The government rebuffs HSC report

Dental practitioners have condemned the government’s response to the Health Select Committee report on NHS dental reforms for being ‘total denial’ and ‘failing to accept any criticism’.

Derek Watson, chief executive of the Dental Practitioners’ Association called the response from the Department of Health ‘fairly predictable’ and said: ‘The Health Select Committee has done all of this work and it seems to have been ignored’.

In its interim response to the report on dental services in July by the Health Select Committee, the government said that the new dental contract arrangements provide a better basis for Primary Care Trusts (PCTs) to commission services, as the new system equips them with greater powers and flexibility to meet the needs of local people”.

It did accept the Committee’s view that progress on improving access has been disappointing to date and pledged to ‘work with professional and patient groups to review how, both nationally and locally, we and the NHS can achieve the maximum benefits for patients from these reforms’.

Mr Watson said: ‘We were somewhat surprised that given that the Committee came up with a number of valid comments and concerns, the government is sticking very much to their line of view – as indeed they should. They also looked at the problems from the point of view of the providers of the service – again, not unreasonable. Their conclusions were clear and accurate. The system is not working.”

Frequent claims

Did you know that crowns and bridgework account for a huge amount of cases involving claims against dentists? Dental Protection reveals all.

Cash boost

An extra 36,500 people will be able to register with an NHS dentist in Leeds over the next three years after a £2m cash boost. The investment plans were agreed by Leeds Primary Care Trust (PCT) to improve access to dental services across the city in areas including Hyde Park, Pudsey, Horsforth, Harewood, Wetherby and Ackworth. The PCT said the funds were an interim measure until longer-term plans emerged.

Fool’s gold

People brought their dentures to a Nottingham antique dealer after reading an advert wanting to purchase false teeth. But the type of false teeth wanted by dealers, M. Kemp, were crowns and palates, which in former days were completely made from gold. A far cry from modern dentures, a whole palate could be worth hundreds of pounds.

Nowadays, prices offered vary from £10 to £50, per gram of nine carat gold.

UDA increase

The Department of Health has released data under its Dental Reform Monitoring programme, which shows the number of Units of Dental Activity (UDAs) commissioned for 2007-08. The key findings, from the 152 PCTs and Care Trusts, were that 81 million UDAs were commissioned for 2007-08, as on June 30 this year. This was an increase of 1.4 million (1.7 per cent) on UDAs commissioned for 2006-07.

Company pull-out

Dental company, Primecare, is leaving an NHS contract covering thousands of North Yorkshire residents after only one year. The contract in Leyburn, Masham, Harrogate and Bedale, terminates on October 51.

Councillor John Blackie, North Yorkshire health scrutiny committee chairman, said the firm told him the deal signed with North Yorkshire and York Primary Care Trust (PCT) was ‘fawed’ due to a huge backlog.

He explained: ‘Primecare set up in areas without NHS dentists, so there was a large backlog of dental work and the way the contract rewards dentists meant they were unable to pay for it.’

He called on the PCT to find an alternative provider before new dentists take over in April.

Financial re-think

The DII has launched a proposal for maternity payments as set out in its draft GDS statement of dentists’ financial entitlements from April 2009.

I spy…

Is your practice looking a bit flat? Kathy Adams lists the reasons why a feature wall could be the answer – but there’s no room for disorganisation?

Wasted effort?

Nobody wants to deal with an emergency but you can’t afford to take the risk. Sharon Holmes explains why you have to use your time wisely.

The BDA recently called for the ‘reintroduction of effective and constructive consultation with the profession which was so lacking in the development and implementation of the new contract’.

Ms Sanderson added: ‘We hope that the positive response to the BDA’s call for dialogue with the profession and patient groups signals the start of a more constructive period in the relationship between the government and the profession.’

John Benshaw, co-founder of Challenge, a campaign group of general dental practitioners, said: ‘The Department of Health is in total denial of the problems because, in their terms, their planned changes have been totally successful. Their response to the Health Select Committee says as much in so many words.’

He added: ‘The Health Select Committee looked at the problems in the service from a patient’s point of view – as indeed they should. They also looked at the problems from the point of view of the providers of the service – again, not unreasonable. Their conclusions were clear and accurate. The system is not working.”

Clinical Case Studies

Is your practice looking a bit flat? Kathy Adams lists the reasons why a feature wall could be the answer – but there’s no room for disorganisation?

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GDS financial entitlements revealed

The Department of Health has launched a volte face in its proposal for maternity payments as set out in its draft General Dental Service (GDS) statement of dentists’ financial entitlements from April 2009.

The draft letter, sent out by the DH to dentists on October 2, sets down proposals to follow the Statutory Maternity Pay (SMP) route and pay 90 per cent of pensionable earnings for the first six weeks, followed by the standard rate of £110.80 for the remaining 13 weeks, which was likely to be much lower than the dentists’ NHS earnings.

But in a surprise statement on October 30, the DH announced that ‘the intention is to retain current arrangements rather than mirror SMP’.

The payment for Maternity Leave Payments (MLP) is not the same as SMP which covers 59 weeks. MLP pays a sum equivalent to dentists’ net pensionable earnings, for 26 weeks. In contrast, SMP covers 59 weeks, paying 90 per cent of pay for the first six weeks, but dropping considerably for the final 53 weeks.

The letter also states that the DH does not want to introduce a national scheme to ensure quality, as it believes PCTs are beginning to reward quality themselves.

Regarding seniority payments, the DH is proposing to freeze the scheme for ‘current members’, with no newcomers admitted after March 2009.

Eddie Crouch, from Birmingham local dental committee (LDC), said: ‘Until the new contract, dentists were contributing towards eventual receipt of seniority payments to reward older dentists as they slowed their work rate.

‘Stopping these payments to those approaching 55 isn’t acceptable, as the UDA system enables us to manage their work rate. The BDA should look for suitable replacements for those affected.’

He said last summer’s LDC conference requested clarification on seniority payments and passed the following motion. ‘This conference demands that contributions should remain available, returned to contributors and not merged into general payments.’

He said the GPDC should take note of the conference’s overwhelming support for the move.

Peter Ward, chief executive of the BDA, said: ‘The proposed changes raise a number of issues. The BDA is concerned about several of the proposed changes, including seniority payments, and the short timeframe stipulated for responses to them.

‘An urgent meeting is being sought with the DH to address these concerns.’

Derek Watson, CEO of the Dental Practitioners Association, also addressed the issue. He said: ‘Seniority payments were a concern which rewarded dentists by giving them their own top-sliced money back in the latter stage of their careers.

‘PCTs have no intention of replacing this scheme and dentists’ contributions are being stolen by the DH.

‘This will encourage experienced dentists to leave the NHS. The money must be refunded.’

‘We have no evidence that PCTs are setting up quality assurance schemes in any meaningful way or doing anything to replace the seniority element.’

The PDS statement of financial entitlements, which will follow the same financial arrangements as being published in due courses.

The final version on the proposed GDFSE will be published on the DH’s website in December. Comments are welcome until the end of October.

Showcase beats all records

More than 500 exhibitors demonstrated their wares during the BDTA Dental Showcase at ExCel earlier this month, attended by 3000 visitors. Cutting-edge technologies and innovations were complemented by lectures and seminars.

Visitors packed out the world premiere of Smile-on and Dental Protection’s (DP) innovative series, Communications in Dentistry: Options for change. Along with Smile-on founder, Noam Tamir, Stephen Hancock demonstrated through the soap-opera style DVD, the essentials of good communication for the dental team. These include willingness to listen, talking to rather than at, eye contact, taking time and having an open-minded attitude.

Kevin Lewis of DP, who introduced proceedings, said: ‘Effective teams are developed through clear communication. It’s only by setting clear goals, efficient leadership and problem-solving skills that team-work succeeds.’

