DENTAL TRIBUNE
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News in Brief

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 the London Dental 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 Wang 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 Cardiac Science AEDs, which may fail to deliver a shock when needed (serial numbers). The affected AEDs may fail to deliver a shock due to a short circuit, said the MHRA.

GSK Poligrip warning
GlaxoSmithKline (GSK) has informed the British Dental Association that it has issued advice warning consumers about a potential health risk associated with long-term, excessive use of GSK’s zinc-containing denture adhesives Poligrip Ultra and Poligrip Total Care. As a precautionary measure GSK has voluntarily stopped the manufacture, distribution and advertising of these products.

www.dental-tribune.co.uk

Practices ride first pilot wave

Steele review pilots to commence in thirty UK practices in April 2010, will improve new services for patients

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 by the Steele implementation board, and nearly 50 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.

Prof Jimmy Steele, who led the Independent Review of NHS Dental Services, is leading the trials, in addition to more than 50 recommendations to help improve oral health, increase access and ensure high quality dental care for patients in his final report published in June 2009.

Different methods of delivering these recommendations will be piloted thoroughly over the next two years to ensure they meet the needs of the NHS and patients, but the flexibility of 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 more than £2bn of investment in improving NHS dental services.

She added: “As well as continuing to build on this success and drive access even higher, we need to look at the quality as well as quantity of treatment being carried out by the NHS.

“Prof Steele made a number of recommendations for how we can do this and it’s fantastic that the local NHS is so keen to try out new ways of improving the 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 by 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.

Medicaprop

- Established property fund specialising in the dental sector wishes to acquire practice freeholds across the UK.
- Medicaprop will purchase your property freehold in return for a lease to the dentist or partners.
- Sale and leaseback enables you to release 100% of equity from your property.
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- The Fund already has a large portfolio and has an extensive track record in the sector.
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Please contact Phillip Ogg 0203 0668785 or philipp@medicaprop.com

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

Medicaprop
**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: £59

**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.

The latest figures show 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 2006.

“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, has been taken account of, will produce a 0.9 per cent uplift on contract values.

Susie Sanderson, chair of the BDA’s Executive Board, said: “Dentists appreciate the challenging financial climate the nation finds itself in and accept that restraint in public spending is inevitable. 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 Review Body’s advice that efficiency savings should only be considered retrospectively, allowing the scale of these savings to become apparent in earnings and expenses data.”

“In making these recommendations the DDRB 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 recommendation of the pay review body, the Government have decided to abate the DDRB’s recommendations for salaried doctors and dentists have been accepted in full by the Government.”

“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 Bateson, chair of the BDA’s Salaried Dentists Committee, said: “Salaried primary care dental services are particularly vulnerable.

“The latest figures show that 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.”

Hospital dentists, except consultants, have been awarded a salary increase of one per cent.

In line with the recommendation of the Doctors and Dentists’ Review Body (DDRBB), consultants 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 believes that all salaried doctors and dentists below consultant level should receive an award of one per cent. The remainder of the DDRB’s pay recommendations for salaried doctors and dentists have been accepted in full by the Government.”

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Editorial comment

The GDC gets tough

Congratulations to the General Dental Council on the two recent prosecutions of people illegally practicing 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!

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page? If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA
Or email: lisa@dentaltribuneuk.com

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 Deane.

The platform, www.corecpd.com provides dental professionals with all the resources they need under one roof to fulfill 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 running courses for six months of hard work resulted in their Level 4 and Level 7 Courses in Dental Practice Management, accreditation from the University of Chester; dentists will also be delighted to learn that the Postgraduate Certificate in Dental Practice Management 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 or Postgraduate 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, or 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 lead to the completion of the course and the conferring of a certificate.

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 begin shortly.

For more information on this Certificate in Dental Practice Management, Level 4 for Practice Managers or Level 7 for Dentists, contact Simon Goldblum on 0191 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 Harinarayan and Bexley-based Justin Seeley.

Mr Harinarayan 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 implying that he is a registered dentist. Since he is not registered with the GDC these are criminal offences under the Dentists Act.

Mr Harinarayan 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 £900 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’s manifesto and advice on local lobbying are available on their website: www.bda.org/manifesto.

