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Professor Peter Mossey: "There is a real opportunity to build a uniquely Scottish bridge over troubled waters"

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MANAGING EDITOR
David Cameron
david@connectmedia.cc

EDITOR
Will Peakin
Tel: 0141 560 3019
editor@sdmag.co.uk

ADVERTISING
Ann Craib
Tel: 0141 560 3021
ann@connectmedia.cc

DESIGN
Ruth Turnbull

SUBSCRIPTIONS
Claire Nichol
Tel: 0141 560 3026
claire@connectcommunications.co.uk

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Editor

Will Peakin editor@sdmag.co.uk
Follow Scottish Dental on Twitter, Instagram, Facebook and LinkedIn at: @ScottishDental

Like a ninja

Will the National Clinical Director's powers extend to discovering the 'magic formula' for funding NHS dentistry?

I thought I knew my way around Braehead Shopping Centre. You walk in and soon the Apple Store is on your right and then, up ahead on your left, M&S. Next to Marks there's the big stair thingy taking you to who knows what while, up ahead, still on the ground floor – well, again, who knows what?

Who's interested? Not me. Apple and M&S; in the past, that's pretty much been the scope of my engagement with Braehead. Beyond that? Sorry, I must have nodded off while still managing to remain upright and walk in a straight line.

But then – for me, this year – came the Scottish Dental Show. My first. The *Scottish Dental* magazine and Connect teams had scoped out the venue months in advance and had done this plenty of times in years gone by but, again for me, it was a first. But after that visit, you would think I would remember how to access the arena where the show is held.

Then came the day of the show; 7am and I'm thinking: "Right, I know it's here somewhere, but – what the...?" Anyway, after asking a couple of folk, I found it; just after Costa, kind of left at the escalators. Push through one of the sets of heavy double doors (they do actually open) and I'm in the arena. What a great day. Well, two days. They went well, I think.

Except ... on the Friday, around 4.15pm, just outside the double doors, next to Costa, and the team is wondering: Where's Jason Leitch? He's about to be interviewed by our brilliant Kim McAllister. Kim's here and of course I've got his mobile number so I that can confirm he's on his way. Oops.

In fact, I only have an email for his private secretary.

I start walking away from the double doors, towards the stair thingy and back down to the shopping centre entrance where, obviously, the Apple Store will be on my left and Professor Leitch will be walking towards me with his entourage, having been dropped off by his Scottish Government limo.

What the...? Where's the Apple Store? And – I hesitate to say more importantly because, after all, I bought one of the very first Bondi Blue iMacs – where is the Scottish Government entourage with Professor Leitch striding confidently at its head?

At this point I thought to myself, should I just keep walking? Out into the sunshine and a new life. Free from all responsibilities. Of course, that makes sense in the movies.

But then I get a call from our MD, Alan: "He's here, he's dropped off his cycling gear and he's in the speaker room." How on earth? Our National Clinical Director is like a ninja. Well, to me anyway.

Turns out he's cycled from his home in Glasgow's west end, across the river and – I'll need to catch up with him on what route he took that managed to avoid any of the car or bus-induced nightmares that cyclists frequently endure – has pitched up at the only aesthetically enjoyable part of the arena, outside the cargo bay overlooking the Clyde.

So, turn to page 23 for our report on Kim's interview with Professor Leitch. Despite his apparent superpowers, he concedes that the "magic formula" for the funding of NHS dentistry remains elusive. He alludes to the way general practitioners are funded, something which I have wondered about in this column previously (indeed, on page 41, our report from SPICe – on the COVID-19 Recovery Committee's inquiry into NHS dental services – draws this comparison also).

But we'll have to wait until November, when the Scottish Government is due to announce the revised remuneration for Determination 1, to know how close we are to finding that magic formula. In the meantime, read Professor Peter Mossey's excellent piece, on page 47, about the "opportunity to build a uniquely Scottish bridge over the troubled waters ahead".

> "WHERE'S THE SCOTTISH GOVERNMENT ENTOURAGE WITH JASON LEITCH STRIDING CONFIDENTLY AT ITS HEAD?"

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Supply and demand

We need to create the supply or the next 10 years are going to be hellish

I've just listened to Jason Leech speaking at The Scottish Dental Show. Points surrounding COVID and recovery were certainly reasonable. He alluded to the workforce crisis we suffered in the late nineties and early two thousands. In my day-to-day over the last six months, I've reflected a lot on this, been involved in discussions and written about it. I'm now angry and worried for the profession and our patients.

Is this borne of my four-month waiting time? Is it the constant talk of a recovery strategy? Is it the frustration about 'contract' negotiation, or a lack of it, and a mistrust of motives for SDR change? Is it that the dentists we have aren't doing the work that's needed? That's not a slight against the profession; it's simply the truth. I don't think the desire to have a better and less 'hamster-wheel driven' scenario is wrong. Maybe it's the stalling of the corporate's inexorable acquisition agenda due to the rise in interest rates or even their potential collapse? Maybe it's the profession stumbling blindly into a private model which the recession-based economy will not be able to support? I don't care. Actually, I do! That's what's truly annoying. It might not matter to me; I'm getting too old to be affected by the next 10 years. I believe in our profession and its value. I believe in NHS dentistry. I'm really bothered about the next 30 years. I'm egotistical enough to think I know what to do. I'm going to tell you – if you're prepared to listen. I don't think it will ingratiate me with my fellow professionals or the Government, but here goes.

We need to incentivise work, to a point. If people don't want to work, just wait. Recession is coming. The private dental pound is going to shrink. It did it in 2008 but didn't kick in till 2010. Scottish Government, if you're listening: just wait. Those walking away from NHS dentistry will be back. The problem is younger practitioners have a different expectation of what work and life are worth. They haven't ever been poor (sweeping generalisation, but probably accurate). Our value is high right now; we helped during the pandemic and all that. Practice values are about to drop, if they haven't already. For anyone willing to work hard – I mean 60, 70-hour weeks, four hours a night after clinics, dealing with staff, complaints, bills, struggling to make ends meet, hoping like hell your practice is worth something when you retire type of hard work – there's a good life waiting.

SDR change; get it done, fund it with the 0.1 multiplier in the pot. Test it, for God's sake, test it and guarantee that practitioners and practices won't be worse off in the first year till you get the fees right. Practitioners, get on board. It's supposed to make life easier; don't be so cynical. Easier paperwork equals easier life for us, the PSD, the Government. The Government and the CDO, tell the truth; it's not going to happen in November this year, maybe April 2024. Allowances have to be re-set and linked to fee uplifts year-on-year. When was the last time they increased CPDA, prior approval limits, maternity, the VT trainer grant? These shouldn't have to be negotiated separately; it's ridiculous and adds to the administrative burden. They must exist otherwise the pot gets muddled, and you differentiate from those that do the right stuff and those that don't bother. It's human nature; some try really hard, most try a bit and some don't bother their a***. Don't eliminate the incentive to be a good dentist.

Charge 100 per cent for those who pay. Those who can't afford dentistry get help – in the form of benefits and the NHS Low Income Scheme – the safety net is there. Keep the under 26s free; I think it helps. This is the time of most change – and, these days, the highest risk of decay or periodontitis – as people transition from parental control and regular check-ups into the world of work, self-care, low wages, nights out and not brushing their teeth or seeing the dentist. Everyone else can pay. Save the £20m and put it back into the system. Increase the dental budget and deal with health inequalities; make those that can pay support the system.

NHS dentistry, with its Government-controlled fees, is still the biggest bargain in healthcare.

Keep practice allowances; rent, rates and GDPA. Remove the GDPA cap; it's grossly unfair and affects those working in deprived areas. Limit the number of practices, like pharmacy and GP practices; ensure that health boards control opening with business case assessment, like Scottish Dental Access Initiative (SDAI) grants. It drives investment to the right areas by controlling population servicing. It protects that investment by limiting the number of practices overall; you can't just open next door and steal patients. Investment in practices is the only way the system continues. Not all practitioners will but incentives are required to keep ownership viable.

There are not enough people in dentistry. Take the £80m saved every year and plug it in here. Accept that the first really productive dentists will take 10 years to enter the profession. You've got five years to create a better system with supported career pathways. Support the universities. Support colleges to produce nurses and technicians. Support SDAI funding to expand the property portfolio so there are places for people to work. Accept that they all want to work four-day weeks. Put out enough people and practices will be full. Associate percentages will drop. Associates will see the way to make more is to buy and run practices. Controlling practice numbers drives investment into the correct areas and values rise. Those who can't work in general practice will migrate to specialist care and the shortages there will be filled. Specialist practices will be busier and will support this. The private sector will be stimulated by the Government control of what can and can't be done in NHS Dentistry – and everyone knows where the goalposts are.

It's supply and demand. But we need to create the supply and accept that it won't happen tomorrow. Get it done now or the next 10 years are going to be hellish.

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Step away from the treadmill

SCOTLAND'S shadow health spokesperson has called for a "holistic" NHS dental service. Sandesh Gulhane, the Shadow Cabinet Secretary for Health and Social Care, said that prevention of disease should "not only be at the heart of the service but also incentivised".

Speaking at the Conference of Scottish Local Dental Committees' annual conference in April1, he said that this would allow dentists "to step away from the treadmill associated with item of service".

At the conference motions on the crisis facing NHS dentistry in Scotland took centre stage, with the revised Determination 1 of the Statement of Dental Remuneration (SDR), increasing costs, and calls for reform of several allowances within the SDR, all being debated.

The urgent need for payment reform and sustainable funding for NHS dentistry in Scotland underpinned the debates on many of the 21 motions. Recruitment and retention of dentists along with dental team members was an area of concern. Recruitment and retention of dental nurse and auxiliary staff, workforce planning, and training, also featured.

Delegates passed motions calling for the delivery of NHS dentistry to be reformed, following the pandemic, in a way that delivers for patients and the profession. Given the real terms cuts over the past decade, there was significant debate about the sustainability of NHS dentistry and the current remuneration package.

[1] bda.org/news-centre/latest-news-articles/Pages/Scotland-CSLDC-addresses-NHS-dentistry-crisis.aspx

Searching for the 'magic formula'

Scotland's National Clinical Director describes dentistry's funding dilemma

FINDING a funding mechanism for dentistry remains a challenge, Professor Jason Leitch told delegates at the Scottish Dental Show last month.

Asked about the work that had begun before the pandemic to create a new model of care, he said: "Philosophically, that has not stalled."

"The trick is to find a formula, a funding mechanism, that will reward people doing it for a living and that doesn't result in either over-treatment or under-treatment.

"If you pay 'per widget', the danger is that you get too many widgets. If you pay for just caring, you don't get any widgets."

Professor Leitch alluded to the formula which applies to general practitioners (GPs) where they receive a block of funding for caring for a geographically defined population, to keep them healthy, but are also paid for specific kinds of care – prescribing or cervical screening, for example.

"I don't think anyone, worldwide, has – unless somebody can tell me otherwise – found that magic formula for dentistry," he said.

Charlotte Waite, Director of the BDA in Scotland, asked Professor Leitch: "Looking

to the future, what is the single most important lesson that has been learned which would be of most benefit to dental teams?"

He responded: "I hope it's the importance, at every level, of the dental profession – teams, clinics – to the health of the nation.

"Dentistry stepped up; we've talked about the [establishment during the pandemic of the] urgent care centres but also, remember, the country was vaccinated with the help of the dental profession."

What a Show! **See page 23.**

An opportunity to integrate

SUITABLE remuneration is needed to incentivise the uptake of preventive dentistry, according to Peter Mossey, Professor of Craniofacial Development at Dundee Dental Hospital and Research School.

"Remuneration is key; even though the Determination 1 document does not provide the granular detail, the greater emphasis on primary prevention does shine through," he said.

Writing in this issue of *Scottish Dental*, he said: "Even though not every aspect of primary prevention and minimal invasiveness in clinical practice carries the same level of evidence base, there is no doubt that there is a massive room for improvement in the provision of preventive dentistry and less invasive procedures – and suitable remuneration is needed to influence behaviour and incentivise uptake."

Professor Mossey added that there was "an unprecedented opportunity to integrate oral care with holistic care/general health and wellbeing. Oral health is now on the elevated platform of the NCD Alliance alongside cardiovascular diseases, diabetes/obesity, cancers and respiratory disorders.

"One of the unique aspects of dentistry is the access to healthy people and this in turn offers the potential for dentists to play a much more proactive role in general risk assessment and screening for a range of conditions such as cardiovascular disease, type 2 diabetes and a whole range of diseases, disorders and health conditions that have oral manifestations.

"In addition, there are things that dentists are uniquely qualified to diagnose early such as oral cancers, but dentists could also play a role in the screening for other cancers and a range of other general health conditions.

"There is also evidence of reciprocation – it is noteworthy that in the United States, the American Medical Association has announced what is hailed to be a landmark gesture towards dental caries prevention – the approval of the application of silver diamine fluoride (SDF) by medical professionals to arrest cavities."

An exemplary model **See Page 47.**

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Driving clinical excellence

Scottish dental group adds to leadership team in bid to drive digital dentistry and clinical excellence

Dr Graham has been part of Clyde Munro since 2016

CLYDE MUNRO has made a significant senior management appointment as part of its wider strategy to invest in transformational digital dentistry and drive exceptional clinical standards.

It has appointed Callum Graham as Head of Clinical and Digital Dentistry within the group. The newly formed role has been created to further reinforce Clyde Munro's commitment to digital dentistry, innovation and technology – positioning it firmly as a leader within the sector.

Over the past three years, Clyde Munro has invested £2.5 million in dental scanners and digital learning and development tools as well as an additional £1 million in its purpose-built training academy, the Advanced Dentistry and Clinical Skills Centre, in Perth.

Dr Graham has been part of Clyde Munro since 2016 when he sold his practice to the group in a move that allowed him to refocus on clinical hours, passing the management of the practice on to Clyde Munro. His new role will allow him to continue working in clinical environments, while exploring and testing cutting-edge digital technology for the group.

"In the seven years I have been a part of Clyde Munro, I have seen the passion and commitment from across the teams to pursue digital dentistry, recognising the significant benefits it has for dentists and patients alike," said Dr Graham.

"We invest heavily in cutting-edge technology, digital scanners and on-site milling equipment but crucially, we invest heavily in training and development across the business to ensure our patients receive seamless, efficient care at every practice in Scotland.

"I'm really pleased to see this role being formed and delighted that I have been chosen to take the reins. Digital dentistry is going to revolutionise oral healthcare in Scotland; it's more efficient, there is less room for human error and ultimately this will free up much needed capacity, allowing us to provide more dentist appointments at a local level."

> "DIGITAL DENTISTRY IS GOING TO REVOLUTIONISE ORAL HEALTHCARE IN SCOTLAND"
>
> CALLUM GRAHAM

Clyde Munro has set out an ambitious growth plan to reinforce its position as a digital dentistry trailblazer. Through its sector-leading training and development academy to its innovative outlook on the patient journey, Clyde Munro's latest appointment hopes to set a benchmark for dedicated digital dentistry resource and focus within the sector.

The group is committed to providing sector-leading care for NHS patients, as well as private patients. Currently the group provides services for more than 600,000 patients, with the majority being NHS registered.

Clyde Munro operates across Scotland providing routine and specialist dental services for NHS and private patients.

The group comprises more than 250 clinicians and 600 support staff and is committed to the recruitment and retention of talented dental professionals across the sector.

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Recycle and smile

Initiative aims to avoid Scotland's pioneering oral health programme going to waste

NHS National Services Scotland (NSS) and Childsmile have joined forces to launch Recycle and Smile – a new initiative which will recycle toothbrushes and empty toothpaste tubes used as part of Childsmile's supervised toothbrushing programme.

NSS distributes toothbrushes and toothpaste to Childsmile, the national programme to improve children's oral health and tackle oral health inequalities. More than one million toothbrushes and 178,000 tubes of toothpaste are used each year as part of Childsmile's supervised toothbrushing programme in schools and nurseries across Scotland.

Currently, there is no consistent way of recycling these items – but Recycle and Smile is set to change this; Childsmile professionals will take the programme's used toothpaste tubes and toothbrushes to the local Public Dental Service collection site. NSS's recycling partner will collect the used items and break the plastic down into small chips and, once sterilised, it will be ready to be recycled into items such as vehicle parts, garden planters and playground equipment.

Recycle and Smile has been running as a pilot in Highland, Ayrshire & Arran, Borders, Orkney and Greater Glasgow & Clyde from April. It will be rolled out to all health board areas across Scotland later this year. Paul Cushley, Director of Dentistry, NSS, said: "Like all health boards across the country, sustainability is high on our agenda as we work towards our ambition of becoming a net zero organisation by 2040.

"Given our role in Scotland's NHS, NSS is uniquely positioned to support NHS Scotland and the wider health and social care sector to embed sustainability in everyday practice. This is an excellent circular economy initiative which ensures products used as part of vital public health programmes are given another lease of life."

Peter King, Childsmile Programme Manager said: "Childsmile is committed to improving the oral health of children in Scotland and reducing inequalities. Ensuring that our practices are as sustainable as possible is very important to us and this is such a simple way to make a difference.

"Nurseries, schools and Childsmile teams across the country are vital to this programme's success.

"Recycling all this plastic will contribute to a cleaner, greener and more sustainable Scotland — and that's certainly something to smile about."

For more information about Childsmile visit ***childsmile.nhs.scot*** *and watch an animation/ infographic here:* ***youtu.be/o-aoBYQnHzE***

Johnston Carmichael appoints new Head of Dentistry

UK accountancy firm Johnston Carmichael has welcomed a new Head of Dentistry as it seeks to grow its reach across Scotland and beyond. Roy Hogg, who brings more than 30 years' dental finance experience to the role, will be based in the firm's Stirling office, and is taking over the role from Roddy Anderson.

Roy owned his own accountancy firm specialising in providing dedicated financial advice to dental practice owners before merging with a bigger firm in 2006. He is additionally the Scottish Chairman of the National Association of Specialist Dental Accountants and Lawyers (NASDAL), an organisation dedicated to acting for and looking after the accounting, tax and legal affairs of dentists.

"The dental sector has been in a stage of transition for a few years now," commented Roy. "Over the last decade, there was a distinct trend of private buyers and dental groups entering the market, purchasing a range of independent practices and operating them with centralised finance, marketing and support services.

"However, we have seen a recent return towards the more traditional ownership structure, with dental associates looking to become practice owners once again, potentially purchasing their first practice, or extending their reach with a second.

"Buying a practice is extremely complex and requires a capital heavy investment, with most practices costing upwards of £1 million. NHS funding and legislation also change frequently, and it can be difficult to keep up. Without the backing of a private buyer to run the business operations, it becomes essential that new practice owners have the right team behind them to ensure that they can succeed.

"I like to think of it as a wheel of support – with solicitors, accountants, banking advisers and other key stakeholders of the business being spokes on the wheel, joined together to provide trustworthy and accurate support, dedicated to practice specific needs.

"Our role, as trusted accountants and members of this wheel, is to work with other key members of the practice's support team, creating a seamless service that allows independent practice owners to thrive."

Andrew Walker, CEO, Johnston Carmichael, said: "Roy is an exceptional figure in the dental sector, with decades of in-depth experience of dental finance. I can't think of anyone better to lead and build our dentistry business on the back of the efforts of Roddy and Samantha Nicholson."

Royal College announces new dental Dean-Elect

Grant McIntyre (pictured) to take over from Phil Taylor this autumn

THE Royal College of Surgeons of Edinburgh (RCSEd) has announced the appointment of Professor Grant McIntyre as the Dean-Elect of its Faculty of Dental Surgery.

