Dentistry hits headlines early in election campaign

NHS dental services become an early key election topic as the political parties draw battle lines in Reading West constituency

About tooth decay among children in the Reading West area rather than a lack of capacity. She commented: “When I have put the question to the authorities they say there are enough dentists and places for NHS patients.

“But they need to work much more closely with the council to advertise properly and help people get to see these dentists.”

Adrian Windisch, candidate for the Green Party, said: “The idea of the NHS was that all dental health would be free, but that is not the case.

“We would bring back free dentists for all by saving money on scrapping things like nuclear weapons.”

NHS dentistry hit the headlines early in the official election campaign trail as NHS dental services are highlighted in a trip to Reading West.

Conservative Shadow Health Secretary Andrew Lansley (pic-tured) visited the constituency, tipped to be one of the more hotly contested seats in May’s General Election, at the local Castle Hill Dental Clinic. The aim of the visit, in conjunction with Tory local candidate Alok Sharma, was to hear firsthand the views of patients and practitioners about NHS dental provision in the area.

Speaking at Castle Hill, Mr Lansley said: “It has been made clear that access to dentistry is one of the things people in Reading West are particularly concerned about.

We are very aware that if we get the right kind of relationship with a dentist where we focus on good dental health and prevention, we can end up with more people.”

Labour candidate Naz Sarkar commented that if he won the seat in May he would scrutinise dentistry in the area to make sure no-one was missing out, regardless of their financial situation.

“The Labour Party must not get complacent over the issue of NHS Dentistry. I don’t think dental services are that bad here. Most people are catered for well, but there are pockets that we need to look at.”

The Liberal Democrat Party candidate Daisy Benson said she was more concerned...
Open wide with Lucky

Lucky the Lion launched a major schools initiative by The Midcounties Co-operative in Oxfordshire to encourage children to look after their teeth. The 6ft cuddly character joined in the fun in a pilot scheme which started at Pegasus Primary School in Blackbird Leys, Oxford.

Some 130 pupils aged five seven learned about the importance of brushing their teeth regularly and the need to reduce sugary snacks and to eat the right foods.

Each child received a special information pack which included a funky toothbrush, toothpaste and a wooden toothbrush holder. The youngsters also decorated the holder, which has a two minute timer; so they knew how long to brush their teeth each time.

Lucky the Lion took part in demonstrations, which also featured a giant toothbrush and a huge pair of teeth, to get the message across.

Dr Komal Suri and her team (pictured) have been present in Oxfordshire to encourage the children to do so and to eat the right foods.

Dr Suri bought the practice in 2002 and over the past eight years she has updated the building and invested heavily in state of the art equipment and training to enable them to offer patients a complete care package.

She said: “The key to our success has been the strength of our practice-patient relationships. We spend a great deal of time with our patients to ensure they are educated about their mouths and have all clinical findings explained fully before embarking on any treatments or programmes.

“The level of training for all our team is extremely high with most of our clinical team considered among the leaders in their profession.”

The Bucks Enterprise Awards were created by the Buckinghamshire Ambassadors who formed just five years ago. The awards event was organised by Buckinghamshire Economic & Learning Partnership (BELP) which aims to promote the sustainable economic development of Buckinghamshire.

New GDC Council member

The Appointments Commission has confirmed that David Murphy (pictured) has been appointed to the Council of the General Dental Council (GDC) with immediate effect.

David is a returning member of the Council, having previously been on the Council between 2005 and 2009. He is one of 24 members, 12 lay and 12 professional.

David is currently Deputy Secretary of NILGOSC, the Northern Ireland Local Government Pension Scheme and previously held positions with Methodist College, Grant Thornton, and Queen’s University Belfast.

He is a Fellow of the Institute of Chartered Accountants in Ireland.

Dr Suri said: ‘We are delighted to have won this award, particularly as it is a team award and recognises the efforts we all put in to make this a successful practice from a patient, employee and business perspective.’

Smile Design Dental Practice is recognised as one of the country’s leading practices for cosmetic and restorative dental care, but it is also very much a local practice providing general dental care for residents in south Buckinghamshire.

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Dental practice wins Small Enterprise of the Year

A dental practice in Buckinghamshire has won the Small Enterprise of the Year award.

Smile Design Dental Practice won the Small Enterprise of the Year category at this year’s Buckinghamshire Ambassadors Awards.

Dr Komal Suri and her team (pictured) have been present in Oxfordshire to encourage the children to do so and to eat the right foods.

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“The level of training for all our team is extremely high with most of our clinical team considered among the leaders in their profession.”

Save your business records – before the tax inspector does it for you

Specialist accountants are warning dental practitioners to ensure their business records are in order.

The warnings come after an announcement by HM Revenue and Customs (HMRC) that it is cracking down on dentists and other medical practitioners, tracking down those who have not declared their full income.

The Association of Specialist Providers to Dentists (ASPD), have set out some of the HMRC’s basic record keeping guidelines for dentists.

These are:

• Don’t throw away business records - keep business records for at least five years and ten months after the end of the tax year the records relate to. Failure to do so could result in a fine of up to £5,000.

• Keep business and home life separate - business records and personal records are kept separate, with the help of a separate business bank account.

• Sorry, sir. The dog ate it… - if your business records are lost or destroyed, unfortunately they will have to be recreated.

Practitioners looking to stay in HMRC’s good books should enlist the help of a specialist accountant for dentists who is well versed in the preparation of tax returns and submitting them to the Inland Revenue, said the ASPD.

Effective way to look after their teeth.

“We hope parents will rein force that message at home. The information packs we provide include a toothbrush chart for the children to draw a smiley face on a calendar each day if they have brushed their teeth once in the morning and last thing before bed.”

Pegasus headteacher Jill Hudson said: “The children really enjoyed the sessions and meeting Lucky. The project complemented what they learn in school as part of the curriculum for personal, social and health education.”

Nicky Wadley, lead for Dental Commissioning for Oxfordshire PCT, said: “We were happy to give our support when Midcounties approached us with this initiative. There are obvious benefits if the children understand what they need to do to keep their teeth healthy and strong, including seeing a dentist for check-ups.”

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Editorial comment

Election fever – there is no cure!

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With this campaign being one of the most publicly fought election in the UK, thanks to our 24/7 need-to-know-all society of news channels and social media, it’s going to be hard to get away from all aspects of the election (although I’ll be giving it a good go – I’m in Tanzania with B2A for two weeks before the election!). I’m sure that NHS dentistry will remain at the forefront of the campaign trail, and I hope that after its all over, nothing but good will come out of it for practitioners and patients.

And at least it’ll give us something else to concentrate on than a certain striker’s ankle and an upcoming football event...

DT

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Newsletter

Education and training provider, Smile-on, offers busy dental professionals an easy way to keep their finger on the pulse through its online newsletter.

By signing up for the free Smile-on newsletter, you will receive regular updates on training, healthcare news and also any special offers that will help build your Continuing Professional Development (CPD).

A spokeswoman for Smile-on said: “The Smile-on newsletter will also advise on upcoming webinars. A breakthrough in education, a webinar is an interactive online tutorial from some of the most highly regarded dental professionals in their field. Utilising this technology, you can learn from the very best in your own time, anywhere in the world.

Registered users on the Smile-on website can also track their CPD and explore the vast array of flexible training programmes from Smile-on.”

She added: “Smile-on is dedicated to the dental industry by promoting excellent patient care and career satisfaction through education and training. The expert team from Smile-on are also on hand to offer guidance on the learning material so busy professionals can meet their industry obligations, build their CPD and advance their skills within dentistry.”

For more information or to sign up for the Smile-on newsletter, email info@smile-on.com or visit www.smile-on.com.

Keep your finger on the pulse with the Smile-on newsletter

Registration

Colgate® Sensitive Pro-Relief™ with Pro-Argin™ Technology

New instant & lasting sensitivity relief with Pro-Argin™ Technology

Colgate® Sensitive Pro-Relief™ Toothpaste for the daily oral care of sensitive teeth

6 Docimo R et al J Clin Dent 2009; 20 (Spec Iss): 137-143

Keep your finger on the pulse with the Smile-on newsletter

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Colgate® Sensitive Pro-Relief™ Toothpaste for the daily oral care of sensitive teeth

6 Docimo R et al J Clin Dent 2009; 20 (Spec Iss): 137-143
Cuts to dental school budgets could affect the training of dental students, impacting on the skills and quality of new dentists, according to the British Dental Association.

The British Dental Association’s (BDA’s) warning follows the recent announcement by the Higher Education Funding Council for England (HEFCE) that funding allocations for universities and higher education colleges for 2010-11 will be reduced.

Prof Paul Wright, chair of the BDA’s Central Committee for Dental Academic Staff (CCDAS), writing in the latest edition of the British Dental Journal (BDJ), claimed that cuts to posts in dental schools would exacerbate the inadequate staff resources that institutions are already confronting.

He argued that every extra student in a clinical session without a concomitant increase in supervision means risking a reduction in the quality of care for patients that can be assured.

Prof Wright also warned that dental academia is funded, with money coming from both the HEFCE and the NHS, means that schools are at risk of a far greater cut to their finances than might be anticipated or intended.

Prof Wright said: “We recognise that academics in many disciplines will be making their cases for the preservation of their particular subject areas. Dentistry really is in a unique position though; in the way it is funded, the already stretched position it is in, and the value to society of the graduates it produces.”

He added: “Cuts to dental schools’ budgets threaten the high quality of both the dentists and the research that UK institutions produce. We urge extreme caution by universities as they absorb HEFCE’s announcement.”

The BDA will be submitting evidence to the Independent Higher Education and Student Finance Review. The review has been tasked with looking at the higher education system in its entirety.