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Smiles all round – a manifesto for better oral health in England

www.bda.org/manifesto

The manifesto from the BDA
The AOG and Smile-on in association with the Dental Directory bring you

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The Royal College of Physicians, Regent’s Park, London

World Class Speakers: Julian Webber, Kevin Lewis, Achim Schmidt, Eddie Lynch, Balil Mizrahi, Wyman Chan, Trevor Bigg, Luca Giachetti, Jonothan Britto, Joe Omar, Seema Sharma, Bruce Bernstein ...many more to come.

Go to www.clinicalinnovations.co.uk for an early booking discount.
Revenge with a bang

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

Peter McShane
of Pembooke 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
Pembooke Dock.

It led to a major police opera-
tion, the hoax bomb was in
a controlled explosion and
houses surrounding the sur-
gery were evacuated.

Haverfordwest Magis-
trates Court heard how Mc-
Shane admitted making the bo-
gus bomb and leaving it on the
surgery steps.

He also admitted seven other
charges including criminal dam-
age against the premises of den-
tist Michael Williams and a
handful of neighbours.

The revenge attacks
began after McShane
was charged £185 after
visiting the dentist in Oc-
tober 2007, according to the
prosecution. McShane was ap-
parently upset because he felt that
he was an NHS patient not a pri-
vate one.

Despite McShane being reim-
bursed, he continued his attacks,
which included wreking door
locks at the practice by
putting super glue in-
side and taking a plaque
from a wall. He also
used super glue in dis-
putes with neighbours and
at the premises of a newsagent.

When police searched his
home they discovered sev-
en tubes of super glue and a
double glue gun to apply it. Po-
lace identified McShane through
CCTV footage.

The defence called his at-
tempt to frighten the dentist
‘extremely amateurish’ and re-
ferred 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

T
he Orthodontic Therapy
Charity Foundation has been
launched at Na-
tional Orthodontic Week.

The Foundation has been
conceived by a group of ortho-
dontic 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 lau-
nched 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 As-
assembly) will be the first char-
ity to benefit from the Founda-
tion’s fundraising efforts.

This charity is a wide vol-
untary 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

T
he upward curve in pri-
ivate practice profits suf-
fereed 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 bench-
marking exercise carried out by
the National Association of Spe-
cialist Dental Accountants (NAS-
DA) and announced at a press
conference.

The gross profit of the typi-
cal dental practice (NHS, private
and mixed practices) fell from £255,065
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 in-
come was less than in 06/07 and
07/08. This trend was reversed
for principals in NHS practices
whose net profit rose by 8.9 per
cent. The reasons for this are
probably the onset of the reces-
sion combined with increases in
the NHS charging rates.

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 inc-
ease in their earnings in the
last three years. While associ-
ate costs have risen in NHS
and mixed practices, they have fall-
en in private practices.

Ian Simpson, who is respon-
sible for the benchmarking ex-
curse and who is a Partner
in Specialist Dental Accoun-
tants Humphrey and Co, said
at the annual press conference
that the statistics reflect the on-
set of the recession combined
with the Department of Health’s
commitment to improved access
to NHS dentistry.

Nick Ledingham, chairman of
NASSA and senior partner in
Specialist Dental Accountants
Morris and Co, predicted that
there may well be a continued
downward turn in 09/10. He ob-
erved that while gross profits declined, current dental practice
values remain steady.

Anyone can donate to the
Orthodontic Therapy Founda-
tion either by fundraising them-
sehvs or via a new website
which has been set up by the Or-
thodontic Therapy Charity Fou-
ndation www.otcf.org.uk.

To find out more informa-
tion about National Orthod-
ontic Week, go to page eight of
this issue.
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.

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

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 Meon 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 state commissioning manager of primary care dental services, said: “We are really pleased to be working on providing further NHS dental services in Winchester and the surrounding area.

“The mobile service that is included in this contract will help us bring these services closer to people’s homes which we know can be an issue for people living in rural communities.

“Once the contract is awarded, we will be in a position to make more information available, and then we will start to take the details of people who want to register. In the meantime we would encourage anyone seeking an NHS dentist to check Hampshire Dental Helpline on a regular basis as details of availability across the whole of Hampshire are frequently updated.”

The trust wants to avoid patients queuing for the places so will not be releasing them all at once but will be allocating them in weekly or monthly batches.

