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Fake qualifications

A dentist has pleaded not guilty to allegations he used fake qualifications including a fake Bachelor of Dental Surgery degree, enabling her to work in NHS hospitals for eight years.

Vinisha Sharma pleaded not guilty to a total of 10 charges at Wolverhampton Crown Court. The 56-year-old is due to stand trial on March 8 following an investigation carried out by the NHS Counter Fraud and Security Management Service.

Sharma has pleaded not guilty to charges of using a fake Bachelor of Dental Surgery degree, a certificate saying she had completed a course on aesthetics and a certificate of registration from the Punjabi Dental Council.

She has also denied five counts of obtaining pecuniary advantage by deception, one while with Royal Wolverhampton NHS Trust.

Sharma also denied fraud by false representation.

The charges cover a period of eight years from 2000 to 2008. Sharma has been granted bail.

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Life or Death

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with a medical emergency

UDA value variation highlighted by Tories

The shadow health secretary, Andrew Lansley, claimed that the wide variation in pay for UDAs shows the system is not working.

He said: “It must be hugely frustrating for many dentists to know that others just down the road are being paid so much more for doing very similar work.

The contract the government has introduced for NHS dentists needs a complete overhaul if we are to turn things around. We need to give our NHS dentists a better system in which to work if people are to get the dental care they need.

That’s why a Conservative government would scrap Labour’s flawed UDA system and introduce a fairer system for dentists and patients.”

John Milne, chair of the BDA’s General Dental Practice Committee, conceded that the value of units of dental activity does “vary according to the historical earnings and activity of practi-
tioners, the provision of specialist services and the oral health needs of each PCT’s population”.

He said: “These factors lead to a variation in values, although the national average is around £25.”

He added that “the main flaw with the current dental contract is the way it is centred on targets, rather than providing high-quality care to patients. It’s important now that the conclusions of Professor Steele’s review are consulted on and piloted so that a new system can be developed that works for patients and practitioners alike.”

Derek Watson, chair executive of the Dental Practitioners Association, said: “The idea that dentists can be paid different amounts for carrying out the same courses of treatment is based on the assumption that costs vary and that different dentists do different amounts of treatment in the same course (and will continue to do so).

The amount of work in each course has now stabilised at the lowest common denominator and costs do not vary enough to justify one dentist earning ten times more than another dentist for a UDA.”

He criticised the process of tendering claiming it “is no substi-
tute for the free market as it is slow, inefficient and frequently unfair”.

Some figures may also reflect the income guarantee which helped to keep dentists in the NHS when the dental contract was introduced in 2006.”

A DH spokesperson said: “The dental contract is working – the number of dentists working in the NHS is growing and more people have seen an NHS dentist in the last year.

PCTs have control over how much they pay for a unit of dental activity – it is only right that this can vary depending on local challenges and needs.

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News in brief

Queen fan

Queen guitarist Brian May aid he was ‘delighted’ to sup-
port a music festival held in the
memory of a dentist who was an ardent fan.

Ten bands appeared at the festi-
val in Wichenford near Worces-
ter, playing Queen tracks as part of set.

The festival was held in mem-
ory of John Bue, who worked at the
Green Dental Practice in Dines Green, and died in a
motorcycle crash in June.

The organisers of the concert contacted Brian May and told him about the festival. He said he was ‘delighted to support the festival’ and sent signed Queen merchandise for the raffle.

He also sent his condolences to
Dr Bue’s wife and their two
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Flouridation plan goes to the High Courts

Claims that health chiefs ignored public opinion when they approved plans to flouridate parts of Hampshire are to be examined by the Royal Courts of Justice.

Mr Justice Mitting has given permission for a Judicial Review of the strategic health authority's decision stating that the case raised important questions of public law.

However the South Central Strategic Health Authority (SCSHA) claims it is confident it followed the law. The South Central Strategic Health Authority (SCSHA) board's decision was made in February, despite 72 per cent of 10,000 respondents in a public consultation opposing the move.

The judge accepted the SHA's defence it followed the law, which says it only had to 'pay regard' to public opinion, but wants the fullness of that approach to be looked at in court.

Government ministers had said that SHAs could only go ahead with flouridation if they had the residents' support.

The application for a judicial review was lodged by a Southampton resident Geraldine Milner.

A statement from Leigh Day & Co representing Ms Milner said: “Ms Milner is opposed to the proposals to flouridate the water supply on account of the continuing uncertainties with regard to the long term health risks associated with flouridation, as well as concerns with regard to the possible adverse environmental effects. She also considers that more targeted and less intrusive measures should be used to deal with problems of tooth decay in the Southampton area.”

The legal challenge argues that the SCSHA failed to have regard to the government's policy that mass flouridation of drinking water should only go ahead in any particular area if a majority of the local people are in favour of it.

Leigh Day & Co claim in part of the Water Bill that became the Water Act in 2003, Lord Warner, the Junior Health Minister, stated in Parliament that it was government policy that “no new flouridation scheme would go ahead without the support of the majority of the local populations determined by local consultations conducted by strategic health authorities…”

The SCSHA said in a statement that the board is “satisfied that, based on existing research, water flouridation is a safe and effective way to tackle tooth decay and that the health benefits outweigh all other arguments against water flouridation”.

If the SCSHA gets its way, Southampton will be the first place in England to introduce flouridation since Health Minister Alan Johnson's flouridation for all proposal in February 2008.

A SHA spokesman said: “Mr Justice Mitting found that there was an arguable case in relation to whether South Central Strategic Health Authority was entitled to rely on the regulations, or whether it should have had regard to verbal statements made in Parliament.”

South Central Strategic Health Authority is pleased with the ruling and the Judge’s view that “in all other respects the decision-making process was unimpeachable”.

The SHA remains confident that the decision that has been made by the SHA board was carried out in accordance with the relevant legislation laid down by Parliament, and is in the best interest of the health of local people.”

“I am afraid this is consistent with the past arrogance that has seen local opinion ignored.”

Health chiefs want to add flouridation to the water supplies of 200,000 homes in parts of Southampton, Eastleigh, Totton, Netley and Rowhams.

The law was changed in 2002 to allow SHAs, rather than water companies, to decide on fluoridation.

Any result from a judicial review will not be known until February 2010.

Following the successful request for a Judicial Review of the South Central SHA decision on flouridation, all proposals for schemes in the North West of England have been put on hold.

£1m NHS dental centre opens in Scotland

A £1m dental centre has been officially opened in the Borders in Scotland.

Public Health Minister Shona Robison opened the Coldstream dental centre and called the centre which has five dentists - a perfect example of a local health board delivering the right services, in the right place for the community they serve.

The Scottish government has put £1m of funding into the centre which is housed in the former Coldstream Cottage Hospital.

Ms Robison said: "The Scottish Government is committed to improving Scotland’s dental service and oral health. "A big part of this is ensuring dental facilities of the highest standard are available across the country.”

Mary Wilson, chair of NHS Borders Board, said: “I am also delighted with our two new NHS Borders dental centres at Coldstream and at Hawick. These facilities allow us to make real improvements in dental health and let many more people in the Borders have NHS dentistry.”

Christopher Lynch

A paper on the teaching of implant dentistry in undergraduate dental schools has scooped the Young Dental Writers’ Award.

Christopher Lynch was presented with the first prize by the British Dental Trade Association’s (BDTA) president, Simon Gambold for his paper “The teaching of implant dentistry in undergraduate dental schools in the UK and Ireland” which was published in the British Dental Journal.

Leila Khamashia ledezma won second prize for her paper ‘Be alert to the signs! Non-accidental injuries and the dental team’ which was published in Team in Practice.

Implant dentistry paper scoops award

The BDTA sponsored the Young Dental Writers’ Award category at the recent British Dental Editors’ Forum, which was held at the offices of the British Dental Association.

Tony Reed, executive director at the BDTA, said: “We were pleased to support this worthwhile contest which encourages young dental professionals to research and present information on topical issues affecting their day to day tasks and the industry as a whole.

“It beieve the standard of entries was exceptionally high so I would like to offer my congratulations to both Christopher and Leila on their possible adverse advances.”

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Editorial comment

A question of access

The big news recently for the dental profession has been the release of a draft copy of the Dental Access Contract, developed by Mike Warburton and his team. Since its appearance on the GDPUK mailing list last week, rumours have been flying about the contract and what it means for practitioners. So, in this week’s issue, we have a piece from Barry Cockcroft, Chief Dental Officer for England, and Tony Jacobs, founder of GDPUK. How will the Warburton contract affect your practice? E-mail us and let us know.

Calderdale’s petition against fluoridation

A Yorkshire councillor has started up a petition against fluoridating the region – a move currently being considered by the Yorkshire and Humber Strategic Health Authority.

The fluoride would be added to water in Kirklees and Bradford in a bid to improve dental health, however supplies in Calderdale could also be affected.

Councillor Craig Whittaker said: “It is totally unacceptable that the Strategic Health Authority (SHA) is able to force people to have fluoride in their water; it defies the most basic of human rights, that people have control over their own bodies.

“The rationale given for adding fluoride is to improve the dental health of children, but such attempts always prove controversial.”

“Despite the fact that 72 per cent of those who responded to consultation were against fluoridation, Southampton Council recently voted to support South Central SHA, which has resulted in significant public backlash.”

He added: “Research clearly shows that continued exposure to fluoride can have significant health implications; the process that the government has set down for making this decision goes against the fundamental principle of freedom of choice. People can choose to buy fluoride toothpaste, which is no more expensive, or fluoride tablets. Mass medication is not, and never will be the answer.”

Six years ago, Calderdale Council said it was opposed to fluoridation.

On October 1, the council will be asked to ‘reaffirm its position’, said Councillor Whittaker.

NHS Calderdale is looking into the benefits and drawbacks of water fluoridation. This study is due to be completed in spring 2010.

It will then consult the public on its findings.
Dental hygienists and therapists to sell and supply medicine

Dental hygienists and dental therapists will be able to sell, supply and administer medicines, if new proposals by the government get the go ahead. The proposal to amend medicines legislation to enable dental hygienists and dental therapists to sell, supply and administer medicines under a Patient Group Direction (PGD), is currently out to public consultation.

In practice, the PGD will enable dental therapists and dental hygienists to sell or supply fluoride supplements and toothpastes with high fluoride content of 2800 and 5000 ppm and to administer oral or parenteral anaesthesia licensed for dental use.

The consultation document states that “the supply and/or administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability”.

PGDs are drawn up locally by a multi-disciplinary group involving a doctor, a pharmacist and a representative from the professional group that is expected to supply/administer medicines using the PGD. The PGD must be signed by a doctor or dentist and a pharmacist, and formally authorised by the organisation in which they are going to be used.

Following the consultation, the Commission on Human Medicines (CHM) will be asked to make formal recommendations to ministers, in light of the responses received.

The proposals, if agreed, will be achieved by amendments to the Prescription Only Medicines for (Human Use) Order 1997, (the POM Order), the Medicine (Pharmacy and General Sale – Exemption) Order 1980 and the Medicines (Sale and Supply) (Miscellaneous Provisions) Regulations 1990.

The public consultation is being held in the UK and Northern Ireland.

Medicines regulation is not an excepted or reserved matter as far as Northern Ireland is concerned and Northern Ireland’s health minister will be a co-signatory to any legislative amendments.

The Medicines and Healthcare products Regulatory Agency (MHRA) and the Department of Health are also seeking views on any amendments that will be required to NHS regulations to enable the supply of medicines by dental hygienists and dental therapists, under a PGD at public expense.

No changes are required to the NHS regulations in England. Changes may be required to relevant NHS regulations in Wales, Scotland and Northern Ireland together with any associated aspects of the relevant drug tariffs.

The consultation is open for 12 weeks and responses should arrive no later than 20 November.

The consultation can be found at www.mhra.gov.uk.

Burnley to get new 10-surgery NHS dental centre

East Lancashire Primary Care Trust is joining forces with Burnley Borough Council to set up a dental super centre which could take up to 10,000 new patients in the Burnley area.

It is hoped that up to 10 surgeries will be built at the super centre. However a location for the facility is yet to be decided.

Burnley Borough Council’s deputy leader Councillor Margaret Lishman said in a report to the full council “The council is working with the PCT on the development of a new 10-surgery NHS dental centre and teaching facility.

“The council has identified a number of potential sites and it is envisaged that the PCT will decide on their preferred site very soon and they hope to have the new facility open by autumn 2010.”

Last December, the PCT commissioned additional dental services for 17,000 patients, which are currently being introduced across the borough.
Saliva samples help with early detection of mouth cancer

Saliva samples have been found to help with the early diagnosis of mouth cancer, according to new research.

The research published in the Clinical Cancer Journal saw scientists assess mouth cancer by checking saliva.

Professor David Wong and a team of researchers from the University of California Los Angeles compared 50 samples obtained from mouth cancer patients with 50 healthy specimens. They found 50 microRNA chemicals that could help cancer diagnosis.