New editor for FGDP journal

J ohn Stanfield has been made the new editor of Team in Practice, the Faculty of General Dental Practice (UK’s) journal for dental care professionals.

Mr Stanfield, a dental hygienist, replaces Professor Ken Eaton who has held the post of editor since the journal was launched in 2004.

Team in Practice is a continuing professional development journal, written by dental care professionals (DCPs), with a focus on peer learning and best practice.

The journal aims to update all members of the dental team on issues affecting everyday working practice, including analyses of how and why problems arise and ways to improve outcomes.

Mr Stanfield has served on the editorial board of Team in Practice for the last three years and has represented dental hygienists on the FGDP (UK) Board since 2006.

He is also an assessor in key skills for DCPs and is vice chair of the Faculty of General Dental Practice (FGDP) (UK)’s DCP Committee.

He called it a ‘great honour’ and said: “Team in Practice offers readers a great opportunity to learn from the practical experiences of colleagues and read the latest evidence for best practice. I hope to see the journal go from strength to strength in supporting the dental team to achieve excellence in their work.”

Cuts in dental school budgets
DIO Professional Implant Education

Following the success of the UK’s first public live theatre at the Dentistry Show, DIO Implant continues to boldly progress with its mission to change the face of the UK implant market for the better of everyone. DIO’s Managing Director explains, “For most patients, dental implants are a necessity. At DIO, we aim to bring the benefits DIO provides in overseas markets to the UK.” He continues, “Dental implant treatment should be accessible by any patient who needs it, without compromising on quality of treatment or jeopardising the livelihoods of our valued UK implantologists.”

The next stage of their roadmap is to introduce a dedicated educational programme, designed especially for dentists wishing to provide the highest standard of care to their patients.

The format of the course addresses both the requirements of practitioners looking to start providing dental implants as well as those who are already placing implants from other manufacturers.

For non-implant dentists, the introduction days lead on to a one-year, hands-on and distance learning certified course, equivalent to approximately 120 hours of verifiable CPD. The course, directed by Sam Mohamed of Smile Lincs, aims to impart everything a qualified dentist needs to know in order to confidently provide dental implants to their patients.

Introductory two-day course
During an initial two-day course practitioners are given an overview of the evolution of dental implants and how they can be integrated into a normal dentistry practice in the most cost-effective way. The course looks at the basics of dental implantology, discussing osteointegration, treatment planning principles, radiographic techniques and restorative techniques. It also covers more practical aspects of dental implantology such as practice setup and marketing and introduces patients to implantology to ensure a good return on investment.

Day 1 is aimed at providing non-implant dentists with an introduction to implant procedures. Practitioners will leave knowing whether dental implants are both right for them as an individual and a feasible business proposition for their practice. DIO is also welcoming existing implant practitioners on the introduction day, which DIO claim exposes them to a new perspective and allows for non-biased discussions and a healthy propagation of expertise to all attending.

Day 2 focuses on the clinical and restorative aspects of DIO Implants in more depth and is therefore applicable to both new and existing implantologists alike.

Once the introductory course is complete, practitioners can confidently decide whether to sign up for the year-long modular course to expand their knowledge and become implantologists. Mr Forster states, “Dr Mohamed and I struck a chord – we both have the interests of UK dentists at heart. Sam has extensive expertise and relentless enthusiasm. Combine these qualities with a genuine desire to help individuals achieve at the highest level and you have the ingredients for success.”

Modular Course
The year-long modular course aims to provide dentists with everything they need to know to become knowledgeable and confident implantologists. The course includes ten in-depth modules, both theoretical and practical, covering:

- Osteointegration
- Biomaterial in relation to bone segmentation and membranes
- How to select suitable dental implant patients
- Treatment planning
- Radiographic techniques in implant dentistry
- Surgical techniques
- Surgical kit orientation
- Possible surgical complications
- Restorative techniques
- CT scanning and computer guided surgery
- Marketing and promoting your new service

Marketing Assistance
DIO is very much aware that it’s all very well for dentists to learn new skills and develop new products, but the effort is useless if their patients are not made aware of the services that are on offer.

Dentists are mentored throughout the course by Dr. Sam Mohamed and his team. Dr. Mohamed is a highly trained dental implant surgeon. Having trained with some of the world leaders in implant dentistry, including Dr. Hilt Tatum Jr., the former president of the American Academy of Implant Dentistry (AAID), and Prof. Manuel Chanavaz, the Head of Oral and Maxillofacial Implantology Department at the University of Lille2, Dr. Mohamed has been placing implants for over 15 years. He is a member of both the Association of Dental Implantologists (U.K.) and the AAID.

Dr. Mohamed said, “Practitioners will attend our purpose built once a month to perform implant surgery under close supervision. This will give them real, hands-on experience and will quickly build their confidence in their own skills.” To supplement the hands-on training, Dr Mohamed is providing distance-learning facilities via the Internet.

Once the course has been completed practitioners will be awarded a certificate and logbook showing the number of patients they have treated and the individual details of each case. Most importantly, though, dentists completing the course will have all of the skills they need to effectively place implants and treat most patient cases. However, the professional support doesn’t stop there. Successful implantologists are supported by Dr Mohamed’s “Continuing in Excellence” mentor program.

So, to help dentists promote their new techniques the company is providing advice and guidance on marketing techniques that dentists can employ to spread the word. These can include help with local PR, website design, brochure and leaflet design and production, Search Engine Optimisation, the use of social networking, etc.

For more information on DIO implants and their training programmes visit www.DIOUK.com or call 0845 125 3086.
Specialist Care Dentistry deadline approaches

The deadline for joining the Special Care Dentistry List is fast approaching. The General Dental Council’s (GDC) Special Care Dentistry list opened on 1 October 2008 and the transitional period will close on 30 September 2010.

There are now only six months until the end of the transitional period for joining the Special Care Dentistry list.

After this date, UK applicants will need to hold a Certificate of Completion in Specialist Training to join the list. Registered dentists can currently apply to join the list on the basis of the relevant specialist training, qualifications and experience they have acquired to date.

Special care dentistry is concerned with improving the oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability, or a combination of these.

In particular, this area of dentistry focuses on adults and adolescents requiring special care.

A spokeswoman for the GDC said: "Since the list opened in October 2008, 119 dentists have joined it. But we would strongly encourage other appropriately trained, qualified and experienced dentists who wish to join the list to submit their applications as soon as possible to avoid unnecessary delays or missing the deadline of the transitional period on 30 September."

Dentists wishing to join the list can download an application pack from the GDC website www.gdc-uk.org or contact the GDC registration team by email assessments@gdc-uk.org or by phone on 020 7344 3741.

Eastman paediatric dentist wins prestigious award

The UCL Eastman Dental Institute (EDI) would like to congratulate Purvi Shah, an SpR in Paediatric Dentistry at the Eastman Dental Hospital (EDI) on winning the British Society of Paediatric Dentistry (BSPD) Poster Prize at the National meeting in September 2009.

The prize is awarded annually to a BSPD member for the best poster presentation of the conference. Entitled Double teeth: A review of cases at the Eastman Dental Hospital, the poster was based on work she undertook as part of her training.

The prize-winning project had been supervised by Dr Paul Ashley of UCL Eastman Dental Institute, Mr Joe Noar and Mrs Prabhleen Anand of EDH, who were all co-authors of the poster.

The Eastman Dental Hospital is part of University College London Hospitals NHS Foundation Trust.

For more information on taught or research programmes, please contact the Admissions Officer on 020 7915 1092 or academic@eastman.ucl.ac.uk.

New President for British Dental Health Foundation

Daniel Davis has been elected as the 19th President of the British Dental Health Foundation.

The news was announced at the Foundation’s Annual General Meeting, held on March 24 at the Royal Society for the Promotion of Health in London.

Daniel, Operations director at dental supplier Plandent Limited, follows in his father’s footsteps, John Davis, who was instrumental in setting up the Foundation back in 1971 and became the first non-dentist Chairman in 1989.

After the ceremony Daniel began his two-year term by thanking predecessor Chris Potts and said he was looking forward to moving the Foundation forward during his presidency.

He commented: “The coming years see an exciting challenge for the Foundation both in the United Kingdom and internationally. The audience to which we are promoting good oral health messages to is growing all the time and with the implementation of newer and more efficient strategies I hope this trend will continue.

As President, Daniel will lead the trustee board and act as a figurehead for the British Dental Health Foundation.

The charity has been working hard to improve the public’s oral health, raising awareness and encouraging healthy lifestyles. Daniel added: “I would like thank the board and Foundation’s members for electing me and hope 2010 will prove a great success.”

"We don't worry about our NHS compliance anymore".

Dental Air has one of the best customer service reputations in the dental industry, and with our fast call out times, it is no surprise that we are the leading supplier of oil-free compressed air packages.
GDPUK round-up

The GDPUK online community is always keen to air and share its views, and this month sees the launch of its new exhibition review section, says Tony Jacobs

This has been another busy month on GDPUK, with the launch of our Dental Show Reviews site www.dental-showreviews.co.uk. This new part of the site is like ‘Trip Advisor’ for the present proliferation of dental exhibitions. It allows dentists, their teams and the dental trade, the exhibitors who pay for the shows, to rate events themselves, and thus provide mutual feedback. This in turn will help colleagues, and perhaps the trade, to decide which show is best for them to visit.

On a more serious note, some exclusive news has already been published on the site concerning a GDC meeting held in camera, when it is usually open to the public. As secrecy was maintained, rumours concerning what was discussed began to circulate, culminating in someone resigning from the GDC, and that there was a financial problem and a potential rise in the ARF. The truth in these matters is yet to be clarified, but as you can imagine this provided grist to the GDPUK mill.

