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LOOKING TO THE FUTURE

New RCPSG dental dean Professor Graham Ogden on his plans for the dental faculty

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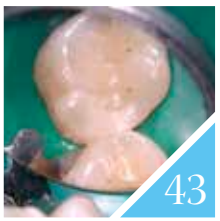

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Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
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KEEPING CANCER ON THE AGENDA

Do you talk to your patients about their alcohol intake?

November is Mouth Cancer Action Month, an awareness campaign that has grown in prominence in recent years. Not only is mouth cancer now a recommended core topic for CPD, it is no longer a once in a career event.

While in the past, a practitioner might see one incidence of mouth cancer in 20 years, it is not unusual for dentists to have as many as one every five years or so.

This alarming rise in incidences can be attributed to a number of factors, but academics continually point to alcohol and tobacco as the main risk factors behind the alarming increase in cases.

Our main interview on page 24 features Professor Graham Ogden, the new dean of dentistry at the Royal College of Physicians and Surgeons of Glasgow and one of the UK's foremost mouth cancer experts. As well as discussing his new role he spoke to *Scottish Dental* about what he sees as the most important things for dentists to look out for when it comes to cancer of the mouth, head and neck (p10).

As well as advice on what warning signs to look out for, he says that dentists are in the perfect position to broach the subject of alcohol and highlighting it as a key risk factor. Prof Ogden acknowledges that it might be an uncomfortable conversation but there is help out there to structure these conversations in a non-confrontational manner.

Alcohol brief interventions are not uncommon in other health settings, such as A&E, but dentists often have a long-standing relationship with their patients that could stand them in good stead here. The idea is to motivate and support the individual and give them all the information they need. What they do with that when they leave is then up to them. Much like their oral healthcare regime is.

Elsewhere in this issue we have an interview with NES hygienist/therapist vocational training (HTVT) advisor Lorraine Keith. Lorraine has been in post for a few months and she is looking to raise awareness of the programme in Scotland and make sure that the standards of the training is at the same level as BDS graduates.

We also have an interview with the keynote speaker at next year's Scottish Dental Show. Dr Christopher Orr is one of the UK's most sought-after speakers and we are delighted he has agreed to come up to Brahead Arena on Friday 19 May.

Academics continually point to alcohol and tobacco as the main risk factors behind the alarming increase in cases

Registration for the 2017 Show has been open for a couple of months – www.sdshow.co.uk – and the initial response has been greater than ever. At the time of writing, registrations are up by more than 30 per cent compared to this time last year, so we are expecting a bumper crowd again in May.

MORE INFO
And finally, don't forget that you can now also nominate individuals, teams and practices for next year's Scottish Dental Awards, visit www.sdawards.co.uk for more information

WE COULDN'T HAVE DONE IT WITHOUT...

1

GRAHAM OGDEN
(ON HIS NEW RCPSG ROLE)
Professor Graham Ogden is professor of oral surgery at the University of Dundee and the new dean of the RCPSG Dental Faculty.

2

LORRAINE KEITH
(ON SCOTTISH HTVT)
Lorraine Keith is the new hygienist/therapist vocational training advisor at NHS Education for Scotland.

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JEREMY COOPER
(ON THE VENEER REVOLUTION)
Jeremy Cooper is a general dentist from Manchester and a fellow of the International Academy of Dental and Facial Esthetics.

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ASHLEY LATTER
(ON BUILDING RAPPORT)
Ashley Latter is one of the most recognisable faces in UK dentistry. He has personally trained more than 10,500 dentists worldwide in his career.

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

WHO'S BUYING?

Arthur asks whether it is a case of "better the devil you know" when it comes to selling your practice

Every week, practice owners receive unsolicited letters from brokers offering to sell their practice on their behalf. The all say that practice values have gone up exponentially, and that now is a good time to sell. Similarly, IDH/mydentist will speculatively phone to see if you are thinking of selling up. If you are close to retirement, it certainly looks like it's a good time to go.

BUT IS IT A GOOD TIME TO BUY?

This year's Scottish Conference of LDCs passed a motion proposed by Glasgow and Clyde: "This conference proposes that new NHS practices should only be permitted to be established in areas where there is proven to be a lack of NHS provision."

A short walk through any city or town centre in Glasgow and Clyde will show a plethora of dental practices, all fighting for the same pool of patients. The advantage of a cold squat is that you are not buying goodwill, which can be the most expensive part of a practice purchase. The disadvantage is, of course, that you will have to fund, at a minimum, one surgery and an LDU – so at least £50,000 with no certainty you can repay this. The "hooks" to get patients in have become ever more surprising – one practice offering lifetime whitening for patients for nothing if they register. Another practice run by a married couple is now offering appointments seven days a week. I can see this seeming like a good idea now – but impossible in the long term.

At the conference, a young dentist bemoaned the difficulty in buying a practice. Setting up a cold squat is no longer a good option, and many practice owners are selling to group practices or body corporates without giving associates first refusal. Patients do not appear to be leaving these bought-over practices in droves, despite the higher than average turnover of staff and associates.

Practice owners have cited the improved prices offered by the corporates, although it is difficult to say that this is true when there has not been an open selling price offered to associates, many of whom, I think, would have been happy to match the price.

ABOVE: Our business models now might be worthless in a few years, so why not sell now?

Despite the recent economic uncertainty, banks have still been happy to lend to dentists looking to purchase. Principals have also said that selling to dental bodies corporate avoids a period of uncertainty in case the money is not available, and avoids other associates preemptively leaving and decreasing cash flow to the practice. Some smaller corporates are also offering a shorter "tie-in period" and not giving targets for the seller to meet. The largest corporate offers a "golden hello" to associates who stay for three years after the takeover.

Setting up a cold squat is no longer a good option, and many practice owners are selling to group practices or corporates

We are now facing the new SGHD dental consultation. The Chief Dental Officer has said she foresees "evolution, not revolution" and has mentioned perhaps running two systems in parallel, as well as the task of persuading patients to pay for prevention.

We won't know the outcome of the consultation for a long time yet, but one thing is certain, there will not be any more money coming our way. This uncertainty also has an impact on business and retirement planning. Our business models now might be worthless in a few years, so why not sell now?

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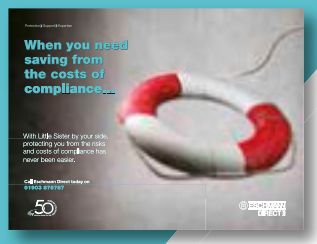

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CONSULTANT IS 'HUMBLED' BY BDA FELLOWSHIP

NHS Health Scotland dental public health consultant honoured for distinguished service

Edinburgh-based consultant in dental public health Colwyn Jones has been awarded the Fellowship of the British Dental Association (BDA) for his distinguished service to the profession and the BDA.

As well as working as a consultant for NHS Health Scotland, Colwyn is an honorary senior lecturer at the University of Edinburgh and East of Scotland Branch representative on the BDA's Scottish Council. He graduated from Edinburgh in 1981 and has been a member of the BDA since his undergraduate days. Most recently he was the East of Scotland BDA branch president from 2008 to 2010.

After a career that has seen him work in Aberdeen, Cardiff, Glasgow and latterly Edinburgh again, he will be presented with the Fellowship of the BDA at the association's annual conference next year. Talking about the honour, Colwyn said: "When I discovered I had been honoured with the BDA Fellowship, my first reaction was this must be a case of mistaken identity!

"I have been an active member of the BDA all of my professional life and have held a large number of official BDA positions wherever I have been working. I understand that it was my colleagues on the BDA Scottish Council who kindly nominated me for the honour and I am very grateful for that recognition and peer support.

"For me, recognition and appreciation of my dental colleagues is humbling and the best acknowledgement of any achievements during my dental career. I am grateful for that lifelong professional care and companionship, and I think this Fellowship is really a testament to the help of many dental colleagues with whom I have worked to date.

NOW TRENDING

81%

of people believe that mouth cancer patients should be exempt from paying fees for ongoing restorative or dental care*

* Mouth Cancer Action Month 2016 Survey

WRIGHT'S PROFITS INCREASE DESPITE TOUGH TRADING CONDITIONS

Dundee-based dental supply company Wright Health Group has announced increased profits of 46 per cent despite what directors described as "challenging trading conditions".

The group, which is led by managing director Ian Matheson, made a £1.9 million pre-tax profit in 2015, compared with £1.3m the previous year. Sales increased by £7.4m in the period to £59.1m, marking a 14 per cent uplift.

The group's directors noted in the strategic report in the accounts that: "In common with its major competitors, sales of capital equipment were difficult as both state and private dentists curtailed their levels of capital investment."

It continued: "Our customers face the challenge of reduced state funding and potential changes in the sophistication of treatment plans due to the pressures on disposable incomes of patients and their families."

However, the report also stated that the company has a strong balance sheet which allows it to invest in organic growth and to make acquisitions when suitable opportunities come up.

CASE EXAMINERS MOVE IS WELCOMED BY BDA

New appointments will take over the decision-making functions of the Investigating Committee at the GDC

The introduction of case examiners by the General Dental Council (GDC) is a step in the right direction, according to the head of the British Dental Association (BDA).

The regulator's 14 new case examiners started work at the beginning of November and will carry out the decision-making functions previously performed by the Investigating Committee.

BDA chair Mick Armstrong said: "Increasing registration fees combined with lengthy complaints processes and a history of poor performance have left dentists with a serious lack of trust in their regulator. The BDA supported the move towards case examiners when it was first suggested as a way to speed up and improve the Fitness to Practise process.

"However, while this is a step in the right direction, the proof is in the pudding. We look forward to seeing how these changes translate into financial savings, appropriate decision-making and a faster resolution to some cases as part of an overall improvement in performance and credibility."

Jonathan Green, director of Fitness to Practise at the GDC, said: "Introducing case examiners will benefit patients, the public and dental professionals and improve the efficiency of the GDC's fitness to practise process.

"By not having to frequently convene an Investigating Committee, we will be able to make decisions quicker than before which benefits patients. We can take action straight away action to support the dental professional to improve his practise. This new way of working is also more cost-effective, and at the same time relieves unnecessary stress to the dental professional.

"Where a professional demonstrates insight into their failings, remorse and a desire to remediate, we now have a mechanism to be much more proportionate and to agree undertakings in suitable cases without having to hold a full hearing."

DUNDEE PROFESSOR ADVISES ALCOHOL INTERVENTIONS

Advice on mouth cancer warning signs and providing information on alcohol intake could save patients lives


Professor Graham Ogden

As Mouth Cancer Action Month continues, oral cancer expert Professor Graham Ogden is advising dental professionals to be on the lookout for warning signs as well as advising moderation in alcohol intake.

Graham, who is a professor of oral surgery at the University of Dundee, explained that it is important to screen the whole mouth and take care when recording findings. He said: "The main message is to remember to screen the entire mucosa, both intra-orally and extra-orally and to record negatives so that if anybody disputes or questions whether you have missed a cancer, then you can show that you have screened the mucosa.

"Looking for warning signs, colour especially, is really still the most important thing do – red/white lesions or red lesions in particular, and those that have been there for two to three weeks without showing any signs of improvement such as a swelling or an ulcer."

Graham, who is also the new dean of the dental faculty at the Royal College of Physicians and Surgeons of Glasgow (RCPSG), explained that providing advice on alcohol is an area that dentists could have a big impact. He said: "The two main risk factors are still very much tobacco and alcohol. We've talked a lot about smoking cessation but perhaps the role of the GDP in advising moderation in alcohol intake is something we still need to develop. Maybe some people find it a little uncomfortable, maybe some people who don't actually take alcohol see it as not being their role and that they don't have enough knowledge about it. But it is a legitimate area to question and then provide the information to the patient. They can then make up their own minds."

MORE INFORMATION

To read an interview with Professor Graham Ogden about his career and his new role at the RCPSG, turn to page 24 of this issue. Prof Ogden is also speaking at the Scottish Dental Show in May.

To register for the Show, visit www.sdshow.co.uk

Mouth Cancer Action Month November 2016
Oral Health Foundation

NOW TRENDING

39%

Mouth cancer cases have increased by nearly 40 per cent in the last decade and by 92 per cent since the 1970s*

* Cancer Research UK, oral cancer statistics

DENTIST DEMAND WILL BE MET, SAYS NES

The increasing demand for NHS dentistry in Scotland will be more than matched by an increase in the number of dentists, according to NHS Education for Scotland (NES).

Despite the ageing population and increased levels of attendance among the population, David Felix, director of dentistry at NES (below), insists that this demand is expected to be outweighed by dentists entering or re-entering NHS practice.

Dr Felix was commenting on the publication of the recent Dental Workforce in Scotland 2016 report that informs workforce planning in Scotland. He said: "We work with our partners to ensure that Scotland has the right numbers of dentists to deliver high-quality NHS treatment for everyone who wants it, in line with the Government's 2020 Vision.

"These forecasts indicate that the capacity of the system to deliver dental services to the people of Scotland is greater than ever before and is forecast to increase in the future."

SHOWCASE HAS A NEW HOME

The rights to one of the biggest dental trade shows in the UK have been sold to dental publishing company George Warman Publications.

From 2017, the BDIA Dental Showcase will be run by the publishing house which is part of the Mark Allen Group. George Warman publishes *Dental Update, The Dentist, Dental Nursing* and *Orthodontic Update* and various associated websites.

Mike Cann, president of the BDIA, said that Showcase will continue to be known as the BDIA Dental Showcase for at least five years.

He said: "Dental Showcase will benefit greatly from this new arrangement, providing fresh initiatives to maintain the show's position as the market leader.

"George Warman and The Mark Allen Group run leading exhibitions and events across diverse sectors and I believe their experience and expertise will make Showcase an event that will be the envy of most."

THREE SCOTTISH CANDIDATES MAKE CASE FOR PEC SEAT

Dentists up for election in BDA vote

Voting for the Principal Executive Committee (PEC) of the British Dental Association (BDA) is now under way, with the results set to be announced on 19 December.

There are three candidates for the Scottish seat on the PEC, Derek Harper, Robert Kinloch – who is also standing for a UK-wide seat on the committee – and Graham Smith.

Derek Harper is a GDP from Fife who has been involved in dental politics since 1984. He is on the Fife ADC and chairs the Fife LDC. He said: "The BDA faces many potential problems. Brexit may throw up many such problems though only time will tell.

"General practice is reaching a crossroads in all parts of the UK and steadfast leadership of the profession through the BDA is more vital than ever. The PEC, as the overarching body of the association, has a great deal to do to maintain membership and guide these members through the trials ahead.

"I feel I have a lot to offer to help the PEC operate successfully in all these facets. The association needs a strong PEC where all the members of it have experience and knowledge vital in these difficult times."

Robert Kinloch (pictured), who has been a BDA member since qualifying from Glasgow in 1977, is currently the elected member for Scotland on the PEC. He is a former chair of the Scottish Dental Practice Committee and of the BDA's Scottish Council.

He said: "I feel that I have the experience, expertise and commitment to continue to promote and champion Scottish issues as they are brought before the PEC."

He has pledged to support the work and staff of the Scottish office, make members aware of the consequences of the ongoing consultant around the new oral health plan, to support all the craft committees "in these difficult times especially issues of deprivation and rurality", to work for further reform of the GDC and to look at the future of practice arrangements around associate contracts.

Graham Smith is a PDS dentist in Skye and is the current chair of the Scottish Salaried Dentists Committee. He said: "Dentistry is at a crossroads. Scottish Government is consulting on Scotland's Oral Health Plan, and this will affect how we practice dentistry for the decade to come.

"GDPs provide the majority of dental care across Scotland. They have seen a 30 per cent decrease in income between 2008 and 2013 and this trend is continuing. In addition, we are dealing with a failing regulator and increasing bureaucratic control.

"This has made general dental practice less viable and Scottish Government needs to recognise the longer term impact on NHS dentistry and on the profession and address this in the OHP."

MORE INFORMATION
To read the candidates' statements in full, visit the www.bda.org

YOUNG DENTIST WINS AWARD NAMED IN HONOUR OF THE MAN WHO INSPIRED HER

Katie MacDonald receives Herd Medal for best case presentation by a VDP in Forth Valley

An award named in honour of two dentist brothers has been presented to a young dentist who was inspired to take up dentistry by one of the brothers themselves.

Katie MacDonald was named as the recipient of the Herd Medal, which was named after Douglas and Ian Herd. The award is awarded each year to the Vocational Dental Practitioner (VDP) working in the Forth Valley who submits the best case presentation.

Ian Herd practised in Grangemouth and his brother Douglas in Stirling. They were both heavily involved in the VT scheme in the health board and, when they both died within a couple of years of each other, the Forth Valley LDC decided to honour their careers with the formation of the Herd Medal. Douglas died in February 2010 and Ian died in October 2011 after a long illness.

Katie, who is currently working at Airthrey Park Dental Practice at Stirling University, has been a patient of Platt and Common where Douglas worked, since she was a child.

She said: "I did some work experience with Mr Herd in 2007 when I was in S4 at school and I feel he helped to influence my decision to study dentistry.

(L-R) Charles MacDonald, FVLDC, with Katie, along with Ann and Angela Herd, widows of the Herd brothers

"I actually found university quite challenging, but feel I really embraced VT and benefited massively from the support and guidance of my trainer. It's a massive achievement for my clinical skills to have been recognised especially at such an early stage of my career."

Gordon Morson, a member of the Forth Valley LDC, said: "Both brothers had been notable local dentists and involved in dental politics, especially Ian. We felt that their loss, in such a short period, should be marked and, as they were both VT trainers and GDPs, we thought honouring them by selecting the outstanding VDP annually would be suitable.

"The marking scheme suggests that the winning case presentation should be something that reflects the treatment of general patients within GDS."

SCOTTISH HEALTH AWARD FOR DUNDEE DENTIST

A Dundee dentist has won a Scottish Health Award for her compassionate care of a dementia patient at King's Cross Hospital in the city.

Jennifer Watson was nominated for the Dentist Award at the annual awards ceremony, which this year took place at the Corn Exchange in Edinburgh on 3 November.

Jennifer was nominated by the daughter of an elderly patient for the "excellent, person-centred and compassionate dental care" provided to her mother who has dementia. The nomination read: "Jennifer always treats my mum so respectfully and makes sure she is comfortable and understands what is happening so that she is willing to take part in the treatment.

"Mum has had a long time without adequate teeth to eat her meals at a normal speed and has also been distressed about how her mouth looked. It is wonderful for her to once more have a mouth full of teeth."

NOW TRENDING

16

Categories at the 2017 Scottish Dental Awards, to be held at the Glasgow Hilton on Friday 19 May*

*To nominate, visit sdawards.co.uk

SCOTTISH GOVERNMENT URGES DRINKS INDUSTRY TO RESPECT PRICES RULING

The Scottish Government has called on the drinks industry to respect the judgement of the Court of Session, which has given its approval for minimum pricing legislation to finally be introduced.

The Scotch Whisky Association had brought about a legal challenge in Scotland's highest court, that the policy was unlawful. It was passed by the Scottish Parliament more than four years ago.

The Court of Session decision comes on the back of a ruling from the European Court of Justice, which said that it was for the Scottish courts to make a final judgment on the scheme.

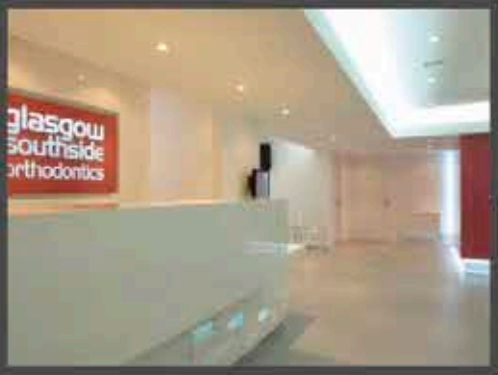
Responding to the judgement, Aileen Campbell, Minister for Public Health and Sport, said: "The Scotch Whisky Association represents some of Scotland's finest whisky brands, and while they were entitled to raise this action, they and the wider drinks industry must now respect the democratic will of the Scottish Parliament and the ruling of the Court of Session and enable this lifesaving measure to be introduced.

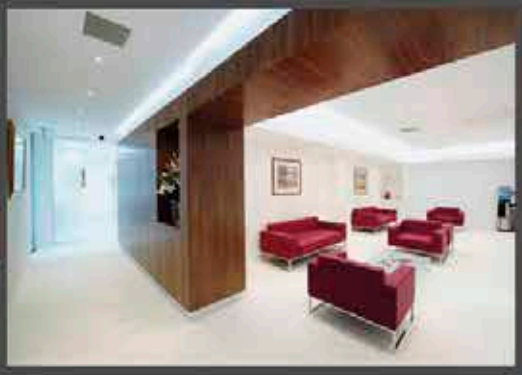
"This policy was passed by the Scottish Parliament unopposed more than four years ago. In that time, the democratic will of our national parliament has been thwarted by this ongoing legal challenge, while many people in Scotland have continued to die from the effects of alcohol misuse. "

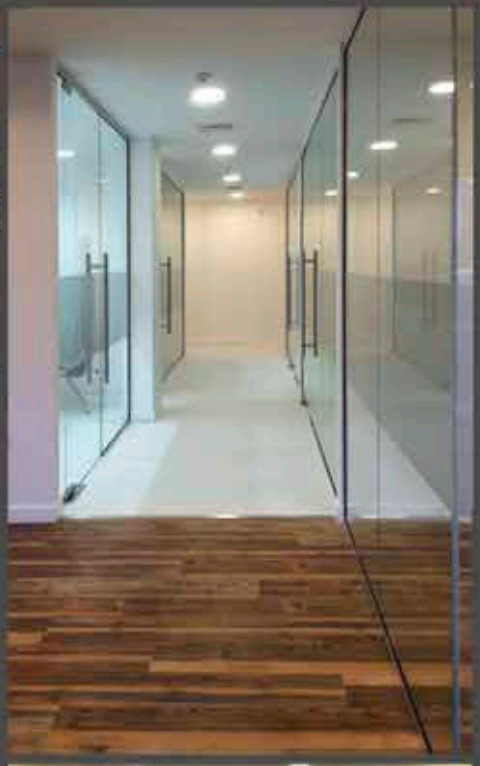
"Minimum unit pricing is the most proportionate and effective way to reduce the harm caused by cheap, high strength alcohol.

"We have always been convinced that this policy will save the lives of many of the people who die each year from alcohol.

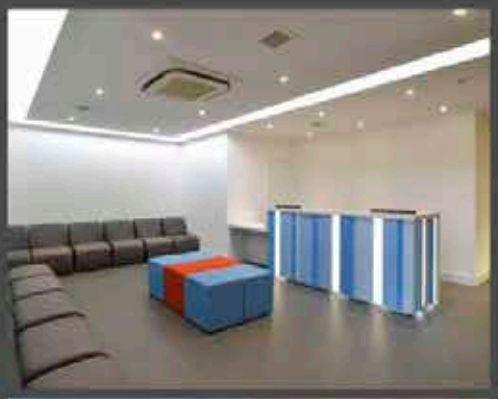
"Recently we have seen the publication of yet more statistics which show that alcohol related deaths remain unacceptably high."

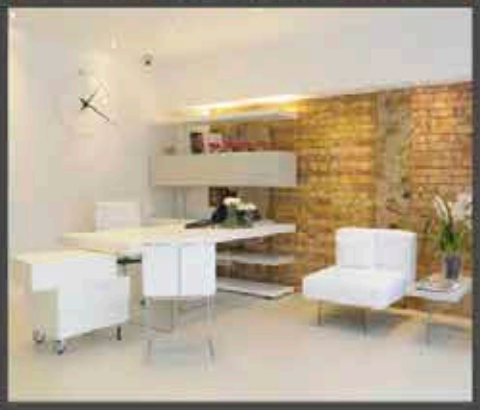






A FRESH APPROACH TO DENTAL DESIGN & CONSTRUCTION





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A DIGITAL REVOLUTION IN EDINBURGH

Annual conference attracts hundreds of cosmetic dentists to hear renowned speakers on technology

Hundreds of cosmetic dentists from all over the UK descended on Edinburgh recently for the British Academy of Cosmetic Dentistry's (BACD) Annual Conference.

