyde LDC, called for assurances from the Scottish Government that "it will not use evidence of perceived cost savings facilitated by DenPro as a negotiating tool to reduce funding in matters relating to the delivery and remuneration of dental services by non-salaried general dental practitioners". This was passed unanimously.

Other motions passed included motions condemning the increase in waiting time for prior approval and a motion stating that the SDR is unfit for purpose and a review is needed.

GDC CHAIR RECEIVES FROSTY RECEPTION

LDCs conference not impressed with response to complaints grilling

GDC chairman Bill Moyes was "laughed out of the room" when he made an appearance at the recent Scottish Conference of LDCs in Stirling.

During his presentation he claimed that he didn't know why complaints had risen by more than 110 per cent since 2010 and, despite spending thousands of pounds of registrants' funds on the infamous advert in *the Telegraph*, he claimed it was in no way responsible for the rise in complaints.

Mr Moyes was asked why he had refused to meet with the SDPC, despite repeated invitations, to which he replied that he would meet them "when they had something serious to contribute".

One delegate also asked him why he hadn't resigned; he replied by saying that he was "part of the solution, not part of the problem" and reiterated that he would not resign.

Scottish Dental magazine columnist Arthur Dent, who was at the conference, said: "To be honest Bill Moyes was all but laughed out of the room. Literally. I can't say we all acted terribly professionally, but in our defence we were sorely provoked."

And another delegate from North Lanarkshire said: "Grudgingly, I have to take my hat off to him for actually turning up as many of us didn't think he would."

In her pre-conference speech, conference chair Jacqueline Frederick, took a moment to comment on the appearance of the GDC chair the following day by saying: "Our relationship with our regulator has probably never been worse."

She said the profession in Scotland was "irritated at the level of GDC fees we pay", that there was a sense of unfairness at "the shoehorning in of regulation of DCPs" when other healthcare groups have separate regulators for complementary groups, and she expressed "disbelief that our regulator was advertising for complaints".

These issues, however, "pale into insignificance compared to the stress, of a lengthy GDC investigation".

The Greenock GDP argued that "stress is maybe not the right word for our problems. Delving deeper, it would seem that, in our situation, fear and anxiety fit the bill better".

Read Arthur Dent's take on Dr Bill Moyes' appearance at the conference on page 7.

NEW NHS PROCUREMENT SCHEME IS LAUNCHED

The Dental Directory is officially announced as procurement partner

Dental dealer, The Dental Directory, has been confirmed as the supply partner for the NHS Scotland-run procurement scheme DenPro, which launched on 3 May.

The new scheme, which has signed up more than 400 dental practices, is the brainchild of Scotland's Chief Dental Officer Margie Taylor.

The aim is to help practices cut costs by gathering together into a buying group to negotiate best prices on consumables and sundries.

After a competitive tender process, The Dental Directory won the contract to provide general hygiene and safety products, instruments, impression materials, cements and general consumables. If successful, the range could be extended to other products in the future.

Paul Cushley, NHS National Services Scotland director of dentistry, said: "The planning and implementation of DenPro has been a long time coming so the launch is a very exciting time for us.

"The responses and feedback from dentists across the country has been very positive so we're pleased to see the programme come to fruition and benefit the greatest number of practices."

ABOVE: NHS NSS director of dentistry Paul Cushley

James Murray, commercial director at The Dental Directory, said: "We have a long history of working closely with NHSScotland and are pleased to support this unique venture. The awarding of this contract will enable us to offer competitive prices on a range of products and value-added services to DenPro members."

Louise Reay, dentist and co-owner of Uddingston Dental Care, signed up to DenPro after attending one of the roadshows held in September 2015.

Louise said: "I thought that joining DenPro would be very beneficial for our practice. Costs of running a practice are rising each year, and despite our best efforts it can be difficult to secure the best prices for stock as we are not formally trained in procurement.

"DenPro will make the process of purchasing easier and less time consuming for practices, and I like the idea that the initiative will create a community of practices coming together to help and support each other with the running costs of our businesses.

"Ultimately, if we can save money on stock and supplies it means we can invest more in the practice to benefit patients and staff alike."

To access the DenPro members' catalogue, please visit www.nhsdenpro.org

VIEWS SOUGHT OVER PUBLICATION OF ADDRESSES

The GDC has launched a consultation following its decision to cease publishing the full address details of dental professionals online.

Currently, the regulator has a search function whereby members of the public can search for dental professionals by name, town, postcode or registration number. In April the GDC announced it will no longer include full details and it has recently opened a consultation to hear views on whether it should publish the name and registration number only, or the name, registration number and town where the dental professionals lives.

Ian Brack, chief executive of the General Dental Council, said: "It was a significant decision by Council to move away from publishing dental professionals' full address details to the two options we are progressing.

"We want to bring GDC in line with other professional healthcare regulators, balancing our role in protecting the public with the need to treat dental professionals fairly, whilst protecting their personal information. We are very keen to hear from all interested parties of the merits of publishing the name and number of the dental professional, compared with the name, number and home town appearing on the register, before we make our final decision.

"Whatever outcome is reached, the registration number will become the primary identifier of registration status, so it is good practice for dentists and dental care professionals to start to display it appropriately."

The consultation will run until 30 June. Visit http://bit.ly/1NHo9Yz to respond.

DUNDEE RANKED BEST IN SCOTLAND

Dundee Dental School has come out top in Scotland in the annual Guardian University Rankings, being placed fourth behind Queens University Belfast, Plymouth and Queen Mary in London.

Glasgow Dental School was ranked in seventh place behind Cardiff in fifth and Liverpool in sixth.

Dundee received an overall score of 94.3 out of 100, with a 96 per cent satisfaction rating for teaching and a 98 per cent rating for the overall course.

Professor Mark Hector, Dean of the School of Dentistry, said: "I am delighted that we have been ranked the best in Scotland for studying dentistry. Everyone in the school works very hard to give the best possible experience for our students. This result reflects the commitment of our staff and our students to excellence".

The University of Dundee as a whole was placed 28th in the UK rankings, with the University of Glasgow placed 26th overall.

MDDUS SNAPS UP £30M LONDON PROPERTY

The Medical Dental Defence Union of Scotland (MDDUS) has bought a £30m property in the City of London as it continues to expand its property portfolio.

The 26,115 sq ft office building at 50 Cannon Street was bought for £29.625m from Ferreiro Properties S.L.

In addition, MDDUS has completed a major refurbishment and re-letting of the building housing its London offices, 1 Pemberton Row, to increase rental income.

MDDUS CEO Chris Kenny said: "These changes enable us to diversify our assets, secure significant capital growth and generate extra income, so ensuring that we provide members with the best value in their subscription. Our separate property company [MDDUS Property Ltd], which now has specific sector experience on its board, ensures that we manage our four-building portfolio in the most professional way."

Last year MDDUS purchased Grade-II listed Hend House in the West End for £21.35m and Bracton House in Midtown for £20.87m.

NOW TRENDING

92

DAYS

Women change their toothbrushes on average every 92 days, compared to men who wait 185 days

* Source: Survey of 1,000 patients by Carisbrook Dental in Manchester

SURPRISE INSPECTION DETAILS PUBLISHED

SDPC says there are still several issues that need resolving with regards to the Scottish Government's controversial plans

The Scottish Dental Practice Committee (SDPC) says it still has "serious concerns" after the Scottish Government revealed details of its controversial surprise inspections.

An NHS amendment published on 29 April stated that, from 1 April, NHS boards could make unannounced inspections where there are either concerns raised about patient safety during a routine NHS inspection or when "information comes to light that necessitates investigation by the NHS".

The amendment sets out the purpose of a surprise inspection saying: "An unannounced inspection will allow the board to satisfy itself that patient safety has not been compromised by any actions or omissions of the dentists or dental staff within the practice."

However, it goes on to say: "The inspection cannot be used as a general inspection of the premises, or to consider other issues that are not directly linked to the patient safety issue."

SDPC chairman Robert Donald said: "NHS Boards already had levers at their disposal to provide for unscheduled inspections when allegations of breaches of patient safety are made. So the question remains why we even need formal amendments to the regulations?

"Dental practice advisers are usually the first point of contact for anyone raising any concerns relating to patient safety, and are best placed to deal with these issues without

SDPC chairman Robert Donald

the need for a formal unannounced inspection by a full inspection team. The power has to be used sparingly. Unannounced inspections should only be considered by NHS Boards when there is a considerable risk to patient safety. We remain seriously concerned about how information will be gathered to justify any unannounced inspections – specifically in cases of whistleblowing where it's vital to ensure claims can be legitimately corroborated.

"We've raised our concerns directly with the Chief Dental Officer. Any practices will need support following an unannounced practice visit. DPAs are placed in a difficult position, as part of the inspection team, but also providing support to the practice in delivering any changes to clinical practice following that inspection. While these changes are now enshrined in the new revised NHS (General Dental Services) (Scotland) Regulations, there remain several practical and operational issues which Scottish Government must resolve."

ABOVE: The event, which attracted more than 300, was a huge success

PEER ASSISTED LEARNING EVENT AT GLASGOW UNIVERSITY

More than 300 undergraduates from across Scotland and the UK attended the largest peer-assisted dental learning project in the UK recently.

Held at the Wolfson Medical School Building at the University of Glasgow, the BDS Undergraduate Conference saw two days of revision presentations, mock-practical sessions and a mock exam as well as a trade show featuring 10 companies and organisations.

Led by final year Glasgow student Abdulwahab Aslam-Pervez and supported by an organising committee, the event provided an opportunity for students to support each other and to learn collaboratively under the guidance of senior students.

Abdulwahab said: "Dental students delivered presentations on various topics, creating a forum of interactive learning. The revision materials were fully quality assured and covered a wide array of topics including orthodontics, paediatrics, human diseases, oral medicine and oral surgery, to name a few. The committee strived to provide a well-supported, structured and friendly environment in which students could discuss and explore topics to consolidate their learning.

"The conference was a huge success and feedback was conclusive that students valued the experience and were eager to register for next year.

"The aim is to open the event to more dental students and enhance learning through further teaching modalities."

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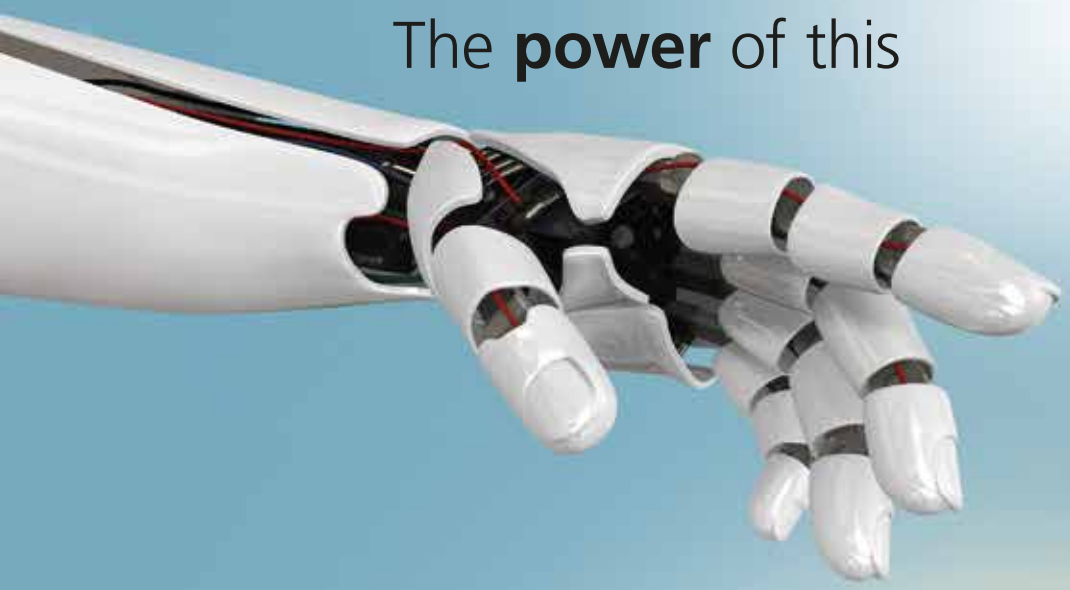

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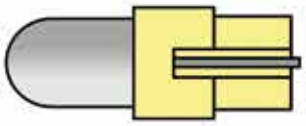

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PROGRAMME ACHIEVES A NOTABLE FIRST

SDCEP receives NICE accreditation

The Scottish Dental Clinical Effectiveness Programme (SDCEP) has become the first dental initiative to receive accreditation from the National Institute for Health and Care Excellence (NICE).

NICE accreditation signifies independent recognition of the rigorous, high-quality process that SDCEP uses to produce guidance. It aims to "help health and social care professionals identify the most robustly produced guidance available, enabling them to deliver high-quality care".

Caroline Lamb, chief executive of NES, said: "The SDCEP team is to be congratulated on achieving NICE accreditation. This is an excellent example of one of the many high-quality initiatives delivered by NES that inform and develop the healthcare workforce in Scotland and beyond to enhance patient care."

Professor Martin Underwood, chair of the NICE Accreditation Advisory Committee, said: "I am delighted to congratulate the programme on this achievement. The process used to produce the dental clinical guidance is systematic and transparent, with consideration of the strength of the evidence and benefits, risks and side effects."

According to SDCEP director Professor Jan Clarkson, the programme's partnership with Translation Research in a Dental Setting (TRiaDS) – also part of NHS Education for Scotland – has been crucial to ultimately securing accreditation.

TRiaDS helps identify stakeholder views, current practice and potential barriers to implementation of guidance recommendations. It also informs, designs and tests theoretically guided interventions to promote guidance implementation.

"We are delighted to have successfully achieved NICE accreditation," Professor Clarkson said.

"This is not only recognition of the high-quality guidance that SDCEP provides to improve patient care but also testament to TRiaDS' invaluable contribution to support its translation into everyday practice."

GDC CHIEF EXECUTIVE IS CONFIRMED

Ian Brack has been officially confirmed as the new permanent chief executive and registrar of the GDC.

Brack, who has held the post on an interim basis since January, officially took up the permanent post on 16 May. He said: "I am extremely pleased to be joining the GDC on a permanent basis. I have been struck by the commitment, dedication and enthusiasm I have witnessed at the GDC and how hard staff work to ensure we ultimately achieve our mission of protecting patients.

"I am committed to helping the GDC to rebuild trust with patients, the professions we regulate and our partners. We will do this by achieving the ambitions set out in our three-year road map, Patients, Professions, Partners and Performance. I am very much looking forward to working with colleagues to achieving this."

DENPLAN LAUNCHES NEW NATIONAL HYGIENE PLAN

Denplan, the UK's leading dental payment plan specialist, has announced plans to roll out its new hygiene plan nationwide. Denplan's Hygiene Plan supports dental practices aiming to increase their income from private hygiene treatments and allows patients to spread the cost of dental hygiene treatments with a hygienist at a practice.

Chris Mackenzie, customer and product strategy manager at Denplan, said: "Hygiene Plan will help patients enjoy that 'just cleaned' feeling without having to worry about the cost.

"By using hygiene plan, practices can eliminate unwanted white space from the diary, generate additional income [and] enjoy the benefit of a more regular private hygiene income with patients that are likely to attend more regularly."

The plan is priced for practices with a patient administration fee of £1 per patient per month.

STUDENTS DESIGN WORKSHOPS TO RAISE AWARENESS

Students from the University of Dundee School of Dentistry have had their work with socially-excluded groups recognised by a panel of expert judges.

The fourth-year students designed workshops to raise awareness of dental health and oral hygiene among marginalised groups such as people with mental health problems, learning disabilities, those experiencing homelessness and the elderly.

The workshops were an important step towards the goal of the overall project to identify and address the barriers preventing people from maintaining good oral health.

The winning group worked together with The Willow Centre, a drop-in service set up by the Dundee Association for Mental Health, to identify dental anxiety as the biggest factor preventing good oral health among the service users. They then designed a series of five workshops to educate service users on the importance of proper dental health and instil a sense of confidence and comfort with dental care over time.

Michael Young, a member of the winning group, said: "Being able to spend time at the Willow Centre talking to the service users was a rewarding and insightful opportunity. It was a privilege to visit the centre and our whole group learned so much as a result."

Dr. Sucharita Nanjappa, lecturer in Dental Public Health, said: "The Dental Public Health Programme provides a platform for students to not only apply their knowledge but also to interact with those experiencing complex needs, thus increasing the students' awareness of health inequality in the Tayside area."

SCOTTISH CHARITY ATTENDS GLOBAL CANCER FORUM

Trustees from Let's Talk About Mouth Cancer take part in inaugural event in New York

Five trustees from Scottish dental charity Let's Talk About Mouth Cancer attended the inaugural Global Cancer Forum in New York recently.

The event, which was held at the Kimmel Centre at New York University, saw 200 delegates from 33 countries come together to work on reducing the global oral cancer burden which claims the lives of 150,000 people each year.

The five trustees who attended the forum were convenor Niall Mc Goldrick, Dental Core Trainee 2, Oral and Maxillofacial Surgery, Queen Elizabeth Hospital; secretary Stephanie Sammut, Consultant Oral Surgeon, Dundee Dental Hospital; treasurer Ewan MacKessack-Leitch, General Dental Practitioner, Fife; research lead Orna Ni Choileain,

Dental Core Trainee 2, Oral and Maxillofacial Surgery, Forth Valley Royal; and policy advisor Professor Victor Lopes, Consultant Maxillofacial Surgeon, Edinburgh DentalInstitute.

Two of the trustees of the Scottish charity, Niall and Orna, submitted poster presentations at the forum detailing the findings from the Let's Talk About Mouth Cancer public awareness and empowerment campaigns delivered in Edinburgh and Dundee. These were well received and garnered interest from delegates of various backgrounds and nationality.

The two-day forum covered topics designed to "highlight gaps and innovations in prevention, patient care, technology, and services across the oral cancer continuum" with the aim of instigating changes to turn the tide on oral cancer. The programme included sessions of strong resonance to the charity's work including: assessing the current global disease profile, the efficacy of oral cancer screening and the role of public policy and not-for-profit organisations.

Ewan said: "The take-home message for the team was the importance of advocacy to politicians, health authorities and health professionals to make mouth cancer prevention, detection and early referral a priority. The next steps for the charity – which has already had success in promoting mouth cancer awareness in Scotland – will aim to meet these challenges and report back to the next GOCF provisionally scheduled for two years' time."

As a charity, Let's Talk About Mouth Cancer relies on donations and sponsorship. If you would like to know more, please visit www.letstalkaboutmouthcancer.co.uk or e-mail letstalkaboutmouthcancer@gmail.com

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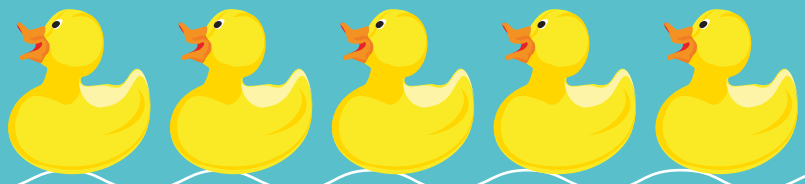

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BDA'S FIVE-POINT PLAN FOR BETTER ORAL HEALTHCARE

Scottish Government urged to make a stand against 'oral disease epidemic'

The new Scottish Government needs to place a higher priority on fighting Scotland's "oral disease epidemic", according to the BDA in Scotland.

The association revealed details of its oral health manifesto ahead of the Scottish Parliament elections. It has called on the new SNP Government to work on raising awareness of oral cancer through better public dental education on the signs and symptoms.

The BDA's five-point plan for improving oral health also calls for an extension to Childsmile, creating a more transparent NHS payment system, extending provision to care home patients and putting cost-effective oral health measures around sugar and targeted fluoridation.

The chair of the BDA's Scottish Council, Adrian Hart, said: "We are facing an oral disease epidemic, and the next government has to decide whether it's willing to step up and make a stand.

"Scotland has been topping the league tables on oral cancer. If spotted early survival rates can reach 90 per cent, but delay is costing lives. The government has to ensure the shortage of oral surgeons is addressed, and that the public are fully aware of the risks. We need a plan on education, prevention and diagnosis.

"Recent governments have been pioneers in prevention. Childsmile has brought down decay, but it's not right that a child growing up in a poorer part of Scotland is still over 20 per cent more likely to end up with visible decay than one born in an affluent area.

"The initiative is currently saving baby teeth, and a fortune in treatment costs. Extending this scheme to cover 5-12-year-olds means we can start saving permanent teeth and take more pressure off a cash strapped service.

