No.1 for dental professionals in Scotland

December 2012/January 2013

Scottish Dental magazine

Glasgow Dental School gets £2.5m cash injection

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THE RIGHT TIME

Outgoing BDA national director Andrew Lamb on his retirement

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DÜRR DENTAL

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Editor's desk

with Bruce Oxley

Debate it out

There seems to have been a bit of a backlash of late among some sections of the profession towards the subject of dental awards.

While the criticism may seem harsh to some, others may well feel it doesn't go far enough. For me, the truth – or the general consensus of opinion – will lie somewhere in between and the fact remains that if these awards were not entered and attended by the profession, then they simply wouldn't exist.

There seems to be an element of bad humour about the whole subject – and I'm not talking about 'funny' cartoon strips here. If you don't like them, don't enter. If you don't think your colleagues should enter, tell them. I'll happily print any correspondence for and against awards in the magazine. But be prepared to have your point of view questioned.

Debate is good. But in order to have a debate there must be at least two sides to an argument.

I'm pretty sure that there is an appetite for dental awards, but if there isn't then the proof will be in how many entries we get for the Scottish Dental Awards that we are hosting on 16 May 2013.

We are not doing this to make money, or to exploit the profession. In fact, entry to our awards is free and we are holding it at Hampden on the evening of the first day of the Scottish Dental Show to kill two birds with one stone, so to speak.

We see this as a way to celebrate good practice and good practices. To reward your colleagues, your staff and your friends for their hard work, dedication and overall commitment to fantastic patient care.

We are very lucky in Scotland to have some of the best practices, practitioners and teams in the country and in some cases the world. I think that is something to celebrate and if anyone out there can tell me of a better way to do that, then I'm all ears.

I won't pretend for one second that our awards are more important than postgraduate or specialist qualifications, and I'm sure the winners of these awards don't think like that.

If you are good at what you do, your patients and your peers will know that. However, I'd like to think that our awards will help the rest of the dental team get some recognition, not just the 'celebrity dentists'.

That is why we have categories for nurses, student nurses, hygienist/therapists and dental business managers as well as practices themselves.

Turn to page 7 for more details and let me know what you think... ■

Bruce Oxley is the editor of Scottish Dental magazine. To contact Bruce, email bruce@connectcommunications.co.uk

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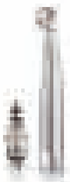

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Biting back

with Arthur Dent

Tightening the purse strings

In a previous 'Biting Back' column (Scottish Dental June/July 2012), I challenged the Scottish Government (SG) to implement the recommendations of the Doctors' and Dentists' Review Body: 1 per cent in 2011-12 and a further 1.38 per cent in the current year 2012-13. These fee increases were recommended purely to allow dental practices to try to mitigate the ever-increasing cost of overheads.

SG promised a decision by the end of March, but so far no announcement has been made. However, that does not mean SG has been ignoring the topic of dental practice funding – quite the opposite. The Chief Dental Officer (CDO) and her team (on the orders of their political masters) have been busily considering what CUTS can be made to dental practice funding; the resultant changes were implemented on 1 December.

These cuts are wide-ranging and few, if any, general dental practitioners will remain unaffected by them. Among these are:

- the removal of payment for free replacement of restorations. Dentists will still have to provide a 12-month guarantee on restorations but will have to do this unpaid by PSD
- the removal of fees for repairs to orthodontic appliances, these will now have to be done without payment
- the abolition of the VT Recruitment Allowance (Golden Hello)
- significant changes to the VT Practice Improvement Grant (Determination X). An initial grant of up to £10k only for practices new to VT; existing VT practices may access up to £6k after five financial years and any grant funding must be used solely for the designated VT surgery
- rent reimbursement will be abated by the percentage of NHS fees to total fee earnings and EVERY practice will have to submit an annual declaration of this percentage signed by their accountant.

The GDPA was under serious risk of severe reduction but the SDPC resisted vehemently

When these cuts were in the planning stage, the CDO was in discussion with the Scottish Dental Practice Committee (SDPC) of the BDA. SDPC has made clear that it was opposed to ANY cuts in funding, and it did endeavour to minimise the impact of any SG cuts on dentists and patients.

I have heard that the General Dental Practice Allowance (GDPA) was under serious risk of severe reduction but that SDPC resisted this most vehemently. The GDPA is a financial lifeline to all hard-pressed dental practices and without it many would face bankruptcy. It is vital that GDPA remains intact and it must be free from any SG meddling!

As I understand, these cuts are merely the first round and that SG will seek further savings in the next financial year. I can almost hear the sharp intake of breath as you read...

So, it's a happy New Year to Scottish dentists, staff and patients from the Scottish Government! ■

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1 year, 6 issue subscriptions: UK £60; overseas £75; students £30.
Back issues: £5, subject to availability.

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ISSN 2042-9762

Scottish Dental magazine
is published by
connect publications

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Dental Show is now online

New website to showcase everything the 2013 event has to offer

The brand-new website for the Scottish Dental Show 2013 is now LIVE, featuring all you need to know about the Hampden Park event.

With a regularly-updated news section, we will be able to keep you up to date on the latest developments in the run-up to the show on 16 and 17 May 2013. From breaking news on who is speaking and when, to details of the exhibitors, their deals and any product launches they are unveiling at the event.

The new site features a detailed listings section where you can see who is exhibiting at the show, and where to find them when you are there. Contact details and company information is included alongside a comprehensive floorplan for each of the three halls and reception area at Hampden.

The lecture programme will be unveiled in the new year to coincide with the opening of registrations. Two of the most popular speakers from last year's show, Ashley Latter and Paul Tipton, are confirmed for both days and we will be announcing more speakers in the days and weeks to come.

SCOTTISH DENTAL SHOW 2013

Don't forget, you can also find all the latest news about the Scottish dental world by logging on to **www.sdmag.co.uk** by following us on Twitter **@ScottishDental** – don't forget the **#ScottishDentalShow** hashtag if you tweet about the show – or by **'liking'** us on **Facebook.com/ScottishDental**

Scottish Dental Awards 2013

Nominations are now open for the first-ever Scottish Dental Awards, which will be held on 16 May 2013 at Hampden.

The event will build on the success of the 2012 Scottish Dental Lifetime Achievement Award, which was won by former Dundee Dental School dean, Professor William Saunders.

The organisers of the 2013 show have decided to expand the occasion to include a black tie dinner and extended awards ceremony. The 2012 drinks reception was hosted by BBC Scotland's football correspondent Chick Young and he had guests, from north and south of the border, holding their sides with laughter. The identity of the host for next year's awards ceremony will be announced soon and the organisers are confident it will be an evening to remember.

Alongside the Lifetime Achievement Award, which will remain as the headline prize, there will be 11 categories for dentists and their teams to enter. Full details of the categories and how to enter are available on the awards page of the website.

Nominations will close on 1 March 2013 and the winners, to be chosen by a panel of judges from across the profession, will be announced at the ceremony on 16 May.

Tickets and tables of ten are available along with sponsorship packages. Contact Ann Craib on 0141 560 3021 or ann@connectcommunications.co.uk for details.

JUDGING PANEL

The final line-up is still to be confimed but the dental professionals who have so far agreed to join our judging panel are:

- **Margie Taylor** – Chief Dental Officer, Scottish Government
- **Kieran Fallon** – GDP, Glasgow
- **Margaret Ross** – senior lecturer and programme director, Edinburgh Postgraduate Dental Institute
- **John Glen** – GDP, Cowdenbeath
- **Nicola Docherty** – British Association of Dental Nurses president
- **Jill Taylor** – president of the Association of Dental Administrators and Managers
- **Bruce Oxley** – editor of Scottish Dental magazine
- **Ann Craib** – advertising and events manager, Scottish Dental magazine.

Unfortunately, due to circumstances beyond our control, Stephen Jacobs has been forced to take a step back from the scientific committee, but he has agreed to give whatever support he can to our new chair Kevin Lochhead of Edinburgh Dental Specialists. Kevin will be instrumental in shaping the programme and making sure that it is as relevant to general practitioners and their teams as possible.

There will be four main lecture streams at the show: dentists, technicians, DCPs and dental business. Some sessions will be relevant to all members of the team and we will endeavour to communicate this through the new website. Core CPD topics will also be covered, including the most recently added topic, oral cancer.

The new website also features a section devoted to the Scottish Dental Awards, with details on the categories, nomination process and the judges (see above right).

Inaugural show recognised at the 2012 Scottish Magazine Awards

Connect Publications' MD Alan Ramsay picks up the award

The first Scottish Dental Show won a major award recently as it was named winner of the Best Brand Extension prize at the 2012 Scottish Magazine Awards.

The awards, organised by the Professional Publishers Association (PPA), recognised the success of an event that attracted more than 100 exhibitors and 1,200 dental professionals to Hampden Park in May.

The show prevailed in a very strong category featuring some of the heavyweights in the Scottish publishing industry. DC Thomson, famous for publishing the Beano, Dandy and other titles, had a trio of publications in the Brand Extension category. They were: The Beano, The People's Friend and The Official Jacqueline Wilson Magazine. The final nominee was Country Lifestyle Scotland, published by Newsquest (Herald & Times).

Dentist banks stem cells from daughter

STEM CELL RESEARCH

A dentist from East Kilbride has become the first practitioner in Scotland to bank stem cells from his own daughter's baby teeth.

Callum Graham, who owns Queen's Park Dental Practice in the south side of Glasgow as well as the Tooth Doctor practice in Carluke, took the unusual decision to freeze and store his daughter Becca's milk teeth so the seven year old can take advantage of future medical advances in stem cell research.

Speaking to the *Daily Record*, Callum said: "There's been an awful lot of research lately regarding stem cells and how to deliver them and use them to cure diseases, leukaemia, diabetes and

cancers. We had been looking for a way to store stem cells when Rebecca was born. We'd heard all about it and thought it was a good idea.

"Although there's not a lot of treatments just now, we knew there was a future in it, in personalised bio-technology, where everybody cures themselves. It's a fabulous service to be able to offer your children.

"Becca was brilliant. We explained the relevance of it, why we were going to take her tooth and she was a brilliant wee patient.

"It's always a little bit nerve-wracking treating members of your family or your friends. You feel a great deal of empathy with them, as you do with all your patients, but more so with people you know."

Dentists launch online protest over latest cuts

DENTAL REMUNERATION

e-Petition. Anger boils to the surface over the latest amendment to the SDR

A disgruntled group of Scottish dentists has launched an e-petition to protest about the recent cuts to the Statement of Dental Remuneration (SDR).

Revisions announced on 26 November include: the end of payments for free repairs or replacements of restorations, with the exception of trauma and denture repairs or replacements; the end of payments for repairs to fixed orthodontic appliances, with the exception of repairs undertaken by dentists on behalf of orthodontists in remote areas; the abolition of the VT recruitment allowance; and significant changes to the VT practice improvement grant.

The organisers said: "In addition to other health professionals, general dental practitioners have been integral in the delivery of oral healthcare for the people of Scotland. Year upon year, the fees assigned for work in general dental services by means of the SDR have not increased in accordance with inflation and/or similar indexes, even though the cost of providing such work has increased significantly.

"Furthermore, the constant 'cuts' have challenged our ability to provide adequate care within our means. The latest amendment (No. 122) has further compounded such concerns to a degree which has infuriated GDS dentists across the country.

"As independent contractors in our thousands, we feel that proper consultation in relation to these changes has NOT been conducted by conventional means before implementation and are now making a stand in protest."

The petition encourages people to sign their names to the following statement: "We, the undersigned, call on the Scottish Government and health boards within Scotland to reverse the decisions taken within Amendment No. 122 to the SDR, undertake proper consultations and obtain consents for this and any future amendments to the SDR before implementation OR any changes in policies affecting dentists by practitioner services and/or local health boards.

"Failure to do so may result in thousands of dentists across the country choosing to strike in protest. Such action, although regrettable, will dramatically affect primary healthcare services across Scotland."

To view and sign the petition, go to www.gopetition.com/petitions/stop-sdr-cuts.html

BDA response to latest SDR cuts

Dr Robert Donald, chairman of the SDPC, said: "SDPC opposes any cut to the funding of dental services. But where changes have to be made, it is important they be implemented in the least damaging way possible, in consultation with the profession and with the best outcome for patients as their end goal. The BDA has consistently stressed the importance of the General Dental Practice Allowance and its retention was highlighted in the BDA's manifesto for the Scottish Government elections last year as a key commitment that the new government should make. We are pleased to see that appears to have been taken on board."

To read Amendment No 122, see www.sehd.scot.nhs.uk/pca/PCA2012(D)04.pdf

Contracts. New pay, terms and conditions set to be introduced for salaried dentists

Negotiations near end

Negotiations for the new contract for salaried dentists is finally nearing the end, according to the BDA's recently retired national director for Scotland.

Andrew Lamb told *Scottish Dental magazine* that the association will be in a position to ballot its members on the new contract "in the next few months".

The current Chief Dental Officer Margie Taylor wrote a report, published in 2006, about combining the community dental service and the salaried general dental service, and negotiations have been dragging on since that time.

Andrew, who left his role at the BDA at the beginning of November, said that getting the health boards on side was one of the main reasons behind the delay.

He said: "It took a long time for the NHS employers in Scotland to come on board. We had very fruitful discussions with the Scottish Government, but without the employers, making substantial progress wasn't going to happen.

"However, in the last year or so, the representatives of the employers – which is the management steering group made up of the chief executives and finance directors of the NHS boards – have agreed to take part in tripartite talks with the BDA and the Scottish Government to try to take this forward."

Andrew and the CDO put out joint letters in July and October this year on the new Scottish Public Dental Service stating, most recently, that they have formally entered into negotiations about new pay and terms and conditions of service package.

"It took a long time for the NHS employers in Scotland to come on board"

Andrew Lamb

However, with the end finally in sight, Andrew revealed that not being around when the deal is finally done is one of his biggest regrets in his nine years as national director.

He said: "I am hopeful now that within the next few months, we will see the end of this piece of work. I am just disappointed that I didn't manage to see it through to fruition."

Read our in-depth interview with Andrew Lamb on page 22.

GDC is "out of touch with registrants" says BADN president

ANNUAL RETENTION FEE

The decision by the General Dental Council to freeze the Annual Retention Fee (ARF) in 2013 has been criticised by the British Association for Dental Nurses (BADN).

President Nicola Docherty, pictured, who is also a senior dental nurse tutor for NHS Education for Scotland, said that keeping the ARF at £120 shows that the GDC is "out of touch with residents".

She said: "We have supplied the GDC with detailed information on dental nurse salaries, showing that the £120 ARF causes considerable financial hardship to dental nurses.

"We have also requested that the GDC lower the ARF for dental nurses to a fee more in line with salaries – instead of charging dental nurses the same ARF as hygienists and therapists – and that they implement a special fee for those working part time."

Nicola pointed to a recent BADN survey that found the majority of dental nurses are paid between £10,000 and £20,000 a year, compared to hygienists and therapists whose starting salary is £26,000.

She continued: "BADN has always supported, and continues to support, registration in principle, as being in the best interests of the patient.

"However, the GDC's heavy-handed and insensitive implementation, including the imposing of an unreasonable ARF, has alienated many dental nurses and must be rectified as soon as possible."

John Lennon's tooth comes to Glasgow

Glasgow dentist Mark Skimming's south side practice will welcome an unusual piece of music memorabilia in January, when John Lennon's tooth comes to town.

Dentistry on the Square will play host to the John Lennon Tooth Tour on 15 January as part of a 15-practice UK tour to raise money for an oral cancer charity. Canadian dentist Michael 'Yar' Zuk, who also owns a porcelain crown and model of Elvis Presley's teeth, bought John Lennon's tooth for £19,500 at an auction last year. The Beatles front man gave the tooth to his housekeeper in the 1960s and her family recently made it available for auction.

With the help of a jeweller from Beverly Hills, Zuk has turned the tooth into three John Lennon DNA pendants, with one of these pieces of jewellery being donated to charity to raise money in the fight against oral cancer.

Conduct. GDC committee hears of a "serious breach of patient trust"

Shetland dental nurse is struck off

GDC RULING

A dental nurse from Shetland has been struck off by the Dental Council after failing to attend a public hearing where she was accused of stealing from her patients.

The GDC's Professional Conduct Committee (PCC) heard that Lerwick-based Melanie Inkster overcharged patients for their treatment, falsely recorded lower payments as having been received and took the sum overcharged for her own use.

The hearing was told that Ms Inkster admitted her actions during her employer's disciplinary process, when it was recorded that she said: "It was not something I would normally do, but it started and got out of hand."

A spokesman for the PCC said: "Ms Inkster's actions fell far short of the standards of the profession, and her conduct was inappropriate and dishonest. Ms Inkster's action was a serious breach of patient trust and disregarded basic tenets of the profession.

"Her actions in stealing from patients and the practice were dishonest, systematic and sustained conduct over a period of time.

"While recognising that dishonesty does not inevitably lead to erasure from the GDC's register, the case also involved breaches of patient trust.

"Ms Inkster's behaviour has been deemed so unacceptable to the reputation of the profession that erasure is the only appropriate and proportionate sanction."

To see the GDC's full determination, visit the GDC's website at www.gdc-uk.org

Above: Dental Protection's dental director Kevin Lewis, Dr Jason Leitch, Dr Gerald Hickson, Professor Trevor Burke and Helen Kaney, dento legal adviser for Dental Protection based in Edinburgh

Dr Leitch speaks at Symposium

EVENT

Dentist and newly appointed clinical director for the NHS in Scotland Jason Leitch was one of the key speakers at the 12th annual Premier Symposium in London recently.

The event, organised by Dental Protection in association with Shülke, saw nearly 300 delegates enjoy talks from Professor Trevor Burke, Dr Lloyd Searson, Dr Jason Leitch, Dr Gerald Hickson and Professor Mark McGurk at the Shaw Theatre.

Professor Burke's talk, entitled 'Fools rush in…', focused on the challenges facing practitioners when choosing dental materials and how to make an informed decision based on the evidence rather than the advertising.

He was followed onto the podium by Dr Lloyd Searson whose talk, '…where angels fear to tread', neatly bookended the previous presentation. He spoke about the potential problems in implant dentistry, calling on his extensive experience as one of the leading implant surgeons in the UK.

Dr Leitch took to the stage to give an entertaining and impassioned overview of the healthcare system in Scotland and his newly created role in the NHS.

He spoke about mortality rates and health inequalities and outlined the work of the Healthcare Quality Strategy for Scotland and the expected launch of the Scottish Patient Safety Programme in March 2013.

Mouth cancer rises among young Scots

New figures released by the Faculty of General Dental Practitioners (FGDP) have found that a growing number of young people in Scotland who neither smoke nor drink are being diagnosed with mouth cancer.

While men aged 50 and over who smoke and drink heavily remain most at risk, the FGDP revealed that they predict around one tenth of the expected 800 people who will be diagnosed with the disease in the next year will be young people who do not drink or smoke excessively.

The figures were released to coincide with November's Mouth Cancer Action Month and the FGDP said it would be encouraging dentists and dental hygienists to be extra vigilant to detect early stage mouth cancer.

A spokesman said: "Dental practices are on the front line for mouth cancer prevention and are being urged to emphasise Health Scotland's messages on diet, alcohol and smoking.

"It is hoped that identifying cases early will lead to better survival rates and that research will help pinpoint the causes."

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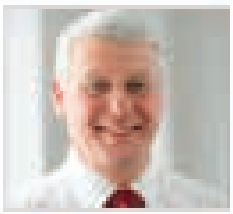





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BDA predicts a "challenging" future

NHS INFORMATION CENTRE

Reports. Dentists see fall earnings

Dentists are facing "very challenging circumstances", according to the BDA in Scotland after the publication of two reports from the NHS Information Centre.

The association has emphasised the need for dental care to be fully supported in light of the Dental Earnings and Expenses and Dental Working Hours reports. The BDA says the publications "paint a picture of a profession facing up to the challenge of caring for patients in Scotland by increasing its commitment to NHS care, coping with an increasing burden of non-clinical demands and struggling with increasing expenses, but, despite its efforts, seeing incomes falling".

The earnings and expenses report shows that average taxable income for self-employed dentists working in general dental services in Scotland fell by 7.6 per cent from £79,300 in the 2009/10 financial year to £73,300 in the following 12 months. In the same period, dental practice owners saw their average business expenses increase by more than £10,000.

The working hours report shows the percentage of time spent providing NHS care increased from 76.1 per cent in 2008/09 to 79.7 per cent in 2011/12. Over the same period, the percentage of the average dentist's time spent on non-clinical activity rose from 13.9 per cent to 14.5 per cent.

Dr Robert Donald, chair of the BDA's Scottish Dental Practice Committee, said: "These reports underline the very challenging circumstances confronting dentists in Scotland and serve as a reminder to the Scottish Government of the importance of practitioners being fully supported as they care for patients.