Held at the Edinburgh International Conference Centre, the theme of the event was 'The Digital Revolution' and focused on the accessibility of new technologies to modern dental practice.

Speakers over the three-day event included world-famous Romanian dentist Dr Florin Cofar, Perthshire's very own Dr Elaine Halley and London 3D dentistry pioneer Dr Andrew Dawood.

There was also a first appearance in Scotland for American Gary Takacs who,


Dr Florin Cofar

while not a dentist, owns a dental practice in Phoenix, Arizona and lectures all over the world on how to develop a thriving practice.

The conference also saw the inauguration of new president Dr Andrew Chandrapal, who said he will use his time as president to continue to redefine the academy as a professional institution and the champion of cosmetic dentistry in the UK. He said: "I want the BACD to be a strong, academic base for the profession that is based upon high-quality, good education and inflexible ethics that holds the interests of patients at the centre of its decision-making process.

"Overall, I want the BACD to become one of the most dynamic, inviting and open academies in the UK. I want to see our community grow."

Dr Donald Sloss, Glasgow graduate and now president-elect of the BACD, said: "It was great to see so many colleagues in Edinburgh.

"The annual conference gives us the chance not only to learn together, but also to play together in the true spirit of the BACD. This interaction is at the academy's core and it just gets better year on year.

"I think the BACD occupies a great place in British dentistry and will continue to do so. We must to stick to and promote our core values and help dentists transform the lives of their patients through beautiful and ethical treatment."

BLACKHILLS' ANNUAL SYMPOSIUM A SELL-OUT

Perth Racecourse was again the location for the annual Blackhills Clinic Symposium which attracted more than 165 dentists from Perthshire and beyond.

Ben Greer from the Thrive Programme opened the day's plenary session and he was followed onto the podium by MDDUS dental advisor Douglas Hamilton, and Dr Mike Gow, past president of the British Society of Medical and Dental Hypnosis.

In the afternoon, the symposium split into three parallel sessions for clinicians, practice owners/managers and DCPs. Highlights of the clinicians' programme included an oral cancer presentation by Dr Sharon White, consultant pathologist at Dundee Dental Hospital (DDH), and a talk by Dr Elizabeth Theaker, also of DDH.

MORE INFORMATION
For more information on this year's event and to enquire about the 2017 Symposium, visit www.blackhillsclinic.com

£3,000 FOR DENTAL PROJECT TO HELP KENYAN CHILDREN

Thirty members of the Clyde Munro Dental Group ran the Bank of Scotland Glasgow 10k recently and raised nearly £3,000 for charity in the process.

The money, which was raised in conjunction with investment partners Synova Capital, was given to the Global Child Dental Fund who will co-ordinate a project to fissure seal and provide urgent dental care for children in the Kibera district of Nairobi in Kenya. The project will be overseen by the Kenyan Paediatric Dental Association (KPDA).

Professor Arthur Kemoli, president of the KPDA, said: "Kibera is the largest slum in Nairobi and the largest urban slum in Africa. Most of Kibera's children live in extreme poverty, their parents earning less than $1 a day.

"Unemployment rates are high and HIV continues to increase. There is little in terms of government clinics and no hospitals in Kibera, and this money raised by Clyde Munro Dental Group and Synova Capital will help us provide both urgent treatment and prevention for these children.Thank you so much for all your kindness."

Professor Raman Bedi, a paediatric dentist and chairman of Clyde Munro Dental Group, will take the money raised to Nairobi and join the Kenyan dentists who will be providing free dental treatment for Kibera children.

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FELLOWSHIP HONOUR FOR GLASGOW DENTIST

International recognition for Dental fx principal Dr Stephen Jacobs

Dr Stephen Jacobs (centre) receiving the award from Dr Russell Nishimura (AO past president) and Dr Michael Norton (AO president-elect)

Bearsden dentist Dr Stephen Jacobs has become only the second UK clinician to be awarded Fellowship of the Academy of Osseointegration (AO).

Stephen, who is the principal dentist at Dental fx, received the honour at the academy's annual meeting held in San Diego, California. Despite having more than 6,000 members in 70 countries around the world, the AO has fewer than 100 Fellows.

Speaking about his award, Stephen said: "I was extremely honoured to become a Fellow of the AO, as it recognises achievement and work in the field of implant dentistry, both from a patient care perspective and education of our profession, and is awarded by what I regard to be the most important implant body of them all.

"I have been involved in this field of dentistry for more than 25 years which actually comprises most of my career. I first joined AO in 1999, and have been regularly attending the annual meeting, which is, year on year, the best implant congress one can attend."

Stephen explained that more Scottish dentists should consider joining the AO.

He said: "While, for many years the Academy has been a North American-centric association, over 25 per cent of the membership is in fact non-American. The last four to five years has seen a push by the Academy to recognise this and become more global.

"I am in fact the chair of the Global Development Committee of AO, which organises and oversees all projects outside North America, and we now have regular study clubs and conferences in many countries, with more coming on board. We are holding our fourth UK AO meeting during 2017."

To find out more about attending the UK Charter Chapter meeting in 2017, the annual meetings or indeed anything AO, then contact Stephen at stephen@dentalfx.co.uk

PSA REPORT PRAISES IMPROVEMENTS IN COUNCIL'S STANDARDS

The General Dental Council (GDC) has demonstrated "a significant improvement" according to the latest review from the Professional Standards Authority (PSA).

The PSA, which has been highly critical of the regulator in recent years, found that the GDC was meeting 21 of the 24 standards, up from 15 in 2015. This includes seven of the 10 Fitness to Practise standards compared with two in last year's report.

Commenting on the report Ian Brack, chief executive of the GDC, said: "We have invested significant effort in improving our performance against the standards of good regulation, and that effort is paying off.

"Once again, we have met all the requirements in Standards and Guidance, and Education and Training, and we are now meeting all those for Registration.

"We know that our performance in Fitness to Practise has struggled in the face of enormous increases in caseload in recent years and we've worked very hard to turn that around.

"And we know there is still much work to be done. But if the system of dental regulation is really going to protect patients effectively, be fair to registrants and be cost effective we know that it needs fundamental reform based on strong partnerships and collaboration by all involved, including the profession itself.

"We can't count on or wait for legislation to do it all for us.

"We cannot do this alone, and we will be shortly outlining proposals which will set out in detail the further improvements we want to make through our programme of regulatory reform, working with our partners, the profession and patients."

DON'T FORGET TO DECLARE

Dental defence reminder on indemnity

Scottish-based dental defence organisation MDDUS is reminding dentists that they need to declare their indemnity when they renew their Annual Retention Fee with the GDC.

The GDC changed the rules on registration in November 2015, meaning that dentists and dental care professionals now must declare that they have indemnity in place – or will have by the time they start practising.

MDDUS dental adviser Rachael Bell said: "This is not a new requirement as dentists have always needed to have appropriate indemnity in place to practise dentistry. The only difference now is that practitioners must complete an indemnity declaration as part of their annual renewal process.

"The GDC does not require registrants to provide an indemnity certificate unless specifically requested for further information. However, practising without appropriate indemnity in place is contrary to guidance and can result in a fitness to practise investigation.

NOMINATIONS ARE NOW OPEN!

The countdown to the 2017 Scottish Dental Awards is now on and we are looking for entries from members of the whole dental team and from all across the country

ABOVE: Hugh receiving his award from Tom Ferris

The 2017 Scottish Dental Awards nomination process is now open with all roads leading to the Glasgow Hilton on Friday 19 May. Hosted by comedian and radio presenter Des Clarke, the Awards Dinner and Ceremony promises to be another great celebration of the great and the good in Scottish dentistry.

More than 450 guests were welcomed to the Glasgow Hilton for the 2016 Scottish Dental Awards in May, and they saw Dental Protection's former head dental services in Scotland Hugh Harvie pick up the night's most prestigious honour in the shape of the Scottish Dental Lifetime Achievement Award.

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

NEW FOR 2017

The 2017 Scottish Dental Awards will see the introduction of a new category, bringing the total to 16 in all. The new award, the Best Professional Advisor, celebrates the business side of dentistry which has grown in prominence in recent years as more and more companies and individuals have started to offer direct dental-specific advice to the profession.

From specialist dental accountants and lawyers to business coaches and mentors, this new award aims to recognise those companies and individuals who are offering the best advice and making a real difference to Scottish dental practices.

However, while created with business in mind, this category is open to anyone advising the profession, be they financial, legal or compliance related. If they help you and your business thrive, we want to hear about it.

INTRODUCING YOUR HOST

Comedian and radio personality Des Clarke will be the face of the 2017 awards, taking over from last year's host Carol Smillie. In 2014, Des performed live to a quarter of a million people during the Commonwealth Games and hosted the closing ceremony to a global TV audience of more than one billion viewers.

He is also a much-loved voice on the airwaves and can be heard waking up central Scotland every morning as host of the Capital Breakfast Show. His radio work has earned him widespread industry recognition, winning a British Radio Award and receiving nominations in both the Arqiva and Sony Awards.

Over the years he has interviewed some of the showbiz world's biggest names including Rihanna, Robbie Williams, Britney Spears, One Direction and Katy Perry.

MORE INFO

To nominate for the 2017 Scottish Dental Awards, visit www.sdawards.co.uk

Closing date for entries is 17 March 2017, so get online and start nominating today!

KEYNOTE REVEALS LECTURE TOPICS

Full speaker programme is now available online

Registration is also open for the 2017 Scottish Dental Show with the full speaker programme now available online.

Dr Christopher Orr, the event's keynote speaker, will open the show on Friday 19 May with two one-hour lectures, with the first entitled: "Beyond smile design: planning the whole mouth for function and aesthetics". His second talk is called: "Inlays, onlays and endocrowns – is it time to say goodbye to traditional posterior crown preparations?"

In an interview on page 33 of this issue, Professor Orr talks about his life and career in dentistry. He also explains what he hopes delegates will take from his two talks.

He said: "The two presentations are on quite different topics. From the inlays presentation, I hope that they will come away with an understanding of some new ways of working, which can be implemented the next day in the practice. And from the treatment planning lecture, I hope that they will gain an understanding of the bigger picture of planning a mouth for aesthetics and function."

Other speakers at the two-day event will include Prof Brian Millar, Ashley Latter, Adam Morgan, Mike Gow, Andrew Carton, Attiq Rahman and Arshad Ali, among many others.

To register for your FREE delegate pass, which gets you access to up to nine hours of verifiable CPD and more than 140 exhibitors, visit www.sdshow.co.uk

SCOTTISH DENTAL AWARDS 2017 CATEGORIES

SCOTTISH DENTAL LIFETIME ACHIEVEMENT AWARD 2017

Last year's recipient:

Hugh Harvie

SCOTTISH DENTAL REPRESENTATIVE 2017

Last year's winner:

Angela Glasgow, NSK

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NEW FOR 2017

BUSINESS EXCELLENCE AWARD

Last year's winner:

CDC Products

THE STYLE AWARD

Last year's winner:

Inverurie Dental Practice

COMMUNITY AWARD

Last year's winner:

Dental Inspirations, Aberdeen

BUSINESS MANAGER/ ADMINISTRATOR OF THE YEAR

Last year's winner:

Donella MacLennan, The Peppermint Group

DCP STAR

Last year's winner:

Linda McPartlin, Monklands Hospital

UNSUNG HERO AWARD

Last year's winner:

Gemma Furlong, Grays Dental Practice, Cambuslang

LABORATORY OF THE YEAR

Last year's winner:

Porter Boyes, Glasgow

DENTAL TEAM AWARD

Last year's winner:

Lockerbie Dental

DENTIST OF THE YEAR

Last year's winner:

Colin Burns, Mydentist Crow Road, Glasgow

PRACTICE OF THE YEAR

Last year's winner:

Whitecart Dental Care, Glasgow

EMPLOYER OF THE YEAR

Last year's winner:

Fern Stewart and Nadia Hajjaj, Glasgow Southside Orthodontics

YOUNG DENTIST AWARD

Last year's winner:

Alan Macleod, Greenlaw Dental Practice, Newton Mearns

WEBSITE OF THE YEAR

Last year's winner:

Southside Dental Care, Edinburgh

NOMINATE AT WWW.SDAWARDS.CO.UK

UPCOMING EVENTS

WE'VE GOT THIS COVERED

20 JANUARY 2017
Scottish Orthodontic Symposium
Royal College of Physicians and Surgeons of Glasgow
For more information, visit rcp.sg/events

3 FEBRUARY 2017
Refining your techniques in implant dentistry
Walpole Street Practice Dental Surgery, London
Contact General Medical on +44 (0) 1380 734 990 or email info@generalmedical.co.uk to book.

7-9 FEBRUARY 2017
AEEDC Dubai 2017
Dubai International Convention and Exhibition Centre
For more information, visit aeedc.com

10 FEBRUARY 2017
Top Tips for VDPs
Royal College of Physicians and Surgeons of Glasgow
For more info, visit rcp.sg/events

2-4 MARCH 2017
ADI Congress 2017
ExCel, London
Visit www.adi.org.uk for more information.

10 MARCH 2017
Royal Odonto-Chirurgical Society of Scotland conference
Royal College of Surgeons of Edinburgh
To find out more, visit www.royalodonto.co.uk

21-25 MARCH 2017
37th International Dental Show
Cologne
For more information, visit www.english.ids-cologne.de

12-13 MAY 2017
Dentistry Show
NEC, Birmingham
www.thedentistryshow.co.uk

15 MAY - 15 JUNE 2017
National Smile Month

19-20 MAY 2017
Scottish Dental Show
Braehead Arena, Glasgow
www.sdshow.co.uk

19 MAY 2017
Scottish Dental Awards
Hilton Hotel, Glasgow
www.sdawards.co.uk

25-27 MAY 2017
British Dental Conference and Exhibition
Manchester Central Convention Centre
www.bda.org/conference/Exhibition/2017-exhibition

1 JUNE 2017
TC White Conference – Dental Trauma
Royal College of Physicians and Surgeons of Glasgow
For more information, visit rcp.sg/events

2 JUNE 2017
Top Tips for GDPs
Royal College of Physicians and Surgeons of Glasgow
For more information, visit rcp.sg/events

22-23 JUNE 2017
British Society of Periodontology Conference 2017
Kings Place, London
For more information, visit www.bsperio.org.uk

29 AUGUST - 1 SEPTEMBER 2017
FDI Annual World Dental Congress
Madrid
To find out more, visit www.fdiworldental.org

LET US KNOW ABOUT YOUR EVENTS BY EMAILING BRUCE@SDMAG.CO.UK

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1 x One Coat 7 Universal Bond 5ml +50 brushes,
2 DIATECH ShapeGuard brushes for composite
(1 x pre-polisher and 1 high lustre)

Restoration Highlight Kit - Tips
ART# 6002 0091

30 BRILLIANT EverGlow Tips 0.2g, 10 tips of each
(A1/B1, A2/B2, A3/D3),
1 x One Coat 7 Universal Bond 5ml +50 brushes,
2 DIATECH ShapeGuard brushes for composite
(1 x pre-polisher and 1 high lustre)

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ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

HANDS-ON

HTVT PARTICIPANTS TALK ABOUT THE BENEFITS OF THEIR TRAINING

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SELF-DETERMINATION IN ACTION

THE NEW DEAN OF THE DENTAL FACULTY AT THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW (RCPSG), PROFESSOR GRAHAM OGDEN, LOOKS BACK ON HIS CAREER

BRUCE OXLEY MARK K JACKSON

At the tender age of 11 years old, Graham Ogden was faced with his first major career obstacle. Having failed the 11-plus and missing out on a grammar school education, he was sent to the local secondary modern. However, coming from a long line of dentists – he was determined to be the fifth generation of his family to enter the profession – he found his route to dental school was now a lot more difficult.

He said: "I was one of only two people in my year who went to university, and the other lad dropped out after his first year. Nobody had done medicine or dentistry at that stage from my school."

Graham admits that the ethos of the school at the time was that "they worried more about you not attending the Christmas party, than if you didn't hand in your homework". In fact, at the end of his studies, his chemistry teacher admitted to them that he was actually a biology teacher.

Graham said: "We practically taught ourselves chemistry. I remember going to the library and getting out chemistry textbooks to take home and working my way through them."

This early setback instilled a steely determination and a drive to succeed in the young Graham, and he duly earned a place studying dentistry at Sheffield University in the mid-1970s. He qualified in 1980 and went into general practice in Mansfield before following his interest in oral surgery and securing a houseman's job at Dudley Road Hospital (now City Hospital) in Birmingham.

After a year, he went on to an SHO post in Bristol and spent half his time working under Professor Crispian Scully and subsequently completed the first part of his FDS before becoming a registrar at Guy's Hospital in London.

It was at this point he started looking for a lectureship and the first one that came up was at the University of Dundee. He was initially employed on a two-year contract in 1985 which was subsequently extended. He completed his Masters degree and then, towards the end of his PhD studies, the senior lecturer in the department moved to another university.

Having also finished his higher training through the newly-created Academic Advisory Committee for Oral and Maxillofacial Surgery (AACOMS), he was encouraged to apply. Being successful, he took over as honorary consultant in January 1993 and was promoted to the first chair of oral and maxillofacial surgery in 1999. His title was subsequently altered to professor of oral surgery, when his clinical practice changed and the specialist list of oral surgery was created.

During his Masters degree and PhD studies, Graham had been looking at developing the role of exfoliative cytology. He said: "My colleague Dr Cowpe had started this re-evaluation of exfoliative cytology by applying quantitative cytomorphology and DNA analysis, and had shown that it was worth looking at again.

"Nobody had looked at applying some of the advances in molecular biology to oral smears, so I thought that maybe it was worth applying these techniques in an attempt to refine its role in the early diagnosis of oral cancer.

"For my Masters, I looked at various factors that might influence the results for cytomorphology and DNA profile but, for my PhD, I then studied the cytokeratin profile and p53 immunoreactivity of cells removed from clinically suspicious lesions.

This provided a further refinement of the utility of oral exfoliative cytology."

For that work he was awarded the Senior Colgate Prize by the British Society for Dental Research as well as the British Society for Oral Medicine Prize and the Howard Elder Prize from the University of Dundee for Cancer Research.

GIVING BACK TO THE COLLEGE

Graham explained that, while his first contact with the RCPSG was during his FDS studies – he completed his second part in 1984 – he admitted that, until 2010, he didn't really have much contact with the Glasgow college.

He said: "It occurred to me that, for all these years I had been putting in a great deal of work in for the University of Dundee and also I had been chair of AACOMS and later went on to be chair of the first SAC in oral surgery. So, I had done a lot of work for colleges in general but I didn't feel I had put anything back into the Glasgow college.

"I then saw an advert for the Dental Education and Professional Development Board so I put my name forward for that and became part of the board in 2010."

While on the board, he was asked by the dental dean of the day, Alyson Wray, if he would organise the dental aspect of the Triennial Conference for the college in 2014.

He said: "I think the feeling was that we had achieved a good balance of speakers for the two days of the conference and it was generally well received. Then, both Alyson, who was the outgoing dean, and the new dean-elect, Professor Richard Welbury, asked me if I would consider putting my name forward to be one of the two vice-deans for the Dental Faculty. So, I decided to apply for that."

In the second year of the two-year appointment, Graham was encouraged to put his name forward for the dean-elect role and he was subsequently elected as understudy to Prof Welbury. He took over at the AGM on 21 October this year and his term will run from 2016 until 2019.

He said: "For so many years I took the role of the college for granted to be honest. I came back to the college reasonably late on but maybe that's not so surprising, given the many demands of a clinical academic career.

"I am immensely proud to have been elected to the role of dental dean. I certainly never joined the dental education and professional development board with an eye to becoming a vice-dean or even dean. I can honestly say that, without the encouragement of both Alyson Wray and Richard Welbury, I would never have applied for the vice-dean post and thus be in this position now as dean."

> "I HAD DONE A LOT OF WORK FOR COLLEGES IN GENERAL BUT I DIDN'T FEEL I HAD PUT ANYTHING BACK INTO GLASGOW"

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A MORE INCLUSIVE FACULTY

Graham admits that his main focus is simply continuing the good work of his predecessor, by improving the membership and making sure that they continue to present high levels of educational and CPD opportunities for the whole dental team.

He said: "I see my role as ensuring that we continue the good work that Richard has put in place where we have seen an 11 per cent increase in our membership for the Dental Faculty.

"I may be biased but a lot of people have commented on how friendly the Glasgow college is, and I think that is a reflection on the relative size of the college. We have a great team around us who are really committed to the college and make it very easy to become a part of the college. So, I'd like to continue that ethos."

Graham admits that the faculty is keen to dispel any notions that the RCPSG Dental Faculty is just for specialists and hospital dentists. He said: "In actual fact, when you look at our membership, you'll see that many of our members are in general dental practice and we are putting on a great deal of core material for them. We have the annual Top Tips for VTs, Top Tips for GDPs and Top Tips for DCPs events so we don't want to be seen as just a hospital-based group.

"We have methods by which people can become Fellows who have been Members through involvement in the college because, at the present moment, you do have to be a Fellow to take on certain roles within the college. So, we are trying to encourage people to get a little bit more involved, and it doesn't have to be a huge involvement."

Graham also explained that they are trying to develop an international footprint with links in countries such as India and, more recently Panang, Malaysia.

50 YEARS AND BEYOND

Next year marks the 50th anniversary of the Dental Faculty at the RCPSG and Graham revealed that there are a number of events to mark the occasion.

He said: "We have already planned two one-day events: our annual TC White Conference which will be on dental trauma, on Thursday 1 June and then, on Friday 2 June, we have more of a Top Tips-type approach with a number of speakers speaking for relatively short periods of time giving an overview of various areas of dentistry. A celebratory dinner entitled '50 years of Dental Fellowship', will also be held on the Thursday evening.

And he reiterated his desire to increase numbers of people becoming involved in the faculty. He said: "I want us to maintain our steady increase in membership, certainly we need to increase our Fellows because, at the current time the way the constitution is written, only Fellows can become office bearers. We do need people to take on these roles.

"We are keen to have people from a wider background, for example one of the two vice dean positions is responsible for organising and supporting our regional advisors, so that role could be well served by a non-hospital based person."

And looking to the future, Graham admits that he is not looking to retire any time soon. He said: "I really look forward to the next three years in terms of fulfilling my duties as dean of the Dental Faculty.

"I'm also looking to continuing to build a strong department at the University of Dundee, where I am also responsible for the Masters Degree (MRes) in oral cancer.

"Helping to support the career progression of those staff within my unit is also very important to me, as well as seeing undergraduates leave with a sound oral surgical training."

And, much like the alcohol brief interventions that he espouses in his academic life, Graham said that the influence of colleagues has had a profound affect on his career and inspired him to affect change and meaningful development in others. He said: "You could argue that Alyson Wray and Richard Welbury's was a brief intervention, it was short-lived but it had a long-term impact.

"I think that I would see my role now as very much facilitating other peoples' development. That's what I would like it to be seen as – facilitating their development and seeing them reach their potential, both at Dundee and the Glasgow college."

CANCER PIONEERS

Professor Ogden was part of the group that lobbied the GDC for oral cancer to be a recommended topic more than 10 years ago. He said: "Mike Walton of the Ben Walton Trust approached us about setting up the Scottish Oral Cancer Action Group. I remember writing to the GDC at the time and asking them if they would consider making oral cancer a defined topic that dentists should routinely be covering.

