SHAs to be axed by 2012 says Dept of Health

Decision welcomed by Southampton residents opposing water supply fluoridation plans

All Strategic Health Authorities (SHAs) are to be abolished by 2012.

The Department of Health (DH) broke the news to the SHAs through a Q&A document which said: "Subject to legislation, the NHS commissioning board will become fully operational from April 2012, removing the need for separate statutory strategic health authorities".

The Department of Health claims that the new independent NHS board will combine functions currently provided by the DH and SHAs, and deliver those in a much more streamlined way.

The move has been welcomed in places such as Southampton where the SHAs decision to approve water fluoridation has been vehemently opposed.

Stephen Peckham, chairman of Hampshire Against Fluoridation, said he is encouraged by the news, particularly as those in office are not keen to force fluoridation without proper public consultation.

All fluoride schemes across the country are currently on hold while the courts examine the decision by South Central SHA in February 2009 to add fluoride to the water in 200,000 homes in Southampton and parts of Hampshire. The judicial review is to be heard in the Autumn, according to the new Health Minister Simon Burns.

Southampton resident Ger aldine Milner is arguing that the SHA should have listened to the views of residents before giving the scheme the go-ahead, after 72 per cent of 10,000 people consulted against the scheme the go-ahead, after 72 per cent of 10,000 people consulted said they were against the idea.

In response to a question in parliament from Dr Julian Lewis over the government’s fluoridation policy, Conservative MP for New Forest East, Mr Burns said: “Section 58 of the Water Act 2005 empowers Strategic Health Authorities (SHAs) to contract with water undertak ers to fluoridate a water supply after conducting public consultations. It is essential that any consultation gives people a real opportunity to make their views known and that those views are taken into account before a final decision is made. The decision by South Central SHA to approve the fluoridation of water supplies to the Southampton area is the subject of a judicial review, which is likely to be heard in the autumn, and so due to the legal challenge the Department is unable to comment.”

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Murderer gets £44k in compensation for poor dental care

The Court of Appeal has reduced a triple murde- rer's compensation to £44,500 after he sued over inade- quate dental care in prison. Michael Steele, serving life for a triple gangland killing, was awarded £66,400, after suffering toothache for nearly seven years. The Home Office appealed against the award made in 2009. The appeal judges reduced his original damages to £25,000 and with interest and £16,000 for Steele's ‘pecuniary loss’, the total payout comes to £44,500.

The court heard how Steele sustained damage to his teeth while playing rugby football. Steele said in his submis- sion that his pain and suffering was aggravated by the fact that he was locked up for much of the day and had nothing to do other than think about his toothache.

The court ruled that the original damages award was out of line with cases of other types by ‘quite a substantial margin’.

The Appeal Court heard how Steele's fillings fell out at Bel- marsh Prison soon after he was given his three life sentences. Since then, while being moved between high security prisons, Steele has suffered ‘persistent severe pain’.

For the third year in a row the fee is £96 for dental nurses, dental technicians, dental thera- peutics, hygiene technicians, clinical dental technicians and ortho-odontic therapists.

The GDC's head of registra- tion, Gurvinder Soomal, said: “The GDC has more than 57,000 DCPS on its register and we want to thank those who have already paid this year’s ARF.

“We now want to make sure that every dental care professional who wants to stay on our register under- stands they must pay by 31 July. If you haven’t paid yet please get in touch as soon as possi- ble. If your employer normally pays for you – check they’ve done so again this year. If you lead a team, check whether your colleagues are up to date. You can also let us know if you have decided to take a career break or not to stay on the register.”

Any DCPS who fail to make the payment will be removed from the GDC’s register and will no longer be able to work legally in the UK.

If they decide to apply to rejoin the register they will have to pay a higher fee of £120.

If you have any questions, you can contact the GDC customer advice and information team on 0845 222 4141 or by email information@gdc-uk.org.

DCPs who fail to pay in time will be removed from the register, warns GDC

D ental care professionals who fail to pay their an- nual retention fee by the end of July will be removed from the register, warns the General Dental Council.

Dental care profession- als (DCPs) who haven’t yet paid their annual retention fee (ARF) to the General Dental Council (GDC) are running out of time.

Payments must be received on or before 31 July 2010 if they want to remain on the GDC’s register and eligible to work.

No payments can be pro- cessed after the deadline.

All dental care professionals must be registered with the GDC to work in the UK, giving pa- tients reassurance that they are meeting GDC standards.

For more information about Smi- le-on and its healthcare education programmes please call 020 7400 8989 or email info@smile-on.com.

Smile-on celebrates 10th anniversary

S mile-on celebrated its 10th anniversary in style aboard the luxury Thames cruiser, the Silver Sturgeon.

Friends and colleagues enjoyed a spectacular meal, while being entertained by a Jazz Quartet, on a trip down the Thames.

A spokeswoman for Smile- on said: “The event provided the company the opportunity to say thank you to all those who have helped the business grow over the past decade to become the UK’s leading healthcare learning provider.

“Those who attended looked back over the journey the company had taken over the last ten years and shared some very special highlights.”

As the boat sailed along the Thames, partygoers took par in a charity auction of which the proceeds will be split between the three charities nominated by Smile-on’s directors: Cancer Re- search UK, Age Exchange and Three Faiths Forum.

The Smile-on spokeswoman added: “Smile-on offers practi- tioners a variety of courses de- signed to inspire, motivate and encourage clinical excellence in dentistry. The business is already looking forward to the future and hopes for another fruitful ten years of creativity, professional- ism, enterprise, trust and most importantly – education.”

For more information about Smile-on and its healthcare education programmes please call 020 7400 8989 or email info@smile-on.com.

Dentist who faked death arrested

a dentist who is alleged to have faked his own death has been arrested in connection with a £1.8m fraud.

Police have revealed that Neil McClaren, 46, previously known as Emmanouil Parisi- sis, was arrested in Peterhead, Scotland. Police said his arrest followed a compliant from the NHS and other financial institu- tions that money had been wrongly paid out following Mc- Claren’s alleged death last year. In total, three people have been charged with conspiracy to defraud financial institutions in excess of £1.8m.

McClaren appeared at Ex- ter Magistrates Court with his wife, Stiliani Theodoropou- lou, and sister-in-law Nikoleta Theodoropoulou.

Emmanouil Parisis was previously listed as a dental practitioner at St John’s Den- tal Centre in Barnstaple. The court heard that the former den- tist faked his own death so his wife and sister could claim £1.8m in life insurance.

Prosecutors claimed Mc- Claren, who was originally from Greece, and travel documents were faked as he looked as if he had died while on a trip to Jordan.

Neither McClaren nor his sis- ter-in-law applied for bail. It was requested for Stiliani Theodoro- poulou, but was refused.

The case has been committed to Exeter Crown Court, where a preliminary hearing took place on Friday 9 July.

Judge Edward Bailey last year ruled the Home Office had been negligent in failing to give him the dental treatment he needed and awarded him £68,400 dam- ages, including £250 for every week of toothache endured.

Lady Justice Smith, sitting in the appeal court, called it ‘a bad case involving persistent severe pain over nearly four years, together with more mod- erate pain for two years and some significant deterioration in the general condition of his teeth’.

Steele was jailed in 1998 for shooting dead ‘Essex Boys’ Patrick Tate, Anthony Tucker and Craig Rolfe as they sat in a Range Rover.
Editorial comment
Learning and growing
Dental Tribune has been in Glasgow recently, attending the International Symposium of Dental Hygiene. More than 1,300 delegates were registered, and this international meeting certainly lived up to its billing! Speaking with many of the delegates there was a real sense of coming together and learning from each other.

‘Perverse incentives’
In a recent exchange in the House of Commons, the new Parliamentary Under-Secretary of State for Health, Anne Milton, gave her response to MP, Sir Paul Beresford, who said the biggest disincentive in the contract is ‘its targets, its units of dental activity (UDAs), its clawbacks’.

Ms Milton thanked Sir Paul for ‘highlighting the perverse incentives in the contract’ and said: ‘It is absolutely critical that we take those out of any new contract’.

The British Dental Association has already begun formal meetings with the new dentistry minister to discuss the issues facing NHS dentists.

Speaking afterwards, Ms Sanderson said: ‘This was a constructive introductory meeting that afforded an opportunity to discuss briefly the issues confronting dentistry in this country. We look forward to continuing this dialogue and discussing in greater depth the issues that have been raised’.