“It’s a Holy Grail of cancer detection to be able to measure the presence of a cancer without a biopsy, so it is very appealing to think that we could detect a cancer-specific marker in a patient’s saliva,” said Jennifer Grandis, professor of otalaryngology and pharmacology at the University of Pittsburgh School of Medicine and Cancer Institute and a senior editor of Clinical Cancer Research.

The news has been welcomed by the British Dental Health Foundation - organisers of Mouth Cancer Action Month which runs throughout November.

Early detection saves lives in the fight against mouth cancer – improving survival chances to more than 90 per cent from the current five-year survival rate of just half of cases.

Foundation chief executive Dr Nigel Carter said: “With early diagnosis so vital these studies could hopefully provide a lifesaving boost. However it is important for further studies to prove this an effective and accurate test even in pre-cancerous cells. These early studies used only saliva samples where mouth cancer is present.

“We have committed more resources than ever to Mouth Cancer Action Month after the shocking figures released this year. It really is time for action and to heed the campaign’s message – ‘If In Doubt, Get Checked Out.”

Dental professionals’ annual retention fee frozen

Dental professionals’ annual retention fee has been frozen and will stay the same for the third year running, according to the General Dental Council (GDC).

Council members have decided not to increase the annual retention fee (ARF) for dentists later this year (deadline 31 December) and dental care professionals next year (31 July 2010).

This means the cost of annual registration renewal for dentists will remain at £438 and £96 for dental care professionals.

Wales gets its first giant integrated health centre

Wales’s first giant integrated health centre, bringing together a range of health professionals, including dentists, nurses, GPs, physiotherapists and nutritionists, is opening this month.

The £10m centre will change health services for thousands of people.

The Port Talbot Primary Care Resource Centre has been developed by Neath Port Talbot Local Health Board (LHB) and brings together health, local authority and voluntary sector staff under one roof.

An LHB spokeswoman said: “The resource centre will provide a base for a variety of services including GP, district nursing, health visiting, dentistry, pharmacy, physiotherapy, nutrition and dietetic services.

“Social services staff and various voluntary sector agencies will also provide services from there. From August 2010, a dental training practice will be established, offering placements for five trainees, which will greatly assist in the recruitment and retention of local professionals.”

LHB chairman Ed Roberts said: “This is the first resource centre of its kind in Wales which offers huge opportunities for modernising the way services can be provided.

“Four years of planning has now come to fruition and I would like to thank the many people who have been involved.”

Assembly Health Minister Edwina Hart will formally open the centre in November.

BACD holds restorative dentistry study club

The British Academy of Cosmetic Dentistry is holding a study club on ‘Symbiosis in Dentistry – Orthodontics and the Restorative Dentist’.

Dr Peter Huntley, founder of Quality Orthodontics, one of the country’s largest adult orthodontic practices, will be doing the presentation.

Dr Huntley is also a part-time lecturer at the Royal London and Eastman Dental Hospitals and in this session will be focusing on how interdisciplinary management of complex problems can generate improved outcomes.

The presentation will cover areas including gingival margin problems, the redistribution of space, paralleling teeth and access for hygiene and third molar issues.

The session on restorative dentistry will take place on 5 November at the British Dental Association.

For more information or a booking form contact Suzy Rowlands on 020 8241 8526 or email suzy@bacd.com
FDI closes Annual World Dental Congress in Singapore

World Dental Federation appoints new president and invites to Brazil

Singapore: Singapore has a long and successful relationship with the dental profession. Not only does the city state host the oldest running dental school in Asia; first implants were placed here by Dr Henry Lee almost 20 years ago. Nowadays, the island boosts a workforce of 1000 dentists that are both educated internationally and make use of the latest state-of-the-art equipment. Large international manufacturers such as 3M ESPE and Straumann have taken advantage of the Singapore’s position as a trading state to host the oldest running World Dental Congresses (AWDC) in Singapore. An AWDC was held here before in 1994 and the FDI has been cooperating with the Singapore Dental Association (SDA) in organising IDEM Singapore’s scientific programme for almost four years.

This year’s congress was held in conjunction with Singapore’s Oral Health Month, an annual campaign that aims to improve oral health by offering free dental screenings to every Singaporean. According to the latest Adult Oral Health Survey conducted island-wide in 2005, almost half (46 per cent) of the respondents indicated that they visit the dentist at least once a year; the average mean DMFT was 8.1 and about 10 per cent of the respondents were caries free. A SDA spokesperson said that more than 200 private dentists will be participating in the screenings that will take place during weekends over the course of September.

Visitors were spoilt by this year’s scientific programme, which did not only feature popular topics such as implants, aesthetics, and periodontics, but also gave insight into new challenges and developments in dentistry. Among others, the prevalence of oral cancer, salivary biomarkers as well as the therapeutic potential of dental stem cells and tissue engineering were discussed. Limited Attendance Courses were expedited to give participants the chance to learn in a more intensive and intimate environment. Auxiliaries and office personnel had the chance to get their hands on the New Patient Experience in a special full day programme. As one participant put it: “What strikes me about this congress is how it brings together so many different specialist areas in dentistry, all under the roof.”

Though official numbers have not yet been released, exhibitors speaking to Dental Tribune Asia Pacific said that visitor’s numbers clearly did not meet their expectations. In spite of this, most exhibitors also reported increased numbers in sales and business deals. Plenty of new products and processes were introduced, for example surgical instruments and handpieces that now come with built-in and long-lasting LED lights. Nobel Biocare introduced their newest product NobelProcera for the first time to Singaporean dentists during an official launch dinner held at the Charlton Hotel. The system aims to combine industrialised production processes with versatile and individualised aesthetics for dental restorations.

In addition, continuing education was offered to trade show visitors through Dental Tribune in collaboration with the DT Study Club, who held their first online symposia outside the United States.

Members of the 2010 Local Organising Committee invited to next year’s congress in Salvador da Bahia in Brazil, home country of the newly appointed FDI president Dr Roberto Vianna. Dr Vianna, who took over the presidency from Dr Burton Conrad, Canada, received his DDS from the Federal University of Rio de Janeiro in 1965. Since then, he has been serving for many national and international health organisations, including the World Health Organization and the Latin America Association of Dental Schools.

“FDI is a collaborative project led by the FDI with the long-term goal of eradicating dental caries. In July 2009, the Rio Caries Conference was held in Brazil to launch the initiative and a series of follow-up events are expected over the next ten years. Dr Vianna also announced that he will support the GCI throughout his term as president.

Another important advocacy tool during his term will be the new Oral Health Atlas, which was unveiled during the FDI Congress in Singapore and will be available at Amazon UK after the FDI congress. According to Dr Vianna, this will be a landmark publication that will strengthen the FDI’s role as a world leader for the promotion of oral health information by demonstrating the state of world oral health in easy language, for everybody (from dentists to government delegates to the general public).

Speaking about the 2010 FDI Annual World Dental Congress in his home country Brazil, Dr Vianna borrowed a phrase from France’s national anthem, “le jour de gloire est arrivé” (now is our glorious day): “I am very happy with the direction we are moving in. Since I became part of the Executive Committee, there have been a lot of positive changes—new staff members, relocation of head office, our new Executive Director—and important projects, like the Global Caries Initiative (GCI),” he added.

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Change to complaints procedure triggers more queries

The new two-stage NHS complaints procedure has led to more dental professionals seeking advice from the Dental Defence Union on how best to respond to patients’ complaints.

The Dental Defence Union (DDU) saw a 20 per cent increase in members notifying them of patients’ complaints in 2008.

Rupert Hoppenbrouwers, head of the DDU said: “We don’t believe that the increase reflects a decline in standards but that members are sensibly contacting us for advice about the new two-stage NHS complaints procedure which came into effect on 1 April 2009 in order to ensure they meet its requirements.

“In addition, our experience is that members want to respond appropriately to a complaint in order to maintain a good professional relationship with the patient, because it is their ethical duty and to prevent the complaint from escalating into a General Dental Council (GDC) complaint or a claim for compensation.”

He added: “As I explain in my Dental Review in the 2008 MDU Annual Report, the emphasis of the new NHS procedure is local resolution, and we are encouraging members to comply closely with regulations that require careful planning of investigations and responses, as well as evidence for complainants that, if appropriate, lessons have been learned and changes made.”

The DDU has extensive experience of assisting members with complaints. It can help members draft initial responses to complaints and, on the rare occasions that complaints are referred to the Ombudsman or the Dental Complaints Service, it can also support members with this procedure.

The DDU’s Continuing Professional Development courses also provide specific practical advice on complaints handling.

Scottish dental centre up for design award

Dumfries Dental Centre in Scotland has been nominated for the Roses Design Awards.

The £2.7m Dumfries Dental Centre and Outreach Teaching Facility in Dumfries is a multi-functional dental centre incorporating eight general practitioner surgeries, six outreach training surgeries and four primary care dentistry training surgeries.

The centre is situated within the grounds of Dumfries Royal Infirmary located between the infirmary campus and the Crichton campus.

The building, designed by Archial Architects is long and linear in plan, culminating in a semi-circular form at its southern point.

A spokesman for the centre said: “A palette of bright, bold colours has been used to enliven the internal environment and make it visually stimulating. It is hoped that this has the benefit of helping dentally anxious patients by making the visit to the dentist less daunting.

“Views over the Nith Valley towards the Dumfriesshire hills have been exploited by maximising glazed areas to the waiting area and from the dental surgeries on the Southern and Western facades.”

The Roses Awards is an annual competition open to design and architecture companies outside the M25 boundary. The results of the 2009 Roses Design Awards will be announced at the awards ceremony which is taking place on Friday 23 October in Nottingham.

Dumfries Dental Centre won the NHS Scotland Environment, Estates and Facilities Annual Design Award in 2007.
Dental Access contract – read the small print

By Tony Jacobs BDS

T he name of Dr Mike Warbuton, a medical practitioner working for the Department of Health was one which had been coming up more frequently, and over the summer there was talk of the development of a new contract for dentistry, devised and pushed forward by this man and his team. Rumours were transmitted which suggested this contract would include some of the components from the Steele Review, which had been warmly received, but minus the piloting aspect that Steele had insisted upon. In fact Prof Steele had insisted on a long pilot with proper evaluation, and events now show us this “Warbuton” contract was being pushed to the front without any semblance of piloting. Dr Warbuton headed a “dental access team” and used the expertise of the DH’s commercial division in composing this complex document.

Through GDFUK, more whispers emerged, and a copy of this document arrived mysteriously in my inbox. More whispers followed and it transpired one of the dental unions expressed dissatisfaction on this in the GDFUK forum, having walked away from any further discussions with Dr Warbuton. Furthermore, it also emerged that the BDA had been discussing this contract simultaneously, and they too had a showdown meeting with the DH, and were also poised to cease discussions too.

GDFUK.com was able to publish this draft contract and a spreadsheet showing the application of the targets in the contract, and their bearing on the contract value, this is available to download at www.gdfuk.com/news and makes interesting reading for dentists concerned about the future of NHS dental contracting.

The contract is weighted differently to the present one, and as such does not base all the payments on achievement of UDAs, merely 51 per cent. This might sound like a good starting premise, but the remaining part of the contract value can be achieved by reaching other targets. 19 per cent of the contract value is made up of giving value for money plus good response from patients. Taut questionnaires about waiting times, the practice and treatment received, plus a further 30 per cent is based on reaching key performance indicators, which are outlined in the spreadsheet named in the above.

An example is the prescribing of antibiotics, and if a practitioner prescribed these at a rate lower than the average for the local PCT, then this reaches the target for that KPI. Inevitably this number would therefore fall each year, making a serious effect on practitioners’ prescribing patterns, and clearly affecting so-called “clinical freedom.” Other targets include reducing the number of regular patients seen each quarter, and gives more pay for seeing them yearly. Each of these requirements is listed and weighted, but not all of them is necessary to earn that 50 per cent of the contract value.

An example in the value for money category is to reduce the number of patients who have more than 24 UDAs of treatment in a 12-month rolling period. In other words, gaming the contract will be squashed, and genuine patients who need antibiotics, or who genuinely break teeth three times in 12 months will find it difficult to have a third lab item if the dentist is to meet targets. There is an example of the DH trying to ensure that previous suspected gaming by practitioners is not unpunished.

The KPIs are split into three weighted 10 per cent categories, access, effective care and health promotion. Under the contract, every patient must be asked about smoking, and then 90 per cent are to be “signposted” to cessation services to meet the next target. This might help oral health, but is not what has been seen as dentistry. This is only a selective summary and the detail is available to download.

In addition, the contract is composed of many schedules. This might sound like a good start. Or is this a last gasp move to give ownership of the practice to the PCT in the event of termination of the contract, imposes many requirements on the contractor concerning terms of who is employed and how, and more akin to a contract of employment than one between an independent contractor and a health commissioner.