"Every year over 7,000 patients are diagnosed with dementia, and officials can't let their oral care remain an afterthought. We need to get patients in care homes registered with dentists so they can get the expert care they deserve."

The BDA manifesto for the 2016 Scottish Elections is available to download www.bda.org/scotland2016

NOW TRENDING

29%

Less than one in three people show their teeth in photographs due to poor oral health

* Oral Health Foundation

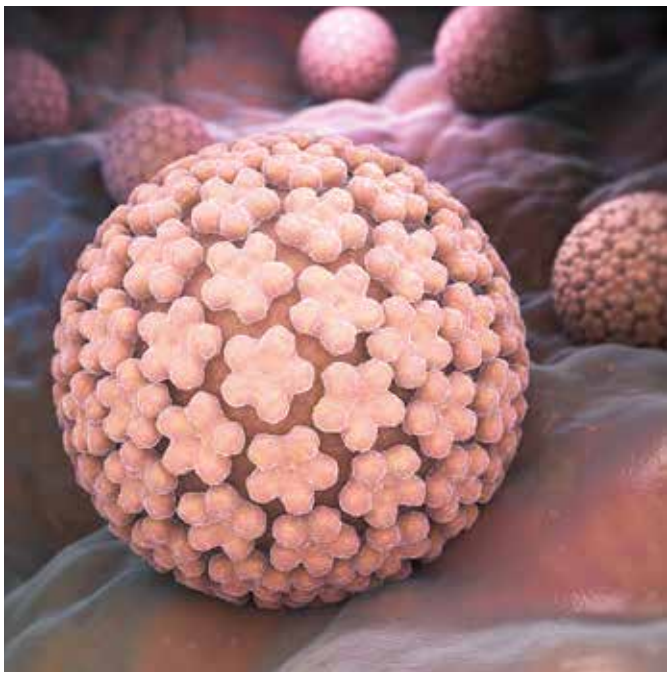
MIXED AND NHS PRACTICE VALUES CONTINUE TO SOAR

The National Association of Special Dental Accountants and Lawyers put to rest fears of an impending downturn with a new study that shows practice sales as a percentage of goodwill continue to increase, particularly in the NHS and mixed sectors.

The average goodwill value for practices being sold with an NHS contract is 153 per cent of turnover, up from 140 per cent in the previous quarter. Mixed practices have seen the average goodwill rise from 104 per cent to 123 per cent in only nine months.

Michael Royden, Partner and Head of Dental Team at Thorntons Law LLP, said: "Goodwill values as a percentage of turnover are around 10 per cent behind England and Wales overall, but we are seeing a very strong practice sales market."

DENTISTS CALL FOR INCREASED ACTION AGAINST HPV



The British Dental Association (BDA) has called on the profession to lend its support to gender-neutral vaccinations for the human papillomavirus (HPV), a virus that is the cause of numerous diseases, including cervical and oral cancer. The National Cancer Institute estimates it is responsible for 5 per cent of all cancer cases.

The BDA is one of 44 organisations supporting the HPV Action Coalition, a movement looking to see the current UK vaccination programme for girls extended to include all adolescent boys.

The coalition used 'crowdspeaking' platform Thunderclap – which gathers the support of advocates before releasing one message across potentially thousands of social media accounts at once to gain recognition, boosting reach and engagement – to mark European Immunisation Week in April.

Russ Ladwa, chair of the BDA's Health and Science Committee, said: "The condition is now the tenth most common cancer among men and government can and should be doing more to prevent the condition. We were proud to support HPV Action's fight for the UK vaccination programme for girls to include all adolescent boys. The failure to provide a gender-neutral programme is unfair to boys and is costing lives. It's vital health professionals speak with one voice on this life-and-death issue."

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SALDC LATEST

A year after being reconvened at the 2015 Scottish LDC Conference, the SALDC is setting out its aims to work for the profession

The Scottish Association of LDCs (SALDC) was established in the 1990s in order to facilitate a better cooperation between Scottish LDCs. This led to the first Conference of Scottish LDCs, which was held at the Ingliston Conference Centre in Edinburgh.

Prior to this, the only regular dialogue between Scottish LDCs was at the annual UK Conference of LDCs, held in London. Needless to say, this presented only a very limited opportunity to debate Scottish affairs. The Scottish Conference immediately became a very valuable annual event. It has continued to be efficiently serviced by the BDA Scottish office and so the decision was subsequently made to formally place the SALDC in abeyance.

However, with the current changing dento-political atmosphere, the decision was made, by the 2015 Conference, to revive the dormant SALDC, so as to further the collective drive of the Scottish LDCs.

The Council met for the first time in August 2015. Each LDC may send two representatives to the Council.

We realised that stress is massively impacting upon the profession, and sent a survey about this out through participating LDCs – the results have been published in this magazine. As a consequence, Viv Binnie, senior clinical teacher at GDH, will start training in coping with stress for undergraduates. It is hoped it will be rolled out to VDPs and eventually the wider profession.

SALDC Council has met with Hew Mathewson, chair of SDPB, and Martin Morrison, assistant director of PSD. We also aim to meet with the GDC, BDA and CDO. We want to keep our doors open and listen to the profession, and those who have an impact on the profession. We want to work together to improve dentistry for patients, and for dentists.

The SALDC website will be launched later this year. We hope to have a registration process via GDC number so we can disseminate information to the profession, and will let dentists know via their LDCs and *Scottish Dental* magazine when this is launched.

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In depth

ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

SHOW STOPPER

2016 EVENT EXCEEDS EXPECTATIONS

See page 28

SCIENCE THAT MAKES A MATERIAL DIFFERENCE

IN HIS CUTTING-EDGE LABORATORY AT DUNDEE DENTAL SCHOOL, PROFESSOR GRAHAM CHADWICK PURSUES HIS GROUNDBREAKING RESEARCH IN A SPECIALITY THAT IS MAKING A BIG IMPRESSION ON STUDENTS

BRUCE OXLEY MARK K JACKSON

When Professor Graham Chadwick joined Dundee Dental School 26 years ago, the world was a very different place. This was the year Nelson Mandela was released from prison and Margaret Thatcher resigned; it was also the year Tim Berners-Lee created the first web server to lay the foundations of the world wide web.

In terms of the dental world, things have certainly moved on radically since then as well, specifically in terms of the materials that are used and how they are tested.

The son of a Carlisle dentist, Graham followed in his father's footsteps and studied dentistry at Newcastle, graduating in 1985. His interest in dental materials was inspired by his materials science lecturer John McCabe, now emeritus professor at Newcastle. Graham said that he was one of the few who took an interest in the subject as it was not seen as "stimulating" as other areas. He said: "I think this view is a bit of a shame because materials science is the pharmacology of dentistry. If you make wrong choices about materials and their application, you get in to trouble, so it's actually very, very important."

After graduation, Prof Chadwick moved into a full-time research role in dental materials at Newcastle, focusing on 3D measurement of new posterior composites. The techniques and collaborations applied in his PhD research would be used later to measure dental erosion. Full-time materials science research posts were rare in the late 1980s but Graham became the first recipient of the Tregarthen Research Studentship which helped fund his research activities.

During this time he also did a locum at his father's Carlisle practice as well as some sessions in a practice in Newcastle, before undertaking hospital jobs in Newcastle for a couple of years after being awarded his PhD in 1988.

Graham explained that, while he saw a career in research and was keen to continue his interest in materials science, he says it was important to continue his clinical work as well. He said: "All that I do is influenced by my experiences as a practising dentist so I'm not just a lab-based person. I think if you're just a lab-based person you get out of touch with what's actually going on, so clinical work is important. Clinical work will occasionally flag up issues about materials, stimulating laboratory investigation that hopefully gives answers to improve the situation."

> "I THINK IF YOU ARE JUST A LAB-BASED PERSON YOU GET OUT OF TOUCH WITH WHAT IS GOING ON, SO CLINICAL WORK IS IMPORTANT"
>
> PROFESSOR GRAHAM CHADWICK

It was at this point that Graham came up to Dundee, initially as a lecturer in conservative dentistry. He was promoted to senior lecturer in 1999 and in 2012 to the post of Professor of Operative Dentistry and Dental Material Science (personal chair).

He explained that Dundee has a significant historical pedigree in dental materials, firstly in the form of the late John Anderson who is believed to have penned the first key textbook on dental materials for dental students.

And Graham's predecessor in the role was Dr Charles Lloyd, a world authority on fracture toughness in resin composites, who did a lot of work on the International Standards scene and introduced him to the area himself.

Graham currently participates on a number of committees looking at International Standards, including filling and orthodontic materials (CH101/1) and prosthodontic materials (CH106/2). He

A world authority in materials science, Professor Graham Chadwick says that all that he does is influenced by his experiences as a practising dentist

also represents the UK as principal expert at ISO for ceramics, cements with adhesive components, polymer-based restorative materials, impression materials and CD CAM.

THE DUNDEE DENTAL MATERIALS LABORATORY

The materials laboratory at Dundee Dental School is situated right at the top of the building at Park Place and was refurbished three years ago to Graham's precise specifications. The lab focuses upon the aetiology and prevention of dental erosion and the performance of the materials used to treat this condition. The lab supports undergraduate materials teaching, the Dundee-taught masters course in prosthodontics as well as those undertaking research for higher degrees.

Filled with an array of machines, both mechanical and digital, the laboratory is able to test the hardness, toughness and durability of a range of materials and substances. Alongside the computer screens there are a number of pieces of equipment that Graham explained are not in regular use anymore but serve a very important function, such as the valve- driven Instron machine from the 1950s. He explained that the older pieces of equipment actually give students a better idea of what is going on in some cases.

He said: "These older machines provide a more visual means of teaching people how testing equipment works because you can actually feel and see how it works. Whereas when we get on to our more modern pieces of equipment, that in some cases have superseded the ones that we've retained, it's just an electronic box of tricks and it's difficult to see what's actually going on."

And one of the areas that Graham explained he is most proud of is the development of three robots – Romulus, Remus and Hadrian – that measure in vivo tooth wear. Bizarrely, their creation involved a collaboration with an oceanographic surveyor from Australia and engineers in medical physics. Graham met the surveyor, Dr Harvey Mitchell, during his time at Newcastle when Mitchell was across from the University of Newcastle in New South Wales. He contacted him again in the late-1990s when he was continuing his research into tooth wear.

He said: "Through Dr Mitchell we devised a system for measuring the wear of these new composite materials. At that time we were placing them on denture teeth in order to make replicas readily and they were photographed down a microscope in stereo. He taught me to use an old-fashioned Second World War stereo comparator – big plates and wheels in a dark room where we could data log and fly something called a floating mark about on the surface, so that was in essence 3D measuring. Although rather crude."

The development of these robots was

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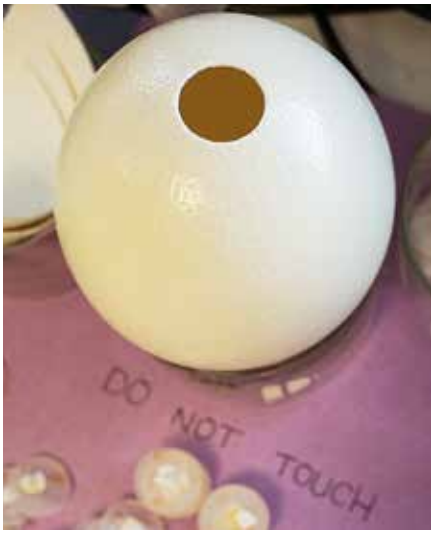
state of the art in the late 90s and produced an early form of "DIY CAD/CAM". Graham continued: "I think the development of Romulus, Remus and Hadrian has to be one of the proudest moments in my time at Dundee. Their findings challenged the assertion that erosion was cause and effect and indicated that individual susceptibility played a major role."

More recently, erosion research has led to the development of an artificial mouth model called Saltus which, following the Roman theme, is named after the Roman garrison town near where PhD student Abubaker Qutieshat is from originally. Earlier this year the model won the European Federation of Conservative Dentistry Merit Award for its ability to mimic the interaction of saliva and the dental substrate during the process of consuming an erosive beverage.

And, due to the difficulties in sourcing human teeth for use in the laboratory, Graham and Abubaker have managed to find quite an unusual tooth substitute, namely ostrich eggshell. He explained: "Our initial results, because we're still in the early days yet, indicate that it is quite good. It is also very thick, so from a little square that we might cut out of it we have a lot of mileage for the erosion research."

Graham explained that, unlike human teeth where the red tape needed to source is prohibitive, the ostrich eggs can be easily bought quite cheaply on Amazon. He said: "When we started the work on the artificial mouth we envisaged we'd get through a lot and we actually haven't even got through one because they're so big!

"We would envisage this substrate as a preliminary screener reserving scarce tooth tissue to more detailed testing of promising drink formulations."



ABOVE: Ostrich eggshell is used as an unusual tooth substitute in the materials laboratory

THE NEXT GENERATION

Dental students at Dundee get their first taste of the materials lab in first year and Graham believes these practical lessons are important to supporting their undergraduate tuition.

"First-year students, who haven't met patients yet, will do practicals on impression materials and they'll come in to use some of the testing equipment in here to find out about the properties of those materials that they've been taught about in lectures," he said.

"I think the students appreciate this because, certainly in the early years of the undergraduate programme, they can feel that there's a lot of science and they're looking to translate that to the chair side."

And, in their final year, Graham explained another initiative in the dental materials course, the Dental Materials Den, which has really brought the subject alive for students. The final years are separated into small discussion groups and are tasked with developing a new (theoretical) material. They take an existing material and they have to give it a novel tweak before presenting their idea to their peers and a sceptical panel of judges including a sales rep and scientific rep from a dental company.

He said: "It brings materials alive and that's the point really. The students actually do get genuinely excited about materials which is a good thing.

"They participate in arguing and questioning their peers with sensible scientific questions, which is good because it all feeds back into the learning process."

Graham explained that while one might expect there to be a lot of funded research going on in the dental materials field, the number of pure dental funded research projects is very small. Most of it is done at company level but he believes the clinical academic and the GDP still have roles to play.

He said: "Even today products will come onto the market but, although they might comply with a standard, there may well be issues. A clinical academic or a GDP can sometimes spot something and it has been known for products on the market to suddenly come off the market because someone with a box of materials has found something new and surprising, and tested it in a different way."

SCOTTISH DENTAL SHOW 2016

RECORD-BREAKING DENTAL SHOW

MORE DELEGATES, MORE SPEAKERS AND MORE EXHIBITORS MEANT THE 2016 SHOW WAS THE BIGGEST AND BEST SO FAR

BRUCE OXLEY MIKE WILKINSON

Nearly 2,000 people were welcomed through the doors at the 2016 Scottish Dental Show as the biggest dental event in Scotland continued to break records.

The 2016 Show, held for the third year at Braehead Arena in Glasgow, saw a 23 per cent increase in delegate numbers from last year with record numbers at the lecture sessions as well.

Two speaker sessions, Laura Wilson's infection control and decontamination update and Christine Park's child protection lecture, saw crowds of more than 300 attend and five other sessions, including Prof Mike Lewis's two-part mouth cancer presentation, attracted more than 200 delegates.

There were then three lectures that broke the 100-delegate barrier, including Ian Robertson's resuscitation guidelines update, Aubrey Craig from MDDUS's 'Once more unto the bleach' talk and Professor Tim Newton's presentation on managing stress in practice.

All in there were nearly 50 lectures and hands-on workshops at the event, providing up to nine hours of verifiable CPD including 10 sessions of core CPD.

The workshops at the show covered everything from implants and extractions with Philip Friel to BLS with Lezley Ann Walker and Liz Webster from Glasgow Dental School. We also had hands-on composite workshops with Arshad Ali from the Scottish Centre for Excellence in Dentistry and Professor Brian Millar from King's College London.

The trade show was also the busiest yet with more than 140 stands, featuring some of the biggest names in the dental industry. Dentsply Sirona, who hosted a series of workshops on the trade show floor, won the Best Stand Award which was presented by *Scottish Dental's* sales and events manager Ann Craib.

The 2016 show was supported by 10 fantastic sponsors – Leca Dental Laboratory (Diamond), DTS (Platinum), The Dental Directory (Gold), Dentsply Sirona (Silver), A-dec (Bronze), MDDUS (Media) and four Associate Sponsors – AWB Textiles, Barry Packaging, {my}dentist and Coltene.

Ann Craib said: "Without our sponsors and exhibitors this show wouldn't have got off the ground five years ago. With the support of the dental industry in Scotland we have managed to grow the event to become the biggest dental event of its kind in Scotland.

"I'm already taking bookings for next year's show and I'm delighted to say that I've already sold more than 80 stands in the 2017 exhibition."

As well as the Best Stand Award, intu Braehead presented a £500 shopping voucher to dentist Sam Lockhart from Enhance Dental in East Kilbride and Andrea Stevenson, a dental nurse from Kingsport Dental Clinic in Livingston, won the iPad in our registration prize draw.

Planning is already well under way for the 2017 show, which will return to Braehead Arena on 19 and 20 May. If you haven't already done so, please complete the online feedback questionnaire which you will find in your CPD certificate email. We rely on your feedback to help us shape the show and keep giving the Sottish dental community the great show it deserves.

Sam Lockhart picks up his £500 intu Braehead voucher

Ann Craib (left) presents Dentsply Sirona's Diane Wales with the Best Stand Award

Professor Mike Lewis' two lectures saw more than 260 people in attendance

The Dental Directory team with the 2016 show hashtag

Stephen Henderson from Dental Protection

Philip Friel's atraumatic extraction and implant placement workshop

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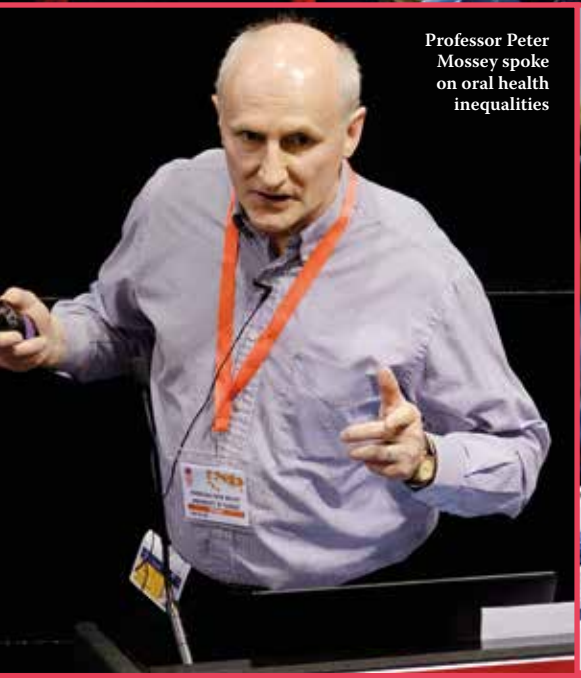
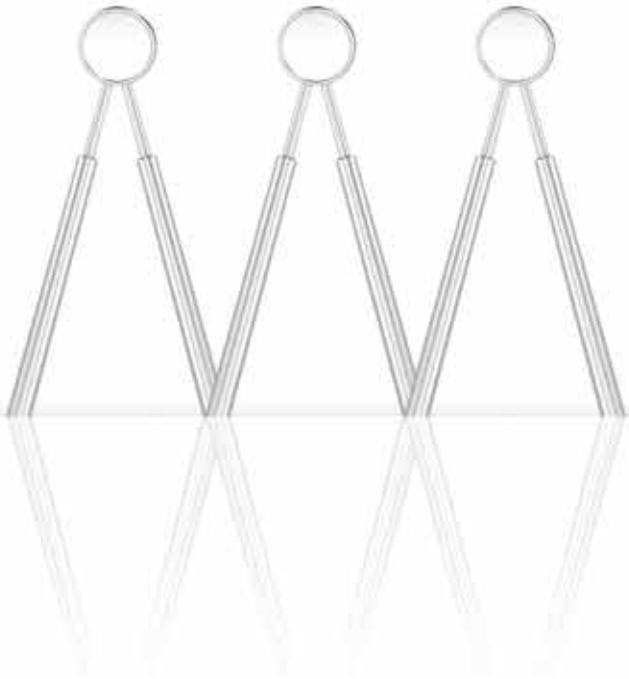
Adam Morgan hosting his communication workshop



Professor Peter Mossey spoke on oral health inequalities



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SCOTTISH DENTAL AWARDS 2016

ALL SMILES

THE FOURTH SCOTTISH DENTAL AWARDS WAS A REAL CELEBRATION OF ALL THAT IS GREAT ABOUT SCOTTISH DENTISTRY

BRUCE OXLEY MIKE WILKINSON

Hugh Harvie, Dental Protection's former head of dental services in Scotland, picked up the lifetime achievement award on Friday 13 May at the fourth annual Scottish Dental Awards.