The trust will take applications by phone or e-mail until the spaces for each period are gone. Those who miss out will have to wait until the next batch of places comes up.

Once the new surgery opens, Hampshire PCT hopes it will be open to the public seven days a week.

New deputy CDO for Denplan

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

A former general dental practitioner, Henry converted his own practice to private practice in 1993. 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 responsibilities 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 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.”
Picture perfect for NOW launch

The British Orthodontic Society launched the first ever National Orthodontic Week last week in London Dental Tribune was there.

It’s not the worst start to the week when you get to spend it in the calm surroundings of the National Portrait Gallery in London’s Trafalgar Square, looking at some of the most famous faces in the 20th Century photographed by Irving Penn. This is where I found myself at the launch of National Orthodontic Week, the brainchild of 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 menu 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:
  • 18 per cent 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 whole-heartedly taken up the mantle of NOW, with fundraising and awareness campaigns in their practices as well as purchasing some of the merchandising and apparel available to promote the event.

National Orthodontic Week ran from 22-28 March and to find out more visit www.nowsmile.org or www.bos.org.uk.
CPD for CQC

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

A ll NHS and private prac-tices have to register with The Care Quality Com-mission (CQC) in 2011 and all GDC professionals have to under-take Continuing Professional Development (CPD).

For CQC, practices will be ex-pected 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 estab-lished 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 imple-ment simple systems which can be used to demonstrate to the Care (Quality Commission that your team have put their knowl-edge into action. Individual prac-tice 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 an-nual risk assessment and audit. For assistance with achieving these standards, sample health and safety, infection control and radiation risk assessments/au-dits 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 De-partment of Health. Infection Con-trol 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 medi-cal 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 dedi-cated 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 be-fore work commences with X-rays, and all practices must be com-plainant with two sets of regulations:

- Ionising Radiations Regulations 1999 (IRR99) is aimed at employers. Under IRR99 the em-ployer is required to comply with the HSE's Approved Code of Prac-tice (ACP) 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 protec-tion for all staff.
  6. Radiation monitoring, record keeping and review.
  7. A Quality Assurance Programme

- Ionising Radiation (Medi-cal Exposure) Regulations 2001 (IRMER) addresses patient safety and describes the personnel in-volved in the use of radiation, the referrer, the operator and the Med-ical Physics Expert (MPE).

Jimmy Makdessi 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 man-age the medical emergencies that might occur in the practice.

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

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

CPD for CQC topic 4 – Complaints

CQC states: “For the purposes of preventing or reducing the inci-dence of unsafe or inappropriate care or treatment, the registered person must have an effective system in place for receiving, handling and responding appropri-ately to complaints and com-ments 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 com-plaint resolution and Raj Rattan will be sharing his tips for how you can meet the CQC regula-tion as well as use compliments and complaints management as a tool for practice growth by train-ing the most empathetic commu-nicator 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 man-age the common issues encoun-tered in dental practice, including consent, confidentiality and chal-lenges in the NHS.

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SPEAKERS

RAJ RATTAN: (1.5 hour)
Dental Protection
Legal & Ethical Challenges & Solutions
SANJAY SHARMA: (2 hours)
Medical Director, London Marathon Medical Emergencies
JIMMY MAKKIDISSI: (1 hour)
Dental Radiologist
Radiography Essentials
SANDRA SMITH: (2.5 hours)
Infection Control Adviser
Decontamination & HTM 01-05 made easy

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- Regulation 13 - Premises
- Regulation 14 - Equipment
- Regulation 16 - Consent to Care
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About the author

An impassioned advocate of mixed practices, Seema has a successful dentist who owns four practices, in-cluding a six-chair mixed-disciplinary centre in the heart of Docklands, and is a practice manage-ment consultant, Dentabyte Ltd. At-tending her success to sound man-agement and investment strategies, she recently visited the slums of Mumbai to give away £50,000 to underprive-ledged communities living in absolute poverty, and established a philanthrop-ic 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

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

Dental Tribune speaks to Lisa Roche, marketing director UK & Ireland for Nobel Biocare, about her return to Nobel to head up the Back to Basics campaign and the innovations in the implant industry

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 Dawood 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 Greenall 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 often said you should ‘never go back’ – so why did you?

