New guidelines on antibiotics for ‘heart’ patients

Ever since most of us qualified, we have asked standard medical history questions to try to identify those who might be at risk of infective endocarditis as a result of invasive dental procedures. Most of such patients are now accustomed to receiving prophylactic doses of antibiotics such as amoxicillin before treatment.

Now it is time for change. The National Institute for Health and Clinical Excellence (NICE) has issued a new clinical guideline on this issue. This recommends that antibiotics to prevent infective endocarditis should not be given to adults and children with structural cardiac defects, who are undergoing dental and a number of non-dental interventional procedures.

The 2008 NICE guideline is based on the best available published evidence and a consensus of multidisciplinary, expert opinion within the Guidelines Development Group (GDG). The guideline concludes that there is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE and that the clinical effectiveness of antibiotic prophylaxis is not proven.

The evidence also suggests that antibiotic prophylaxis against IE for dental procedures is not cost effective and may lead to a greater number of deaths through fatal anaephalactic reactions than not using preventive antibiotics. NICE has also issued the guidance in a patient-friendly form for the general public; this may be useful when explaining the new protocol to patients. The new guidelines are also summarised in the new edition (No 55, March 2008) of the British National Formulary.

In a revised position statement, Dental Protection advises its members that dentists working within an NHS contract are required under the terms of their contract to observe the guidance of NICE when writing prescriptions. Clinicians working privately may not have a contractual obligation to follow this guidance, but they would need a very strong justification for choosing not to do so. Dental Protection has also issued a most useful set of answers to frequently asked questions for its members.

The chief dental officer for England has stated, ‘I am delighted that NICE have produced definitive guidance on this complex issue. This will ensure that dentists can give consistent and evidence based advice to their patients. We will work with NICE and other professional bodies to ensure that this advice is disseminated to the profession so that dentists will be in a position to start applying this guidance immediately.’

The British Dental Association’s (BDA) scientific adviser, Professor Damien Walshe, told Dental Tribune that the association welcomed the new guidance that clarified best practice and places the UK as a leader in this area. BDA members (including Professor David Wray and Martin Fulford) had been on the reference group and they were able to brief the Health and Science Committee and in turn the Executive Board on this issue.

Some disquiet had been expressed by dentists about how to deal with a situation where the patient’s cardiologist recommends that antibiotics should continue to be prescribed despite what the guideline says. Professor Walsley said that the new guidelines applied to everyone working in the NHS and they were now the definitive guidance. He also pointed out that there were several well respected and eminent cardiologists on the reference group.

NICE’s summary of the guidance is reproduced on page 2 of this issue, but readers may find it useful to look at the full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) which can be found at: www.nice.org.uk
National Institute for Health and Clinical Excellence: prophylaxis against infective endocarditis

Summary and list of all recommendations on antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures – issued March 2008

Adults and children with structural cardiac defects at risk of developing infective endocarditis

Healthcare professionals should regard people with the following cardiac conditions as being at risk of developing infective endocarditis:

- Acquired valvular heart disease with stenosis or regurgitation
- Repair or replacement
- Structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired tetralogy of Fallot, arterio-venous fistulae and closure devices that are treated as being endovascularly.
- Previous infective endocarditis
- Hyperthermic cardiomyopathy

Patient advice

Healthcare professionals should offer people at risk of infective endocarditis clear and consistent information about prevention, including:

- The risks of undergoing invasive procedures, including dental procedures.
- The importance of maintaining good oral health.
- The need for prophylactic antibiotic use.
- The need to discuss antibiotic prophylaxis with people undergoing dental procedures and to offer advice on when prophylaxis may be required.
- The potential for local factors to contribute to the risk of infective endocarditis.

Antimicrobial prophylaxis against infective endocarditis

Antibiotic prophylaxis against infective endocarditis is NOT recommended:

- For people undergoing dental procedures.
- For people undergoing non-dental procedures at the following sites:
  - Upper and lower gastrointestinal tract.
  - Genitourinary tract; this includes urological, gynaecological and obstetric procedures, and childbirth.
  - Upper and lower respiratory tract; this includes ear, nose and throat procedures and bronchoscopy.

Chlorhexidine mouthwash should not be offered as prophylaxis against infective endocarditis to people at risk of infective endocarditis undergoing dental procedures.

Infection

Any episode of infection in people at risk of infective endocarditis should be investigated and treated promptly to reduce the risk of endocarditis developing.

If a person at risk of infective endocarditis is receiving anti-microbial therapy because they are undergoing a gastrointestinal or genitourinary procedure, prophylaxis is no longer routinely recommended.

The predisposing factors for the development of IE have changed in the past 50 years, mainly with the decreasing incidence of rheumatic heart disease and the increasing impact of prosthetic heart valves, nosocomial infection and intravenous drug misuse.

Published medical literature contains many case reports of IE being prevented by an interventional procedure, most frequently dentistry. IE can be caused by sev-

eral different organisms, many of which could be transferred into the blood during an interventional procedure. Streptococci, Staphylococcus aureus and enterococci are important causative organisms.

It is accepted that many cases of IE are not caused by interventional procedures (Bruncat et al, 2006), but with such a serious condition it must be

The recommendations of these four guidelines, and where reported the rationale for their recommendations, have been considered by the GDG in the development of this guideline. However, it should be emphasised that the GDG has based its recommendations on an independent consideration of the available clinical and cost-effectiveness evidence and, where appropriate, expert opinion. The guideline developers have also sought to make the rationale for their recommendations as transparent as possible, set out in the relevant ‘Evidence to recommendations’ sections.

This clinical guideline aims to provide clear guidance to the NHS in England, Wales and Northern Ireland regarding which dental and non-dental interventional procedures require, or do not require, antimicrobial prophylaxis against IE. In contrast to other recently published national and international guidelines, it explicitly considers the likely cost effectiveness as well as the clinical effectiveness of antibiotic prophylaxis.

In summary, this guideline recommends that antibiotic prophylaxis solely to prevent IE should not be given to people at risk of IE undergoing dental and non-dental procedures. The basis to support this recommendation is:

- There is no consistent association between having an interventional procedure and the development of IE.
- Regular tooth brushing almost certainly presents a greater risk of IE than a single dental procedure because of repetitive exposure to bacteria and oral flora.
- The clinical effectiveness of antibiotic prophylaxis against IE for dental procedures may lead to a greater number of deaths through fatal anaphylaxis than a strategy of no antibiotic prophylaxis, and is not cost effective.

Given the difficulties in relating risk definitions, a simple classification of conditions into either groups at risk and not at risk was undertaken.

The full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) and guidance for patients can be seen at:www.nice.org.uk
Is the answer the £1 UDA?

Michael Watson looks at the controversy over units of dental activity (UDAs) and suggests a fundamental rethink on the issue.

When the concept of the £1 UDA was first put to me by an economics expert, my first reaction was to suggest that she take a little more water with it. After all much of the controversy over UDAs centre around their low value especially after a tendering process and concern about what might happen after 2009. But as she explained the concept I warmed to it.

But first let us look at the background. At this time of year the media runs stories about dentists running out of UDAs and spend more time with their golf clubs or on exotic foreign holidays, leaving patients in the lurch. As an aside we might question why this is a story, if dentists have worked hard to achieve their targets, surely they deserve some relaxation.

Nevertheless there are sections of the media that disapprove of dentists enjoying themselves and the department of health says that they should manage their workload evenly throughout the year. Some PCTs are in a position to offer some additional UDAs on a temporary basis to ensure continuity of services.

So where does the £1 UDA fit in? Under this suggestion all UDAs would be valued at £1. In an average contract this would mean about £7,000 of the contract value would be accounted for by UDAs. This would be the maximum that could be clawed back for failing to reach the target, although in reality such clawbacks would be far less.

The rest of the contract value is a payment to the dentist(s) for keeping the practice open and being available to patients; opening times already form part everyone’s contract as it is. The primary care trust (PCT) could agree with the practice a range of services that could be offered, such as a prevention programme, simply to see more patients or patients from specific postcodes.

In coming years the focus of PCTs will have to move away from UDA targets and towards better access to more patients. This is now a national NHS requirement and they will be judged on whether they achieve it. They will not do this by continuing with their current obsession over UDAs.

The £1 UDA does not require redrafting of the regulations and it removes from dentists the threat of clawback. It also allows dentists and PCTs to work together to provide services that are more effective and more relevant to their patients. Not the bad idea I first supposed.

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The rest of the contract value would be paid for the other services that the practice must provide. For instance nearly half used to pay overheads, such as staff wages, rent, equipment materials and office expenses. These must be paid whether or not the practice achieves its UDA target. It is iniquitous that this element of the contract value is subject to clawback when the payments have been made.

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Polish dental tourism expands

British-Polish medical tourism provider, StatMedica, has added a new dental clinic in the outskirts of Warsaw to its portfolio. The company now claims to be able to expand on its ability to offer high quality dental care at some of the most competitive prices in Europe, with dental implants starting at £480, crowns starting at £200 and veneers starting at £250. These prices, it says, ‘are approximately 70 per cent less than the typical price of treatment in the UK’.