Publication of the draft provoked a cascade of responses. The following day, the BDA issued a press release, and wrote to GDFUK members. The BDA summary was clear, they saw the contract as initiating micromanagement of dental practices, with a vast array of detailed requirements. The contract would have been better used for family practices, and would leave them at constant risk of breach if they did take it on. GDFUK had met with the DH on this matter, but had made no progress in making it even slightly suitable. The GDFP Executive had decided to continue with discussions rather than walking away. Their advice went on to tell members that this was largely a copy of the Warburton Dental Access Contract as it is unsuitable, and open to lengthy and complex litigation. The KPIs was not evidence based, just invented to fit with the spreadsheet.

Advice from all sides is not to enter into this arrangement – the corporate practices are led the way with their commercial nous – if they will not attempt to make this work, it has to be a poisoned chalice for any practitioner.

About the author

Tony Jacobs, 52, is a GDP in the suburbs of Manchester. He is married to Steve Lazarus at 66Dental (www.66dental.co.uk). He has had roles in local DCG, local DCS and with the annual conference of LCDGs, and is chair of the Dental Protection Protection. Nowadays, he concentrates on GDFUK, the web group for UK dentists to discuss their professional and commercial issues rather than walking away. He enjoys reading for dentists concerned about the future of NHS dental contracting.

Dr Roger Matthews on £AC

In the past four years, the cost to the taxpayer of NHS dental primary care has virtually doubled, from just over £1.2bn to nearly £2.3bn. What do we have to show for this? Despite a small upturn in attendance figures from June 2008 to March 2009, there are still over 600,000 fewer NHS patients being seen.

Given this situation, and faced with criticism from politicians, the profession, patient groups and from within the NHS itself, clearly something had to be done. Professor Jimmy Steele’s Review – with which we have all been preoccupied for the past two months – was the obvious choice.

But behind the scenes a much larger policy initiative has been underway. A grand concept: to unite all primary care providers under one contractual formula. And only now do we see the result – the Warburton Dental Access Contract. The framework calls for a five-year contract – into the relative unknown of post-election public spending uncertainties. So is there funding for those five years, earmarked in advance? If yes, that suggests that dentistry still enjoys a unique position as a ring-fenced NHS budget (until the election). If not, then it is doubly unwise to consider accepting these onerous terms would say punitive terms.

So is this a development of the process which started in 2005 with the New Contract? The CDO has claimed that the 2006 reforms were tailored requirements. The contract as it is unsuitable, and open to lengthy and complex litigation. The KPIs was not evidence based, just invented to fit with the spreadsheet.

Advice from all sides is not to enter into this arrangement – the corporate practices are led the way with their commercial nous – if they will not attempt to make this work, it has to be a poisoned chalice for any practitioner.
The thing to remember about the Access Contract is that it is only linked to the work that Mike Warburton’s team is doing; it is focused on the access programme, working with PCTs, to develop around 150 brand new practices across the country. The draft of the access contract that has been released was an early draft that the team shared with the NHS to get their feedback. The team also shared it with the British Dental Association (BDA); we agree with the BDA that this is a work in progress. The access team has met with the BDA several times and there are more meetings planned.

The contract does include some suggestions that Jimmy offered in the Steele review but then again the access programme pre-dated the Steele review so it would have been silly to ignore the work that Jimmy was doing.

The most significant work relating to Steele will be piloting with existing practices. We are committed to getting that running as soon as possible, but we need to agree what we are going to pilot, where we are going to pilot, how long are we going to pilot for and how we are going to evaluate them. The intention is certainly to have Steele review pilot lots up and running by the Spring.

There have been many reports on dentistry in the past and we have a long history of not implementing them. What the Secretary of State Andy Burnham said at the press conference when we launched the Steele review was that we have to make sure we implement these recommendations. I am committed to doing just that — we will have a implementation board to make sure we implement it and, like the review itself that will have considerable engagement with stakeholders.

Going it alone
Trading as a limited company can hold benefits for dentists. Michael Lansdell explains

Going limited" might not be suitable for everyone; for dental professionals to decide whether their circumstances would benefit from incorporation, it is vital that they fully understand the role of each specialist. Just as members of the dental team work well together and complement each other through their specific strengths, so accountants, brokers and solicitors make up a synergistic team when dealing in their own area of expertise. Although multitasking to a certain extent can be helpful, the intricate balance between all parties is at its optimum when roles are kept separate.

The next step
The role of the specialist accountant is to completely evaluate a dentist’s business and personal circumstances to work out whether incorporation is the best step forward. Skilled at identifying tax savings and other benefits to the client, a good accountant should provide a balanced view on incorporation, detailing what the dentist can expect after becoming a limited company. Taking into account the ultimate sale value to third party and if the total net benefit is worth the process, the accountant will then create a unique incorporation blueprint for the practice.

Brokers who have considerable experience in gaining the proper valuation of a business, as well as providing a goodwill valuation well supported by comparable sales of similar practices should be approached when ‘going limited’. Gaining such a valuation is key in the event that the transaction is examined by HM Revenue and Customs, ensuring the dentist has a justified explanation of methodology and negotiating comparisons to support the true practice value.

Solicitors assist in the sale of the business agreement from sole trader to limited company; their skills are needed to set out a legally enforceable sale agreement that is appropriate for everyone’s needs. Flexible enough to not create any restrictions pertaining to the agreement by taking into account the close association between vendor and purchaser, the solicitor will protect the interests of both parties. Dentists can also benefit from the solicitor aiding any possible conveyancing process, for example, property sale and rental agreements back to the limited company.

Ask for advice
Consulting an Independent Financial Adviser (IFA) is useful when assessing whether the rules will allow the transfer of a freehold property into a Self Invested Personal Pension (SIPP).

They will also give advice on pension investments, and deal with additional contributions from savings generated by incorporation, to increase the size of pension pots. This kind of expert team will guide a dental professional through a successful incorporation, provided each member works to their strengths, as there are potential problems that might occur if specialist’s roles are confused.

Although trained in valuation techniques, accountants are not open to the same information on comparable practice sales and prices as brokers. Brokers will be able to provide an accurate, justified goodwill value that will be sustainable under HMRC scrutiny.

Accountants are involved in liaising with the solicitor and coordinating the incorporation, however they should avoid attempting legal advice such as negotiating with a for contract transfer as it might cause problems. A solicitor should always be involved when documenting the terms of sale between the sole trader and limited company in a genuine arm’s length sale.

Defining roles
Keeping roles clarified throughout the incorporation process will ensure the dentist receives advice tailored to his specific circumstances. Approaching a solicitor for accounting tax advice on incorporation might prove problematic, a conclusive answer will be provided by an accountant skilled in calculating whether becoming limited would be a net benefit or net cost to the dentist. By assessing the potential savings against financial downsides, incorporating fees and potential risks, the accountant will advise whether the business will be strengthened by incorporation.

For the right practitioner, there are numerous advantages to becoming a limited company, and with expert advisers, it can be an uncomplicated course to take. Working with an interdisciplinary team that knows their strengths and limits can make the incorporation process effortless, and with clear boundaries of responsibility dental professionals will know what to expect from their respective advisers.

About the author
Michael Lansdell was brought up in South Africa, receiving his honours degree there in 1991. He completed his training with international accounting firm Deloitte in 1994, and went on to become a founding partner at Lansdell & Rose Chartered Accountants (SA) a year later. Based in Kensington, London, Lansdell & Rose deal only on a long-term retained basis, exclusively with owner-managed clients, generally dentists and doctors, and specialising in the incorporation of dental practices. To contact Lansdell & Rose, call 020 7376 9333.

Dental Tribune spoke to CDO Dr Barry Cockcroft about the Dental Access Contract

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News
Periodontal disease encompasses a wide range of conditions which affect the supporting structures of the teeth. The term “periodontal disease” refers to chronic periodontitis among other conditions.

When presented with a patient with periodontal disease, a risk assessment would be beneficial in order to ascertain the patient’s susceptibility and risk of disease progression. A risk assessment is beneficial for our patients so that appropriate and individualised management and treatment plans can be devised. The benefits of such an approach are multiple. A risk factor is defined as a factor that increases the probability of developing the disease. Smoking is an example of a risk factor for periodontal disease. Numerous studies have shown smokers are more likely to develop periodontal disease compared to non-smokers.

Another risk factor is plaque. The presence of plaque bacteria and the development of a mature bacterial community will lead to development of disease in a susceptible host. Smoking and plaque are risk factors that are modifiable. Perhaps it would be more appropriate to consider plaque as an aetiological factor.

Plaque is considered to be an important aetiological factor in the development and progression of periodontal disease in a susceptible host. Pathogenic organisms found in dental plaque have been associated with the development and progression of periodontal disease. While various periodontopathogenic organisms have been associated with disease, it has been difficult to identify one (or a group) of specific organisms that are specifically causal for periodontal disease.

In the 1960s it was believed that it was the entire plaque mass and its constituent organisms caused periodontal disease. Treatments were aimed at removing the entire plaque mass. The non-specific plaque hypothesis was the accepted theory and assumed that it was the collective accumulation of all the bacteria and the noxious bacterial products that caused the destruction of supporting tissues and development of periodontal disease.

Much research work has since focused on trying to identify specific bacterial pathogens that may be contributing to periodontal disease. Although high counts of certain specific pathogens such a P. Gingivalis, A. Actinomyces, P. Intermedia and T. Pyothorus have been associated with diseased sites, it has been difficult to identify any specific micro-organisms that are the definite cause for disease. Although the specific plaque hypothesis was suggested, proving it has not been as simple or straightforward. Furthermore, the presence of absence of these periodontopathogens has not been useful to predict future disease activity. Hence, their presence does not indicate cause in all cases.

The ecological plaque hypothesis has therefore been considered. This is somewhere in between the two previous hypotheses. It is thought that the presence of certain bacteria is more likely to cause disease in a susceptible host in the right environment. These bacterial species may be highly associated with development or progression of disease in the right conditions and a susceptible host. This explains the complexity of periodontal disease and how it is influenced by so many risk factors.

Despite having an understanding of the risk factors and susceptible factors, very few factors can be modified. Behavioural characteristics that can be modified include improvements in oral hygiene and smoking cessation. Influencing the host susceptibility is not always possible. Identifying causal microorganisms is not always straightforward either and therefore treatment aimed at eliminating only specific periodontopathogenic microorganisms is not always successful. However removal of the entire plaque mass and aiming to address modifiable factors such as smoking and poor oral hygiene would result in much more predictable outcomes.

In view of this, the main mode of treatment for periodontal disease is aimed at removing the entire mass of plaque. The treatment regime therefore adopts the non-specific plaque hypothesis. These limitations therefore explain why the treatment regimes in periodontology have remained unchanged for so many years. What can be questioned is that despite knowing this mode of treatment for so long, why do clinicians still get limited success when treating periodontal disease?

It may be because the success of treatment relies on many factors, some of which are influenced by the clinician and the patient and others which are not.

One of the most important factors is oral hygiene, and the motivation of the patients to achieve and maintain optimal oral hygiene.

When presented with a patient who has established chronic periodontitis, it is important to include patient education and supragingival and subgingival plaque debridement as part of the initial management plan. Evidence has shown that in the presence of plaque, the outcome of any treatment (surgical or non-surgical) will be very poor. It must therefore be stressed to the patient that their role in maintaining an optimal level of oral hygiene is very important.

‘Plaque is considered to be an important aetiological factor in the development and progression of periodontal disease in a susceptible host’

Educating and motivating patients is a very important stage in periodontal treatment plan. Patients would normally present with complaints such as bleeding gums, mobile teeth, periodontal abscesses or sensitive teeth. However a simple “brush your teeth”, or “use an electric toothbrush” advice may not suffice. Following a thorough examination and periodontal assessment, a more detailed and individualised approach in oral hygiene instruction would perhaps yield better results. Such an approach would need time, patience and regular reinforcement from the clinician. A suggested approach may be to approach it using these steps.

1. Explanation and Education

Explain and educate the patient on the role of plaque in the development and progression of periodontal disease. It is important to stress to the patient, their susceptibility and risk of disease.
role in achieving optimal supragingival plaque control and how this would positively influence the outcome of the treatment.

2. Visual Aids

There is no better method of education than visual aids and actually showing the patient the main areas of plaque accumulation in their mouth may have a greater impact, rather than simply saying where the plaque is. In addition, a quantitative method of measuring plaque would help set and achieve targets for patients this can be done using 2 stages.

a. The first stage would be to use disclosing solution so that the areas of plaque accumulation can be shown to the patient (using either a mirror or a photograph). This will act as a visual guide for the patient.

b. The second stage would be to record these areas of accumulation on a plaque chart and calculate the plaque score as a percentage.