LR: There is a change in the air at Nobel, and a focus on a new direction. I think it is very refreshing when a company can stand up and say ‘we need to do things differently, we’ve let many of the relationships we had built go’ and begin asking to return and to help restructure was something I couldn’t resist.

It is now so different. David Thoni (Regional Director, UK, Ireland and South Africa) is very dynamic and is very much the reason I came back. There is a whole new buzz about the company now – David is really making inroads in getting the best from both the new staff he is putting place and the staff already established at Nobel. It’s a huge challenge ahead of me but I love it.

DT: So, Back to Basics, what is it about?

LR: 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 Preisel 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: Nobel is concentrating on the All-on-4 concept, which is bringing a cheaper option to patients. So, where previously dentists might have put in eight implants, now the concept is four. There is a lot of charity and academia behind it, a lot of clinical research behind it and we know it works. Eight implants is obviously more expensive than four – looking at the edentulous population, those people who don’t have dentists already or those who basically carry a bag of dentures around from practice to practice trying to get dentists that fit, instead of saying to these people we can give you eight implants and a fixed bridge, why not try angling the two distal implants of four and cover a much wider load.

DT: What is the biggest development in implant technology so far in your opinion?

LR: Easily it is the CAD-CAM (Computer-Aided Design and Computer-Aided Manufacturing) innovations. You can design a concept in CAD and it also brings in a real team effort to the process. It’s not just the dentists, it is also the dental technicians and being able to work together with CAD-CAM for the benefit of patients.

DT: What about the future?

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 getting the implants in themselves but referring to the right people. Nobel has stopped concentrating on short courses and are concentrating on longer 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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The 10th dimension... the power of ten

Dr Ed Bonner and Adrianne 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.

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DT
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

During a typical morning at our practice, to boost team spirit and motivate staff for the day, we’ll put the ball on, look at the daily to-do list and together we will see what the day has in store for us. But hey, this is dentistry and every day is different, so we prepare for a perhaps uncertain day ahead.

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.

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 this 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 a practice pension scheme
- Offer a 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

Another way of dealing with this would be to divide the monetary amount throughout the year, and pay it 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.

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 to the profession. She has her own company, JA Team Assessor, BDA Good Practice Regional Assessor, 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 to the profession.

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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.

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**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

S
ooner 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 about having nothing to do once you have – all of us hope that when the time finally does come, the process 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 which 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 this 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 viewings 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 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

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 that you’ll receive more than one offer. 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 be 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.

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 specialist banks develop their services to the dental profession, including NatWest and Bank of Ireland. For more information, call 08456 123434, email team@ft-associates.com or visit www.ft-associates.com.
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.

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’.

‘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).

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.

These plans differ vastly and having a firm understanding of which plan type you feel would be more relevant to you will be of great benefit when investing in income protection.

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Reviewable rates effectively put the insurance company in charge of future premiums, with review of rates normally taking place every five years, although
they can be conducted annually. Reviewable rate products tend to be cheaper at first and may be suitable for those looking to move abroad at some point in the near future, or for those who don’t foresee a long-term future in dentistry.

However, it is important not to wait too long to consider ‘re-viewing’ your premium after five years has expired, because after this, the insurance company can increase (or theoretically decrease) your premium based on their overall claims experience. This figure is derived from the number of claims they have paid out and their predicted future claims.

Choosing a guaranteed rate means you will pay a set amount for your cover over the duration of your plan (usually to age 60). This rate never changes, regardless of how many claims you make or the company receives in general. Considering this, you should consider guaranteed premiums if you plan to remain a UK dentist in the medium to long term.

What’s excluded

By checking policy exclusions, you can reduce the risk of being tied into a plan that may not provide you with comprehensive cover. Some plans on the market have as many as 15 exclusion policies, with common ones including: excessive alcohol, failure to seek medical advice, and dangerous activities such as mountaineering or scuba diving.

What inclusions should you expect from your policy? Basic 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 IFAs 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.

Having a safety net in place can give piece of mind

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 1996, 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.

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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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Independent Financial Advice (IFA) is available from firms who offer financial products from the ‘whole of the market’ and offer a fee-based option. Firms who offer products from a limited range of products and without fee-based options can’t call themselves independent.