Professor McIntyre has served as Vice Dean since September 2022 alongside Professor Phil Taylor, who currently holds the position of Dean of the Faculty.

As Dean, Professor McIntyre will be responsible for overseeing the dental education, examination and internationalisation portfolios offered by RCSEd, as well as ensuring the College remains at the forefront of dentistry in the UK and globally.

Professor McIntyre will officially take on the role at the College's AGM in September, where a traditional ceremony will mark the change of Dean.

Professor McIntyre brings a wealth of experience to his new role. After graduating from the University of Glasgow with a degree in Dentistry in 1993, he went on to complete his PhD in Orthodontics at the University of Dundee in 2001. He has been a consultant in orthodontics for the past 20 years, with a particular focus on cleft lip and palate care and facial deformity in that time.

Professor Taylor said: "I am delighted to announce the appointment of Professor Grant McIntyre as Dean-Elect of the Faculty of Dental Surgery.

"Carrying out this role has been an incredible privilege for me, and I am pleased to hand over the reins to someone with not only an abundance of ability but plenty of passion too.

"I am sure he will do a fantastic job of driving the Faculty and the College forward, continually striving to make things better for patients and healthcare professionals alike."

Professor McIntyre said: "Being elected to this position is an incredible honour.

"I am thoroughly looking forward to leading our wonderful Faculty over the coming years. I've gained invaluable experience over the years as a member of Dental Council and latterly as Vice-Dean.

"I am grateful to be able to work with such an incredible professional and personal support team both inside and beyond the College."

To find out more about the RCSEd's Dental Faculty, visit ***www.rcsed.ac.uk/faculties/faculty-of-dental-surgery****.*

> "BEING ELECTED TO THIS POSITION IS AN INCREDIBLE HONOUR. I AM THOROUGHLY LOOKING FORWARD TO LEADING OUR WONDERFUL FACULTY OVER THE COMING YEARS"
>
> PROFESSOR GRANT MCINTYRE

Innovators in gum health awarded

WINNERS of the European Federation of Periodontology (EFP) Innovation Award for Digital Solutions for Gum Health, sponsored by Haleon, have been announced.

First prize was given to by Claire Bigot, of Paris Cité University, for her My PerioCare[1]. The application addresses both patients and dentists' unmet needs to better manage periodontal care, from primary prevention to disease therapy.

Second prize went to my.periodontal-health.com[2], presented by Christoph Ramseier, of the University of Bern. Developed in collaboration with Ukraine-based IT professionals, it supports personalised periodontal care.

Third prize was awarded to *Digital technology monitored and controlled oral endotoxin activity levels for personalised primary and secondary prevention of gum diseases and related systemic complications*[3], developed by Svetislav Zaric, of King's College London. It comprises two rapid and reliable tests; a subgingival plaque test performed by dental professionals for site-specific management of gum health conditions and a salivary self-test for the public to be performed at home.

"The EFP is happy to reward innovative work to support clinicians, and to boost periodontal health for the benefit of our patients and society at large," said Andreas Stavropoulos, chair of the EFP scientific affairs committee and past president. "The EFP will continue to support cutting-edge digital technology, with the support of its partner Haleon."

[1]*www.efp.org/fileadmin/uploads/efp/Documents/Past_prize_winners/1st_EFP_Innovation_Award_2023.pdf*

[2]*www.efp.org/fileadmin/uploads/efp/Documents/Past_prize_winners/2nd_EFP_Innovation_Award_2023.pdf*

[3]*www.efp.org/fileadmin/uploads/efp/Documents/Past_prize_winners/3rd_EFP_Innovation_Award_2023.pptx*

First prize winner Claire Bigot

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Addressing inequality through public engagement

Jessica Mannion and Ruby Soldan describe a Dundee co-creation project

AS part of *Dental Connect* – a staff/student co-creation project at Dundee Dental Hospital and Research School – our aim is to reduce health inequalities by promoting access to oral health education and providing advice and resources for those most in need.

Our most recent event was held at a local hotel which houses Ukrainian refugees. We used models, aids and translated leaflets to promote dental-related advice, while providing resources such as free toothbrushes and toothpaste.

Although refugees are entitled to free treatment under the NHS, there is limited availability to be seen, with many Dundee practices unable to take on new patients. We offered and assisted anyone to access treatment in our student clinics. This self-referral pathway is available to anyone in our community, but a lot of those attending were unaware of this.

The event proved very successful, with those in attendance expressing their gratitude and dental hospital sign-ups reaching double figures on the night. As students, we also beneftitted; not only did we improve our communication skills, but we gained a further appreciation of our broader role within the community, learning first-hand how impactful this can be. The evening proved a truly humbling, fulfilling experience. Through acknowledging the obvious inequalities experienced by many on our doorstep — and observing the impact that such events can have — an appetite to expand our reach has been fostered. With plans in place to collaborate with local food banks and The International Women's Centre, it looks to be a busy – but rewarding – future for *Dental Connect*.

(Left to right) Katie Munro, Shannon Polson, Hannah Milner, Ruby Soldan and Jessica Mannion. Image: Kim Cessford / DC Thomson

Riva Cem Automix... a revolutionary glass ionomer luting cement

SDI has launched Riva Cem Automix, an all-new resin-modified glass ionomer luting cement that offers superior bond, high strength, five-second tack cure for easy removal of excess and less waste. It is indicated for the permanent cementation of metal and ceramic restorations including high-strength ceramics such as zirconia.

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Alongside excellent bond strength to enamel and dentine, its high flexural strength of 49.3 MPa enhances the longevity of a cement restoration by better withstanding mastication forces while increasing its durability in the oral environment. This allows Riva Cem Automix to be used for reliable restorations across crown and bridges, posts, inlays and onlays, and orthodontic appliances.

Riva Cem Automix offers more tips than other leading competitors. Each supplied tip has less waste than other cements, providing more material for more patients.

Riva Cem Automix has a light tack cure option for easy removal of excess cement. Simply light tack cure any excess material for five seconds with an LED curing light then gently remove. Alternatively, excess cement can be removed after the self-curing phase if preferred.

Colour changes within luting materials can clinically affect the aesthetic appearance of a restoration. However, external tests have confirmed that Riva Cem Automix has the best-in-class colour stability with the least colour change over time[1].

To find out more about Riva Cem Automix visit ***sdirestoratives.co.uk/riva-cem-automix/***

[1] *Source: SDI internal data*

Celebrating 30 years!

Profession pays tribute to Ann Craib, Scottish Dental magazine's Sales and Events Manager

WORDS
DAVID CAMERON, CHAIRMAN, CONNECT

ACCORDING to the dictionary, a "force of nature" is someone of "exceptionally strong personality or character – full of energy, unstoppable, and unforgettable". For those of you lucky enough to know her, and to those yet to meet her, I give you Ann Craib; the most powerful force of nature I have ever met.

Let me tell you a story. Thirteen years ago, Ann burst into my office on her usual irrepressible wave of enthusiasm and declared: "I want to launch a dental show in Scotland!" My dismissive retort? "No, you're not...we're magazine publishers not event organisers," I said, trying to exude chairman-like authority.

Undeterred, she convinced our managing director to let her try. "Get some sales", he said, "and I'll tell 'him' [me] he's wrong." Conclusion? Never, ever, tell Ann Craib: "No." Today, along with the *Scottish* and *Ireland's Dental* magazines that she is the hugely successful commercial engine room for, the show is an outstanding success; attracting hundreds of exhibitors and tens of thousands of guests over the years. And all that is down – with the support of her colleagues – to the truly remarkable Ann, to whom I have the pleasure of paying tribute here. It's now 30 years since Ann began the success story that is all things *Scottish Dental*.

Today, she continues to live and breathe the magazine and the show with the same commitment and determination that she brought to the job on day one. No-one (other than her daughter, Erin) is more important to Ann than her customers, each one regarded like friends to be valued and supported. Connect would not be Connect without Ann Craib and I am genuinely proud of, and immensely grateful for, everything that she achieved.

She truly is a force of nature!

> SHE CONTINUES TO LIVE AND BREATHE THE MAGAZINE AND THE SHOW WITH THE SAME COMMITMENT AND DETERMINATION THAT SHE BROUGHT TO THE JOB ON DAY ONE"

"Many congratulations Ann as you celebrate your 30-year work anniversary! We would also like to say thank you for all your help over the years – we have thoroughly enjoyed working with you. Here's to many more years of working together!"

From the whole team at Eschmann

ESCHMANN

"To our lovely Ann – we would like to express our genuine gratitude for your kind support of our company over the years. It has truly been invaluable, and we are so grateful for everything you have done for us. Your continued assistance has allowed us to achieve great success, and we could not have done it without you. We really value our relationship with you (because you're just fabulous) and we look forward to continuing to work with you in the future. The fact you have been doing this for 30 years (and doing it so well) says it all.

Thank you for everything; your help, your professionalism and generally for being an all-round awesome person! Once again, thank you for your ongoing support. We truly appreciate it! Wishing you a happy 30th work anniversary!!"

Lisa, Ivin and the team at
The Orthodontic Clinic

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Trisha and Gillian at
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"Many congratulations Ann! A fantastic achievement! All the best for another 30 years and thanks for all that you do for us!"

The teams at Scottish Dental Care and Advanced Dentistry

SCOTTISH DENTAL CARE
ADVANCED DENTISTRY

"Congratulations on your 30-year work anniversary, Ann. Thank you for your help, support and friendship over the years – here's to many more! Special kisses to Milli from Locke and Busta."

With love, Team DMG UK

DMG

Plaque? There's an app for that

Graduate's innovation enables users to scan their own teeth

A SMARTPHONE app that scans dental plaque and can flag potential oral hygiene issues has been launched by an engineering graduate.

The Testmyteeth app[1] allows users to perform a scan of their teeth to measure the levels of plaque build-up – one of the primary causes of dental disease – and to highlight areas where users are failing to brush adequately.

The app was developed by James Russ, an integrated design engineering graduate of the University of Bath, who was supported by the university's Enterprise and Entrepreneurship programme[2] which helps staff, students, graduates and local entrepreneurs with their enterprise ambitions.

"I was in my first year of university when I had trouble with my wisdom tooth," said Russ, "and the treatment ended up costing over £100 of my limited student budget. This was particularly frustrating as it could have been easily prevented had I taken better care of my oral hygiene. It inspired my vision for a dental app to assist patients at home."

He set to work on the Testmyteeth app after completing an industrial placement in the design and development team at innovative household appliances manufacturer Dyson, an experience he described as "fast-paced and exciting".

"Oral disease affects around 3.5 billion people worldwide and I thought it would be great to have an app that focuses on the preventative side of dentistry. Using artificial intelligence, Testmyteeth will tell you areas where you have missed when brushing and highlight plaque accumulation," he said.

"More than that, we'll also provide educational guides on how to improve your brushing technique and what the early signs of tooth decay and gum disease look like."

[1] www.testmyteeth.com
[2] www.bath.ac.uk/topics/enterprise-and-entrepreneurship/

DATES FOR YOUR DIARY

2023

23 JUNE
Contemporary treatment of the worn dentition
London
www.bda.org/events/Pages/contemporary-treatment-of-the-worn-dentition-friday-23-june-2023.aspx

28-30 JUNE
BAOMS Annual Scientific Meeting 2023
London
www.baoms.org.uk/professionals/events/2750/baoms_annual_scientific_meeting_2023

01-31 JULY
IRMER radiography and radiation protection
Online
www.bda.org/events/Pages/IRMER-radiography-and-radiation-protection-update-July-2023-online.aspx

16 SEPTEMBER
BACD Young Dentists Day
Royal Lancaster, London
www.bacd.com/event/young-dentists-day-2023/

28-30 SEPTEMBER
British Orthodontic Conference
Queen Elizabeth II Centre, London
www.bos.org.uk/boc2023

09-11 NOVEMBER
BACD 19th Annual Conference
IET Savoy Place, London
www.bacd.com/annual-conference/bacd-19th-annual-conference-2023-new-horizons/

07 DECEMBER
BDIA Midwinter Lunch 2023
Venue Tbc
www.bdia.org.uk/dental/events/midwinter-lunch-2023

2024

31 MAY-1 JUNE
Scottish Dental Show
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www.sdshow.co.uk/

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

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MClinDent (Edin)
MRD RCS (Edin)
- GDC NO 81960

CHARLIE MARAN
Specialist Periodontist
BDS MSc (Restorative Dentistry)
- GDC NO 63897

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

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

KATHY HARLEY
Specialist in Paediatrics
BDS MSc FDSRCS (ED)
FDSRCS (England)
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What a show!

More than 140 exhibitors, 60-plus talks and 50 speakers – it's Scotland's leading dental profession event

More than 1,800 people attended the 2023 Scottish Dental Show, which featured a packed programme of lectures and workshops as well as more than 140 exhibitors showcasing the latest in dental technology, supplies and services.

"It was great to see so many familiar – and new – faces from the profession and the industry," said Ann Craib, advertising sales and events manager. "There was a tremendous buzz across both days. I'd like to thank all the exhibitors for helping make the show such a success – and the team behind it for all the hard work in staging Scotland's premier dental event."

Will Peakin, editor of *Scottish Dental* magazine, added: "I think it makes a real difference for the profession and the industry meeting in person – people are able to make connections and exchange insights in a way that's just not possible online. A big thank you to our more than 50 speakers who gave their time and knowledge to deliver 60-plus lectures and workshops."

The show was sponsored by Align Technology, Clyde Munro, Medimatch Dental Laboratory, Real Good Dental and Atelier Dentistry. The Education Programme included all eight GDC Recommended and Highly Recommended topics, 22 clinical expertise sessions, 10 on business and finance, a stream dedicated to dental nurses, therapists and hygienists as well as talks on regulation, wellbeing and the future of dental education.

One of the many highlights of the show was the session featuring Jason Leitch, Scotland's National Clinical Director, hosted by Kim McAllister, the BBC presenter and a consultant with Connect, publishers of *Scottish Dental*. Before taking questions from Kim and the audience, Professor Leitch spoke about his experience of the pandemic, both personally and at a Scottish Government level. It included his team dealing

> "IT WAS GREAT TO SEE SO MANY FAMILIAR – AND NEW – FACES FROM THE PROFESSION AND THE INDUSTRY"

with physical mail that was both threatening (a facemask sprinkled with white powder) and uplifting (an oil painting depicting the pictures that television viewers would see behind him on the wall when he spoke to the nation from his dining room). Another correspondent wrote to highlight his grammatical errors when speaking (Professor Leitch's wife, an English teacher, concurred). Then there was the self-styled King of Shetland who contended that any edict of the Scottish Government did not apply to the islands.

Professor Leitch went on to outline his experience – and that of his colleagues – at a Scottish Government level. He detailed how they faced the pandemic according to the "four harms" that it caused: to public health, to the health and care system, to social wellbeing and to the economy. His role, and that of his colleagues, was to outline to ministers both the positive and negative effects of the different actions that could be taken to mitigate these harms. "And, all the time, you are dealing with

> "WE WERE FACING A VIRUS THAT HAD REACHED NORTHERN ITALY WHERE PEOPLE WERE LYING IN CORRIDORS BECAUSE THERE WERE NOT ENOUGH BEDS"

partial knowledge," he said. "I say all this, not for you to feel sorry for me, for Nicola Sturgeon, Boris Johnson or anyone else involved in making those choices – I do it to illustrate the complexity of what we were facing every single day, in those rooms at eight o'clock when we were making the choices, giving the advice and then having to go on TV to try and describe it to the population."

Responding to a question from Kim McAllister, the National Clinical Director reflected on whether – based on the knowledge they had at the time – their decisions might have been different: "This answer is no, not on the big choices, not with the knowledge we had at the time." The 'big choices', as he described them, were the transfer of elderly patients out of hospital into care homes and the closure of schools – both of which have become the subject of global debate. In fact, Professor Leitch said, he believed that the single toughest choice they made was to stop screening for cancer.

But, regarding the transfer of patients and the closure of schools he said that – knowing what we know now – those decisions were "worthy of investigation". He added: "In hindsight, I don't know if they were right or wrong. Regarding schools, the evidence would seem to point to children, unless immunocompromised, not being

Jason Leitch

as adversely affected by the disease as the rest of the population and that schools – as an environment – are pretty good at protecting against viruses.

"The issue with discharge to care homes is complex and I am sure the public inquiry will spend a good deal of time on this – but, you have to remember what we were facing at the time; a virus that had reached northern Italy where people were lying in corridors outside intensive care units because there were not enough beds.

"So, we knew we needed extra beds. We had around 1,500 people in hospital who were fit enough to be discharged – some to care homes. We tested as much as we could, but we didn't know at the time about asymptomatic spread. So, there wasn't one door leading to a good path and another leading to a bad; there were only two bad paths.

"We gave the advice that we thought was right at the time, which was to free up beds so that seriously ill people could be treated and their lives saved. I still think that decision was right and somebody else will have to judge whether we could have done it differently."

Professor Leitch was asked about the impact making these decisions had on him personally and he said that, at the time, "you had to compartmentalise it". It was, he said, what health workers must do every day. He recalled visiting the infectious diseases unit at Monklands Hospital where they had not had a death in three years; the week of his visit there had been 19.

Just recently, he added, he met an intensive care nurse: "She is one of those people born to be an intensive care nurse; she had seen everything. I asked her: 'How was COVID for you?' – because I hadn't seen her since – and she just cried, instantaneously. She told me how five of her patients had died in four hours.

"And, obviously, it is not just her who is affected; there are the other staff who looked after them, then there's the porters and the mortuary staff and the rest. So, dealing with that on a daily basis – while being buffeted by industry who are asking: 'Why do I have to shut?' – and trying to give the right advice to ministers, is the challenge."

Jason Leitch and Kim McAllister

The questions then turned to the dental profession and Professor Leitch said he thought it had responded "magnificently", citing the rapid establishment of the urgent dental care centres and dental professionals' involvement in the vaccination programme.

The suspension of everyday care had clearly created a treatment backlog which needs to be worked through, he said. He added: "I fear we also have an invisible backlog from a lack of preventative care; people we haven't seen and had check-ups. It's not unique to dentistry; it's true in a range

> "I FEAR WE ALSO HAVE AN INVISIBLE BACKLOG FROM A LACK OF PREVENTATIVE CARE; PEOPLE WE HAVEN'T SEEN AND HAD CHECK-UPS"

“REMEMBER THE COUNTRY WAS VACCINATED WITH THE HELP OF THE DENTAL PROFESSION”

of disciplines. It’s going to take a lot from the profession, from government and funders to get through that.”

Kim McAllister asked about the work that had begun before the pandemic to create a new model of care: “Philosophically, that has not stalled,” said Professor Leitch. “The trick is to find a formula, a funding mechanism, that will reward people doing it for a living and that doesn’t result in either over-treatment or under-treatment. If you pay ‘per widget’, the danger is that you get too many widgets. If you pay for just caring, you don’t get any widgets.”

Professor Leitch alluded to the formula which applies to general practitioners (GPs) where they receive a block of funding for caring for a geographically defined population, to keep them healthy, but are also paid for specific kinds of care; prescribing or cervical screening, for example. “I don’t think anyone, worldwide, has – unless somebody can tell me otherwise – found that magic formula for dentistry,” he said.

Taking questions from the audience, Professor Leitch was asked about one potential widget; a payment for oral cancer screening of NHS patients – who would not have to be registered with a practice to undergo the process – with the questioner adding: “I’m terrified of all the patients we have not seen and I think payment for occasional oral cancer screening would make a world of difference.”

