Practices ride first pilot wave

The Department of Health is trialling a blended contract which will see dentists' pay linked to the number of patients they see. It is one of the recommendations being piloted from the Steele report into NHS dentistry carried out last year.

The pilots, which are expected to take place over a two-year period, will be carried out at least 50 NHS dental practices. They will be trialling new ways to improve services for patients with improved access and new ways of measuring quality.

The NHS responded well to last month's call for pilot sites and nearly 30 sites around the country will now pilot new ways of improving services for patients and the NHS from April.

One of the successful sites is City and Hackney, where the new blended contract is being trialled, which sees dentists being directly rewarded for the number of patients seen, the level of treatment each patient receives and the quality of that care.

The current dental contract means that if the local NHS wants to adopt changes sooner they are able to.

Health Minister Ann Keen said: "We know that access to NHS dentists is improving - more people visited a dentist in the last two years than at any period in the last decade. This is great news for patients who are now seeing the benefits of income protection for dental care it delivers. I look forward to seeing the results of these pilots and extending them with wider piloting later this year."

Chief Dental Officer Barry Cockcroft said: "Prevention and quality are two of the most important principles of today's NHS and the sites piloting Professor Steele's recommendations will be at the forefront of delivering high quality services built around patients' needs."

The Steele implementation board, which includes Prof Steele and Dr Cockcroft, are still inviting expressions of interest for sites to be part of the next wave of pilots which will start in September.

Informing of the pioneer wave of pilots, the next wave will trial a wider range of options to cover all the areas of the Steele review including; increasing access to NHS dentists, introducing patient registration, measuring quality as well as quantity of treatment; and encouraging dentists to carry out more preventative work.

Surfing the first wave of practice pilots of the Steele revise recommendations

Dentist treats orang-utan

A dentist carried out an operation on an orang-utan at Colchester Zoo - removing three of his teeth. West End dentist Peter Kertesz treated Rajang the orang-utan, who is 41-years-old. Dr Kertesz treats animals at zoos all over the world, but also treats human patients at his London clinic. Rajang was very sleepy after the operation but made a full recovery.

Birmingham student wins

A PhD student from Birmingham University School of Dentistry has won the Midlands heat of the Young Persons' Lecture Competition, Anqi Yang won the Midlands heat of the competition which is organised by the Institute of Materials, Minerals and Mining.

She will go on to represent the Midlands in the UK national final in London on 28 April. The winner of that will then go on to represent the UK in the world competition.

Graffiti artist dentist

A dentist in Surrey has been adding 'light graffiti' to the countryside by drawing 'light paintings' with torches. Ben Matthews said: "Last year, frustrated by getting home from work after dark and having nothing to photograph, I decided to construct my own images." So far he has created 400 'light paintings'. By wearing dark clothing and using long exposures, Dr Matthews makes himself invisible in the images.

MHRA warning

The Medicines and Healthcare products Regulatory Agency (MHRA) has issued an immediate action alert for users of Poligrip Ultra and Poligrip To-Thrive containing denture adhesives due to an internal short-circuit, said the MHRA.

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NHS charges in Wales frozen

Dental patient charges in Wales have been frozen for the fourth year running, so more people can afford to access NHS dentists, according to the Welsh Assembly Government.

The current level of patient charges in Wales has remained the same since April 2006 and is set to stay at the 2006 level for 2010/11. The charges are:

Band 1 – Diagnosis, treatment planning and maintenance: £12

Band 2 – Treatment: £39

Band 5 – Provision of appliances: £177

Urgent treatment: £12

Health Minister Edwin Poots said: “Thanks to significant extra investment from the Welsh Assembly Government, access to general dental services continues to improve although I appreciate that there may be particular areas where access is still difficult.”

“This latest figure shows that more work is being done for the National Health Service by more dentists in Wales. Areas where access has proved difficult in the past have seen some of the greatest improvements.”

She added: “In the Hywel Dda LHB area for example, there are now more than 40,000 more people accessing NHS dental care than in March 2008.”

“By freezing dental charges again we are maintaining access to NHS dentistry for Welsh citizens and helping to tackle oral health inequalities. In addition to increasing access to dentists, we are also investing in raising awareness of people’s responsibility in taking care of their own oral health as they should for their general health and well-being.”

On the flip side of this, the seven new health boards that run the NHS in Wales and control all dentist funding, are set to go more than £45m over budget, according to research by BBC Wales.

The research shows the seven boards have a running deficit of around £67m, which they forecast being able to bring down to £45m.

The boards control all dentist funding, hospitals and community services and GP funding.

A Welsh Assembly Government spokesman claimed that the forecast “represents a point in time, and is less than one per cent of the total NHS budget.”

‘Disappointment’ at pay increase

The British Dental Association (BDA) has expressed its ‘disappointment’ over the one per cent pay rise that has been awarded to dentists in the next financial year.

Salaried dentists have been awarded a one per cent increase, while general dental practitioners have been awarded an increase that, after efficiency savings, will produce a 0.9 per cent uplift in the value of contract earnings.

Salaried dental services and the salaried dental service are a key part of the NHS. The charges are still frozen, it is expected they will produce a 0.9 per cent uplift in the value of contract earnings.

Ms Sanderson added that high street dentists will be particularly disappointed that “the Government has chosen to disregard the BDA’s evidence that efficiency savings should only be considered retrospectively, allowing the scale of these savings to become apparent in earnings and expenses data.”

“Dentists appreciate the challenging financial climate the nation finds itself in and accept that restraint in public spending is inescapable. But what we also know is that the cost of providing dental care has soared in recent years.”

Ms Sanderson added that high street dentists will be particularly disappointed that “the Government has chosen to disregard the BDA’s evidence that efficiency savings should only be considered retrospectively, allowing the scale of these savings to become apparent in earnings and expenses data.”

“Failure to accept it, ignores what we know about increasing expenses in dentistry and the real cost of providing care to patients,” she said.

Peter Bateman, chair of the BDA’s Salaried Dentists Committee, said: “Salaried primary care dentists treat some of the most vulnerable patients in the community.

“Two thirds of services already face significant difficulties filling vacancies. Where these difficulties exist, they threaten the ability of the dental professionals working in them to provide the care for patients such as those with severe learning difficulties, mental health problems and vulnerable children.

“Salaried dentists appreciate the necessary constraints on the public purse, but they are also aware of the challenges facing salaried dental services and the urgent need to address the problems of recruiting to the service in the Hywel Dda LHB area for example, there are now more than 40,000 more people accessing NHS dental care than in March 2008.”

In line with the recommendation of the Doctors’ and Dentists’ Review Body (DDBR), consults have been awarded zero per cent.

In a Ministerial statement, Andy Burnham (Secretary of State, Department of Health) commented: “The Government do not accept that there is a compelling case for the recommended award of 1.5 per cent for foundation house officers and their equivalents and in line with its evidence believe that all salaried doctors and dentists below consultant level should receive an award of the same level.”

The remainder of the DDBR’s pay recommendations for salaried doctors and dentists have been accepted in full by the Government.

“In making these recommendations the DDBR has indicated that it considers efficiency savings made by GP and dental practices should only be taken into account retrospectively, after the scale of these savings becomes apparent in data showing trends in earnings and expenses. The Government do not consider this approach sustainable at a time when most areas of the public sector are having to achieve efficiency savings in order to sustain jobs and income levels. In view of this, and in line with the pay review body, the Government has decided to abate the DDBR’s recommendations for GMPs and GDPs supplying a prospicuous efficiency assumption of one per cent of contractors’ operational costs. This will have the effect of reducing the proposed uplift in the value of contract pay-maps to 0.8 per cent, for GP practices and 0.9 per cent for dental practices.”
Editorial comment
The GDC gets tough

Congratulations to the General Dental Council on the two recent prosecutions of people illegally practising dentistry.

Those you know me well may think I am being my rather sarcastic self when I say that, but I am not – it is not only good for patients who can be safe in the knowledge that the regulatory body that protects their mouths is catching people who will only do more harm than good; but it is also good news for practitioners whose reputation gets tarnished when rogue traders like these end up hurting patients.

The GDC comes in for a lot of criticism, usually when the Annual Retention Fee goes up, but it sits in the rather awkward position of being the dentist ‘police’ and sometimes that makes it an easy target. Remember though, the police don’t just nick criminals, they support victims.

I hope those of you who went to the Dentistry Show had as good an experience as I did. Look out in the next issue when I’ll be talking about some innovations and reliving a UK first in implant surgery – and yes, I did make it through the whole thing!

Celebrations

Education and training provider, Smile-on, will be treating delegates at the British Dental Conference to a drinks reception to celebrate the company’s 10th anniversary.

Smile-on will be at stand A012 at the British Dental Conference 2010, which is being held on 20-22 May at the Arena and Convention Centre in Liverpool.

A spokeswoman for the company said: “Smile-on has spent the last decade providing education and training solutions that are flexible, involving and inspirational for everyone in the dental profession. Visit Stand A012 to discover how these specially designed programmes can help busy professionals meet their industry obligations.”

The team has recently launched a learning and management platform in conjunction with UCL Eastman Dental Institute and KSS Deanevery.

The platform, www.corecpd.com provides dental professionals with all the resources they need under one roof to fulfil the new core subject requirements as stated by the General Dental Council.

Smile-on will also be showcasing their course on Dental Nursing Education to delegates at the conference.

DNNET II is designed to help training dental nurses studying for the National Certificate or NVQ level 3 in Oral Health Care Dental Nursing and as an update for established nurses.

The spokeswoman added: “Smile-on’s key values of partnership, imagination, innovation, creativity and potential have helped evolve the products from simple training courses into the multi-media learning platforms of today and helped Smile-on become the source for cutting edge software and training resources.”

For more information call 020 7400 8989 or visit www.smile-on.com.
**Course accreditation by Chester University**

The Partners at The Dentistry Business have been celebrating earlier this month, six months of hard work resulted in their Level 4 and Level 7 courses in Dental Practice Management, one accreditation from the University of Chester; dentists will also be delighted to learn that the Postgraduate Certificate in Dental Practice Management has now been accredited by the Faculty of General Dental Practitioners.