Surprisingly to me, the NHS dentistry pay cut announced by the Government in mid March was met with little comment on the forum. There was no rush to man the barricades. How can this be analysed?

Strange but true?

Of course GDPUK wouldn’t be the same without its range of little anecdotal snippets floating around its cyberspaces. For example, one asked whether silicone impression material could be removed from one’s clothing. Another raised the topic concerning the difficulty in sometimes identifying an implant from the radiograph, suggesting that a national register would help. Therefore, in say 20 years, one could go there and see the make and type of implant placed. Especially amusing was the story of a patient (aged 84!) who took revenge on a dentist by leaving a home-made bomb outside the practice.

As always, there are many topics lifting the spirits of those involved in the thread. One of these is the story of concerning the consolidation of the hundreds of thousands of messages on GDPUK. As part of this project, a colleague will collect and collate the 100,000 messages posted on Yahoo groups, so that other colleagues can turn it into a searchable database, which will eventually be part of the present GDPUK.com site. Hopefully, this project will probably be complete by the time you read this.

One colleague is determined the British Library shall be able to access the data for future historians to consult on the way trends in UK dentistry unfolded.
It's one week to go before the trip, and I'm getting in a right flap about everything! What to pack, what not to pack, remembering any of the Swahili phrases which might come in handy, sourcing my malaria tablets... you name it, I'm flapping about it!

Of course, all of this flapping is covering up my anxiety about the trip. Don't get me wrong, I'm extremely excited, but you can't help worrying about whether or not you'll cope in the heat. However, I know that when we get out there all the worrying will be in vain as I know that we will be a very motivated and committed team and will throw ourselves into the experience.

Speaking of committed, or needing to be, four intrepid fundraisers stepped out very early into the Kent countryside to complete a marathon hike around Bewl Water, the perimeter of which is 17 miles. Having endured all the 'jokes' about walking around Bluewater, which for those not living in the Southeast is a shopping complex (and believe me by the end of it I was wishing it was Bluewater!) it was time for Schülke UK's Andrew Thurston, Anne Harris, Jacqui Entwistle and myself to follow the picturesque Round Bewl Water walk. This name is a bit of a misnomer, as for long stretches of the walk we couldn't even see the water! However, it was a beautiful place to trek for miles, we were extremely lucky with the weather as it was a lovely sunny Spring day with just enough breeze to stop us from overheating and we were suitably exhausted at the finish to regret any plans more energetic than sitting in a warm bath that we had made for the rest of the weekend!

A big congratulations to the team for completing the walk and keeping their enthusiasm and spirits up, even in the face of Andrew's terrible jokes (it'll be a long two weeks in Tanzania if that was his best material...); even bigger congrats to Jacqui who did the majority of the walk with an extremely painful blister on her foot and who by the end was barely able to hobble.

Another fundraising effort from a member of the team going to Bukumbi was led recently by Henry Schein Minerva's Len Camporeale, who with some members of the HSM team (Louie (Marketing) and Wayne (Warehouse)) camped in the car park of the company's UK head office and asked the TSMs to donate a day or a week's commuting expense to the project. From all accounts, it was more comfortable than some of the hotels the team had stayed in!

To support these fundraising efforts, go to www.justgiving.com/bukumbibound and donate. This easy way of helping us raise money for this worthy cause goes straight to the charity, and allows you to add Gift Aid to your donation.
Commentary on “Facing the judge and jury”

Chris Morris comments on DT’s article Facing the Judge and Jury published in Volume 4, No. 5 of Dental Tribune

I have spent nearly 20 years defending hundreds of dentists before the various Committees of the General Dental Council (GDC) and so read Mr Goodwin’s article with interest. Unfortunately, I fear that in a number of respects I found the article confusing and I hope you will permit me to offer some observations for the benefit of readers of the Dental Tribune.

Fitness to Practise Procedures

The Fitness to Practise procedures at the GDC are fairly labyrinthine but Mr Goodwin’s article makes them appear more impenetrable than need be. Indeed, I am still not sure whether his article intends to refer to the Interim Orders Committee (“IOC”); the Professional Conduct Committee; or the Investigating Committee.

Put simply, all complaints and convictions notified to the Fitness to Practise Department at the GDC (other than those screened out at an early stage) are referred to an Investigating Committee for consideration. That Committee can decide to take no further action; issue an advice or a warning; or refer the case to one of the Practice Committees. The Practice Committees comprise the Professional Conduct Committee, the Health Committee and the Professional Performance Committee.

Their titles are self-explanatory and the Committees deal with conduct, health and performance issues respectively.

A practitioner receiving any correspondence from the Fitness to Practise Department of the GDC would be well advised to seek immediate assistance from his defence organisation (or a suitably experienced lawyer if he does not have defence organisation membership).

The IOC

There is a further strand to the GDC’s Fitness to Practise procedures which is also referred to in Mr Goodwin’s article. This is the IOC. This Committee has the power to impose an Interim Order upon a practitioner’s registration for a period up to 18 months (and thereafter the High Court can extend the Order for longer) if the Committee consider that it is necessary to do so to protect the safety of the public; or the practitioner; or it is otherwise in the public interest to do so. This Committee decides whether it is necessary to impose an Interim Order usually until such time as the case has been considered by a Practice Committee. It does not make any determination as to whether a practitioner’s fitness to practise is impaired, which is a decision only a Practice Committee can make.

Cases may be referred to the IOC at various stages of the Fitness to Practise procedures including at the outset (ie before the case is even considered by an Investigating Committee); or by the Investigating Committee following its deliberations.

It is right to indicate that time can be quite light when preparing for an IOC hearing, although this should never be a barrier to a properly prepared case.

In the event that a case is referred to the IOC, the appropriate document to be considered by the dentist and his defence team is entitled Guidance for the Interim Orders Committee – the latest version of which was published by the GDC in October 2009 and available on their website at www.gdc-uk.org (and not the document referred to in Mr Goodwin’s article).

Mr Goodwin’s article indicates that a dentist will need to take a number of steps to defend his position in the event of an IOC referral. In reality those steps will be taken on his behalf by his solicitor albeit with very considerable input from the practitioner. These are likely to include the taking of detailed instructions (not necessarily in the form of a statement) – for the eyes of the defence team only; the obtaining of any expert evidence required; the obtaining of references (if appropriate although they are not frequently used at an IOC hearing); the obtaining of any documentary evidence which may assist to present the dentist’s defence; and a careful consideration of any conditions which might be proposed to the Committee on the dentist’s behalf.

It is highly likely that the solicitors will also brief a barrister on a dentist’s behalf who will present the defence case before the Committee at the hearing.

It is important to emphasise that the IOC is required to review its Order every six months which provides an opportunity for the dentist (or the GDC) to apply for amendments to the Order if there has been a change of circumstances (either for the better or worse).

Finally, Mr Goodwin, very openly, accepts that he has not dealt with what he describes as the “appeal procedure” that is available against Interim Orders. It is not, in fact, an “appeal procedure” but an application to set aside an Interim Order, which is made to the High Court. My firm obtained such an Order against the GDC in 2008 in the case of R (on the application of Sheikh) v General Dental Council (2007) which is now referred to as a benchmark by lawyers in most GDC and GMC Interim Orders hearings. It should be noted that an application of this nature is unlikely to succeed except in unusual circumstances and the practitioner (or his defence organisation) is put to a considerable costs risk if it fails.

My firm has produced a brochure headed “The General Dental Council’s Fitness to Practise Procedures” which I would be delighted to make available to any readers if they would like to contact me at c.morris@hempson.co.uk (or call me on 020 7859 0278).

About the author

Chris Morris BDS LLM MBA is a partner at Hempsons Solicitors and Head of the Dental Team. He first qualified as a dentist and spent seven years in general dental practice before returning as a solicitor with Hempsons. Chris specialises in all aspects of dental law acting for defence organisations, dental institutions and many individual practitioners. He is the current President of the Dental Law & Ethics Forum.
F rom October 2009, the new Personal Dental Services Plus Agreement was released ahead of schedule by sev-
eral Primary Care Trusts (PCTs) and the Department of Health (DH) into a stand off. The main concerns appear to include the complexity surrounding the calculation of the payments due under the new regime, as well as the significantly increased ad-
ministrative burden facing den-
tists under the provisions of the
new agreement.

Payment issues Under the revised provisions, the payment system will be overhauled with practices only receiving half the agreed pay-
ments each month and the remain-
der being paid in quarterly lump sums. The reliance on UDA s as the sole measure of perform-
ance will be a thing of the past. Instead dentists will be obliged to provide their services to patients in accordance with and subject to the key perfor-
ance indicators (KPIs) set out in the
agreement.

The KPIs fall into five cat-
egories – Access, Effective Care, Health Promotion, Value for Mon-
ey and Patient Experience (all of which are weighted differently under the agreement in terms of importance). Fur-
thermore, there are three bands of performance level in respect of each category: Band A (desired performance), Band B (minimum acceptable performance) and Band C (unac-
cceptable performance).

For each KPI category and relevant performance band (in respect of which guidance is given within the agreement as to what level of performance would equate to the appropriate band), there is a corresponding pay-
ment band.

However, in this regard the KPI payment calculations are so intrinsically complex that it is envisaged that the calculation of the end figures ultimately payable will prove extremely prob-
elastic for dentists.

Administrative burden There is considerable concern that dentists will become em-
broiled in a mountain of paper-
work and bureaucracy under the provisions of the new agreement. It is generally considered that at least one very competent practice manager will be essential to deal with such administrative require-
ments, which will include the implementation of the following policies and procedures:

- The contracting dentist will be obliged to develop and imple-
ment a “continuous improvement plan” in relation to the services, utilising an evaluation process and patient satisfaction surveys agreed with the PCT, to ensure that the quality of the service is improved. In addition, there will be a requirement to regularly re-
view the KPIs in accordance with the performance bands specified under the agreement so as to en-
sure that the performance of the services is improved.