The National Clinical Director responded: “Your fundamental point is correct; that in the present climate we can’t do all the treatments that a cohort requires so we should prioritise what is required – and that might be cancer screening. I’m just not sure your route to it is entirely correct; a system of payment could be open to abuse.”

Later, Professor Leitch heard from an audience member, a former dental nurse now working in palliative care who, last year, had not experienced anyone with oral cancer but “now, it’s only May and I’m on my ninth patient.” She described the pain they experienced and the challenge in maintaining their oral health at end of life.

Professor Leitch said he had experience of palliative care, from his time working as a consultant oral surgeon, and of the importance of the profession “making yourself prominent in those environments, available to end-of-life care teams, that you got to hospices – these are crucial parts of our healthcare system and dentistry, in its broadest sense, can provide these valuable services.”

Charlotte Waite, Director of the BDA in Scotland, asked Professor Leitch: “Looking to the future, what is the single most important lesson that has been learned which would be of most benefit to dental teams?”

He responded: "I hope it's the importance, at every level, of the dental profession to the health of the nation. Dentistry stepped up; we've talked about the urgent care centres but also, remember the country was vaccinated with the help of the dental profession.

"It's our job to make sure that [recognition] is maintained. That gives you currency at the BDA to have conversations in the key rooms where you can say the dental profession is not just widgets; it's cancer, it's the health of the nation in the bigger picture. I hope that's the biggest thing we have learned."

He added: "More of the profession should be in some of the key healthcare jobs, not just advocating for the profession but for the health of the nation with their knowledge of, and insight into, the links between oral health and general health."

Lynn Hood, the recently appointed chief executive of the Scottish Dental Care Group, asked how Scotland could position itself as the first-choice destination for dental professionals and how the barriers to them working here could be overcome.

Professor Leitch said that a previous workforce challenge had been met with financial resources to attract overseas workers which, today, are not available.

He said that if there were bureaucratic hurdles then, yes, those should be removed but he also cautioned about attempting to "poach" workers from other countries who could not afford to lose them.

Ms Hood said that one issue was health boards recruiting separately and that there should be a more joined-up approach, to which Professor Leitch said it would be useful for her to have a conversation with the Scottish Government's recently appointed Director of People.

Speakers

As well as the session with the National Clinical Director, delegates were able to attend lectures and workshops delivered by:

GDC Recommended and Highly Recommended

Mark Worrall, Head of Medical Physics, NHS Tayside

Aubrey Craig, Head of Dental Division, MDDUS

Christine Park, Honorary Consultant in Paediatric Dentistry, University of Glasgow

Jane Holt, Senior Teaching Fellow, and Suzanne Riordan, Teaching Fellow, University of Leeds

Emma Riley, Dental Nurse and Oral Health Educator

Mark Greenwood, Consultant Oral and Maxillofacial Surgeon, Royal Victoria Infirmary, Newcastle

Stacy O'Donoghue, Dental Tutor, QIiPT, NES

Mike Lewis, Professor of Oral Surgery, Cardiff University

Nick Beacher, Clinical Senior Lecturer/ Honorary Consultant in Special Care Dentistry, University of Glasgow

Stuart Clark, Consultant Oral and Maxillofacial Surgeon

Clinical Expertise

Paul Tipton, Clinical Lead, Tipton Training

Flora Couper, Patient Journey Designer

Jordan Gilmour, Sales Director and Co-Founder, OurCrown

Tariq Ali, Principal Dentist, Centre for Implant Dentistry

Lisa Currie, Clinical Director, The Orthodontic Clinic

Paula Mann, Aesthetic Training Academy

Caroline Henderson, Aesthetic Training Academy

Arshad Ali, Specialist in Restorative Dentistry, Scottish Centre of Excellence for Dentistry

Siobhan Hewson, Associate Dentist, The Dental Practice

Elaine Halley, Director, Cherrybank Dental Spa

Tariq Bashir, Scottish Dental Study Club

Rob Endicott, CEO and Founder, UKSedation

Arvind Sharma, Dental Surgeon, AS Endodontics

Lochana Nanayakkara, Consultant in Restorative Dentistry, Barts Health NHS Trust

Martina Hodgson, Principal Dentist, The Dental Studio

James Green, Maxillofacial and Dental Laboratory Manager for Great Ormond Street Hospital

Gurjit Pall, Legal Director, Thorntons LLP

India Beason, Dento Legal Advisor, Densura

Dental nurses, therapists and hygienists

Illona McLay, Dental Business Coach

Kayleigh Robinson, Treatment Co-ordinator

Lauren Long, Dental Therapist

Fiona Perry, Registered Dental Hygienist

Business and Finance

Frank Parsons, IFA Development Manager, Lloyd & Whyte

Anna Coff, Manager, EQ Accountants

Samantha Turkington, Senior Chartered Accountant, EQ Accountants

Noele McClelland, Partner and Head of Employment Team, Thorntons

Scott Lawson, Independent Financial Adviser, Martin Aitken and Co

Anne Smith, Partner, and Vanessa Pople, Partner, Azets

Trisha Munro, Strictly Confidental

Anthony Hodges, GA Business Finance

Carly Millan, Business Development Specialist, Chase de Vere

Stephen Pryce, Independent Financial Adviser, Chase de Vere

Regulation

John Cullinane, Executive Director FtP, GDC

Ross Scales, Head of Upstream Regulation, GDC

Wellbeing

Siobhan Kelleher, Dental Team Coach

Jeremy Cooper, Founder, Confidental

Save the date!

The Scottish Dental Show 2024: **Friday 31 May & Saturday 1 June** at Braehead Arena

REACHING A CONSENSUS

Periodontists and GPs should collaborate to treat their patients' overall health

WORDS
WILL PEAKIN

Close collaboration between GPs, periodontists and other oral health professionals is necessary for the effective prevention, early detection and management of widespread systemic health conditions affecting millions of people. That is one of the main conclusions of the new scientific paper titled: 'Association between periodontal diseases and cardiovascular diseases, diabetes and respiratory diseases: consensus report of the joint workshop by the EFP and the European arm of the World Organisation of Family Doctors (WONCA Europe)', which has been published[1] in the Journal of Clinical Periodontology.

This consensus report, authored by 18 global leading experts in periodontology and family medicine, updates and improves the scientific evidence that gum disease, in particular periodontitis or chronic inflammation of gums, is independently associated with cardiovascular diseases, diabetes mellitus, and respiratory diseases, such as chronic obstructive pulmonary disease, sleep apnoea, or COVID-19 complications.

The paper builds on the scientific reports from previous workshops organised by the EFP with the International Diabetes Federation on links between gum disease and diabetes in 2017, and with the World Heart Federation on associations between gum disease and cardiovascular disease (CVD) in 2019. "Both reports suggested that family doctors have a pivotal role in the implications of the associations between conditions, since they treat most patients with diabetes or CVD," said David Herrera, lead paper author and chair of the EFP's Workshop Committee.

"Our paper presents a critical update of the evidence supporting the associations between periodontitis and very important systemic conditions, but our main objective was to understand the interpretation of this information by the family doctors, and the derived implications, developed to improve the management of our patients' health," he added.

The document advocates for family doctors and oral healthcare professionals to work together in preventing, detecting and treating these major systemic health issues, in exchanging information and mutually referring their patients, and in promoting healthy lifestyles among them. There is consensus in considering gum health-related input as essential for family physicians to correctly manage their patients' overall health.

For example, it is recommended that periodontists and family doctors implement effective strategies for early detection of gum disease in primary healthcare centres, and of

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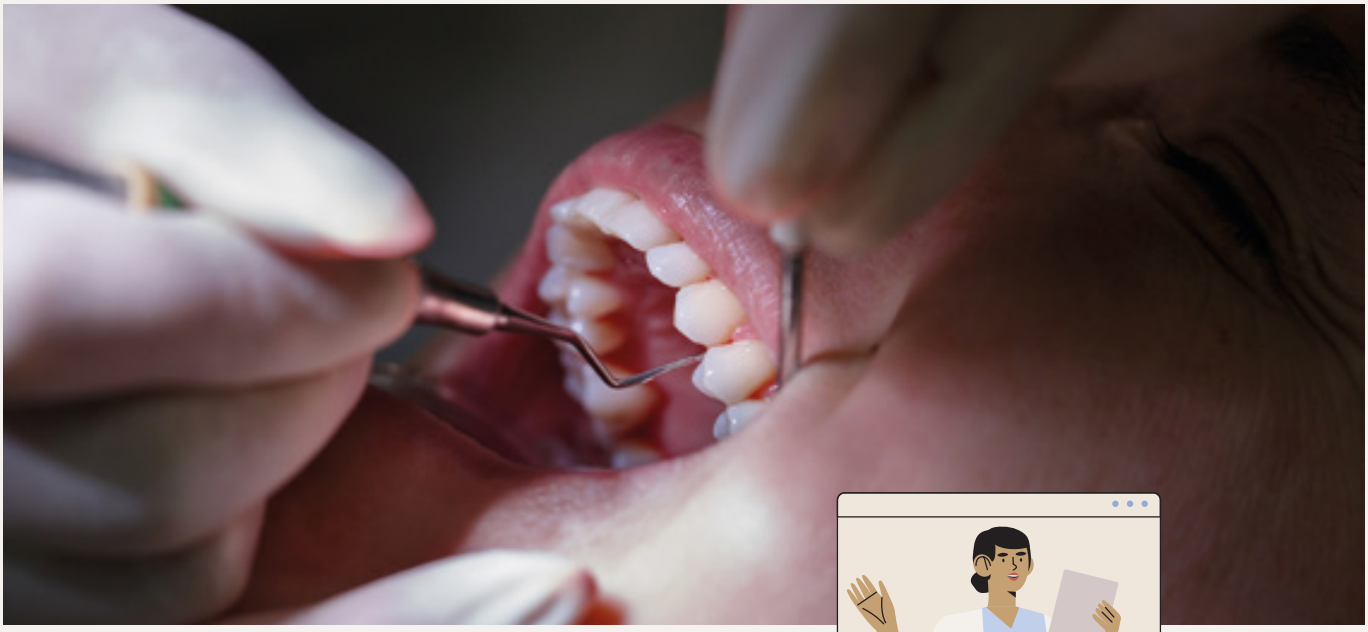

> **THE CURRENT SPLIT BETWEEN DENTAL HEALTH PROFESSIONALS ON ONE SIDE AND SYSTEMIC DISEASE PROFESSIONALS ON THE OTHER MAKES NO SENSE"**
>
> – SHLOMO VINKER

cardiovascular disease (CVD) and diabetes in dental practices. General practitioners are encouraged to seek information about the periodontal health of their patients, and oral health professionals about the cardiovascular and metabolic risk factors.

The consensus report is based on the outcomes of the Focused Workshop on Periodontology and Family Doctors, a joint scientific initiative by the EFP and the European branch of the World Organisation of Family Doctors (WONCA Europe) which was held in Madrid last summer with sponsorship from EFP partner Curasept. The workshop's aim was to draw up a set of recommendations for a new approach to the systemic impact of periodontitis on overall health conditions.

Currently, the EFP is preparing an outreach campaign based on the paper, targeting specific groups such as primary care and dental patients, policymakers, family physicians, dentists, periodontists and dental hygienists.

Higher risk of CVD and diabetes

"When treating patients with periodontitis, oral health professionals should inform them that their risk of CVD is higher," said Lior Shapira, past EFP president (2021-22), workshop co-chair and paper co-author.

"Also, they should collect a careful history of reported CV risk factors including diabetes, obesity, hypertension and smoking, and screen for other CV risk factors, such as as physical activity, excess weight, blood pressure and lipids or glucose management. If the patient presents obvious risk factors, they should be advised to consult with their family doctor and to adopt active lifestyle measures such as weight loss, smoking cessation and physical activity.

"In the case of patients with diabetes or prediabetes, family doctors are invited to inform them of a higher risk of suffering from a gum disease, so they need to go to their dentist and screen their gums' health. Besides, gum inflammation is a major risk factor to develop a metabolic disease such as diabetes.

"Importantly, at the dental practice we can screen periodontitis patients and identify those with diabetes or prediabetes who haven't been previously diagnosed, which may save their lives. All in all, the main conclusion is that we, dental professionals, need to be in touch with our patients' family physicians all the time," added Professor Shapira.

"The current split between dental health professionals on one side, and systemic disease professionals on the other makes no sense," commented Shlomo Vinker, president of WONCA Europe and paper co-author. "We should strive for greater integration and better sharing of information. More collaboration on screening, prevention, and referrals would clearly benefit our patients and the public health."

REFERENCES:

[1] https://doi.org/10.1111/jcpe.13807

About EFP

The European Federation of Periodontology (www.efp.org) is a non-profit organisation dedicated to promoting awareness of periodontal science and the importance of gum health. Its guiding vision is "periodontal health for a better life". Founded in 1991, the EFP is a federation of 37 national periodontal member societies that represents more than 16,000 periodontists, dentists, researchers, and oral-health professionals from Europe and around the world. It supports evidence-based science in periodontal and oral health and it promotes events and campaigns aimed at both professionals and the public. The EFP organises EuroPerio, the world's leading congress in periodontology and implant dentistry, as well as other important professional and expert events such as Perio Master Clinic and Perio Workshop. The annual Gum Health Day, held in May and organised by the EFP and its member societies, brings key messages on gum health to millions of people across the world.

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Andrew Hadden has been awarded the prestigious College Medal

Reserved for just one recipient per year, the CGDent College Medal is awarded for exceptional service to the dental profession and its patients in a manner aligned with the values and mission of the College of General Dentistry (CGDent).

Dr Andrew Hadden receives the award in recognition of his considerable contributions over many years, including through the College and the former Faculty of General Dental Practice UK (FGDP).

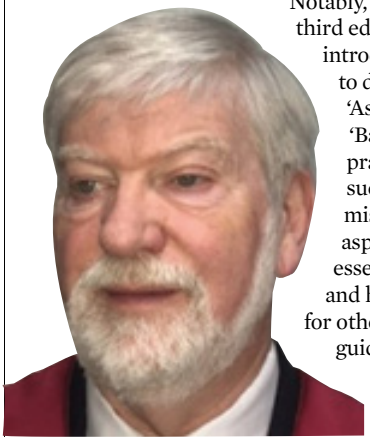
After graduating BDS from the University of Glasgow in 1974, Dr Hadden worked in the dental hospital service for several years before entering general practice. In 1984, he became a partner in practice and continued part-time as a hospital practitioner in oral surgery for more than 20 years. He remained a partner until 2007 and continued with part-time associate work until 2010.

In 1993, Dr Hadden became a part-time dental advisor with the Medical and Dental Defence Union of Scotland (MDDUS), becoming a full-time advisor in 2007, while retaining some sessional work in general practice. He holds an MPhil in Medical Law and Ethics and, on leaving the MDDUS in 2013, continued to be involved in the dento-legal field on a freelance basis, and to deliver undergraduate and postgraduate education in dental law and ethics.

Involved with the FGDP from its inception in 1992, he was one of the early holders of the coveted Membership in General Dental Surgery (MGDS) qualification, and subsequently the Fellowship (FFGDP(UK)). An active member in the Faculty's West of Scotland Division, he was secretary for 11 years and is currently assisting in the compilation of its history. He was an examiner for the faculty's membership examination (MFGDP) from 1995 to 2004, and an Assessor for its Career Pathway route to Fellowship, becoming Chair of the Fellowship Assessment Board in 2009. He then served as a member of the Fellowship Development Group which rationalised the five different routes previously available, and in 2013 was appointed Chief Assessor for the newly unified route.

In 2003, Dr Hadden was elected to the National FGDP Board, and over the next 11 years, was a member and/or chair of its Education, Examinations, External Affairs, Revalidation, Finance and Credit Transfer Committees, served twice as Vice Dean and was closely involved in its Dental Care Professional Development Group. In 2020, he was appointed to the Faculty Academy as a Senior Member, and he is now a Fellow of CGDent.

He is well known as editor of the second and third editions of *Clinical Examination & Record Keeping: Good Practice Guidelines*, which has received more than a million views online and of which 10,000 print copies have been sold. Originally developed under the auspices of the FGDP, and now published by the College, it has been praised for its relevance, clarity and structure, and has for many years been the primary reference on its subject for practitioners and regulators alike, both in the UK and elsewhere.



Notably, in the current third edition, Dr Hadden introduced terminology to differentiate between 'Aspirational' and 'Basic' standards of practice. This change succeeded in reducing misinterpretation of aspirational guidance as essential an requirement and has since been adopted for other FGDP/CGDent guidance and standards publications.

He was also a contributor to the Faculty's Key Skills in Primary Dental Care distance learning modules, and a reviewer for the second edition of *Standards in Dentistry* and most recently the College's *Mentoring in Implant Dentistry: Good Practice Guidelines publication*. He served on the National Examining Board for Dental Nurses (1988-1997), as President of the Glasgow Odontological Society (1993-94) and Council Member and President (2013-14) of the West of Scotland branch of the British Dental Association. He was also a member of the Dental Council and Education Board of the Royal College of Physicians and Surgeons of Glasgow, the General Dental Council's Technical Advisory Committee on Continuing Assurance and the CPD Expert Advisory Group of the UK Committee of Postgraduate Dental Deans and Directors.

Over the past 18 months, he has represented the College on a group which succeeded in persuading NHS England to reverse a recent change in its *Record Keeping Code of Practice* which had extended the retention period for dental records from eleven to fifteen years.

A Fellow of the Royal College of Physicians and Surgeons of Glasgow, he has also been awarded the Certificate in Mentoring and Certificate in Practice Appraisal of the Royal College of Surgeons of England. The College Medal was presented to Dr Hadden at the CGDent Fellows' Summer Reception earlier this month.

Abhi Pal, the President, said: "Andrew is an exceptional colleague who has made an extraordinary contribution to the College, former Faculty and the profession at large. His altruistic dedication of innumerable hours, decade on decade, has been of immeasurable benefit to dentistry and dental patients and is an example to us all. The College Medal is the greatest honour we can give, and it is my immense pleasure and privilege to be able to confer upon Andrew this most deserved recognition of his commitment and achievements."

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A first for Scotland

Nation set to have its own – increasingly data-rich – set of statistics for practice profitability

WORDS
WILL PEAKIN

This month saw the National Association of Specialist Dental Accountants and Lawyers (NASDAL) launch its inaugural Scottish benchmarking statistics.

As Johnny Minford, Principal of Minford Chartered Accountants and NASDAL's Media Officer, commented: "The NASDAL annual profit and loss benchmarking report is a unique and valuable tool which enables NASDAL accountant members to compare their practice-owning clients with industry norms. It means that we help our clients really understand what is happening in their dental business."

Now, and going forward, Scotland has its own – increasingly data-rich – version. The first set, unveiled during a special NASDAL Scotland event held at the offices of Johnston Carmichael in Edinburgh, covers the financial period 2021-22. It showed:

- An increase in net profit for NHS and mixed practices compared with 2020-21 (as noted at the event, this may have been expected as practices operated at reduced levels of activity during the previous year due to lockdown).
- An increase in average net profit per NHS principal from £120,666 to £134,594.
- An increase in average net profit per mixed practice principal from £160,343 to £178,802.
- Private practices experienced a big drop in average net profit per principal, from £237,442 to £207,575.
- Associate average remuneration sees profit up from £53,327 to £65,393.