"Recent years have seen a number of constructive initiatives, including Childsmile and the General Dental Practice Allowance, that the profession feels are making a positive difference in the fight against the oral health inequalities that persist in Scotland. Support for these initiatives must continue.

"The Government must consider these Information Centre reports carefully. Dentists recognise the pressures facing the public purse, but oral health is something that must be invested in."

The reports are available on the NHS Information Centre website.

UK dentistry is highly rated

BDA REPORT

Dental treatment in the UK is well-explained, good value for money and delivers high levels of patient satisfaction, according to a report by the British Dental Association (BDA).

The GfK NOP survey, entitled 'Public perceptions of choice in UK dental care', was answered by 1,000 consumers and found that eight out of 10 patients who had seen their dentist in the last two years were 'highly satisfied' with their treatment.

Of those who paid for their treatment, eight out of ten thought the explanation of fees and charges was 'good' or 'very good' and more than three quarters rated their treatment as 'good' or 'very good' value for money. Four out of five reported they had visited their dentist during the previous 24 months, with about one in 15 saying they never visited a dentist. Cost and fear of dentists were reasons cited separately but in equal measure by one in six of non-attendees.

Dr Martin Fallowfield, chair of the BDA Principal Executive Committee, said: "The dental profession should be reassured by these findings as a healthy dental market is one which is able to meet patients' needs.

"This said, we should not be complacent. There are still one in four people not attending the dentist regularly, and those figures are substantially higher among the more financially pressed social groups, which impacts on preventive care and early detection of health risks and oral cancer."

To see the report, visit http://bda.org/dentists/policy-campaigns/research/patient-care/patientexperience.aspx

David Jones

Two new specialists at Vermilion

Edinburgh-based referral clinic Vermilion has announced the appointment of two new members of their clinical team.

Dr David Jones will introduce an endodontic service to the Corstorphine practice, while Dr Zannar Ossi joins the prosthodontic team.

Dr Jones, who graduated from Glasgow in 2005, attained his MFDS in 2009 and completed his specialist training programme in endodontics at Guys and St Thomas' Hospital in London.

Dr Ossi graduated from Kharkov State Medical University, Ukraine, with honours in 1998. In 2005, he was enrolled in the specialist training in prosthodontics at the University of Edinburgh, completing the programme in 2007 with M.Clin.Dent.(Prosthodontics).

He developed an interest in dental implants, and decided to take up the subject as his PhD project. He is now in the final stage of completing his thesis. He is an examiner for the Royal College of Surgeons of Edinburgh.

Zannar Ossi

bod
the business of dentistry

Business of Dentistry

MANAGERS' CONFERENCE

Scottish dental consultant Sheila Scott hosted the recent Business of Dentistry Practice Managers' Conference at the King James Hotel in Edinburgh.

Simon Tucker, of patient finance company Medenta, spoke about 'Crucial conversations' and how to use communication and selling skills in dental practice.

He was followed by dental practice consultant Laura Horton, who spoke about the role of the treatment co-ordinator (TCO), explaining it is to remove 90 per cent of the non-clinical aspects of dentistry from the dentist and allow the practice to provide a higher level of customer service.

Sheila Scott spoke about 'Running the extra mile' and how to impress your customers. She outlined what patients want, what they think and what is most important to them. The final speaker was Ian Langford of Peninsula Business Services, who spoke about employment law and managed to make the thorny subject of workplace sickness and absence very entertaining.

The event provided an opportunity for practice managers to make presentations to delegates. Victoria Foster from Ashby Dental Practice in Wetherby, Susi Morton of Craigentinny Dental Care in Edinburgh, and Lisa Johnston, practice development manager of Restalrig Park Medical Centre, also in Edinburgh, all spoke about their experiences in practice.

Major investment at dental hospital

Funding. £2.5m boost for teaching facility

REFURBISHMENT

A £2.5 million programme of refurbishments has recently been completed at Glasgow Dental Hospital and School.

The works have seen the hospital's restorative clinics modernised and the central instrument decontamination unit expanded thanks to a £2m funding injection from NHS Greater Glasgow and Clyde.

The University of Glasgow has also invested £500,000 in transforming a traditional biochemistry laboratory into a state-of-the-art multi-media teaching facility. The suite has been named after the late Professor Dorothy Geddes, a pioneering dental surgeon and oral biologist who became the first woman to hold a professorship in dentistry at a UK university.

Professor Jeremy Bagg, dean of dentistry at Glasgow Dental Hospital and School, said: "The investment will make a real difference to the quality of the teaching we deliver for our students and help us to maintain our current position in the Complete University Guide as the top dental school in the United Kingdom.

"The new multi-media suite is also a wonderful tribute to Professor Geddes, who did so much to advance the field of dental surgery during her life, and we are extremely happy to honour her contribution to Glasgow through this new facility."

NHSGGC Chairman Andrew Robertson said: "The benefit of these investments will reach many thousands of dental patients treated each year. The newly refurbished and expanded decontamination unit will serve not only the dental hospital, but also 17 community dental clinics in and around Glasgow offering the very highest standard of instrument decontamination available."

Glasgow Dental Hospital and School lead consultant Lee Savarrio in the newly refurbished restorative dental clinic

CPD conference is a sell-out

The fourth annual Core CPD conference was a sell-out, attended by more than 370 dentists and DCPs.

Dr Alexander Crighton, consultant in oral medicine at Glasgow Dental Hospital and School, spoke on 'Detecting oral cancer in primary dental care'; radiologist from Barts and The London School of Medicine and Dentistry Dr Jimmy Makdissi covered 'Radiography, radiation protection, radiology and much more in 60 minutes!' before Dental Protection's Hugh Harvie presented on 'Complaints – looking on the bright side'. The line-up was completed by Professor StJohn Crean from the University of Central Lancashire, who spoke on 'The management of medical emergencies for the dental team – the ABCDE approach'; and Professor Wil Coulter, professor of Oral Microbiology at the University of Ulster, who presented on 'Infection control and prevention in dental practice'.

Charity ball for hospital

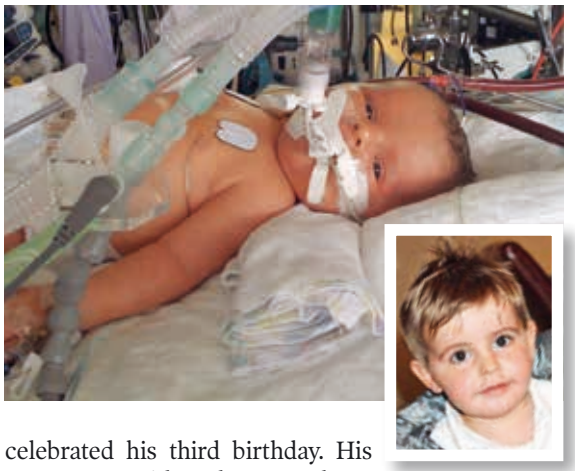
CHARITY BALL

Hours after Garrowhill dentist David Cunningham's son Harry was born at the Princess Royal Maternity Hospital, he was diagnosed with persistent pulmonary hypertension and his life was hanging in the balance.

At just two days old, he was transferred to Yorkhill Children's Hospital where he was lucky enough to secure a space on an ECMO (extracorporeal membrane oxygenation) machine.

The ECMO machine provided vital life support by bypassing Harry's organs, giving his lungs a chance to recover. After three days, he was well enough to be transferred back to the Royal Infirmary, where he stayed for the next two weeks.

Thankfully, Harry has since made a full recovery and has just celebrated his third birthday. His parents, David and Dawn, have committed themselves to raising as much money as possible for the ECMO unit at Yorkhill.



Above: Harry was lucky to be given access to an ECMO machine as a baby, inset

David said: "We know how lucky we are to have Harry with us, as there is only one of these units for children in Scotland and beds within it are few and far between. Needless to say, if there wasn't a bed for Harry, he wouldn't be with us today."

The Cunninghams have raised just over £12,000 through events such as a charity ball, taking part in 5k runs, selling football cards and completing a charity cycle around Cumbrae. They have set themselves a target of £20,000 and are currently in the process of arranging a second ball to be held at the Glasgow Radisson Blu on 23 February.

Hosted by Gina McKee of Clyde1, the ball will include a Champagne reception, three-course meal, charity auction and raffle followed by dancing.

To book tickets, advertise in the brochure, or to donate a prize, call Gillian on 0141 771 0800 or email info@springgroveclinic.com

Masterclass from John Kanca

John Kanca Masterclass

More than 350 dentists converged on the Crowne Plaza in October to witness an 'Adhesive Dentistry Masterclass' from Dr John Kanca.

Dr Kanca participated in the first study to validate the etching and bonding of dentine, making it the everyday procedure used in practices worldwide. As well as discovering 'wet bonding', he created the fourth generation of bonding systems and the concept of pulse activation of composites.

Running alongside the main session was a DCP conference that attracted more than 100 DCPs. Specialist radiographer Barbara Lamb gave an update on IRMER and quality assurance before Jamie Newlands, clinical director at the Berkeley Clinic in Glasgow gave a talk entitled 'Restoring your smile'.

Helen Kaney, dento-legal adviser with Dental Protection, then gave a presentation on effective complaints handling before GDP David MacPherson talked about facial aesthetics and how to give patients the best care.

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CLARKDENTAL

BDA signs anti-fraud agreement

The British Dental Association in Scotland has signed an anti-fraud charter in an effort to stamp out illegal activity in NHS dentistry.

The association, along with NHS Scotland Counter Fraud Services (CFS), has put its name to the charter that aims to encourage a working partnership between CFS and dental professionals and promote a counter fraud culture in the delivery of dental services.

The document will also work to enhance perceptions and attitudes towards combating fraud, as well as promoting ethical conduct.

The charter will see the BDA and CFS working together to meet a number of commitments, including: revising policies, procedures and systems to minimise any fraud risk; establishing arrangements to maximise transparency and minimise conflicts of interest; and clarifying the crucial distinction between deliberate fraud and unintentional error, removing wherever possible any confusion or ambiguity.

To see the anti-fraud charter, visit http://bit.ly/fraudcharter

Improving quality in healthcare conference

Edinburgh. Event focuses on the translation of knowledge into practice

International experts on healthcare knowledge translation, implementation science and evidence synthesis came together in Edinburgh for a major conference.

'Improving Quality in Healthcare: Translating Evidence into Practice' has been organised by the NHS Education for Scotland (NES) TRiaDS Unit and the Health Services Research Unit, part of the University of Aberdeen. The keynote address was given by Minister for Public Health Michael Matheson MSP.

Professor Jan Clarkson, director of the Scottish Dental Clinical Effectiveness Programme, explained: "A consistent finding in health services research is that translating research findings into practice is unpredictable and can be a slow and haphazard process.

"The conference was a wonderful opportunity to gather together experts in the field of knowledge translation to help ensure we help deliver the NHS Scotland Healthcare Quality commitment to implementing evidence-based practice to ensure patients gain the maximum benefit from receiving the most appropriate care at the right time."

During the past 15 years, there has been increased interest in the scientific study of methods to promote the systematic uptake of research findings into routine clinical practice. It has been demonstrated that knowledge translation interventions are more likely to be effective if they are informed by an assessment of likely barriers and enablers. However, there is limited understanding of the impact, and how best to address potential barriers and enablers.

The challenge for researchers is to move beyond single studies and develop and evaluate a theory based framework to support the choice, development, content, delivery and evaluation of knowledge transfer interventions.

TRiaDS (Translation Research in a Dental Setting) is a collaborative, multi-disciplinary research programme established in 2008. It is funded through the Scottish Government and NES to develop a programme of knowledge translation research embedded within the Scottish Dental Clinical Effectiveness Programme (SDCEP) guidance development process.

TRiaDS has public, academic, policy, service and professional members, including external national and international leaders in the area of knowledge translation science and provides a research laboratory for the provision and exchange of evidence-based information between TRiaDS, dental healthcare professionals, educators and policy makers on how best to translate service and educational initiatives into routine clinical practice.

Although based in primary dental care in Scotland and centred on clinical guidance for dentistry, TRiaDS has developed an innovative generalisable, evaluative knowledge translation framework that is readily transferable across national and international jurisdictions and professional disciplines.

The gift that keeps on giving

If you're looking for the perfect present, then dental development charity Bridge2Aid (B2A) may have the answer.

B2A gift cards result in a specific purchase so you will know that your present has been of direct benefit to people in the B2A community.

The East African-based charity was set up by Edinburgh graduate Ian Wilson and has provided access to safe treatment to an estimated two million people since 2004.

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To buy a gift card, email Kerry Dutton at fundraising@bridge2aid.org To find out more about B2A, visit www.bridge2aid.org

From the chairside

with Alison McKenzie

Teamwork and oral health

There are many areas in dentistry that involve successful teamwork. The most obvious is between members of the dental surgery: reception staff, practice manager, dentists and dental nurse, who are all essential in the smooth running of the practice. However, there are other areas in dentistry where teamwork is also effective, especially in larger projects.

One is oral health promotion and prevention. This is especially important because the aim is to reduce the level of decay and improve oral health within different public sectors throughout Scotland. The focus is on not only healthy gums and teeth, but also the benefits of a healthy diet in conjunction with demonstrations on toothbrushing techniques and oral hygiene aids.

These three areas have initially been the responsibility of key members of the dental team: the dentist and dental hygienist. The disadvantage of this system was that it targeted the patients who regularly attended the dental practice and excluded those who were not regular attenders or could not access the service. Therefore, a new project was required to improve the oral health of people in Scotland.

"Additional duties can only enhance the role of the dental nurse"

The Scottish Executive's *Action plan for oral health and modernising NHS dental services 2005* began by involving the public with discussion on their views and recommended improvements. The group discussed concerns such as the lack of dentists and limited access to dental service within areas of Scotland.

The recommendations to increase the numbers of dentists would thereby allow more people to access a dental practice in their area, although this would require additional finance as more training would be required. The advantage would be that all target groups – adults, the disadvantaged, prisoners, the homeless, the elderly and people with special needs – would benefit.

There was a strong focus on the oral health of children, as the level of decay was particularly high. A programme to secure dental health promotion and prevention from birth to secondary school was introduced that would involve midwives, health visitors, the education and dental sectors. This was, of course, the Childsmile programme.

With this programme, there came a new role and opportunity for additional training for dental nurses. The Childsmile training programme is delivered by NHS education Scotland (NES) and covers a range of topics including caries and fluoride, application of fluoride, health/safety and infection control, breastfeeding/weaning and early nutrition and child protection.

It also covers working with children in the clinical/community setting, health behaviour change, and action planning a Childsmile oral health promotion session.

Additional duties can only enhance the role of the dental nurse. I have given oral health instruction and demonstrations to children and adults in the past. It is not only a rewarding experience, but can also act as a confidence builder.

The introduction of the Childsmile programme is another positive training opportunity for the dental nurse and I hope many get the opportunity, support and encouragement to take part. ■

Glasgow 2014 needs you

Deputy CDO Tom Ferris and Olympic dentist Mike Blackie tell *Scottish Dental magazine* why volunteering at the 20th Commonwealth Games in Glasgow is an opportunity not to be missed

(l-r) Fiona McEwan, Commonwealth Games Scotland; Shona Robison, MSP; Clyde, 2014 Mascot; Lord Smith, Chair of Glasgow 2014; and Councillor Archie Graham, at the volunteering launch

"I think this is a once in a lifetime opportunity, a chance to get involved in something that is really special. I don't think many dentists will see anything quite like this again in their working careers."

As Deputy Chief Dental Officer at the Scottish Government, Tom Ferris is not a man prone to hyperbole, but it is clear that he is genuinely excited by his role as organiser of the dental recruitment at the Glasgow Games.

He explained that the volunteering roles at the event will be incredibly varied. He said: "At the actual venues it will be reacting to what is happening and that is about dealing with trauma, avulsion and facial injuries, basically anything that comes our way. Follow up care will be delivered, either through A&E or if it is just a dentist that is needed, it will be dealt with in the polyclinic the next day or the days thereafter.

"There is also an oral health message that we want to get across to athletes from around the world who have got different experiences in terms of access to services, the level of oral health and so on."

The registration process for volunteering at the Games officially opens in mid-January but planning for the dental facilities and services is already well under way. Tom explained that it has been a steep, but interesting learning curve.

"It is a matter of getting as much information from people who have had similar experiences before and trying to learn from them to make as best a fist of it as we can."

"She had lunged forward and her mask had clattered into her teeth. She actually had the marks of her mask on her teeth"
Mike Blackie

To this end, Tom has been in touch with Glasgow dentist Mike Blackie who was the only Scottish volunteer down at the London Olympics in the summer. Glasgow graduate Mike, who is the principal dentist at The Park Practice in the west end, worked at the ExCel Arena during the Games.

He said: "I had assumed I would just be working at the polyclinic seeing athletes and their entourage every day. But after I got the offer I soon realised that I was going to be involved with all the combat sports, so it tallied up with all my sporting experience. I have had various trauma cases over the years as a result of dealing with some the Glasgow Warriors rugby team."

The ExCel Arena was home to the boxing, taekwondo, judo, fencing and wrestling but apart from a couple of Iranian wrestlers who had bits of their teeth knocked out and some split lips from an energetic taekwondo demonstration, Mike said the injuries were, thankfully, few and far between.

He said: "There was one interesting dental case involving a Greek fencer who had a couple

Mike (second from left) with his medical team colleagues at the London 2012 Polyclinic

of crowns knocked out.

"She had lunged forward and her mask had clattered into her teeth. She actually had the marks of her mask on her teeth."

Mike revealed that one of the most touching moments of the Games was not related to the sporting action. He was fortunate enough to be in the same team as Andrew Hartle, an intensive care consultant who treated many of the victims of the 7/7 bombings in London.

He said: "It was a humbling experience just being around him. He is a fantastic guy, very calm and nothing seemed to bother him."

Looking forward to Glasgow, Mike is keen to get involved again. He said: "I think it's going to be great, I'm sure there will be no shortage of people offering their time."

And he is encouraging as many dental professionals as possible to get involved and help make Glasgow 2014 an event to remember.

He said: "I think, if you are a general practitioner, you tend work away in your own practice every day and this is a great chance for a whole new experience being involved in a massive event with so many interesting people who are from different professional walks of life.

"I met so many fantastic people and will keep in touch with many of them. You make good contacts, you learn a lot and, if you have a sporting interest, combining that with your professional abilities is a fantastic opportunity." ■

For more information and to register your interest in volunteering for Glasgow 2014, visit volunteer.glasgow2014.com

By Bruce Oxley

The BDA's former national director for Scotland, Andrew Lamb, tells *Scottish Dental* how leaving the association was one of the toughest things he has done

Looking to the future

Despite his softly spoken and unassuming demeanour, Andrew Lamb is not one to shirk the tough decisions. Even so, he acknowledges that his decision to step down as national director of the BDA in Scotland after nearly a decade in the hotseat was one of the most difficult he has ever made.

He said: "I didn't want to leave the BDA. I thoroughly enjoyed my time, right up until the day I left, actually.

"But I really do think it is easy to carry on doing that and I think the hard decision is to make a break and go off and do all the things that you have always wanted to do."

Born and brought up in Surrey, Andrew's parents moved to Glasgow when he was 16. With a doctor for a father and a nurse for a mother, choosing a career in medicine was maybe not a huge surprise, but Andrew revealed that he wasn't particularly interested in being a medical doctor.

He said: "I was always keen on helping people and I didn't really want to be a doctor, so I decided on dentistry. It was a profession where you could practise manual skills, treat and look after people, and I preferred that in my mind to ever wanting to be a doctor."

Andrew graduated from Glasgow Dental School in 1972 and stayed on at the hospital, firstly as a house officer, then a registrar, before being offered a lecturing role in prosthodontics in 1976. He then completed his postgraduate training at Glasgow, becoming a senior lecturer in 1984.

With that role, Andrew became an honorary consultant and he explained that he revelled in the variety the role offered. He said: "One thing I especially enjoyed was the contact with the students. There was a great sense of satisfaction involved with putting over whatever skills you have.

"I also very much enjoyed dealing with patients who had real problems and who had been referred in by general dentists. It was very satisfying treating those people and treating them successfully."

From there, he completed his doctorate in dental surgery in 1990, a combination of restorative dentistry and oral medicine. The topic he chose was burning mouth syndrome (BMS), as he explained: "The cause of BMS is multifactorial it can be a problem related to the tissues themselves on which dentures sit or it could be the dentures themselves that are causing the problems. It was a very interesting time in my life and I enjoyed that."

In 1995, Andrew was appointed the associate dean for dental education in the dental school in Glasgow, a role he held for five years. Then, in 2002, the BDA's Scottish secretary Alastair MacLean announced his retirement and Andrew applied for the role.

A member of the BDA since his student days, Andrew became the University of Glasgow's representative on the association's academic committee in 1982, becoming chairman in 1997, which meant he became a member of the BDA's UK Council. At the time of Alastair MacLean's retirement, Andrew had already decided to retire from the university to seek a new challenge. So, the timing was perfect and he was appointed national director for Scotland in 2003.