Clearly, this is going to be a very intensive and time-consum-
ming process.

The dentist will be required at all times to act with full regard to the safety of all people at the practice premises (this will in-
clude the preparation of a suitable Health and Safety Plan), to comply with all Care Quality Commis-
nion requirements and “aspire” to achieve a top performance rating in respect of the KPIs (although quite how such “aspiration” is to be measured remains a mystery).

A “quality assurance system” must be put in place that is fol-
lowed by anyone assisting in the performance of the services un-
der the agreement. This system must reflect the KPI requirements under the agreement.

The contracting dentist is re-
quired to ensure that there are in place arrangements for all per-
formers and staff at the relevant practice to maintain and update their level of competence, skills and knowledge.

No further detail is provided under the agreement, but the impli-
cation is that associates need time allowed for career development and that the practice needs to have a firm training policy in place.

The revised Clinical Govern-
ance provisions in the agreement require the dentist to go beyond simply complying with the PCT’s arrangements in this regard and instead the putting in place of an “effective system” of clinical gov-
ernance (for example, a firm and struc-
tured arrangement through which the dentist endeavours to continuously improve the serv-
ices offered).

Aside from this, little guid-
ance is provided as to the crea-
tion of an effective system of clinical governance save that there is a requirement to comply with the PCT’s instructions in this regard.

There is a formal require-
ment of strict compliance with the Data Protection Act 1998 and for dentists to be able to have in place suitable systems and policies to ensure informa-
tion security.

In this regard, the BDA has con-
firmed that it will shortly be providing comprehensive advice regarding the handling and man-
ger of patient information.

An unfortunate paradox

Such issues as highlighted in this article only serve to illumi-
nate the stark paradox begin-
ing to progressively engulf the Personal Dental Services Plus Agreement. Namely, that in its present form, it will appear that the agreement throu-
gh its heightened bureau-
cracy and innate complexity carries the danger of further re-
ducing the accessibility of the pub-
lic to NHS dental services, as well as the ability of dentists to concentrate on the provision of such services.

These are of course the very same issues that it was hoped this new form of NHS agreement would tackle upon its inception.

Help or hindrance?

James Shedlow discusses the new Personal Dental Services Plus Agreement and the array of new practices and procedures dentists will need to put in place as part of its implementation.

About the author

James Shedlow joined Cohen Cramer in 2008 and is a key member of the dental team working on prac-
tice sale and acqui-
sition transactions. His particular area of expertise is in the corporate field, specialising in the preparation of expense share agree-
ments and the incorporation of dental practices. To contact Cohen Cramer en-
litigators, call 0113 2440597, email den-
tal.team@cohencramer.co.uk or visit www.cohencramer.co.uk.
Looking good

Referrals in the facial aesthetics field are growing says Dr Bob Khanna

Referrals are the lifeline of many specialist dental practices, with professionals relying on the confidence of their peers to provide a steady flow of patients.

This is a method that has worked well in the industry for many years, but doesn't seem to have taken off within the facial aesthetics field with quite the same gusto. However, I think this is changing, and would suggest that facial aesthetic referral practices are the next progression for optimum aesthetic delivery.

A facial aesthetic referral practice works in the same way as any other referral practice. If someone is not confident in carrying out a treatment, they contact a peer who may be more proficient in the treatment concerned. After all, not many GDPs would be prepared to carry out full-mouth implant restorations. Similarly, someone who is proficient in dealing with simple marionette lines is hardly likely to want to attempt a full facial rebuild with dermal fillers.

Pain relief

I receive a lot of referrals, not only from dentists but also from GPs and plastic surgeons, whose patients have come to them seeking help for genuine medical problems, as opposed to aesthetics. Many people are unaware that the mainstay of the utilisation of Botox is still medical therapeutics and not aesthetic at all. The therapeutic use of Botox and dermal fillers is growing at a great pace.

Everyone knows about the anti-wrinkle effects of Botox, but it is not widely known that it can also act as a powerful muscle relaxant, often easing pain and suffering in areas such as the neck, shoulders and jaw. It has also recently hit the headlines with news of people having treatment for common medical complaints, such as bruxism, persistent headaches and other muscle spasms.

When someone has received appropriate training in delivering facial aesthetic treatments, its implementation within a surgery is very simple. Courses should provide help and support to newly qualified practitioners, and offer advice as to how best to market the practitioner’s new found skills to patients. However, setting up a referral practice is slightly different, especially if a practitioner is already well known for a different modality.

That said, I still believe that setting up a facial aesthetic referral practice is easier than setting up, for example, an endodontic referral practice. If a patient needs endodontic treatment, they need it, regardless of whether they want it. A ‘need’ is never as desirable as a ‘want’. People seek facial aesthetic treatments because they ‘want’ to look younger and better. It has also been shown in numerous surveys that people will spend on ‘wants’ regardless of poor economic climates. Hence the demand is clearly out there for patients wanting such treatment, therefore driving the process forward.

A practitioner is in the unique position of being able offer patients effective and successful treatment. The market is already there, and it is booming. Not having to create a market, instead having to tap into an already existing one, makes setting up a successful referral practice simple and effective.

About the author

Dr Bob Khanna is widely regarded as one of the world’s leading exemplars of dentistry and facial aesthetics. He is the appointed clinical tutor in facial aesthetics at the Royal College of Surgeons and has trained thousands of dentists and doctors through the Dr Bob Khanna Training Institute. For information, call 0118 9606 930 or visit www.drbk.co.uk.
Countdown to CQC registration

Is your PCT (preventive care team) ready? asks Seema Sharma

All NHS and private dentists have to register with The Care Quality Commission in 2011, and CQC has developed a set of outcomes around personalised care, treatment and support.

How many times have you been to a practice building seminar which tells you that your hygienist is the key to your practice’s success? Well, here is an opportunity to tie this success back to CQC requirements, demonstrate how you provide person-centred care for all patients and free your time up for higher production dentistry – the dentistry you trained to do. Practice management gurus tell you time and time again that most of your practice’s success and the care pathways outlined in the Sзавa Review, and why wouldn’t it? After all it’s just “good dentistry”!

Green (low needs) patients do not need to log your diary up by coming in for a chat and a check-up! Send them away for a two-year ‘NICE recall’ but remember a recall is a “review of oral health”, not a scale and polish, so that is not going to take care of their dental and periodontal maintenance requirements or your risk of unwittingly providing super- vised neglect. A lot can happen in two years! Bring them back with your hygienist for their interim care at least six monthly for younger patients, and 12 monthly for older patients with no disease and no risk factors.

Amber (moderate needs) patients are at a higher risk of dental disease because they have risk factors, but not necessarily active disease. They are often the patients you will need to provide the most high end treatment for such as whitening, implants, cosmetic dentistry etc, because they do not have active disease precluding treatment but they are not problem free. Such patients should be on a four- or six-monthly regime with the preventive care team that can play an invaluable role by devoting TIME to motivating and education patients, just as a personal trainer can sometimes be the only motivator for weight loss. This work can be funded by a payment plan, an innovative NHS contract or the patient themselves...it does not matter as long as your whole team’s communication skills ensure that the patient understands the benefit of a preventive approach for long term comfort, aesthetics and avoidance of unexpected bills, and signs up to your advice.

Red (high needs) patients have active disease which can preclude you from undertaking any advanced work until their oral environment is fit to receive more complex treatment. The preventive care team really comes into its own here as they enable you to keep your diary time reserved for disease management and therapy. Delegated personalisation of care, quarterly fluoride varnish applications on kids (yes, that’s in the evidence base), flossing demos and all the other aspects of care that can be delivered by dental care professionals and would otherwise require you to work every night...and on Sundays.

Just pop the guide below on the wall in your surgery and in your hygienist’s surgery, delegate effectively, get your whole team delivering person- alised care, treatment and support and do the dentistry you enjoy.

Preventive Care Team

Advice & Intervention

4-6 MONTHLY PROFESSIONAL CARE

With hygienist/preventive care team

PERIODONTAL DISEASE

As for green plus:

• Diet Recording & Analysis
• Fluoride varnish applications
• Perio risk review

PERIODONTAL DISEASE

As for green plus:

• Diet Recording & Analysis
• Fluoride varnish applications
• Perio risk review

FLUORIDE VARNISH

[Age 3-18] 2 x annual

CANCER RISKS

Smoking/tobacco cessation

Alcohol consumption advice

Advice/Intervention by Dentist reinforced by preventive team, website and literature

SKILL MIX

• Dental Nurse (F V apps)
• Hygienist (period control)
• Therapist (caries control)

SKILL MIX

• Dental Nurse (F V apps)
• DNT (Oral Health Advice)
• Hygienist (period control)
• Therapist (caries control)

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12 Feature

www.dentabyte.co.uk
info@dentabyte.co.uk
0208 297 9100
Infection control in the dental setting is a fundamental topic in terms of patient safety and regulatory compliance. However, in a European context, it is very difficult to have a consensus across the member states as each country has its own directives.

This is where the Association for European Safety & Infection Control in Dentistry (AESIC) comes in. Recently established, AESIC is a European organisation for information on infection prevention, infection control and hygiene within dentistry. The AESIC mission statement is to be the leading European source of information on safety, infection prevention and infection control for academia, corporations, policy-makers and clinicians alike.

Even though the organisation is still in its infancy, it is bringing together the leading minds in the arena of infection control to campaign for consistency in infection control policy across the European member states. One such mind is Mikael Zimmerman, one of the foremost academics behind quality assurance in Swedish dentistry. He is the author of more than 50 papers on cross infection control and has on several occasions been an advisor to the Swedish Foreign Ministry on hygiene and infection control. Mikael has also worked as advisor to the Swedish Armed Forces in the development of the new Medical Care System to be used by The Nordic Battle Group.

