Sainsbury’s dentist
The UK’s first supermarket dentist has opened in Sainsbury’s. The dental surgery in the branch of Sainsbury’s in Sale, Greater Manchester, opened earlier this month. It is open every day and check-ups are virtually the same as those of an NHS dentist. Patients can get two for the price of one by hopping into the dentist after stocking up their shopping trolley.

Dental practitioner, Dr Lance Knight, the brainchild behind the surgery’s novel location, plans to create more dental surgeries in supermarkets, if the pilot scheme turns up trumps.

Patients are welcome to just drop in or they can book an appointment in advance.

The dental surgery follows hot on the heels of the first GP surgery, which was opened several months ago at a nearby Sainsbury’s branch.

Free tickets
The BDTA Dental Showcase 2008 takes place from Thursday, October 2 to Saturday, October 4 at, Excel, London. To reserve your complimentary ticket, log onto www.dentalshowcase.com, telephone the registration hotline on 01494 729959 or text your name, address, occupation and GDC no. to 07786 206 276. Advance registration closes on September 26. With registration on the day at £10 per person.

Reservation Highway is the official booking agency for the event. For advice and information or to book a hotel, call the hotline on 01423 525 577, quoting BDTA Dental Showcase.

Eastern Europe
About 55,000 people living in the UK have travelled largely to Eastern Europe for dental work, ranging from implants to braces and crowns, according to the latest available figures from 2006.

Smile-on launch
Don’t miss Smile-on’s launch of module two and three from Communication in dentistry: Stories from the practice at BDTA’s Showcase, October 2. Communicating with your patients and communicating with your team is to be unveiled in a special screening at the show. Visitors can enjoy hotdogs, popcorn and champagne at the event. Visit stand R12 for this exciting launch.

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LDCs applaud ‘quality’ initiative

A meeting of regional Local Dental Committees (LDCs) up and down the country has discovered an innovative initiative from a Northern PCT bringing the quality back into dentistry.

In contrast to many PCTs which tend to look for the cheapest bid when tendering contracts, Bradford PCT has put its money where its mouth is, by banning bids below a certain level.

The PCT is determined to put more emphasis into encouraging quality in dentistry, as well as hitting targets.

Under the new 2006 contract, quality is not incorporated into the Units of Dental Activity, (UDAs) which are allocated to dental practices. But 40 per cent of the money allocated for three Bradford dental practices is earmarked for the quality of dental work carried out, with 60 per cent of the cash set aside for standard UDAs.

This means that if they fail to complete their UDA targets, the newly commissioned tenders will still qualify for a large proportion of the cash.

Eddie Crouch, from Birmingham Local Dental Committee, who spoke at the recent national LDC meeting in London, said the move to encourage quality control in dentistry was very welcome. He said: ‘There is no UDA criteria relating to the importance of ongoing monitoring of the quality of dental work, so it is good news that in Bradford’s case, if evidence of qualitative patient care is produced, even if the dental targets are not completely reached, the practices will still get a large proportion paid.’

Bradford PCT has commissioned three new practices, with each given a subsidy for equipment to be bought or provided by the PCT, two of which are corporates.

Mr Crouch added: ‘Bradford has also innovated new time-limited General Dental Service contracts, which were previously open-ended. When the new contract was set in place in 2006, GDS contracts were always open-ended, but Personal Dental Contracts (PDCs) were limited from three to five years. This new style of time-limited GDS contract could be worrying if a dental practice buys equipment and premises and then ends up without a contract after five years.’

But he added that the positive side of a time-limited GDS was that it could provide more flexibility and it was unlikely a contract would be terminated after five years without a very good reason.

Mr Crouch said it was vital that there was an amendment for quality to be incorporated into the contract. He said the need for quality to be incorporated in the new contract, would be backed up by the Department of Health’s (DoH) response to the Health Select Committee’s report, which was coming up in the next few weeks.

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**DDU advises the expert witnesses**

The Defence Dental Union (DDU), the specialist dental division of the Medical Defence Union (MDU), has issued advice to dentists who write expert reports or give evidence in court to help them avoid common pitfalls.

Common allegations against expert witnesses are failure to be impartial, not examining papers or patients properly, giving misleading advice and not declaring conflicts of interest.

The DDU’s tips for dental professionals who act as expert witnesses are to ensure that intelligible instructions are given, to understand legal and civil procedure rules, to keep up-to-date in specialist areas of practice and be aware of ethical codes, to avoid acting as both an expert and factual witness on the same case, to inform the court if a conflict of interest exists, to not give opinions on things little known about.

**Leeds Dental Institute fights the fear factor**

Leeds Dental Institute, ranked the top school in the UK for dentistry is currently looking at better ways to improve dental treatment and take the fear factor out of the patient experience for good.

Professor Jennifer Kirkham, research director of Leeds Dental Institute said the laboratory was looking for safe new ways to control plaque which do not rely on toothpaste.

She said: ‘We see patients in the clinic who are not able to brush effectively because the shape of the mouth may not allow sufficient access, the patient could be disabled or just not a proficient brusher. One of the new treatments makes use of a readily available compound in an innovative way to control plaque formation, using photo dynamic therapy (PDT). The patient uses a mouth wash containing an anti-bacterial agent which is activated by bright light and results in plaque destruction. This is trialled in the clinic and patient feedback helps researchers identify where further modifications are needed.’

‘The principle of working from bench to clinic and back to bench will see a circle of constant improvement between research and clinical work and it is this partnership with patients which ensures research has an impact.’

Another research project could transform the approach to filling teeth forever, Professor Kirkham explains.

‘We have developed a method for Filling without Drilling, which uses a low viscosity protein based fluid which is painted onto the teeth where it infiltrates into the pores. Inside the pores, the fluid solidifies, becoming a gel which then allows calcium to rebuild the tooth mineral, bringing about a natural repair, without the pain or discomfort usually associated with a traditional drilling procedure.’

A £1.5 million investment by the University of Leeds has set to bring the new Dental Clinic and Translational Research Unit to the forefront of global research and development in oral health by linking the laboratory activity directly to the needs of patients treated in the clinic.

The flagship centre for world class dental research and clinical practice, the first of its kind in the UK, opens at the Leeds Dental Institute in January 2009.
To say hearing good news for the dental profession is ‘refreshing’ is a massive understatement. It is certainly well overdue—for sure—but news that a Northern PCT is leading the way with initiatives on how to reward dentists for quality work is ground-breaking. The newly commissioned tenders for three dental practices in Bradford are certainly unique, and possibly the envy of many. For how can three lucky practices still get paid if they haven’t met their UDA targets, when others don’t get anything? It’s the luck of the draw when it comes to what PCT you have, but clearly Bradford is the best of the bunch so far. Quite how the ‘quality of work’ will be measured remains a mystery, but you can be sure it will be reported here first in Dental Tribune.

But that’s not all the good news. For if new time-limited General Dental Service contracts mean it is more unlikely that a contract would be terminated after five years without ‘a very good reason’ then hip, hip hooray. Other PCTs should watch and learn. London PCT staff are turning up unannounced at practices demanding to know where and if there are emergency drugs kits and the like. But isn’t the provider the responsible person for the contract?!

At least some dentists can feel rest assured that there is security and a living to be made post 2009. All we need now is for the other PCTs to wake up and smell the innovation. Like cattle, they are bound to follow.

Growing services

And even more good news via the BDTA! Apparently there were more than one million units of dental activity commissioned by PCTs last year with ‘many new practices opening.’ But how much of this is via the NHS remains a mystery. Obvi-ously, single-use endodontic instruments and oral hygiene and headpieces account for half the increase. This means no more than a rising trend towards cross-infection prevention and control, and fits in nicely with NHS aspirations.

Nevertheless, it is no surprise to hear that growth of the private sector is the biggest trend. With half the population visiting a dentist under the NHS, a quarter of these visits are attributed to private dentistry. The repercussions continue, with dental laboratories reporting big shifts. They lost a whopping 50 per cent of NHS work compared to pre-new contract days, with private work growing to 54 per cent from 50 per cent.

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

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So the search for systemic disease link with periodontitis is con- firmed at last at a day-long conference, The im-pact of oral disease on systemic health: What is the evidence and how big is the problem? With more people than ever before contracting Diabetes Mellitus, Dr Philip Preshaw is resolute with his links to periodontitis, as are other prestigious professors armed now with the scientific facts to back up their views. So now it’s over the medical world to listen and take action. Let’s hope they do.

Systemic debate

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Mixed views for Scotland’s Action Plan

The Scottish Dental Action Plan has received a mixed reception from dental practitioners across Scotland, since its launch three years ago. A survey by the British Dental Association (BDA) found that only 37 per cent - a third of high street dentists in Scotland - believe that the Action Plan has changed dentistry for the better, since it was introduced by the then Scottish Executive in April 2005.

Although nearly a fifth of dental practitioners (17 per cent) are of the opinion that the dental action plan has actually made things better, just under half of those surveyed (46 per cent) said they did not think the scheme had made either a positive or negative impact.

Andrew Lamb, BDA director for Scotland, said: 'The results of this survey highlight ongoing concerns about the future of dentistry in Scotland. It is clear that the Scottish Government still has a number of issues to address if access to NHS dentistry for patients across Scotland is to be improved. It is only through constructive dialogue between the profession and the Scottish Government that these matters can be addressed. The Minister for Public Health has demonstrated a willingness to discuss these issues with representatives of the BDA’s Scottish dental practice committee. This must continue.'

The survey also investigated other issues facing dentistry in Scotland. For example, despite dentists investing heavily in patient practice facilities in recent years, 24 per cent of respondents said their practices were not allowed to comply with the decontamination guidelines currently being consulted on by the Scottish Government, which raises the spectre of possible forced practice closures. The potential impact of practitioners retirement, with regard to the accessibility of patients to NHS care, was also highlighted by the survey. It revealed that practitioners aged 50 and over has larger NHS patient lists than their younger colleagues.

New managers for IDH

Matt Jackson has also been recruited to the new role of director of private and specialist cattle development from October 1. Mr Barrow has more than 12 years experience of implementing high quality and innovative systems and standards in the UK practice.

