Future unclear for Clearstep as administration looms

Chaos for Clearstep clinicians and patients as clear aligner firm goes to the wall

Thousands of patients and practitioners have been left mid case as Clearstep, the clear aligner company has officially gone into administration.

Following weeks of rumours and confusion, insolvent specialists FRP Advisory has announced that the company has indeed been put into administration. A spokesperson for FRP commented: “The company has gone into administration, and unfortunately all of the staff have been made redundant. It’s a sad day; it’s the end of the line.

“All practitioners will be written to, and will be receiving letters shortly. For more information, contact FRP Advisory on 02070054600.”

For practitioners, the announcement has given closure to the first chapter of a situation that will have repercussions for some time to come. Dental practitioners are left with the situation of patients now needing alternative treatment plans; many of which will have paid in advance. Practitioners are also left counting the cost of treatment plans that they paid for in advance for patients.

During the weeks of uncertainty, patients and clinicians have been taking to social media to vent their frustrations at the lack of information coming from Clearstep. One clinician took to Facebook, many discussed their anger on dental online forums and patients voiced their concerns on sites such as monsters.com. The main issue was the inability to talk to someone and get clarity on the situation so they could move forward with finding alternative solutions for their patients.

Support from the trade has been welcomed, with many orthodontic treatment system providers offering support and advice where needed. Dental Protection too has issued a briefing offering advice. One of its main messages for practitioners states: “There are key principles to follow in order to minimise the dento-legal consequences of these situations are:

1) Find out the facts rather than acting on the basis of rumour and hearsay information. In a fluid situation, you need to be doing this on a daily basis and trying to speak to reliable, authoritative sources of information.

2) Stay in close and regular communication with the patients involved. Make sure that they are talking to you rather than to third parties, so that you give yourself as much opportunity as possible to influence and control events. If patients feel the need to seek advice from a second clinician and are perhaps told (rightly or wrongly) that aligners were never the correct treatment approach in the first place, their dissatisfaction will be all the greater.

3) Let the patients see you understand their concerns, that you are doing your very best to achieve them, and you will ensure they are not financially disadvantaged.

4) Do something positive – be proactive, don’t just cross your fingers and hope for the best. Assess the situation of each patient individually, prioritise their needs, and explore all the available options in the best interests of each individual patient. Keep full records of all of this, including any phone calls that you make, and detailed notes of all discussions and the name(s) and contact details of all the people that you speak to.

Dental Tribune has made repeated attempts to contact the management team at Clearstep, without success.
Dental clinic helps adults with severe phobia

Queenway Dental Clinic in Billingham, Teesside has announced a new partnership with the University Hospital of Hartlepool to provide a general anaesthetic service for those patients who have a severe phobia.

Managing Partner, Dr Paul Averley, Queenway Dental Clinic, explains: “There are a small number of people whose phobia of the dentist is so severe that they haven’t attended check-ups nor had their dental issues attended to for many years, sometimes even decades, resulting in substantial oral health issues. It is for these patients for whom all other pain and anxiety control methods have been exhausted, that we have introduced this general anaesthetic service.”

Private adult patients wanting to undergo dental treatment with the support of general anaesthetic will attend an initial assessment at Queenway Dental Clinic in Billingham, where Dr Paul Averley will ensure that all patients who are to be put forward for a general anaesthetic have genuine oral health issues which cannot be met using other methods, such as conscious sedation.

If the patient is deemed suitable they will have an appointment made for them at the University Hospital of Hartlepool where an experienced team from Queensway comprising a lead dentist, anaesthetist and nurse will work with the Hospital’s staff to provide treatment and after care.

For dentist and patient information on the general anaesthetic service, visit www.queensway.co.uk.

Five per cent of dental patients make complaints

A survey of more than 1,800 people across the UK has revealed how few patients think about complaining about their dental professionals.

Two per cent of those who say they have visited a dentist say they have complained or even considered making a formal complaint about a dental professional during the last 12 months. Specifically, 95 per cent say they had never complained and 95 per cent of these say they have never considered complaining.

When people complain, or consider making a complaint, they tend to complain or want to complain directly to the practice where they had the treatment. More than a third (37 per cent) approached or would approach their dental practice to make a complaint.

However, 52 per cent of those who’d complained, or considered making a complaint, weren’t sure who to complain to. The survey also asked those who had considered making a complaint, what prevented them from doing so. Twenty nine per cent said they did not know where to start and a further 26 per cent said they didn’t know who or where to go to for information on how to complain.

“Better oral health is a key priority of the Government and we recently extended the dental pilot programme which will see preventative care at the heart of dentistry going forward.”

Dentist admits illegal practice

The General Dental Council (GDC), has successfully prosecuted a woman for the illegal practice of dentistry.

Ms Joana Antunes Catre Dos Santos, who was working as a dentist at the Advanced Dental Clinic, 25-27 Moorland Road, Burslem, Stoke-on-Trent ST6 1DS appeared at Newcastle-under-Lyme Magistrates’ Court.

She pleaded guilty to four offences of unlawfully practising dentistry and was not registered, contrary to Section 58 (1) and (2) of the Dentists’ Act 1984.

Ms Santos has never been registered with the GDC.

In addition she must pay a victim surcharge of £120 and a total of £248 in costs.

Chief Executive of the GDC, Evany Gilvarry said: “People who practise dentistry unlawfully pose a significant risk to the patients they treat. The GDC is committed to ensuring public safety and I hope this prosecution sends a clear message to others who may be tempted to practise without being registered with the GDC.”

Opportunities for dentists with the TA

Last month, the UK Army began broadcasting a series of live television adverts filming Territorial Army (TA) members live from operations.

The TA LIVE recruitment drive is intended to demonstrate the wealth of the opportunities for specialist professionals such as dentists with the TA and raise awareness of the Army’s current recruitment targets.

The Royal Army Dental Corps provides an opportunity for dentists looking to do something extra with their time and seek a rewarding experience outside of normal working hours.

The Royal Army Dental Corps (RADC) is responsible for the maintenance of the Army’s dental health. TA personnel with the RADC serve in dental centres, in many locations around the world, but they are soldiers too and have a role within field hospitals during military operations.

As part of TA LIVE, over 150 TA recruitment events took place across the country throughout February. TA units also took over the city centres in London, Birmingham, Cardiff, Glasgow, Liverpool, Newcastle and Portsmouth on 16th February to put on seven extensive TA open events to demonstrate to the public what the TA is all about.

Each unit brought a range of specialist equipment and supplies to put on demonstrations and educate the public about the role of the TA and its importance to the UK Armed Forces. Stands included TA ambulances, assault boats, weapon displays, armoured vehicles, mobile bridges, air portable dozers and light-weight vehicles.

For more information about the career opportunities available for medics and other specialist professionals in the Territorial Army, visit www.army.mod.uk/join or call 0845 600 80 80.

Dentistry gets £30 million cash boost

The Department of Health has announced a £30 million boost for NHS dentists. This will allow more patients to register with a dentist, and get their oral health checked.

Lord Howe, Health Minister, said: “Since May 2010 more than a million new patients are seeing an NHS dentist.

“We want to make sure that this progress continues and that dentists give the highest standards of care as well as treating more patients. That's why we have invested this extra £30 million in funding.

