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Ireland's policymakers presented with plans for new oral healthcare system

Page 5

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1. Data at Align Technology, as of September 30, 2021

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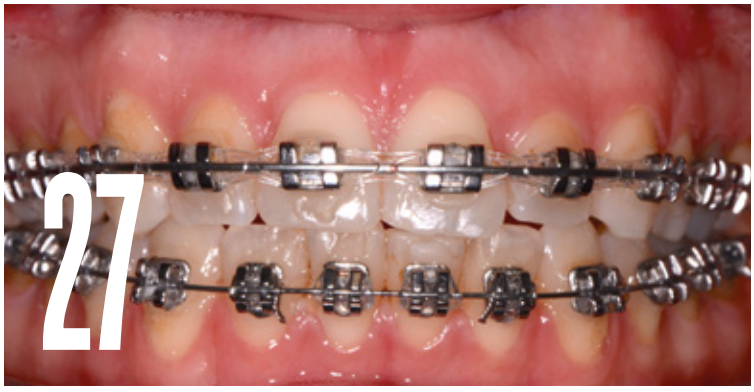

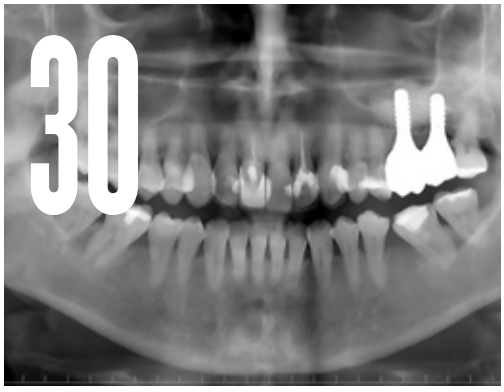

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Get a grip

It's time for politicians and policymakers to confront the crisis in their population's oral health

The chief dental officers of Northern Ireland, Scotland, England, and Wales were scheduled to outline their visions for the future of oral healthcare systems at an event[1] towards the end of March.

It came in the wake of the British Dental Association Northern Ireland publishing its manifesto, Rebuilding and reforming dentistry, ahead of the Stormont elections in May. The manifesto set out policy priorities for the Northern Ireland Executive to deliver, including putting the necessary resources in place to underpin recovery, and parallel development of a new General Dental Services Contract. They also included developing a dental workforce strategy that's fit for the future so that Northern Ireland has the dentists it needs, and an oral health strategy that will both deliver better oral health for all and reduce expenditure on treating disease.

If Scotland and England's experience is anything to go by, then the profession in Northern Ireland should not expect a great deal. In March, the British Dental Association Scotland warned that dental practices would continue to face "grave uncertainty", as the Scottish Government moved to impose an interim funding model for the service "without meaningful negotiation". One positive was the news that an advisory group will be established to consider long-term reform of the sector and the future structure of NHS dentistry in Scotland.

That's more than can be said for England where the testing of new ways of providing NHS dental care – with an increased emphasis on preventing dental disease – has been abandoned. Around 100 practices that were taking part in the Dental Prototype Agreement Scheme were told that from 31 March they would revert to the historic, target-based, model of care.

Under the prototype scheme, dentists had been allocated greater time to assess the oral health needs of patients and provide necessary care.

Only in Wales has the pandemic been seen as an opportunity to accelerate the move towards a more disease prevention orientated model. So, it is without a great deal of optimism that we can await the outcome of whatever deliberations the Northern Ireland politicians and policymakers have on the future of the oral healthcare system.

What of the situation in the Republic of Ireland? In the run-up to the general election in February, the Irish Dental Association campaigned for a new deal for oral health with appropriate funding, the reversal of Government cuts and increasing the provision of public service dentistry, a renewed focus on prevention, better access for patients and increased capacity. The IDA warned that the country's medical card scheme is "near total collapse".

There are now believed to be just 750 dentists treating medical card patients, which is less than half the number of DTSS contracts held by dentists up to two years ago. To put it in context, that is one dentist per 2,000 medical card patients and parts of the country where there is just one dentist covering an entire town or region. An independently commissioned research paper by Ciaran O'Neill, Professor of Health Economics at Queens University Belfast, published earlier this year says a credit or voucher scheme would "remove perversities in the current system and help rebuild relations between the public, providers, and Government." Professor O'Neill said the scheme would provide coverage for commonly required services at levels of reimbursement that reflect the cost of care. In Portugal, a scheme of this type has shown to be associated with improved oral health outcomes.

Welcoming the research paper, Dr Caroline Robins, President-Elect of the Irish Dental Association, said: "Dentists want an entirely new scheme that reflects modern dental practice, one that allows vulnerable groups to access routine dental care in their community." According to the paper, a 'Dental Credit Scheme' would bring the necessary reform to the current practices and fee structure. The annual cost of a scheme offering a voucher or credit towards dental care of €100 to €500 would be € 108m and €232.5m respectively, giving medical card holders access to increased care and treatment that is currently only available to them in emergency circumstances. It really is time for politicians and policymakers in Northern Ireland and the Republic of Ireland to get to grips with the crisis in their respective populations' oral health, engage in meaningful discussion with the profession, embrace new ways of thinking, and support the design of a system that delivers improved oral health care for all in a way that is cost-effective.

[1] *https://community.rcpsg.ac.uk/event/view/top-tips-for-dental-trainees-23-mar-22*

Dr Paul O' Dwyer BDS MSc (Healthcare Mgmt)

MSD: the main reason for early retiral

The average working life of a GDP is 60,000 hours. A lot are spent in tense or distorted positions

As the risk of COVID-19 continues to recede, things are slowly returning to the familiar pre-COVID pattern. Some long-absent patients are returning and practices are getting busier.

Before we all get lost and caught up in the day-to-day running of our practices, some dentists have made the smart move to analyse their workplaces a little more. The pandemic has shone a spotlight on health and safety for us all. Dentists traditionally are very good in responding to patient needs, but tend to be slower to respond to their own needs.

The literature tells us that a prime reason for dentists to retire early from clinical practice is musculoskeletal disorders (MSD). Common examples of workplace risk factors include repetitive, forceful or prolonged exertions of the hand/wrist joint. The level of risk is entirely dependent on the intensity, frequency and duration of these exertions over time. How many of us have found ourselves stretched awkwardly trying to extract that difficult to reach upper molar? Such contortions may be easy at 25 but not so wise when you're 50.

Research findings, coupled with a close look at our work environment, will hopefully lead to better health and more productive clinical time. It is refreshing to see the science of ergonomics coming to the fore in general dental practice in this regard. For those who are unfamiliar with ergonomics, it can be defined as: "...the scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimise human well-being and overall system performance".

Particularly among dental practitioners, lower back pain, upper back pain and neck strain are all leading causes of absenteeism. Improvements in operator chair positioning and construction are helping to turn the tide on some of these ailments. These improvements coupled with instruction at undergraduate level will hopefully see MSDs become a less impactful factor for our working lives.

AS YOU ARE READING THIS COLUMN, PERHAPS A STRETCH BREAK BY THE CHAIR MIGHT START A GOOD HABIT?

While operator position and physical movement come immediately to mind when we think of ergonomics, there are other areas in our surgery work environment that merit closer examination also. Noise, odours and lighting are just some of the other key factors that can influence our wellbeing. How many of us have breathed a deep sigh (of despair?) when the leaking three-in-one drips constantly? Or when the whine of the foot pedal takes that few seconds longer to fade away? Or the flickering light from the bulb that's about to expire? While many of these are instantly remedied, I'm sure we have all worked in surgeries where conditions may have been sub-optimal.

The stresses and strains of clinical work itself cannot be underestimated either. One of the key tenets of general dental practice can be that feeling of isolation. Though we are seeing a distinct move away from one-person surgeries, it can sometimes be intimidating to discuss clinical cases with our colleagues just next door. However, generally the experience when asking for help is a good one. All too often, we can regret not seeking advice or counsel from our more seasoned colleagues.

A recent paper Gupta et al., (2017)[1] discussed six key points for better ergonomics in the dental surgery.

- First and foremost, correct the ergonomic issues in the dental surgery.
- Physical therapists and neuromuscular therapists should be consulted for musculoskeletal disorders.
- Major trigger points should be resolved before any strengthening exercise is attempted.
- Strengthen specific stabilising muscles (like shoulder and back).
- Be patient, but most of all commit to a regular regimen of prevention strategies.
- Chairside stretching is an important strategy to perform throughout the workday to prevent microtrauma and muscle imbalances.

It is estimated that the average working life for a general dental practitioner can be 60,000 hours. A lot of this time can be spent in tense or distorted positions, greatly adding to the risk of MSDs. As you are reading this column now, perhaps a stretch break by the chair might start a good habit?

[1]*Gupta A, Bhat M, Mohammed T, Bansal N, Gupta G. Ergonomics in Dentistry. Int J Clin Pediatr Dent 2014;7(1):30-34*

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Full re-start of ORE announced

A 'vital' step forward for overseas qualified dentists, says regulator

THE GENERAL Dental Council (GDC) announced last month the full re-start of Parts 1 and 2 of the Overseas Registration Exam (ORE), following its suspension in March 2020 because of COVID-19.

The GDC has also published the full 2022 schedule of the Part 1[1] and Part 2 exam[2].

Because the Part 2 exam takes place in a clinical setting, the regulator has previously highlighted that enhanced COVID-19 restrictions over and above those in place for broader society meant resumption of the ORE has not been viable until recently.

A Part 2 exam was successfully run in January this year, but the announcement marks an important milestone in the recovery of international routes to registration.

Gurvinder Soomal, the GDC's Chief Operating Officer, said: "The suspension of the exams due to COVID restrictions – for almost two years – represents a long and frustrating period of uncertainty for candidates.

"I am grateful to GDC colleagues and our exam providers for their hard work in getting us to this point, but we know there are many candidates waiting to sit the ORE. Publishing the schedule and starting to book candidates on exams today are, therefore, vital steps forward in reopening routes for overseas qualified dentists to be able to come and work here in the UK."

Meanwhile, the regulator welcomed the UK Government's proposals to amend the restrictive legislation which governs international routes to registration with the GDC.

One aim of the proposals is to address long-standing capacity issues with ORE which have been exacerbated by COVID.

The proposed changes in law are the first step in removing these issues.

The GDC believes they will ensure a proportionate, clear and robust route to registration for those who have qualified outside the UK.

The Government is consulting on the proposals until Friday, 6 May 2022.

[1]www.gdc-uk.org/registration/overseas-registration-exam/ore-part-1
[2]www.gdc-uk.org/registration/overseas-registration-exam/ore-part-2

Northern Ireland programme launch

THE BDA Northern Ireland Branch programme[1] has been launched and paper copies have been landing with members.

This year's programme of CPD events aims to deliver maximum benefit to dental professionals, with engaging thought-leadership from some inspiring speakers. It began last month with forensic dentistry with Séamus Napier, and continues with:

- Minimally invasive dentistry in paediatrics with Nora O'Murchu and Shaunine Gallagher on 15 March
- 'Mutating microbes – what has the pandemic done to us?' with Wendy Thompson on 12 April
- Tooth auto-transplantation with Laura Cross on 13 September.

As Branch President for 2022, Peter Crooks, writes: "In developing this CPD programme for 2022, I am hoping that we will be encouraged to do something different, perhaps learn a new technique for our clinical practice, look at dentistry with a wider perspective or consider if our skills could be valued further afield." It's not all CPD, however. The BDA Northern Ireland Branch is also planning social events, providing the profession with excellent networking opportunities and peer support. Included in this year's calendar are:

- The Presidential Installation Dinner, date to be confirmed
- Spring Walk at Mountsandel Forest on 7 May
- Golf Events at Ardglass Golf Club on 1 April and Royal Belfast Golf Club on 17 June.

[1]www.tinyurl.com/2p89jybu

NI DPC chair elected

THE NORTHERN Ireland Dental Practice Committee (NI DPC) has elected Ciara Gallagher as chair at its first meeting for the new triennium (2022-2025).

Philip McLorinan and Helen Brogan were elected vice chairs.

"The next three years will be crucial for the survival of health service dentistry in Northern Ireland," said Ciara. NI DPC has both challenges and opportunities ahead. The past few years have been particularly difficult for dentists and dentistry in Northern Ireland, navigating the unprecedented challenges of the pandemic, while also managing the ongoing, day-to-day clinical and practical elements of running a dental practice.

"With the full force and support of the Committee behind me, I am looking forward to leading health service dentistry into a new era."

Ciara brings more than 25 years' experience to the role of NI DPC chair.

She qualified as a dentist from the University of Birmingham in 1996, working in Nottingham and Birmingham for two years before coming home to Northern Ireland. She is now the sole owner of a seven-surgery dental practice in Downpatrick, where family NHS dentistry and high-quality private implant and cosmetic dentistry sit comfortably side by side. One of her first duties as chair has been to respond to the "totally inadequate" new funding arrangements for General Dental Services announced by the Department of Health in March. A 'Rebuilding Support Scheme' will see a 25% enhancement apply to dental fees, as opposed to a 35% increase that had previously been put forward and which compares unfavourably to an initial 70% enhancement introduced in Scotland.

Rebuilding NHS dentistry, see page 20.

Irish fund invests in Scottish dental group

SDC Group secures multi-million pound deal with BGF


Philip and Christopher Friel

BGF, IRELAND'S most active growth capital investor, has agreed a multi-million pound minority investment in the Scottish Dental Care Group (SDC Group), based in Glasgow.

With a turnover of £11 million, the SDC Group currently operates 15 clinics across Scotland's central belt, Dumfries and Galloway, the Highlands and Grampian.

This includes the recently acquired Castle House clinic in Inverness, and the Grandholm and Granite City clinics in Aberdeen. BGF's investment will enable the growing dental group to implement ambitious growth plans in the coming years through the continued acquisition of high-quality clinics across Scotland.

Founded in 2016 by brothers Philip and Christopher Friel, SDC offers a full range of NHS, private and cosmetic dental treatments, including all aspects of dental implant and reconstructive dentistry, together with short term orthodontics and facial aesthetic treatments.