The division’s aim is to create a new business model for acquiring dental practices in a way which allows the principal dentist to retain a share of the capital value and continue to benefit financially from the development of their business.

Practice owners can therefore effectively hand over the daily responsibility of running their business while aiming to create long-term financial growth and above that which would be achieved as an independent outfit.

IDH is setting in place a range of business solutions to private practitioners which include financial modelling, marketing, sales and operational systems.

The IDH teams including Mr Barrow and Mr Jackson will be attending the 2008 Dental Showcase in October where they will be unveiling the new division.

Integrated Dental Holdings (IDH) is a leading UK dental practice owner, with over 140 practices providing both NHS and private dental care.

CODE backs guidance review

MAIL FROM THE GENERAL DENTAL COUNCIL (GDC) TO REVIEW ITS GUIDANCE ON NON-SURGICAL DENTAL PROCEDURES HAS BEEN WELcomed by dental and allied health management associations, CODE.

The organisation, which runs the membership services for the Association for Facial Aesthetics (AFA) represents business owners in the dental and cosmetic fields and is committed to developing and maintaining high standards.

Paul Mendlesohn, chief executive of CODE, wrote to the GDC calling for a constructive dialogue, after the council ruled that ‘non-surgical cosmetic procedures should not be considered as legitimate additions to dentistry and they must be advertised separately to dentists’ practice of dentistry’.

He commented: ‘We appreciate that the GDC was trying to clarify the situation on non-surgical cosmetic procedures. However, the impact of its statement was just to add to the confusion. So we are absolutely delighted that the GDC is going to have a rethink about dentists advertising cosmetic procedures.’

Dr Mendlesohn continued: ‘It is the AFA’s view that it is far safer for a member of the public to receive non-surgical skin treatments form a qualified doctor, dentist or nurse. In the light of that, if qualified professionals cannot advertise their status clearly, the public will find it extremely difficult to know what practitioner has the most appropriate skills. This must include skills in surgery and infection control, as well as knowledge of how to deal with medical emergencies, in order to provide the safest and most effective and appropriate treatment.

The GDC decided at its September meeting that it would review the statement it had previously released, hailing the advertising of cosmetic procedures by dentists.

CODE believes advertisements for facial treatments should state that the provider is a dentist. This would be in the public health interest because the public could then discriminate between medically qualified and non-medically qualified providers.

It also thinks the GDC’s previous guidance could be unworkable. For example, it is unclear whether dentists would be allowed to advertise for aesthetic treatment immediately alongside adverts for dentistry or if they could place separate adverts in the same publications.

Dr Mendlesohn is campaigning for dentists to advertise cosmetic procedures alongside dentistry.

Mendlesohn and the chairmen of CODE AFA, Dr Reg O’Neill, will be meeting GDC representatives in the coming weeks.

Conference confirms perio and systemic disease link

A prestigious panel addressed an audience of dentists, doctors and scientists at a day-long conference on: The impact of oral disease on systemic health: what is the evidence and how big is the problem?

The event at the QE11 Conference Centre in London on Tuesday, September 9, was organised by the Oral and Dental Research Trust (ODRT). Its chairman, Professor Nairn Wilson introduced speakers followed: Professor Rhys Williams, from Swansea Medical School, who reported on the increasing numbers of people of all ages around the world who are contracting Diabetes Mellitus. Dr Philip Preskash, from the School of Dental Surgery in Newcastle, drew out the causal link between Periodontitis and Diabetes, while Dr Christine Bichtra from the University of Alabama in Birmingham explained, the scientific basis up for the mechanistic links between the two conditions. Three more distinguished speakers followed: Professor Andrew Lamb talked about Atheromatous vascular disease and ischemic stroke as some of the major killers of our age.

Professor Pasop Papapanou from Columbia University pointed to the increasing evidence for the link between Periodontitis and Macrovascular disease, while Professor Thomas Van Dyke highlighted how inflammation is common to both Periodontitis and Vascular disease, pointing to mechanistic links between the conditions.

Finally, a panel discussion stressed the need for collaboration between dentists and doctors and the need for all research undertaken to be multi-disciplinary.
“When we opened our new practice, cashflow was a key priority for us. We operate a “just in time” ordering system so that we don’t have too much money tied up in stock and Henry Schein Minerva’s stock audit makes this much easier. We regularly order on-line and because we know we can rely on Henry Schein Minerva’s excellent service and delivery, we can maximise our cashflow and credit terms.”

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Taking the plunge!

Briercliffe Road Dental Practice in Burnley could be considered by some as an unlikely place to find a thriving, dynamic private dental practice. Helen Powell – Practice Manager and wife of Dentist Mike Powell, explains their journey into Private Practice and how help came from an unexpected source.

The practice stopped taking adult NHS patients in March 2003, now 5 years later they are really experiencing the benefits of what, at the time, seemed to be a momentous decision. Mike’s commitment to providing high quality treatment and the booming NHS contract changes were the real driving forces behind their decision and although they knew that similar decisions were being taken by many practitioners, their location, in a less than prosperous area of North West England, made the decision to become a private practice more difficult. Up until 2003, their patient base had grown steadily, as they had picked up patients from practices around them who had taken the private road years before and they were worried that their decision would result in a loss of patients. In fact, they had one of the most successful single handed Denplan conversions ever, with over 1,000 of their patients becoming enrolled in one way or another. Mike and Helen had a visit from Steve Gates, Denplan’s MD and were asked to talk on several occasions to groups of dentists considering a Denplan conversion.

Since converting to private practice they have received a great deal of help in establishing and driving their business forward and at the forefront of much of their endeavours was help which came from what some may see as an unexpected source.

Alistair Newsham – who Mike and Helen had known for many years, came to see them in the middle of 2003. He had recently been taken on by Henry Schein Minerva in the role of Business Consultant and came to tell them about his new role and how it might be of interest to them. Naturally, having known and trusted Alistair for a number of years Mike and Helen were keen to explore any ways in which they could add to their now steadily growing private practice. Alistair explained to them that Henry Schein Minerva’s philosophy was to help practitioners maximise profitability by helping them to run successful businesses. A philosophy that encourages those running the practice to look at the “bigger picture” and not get too obsessed with comparing the relative costs of a box of gloves!

From the outset, Alistair encouraged them to think about where they wanted their practice to be in the future and helped them to pinpoint where they could improve productivity and efficiency. Most of the ideas Alistair put forward would be straightforward for most large, established businesses, but for a small business like Mike and Helen’s it was nothing short of a revelation.

They have incorporated a number of marketing ideas, mostly based on the advice given by Alistair and their marketing now extends to almost every area of the practice. Some activities are naturally more costly than others, but they all contribute to the growth of new patients and the delivery of excellent services and treatments to their existing ones.

Staff training is a vital element in effective marketing and when Mike and Helen decided that a dedicated Treatment Co-ordinator would be a good addition to their practice, Henry Schein Minerva arranged for another of their Consultants to visit the practice from Scotland. Gillian spent time with Mike and Helen explaining the role of Treatment Co-ordinator and how they could make this work in their practice. This role is still in its early stages but Mike has already seen the benefits of having someone else to assist the patient in treatment choices.

Since their conversion to Private Practice and through the undoubted help of Alistair and the team at Henry Schein Minerva, Helen has reassessed how she spends her time.

Since 2005, and as they gained more confidence, Mike and Helen have followed a series of business programmes that they are certain have contributed to their success. In 2005, they achieved Investors in People, BDA Good Practice Award and completed their hat trick with the Denplan Excel accreditation, awarded in May 2005. As a team, Mike and Helen feel it is important to measure themselves regularly against these external standards, ensuring they are the best they can possibly be. Of course time does not stand still and Mike and Helen continue to be pushed and prodded by Alistair, with the backing of Henry Schein Minerva, to set objectives and achieve more for the benefit of their patients. “Our immediate goals for the practice are to make sure we make much better use of our intra-oral camera; - equipment we have only used for over 5 years! Alistair has given us the idea of doing "mouth tours", to encourage patients to take more responsibility for their oral health and to ask patients what improvements they would like to see. We are also exploring the sale of Oral Hygiene products in practice and how we can maximise the potential of this part of our service.”

The decision to go private is not an easy one, it is a very hard work, but it was definitely the right one for Mike and Helen and although times are changing and they know they will lose a percentage of their patients as some new NHS practices spring up around them, they are quietly confident that discerning patients will see the benefits they have to offer. “Our practice is busy and Mike has no desire to be more than a single handed practitioner, so for us, success is built around having a great team and being able to provide high quality dental treatment to motivated, enthusiastic patients in a pleasant comfortable environment.

For more information email: me@henschein.co.uk

“As Practice Manager I can now see the value of spending time working on aspects of the practice that will build our patient base, rather than searching through catalogues saving pennies on a couple of products. Ironically, by putting the bulk of our orders through Henry Schein Minerva we were able to negotiate extra discount anyway. Of course, we still take advantage of good value savings, but it has become much less of a driving factor for me.”
“Henry Schein Minerva’s philosophy is to help practitioners maximise profitability by helping them run successful businesses. From the outset, they encouraged us to think about where we could improve productivity and efficiency, providing practical advice and marketing ideas based on our individual circumstances. Working with Henry Schein Minerva in this way has been nothing short of a revelation.”

Mike & Helen - Briercliffe Road Dental Practice, Burnley

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Dental services continue to grow

Despite the credit crunch, demand for dental services continues to grow, according to the British Dental Trade Association (BDTA). Last month it was announced that more than one million units of dental activity had been commissioned by PCTs in the past year and many new practices opened.

A BDTA spokesman said: 'Dentists are increasing their spending, although how much of this is accounted for by NHS expenses or because of increased private sector spending cannot be known accurately. Over half the increase results from single-use endodontic instruments, as well as oral hygiene and headpieces.

'This points to trends towards cross-infection prevention and control and practices will need to review their equipment and materials, in order to fulfil new requirements.'

Although many dentists feel that effective prevention is no more deliverable under the new contract, it still remains an NHS aspiration, with a Toolkit produced last year to encourage expansion of preventative practices.