With limited University accredited training available in the specific area of Dental Practice Management, these unique courses, which will be offered nationally, provide an opportunity to gain formal recognition through a Professional Certificate – a move that has been welcomed by the profession.

The Professional Certificate, scheduled to start in May 2010, is designed for dental practice staff who are either already Practice Managers or who aspire to such a position. It will provide the theoretical and practical tools required to support a Practice owner, in the operation of a single or multi-site practice and provide an in-depth understanding of the mechanics of running a business and the techniques required to address the many problems that occur at both strategic and tactical levels.

The course comprises three modules which will run over 10 full-day sessions. A successful pass will attract 60 credits that are transferable to any University or College for future studies, if desired. The modules include:

**Module 1 - Planning and controlling a dental practice**

**Module 2 - Managing people and developing teamwork in dental practice**

**Module 3 - Creating a service-led dental practice**

The Postgraduate course will be available from October 2010.

For more information on this Certificate in Dental Practice Management, Level 4 for Practice Managers or Level 7 for Dentists, contact Simon Goldblum on 0101 928 5995 or visit www.thedentistrybusiness.com.

**Illegal dentistry clampdown**

The General Dental Council has seen two successful prosecutions for the practice of illegal dentistry.

In the past week, the GDC has prosecuted Bristol man Samuel Haranrayan and Bexley-based Justin Seeley.

Mr Haranrayan pleaded guilty to three offences at Bristol Magistrates Court.

The case was brought after he unlawfully held himself out as being prepared to practise dentistry. He also used a description on a signage image that he is a registered dentist. Since he is not registered with the GDC these are criminal offences under the Dentists Act.

Mr Haranrayan was given a conditional discharge for six months on each count and has been ordered to pay £500 towards the GDC’s costs.

In the case of Mr Seeley, he pleaded guilty to the same offence at Bexley Magistrates Court in Kent.

Mr Seeley was fined £100 and has been ordered to pay £90 towards the GDC’s costs. He has also been asked to make a £15 contribution to the general victims’ fund.

Commenting on the court rulings, Interim Chief Executive and Registrar of the General Dental Council, Alison White said: “The General Dental Council’s priority is to protect the public. One of the tools that we use to do this is by taking action against individuals who practise illegally.”

**Finalists announced for Dental Awards**

The BDA Awards is pleased to announce the finalists for this year’s annual awards ceremony, which takes place on April 23rd in London and will showcase the best in the dental profession.

The judging panel, which was made up of members from various dental professional associations and practitioners who have selected the finalists, these professionals, dental teams and practices across the UK have been notified and are now gearing up to celebrate at a black-tie awards ceremony taking place at the Royal Lancaster Hotel in London’s West End.

Commenting on the list, chair of the judging panel, Sophie-Marie Odum said: “We are pleased to announce the dental practices, professionals and dental teams that have been shortlisted as finalists by judges in this year’s Dental Awards. This is an immense achievement, especially given the high quality of entries that we have seen this year. It is fantastic to know that there are so many dental professionals providing the best clinical care and patient service possible. So many entries have reflected the high quality of the UK dental profession. I would like to take this opportunity to congratulate the finalists and wish them all the best of luck on the night.”

This year, the national event received entries from across the country, including Devon, Sheffield, London, Liverpool and Glasgow. In its 12th year, the Dental Awards will host a glitzy event, which will include a cocktail reception, four-course meal and awards ceremony, fronted by celebrity compere, Fred MacAulay.

**GDC’s finance chair resigns**

The chair of the Finance and Human Resources Committee has resigned from the Council of the General Dental Council (GDC).

Suzanne Cosgrove was a lay member of the Council from April 2003 and also chaired the Finance and Human Resources Committee.

Ms Cosgrove was also chief executive of Worthing Care NHS Trust from 1995-1998, chambers director at Wilberforce Chambers until 2001 and then operations director for Corporate Tax at Ernst and Young.

In 2005, she joined the firm of city lawyers, Berwin Leighton Paisner, where she is senior business manager - Real Estate.

Suzanne was vice-chair of the Council for Professions Supplementary to Medicine in the years immediately before its replacement by the Health Professions Council.

From July 1999 to April 2001 she was secretary of the Legal Practice Management Association.

Chair of the GDC Alison Lockyer said: “On behalf of the General Dental Council, I would like to express our gratitude for all of Suzanne’s work during her years as a Council member. We all wish her well in the future.”

The process for appointing a new Council Member and for appointing a replacement chair for the Finance and Human Resources Committee will begin shortly.

**‘Major challenges’ says BDA manifesto**

The new government will inherit a flawed dental contract and an unacceptable and growing chasm in oral health inequalities, according to the British Dental Association’s (BDA) manifesto.

The manifesto, Smiles all round - a manifesto for better oral health in England, has been published by the (BDA) for the forthcoming General Election.

The GDC warns that the next government must get to grips with the process of developing new contractual arrangements based on the recommendations of the Steele Review, and do so while at the same time increasing access to NHS dental care and contending with an already stretched public purse.

BDA Executive Board chair, Dr Susie Sanderson, said: “Whoever is elected this year will inherit major challenges.

“I am confident that the key themes we have highlighted in our manifesto – better oral health for all, a fairer dental contract and the need to properly support primary care – will be priorities for the new government. We need to properly support primary care; the completion of the reform process arising from the Steele Review, the need to properly support primary care, the eradication of oral health inequalities, harnessing fluoride as a preventive measure, and safeguarding the future of the hospital and salaried services and dental academia.

The GDC will produce manifestos for the elections in Northern Ireland, Scotland and Wales next year.

The BDA’s manifesto and advice on local lobbying are available on their website: www.bda.org/manifesto.

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Revenge with a bang

An eighty-four year-old pensioner left a bogus bomb on the steps of a dental surgery in revenge because he believed he had been overcharged, a court heard.

Peter McShane of Pembroke Dock, west Wales, left a large, oblong box with a ticking alarm clock and twisted wire wrapped up in a bin bag on the steps of Bush Street dental surgery in Pembroke Dock.

It led to a major police operation, the hoax bomb was in a controlled explosion and houses surrounding the surgery were evacuated.

Haverfordwest Magistrates Court heard how McShane admitted making the bogus bomb and leaving it on the surgery steps.

He also admitted seven other charges including criminal damage against the premises of dentist Michael Williams and a handful of neighbours.

The revenge attacks began after McShane was charged £185 after visiting the dentist in October 2007, according to the prosecution. McShane was apparently upset because he felt that he was an NHS patient not a private one.

Despite McShane being reprimanded, he continued his attacks, which included wrecking door locks at the practice by putting super glue inside and taking a plaque from a wall. He also used super glue in disputes with neighbours and at the premises of a newsagent.

When police searched his home they discovered seven tubes of super glue and a double glue gun to apply it. Police identified McShane through CCTV footage.

The defence called his attempt to frighten the dentist ‘extremely amateurish’ and referred to it as ‘a juvenile prank which has completely got out of control’.

Magistrates have referred him to the crown court due to the seriousness of the offence. He has been released on conditional bail and will appear at Swansea Crown Court on 9 April.

NOW Foundation launched

The Orthodontic Therapy Charity Foundation has been launched at National Orthodontic Week.

The Foundation has been conceived by a group of orthodontic therapists, which aims to raise funds for worthwhile causes, and all orthodontic therapists in the UK will be encouraged to take part in the fundraising.

The Foundation was launched at the National Portrait Gallery in London on 22 March.

Each year, a charity will be chosen, and for the first year, CLAPA (Cleft Lip and Palate Association) will be the first charity to benefit from the Foundation’s fundraising efforts.

This charity is a wide voluntary organisation specifically helping those with or affected by cleft lip and palate.

One in every 700 children in the UK is born with a cleft lip and/or palate. At the end of the year, all the funds raised will be tallied and a single sum donated to this good cause.

Private practice suffers in 08/09

The upward curve in private practice profits suffered a setback in the financial year 08/09 when the average net profit dropped by 4.5 per cent below the profits achieved in 07/08. This is one of the key findings from the annual dental practice statistics benchmarking exercise carried out by the National Association of Specialist Dental Accountants (NASDA) and announced at a press conference.

The gross profit of the typical dental practice (NHS, private and mixed practices) fell from £257,189 in 2007/8 to £255,085 in 2008/9. However as private and mixed practices were able to reduce their costs the gross profit as a percentage of the income of the typical practice has actually increased in the year from 66.9 per cent in 2008 to 67.5 per cent in 2009.

Meanwhile, NHS practices saw increases in their direct costs and as a result their gross profit percentage fell from 67.8 per cent in 2008 to 67.4 per cent in 2009. Private practices saw a 4.3 per cent fall in net profits while mixed practices profits fell by 1.4 per cent.

In addition to examining the income and expenses of typical practices, NASDA statistics offer a breakdown of the average fee income and profits of dentists. These figures show that in 08/09, a private dentist’s total fee income was less than in 08/07 and 07/08. This trend was reversed for principals in NHS practices whose net profit rose by 8.8 per cent. The reasons for this are probably the onset of the recession combined with the Department of Health’s commitment to improved access to NHS dentistry.

As a result the average net profit per associate has increased this year to £72,988 from £70,299 in 2008. This is the first increase in their earnings in the last three years. While associate costs have risen in NHS and mixed practices, they have fallen in private practices.

Anyone can donate to the Orthodontic Therapy Foundation either by fundraising themselves or via a new website which has been set up by the Orthodontic Therapy Charity Foundation www.otcf.org.uk.

To find out more information about National Orthodontic Week, go to page eight of this issue.

With GDP UK Dental Show Reviews you can rate your favourite dental show • which exhibition was your favourite? which exhibition let you down? • see league tables & star ratings is it worth a trip abroad? • visitor and exhibitor perspective Dental Show Reviews is part of GDP UK.com

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www.dentalshowreviews.co.uk
A new Facebook group called ‘British Dental Conference and Exhibition’ has been launched.

The Facebook group already has nearly 200 members networking and chatting online about the 2010 British Dental Conference and Exhibition in Liverpool on 20-22 May.