Clearstep, which focuses on clear positioning, launched its new orthodontic systems. MD, Alistair McCance, said: ‘Our orthodontists are designed to treat any malocclusion, from mild to severe, with minimal discomfort.’

PracticeWorks launched its new Kodak R4 version 111, with functions including automatic software updates and virus protection with a hosted service, a comprehensive appointment di- alog, online booking for patients and a new report manager, which almost instantly locates relevant data. There is also simple encrypted credit-card processing system.

The BDA also supports an urgent explanation from the DH of the apparent decline in the number of complex treatments since the new contract. It is committed to showing work on good practice in commissioning, launched at a special conference in April. In addition, it supports calls for review of items such as units of dental activity and treatment bands.

The BDA proposes the review should address future service provision and how far NHS dentistry should offer ‘the growing number of treatments which do not address clinical ill-health but are concerned with improving quality of life’.

Modern dentistry needs time, says BDA

The British Dental Association (BDA) has told the Government that dentists must be given the time to provide patients with top quality modern dentistry. BDA executive chairman, Susie Sanderson wrote to health minister, Anna Keen, urging the Department of Health (DH) to undertake an exercise on timing, following the Health Committee’s (HC) critical report on the Government’s reorganisation of NHS dental services.

Ms Sanderson said: ‘This exercise must consider the time required to deliver a genuinely personalised service in line with thefour pillars of the new contract – the Next step Review and the time required to undertake treatment to the quality and standard that patients expect. Without this information, we believe it is impossible to develop a system to provide a sustainable future for NHS dentistry.’

Dr Sanderson’s letter accompanies the publication of the BDA’s detailed response to the July publication of the HC report. She continued: ‘The introduction of the new contract has led to confusion for dentists and patients and it is important that the HC report has made those problems a matter of public record.’

The BDA response reinforces criticism of the new target-driven contract and highlights the failure of the Government to meet its own success criteria, as set out in the DH report, NDS Dentistry: Options for change. These included facilitating a more preventive approach to care and improving patient access.

A BDA spokesman said: ‘Recent BDA negotiations with NHS employers over the salaried primary dental care contract provide an excellent example of open and transparent talk.’

The BDA also supports an urgent explanation from the DH of the apparent decline in the number of complex treatments since the new contract. It is committed to showing work on good practice in commissioning, launched at a special conference in April. In addition, it supports calls for review of items such as units of dental activity and treatment bands.

It has challenged the DH to publish a review of how services might develop over the next five years.

The BDA proposes the review should address future service provision and how far NHS dentistry should offer ‘the growing number of treatments which do not address clinical ill-health but are concerned with improving quality of life’.

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Editorial comment

Turning a blind eye

The government’s response to the Health Select Committee report conjures up the old adage of the three wise monkeys does it not; ‘See no evil, hear no evil, speak no evil’. For it’s an easy path to follow isn’t it.

In short, turning a wilful blind eye to the situation is one way of dealing with a somewhat ‘difficult’ situation. But waves of disappointment are breaking on the profession. Has the hard graft required to compile the report been wasted? The meticulous detail combed together from the Committee was black and white i.e. ‘Things have worsened since the changes of 1989 and we must work with the NHS to make any changes’. It has promised to ‘work with professional and patient groups to review how nationally and locally professional and patient groups to review how nationally and locally’ and will further improve access.

Acknowledging that ‘progress is being made’ and will further improve access has been an entirely different story. We all love UDA’s apparently, more really, we must do, because ‘the available evidence supports the view that this has led, as intended to a reduction of workload AND dentists working hours are shorter than they were in 2000.’ But is the reduction of workload to do with some dentists who were under-allocated in the first place? Or maybe it’s down to those forced to extract teeth instead of performing complex treatments through lack of funding? Something doesn’t quite add up but the Department has done its bit from every possible perspective. If only the government would follow suit.

Okay, so it’s not exactly good news for the government to deal with, but to blatantly deny such evidence is not the way to go if it wants to build bridges. The local bhrb is good though and we like that – but what’s the point of having a system that provides local dental services if there aren’t enough NHS dentists to provide the services anymore? Acknowledging that ‘progress on improving access has been disappointing to date’ is a start. And pledging to ‘work with professional and patient groups to review how nationally and locally’ and will further improve access.

Continuing on the thread of denial is the response to the Committee’s evidence that UDAs remain ‘extremely unpopular with dentists.’ It appears the government has its own separate evidence which tells an entirely different story. We all love UDAs apparently.

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NHS Dentistry Boost in Yorkshire

S

pending on NHS dentistry in Yorkshire is set to increase over the next two years by more than £6m, which is expected to increase people using NHS dentists by about ten per cent by 2010.

Although £1.9m was ploughed into dental services in Richmond, York, Scarborough and Harrogate last year, moves to the private sec-
tor meant fewer patients could see an NHS dentist, North York-
shire and York Primary Care Trust (PCT) is therefore expanding NHS dental provision, with £2.9m next year and £4.6m the following one, especially in areas such as Richmond, Selby, Northallerton, rural Harrogate, Pateley Bridge, Whitby and Byedale.

The PCT also wants to recom-
mmission NHS dentistry in Ley-
burn, Northallerton and Pateley Bridge where some dentists have announced they are set to reduce NHS provision. In March 2006, 55.7 per cent of the adult North Yorkshire population was using NHS dental care along with 74.8 per cent of children. In March last year, it fell to 52.8 per cent for adults and 73.5 per cent for children. Jane Marshall, di-
rector of commissioning and service development, said al-
though the proportion of the population accessing NHS den-
tistry was slightly above the Eng-
land average, the downward trend was a concern, which would be addressed by the PCTs commissioning plans. She said:

The scale of investment re-
quired to bring about improve-
ments in access to NHS dentistry and orthodontic services is con-
siderable.

The GDC confirms registration

T

he General Dental Coun-
cil (GDC) has confirmed that dental professionals have to be registered with the body, whatever their job titles. Titles such as dental nurse, den-
tal surgery assistant, dental technician and dental technolo-
gist are protected by law, so if a title is used which misleadingly implies registration of the GDC, there is a risk of prosecution in the courts.

Unregistered dental nurses and dental technicians are effec-
tively outlawed by GDC stan-
dards which make it clear that registrants—dental professionals who are literally signed up to the high standards set in the UK for their profession—must employ and work with appropriately reg-
istered people.

If a registered dentist or den-
tal technician employs someone to work as a dental nurse or den-
tal technician they have a duty to ensure that the employee is reg-
istered or in training. If they don’t, they risk losing their own registration.

Transitional arrangements that were in place for two years, which allowed existing dental nurses and dental technicians to register on the basis of experi-
ence, are now closed. This means that men and women who are working as dental nurses and dental technicians can no longer apply for registra-
tion on this basis.

GDC director of operations, Edward Bannatyne, said: ‘You have to be registered or in train-
ing to work as a dental nurse or den-
tal technician. If you don’t call yourself a dental nurse or dental technician, then who-
ever employs you risks a GDC fitness to practice investigation and is putting their own registra-
tion at risk.’

‘The time to register under transitional arrangements that recognized existing experience is over. To be a dental nurse or dental technician, you must reg-
ister or be in training. It’s as sim-
ple as that.’

For information on register-
ing as a dental nurse or dental technician, visit www.gdc-
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2008 campaign against mouth cancer has just been announced by one of the UK’s leading oral health charities, which claims it is time to take action against the disease. ‘Action speaks louder than words’ is the message from the British Dental Health Foundation (BDHF) which is gearing up to stage a November spotlight on this hidden killer disease.