It is very useful to record the plaque score as a percentage and therefore provide the patient with a quantitative method of measuring plaque. A measureable method is very useful to set achievable targets for the patient to reduce their plaque score. Thus the patients are actively involved in their own management, keeping them interested and motivated. Patients also feel that they have a degree of control over the treatment outcomes. If the plaque score is then measured at each subsequent visit, it is possible to inform the patient about their progress in a measurable and numerical form, which they will understand better.

3. Oral Hygiene

Demonstration

The next stage would be to show and physically demonstrate to the patient, the best methods to achieve plaque control in the areas where there are visible deposits. This would involve demonstrating effective methods of toothbrushing (such as the modified bass method) and interdental aids such as flossing, tepe brushes or bottle brushes.

The clinician should also ensure that the patient is actually using these aids correctly by asking them to physically use them while in the dental chair. Any errors can thus be corrected immediately.

4. Written Instructions

While good education and instructions in oral hygiene and plaque scoring, actively engages the patients whilst they are in the dental chair, they may not immediately absorb all the information. Providing them with a written summary of the main points discussed and the targets set for the next visit would actively engage them and also perhaps motivate them to continue to focus on oral hygiene improvements.

The plaque scores and other set targets can then be reviewed at subsequent visits. This method of oral hygiene improvement can be used by the periodontist, the dentist or the hygienist. Its simplicity makes it versatile and allows the patient to get the benefit of a team-based approach. It also provides a way in which to assess the patient motivation, prior to embarking on a more time and expense consuming course of complex periodontal treatment. There is no doubt that such a process is time consuming and the constraints within the surgery may have a make is difficult to achieve. However the benefits are numerous and the process can be followed over multiple visits if need be.

In motivated patients, such an approach would help to improve their plaque control and hence provide more predictable treatment outcomes. However, the clinician must remember that periodontal disease is complex, and various other risk factors and susceptibility factors can influence the outcome. Host susceptibility, genetic factors and systemic factors are examples of these. Therefore while plaque control is the definite mainstay, it is not the only factor.

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When I was a dental student lots of years ago, we all used to read stories by Damon Runyon, from which the musical Guys and Dolls was derived, and one of the characters we really liked was known as Mr Nicely-Nicely Jones. He was always smiling, and everyone liked him. Whenever anyone asked how things were going, he would respond: “Nicely, nicely.” Despite the fact that I have met some sticklers, cads, bounders and rotters in my time, the British are generally known to be “nice”, a nation that prides itself on “good” behaviour and consideration for others. There is a problem to this epithet, however – it is used too frequently. This creates a certain laziness of phrase: instead of describing someone with meaningful words such as kind, considerate, decent, intelligent and wise, we say they are “really nice”. The converse is also true: when we talk of the aforementioned sticklers, cads, bounders and rotters, the most commonly used descriptive phrase is that they are really “not very nice”.

There are other problems associated with being nice. Niceness is often associated with blandness, and I would generally prefer to be called anything other than nice (and have indeed been)! A recent survey has highlighted the fact that “nice” people earn on average £1,500 less per annum than others who are more aggressive or even nasty.

Does this have significance in the context of dentistry? Not really. Patients will attend a dentist who is nice to them, but will avoid one who is not very nice – in fact, being not very nice is often the precursor to a complaint being lodged. So, one phrase that a dentist who is not very nice could learn to employ is “I’m sorry that you did not have a good experience here today, but I will try to ensure a better one next time” or a more succinct version of this.

Although the two words “nice” and “good” are often used in similar contexts, they are by no means interchangeable. A dentist can be nice but not good, and the converse is true. Now, here lies the conundrum: it is extremely easy for a patient to know whether a dentist is nice, but not whether they are good at their job. The consequence of this may be that dentists doing poor work but who are nice to their patients are far less likely to have complaints levelled against them than dentists who are good at their job, but lack the ability to relate easily with their patients. From this, we may reasonably come to the conclusion that it is better to be nice than good.

Being good, however, raises another problem: is “good” good enough in dentistry? There may not be a simple answer to this, and it really rather depends on the expectations of those paying the bills, whether patient or employer. If a payee believes they have got value for their money, then good may sometimes suffice, but the more they spend, the greater the expectation.

Remember the immortal words uttered by Gerald Ratner when he was addressing the CBI. He was asked how it was possible to sell a piece of jewellery at lower cost than a Marks and Spencer’s prawn sandwich, and he responded by saying that his goods were “crap”, and would not last as long. Now, crap is not a nice word, and while until then the public were prepared to buy his goods in large quantity, they were not prepared to do so when he appeared not to be nice. His business went down the tubes as if slurped by high-speed suction. It behoves us therefore to ensure that we do not make a similar mistake. Be good, or even better, very good, but just as important, be nice – unless you want to earn £1,500 pounds per annum more than you do.

Ed Bonner considers The case for... and against Being nice and good

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Look to the future

To make sure you have a fruitful retirement, it makes sense to capitalise on your assets ahead of time. ASPD member Lyndsay Luquoq of Libran Management offers some advice.

Ideally, retirement is an exciting time, which if prepared properly, should see career efforts come to fruition. However, for some, retirement is an event that has not been properly prepared for and inevitably will fill individuals with uncertainty. Knowing where you stand with pension and retirement planning is crucial, and the first step towards planning for the future.

Facing reality with retirement plans enables maximum preparation, and if retirement is five or more years away, it is still possible, with expert help, to consider all options as a proactive attitude will make your retirement plan a productive experience.

Unless you have a stable retirement plan in place, receiving guidance from a dedicated dental industry management company is highly beneficial and will include invaluable guidance on methods to improve your practice for an enhanced sale price. Experienced management consultants will have firsthand knowledge of the pitfalls practitioners can experience when they are not correctly prepared for selling their practice and the impact it can have on them and their staff.

The sale of a dental practice is a vital factor to think about when planning for retirement, and in preparation, a practitioner can assess whether they will need assistance by considering the following factors:

Confidence in potential

Consider ideas that would benefit the growth of the practice to its potential maximum, implementable ideas that would increase the gross income of your practice will ultimately increase gross practice value. Ideas to consider include widening the patient base by employing alternative treatments, or renovation of surgery and waiting area. Increasing patient lists and patient retention may also enhance practice image, making it more attractive to prospective buyers.

Objective practice view

Gaining an outside opinion on your practice potential enables practitioners to see if there are any aspects you have not thought of that can be improved upon. Sometimes it is difficult, due an excessive workload or too much involvement in practice, to realise areas in which more attention should be placed.

Involvement of staff

Involving staff is essential in the effective management of a practice. Assessing whether your practice is both cost effective and organisationally efficient can be aided by full involvement of practice staff to gain their opinion.

Factors such as both external and internal decor of your practice should also be considered. If you would not be happy attempting to sell your practice in its current state it will need an update to maximise sale potential.

Patient base

Awareness of an updated patient list will aid a practitioner’s assessment of practice potential and assist the implementation of plans for pre-retirement business growth.

Staff job descriptions

The majority of practices sold come with staff already employed, and to make the new practitioner’s transition as smooth as possible, job descriptions are key.

Keeping contracts for all staff is fair to both employer and employee, including practice associates and therapists. Potential buyers are more likely to feel secure buying a practice if contracts are already signed and in place, and knowing if associates will leave once the practice is sold will aid the buyer in planning for future recruitment.

Practice health and safety

Passing health and safety and infection control inspections is crucial to maintaining a practice and fulfilling legal obligations. A practitioner should have confidence in their practice to pass inspections to a satisfactory level once every two years.

Insurance policies

Reviewing current insurance policies to ensure the practice is both correctly insured and paying a cost effective premium is essential to reducing unnecessary overheads and safety assurance.

Organisation finances

Regular contact with the Financial Services Authority or an IFA will aid a practitioner in managing both personal and business finances to their optimum level. Being aware of what your pension income will be after retirement is crucial to future planning, as is noting the current total of a pension fund.

Ease of potential sale

Is the practice leasehold? If so, is the current lease long enough and sufficiently safe to make a sale possible when a sale is attempted?

Preparing your practice for sale is just one factor to be considered when reviewing retirement plans, and should not be overlooked. By working with an experienced management support company, dental professionals can ensure their practice is ‘up to speed’ and is achieving full potential, vital when planning ahead for retirement.

ASPD member Libran Management deliver management solutions supporting dentists in all non-clinical aspects of their practice, and offers dental professionals an expert retirement support service for those considering retirement in the next five to 10 years.

About the author

Lyndsay Luquoq

For more information on the ASPD please call 0800 458 6773 or visit www.aspdm.co.uk.

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When Henry Schein acquired Minerva Dental in the summer of 2008 they both had teams of highly qualified service engineers and naturally there was some concern amongst the teams as to what the new combined department would look like and how it would work. They needn’t have worried. What emerged from this union was a symbiotic relationship that has proved extremely valuable for Henry Schein Minerva, for their team of Service Engineers and most importantly for their customers.

Gary Maycey and Lee Totterdale are two of Henry Schein Minerva’s Service Engineers, each come from very different backgrounds, but each have the same drive and desire to solve problems and help customers run smooth and efficient practices.

Gary joined Henry Schein in 2002 and is predominantly based in the South East, while Lee covers territories in Wales. Henry Schein Minerva’s extensive resources are now enabling each Service Engineer to cover a smaller and more local area, allowing them to be more responsive to customer needs.

Lee’s first experience of Henry Schein was when Minerva Dental, was acquired in the summer of 2008. Of course there were some initial reservations about procedures and ways of working that naturally go alongside such an event, but Lee admits these concerns were unfounded.

“We were about 15 of us working for Minerva Dental whereas now we have a team of about 40, this means we have more resources to call upon when we need them. We’ve really formed a tight unit, share our experience and help wherever we can. We also work very closely and are part of an overall field team of 100 who are calling on practices every day”.

Although Henry Schein Minerva’s team of Service Engineers covers the whole of the UK, individually they tend to work in the same local area most of the time, servicing their local customers and managing their work and time locally. But behind them lies a rigorous system that co-ordinates schedules, plans installations and ensures that the whole team is working efficiently and meeting the needs of customers at every level.

Gary and Lee tend to divide their time between installations, service call-outs and Henry Schein Minerva’s Planned Maintenance Programme. Maintenance of surgery equipment is extremely important with the rigors of everyday practice taking its toll. It should be just like servicing a car regularly. Signing up to the PMP is a way of ensuring as far as possible that all surgery equipment stays in excellent working order.

Henry Schein Minerva are suppliers of a wide range of manufacturers’ equipment including chairs, digital x-ray systems, OPGs, scanner systems, and the knowledge the service engineers have of the many types of hardware and software is extensive. One aspect that Lee has found particularly impressive about Henry Schein Minerva is the level of training they receive as engineers.

“We are all factory-trained and visit the manufacturers’ facilities to be trained by their people. This gives us a fantastic in-depth knowledge of the working capacity of the equipment.”

Gary also appreciates the importance of really good training and his experience of the speed of technological advancement within dental equipment underlines “Part of our job is to be a ‘friendly face’ for Henry Schein Minerva and this role involves lots of different aspects. Part of it is to set the customer’s mind at ease and reassure them that we are only a phone call away.”

“Part of our job is to be a ‘friendly face’ for Henry Schein Minerva and this role involves lots of different aspects. Part of it is to set the customer’s mind at ease and reassure them that we are only a phone call away.”

After installing, repairing or servicing equipment, a formal “handover” strike normally takes place with the practice principal and relevant members of staff. This includes a broad summary of the workings although more in-depth training is available from Henry Schein Minerva’s team of hi-tech specialists if required.

After-sales support is a key factor at Henry Schein Minerva and Gary and Lee are proud of the role they play, ensuring the customer experience is always a positive one and encouraging personal recommendation.

“Part of our job is to be a ‘friendly face’ for Henry Schein Minerva and this role involves lots of different aspects. Part of it is to set the customer’s mind at ease and reassure them that we are only a phone call away.”

Both Lee and Gary have worked on a number of installations during their time at Henry Schein Minerva. One of the biggest installations Gary worked on was a complete refit of a 7-surgery practice in London’s West End. The practice refit involved surgeries located on three floors and in a basement and the project provided some unique challenges to the team, who completed the refit in just seven days. The Henry Schein Minerva team worked with technicians from a number of different manufacturers to achieve the desired goal and the dentist was delighted, not only with the speed of the refit but also with the quality of the craftsmanship.

“We planned the whole job with military precision and it was quite a challenge to keep to the very strict deadlines we set ourselves. Maneuvering the dental chairs up the building’s narrow staircase gave us a few scary moments but those are the challenges that give you most job satisfaction.”

Both Gary and Lee clearly have great enthusiasm for their jobs and they enjoy being in control of and responsible for their day to day time management. Gary loves speaking directly with the customers and has an amazing knowledge of a wide variety of equipment.

“Everyday is varied, whether installing new equipment or carrying out planned maintenance, providing the best solutions for our customers is the most satisfying part of the job. It’s great to be part of a highly trained national team, but doing a fantastic job for the customer is what really makes the difference.”