John Milne welcomed commitments on the reform of general dental services. He said: ‘I am pleased to report that the new Minister has committed to continuing the reform of NHS dentistry in England. He has pledged to review the progress so far and then take reform forward. Importantly, he has also committed the new government to discussing change with the profession and to the piloting of long-term change’.

Peter Bateman also gave a positive verdict on the meeting and said: ‘This meeting provided an early opportunity to raise some of the key issues confronting the salaried dentists who treat the most disadvantaged patient groups. A dialogue has begun and I look forward to discussing how care for vulnerable people will develop’.

I really enjoyed the lectures I attended – watch out in future issues for a write-up!

The Smile-on 10th anniversary celebration was held recently on a luxury boat on the Thames. It was a fantastic evening, as the weather was perfect and the company... well it was pretty good too! There was a real mix of guests on board, all enjoying the occasion. There were a few surprises too, with Singing Dentist Andrew Bain entertaining the guests and a moving rendition of Rudyard Kipling’s If by actress Ruth Rosen. The aim of the event was both to celebrate 10 years of Smile-on but also to say thanks to everyone who had supported the company along the way. From the happy smiles on people’s faces as they collected their limited edition anniversary watches and went off into the London night air, I’d say it was mission completed.
NI pay award ‘unrealistic’

Northern Ireland Health Minister Michael McGimpsey has announced the pay award arising from the recommendations of the Review Body on Doctors and Dentists (DDRB) pay for 2010-2011. He revealed that “there will be no increase in net income for independent contractor General Dental Practitioners (GDPs). However, the expenses element of certain items of service will be increased by 0.9 per cent to reflect increase in GDP practice expenses.”

Salaried dentists working in Trusts are to receive a one per cent pay increase.

The British Dental Association in Northern Ireland called the uplift to practice expenses ‘minimal’ and criticised the funding of Health Service for dentistry in Northern Ireland as ‘unrealistic’.

Claudette Christie, BDA director for Northern Ireland, said: “The basis of this announcement is simply unrealistic. Northern Ireland’s dentists have provided health service care to 900,000 people in the communities they serve this year. Salaried dentists working in Trusts treat some of the most vulnerable patients in the community. For dentists to fulfill their responsibilities to these patients it is important they are properly supported.”

She added: “The idea that practitioners can reduce practice running costs does not reflect the reality of a situation where practices face sharply escalating costs. This approach by the Department of Health, Social Services and Public Safety (DHSSPS) is particularly disappointing given their acknowledgement in evidence that in view of a new contract continuing to be some way off, then efficiency gains should not be sought in practice in Northern Ireland.

“With dental practices as small businesses at the cornerstone of communities across Northern Ireland, dentists are all too aware of the difficult financial circumstances we all confront.

“But as clinicians, employing highly skilled staff, they’re also aware of the absolute importance of maintaining standards for their patients and investing in the care they provide. Today’s announcement does little to support those aims.”

New dental training centre appoints leadership team

The new £55m University of Portsmouth Dental Academy has appointed its senior leadership team.

Sara Holmes, newly appointed Dental Academy director, is joined by clinical directors, John Weldon and Sarah Hatridge, and David Radford of KCLLDI has been seconded as director of clinical studies/senior lecturer in integrated dental education and multi-professional care, together with new business manager, Sophie Dampier.

The new Dental Academy is the shared vision of the University of Portsmouth and King’s College London Dental Institute (KCLLDI), and is due to open in September.

The collaboration will see final year undergraduate student dentists from KCLLDI and dental care professionals from the University training together in teams in a state-of-the-art facility.

Sara Holmes commented: “We’re pursuing a model of team training.

“By teaching in a team-based primary care setting we’re breaking new ground in dental education.”

Students and staff will work with dental professionals and health organisations in the area in a joint endeavour to raise the oral health of communities in and around Portsmouth, Hampshire and the Isle of Wight.

The Dental Academy will also offer a proactive and dynamic programme of continuing professional development training events to local dental care professionals and there will be opportunities for new research on integrated dental team training.

Too much regulation says Dental Protection

Dental Protection is calling for less regulation, after being inundated with inquiries from anxious dental professionals.

The indemnity insurance provider has found there has been an unprecedented demand for its advisory services.

Its team of 48 dental-legal advisers has handled 3,700 new case files since the start of the year, as well as responding to almost 10,000 helpline calls over the same period.

Prominent within this additional workload are concerns about the rapid proliferation of guidelines, governance, scrutiny and accountability from many quarters, and the time and costs involved. HTM 01-05, PCT/LHB practice inspections, HWI registration and inspections in Wales, and the fast-approaching Care Quality Commission registration are all part of today’s compliance demands, and General Dental Council revalidation is not that far away.

In response, director of Dental Protection Kevin Lewis, has called for more reasonable and proportional regulation of the dental healthcare environment.

He said: “The controls are out of control. There is a widespread feeling in the profession – and a growing sense of anger and frus-
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Students in Residence
Elaine Halley details the first residential course for the MSc in Restorative and Aesthetic dentistry, held recently in London

The first residential for the MSc was held at the Strand Palace Hotel in London in mid-May. The flight down was an excellent opportunity for me to catch up on the background reading so I arrived feeling well prepared! The residential was compulsory for all students and started with an overview of the remainder of the course by Fiona Clarke from The University of Manchester.

The diversity of the student group was evident – I met students from Kenya, India and Qatar, as well as the many different nationalities working in the United Kingdom – it made for fascinating lunch-time conversations! There is also a real mix of age-groups and experience, from young NHS associates to the not-so-young (myself included) private practice owners.

For many of us, learning about the thesis was nerve-wracking but essential! We are to start thinking about possible topics for this research project which will be a structured clinical review rather than a clinical or laboratory based project. This is to fit in with the distance-learning nature of the course. Fiona advised us that the thesis comprises the last six months of the course starting in May 2011 but we should start collecting references and sources as we come across them. We will be assigned a tutor in due course who will make suggestions and offer guidance but this is a major undertaking – there was some nervousness about the unknown nature of this expressed by participants.

This nervousness was quickly overtaken by the realisation that this is a clinical MSc – we seem to have had it fairly easy in the first unit which has consisted of lectures and assessments. Now, the dentistry is really going to be evaluated – we have 26 clinical cases to submit for Unit 2 and 3 of the course! A lot of time was spent on photography and being sure that we could all take the correct photos and are able to upload them onto our learning plan and send them to be evaluated. I am pleased to report that after a slight panic about how to attach my flash, my photography came flooding back to me – I managed fine although must book myself in for a whitening after seeing my caffeine tinged lower incisors on the big screen!

The clinical cases so far include six whitening cases, simple orthodontics, restoration of the endodontically treated teeth and single tooth indirect restorations. I think we are going to have lectures in the practical techniques but at this point I’m not sure. The current unit’s lectures are mostly about communication, legal record-keeping etc – we have two with Kevin Lewis coming up on Thursday.

After photography, Chris Orr covered treatment planning and shade taking with an eye-crossing exercise in matching values on the computer. All of this with Covent Garden beckoning outside and an ash cloud to disrupt our homeward travel – the joys of CPD.

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About the author
Elaine Halley BDS (Glasg) (FDSRCS) (UK), Immediate Past President and the principal of Cherrybank Dental Spa, a private practice in Perth. She is an active member of the AADC and her main interest is cosmetic and advanced restorative dentistry and she has studied extensively in the United States, Europe and the UK.
Prof wins National Teaching Fellowship

A dental professor from The University of Manchester has won the National Teaching Fellowship and an award of £10,000. Prof Nick Grey (pictured, right) in the School of Dentistry was chosen from nearly 200 nominations submitted by higher education institutions across England and Northern Ireland.

The award of £10,000 from the Higher Education Academy may be used for Fellows’ professional development in teaching and learning or aspects of pedagogy.

Prof Grey has a major role in developing all aspects of the teaching and learning agenda and his main role within the School of Dentistry is in teaching. He has been heavily involved in the development of the new curriculum in Manchester, with an emphasis on Manchester, with an emphasis on learning outcomes in the delivery of teaching and learning.

He has encouraged a team approach to teaching and broadening the student experience across all dental care professions, and has been involved in the recent collaboration with Manchester Metropolitan University.

The Academy, based in the US and founded in 1918, consists of the oldest speciality organisation mainly from North America, Australia and one other European.