Mouth Cancer Action Week takes place from November 16 to 22, as campaign organisers take up on a new, positive stance against the condition. The new Action Week replaces the former Mouth Cancer Awareness Week name, as the BDHF together with health professionals across the land take action on this disease, which kills more people than cervical and testicular cancer combined. However, in the light of this, a fifth of the UK population still remain unaware of mouth cancer, with which nearly 5,000 are diagnosed annually. Mortality figures have remained above 1,500 deaths per year for a decade for mouth cancer, which kills someone every five hours in the UK.

The BDHF’s Blue Ribbon Badge campaign is continuing to promote awareness by sending badges and collection boxes to dental practices, doctor’s surgeries, pharmacies and health centres across the country, which will be on-sale to the public, with the key message: ‘If in doubt, get checked out.’

Easily recognisable symptoms and regular check ups can boost survival rates to 90 per cent with early detection. But survival rates once mouth cancer has spread can be as low as 50 per cent.

Foundation chief executive Dr Nigel Carter BDS LDS (RCS) said: ‘Our slogan reinforces our call to action. We are encouraging the public and the health profession to wear their Blue Ribbons with pride, and not only talk about mouth cancer but take positive steps. Action can be as simple as visiting the dentist regularly to making lifestyle choices such as quitting smoking or drinking in moderation.’

Early detection of mouth cancer can save lives, so people should look out for ulcers which don’t heal, red and white patches in the mouth or other unusual changes.

Common causes are smoking, chewing tobacco, drinking to excess and poor diets. Links have also been found between oral sex and mouth cancer.

For more information or for order forms for Blue Ribbon Badge campaign collection boxes, log onto: www.mouthcancer.org.
Flu pandemic advice

The Department of Health has issued advice to dentists in the event of a flu pandemic. This includes contacting asymptomatic patients 24 hours before an appointment to ensure they are symptom-free and screening them when they arrive.

In the case of infected patients, treatment should be delayed until they are asymptomatic, if possible. PCTs will provide advice on additional precautions required for emergency care.

During a flu epidemic, dental practices should ensure excellent hygiene, with disposable tissues for staff to cover the face during and after sneezing, coughing and wiping or blowing the nose, or during and after contact with respiratory secretions and contaminated objects. Hands should be thoroughly washed with soap and water or alcohol rub for 30 seconds.

Coughing and sneezing patients in waiting areas should wear surgical masks. Non-essential items such as soft furnishings, as well as toys, books, newspapers and magazines should be removed from reception and waiting areas.

NASDA members celebrate

The bi-annual meeting of the National Association of Specialist Dental Accountants (NASDA) has marked its tenth anniversary. At the meeting, members heard that hits on the NASDA website are rising with frequent enquiries from dentists seeking a NASDA accountant.

Attendees planned the publication of the NASDA annual benchmarking statistics - the earliest opportunity for an overview of UK dental accounts.

NASDA enables accountants with a significant commitment to dental clients to share knowledge and enhance their service. Lawyers can join as associate members of NASDA, which is forming a database of surgery sale prices.

Chairman, Nick Ledingham, of Morris and Co, paid tribute to NASDA founder, Paul Kendall, along with founder members, John Flewitt and Peter Howard.

Mr Ledingham said: ‘As a result of the 2006 dental contract, NASDA members find their specialist knowledge in greater demand. We are now more focused than ever before on sharing information with a view to providing a higher level of service to the dental profession.’

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News & Opinions

Fluoridation expert visit

One of the world’s leading experts on fluoride flew over to Southampton from the US to voice his views on the city’s current consultation on whether to add fluoride to its tap water to improve dental health.

Dr Paul Connett, who is fiercely against fluoridation, is director of Fluoride Action Network and a retired professor of chemistry at St Lawrence University in New York. He has spoken about fluoride at conferences across the globe, he says, since he began researching its health impact more than 10 years ago.

Dr Connett believes that fluoride is attractive to Primary Care Trusts, because they do not have to bother educating parents or improving living family conditions.

He said: ‘There is a far stronger relationship between tooth decay and living standards than you will ever find between tooth decay and fluoride. The answer should be to target vulnerable children in low income families and make sure that pregnant women in those areas eat a good diet.’

He thinks it is not right to force fluoride on people who may be sensitive to it or who do not want it, because it can cause serious side-effects such as lowering IQ and fluorosis.

Amblenwyd dentistry increase

Campaigners in Ambleside have celebrated the opening of a new dental surgery with 2,000 NHS places. Mint Dental Practice, which has practices in Barrow and Windermere, has opened its Ambleside branch at the Old Quaker House in Rydal Road.

Westmorland and Lonsdale MP, Tim Farron, who officially opened the surgery, said it was a triumph for everyone who had put pressure on Cumbria Primary Care Trust (PCT) to keep a surgery in Ambleside. On behalf of residents, he lobbied the PCT, along with South Lakeland District councillors, Vivienne Rees and David Vatcher, following the closure of an NHS dental surgery earlier this year. The PCT were previously not planning to open a new dental surgery in Ambleside, but instead to provide more NHS places in Windermere. But members changed their minds when more than 2,000 residents appealed for the service to stay.

Mr Farron said: ‘This is an important victory for local people. I am delighted that people in Ambleside and the surrounding villages will continue to have access to good quality, local NHS dentistry. This is further proof that when communities stand together and campaign hard, they can win.’

Eric Rooney, consultant in dental public health at NHS Cumbria, said Mint’s opening illustrated the organisation’s commitment to meeting the needs of the local population. A further 11,600 NHS dental places are expected to become available to the county’s patients over the next 12 months.

Oral probiotic helps Xerostomia symptoms

A new product claims to reduce Xerostomia, (dry mouth) a condition carrying an increased risk of periodontitis and dental caries, because oral mucosa are more vulnerable to infection and saliva is no longer re-mineralizing tooth enamel. Often, it is not possible to correct the Xerostomia itself so treatment focuses on relieving the symptoms and preventing damage to the gums and teeth.

Dr Connett is keen to see in-depth studies of fluoride’s side effects and claims there has been no research as to whether fluoride can stop decay in growing teeth cells, without damaging other tissue.

He said: ‘Countries that have had fluoridation since 1950 have never done the basic studies to check this hypothesis out. If you don’t study it properly, you don’t notice the subtle changes.’

He claims studies from countries that do not fluoridate their water but have naturally high levels of fluoride, ‘have been ignored, such as 25 studies done in China, Iran and Mexico’.

Scottish phobia dentists

Phobia dentists use a variety of other methods to help patients relax, which can include scented oils, relaxing music or aromatherapy.

The new facility, which offers NHS care as well as specialist dental services, is made-up of five purpose-built surgeries within the former Bonnyrigg Health Centre, with a team of 20 dental professionals. As well as treatment for dental phobics, the practice offers specialist care for the elderly, frail people and children, as well as an emergency facility for unregistered patients.
Unlocking website potential

With the benefits of broadband, you can afford to create a better quality website to boost your practice brand. Amy Rose offers some tips

When a visitor accesses your website, all of those pictures and reams of text need to be downloaded. With broadband officially the choice of connection for the average home internet user nowadays, it is now practical and feasible for websites to include files that might once have taken too long to download. Pretty soon, dial-up internet access will be consigned to the attic of history along with the mouse that only had two buttons. In fact, broadband access has already supplanted dial-up as the first choice for home Internet users.

According to the Office for National Statistics, 61 per cent of UK households had access to the Internet in 2007, an increase of one million households since 2006, making a total of 15 million households. Of these, a massive 84 per cent had a broadband connection. In London, this was even higher, at 88 per cent.

Easy access

The benefits of broadband are clear. Not only is it easier for the user to control the expenditure and retain the use of their telephone while on-line, broadband lets you download songs and music videos in seconds. Now, Internet users can watch highlights from football matches, and with the BBC iPlayer – surely unthinkable in the days of dial-up! – see their favourite TV shows at a time that suits them. According to broadbandchoices.co.uk, broadband is ‘up to 480 times faster than dial-up’. You should be taking advantage of this.