Speaking to Dental Tribune about the founding of AESIC, Mikael was very pleased with how the organisation was shaping up. “We have been talking about the need for a European organisation to focus on infection control for several years – we have been meeting together and work with each other to contribute towards the best practice for infection control. While infectious diseases are a very big issue and healthcare associated infections are a big issue. And maybe the biggest issue of all is the development of antibiotic resistance and we have a lot of European norms giving us information about what infection control ought to be in all 27 member countries. And although we have many common norms and directives, there are also 27 different national recommendations.

“It’s a bit strange that we can’t get European countries to work together on the issue of infection control and antibiotic resistance so we thought that AESIC was a good idea to get some common ground where we can start the discussion – what do we agree about?”

Mikael calls AESIC an ‘interimistic’ association as although it now exists, AESIC won’t be fully established until its first meeting in Leuven on November 18th, where a board will be elected. Mikael said: “So far it has been a lot of practical issues such as founding the association, getting bank accounts in place and attracting members, trying to figure out how to work with other associations, setting up the website and e-newsletter system... things like that.”

The plan for AESIC is that it will be an all-inclusive community for dental professionals and manufacturers across Europe to come together and have a place to be able to discuss issues surrounding infection control. “We want to include everybody concerned with infection control who works within the dental team. At the moment we are targeting mainly dental professionals, the unique thing is to get users, producers, academics and those working in a regulatory capacity to come together and work with each other to contribute towards the best practice for infection control.

To find out more about AESIC and to become a member, go to www.aesic.eu. www.aesic.eu.

European view on infection control

Dental Tribune looks at AESIC, a new organisation focusing on infection control, and speaks to one of the founding members about its aims and aspirations.

“...SOLUTION

Contiu alcohol free hand wash and sanitising foam products are now available in sealed disposable cartridges and wall mounted dispensers to comply with HTM 01-05 but unlike alcohol based alternatives they are very kind to skin.

PROBLEM... H'TM 01-05 states that, ‘no currently available single method or device will completely eliminate biocontamination of dental unit water lines or exclude the risk of cross-infection’

...SOLUTION

Contiu Disinfectant for Dental Unit Water Lines is highly effective at eliminating biofilm to achieve long term reduction in microbial contamination yet, being water based, it is very gentle, making it harmless to water lines and safe for patients. It is also very economical compared to existing solutions.

PROBLEM... A12 asks, ‘What cleaning agents are recommended – do they comply with COSHH and Health & Safety requirements?’

BDA Advice Note 58 lists the hazardous substances & risks to health of many products commonly used in dental practices.

...SOLUTION

Contiu free disinfectants have the same hazard rating as distilled water. They are non flammable and non irritant making them incredibly safe for staff and patients.

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For further information contact Mike Lotus Nuview Ltd, Vine House, Selsley Road, North Woodchester, Gloucestershire, GL5 5NR UK Tel: +44 (0) 1453 872266 Fax: +44 (0) 1453 872288 Email: continu@nuview-ltd.com Web: www.voroscopes.co.uk
Simple Ideas for eliminating the risk of cross-infection

Kathy Porter, Senior Dental Nurse (Decontamination) at Birmingham Dental Hospital, describes the common cross infection threats faced by everyone in the dental practice and “Best Practice” for eliminating them.

The Department of Health’s Decontamination Health Technical Memorandum 01-01 Decontamination in primary care dental practices says – “Patients deserve to be treated in a safe and clean environment with consistent standards of care every time they receive treatment. It is essential that the risk of person-to-person transmission of infections be minimised as much as possible”.

Unfortunately, everyday patients and all of a practice’s staff members face the potential risk of coming into contact with potentially harmful, even fatal, hidden threats from various microorganisms which might be covering the surfaces of every piece of equipment they come into contact with. The hidden hidden threats from these potential hazards are frequently overlooked, maybe even ignored, even though they represent a significant risk to all concerned.

There cannot be a dental practice in the country that is unaware of the cross infection risks posed by inadequate decontamination and subsequent sterilisation of their dental equipment. Therefore, the routine use of ultrasonic cleaners, washer disinfectors, various types of autoclave or steam steriliser is taken for granted. However there may be many equally dangerous, hidden, threats lying undiscovered and neglected on virtually every hard surface within the practice, certainly within the clinical areas.

What are these risks?

Virtually every day, each individual is exposed to countless millions of microorganisms which are entirely safe and present no threat to any one. However, there are also a multitude of pathogenic microorganisms, which can cause infections, also circulating in the population. These microorganisms can be transferred from one individual to another in a variety of ways. The most likely routes within the dental practice environment are:

Hands - probably the most important vector for the transmission of infection between patients and the practice’s team members.

Indirect contact - via an intermediate carrier (eg clawing or flying insects or an inanimate object) which has become contaminated with infected organisms.

Inhalation - whereby pathogenic microorganisms are exhaled or discharged into the atmosphere by an infected person and then inhaled by another person (eg the common cold).

Direct contact - when one person infects another person by direct person-to-person contact (eg chicken pox).

Ingestion - when microorganisms capable of infecting the gastro-intestinal tract are ingested (eg “common” stomach bugs).

Many of the above can be relatively easily prevented by taking appropriate basic hygiene precautions. These include washing hands between patients and wearing appropriate protective clothing (disposable gloves, face masks, etc). Such precautions protect the patient from the dentist and visa versa. However, not all of them! Some of the above, those involving intermediaries eg inanimate objects, necessitate the thorough implementation of appropriate and effective cleaning regimes in between patients.

The Chain of Infection

The Chain of Infection was first described by Storr and Clayton-Kent in 2004. It consists of the source of the infection, the mode by which it is spread, the person at risk and any potential points of entry. The easiest way to break this chain is by interrupting the mode by which it is spread.

Because hands represent the most important vector for the transmission of infection between patients and members of the practice team, the single most effective way to prevent the spread of pathogenic microorganisms within any clinical environment is effective hand washing. This should be performed for at least two minutes when entering and leaving the clinical area, between patients, after visiting the toilet, when changing gloves and whenever one’s hands are visibly soiled. Alcohol gels can be used on visibly clean hands, but if left alone they cause a build up. Therefore, they should never be used solely, as an alternative to effective hand washing with soap and water, and it is never acceptable to wash or gel gloves with a view to reusing them. Gloves should always be replaced in between patients.

Best Practice for hard surfaces

Ideally, all basic decontamination processes for small items of equipment etc should take place away from any other activities, preferably in two dedicated decontamination rooms with a clearly defined route from dirty to clean. This is not possible for larger items of equipment, fixtures and furnishings however. Therefore, wherever possible, any work surfaces and equipment should be impermeable and easily cleanable. The work surfaces and floor coverings should be continuous, non-slip and ideally seamless. Wherever possible, carpets should be avoided within any clinical or associated areas. Gowns should be used between the floors and walls to prevent any dust and dirt accumulating in corners and crevices, with any unavoidable joins welded or sealed shut.

A thorough and effective cleaning protocol can be easily based upon utilising simple techniques employing disposable clothes moistened with either clean water or a suitable alcohol-based or alcohol-free disinfectant. Alcohol-free wipes are particularly suitable for alcohol susceptible surfaces eg the leather and synthetic upholstery of dental chairs, plastics, vinyl’s etc. Wherever possible, cleaning using dry cloths should be avoided because this creates dust, which can form another hazard.

Should any blood contamination occur, one per cent sodium hypochlorite with a yield of 1,000 ppm free chlorine is recommended (unless the PCT policy advises something else). However an even higher free chlorine yield of 10000 ppm is better still. Contact times should be reason-ably prolonged and instigated as quickly as possible. Care should be taken to avoid corrosive damage to metal fittings etc. Use of alcohol within the same cleaning process is not recommended because it binds blood and protein to metal surfaces.

Even if they appear uncontaminated, all clinical areas should be cleaned in between patients using disposable cloths or microfiber materials. The areas and equipment to be cleaned in between patients include all the work surfaces, chairs, curing lights, inspection lights, keyboards and mice, hand controls, X-ray units, trolleys, spittoons and aspirators. Disposable single-use protective covers are available for use on many of these items, but they should not be considered or used in place of implementing a thorough and regular cleaning protocol. Therefore, in between patients they should still be removed and the underlying surfaces cleaned.

The main areas and items of equipment to be cleaned after each session include taps, drainage points, splashbacks, cupboard doors and sinks. While items of furniture that need to be cleaned regularly include window blinds, door handles, inci-dental chairs and furniture.

Hard surface disinfectants

Nowadays, more environmentally friendly materials (eg Ammonium Chlorides and Ethanol) are available compared with the unpleasant smelling and aggressive chemicals (glu-
the waste, mess and inconvenience associated with aerosol spray disinfectants.

Finally
To implement best practice for infection control, dental surgeons must identify all the potential sources of infection and transmission routes within their practices, and adopt appropriate protocols to break the chain. To ensure these protocols are actioned properly it is vitally important that all new staff members are thoroughly trained in this essential component of practice life. This training must be accurately documented, along with the practice infection control policy, and made available for external audit upon request. Both the policy and the training must be updated and reviewed regularly, at least once a year, and these reviews documented too. Correct implementation of these protocols should also be monitored regularly to ensure that standards are maintained throughout the practice. This should involve undertaking audits and assessments which should be retained for inspection if requested. All of these audits should be carried out in compliance with appropriate local PCT policies.

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Powerful antibacterial action for all sensitive and non-sensitive surfaces within treatment and decontamination areas!

