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 £5.7m 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 circa £14m remaining 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 cases in 2009.

Currently, there are more than 850 cases in the system, of which roughly 180 are more than 12 months old. The GDC received 1,437 new cases in 2009, which represented a rise of 40 per cent on 2008. Of these, 1,249 (87 per cent) went to assessment and 852 were referred to the Investigating Committee (IC). The 852 IC referrals represent a rise of 40 per cent on 2008. Of these, 1,249 were referred to the Investigation and Fortification Committee (IFC) in the volume of work in our core regulatory functions.

The level of delay has been a cause of concern, as stated in the proposal document. It is clear that we are not currently dealing with all cases in a timely manner and that a new approach is needed. A significantly reduced throughput time for all but the most complex cases is desirable in terms of both patient protection and fairness to registrants who are practising under the shadow of an allegation.”

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 those who are under investigation and to protect the reputation of all dental professionals.”

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

Other issues facing the Council include:
- Regularisation of the staffing budget to recognise commitments made in 2009 - £708k.
- Changes to meeting profiles of Committees and associated arrangements commissioned by this Council - £580k.
- Proposals for tackling the challenging backlog of Fitness to Practise allegations where there is the experience of a 40 per cent increase in volumes in 2009 - £5.7m.
- Recruitment of replacement Legal Advisers for Hearings - £10k.
- Revalidation project funding - £250k.
- Overseas Registration Exam budget regularisation - £179k.
- Registration proposals (part head count/part projects) - £470k.
- Customer Advice and Information Team capacity - £5.7k.
- Finance related projects (X5) - £102k.
- Changes to the priorities and the restructuring for the External Relations team - £270k.

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

GDC to address fitness to practice investigations

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Acupuncture can help dental phobes

P eople 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 per cent 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 created a study of 30 dental phobics. 16 of the patients were treated with acupuncture and all 20 patients included in the study were given a placebo treatment.

Scores fell from 26.5 to 11.5 after 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.

There were no reported side effects of acupuncture and all 20 patients were able to undergo 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 hypnotherapy.

Changes for dental therapists and hygienists

D ental 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

E ducation and training provider, Smile-on, is host ing this year’s Clinical Innovations Conference, along with the AOG and the Dental Directory.

Now in its seventh year, the Clinical Innovations Conference (CIC) will be held on the 7-8 May at the Royal College of Physicians in Regent’s Park, London.

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 delegations 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.

Clinical Innovations Conference website

Course in sports dentistry

T he 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 offered in 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 psychology, nutrition, diet and nutrition, therapeutics and drugs in sport plus medico-legal aspects of dental injuries.

The course may be taken as either an optional module of the Restorative Dental Practice programme, or as a stand-alone 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. 1281 or visit www.eastman.ucl.ac.uk/cpd.
Editorial comment

Going up in smoke

So the General Dental Council (GDC) has dipped into its reserves to the tune of £5m to get through the backlog of Fitness to Practise 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 had have the ARF frozen for the last couple of years.

Interesting times indeed for 37 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 Schülke 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 air-space. I have friends ‘stack’ (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 unfortunates 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.justgiving.com/bukumbi-bound. And keep a look out for my reports from Tanzania after I get back! See, ever the optimist...
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 pulled out, but refused to give her gas during the procedure, despite her asking for it.

Henthorn failed to notice the patient’s ‘severe’ loss of tissue and gum disease, despite her making frequent visits to his practice in Slack’s Lane Heath, Charnock, Lancashire.

The patient told the General Dental Council (GDC), that her gums became ‘baggy’ in 2001 and abscesses appeared in June 2002.

In May 2007, the woman changed practices after Henthorn refused her requests for sedation.

She then had to have nine teeth removed, the GDC heard.

In July 2008, Henthorn was only allowed to work subject to conditions, after being criticised for ‘gross negligence’.

However at a new hearing Ja- son Leitch, chairman of the GDC tribunal, said the dentist still represented a risk to patients. He said: “The committee has determined that it is necessary for the protection of the public and in your own interests that your conditional registration should continue.”

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 & Well-being 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 high education-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 3.5 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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WESSEX DENTAL SPECIALIST CENTRE  
FAREHAM, HAMPSHIRE

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**GDPUK launches dental exhibition website**

GDPUK, a website for dentists wanting to share ideas and information, has recently added a dental exhibition review section to its site.

Everyone who is working within the dental arena, including the exhibitors at the events, who are registered on GDPUK, can access the section, Dental Show Reviews.

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.

**New diagnostic tool to help early detection of oral cancer**

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 93 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*. 