Roy Hogg, a partner in Johnston Carmichael, commented: "The increase in profits for NHS and mixed practices was perhaps to be expected due to lockdown restrictions which had a greater impact during the previous year. It must also be noted, however, that Scottish Government support

> "SCOTTISH GOVERNMENT SUPPORT FOR NHS DENTISTRY HAS BEEN VERY GENEROUS ACROSS THE ENTIRE PANDEMIC PERIOD"
>
> ROY HOGG, A PARTNER IN JOHNSTON CARMICHAEL

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for NHS dentistry has been very generous across the entire pandemic period. It will be interesting to look at NHS and mixed practices going forward – NHS practices cannot readily pass on increased material and wage costs and this may worsen over the next year – for instance, these figures have not taken into account inflation of more than 10 per cent and the energy price increases that have occurred more recently.

"In the absence of external government financial support, private practices have been slower to return to pre-pandemic levels of profitability, but I expect that the 2023 figures will see them returning to normality. However, because of their typically higher fee income levels, they have continued to operate with noticeably lower wage costs as a percentage of turnover. The increase in Associates' income is welcome but, in reality, only reflects their greater levels of private activity when compared with the previous year as lockdown restrictions eased."

The annual Benchmarking Survey statistics are gathered from the accountant members of NASDAL across Scotland. The statistics provide average 'state-of-the-nation' figures so that NASDAL accountants can benchmark their clients' earnings and expenditure and help them run their practices more profitably. The basis of the survey figures is 2022 tax returns and accounts with year ends up to 5 April 2022.

NASDAL's designation of practices as either private or NHS reflects that 80 per cent of business income comes from that source.
The sample size is 110 practices and 98 associates.

NASDAL was set up in 1998. It is an association of accountants and lawyers who specialise in acting for and looking after the accounting, tax and legal affairs of dentists.
It is the pre-eminent centre of excellence for accounting, tax and legal matters concerning dentists. Its members are required to pass strict admission criteria, and it regulates the performance of its members to ensure high standards of technical knowledge and service.

Across the UK

Earlier this year, NASDAL published its statistics for the UK. These showed:

- Overall, an increase in net profit across the board. This was to be expected as practices were closed for two-to-three months of the previous year due to lockdown.
- An increase in average net profit per principal from £152,414 to £168,826 for a typical dental practice.
- A big increase in average net profit per principal in private practices: £143,418 to £178,513.
- An increase in average net profit per principal in mixed practices: £168,326 to £177,072.
- A small increase in average net profit per principal in NHS practices, from £145,498 to £150,894.
- Associate average remuneration was up for the first time in a number of years, from £63,304 to £75,488.

Ian Simpson, a partner in Humphrey and Co, commented: "The increase in profits was to be expected due to lockdown in the previous year. The increase was seen by all practices but NHS practices only saw a marginal increase compared with those experienced by mixed and private practices.

"In fact, there was a differential of more than £25,000 in both cases. NHS practices cannot pass on increased material and wage costs and this may worsen over the next year – for instance, these figures have not taken into account inflation of more than 10 per cent and the massive energy price increases that have occurred more recently.

"The increase in Associates' income is welcome but only reflects their earning of private income over a full twelve months rather than the nine or ten of the previous year. As we look forward to the 2023 figures, we might expect to see NHS practice profits fall back further and a possible slowdown in the growth in private practice profitability."

Heidi Marshall, Chair of NASDAL, added: "While there have been increases in the profitability of all practices, it is worth noting that NHS profits are still at a similar level to that of 15 years ago."

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NHS dental services are the subject of an inquiry by the Scottish Parliament's COVID-19 Recovery Committee

The last time detailed scrutiny was carried out on dentistry in the Scottish Parliament was in 2005, when the Health Committee commissioned research and held a short inquiry. The Scottish Parliament Information Centre (SPICe) has received a considerable number of enquiries about people finding it hard to access an NHS dentist. This article looks as some of the factors involved. There has also been a high volume of Parliamentary questions asked about access to NHS dentists and the challenges facing NHS dental services. The COVID-19 Recovery Committee is carrying out a short inquiry into NHS dental services in Scotland.

Why are dentists not like GPs?

All dentists, like doctors, have to be registered with the UK regulatory body – the General Dental Council – in order to practice in the UK, regardless of whether they are doing private work, solely NHS work or a mix of the two. Dentists have never been quite so embedded within the National Health Service as, say, GPs.

One of the key differences is that dentists can carry out both NHS and private dentistry from the same practice. GPs can set up a private practice but would have no contract with the health board. If a GP contracts their services to the local NHS board, they have to provide primary care services to the population in their local catchment area. This work would practically exclude any option of taking on private patients.

There is no contractual requirement for a dentist to provide a basic level of service, whereas there is for a GP. A dentist is directly reimbursed for the treatments they provide to their NHS patients. These treatments are limited, and detailed in the Statement of Dental Remuneration (SDR). For example, if a person is receiving NHS treatment only from their dentist, they couldn't have implants fitted or any cosmetic dentistry carried out. However, health boards do directly employ dentists to work as salaried dentists. Most of these will work within the Public Dental Service.

Legislation

Section 2C of the NHS (Scotland) Act 1978 places a duty on NHS boards to provide and secure provision of primary medical, or GP services for their populations. NHS Boards aren't, on the other hand, required to provide a full dental service to their populations, but are required to keep a list of dentists providing NHS services available in their area. The go-to regulations that apply to General Dental Services – high street dental practices – are the NHS (GDS) (Scotland) Regulations 2010. More information on general dental services can be found on NHS Scotland's public-facing website, NHS Inform.

Section 25 of the 1978 Act merely requires boards to 'make arrangements' with dental practitioners and to publish a list of dentists who undertake general dental services under those arrangements. However, health boards do provide emergency dental care through the Public Dental Service if someone is not registered with a high street dentist.

'High street' dentists

The vast majority of the population is registered with a high street dentist who will offer NHS and private services and often a combination of the two. Since 2010, once a patient registers with a dental practice, they are registered for life, unless of course they move and register with a new dentist. It used to be that if someone didn't make contact with the practice within 15 months, they would be removed from the list. Dentists get paid a continuing care and capitation fee on a monthly basis for the patients on their list. This fee reduces to 20 per cent if a patient isn't seen within three years, creating an incentive for dentists to remind patients to have a check-up.

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The Public Dental Service

Since 2014, there has also been a Public Dental Service (PDS), run by NHS boards. Dentists working for the PDS are salaried, employed by the NHS board and can provide general dental services, working in a similar way to high street dentists, but from NHS premises and only offering NHS services, no private ones. The PDS replaced the Community Dental Service in 2014.

The way the PDS operates across Scotland varies widely. It is far more prominent, and does register patients for routine care where there is a shortage of high street dentists. NHS Western Isles and NHS Borders are two boards where the PDS provides a wider service, whereas in most other health boards the PDS provides emergency care for people who are not registered with a dentist, as well as providing services to people with higher access needs. NHS Fife provides information about its Public Dental Service on its website, which explains the role of the PDS there.

Health boards have told the COVID-19 Recovery Committee that their PDS has been under pressure over recent months as people find it hard to register or access care from a high street dentist. Some are looking to recruit additional staff to the service.

Independent dental practitioners – high street dentists – will sometimes make themselves available to cover out of hours shifts with the public dental service for emergencies. High street dentists will have arrangements for covering out of hours care, and those offering NHS services must have them in place.

Dentistry in secondary care

The NHS Hospital Dental Service (HDS) accepts patients on referral from medical and dental practitioners. Consultants in other areas and specialties, including emergency dental services, also make referrals. Through the HDS, patients can be either treated in out-patient clinics or, if needed, admitted as in-patients or a day cases.

Inpatient and day case treatment is available at Glasgow Dental Hospital, Dundee Dental Hospital, Edinburgh Dental Institute and general hospitals.

There are no in-patient beds in the dental hospitals or the dental institute so all in-patient activity occurs in the general hospitals. Dentists working in the hospital dental service are salaried dentists, employed directly by health boards.

What about the finances?

Most people register with a high street dentist – a private contractor who may or may not offer NHS services. NHS patients pay 80 per cent of the cost of their treatment, but the cost is capped at £384 for a course of treatment. Some people, including children and those under 26, receive their treatment free.

The Scottish Government has pledged to make NHS treatment free for everyone before the end of this Parliament, which, based on receipts, would cost the government around £75 million a year. The budget for dentistry for 2023-4 is just over £476 million, which presumably covers the continuation of Childsmile, the preventative programme aimed at young children. The overall budget for NHS health services for 2023-4 is £12.1 billion.

How are dentists paid?

Dentists providing General Dental Services submit itemised claims monthly to Practitioner Services, part of NHS National Services Scotland, for the work they have carried out. Dentists can also receive a range of other payments, allowances and grants, including capitation payments for the continuity of care they give to their registered patients.

Issues facing dentistry

General dental services were hard hit by the pandemic. Many procedures produce AGPs and dentists were required to stop carrying out any of these procedures for a time. In addition, because a dental patient cannot wear a mask when undergoing treatment, dental surgeries had to have a 'fallow' period between each patient to allow for air changes. The length of time for these gaps depended on the quality of ventilation. Some surgeries would have no mechanical ventilation and only windows, whereas others might have sophisticated equipment allowing for faster throughput of patients.

In addition, a whole cohort of trainee dentists were unable to qualify because they could not fulfil the practical aspects of their training during the pandemic. Also, fewer dentists are coming from abroad to work in the UK. According to the NHS Scotland dental workforce report 2021, there were also reduced intake targets to BDS courses in 2021 and 2022, meaning that six years on, there will be fewer dentists entering the profession.

As in all settings, government advice was frequently updated over the two years and final restrictions, including mask wearing when not in the dentist's chair, were some of the last to be lifted from healthcare settings. Scottish Dental is the web portal for information about dentistry, and a COVID-19 hub provided all the official guidance and other information for dentists throughout the pandemic (www.scottishdental.org/category/covid-19).

Funding was provided through health boards for high street dentists to improve ventilation or to buy variable speed drills. However, there was a condition imposed that contractors applying for funding for ventilation had to continue to provide NHS dental services till 1 April 2024. Dentists were also compensated for the reduction in work they were able to carry out in the form of emergency support payments, sustainability payments and, later, from April 2022, a top-up payment regime whereby they were paid a multiplier of their regular fees for the work they carried out. Calculations were based on their activity and income levels prior to the pandemic.

The pandemic and the resultant complex payment and support arrangements for high street dentists has exposed long-standing calls from the profession for reform. Dentists argue that they cannot afford to continue to participate in NHS dentistry, because the sums paid for the work do not cover the costs and fees associated with carrying it out. The British Dental Association, the body that represents dentists working across the UK, presented the case for reform and improved remuneration to the Review Body on Doctors' and Dentists' Remuneration for 2023-24.

From the point of view of people needing to be seen by a dentist or wishing to register for NHS dental services, problems of access, waiting lists to register and to be seen, have been increasing over recent months. NHS Scotland workforce projections up to 2030 highlight the following:

- Based on the current number of registered patients per dentist, the forecast increase in the demand for dental services is forecast to increase the demand for dentists.
- Based on a series of estimates and assumptions, the supply of dentists is forecast to fall short of the number of dentists required to maintain current registration rates.
- There is considerable uncertainty over the inflows from other, typically non-UK, sources that have an immediate impact on the number of dentists in Scotland.

Participation and access

The availability of NHS dentists inevitably has an impact on access to dentistry. There has been anecdotal

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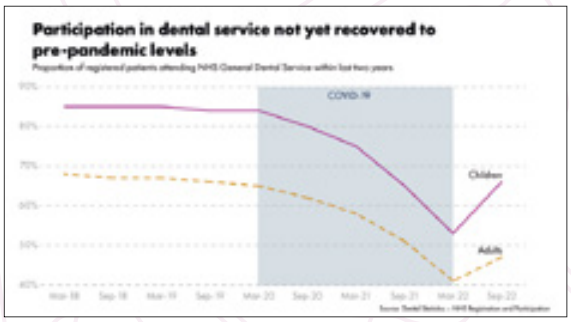
evidence of dentists ceasing to carry out NHS work, de-registering patients and switching to private only practice. The COVID-19 Recovery Committee surveyed all the geographical health boards and asked how many high street dentists had ceased to offer general dental services to patients. See *tinyurl.com/ytvksx5k* for the results.

Nearly all health boards cite that recruitment and retention of staff – both dentists and other dental professionals – impacted on the ability to deliver NHS dental services, both in the Public Dental Service (NHS salaried dentists) and in independent high street practices. Many are not working at their pre-COVID-19 activity levels.

The chart below shows the proportion of registered patients who attended their NHS dentist over a number of years. The area in grey covers the two years when COVID-19 restrictions were in place. The decline in activity is unsurprising because of the restrictions. Up to September 2022 (the most recent data) participation was recovering. However, given the information received from health boards about reductions in provision and recruitment and retention issues, it will be interesting to see whether participation levels continue to rise steeply or suffer as a consequence.

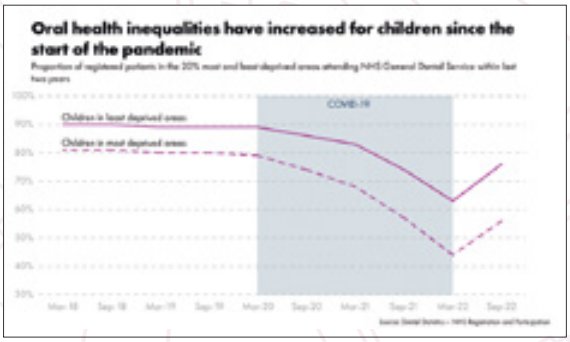


Participation by adults went from a high of 68 per cent in March 2018 to a low of 41 per cent in March 2022, recovering to 47 per cent by September. Participation by children was better, going from 53 per cent in March 2022 to 66 per cent in September 2022. Participation by children was 85 per cent in September 2018.

Inequalities

Access to health services is linked to inequality. Researchers based at the University of Glasgow sought to quantify the impact of COVID-19 pandemic on access and inequalities in primary care dental services in Scotland using data from 2019 to 2022. They found that while inequality was exacerbated during the pandemic, it existed before, with a higher proportion of adults and children from the less deprived areas having contact with a dentist than those in the most deprived.

The chart below shows only inequality in relation to children, where the inequality gap grew during the pandemic, and persists. Children's participation dropped more in the most deprived areas than in the least deprived. In March 2022, participation was 44 per cent in the most deprived and 63 per cent in the least deprived. The gap was nine per cent in March 2018, and rose to 19 per cent in 2022. By September 2022 it had widened further to 20 per cent.



The workforce

Recruitment and retention issues in dentistry are not unique to Scotland, and in January 2023 a scoping review was carried out because these had been highlighted as a concern, particularly in rural and coastal areas of England, and a contributory factor in recovery of dental services. A scoping review addresses wider questions than a systematic review and entails looking at a wide range of evidence, including websites, rather than conducting any empirical research.

The review came up with five factors affecting recruitment and retention: The contract – the way that dentists are remunerated for providing dental services; limited opportunity for career progression with NHS dentistry; increasing costs and indemnity undermining and reducing income; Brexit and the pandemic making it difficult for overseas applicants to register to work in the UK; and specific geographical challenges in rural areas including transport links, lack of training opportunities and lack of family/personal connections. The review also commented on anticipated challenges to the future workforce and some potential strategies. The reviewers concluded: "Within the literature the perilous state of NHS dentistry is widely acknowledged, although there appears to have been little progress in addressing the underlying issues. Further delays will undoubtedly impact on patient care, leading to a deterioration in oral health and unnecessary suffering for many. This will predominantly affect the most vulnerable in society, resulting in greater oral health inequality.

"Our review also found that the situation appears to be particularly acute within R[ural] and C[oastal] areas, but data needs to be collected and analysed to provide a better understanding. Well-informed, evidence-based decisions are essential in mapping out the future of dentistry in the UK, but this must not delay immediate action at a local, regional and national level."

For SPICe's appraisal of the drop in the number of registered dentists, its appraisal of the Scottish Government's overall response and for links to information quoted in this article please visit tinyurl.com/ytvksx5k

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DDS, PhD
Specialist in Periodontics and Prosthodontics

Dr Chris Millen
GDC No. 85443
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GDC No. 174657
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Specialist in Prosthodontics

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An exemplary model

There is a real opportunity to build a 'uniquely Scottish bridge over the troubled waters ahead'

WORDS
PETER MOSSEY

I was particularly interested in The Insider's article – *Troubled Waters Ahead* – in the last edition of *Scottish Dental*. The author made some extremely important points. The current situation with NHS dentistry is undoubtedly a threat; but as well as being a threat, and one that we must take very seriously, it is also a massive opportunity for change – and change will undoubtedly be required if NHS dentistry is to survive.

In 2019, a forum called Vision 2030 (V2030) was set up by the FDI World Dental Federation (FDI), and much of what I will say here comes from the consultations within the profession arising from that. The pandemic, of course, has had a serious impact but the FDI V2030 report was not published until 2021 when the effects on the profession were observed and only served to reinforce these concerns that significant changes are required. The Insider made some very good points about political will being a crucial factor and I particularly liked the comment that 'workforce planning and training must be the priority'. The situation we find ourselves in here in Scotland, with a changing administration, are ideal for feeding these ideas into the political arena. In fact, on the following page in the same edition, David McColl, Chair of the BDA's Scottish Dental Practice Committee, is quoted as saying: "NHS dentistry's survival requires rapid action, with meaningful reform and sustainable funding."

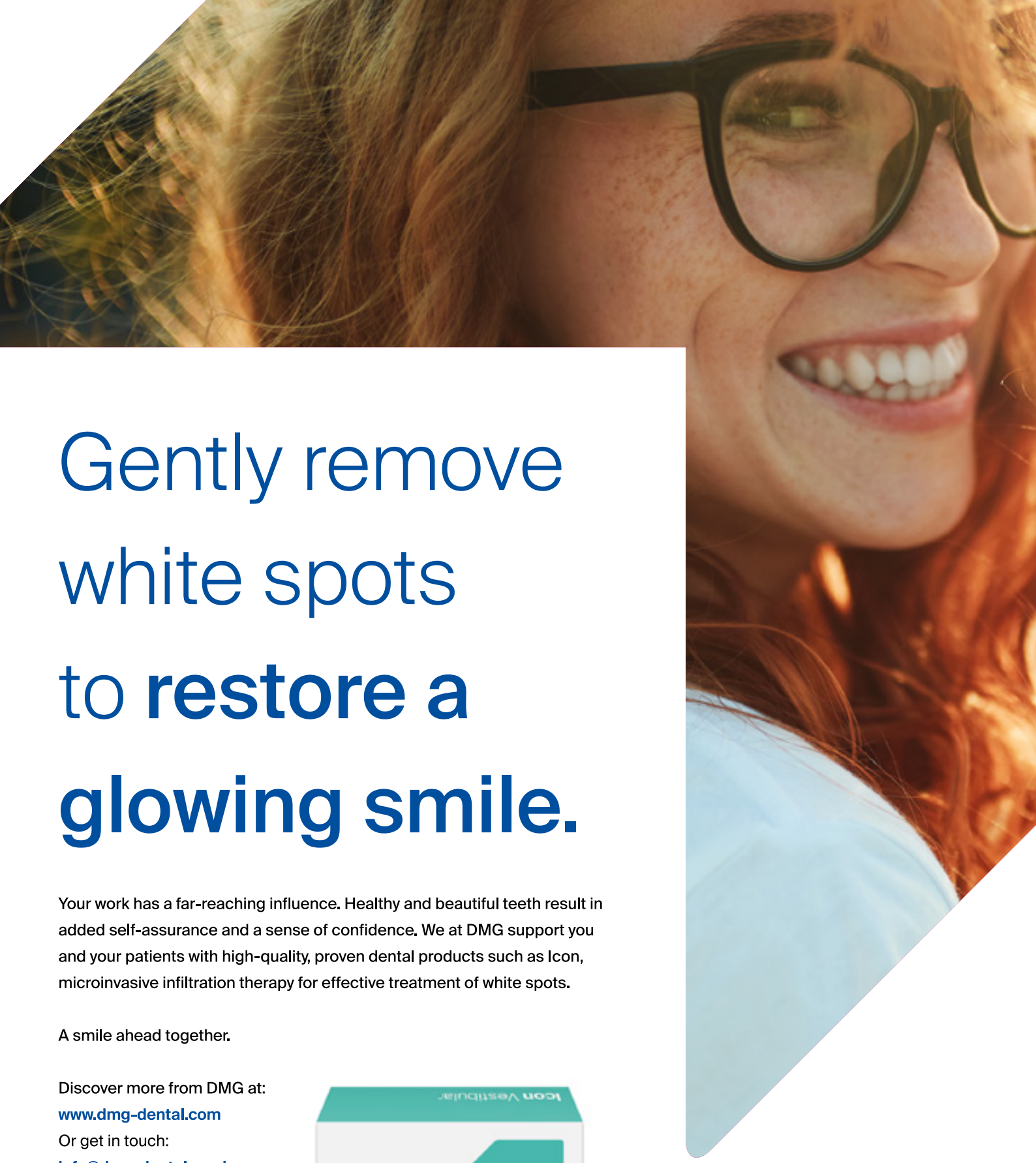
I was pleased to note the publication of the draft dental practice guidelines for Scotland (Determination 1) and I am keen to provide some feedback. Firstly, I understand that the remuneration structures are still under consideration, and this will be a crucial element of the ultimate uptake and implementation (and that was the main reason for sending the communication). Remuneration is key; even though the Determination 1 document does not provide the granular detail, the greater emphasis on primary prevention does shine through. Even though not every aspect of primary prevention and minimal invasiveness in clinical practice carries the same level of evidence base, there is no doubt that there is a massive room for improvement in the provision of preventive dentistry and less invasive procedures – and suitable remuneration is needed to influence behaviour and incentivise uptake.