About the author

Kathryn (Kathy) Porter has been a qualified and non-registered Dental Nurse for nearly 40 years, mainly spent in various guises at Birmingham Dental Hospital. Her title now is ‘Senior Dental Nurse (Decontamination). She is a member of the editorial board of the ‘Dental Nursing’ Journal and also writes articles for them. She has had a book, entitled “The Dental Nurses Guide to Infection Control and Decontamination”, published in the spring of 2008. Kathy is a trained Infection Prevention and Control Link Practitioner and co-ordinates the group of Link Practitioners at Birmingham Dental Hospital. She is a Fellow of the BADN.

Disclaimer:
The pictures used to illustrate this article show examples of some of the many products available in this field. The author does not endorse these or any other product, this must be a decision made by the user.
Cleaning up

One way of making sure infection control procedures are carried out properly is to delegate the management of the process to a company dedicated to providing a guaranteed decontamination service. Ken Turley explains...

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nfection control is an essential element of any modern dental practice. It is also part of the duty of care: there is a legal obligation to ensure that when a patient consents to dental treatment they receive a standard of care that puts them above any reasonable risk of contamination. 

As practice managers will be aware, staff have a statutory duty of care to ensure that all instruments and equipment are safe for use, have undergone a thorough process of cleaning/disinfection, sterilisation and storage, and that any instrument is free from contamination from blood or other body fluids.

The practice’s infection control policy, which all staff should be familiarised with and guided by at all times, forms the basis of a training and reference guide for staff, particularly during their inductions. There should also be a nominated lead member of staff responsible for infection control and decontamination. If the practice has yet to draft their Infection Control policy, it is advised to consult with an expert provider of decontamination services who can help formulate the document correctly.

Follow the rules

Within the policy, the correct procedure for decontamination of instruments should be recorded. There is the need for a clearly defined cycle that ensures reusable items are rendered safe for further use and for staff to handle: this method of reprocessing is detailed in the HTM 01-05 document. It is essential that there is a systematic approach to this process by having clear ‘dirty’ and ‘clean’ zones in the surgery to avoid the cross contamination of used instruments with clean ones.

HTM 01-05 states that, wherever possible, disposable items should be used. Single use items will be clearly marked as such, and reusing such items can seriously affect their safety, performance and effectiveness. Instruments that are difficult to clean, such as matrix bands, saliva ejectors, aspirator tips and three-in-one tips should be considered for replacement by single-use items if appropriate.

Where single-use items are not practical, instruments and appliances must be processed using the correct procedure. This is the only way of ensuring the equipment is free of any possible contamination and therefore safe to use.

The decontamination process

Any instrument contaminated with blood or saliva must be completely clean before it can be sterilised. Manual cleaning is considered to be unsuitable, primarily because of the lack of reproducibility of the conditions. There is, however, still the need for manual inspection after the decontamination process has been completed, to ensure the instruments have been successfully reprocessed.

Washer disinfectors are considered to be the best solution to the cleaning process because they offer a validated, controlled and efficient process of cleaning instruments compared with manual cleaning and most ultrasonic baths. These machines are fully automated and provide a reproducible and validated cycle of cleaning and disinfection. Always consult with a reputable manufacturer on type, requirements, installation etc to ensure you have the right machine and that you and your team fully understand how to gain the most from their use.

Careful loading of the instrument is required, as incorrect loading will inhibit the machine’s ability to clean effectively:

• Do not overload instrument carriers or overlap instruments. Open instrument hangers and joints fully. Attach instruments that require irrigation to the irrigation system correctly, ensuring filters are in place if required.

• The sterilisation process can only take place once the instruments have been successfully disinfected. A record needs to be kept of the temperature (optimally 134° C or 137° C) and pressure achieved during the cycle and modern machines will do this automatically; there is one solution to storing data, with a wireless data logger that can be connected directly to the practice’s computer system.

• For dentistry, the two standard types of autoclaves are Type N (non-vacuum) and Type B (vacuum). There is one UK manufacturer who has developed a “hybrid” B and N steriliser, giving practices greater flexibility in their decontamination options.

Safe storage

Once satisfied that the instrument has been successfully cleaned, storing it safely is vital in preventing the recontamination by pathogens. This is an area of instrument decontamination that must be rigorously controlled and a dedicated storage area, separate from the clinical area, is required to meet ‘best practice’ standards. There needs to be a clear rotation system of ‘first-in first-out’ so instruments are used within the time limit stated in HTM 01-05.

Using trays covered with lids is a practical way for storing and transporting instruments, while pouches are useful for instruments that are used less frequently. By organising instruments into treatment bundles, it is possible for the surgery to identify the cost of decontamination for specific services. This could become a useful method of business cost diagnostics.

The reproprocessing of instruments is an integral part of the decontamination procedures of a surgery. Naturally, the new regulations that apply to dentistry will entail a greater burden of administration upon an already busy management team. One solution is to delegate the management of the process to a company dedicated to providing a guaranteed decontamination service to the practice that covers all aspects, from supplies to surgery design.

The HTM 01-05 document states that, wherever possible, disposable items should be used.

Ken Turley is the founding director of the YoYo Dental Group, following a 25-year military career, Ken worked globally in the mobile telecommunications industry until 2005 when he became the managing director of Salpharma, a 35-year-old hospital autoclave company providing decontamination equipment which he later acquired and re-branded as YoYo in 2008.
Preventing cross-infection is a ceaseless war of attrition against an implacable, unseen enemy whose stormtroopers are carried into every healthcare facility worldwide on the clothing, the skin, even the breath of every person who enters the premises.

The most vital elements in checking the enemy’s advance are the training and the vigilance of the defenders, and every member of a dental practice team has a role to play in blocking the transfer of pathogens from patient to patient, clinician to clinician, or even to the postman or delivery driver. From the consultant implant surgeon to the receptionist, rigid adherence to established hygiene protocols is a personal, professional and social responsibility.

AWARE OF DANGER
While existing staff must guard against complacency, new recruits must immediately be made aware of the dangers and receive comprehensive infection control training before they are permitted to start work. Even those with previous experience must be advised of the precise hygiene schedules adopted by their new practice, as anti-infection procedures and equipment will naturally vary according to the different physical characteristics and treatments offered by each practice.

Individual staff members must always assume the responsibility for their own safety. Inevitably, clinical staff present during invasive treatments are at greater risk and need to exercise increased vigilance over their own health. They should voice any concerns as they arise, and seek prompt medical advice in cases of doubt. They need to be fully trained in the wearing and use of barrier protection (aprons, gloves, goggles), and should take advantage of the security offered by immunisation from common infections such as measles, mumps and rubella. For those who come into contact with blood or other bodily fluids, protection is also available against hepatitis B.

GETTING RID OF WASTE

The battleground extends beyond the surgery into the area of waste disposal. The growing popularity of single use instruments and sundries with some practitioners highlights the need for care in handling contaminated materials. There are also legal constraints on the disposal of many chemicals and cleaning agents, and obvious risks are attached to handling contaminated sharps, whether for re-sterilisation or disposal.

Training should always include the procedures to be followed in the event of an accident. If an elderly patient should have a fall, for exam-
As a reminder, a copy of the practice's own cross-infection policy and the latest (2009) Department of Health (DH) HTM 01-05 Decontamination Protocols may be awarded to every member of staff at the completion of their training. At the very least, the DH publication should be readily accessible for reference to anyone working in the practice. Although the nature of the perceived threat may change – in recent years from Asian flu to bird flu to swine flu, for instance, and now, following the MMR inoculation controversy, perhaps measles will become a higher risk factor – the fundamentals of cross infection control are constant. The intention is to remove to the limit of possibility all pathogens from the surgery and practice environment, and since most pathogens are killed by the same products and procedures, a rigidly observed hygiene routine becomes a ‘one size fits all’ solution, although there may still be occasions when specific action is required to combat a specific potential risk; MRSA, for example, has recently dominated the headlines in even the mainstream media. At the same time, research and new technology continually bring new products to the market, along with innovative clinical equipment which may have its own discrete hygiene regimes, and regular reviews of the practice’s cross-infection policy should take these advances into account in the quest for an ever safer working environment. Whenever changes are introduced, it is imperative that all staff are fully informed. Regular reviews of policy and procedures guard against complacency and encourage staff to monitor their own health. They also present opportunities to identify local or particular threats, which not all staff may have appreciated and which demand increased attention – an epidemic at a local school, for example. Regular access to professional training ensures that standards are maintained for both existing and new staff members, and that practices are always familiar with the latest products, ideas and procedures in this essential aspect of safely delivering dental care within the community.

About the author

Richard Musgrave has been in the industry for 18 years, and brought his knowledge and experience to Schülke five years ago. Initially working to develop both the range of infection control products as well as the acclaimed infection control training division, Richard is now responsible for the UK marketing team. He attributes the success of Schülke to the quality of its product and its dedication to providing the best possible support to the dental profession, both in the UK and beyond. This commitment is demonstrated through Schülke’s association with leading companies such as Dental Protection, for example. More information on infection control training is available from Schülke on 0114 254 3500 or at www.s4dental.com.
Getting cross infection control right

Dave Gibson, discusses the advances in cross infection control and some of the ways you can secure a completely decontaminated environment in your dental practice.

In order to secure a completely decontaminated environment, make sure that your practice puts in place ‘dirty to clean surgery areas’. We now refer to this process as Decom360 (Dental Decontamination Room) to meet the latest HTM 01-05 directives.

Implementing in-surgery cross infection control

To comply with this directive in its entirety, make sure that you start with a ‘Dirty Instrument Set Down’ zone. This will always be positioned near to the entrance/exit to ensure that contaminated instruments do not travel around the surgery. Within the same vicinity a built-in non-splash back sink(s) for instrument washing / rinsing can be integrated with a knee-operated bin and optional waste chute underneath each sink unit.