“Better oral health is a key priority of the Government and we recently extended the dental pilot programme which will see preventative care at the heart of dentistry going forward.”

The second year the Government has made extra dental funding available. Dental practices can use the extra funds to either put on extra clinical training, attract new patients or buy in new services such as orthodontics.
Editorial comment

Last week saw the Dentistry Show, the first major event of the dental calendar. This show has been going from strength to strength and really is becoming a major force in the dental exhibition sector.

One of the big talking points at the event was the allowance of an illegal whitening company to take a stand. Due to a sustained protest by event goers this stand was withdrawn a few days before the opening of the show.

This story is interesting for a couple of reasons. One – it shows that the companies providing illegal whitening services and training are coming to realise that they need to be a bit more legit to survive in the era of new regulation; and two – practitioners are becoming more united in protecting their patients and promoting best practice of whitening procedures. Groups such as Stamp out Illegal Whitening and the Tooth Whitening Action Group are beginning to make a lot of noise against illegal bleaching... we should be applauding their efforts and getting behind the cause.

New application offered in implant surgery

Dental techniques to modify the alveolar ridge have been around for many years, often as a means of support for dentures. As dental implants have now become common procedures, so has pre-implant preparation of the bone. The ridge-split procedure is one such method of widening and augmenting the alveolar ridge that is finding renewed interest.

A new article in the Journal of Oral Implantology presents a detailed description of the alveolar ridge-split procedure. The alveolar ridge is the bony ridge on both the upper and lower jaws that contains the sockets of the teeth. Establishing an alveolar ridge of proper dimensions has become essential with the advent of rootform endosseous dental implants, the most common type of implants.

The ridge-split procedure described in this article is a form of ridge widening or augmentation. In cases of narrow alveolar ridges, it has proven to be consistently successful. Use of this minimally invasive technique has many advantages in the pre-prosthetic stage of dental implants; low risk of inferior alveolar nerve injury, less pain and swelling, and no need for a second surgical site as donor are among the benefits.

Because of differences in bone density, the ridge-split technique requires a single surgical stage in the maxilla, or upper jaw, and a two-stage approach in the mandible. The two stages of mandible surgery consist of corticotomy, a bone-cutting procedure, followed by splitting and grafting performed three to five weeks later. The staged approach of the ridge-split procedure has shown a higher implant success rate and better buccal cortical bone preservation.
Children's oral health initiative launched

Temple University Kornberg School of Dentistry has launched Project ENGAGE, a $1.75 million initiative designed to improve children's access to oral health care.

The program will be available to North Philadelphia children under the age of six and their families who are enrolled in the state's Medicaid plan. The goal is to eventually expand the initiative to other parts of Pennsylvania and country.

"Project ENGAGE is an example of a new health promotion system that will reach out to children and families to assist them in getting dental care and remove barriers that prevent these children from having a dental home," said Amad Imain, dean of the Kornberg School of Dentistry.

Currently, fewer than 50 per cent of the children under six living in the five zip codes surrounding Kornberg's North Philadelphia campus have access to proper dental care, often due to lacking the importance of oral health, limited transportation and access to qualified dental care providers. One of the program's goals is to increase that access to at least 60 per cent of the children.

The new high profile campaign is being spread the message to UK consumers that chewing sugar-free gum after eating and drinking, especially for people who are busy and "grazing" are on the increase.

Dental X-rays increase brain tumour risk

The study was conducted at the China Medical University in collaboration with several other scientific health institutions throughout China.

According to the American Brain Tumor Association, an estimated 69,720 new cases of primary brain tumours are expected to be diagnosed in 2015 in the US, including both malignant (24,620) and benign (45,100) brain tumours. Meningiomas, which are primarily benign brain tumours, represent 54 per cent of all primary brain tumours, making them the most common primary brain tumour.

The study was published online on 15 February in the Annals of Oncology ahead of print.

New drug combination could prevent neck cancer

Eleven patients with advanced oral precancerous lesions were assigned to treatment with erlotinib and celecoxib. Tissue samples from the patients were obtained and evaluated pathologically at three, six and 12 months after therapy initiation. Biopsies at baseline and follow-up were available for seven patients.

"Finding that this drug combination caused some advanced premalignant lesions to completely disappear was great news," said Shi Min. "Advanced premalignant lesions rarely regress, so our data are proof-of-principle that a combination chemopreventive strategy with molecularly targeted agents is possible."

New drug combination shows promise in reducing the risk for patients with advanced oral precancerous lesions to develop squamous cell carcinomas of the head and neck. The results of the study, which included preclinical and clinical analyses, were published in Clinical Cancer Research.

"Squamous cell carcinoma of the head and neck (SCCHN) is the most common type of head and neck cancer," said Dong Moun Shin, MD. "The survival rate for patients with SCCHN is very poor. An effective preventive approach is desperately needed, especially since we can identify patients who are at extremely high risk: those with advanced oral precancerous lesions." Based on prior research suggesting a role for epidermal growth factor receptor (EGFR) and cyclooxygenase-2 (COX-2) in promoting SCCHN, Shin and colleagues believed combining an EGFR inhibitor and a COX-2 inhibitor could provide an effective chemopreventive approach.

They found that the combination of the EGFR inhibitor erlotinib and the COX-2 inhibitor celecoxib was more effective at inhibiting the growth of human SCCHN cell lines compared with either drug alone.

The benefits of breaking up and moving barriers that prevent these children and their families, including siblings and pregnant women, from accessing care.

The program will also provide training for primary care physicians to encourage preventive screenings and to apply dental varnish, while also giving general dentists who do not currently provide dental care for very young children the support and information needed to care for children. Studies show that children should begin seeing a dentist before their first birthday.

New national TV advertising campaign launched

A new national TV advertising campaign launched by Wrigley on 14th February is encouraging consumers to chew sugarfree gum after eating and drinking, especially for people who are busy and 'grazing' are on the increase.

Louisa Rowntree, Wrigley Oral Healthcare Programme Manager in the UK, says: "Wrigley is spreading the message to UK consumers that chewing sugar-free gum benefits oral health, especially for people who are busy and eating and drinking on-the-go. The Wrigley Oral Healthcare Programme supports this through our work with dental professionals, to help them understand and educate their patients about the benefits of chewing and encourage them to Eat, Drink, Chew."

Dentist tackles desert for charity

Dr Mark-Steven Howe from Broadway Dental Care in Worcestershire is heading to Africa in April to compete in one of the toughest foot races on earth.

He will take part in the 28th annual Marathon Des Sables, a 156 mile challenge which consists of six consecutive marathons, in aid of the Air Ambulance.

The marathon will take place over six days. The rules of the race state that all runners must carry all their own belongings throughout, except water.

Dr Howe said: "Looking after your feet will be important and not believing you are indestructible. I have done iron man events ahead of print.

The study was published on-line on 15 February in the Annals of Oncology ahead of print.
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Age affects presence of artifacts in CBCT scan

DNA preserved in calcified bacteria on the teeth of ancient human skeletons has shed light on the health consequences of the evolving diet and behaviour from the Stone Age to the modern day.

The ancient genetic record reveals the negative changes in oral bacteria brought about by the dietary shifts as humans became farmers, and later with the introduction of food manufacturing in the Industrial Revolution.

