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 now 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-aline 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 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 undertakings 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.”

The move to abolish SHAs has been welcomed by opponents of water fluoridation
Murderer gets £44k in compensation for poor dental care

The Court of Appeal has reduced a triple murderer’s compensation to £44,500 after he sued over inadequate dental care in prison.

Michael Steele, serving life for a triple gangland killing, was awarded £60,400, 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 £14,000 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 submission 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 Belmarsh 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’.

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 £66,400 damages, 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 moderate 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.

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

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

Dental care professionals (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 processed after the deadline.

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

For the third year in a row the fee is £96 for dental nurses, dental technicians, dental therapists, hygienists, clinical dental technicians and orthodontic therapists.

The GDC’s head of registration, 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 understands they must pay by 31 July. If you haven’t paid yet please get in touch as soon as possible. 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.

Smile-on celebrates 10th anniversary

Smile-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.

“You 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 part in a charity auction of which the proceeds will be split between the three charities nominated by Smile-on’s directors: Cancer Research UK, Age Exchange and Three Faiths Forum.

The Smile-on spokeswoman added: “Smile-on offers practitioners a variety of courses designed 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, professionalism, 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 complaint from the NHS and other financial institutions that money had been wrongly paid out following McClaren’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 Exeter Magistrates Court with his wife, Stilianai Theodoropou- lous and sister-in-law Nikoletta Theodoropouli.

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

Prosecutors claimed McClaren and his wife and travel documents were faked as he looked as if he had died while on a trip to Jordan.

Neither McClaren nor his sister-in-law applied for bail. It was requested for Stilianai Theodorou- poulous, but was refused.

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

Learning and growing

Dental Tribune has been in Glasgow recently, attending the International Symposium of Dental Hygiene. More than 1,500 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.’
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 dentists working in Trusts 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 fulfil 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 £60m 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 KCLDI 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 (KCLDI), and is due to open in September.

The collaboration will see final year undergraduate student dentists from KCLDI 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 education where final year dental students work alongside dental therapists, hygienists and nurses in teams that will prepare them all for the transition to general dental practice. 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 effort 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 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 dento-legal advisors has opened 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, HW regisar and inspectors 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-
The NEW Universal Hand Piece Cleaner from Prestige Medical.
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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 Units 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.

About the author
Elaine Halley BDS, DGDSEP(UK), FDSRCS (Glas), 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 in 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 learning outcomes in the delivery of teaching and learning.

He has encouraged a team approach to learning to broaden the student experience across all dental care professions, and has been involved in the recent collaboration with Manchester Metropolitan University, which teaches students of dental technology.

Prof Grey said: “The award is especially pleasing to receive, as it is a testament to the great importance the University of Manchester places on excellence in teaching and learning. I am very fortunate and grateful to be part of a School, Faculty and University that have enabled and encouraged me to achieve this.”

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 recognises 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 London 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 specialist 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 prosthodontics 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.

Meditec, 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, Meditec Managing Director, Chris Bunkenham 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 suction catheters and tubing eg, the Yankauer sucker; ‘Spacer’ device for inhaled bronchodilators.

Automated blood glucose measurement device. Single use sterile syringes and needles and Automated External Defibrillator are also recommended but are not included in this kit.

The kit is contained in an easy to carry case, ready for quick use in an emergency. Because the drugs and needles are not included in this kit, it can be made available in a highly conspicuous, easily grabbed position.

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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 businesses 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 percent 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...

Dental practices set out planning to have the right staff with the right skills. Qualifications, experience and knowledge to look after patients and the practice. Somehow along the line, things have gone wrong. It can be difficult toCorporate disclose some of the complaints about the team members. It is possible to have 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 “float” staff, recruitment is not quick, but the payroll is not “in sync” with the practice. This means that dentists, nurses and staff are in with patients all day. Any spare time a nurse has is likely to have to be spent on decontamination these days!

Why?