"It was a pretty radical plan, it made some major changes to the way dental services were delivered"

When asked what he felt his biggest achievement was during his time in office, he said: "This is a really difficult question because an awful lot of what you do within the BDA is long term. I think the biggest achievement that I feel I have made is building up good working relationships with the Scottish Government.

"Now, this doesn't mean we always got our way with the Scottish Government, but I think we developed good relationships with both politicians and civil servants.

"I think part of the secret is down to networking with them when they were in opposition. I think it is often easier to meet with and converse with MSPs in opposition. But I've met with politicians from all parties and I think the working relationships we have are considerably better than they were a few years ago.

"But it was not just me – it was very much a team effort. We worked very closely with the elected members, the committee members and also the other staff members within the BDA to develop and maintain those relationships."

Not long after Andrew joined the BDA, the Scottish Government consulted on the way forward for both adult and children's dentistry, a consultation that became the Dental Action Plan in 2005. Andrew said: "It was a pretty radical plan – it made some major changes to the way the dental services in Scotland were delivered, and the way that they were funded.

"The Lib-Lab coalition invested substantial sums of money at that time – from a baseline funding of about £200 million in 2005, three years later it

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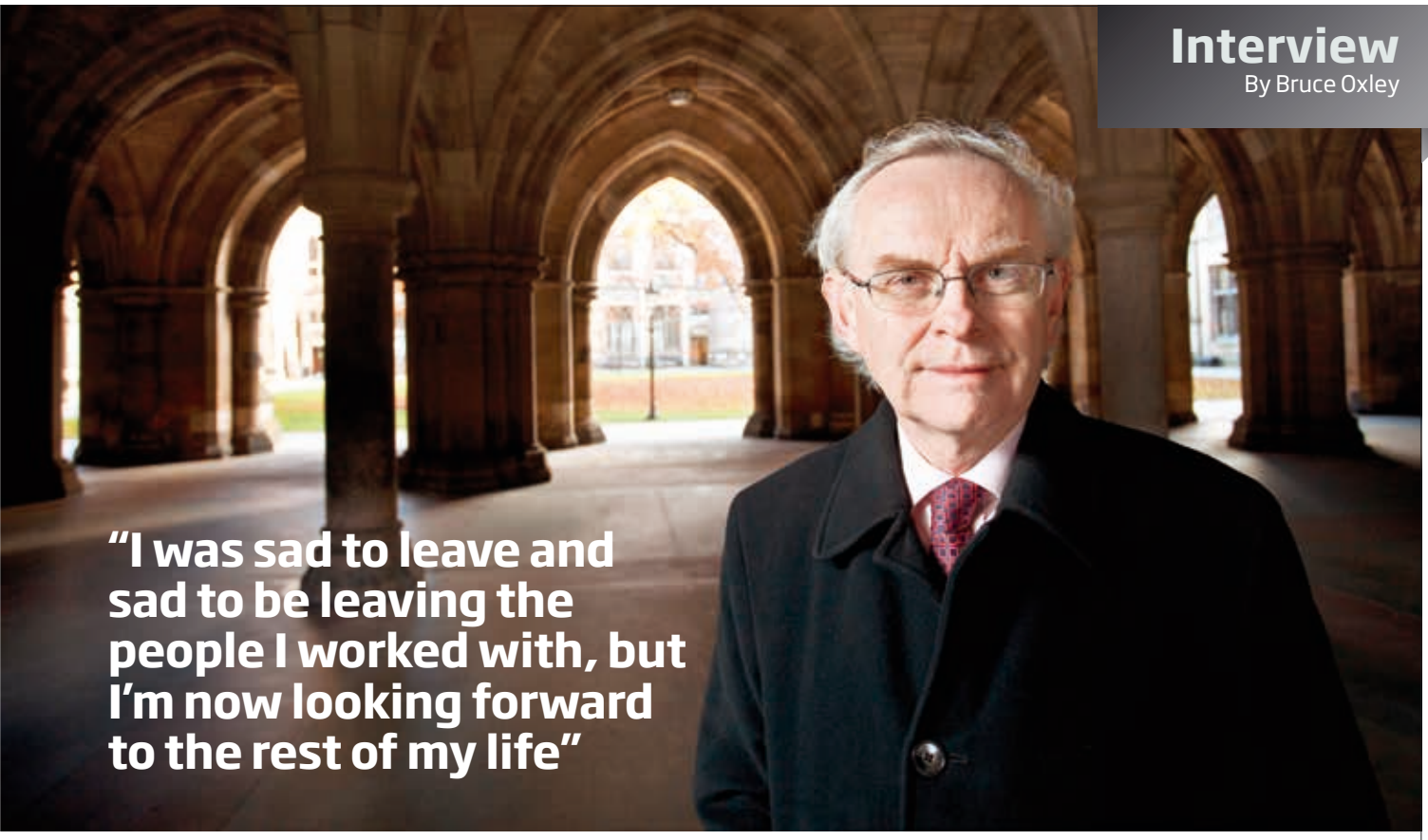

"I was sad to leave and sad to be leaving the people I worked with, but I'm now looking forward to the rest of my life"

Continued »

was £350m. The current Government, since coming into office in 2007, has continued to fund dentistry and, indeed, the funding for dentistry is now just under £400m.

"So, in six years we have seen the spend on dentistry double and an increase in the numbers of dentists working in Scotland."

Andrew explained that the initial challenge for him and his team was to respond to the consultation and ensure that the way the money was delivered to dentists to provide dental services was as effective as it possibly could be.

He said: "One of the biggest challenges was the way that dentists were deemed to be committed to the NHS and we had a lot of negotiations around the measure of commitment to the NHS, which determined dentists' ability to access the General Dental Practice Allowance (GDPA). We saw this as a priority to keep people who want to work within the NHS in viable practices.

"The viability of NHS dental practices is very much down to the GDPA and the BDA is committed to try to preserve that as much as it possibly can. At the moment, as we go through difficult financial times as a country in general, we have been making sure that the GDPA was high on the agenda."

When *Scottish Dental* spoke to Andrew, his successor hadn't been announced (see box-out), but he said that whoever came in would need to focus on maintaining relationships.

He said: "I think it is an exciting time for the BDA in Scotland, with a new person coming in perhaps with different ideas, different thoughts and maybe a different focus.

"But if I was to offer one piece of advice, the main thing I would say is to make sure that they build up the relationships between the various stakeholders in Scotland, build on the working relationships that the BDA already has. There may be other working relationships that they think are important as well. It is important to build on these and recognise that change can take time."

But why did he decide to retire now? Andrew said: "I'm 63 next year, I reckon I'm reasonably fit and there are plenty of things in life that I want to do. I very much enjoy hill walking, I want to keep fit, I have grandchildren who I want to spend time with and I think it is time to move on to the next phase of my life.

"And, as Peter Ward [the BDA's chief executive] said, it is better to leave a job when you are enjoying it rather than carrying on until you maybe stop enjoying it. I think on that basis it was the right decision to make.

"I was sad to leave and sad to leave the people I worked with, but I'm now looking forward to the rest of my life." ■

BDA ANNOUNCES PAT KILPATRICK TO TAKE OVER AS NATIONAL DIRECTOR FOR SCOTLAND

The British Dental Association (BDA) in Scotland has recently announced Andrew's replacement as national director Pat Kilpatrick, who will take up the post in the new year.

Graduating from the University of Dundee, Pat joined the Graduate Training Scheme for NHS management before going on to senior roles within NHS Scotland, including director of clinical development at NHS Argyll and Clyde and director of planning at North Glasgow University Hospitals Trust. She led the National Task Force on the development of Primary Care Trusts in Scotland in 1997.

As academic director in the School of Management at the University of Stirling, she developed the first MBA postgraduate degree programme designed to develop the management skills of both doctors and dentists.

Latterly, her career has been in consulting. She joined Tribal Consulting in 2006 as a director, before going on to launch her own business in 2010.

Pat said: "Dentistry in Scotland faces a complex set of challenges. I look forward to playing my part in helping the profession overcome them and advancing the cause of oral health in Scotland."


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Ferhan Ahmed

We put Ferhan Ahmed, sedationist and oral surgeon at Cadden Dental Clinic and Monklands Hospital in Airdrie, under the spotlight

Q. What do you love most about your job?
The variety and the team of people I work with. My job covers so many different aspects of dentistry that I am always challenged and my days are never the same.

Q. If you weren't a dentist, what would you be?
Probably a pharmacist, boring I know but that is the other degree course I applied for when leaving university. Although, in a perfect world I would have quite liked to have been a pilot or a professional sportsman.

Q. Best piece of technology you own (dental or otherwise)?

"I am always challenged and my days are never the same"

Without a question my iPhone. It is essential for my day to day work and keeping in touch.

Q. Best piece of advice you've ever been given?
The importance of hard work and perseverance. If you work hard you can achieve whatever you want and don't give up till you get there.

Q. On a day off, what would we find you doing out of the surgery?
I would be out cycling, running or at the gym.

Q. Who's your hero (dentistry or otherwise)?
Paul Farmer, an American anthropologist and physician. His work to improve third world health is inspirational.

Q. If you could relocate your practice to any time or place, where would it be?
Hong Kong. I spent a number of childhood summers there and it is such a wonderful place. Plus it has better weather than Glasgow!

Q. Favourite film (doesn't have to relate to dentistry..!)
Christopher Nolan's Batman trilogy. I could watch them again and again.

Q. Favourite food?
Homemade lasagne. I love pasta and meat and this is a great combination.

After the feast cometh the famine

NHS dentistry has for too long been a burden on taxpayers, argues Dr Eilert Eilertson. Now is the time to shake up the system

Britain, for the first time ever, is now over £1 trillion in debt – a staggeringly enormous figure. If you counted one pound every second, it would take about 35,000 years to add it all up.

The highly wasteful interest on this tidy pile amounts to just short of £45 billion every year, or more than Great Britain's annual defence budget. This money has to come from taxation and is topped up by yet more borrowing. The not-so-big secret is that nobody knows how to pay it off and if nothing is done, it is going to eat your lunch or, more likely, your pension!

How on earth does Government manage to get through such colossal amounts of money? Currently, Government spending is dominated by welfare and healthcare, amounting to some £310bn in 2010/11 out of a total of £700bn, including the interest. Taxes raised were short of £500bn, so we are failing to balance the books or even begin to pay our way.

Clearly, we are broke. The national overdraft is as high as it has ever been and it is getting worse, not better. It is estimated that the debt will rocket to £1.6 trillion by 2015! The pips squeaketh; we are in an unsustainable, taxed-to-the-max, spend-to-the-end, vicious circle.

What is going to happen? Firstly, the only way out of this mess is for politicians to stop spending and to balance the books by being honest about what services we can actually afford.

The spending binge of the last decade when prudence let rip with the country's credit card is rapidly coming to an end and politicians who have bribed the electorate with ever-more freebies are going to have to come to terms with the dishonesty of their policies and the hangover of their lack of sustainability. Needless to say, anyone who speaks out against politicians' profligacy and public waste is pilloried, but that will change as the debt accumulates and the cash runs out.

I believe that before the end of this decade, we will see our economy rebalance to a low tax economy that allows enterprise to flourish as it does in the Far East. I think we will see an end to welfarism, with people having to relearn the joy of standing on their own two feet and looking after themselves. In the long term, this works, whereas our 50-year experiment in socialism has been an abject failure that has bankrupted the country.

So, how will this affect the tiny world of dentistry in Britain? Looking back, I think taxpayers' cash has been wastefully sprayed at NHS dentistry. Instead of wise public health, preventively orientated, and policies that are highly cost effective, our professional leaders and their political masters have gone off in the old drill-and-fill (badly) direction.

GOVERNMENT RESPONSE

Margie Taylor, Chief Dental Officer for the Scottish Government, said: "As a direct result of our preventive approach to dental health, this Government is already seeing improvements in the nation's oral health.

"We believe that capital developments, such as extensions of outreach centres, have improved access to NHS dentistry and the expansion of training facilities for dental graduates and therapists lays the foundations for continuing to improve access in the future.

"Such Government grants recognise the pressures on dentists to meet the range of requirements placed upon them, such as funding purpose-built decontamination units to ensure the highest standards of hygiene and infection control for patients."

We have had on offer preferential loans for anything from a sterilising room to a disabled access lift. Golden hellos, grants for this and that, even postgraduate centres that we cannot actually afford, that have nonetheless been built with private finance initiatives that inflate the real cost by as much as 300 times the actual build cost.

The felony has been greater compounded by hugely expensive clinics that have opened (where there was no need), which are often grossly inefficient centres for mostly drilling and refilling. A rash of therapists, who at best are half trained and at worst do not understand the beneficial role that a hygienist has to play in high-quality long-term dental care, have been pushed through. All this to assuage the politicians' discomfiture about the lack of availability of NHS dentistry in the past.

"I believe that before the end of this decade, we will see our economy rebalance to a low tax economy that allows enterprise to flourish as it does in the Far East"

Eilert Eilertsen

The only thing that really works in dentistry is prevention. For a tiny fraction of the cost of the above, the water supply could be fluoridated and all those drillers and fillers would be redundant.

So, in 2020, I am looking forward to a welfare-free Great Britain where the Government is much smaller than it is at the moment. Where we are honest about what we can collectively afford and we are prepared to downsize to debt-free. Where people are proud to stand on their own two feet and pay for the cost of their treatment either through mutual funds or insurance.

Where the cycle of generational welfarism has been broken and the great populous is proud to work at every level. Where NHS dentistry has been finally consigned to the dustbin of bad ideas that gradually got worse and dentists are proud of the work they deliver, which is paid for by their patients or their insurers and so does not cost the taxpayer a penny.

A new era of patient motivation and education, where over-zealous therapists, keen to hone their skills like dinosaurs and new cross-auxiliaries, have thankfully passed into history.

Dream or reality, it is a better vision for the future! ■

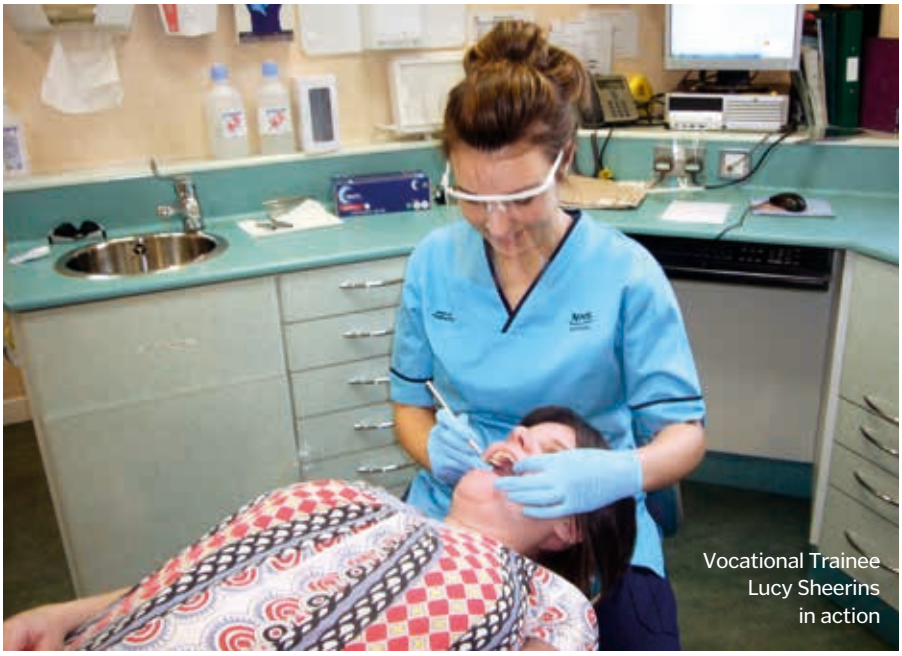
Do you agree with Dr Eilertsen? Email your comments to bruce@connectcommunications.co.uk

ABOUT THE AUTHOR

Dr Eilertsen graduated from the University of Dundee in 1976, and opened his first practice in Dingwall in 1978. He has maintained a special interest in restorative dentistry and implantology since 1994. With his wife Margaret, also a Dundee graduate, he opened Eilertsen Dental Care in Inverness in 2010.

HTVT training

A pilot scheme for Hygiene/Therapy Vocational Training is running in Scotland



Vocational Trainee Lucy Sheerins in action

NHS Education for Scotland is committed to providing vocational training for dental hygienists and therapists in Scotland, currently on a non-mandatory basis.

A vocational training scheme for hygienists/therapists has been in place for some time, and has been taken up by cohorts of students from the teaching groups at the Universities of Glasgow, Edinburgh and Dundee.

In order to develop the scheme, and with the progression to three-year BSc ordinary and four-year honours degree programmes at four schools, including the Universities of Dundee, Edinburgh, Glasgow Caledonian and UHI, a new pilot programme using Technology Enhanced Learning (TEL) began in September 2012, with seven places across Scotland.

Up to 15 places on the Hygiene/Therapy Vocational Training (HTVT) Programme will be offered for the year commencing August 2013, and the application process for trainers is open until January 2013.

The HTVTs registered with the programme this year are working in either the general or salaried dental services, in Fort William, Perth, Glenrothes, Kirkcaldy, Bathgate and Glasgow. The VTs include graduates from UHI, Dundee, Edinburgh and Birmingham.

NES provides funding for six sessions (including one study session) per week at Agenda for Change Band 5, and a training grant and LEP allowance are available to GDPs working as trainers within the scheme.

The HTVTs work under the direction of a dentist, to a set treatment plan. Trainers therefore act as mentors, and are asked to meet their HTVT for tutorial teaching for two hours per month, as well as offering support and guidance for clinical care.

Formal teaching is also provided by NES using a Virtual Learning Environment (VLE) on the Knowledge Network, and 10 face-to-face study days held at venues across the country. A group of invited speakers are contributing to these days, and have given valuable contributions to the resource base of the course.

Subjects for study days include: restorative dentistry; periodontology; paediatric dentistry; management and teamwork; smoking cessation; radiology; medical emergencies and CPR; cross infection; health and safety; career planning; audit and research; clinical governance; clinical photography.

All learning materials used on the study days are available on the VLE, so that HTVTs and their trainers can review these throughout the course.

The VLE has proved popular with trainers and HTVTs alike, allowing contact across the wide geography of the country. As well as pages for each teaching module, the users can link into the Resource Library of the Knowledge Network, and have direct access to the NES Dental Portal and SDCEP.

There is a discussion board, blog, WIKI areas and dedicated web pages that have been set up for trainers to discuss the programme among themselves and for HTVTs to chat and exchange ideas.

The assessment of training has been set up in a similar way to that of the established dental VT. A programme of 26 internal and four external LEPs are completed over three blocks, and in conjunction with these, clinical case presentations are prepared by the HTVTs on cases completed in restorative dentistry, periodontology, paediatric dentistry and smoking cessation.

These case presentations are available in PDF form on the website, and are formally assessed at the external LEPs.

The test of knowledge, PAQs, equality and diversity training and medical emergencies and life support are also completed during the year.

Use of the VLE provides all the information required to complete the various assessments, and is proving to be of great benefit to the programme.

NES welcomes applications from dentists who wish to participate in the HTVT programme. Prospective candidates should have completed the START course, but can apply to do so during the next year. ■

Further information and application forms are available at http://bit.ly/VTinfo
Practitioners interested in becoming a trainer can contact training advisor Dr Isobel Madden at the Centre for Health Science in Inverness.
Tel: 01463 255 719
Email: isobel.madden@nes.scot.nhs.uk

'Like' ethics

Social networking can be fun to use in a personal capacity, as well as a useful business tool. But it is important to be aware of some of the complications it can cause, says Angela Harkins

Social networking has come a long way. Just five years ago, Facebook was a website mainly used by students and young graduates, while few people had even heard of Twitter. But, as time went on, both sites widened their reach, and more such sites have appeared, attracting more users who use them for personal and business purposes.

Dental professionals should be aware of the pitfalls of using social media and make sure you are using it in the right way.

Friendships and following

The ease with which you can make contact with people online can lead some patients to approach a dental professional even though they wouldn't dream of contacting them outside the dental practice in the 'real' world.

While it may be flattering to receive a friendship request or be followed by a patient, it is important not to accept these advances as you may be blurring the dental professional-patient boundary and could soon regret it.

The Dental Defence Union is aware of cases where patients have made romantic advances to dental professionals via social networking sites and it can be far more difficult to rebuff these advances if they have already inadvertently encouraged the behaviour by communicating online. If a patient does try to make contact, it is best to explain that you cannot accept their request due to your ethical duty to maintain a purely professional relationship.

Privacy settings

If a patient has managed to find you online then you may want to consider what privacy settings you have in place on your social networking accounts. Some dental professionals choose to make their accounts totally private while others post on sites such as Twitter under a pseudonym and keep their real identity secret.