An international team, led by the University of Adelaide's Centre for Ancient DNA (ACAD), where the research was performed, has published the results in Nature Genetics. Other team members include the Department of Archaeology at the University of Aberdeen and the Wellcome Trust Sanger Institute in Cambridge (UK).

“This is the first record of how our evolution over the last 7,500 years has impacted the bacteria we carry with us, and the important health consequences,” says study leader Professor Alan Cooper, ACAD Director.

“Oral bacteria in modern man are markedly more diverse than historic populations and this is thought to contribute to chronic oral and other diseases in post-industrial lifestyles.”

The researchers extracted DNA from tartar (calcified dental plaque) from 34 prehistoric northern European human skeletons, and traced changes in the nature of oral bacteria from the last hunter-gatherers, through the first farmers to the Bronze Age and Medieval times.

“Dental plaque represents the only easily accessible source of preserved human bacteria,” says lead author Dr Christina Adler, who conducted the research while a PhD student at the University of Adelaide, now at the University of Sydney.

“Genetic analysis of plaque can create a powerful new record of dietary impacts, health changes and oral pathogen genomic evolution, deep into the past.”

Professor Cooper says: “The composition of oral bacteria changed markedly with the introduction of farming, and again around 150 years ago. With the introduction of processed sugar and flour in the Industrial Revolution, we can see a dramatically decreased diversity in our oral bacteria, allowing domination by caries-causing strains. The modern mouth basically exists in a permanent disease state.”

Pilot underway for mouth cancer screening scheme

More than a hundred dentists from fifty dental practices across the UK have started the Mouth Cancer Screening Accreditation Pilot Scheme.

The scheme, which is supported by Henry Schein, DPAS and ProDental(CPD), is the brainchild of Dr Vinod Joshi, Founder of the Mouth Cancer Foundation. It will recognise dental practices that demonstrate a visible commitment to increasing public awareness of mouth cancer screening to all patients and to establish a documented referral pathway with a local specialist department.

The practices who have signed up to take part in the pilot will start the annual membership programme today ahead of the official launch at the BDA Conference on Saturday 27th April 2013. They will road test all aspects of the initiative to ensure it runs smoothly. The pilot practices will work through the accreditation process and act as a focus group capacity by feeding back on the scheme, its methods, quality and efficiency. On completion of the relevant criteria they will receive full accreditation when the Mouth Cancer Screening Accreditation Scheme launches.

Concern over illegal whitening in Ireland

The body representing the Irish dental industry has expressed reservations that companies offering cosmetic tooth whitening services in Ireland may not be operating in compliance with new European laws.

As reported in thejournal.ie, a European directive which came into force last October places a limit on the amount of hydrogen peroxide – the key bleaching agent – that can be used in a whitening solution administered by dentists.

However, the Irish Dental Association says it asked four tooth whitening businesses to provide details on the whitening gels they used, and none could do so. Meanwhile, only one of the four said their practice was overseen by a qualified dentist.

The European rules also require a dentist to approve the administration of the whitening gel in the first instance, and requires a full clinical exam of the patient before the process can begin.

IDA representative Tom Freeney said the purpose of the directive was to ensure patient safety but that this was being threatened by the continued operation of others outside the law. He also warned that tooth whitening products bought over the internet may not be in compliance with the European rules, and that their safety could therefore not be guaranteed.

The issue is to be discussed at the Irish Dental Association’s next national council meeting in three weeks’ time.
CT analysis of tumours may be biomarker in oesophageal cancer

CT texture analysis of primary tumours may be a potential imaging biomarker in localised oesophageal cancer following neoadjuvant chemotherapy, according to research presented at the 2013 Cancer Imaging and Radiation Therapy Symposium.

This study evaluated the tumour-staging predictive ability of texture analysis in the planning line and post-treatment CT scans of 51 patients with localised resectable oesophageal cancer patients with a median age of 65 and who received neoadjuvant chemotherapy between 2007 and 2010. CT scans were performed before and after the use of chemotheraphy and prior to surgery. All patients received platinum and fluorouracil-based chemotherapy followed by surgery.

Primary tumours became more homogenous following chemotherapy, as entropy decreased and uniformity increased. Smaller change in skewness following chemotherapy was a significant prognostic factor. Lower baseline entropy and lower post-treatment MGI were also associated with improved survival, although they demonstrated only a trend toward significance.

“Though these results are for a very small number of patients, they suggest that the tumoural texture features may provide valuable information that could help us to distinguish which patients will do well following chemotherapy and which ones will do poorly,” said Connie Yip, MD, the lead study author, a clinical research fellow at King’s College London, United Kingdom and an associate consultant in radiation oncology at the National Cancer Centre, Singapore.

“As a biomarker for treatment efficacy, this technique could save patients from unnecessary surgery and provide more definitive guidance in developing patient treatment plans with improved outcomes.”

‘Snackers’ at greater risk of problems

Dentists and hygienists across the UK were polled alongside 1,000 consumers by sugarfree gum brand Extra® to examine current oral health understanding and behaviour.

Nearly half (42 per cent) of the UK dentists and hygienists polled identified ‘grazers’ – people who eat small meals and snacks throughout the day – as one of the groups most at risk of developing oral health problems. And the majority (84 per cent) believe that awareness of the oral health-care issues surrounding ‘grazing’ is low. Snacking, rather than eating three meals a day, prevents the mouths’ pH levels from stabilising and the acid attacks caused by food are more frequent and prolonged.

The survey also identified office workers as the worst culprits for snacking at their desks, with 40 per cent admitting to snacking throughout the day. People who drink wine or mixed long drinks three or more times a week (51 per cent) and coffee shop regulars (25 per cent) were also high risk categories, suggesting how modern work and lifestyle trends are contributing to poor oral health habits.

The majority (79 per cent) of dental professionals questioned believed that most patients are failing to follow even the simplest oral care recommendations – such as brushing for two minutes twice a day. Dentists’ concerns are substantiated by the consumer research, which revealed that a fifth of office based employees (21 per cent) regularly miss brushing their teeth in their rush to get to work. And when they do brush a massive 88 per cent fail to do so for the recommended two minutes.

Fitness to Practise changes start to show results

Further work is underway to improve the General Dental Council’s handling of complaints against dental professionals.

A raft of changes, which began in 2011, have already been implemented to its Fitness to Practise system, and further improvements are currently taking place.

Some key measurements show the progress made so far:

• The number of cases completed at the planning stage within six months of being received has increased from 68 per cent at the end of 2011 to 78 per cent at the end of 2012;

• There has been an increase of 13 per cent at the end of 2012 for cases progressed from Investigating Committee to reaching a Hearing within nine months compared to the end of 2011;

• There has been a reduction in the length of the queue of cases awaiting a hearing to 129 at the end of 2012 compared to the 155 at the first quarter of 2011;

Some of the changes introduced to try to tackle are:

• Procedures throughout the entire process have been reviewed and improved and new operating guidance has been published to document the new system;

• More Investigating Committee meetings are being scheduled and legally qualified Investigating Committee managers have been appointed to support the Committee to ensure that all information needed to make decisions is provided to the committee;

• A new triage process has been introduced to scrutinise cases as soon as they arrive to plan what action needs to be taken, or to close cases early on if appropriate to do so;

• The National Clinical Assessment Service is providing early clinical input to cases before the initial assessment of a case to ensure that case-workers are fully apprised of the significance of clinical matters raised from an early stage in the case.
During 2012, 834 Dental Practices made a choice...