The event, which was hosted by Carol Smillie at the Glasgow Hilton Hotel, saw nearly 450 guests celebrate the great and the good of Scottish dentistry.

Harvie proved to be an immensely popular choice for the final award of the night after a 40-year career as a general dentist and lecturer before moving into the dento-legal world first as a dental adviser with MDDUS and then, in 2009, being appointed head of dental services in Scotland for Dental Protection.

Elsewhere it was a good night for Glasgow dentists as many of the main awards were awarded to west coast practices and practitioners. Whitecart Dental Care in Cathcart was named Practice of the Year, Colin Burns of mydentist Crow Road was named Dentist of the Year and Glasgow-based dental lab Porter Boyes won Laboratory of the Year.

Glasgow Southside Orthodontics' Fern Stewart and Nadia Hajjaj were named Employers of the Year and CDC Products – which is owned and run by dentists Clive Schmulian and Stuart Davidson and is headquartered on St Vincent Street – won the Business Excellence Award. Donella MacLennan, practice manager at the Peppermint Group which has practices on Bath Street in Glasgow as well as Maryhill and Chapelhall, won the Business Manager/Administrator of the Year award.

Moving further afield, Alan Macleod of Greenlaw Dental Practice in Newton Mearns picked up the Young Dentist Award, Gemma Furlong a dental nurse from Grays Dental Practice in Cambuslang was the Unsung Hero award winner, the Dental Team Award was won by Lockerbie Dental and Linda McPartlin, a dental nurse at Monklands Hospital, picked up the DCP Star award.

The Community Award was won by Dental Inspirations from Aberdeen, the Style Award by Inverurie Dental Practice, Website of the Year went to Southside Dental Care in Edinburgh and the Scottish Dental Representative Award went to Angela Glasgow from NSK.

A charity raffle held on the night raised nearly £2,600 for Smileawi, a dental charity set up by Dunoon dentists Nigel and Vicky Milne.

The 2017 awards will be held on Friday 19 May. So get ready to start nominating!

SCOTTISH DENTAL AWARDS 2016 WINNERS IN FULL:

- Scottish Dental Representative Award – Angela Glasgow, NSK
- Business Excellence Award – CDC Products, Glasgow
- Style Award – Inverurie Dental Practice
- Website of the Year – Southside Dental Care
- Community Award – Dental Inspirations, Aberdeen
- Business Manager/Administrator of the Year – Donella MacLennan, The Peppermint Group
- DCP Star – Linda McPartlin, Monklands Hospital
- Unsung Hero – Gemma Furlong, Grays Dental Practice, Cambuslang
- Laboratory of the Year – Porter Boyes, Glasgow
- Dental Team Award – Lockerbie Dental, Lockerbie
- Employer of the Year – Fern Stewart and Nadia Hajjaj, Glasgow Southside Orthodontics
- Young Dentist Award – Alan Macleod, Greenlaw Dental Practice, Newton Mearns
- Dentist of the Year – Colin Burns, mydentist Crow Road, Glasgow
- Practice of the Year – Whitecart Dental Care, Glasgow
- Scottish Dental Lifetime Achievement Award 2016 – Hugh Harvie

(Above) Tom Ferris presents Hugh Harvie with the Lifetime Achievement Award, (left) Dental Inspirations win the Community Award, (below) Angela Glasgow (right), winner of the Scottish Dental Representative Award, and (right) Clive Schmulian picks up the Business Excellence award

The Style Award winners Inverurie Dental Practice

DCP Star Linda McPartlin (left) with Donna Morrison of The Dental Directory

Lockerbie Dental won the Dental Team Award, presented by John Laverty from The Dental Directory

Tricia Munro from Strictly Confidental presents Alan Macleod with the Young Dentist Award

Melanie Young accepted Gemma Furlong's Unsung Hero Award

Website of the Year winners Southside Dental Care

April East of PS New Job (left) presents Donella McLennan with the Business Manager/Administrator of the Year award

Employers of the Year Fern Stewart and Nadia Hajjaj

Porter Boyes won the Laboratory of the Year award

Dentist of the Year Colin Burns

Whitecart Dental Care was named Practice of the Year

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NSK'S ANGELA GLASGOW IS NAMED SCOTTISH DENTAL REPRESENTATIVE OF THE YEAR

NSK is delighted to celebrate the success of Angela Glasgow at the Scottish Dental Awards 2016 as she was awarded Scottish Dental Representative of the Year.

Angela, as many of you will know, is NSK's territory manager for Scotland and Ireland and works extremely hard to make sure practices are kept up to date with the latest product developments.

Alexander Breitenbach, NSK's UK managing director, said: "We are all very proud of Angela's achievements and she is a great credit to NSK.

"Angela has worked with us for the past eight years and over this time she has tirelessly supported practices to deliver high-quality dentistry using a range of handpieces and small equipment."

Anne Marie Taylor, hygienist, Saracen Street Dental in Glasgow, said: "The support and service I have received from NSK, in particular Angela, has been amazing, she has really helped us with all our practice needs."

Angela said: "I'm delighted to have won this award, but for me it's always about delivering for the customer. One of the most important aspects of my working day is to make sure we can meet our customers' expectations and I feel there's no other handpiece manufacturer who has got the breadth of product range we have.

"We can supply pretty much anything a practice could possibly need as our range covers oral hygiene, endodontics, surgical, restorative through to minimal intervention and decontamination."

Angela (right) with Scottish Dental's Ann Craib

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ELECTIVE REFLECTIONS

FINAL YEAR GLASGOW DENTAL SCHOOL STUDENTS EVELYN RENNIE AND GABRIELE BANIULYTE TALK ABOUT THEIR RESPECTIVE TRAVELS IN THE USA AND JAPAN, HIGHLIGHTING THE BENEFITS OF OBSERVATIONAL AND RESEARCH-BASED ELECTIVE PROJECTS

For many dental and medical students, it is assumed that the best elective experience can only arise from a "hands-on" project undertaken in a developing country. In recent years, Glasgow Dental School has moved away from students participating in exposure-prone procedures if they are overseas during the elective period. There are several reasons for this, including ethical, safety and educational aspects.

We decided to pursue observational projects outside the UK, with one of us working in the USA and the other in Japan. There are advantages and disadvantages to carrying out elective studies in a developed country. Advantages include increased opportunities for research, comparisons between countries with similar demographics, ability to travel and, possibly, higher assurances of personal safety. On the other hand, dental procedures and research methods may be similar to those at home and with a resultant decrease in exposure to novel clinical procedures.

As we have learned during our dental education, many conditions are multi-system and can first present in the oral cavity. This makes oral medicine a vital component of the dental curriculum. For this reason, we both decided to focus on conditions that have clear manifestations in the mouth. We had yet to encounter these disorders in the UK population, but the prevalence is higher in our countries of choice.

EVELYN – SICKLE CELL DISEASE IN THE USA

I decided to focus my elective project on the dental manifestations of sickle cell disease (SCD). This condition is close to my heart as a large proportion of sufferers are of African or Afro-Caribbean descent. My grandmother is Jamaican, but fortunately no-one in my family carries the sickle cell gene.

> "THIS CONDITION IS CLOSE TO MY HEART AS A LARGE PROPORTION OF SUFFERERS ARE OF AFRICAN OR AFRO-CARIBBEAN DESCENT"
>
> EVELYN RENNIE

SCD affects the whole body, including the oral cavity, and dental manifestations include: severe pain in areas of sickling crisis, increased infection risk, mucosal pallor, delayed eruption of teeth, pulp calcification and necrosis, enamel and dentine defects, osteomyelitis, osteonecrosis and inferior alveolar nerve anaesthesia amongst many others[1,2]. After doing a literature review and discovering the number of oral side-effects these patients can suffer from, I wanted to spend time witnessing treatment in a dental and medical setting.

There is a high prevalence of SCD in the American population, with one in every 500 African-Americans suffering from SCD[3]. For this reason, the USA was a good fit for my elective project. Through well-established links between Glasgow and Charlotte, NC, USA, I arranged a placement in Carolinas Medical Center (CMC) in Charlotte. I was offered a placement for two weeks, during which I could observe both the dental clinic and CMC's dedicated sickle cell centre for the medical treatment of SCD. My time

LEFT: Final year students Evelyn and Gabriele

BOTTOM: Carolinas Medical Center, Charlotte, NC

"OVERALL, I HAD LITTLE STRESS ASSOCIATED WITH THE PLANNING AND EXECUTION OF MY ELECTIVE IN NORTH CAROLINA"

EVELYN RENNIE

spent at CMC was extremely beneficial, as I learned so much about both SCD and dental treatment in general within the healthcare system in the USA.

Staying in Charlotte was an exciting experience, as I had never been to the "Deep South" before. I wasn't sure what to expect, other than the amazing food and the legendary southern hospitality! I found both and more. The people in Charlotte were all extremely friendly and I felt right at home. The city has developed significantly in the last two decades due to an influx of financial institutions and other Fortune 500 businesses settling in the city. It also helped that, while I was there, the weather was a scorching 38 degrees! I wasn't sure what to expect from the city or my placement, but I was pleasantly surprised with both.

While I was in North America, I took the opportunity to travel and spent my time exploring the East Coast, from Toronto, Canada to Miami, Florida. I visited family and existing friends and made new ones. I have created amazing memories on my trip and hope to visit the USA again very soon.

The benefits for me in choosing to do my elective there was that there was a pre-existing relationship between Glasgow and Charlotte, and so there was good communication between myself and the staff at CMC prior to and during my trip. I know that many students had difficulty establishing contacts in other countries for their elective study, or once it had been set up, they had difficulty maintaining communication. I could also guarantee a certain standard of safety for my health, as I was working within a well-established hospital which is affiliated with the University of North Carolina for student placements. Overall, I had little stress associated with the planning and execution of my elective in North Carolina and would recommend it, and the United States, to anyone considering spending their elective there.

GABRIELE – BEHCET'S SYNDROME IN JAPAN

Behcet's syndrome (BS) sparked my interest when it was first mentioned during one of our oral medicine lectures. Initially, a foundation literature review was carried out to find some answers; however, I soon began to realise that this was just the tip of the iceberg. In order to learn more about how to help patients, I had to understand what they have to go through. The manifestations of BS include a wide range of signs and symptoms including oral recurrent aphthous ulceration, fatigue, arthralgia, uveitis, acne-like eruptions, migraine, depression and gastrointestinal symptoms[4,5].

As part of my investigations, I attended the Behcet's Syndrome Society meeting in Liverpool, where it was stated that, in the UK, on average it takes up to 12 years to provide a BS patient with a diagnosis. During this time patients see upwards of six doctors. I found that scenario difficult to comprehend

Currently, Scotland does not have a dedicated centre to manage patients with this syndrome – all patients are seen by hospital physicians and/or have to be referred to a centre of excellence for BS in England. For my elective, I observed the diagnosis and treatment of these patients at the centre in Birmingham. Multidisciplinary clinics, as well as the research department, were visited and it provided a potential blueprint for a Scottish centre of excellence.

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TOP LEFT: Gabriele in front of one of the many majestic castles of Japan

TOP RIGHT: Gabriele swimming off Zamami Island

BOTTOM LEFT: Evelyn and Gabriele at the Royal College of Physicians and Surgeons of Glasgow admissions ceremony collecting an award for their elective projects

BOTTOM RIGHT: Evelyn viewing New York city from the top of the Rockefeller Center

FROM PREVIOUS PAGE>

BS is also known as the "old silk-route disease". It is quite prevalent in Japan, hence why it is leading research in this field[6]. I visited Japan for a total of nine weeks with an observation focus in Minami Tohoku Hospital, Koryama, where I managed to shadow staff in both dentistry and dermatology clinics. Different diagnostic tests were shown and the treatments observed.

Japan is an extremely welcoming country, although unfortunately, a language barrier did exist. However, almost all professors and clinicians can speak English really well, therefore their translation skills for other non-English speaking staff and patients were useful. At the end of my observation period, the conclusions were drawn up and a general comparison produced between the management of BS in Japan and UK.

Once the elective period was over, I had the opportunity to travel around and see more of the country. Japan has an amazing transport system and their "bullet trains" are always on-time, which made getting around really simple. I travelled the main island (Honshu) from top to bottom – Aomori to Yamaguchi. Some time was spent in the big cities, such as Tokyo, Osaka, Kyoto and Hiroshima. However, the main portion of the trip was dedicated to discovering the countryside. One of the highlights of the trip was climbing Mount Fuji and staying in the villages surrounding it. As well as that, I was able to stay in a Buddhist temple in the mountains and learn their methods for meditation and self-recognition first-hand.

I had time to visit a couple of tropical islands, which are near Taiwan geographically but belong to Japan – Okinawa and Zamami. They are world famous for whale watching and diving, both of which are unforgettable experiences.

> "BS IS ALSO KNOWN AS THE 'OLD SILK ROUTE DISEASE'. IT IS QUITE PREVALENT IN JAPAN, HENCE WHY IT IS LEADING RESEARCH IN THIS FIELD"
>
> GABRIELE BANIULYTE

I was truly amazed by how much Japan has to offer. From extremely hospitable people to amazing countryside and delicious sushi, I loved it all and if I had the chance I would do it all over again in an instant.

REFLECTION

This elective period has encouraged us to think outside of the dental curriculum. Overall, our projects have provided us with the opportunity to increase personal knowledge and awareness of our chosen conditions, travel extensively and have given us future research opportunities which can be continued post-graduation. We had unforgettable experiences and would like to thank everyone who contributed to the success of our elective projects.

Our advice to future students contemplating electives without "hands-on" clinical experience would be to not give up on overseas opportunities. Find a topic you are passionate about, review the literature and locate a gap in current knowledge. Decide if your research could benefit this area of dentistry and not overlap the research currently available. If you feel it would be worth pursuing, match your project with the appropriate country and make professional contacts.

Keep being inspired by researching further. Although a research-based elective can be time-consuming and demanding, it will expand your horizons and working abroad is an incredible experience. Immersing yourself in a different culture, language, society or work environment will give you a greater appreciation for dentistry.

By utilising the values promoted by your dental school, you have the opportunity to create a lasting and meaningful relationship between the healthcare institutes. We hope that whatever you choose you enjoy every minute. We definitely did.

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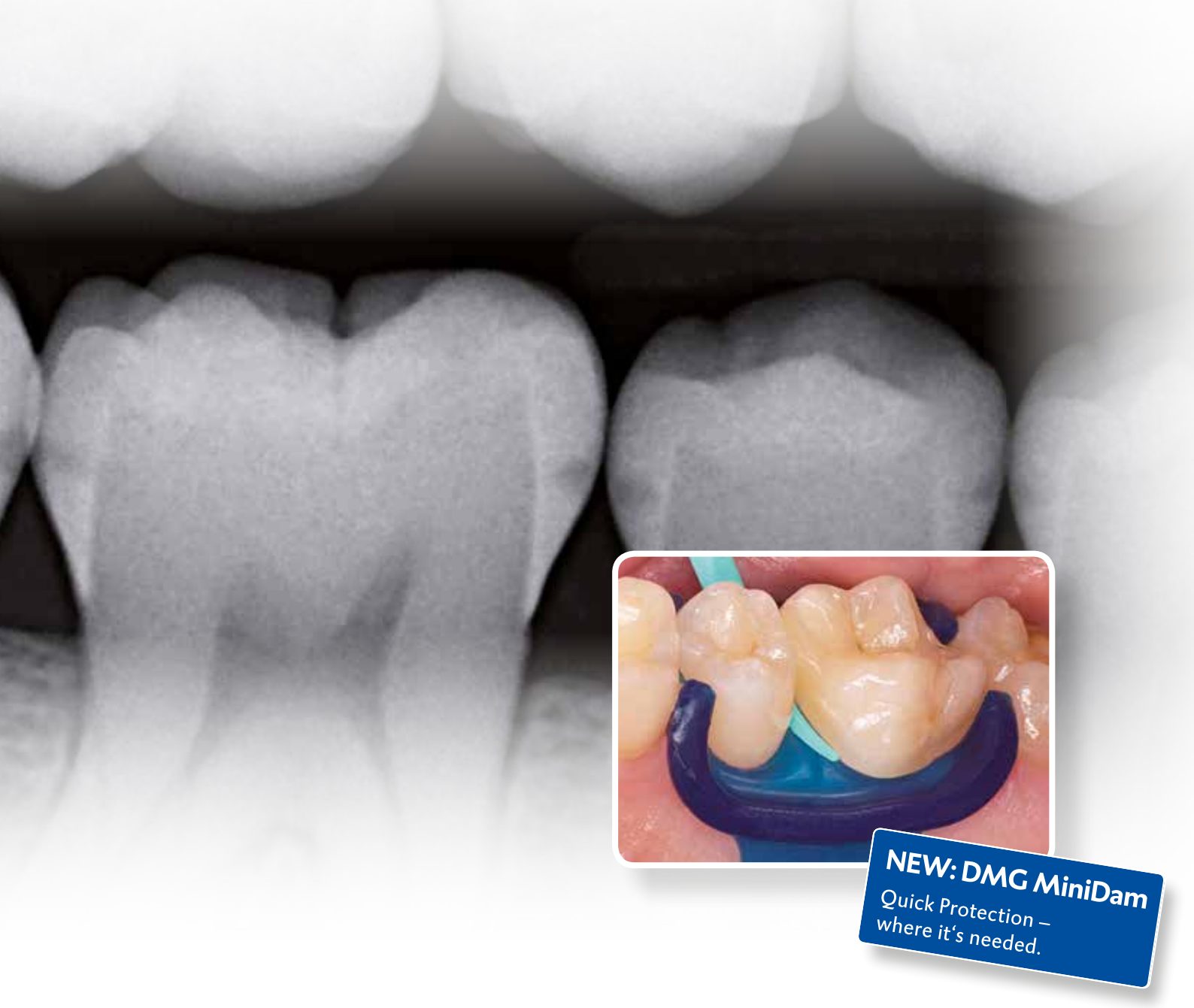

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Clinical

HOW DO DENTISTS VIEW DIRECT ACCESS?

RESEARCH

An attitudinal survey of dental practitioners covered the impact on dental services and clinical competencies of dental hygienists and therapists

MARGARET ROSS AND STEPHEN TURNER

Following a period of consultation and evidence gathering, in May 2013 the General Dental Council (GDC) removed the requirement for patients to be referred by a dentist prior to being seen by a dental hygienist or therapist. Thus, the UK joined a number of other countries in Europe and elsewhere which had developed provision for direct access in one form or another over the last 20 years. [1]

The British Dental Association was opposed to this change [2]. Earlier research by the authors indicated that dentists were concerned about the education, competence and ability of hygienists and therapists to undertake treatments which had been previously viewed as only within the scope of practice of dentists [3]. However, it was unclear how dentists, and particularly general dental practitioners, viewed the reform once it had been implemented and the evidence-base for the decision made public [1 4]. The aims of this study were to investigate the perceptions of a representative sample of dentists on the likely impact of direct access on dental services, the extent to which different procedures were viewed as being within the clinical competence of hygienists and therapists acting autonomously, and possible predictors of such views.

For brevity the terms 'dental hygienists' and 'dental therapists' are used here, although the dental therapists of today are dually qualified in dental hygiene and dental therapy.

I am worried about patients avoiding dentists for years, in favour of hygienists who are unable to diagnose

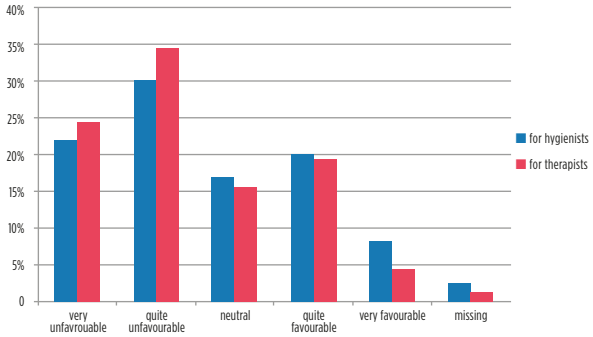
Methods

The sampling frame was based on the UK GDC Register, to which the authors were given access under strict conditions of use and confidentiality. The sample size was calculated on the basis of dentists' likely experience of teamworking, as it was felt that such experience may be an important influence on their views on direct access and issues of clinical competence. It was estimated that approximately 40 per cent of dentists work with a hygienist or therapist. A random sample of 195 was required to reflect this proportion +/- 5 per cent at p=0.05 and 80 per cent power. It was not possible to sample only those working as general dental practitioners or in primary dental care, as this information is not recorded on the GDC register. Data from the GDC register was used to investigate response bias by comparing respondents with non-respondents.