Dr Philip Friel has been a practising dentist for more than 20 years and leads the clinical side of the organisation. A former president of the Association of Dental Implantology, Philip is one of the most sought-after dental practitioners in Scotland.

Meanwhile, Christopher Friel, formerly a successful corporate lawyer before joining SDC as Managing Director, leads the business operationally and identifies expansion opportunities.

Scottish Dental Care's head office is based at its Advanced Dentistry clinic in Hyndland, Glasgow. It is widely recognised as a centre for excellence in the cosmetic and implant reconstructive dentistry field and attracts patients from across Scotland and beyond.

Euan Baxter, of BGF, commented: "Philip and Christopher have grown an excellent business through their commitment to providing high-quality care and the provision of desirable dental treatments. There is no doubt their success is rooted in their commitment to excellence and the welcoming culture they have fostered.

"Favourable market conditions and a clear growth strategy puts Scottish Dental Care on an incredibly positive trajectory. BGF is pleased to be able to support them as they expand and seek to acquire other clinics in key growth areas across the country. We are delighted to be supporting them."

BGF is a long-term patient investor, making initial investments between £1 million to £15 million for a minority equity stake.

The investment in SDC comes off the back of a record year for BGF in Scotland, having invested close to £60 million in a diverse range of sectors, from technology to healthcare to consumer goods.

The advisors to the transaction were Pinsent Mason (legal) and Azets (tax) for the company, and CMS (legal) and Mazars (tax) for BGF.

CGDent broadens membership eligibility

THE COLLEGE of General Dentistry has broadened its eligibility criteria for membership, enabling suitably qualified non-registrants to join, and offering practitioners with relevant non-dental qualifications the ability to progress to higher grades of membership[1].

Registration with the General Dental Council or an equivalent overseas authority is normally required for entry as an Associate Member. However, former registrants, and those who hold a relevant qualification but may not be required to register with the GDC due to their job role – such as dental academics – are now eligible to join.

Those wishing to join as Full Members (MCGDent), or upgrade to Full Membership, have until now been required, in addition to meeting the requirements for Associate Membership, to hold either the DGDP, MJDF, MFGDP(UK), MFDS or a Postgraduate Certificate level qualification in a 'relevant dental subject'. However, Full Membership is now also open to those whose qualification is in a 'subject relevant to the enhancement of oral healthcare'.

Those wishing to join at, or upgrade to, Associate Fellowship (AssocFCGDent), have up to this point needed to hold the MGDS, a Specialty Membership of a UK dental faculty, or a Postgraduate Diploma level or Master's level qualification in a dental subject. However, this recently instituted membership grade, which offers a stepping stone to Fellowship, is similarly now available to those whose qualification is relevant to oral heath rather than being strictly 'dental' in scope.

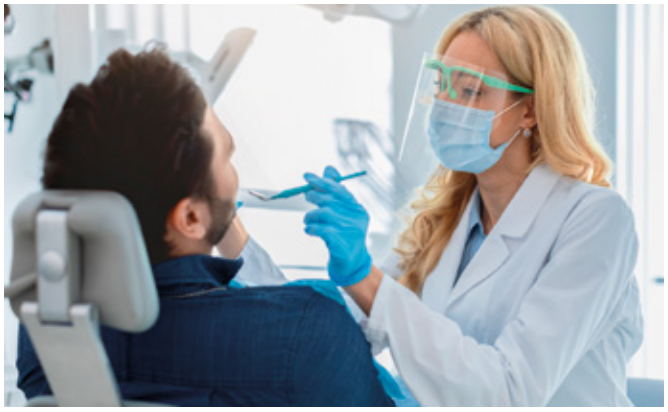
Individuals qualifying under these extended criteria would then be eligible to apply for Fellowship (FCGDent) on the same basis as all other members. This is open to existing Fellows of a UK Royal College or overseas equivalent, with a Fellowship by Experience route expected to be announced soon.

Dr Abhi Pal, President of the College, said: "These changes offer recognition to a wide range of individuals whose contribution is hugely significant."

[1] *https://cgdent.uk/membership-eligibility/*

Ireland's low check-up rate revealed

Republic languishes in the bottom 10 for annual visits to the dentist



PEOPLE IN Ireland are among the least frequent visitors to the dentist for check-ups, a study has revealed.

Of 28 European nations analysed, Norway came out as the most teeth-conscious country, followed by Luxembourg in second place with Germany coming in third place. Serbia was the least teeth-conscious country in Europe, ranking just below Latvia and Poland.

The analysis is based on data including the number of dentists per 10,000 people, sugar consumption, the prevalence of current tobacco use, and the average number of dentist visits per person each year. The study also revealed that Sweden has the highest number (17.9 per 10,000 people) of dentists.

Kent Express, the UK's largest mail-order dental supplier, carried out the study to find the most teeth-conscious countries, analysing a total of 178 countries around the globe.

Chris Moffatt, dental expert at Kent Express, said: "Dentists are increasingly choosing to work privately rather than through the NHS, large corporations are buying up independent dental practices, and technology is opening up new treatment options. We want people to take more notice of their oral health, and more pride in their teeth. That needs to start with regular dental check-ups. Your dentist can spot many problems early on to ensure they don't develop into something more serious.

"Things are changing with Generation Z (under 25 year-olds). Statistics show that they are smoking and drinking less than previous generations, with a healthier outlook, perhaps due to the impact of social media. They like to be in control of their personal branding, and part of that is ensuring good oral hygiene."

Anna Middleton, dental therapist and founder of London Hygienist, said: "Access to dental health services has impacted the public being able to prioritise their oral health.

"More focus on prevention over treatment is still needed. Ensuring we look after our mouths at home will significantly reduce the risk of us needing dental treatment in the future."

The data – which highlights dentists per 10,000 people, average dentist visits per year, sugar consumption per year and prevalence of current tobacco use – can be found here: www.tinyurl.com/4stkjcu3

Braemar appoints new RoI sales manager

BRAEMAR FINANCE has announced the appointment of Lorraine Blake to the position of Area Sales Manager for the Republic of Ireland to support and drive the funder's range of flexible funding offerings for new and existing clients in the professions, including dental.

Lorraine is an accomplished senior business and relationship development executive with more than 20 years' commercial experience in the asset finance sector. She has held key senior commercial positions working across a wide range of customer-facing roles with a number of high-profile organisations supporting Irish businesses across a broad range of sectors.

David Angus, Sales Director at Braemar Finance, said: "I'm delighted that Lorraine's joined us, not only to help us build and expand our presence within the professions across Ireland, but also for our existing clients and suppliers who will benefit from Lorraine's experience and expertise.

"Lorraine's appointment further underlines our long-term commitment to supporting the professions in Ireland."

Lorraine added: "This is an incredibly exciting time for asset finance and professions' clients across the Republic of Ireland who are looking to enhance, grow and expand their business. Braemar Finance is a leading provider of finance to the professions sector and has been a well-known name across the UK for the past 30 years and has had a presence in Ireland for the past seven. I will be looking to actively grow our prominence with our growing network of clients and suppliers and am thrilled to be joining the business at this pivotal moment."

Meet the Representatives, see page 34

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EuroPerio10 offers its 'best-ever' programme

More than 130 speakers on periodontology and implant dentistry

THE TENTH edition of EuroPerio, the triennial world-leading congress in periodontology and implant dentistry, returns this year after having been postponed because of the COVID-19 pandemic. Organised by the European Federation of Periodontology (EFP), EuroPerio10 will take place on June 15-18 in Copenhagen, Denmark.

It features a top-level scientific programme packed with sessions covering all the latest trends and hottest topics for oral-healthcare professionals, with an outstanding faculty of 135 well-known speakers from more than 30 countries in the main programme.

The EuroPerio10 scientific programme excels by offering the best researchers, clinicians, and academics in the world of periodontology.

But it also features a wide variety of innovative formats, including live mucogingival and bone-regeneration surgeries, interactive sessions, "nightmare sessions" (depicting worst-case scenarios), video sessions, debates, interviews, symposia and more.

Attention will be also given to the EFP's S3-level clinical guidelines on the treatment of periodontitis – the newest guideline, on stage IV periodontitis, will be presented at the congress.

Dentists, periodontists, oral surgeons, orthodontists, prosthodontists, dental hygienists, dental students, dental nurses, and other dental and medical professionals are all offered the option of creating their own itinerary according to their preferences.

To help attendees enjoy a better EuroPerio10 experience, the organisers suggest a series of tracks based on their professional profile (specialist, academic, clinician, oral hygiene and prevention, researcher), plus three tracks based on topics (periodontology, implant dentistry, and multidisciplinary).

David Herrera and Phoebus Madianos

Besides the regular programme, registration for EuroPerio10 includes access to a series of sponsored workshops and a networking programme with special events. Abstract presentations, contests, award ceremonies, a major industry exhibition, the EFP Village, and other activities are also key elements of the congress.

"The scientific programme addresses the interests of every member of the dental community and provides them with an updated snapshot of what perio is today," said David Herrera, scientific chair of EuroPerio10. "We have a great faculty, complete and diverse, addressing the main challenges of our profession with the most engaging session formats."

Phoebus Madianos, chair of EuroPerio10, added: "EuroPerio10 will allow the dental community to gather together again for the first time in a long time.

"So, we are proud to have prepared an exciting congress up to the task of bringing dental professionals up to date in terms of knowledge, skills, trends and solutions, but also in terms of personal interaction and networking with colleagues."

Registration for EuroPerio10 is via the EFP website www.efp.org/attendance/registration

Sensodyne maker's new name announced by GSK

GLAXOSMITHKLINE (GSK) has announced that a new company resulting from the proposed demerger of its consumer healthcare business later this year will be called Haleon.

A statement explained: "Haleon is the merging of 'hale', an old English word meaning 'in good health' and leon, which is associated with the word 'strength'."

Haleon will have a range of global brands, including Sensodyne, Voltaren, Panadol and Centrum.

The company said that the new brand identity was developed with input from employees, healthcare practitioners and consumers and will be deployed in more than 100 markets around the world.

The creation of Haleon results from a series of investments and strategic changes to GSK's consumer health business over the past eight years, including integrations of the consumer product portfolios from Novartis and Pfizer. The company is now a global business generating annual sales of approximately £10 billion.

Brian McNamara, chief executive officer-designate of Haleon, said: "Introducing Haleon to the world marks another step in our journey to become a new, standalone company. Our name is grounded in our purpose to deliver better everyday health with humanity and to be a world-leader in consumer healthcare."

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DATES FOR YOUR DIARY

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

17-19 MARCH
ICOI Winter Implant Symposium
Georgia, Atlanta, USA
https://tinyurl.com/mrxz9ycn

25-26 MARCH
BDIA Dental Showcase
London Excel, UK
www.dentalshowcase.com

25-26 MARCH
EVDA Congress 2022
Edinburgh Surgeons Quarter, Scotland
https://evda-online.com/product/evda-congress-edinburgh-2022/

1-2 APRIL
European Carriere Symposium
Lisbon, Portugal
https://web.cvent.com/event/70ccbece-04c1-4ccb-93f2-5183ed39da80/summary

7-8 APRIL
Euro Implanto 2022
Nice, France
www.dental-tribune.com/event/euro-implanto-2021/

12 MAY
IDA Annual Conference
The Galmont Hotel, Galway, Ireland
https://jida.ie/annual-conference-2022/

13-14 MAY
British Dental Conference & Dentistry Show
NEC, Birmingham, UK
birmingham.dentistryshow.co.uk

26-28 MAY
ADI Congress
Central Convention Complex, Manchester, UK
www.adi.org.uk/congress22.aspx

15-18 JUNE
EuroPerio10
Copenhagen, Denmark
www.efp.org/europerio

24-25 JUNE
Scottish Dental Show
Glasgow, Scotland
www.sdshow.co.uk

11-13 AUGUST
International Symposium on Dental Hygiene
Dublin, Ireland
www.isdh2022.com

7-8 OCTOBER
BADT Conference 2022
Crewe, UK
www.dental-tribune.com/event/badt-conference-2022/

28 OCTOBER
RCSI Faculty of Dentistry 2022 Joint Symposium with the AAPD
Dublin, Ireland
https://tinyurl.com/yckrvw95

10-12 NOVEMBER
BACD 18th Annual Conference
ICC Wales
https://bacd.com/

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Guidance published for... Teledentistry

Despite pushback, one 'DIY ortho' provider says it will continue to grow in Ireland and the UK

The British Orthodontic Society (BOS) has released its guidance on teledentistry and remote interactions in orthodontic care[1].

Further to statements from both the General Dental Council (GDC) and the Care Quality Commission in 2021, the BOS has produced this guidance to help orthodontic providers and their teams better understand the scope of teledentistry services and technologies as part of orthodontic care, as well as the associated issues. In addition, it will direct teams to the current regulatory frameworks and resources, and highlight best operational practice.

Teledentistry is a term which covers a range of technologies and operational practices. These include various communications via interactive, two-way audio or video as well as indirect, synchronous communications, in which a patient's information (such as questions, requests, photographs, videos) is exchanged with a dental professional for review. This may be via messaging platforms or dedicated hardware and applications.

Teledentistry can enhance patient care, assist in achieving agreed treatment outcomes and strengthen the relationship between clinician and patient. Potential benefits of integrating teledentistry technologies and procedures into orthodontic care include greater accessibility, better patient engagement and experience, reduced physical appointments – ideal from a COVID-19 perspective as well as reduced carbon footprint – and above all, increased treatment efficiency.

In accordance with the GDC Scope of Practice, all diagnostic and prescriptive decisions must be made by the treating orthodontist/dentist who have adequate training and skills. The direct involvement of an appropriately trained and registered orthodontist/dentist is essential for the monitoring of orthodontic care.

WORDS
WILL PEAKIN

Launch of 'DIY ortho' firms such as Smile Direct Club have been controversial

Patients undergoing treatment must be made aware of the name of the clinician responsible for their care and be able to make direct contact with this clinician as well as be able to arrange appropriate face-to-face appointments when required. Patients should be informed that clear aligner treatment, even for cosmetic purposes, is not a simple process but is a medical procedure using a medical device. Treatment should only be undertaken with the direct guidance and ongoing supervision of a named orthodontist or suitably trained dentist.