Whichever privacy settings you choose, it is important to consider how you would feel if a patient saw the content that is publicly available. You may be happy for extended family and friends to see photos of your latest holiday or a night out, but do you want any of your patients to be able to access this information?

Be careful what you post

Nowadays, many people take to social networking sites to have a seemingly harmless and private rant about something that has annoyed them in their day. However, it can be dangerous to assume that this is totally private. Think carefully before discussing colleagues, posting amusing tales about a patient or sharing a private joke online. Even if you think you have removed

"Think carefully before discussing colleagues, posting amusing tales about a patient or sharing a private joke online"

the identifying information about the patient, you may find that you have actually broken their confidentiality.

There have been cases of dental professionals not realising that their patient is a friend of a friend who happened to know that the patient had attended the dental practice that day and so they could identify who the story was about. Similarly, before posting your thoughts about colleagues or information about your personal life, consider whether this really ties in with the professional image you want to project to others.

Advertising your practice

Many dental practices now use social networking sites to advertise the services their practice offers. It can be a great way of drumming up business and communicating new services or changes to the local community. Earlier this year, the GDC released guidance titled 'Principles of Ethical Advertising' and it is important that any marketing material for your practice, including social networking pages and profiles, complies with this.

The GDC is clear that dental professionals may face a fitness to practise investigation if they fall short of its standards. It states: "Patients may be confused and uncertain about dental treatment so you should take special care when explaining your services to them. This includes providing balanced, factual information enabling them to make an informed choice about their treatment... Misleading claims can make it very difficult for patients to choose a dental professional or dental services and this can lead to expectations which cannot be fulfilled and, in more serious cases, can put patients at risk of harm from an inappropriate choice."

Responding to criticism

It is becoming increasingly common for people to go online to complain about a service or product they are unhappy with and dental practices do not escape this new, very public method of providing criticism. No one likes to be criticised and it can be easy to respond without thinking through the consequences.

The way in which you deal with the criticism can make a big difference to whether the patient chooses to make a formal complaint.

It is important to fully consider the best course of action and whether you really want to respond. If you feel a response is appropriate, remember that anything you post will be online for all to see. Also remember that although you are bound by a duty of confidentiality, the patient is free to republish what you say elsewhere online.

If you do receive negative comments online, you may wish to acknowledge the patient's dissatisfaction directly, apologise if appropriate and ask them to contact the practice so that you can address their concerns, while preserving confidentiality.

It is important to always avoid getting into an online spat with a patient. You may end up giving a wrong impression of your practice's professionalism and could inadvertently break confidentiality. ■

ABOUT THE AUTHOR

Angela Harkins has worked predominantly in NHS dental practices for 19 years as both an associate and principal. She continues to work part-time in practice, and has a keen interest in the management of the anxious patient.
Angela is also a Scottish dento-legal adviser at the Medical Defence Union having previously completed an MPhil in law and ethics.

Follow the evidence trail

What could be a better advertisement for your practice than a testimonial from a happy patient? Ashley Latter looks at how to maximise the impact of positive feedback

In my previous article, I wrote about the importance of using the correct language when you are presenting treatment plans to your patients. I also wrote about the importance of communicating features and benefits when presenting to your patients and not to talk too technically.

Although the correct language is important, it might not be enough to influence your patients. Another thing that might help, however, is evidence. So what is evidence? It is anything we can use to back up what we say when presenting our treatment options. Let me give you an example on why it is so important.

A few weeks ago, I decided to go for a run. I had the evening planned, I was going to come back to a hot bath and then settle down to watch some TV. As I left the house, my wife Graziella was on the computer reading customer feedback on a couple of vacuum cleaners that she was interested in buying. When I came back about an hour later, guess what? She was still on the computer reading these reviews and she stayed on for a further 20 minutes.

Three things really hit home to me. These were:

1. People read customer feedback before making a decision on purchasing something.
2. The power of evidence and the importance of having good feedback from your clients.
3. People will spend a long time reading and researching before making a decision to buy something. My wife spent the best part of two hours researching to make a £250 purchase.

My gut feeling is that some people take longer. I also know that a lot of people, including my wife, will carefully read reviews from websites such as TripAdvisor before booking a holiday, or hotel. I believe that we are all becoming more investigative and doing our research before we make a purchase. This is mainly due to the prolonged recession we are currently experiencing.

The one thing you need to be aware of is that people's buying habits have changed. They are still spending, but there is another barrier in the way before they will get their credit cards out. They need more reassurance, they need convincing and evidence can play a large part in this. With this in mind – if people are indeed influenced by reviews and testimonials – how can we take this concept and apply it to our dental practices? Here, I look at two types of evidence – video and testimonial letters.

"If you do an outstanding job for your patients, on the whole, they will want to help you"

Ashley Latter

A good place to start using evidence is your website and the most important page, which is the home page. When people are seeking out services of any kind on the web, they are in fact surfing and not actually buying at this stage. So, after looking at your website, if you don't have them switched on and excited after about 10 seconds, they will most likely leave and go surfing somewhere else.

I could fill several articles on this topic alone, but let's get back to the evidence and how it plays an important part on your front page.

I would strongly recommend a short video on the home page. This could involve a short tour of your practice and some brief background on yourself and the philosophy you and your team abide by. I would also include live testimonials from patients explaining the real benefits and get them to share their experiences of using your services.

I believe there is nothing better than third-party references and this will make your video very powerful. Many of my clients now have a video on the home page of their website and have reported an increase in new opportunities and enquiries. I have one on my website – www.ashleylatter.com – and I have been amazed at how many people have watched the video and commented on how much they like it.

When you are filming the video, ask your patients to really go into

the real tangible benefits they have gained since using your services and how pleased they have been using your practice. In addition, if you think about the top three objections, or reservations, your patients share with you on a weekly basis, if you can somehow get your patients to overcome some of these themselves verbally in your video, it will go a long way to inspiring potential clients to make contact.

For example, if patients are worried about the cost of a treatment, and in the video you can get one of your patients explaining the real benefits and that the treatment was a great investment of time and money, not only will it increase the volume of calls to your practice, it will also help increase your treatment acceptance.

Another advantage of using video is that it can help promote your services and create new sales. Let's say, for example, you are an orthodontist specialising in providing treatment for children. If you can have a couple of videos from adults, it should encourage more enquiries and sales of adult orthodontics.

Testimonial letters can form another part of your evidence and these are extremely powerful.

ABOUT THE AUTHOR

For the last 18 years, Ashley Latter has coached and trained more than 5,500 delegates on his 'Dental Ethical Sales & Communication Programme'. He is also the author of Helping Patients to Say Yes and Don't Wait for the Tooth Fairy. For more information, visit his website at www.ashleylatter.com You can also sign up to his free email newsletter, which is read by more than 10,750 dentists worldwide.

These are letters from your patients explaining the benefits they have gained by using your services and having treatment done by you. In the same way as video, they should address the major benefits they have gained by using your services and if possible address any objections your clients give you. Once you have obtained several letters, I strongly suggest you place them in a nice leather folder, or something similar, and place it in the reception area and, of course, have one handy in the surgery.

You would need to have your patients' permission to use these, but if you do an outstanding job for them, on the whole, they will want to help you. I cannot stress the importance of obtaining this type of evidence.

We are living in increasingly challenging times and having third-party evidence to show your patients is one of the best ways to improve the number of calls to your practice and increase treatment plan acceptance. ■

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LEADING REGENERATION

Delegates head to London to learn about the latest advances in soft tissue management

From treatment planning to clinical application

More than 130 delegates from all over the UK gathered to learn about the latest advances in soft tissue management at the recent Osteology Symposium London: Soft tissue management – from treatment planning to clinical application. Chaired by Professor Nikolaos Donos and Professor Mariano Sanz, the event featured an international faculty of experts who gave a series of scientific lectures and workshops.

Several surgical techniques can be used for periodontal plastic surgery to treat gingival recession and lack of keratinised tissues around the teeth or implants. Prof Donos outlined the options available and reviewed the evidence on success rates.

Soft tissue management around implants

The most frequent soft tissue problems around implants are mucosal recessions, and areas of lack of keratinised tissue that may compromise mucosal stability. The gold standard for the treatment is autograft surgery. However, these techniques involve a second surgical site for harvesting the graft material, with a consequent increase in post-operative pain and morbidity.

Allografts with soft tissue substitutes eliminate the need for a second surgical site, and studies show that patients generally experience lower levels of post-operative pain and reduced need for analgesia. Soft tissue substitutes are available in the form of cadaver-derived tissue (Alloderm, LifeCell Corp) or three-dimensional matrix of porcine type I collagen (Mucograft, Geistlich Biomaterials).

The efficacy of Mucograft in augmenting the keratinised tissue around implants was assessed in a randomised controlled trial recently published by Prof Sanz and his team[1]. The patients treated with Mucograft reported less pain, needed less pain medication, and the surgical time was shorter, although these differences did not achieve statistical significance. The study concluded that Mucograft was as effective and predictable as CTG for attaining a band of keratinised tissue around implants.

Covering multiple gingival recessions

Predictable coverage of multiple gingival recession still presents a challenge, said Professor Anton Sculean of the University of Bern. The more extensive the recession, the less likely it is that treatment will achieve 100 per cent root coverage. Recessions wider than 3mm and those 5mm deep or greater are less likely to have favourable results.

"For successful root coverage you must select the right technique for the right patients," Prof Sculean emphasised.

The data from longitudinal or randomised controlled studies are limited, but indicate that various modifications of the coronally advanced flap may give improved recession depth, better clinical attachment and improved thickness and stability of soft tissue. The thicker the flap and the lower the tension on the flap, the better the result. Prof Sculean reviewed recent data on use of the modified coronally advanced tunnel, known as MCAT. This technique, combined with enamel matrix derivative, connective tissue graft or collagen-based tissue substitutes (Mucograft), has recently been shown to produce predictable coverage of multiple recessions in Miller class I and II. The literature to date shows lower rates of complete root coverage with Mucograft compared with CTG, but Mucograft may represent a valuable alternative in terms of reducing patient morbidity and shorter surgical times, he said.

Techniques for soft tissue management after tooth extraction

What is the place of alveolar ridge preservation (ARP) after tooth extraction, and how predictable and effective is it? Is ARP a valid treatment modality, or is it over-treatment? We still only have partial answers to these questions, said Dr Nikos Mardas of UCL Eastman Dental Institute, London. The tooth socket heals like any other bony defect, with socket remodelling and growth of lamellar bone evident at 30 days post-extraction. Alveolar atrophy occurs and the alveolar ridge is lost, though the extent of atrophy does vary.

A newly published systematic review by the Eastman Periodontology group examined the effects of ARP compared with unassisted socket healing[2]. The authors concluded that post-extraction resorption of the alveolar ridge might be limited, but cannot be eliminated by ARP. Randomised controlled trials with unassisted socket healing and implant placement are needed. A comprehensive list of indications and contraindications for ARP has yet to be developed Dr Mardas said.

A soft tissue 'socket seal' may promote better outcomes with ARP, but more evidence is needed to confirm this.

Dr Mardas said that, in his opinion, it was indicated in patients who are willing to wait for treatment, in cases where implants are not going to be placed, and in cases where high levels of resorption are expected. ■

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1 Lorenzo et al, Clin Oral Implants Res 2012, 23:316-24
2Horvath et al., Clin Oral Investig 2012, Jul 20, Epub ahead of print

All-on-4 an introduction

In the first of a series of articles, Kevin Lochhead looks at the history, and the pros and cons, of this method of dental implants

In recent years, All-on-4 has gathered considerable interest in the part of the dental community involved with dental implants. This article, and those that follow, will explain where the term has arisen from, how the procedure differs from other techniques and the specific advantages and compromises to the patient that are necessary when electing to have this treatment option.

Securing a full arch bridge with four implants is not a new concept. The original Brånemark mandibular full arch implant protocol[1,2] outlined positioning five parallel implants between the mandibular foramen to secure a screw-retained cast beam veneered with acrylic and resin teeth *(figures 1 and 2)*. The original protocol adopted by the Brånemark clinic was later adapted to four implants. This treatment option (with or without immediate loading) has for more than 30 years been the standard 'fixed' solution for the edentulous mandible when there is insufficient bone above the inferior dental canal for more posterior implants.

The situation has been more challenging in the maxillae. Due to the increased incidence of implant failure in the maxillae, and more specifically the posterior maxillae where the bone has less volume and is less dense, the treatment protocol was for the use of six or eight implants *(figure 3)*. Eight implants is by no means the maximum number of implants that can be used in the maxillae and in their drive to seek the best long-term solution, some clinicians have advocated using 12 to 14 implants and cemented-bonded restorations.

As the number of implants increases, other problems appear: there is a need for more bone volume to retain the implants, time for surgery and restorative phases increases significantly, costs increase and maintenance becomes more difficult. Research in dental implants and the introduction of surface modifications have seen a reduction in failure rates[3], and CAD/CAM technology being introduced for the fabrication of superstructures[4].

As the confidence with dental implant success has grown, there has been a drive to provide patients with the results they seek more quickly. The conventional approach to managing the maxillae may take a year to 18 months from initiation to completion, allowing for healing after extraction, implant integration, second stage surgery and restoration fabrication, all the while the patient having to wear a complete upper denture, which they hate.

The challenge to reduce the cost and the time involved started with immediate loading protocols,

ABOUT THE AUTHOR

This article is presented by Kevin Lochhead, specialist prosthodontist at Edinburgh Dental Specialists. Surgical expertise by Professor Glen Lello, Prof Lars Sennerby, Mr Martin Paley and Mrs Gillian Ainsworth. All laboratory work was carried out by the team at Edinburgh Dental Implant Laboratory.

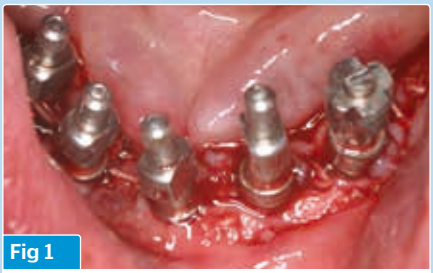

Fig 1
Impression copings on five implants between mandibular foramen

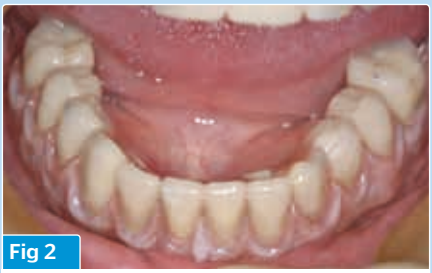

Fig 2
Fixed cast beam and acrylic teeth on five implants

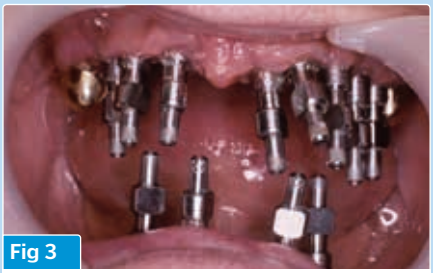

Fig 3
Eight implants in maxillae for fixed PMA restoration

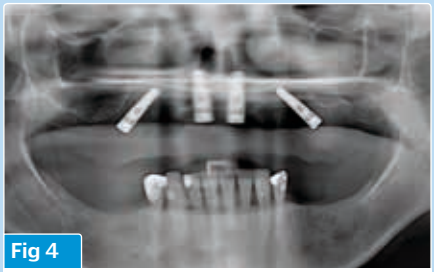

Fig 4
Positioning of implants for all-on-4

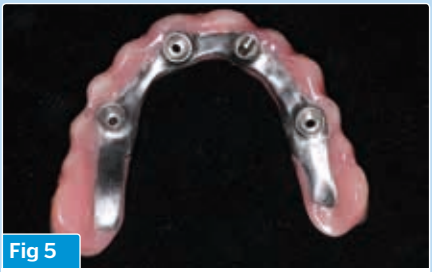

Fig 5
Fit surface of All-on-4 bridge showing titanium framework

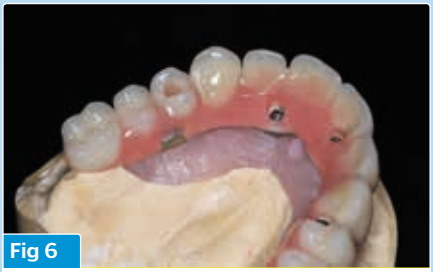

Fig 6
All-on-4 bridge showing titanium reinforcement on cantilever

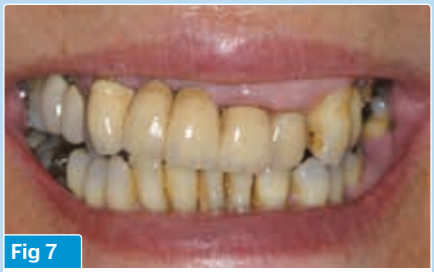

Fig 7
Visible gingival margins prior to treatment

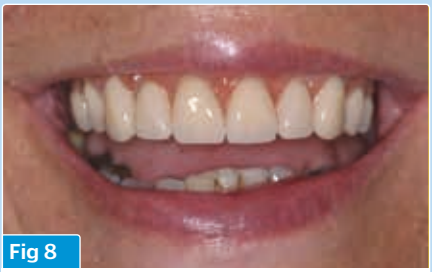

Fig 8
After All-on-4 transition zone moved under lip

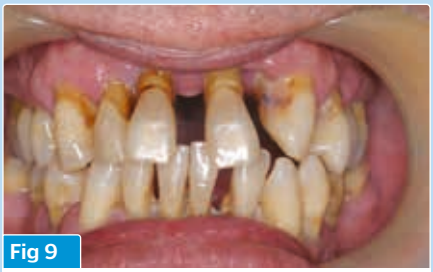

Fig 9
Compromised aesthetics

which began in the mandible[5], where success rates were already high and treatment time was the shortest. Single teeth immediate restoration in the upper arch came next and finally immediate full arch restoration. Initially, the number of implants remained the same, often with researchers placing "sleeper implants" in case of failure[6,7].

With so much at risk, biologically and fiscally, it is essential that general practice adopts protocols only after there is a body of evidence to suggest efficacy.

The evidence for management of the edentulous maxillae with four implants is now over 10 years. The concept of All-on-4 was created by Portuguese dentist Paulo Malo and development was carried out in the 1990s funded by Nobel Biocare, initially for the mandible and then the maxillae[8,9] *(figure 4)*. The protocol is specific for Nobel Biocare implants and the term has been trademarked. Given the dramatic impact this treatment protocol has had, many other implant companies are now marketing that their systems are also suitable. Clinicians should be cautious as, in many instances, there is limited evidence to validate the claims.

The significant features with the All-on-4 concept are:

1. Four, or more, Nobel Biocare implants to support a full arch maxillary or mandibular hybrid bridge (hybrid bridge = a fixed bar, usually of CAD/CAM titanium and veneered with acrylic resins and denture teeth *[figures 5 and 6]*)
2. The two most distal implants are angled in order to avoid anatomical structures (mental foramen and ID canal in the mandible, maxillary sinus in the maxilla), to allow implants of optimum dimensions in more dense bone and reduce cantilevering
3. In the maxilla, the residual alveolar ridge is, in most instances, resected to increase the restorative space and hide the transition from restoration to patient under the upper lip (transition zone) *(figures 7 and 8)*
4. Following insertion of the implants, a provisional bridge is immediately fabricated on site, and fitted, which acts to splint the implants together
5. The bridge and implants are under functional immediate load
6. The definitive hybrid bridge is fabricated following the required integration and healing period (usually not less than three months).