A questionnaire was developed and piloted, covering issues relating to direct patient access to dental hygienists and therapists within the context of their respective scope of practice, including periodontal and preventive treatment, oral health advice, referral for treatment by a dentist and, for therapists, restorative treatment. It also explored the dentist's experience of working and training with these professionals. Most questions used a five-point response scale i.e. 'very negative' to 'very positive', or 'strongly disagree' to 'strongly agree', with space for open-ended comments. The means of values ascribed to items on clinical independent working by hygienists and therapists were computed separately. These summary variables had a range of 1 to 5, with a higher score denoting a more positive view i.e. 'strongly agree' with independent working.

In late February 2014, those practitioners for whom the authors had an email address were sent an email introducing the study which contained a hyperlink unique to that individual through which the online questionnaire could be

FIGURE 1
Dentists' views on the GDC's decision to permit DA (n=159)



accessed [7]. Those without an email address on their GDC record were sent the same information by post. An email reminder to non-respondents was followed by a mailed paper questionnaire sent after the original communication, and a final reminder/thank you email was sent to all 600 included in the original communication.

Results

In total, 159 usable questionnaires were returned, representing a response rate of 27 per cent. There were no significant differences between respondents and non-respondents by gender, UK country of employment, UK vs non-UK dental school attended, specialist status or years since qualification. The 159 respondents included 80 males (50.3 per cent) and 78 females (49.7 per cent). The majority, 125 (78.6 per cent) worked in England, 21 (13.2 per cent) in Scotland, seven (4.4 per cent) in Northern Ireland and four (2.5 per cent) in Wales. One hundred and twenty (75.5 per cent) worked in general dental practice, including 111 (69.8 per cent) with a mixed private/NHS or predominantly NHS patient list. Thirty six (22.6 per cent) were practice owners (63.9 per cent males), while 78 (49.1 per cent) were practice associates (69.2 per cent females).

Experience of teamwork

The majority of dentists had not undergone any joint undergraduate training sessions with dental hygienists or therapists; 16 (10.2 per cent) had trained with hygienists but not therapists, five (3.2 per cent) had trained with therapists but not hygienists, and 13 (8.3 per cent) had trained with both.

With regard to current or past experience of teamworking, 148 (94.2 per cent) had experience of working with a hygienist and 76 (48.5 per cent) had experience of working with a therapist.

Overall view of Direct Access (DA)

Dentists were asked to indicate their overall view of the GDC decision to allow DA to dental hygienists and for therapists, using a five point Likert-type scale ranging from 'very unfavourable' to 'very favourable' (Figure 1).

For both sets of responses, a majority held unfavourable views. However, dentists' views were significantly more unfavourable regarding DA being made available to dental therapists than to hygienists (z=-2.20, p=0.02).

A representative selection of positive and negative comments relating to this overall question are given below and grouped by their general theme.

Positive comments

- Patient benefit (21 comments)
- Re: hygienists (9 comments)

"Because a minority of [the UK population] attend a dentist* and as a nation our oral hygiene is shocking. It stares you in the face every day, all social classes."
Salaried dentist
*In fact in 2012-13 just under half of the adult population had not attended a GDP in the previous two years [8].

"In many cases, this is all the patient needs and it can reduce the time taken by dentists doing scale and polishes and non-surgical periodontal treatment to leave time for other treatment."
Male associate

"Well trained, professional person can see patients easily."
Practice owner

"A dental practice operating with hygienists is ideal. It will cover and provide good general dentistry with hygiene and a solid base for referral for specialists if and when necessary and will serve the population very well."
Senior partner

- Re: Therapists (13 comments)

"Personal experience of how good they are."
Respondent 47, female salaried dentist, qualified 1980

"Highly qualified professionals."
Practice owner

"Workload reduced for dentist."
Practice owner

"Patients can get good basic care at the right time without delay caused during waiting for GDP appointments."
Salaried dentist

Negative comments

- Patient safety (23 comments)
- Re: hygienists (11 comments)

"People will take the easier and cheaper option of visiting the hygienist and believe they have had a dental check-up. Therefore pathology stays undiagnosed."
Practice owner

"I am worried about patients avoiding dentists for years, in favour of hygienists who are unable to diagnose and manage a range of dental diseases."
Associate

"[It] could affect [patient] care with regard to dental issues other than perio, e.g. oral cancer screening/ caries etc."
Associate

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FIGURE 2
Dentists' views of likely impact of DA to hygienists in ten aspects of care (n=155-158: (Chronbach's alpha 0.918)

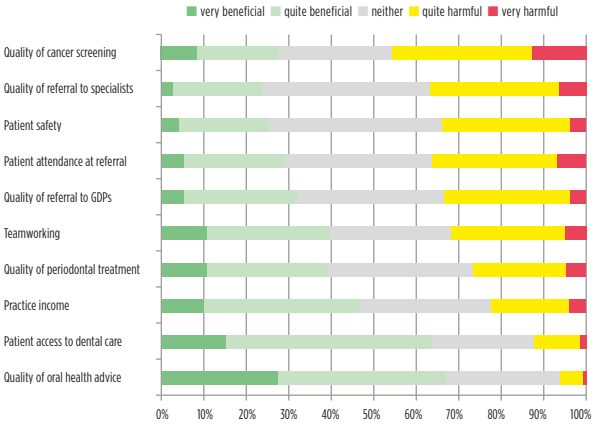
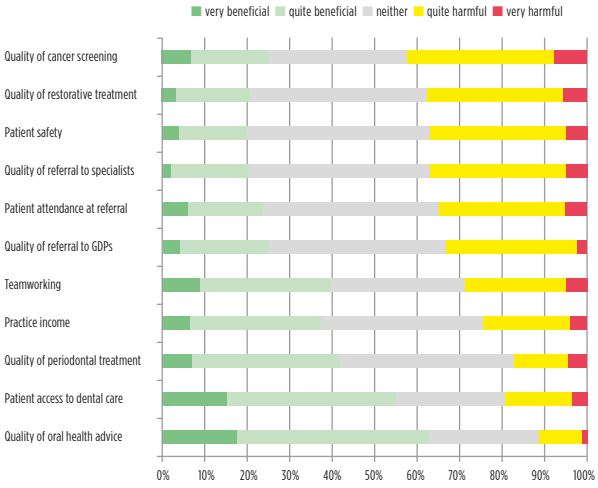


FIGURE 3
Dentists' views of likely impact of DA to therapists in eleven aspects of care (n=155-158: (Chronbach's alpha 0.689)



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"[Patients] may just attend hygienist rather than attending for routine dental appointments which could result in caries."
Associate

● Re: therapists (12 comments)
"I think patients should have a proper exam with a dentist to determine the treatment plan with x-ray if necessary and/or prescribed medication."
Associate

"I think it will confuse patients and put some at risk of being incorrectly diagnosed and treated."
Associate

"To diagnose and carry out restorative treatment with no regular dentist exam may lead to under/over diagnoses going unchecked. At least yearly dentist check-ups to make sure nothing getting missed."
Practice owner

"Patients may be under the false impression they do not need to see their dentist if seen by therapists."
Associate

● Undermining the dentist's role, poor service planning
● Re: hygienists (4 comments)
"I consider this to be a diluting of my profession."
Practice owner

"Patients will be confused by each team member's role."
Salaried dentist

"It's an attempt to meet a need for areas where NHS dental access is poor by providing a service which isn't dentistry. Instead the reasons why dentists left NHS dentistry in these areas should have been addressed."
Associate

"The huge raft of regulations make it quite difficult to run an operation for a hygienist. Possible problem of incentivised referrals to certain professionals. There are no NHS contracts for hygienists so it will all be private."
Associate

● Re: therapists (9 comments)
"The decision making process was pushed through ignoring dentists."
Corporate dentist

"No good evidence to support the decision."
Specialist

"I feel there was nothing wrong with the previous system of patients being seen first by dentist then referred on to the therapist."
Salaried dentist

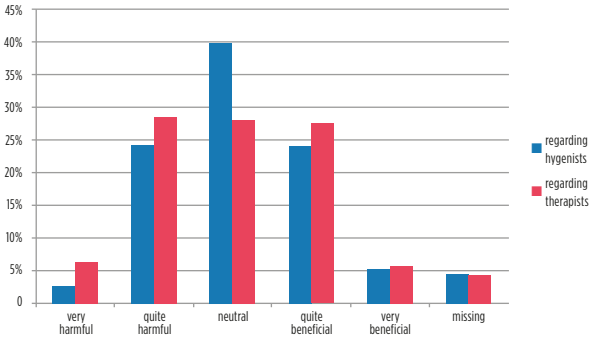
● Cost-cutting (3 comments re: Therapists)
"I feel dentists are being pushed out of the NHS as a cost saving exercise."
Salaried dentist

"Because cost motivates this decision. Not patient welfare."
Practice owner

"They represent the views of government cuts."
Male associate

Figure 2 indicates views on the impact of DA on specific

FIGURE 4
Impact of DA on dentists' workload (n=158, 156)



aspects of dental services in relation to hygienists, ordered by perceptions of the level of benefit, from least beneficial to most beneficial. Figure 3 shows the same information in relation to therapists, with one extra item relating to restorative treatment. The lower Chronbach's alpha score in relation to the items concerning therapists implies a less consistent view of the likely impact of independent working by therapists, with dentists indicating it would be beneficial in some respects and harmful in others.

- Impact on dentists' workload

Views about the potential impact on dentists' workload were equivocal (Figure 4).
The potential benefit was often viewed in terms of more appropriate specialisation of roles.

"Allows us to concentrate on more complex cases, cutting waiting times for such treatments."
Practice owner (re: hygienists)

"Dentists able to see more patients for check ups without time being wasted doing simple restorative treatment."
Salaried dentist (re: therapists)

"Dentists will expect therapist to carry out less well remunerated work to free them up for other treatments."
Practice owner (re: therapists)

"Transfer of focus onto elements of dentistry that dentists may only perform."
Corporate dentist (re: therapists)

- Harm was mainly related to a reduction in workload and therefore income. All eight comments refer to therapists:

"I think GDPs will be pushed out the NHS."
Salaried dentist

"The country has trained enough dentists. If management was optimal, access shouldn't need more providers. The dentists who pump out UDA's without a good level of care will no doubt employ more therapists to reduce their costs, lower their level of care."
Practice owner

"There are already too many dentists treating too few patients, adding more professionals will exacerbate the problem."
Salaried dentist

"They are stealing part of my role and also my income!"
Associate

"Patients will deem that attending a hygienist or therapist is cheaper and so the patients will want the hygienist or therapist to do the same job but cheaper."
Associate

"As they would be cheaper to employ, practice principles (sic) could tend to favour them to do the bulk of the work in order to profit more personally."
Associate

"More providers the same demand."
Practice owner

"Reduce potential for private work."
Associate

Referrals from hygienists and therapists

Dentists were asked for their reaction to the possibility of receiving referrals from hygienists and therapists for treatments that were outwith their scope of practice. Here, respondents were generally favourable to such teamworking (Figure 5).

Clinical competence and DA

A series of questions investigated dentists' views on the clinical competence of hygienists and therapists to work without a prescription from a dentist (Figure 6).

A substantial majority expressed concerns. There was no significant difference between the two sets of responses (z=-1.47, p=0.14 (n.s.) excluding 'can't say' responses).

More detail on the nature of such concerns was sought by asking the extent to which dentists agreed or disagreed with hygienists and therapists being permitted to undertake a range of procedures. Figures 7 and 8 illustrate their responses, ordered by level of agreement, which is shown in green.

FIGURE 5
Dentists' views on receiving referrals from a hygienist or therapist for treatments outwith their scope of practice. n=159

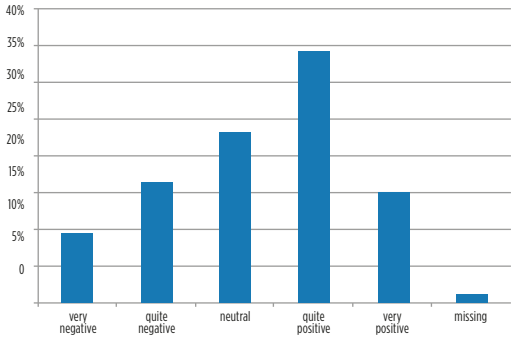
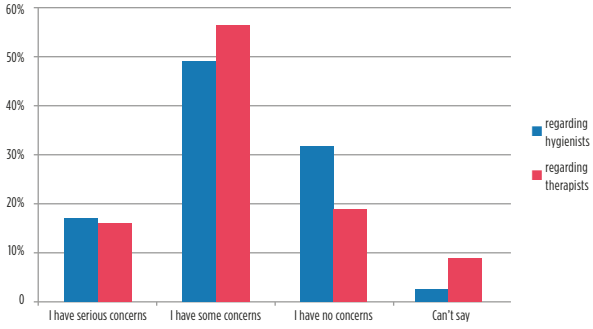


FIGURE 6
Overall concerns regarding clinical competence to practice without a dentist's prescription (n=156, 159)



NHS list/performer numbers

At present NHS list numbers are restricted to dentists. Only 20 (12.7 per cent) agreed that they should be de-restricted while 95 (60.1 per cent) disagreed and 43 (27.2 per cent) were unsure. Comments made by the first group mainly emphasised widening patient access to treatment and greater division of labour, and the

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cost savings this could bring. Comments by those in the second group covered three main themes: quality of care, dentists' role as the mainstay of dental care, and workforce issues.

Predictors of polarity of views on DA

The two variables summarising dentists' views on clinical independent working had a mean of 3.08, sd 0.94, n=156 for hygienist-performed treatments, and 2.99, sd 0.92, n=156 for therapists. The two scores correlated at r=0.66, p=0.001, n=156. The only significant association found was between GDS status and views on DA for therapists. The 44 practice owners and senior partners tended to have a more positive view of therapists working without a dentist's prescription than did the 77 associates (mean 3.32 vs mean 2.89, p=0.037, with Bonferroni correction).

Discussion

The overall response rate to the survey was poor (27 per cent), but perhaps not atypical. For example, a recent survey of UK General Dental Practitioners (GDPs) achieved a response rate of 31 per cent [9]. Pressure of work, office policy, and frequent requests to complete commercial surveys have been cited as reasons for poor response rates amongst dentists [10]. While methodological reviews suggest features such as brevity or incentives may increase response rates [11], this may not be the case for surveys of dentists [12], [13].

Low response raises the possibility of response bias and threats to the validity and generalisability of the findings. However it has been argued that non-response is a source of error only if responders and non-responders differ in crucial ways [14], [15]. There was no response bias in regard to gender, UK country of employment, UK/non-UK dental school attended, specialist status, or years since qualification. Experience of team-working was similar to the level indicated by published GDC statistics. However this does not necessarily mean that responders and non-responders were similar in relevant attitudes and beliefs, and that non-responders were 'missing at random' [14]. The findings of the study should therefore be interpreted with caution.

As Figures 2 and 3 show, dentists' views on the impact of more independent clinical working varied considerably. For 'traditional' hygienist and therapist activities, positive responses tended to outnumber negative ones, and, taken with the considerable numbers of neutral responses, indicate that most dentists were either favourable or impartial regarding the implications of the DA reform. However, this was not true for procedures often seen as within the dentist's sole remit. Referral decisions, risk assessment, diagnosis and treatment planning, and, for therapists, restorations, were felt by a majority to be inappropriate treatments to be undertaken without a dentist's prescription (Figures 7 and 8).

Attitudes regarding hygienists and therapists performing a range of treatments without a dentist's prescription were difficult to predict. Gender, years since qualification, sector of employment and, perhaps most surprisingly,

It allows us to concentrate on more complex cases, cutting waiting times for treatments

FIGURE 7
Dentists' views on hygienists undertaking a selection of procedures without a dentist's prescription (n=157: (Chronbach's alpha 0.666)

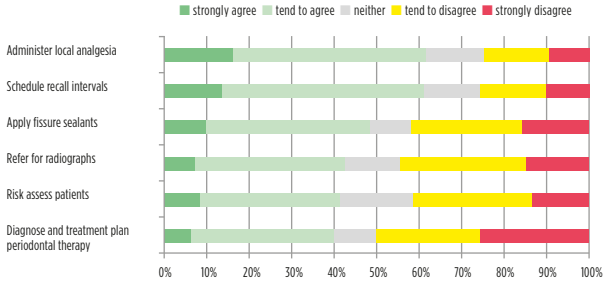
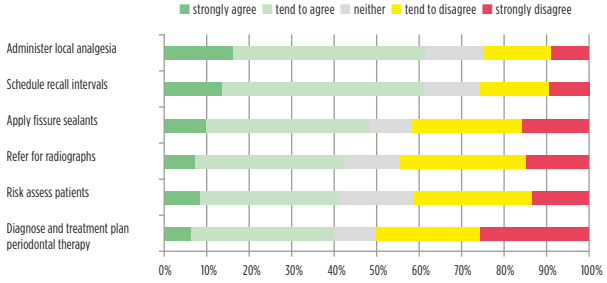


FIGURE 8
Dentists' views on therapists undertaking a selection of procedures without a dentist's prescription (n=156-158: (Chronbach's alpha 0.925)



previous or current experience of working with a hygienist or therapist, were irrelevant in this respect. However, among general dental practitioners, associates were significantly more negative towards therapists performing a range of treatments without a dentist's prescription than were practice owners. This may reflect associates' concern over role substitution by therapists. As one practice associate put it: "It will put associates at risk of unemployment."

The numerous comments should be seen as indicative of the views and attitudes of some dentists rather than necessarily representative of the majority. Although some positive observations were made, it would appear that there is still much concern and distrust surrounding hygienists and therapists working with greater autonomy. A variety of reasons were put forward, including patient safety, lack of training, and the reform being cost rather than quality driven.

Patient safety was cited by the GDC as the foremost consideration in relation to the DA reform. While two recent reviews [1], [15] of the research evidence regarding the comparative performance of dentists and DCPs found no evidence that patient safety was at risk, both refer to a shortage of recent good quality comparative studies, and were unable to reach any firm conclusions about the relative effectiveness of dental auxiliaries and dentists. In the present study, references to patient safety most commonly cited the possibility of missed pathology, which depends largely on the level of training received by therapists and hygienists.

The educational process of dental hygienists and hygienist-therapists has changed exponentially in recent years. Most establishments in the UK now offer a three or four-year BSc or BSc (Hons) degree in Oral Health Sciences. The learning outcomes contained within the GDC curriculum guidance document 'Preparing for Practice'

are almost identical for dentists, hygienists and hygienist-therapists, within their respective scope of practice [16]. A number of subject areas are taught jointly with BDS undergraduates, as the level of knowledge required of each group is the same. It could be argued that because of their narrower curriculum, hygienists and therapists spend more time in a clinically supervised environment developing their skills in routine dentistry than do undergraduate dental students. The dissemination of information on curricula and Scope of Practice may also help allay dentists' concerns, as may a greater emphasis on joint training during programmes of Continuing Professional Development.

Dentists' concerns about hygienists' and therapists' standards of operative dentistry may therefore be due to dentists' lack of awareness of their curricula, which suggests that education regarding the quality and extent of training and resulting clinical competence of therapists and hygienists may be required. As one respondent admitted: "We don't know their level of training."

Other comments related to the possible financial disadvantages for dentists. There were concerns that there would be a reduced potential for their own private work, and that their role and/or income would be significantly reduced as a result of increased competition. Such concerns are not supported by evidence from abroad, or from medical general practice in the UK, which has seen the emergence of several groups of allied health professionals which work very successfully in their areas of expertise and in tandem with others without detriment to GPs' income (or indeed to patient safety) [1, 17, 18].

The 2013 Direct Access reform has served to highlight several areas of regulatory restriction to which hygienists and therapists working in the NHS are still subject. These principally involve prescribing rights in terms of the use of local anaesthesia and fluoride-containing agents, and reporting on radiographic findings. In addition, NHS regulations still permit only dentists to hold a list or performer Number which dictates that any hygienist or therapist wishing to set up in independent practice can only do so on a private patient basis.