All problems therefore end up at the practice manager, and can be 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 the following:

• 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 2: Tighten up on Rotas

Unplanned absence is the bane of every practice manager’s life! Persistent absences 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 3: 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 personalisation, care and treatment. Support them.

(If you are not up to speed on CQC yet, email Seema at 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 in addition to 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, vulnerability 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.

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Andy Acton
Director, Frank Taylor and Associates

Frank Taylor and Associates have helped thousands of clients in the dental business arena – from benchmark practice valuations to hands-on programmes to improve practice performance.

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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 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 wherever possible to give everybody a sense that we do not want to go down the path of separating NHS services. This does also mean equal access to NHS dental services. People who cannot access NHS dentistry will have to go to private dentists and 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.

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.

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.

‘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.’

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.

There have been a number of people who have argued that the new contract was designed to be based on the experience of the PDS pilots. This is not true. The new contract was designed to be based on the experience of the PDS pilots and those involved with subsequent discussions with the DoH about the new contract. The conclusion they reached was that it didn’t happen for a very simple reason: finance. When the Audit Commission came in and looked at the PDS pilots, they concluded that if you actually concentrate on capitatisation and delivering better health outcomes for patients, the net outcome is that you do fewer procedures. This reduces the capacity to charge patients, which relates to a shortfall on patient charge revenue. Based on second-hand information this shortfall in finances eventually led to the PDS pilots being torpedoed.

I think this rather an interesting question and I don’t pretend that I have any special knowledge of this, but I have talked to plenty of people who do, including many dentists involved with PDS pilots and those involved with subsequent discussions with the DoH about the new contract. The conclusion they reached was that it didn’t happen for a very simple reason: finance. When the Audit Commission came in and looked at the PDS pilots, they concluded that if you actually concentrate on capitatisation and delivering better health outcomes for patients, the net outcome is that you do fewer procedures. This reduces the capacity to charge patients, which relates to a shortfall on patient charge revenue. Based on second-hand information this shortfall in finances eventually led to the PDS pilots being torpedoed.

‘So why did all this happen?’

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 perverseities 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. Understandably so, wherever you look in the NHS and beyond, if you create a structure of financial incentives you should not be surprised if people behave in perverse ways.

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.

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 number of postgraduate certificates 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.

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Half Brained website?

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

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 majority 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, brains 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 will 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.

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.

Are you happy with your website?

So look at your website objectively: is it only half brained or have you achieved that rare website nirvana? That is, a fully brained website with both beautiful web design and excellent technical functionality. If you have, you’ll be attracting and converting more patients than you can deal with, which I’m sure you’ll agree, is a great situation to find yourself in.
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**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. A new look at some ‘old’ technology by Neil Photay and David Hands

Editors of Aesthetics

Roger Matthews speaks to Professor Richard Bellion on the ethics of cosmetic dentistry

Art & Hot ABA

Ted Quebedeaux details the latest treatment sequence
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 used Discus Dental as suppliers before, I was confident that my experience this time around would be just as positive, and I wasn’t disappointed. They have a highly efficient team and the direct sales models means that Discus Dental can remain in direct contact with you. There is no one in the middle and there are no marked up fees, which is great. Discus Dental also maintains direct access with the manufacturer enabling them to address your specific queries and concerns.”

“We have seen an increase in our profits since the special offer incentive was launched and have experienced growth in client requests for whitening.”

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!”

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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.
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.
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?

“Dental care is about keeping people pain-free and healthy, while trying to satisfy their cosmetic concerns. However, with magazines full of adverts for cosmetic dentistry and more people aspiring to celebrity ideals, aggressive dental treatments for aesthetic reasons alone are on the rise to a worrying degree. 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 severe treatments and recurring problems.”

“As a profession we should be ensuring that teeth last a lifetime, 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 treatment 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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**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-cutting 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 treated. 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 is important. Golden proportion ideals, tooth width length 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 \( \frac{3}{4} \) 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 creates aesthetic issues immediately. Large unsightly embrasures were made worse around the canines. The in standing laterals appeared darker and in the shadow of the lips, the left one being in slight cross-bite. With the centrals splayed 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.