Successful application of this technique requires full understanding of many advanced and challenging principles, among which are:

1. The fundamentals of comprehensive rehabilitation and aesthetic smile design
2. Experience in managing the psychological aspects of providing full arch implant restorations
3. Occlusal concepts including management of a patients occluso-vertical dimension in centric relation

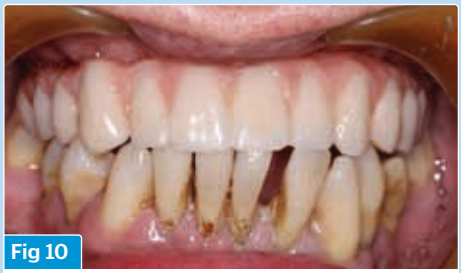

Fig 10
Improvement of aesthetics with provisional bridge fitted same day as extractions and implant placement

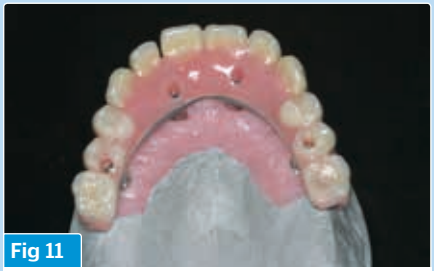

Fig 11
Need for an anterior bite plane may cause speech dysfunction

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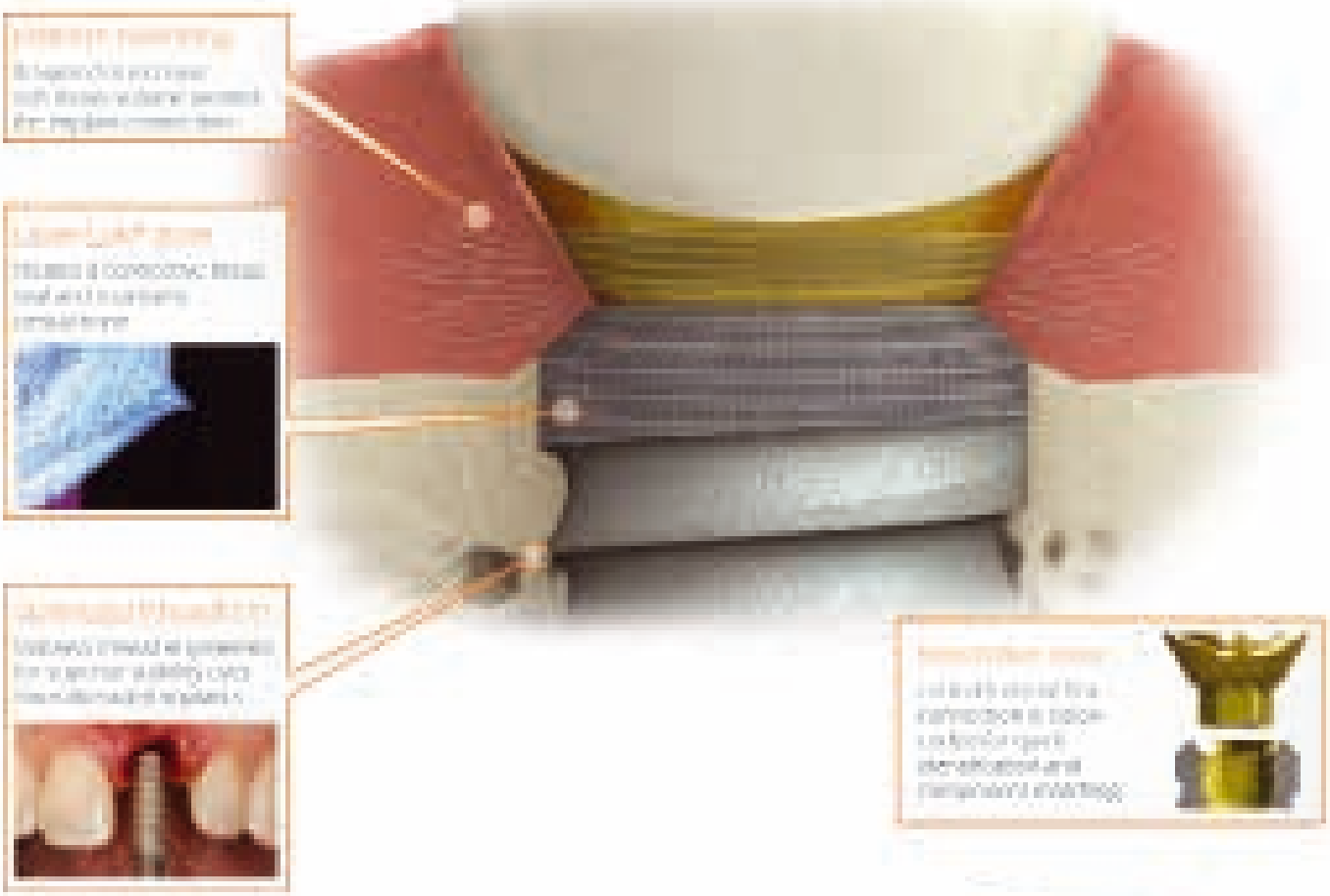
make the switch



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4. Intimate knowledge of the materials, techniques and recommended implant components required
5. Experience in management of surgical and restorative implant complications and challenges
6. Knowledge of laboratory techniques and materials with access to an onsite dental laboratory
7. Comprehensive knowledge of the oral anatomy and advanced surgical planning techniques including CBCT interpretation
8. Experience in advanced surgical techniques including mental nerve location, sinus mapping, alveolar ridge reduction and soft tissue resection
9. Immediate extraction and implant placement techniques
10. Design and use of radiographic and surgical guides
11. Use of grafting materials and barrier membranes
12. Achieving adequate primary stability in all bone types and immediate loading concepts
13. Full arch bridge design concepts for long-term maintenance and oral hygiene
14. Surgical and non-surgical management of soft and hard tissue implant complications.

Despite the challenges in providing this treatment option, there is significant marketing by dentists and implant companies alike about the concept. The reasons for this can be attributed to the significant advantages over previous options, which the patient may benefit from:

1. Implants are placed and a bridge is fitted on the same day, avoiding the need for a complete denture
2. There is only one surgical experience for the patient. Conventionally implants were covered under the gingivae and a second surgical appointment was required to uncover them
3. Patients previously requiring sinus grafts or onlay grafts may now be treated in one visit more cost effectively and without the need for a two stage six to 10-month healing period
4. In a periodontally or restoratively compromised dentition patients may proceed from dentate to implant supported bridgework without ever having to experience a denture
5. A predictable long-term result
6. With only using four implants costs can be significantly lower than previous full arch alternatives
7. Maintenance and oral hygiene measures can be performed much more easily than on more conventional bridgework
8. Significant aesthetic compromises can now be immediately improved and self confidence regained *(figures 9 and 10)*.

"Patients need to be made aware that the procedure is not designed to give them their teeth back, but to offer them a replacement for having no teeth"

Disadvantages specific to this technique are few, but need to addressed at the earliest opportunity:

1. Realising expectations – the final restoration is, in effect, a screw-retained palateless denture. Patients need to be made aware that the procedure is not designed to give them their teeth back, but to offer them a replacement for having no teeth. Essentially, it is the replacement of a body part with a prosthesis in much the same way that a missing arm or leg may be replaced
2. There may be short and long-term challenges such as failure to achieve the required primary stability for immediate loading, restoration fracture, speech and functional changes *(figure 11)*
3. Despite being more cost effective than options involving more implants, a brief review of costs advertising the technique, using the recommended Nobel Biocare implant systems, shows costs in the region of £10,000 to £15,000. These are still significant and need to be carefully discussed and explained prior to any treatment being carried out.

Achieving a positive patient outcome requires careful planning and execution. We will over the next two articles review two cases showing how the treatment was planned and executed from consultation and differential treatment planning through surgical implant placement, final restoration and long term maintenance procedures. ■

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An introduction to implant nursing in general practice, by Tara Crabtree

Patient care is number one

Long gone are the days of a 'dental assistant' who just aspirates. Being a qualified and confident nurse to assist during implant and surgical work is essential.

Thorough planning and the use of protocols are vital to ensure the smooth and safe running of the appointment. At Botanics Dental Care, where I work, patient care is always the priority, so when it comes to implants, as with any other treatment, the highest standards must be maintained.

I would like to provide a brief overview of the basics involved for the dental nurse during these procedures, training tips and what is expected of the dental nurse.

Pre-operative patient care

Before the patient is in the chair, it is common for them to express their concerns to the dental nurse. Will it hurt? Can I drive today? How do I care for my mouth after? It is during this uncertain time for the patient that a well-trained and compassionate dental nurse can really help ease the patient's apprehensions. In my experience, this is truly appreciated – somebody taking the time to sit with them and answer their concerns gives all the reassurance they need.

It creates a feeling of security for the patient and shows that their wellbeing is of the utmost importance. We discuss pre and post-op instructions in a non-clinical environment and provide the patient with a written copy. The nurse should be confident in raising all these points with the patient and should have enough time to discuss them.

"A quick chat and a hello will make the patient feel that their procedure is important and their feelings are being taken into consideration"

Tara Crabtree

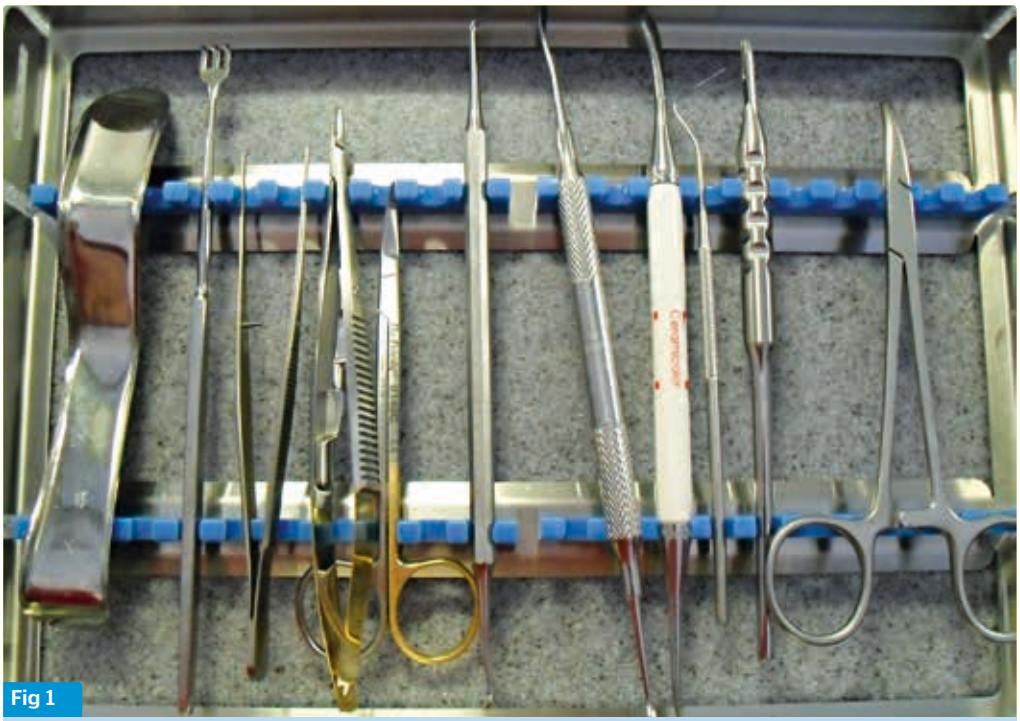

Fig 1
Basic instrument tray for implant surgery

Taking the time to get to know your patients is very useful, it instils trust and co-operation. Even if you have a patient who has no nerves about the appointment or is used to having the procedure, it is still good practice to have a quick chat with them prior to the appointment to find out how they are. As we are well aware, some patients don't like to tell you how they are really feeling.

A quick chat and a hello will make the patient feel that their procedure is important and their emotions are being taken into consideration. For the dental team it could be just another appointment in the day, but for the patient it is an event, one that may have required some planning, time off work and considerable investment.

The set up

Well in advance of the appointment, all consent forms, medical histories, implants, healing abutments, augmentation materials and lab work should be checked. If there is any doubt, then this should be clarified prior to the appointment. When first starting out in the world of implants, all of the different components, systems and small items of equipment can seem daunting. Nurses who are new or relatively new to this kind of work should review equipment and procedures prior to the appointment with a more experienced staff member. Creating protocols for every procedure and having a photo set up checklist for instruments and equipment can save time and aid with training. It provides a quick reference for nurses to refer to if they are struggling with the set up.

This provides piece of mind for the nurse and the dentist and minimises the risk of errors.

The stringent nature of the infection control policies means that everything must be standardised and any small error could have a big impact. Placing a dirty, non-sterile pair of gloves on a sterile area could mean a complete new set up process.

There are two different roles for the dental nurse during implant surgery: sterile and non-sterile. Both of these roles are of equal importance, working closely together during the set up to keep things as sterile as possible. This requires practice, communication and training within the team to work effectively.

The idea of surgical asepsis is important to all surgical procedures. Protocols for preparation, sterilisation and correct storage of instruments should be followed at all times. The dental team have to aim to reduce the number of micro-organisms in contact with the surgical site, utilising strict protocols. A surgical hand and forearm scrub should be undertaken by all members of the team. This is a very important step in reducing the risk of infection. Only then should the team don a surgical gown, sterile gloves and hat. All team members in sterile gowns will remain in the sterile zone at all times.

The purpose of surgical hand scrub is to:

- Remove visible debris and micro-organisms from the nails, hands, and forearms
- Reduce the microbial count
- Reduce growth of micro-organisms.

The procedure for the timed five-minute scrub consists of:

- Removal of all jewellery and nail varnish/false nails (rings, watches, bracelets)
- Washing hands and arms with soap. Ensure the correct temperature – excessively hot water is harder on the skin, dries the skin and is too uncomfortable to wash with for the recommended time
- Start timing. Scrub each side of each finger, between the fingers, and the back and front of the hand for two minutes
- Proceed to scrub the arms, keeping the hand higher than the arm at all times. This prevents bacteria from contaminating the hand
- Wash each side of the arm to the elbow for one minute
- Repeat the process on the other hand and arm, keeping hands above elbows at all times
- Rinse hands and arms by passing them through the water in one direction only, from fingertips to elbow

Continued »

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• Finished, hands and arms should be dried using a sterile towel and aseptic technique. You are now ready to don your gown and sterile gloves.

The sterile area will be set up with everything that could possibly be needed for the procedure, including surgical instruments, sterile gauze and extra suction tips (these can easily get blocked when carrying out surgical procedures). The sterile nurse should be providing adequate retraction and moisture control at all times as well as being acutely aware of the areas of the surgery that she can and cannot touch during the procedures.

Another thing to consider is the use of non-latex products. This will benefit the team and the patients as the number of latex sensitivities and allergies is on the increase. It is best practice to aim to be latex free to reduce the chance of an allergic reaction.

All dentists will have their own preferences when it comes to instruments, but below is a basic list of surgical instruments *(figure 1)*.

1. Minnesota retractor
2. Cat's paw retractor
3. Tissue tweezers
4. Needle holders
5. Scissors
6. Mitchell's trimmer
7. Periosteal elevator (small)
8. Periosteal elevator (large)
9. Periodontal probe
10. Blade handle
11. Spencer-Wells forceps.

The use of local decontamination units are making all dental care professionals aware of 'zoning' techniques, a useful skill to have when working with implants.

Nurses who are non-sterile are responsible for maintaining the clinical area outwith the sterile zone. This can include changing programme settings on equipment, opening presterilised packets for the sterile nurse, drafting a surgical report for the dentist, recording drill usage charts and keeping a copy of implant labels.

By no means should the non-sterile nurse be considered to have the 'easy job'. Making the most of the time available and forward thinking should reduce the need for a nurse to be standing waiting and make the appointment more efficient.

For more advanced procedures involving sinus lifts, block grafts or augmentation, there is a whole new set of procedures and equipment to learn. The excellent advanced nurse's course run by the ADI was very useful for expanding my knowledge and skills in this area. I would urge all team members involved in implant dentistry to join.

Having a practice set of surgical drapes and gowns is a good idea to use for training new staff members and honing the skills of the more experienced team members. Implants may not be an everyday occurrence and having the items to practice with can really help boost confidence on the day.

ABOUT THE AUTHOR

Tara Crabtree has worked as a dental nurse for six years and qualified with her national certificate in 2010 with a merit pass. She has been involved in implant work since 2009 when joining Botanics Dental Care in the west end of Glasgow, working with Dr Colin Gardner. After completing several implant training courses and attending the ADI team conference in 2010, Tara decided to join the ADI as a DCP member to keep her knowledge up to date. She recently attended the ADI Advanced Nurse's Course in Edinburgh.

Useful training tips

• Good planning prior to the appointment – know what to expect and what you need. Be prepared for the unexpected as quite often it happens!
• Create check lists and photo guides to aid set up
• Regular 'dress rehearsals' using a spare drape kit and gown
• Reflective learning. After the appointment discuss with the rest of the team how it went, is there anything to be learned from what happened? Did it go well? How can we improve?
• Engage with the patient – possibly have a dedicated nurse for the whole implant journey that the patient can get to know and call if they need advice
• If in any doubt seek advice, don't be afraid to ask
• Join a professional body, such as the ADI, to keep up to date with protocols and training.

Dental nurses have been granted professional status, which is fantastic for our profession. We have worked hard to get where we are now. I am fortunate to work within a team who fully appreciates the role that a dental nurse plays. I have been lucky enough to have been supported initially by an experienced nurse from another practice who has a wealth of experience on the subject, along with excellent help from implant company reps, dentists and fellow nurses.

Implants may seem daunting to the inexperienced, but they are not something to be feared. There is always the opportunity to learn more and gain more experience and that is what I aim to do. We are now in an environment where patients are much more informed and have a better idea of what is expected from their dental care professionals.

Training and CPD must be at the forefront of everyone's minds and it is important that dental nurses are aware of the implications and the risk to their GDC registration is they do not follow procedure. It is now essential that we not only have these procedures and protocols in place, but that we are also able to demonstrate that we have followed them for each and every case. ■

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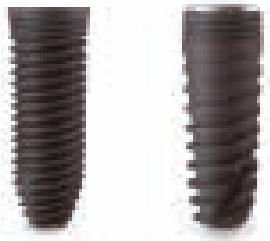

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Spring Grove Clinic's principal dentist launches their referral service

Referral focus – David Cunningham

For many general dental practitioners, their main concern when referring a patient to another dentist is whether they will ever see them again. The worry is they will get their treatment and then the referral dentist will simply poach them and add them to their own list.

However, David Cunningham, at Spring Grove Clinic, offers a very simple, but powerful guarantee: at Spring Grove Clinic, your patient will remain your patient.

He has developed a successful private practice and has now recruited specialists Dr Craig Wales and Dr Colin McIver to carry out oral surgery and Dr Marcin Paradowski to take endodontic referrals at the clinic. David himself, who has been involved in implant dentistry for more than 10 years and is a mentor for the ITI, also takes referrals for restorative dentistry and treatment planning.

David explained that the clinic had been seeing other dentists' patients for some time and, over the last couple of years, he has assembled the team that will allow him to continue to offer a first-class service to his referring colleagues.

He believes that the relationship with referring dentists will be at the heart of all that they do. He said: "I don't want the relationship to be in any way distant. It needs to be a two-way thing and we are committed to the Spring Grove Guarantee that your patient will absolutely remain your patient."

As part of his implant mentoring, David is seeing more and more dentists attending the practice to watch procedures and witness first hand the work of the specialists. He is keen for this to continue for his referring dentists and the clinic will be holding regular education events – including refer and restore courses through Southern Implants and Straumann – to help broaden knowledge and harvest a culture of learning for participants.

Spring Grove is taking referrals for treatment planning and advanced restorative work, implants and oral surgery, including block grafts and sinus augmentation. David said: "We are in the east end of Glasgow and we place hundreds of implants each year. That is not geographically where you would normally expect that to be happening. But we are seeing patients on referral from all over the country, from Argyll, Stirling, Ayrshire and elsewhere."

The clinic has a system in place to receive referrals through the website (www.springgroveclinic.com) by email, phone, fax or post and it will aim to contact the patient within 24 hours and see them in the surgery in the next fortnight or sooner if possible. The referring dentist will receive regular updates on treatment and a comprehensive letter detailing the exact treatment upon completion.

David is also in the final year of an MSc in Restorative Dentistry at Manchester University and he revealed it has given him greater confidence and skill when dealing with the evidence base. He said: "I am much more able to read the literature and make treatment decisions based on an evidence-based approach. It has enabled me to look at manufacturers' products and look at the evidence provided for why they should be used with a properly educated eye."

He also believes the course has inspired a new goal for his career. He said: "My heart is in both the worlds of aesthetic dentistry and restorative dentistry. My personal opinion is that they are too far apart at the moment and my mission for the second half of my career is to try to bring them closer together.