Perhaps the time has also come to explore other options for the delivery of dental education. While there is much commonality among the BDS and BSc curricula, they continue to remain separate in many ways. We exist in a totally different educational and professional environment, and the BDS programme continues perhaps without sufficient recognition that both the workforce and the oral health needs of the population are changing.

Such prohibitive regulations and inadequately integrated educational programmes now appear outdated. The 2013 Direct Access reform may only be the first step towards the provision of a more flexible, comprehensive and coordinated oral health care service which will be required to meet the evolving needs of the public [19, 20].

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ABOUT THE AUTHORS

Margaret Ross, senior lecturer for DCPs, Edinburgh Dental Institute, University of Edinburgh.

Stephen Turner, senior researcher, Scottish Dental Practice Based Research Network.

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LINGUAL ORTHODONTICS – OVERCOMING THE HURDLES

ORTHODONTICS

While advances in technology have provided the platform for clinicians to plan and produce incredibly precise orthodontic treatment, a thorough understanding of the principles and mechanics is still essential

ROBBIE LAWSON

There is rising interest in and demand for adult orthodontics in the UK. While much of this demand is met by the specialist orthodontist body, there are a number of techniques marketed to general dental practitioners as being more acceptable to adult patients.

Whether a clear aligner system or a "short term orthodontics" system with limited objectives, the principle aims of these systems seem to be trying to minimise the duration and cosmetic impact of treatment, while perhaps accepting that significant objectives, such as occlusal correction, root paralleling or torque control are sacrificed.

Lingual orthodontics has the potential to offer a truly aesthetic solution to both adult and adolescent orthodontic treatments, without making unnecessary compromises to the clinical outcomes. Surprisingly, the uptake in the UK remains marginal. In 2014, of 1,357 GDC registered specialists, approximately 750 had undergone training or certification in lingual appliance systems. However, less than one third of these trained specialists carried out any lingual treatments, with only around 3,000 cases treated annually. It would seem that there are significant barriers to patients being offered lingual treatment. This article aims to examine these barriers and see how they can be overcome.

Contemporary, fully customised, lingual appliances start with the end point in mind. There are many systems available. The most commonly-used system worldwide is Incognito (3M healthcare) developed by Dr Weichmann [1]. After taking accurate silicone impressions or intra-oral scans, a physical or virtual set up of the idealised occlusion is produced. Following this, brackets are digitally designed to be as close fitting to the lingual tooth surface as possible.

Wires are then custom bent by a 3D bending robot to connect the brackets that, when fully aligned, will precisely deliver the set up occlusion. Accurate bracket placement is crucial and indirect bonding trays must be used. Excellent precision of the final archwire to bracket contact is essential to ensure precise delivery of the setup (Fig 1).

Patient adaptation

Early lingual appliances, such as the Ormco 7th Generation (Fig 2) bracket were large and the indirect bonding customisation often resulted in significant protrusion from the lingual aspect of the tooth, encroaching upon tongue space. Patients would often report slow adaptation including difficulty with speech, tongue discomfort and eating [2]. Over the last two decades, manufacturers have produced smaller brackets and the advent of fully customised systems that minimise both bracket and wire protrusion towards the tongue have greatly reduced these problems [3].

Dental health

It would seem logical that placing brackets lingually would complicate oral hygiene, increasing the risk of periodontal problems and caries. When periodontal health has been monitored, it has been shown that lingual appliances do result in slightly increased plaque and bleeding indices [4] but that these changes are completely reversible with no long-term increase in the presence of periodontal pathogens [5].

When the incidence of caries and white spot lesions has been examined, the results are surprising. Compared with labial appliances, lingual appliances result in 4.8 times fewer lesions, which, when present, show up to 10 times less

Lingual appliances do result in slightly increased plaque and bleeding indices but these changes are completely reversible

intensity of decalcification [6]. Therefore, there is in fact a compelling argument to use lingual appliances to reduce the risk of iatrogenic enamel damage compared with conventional labial appliances.

Outcomes

A possible barrier to the use of lingual appliances is the perception that clinical outcomes may not be as good as with labial appliances. Indeed, for any dentist to use a newer clinical approach, there is an ethical obligation to ensure that it will provide an outcome which is at least as good as that achieved by other proven, tried and tested appliances and techniques. There is evidence that well managed lingual appliances fulfil this requirement.

In a prospective comparison with matched labial and lingual cases, no difference was found in quality of outcomes, treatment time or apical root resorption between the two appliance groups [7]. Further evidence on the potential accuracy of contemporary lingual appliances is in how closely treatment outcomes match the predicted set up occlusion. In a study where digital scans of the final occlusion were superimposed on the predicted setup, it was shown that 94 per cent of the planned movements were achieved [8]. By comparison, the accuracy of Invisalign under similar investigations varied from 41 per cent to 59 per cent [9,10]. It seems that lingual appliances have the potential to aesthetically deliver outcomes that are at least as good as those that we can achieve with conventional labial comprehensive orthodontic treatment.

Biomechanics

By applying forces to the lingual aspect of the teeth, the actions, reactions and moments are different to what we see with labial appliances. As the point of force application is distant from the labial surface of the tooth, we are effectively carrying out orthodontics at the end of a broom-handle! Accuracy and precision is essential. Finite element studies have shown that there is a greater tendency towards lingual tipping, vertical bowing of the occlusal planes and torque loss upon retraction [11,12]. Various appliance modifications are made to counter these effects, such as optimal bracket and wire precision, close fit of bracket to tooth surface and ribbon-wise rather than edgewise archwires.

Technique sensitivity

This is perhaps the greatest hurdle to the widespread use of lingual appliances. The access to the lingual aspect of the teeth is certainly more difficult than with labial appliances or aligner systems. Contemporary brackets are small to ensure comfort and there is a lack of familiarity for the new lingual operator. The manufactures are aware of this issue and all systems are constantly evolving features and ligation techniques to make the life of a lingual orthodontist easier. It has been shown that self-ligating lingual brackets (Fig 3) will make life easier for the novice clinician, but that this benefit over a ligature-based system decreases as experience is gained [13]. As with other fields of clinical practice, skills increase exponentially with experience and focused learning.

Digital planning

There has been much debate in the orthodontic world on where we should plan to position teeth. Decades of research and retrospective analysis have suggested that maintaining

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FIGURE 1A
Digital set up

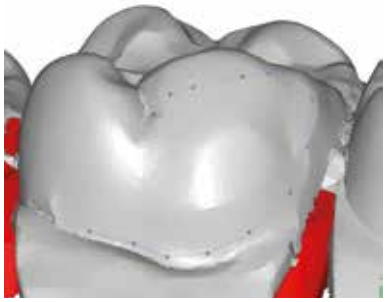

FIGURE 1B
Digital bracket design

FIGURE 1C
Digital bracket design

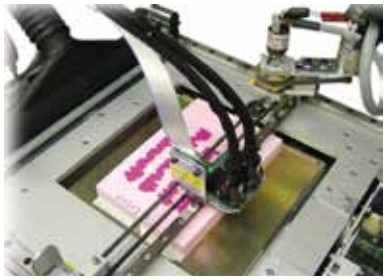

FIGURE 1D
3-D printing of brackets in wax polymer

FIGURE 1E
Wire bending "robot"

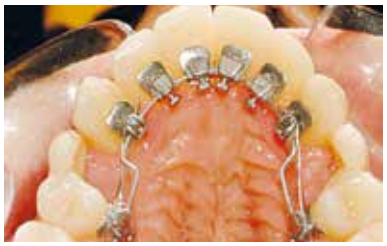

FIGURE 2
The Ormco 7th Generation bracket

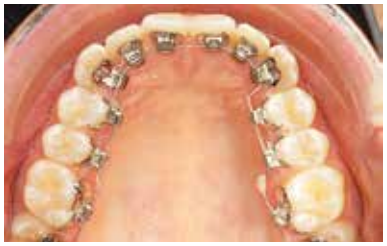

FIGURE 3
A self-ligating lingual bracket

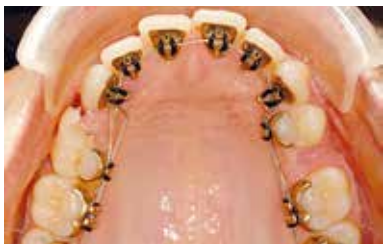

FIGURE 4
Precision customised appliance

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initial archform will minimise the risk of relapse [14]. The introduction of novel treatment philosophies based on avoiding extractions [15] have optimistically hypothesised that there are no limits to where we can place teeth and that the alveolar bone will develop to accommodate any positions that we choose to place teeth.

However, met-analysis of clinical studies [16] and CBCT studies [17] have shown that the alveolus has limited adaptive potential. Basically, we must place the roots within the pre-treatment trough of alveolar bone if we are to maximise stability and minimise the risk of gingival recessions.

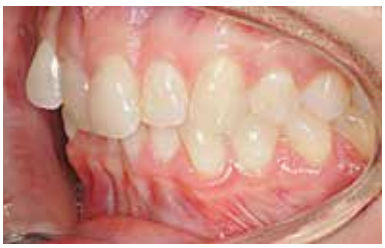
The digital planning platforms, such as 3M Treatment Management Portal or Sure Smile software allow the clinician to precisely plan where the final occlusion and tooth position will be, with reference to pre-treatment anatomy, considering aesthetics, stability and respecting constraints of the supporting tissues. With the precision of customised lingual appliances, we have the ability to accurately deliver the planned final occlusion (Fig 4), improving our treatment outcomes and potentially reducing iatrogenic effects.

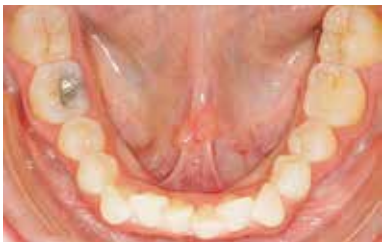
As technology develops to allow better integration with CBCT and digital photography for aesthetic analysis, the clinician's ability to plan and deliver optimal outcomes will continue to be enhanced.

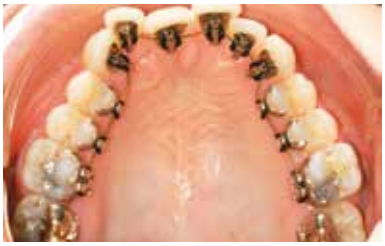
Conclusions

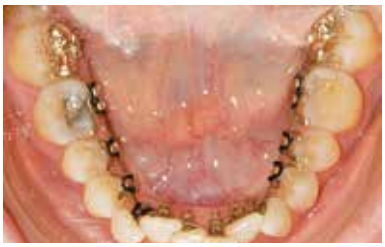
There is a danger in hoping that technology or smart marketing can solve all of our clinical problems. For a clinician to become truly competent in a technique, he must be prepared to invest effort and time in becoming familiar with the principles, mechanics and effects of an appliance in both the educational and clinical settings. For those prepared to do so, the rewards for our patients are apparent. Carefully managed lingual appliances with digital planning platforms now provide the clinician with the tools to plan and precisely deliver optimal orthodontic treatment (Fig 5).

FIGURE 5A-5N
Optimal orthodontic treatment





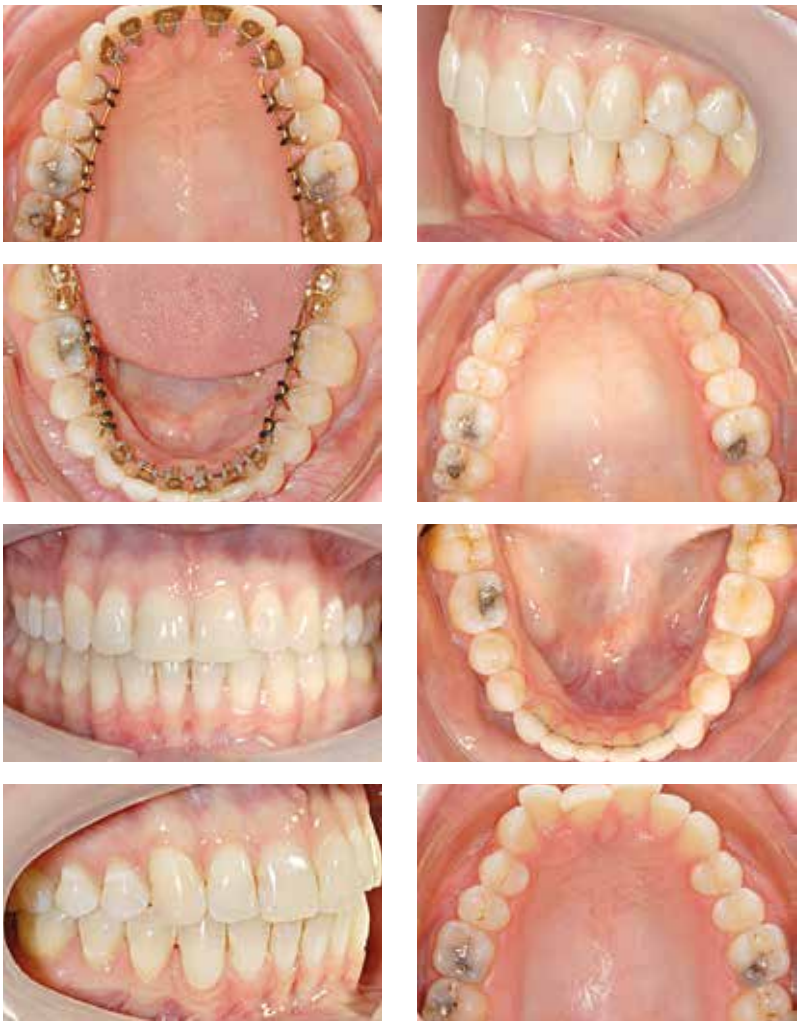




ABOUT THE AUTHOR

Robbie Lawson is a partner in Edinburgh Orthodontics, a specialist practice committed to achieving optimal outcomes for all patients. He did his dental training at Dundee University, graduating with honours in 1990. He undertook his orthodontic specialty programme at the University of Wales, graduating with distinction in 1996. He gained his Membership in Orthodontics from the Royal College of Surgeons of Edinburgh, winning the William Houston gold medal. Since 1996, he has been in specialist practice in Edinburgh. He is past chairman of the Scottish Orthodontic Specialists Group, and is an examiner at the Royal College of Surgeons of Edinburgh.

He has had a special interest in lingual orthodontics since 1999, having used a wide range of lingual appliance systems over the years. He has published clinical and research papers and presents regularly nationally and internationally on fully customised aesthetic appliances. He is a member of the Worldwide Incognito Lingual Appliance Advisory Board.



VERIFIABLE CPD QUESTIONS

AIMS

- To discuss the concepts that underpin lingual orthodontics
- To discuss the barriers to provision of lingual orthodontic treatment
- To consider strategies to overcome these barriers
- To outline the possible benefits of digital treatment planning in orthodontics.

LEARNING OBJECTIVES

- To have an understanding of the concepts behind lingual orthodontics
- To be aware of the barriers to provision of lingual orthodontic treatment
- To understand strategies to overcome these barriers
- To be aware of the concept and possible benefits of digital orthodontic treatment planning.

HOW TO VERIFY YOUR CPD

Go online to www.sdmag.co.uk and clickon the CPD tab to access this month's CPD quizzes

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INTEGRATING DSM IN YOUR PRACTICE

SLEEP APNOEA

Dental Sleep Medicine (DSM) is a fascinating and fulfilling addition to the practice of dentistry. Dr Aditi Desai explains how to introduce it into your practice

ADITI DESAI

Would you turn away more than half your patients because you don't offer the treatment they need? That's just what you could be doing. A recent survey [1] of 2,438 UK residents in co-habiting relationships found that 61 per cent of respondents in Scotland admitted that either they or their partner snored. Of all the regions and counties in the UK, Scotland came out top in terms of percentage of snorers in the population.

With training and minimal outlay on equipment, you could treat those of your patients who snore and market the treatment as a service to potential new patients. To assess the demand, simply add these questions to your routine medical health questionnaire:

- Do you wake with a headache in the morning? Or do you or your partner snore?
- Do you feel tired or sleepy during the day?

Sleep apnoea explained

Before I explain how to introduce Dental Sleep Medicine (DSM) in your practice, here's some background information. Snoring is a sleep-related breathing disorder (SRBD), along with or without obstructive sleep apnoea (OSA).

Snoring and excessive daytime sleepiness are two cardinal symptoms of obstructive sleep apnoea. All apnoeacs are snorers but all snorers are not apnoeac. There is a distinction between central sleep apnoea (CSA) and OSA. CSA is the result of the sleeping person not breathing due to problems with the central respiratory drive that fails to transmit the appropriate signals between the brain's respiratory centre and the respiratory muscles, which fail to act. OSA is the result of collapse of the unsupported airway due to disparity between the pressure within the airway versus that outside the airway. This leads to reduction of oxygen saturation in the blood and increase of carbon dioxide in the system due to failure to exhale it – hypoxia and hypercapnia.

CPAP and MRDs

Continuous Positive Airway Pressure (CPAP), where sleeping patients wear a face or nasal mask connected to a pump that produces a positive flow of air into the nasal passages to keep the airway open, is widely regarded as the most effective treatment. Surgery is usually an option of last resort.

However, although CPAP is very effective, many people can't tolerate wearing the mask. This is where DSM comes in because the alternative, a custom-made intra-oral appliance or mandibular repositioning device (MRD), worn in the mouth at night can greatly reduce, if not completely eliminate, snoring. MRDs are primarily indicated for the treatment of simple, non-apnoeic snoring as well as for mild to moderate OSA when prescribed and monitored as part of a multidisciplinary team. I'll write more about MRDs below.

Integrating DSM

The steps involved in becoming a practice that offers treatment for snoring are training, networking, continuous education and promotion. A dentist in the team needs appropriate training, they should network with local medical

Snoring and excessive daytime sleepiness are two cardinal symptoms of obstructive sleep apnoea

FIGURE 1
The SomnoDent

FIGURE 2
ResMed
Narval CC

practitioners and specialists in respiratory medicine and ENT, the reception staff, hygienist and nurses must be educated in the practice's new dental sleep medicine service and promote the service widely.

Training

Knowledge of the disease is essential for introducing DSM into your practice. A wider knowledge of other sleep disorders is useful but not essential. The British Society of Dental Sleep Medicine (BSDSM) of which I am president, trains dentists to screen, assess for SRBDs and follow a documented pathway of practice to provide the most appropriate treatment for the patient. Most BSDSM courses are of one-day duration and include hands-on experience with MRDs. You will learn what equipment you need (not very much) and meet people who have introduced DSM into their practice. Dental technicians also attend these courses to learn about MRDs so you may wish to team up with someone from the laboratory you use. Go to www.dentalsleepmed.org.uk for more information and details of BSDSM courses.

The treatment of snoring and OSA does not fall within the scope of dentistry. However, the professional indemnity insurers, DPL and DDU, each have a position statement for their members who provide DSM treatment who can seek medico-legal advice, if the member has documented evidence of having followed appropriate care and is duly qualified to provide such treatment.

Networking

While in the past it was often not keen to work with dentists, the medical profession – physicians and ENT consultants – is actively seeking qualified dentists to treat patients not suitable for or intolerant of CPAP. Also, GPs refer simple snorers and mild apnoeacs, who are not suitable nor eligible for secondary referral to a sleep centre, to dentists. You should introduce yourself to local medical practitioners and specialists in respiratory medicine and ENT.

Education

It's important to disseminate information about your new DSM service to all your team members, including reception staff. When asked if there's a treatment for snoring, they should answer with sufficient knowledge to encourage the person to make an appointment for an initial assessment. They also need to provide a broad guide to the likely costs involved.

You'll need to decide on a fee scale for DSM. Allow at least an hour for a new patient's first visit for a snoring and OSA assessment and possibly impressions for an MRD. Most practices have a standard initial assessment charge, then an overall fee for providing an MRD (each device will have a different cost) and initial follow-up visits for adjustment.

Promotion

Members of the BSDSM who are dentists with a special interest in snoring and sleep apnoea are listed on the 'Find a dentist near you' page of the BSDSM website. There are currently only four in Scotland so you will be entering a field where likely demand is much greater than supply. Nevertheless, you should promote your new service in all the usual ways, including adding (for example) 'Do you snore?' to your patient medical history form.