Why not visit the websites of your competitors? What do their sites say about the services offered? It is not just a question of the data on the site, but also a question of how that data is communicated. Since most visitors will be using broadband, why not employ the latest techniques to communicate more effectively with your visitors?

By enlisting a website design agency you can make use of the latest web-design concepts. The market leader offers exclusive, high-definition animations to show visitors in the most accessible way possible what to expect from treatment, with professionally written treatment text to expand on the animation content.

In short, because most of the people using your site will have a broadband connection, you can tailor the content for them, using more detailed images, high-quality animations and as much information as you want to impart. Just like your practice interior, the website says a lot about your commitment to a modern, professional service. Take advantage of the opportunities afforded by broadband, and contact a website design agency today.

Amy Rose

Amy Rose has over six years experience in the dental profession, working predominantly in a marketing capacity. She currently heads up the design and marketing team at Dental Design Ltd. For more information on how you can maximise the potential of your website, contact Dental Design on 01202 677277 or email contact@dental-design.co.uk.

About the author

Easy come, easy go

Here at Dental Services Direct we thrive on keeping our customers happy. It’s a rewarding job but can be hard work too. So this year we didn’t exhibit at BDTA Dental Showcase but took a well earned rest instead.

But that gave us a problem, what would we do with the money we saved by staying at home? After a good deal of thought someone had the brilliant idea of giving it to our customers – well in the current economic climate we could all do with a little extra help couldn’t we?

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If you want to brighten up your practice, Kathy Adams suggests adding a feature wall. It will help add a bit of colour without going over the top.

One good way of adding interest to an area and creating visual impact is with a feature wall, commonly used in shops and retail premises. Whether you are decorating or having a complete practice retrofit, a feature wall can easily add impact to a room. It’s a simple, cost-effective solution, using either colour and/or a change in materials.

While feature walls are most commonly used as a highlight in a neutral-schemed space, they work well to define areas rather than having expanses of the same colour. If you would like to draw attention to the reception area or waiting room, then a feature wall will accent it perfectly.

Why not use it to delineate an area for merchandise, promotions or behind reception? Try to use a wall that is dominant in the room and wash it with light or use an internally illuminated sign or display to draw the attention of your patients.

Add a touch of colour

The most important thing to remember when adding colour into your practice is not to have a disorganised approach. When colour is used inappropriately it can be counter productive. Colour needs to be co-ordinated; for example, why not use your corporate colours? These could be displayed in a variety of shades, or you could even introduce another colour to complement them. Take some time to experiment with colour, one suggestion is to get a few sample pots to paint panels and see how the colours look.

A feature wall will have a dramatic effect on the whole room and works just as well to alter the room shape. A dark colour will make the feature wall advance and appear closer, while a lighter shade will make the wall recede and appear further away. So if you want to make a long room appear squarer, paint the far wall in a darker colour to draw the wall into the room.

With a variety of materials to choose from, a feature wall is an attractive and practical option that works every time. Different options include paints, an inexpensive yet effective route; wood for that classic quality solution, a light wood for a more contemporary high-street solution or a dark wood such as cherry, for a luxurious hotel feel. If you have that little bit extra to spend, why not install a wall of coloured glass? This creates a dramatic impact and is surprisingly easy to fit. Lacobel glass comes in many stunning colours and is certain to make an instant and lasting impression.

About the author

Kathy Adams is design director at Admor. For more information, contact Admor on 01273 553078 or visit www.admor.co.uk.
Dealing with difficult staff

In previous articles, I have dwelt at length on the difficulties of selection, induction and retention of new members of staff. Possibly the most difficult step is the first – selection. This is because we tend to make decisions based only on what we see or hear at a fairly short interview or couple thereof. Let me give you an example.

An obvious contender

A while back, in the pre-registration days, we had advertised for a trainee nurse. The response had been high, and my manager and I had sifted through the long-list, selected a short-list and invited six people to attend for interviews. We were in total agreement that one bright young sixteen-year-old stood head and shoulders above the others. She was bright, alert, intelligent, presentable and tidy. She spoke well and with confidence and maintained good eye contact. Her schooling record was good, and she even brought in a couple of character references.

She was invited to come in on a one-month trial basis at a nominal salary, and told that if she cut the mustard her salary would be increased and she would be given a contract. She agreed to this and seemed pleased. She duly arrived on time, but within an hour had requested the afternoon off to attend the doctor. Fine, no sweat. She arrived back the following day, worked well, and at the end of the day said she could not come in the following day as she had to attend the funeral of a relative. Well, as you know, people do die and they must be mourned, so, again, no sweat. On the fourth day she returned, again worked well in the morning and at lunchtime asked to speak to me in my office. She duly told me that she thought her induction salary was inadequate...

Gummers are the pits

'We were amazed when she collected her coat and rushed out in mortal fear of her life.'
and demanded an increase of 50 per cent with immediate effect. My other staff were amazed when she returned seconds later to the staffroom, collected her coat and rushed out of the surgery in mortal fear of her life.

The Umper Band

The bottom line was that I, and my manager, with all our experience, had comprehensively cocked up our selection. So it goes. Anyway, it got me thinking, and that got me reading, and I came across a lovely little book entitled *Dealing with Difficult People* by Christina Osborne. Ms Osborne presents a list of seven ‘Umpers’ which covered a broad spectrum of personality types. Look just be patient, you will soon learn what an Umper is, all right? I’ve added three more, so now we’ve got to the Power of 10. (Any of you picking which three that I’ve added can consider yourselfs pure genius.)

The 10 Uber-Umpers

1. **DUMPERS:** These are the people who, when given a series of jobs, select those which they will enjoy doing and dump the others, usually on the weakest or newest members of staff. They are self-centered and make poor team members.

2. **SLUMPERS:** These are a debilitating type. They have zero enthusiasm. They never complain verbally, but slump around looking sad, demanding silently that everyone else feel sorry for them. If you ask what is wrong, the answer is invariably: ‘nothing’. Despite being team players, they have no energy but drain everyone else’s. Hard to fire, so try poisoning.

3. **JUMPERS:** These are the ambitious lot. They want to climb the corporate ladder. They have zero enthusiasm. They never complain verbally, but slump around looking sad, demanding silently that everyone else feel sorry for them. If you ask what is wrong, the answer is invariably: ‘nothing’. Despite being team players, they have no energy but drain everyone else’s. Hard to fire, so try poisoning.

4. **GRUMPERS:** Are the pits. They are impossible to please. Nothing is ever right. They constantly complain and grumble all the time. They find a dark cloud in every silver lining. They are the apples that poison the barrel. Keep them away from staff meetings. In fact keep them away from everything - permanently!

5. **STUMPERS:** These are the unpredictables, and are usually a function of their own chemicals. Just when you think you’ve got them sussed, they do something unexpected and leave you stumped.

6. **TRUMPERS:** They always have to have the first and last word (and sometimes the middle ones as well). They have to be and are always one step ahead of everyone else. They can be very useful but have to be properly managed. The best way is to challenge them to put their money where their mouth is!

7. **HUMPERS:** These are the work horses. Nothing is too much for them. What they lack in personality they more than compensate with endeavour. Use them where hard work is required rather than the gift of the gab.

8. **BUMPERs:** They are a dodgy lot. When something works, it works because of them. When it doesn’t, it fails because of someone else. Again, this type can be useful if they are kept challenged, with lines of responsibility clearly set out.

9. **THUMPERS:** These are the bully-boys and girls. They get their own way by being aggressive and intimidating others. Being assertive with them usually suffices.

10. **FRUMPERS:** An untidy lot. It’s not that they don’t want to tidy the mess around them, they just cannot see it. Can be managed by simply asking them to do the job rather than criticising what they haven’t done.