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 in 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 gives us the Available space. The difference between these two measurements is calculated automatically 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 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 anteriors to align. 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 (0.1mm 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 progressively 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. Composite 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 2-3 weeks to check progress and re-perform a little IPR if necessary.

The patient was instructed to wear the Inman Aligner for 16-
18 hours a day. Studies[6,12] show that this is far less likely to cause root resorption and the Inman Aligner is highly effective even when used for up to 18 hours a day. This allows better hygiene and patients can also function with day-to-day activities more normally.

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 on how to clean and maintain them.

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 35-45 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 Kuzler was used in dentine and enamel 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 fair flat smile line was created. One week later she returned and asked for another 1.5mm 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 anatomically respectful IPR.

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 practice. This approach is becoming common with dentists who offer orthodontics as an orthodontic service not offering it and only offering ceramic solutions could result in potential consent issues.

The simple fact is that once a dentist is engaged 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, Nimorden Dental Lab Paddington London (The only STS Certified Inman Aligner Laboratories.)

Course Information

Information about course dates and training can be received from www.straight-talks.com or www.inmanalign.com. Alternatively contact Carnarvon House; +44(0)1242 521259 email info@straight-talks.com

Tif Qureshi will be speaking at the BACD Conference ‘Aesthetics Meets Dentistry’ on 21 - 23 September 2010 at the Hilton London Metropole. To register, visit www.aacd.org.

References

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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.

Watch out for another Learning Curve from Dental Protection in future editions of Dental Tribune UK.
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 identified over 220 implant brands in the dental marketplace. With variability in surface, shape, length, width and form, there are potentially more than 2000 implants for any given treatment situation. A systematic review by Berglundh et al assessed the reporting of biologic
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Indications: Plaque inhibition; gingivitis; maintenance of oral hygiene; post periodontal surgery or treatment; aphthous ulceration; oral candida.

Dosage & Administration: Adults and children 12 years and over: 10ml rinse for 1 minute twice daily or pre-surgery. Soak dentures for 15 minutes twice daily. Treatment length: gingivitis 1 month; ulcers, oral candida 48 hours after clinical resolution. Children under 12 on healthcare professional advice only.

Contraindications: Hypersensitivity to chlorhexidine or excipients.

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.

Side effects: Superficial discoloration of tongue, teeth and tooth-coloured restorations, usually reversible; transient taste disturbances and burning sensation of tongue on initial use; oral desquamation; parotid swelling; irritable skin reactions; extremely rare, generalised allergic reactions, hypersensitivity and anaphylaxis.

Legal category: GSL.

Numbers and RSP excl. VAT:
- Mint Mouthwash: PL 00079/0312 300ml £3.99, 600ml £7.82.
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References:

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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 cre- stal 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 market- ing 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 10.

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 teeth, and 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 provided. Further- more, it is advisable to forego being clinically ‘conservative’. Treatment should not be initi- ated in the absence of a critical evaluation of the potential for all contributing factors to equate 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 19.

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 frequency than maxillary first molars; 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) 12.

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 teeth in that in the comprehen- sive care decision making process.

‘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 teeth in that in the comprehensive care decision making process.’

### About the author

Kennerly J. Savannah, DDS, MBA, graduated from the University of Toronto, Faculty of Dentistry in 1975 and was awarded the George W. Bantzer Memorial Key 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- dondontology Memorial Research Award for his work in nuclear medi- cine screening procedures related to dental pathology, 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 1865 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. implants.com) and www.endoconnection.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.

### References

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S4S announces Bruxism Awareness

At WAC 2010

S4S was delighted to announce at this year’s World Dental Congress in London that S4S will be holding a Bruxism Awareness Week from 22nd to 27th November 2010.