Low-cost flights from cities across the United Kingdom to destinations across Poland and affordable hotel accommodation in Poland ensure that significant cost savings can apparently be made by travelling to Poland. Alison Hope, director of StatMedica’s London office said: ‘The cost savings that can be made by travelling to Poland for dental treatment are immense even once you factor in the cost of flights and accommodation’

But BDHF advises against

However the British Dental Health Foundation (BDHF) has backed a ‘Which?’ report advising against going for medical treatments abroad. It has urged members of the public not to travel abroad for dental treatment after a report by consumer advice group found that almost one in five medical tourists suffer problems after treatment.

The BDHF was speaking after the report revealed that more than a quarter of patients travelling abroad for medical treatment did not feel they received the follow-up care they needed, while a further 18 per cent reported complications.

The survey followed a recent warning against dental tourism by the Foundation after a number of callers to its free Dental Helpline service (0845 063 1188) reported that they did not know how to resolve their complaint after treatment.

‘This is what I object to the most’, said Baroness Gardner speaking to the DPA. ‘You get a letter saying you have been struck off after a lifetime of honourable service. It is the same whether you are a retired dentist or have been struck off for malpractice’. The DPA believes that all dental professionals have a right to appear on the register as a right by virtue of their qualifications—except those who have been moved on disciplinary grounds.

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Record entries for the student technician award

Congratulations go to Rachel McMichan on winning the 2008 British Orthodontic Society (BOS) student technician award.

Rachel received her award at the Orthodontic Technicians Association (OTA) annual conference in Edinburgh, which took place on March 14–16, 2008, from David Bearn, chairman of the BOS scholarship & grants committee.

This year’s competition attracted a record number of entries and the judges had a very difficult time selecting the winner.

The entrants were required to prepare a removable appliance to a given prescription, and Rachel’s imaginative use of colour in the baseplate certainly stood out. The entrants also had to design and produce an appliance to achieve certain tooth movements and present a written commentary on the rationale for the design chosen.

Rachel’s prize was a complimentary conference package to attend the OTA conference in Edinburgh, along with a cheque from the BOS.
For as long as most of us can remember access to NHS dentistry, or rather lack of it, has dominated the media. This was accentuated by the recent figures showing that since the new contract came in a quarter of a million fewer patients had been seen.

Primary Care Trusts (PCTs) have been pulling out all the stops to try and paint the opposite picture, putting out press-releases whenever new practices have been established. The department of health tells us that from this April the focus will be on making sure more people are seen, rather than the current pre-occupation with units of dental activity. In the meantime, here are some stories from around the country.

**PCT’s dental access pledge**

PCT managers have pledged that soon no-one in Burnley and Padiham should be waiting to see an NHS dentist. Thousands of people in East Lancashire gave up trying to find a dentist two or three years ago, amid a number of practices deciding to see only private patients.

But now Burnley MP Kitty Ussher says more dentists are carrying out NHS work and she has received a letter from East Lancashire Primary Care Trust saying that substantial progress has been made in tackling the issue. Trust chief executive David Peat has told the MP it is hoped that everyone currently on their dental access allocation list will be offered an NHS dentist in the near future.

**Sheffield PCT invests in services**

People across Sheffield are set to benefit from a £400,000 investment from Sheffield PCT in NHS dental practices. The investment is expected to increase access for NHS patients in the city. 17 practices that offer an NHS service throughout the city will be receiving the funding, which will allow them to either to continue to accept new NHS patients if they currently do so or give faster treatment to those patients who are waiting to receive NHS dental care.

John Green, director of dental public health said: ‘This is a great opportunity to make sure people don’t have to wait too long for dental care, by offering earlier treatment appointments.’

**Scarborough in news again**

In 2004 Scarborough hit the national media when hundreds of people were filmed as they queued to be put on the list of an NHS dentist in the town. Now, a spokesman for North Yorkshire and York PCT said the current situation was ‘very positive’ and so far this year 2,189 patients had been allocated an NHS dentist.
At prime minister’s questions on March 26, conservative MP and dentist Sir Paul Beresford asked Gordon Brown to confirm that he agreed with the need for fluoridation, and would he meet a delegation to discuss the changes needed to implement it.

The prime minister replied that he was personally very sympathetic to what Sir Paul had said and had seen the benefits of fluoridation himself. One reason for the Government putting extra money from the health budget into fluoridation was to encourage that to happen around the country. He added that he would be very happy to meet the proposed delegation. ‘It is a good thing for the teeth of the people of this country’ said the prime minister.

Health questions

Philip Hollobone conservative MP for Kettering had an oral question down for health ministers last month. He wanted a statement on access to NHS dentistry in both his constituency and England. The reply was given by the minister of state, Ben Bradshaw, who said that there had been an increase of seven per cent in the number of dentists in Northamptonshire last year; nationally there were 4,000 more dentists than in 1997, and investment in NHS dentistry has more than doubled.

Mr Hollobone pointed out, however, that according to the latest figures the number of patients in Northamptonshire seen by their dentist has fallen by 13,000 since the new dental contracts were introduced. He also pointed out that Northamptonshire primary care trust (PCT) had yet to undertake a needs assessment of children’s orthodontics. The minister urged the PCT to get on and do it. He also said there was now a requirement for all PCTs to increase, year on year, public access to NHS dentists. ‘There is no excuse for any PCT, including the hon. Gentleman’s, not to improve its results’, he said.

A friendly labour back-bencher and fellow Devon MP, Linda Gilroy asked the minister to join her in congratulating Plymouth PCT, which a short time ago had 12,000 patients on its waiting list, but had turned things around and now had about 500 patients on it. The minister was happy to do this and also congratulated his own PCT (Exeter), which had halved the number of people on its waiting list in the past 12 months.

However the conservative shadow dentistry minister, Mike Penning, attacked the minister for denying that there was a crisis in NHS dentistry, despite the evidence in the recent Patients Association report, ‘Whom should we believe’ he asked, ‘the Government or the Patients Association’. The minister said he would rather listen to the testimony of MPs, speaking from experience of their constituency, and to the facts.

‘Given the introduction of the new contract, and the new investment that is now coming on stream in dentistry, I am afraid I have to tell the hon. Gentleman that not for much longer will he be able to say in the House that NHS dentistry is in crisis’, he concluded.

Introductory Seminars

At the first event in the Clearstep Educational Continuum, the introductory seminar is aimed primarily at General Dental Practitioners whatever your expertise and experience.

By the end of the programme you will understand the benefits of ‘combined treatment plan’ and feel confident about treating any patient with the Clearstep system together with traditional orthodontic techniques.

Expand your range of treatments and further your skills. Book onto the Clearstep introductory seminar today.

BOOK ON-LINE FOR THE INTRODUCTORY SEMINARS:
www.clearstep.co.uk or contact info@clearstep.co.uk
Grey health
A study by Tefen USA, a management consulting company, warns that the approaching onslaught of more than 70 million aging baby boomers could overwhelm the USA health care system and engulf the economy. A recent report from the Centers for Medicare and Medicaid Services (CMS) predicts that US health care spending will double just over $4.5 trillion by 2017, nearly 20 percent of the nation’s gross domestic product. Tefen warns that CMS’ projection could actually be too low because people over 65 face nearly three times as many hospital days per thousand as the general population, and 62 percent of 50-to-64-year-olds have at least one of six chronic health conditions: arthritis, high cholesterol, cancer, diabetes, heart disease and hypertension.

Oral Cancer
Approximately 35,000 Americans are diagnosed with oral cancer each year and nearly 8,000 people died of these cancers in 2007 alone. Early detection is an integral part in battling the disease and can even help identify precancerous cells before they become cancerous. The Pennsylvania Dental Association (PDA) stresses that regular dental checkups play an essential part in the early detection of oral cancer.

No laughing matter
A Long Island dentist has been arrested for inhaling laughing gas (nitrous oxide) for non-medical reasons. Police arrested Dr Norman Rubin and charged him with inhalation of hazardous inhalants, a misdemeanor. They were called to Rubin’s office by a patient who found the dentist in apparent distress. Police and emergency medical technicians learned that Rubin had been inhaling nitrous oxide. After being treated, he was arrested.

Independent hygienists
Dental hygienists in the USA may secure right to operate independently. The New Hampshire and Maine state legislatures are considering whether dental hygienists should be allowed to set up their own practices, or at least operate with more autonomy. However retired dentist Ray Jarvis of Rye, secretary of the New Hampshire Board of Dental Examiners, said the board is opposed to any legislation that would let hygienists establish private practices. Jarvis said hygienists must work under dental supervision so serious oral diseases are not missed.

Shop and bleach
Regulators in the States are looking into business that set up in shopping malls and offer tooth whitening. Many not only sell the products but offer customers the opportunity to use them right then and there. Shoppers like them because they are convenient and cheap — usually about $100 instead of the $500 or $600 charged at a dentist’s office. But regulators and dentists have raised concerns about the safety of such practices. Officials say the question that needs to be answered is whether the people at the kiosks are technically performing dental work, which would be illegal.
The 10th Dimension—The power of 10...