Prof Colin Stirling, vice-president of teaching and learning at Manchester, said: “Nick has contributed enormously to the strategic development of teaching, learning and the student experience in his school, and across the Faculty of Medical and Human Sciences where his expertise in assessment, feedback, and student communication have been of immense value to other schools.”

Prof Grey is an examiner for the Royal College of Surgeons and a member of their Advisory Board in Restorative Dentistry. He has lectured nationally and internationally and co-authored one textbook. In 2007, he was awarded ‘Teacher of the Year’ for his efforts in enhancing the learning experience for students.

In 2009, Nick was promoted to professor of dental education and also associate dean for teaching and learning in the Faculty of Medical and Human Sciences.

The National Teaching Fellowship Scheme (NTFS) aims to raise the profile of learning and teaching in higher education and encourages and celebrates individuals who make an outstanding impact on the student learning experience.

The awards will be presented in London in September.

Prof elected to specialist academy

A professor from Kings College has been elected as an associate fellow of the Academy of Prosthodontics.

Prof David Bartlett, head of prosthodontics at the Institute, has been chosen by his peers to join the oldest specialty organisation in prosthetic dentistry.

The Academy, based in the US and founded in 1918, consists of a small group of prosthodontists, all of whom are elected by their peers. There are only two British members, Prof Harold Preiskel and David Bartlett.

The Academy has amongst its members, prominent academic and clinical practitioners, mainly from North America, and its mission is to support and promote the art and science of prosthodontics to the profession and the public. All associate Academy members are mentored during a three-year period and eventually become fellows after a final vote from the membership.

The Academy contains many of the most prominent North American prosthodontists and has amongst its overseas fellows, those from Australia and one other European.

Quick! It’s an emergency!

Medical emergencies are one of the core continuous professional development subjects specified by the GDC. This reflects the importance to a dental practice in addressing this key area.

Meditech, a UK manufacturer of emergency resuscitation systems, has developed a kit to help dental practices meet the recommendations of the Resuscitation Council (UK), recommendations endorsed by the GDC. The kit is being sold through Dental Directory, Meditech Managing Director, Chris Buckenham said: “Dental Directory have the contacts and support structure to enable dental practices to easily implement this solution”.

The kit contains all the equipment recommended except the drugs and defibrillator: Portable oxygen cylinder (D size) with pressure reduction valve and flowmeter; Oxygen face mask with tubing; Basic set of oropharyngeal airways (sizes 1, 2, 3 and 4); Pocket mask with oxygen port; Self-inflating bag and mask apparatus with oxygen reservoir and tubing (1 litre size bag) where staff have been appropriately trained; Variety of well fitting adult and child face masks for attaching to self-inflating bag; Portable suction with appropriate

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As a result of Chancellor George Osborne’s first Budget, VAT is going up, Capital Gains Tax is going up and the Annual Investment Allowance is decreasing, according to The National Association of Specialist Dental Accountants (NASDA).

But it is not all bad news. The hike in Capital Gains Tax - up from 18 per cent to 28 per cent - has been offset by continuation of Entrepreneurs’ Relief, which has been retained and actually extended to cover lifetime gains of up to £5m. This will keep the tax rate on dental practice sales and incorporation at 10 per cent. Also, large practices and corporate groups with profits more than £500,000 will see tax rates reduce from 28 per cent to 24 per cent with a series of one per cent reductions starting on 1 April 2011.

The increase in VAT will not directly affect dental practice income, but the cost of dental supplies and services will rise as a result of the higher VAT rate. Some patients may feel that they have less money to spend on dental care as they pay out more VAT on many essentials.

The reduction in tax relief on dental equipment will be unwelcome news for any dental practice planning an overhaul and for the trade. The main rates of annual allowances will go down by two per cent (to 18 per cent or eight per cent ) and the Annual Investment Allowance limit will reduce from £100,000 to £25,000 in April 2011. Dentists who have practice refurbishment in mind should consider doing this before next April and probably before January to save VAT and maximise tax reliefs on spending.

The personal allowance - the amount all taxpayers can earn before they are taxed - will be increased by £1,000 to £7,475 for those aged under 65 next April. However, the basic rate limit will be reduced so that higher rate taxpayers do not benefit from the increase in the personal allowance. Dental nurses should benefit from this tax break, which is worth £200 per year to basic rate taxpayers.

The new chancellor has shown his support for employers with changes to National Insurance Contributions (NICs). The threshold at which employers start to pay NICs on employee wages will increase by £21 per week from 6 April 2011. This will produce an annual saving of up to £140 per employee.

In an incentive to new businesses, plans have been announced to reduce NICs payable by new employers. This could give a boost to squats and will apply to business starting after 22 June 2010, although the relief will not be fully implemented until September 2010 at the earliest. The countries and regions which will benefit will be Scotland, Wales, Northern Ireland, the North East, Yorkshire and the Humber, the North West, the East Midlands, the West Midlands and the South West.

Company tax rates are to be reduced - from 21 per cent to 20 per cent from 1 April 2011 - which may provide an incentive to some dental practices to incorporate. Tax payable on incorporation has not gone up as had previously been thought.

However, some in the profession will feel the brunt of higher taxes on a personal level as gains on sale of quoted shares, second homes and other investment assets will be hit by the new tax rate, thus adding 10 per cent to some tax bills.
It’s never too late to build a dream team
says Seema Sharma

If it wasn’t for the people...

D

talent practices set out planning to have the right staff with the right skills, qualifications, experience and knowledge to look after patients and the practice. Somewhere along the line, things go wrong, teams malfunction and emotions run high. When one of my own practice managers has a bad day at the ranch, nine out of ten times the complaints are about a team member who did not pull their weight or a process that went wrong which could have been prevented with some pre-planning or effort on the part of a team member.

So what goes wrong? Dental practices are busy places and time is at a premium! There are few other professions where everyone has to be on stage from the moment they arrive to the moment they leave. As small businesses, we do not have the capacity to have “floating” staff, recruitment is expensive and we cannot afford to lose a nurse, and phones are in with patients all day. Any spare time a nurse has is likely to have to be spent on decontamination these days!

All problems therefore end up at the practice manager’s doorstep, who can easily find that fire fighting chews up half of his or her time.

Rebuild your dream team in five simple steps

It’s worth reviewing the processes that are in place for “people management”, to see where things can be improved. A good leader creates vision for the practice and a good manager knows how to implement that vision by selecting appropriate team members for each role, and nurturing their individual strengths. In many smaller practices the leader’s and manager’s roles overlap, and the owner and manager work closely to implement the vision.

Each time we recruit, we try to get “the right person” but if you feel let down by your team, there are five steps that practice managers can put in place to create the culture that they want within the practice.

STEP 1: Create a team manual

Each time a new team member is recruited, there is potential for miscommunication and disruption to the practice. It is possible to minimise this by taking the time to develop a dedicated staff handbook or team manual as a handy reference tool. This should include day to day operational procedures, code of conduct, practice policies and procedures, health and safety, infection control, information governance and local child protection pathways.

STEP 2: Tighten up on Rotas

Unplanned absence is the bane of every practice manager’s life! Persistent offenders need to be encouraged to take ownership of the disruption caused to patients and the practice, without the practice manager having to turn into an ogre.

Most managers are familiar with PLANNED holiday charts to organise rotas, but try putting up an UN-PLANNED leave chart. Mark planned absence in GREEN and unplanned absence in RED and without saying too much you will find that persistent offenders are embarrassed into mending their ways.

STEP 5: Repeat the mantra - Smile you’re on stage!

Encourage a culture of accepting that everyone is human but when the team is at work, personal problems are left outside the front door. It is important for the practice to be supportive of individuals with personal problems, when appropriate, but to know how to ensure that they do not impact on patient care. By taking the time to understand individual strengths and weaknesses, and acknowledging that life outside work can imbalance emotions, practice managers command respect, instead of demanding it.

STEP 4: Re-induct using CQC as your goal

Tell the team that you are getting organised for Care Quality Commission registration, which all practices are affected by from October 2010, and focus on the first two sections - patient information and involvement, and personalised care, treatment and support. (If you are not up to speed on CQC yet, email seema.sharma@dentabyte.co.uk to find out the outcomes that are expected from dental practices)

CQC registration provides a timely reminder that teams should be able to demonstrate:

• Practice culture and values – it is key to ensure team members understand the vision created by the leader of the practice.
• Organisational structure – outline of each team member’s role as an individual and within the team.
• Policies and procedures – tell the team about your new team manual!