The BOS still has significant concerns surrounding the appropriate examination, diagnosis and consent process for 'DIY orthodontic' systems, as well as ongoing supervision and the nature of the relationship between patient and treating clinician.

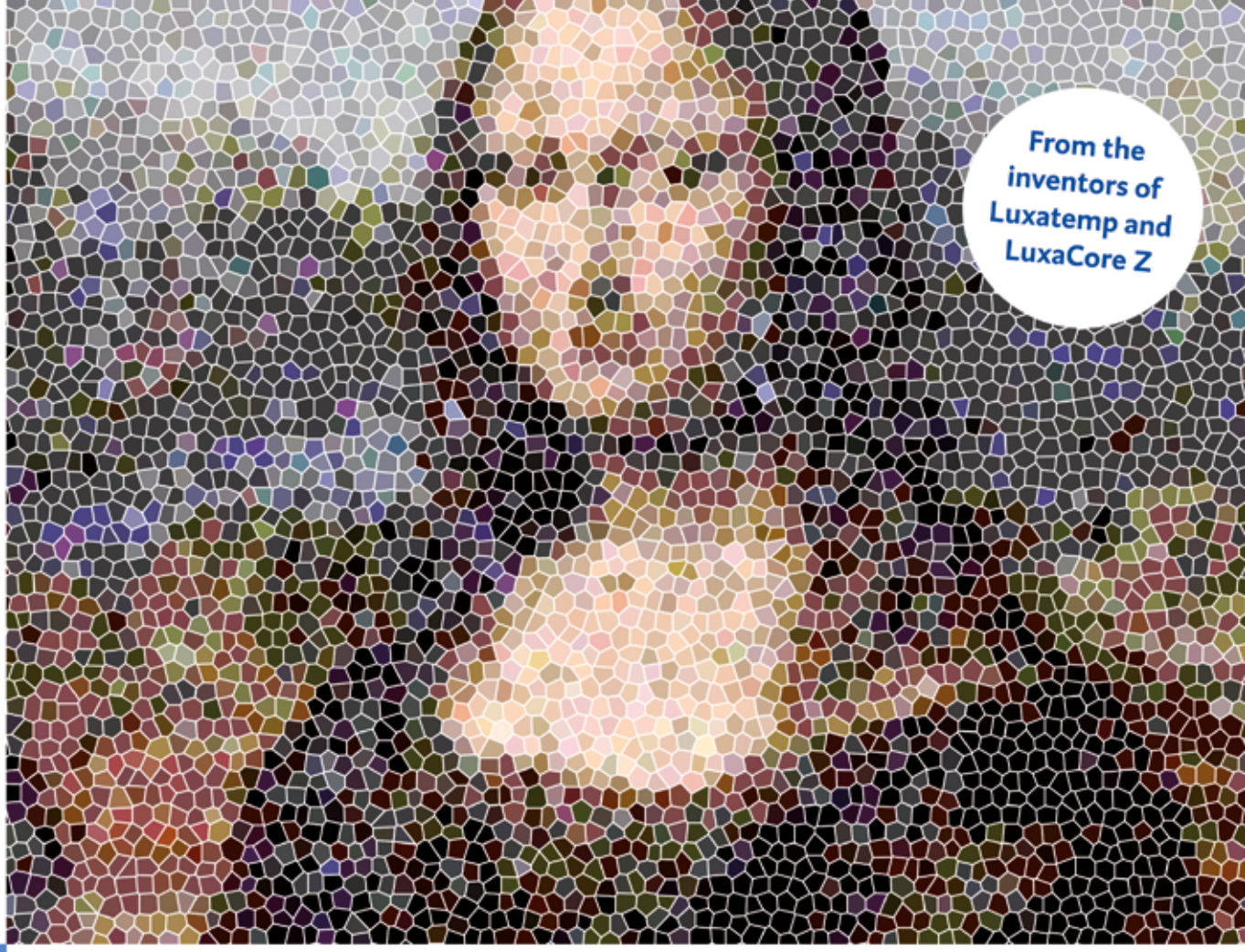
Anjli Patel, the BOS's Director of External Relations, commented: "If used responsibly, digital technologies and associated tools or applications have potential to improve professional care and enhance both patient outcomes and convenience, adding a potentially convenient way for clinicians to engage with current or prospective patients.

"It can enhance patient care, assist in achieving agreed treatment outcomes, and strengthen the relationship between clinician and patient. However, it should never be used to alter clinical practice in such a way that patient safety, valid consent or treatment planning and outcomes are compromised."

Earlier this year one provider, SmileDirectClub, announced redundancies and sweeping operational changes, including halting operations in several countries, as it sought to turn a profit more than two years after it became a public company. The company has reported quarterly losses since it went public in 2019.

SmileDirectClub has faced criticism that its 'teledentistry' model is detrimental to patients; claims it has refuted, pointing to thousands of satisfied customers. SmileDirect said it would halt operations in several other countries such as Germany, Spain and New Zealand, but will continue to operate "and grow" in the US, Canada, Australia, France, Ireland and the UK.

[1] *https://view.publitas.com/british-orthodontic-society/guidance-on-teledentistry-and-remote-interactions-in-orthodontic-carefinal-v5awamended-xgqpe76_g7go/page/1*



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Paying the price for treatment abroad

Travelling abroad for dental treatment comes at a cost – and not just for patients

WORDS
CATHERINE MOSHKUN

Many UK patients in the search for their perfect smile have now decided to have their dental treatment abroad, the main reason being that they believe they can have the same treatment but at a much lower price. With many overseas clinics offering treatment packages that also include a holiday, dental tourism seems an opportunity not to be missed. But, although not always the case, some treatments unfortunately do not go to plan, often leaving distraught patients and their apprehensive dentists in a difficult situation.

This article will discuss the reasons behind dental tourism and if the health system has contributed to the increasing demand for dental tourism. We will touch on the impact dental tourism has had on UK dentistry and if the NHS should be responsible for handling the consequences of any failed or incomplete dental treatment carried out abroad. It will also put the spotlight on dentists' responsibilities and to what extent they should treat these patients, as these cases can leave clinicians in primary and secondary care in a challenging predicament, not only clinically but also ethically and medico-legally.

In 2010, around 63,000 UK citizens travelled abroad for treatment. It has been reported that the number of Britons going abroad for treatment has increased significantly from 48,000 patients in 2014 to 144,000 in 2016. Also, it was reported that Medigo, which was a medical travel platform, had more than 350,000 visits a month by 2016, and in 2015, it was estimated that at least 190,000 patients were thinking of treatment abroad because of long NHS waiting lists. The estimated value of the medical tourism market worldwide was 60 billion US dollars in 2006, which increased to 100 billion US dollars in 2012.

Many foreign dental practices are enticing UK patients by advertising an attractive full package, including dental treatment with a holiday, flights, accommodation and airport transfers, for competitive prices. But no matter how cheap and accessible these treatments seem to be, they

> "A PATIENT WHO TRAVELLED TO HUNGARY FOR DENTAL IMPLANTS HAD TO SPEND MORE THAN £40,000 ON REMEDIAL TREATMENT

> DENTAL TOURISM HAS CREATED A COMPETITIVE ATMOSPHERE THAT HAS LED TO A NOTICEABLE DROP IN PRICES

may unfortunately come at a price, with unexpected complications. Lunt et al. described a patient who travelled to Hungary for dental implants, which were unsuccessful, and the patient ultimately had to spend over £40,000 on remedial treatment.

Ongoing care

Furthermore, patients may face difficulties in that the dentist abroad may not accept responsibility for ongoing care.

The clinics abroad may tell the patients they have been discharged from their care following treatment. Alternatively, they may offer the patient further treatment; however, this may include the costs of flights and accommodation. If patients seek help from a UK dentist, they may struggle to find someone who feels competent to address their concerns.

As a minimum, whether NHS or private, dentists should address any acute problems, such as pain or infection. However, one must consider who should pick up the tab for any remedial work required. If a patient were to attend with failing implants, perhaps removal may be acceptable on the NHS, but surely not their replacement. Imagine the situation where a patient has had several implants placed abroad, but they have not been restored; would any dentist try to restore these for the patient? If a dentist in the UK accepted to restore them and they later fail, who is responsible? If no dentist was willing to restore them, could we really justify the surgical risk of removing them and starting the treatment again if the unrestored implants did not appear to be failing?

It has been estimated by a cohort study over three years that the cost to the NHS for remedial treatment after cosmetic surgery abroad was an average of £6,360 per patient and ranged from £114 to £57,968. Arguably, the harm from this cosmetic surgery or dental treatment abroad is self-inflicted, so raises the question if valuable NHS resources should be used for this purpose. However, it could be difficult to enforce this, as equally, the same could be said about, for example, injuries from extreme sports; these are self-inflicted, yet the NHS pays for the treatment. Perhaps patients should be expected to subsidise their treatment costs or take out insurance that covers such complications.

The increase of dental tourism has had a significant impact on UK dentistry. The founder of the UK cosmetic dentistry cost and clinic comparison website, Eoin Holohan, explains that dental tourism has created a competitive atmosphere that led to a noticeable drop in prices, especially dental implants that have been available for about £995 in the UK. This raises the question of how these implants are being offered at such a reduced rate, and we must consider if treatment standards and quality are being compromised in order to do this.

Best deals

It is easy to see why patients are driven to seek dental treatment abroad. Dentistry is becoming increasingly consumer-driven around the world, including the UK, meaning patients will look around for the best deal. However, perhaps they travel oblivious to the potential consequences should things go wrong. When patients attend requiring remedial work, from an NHS point of view, we must consider which patients should take priority and assess how these limited resources should be allocated. From a dentist's point of view, the risk of litigation will always be a deciding factor as to whether they should carry out any remedial work.

More research is required to identify if dental tourism has the same financial impact on the NHS as failed cosmetic surgery done abroad, as well as collecting data on failure rates of overseas treatments in comparison with UK treatments and more accurate information on the cost of remedial dental treatment. We also need clearer guidelines on what dentists should offer these patients.

Dental tourism: one patient's experience

WORDS
ARAN MAXWELL

Every time I open my phone or laptop, there is another influencer showing off their shiny new teeth from Turkey.

One report[1] suggests that the Global Dental Tourism market is growing fast and going to be worth $5.83 billion by 2025.

Anecdotally, Turkey appears to be the most common dental tourism destination but Romania, Poland, Spain, and even India and Thailand, are also popular.

A story that highlights the dangers of going abroad comes from one of my own patients. She is a social media influencer, has been on reality television and I had treated her for many years. One day, she attended my clinic for a check-up and showed me her twenty new '360 degree veneers' that she was given for free as long as she advertised the clinic on her Instagram feed, documenting the whole experience and tagging them in the selfies taken afterwards.

These '360 degree veneers' were, in fact, full coverage crowns. This sort of treatment in the UK is reserved for severely broken down or root canal treated teeth, where it is clearly indicated to protect the tooth. This lady's teeth were perfectly sound before having these crowns placed. Where crowns are placed on healthy teeth it requires a lot of tooth structure to be shaved off. It is irreversible, as the removed tooth cannot be brought back, and puts the nerve in the middle of the tooth under severe strain; with one-in-five requiring root canal treatment, and one-in-ten requiring extraction, after 10 years[2].

A few months later, one of her teeth did require root canal treatment as the nerve had died off leaving her with a very painful infection. As the work had been done in Turkey this patient had to seek treatment from that clinic first. However, upon telling them about what had happened they blocked her on all channels – leaving her with nowhere to go.

Luckily, in this case I was able to help.

Aran Maxwell is a facial aesthetic clinician who graduated with a BDS degree from the University of Dundee in 2014

[1] *www.tinyurl.com/3cs5bu4x*
[2] *www.tinyurl.com/yckzyaym*

Rebuilding NHS dentistry

Northern Ireland Dental Practice Committee's new chair on the work being done to reform and secure the future of NHS dentistry

WORDS
WILL PEAKIN

In January, Ciara Gallagher was elected Chair of the Northern Ireland Dental Practice Committee (NIDPC) for the next triennium (2022-25). Ciara qualified as a dentist from the University of Birmingham in 1996, working in Nottingham and Birmingham for two years before coming home to Northern Ireland. Ciara is the sole owner of a mixed seven-surgery dental practice in Downpatrick. Having worked in NHS dentistry for more than two decades, she has felt first-hand the rising pressures of providing quality NHS care under an increasingly pinched budget.

A passionate believer that everyone should have access to quality dental care regardless of ability to pay, Ciara said she welcomed the opportunity for NIDPC to work closely and collaboratively with the Department of Health to formulate a new contract which works for patients, dentists, and the government.

"As a practice owner, I am all too aware of the spectrum of issues that face the profession," said Ciara in a blog post[1]. "This work includes 'here and now' issues as we emerge from a global pandemic and rebuild services," she added, "and the work to reform and secure the future of NHS dentistry with a new contract."

The committee is divided into sub-groups to better progress key issues and is in constant communication both with the team at the BDA NI office and through them regularly meeting with Department of Health officials, arms-length bodies and of course, the Northern Ireland Assembly, Health Committee, political parties and MLAs.

"The past few years have been an unprecedented era in the history of general dental services in Northern Ireland," said Ciara, "with persistent, ever evolving and complex challenges impacting us in a way that could not have been anticipated prior to the beginning of 2020."

Revenue Grant Scheme

The department announced a £5million Revenue Grant Scheme for dental practices to help upgrade and make improvements. Having requested this in a recent submission to the department, Ciara said that BDA NI welcomed the scheme as an "important, tangible benefit to GDS".

Financial Support Scheme

A lifeline and a safety net for practices providing NHS dentistry, the Financial Support Scheme (FSS) has helped see GDS through the various lockdowns and extremely difficult working conditions. In January, practitioners were notified that the FSS will soon come to an

end. Activity thresholds have been kept under review, and the new financial year from 1 April will see changes come into place where remuneration is more closely linked to activity. This new Rebuilding Support Scheme (see 'Near Future', on this page) is intended to help practices as IPC relaxes, community transmissions decrease, and patient throughput increases.