World Health Assembly

I would be keen to feedback on one other aspect that I have taken from my experiences with the WHO's oral health work and I comment in the capacity of my involvement as a co-author of the V2030 document[1] released in January 2021. This was followed up at the World Health Assembly in May 2021 with the "landmark resolution", as the WHO's Director General Dr Tedros Adhanom Ghebreyesus described it, of oral diseases being added to the list of noncommunicable diseases (NCDs)[2]. This offers the oral health profession (including, but not confined to, primary care dentists) an unprecedented opportunity to integrate oral care with holistic care/general health and wellbeing; and oral health is now on the elevated platform of the NCD Alliance alongside cardiovascular diseases, diabetes/obesity, cancers and respiratory disorders.

Unique access

One of the unique aspects of dentistry is the access to healthy people and this in turn offers the potential for dentists to play a much more proactive role in general risk assessment and screening for a range of conditions, such as cardiovascular disease, type 2 diabetes and a whole range of diseases, disorders and health conditions that have oral manifestations. In addition, there are things that dentists are uniquely



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qualified to diagnose early such as oral cancers, but dentists could also play a role in the screening for other cancers and a range of other general health conditions. There is also evidence of reciprocation – it is noteworthy that in the United States, the American Medical Association has announced what is hailed to be a landmark gesture towards dental caries prevention – the approval of the application of silver diamine fluoride (SDF) by medical professionals to arrest cavities[3].

Undergraduate dental curricula

In the dental profession, in the modern era, Bachelor of Dental Surgery (BDS) curricula are placing more emphasis on the need for primary prevention and new graduates are being trained to appreciate the possibilities for prevention of oral diseases, and the role of oral health in overall health. The basic principle of the reduction in the inflammatory load in the oral cavity through healthy gingivae and periodontal health having beneficial effects on the cardiovascular and endocrine systems by reducing inflammation in general. There is unprecedented focus on evidence-based dentistry and dental graduates are motivated by their ability to offer real health benefits by their oral interventions.

The role of dental educators

It is well known that entry to undergraduate dental programmes has become highly competitive and as a result dental graduates need to be stimulated to achieve their potential and that self-directed learning prepares them for a more problem-solving approach to their professional practice. There is undoubtedly a greater emphasis on public health and the primary prevention agenda and the workforce of the future can be well prepared for a new future with new challenges. If we can motivate these graduate dentists and provide remunerative incentives aligned to prevention and holistic care, with greater integration with medicine, there is a good prospect of 'building back better' and restoring a functioning and productive NHS dental service in the UK – and the development of this in Scotland as a pilot for the rest of the UK, and potentially the rest of the world, would be possible.

Scotland's ChildSmile

This programme[4] is acknowledged worldwide as an example of an intervention in primary care, and it is highly encouraging to note that it is yielding such tremendous results in reducing the prevalence of dental caries. This Scottish Government-supported initiative has the amazing bonus of having been tried and tested in Scotland. It is regarded all over the world as a game changer in terms of primary prevention with the impact of supervised toothbrushing being greatest in areas of high socioeconomic deprivation. This reinforces the need for an emphasis on prevention and, provided this is supported by the Scottish Government, it will mean that dentists in primary care in Scotland can lead the rest of the world.

The question is could every dental practice in Scotland be empowered to offer evidence-based preventive treatments using the ChildSmile model of intervention at birth for ensuring optimal dental health? This would be regarded as a very progressive gesture – and the benefits of such a programme go well beyond oral health into general health and wellbeing and levelling-up in terms of the inequalities agenda. This is strongly supported by the NCD Alliance and the World Health Organization (WHO) department of Maternal, Newborn and Child Heath (MNCH).

Health Coaching

Evaluation of the role and impact of health educational initiatives over decades has revealed that health education alone remains ineffective, and the prevalence of dental diseases remains largely unaffected. A new tool is emerging, however, and the evidence for its efficacy is ever increasing – this is called health coaching or motivational interviewing, and a uniquely Scottish model is emerging with the Motivation, Action and Prompts (MAP) initiative implemented by Highland Health Board. The use of MAP in dealing with a range of NCDs is potentially a powerful and extremely cost-effective tool in actioning the common risk factor (CRF) approach whereby the risk factors for a range of NCDs can be simultaneously addressed. In dentistry, we already do some of this very well – the prime example being the smoking cessation programmes that are undertaken in primary and secondary dental care settings, but so much more could be achieved in terms of cardiovascular disease (CVD) and diabetes or obesity.

Integrated workforce

The other aspect of health and prevention that utilises the dental skillset in a really special way is vaccination programmes; dentists rose to the challenge of being vaccinators throughout the COVID pandemic and they were involved in the actioning of a preventative agenda in the interests of the overall health of the population. Other dental healthcare professionals such as nurses, therapists and technicians were also deployed to play roles in the health of the nation and were motivated and incentivised by their roles and teamwork.

Better connectivity

A final point relates to the need for closer working relationships between a range of stakeholders, firstly within dentistry – between NHS primary care and secondary care – universities and NHS Education Scotland (NES). But I also believe this would be an ideal opportunity to take a meaningful step towards integration with medicine and a range of other health professionals, with social care and all this in a way that utilises the skills of dental professionals fully. I am involved in these discussions at WHO, FDI and IADR levels, and I am always impressed around the world how much countries are aware of Scotland, through initiatives such as ChildSmile, SDCEP and their global guidelines during the pandemic, and the sensible approaches that we adopt. My offer would be – work with the Scottish Government and others to bring those issues pertaining to Scotland (and building back NHS dentistry) to bear on the ongoing discussions. Could Scotland provide one, perhaps exemplary, model for the delivery of dentistry – a model that others might adopt or adapt to their own circumstances? It could also be applicable to low resource settings – in the spirit of universal health coverage (UHC). This is already happening in Malawi with the Jeremy Bagg and Lorna Macpherson interventions. I am therefore suggesting that perhaps there is a real opportunity to build a uniquely Scottish bridge over the troubled waters that you may anticipate ahead. Please contact me if you would like further dialogue or discussion (p.a.mossey@dundee.ac.uk).

Peter Mossey is Professor of Craniofacial Development and Associate Dean for Internationalisation at the Dundee Dental Hospital & Research School.

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Trying to imitate rivals will get you nowhere

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MOST companies want to be the best at what they do. But in most businesses, there is no such thing as 'the best'. Trying to imitate rivals will get you nowhere. It's impossible to do exactly what your competitors are doing and end up with superior results. Customers, clients or consumers choose different products and services for different reasons, and it's unlikely you'll win them all. Instead, focus on creating superior value for the customers that choose your business. Doing this profitably may possibly mean accepting some limits and making trade-offs – you probably cannot meet every need of every customer. Don't set out to win a war. Instead, find your audience and capture their attention and loyalty.

Dan Akerson, one time CEO of General Motors (GM), said what he thought was expected when he launched a new GM car by throwing down the gauntlet: "May the best car win!" The phrase reflects an underlying belief about the nature of competition that feels correct so that it is almost never examined or questioned. But, if you want to win, this is absolutely the wrong way to think about competition. In fact, it's practically a guarantee of mediocre performance. The first problem with the competition to be the best mind-set is that, in most businesses, there is simply no such thing as 'the best'.

Think about all of the industries in the economy. In how many does the idea of 'being the best' make real sense? The best hotel for one customer is not the best for another. The best sales encounter for one customer is not the best for another. There is no best car. There is no best art museum. Yet, it's a pervasive idea. Management writers regularly reinforce it by using colourful metaphors from warfare and sports, lending emotion and drama to competition. They are misleading.

In war, there can be only one winner. Not so in business, where Waitrose, Lidl, garage forecourts and specialist shops can thrive and co-exist, each offering a different kind of value to its customers. In sports there is just one contest with one set of rules, but business is more complex and open-ended. Within an industry, there can be multiple contests, not just one, based on which needs are to be served.

Michael Porter, the Bishop William Lawrence University Professor at Harvard Business School, cautioned that when rivals pursue the 'one best way' to compete, they find themselves on a collision course; trapped in a destructive, zero-sum competition that no one can win. Porter urged a different kind of competition: compete to be unique. Focus on innovating to create superior value for your chosen customers, not on imitating and matching rivals. Give customers real choice and price becomes only one competitive variable. In dentistry, doing this profitably probably means making trade-offs and accepting limits. You can't meet every need of every customer. Nothing is more absurd – and yet more widespread – than the belief that somehow you can do exactly what everyone else is doing and yet end up with superior results. Grasp the true nature of business competition and you'll see that the performing arts provide a better analogy than war or sports. There can be many good singers or actors – each outstanding and successful in a distinctive way. Each finds and creates an audience. The more good performers there are, the more audiences grow and the arts flourish. This approach produces positive sum competition. Businesses that do a good job can earn sustainable returns because they create more value. At the same time, customers benefit by getting real choice in how their needs are met.

What's your organisation's underlying model of how competition works? It's a question well worth asking. How you think about competition will define the choices you make and your ability to assess those choices critically. Beware of making overblown claims. Are patients really impressed by you calling yourself a 'cosmetic' dentist? And if they are attracted by that, might you have to keep inflating your title to retain them when a dental 'marketing scientist' opens down the road? As Judy Garland said: "Be a first-rate version of yourself, not a second-rate version of someone else."

Influence of different restoring materials on stress distribution in prosthesis on implants: a review of finite element studies

Fabiano Resmer Vieira, Department of Dental Materials and Prosthodontics, School of Dentistry, São Paulo State University.[1]

Sandro Basso Bitencourt, Department of Dentistry, University Centre of Espírito Santo-UNESC, Colatina.[2]

Introduction

Dental implants have improved the quality of life of millions of patients in recent decades and have shown a high predictability of success. The high success rates and long-term follow-up (over 20 years) of patients treated with osseointegrated dental implants have attracted the interest of clinicians and researchers worldwide. Occlusal loading of osseointegrated implants is a determining factor in the longevity of treatments with implants. The selection of material used on the occlusal surface of implant-supported prostheses is also important, as these can transmit damaging forces to the interface between the alveolar bone and the implant.

Different prosthetic materials are suggested for the fabrication of implant-supported prostheses. The choice of this material is controversial although there is a consensus that implant survival is not affected by the prosthetic material. Skalak et al stated the theory that loading an implant made of a hard occlusal material, either porcelain or metal, can result in high intensity loading between the implant and the supporting bone. While a material with a low modulus of elasticity has stress-absorbing properties, it can prevent the surrounding bone from possible destruction linked to the magnitude of the load.

Three-dimensional finite element analyses (3D-FEA) are frequently used in dentistry to estimate the stress distribution that occurs in the implant system, peri-implant bone, and prosthetic components. 3D-FEA allows the simulation of a condition that would be impossible to achieve in a clinical study. Therefore, traditional finite elements have become a useful tool to study stress distribution in implant dentistry.

The purpose of this review of the literature on finite element studies is to investigate the influence of the prosthetic material on the stresses induced in bone tissue in implant-supported prostheses.

Methods

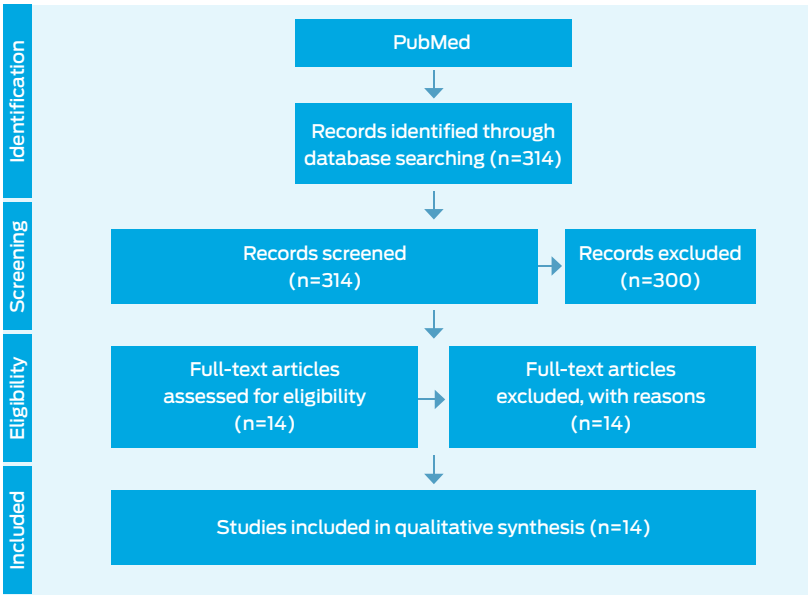
The search for articles of this review of the literature was performed in the PubMed/Medline database for articles published up to November 2021. The search strategy used was (finite element analysis) and ('occlusal device' or 'occlusal surface' or 'occlusal materials' or 'veneering materials') and ('implants' or 'dental implants'). The inclusion criteria were studies using the 3D-FEA methodology that evaluated the stress distribution in bone tissue, among different prosthetic/restorative materials, published only in English. The exclusion criteria were studies that did not follow the 3D-FEA methodology. The selected articles were independently evaluated by two different reviewers. The information collected was author and year of publication, dimensions of implants used, the material used in the prosthetic crown, simulated force and direction, and conclusion and effect.

Articles of the in vitro study were selected following evidence-based laboratory medicine. These principles are (1) asking the question, (2) searching for evidence, (3) appraising the evidence, (4) applying the evidence, and (5) assessing the experience.

Results

During the search process, 314 references were found, of which 14 were selected after reading the title and abstract, to be analysed for their full text. After this step, all 14 articles were included for data collection. The search strategy is detailed in in the illustration below.

The selected studies were dated from 1996



to 2021. The simulated implants were of varying diameters, ranging from 3.8 mm to 5 mm. The length of the implants also varied, with the shortest length being 7 mm and the longest being 13 mm. Regarding the prosthetic materials, a variety of metal-ceramic prostheses can be seen, varying the material of the infrastructure and the veneering ceramic, in addition, prostheses in lithium disilicate and zirconia, acrylic resin, and composite resin. The simulated forces ranged from 30 to 1000 N, using either axial or oblique loads.

Twelve studies found no differences in force dissipation in bone tissue between different prosthetic materials. Only two studies found a positive relationship between the restorative material and bone tissue tension.

Discussion

Biomechanical considerations are recognised as being one of the most important factors for the long-term success of osseointegrated implants. Among the methods for evaluating implant biomechanics, 3D-FEA has been widely used for the quantitative assessment of bone stresses. This analysis identifies stresses and their dissipation at the prosthesis-implant-bone interface, which can be difficult to assess by other biomechanical methods.

After the review of included studies, it was found that most of the articles indicate that the prosthetic material does not influence the generation of tension and dissipation in the bone and peri-implant tissue. This can be justified due to the use of different prosthetic materials having less influence on the stresses in the supporting bone with one per cent of the variance. According to Sotto-Maior et al, the dissipation of forces was not influenced by the prosthetic material although the occlusal force is the factor that has the highest weight about the stresses generated in the implants, abutment being the second. Despite not affecting bone tissue, occlusal materials show differences in stress distributions in the crown structure and abutment.

Sevimay et al evaluated prosthetic crowns made with IPS Empress 2, In-Ceram, PFM with a chromium-cobalt framework, PFM with a gold-silver-palladium framework, and states that the different prosthetic materials did not influence the distribution of forces in bone and peri-implant bone tissue. However, when evaluating the ceramic, IPS Empress 2 showed the highest stress concentration. When the stress distribution in the framework was evaluated, the stress values were different for each model. In-Ceram porcelain (173 MPa) and PFM crown with a cobalt-chromium framework (149 MPa) induced higher von Mises stress values than PFM crown with a gold-silver-palladium framework (108 MPa) and IPS Empress 2 (119 MPa). The reason for these differences may be related to the elastic modulus of the materials. In-Ceram and PFM crown with chromium-cobalt framework have a higher modulus of elasticity compared with IPS Empress 2 and PFM crown with a gold-silver-palladium framework.

Sannino et al analysed the stresses of the prosthesis-implant system and showed that the choice of material was crucial for the distribution of stresses in different components. It was noted that due to the large difference in the hardness between the materials of the system, the main stress gradient in the cement layer increased in the situation of zirconia abutment with micro-hybrid composite core and titanium abutment with a micro-hybrid composite core. For the situation of zirconia on abutment and core, and titanium abutment and zirconia core, the stress distribution in the cement layer was more homogeneous. Higher failure risks for the cement layer placed between the core and the abutments were found when a micro-hybrid composite core was used.

Gungor and Yilmaz reported that higher stress levels were observed in the models with zirconia (93.6 MPa) compared with models with lithium disilicate (76.3 MPa). One justification for this is that stresses in the framework materials increased with the decrease in the modulus of elasticity of the layering material. Higher differences between the modulus of elasticity of the framework and the veneer material transmit greater concentrations of stress in the framework. Yegin and Atala also agree that higher differences between the modulus of elasticity of the infrastructure and the veneer ceramics lead to a higher concentration of stress in the framework. Thus, the monolithic crowns showed a decrease in stress concentration, as the stresses were more concentrated on the ceramic surface due to the elastic modulus being the same throughout the prosthesis, which reduced the load transmission to the implant and the bone, consequently.