Moving to the next stage of the process, a washer disinfector can be installed on or again underneath the work surface. (I will discuss options regarding the types of systems available). The fourth zone that needs to be considered in your Decom room is an ‘Instrument Inspection’ area. Normally the space above the washer disinfector can be used for initial instrument inspection after washing and disinfection has taken place.

Next door to this zone allocate space for your Autoclave(s) followed by a ‘Final inspection and packing area’ prior to storage or use of fully decontaminated instruments. Your seventh and final zone will be set aside for ‘Instrument Storage’. These units can either be wall mounted or positioned as cabinets underneath the final packing area.

Additional points to consider in this first phase include: location of sink which needs to be placed in a neutral zone between the clean and dirty areas. A single basin can also be wall mounted behind the entrance / exit as a final precaution.

Delivering safe non-contaminated instruments

Applying strict cross infection control conditions to your working environment is the best way of ensuring that cross contamination cannot take place. A well organised system can decrease the risk of decontamination which is why it is essential to design your Decom room in stages. Always make sure that you leave space between equipment to allow for ease of access when an engineer attends to service and maintain your products.

This important aspect of delivering non-contaminated instruments leads me to discuss how you go about choosing the right washer disinfectors and autoclaves to your practice followed by the type of autoclave you should consider. Again, planning is the key to success. There are two primary elements to consider for washer disinfectors:

• Free-standing
• Bench top

‘Cross infection control, in its simplest form, is the non decontamination of surgery instruments between patients’
Of course, this can only be decided once you know exactly what room is available. If you have a practice with two or more surgeries, then the best option will be a free-standing washer disinfector as this will provide the internal room required to clean the amount of instruments used.

On the other hand, a bench top product is best utilised by practices who possess only one or two chairs maximum, providing the optimum amount of room for smaller sized cleaning quantities. In terms of purchasing the correct level model, you need to understand the decontamination process on offer. In this regard, there are major differences between manufacturers. For ease of reference, I have listed below some of the unique features you should have on your tick list prior to choosing or upgrading a washer disinfector.

1. Make sure your equipment is either EN15883, HTM2030 or HTM 01-05 compliant
2. Has ‘Unique Directional irrigation’
3. Ceramic micro filtration for fully effective dental handpiece blemens cleaning
4. Rapid Wash/Disinfect cycle in under 40 / 45 minutes
5. Rack(s) for HHST cassettes and mesh instrument basket
6. Compressed air drying system
7. Built-in water softer for hard water areas (detailed maps available upon request)
8. Touch screen controls
9. ICPS/Neodisher detergent starter kit
10. Integral detergent monitoring system to maintain product to highest level possible
11. Look out for low running costs at under 50 pence per cycle
12. RO water ready systems
13. CarePlan service and support options
14. HTM 01-05 validation and annual service including warranty aspects

With regards to autoclaves, there are again two main considerations:

- Non-Vacuum
- Vacuum

Vacuum will be your best choice if you have a high number of patients. This type of equipment will dry your instruments with increased sterilisation input. On the other hand, if you run a practice where the emphasis is mainly on private work, you should consider non-vacuum as the instruments will dry naturally while being sterilised by the remaining heat within the autoclave.

I have once again, for ease of reference, listed below some key pointers to place on your tick list prior to purchase or upgrade.

1. Make sure it is BS EN15060 compliant
2. Look out for an 11 or 22 Litre, six or 15 tray, HTST 10 capacity autoclave
3. B Type model with rapid non-vacuum cycles
4. One touch operation
5. Self checking cycles
6. Advanced air detector (vacuum model only)
7. Twin water reservoirs
8. Direct drain options
9. Direct Data Download to PC as standard
10. HTM 01-05 validation and service including warranty aspects
11. Large chamber capacity is ideally suited for use with a washer disinfector

Difference prior to purchase
Understanding the entire process of cross infection control and how to maintain a ‘Decon-Free’ environment will help you save time and unnecessary long-term costs.

These vital pieces of equipment go one stage further than previous cross infection recommendations. A Handpiece Care System ensures that you actually clean the insides of your dental handpieces. Similar to a washer disinfector and autoclave, this unique piece of equipment washes away debris left on the inside of your handpieces to keep them running smoothly and more efficiently, while adding years to their lifecycle.

The surgery disinfection system will actually sterilise your surgery once you have completed your day’s work. By using this piece of equipment, you and your patients will be safeguarded from the risks of cross infection.

Again it is worth bearing in mind the features that you must look out for prior to purchase. For a handpiece care system, take into consideration the following tick boxes:

1. A system that can automatically and thoroughly penetrate all handpieces in 45 seconds
2. Precise dosing of the exact amount of lubricating spray oil with no mess, or over-oiling
3. Chuck care system
4. One handed operation
5. Self contained cleaning and lubricating spray
6. Suitability for high and low speed instruments
7. Free lubricating spray and absorption pads to care for more than 1800 handpieces
8. Couplings for all major makes of handpiece

Getting ready for compliance
Cross infection control is now the ‘hot topic’ for anyone involved in dentistry. Because the guidelines have changed so dramatically over the last few years, it is essential to constantly re-survey you own practice procedures. This can only be carried out by talking with experts in their field who understand the many pitfalls involved with setting up a fully functional Decon room for the purposes of becoming 100 per cent compliant in today’s clinical environment.

About the author
Dave Gibbons is the Marketing Manager of Eschmann. For more information contact Dave on 01903 875 287 or email ic.sales@eschmann.co.uk
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Stormy seas for pension plans?

Jon Drysdale asks whether your NHS pension is secure in the eye of the financial storm of recently implemented changes

With many a negative story on mortgage borrowing in the national press and savings rates at a historically low level, many dentists are wondering in which direction their financial planning is heading. With a raft of recent changes made to the NHS pension scheme, here we discuss its benefits and consider whether the scheme remains one of the best.

Retirement mainstay

Dental practitioners with predominantly NHS income should continue to see the NHS Superannuation scheme as the mainstay of their retirement planning. In fact, other than GPs, dentists are the only self-employed professional group, who benefit from an employer’s pension scheme.

The benefits for dentists are sometimes misunderstood and should be differentiated from the main NHS ‘final salary’ scheme. In practice, many dentists will have an NHS pension based on a combination of two different sources of income – practice principal earnings and associate earnings.

Pension benefits:

Initial career phase (associates): Pensionable NHS earnings for associate dentists should be based on the amount of contract allocated to them by their principal. On that basis, their total associate (NHS) earnings will be £80,000 x 10 = £800,000. The resulting pension will be 1.4 per cent of total associate earnings resulting in a pension of £11,200 per year, for life.

Secondary career phase (principal dentists): The final pension is based on 1.4 per cent of total career average re-valued earnings (CARE). For principals ‘NHS earnings’ are effectively their contract value less a fixed percentage (56.1 per cent) to allow for non-pensionable ‘expenses’. For example a principal with NHS ‘earnings’ of £100,000 for 25 years, CARE in this situation would be £2.5 million. The resulting annual pension will be 1.4 per cent of this figure – £35,000 per year, for life.

Total career pension using the case study above gives a total pension of £46,200 per year from 60, for life. The earnings on which the pension is based are ‘uprated’ to allow for inflation and the resulting pension is index-linked to keep pace with inflation after retirement.

There are many variables that will come into play, not least the size of the NHS contract and the length of service.

Further NHS pension scheme benefits include an optional tax-free lump sum, discretionary ill-health benefits, death-in-service benefits including a lump sum and partner/dependents pensions.

What changes mean

For those who joined the scheme before April 2008, the retirement age remains at 60. For those joining after April 2008 the retirement age is 65. To compensate for the later retirement age, the accrual rate was increased from 1.4 per cent to 1.87 per cent. All members now have increased flexibility on retiring and returning to work, with options to increase the lump sum at the expense of pension.

On a less positive note contributions levels were increased in April 2008 from the standard six per cent. Dentists now contribute from 6.5 per cent to 8.5 per cent dependent upon NHS income levels. Added years purchase has been replaced by the less attractive additional pension purchase.

Despite recent changes, the NHS pension scheme remains one of the best available. However, with life expectancy steadily increasing, the cost of funding the scheme is an increasing burden to the NHS and ultimately a drain on UK Treasury funding. It remains to be seen if the changes implemented in April 2008 will be enough to prevent cost cutting further dilution of scheme benefits.

A note of caution

For dentists with private fee income, it’s good to remember that the NHS pension accrues only from NHS income. Those practitioners with increasing private fee income should take independent advice on mitigating the resulting loss of NHS pension benefits.

Further information on the NHS pension scheme can be found at www.nhsbsa.nhs.uk/pensions. The NHS pension scheme advises that: “If you are in any doubt about the pension arrangement that will be the best one for you, you should seek independent financial advice”.

There are further related subjects that dentists should seek independent financial advice on. These are: The ‘lifetime limit’ on pension funds, annual allowance for pension contributions, early retirement options and the nomination of beneficiaries for death in service benefits.

About the author

Jon Drysdale is a qualified mortgage adviser, an independent financial adviser and a director of Practice Financial Management Limited (PFM), an ASPD member. ASPD members offer professional, objective and practical advice and services, based on experience within the industry, to dental practices and other businesses within the dental sector. ASPD members include solicitors, accountants, banks, financial advisers, valuers and sales agencies, insurance brokers and leasing and finance companies. For more information on the ASPD, call 0800 458 6775 or visit www.aspd.co.uk. To contact PFM, visit www.pfmdental.co.uk.
horizontal bone augmentation

Dr Riz Syed discusses the importance of general bone augmentation in the arena of implantology and some treatment options

Dental implants require sufficient bone to be adequately stabilised. For some patients, implant treatment would not be an option without horizontal or vertical bone augmentation. Therefore, general bone augmentation is an area of immense importance in implantology.