The job of a Henry Schein Minerva service engineer is both varied and challenging and one day is never like another. Both Gary and Lee appreciate this flexibility and the fact they are able to work with a wide range of equipment from some of the world’s leading manufacturers, all underpinned by the solid foundation of Henry Schein Minerva is a winning combination.

For more information email: me@henryschein.co.uk
“Everyday is varied, whether installing new equipment or carrying out planned maintenance, providing the best solutions for our customers is the most satisfying part of the job. It’s great to be part of a highly trained national team, but doing a fantastic job for the customer is what really makes the difference.”

Lee Totterdale & Gary Maycey - Henry Schein Minerva Service Engineers

Partnership in Practice

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Trading up?

If you’ve a second property that you wish to rent out, doing so as a holiday let could allow you tax benefits, says Richard Lishman.

The letting or property is not a trade. However, the Furnished Holiday Lettings rules allow landlords of furnished holiday properties, which satisfy certain conditions, some of the tax treatments available to traders.

In the April 2009 Budget, changes were made to the rules for Furnished Holiday Lettings. These changes will potentially affect owners who let their UK holiday home out on a short-term basis and who are liable to pay UK tax. Owners liable to pay UK tax who rent out furnished holiday accommodation in the European Economic Area (EEA) will also be affected by the new rules. Since 1984, special tax rules have applied to the business of furnished holiday lettings (FHL). These rules give FHL, some of the tax reliefs afforded to trading businesses, provided certain conditions are satisfied.

Historically, to qualify as a furnished holiday letting, the following conditions had to be satisfied:

- The property must be let on a commercial basis
- The tenant must be entitled to the use of the property for at least 40 days and let for at least 70 days, in a 12-month period
- The property must be available for letting to the public for at least 20 months to the same person, and for the property to still qualify as a holiday let. This would not be uncommon in areas with defined holiday seasons, and where a reduced rent is charged over the winter to ensure occupation.

However, notice was effectively served on the tax efficiency of FHLs (following the requirement to extend the relief to EU properties – holiday homes abroad – in order to avoid offending non discrimination) in the Budget 2009, which announced that these tax reliefs will be discontinued from 4 April 2010. From that date, in order to benefit from the special tax reliefs that previously applied, businesses operating as FHLs will need to demonstrate that they are operating as trades.

**Tax reliefs available**

- The business will be treated as trading and therefore any income will be taxed as earned income.
- Any losses that arise can, as trading losses, be offset against other income and capital gains.
- Capital gains tax roll-over relief, hold-over relief and entrepreneurs’ relief will be available.
- An FHL will be counted as a qualifying activity for capital allowance purposes.

**The current FHL rules**

To qualify as an FHL, a business must currently satisfy both the (1) commercial condition and (2) the letting condition.

**Furnished Holiday Lettings**

1. **Commercial condition**
   The property must be let on a commercial basis with a view to the realisation of profits. It is important to note that the property must be commercially let to obtain the tax reliefs. This is particularly important when one is considering loss relief. For example, if losses arise over three consecutive years, it may be difficult to justify that the property is being let commercially.

2. **The position on 6 April 2010**
   It is proposed that the statutory reliefs for FHL will be repealed from tax year 2010/11. This means that for a FHL business to continue to qualify for all the tax reliefs mentioned above, it will need to be able to demonstrate that it does, as a matter of fact, operate as a trade – this is exactly the position that existed before Finance Act 1984!

3. **Operating as a trade**
   There is little statutory guidance on what is a trade other than the definition in section 900 ITA 2007 which defines a trade as including any venture in the nature of trade. Further guidance can be obtained from the judgements in various Court cases. The fundamental point will frequently be whether a person is deriving income by trading or is a mere landowner who is deriving income from exploiting the property.

**Defining a trade**

Frequently, for example, the activity of a hotelier would amount to a trade because of the extensive services that are provided whereas at the other end of the spectrum a person offering a self-catering apartment for hire and who was not providing any ancillary services would probably be regarded as undertaking an investment business. There will, of course, be many cases in between and property owners should contact their tax advisers in advance of 6 April 2010 to make sure that their business profile gives them maximum scope for tax reliefs.

(1) **National Insurance aspects**

Typically, FHL income has been regarded as land property income for NIC purposes. After all, given the special statutory provisions that exist, there has been no need to try to justify that an FHL is a trade. However, if it is desired to keep the tax advantages of a trade with effect from 6 April 2010, it will be necessary for the business concerned to qualify as a trade in the own right. This means the business will need to be registered as a trade under Class 2 and Class 4.

(2) **Inheritance tax aspects**

In the context of FHL, inheritance tax business property reliefs do not rely on a business satisfying the letting condition within section 525(2) ITOA 2003. Instead, the FHL must amount to a business and that business must not be an investment business i.e. one that deals in or holds investments – in this case land. In the past, it seems that HMRC has agreed business property relief where:

- The lettings were short term, grand.
- The owner was substantially involved with the holiday makers in terms of their activities from the premises. This whole area could be under review and it seems likely that, in order to obtain business property relief, the owner of FHL will need to demonstrate that a reasonable level of services is provided by the owner to the tenants.

4. **Extension to EEA**

In the meantime (and very possibly one of the main reasons for the change), the current statutory relief is being extended to all parts of the European Economic Area and this will open up opportunities to recover tax relief for previous years with scope to go back and amend previously submitted tax returns. For 2007 returns, HMRC has extended the amendment deadline to 31 July 2009. Professional advice is essential.

About the author

Richard T Lishman is a partner at Money4Dentists, a specialist firm of independent financial advisers who help dentists across the UK manage their money and achieve their financial and lifestyle goals. For more information, call 0845 545 5060, email info@money4dentists.com or visit www.money4dentists.com.
Marketing made easy
When it comes to communicating with patients, what language do you use? Simon Hocken finds out

Investing in various marketing strategies is crucial to communicate a commitment to excellence, in order to reach prospective patients and reinforce relationships with current clients. However, one of the key reasons patients choose your practice is your direct communication – whether face-to-face, over the telephone or by email.

These days, many patients are more tentative in their spending; this is not to say that they will not invest in treatment, but they need to know that they are receiving a quality service that they value. In the midst of a credit crunch, nobody likes to entertain spending unnecessarily. So how do you ensure that patients pick up on your professionalism and dedication?

Positive communication is not just about listening to patients and ascertaining their specific needs; nor is it just about being able to explain clearly and succinctly about what options they have, and what each procedure entails.

Answering the phone
A crucial and often overlooked aspect of effective communication is ‘word choice’ and ‘tone’. This starts with answering the phone at reception to potential or existing patients. For instance, answering the phone with a “Hello, the dental practice” presents a different picture to the caller than a sunny “Good morning, the dental practice, this is <name> speaking, how can I help you today?”

Certain words are loaded with negativity. When a patient calls to make an appointment on a particular day, but there are no convenient slots available, it is better to say that this is your “most popular day” rather than your “busiest”. It creates an image of patients choosing your practice because of the quality of your service.

Then there are the labels so many practices use. Why indicate that patients are likely to experience a delay before their appointment by calling the area the “waiting room”? Have refreshments, comfortable chairs, up-to-date magazines and stylish décor and call it a “client lounge”. If there is a delay, do not say: “Hope- fully you will not be waiting long”, go that extra mile by saying: “Mr Dentist is just going to be a few minutes longer while he cares for another patient, could I offer you a drink?”

Service with a smile
Patients want to be greeted and cared for from the moment they first contact the team until after their first appointment and your follow-up to that appointment.

Choosing your words and your tone and being “relentlessly positive” is infectious: it makes your patients (and you!) feel better and it’s very attractive. Patients remember how you made them feel. If you made them feel good when they rang up to enquire, then they will choose to make their first appointment with you. If you then follow this up by making them feel good throughout their experience within the practice and afterwards, then they are very likely to continue to come back to you. The simplest (and most cost-effective) marketing strategy there is!

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About the author
Dr Simon Hocken, founding partner of Breathe Business, a unique leading coaching and consultancy company which specialises in working with dental principals and their teams in order to develop and grow their practices. For more information, contact Dr Simon Hocken and the Breathe team by calling 0945 299 7209 or emailing info@nowbreather.co.uk.
O
ev over the past year I have noticed the economic downturn affecting more and more dentists. Twelve months ago, it was just referral practices or private practices suffering. Now, virtually every dental practice I visit is experiencing the downturn – even the NHS ones.

My new research on dental practice failure has led me to conclude that failure always is down to three things:

i) Spending too much money

ii) Low gross income

iii) Poor appointment book control.

Spending too much

Murphy’s Law on money says that people will always spend more than they earn, providing the bank manager will let them. So it is not surprising that dentists, who after all are grade-A professionals, can find their spending run away with themselves. It is very easy to do this, particularly given the ease with which dentists can get finance. There are dental banks, building societies, leasing companies, even specialist Islamic lenders – all of which will fall over themselves to lend to dentists. So rather than reign in the spending, the dentist simply gets another loan. This is fine in the short term; but it always ends in tears. Over the years, we have seen many causes of dental overspending – expensive cars, boats, excessive lifestyles, large houses, extensions, private school fees, horses, drinks and nights out, indulgent dental equipment, to name a few. The worst case we came across involved total indebtedness in excess of £2 million. And that was just for one dentist.

Low gross income

The second reason for failure is not grossing enough fee income on a day-to-day basis. So how can you increase your gross income? Here are some ideas.

1. Written treatment planning would help. It is surprising the positive response you will get from patients when you give them options of differing sophistication and quality. Remember, patients will always buy the best quality they can afford, providing the choice is given and the quality of solution is perceived. If you don’t believe it, think about the car you drive and why you bought it?

2. Recommendation system. Dentists produce some excellent work but few, if any, have a system to ask the patient for a positive recommendation. This is made worse by the fact that patients are often busy people themselves and forget all about your amazing dentistry the moment they walk out of the door. In any case you’ve a state of the art surgery with all the mod cons – you obviously don’t need any new patients do you? If only they new the truth!

3. Intra oral camera. A picture is worth a thousand words. Intra oral cameras can now be purchased for as little as £600. Forty times magnification can be a powerful persuader when selling your dentistry.

4. Practice brochure. This tells the patient your philosophy and explains your particular unique style of dentistry. It also lists the services the practice provides. And words he can’t understand and the brochure is too complicated.

5. Questionnaire. The result of patient surveys are a common problem for NHS practices either side of lunch too. It provides the patient an opportunity to ask the questions they are concerned about, which means not enough dentistry is being done, which means not enough gross income. The fact is, you will gross more out of seven to 10 patients a day treating them properly than you will seeing 60 patients for three minutes each. In the latter case, no dentistry whatsoever will be done. The same goes for the appointment book control.

Remember the old adage: Too many patients means not enough dentistry is being done, which means not enough gross income. The fact is, you will gross more out of seven to 10 patients a day treating them properly than you will seeing 60 patients for three minutes each. In the latter case, no dentistry whatsoever will be done. The same goes for the appointment book control.

About the author

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is a specialist dental accountant based in Hertfordshire. Geoff advises on a wide range of dental tax issues and regularly writes for the dental press. Geoff has more than 15 years experience with dentists’ accounts and is recognised for his proactive approach to dental taxation and business problems. He can be contacted on 01438 722224 or by emailing office@dentax.biz.
Before the ambulance arrives

Receptionists and practice managers are often left alone in the practice with patients, so it’s vital they know exactly what to do in a medical emergency.

There is now a requirement for registered dental care professionals to complete lifelong learning programmes on core subjects to ensure they maintain high standards of competence for patient care. Although receptionists who aren’t qualified dental nurses do not need to keep up-to-date with the finer details of decontamination management and radiological protection – one of the core subjects for DCPs—it is a vital area for every member of the dental team to maintain current skills and knowledge on what to do in a medical emergency.

It is not unusual for receptionists or practice managers to find themselves ‘home alone’ at the practice, with members of the public and patients able to enter the premises. So, if the worst was to happen, calling upon a suitably qualified colleague may not be enough to prepare the receptionist should a medical emergency occur.

Every team member should have a working knowledge of first aid. Simply speaking this is the first response to the situation prior to the arrival of a more medically qualified person. First aid should be straightforward. You will reassure the person and attend to the ABC of life by protecting the Airway, checking for Breathing and Circulation (ie heart beat), and dealing with any bleeding.

First Aid calls on simple skills, the easier of which can be learned in a few hours. You don’t need to know all about how the body works, you just need to understand what effects a certain injury or condition will have on a person and how you can help minimise the problem or compensate for it, until the ambulance crew take over.

Everyone knows you should not move an injured person. If you do and they have an injury as a result of a serious fall, the force of impact could have damaged their spine. What you need to do is concentrate on the things that will keep your patient alive like, protecting their Airway, checking for Breathing and Blood Circulation and dealing with blood loss. These are the things that can kill a person before the ambulance arrives, not a broken arm.