*Image credits: Jeff Fitlow/Rice University*
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 Bush 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.’

Murder trial

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, who 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.

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The perfect learning solution

Dental Tribune catches up with online MSc student Elaine Halley

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 peri, endo and caries detection, foundations of occlusion and foundations of material science. We have had a variety of lecturers from Manchester and beyond – including Peter Galgut on peri, 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 incompletes, 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 them...... better get to it!

About the author

Elaine Halley BDS (Glasg) (UK) is the BACD Immediate Past President and the principal of Cherrybank Dental Spa, a private practice in Perth. She is an active member of the AACD and her main interest is cosmetic and advanced restorative dentistry and she has studied extensively in the United States, Europe and the UK.
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 certificates from Dr 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).

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.

In his lively and amusing presentation Dr Omar will explain what constitutes an emergency and engage with delegates about the time-critical ways to tackle them. After establishing what problems may arise in the surgery, delegates will be shown the vital equipment needed by every dental practice, which falls into one of five key categories: oxygen, resuscitation, drug box, portable suction and defibrillation. Dr Omar will then round up by describing the key conditions likely to be encountered in the dental practice including breathing difficulties and choking and the best ways to treat them.

3. Have a chance to speak to the cream of dental manufacturing and service at the trade exhibition. Representatives from each of the companies will be on hand to guide you through the latest innovations designed to make life easier in practice.

Exhibitors include:

- The Dental Directory
- KaVo
- Enlighten
- Numico Nutton
- Practice Works
- P&G Oral Health
- Osmpray
- Wy10
- Costech
- Sybron Implant Solutions
- NSK
- Dental Protection Ltd
- Q3Lant

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

Endodontic success rates vary considerably around the world from 50-90 per cent, which implies that many endodontic treatments are failing. The management of endodontic failure is one of the biggest challenges practitioners will face in modern dentistry, and as a result, many teeth are unnecessarily extracted and replaced with implants. Widely recognised as one of the country’s leading voices in endodontics, Dr Julian Webber will be sharing his views on how to manage endodontic failure.

5. Let your hair down and raise some money as Smile-on, the MOG 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 Grosvenor Square. 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.’

In addition to a delicious meal and fabulous music, Channel 4’s Shamshad Servet Millionaire Seema Sharma will provide food for thought on giving something back to dentistry.

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

- Wyman Chan
- Trevor Bigg
- Sia Mirfendereski

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.

In recent years, the College has created exceptional conference, meeting and banqueting facilities and is accredited to many national and international organisations such as Unique Venues of London and the International Association of Conference Centres to name a few. These facilities are enhanced by an open display of treasures and artefacts, making the College a genuinely unique venue.

9. Broaden your horizon with Dr Achim Schmidt who will be discussing aesthetics and ethics. Dr Schmidt will be drawing from his experiences 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 what they are doing well as there is no quick fix for poor systems. As CQC looms 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
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 demonstrates 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 clinical effectiveness
The aim of dental treatment is to repair the damage caused to teeth and supporting tissues, and to provide personal 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)

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!

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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 Norther accent: ‘The train arriving at Platform 5 is the 6.20pm to Llanfairpwllgwyngyllgogerychwyrndrobwllllantysiliogogoch.’ 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, we were the only people who have a mobility disability as this is a seated job.

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 being the only person with no qualifications I didn’t wear gloves or eye protection, maining wasn’t enough!

Nevertheless, I applied to a local dental practice for the position of trainee dental nurse. The pay was £4.50 per week. I had arrived. I was loaded, until my mother mentioned the word ‘board’. Suddenly my pay was reduced to £5 a week and all the years of being fed and supported came to a halt. I had to pay to live and what a shock to the system it was – as if working wasn’t enough!

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 a patient’s toupee on the end of the high-speed drill, sending it flying away from the dentist as a child, leaving my dad to explain? Dentists, extractions and Jane didn’t go together.

Nevertheless, I applied to a local dental practice for the position of trainee dental nurse. The pay was £4.50 per week. I had arrived. I was loaded, until my mother mentioned the word “board”. Suddenly my pay was reduced to £5 a week and all the years of being fed and supported came to a halt. I had to pay to live and what a shock to the system it was – as if working wasn’t enough!

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 were 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 my illness finally took over my life. Were they really the good old days? Perhaps this is something we can discuss another day.

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.

