GDC to address FtP backlog

Additional funding agreed from reserves to help clear case backlog and ensure capacity for rise in Fitness to Practise investigations

The General Dental Council (GDC) has agreed an additional £5.5m of funding to its budget for 2010. The measure was agreed at its March Council meeting, it was also decided at that time to make the information public.

The GDC stated: “The GDC is financially stable, with 87p in the pound in our reserves. The discussions at our last Council meeting were not around our financial stability, but around our desire to address some issues in the regulatory process such as Fitness to Practise.”

The main reason for the additional funding is a £5.7m deficit in the money needed to bring the backlog of Fitness to Practise (FtP) investigations up to date. There was a 40 per cent increase in the volume of work in our core regulatory functions. This is essential for those who are under investigation to protect the reputation of all dental professionals.”

Chair of the Council of the GDC, Alison Lockyer, said: “We had a robust discussion at the last Council meeting about making this significant investment in improving our regulatory processes. This will help us address some of the Fitness to Practise issues which our CHRE 2009 review is likely to flag up. Making the investment now will put us in a better position to manage our cases more effectively. This is essential for the future financial position of the GDC will include a look at raising the Annual Retention Fee.”

The implications for the future financial position of the GDC will include a look at raising the Annual Retention Fee by £80-£100 and the use of ‘hot-desking’ in the Council offices to maximise office capacity.

News in Brief

CIC conference
One of the highlights of this year’s Clinical Innovations Conference is a presentation by periodontist Dr Peter Galgut. The Clinical Innovations Conference (CIC) is being held at the Royal College of Physicians on 7-8 May. The talk, which is being supported by Philips Sonicare, will highlight the most recent periodontal innovations to help patients achieve superior results. Dr Galgut qualified as a dentist in 1971, and gained an MSc with distinction in Periodontology in 1983. Subsequently he obtained the MRD (Membership in Restorative Dentistry) and also the MFDP from the Royal College of Surgeons of England.

James Hall winners
The James Hall Group has announced the winners for its annual awards programme. Peter Embling has been named as practice manager of the year. Sue Hall won dental nurse of the year and Pam Streates won receptionist of the year. Paul Dutton has been awarded employee of the year and Megan Howlett-Permain won the CEO’s award. A spokesperson for the James Hall Group said: ‘Peter Embling’s dedication to dentistry, his ability to develop and run a very strong team, and his sense of humour have all earned him this well-deserved award.’ The dentist chain also praised Sue Hall for ‘her ability to turn her hand to anything in the practice and her ability to keep her cool under pressure, even when simultaneous servicing management support to two practices.’

Harald Heymann returns
World-renowned expert Dr Harald Heymann returns to London on 16 July to lead a British Dental Association seminar on issues in adhesive and aesthetic dentistry, which is part of the BDA’s Clinical Expert Series, will consider the issues facing practitioners aiming to achieve consistent, long-term success in conserva-tive aesthetic dentistry, beginning with an evidence-based overview of what works. The full-day seminar takes place on Friday 16 July at London’s Novotel London St Pancras Hotel. Dr Heymann is professor and graduate programme director at the Department of Operative Dentistry at the University of Carolina in the USA. He is a consultant to the American Dental Association, the author of more than 180 scientific publications and editor-in-chief of the Journal of Esthetic and Restorative Dentistry.

www.dental-tribune.co.uk
Acupuncture can help dental phobes

People suffering from phobia could be helped by acupuncture, according to new research.

The study found that five minutes of acupuncture treatment in the top of the head cut anxiety levels by more than half.

Twenty people with an average age of 40 took part in the research, published in the journal *Acupuncture in Medicine.*

All had suffered from fear of the dentist for between two and 50 years.

On previous visits to the dentist, three patients had had to have general anaesthetic, while six others had needed sedatives. In 14 cases, the treatment had to be cancelled because the patient could not go through with it.

The patients received the acupuncture from their own dentists, who are all members of the British Dental Acupuncture Society. They had acupuncture needles inserted into their heads at acupuncture points GV20 and EX6, which have been reported to aid relaxation.

Using a well-known anxiety reporting scheme, the Beck Anxiety Inventory (BAI), the patients’ levels of distress were measured. Scores fell from 20.5 to 11.5 after acupuncture and all 20 patients were able to undergo treatment.

Statistics suggest that, in western countries, phobias afflict seven to 15 percent of the population and that women are twice as likely to suffer from a phobia as men. However, as many people do not feel comfortable talking about their phobias, it is thought that this figure could be a lot higher.

Dr Palle Bosted and colleagues from Sheffield and other centres in the UK and Denmark carried out the research. They said more studies are needed but concluded ‘acupuncture prior to dental treatment has a beneficial effect on the level of anxiety in patients with dental anxiety and may offer a simple and inexpensive method of treatment’.

However, the NHS Choices website noted that the study did not include a control group of people not receiving acupuncture to compare against.

This made it difficult to determine whether any reduction in fear seen in the treated individuals would have occurred naturally over time.

As no other anxiety treatment was compared, it is also not possible to say whether acupuncture would be any better than other approaches, such as hypnosis.

Changes for dental therapists and hygienists

Dental therapist and hygienists are to be allowed to administer local anaesthetics and supply fluoride supplements, under new changes.

The Medicines and Healthcare products Regulatory Agency (MHRA) is to allow dental therapists and dental hygienists to perform new functions under a Patient Group Direction.

These are the administration of local anaesthetics plus the sale, supply or oral administration of fluoride supplements and toothpastes with high fluoride content.

The Department of Health hopes to make the necessary amendments to the Medicines Act 1968 within the next three months.

Kevin Lewis, dental director for the indemnity and risk management advisers Dental Protection, welcomed the change and said: “As an organisation, that is very much at the heart of the profession, Dental Protection has long been aware of the frustration and dento-legal danger created for dental hygienists and dental therapists created by existing legislation. I am delighted to hear from the chief dental officer that this unintended consequence will soon be removed.”

Clinical Innovations Conference

Education and training provider, Smile-on, is hosting this year’s Clinical Innovations Conference, along with the AOG and the Dental Directory.

Promising to be the biggest conference yet, the CIC programme has been put together in consultation with a panel of international experts with the aim being to update participants on new technologies, materials and techniques in dentistry.

The 2010 conference will host a line-up of highly prestigious international speakers alongside exhibitors offering the latest dental technologies from around the world.

A spokeswoman for Smile-on said: “Together with the AOG we have brought together an impressive programme that will be both inspirational and motivating, preparing your practice for the future and ensuring that you too are at the leading edge of dentistry.”

After the success of last year’s CIC, the Clinical Innovations Conference is growing and the 2010 conference is expecting delegate numbers in excess of 500 highly motivated dentists who are passionate about learning.

For more information call 020 7400 8889 or email info@smile-on.com.

Course in sports dentistry

The UCL Eastman has joined forces with the London Sports Institute of Middlesex University and is offering a course for dentists wishing to treat athletes.

The course will be comprised of lectures, seminars and clinical sessions along with practical and laboratory skills. It will explore:

• The recognition of neurological injury
• Healing of hard and soft tissues to include suturing
• Stress and TMJ dysfunction

In addition to the dental and maxillo-facial subjects, there will be lectures and demonstrations on sports physiology, psychology of sports injury, diet and nutrition, therapeutics and drugs in sport plus medico-legal aspects of dental injuries.

The course may be taken either as an optional module of the Restorative Dental Practice programme, or as a standalone course.

For further information or to register for September 2010, please contact the programme administrator on 020 7905 1281 or visit www.eastman.ucl.ac.uk/cpd.
Editorial comment

Going up in smoke

So the General Dental Council (GDC) is dipping into its reserves to the tune of £5m to get through the backlog of Fitness to Practice cases sitting in its case files. This is not the only reason for the funding: Revalidation, Overseas Registration Exam regulation, Customer Advice and Information Team capacity... many of the facets of the GDC’s regulatory role need additional funding to cope with the rise in demand of the GDC’s services.

It is good also that the GDC has decided to share this fairly critical set of documents with the public and practitioners – it gives an air of transparency to an area of the Council’s operations that can be given to rumour and conjecture.

Of course the document does not give happy reading that one of the ways in which the GDC will have to fund in the future is to raise the Annual Retention Fee (ARF) by up to £100 for dentists (DCPs are not specified in the document). In these cash-squeezed times, anything extra that has to be paid out will be unpopular; the flip side is of course that dentists have had the ARF frozen for the last couple of years.

Interesting times indeed for 57 Wimpole St.

As you read this I will be weather and beginning my trip to the village of Bukumbi to renovate a community centre and provide support for the charity Bridge2Aid with colleagues from Schulte UK and Henry Schein Minerva. It is a strange feeling having to mentally (and packing-ly) prepare for a trip that would be the experience of a lifetime, whilst having to hear about the doom and gloom of yet more delays in the reopening of the airspace. I have friends ‘stuck’ (being trapped in New York doesn’t sound much like stuck to me!) all over the world and I have been hearing stories of dental practitioners forced into expensive trips via hired cars and Eurostar (and don’t forget the poor unfortunate who are stranded in Singapore after IDEM last week!). In fact the only winners seem to be the temp agencies that are doing a roaring trade in providing cover!

Anyway, back to Bukumbi. There is still time to support me and the team – go to www.just-giving.com/bukumbi-bound. And keep a look out for my reports from Tanzania after I get back! See, ever the optimist...

Erratum

Dental Tribune has received comment from Ingenious Media regarding the recently published column “A sensible alternative”, by Michael Lansdell (DT; Volume 4, Issue 6 pg 24-25).

Ingenious was the company featured in the Mail on Sunday article of 14 February to which Mr. Lansdell refers. There are two major errors in his piece to which they object:

1. Mr Lansdell refers to “the Inland Revenue’s position... [that] the arrangement was principally aimed at tax avoidance”. This is untrue. It is the job of the HMRC to distinguish between bona fide trading businesses and schemes aimed at simply exploiting tax benefits. As a matter of routine, all of our businesses are subject to rigorous scrutiny and have been found to have been operated in the proper manner.