CONTINUED OVERLEAF>

FIGURE 3
George Gauges. Photo courtesy of Eurodontic Ltd

FROM PREVIOUS PAGE>

MRDs – an overview

Although there are several types of MRD and around 100 different ones on the market, they all share these principles: – to open the vertical dimension of the airway – there are different theories about the amount of opening vertical dimension (OVD) required and to position the mandible and tongue forward.

They must also satisfy the following criteria:

- Be made from biocompatible materials
- Be durable
- Have an acceptable neutral taste and smell
- Be adjustable
- Have good retention
- Have a track record of minimal side effects
- Have acceptable aesthetics
- Be cost effective – which may be countermanded by durability.

The materials used range across hard acrylic and soft thermoplastic to cobalt chrome and can affect the degree of customisation possible. Coupling mechanisms – used to connect the upper and lower splints – may be located in anterior or posterior segments. Some MRDs allow lateral and vertical mandibular movement, whereas others lock the mandible in position.

In summary, an MRD that functions correctly and is comfortable for the patient results from an accurate clinical assessment by the dentist combined with expertise and skill from the dental technician and close liaison between the two is vital.

Conclusions

Integrating DSM into a dental practice is straightforward, not expensive and not time consuming. In Scotland, even more so than other parts of the UK, there is a large cohort of potential patients. Globally, steady growth has been consistently forecast in the sleep apnoea devices market – a recent report [2] predicting a 7.7 per cent increase by 2020. What are you waiting for?

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To establish the background to dental sleep medicine including the likely demand for treatment
- To explain the elements for introducing dental sleep medicine into a dental practice
- To give concise explanations of sleep related breathing disorders relevant to dental sleep medicine
- To give an overview of the features of mandibular repositioning devices used in dental sleep medicine.

LEARNING OUTCOMES

- A basic understanding of sleep related breathing disorders including snoring and sleep apnoea
- Sufficient knowledge of the various elements involved in introducing dental sleep medicine into a dental practice to decide whether to pursue it further
- Know where to access training in dental sleep medicine
- Understand the basic features of mandibular repositioning devices used in dental sleep medicine treatment.

HOW TO VERIFY YOUR CPD
Go online to www.sdmag.co.uk and clickon the CPD tab to access this month's CPD quizzes

ABOUT THE AUTHOR
Dr Aditi Desai is President of the British Society of Dental Sleep Medicine (BSDSM). She has accreditation from the European Academy of Dental Sleep Medicine, serves on the Council of the Odontological and Sleep Section at the Royal Society of Medicine. Dr Desai consults from 76 Harley Street, and London Bridge Hospital.

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ABOUT PHIL OWER

Phil qualified from King's London in 1978. He joined the RAF after qualifying and was a general dental practitioner until taking an MSc in Periodontology in 1992, after which he was RAF Adviser in Periodontology and ran the RAF School of Dental Hygiene.

After leaving the RAF he lectured at the Eastman Dental Institute and worked in several specialist practices. For 10 years he worked alongside Bernie Kieser at the Periodontal Practice in London and now practices at the Briars Dental Centre in Newbury.

YEARS OF CO-OPERATION

HAMILTON ORTHODONTIST EXPRESSES HER APPRECIATION FOR THE SUPPORT AND CO-OPERATION OF LOCAL REFERRING PRACTITIONERS

Dr Karina Pawlaczyk has been treating the patients at Hamilton Orthodontics for the last five years. Throughout this time, she has received very good feedback from patients and referring dentists. Karina said: "I'd like to take the opportunity to say thank you to all the dentists who have been referring patients to Auchingramont Road, and also to the dental staff in the practice whose input cannot be underestimated."

Karina graduated in 1997 from the University of Poznan, where in 2004 she achieved a PhD in orthodontics and, in 2006, she became a specialist orthodontist. She is registered on the UK specialist list.

She works full-time at Hamilton Orthodontics treating a wide variety of patients, both children and adults.

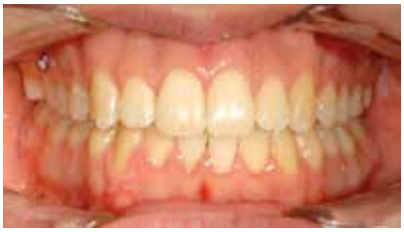
Generally, patients are referred to specialist practice for routine orthodontic check-ups. Since the introduction of IOTN in 2011, all patients are entitled to professional advice and their treatment options. Unfortunately, due to IOTN restrictions, some patients might be classified as too mild for treatment on the NHS. Therefore, we have special care plans and payment options for those patients who do not qualify for treatment within the NHS guidelines.

Karina continued: "Thank you for your continuing support and patient referrals. We appreciate that there has been a tradition of several years of co-operation between the dental professionals in Hamilton and our practice.

"If you wish your patients treated to the highest standard, I look forward to treating them. There is no waiting list and patients can be seen quickly."

Edinburgh Orthodontics

Expert care for beautiful smiles



Edinburgh Orthodontics is now in its fifteenth year at our Gilmore Place practice.

While our core activity is providing quality outcomes and service to your NHS patients, we have also developed a reputation for optimal treatment for adult patients, both as “stand alone” orthodontic cases and as combined orthodontic / restorative cases with the referring practitioner.

Our comprehensive approach to treatment planning and delivery can allow you to treat your patients to optimal restorative outcomes. Excellent communication with the referring dentist is key to the success of these cases. We are always happy to discuss treatments with you by phone or e-mail.

We have years of experience in aesthetic ceramic appliances and using Invisalign for a wide range of malocclusions. We have unparalleled experience in the use of hidden Lingual Appliances, offering a truly invisible option for your patients without any compromise in treatment outcomes.

Our practice has embraced new developments, such as self-ligation, miniscrew implant temporary anchorage devices and digital technologies to help us in our “no-compromise” approach.

Our team contributes locally and nationally to general dental and specialist societies and committees.

All our orthodontists are GDC registered specialists, who will provide continuity of care for your patients, from beginning to end of treatment.

We can offer your patients:

- Efficient, professional NHS care
- No waiting lists
- Convenient city-center location with excellent bus route access
- Full range of aesthetic appliances for your adult patients
- Unparalleled experience with Lingual Appliances
- Commitment to long term maintenance of treatment results.

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ENHANCED PATIENT EXPERIENCE

ALINA SHEIKH, PRINCIPAL DENTIST AT ENHANCE DENTAL CARE, EAST KILBRIDE, DISCUSSES THE PHILOSOPHY BEHIND THE CARE HER TEAM PROVIDES

Our approach to our mixed NHS and private-patient base is to provide inclusive and consultative treatments to achieve the best dental health possible. Many of our patients are young professionals who are progressing their careers so excellent oral health and appearance are of great importance to them, and we're here to help them look their best, and keep them that way.

We are also very keen that we use equipment that enhances our patient experience, which is why I use a range of NSK handpieces, and in particular the NSK Z900L air turbine. The LED optics are exceptional and the Z900L takes my restorative work to a new level as it delivers a powerful and responsive performance and best of all, it is unbelievably quiet, which my patients love. I would find it difficult to work without it!

TRUSTING YOUR EQUIPMENT

I place and restore dental implants on a regular basis, as many of my patients prefer an implant to a bridge. We also have a couple of clinicians who visit the practice to help with more complex cases as needed. When it comes to complex treatments, such as implant placement or successful endodontic treatments, it is vital to use equipment that you trust. We have the NSK SurgicPro in the practice and this is used routinely for the placement of dental implants. The SurgicPro is an excellent piece of equipment that offers a wide range of speeds and torque settings allowing it to be used with any implant system. When it comes to endo treatments I think we all need a little bit of help! I use an NSK apex locator, the iPex ll which uses SmartLogic technology to provide superior accuracy in detecting the apex of the root and provides a clear, accurate image of the file tip location on its LCD panel, which is absolutely invaluable.

SPARKLING RESULTS

Ultimately, patients want to go home with a sparkling smile and to achieve this we use the NSK Prophy-Mate neo air polishing system. The Prophy-Mate neo is ergonomic and easy to use, making routine cleaning and polishing procedures a pleasure to deliver.

I am very happy with all the NSK equipment I have and would highly recommend it to other clinicians.

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Management

PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

LEAD THE WAY

TAKING YOUR TEAM TO HIGHER LEVELS OF SUCCESS

See page 68

LEAD THE LIFE YOU LOVE

ADAM MORGAN EXPLAINS THAT IT DOESN'T MATTER IF YOU ARE A BUSINESS OWNER, PRACTICE MANAGER OR TEAM MEMBER, YOU CAN ALL BE GREAT LEADERS

Today I want to talk about the impact you have as a leader. Now, before you switch off and think "I'm not a leader," or "I've got this," I want to assure you – you are more important than you probably realise. One thing I find fascinating about human behaviour is this – **it is rarely the owner of the company who has all of the power or is the real leader.** Yes, they have a certain amount of authority with the ability to terminate a contract – but that is not the real powerhouse of the team.

I often find that it is someone that does not hold a managerial role who has the most influence over the team. Leadership, simply put, is influence **Whoever has the most influence is the strongest leader,** for good or bad.

I have met more bad leaders in my working lifetime than good ones and the sad thing I often see is that underneath their poor leadership is a team of beat-down, worn-out employees who would flourish with the right leader in place.

Regardless of whether you are the positional leader – such as the business owner – or you are the influential leader, you truly have the ability to make or break your team. Let me ask you this: Have you ever worked for someone who motivated you to do your best, who valued you as a person and not just for what you brought to the table and made you a better version of yourself just by being around them? These people are extremely rare – and often earn vast amounts of money for large organisations because of the impact they have on the whole company.

In our world of dentistry, **we need more great leaders and people who ignite passion in the people around them.** We also need more people who are consistent from one day to the next in their approach to become better.

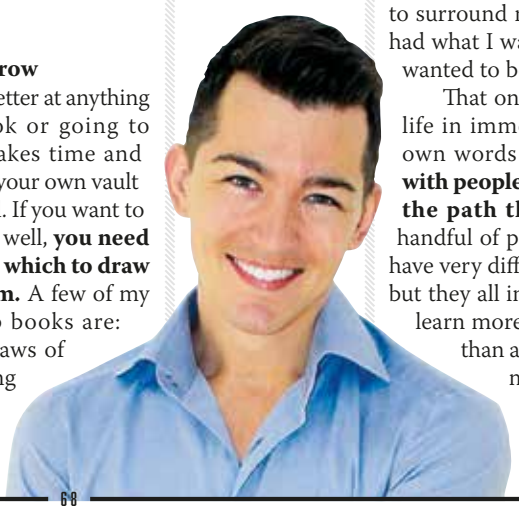
Leadership, as we all know, is such a huge topic but I want to share with you just a few ways that if implemented religiously will help you to become a stronger, more effective leader – regardless of whether you are the business owner, associate, manager, or member of the team. **Remember this – you do not have to be the one at the top to be a great leader.**

LEAD YOURSELF FIRST

If you want to become a better leader, start by investing in yourself. Here's how:

1. Read, learn and grow

No one can become better at anything by reading one book or going to one conference! It takes time and discipline to invest in your own vault of knowledge and skill. If you want to be able to lead others well, **you need a constant well from which to draw strength and wisdom.** A few of my favourite leadership books are: The 21 Irrefutable Laws of Leadership and Failing Forward – both by John C Maxwell.



I have a reading list that continues to grow and, as I learn more, more books, podcasts and events appeal to me as my mind grows and opens to new thinking and ways to lead.

If you don't know where to start, email me and I will happily share some brilliant books and podcasts to get you going. The thing to remember is – do not leave it in the book. Use what you learn every day.

2. Seek out people that inspire you

When I was 16, I attended an event held by a local successful entrepreneur. He was a bit of a celebrity in the town and I was so excited to see what he had to say. At the end of his speech the group had the opportunity to ask questions. My hand shot up and I asked: "What one thing helped you the most, to get to where you are today?" He sat and thought for a moment and then said: "I learned early on, that I had to surround myself with people that had what I wanted and were where I wanted to be."

That one line has impacted my life in immeasurable ways. In my own words – **surround yourself with people that are further down the path than you are.** I have a handful of people in my life that all have very different skills and careers, but they all inspire me to be better. I learn more from these five people than any book has ever taught me or ever will. Find people that you admire and wholeheartedly

respect. Get to know them and learn – **find people outside of your usual circle and the world will instantly open new doors for you.**

DO NOT ALLOW OTHERS TO DETERMINE YOUR SUCCESS

If you work with someone right now who is holding you back from doing the type of work you would like to do more of or from giving the type of service you know should be given, then to do something about it.

Show others what to do differently. Teach new skills or raise the bar. **Great leaders know how to help others do and be better.** They take the time to show others how to raise their game and in doing so, elevate their own influence and leadership. You can only get better by helping others get better too.

Good leaders also choose their battles carefully. If you need to have a difficult or challenging conversation to lift the lid or break the ceiling that has been in place, then always do it in private. What is said in private should not be discussed with anyone else outside of the people involved. Gossip and bad-mouthing are the fastest ways to ruin your influence and leadership – do not engage in it and actively cut it off if you hear others doing it. **Great leaders do not take value from others – they elevate and intentionally add value to them.**

BE INTERESTED AND INTERESTING

This is a very personal point about being someone that people **want** to follow and be around. If you want to lead others well, you have to be interested in other people's lives and be someone who is interesting in return. Great leaders always make people feel important by taking a keen interest in what is important in their lives. They remember details and spend time talking and being around them.

Too often I see the business owner shut themselves away at lunch times to "catch up on paperwork" or do admin. This should never happen. **When the team is enjoying time together, you should be there too.** Have fun with the team and in turn have something interesting to say. This is not about work – i**t is about taking an interest in others, knowing what is important to them and then adding to the conversation.**

Be someone who is interesting – add colour to your life by joining a club or following a passion from your youth. Get back in touch with something you enjoyed doing and then put on hold when life got busy. The more colourful your world is, the more you are able to add colour to other people's worlds. Remember – **there aren't many beige masterpieces out there – the best are all full of colour and complexity.**

ABOUT THE AUTHOR

Adam Morgan is an award-winning training specialist who teaches businesses and individuals how to grow and create greatness in their marketplace. His fresh approach and dynamic style make him highly popular with companies around the world.

Adam works specifically with practices throughout the UK and helps dental teams to raise the bar, be more successful and achieve their goals and vision. With more than a decade of expertise working with many of the leading hotels and resorts, retailers, financial institutions of the world, he is a talented consultant able to deliver results.

IN SUMMARY

Give people a part of yourself that is interesting and alive with passion, depth and colour. All of the great leaders I know are the most interesting people I have ever met. They make me feel great about who I am and what I do and they always teach me something when I least expect it. They are as steady and consistent as a steam train and they are constantly growing and developing themselves to be even better.

It really doesn't matter whether you own the business or are part of the team – anyone can be a great leader that takes the whole team to higher levels of success. **Do something today that will make tomorrow even better, for yourself, your team and your life for years to come.**

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PRACTICE SALES AND PURCHASES ROUND-UP

FOLLOWING HIS TALKS AT THE SCOTTISH DENTAL SHOW ON PRACTICE SALES AND PRACTICE PURCHASES, MARTYN BRADSHAW SHARES HIS CONSIDERABLE KNOWLEDGE OF THE CURRENT MARKET

MARTYN BRADSHAW

To my mind this year's show was the busiest and most successful ever and I have had the pleasure of being a CPD speaker at every Scottish Dental Show. My talks on practice sales and practice purchases are always popular and so it was this year. I was also able to chat informally to a number of visitors to the show who were either thinking of purchasing or selling a practice. I gave them advice which I hope they will find helpful.

For those of you unable to attend the show or to speak with me, I'm pleased to give an overview of what I talked about as well as adding more information on some points.

CURRENT MARKET CONDITIONS

Things are changing very fast at the moment and stock exchange traders would probably describe it as a 'bull market'. The values now being achieved are in excess of those of a couple of years ago. This is mainly due to the high demand for practices – especially those where the majority of income is through the NHS, which may surprise some practice owners.

On average, I expect around 10 to 15 interested parties, and subsequent offers, for each practice sale we handle. This is especially true for practices located in and around Edinburgh or Glasgow.

Because of the current state of the market, it is imperative that potential purchasers or sellers arrange for a formal valuation. Failure to do so could result in a huge discrepancy between the price achieved or paid and the true market worth of the practice.

Although the situation changes daily and not all practices for sale are shown, you can look on the Practices for Sale section of our website to get an idea of prices.

DENTAL PRACTICE VALUATIONS

One of the main topics of my talks was valuations and chiefly how they are conducted. Gone are the days when a practice was valued on turnover. There are now two ways my team and I value the majority of practices, both of which are based on multiples of profitability.

A so-called associate-led practice assumes that all income at the practice is generated by associates. We make adjustments for 'tax reducers' and personal items in the accounts, which then provides us with the true profitability of the practice. This is commonly referred to as the 'earnings before interest, tax, depreciation and amortisation' or EBITDA.

For principal-led practices the valuation is similar to the EBITDA calculation. However, where it is assumed (and financially modelled) that a principal will remain at the practice there is a higher level of profitability, although a smaller income multiple is then used.

To ensure that people selling get the best value for their practice we determine which model is the most financially rewarding. The valuation basis could mean that different practices appeal to corporate rather than private buyers. However, an attractive EBITDA model would attract interest from the whole market.

BODY CORPORATES

When I refer to body corporates, I mean someone who is looking to have an associate-led practice, i.e. not work in it themselves. Contrary to popular beliefs I tend to find that the well-established body corporates do not pay the higher prices. In fact, private buyers and smaller 'boutique corporates' can offer tens or hundreds of thousands of pounds more.

ABOUT THE AUTHOR
Martyn Bradshaw is a director of leading practice sales agents, PFM Dental, with offices in Edinburgh and York. For practice sales and valuations and information on practices for sale in Scotland, visit www.pfmdental.co.uk

Caring for your business

IT MAKES COMMERCIAL SENSE TO PREPARE FOR THE UNFORESEEN BY APPOINTING A POWER OF ATTORNEY TO MANAGE YOUR AFFAIRS

JOHN COWAN

Anyone in business should consider what would happen if there was an unforeseen event preventing them from performing essential day-to-day tasks. Of course, not always the cheeriest thought process, but it makes good commercial sense to identify what steps can be taken to make matters easier if you suddenly lost mental capacity or were rendered physically incapable and unable to manage your own affairs.

The majority of people understandably believe this is a worry that should be dealt with in later life but there are risks that are always there, however remote. Most folk routinely take out insurances as a protection against calamity but not so many give thought to who would act on their behalf if they no longer had capacity and what would happen to the running of their business or indeed their personal matters in such a situation.

Depending on the business structure, a prudent and straight-forward step to take would be to grant a Continuing Power of Attorney which is a legal document appointing someone to act on your behalf and to make decisions for you when you are unable to do so yourself. The powers given to an attorney can extend to dealing with financial and business matters on behalf of the granter of the deed.

The Power of Attorney can be stated to commence immediately or at a later date and upon the loss of capacity but can only be granted while the granter has the proper capacity. In the absence of a Power of Attorney it might be necessary to apply to the courts for a Guardianship Order for authority to deal with matters and this process will involve more expense and delay.

A person can choose whomever they want to be their attorney – this should be a trusted person suitably placed to carry out the duties asked of them – and the procedure is regulated through the Office of the Public Guardian.

ABOUT THE AUTHOR
John Cowan is a partner in Miller Samuel Hill Brown LLP. To contact John, email jbc@mshblegal.com

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Know your value

PAUL GRAHAM, ASSOCIATE DIRECTOR AT CHRISTIE & CO, EXPLAINS THE IMPORTANCE OF ENLISTING A SPECIALIST ADVISER WHEN IT COMES TO SELLING YOUR PRACTICE

Christie & Co has been providing dental professionals with expert advice for many years and I, myself, have more than a decade of experience in the business sales market.

You would be correct in believing that the Scottish market is strong right now, but buyers – and importantly their independent advisers/surveyors – are still sensitive to values. I often put myself in the position of a principal looking to sell and completely understand why so many are confused about what their practice is potentially worth.

It never ceases to amaze me how much inconsistent and inaccurate advice gets circulated among practice owners who are considering a sale. From practices being undervalued and sold because a sales agent claims that "the buyer pays the sales fee", to recently seeing agents adopt the "English" methodology to valuing a practice in Scotland and therefore placing a totally unachievable figure on what should be a very sellable practice. Even more frustratingly, I see many examples where a local accountant has 'spread' the word around a few contacts that are active in the market place – this is not how to conduct a sale!

For practice owners who are considering selling, it is imperative that ample time is allocated well in advance of your planned exit date and then enlisting the services of a trusted dental sales specialist.