"I run the BACD group in Scotland and, with this in mind, I try to encourage the guys from the implant groups to come to the BACD group and vice versa." ■

"...to help broaden knowledge and harvest a culture of learning"

David Cunningham

For more information on the clinic, including details of David's Facebook page where clinicians can post cases and benefit from the advice some of the finest restorative dentists in the UK and the world, visit www.springgroveclinic.com

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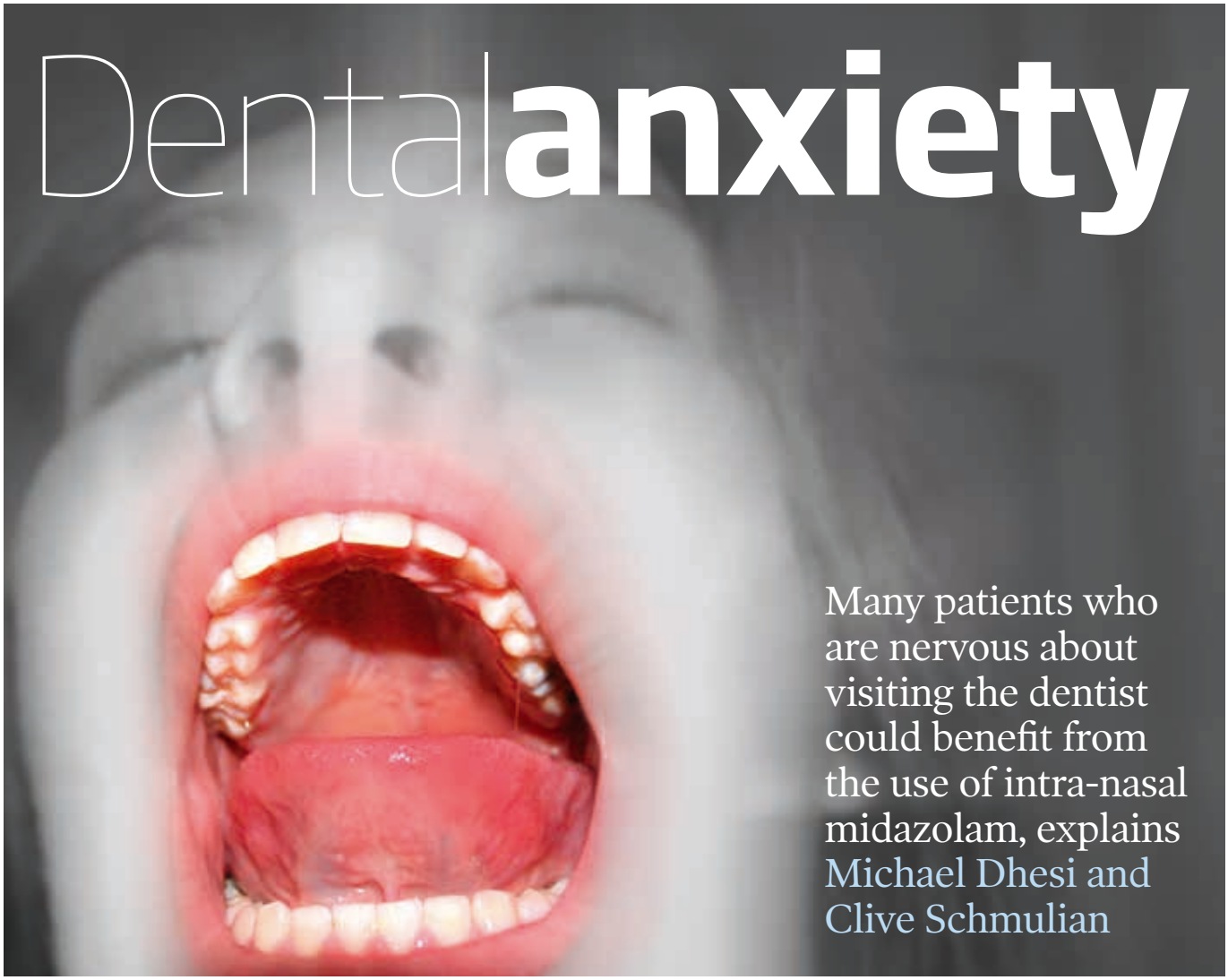

Many patients who are nervous about visiting the dentist could benefit from the use of intra-nasal midazolam, explains Michael Dhesi and Clive Schmulian

Dental anxiety commonly presents a barrier for patients in achieving oral health. The Scottish Health Survey 2009 found that 20 per cent of women and 11 per cent of men surveyed were 'very nervous' about visiting the dentist[1]. Clearly, this barrier of anxiety and phobia must be addressed in order that access to high-quality care is an achievable goal for all.

Numerous techniques are available to the dental profession to assist patients in accessing and accepting dental treatment they require. Non-pharmacological behaviour management techniques such as acclimatisation, desensitisation and positive reinforcement are essential in treating patients with dental anxiety. However, for a significant proportion of patients, non-pharmacological techniques will require to be supplemented with conscious sedation in order that treatment can be carried out with a minimum level of stress.

The General Dental Council defines conscious sedation as: "A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. The level of sedation must be such that the patient remains conscious, retains protective reflexes, and is able to understand and to respond to verbal commands." [2]

The Scottish Dental Clinical Effectiveness Programme guidance on 'Conscious Sedation in Dentistry' gives the following indications for the use of conscious sedation techniques:

- Dental anxiety and phobia
- Prolonged or traumatic dental procedures
- Medical conditions potentially aggravated by stress
- Medical conditions affecting the patients ability to co-operate
- Special needs[3].

"The level of sedation must be such that the patient remains conscious, retains protective reflexes, and is able to understand and to respond to verbal commands"

With an ageing population and an increasing demand for advanced and complex treatment plans, a diverse range of people, including both adult and child patients, will require a form of dental sedation at some point in their lifetime.

A number of methods are available for the delivery of pharmacological agents that will induce a state of sedation in patients including intravenous midazolam, oral midazolam and relative analgesia (RA) using nitrous oxide. These methods all have an important place in a general practice; however, a further method

Fig 1
Mucosal Atomisation Device (MAD)

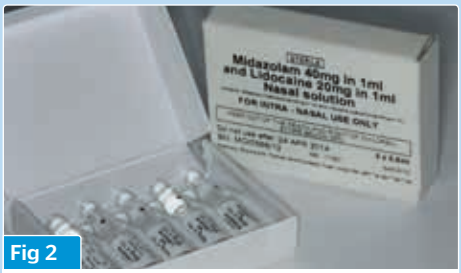

Fig 2
Midazolam 40mg/1ml and lidocaine 20mg/1ml solution

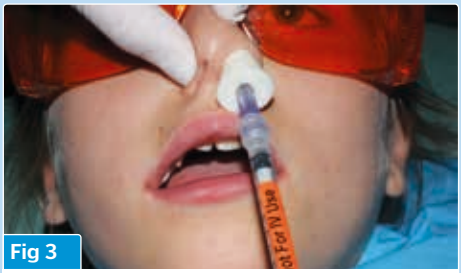

Fig 3
The MAD in action

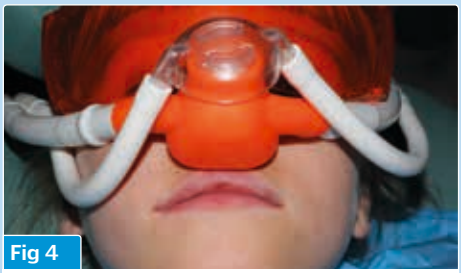

Fig 4
Inhalation sedation of nitrous oxide and oxygen

of delivery of midazolam through an intranasal atomiser could prove an invaluable form of sedation, particularly for children and adults with a needle phobia.

Delivering midazolam through the nose is a simple and convenient method, as access is easy, delivery is painless and the risk of a needlestick injury to the sedationist is avoided. The olfactory mucosa is in direct contact with the brain and CSF allowing the medication absorbed to directly enter the brain.

This method avoids 'first pass metabolism' by the portal circulation and, as such, the administered drug is not subject to destruction by hepatic enzymes. Overall, this allows for a bioavailability of between 55-100 per cent. Midazolam should be delivered in a low-volume and high-concentration solution, as large volumes are likely to be unpleasant for the patient.

Atomisation of the drug results in a higher bioavailability than either spray or drops. The broad 30-micron spray is designed to ensure excellent mucosal coverage and the highest bioavailability possible. Mucosal Atomisation Devices (MAD) *(fig 1)* are single use, disposable and can fit onto a standard syringe. In an atomised form, midazolam has a bioavailability of up to 85 per cent, with a clinical onset of action of around five to 10 minutes. About 40 minutes of useful sedation are available for clinical procedures to be carried out.

Intranasal midazolam has been studied extensively, with hundreds of studies published regarding its effectiveness in sedation, particularly in relation to paediatric patients. It is also highly valuable in the treatment of acute seizures and status epilepticus.

A study by Wood in *Society for the Advancement of Anaesthesia in Dentistry Digest* aimed to determine whether a combination of intranasal midazolam and RA sedation was a 'practical alternative' to general anaesthesia. A clinical audit of 100 cases on paediatric patients aged three to 13 years who had been referred for GA were treated with a combination of intra-nasal midazolam and RA.

The study found that 96 per cent of the required dental treatment was successfully completed using this technique. No clinically relevant oxygen desaturation occurred during the procedures and the study concluded that in selected cases, this technique provides a safe alternative to general anaesthesia [5].

A study in the *Australian Dental Journal* 2012 by Özen et al aimed to evaluate the outcomes of moderate sedation alone or combined with different dosages and administration routes of midazolam in unco-operative paediatric patents. The study examined 240 children and randomly allocated them to one of four groups where midazolam was administered intra-nasally, orally or sedation was achieved with nitrous oxide only.

The highest success rate (87 per cent) was found in the group who received 0.2mg/kg intra-nasally. The authors were able to conclude that the evidence indicates a sufficient basis to justify the use of this technique in primary care "as part of the spectrum of anxiety and behaviour management for this group".

At Clyde Dental Practice, we have used the intra-nasal route to sedate adult needle-phobic patients and also to manage dental anxiety in children. All patients referred to the practice attend for an initial sedation assessment appointment at which a full medical history is taken, including baseline oxygen saturation, and heart rate and blood pressure are recorded.

Dental history, including reasons for dental anxiety, is noted. Options for sedation are discussed with the patient and with children and their parents/guardian. Written consent for both sedation and treatment is signed and scanned into the practice computer system.

Where intra-nasal sedation is being used, the patient's weight is recorded and used to calculate the dose of midazolam required, for example, a child of 40kg at 0.2mg/kg, 8mg of midazolam, giving a volume of 0.2ml of a solution of 40mg/1ml. *(figure 2)*. This high concentration/low volume results in greater bioavailability. Volumes over 1ml result in run off out of the nostril, lower bioavailability and poor patient experience.

Intra-nasal midazolam is given in conjunction with inhalation sedation of nitrous oxide and oxygen. Following administration of intra-nasal anaesthesia, it is not uncommon for children to cough

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and cry. Parents are advised in advance to expect this. Despite the low volume of drug being given, some of this can run into the patient's oropharynx and it can taste unpleasant. Combining midazolam with lignocaine helps minimise any discomfort from intra nasal administration.

Onset of action takes approximately 10 minutes. Oxygen saturation and heart rate are monitored throughout treatment until discharge from recovery. Duration of sedation is between 30-45 minutes, allowing most routine treatment to be undertaken on child patients. The degree of sedation can be variable, particularly in child patients, and restlessness is more common than with adult IV sedation. Intra-nasal midazolam results in retrograde amnesia, helping patients to forget or have little memory of their treatment.

The combination of intra-nasal midazolam with inhalation sedation is considered to be an advanced form of sedation by SAAD and should be restricted to those with postgraduate training in sedation. At Clyde Dental, a sedationist separate from the operating dentist is used. As with other forms of sedation, intra-nasal is not a replacement for general anaesthesia. Patients must be willing to co-operate and accept the need for dental treatment. Intra-nasal sedation provides another option to help manage anxious patients.

In summary, the use of intra-nasal midazolam is clearly shown in the literature to be a highly effective method of sedation. However, it is essential that practitioners using this advanced technique undertake an adequate level of training. Cases should be carefully selected in order to achieve a high level of success with this technique. Sedation should be used in conjunction with effective communication and non-pharmacological behaviour management techniques. ■

"Cases should be carefully selected in order to achieve a high level of success with this technique"

ABOUT THE AUTHOR

Clive graduated from Glasgow University in 1993 and is currently a partner at Clyde Dental Practice, Ivy Cottage Dental Practice and Commonwealth Dental Practice. He has been very active in post-graduate education, having achieved the following qualifications: DGDP(UK) 1996, MGDS(Glas) 1999, FFGDP(UK) 2002, Diploma in Conscious Sedation (Newcastle) 2004, Diploma in Implant Dentistry RCS 2007 and Fellowship in Dental Surgery (RCS Ed) 2011.
He is a visiting GDP supervising undergraduates in the restorative department at Glasgow Dental School, teaches on the Scottish Dental Implant Year Course and lectures on CBCT in dental practice. He was previously a diploma tutor for the West of Scotland MFDGP(UK)/MJDF study group and remains involved with the FGDP(UK).
His practices welcome patient referrals for restorative and oral surgery under conscious sedation (intravenous and inhalation). Clive accept referrals for implant dentistry including bone grafting and sinus augmentation.

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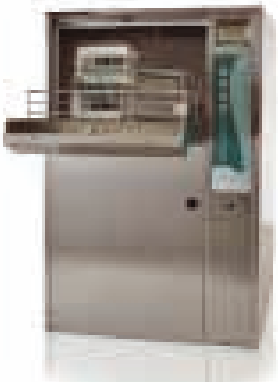

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Washer disinfectors – Why we need them!

By Christine Bowness, Prestige Medical's sales and marketing manager

Dentists will have received a letter from the Chief Dental Officer advising that funds have been released for dental practices who have yet to purchase a washer disinfector – but why are they seen as so essential in the decontamination process?

Washer disinfectors are complimentary to autoclaves, not a replacement or alternative, but a key step in providing best practice infection control.

Instrument cleaning is vital if effective sterilisation is to take place. If an instrument is not clean, it cannot be sterilised. Any tissue or debris remaining on the surface of an instrument will be a barrier to steam penetration and the area beneath that deposit will not be sterilised properly.

Additionally, while sterilisation will kill bacteria and viruses, it will not kill prions of the virus associated with variant Creutzfeld-Jakob disease. The need to physically remove any potentially harmful material is critical.

In choosing a washer disinfector, it is important to choose the right size for the practice. In some cases, the practice may be better served by two smaller bench-top or under-bench machines rather than one big under-bench machine.

This will give more flexibility in siting, reduce the time waiting to have a full load and reduce the requirement for extra autoclaves to cope with the big daily influx of instruments.

Some smaller practices with limited work surface area might benefit from an under-bench machine designed to meet their needs, perhaps incorporating additional storage space, rather than a big machine which has a capacity for a much larger number of instruments than the practice uses. Look for a manufacturer who is able to provide guidance on this. ■

Washer disinfectors are a key step in infection control

"The need to physically remove any potentially harmful material is critical"

Prion diseases, what are they?

By Professor Jean Manson, Prof RG Will and Prof Andrew Smith

Prions and dentistry

The prion diseases (or transmissible spongiform encephalopathies) belong to a group of diseases known as the protein misfolding diseases. This group also includes diseases such as Alzheimer's and Parkinson's disease. In these diseases, a normal host protein does not assume its normal functional structure but is described as misfolding and as such accumulates in large deposits in the brain.

In prion diseases, the protein which misfolds is known as the prion protein (PrP^{C}) and the misfolded form PrP^{Sc}. These diseases typically have a very long asymptomatic phase during which the protein accumulates in the brain and there is a gradual loss of neurones and neuronal function. This results, finally, in a relatively short clinical phase with a variety of clinical symptoms depending on which region of the brain is affected.

The folding and misfolding pathways of a protein are very complex and result in many different forms of the protein. Which of these forms is involved in the death of neurones is not known. It is, however, known that the host protein is central to the disease as removal of the PrP^{C} in animal models leads to a total resistance to prion disease[1, 2].

Prion diseases are set apart from the other protein misfolding diseases, as they are known to be infectious. This was first demonstrated as early as 1936, when the prion disease in sheep known as sheep scrapie was shown to be experimentally transmitted between sheep[3]. Infection has since been demonstrated for a variety of prion diseases of both animals and humans by transmission to animal models[4, 5].

Importantly, although diseases in animals had been recorded for more than 200 years, there was never any evidence prior to 1996 of prion disease in animals transmitting to humans[6, 7]. Moreover, while many prion diseases have been shown to be infectious, it is not certain that all prion diseases are infectious[8].

The nature of the infectious agent has been proposed to be the misfolded form of the prion protein known as PrP^{Sc}[9]. There is, however, no certainty over which form of the misfolded protein is infectious or whether indeed other components are required to render the protein infectious.

Prion diseases can pass from individual to individual within a species and on occasions have been shown to pass from one species to another. However, there is a major barrier for transmission between species[10], which is in part, but not solely, dependent on the differences in prion protein from species to species[11].

This 'species barrier' is likely to explain the relatively low numbers of variant Creutzfeld-Jakob disease (vCJD) in the human population when compared with the very large number of cases of bovine spongiform encephalopathy (BSE) and the widespread exposure of the human population to BSE-infected meat products. However, the implementation of regulations preventing the highly infected tissues from entering the food chain[12] were also likely to have been important in containing the epidemic. The current position of the vCJD epidemic is described below.

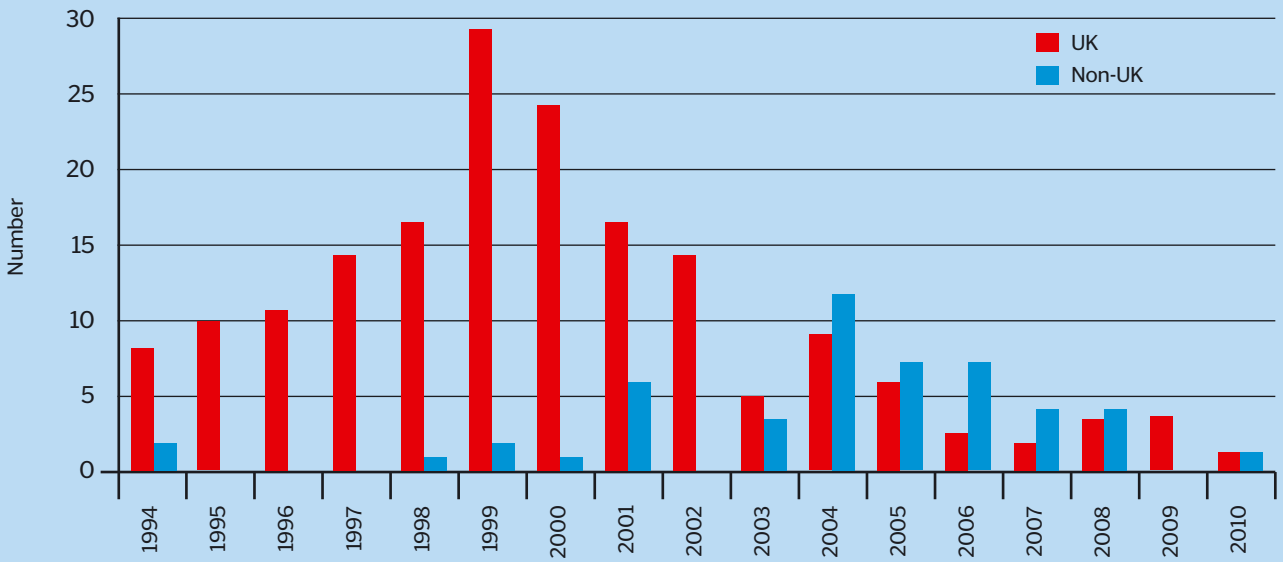
vCJD – the current position

Variant CJD was identified in 1996[6] and the hypothesis that this novel human disease was caused by BSE has been supported by a range of epidemiological and laboratory evidence. Notably, transmission studies in animal models have demonstrated that the prion strain in vCJD is the same as that causing BSE and different from the prion strains in other human prion disease such as sporadic CJD[7].

Risk factors for vCJD include residence in the UK, dietary exposure to foodstuffs containing high levels of BSE infectivity and a specific genetic

YEAR OF ONSET OF vCJD SYMPTOMS

Table 1



background, homozygosity at codon 129 of the human prion protein gene. There is no evidence, as yet, that other potential risk factors such as occupation and exposure to surgical or dental instruments increase the risk for vCJD.

The UK population was extensively exposed to the BSE agent in the human food chain, mainly in the 1980s, and there were fears of a large epidemic of vCJD. However, deaths in the outbreak peaked in 2000 and has subsequently declined with only small numbers of new cases in recent years (Table 1). There have been limited outbreaks of BSE in cattle populations in other countries, mainly in Europe, and potentially infected cattle and cattle products were exported from the UK. As a result, small numbers of vCJD cases have been identified in other countries *(table 2)* and this includes cases that were likely exposed to BSE while living in the UK.

Just as with the British outbreak, there has been a decline in the number of new cases of vCJD in countries outside the UK in recent years. It is possible that the primary outbreak of vCJD may be nearly over, but there is the possibility of further cases in individuals with alternative genetic backgrounds and extended incubation periods.

vCJD differs from other human prion disease as the infectious agent is found not only in the central nervous system, but also extensively in lymphoreticular tissue such as the spleen and lymph nodes. This has resulted in concern about transmission of infection through blood transfusion or surgical instruments that contact these infected peripheral tissues.

There is evidence of transmission of vCJD from person to person through blood transfusion, including three individuals who developed vCJD six to eight years after receiving blood donated by individuals who themselves developed vCJD[13]. Concern about secondary transmission of vCJD has been heightened by evidence from prevalence studies of routine appendicetomy specimens, which suggest that there may be thousands of individuals in the UK who are cryptically infected[14].

These individuals may never develop clinical disease, but may have asymptomatic infection in lymphoreticular tissues, which might be present for many years. While secondary transmission of vCJD has been identified via blood transfusion, there is no indication of transmission by other routes.

However, the incubation periods in human prion disease can extend to decades and the period of observation is currently too short to exclude the possibility that further routes of transmission of vCJD will be identified. This suggests that measures to minimise human exposure to infection continue to be important. One area of concern for transmission of vCJD is through dental procedures as discussed below.