The distinction between different types of financial adviser already exists. Good quality IFA firms already promote fee-based advice and our experience is that fee-based planning is fast becoming the preferred route for dentists. Whilst fee-based advice will have you reaching for your cheque book, investment charges are usually reduced making this potentially cost-effective over the medium to long-term.

Our example compares fee-based and commission-based advice for a dentist making a pension contribution of £500 per month. The figures speak for themselves.

If your adviser is not independent they may not offer you this saving. Combine this with the fact that they impose limitations on fund and pension provider choice and the case for non-independent advice is difficult to understand. This is especially so for dentists, who often make larger than average personal pension contributions whilst requiring specialist advice.

If you have received advice from a bank or building society it is possible that your adviser was not independent, let alone experienced in advising dentists. This may deny you access to fee-based advice and specialist knowledge on areas such as the NHS pension. Even some national firms who offer dental specific financial advice, don’t offer independent financial advice. If you are currently taking advice from one of these firms make sure you ask hard questions of the adviser relating to investment charges, commission and their very limited product range.

Dentists should settle for nothing less than independent financial advice from a firm specialising in financial planning for dentists.

About the author
Martyn Bradshaw BA (Hons) Dip PFS, is a director of PFM’s Dental Practice Finance department and has over 20 years experience working with dental practices. Further information about PFM’s practice valuations and sales services can be found at www.pfmdental.co.uk.

Money Matters
Internal whitening of UL1

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

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 discolourations 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.

About the author

Jacob Krikor graduated from dental school (Odontologen) in Gothenburg, Sweden in 1998. After working in general practice in Sweden for two years, he moved to the UK and now has his own practice in Bexhill-on-Sea. He is especially interested in cosmetic dentistry and has been in general practice since graduating. Jacob is also the founder of two websites: www.askyoursdentist.com for patient information and www.odonti.com, which was created to make life easier for dental professionals. To contact him, email drjacobkrikor@odonti.com.
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.

A practice lifesaver

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

Stabident
intraosseous anesthesia delivery system

ADVANTAGES

The technique of intraosseous anesthesia 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 anesthetized with a small injection of local anesthetic 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 Anesthesia 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 ballooning 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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**Clinical**

X-tip system where the sleeve stays in situ, but may with the Stabident 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 spread 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 (0-50 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 Intranasal 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.**

**About the author**

Dr Michael Sultan BDS MSc DFO is a specialist in endodontics and the clinical director of Endocare, a body representing a specialist group of practices. Michael qualified at Bristol University in 1986 and worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital, London. He completed his MSc in endodontics in 1993 and worked as an in-house endodontist in various practices before setting up in London’s Harley Street in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on endodontic courses at the Eastman University in London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. To talk to a member of the Endocare team, call 020 7224 0999, email reception@endocare.co.uk or visit www.endocare.co.uk.

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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. When you 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 weighted and distribute your revision, but try and work on the things – from cranial nerves to treatment, or undertaking a finite amount of information 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 – 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 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 dentalistry; the slightest query about a radiolucency on a peri-apical 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 for 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 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.

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“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.”

**About the author**

Sarah Armstrong qualified from Newcastle University in 2008 and is currently working as a vocational dental practitioner in Brampton, Cumbria.
W hen it comes to preventive 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 pa-tients on efficient strategies for home-based cleaning, and also in preventing the disease from occurring.

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

Gold standard? 

 Mouth rinses containing CHX have been shown to be most efficacious in reducing supra-gingival plaque and gingivitis when compared with other anti-microbial agents.1,2,3 Although it is recognized that a ‘gold stand-ard’ of chemical anti-plaque agents, there are some limi-tations and drawbacks.

For instance, CHX was found not to be as effective with pre-existing plaque and gingivitis and where no oral hygiene in-struction or professional clean-ing was undertaken.1 The other main disadvantages for CHX are the established side effects, including discoloration of the pellicle, especially in the inter-proximal areas, caused by a precipitation reaction between tooth-bound CHX and chlo-roogens from food or beverages.

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

One long-term study3 sought to examine the antibacterial ca-pacity and side effects of an eth-anol-free lower concentration of CHX (0.05 per cent), combined with 0.05 per cent CPC, and found it had an anti-plaque ef-fect 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 such as burning sen-sation and irritation of soft tissue (unpleasant especially for pa-tients with mucositis or recurrent oral ulcers), there has been debate about wider health and social concerns. Some of the ‘cos-metic’ over-the-counter brands can contain anywhere between 18 per cent and 26 per cent alcohol.