- Private dentistry
  The really big trend in dentistry is the growth of the private sector over the last ten years. A survey, 'IMRevealed' and Customs figures showed more than half of dentists' income is generated in the private sector.

The recent Healthcare Commission's survey of patients' views on primary care showed that, although half the population visited a dentist under the NHS, about a quarter saw a dentist privately, with the rest not going regularly.

- Laboratories
  Dental laboratories lost more than 50 per cent of the amount of NHS work ordered by practices during the first year of the new contract. A recent survey of laboratory owners found a major impact was the shift from NHS to private work. On average, owners reported 45 per cent of turnover came from private cases, with one-fifth only doing private work.

- Regulation and education
  Since August, all dental team members must now be registered with the General Dental Council (GDC). There is also a move towards increased PCT regulation, but a major development is the Care Quality Commission, which will oversee both NHS and private practices.

2008 compared to 50 per cent last year. Private work grew to 54 per cent in 2008 from 50 per cent in 2007. About 50 per cent of labs said that at least 80 per cent of turnover came from private cases, with one-fifth only doing private work.

Teeth brushing could reduce heart attack risk

A new study claims that thorough teeth brushing not only reduces the risk of tooth decay, but also cuts the risk of a heart disease.

Previous studies showed an unexplained link between gum disease and the increased likelihood of suffering from heart disease or a stroke. But a team has now discovered that the organism's defence mechanism can sometimes destroy its own protective cells by over-responding to gum-disease. This can lead to athero-sclerosis, a cause of heart attacks.

A team led by Greg Seymour of the University of Otago in New Zealand uncovered the link, after observing how intensive brushing affected people with cardiovascular disease.

He said: 'An understanding of all the possible risk factors could help lower the risk of developing heart disease and lead to a significant change in disease burden.'

The study's findings will be discussed at the Society for General Microbiology's Autumn meeting at Trinity College, Dublin.

Denplan launches Essentials Direct

Leading UK dental plan provider, Denplan has launched a new online service called, Essentials Direct to enable dentists to grow their business.

Up to 9,000 patients a month use Denplan's, Find a Dentist, search facility at www.denplan.co.uk; and they can now sign up to the Essentials Direct dental plan immediately.

Essentials Direct is specifically designed to enable dentists to increase their Denplan Essentials patient numbers, without having to actively promote the scheme in their practices.

Jolly good Fellows

Two leading figures in the dental profession have received Fellowships from the prestigious Edinburgh Royal College of Surgeons in recognition of their support to postgraduate education.

Dr Roger Matthews, chief dental officer, for Denplan together with Dr Mike Busby, a consultant trainer for over 18 years, received their Fellowships from the dean of the Faculty, Professor Jonathan Cowpe.

Commenting on the award, Dr Matthews said: 'As a significant stakeholder within the profession, Denplan has and will continue to sponsor dental conferences, seminars and study days at all UK colleges, maintaining a dialogue with and support for the Faculty at a time of continuing turbulence for the profession in the UK.'

Denplan's Michael Rudman said: 'Denplan Essentials is such a popular product and Essentials Direct now makes it quick and easy for patients looking for a dentist to sign up with. It is great for the patient as they don't have to make a special trip into the practice. It is also great for the dentist, because they don't have to take time away from their patients to market the service in their surgery and can develop their business with the minimum of effort.'

For more information phone: 0800 328 3223 or log onto: www.denplan.co.uk

Denplan's fundraising assistant, Felicity Patterson before the jump, with her instructor.
“Sometimes people think that big companies aren’t interested in NHS dental practices, my experience of Henry Schein Minerva is just the opposite. They have encouraged and supported us in many ways, providing an excellent staff training programme which has really helped develop our personnel. We now have an established facility that provides outstanding care for our patients, all made possible by the first class service we receive from Henry Schein Minerva.”

Yemi Opaleye – Tetbury Dental Practice, Tetbury
Confidential service launch

The Dental Practitioners Association (DPA) is launching a confidential email service for dentists and dental care professionals to report any concerns about the new contract introduced in April 2006.

The service, which was set to go live on September 15, can be used to report abuse of power by Primary Care Trusts (PCTs) and Local Health Boards, (LHBS) irregularities in awarding contracts and any other matter in the public interest such as waste of public funds or cronyism. The objective of the service is to use actual examples of inefficiency, inflexibility or unfairness and to work with the Department of Health (DoH) constructively to improve the dental public health system.

Derek Watson, DPA’s chief executive, said: ‘If a dentist or dental professional has a matter which they think requires investigation or involves a matter of public interest, they are encouraged to email details of it to me in complete confidence. This service is open to DPA members and non-members alike and contact details do not have to be given. If we receive a large amount of emails on a particular topic we will follow this up, obtain information if necessary by Freedom of Information requests and then publish our general findings. No individual will ever be identified as a result.’

He said the service was necessary because some DPA members had expressed concern that the new contract was at odds with the dental service they wanted to provide. He added that there was a worrying amount of anecdotal evidence that the contract was having serious adverse effects on provision, with regulations sometimes wrongly applied by PCTs and LHBS either deliberately or just through ignorance.

Dr Watson added: ‘An individual dentist now finds it very hard to push for justice, particularly when it would bring him or her into direct conflict with the commissioning body. There is a perception that a campaigning individual is seen as a troublemaker. This is precisely the reason that the DPA directly supports and represents its members. Using our strength we can expose matters and effect change.’

Dentists can email any relevant issues of concern to anon@uk-dentistry.org.

No work for new graduates

A dentist has expressed worry that the new contract is setting a trend towards rising dental graduate unemployment. Eddie Crouch, from Birmingham local dental committee (LDC), who also runs campaigning group, Challenge, said there were a growing number of graduates in the area who could not find full-time work.

He said: ‘In Birmingham, far too many graduates have been given part-time temporary contracts, which is a terrible waste of resources. This is because the new contract limits expansion to one Per Cent of undergraduates. It means that the contracts were issued could be a factor leading to unemployment. She said: ‘Because the contracts were issued according to a practice’s work history, this could mean there is no lee-way to take on new dentists.’ She said there were concerns that some PCTs were rather rigid in budget application, although others were very innovative. She added: ‘They vary enormously across the country.’

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A BDA spokesman said the way in which the new contracts were issued could be a factor leading to unemployment. She said: ‘Because the contracts were issued according to a practice’s work history, this could mean there is no lee-way to take on new dentists.’ She said there were concerns that some PCTs were rather rigid in budget application, although others were very innovative. She added: ‘They vary enormously across the country.’
The high cost of avoiding practice conflicts

Because of the fast pace of most dental practices, doctors can fall into the habit of avoiding conflicts with staff members, believing it’s the most expedient choice. However, as the following Levin Group case study illustrates, with a dentist we’ll call Dr. Smith, routinely avoiding conflict has a price.

Dr. Smith was becoming increasingly worried about the profits in his dental practice. Most weeks the schedule was full and his staff of three hygienists seemed busy enough. But something wasn’t right. Even with consistent production he couldn’t afford to give some of his hardworking staff the raises they deserved. Dr. Smith suspected there was a problem in how Joan, his financial coordinator, was handling the billing. But when he spoke to her she was negative, confrontational and accused him of claiming she wasn’t doing her job. Joan had been with the practice for 20 years and he considered her a loyal employee. Dr. Smith didn’t want to hurt her feelings so he didn’t mention it again. But he felt like the weight of the world was on his shoulders and he could likewise feel his staff’s frustration. He pressured his team to meet production and was often irritable. Some mornings he dreaded going to the office and repeating it all over again. Did the practice just need to somehow book more patients, or do more treatments? He didn’t know what the answer was.

What happens when dentists habitually avoid

Dr. Smith’s practice was an extremely tense place to work, with pressured employees, a highly stressed doctor and unsatisfying profits. The situation developed in part, because Dr. Smith, like many dentists, dealt with conflict by avoidance. The price of avoidance for dentists includes:

- Important issues are not addressed
- Doctors or staff working in a “walking on eggsheels” environment
- One or more individuals are deprived of valuable input
- Decisions happen by default
- Problems become increasingly complicated
- Hostility and tension build

Moving from avoidance to collaboration

Levin Group has consulted to thousands of practices over 22 years, encountering many dentists like Dr. Smith who felt they’d exhausted possible solutions. This case illustrates an important shift that dentists like Dr. Smith usually need to make — moving from avoiding conflict to fostering collaboration within the dental team.

Collaboration is the opposite of avoidance. It entails digging down into a problem to uncover what will meet the needs of all individuals involved. How did a practice like Dr. Smith’s make the move from avoiding problems to really tackling them and working together as a team?

Levin Group Findings

On close examination, the practice had outgrown its basic operating systems, particularly practice financial management and budgeting, accounts receivable, patient billing and case presentation. As Dr. Smith suspected, his financial coordinator, Joan, was indeed at the center of the problem. Joan had joined the practice at a time when billing and financial management were more easily managed for a smaller practice. However as the practice grew, the number of insurance claims to be billed and managed also increased. Dr. Smith’s practice was carrying an extremely high accounts receivable balance, due to treatments that were not being billed to insurance companies in a timely fashion and the absence of proper follow-up for patient payments.

Levin Group analysis indicated that the practice could grow and reduce stress by streamlining operations (particularly financial), and creating better systems. The strained atmosphere in the practice was an
1. Improve practice communication with effective staff meetings.
Dr. Smith’s practice needed consistent occasions when the team could work collaboratively. Daily team meetings and monthly staff meetings provided these opportunities. For the first time the dentist was approaching practice issues as a team project, rather than his own personal headache. Dr. Smith was encouraged to ask for staff input during meetings in discussing office policies, problems areas and redesigning practice systems.

2. Commit to becoming a better leader.
Dr. Smith began to see that becoming more involved and supportive of his team could help them do their jobs better. His tendency had been to expect the office manager to handle all the problems. Yet he had often undone her decisions when staff came to him to complain. His leadership development included courses, books and mentoring.