10 things you should know about delegation

1. Understanding delegation

Delegation is a skill essential to any manager and practice owner. Used effectively, it enables expansion of that most powerful and elusive of resources available to a leader.

2. Selecting tasks

An example of a delegatable task is stock control. The practice owner should be the one finding out what materials are required, where to get them at the best possible price, and ensuring that the practice neither runs short of nor has a surfeit of necessary materials. An intelligent leader will appoint someone competent to carry out these tasks, and the sole responsibility of the leader is to monitor levels of spending and stock volumes. While someone else is sitting at the computer or telephone doing the ordering, the healthcare professional is either attending to patients, writing reports or letters or reading journals, none tasks which can be delegated.

3. Why delegate?

If you often say ‘I don’t have enough time’, you are badly organised and a poor delegator.

4. Under-use of delegation

Insecure managers who do not delegate undue employables, which acts as a demotivator to others who know they can do the job at least as well as you but at significantly lower cost. The cost of delegation should not outweigh the costs of non-delegation.

5. What is involved in delegation?

Delegation involves the loss of direct control but the retention of direct responsibility. The basic elements involved in delegation are autonomy and control. When delegating, ensure that the delegate is fully aware of the objectives, which should be stated clearly and concisely. Base the experiences on required outcomes.

6. Accountability

Accountability is at the very core of delegation, so it is essential that delegates know what their responsibilities are. All guidelines should be set in writing. Delegation works best when accountability for any particular task rests with one individual.

7. Choosing the right person

It is very important to choose the right person for the task in hand. The first few times it will be trial and error, but experience brings improved skill assessment and better person selection. Letting go of work gets easier the more you do. Show faith in your chosen person, even if others have reservations. Do strive to regard your staff as competent people. If you do not trust a member of staff to do a job, it is better not to retain that person.

8. Training

Delegation is an important part of the training process. Consider which skills need to be developed and taught to enable the delegate to be able to carry out the task. Quality feedback when delegating will motivate the delegate and strengthen their self-confidence.

9. Feedback

Meet regularly, but not over-frequently, for feedback sessions. As a delegation proceeds, you should gradually reduce the frequency of meetings. When discussing progress always use questions in a positive way that is likely to bring solutions to problem areas rather than being overly-critical. Encourage delegates to provide their own solutions.

10. Provide backup

Ensure you provide enough support and back-up to each person delegated a task, especially when things go wrong. Don’t use delegates as scapegoats when things go wrong. Establish a culture that recognises success and avoids blame for failure. If delegation is not working, ask yourself: ‘What am I doing wrong?’

Listening to the market

This is the fifth in a new series of articles by Dr Ed Bonner

A modern adage: when you can see a bandwagon, you’ve missed it!

Market opportunities

Every business (and dentistry is no exception) needs to be able to identify new market opportunities. None can rely nor depend on present products or services, nor on the existing market lasting forever. Many practice owners may think that there are few opportunities to develop and renew themselves regularly, but this simply shows a lack of a strategic overview and a lack of belief in their own abundant strengths. In preparing a marketing plan, we need to listen carefully to what the world out there is saying about itself, about us, and to us. We don’t want surprises. We dare not live in that protected cocoon called ‘this does not apply to me, I’m a dentist not a businessman’. Our comfort zone of the past is under siege.

We require information

To understand what our patients/customers want, we need a plentiful supply of timely, accurate information: information about the environment; about how we are perceived by the media and by the public; about government thinking. We need all of this because we need to be able to respond rapidly to current fashions, trends and, not least, prejudices. This information will come from market research, which tends to be an expensive luxury for us. For us, but not for our suppliers, so it is they who will set the agenda for us, rather than the other way round. We thus need to know what our suppliers are thinking about, what our researchers and scientists are doing. We can also benefit indirectly from their education of the public through advertisements. If a major company spends millions on extolling the virtues of their new electric toothbrush, we can sell them like hotcakes because our patients will be asking about them. On the other hand, some professionals may see this as coercive indoctrination where the process moves from informative to persuasive, and they may wish to have no truck with whatever with such a process.

Gathering market intelligence

What dentists can do is involve themselves more actively in intelligence gathering. Market intelligence is everyday information about important environmental events, new laws, social trends, technological breakthroughs, demographic shifts and competitor manoeuvres. From a marketing perspective, the following questions need to be answered:

- What decisions are we regularly called on to make?
- What types of information do we need to make those decisions?
- How do we get the information we need?

We can get this information in a variety of ways: here’s 10:

- Reading dental journals and magazines from a different perspective
- Attending lectures, courses, seminars and workshops
- Talking to trade representatives
- Government publications
- Through associations/organisations such as CODE
- Reading adverts and advertisement

als by other practices in local magazines
- New staff employed from other practices – they are competitor ex-employees!
- Listening to our patients
- Watching television and reading newspapers
- Searching the web.

The good news is that all the above are within our existing capabilities. The better news is that not one of the above list will cost you a single penny. What will cost you is not to do anything.

Planning from strength

Once we have the necessary information, we can plan either defensively, for example, re-
Measure for measure

If you want to increase production and revenue at your practice, you need to keep a close eye on your progress and spending, says Simon Hocken

I am still amazed how many clients continue to run their businesses on their bank statements, plus the annual meeting with their accountant. Each month, they roll the dice and take home whatever’s left in their business accounts (and sometimes more). In this article, I want to make the case for a coaching phenomenon; that if you measure your performance, you will improve your performance.

The reason for this is that the daybook acts as a ‘real-time’ record of how the day is going (financially) and if halfway through, it’s not looking good, it may be possible during the second half of the day to make up some lost ground by changing the focus of an appointment(s).

Attention to detail

In many cases, this small task is all that’s necessary to improve the personal production of the dentists and other fee earners and get a poorly performing practice back on track. The very act of measuring focus’s your team’s attention on what they are doing/not doing and their production improves. I recently worked with a dentist whose daily gross fees increased by a third just by doing this!

The next step in using this tool is to set targets and to measure your situation against a target that represents success, (be it; weight loss, debt reduction or dental productivity)! The trick here is to measure and measure often against a realistic, incremental target. And the next trick is to give yourself/them a reward when you/reach these targets!

Key performance indicators

I find that I can often measure a dental practice’s financial success by using a relatively small number of key performance indicators. I think of them as like a health check. Just like the clipboard that used to hang on the end of a patient’s bed, which the Consultant would pick up and quickly see the vital signs and progress of the patient. I have observed that dental principals who have put in place their own version of this “health check” and look at it regularly, often have more successful practices than those that don’t.

Setting goals for the turnover of your practice, the net profit it creates and your personal income forms part of your vision for your professional future and should never be left to chance. Measuring your progress against targets is an effective way of making real progress and turning your plans into reality.

Ten things worth mentioning in your practice:

1. Daily production of every fee earner in pounds
2. Daily collection of every fee earner in pounds
3. Total practice sales
4. Total Practice expenses
5. Net profit
6. Cash flow
7. New patients
8. Patient retention (as a percentage)
9. Client satisfaction (using feedback questionnaires)
10. Employee satisfaction (using personal interviews).

Ten things worth measuring in your personal life:

1. Weight
2. Fitness/health
3. Net worth
4. Bank balance
5. Wealth creation activities (as opposed to income)
6. Days off
7. Glasses of water daily
8. Cups of coffee/tea daily and alcohol units weekly
9. Time spent exercising weekly
10. Cholesterol / blood pressure / resting pulse rate.

The practice health check

Five key performance indicators for every dental practice.
1. Average daily productivity in £ of all fee earners (from day book, not from money over counter) graphed each month to show trends.
2. Net Profit of practice as a percentage graphed each month to show trends.
3. Bank account, worst figure, best figure each month, (tracked as a graph).
4. Active patient list size for each dentist, (tracked as a graph)
5. New patient numbers per month, sex, age, location, source.

And I suggest you measure people by what they do, not by what they say they will do.

‘Everything You Measure Gets Better’ is a coaching phrase that’s worth a second look. Here’s how it works. If you want to lose weight, weigh yourself often and keep a record. The act of weighing yourself and recording it reminds you and your subconscious that you want to lose weight. If you want to reduce your personal debt, create a spreadsheet that measures your situation and refer to it monthly. Circle a date in your planner when you will update the spreadsheet, look at the result and see the progress.

Keeping a record

If you want to increase the production in your practice, put a notebook in the surgeries of all fee earners. Then ask all the fee earners (not their nursing assistants) to write down the procedures they carry out for every patient (fee earners) to write down the procedures they carry out for every patient on their list of fee earners.