The study by Mourya et al reveals that the use of a material with a lower modulus of elasticity in the crown, such as PEEK crowns with a composite resin layer, implies greater stress on the abutment than a metal-ceramic crown. The PEEK group in the axial loading presents 514 MPa in the abutment, While the metal-fused porcelain crown has a tension of 123Mpa. In the oblique loading, which is the most harmful to the implants, these values increase to 1347 MPa (PEEK) and 400 MPa (PFM). Due to this, the use of prosthetic materials with a low modulus of elasticity may be associated with failures in the abutment region, with the retaining screw being the most subject to failure. Alves Gomes et al[3] observed that porcelain crowns absorbed less stress than composite resin crowns. The use of porcelain as a veneer material reduced the stress that was transmitted to the retaining screw. Composite resin has a low modulus of elasticity and is more deformable than porcelain. Thus, resin exhibits greater displacement and transfers stress directly to the retaining screw, different from the porcelain. Low abrasion resistance is a disadvantage of the composite resin. If the occlusal scheme and morphology cannot be maintained over time, undesirable lateral forces may increase.

When evaluating complete dentures fixed to implants, studies agreed that different occlusal materials did not influence the tension transmitted to the bone tissue. However, Ferreira et al shows that although the resin teeth had lower values of von Mises stress, the groups with porcelain teeth significantly decreased the stresses on the metallic frameworks.

Although different occlusal materials do not influence the tension transmitted to the bone and peri-implant tissue, there is a tendency where materials with low elastic modulus transmit greater tensions to the infrastructure materials both in single prostheses and in protocol-type prostheses. In contrast to the 12 studies that did not show a positive relationship between the prosthetic material and the increase in stress in the bone tissue, two articles found a positive result, which can be explained by the different designs of the 3D-FEA studies, where the change in the implant geometry and bone density between studies may explain the discrepancies between the results. Finite element studies allow an approximation of the behaviour of the material to the real situation.

Therefore, further investigations related to dynamic applications of forces and long-term clinical studies are needed to assist the dentist in choosing the appropriate prosthetic material in implant-supported restorations.

Conclusion

Evaluating the stress distribution by 3D-FEA, the prosthetic materials used on the occlusal surface did not interfere with the distribution of stresses to the bone and peri-implant tissue, both in single prostheses and protocol-type prostheses.

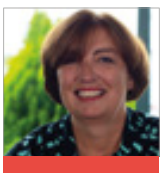
FOR FULL REFERENCES AND AUTHORS VISIT:

www.sdmag.co.uk/2023/05/31/clinical-june/

Selling the practice?

One of the key issues for practice owners planning to retire or sell a business, centres on how best they plan their tax liability, specifically Capital Gains Tax (CGT) and Inheritance Tax (IHT), writes Jayne Clifford

WORDS
JAYNE CLIFFORD



Jayne Clifford,
Martin Aitken
0141 272 0000
jfc@maco.co.uk
www.maco.co.uk

In our experience it is never too early to consider financial planning and while 'younger' principals may not place this at the top of the agenda right now, the reality is that planning at an early stage can be structured to help with current tax liabilities as well as those on retirement or sale.

Don't hand the tax man a blank cheque

Both CGT and IHT need to be considered carefully as part of the planning exercise and examined in close detail – without appropriate planning for these two very real scenarios practice owners might find themselves or their 'estate' handing a blank cheque to the tax man.

CGT is payable when you sell an asset, for example, premises or a dental business, and there has been an increase in the value of the asset. Currently, CGT rates on most gains are 10 per cent for basic rate taxpayers and 20 per cent for higher rate taxpayers.

Furthermore, where you sell a business asset – such as a dental practice – Business Asset Disposal Relief can reduce the tax rate to 10 per cent on the total gain.

However, there are exceptions: for example, gains from the sale of a residential property that does not qualify for principal private residence relief continue to be taxed at 18 or 28 per cent.

CGT liabilities can be reduced by utilising the tax allowances to which you are entitled and by careful planning of your CGT position throughout your life. If you leave it too late to consider your CGT liabilities, especially if you are planning to sell investments made many years ago, it can be quite a shock to realise how large the CGT liability can be.

You can also offset capital gains on successful investments with losses from investments that haven't worked out so well. Losses can also

be carried forward to offset gains in future tax years and equally important is the use of your Annual Exempt Amount (AEA). See our Tax Rate Card on maco.co.uk for the current rates and allowances.

A will is a very effective tax planning tool

Moreover, a priority for any practice owner should be the setting up of a will as the first step in any estate-planning exercise, not only to make certain that matters are dealt with in a tax-efficient way, but to ensure that your exact wishes are carried out.

Having a will means you avoid relying on the intestacy rules that come into play where there is no will. Effectively the law decides what happens to the estate – remember the point above about writing a blank cheque to the tax man! This can lead to financial anxiety for the surviving spouse/family along with a possible immediate charge to IHT.

Consider setting up a trust

If you don't want to give directly, you could consider a trust. With a little planning, you can transfer the asset(s) into a trust with minimal CGT or IHT consequences and it can also reduce your taxable estate.

There are, however, some additional tax charges and costs related to trusts that may be applicable. If you are interested in setting up a trust, you should have a conversation with your accountant/lawyer first to ensure that setting up a trust will meet your requirements.

Know your allowances and reliefs

Everyone has an inheritance tax (IHT) Nil Rate Band of £325,000 and this will remain frozen until 2028. In addition to the main nil-rate band, the Residence Nil Rate (RNRB) came into force in April 2017. The maximum RNRB allowance is £175,000, which effectively raises the IHT free allowance to £500,000 per person. Where married couples jointly own a family home and wish to leave this to their children, the total IHT exemption is now £1m.

Business Property Relief can, with careful planning, remove the full value of a dental business – sole trader, partnership, or shares in private company – from being subject to an IHT charge, either via lifetime gifts or on death.

You can also gift as many assets as you wish during your lifetime, in what is referred to as a 'potentially exempt transfer'. Should you survive for seven years from the gift, the assets will be completely outside your estate.

Acts of benevolence have a double impact

Gifting income producing assets to your children, such as shares in the family business or an investment property, may also be a good way of reducing the overall family income tax bill whilst at the same time conducting succession planning. Do take care to ensure there are no income tax consequences or CGT/IHT liabilities that crystallise on the gift/transfer.

Remember, always to seek professional advice.

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DENTAL IMPLANTS & SEDATION
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DR. KEVIN LEEMING
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To create a more natural energy flow the front door was repositioned in accordance with a Feng Shui Master's recommendations, meaning a new frontage had to be custom built.

STRIVING FOR EXCELLENCE

AS Endodontics provides a leading service for valued referring dentists as well as effective and timely treatment and care for patients

AS Endodontics was established in 2016 by Dr Arvind Sharma. As a general dentist, Arvind saw a significant need for more services offering endodontic treatment in Edinburgh and the surrounding area. Existing services were limited and waiting times for patients were long. This led him, in 2016, to complete his masters in endodontology at the University of Central Lancashire – with a view to limiting his practice to endodontics.

Since then, he has done exactly that and has now established a purpose-built clinic with multiple practitioners offering endodontic treatment five days a week.

Arvind draws on evidence-based approaches, combined with modern techniques, to ensure his patients receive outstanding care.

"At AS Endodontics, we strive for excellence and aim to provide the leading endodontic service for our valued referring dentists and the most effective and timely treatment and care for patients," said Arvind.

"Our commitment to help reduce waiting times ensures patients are not experiencing discomfort or pain longer than necessary and assists our referring dentists in providing the best care.

"Patients and referring dental practitioners know we are reliable; we have integrity, and they can trust AS Endodontics."

> "AS ENDODONTICS WE ENSURE THAT WE COMMUNICATE WITH OUR REFERRING DENTISTS, WE DELIVER EXCEPTIONAL CARE AND TREATMENT TO PATIENTS AS SOON AS POSSIBLE IN A CALM AND CARING ENVIRONMENT"

Arvind's wife, Joty, holds a BBA – from Simon Fraser University in Canada, and has a background in marketing, public relations and event management.

While taking a career break to raise their family, she pursued her interest in property and developed a small property portfolio which she manages. Joty also works part-time for a leading Edinburgh estate agency.

"It was my broad interests and knowledge in marketing, customer service and property development that motivated me to help Arvind take AS Endodontics to the next level. Being on-site during the building works was exciting and stressful at the same time.

"However, seeing the builders and communicating with them almost every day ensured that everything went to plan.

"More importantly, it allowed Arvind to focus on what he does best and that is dentistry!

"By each of us focusing on our own strengths and bringing them together, it allowed us to create a practice that not only provides a seamless service to referring dentists but also ensures the patient journey is smooth.

"Customer service in any industry is key, therefore at AS Endodontics we ensure that

Staff have a large kitchen with dining area, their own changing area and spacious lockers

we communicate with our referring dentists, we deliver exceptional care and treatment to patients as soon as possible in a calm and caring environment.

"We then provide a report to the referring dentist and discharge the patient back to their care. The referral and patient journey are at the centre of everything we do."

AS Endodontics is situated at 109 Comiston Road in Morningside, a building which was previously home to Henderson Wines.

"When the property became available, we were very excited because the location is fantastic, the building is a great size and, most importantly, we felt a connection to the property because it is near our home and is so well-known in this area," said Joty.

Planning permission took time to obtain because of the pandemic and the specification provided to the project architect and builder was demanding.

Not least because of Arvind and Joty's insistence that the property be stripped back to its shell (which inevitably revealed construction challenges) and that the layout follow the recommendations of a Feng Shui Master to create a more natural energy flow.

"NVDC Architects had one of the most challenging roles because they had to work within the confines of the feng shui suggestions – each room of the practice was allocated to a specific location according to how the energy benefited each space," said Arvind.

"With patience and perseverance, Farahbod [Nakhaei, the studio principal] and his team took a very old building and succeeded in designing the optimal space. They helped bring my vision to light and created an amazing environment that enhanced energy flow and designed ideal spaces for patients to feel relaxed and employees to feel rejuvenated.

"They were always on hand throughout the project to guide us and answer any questions we, or our builder, had."

The building was completely renovated, with new electrics and plumbing as well. The front door was moved to create a more natural flow entering the building which, in turn, required a new 'shop front' to be custom built. Creating Arvind's surgery required walls to be moved and new structural work to be undertaken.

"Our contractor, Eastern Property Management had previous experience in building dental practices," said Arvind.

"They understood our requirements and managed the whole build from beginning

Both surgeries are equipped with state-of-the-art Zeiss dental microscopes

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"Working with NVDC Architects was the best decision I made. Farahbod and his team took a very old building and succeeded in designing the optimal space that worked with our requirements. They brought my vision to light creating an amazing environment which enhanced energy flow. They were always on hand throughout the project to guide us and answer any questions."
Dr Arvind Sharma, AS Endodontics, Edinburgh

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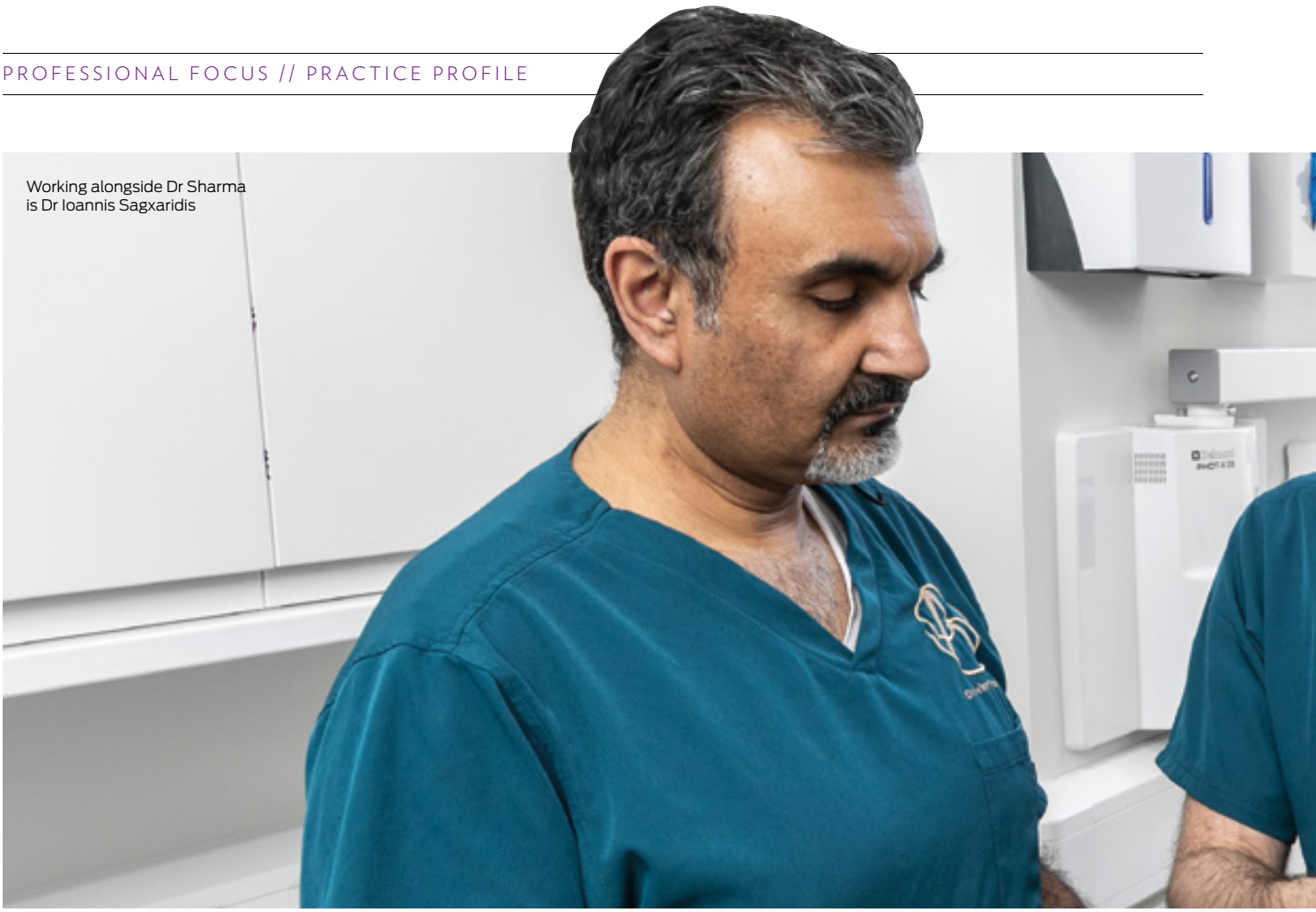


Working alongside Dr Sharma is Dr Ioannis Sagxaridis

to end. They also used reputable subcontractors and suppliers when required. Eastern's workmanship and attention to detail was phenomenal!

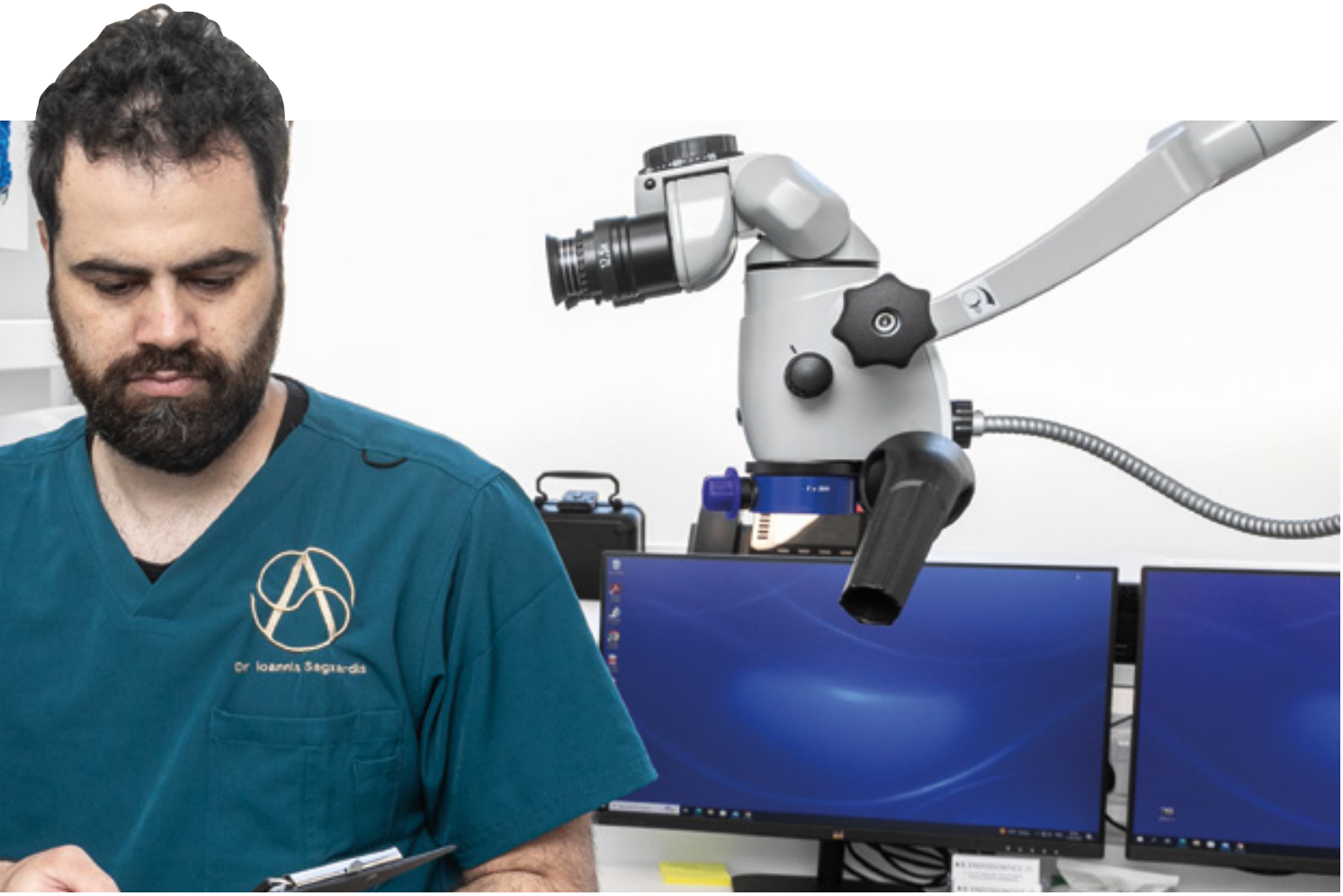
"Nothing was too big or too small a job, they always wanted to satisfy the client. They were also great at putting forward ideas and opinions that they thought would enhance the project.

"They worked closely with Joty to ensure they were achieving not only the build requirements, but the overall look and feel of the practice as well. We felt they took pride in their work and were very keen to deliver an amazing space."

Finance was arranged by Performance Finance. "They believed in the business and the business plan and their customer service was outstanding," said Arvind.

Logic IT Solutions provided all the software and hardware, including televisions. "They were very efficient, organised and competitively priced. Their team communicated well and worked closely with the builder in ensuring their wiring was completed at key stages.

"HAVING MULTIPLE PRACTITIONERS OFFERING ENDODONTIC TREATMENT ENSURES THAT WE CAN PROVIDE REFERRING DENTISTS A QUICKER AND MORE EFFICIENT SERVICE"



"On completion of the building work, they installed their equipment and provided the relevant training. Their online support has also been helpful, especially the first few days into opening.

"We have a long-standing relationship with Wrights and trusted their ability to supply everything from the equipment, chairs, to the LDU.

"Their team was very reliable and worked closely with the builder in providing the surgery drawings, to making site visits when necessary.

At AS Endodontics, Arvind is joined by Dr Ioannis Sagxaridis and, come September, by Dr Nabeel Abdur Rashid.

"Having multiple practitioners offering endodontic treatment ensures that we can provide referring dentists a quicker and more efficient service which not only helps them in their patients' journey," he said.