Amarjit Gill, president elect of the British Dental Association (BDA), said: “The main reason to attend this flagship event is to access inspirational leaders from both inside and outside the profession.

Dr Phil Hammond will be opening this year’s conference, Phil Hammond is a GP, writer and award winning broadcaster and comedian, and will present an uplifting session which will serve as a very warm welcome to the event. What developments will have stemmed from the Steele Report, one year on? Jimmy Steele will be just one of a panel of speakers giving thought to how these changes will impact on you. We will also bring you the best speakers, on the hottest topics, in all areas of clinical dentistry and plenty of updates from those leading the way for dental care professionals.”

You can register for the conference at www.bda.org/conference or by calling the booking hotline 0870 166 6625.

New NHS surgery for Winchester

Health chiefs in Hampshire hope to open a new NHS dental surgery in Winchester offering dental care for up to 9,500 patients.

Hampshire Primary Care Trust, which is currently holding talks with bidders who want to run the new practice, also wants the surgery to offer an outreach service to cater for some patients in Stockbridge and the Moon Valley.

Winchester is seen as having a shortage of NHS dentists, with Government figures revealing that in some parts of the city, less than half the people have NHS dental care.

The trust has not yet revealed when the new Winchester surgery will open, or where it will be.

Natalie Jones, NHS Hampshire lead commissioning manager of primary care dental services, said: “We are really pleased that Henry Clover joined Denplan’s Professional Services Team will most certainly bring. Here at Denplan we always strive to listen to our members and offer services, solutions and training designed to meet their individual needs, particularly at a time of increasing regulation and change within the profession. I will do everything I can to help my team achieve this goal.”

New deputy CDO for Denplan

Denplan has announced that Henry Clover (BDS) has been promoted to Deputy Chief Dental Officer. Henry will also join the Denplan Executive Leadership Team (Denplan’s Board), representing Professional Services.

Henry has his own practice to private practice in 1995. With his experience as a Denplan member dentist, he joined Denplan’s Professional Services department on a part-time basis in 1998 and full-time in 1999, with responsibility for professional support and member services.

Commenting on his promotion, Henry said: “I am delighted to take on this new role and look forward to the challenges that leading the Professional Services Team will most certainly bring. Here at Denplan we will always strive to listen to our members and offer services, solutions and training designed to meet their individual needs, particularly at a time of increasing regulation and change within the profession. I will do everything I can to help my team achieve this goal.”

Facebook website with the new group called ‘British Dental Conference and Exhibition’

Photos
I highlight the options available to orthodontics to the public and awareness of the benefits of orthodontics to the public and the British Orthodontic Society.

This event, newly launched for 2010, is aiming to raise the awareness of the benefits of orthodontics to the public and highlight the options available to patients.

NOW was launched in a presentation given by BOS chair Nigel Harradine, where he likened the importance of the face in portraits to the fascination of orthodontists in aspects of the face. One of Penn’s most famous photos was of Picasso, and Dr Harradine used a famous quote of Picasso’s, where he said ‘Photographers, along with dentists, are the two professions never satisfied with what they do. Every dentist would like to be a doctor and inside every photographer is a painter trying to get out!’

Nigel took the quote very tongue in cheek – as he said he was very proud to be a dentist and an orthodontist and wouldn’t want to be anything else – and his lively style kept the audience amused as he detailed what NOW had been established to achieve. He showed some case presentations of how orthodontics had been able to change not just the dentition and the facial shape of his patients, but their self-esteem and quality of life. This, he said, was one of the most fundamental aspects of orthodontic treatment – it was not only about the physical benefits, rather the effect of treatment on the psychology of patients that mattered.

One of the main focus points of the NOW campaign is the website (www.nowsmile.org). Nigel gave a quick tour of the site and recommended the use of it for both patients and practitioners. Its bright colours and easy navigation is very engaging, whilst still focusing attention on the ways the look and function of teeth can be improved; and providing clear and impartial information about orthodontic treatment to encourage patients to find out more.

To highlight the need for orthodontic treatment in the UK, BOS had commissioned a YouGov survey to highlight people’s impressions about their teeth. The survey canvassed the opinions of 2,050 people split into eight categories according to sex, age, social status, geographical location, working status, marital status and number of children in the household. The findings reveal that:

- 45 per cent of UK adults are unhappy with the appearance of their teeth
- 20 per cent of UK adults would consider having some form of orthodontic treatment to improve the alignment and appearance of their teeth
- Of the adults who felt orthodontic treatment would be of benefit:
  - 56 per cent would contemplate treatment for an improvement in appearance
  - 25 per cent for an improvement in self esteem
  - 18 per cent for an improvement in oral health and function.

Commenting on the survey, Nigel said: “We already had evidence from several studies which indicates that one third of all children assessed at the age of 12 have a significant need for orthodontic treatment, and now this survey shows that 20 per cent of adults are unhappy with the alignment and appearance of their teeth and would consider having orthodontic treatment. Such findings corroborate anecdotal evidence from orthodontists who are experiencing a significant increase in enquiries from adults who may not have had an opportunity to correct their bite and their smile earlier in life. This reflects both a change in attitude towards orthodontic treatment and recent advances in treatment techniques.”

Nigel mentioned that many orthodontic practices had wholeheartedly taken up the mantle of NOW, with fundraising and awareness campaigns in their practices as well as purchasing some of the merchandise and apparel available to promote the event.
CPD for CQC

“Tie this year’s CPD to your CQC requirements and make life easier,” says dentist and practice management consultant, Seema Sharma.

All NHS and private practices have to register with the Care Quality Commission (CQC) in 2011 and all GDC professionals have to undertake Continuing Professional Development (CPD).

For CQC, practices will be expected to demonstrate how they have translated learning into team action, so at Dentabyte we have launched innovative core CPD courses to help you do that.

CPD for CQC requirements

The Care Quality Commission expects practices to have established written and operational systems for Infection Control, Dental Radiography, Medical Emergencies, and Complaints Handling, including:

• Written policies and procedures
• Leadership and team member roles
• Risk and hazard assessments
• Induction, training & review
• Regular audit, continuous learning and monitoring

Our aim is to help you implement simple systems which can be used to demonstrate to the Care Quality Commission that your team have put their knowledge into action. Individual practice support is also available from Dentabyte for those who need it.

The most consistent method to maintain compliance with health and safety regulations is to conduct a comprehensive annual risk assessment and audit. For assistance with achieving these standards, sample health and safety, infection control and radiation risk assessments/audits are available at our CPD for CQC courses.

Key considerations for your practice team

CPD for CQC topic 1 - Infection Control

HTM 01-05 (2009) is the latest guidance, available from the Department of Health. Infection Control Advisor, Sandra Smith, will be outlining the key requirements for compliance with seven standards for infection control in dentistry:

1. Prevention of blood-borne virus exposure
2. Decontamination
3. Environmental design and cleaning
4. Hand hygiene
5. Management of dental medical devices – equipment and dental instruments
6. Personal protective equipment
7. Waste control

Aspects of HTM 01-05 that are particularly challenging include the requirement for separate dedicated decontamination facilities and the increased volume, and resultant cost, of infection control consumables.

CPD for CQC topic 2 - Radiation Protection

The Health and Safety Executive (HSE) must be notified 28 days before work commences with X-rays, and all practices must be compliant with two sets of regulations:

• Ionising Radiations Regulations 1999 (IRR99) is aimed at employers. Under IRR99 the employer is required to comply with the HSE’s Approved Code of Practice (ACoP) and demonstrate a structured approach to radiation protection to ensure dose is kept as low as reasonably practicable (ALARP), including:
  1. Formal (prior) radiation risk assessment.
  2. Establishment of Local Rules.
  3. Restriction of exposure.
  4. Designation of areas (Controlled or Supervised).
  5. Training in radiation protection for all staff.
  6. Radiation monitoring, record keeping and review.
  7. A Quality Assurance Programme

Ionising Radiation (Medical Exposure) Regulations 2001 (IRMER) addresses patient safety and describes the personnel involved in the use of radiation, the referrer, the operator and the Medical Physics Expert (MPE).

Jimmy Makdisi will outline how to meet the responsibility that IRMER also places on the employer to:

• maintain an equipment log
• set out a framework for procedures
• conduct radiographic audits and
• record certified training for team members
• rate all radiographs in patient notes
• monitor quality

CPD for CQC topic 3 – Medical Emergencies

Practice teams must be fully equipped to appropriately manage the medical emergencies that might occur in the practice.

Professor Sharma is a consultant cardiologist at St George’s Hospital, and has implemented, organized and supported the medical emergency systems for the London Marathon for several years, by coordinating and training more than 100 doctors.

A renowned speaker at medical and cardiology events, he will provide a lively insight into medical emergency management in dental practices.

CPD for CQC topic 4 – Complaints

CQC states: “For the purposes of preventing or reducing the incidence of unsafe or inappropriate care or treatment, the registered person must have an effective system in place for receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, in relation to the carrying on of the regulated activity”

Complaints should be dealt with swiftly in line with GDC guidelines. Attitude is one of the main factors influencing complaint resolution and Raj Rattan will be sharing his tips for how you can meet the CQC regulation as well as use compliments and complaints management as a tool for practice growth by training the most empathetic communicator in your practice to listen, respond, act and improve.

CPD for CQC topic 5 – Legal and Ethical Issues

Raj Rattan of Dental Protection will outline how to successfully manage the common issues encountered in dental practice, including consent, confidentiality and challenges in the NHS.

In registering for Care Quality Commission, practices will have to clearly demonstrate how they have translated learning into team action.

FORTHCOMING COURSE DATES

CORE CPD

• 30 April 2010 - Watford
• 14 May 2010 - Gatwick

CPD4CQC

• 19 June 2010 - Docklands

SPEAKERS

RAJ RATTAN: (3.5 hours)
Dental Protection
Legal & Ethical Challenges
& Solutions

SANJAY SHARMA: (2 hours)
Medical Director, London Marathon
Medical Emergencies

JIMMY MAKDISSI: (1 hour)
Dental Radiologist
Radiography Essentials

SANDRA SMITH: (3/4 hour)
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In registering for Care Quality Commission, practices will have to clearly demonstrate how they have translated learning into team action.