A variety of materials and surgical techniques are available for bone augmentation, depending on the case and patient – after all, each case is different.

One option is a block graft, a bone augmentation technique ideally suited for simply building up bone matter. Firstly, the area to be augmented is measured and then cortical blocks are harvested from either the chin or the ramus of the mandible. First the area to be augmented is measured. After raising a flap from the donor site, a block is cut either by using peizo-surgical instrument or by drilling small holes to trace the outline of the block. A fissure bur then links these and the block is separated from the underlying bone using chisels.

The donor site can be filled with collagen sponges to aid healing, before being sutured. On the host site, the cortical plate is perforated numerous times to promote bleeding using small diamond burs. The block is then shaped using large burs to fill the void and follow the curve of the dip. Small holes are drilled through the block and the cortical plate to allow for a screw to secure the block in place.

Particulate bone can be used around the block and a resorbable membrane draped over the graft. This is left for at least six months before implant placement.

Non-resorbable membranes

A more tricky technique is to use non-resorbable membranes to build up the bone mass. The use of these membranes is technique sensitive and in inexperienced hands can easily lead to failures, resulting in the removal of grafts.

Generally there are two types of commonly used membranes. One of which is titanium reinforced, while the other is not. In areas of augmentation, xenografts alone with these membranes cannot be used. In my experience, although the ridge will augment, the quality of bone formed is very poor and unsuitable for implant placement.

It is therefore important to mix autogenous bone and xenografts together with an equal ratio to achieve better results. The autogenous bone can be taken from the tuberosity or ramus and crushed.

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Opportunity

This innovative programme establishes the academic and clinical parameters and standards for restorative and aesthetic dentistry. Students will leave with a world recognised MSc.
A tension-free flap is then sutured over the graft, and left to heal for at least six months before the membrane is removed – a vital stage in all augmentation cases. The peristium at the base of the flap can be scored using a scalpel to allow for greater flexibility.

Alternatively, ridge augmentation can also be achieved using resorbable membranes. An example would be a severely atrophic posterior ridge. Once the cortical plate is perforated, a mixture of autogenous bone and particulate bovine bone can be mixed and placed onto the atrophic ridge. A resorbable membrane can then be secured over the augmented area and left for a period of six months.

Demineralised Bone Matrix
A relatively new concept to enter the arena is the use of Demineralised Bone Matrix (DBM). Al-

This is human cadaver bone prepared in such a way that growth factors are released to aid augmentation. The bone comes in a putty form and is therefore very easy to use, simply mixed with autogenous bone, usually taken with bone scrapers or blocks, and crushed in a bone mill. In large defects, the cortical bed is further prepared by small perforations. Tenting screws are then placed to achieve the correct dimensions, before the putty bone is moulded in position and covered with a resorbable membrane. The area is sutured over using a tension free flap and allowed to heal for at least six months, after which the screws are removed and implants placed in this newly augmented firm bone bed.

Ridge splitting is a technique that allows the surgeon to open a thin ridge by cutting into the coronal portion of the cortical plate and gently widening the ridge using progressively larger sized instruments into the slit ridge. Implants are then placed, and the void filled with a bone matrix. This technique, although effective, can also lead to varying degrees of resorption.

A number of options are outlined in this column and all are very effective depending on case selection and surgical skills. Training courses are available on hard tissue augmentation. 

Dr. Riz Syed qualified at the Royal London Hospital in 1989 and was a consultant in Islington and Walthamstow Clinics in Islington. As one of the first surgeons in the country to use Nobelguide he is a mentor for Nobel Biocare, helping to train 1K implant surgeons. Regularly consulted for complex treatment planning cases, Dr. Syed lectures internationally on guided implant surgery. He is a member of the Association of Dental Implantology, the International Congress of Oral Implantologists and Fellow of the Royal Society of Medicine, and has been awarded the Clinic of Excellence in Implant Dentistry. To contact Dr. Syed, visit www.leadingimplants.com.
Waging war on dental nurse wages

The majority of dental nurses are still earning less than £20,000 a year, according to BADN’s recent salary survey.

A survey into the salaries of dental nurses in the UK, conducted by BADN at the end of 2009, shows that the majority of dental nurses are earning less than £20,000 a year.

The majority of dental nurses who participated in the survey had been working in dental nursing for more than 10 years (60 per cent), worked more than 55 hours a week (55 per cent), in general practice (63 per cent), and earned between £10,000 and £20,000 a year (62 per cent).

Dental nurse salaries are still calculated by the hour (55 per cent), rather than as an annual salary (52 per cent), and are paid monthly (94 per cent) into a bank account (87 per cent), although one per cent are still paid in cash. Nearly a fifth (17 per cent) have second jobs, and over a third (35 per cent) are the sole or primary earners in their household.

Other findings

- 71 per cent of registered dental nurses pay their own GDC registration fees.
- 92 per cent of BADN members pay their own BADN membership fees.
- 54 per cent of student dental nurses pay their own training costs.
- 45 per cent of employers make no contribution towards CPD costs; only 15 per cent cover all costs associated with CPD.
- 92 per cent of employers do not provide any additional benefits, such as health insurance, pensions, childcare vouchers.
- 52 per cent of registered dental nurses do not have their own indemnity cover.
- 18 per cent of registered dental nurses have no indemnity cover at all.

“We were shocked, but not particularly surprised, at the results of the survey,” said BADN President Sue Bruckel. “What is particularly disturbing is that the majority of the respondents were full time, fairly senior, dental nurses with more than 10 years experience – and the salaries are still well below the median pay for full time employees in the UK of around £25,500, according to ASHE and less than half the median pay for full time ‘health professionals’ of around £53,500.”

“We discovered that most part-time dental nurses, or those who are younger or in more junior posts, were reluctant to participate in the survey because their salaries were so low. Of course, had these dental nurses actually participated, the results would have been even more damning, and shown more fully the exploitation of a predominantly female workforce.”

Inadequate insurance

“What is particularly disturbing is the number of dental nurses working without adequate, or in some cases any, indemnity cover. BADN included indemnity cover in its Full Membership package so dental nurses wouldn’t have the hassle of having to research the subject themselves, and because economies of scale mean we can obtain cover at a very low premium. I appreciate that the membership fee initially seems a considerable sum of money, but when you consider that this includes £1m indemnity cover - as well as free verifiable CPD, legal advice and a Journal, in addition to other benefits - or the cost of NOT having cover, it really is worth every penny.”

“BADN will be offering free money boxes to BADN members who visit our stand at the Dental Technology Show, the BDA Conference, Dental Showcase and our own National Dental Nursing Conference to encourage them to save £3.50 each week to cover the cost of BADN membership and the GDC registration fee.

“In the meantime, BADN will continue to lobby for a reduction in the GDC registration fee for dental nurses. BADN chief executive Pam Swain and I shall be meeting with the GDC’s new Chair Alison Lockyer and new chief executive Alison White to present them with full details of our survey and a firm request that the matter of dental nurse registration fees be put at the top of the GDC agenda.”

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For more information about the BDA / DENTSPFL Student Clinician Programme, contact DENTSPFL on 0800 307 3213 or visit www.dentalco.uk

The BDA / DENTSPFL Student Clinician Awards in Edinburgh was a fantastic event. I got to meet the finalists from the other dental schools who had been working for the first time on their projects, which was a great honour. For one of the fifteen finalists also suffered a nagging tooth pain, which was a great achievement.

I had been working on an investigation into how cancer spreads, and the role of a particular molecule in the loss of cell adhesion, seen in the metastasis process.

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Educational programmes
In the UK, DPL provides a variety of educational programmes, in different parts of the country and focusing on different areas of professional practice.

Premier Symposium
Now in its tenth year, the Premier Symposium in association with Schülke, is a clinical programme which focuses on risk management and infection control. The event, which attracts 400 dentists each December in London, also includes a series of Awards, offering prizes for risk management projects which aim to reduce potential harm to patients.

Young Dentist Conference
Now in its fifth year, the Young Dentist Conference is hosted in association with the BDA and BDJ and offers practical, non-clinical advice for dentists at the start of their career.

Horizons
Following on from the success of these and other events DPL launched Horizons. The team-oriented Horizons roadshow visited venues across England during 2008 and venues in Northern Ireland and Scotland during 2009. Further to the success of the event in Scotland, Dental Protection is pleased to announce that further Horizons roadshows will be presented in Glasgow, Edinburgh and Dundee in May 2010. It will later visit venues in England and Wales in September.

The team-focused, Horizons events feature two very well-known speakers, Kevin Lewis and Hugh Harvie who will present a programme of relevant and practical subjects that will be useful for all members of the practice team. Entitled, The Good, The Bad and The Ugly, the programme will explore the management of difficult people and difficult situations that can arise throughout the practice - from chairside to reception.

The evening events include 2.5 hours' verifiable CPD for all members of the dental team who are GDC-registered. Tickets cost £60 for members and £75 for non-members. Tickets for DPL Xtra Practices and their staff are priced at just £50 per person, and accompanying staff members can attend free of charge.

Sponsoring education nationwide
In addition to the wide range of educational events that Dental Protection provides, we are proud to support a number of other educational events throughout the UK. Here you will find members of the DPL team are on-hand throughout the course of the conference to answer queries you may have relating to your membership, the benefits available to members or more specific advice from a dento-legal adviser.

Meet DPL at the following events in 2010
• BDA Conference 20-22 May, Liverpool
• International Symposium on Dental Hygiene 1-5 July, Glasgow.

For more information about any of the educational events that DPL supports, please contact Sarah Garry, Dental Events Manager on sarah.garry@mps.org.uk or telephone 020 7399 1550.
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