"At that stage they were quite dismissive of it and they weren't inclined to go down that path. But, of course, we have now seen that change and there are now a number of topics that they consider core CPD. So, it has been particularly satisfying to see that develop and that recognition by the GDC."

MAKING SURE THAT HYGIENIST/THERAPIST VOCATIONAL TRAINING (HTVT) MEETS THE SAME STANDARDS AS BDS GRADUATES, IS THE AIM OF NEW PROGRAMME LEAD LORRAINE KEITH

VOCATIONAL TRAINING FOR ALL

Vocational training for dental hygienists/therapists should mirror, as closely as possible, the same as the training for dentists. That is the belief of Lorraine Keith who is the hygienist/therapist vocational training advisor for the programme in Scotland.

The training course, which has been running since 2006 in its current format, is for hygienist/therapist graduates. Beginning in August and completing the following July, it involves an induction day and 10 study days, which take place at locations across the country. Those study days cover most of the elements within the scope of a hygienist/therapist practice. In other words, subjects such as paediatrics, periodontics, restorative dentistry, smoking cessation, radiography, oral medicine, medical emergencies and clinical audit. A final study day involves presenting a case study of the holistic care of a patient to their peers.

> "THIS YEAR, DESPITE HAVING 10 VACANCIES, WE ONLY HAVE EIGHT TRAINING POSTS, WHICH MAKES COMPETITION FIERCE"
>
> LORRAINE KEITH

Trainees also complete a 'test of knowledge' covering areas such as management and communication that they may not have studied as an undergraduate. Later in their year, they undertake patient assessment questionnaires which involves gathering feedback from a minimum of 30 patients they have seen.

"The aim is to match the training for BDS graduates, as closely as possible," said Lorraine, who took up her role in January 2016 and is the first hygienist/therapist to assume the post.

"I'm currently an associate lecturer and outreach tutor at Glasgow Caledonian University and NHS Education for Scotland (NES) decided it was appropriate to have a

hygienist/therapist in the role."

Vocational training for hygienists/therapists, unlike dentists, is currently part time. It takes up six sessions, in other words three days a week. On the other two days, trainees can, in theory, take work elsewhere or within the training practice, which, among other things, means the practice does not have to find surgery space five days a week if this is not practicable, and the trainee can supplement their salary in another, or the same practice.

In addition, hygienist/therapist vocational training is delivered as a national programme, rather than

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DIRECT ACCESS CHANGES ON THE WAY

Although the GDC removed its barrier to Direct Access for some dental professionals in 2013, according to Lorraine Keith there remain shades of grey. Since hygienists/therapists can't get a list number, they can only undertake Direct Access in a private practice. And, as explained in the main article, they don't have to undertake vocational training.

Lorraine's personal view is that the future lies in hygienist/therapists having a list number. That would mean Direct Access happening in NHS practices and the necessity for vocational training.

"In addition, as the sector develops and there is more focus on things like domiciliary visits, it's likely that hygienists/therapists will have a greater role. I believe this change will happen at some point in the future."

Lorraine Keith

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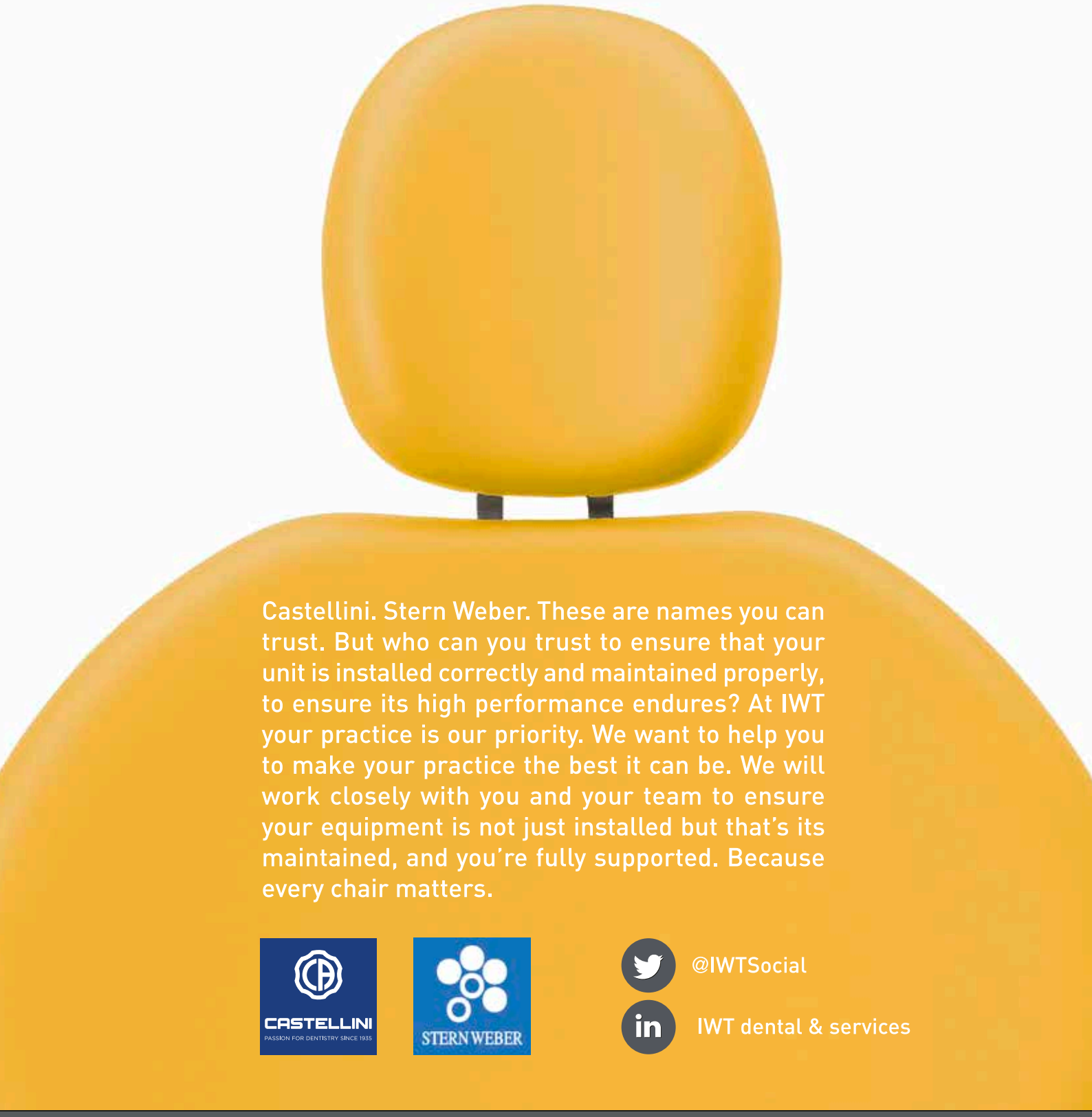

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(L-R) HTVT students Katie Lee, Rafeen Altaf, Mia Mortimer and Jyoti Sumel

FROM PREVIOUS PAGE>

regionally as is the case with most dentists. "The reason for that is the comparatively low number of spaces available," said Lorraine. "At the moment there is the potential for around 45 hygienist/therapists to graduate from Scotland's four dental schools every year. However, this year, despite having 10 vacancies, we only have eight training posts, which makes competition very fierce."

MORE TRAINERS PLEASE

Part of the solution, she suggests, is to increase the number of trainers. At the moment there is one trainer in Edinburgh, one in Aberdeen, three in the Glasgow area and three further north. Circumstances dictate that the number available fluctuates constantly. "If, for example, a trainer decides to take on the trainee she/he is working with, there is maybe no capacity to take on another graduate the following year."

Unsurprisingly, NES is always looking to recruit new trainers. Lorraine added: "There is the possibility to be a multi-trainer – to take on both a dentist and a hygienist or take on two HTVTs if that model suited the practice better. Additionally, it would be possible for two trainers in different practices to share a HTVT.

"I know the GDC has strong emphasis on joint undergraduate training. It would seem to make sense, then, to take that concept to postgraduate level and have dentists and hygienists/therapists training alongside one another. They could learn from each other and learn more about the patient journey together. That would be good for the individuals involved, the practice, team building and, most importantly, the patient.

"We arrange mentoring visits for prospective trainers. In essence, the demands are the same as for dental training, except equipment required for vocational dental hygienist/therapists (VDHT) may be slightly different. Requirements include a proper decontamination area and a nurse available at all times. "A potential new trainer would attend 'START' training," said Lorraine. "Among other things, this prepares them for carrying out the trainee assessments known as LEPS (longitudinal evaluation of performance) and conducting fortnightly tutorials."

Although it involves a certain commitment, being a training practice brings its benefits. As well as playing a part in preparing the dental workforce of the future, there's a payment for having a trainee in the practice.

And, because the time demands are currently fewer than for a dental trainee, hygienist/therapist vocational training offers more flexibility. There is no need for the practice owner to be the trainer – that can be taken on by an associate. Since trainers can also attend study days, there's the chance to refresh your knowledge and gain valuable CPD hours.

The ultimate aim for everyone involved is for the trainee to achieve 'satisfactory completion' at the end of the year. As Lorraine pointed out, if they don't attain that it does not block career progression. "Someone who has undergone vocational training is in a better position than someone who has gone straight from being an undergraduate to the working environment. They've benefited from a year of increasing their knowledge, gaining confidence and undertaking assessments with trainer support."

KNOWLEDGE AND HANDS-ON EXPERIENCE

Participants on the current hygienist/therapist vocational training programme are gaining greater knowledge and hands-on experience.

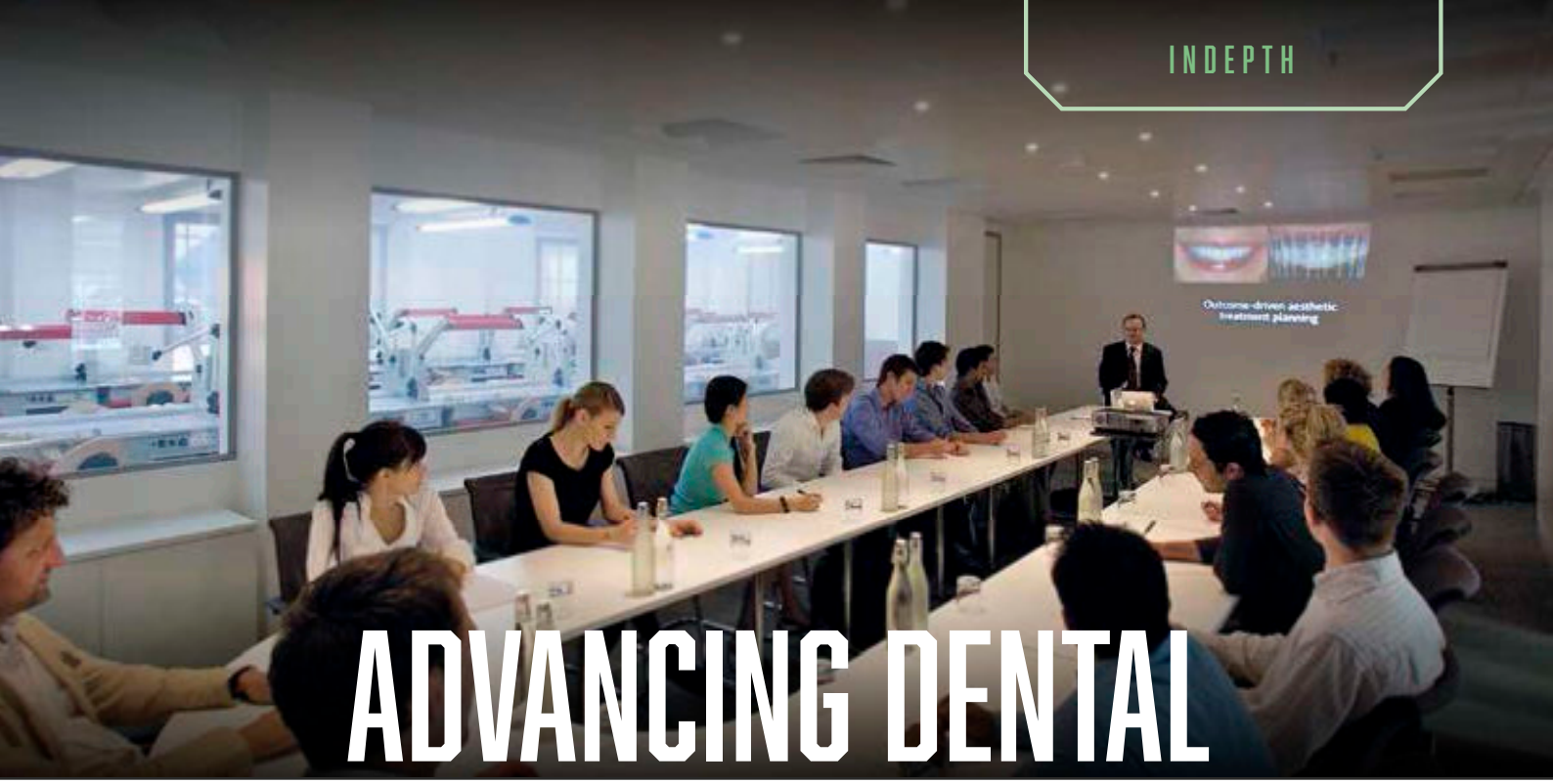
Katie Lee is at a training practice in the north of Scotland. She said: "I'm enjoying working in a supported environment where there's an open-door policy and I can approach the dentists whenever I need help. I'm getting a lot of practice with paediatrics, adult and elderly patients. I'm doing periodontal treatment and restorative as well."

Rafeen Altaf, also training in the north, said: "I've found the vocational training scheme a good transition from university. Until now, I've seen a lot of adult periodontal treatment but I'm gradually seeing a greater variety of work, including restorative."

Mia Mortimer is at a practice near Glasgow. She said: "It's a very large practice with a lot of associates and a large, loyal patient base. I do a lot of restorative work on younger patients, and see a lot of adult and older people – I'm really able to utilise my skills. There are a few associates who have recently come out of vocational training so they really understand my situation."

Jyoti Sumel, from Birmingham, is at a training practice in Glasgow. She added: "This has really got me used to the way a practice works. At university you have hour-long appointments; in practice it's 40 minutes or half an hour. It helps you get faster and gain confidence. I get a good mix, including patients with complicated medical histories."

I enjoy working on these tasks."



ADVANCING DENTAL EDUCATION

SCOTTISH DENTAL SHOW KEYNOTE SPEAKER DR CHRISTOPHER ORR ON SETTING UP HIS SEMINAR BUSINESS AND WHAT IT MEANS TO BE OPENING THE 2017 GLASGOW EVENT

BRUCE OXLEY

From the UK to the US and all the way to Kazakhstan, Canada, Singapore and Malaysia, Dr Christopher Orr has plenty of experience lecturing to big audiences at major dental events. And now, the past president of both the British Academy of Cosmetic Dentistry (BACD) and the Odontological Section of the Royal Society of Medicine, will be opening the 2017 Scottish Dental Show in May next year. He will be presenting two one-hour lectures at the event which is returning to Braehead Arena in Glasgow on 19 and 20 May.

Dr Orr runs a multidisciplinary clinic in central London and started his own education company, Advanced Dental Seminars, with his wife and fellow dentist Zeynep in 2003. It all started, he explained, when he was a young graduate giving presentations on clinical photography and adhesive dentistry. He said: "Some of the adhesive dentistry I was doing at that time was also quite different from what was 'normal' by other clinicians' standards, so I started getting invitations to speak about it at conferences in faraway places."

He explained that, as the clinical director for a group of practices with a focus on cosmetic dentistry earlier in his career, he was asked to run the in-house training course for new dentists. While he enjoyed the teaching aspect, the scope of the training was limited to the range of treatment the group provided. Dr Orr continued: "I felt that aesthetic dentistry encompassed a lot more, so Zeynep and I devised the year-long course to make comprehensive education available to anyone who wanted to come along."

The year course premiered in 2003 and proved so successful that it was soon expanded. Dr Orr said: "The programme we announced that first year proved to be very popular and we were soon running multiple cohorts of delegates. From year one, it became obvious that we needed to build our own venue in order to provide a better quality hands-on experience for the delegates.

"It is still fun, but we never planned that things would get so big."

Despite his experience presenting and lecturing, Dr Orr still remembers the nerves he felt at his first major dental lecture. He said: "The first 'big' thing I did in the UK was a single day lecture in 2003. This combined a lot of material from other presentations to make a day's course – probably too much. It was a bit nerve-wracking to make sure we ran on time and got through all the material. But worse was having Zeynep sit in the audience as I knew she would tell me if I was not good enough. But having some of the audience members of that first lecture sign up to our year-long programme proves that I was not bad at all."

And he believes that, as a GDP, his emphasis on practicality has stood him in good stead. He said: "I am a general dental practitioner so I know exactly what goes on in the everyday surgery environment, therefore it is not hard to give information that is relevant to daily dental practice in the UK. People who come to listen to you should leave with information that they can put back straight in to their daily practice."

ROLE MODELS

Dr Orr revealed that there are a number of people whom he believes have had a major influence on his career. He said: "The late Sverker Toreskog was the first person to make me realise that dentistry could be very different from what I was learning at

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the dental school at the time. He made me see that if I understood materials science and occlusion, then I could do some very adventurous things with adhesively-retained porcelain. I have developed these concepts over the last 20 years, and they form the basis of the presentation on onlays that I will give at the Scottish Dental Show.

"My other role models would have to be: Frank Spear, who has an incredible ability to make complex topics understandable without dumbing them down; Newton Fahl, because of his outstanding artistic skills and his ability to inspire other people to provide better dentistry for their patients; and Christian Coachman, for his never-ending energy and his creativity in combining digital technology to produce new and exciting ways to work."

SCOTTISH DENTAL SHOW

His presentations in Glasgow in May will mark Dr Orr's first appearance at the Scottish Dental Show since its inception in 2012 and he said he was looking forward to travelling up to Glasgow.

He said: "I'm excited to be speaking at the Scottish Dental Show – it's always good to be able to reach a new audience. The show seems to be a very well-established meeting in the Scottish dental calendar and it is wonderful to be asked to open the meeting."

Dr Orr's first lecture, at 9am on Friday 19 May, is entitled: 'Beyond smile design: planning the whole mouth for function and aesthetics', while his second lecture, at 10.45am, will be: 'Inlays, onlays and endocrowns – is it time to say goodbye to traditional posterior crown preparations?' He explained that even though the two lectures are quite different, delegates will be able to take plenty of things back to their practices.

He said: "The two presentations are on quite different topics. From the inlays presentation, I hope that they will come away with an understanding of some new ways of working, which can be implemented the next day in the practice. And from the treatment planning lecture, I hope that they will gain an understanding of the bigger picture of planning a mouth for aesthetics and function."

And he believes that events such as the Scottish Dental Show are vital for the profession. He said: "Events such as the Scottish Dental Show are very important for the profession as it gives everyone an opportunity to get away from the practice for a day or two and hear about what's new, both clinically from the speakers in the CPD programme and from the industry in the exhibition hall.

"These events also create a platform for dentists to network with the others who are all doing similar work day in day out. Dentistry can be a lonely profession when you consider working in a small room surrounded by only your team and patients. So it is good to meet others and share information."

LOOKING TO THE FUTURE

Dr Orr believes that there has been a worrying increase in stress among the profession and he hopes that his courses can help to inject a bit of fun back into some dentists' careers. He said: "In the future, I hope that the profession can find a balance between protection of the public and the over-regulation we seem to be in the midst of… we spend too much time doing things just to cover our backs, and too little time helping our patients. I believe this causes the most of the stress and the disillusionment from the profession.

"We meet a lot of dentists every year who have lost the joy in their profession. We have been trying to put the fun and enjoyment back to their lives for the last 14 years with our courses and I hope that we can continue to provide inspiration and value for our colleagues for many years to come."

AND FINALLY...

When asked if he hadn't chosen dentistry, what did he think he would be doing now? He said: "If I could do anything, I'd go for airline pilot or celebrity chef. But if it has to be a job I could actually do, I probably would have ended up following my father into his accountancy practice. But I'm terrible with numbers so I don't think that would have been a very good idea. At least in dentistry I only have to count up to eight!"

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THE VENEER REVOLUTION

RESTORATIVE

A new generation of plastic veneer templates means that porcelain is no longer the automatic choice

JEREMY COOPER

According to the Oxford English Dictionary, one definition of revolution is: "a dramatic and wide-reaching change in attitude". For decades the porcelain veneer has reigned supreme and the use of other materials for veneering teeth has received little support. Etching of enamel had been demonstrated by Buonocore in the late 1950s, but it was not until as recently as 1982 that Simonsen and Calamia demonstrated that, by etching porcelain with hydrofluoric acid, porcelain could be bonded to enamel with composite resin [1].

FIGURE 1
UVeneer templates arranged in racks

This discovery led to dentists suddenly being able to transform a patient's appearance with a relatively minimally invasive technique. Initially there was a debate to whether tooth preparation was necessary but, over time, it was generally accepted that the tooth was prepared before construction of veneers, otherwise the tooth appeared a little over-contoured. Obviously, with a peg-shaped lateral incisor, tooth preparation might be minimal or not necessary. Direct composite veneers have always been part of the dentist's armamentarium but have been provided as either a provisional restoration or on the grounds of economics.

The preparation of teeth has attracted some controversy. Incisal coverage or removal of contact points are two areas where dentists differ in their approach. In fact, there is a metaphorical fine dividing line between a veneer and a 'veneer crown', depending on one's point of view, in teeth that have been prepared towards the palatal margin and where the contacts have been removed.

New manufacturing techniques have allowed porcelain veneers to be made extremely thin and so negating the need for tooth preparation in many cases (e.g. Lumineers). Whitening or dental bleaching has concomitantly developed over the past few decades, and has become more predictable. In a large number of cases this should mean that the need for full mouth veneers is reduced. Sadly, this is not the case and has led to the term "porcelain pornography" being coined by Professor Martin Kelleher [2] with regards to unnecessary restorative dentistry being performed to enhance a patient's appearance.

Furthermore, while on the face of it veneers seem very simple to perform, they are extremely technique sensitive and demanding. Inappropriate case selection, over preparation, over contouring, shade errors and poor execution of bonding techniques are just a few of the problems that have plagued the provision of porcelain veneers.

Composites and bonding techniques have exponentially improved from the original materials developed in the 1960s and 70s. Microfills, hybrids, nano hybrids along with multi-generation bonding agents has meant that both longevity of restorations and aesthetics have improved dramatically. In the past year or so a template system for use with composites has been introduced to the market, the UVeneer (Ultradent). It was developed by dentist Dr Sigal Jacobson [3], and has given the clinician more choice when providing definitive veneer restorations. No longer should the automatic choice be porcelain and serious consideration should be given to the UVeneer as an alternative.

UVeneers are fully autoclaveable plastic templates that are available in two sizes, large and universal (Figure 1). They are arranged in racks, from first premolar to first premolar, for both arches. When used with composite they block out the oxygen inhibited layer, which gives a harder more colour stable surface with an

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2. Kelleher M. Porcelain pornography. Fac Den J 2011; 2: 134–141.
3. Jacobson S. Direct Veneers Just Got a Whole Lot Easier. Dentistry Today, Aug 2014

unrivalled gloss. The advantages and disadvantages of the UVeneer are outlined below:

Advantages

- One visit
- Once mastered, technique is simple and repeatable
- No laboratory costs
- Shade changes easily made as necessary at time of visit
- Only necessary to trim margins and no need to polish
- Enhanced physical properties to outer surface and therefore potentially longer lasting than a direct restoration without a templates
- Easily repaired or renewed
- Time?
- Cost to the patients.