While there have been sug-gestions of a link between the al-cohol content and oral cancer, a critical analysis of literature3 con-cluded that establishing a direct causal link is problematic and so far unsubstantiated. Interestingly, the same study also concluded that there is no evidence that al-cohol increases the effects of the anti-plaque agents. The demand for effective non-alcohol-mouth washes has increased and prod-ucts 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,14,15 a com-mercially available mouth rinse containing essential oils (Lis-terine) was compared with an experimental mouth rinse con-taining 0.07 per cent CPC (Crest Pro-Health) and found both to be effective in reducing gingivi-tis and the proportions of peri-odontal pathogens. Furthermore, a meta-analysis of six-month studies11 found six studies that showed essential oils to be effective as both an anti-plaque and anti-gingivitis agent, com-pareable 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 ingredi-ents of the mouth rinses, there are always two fundamental drawbacks to the efficacy 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 ex-amined the efficacy.

For instance, one study15 con-cluded that using a subgingival irrigation tip ( Pik Pocket Tip) 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 a earlier study13 that penetration of periodontal pocket by supra-gingival irrigation tip with a pow-ered device ranged from 44 per cent to 71 per cent.

Having the ability to penetrate subgingivally helps to reduce plaque biofilm and the patho-gens that can cause gingivitis, calculus and bleeding. Using mouth rinses in conjunction with a dental water jet has been shown to move 90 per cent of biofilm along with the irrigation device provides better interdental and subgingival penetration.

A six-month clinical observa-tion of 222 patients11 sought to as-sess the efficacy of supra-gingival irrigation with 0.06 per cent CHX when compared against water ir-rigation 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 re-ductions in the per cent of mar-ginal gingival bleeding sites, with the greatest reduction in the CHX irrigation group (46.5 per cent)
• Significantly reduced the per-cent 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 irriga-tion with the a dental water jet was the most effective regimen for reducing the Plaque Index, Gingival Index, BOP, and margin-al gingival bleeding. Significantly, the report also noted that water irrigation was equally effective as CHX rinsing in reducing gingivi-tis 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 appro- priate for long-term use and the documented side effects, such as staining and altered taste sensa-tions, are likely to make patient compliance problematic.

Alternatives such as essen-tial oils and CPC also have their drawbacks in terms of efficacy and all mouth rinses suffer the social concerns. Some of the ‘cos-metic’ over-the-counter brands are likely to make patient compliance problematic.

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 gin-gival inflammation.13,14

A satisfying rinse?

Deborah Lyle discusses the benefits and limi-tations of mouth rinses as an adjunctive treat-ment to conventional home-based cleaning, and whether using a water jet proves a better option.

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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.

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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, have 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 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 either; 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!

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UCL EASTMAN DENTAL INSTITUTE

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.

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UCL EASTMAN DENTAL INSTITUTE

THIS UNIQUE AND CHALLENGING PROGRAMME BRINGS TOGETHER CLINICAL EXCELLENCY AND LEADERSHIP SKILLS TO ACHIEVE IMPROVED LEVELS OF ORAL HEALTH THROUGH ACTIVE PREVENTION AND THE DELIVERY OF QUALITY CARE

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 carries 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: £8,960 (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

tel: +44 (0)20 7905 1324 or +44 (0)20 7905 1261
e-mail: m.kelly@eastman.ucl.ac.uk
web: www.eastman.ucl.ac.uk/cpd

In association with

DENTAL TRIBUNE United Kingdom Edition · March 29 - April 4, 2010

Special Feature 25
Certificate comes to Edinburgh

Melanie Venables from the Faculty of General Dental Practice (UK) details the launch of a new course in Scotland

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 this 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 13 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 gdp-education@rcseng.ac.uk or call 020 7869 6760.
Inaugural Study Club Event

The Academy of Cosmetic Dentistry is pleased to announce the inaugural Launch of the London Study Club.

Taking place on Wednesday 21st April 2010 at the New Oxford Garden Restaurant.

With the support of DARE: Dental Advancement Refinement and Education, this launch event is intended to encourage members to network with other practitioners in London.