With the dental profession facing ever-increasing regulatory and running costs, getting the right deal from your dental supplier has never been more important. That’s exactly what 834 dental practices did in 2012 by opening a new account with The Dental Directory.

The Dental Directory recognises this and wants to assist every dental practitioner in the country by continuing to cut the prices on everyday, essential dental products.

Despite considerable price increases from dental product manufacturers, The Dental Directory is the ONLY dental dealer who did not increase the vast majority of its prices during 2012.

Independently Verified Best Priced Dealer

The Dental Directory, along with all other major dental dealers, submits their sales out data every quarter to an independent research company, Strategic Data Marketing LLC. They then analyse all of the data on behalf of the large dental product manufacturers.

SDM compared the final selling out prices of 25 top-selling branded products from the categories shown below. These are the final prices charged to customers, after all discounts and promotions have been applied, and they found that The Dental Directory were an average of 5.4%† cheaper than our competitors during 2012!

Dare to Compare

We continuously compare our prices with our largest competitor – the American-owned, $7billion turnover, multi-national dental dealer, Henry Schein Minerva.

In a recent comparison of 100 like-for-like products featured in the Henry Schein Minerva Essentials Mini Catalogue and Dental Directory manufacturer dedicated flyers, our prices were found to be an average of 7.21% cheaper.*


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At The Dental Directory, we understand the importance of good service. Massive stock holdings that virtually eliminate back orders, and an average daily order fulfilment rate in 2012 of 99.2% enable us to give our customers the products they need, when they need them.

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We firmly believe that The Dental Directory offers the best combination of value and service: working with the dental profession to give every dentist the pricing and added-value services that are needed in these difficult times.

So if your current dental dealer doesn’t offer the same, join the 634 dental practices who opened a new account with The Dental Directory in the last 12 months.

To find out more about The Dental Directory, or to arrange for your local Business Consultant to visit your practice, please call us FREE on 0800 585 586

Trust…
Speakers announced for the Clinical Innovations Conference 2013

10th annual event to be biggest yet!

Celebrating 10 years of success, the widely anticipated Clinical Innovations Conference 2013 (CIC) will be held 17 - 18 May at the Millennium Gloucester Hotel in Kensington. Brought to you by Healthcare Learning: Smile-on, in collaboration with the AOG, the event is renowned for providing up-to-date, quality education specifically for the dental profession. Various lectures and practical workshops will cover a range of different topics, exploring the latest clinical techniques and introducing delegates to the newest innovations and products in dentistry. The internationally recognised selection of speakers will include names from the very forefront of the industry, with the likes of Richard Kahan, Jan-sie Van Rensburg, Wyman Chan, Ian Buckle and Louis Mackenzie already confirmed.

For experienced lecturers such as Dr Jansie Van Rensburg, the CIC provides a fantastic platform to discuss the latest developments in the UK market. Dr Van Rensburg obtained his degree in dentistry at the University of Pretoria, South Africa, before completing a two-year extended course in Orthodontics at the Conquest Hospital in Hastings, East Sussex. Dr Van Rensburg has lectured at numerous dental events around the globe, and also has a special interest in fibre reinforced composite restorations. In addition, he was nominated for ‘Trainer of the Year’ in 2005 by Stick Tech Ltd. in Finland.

Dr Van Rensburg is looking forward to his first experience of CIC, and he will be discussing an innovative new technique in restorative dentistry.

“I was delighted to accept the invitation to speak at this year’s CIC and I will be discussing various simple approaches to performing safe and predictable everyday dentistry,” he explains. “I will go on to look at a specific technique that has only been developed in the last couple of years by Swedish dentists, using a new type of sectional matrix system.

“This innovative system allows for an adjacent wedge and protecting shield to be used in order to safeguard both the teeth and the gingiva when preparing...
and drilling the affected tooth. One of the major problems faced when performing posterior composite restorations is creating tight proximal contact between the restoration and the adjacent tooth. Failure to do this of course increases the risk of trapped food and plaque formation. The new system provides a high quality filling with a much more reliable tight proximal contact, encouraging a higher standard of oral health.

“In addition, this new technique boasts an accuracy that enables practitioners to avoid creating a proximal marginal overhang, which is also very often associated with posterior composite restorations. This method can therefore be performed much quicker than others, and in an industry where time is money, this can be a hugely significant benefit. It is one of the quickest, safest and easiest sectional matrix systems available in the UK, and in most cases, it produces highly predictable results.

“During my lecture at the CIC, I will discuss how this carefully designed matrix/wedge combination works, giving a step-by-step guide to using the product and highlighting its advantages to both the patient and the dentist. Of course, all techniques and products have limitations and it is also important to know and understand these in order to achieve the best results, so I will consider these too. I believe this matrix system however, could provide a solution to the daily problems associated with restorative dentistry in the UK.”

Over the course of the two days, the CIC will provide up to 14 hours of verifiable CPD, helping delegates to meet the GDC’s requirements for continued registration. For the second year running, the event will also host sessions for the London Deanery DFT Conference, designed specifically to captivate and inspire London Deanery Foundation students, and introduce them to the modern dental profession.

Hands-on workshops, live clinical demonstrations and a quality trade exhibition will also be presented in May, further enriching the learning experience available to delegates. Not only does this provide access to the very latest equipment and technology within aesthetic and restorative dentistry, but it also encourages delegates to broaden their knowledge of the industry.

In addition to all this, the evening of Friday 17th will also see the Clinical Innovations Awards, offering delegates an opportunity to relax and network within the profession while enjoying delicious cuisine and live entertainment. The winner of the Award will be announced during the evening, celebrating the latest, most innovative products to be developed and introduced to the dental market.

Although he has not yet attended the CIC, Dr Van Rensburg believes such events are hugely beneficial for dental professionals to attend.

“I think the combination of lectures, workshops and trade is brilliant,” he says. “As dentists, we love our gadgets, and we love seeing new things. This conference is a great way of discovering new products, techniques, ideas and perspectives in a variety of different areas. I can’t understand how I have never attended this excellent event before, but I am now greatly looking forward to May!”

Registration for the CIC 2015 is now open, so book soon to avoid disappointment!
Selling an incorporated business? How do you get the money out?

Jeff Williamson looks at your options...

With many dental practices now trading as a Limited Company, Jeff Williamson from specialist dental accountants PFM Townends considers how such status affects your exit strategy from the business.

Asset sale
For the purposes of this article we are considering a Company that has sold its assets and the business.

Second time around
For the vast majority of cases this will have been the second time that you have sold your business, the first being the incorporation of your self-employment business.

Indeed the proximity of your business sale as a Company to the date of your original incorporation is crucial, as it will have been any appreciation in the value of the Goodwill over that period.

Corporation tax
The Company will pay corporation tax on the uplift in value of the Goodwill since incorporation. Remember that because you were “connected” at the time of incorporation you have been unable to claim any tax relief for the annual amortisation or writing down of the Goodwill so your base cost is unaltered for tax purposes.

So subject to other income levels, dividends may avoid tax altogether but it will take longer to move the money out of the Company. If you retire at 55 you might consider deferring potentially taxable pensions until age 60 and drawing dividends for five years. This route can be especially useful where both spouses own shares.