Disadvantages

- Multiple units are demanding
- Wear incisally and labially/buccally
- Staining
- Longevity less than porcelain/ceramics?
- Two sizes enough for all cases?
- Patient acceptance as opposed to conventional porcelain/ceramic.

The time element is variable but experience as well as the individual complexity of the case will determine this factor. Given that only one visit is required and there is no temporisation required, the time element may work in favour of the UVeneer when compared to porcelain. The physical properties of composite have improved dramatically since the 1970s, but it would be a bold statement to make that they rival porcelain in all aspects.

With exceptionally large or small teeth the UVeneer is not suitable, but suffice to say it can be used for the vast majority of cases. Multiple units can mean lengthy appointment times, which with porcelain is spread over two appointments. Wear due to abrasion or attrition may occur over prolonged periods and may be a deciding factor in the choice of material.

Clinical technique

A middle-aged female presented with a very white veneer, and wished to have it replaced (Figs 2 and 3). She had no desire to whiten the rest of her teeth but rather wanted the veneer to match her existing teeth. The veneer was removed and the preparation modified. It will be noticed that some veneer cement is still present adhered to the preparation (Fig 4). Air abrasion is utilised and, consequently, the necessity to completely eradicate every vestige of bonding material is negated (Fig 5).

The choice of template is easy to make as for every anterior tooth it is either universal or large. The tooth is etched and bonded in the usual fashion and either metal or clear matrix strips are used to prevent overhangs or bonding to the adjacent teeth (Fig 6). For optimal results, a small amount of flowable composite is placed onto the inner surface of the template chosen (Fig 7). Directly onto the flowable composite a small amount of enamel composite is placed and spread out thinly over the surface of the template, with a flat plastic instrument (Fig 8).

Dentine composite is then applied onto the tooth and spread over the surface, before placing the template directly onto it. The excess is removed with a probe, with care being taken not traumatise the gingiva and cause it to bleed. It is important to ensure excess material is removed, as this will

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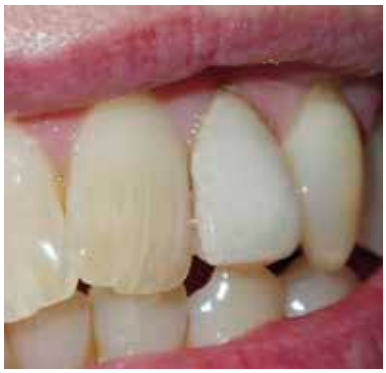

FIGURE 2
A middle-aged lady presented with a very white and unsightly porcelain veneer

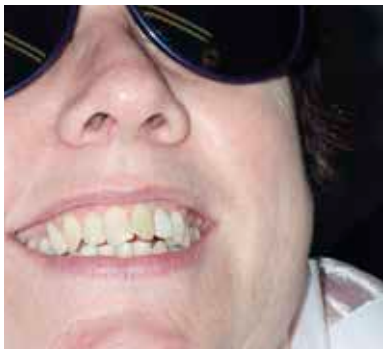

FIGURE 3
The patient requested to have the existing veneer replaced

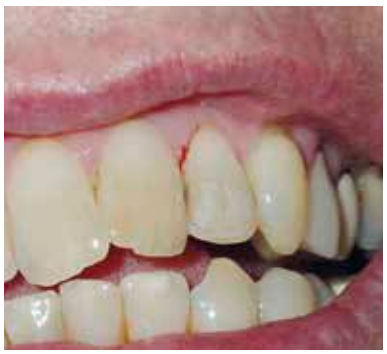

FIGURE 4
Old veneer is removed. Note that some veneer cement is still adhered to the labial surface of the tooth

FIGURE 5
Air abrasion is used on the labial surface of the tooth

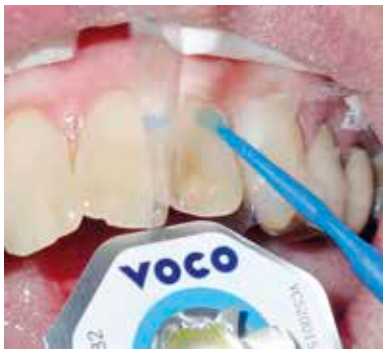

FIGURE 6
Bonding agent is applied to the tooth surface

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mean quicker and easier finishing later (Fig 9). The tooth is subsequently light cured.

If in any doubt to the health of the gingiva, ideally delay the procedure until this has improved or, at the very least, cure the restoration first before finishing as the margins would be contaminated with blood or gingival exudate. There is also a vertical line on the outer surface of the template to aid the placement vertically on the long axis of the tooth.

There are many enamel and dentine composite systems on the market and, in this particular case, VOCO Amaris was used, with the added advantage that a highly translucent flowable is available with the system. It is possible to use any flowable composite, as the layer is so thin as to have very little influence on colour. Furthermore, it is possible to use a single shade composite rather than separate dentine and enamel shades as with conventional restorations, but for optimal aesthetics the latter method is preferred.

The template is pulled off the composite after curing (Fig 10) and, after careful cleaning, can be autoclaved and reused. There is no need to polish the facial surface of the finished restoration. A fine finishing diamond bur is all that is required to remove excess restorative material (Figs 11 and 12).

Conclusions

As with any new technique, there is a learning curve and the UVeneer is no different. The UVeneer can be used to provide "facings" for temporary or provisional restorations. If a tooth is lost whether from periodontal disease, trauma or an extraction, the UVeneer can provide aesthetic form to an immediate pontic. There are obviously many other scenarios where the Uveneer might prove useful. Once proficient with the technique, the question whether to use porcelain or a UVeneer and composite becomes a foremost consideration when providing veneers.

ABOUT THE AUTHOR

Jeremy Cooper qualified from the London Hospital in 1982 and in 1992 he was awarded the Diploma in General Dental Practice from the Royal College of Surgeons.
In 2012, Jeremy was made a Fellow of the International Academy of Dental Facial Esthetics in New York.

He has published numerous articles on a diverse variety of subjects including management issues, dental aesthetics, dental emergencies and restorative dentistry. He is regular contributor on GDPUK and has lectured both in the UK and abroad. He is a member of the BDA and the FGDP.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- Introduce the UVeneer as a credible alternative to the porcelain veneer
- Provide a practical protocol to the clinical steps necessary to perform this treatment
- Increase the restorative options for the clinician providing cosmetic dentistry.

LEARNING OUTCOMES:

- The knowledge to be able to provide the UVeneer as a part of everyday clinical practice
- To understand the advantages and limitations of the UVeneer
- To offer a potentially more cost-effective restorative option for your patients.

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FIGURE 7
Flowable composite is placed on the inner surface of the UVeneer template

FIGURE 8
A thin layer of enamel composite is then laid upon the flowable composite

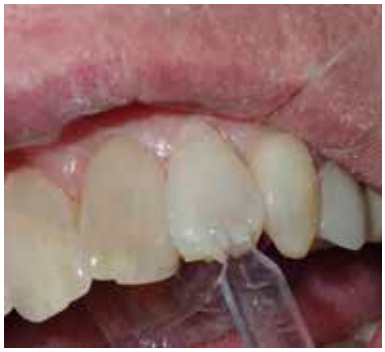

FIGURE 9
After administering the dentine composite to the tooth surface, the template is carefully seated before removing any excess material

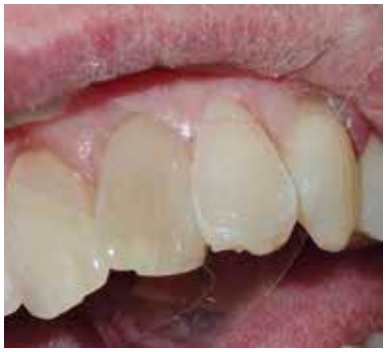

FIGURE 10
After light curing, the template is removed and a finishing bur can then excise any flash at the margin. Care must be taken not to touch the facial surface of the restoration

FIGURE 11
The completed restoration

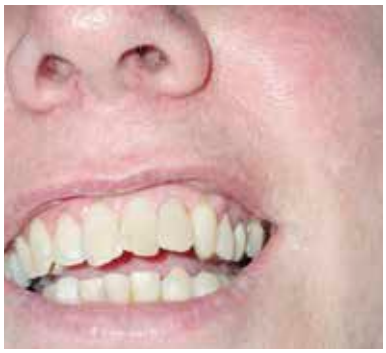

FIGURE 12
A more natural and aesthetically pleasing veneer

LOW-STRESS ALTERNATIVES

MATERIALS

The resolution of symptoms of pain caused by polymerisation shrinkage stresses by using a bulk-fill resin composite material

STEVE BONSOR

When resin-based composite is cured it shrinks by a factor of between 2 to 4 per cent depending on the product. This polymerisation shrinkage causes stresses to be incorporated in the system, either within the surrounding tooth tissue, at the restoration/tooth interface or within the body of the restorative material. These stresses may lead to partial or total debond, recurrent caries, microleakage, pulpal inflammation, marginal staining, fracture or micro-fracture of the surrounding tooth or pain on chewing [1-5].

Furthermore, the depth of light cure of conventional resin composite products is limited [6,7]. To achieve a full curing of the resin composite, sufficient light energy of the correct wavelength of light must be provided to all of the material. In an attempt to overcome these potential problems, an incremental placement technique has long been advocated [8,9] particularly when restoring posterior teeth.

Firstly, the shrinkage which occurs with the first increment may be compensated for by the subsequent increment and so on. Secondly, it permits the dentist to place each increment such that as few walls are bonded together as possible to reduce the configuration or C factor [10] in attempt to control the stresses. Lastly, each incremental of material may be fully cured as sufficient light may attenuate through the smaller bulk of material. This placement technique is therefore time consuming, tedious and requires meticulous technique [6].

The so-called bulk-fill resin composite materials have been introduced to the market in recent years with the aim of reducing polymerisation shrinkage stresses as well as simplifying and quickening the clinical placement of the material. This case report describes the successful resolution of symptoms of pain when a conventional methacrylate based posterior resin composite material was replaced by a bulk-fill restorative material.

Case report

A 35-year-old female geotech engineer with a clear medical history presented for her routine dental examination. A debonded, but still in situ, disto-occlusal resin composite in 16 was diagnosed with no obvious caries present. An appointment was made so that the restoration could be replaced.

At the treatment appointment, a local anaesthetic was administered and rubber dam placed. The existing restoration was removed and cavity refined. As it was considered not to be deep, no lining was considered necessary. After a sectional matrix system (V Ring, Triodent) had been placed, the cavity was etched with Scotchbond Universal Etchant (3M ESPE) for 15 seconds, washed for 15 seconds and lightly air-dried leaving a glassy dentine surface.

Adper Scotchbond 1XT (3M ESPE) was then applied, air thinned and cured for 20 seconds. Filtek P60 Posterior Restorative (3M ESPE) was placed into the cavity using an incremental placement technique with each increment cured for 40 seconds. The matrix system was removed and gross finishing done using diamond finishing burs (Figure 1). Once the rubber dam had been removed and the occlusion checked, the restoration was polished using rubber points.

However, the patient returned two weeks later

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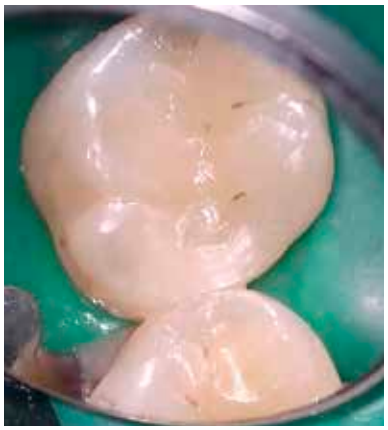

FIGURE 1
16 DO cavity restored with Filtek P60 Posterior Restorative (3M ESPE) after gross finishing but before the rubber dam had been removed

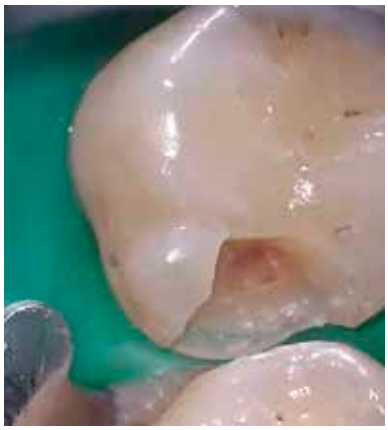

FIGURE 2
The completed cavity after the restoration had been removed

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complaining of a tenderness on biting which necessitated her avoiding using the tooth. She had some sensitivity to cold stimuli but this had settled a few days before the unscheduled appointment. Clinical examination revealed nothing untoward and so the patient was reassured but advised to return if things did not settle. Unfortunately, as the same pain on biting was persisting, she returned a fortnight later. Clinical examination revealed that 16 was tender on application of a Tooth Slooth and when pressure was released when the tooth was squeezed. The diagnosis was therefore made of cracked cusp syndrome most likely precipitated by stresses caused by the polymerisation shrinkage of the resin composite. The patient was advised that the restoration should be replaced in an attempt to remove any stresses within the tooth tissue.

At a subsequent appointment, local anaesthetic was again administered, rubber dam placed and the restoration removed (Figure 2). A sectional matrix system (V Ring, Triodent) was placed, the cavity was etched with Scotchbond Universal Etchant (3M ESPE) for 15 seconds (Figure 3).

The etchant was washed using water from the three-in-one syringe for 15 seconds and lightly air dried leaving a glassy dentine surface. Adper Scotchbond 1XT (3M ESPE) was applied, air-thinned and cured for 20 seconds. As before, no lining was considered necessary as the bonding agent would seal the dentinal tubules. Filtek Bulk Fill Posterior (3M ESPE) was placed into the cavity in a single increment, contoured before being light cured for 40 seconds (Figure 4).

The restoration was grossly finished using diamond finishing burs after the sectional matrix had been removed (Figures 5 and 6). The rubber dam was removed, the occlusion checked and the restoration finished and polished (Figure 7).

The patient was reviewed at her routine six-monthly dental examination four months later. She had no complaints as the symptoms of pain had resolved completely and very quickly after the appointment to replace the conventional posterior resin composite restoration with the bulk-fill product. The patient has been reviewed for her routine dental examination six months subsequent to this and the tooth remains asymptomatic and signless.

Discussion

This case is interesting as, in many respects, direct comparison may be made between both the original appointment and the subsequent remedial appointment as the procedure performed was largely identical. The operator, the method of anaesthesia, timing and placement of rubber dam, burs, sectional matrix system, etch, bonding agent and method and instruments used to finish the restoration were the same at both appointments.

The only differences were that a bulk-fill product was used instead of a conventional posterior resin composite and the former product was placed in one increment by definition. The placement of the conventional resin composite could be viewed as a "control" and a direct means of comparison to the new bulk-fill product.

It is known that stresses may be incorporated into the system as a result of polymerisation shrinkage which occurs when the resin composite is cured[1]. In this case, these stresses had precipitated signs and symptoms of incomplete fracture of the tooth structure (cracked cusp syndrome) despite its meticulous placement in the first instance. Bulk-fill resin composites were developed in an attempt to reduce these stresses and simplify and so quicken their clinical placement. This has been made possible by the manufacturer making some modifications to the constituents of the material.

In the case of the product used in this case, BisGMA (the most commonly used monomer in resin composite products) has been omitted in favour of other monomers such as ERGP-DMA, urethane dimethacrylate (UDMA) or 1,12-Dodecane dimethacrylate (DDDMA)[1,1]. UDMA is relatively low viscosity high-molecular weight monomer which means that there are

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He has previously held posts as clinical teacher at Dundee Dental Hospital and School and honorary clinical teacher at the University of Dundee in the sections of operative dentistry, fixed prosthodontics, endodontology and integrated oral care.

Steve currently holds appointments at the University of Edinburgh as an online tutor on the MSc in Primary Dental Care programme and at the University of Aberdeen as honorary senior clinical lecturer and senior clinical teaching fellow leading the applied dental materials teaching at Aberdeen Dental School. In addition, he is heavily involved in postgraduate dental education having lectured throughout the UK.

To contact Steve, email steve.b@thedentalpracticeaberdeen.co.uk

FIGURE 3
A V Ring (Triodent) sectional matrix placed and the cavity etched with Scotchbond Universal Etchant (3M ESPE)

FIGURE 4
Filtek Bulk Fill Posterior (3M ESPE) after light curing

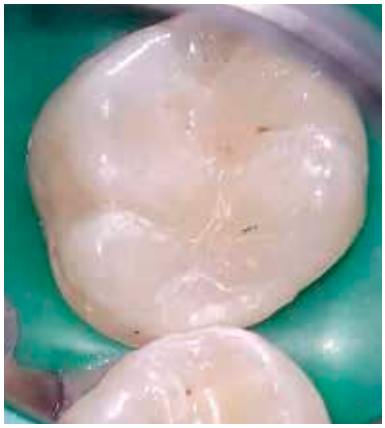

FIGURE 5
The Filtek Bulk Fill Posterior (3M ESPE) restoration after gross finishing

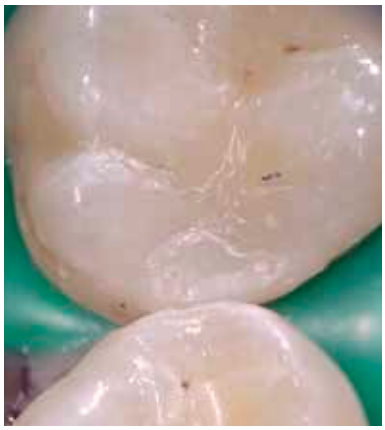

FIGURE 6
A higher magnification photograph, note the good contact area

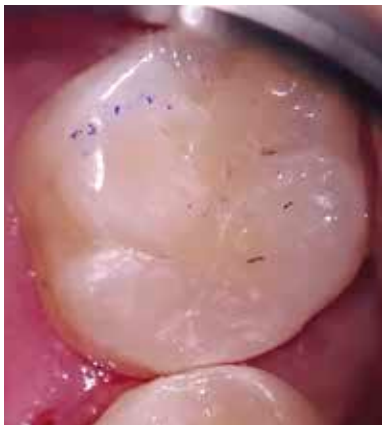

FIGURE 7
The completed 16DO Filtek™ Bulk Fill Posterior (3M ESPE)

fewer reactive groups and so the volumetric shrinkage is minimised. Furthermore, the stiffness of developing and final polymer matrix is decreased but a tough, highly cross-linked network is still created.

DDDMA provides a high modulus resin with good flexibility and impact resistance. This monomer cures quickly and exhibits a low exotherm and low shrinkage. The omission of BisGMA means that bisphenol A is, by definition, absent following concerns over its potentially oestrogenic side effects such as breast and prostatic carcinomas and male infertility. Two other monomers have been incorporated in the resin system which work in combination to reduce polymerisation stresses [11] One is a high molecular weight aromatic dimethacrylate (AUDMA) with a reduced number of reactive groups. This moderates the volumetric shrinkage and the stiffness of the developing and final polymer matrix.

Another class of compounds called addition-fragmentation monomers (AFM) work in combination with AUDMA to decrease the shrinkage stress. These methacrylate molecules react into the developing polymer by forming crosslinks between adjacent polymer chains. When stressed during polymerisation, these molecules may break or fragment so providing a means for relaxation of the developing polymer network and so stresses are relieved.

These fragments also react with each other or other nearby reactive sites in a less-stressed environment as the polymer develops. This process goes to completion maintaining the physical properties of the polymer as the conversation is the same but with greatly reduced polymerisation stress. This was well illustrated in the present case with almost immediate resolution of the patient's symptoms of pain.

The bulk fill product was placed in one increment as the cavity was shallower than 4mm. To enable light to fully penetrate through the material to permit an increased depth of cure, the manufacturers may utilise three strategies to achieve this:

1. Lower the filler content and/or increase the filler particle size

2. Modify the resin to increase its translucency

3. Use a different photoinitiator system.

The filler used in Filtek Bulk Fill Posterior (3M ESPE) is

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a silicon/zirconia nanofiller which conveys good wear resistance, increased strength, excellent polish retention and favourable handling. The total inorganic filler loading of approximately 76.5 per cent by weight (58.4 per cent by volume) [11]. This may be compared to the filler loading of a flowable resin composite which is approximately 65 per cent by weight.

This means that the second generation of bulk fill products of which Filtek Bulk Fill Posterior (3M ESPE) is an example, can be used to restore the entire cavity without the need for a veneering layer using a resin composite indicated for use in the posterior region which is necessary with the lower viscosity products [12] as they have inferior mechanical properties due to their lower filler loading. Due to other modifications in the chemistry of the material discussed elsewhere in this paper, the higher filler load has been possible without any detrimental effect on light attenuation.

Bulk-fill materials tend to be more translucent to permit increased light attenuation through its mass. The manufacturer of the product used in the present case describes the material as semi-translucent [11]. As can be seen in Figure 7, the aesthetics of the cured material are acceptable but a slight mismatch in shade is evident between the resin composite and tooth tissue. This is considered advantageous by many clinicians because, if the restoration requires to be subsequently removed, the tooth tissue may be more easily identifiable and so may be preserved [6].

Many of the bulk-fill products available on the market use photoinitiators which have a higher visible light absorption rate which allows increased quantum efficiency. In simple terms, this means that a lower quantity of light (photons) is required to trigger the polymerisation free-radical chain reaction. This results in improved light-curing performance and an increase depth of cure.

These modifications to the chemistry of this product has allowed the placement of Filtek Bulk Fill Posterior (3M ESPE) in one increment which greatly simplified and quickened the clinical procedure.

Conclusion

This case illustrates that an alternative low-stress material (so-called bulk fill) may successfully resolve symptoms caused by polymerisation stresses when conventional resin composite is cured as it exhibits markedly reduced polymerisation stresses. Consideration should be given to selecting one of these bulk-fill materials in preference to a conventional posterior resin composite material when working in the posterior region of the mouth, not only in terms of stress reduction but the clinical procedure is simpler and quicker.

Conflict of interest/commercial interests

The author denies any commercial interest in any of the products or companies mentioned in this paper.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To present a clinical case treated with a bulk-fill resin composite material.
- To highlight how a patient's symptoms caused by polymerisation stresses may be resolved by the use of an alternative resin composite material.

LEARNING OUTCOMES:

- Be aware of how bulk-fill resin composite materials may be used clinically.
- Have a greater appreciation of types of resin composite materials available and how the clinician may select a traditional product or a bulk fill.
- Have an appreciation of how the chemistry of bulk-fill materials has been changed to decrease polymerisation stress and facilitate light attenuation.

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SEEK AND YE SHALL FIND

PERI-IMPLANTITIS

The risk of over-diagnosis of disease when using periodontal diagnostic techniques for dental implants

PIERLUIGI COLI, KEVIN LOCHHEAD, LARS SENNERBY

As one of the largest specialist referral dental practices in the country and with more than 20 years of experience managing patients with dental implants, we have seen many surgical and restorative "trends" come and go (often on more than one occasion). These include: block bone grafting, guided surgery, distraction osteogenesis, cemented restorations, platform switching and composite resin bridgework.

In the last few years, the most concerning of these, for us, has been the rise of peri-implantitis, both in terms of perceived incidence and proposed management. Well-meaning practitioners (generalist and specialist), together with representative bodies in the profession, have advocated using periodontal indices to produce algorithms for monitoring dental implants (See ADI algorithm overleaf).

The algorithms dictate when and how "ailing" implants should be treated. Such algorithms are only effective if periodontal indices are a reliable predictor of treatment needs. If not, there is a very real concern that many patients will, and are being, unnecessarily treated, often at great expense and with significant mental anguish.

Our prosthodontists, periodontists and oral surgeons have analysed and discussed at length the literature available on peri-implantitis.