New contract negotiations

The NIDPC New Contract group will be progressing vital negotiations towards a new GDS contract. "This as you know, is long overdue for Northern Ireland and if we are to secure the future for health service dentistry, we need to get this right from the outset," said Ciara.

"We all know how much is at stake and I can confirm that NIDPC and its sub-groups will be working tirelessly behind the scenes, often into the small hours – to do everything we can to help government get it right for the full profession – for practice owners, for associates, for dental nurses, for our non-clinical staff and most of all, for our patients."

Near future

From April there will be a transition from the FSS to the Rebuilding Support Scheme. But Ciara said: "The latest DoH offer does nothing to address those real costs of delivering dental care, or provide anything by way of future certainty. Practitioners have had enough. Unless this is remedied, we are likely to face a possible exodus of dentists away from health service dentistry.

"We were left bitterly disappointed when an initial offer of a 35 per cent enhancement in fees was subsequently downgraded to 25 per cent, and this despite papers from BDA outlining the crisis the sector is in, including a 40 per cent reduction in dental earnings since 2008, costs soaring, and the continued impact of the pandemic.

"Our warnings to the Department have been clear in recent months – yet we feel strongly that our words have fallen on deaf ears.

"On the very day that we urged political parties to commit to the rebuilding and reform of Health Service dentistry at our BDA Manifesto launch, any hopes we had that Government was serious about moving forward on dentistry have been left shattered.

"We provided the Department with a carefully thought-through counter offer that clearly detailed what was required for a reasoned, sustainable, safe service. We are disappointed this has been rejected, and that the Department has steam rollered ahead with its enhancements which fails to adequately reward or properly incentivise ailing practices. In order to maintain viable businesses, dental practice owners increasingly feel they are being pushed towards private practice. They will have no alternative. Associates – who often do the bulk of health service dentistry – will increasingly be driven into private practice, because working in the Health Service means their salaries will not reflect the years of learning, the cost of living or the university fees that need repaid.

"Stress levels have soared. Morale has reached an all-time low. And we have a crisis of confidence among GDPs in Health Service dentistry having a viable future. It isn't practitioners wanting to step away from their NHS patients, this is government pushing practitioners out. We simply cannot endorse a return back to the pre-pandemic treadmill of high volume, and low / loss-making fees with the promise of jam tomorrow.

"At the very point in time when a new package should have been about incentivising GDPs to increase Health Service treatments and get through high patient backlogs, this scheme falls flat.

"We had high hopes that our solutions-based approach to negotiations would lead to a fair outcome for both patients and practitioners. Sadly, we are left dismayed.

"Reverting back to a situation where decisions are once again based solely around DoH budgetary constraints while ignoring the financial realities practitioners are facing, is repeating the mistakes of the past. It is for the Minister and his Department to explain to the public -and the profession -how this will help move dentistry forward at this critical juncture.

"Sadly, health service dentistry and patients in Northern Ireland are left with nothing to smile about. We urge all political parties to take action to salvage dental services now, and into the next Assembly mandate."

> "WE CANNOT RETURN TO THE UNDERFUNDED TREADMILL WITH ALL ITS ADVERSE CONSEQUENCES

> "I THINK WE CAN GET HIGH STREET HEALTH SERVICE DENTISTRY BACK ON AN EVEN KEEL

For help, or if you would like to share your views you can contact Ciara via: northernirelandoffice@bda.org

Workforce challenges

NI BDA's Council Chair on the key challenges facing the dental workforce

WORDS
ROZ
MCMULLAN

The start of the year is always a good point for reflection and setting goals. This has been difficult over the past two years, given the need to navigate the acute stages of a global pandemic and manage future uncertainty. Here is how the BDA is focusing our efforts, to support our members and the profession over the next three years and beyond.

Although it is often referred to as "recovery", the COVID-19 response has changed how we operate to such an extent that we cannot go back to how we were. The GDS contract was broken before the pandemic, and the viability of NHS dentistry in general practice has, for some considerable time, depended on the private income of practices balancing the books. The contract in Northern Ireland (NI) remains a fee per item model, where the importance of prevention is not recognised and patients with greater care needs are not prioritised.

The elderly population with complex co-morbidities is a growing patient base and the pandemic response has caused a worrying reduction in oral cancer diagnosis. Going back to full waiting rooms and insufficient time with patients cannot be an option for GDPs. These problems are now widely recognised by everyone, from individual dentists and their teams, to those responsible for commissioning the services and training the workforce.

This is clear from the most recent BDA survey which showed associates' reluctance to work in the NHS as one of the main reasons (40 per cent) practice owners are finding it difficult to recruit. The survey also revealed a collapse of morale in dentistry, with no associates and just 12 per cent of practice owners in NI describing their morale as 'high' or 'very high'. Respondents indicated that financial uncertainty is one of the major causes of stress. Around half of associates and practice owners confirmed they intend to increase their proportion of private work over the next five years.

These startling statistics illustrate the urgency of a sweeping reform programme to make health service dentistry sustainable and attractive for the profession. It simply must serve as a wake-up call if there is to be a future for health service dentistry.

Workforce struggles

Care backlogs in the CDS are having a real impact on oral health. However, the CDS dentist workforce also has a potential crisis looming, with one third due to retire in the next eight years. It is hard to see that, even if they could start tomorrow, they will be able to recruit and train at sufficient pace to replace the potential loss of skills and experience and avoid some service disruption.

The success of specialist services, depends on attracting the brightest and best to training pathways. Offering trainees lower salaries than those provided in the rest of the UK, places NI and our patients at a disadvantage now and for many years to come. This continues at consultant level, where hard-working dentists are without mitigation for adverse pension penalties or clinical excellence awards, both of which are enjoyed by their counterparts elsewhere in the UK.

A new service delivery model to deliver targeted, preventative and evidenced-based care to the population, will influence the workforce we need. The present fee per item model does not support the business case for dental therapists in the GDS and we have had no dental hygienists trained in Northern Ireland for some years. Both groups provide an invaluable part of the workforce in the CDS, where the service can arguably use the right skills, in the right place, and at the right time. However, our CDS colleagues tell us that recruiting to these grades is increasingly difficult.

Dental nurse training has been a problem in Northern Ireland for many years, and there are significant barriers to valuing what nurses can offer in the dental workplace.

Many are leaving for similarly or better paid jobs with a better work/life balance.

The challenge ahead

Workforce planning is not easy. But for the sake of NHS dentistry and the patients who rely on it, the profession and government must use all their skills and knowledge to secure a highly skilled and valued workforce. Our patients need and deserve quality and timely dental care.

We are clear that the time for bold reform in dentistry is now. In the next three years, I believe we can build a solid foundation for dentists and their teams and secure the care our NHS patients so desperately need. The BDA will continue to challenge those charged with leadership in dentistry and support our members – whether working in NHS, mixed or private practice, or in the community, hospital and academic services.

The next three years will be pivotal for the future of dentistry in Northern Ireland. Your committee representatives, supported by the BDA Northern Ireland office, will continue to ensure your voice is heard. Together we are stronger.

Roz McMullan is Chair of Probing Stress in Dentistry in Northern Ireland (NI)

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New Dean Elect announced

Chris Lynch, Professor and Consultant of Restorative Dentistry, to lead Faculty from next year

The Faculty of Dentistry, Royal College of Surgeons in Ireland has announced that Professor Chris Lynch has been elected Dean Elect of the Faculty and will become Dean in February 2023.

Professor Lynch is currently Professor & Consultant of Restorative Dentistry at Cork University Dental School & Hospital, University College Cork. He is the Editor-in-Chief of Journal of Dentistry, the leading international journal in the field of Restorative Dentistry (2011 – present). Professor Lynch was awarded a Senior Doctorate by assessment from Cardiff University (2019), which is understood to be the first such recognition for an Irish-based dentist.

WORDS
WILL PEAKIN

Excellence

He holds a Principal Fellowship from the Higher Education Academy UK (2019). Professor Lynch is one of Ireland's inaugural Learning & Teaching Research Fellows (National Forum for the Enhancement of Teaching and Learning in Higher Education, 2020). Professor Lynch received the Award of Excellence in Dental Education from the Association for Dental Education in Europe in 2014.

Professor Lynch has held a number of important leadership roles within the Faculty of Dentistry, including serving as Vice Dean of the Faculty (2019 – 2021), Chair of the Scientific Committee of the Faculty of Dentistry (2020 – present), and various senior roles of responsibility for Faculty examinations (e.g. Diploma of Primary Care Dentistry, MFD and FFD examinations), and various educational events (e.g. 'Back to School' webinar 2020, Fergal Nally lecture 2021, Annual Scientific Meeting 2020 and 2021).

He graduated from the Cork University Dental School in 1999 and worked in general practice in London before returning to Cork to take up a hospital post. He was awarded his FDS (Inter Collegiate Specialty Fellowship) by assessment in 2006.

Professor Lynch was appointed a Senior Lecturer and Consultant in Restorative Dentistry at Cardiff University in 2006. He completed his PhD in 2007 and was promoted to Reader (2013) and then Professor in Restorative Dentistry & Dental Education in 2015. While at Cardiff University Dental School, he held a number of important leadership positions, including Lead for Prosthodontics teaching, Lead for Clinical Dentistry teaching, and Head of the Learning & Scholarship Department. He holds a Visiting Professorship at Cardiff University, as well as current external examinerships at Bristol University, Peninsula Dental School and Hong Kong University.

To date Professor Lynch has published more than 200 full length papers in international peer-reviewed journals. He has been awarded Fellowships from the Faculty of Dental Surgery Royal College of Surgeons of England, the Faculty of Dental Surgery of the Royal College of Physicians & Surgeons of Glasgow, the Faculty of General Dental Practice (UK), the Academy of Dental Materials, the American College of Dentists and the International College of Dentists.

Professor Albert Leung, the current Dean of the Faculty, said: "Many congratulations and a very warm welcome to Professor Lynch as our Dean Elect. This is a tremendous and most deserving achievement for Chris, and I immensely look forward to working with him over the next year and beyond."

The Faculty of Dentistry of the Royal College of Surgeons in Ireland (RCSI) was founded in 1963 with the core mission of advancing the science, art and practice of dentistry by the promotion of education, study and research. It is delighted to work with dentists in Ireland and from all around the world.

Further information about the Faculty's activities can be found here: https://facultyofdentistry.ie

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Accessing digital treatments

Dentsply Sirona partners with FDI and Smile Train to create best-in-class cleft care protocols

WORDS
WILL PEAKIN

Dentsply Sirona, the world's largest manufacturer of professional dental products and technologies, has announced a partnership with FDI World Dental Federation (FDI) and Smile Train, the world's largest cleft-focused organisation, to develop global standard protocols for digital cleft treatment.

The initiative will increase access to digital treatments for patients with clefts and advance cleft care for the 1 in 700 babies born with cleft lip and/or palate around the globe.

The three partners will jointly work on integrating digital workflows and sustainable solutions into these new protocols as well as creating and providing the necessary clinical education infrastructure to oral health professionals around the world. The unique partnership also includes designing and setting up online courses and webinars to introduce dental professionals around the world to digital cleft care.

Prior to this partnership, Dentsply Sirona pledged a $5m donation to Smile Train as part of a five-year commitment to help children around the world gain access to cleft treatment, offering them the chance to live full and healthy lives.

"At Dentsply Sirona, we live our sustainability strategy every day in numerous ways. One of the most rewarding aspects is working with Smile Train and FDI to be able to offer the best care possible to children with clefts," said Jorge M. Gomez, Chief Financial Officer and Head of the Dentsply Sirona Sustainability Programme. "Giving these children healthy smiles by utilising the most advanced digital technologies is part of our larger sustainability goal to improve global oral health care and create millions of healthy smiles around the world. We are happy to contribute our knowledge and technologies for this important cause."

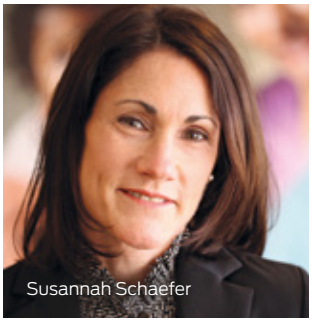
> "CLEFT SURGERIES AND CLEFT CARE BENEFIT HUGELY FROM DIGITISATION"
>
> PROF. IHSANE BEN YAHYA

Professor Ihsane Ben Yahya, President of the FDI World Dental Federation, added: "We are proud to be working with Dentsply Sirona and Smile Train to increase the global access to the best possible cleft care."

"Cleft surgeries and cleft care benefit hugely from digitisation and together with our partners we work fervently on providing oral health professionals, especially in limited-resource settings and remote regions, with the infrastructure and training necessary to correctly use these digital technologies."

Susannah Schaefer, President and Chief Executive Officer of Smile Train, said: "Children with clefts are more susceptible to poor oral health which can greatly impact their speech, ability to eat, and their overall well-being.

"We are delighted that our new partnership with Dentsply Sirona and FDI ensures that Smile Train centres around the world will have access to digital treatment protocols that integrate the latest, newest technologies to provide best-in-class digital oral healthcare."


Susannah Schaefer


Jorge M. Gomez


Professor Ihsane Ben Yahya

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Utilising fixed orthodontics with minimally invasive finishing touches

Dr Sebastian Crudden
Associate dentist, Kelly Dental Care, Derry City

Introduction

A female patient presented to the practice with concerns about the appearance of her smile. She disliked the upper and lower crowding and was looking for a solution. A full medical history was taken, and no abnormalities were found. The patient had undergone orthodontic treatment as a teenager but had since experienced relapse.

As per the IAS Academy protocol, a comprehensive orthodontic assessment was conducted (Table 1). The patient's oral hygiene was good, the gingivae were healthy, and no bone loss was evident from the radiograph taken. A grade 2 gingival biotype was recorded in the lower anterior region.