Christie & Co is the only national firm undertaking formal, accredited RICS valuations, as well as selling dental practices, so we have a unique insight into prices that are actually achieved. We provide confidential, simple and accurate advice for you – the seller, in order to take the hassle out of your practice sale.

If you're looking to sell or buy, or would like to learn more about the value of your own practice, please get in touch.

ABOUT THE AUTHOR
Paul Graham is an associate director at Christie & Co covering dental practice sales across Scotland. Contact him on 0131 524 3416 or email paul.graham@christie.com

Checklist to map out the direction of your practice

IAN MAIN

Well that's another Scottish Dental Show past and what a great couple of days it was. It was great to see so many people attending and I was delighted to be invited to speak about 'The Business of Dentistry'.

I feel strongly that your practice is a business and should be run in that way and by measuring the key performance indicators in the practice you will be able to manage the numbers which matter and plan for the future.

How do you plan to grow your practice? What percentage chair utilisation rates do you achieve? What are your recall rates? How are you acquiring new patients? Does your practice structure work for you? How does your performance rank versus your competitors?

These are all fundamental questions for you to answer in regard to your practice and allow you to take it forward dynamically, and where relevant, enhance your current performance and exit success opportunities.

Our Dental Success Checklist can be a great place to start and allows you to rate your abilities, and indeed blind spots, in the areas of leadership, financials, operations, marketing, sales, team, HR, personal finance and implementation plans.

In the time it takes you to complete with a cuppa you will have a clearer direction on where the practice could be taken, allow you to find your passion for the profession again and get your team on board.

If you would like a free copy of our checklist do get in touch.

I wish you all the best of luck in achieving success in your dental businesses.

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

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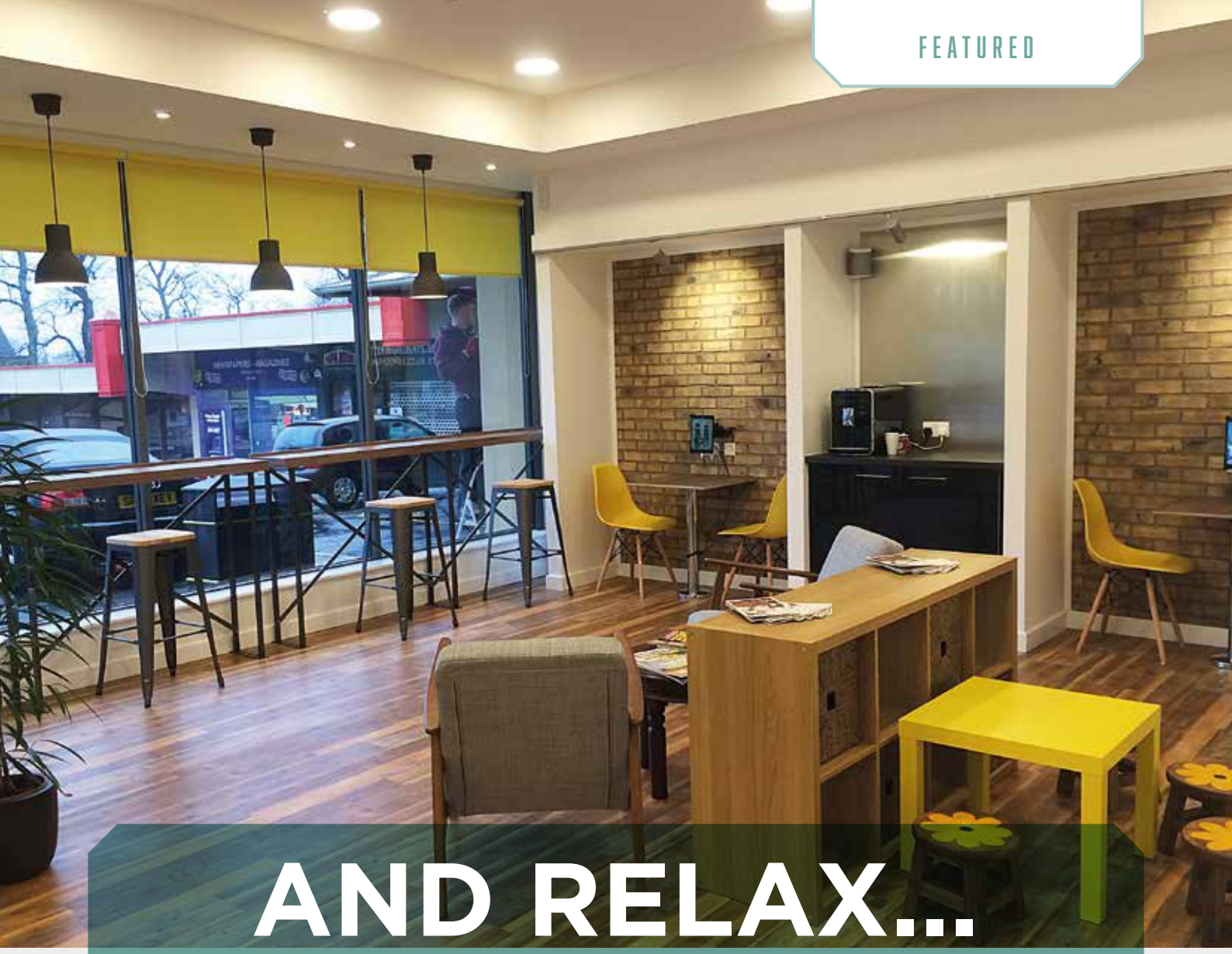

AND RELAX...

ANGELA AND GERWYN ROWLANDS WANTED THEIR NEW PRACTICE TO BE WELCOMING AND COMFORTABLE. THEY'VE DONE IT WITH STYLE

BRUCE OXLEY

When you walk through the front door of Buttercup 7 Day Dental in Broomhill you could be forgiven for thinking you had wandered into one of the west end's many coffee shops.

With cafe-style tables and seating, stools along the big floor-to-ceiling front windows and wooden flooring it certainly doesn't look like your average dental practice waiting area.

But don't let the relaxed facade fool you, the look, feel and atmosphere is no accident. The practice owners, husband-and-wife team Angela and Gerwyn Rowlands, were determined to provide something very specific for their new "squat" practice.

Angela explained: "I guess you could say we had a vision of what we wanted when we were designing the practice. We wanted something relaxing and welcoming,

and that coffee-shop feel seemed like the perfect fit.

"We want patients to come in and be really relaxed and comfortable before they see the dentist. I think this waiting area really helps with that as it is not like your stereotypical waiting room."

The couple, who live in the west end with their young children, see themselves as a typical Glasgow family and they were eager to create a practice where families and especially kids can feel comfortable.

Gerwyn said: "As a family with young children we know it's important that kids get a good experience coming to the dentist from a young age, so we've made sure the waiting room has things for them to do, like iPads with games etc, and coming to the dentists isn't scary, because that's how dental phobia starts, and hopefully that will help them form good habits and improve their dental health as they get older."

Angela and Gerwyn met as students at Glasgow Dental School, both graduating in 2004 before marrying in 2007. They did their VT years in the south of England – Angela in Exeter and Gerwyn in Brighton – before returning to Glasgow to work in general practice.

While Angela was brought up in Glasgow, Gerwyn was raised in Aberdare in the Welsh valleys and had already completed a degree in applied biology at Nottingham before studying dentistry. The

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FROM PAGE 79>

couple got together in fourth year and have been together ever since.

After associate positions in Glasgow and Paisley, they bought a long-established practice in Mount Florida, in 2010 where they learned the ropes of being practice owners. However, they had always fancied the idea of opening a squat practice so they could really put their stamp on it.

Gerwyn explained: "We really wanted a practice that we had designed from the ground up. Mount Florida was great and it was probably the best six years of my career, but Buttercup is all ours. It isn't an established practice, we can create something unique and something that is maybe a little bit different to what's out there at the moment."

Angela and Gerwyn started looking for potential premises at the start of 2015 and they viewed dozens of buildings in and around Glasgow and as far out as Blanytre in South Lanarkshire. Gerwyn said: "It was a horrible experience to be honest. We didn't have a clue where to look and we just felt so lost. At one point we got a map of Glasgow and started to put pins in to represent practices in an attempt to try to find an area that was perhaps underserved. As it turned out there are quite a lot of practices in Glasgow!

"But we then got some professional advice and we started to focus on finding the ideal building rather than worrying about the 'perfect' location."

As it turned out, the couple managed to stumble across their current premises while looking online at another retail unit. A former betting shop in Broomhill shopping centre, they fell in love with it.

Angela said: "As soon as we saw it we thought it was ideal. It needed a bit of work inside but the location was fantastic and we knew that with the right people, we could turn it into a really great dental practice."

The lease was signed in July 2015 and before they got the keys in October Angela and Gerwyn contacted Farahbod Nakhaei of NV Design and Construction to draw up the plans. Gerwyn said: "Initially we spent a lot of time working with Farahbod to get the plans exactly how we wanted and then work started in December 2015.

"We initially toyed with the idea of project managing it ourselves but, having seen Malcolm in action and taking into account all that he did, I'm pretty sure we wouldn't have made it without him. He kept us in the loop constantly and, even though there were still a lot of decisions for us to make, it all went really smoothly. Most importantly for us, they came in on budget and on time, which was absolutely great."

NV brought in Peter Newton from Pan Joiners who carried out all the construction and fit-out work. Angela explained the work went pretty much to plan apart from the crew discovering that the previous tenants of the unit had just laid flooring on top of the existing flooring so that they had to dig down five layers just to get it back to its original state.

The practice opened in March they are delighted with the outcome. And, what about that name? Angela explained that they had agonised over the name for some time before their daughter Layla

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FROM PAGE 81>

suggested calling the practice Buttercup. They took it to their business consultants Fine Company, who they were working with to build their brand and website, and they loved it.

Angela said: "We wanted something different and I think the name captures that feeling. No one is going to forget it in a hurry that's for sure."

The two surgery practice features A-dec 300 chairs with LED lights, intraoral camera and micromotor and there is a third surgery waiting to be kitted out when the patient list gets large enough. Cameron Walker will be joining the practice to undertake any oral surgery and they will soon welcome their new associate Ryan Stewart in August. Ryan is currently completing his VT year in Forres.

The LDU is kitted out with Thermoklenz washer disinfectors and autoclaves from Dolby Medical and to the rear of the practice there is a staff room and kitchen, compressor room and a patient toilet.

Angela and Gerwyn are clearly very proud of their new venture but it is clear that the beautiful surroundings, the iPads and flat-screen televisions are not just for show; they are all tools for building trust between dentist and patient.

Angela said: "We try to spend as much time as possible with new patients getting to know them and building trust. The only currency that has any value to us is our patients' trust

"We live here, and we expect to make a strong long-term relationship with them. We know that it's only once we have won that trust that they will truly be relaxed in our practice."

THE MACHINE THAT CHANGED MY LIFE

GRAHAM LITTLEJOHN, DENTAL TECHNOLOGY SERVICES GROUP, TAKES A LOOK BACK AT THE COMPANY'S FIRST LAVA MILLING MACHINE

It's a very sad time in the life of our company (DTS and Core3dcentres UK), as we decommissioned our very first Lava milling machine. Why have so much emotion about a piece of machinery? Well, because it single-handedly transformed the way we worked our dental laboratory, and our thinking has never been the same again.

Twelve years ago we were a traditional dental lab, working in both crown and bridge and prosthetics, relatively successful and comfortable with our company. We had a good reputation for veneers, completed a few implant cases – as rare as they were then – and had embraced this new product from Nobel Biocare called Procera. In fact, we had embraced it so well we made more Procera than any other dental laboratory in the UK. However, our customers were crying out for bridgework. We waited for the promise of Procera bridges and, when delivered, the initial process bridges were a bit of a disappointment as they involved scanning and receiving the bridge in multiple parts so the lab had to bond the pieces together.

It was at this point that my father heard that a company called Espe had developed this new material and technique which could deliver crowns and bridges. However, it was not like Procera; we needed to make these ourselves in house with CAD/CAM. What is CAD/CAM was our first question. Oh, how times have changed!

We travelled over to Seefeld in Germany to see these wondrous machines and scanners. We came home impressed by the technology but panicked by the cost. No one had even heard of Zirconia and what a stupid name for a dental material – "Lava"... Surely lava is black not white?

I remember very well our first meeting back in the office at home with my father and my two brothers. Can we afford the investment? The biggest investment as a lab we had made previous to this was maybe a porcelain furnace or the Procera scanner at around £30,000 maximum. This was an investment, not just in the machine, but in the equipment, training and space required to run a milling machine. From memory, we invested around £180,000 in preparing and buying that first lava milling machine. Then there was the marketing so dentists knew what it was.

The very first DTS lava milling machine has been decommissioned. It helped transform the company from a traditional dental lab to a digital manufacturer

We were so naïve. Little did we know the pain and the learning curve we would encounter. Just at the same time as we ordered the Lava mill, 3M bought the Espe company. So, to add to us not knowing what we were doing, neither did 3M. Complete pandemonium ensued.

We marketed this "lava" product with flyers featuring volcanos and flames shooting out of them. Anyone who has had dealings with the 3M marketing department will tell you that they don't like you messing with their brand image, so we got a letter telling us, in no uncertain terms, to "stop it" or legal action would follow. We are only trying to sell your product was our answer. "Stop it now," was theirs.

As I was the youngest partner in the company, obviously I must know about computers. I was therefore put in charge of the day-to-day running of the machine. I will always remember the (many) times when I had my phone clamped between my ear and my shoulder, speaking phonetic English to a German technician trying to change broken parts rather than pay the price of flying someone over every time it broke down.

And did it break down? Oh yes. I had no idea that machines could be vindictive. We were trying to build a market which had never heard of Zirconia so the machine needed to reliably supply frameworks when we managed to get our customers to change. Typically the most important and time-critical cases were the ones where something went wrong. The machine, on one occasion, tried to self-mutilate; it decided to drill a hole in its own arm. Yippee, how fun that was.

Anyway, with all that said, once we made the leap, we made it work. We learned fast, we adapted and we made it a success. So much so that we modified the machine's loader, that could initially only take 20 blocks, with cardboard pieces to extend the height of the loader to be able to run all night long. Within the first year that machine was milling just under 1,000 units a month, much more than anyone recommended or thought it could do. Within two years we had four Lava mills all running at full capacity. We made every Lava crown and bridge framework in the UK for almost four years.

That Lava milling machine started our journey to digital manufacturing. It taught us everything we needed to know about working (and repairing) a milling machine. Now, as we look at our business, 75 per cent of all our crown and bridge cases are made with CAD/CAM technology.

We now run more than 15 milling machines from our UK site and hundreds worldwide through our global Core3dcentres digital manufacturing sites. Not only that, we have multiple oral and lab scanners. Maybe another day, when it's less raw, I will write fondly about our 3D printers.

So, after 12 years and almost 250,000 units from that one machine, our business is different now, and better. Today, as I watch it being stripped, I see the guts of the machine – with cable ties and small bits of wire I used to bypass sensors rather than calling the German engineer – I can't help thinking what my life would be like if we hadn't made that leap of faith. It would definitely be different – with maybe a little more hair – and our business would not have grown into our digital future.

Graham Littlejohn

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DTS BUILDS A GLOBAL BACKBONE

THE INDUSTRY IS IN A 'PERFECT STORM' OF CHANGE, BUT IT HAS NEVER BEEN MORE EXCITING, SAYS GRAHAM LITTLEJOHN, DENTAL TECHNOLOGY SERVICES

The dental industry is a rapidly moving landscape and we are completely in "the perfect storm" of change. Each of those changes, whether they are scanners, materials, restorations, customer services or workflows, requires time to develop and finance to deliver. Build in to this, the ever-increasing regulations that are added daily and there has never been a more difficult time to be a dental business.

However, with that said, there has also never been a more exciting time as with each change and development a multitude of possibilities and opportunities appear.

Dental Technology Services (DTS) was one of the first dental laboratories in Europe to start working with CAD/CAM technology. Little did we know then the complete transformation that it would bring to our industry? Due to our long-standing expertise in this area, the directors of DTS nine years ago were among the founding members of the Core3dcentres group. Core3dcentres has grown to be one of the largest manufacturers of digital dental restorations in the world. Core3dcentres has advanced digital dental production centres in 11 countries throughout the world, manufacturing CAD/CAM dental appliances for dental laboratories, who in turn supply more than 65,000 dentists on a daily basis. Historically Core3dcentres has not dealt directly with dentists, therefore you may not have heard of us, but like "Intel" our substructures are "inside" a vast quantity of the restorations you may have fitted.

As more and more restorations are being made to completion by CAD/CAM, the lines between a CAD/CAM centre and a dental laboratory are becoming blurred. Many of the traditional supply companies such as Straumann, Dentsply and Henry Schien are starting to manufacture restorations themselves. However, they do not yet have the skill set of the traditional local dental laboratory.

Now as digital scanners enter the market and newer monolithic materials become common practice, the capital investment for machinery is too much of a barrier for local manufacturing of specific products, while remaining competitive. We have seen this happen already at DTS and through our existing Core3dcentres global network. DTS has now taken the next step to develop an efficient and modern dental manufacturing company.

At the end of 2015, DTS announced a strategic relationship with some of the world's leading dental laboratories in North America, Holland, Germany, Japan, China and Australia with a few more countries to join us in 2016. Working in a much closer relationship with these forward-thinking and like-minded dental businesses is helping us to quickly develop the workflows and restorations our dentists want. This relationship will allow us to share resources and production capacity to deliver a cost-effective and high-quality solution to our local markets like never before.

What will our customers see change? Nothing but good things.

We have been working closely with these global businesses for many years now and have already integrated some of their ideas in our business. We will always remain a local, family business but now with a backbone that can develop us in to a new generation of dental laboratories.

Our dental world is changing and DTS has embraced it and is developing with it. We hope you will join us on our journey to the new world.

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It is encouraging to see that the number of practices choosing to move to 'Best Practice' in decontamination standards is on the rise again. More and more dentists are realising that there are significant business benefits to be gained, in addition to providing patients and staff with the highest infection control standards and reassurance that their safety and comfort is a top priority.

INSTRUMENT CLEANING IS FIRST STEP

For a number of years, it has been generally accepted that the best method of cleaning and preparing instruments for sterilisation has been the use of a washer disinfector. While some practices had, perhaps understandably, held back from making such a big investment, the increased risk of cross-infection – from HIV, Hepatitis C, Herpes and even from those diseases we thought we had eradicated such as TB and polio – together with an increasing resistance to antibiotics, will continue to drive cross-infection control standards ever higher. In addition, evidence exists to show that sharps injuries to staff are significantly lower or completely eliminated in those practices using a washer disinfector to replace the manual processes involved in either scrubbing or using an ultrasonic bath.

A wide choice of machines means that there are now sizes and capacities available to suit the needs of most practices, while advances in technology have enabled the process to be completed much faster – in the past one of the main reasons given for delaying purchase. Most dentists now recognise that a washer disinfector can provide valuable time and throughput efficiencies in the practice and many have already made room to accommodate them but still there are those who remain to be convinced!

SAVE TIME AND MONEY

Let us consider how cost-effective a washer disinfector could be in your decontamination process. The starting salary for a dental nurse will be around £8.50 per hour. Once qualified, this will rise to between £9.75 and £11.50. These costs don't, of course, take into account insurance and pension contributions etc.

MANUALLY SCRUBBING

The protocol is arduous to say the least. It includes constant monitoring of water temperature using a non-mercury thermometer, monitoring of detergent concentration, scrubbing of each instrument below the water level for two minutes, and full inspection of each instrument under a magnified illuminated source. To prevent inhalation of, or contamination from, an aerosol spray of contaminated water, full personal protective equipment (PPE) should be worn. Even if all of these protocols are observed, which often they are not, the risk of sharps injury is high, especially if such procedures are performed regularly over a long period of time during a nurse's career.

Taking the starting salary as the minimum cost then, a dental nurse will take at least two minutes to clean an instrument. It would take four hours to clean 120 instruments – at a cost of £34 in terms of labour. Throughput – 30 instruments per hour (Fig 1).

A washer disinfector will cost around £4,000 and will clean those same 120 instruments in around 60 minutes. Using instrument cassette trays (that can then be transported directly from the washer disinfector into the autoclave) and allowing time for loading/unloading, in four hours it could clean 480 instruments. Throughput –120 instruments per hour.