This article and the one that follows are taken from a more extensive paper which investigates in detail the evidence to support the use of periodontal indices in implant monitoring. The paper has been submitted and accepted for publication in *Periodontology 2000*.


The Telegraph

Peri-implantitis: The 'time bomb' in dental implants

A little-known disease is emerging in which bacterial infection causes the loss of the bone supporting the implant

Catherine Gunnell's dentist diagnosed her with peri-implantitis Photo: Jay Williams

FIGURE 4
Article from *The Telegraph* website (14 July 2014)

Clinical evidence does not support the published data

Osseointegrated dental implants have been used for more than 50 years and have truly revolutionised modern clinical dentistry. This treatment modality has given clinicians the possibility to give totally edentulous patients back their teeth and dignity.

In the same way, partial edentulism and single tooth gaps can be successfully managed with dental implants as a first choice of treatment to restore function and aesthetics without damaging remaining teeth. The use of dental implants is scientifically well documented and numerous long-term studies have shown predictable results with few serious complications. Moreover, due to better understanding of the biology of implants, improved components and clinical

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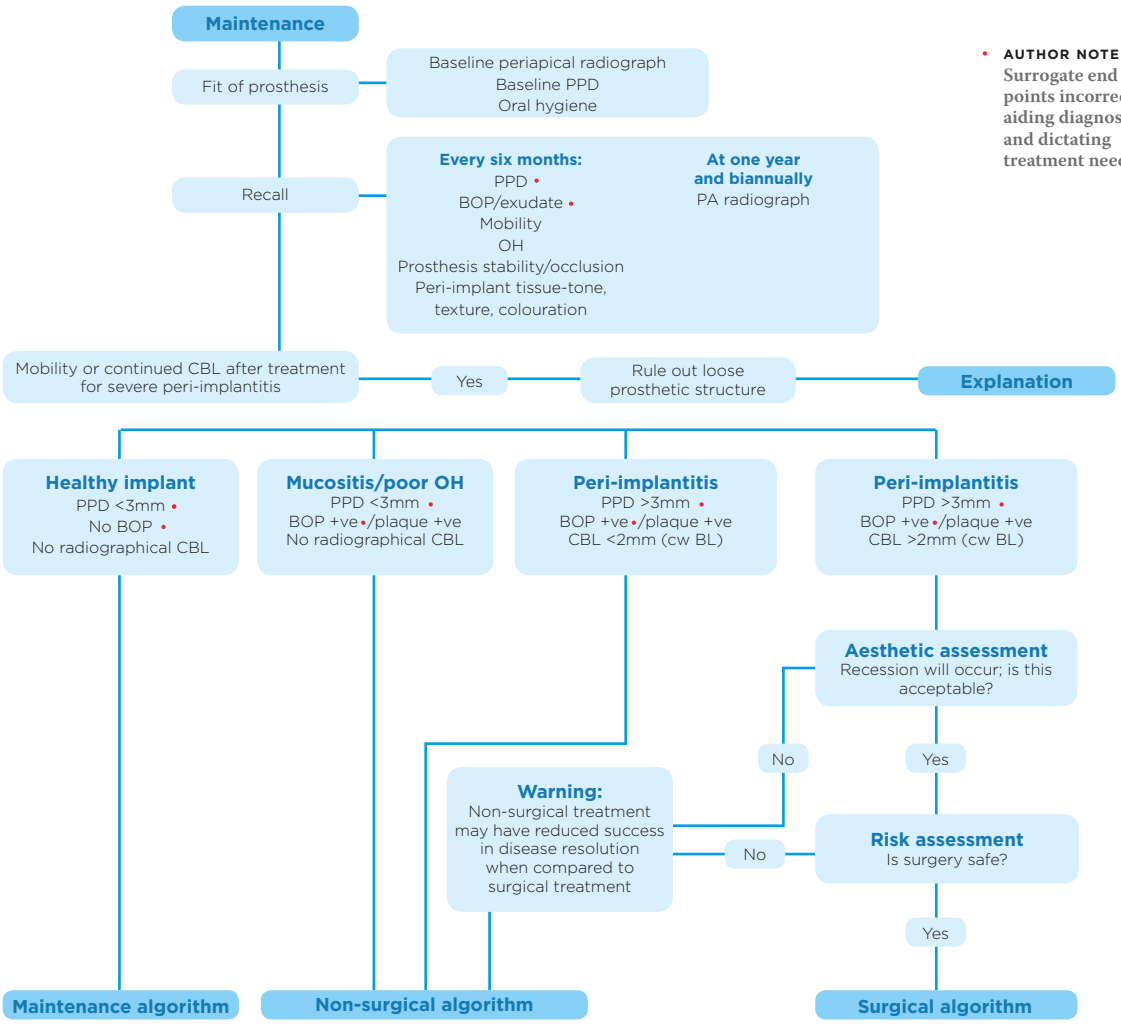
ADI MAINTENANCE ALGORITHM



• **AUTHOR NOTE**
Surrogate end points incorrectly aiding diagnosis and dictating treatment needs

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techniques, the literature has shown increasingly improved clinical outcomes with time (Figures 1, 2 and 3).

In spite of this, critical reports claim that up to 56 per cent of dental implants show signs of disease when examined with periodontal indices such as probing pocket depth (PPD), bleeding on probing (BoP) and radiographic marginal bone loss (MBL)[1,2]. Extrapolation of these findings based on the rationalities of periodontal diagnostics tools, suggests a future tsunami of "peri-implantitis", i.e. severe marginal bone resorption, and subsequent implant losses (Figure 4).

Based on the same logic, it is recommended that the diseased implants need to be treated with non-surgical or surgical interventions to "resolve the disease"[3]. In an editorial in a highly ranked dental journal[4], a restricted use of dental implants was advocated. This advice was based on the findings from a series of studies[5-7] in the same journal claiming high levels of peri-implant disease among a large group of patients. If correct, our waiting rooms would be crowded by previously treated implant patients, now suffering from peri-implantitis.

In addition, the literature would be dominated by clinical reports with catastrophic failure rates. On the contrary, large numbers of suffering implant patients are missing and the scientific literature repeatedly demonstrates dental implants to be very successful with failure rates around 5 per cent after 10 years with about 2-3 per cent of implants affected by severe marginal bone loss and so called peri-implantitis[8].

TABLE 1. TRUE VS SURROGATE END POINTS

TRUE END POINTS OF IMPLANT DISEASE	SURROGATE END POINTS
Loss of implant and restoration	Bleeding on Probing (BoP) Pocket depth > 4mm Increasing pocket depth

One may argue that most scientific follow-up studies are made in well-controlled academic environments and for that reason the results do not reflect clinical reality out in the field. However, it is notable that from the series of studies claiming high levels of peri-implant disease as referred to in the critical editorial, the same research group demonstrated only a 1.4 per cent early failure rate for 11,311 implants placed in 2,765 patients in the hands of more than 800 clinicians, and a 3 per cent total failure rate for a subgroup of 596 patients examined after nine years of function[6]. However, in spite of this, the authors of the study[6] concluded that "implant failure is not an uncommon event". In reality most of us would rejoice over such outstanding results.

Risks with surrogate endpoints in clinical research

How is it even possible to reach so different conclusions based on the same knowledge?

The answer is that the different research groups use different endpoints in their research[9]. Most clinical implant investigations are using true endpoints as primary parameters and measuring clinical outcomes in terms of definitive events, i.e. loss and removal of the implants and of the associated prosthetic restorations, whereas others are using surrogate endpoints (BoP, increased PPD) that, according to their hypothesis, will eventually lead to a definitive event (implant loss).

One example is one of the first studies reporting on alarming levels of peri-implant disease based on BoP and bone loss occurring after the first year of function[10]. According to the authors, about 56 per cent of all implants were affected by disease and had an expected poor prognosis. However, when analysing the same patient cohort nine years later, there were no differences between "affected" and healthy implants with regard to implant failures[11]. Moreover, 91.4 per cent of the implants in the patients diagnosed with peri-implantitis showed either no or minimal annual bone loss during the nine years from the diagnosis. Hence, the surrogate endpoints used by the authors, namely bone loss associated with bleeding on probing, were shown to be poor predictors of future bone loss and implant failure and consequently poor indicators of treatment needs (Table 1). With such a periodontal approach for the diagnosis of peri-implant diseases, there is an obvious risk that patients will be subjected to unnecessary treatment, which is unacceptable from an ethical point of view as it may create iatrogenic as well as economic damage to the patients.

Teeth versus implants (Figure 5)

The periodontal complex is the result of millions of years of evolution and is built up by highly differentiated and specialised tissues. Osseointegration on the other hand, is the result of a foreign body reaction to an implant. The soft and bone tissue interfaces consist of lowly differentiated scar tissues[12,13]. Hence, from a morphological point of view, the tooth and the implant represent two different entities, which cannot be directly compared.

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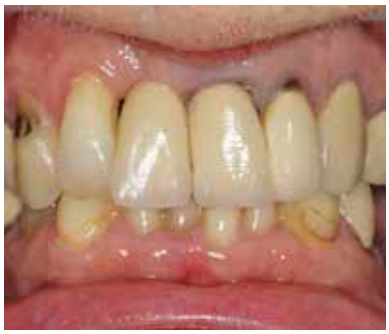


FIGURE 1
Failing crown and bridgework

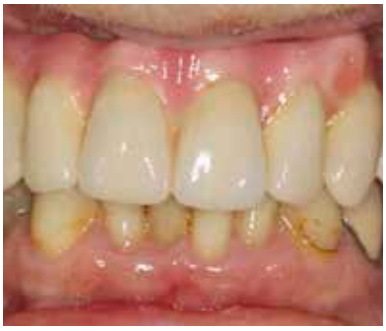
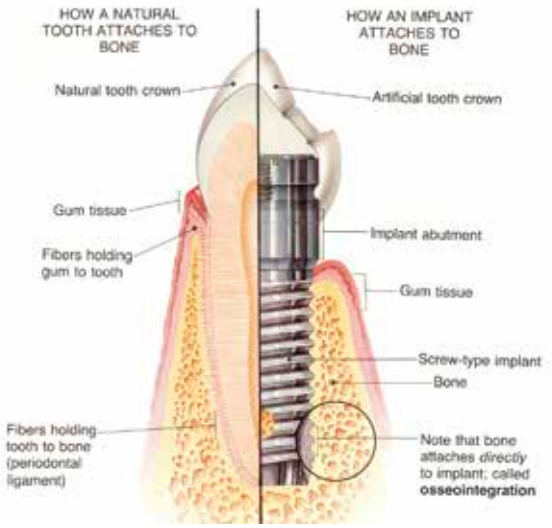


FIGURE 2
Fixed full arch bridge porcelain finish

FIGURE 3
Appearance, function and dignity predictably returned

FIGURE 5



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Inflammation and marginal bone loss at teeth, i.e. gingivitis and periodontitis, are considered as infectious and biofilm-mediated conditions. These are diagnosed by probing, where bleeding (BoP) indicates gingivitis and increased pocket depths (PPD) with bleeding (BoP) and bone loss indicate periodontitis. Removal of the biofilm and bacteria formation will resolve the inflammation/infection. This means that clean teeth will not show any signs of bleeding and increased pocket depths.

Dental implants and mucosa-piercing components are placed in edentulous areas of the jaws during one or two surgical interventions. It is well documented that some marginal remodelling will occur during the first year as a response to surgery, piercing of the mucosa and loading. For a large group of implants, the average bone loss during the first year in function varies from 0.5 to 1.5 mm, mainly depending on the geometry of the implant [14,15]. After the first year in service, small changes of marginal bone loss are observed over the following years of follow-up.

However, if making a frequency distribution of bone loss, some implants will show more bone loss than other implants [16]. The reasons for bone loss can be physiological atrophy after tooth extraction, non-optimal surgery and prosthetic design, overload, thin bone, soft bone, cement residues just to mention a few (Figure 6). This means that healthy and well-functioning dental implants, in contrast to teeth, can show non-infectious marginal bone resorption. Even in a hypothetical environment without bacteria, there will be bone loss around implants. For this reason, a zero-tolerance approach to bleeding, pocket depths and some marginal bone loss does not appear to be justified.

It is often pointed out that patients with a history of severe periodontitis are more susceptible to marginal bone loss at dental implant (Figure 7). Some authors see this as a proof of a bacterial and biofilm-induced process. However, another plausible explanation is that this is related to the immunologic foreign-body response to plaque and implant components in these patients, which for some reason is exaggerated [11].

The use of periodontal diagnostic techniques at implants

In analogy with teeth, the rationale for using a dental probe round implants is to identify "affected" implants based

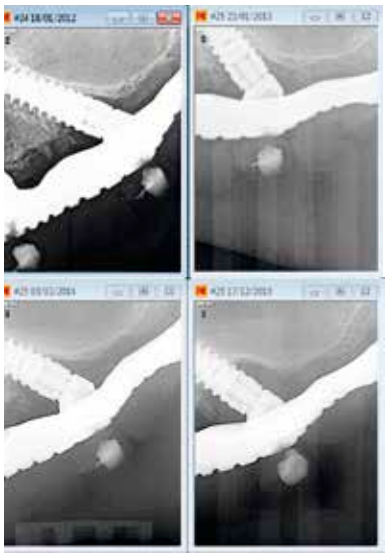

FIGURE 6
Bone remodelling is to be expected round healthy implants and is not necessarily due to biofilm mediated pathology

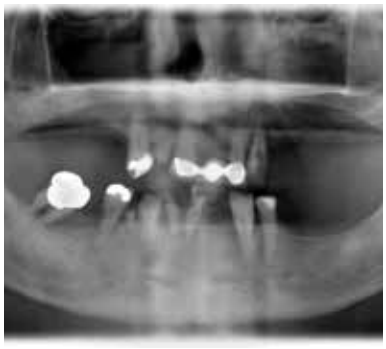

FIGURE 7
Are periodontitis patients more susceptible to periimplantitis

FIGURE 8
Perfectly healthy implant with more than 4mm pocket depth and BoP

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on the presence of any BoP and PPDs deeper than 4 mm, which in combination with any radiographic bone loss, would indicate disease. In reviewing the literature, it is evident that BoP may be detected in more than 90 per cent of well-functioning dental implants [17]. Likewise, PPDs over 4 mm are frequent round healthy implants (Figure 8). The depth of the peri-implant pocket is not immediately pathological; it is, of course, dependant on the thickness of the mucosa and how deep the implant was placed.

As discussed earlier, literally all implants will show some bone loss over time as a result of many other factors than simply the "catch all" of biofilm-mediated resorption. A recent review of the literature, where studies on the use of periodontal probes to diagnose peri-implant health have been used, [17] concluded that:

1. Probing pocket depth values of >4 mm at dental implants cannot be seen as a sign of pathology or an alarming signal regarding the conditions of the peri-implant tissues.

2. An increase of probing pocket depth values over time is not necessarily associated with loss of supporting bone around dental implants. Therefore, probing does not appear to be a reliable tool for the assessment of peri-implant marginal soft- and hard-tissue conditions.

3. From a biomaterials science point of view, osseointegration is a foreign-body reaction. As a consequence, bleeding on probing does not always indicate the presence of acute inflammation in the peri-implant mucosa, but may rather reflect the nature of the scar tissue–implant interface. Therefore, bleeding on probing does not appear to be a predictor for future loss of tissue support. Similarly, absence of bleeding on probing does not appear to be a predictor of future stability. Hence, probing pocket depth and bleeding on probing cannot be considered to be reliable tools for monitoring peri-implant health and disease.

4. Radiographic evaluation of crestal bone levels over time seems to be the most reliable tool to identify those implants undergoing continuous bone loss and therefore in need of treatment.

5. A single episode of bone loss does not necessarily call for treatment unless associated with clear signs of inflammation, such as profuse bleeding/suppuration and discomfort at pressure/palpation.

Conclusion

This first of a two-part paper has been written to address the possibility that using periodontal indices to monitor dental implant health may not only be unnecessary but in many circumstances may result in patients receiving treatment that they don't need.

In part two, we will look at proposed guidelines for routine follow up of dental implants and how true peri-implantitis lesions may be managed.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To draw attention to the questionable use of periodontal indices to monitor dental implants
- To explained why periodontal probing may not be justified
- To explain why there is contention within the profession regarding monitoring of implants
- To draw attention to the potential for overdiagnosis and overtreatment.

LEARNING OUTCOMES:

- To understand that most implants will bleed on probing
- To understand that pocket depth is not an accurate measure of treatment needs
- To understand that bacterial biofilm induced bone loss is only one of many causes of bone loss round implants.

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NON-INVASIVE FACIAL AESTHETICS

AESTHETICS

A demonstration of the effectiveness of the Forma device for non-invasive skin tightening. The second part of this article will look at a case treatment step by step at the Scottish Centre for Excellence in Aesthetics

ANDREW NELSON, DAVID BEYNET AND GARY LASK

As we age, our collagen and elastic tissues degrade, resulting in excess, loose skin; this is often one of the first signs of facial ageing. As a result, surgical rhytidectomy (facelifts) remains a common surgical procedure to help reverse this ageing process, with 133,320 facelift procedures performed in 2013, the most recent year for which data is available from the American Society of Plastic Surgeons [1]. While facelifts remain an extremely effective method to reduce static rhytids, there has been a dramatic paradigm shift toward non-surgical skin tightening and rejuvenation techniques, as patients seek to achieve skin tightening with no or minimal downtime procedures.

In 2013, 293,388 non-surgical skin tightening procedures and 456,613 photo-rejuvenation procedures were performed, a much higher volume than traditional surgical facelifts, according to the American Society for Aesthetic Plastic Surgery [2].

While many technologies including infrared lasers, intense pulsed light devices, and resurfacing lasers have been utilised to heat the deep dermis, thereby resulting in skin tightening, the results have typically been modest [3-5]. Recently, intense focused ultrasound has been proposed as a potential option for skin tightening; however, these treatments are associated with pain and downtime [6]. An ideal skin tightening treatment would be efficacious, pain free, require no anaesthesia, and result in no downtime.

Radiofrequency (RF) technology represents a potentially promising option for non-invasive skin tightening to achieve these ideals. RF devices utilise electrical conductance, in the form of rapidly alternating electrical current (various frequencies can be utilised, but they are typically greater than 1,000,000 cycles per second), to cause oscillation of cellular structures that are in the electrical path, thereby increasing intermolecular motion. As the current flows alternatively, molecular collisions increase, thereby creating thermal energy (heat). Thus, RF technology utilises the impedance (resistance) of tissue to generate heat rather than directly transferring heat.

Historically, the majority of RF devices were monopolar devices; however, these initial devices had relatively limited efficacy in skin tightening and could be associated with pain, burns, or other adverse effects [7,8]. More recently, bipolar RF devices, incorporating both positive and negative electrodes, have been developed with potentially greater efficacy and an improved safety profile due to the creation of a closed electrical circuit. The depth to which the current penetrates is a function of the distance between the positive and negative electrodes; greater distance between the bipolar terminals results in greater depth of energy penetration.

The controlled heat exposure from bipolar RF devices can be directed to the dermis of the tissue, causing controlled dermal heating of collagen, while sparing the epidermis. As the dermis is heated, the triple helical shape of collagen is broken due to disruption of the intramolecular heat-labile bonds connecting the helices, while the heat-stable intermolecular bonds are unaffected. These effects allow the triple helix to unravel and shorten, resulting in tighter, more compact collagen [9].

Ultimately, dermal heating results in collagen stimulation and neocollagenesis [10]. The heating of collagen can be modelled by the principles of the Arrhenius equation, indicating that the reaction rate of heating collagen is dependent both on time and temperature [11,12]. If high dermal temperatures are achieved, low exposure times are necessary. At a temperature of 85°C, an exposure

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This is an abridged version of an article that first appeared in the *Journal of Cosmetic and Laser Therapy*.

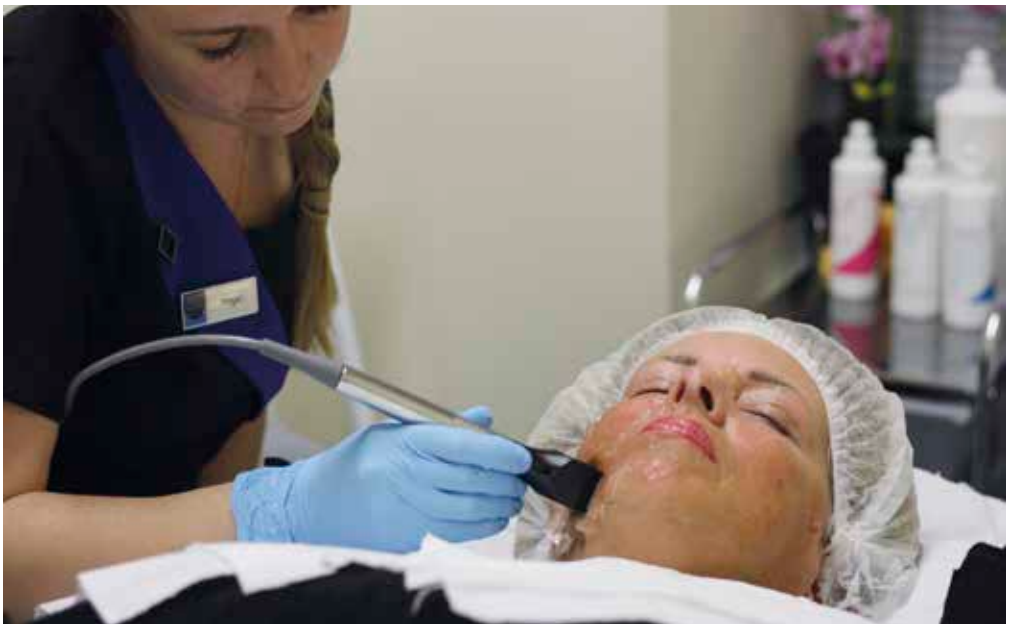

FIGURE 1
The Forma device in use

time of ~1 ms is enough to induce structural changes to collagen [13].

Historically, static (or stamping) RF devices utilised relatively higher peak temperatures with low exposure times; however, high peak temperatures also increase the risk of burns and other adverse events. Alternatively, according to the Arrhenius equation, lower peak temperatures could be utilised to reduce the risk of side effects, but this would require longer exposure periods in order to effectively remodel collagen. As an example, at a temperature of 43°C, an exposure time ranging from ~90 seconds to 5 minutes is necessary to induce collagen remodelling. Recently, novel dynamic (or moving) RF devices have been developed, which utilise lower peak temperatures with longer exposure times; these devices require that the handpiece is moved across the skin surface during the treatment to sustain the dermal matrix at an elevated temperature.

Historically, RF devices had difficulty in uniformly achieving and maintaining these constant temperatures for several minutes to effectively remodel collagen, thereby limiting the effectiveness of these dynamic RF devices [14].

Equipment

Forma (InMode Inc, Richmond Hill, ON, Canada, North America) is an FDA-approved, bipolar, noninvasive RF device that generates controlled dermal heating. The device incorporates multiple novel technologies to allow for prolonged, controlled dermal heating while limiting the potential for side effects. The device handpiece incorporates two central rows of seven smooth RF-emitting positive electrodes (14 polar) with current flowing from the positive electrodes to the two negative side electrode bars (Figure 2). The RF current travels to a maximum depth of half the distance between the electrodes and is thus confined to the dermis, creating a uniform dermal heating pattern (Figure 3).

The device also allows the treating physician to determine and set the optimal dermal temperatures (in Celsius) to be maintained throughout the treatment, as well as the energy delivered via the handpiece (in millijoules). In order to achieve and maintain this temperature, the device handpiece incorporates several sensors, including high and low impedance sensors, a contact sensor, and an epidermal thermal sensor. The device measures skin temperature, impedance, and epidermal contact 10 times per second allowing for real-time feedback.