Assess for responsiveness

Tap the casualty hard on the collarbone (being careful not to cause any movement of the head or neck). Identify yourself to the casualty, even if they appear unconscious.

Check the Airway/protect the spine

Where possible, get a colleague or bystander to support the casualty’s head by placing their hands on either side of the casualty’s head. If the casualty is unconscious, you must protect their airway as the tongue may fall back obstructing it. Place one hand on the forehead (to prevent head movement) and have a quick look in the mouth for any obvious obstructions.

To check for skin temperature, place the back of your hand against your own forehead, then place it on the casualty’s forehead and make a comparison. Check for colour by turning the casualty’s lips back and look at the inside edge (it should be a red/pink colour). Check the pulse in the wrist or the neck. The normal adult pulse rate at rest is between 70 and 80 beats per minute.

Opening the airway

Kneel beside the patient on the side to which you want to turn them on to. If they are wearing glasses, carefully remove them putting them in a safe place. Straighten the casualty’s legs and open the airway by tilting their head backwards slightly and lifting the chin.

Ready for the turn

Place the arm nearest to you, out at right angles to the casualty’s body and bend the elbow so the upper arm is parallel to the head, palm upwards. Do not try to force the arm down or in to a position it does not want to go in to, just place it as above, as best you can. Bring the arm furthest away from you, across the chest and place it palm up, against the cheek nearest you. Hold the casualty’s hand there with your left hand, palm to palm, otherwise it will drop down again.

With your left hand, grip the leg furthest away from you and placing your hand under the casualty’s knee, bring the knee up so that the casualty’s foot is resting on the floor, tucked in next to their other knee.

Turning the casualty

Keeping your left hand holding the casualty’s hand palm to palm, against their cheek, place your right hand on the knee of the raised leg. Move back slightly from the casualty and roll them towards you and on to their side, by pulling on the knee.

Once the casualty is over, gently lay their head on the floor. Tilt the head back (moving the casualty’s head under the check as required), ensuring the airway stays open and is not obstructed by their own body. Move the upper leg so that the hip and knee are bent out at right angles to the body. This prevents the casualty from rolling backwards. Recheck breathing, pulse and return to a primary survey, every couple of minutes.

Remember: knowledge alone is not enough and cannot replace the need for organised hands-on training. So don’t just read this article, learn a life skill, get on a course and learn to save a life.

For more information, visit www.dental-resource.com.
BADN talks money

The British Association of Dental Nurses calls for all dental nurses to take part in its salary survey

BADN’s proposed survey, which is carried out online, asks dental nurses about their salary, how they are paid, what additional benefits their employer provides and about their specific domestic circumstances. BADN will then use the collated information to present a case to the General Dental Council for lowering the annual retention fee paid by dental nurses.

“We are receiving many calls at the BADN office from dental nurses – particularly those who work part-time – who find that the £96 annual registration fee is more than they can afford,” says BADN president Angie McBain.

She continues: “BADN participated in the GDC’s consultation exercise on the registration fee and advised that the fee charged to dental nurses should be lowered considerably; and that registrants who work part time should charged a lower fee. However, the response we received from the GDC was that there is insufficient evidence to suggest that changes to the fees policy or the current fee structure are necessary at present.

A dental nurse working full time on minimum wage earns around £9,600 a year before tax and pays a £96 registration fee. In comparison, a dentist (average earnings £89,000 before tax) pays £438. So, we decided to gather evidence on dental nurse salaries in the UK to present to the GDC.

How to participate

Anyone who has attended a BADN event over the last few years has been sent an email invitation to participate in the survey. Everyone else can access the survey through a link on the ‘Latest News’ page of the BADN website www.badn.org.uk, or through a link on the BADN page on Facebook. Participants can then forward an invitation to participate to colleagues.

‘All dental nurses in the UK are encouraged to participate in this survey,’ says Angie. ‘You don’t have to be a BADN member, and the more dental nurses add their information, the more viable our case will be.’

‘You don’t have to be a BADN member, and the more dental nurses add their information, the more viable our case will be.’

(1) NHS Information Centre – average earnings of all self-employed dentists (before tax) for year 2007-08

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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

Most businesses operating in the service sector pride themselves on the speed of their responses. With time, people who buy those services come to expect a rapid response as normal and may be disappointed when their level of expectation is not met. Dentistry is perceived as a service by most patients and by default the dental team is expected to be efficient.

Consider the instance when a dentist has amended a patient’s course of treatment on several occasions. Not only were more items of treatment required, the choice of materials was also altered. On leaving the practice, the patient always stopped at the reception desk to book the next appointment and was given a new bill on each visit. By the fourth visit, the patient was sufficiently confused that he refused to pay the bill and wrote a letter of complaint instead. The dentist countered this by not replying. Rather than following the protocol outlined in the practice complaints procedure, he sent a final demand to the patient, four weeks later.

Grounds for complaint?

The patient complained to the local PCT, who in turn wrote to the practitioner, asking him to deal with the matter by following his own in-house complaints procedure. The dentist in turn consulted Dental Protection. A letter was drafted, whereby the dentist explained that he regretted the lack of communication during the treatment. He apologised and explained the reasons behind the changes in treatment and the consequent revision of the costs.

The patient was reassured that the practitioner was reviewing the practice systems and offered an apology for the delay. This approach worked, as the outstanding amount was forwarded by return. In addition, a short letter was drafted to the PCT confirming that the member would in future respond promptly to any complaints, should they ever arise. Although it may seem irksome, replying to complaints swiftly and sympathetically, is certainly worth doing and always advisable.

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PracticeWorks
The Use of Mineral Trioxide Aggregate (MTA) in Root End Surgery: A Case Report

By Dr Satinder Matharu

Non-surgical endodontic treatment gives good and predictable results in most cases, and even in those that present with persistent apical periodontitis, re-treatment and re-treatment is usually the preferred option. However, there may be cases when a surgical approach is appropriate:
- When canals cannot be negotiated
- Failure of previous surgery
- Failure of previous non-surgical treatment, presenting with persistent symptoms or a periapical radiolucency
- Failure of previous surgery
- Inability to access the root apex non-surgically
- In cases with long post and cores, the attempted removal of which could result in root fracture

A predictable treatment

Surgical endodontics has evolved to become a treatment option with predictable outcomes by incorporating the use of modern equipment and techniques such as the operating microscope, micro-surgical instruments, ultrasonic root end preparation, sutures and flap designs and new retrograde root end filling materials.

An ideal root-end filling material should seal the prepared root surface to prevent bacteria and their products from leaving or entering the canal. Many materials have been used for this purpose with varying degrees of success; amalgam, glass ionomer cement, zinc oxide-eugenol mixtures, glass ionomers, composite resins and mineral trioxide aggregate (MTA).

MTA has caused great excitement since it was introduced in 1995 as a root-end filling material. It consists of tricalcium silicate, tricalcium aluminate tricalcium oxide and bismuth oxide and exists as a fine grey powder (see Figure 1). MTA stimulates cementogenesis and bone formation and also has the superior sealing ability and biocompatibility that is the material of choice for endodontists. So much so, that it has also been used for pulp capping, furcal repairs, root perforation repair, resorption repair and apexification.

The material is mixed with sterile water to provide a grainy, sandy mixture. Recent reports also indicate a favourable clinical response when mixed with chlorohexidine though there may be differences in sealing ability. The mixture is loaded into special canals (see Figure 2) and introduced to the site and packed with micro-pluggers. There is a learning curve in getting a usable consistency, but as it is hydrophilic paper points can remove some moisture before further increments to allow better packing. Its hydrophilic nature means that moisture or blood does not affect the setting time.

It has a long setting time – three hours, which allows for low conduction and good marginal adaptation. In some techniques, such as perforation repair/apexification, the placement of a moist cotton pellet directly in contact with the MTA is necessary to allow proper setting. More recently a white powder version has also been marketed with a reported reduced setting time and better aesthetics but possibly not as good marginal adaptation.

A Case Report

A 56-year-old male was referred for treatment of UL1 and UL2 due to persistent infection and a previous failed attempt at periapical surgery of UL1. There was a history of trauma when aged 10 with root-oral treatment being carried out on both teeth by his general dentist. The UL1 was restored with a post-retained crown in his late teens. Subsequent to infection an attempt at apical surgery of the UL1 was also carried out.

The initial presentation was of a painless discharging sinus above UL2 of approximately ten years duration. There was evidence of scarring in the buccal sulcus above the UL1, UL2 with a sinus tract present over the UL2. The UL1 was restored with a well-fitting metal-ceramic crown. The UL2 was discoloured and had a palatal amalgam restoration. There was no tenderness on palpation or percussion associated with either tooth or the surrounding tissues (see Figure 3).

A diagnosis of chronic suppurative periodontitis with prior root treatment was made at UL2, and chronic periapical periodontitis with inadequate root treatment at UL1.

The patient was keen to save both teeth and it was decided to attempt non-surgical retreatment of UL2 and surgery of UL1, and also UL2 if the sinus failed to heal.

The existing gutta percha root filling was removed and endodontic re-treatment of the UL2 was carried out with copious irrigation using sodium hypochlorite. An inter-appointment dressing of calcium hydroxide was placed and at a subsequent appointment the excitor was obturated to the apex using gutta percha and sealer. Glass ionomer cement was used to restore the access cavity (see Figure 4).

Surgical treatment of UL1 and UL2

Due to his previous experience of surgery, he was extremely nervous and requested oral sedation. Consent was obtained and under local anaesthesia a full thickness rectangular mucoperiosteal flap was raised to expose the cortical bone and a fenestration approximately 5mm in diameter between the roots of UL1 and UL2. This was filled with granulation tissue. The bone cavity was extended using a surgical air-rotor and the soft tissue lesion curetted with excavators and preserved for pathological diagnosis (see Figure 6).

The root-ends of both teeth were resected approximately 5mm with as minimal a level as possible exposing gutta percha fillings and inspected for fracture lines using methylene blue stain.

Gutta percha removal and retrograde cavity preparation was carried out using a piezo-electric ultrasonic unit with surgical retractors. The prepared canals were dried with sterile paper points and the MTA mixed to manufactures’ instructions and loaded into the carrier. Increments of the mixture were plugged into the prepared cavities until flush, smoothed over with a moist cotton pellet and the flap replaced and sutured in place. A post-operative radiograph (see Figure 7) was taken and 400mg Ibuprofen prescribed to be taken at six-hourly intervals.

Clinical
Treatment review

At a review appointment six days later, the patient reported very little discomfort from the area. The soft tissues were healing well and all sutures were removed. The histopathology diagnosis indicated a radicular cyst.

At a review seven months post-surgery, the patient reported no swelling, discharging sinus or discomfort from the area. Clinically, the soft tissues had healed well.

A periapical radiograph revealed an almost complete reduction in size of the radiolucent lesion, which was limited to a small area at the resected root apices (see Figure 8).

It was decided to review the patient again in a further six months.

A positive outcome

There were no clinical or radiographic signs of healing after root-canal re-treatment and with the history of the lesion, surgical treatment was appropriate. The healing response in the seven months post surgery has been excellent. MTA has been shown to be biologically friendly in endodontic surgery and is to date the nearest thing to an ‘ideal’ material; it is non-toxic, non-resorbable with minimal or no leakage around the margins.

It does require careful handling and the need for moisture may mean a subsequent visit to ensure it has set to a concrete-like consistency in situations such as pulp capping, aprexification and perforation repair. To date the biological response to MTA has been excellent but as with all relatively new materials further trials and time will tell if it is to be the gold standard in surgical endodontics.

Simple smile restoration

Dr Andrew Croston outlines a successful treatment plan to create a better smile using the Clearstep system

A 55-year-old lady attended our practice seeking treatment to improve her deteriorating smile. A thorough examination revealed a well cared for dentition with minor posterior restorations and an excellent level of oral hygiene. Her upper incisors showed moderate incisal wear caused by an edge-to-edge incisal relationship. Both maxillary and mandibular incisors were proclined and the latter were crowded into a more labial position. The resultant wear was producing a noticeable negative smile line on 12, 11, 21, 22. The patient was keen to have veneers placed as she had seen this on a makeover TV programme.

Discussing the case

After photographs and study models were taken, the case was discussed at length with the patient. The fundamental problem with restoring the lost upper incisal tissue was the position of the lower incisors. As all the incisors were un-restored, any heavy preparation to provide crowns was dismissed. Also, if veneers were to be simply placed on 12, 11, 22, 21 this would result in further proclination which would be aesthetically unacceptable and also unstable as they would be under constant stress from the lower incisors.

It was recommended that orthodontic repositioning of 42, 41, 51, 52 first be accomplished into a more favourable position to provide enough space to restore the upper incisors. Simple lingual tilting of the lower incisors would provide this.