2. Mr Lansdell goes on to state that “the firm that developed the scheme had problems of its own...”. Again, Mr Lansdell has got this wrong, confusing Ingenious with another company mentioned in the piece (Vantis). Apologies for any confusion caused.

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Go to www.clinicalinnovations.co.uk or call 020 7400 8967
Dentist ‘still poses risk to patients’ – GDC

A dentist who refused to give a woman gas during surgery still represents a risk to patients, according to the General Dental Council.

David Henthorn told the woman she needed to have her teeth removed, the GDC heard. He then re-imposed 10 conditions on his practice for a further year.

These include informing the GDC of any professional appointment, allowing it to exchange contact details of any colleague prepared to take on his practice and notifying the GDC of any formal disciplinary proceedings taken against him.

Multi-media dentist guide

People in Scotland looking for information on NHS dentists can now go to a website or watch a DVD available in 17 different languages.

The new multi-media NHS services guide has been launched to raise the profile of all the major services offered by NHS Scotland.

The ‘How to use the health service in Scotland’ initiative comprises of a website, online videos and resources and a DVD, available in 17 different languages including British Sign Language, giving information about dentists, family doctors, opticians, pharmacists, and out of hours services.

There is an introduction which contains some important general information, and a short section on how to give comments, whether good or bad, about services.

Nicola Sturgeon, the Cabinet Secretary for Health & Wellbeing said: “Our aim is to put patients at the heart of the NHS and make them partners in their own care. Initiatives like this will help us achieve this. Good patient care depends on understanding patients’ needs and effective communication is key to this.”

Memory decline research

Breakthrough scientific research has suggested there could be a link between having a low number of teeth and poor memory.

The study, specifically related to memory decline, examined the participant’s from a series of cognitive assessments and their ability to recall words.

The results showed that people with fewer teeth scored lower than those with more teeth in the first examination and declined far quicker after further testing in later years.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, says this study adds to a growing list of evidence of the wide ranging systemic links relating to poor oral health.

Dr Carter said: “Heart disease, strokes, diabetes, lung disease and pre and low weight babies have all been found to be linked with poor dental health. This latest research could highlight yet another worrying risk factor of having poor oral health.”

Participants were aged between 75 and 98 years old and were mostly of a higher educational background – 85 per cent had a bachelor’s degree or greater while 88 per cent were teachers by profession.

They were assessed by the Delayed Word Recall test, which involved the subjects being presented with ten words, waiting five minutes and then testing them for how many they could remember.

Each participant had their score recorded in three consecutive years.

Results showed that participants with more than ten teeth achieved an average recall of 5.5 words at age 75, while those who had less than nine teeth only averaged three. By the age of 90 those who had more than ten teeth still averaged 5.5 words, however, those who had between zero and nine teeth fell dramatically and could only average a recall of less than two words.

Low levels of education were also associated with missing teeth. While only 14 of the 144 participants were of a lower education, 86 per cent of these individuals had less than nine teeth, compared the 50 per cent of those with a better education.

The study was conducted at the University of Kentucky in America with lead author Pam Stein and published in the Journal of Dental Research.

They also managed to establish a link between a low number of teeth and a person’s genes.

It has previously been proved that gum disease is the major cause of tooth loss in adults.
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GDPUK launches dental exhibition website

A new diagnostic tool to help detect oral cancer in its early stages has successfully been developed by researchers.

The highly-receptive instrument, which looks similar to a toothbrush, is able to achieve extremely accurate results by lightly touching a lesion on the tongue or cheek.

Trials carried out on the nano-bio-chip sensor showed it was 97 per cent ‘sensitive’ and 95 per cent specific in detecting which patients had malignant or premalignant lesions - results that compared well with traditional tests.

Chief executive of the British Dental Health Foundation, Dr Nigel Carter, has welcomed the new technology into the dental practice. Dr Carter said: “Mouth cancer is a deadly and debilitating disease that would greatly benefit from such early diagnostic technology as the nano-bio-chip.

“Currently the best chance of beating the cancer comes from early detection, which improves survival rates to 90 per cent.

“Mouth cancer is a potentially fatal condition that is taking more lives each year. Without early diagnosis, chances of survival plummet to 50 per cent.”

If introduced, the brush could be used by dentists while treating patients in the dental chair during a regular appointment.

The minimally invasive technique would deliver results in 15 minutes instead of several days, as lab-based diagnostics do now, and offer an alternative to often invasive, painful biopsies.

A larger trial involving 500 patients has been planned, while researchers hope the eventual deployment of nano-bio-chips will dramatically cut the cost of medical diagnostics and contribute significantly to the task of bringing quality health care to the world.

In the United Kingdom, approximately 5,000 people are diagnosed with mouth cancer each year, claiming the lives of almost 2,000, making it the UK’s fastest growing cancer.

Mouth cancer has previously been found to be more common in men than women and people over the age of 40, though an increasing number of women and young people are developing the condition.

The new nano-bio-chip was developed by Prof John McDevitt and his team at Rice University in Houston, Texas.

The study appeared online in the journal Cancer Prevention Research.

New diagnostic tool to help early detection of oral cancer

The site benefits from being an independent source of information. Exhibition visitors will be able to rate the events on an ongoing basis so comments will always be up to date and relevant.

Information provided by organisers, the quality of speakers, general organisation, value for money and usefulness are amongst the aspects that are rated.

Tony Jacobs, owner of GDPUK, a practising dentist in Manchester, said: “We all know that different events appeal to different people depending on type of practice, specialist area or if seeking new equipment for the practice or laboratory.

“This online service helps members of the team to select the event most suitable to their needs and give preference to the events rated highly.

“We all have to ensure that if we take time out of the practice, it is vital to get the maximum return and making a wise choice about the dental event to attend is the only way of assisting this.”

Anyone rating a dental event that they have recently attended, will be entered into a draw to win an iPod Nano!

It takes only a few minutes to register free on the site, visit www.gdpuk.com to register and http://www.dentalshowreviews.co.uk to vote.
Pensioner banned from dental surgery for life

A pensioner has been banned from a dental surgery for life after he left a hoax bomb outside the surgery.

Peter McShane, aged 84, put a ticking clock inside a box with wires showing and left it outside Rush Street dental surgery in Pembroke Dock in Pembrokeshire. Police closed off the area and evacuated nearby residents from their homes. The box was destroyed in a controlled explosion.

McShane, who lives very close to the surgery, was among those who were asked to leave their homes, yet he still did not tell the police that the bomb was in fact a hoax.

He was caught on CCTV camera and he admitted to leaving the hoax bomb and vandalism when he was arrested.

Swansea Crown Court heard that the hoax bomb was the latest in a string of attacks on the surgery, after being charged £187 for dental work in 2002. The money was later refunded to him by the surgery, but he still carried out the revenge attack.

His barrister, Georgina Buckley, said he was ‘extremely remorseful’ and added that he had not fully appreciated what he was doing and was shocked by his behaviour.

McShane received a 34-week suspended jail sentence and a curfew order.

Judge Keith Thomas called him a vindictive man ‘determined to get his own back on people who had upset him’.

The judge said the offences would normally attract a prison sentence, and it was only because of McShane’s age that he was agreeing to suspend the jail term.

McShane was also placed under a 12-month supervision order, banned indefinitely from visiting the dental surgery, and also placed under a curfew between 8pm and 8am for the next three months.

A dentist and his ex-lover, who have been charged with murdering their partners nearly 19 years ago, have been sent to the crown court for trial.

Colin Howell, 51, and Hazel Stewart, 47, appeared at North Antrim Magistrates’ Court in Coleraine, Northern Ireland, and were told they will be tried for murder at Antrim Crown Court.

The trial is expected to go ahead later in the year.

Howell and Stewart, have been charged with murdering his wife Lesley, 31, and Stewart’s husband, 31, in May 1991.

Their bodies were found in a car filled with exhaust fumes at a garage behind a row of houses in Castlerock, Co Londonderry.

Howell, who once ran a dental implant clinic in Ballymoney, Co Antrim, has been in custody since his arrest and was sent back to Maghaberry Prison, near Lisburn.

Stewart was granted continuing bail but she must report daily to police in Coleraine. She has already handed over her passport.

Howell was known as a top implant specialist. He did a lot of lecturing in the Middle East and was hired by King Abdullah II to teach his own team of dentists the latest techniques.
Believe it or not, three months on and I am still enjoying the studying! The format of the course is that lectures can be viewed live with a live webcam of the lecturer and the opportunity to type in the ‘chat’ box questions either during the lectures or at breaks. I have only attended a few lectures live – mostly due to conflicts of schedule. The lectures are posted on the web a few days later to be viewed at our leisure. They can then be paused at any point to give you time to write notes or copy down a slide – there is a running time on the footnote which allows you to note down where you are in a presentation if you are interrupted and have to re-start later. The perfect solution for distance learning amidst a hectic lifestyle.

So, inspired by the looming date for handing in my first assessments, I have been on a crash course of catch-up. So far, we’re in Unit 1 – we’ve covered Anatomy, Basic disease processes, Diagnostics in perio, endo and caries detection, foundations of occlusion and foundations of materials science. We have had a variety of lecturers from Manchester and beyond – including Peter Galgut on perio, Prof Nigel Pitts from Dundee on caries and Prof David Watts from the University of Manchester on dental materials. Each webinar is accompanied by critical reading which for the most part can be accessed very easily using the University of Manchester library. The library remote access is really slick, and I have been able to create a VPN link (which means virtual private network) so that I can download and print articles. The technical helpdesk assistance has been outstanding although my bill for printer ink has more than trebled!