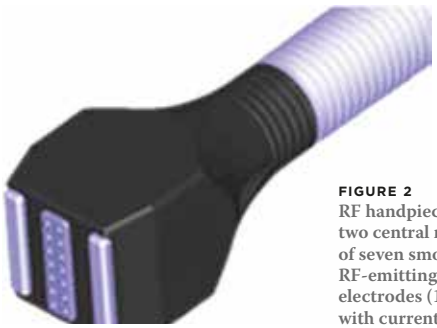

FIGURE 2
RF handpiece with two central rows of seven smooth RF-emitting positive electrodes (14 polar) with current flowing from the positive electrodes to the two negative side electrodes.

When the treatment area reaches the predetermined temperature, or if the tissue impedance drops quickly or contact is broken, the device immediately, automatically, and temporarily terminates the delivery of RF energy to this area. Once the temperature of this treatment area drops to 0.1°C below the set target temperature, or as the physician moves the treatment applicator over a new area, which has not yet reached the predetermined temperature, the device automatically reactivates the RF energy. This real-time immediate feedback allows for the physician to achieve, control, and extend the thermal treatment while limiting the potential for adverse effects. As a result, the physician is able to safely, comfortably, and effectively achieve uniform heating of large treatment areas (Figure 4), while minimising pain and the potential for burns or other adverse effects.

Discussion

Non-invasive skin tightening represents a rapidly emerging

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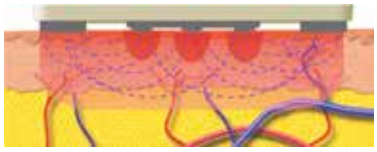
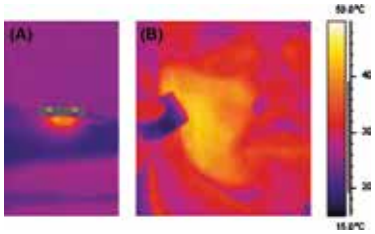
FIGURE 3
Representation of alternating current flowing between the positive (central) electrodes and negative (side) return plates



area in cosmetics, as patients increasingly seek to avoid facelifts and other invasive procedures. Non-ablative heating of the dermis and subcutaneous tissue offers the potential for skin tightening and rhytid reduction with minimal pain, downtime, and low risk of scars or other adverse events. Multiple non-invasive technologies including intense pulsed light, lasers, RF, and ultrasound have been studied as therapeutic options; however, the clinical efficacy of these modalities has been limited and difficult to reproduce on a consistent basis. Additionally, several devices, such as focused ultrasound, have been associated with significant pain and/or downtime.

FIGURE 4
In vivo thermal view showing the initial application of Forma handpiece (A) and following treatment, a uniform heat distribution at 43°C across an entire right cheek (B).



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The bipolar RF device mentioned in this article is a novel, safe, and effective technology for inducing skin tightening. In a study, of 14 patients conducted by the authors [1] [5], all treated patients were determined to have an effective treatment resulting in skin tightening and rhytid reduction following a series of four to six-weekly RF treatments; over 70 per cent of treated patients were observed to have a moderate or significant clinical improvement. This represents an extremely high response rate, as well as significant level of improvement not seen with previous RF and other non-invasive skin-tightening technologies.

This RF device offers several advantages over currently available technologies, which likely explains this high level of clinical efficacy. The Forma device utilises real-time temperature-monitoring mechanisms, assessed by measuring tissue impedance, temperature, and epidermal contact throughout the treatment. This allows the device to continuously monitor the targeted tissue, and adjust the delivery of the RF energy to create a uniform heating exposure. The device is also able to maintain this constant uniform heating exposure for prolonged periods over relatively large treatment areas, such as an entire unilateral cheek. This uniform, long exposure is likely more effective at inducing collagen remodelling and neocollagenesis. Additionally, since the thermal exposure can be extended and prolonged, lower temperatures that do not induce any pain can be utilised.

Rather than applying high, painful temperatures for seconds, this device allows for controlled, comfortable dermal heating to be maintained for several minutes to induce collagen tightening and remodelling. The use of lower temperatures over a longer exposure period allows for the treatment to be pain free with no downtime. In contrast to many other devices, when using the device under investigation, none of the subjects in our study required any anaesthesia, including topical, and none required stopping the treatment or reducing the treatment parameters. Thus, this device represents a safe and effective non-invasive option for facial skin tightening.

Our study, of course, has its limitations. Face tightening, particularly of the lower face, is difficult to assess with quantifiable measures. There are no fixed anatomic structures that lend themselves well to measurement on the lower face to determine lift or tightening effects. As a result, we utilised randomised photographic comparisons in this study, similar to other peer-reviewed skin tightening clinical studies. In the future, perhaps it will be possible to develop and validate more objective measures for lower face tightening and rhytid reduction. This study was also conducted in a single centre, with a female study population; this may impact the generalisability of the data to larger, more diverse populations. Finally, the long-term impact of the treatments on skin tightening over the course of years is not yet known.

More info

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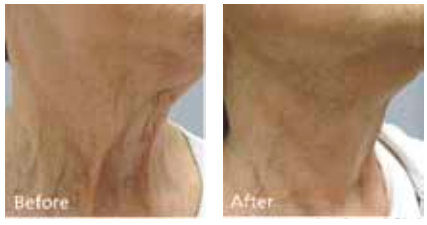

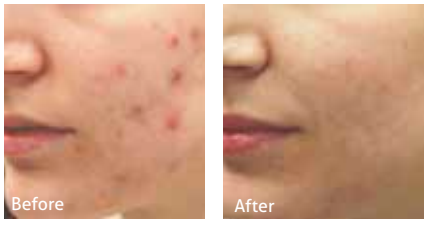

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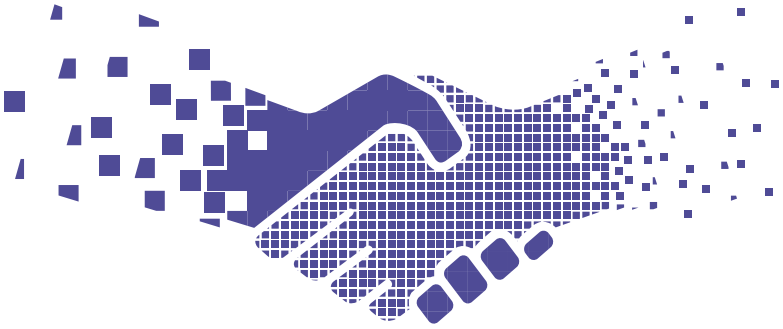

BUILDING RAPPORT

THE MOST IMPORTANT COMMUNICATION SKILLS THAT WILL HELP YOU CREATE LIFELONG RELATIONSHIPS WITH BOTH YOUR STAFF AND PATIENTS

ASHLEY LATTER

I am going to go through the most important skill that you can possess. In fact, if you have this skill in your make-up, you will be welcome anywhere in the world. The key skill here is the ability to build rapport with people. If you can build rapport with your patients, colleagues and suppliers, then people are more likely to listen to you, take on board your suggestions and, most importantly, trust you. Without rapport, then the rest of the sales process will just not happen.

I have learned over thousands of appointments and interactions in my life that people always buy people first, before anything else. Have you ever tried to buy anything off anyone you don't like or trust? It's not easy.

All our successes in life, and you will have your own definition of success, are created by interaction with other people. We cannot persuade people if you have little or no rapport with them.

My definition of rapport building is when you have a mutual understanding and trust. You are on the same wavelength, in-sync with the person you are speaking to. Let me share with you a story from one of my clients who recently took one of my "Ethical Sales & Communication Skills Programmes". There are many lessons to be taken from this story.

One of my clients is a dentist called Simon who has a practice in the south of England. He takes the importance of rapport building to another level. He received an enquiry from a potential patient one evening, who was asking about implant treatment. Simon responded to the patient more or less straight away. When we have discussed this on my courses, some of my delegates have stated that it sounded like a state of desperation. But, I thought that, in this day and age, the fact that Simon responded immediately was pretty impressive. The patient got in touch the next day, and after several emails, an appointment was made for the following week.

The night before his new appointment, Simon did his research about the patient by going online, and he soon discovered his patient was a professional speaker and had many videos on YouTube, which Simon subsequently watched. The next morning, after a morning huddle with the rest of his team, something that Simon and his team did every morning to plan the day, he welcomed the patient. He instantly built rapport with him, asked questions about his job as a speaker and a genuine bond was built between the two of them. He complimented the patient on the quality of his YouTube videos and, as Simon was just starting out on his own speaking career speaking at local dental meetings, with a view to growing his referring practice, common ground was discovered.

After further questions to identify the patient's problems, and after a thorough examination a large treatment plan was agreed between Simon and the patient, and a new relationship was formed. Subsequently, the same patient has come back for more treatment and he has also recommended other patients to Simon's practice. The natural conclusion was a win-win for both parties.

The lessons you can take away from this story are:

1. If you receive a new enquiry, act quickly, because speed is important. We live in an age of instant communication, and I honestly believe people are becoming more impatient, so act straight away. If the

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"WITHOUT TRUST, THERE IS NO RAPPORT, WITHOUT RAPPORT, NO TRANSACTION CAN TAKE PLACE"

FROM PREVIOUS PAGE>

enquiry comes in by email, but the patient leaves a telephone number, why not call the potential patient and engage in rapport building? You can invite the patient in for an appointment. Nothing beats a good conversation.

2. There is no excuse now not to do your preparation. Years ago, there was only the local library for resources; now there are many such as going online, doing a Google search and using Facebook and LinkedIn. You can learn so much about a new person in seconds, at the push of a button.

3. I am a massive fan of group huddles in the morning before the patients walk through the door. Sometimes, if the receptionist has done a good job at the initial call, they can then share with the rest of the team important information about the new patients who are coming into the practice that day. On our reception programme, we encourage the reception team to complete a new enquiry sheet and these are treated like gold dust. The reception team has to communicate all the information in a group huddle in the morning.

4. By spending time building genuine rapport, trust was built. Without trust, there is no rapport, without rapport, no transaction can take place. When you build rapport and you find common ground with your patients, amazing things happen afterwards. The key lesson here is to become genuinely interested in your patients, and they will become genuinely interested in what you have got to offer. Remember one thing: patients don't care how much you know until you demonstrate how much you care about them.

I always suggest, if you can, to find two chairs, or maybe construct a consulting room, and to have a conversation, with your patient before you put them on the dental chair. It might be a scary experience for a patient to go to the dentist and having a two-way conversation puts the patient at ease and makes them feel important. If you haven't got two chairs and your surgery space does not allow it, then perhaps you can put the patient on the dental chair in an upright position and you can bring your chair round facing the patient. It shows that you are genuinely interested and, most importantly, it will put the patient at ease. Remember, sometimes patients are nervous and apprehensive about going to the dentist – this process puts them at ease.

Over a lifetime, a single patient is worth thousands of pounds to your practice and this relationship needs to be nourished on an on-going basis. I have learnt in my lifetime never to take my clients for granted. If you have excellent relationships with your patients, then you are more likely to get referrals from them. I usually find that if some of these patients are nice and value what you do, then you are more likely to get people of similar characteristics. Nice people know nice people, they can help grow your practice and ensure it flourishes forever. Just imagine receiving one patient referral from each patient, is it possible? Yes it is, but they will only do it if you have amazing rapport with your patients.

I recently spoke to a client who told me that they had now decided to collect their patients from the reception and take them to the surgery and then escort them back to the desk after each appointment. They even got the reception team to ring through to the nurse to inform her what the patient was wearing, so that when she went to collect the patient, the dentist could go straight to the patient and use their name. That really is going the extra mile.

ABOUT THE AUTHORS

Since 1997, Ashley has personally trained and coached more than 10,500 dentists on his two-day "Ethical Sales & Communication Skills Programme", in 13 countries worldwide helping them to develop world-class communication skills, so that they can deliver the dentistry they love to do and patients want, all in an ethical way. He has personally delivered more than 24,000 hours of business coaching to the dental profession and has written hundreds of articles on this subject which can be found on his learning zone at www.ashleylatter.com Ashley will also be presenting at the Scottish Dental Show at Braehead Arena in Glasgow on 19 and 20 May 2017.

BREXIT GUIDANCE FOR INVESTORS

WHILE EXPERTS ARE ADVISING A "WAIT AND SEE" APPROACH IN THE WAKE OF THE SUMMER'S EU REFERENDUM, THERE ARE SOME THINGS TO LOOK OUT FOR IN THE SHORT TERM

IAN FINCH

The announcement of the result of the UK's EU Referendum on Friday 24 June came as a shock to many people at home and abroad. Within hours David Cameron had announced his resignation. The pound fell to its lowest level against the dollar for more than 30 years. Stock markets around the world lost ground on the news.

The UK was stripped of its triple A credit rating and Nicola Sturgeon announced that a second independence referendum in Scotland was highly likely. Scotland's First Minister has since announced at the SNP's Conference in Glasgow that she will publish a new Referendum Bill for Scotland.

Whether it will be a 'Hard-Brexit', or a 'Soft-Brexit', or a 'Norwegian-Brexit', or even a 'Canadian-style-Brexit', remains to be seen. We got a few brief insights into what Prime Minister, Theresa May and her team of Brexit ministers are considering at the recent Conservative Party conference. But we're likely to find out a lot more about the UK Governments stance, and the position they will take, in November's Autumn Statement.

Theresa May told the Conservative conference that the UK will aim to begin formal negotiations to leave the EU by the end of March 2017.

DATES FOR YOUR DIARY

The new Chancellor, Philip Hammond, will deliver his Autumn Statement on 23 November and he has made it clear that many austerity measures will be relaxed to stimulate the economy. He has already talked about a "fiscal reset" and the target of clearing the deficit by 2020, set by his predecessor George Osborne, has already been dropped.

It is expected that the UK Government will use fiscal policy tools to protect the economy from a Brexit-related downturn. A significant investment in infrastructure projects designed to boost domestic growth is widely expected. Following quickly on Mr Hammond's heels, Derek Mackay, the Scottish finance secretary, will announce his first Scottish Budget on 15 December.

In a change to the usual timing of the Scottish Budget, Mr Mackay announced that, due to the uncertainty around Brexit and what the UK Government intends to announce, he has decided to delay the publication of the Scottish Budget until after the Autumn Statement. So, it could very well turn out to be a busy three weeks of policy making at SNP HQ.

GUIDANCE FOR INVESTORS

From a consumer perspective, there is some good news around. Incomes are rising and employment is at an all-time high. House prices have yet to fall far from their pre-referendum levels.

While stocks and shares initially fell sharply on the news, both the FTSE 100 and FTSE 250 have recovered ground. The fall in the value of the pound is good news for exporters as their products become cheaper for foreign buyers; the devaluation acting as an enticing discount.

The Bank of England's Monetary Policy Committee has already introduced a rate cut to 0.25 per cent and has indicated that further stimulus measures could continue to be applied if necessary to steady the economy. Many commentators have concluded that, so far, the impact has been rather less pronounced than many had predicted. There will no doubt continue to be good and bad economic news in the coming months as events unfold.

In the short term, it's widely accepted that there will be shocks in currency, shares and property markets ahead. But for now, there is no reason to panic, and every reason to adopt a "wait and see" stance.

All eyes will now be on the Autumn Statement on 23 November and the Scottish Budget on 15 December. We will publish highlights of both statements and their implications for our clients on www.maco.co.uk and www.mafsltd.co.uk

This article is intended to provide a general review of certain topics and its purpose is to inform but NOT recommend or support any specific investment or course of action. It is important to take professional advice before making any decision relating to your personal finances. Martin Aitken Financial Services Limited is authorised and regulated by the Financial Conduct Authority.

ABOUT THE AUTHOR
Ian Finch is a director at Martin Aitken Financial Services. To contact Ian, email if@maco.co.uk

Market value versus security value

VALUATIONS OF HEALTHCARE BUSINESSES IS A SPECIALIST FIELD AND REQUIRES AN ACCREDITED VALUER WITH A PROVEN TRACK RECORD

GEORGE NISBET

You will no doubt have heard of cases where a sale has been agreed but has not completed because the purchaser was unable to secure loan funding and the reason given is that the valuation did not come up to expectation.

Prospective vendors and purchasers should therefore be aware that an agreed sale price will not necessarily be supported by a valuer instructed by a lender. There are several reasons why this could happen, but the overriding issue is that market value does not necessarily accord with a security value.

When instructing valuers, lenders require several valuations reflecting differing circumstances of sale, and often reflect a restricted marketing period. A lack of accounts in extreme cases would assume the practice has ceased to operate. Critically, a security valuation will reflect a business or property that is being sold in distress or under compulsion.

One of the principal tenets of market value is a willing seller, whereas a security valuation reflects an unwilling seller, which changes completely the dynamics of the valuation exercise. Every lender will seek confirmation that an agreed purchase price is a fair reflection of the market value of that practice. However, lenders also require additional valuations that reflect the circumstances of sale they could be faced with in the event that they had to compel a sale.

Therefore, potential sellers and buyers should recognise that until such time as any required valuation has been undertaken they should not assume that a deal will be concluded. This should avoid much of the stress, inconvenience and heartache that often results when an agreed deal does not complete for this reason.

Different lenders have differing valuation requirements with differing valuation definitions that reflect different sales dynamics. The valuation of healthcare businesses and property is recognised as a particularly specialist field, with only a handful of valuers in Scotland who are recognised by lenders for such valuations. It is important that any prospective purchasers make sure that they engage a suitably experienced, recognised and accredited valuer if and when considering a purchase.

ABOUT THE AUTHOR
George Nisbet FRICS is a consultant with DM Hall LLP. To contact George, email george.nisbet@dmhall.co.uk and to find out more about ASDP, visit www.asdp.org.uk

Don't sleepwalk into practice ownership

IAN MAIN EXPLAINS THAT BEING YOUR OWN BOSS ISN'T FOR EVERYONE, BUT IF YOU ARE CONSIDERING TAKING THE PLUNGE, YOU NEED THE RIGHT ADVICE

We continue to see high activity levels in the Scottish dental market for practice acquisitions and it's clear that demand still outstrips supply. Goodwill prices are continuing an upwards trend (for the right practices) and multiple bidders are common.

With the corresponding downward trend on associate fee share percentages it's understandable that the ambitious associate may consider practice purchase options. It's also seen as a natural career path for dental professionals and the peer pressure expectations can exist to encourage you to 'take the plunge'.

This said, practice ownership is categorically not right for everyone so don't 'sleepwalk' into this and regret your decision once you understand the additional stresses and strains of ownership which sometimes go unnoticed by the team. The added responsibilities of employment law, practice management, finance, and operations can be underestimated and can prove to be a huge challenge, particularly if this is your first practice.

That said, if you are well equipped/supported to undertake the transition, it can be a hugely rewarding journey for you both personally and financially. With full strategic control over your future and the opportunity to 'be your own boss' and grow capital value this remains attractive. To paraphrase the words of the business guru Michael Gerber: "Just be careful you don't end up working for a madman/woman (i.e. you)."

We regularly assist with the planning and due diligence for potential practice owners and are currently involved in six live transactions at time of writing. As such, we are well placed to help you structure and decide if a practice opportunity is right for you and to help you identify the risks. If you are thinking about buying a practice in Scotland, please get in touch and we will be delighted to offer you a free opinion on the target practice.

We look forward to making a difference together.

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Ray Ross, Edinburgh

"The service has been fantastic and you truly provided a hand holding service throughout. A must for anyone selling to a Corporate."

Adelle McElrath, Kilmarnock

CONTACT US TO DISCUSS THE SALE OF YOUR PRACTICE

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*PFM Dental have registered "Priority Buyers" who will pay the agency fee in addition to their offer on behalf of our clients. All payments are sent to our client's solicitor and fees are charged as normal

IS THE ANNUITY DEAD?

JON DRYSDALE EXPLAINS WHY SWAPPING YOUR PENSION FOR AN ANNUITY MAY NOT BE SUCH A GOOD IDEA

When the NHS was founded in 1948, the life expectancy for men retiring at 60 was 66, and for women, 71. Those figures are now 82 and 85 respectively, which is why legislation in 2015 forced public sector pension schemes to link their retirement age to State Pension age.

WHAT ARE ANNUITIES?

An annuity is an income for life and you can buy this with your pension fund at retirement. However, if you are approaching your personal pension retirement age (often set at 55, 60 or 65) an annuity may not be the best option. In past years, pension rules compelled you to swap your fund for an annuity. Now you can take income from your pension any time from age 55.

ANNUITIES RATES ARE FALLING

When you buy an annuity you give up your pension fund in exchange for a fixed (or increasing) income. If you live longer than average, you gain. Die sooner and you lose out. As life expectancy continues to increase, annuity companies compensate for having to pay incomes for longer by lowering the rate they pay. Building in guarantees (in the event of premature death) might offer some reassurance against the gamble but further reduces the initial rate you get. Likewise, adding inflation protection reduces your annuity rate. Annuity rates are also affected by government bond (gilt) yields as these are the financial instruments that providers use to support your annuity.

ANNUITIES CAN'T BE PASSED TO THE NEXT GENERATION

A pension can be left to the next generation (by nominating beneficiaries) usually free of inheritance tax. Once annuity income starts, you lose this option.

ANNUITIES DON'T OFFER LIFETIME ALLOWANCE FLEXIBILITY

Taking annuity income will trigger an HMRC Lifetime Allowance test. Personal pensions allow this test to be deferred until age 75 or triggered when you choose. You may wish to do this if your overall pension values (including NHS) are approaching £1m. As an example, an annual NHS pension of £43,000 taken at age 60 will use up the £1m allowance. Subsequently triggering an annuity could result in a charge of 25 per cent plus income tax. There are ways of managing this through a phased withdrawal of tax-free cash or income, only achievable by leaving your pension invested.

Expanding life expectancy, low interest rates and falling gilt yields have contributed to a steady decline in annuity rates

"IF YOU LIVE LONGER THAN AVERAGE, YOU GAIN. DIE SOONER AND YOU LOSE OUT"

ANNUITIES ATTRACT INCOME TAX

Annuity income is subject to income tax. Withdrawal from pensions (known as drawdown) can be tailored to suit your income tax position. For example, you can defer drawing income until your self-employed income has reduced. Drawdown can facilitate a phased withdrawal of tax-free cash whereas annuities cannot. Funds that aren't required remain invested. This may enable your pension to grow further and supply a greater income in later years or allow for a fund to be passed to the next generation.

WHAT ABOUT ANNUITY GUARANTEES?

Many pensions and usually those pre-2000, offer guaranteed annuity rates. The merits of these are varied and you should always check with your pension provider or your adviser what conditions apply to the guarantees. While a guaranteed rate might be in excess of prevailing market annuity rates, this doesn't mean it is the most suitable option.

Careful consideration should be given to the alternative income options that pensions offer before committing to an inflexible gamble on life expectancy. The value of the guarantee requires careful assessment and advice is recommended.

In summary, an annuity is the fixed lifetime income that you exchange your pension fund for when you retire. Expanding life expectancy, low interest rates and falling gilt yields have contributed to a steady decline in annuity rates. I recommend you seek advice on technical issues, such as the Lifetime Allowance, or where you need to consider the value of a guaranteed annuity rate.

MORE INFORMATION

Jon Drysdale is an independent financial adviser for chartered financial planners, PFM Dental, which has offices in Edinburgh and York. Go to www.pfmdental.co.uk

Do you know the drill?

AAB'S JILL WALKER DISCUSSES THE IMPACT OF BUDGET CHANGES FOR LIMITED COMPANIES

JILL WALKER

Trading through a limited company is not a new concept – it is widely used in the dental profession. The latest Budget, however, set out a number of tax changes for companies and it is important to be aware of these where you are either already trading as a company or are considering doing so.