The point of this list is not that it helps you select the right person, but it assists in assessing the personality type that will best suit the job spec that you need to fill. That way, you don’t try to fit square pegs in round holes. Since selling his prize-winning dentistry100 practice, Ed Bonner acts as a consultant (guru) and practice coach to the dental profession, working with individuals as well as groups of dentists. He can be reached at bonner.edwin@gmail.com

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I’d like to explore some of the problems a practice owner might face if one of their associates turned out to be an employee. It may be putting the cart before the horse to look at problems before examining the causes, but it will help focus on the importance of getting the principal/associate legal relationship right, at the outset.

An increasing number of associates, who although their status has apparently been that of self-employed, are raising employment law claims that might not be possible if they were self-employed. A reduced number of associateship posts, commercial pressures on practices, and a heightened awareness of legal rights, are all beginning to raise question marks about the legal status of some associateship arrangements.

There are also significant tax implications for practice owners, when it turns out that a self-employed taxpayer should have been subject to the PAYE scheme. Many practice owners are aware of such potential problems that may exist with self-employed hygienists and therapists, but how much longer will it be before HM Revenue and Customs (HMRC) start to eye-up the legal and tax status of some associates?

Against a background of high public expenditure and reduced tax revenues, and with the likelihood of such pressures continuing for some time in the future, can we expect to see HMRC starting to raise challenges to the tax status of self-employed associates?

The employer’s position

Problems employers face where such challenges are mounted include HMRC trying to revisit the tax position by re-categorising the self-employed individual as an employee and seeking to levy extra tax, going back up to six years (or more in some cases).

Indeed, following the Demi-bourne case, (which involved a self-employed worker who the Special Commissioner decided was in fact an employee) it was held that, in such cases, the whole amount of back-tax and National Insurance (NI) con-
Money Matters

DENTAL TRIBUNE United Kingdom Edition - October 20–26, 2008

Dental contributions over the period of ‘self-employment’, was due from the employer. No credit was given for the tax and NI that the worker had already paid.

Some light relief

Some relief from this draconian state of affairs was reached in April 2008 when the Income Tax (PAYE) Amended Regulations 2008 came into effect. These regulations enable HMRC to issue directions, both to the employer and the employee concerned, so that where an employee has paid tax on earnings under self assessment (rather than PAYE), then the employee may be able to claim some PAYE credit and the employer may be relieved of some PAYE liability for the amount of tax specified in the direction. However, practice owners who find themselves in this situation still face the problem that:

1. A direction by HMRC will not cover any penalties for which the employer may be liable for breaches of the PAYE Regulations (by not making the PAYE deductions) (although, fortunately, no interest will be charged)

2. There are likely to be limits to the amounts of such credits.

Since one of the perceived advantages of associates being self-employed is a favourable tax regime, it’s quite likely that there will be excess to be paid by the practice owner.

NI shortfalls

The other problem that practice owners face in such circumstances is that the regulations only cover PAYE. They do not cover NI shortfalls, which will also have to be made up by owners. And of course, HMRC may decline to make the appropriate directions, and seek to collect the whole of the tax from the employer (which they can do in certain circumstances).

If HMRC does collect all the outstanding tax and NI contributions from the practice owner, you might think that all the practice owner has to do is recover it from the (usually former) employee/associate. Think again – surprisingly it is not entirely clear whether a practice owner does have a legal right to make such a recovery.

Of course, the associateship agreement may contain a contractual provision to enable recovery. However, if there is no such written agreement, although there is some recent case law to suggest that the practice owner might have the right to require ‘restitution’, from the former employee/associate, the process is still unclear and potentially legally expensive. The position about the recovery of NI contributions is even less clear.

Suitable arrangements

It is not all doom and gloom on the horizon, though. Provided that there are property and carefully considered (and the strong advice is – written) arrangements in place to ensure the legal and tax status of the parties, then these problems may be avoided.

The next article in the series will explore some of the employment law implications when an associate claims to be an employee.

About the author

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How much longer will it be before HMRC start to eye-up the tax status of some associates?
Business by numbers

Determining a comprehensive plan and using it as a document to measure your success each month puts you in control. Andy McDougall explains.

S

o many practices wait for their accountant to tell them the score when 12 months of trading has past. Throughout the year, those responsible for managing the practice will have attempted to keep an eye on things periodically by various means. But without independent and monthly financial control through a review of management accounts, the result highlighted by the accountant is usually unexpected and often disappointing.

The biggest mistake

So what are the common mistakes practices make? The biggest one is failing to have a business plan which focuses their resources on the things that are important; the ones that will deliver the bottom line they had hoped for.

A comprehensive business plan will enable most of the potential mistakes ahead to be made on paper rather than in reality. Using financial models built specifically to reflect their own business, principals and managers can explore different scenarios to see what impact various decisions would have on the performance of the practice over time. The benefits of this approach are huge. Rather than wasting valuable time and money introducing new initiatives that may fail, plans can be agreed and put into action after they have been properly assessed and checked thereby increasing the likelihood of success.

A business plan is not some woolly document containing hopes, visions and aspirations. So many practices have told me they have a business plan, but what I eventually discover is a document detailing the kind of success they want to achieve without any tangible means of getting it. They don’t have a plan, they have a wish.

Planning is the way

A proper business plan is an in-depth map that leads management in a focused way through every aspect of the business: pricing, marketing, staffing, finance, for example, and highlights specific actions within headings associated with each section. The key aspects of each section will be produced in quite a bit of detail. The plan will then be modelled to deliver a budget (one aspect of the planning process) and will be phasing into 12 distinct periods, reflecting the true activity and cash flow of each period. The plan will also identify key metrics for each area by period.

But planning is only the start of the process. Once the plan has been agreed and signed off the real work begins. Now we must measure actual performance in these areas. Just like the driver of a car uses a dashboard with some key navigations implemented to guide him towards a successful journey, guiding a business to success requires some key metrics. Imagine driving a car without some fundamental tools like a petrol gauge, oil light, speedometer, mileage counter. Your journey would be a nightmare. I often wonder how business owners who would never consider taking a car journey without referring to their dashboard are happy to risk their business by driving it blindly.

An uncertain future

Planning helps reduce the uncertainty of the future because it allows you to exert some control. Don’t fall into the trap of thinking you have a plan when what you have decided to do is last year’s result plus 10 per cent extra income and five per cent extra overhead. That is not a plan. Think of all the things that could change in the year ahead.

Perhaps you are used to putting your prices up every year but have reached a point where the market will not accept further increases. Maybe you only discovered you had a problem when your appointment diary contained more gaps than appointment times and if that is the case, your business is already in trouble. It was only the price increases over the years that has kept you profitable what do you do now?

What if the competition has moved into your area, can that be ignored in your plan? What will be you product/service offering going forward? What is happening to the underlying profile of your patients? Do you need more patients and if so who will be your target audience and what marketing techniques will you have to employ to identify and convert them?

Measuring for success

With a sound plan in place we must now move to performance management. We need to measure all sorts of things that we have determined are crucial to success. Remember what gets measured gets done. This means for each part of our plan we will need to set up the processes and systems to ensure we can measure effectively enabling us to constantly assess whether we are on target.

Particularly in relation to financial reporting, we must ensure that we are looking at a true representation of the performance of the business and avoid ‘spiky’ results that are distorted by the wrong accounting treatment. Remember measuring profit and measuring cash are not the same thing. For example if in the second accounting period you receive a very large insurance bill, you might need the cash but spread that cost equally over the time period you receive the benefit of the service, for example, 12 months. This is known as a pre-payment. Similarly if you get to period 11 and you receive a large bill for some service you have been using all year, you should have been taking account of that in your numbers using accruals.