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2. Net Profit of practice as a percentage graphed each month to show trends.
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And I suggest you measure people by what they do, not by what they say they will do.
New faces on BADN Council
Meet the new additions to the BADN team

Susan Bruckel has taken over from retiring chairman Elena Graham on the BADN Council from March 2008. Sue qualified as a dental nurse in 1972 and since then has worked for the community services. In 2001, she qualified as a special care dental nurse and in 2005 passed the National Diploma in Occupational Health and Safety. Most recently, Sue gained a City and Guilds Licentiateship Award in Dental Nursing and also became a Justice of the Peace.

New regional coordinators
The BADN Council also includes three new regional coordinators, for the North East, East Midlands and South Central regions. Melanie Joyce began dental nursing in a mixed NHS and private practice in Leeds city centre and obtained the NVQ5 in 2008. She currently works in a mixed practice also in Leeds. Melanie has also completed the ILM Certificate in First Line Management Level 3 and the Certificate in Dental Radiography, as well as the 7503 teaching qualification. She is currently completing the 7504 qualification.

Vicky Norton began dental nursing in 1996 in an NHS general dental practice. She moved to Leicester in 1999 and worked again in general practice. She is currently working as clinical manager in a predominantly private practice in Leicester, which provides implants, sedation, orthodontics and cosmetic and general dentistry. Vicky obtained the NVQ5 in 2005 and the Sedation qualification in 2007, and plans to take the Radiography qualification next year.

Leanne Covey began dental nursing in general practice in 1986, qualifying in 1990 before moving to maxillo-facial hospitals. Leanne is a qualified Operating Department Practitioner, Assessor and Internal Verifier. She also holds a Certificate in Education, the General Anaesthetic Dental Nursing award and is currently studying for a BA Hons in Education and Training.

A new chairman
Two BADN national groups: the Armed Forces National Group and the National Education Group, also have new chairmen. Amanda Watson is currently employed as a dental practice management tutor in the Defence Dental Services Training School in Aldershot. She began her dental nursing career in 1990 at a dental practice in Ormskirk, gaining the National Certificate in 1993 and joining the Royal Navy in 1994. Since joining, she has served in Portsmouth, Somerset, Scotland, Gibraltar and Aldershot. Amanda has been a member of the AFG since 2002 as the Royal Navy representative, Secretary and now Chairman.

Sam O’Neill is employed as a dental nurse tutor by Bury Primary Care Trust. She qualified as a dental nurse in 1996 by achieving the National Certificate in Dental Nursing. Since then, she has been awarded the NEDN Certificates in Conscious Sedation, Dental Radiography and Oral Health Education, as well as the Diploma in Management and the 7407 Adult Teaching Certificate. Sam is currently studying towards the Certificate in Education and the A1 NVQ Assessor award which she is due to complete in June 2007.

Further enquiries, contact Pam Swain on 01253 338365 or email pam@badn.org.uk
Taking technology forward – technicians and technical skills

Another article from the Dental Laboratories Association: this month on keeping technical skills up to date and CPD

Competition is a relatively new phenomenon in dentistry. Twenty or thirty years ago most patients who needed a dentist approached the local surgery with no thought of seeking a second opinion, took what was on offer and went contentedly on their way.

Not any more. Today’s patients coming into surgery, who have access to a wide variety of information about treatments, are prepared to travel for the best deal, and thanks to the media’s new found interest in dentistry have a far greater knowledge of different procedures and awareness of what is possible in terms of improving their appearance. And the tentacles of competition reach beyond the high street; technicians too have a responsibility to constantly hone their skills to ensure the practice they serve maintain a competitive edge and keep up to date with the latest developments in materials and methods.

All dentists seek to offer a wide spectrum of treatment options, each reflecting the highest standards of professional care. Technicians have the same ambition, to create protheses and appliances of the highest quality which satisfy patient expectations and complement the talents of their clinician partners. However, compatible ambitions need compatible knowledge. To ensure the mid-field and the striker are playing the same tactical game, both must pay attention to the team talk. Continuing Professional Development (CPD) keeps the different elements of the dental team not only up to date but communicating in the same language.

Learning new skills is personally challenging and commercially productive. For practices which engage with and exploit the latest developments as they occur, unlimited progress becomes possible. Staff are highly motivated, the patients benefit, and profitability soars. In many respects, technicians man the engine room driving the practice forward; advanced clinical management calendar. It provides delegates with a two-pronged approach to success by firstly concentrating on personal accomplishment and then moving on to team achievement.

It’s aimed at everyone associated with management including practice managers, principals, senior nurses and receptionists and to encourage team development, BDPMA members can extend their privileged rate to other members of their teams.

Speakers include Stephen Hancocks OBE, Chair Clare Macnamara, representatives from BDA Good Practice, Investors in People, NHS BSA and NHS PCT, and colleagues Shaenna and Phil Loughnane from the award-winning Chipping Manor Dental Practice.

Boost your career

What happens when we meet a challenge at work? We usually feel unconfident to tackle it. It could be a new payroll system, determining budgets or creating a marketing plan but whatever it is, it fills us with fear.

The remit of the practice manager is broad so developing a broad skill base is important. That’s why the BDPMA, in association with Henry Schein, offers all members the opportunity to further their management capabilities with funding of up to £2500 towards a recognised management qualification.

To enter, just appraise your practice; what are its strengths and weaknesses? How do you derive value to your patients and how can you increase this value? Look at your patient journey and what needs to be changed? How can you make those changes and what do you need to be able to facilitate that change?

You don’t need to write an essay – bullet points are fine. Download an entry form from www.bdpma.org.uk or ask your Henry Schein representative to send you one. Follow the instructions; send it to the BDPMA by APRIL 25th. Don’t forget to keep a copy for yourself, after all, it’s an action plan for your practice and is a useful tool even if you don’t win. But – you’ve got to be in to win it!

What is a manager worth?

As a manager of a dental practice, how do you know if you package adequately reflects your skills and worth? As a principal,

The BDPMA means business

If you’re in need of an inspirational boost, the BDPMA has events and training courses to suit everyone involved in dental practice management, says Vikki Harper

Has your career hit a plateau and is to know – as quickly as possible? How on earth you’ll learn all there is, it fills us with fear.

The 2008 BDPMA Conference & Celebration Dinner on June 15 and 14 at Stratford upon Avon is set to be the highlight of the dental management calendar. It provides delegates with a two-pronged approach to success by firstly concentrating on personal accomplishment and then moving on to team achievement.

Each issue provides one hours verifiable CPD so for BDPMA members that’s four hours of verifiable CPD per year just from reading Dental Management. To receive your copy each quarter, join the BDPMA.

The British Dental Practice Managers’ Association is growing quickly because it fulfils the needs of managers striving to climb that ladder of success. Take your first step towards management success by joining now.

Contact the BDPMA on 01452 886 364 or by emailing info@bdpma.org.uk
The rationale for infection control and safety
Dr. Raghunath Puttaiah

Many countries in the Western hemisphere have followed acceptable standards in dental infection control and safety dictated by a higher level of practice standards. These standards are formulated by regulatory agencies in their respective countries or regions to improve the level of patient care and personnel safety.

Many patients were infected with the Hepatitis-B virus by dentists and dental surgeons in the United States in the 1960s and '70s. Despite this, infection control did not gain in importance, possibly due to the advent of vaccines to combat the Hepatitis-B virus. Although concepts in dental infection control were developed in the 1960s (due to Hepatitis-B virus infections), this field only gained priority after HIV infections reached epidemic proportions.

Infection control gained further momentum in the U.S. after patients treated by an HIV-positive dentist later tested positive for the virus, and also after health care workers became infected while involved in patient care activities.

While this disease has been ravaging the African subcontinent since the late 1980s, and today in Asia and South Asia in particular, it is now being controlled in the U.S. and Western Europe where dentists have improved their practice of infection control either voluntarily or involuntarily.

The number of individuals infected with HIV and developing severe disease (i.e., AIDS) continues to rise worldwide. There is an annual increase, each with high morbidity levels within the populations, but with dramatic regional variations. While the case loads in the Americas and Europe are increasing, it is not as much as in Asia, with India having about 5.7 million cases, and China about 850,000 cases of HIV infections.

Apart from HIV and AIDS, there are a plethora of blood-borne and other common diseases encountered in the dental clinic that may pose a risk (see Table 1 for a list of conditions/pathogens, habitat and routes of transmission).