Before considering incorporation, you need to weigh up the changes in entitlements to certain NHS benefits as these may no longer be available when you operate through a company. As such the impact of any potential loss on these entitlements needs to be considered.

The most widely publicised change was to the tax rate on dividends. Shareholders can no longer draw tax-free dividends up to the value of around £42,000; instead, a much lower annual tax-free dividend allowance of £5,000 has been introduced. In addition, the tax rate on dividends has increased by 7.5 per cent compared with rates in force previously.

However, it is still more tax efficient to draw a dividend than remunerate yourself via a salary or self-employment since income tax rates on these sources continue to be higher than the dividend rate.

A company also gives you the flexibility of being taxable only on the remuneration paid to you, rather than your entire profit, whether you draw this from the business or not.

The reduction in the rate of capital gains tax to 20 per cent has also meant the tax cost of recognising goodwill on incorporation is less, giving more flexibility for profit extraction planning once the company is in place.

Finally, the rate of corporation tax is set to fall to 19 per cent in April 2017 and then 17 per cent by 2020, increasing the potential saving when compared to income tax rates of 40 per cent and 45 per cent for higher and additional rate taxpayers.

Incorporation continues to provide savings, in the right circumstances, and although there will be winners and losers as a result of the recent changes, it is still worthwhile exploring the benefits with the support of a professional advisor.

MORE INFO
Jill Walker is a tax senior manager within AAB's Private Client Department.

Things to know when selling your dental practice

PAUL GRAHAM

Valuation in the dental sector has historically been based on 'pence in the pound', i.e. a simple multiple of turnover. However, in an increasingly sophisticated sector, the EBITDA (profits) method is more often being used to drive dental practice sales, particularly in the higher value ranges.

Crucially this is also the method adopted by the banks when they consider lending, so if you are selling your practice and an independent valuation is undertaken, this is how it will be valued to show the bank that the practice can pay back the loan.

WHAT IS EBITDA?

EBITDA is an acronym for earnings before interest, tax, depreciation and amortisation. Basically, it is the profit a practice makes before non-cash and non-operational costs are charged to the profit and loss account.

Non-operational costs typically include: depreciation and amortisation, loan interest, one-off capital improvements and wages paid to family members who are non-core to the practice.

Other adjustments could be: excess motor costs, one-off repair costs and improvement costs.

A competent valuer will adopt 'fair maintainable' levels of income and cost to arrive at a sustainable EBITDA. An 'all risk' multiple will then be applied to arrive at capital value.

WHAT SHOULD A PROFESSIONAL VALUER AND BANK NOT DO?

It is important to ensure that valuers do not arbitrarily reduce or omit costs to artificially boost profit. Also, future income derived from hypothetical changes to the business cannot really be counted as they represent the buyer's potential rather than current value.

WHAT DO BUYERS LOOK FOR WHEN APPRAISING A DENTAL PRACTICE PURCHASE?

The best way to prepare for a sale is to put yourself in the buyer's shoes and look at your practice from their point of view. This will mean thinking about: quality of location and patient demand, history and reputation, mix of income – NHS and private, growth potential through reduction of 'white space' and a reasonable cost base with sensible terms for associates and non-clinical staff.

It is always a good idea to seek advice before considering a sale so you can prepare your practice for a valuation in the best way possible.

MORE INFO

Paul Graham, associate director at Christie & Co has more than 10 years' experience in business sales. He specialises in the dental sector in which Christie & Co has sold and advised on more than £200 million of dental projects in the last 12 months.

A polished performance

DUNDEE DENTISTS FOLLOW THEIR SHARED DREAM TO SET UP THEIR IDEAL PRACTICE, WITH A LITTLE HELP FROM EQ ACCOUNTANTS

Setting up a business is a huge step for anyone. But when you're doing so while holding down full-time posts elsewhere and with limited knowledge of legalities or finance, that step is a little bit more daunting.

However, what has driven Patricia Barry-Murphy and Duncan Graham of Dundee throughout their journey is a shared dream, a passion for providing the very best dental care within a comfortable and welcoming environment.

Partners at work and at home, the couple's vision extended beyond the provision of everyday dental care, building on their significant postgraduate training. They dreamt of creating a spa, a place where patients would want to spend time, to transform their looks and their health, with treatments ranging from cosmetic smile makeovers, teeth whitening and teeth straightening to replacing missing teeth and facial rejuvenation treatments.

And so Vita Dental Spa in Monifeith, by Dundee, was born (after its own transformation of course, carried out during the couple's precious evenings and any other spare time).

Patricia said: "The previous owner was eager to complete a sale as soon as possible and, after falling for the location almost instantly, we had contacted a bank and solicitor to proceed within a matter of days – time really was of the essence."

This crucial stage in proceedings also marked the start of the couple's business relationship with EQ Chartered Accountants in Dundee.

Patricia continued: "Our relationship with EQ began a week after we discovered that the former practice was up for sale. We now consider them, and especially Louise Grant, a key part of the Vita team. Putting the compliance matters aside, including invaluable help with the business plan and projected accounts, EQ go way beyond the call of duty and are always at the end of the phone for advice and guidance.

"I always knew what I wanted to achieve but didn't know how to achieve it. Louise was instrumental both then and now in making our dreams and aspirations a reality. Indeed, Duncan and I intend to expand our business portfolio, possibly beyond dental circles. EQ have given us the confidence to move forwards, and plan for that."

(L-R) Duncan Graham, Louise Grant, Patricia Barry-Murphy

Having welcomed its first patients in October 2013, Vita Dental Spa now employs a team of seven, including three dentists.

MORE INFO
For more information, visit www.vitadentalspa.co.uk or log onto www.eqaccountants.co.uk

ARCS SCOTLAND

New College Lanarkshire

ADVANCED RESTORATIVE COURSE SCOTLAND

SCOTTISH DENTAL COURSES 2017

YOUR COURSE YOUR FUTURE

COURSE CONTENT & TOPICS COVERED

The aim of this comprehensive modular course is to enhance and develop the knowledge and skills of each clinician, above and beyond their current practicing techniques in:

- Functional Occlusion in General Practice
- Minimal intervention
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- Anterior/Posterior Direct and Indirect Composites
- Smile Design
- Photography
- Diagnostics and Lab Communication
- Fundamentals of Aesthetics
- Treatment Planning
- Crown/Bridge & Veneer Preps
- Implant Planning, Restoring & Maintenance

Dr Bob McLelland

65 Hours
Verifiable CPD

For more information please visit www.optident.co.uk

THE COURSE AT A GLANCE

Module	Date	Venue	Title
Module 1	27th & 28th January	Cricklewood Hotel & Bothwell Dental Practice	Functional Occlusion in General Practice
Module 2	24th & 25th February	New College, Lanarkshire	The Art of Composite - anterior / posterior, direct / indirect
Module 3	31st March & 1st April	New College, Lanarkshire	Smile Design - The Works
Module 4	28th & 29th April	New College, Lanarkshire	Advanced treatment planning/TMJ & preparations
Module 5	2nd & 3rd June	Cricklewood Hotel & Bothwell Dental Practice	Implants in General Practice - restoring & maintaining

BOOK NOW

THIS COURSE IS LIMITED TO 12 PLACES, SO AN EARLY BOOKING IS RECOMMENDED.

Contact: 01698 854048 **info@bothwelldentalcare.co.uk**

Total Cost - £4250.00 (Eligible for post-grad funding)

In association with BOTHWELL DENTAL CARE

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A course deposit of £250.00 is needed to secure your booking. Finance option available.

Cancellation Policy

Please confirm in writing, fourteen days prior to the course. After this period, additional costs will be incurred. Bothwell Dental Care reserve the right to cancel and/or reschedule the course should unforeseen circumstances arise. Please note the minimum number of delegates the course will run with is 8. In this case the course will be cancelled and the booking and payment can be refunded or transferred.

PROFESSIONAL ADVANCEMENT

BOTHWELL GDP AND RESTORATIVE COURSE FOUNDER RAYMOND MURPHY DESCRIBES WHAT THE FIRST INTAKE MADE OF THE TRAINING PROGRAMME

It was a beautiful, sunny Friday morning (too good to be working) when our eager delegates met up for module one of the much anticipated Advanced Restorative Course Scotland (ARCS) 2016. After the obligatory teas, coffees and introductions, Bob McLelland set about demystifying the dark art of occlusion in a well-structured way which made it enjoyable and easy to understand.

By lunchtime we were well clued up on occlusal acronyms and made a lateral excursion to the lingual bar for lunch. After an enjoyable lunchtime spent discussing our ICP, RCP, CO and CRs, we headed to the surgery for an afternoon of getting to know more about facebows, articulators and romancing each others condyles – a sort of speed-dating session on occlusion! This continued into day two and led one of our delegates to comment "what an excellent eye (and jaw) opening experience these two days have been".

Three weeks later it was off to our venue for modules two, three and four at New Lanarkshire College. The superb, 21st century facilities allowed our delegates to spend the mornings in interactive tutorials and the afternoons carry out the operative techniques in the state-of-the-art phantom-head room with its fantastic audiovisual facilities. Module two on adhesive dentistry got wonderful feedback and one dentist said he had learned "amazing new techniques for composite restorations" despite being in practice for many years.

The much-awaited smile design module introduced techniques for facial and smile analysis followed by the dentists trying out new veneer preparation, temporisation and cementation techniques to improve the aesthetic and functional outcome of their cosmetic dentistry. One delegate said they would "completely change their approach to any cosmetic restoration" and remarked on the "lively discussions" that had taken place throughout the two days.

In module four, Bob pulled together all the previous learning in a treatment planning session which will give confidence when tackling more challenging cases. After our TMJ/splint session we broke into pairs where we got a bit more intimate and examined each other's TMJs (pictured) and palpated the muscles of mastication before adjusting the Michigan splints on three of the unsuspecting delegates. Thankfully no premature contacts took place.

The final practical session covered preparations for inlay, onlay and crown and bridgework using traditional and all ceramic materials. One feedback form said this was "the best session so far".

Over the five restorative sessions the group has grown and interacted using our WhatsApp group to communicate and discuss cases between sessions. With delegates ranging in age from their 20s to 50s, it shows you are never too old or young to learn new clinical skills and have a more rewarding life in practice. Already the ARCS dentists are using the course knowledge to take on more challenging and remunerative dentistry which they would previously have avoided or referred out with their practice. They know that their patients will benefit from more predictable dentistry and they will gain the professional satisfaction of delivering it.

All that remains is to thank Bob for delivering the course and the delegates for participating and making it such a great learning experience for all involved. And finally, I look forward to working with a new eager group of dentists on the ARCS 2017 course.

NEW TO SCOTLAND AND IRELAND

ENDOSSEOUS LTD HAS RECENTLY BEEN AWARDED THE SOLE DISTRIBUTION RIGHTS FOR BEGO IMPLANTOLOGY WITHIN SCOTLAND AND IRELAND

Endosseous directors Alexander Adair and Colin Hogg are thrilled to be teaming up with one of the oldest and most well-respected dental companies within both Germany and throughout the globe.

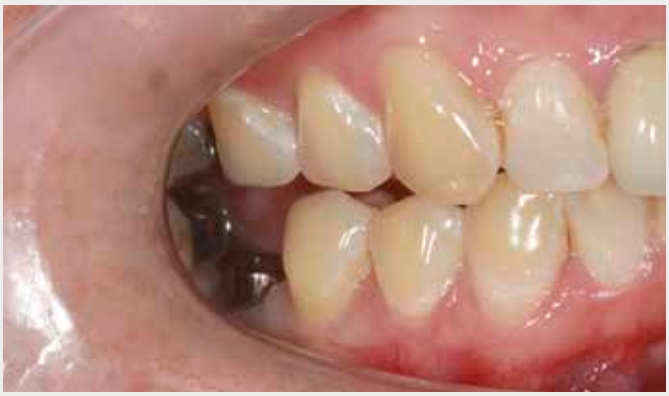
In 2016, Bego celebrated its 125th anniversary. Its motto, 'Partners in Progress' is a philosophy integral to the entire ethos of Endosseous Ltd.

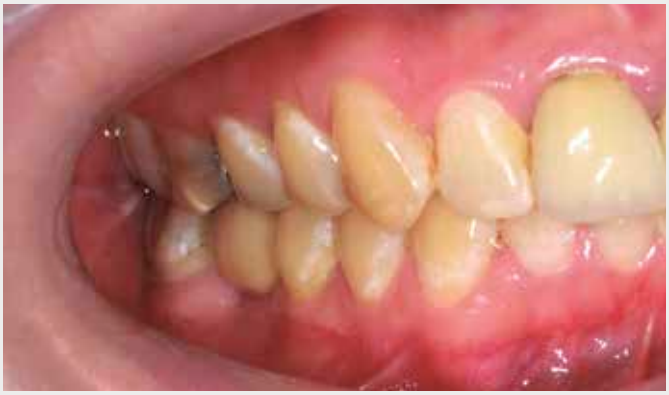
Alex said: "We formed in May 2016 and are drawing on a wealth of experience. Our intention is for Endosseous Ltd to lead the way within the UK dental implant market by combining our experience with renowned German expertise. Between us, we have more than 50 years of involvement with dental implants – myself within the technical aspect of the business for more than 30 years, and Colin within the commercial side for 20 years.

"Our motivation is to offer clinicians excellent value while delivering a comprehensive and well-researched implant system. There has been a paradigm shift within our industry. More and more dental professionals are seeking solutions which (a) work and (b) are cost effective, without compromising patient outcome. To prove that it can be achieved, and in a first for our industry, Bego will guarantee not only their components but the prosthetic work as well.

"We know that every implant practice has different needs and wants. We are uniquely positioned to support our clients to deliver solutions which please both themselves and their patients. Our customers are our business and not just a number on a computer system."

Within its portfolio, Endosseous has several implants for different indications:





(BEFORE & AFTER) One of the very first Bego implant cases, picture courtesy of R Murphy. Lab work by Vitality Dental

S-LINE IMPLANTS

A parallel-sided implant for all bone qualities. Standard V-shape self-tapping threads provide good stability. The reducing thread depth around the neck is achieved by expanding the core diameter, while maintaining the outer diameter to reduce stress and maintain marginal bone. This is in addition to the moderately roughened surface and an implant interface, which more than matches the strength of similar implants. The interface consists of a deep internal hex, along with an internal 45° cone, which provides resistance to horizontal forces and maintains the integrity of the micro-gap.

RS(X) IMPLANT

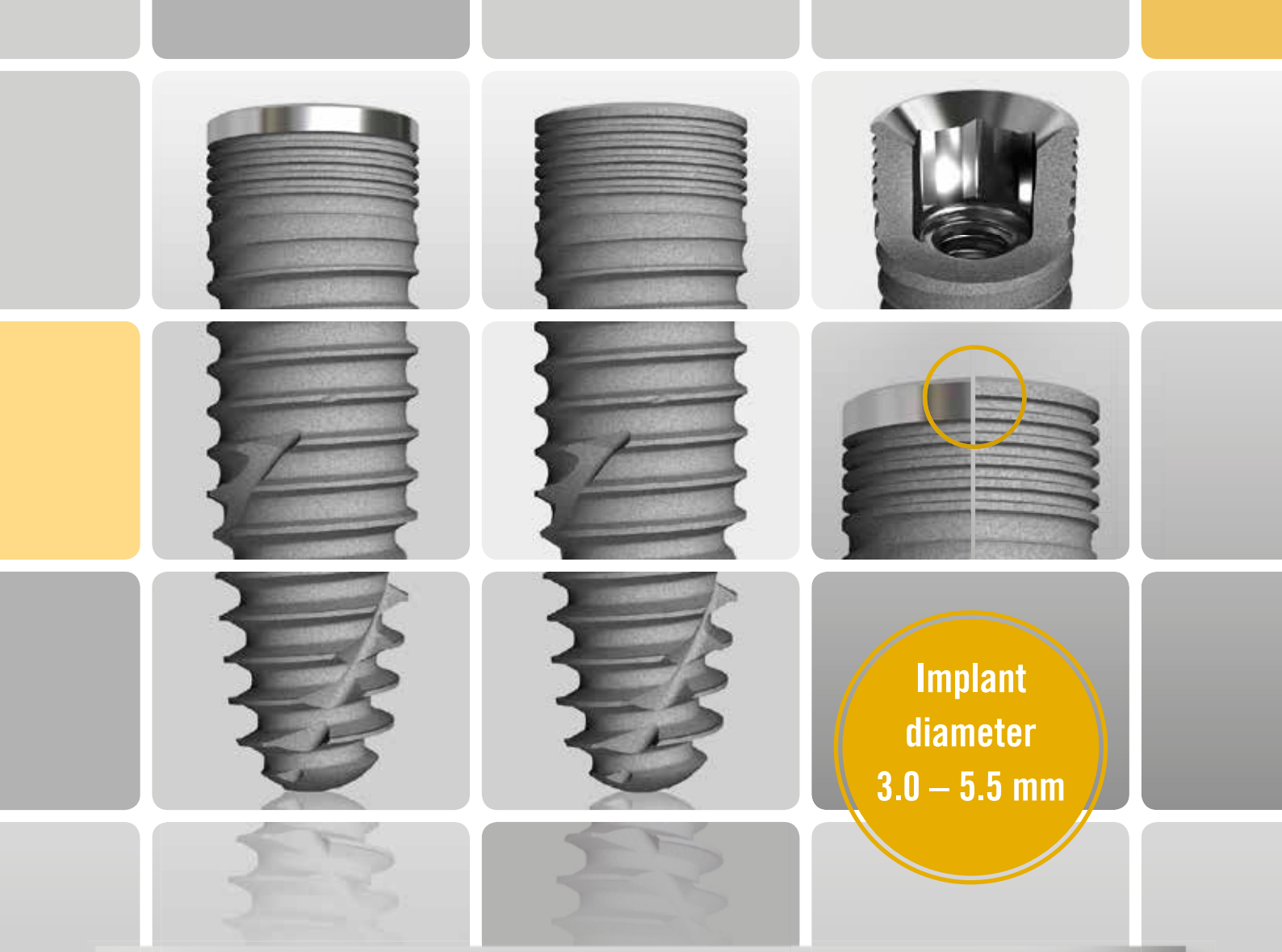
The implants in the RS/RSX-Line display a conical implant body. The implant body is equipped with a self-tapping, bionic thread. The bionic thread reduces the mechanical loading on the implant body and is advantageous for the surrounding bone. The implant-abutment connection was designed employing the tried-and-tested principle of the 45° cone. The 45° cone allows biomechanically advantageous transmission of forces from the abutment to the implant. At the same time, no micro-gap appears when subjected to physiological loading. The RS/RSX implants feature platform switching of 0.25 mm. The platform switching reduces the loading peaks in the bone along the bone margin.

MINI-LINE

Ideally designed for the edentulous jaw, narrow ridges with pronounced resorption and the small anterior gaps, the Semados Mini-Line enables implant solutions that might have been overlooked for more traditional treatment. The Semados Mini-Line provides an economical and swift restoration.

MORE INFORMATION

To complement the implant range, Endosseous offer the complete range of prosthetic solutions from convention cast on abutments, stock abutments to CAD milled abutments and bar frameworks, and we also a comprehensive range of regeneration products.



Self-tapping, conical, modern, bionic

BEGO SEMADOS®
RS/RSX Implants

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CALL TRISHA

A TRUSTED ADVISOR, WELL-VERSED IN THE WAYS OF PRACTICE SALES AND ACQUISITIONS, PATRICIA MUNRO IS SOMEONE YOU WANT IN YOUR CORNER

When you are looking to buy a practice or move on and sell up, you want someone in your corner who you can trust and who you know will get you the best deal on the best practice for you.

For Patricia Munro, hers is a relationship business. She has spent 30 years in the dental industry in Scotland and in that time she has built up not just an enviable reputation, but a formidable network of contacts. Buying and selling practices is just as much about the hopes and aspirations of the people involved as much as it is about bricks and mortar and money.

So, when dentists in Scotland are looking to get on the practice property ladder for the first time, to expand from one to two premises or to wind down their career and pass on their established practice to a pair of trusted hands, there is usually only one piece of advice given.

Gareth McMorrow, principal dentist Landsowne Dental in Glasgow, explains why he decided to get in touch with Patricia Munro in the first place: "I once asked an experienced dental colleague, who I respected and trusted, what he thought the first step should be when buying a dental practice. He answered without hesitation: 'Call Trisha.'"

"For anyone who doesn't already know, Patricia Munro provides a service to dentists who want to buy or sell a dental practice. She has been in the dental business for more than 40 years and is the expert in the dental market. Whether you are a young associate or an experienced practice owner, Trisha is the go-to person for dental practice acquisitions and sales. She has built up a highly regarded reputation over many years of not only being successful at finding people the right practice, but doing so with discretion and confidentiality.

"My business partner Paul McAllister and I have utilised Trisha's services to buy both of our practices. Buying your first practice can be a daunting experience, Trisha's guidance and expertise made the process for us manageable and smooth. When buying your second practice, you have the experience, but not necessarily the time, and again, Trisha stepped in and took the strain.

"She not only knows the dental market inside out, but her experience and advice is invaluable. From the very first meeting, Trisha listened to the vision we had for our future and what style of dentistry we wanted to practice. Her experience, knowledge and trust made the whole process much smoother and enjoyable. I couldn't even imagine buying a practice without Trisha on my team.

"Buying any dental practice takes at least a few months and during that time you can be sure of one thing – there will be hiccups along the way with solicitors and accountants etc. Most problems are small and unintentional but with Trisha on your side and her vast experience (she has seen all these problems before and often has a sixth sense on how things are progressing), problems don't escalate and you can move forward with confidence and little disruption to your day. One of most useful aspects of Trisha's service in my opinion is that she acts for both the seller and buyer; this means that she can quickly and effectively communicate with both parties and keep the whole buying or selling process on track and on time and all parties agreeable.

"I genuinely can't recommend Trisha and her Strictly Confidental business highly enough, and having been through the process twice already, I can call Trisha a friend to have a lunch with to bounce ideas off or just put the world to rights. And that says it all."

MORE INFORMATION

To find out more about Strictly Confidental, call 0141 641 3963, 07906 135 033 or visit www.strictlyconfidental.co.uk

Landsdowne Dental Care takes referrals for implants placed by visiting specialist consultant Sachin Jauhar, to contact the practice, call 0141 334 1313.

ACCESSIBLE SURGERY

ARE YOU CONSIDERING ADDING SINUS LIFTS TO YOUR IMPLANT TREATMENT PORTFOLIO?

For several years, implant dentists have been negotiating the sinus floor and looking for solutions to insufficient residual bone height. These solutions have ranged from horizontally placed coaxial implants, short implants and surgically moving the sinus membrane and utilising bone grafting to increase bone height. The DASK kit was released in 2009 and as such has become the equipment of choice for this procedure for many implant dentists.

Maxillary sinus floor elevation by means of a lateral window was first described by Tatum at an implant conference in Alabama in 1976 and subsequently published by Boyne in 1980. The transcrestal sinus floor elevation was first described by Summers 1994, hence the term "Summers lift".

The Dentium Advanced Sinus Kit (DASK), a series of specifically-designed surgical drills and curettes, was developed to make the process of membrane elevation, quicker and safer. The DASK can be used for crestal as well as lateral approaches. Hydraulic pressure from sterile saline and drill pump raises the membrane to allow the bone of the sinus floor to be breached and to keep the membrane intact.

As with all equipment, it is important that the clinician is knowledgeable about its use, indications and limitations, and to this end additional training is advised.

Utilisation of the DASK means there is much reduced risk of membrane perforation when preparing a lateral window. Lateral window SFEs are much quicker than other conventional methods.