Prions and dentistry

The Department of Health has published two risk assessments assessing the potential for vCJD transmission risks via dentistry. The first was published in 2003 and the second in 2007. Both attempted to clarify the level of risk to public health and the relative impact of risk reductions methods.

This was dealt with on a number of levels: the possible scale of risk, infectivity in relevant tissues, efficacy of decontamination and the epidemiology of vCJD. Each of these inputs is compounded by multiple uncertainties and the very large number of dental procedures undertaken annually means that even small transmission risks per procedure could create an appreciable risk to public health.

The report further describes that the impact of dentistry on vCJD transmission dynamics could range from no detectable effect to several hundred transmissions per annum, dependent on a number of variables including infectivity in oral tissues and efficacy of instrument decontamination.

The Scottish approach to limiting the risk of iatrogenic CJD via operative dental procedures followed on from work undertaken first by the 'Old' group, reported in 2001, which included an observational survey of Sterile Service Departments, general medical practices and five general dental practices in Scotland[15]. This

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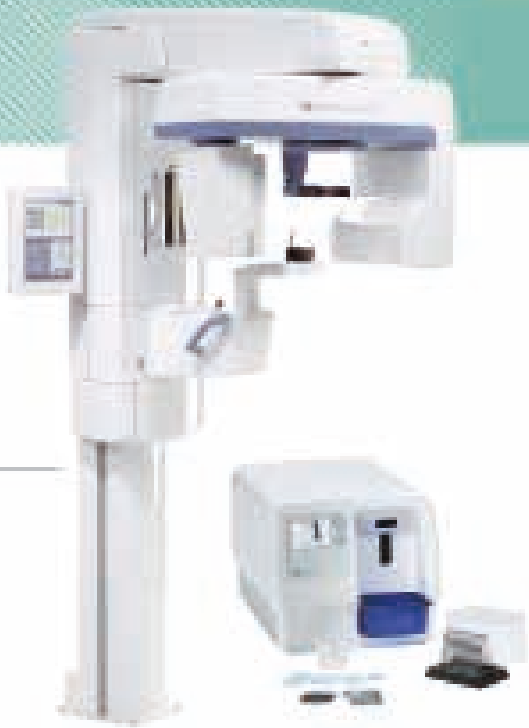

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VARIANT CREUTZFELDT-JAKOB DISEASE CURRENT DATA (NOVEMBER 2012)

Table 2

Country	Total number of primary cases (number alive)	Total number of secondary cases: blood transfusion (number alive)	Residence in UK > 6 months during period 1980-1996
UK	173 (0)	3 (0)	176
France	27 (2)	-	1
R of Ireland	4 (0)	-	1
Italy	2 (0)	-	0
USA	3* (0)	-	2
Canada	2 (1)	-	1
Saudi Arabia	1 (0)	-	0
Japan	1**	-	0
Netherlands	3 (0)	-	0
Portugal	2 0)	-	0
Spain	5 (0)	-	0
Taiwan	1 (0)	-	1

* The third patient with vCJD was born and raised in Saudi Arabia and has lived permanently in the United States since late 2005. According to the US case-report, the patient was most likely infected as a child living in Saudi Arabia.
** The case from Japan resided in the UK for 24 days in the period from 1980-1996.

Continued »

was the first reported study in over 40 years investigating instrument decontamination in the NHS and in common with earlier work demonstrated deficiencies in a number of key areas across all sectors.

A risk-based approach was taken to reduce the likelihood of iatrogenic CJD from contaminated medical devices. Surgical instruments were classified into high, medium or low risk for vCJD, dependant on the tissues they were likely to encounter during surgical procedures *(table 3)*. A programme of work to improve decontamination processes then followed which initially focused on interventions involving tissues containing high levels of infectivity (CNS and posterior orbit of eye) and subsequently medium risk tissues (lymphoreticular tissue), which involved major upgrades to central decontamination units.

To inform the development of an evidence-based approach to limit risks associated with dental surgery (low risk), a number of pieces of work were undertaken. The first of these was a large observational investigation into the current practice of instrument decontamination against a benchmark of the BDA A12 advice sheet and good practice recommendations for the decontamination of surgical instruments[16].

The findings in dental practice were in principle no different from those undertaken in sterile service departments and endoscope reprocessing units in demonstrating several shortcomings. This led to the publication of the Health Protection Scotland (HPS) Local Decontamination Unit (LDU) guidance[17] and a series of Scottish Executive Health Department letters outlining recommendations for the upgrading of instrument reprocessing in dental practice (and dental hospitals).

Additional elements of evidence have been published on inadequate cleaning of first, matrix bands[18] and then endodontic files[19]. These pieces of work perhaps sum up many of the challenges in adapting to calls to improve decontamination in dental practice in that, although this work demonstrated residual blood and tissue residues on reprocessed devices, it was not linked directly to adverse events in patients.

Nevertheless, these instruments are now single-use devices. Further risk is reduced by good decontamination practice and the methods

Continued »

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Jennifer Lowe commented:
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to achieve good decontamination practice are outlined in the HPS LDU guidelines[17].

Although the BSE epidemic is substantially over, there are still considerable uncertainties over the number of cases of vCJD that may appear in the future. Moreover, there are a number of prion diseases still present in animals. Chronic Wasting disease has been found in both farmed and wild deer populations in the USA and increased surveillance in Europe has detected a number of newly identified diseases in cattle, sheep and goats.

The ability of these diseases to transmit to humans is not known. It therefore remains important to retain both animal and human surveillance for prion diseases. Additionally, it is important to ensure safe practices are maintained to prevent such disease entering the animal or human food chain to ensure another prion disease does not impact on human health. ■

RISK CATEGORISATION

Table 3

Risk categorisation for surgical instruments in contact with different tissues

Categorisation of risk	Clinical procedures
High	All procedures that involve piercing the dura, or contact with the trigeminal and dorsal root ganglia, or the pineal and pituitary glands. Procedures involving the optic nerve and retina.
Medium	Other procedures involving the eye, including conjunctiva, cornea, sclera and iris. Procedures that involve contact with lymphoreticular system (LRS). Anaesthetic procedures that involve contact with LRS during tonsil surgery (for example, laryngeal masks). Procedures in which biopsy forceps come into contact with LRS tissue. Procedures that involve contact with olfactory epithelium.
Low	All other invasive procedures including other anaesthetic procedures and procedures involving contact with cerebrospinal fluid. Dental tissues.

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Dolby's experience, project management, innovative approach and impartiality has recently seen them selected as key supplier to GG&C and NHS National Procurement, to supply in the region of 600 washer disinfectors to practices. This is the largest contract awarded in Scotland, a testament to Dolby's business model and partnership approach which focusses on the needs and best interests of dentists.

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Compliant washer disinfectors start from £3,895 with validation packages ensuring compliance from only £27 per month. Fully comprehensive packages, including service and validation, start from just £47 per month. ■

For more information, call 01786 235 500, visit www.dolbymedical.com or email dental@dolbymedical.com

Celebrating Scotland's practices

We highlight some of the best dental practices in Scotland today

EILERTSEN DENTAL CARE

Set against the beautiful backdrop of the Scottish Highlands, Eilertsen Dental Care is an exclusively private practice. The four-surgery facility, which opened in Inverness in 2009, is purpose built to afford the ultimate in contemporary design, comfort and cleanliness for patients.

The practice is based on all aspects of reconstructive and cosmetic dentistry including dental implants, many of which are placed for referring dentists who are encouraged to restore their own cases.

The practice is equipped to the highest standards including its own CBCT scanner enabling referring dentists to scrutinise and plan cases before treatment commences. 'Expertease' software is available for virtual placement and stent construction, thereby removing the guesswork from more challenging implant cases.

The driving force behind the practice is Dr Eilert Eilertsen who has been providing excellence in private dentistry in the Highlands for over 30 years. Dr Margaret Eilertsen adds her skills to the team in conjunction with Dr Mark Skinner, who recently completed his Diploma in implantology at the University of Bristol. Jackie Thain is the practice receptionist who has been with the Eilertsens for more than 30 years.

Hygienist Louise Shenfield, head nurse Lindsey Munro and practice manager Diane Patience are long standing team members. Qualified nurse Sophie Polworth and Francesca Bain, who will be qualified in 2013, complete the team.

Dr Eilertsen said "I am very proud to lead such a dedicated and caring team. The success of our practice is due to their commitment; each in their own way makes a vital contribution to the success of the practice.

"They are always prepared to go the extra mile."

GLASGOW ORTHODONTICS

Glasgow Orthodontics is now in its eighth year and flourishing, with over 250 referrals per month and new treatment modalities on offer, particularly aimed at avoiding extractions for the patients (and dentists!)

New developments include the use of self-ligating bracket systems, like Damon, which can not only reduce the need for extractions, but helps create a beautiful wide arc to the dental arches.

Also on offer is the Harmony Lingual appliance which uses CAD/CAM technology to design and manufacture their lingual brackets; fully customised to meet the occlusal/aesthetic needs of the patient and orthodontist.

Its city centre location is ideally suited to patients/practices on either side of the river, and there is no waiting list.

The practice maintains the system of same-operator-per-patient as gold standard for patient continuity and its orthodontic therapists are supervised at all times.

As always, the practice strives to offer adjunctive treatment for colleagues in general practice, such as increasing a space for an implant or uprighting a pontic for a bridge.

This can enhance the scope of what GDPs can offer their own patients and the orthodontic part can be localised and the duration shortened.

Visit them online at www.glasgoworthodontics.co.uk

DENTISTRY ON THE SQUARE

Dentistry on the Square is a multi award-winning practice mainly treating patients for restorative and implant dentistry.

The clinical team is led by Mark Skimming BDS MFDS MFGDP Dip Rest Dent RCS as well as visiting specialists in maxillo-facial surgery and orthodontics.

The team provide a 'dental phobic' centered approach to treatment with a particular interest in hard and soft tissue laser treatment and painless anaesthesia.

The practice accepts referrals for restorative and implant dentistry as well as running a refer and restore partnership with many other practices.

GIFFNOCK ORTHODONTIC CENTRE

Giffnock Orthodontic Centre is situated on the south side of Glasgow. The practice has been established since 1986 and offers treatments including Invisalign, Incognito and fixed appliances using metal and ceramic technology.

It offers both NHS and private treatment for adults and children and works hard to ensure that there is no waiting lists for patients wishing to be seen. Free private consultations are also available for any patient looking to find out about which treatments best suit their individual needs.

The practice's aim is to ensure that each patient is given the time needed to understand their treatment options.

With two full-time orthodontists, Yas Aljubouri (principal) and George Kantopoulos, and with help from our orthodontic therapist Amanda McRae, they welcome referrals from practices throughout Scotland.

EDINBURGH DENTAL SPECIALISTS

Edinburgh Dental Specialists is a multi-disciplinary specialist referral centre situated in the heart of Edinburgh.

All patients require a referral from their own dentist to receive an appointment and once we have received the referral, we aim to provide the very best advice, care and treatment currently available.

On completion of treatment all patients are returned to their own dentists for their continuing care.

Why you should you consider referring your patients:

• All of our specialist clinicians have held an academic teaching or research position at universities in the UK, Europe or North America.

• Each specialist has more than 10 years practical experience in their chosen field.

• Our clinicians meet every week to discuss optimum care for referred patients.

• Over 1,000 dentists have referred their patients to us over the past 10 years.

• Established since 1994.

Edinburgh Dental Specialists
Established 1994

Letting in the light at Milngavie Orthodontics

In 2007, Geoff Glass took over Milngavie Orthodontics, a practice with, as he describes it, "one and a half surgeries – it was that small..."

By April 2010, the Glasgow graduate had started the search for new premises, to make a dent in – and eventually eradicate – the practice's growing waiting list and to comply with health board regulations to accommodate a separate LDU and X-ray room.

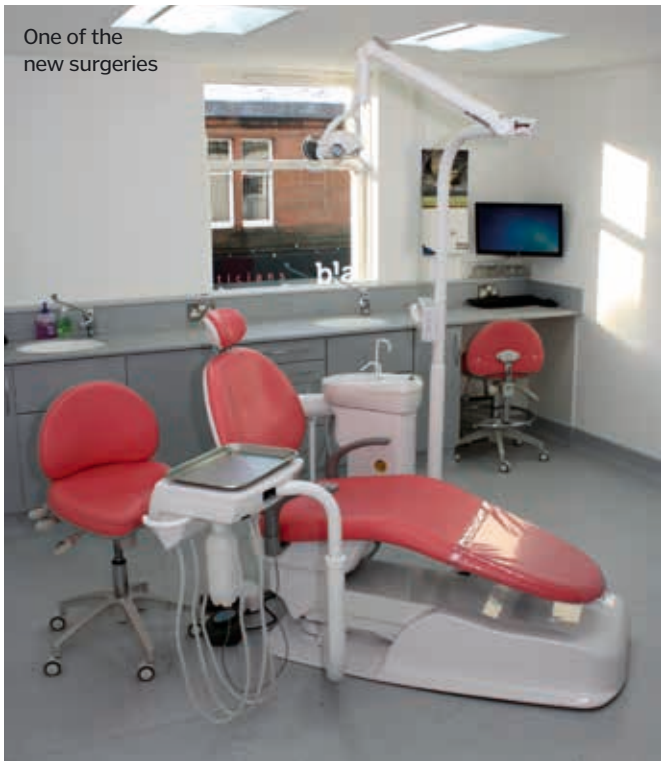
He was determined to keep the service within Milngavie and, after a couple of false starts, he came upon premises that were just 50 yards away from the current practice. Having agreed terms with the landlord, Geoff signed the paperwork in December 2011 and was now faced with the prospect of turning a first-floor open-plan office space into a modern orthodontic practice.

The new reception area with surgeries to the right

Before work could start, the landlord needed to carry out some building works to split the premises into separate ground floor and first floor accommodation. This meant Geoff had to wait until June 2012 before he could start planning properly, and he brought in Farahbod and Homan from NV Design to help him out.

He had spoken to a few colleagues, including his old boss Fraser Stewart and Fern Stewart at Glasgow Southside Orthodontics in Thornliebank, and received glowing reviews on the work provided by NV.

Farahbod and his team came on board in July and work began in early August. As the old practice was quite dark and natural



One of the new surgeries

light was in short supply, Geoff was adamant that the new practice should make as much use of the light available. To that end, NV managed to design a practice that is clean, bright and clinical, without being cold. It harnesses the natural light coming through the external windows and, by using glass panelled walls with frosted sections for privacy, the corridor, reception and waiting area all benefit from the daylight.

The new surgery comprises three surgeries – with space for a fourth – an LDU, small laboratory, X-ray room, staff room, reception area with back office adjacent and a large open plan waiting area. All the equipment and cabinetry was sourced through Michael Adair at Henry Schein.

In preparation for the move and to keep his practice up to date, Geoff had brought Ian Wilson of IW Technology Services on board in 2011 to upgrade all of its IT equipment and install Orthotrac software.

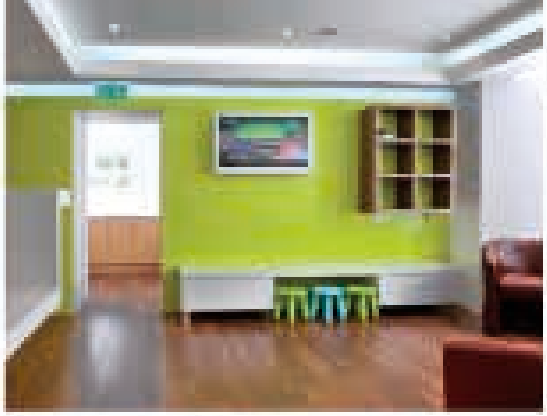
He was again involved in the move to the new practice and installed networked computers in each surgery, a flat-screen TV in the waiting area and a self check-in point.

NV estimated the work would take 12 weeks and Geoff was delighted when he was told they would be finished a week early at the end of October. The fit out involved bringing across one of the nearly new dental chairs from the old practice and "about a tonne and a half of patient models" as Geoff described it.

The old practice closed for good on the afternoon of Friday, 16 November 2012 and the new one opened its doors to patients on the following Monday morning. Over the weekend, Geoff drafted in friends, family and staff members to help add the finishing touches, including making signs to direct patients across to the new practice.

Milngavie Orthodontics has now wiped out its waiting list and employs four part-time orthodontists to work alongside Geoff. They are John Southcott, Alison Roberts, Janice MacKinnon and Hilary MacIntyre, who all work between a day and two days a week.

Asked how he felt about the new practice, Geoff said: "It is a breath of fresh air, it has reinvigorated the practice and I couldn't be happier." ■

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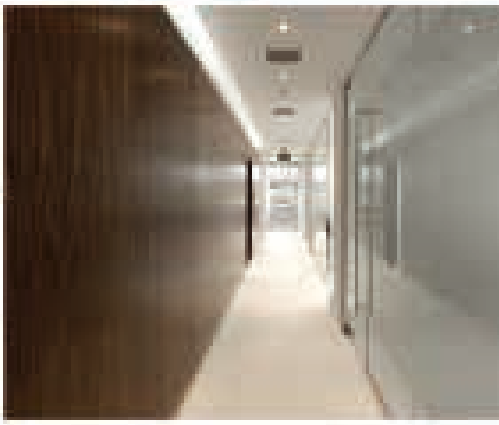

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Making a great entrance for EK practice

Enhancing first impressions for Avondale Dental Practice

Since their refurbishment, staff at Avondale Dental Practice have got used to patients walking in and thinking they have got the wrong building.

When they finally realise that they have the right place, the general reaction is one of astonishment, such is the transformation of the entrance and reception area.

When Mairi Maclean took over the practice 11 years ago it hadn't been properly renovated since the 1970s and the seven surgeries meant that space was at a premium. One of the first things Mairi did was to convert the practice from seven down to three surgeries and refurbish. However, even at that time it was clear that the entrance area was a major weakness.

When patients walked in the door they were met with a narrow corridor with no natural light. A hatch on the right hand side signalled the reception and patients had to double back to find the waiting room, that consisted of a large front room.

Mairi along with her husband and practice manager Donny Black, knew they wanted to change the layout and get rid of the hatch. They contacted Farahbod and Homan at NV Design and Construction and tasked them with reinvigorating the practice.

Mairi said: "When Farahbod came on board it really opened up options that we never really expected. It is amazing to think of how much space we were wasting before this."

The new waiting room and reception area

The design that Mairi and Donny settled on involved a complete restructuring and re-ordering of the downstairs accommodation. Walls were knocked down in the reception and office areas, creating an open plan space that would become the waiting room and reception. Natural light that was blocked out by the partition and reception hatch, now flows into the waiting room and the office spaces are situated behind glass panelling at the rear of reception.

The old waiting room is now a large downstairs surgery, with the old small surgery at the rear of the building turned into two separate spaces, a disabled toilet and OPG room adjacent. The designs have managed to maximise space and find innovative storage solutions in easily accessible but unobtrusive locations.

Despite the scale of the work involved, NV and its contractors ensured that the practice was only closed for two weeks. After the initial phase of work, the practice was able to use an alternative entrance and operate their two upstairs surgeries.

NV were on site for a further six weeks finishing up, with Mairi explaining that the contractors bent over backwards to work around the staff and, most importantly, the patients. She said: "The were very accommodating to both staff and patients and nothing was too much trouble. They were always on time and we have even had patients who are in the building trade complimenting us on the standard of the work. We knew it was good, but to get praise from people who know their stuff is really reassuring."

"We knew it was good, but to get praise from people who know their stuff is really reassuring"

As well as the aesthetic elements of the new practice, Mairi explained that the building is now greener thanks to better insulation and a new central heating system. Summing up their experience, Mairi said: "The difference between then and now is night and day. The entrance is now bright, modern and very welcoming.

"So much so that some of our nervous patients have said that it doesn't feel like a dental practice, it is more friendly and puts them at ease." ■

Dental Protection

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Scottish members of Dental Protection do not subsidise members in other parts of the UK, nor other parts of the world. Scottish members have a much better claims experience, and it is only right that Scottish dentists should see the benefit of this.

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So a full-time general dental practitioner in Scotland pays 37% (almost £900) less to be a member of Dental Protection than colleagues in the rest of the UK while enjoying loads of additional services like free CPD in a variety of forms for the whole dental team.

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E: member.help@mpsa.org.uk

the **complete** package

Avoid the tax traps

With many practices looking at providing dental care by trading through a company, Tricia Halliday looks at pitfalls and advantages associated with the sale or transfer of company shares

Since the removal of restrictions on Dental Bodies Corporates (DBCs) announced in 2005, a growing number of practices have chosen to provide dental care through the medium of a company.

There can be a number of advantages in trading through a company, the most notable being the relatively low rate of tax. However, there are disadvantages to incorporation which should not be overlooked and in previous articles Stephen Neville highlighted the dilemma faced by DBCs – in particular the importance of registering on NHS lists and the potential loss of grants and training allowances.