About the author
Jeff Williamson is a chartered accountant and leads the dental team at PFM Townends LLP. PFM Townends LLP provides specialist dental accounting services for associations and practice owners. To contact Jeff and his team call 01904 656083 or visit www.pfmdental.co.uk

‘It definitely pays to have clear tax advice alongside pensions and investment advice to ensure available reliefs and allowances are fully utilised. Early planning is strongly advised’

Options

1. Director’s loan account
   Repaying your Director’s loan account will not incur any tax so do this first.

2. Dissolve the Company
   Extra Statutory Concession C16 is no longer available so you will probably have to undertake a solvent liquidation of your Company. You will need a firm of Insolvency Practitioners and the likely cost is £1,500 to £2,500.

   The reserves paid to you, as the shareholder, will be taxed as capital and so long as you don’t delay, the distribution should qualify for Entrepreneur’s Relief and therefore 10 per cent capital gains tax. This is a second tax charge on the sale proceeds!

3. Dividend stream
   The company could pay the reserves out to the shareholders over time as dividends. If you are a basic rate tax payer then there is no tax to pay on dividend income, unless of course the dividend pushes you beyond the basic rate tax threshold where you would then pay 25 per cent income tax on the (net) dividend received.

   If, however, you set up a Limited Company and purchased a Practice from an unconnected third party, you were able to claim tax relief on the annual amortisation of the Goodwill. So when the Company sells its Goodwill it will pay tax on the proceeds less the unamortised amount of the original Goodwill.

   You always have the option to keep the Company going and purchase another business or perhaps invest in property without suffering the exit tax.

   You may be able to claim Reinvestment Relief if you use the Goodwill sale proceeds to purchase new Goodwill of another business and this will enable you to defer the corporation tax arising on the original sale.

   This can open up several planning opportunities for accumulating capital and involving your children as shareholders to begin planning for Inheritance Tax.

Conclusion
Selling your business is just one component of your retirement plan. It definitely pays to have clear tax advice alongside pensions and investment advice to ensure available reliefs and allowances are fully utilised. Early planning is strongly advised.

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That was painless!
Brian Carter explains why finance really can benefit both the practice and the patient

As he brushed his teeth, John looked forward to the morning with a sense of foreboding. Not only did he have a visit to the dentist to look forward to but it was also a new dentist – what would he be like? John had called into the practice when he moved to the area 20 years ago and had gone there ever since. Dr Down had been an NHS dentist when John first went to the practice. John understood that Dr Down had recently provided some treatments on a private basis but what they were and why he offered them John was not quite sure – Dr Down had not been a great communicator.

There was one occasion when Dr Down had talked to him about a private treatment but it was in medical terms and he hadn’t really understood the benefits. When Dr Down finished by saying: ‘I don’t expect you want that anyway’, it made his decision easy – John didn’t have it.

However, John had become comfortable with the practice – he had even got used to the receptionists who barely looked up before directing him to one of a row of seats that had not been changed in the 20 years he had been attending. John wondered what the receptionists’ names were.

He took one last look in the mirror. He was not blessed with the whitest teeth and there were a couple of crooked ones at the top but he looked after them and they were all his own!

When John arrived at the practice he briefly thought he had come to the wrong place. The floor tiles had been replaced with carpet. The wooden chairs had been swapped for armchairs. The newspapers and magazines were up to date and a tea and coffee machine had replaced the old water dispenser.

Most importantly, the ‘barricade’ had been replaced with a desk. The two receptionists, each in smart new uniforms, both looked up with a smile and a ‘good morning Mr Phillips’ when he entered. Their badges said ‘Jenny’ and ‘Sue’ – so they do have names!

John sat down as requested and noticed there was a new flat screen TV on the wall introducing various treatments that were available and how you could spread the cost if required – that seemed a good idea. He had only been looking at the screen for a couple of minutes when another smiling young woman came and introduced herself as the new...
Patient Co-ordinator, Patricia. He accompanied her to a private area where she explained that her job was to find out a little more about patients and explore concerns they had about their teeth before they saw the dentist. She also ensured that patients understood any suggested treatments after they’d seen the dentist.

Initially John became a little apprehensive – this was completely different to what he was used to. However, she was very pleasant and within a couple of minutes he was telling her of his concerns about the colour and unevenness of his teeth. He had never discussed such issues before and Dr Down had never asked him.

As soon as they had finished, Patricia took him into the treatment room and introduced him to the dentist – Peter Johnson. Another smile and a pleasant ‘good morning’ – he had entered a whole new world! Peter explained that he would initially carry out an examination and then consider any specific concerns he had discussed with Patricia. Having performed the examination and taken some X-rays, Peter considered the unevenness of John’s teeth as well as the discolouration.

He explained that tooth whitening and an invisible brace on the top jaw could resolve these issues. These treatments were not available on the NHS but could be carried out on a private basis and the total cost would be £2,000.

Whilst the treatment suggested sounded great and he would love to have it done, John had been a bit taken aback by the cost and said he would need to think about it. He thought to himself that he would not be able to pay that sort of sum at the current time.

As if reading John’s mind, Peter said he didn’t need to pay all at the current time. He explained that tooth whitening was usually one and a half to two years’ worth of payments. Alternatively, he could spread the cost over a longer term. If he did this John would need to pay interest at a rate of 9.9 per cent APR but the monthly payments would be lower. Over the longest term of 60 months the payments would be as low as £42 per month – less than £10 a week!

Based on these figures John could easily finance the total cost of the treatment. In actual fact he was just paying off a loan for his furniture so a similar monthly repayment would virtually go unnoticed. Patricia also pointed out that if he paid a deposit the monthly repayments would be lower still.

Suddenly John’s concerns regarding affordability disappeared. He realised he could easily afford the treatment by spreading the cost and pictured looking into the mirror with straight white teeth. All those years of not being happy with his smile would be behind him – John would be able to smile without worrying about it!

John decided to pay a £200 deposit and finance the balance on an interest-free basis over 12 months with a monthly payment of £150 – an amount that was readily affordable given his salary. John completed a straightforward application form for the finance and Patricia booked him in for his next appointment to get the treatment underway. It was all very painless.

As he left the practice, John considered what a difference the whole experience had been – he would have to mention this to his friends!

NB: Although this story is based on actual case studies, all names are fictitious.

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About the author

Brian Carter has been a director at Dental Finance since 2007. The company provides consumer finance facilities, primarily in the dental sector. It offers a range of flexible and affordable finance plans to increase treatment take up, patient satisfaction and improve practice profitability. Previously, Brian worked at Barclays Bank and then First National Bank in various management roles. He is an Associate of the Chartered Institute of Bankers (ACIB). For further information, please contact Brian Carter at Dental Finance on 07801 951921 (direct line) or visit www.financingfirst-dental.co.uk.
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S everal factors must be taken into consideration when replacing missing teeth: cost of treatment, periodontal health, aesthetics, biomechanical properties of the prosthesis, as well as patient expectations. Dental implants are becoming the preferable option in many clinical situations, however a number of patients reject this option due to high cost, length of time needed for healing after implant placement or apprehension to surgical dental treatment. The minimally invasive bridge can become the treatment of choice when dealing with defect-free abutments.