Safe elevation of the sinus membrane over a greater area during crestal SFEs gives more controlled and predictable elevation of the membrane. This is

CONTINUED OVERLEAF>

After Ø3.8 final drilling, eliminate the residual bone (1mm) using the DASK Drill #1 or #2 (in hard bone) until you feel a slight drop

Detach sinus membrane using the dome-shape sinus curette

Detaching the sinus membrane to create adequate space for graft material

Fill the sinus cavity with OSTEON Lifting graft material

Fill and distribute OSTEON graft material evenly throughout the achieved space

Placement of implant into the osteotomy

TESTIMONIALS

"The DASK is the most important tool for the restoration of the posterior maxilla, and the last thing I can do without. I have not torn a single lateral window since starting using the DASK" – **Peter Fairbairn**

"The DASK sinus kit is unreal! After a giant leap of faith this kit does exactly what it says on the box." – **Nigel Saynor**

"A really important development." – **Paul Stone**

"Very impressive." – **Michael Norton**

"It's so quick and easy. It's allowed me to do sinus lifts for patients who otherwise wouldn't have been able to stand the procedure." – **Lidia Ferritto**

DASK™ Sinus Lift Course is coming to Glasgow

with Kevin Bruce GDC 70499

£1375 +VAT per delegate

4th February 2017 at Bothwell Dental Care, Glasgow

7 hours verifiable CPD - 7 hours verifiable CPD - 7 hours verifiable CPD

Suitable for all experienced implant dentists, this course aims to increase an implant dentists understanding of the skills required to perform a sinus lift and demonstrate the correct use of the DASK system.

At the end of this course we would expect an experienced implant dentist to be able to safely undertake a sinus lift procedure using the DASK kit.

Kevin Bruce, BDS Glasg FDS RCS Eng

Kevin has worked and trained in the hospital based dental speciality of Oral and Maxillofacial Surgery. In addition to his years of hospital surgical training, he has undertaken extensive postgraduate training throughout Europe and the USA in implant dentistry and its associated procedures. He mentors and lectures dentists and ancillary staff from all over the UK in the field of implant dentistry at the Dentale teaching clinics.

Course includes a FREE DASK Kit

Completing a sinus lift is a delicate process. DASK creates a lateral window quickly and safely which should all but eliminate perforations. The concept is beautifully simple utilising hydraulic pressure and can be used for a crestal or lateral approach.

"The Dask is the most important tool for the restoration of the posterior maxilla, and the last thing I can do without. I have not torn a single lateral window since starting using the Dask. Superb." Peter Fairbairn

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FROM PREVIOUS PAGE>

facilitated with the hand curettes included in the kit, which have been specifically developed to allow access.

The reduced risk of perforation allows for greater height gain with bone grafting. The kit allows more cases to be treated by a transcrestal technique thereby avoiding morbidity of a lateral window SFE. No hammering is required, giving a negligible risk of benign paroxysmal positional vertigo.

When used in a lateral approach, irrigated burs remove the buccal window of bone and keep the sinus membrane intact by using hydraulic pressure from the sterile saline and drill pump to keep the membrane clear of the rough surface of the drill.

Clinical observations suggest that the procedure can reduce the possibility of perforation of the maxillary sinus membrane during the lateral and crestal approaches to the grafting of the maxillary sinus floor.

For the lateral approach to the maxillary sinus, a dome-shaped drill (6mm in diameter by 4mm in height) is used to prepare the lateral wall of the maxillary sinus.

The drill uses internal and external irrigation for cooling at a speed of 800-1200rpm (see Figure 1). Bone thinning is accomplished with light pressure and rotating strokes under copious irrigation on the lateral aspect of the sinus wall to gradually eliminate the bony thickness until reaching the maxillary sinus.

ONGOING SUPPORT

Established in 2007, Dentale has trained more than 400 implant professionals. With three locations across the UK and phantom head provision, Dentale has extended its course portfolio to include one day courses for implant dentists, laboratory technicians and their teams. Featuring minimally invasive implant dentistry, guided surgery, accelerated implants, suture courses, grafting and abutment selection. Dentale has also recently started their roadshow courses bringing Dentale to other areas of the country.

The classic week-long introduction course involving hands-on is still popular. Each delegate places an implant on a patient at the end of the week providing the entry level into the 10-day advanced course.

This course takes place over several months and culminates in provision of an implant evidence portfolio which can be used to complement further training qualifications. With all patients provided, Dentale is able to allow the delegate to follow their patient's treatment journey. This course has been recognised among the profession, for almost a decade, as being able to offer a comprehensive quality hands-on approach.

DASK™

MORE INFORMATION

Clinical videos are available at www.implantium.co.uk

Dentale training clinics are able to offer a sinus lift course that discusses sinus anatomy, treatment planning, case selection, radiographic assessment, patient suitability, classification of tears, complications, pricing and costs.

The hands-on course also features using the DASK kit on pigs heads and a live patient demonstration. This course is coming to Glasgow in February with course tutor Kevin Bruce.

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Tatum. O.H., Maxillary and sinus implant reconstruction. Dent Clin North Am. (1986)
Boyne. P., Grafting of the maxillary sinus floor with autogenuous marrow and bone. J Oral Max Fac Surg (1980)
Summers RB, Compendium 15 1994. (J Prosthet Dent 2011;105:147-153)

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MORE INFORMATION
Find out more about Professional Mortgages at scottishbs.co.uk or call our qualified mortgage advisers on 0345 600 4085.

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SCOTTISH BUILDING SOCIETY

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Best Guarantor/Assisted Mortgage Lender

HANDS-ON IMPLANT NURSE TRAINING

BEARSDEN REFERRAL PRACTICE LAUNCHES NEW COURSE IN DENTAL IMPLANT NURSING

Dentists in Scotland who are keen to place dental implants in their practice have a number of courses available to them right on their doorstep. What has been lacking north of the border, however, is a practical course for the nurses who will be assisting chairside, in what is clearly a highly skilled field of dentistry.

To fulfil this need, Susie Anderson-Sharkey has developed the Scottish Dental Nurses Implant Training Course, a one-day course for nurses who are currently assisting their dentist in placing implants, or those who are interested in doing so.

Susie has been the practice manager at Dental fx, an implant referral dental practice lead by Dr Stephen Jacobs, since 2006. She has 25 years' experience in the dental industry as well as holding a qualification in training and education, so is well equipped to have developed this course, which carries seven hours of verifiable CPD. The course covers areas such as asepsis, gowning and draping, surgery preparation, components and concludes with live surgery performed by Dr Stephen Jacobs at his Bearsden Practice.

Susie Anderson-Sharkey

The course is being presented by Dr Jacobs' nurses, Jackie, Lisa and Jenna, who have all been individually trained by Dr Jacobs to an exceedingly high standard and they are excited to have the opportunity to pass on their knowledge and experience to other implant nurses. The course has a large "hands-on" element and promises to be a lively, informative day.

The course is being run on Friday 3 and Friday 17 February. It is limited to eight delegates per course to enable each nurse to have plenty of practical experience. The fee is £195, which includes lunch and all refreshments.

MORE INFORMATION
For more information or to book a place on the course, please contact Susie on 07901 727 277 or email susie@dentalfx.co.uk

TO ERR IS HUMAN

THE SPECIALIST TEAM FROM BLACKHILLS CLINIC RECOGNISE THAT NOBODY IS IMMUNE FROM MAKING MISTAKES. JUST TRY TO REMEMBER TO STOP DIGGING IF YOU FIND YOURSELF IN A HOLE

The phrases "Everyone makes mistakes" and "Nobody's perfect" epitomise the very essence of humanity – unless perhaps you are the dental regulator...

At Blackhills Specialist Dental Clinic we strongly believe that almost no one (especially a dental colleague) goes to work to cause harm. But in the complex world of modern dentistry things occasionally do go wrong, and we can all have a bad day at the office. This can clearly be very upsetting for the patient, but also adds greatly to the stress of daily practice life.

So, the advice here is that, if you find yourself in such a hole (especially one you can't even see out of), STOP DIGGING. Explain the situation and get some help.

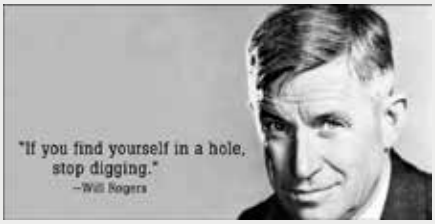
The specialist team at Blackhills Clinic often receives referrals from colleagues where problems have occurred, but they usually find that patients are grateful for the honesty and insight shown by their dentist and are happy to be seen for specialist treatment. This means that problems can be resolved, anxiety eased and the chance of medico-legal action reduced.

All the adult dental specialities are represented at the clinic: restorative, endodontics, periodontics, oral surgery, prosthodontics and maxillofacial radiology. The team also has very many years of experience in all aspects of implant dentistry along with several thousand successful cases.

We all want the best for our patients and this is even more important when things don't go well. The specialists – as well as the rest of the staff – at Blackhills Clinic are friendly, approachable and will actively support dental colleagues to help address difficult situations. But, it is always helpful if a referral is made sooner rather than later. Don't forget that they also welcome referrals where things haven't gone wrong!

Share the care with a specialist.

MORE INFORMATION
To start working with Blackhills Clinic, visit www.blackhillsclinic.com and click "refer your patient"



FORWARD-THINKING PRACTICE MANAGEMENT

SYSTEMS FOR DENTISTS ARE AT THE FOREFRONT OF THE DIGITAL EVOLUTION IN NHS DENTAL CLAIMS IN SCOTLAND

For many dentists throughout Scotland, emerging advances in practice management system design will soon be available to further support the future changing needs of NHS claims management.

These new changes, which are set to revolutionise claims management in Scotland, will be welcome news for many.

The exciting new scheme, known as eDental, will be launched in a controlled and phased manor as a direct response to NHS Scotland's forward-thinking drive to modernise the payment and approval processes for NHS dental claims in Scotland.

Not only will eDental provide a real opportunity to deliver a range of improvements around clinical decision making, it is set to lead the way for improvements in patient and practitioner experience, risk management, operational efficiency and financial governance.

Add to this the many benefits of the new system outlined by Practitioner Services on its website, and it's no surprise that eDental will be a welcome change when it becomes available in the near future.

Currently, Systems for Dentists, a leading supplier of Dental Software in Scotland, is working closely with Practitioner Services to gain accreditation through the fit-for-purpose testing process.

And while other software suppliers will also follow suit, the team of forward-looking developers at Systems for Dentists is working towards being the first partner to release its eDental solution to NHS dental practices in Scotland.

This news follows the announcement earlier in 2016, when Systems for Dentists was also the first dental practice management software supplier to release its electronic version of the GP17pr form, having been a very early adopter to seek approval from the NHS.

And speaking about the work under way on the eDental platform in Scotland, Ryszard Jurowski, managing director of Systems for Dentists, said: "The emerging eDental will be a revolutionary new processing system allowing NHS dental practices to better manage their claims.

When fully implemented, the electronic prior approval process will not only speed up the process of prior approvals but also enable our clients to be truly paperless.

"The team at NHS Scotland have been tireless in their desire to modernise the payment and approval process. We have been delighted to work closely with them on this exciting project which stands to ensure our clients can take advantage of the significant benefits this solution offers, as early as possible."

In addition to working closely with the main dental software suppliers in Scotland, Practitioner Services has also designed a new web form. For practices that do not have a full practice management solution, the web form will allow for electronic claims over the SWAN (formally N3) connection.

In time, it is likely that NHS Scotland will require all claims to be made electronically, this is certainly an understandable approach, as more than 90 per cent of all general dental claims are now made electronically, ensuring accuracy and far more forgiving on the environment. When this time comes, Scotland will once again be leading the way in the UK.

The free web form solution from Practitioner Services is not intended to replace a fully-fledged dental software, but is a good start for any practice new to technology.

Dental software suppliers have all self-funded their development of the new interface with the eDental system, though NHS Scotland has invested heavily in the development of both the back-end solution and an adaptor to ensure the process is as simple as possible.

In response to the significant investment made by Systems for Dentists for their own connection to the eDental platform, Mr Jurowski continued: "We have always valued our Scottish clients. Our services are designed to offer outstanding service, value and improve efficiencies. It would be unimaginable for us to ignore such a fantastic opportunity to improve the working lives of all our clients in Scotland."

MORE INFORMATION

To find out more about Systems for Dentists, visit www.sfd.co or call 0845 643 2828.

For more information about eDental, visit www.psd.scot.nhs.uk/professionals/dental/edental.html

Excellence driven by innovation

GLASGOW CENTRE CONTINUES TO INVEST IN NEW TECHNOLOGY TO PROVIDE THE VERY BEST PATIENT CARE

Scottish Centre for Excellence in Dentistry has never let the grass grow under its feet and, with the recent purchase of two new pieces of equipment to enhance the services it provides to referring dentists and their patients, the investment and growth continues.

Impression Free Dentistry – this is a great step forward for patients who have problems with gagging reflex and gagging/impression phobia. The TRIOS intraoral scanning equipment is quick, sleek, more efficient and provides impression-free 3D images directly through to the laboratory. A full arch takes only 30 seconds. This equipment can be used on all patients referred into the centre.

Navident Guided Surgery – this state-of-the-art computerised technology completely enhances the skills of the implant surgeons at the clinic, and in turn gives great benefits to patients. Scottish Centre for Excellence in Dentistry is the first clinic in Scotland to have this equipment and will become a training centre for other clinicians to gain the skills to use the equipment. The 3D image of patients' anatomy is used to guide clinicians during surgery – this may lead to smaller incisions, less blood loss, less post-operative pain and decreased recovery time.

Courses – there is one complimentary update seminar left to run this year in November on endodontics. Please contact secretary@scottishdentistry.com if you wish to attend. Please look out for dates for courses and seminars for 2017 on the website (scottishdentistry.com).

The dental team would like to take this opportunity to thank everyone who has used the services of the centre during 2016, it is very much appreciated. 2017 is already shaping up to be an exciting year so, watch this space.

A COMPLETE PRACTICE SERVICE

WOODSHIRES DISCUSS RESEARCH AND DEVELOPMENT TAX CREDITS AND WHAT IT COULD MEAN FOR YOU AND YOUR PRACTICE

MediEstates works in conjunction with a number of dental specialists in all aspects of business to provide a complete service to its clients. This includes dental accountants, solicitors, software providers, business consultants and tax consultants.

Woodshires is a team of specialist consultants in tax and funding for businesses and business owners.

R&D TAX CREDITS – WHAT ARE THEY?

Research and development (R&D) for businesses can be attributed to many activities. However, to put it simply, if your business has been or is developing or adapting a new or existing idea, system or product, then the time and costs incurred could qualify for the R&D tax credit.

COULD DENTAL BUSINESSES CLAIM THE TAX CREDIT?

To be eligible to claim, a business has to be a UK limited company with at least one employee with a tax and NI liability. Partnerships and individuals are not eligible.

To qualify, the business has to have reported 'Research and Development' activity. This is where it gets interesting as most business owners and professional support services do not understand where R&D activity is within a business. This is because nine times out of 10 it is just what they do in their day-to-day activities, but do not see it as anything other than their daily work.

To explain this complex relief as simply as possible, R&D is where a business is solving an uncertainty and cannot solve that problem by buying an existing and readily available solution. The items a business cannot claim for are the written word, image, or method. If you are adapting or creating an individual product or combining multiple products together to solve a problem (even if you are paying another party to do it for you) then an element, if not all of the time and costs incurred, are eligible. Products and software developments are the most common areas looked at.

WHAT IS THIS TAX CREDIT WORTH?

R&D tax credit gives an additional uplift of up to 130 per cent of all relevant costs. This is to offset against your companies tax position and can create a cash refund (even for a loss-making business).

The average refund is in excess of £50,000, and does not affect the profit-and-loss position of your business as this allowance is against tax.

HOW IS THIS ALLOWANCE USED?

The tax credit is made available either as a tax deduction based on R&D costs or it may be surrendered for a cash tax credit.

Claims may be made to adjust and recover R&D costs for up to two immediate past accountancy periods.

SURELY MY ACCOUNTANT IS CLAIMING THIS FOR ME?

Accountants will be rightly claiming as much as they can. However, to gain the correct and full additional uplifts, a specialist report has to be written that clearly analyses all of the qualifying activities both in time and costs. Generally this is where an accountant will ask the business owner to complete and write down all qualifying R&D expenditure. However, when a business is unsure where all their R&D is, our specialists complete all relevant information in a format that the HMRC are happy with and most importantly, all of it.

I BELIEVE I MAY QUALIFY, WHAT SHALL I DO NOW?

For more information and to see if your business does qualify, contact Woodshires on 01527 549797. The staff will discuss what your business does and see where they can help.

R&D is a very useful tax relief but is one of 14 Woodshires specialise in, so it is always good to talk and help where we can.

PRACTICE SALES INTELLIGENCE: PRACTICE ONE

Location – Established approximately 20 years ago, this practice was acquired by the current principal in 1999. It is located within a converted residential property with free on-road parking in a large city in the Midlands.

Type of practice – This NHS practice has eight surgeries, one of which is used by a hygienist. The outgoing principal owned the freehold valued at c.£450,000 and was open to options with regards to selling the freehold or leasing the premises to an incoming buyer.

CONTINUED OVERLEAF>

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Financials – The practice holds an NHS contract with a value of £1,350,000 for the provision of 44,000 UDAs representing an excellent UDA rate of £30.68. In addition to the NHS turnover, a small amount of private fee-per-item income is generated by the hygienist.

Buyer appetite – Due to the size and desirability of the practice it was marketed to our premier-tier buyers, with corporate purchasers showing particular interest. A large amount of specialist work was being referred out of the practice and this presented an opportunity for the incoming buyer to provide in-house specialist treatments, thus driving growth through private income.

Reason for sale/incoming purchaser – The outgoing principal was looking for eventual retirement but was happy to continue at the practice for a period of time. As the practice was purchased by a corporate, agreeable associate terms were negotiated with the outgoing principal to ensure the continuity of turnover post-sale. The sale took eight months from marketing to completion.

Price achieved - £2,950,000 inclusive of goodwill, equipment, fixtures and fittings, with the freehold retained by the outgoing principal.

PRACTICE TWO

Practice location – This practice was established more than 80 years ago and is located in a popular town within the home counties. The practice is centrally positioned in the town centre which helps to attract footfall and is easily accessible with a pay and display car-park to the rear.

Type of practice – This expense sharing, mixed practice has three surgeries; one owned by each partner and the third surgery occupied by a shared associate. There is significant potential for an incoming buyer to maximise chair-time and drive income growth. The premises, a converted residential property, are to be transferred on a leasehold basis.

Financials – The annual turnover of £306,000 is made up of £61,000 fee-per-item income and £245,000 NHS income for 10,500 UDAs. The majority of work was being completed by the principal, with the associate contributing 25 per cent of the UDAs.

Buyer appetite – The practice was marketed to our general-tier buyers which generated a good level of interest with 1,170 web views, 719 individuals receiving full sales particulars and 15 prospective purchasers attending viewings.

Reason for sale/incoming purchaser – The current principal was looking to relocate and so wanted a clean break from the practice on completion. This suited the incoming buyer who was purchasing their first practice and looking to work within the outgoing principal's surgery full time.

Price achieved – £490,000 inclusive of goodwill, equipment, fixtures and fittings.

PRACTICE THREE

Practice location – Located in Wales, this traditional practice has been operating since the 1970s, and was purchased by the current principal 20 years ago. The practice is located within a busy town centre and is easily accessible for patients with free parking immediately outside.

Type of practice – This is a two-surgery, mainly NHS practice located within a converted residential terraced property. The premises comprise two floors with plenty of expansion space to add an additional surgery which could be occupied by a new associate or specialist. There is a significant amount of orthodontic work being referred out of the practice, which could be provided on-site from a third surgery if the expansion was carried out. The freehold, valued at £130,000, was included within the sale.

Financials – Turnover is stable year-on-year at £503,000 with 97.5 per cent income generated from a GDS NHS contract for 19,000 UDAs.

Buyer appetite – This practice matched to the buying specs of 437 individuals registered as buyers with MediEstates. Numerous offers were received with the vendor accepting an offer from one of our priority tier buyers.

Reason for sale/incoming purchaser – The vendor was looking to retire and was happy to continue working at the practice post-sale. This suited the incoming buyer who was purchasing as an investment opportunity to increase their small portfolio of dental practices. The transaction took six months from marketing to completion.

Price achieved – £765,000 inclusive of goodwill, equipment, fixtures and fittings, with the freehold of £130,000 in addition.

KEEP 'UP TO DATE' WITH ORAL-B

Oral-B has released the dates for their next series of Up To Date seminars. Each of these popular evening sessions will be comprised of two 45-minute lectures, providing two-and-a-half hours of verifiable CPD.

Prof Nicola West will be exploring clinical strategies to prevent and manage dental erosion. She will unveil the aetiology, susceptibility and impact of erosive toothwear as well as giving advice on preventative management and when to refer.

Dr Phil Ower will be reviewing the aetiology and classification of gingival recession, showing how to manage recession defects for different groups of patients and giving guidance on when it is appropriate to refer patients and what specialist care may be appropriate.

This complimentary CPD accredited evening event is taking place in: Bristol, 21 November, Aztec Hotel; Birmingham, 20 February 2017, St Johns Hotel (Solihull); Leeds, 9 March 2017, Village Hotel (North); Manchester, 27 April 2017, Copthorne Hotel; or Newcastle, 4 May 2017, Hilton Hotel (Gateshead).

Spaces at these events are limited and are allocated on a first come, first served basis. Register online at www.dentalcare.co.uk/uptodateseminars. For enquiries, please email customerservice@dentalcare.co.uk or call 0870 242 1850.

UP TO DATE

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He added: "Initially, I was concerned about moving to electric motor hand pieces, but thanks to the EVO.15's CoolTouch+ heat-arresting technology, my mind is now completely at ease. Even after prolonged use the head does not heat up, which is extremely reassuring.

"Because of its excellent fibre optics and accurate water spray, I have also noticed a significant reduction in my preparation times.

"To begin with, I was only using the Bien Air handpiece for difficult cases and using my turbines for everything else. Eventually the penny dropped, however, and I realised that I could save a lot of time and effort if I used it for all cases.

"As such, I have ordered another one!"

For more information contact Wrights on 0800 668 899 or visit www.wright-cottrell.co.uk

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If you would like to participate in this Trial Programme contact your Oral-B representative.

GET YOUR BLUE ON FOR MOUTH CANCER

The colour blue isn't the only common theme shared between J&S Davis and Mouth Cancer Action Month, we are both strong supporters of raising awareness and funds for mouth cancer.

From putting up posters, to selling blue ribbon badges, every little helps when it comes to making people aware of the signs and symptoms of this deadly illness. Mouth Cancer Action Month relies on the efforts of supporters to raise money to allow the Oral Health Foundation to continue their charitable work, aiming to reduce mouth cancer incidences in the UK.

www.mouthcancer.org

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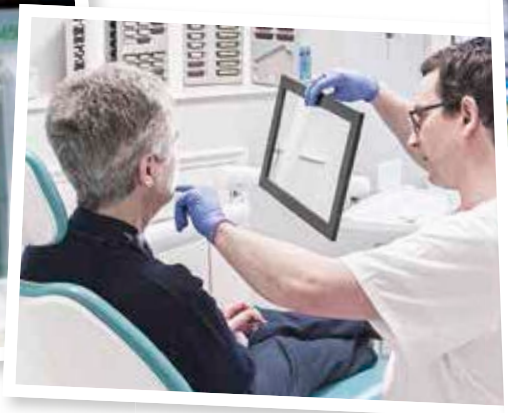

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