Approximately 5mm of crowding was identified in the labial segment of the lower arch and the lower canines were mesiobuccally rotated. In the buccal segment, there was 1mm of crowding on the left-hand side. For the upper arch, 2mm crowding was recorded, with triangular central incisors.

The possible treatment options were presented and explained to the patient. The ideal treatment would have involved a surgical aspect to correct the skeletal base, as well as the upper and lower arch crowding. However,

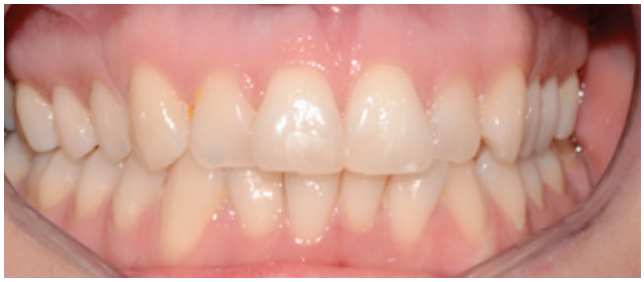


Figure 1: Pre-treatment anterior

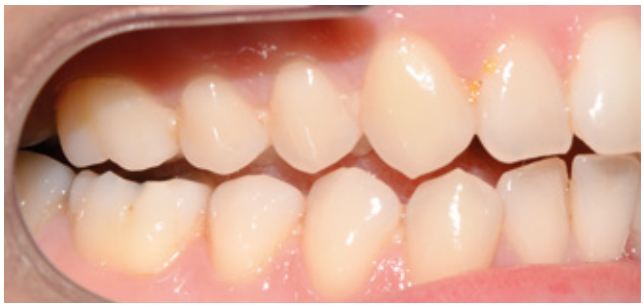


Figure 2: Pre-treatment right lateral

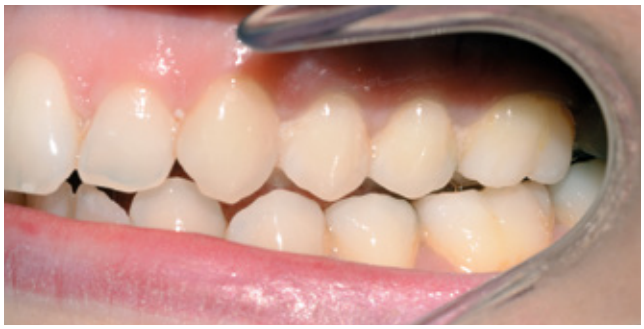


Figure 3: Pre-treatment left lateral

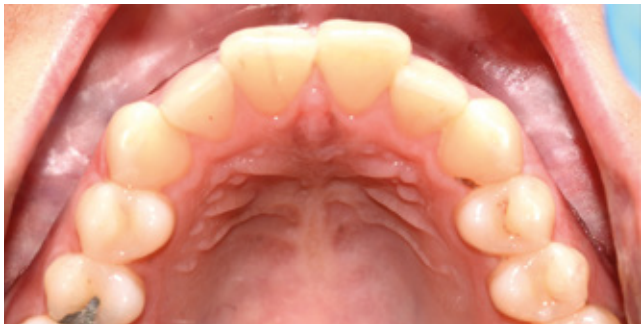


Figure 4: Pre-treatment upper occlusal

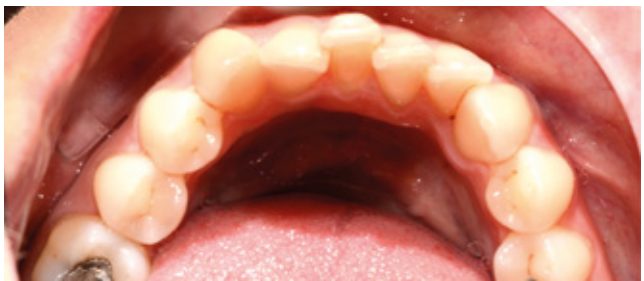


Figure 5: Pre-treatment lower

ORTHODONTIC ASSESSMENT

Skeletal Pattern	Class III
FMPA	Reduced
Lower Face Height	Increased
Facial Asymmetry	None
TMJ	None
Soft Tissues	Lips forced competent, hypotonic lips, lip line normal, nasiolabial angle increased
Overjet	2mm
Overbite	20%
Crossbite	None
Displacement on closure	None
Incisor relationship	Class III
Molar relationship	Right: Class I Left: Class I
Canine relationship	Right: Class I Left: Class III ¼ unit
Teeth Present	7654321 1234567 7654321 1234567
Centrelines	Coincident

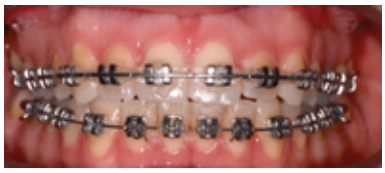


Figure 5b: Mid-treatment

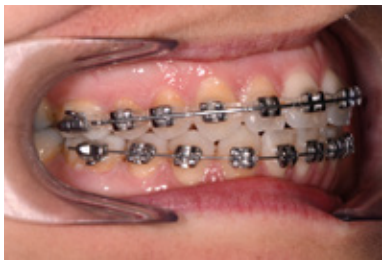


Figure 6: Mid-treatment right lateral

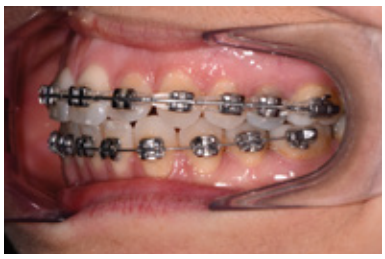


Figure 7: Mid-treatment left lateral

the patient was keen to avoid this and so was more than happy to accept a slightly compromised result (Table 2).

A Spacewize™+ online calculation was made to determine the overall amount of space that would need to be created – 2.44mm in the lower arch and 0.7mm in the upper – and treatment with the ClearSmile Brace was proposed. All the benefits, limitations and risks associated with treatment were discussed in detail with the patient, who provided informed consent to get started.

Treatment provision

The ClearSmile Brace was bonded in October 2018 and the standard IAS Academy archwire sequence was followed. Progressive proximal reduction (PPR) was performed on the central incisors to encourage tooth movement and de-rotation as and when it was required. The lower incisor brackets were repositioned approximately five months into treatment in order to further improve the movement of the teeth.

The patient remained compliant with oral health instructions throughout treatment and attended all review appointments as scheduled. By September 2019, she was very pleased with the alignment achieved and we agreed together to bring this phase of treatment to a close. Impressions were taken for a bonded retainer, which was fixed a few weeks later during the debond appointment.

TREATMENT SURVEY

PROBLEM LIST

- Class III Skeletal base
- Class III incisor relationship
- Upper and lower crowding
- Reduced Overbite
- Triangular shaped upper centrals (black triangle risk)
- Uneven wear of upper and lower incisors

IDEAL TREATMENT AIMS

- Correct to Skeletal Class I
- Achieve Class I with incisors, canines and molars
- Normal Overbite
- Relieve upper and lower crowding
- No black triangles
- Restore worn incisor edges

COMPROMISED TREATMENT AIMS

- Maintain overbite and improve with composite edge bonding
- Relieve 6-6 upper and lower crowding only
- PPR to reshape upper centrals (no black triangles)
- Restore worn incisor edges

In November 2019, composite edge bonding was performed on the canines to enhance the aesthetics of the teeth and finish off treatment. The patient was delighted with the result.

Case appraisal

Overall, I am extremely happy with the outcome of this case following alignment. I managed to use PPR on the distal aspect of the upper centrals to reduce the triangular appearance of these teeth and avoid the risk of black triangle formation. This has allowed us to use the space required to achieve alignment, while also reshaping the upper centrals to provide a more aesthetic result. Throughout, both good interdigitation and the Class I canine and molar relationships in the buccal segment were maintained. The gingival levels of the upper and lower incisors are also now coincident, and the reduced overbite has been maintained.

In addition, the overbite was improved by the composite edge bonding after alignment, which restored the lost incisor wear. The result prior to edge bonding gave the appearance of uneven incisor edges, so adding the composite in a minimally invasive way therefore elevates the final result. It provides both a more aesthetically pleasing and more functionally stable outcome.

Treatment in this case was probably delayed somewhat by bracket positioning in the lower incisors. This is an area that I am focusing my learning on as I wish to develop my skills to avoid this issue in the future.

For more information on upcoming IAS Academy training courses, including those for the Inman Aligner, visit www.iasortho.com or call 01932 336470 (Press 1)

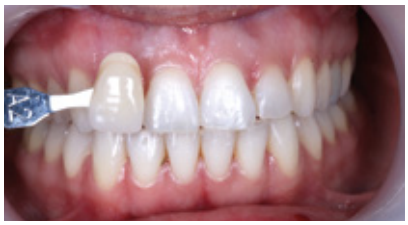


Figure 8: Pre-whitening

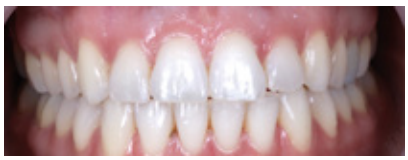


Figure 9: Post-whitening

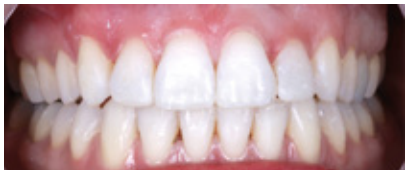


Figure 10: Post-edge bonding

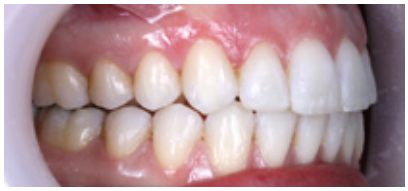


Figure 11: Post-treatment right lateral

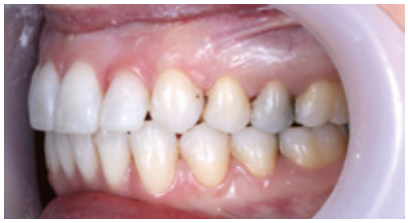


Figure 12: Post-treatment left lateral

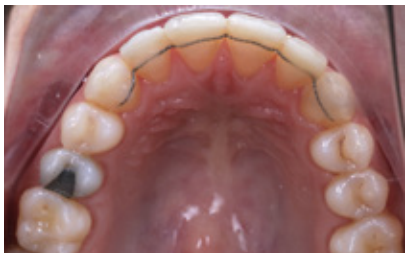


Figure 13: Post-treatment upper occlusal

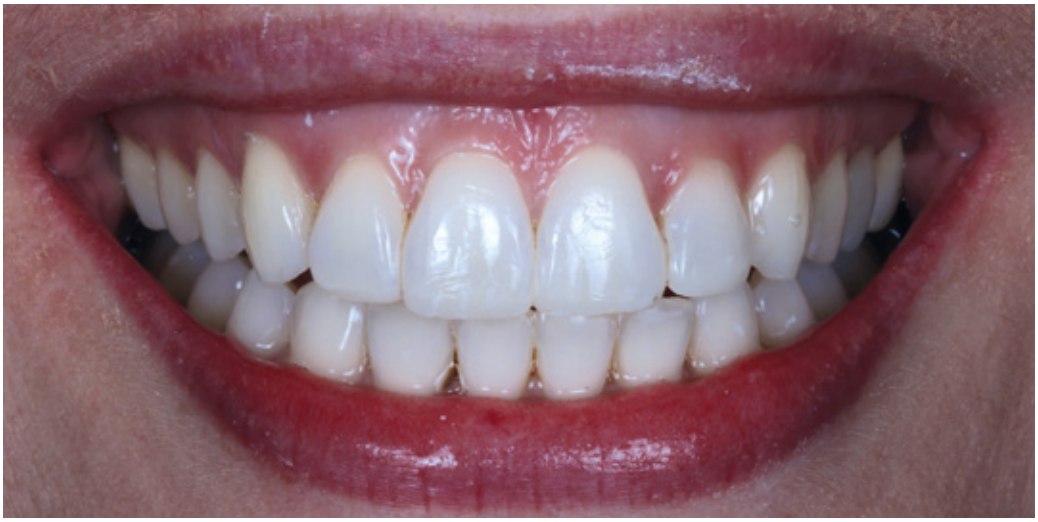
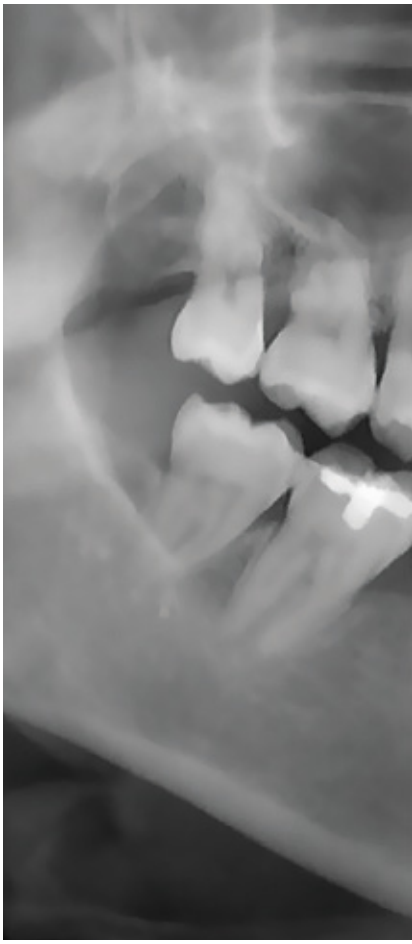


Figure 14: Post-treatment smile (post polish)

The clinical application of two-piece zirconia implants



Professors Chen, André; Chevalier, Jérôme; Fischer, Jens; Gahlert, Michael; Kohal, Ralf; Özcan, Mutlu; Payer, Michael; Piconi, Corrado; Zechner, Werner; & Drs Maier, Frank; Röhling, Stefan; Tartsch, Jens[1]

[1]Scientific Advisory Board and Board of Directors, The European Society for Ceramic Implantology (ESCI)

Background of zirconia oral implants

The development of high-performance ceramics – like zirconia – has provided new, metal-free treatment options for both patients and practitioners. Due to its superior biomechanical and biocompatible properties, zirconium dioxide (zirconia, ZrO_2) has pre-vailed over other oxide ceramics and has been used in dentistry for about 25 years. In comparison with other oxide ceramics (for example, alumina), zirconia shows superior biomechanical properties such as high fracture toughness and bending strength[1] that give zirconia implants the ability to withstand oral occlusal forces.[2, 3] Thus, zirconia as implant material has successfully been established on the market as a reliable alternative to titanium in implant dentistry.[4]

Ceramic implants made of zirconia are not only the focus of current scientific research, also the desire of patients for metal-free, respectively full ceramic dental rehabilitations, is becoming increasingly important: ceramic implants are attractive to patients. A current interview including more than 270 patients in two countries has reported that 80 per cent of the patients would prefer ceramic over metal implants.[5]

In order to establish zirconia as a reliable alternative to titanium as oral implant material, stable zirconia implants with micro-rough surfaces, showing a safe and predictable capacity for osseous integration, have been developed. At the beginning of 2004, the first one-piece zirconia oral implants were established on the market. Initially, creating micro-rough surface topographies on zirconia implants without compromising the bio-mechanical stability (such as fracture toughness and fatigue strength) was a challenging procedure from a technical point of view. Consequently, reduced survival rates[6, 7] and numerous zirconia implant fractures were reported for this "first generation" zirconia implants.[8-10] Since then, the industry has continuously improved manufacture processes to produce micro-roughened zirconia implants with reliable fracture toughness and fatigue strength that show a predictable osseointegration[11] and high clinical survival rates at the level of conventionally used titanium implants mid-term[6, 12-15]

Experimental studies have shown that the latest generation of zirconia implants with micro-rough surfaces show an identical hard tissue integration compared with titanium implants.[11, 16-20] However, the different zirconia implant systems on the market show varying surface topographies and not every company offers evidence-based data or provides information regarding the implant surface and the osseointegration performance of the appropriate product. Consequently, clinicians must scrutinise if the chosen zirconia implant system offers scientific data regarding the osseointegration capacity.