Another surprise comes when you count stock once a year and find (as is nearly always the case) that you have a large write-off for stock that is missing. Your result worsens just as you are approaching the finishing line. If you had used a system of perpetual inventory throughout the year with a robust stock control system, you would have avoided the surprise and had the opportunity to investigate where the stock had gone missing so corrective action could have been taken.

In comparing the actual result on the above basis against a robust budget and plan, you discover something called variances. These are the clues in your result that tell you where your business is on track and where you need to make greater effort to get behind the things that are not going to plan. Invariably this will come down to people as not much happens in business without them. Does your business plan integrate and align their activities with what they should be focused on in order to deliver your desired result? Are they clear about what their part of the plan is and are they trained to do the job? Do you give them regular feedback on how well they are doing? If not how do you expect the key points in the plan to be executed. People, processes, finances; they all form part of the performance management process.

Your final destination

Determining a comprehensive plan and using it as a working document to measure your business success each month puts you in control. By comparing actual performance against a plan using variances, you proactively manage your result. Like a driver who constantly refers to his dashboard of instruments to get him from A to B safely, your plan will enable you to identify the risk as possible out of your business process so you can be confident of arriving at your destination, on time.

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Speaker: Patrick Holmes
Date: 24th February 2009

Webinar 4: TBA
Speaker: TBA
Date: TBA

For better dentistry

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Inspiring Better Care
BADN conference hits Blackpool

This year’s new and improved BADN conference hits the seaside and tickets are selling fast, says Pam Swain

The annual Dental Nursing Conference will be held at the Blackpool Hilton on Friday October 31 and Saturday November 1, and this year sees some changes in the conference format. Mostly notably, we’ve decided to hold a formal Halloween dinner (fancy dress optional) instead of the Black tie Presidential dinner held in previous years. The menu will also be slightly different, too, serving such delicacies as Witches’ Broth, Frankenstein Chicken and Creepy Chocolate...

The conference doesn’t only take place at Halloween. It’s also the last weekend of the Blackpool Illuminations, so for those interested, we’ve arranged: a tram ride through the city to see the lights after dinner, which will either drop delegates off at the Pleasure Beach, or in the centre of town if they want to go clubbing (Conference delegates will get free VIP entry to both Walkabout and Sanuk in Blackpool or back to the hotel for a quieter night catching up with old friends.

Pre-book presentations

Our second innovation is the new conference registration site, provided through CVENT and sponsored by Schulke, where delegates can choose which presentations they want to attend in advance. The conference programme itself covers a wide variety of subjects, which cover the subject of CPD itself:

• Professional Portfolio Development by BADN
• CPD by Stephen Hancocks, sponsored by P&G Oral Healthcare
• Revalidation by the GDC

Core CPD subjects:

• Decontamination, sponsored by Kemdent
• Cross Infection by Dentisply

Advice on how to rise to the challenge of being a registered professional.

• Keynote speaker Duncan Rudkin of the GDC on professionalism in practice
• Professional indemnity by WR Berkley
• Professional governance (whistleblowing) by the NCAS
• Safeguarding (child protection) by Blackpool PCT’s named nurse for child protection

A look at possible future roles for dental nurses with:

• Dental nursing in the British Army by the RADC
• Dental public health
• Sleep apnoea screening – a role for dental nurses, sponsored by Healthcare Marketing

There will also be presentations, which focus on looking after yourself:

• How to use nutrition to keep yourself healthy by renowned author Dr Marilyn Glenville, sponsored by Molar Ltd
• Occupational dermatitis by the Health and Safety Executive and employment law by Peninsulas

Don’t forget the two perennial favourite presentations in each time slot and full attendance at conference will give eight hours verifiable CPD.

The exam revision day is facilitated by DN Training? Solutions! and is open to all student dental nurses sitting the National in November this year or next May. Due to Dentisply’s sponsorship, the price has been reduced to £40 and there are still a few places left, so if you would like to attend, contact me at conference@badn.org.uk as soon as possible.

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A life-saving chore

It can get in the way of daily tasks, but taking time out to give a new member of staff an induction can save you a lot of wasted time in the long run. Sharon Holmes shows you how it’s done

Imagine the scene: today is the beginning of a really busy day. It’s month-end and all the financial reports are due. Staff need to be paid, and to add to the chaos, Emily the new nurse is due to start work. Emily arrives at 8.45am as arranged and is shown to her surgery and told where to change. Meanwhile, before you can so much as talk to Emily, the receptionist calls to tell you there’s a patient in the waiting room who wants an emergency appointment. From this point onwards, you never look back... the day moves forward at a fast pace.

Not time wasted

To avoid such a situation, I have learned to put aside enough time to go through a full induction with all new members of staff. This may sound like a waste of time and effort, but it’s not. Yes, it takes a whole two hours, but it is vitally important that each member of staff knows exactly how the practice functions on a whole. Is an induction worth two hours or is it worth a life? That is what it could cost you.

I have seen various templates you can use as a guideline for carrying out an induction but I haven’t seen one that covers all aspects each member of staff should be aware of. It is a lot to take in on your first day as a new member of staff, and it is time-consuming to constantly reiterate to members of staff what they need to remember – this is obviously why you have yearly training session on CPR, Infection Control and Radiation.

‘Starting off with a good foundation is important to the development of the practice.’

An induction to any practice is more than just explaining the future plan of the practice and its goals, handing the new member their contract and copy of the staff handbook, and making sure you have a copy of their work papers and certificates. With the changing face of dentistry, especially for nurses, the paperwork is now becoming endless. Some PCTs are requesting CRBs on all staff – not just the dentists. This should also become part and parcel of your induction package as it’s part of the initial stage of employing a new member of staff and settling them into your practice environment. Starting off with a good foundation is important to the development of the practice. You can use a sample template and build on this to suit your own needs. I have found some useful templates on the BDJMA or Code-AP websites.

‘At this point, you don’t know where Emily is as you were all just returning from lunch when the fire broke out.’

At 2.30pm, the fire alarm goes off. You are doing a head-count, when suddenly you realise your new nurse is not there. The fireman asks you for confirmation of members of staff. At this point, you don’t know where Emily is as you were all just returning from lunch when the fire broke out. The fireman reminds you he won’t risk the life of one of his men if there’s a chance the building is empty and it’s absolutely necessary. These words have stuck in my head.

At 2.50pm, the fire alarm broke out. Everyone was evacuated and is shown to her surgery and an emergency appointment is arranged for the new member of staff. ‘At this point, you don’t know where Emily is as you were all just returning from lunch when the fire broke out.’

Toolbox talks

During staff meetings, it is a good time to refresh staff members’ memories with what I call a ‘toolbox talk’ just to keep reminding them of the importance of knowing the layout of the practice. Try to carry out regular fire drills and make sure that all your staff are aware of where the emergency drug kits are kept, as well as the oxygen cylinders.

At the Dental Arts Studio, we carry out weekly audits on infection control, as well as health and safety, with regards to drugs and oxygen cylinders. To do this, I have created teams consisting of a dentist and nurse. Each team takes it in turns to check both the drug kit and oxygen together, so in the event of an emergency, they are familiar with the equipment they are working with, because under stress it is easy to panic and to fumble let alone administer the emergency drugs.

I have learned that it is best not to leave no stone unturned. This may sound over-cautious, but I believe that being forewarned is forewarned. After all, we are working in a medical environment.

I no longer work as a practice manager, but as an operations director. As a result, I have had to create an audit checklist for myself, as I now have to ensure that the practice managers carry out all relevant procedures with regards to these most important aspects of managing a practice.

As Winston Churchill once said, ‘It is no use saying, “We are doing our best.” You have got to succeed in doing what is necessary’.