"But it also helps patients be seen in a timelier manner, therefore reducing any pain or discomfort they may be experiencing Ultimately, our goal is to help a patient save their tooth."

Both surgeries are spacious and bright, with natural light and allowing ease of movement. Each is equipped with state-of-the-art Zeiss dental microscopes which enables the team to treat all aspects of complex endodontic referrals, including root canal re-treatments.

There are two sinks in each, for the dentist and the nurse, and air conditioning is available if required.

From September, the team will be expanding their services to include surgical endodontics.

Provision has been made for the installation of 3D imaging with CBCT which will assist in endodontic diagnosis and treatment planning. The reception area is tranquil, with a calming colour scheme, indoor plants, air conditioning and a lot of natural light.

Staff have their own changing area, WC, spacious lockers and a large kitchen with dining area which, again, benefits from natural light. A rear exit allows staff to easily step out for fresh air.

> "JOTY'S AN INCREDIBLE LADY AND I'M BLESSED TO HAVE HER BY MY SIDE"
>
> – ARVIND SHARMA


Arvind and Joty

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"Listening to employees is important," said Arvind, "as well as providing them with an environment that respects their opinions and recommendations.

"It's also easier for employees to be heard in a smaller dental practice and it's easier for the principal to provide and order what is required quickly.

Arvind added: "This project could not have been possible without the constant support of my wife, daughters and parents. Joty is the real reason this has all happened.

"She was the project manager and liaised, almost daily, with the builder and companies and pretty much all aspects of this project. She's an incredible lady and I'm blessed to have her by my side."

> "PATIENTS AND REFERRING DENTAL PRACTITIONERS KNOW WE ARE RELIABLE; WE HAVE INTEGRITY, AND THEY CAN TRUST AS ENDODONTICS"

THE TEAM

Alongside Arvind is Dr Ioannis Sagxaridis, Dental Surgeon. Ioannis is an experienced and passionate dentist who provides the highest quality treatment for his patients.

He completed his degree in dentistry at Thessaloniki, Greece, in 2008. After moving to Scotland in 2010 he gained extensive experience in general dentistry in Glasgow, Falkirk, and Ayrshire.

In 2015 Ioannis undertook postgraduate training and was awarded a Diploma in Endodontics, with Merit, by the University of Central Lancashire.

From September, they will be joined by Dr Nabeel Abdur Rashid. a member of the Royal College of Surgeons of Edinburgh, where he received his Speciality Diploma - Membership in Endodontics in 2020.

Nabeel holds an MSc in Endodontics from the University of Warwick and an MSc in Prosthodontics from the University of Edinburgh.

During his time in the University of Edinburgh, Nabeel was trained in both Endodontic and Prosthodontic specialties for three years by leading specialists in Scotland. Prior to his career in Scotland, Nabeel completed his BDS from Manipal, India in 2009.


Louise Rae

They are supported by a team who bring a wealth of experience working in the healthcare sector. Each member is passionate about the work they do and creates a friendly, caring and supportive environment.

Particularly Louise Rae, who spent several years as a manager in the optical industry before moving into dentalcare where she found her calling.

Organised, efficient and caring, Louise provides a supportive and warm environment for all patients and ensures their experience is seamless from beginning to end.

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"We are delighted to have been involved with the AS Endodontics project and wish the team every success in the future".

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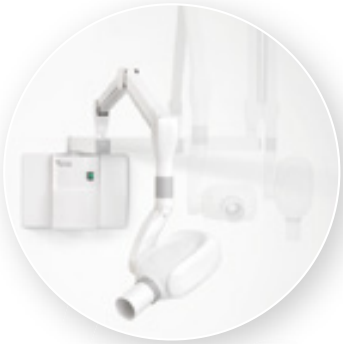

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Removing risk

From the patient referral process

WORDS
JOHN MAKIN

It is important that colleagues and organisations accepting referrals pro-actively provide information to their referring practices. To do so helps to manage patient expectations, avoid inappropriate referrals and reduce the risk of patients being frustrated at having waited for an appointment only to find that they cannot be seen and treated.

Practice protocols

The GDC requires that colleagues communicate and work effectively as a team in patients' best interests. Practices should have protocols in place so that all team members understand their roles and responsibilities within the referral process. This can help ensure it runs efficiently and, as far as is possible, reduces the risk of a delayed referral, with its potentially serious attendant consequences.

Protocols between practices and other organisations should be clear. For example, when referrals are made for imaging, we would suggest it is the responsibility of both the referring clinician and the professional accepting the referral to be clear on whether the patient is being referred for the radiographic exposure alone, with the images to be reported by the referrer, or both the radiographic exposure and a report on the images.

The specialist societies often provide helpful guides for referring clinicians, such as that provided by the British Orthodontic Society[1].

Fees and charges

The GDC generally takes a dim view of any referral fees changing hands, with the Standards stating that:

- patients' interests must always come before any financial, personal or other gain
- you must not accept gifts, payment or hospitality if they could affect your professional judgment, or appear to do so
- referrals must be made in the patients' best interests and not for anyone else's financial gain or benefit.

To help avoid patient complaints, those working in the NHS need to understand and carefully apply the current rules and regulations governing referrals.

In summary, as patients' expectations and the ever-increasing range of treatments available continue to grow it is likely that practices will see an increase in the need for both internal and external referrals. Careful attention to detail in terms of communication between clinician and patient, colleague to colleague, record-keeping and adherence to up-to-date protocols will all contribute to risk management of the process.

Making and receiving patient referrals are part and parcel of everyday practice. However, the process can and does give rise to patient complaints and claims. Following a few key principles can help reduce the risk of problems occurring.

Patients seem to readily accept that their GP will, on occasion, need to refer them on to a colleague for a consultation or treatment, either within the practice or to secondary care. Dental patients, in contrast, often appear to have an expectation that their GDP can and should deliver all of their care, and may be surprised or even suspicious of the suggestion of such a referral.

> "THE GDC REQUIRES THAT COLLEAGUES COMMUNICATE AND WORK EFFECTIVELY AS A TEAM IN PATIENTS' BEST INTERESTS"

GDC advice

Good communication and record-keeping are, therefore, fundamentally important in managing the situation. The GDC's Standards for the Dental Team makes this clear, stating that: "You should provide patients with clear information about any referral arrangements related to their treatment,"[2] and that: "If you refer a patient to another dental professional or other health professional, you must make an accurate record of this referral in the patient's notes and include a written prescription when necessary."[3]

Patients should be given clear information about the reason for the referral, options including NHS or private, the person or organisation to whom the referral is to be made, any costs involved and a realistic indication of the timeframe.

The GDC's Standards also state that you must not mislead patients into thinking that NHS-available treatments can only be provided privately[4]. This is particularly true for purely private practices, where patients should be made aware of this before being treated.

For mixed practices, the Standards are also clear that patients must not be pressured into private treatment if it's also available, and they would prefer to have it, under the NHS[4].

Check and double-check

It is vital, therefore, that you are sure of the currency and accuracy of the information you provide, as a failure to do so may leave you open to allegations of being misleading or even dishonest.

For example, when a patient is to be referred for molar endodontics, it is essential to have up-to-date knowledge of the local referral options. Reliance on anecdotal information or an assumption that there is no NHS provision can be risky, as the commissioning of such services may change from time to time and from area to area.

Practices can double-check their information by contacting their NHS Primary Care organisation and referral centres (such as dental hospitals) for written confirmation about referral options, criteria and protocols, and ask that they be updated when there are any changes. In this way colleagues can be confident that patients are not inadvertently given inaccurate information at the time of referral.

John Makin is Head of the DDU.
This article first appeared in The DDU Journal (ddujournal.theddu.com)

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[1]www.bos.org.uk/information-for-dentists/making-an-orthodontic-referral

[2]http://standards.gdc-uk.org/pages/principle2/principle2.aspx

[3]http://standards.gdc-uk.org/pages/principle4/principle4.aspx

[4]http://standards.gdc-uk.org/pages/principle1/principle1.aspx

ARE YOU PREPARED FOR THE BASIS PERIOD REFORM?

Basis Period Reform (BPR) will have implications for dental sole traders and partnerships who have non-31 March/5 April year ends, writes Samantha Nicholson

The Government confirmed its plans in the Autumn 2021 Budget for BPR, which will take effect from 6 April 2024. This will change the way in which self-employed traders are taxed from 6 April 2024.

BPR means that a business's taxable profit or loss for a tax year will no longer be based on the profits/losses for the accounting year end that falls into the tax year (for example, a year end of 30 April 2022 is currently taxed in the 2022/23 tax year) but will be based on the taxable profit or loss arising in the tax year itself.

Transitional calculations will be required in the 2023/24 tax year. The transitional period profits will consist of additional taxable profits for the period from the day after normal accounting year end falling in 2023/24 to 31 March/5 April 2024 (for a 30 April year end, 1 May 2023 to 31 March 2024).

Samantha Nicholson, Business Advisory Director at Johnston Carmichael
E: Samantha.nicholson@jcca.co.uk.

Overlap profits which are usually created when you have started to trade, such as joining a dental practice, can be deducted from the taxable profits arising in the transitional period.

When transitional year profits exceed overlap profits there is the option to spread the net figure over five years.

So, what can business owners do to help prepare for this?

- Identify overlap profits. Your accountant should hold this information. Each partner has their own overlap figure.
- Review plans surrounding capital expenditure, succession planning, business cessation, partner retirement and saving for retirement via personal pension contributions; in particular the best timing for such events and whether to permanently change the year end date.
- Assess pros and cons of incorporation and running the business as a company.

Our specialist Medical & Healthcare team[1] can support you with preparing for these upcoming changes. Get in touch.

[1] *johnstoncarmichael.com/industry-experience/medical-healthcare*

RECRUITMENT AND RETENTION

Can sponsorship of international staff help tackle the shortage of dentists and dental practitioners in the UK?

The British Dental Association (BDA) reports[1] that: "Two-thirds (65 per cent) say their practices have unfilled vacancies for dentists. 82 per cent of those reporting vacancies cite working under the current discredited NHS contract as a key barrier to filling posts, over half (59 per cent) cite issues relating to remuneration levels, and 30 per cent difficulties attracting candidates to remote, rural or deprived communities. 29 per cent say posts have been unfilled for more than a year."

One option to address the shortage of staff is to sponsor dentists and other dentistry roles from overseas to work in the UK. The following roles are eligible for the Health and Care Worker visa, which is a sub-category of the Skilled Worker visa:

- Dental surgeon, dentist, orthodontist, periodontist
- Dental hygiene therapist
- Dental hygienist and dental technician
- Dental assistant, Dental nurse, Dental nurse-receptionist and Dental surgery assistant.

What does this mean for dental surgeries in practice?

SPONSOR LICENCE

To sponsor oversees workers, including dentists, employers need to apply and obtain a sponsor licence from the Home Office, specifically confirming their intention to sponsor Skilled Workers. An organisation needs to show it meets certain requirements such as it is a genuine business and are operating lawfully in the UK.

The cost of applying for a sponsor licence depends on the size of the business. A dental surgery, which comes within the definition of a 'small sponsor', pays a lower fee of £536 and for all other dentistry businesses, the fee is £1,476.

REDUCED VISA FEES AND QUICKER VISA DECISIONS

For dental businesses to be eligible to sponsor under the Health and Care Worker visa, you must be the NHS or provide medical services to the NHS. Alternatively, if the worker is employed or engaged by, or registered with the General Dental Council, they can be sponsored under this route, subject to the visa requirements being met.

The inclusion of the aforementioned dentistry roles on the Health and Care Worker Visa route permits eligible employers to sponsor employees with the benefit of the employee no longer being required to pay the Immigration Health Surcharge, which would be applicable to those sponsored under the Skilled Worker visa route. Eligible sponsored workers under the Health and Care Worker visa route will also benefit from reduced application visa costs: £247 for sponsorship for up to three years and £479 for more than three years.

From a business continuity perspective, the Home Office prioritises the Health and Care Worker visa applications, with applications submitted from outside the UK being determined within three weeks.

Gurjit Pall
Legal Director
E: gurjit pall@thorntons-law.co.uk
DD: 0141-4839025
W: www.thorntons-law.co.uk

Jacqueline Moore
Consultant
E: jmoore@thorntons-law.co.uk
DD: 0131 376 0256

CAN YOU SPONSOR SELF-EMPLOYED ASSOCIATES?

An important aspect to consider is the employment status of the worker you would like to sponsor. The BDA reports[1] that: "Self-employment has long been the default status for associates in general dental practice. Discussions with our members over the years, and more recently, have confirmed that most practice owners and associates prefer the self-employed model to any other." Sponsor licence holders with permission to sponsor under the Skilled Worker route will be able to sponsor self-employed workers, including associates in your dental practice, subject to there being a genuine contract for employment or services between you and the worker.

BENEFITS OF SPONSORSHIP

There are a number of benefits to sponsorship for employers. From a recruitment perspective, your dental practice will have access to overseas workers and have a greater degree of confidence in being able to retain your staff. Importantly, sponsored workers tend to stay with their employers for at least the duration of their sponsorship visas, particularly as they must complete five years continuously on the Skilled Worker visa route before they can consider settlement (indefinite leave to remain) in the UK.

Dentistry has been affected by unprecedented levels of staff shortages and, for the reasons outlined above, we would recommend you carefully consider applying for a sponsor licence as a solution to these staff shortages.

[1] *bda.org/news-centre/press-releases/Pages/nearly-half-of-dentists-severing-ties-with-nhs.aspx*

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EVALUATING THE BARRIERS TO RUBBER DAM USE IN ENDODONTICS

With proficient use clinicians will find application straightforward, writes Mark Allen

The use of a rubber dam for endodontic treatment is crucial to effectively isolate the tooth, including the root canal, from bacteria, as well as protecting the patient's airway. Even though the rubber dam presents a range of benefits to the clinician and the patient, as well as improving surgical outcomes, many dentists choose not to use them after qualifying. Because of this, endodontic treatment may be performed without one. This decision brings with it a number of risks, so it is important that clinicians consider the regular use of rubber dams during endodontic treatment and ensure that patients are informed of the benefits.

THE RISK OF NOT USING A RUBBER DAM

Without the use of a rubber dam, the risk of a patient accidently swallowing or aspirating a dental instrument, irrigation fluid, or debris is significantly higher. This presents a number of issues for both the patient and the clinician. Injury can be caused to the patient, for example, if an instrument is swallowed and becomes lodged, or irrigation fluid (such as NaOCl) is ingested, as it is an irritant. These risks can also present medicolegal challenges for clinicians.[2] When a rubber dam is used, these potential problems are less likely, and therefore you are protected from any legal responsibility if accidents happen.[2]

Cross-contamination is another major risk when a rubber dam is not used during endodontic treatment. Because of this risk, the use of a rubber dam could be considered essential when carrying out endodontic treatment. A rubber dam creates a seal, separating the treatment area from the patient. This means that the patient will be unaffected by irrigating fluids and medicaments used during the procedure. Similarly, the treatment site is protected from any harmful bacteria present in the patient's mouth. When this simple step is implemented, you protect yourself from litigation and your patients from infection.[1]

BARRIERS TO RUBBER DAM USE

Research shows that the majority of dental students expect that they will use rubber dams during treatment in practice, having used them as part of their education. However, the use of rubber dams appears to dramatically decrease post-graduation. In fact, endodontic treatment is generally performed without the use of a rubber dam.[2]

Mark Allen is General Manager at COLTENE

Even though there are a multitude of benefits for both the patient and the practitioner, a number of reasons are given as to why rubber dams are not used during treatment. These include lack of patient acceptance, more time needed for application, insufficient training/practice, difficult to use, as well as cost of materials and equipment.[2] Even though these may be barriers in some cases, rubber dam placement is simple once the clinician has a good understanding of it. With proficient use of a rubber dam, clinicians will find application straightforward and the process will become much faster.[1]

Those who use rubber dams frequently report that they face minimal patient resistance.[2] A useful parallel to help patients understand the reasoning is that it isolates the operating site in the same way as a surgical drape, protecting the site from contamination. Once the reasoning behind the use of a rubber dam has been explained to patients, they are unlikely to reject it.[1]

BENEFITS OF USING A RUBBER DAM

So, what are the benefits? In addition to protecting your patients from injury and infection, the use of a rubber dam results in significantly reduced microbial content of the aerosols produced during treatment.[2] This is beneficial to the dental team as it reduces the risk of infection in the practice by up to 98.5 per cent.[1] They also present the additional advantage of improved visibility and access to the treatment site as the rubber dam retracts the soft tissues, protecting them from injury, and making access to the field more straightforward. Visibility is also improved as they provide a dry field (which reduces mirror fogging) and creates a contrast.[2]

The HySolate range of dental dams from COLTENE ensures complete isolation, crucial for providing effective and predictable dental treatment. Available in a range of colours and shades, including HySolate Black Edition, you can illuminate your site or create a clear contrast for excellent visibility. Plus, HySolate dental dams are available in a powder-free latex or a latex-free range to accommodate the needs of you and your patients.

Consider the use of a rubber dam for your endodontic treatment. They provide you with improved access to and visibility of the treatment site, helping to improve outcomes, while removing the risk of injury, contamination and infection. This allows you to focus entirely on the treatment itself, rather than being concerned with protecting the patient's airways and retracting the patient's soft tissues.

For more on COLTENE, visit www.coltene.com, email info.uk@coltene.com or call 0800 254 5115.

The HySolate range of dental dams from COLTENE ensures complete isolation, crucial for providing effective and predictable dental treatment

Available in a range of colours and shades you can illuminate your site or create a clear contrast for excellent visibility

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[1] Carrotte, P. Endodontics: Part 6 Rubber dam and access cavities. Br Dent J 197, 527–534 (2004). https://doi.org/10.1038/sj.bdj.4811799 https://www.nature.com/articles/4811799

[2] Ahmad, I. A. "Rubber dam usage for endodontic treatment: a review." International endodontic journal 42.11 (2009): 963-972. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1111/j.1365-2591.2009.01623.x

TIME TO OUTSOURCE YOUR PRACTICE'S BOOKKEEPING?

Your time could be better served focusing on providing great care to your patients

Are you spending your evenings and weekends struggling with your accounting records? Is maintaining your books part of your practice manager's never-ending to do list? If so, it may be time to outsource your bookkeeping.

Whether you, or a member of your team, are maintaining your books, your time could be better served focusing on providing great care to your patients and ensuring the smooth running of your practice.

Samantha Turkington
E: samantha.turkington@eqaccountants.co.uk
T: 01307 474274

Not only does outsourcing your bookkeeping free up your precious time, but it can also be cost-effective. By keeping your records yourself, you are taking time away from your clinic and patients, impacting the amount you can earn. Although you will have to pay a fee for someone else to maintain your books, by using an expert such as our EQ Healthcare Dental team, it will ensure your books are accurate and up to date. This allows for greater efficiency in the preparation of your financial statements, as well as access to current management information, allowing you to manage your finances better.

By outsourcing, you will have access to up-to-date software and any questions you have regarding the running of your business can be answered immediately. We can also prepare management accounts to allow for periodic review of the business's performance, compare to benchmarks and allow for tax planning of expenditure to ensure you make the most of reliefs and allowances available. If you wait until your accounts are prepared, months after your year end, to discuss your taxable position, you have completely missed the boat to undertake any tax saving expenditure.

Another key area that many businesses tend to outsource is payroll. Due to the tight timeframes involved, outsourcing your payroll can alleviate any stress with paying employees and HMRC the correct amount on time. Expert advice in this area can be crucial when dealing with new starts, pensions and even benefits in kind.

If you would like more information on our bookkeeping or payroll services, please get in touch with Samantha.