STEP 5: Appraise and develop

Staff training needs should be identified and supported, with protected time for learning and development to optimise the team’s skills, happiness, performance and staying power! Ideally a practice should have monthly meetings for clinical governance, training and practice management, to keep the team aligned. The quality of the service being provided by the team should be audited regularly and training arranged to align the skills and work of those who are not on track.

Key tips for practice managers

• Define individual roles
• Create clear job descriptions for all roles
• Ensure advertisements clearly outline the role which the candidate is applying for
• Treat all applicants equally by using template interview forms and processes
• Offer the job in writing and provide written terms and conditions (contracts or licences)
• Conduct thorough pre-employment checks
• If the new staff member has a probationary period, ensure the details are outlined in the offer letter
• Put new staff members through an induction process
• Provide all team members with a staff handbook / team manual outlining practice policies and procedures
• Organise and record all staff training and continuing professional development
• Monitor individual performance
• Conduct annual appraisals for all team members
• Ensure that all team members have personal/professional development plans to maintain and develop their individual skill sets
• Be aware of the human resource legislative frameworks around working times, holidays, rest breaks, disciplinary procedures, stress, disability etc
• Maintain an accurate HR record for each team member

Tomorrow’s Manager

So how does a practice manager fit all this in? Tomorrow’s practice manager needs to learn to work smarter not harder, to run a smooth practice and maximise the team’s potential. Email the author at seema.sharma@dentabyte.co.uk for a job description for the practice manager of the future, then set about developing your skill set. Your knowledge will translate into an increased bottom line and a stress free practice, your boss will be happy!

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Feature

DENTAL TRIBUNE

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About the author

Seema Sharma qualified as a dentist but gave up clinical work after 10 years in practice to go into full time practice management. Today she runs these programmes, including one which is a multi-disciplinary specialist centre. Seema established Dentabyte Ltd to provide affordable “real-world” practice management programmes to help practice managers and practice owners keep pace with the changing clinical and commercial environment facing them today. Visit www.Dentabyte.co.uk to register for updates on practice management and email Seema at seema.sharma@dentabyte.co.uk to find out more.

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Question time for Tory policy

Addressing an audience of general dental practitioners at Addenbrookes Hospital, Cambridge, Secretary of State for Health, Andrew Lansley, outlined the Conservative Party’s policies on NHS dentistry. Neel Kothari reports

Firstly, wherever possible, people should have equal access to NHS services. Although NHS dentistry has always been different in that dentistry has not always been free at the point of delivery, in general, we believe NHS dentistry should be part of a service funded through general taxation, and wherever possible, people should expect to have equal access to NHS dental services. This does also mean that we do not want to go down the path of separating NHS dentistry into two parts, for those people who cannot afford private dentistry and for those people who cannot access NHS dentistry, we firmly would like to give everybody a sense that they do have access to NHS dentistry.

Secondly, we want have a service centered around patients and address what they are looking for, their expectations and their needs. We want to move away from an NHS designed from the centre and then handed out to public and move towards a service designed around the public’s needs.

The next principle is that we should, wherever possible, seek to maximise beneficial health outcomes. Where dentistry is concerned like other areas in the NHS I want us to be thinking about what the new contract would look like (not the one we currently have). I had met with many dentists involved with PDS pilots and it seemed to me on the face of it the new contract was designed to be based on the experience of the PDS pilots.

So why did all of this happen?

‘I had met with many dentists involved with PDS pilots and it seemed to me on the face of it the new contract was designed to be based on the experience of the PDS pilots.’

From the public’s point of view this has not delivered; we are still in a position where overall the public’s access to NHS dentistry is less now than it was just prior to when the new contract was introduced.

In the short run this did precisely the opposite, as 1,000+ dentists said we really don’t want to go down the path of this new contract. Dentists will understand about some of the perversities of the new contract probably better than I do. I find it very strange when you go around the country and ask dentists ‘how much are UDA’s worth here?’ and you get very different results in different parts of the country and sometimes you can have very different results within the same PCT area.

It is also very perverse how the UDA structure creates a powerful incentive to pull a tooth out rather than carry out proper root canal work as well as many other perverse incentives you should not be surprised if people behave in perverse ways.

The next principle is that we should respect this and try wherever possible, to allow PCTs to go out and buy services, and that access doesn’t matter, but I certainly do resist the proposition that access is the only measure that matters. I’m not saying that access doesn’t matter, but I certainly do resist the proposition that access is the only measure that matters.

The history of the current NHS contract

If we go back to the point at which there were PDS pilots and dentistry was contemplating what the new contract would look like (not the one we currently have), I had met with many dentists involved with PDS pilots and it seemed to me on the face of it the new contract was designed to be based on the experience of the PDS pilots. To a considerable extent we were quite supportive of the pilots and felt optimistic that this was to be the case. What of course happened was that the new contract seemed to almost ignore them.

The new contract seemed to almost ignore them.

The last of the principles I will try to apply is to do with the working professionals within the NHS. The NHS is an organisation based on 1.3 million personnel, the great majority of whom are health professionals and should be treated like professionals. All of you have [addressing the audience] professional judgements, professional competencies and qualifications often acquired over a considerable period of time with a considerable amount of effort on your part and we should respect this and try and deliver the best possible service by recognising in every walk of life the best way of achieving any outcome is to have a positive engagement with the staff who are trying to deliver it. This is not done by competing or by making life more difficult for staff. Managing to deliver an outcome is about managing with and through people who work in the service.

Dentists now share along with GPs in the results of a government that has become completely obsessed with being able to tell the public that they are going to have increasing access to services, and that access seems to be the only measure that matters. I’m not saying that access doesn’t matter, but I certainly do resist the proposition that access is the only measure that matters. Introducing the new dental contract allowed PCTs to have control over the dental budget and was aimed to allow PCTs to go out and buy more access.

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MP Andrew Lansley

Andrew Lansley, Secretary of State for Health, outlined the Conservative Party’s policies on NHS dentistry. Neel Kothari reports.

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCLA Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes brought about through the introduction of the new NHS system. Like many other dentists, he has concerns for what the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.
Half Brained website?

Iain Scott highlights how dental websites need to focus not only on aesthetics, but also on function.

It is rarer to see websites that have both effective design and function, these I’d define as being full brained: not only is the design captivating, influential and appeals to the general dental patient (or potential patient), but the site’s functionality works: it’s quick to load, easy to navigate and all the relevant information is easy to find as it’s right where it should be.

This is the advantage of using a good web design agency that have a team in place with both right brained designers and left brained developers working on the website design projects. Their work is balanced and effective; it attracts qualified potential patients through effective Search Engine Optimisation, and then converts them into paying patients through excellent conversion tools from the design.

You may be aware that the different sides of the brain are responsible for different functions; the left half of the brain is logical, analytical and objective, whereas the right half is random, intuitive, creative and subjective. In the many of people, one side of the brain is dominant leading to distinct personalities and skill-sets: left brained people tend to be methodical, organised, technical, deep thinkers, while right brained people are geared towards being creative, abstract and conceptual thinking.

Looking around our studio, I see developers typing away, boxes furrowed in concentration, writing the lines of code and planning the infrastructure that makes our websites work. Clearly they are left brained. Across from me I can see David, our lead designer; he’s leaning back in his chair, focusing on his sketch pad, thinking about design concepts and ideas for one of our current projects, creativity oozing from him: clearly he’s right brained, guided by his imagination and powers of visualisation.

Not a team effort

It is amazing how many dental websites I see that have clearly been put together by only a designer: they’ll be visually exciting, quite often with striking graphics or animations, but lack easy navigation, the structure is not intuitive and they are virtually invisible to the search engines. Alternatively there are many that have been put together by only a developer or programmer: the website design will be laid out in an orderly fashion, there may be one or two graphics, but nothing creative. On the other hand, it will probably do well from an SEO point of view (attraction) as the content will be well organised, and it’ll have been built with future updates in mind.

However, will it actually promote the practice and lead to increased sales, almost certainly not! Clearly, more attention is required for conversion.

For both types of websites, I’d describe them as being only half brained, not through any fault of the site author, but just because of the way the human brain functions.

About the author

Iain Scott is managing director of website design agency, Base Creative. He will be speaking at the BACD Conference, Esthetics Meets Aesthetics, on 25-26 September 2010 at the Hilton London Metropole. To register, visit www.basecd.org.
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Cosmetic Tribune

The wonders of teeth-whitening treatment!