### Table 1: Infectious diseases commonly encountered in dentistry

<table>
<thead>
<tr>
<th>Condition</th>
<th>Habitat</th>
<th>Routes Of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Herpetic Infections</td>
<td>Oral, pharynx, anogenital, skin, eyes, exudate</td>
<td>Contact-lesion exudate, saliva, blood, contact, blood</td>
</tr>
<tr>
<td>2. Acute herpetic gingivostomatitis</td>
<td>Oral, gingiva, pharynx</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td>3. Herpetic Whitlow</td>
<td>Finger, hand</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td>4. Varicella-zoster Infections</td>
<td>Oral, pharynx, skin</td>
<td>Contact-lesion exudate, saliva, blood, nasopharyngeal secretions</td>
</tr>
<tr>
<td>5. Chlamydial Infections</td>
<td>Genitalia, eyes, ophrynx</td>
<td>Contact-lesion exudate, genital secretions, secretions from eye</td>
</tr>
<tr>
<td>6. Trichomonal Infections</td>
<td>Genitalia, pharynx, oral, gastrointestinal</td>
<td>Contact-lesion exudate, mucus, saliva, blood, body fluids</td>
</tr>
<tr>
<td>7. Chlamydia trachomatis</td>
<td>Anogenital skin, oral, mucosal areas</td>
<td>Contact-lesion, mucus, saliva, blood, body fluids</td>
</tr>
<tr>
<td>8. Syphilis</td>
<td>Genitalia, skin, oral mucosa, oropharynx, eye</td>
<td>Contact-lesion exudate, saliva, blood</td>
</tr>
<tr>
<td>9. Infections Molluscum Contagiosum</td>
<td>Skin, oral mucosa, genitals, genital, saliva</td>
<td>Contact-lesion, saliva, lesion exudate</td>
</tr>
<tr>
<td>10. Hepatitis B Virus Infection</td>
<td>Liver, blood, body fluids</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td>11. Hepatitis D Virus Infection</td>
<td>Liver, blood</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td>12. Hepatitis C Virus Infection</td>
<td>Liver, blood</td>
<td>Contact-blood, saliva, body fluids</td>
</tr>
<tr>
<td>13. Human Immunodeficiency Virus Infection</td>
<td>Blood, oral mucosa, skin</td>
<td>Contact-blood, semen, non-intact skin</td>
</tr>
</tbody>
</table>

**Respiratory Diseases**

1. Common Cold
   - Upper Respiratory Tract
   - Arousal, droplet, contact

2. Sinusitis
   - Upper Respiratory Tract
   - Arousal, droplet, contact

3. Pharyngitis
   - Upper Respiratory Tract
   - Arousal, droplet, contact

4. Perimembranous
   - Respiratory Tract
   - Arousal, droplet, contact

5. Tuberculosis
   - Respiratory Tract
   - Arousal, droplet, contact

6. Staphylococcus Infection
   - Respiratory Tract
   - Arousal, droplet, contact

7. Strep Throat
   - Respiratory Tract
   - Arousal, droplet, contact

**Childhood Diseases**

1. Chickenpox
   - Oral, skin
   - Droplet, contact

2. Herpangina
   - Oral, pharynx
   - Droplet, contact

3. Hand, foot and mouth disease
   - Oral, hands, feet
   - Droplet, contact, ingestion

4. Rabies
   - Respiratory Tract
   - Droplet, contact, ingestion

5. Mumps
   - Parotid, pancreas, tracts, CNS
   - Droplet, contact, saliva

6. Cystomegalovirus infection
   - Salivary glands
   - Droplet, contact, saliva, blood

**Other Common Conditions**

1. Herpes Zoster Infection
   - Liver, gastrointestinal tract
   - Ingestion, rarely blood

2. Hepatitis A Virus Infection
   - Liver, gastrointestinal tract
   - Ingestion, rarely blood

**Note:** Conditions addressed in the table are frequently seen in dental patients and therefore need to be considered in protecting patients and the dental health care workers. The modes of transmission in dentistry are commonly direct contact with lesions, saliva, blood, oral mucosa, and droplets and aerosols containing infectious agents.

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**Table 1:** Infectious diseases commonly encountered in dentistry
Percutaneous (high risk): Inoculation of microbes from blood and saliva transmitted through needles and sharps.

Inhalation of aerosols or droplets containing pathogens (moderate risk): Breathing bioaerosols suspended in the clinic’s ambient air laden with microbes. The terms “infection control” or “infection prevention” do not mean total prevention of iatrogenic, nosocomial infections or occupational exposure to blood and other potentially infectious material. Although the goals are the same in both worlds, the risk of disease prevention, reduction in potential risks of disease spread is only practical.

Contact (high risk): Touching or exposing non-intact skin to infectious oral lesions, infected tissue surfaces or infected fluids, splash and spatter of infected fluids.

Rationale
The rationale is to control iatrogenic, nosocomial infections and potential occupational exposure of care providers to diseases causing microbes. The terms “disease control” or “infection control” do not mean total prevention of iatrogenic, nosocomial infections or occupational exposure to blood and other potentially infectious material. Although the goals are the same in both worlds, the risk of disease prevention, reduction in potential risks of disease spread is only practical.

Routes of disease transmission
Routes of disease transmission can be specific to various fields of health care. In dentistry, diseases can be transmitted from patient to patient, dentist to patient, and patient to dentist when adequate precautions are not followed. Dental health care workers and patients can further transmit the diseases to their families and friends. The common modes of disease transmission in their order of severity are:

1. Percutaneous (high risk): Inoculation of microbes from blood and saliva transmitted through needles and sharps.
2. Contact (high risk): Touching or exposing non-intact skin to infectious oral lesions, infected tissue surfaces or infected fluids, splash and spatter of infected fluids.
3. Inhalation of aerosols or droplets containing pathogens (moderate risk): Breathing bioaerosols suspended in the clinic’s ambient air laden with infectious material while using hand pieces and scalers or droplet nuclei from coughing.
4. Indirect contact through fomites (low risk): Touching contaminated inanimate surfaces in the dental treatment room or operatory.

The risks of disease transmission may vary depending upon host susceptibility, virulence and infectivity of the organism, the dose of or number of organisms, period of exposure (time span) and, finally, the mode of transmission. Controlling virulence of all pathogenic organisms or trying to reduce inherent patient susceptibility is next to impossible.

A practical approach would be to understand the disease processes, routes of transmission, and methods to control and better understand the disease control measure, it is necessary to understand the criticality of surfaces. In 1968, Earle H. Spaulding categorized medical devices based on the risk of disease transmission and their reprocessing methods prior to their use in patient care. The same principles were modified by Faverio & Bond10 to include four categories (to include environmental surfaces as a category). Table 2 is an explanation of this modified classification as it applies to dentistry.

Table 2: Adaptation of Spaulding’s Classification.

<table>
<thead>
<tr>
<th>Category/Level</th>
<th>Disease Risks</th>
<th>Control methods</th>
<th>Materials/Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>High</td>
<td>Sterilization by:</td>
<td>Items that are used in surgery which pierce soft and hard tissue—Scalpels, blades, forceps, vessels, needles, files, burs, rongeurs, periodontal instru- ments used in prophylaxis, surgical drains for abscesses, and any other instrument used in surgery, dental explorers, periodontal probes, biopsy punch, surgical drains, endodontic files and root canal instruments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Autoclave</td>
<td>• Iodophors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chemicals</td>
<td>• Phenols</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dry Heat</td>
<td>• Clean but non-sterile single-use-disposables</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Immersion in full strength Glutaraldehyde (8 hours for sterilization and rinsed with sterile water)</td>
<td>• Sterile single-use-disposables</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td></td>
<td>or</td>
<td>• Sterile single-use-disposables</td>
</tr>
<tr>
<td>Semicritical</td>
<td>High</td>
<td>Sterilization by:</td>
<td>Items that do not necessarily penetrate soft and hard tissues but which cross the vermilion border tips into the oral cavity—Mouth mirrors, handpiece, anesthetic syringes, chip syringes, amalgam condensers, impression trays, air/water syringe tips, high-volume evacuator tips</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Autoclave</td>
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<td>• Immersion in full strength Glutaraldehyde (8 hours for sterilization and rinsed with sterile water)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td>Noncritical</td>
<td>Moderate to low</td>
<td>Surface Disinfection with intermediate level hospital disinfectants:</td>
<td>Items used in dentistry which do not cross the vermilion border or penetrate the soft tissues—chair light handles, instrument trays, high touch work surfaces, brackets, chair controls, Air/water syringes, hoses and dental chairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Phenols</td>
<td>• Quaternary Ammonia Compounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Iodophers</td>
<td>• Disposables Barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quaternary Ammonia Compounds</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>Low</td>
<td>Disinfection with Intermediate to low level disinfectants:</td>
<td>Items used in dentistry which do not cross the vermilion border or penetrate the soft tissues—chair light handles, instrument trays, high touch work surfaces, brackets, chair controls, Air/water syringes, hoses and dental chairs</td>
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<td>• Quaternary Ammonia Compounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sanitisation:</td>
<td>• Scrub wash with soap and water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Scrub wash with soap and water</td>
<td></td>
</tr>
</tbody>
</table>

Fig. 3a, b: Examples of the “Non-Critical Category” of devices in high-touch areas (constantly contaminated, but do not enter the patient’s mouth) that need to be disinfected or need to be covered by an impermeable barrier between patients. Barriers can be perforated disposable plastic covers, plastic drape-wrap or aluminum foil.

Fig. 4: Examples of the “Environmental Surfaces Category” are floors, walls and other surfaces that are not normally touched during patient care and may be cleaned or disinfected with a low-level disinfectant during routine housekeeping.