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

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WHAT CAN I DO TO GET THE BEST PRICE FOR MY PRACTICE?

If you're looking to improve its valuation there are some things to consider, writes Jamie Savage

In the first three months of 2023, we valued more than 100 medical businesses with a combined value of £82.7 million, so we know what we're talking about when it comes to pricing and potential. Here are the key things we look at when valuing a practice:

- Is it NHS, private, or mixed-income – each will impact on turnover and costs in different ways and likely impact the types of buyers attracted.
- What kind of services are on offer? Does the practice offer specialist procedures, such as implants, Invisalign, facial aesthetics?
- What are its outgoing costs and, more importantly, are they under control?
- Is the practice Associate-led or is it operated by the Principal dentist? How would the market perceive the asset?
- How is the practice laid out, i.e. how many surgeries? What is the finish of the practice like?
- Does the practice need any refurbishment/redecoration? Is there room to expand?

If you're looking to make changes to your practice to improve its valuation outcome, here are some things you can consider:

- If you want to sell imminently, spending money on small tweaks and furnishings won't necessarily translate into value. Many buyers will want to put their own mark on the decor/furnishings when they take over, so this may be wasted expense.
- Keep a close eye on costs – are you getting the best prices suppliers can offer? Have a clear plan to show how you are tackling any rising costs such as heating, lighting and wage costs.
- Get your team on board for upselling/cross-referral opportunities when possible.
- Use your hygienists/therapists to their maximum potential.
- Finally, and most importantly, keep your accounts and management information as up to date as possible. This will help to show the current performance rather than previous years perhaps distorted levels due to COVID-19 subsidy/multiplier payments and distorted costs.

To find out more about your business's valuation, contact Jamie Savage.

Jamie Savage
Director of Valuation Services, Christie & Co
E: jamie.savage@christie.com
M: +44 7840 022 116

WHERE NEXT FOR THE NHS?

Considering a move to private provision is complex – clinically, emotionally and financially, writes Victoria Forbes

With a further delay of the revised SDR announced recently, many practices and practitioners are feeling increasingly anxious about the future of NHS dentistry in Scotland.

While we are not seeing the mass exodus from NHS provision that is being witnessed in England at present, it is clear that many mixed practices are considering whether they remain NHS committed or should switch to a fully private provision.

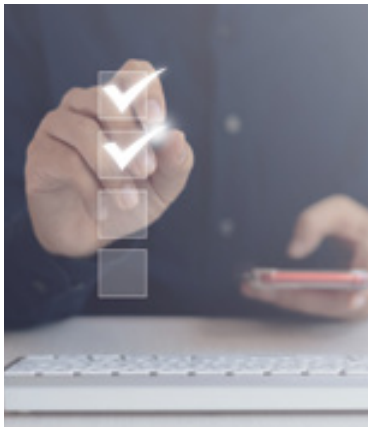
This is a complex area both clinically, emotionally and financially and also a highly emotive subject with many considerations involved in the decision process.

We were pleased to see the extension of the SDAI funding stream for new or expanding NHS practices and have already supported a number of our clients to take full advantage of the valuable grant funding support available. If you are currently or would like to practice in one of the eligible geographical areas, this grant funding can provide a hugely valuable contribution to your capital costs and is definitely worth investigation.

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

The unique model of dental delivery in the UK, which involves independent contractors for the public health provision, technically causes a three-way arrangement. The design of an optimal solution for all three parties is clearly causing the policy makers a significant challenge and the lack of certainty does not ease any anxieties.

Regardless of the shape of the new SDR, there are many ways that a practice can stay efficient, energetic, successful and forward facing. If you need help to decide your next step we would be delighted to help. It is good to talk and our expert team can help you navigate the current challenges. Good luck.



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THINK CAREFULLY

Martyn Bradshaw of PFM Dental – one of the UK's largest dental practice sales agents – discusses his top five tips when selling a dental practice

1. ACCURATE VALUATIONS

To ensure that you get the best price, you need to have the practice assessed properly. A decade ago, turnover was often used in calculating the values of dental practices. However, since then, we use a multiple of EBITDA (earnings before interest, tax, depreciation and amortisation). There are many other deductions and amendments when working under this type of model, so making sure that this is accuracy calculated is very important, especially as this figure will then be multiplied to calculate the value. Getting the calculation wrong by only £10,000 can mean a difference of up to £75,000 in value.

There are also a number of different EBITDA calculations; using a principal-led model (assuming one principal at the practice) and an associate-led model (all income being generated by associates – or simply that we are adding an associate cost against all income). Both EBITDAs then have a different multiple applied to them. As such, some practices will work better under a principal-led model and some will work better under an associate-led model. We would use the better of the two, but this will have an impact on the likely types of buyers.

When buyers review practices, it is also important that they are confident with the figures presented to them. We are a firm believer that every cost that has been amended has to be justified and, as such, ensures that we can, to the pound, explain each and every one. With a buyer who is confident with the figures, comes a stronger offer.

2. DEMAND = PRICE

There is no doubt that the more potential buyers that people have, the higher the offers received. Using a specialist dental agent will ensure that your practice is marketed to as many suitable buyers as possible – and the right types of buyers. With multiple offers, often 'best and final' offers are asked for, which will lead to the price being pushed up. Not only this, but you would have the choice of your perfect buyer – the person who will look after your practice, staff and patients.

Martyn Bradshaw is a director of PFM Dental
T: 01904 670820
M: 07779 658332
W: pfmdental.co.uk

3. TERMS

While this usually relates to large practice sales, this can affect some smaller practices also. Some buyers may require certain terms alongside their (price) offer. This could be as simple as asking the vendor to remain at the practice after the sale, or some legally binding terms. With some of the corporates, there may also be tie ins for the vendors, targets for future income, deferred consideration and financial penalties if these are not met.

Each buyer will be focused on different areas, with some buyers asking for a high number of terms and some asking for very little. An agent's job is to ensure that each offer is considered in its entirety, which may be a balance between price and the terms.

It is likely that most people will want to minimise the risk of any deferred payment. Often the terms can also be negotiated, which may vary from practice-to-practice dependant on the setup.

4. NOT FINISHED UNTIL COMPLETION

One thing that is certain is that until the dotted line is signed, the deal is not done. This is why, as an agent, we keep on top of the sale throughout the process.

However, under the current climate we have seen some vendors take their foot off the gas once a buyer has been found. It should be noted, however, that the buyers, banks and the solicitors will request updated income details prior to completing to ensure that income is in line with what was previously achieved. As such, it is really important that the practice continues in a similar manner all the way through to completion.

5. TIMING

If you are considering selling to a body corporate or have a large practice that may not be affordable to individuals, then you would need to leave yourself with sufficient time to work any tie-in post sale. A body corporate may require one to three years if NHS, or three to five years if private. This needs to be taken into account when considering the timing of your sale, or you may find that you cannot sell to this type of buyer. Typically the legal work, regardless of buyer, will take between six and 12 months, and you will need to ensure that this has been considered before your ideal retirement date. Not allowing sufficient timescales may mean that you cannot sell to your ideal buyer or could impact on your plans for the future.

If you are considering the sale of your practice then it is never too late to start the discussion with an agent. If you are interested in looking at the sale of your dental practice then, please, get in touch with us.

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DENTAL CHAIR SUPPLY

Dentistry requires precision and dexterity, and your equipment should be designed to work for you. IWT partners with trusted, industry-leading vendors of dental chairs and dental furniture to ensure the success of our installations. Working with innovative, practical and established dental chair manufacturers, such as Stern Weber, we provide various chair packages for any purpose. Our dental chair philosophy is founded on the perfection of technology modelled around your work. Our chair packages provide a wide range of functionality that can be personalised to suit your specific operating style and skills. Simplicity and integration ensure a perfect match of efficiency and speed. Innovation is one of our key principles, encompassing the integration of multimedia and X-ray diagnostic devices providing our customers multiple layers of versatility.

Supporting our dental equipment supplies, we have a dedicated service team who deliver industry leading advice and support, ensuring we deal with your service requirements promptly and effectively. We offer comprehensive dental chair and IT support contracts, providing you peace of mind for your most valued practice equipment. Our range of dental cabinetry options offers you control over dimensions, colour, base configuration and cabinet finish, providing your surgery with contemporary and hard-wearing furniture you can rely on. No matter your specialisation or operating style, we can provide you with the perfect dental furniture for a fluid workflow. Our furniture service extends to transformation of your reception and waiting areas.

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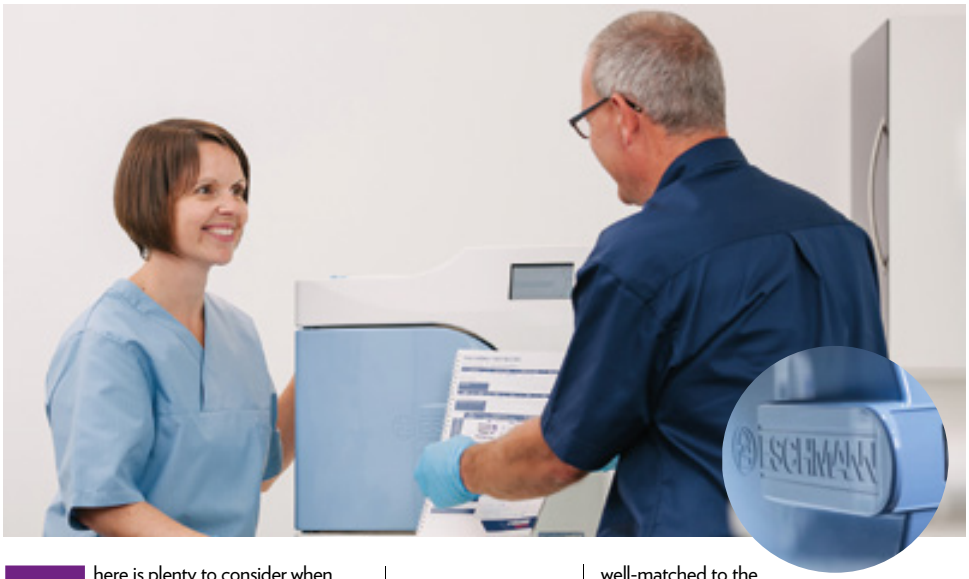
PROJECT MANAGEMENT

IWT specialises in providing end-to-end project managed solutions. When carrying out dental surgery or full practice renovations, we provide a comprehensive solution that is second to none. Project management includes installation of all equipment, plumbing and electrical works, to final decoration of the new area. We provide every required service to complete all installations, to remove the stress of your refurbishment project from all practice staff. Our high client retention rate is of great pride to all at IWT and is testimony to our dedicated team of expert technicians and the exceptional service we provide.

SUPPORT FOR DECONTAMINATION EQUIPMENT

When looking to invest in an autoclave, it is vital that you make the right decision for your dental practice, says Nicky Varney



There is plenty to consider when purchasing a new autoclave – this is where support from the manufacturer proves incredibly useful. Not only should the model be appropriate for your needs, but you should also take into account the service that is provided with the product. In the rare event of a breakdown, your autoclave needs to get back up and running as soon as possible, to avoid excessive downtime. The right service contract is a key consideration.

PRIOR TO YOUR INVESTMENT

With the sheer number of models available on the market, you need appropriate guidance to make the right decision for you. You may have always used a particular autoclave model or have been recommended one by a peer. Regardless, it is always worthwhile seeing what other options there are for you. The choice can be overwhelming, which is why you should contact the manufacturer for further guidance. Leading product providers are dedicated to ensuring you receive the right help. They will take the time to walk you through their product offerings to make sure you are well-informed before making your decision.

No two dental practices are the same – that includes their size, in addition to their patient footfall, the services they offer and the volume of instruments that are required for sterilisation. Autoclaves are available as types 'B' and 'N', with models available that provide the choice between both 'B" and 'N' cycles. Leading manufacturers will ensure that you are well-matched to the autoclave you are considering.

Nicky Varney, Marketing Manager at Eschmann

SERVICE OFFERINGS

An equally important consideration when making an investment such as this is whether the manufacturer provides extended support that suits your needs and requirements. This is something you should be looking out for when researching autoclaves and their manufacturers. All autoclave units will come with a warranty, but doing your research will ensure you choose the one that offers the best additional benefits for the years following the warranty. In fact, the right service and maintenance plan would help to extend the working life of your autoclave, in addition to helping you to remain compliant to HTM-0105/SDCEP standards and minimising downtime should a breakdown occur.

Breakdowns are an unfortunate reality of owning any kind of equipment in a dental practice but with the right service and maintenance plan, you can gain much-needed peace of mind that, in times of emergency, you are covered. It is always best to be prepared for the event of a malfunction, and ensure the manufacturer is committed to providing a rapid response in times of need. Some manufacturers may not only offer this, but also include an annual validation and pressure vessel certification, which are legal requirements. Plus, you may receive free software upgrades and Enhanced CPD User training, so your autoclave software is always up-to-date. Leading equipment manufacturers will ensure their customers are educated on the product's use and features and what is included, for total transparency so you can make an informed decision.

POST-SALE SUPPORT

Once you have purchased your autoclave, the support from the manufacturer should certainly not end once you have received your equipment. In fact, this is where the right manufacturer will play a significant role. In the rare event of an emergency, having access to on-site and technical telephone support can be vital to minimise downtime.

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A long-standing Eschmann customer comments: "[Eschmann] equipment is something you buy if you are looking for quality and long-term reliability – when you buy an autoclave from Eschmann you receive an exceptional level of support that you don't often get from other manufacturers. The Care & Cover service gives you peace of mind, too."

RELY ON YOUR AUTOCLAVE AND YOUR SERVICE CONTRACT

Purchasing a new autoclave for your practice is a big investment, one that you must get right to ensure you can protect your patients and staff from harm. The right manufacturer will not only provide a high-quality, reliable and durable autoclave, but will also ensure you are adequately supported before, during and long after the transaction has completed, for total peace of mind.

For more information on the highly effective and affordable range of decontamination equipment and products from Eschmann, please visit www.eschmann.co.uk/decontamination-guidance or call 01903 875787

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FULFILLING THE DREAM

OUR EQ Healthcare team offers specific accountancy, taxation and business advisory services to each of the healthcare professions, particularly within the dental sector.

Anna Coff, a manager based in our Forfar office and member of EQ Healthcare, acts for numerous dental practices of all shapes and sizes across Scotland. As well as supporting her clients with accounting and taxation issues, Anna has assisted many dental professionals to fulfil their dream of owning their own practice, either on their own or with other business partners.

Anna keeps up to date with topical issues affecting her clients and together with other members of our EQ Dental team, Louise Grant and Samantha Turkington, she attends and delivers talks at various dental events including the Scottish Dental Show. If you would like more information on the services and support that we can offer you and your dental practice, contact our EQ Healthcare team.

Anna Coff, BAcc (Hons) FCCA
Manager
E: anna.coff@eqaccountants.co.uk
T: 01307 474274
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COLIN HOGG • SOUTHERN IMPLANTS

BRINGING A WEALTH OF EXPERIENCE

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

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

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

Colin Hogg,
West of Scotland Representative
E: colin.hogg@southernimplants.co.uk
T: 07586317506
W: www.southernimplants.co.uk

ALLAN WRIGHT • A-DEC

IN-DEPTH KNOWLEDGE

AS one of the largest dental equipment manufacturers in the world, A-dec designs and builds much of what you see in the dental treatment room, including chairs, stools, delivery systems, dental lights and a full line of accessories.

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

Allan Wright
Territory Manager for Scotland
E: allan.wright@a-dec.com
M: 07803 627247
T: 0800 233 285
W: www.a-dec.co.uk

JANE WEBBER • DENSURA SCOTLAND

INTRODUCING DENSURA TO SCOTLAND

HI, I'm Jane from Densura.

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Based in Glasgow, I can attend your Scottish practice and host meetings to introduce myself and Densura in the form of a lunch and learn.

Outside of work, I keep busy with my horse, two cats, board sports, Muay Thai, and I am an avid car enthusiast!

Jane Webber
Business Development Executive
E: jane.webber@lockton.com
M: 07769243179
T: 020 79330343
W: www.densura.com
L: linkedin.com/in/jane-webber-a17375163
F: Jane Webber

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For more information visit www.carestreamdental.co.uk
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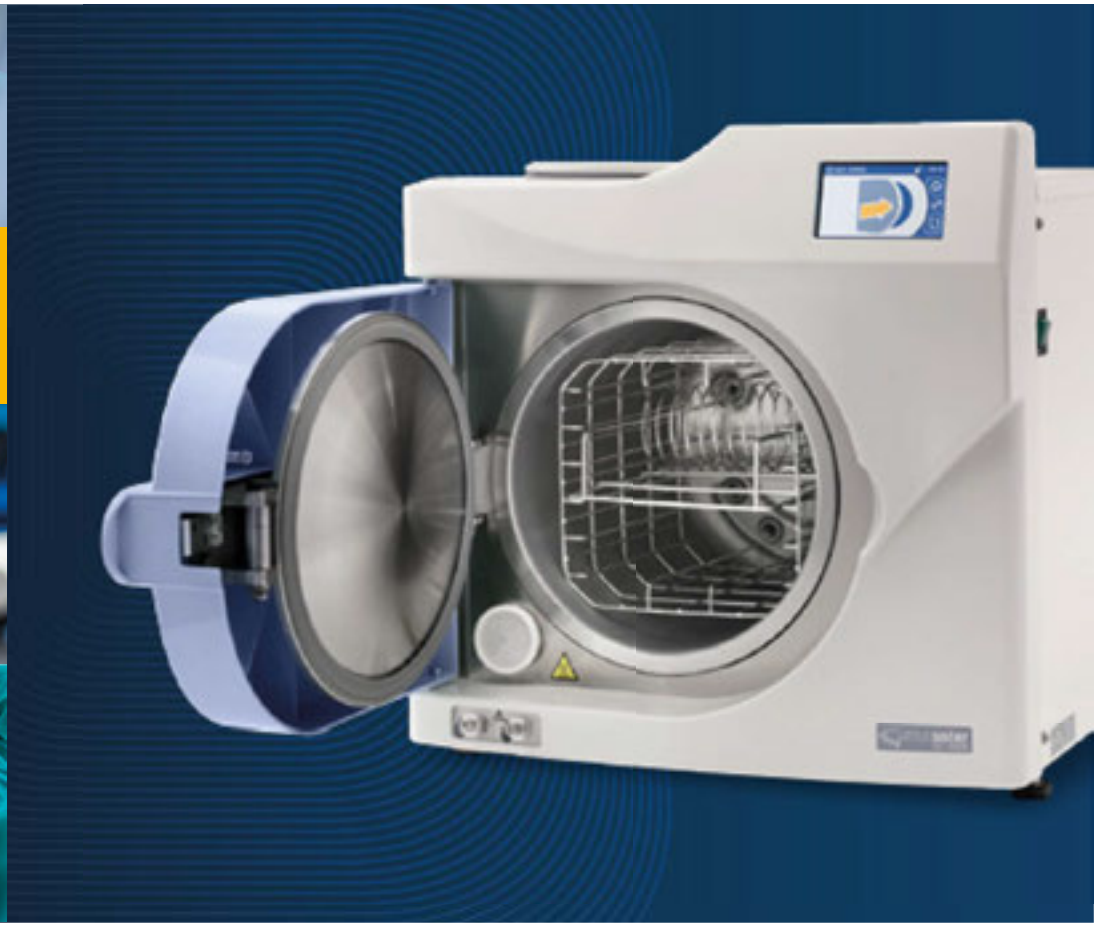

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Alastair Fraser, Principal Dentist, Greygables Dental

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