At this point, I am (still) a few lectures behind but I have spent an enormous amount of time in the last few weeks catching up on reading and lectures. It is amazing how many hours can whizz by when you are sat at a computer with headphones on and a notebook & pen by your side – even 10-minute bursts between patients, or whilst the tea is cooking or even after the kids are in bed. ‘Mummy’s doing her homework’ is becoming a familiar tune in our house.

Part of the final mark for the course is made up from continuous feedback from each webinar – and there are self-assessment quizzes to take on-line to assess your understanding. The Msc website keeps a log of all your completed and incompleted tasks, so there is a certain satisfaction to completing reading, the webinar, the feedback and the self-assessments – four items ticked off the list! My only complaint is that some of the self-assessments aren’t working, which is frustrating but due to a technical glitch.

Still – I have five questions to answer in only 200 words each for 20 marks before next week. I’ve worked out that’s 10 words per mark – not much room for waffling on then...... better get to it!
Ten reasons to be at Clinical Innovations

*Dental Tribune* looks at some of the reasons why this year’s CIC should be in your diary

1. **Get 14 hours worth of verifiable CPD at one of the leading conferences in the country for innovations in dentistry.**

2. **Get your Core Subject Medical Emergencies certificate with Joe Omar, who will take you through a session of BLS (basic life support) on Resus-Ann dummies and also a demonstration of the correct use of an AED (automated external defibrillator).**

3. **Medical Emergencies has the reputation of being a rather dry and theoretical subject. Not so when presented by Dr Joe Omar. Dr Omar is a Clinical Lecturer at the Eastman Dental Institute and runs a private practice in Dental Anaesthesia and Sedation in Central London with more than 200 referring dentists.**

4. **Learn how to manage endodontic failure with Dr Julian Webber.**

5. **Let your hair down and raise some money as Smile-on, the AOG and The Dental Directory host the glittering State of the Nation Charity Ball. This will be held on Friday 7th May at the London Marriott Hotel in Grosvenor Square, London. The hotel is situated in fashionable Mayfair and just minutes from Park Lane and Oxford Street. Speaking at the charity ball will be two key speakers expressing their opinions on ‘The State of the Nation.’**

6. **Have the unique chance to get ‘Hands-on’ experience in a variety of disciplines including whitening, facial aesthetics and periodontics.**

7. **Hear the leading speakers in the subject of Whitening give their views on the latest developments. Speakers include**

8. **Network with your colleagues and peers from around the globe in a fantastic venue, The Royal College of Physicians, Regents Park, London. The Royal College of Physicians is the oldest and most prestigious English medical foundation, incorporated by Royal Charter in 1518. Since then, for nearly 500 years, the College has promoted the highest standards of medical practice.**

9. **Broaden your horizons with Dr Achim Schmidt who will be discussing aesthetics and ethics. Dr Schmidt will be drawing from his experience as a private practitioner in Munich, Germany and also as a frequent lecturer at national and international meetings.**

10. **Meet the team at Smile-on who will be on hand to demonstrate how they can help with education and development for the whole dental team using their extensive library of products. Come to the stand to hear about e-learning solutions such as the MSc in Restorative and Aesthetic Dentistry, in conjunction with The University of Manchester.**

And as it is Smile-on’s 10th Anniversary year you will be able to find out the journey they have made over the last decade and their plans for the future of healthcare learning.

The Clinical Innovations Conference will take place on Friday 7th and Saturday 8th May at the Royal College of Physicians in London.

For more information please contact us on 020 7400 8989 or email info@smile-on.com.
CQC - the three M’s

Now is the time to look at the three M’s: measure, monitor and maintain says Seema Sharma

This article explores the key outcomes and performance indicators expected by CQC in the area of quality and management. Practice management systems take time to prepare and practices need to start to think about where they are and where they want to be. Some quick fixes may solve some problems but do not address the root cause. As CQC looks ahead for NHS and private practices, our aim at Dentabyte is to assist practice managers and owners to meet the new requirements by implementing sound management structures that will stand them in good stead when registration becomes mandatory.

Defining Quality
Quality is divided into three domains: safety, clinical effectiveness and the patient experience. Practices will be expected to have a quality policy or statement and to submit incident reports to the Care Quality Commission. These would include near misses and health and safety breaches. Measurement, monitoring and maintenance of quality is best done with a regular systematic approach to audit.

Quality indicators for safety
Dental practices have a duty to ensure that safety and safeguarding patients and team members is a priority at all times. (CQC Section 1).

Safety is a wide-reaching subject covering general health and safety, infection control and use of radiation in dentistry, all of which should be audited in practice at least annually.

The Department of Health have produced a comprehensive infection control audit tool for practices to use covering:

- Prevention of blood-borne virus exposure
- Decontamination
- Environmental design and cleaning
- Hand Hygiene
- Management of dental devices eg water lines
- Personal protective equipment
- Waste Disposal

This can be quite daunting to use, but help is available from trained personnel to assist with implementation of all safety measures. All practices should also be compliant with the new vetting and barring scheme and local child protection pathways, and a range of other health and safety audits are available from the author as well as many large dental organisations.

Quality indicators for clinical effectiveness
The aim of dental treatment is to repair the damage caused to teeth and supporting tissues, and to provide personalised care, treatment and support to prevent problems in the future. (CQC Section 2)

A quarterly records audit provides a sound tool for assessing if the practice’s clinicians follow a consistent reproducible approach to care. The audit should include a range of indicators for each stage of the patient journey including:

- Patient details
- Patient perceptions
- Detailed clinical records
- Risk assessment from future disease
- Care Plan incorporating self-care, professional prevention and professional treatments
- Documented intervals for preventive care
- Documented intervals for recalls (oral health review)

Well kept records soundly demonstrate if longitudinal health improvements are made at an individual level, and reflect the quality of the service and management. Other software based tools are in development and will be useful for practice population measures of clinical effectiveness.

Quality Indicators for the patient experience
Informing and involving the patient at every stage of the journey through your practice is the key to keeping the patient at the centre of your service and ensuring patient satisfaction, return visits and referral of friends and family. (CQC Section 1).

Patients want to feel they made the right decision about visiting the dentist. As it is reasonable to expect a high standard of technical skill when visiting any professional, their experience and satisfaction level is likely to be determined by their emotional experience on three levels:

Did they like you?
Did they trust you?
Were they impressed by the service you provided?

It is possible to capture the patient experience in four easy ways:

1. The satisfaction questionnaire
   - At the end of a course of treatment ask the patient at least two key questions:
   - How satisfied are you with the care you received?
   - Would you recommend our service to friends & family?

   A high positive response rate (>90 per cent) to these questions indicates a good quality service and should be the whole team’s goal at all times.

2. Comments and Compliments
   - Start to capture comments and compliments via your website, by email or in a simple book at reception, and then make a point to congratulate individual team members who have been praised for attention to detail by a patient, and to pull up and TRAIN those who did not impress. Staff attitude is the single most important factor in whether or not patients come back or recommend your practice, and feedback is evidence of how high the quality of your service is perceived to be.

3. Complaints Handling
   - Practices are expected to comply with GDC guidelines and demonstrate attendance at core CPD courses in complaints handling. Successful complaints resolution is often less about the incident that upset the patient and more about the way in which their concerns were addressed. Teams need to be developed in listening, responding, acting and improving to prevent future problems, and this can only be done with dedicated time and training over a period of time.

4. Focus groups
   - Set aside time to invite patients to a meeting and find out what they want! The customer is the best judge of what he or she wants!

   Timely reorganisation of management structures in coming months will ensure that you achieve hassle-free CQC registration in 2012.

Relevant CQC Regulations
The following regulations are relevant in this section:

Regulation 3: Accessing and monitoring the quality of service provision
Do you identify, monitor and manage risks to people who use, work in or visit your service?
Do you seek professional advice in areas where your knowledge is deficient?
Regulation 17: Complaints
Do your patients know how to complain or complain about your service?
Do you have systems in place to listen, respond and learn from complaints?
Regulation 23: Statement of purpose
Do you have a statement of purpose and quality assurance that you can give to the CQC?
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SWISS PREMIUM ORAL CARE
The good old days?

With fewer quality systems and employment laws in place, working as a dental nurse in the 1970s was a lot easier. But were things really as good as they seemed at the time? Jane Armitage reminisces

When I was asked by the Editor of Dental Tribune to consider writing a monthly column it was suggested that I write topics on various subjects that you the readers would find interesting. With this in mind, I've decided to look back and reminisce at my own career, hoping some of you will feel compelled to share your own memories with me.

I left school at the age of 15 with no qualifications. I didn't want to continue with any further education – I felt I had served my time and now I wanted the money. After all, at 15 you know it all, or at least you think you do at the time.

My initial chosen career was to be a train announcer, I could visualise myself saying in my Northern accent: 'The train arriving at Platform 5 is the 6.20pm to Llanfairpwllgwyngyllgogogoch. So off I went to our local railway station to request an application form. After listening to my request for a form I was flatly told 'sorry we only take people who have a mobility disability as this is a seated job'.

Hang on, where was the Equal Opportunities Policy when I needed it? The fact was, the wasn’t one. The Equal Pay Act 1970 had been introduced, but nothing else, so it was back to the drawing board for career ideas. It was while I was on holiday one year in Brixham, South Devon, that I found my new career path.

Talking to the landlady at our boarding house, she asked me what did I want to do. I said I had no idea, and she went on to tell me about her daughter who had been working as a dental nurse in the local practice and how much she loved it. This inspired me to try dentistry. But away from the dentist as a child, especially as I had once run away from the dentist as a child, leaving my dad to explain? Dentists, extractions and Jane didn't support came to a halt. I had to pay to live and what a shock it was to be a train announcer, I was frightened to death of the experience all the same.