3. Implement documented systems
Out-of-date financial systems were behind many of the problems experienced by the financial coordinator, with a subsequent ripple effect through the rest of Dr. Smith’s practice. When new procedures for patient financial management, billing, budgeting and accounts receivable were advised by Levin Group, the financial coordinator, with the team’s help, documented, step-by-step how each process would be carried out.

4. Script all billing conversations with insurance companies and patients.
The financial coordinator had routinely avoided uncomfortable financial conversations with insurance companies and patients. To resolve this problem, scripts were devised to provide clear, yet assertive wording for some of these necessary awkward phone calls and insurance transactions. This new way of handling financial issues was reinforced when team members practiced the scripts with role-playing in monthly staff meetings.

5. Train the team
Once new systems are in place, the next step is training. After Dr. Smith’s staff wrote out new procedures step-by-step with accompanying scripts, the practice could better train the dental team. This standardised approach established a level of responsibility and clear expectations for each team position.

6. Clear outstanding accounts receivables
Levin Group recommended a method that employed scripting to help the financial coordinator clear the majority of accounts receivables from the practice’s books. This activity alone brought substantial income into the practice when insurance reimbursements began coming in.

7. Retrain the Financial Coordinator
The financial coordinator was retrained on more effective financial management techniques and four additional financial options. These included offering a 5% discount with cash upfront, credit cards, half payment at the initial consultation and the balance due before treatment begins, and third-party financing. The practice enrolled in a third-party patient financing program, which meant that patients had comfortable options beyond traditional dental insurance. This strategy helped reduce the practice’s dependence on dental insurance as patients began to choose other payment options. It also helped to lessen the financial paperwork and some of the financial coordinator’s billing obligations.

Conclusion
When practices like Dr. Smith’s realise how much outdated systems can adversely impact stress levels and profitability, the dentist and team grow excited about changing internal systems. This often requires the dentist to shift from avoiding practice conflicts and shoulder considerable stress, to a collaborative team approach where everyone’s input is considered valuable. Leadership development on the dentist’s part is key, as Dr. Smith learned. A willingness to try new methods, and being open to the guidance of consultants can pay off with predictable changes in practice profitability, increased efficiency and noticeably lower stress.
A new solution
If there is a lack of orthodontic specialists in your area, Dr Andrew McCance suggests that you read on...

The demand for cosmetic dental treatments is growing at an exponential rate, and it is the duty of dentists to meet this demand. More and more patients are beginning to appreciate the importance of a nice smile, but whether they can get the results they need or not depends on many factors – not least of which being geography.

Not so simple
Imagine for a moment that you wanted restorative treatment, to build your confidence and provide a boost to your quality of life. How would you feel if, having taken the first step, you now had to wait perhaps several weeks or even longer, to see an orthodontist because there was a shortage of specialists in your local area? Now imagine how you would feel when, having waited a considerable distance, it turned out that the orthodontic work was very minor in nature. Wouldn't you ask yourself why your dentist couldn't provide even this simple procedure?

Of course, patients do not understand the finer points of dentistry, or the huge amount of education and skill that goes into even the most straightforward treatment. What they do understand, in cases like the one above, is that they have not received the service they expect. If they are willing to pay for treatment, their dentists should be willing to provide as comprehensive a treatment list as possible.

A problem solved
Thanks to a wealth of in-depth research and many years of development, there are now solutions to this problem. General Dental Practitioners can now, with the aid of state of the art systems, offer orthodontic treatments so that patients in areas where there is a shortage of specialists will not have to undertake an odyssey before they can receive minor pre-restorative and mild crowding treatment.

‘How pleased would you be, emerging from the practice with a brand new smile?’

New clear-brace systems are not only wire and metal free, they are easy to fit and remove, and cost-effective, too. Although more complex orthodontic procedures may still need to be referred to experienced specialists, the facility of the clear brace to be combined with more traditional forms of treatment makes it very flexible, so you can refer fewer patients. The upshot of this is that you can develop a relationship with many of your patients, and oversee their treatment from beginning to end.

With this in mind, imagine you are this patient. You have decided to undergo cosmetic dental treatment, and your local dentist is able to carry out every stage of the process. How pleased would you be, emerging from the practice with a brand new smile, having experienced not only a high standard of convenience but also with the knowledge that your dentist has made the effort to meet your every need?

Customer service first
By putting yourself in the place of a cosmetic dentistry patient, you can see exactly why the demand for a better system has led to the development of clear-brace systems. Orthodontists still have a place of course, when more complex procedures are necessary. However, for minor treatments it is becoming more important, in the interests of competitiveness and plain customer service, for GDPs to offer more of a ‘total’ service – especially in those parts of the country where there is a shortage of specialists.

For more information on the Clearstep solution, call 01342 557810 or email info@clearstep.co.uk

About the author

Dr Andrew McCance has gained a wealth of experience in multi-disciplinary practices. He has held several distinguished positions including senior house dental surgeon at St George’s Hospital, Tooting, and then the post of senior lecturer at Great Ormond Street, he continued to develop his expertise culminating in a PhD at University College London. In the mid 1990s Dr McCance began to develop the Clearstep brace, based on the demands of the 4,000 patients treated annually in his specialist practices. He is currently taking his Clearstep vision to a worldwide audience.
Innovative equipment solutions for performance beyond the expected

The stylish design and robust quality of A-dec equipment is clear to see, and as you would expect, it provides all the functionality and flexibility required for efficient and ergonomic working. But A-dec also believes in developing solutions which go beyond the expected and offer improvements to the usual ways of working. Like thinking about the critical role of the nurse in 4-handed dentistry, which led to our unique A-dec 545 Nurses Console, cabinet mounted at the 12 o’clock position that improves ergonomics for the whole surgery team. And thinking about the management of today’s modern dental materials led to our Treatment Console solutions which enable the usage of Procedure Tubs and Trays. Such innovations require ‘out of the box’ thinking unconstrained by convention – and we encourage you to think differently as well. So to explore the possibilities and seek a better way, give us a call and ask for a copy of our new A-dec solutions brochure.

Think differently • • • • • For details call: 0800 233 285 or contact your local authorised A-dec dealer

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Exercising dietary control

An area where moderation is considered virtuous is dietary control. Eric Schlosser, in Fast Food Nation says that rather than indulging in junk food, our diet should be limited in scope, size, production, distribution, selection and profitability. Pigging out is considered to be very bad form indeed, an extreme type of human conduct, whereas careful, sensible and controlled dieting is considered to be moderate and therefore good. But what happens when we become calorie-counting zealots, eating nothing bad? In such a situation we become extremely self-controlling, which is not moderate at all!

Earning enough money

As a dentist, my earnings by comparison to City business folk are very moderate. On the other hand, the same earnings by comparison to your average citizen of Bangladesh or Ethiopia or Chad are outrageously excessive. Do I need all that excess?

Extremism – or not?

At the other end of the spectrum from moderation lies extremism. One of the core characteristics underpinning an open, modern society is that it sets no preconceived parameters on our ability to enhance and cultivate our most humane aspirations. Mahatma Gandhi advocated non-violence, demanded that the Indian nation accept his creed, and was prepared to starve himself to death to achieve his objectives, which seems a rather extreme measure in itself. Nelson Mandela, faced the death penalty because of his belief that, when circumstances demanded it, no act (including causing death and destruction) was too extreme to defeat a regime that practised Apartheid.

Should we change?

Can we change to a more moderate course in the way we live our everyday lives? Is it desirable, much less necessary? Surely, just as there are permissible, damaging and negative forms, there are also excellent forms of excess – such as when you test and expand the limits of your aptitudes and abilities, of your courage and social conscience. So ‘everything in moderation’ might not always be good advice.

Do you think concern with moderation is important, or is it an outmoded concept? Email jury@dentaltribuneuk.com and let us have your views.
A prosperous retirement

If you want to transfer your pension fund for even greater financial flexibility, perhaps you should consider an Income Drawdown Pension? Thomas Dickson explains what exactly it is and why it’s a good option.

Regular cash payments

With an IDP, you withdraw a regular income within limits set by HM Revenue & Customs, which you can vary according to your needs, while the remainder of your fund remains invested until you reach the age of 75. After this age, your pension will depend on the residual value of your fund and may be lower than a conventional annuity taken immediately on retirement.

The maximum permitted withdrawals are based on the calculations of the Government’s Actuary Department and calculated every five years to reflect the remaining funds and current annuity rates. At age 75, you must buy an annuity or transfer to an Alternatively Secured Pension. These phased withdrawals allow annual income to include both the tax-free cash and the taxable income, provide improved death benefits and often reduce tax liabilities.

Who does it suit?

An IDP can be taken out by anyone aged between 50 and 75 (55 from 2010), and may be suitable for you if:

- You need a regular income but not a tax-free lump sum.
- You are in good health – those in poor health may be better suited by an enhanced annuity.
- A large proportion of your expenditure is discretionary, on hobbies or holidays, for example.

The principal disadvantage of ID compared with a conventional annuity is reduced income security. For example, your fund may not perform as well as you anticipate and when you do purchase an annuity, your income will be reduced. You also need to take into account that:

- Annuity rates vary. If you defer a purchase until the last moment you will have to accept the rates available at that time.
- The charges for an IDP are higher than for a conventional annuity.
- Annuity rates depend on mortality rates, and those who die earlier cross subsidise those who live longer. If you delay taking your annuity, your income will be reduced. You also need to take into account that:

- Annuity rates are reference.

Alternatively Secured Pension.

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An IDP can make all the difference.
Dental practice owners seeking to sell up, usually ask an agent how to do it quickly, while maximising the value of their asset. With the Internet now a major part of all our lives, Google is often the first port of call for practice vendors.

However, as many of us have learned from experience, when you use the Internet, it’s good to exercise a little caution. Instituting a Google search for a specific company or product generates a list of names or sponsored links on the right side of the screen, each with some relevance to the search. These advertisers have to pay Google every time a user clicks on them, and they also ‘bid’ on keywords so those clicks on them, and they also ‘bid’ on the use of the trademarked term as a keyword trigger. When we receive a complaint from a trademark owner, we will only investigate the use of the trademark in ad text.2 In other words, as long as the text which appears on the screen does not include the injured company’s name, Google will take no action.