About the author

Originally from South Africa, Sharon Holmes moved to the UK in 2002. She thoroughly enjoys her position as business development manager at the Dental Arts Studio and her role in the dental industry, which has moulded her into a winner in her field. She believes that her position is based on common sense.
Margins of error

The importance of monitoring previously placed crowns and bridges

Crown and bridgework is responsible for the largest number of cases involving claims against dentists. Along with endodontics, the next most frequent source of claims account for a significant proportion of the total cost of claims made against the dental profession.

There has been a progressive increase in the number of teeth restored with crowns. Standing alone or serving as bridge abutments, crowns are being provided in greater numbers than ever before. Advantages in materials and technology have given more and more dentists the confidence to treat cases of increasing size and complexity. When these trends are matched by an increased life expectancy of our patients, we may find that these complex restorations are now as prevalent in the older age groups, as once were complete dentures.

An aspect of crown and bridgework that is often overlooked is the dentist’s obligation to monitor the integrity of these restorations, especially their marginal fit. In addition we need to review the patient’s ability to effectively clean them, the health of the adjacent periodontal tissues and the vitality of the teeth in question. There is ample evidence to suggest that a significant proportion of crowned teeth are likely to lose their vitality.

A superficial examination of most crowns and bridges can create a false confidence, which deflects the clinician from looking more closely. A methodical evaluation of any fixed restorations present in the patient’s mouth is just as important as the time spent assessing natural teeth or the integrity of existing fillings.

Marginal fit

Horizontal defects take the form of ledges (the restoration is wider than the prepared margin of the tooth), or steps (the crown margin sits within the outer aspect of the tooth). Some ledges are associated with a generalised overbuilding of the cervical aspect of the restoration. The most common kind of vertical defect is a gap between the fitted crown margin, and the tooth surface. These are easier to detect when they arise on the buccal (labial) or palatal (lingual) aspect of the tooth or on a mesial or distal surface where there is no adjacent tooth. A poorly fitting margin on the interproximal aspect of a posterior tooth is the one most likely to be overlooked. This fact alone makes it all the more important to prevent such defects arising in the first place.

Avoiding problems with marginal fit is the product of consistently accurate tooth preparation, attention to detail in impression techniques and a critical evaluation of the completed impression. A close working relationship with the laboratory technician allows potential problems to be identified at an early stage and therefore avoided. It is usually quicker and more cost effective to repeat a stage, than to proceed on the basis of an impression that leaves room for doubt as to the intended margin of the restoration(s).

Practical checklist

Probing

Identifying a problem margin at the time of fitting can be achieved through a combination of visual examination and probing with either a conventional probe, or a ball-ended (e.g. CPTN/BPE) probe which is particularly useful in detecting ledges. The use of dental floss or tape prior to fitting can be another useful aid, and is invaluable in checking for any residual cement. These same routines also form the basis of periodic monitoring of the margin of existing crowns.

X-rays

Retrograding x-rays at appropriate intervals can help reveal failing margins of posterior restorations, and may even display ledges or other problems undetected at the time of fitting.

Signs and symptoms

Signs and symptoms of possible marginal leakage might include sensitivity, and possibly “a bad taste” reported by the patient. Later, the patient may report a sense of slight movement of the restoration. Any symptoms of this nature indicate the need for a very close examination, the details of which should be recorded in the patient’s clinical notes.

Plaque control and diet

Whenever fitting fixed restorations, it is important to ensure that the patient understands the importance of maintaining a high standard of plaque control. Techniques that are appropriate both to the clinical situation and to the patient’s ability and manual dexterity should be explained and demonstrated. Check to ensure that the patient is capable of carrying out these techniques to an acceptable standard. The patient’s ability (and willingness) to maintain a satisfactory level of plaque control is not static, and it should be monitored in the years following the fitting of crown and bridge restorations. Elderly patients with extensive crown and bridge restorations may find it more difficult to maintain adequate plaque control. Failing eyesight, arthritis and similar problems only serve to make matters worse. If a patient’s diet becomes more cariogenic (classically, the smoker who gives up cigarettes and turns to peppermints), the clinician needs to be alert to the danger of caries in those parts of the mouth where plaque might be retained. A destructive margin in such an area may be followed by a rapid and unseen destruction of the underlying tooth structure. This typically occurs when a bridge becomes uncemented on one retainer, but is held in place by the other retainer(s).

Periodontal health

When the margins of restorations are subgingival, the ‘blanching’ of the adjacent gingival tissues on fitting can be an indicator of a possible ledge, or over-built emergence profile of the restoration. In the months and years after fitting, the health of the adjacent periodontal tissues can be a useful indicator of the status of the margins of any restorations. BLEEDING points and inflammatory changes should always be noted, investigated and appropriate treatment provided. One common problem, which can arise when anterior restorations are being...
placed, is that of gingival recession occurring after crowns have been placed.

This is particularly common when less-than-optimal crown margins have been placed at or below the gingival margin, where recession can reveal crown margins and root surface. If the tooth is non-vital, an added complication is the visible darkened tooth structure, which may be aesthetically unacceptable.

**Aesthetics**

One of the advantages of modern dental materials, compared with some of the materials used for crowns and bridges in previous years, is that there is little or no colour change over time. On the other hand, adjacent natural tooth tissue can and does discoulour and this can present problems of a different kind. Wear, which is accentuated when dissimilar materials oppose each other in occlusal function, can reveal underlying metal in porcelain/metal bonded restoration. This can be anticipated and sometimes avoided by regular monitoring of the occlusal relationship.

**Occlusion**

One aspect of existing crown and bridge work that tends to be checked least often is the occlusal relationship of these restorations. Early porcelain fractures are frustrating for patients and clinicians alike and are a common cause of patient dissatisfaction.

Less obvious is the need to consider the implications of treatment carried out in other parts of the mouth, which might result in additional occlusal loading being placed upon previously inserted crowns and bridges. The loss of one or more posterior teeth, or perhaps the patient’s reluctance to wear a partial denture, may suddenly place anterior teeth under excessive occlusal loading and additional risks. Particularly vulnerable are post crowns in upper lateral incisors and such restorations should always have their occlusal contacts checked regularly. The clinical records should contain a clear note that these investigations have been carried out, and any subsequent adjustment of the occlusion should be similarly noted.

**Summary**

Existing crowns and bridges along with other fixed restorations require exactly the same detailed periodic clinical examination as the natural dentition. This should include a systematic surface-by-surface examination of each tooth in turn, as well as a review of the occlusion. Every crown should be checked for movement and any sign of wear or other damage. Patients should be asked specifically whether they have noticed any bleeding, bad taste or sense of movement around any existing restorations, and their responses recorded. In the years ahead, many of us will be treating a steadily increasing number of patients with multiple fixed restorations in situ.

We may or may not have placed these restorations ourselves, and where we have not done so, the patient should be asked if they can confirm when the restorations were placed. Monitoring the continued health and integrity of these restorations will present us with new and different challenges and it is important to remember that we have the same duty of care to the patient to carry out this monitoring process, irrespective of whether or not we placed the original restorations ourselves. Any patient’s clinical record should be capable of demonstrating that we have regularly monitored all crown and bridge work, thereby avoiding the allegation that we have failed to diagnose the failure of those restorations or that a delayed diagnosis has worsened the prognosis for corrective treatment.
Following tooth extraction, physiologic wound healing leads to alterations in gingival architecture including alveolar bone resorption, gingival recession and papilla loss. This is especially common in patients with thin periodontal biotypes. These alterations very often compromise tissue morphology and lead to esthetic challenges with implant restorations.

Numerous surgical techniques are available to reconstruct post extraction defects. However, the old cliché, ‘An ounce of prevention is worth a pound of cure’ very much applies to the extraction defect and all efforts should be made to minimize these morphologic changes. It is technically easier and less costly to preserve the alveolus at the time of tooth extraction as opposed to enhancing it following physiologic remodeling.