I would like to present a case when innovative combined porcelain and fibre-reinforced bridge was constructed and fitted. This bridge was designed as an alternative to traditional porcelain fused to metal resin bonded bridge, which despite obvious advantages like hard tissue preservation is becoming less desirable for aesthetically orientated dentists due to discolouring of abutment teeth caused by metal wings.

**Case presentation**
A 24-year-old male patient presented to our surgery with missing upper front central...
incisors and upper right canine which he lost four years ago in a car accident. He was extremely disappointed with his acrylic denture and requested a fixed prosthesis with life-like appearance. The patient rejected implants as being too expensive, however he stated it will remain his preferable option in future.

At this stage we discussed minimally invasive bridges and the patient felt it was a right option for him. Our treatment plan consisted of traditional RBB to replace UR3 and a hybrid bridge to replace missing central incisors. Due to the small size of the UR3 pontic (width only six mm) we opted for cantilever design with full coverage of palatal cusp of UR4 to increase bonding area and rigidity.

The preparation involved only light chamfer line. This bridge was fitted with Panavia (Kuraray Co), and no preparation was made for UR2-UL2 bridge. Impressions, dyes and working casts were made using conventional methods and materials. The next step was to form a wax pattern with inner canal, which was filled with fibre-reinforced composite core at the later stage. Small irregularities inside the canal will create additional mechanical anchorage. The wax pattern was converted to replicate in dental alloy using lost-wax technique and then porcelain was added and tried-in to ensure good aesthetic result.

Prior to glass fibre application Alloy primer (Kuraray Co) was applied to sandblasted metal surface to increase bonding strength of composite to dental alloy. At this stage we covered the labial wall of the inner canal with one mm of Gradia composite and light cured. Pre-cut single pre-impregnated fibre strip was inserted (Dentapreg PFU) and bonded to both ends with flowable composite (Filtrek, 3M). The outer layer of composite was built incrementally with Gradia.

The strip must be completely embedded in resin to protect glass fibres from oral exposure; the retainers were formed and light-cured using the same principle. Additionally, after shaping and finishing, the bridge can be placed into the light curing unit, eg. Dentacolor XS (Kultzer), for the final application of light to

‘At this stage we discussed minimally invasive bridges and the patient felt it was a right option for him’

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maximise polymerisation of fibre-reinforced composite. Bridge delivery involves the same procedures as for all bonded restorations.

Abutment teeth were cleaned with pumice and rubber prophylaxis cup, etched with 37 per cent phosphoric acid and thoroughly rinsed, then lightly dried and treated with bonding agent. Bonding areas of prosthesis were sandblasted, following by etching and application of bonding agent. Low-viscosity, dual-cured resin luting material [RelayX Unicem] was placed inside the retainers. After insertion, the excess of luting cement was removed with floss and small brush and prosthesis light-cured. The luting cement will form a unified structure with composite retainers linking them to the etched enamel. Final occlusal adjustments were made using a high-speed hand piece and composite polishing bur.

Discussion

This type of bridge may prove to be a successful way for fixed tooth replacement in anterior and premolar areas as well as long term provisional restoration, providing many benefits for patients resulting from aesthetic appearance of porcelain pontic, due to the good adhesive property of fibre-reinforced composite and minimally invasive nature of resin bonded bridge. Porcelain pontics and crowns continue to be a mainstay of fixed prosthodontics with long track record of reliability, low plaque accumulation and shade stability. Fibre-reinforced bridges alone did not gain wide spread acceptance among dental practitioners, however many publications underlined high potential of this technique resulting from favourable mechanical properties, good bonding and ease to repair. Further improvements and clinical developments are needed to combine glass fibre with porcelain pontic, but this idea shows great potential.

About the author

Dariusz Sinkiewicz is a dental practitioner at 1A Dental Practice in Bretton, Peterborough. During his career he has developed an interest in resin bonded bridges, particularly made of fibre-reinforced composite. He has recently constructed an innovative combined porcelain and FRC bridge which he believes has a potential to be useful in some clinical situations.

References

The importance of occlusion
Peter Bausch discusses occlusion and function

The correct physiological restoration of occlusion poses a major challenge for every dentist and technician. Even the smallest high spot, measuring just a few microns, can cause dysfunction in a patient’s masticatory system. In restorative dentistry, occlusal proportions are constantly changing. It is therefore essential, for the benefit of the patient, to understand and monitor the function of teeth in static and dynamic occlusion. Functional occlusion is important for the overall health of the patient. The interdisciplinary verification of symptoms and treatment is an integral part of daily practice. Therefore, checking the occlusion during treatment is strongly encouraged.

Occlusion and the potential effects of occlusal interference on patients
Every restoration, extraction, prosthetic device and orthodontic treatment changes the static and dynamic occlusion. The smallest occlusal interference of just a few microns is disruptive to the proprioceptors of the stomatological system. This can cause bruxism (clenching or grinding), which can result in functional disorder of the craniomandibular system. Overstraining teeth, periodontium, muscles and joints are the effects.

It is important not only to detect, but also to avoid further functional disorder in the craniomandibular system. The smallest interference to habitual occlusion can cause serious disturbances for the patient. An acute functional disorder such as clenching or grinding can become chronic in the long term.

Patients with new fillings, crowns and bridges, or who have undergone orthodontic treatment, who complain of typical symptoms (craniomandibular dysfunction syndrome) should undergo examination of their occlusion specifically. Premature contacts are often uncomfortable, as the proprioceptors are sensitive to pressure. The patient will try to compensate for the occlusal interference by adopting a new habitual position, with consequences for the attached tissue structures.

Position for occlusal restoration
Essential to any kind of occlusal restoration is the position of the mandible. Most patients are treated in their habitual position of the mandible, which is the correct position for most patients. For patients with more complex restorations or patients suffering from temporomandibular joint disorders, a new physiological positioning of the mandible is essential. In most cases, centric occlusion is the new therapeutic position.
Centric relation is the position of the mandible relative to the maxilla, with the intra-articular disc in place, when the heads of the mandibular condyles are against the most superior part of the distal-fac- ing incline of the glenoid fossa (i.e. the mandibular condyles are in their most superior and anterior position).

For balanced occlusion in a static position, the patient should have enough ABC contacts on each quadrant in the intercuspal position. In this position, the teeth of the opposing jaws achieve complete intercuspation and are in maximum contact with each other.

The physiological influence of interfering initial contacts
For most of the patients, their habitual position of the mandible in maximum occlusion is the preferred position for occlusal restoration. However, even a tiny interfering premature contact of only 20 μ can trigger a compensatory reaction, placing the mandible into a new physiological position. This is a natural reaction of our biological system to avoid higher forces focused only on one area.

For example, if you are eating something and you chew on a little grain of sand, you automatically shift your mandible to a different position to protect your teeth. A persistent "grain of sand" (occlusal interference) can trigger an overload of the biological system, in which case the patient will have reached his or her maximum capacity for compensation. Pain symptoms can then become chronic.

Occlusal restoration
In order to reconstruct physiological occlusion, correct visual identification of contact points is essential. Occlusion checking materials (articulating papers) with the effect of progressive colour transfer are helpful in identifying occlusal forces in intercuspal habitual position. Areas with higher force loads can be identified as darker-shaded markings with higher contrast. These markings likely indicate the initial contacts. Areas with less intense colour markings indicate contacts with lower occlusal forces or areas with no contact. Upon close examination, these markings look like a donut. The centre of the contact point has a lighter shade. The more intense-coloured edge of the contact point is not part of the contact. Just the lighter-coloured centre is the real contact area. For occlusal equilibration, only these areas should be adjusted. For a balanced occlusion, the patient should have enough ABC contacts on each quadrant.