Choosing wisely
For most dentists, buying or selling a practice is a pivotal moment in their lives, and peace of mind depends on complete confidence in their agent’s integrity and competence. Even with the benefit of a recommendation, before making a commitment, vendors should satisfy themselves that personal connections matter. They need to check out any companies pre-registered in their key-word text.2

To prevent companies bidding on thousands of key words for places on the list, so those clicks on them, and they also ‘bid’ on the use of the trademarked term as a keyword trigger. When we receive a complaint from a trademark owner, we will only investigate the use of the trademark in ad text.2 In other words, as long as the text which appears on the screen does not include the injured company’s name, Google will take no action.

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Reaching a common goal

Building a great team can be quite a challenge but when achieved, it is hugely rewarding. Vikki Harper, BDPMA marketing co-ordinator offers some advice.

Humans are naturally social animals; we don’t like spending our lives alone yet ironically we often struggle with the dynamics of maintaining a positive team environment. There is widespread belief that teams deliver more than the sum of their parts and therefore generate greater achievement and value than a bunch of individuals. Teams can create a collective culture that allows individuals to feel part of something, where ideas can be shared and support can be found, but they can also be highly divisive things that are more trouble than they are worth! So how can you build and maintain a team to be proud of?

Is your team effective?

A real team is a living, dynamic force in which a number of people come together to work towards a common goal. In your practice, how clear is that common goal? If each member of your team was asked to state the common goal of the practice, would there be a cohesive goal, an individual goal, or no goal at all? If you get lots of different answers you know where your work must begin.

Each team member has something to contribute to the team and must therefore be given the opportunity to do so. It’s not always the loudest or the brightest who has the winning idea. It is important to realise that sometimes it is the quiet person, who is averse to speaking up, who will have the solution you have been seeking.

Good leaders know how to get their team members to generate ideas. In your process, how often do team members come to you with ideas and when they do, how long has it been since you put one into action? If your team members don’t bring ideas to the table you may need to consider why and do something about it. Maybe they gave up when none of their ideas was ever acted upon!

An effective team

No football team would succeed if everyone wanted to be the striker. A great balance is required to ensure that the team has the correct blend of skills necessary to deliver its objectives. Those skills will vary upon the nature and purpose of the team.

A good leader

It all starts with leadership because great teams don’t just happen. They are created by leaders with very clear plans for how their organisations should operate, deliver services, interact with stakeholders and meet specific targets. Problems within teams usually result with unclear and/or unspecified goals. Communicating clear goals and objectives is a must along with providing measurable progress towards those goals through regular updates (1:2:1s). Do you have 1:2:1s with your team members and if so, are they regular enough to keep them focused? Are the meetings fulfilling the needs of both parties; have you ever checked to see?

Clarity of function

A team must contain the necessary blend of skills to meet the demands and aspirations of the practice and there should be sufficient resources in the long term to ensure that undue pressure is not placed on them. Team members should be clear about their specific role and what tasks form the basis of their functions. If you have individuals complaining that other team members have encroached on their duties, then roles and responsibilities are not clear enough.

Team members should know each other well enough to recognise and accept each others’ strengths and weaknesses and to work to maximise these strengths and compensate to overcome any weaknesses by covering for each other. They should be willing to share responsibility. If you have individuals who complain that others are not ‘pulling their weight’ then perhaps you should pull everyone together to talk more about how they can be more supportive of one another.

Established ground rules

Great teams usually have established ground rules for working together (team charter). They have developed agreed working practices and processes to get things done, and support each other by listening and responding supportively and constructively. They recognise and celebrate individual and team successes, handle conflict constructively and openly, and when they agree a course of action, they collectively buy-in.

Do you have a team charter? If not, perhaps at your next team meeting you can seek your team’s input by asking them to put forward their top three suggestions for team ‘rules’. Draw up a charter, circulate it, seek feedback, and finalise it. The rules of the charter cannot be handed down by one person; they must be agreed among the team. By participating in the development of their charter, team members sign up to behave in a self-determined way. They can, not at some future point, plead ignorance or excuse anti-social behaviour. Remember that once you have agreed your charter every team member must sign up to it.

The charter should become part of your recruitment process too. Whenever you interview a potential new team member you should explain what the charter is, what each point means and you should ask the candidate if she or she could work within the rules you have defined.

Like everything else, there will be times when members of the team will behave in ways that are inconsistent with the charter. It is the team leader’s job to point out to the person the implications of their actions and to get them back working consistently within the framework of the charter.

The characteristics of failing teams

Failing teams usually show symptoms and the most common ones are:

- Inappropriate goals and objectives
- Non-measurable goals
- Ill-defined boundaries and responsibilities
- Inappropriate members, creating a skills gap
- Lack of training in teamwork
- Rivalry and divisions in the group
- Ineffective meetings
- Lack of understanding and lack of willingness to recognise and compensate for weaknesses
- Resistance and politics
- Team members who do not want to be part of the team
- Team charter ‘lip service’

Any one of these points will undermine the success of the team and should therefore be overcome. You may recognise one or more of these points in being characteristic of a team you belong to now or have been a part of in the past. But don’t be deterred, recognition is the first step towards remedy.

A positive experience

All teams, no matter how long they have been together, and no matter how successful they have been, will go through peaks and troughs, and dynamics change with new starters and leavers, external business and personal pressures, changes to rules and responsibilities and any one of a hundred other reasons. They are not always successful. Even if you can boast a great team there is no resting on your laurels. Great leaders constantly seek to keep their team united, focused, challenged, developed, motivated, involved, on target...

Building a great team can be quite a challenge but when achieved, it is hugely rewarding. It won’t happen over night and it is an evolutionary process, so above all, don’t forget to celebrate successes at each stage of the process.

The BDPMA represents a national ‘team of dental practice managers who share good practice and pursue continual professional development through events like the autumn Management Development Seminars that focus on Finance. For details of the seminars and to join the BDPMA visit www.bdpma.org.uk, email d.simpson@bdpma.org.uk or call 01452 880564.
Exciting times ahead?

DCPs must now legally invest in building their skills through CPD. Sounds like the perfect chance to boost your career, but the change is also a little daunting. Mhari Coxon explains

S
o, change is finally here. As of the August 1 2008, every Dental Care Professional (DCP) registered with the GDC must complete 150 hours of Continuing Professional Development (CPD) over five years. Fifty of these hours must be verifiable, while the other 100 will be made up of un-supervised development, reading Dental Tribune UK, for example.

From talking to colleagues and friends, there are mixed feelings about this enforcement. I personally am looking forward to developing my clinical skills and improving the quality of my care for my patients, as well as keeping up to date with the most recent evidence.

Attending lectures and courses is something I have always enjoyed. It can boost my motivation for my career, and allows me a chance to catch up with colleagues and discuss our profession. I have often been the only hygienist in a practice so haven’t always had a fellow colleague to talk about daily clinical, Dental trade companies support meetings and show you the latest products. There is almost always a chance to catch up with the ‘if you don’t use it you lose it’ group.

Last-minute nerves

Some hygienists and therapists, through family commitments and other restraints, have not been able to attend courses regularly and will be slightly nervous about starting. A minority have had no interest in developing their skills and have not attended any meetings since qualification and see this enforcement as an intrusion. Dental nurses have been limited by the availability of courses for them and again may feel slightly nervous about attending training days.

I think this compulsory lifelong learning can only be a benefit to the profession as a whole. Evidence-based dentistry is seen as best practice. It is important we all update regularly and make sure we are giving the quality of care our clients deserve. All DCPs will have a professional role, which will give some a career-development path that was previously not an option. The dental team will benefit, as they will be able to develop skills to suit the practice environment.

Choosing skills to develop

In May this year, the GDC took consultation regarding Scope for Practice for all dental professionals. The paper was designed to look at what skill groups we would expect each group to have upon qualification, and what other skills could be developed as a postgraduate. A team of professionals, representing all DCP groups, formulated a proposal and the paper was open to all professional and the public for comment.

Since the consultation closed, it has been made clear that, once suitable training has been completed, dental hygienists and therapists will be able to perform tooth whitening under prescription of a dentist. Dental nurses, again with suitable training, will be able to take impressions and make vacuum trays. The skill list for nurses will be extended more and we await the final guidance which is due out in the autumn.

Planning for the future

What I see emerging is a real opportunity for the team to be utilised and make the day-to-day running of practices more efficient and cost-effective. For example, one rainy lunchtime, we were hypothesically planning the future for our practice. We could see a new client being interviewed by the nurse and a full dental history, lifestyle and diet assessment, and medical history be taken. The client would then move in to the clinical environment and have their consultation with the dentist. The nurse would take impressions if necessary, and chart the patients bleeding and plaque score. They would take a sample of bacteria and document what was seen under the microscope, disclose the patient, take digital photographs and discuss oral hygiene with the patient, giving them a tailored hygiene kit to take home. Diet assessment sheets could be given if deemed necessary, and an appointment organised for there first hygiene session. I could introduce myself briefly and give the client some literature to read before their first hygiene visit.

Obviously, if this is to be a reality, detailed training would be required. But we could all see how our clinical day would be improved as well as expanding the quality of care for our new clients.

The client would feel valued as they were asked for information, the dentist would have more time to devote to high-skilled treatment, the nurse would have a more involved and interactive role and the hygienist would get a patient who has already improved their oral hygiene, enabling a more comfortable first cleaning session. All round, a good improvement.

Of course, this is all a pipe dream just now, but you can see why continuing development becoming compulsory could actually be just what the profession needs. I genuinely believe this is a great time to be in dentistry and our profession will go from strength to strength.

Choose your training

There will be more courses available to DCPs now and, as well as completing the compulsory elements; you will be able to choose training that will benefit your particular practice environment. So, don’t see this compulsory addition to your working time as a chore, enjoy developing yourself and boosting your enthusiasm for your chosen career.

For more information on CPD requirements, visit www.gdc-uk.org/Current+registrant/CPDrequirements

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BS- DHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact Mhari, email mhari.coxon@cpdfordcp.co.uk.