About the author

An impassioned advocate of mixed practices, Seema Sharma is a successful dentist who owns four practices, including a six-chair multi-disciplinary centre in the heart of Docklands, and is a practice management consultant, Dentabyte Ltd. Attributing her success to sound management and investment strategies, she recently raised the alarm of Mumbai to give away £50,000 to underprivileged communities living in absolute poverty, and established a philanthropic charity, The Sharma Foundation. If you would like to know more about her humanitarian efforts, email info@seemasharma.co.uk.

For practice management and CQC support email info@dentabyte.co.uk.

Website: Dentabyte.co.uk

Develop
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Dentbyte
Going back to basics

Dental Tribune: So, how did you get involved in the dental industry?

Lisa Roche: I started in dentistry straight after school. I decided to rebel against my mother, not go to university and thought I’d be able to relax for a year. However, she literally took me by the hand and said ‘I know a great job for you’. She then took me to the local dentist and practically sat the interview for me! So I started as a dental nurse and have been in dentistry ever since. I have been lucky enough to work for some very good people, which have given me my opportunities to progress. For example, when I worked for Andrew De-Wood in Wimpole St, the Nobel Territory Manager for London was leaving and said to me ‘I think you’d be really good at this’. So I left Andrew’s practice and started working for Nobel.

I was at Nobel for nine years and then an opportunity arose for me to be involved in the foundation of Discus Dental in the UK working alongside Linda Greenwall and The British Dental Bleaching Society. I was at Discus Dental for five years then another opportunity presented itself in the form of Nobel again under a new director to help really kick-start the back to basics concept.

DT: It is about going back to what we did originally – to the training, education and evidence-based approach Nobel had started from. In the recent past the focus had changed to a more sales-oriented approach and now we are trying to ensure we are concentrating on innovation, training and education these are the most important facets of what we do. We want to be more science and evidence-based, producing total solutions for dentists to empower their patients. Volume isn’t important, its quality that’s important.

DT: What do you have planned?

LR: We do have some events coming up which encapsulate the kind of things we want to achieve. In May we are offering a course given by Ophir Fromovich, inventor of the NobelActiveTM implant. We are looking to send people to Israel for a two-day course and a two-day tour of Jerusalem. People will get to spend time with the inventor, which is great and so different from sitting in front of a marketing person telling you how wonderful NobelActiveTM is and what it does. Ophir can tell you why it does it, how it does it and where he changed it from to make it the most anticipated implant in the profession.

One very important event I am currently organising is the Scientific Symposium 5-4 September at the King’s Fund London. It’s a really exciting project, and the biggest thing I am doing this year. Chairing the event is Prof Ian Brook from Sheffield University and co-chairing is Prof Howard Preiselk from Guy’s. It isn’t just about Nobel either – we are inviting speakers in from other implant system companies too.

DT: What is Nobel focussing on at the moment?

LR: For me the main focus for the future is acceptance – not by patients but by practitioners. I think that patients have accepted this for a long time. This isn’t quite the same for dentists – for many I think that more education about the potential benefits to patients is needed.

Everybody now agrees that implants work – it’s still getting the right people not necessarily putting the implants in themselves but referring to the right people. Nobel has stopped concentrating on long courses and are concentrating on long-term learning activities and our mentoring program.

For me, implants are very much like basic carpentry except with real people and soft tissue. It is in essence a screw, it just doesn’t go through a piece of wood. But you wouldn’t ask a carpenter to come to your house and put in a staircase after just a two-day course; however we were expecting dentists to go out after a two-day course and put implants into real live people!

I think the industry is now looking at different ways to help patients rather than trying to market implants as something that works. We know they work, so now it is a case of seeing how to use them best.

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‘There is a change in the air at Nobel, and a focus on a new direction.’

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SWISS PREMIUM ORAL CARE
The 10th dimension... the power of ten

Dr Ed Bonner and Adrienne Morris discuss what it means to be resilient

A recently published book by Jane Clarke and Dr John Nicholson called Resilience, Bounce Back From Whatever Life Throws At You, considers the personality characteristics that allow individuals to triumph in difficult circumstances. In the current economic climate, which unfortunately fosters a litigious mentality, we observe many traumatised people – yet some seem to weather the storm far more easily than others. What sets these people apart? Using psychometric testing, Clarke and Nicholson have measured individuals’ resilience levels and have coined a new term called RQ – Resilience Quotient – to sit alongside IQ & EQ.

Who is resilient? Think of individuals such as Barack Obama, Nelson Mandela, Terry Waite and John McCarthy. These individuals were not born with silver spoons in their oral cavities; they have all endured hardship, poverty and/or incarceration – yet each has emerged with head held high and spirit intact to achieve the highest levels of respect.

The 10 skills
Not all of us have this as inborn, but it is possible for any and all of us to develop the skills required to deal more positively and effectively with trying circumstances and emerge sunny side up. What are these skills?

Clarke and Nicholson have isolated some key factors: optimism; freedom from anxiety; taking personal responsibility; openness; adaptability; a positive and active approach to problem solving, a can-do attitude.

To this list I would add: a sense of humour; a lack of self-deprecation; a lack of envy – not focusing on what you do not have; taking credit for what you have achieved rather than focusing on what you have not done well or at all.

The power of positive doing
Norman Vincent Peale may have summed this up years ago by the phrase, “The Power of Positive Thinking”, but in truth, thinking is not in itself sufficient – we also need to do positive things, which include:

1. Taking care of our health by regular exercise and controlled diet
2. Dealing with issues as they arise (avoiding procrastination)
3. Living in the present rather than the past or future
4. Developing interests other than work: staying busy, and being prepared to learn new skills
5. Breaking down indigestible big problems into bite-sized smaller ones
6. Being willing to apologise – we are not always right
7. “Reframing” – turning ill-considered confrontation into reasoned negotiation
8. Avoiding sticking to untenable or unreasonable positions, for example, being prepared to move on
9. Replacing aggression with assertiveness
10. Developing an internal “locus of control”: creating solutions rather than waiting for others to bring them to you.

The 10th dimension… the power of ten

Dr Ed Bonner and Adrienne Morris discuss what it means to be resilient

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About the author
Adrienne Morris is a highly trained success coach whose aim is to get people from where they are now to where they want to be, in clear measured steps.

Ed Bonner has owned many practices, and now consults with and coaches dentists and their staff to achieve their potential. For a free consultation, or a complementary copy of The Power of Ten e-zine, email Adrienne at alphaplacecoach@yahoo.com or Ed on bonner.edwin@gmail.com, or visit www.thepoweroften.co.uk.
Motivate and inspire

If you nurture your staff, it’s likely they’ll feel a lot more satisfied in their roles, which means better team spirit and higher productivity, says Jane Armitage

“Team spirit can be heavily influenced by other team members’ motives and attitudes. To ensure a happy, well-motivated team, you need the right people with the right attitudes working towards the same goal. They will only know that goal if you share that information with them to enable you all to work together.”

Room to grow

Good team spirit can only occur when people are satisfied and nurtured with room to grow. To ensure team spirit is maintained, it is essential to ensure that a happy team is a well-motivated one. With this in mind, I would apply the following management tactics.

1 Inform all staff of any changes that are happening to affect their role. Have regular staff meetings with open discussions and seek the team’s views. During these team meetings, ask for their ideas on how to improve the service we are already giving. It is often surprising when you collect information on an open basis like this, as it can encourage each member to give his or her opinion. Some of our best ideas have occurred from holding open meetings like this.

2 Make staff aware of what innovations are being introduced to the practice. Ask for their suggestions on how to improve existing procedures and systems. Be open to new ideas and accept different opinions. Encourage a climate of openness and cooperation. To ensure individual ideas are followed through, staff have to take ownership of their ideas knowing the management team is supporting them.

3 Have regular discussions with staff to encourage a two-way flow of information, so that staff feel safe in the knowledge that no idea would be considered foolish and that sometimes these are often the best ideas. However, the practice culture of openness has to be well established prior to that.

4 Carry out regular appraisals. Individual appraisals are the perfect opportunity to create a personal development plan, which is bespoke to both the member of staff and the needs of the practice. During appraisal, assess how far their performance has met the standards of their job description. See it as a chance to be open, to look at what they are doing and together draft a plan giving targets to aim for. Give feedback using your own management style and ask if there are other ways you can manage them more effectively.

5 Ask probing questions, even if an individual shows no ambition for promotion, they may still wish to develop skills to make their day more interesting. Encourage further training; allow the study days as in the end it is a win-win situation.

Financial incentives

So what incentives can you offer to increase productivity and increase motivation? Examples I have used are:

• Link pay increases to individual performance using the results of appraisals
• Offer private medical cover, or membership to a local health club
• Offer a practice pension scheme
• Introduce a Christmas bonus and mid-year bonus scheme based on performance, attendance and time keeping. I must admit that when the mid-year review bonus idea was suggested in our practice, I worried about the expense. However, since it has been introduced, we have had fewer sick days and a better team spirit

Encouraging staff to perform effectively and achieve objectives is an important part of good management practice. Although motivation is crucial to this process, it can also be effective to reward your staff directly for promoting the practice by maybe having a bonus incentive or doing something which makes them feel appreciated.

Another way of dealing with this would be to divide the monetary amount throughout the year, and pay in two lots: one in June and one in December. Whatever the amount, the team appreciates it as it is given when needed the most, for example, around holiday and Christmas time.

To summarise

• Ensure you follow the code of equal opportunities
• These are purely suggestions: what works for one won’t for another. Introducing a bonus scheme will add to the practice costs; therefore you need to choose wisely
• By maintaining at least some of the suggestions set out in this article, should increase team motivation, however you have to maintain it
• By delivering fairness and opportunity to each and every one should maintain stability between staff
• Show appreciation: it takes nothing to say thank you at the end of the session and it goes a long way. It’s the name of the game.