In the last two decades, not only surface micro-texture but also implant macro design has been adapted. Whereas the first zirconia implant systems were limited to a one-piece design, two-piece zirconia implants are now available. This developmental process has also been strongly influenced by the predilection

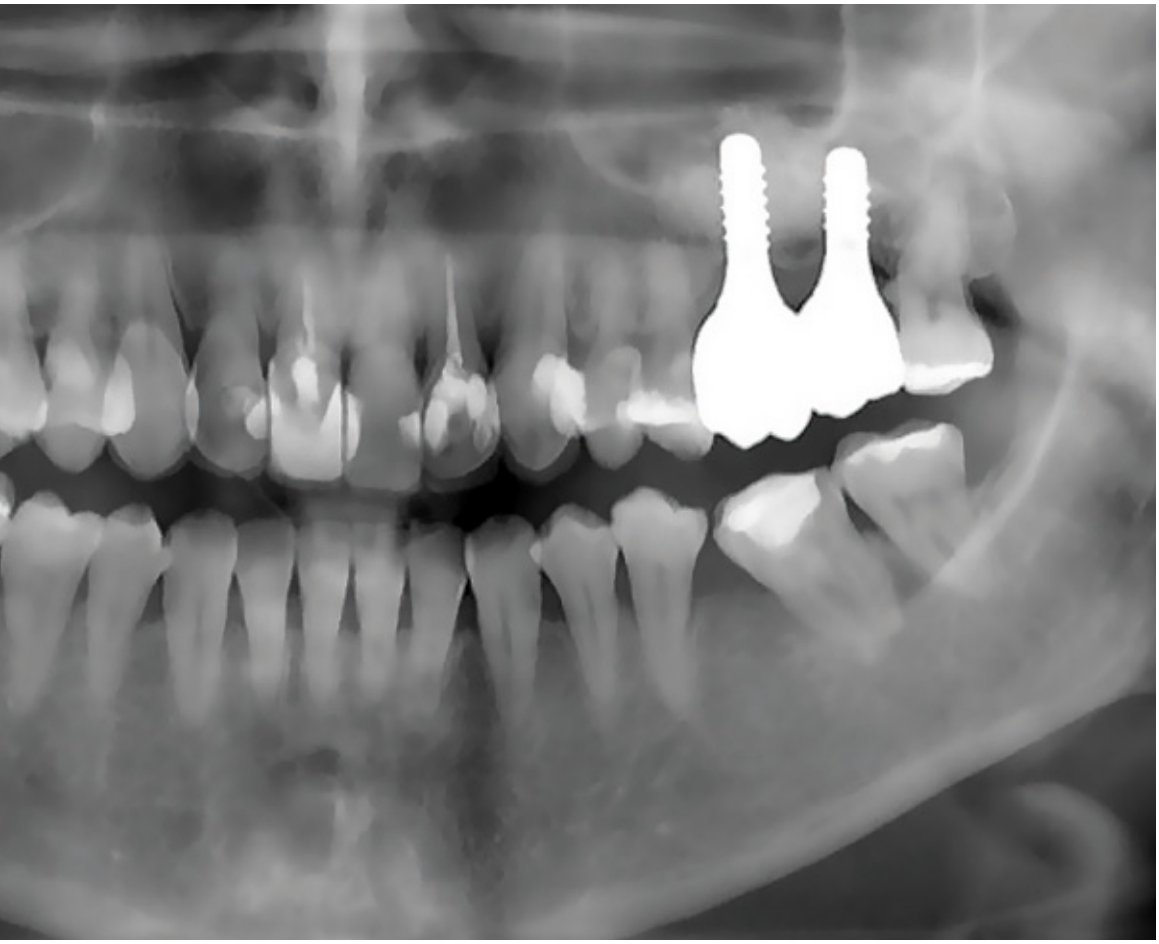


Figure 1: Orthopantomograph after two-piece implant placement+

of clinicians for two-piece implant designs and confirms a clear trend for two-piece implant designs not only for titanium but also for zirconia implants. Nowadays, one- and two-piece zirconia implants with different designs and diameters that allow the treatment of partially and completely edentulous patients have become available on the market.

Clinical data

Due to the large number of adaptations and further developments regarding zirconia implant designs and manufacture processes in a relatively short period of time, it has become quite difficult for clinicians to assess the available clinical data in relation to the zirconia implants under investigation and to evaluate the clinical relevance of the investigated implant type and the reported results.

Various clinical studies investigating different types of zirconia implants were published in the last couple of years. However, it must be considered that some recently published clinical studies investigated zirconia implant systems that have been further developed in the meantime and that are not any longer available on the market. A meta-analysis has reported that physical properties and ongoing market availability significantly influenced the reported zirconia implant survival rates.[6] In a systematic review, the authors evaluated clinical studies investigating zirconia implants that were published between 2004 and 2017. The reported one-year mean survival rates for commercially available zirconia implants (98.3 per cent) were significantly higher compared with zirconia implants that are not any longer commercially available on the market (91.2 per cent). In addition, a mean two-year survival rate for commercially available zirconia implants of 97.2 per cent was evaluated whereas the zirconia implant design – one-piece compared with two-piece designs – did not significantly influence the reported survival rates. In this context, it has been shown that zirconia implant survival rates have significantly increased between 2004 and 2017 and that the fracture incidence of zirconia oral implants was significantly reduced from 3.4 per cent to 0.2 per cent.[6] Even though meta-analyses estimating overall survival rates are currently limited to one- and two-years' data, single studies reported longer clinical follow-up periods. Regarding commercially available zirconia implants, clinical data up to and after five years of functional loading reporting survival rates of 95 per cent are now available.[12, 14, 15, 21, 22]

The data of the previously reported meta-analysis were the basis for the clinical recommendations that were created for the sixth ITI Consensus Conference.[6] In this systematic review, more clinical studies investigating zirconia implants with a one-piece design were included than studies evaluating two-piece zirconia implant designs. Consequently, the main statement of the consensus conference on the clinical application of zirconia implants referred to one-piece implant designs.[7] However, the data of the meta-analysis has reported that the implant design did not significantly influence the reported survival rates. Based on the currently available clinical data,

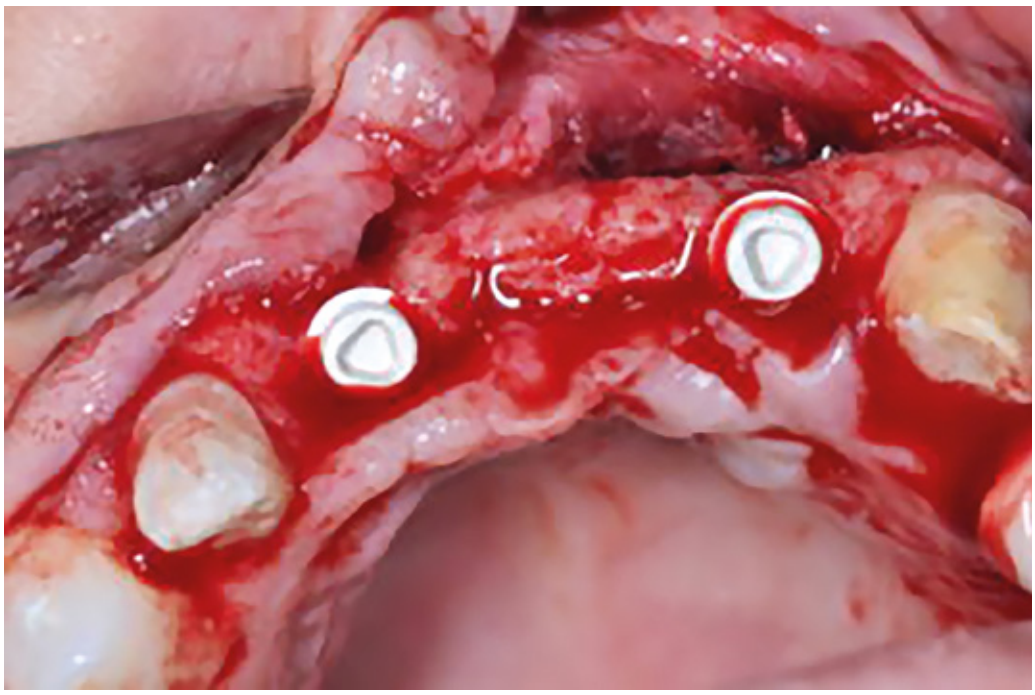


Figure 2: Placement of two-piece zirconia implants

it seems that the studies investigating two-piece zirconia implants report similar survival rates compared with one-piece zirconia implants.

Two-piece zirconia implants – reliable prosthetic connections

Scientific studies have not only examined the clinical performance of two-piece zirconia implant systems, but also evaluated the reliability and stability of screw-retained implant-abutment connections. Most recently, the stability of a titanium-zirconia screw-retained connection has been directly compared with a conventional titanium-based connection in an in vitro study. The results have shown no statistically significant differences between the investigated groups. Consequently, the authors reported: "The connection of the tested screw-retained zirconia crowns in two-piece zirconia implants is comparable to standard titanium implants in the specific in vitro testing" and: "Based on the results of the present study, the connection between crown and the two-piece zirconia implant seems to be suitable for clinical application."[23]

It is particularly important to evaluate studies and implant systems individually according to the material and type of connection. For example, the stability and fracture resistance of ceramic implant systems was tested in vitro in accordance with ISO standard DIN 14801 in various studies. These studies demonstrated that the tested two-part zirconia ceramic implant systems can withstand the physiological masticatory forces in the long term and the stability is considered sufficient for clinical application.[24-29]

Two-piece zirconia implants – reliable clinical applications

Regardless of the available scientific studies, the question whether one- or two-piece zirconia implants are used depends not only on the preference of the dentist/surgeon, but mainly on the individual clinical situation.

There are specific indications in which the use of a two-piece zirconia implant concept offers a more reliable clinical outcome compared with a one-piece implant design. For example, completely edentulous jaws, soft bone conditions or when bone augmentations are performed simultaneously with implant placement and/or when primary implant stability is difficult to achieve, respectively when uncontrolled mechanical loading of the implant must be avoided.

With a one-piece implant concept, the abutment is an inherent part of the implant that penetrates the soft tissue into the oral cavity. Thus, uncontrolled early loading cannot be completely avoided. Furthermore, with one-piece implants the prosthetic superstructure has to be cemented on the implant. In addition, not every clinical situation allows placing the implant in a correct prosthetic angulation and the implant has to be inserted in an angled axis. Regarding prosthetic implant axis corrections, two-piece zirconia implant concepts offer more options than one-piece concepts due to the fact, that individually designed abutments can be fabricated.

Moreover, cementation of the prosthetic superstructures can be avoided since two-piece zirconia implant concepts allow for the fabrication of reversibly screw-retained prosthetic reconstructions. Thus, prosthetic "flexibility" and "reversibility" must be emphasised in many clinical situations. Therefore, the use of two-piece zirconia implant concepts – as with titanium implants – has become indispensable in everyday clinical practice.

So far, more clinical studies are available that investigate one-piece compared with two-piece implant concepts. However, based on the clinical data available so far, meta-analyses have reported that the zirconia implant concept – one-piece compared with two-piece – did not significantly influence the clinical survival rates up to 5.1 years (mean follow up: 2.4 years).[6] Single studies investigating two-piece zirconia implant designs even reported clinical data up to and after 6.7 years of functional loading.[30, 31]

Summary and Conclusion

Based on the scientific data available to date, micro-rough zirconia implant surfaces show osseointegration capacity compared to their micro-rough titanium implants counterparts.[11, 16-20]

References: https://tinyurl.com/2p8eakp4

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ON BRANDING, IN 2022 AND BEYOND

Building and maintaining relationships with patients is the key to succeeding in our profession

[WORDS: ALUN K REES]

I'M WRITING THIS PIECE AS A NEW Year starts to stretch its legs and, although not quite running flat out, is taking longer strides. As the thoughts of resolutions are replaced by reality, I want to look at one thing that inhabits and influences the outcomes of everything we do – our brand.