The launch, entitled ’3D Treatment Planning: 10 Steps to Plausible Aesthetics and Function’ will give attendees a structured method for effective diagnosis planning.

The hands-on Gradia course shows how to craft functional composite restorations, even monochromatic restorations become beautiful due to the unique charmeleon effect of GC Gradia.

The Gradia hands-on course includes flights from London Heathrow, transfers to the hotel and training centre, 1 night hotel accommodation, all meals; together with all materials, model and equipment.

For full details of the Gradia courses, which are contained within GC’s Training Calendar Booklet or for further information please contact GC UK on 01908 219999.

BACD Belfast Study Club Announced

Dr Ian Buckle will be sharing his expertise with members of the British Academy of Cosmetic Dentistry (BACD) Belfast Study Club on Thursday 17th June 2010.

The lecture, entitled ’3D Treatment Planning: 10 Steps to Plausible Aesthetics and Function’ will give attendees a structured method for effective diagnosis planning.

This module will provide a comprehensive overview of the diagnosis, management and treatment planning of patients within the scope of NHS general dental practice.

Clinicians will gain an understanding of the management of the patient, the effects of smoking, and the impact of other habits, such as nail-biting.

The programme will incorporate the following modules:

"Developing Leadership and Clinical Excellence within the NHS"

The UCL Eastman CPD module will provide a comprehensive overview of the diagnosis, management and treatment planning of patients within the scope of NHS general dental practice.

"Hands-on Gradia Composite Restoration Course"

Special interest will be placed on the four options of treatment: reshaping, reporstoning, restoring, and surgical correction, so that the correct options are chosen for each patient.

The lecture will also demonstrate how to segment large treatment plans, so that patients with financial issues can receive optimum care over time.

For more information or a booking form please contact Suzy Rowlands on 0208 241 8526 or email suzy@bacd.com.

Important date for the diary

The British Academy of Cosmetic Dentistry (BACD) is pleased to announce another of its information packed Study Clubs, with a focus on one of Dr Carl E. Misch’s book ‘Contemporary Implant Dentistry, 3rd Edition’.

As Director of the Misch International Implant Institute® (MII) as well as Clinical Professor and Director of Oral Implantology at Temple University, Philadelphia, Dr. Carl Misch is currently Co-Chairman of the Board of Directors of International Congress of Oral Implantsologists, which, with more than 75 countries represented, is the world’s largest implant organization.

This highly anticipated course will set out quickly to register your interest or to book now please contact BioHorizons, the course sponsors, on +44 (0)1344 708338 or email Cindy Maticic at cmaticic@biohorizons.com.

For more information or a booking form please contact Suzy Rowlands on 0208 241 8526 or email suzy@bacd.com.
That confirmed the favourable anaesthetic efficacy of Oraqix over placebo in The benefits of using Oraqix have also been supported by a clinical study usage of up to five cartridges per patient. This allows clinicians time to conduct The anaesthetic effects of Oraqix last for approximately 20 minutes, with safe equipment. The Cavitron THINsert aids subgingival biofilm removal more effectively than insert, giving easy access to difficult to reach areas and maximising patient cleaning.

The range is effective against: MRSA, E. Coli, MR B, Pseudomonas aeruginosa, Enterococcus faecalis, Coinstedium (IC D-M) vegetative cell formation (growing cells of gram positive organisms, Staphylococcus aureus, Anaerobic, Candida albicans and is tested to standards: BS EN 14470, BS EN 13705, BS EN 10142, BS EN 13704, BS EN 13624 and according to DGHM guidelines). Topdental manufacture a wide range of infection control chemicals, which cover all requirements in a typical dental surgery environment. Topdental are also a leading supplier of non-toxic and disposable dental products. The current offer sheet features new A.F. range and can be requested FREE by phoning 0800 132 173 or downloaded from our website www.topdental.co.uk.

The Velopex Diode Laser contains two lasers: a 10 Watt Gallium Aluminium Arsenetate (GaAlAs) diode laser and a small laser pointer. The GaAlAs laser is ideal for soft tissue (papillae work) - it does not interact with teeth or bone. The GaAlAs laser has a wavelength that makes it an ideal way to do minor oral surgery. Using this laser, an area can be cut with localised haemostasis. Not only does the laser cut but it also cools the tissue too making it well for good post-operative results. The Velopex Diode Laser can also be used for Tooth Whitening. This allows superb results to be obtained in surgery, in relatively short times. Patient feedback continues to be very positive with many patients commenting positively on the laser.