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About the author

Jane Armitage is an award-winning practice manager and has almost 40 years industry experience. She is currently a practice manager for Thompson & Thomas, and holds a Vocational Assessors award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BHA Certificate of Merit for services in the profession. She has her own company, JA Team Illumination, practice management consultancy service, which includes on-site assistance covering all aspects of practice management with a pathway if required for managers to take their qualification in dental practice management. To get in touch, contact 0114 2343346.
What’s yours to claim?

It’s vital you know exactly what you can claim as a business expense, to keep your tax bill to its minimum, urges Geoff Long.

Granted: dentistry is stressful. This stress is the result of a number of factors:

• Might it go wrong?
• Will it work?
• Running late, keeping patients waiting
• Clinical risk – where will this action lead?
• Will it look right?
• And of course money!

This one became even more stressful recently with The Chancellor introducing the 50 pence tax bracket and even an unpublished 60 per cent tax rate for those earning more than £100,000, so it is now doubly important for dentists to claim all the expenses they are entitled to. With that in mind I have put together some expenses often raised for dentists.

Motor expenses

Dentists should record petrol, insurance, spares, servicing, AA, RAC, and MOT costs. Your accountant will negotiate a suitable business use proportion with Inland Revenue. It would help your accountant in his negotiations if you keep a mileage log for one month. Remember home to the surgery is a private trip.

Bank interest

This is allowable, providing it is used for commercial purposes.

Your wife’s wages

Dentists can pay a non-working spouse an annual salary typically £5,000 per annum. This will reduce profits and help wash away the tax bill. However, this is an area the Revenue is scrutinising at the moment. To obtain a deduction wages must be:

• Actually paid
• Paid via a payroll system
• Be justified in terms of work done

Staff meals & entertaining

Each practice has an annual budget of £150 per member of staff for Christmas lunch and seminar events. On top of this, reasonable food at a staff meeting is allowable.

Professional promotion

Advertising, leaflets and mail shots are allowable. So too is the cost of PR (Public Relations). PR can get you on television, in the Sunday Mirror or Evening Standard. It is very effective. Cost is £4,000 a month plus dining expenses. Be careful because you can get taken for a ride, it is best to go by recommendation.

Educational toys

If you treat children, then do not forget to buy children’s toys for the waiting room to keep the children occupied.

Medicinal brandy

Brandy is very handy in a surgical setting, particularly to bring the patients round after a lengthy treatment session. Fully allowable – providing the practice accountant is offered some!

Laundry and cleaning

With the new regulations, clinical garments and Health and Safety Regulation these days, your accountant should be able to work on an effective claim in this area.

About the author

Geoffrey Long FCA is a specialist dental accountant based in Hertfordshire. Geoff advises on a wide range of dental tax issues and regularly writes for the dental press. Geoff has more than 15 years’ experience managing dentists’ accounts and is recognised for his proactive approach to dental taxation and business problems. Call him on 01438 722224 or email office@dentax.biz.
Cashing in your assets

Andy Acton aims to take the anxiety out of practice sales with some sound advice

Soon or later, most of us will enjoy the privilege of retirement. Whether you cannot wait to put your drill down for the last time, or you feel slightly anxious thought of having nothing to do once you have – all of us hope that when the time comes, everything will go as smoothly as possible.

Retirement is one of the many reasons dentists put their practice up for sale, and it's only natural to hope to maximise its value with the minimum of stress. The practice will, in all probability, represent a lifetime of hard work and dedication. However, its sale encompasses much more than simply finding a willing purchaser with access to sufficient financial backing.

The list of parties involved in the sale of a practice is extensive and includes business partners, landlords, the local PCT, potential lenders to the purchaser, solicitors and accountants on both sides. The local authorities and the GDC will also have an interest. Even the Inland Revenue will need to be informed should they require cessation accounts. It is the agent's role to act as a mediator and to liaise with all of the concerned parties in order to resolve any conflicts of interest that may arise.

Finding an agent

At the start of the process, the agent should supply the vendor with a comprehensive information pack detailing the agent's procedures, fee structure and terms of business. In order to effectively promote the practice to the correct buyers, it will be necessary to collate as much data as possible about the practice. A reputable agent will already have a register of dentists actively seeking to purchase a new practice, and the agent will convey the collected information to the buyer if their requirements match the details of the surgery.

Discretion is a critical factor at this stage. Good agents should engage the interest of potential buyers without compromising the vendor’s trading position pending a sale.

Filter out the timewasters

If the premises to be sold are not freehold, then all new draft business details will have to be agreed with the site owner as well as the practice tenant. It is only now, once everyone is in agreement, that views may start taking place. This stage no doubt takes a great deal of time and effort on the part of the vendor, and they may find it useful to pencil in a specific ‘open day’ into their diary so that they can dedicate themselves fully to meeting potential buyers in person. After all, who better to sell the practice than the person who works there themselves? Unfortunately, the practitioner may well find that they come across a timewaster, and it is down to the agent to root those ‘buyers’ out and restrict any viewings to applicants with genuine interest and sufficient funds.

And the winner is...

At this highly uncertain stage, it is vital to foster clear communication between vendor and agent. Regular discussions need to be held in order to inform the vendor of the levels of interest prospective buyers have shown, and what they should expect if the sale moves forward. Now is the time when the accuracy of the practice's original valuation will be revealed, as preliminary offers will start to be made.

This is when the agent's experience of the prevailing market and previous practice sales really comes into play. They should be able to identify which offers are the most promising and from this present the vendor with a list of buyers, suggesting those that merit serious consideration. If after a number of viewings the interest demonstrated has been disappointing, the practice’s valuation will need to be reconsidered.

Maximising offers

If it's the agent's responsibility to maximise each offer placed before presenting them to the vendor, right now, the popularity of purchasing a practice is still high given the opportunities the profession currently offers, and with this in mind, it is likely you’ll receive more than one offers. In this situation, the vendor will have to make an informed decision, taking into consideration not only the price offered, but also the time scale the buyers are working to. Vendors should keep in mind that the agent is acting on their behalf, but will also have to privy to certain information regarding the purchaser’s circumstances that is unavailable to the vendor, and should therefore proceed with caution.

Once the best bid is accepted, a Heads of Agreement is compiled to satisfy both parties. A reliable agent will be able to facilitate negotiations for a smooth transaction and a straightforward handover. Underbidders' details should be kept on file as a backup in the event of an unforeseen complication during the sale.

The best valuers and sales agents will have good relationships with other specialist providers to dentists, including financial advisors and solicitors. This will enable both vendor and purchaser to have access to a range of experts who understand the specific difficulties associated with dental practice sales.

The best valuers and sales agents will have good relationships with other specialist providers to dentists, including financial advisors and solicitors. This will enable both vendor and purchaser to have access to a range of experts who understand the specific difficulties associated with dental practice sales.

About the author

Andy Acton is director of Frank Taylor & Associates, independent valuers and consultants to the dental profession. Andy has helped a number of dental specialists buy or sell their practices, and is director of Frank Taylor & Associates in the UK.

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Andrew Acton

Dental Tribune United Kingdom Edition · March 29 - April 4, 2010

Cashing in your assets

‘Retirement is one of the many reasons dentists put their practice up for sale.’

Retirement is one of the many reasons dentists put their practice up for sale.
If you were faced with illness, accident or injury for an indefinite period of time, an income-protection policy would support you and your family until you returned to work, allowing you time to fully recover without the stress of coping with your finances. Without this comprehensive cover in place, or worse, no cover at all – how would you cope? A self-employed dentist without substantial savings, who cannot rely on an employer or anyone else, should view comprehensive income protection as a priority.

So what should you consider when choosing or reviewing an income protection policy, and how do you get cover? The three most important things to consider when choosing the correct income protection plan are; Plan Type, Premiums, and Policy Exclusions.

**Plan Type**

All insurance companies base their claims on how ill you have to be prior to any benefit being paid out, and currently offer three plan types to consider; ‘Own occupation’, ‘Suited occupation’ and ‘Any occupation’.

An ‘Own occupation’ definition of disability means that if you are ill, you will receive your claim based on your inability to perform your duties as a dentist. ‘Own occupation’ will provide you with the most comprehensive cover, and an increased likelihood that you will receive a benefit payout if you do become unable to work.

The majority of plans carry a ‘Suited’ by training, education or experience definition, in which case benefits would be paid only if you were unable to perform an alternative role, such as research or working for a pharmaceutical company.

‘Any’ occupation plans should be avoided at all costs – as the wording of the plan suggests, you will have to be very ill/injured, and not to be able to do any work whatsoever before you receive benefit.

**Paying premiums**

Income protection cover is usually payable on a monthly basis, and is either on guaranteed rates or reviewable rates (which actually tends to be guaranteed for the first five years).

Reviewable rates effectively put the insurance company in charge of future premiums, with review of rates normally taking place every five years, although...
comprehensive policy features may include:

- Worldwide cover – ideal for non-domicile dentists
- HIV cover – included to cover needle-stick injuries, some plans include cover regardless of how infection occurs
- Inflation protection – if you are in your 20s, 50s or early 40s, you may want to ensure your standard of living against inflation. This is called Index Linking.
- Insuring to age 60 – or tie in with your NHS retirement date aged 60 or 65 depending if you joined pre or post April 2008
- Deferred period – most dentists select to have immediate cover from day one.

Once you have considered your options, how do you ensure you find the correct policy that will provide comprehensive cover? The most reliable way to guarantee you are insured on a policy best suited to your needs is by employing the services of a specialist Independent Financial Adviser. Simply put, an IFA’s role is to make choosing the right income protection cover as painless as possible and help you get the best value for money. They can also assist from the beginning of an application to after approval, including policy research, negotiating with insurers, and removal of exclusions.

**About the author**

Thomas was brought up in Hong Kong and studied at Aston University, Birmingham and in Tokyo. Thomas started working as a financial adviser in 1993, became an independent financial adviser in 1998, and is now a director of Essential Money Limited. Essential Money provides independent financial advice to dentists throughout the UK. Thomas has been awarded the Advanced Financial Planning Certificate by the Chartered Insurance Institute and is a Certified Financial Planner. For advice, call Essential Money on 0121 685 5060, email Thomas@essentialmoney.co.uk or visit www.essentialmoney.co.uk.
Getting what you pay for

Specialist fee-based financial advice for dentists by Martyn Bradshaw

From 2012 new rules from the Financial Services Authority (FSA) mean financial advisers will be required to provide their clients with clearer guidelines on the cost of their advice and how charges affect pension and investment products. The Financial Services Authority (FSA) will implement a wide range of changes intended to remove ‘commission bias’ to ensure recommendations are not influenced by product providers and to raise the bar on adviser qualifications.