A brief history. The brand started as a distinguishing mark, cattle owners would "brand" their cattle to show ownership. The American Marketing Association's definition is: "Name, term, design, symbol, or any other feature that identifies one seller's good or service as distinct from those of other sellers." It applies to something you make. Successive waves of thought saw branding defined as something that "you own inside the mind of a prospect", (Ries & Trout) and then "a container for a customer's complete experience with a company or business" (Zyman).

Finally, we arrived at the point where branding establishes the relationship between provider and consumer. The old business model in dentistry was like that of the patrician surgeon and the plebeian patient, where the dentist was the expert whose advice was always taken and the patient was grateful for whatever they received. At last we can recognise there are multiple facets including doctor/patient, teacher/student, guide/traveller and leader/follower. There should also be a larger element of equality in the relationship that fosters better communication, respect and mutual openness and trust.

If I haven't lost you in the business school jargon, I would ask that you consider these fundamental questions:

- What do you do?
- How do you want to be perceived by your patients?
- Why is that important to you?
- What makes you different from the others in the 'High Street'?
- How are you going to communicate those differences to your current and prospective patients?
- How will you ensure the loyalty of your patients?

If you have never asked yourself those questions or have not repeated the exercise recently, then I suggest that you do so without delay. We all live in times of change, the past couple of years have shown that our very existence can be shaken by a virus and the profound effects of COVID will cast a long shadow.

> "IT IS IMPORTANT TO UNDERSTAND YOUR OWN MOTIVATIONS AND WANTS

It is important for personal and professional success, happiness and fulfilment to understand your own motivations, needs and wants. If you don't know those how will you know when you achieve them?

It can be difficult to differentiate the margins of personal and professional. I first wrote of my unease about the phrase "work/life balance" a decade-and-a-half ago because they are not separate things they are inexorably meshed.

We have always known that relationships were important, but now relationships are everything. Increasing emphasis on selling branded 'systems' to treat crowding for instance, are fine as long as you, the professional, are the person in control and not part of the 'product'. This could be the tip of a corporate iceberg. The push towards selling 'things' has already led to an increased demand from transactional motivated patients who believe they know what they want. The challenges include avoiding a race to the bottom by competing on price and ease of availability, amongst other factors.

A transactional patient is all about the "product". On the other hand, a relationship patient is all about your values. They want reliability, the longterm, focussing on "same place, same face", and above all to trust. You are their source of knowledge of all things "dental" and more.

Practical challenges of branding within every business are ensuring that your values, messages and image are consistent throughout every team member. This can bring difficulties with (for instance) associates; you want them to be memorable, to have their own personalities with a personal brand, not automatons but remaining onside. This makes the messages made by the practice even more important; they must be clear, honest and easily understood. The greater the complication the more there is a chance of confusion.

I haven't attempted to answer the half a dozen questions I suggested that you ask yourself. They are not my questions to answer, nor should they be, if you want to set yourself apart from other dental businesses then be absolutely clear what you stand for and avoid being a pale impression of everyone else.

Before I opened my first practice, my first ten years in dentistry post-BDS were spent firstly in the hospital system and then in a variety of associate posts. I usually describe that decade, as "where I learned how I didn't want to practise". I realised then that there are two sorts of motivations, away and towards; of these away is by far the stronger. So if you don't know what you do want, work out what you definitely do not want and move away from it. One step, stroke, thought and idea at a time until you can see your way towards what you do want.

(It could be that you need help, in which case I'm your man.).

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

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MERZ AESTHETICS – A VISIONARY APPROACH TO THE USE OF ULTRASOUND IMAGING

Over the last decade, medical ultrasound imaging technology has improved dramatically, creating clearer and more defined pictures. The advancement to portable devices has improved the accessibility of ultrasound and therefore improved patient care. We find ourselves in an age where ultrasound is sophisticated enough to fit in your pocket whilst seamlessly sending images to your mobile device.

Merz Aesthetics recognise the importance of patient-centered treatment and care, and the role ultrasound will play in the field of Medical Aesthetics and therefore have invested in Vscan Air™ and Venue Fit Utrasound™ (both from GE Healthcare) for all of the Healthcare Practitioners that deliver training on their behalf. Coming together with the team from Cutaneous (www.cutaneous.org), Merz Aesthetics training partners practically worked through the many advantages towards patient treatment protocols; identifying previous Hyaluronic Acid filler treatments, mapping vascular anatomy and managing complications over two days training in Glasgow.

DR SEVI SAYS...

Merz Innovation Board Member Dr Julia Sevi attended the training in Glasgow and has this to say:

"Merz has taken a visionary approach to the future of ultrasound imaging in aesthetic medicine by facilitating skills training, and creating a collaborative environment in which the many potential applications can be developed."

Merz Aesthetics believe their substantial investment in medical ultrasound imaging demonstrates their commitment to improving patient safety and setting the standards for future patient care in aesthetic medicine. UK colleagues and international experts spent two inspiring days learning to visualise live facial anatomy through ultrasound imaging, and also gained insights into the ultrasound-led assessment and management of adverse events from leaders in the field.

Accessible high definition ultrasound could now be within the reach of many clinics, and I believe this will herald a revolution in care. The introduction of point of care routine scanning has the potential to improve safety and efficacy, and having been privileged to now use it in my daily practice, I cannot imagine ever working without it - it would feel like being asked to drive my car with my eyes closed! At Aesthetic Health we now increasingly use ultrasound imaging throughout our patient journeys, and so far the patients and team love it. This starts with assessment of tissue depth, thickness and individual anatomy during consultation, to better plan the treatment prescriptions. Patients' fascination at visualising their internal anatomy supports patient engagement and a greater understanding of the rationale behind their treatment plans. Regular review of the evolving changes in tissues help us monitor the regenerative responses, to keep the plan on track, and to illustrate the internal tissue changes to our patients.

At the point of care in the treatment room, ultrasound can be used before, during and after treatment for vascular mapping and optimal placement of treatment for enhanced safety and efficacy. In adverse event management, ultrasound opens up the potential to improve outcomes through a national network of trained practitioners with centralised skills and audit. It also has the potential to augment aesthetic medical training through upgrading 3-D anatomy via live anatomical assessment of all facial layers and fine tuning our accuracy of treatment delivery. For anyone feeling daunted at the thought, I would encourage you to dive in, because surely any direct vison of the internal anatomy of your patients is better than none. Your skills will evolve quickly once you start and soon you will wonder how you ever treated without visualising the internal landscape of your patient, before diving in.

For all enquiries, please contact Lucy Dowling: lucy.dowling@merz.com

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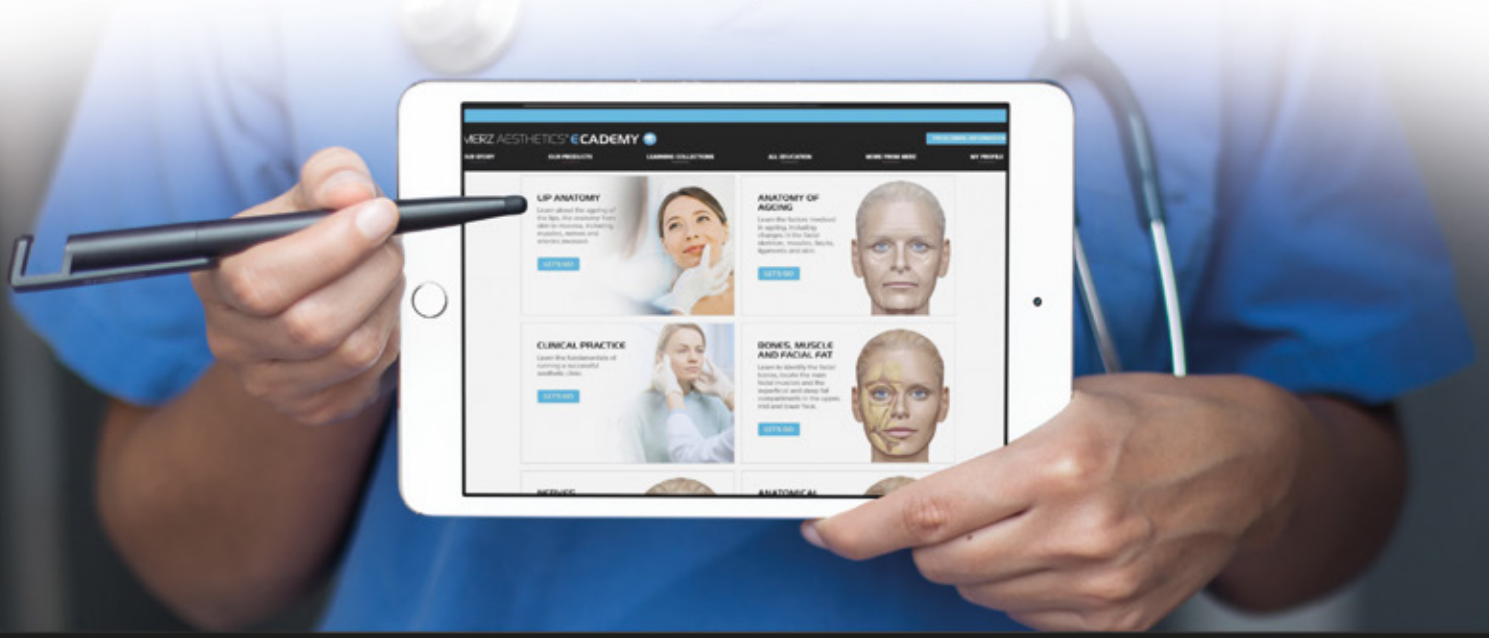

ADVANCING MEDICINE IN AESTHETICS

M-MA-UKI-1720
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UTILISING SMART TAX STRATEGIES

This is the story of Dympna the dentist...

Dympna was born in 1972 to farming parents. She was a very intelligent girl, getting three A levels in sciences. She decided to go to dental school in Belfast at age 18 in 1990. She qualified with a 2:1 degree in dentistry, aged 23, in 1995. She decided then to travel for a year and went to Australia and New Zealand and worked in hospitality part-time.

Upon returning in 1997, she worked as an associate dentist for a reputable dental mixed practice in Co. Fermanagh for 10 years. She married in 2000, aged 28, to John, an engineer, and settled in Enniskillen, Co. Fermanagh, Northern Ireland.

After the birth of Dympna's first child, Peter, in 2002 the principal decided to retire, and asked Dympna if she would be interested in buying the practice. Dympna, now 35, decided to buy it as it was always her dream to own her own practice. She worked her socks off for eight years and even acquired another NHS practice down the road from her. She was blessed with a wee girl, Della in 2005.

The acquisition, RQIA, BDA, GDPR, GDC, CQC, HR and all other compliances got on top of her. She found herself working 80 hours per week including Saturdays, with the help of three associates and a dental team of a practice manager, four nurses and a receptionist — 10 in total, she was drained. Her dream was turning into a nightmare.

Now aged 43 in 2005, Dympna decided to call Corrigan & Co Ltd after seeing Eamonn do a presentation at a dental conference. We are a firm of accountants and tax consultants who specialise in dental clients' tax and accounting.

After spending time with Dympna, which is crucial in our opinion, and going through her goals we quickly established her main personal goal was to get back her time, so she could spend more time with her family. Her main business goal was to sell up by the age of 53 for £3million in 2025. This gave us 10 years.

We looked at the last three years' financial accounts prepared by the previous accountant in Belfast. Then we listed out what we could do:

- Practice health check
- 71 tax tips

- Incorporation
- Are all expenses claimed
- Are we utilising all relief (e.g. R&D)?
- What is the level of gearing?
- Drew up a personal balance sheet
- Looked at the surgeries for capacity issues
- Is team morale good?
- Are there any profitability killers (e.g. staff, debt, tax, marketing, overheads, waste ?

We enlisted the services of Spot On Business Planning (SOBP) and Andy McDougall (who doubles dentists profit every three years and delivers) as the NHS practice was now loss making and putting severe strain on the other practice. On a profit of £150,000 Dympna was paying £60,000 in taxes as a sole trader.

With profits now beginning to increase we decided to incorporate her twi practices in 2016 and the results were impressive for the next five years . As we could use Incorporation relief for the goodwill CGT we postponed as we knew she was selling up further down the line.

We used a mix of salary and dividends to utilise Dympna's remuneration. Dympna was paying life insurance and pension and we got the company pension consultant to get a tax deduction in the company for their payments. We established £60,000 would be enough for Dympna to live on, since her drawings in the sole trader accounts of £145,000 included personal pension at £25,000 and tax £60,000.

With the extra profits by SOBP and tax saved by us, Dympna bought another practice. We did due diligence on this practice and arranged finance via a SSAS — arranged by Darren McDermott (the practice financial advisor).

Dympna's son Peter meanwhile was showing signs of wanting to become a dentist and go to QUB in Belfast like his mother in 2020. We advised her to buy a property in Belfast for £200,000 in Peter's name and the parents arrange the mortgage. Peter can live with three friends and take advantage of rent-a-room relief at £7,800 at no tax and also avoid the 3% stamp duty charge on second homes. He can then sell the property free of CGT as it's his principal residence at an estimated profit of £100,000.

So, by now Dympna has three efficient practices, all Limited companies, and we decided to form a group as the profits, cash, and team structures were all going great.

A group of companies has many advantages:

- Cash can be lent to each other
- Can buy better as part of a larger group — economies of sale
- Charge a management fee that is tax deductible
- Appoint a group practice manager
- Marketing can be done for the group
- And Substantial shareholder exemption (SSE) where a subsidiary can be sold CGT free

Dympna decided to sell the NHS practice, which was now turning a profit of £50,000 on an EBITDA factor of six and take advantage of SSE (sale value £300,000). It is November 2020. Each practice is showing a profit of £100,000 each, five years into our journey. With profit forecasted to double every three years, a profit of £500,000 is achievable by 2025.

John, her husband decided to invest £50,000 in a SEIS company he liked, getting him 50% income tax rebate.

Since the practice is run efficiently and effectively an EBITDA of eight is achievable; the sale in 2025 = 500,000 x 8 = £4,000,000.

Since we postponed the capital gains of the business in 2016 by £1m, a capital gains tax bill is payable on £3m (not £4m).