About the author

Jane Armitage is an award-winning practice manager and has almost 40 years’ industry experience. She is currently a practice manager for Thompsons in Thoms, and holds a Vocational Assessors award. She is also a BDA Good Practice Assessor, BDA Good Practice Regional Consultant, and has a BDA Certificate of Merit for services to the profession. She has her own company, JA Team Training, offering a practice manage- ment consultancy service, which includes on-site assistance covering all aspects of practice management with a pathway if required for managers to take their qualification in dental practice management. If you’re any mem- bers of the early 1970s or any specific choices of topics you’d like addressed, call Jane on 01142 545545 or email jaarmitage@tiscali.co.uk.

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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

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They can be useful when trying to establish confidence and communication with a nervous, quiet, or uncommunicative patient but are of limited value when seeking specific accurate information or a more detailed reply. 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 which patients are asked to complete when attending the practice 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 dental 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 bleedings, 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 status is not static, 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.

Cases brought against dentists have at the heart of negligence claims been over the 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 prescribed by others may change from visit to visit – it is prudent, therefore, to ensure not only that changes in medical history (including medication) are regularly checked and updated, but also that this fact is clearly recorded as a dated entry in the patient’s clinical notes.

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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 may be suitable in the case of dental histories, and is certainly a key part of a dentist’s duty of care. 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 past 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 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 a periodic update of the patient’s medical history.

The ability to attend for appointments could affect the success of complex or extensive treatment, eg 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 patient’s 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
• Keratolentigina in (pilots and cabin crew)
• Stress and its relation to periodontal disease (including episodes of pericoronitis 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 some aspect of their history.

Contact Information

Dental Protection is the world’s largest specialist provider of dental professional indemnity and risk management for the whole dental team. The articles in this series are based upon Dental Protection’s 100 years of expertise, currently handling more than 8,200 cases for over 65,000 members in 70 countries. E-mail: querydept@mps.org.uk or visit www.dentalprotection.org.
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.

Ever 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 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, life assurance (within certain limits) and contributions to 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 accounts, assets and liabilities, employs staff in its own name and enters into contracts in its own name.

Some limited companies have a company secretary who is responsible for keeping the statutory records of the company up to date and filing fiscal returns. In smaller companies, such as dental practices, these duties are usually carried out by the practice’s accountants.

How do I convert my sole trader business or partnership to a limited company (incorporation)?

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 er 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 and purchase 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 normal living expenses. If you choose deferred payments, the terms should form part of the sale agreement.

5) All your existing contracts, including PCT contracts, should be transferred into the name of the new company; PAYE registrations should be reregistered to the new company; and direct debit and standing orders switched to its bank account.

6) 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 partner at Lansdell & Rose Chartered Accountants (UK) 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 7578 9355.
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To 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.

Inefficiency 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 whether 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 the sales literature for the property, and as such, they act as a cautionary for improving the energy efficiency of a building.

Asset ratings

The EPC shows the energy efficiency of a building as an ‘Asset Rating’ in bands from ‘A’ for most efficient, to a less efficient ‘G’ rating. The certificate also gives a numerical indicator of energy performance for each building based on its standardised use. A Recommendation Report is produced as part of the EPC process – a computer-generated document listing recommended changes that could improve the asset rating. An Energy Assessor can provide advice and guidance on how best to improve asset ratings, following an assessment of the property.

Most business owners are decreed by the process of obtaining an EPC. A software model calculates the property’s 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 (SBSM) 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.

A wise move

Given the pressure on the Government to get cracking on their carbon reduction commitment, decreasing your practice’s CO2 output with a 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 of 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 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 anywhere 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 new environmentally dimension 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 helped a number of dental specialist banks develop their service to dental practitioners, including NatWest and Bank of Ireland. For more information, call 084456 125438, email team@ft-associates.com or visit www.ft-associates.com.
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 therapy was regarded initially as having a ‘questionable’ prognosis, were subject to a course of non-surgical periodontal therapy.

Despite the impressive radiographic appearance of dramatically advanced loss, the general 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 reoccurrence 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 8). The patient has been followed for eight years without any significant change to his periodontal and perio-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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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 particular 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 material. From my perspective, it is great to be able to offer a patient a much harder tooth, but one that still bonds well with 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.
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’. 

Effective administration
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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.”
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.

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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.

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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/~sfhwcmu/iaoo/index.html), and the Multinational Association of Supportive Care in Cancer (MASCC) (www.mascc.org/me/page. do?sessionid=27F70516F8F947514C17F98E6CFD17. mcf?SitePageId=46090).

The importance of early detection of oral cancer involves life-threatening. 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 aetiology of oral cancer, and the role of multidisciplinary teams in cancer detection and management. The Faculty include European leaders in the field (Table 1).