Giving the people of Liverpool beautiful teeth behind happy, confident, smiles says Dr Daz Singh BDS

In the heart of Liverpool city centre sits a unique, award winning cosmetic dental clinic. Ollie & Darsh is the most exciting new cosmetic dentist around and has a simple ethos: to provide the people of Liverpool with beautiful teeth behind happy, confident smiles. With a range of treatments available to help members achieve and maintain the best possible dental health, Ollie & Darsh prides itself on its professionalism, skill and relaxed, stress-free environment. This isn’t just an idle claim either: last year Ollie & Darsh received the Most Attractive Practice award at the Private Dentistry Awards 2009; a fantastic achievement for any dental practice old or new.

Confidence to smile

Ollie & Darsh offers an extensive range of treatments designed to give confidence to patients and peace of mind with regards to dental hygiene and general oral health. Dr Daz Singh BDS, is the Co-Clinical Director at Ollie & Darsh, and is passionate about furthering his learning in the field of dentistry, having learnt under the guidance of internationally renowned dentists in both the UK and the USA.

A highly popular and relatively new form of cosmetic dentistry is teeth-whitening. Dr Singh decided to introduce this treatment at Ollie & Darsh and explains why, “Whitening treatment has become very popular and is one of the most frequently requested forms of cosmetic treatment. In today’s society, people are increasingly aware of not only the health of their teeth, but also their aesthetic appeal. As a result of this, myself and doubtless many other practitioners have noticed a sharp increase in the demand for teeth-whitening treatment. We offer clients three extremely effective teeth whitening treatments, all of which are approved by the British Dental Health Foundation. The latest “laser” whitening technique is called Zoom 3D Advance as is without doubt the quickest way to lighten your teeth by up to ten shades.”

Choice of suppliers

There are many whitening products available on the market today, so the choice of suppliers is potentially enormous. How did Dr Singh decide which supplier was right for his practice?

“When deciding on which supplier to use, it was an easy decision. I chose Discus Dental. Having used and experienced the products from Discus Dental for many years now, I have always found them to be easy to use, highly effective and good value for money; I saw no reason to look elsewhere. I am currently using Zoom 3D Advance at Ollie & Darsh, which is the most recent addition to the Zoom range, and, having used the previous versions, I felt comfortable and confident that both my clients and myself would benefit from using it. Discus Dental is well known for whitening products and is, in fact, the world leader in this category. The company seemed like an obvious choice, and the fact that I have had positive, first hand experience of working with them made my decision all the easier.”

Whitening Wednesdays

As with the introduction of most new concepts, intelligent marketing plays an integral role. Due to the fact that many other dental practices offer whitening treatment, it was essential that Dr Singh thought carefully about the best way to go about promoting Ollie & Darsh’s own unique teeth-whitening service. He explains, “I was aware of the need to make our whitening treatment stand out amongst the crowd of other clinics offering the same service, and, as a result, the marketing was given a lot of thought. After much consideration, we decided on promoting our whitening treatment by offering 50 per cent off Zoom 3D Laser Whitening every Wednesday. We called it Whitening Wednesdays.”

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day and our aim was to attract our existing (and potential!) members, by offering a very popular treatment for outstanding value once every week. The response was immediate and very impressive! We have certainly seen a significant increase in our profits since the special offer incentive was launched and have experienced a noticeable growth in client requests for whitening; we’ve even taken the occasional referral from other clinics.”

**Client Feedback**

With teeth whitening treatment in such high demand, how have clients at Ollie & Darsh responded to the ‘Whitening Wednesday’ incentive?

“The ‘Whitening Wednesday’ special offer has been a total success with clients. We’ve received incredibly positive feedback from all our clients who have had Zoom 3D Laser Whitening treatment and many more have booked appointments. What many people don’t know is that you only need a single 90-minute appointment to whiten and give sparkle to your smile. It’s an extremely efficient and efficient form of treatment.”

Having used Discus Dental as suppliers for the teeth-whitening product Zoom 3D, Dr Singh offers an insight into working with Discus. “Having successfully launched, marketed and reaped the financial rewards of a new treatment within the practice, what advice would Dr Singh have for other practitioners musing on following suit?

“I would encourage any dentist considering launching a new treatment like whitening, to think carefully about the way in which they plan to market it. It’s such a crucial aspect of any business, and one, which, if done effectively, will draw in new clients and impress your existing ones! In addition to this is making sure that you have a reliable, professional and expert supplier as this makes a massive difference. Working with products that you have faith in and know to be highly effective and efficient is vital, it gives peace of mind to both practitioner and client. I’ve been delighted at the success of ‘Whitening Wednesday’s’ at Ollie & Darsh. It’s clear to me that by combining strong marketing and excellent product suppliers, you are guaranteed success!”

For more details call Discus Dental on 01923 850423.

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**Dr Daz Singh of Ollie & Darsh**

Dr Daz Singh BDS is Clinical Director at Ollie & Darsh.

He is a great sports enthusiast and enjoys playing football and cricket. He is also an avid West Bromwich Albion Fan. Dr Singh graduated from the University of Liverpool and has settled and worked in the city ever since.

He has passionately sought further learning and under the guidance of internationally renowned dentists in the UK and the USA, has honed his clinical ability to provide the best level of care for patients at Ollie & Darsh.
The new ‘old’ technology
Neil Photay and David Hands look at All-ceramic restorations

There is an old saying that ‘nothing is ever invented and perfected at the same time.’ Take a moment to consider the advancements seen in the dental industry and it’s clear that many innovative techniques and materials have required a great deal of refinement in order to become successful treatments patients now benefit from today.

Consider restorations. In the past the profession has seen great leaps forward in the materials and methods used to create and fit restorative implants. One of the central concerns of any restorative work is the balance between strength and aesthetics of the implant. The progress made using titanium helped address some of the strength issues, but clinicians have long known the aesthetic limitations of metal. As a result, maintaining the aesthetic integrity has always been a challenge.

In today’s image-conscious society, providing restorations that are aesthetically pleasing is often now a priority for more patients. Clinicians who address this demand are the ones who will ultimately benefit from a developed patient base: that is why it is time to reconsider all-ceramic implants.

At the time of its introduction, when dental professionals did their research, they found that while the all-ceramic could meet the aesthetic needs, it was compromised by a lack of strength and durability. Like so many new innovations, it failed to live up to the expectations.

But that was then. Now there have been great advances in both the materials themselves as well as the technologies at the disposal of dental laboratories to create outstanding restorative work that surpasses all expectations in terms of both strength and aesthetics. All-ceramic has had time to mature into an effective restorative solution, and this is supported by an abundance of research and clinical evidence.

Cubic zirconia possesses several advantages over traditional crown and bridgework materials of metal and porcelain, but chiefly it possesses the strength required to maintain a durable restoration whilst retaining the advantage of being lighter and more natural looking. One criticism leveled at zirconia in the past is that it is not biocompatible, but how compatible is metal? Many clinicians are seeing less of an allergic reaction between the all-ceramic restoration and the gum line, maintaining the aesthetically pleasing nature of the work, to the overall satisfaction of the patient.

As well as materials, the technology has undergone rapid transformations over the recent years. At the scanning stage, the model created from the impression taken is scanned by a machine capable of providing a phenomenal 100,000 points of data per laser-triangulated scan. This means an accuracy of 20 microns is achieved and helping to create a finished product engineered to the highest degree of quality.

Those dentists already using all-ceramic restorations are seeing the benefits of being able to market the work as a more cost-effective solution, and the opportunity it presents to grow patient base and treatment acceptance.

**About the authors**

Neil Photay BAC (Elites) GDC Reg. Technician. Neil proudly carries his family tradition of working in the dental industry and creating and manufacturing dental innovations and technologies. Working at both the_cos Tech Laboratory and family dental surgeries from the age of 16, Neil completed a BSc(hons) in Computer Science, before returning to the CosTech Elite Laboratory in 2003.

The aesthetics of dental restorations have always been important and over the last few years there has been a big increase in both the demand for, and the supply of cosmetic dentistry. There are ultimately three factors responsible for this – the media, patients and dentists themselves.

However, the fact of the matter is that some modern cosmetic treatments may give little or no thought to the future of the patient or what will happen to them down the line. With treatments such as veneers and implants on the rise, dentists should be asking themselves, “what is best for the patient?” not “what does the patient want right now?”