Pros and cons

All orthodontic procedures were discussed with the pros and cons of each being fully described. It was decided to proceed with Clearstep as the patient specifically preferred the fact these would be ‘invisible’ and could be easily removed for eating and cleaning. Silicone impressions, photographs, radiographs and a detailed description of what we required was sent to the Clearstep diagnostic faculty.

Clearstep then sent us a full diagnostic report detailing the number of ‘boxes’ required, the estimated timescale and the cost. The case was presented to the patient, consent received and the go-ahead given to Clearstep to proceed with treatment. We were then sent the first box of aligners along with a detailed description of the interproximal reduction (stripping) required to provide the space required. This was achieved by accurately removing between 0.5mm and 1mm off the distal...
I

and/or mesial contact surfaces of 45, 44, 45, 54, 55. Once the stripping was complete the first aligner was fitted. The patient was told to wear each retainer for 10-14 days and only remove when eating and brushing. Full care instructions were provided and the patient was told to make her next appointment after the final (eighth) aligner had been worn for 10 days.

The patient returned to practice and new silicone impressions and bite registration were taken and sent to Clearstep. The patient continued to wear the last aligner until the new box arrived.

On completion of the second box of aligners, the predicted movement was complete. Clearstep provided several retainers as long-term, night-time retention was required to prevent relapse. The patient had no complaints about the system and found the whole experience easily tolerable.

A successful outcome

New impressions were taken and a diagnostic wax-up of 12, 11, 21, 22 was provided and shown to the patient. A silicone matrix was made from the wax-up and used to rebuild the incisors with Miris composite resin to demonstrate the possible final appearance after the provision of veneers.

The patient was delighted with the result achieved with the composites and postponed the veneers.

We had achieved full restoration of anatomical form of 12, 11, 21, 22 using the following principles promoting an aesthetically pleasing smile line whilst also creating a 2mm overbite/incisal relationship without removing anymore tooth tissue.

In conclusion, this case highlights how Clearstep can be incorporated into a smile-design treatment plan to promote more conservative, minimally invasive restorative procedures.
Onwards and upwards

Julie O’Sullivan, head of education at the FGDP (UK) reports on the recent DwSI conference

The Faculty of General Dental Practice (UK), in conjunction with the Department of Health (DH) England and the Oxford Dental Deanery, organised the ‘moving on’ conference to support and encourage the commissioning of services involving dentists with special interests (DwSI).

Developing new frameworks

The FGDP(UK) and the DH have worked collaboratively to develop competency frameworks in conscious sedation, endodontics, minor oral surgery, orthodontics, periodontics and prison dentistry. The FGDP(UK)’s commitment to promoting excellence in dentistry extends to the personal and professional development of the whole dental team, and the FGDP(UK)’s accredited diploma programmes in primary care orthodontics, restorative, and implant dentistry, work within the remit of the GDC’s recent consultation on flexible training to specialists.

The programme for the day included six presentations on specialty areas, followed by two concurrent workshops in the afternoon; both workshops were designed to enable delegates to share good practice.

Keynote speech

Sue Gregory, Deputy Chief Dental Officer gave the keynote address. She highlighted acknowledgement of the DwSI scheme in the recent Steele Review on NHS Dental Services in England. The emphasis of the address was on the changing context of practice, also the potential implications of two year foundation training for the workforce, including future demand for DwSI and specialists.

The common themes arising from six specialty areas were:

- The need for an oral needs healthcare assessment to ensure the service provision is accurate.
- The DwSI role is a contractual one where practitioners with particular skills are contracted to provide a service, so does not detract from the traditional and important role of the generalist.
- Clinical networks of specialists and DwSI enable good communication.
- Training needs for aspiring and current DwSI.
- Standards on the roles of the GDPs and PCTs should be put in place to reduce variation in experiences, while acknowledging the need for local implementation/patient needs.

The workshop session on prison dentistry highlighted competencies needed by prison dentists in addition to generalist skills. Speaking on her own experiences as a prison dentist, Judith Husband emphasised the importance of communication between members of the dental and prison team to ensure that the priorities of security and patient care are met. Theo Papadakis presented the new DH guidance, noting that it was to support PCTs and prison dental teams leading to better quality of care for patients in prisons.

Considering solutions

The workshop session on commissioning, contracting and implementing a DwSI scheme gave delegates the opportunity to discuss the issues and consider the solutions. David Cheshire, Consultant in Restorative Dentistry in West Sussex PCT, shared his experiences as an outreach consultant, providing the local interface between the PCTs and GDPs. Peter Briggs, Consultant in Restorative Dentistry at St George’s Hospital, London, shared the experiences of the pilot training programme funded by the PCTs for DwSI in endodontics.

Candidates’ feedback concluded that the day was an excellent opportunity to network and share experiences. We also asked delegates what else could be offered to support DwSI and suggestions included a national network, study days and an online register of current schemes to facilitate the development of new schemes.

Julia O’Sullivan, head of education at the FGDP (UK) reports on the recent DwSI conference.

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Webinar 1: Difficult Dentures Made Easier
Speaker: Justin Stewart
Date: 17th September 2009

Webinar 2: Whitening
Speaker: Trevor Bigg
Date: 13th October 2009

Webinar 3: Endodontics Part 1
Speaker: Julian Webber
Date: Early October

Webinar 4: Endodontics Part 2
Speaker: Julian Webber
Date: Early October

Webinar 5: Preventing Periodontal Disease
Speaker: Baldev Chana and Sarah Murray
Date: 30th November 2009
Velopex Service Team Expands

The Velopex Service Department, dedicated to supporting the growing range of high Quality Products supplied by the Company, is delighted to welcome David Ball to the Team.

David is based in North Hertfordshire and covers the East of England, Midlands and North London. His background is within manufacturing industry having also spent 10 years working for the Company. This further strengthens the Velopex Service Team in an important area of the Country.

The Velopex Range of Products ranges from the widely used processors such as the Velopex Intra-X and Extra-X to the Aqualine Quattro and Diode Laser. All of the products are supported, demonstrated and maintained by the Velopex Service Team.

For more information, please contact:

Owen Reilly,
Service Coordinator
Velopex Service
Email: enquiries@velopex.com
www.velopex.com

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If you are looking for any Sirona equipment, get it from Sident Dental Systems, the UK’s only Specialist Supplier of Siemens/Sirona equipment. Only Sident Dental Systems can offer you:

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Sirona Specialists, Sident Dental Systems offer the choice from the complete range of Sirona Treatment Centres, 2D and 3D digital and film based x-ray apparatus – including the very latest Galileos 3D digital cone-beam equipment, their extensive range of Sirona handpieces, and auxiliary items including SironLaser, SIBROEndo and the DAC Universal sterilisation unit.

Wherever possible potential clients are invited to visit The Courtyard, Sident’s state-of-the-art training and show-room facility, where they will be able to see the complete product range in action.

Finally Sident will undertake a complete Project Management Service, including installation and post installation service support, to enable these dreams to become reality.

For further information call Sident Dental Systems on 01952 582980 or email info@sidentdental.co.uk

CEREC has successfully provided dental restorations for millions of patients and dentists globally. Using CEREC allows you to produce perfect chairside ceramic restorations in the same visit whilst saving you and your patient time, laboratory fees and ultimately making your business more profitable.

To find out how the Sirona team can directly support your practice and for a no obligation demonstration of the CEREC 5D system telephone 0845 071 5049 or email: info@sironadental.co.uk or goto http://www.sironacad.com/solutions.co.uk

Outstanding Views With The OPMI Pico

Nuview is renowned for providing dentists with the highest quality illumination equipment. The OPMI Pico microscope, specifically designed by world leader Carl Zeiss exclusively for use in dental practices, represents a cost-effective and versatile equipment solution.

Dr Henry Hoy’s dental practice in Chinnor, Oxfordshire focuses on cosmetic treatments, including crown, bridge and veneers. “I have a huge interest in endodontics,” he says, “and when you love something, you want to do it well. At first I used the OPMI Pico just for endodontic treatment but now I use it for everything.”

The image is absolutely outstanding,” Dr Hoy continues “and the combination of light and magnification is the main reason I use the OPMI Pico.

Nuview offers a comprehensive service to dentists, including surveys of equipment, full installation and training, as well as prompt and reliable aftercare.

“Nuview have been fantastic,” Dr Hoy concludes. “I am really pleased with my OPMI Pico.”

For more information please call Nuview on 01455 758658, email info@nuview-ltd.co.uk or visit www.voroscopec.co.uk

Sient Dental Systems on training two day course on Bleaching Seminar and hands on training day course on 29th to 30th October 2009.

Banish Tooth Whitening Sensitivity

Sensitivity is often an issue associated with Tooth Whitening, which applies to both home and power (surgery) whitening procedures.

The British Dental Bleaching Society provides training and is the only UK body to offer certification of tooth whitening procedures to all members of the dental team.

The wy10 whitening products are available in the UK exclusively from The Dental Directory. To find out more call free on 0800 585 586 or go on-line at www.dental-directory.co.uk

The presentation will cover areas including: Gingival margin problems; the redistribution of space; paralleling teeth and access for hygiene; and third molar issues.

Any practitioner looking to expand their skills base for restorative dentistry would find something of benefit from Dr. Hunley’s address, which will take place on Tuesday 3rd November 2009 at the British Dental Association.

For more information or a booking form please contact Suzy Boxall on 01453 759659 or email suzy@badc.com

Dental Bleaching, Education and Training

The wy10 Whitening Kit

The wy10 product range has wy10 whitening products specifically from The Dental Directory. To find out more call free on 0800 585 586 or go on-line at www.dental-directory.co.uk

Everyone wants a brighter white smile and we all know that in the UK there is much confusion surrounding the legality, techniques and products that dentists use to perform these treatments.

The British Dental Bleaching Society provides training and is the only UK body to offer certification of tooth whitening procedures to all members of the dental team.

There are two levels of membership to the society regular and gold, and once joined you will have access to the latest information on bleaching, education and training. In order to attend a master class on Wednesday 21st October or the Advanced Bleaching Seminar and hands on training day course on 29th to 30th October 2009.

The Dental Directory is the proud sponsor of the BDBS, supporting the society and members to ensure the correct practice of tooth whitening. Members are eligible for an exclusive package of benefits provided by The Dental Directory.

For more information on the society, membership and forthcoming training courses, call The British Dental Bleaching Society on 0207 7267 7070 or visit www.bdsbs.co.uk

The wy10 product range has made a substantial impact on the Dental Whitening market in 2009 with new products and updated packaging.

Under the guidance and experience of Dr Wyman Chan, the company has developed a range which is not only competitive in this economic climate, but innovative too!

Referring to the new look ‘wy10 chairside kit’, Dr Chan accentuated the streaming line of the components, additional procedural information and the restyled packaging, which will continue to harmonise and develop its range professionally and aesthetically.

The key feature? Each whitening gel syringe is now individually packaged in a vacuum sealed aluminium foil pouch. This provides a controlled environment which enhances the stability and shelf life of the gels.

Dentists worldwide are finding new Chairside System the simplest and most effective tooth whitening treatment available.

Secure Your Future with CEREC

Terry Patuzzo, Sirona Dental Systems MD has commented how important it is for practices, in this day and age, to secure their financial stability and raise their revenue whilst trading in difficult times. One tried and tested method is to offer your patients something that they cannot necessarily get from your own dental practices locally which has a real advantage for the patient.

CEREC is proven to increase profits plus it adds the ‘wow’ factor to any practice. CEREC enables you to offer your patients the same day crowns, bridges etc without the expense and time of waiting for the laboratory to construct the prosthesis.

The presentation will cover areas including: Gingival margin problems; the redistribution of space; paralleling teeth and access for hygiene; and third molar issues.

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Banish Tooth Whitening Sensitivity

Sensitivity is often an issue associated with Tooth Whitening, which applies to both home and surgery procedures.

GC has introduced Tooth Mousse that is the perfect adjunct to your usual tooth whitening treatments. Apply immediately after tooth whitening to relieve sensitivity caused by dehydration in the surgery or provide your patients with a tube to take home with their home whitening kit.

GC Tooth Mousse is water based, sugar free topical cream
DENTSPILY Promotes World-Class Expertise With Ceram.X™

At the beginning of the year, DENTSPILY launched the 2009 Ceram.X Case Contest to find the ‘Best Ceram.X Dental Stu-
dent in the UK’. The competition gave dental students the chance to practice composite laying technique using the required den-
tal students to restore a tooth with Ceram.X duo. The winner was Ms Reena Wadia, a third year dental student at Barts & The London School of Medicine & Dentistry, who was presented with an iPod Touch and Docking Station. Dental Schools across the country participated, including those in Leeds, Sheffield, Manches-
ter and Kings College London. With such a high standard of entries, DENTSPILY look forward to running another Ceram.X Case Contest in 2010...