Universal precautions/standard precautions for dentistry
Some infectious diseases have symptoms and signs that are readily recognizable in a clinical situation, while other conditions are clinically undetectable without further laboratory tests. Therefore, it is recommended by the Centers for Disease Control and Prevention that all patients be treated as potentially infectious. One should not discriminate against patients based on their appearance, medical history only or based on other possible tell-tale signs of disease. Appropriate levels of infection control measures, such as use of personal protective equipment or other levels of control, should be the same for all patients.

For example, the clinician should not double glove for only known patients who know their infections disease status, as only 20 percent to 30 percent of HBV patients know they are infected. If one needs to double glove, it should be done for all patients and not only for patients who are known to have an infectious disease. The level of infection control should be based upon the ana...
ticipated clinical procedures to be carried out and not on the occupational exposures and hazards for both dental personnel and patients in the operatory.


The 21st century practice-builder is Botox

The impressive Bishopsgate dental centre in London’s Spitalfields was the venue for the most recent of CODE’s hands-on Botulinum Toxin Type A courses. By the end of the day, its principal, Dr Russell McDonald, and four other dentist delegates had acquired the knowledge and experience necessary to start offering facial aesthetics to patients.

The tutor was Dr Tim Eldridge, a board member of CODE Association of Facial Aesthetics (AFA) and a dentist in Hereford. With five years worth of experience in the field, he has found BOTOX provision to be a successful practice builder and he enjoys building confidence in colleagues who, like himself, have patients wanting the treatments.

Dr McDonald said: ‘I thought the course was very well run and Tim in particular is a very good presenter and demonstrator. By the end of the day I felt very at home with the whole procedure.’

The day started with Tim covering all aspects of Botulinum Toxin Type A: the history, the brands and pharmacology, contraindications, patient selection and then he moved on to discuss injection techniques, dosage and injection sites, post-treatment advice, advertising, insurance and pricing. (see box for top tips)

In brief, the bacterium Clostridium Botulinum was first isolated 201 years ago. It wasn’t until more than a century later that its benefit for patients with uncontrolled muscular movements such as dystonia, was identified. Botulinum Toxin Type A was first approved for medical use in 1989 – mostly for patients with conditions like strabismus, blepharospasm and then for cosmetic use in 1997. In the UK it is approved for medical use but only the Vistabel brand has a licence for cosmetic use and this is limited to the treatment of glabellar lines. For any other area of the face the UK practitioner is off licence.

However, the protein has a favourable safety record with no studies reporting any severe adverse events. Tim stressed the importance of talking honestly to patients about risks and side effects as well as the limits to its efficacy. ‘Never,’ he said, ‘imply you can turn back time.’

Botulinum Toxins are biological products and not pharmacetical preparations and so there can be no generic products. Delegates worked with Dysport, a less condensed type of Botulinum Toxin Type A and Tim made sure his group gained experience in reconstituting the protein accurately by combining with preserved saline to achieve the correct dose and a syringe without bubbles.

FACEdplan – the payment scheme for facial aesthetics

CODEplan has now launched FACEdplan, a payment scheme for facial aesthetic maintenance treatments. Your own FACEdplan will be tailor made to include the treatments that you provide and can evolve over time as you build up your armamentarium. Patients will typically pay £60 to £150 per month for their FACEdplan and all skin treatments can be covered. Contact CODEplan on 01409 255511 or info@CODEplan.co.uk or visit www.CODEplan.co.uk for more information.

Tips for injecting Botulinum Toxin Type A

• Always inject away from the eye
• Keep patients sitting back slightly, not lying down
• Recommended saline dilution is 2.5cm of saline in a 100 unit Botox bottle or of a 500 unit bottle of Dysport®, 1.25ml saline in a 50 unit bottle of Vistabel® - the more it is diluted, the more it will spread, which is to be avoided
• Make sure you inject 1cm at least away from the orbital rim which is usually below the eyebrow but be aware that in some people the orbital rim is within or above the eyebrow line
• Always lightly touch the area you are about to inject so that the patient knows where to expect the injection
• Always use a new needle when injecting to make it more comfortable for the patient
• Always take photographs before and after treatment and make sure patients are aware of their facial asymmetries before embarking on treatment
• Patients should be informed that injections can activate reciprocal muscles and this may have pros and cons - for instance injections in the corrugator muscles might make eyebrows more arched which women may like but men would want to avoid
• Men can need higher doses than women but are also more likely to want to retain more lines, illustrating how important it is to ensure patient expectations are fully discussed
• Botulinum Toxin is a prescription drug and cannot be advertised although you can tell your patients about dermal fillers – most often injected into the lower two thirds of the face - which can be used to good effect in combination with BOTOX®, because the BOTOX® relaxes muscles – by blocking the release of acetylcholine – the filler particles are not broken down so quickly.

There are 40 more CODE AFA hands-on courses in 2008 and they include dermal fillers, advanced BOTOX®, chemical peels and next month there is Lips Masterclass. They are held in various parts of England and Scotland and the tutors are members of the CODE AFA advisory board.

The day ends with a test for which delegates are well prepared and the result is a CODE AFA certificate confirming competence. Course evaluations confirm that dentists and those team members who accompany their dentists get enough information and experience to start out on a new and rewarding area of practice.
Clinical photography – how, why and when

With the right equipment and knowledge, mastering the art of clinical photography can improve the quality of your dentistry, say Jay Padayachy and David R Bloom of Senova Dental Studios

The idea of clinical photography scares many practitioners unnecessarily. With the correct equipment, practice and knowing which photographs to take, it will become one your most useful tools. This will have the knock-on effect of improving the quality of your clinical dentistry, aid in patient communication and enable postgraduate credentialing including that for the British Academy of Cosmetic Dentistry (BACD), www.bacd.com

Which Camera do I get?
While there are still many film cameras still available, there is no doubt that digital cameras offer the greatest number of advantages. This includes seeing the image instantly, ease of image storage and easy incorporation onto websites, into practice literature and for presentations. When considering which camera to get, there are only two manufacturers that currently meet the needs with respect to clinical dental photography:

1 – Nikon D80 and D200 (older versions include the D70 and D100 which you may be able to pick up second hand but these do not take raw and jpeg images simultaneously) with a 105mm macro lens and SB R1-C1 macro flash (two flash heads and hot shoe collar – this is very good for technicians) or Nikon R1 macro flash.

2 – Canon D400 (Rebel Xti) or 30D (older versions include the D350, 10D and 20D which you may be able to pick up second hand) with a Canon 100mm macro lens and Canon MR14EX ring flash. If you wish to take more artistic photos then the Canon MT24EX twin light is an excellent second choice al...
though the ring flash is more convenient.

Higher specified camera bodies from these companies are available, for example the Canon 5D, but these are probably overkill unless photography also happens to be your hobby. It is possible to use the 105mm macro lens and EM-140 DG ring flash from Sigma if you want to reduce your costs. But if using a Sigma lens then use a Sigma ring flash rather than trying to mix and match a Sigma product with a Nikon or Canon product. Details and help concerning choices can be found from Photomed (www.photomed.net) or Calumet (www.calumetphoto.co.uk).

All the newer models mentioned have the ability to take pictures in both a RAW and JPEG format. The raw file is essentially a digital negative and cannot be tampered with. This is very important if the case is being submitted for any form of accreditation and is compulsory for BACD accreditation for pre-op and post-op pictures from January 2009.

The JPEG file offers high resolution and is fine for all other forms of clinical photography not related to post-graduate examinations. However it will loose quality each time it is saved as it is in, lossless format rather than non-lossless which is called a TIFF file and need not concern us in this article. The other advantage of JPEG files is they can be easily sent in e-mails, used in presentations and stored, as they do not use as much space on your hard disc as a raw file.

Photographic shots required

This part is divided into three parts, one for the shots for BACD accreditation and these we take for all our new patients together with two additional shots which are also useful for lab communication and any other views which may be required to show other aspects of the patients mouth.

For BACD accreditation:

**1.10 full face and natural smile** (Fig. 1) - the head should be in full view with the patient exhibiting a full natural smile from their chin to nearly the top of their head without showing the shoulders (Fig. 2) or too little of their head (Fig. 3). The patient’s nose should be in the centre of the photograph that is taken directly in front of the patient using a uniform background.
1:2 natural smile including lateral views (Fig. 4) – the patient needs to show a full natural smile to document the number of teeth and extent of the gingivae they normally display when smiling. The incisal plane of the upper teeth should be the horizontal midline of the photo. Focus on the incisors to allow an adequate depth of field so that all visible teeth are in focus. Do not tilt the camera to compensate for canted teeth. For the lateral views, focus on the lateral incisor. The vertical midline of the photo should also be the lateral incisor. This is not a profile view and the contralateral central incisor and possibly the contralateral lateral incisor should be visible.

1:2 retracted teeth apart including lateral views (Fig. 5) – the retracted shots should be taken with the teeth slightly parted to show the incisal edges and as much of the gingivae should be on view as possible. For the lateral views the same criteria as the un-retracted views apply.