Dental Hygienists and therapists can perform tooth whitening under prescription of a dentist

Dental Hygiene and Therapy (BS-DHT)
Dr Zaki Kanaan argues the case that when it comes to implants, treatment should be kept as simple as possible.

The old adage goes that if 10 dentists were to treatment plan a case you will get as many varying opinions. There is nothing wrong with this for simple general restorative cases, but when planning for implants, it is wise to opt for the simpler option. The following case highlights the point that proceeding with a more complex treatment plan may have been a poor final result, as well as an unpredictable long term prognosis and outcome for a young patient.

History andPresentingComplaint

This young gentleman presented for an opinion, after being recommended by a hygienist. She was concerned about, what she felt was a drastic treatment plan that was recommended to her son by another respected dental centre.

Her son, a student on his gap year, had lost his upper right lateral incisor through a skiing accident. A provisional acrylic crown was bonded to adjacent teeth as an emergency measure and the centrals were splinted at this visit (Fig. 1, 2, 3, 4). The upper centrals were also traumatized during the accident, with periapical radiographs exhibiting signs of horizontal fracture lines at various levels (Fig. 5). The upper right lateral and central had also been root treated shortly after the accident and all teeth have been symptomless since.

Treatment Plan by AnotherDental Centre

The initial suggested treatment plan included the extraction of the upper right lateral and central incisors and the upper left central incisor, with the provision of an immediate partial acrylic denture. This would have been followed by the placement of an implant supported bridge with implants in the upper right lateral incisor and upper left central incisor positions. Although this is a viable option, it would have lead to the extraction of 3 important incisors and labial inclination and position to the previous root apex, to avoid perforating labially. The site was prepared using a standard sequence and saline, with special attention to avoid the thin buccal plate of bone during preparation. A 3.5 x 16mm NobelReplace tapered Groovy implant was torqued into position with an initial stability of 20Ncm and ensuring that a tri-channel in-labor is positioned mid buc cally. The initial stability of 20Ncm is not enough to immediately re store an implant. If immediate loading has been planned, you should always have a contingency plan of good primary stability of the implant is not achieved. The implant head was placed 5mm apical from the anticipated final labial gingival margin (adjacent den toringival levels can also be used as a guide if needed). There was a 2.5mm space between the buccal plate and the implant. A narrow healing abutment was placed and the void was filled with a mixture of BioOs™ (Geistlich) and autogenous bone harvested with an Astra™ Bone Trap. It was my usual protocol to fill voids that are approxi mately 1.5mm or more. No su tures were needed.

Restorative Phase

12 weeks later, open tray impressions were taken and custom shade matching was carried out. It is important to take a photo of the contralateral tooth for comparison (Fig. 7) and a discussion with the patient about whether to copy this tooth needs to be communicated with the lab, especially if there are any unusual characteristics. In this case the upper left lateral had a mesio-buccal rotation and the patient wanted a slight element of rotation with his new tooth. Due to the depth of the implant head it was decided best to use a goldadapt abutment. This was covered with a layer of opaque porcelain to help mask any possible metal shine through as much as possible. This was torqued down 20Ncm and the access filled with GP and Syntemp provisional composite. It was also decided to make a Lava crown with an opaque core (3M ESPE). The Lava crown was tried in and approved by the patient for shade and form before being cemented with temporary cement.

My Proposed Treatment Plan

My treatment plan was accepted by the young gentleman and his parents, but fortunately, due to a waiting list for the implant phase of treatment, this treatment plan had still not been carried out.

Surgical Phase

The patient attended for treatment and was given an Arnica 200c pillule (a small succrose pill, coated with the remedy) to take preoperatively. Arnica is a homeopathic remedy that I routinely use for all elective surgical procedures. It has been shown to help reduce bruising and swelling associated with surgery and I have noticed a marked difference in both patient reported symptoms, as well as clinical symptoms, including the speed of healing. A 50 second Chlorhexidine pre-surgical rinse was carried out prior to administration of local infiltration anaesthesia. A flapless surgical technique was utilised by using a size 15c micro-blade into the dentogingival sulcus around the upper right lateral incisor root. The root was then gently andatraumatically elevated using periotomes, taking care not to stress or damage the fragile buccal plate. The resulting socket was inspected, especially for the integrity of the buccal plate. A nice instrument to do this with is the AstraTech™ measure ment gauge. It has a blunt, hemispherical end, which gives tactile feedback and can also be used to measure the length of the socket. It can also be used to give visual feedback on the direction of the imminent osteotomy site preparation. Socket curettage was carried out to ensure it is free from any granulation tissue. The buccal plate, although thin proved to be intact and ended approximately 5mm below the labial gingival level. The initial pilot drill used was positioned with a slight palatal inclination and position to the previous root apex, to avoid perforating labially. The site was then prepared using a standard sequence and saline, with special attention to avoid the thin buccal plate of bone during preparation. A 3.5 x 16mm NobelReplace tapered Groovy implant was torqued into position with an initial stability of 20Ncm and ensuring that a tri-channel in-labor is positioned mid buccally. The initial stability of 20Ncm is not enough to immediately restore an implant. If immediate loading has been planned, you should always have a contingency plan of good primary stability of the implant is not achieved. The implant head was placed 5mm apical from the anticipated final labial gingival margin (adjacent dentoringival levels can also be used as a guide if needed). There was a 2.5mm space between the buccal plate and the implant. A narrow healing abutment was placed and the void was filled with a mixture of BioOs™ (Geistlich) and autogenous bone harvested with an Astra™ Bone Trap. It was my usual protocol to fill voids that are approximately 1.5mm or more. No sutures were needed.

A Maryland acrylic provisional bridge was bonded in place with a wing on the adjacent canine. The pontic was adjusted and polished labially. A Maryland acrylic provisional bridge was bonded in place with a wing on the adjacent canine. The pontic was adjusted and polished labially (Fig. 6).

It is often the case that the embarrassment between a canine and a new crown is increased, as it was here (Fig. 9). This can easily be remedied by bonding some composite to the mesial of the canine, as was done in this case, which reduces the embarrassment giving a more aesthetic result, which was to the patient’s satisfaction (Fig. 10).

It is always advisable in aesthetic situations such as this, to condition the tissues by providing

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a prototype restoration. In situations where tissue conditioning has not been carried out, the final crown will most likely have a different emergence profile to the healing abutment. In these cases the final crown needs to be tried in and seated with constant force to overcome the pressure from the circumferential tissues. As this is done blanching will be evident (Fig. 8). It is important to wait for the blanched tissues to return to their normal colour before final cementation. Failure to do this may result in ischaemia of the surrounding tissues, pain and may even lead to an element of necrosis, if the patient is allowed to leave in this way.

Occlusion was checked with articulating paper in centric relation, as well as in excursive movements until shimstock foil glided through with light contacts. A post-restorative baseline radiograph was taken showing good bone levels.

A 3 month review and 1 year follow up were carried out (Fig. 11, 12, 13). The centrals were still symptom free with no radiographic changes at both appointments. Bone levels were also as they were at baseline.

Conclusion
Implant treatment involves many variables and as clinicians we must consider all these parameters to provide the best outcomes for our patients. If we aim to keep treatment as simple as possible, then the success of the final case will be greatly increased. Careful consideration needs to be given to the proximity of the implant surface to the labial bone, as well as the position of the implant head to adjacent teeth, as there is a horizontal, as well as vertical component to the biologic width5 (sometimes now termed the biologic doughnut).

No matter how talented your ceramist, if the final restoration is not framed by the surrounding tissues in the correct way, the outcome may be compromised. A key aesthetic concern in implants is to maintain the gingival architecture and harmony, especially the interdental papilla5. The immediate implant protocol, in combination with a flapless, single stage technique, seems effective at maintaining the gingival architecture and when combined with a good ceramist, gives the clinician every chance of replicating nature.
With our current level of knowledge and understanding of implants as well as having the services of the most talented master ceramists, we have no excuse not to deliver the very best for our patients.

Acknowledgement
I would like to thank Atsu Kakinuma at Dental Excellence, for his invaluable contribution for the technical aspects and ceramist work in this case.

Disclosure
The author has no financial or personal relationships, directly or indirectly, with any companies or products mentioned in this article, that could have influenced this work inappropriately.

A complete list of references is available from the publisher.

Zaki Kanaan, BDS, MSc (Implant Dentistry), DipDSed, LFHom
Zaki qualified from Guy’s Hospital in 1996. His main interests lie in all aspects of Cosmetic Dentistry with a special interest in Dental Implant Treatment, where he has achieved a Masters Degree from the GKT Dental Institute in 2001. He strongly believes in Continuing Professional Development and lectures on all aspects of implant and cosmetic dentistry. He sits on the Board of Directors of the British Academy of Cosmetic Dentistry as Chairman of the Study Clubs Committee and is a member of the American Academy of Cosmetic Dentistry. He is also an editorial consultant for Dental Implant Summaries, a widely distributed international implant journal and is a member of the Association of Dental Implantology in the UK.

He has embarked upon a career pathway leading to him gaining a Diploma in Sedation, a Diploma in Hypnosis, and most recently he has become a Licenciate of the Faculty of Homeopathy.

Zaki will be lecturing at the BACD conference in Birmingham on November 13th-15th, go to www.bacd.com for more information.

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Working with composites

Although there are many composite materials on the market, it’s not necessarily the performance of the material that is most important, but the skill in carrying out restoration, says Dr Gordon Penman

For the past few years, I have been using Esthet-X from Dentsply as my material of choice for anterior and posterior composite restorations. This is a visible light-cured, radiopaque composite restorative material. I also use X-flow, which is another Dentsply product, for any situations where I feel that a flowable composite is indicated.

A composite is a material that consists of two or more components, and a dental composite contains inorganic fillers that are incorporated in a resin matrix. The filler particles mainly confer the required physical properties of the material such as strength, modulus of elasticity, polymerisation shrinkage, coefficient of thermal expansion and water sorption.