A natural talent

Surprisingly, I took to the job like a duck to water; I loved every minute of surgery work. As it is now, every day was varied. I spent my time charting, working chairside, sterilising instruments in either Dettol or boiling water, I didn’t wear gloves or eye protection, maintaining the aspirator bottle by emptying it down the drain, collecting blood and saliva on a paper towel, to name a few. We worked hard, but when you look back, exactly what did we have in place? Where were the quality systems then? The Health & Safety Act 1974 had not yet been introduced, and neither had COSHH which came later in 1988.

Failing health

It was during the first 18 months of my dental nursing that I became ill. I started to have seizures that were diagnosed as Petit Mal Epilepsy. My surgery life was over, as the hospital tried to get my medication right. I continued to work though, but now as a receptionist.

Gone are the days I would work alongside the dentist I had become attached to. Working alongside him was a story in itself. I was frightened to death of him and I quite often received a smack on the hand while nursing, usually for doing something I was unaware of, but I enjoyed the experience all the same.

Gone were the days I would watch as he accidently caught a patient’s toupee on the end of the high-speed drill, sending it whizzing around and around, before placing it back on the patient’s head back to front, as he apologised profusely. Oh, how I miss the 1970s surgery days.

My illness finally took over and I had to leave dentistry, until the time came when I was fully controlled by medication. The Disability Act was introduced in 1975, which I could have done with earlier as I had already been sacked from one position for being epileptic.

The moral of this article is to give a little insight into how I became involved in practice management, and how the limitation of employment law has affected my own life. Were they really the good old days? Perhaps this is something we can discuss another day.

‘My surgery life was over, as the hospital tried to get my medication right. I continued to work though, but now as a receptionist’

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Getting to know you

A detailed history is an essential element in understanding the background to a patient’s oral health and planning effectively for their present and future treatment - Dental Protection

Before providing any treatment, it is a clinician’s responsibility to ask the right questions, in the right way, and to listen carefully to the patient’s responses. If an important aspect of a patient’s history does not come to light in the consultation process, and problems arise as a result of this, attention tends to focus upon the clinical records and what they do (and do not) contain. In the absence of any evidence that certain key questions were ever asked, it is extremely difficult to demonstrate at a later date that they were.

If, on the other hand, there is a clear answer – perhaps in a medical history questionnaire which has been completed (and preferably, signed and dated) by the patient on a particular day, then there can be no doubt that the clinician asked the relevant question and was entitled to work from the assumption that the answer(s) given were correct.

Four specific areas of the patient’s history are worthy of particular consideration in this brief overview:

- Medical history
- Dental history
- Personal/social history
- History of the presenting complaint (if any)

General observations

Creating any history about a patient is essentially an information gathering exercise. Specific techniques can usefully be employed to maximise the effectiveness of the process. The experienced clinician will choose between the available techniques according to the communication abilities of the individual patient that they are dealing with.

Closed questions

There are times when you need a definite ‘yes’ or ‘no’ answer to a specific question. The first stage of medical history screening may be one such occasion. Such questions are sometimes called ‘closed’ questions because there is little or no opportunity to obtain a more detailed reply from the patient. A direct ‘yes’ or ‘no’ is exactly what you are looking for. Closed questions can also be useful when dealing with patients whose answers tend to stray from the purpose of the question.

Open questions

These questions tend to begin with... What? Why? When? How? etc and because of this, they require the patient to provide more information for you in their reply. This is often helpful when dealing with less communicative patients, or when you are hoping to gather information of a better quality, and in greater detail.

‘Why’ questions

These questions, which are a specific kind of open question, can be extremely useful. They usually require a ‘Because...’ answer, and such answers can provide a useful insight into the patient’s attitudes, priorities, preferences and behaviour.

‘Shopping list’ questions

This approach is a little like a multiple-choice test, where you give the patient several possible answers to choose from. For example ‘What makes the pain...?’

References

The importance of taking a detailed medical history before treating any patient. Most dental schools have their own design of medical history questionnaire, and this shapes the format, style and extent of any further questioning of the patient on particular points arising from the medical history.

Medical history
One of the first principles one learns at dental school is that of the importance of taking a detailed medical history before treating any patient. Most dental schools have their own design of medical history questionnaire, and this shapes the format, style and extent of any further questioning of the patient on particular points arising from the medical history.

Many practices, in similar fashion, take commendable care in designing and using their own medical history questionnaires for the first time. In most cases the design provides for the patient to answer ‘yes’ or ‘no’ to a set of specific predetermined questions, and then to sign and date the completed questionnaire. The dentist surgeon then ensures that the patient has properly understood all of the questions (for example, where patients leave one or more answers blank), and where ‘yes’ answers have been given, further questioning of the patient will allow the details of any response to be clarified and expanded upon. Sometimes this highlights areas where further information needs to be gathered – perhaps by contacting the patient’s medical practitioner, perhaps by asking the patient to bring any medication they are taking along to the next visit, so that the precise drugs and dosages can be identified with certainty.

In several recent cases, the patient’s medical history has been at the heart of negligence claims brought against dentists and other dental team members. It is crucially important, for example, to investigate the nature of heart murmurs, or other functional heart disease, in order to decide whether prophylactic antibiotics are indicated to prevent the risk of infective endocarditis. Infective endocarditis is a serious and life-threatening disease, and most patients are left with permanent damage which has the potential to shorten their life and/or restrict its quality. Damages in such cases are therefore very high indeed, often including a lifetime’s loss of earnings.

Other recent cases have involved, for example, a failure to take into account certain allergies to drugs (especially penicillin and other antibiotics), or to recognise the significance of long-term aspirin medication predisposing to postoperative bleeding, or to recognise the potential for drug interactions.

Cases such as these often reveal the fact that although a practitioner might have taken a comprehensive medical history when the patient first attended as a new patient, this process has either not been repeated, or has been much more superficial, when the patient has returned for successive courses of treatment. In the majority of cases, no further written medical history questionnaire is ever undertaken, and indeed there is rarely any note on the record card to confirm what (if any) further questioning has taken place to update the patient’s medical history. This can be a considerable embarrassment when the patient has attended the same practice over a large number of years, and the practitioner is apparently still relying upon the patient’s original medical history details.

It is self-evident that a patient’s medical status is not static, and indeed, a patient’s medical history needs to be gathered – perhaps by contacting the patient’s medical practitioner, perhaps by asking the patient to bring any medication they are taking along to the next visit, so that the precise drugs and dosages can be identified with certainty.

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Many practices take medical histories verbally and if no positive or significant responses are elicited, an entry such as ‘MH – nil’ is made in the records. While better than nothing at all, this approach carries the disadvantage that it can be difficult or impossible to establish precisely what questions were asked of the patient, in what terms, and what answers were given. Clearly, a well-structured medical history questionnaire form, which is completed, signed and dated by the patient, and subsequently updated when requested, can eliminate much of the uncertainty of cases where failure to elicit or act upon a relevant aspect of medical history leads to avoidable harm to the patient.

In all cases, the taking and confirmation of a medical history is the role of the dental surgeon and is certainly a key part of a dentist’s duty of care. If in doubt, it may be sensible to defer treatment pending clarification of any areas of uncertainty in a patient’s medical history.

Dental history
However thoroughly it is carried out, any clinical examination is still only a snapshot of a patient’s dental and oral tissues at a moment in time. While it will provide a lot of useful basic information, the clinician’s understanding of the patient’s presenting condition is greatly improved by knowing how the patient reached the present position.

• Is the patient a regular or irregular attender?
• What treatment has been provided in the last five years?
• Is there a history of fractured teeth/fillings?
• Are any teeth painful or sensitive?
• If so, what causes any such sensitivity?
• Do the patient’s gums bleed on tooth brushing or spontaneously?
• Is the patient apprehensive about receiving dental care?
• If so, do these concerns relate to any particular dental procedure(s) or to the experience in general?
• Has the patient experienced any particular problems associated with treatment provided for them in the past?
• If so, what?

Not only will questions like those above help to inform the clinician regarding areas which may or may not need treatment, or which should be kept under review, they will also guide the clinician regarding the success (or failure) of treatment approaches that have been tried in the past. If this knowledge helps the clinician to avoid repeating the previous mistakes of other clinicians, it can also help to avoid claims and complaints that might otherwise have resulted.

Social history
The social history should include details of employment (and interests, hobbies, etc) as well as other social and family related information. The patient’s occupation should be included in the consideration of relevant factors affecting diagnosis, treatment planning, consent and treatment, bearing in mind the fact that this is an aspect of a patient’s history that may change as time passes. It is worth establishing a routine of checking the patient’s contact details and employment, when carrying out an update of the patient’s medical history.

The ability to attend for appointments could affect the success of complex or extensive treatment, e.g. crown and bridgework, implants, long term periodontal treatment and orthodontics. Certain occupations can place severe constraints on a patient’s ability to attend regularly for appointments.

Issues relating to a patients employment or recreational interests have also been known to have an impact on treatment:

For example:
• Bruxism in air traffic controllers, marathon runners and certain other sports players
• Keratolentalgia in (pilots and cabin crew)
• Stress and its relation to periodontal disease (including episo- doses of pericoroniitits involving young adults in the armed forces, or studying for examinations)

The outcome of treatment can have a general effect or a more specific effect on a given patient. For example, chronic severe pain, which can arise from some form of nerve damage, or TMJ/muscle disturbance associated with dental procedures, or perhaps a facial paralysis, or permanent loss of sensation in the lip or tongue, would all be likely to reduce the quality of life for most patients.

Later in the treatment planning process, when it becomes a little clearer what treatment possibilities are under consideration, it may be necessary to explore some aspects of the history in greater depth, in order to ensure that the patient is aware of any way in which their treatment (and its prognosis) might be affected by any aspect of their history.

Summary
It will be appreciated that there is very little value in gathering information from the above sources if the responses are not collected and recorded in a clear and logical fashion. Having a structured and systematic approach to history taking and record keeping makes it less likely that critical information will be overlooked, or lost.

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The incorporation process

Michael Lansdell aims to answer the basic questions about incorporation that all dentists operating as sole traders or in a partnership should be asking.