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About the author

Martyn Bradshaw BA (Hons) Dip PFS, is a director of Practice Financial Management Ltd (PFM), one of the UK’s leading dental practice valuers and agents. Further information about PFM’s practice valuations and sales services can be found at www.pfmdental.co.uk.
Internal whitening of UL1

Jacob Krikor shares his experience of teeth whitening when it comes to incisors

In my previous article, we discussed the classic clinical situation we face when we need to match a broken or discoloured single incisor in the front with the neighbouring teeth. In this article I want to share my experience regarding internal whitening and I am keen to hear your tips and advice about this topic.

In this case (Fig 1), I was asked by the patient in the picture whether I could do something to improve the look of the upper-left central incisor. I offered him two options:

1. Internal whitening
2. A veneer to cover the tooth.

The patient opted for the internal whitening. It is very important to inform the patient that the treatment outcome is unpredictable and that the tooth may need veneering in the future after all.

The procedure explained

I removed the palatinal filling and cleaned the pulp chamber properly and even removed some of the root-filling material, up to one mm apical of the gingival margin. Glass Ionomer was used to seal the canal and the cavity was filled with a cotton pellet saturated with Opalescence 10 per cent Carbamide Peroxide gel. A temporary filling sealed the cavity. The patient was scheduled to come back after a week for evaluation.

A week later, the result was very satisfactory (Fig 2). The temporary filling was removed and the cavity was cleaned properly with water to remove any whitening gel remnants. It was then filled with the lightest shade composite I had after etching and bonding the inner walls of the chamber. And the patient was very pleased about the quick transformation of the discoloured tooth.

Challenges faced

I have to admit that I tried the internal whitening a few times in the past with varied results where some teeth did not respond at all. I relate this to blocked dentine tubuli or discolorations that are very tough to remove with whitening agents. Some of the successfully whitened teeth discoloured again over time albeit not to the same extent as they were before the treatment.

The long-term success of internal whitening can be disappointing even when using a stronger 50 per cent hydrogen peroxide to whiten the teeth. In this study, the short-term results proved very successful aesthetically, but in the long-term the success rate falls below 50 per cent. It also demonstrated how the procedure is associated with a risk of external root resorption.

The use of sodium perborate mixed with water was recommended so the aesthetic outcome is still acceptable and the potential for resorption may be minimised.

You can also read more about internal whitening in one of my favourite books, Bonded Porcelain Restorations in the Anterior Dentition, A Biomimetic Approach, by Dr Pascal Magne and Prof Urs Belser.

If you want to share your tips and tricks with your colleagues, just go to the knowledge bank on www.odonti.com and leave your comments on this case or publish your own cases.

'it is very important to inform the patient that the treatment outcome is unpredictable and that the tooth may need veneering in the future after all.'
Numbing the pain

Dr Michael Sultan looks at how treating inflamed teeth with intra-osseous anaesthesia can help relax a nervous patient

One of the most challenging tasks in endodontics is successfully treating a patient who is anxious and has been in pain from a severe pulpitis. But the key to making sure it goes smoothly is a fantastic anaesthesia.

When faced with “Hot Pulps” (usually mandibular molars that have caused severe pain and seem impossible to anaesthetise), the normal injection of choice is the inferior dental block. The cortical plate of the posterior mandible is quite thick and the easier infiltration injections are rarely found successful in this situation.

As a practice lifesaver

Intra-osseous injection is more often than not the lifesaver in the practice. Often, patients referred in due to anaesthetic failure and this injection technique has prevented procedures from being abandoned.

The intra-osseous injection is where the buccal mucosa adjacent to the tooth is anaesthetised and a perforator is used to drill through the cortical plate into the cancellous bone, allowing direct placement of the anaesthetic into the bone. Success rate of this injection, if coupled with an inferior dental block, is high at approximately 80 per cent and rises to 98 per cent for repeat LA.

Intra-osseous injections can be used as a stand-alone procedure and as an alternative to local infiltrations. When used as a stand-alone injection, a study has shown that in the upper incisor region, intra-osseous injections had a quicker onset, but shorter duration than an infiltration injection. It has been suggested that the advantages of injecting into the upper incisor is to obtain single-tooth anaesthesia and avoid uncomfortable labial or lingual numbness. But generally for the hot pulps, it is recommended that the intra-osseous injection can be used as a supplementary injection.

As a practice lifesaver

The technique of Intraosseous Anaesthesia therefore consists of three essential steps:

1. Anesthetizing the attached gingiva
2. Perforating the cortical plate of bone
3. Injecting anaesthetic into the cancellous bone space around the tooth

ADVANTAGES

The technique of intraosseous anaesthesia is one whereby teeth are anesthetized by injecting local anesthetic solution directly into the cancellous bone spaces around the tooth. In order to reach the cancellous bone from the outside it is necessary to pass through four tissue layers; epithelium, connective tissue, periosteum and cortical bone.

The outer three layers, which comprise the attached gingiva, contain sensory innervation but can easily be anaesthetized with a small injection of local anaesthetic solution. The fourth layer, cortical bone, does NOT have sensory innervation and can be perforated painlessly using a rotary instrument.

ADVANTAGES FOR THE CLINICIAN

• When anesthetic solution is delivered into cancellous bone, excellent pulpal anesthesia is obtained, even in patients with irreversible pulpsitis or hypersensitive teeth.

• Intraosseous Anaesthesia saves valuable time because there is no delay between injection and effect. Work on the tooth can commence in less than 30 seconds after the injection.

• The Clinician will find patients to be very appreciative of the absence of pain and numbness.

ADVANTAGES FOR THE PATIENT

• The patient experiences minimal pain during the dental procedure itself, and on leaving the dental office there will be no bloating of soft tissues and a much lessened feeling of numbness.

• If an extraction is required, the patient is often spared the need for an unpleasant palatal injection.

• Postoperative pain is rare.

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Dr Michael Sultan looks at how treating inflamed teeth with intra-osseous anaesthesia can help relax a nervous patient.
X-tip system where the sleeve stays in situ, but may with the Stabi- dent system, where the perforation site has to be located. Sites such as between the maxillary or mandibular central incisors where there is minimal cancellous bone should be avoided and caution should be used in mixed-dentition cases to avoid trauma to an under-developed tooth. The injection does not need to be in the apical area of the root as there is rapid spr-ead of anaesthetic through the cancellous space.

Avoiding problems
There are many other considerations that must be factored into the treatment, including the choice of anaesthetics and technique but even so, you may encounter a problem if just one aspect is not right. The problems that may arise include:

*Poor anaesthesia.* If there is back flow of anaesthetic solution, the anaesthetic will be ineffective. A rubber stop may help in improving the seal between the needle and the sleeve, however sometimes the problem is that the cortical bone hasn't been fully perforated and a second site may need to be chosen.

*Pain.* There can be some pain on perforation (0-10 per cent) and some on injection (0-30 per cent), but while uncomfortable, this is generally not a problem.

*Perforator breakage.* With some systems, the metal perforator may detach from the plastic shank. This usually occurs with the heat generation on perforating the dense cortical plate and normally the metal part can easily be retrieved with haemostats.

*Systemic effects.* Patients may have an increase in heart rate when using adrenaline-containing anaesthetics. However, studies show a return to baseline within four minutes is common in most patients. A slower injection was shown to offer a lower level of increase. There was however no cardiac effect when using three per cent Mepivacaine in Intra-osseous anaesthesia.

*Post-operative problems.* Pain and swelling may occur around the perforator sites with Stabident (five per cent) and slightly higher with the X-tip. This may be present for a few weeks but is self-limiting.

Anaesthesia for an inflamed tooth can be difficult and time consuming but without it optimal patient care and ideal endodontic treatment cannot take place.
Avoiding exam meltdown

Sarah Armstrong urges you not to panic if you’re preparing for your final exams. If you’re organised and stay focused on what you need to do, you’ll cope with the pressure.

Finals exams are drawing close for final year students across the UK and by now revision will be in full swing. But sit your exams the most important piece of advice is, try not to panic! As easy as that may sound, students can often worry themselves to a standstill, getting caught up by everything they don’t know. Remember, you are not expected to be experts in every dental discipline, these are not specialist exams – try and focus on what you do know, and build on these foundations.

Unfortunately, there isn’t a finite amount of information you need to know, which can be frustrating when tackling your revision, but try and work on the premise that “common things are common” rather than getting caught up in the complexities of weird and wonderful rare conditions. Examiners just want to see that you are safe, competent practitioners who are aware of their limitations.

Organisation is a key factor to exam success. Make sure you have all your notes in order, and if in doubt compare with your colleagues and get copies of what is missing. Dental schools often have set criteria which must be met prior to sitting your exams for example completing quotas of treatment, or undertaking clinical assessments etc. Make sure you are aware of these and have completed these by the deadlines set. Be aware of when/where your exams are to be held, and what each entails to enable you to plan your revision accordingly. Find out how each exam is set and what each entails to enable you to sit your exams the most important piece of advice is, try not to panic! As easy as that may sound, students can often worry themselves to a standstill, getting caught up by everything they don’t know. Remember, you are not expected to be experts in every dental discipline, these are not specialist exams – try and focus on what you do know, and build on these foundations.

Practice exam questions are very difficult to set and tend to be from a limited bank of questions available. This can be frustrating, however, there are plenty of textbooks available containing practice questions, and although these may not be in the same format as your dental school exams, they are ideal for identifying gaps in your knowledge. If you had mock exams, try and think back to what and how the questions were asked. Although you are unlikely to get the same questions, mock exams can give you an idea of how questions are set and the depth of knowledge required.