1:1 retracted teeth (anterior) apart including lateral views (Fig. 6) – use the midline to centre the teeth in the frame. The opposing eth should not be visible but the gingiva adjacent to the teeth in the frame should be clearly visible. For the lateral views the lateral incisor should be centred in this view. For all these three views, the retractors and opposing teeth should not be visible, a contrasting device to mask out the background is optional.

1:2 upper and lower occlusal (Fig. 7) – these are the hardest shots to take and do need much practice. Always use a high quality photographic mirror and ensure that the retractors are in place to avoid the soft tissues obscuring the teeth. The central incisors should be visible near the outer frame of the photo and should extend to the mesial of the second molars.

1:1 posterior quadrant (Fig. 8) – as above but ensure the sextant of molars and pre-molar teeth are visible.

Two additional views for lab communication:

1:2 lips at rest, ‘M’ sound (Fig. 9) – enables you to see how much tooth is visible when the lips are relaxed and at rest.

1:2 retracted teeth together (Fig. 10) – to give an understanding of how the teeth occlude.

Other views:

1:2 ‘E’ sound (Fig. 11) – ask the patient to say a long lasting ‘E’ sound to show maximum gingival display to help ascertain if the patient is guarding their smile, which will often be the case if they do not like their smile as they do not know how to smile.

1:2 True lateral views (Fig. 12) – these may be more appropriate for orthodontics or if you want to
check a patient’s overjet or lip position.

Post-op views for marketing (Figs. 13-15) – If you are confident in your photographic skills and you set aside part of your practice which can be turned into a small studio, you can take portrait or staged shots. These can be placed on your web site, used in your practice literature or blown up and framed to use as artwork around your practice. If not then build a relationship with a local photographic studio to do these for you.

The BACD run various hands-on workshops for its members on photography from the basics up to accreditation standard. If you are not a member go to www.bacd.com for details of how to join and benefit from these.

Uses of Clinical Photography
1. As a point of reference for how the teeth looked at that particular point in time i.e. a medico-legal record. This is especially important before embarking on any form of restorative treatment.

2. Diagnosis and treatment planning for any case involving the anterior teeth so that you can assess the patient’s smile on a large screen.

3. Case presentation of your findings to the patient, this can even be placed onto a disc in the form of a PowerPoint presentation for them to take home.

4. Digital imaging with the appropriate software or Photoshop.

5. Lab communication for any form of diagnostic work especially in the case of implant work.

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**CO-OP R8 SEMINARS PRESENTS**

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Friday 10th October 2008
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Friday 7th November 2008
Saturday 8th November 2008

Venue:
Senior Dental Studios, 10 Bensham Grove, Watford, Herts, WD1 2AD

Presented by:
Dr David Bloom BDS MSc
Dr Jay Padayachee BDS MSc
Melanie Prebble BDT EDM

**COURSE OVERVIEW**
- Concepts of Smile Design
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Head Phone 01923 717 886
or email info@coopr8.com

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Actual CO-OP R8 Course patient

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cially wax-ups and of the provi-
sionals prior to construction of
the definitive restorations.

6. Assessing your provisional
restorations in a smile design
case that can be looked at be-
fore the patient comes back for
their review, as you will often
spot potential issues to be cor-
rected when the patient re-
turns. One cannot emphasise
how much easier it is to see
these on a 17 or 19 inch moni-
tor than in a four-inch smile.

7. Building a portfolio of your
own work for use in marketing
equal.

Conclusion
Clinical photography is now
such a useful and important
tool in a clinician's armamentarium,
and with the advent of high qual-
ity digital cameras it has never
been so easy. However, it does
take time and practice initially,
but like riding a bike once you
know how to you never forget.
This can also be carried out by
your team to free up your time for
something more productive,
whilst also being rewarding for
them as they now have another
feather in their cap.

Fig. 14

David Bloom
is a graduate of the Newcastle-
upon-Tyne Dental School, and
has been a principal at Senova Dental
Studios since 1990 focusing on
comprehensive restorative and
cosmetic dentistry. A full member
of the British Academy of Cosmetic
Dentistry. David was appointed
President in 2007. He is a member
of The British Society of Occlusal
Studies, The British Society of
Restorative Dentistry, The British
Dental Association and is a sus-
taining member of The American
Academy of Cosmetic Dentistry
(AACD). He is also a fellow of the
International Academy of Dental
Facial Aesthetics and a clinical di-
rector for Coopr8 Seminars.

About the author

Jay Padayachy
is a graduate of the Newcastle-
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Restorative Dentistry, The Pankey
Association, The British Society of
Periodontology and the American
Academy of Cosmetic Dentistry of
which he is a sustaining member.
He is also a clinical director for
Coopr8 Seminars.

About the author
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The Glove Directory is a bimonthly flier from The Dental Directory offering a large selection of quality gloves at unbelievably low prices. As the biggest dental dealer in the country, The Dental Directory has formidable purchasing power and can negotiate better prices with suppliers, which allows them to pass on the savings to their customers.

To find out more call (0800 585 586), fax (01757 500 581) or order electronically via the Internet at www.dental-direct.co.uk.

ChairSafe

ChairSafe is the new disinfectant foam cleaner from the Kentdent range of cross infection control products. Chairsafe foam is specially formulated to clean and protect all types of dental chairs including leather and synthetic seatings. As soon as you try it you will recognise the real benefit of the chair range. It is non-drip. It remains exactly where you spray it, making it ideal for the angles and contours of a dental chair.

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For further information contact Burtons on 01622 834990, email info@burtons.co.uk or visit www.burtons.co.uk.

Completing the Cycle

The Compact Washer Disinfector from Paterson

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Burtons Instaclave Series 5 £200 Trade In Offer

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All Burtons Instaclave Series 5 autoclaves feature a single use water system, enabling Practices to use clean, fresh water for every cycle. Starting a sterilization cycle could not be simpler - just select the required cycle and close the door! The touch sensitive control panel is easy to operate, with status indicators that show the progress of the cycle at all stages.

Burtons are so confident in the Instaclave Series 5 that they offer it available with a 50 day money back guarantee.

Burton UK health group

The high performance circulation pump produces excellent washing power, powerful cleaning and doesn’t lose time. The unit also includes an integrated water
Infra-Red Rub

Anything that simplifies cross infection control is likely to increase its effectiveness. Avoiding use in either Ultrasonic cleaner, sinks/soaking baths, washer-disinfector, Alkazyme™ cleans instruments rapidly removing protein, blood, saliva, mucus etc. Rendering instruments clean & bright. Active against both Gram positive & Gram negative bacteria. Alkazyme™ also removes biofilm contamination whilst continuously disinfecting contaminated wash water as created by the cleaning action.

For further information or to request your FREE catalogue please contact Dental Sky on 0800 294 4700.

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The popular and ever growing Hygitech brand from Dental Sky now includes 5 more innovative products.

The clever design of the Hygitech Shoe Cover Dispenser saves you the trouble of bending down to don shoe covers as well as helping to prevent cross contamination from inadvertently touching dirty footwear. Simply step on to the centre of the shoe and dispense the shoe cover, the shoe cover will be released immediately - as easy as that!

For further information call Takara Belmont on 020 7515 0333 or email dental@takara.co.uk.

Cross infection control is your responsibility

The dental team spend their time at work in an environment where real danger exists not only for the team but also the potential for spread of infections to patients. The Safety, Health and Welfare at Work Act, 1989, states that “members of the dental team have a duty to ensure that all necessary steps are taken to prevent cross infection in order to protect their patients, themselves, their families and others.”

To help you abide by this Act, DENTSPLI offers a range of products to help reduce the risk of cross infection. The range of Disposa-Shields™ (a barrier method) are designed to fit a variety of sizes and shapes within the surgery. For example, Disposa-Shield number 1 covers control panels and light handles; number 5 fits snugly over curing ringes, both body and nozzle, are full autoclavable.

Takara Belmont has two dental showrooms to demonstrate treatment centres and allow dentists to “road test” and put the equipment through its paces. Located in London (020 7515 0333) and Manchester (0161 745 9992) these two facilities are the ideal venue to view the entire range of Belmont products.

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Infection Control 27

Infra-Red Rub

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The first prize of an all expenses paid trip to the American Dental Association meeting in San Antonio later this year went to Ryan Olley from Kings College London Dental Institute. Second prize of £500 went to Paul Hooi from Dublin Dental School and third prize, the adjudicators’ prize for professionalism, went to Shiva Abbassi from Cork University Dental School.

The Breathe team are currently running a training day to Focus on Time and Money. With expert coaching, you will discover how to realise your business vision and achieve your goals by making time work for you rather than against you.

Motivate and energise your team with stand-alone training days for you and your team. When you need a boost of inspiration to make that next step, or enhance your leadership skills and your team’s understanding of the business, call Breathe and learn from the best. Focus on Time and Money will be running at various locations throughout April to June. Call the Breathe team to book on one of these popular dates.