Esthet-X utilises barium aluminium fluoroaluminoarsenate (BAPF) with silicone dioxide particles as the filler and these are embedded in a resin matrix which chemically is made up of bisGMA adduct, ethoxylated bisphenol-A-dimethacrylate and triethylsilane glycol dimethacrylate (TEGDMA). The material also contains photoinitiators, stabilisers and tints. The TEGDMA is added to dilute the monomer, which is very viscous. This makes the resin easier to use.

Esthet-X contains 77.5 per cent filler by weight and 60 per cent filler by volume. The average particle size is 0.7 microns and it is classed as a micro hybrid composite.

Know your material

As with any material, there is a learning curve that needs to be negotiated before one can utilise the material to maximise its optimum performance. I feel that perseverance is justified as I am becoming increasingly confident of achieving good quality, aesthetic restorations with Esthet-X.

The composite handles well with minimal stickiness to instruments and little slump. This allows it to be sculpted into the desired anatomical form, which I like. There is a wide range of opaque, body and enamel shades which facilitates a layering technique to fabricate a restoration which closely resembles natural tooth in appearance.

The shade guide, although at first quite daunting in complexity, provides a ‘recipe’ card, which advocates the mix of shades which should be chosen to build a restoration that will have the desired shade and translucency.

Choosing a colour

For small cavities, simply selecting the body shade gives a relatively quick and aesthetically pleasing result. More extensive restorations where there has been extensive tooth tissue lost, allow the use of the opaque, body and dentine shades to create an extremely life-like restoration.

In the kit, the compules are colour coded for easy differentiation and identification.

I use a Ronvig composite warmer to pre-heat the Esthet-X compules. I find that this allows me to place the material more easily into the prepared cavity and studies suggest that pre-warming composite enhances the conversion rate and produces a more highly cross-linked polymer network. It is suggested that this should improve the mechanical and physical properties of the final restoration.

I use a Dentsply LED curing light, Smartlite PS to initiate the curing reaction. This is a portable, chargeable light, which is ergonomic to use and allows good access to all parts of the oral cavity. Studies suggest that LED lights can reduce curing times, although care must be taken to adequately cure all the increments, especially those in the base of deeper cavities.

The finishing touches

Achieving a smooth, well-polished surface can improve the longevity and aesthetic success of a restoration by decreasing plaque accumulation and surface stain. Having a smooth surface is also less likely to cause wear of opposing enamel or restorative materials. I find that I can achieve a well-polished, high-lustre restoration by using the Enamel system incorporating Prisma Gloss polish.

There are many composite materials on the market and it can be difficult to decide on which product to use. I don’t believe that there are major differences in performance between many of the well-known brands, and that the technique and skill level used to place these types of restoration is probably more important than the material itself.

References
According to the Mouth Cancer Foundation, cancer can occur in any part of the mouth, tongue, lips, throat, salivary glands, pharynx, larynx, sinuses, and other sites located in the head and neck area. These mouth cancers have a higher proportion of deaths per number of cases than breast cancer, cervical cancer or skin melanoma.

The treatment of cancers of head, neck and mouth can create a range of difficulties in oral hygiene care. Maintaining as healthy a dentition as possible during and post-surgical, radio and chemotherapy treatment can be challenging for the dentist and the patient.

Oral cancer itself is relatively rare comprising just 1.7 per cent of all cancers diagnosed in the UK each year. There is no substitute for early detection and prevention by the whole dental health team and part of this is identifying at risk groups by focusing on at risk factors including age, gender, smoking and alcohol use, diet, exposure to sunlight, HPV (Human Papillomavirus), oral cleanliness, and prior history are also beneficial; however definitive causes of oral cancer have yet to be identified.

Before treatment begins
Ideally, before a patient commences cancer treatment, time permitting, the mouth needs to be at optimal possible health: restorative and hygiene treatments should be completed and an exemplary oral hygiene routine instigated. This reduces the frequency and duration of complications of oral cancer treatment.

This hygiene routine should encompass a three-step process of:
1. Mechanical plaque removal with a soft toothbrush. Where there is soreness and irritation present and brushing causes discomfort an ultra soft brush should be used. Brushing in conjunction with a dentifrice such as GUM Paroex Dentifrice Gel optimizes plaque removal and promotes healthier gums. This gel contains Vitamin E an antioxidant, D-Panthenol a pro-vitamin B5, and chlorhexidine 0.12 per cent an oral antiseptic agent.

2. Interdental cleaning using soft floss or soft toothpicks to reduce the plaque between the teeth and below the gum line. Alternatively, for those who find floss awkward to use, soft toothpicks are a good alternative, finely tapered for small spaces.

3. For optimal health, these two steps should be followed by the use of a mouth rinse, either saline (salt water) or a preferred proprietary brand.

Where there is the presence of inflammation such as gingivitis and periodontitis the use of a chlorhexidine digluconate mouthwash is indicated prior to treatment. It is recommended that the use of mouth rinses containing chlorhexidine digluconate are used for a limited period of time as they can cause unwanted side effects such as dry mouth and loss of taste. These are side effects that are often already present during and after cancer therapy and prolonged use of a chlorhexidine digluconate mouthwash will only exacerbate these problems.

Benefit of probiotics
In conjunction with these three steps I would strongly rec-

Effective mouth resuscitation
With Oral Cancer Awareness Month approaching, dentist Dr Fran Du Corbier explores the latest ways to improve oral hygiene among patients before, during and after mouth-cancer treatment.

A

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² Handbook of local Anaesthetic, Stanley F. Malamed
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- Caution must be taken to avoid accidental i.v. injection as it may give rise to rapid onset of toxicity. Use cautiously in the elderly, patients with epilepsy, severe or untreated hypertension, severe heart disease, impaired cardiac conduction or respiratory function, liver or kidney damage or poor health, if high blood levels are anticipated. Avoid injection if site is inflamed. Facilities for resuscitation should be available.

Side effects:
- Extremely rare in dental practice and usually the result of excessive blood concentrations.

Nervousness, dizziness, blurred vision, tremors, drowsiness, convulsions, unconsciousness, hypotension, myocardial depression, bradycardia and possibly respiratory or cardiac arrest. Allergic reactions. Methaemoglobinaemia; consider giving 1% methylene blue i.v. 1mg/kg over 5 minutes. Pregnancy: Use in caution during early pregnancy. Prilocaine enters mothers milk with no general risk at recommended doses.

Interactions:
- With sulphonamides e.g. cotrimoxazole. Vasopressor properties of Octapressin should be considered. Observe caution when concomitant use with other amide-type local anaesthetics.

For better dentistry
ommend that all patients use a probiotic prior to oral cancer therapy, as well as during and for a considerable period post-treatment. A probiotic adapted to living in the whole digestive tract, including the oral cavity and that can competitively exclude pathogenic organisms and stimulate the immune system, such as GUM PerioBalance, is recommended. It is the first and only probiotic lozenge specifically patented for oral care and endorsed by the dental health foundation. Clinical trials have found that it is side-effect free and can be safely used in all categories of patients from those who have compromised immune systems to pregnant women and children.

Reducing inflammation
PerioBalance has been found to reduce the inflammation of gingivitis stabilise periodontitis and reduce cariogenic activity. It binds to the mucosal epithelium producing a more beneficial biofilm as well as producing inhibitors to pathogenic growth, thus preventing or limiting the undesirable effects of pathogens and stimulating the immune system. Where the natural healthy bioflora of the mouth has been altered by oral cancer therapy a probiotic will seek to rectify any imbalance produced by restoring the healthy microflora balance.

Providing supporting reinforcement
Specific problems that occur after and during radiation/chemotherapy to head and neck region require supportive reinforcement of oral hygiene and amelioration of problems consequent to therapy. These problems include mucositis, stomatitis, xerostomia, opportunistic infections both bacterial and viral and hypersensitive teeth.

The same three-step process as outlined above should be reinforced to the recovering patient and modifications made to the oral hygiene regime were necessary. These may include where inflammation and soreness limit its mechanical cleaning, the use of an ultra soft brush so that no further trauma is induced. When using soft floss, great care should be taken not to cut the gums. Adhesive plaques can be limited by pain.

To combat demineralisation of teeth surfaces and hypersensitivity, the use of a non-alcohol, high fluoride mouthwash and a high-fluoride toothpaste or prescription high fluoride toothpaste is indicated. Some chlorhexidine mouthwashes contain alcohol, which can make them uncomfortable to use post-treatment as they can exacerbate some undesirable complications of cancer therapy; whereas the prolonged use of a probiotic is essential to combat all post treatment complications particularly opportunistic infections.

Dr Vinod Joshi, Founder and Chief Executive of the Mouth Cancer Foundation says, 'Following chemotherapy and radiotherapy, the mouth tissues can get very sore and sensitive to normal toothpastes and mouthwashes. The protection of the normal bacteria found in a normal healthy mouth is also lost. GUM's Delicate Postoperative Surgical Toothbrush, Paroex Dentifrice Gel and PerioBalance probiotic should be helpful in the care of the mouth following cancer.'
Beating oral cancer

Vizilite Plus with T Blue is the most advanced oral lesion identification and marking system available

In a recent survey carried out by a leading UK dental charity, 79 per cent of the people said their dentist had never checked them for mouth cancer and 87 per cent said their dentist had never spoken to them about it. Dr Nigel Carter (Dental Tribune UK June 25 to 29) chief executive of the British Dental Health Foundation (BDHF) says: ‘The problem here appears to be twofold. Firstly, not enough dentists are carrying out the checks and secondly those who carry them out are failing to communicate this with their patients.’

Higher survival rates

Most people are surprised to learn that in the UK, according to Cancer Research UK, over 4,770 new cases of mouth cancer are diagnosed annually and that early treatment as a result of earlier detection can improve patient survival rates from 50 per cent to nearly 90 per cent.

Mouth cancer is far too often discovered in late stage development. This is the primary reason for the consistently high death rate. Five people each day die of mouth cancer in the UK. Mouth cancer treatment often results in severe disfigurement, and can seriously compromise the quality of life for sufferers. Early detection and diagnosis can make a tremendous difference in life expectancy; mouth cancer is 90 per cent curable when found in its early stages. Unfortunately, 70 per cent of mouth cancers are diagnosed in the late stages, III and IV, leading to a five-year survival rate of 57 per cent. Routine check ups are, therefore, vital.