When it comes to revision, do what works for you. There will always be several people in your year who, come exam time, take up residency in the library. Although the very sight of them is enough to strike fear in the rest of us, it doesn’t work for everyone. Choose your own location to work in, only you know where you can concentrate. Some students irritatingly seem to have the knack of sitting in front of the television to revise – from cranial nerves to Coronation Street, but for most of us, this isn’t going to work!

Focus on yourself As I’ve mentioned in previous articles, by final year most of your friends and often your flatmates are dental students. Although this may have seemed liked like a good idea at the time – come exam time it can make the situation an awful lot more stressful. Tempers are fraught, conversation seldom veers from dentistry; the slightest query about a radiolucency on a periapical can erupt into a full-blown panic across the dinner table. By this stage of the course you will have found out what style of revision works best for you, so try not to get sidetracked by what everyone else is doing and focus on yourself.

Taking time off is essential. Make sure you schedule regular breaks into your revision – even if it’s just to pop out for a coffee or an hour – there’s only so much revision a brain can take in one go. Make sure you are getting enough sleep, staying up working until 2am every morning is unlikely to help in the long run and cramming can frequently have the opposite of its intended effect.

Seek advice If you find you are struggling – ask for help, your dental school is full of specialists, if you don’t understand something, there’s bound to be someone who will be more than happy to help!

‘If you find you are struggling – ask for help, your dental school is full of specialists, if you don’t understand something, there’s bound to be someone who will be more than happy to help’
A satisfying rinse?

Deborah Lyle discusses the benefits and limitations of mouth rinses as an adjunctive treatment to conventional home-based cleaning, and whether using a water jet is a better option.

When it comes to preventative oral health care, or tackling periodontal disease, dental professionals are in some ways restricted by what can be achieved in the appointments they have with the patient. Educating patients on efficient strategies for home-based oral healthcare can ensure greater success in not only treating the disease, but also preventing it from occurring.

The use of mouth rinses as a means of controlling supragingival plaque and gingivitis, as an adjunct to conventional mechanised cleaning, has been in existence for approximately 40 years, and numerous clinical studies have sought to establish the effectiveness of anti-plaque agents such as chlorhexidine (CHX), cetylpyridinium chloride (CPC) and essential oils.

Gold standard? Mouth rinses containing CHX have shown to be most efficacious in reducing supragingival plaque and gingivitis when compared with other anti-microbial agents. Although it is true that the “gold standard” for “gold standard” of chemical anti-plaque agents, there are some limitations and drawbacks.

For instance, CHX was found not to be as effective with pre-existing plaque and gingivitis and where no oral hygiene instruction or professional cleaning was undertaken. The other major disadvantages for CHX are the established side effects, including discoloration of the pellicle, especially in the interproximal areas, caused by a precipitation reaction between tooth-bound CHX and chromogens from food or beverages.

In an attempt to rectify this, studies have examined the effectiveness of various formulations of agents alongside CHX (such as sodium fluoride and cetylpyridinium chloride) as well as examining whether removing the alcohol content has an adverse effect on inhibiting plaque re-growth and gingivitis.

One long-term study sought to examine the antibacterial capacity and side effects of an alcohol-free lower concentration of CHX (0.05 per cent), combined with 0.05 per cent CPC, and found it had an anti-plaque effect comparable with that of a 0.2 per cent CHX + alcohol solution, but with reduced subjective side effects: slightly less staining and better taste.

Alcohol presence The presence of alcohol in mouth rinses has become somewhat of a contentious issue. Besides known side effects associated with sensory irritation and irritation of soft tissue (unpleasant especially for patients with mucositis or recurrent oral ulcerations), there has been debate about wider health and social concerns. Some of the ‘cosmetic’ over-the-counter brands can contain anywhere between 18 per cent and 26 per cent alcohol.

While there have been suggestions of a link between the alcohol content and oral cancer, a critical analysis of literature concluded that establishing a direct causal link is problematic and so far unsubstantiated. Interestingly, the same study also concluded that there is no evidence that alcohol increases the effects of the anti-plaque agents. The demand for non-alcohol mouthwashes has increased and products containing different active ingredients, such as CPC, need to be studied further for efficacy.

Another chemical plaque-control agent studied is essential oils. In a six-month randomised controlled trial, a commercially available mouth rinse containing essential oils (Listerine) was compared with an experimental mouth rinse containing 0.07 per cent CPC (Crest Pro-Health) and found both to be effective in reducing gingivitis and the proportions of periodontal pockets. Furthermore, a meta-analysis of six-month studies found six studies that showed essential oils to be effective as both an anti-plaque and anti-gingivitis agent, comparable with the results achieved by 0.12 per cent CHX. Essential oils have the disadvantage of poor substantivity and, in some cases, an unpleasant bitter taste and burning sensation.

Main drawbacks Regardless of the active ingredients mouth rinses, there are always two fundamental drawbacks to the efficiency of its delivery interdentally and to the sub-gingival areas. One way in which delivery can be improved is through using a dental water jet and several studies have examined the efficacy.

For instance, one study concluded that using a subgingival irrigation tip ( Pik Pocket) was effective in delivering a solution to 90 per cent of a six mm pocket, whilst rinsing only achieved 21 per cent. This is supported by an earlier study which penetration of periodontal pockets by supragingival irrigation tip with a powered device ranged from 44 per cent to 71 per cent.

Having the ability to penetrate subgingivally helps to reduce plaque biofilm and the pathogens that can cause gingivitis, calculus and bleeding. Using mouth rinses in conjunction with a dental waterjet has been shown to be more efficient than rinsing alone, as the irrigation device provides better interdental and subgingival penetration.

A six-month clinical observation of 222 patients sought to assess the efficacy of supragingival irrigation with 0.06 per cent CHX when compared against water irrigation and CHX rinsing. After six months, researchers found that all treatment groups:
- Had a significant reduction in the Gingival Index and the greatest reduction (42.5 per cent) occurred in the CHX irrigation group
- Demonstrated significant reductions in the per cent of marginal gingival bleeding sites, with the greatest reduction in the CHX irrigation group (46.5 per cent)
- Significantly reduced the percent of Bleeding on Probing (BOP) with the CHX irrigation group reducing by 55.4 per cent

The study concludes that a low concentration of CHX irrigation with the a dental water jet was the most effective regimen for reducing the Plaque Index, Gingival Index, BOP, and marginal gingival bleeding. Significantly, the report also noted that water irrigation was equivalently as effective as CHX rinsing in reducing gingivitis and was 37.5 per cent better in reducing gingival bleeding.

The best option? While it is clear that mouth rinses provide an effective adjunct to mechanical cleaning, there are significant disadvantages with the chemical agents being used. Although CHX is the “gold standard” for antimicrobial rinses, it isn’t considered appropriate for long-term use and the documented side effects, such as staining and altered taste sensations, are likely to make patient compliance problematic.

Alternatives such as essential oils and CPC also have their drawbacks in terms of efficacy and all mouth rinses suffer the disadvantage of being unable to reach subgingival and interdental areas. It is also worth considering the long-term cost implication of having to use mouth rinses as a daily adjunct to mechanical cleaning.

Although it has been shown that irrigation with a CHX solution of a lower dosage can still have a significant impact on plaque and gingivitis, it has been demonstrated that irrigation with water alone is highly effective in removing plaque biofilm and reducing gingival inflammation.

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About the author
Deborah M Lyle received her BS in Dental Hygiene and Psychology from the University of Missouri - Kansas City School of Dentistry in 1986, after a 16 year’s clinical experience in dental hygiene in the US and Saudi Arabia with an emphasis in periodontal therapy. Deborah is an editorial board member for the Journal of Dental Hygiene, Modern Hygiene, RDH, and Journal of Practical Hygiene. Currently, Deborah is the director of Professional and Clinical Affairs for Water Pik, Inc.
Rise above the crowd

Boost your self esteem and the practice image by positively engaging with callers, says Glenys Bridges

Whether it's in person or over the telephone, the receptionist is usually the first person patients and suppliers encounter when they contact a dental practice. And it's likely that their opinion of a practice is based on their impression of the receptionist.

As well as working on the front desk and greeting patients, telephone skills are an important aspect of working on a reception. When you work on the phone all day in a customer-service role, the telephone is a work tool for which you need to develop a high level of skill. Learning and honing telephone and listening skills should feature in each receptionist’s on-going professional development plan (PDP).

Great telephone skills do many things to maintain an excellent relationship with patients, which in turn benefit every person involved in the practice. Some people will have a knack for these skills, and will find it easy to learn them. Others may have to work a little harder. However, even if you are one of the lucky ones with a knack for these skills, it is a good idea to reflect from time to time on what good telephone skills actually are.

Why are skills important?

Let’s say a patient calls to query an RCT estimate, because she doesn’t understand why there are so many visits and X-rays. If the receptionist adopts a ‘take it, or leave it’ attitude, rather than outlining what’s involved in the treatment, a breakdown in communication happens, which could lead to dissatisfaction, or even a complaint.

However, if the receptionist were to acknowledge the customer’s concerns, look into the query and explain why the charges are valid, they will settle the matter. However, to do this, receptionists need a good understanding of treatment procedures, so care co-ordination training would be ideal for this type of query.

Some of the most important aspects of great customer service are in the telephone skills. Even if a receptionist has a great service attitude, without these basic skills, he or she doesn’t stand a chance of being more than mediocre. However, if you implement the following skills in your daily reception work, you will rise above the crowd:

• Smiling: Smiles and gestures can easily be heard over the phone, so keeping that smile on your face helps to create a positive engagement with a caller every time you talk to them.

• Empathy: If you can’t put yourself in a caller’s shoes especially when you know they are wrong, how can you understand why they have the feelings they do about the issues they have called in about?

• Problem-solving skills: No question about it, you will get problem calls that require some solving. Ask the practice manager or owner for information and guidance, tools to solve any problem a customer may have, then it is your job to learn how to use them effectively.

Achieving excellence goes beyond simply knowing what these skills are and what they can do to help build trusting relationships between the dental team and patients. Practice makes perfect is what many people say, and this saying fits perfectly into this equation. When telephone queries are handled well, you should reflect on why things went so well, identify good practice and share it with colleagues.