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

Table 1 Faculty involved

<table>
<thead>
<tr>
<th>Professor Jose BAGAN</th>
<th>Spain</th>
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<tr>
<td>Professor Marco CARROZZO</td>
<td>UK</td>
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<tr>
<td>Professor Luca Di ALBERTI</td>
<td>Italy</td>
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<tr>
<td>Professor Pedro Diz DIOS</td>
<td>Spain</td>
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<tr>
<td>Professor Jose-Pedro FIGUEIREDO</td>
<td>Portugal</td>
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<tr>
<td>Professor Michele GIULIANI</td>
<td>Italy</td>
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<tr>
<td>Professor Miguel GONZALEZ-MOLES</td>
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<td>Dr Tim HODGSON</td>
<td>UK</td>
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<tr>
<td>Dr Vinod JOSHI</td>
<td>UK</td>
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<td>Mr Nick KALAVREZOS</td>
<td>UK</td>
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<td>Mr Cyrus KERAWALA</td>
<td>UK</td>
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<tr>
<td>Dr Carlos MADRID</td>
<td>Switzerland</td>
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<td>Professor Jukka MEURMAN</td>
<td>Finland</td>
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<tr>
<td>Professor Tim NEWTON</td>
<td>UK</td>
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<tr>
<td>Dr Chris NUTTING</td>
<td>UK</td>
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<tr>
<td>Professor Stephen PORTER</td>
<td>UK</td>
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<tr>
<td>Dr Judith RABER-DURLACHER</td>
<td>Netherlands</td>
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<tr>
<td>Professor Crispian SCULLY</td>
<td>UK</td>
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<tr>
<td>Professor Simon ROGERS</td>
<td>UK</td>
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<tr>
<td>Dr Rosie SHOTTS</td>
<td>UK</td>
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<tr>
<td>Professor Isaac van der WAAL</td>
<td>Netherlands</td>
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<tr>
<td>Professor Saman WARNAKULASURIYA</td>
<td>UK</td>
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</table>

Table 2. Challenges that may be faced by the patient with cancer

<table>
<thead>
<tr>
<th>Many patients</th>
<th>Complications from radiotherapy</th>
<th>Complications from surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>Disturbed taste, mastication, swallowing and speech</td>
<td>Disturbed sensation, mastication, swallowing and speech</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Mucositis</td>
<td>Scarring</td>
</tr>
<tr>
<td>and psychological distress</td>
<td>Dry mouth</td>
<td>Deformity</td>
</tr>
<tr>
<td></td>
<td>Osteonecrosis</td>
<td>Air embolism</td>
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<tr>
<td></td>
<td>Trismus</td>
<td>Pneumothorax</td>
</tr>
<tr>
<td></td>
<td>Dermatitis</td>
<td>Carotid blow-out</td>
</tr>
<tr>
<td></td>
<td>Scarring</td>
<td>Chyle leakage</td>
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<tr>
<td></td>
<td>Hearing loss</td>
<td>Salivary leakage</td>
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<tr>
<td></td>
<td>Laryngeal cartilage necrosis</td>
<td>Nerve damage</td>
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</table>

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 undesirable 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/journaldescription.cws_home/10530441/description#description), the official journal of the European Association of Oral Medicine, the International Association of Oral Pathologists, and the IAOO.

Professor Crispian Scully CBE, MD, PhD, MDS, MRCS, BSc, FDSRCS, FDSRCS (Plast), FFFDRCSI, FDSRCS(S), FRCPath, FFMedSci, FHEA, FRCPath, FMedSci, FRS, FCRS (Lond), DChD, DMed(HC), Dr h.c., UCL, Eastman, 256 Gray's Inn Road, LONDON, WC1X 8LD. UK. Email: crispian.scully@eastman.ucl.ac.uk.
Following the success of the UK’s first public live theatre at the Dentistry Show, DIO Implant continues to boldly progress with its mission to change the face of the UK implant market for the better of everyone. DIO’s Managing Director explains, “For most patients, dental implants are a necessity. At DIO, we aim to bring the benefits DIO provides in overseas markets to the UK.” He continues, “Dental implant treatment should be accessible by any patient who needs it, without compromising on quality of treatment or jeopardising the livelihoods of our valued UK implantologists.”

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

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

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

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

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

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

Once the introductory course is complete, practitioners can confidently decide whether to sign up for the year-long modular course to provide the highest standard of care to their patients. 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.

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.

We hope that our readers will take note of DIO’s course, both educational and marketing, that are excellent tools for dental practitioners to help them achieve their professional goals.
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.

Jan Skrybant reports on Dr David Sonntag course on root canal instrumentation and obturation made in Germany, at the University of Warwick.
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References:

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