Occlusal corrections can be additive or subtractive. If modification of the occlusal relationship in patients who have been grinding their teeth over a long period is needed, this may be challenging, as they would already have lost a significant part of their hard tooth tissue. A splint is indicated for treating such patients (additive occlusion).

Conclusion
The reconstruction of physiological occlusion is essential for the complex functioning of the entire stomatognathic system. There are various concepts of occlusion. For recording and analysing the complex movement of the mandible, a wide range of electronic devices are available.

Beside all these tools, a basic understanding of the biomechanical design of an occlusal surface is essential. Today, we have a wide selection of different occlusion indicators to visualise these biomechanical structures. Soft colour-impregnated occlusion checking papers, in combination with thin occlusion checking films, are optimised for visual checking of the occlusal relationship between the maxilla and mandible.
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AT W&H PEOPLE HAVE PRIORITY
10 Top Tips - Financing the purchase of your first dental practice

David Brewer offers practical purchasing advice

As we settle into 2015 many associates may well be considering their future options and in particular thinking about buying their first Practice.

We hear of many associates unhappy with their 'lot' and only seeing potential tougher times ahead so it is no wonder the past 18 months have seen a sizable rise in the number of associates looking to purchase.

FT&A Finance is headed up by David Brewer who has more than 20 years’ experience in the dental market arranging funding for both first time buyers and established practitioners.

Before any associates make any decision to purchase David has outlined the following top tips that it is worth considering:-

1 It is certainly more challenging than previously to gain finance, however the banks ARE still lending but to whom they perceive are the strongest applicants – and all banks are different. Do not go direct to your High Street Bank – instead find out about working with an independent adviser who will be able to provide you with an overview of the whole market (rather than just the thoughts of one bank) and then work with you on your proposal to ensure you have the best chance of a positive response and to negotiate best terms.

2 The good news is there are currently eleven high street banks who are lending to dentists – and they REALLY do want to lend to you – Dentists have the green light! And remember, the cost of borrowing is currently at an historic low. Speak to someone about Government lending initiatives under FLS or NLGS – it could mean your cost of borrowing can be even lower.

3 You need a sound business plan with realistic and up to date figures. Again work with an independent business adviser as they know exactly what the banks like to see and the format in which to present it. This should include; • Your CV including confirmation of your current income levels • Executive summary of your proposal • Financials for the subject Practice • Proposed working arrangements and impact on bottom line profit • Financial Forecasts (P&L/ Cash flow) including assumptions behind the figures

4 Are you buying on your own or jointly? There are advantages to a partnership but also certain disadvantages which you need to be made aware of.

5 An independent practice valuation is vital. You need to ensure that the figure being quoted by the seller is not inflated and is realistic. This report will also give any potential lenders the majority of the background information that they require.

6 Always seek specialist legal advice from experienced dental solicitors. It is false economy to use a lawyer without this specialist knowledge, particularly if there is any NHS element in the purchase.

7 Choose the right lender. Several of the major banks have specialist dental lending teams. This means that the decision whether to agree to your loan will be taken by people with experience of the dental sector and how a dental practice functions. Alternatively there are a number of companies that offer independent advice and search lenders on your behalf – effectively doing the ‘leg work’ for you enabling you to concentrate on your dentistry. This can be seen as the ideal option as you will have had access to the full range of lending deals on offer.

8 This is the boring but vital bit - most lenders will insist upon life cover, income protection and practice/property insurance. You should always seek independent ‘whole of market’ advice and from a specialist dental IFA.

9 Make sure you use a specialist dental accountant – especially if you are to purchase your first Practice.

10 Enjoy it when it comes to fruition! Owning and running a practice isn’t for everyone but for many it does bring enormous rewards and fulfilment.

Make sure you book on one of our Beginners Guide to buying a dental practice, they provide a rich source of information and knowledge and an opportunity to meet the team of FT&A Finance. There is no cost to attend one of our events, and you get CPD points!

In 2012 we added to our team and were fortunate to secure the services of Helen Skinner who will be known to many dentists from her previous role with BHS where she specialised in the dental sector. Alongside David and Helen is Dino Charalambous, our specialist ‘whole of market’ Dental IFA who can assist with all practice and personal insurance requirements as well as mortgages and investments. These experts are not only knowledgeable and understand your sector but are totally approachable and well known for their efficiency and positive can-do attitude. With over 93 per cent of their funding proposals approved by the Banks they have a high success rate as well as being able to secure best terms so if you are considering making a purchase either for your first practice or to add to your portfolio or simply wish to acquire new equipment.

About the author

David Brewer Head of FT&A Finance has worked in the health care sector for over 20 years and is responsible for arranging funding of pounds for the dental profession to enable practice purchasers. For more information David can be contacted on 07817 755848 or email david.brewer@ft-associates.com
“Setting Up On Your Own”

“Kitting Out” the Practice – Tangible Assets

This month, we will look at kitting out the practice with essential assets and equipment. You will be purchasing/leasing an empty shell and effectively will be starting with a “blank canvas”. You will therefore need to consider the layout of the surgery, planning design, equipment and stock, IT system and suppliers.

Subject to any planning restrictions etc, or any restrictions in your Lease (if applicable), you will have free reign to design the lay-out of the surgery as you wish. Plan in advance and have a detailed idea of how you want the surgery to look. Depending upon your budget, you may want to engage a designer or architect to help.

Every practice will need an efficient and suitable IT system. How will you know which one would suit your practice? You will need to consider what information it will need to hold, its accessibility capabilities and user friendliness. To get significant benefits from IT, you need to be able to trust your IT systems. This means having confidence in the company supplying, managing and maintaining them. Choosing the right IT supplier is therefore an essential part of selecting an effective IT solution. Watch out however for the cost of maintenance contracts. You need proper maintenance but some costs can be high and some providers try and lock you into long terms. It is a good idea to shop around.

You must purchase equipment that is suitable for your requirements and needs. Dental equipment can be expensive and you should not rush in making your decision by purchasing the newest, most expensive equipment. It is always worthwhile taking advice from colleagues and other dentists and at the same time, testing out equipment at exhibitions or conferences. Some companies may have showrooms where they demonstrate their equipment and this gives you a good opportunity to try out the equipment. Research all of the suppliers thoroughly to ensure that they provide quality equipment as well as offering reasonable servicing and repair facilities.

Purchasing, and therefore owning, equipment outright may not always be a viable financial option for you. The high initial costs in purchasing equipment may not be feasible and, if so, you will need to consider hiring equipment or entering into a leasing arrangement. Be aware of the pros and cons of leasing/hiring equipment.

The obvious advantage is that there will be a minimal initial expenditure, thereby saving costs in the short run and enabling funds to be directed to other areas of the business i.e. marketing/advertising. However, whilst it will be a minimal initial expenditure, it is usually the case that leasing equipment will be more expensive than buying in the long run. Additionally, you will have built up no equity in the equipment as you will not have ownership (unless of course the equipment is obsolete at the end of the lease in which case ownership would not matter).