Denplan’s Chief Dental Officer, Roger Matthews, interviews Professor Richard Ibbetson to discuss the ethical implications of ‘selling’ cosmetic dentistry and how much dentists should allow themselves to be influenced by the desires of their patients.

In your opinion, what is the dentist’s ethical obligation to their patient when it comes to cosmetic treatments?

“In my view, any dental treatment undertaken should always be:
- Safe
- Conservative
- Predictable
- Patient directed
- Dentist monitored

“Many patients will come into a surgery convinced of the treatment they want. It is the dentist’s job to ensure the decision is not rushed, that less invasive routes are explored and that the risks are discussed in full. We are taught as business owners that the customer is always right, but when measuring the aesthetic outcomes of various treatments, what the customer perceives can be subjective. In fact, many patients will be open to trying less aggressive procedures first, when they are fully appraised of the potential downside of their initial preference.”

It has been a rising trend for many years now that amalgam fillings are being replaced with the more aesthetically pleasing composite fillings. Is this a problem?

“In many cases dentists use composite as a matter of course, without ever giving patients the choice. There are some situations where composite is the best material for restoring a posterior tooth as it can be more conservative of tooth tissue. However, dentists know that direct composite fillings, particularly large ones, are more difficult to perform and have a significantly shorter life-span.

“As oral healthcare professionals, obliged by codes of practice, we should therefore always talk through potential risks with patients in order for them to make an informed decision. In the same way that dentists will often choose amalgam fillings for their own treatment, in practice I have found that patients are far more open to amalgam, when they understand that composite fillings are not without their disadvantages.”

What impact has celebrity culture had on the profession?

“Celebrities such as Britney Spears and Simon Cowell have a lot to answer for when it comes to dental treatment! Their “too-perfect” teeth have all too often brought peo-
ple into the dental surgery with unrealistic goals, which subsequently can pose a moral issue for the treating dentist.

"The risks involved in porcelain veneers are significant, but this fact is often lost on people who are continually bombarded with images of ‘perfect’ teeth in the media. Although fracture or loss of cementation of a veneer is rare, deterioration in appearance particularly due to marginal discoloration is more common and constitutes a failure. Therefore, it is our responsibility to inform patients of the risks and benefits of veneers before they willingly agree to the removal of healthy tooth structure.

"Interestingly, an increasing number of people opt for veneers simply to make their teeth whiter. For a dentist to agree to this method of treatment solely for this reason is unethical, as more often than not, the results look unnatural, over the top and simply odd. In many cases, bleaching teeth can achieve much of the desired result without the loss of healthy tooth structure. It is one of the least harmful procedures and many patients who were considering aggressive treatments such as veneers are often completely happy with the results of whitening alone."

"This illustrates why dentists should always explore a range of options with the patient (including no treatment), before agreeing to a more complex approach. Investigating other avenues allows the patient to make an informed decision and the dentist to convey the benefits and risks of each procedure, while protecting professional ethics. Remember, just because a patient says they want something, does not mean that a dentist must do it."

Another trend to appear in recent years is that of ‘instant orthodontics’. How do you think this will affect younger patients?

"More and more patients, young adults in particular, are coming to dentists for treatments such as implants and veneers to avoid the traditional ‘train-track’ orthodontic route. This, however, is simply bad dentistry. To destroy good teeth for a quick aesthetic result is not only unethical but will subject the young patient to a lifetime of repeat treatments and recurring problems."

"As a profession we should be ensuring that teeth last out long, not the other way round. The first principle is to preserve the patient’s tooth structure wherever possible. The life of the tooth is far more important than the life of the crown or veneer. Treatments such as all ceramic crowns and aggressive preparations for veneers may mean the extensive removal of tooth tissue. In the event of a restoration failure or future problems, there can be little tooth structure left to work with."

"As healthcare professionals we should be continually working under a system of compliance, education and communication. All dental treatments are temporary: deterioration and failure are inevitable. Dentists should reflect on modern trends and decide whether the demands of their patients outweigh their moral obligations. As such, it should be a matter of professional pride to decline treatments if they are felt to be unnecessary or unethical. If we fail to do this it is only a matter of time before we are truly a lost profession."

**Final thoughts**

I didn’t know it at the time, but back in the Seventies I became an enthusiast for minimally invasive dentistry. Back then, the idea of keeping as much tooth structure intact seemed much more appealing than gambling on the success of full dentures and this is still true when looking at the costs of implants today.

It is clear that both Richard and I are keen supporters of prevention where possible and high-quality preservation when appropriate. To act otherwise is a breach of our professional ethics: and this should apply whether the impetus for treatment originates with the dentist’s diagnosis or the patient’s aspirations. Both are legitimate, and both need the same care in evaluating."

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**Prof Richard Ibbetson**

Richard Ibbetson – Director, Edinburgh Postgraduate Dental Institute and Honorary Consultant in Restorative Dentistry, Lothian Primary Care NHS Trust. Richard graduated from Guy’s Hospital in 1978 and completed an MSc at the Eastman Dental Institute in 1981. He worked at the Eastman for 20 years before taking up the post of Director of Postgraduate Dental Institute in Edinburgh. His main clinical interests centre on the postgraduate teaching and practice of Fixed Prosthodontics.
ABB (Alignment, Bleaching, Bonding)

The Treatment Sequence that should change Cosmetic Dentistry says Tif Qureshi

This article will outline how the combined and simultaneous use of the Inman Aligner, tooth whitening followed by edge bonding can redefine the approach taken to smile design. It also highlights how it will help dentists respect a patient’s decision as their treatment progresses rather than short-circuiting to an end result using ceramics setup with classic smile design principles.

Discussion.

“Changing cosmetic dentistry” might seem like a pretty big goal, but it’s become very clear from lecturing and writing about this particular discipline that it creates a huge amount of excitement and positive reaction. Dentists see the logic in it very quickly and can also see how, with some education, they can employ a safe, low risk technique that they know their patients will want and will massively change their approach to cosmetic and aesthetic dentistry. They also understand that there is a massive market of patients who will accept this kind of non-invasive treatment happily.

Treatment with the Inman Aligner has been further developed in the UK where techniques are used to make it dramatically effective as a solution for certain mild and moderate anterior orthodontic issues. Cases, which traditionally would take six-10 months with clear aligner systems can, with education, be treated in six-16 weeks.

We have all seen how bleaching can affect a smile. We know how much bonding can improve aesthetics and tooth anatomy. Now that alignment is potentially so simple, these three disciplines have been brought together to create results that easily challenge traditional veneer based smile makeovers. And, if the three treatments are combined with some thought, it is possible to massively improve a patient’s smile in around three months.

All of a sudden the six-10 unit veneer case used for a smile makeover can look ridiculous and be seriously in danger of becoming over treatment. There are always situations where ceramics are highly appropriate, such as in wear cases or in major reconstructions, but for anyone with good quality intact enamel, I believe this kind of treatment represents a far more ethical, patient centric approach.

This is because I believe the way smile design is approached, and perhaps even taught, is wrong. The final outcome, for what is aesthetic and important, Golden proportion ideals, tooth width ratio, gingival zeniths etc all together create something we know to me almost mathematically correct. The problem is that most dentists’ experience their smile design education attached to a lecture or course based on veneer dentistry. As a result dentists will naturally think this to be the only and perhaps fastest way to achieve a “perfect smile”.

If we assess a patient’s smile and try to preview an end result at the first consult, using imaging software, a wax up or even a preview try in, we are not really letting the patient see their teeth improve at different stages to see if their expectations are being met along the way.

The smile design rules are there, but how many patients if they see their teeth improving with alignment then bleaching and then bonding, would actually then take another step with porcelain and some tooth destruction to achieve total perfection? In my experience, very few.

Some still do go further, but at least by then their teeth are straight and we can use truly minimal and almost no prep veneers to improve the aesthetics further.

Most of the time, once we are 3/4 through alignment and start to bleach it becomes very clear that simple bonding is all that will be needed to create a very aesthetic smile that previously would only have been achieved with aggressive veneer preps.

The case outlined below is a typical case of a patient who once wanted and considered having porcelain veneers. Instead she opted to align her teeth then bleach and bond.

Case and Diagnosis

This 32-year-old patient complained about the “crooked look” of her smile. The patient was aware of what a smile makeover could achieve, but wanted to achieve something without damaging her teeth.