For more information on receptionist skills, visit www.dental-resource.com.
Satisfying the hunger for knowledge

Dental Tribune savours the choice of continuing professional development options available to dentists and their teams

Sir Winston Churchill is quoted as having said “The most important thing about education is appetite.”

This analogy is prevalent in many areas when discussing education – a thirst for knowledge, the hunger to learn – and describes the drive which is contained in the desire to provide the best care for patients and the most satisfying career for dental professionals.

Everyone, whether they are aware of it or not, has ambition. It may be in the form of someone who just wants to make a difference to their working environment to someone who is aiming to be the leader in their field. And it is this hunger to improve that is the cornerstone to continuing education.

Now, I am not going to bore you with the fundamentals of Continuing Professional Development and what you need to do to keep the General Dental Council from deeming you unfit to practice – we all know the requirements! It is the how that I want to talk about; a quick look at some of the many ways in which you can feed your hunger to learn and develop in your chosen career.

Since the introduction of CPD, a veritable feast of ways to make up your hours and fill in your personal development plan has been released. In addition, for those whose palate craves something a little more refined, the menu of post-graduate qualifications is ever increasing. This is not just for dentists; there are opportunities for MScs in subjects such as Primary Dental Care. There is the facility to digest your CPD in bite-sized chunks (for example DCPBites available from UCL Eastman CPD), course by course, or go the whole hog and sample the all you can eat style of conferences and events (ie Clinical Innovations Conference, British Dental Conference, International Symposium on Dental Hygiene...) – or you can even get it to go!

The traditional ways to get your fill include: reading journals, attending conferences, participating in study days, going on courses. Technology has made this even easier, allowing for virtual attendance to events such as webinars and live streaming of presentations, or the collection and storage of education online (Core CPD).

You can also choose from a variety of takeaway options in the form of CD-ROM programmes covering the whole spectrum of topics in dentistry or paper-based educational resources depending on your preferences.

For those wanting to take the gourmet post-graduate option, convenience is still the key. Local events, part-time courses, there is even the opportunity for a home delivery option with an online MSc (available in Restorative and Aesthetic dentistry from the University of Manchester).

So, there really is no excuse these days to go hungry when it comes to CPD and furthering your knowledge in your chosen profession – eat, drink and be merry!

Developing leadership and clinical excellence within the NHS General Dental Services

This innovative programme is offered by the UCL Eastman Dental Institute with the support of the Chief Dental Officer and the Department of Health in order to encourage and support the whole dental team in their desire to deliver effective leadership and clinical excellence within the NHS whilst improving oral health through the delivery of effective preventive dentistry.

WHO IS THE COURSE FOR?

This programme is designed for NHS general dental practitioners who wish to embrace the delivery of clinical excellence through a commissioning framework and introduce new concepts and approaches to leadership, clinical management and team development within the primary care setting. DCPs working with course participants will be invited to attend selected training sessions.

COURSE DELIVERY

This challenging and thought provoking blended-learning programme will offer verifiable CPD and be delivered through 28 days of didactic and skills laboratory training over 15 months (approximately one day every three weeks) supported by work-based distance learning and assignments to include a service improvement project. Elements of Core CPD will also be made available to course participants and DCP colleagues.

FACULTY

Programme Director
Professor Andrew Eder

Programme Coordinator
Dr Rishi Patel

Module & Teaching Leads
Dr Janine Brooks MBE
Mr Robert Craig
Mrs Helen Falcon
Dr Sue Gregory OBE
Dr Shazad Saleem
Professor Peter Spurgeon
Dr Vivian Ward
Professor Richard Watt

Supported by an experienced faculty of dynamic teachers and clinicians invited by both the Eastman and the Department of Health.

Module 1 Clinical Leadership and Service Delivery

This module will cover the five leadership domains outlined in the Medical Leadership Competency Framework (2009); namely demonstrating personal qualities, working with others, managing services, improving services and setting direction.

Module 2 Achieving Clinical Excellence

Through an evidence-based understanding of the dental literature, this largely hands-on skills laboratory based module will provide a comprehensive review of the diagnosis, treatment planning and management of patients within the scope of NHS general dental practice. The challenges presented by both young and old patients, as well as those who may require special care in the community, will also be considered.

Module 3 Improving Oral Health

Current concepts in the aetiology and management of caries and periodontal disease, as well as behaviour management and an understanding of patient psychology, will all be considered as part of the team approach to improving oral health.

COURSE OUTCOMES

This programme is designed to support dental professionals:
• to lead the delivery of dental health services
• to manage the dental team
• to deliver effective prevention
• to improve oral health
• to deliver quality dental care

Course fees: £3,960 (to be confirmed by fees committee). Individual modules may be taken by those who have a specific training need.

Closing date for applications: 31st August 2010

For further information or to register, please contact: Marjorie Kelly, Programme Administrator, UCL Eastman CPD, 123 Gray’s Inn Road, London WC1X 8WD

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DENTAL TRIBUNE United Kingdom Edition · March 29 · April 4, 2010
When the first textbook about dentistry written in English, 'Operator for the Teeth' by Charles Allen, was published in 1685, it was a step away from the charlatans in the marketplace of the time, and can be seen as an initial move towards quality assurance. Today, there is much legislation on the subject of 'Tooth-Ake', and with the advent of the Care Quality Commission and the GDC's revalidation scheme, quality assurance in dentistry is set to receive even more attention. The Faculty of General Dental Practice (UK) introduced the Certificate in Appraisal of Dental Practices in 2004 to offer a universal educational approach to quality assurance in primary dental care. In a move that broadens access to the course to the North of England and Scotland, this Spring will see the programme offered for the first time in Scotland, at The Royal College of Surgeons of Edinburgh.

Encouraging team solutions

A broad range of skills are needed to enable practice appraisals to be carried out in a helpful, sensitive and professional manner, and assessors should be trained in how best to use these skills to effect and manage change. The FGDP(UK) practice appraisal programme trains all members of the dental team to appraise the quality of clinical and non-clinical care delivered in the primary dental care setting. The teaching is outcome-focused and participants undertake three practice appraisals between the initial two contact study days and the third, nine months later. As well as knowledge of current legislation and the skills needed to work with others to evaluate and bring about change, participants learn to identify the issues underlying health care quality, and part of the assessment is based upon reflection on one of these appraisals.

Keith Hayes, a current course participant, says that “each practice visit is unique and offers an opportunity to both parties to benefit from a new experience. Part of the value of a successful appraisal visit is to open the channels of communication in order to focus on these specific opportunities and develop a favourable environment for team solutions.”

The FGDP(UK) Certificate in Appraisal of Dental Practices is available to all dental professionals, and is delivered by two experienced clinicians and appraisers, Patricia Langley and Jerry Watson. As clinical director for Oasis Healthcare, Pat has overall responsibility for quality assurance and clinical governance compliance across the Oasis estate of more than 15 dental practices. Jerry is passionate about the importance of communication skills, teamwork and excellent customer care in general practice, and founded the first dental practice to be accredited with ‘Investors in People’. Both have spent the last 20 years delivering a range of postgraduate programmes.

Applications are invited from all members of the dental team with an interest in quality assurance, either in their own practice or for those tasked with assessing the practices of others. Applications should be received by the 25 April 2010 to avoid disappointment. The course dates are the 7 and 8 May 2010, with a third day to follow on the 4 February 2011, and successful completion of the programme gives 20 ‘management credits’ towards the FGDP(UK) Career Pathway. For more information please contact fgdp-education@rcseng.ac.uk or call 020 7869 6760.
For more information or a booking form please contact Suzy Rowlands on 0208 241 8526 or email suzy@bacd.com.
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For more information please contact GC UK on (0340) 1968 21999 or e-mail ukinfo@gc-dental.com.

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Sponsor Kitongo Hospital

With the help of Dentaid, you can help provide vital new equipment for Kitongo Hospital’s dental school in Uganda

As part of an ongoing project, dental health charity Dentaid is aiming to raise enough money to help provide Kitongo Hospital in Uganda with a fully equipped refurbished dental surgery. This will allow for a significant expansion of the school and community outreach services they can offer by providing a referral centre within the hospital to which more serious and complicated cases can be sent.

Kitongo Hospital was originally a community health centre, however in January 2007 it was upgraded to hospital status when new departments, including a new dental department were introduced. The renovation of the centre has not yet been complete and plans to put in a theatre and increase the number of buildings are underway. The reasons for this change of status came about due to the high population and poverty level of the area; people could not afford to travel long instances to the next hospital and sometimes emergency cases were not reaching hospital in time.

Uncomfortable surroundings

Dental services were introduced to the hospital in January 2007, but due to lack of equipment extraction is the only service offered. Dental procedures are carried out in an office chair, which makes the work extremely uncomfortable for both dentist and patients. The instruments are sterilised using a boiler as there is no proper sterilisation equipment.

There is currently one full-time dentist and a dental nurse who are supported by volunteer students from the community who help out at chairside and with the community outreach programmes. Treatment is carried out for free as the hospital is supported by the Government, while wages and consumables are provided by Government funding.

The Government, however, does not give oral health high priority and there is no funding put aside for any kind of promotion of oral health care services in the district communities. Dr Angel, the full-time dentist for the Kitongo Hospital dental department has instigated outreach clinics which take place in schools and local community centres once a month. Volunteers are also used for these clinics. The school outreaches are undertaken for children aged between six and 15 and priority is given to the most rural schools where the population would struggle the most to receive dental care.

Filling the gaps

There is no national provision for dental health care; it is up to these kinds of dental centres to fill this gap until a national strategy comes becomes reality. Dentaid is also involved in attempting to make changes at a higher level through its advocacy strategic priority. However, changes won’t happen in the near future and oral health problems at the grass roots need to be addressed now. The project has significant support from both the community and the government.

If you are interested in sponsoring this project, contact Dentaid to find out more about the costs on 01794 524249 or by emailing info@dentaid.org.

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*SmileGuard - the first to provide independent certification relating to EC Directive 89/686/EEC and CE marking for mouthguards.*

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