Even since the General Dental Council (GDC) amended the regulations to allow dentists to trade through limited companies from July 2006, the issue has been clouded with speculation and misinformation that has deterred many practitioners from investigating the possibilities.

While it’s true that incorporation will not suit every practice, the decision should at least be made in full knowledge of the facts. Individual practice circumstances vary widely, and objective, professional advice should always be sought before a change of status is contemplated. This article is dedicated to answering the basic questions about incorporation that all dentists operating as sole traders or within a partnership should be asking.

What is incorporation?

Incorporation is the process that transfers the ownership of an existing sole trader dental practice or partnership to a limited company (usually newly formed). Incorporation is now an option for practice principals and partners, and also for self-employed associates.

What is a limited company?

A limited company is a separate legal entity, with its own legal identity, which is owned by one or more shareholders and managed by one or more directors. In a sole trader or a partnership, both ownership and management vest in the sole trader or partners.

What does ‘limited’ mean?

Assuming the company has not traded fraudulently or recklessly, and the directors or shareholders have not given creditors any personal guarantees, their liability for the company’s debts is limited to their original investment in the company. This is usually a nominal sum between £1 and £1,000.

Are there any special rules for dental practices?

Yes. The GDC requires that a majority of the directors in a dental practice limited company are registered with the GDC, but there is no GDC restriction on who can be a shareholder.

How will I be paid?

Directors in a limited company may become employees and be paid a salary as well as receiving both taxable and tax free benefits. Taxable benefits could include private medical insurance, a company car or company share benefits (within certain limits) include child care vouchers and pension contributions.

Shareholders in a limited company receive dividends, which represent their share of some or all of the company’s net profit after Corporation Tax has been paid.

How does the limited company work?

Because it is a separate legal entity, the company has its own bank account, assets and liabilities, employs staff in its own name and enters into contracts in its own name.

1) Set up a new limited company at Companies House (usually done by accountants), with you and any partners as director(s) and shareholder(s). The sharehold- ers can also include any one else involved in the business, family members for example.

2) Open a bank account in the name of the new company.

3) Sell your practice assets and goodwill to the new company (freehold land and buildings are usually excluded) using a sale agreement prepared by a solicitor. Capital Gains Tax, normally 10 per cent, is payable on any profit on the original practice purchase price.

4) Decide whether the limited company should immediately borrow the money to pay you for the practice, enabling you to repay non-tax-deductible personal debts, a mortgage on your home for example; or maintain a loan due to you, which can be drawn on free of tax until it is paid off to defray your personal living expenses. If you choose deferred payments, the terms should form part of the sale agreement.

5) You have now ceased trading as a sole trader, and your practice is trading as a limited company.

Of course, this is only a brief summary of the incorporation process and cannot take into account individual practice differences. As we stated at the outset, a limited company may not be the ideal trading vehicle for everybody, and the value of professional advice cannot be overstated, but for those who do choose this route, the mechanics of conversion are straightforward. In later articles we shall be assessing the potential benefits.

About the author

Michael Lansdell was brought up in South Africa, receiving his honours degree there in 1991. He completed his training with international accounting firm Deloitte in 1994, and went on to become a founding partner at Lansdell & Rose Chartered Accountants (SA) a year later. Based in Kensington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner-managed clients, generally dentists and doctors, and specialising in the incorporation of dental practices. As a client-focused team, they look for sustainable long-term solutions for their clients that maximise profits, minimise tax and build wealth. For more information, visit www.lansdellandrose.co.uk or call 020 7378 9515.
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Go green for your future

Decreasing your practice’s CO2 output would be a wise, pre-emptive move to protect your practice’s future selling power. Andy Acton explains

Whatever their personal ‘green’ credentials, most dentists will have heard talk of the Copenhagen climate summit in recent months. But whether you’re a bona fide eco warrior, or you believe that climate change is all just a load of hot air, all practitioners had better sit up and take notice. Decisions that emerge from these talks will affect us all, and the energy efficiency of all commercial properties is now in the Government’s firing line.

Since October 1 2008, all commercial buildings more than 50 square metres require, by law, a commercial Energy Performance Certificate (EPC) whenever they are built, modified, rented or sold. According to The Carbon Trust, this is simply not enough if we are to hit the Government’s target to reduce CO2 emissions 80 per cent by 2050. Now, the Trust is calling for a massive drive to improve the energy efficiency of commercial buildings, including the imposition of national minimum standards to improve the energy efficiency rating of buildings from grade E to grade C by 2020, and to grade B by 2050.

Inefficient properties

The UK has one of the oldest and least energy-efficient building stocks in Europe, accounting for nearly half of the UK’s carbon emissions. Many dentists will be working in these energy-inefficient properties, and if the Carbon Trust’s calls do not fall on deaf ears, practitioners will have to prepare themselves for making some substantial practice alterations. But if all sounds like too much hard work and expense, especially with so many infection-control regulations coming into effect (a contentious issue in themselves), practitioners should also consider the benefits the EPC can bring to their dental practice.

All commercial properties need them, but there are some specific exceptions, details of which can be found in the Government’s guidance documentation. EPCs must be provided in energy performance, using data captured from a site inspection, drawings, specifications and manuals. A ‘zone matrix’ is then created for each floor, which takes into account heating, cooling, lighting and ventilation. This, together with the shape and size of each floor and zone are entered into the software model, together with details of the buildings construction materials. The energy model is generated using the Simplified Building Energy Model (SBEM) which is a tool approved by the Government for this purpose.

The main advantage for practice principals that The Carbon Trust wants to promote is that better ratings translate into higher perceived value in a market that is increasingly environmentally conscious. By installing more energy-efficient lighting, better insulation and modern boiler systems that improve a building’s efficiency, in theory, dentists should experience shorter void periods and higher income for sale prices.

‘The UK has one of the oldest and least energy-efficient building stocks in Europe’

A wise move

Given the pressure on the Government to get cracking on their carbon reduction commitment, decreasing your practice’s CO2 output is a wise, pre-emptive move to protect your practice’s future selling power. For those practitioners who want to take things to the next level of sustainability, the next stage is to implement low and zero-carbon technologies. With fuel costs rising, the viability of these improvements is increasingly easy to justify in financial terms.

With an EPC, the potential buyers or tenants will be able to get an impartial report of the likely running costs energy use and the likely costs of the existing building. This makes it easier to compare the likely energy costs of occupying seemingly similar buildings. A commercial EPC will also allow sellers and landlords to gain an insight into the areas where energy performance and efficiency could be improved within their property.

However, whether or not the practice’s value really does increase along with its ratings, the dentist has no choice but to have their surgery rated and logged on to the Government’s central database, as a commercial EPC is always required before you can lawfully complete the sale or lease of a non-commercial property. Fines for the failure to produce an EPC can be anything from £500 to £5,000 depending on the property’s rateable value.

Buying or selling a dental practice is a task not to be undertaken lightly, with many potential stumbling blocks on the way. The addition of the next level of sustainability to selling commercial property only serves to make matters that little bit more complicated.

About the author

Andy Acton is director of Frank Taylor & Associates, independent valuers and consultants to the dental profession. Andy has been involved in the creation of a number of dental specialist books and developed their services to the dental profession, including NatWest and Bank of Ireland. For more information, call 01456 125454, email team@ft-associates.com or visit www.ft-associates.com.

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When deciding how to deal with a periodontally compromised tooth in a clinical situation, there are a number of factors to take into consideration. These not only include the prognosis of both the affected tooth and adjacent teeth, but also the periodontal stability of the rest of the mouth, all of which play an important factor in deciding whether to treat the tooth or to go ahead with the placement of implants. Other vital factors to remember are the patient's bone dimensions, their financial restrictions, and any cosmetic implications of treatment.

Early treatment

It is widely accepted among dentists that teeth affected by periodontal disease are unreliable in the long-term, meaning that if implant therapy is a consideration, it should be carried out as early as possible.

Implant therapy is regarded as a safe and reliable method in the treatment of complete and partial edentulism, however, it is also associated with technical and/or biological complications, such as peri-implantitis. This significant and not infrequent complication can result in bone and implant loss, and seems to be more prevalent in periodontally compromised patients.

The following article presents a case that presented with extremely severe generalised chronic periodontal disease that clearly needed restorative treatment and periodontal management. The case has been followed for eight years, which is a reasonable time to evaluate its long-term outcomes.

The Case

This patient was a 47-year-old male in good general health. He complained of tooth mobility (particularly tooth 11), which had triggered his visit to the dentist. As a temporary measure, his dentist had splinted the tooth (Fig 1). Upon examination, dramatic bone loss could be seen (Fig 2) with deep pockets and bleeding on probing (BOP) in all areas. No previous periodontal treatment was reported other than occasional 'scaling and polishing', and his oral hygiene was fair.
After lengthy discussions about the patient's prognosis and treatment options, his wish to avoid removable prosthesis was made quite clear, although his cosmetic demands were low. Extensive implant treatment was beyond the patient's financial means, but he would consider short arch dentition.

A full clinical examination was carried out to evaluate the extent and severity of the disease (pockets, bleeding, mobility, etc). Initial periodontal surgery included the removal of the national fillings present in the anterior region that had deteriorated due to contamination of very compromised teeth (Fig 3). Once full periodontal stability was obtained (absence of pockets >4mm, negligible presence of BOP, good OH and physiological mobility), a strict maintenance programme was designed to prevent recurrences of the disease (Fig 4 & 5).

Subsequently, an implant was installed at 11 with simultaneous connective tissue graft to improve the quality of the soft tissue seal (Fig 6 & 7). The implant was restored three months later with a cemented porcelain-bonded crown over a cast-to-implant (Fig 2). The patient has been followed for eight years without any significant change to his periodontal and peri-implant condition (Fig 9). The only relevant observation was the deterioration of the convectional fillings present in the anterior region that were getting old and needed replacement.