The Market Leader: Cavitron™ Inserts Special Promotion

The Velopex Picasso Laser has been installed at the Dental Practice at number 52 which can now offer all patients the availability of laser treatments as well as the high quality dental care we are so famous for.

The Velopex Diode Laser
Harley Street in London is now well and truly on the map! Their first Velopex Picasso Laser has been installed at the Dental Practice at number 52 which can now offer all patients the availability of laser treatments as well as the high quality dental care we are so famous for.

The Velopex Picasso Laser has been designed for the practitioner and more comfortable for the patient is integral for the effective provision of proactive care.

Simplifies’ supplies a range of products that are specifically designed to provide the best clinical success for all stages of the preventive care treatment process. With the renewed focus on patient care following the recent report “Healthy Mouths”, clinicians can rely on Simplifies’ to ensure that a patient’s oral health is catered for effectively and efficiently. Time is a precious resource for practitioners and patients alike. Research shows that ultrasonic scaling reduces instrumentation time by 30%, when compared to hand scaling alone.

For hygienists who prefer to conclude treatment by hand, the extensive range of “Fluoranch” hand instruments is a popular choice. Ergonomically designed, the deburred, slotted-serrive metal instrument gives unimpeded grip and rotational control, while preventing hand fatigue.

An excellent advert to prophylaxis is SImples’Nay’s paste a low-sulphur polishing paste available in three grit sizes and flavours to provide effective cleaning.

For information call: +44 (0)208 072 3133 or visit www.depthly.co.uk

Reduce instrumental time by over 35% with

Topdental (Products Ltd) have now expanded their best selling alcohol free range, the A. F. hard surface devices to include large size wipes. The A. F. P high strength surface disinfectant releases an active and contains the spray, available in 550ml trigger spray and a 1.5 ml refill bottle size, standard tube size (105 x 175mm) and the newly introduced large tube of 200 wipes (size 200 x 200 x 200). Only available in the new ‘Vaposeal’ delivery form. The amount of adhesive contained in a ‘Vaposeal’ is sufficient for approximately 120 applications. Impeded accessibility of the cavity if the cavity is not accessible with the curing light or if chemically curing composites are used, the dual-cure, excIr led or Dual cure Single Component material is indicated. ExcIr E D is available in hygiene single-dose vials in two sizes: “Regular” for normal preparations and “Small” for micro-caries and endodontic applications.

Just Dental Supplies is a young and vibrant company new to the dental supplies market. Our vision is a simple one, to deliver Quality, Value and Service. Although a new company, Just Dental Supplies’ staff and advisors have a wealth of experience in the dental supplies market. We know what dental professionals’ demands and understand how to deliver it.

Our online sales outlet www.JustDentalSupplies.com provides a streamlined and secure online purchasing environment. All your financial details are encrypted and our site has been designed to ensure your purchasing experience is problem free. Our easy-to-use website gives you the functionality to check your order status, compare products and save money. Just Dental Supplies is an online business but always just a phone call away.


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As part of our commitment to support the dental profession, The Dental Directory is pleased to exclusively offer the new DNNET II training programme for dental nurses.

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The DNNET II programme is ideal for trainee dental nurses, those returning to dental nursing, and those just starting out in another role within dentistry. DNNET II will support them through their studies to help them achieve the National Certificate in Dental Nursing or the NVQ/VRQ in Dental Nursing.

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All this is available for just £149.99 plus VAT. To order your copy call The Dental Directory FREE on 0800 585 586

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+VAT

New DNNET II Training Programme for Dental Nurses
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 distances 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 outreach programmes 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 strategy. 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.

<br>
Contact Us Now!

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OPRoshield – a self-fit guard enabling patients to play sport whilst awaiting their custom-fit guard.

Nightguards – the most comfortable and effective way to protect teeth from bruxism.

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Corsodyl Daily Gum & Tooth Paste is a clinically proven dentifrice, which can kill bacteria that can cause gum disease¹.

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Recommend Corsodyl Daily Gum & Tooth Paste because teeth need gum care too


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