On examination several problems existed. Firstly her teeth were moderately misaligned. This created aesthetic issues immediately. Large unsightly embrasures were made worse around the canines. The standing laterals appeared darker and in the shadow of the lips, the left one being in slight cross-bite. With the centrals spayed out and rotated the line angles of the four incisors were all different.

It was clear at the start by examining the incisal edges that there had been differential degrees of wear meaning that even if the teeth were aligned, the incisal outline would
still look uneven - this meant we needed to have a conversation about some potential edge build ups after.

All options were discussed. The patient ruled out fixed braces, even with more recent faster techniques because she wanted something removable and we had also discussed the possibility of simultaneous bleaching during the alignment phase.

We assessed for an Inman Aligner. At the consultation the occlusion was examined and it was clear that the laterals had room to advance labially and the centrals could also be derotated.

We then needed to assess the actual amount of space needed. Inman Aligner cases should be planned carefully to ensure the case is suitable and also to understand how much space needs to be created. This can be done with models using Hanchers technique 9; The SpaceWize tm crowding calculator was used to assess the patient in the chair.

An occlusal photo was taken with a mirror and the upper central tooth was measured with digital calipers to help calibrate the software.

The occlusal photo is uploaded and the calibration tooth details entered. The mesial distal widths are simply drawn on for all the teeth to be moved which Inman Aligner treatment is always the front 6 teeth. The software calculated the total of the mesial distal widths and this is described as the Required space. An ideal curve is then plotted with the software with the proposed final position. This is made with occlusion, aesthetics and function taken into consideration. The curve can be manipulated easily with the software and this is the amount of space that needs to be created to achieve the final result.

As can be seen in the SpaceWize tracing, 3.1mm of crowding was present. This may seem less than expected when considering the degree of crowding when looking at the occlusal photo, but because the laterals are advancing forward, this will actually create space.

It was decided that an Inman Aligner with incorporated expander would be used to treat the case. Incorporating expanders are a useful tool to create space supplementary to IPR or as an alternative. They must not be expanded beyond 2.5mm and only supply a temporary degree of space to allow the anterior teeth to align. The small degree of posterior expansion will always re-lapse and the midline can even be unwound after the anterior teeth have aligned. Each turn produces 0.25mm of space.

Treatment sequence

The Inman Aligner was fitted at the next appointment. Instructions were given and only a small degree of IPR was performed over the front teeth (0.1 mm per contact).

No IPR was performed initially around the centrals because with the degree of crowding it would be easy to miss the contact point. Instead the teeth are stripped strategically and progressively meaning we release a little room to allow the teeth to align then we re-perform IPR over several visits again only performing a little at a time.

Critically Inman Aligner treatment uses progressive anatomically respectful IPR. Despite calculating the amount of crowding present, the IPR is never carried out in one go. IPR strips or discs are only used. This gives the opportunity to ensure the stripping is far more anatomically respectful than using burs or heavy discs.

This massively reduces the risks of excess space formation, gouging or poor contact anatomy. The contacts are smoothed and the fluoride gel is applied each time.9,10 Composi-te anchors were also placed on the palatal incisal edge of the instanding lateral teeth to ensure the palatal bow engaged correctly.

The patient was also shown how to turn the midline screw. She was instructed to do this once a week and did this for seven weeks, but was seen every 2-5 weeks to check progress and re-perform a little IPR if necessary.

The patient was instructed to wear the Inman Aligner for 16-20page 20
After nine weeks the laterals were already getting close to the proposed position and the centrals were de-rotating nicely.

At this point with Inman Aligner treatment we often start to bleach. Impressions are taken even though the result is 25 per cent from finished.

Sealed, rubber trays are made and careful instructions are given.

While the patient is highly concentrated on using the Inman Aligner, they are always highly receptive to using bleaching trays. It adds greatly to motivation and often means they achieve a far better result. Discuss Dental Day White is used so that the patient only needs to wear the bleaching trays for 55-45 minutes a day. The patient was happy with the degree of whitening achieved.

It was becoming highly apparent to the patient at this stage that she would only need some final edge bonding to achieve a very aesthetic result.

The patient whitened for two weeks. At week 11, alignment with the Inman aligner was almost complete. A single clear aligner was used to correct some minor spacing and also to help bring the right canine into line. After using the Inman Aligner, canines are far more receptive to movement with clear aligners.

At week 15 the incisal edges from canine to canine were only slightly roughened. No local anaesthetic is required with this simple additive bonding.

Venus from Hereaus Kulzer was used in dentine and enameled shades in B1 was used to build the missing incisal outline. The teeth were then polished with discs, pogo sticks and flexibuff discs. The patient initially was not keen to have centrals that were longer than the laterals so a fairly flat smile line was created. One week later she returned and asked for another 1.5 mm of central incisal length. This was again provided by adding more Venus. At the same visit a wire retainer was bonded in place from canine to canine, (12,15)

Her teeth are far better placed and restorative dentistry should be more beautiful.

Discussion

Any dentist offering cosmetic and restorative dentistry should be aware of all developing techniques. Many patients in the UK are choosing this approach and are demanding it in their practices. This approach is becoming common with dentists who offer orthodontics services but do not offer it and only offering ceramic solutions could result in potential cosmetic issues.

The simple fact is that once a dentist is educated in the advanced use of an Inman Aligner, this kind of treatment is far simpler and less risky than treatments where large amounts of tooth structure are removed and where there is a heavy reliance on porcelain for the final result. Being able to align and bleach simultaneously adds huge value and increases motivation tremendously.

Long-term predictability is far better and the patient doesn’t enter a restorative cycle that can easily worsen the long-term prognosis.

Patients are also far happier because the treatment is more affordable, and they understand the benefits of reducing long term risk by aligning, bleaching and bonding. Compared to the traditional methods of providing ideal smile design, ABB represents a radical and arguably revolutionary change in the way cases like this are approached.

A far more truly conservative result that actually respects the opinion of the patient at different stages means that heavy arch form preparations, with aggressive tooth removal just to line teeth up to allow space for veneers, could soon become a thing of the past.

Disclosure

Dr. Qureshi runs hands on courses with Dr. James Russell and Dr. Tim Bradstock-Smith and lectures on the Inman Aligner worldwide.

Acknowledgements.

The author thanks Donal Inman C.D.T. Inman Orthodontic Laboratory, Florida, Nimrodental Ortho Lab Paddington London (The only STS Certified Inman Aligner Laboratories.)

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Learning Curve

With more than 4,500 new cases opened every year, there is a wealth of experience within Dental Protection from which all of us can learn.

The confident approach of the professional can go a long way towards influencing the eventual outcome of a treatment. If nothing else, the dentist’s positive attitude allows the patient to accept a period during which the tooth settles down after treatment. But if treatment becomes a little more complicated than expected, that same confident approach should extend to sharing this information with the patient.

Consider a case of endodontic treatment on a lower first molar. The dentist separated a file in the early stages of the procedure without the apical two thirds of the mesio-buccal canal having been instrumented in any way. The dentist completed the endodontic treatment without any comment to the patient about the separated file or the possible future implications.

The tooth never settled down, in spite of frequent prescriptions of antibiotics. The dentist offered no explanation to the patient, when they asked why the tooth was not responding. Eventually another dentist extracted the tooth while the patient was on holiday.

**A better explanation**

The second dentist explained the need for an extraction and also informed the patient about the broken file. A settlement was agreed with the patient, not because the file had separated during treatment, but because the dentist failed to discuss and document the presence of the file in the records.

The implications that a separated instrument has on the prognosis for a tooth will depend on its position, its effect and whether or not the canals can be effectively sealed. The equipment and techniques for resolving such a situation, where the treatment of choice is the removal of the separated instrument, are often best achieved by referral to a specialist endodontist if available.

It is imperative that patients are fully informed about the risks of any treatment that they are about to undertake, and are given the option of seeing a specialist if appropriate. This is particularly important if the treatment might exceed the dentist's skill and experience, and ability to deliver an acceptable standard of care.

In the absence of a local specialist, dentists should consider making a referral to a more experienced colleague. Any discussions about a referral and the patient’s decision should be carefully documented in the records.