**Purpose**

- To raise awareness of bruxism
- To educate patients on the risks and symptoms of bruxism

**Activities**

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With the skills she has developed in the classroom and putting them into practice at work... Beverly will be leaving the endo lab in order to pursue a career in teaching.

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**Menopause and Oral Health**

The Menopause and Oral Health Study is a comprehensive review of the oral health aspects of care for people with Intellectual Disability. Entitled ‘Dentition and oral health diseases’, the chapter provides a comprehensive review of the oral health aspects of care for people with Intellectual Disability.

Contact eastman.ucl.ac.uk

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**New Zealand Oral Health Survey (NZOHS)**

Two senior clinicians from the UCL Eastman Dental Institute have contributed to a book that provides a major review of the evidence relating to intellectual disability and oral health.

Dr Stefano Feders, Senior Clinical Lecturer in Oral Medicine, and Professor Crispian Scally CBE, Professor of Oral Medicine, have written a chapter of the new publication.

Entitled ‘Dentition and oral health diseases’, the chapter provides a comprehensive review of the oral health aspects of care for people with intellectual disability.

Edited by Joan O’Hara, Jane McCarthy and Nick Bouras and published by the Royal Society of Medicine Press, the book is available now.

For more details about UCL Eastman Dental Institute, please visit www.eastman.ucl.ac.uk or telephone 020 7915 1018.

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British Academy of Cosmetic Dentistry (BACD) membership survey

The BACD membership survey, undertaken by The British Academy of Cosmetic Dentistry (BACD) revealed that members really valued the BACD as a source of continuing professional development and ideas to share knowledge with others. The number one benefit of BACD membership, according to those surveyed, was access to technical information, with opportunities for CPD training second, and regional Study Clubs cited as the third most important membership benefit required to remain a member.

The survey also established a membership profile, with the majority of members (nearly 46%) within the south of England and aged between 35 and 50 years. Many members also expressed an interest in the creation of BACD journals, as well as increasing the opportunities to confer and network with peers.

This reflects a remarkable synergy between the interests of 78% of BACD members and the BACD and its membership base. Committed to excellence in cosmetic dentistry, the BACD has continued to promote the sharing of knowledge and best practice, especially with regard to the latest techniques available, since its inception in 2005.

For more information, contact Suzy Rowlands on 0207 612 4166  
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Due to his ability, Dr. Fean invites all referring practitioners to attend any stage of the treatment process and shows his appreciation of their custom by offering a complimentary implant for any stage of the treatment process.

For more information on referring to Dr Fean, call 0207 224 1488 or visit www.koryfean.co.uk

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With more cosmetic dentistry options that ever before, it is vital that your patients receive the best possible care. The T-Scan allows you to measure inter-occlusal forces, balance and changes through time, unlike T-Scan which allows doctors to perform occlusal balance with accuracy and confidence. It can be the difference between success and failure.

Check the T!-Scan today!
Since Septodont was founded, we have emerged as a company fully committed to a single purpose: to provide dentists with dental products of superior quality and value.

We at Septodont believe that staying ahead of the competition requires more than just supplying dental products. Septodont is actively involved in educational events, conferences, trade shows and CPO courses around the world. We not only develop innovative business in anterior and posterior tooth that is compatible with all leading bonding systems, plus the launch of a revolutionary product to be soon in the UK market, so keep watching our website for more information.

With the Ultra Safety Plus system now available as a completely disposable system with the introduction of the Ultra Safety Plus Single White Handle and our established and well known anaesthetics range now being lave free, Septodont continue to offer improvements on existing ideal.

If you have yet to experience the benefits provided by all essential Septodont products for yourself, please contact Septodont on 0122 6555520 or call your local Septodont product specialist.

Reliable support from Ledermix Dental Cement

Ledermix Dental Cement represents a complete range of products for which dentists can come to rely on as an effective method of treating patients. Where there is a deep cavity and the dentist is not confident of their professional skills, such as in the instance of small pulp exposure, a practitioner can use Ledermix Dental Cement as a pulp capping agent with confidence in the efficacy of the product.