Despite the impressive radiographic appearance of dramatically advanced mobility following initial therapy was degree 1 and all teeth were functionally stable. Generally, bleeding and pockets improved substantially, however a number of sites in the lower jaw still presented deep pockets that responded well to periodontal surgeries (Fig 5). Once full periodontal stability was obtained (absence of pockets >4mm, negligible presence of BOP, good OH and physiological mobility), a strict maintenance programme was designed to prevent recurrences of the disease (Fig 4 & 5).

The prognosis of teeth is not only dependent on the amount of bone that has been lost – and more importantly, what is left – but also the ability to prevent further bone loss. Both the patient's wishes and local or anatomical factors will influence the dentist's chances of controlling the disease.

Despite this, it is very well documented that in the majority of cases periodontal therapy can be quite predictable. The feeling of inevitability that spreads among patients, and the sense that the battle has already been lost, is in many cases, unjustified.

Although often overlooked, periodontal tissues cannot be ignored. As patients become more knowledgeable and discerning, it is increasingly important to update our skills in this area of treatment and provide a first class service for all.

R. D. Pasternack, Dr. Finn DeSantana, D.D.S.

About the author

José Zurdo has extensive experience of general and specialist practice. After graduating in Medicine (Bilbao, 1983) and General Dentistry (Bilbao, 1986) he completed a Masters in Medicine (Bilbao, 1989) and an MSc in Periodontics at the University of Gothenburg (2002) with the approval of the European Federation of Periodontics. The Swedish Board of Health and Welfare recognised him as a Specialist in Clinical Periodontology in 2002. Jose currently runs popular, hands-on periodontal courses and study groups for all dentists interested in extending their skills in this area. He is running courses at the DARE Training centre in Manchester. Please contact Suzanne@daredental.com or call 0161 830 7300 for more information.

Points for discussion

This case illustrates the potential of structured periodontal therapy (conventional non-surgical therapy plus localised corrective surgical treatment and long-term care) to change the prognosis of very compromised teeth in a highly motivated patient.

The prognosis of teeth is not only dependent on the amount of bone that has been lost – and more importantly, what is left – but also the ability to prevent further bone loss. Both the patient's wishes and local or anatomical factors will influence the dentist's chances of controlling the disease.

Despite this, it is very well documented that in the majority of cases periodontal therapy can be quite predictable. The feeling of inevitability that spreads among patients, and the sense that the battle has already been lost, is in many cases, unjustified.

Although often overlooked, periodontal tissues cannot be ignored. As patients become more knowledgeable and discerning, it is increasingly important to update our skills in this area of treatment and provide a first class service for all.

Despite the impressive radiographic appearance of dramatically advanced mobility following initial therapy was degree 1 and all teeth were functionally stable. Generally, bleeding and pockets improved substantially, however a number of sites in the lower jaw still presented deep pockets that responded well to periodontal surgeries (Fig 5). Once full periodontal stability was obtained (absence of pockets >4mm, negligible presence of BOP, good OH and physiological mobility), a strict maintenance programme was designed to prevent recurrences of the disease (Fig 4 & 5).

Subsequently, an implant was installed at 11 with simultaneous connective tissue graft to improve the quality of the soft tissue seal (Fig 6 & 7). The implant was restored three months later with a cemented porcelain-bonded crown over a cast-to-abutment (Fig 2). The patient has been followed for eight years without any significant change to his periodontal and peri-implant condition (Fig 9). The only relevant observation was the deterioration of the conventional fillings present in the anterior region that were getting old and needed replacement.

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Although often overlooked, periodontal tissues cannot be ignored. As patients become more knowledgeable and discerning, it is increasingly important to update our skills in this area of treatment and provide a first class service for all.

R. D. Pasternack, Dr. Finn DeSantana, D.D.S.

About the author

José Zurdo has extensive experience of general and specialist practice. After...
TRADITION inspires our projects,

INNOVATION brings them to life.
Options for dentures

Justin Stewart looks at what’s new in the world of denture teeth

Every time I go to Dental Showcase or talk to sales representatives, I always hear about the ‘latest and greatest’ new crown material, or new companies with the patent for the latest new idea. In comparison, materials relating to dentures don’t seem to have changed much over the years. However, I am happy to report that there is a new denture tooth that, in my mind, is significantly different from the rest of the teeth on the market and should be of interest to dentists wanting to give their patients a choice. In the same way that we might offer the patient two or three options for an anterior crown, why don’t we give patients different options for denture teeth?

Candulor products

There are two new products from a dental manufacturer called Candulor. The first is a nano-filled composite (NFC) tooth; it is based on a urethane dimethylacrylate matrix with organic filler. Abrasion measurements taken at different universities (Innsbruck and Regensburg, both in Germany) show significantly better abrasion values than other acrylic teeth. The tooth also has a particularly natural brilliance; its main properties are outstanding resistance to abrasion, plaque resistance, colour and oral stability. Its natural transparency and translucency create an opalescent cusp, which, in many ways, looks like a ceramic material. The tooth is laminated, being a four-layer tooth, and the neck is made of PMMA, giving a good bond to the denture-based acrylic, which, for example, is arguably a potential downside of using porcelain teeth.

Candulor has an interesting occlusal set-up where it follows the idea of the condyle sitting in the glenoid fossa and they try to reproduce this in the teeth they manufacture. This creates a mortar and pestle effect with the cusp of one arch lying in the bowl like fossa of the opposing arch tooth. Although there are differing views around the best denture occlusion, most of us who do a lot of work in this field would argue that we are looking for balanced occlusion with minimal interferences in lateral excursions.

Good marketing

Overall, Candulor seems to have hit on a great idea of being able to provide harder teeth and a really good occlusal arrangement. Candulor also have a gum-staining kit, and in my view, one of the best things about Candulor is that it has great visual marketing aids for dentists and patients. If you’re trying to inspire your dental technician to do really good work, it is helpful to begin with the end in mind, and Candulor has produced maps of where the staining should be placed to produce the most natural gum effects. These maps show where the soft, medium and strong colours should all be placed. When experienced, the technicians can very quickly carry out gum staining at the denture processing stage.

For more information about trying the NFC teeth or gum staining kits, contact Metrodent on 01484 466 715.

About the author

Justin Stewart was the first qualified Biofunctional Prosthetic System (BPS) dentist in the UK. He is a member of the American Prosthodontic Society and the British Society for the Study of Prosthetic Dentistry. Dr Stewart is dedicated to resolving denture-related problems through teaching and training. For further information, please email Justin Stewart at enquiries@thedentureclinic.co.uk.
Effective administration

Keeping on top of your paperwork helps prevent all kinds of problems says Sharon Holmes

I recently presented my first public PowerPoint presentation at the Dentistry Show in Birmingham. This was a huge challenge for several reasons. Firstly, I had never used PowerPoint as a tool. Secondly, the thought of public speaking was daunting. Finally, I had to make the subject of administration and financial management in dentistry sound interesting.

So, how does one make administration interesting? The answer’s simple. You keep it… simple. Over the past seven years or so I have learned to make use of Excel spreadsheets and Word.

I demonstrated this during my presentation by sharing the company’s three most important spreadsheets used at the end of each month. These are also the same documents we give to our bookkeeper monthly and our accountant yearly. They show turnover for the month, a bank deposit report and petty cash report. All three spreadsheets are used to collate against each other. The system is so closely monitored, should there be an error in any particular area of a transaction on any particular day, the three sets of figures will not match, which is an indicator the administrator needs to locate the error and correct it.

Monitoring performance

The above reports are only three out of 17 month-end reports produced. I use these reports to monitor all the required Key Performer Indicators that inform me of the performance of Dental Arts Studio.

At the beginning of my presentation, I wasn’t sure what my audience would take away from my talk to assist them in monitoring their financial performance. I became encouraged to share my experiences when I noticed some of my audience scribbling away on notepads.

I assumed that what I had to share was being valued. This I greatly appreciated – managing a dental practice is not easy if you are attempting to follow good practice principals, never mind all the PCT requirements being met to hold onto our much needed NHS contracts.

Firm but fair

It is important to be direct and honest as well as approachable. I have always had a good working relationship with our staff, based on these two fundamental parts of running a successful practice and a happy team. There is always a solution to every problem, as long as you address them in a professional manner.

What I did learn about using PowerPoint was that if you kept it simple, clean and uncomplicated it held the attention of the audience in quick bursts of information instead of them trying to read your slides. I have since carried in-house training on customer care and for the second time, I used PowerPoint, which proved to be effective. It sets a tone for learning, which made the training more focused and more enjoyable.

As Winston Churchill once said, ‘Attitude is a little thing that makes a big difference’.

About the author

Originally from South Africa, Sharon Holmes has worked in the field of dental practice management since 1992. In 2003, she moved to London City Dental Practice where, after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is now part of a mini co-operative group called the Dental Arts Studio, of which she has been instrumental in its creation.
From windscreens to whitening

_Dental Tribune_ looks at a new practice which has transformed an old windscreen repair shop in Blackpool into a fabulous dental surgery.

A former widescreen repair workshop might seem an unlikely candidate for conversion to a dental practice, but that was the choice for Ivory Dental Care to expand their Blackpool practice back in December 2008. The growing success of the four dentist partnership meant the team had just run out of space in their existing premises. They also wanted to be able to offer new services to attract additional private patients but their building was bursting at the seams.

After a long search over nearly three years and considering lots of alternatives, the partners settled on a former windscreen replacement workshop and purchased the building in December 2008. The short-term plan for the new site was to provide two additional surgeries enabling expansion of the business from a four to a six surgery practice.

When asked why they finally decided on this building Elena Barlow, the Practice Manager explains “The location is fantastic, it is just a mile from our existing practice which makes working across both sites easy for the team. The building also has all important parking facilities which are difficult to find in the more residential areas around the town. It is also a vast space, with plenty of room to accommodate the future needs of the practice.”