On a seven-hour day, therefore, the cost for manually scrubbing is seven hours x £8.50 = £61.25.

Washer disinfector purchase price £4,000 divided by £61.25 means that it is recovered in around 64 days.

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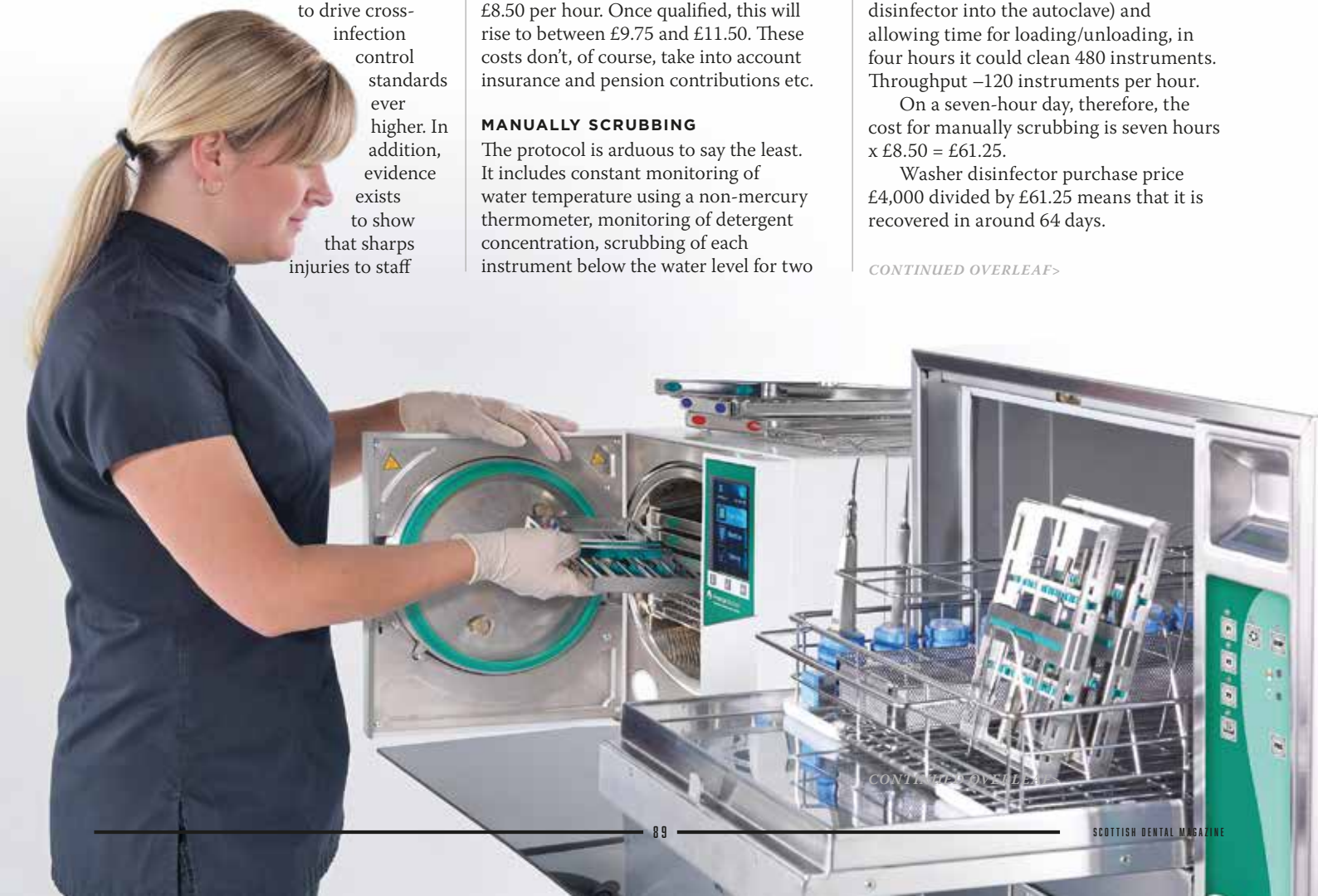

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ULTRASONIC BATH

Ultrasonic cleaning is an effective method of removing contamination from instruments. It is particularly useful when trying to remove hardened on substances or protein rich contamination such as dried blood. Ultrasonic cleaners use a process called cavitation, where bubbles are specially formed in a solution of water and detergent. The bubbles implode on contact with contamination on instruments placed in the solution, and these implosions release a surprising amount of energy in the process, sufficient to forcibly remove even stubborn contamination.

However, ultrasonic cleaners are not the complete answer to instrument cleaning, because even though contamination can be removed from the instruments, the instruments themselves will still be immersed in a toxic soup of contaminated water within the ultrasonic cleaner. When instruments are removed from the ultrasonic cleaner, they need to undergo a washing process before being ready for inspection and sterilisation in the autoclave.

An ultrasonic bath will take a maximum of 45 instruments per load. A cycle takes around 10 minutes, following which the instruments still need to be thoroughly rinsed and then dried manually. Conservatively, this will take another 10 minutes. Throughput – around the same as a washer disinfector, but much less efficient in terms of cleaning efficacy.

So, it is clear that whatever method you are currently using and even taking into account running costs ad detergent, a washer disinfector will have easily paid for itself in less than six months – and it doesn't need to take a holiday!

A WORD ABOUT HANDPIECES

Handpieces, particularly, are difficult to effectively clean, inspect and sterilise due to their intricate nature and their inability to be easily dismantled. Laboratory tests show that sterilisation can only be effective following adequate cleaning. Efficient cleaning and lubrication will also determine handpiece functionality, reducing wear and tear and therefore the need for costly ongoing maintenance and premature replacement. Dental handpieces present a particular challenge because they have both external and internal surfaces which become contaminated during use. When the air and water is switched off, the negative pressure is likely to result in contaminated fluid and air being drawn into the air and water lines.

FIGURE 1
Manually scrubbing

The majority of good quality handpieces can be safely cleaned in a washer disinfector – look for the shower symbol which is located on the body of the instrument. The UltraClean 3 range of washer disinfectors from Prestige Medical can be supplied with baskets containing special connectors for hand pieces with irrigation channels which enable the handpieces to be cleaned and disinfected both externally and, critically, internally – forcing water up through the internal tubes and channels. The addition of forced air drying, which eliminates the need to dry with paper towels or leave to air dry, means that at the end of the process the handpiece is clean and ready for lubrication prior to sterilisation, as recommended by the handpiece manufacturers themselves.

INSTRUMENT STERILISATION

A validated cleaning process, coupled with the appropriate lubrication of the internal components would then be followed by sterilisation. The majority of instruments used by dentists are classed as 'hollow' devices. For example, given their design, for effective handpiece sterilisation, it is necessary for the air to be removed from the lumens and hollows to allow steam penetration by using a 'B Class' vacuum autoclave. This is especially important if the handpiece is to be pouched before sterilisation. The Prestige Medical Advance B Class autoclave also features a non-vacuum cycle for maximum flexibility in use and, with a capacity of six trays, can process more instruments per cycle than most other autoclaves.

IN SUMMARY

There is a wide range of decontamination equipment on offer from a variety of manufacturers. Inevitably, there can be a temptation to go for the cheapest option. However, it is wise to look for a reputable manufacturer who can provide you with a good-quality product at a competitive price as well as full service and technical support.

In summary, then, with the current generation of equipment, the whole decontamination process to meet best practice standards can actually reduce the time you spend on processing instruments. Most reputable manufacturers will offer a range of decontamination solutions and should be able to provide you with sensible advice on choosing the best type of equipment to suit your needs.

ABOUT THE AUTHOR
Christine Bowness is the business manager – UK and Ireland for Prestige Medical. For more information, visit www.prestigemedical.co.uk

FIGURE 2 Basket with handpiece connectors

FIGURE 3 Ultraclean 3 Benchtop

FIGURE 4 Advance Vacuum Autoclave

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"I am glad to hear that Scot has been pleased with my progress. He is an extremely knowledgeable and patient mentor as well as a very skilled clinician. He really creates a superb environment to apply the knowledge gained through the online portion of the course. As for the Smiletube course, I can only compliment Ken for compiling such a comprehensive and detailed course that not only allows you to progress at your own pace but also further your own knowledge through its extensive documents and library. The website is well designed and the videos very informative."
— Dr Richard Alexander GDP Paisley

"I just wanted to say that I'm having so much fun doing smiletube it's really informative and my husband watched the radiography lecture last night and we both looked at our rads in work today in a completely different light, we actually knew what the radiolucencies and opacities were!!"
— Bec September 2015

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A WINNING PARTNERSHIP FOR IMPLANT SUCCESS

THE IMPORTANCE OF CHOOSING AN IMPLANT PARTNER THAT CAN REALLY MAKE A DIFFERENCE TO THE SUCCESS OF YOUR IMPLANT PRACTICE CANNOT BE OVERESTIMATED. WITH THIS IN MIND, JOHN CUCCIO EXPLAINS WHY HE IS SO PLEASED THAT HE HAS PARTNERED WITH BIOHORIZONS.

BioHorizons offers a straightforward, well-designed system that incorporates the latest advances in implant design and surface technology, as well as acknowledging the long-established principles of dental implantology. The surgical and restorative components are well-designed and presented in a very well-formulated and easy-to-follow system.

I consider myself to be in partnership with BioHorizons, because the use of the word 'partner' goes some way in reflecting the attitude of the company towards its users, who are regarded as clients rather than customers.

The company is very proactive in recognising the value of both the very experienced and newcomer to implantology, and is positive in providing, encouraging and organising opportunities for further education and mentoring. Indeed, the educational programmes offered by BioHorizons are broad based and open to anyone who has an interest in either learning or sharing their own knowledge.

COMPANY SUPPORT

With BioHorizons, I have experienced a level of service and support that is both prompt and efficient, offering ease of exchange and returns. In fact, I've found that the company is keen to engage with clients on a level that I have not experienced with other implant companies. In addition, the team at BioHorizons manages to make the individual client feel that whatever his or her level of involvement in implant dentistry,

the client is very important to them. Unlike some other companies, they have a sustained interest in both engaging and listening to their clients and promoting mutual interests. The company demonstrates a unique concern in advancing the clients' interests, as well as that of the company.

PAYING IT FORWARD

When it comes to referrals, the essential thing for a referring dentist is to have complete confidence in the implant practitioner to whom he or she refers, and to know that the patient will be treated professionally and appropriately. Above all, I believe that the referring dentist must be sure that the patient will be returned for ongoing dental care. Indeed, referring is very often a two-way street in that patients referred for implants inevitably raise their "dental awareness" considerably, and this often results in the patient returning to their own dental surgeon requesting further restorative work.

After all, the implant practitioner is very well placed, as a neutral third party, to suggest that, for example, a very old crown or a worn, discoloured filling can be replaced by the referring dentist. The dentist/implant practitioner relationship is very flexible and varies from those who like to be advised of each stage of treatment in detail to those who are satisfied with minimal communication regarding the clinical procedures. Lines of communication with referring dentists are always open, and they are always welcome to observe any stage of the treatment. Monitoring of the implant and restoration is imperative, and I like to review patients some months after treatment, in parallel with their regular dental examinations.

A REWARDING PARTNERSHIP

After three decades of placing parallel-wall implants, the change to using tapered fixtures from BioHorizons was a satisfying and exciting experience. The smooth, firm and positive engagement of the implant threads during placement and the confidence and reassurance this generates is a reward in itself.

ABOUT THE AUTHOR

John Cuccio graduated from Liverpool University Dental School and, following the completion of postgraduate courses in the USA, took over a long-established dental practice on Harley Street where he has worked for 36 years. Placing his first implant more than 35 years ago, he increasingly incorporated implants into his practice. John has worked with many of the early pioneers of implant dentistry. He carries out surgical and restorative treatment, enabling him to see all aspects of treatment from start to finish. John lectures on both the surgical and restorative aspects of implantology, and is an accredited implant mentor from a number of associations and implant companies. He is also a Fellow of the International Congress of Oral Implantology. John's practice is now restricted to implant dentistry.

BIOHORIZONS®

MORE INFORMATION

Please visit www.biohorizons.com to see the entire range of dental implant products and biologics. Whatever your clinical need, BioHorizons has the solution.

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VOCO'S SCOTTISH DENTAL SHOW HIGHLIGHTS

ADMIRA FUSION – THE FIRST PURELY CERAMIC-BASED UNIVERSAL RESTORATIVE MATERIAL

VOCO presented several proven and innovative products at the 2016 Scottish Dental Show, including Admira Fusion, the worldwide first purely ceramic-based universal restorative material. Silicon oxide forms the chemical base for this new nanohybrid ORMOCER restorative material, not only for the fillers but also for the resin matrix.

This offers several remarkable advantages: Admira Fusion, in comparison with all restorative composites of market relevance, shows by far the lowest level of polymerisation shrinkage (1.25 per cent by volume) and extremely low shrinkage stress.

The ORMOCERs used in the manufacture of Admira Fusion make it highly biocompatible, as there is no content of classic monomers. Admira Fusion has an 84 per cent (by weight) content of inorganic fillers and covers a broad spectrum of indications. Admira Fusion's particularly high-colour stability gives it an additional edge. This very homogeneous material offers outstanding handling and is compatible with all conventional bonding materials.

MORE INFO
Contact VOCO GmbH, PO Box 767, 27457 Cuxhaven, Germany, www.voco.com, info@voco.com, Tel. UK: 07500 769 613

INDICATIONS OF ADMIRA FUSION

- Class I to V restorations
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- Facetting of discoloured anteriors
- Correction of shape and shade for improved aesthetic appearance
- Locking, splinting of loose anteriors
- Repairing veneers, small enamel defects and temporary C&B materials
- Restoration of deciduous teeth
- Core build-up
- Composite inlays

Enamel-dentine fracture on tooth 21

Insufficient amalgam restorations in teeth 46 and 47

Aesthetic result after polishing

Finished, polished restorations (clinical photos: Dr Sânzio Marques, Passos/ Brazil)

VOCO
THE DENTALISTS

Admira Fusion, the worldwide first purely ceramic-based restorative material capable of producing highly aesthetic restorations in the anterior and posterior region

GETTING THEIR DUCKS IN A ROW

APRIL EAST, DIRECTOR AT DENTAL RECRUITMENT SPECIALISTS PS NEW JOB, DESCRIBES HER EXPERIENCE AT THE RECENT SCOTTISH DENTAL SHOW

Despite being the company's first outing at the Scottish Dental Show, PS New Job's April and Angela have more than 15 years of experience in the sector.

However, this couldn't prepare them for how busy the 2016 event was and also how popular their stand turned out to be, along with their dental ducks.

April said: "I couldn't believe how busy the exhibition was early Friday morning, people were coming in droves. At just 9.30am our stand and the whole exhibition was buzzing with atmosphere.

"We hosted a game on our stand where delegates had to knock our dental ducks off the shelf and it became the talk of the exhibition. By lunchtime Friday it was clear that our ducks were "flying" out the door.

"I could not believe the demand we were getting for the ducks, and that was from a very established dental professor to our lovely dental nurses all wanting to own and win one of our dental ducks."

As the game proved so popular on the Friday, the Scottish Dental Show's own Ann Craib suggested that they might try and raise some money for charity on the Saturday and the PS New Job stand promptly raised more than £150 for oral cancer research.

April continued: "We would like to thank everyone that took part and helped raise this fantastic amount.

"I was delighted with the response to our stand and to our ducks. I will be making sure that next year we will have more ducks for everyone and hopefully everyone will come visit us again.

"The exhibition put us in contact with a huge amount of people and it was just such a great show. Angela and I loved every minute of it. See you all next year!"

To contact PS New Job, call 0141 202 3000.

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ON COURSE FOR A GREAT YEAR

IT'S BEEN A BUSY 2016 SO FAR FOR THE SCOTTISH CENTRE FOR EXCELLENCE IN DENTISTRY, WITH LOTS STILL TO LOOK FORWARD TO FOR THE TEAM, REFERRING DENTISTS AND THEIR PATIENTS

More than 40 delegates attended the event at Loch Lomond Golf Club on 29 April, sponsored by Nobel Biocare, Emirates and Barrhead Travel. In the morning, delegates attended a seminar where guest speaker Rishi Patel spoke about the 'Management of the failing Anterior Dentition'. Arshad Ali also shared his expert knowledge with top tips for crown and bridge work.

In the afternoon, delegates took part in a golf competition or indulged in a visit to the spa. The winner of the longest drive was Kevin O'Farrell, closest to the pin was Kishore Pranjivan and the overall SCED 2016 Champion was Rico De Rego. John Young won the overall prize of two return flights to Dubai including five-star accommodation courtesy of Emirates and Barrhead Travel.

Congratulations to all the winners. A fantastic day was had by all and we are happy to thank all of our sponsors and delegates who attended.

ESTHETIC ALLIANCE PROGRAMME

The objectives of the course are to consider treatment planning options for missing teeth and to gain hands-on experience for single and multiple implants. It will allow dentists to restore implant crowns on their own patients at their own surgeries after implants have been placed at SCED.

This will be held over two days at SCED. The next course dates are Saturday 1 and 29 October 2016. The cost is £495, including a Nobel Biocare restorative kit. Contact yvonnemuir@scottishdentistry.com for details.

SCOTTISH DENTAL SHOW

Arshad Ali hosted Kerr's workshop on SonicFill at the Scottish Dental Show on Friday 13 May. He demonstrated how quick and easy it is to use SonicFill. Another course will be held at SCED shortly – please contact secretary@scottishdentistry.com for more details.

AESTHETIC RESTORATIONS WITHOUT BONDING

Ionolux is a light-curing glass ionomer restorative material in VITA shades A1, A2, A3, A3.5 and B1, which combines the advantages of glass ionomer materials with those of composites. The dentist can, for example, individually adjust the working time of Ionolux by using a polymerisation light.

Application of Ionolux is quick, and the material can be modelled with ease. It also adapts excellently to cavity walls. Ionolux not only makes conditioning of the dental hard tissue unnecessary, there is also no need to apply a final coat of varnish. Polymerisation times are short and practice-oriented, at 20 seconds per 2mm layer. Ionolux is easy to polish, it is biocompatible and releases fluorides. Our proven Ionolux is now available in the new and particularly practical application capsule.

For more information phone, 07500 769 613, email info@voco.com or visit www.voco.com

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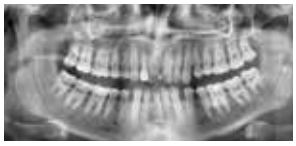
IonoSelect is the world's first product suitable for use in the four main GIC indications: luting, restorations, core build-up and cavity lining. IonoSelect for restorations features excellent physical properties, such as high compressive strength, good adhesion to enamel and dentine, as well as high levels of biocompatibility and fluoride release.

The restorative material is available in a universal tooth-coloured shade as well as pink. It is recommended in particular for use in pediatric dentistry and for patients with a low level of compliance. In addition, strong core build-ups can be constructed with IonoSelect, its pink colourway being particularly advantageous for distinguishing the core build-up from the remaining dental hard tissue.

For more information, call 07500 769 613, email info@voco.com or visit www.voco.com

NO NEED TO 'TAKE TWO'



Dürr Dental's panoramic device is so easy to use you won't need a second take, as the first one will almost certainly be perfect.

VistaPano works completely differently to conventional machines and employs S-Pan technology. This ensures the reconstruction is geared at the actual position of the bite, thus obviating positional errors.

The intuitive software selects only the sharpest images from the many segments taken in a single use.

The unit is exceptionally versatile. In addition to the standard panorama programs, dentists can use options for right, left, and front half-side images and functions for orthogonal bitewing images, mandibular joint images for function diagnostics, and para-nasal sinus images.

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

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For more information, contact Wrights on 0800 66 88 99 or visit www.wright-cottrell.co.uk

COMPLIMENTARY CPD FROM DOLBY

Dolby Medical, Scotland's leading dental products and servicing company, is offering dental practices complimentary CPD-accredited washer disinfector training courses.

The one-hour training sessions, delivered by a Dolby expert, cover the essential dos and don'ts of washer disinfector operation, loading and unloading procedures and the safe and cost-effective operation of these machines. The training is provided free of charge and can be conducted within the dental practice at a time to suit the dental team.

Derek Gordon, managing director of Dolby Medical, said: "With increasing emphasis being placed on the proper utilisation of these machines, our training is the ideal way to provide a reminder for your team and also gain CDP accreditation at the same time."

Interested dental practices should contact Dolby's key accounts manager Gillian Wylie on 07551 203 893.

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