For ease of use, Ledermix dental cement can be prepared with a choice of hardeners. Simply by mixing one drop of the appropriate hardener (fast or slow) hardener with the Ledermix powder, the practitioner can quickly create the necessary crown for application.

For reliable, effective and practical solutions to the challenge of hypersensitive teeth, Ledermix has developed the most recent avenues of advancement in adhesive dentistry. Caries management can be improved by the use of a simple technique using the Ledermix system.

For more information please call John Jesshop of Blackwell Supplies on 0127 342 000, fax 0127 322 7893 or email john.jeshop@blackwellsupplies.co.uk. For further information please visit www.kentimplantstudio.com.

Trust

The Dental Directory: Key Distributor of Cistene® and Ylicxone® – LEDERMIX’s leading anaesthetics

The Dental Directory, the UK’s largest full service dental dealer, is now the UK’s key distributor for LEDERMIX’s leading anaesthetic products: Cistene® and Ylicxone®.

Guaranteeing availability in addition to next day delivery, The Dental Directory offers the best knockdown prices on the following anaesthetics:

- Cistene Standard 2.2ml box of 100 best price £32.75
- Cistene Self-Aspirating 2.2ml box of 100 best price £32.75
- Ylicxone 2.2ml box of 100 – best price £30.75
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With The Dental Directory it couldn’t be easier, dispensing leading anaesthetics and sundries at from under one roof, convenience and customer satisfaction is guaranteed.

To order, simply contact your local Dental Directory Representative, call 0800 585 589, or alternatively visit www.dental-directory.co.uk.

CORSODIL LAUNCH NEW ALCOHOL FREE VARIANT

With more people living teeth to gum disease than tooth decay and 80% of people suffering from gum disease at some point in their lives, the importance of healthy gums and teeth for everyone has never been more apparent. And for patients who prefer an alcohol-free solution, GlassEsthétique Consumer Healthcare (GSH) have developed a new alcohol-free Corsodil Mouthwash variant.

The most favoured variant has been demonstrated to have comparable correlation to Corsodil Mint Mouthwash in inhibiting plaque regrowth in vitro studies and also show comparable performance in reducing oral bacteria, as well as comparable substantivity. Where traditional routine indicates a need for alcohol free mouthwash for treating gum disease, dental professionals can now recommend an alcohol-free Corsodil Mouthwash with confidence.

To support your patient education Corsodil have developed a range of patient materials including a comprehensive patient guide and poster. For further information contact your GSK representative.

KentImplantStudio welcomes periodontist Dr Elena Sances to his team

The Kent Implant Studio, located on Northumberland Road in Maidstone, is pleased to welcome Dr Elena Sances, a new member of staff to its team, Dr Elena Sances who is a respected periodontist, hypnotherapist for periodontal and prosthetic treatment.

Dr Sances graduated from Dentistry in the University of Barcelona and went on to complete an Associateship in Periodontology, Prosthetics and Implants. After practicing as an Associate in Barcelona, Dr Sances works as a Periodontist and Prosthodontist. His main interest is in showing patients on subjects such as occlusion, radiology and mandibular function. In May 2009 Dr Sances received a grant from the Spanish Society of Periodontics to develop a systematic review and meta-analysis of periodontal maintenance, to be published by the Cochrane Collaboration.

For further information on the Kent Implant Studio or to obtain a referral back please call 01622 671 675, or visit www.kentimplantstudio.com.

DENTAL TRIBUNE

United Kingdom Edition

7-12 2010

Easy to pack, with great storage potential.

Dr Mary Burnett of the Kent Implant Dental Practice in Kent has been trialing the latest innovation from DENTSPLY’s – Smart Dental Replacement® - SDR™. The revolutionary new flowable composite base that offers bulk-filling of up to 4mm without the need for layering. As Dr Burnett commented: “I found Smart Dental Replacement very user-friendly, thanks to the Compula® syringe-style tip which allows accurate placement: "I am able to easy to pack and adapts well to the cavity.”