Visualising the potential of the former workshop must certainly have been a challenge but Elena recalls at the time just how convinced she was that it was right for them. “It gave us the blank canvas we wanted to be able to design a practice from scratch. With such a huge open space to work with it granted us the freedom to put our imaginations to work to design a state of the art practice that would complement our existing site and reflect the ethos of the partners.”

Rightly, Elena is very proud of the building’s transformation, few would guess its original function. “We replaced the two huge workshop doors at the front of the building with floor to ceiling windows. The massive expanse of glass gives the whole building, but especially the reception area, a feeling of openness and space.”

See a demonstration at
www.bhasoftware.com/pearl
0800 027 2406

£39 + vat per month for 1 dentist (includes updates and unlimited support)
£275 + vat for installation and training!
No extra charge for several work stations! £18 per month for extra dentists
Building, decorating and kit-ting out a new practice from scratch meant the team had the latitude to invest in exactly the kit they wanted. Much of the equipment was sourced from McKillop Dental Equipment Ltd. Elena explains “We've used McKillop many times before and have always been happy that they understand our requirements and deliver on timescales. They also come very highly recommended locally”.

New cabinetry, X-ray and sterilising equipment and chairs were all on the shopping list. Elena is clear about why they chose the Clesta II Flexible Treatment Centre and Voyager II Treatment Centre both from Takara Belmont.

“We wanted chairs that would look good in a contemporary setting whilst being functional and reliable. Also, the Voyager Treatment Centre gives us the flexibility of right or left handed use. Our existing practice uses Takara Belmont chairs and so we knew the quality of what we were buying. In the end the toughest decision for the team was choice of colour! Both chairs look fabulous against the all-white decor of the surgeries.”

The main building works were project managed by the building contractor but were closely overseen by the partners and Elena. “We had regular meetings with the Project Manager on site so we could keep abreast of the progress being made, ensure that decisions were taken promptly so time wasn’t lost and to ensure the work stayed on track and to our requirements.” She is forthright in her advice for anyone undertaking a similar project. “Take time to plan and then try hard to stick to it. In other circumstances working with four partners to agree on the layout, design and decor might have been tricky, but with plenty of discussion we were able to work through differences in priorities and tastes to come to an end result with which everyone is happy. Fortunately the original partner in the practice, Dr Woodhouse had undertaken refurbishments in the past so his experience was invaluable throughout! This close involvement of the practice team ensured the final product was exactly what they had envisaged. It also meant the project experienced few difficulties and was completed to time and budget.

The new practice now accommodates two new surgeries, an office for the practice manager, sterilising facilities, a spacious reception in the past so his experience was invaluable throughout! This close involvement of the practice team ensured the final product was exactly what they had envisaged. It also meant the project experienced few difficulties and was completed to time and budget.

The new practice now accommodates two new surgeries, an office for the practice manager, sterilising facilities, a spacious reception and enough spare room for the creation of an additional four or five surgeries as and when the extra capacity is needed. Elena is clear that the design of the new building and particularly the new reception space facilitates an excellent patient experience. “All our administrative activities now take place behind the scenes which means the receptionists are dedicated to welcoming and booking in patients and don’t need to be distracted by phones ringing or the hum of photocopiers and printers.”

Since opening at the end of November 2009 patient numbers have already increased by nearly 1,000. Across both practices, Ivory Dental Care now treats nearly 9,000 patients with scope for significant further expansion in the future.

Elena has no regrets about the whole project but so far it has certainly been all work and no play. “Since the new building opened work has been non-stop so we still haven’t had an official opening celebration for the staff.” Surely something the Ivory Dental Care team will work hard to prioritise this year.
showrooms. For more information contact Lucy Moscrop
enquiries@clarkdental.co.uk

Hygiene Matters
There are many mass rejection hazards within a dental surgery which necessitate the need for stringent legislation. Anything that reduces the risk is therefore generally welcomed. With this in mind the handles of any chair have been designed to allow easy access to the patient and ensure the patient’s comfort. Kubo believes that the A-Dec 500 could provide a higher level of reliability and customer support than any other dental chair available today.

For more information contact j.colville@ceramicsystems.co.uk

World-Class dental chairs from
Clark Dental
Clark Dental is synonymous with providing the ultimate in patient chair technology and comfort from the leading manufacturers. Steam Webber offers a range of dental chairs, incorporating the latest innovations to prevent cross contamination.

The S280TRc, with its suspended patient chair gives plenty of space underneath the backrest. The S2878TRt embeds the Stein Webber ethos - materials, systems and design of the highest quality. Anthos is renowned for dental chairs that exude quality and style. Their Classe 4000 gives the perfect balance of style and functionality. The Dentist’s chair and the Assistant’s chair are conveniently located, allowing them to move freely together creating a perfect working environment.

The A-Dec 500 is the latest addition to the A-Dec range and incorporates the latest technology and ergonomics. The chair is designed to be completely adjustable, ensuring the patient’s comfort during treatment.

For further information contact Clark Dental on 01268 733146 or email sales@clarkdental.co.uk or sales@kdv.co.uk

Sitting Pretty After 15 Years
The Bambach Saddle Seat has successfully been in production for 15 years. This market leading seating design is the only one of its kind to be endorsed by the Australian Physiotherapy Association and is very highly recommended. There are many chariots upon the market that do not necessarily have the clinical papers or experience to back their claims. Bambach has been proven time and again over the years with more than 5,000,000 seats sold worldwide.

The correct seating position using the Bambach Saddle Seat can alleviate many of the problems associated with muscle fatigue by encouraging an improved sitting posture. The Seat helps to maintain the natural shape of the spine, preventing the discs from being put under pressure. The hips are kept at the optimum angle, so back and thigh muscles are at their most relaxed. Bambach Saddle Seats are fully adjustable to create a bespoke individual stool just for you.

The company are so convinced of the benefits that they are offering you a free 30-day trial in your own practice. For further information please contact Bambach directly on 0800 381 100.

SiroLaser, SIROEndo and the DAC Universal sterilisation unit.

Designed to meet your needs
Henry Schau Minerva’s equipment division has expertise in every aspect of surgery design and installation and in addition they have access to the widest range of surgery equipment from the world’s leading manufacturers.

The range of chairs available from Henry Schau Minerva incorporates the Sirona TSENO - the ultimate chair in terms of style, innovation, craftsmanship and quality. Poltron-Ceva’s chair creates a pleasant and comfortable patient experience whilst the Belmont Voyager is a versatile option that fulfills every function you might need.

Henry Schau Minerva’s Platinum, Gold and Silver surgery groups help you compare every chair based on price, features and value, so you can be certain that you are getting the best equipment for your needs and budget. As a result we start by giving you a comparison guide of the different range of leasings offers your new chair now even more affordable.

For more information on the range of chairs available from Henry Schau Minerva simply call 0870 120 21 41 or visit www.henry-schau.com

Casting and seating manufactuers
Ceramic Systems CEREC®
One of the world's leading dental chair manufacturers, Castellini, are always at the forefront of dental technology, including the pre-setting of the Implantor brushless micromotor technology, including the pre-setting of the Implantor brushless micromotor technology.

Programmable internal decontamination modes allow the operator to select the correct postures using the Bambach Saddle Seat. The Saddle Seat is the only one of its kind to be endorsed by the Australian Physiotherapy Association and is very highly recommended. There are many chariots upon the market that do not necessarily have the clinical papers or experience to back their claims. Bambach has been proven time and again over the years with more than 5,000,000 seats sold worldwide.

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The range of dental chairs from Castellini includes the DUO, a complete dental chair solution designed to provide the highest level of ergonomics, comfort and efficiency whilst providing patient comfort and a practical, functional, relaxing, ergonomic working position for the dental team.

The DUO is designed to offer all the quality and technology advantages of a KaVo unit, with the added benefit of working flexibility. This unit allows for permanent installation in the either the left or right-handed position, whilst offering ideal patient positioning including an offset backrest articulation and allowing the facility to suit the charting system of your preference.

An exciting range of Gentle imaging products as well as calipers to enhance this comprehensive range of surgery equipment, with the flexibility to fit all working spaces.

For further information regarding the full range of KaVo products, surgery planning, flexible finance and rental schemes’ available Freephone 0800 211 202

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KaVo ESTETICA E80 E/T: Outstanding
ergonomics in its most attractive form.
The ESTETICA E80 from KaVo allows for a flexible adaptation to the individual requirements of the dentist and patient, making ergonomic working a reality.

The innovative technology and concept offers an incomparable increase in freedom of movement, ensuring ergonomic working whilst the highest adaptability of the unit ensures patient positioning is retained.

Both the dentist’s and the assistant’s elements of the ESTETICA E80 are provided with a future-proof configuration and an ergonomically perfect instrument layout. USB interfaces integrated into the dentist’s and assistant’s elements enable USB-compatible equipment to be connected to the treatment unit and linked with ERGOcom 4 at any time.

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KaVo continues to produce exceptional products based on the needs of their customers making sure they are always ahead of the curve.

For further information on the full range of KaVo Sedent products, please contact KaVo on 01944 715100, email sales@kavov.com or visit www.kavo.com.
How to achieve a perfect class 1 and posterior restoration with DENTSPLY

SDR™ marks the beginning of a new generation of posterior composite. A single-dose, perfectly uniform and flowable composite that can be adapted to any residual tooth surface, alternatively you can use AutoMat F®.

Once the tooth is prepared and cleaned apply: Xeno™ V, for an easy, self-etching bond. After light-curing the bond, place the new SDR, a durable posterior flowable composite base (up to 4mm bulk fill) and light-cure for 20 seconds.

Next, for tough, long lasting restorations with great aesthetics place a capping component such as SDR™ Monomer. Your local DENTSPLY Sales Specialist will be able to assist you.

For more information, or to book an appointment with your local DENTSPLY Product Specialist, call 0800 072 3313 or visit www.dentsply.co.uk.