With more than 4,500 new cases opened every year, there is a wealth of experience within Dental Protection from which all of us can learn.
Four thousand years ago, a number of Babylonian legal decisions were compiled in what came to be known as the Code of Hammurabi. The one referencing the construction of dwellings and the responsibility for their safety begins; if a builder engineers a house for a man and does not make it firm, and the structure collapses and causes the death of the owner, the builder shall be put to death.

We are all builders or engineers of sorts; we calculate the path of our arms and legs with the computer of our brain and we catch baseballs and footballs with greater dependability than the most advanced weapons system intercepts missiles. In our professional lives however, in contradistinction to the paradigm of evidence-based dentistry, our efforts as builders often rely solely upon personal experience, intuitive cognition and anecdotal accounts of successful strategies.

Vigilant interaction

The challenges posed by implant-driven treatment planning mandate vigilance of the interaction between those involved in research and development, manufacturing and distribution and the leaders of ideologically diverse disciplines. Temporal shifts and trends in the service mix are part of the evolution of the art and science of dentistry; to some degree, the implant-driven vector has captured the heart and minds of those who seek to nullify preservation of natural tooth structure in the oral ecosystem and deify orthobiologic replacement. The corporate entities from which we derive our tools too often fail to distinguish the point where science ends and policy begins.

Is it responsible therapeutics or irresponsible expediency that justifies the removal and restoration of such teeth from the outset with an implant-supported restoration? Can one ethically argue that extraction is warranted as the financial cost of orthodontic extrusion/soft tissue surgery, endodontic retreatment and post/core/crown fabrication is greater than extraction with an implant-buttressed restoration, and in all likelihood, more predictable?

Jokstad et al (4) identified over 220 implant brands in the dental marketplace. With variability in shape, form, length, width and surface, there are potentially more than 2000 implants for any given treatment situation. A systematic review by Berglundh et al (5) assessed the reporting of biologic...
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Precautions:
- Keep out of eyes and ears, do not swallow, separate use from conventional dentifrices (e.g. rinse mouth between applications). In case of soreness, swelling or irritation of the mouth cease use of the product.


References:
1. A C Nielsen 52 w/e MAT 17.04.10 Corsodyl treatment mouthwashes unit share, medicated mouthwash market.
and technical complications in prospective implant studies.

Their findings indicated that while implant survival and loss were reported in all studies, biologic difficulties such as sensory disturbance, soft tissue complications, peri-implantitis/mucositis and crestal bone loss were considered in only 40 to 60 per cent of studies. Technical complications such as component/con- nection and superstructure failure were addressed in only 60 to 80 per cent of the studies. Are we as a profession standing idly by and watching marketing pressures force treatment decisions to be made empiri- cally, with untested materials and techniques? There is an un- settling similarity between these events and the early days of im- plant development 16.

Favouring endodontics

The endodontic pundits argue that major studies published
to date suggest there is no dif- ference in long-term prognosis between single-tooth implants and restored root-canal-treated cases that in the comprehensive care decision making process.

Salvaging teeth

Whenever possible, the treat- ment choice should be an at- tempt to salvage a tooth us- ing a multidisciplinary team approach, putting aside pre- conceived notions and biases. Finances should not dictate the advice proffered. Further- more, it is advisable to forgo being clinically ‘conservative’. Treatment should not be initi- ated in the absence of a critical evaluation of the potential for all contributing factors to euate with a positive outcome.

When needed, care must be taken to carry out every diag- nostic procedure available, even those of a more invasive nature (see Fig 1). Before arriving at a definitive diagnosis and treat- ment plan, the clinician should obtain consent from the patient to remove any restoration in order to analyse the residual tooth structure and assess the potential to carry out reliably predictable treatment. The pa- tient must understand in detail, the feasibility of and margin for success of each treatment option presented 18.

There are few studies in the endodontic literature ana- lysing the reasons for extraction of endodontically treated teeth. Root-filled teeth are invariably prone to extraction due to non- restorable carious destruction and fracture of unprotected cusps. Tamse et al found that mandibular first molars were extracted with greater frequen- cy than maxillary first molars; thus, the most significant causal dif- ference was the incidence of vertical root fracture (VRF > 1.8 per cent maxillary molar, 9.8 per cent mandibular molar) 19.

Teeth not crowned after obtura- tion are lost with six times the frequency of those restored with full coverage restorations 20.

Procedural failure, iatro- genic perforation or stripping, idiothetic resorption, trauma, and periodontal disease all contribute to a lesser degree. The major biologic factor influ- encing endodontic treatment outcome failure with the possi- bility of extraction appears to be the extent of microbiologi- cal insult to the pulp and periapical tissue, as reflected by the periapical diagnosis and the magnitude of periapical patho- sis 21. (See Table I and Fig 2a, 2b and 2c).

‘Whenever possible, the treatment choice should be an attempt to salvage a tooth using a multidisciplinary team approach, putting aside preconceived notions and biases.’

‘The endodontic pundits argue that major studies published to date suggest there is no difference in long-term prognosis between single-tooth implants and restored root-canal-treated cases that in the comprehensive care decision making process.’

Table I. As reported by Chugal et al, the most significant factor impacting on post-operative healing is the presence and magnitude of periapical apical periodontitis.

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References


‘The multivariate nature of the endodontic implant algorithm mandates the use of mCT (cone beam volumetric tomography) scans for detecting vertical root fractures than with the use of periapical radiography alone.’

Fig 2b.

‘Parts 2 and 3 to be published in further issues of Dental Trib- une UK.’

‘Fig 2c. The multivariate nature of the endodontic implant algorithm mandates the use of mCT (cone beam volumetric tomography) scans for detecting vertical root fractures than with the use of periapical radiography alone.’

Fig 2a.

About the author

Kenneth S Serota, DDS, MBA graduated from the University of Toronto, Faculty of Dentistry in 1975 and was awarded the George W. Martin Research Award for excellence in Prosthodontics. He re- ceived his Certificate in Endodontics and Master of Medical Sci- ences Degree from the Harvard-Forsyth Dental Center in Boston, MA. A recipient of the recipient of the American Association of En- dotontics Memorial Research award for his work in nuclear medi- cine scanning procedures related to dental pathologies, his passion is education and most recently e-learning and rich media. Ken pro- vided an interactive endodontic program for the Ontario Dental Association from 1965 to 1997 and was awarded the ODA Award of Merit for his efforts in the provision of continuing education. He was selected for Fellowship in the Pierre Fauchard Academy and is a Fellow of the Academy of Dentistry International. The author of over sixty publications, he has lectured on Endodontics internationally. He is on the editorial board of Endodontic Practice, Endodontic Tribune and Implant Tribune. The founder of ROOTS – an online educational forum for dentists from around the world who wish to learn cutting edge endodontic therapy, he recently launched IMPLANTS (www.rootso.com) and www.tuberculosis.org in order to provide a clear understanding of the endodontic implant algorithm in foundational dentistry. As well, he lectures on the empowerment digital technologies provide to the sophistication of the dental team and the propagation of comprehensive care.

Fig 2c.

‘The multivariate nature of the endodontic implant algorithm mandates the use of mCT (cone beam volumetric tomography) scans for detecting vertical root fractures than with the use of periapical radiography alone.’

Fig 2a.
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Anniversary celebrations

This year, the Premier Awards announce their 10th anniversary, with more prizes to give away and more subject areas available for submitting entries.

Dental Protection and Schülke have been delighted with the success of the Premier Awards, a major educational event in the dental calendar. This year, the two sponsors are particularly pleased to announce the 10th anniversary of the Premier Awards.

The Premier Awards were originally created to reward dental professionals who recognise the importance of patient safety within the dental practice. Throughout their 10-year history, dental professionals from a variety of specialties have received one of the prestigious awards as recognition for work in their particular field.

**Prize fund**

With a total prize fund of £6,000, the Premier Awards offer one of the largest cash prizes for dental risk management projects in the UK. There are now six subject areas available for submitting entries. These are:

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• Proven long-lasting relief with twice daily brushing2
• A deep, acid-resistant occlusion3,4
• Fluoride to strengthen tooth enamel

The robust occlusion formed by Sensodyne Rapid Relief is still maintained after an acid challenge4

In vitro study of dentinal tubule patency following an acid challenge (immersion in grapefruit juice, pH 3.3) applied after dabbing and massaging for one minute with Sensodyne Rapid Relief. Adapted from4.

Recommend Sensodyne Rapid Relief for rapid relief from the pain of dentine hypersensitivity

* when directly applied with finger tip for one minute ** when used twice daily