The corporate entity can also offer the owner a relatively simple method of selling the practice or passing it on to a successor. The sale of shares in a company is far simpler and cleaner than the alternative of selling the business in a piecemeal fashion.

Share sale

The sale of shares will be subject to Capital Gains Tax (CGT). The gain on sale (the proceeds received less the cost of the shares) will be taxed at either 10 per cent where Entrepreneur's Relief (ER) is available or 18 per cent/28 per cent depending on the seller's personal tax position.

The 10 per cent rate afforded by ER is available for lifetime gains of up to £10 million for each taxpayer. As with most tax reliefs, certain conditions must be satisfied.

A shareholder can qualify for ER on the disposal of all or part of his shareholding if, throughout the 12 months prior to the share disposal:

- the company was a trading company; and
- the company was the individual's 'personal company' where the individual owned at least 5 per cent of the company's ordinary share capital and was able to exercise at least 5 per cent of the voting rights; and
- the individual was an officer or employee of the company.

The last two conditions are not particularly onerous and can easily be given effect with careful planning. The first condition carries a little more risk.

Rather unhelpfully, there is no statutory interpretation of 'trade'. If a company is conducting commercial activities, with a view to making a profit, then HMRC should accept that it is trading. A claim for ER may be denied where a company's activities include 'to a substantial extent' activities other than trading.

HMRC guidance defines 'activities' to include 'the making and holding of investments (including cash). Substantial is defined as 'more than 20 per cent'. To get straight to the point, where a company holds 'too much' cash i.e. more than 20 per cent of its total assets – ER may be denied and the seller subject to higher rates of capital gains tax.

Gift of shares

There are similar considerations when the shareholder wishes to gift his shares in a company to a relative or business partner, say as part of a business succession plan. The gift is potentially liable to Capital Gains Tax (CGT) at the date the shares are gifted and to Inheritance Tax (IHT) on the death of the transferor.

As highlighted above, ER may be available to reduce the amount of CGT payable and Business Property Relief (BPR) is available to mitigate the IHT charge subject to the following three conditions being satisfied. The shares must:

- be 'relevant business property'
- have been owned for a minimum period of two years
- not be subject to a binding contract for sale at date of transfer.

Problems may arise when considering the first condition. Shares in an unquoted trading company are treated as 'relevant business property' and benefit from 100 per cent relief.

However, provisions within the IHT Act will deny relief where the business in question "consists wholly or mainly of making or holding investment".

The phrase 'wholly or mainly' should be interpreted as meaning more than 50 per cent. Hence cash in excess of 50 per cent of the total value of the company's assets may give rise to problems.

Tax planning is the key. Shareholders considering a sale or transfer should start planning at least one year before the proposed sale or transfer date. If cash balances are high, steps should be taken to reduce the levels of cash. Investment in new plant and machinery, company pension contributions and dividend strategies are possible courses of action.

If you are considering a share sale or transfer, speak to your tax advisor as soon as possible. ■

ABOUT THE AUTHOR

Tricia Halliday is a partner at Martin Aitken & Co. Tricia is contactable at ph@maco.co.uk by telephone on 0141 272 0000. You can find out more about Martin Aitken & Co by looking at their website www.maco.co.uk

Profit from individuality

One thing dentists have in common is they're all different

From the remote and rural practices of the Highlands and Islands, to the urban practices in the hustle and bustle of Glasgow, the one thing that they all have in common is that they are all different.

Dental plans specialists I•DENTify recognise this individuality and, whether you are NHS, private or mixed, you can build a plan that suits the needs of both your unique patient base and your unique practice.

I•DENTify's aim is simple. To provide a dedicated dental plan, without complex administrative duties and excessive cost that offers flexibility and freedom to determine plan treatments and set a fair level of fees to suit the patients.

I•DENTify gives the freedom to dentists to decide their own monthly subscription charge based on what they feel is fair and affordable. If you don't know, then the financial team at I•DENTify have financial models to help you figure out what is best for your situation.

There is the choice of a fully comprehensive plan offering all treatments, or a maintenance plan that covers routine visits or both, depending on the patients' preference and the dentists' recommendation. There is no need for patients to be clinically assessed making the plan easy to manage.

I•DENTify will remove the conversion workload from the practice and allow the dentist to focus on what they do best: looking after the dental health of their patients.

By joining with I•DENTify dentists can be sure that their patients are happy and committed to the practice for the long-term. Patients have reported that they have found the plan to be good value for money, easy to understand, their dentists are able to spend more time with them and now offers a wider range of treatments than before.

If you are looking to convert but you don't know where to start, get in touch today and let I•DENTify do all the hard work. ■

For more information, contact I•DENTify on 0141 849 7102 or visit www.identifyscotland.co.uk

Try the Dawson Academy UK, says Steven Lomas of The Old Surgery Dental Practice

Ready to take a quantum leap?

ABOUT THE AUTHOR

Steven Lomas (BDS Dip Rest Dent) is a partner at the Old Surgery Dental Practice in Crewe, a busy six-surgery restorative and referral practice. He is a full member of the BACD and runs the South Cheshire study group for the BARD. He is a Dawson Academy alumni member and a recognised provider of Six Month Smiles and Inman Aligners.

This year has been my 20th in dental practice and, without a shadow of a doubt, it has been the most professionally rewarding, having spent most of it learning the concept of Complete Dentistry with the Dawson Academy.

Over the last 20 years I have dedicated myself to learning the most up-to-date restorative and cosmetic techniques. Despite being able to provide beautiful looking fillings, crowns etc. there was still something missing, a burning set of questions to which I needed answers.

The answer became increasingly clear. I needed to go and solve the mysteries of the dental occlusion or "The Bite".

Occlusion is an area of dentistry largely ignored in undergraduate dental teaching, not just in the UK, but worldwide. Generally dental graduates come out of dental schools without any real comprehension of occlusion beyond it being difficult and that it doesn't really matter. However, providing a correct occlusion not only provides the solution to my questions, but provides long lasting protection to the teeth.

After a lot of research it became clear that the further education lay in the USA, either with the world famous Dawson Academy in Florida or the Kois Centre in Seattle. I could not believe my luck when I discovered that one of the Dawson Academy's Faculty members, Dr Ian Buckle, had set up a European branch of the Academy here in the North West. I enrolled immediately for the full year long course.

Now I am at the end of the course I can reflect on what I have learnt and realise that the Dawson Academy has helped me to make a quantum leap with my dentistry, moving it to a totally different level. After 20 years, everything finally makes sense, and I have a systematic approach that will allow me to solve just about any dental problem I am faced with. ■

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❸ TePe Extra Soft Interdental Brush

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- Recommended for delicate oral tissue
- Available in six brush sizes

❹ TePe Implant Care™

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Dürr Dental also manufactures its own disinfectant box made of tough polypropylene that can be used to disinfect various instruments.

Dürr Dental has four types of hygiene products. All are conveniently colour coded to identify each product's application – blue for instruments, green for surfaces, pink for skin and hands, and yellow for special areas such as suction systems and amalgam separators.

All-on-4 from Nobel Biocare is "life-changing"

Dr Riz Syed, of Leading Dental Implants in London, is a surgeon for Same Day Smiles and a visiting surgeon to over 20 clinics across the UK as well as a lecturer for CADE Advanced Dental Education. He has carried out hundreds of All-on-4 procedures.

He said: "With All-on-4 you can offer an immediate solution in most cases. People with terminal dentition can have an immediate extraction with one surgical procedure and an immediate bridge. There's no transitional denture phase.

"There's less surgery involved, too. Traditionally, patients would need sinus grafting and possibly bone grafting, but with All-on-4 this can all be avoided."

For more information, please call 0208 756 3300, or visit www.nobelbiocare.com

Dental opportunities at UCL Careers Day 2013

The annual, highly anticipated Careers Day conference takes place on the 8 February 2013 at the Hotel Russell in London. Jointly hosted by the UCL Eastman Dental Institute and the British Dental Association, the event promotes the exciting variety of career opportunities available in UK dentistry today.

Packed with seminars, hands-on sessions and a panel debate with key industry figures, attendance will also earn five hours worth of verifiable CPD.

The event is ideal for foundation dentists, students, and overseas professionals, plus dentists considering a change of career.

Dental support agencies and potential new employers can all be found at the exhibition, while guidance, advice and unique insights will be gleaned from a wide-ranging programme of events.

To book your place, contact Dawn Mifsud on 0207 905 1248 or email d.mifsud@ucl.ac.uk

UCL eastman DENTAL INSTITUTE

Have you switched?

Many practices are replacing their old analogue X-ray system with digital radiography such as the Dürr VistaScan Mini, but is it an easy transition?

Well, the plates are the same size and handle in the same manner as film, therefore there is little difference in taking intraoral exposures. One difference, however, is that VistaScan plates are noticeably thinner than film and patients often find them more tolerable intraorally.

The processing of the plates is also cleaner, faster and completely predictable with a one touch button to turn on.

There is minimal upkeep; a simple wipe of the scanning slot from time to time.

For more information, call 01536 526 740.

Wrigley hires new global manager for WOHP

The Wrigley Oral Healthcare Programme (WOHP) has appointed Matthew Kent (pictured) as its new global manager.

Wrigley has hired the senior health comms specialist to drive the further development of the programme which is focused on helping dental care professionals and patients better understand the role of sugarfree gum in their oral care routine. Matthew will be based in Wrigley's UK headquarters putting the spotlight on the UK as leading the way in better oral health. WOHP operates in 47 countries around the world and is grounded in more than two decades of clinical research.

Matthew has a wealth of experience in both the UK and internationally. Previously associate director of London-based healthcare agency 90TEN, Matthew was responsible for delivering innovative solutions in public relations, medical education and treatment adherence. Prior to 90TEN, Matthew held a senior position at Tonic Life Communications in New York where he specialised in delivering high impact programmes for brands and companies in pharmaceutical and consumer health.

Matthew added: "This is an exciting time for Wrigley in oral care and I'm delighted to be driving the global Wrigley Oral Healthcare Programme from here in the UK.

"Much of what happens in the UK informs and inspires our activities across the world, from educational resources to public policy outreach. I'm looking forward to providing new creative and strategic insight, to further engage dental professionals and their patients on the benefits of chewing sugarfree gum as part of an oral care routine."

For more information, visit the dedicated site for dental professionals at www.wrigleyoralhealthcare.co.uk

Seeing is believing

The New LED operating light from Takara Belmont provides excellent light output over their projected lifetime, which is a staggering 40,000 hours or around 25 years for the average user. The 10 shadow-less beams emit excellent light colour immediately making it ideal for colour matching.

Environmental considerations concern us all, and the 900 emanates less heat and consumes less power, offering an estimated 80 per cent power saving over a traditional halogen bulb. Cross infection matters have also been covered; the unit has a touchless sensor to turn the light on/off as well as allowing the user to switch to a composite cure mode setting so that you can work uninterrupted with composite-cure materials.

As the 10 LED lights are encased in a one piece cover there's no risk of dust or mist build-up and the unit is easily cleaned.

For more information, call 020 7515 0333.

UltraClean 3 approved for Scotland

The new UltraClean 3 features a faster cycle time of only 65 minutes, including drying as well as a glass viewing panel and interior chamber illumination – allowing the operator to make a quick visual check on the cleaning process.

Available in bench top or under bench models for maximum flexibility in siting, UltraClean 3 has all the benefits you would expect from Prestige Medical including high load capacity and a reduced cycle time. Supplied with optional data logger or printer for easy, recordable data.

For more information, call 01254 844 103 or email sales@prestigemedical.co.uk

Handpiece care and maintenance

W&H have an exciting range of handpiece care and maintenance and decontamination products with excellent support which are available through the W&H Decontamination Equipment Rental Scheme.

Offering the ultimate in reliability and quality, the W&H family of products includes: The Assistina handpiece maintenance unit; the ThermoKlenz washer disinfector dryer; and the Lisa Type B, Lina Type B and MS sterilisers from a prestigious stable of autoclave manufacturing.

W&H's 24-hour online support offers added information and decontamination guidance at www.wh247support.co.uk.

Contact office.uk@wh.com or +44 01727 874 990.

Video education helps with compliance

Infection control specialists Dentisan has recently released a series of online videos that can help practices comply with decontamination requirements.

Available at www.dentisan.co.uk, the video library covers 'Biofilm Remover for Dental Unit Water Lines'; 'Multi surface cleaning'; 'Pre-treating instruments before cleaning'; and 'Hand and skin care'. Each video demonstrates the ease of use of each product and how practices can use them to comply with local regulations.

Dentisan products are available from Henry Schein Minerva (08700 102 043), Kent Express (01634 87 87 87) and Claudius Ash (0500 500 322).

New Synea Fusion handpieces from W&H

The excellent NEW Synea Fusion range offers great performance at an attractive price, with proven quality and reliability, building on the already established and respected reputation of the W&H Synea brand. W&H range of handpieces offer absolute flexibility to meet the needs of each dental practice.

Synea Fusion offers the choice of a midi (Ø 11.5 mm) and a mini (Ø 10.0 mm) head turbine along with a 1:1 contra-angle, 1:5 speed-increasing contra-angle, 2:1 speed-reducing contra-angle and 1:1 straight handpiece. All turbines have ceramic bearings and all optic turbines offer improved illumination using LED+ technology.

W&H handpieces including Synea Fusion are thermo washer disinfectable and sterilisable, and the Synea range are offered with a two-year warranty.

Contact W&H (UK) Ltd on 01727 874 990 or marketing.uk@wh.com For a free trial of any handpieces from the W&H range, go to www.wh.com

Polio, MRSA and HIV protection from Dürr

Protection against the polio virus, MRSA and HIV is available by using Dürr Dental's FD312 surface disinfectant wipes. These handy cross-infection control wipes contain an aldehyde and phenol-free disinfectant for safe use on all washable surfaces and objects.

With no alcohol in its formulation, the integral disinfectant is ideal for use on dental chairs as it will not damage upholstery.

Dürr Dental manufacture a range of hygiene products that are colour coded to identify each product's application. They range from blue for instruments, green for surfaces, pink for skin and hands, and yellow for special areas such as suction systems and amalgam separators.

Advancing Implant Knowledge Through High Quality Courses

"An excellent thorough grounding for any budding implantologists or experienced operators, with evidence-based references. The course is provided by two experienced and enthusiastic implantologists, in a first class facility." KC Chan, Dental Practitioner, Glasgow

The **GIFT Continuum** teaching programme is an on-going series of specific dental implant based topics that can be attended in any order, delivering units of information that combine to form the building blocks of a course that may be expanded to a postgraduate degree.

Regional and International Training
Training is delivered via a network of regional and international teaching centres. Facilities are appropriate to the practice of implant dentistry, providing the highest quality teaching environment and standard of clinical training.

Theoretical and Clinical
This course is ideal for those practitioners who wish to incorporate implant treatment into their practice, to advance their implant knowledge or consolidate existing expertise, but who are unable to commit to a degree programme. This does not preclude the delegate from following the degree programme at a later date and credit will be given towards the University of Warwick MSc and diploma courses in Implant Dentistry. Both MSc and diploma are registerable with the GDC as additional professional qualifications.

Scottish tutors (Aberdeen) Jacqueline Fergus and George Glover both hold a Master of Science in Implant Dentistry and are experienced GIFT regional tutors and mentors running courses from their state of the art facility in Aberdeen.

GIFT

For further information on Gift Continuum, visit www.gift.org.gg

Tel: 07738 737879 Email: aberdeenimplants@btinternet.com

Versatile and easy to use

Industry leader Nobel Biocare supplies clinicians more restorative options than ever before with the third generation internal conical connection of the new NobelReplace Conical Connection implant.

Offering high primary stability, it provides a safe and reliable solution for all indications in hard and soft bone. The implant minimises micro-movements and potential micro-leakage to preserve marginal bone. It also increases soft tissue height and volume, which leads to healthier tissue.

Versatile and user-friendly, the connection is comfortable to use in surgical as well as prosthetic procedures. Suitable for use with all prefabricated abutments and individualised CAD/CAM NobelProcera abutments, NobelReplace Conical Connection minimises the microgap and achieves natural looking aesthetics.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com

GC Fuji TEMP LT

GC Fuji TEMP LT is especially designed for long-term temporary cementation. Thanks to its balanced formulation, it is very convenient during application and provides a stable retention while assuring the future safe removal of indirect restorations. Besides presenting optimised handling and physical properties, GC Fuji TEMP LT counts on the well-known safety offered by glass ionomers.

It is the ideal choice for long-term temporary cementation of all types of all-ceramic, resin, acrylic and metal-based crowns and bridges, including try-on cementation of long-span prosthetic appliances. It is also specially adapted to assure sufficient retention and retrievability of crowns and bridges cemented on implant abutments.

Call 01908 218 999 or e-mail info@uk.gceurope.com

'Smart' Christmas offer from Oral-B

With Christmas coming, now's a great time to get your patients motivated by investing in the Oral-B Triumph with SmartGuide.

As it's Christmas, selected dealers will be offering a bundle pack of products for only £99.99 (normal RSP for the contents is £332.55). The pack contains 1 x Oral-B Triumph 5000, 2 x Professional Care 1000, 1 x pack of Precision Clean replacement heads (containing 3 brush heads) and 1 x 50m pack of floss. This bundle pack is limited to six per practice.

And it's not just your patients who can save this Christmas. If you haven't already tried the top of the range Triumph 5000, you can purchase a sample pack for just £35.80.

Available until the end of December the offer is available from CTS (0173 776 5400), DHB (0845 6017 086), Dental Directory (01376 391 100) and Survival 32 (0118 951 6161).

Great offer from Bien-Air!

Until the end of this year (31 December 2012) Bien-Air are offering you the opportunity to buy three top of the range Bora L LED turbines for £1,450 plus VAT including: free Unifix coupling, free maintenance DuoPack (oil and cleaning spray) and free three-year warranty.

Incredibly powerful, robust and reliable, Bora turbines boast the very best of Bien-Air technology. They guarantee impeccable hygiene thanks to the Sealed Head air non-return valve and perfect nebulisation with the three separate Accu-Spray air/water sprays. Finally, they have the Cool Touch push-button bur locking mechanism which reduces heating. An additional comfort your patients are sure to appreciate.

Take advantage of the Bien-Air Bora L triple pack's superb price and we guarantee that you won't be disappointed.

Call 01293 550 200 or visit www.bienair.com

Free samples and CPD

In this fast paced world an online resource is the best way to instantly find information. Dentalcare.com is Oral-B's biggest online resource offering dental professionals free CPD and patient samples as well as a wealth of other information.

The site was developed by dental professionals for dental professionals, and is therefore intuitive, easy to access and relevant to every aspect of UK dentistry.

Dentalcare.com is a complete on-line platform where dental professionals can find all the latest news and events, Oral-B innovations and launches, and order both Oral-B and Fixodent samples.

The site also includes interactive educational webinars, videos on a huge range of oral health topics and leaflets to download.

Leading the way

The design of the new tb Compass Treatment Centre from Takara Belmont is so logical. With a delivery unit that can rotate behind the chair, it provides an easy and unobtrusive welcome for your patients.

Nurses will also benefit from this feature as it provides the ideal position for essential clean and prep work.

The unique, centrally mounted pivoting mechanism allows the tb Compass to convert easily from right to left handed use in less than 90 seconds, without the need for any tools! An ambidextrous unit is great for practices where a room is shared, or for those who want the flexibility in the future.

Call 020 7515 0333 for details.

centre for implant dentistry

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12th February 6.00pm Glasgow.
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Tariq Ali BDS (Glas) DiplmpDent RCS (Eng).(74600)
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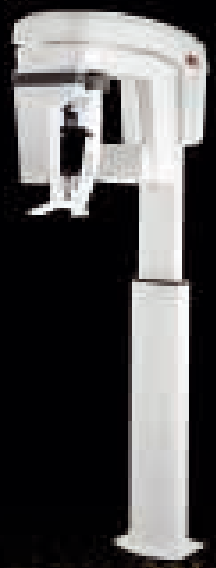

CS 8100

Workflow **integration** | Humanized **technology** | Diagnostic **excellence**

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With compact panoramic imaging, the CS 8100 combines the most sophisticated imaging technology in one simple and compact system. It's perfect for your everyday panoramic needs, providing you with the exact programs and functions you need to effortlessly achieve the high image quality you want, while streamlining your workflow and helping you make a more accurate, real-time diagnosis. The CS 8100 – it's sophisticated technology made thoughtfully simple.

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- Outstanding value for money
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- Plug-and-pan solution – Easy to install, learn and use

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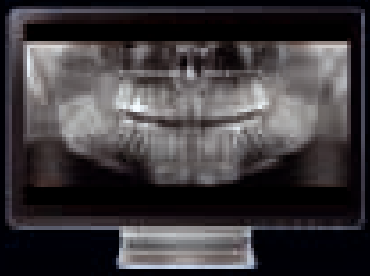

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