Innovative nano-ceramic restorative Ceram.X has re-
markable durability, and its non-sticky handling ensures ease of use, making it ideal for world-class treatment.

With a commitment to pro-
viding dental professionals with the highest quality consum-
ables, DENTSPILY UK is proud to be working with Dental Schools to promote excellence within the industry.

For more information on Ceram.X or the 2010 Case Contest, please contact DENTSPILY on: +44 (0)800 072 5515 or visit our website: www.dentsplyco.co.uk

Review your practise infection control policy with The Alkapharm ‘learning lunch’

The Alkapharm ‘learning lunch’ focuses on profession-
ely recognised procedures for the successful, day to day pre-
vention of cross contamination within the dental surgery envi-
ronment.

The term ‘Lingual’ comes from Latin and means “on the side, towards the tongue”. Lin-
gual orthodontics refers to the correction of malaligned teeth by means of fixed appliances, which are bonded to the inner surface of the teeth to correct

tooth positioning - without the braces being seen.

There are now a number of different lingual systems vying for prominence and details of these and the choices available to provide more information about these are listed on the BLOS website. Also available on the site is a searchable database of orthodontic specialists to whom GDPs can refer patients in their area.

BLOS can also provide patient literature on lingual ortho-
dontics and can be contacted at www.blos.co.uk

Complete Protection from Cardozo

Vista Tee Orange from Cor-
dozo is the newest version of the popular prescription, Vista Tee Orange protects eyes from harmful blue light frequencies emitted by curing lights. The high quality of the orange shield allows an excellent optical view and full-face protection. The shield is easily fixed to the Vista Tee frame to ensure a comfort-
able, lightweight and effective barrier when curing.

Blade protective eyewear features high specification, lightweight metal frames with optically correct wraparound lenses. Blade are supplied with clear or tinted anti-scratch, anti-mist lenses in a titanium coloured frame.

Polydentia Clean is the new cleaner developed specifically for cleaning protective eyewear and shields in the dental sur-
gery. Polydentia Clean is gentle on materials, but hard on dirt and bacteria. It can be sprayed directly onto frames and lenses to provide effective cleaning and care. The liquid evaporates quickly and leaves no residues or streaks.

For further details on these or any of our other products, please contact Cardozo on:01494 775010, info@cardozo.co.uk

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The Sonicare range has been designed so it is possible to tailor patients’ brushing ex-
periences according to their needs.

For a thorough, all-around clean, the Standard brush head has a large surface area and a unique scalloped and rippled bristle configuration which ex-
tends its reach for deep interproximal cleaning and along the gingival margins. If a pa-
tient requires focused cleaning, then the Mini brush head helps them to focus the dynamic cleaning of their FlexCare in areas which need special attention – hard to reach interproximal areas, around posterior teeth, around fixed and partial dentures and im-
plants and on the lingual sur-
faces.

For children using the Soni-
care For kids there are two age-
appropriate brush heads to suit their needs at key development-
tal stages; for the youngest brushers aged 4 the 4+ head has a short neck and small head whilst the 7s brush head has a large head and long neck and is targeted towards chil-
dren who are more independ-
ent brushers.

For more information visit www.sonicare.co.uk/dgp

The Implant Course

Newcastle

Offering GDP’s around the world a unique learning oppor-
tunity to develop the core skills required to successfully and confidently provide dental im-
plants predictably, The Implant Course Newcastle is now en-
rolling for their year-long course Jan–Nov 2010 (last Fri-
day of every month).

Held at the Complete Smile Academy, South Shields, the year long Implant Course is an

intensive hands-on program led by Allen Branley, Clinical Director at Complete Smile and will explore:

• Case Preparation and Plan-
ing
• Crowns made easy / Problem solving
• Predictability, C.T. and Soft-

wax positioning
• Precision Restorations and Laser Welding
• The Art of Aesthetics and Moul-
design

Beverly Hills Formula/ Purity Laboratories

Come and visit us at the BDTA Dental Showcase 2009, stand D17. Upgrade to the healthier side of whitening and stop Gingivitis before it starts. The best recommendation for bright white teeth is the every-
day use of Beverly Hills Formula from Purity Laboratories, be-
cause the range offers a unique combination of anti-bacterial agents, low abrasion and anti-
stain polishers to protect and move over 90% of staining. Beverly Hills Formula has a short neck and small head has a short neck and small head whilst the 7s brush head has a large head and long neck and is targeted towards chil-
dren who are more independ-
ent brushers.

For more information please contact GC UK on (0044) 1908 218999 or e-mail info@uk.gceurope.com

Beverly Hills Formula is available in 5 deli-

uorescentb to arrange a ‘learning lunch’ for your practise telephone:

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mous.

Brilliant Orthodontic Case Contest to find

future Lingual orthodontics comes of age

When CPP-ACP is applied to the tooth surfaces, it binds to biofilms, plaque, bacteria, hy-
droxypatite and surrounding soft tissues, forming bioavail-
able calcium and phosphate. To provide a variety of choices for individual patients, GC Tooth Mousse is available in 5 deli-
cious flavours namely, Straw-
berry, Vanilla, Mint and Tutti Frutti!

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For further information or to arrange a ‘learning lunch’ for your practise telephone: Alkapharm on 01785 714910 or e-mail: enquiries@alka-

pharm.co.uk

Back to the Future Lingual orthodontics comes of age

Exactly eighteen years ago, in June 1991, the first Inter-
national Lingual Ortho-
dontics meeting was orga-
ised. The practice of lingual orthodontics is now growing in popularity – both with orthodontists and patients. This milestone is being ac-
knowledge by The British Lingual Orthodontic Society (BLOS) which was started in 2002 and has a growing number of members, all of whom are orthodontic spe-
cialists with an additional spe-
cial interest in lingual ap-
pliances.

For more information on BLOS or the 2010 Case Contest, please contact DENTSPILY on: +44 (0)800 072 5515 or visit our website: www.dentsplyco.co.uk
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Are you fully
compliant?

First Orthodontic
Commissioning
Education Day has
done
The British Orthodontic
Society has now confirmed the
full line up of the first 'Or-
thodontic Commissioning
Education Day' which is to be
held in parallel with this year's
British Orthodontic Conference
in Edmonton on 14 Septem-
ber 2009. The day is aimed at
individuals and organisations
who are involved in commis-
sioning NHS orthodontic ser-
dices and 100 PCT represen-
tatives have already registered
to attend.

Along with the Department
of Health and the Chief Dental
Officer, the British Orthodontic
Society firmly believes in the
value of shared learning about
local commissioning and con-
tracting between different ar-
cas of the country. Whilst the
new contractual arrangements of
2006 in England and Wales
brought about a number of posi-
tive changes, there are still
many issues that would benefit
from further clarification and
guidance.

According to Richard Jones,
Chairman of Orthodontic Prac-
tice Committee of the British
Orthodontic Society: “There are
already many examples of com-
missoners and providers work-
ing together successfully as part
of local clinical.

A full report of the event
will be published by the British
Orthodontic Society after the
event. For more information
please visit www.bos.org

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Practice Advice
Dental Practice Consultancy
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tial are also available on the
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Extensive financial evalua-
tions, financial projections
(changes to working prac-
tices) and financial optimisa-
tions for areas that could be
improved.

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ments – Expert advice on part-
nerships agreements, associ-
et agreements and PCT or
GDS contracts.

With a proven track record
in providing expert assistance
to the dental profession, IPSCS
is also a member of the Asso-
ciation of Specialist Providers
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formation in 2000, IPSCS has
provided dentists with reliable,
up-to-date guidance and a pro-
fessional and reasonable charge
structure.

For more information call
0161 652 5540 or visit the Den-
tal Practice Consultancy Ser-
tice (DPCS) website

Patient
Communications

The public are largely un-
aware of the risks associated
with periodontal disease let
alone the means of preventing
or controlling it. The British So-
ciety of Periodontology (BSP)
have produced a patient leaflet
that explains in clear language
what the disease is, who can
get it and how it can be treated.
The leaflet has been produced
in conjunction with F&G Oral
Health whose spokesperson
commented, “Consumer press
coverage on dental matters is
starting to increase but most of
this seems to relate to cosmetic
dentistry. Clearly periodontal
disease is not such an attractive
topic, which is ironic consider-
ing that it affects such a large
proportion of the population.
The BSP have done a fantastic
job in putting this leaflet to-
gether and we hope that with
the support of the profession it
will do much to demystify this
prevalent disease”. All BSP
members will also receive
samples in the autumn. Alter-
natively, you may contact your
Oral-B representative who will
also have stock available
for any practices.

Consequently, Leo James
has been appointed to the new
position of UK CAD/CAM Man-
ger. Over the next 2 years Leo
will be instrumental in placing
the company at the forefront
of the industry in the field of
CAD/CAM dentistry.

Ivoroc Vivadent
Apports New
UK CAD/CAM
Manager

Ivoroc Vivadent has had sig-
ificant success in many areas
over the last few years and CAD/CAM dentistry is just one area
that will become more im-
portant over the years to come.
With this in mind senior man-
gagement at the UK headquar-
ters intends to place considerable
focus on this range of products.

Vizilite Plus™
Screening Test
for Oral cancer
Vizilite Plus™ is a simple
technology to assist in the early

What is the beating heart of a
dental practice? Often uninten-
tionally neglected, the air com-
pressor system is relied upon to
provide safe, dry and infection
free compressed air to numer-
ous instruments and hand-
pieces on a daily basis.

To regulate dental air com-
pressors for risk of contami-
ants, all systems must now
be compliant with NHS HTM
2022/1 guidelines and conform
to the following quality condi-
tions:

• Dryer System – Should be ca-
pable of producing air with an
atmospheric dew-point not
less than −20°C.

• Filter System – Should pro-
vide dust filtration down to
1 mm with a DOP (aerosol)
efficiency of not less than
99.97% and bacteria filtration
down to 0.1 mm with a DOP
(aerosol) efficiency of not less
than 99.9999%.

Invest in a cost effective
Dental Air Clean Air Package
for all equipment that includes
servicing, maintenance, break-
down support and air quality
control checks to ensure full
compliance and optimum in-
fection control.

Call Dental Air on FREEP-
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Level Surface
Disinfectant/
Cleaner

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purpose disinfectant/cleaner
• Microbiological Activity
• Bactericidal: (incl MRSA)
• EN15727/EN15697, Tubercu-
locidal; EN14485/EN15697.
• Virucidal: (HIV/HCV/HBV, SARS,
• Vaccinia, Herpes, In-
fuenza H1N1/H5N1, DW/
• RSV/EN 14476, Yeasticidal
• & fungicidal; EN 13624/EN-
15697: within 60 seconds
• 1 litre trigger with trigger dis-
pense
• 5 litre economy drum

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usual dental wholesaler
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IncruXIII
Taking posterior
restorations to a new dimension

Increasing numbers of pa-
tients are demanding metal-
free restorations due to con-
cerns over amalgam and the su-
perior aesthetics that compos-
ites provide. With IncruXIII, DENTSPLY has taken posterior restorations to a new dimen-

sion.

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Rebecca Jacques
Swallow Dental Supplies Ltd
Unit 8, Ryefield Court
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BD20 6DL
Tel: 01535 686312
Fax: 01535 685457
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In August 2006, I spent two weeks with Dental Project Peru (DPP) in the Apurimac Mountains. I never predicted what a life-changing experience it would be for me and I can’t wait to go back. We saw an amazing part of the country that few tourists ever see. This small charity is making a huge difference in an area where there is little other dental care. It is truly lifesaving work, and extremely rewarding.

Rampant decay

The Apurimac is one of the poorest areas of Peru. Some villages had no electricity or running water, yet they had Coca Cola! The introduction of a Westernised diet with no dental education has lead to rampant decay which went largely untreated until DPP started a few years ago.

Much of the treatment was extractions, although we did manage to save quite a few teeth. Each year as the charity returns, the number of extractions decreases and fillings increase – a tribute to the sustainable improvement in dental health and awareness.

Each day started with a fun interactive dental education talk. The children were screened and those requiring treatment were seen straightaway – quite a challenge if a couple of hundred turned up at once! The adults were then treated. Having only limited Spanish, I certainly got to practice my non-verbal communication skills.

Making a difference

Sometimes we had free time to play with the children and get a glimpse into the way of life. They were a kind and simple people and it was a privilege to know you were making such a difference to their lives. Peru is a fascinating country and the trips include sightseeing around Cusco and the Sacred Valley of the Incas. The scenery is spectacular and it is a country immersed in culture and history.

Preventative care

The charity is planning to expand in 2009, requiring dentists, nurses, hygienists and therapists. DPP will now provide much more preventative care, including fluoride application, toothpaste provision and dental education. This is an exciting development, but will require even more volunteers than before!

If you or a friend may be interested, please visit www.dentalprojectperu.org or email info@dentalprojectperu.org. The trips run between July and October.
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