DENTSPLY protocol

Prepare teeth using Hi-Lo Diamond Burs, widely recognised as the "gold standard" in cavity preparation for fast cutting and low risk of fracture. For successful class II restorations, be sure to use a contoured sectional matrix system and apply Xeno™ V to the cavity preparation. This will allow your patient to experience noticeable improvements in post-operative comfort.

In addition to being supplied in bottles and single-dose vessels, Excite F® is now also available in the new SDR™ filling. The amount of adhesive contained in a SDR™ is sufficient for approximately 120 applications.

Impeded accessibility of the cavity

If the cavity is not accessible with the curing light or if chemically curing composites are used, the dual-curing Excite F® SDC (Dual Cure Single Component) material is indicated.

Excite F® SDC is available in hygienic single-dose vessels in two sizes: "Regular" for normal preparations and "Small" for micro-cavities and endodontic applications.

Contact

XeroVid Denture Ltd, Ground Floor, Compass Building, Feldspar Close, EN15 4GE
TEL: 0118 284 7880

Lincoln Street’s first Velpeau Picasso Laser

Lincoln Street in London is now well and truly on the map! Their first Velpeau Picasso Laser has recently been installed at the Dental Practice as number 6 which can now offer all patients the availability of laser treatments as well as the high quality dentistry previously offered.

The Velpeau Diode Laser contains two lasers: a 10 Watt Gallium Aluminium Arsenate (GaAlAs) diode laser and a small laser pointer. The GaAlAs laser is ideal for soft tissue (i.e. gentle) surgery and the diode laser is excellent for hard tissue (i.e. teeth) surgery.

The GaAlAs Laser has a wavelength that makes it ideal for minor oral surgery. Using this laser, an area can be cut with local anaesthesia.

Dr Tan, who is no stranger to lasers said of the Velpeau Diode Laser: “This is a super unit, neat, compact and easy to use.”

Patient feedback continues to be very positive with many patients commenting positively on the laser.

www.cosmeticdentistryguide.co.uk

Dentistry in the 21st century - must read!

The award-winning clinical journal Dentistry Today is available to all dental professionals. The journal covers the latest news and developments in all aspects of dentistry.

To arrange for a Sales Specialist to demonstrate SDR in your practice call +44 (0)800 072 3313 or visit www.dentsply.co.uk.

Simple and efficient filling philosophy with SDR™

Dr Steve Charlton of Cloverdale Dental Practice, Alton, has been trialling the filling SDR™. In the review, a new innovation - a new product from DENTSPLY.

“Using the SDR™ filling material has made a difference to the length of time the procedure involved! It is now simply a question of the length of the flowable SDR™ up to just two millimetres below the margin of the cavity, and then finishing with a single layer of composite-material it’s certainly a quicker technique.”

“It makes life easier from the point of view of keeping the filling dry, as the reduced time of the technique means having to keep the area isolated for less time.”

“As with any new procedure, there is a period of adjusting, but this new technique was very easy to pick up and I shall definitely be using it in the future.”

DENTSPLY is committed to bringing the most advanced technologies into the UK dental market, assisting the provision of the highest quality in dentistry.

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Blending regardless of the light conditions

The light- and dual-curing adhesive system

Impeded accessibility of the cavity

If the cavity is not accessible with the curing light or if chemically curing composites are used, the dual-curing Excite F® SDC (Dual Cure Single Component) material is indicated.

Excite F® SDC is available in hygienic single-dose vessels in two sizes: “Regular” for normal preparations and “Small” for micro-cavities and endodontic applications.

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The Hoges Visor: Essential Cost-Effective Full-Face Protection

Enjoy high quality and reliable full-face protection at a great price with the Hoges Visor. The refined design provides excellent protection in hospitals, nursing homes and other healthcare environments, making it the perfect fit for use in PACU or other areas of the hospital.

Dentomycins: An Effective Adjunctive Treatment for Periodontal Disease

Dentomycins Periodontal Gel from Blackwell Supplies is an effective treatment of moderate to severe chronic adult periodontal disease, when used in conjunction with scaling and root planning.

Supplied in easy to use, pre-filled applicators that allow the delivery of the gel directly into the periodontal pocket for immediate effect. Dentomycins binds to the tooth surface and is released slowly over a period of time to allow you and your patients, keep up to date with this ever-evolving industry.

Simple and efficient filling philosophy with SDR™

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Dentomycins are now available in the new VivaPen delivery form. The amount of adhesive needed is measured before filling the gel applicator. After light-curing the bond, place the new SDR, a durable posterior flowable composite base (up to 4mm bulk fill) and light-cure for 20 seconds.

Next, for tough, long lasting restorations with great aesthetics place a capping component such as SDR™ Monomer. Your local DENTSYP Sales Specialist will be able to assist you.

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Kemdent revive the 3 Rs - Recycling, Reuse and Reusing their tubs. The products are reusing their tubs. Refill rolls are available in packs of 4.

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Oral healthcare in people living with cancer

Do you treat and support patients who are living with oral cancer? Then this day is for you! Dental Tribune details a CPD meeting to be held in June 2010 aiming to enhance awareness of the importance of orofacial signs and symptoms of cancer

A meeting on Oral Healthcare in People Living with Cancer, will be held in London on 11th June 2010, supported by RCSEd. The single day CPD meeting, in parallel sessions, organised by Professor Crispian Scully CBE, is given by a European faculty, and also supported by the International Academy of Oral Oncology (IAOO) (www.homepages.ucl.ac.uk/~sfhwcms/iaoo/index.html), and the Multinational Association of Supportive Care in Cancer (MASCC) (www.mascc.org/mc/page.do?sessionid=2TF7F051F8F847514C17F98E68CFD17.mcf&sitePageId=86007).

The day is aimed at dentists, and specialists mainly in maxillofacial surgery, oral medicine, oral surgery, special care dentistry, and otolaryngology, as well as Dental Care Professionals (DCPs), and the cancer support team. The Faculty include European leaders in the field (Table 1).

Supporters include Philips Oral Healthcare, Elsevier Publishers, Healthcare Learning Company and HCA.

The objectives are to enhance awareness throughout the healthcare team of the importance of early detection of orofacial signs and symptoms of cancers, and of cancer prevention. Much oral cancer presents late, at a stage when not only is more radical treatment necessary, but the prognosis is also less favourable.

The meeting provides an overview of the aetiopathogenesis of cancer (carcinoma) for the healthcare team, a broad understanding of which is crucial for coping with issues related to prevention, diagnosis and management. The World Health Organisation (WHO), other agencies and research workers have produced a considerable amount of epidemiological data showing that oral cancer is increasing, and in younger patients. Tobacco, alcohol and betel remain the main risk factors but the role of human papilloma viruses (HPV) in oropharyngeal cancer in particular is increasingly recognised, as is the beneficial effect of diets rich in fruit and vegetables. Prevention is crucial if there is to be any serious progress. Prevention of oral cancer involves lifestyle decisions which afford protection not only against cancers in many sites, but also against a wide range of other conditions, many of which are equally life-threatening.

The meeting also highlights areas of controversy in the early diagnosis of oral cancer. Earlier diagnosis is likely to be achieved reliably only with the introduction of molecular studies. Early detection and treatment should reduce mortality rate and morbidity from cancers and their treatment. The role of multidisciplinary teams in cancer detection and management is stressed. Medical, surgical and technological management advances have improved the quality of life - though the five-year overall survival of the disease has advanced little at most treatment centres. The basic treatment modalities remain as surgery, radiotherapy and chemotherapy and treatment improvements are largely directed towards reducing the complications, which remain a major issue. Patients with oral cancer may be faced with a range of untoward symptoms, from pain and anxiety, to dry mouth, and disturbed taste, eating, swallowing and speech (Table 2), the prevention and management of which are discussed.

The importance of minimisation of such adverse effects from treatments, and of good support for the oral cancer patient and their family is a major focus of the meeting.

The peer-reviewed papers from the meeting are published in the June issue of Oral Oncology (www.elsevier.com/wps/find/journal-description.cws_home/165750003774906084/description#description), the official journal of the European Association of Oral Medicine, the International Association of Oral Pathologists, and the IAOO.

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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.

Introductions 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 regeneration 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

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. Hill 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.

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.

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 123 5890.
During Dr Sonntag’s recent presentation in March at the University of Warwick, he began by describing the Mtwo endodontic file manufactured by VDW in Germany. The file is NiTi in nature and is supplied in sizes: 10/04, 15/05, 20/06, 25/06, 30/05, 35/04, 40/04, 25/07.

The file is manufactured from an “S”-shaped blank and has therefore two cutting edges allowing it to be very flexible. It is intended for use at 280rpm. The first file and each subsequent file are intended to go to full length. If greater coronal taper is needed, then the 25/07 is the file to achieve the greater taper.

The 10/04 and 15/05 are very useful in shaping the apical third. The files can have a “working part” of either 16mm or 21mm. The latter can be useful in the “long canal” scenario – working on canines. The files can be supplied in 25mm and 51mm lengths.

Perfecting techniques

Dr Sonntag described the techniques he has perfected in using these files and the results were impressive. He demonstrated the re-treating of an upper right first molar which had a discharging extra-oral sinus, prominently situated in the right cheek.

The VDW torque control drive system was used to prepare the canal with the appropriate torque setting and speed control. The VDW ultrasonic was also available for troughing the pulpal floor, especially for the isthmus between MB1 and MB2.

The afternoon was spent discussing the obturation of the canals that had been prepared by the students. The VDW “Bee Fill” gutta percha extruder was demonstrated, which is on par with the other gutta percha extrusion systems on the market at present.

To summarise, this was a very refreshing course on the VDW endodontic spectrum of root canal armamentaria.

A word of thanks

Praise goes to Dr David Sonntag for the tuition; QED for supplying the full range of VDW instruments and files; DP Medical for supplying the Global microscopes and to Dr Liviu Steier as course co-ordinator.
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