Up to selling in 2025, Dympna had BPR at 100%. But the day her £4m hits the bank that ceases and a potential IHT bill of £1.6m is payable if she dies. Dympna and John are advised to update their wills. We advise life insurance is taken out for at least a year, so Dympna has time to plan what to do with her £4m.

2026

Dympna forms a family investment company (FIC) with £2m after her CGT payment and taking a nice family holiday and doing some private investments in ISAs and venture capital companies. Peter wants to buy a practice before the age of 30. Della wants to go into property at age 25. They can offer a loan to family to make purchases, getting tax relief via the FIC.

THE CYCLE CONTINUES

We will form a company for Della: 10 properties We will form a company for Peter: dentist business

Recap on tax strategies used:

- Incorporation
- Research and development (R&D)
- Capital allowances — super deductions (C/A's)
- Rent a room
- Principle private residence (PPR)
- Substantial shareholder exemption (SSE)
- Incorporation relief
- Business property relief (BPR)
- Family investment company (FIC)
- Small self-administered Company pension scheme (SSAS)
- Overlap relief.

CORRIGAN & CO.

"it's not what you earn, it's what you keep"

accounting - taxation -consulting

We are a firm of accountants based in Enniskillen, Co. Fermanagh, N. Ireland who have a niche in dentistry for the past 10 years, with dental clients in NI, ROI and GB. Our research found that very few accountants fully understand the business of dentists.

We are the one stop shop for all your dental needs

Tax planning – Are you paying too much tax? You probably are
All compliance – HMRC, Companies House, Revenue Commissioners etc
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Software for a better clinic – Help collate important data
Marketing - getting more of the right clients – Do you need more patients?
Goal setting – Get you where you want to be
Valuations of practices – Goodwill etc
Benchmarking – How you are doing against the competition
Financial due diligence – In depth reports on a target practice
Succession planning – Passing the torch
Buying/selling practices – We can help on this
Financial planning – Pensions, SEISS, EIS | Family investment companies
Business plans/Recovery plans – Important to set a good plan|Cashflow forecasting|Grants/funding
Cloud accounting – We rave about Xero
R & D claims – Going unclaimed in many dental practices
Group structures – Explore good tax breaks
Incorporations – Better for tax planning and transfer of wealth
Will writing – You're never too young to write a will
Embedded capital allowances claims – Unlock hidden allowances in your surgery
KPI's (Key Performance Indicators) – Tracking these are very important to realise your dreams. What gets measured gets done.
Funding – Asset purchases | Working capital | Practice acquisitions

What we do

Take control of your Dental surgery numbers...

- Get to grip with your accounts
- Know where you stand financially
- Get a handle on your cashflow

Achieve your personal goals & grow your surgery...

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- Get your team on board
- Get your practice to the next level

Improve your surgery results...

- Get more reward from the effort you put in
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Our 3 freedoms for you:

t – time – (more of) | m – money – (more of) | m – mind – (less stress)

For more information please call Eamonn on 028 6632 9255
Or email eamonn@corriganandco.com

BRAEMAR FINANCE

LORRAINE BLAKE, IRELAND AREA SALES MANAGER, BRAEMAR FINANCE

PROVIDING PRACTICES WITH FUNDING NEEDED FOR GROWTH

Tell us about yourself and your background

I'm a senior business and relationship development executive with more than 20 years' commercial experience in asset finance, tailoring solutions to the unique needs of SME customers

What does your role as Area Sales Manager for Braemar Finance in Ireland involve?

I will drive Braemar Finance's business in the Republic of Ireland, offering a range of flexible funding solutions to our new and existing Professions customers.

What sort of assistance can you offer dentists in Ireland?

We provide dental practices with the funding they need to grow. This funding may be for the purchase of new equipment, to extend a current practice, or to buy more dental practices. We offer a choice of finance options, including Business Loans for Limited companies, Hire Purchase and Leasing, ranging from one-to seven-year options.

Why would a dentist need finance?

Buying or starting a dental practice is one of the biggest decisions a dentist is likely to make. We provide practice owners with the opportunity to grow their business at scale and do this by analysing a business in detail and recommending the best possible loan to suit their needs.

BRAEMAR FINANCE
Part of Close Brothers Group

Contact Lorraine Blake
086 772 7552
LBlake@braemarfinance.ie
www.braemarfinance.ie

SOUTHERN IMPLANTS

STEPHEN WILSON, CLINICAL SUPPORT AND PRODUCT SPECIALIST

PROVIDING TOP QUALITY SUPPORT

Southern Implants is a privately owned osseo-integration company, founded in South Africa in 1987, and within the group are companies specialising in spinal, cardiac and tissue regeneration.

Our goal is to give clinicians the tools to achieve successful aesthetic outcomes – and implant design, surface, and the componentry all work hand in hand to enable screw-retained restorations in most cases.

Our clinical support and product specialist in Ireland is Stephen Wilson. Having come from an engineering background, he initially entered the dental field through the supply and repair of dental equipment. His focus is on customer care and specialist support for those customers using Southern's advanced implant solutions.

SOUTHERNIMPLANTS

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University of Central Lancashire UCLan

In collaboration with straumann botiss biomaterials Prestige Dental Technically first class VSSAcademy continuing dental education

MSc Clinical Implantology

2 years, part-time | Scotland and Ireland | September 2022

The world of dentistry continues to change. Patients have increasing expectations and there is more that Dentists can do to meet their wishes and needs. The future is bright for the dental practitioner with enhanced skills working either within the National Health Service or privately. Dentistry is moving towards the establishment of local clinical networks where the dentist possessing additional skills can look forward to a career with greater professional rewards. With the ever-increasing emphasis on the delivery of high quality in primary care, completing one of our postgraduate MSc degrees will allow you to play a strong role in provision of dental treatment in the future. UCLan's Dental Implantology programme provides the busy General Dental Practitioner with a part-time educational route to acquire the skills and knowledge required to undertake more complex and interesting cases in practice. This programme focuses on contemporary practice, evidence-based principles and systems to ensure an optimal outcome for both the patient and practitioner.

Course delivery - This course is made up of virtual classrooms, live webinars and contact days that take place mostly on Saturdays in Glasgow. Clinical supervision days take place at our Regional Training Centres throughout Scotland and Northern Ireland.

Course Overview

Module DX4016 Clinical Implantology Year 1.
MSc course introduction followed by 13 days of lectures and hands-on tutorials:

September 2022:	MSc Course Induction. Two-day virtual MSc in Clinical Implantology course induction. Preston Campus.
1st Oct 2022:	Treatment planning and case selection. Face to face contact day with hands-on workshops.
22nd Oct 2022:	Basic sciences for Implant dentistry. Pre-recorded lectures; live webinar discussions.
12th Nov 2022:	Implant Design. Pre-recorded lectures; live webinar discussions.
3rd Dec 2022:	Surgical skills for Implant dentistry. Face to face contact day with hands-on workshops.
7th Jan 2023:	Occlusion. Pre-recorded lectures; live webinar discussions.
28th Jan 2023:	Restoring Implants. Pre-recorded lectures; face to face contact day with hands-on workshops.
18th Feb 2023:	Digital Workflow in Implant Dentistry. Pre-recorded lectures; face to face contact day with hands-on workshops.
11th March 2023:	Bone Defects. Pre-recorded lectures; live webinar discussions.
15th April 2023	Complications and their management & Revision. Pre-recorded lectures; live webinar discussions.
6th May 2023:	Case reports. Case Report Presentations covering Case selection & treatment planning – each delegate to present one case.
20th May 2023:	Cadaver course. Face to face contact day with hands-on surgical skills workshops.
To be completed before 28th Feb 2023:	CBCT Masterclass. 2 days, consecutive. Day One: On-line Module; Day two: Contact day. Choose from a selection of dates.

Module DX4017 Utilising the evidence base – completed online

Module DX4016 End of year Assessment
Date TBC.

Complete 5 Clinical days - supervised clinical practice.
You will assess and plan appropriate treatment for patients. Includes: case assessment and treatment planning, including use of radiographic stents and CBCT.

Module DX4026 Clinical Implantology Year 2.
Complete 10 Clinical days - supervised clinical practice. Includes: case consultation, implant placement, GBR procedures, restoration, follow up.

Module DX4027 Research Strategy. Prepare and submit a 8,000-word clinically orientated research project, which may take the form of a mini systematic review.

Final examinations.

PLEASE NOTE THAT ALL WEBINARS ARE PRECEDED BY RECORDED LECTURES AND LONG QUESTIONS FOR DISCUSSION.

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> ALIGN TECHNOLOGY

ARE YOU READY TO GO?

Align Technology, Inc. announced the launch of Go Day to enable general dentists to discover more about its Invisalign Go portfolio.

The online event ran on 24 February to give general dentists the opportunity to explore how Invisalign clear aligners and a digital workflow can help them provide comprehensive dental care with improved aesthetic and oral health outcomes, as well as a better patient experience.

The free online event covered these topics with the help of two experts who explored how the integration of the Invisalign Go system with additive prosthetics provides a minimally invasive treatment approach, and how the minimally invasive approach of the Invisalign Go Plus system helps GPs achieve long-lasting treatment in a short timeframe.

Prof. Camillo D'Arcangelo presented 'Non-invasive, simple and predicable dentist for aesehtic and functional rehabilitation'.

Dr Camilla Morrison presented 'Minimally invasive dentistry and the integration with Invisalign Go Plus'.

Align Technology's Jody Carter, Senior Director, Marketing GP Channel EMEA, Abhishek Ganguly VP, Sales GP Channel EMEA, and Lee Taylor, Vice President of Marketing EMEA introduced the Invisalign Go system and provided information on the Invisalign Go portfolio, including Invisalign Go Plus.

The event was open to Invisalign providers and non-providers.

For more information on the Invisalign Portfolio, and how you can benefit from a digital workflow visit http://www.invisalign.eu/provider/gp

> GC EUROPE

TRAIN THE TRAINER FOR INDIRECT RESTORATIONS WITH GC EUROPE

Today's dental professionals are required to work at a fast pace and this is reflected in popular trends with monolithic and/or micro-layered restorations from lithium disilicate or zirconia clearly on the rise. CAD/CAM technology is also being utilised more often, in the lab as well as chairside, especially to provide single-visit dentistry. Even for luting, universal solutions without complex protocols are more in demand than ever.

In January, GC Europe hosted the 3rd 'Train the trainer for indirect restorations' two-day course to bring together highly valued expert trainers and lecturers to provide delegates with new ways to complete their cases in the most efficient way. This year the event was inevitably held online.

A select group of renowned specialists in prosthetics joined the course. Prof. Dr. Marcio Vivan Cardoso (KU Leuven (University of Leuven), Belgium), presented an excellent update on the latest materials and trends and provided guidelines on modern preparation techniques, including digital solutions.

Dr Rumphorst gave a clear overview on good luting procedures to proceed with treatment. Nowadays, luting needs to be straightforward and easy to apply so universal solutions such as G-CEM ONE are an excellent way to meet this demand.

The course concluded with practical demos and case presentations from GC Europe's education team, providing delegates with new insights and helpful tips to share with fellow dental professionals.

For more information on all GC courses contact GC UK on 01908 218999, email info.uk@gc.dental or visit www.gceurope.com/education/courses

> SHOFU DENTAL

BEAUTIFIL FLOW PLUS X: INJECTABLE HYBRID COMPOSITE IN TWO VISCOSITIES

Whether you wish to build up occlusal surfaces and anatomical details, line cavity floors or fill occlusal and cervical cavities: With Beautifil Flow Plus X, SHOFU offers you a universal, durable hybrid composite, available in two viscosities – F00 and F03 – for optimal flowability and dimensional stability in all clinical indications.

This light-cured direct restorative combines the handling properties of flowable composites with the strength, durability and aesthetics of packable hybrid composites.

The special features of Beautifil Flow Plus X include exceptional sculptability, two viscosities and the preventive benefits of the integrated S-PRG filler, such as fluoride release, anti-plaque effect and acid neutralisation.

Excellent light diffusion properties create a well-balanced chameleon effect, so that your restorations harmoniously blend in with the adjacent teeth.

Beautifil Flow Plus X F00 and F03 are only slightly different in viscosity, but this slight difference has a great effect on handling:

- F00 (Zero Flow) – Excellent shape retention, ideal for build-up. The flowability of F00 is so low that the paste is not deformed during layering.
- F03 (Low Flow) – Moderate shape retention and viscosity plus perfect adaptation. The self-levelling F03 paste thoroughly wets the cavity walls and is therefore ideal for filling.

SHOFU DENTAL GmbH
info@shofu.de
www.shofu.de/en

> BELMONT

EURUS S6 TREATMENT CENTRE: PERFECTING THE ART OF DENTISTRY

Belmont's new Eurus S6 treatment centre exudes refinement and brings the next level of ultrasoft comfort, quality, innovation and style to contemporary dentistry.

The super-efficient design offers total accessibility for both patient and operator alike, allowing effortless working positions alongside discreet clean and preparation zones.

The contemporary Eurus S6 has the Belmont renowned below-the-patient swing-arm delivery system, powerful intuitive touch-screen with advanced instrument control and integrated WaveOne technology as a factory built-in option.

The clear and logical touchscreen offers one touch control across a wide range of functions, with an easy-to-read display that tells you all you need to know at a glance. You can pre-programme settings or restore to standard in just one touch. As a combination this brings a wealth of operating options to the fingertips of the dentist.

Uniquely, this treatment centre allows positioning of the doctor table, instruments and assistant tray discreetly out of view behind the chair backrest, easing any patient anxiety as they enter the surgery. Smooth quiet chair movement ensures complete patient comfort, whilst the robust construction enables the Eurus S6 to have a maximum safe working patient weight of 165Kg.

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Note: Connection to external 6mm air & water line sockets are needed to run this unit.

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Joanne Knox - GDC 5893 Company Director Principal Hygienist
Pure Dental Hygiene NI

Scan the QR code to view the NSK Varios Combi Pro Video

Scan the QR code to learn more about the NSK Varios Combi Pro

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