For more information, call 01326 377078 or email bonnie@nowbreathe.co.uk www.nowbreathe.co.uk

The British Orthodontic Society (BOS) spring meeting is to take place at the Celtic Manor in Wales on Saturday 10 May 2008. This world class golf resort is the venue for the 2010 Ryder Cup and is something of a golfing mecca for aficionados of the sport.

To match the preeminence of the venue, the BOS has attracted a number of distinguished speakers to address the conference. Keynote speaker Dr Jason Cope will be presenting a comprehensive series of talks on temporary anchorage devices in orthodontics throughout the day, culminating in clinical presentations relating to Class II and open bite cases. Dr Jonathan Sandler will present some difficult clinical scenarios in addition to considering the involvement of the National Institute of Clinical Excellence (NICE) in provision of temporary anchorage devices. The triumvirate is completed by Sheila Scott, a management consultant with 15 years’ experience within dentistry. Dr Simon Knowles and Dr Jonathan Sandler.

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Breathe Business is here to help you realise your potential, and break through to the next level of excellence. Bringing together the considerable expertise of leading business coaches Chris Barrow and Simon Hocken, every Breathe Intensive workshop is the product of over 15 years’ experience within dentistry and business coaching with over 750 UK practices and small businesses.

With 2008’s Breathe Intensive, Principals and their senior management teams can benefit from invaluable help and creative ideas and solutions. The Inspired Marketer workshop (running on 16th May in London) showcases a real life case study and demonstrates how a dental team has mastered the art of marketing. The Breathe team will work with you throughout the day to help you implement similar effective ideas and principles in your own practice.

To reserve your places, call 01326 377078 or email bonnie@nowbreathe.co.uk www.nowbreathe.co.uk

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CollarDam™
Bring New Product to the 2008 World Aesthetics Congress

Recommended by top industry names, CollarDam™ is delighted to be exhibiting the latest addition to its portfolio, the CollarDam Everyday bib – its new, cost effective, super-absorbent/cellulose patient protection dental bib – at the 2008 World Aesthetics Congress in London from 6-7 June.
UK Wide Dental Equipment Specialists

Clark Dental has a new office and showroom to add to those in Leeds and Wickford. Managed by Richard Beal, this new centre, in Nantwich near Nuke-on-Trent, gives Clark Dental three sales regions across the UK.

With a ‘turn-key’ approach to surgery design, Clark Dental provides its own builder and managed by Richard Beal, this new centre, in Nantwich near Nuke-on-Trent, gives Clark Dental three sales regions across the UK.

For a copy of the Summary of Product Characteristics (SPC) please call John Jesshop of Blackwell Supplies on 07971 120678, e-mail jjeshop@blackwellsupplies.co.uk

The First Line of Defence in the Treatment of Chronic Adult Periodontal Disease

Periodontal health is a crucial element in most dental treatments, and for over 14 years Dentomycin has been helping dentists fight back against periodontal disease.

Dentomycin, active ingredient Minocycline, is proven to significantly reduce key periodontal pathogens and pocket depth1, reducing inflammation and destroying harmful bacteria (when used in conjunction with scaling and root planing) used in conjunction with scaling and root planing the pocket used in conjunction with scaling reducing inflammation and dental disease.

Dentomycin is an effective tool to aid periodontal health, with several key features and benefits including:

• Slows down the periodontal destruction process
• Does not interact with alcohol
• Leaves no unpleasant taste in the patient’s mouth
• Inhibits harmful collagenases

Dentomycin helps clinicians actively promote healing, and root planing to push back against periodontal disease.

For further information on CollarDam™ please call 0845 5104286, email: Collar4uk@collardam.com, or visit www.collardam.com

For further information please visit: www.beverlyhills-formula.com

Record, Store & Print Your CPD For Free

The next issue of FöG Oral B’s Dental Summary Review (DSR), Vol 4 No 1, will be mailed during late April and will contain the usual mix of summaries culled from recently published research papers as well as the customary three hours of free, verifiable CPD.

Beverly Hills Formula

Beverly Hills Formula is working with The British Dental Health Foundation to spread the National Smile Month message “Brush for Health”. Keeping plaque at bay is at the heart of the good oral health message being emphasised by Purify Laboratories (Beverly Hills Formula). The message links a healthy mouth with a healthy attachment promoting connective tissue attachment

The current issue (closing date 31 July 2008) is proving to be the most popular to date with many potential members. Beverly Hills Formula premium brand dental whitening products have unique combinations of anti bacterial agents, low abrasion and anti-stain properties to protect and whiten teeth. They gently remove stains from teeth, without harsh abrasives.

Tests conducted by the BBC Watchdog programme revealed that Beverly Hills Formula Toothpaste removed over 90% of staining. The Beverly Hills Formula Toothpaste not only prevents gum disease by controlling the amount of plaque that builds up on teeth but also, by nourishing and strengthening gums, fighting plaque, re-mineralizing and hardening tooth enamel for cavity protection. It also leaves your breath smelling fresher, but it also helps to restore teeth to their natural colour. The result: teeth that appear whiter, feel smoother and remain fresh.

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Cordless for unlimited mobility, the NEW Bluephase features a lithium polymer battery with a 60 minute capacity. It delivers a high intensity 1,200 mW/cm² output for reduced curing times starting at just 10 seconds, and three modes of operation – maximum, deep and stress-reduced polymerisation. It also features a virtually noiseless built-in fan which means it can be used continuously for an unlimited period, including extensive procedures involving multi-unit restorations.

For further information visit www.clarkdentaltrenchester.co.uk or telephone 01270 613750.

Managed by Richard Beal, this new centre, in Nantwich near Nuke-on-Trent, gives Clark Dental three sales regions across the UK.

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This option allows instant response, a self-download and print certificate (either at the time of taking the CPD or later) as well as a free facility to record and store all CPD hours and benefits from a headrest cover.

A Handheld Revolution on Clark Dental’s Stand at Aesthetic Dentist 2008

Proud suppliers of Schick Technologies, Clark Dental is delighted to be exhibiting the new, handheld x-ray system, NOMAD from Artech® at this year’s Aesthetic Dentist Congress. Simplicity in itself, NO- MAD is the perfect choice for your next x-ray system and crowds are expected with delegates keenly examining the portable device.

Delivering over 180 exposures from a single battery charge, this cordless x-ray system is compatible with both traditional x-ray film and digital sensors, offers ideal image size, and weighs less than 4kg.

The operator is protected by a patented internal radiation shielding as well as an external backscatter shield. No more transporting the patient to the x-ray machine! NOMAD is ideal for remote domiciliary use and confined spaces as well as surgery applications.

For further information visit www.clarkdentaltrenchester.co.uk or telephone 01270 613750, e-mail sales@schicktech.co.uk, or Clark Dental on 01268 735 146, e-mail sales@schicktech.co.uk, or Clark Dental on 01268 735 146, e-mail sales@schicktech.co.uk, or Clark Dental on 01268 735 146, e-mail sales@schicktech.co.uk.
Astra Tech is delighted to have held a special open day for its customers to help increase their referrals. Renowned dental sales coach, Ashley Latter delivered the programme that comprised two excellent presentations and a unique opportunity to speak to him about any aspect of Marketing and Ethical Sales & Communication.

Latter's presentations are for people and companies who are looking for new information, to be inspired and increase opportunities and solutions to their everyday business challenges.

The first presentation at the Astra Tech open day was entitled ‘Strategic Management of Referrals/Accounts’ and covered a range of topics including:

- How to strengthen relationships with existing referral practices.
- How to maximise and increase the number of referrals from existing referral practices.
- How to add value and take relationships to the next stage.
- Grading the referrals to maximise opportunities and new treatment opportunities.
- Attract new referral practices.

‘Introduction to Ethical sales & Communication Skills’ was the final presentation of the day. Ashley took attendees through a seven-step process in a three-hour long presentation that gave an overview of techniques and skills that will enable improved patient relations, increased patient acceptance rates, greater confidence with the sales process from start to finish and much more.

To register your interest or for further information about this interactive, motivational and fun business day, please contact Astra Tech via e-mail to info@astratech.com, telephone 0845 4500586 or visit www.astratechuk.com.

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The British Orthodontic Society (BOS) spring meeting is to take place at the Celtic Manor in Wales on Saturday 10 May 2008. This world class golf resort is the venue for the 2010 Ryder Cup.

To match the pre-eminence of the venue, the BOS has attracted three internationally renowned speakers to address the conference. Keynote speaker Dr Jason Cope will be presenting a comprehensive series of talks on temporary anchorage devices in orthodontics throughout the day, culminating in clinical presentations relating to Class II and open bite cases.

Dr Jonathan Sandler will present some difficult clinical scenarios in addition to considering the involvement of the National Institute of Clinical Excellence (NICE) in provision of temporary anchorage devices. The triumvirate is completed by Sheila Scott, a management expert, highly experienced and respected in the dental field, who will address the difficulties of introducing new techniques to the dental team.

If you would be interested in attending the BOS conference as well as availing yourself of the sporting and leisure facilities during the weekend of 9 and 10 May, please call 020 7353 8680 or visit www.bos.org.uk. Early booking discounts are available.