New screening test

Vizilite Plus is a new oral screening test that works in conjunction to the standard one. ViziLite Plus is an important new medical device that provides dentists and hygienists with an easy-to-use, low cost, disposable and accurate mouth cancer-screening tool.

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How ViziLite Plus works

ViziLite Plus with T Blue is an oral lesion identification and marking system that is used as an adjunct to the conventional head, neck and soft tissue examination. It comprises a chemiluminescent light source (ViziLite) to improve the identification of lesions (even those under the mucosal membrane) and a blue phenothiazine dye to mark those lesions identified by ViziLite Plus. ViziLite Plus with TBlue is designed for use in a patient population at increased risk for mouth cancer.

ViziLite Plus oral-screening protocol

It is recommended that ViziLite Plus be offered annually to all new and re-care adult patients following the standard head, neck and soft tissue exam. Patients with a history of mouth cancer or cancer of the aerodigestive tract should receive at least semi-annual ViziLite Plus exams.

Where to get Vizilite Plus

Panadent is pleased to provide a pack of 40 ViziLite Plus chemiluminescent light devices packed in convenient four packs of 10. Each treatment works out at approximately £15 (including VAT) per patient, per screen. The introductory price for pack of 40 ViziLite is £450 plus VAT. A pack of 10 ViziLite costs £125 plus VAT.

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When CPG-ACP is applied to the tooth surfaces, it binds to biofilm adhesion sites, hydroxyapatite and surrounding soft tissue localising bio-available calcium and phosphate. Saliva also enhances the effectiveness of CPG-ACP and the flavour of the tooth mousse helps to stimulate saliva flow. The longer CPG-ACP is maintained in the mouth, the more effective the result.

There is a wide range of benefits for GC Tooth Mousse. It can be used to provide protection for teeth and to help neutralise an acidic oral environment. Additional professional applications of the mousse will be immediately following bleaching, after ultrasonic, hand scaling or root planing, after removal of orthodontic brackets, following professional tooth cleaning, after application of topical fluoride and also to provide a topical coating for patients suffering from erosions, abrasions and conditions arising from xerostomia.

To provide a variety of choices for individual patients, GC Tooth Mousse is available in 5 delicious flavours namely, Strawberry, Melon, Vanilla, Mint and Tutti Frutti.

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Life Saving

Most surgeries feel ethically obliged to carry an emergency kit in the surgery. For this reason The Dental Directory sells an Emergency Drugs Kit under its Unolent label, which includes first line emergency drugs, accessories and practical guidance on how to treat the most common medical emergencies. Just some of drugs in the kit are adrenaline, aspirin, Piriteze, Diazepam, Glucagon and Hydrocortisone. Various cannulas, syringes, disposable needles and inhalers are also included.

Those who like to ensure that every eventuality is covered, might like to consider a defibrillator. Thankfully, the likelihood of somebody having a heart attack whilst undergoing treatment is minimal. It is, however, advisable for any business or public place where people may be at risk of a sudden cardiac arrest to have a defibrillator. By carrying out the very best treatment and ensuring your chosen equipment supplier, thus enabling them to work through all the technical aspects that are required to ensure the successful refurbishment of your surgery.

The flexible and thorough approach adopted by Genius Interiors ensures complete peace of mind. The full service includes project management so there is no reason to worry about any aspect of the work.

Exceeding practice expecta- tions time and time again, Genius provides a seamless, bespoke design and build service, taking care of all aspects of the work from the initial design and specification of furniture, through to liaising with your chosen equipment supplier, thus enabling them to work through all the technical aspects that are required to ensure the successful refurbishment of your surgery.

The First Choice in the Fight Against Periodontal Disease

An invaluable knowledge of the building industry, coupled with their step-by-step approach and reliability, ensures Genius delivers cost effective designs and high quality interiors within the dental profession, all carefully managed to match agreed budgets and timescale.

Bring your practice into the future with Genius. Visit www.genusinteriors.co.uk or phone 01582 840 484.

Cold Sore Season faces defeat!

We all need some help when it comes to Cold Sores. These very annoying, painful and irritating oral conditions can ruin a family Celebration. Now Pa- tients, Dentists and Staff Mem- bers involved in UK Dentistry all have their own special help with the introduction of the OraLight hand held treatment wand.

Provided for NASA Astro- nauts as a drug and medication Free system, this Clinically Proven device is fully re- searched and plenty of supporting evidence can be found on Medline/Pubmed (under “Low Level Laser Therapy” or “Photo- therapy”). The price is twice a daily ap- plication (2-3 times in extreme cases) of this healing light over 3-4 days is sufficient to get rid of cold sores (although you should continue to use it un- til the skin has completely healed).

Dentists can stock OraLight through Dental Sky (tel 0800 291 4700) now at the special price of £25.00 +vat (Special of- fer RRP £49.00) alternatively, order a pack of 6 and benefit from the starter kit containing Patient Leaflets and a Wall Poster. This allows You to pro- vide this amazing product di- rect to Your Patients - the unit will cost just the same as an electric toothbrush: Normal RRP £64.00 inc VAT Special Offer RRP £49.00 inc VAT. See: www.oralight.co.uk.

Get Special Help in Your Practice Now!

Contact: mark@oralight.co.uk or for more information.

“in my experience with Peri- owave™ when combined with splinting,” Dr Africa continues, “I have seen amazing results, especially in the lower anterior region in patients of all ages. During their follow-up visit, pa- tients immediately tell us about the significant improvement in the feel of their gums, and the disappearance of bleeding that was there before treatment.”

For more information, call OraLight on 01480 862080 or email enquiries@oraldent.co.uk, www.oraldent.co.uk/perio- owave.html

Secure Your Future with CEREC

Terry Patuazzo, Sirona Dental Systems MD has commented how important it is for prac- tice’s, in this day and age, to se- cure their financial stability and raise their revenue whilst trad- ing in difficult times. One tried and tested method is to offer your patients something that they cannot necessarily get from other dental practices lo- cally which has a real advantage for the patient. This is achiev- able with the CEREC CAD/CAM System from Sirona Dental Sys- tems Ltd.

CEREC is proven to increase profits plus it adds the ‘wow’ factor to any practice. CEREC enables you to provide your pa- tients with same day crowns, bridges etc without the expense and time of waiting for the labo- ratory to construct the crown/br- idge. Patients are willing to pay that little bit more for one of the most aesthetic, perfectly fitting ceramic restoration in the mar- ket place today.

Using CEREC allows you to produce perfect chairside ce- ramic 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 ob- ligation demonstration of the CEREC 3D system telephone 0845 071 5040 or email: info@sironadental.co.uk or www.sironacadcamso- lutions.co.uk.

Dental Directory on Team on 0800 585 5856.

Seamless bespoke design and build service

OraLight provides a handy, cost effective and patient friendly solution for any practice looking to treat Cold Sores.

For more information on OraLight please call 01582 840 484.
BACD Fifth Annual Meeting
The A To Z Of Cosmetic Dentistry: From Beginner To Winner!

13th - 15th November 2008
The Hilton Birmingham Metropole
www.bacd.com
This year’s British Society of Dental Hygiene and Therapy (BSDHT) conference at Edinburgh’s ICC, November 21 to 22 gives delegates the opportunity to hear professional speakers deliver topical perspectives ranging from the critical to the clinical. Dr Margie Taylor, chief dental officer, Scotland offers a welcome speech, and a close from Dr Hew Mathewson, president of the GDC.

What’s on offer
On November 21, listen to Professor Angus Walls discuss oral and dental problems of older people with natural teeth in partnership with Colgate and you’ll understand the demographics of ageing and population changes that will impact on clinical practice over the next 20 years, and be aware of changes in disease risk associated with ageing and of the challenges for oral hygiene associated with normal ageing. Or perhaps you’re more interested in radiography for the DCP where Dr Jimmy Makdissi, consultant in oral and dental radiology with look at taking x-rays, the anatomy of dental x-rays and how to identify the most common film faults and their causes.

On November 22, Professor Mike Lewis asks whether there’s a link between the mouth and systemic disease. After this talk, you’ll understand more about the potential relationship between oral disease and systemic disease; gain knowledge of the potential mechanism that link periodontitis with the onset of cardiovascular disease, and the role of members of the oral microflora in the development of ventilator associated pneumonia. Dr Raul Doshi explains how to ensure a successful practice including how to create a five-star new patient experience, the importance of the morning meeting and understanding the importance of nurturing an empowered team.

Not forgetting...
These are just a few of the presentations on offer. For more hands-on learning, there are also workshop sessions on each day too, on subjects from legal and ethical dilemmas in the practice setting, to unravelling clinical papers. There’s also a gala dinner on November 21 at the Sheraton Grand Hotel and Spa.

The conference offers two full days to pick up the salient issues affecting you in a transforming dental market; to meet colleagues and expand your circle of professional contacts. It’s also a chance to earn 9.5 hours of verifiable CPD and receive additional general CPD from attending the exhibition.

For further details and to book your place, visit wwwbsdht.org.uk
Aesthetic Dentistry... today and tomorrow

The Venues:
29th October 2008
The Royal College of Surgeons of England, London
31st October 2008
Cedar Court Hotel, Bradford

Take a closer look at Lava™ Zirconia and chairside intraoral scanning

For more information please contact Judy Dodds:
jdodds@rcseng.ac.uk  tel: 020 7869 6753

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Day 1 Emergencies and Infection Control
Day 2 Dental Radiology and Radiation Protection

Participants can attend one or both days

This is a two day course aimed at the entire dental team. Special rates for the whole team are available

CPD: 5 points on each day

For more information and to book online please visit www.rsm.ac.uk/diary or contact Nicole Leida: nicole.leida@rsm.ac.uk
40% of adults across the world suffer from gum disease
(Source: BBC News - Health)

STOPS GINGIVITIS BEFORE IT STARTS

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