A further advantage is the shade SDR® matches that of dentine, making for a better aesthetic finish – something which Dr Burnett has noticed: “SDR® is a simple and efficient product that I will continue to use when doing posterior restorations.”

Investing in better dentistry is a key element of DENTSPLY’s vision to revolutionise the profession. Developing innovative products, such as SDR® helps dental professionals to achieve that aim.

To arrange for a free demonstration of SDR call +44 0800 072 3313 or visit www.dentsply.co.uk.

Re-usable and disposable products

ChairSafe foam and wipes are alcohol free. They are effective against HBV/ HAV and with the new Kemdent range of durable and economical wipes. These extra large ChairSafe wipes have come to rely upon as an effective hardener with the Ledermix powder, the practitioner can quickly create the necessary crown for application.

For more information or to book your spot on the course call 0800 072 3313, email enquiry@dentply.com or visit www.dentsply.co.uk.

Industry News 29

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Boost revenue and patient attendance through education

Helping patients maintain their oral health is a challenge for today’s dental professionals – and in the wake of a very busy dental year, now is the perfect time to pass on our technical expertise.

NotableBcrian’s NursesProcess has been designed with ease of use in mind, helping busy practitioners to achieve excellent clinical and consistently impressive results each and every time. Non dentists can now offer the highest level of oral healthcare with their own hands, thanks to the patients clear guidance and full product literature.

The system’s patented ergonomic holographic optical viewing works in complete harmony with the very latest in 3D technology, providing superior results with detailed accuracy. GDPs are now able to:

- Achieve a variety of treatment options using the most appropriate solutions
- Demonstrate how to use the latest technology

With the Ultra Safety Plus system now available as a completely disposable system with the introduction of the Ultra Safety Plus Single White Handle and our established and well known anaesthetics range now being lave free, Septodont continue to offer improvements on existing ideal.

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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:

- Ethics and Professionalism
- Record Keeping
- Cross-infection Control
- Teamworking and Skillmix
- Consent and Communication
- Health and Safety

All members of the dental team are eligible to enter, whatever stage of their career they have reached.

- Dental care professionals (undergraduate, postgraduate or practising)
- Dental undergraduates
- Dentists (postgraduate or practising)

Dental Protection, the world’s leader in indemnity and risk management support for the dental team has renewed its longstanding partnership with Schülke, the European leader in infection control, to present the Premier Awards for 2010. Once again the event will recognise individual achievements in developing awareness and the effective management of risk within clinical dentistry.

This year’s Awards will be presented during The Premier Symposium to be held at Kings College, London on Saturday 4 December 2010.

Application forms and leaflets are now available from Dental Protection. Visit www.dental-protection.org.
Good ice-cream
Great lawyers

The Specialists Dental Team at Cohen Cramer Solicitors would like to thank everyone who visited us at our stand at the Birmingham NEC Dentistry Show.

See you again next year with more ice-cream... and legal advice!

For a FIXED Fee quotation please call FREEPHONE 0800 542 9400 dentalpractice@cohenandcramer.co.uk or visit www.cohenandcramer.co.uk/services-to-dentists-services.html

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Firstchoice Scrubs & AWB Textiles are brand names of AW Bent Ltd
“Give me something that works fast and I might be interested”

Patient, UK

Sensodyne Rapid Relief – rapid* and long-lasting** relief from the pain of dentine hypersensitivity¹,²

The strontium acetate formulation of Sensodyne Rapid Relief forms a deep occlusive plug within the dentinal tubules³,⁴ providing:

- Clinically proven relief.¹,²
  Works in 60 seconds*¹
- 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

Unoccluded dentine  | After treatment and a 30 second acid challenge | After treatment and a 10 minute acid challenge

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