Choosing the right suppliers for your practice will involve a lot more than looking at the pricing. You will need to consider:

• Value for money
• Quality
• Reliability
• Accessibility

How you decide on the importance of each of these factors will depend upon your businesses priorities and the overall business strategy.

Next month: “Kitting Out” the Practice – Intangible Assets

About the author

Puja Patel is a member of the Commercial Team at Lockharts and works primarily in advising dentists, dental care professionals and dental corporate bodies on the commercial aspects of dentistry.

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Turn your good practice into a great one – part two

Jacqui Goss continues with your journey toward practice perfection!

Previously, I outlined a suggested practice development programme based on an eight-step patient journey. Here, I shall discuss step one – how a prospective patient finds out that you and your practice exists. Arguably, this is the most important step; it’s the old ‘a journey of a thousand miles begins with a single step’ saying. Maybe in this case it should be a journey of a thousand smiles...

Let me state straightforwardly that I do not know exactly what you need to do to attract a regular flow of potential new patients. I know from first-hand experience some of the things that work and can suggest ideas you may care to try.

By common consent, word of mouth referrals are the most effective at bringing prospective new patients to your door – or at least to the telephone. By most effective, I mean a high conversion rate from recommendation to new patient appointment. Word of mouth referrals are a sort of informal network marketing. And network marketing has produced many large and successful companies (think Herbalife as just one example).

While word of mouth marketing might be highly successful in terms of quality, it can be difficult for dental practices to generate sufficient quantity. You’re going to be very lucky if even 10 per cent of your patients actually recommend you. Simply asking patients to recommend you is unlikely to be very effective. You need to incentivise them – perhaps a free hygienist session or free electric toothbrush for each recommendation that results in an appointment.

You should also take a leaf out of network marketing activity and give your patients some particular benefits of attending your practice which they can pass on. Consider a postcard-size card with, say, a photograph of the practice team on one side (so much friendlier than an image of the inside or outside of your practice) and three or four bullet points on the reverse. These could be:

- Family-friendly practice – we love kids!
- Tooth whitening and cosmetic dentistry a speciality
- Low-cost monthly payment plans
- Late evening and weekend openings

For excellent examples, look at the ‘Thank you’ cards and invitation cards Knight Dental Design includes in its information packs about its laboratory.

Don’t overlook including something as apparently mundane as ‘free parking’ – especially if you are a town centre
practice. But do avoid listing your qualifications or those of your staff. In a network marketing scenario, people want to know who you are, what you believe in and what makes you good for them not how clever the people are who make it!

Don’t forget to include your contact details on these referral cards. Then hand them out to patients but not willy-nilly. Just as not everyone is suited to network marketing, not every patient will feel comfortable recommending you.

Choose patients whom you know or who have confirmed that they have a wide circle of family, friends and colleagues and who have said that they are happy to recommend you.

In many ways, social media is a variation on word of mouth recommendations – people are likely to check and respond to favourable reviews and comments posted on Facebook, Twitter and so on. Indeed, when research suggests that most people judge a web page in just 10 seconds and only read about a quarter of the text on the pages they visit, there’s an argument that you’re more likely to gain enquiries through social media than you are through your website.

Be aware that merely having a Facebook page and/or a Twitter account and posting random images and tweets will be highly ineffective. For a start, just having a Facebook page you are unlikely to be comprehensively penetrating the social media opportunity. Research in the USA by Ship.org, comScore and The Partnering Group has shown that many consumers use YouTube and Pinterest (an online visual pin board) to browse and research products. Think in terms of having a presence on a number of social media and generating visual content for sites such as YouTube and Pinterest as well, of course, as your own blog.

Most of us have heard of the term viral marketing – self-replicating information that spreads from person-to-person mainly via social media. While you’ll be very lucky to achieve worldwide viral marketing, you should always consider the potential ‘viral-ity’ of what you put on social media.

A lengthy article by Jonah Berger and Katherine L. Milkman in the Journal of Marketing Research in 2011 looked at this subject in considerable detail and reported on the research they’d done. To quote from their summary: ‘The results indicate that positive content is more viral than negative content, but the relationship between emotion and social transmission is more complex than valence alone. Virality is partially driven by physiological arousal. Content that evokes high-arousal positive (awe) or negative (anger or anxiety) emotions is more viral. Content that evokes low-arousal, or deactivating, emotions (eg, sadness) is less viral.’

In a nutshell, your social media content should be positive, emotional or interesting (or combinations of these) if it is to be engaging and, therefore, likely to be shared. Just as with having a face-to-face conversation, if you are fascinating, upbeat and personal then people will respond positively. Unlike with a face-to-face conversation, if someone compliments you, your team or your practice on social media lots of people get to read it. And that’s all good.

My reading recommendation this time is the output of Dental Tribune contributor and social media expert, Rita Zamora (recently named a Top 10 Dental Pro in Social Media). Simply go to www.ritzamora.com to read her blog and to sign up for Rita’s free social media marketing updates.
Integrated Care Pathways

Glenys Bridges looks at patient needs

All dental care providers are required to place patient's needs at the centre of dental care provision. This article looks at ways to develop robust patient focused procedures to enable them to work as a team. Integrated care pathways can be used to define practical procedures for the delivery of NHS care, which enables NHS practices to create personal care plans for each patient, within the parameters of a standardised patient journey.

Integrated Pathways have developed in line with the required outcomes that have been stipulated in numerous dental regulations since ‘Options for Change’. It is a tool for ensuring continuous improvement, whilst embedding patients’ wellbeing at the core of practice culture. In the past if a practice appeared orderly and caring, it would have been assumed to be providing high quality care. Today’s regulators need to see evidence of patient focused, structured and systematic dental care provision.

Working to the Pathway’s Standards adds considerable organisational and financial burdens upon Registered Providers and Managers. Time they spend ensuring that Quality Management processes are in place reduces the time they have left to spend on other work tasks. Only when dental professionals working together as a team and share the range of tasks form the patient journey, can care pathways really be integrated.

The origin of UK Care Pathways is the Department of Health’s (DOH) strategic objectives for public health, the NHS and social care in England. Their purpose is to improve England’s health and wellbeing, so as to secure better health, better care, and better value for all.

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About the author
Gleny Bridges is an experienced management trainer and assessor with 20 years experience of working with General Dental Practitioners and their teams. In addition, she has expertise and qualifications in Counselling and Life Coaching. Her first book Dental Practice Management and Reception was published in 2006 her second book, Dental Management in Practice was published during 2012.
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Carson Dental

54 Practice Management Software “keeps everything running smoothly”

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Dr Ronak Patel from Victoria Dental Centre at The Dentistry Show 2013 (March 11-17, 2013)

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"The best experience when learning a new skill is to actually do it yourself, so the hands-on course gave me a great insight into the Inman Aligner. " says Powerfloss Innovator Dr Roy Sorensen. "In a relatively short period of time I came away with a thorough understanding of the new technology and computer programmes. The course was very well structured and was delivered to a high standard. I really enjoyed the day and I have already recommended the course to my colleagues."
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Dr Paul Shortland of Chatsworth Dental, Newcastle-upon-Tyne, says: “I have used Whitewash now for approximately six months and find it a useful adjunct to manual brushing in terms of hygiene and cost-effective first step for patients considering teeth whitening.”

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