Therefore, various procedures and materials have been recom-

**Peri-implant biotype enhancement using interpositional connective tissue grafts**

**Patient 1**

Fig. 1a: Clinical presentation of failing restoration with recurrent decay tooth No. 8.

Fig. 1b: Failing post and core with peri-apical radiolucency.

Fig. 1c: Connective tissue graft draped over the crest, demonstrating large size required for vascularization prior to placement beneath tunnel flaps.

Fig. 1d: Interpositional connective tissue graft placed over socket graft and secured with sutures.

Fig. 1e: Periodontal biotype enhancement with favorable gingival margin and papilla preservation.

Fig. 1f: A flapless surgical approach was used to minimize tissue trauma.

Fig. 1g: Ideal soft tissue esthetics achieved (restoration by Dr. Glenn Bickert).

Fig. 1h: Radiograph of final screw-retained, UCLA restoration.

Fig. 1i: One year post-op demonstrating stable results.

Fig. 1j: One year post-op demonstrating stable results.

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Strategies to manage the extraction defect have been previously published, which provide algorithms to help guide implant treatment procedures immediately following tooth extraction. This article presents three clinical case reports using these guidelines and demonstrates the benefits of using large, thick interpositional connective tissue grafts in conjunction with tooth extraction and site preservation as well as during immediate implant placement to enhance the peri-implant biology and improve soft tissue architecture.

Patient 1
A 52-year-old female patient presents with recurrent decay and a failing post and core restoration on tooth No. 8 (Figs. 1a, b). An interproximal biotype was recognised as noted by the tapered tooth form and long slender papillae and a high smile line further challenges esthetic management.

Immediately following extraction, the socket was categorised as an EDS Type II defect due to the thin periodontal biotype even though the bony socket was completely intact. Therefore, a staged implant approach was chosen preserving the alveolar bone matrix (Bio-Oss, Osteohealth®) and a demineralised bone allograft.

A large, thick autologous connective tissue graft was harvested from the palate and placed beneath the full thickness buccal and palatal tunnels adjacent to the socket in order to improve the periodontal bio-type as well as to contain the bone graft within (Figs. 1c, d).

Vascularity to the soft tissue graft is achieved given the greater graft dimension beneath the tunnel flaps in comparison to the exposed area over the crest (Fig. 1c). Approximately 75 percent of the total soft tissue graft is beneath the full thickness tunnel flaps, and therefore no effort is made to achieve primary closure.

The soft tissue graft is positioned using buccal and palatal purge string sutures and secured on the crest using a single crisscross overlying suture (Fig. 1d). The bone and soft tissue graft complex is allowed to heal for approximately 12 weeks prior to implant placement and results in improved soft tissue architecture with an improved bio-type (Fig. 1e).

A flapless surgical technique utilising a surgical template is then used to place the implant including the healing abutment in order to minimise soft tissue recession often accompanied with a conventional incision and flap exposure (Fig. 1f). The implant is allowed to heal for an additional six months following a screw-retained, single-tooth porcelain fused to metal restoration (Fig. 1g). An ideal restorative outcome was achieved by the maintenance of the gingival margin and papillae.

Patient 2
A 54-year-old male patient presents with a hard and soft tissue defect associated with a periodontal abscess secondary to root resorption on tooth No. 9 (Fig. 2a). An identical treatment approach was followed as with the previous clinical situation. Immediately following extraction, the socket was categorised as an EDS Type III defect due to the more severe buccal bone loss, and therefore a staged implant approach was necessary. The extraction defect was grafted with a composite anorganic bovine bone matrix (Bio-Oss, Osteohealth®) and a demineralised bone allograft (Fig. 2b). A large, thick connective tissue graft was harvested from the palate and placed beneath the full thickness tunnel flaps in order to promote graft vascularity and soft tissue, the periodontal graft was sutured and secured as previously described (Fig. 2d).

A removable partial denture was used as a provisional appliance (Fig. 2e) and the bone and soft tissue graft complex was allowed to heal for approximately four months prior to implant placement.

The site preservation procedure in conjunction with the interpositional connective tissue graft results in improved soft tissue architecture and one of the major advantages of the pre-existing soft tissue defect (Fig. 2f). A flapless surgical technique is then utilised to place the implant (Fig. 2g). The implant is allowed to heal for an additional six months and restored with a porcelain fused to metal restoration cemented onto a custom lab fabricated abutment.

Patient 3
A 42-year-old female patient, presents with a chronic endodontic abscess and buccal fistula involving tooth No. 10. A thin periodontal biotype was noted along with a high smile line including pre-existing gingival recession over the central incisors (Figs. 3a, b). The tooth was extracted atraumatically and the socket debrided, irrigated and evaluated with a periodontal probe. The extraction defect was categorised as an EDS Type II defect due to minor fenestration of the buccal plate. The adjacent socket walls including the buccal crest were otherwise intact; therefore the defect appeared amenable for immediate implant placement in conjunction with ancillary procedures (Fig. 3c).

Following implant placement the residual socket defect was grafted with a composite anorganic bovine bone matrix (Bio-Oss, Osteohealth) and a demineralised bone allograft. Similar to the previous two patients, a large, thick autologous connective tissue graft was harvested and placed beneath the full thickness buccal and palatal tunnels adjacent to the socket as well as over the implant (Fig. 3e).

Once again, vascularity to the soft tissue graft is achieved given the greater graft dimension beneath the tunnel flaps, and therefore primary closure is unnecessary. The soft tissue graft is positioned and secured using the previously described technique. The bone and soft tissue graft complex is allowed to heal for approximately six months prior to uncover. The final restoration of the implant was
achieved using a custom gold abutment (Fig. 3d, e) and porcelain veneers were placed on the maxillary anterior teeth (Fig. 3f). An excellent esthetic outcome was achieved. (Restorations by Dr. Jon Marashi, San Clemente, Calif.)

These three clinical situations demonstrate the clinical benefits of incorporating large, thick interpositional autologous connective tissue grafts during site preservation and immediate implant placement surgery. When used appropriately, these grafts vascularise completely, even without complete primary closure. The grafts seem to improve the soft tissue biotype and enhance soft tissue esthetics adjacent to implant restorations by minimising gingival recession and interproximal papillae loss.

Live surgical demonstration of this technique as well as many others will be showcased during the American Academy of Implant Dentistry’s 57th annual meeting on Oct. 29–Nov. 1 in San Diego. For more information, see www.aaid.com.

References

About the author

Dr. Nick Caplanis is an assistant professor and part-time faculty within the Graduate Program in Implant Dentistry, at Loma Linda University School of Dentistry. Dr. Caplanis has an extremely unique background with formal residency training in the interrelated fields of Implant surgery, Prosthodontics and Periodontics. He is board certified and a diplomate of both the American Board of Periodontology, and the American Board of Oral Implantology and is a Fellow of the American Academy of Implant Dentistry. He is also the general meeting chairman for the 57th Annual Meeting of the American Academy of Implant Dentistry, to be held in San Diego from Oct. 29–Nov. 1.
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A journey to accreditation

Dental Tribune talks to dentists taking part in a new accreditation scheme launched by the Heart of Birmingham Teaching Primary Care Trust

The Heart of Birmingham Teaching Primary Care Trust has launched a new accreditation scheme for dentists. The Dental Practice Accreditation Scheme (DPAS) aims to help dental practices achieve best practice and accredit quality assurance. The scheme is intended to improve patient care.

The scheme focuses on how dental practices can improve elements of customer care and advice for their patients, above and beyond the day to day service that dental practices are contracted to provide.

There are around 500,000 people living in the Heart of Birmingham area, which covers some of the city’s poorest neighbourhoods as well as the wealthier shopping and business districts in the centre of Birmingham. The wards covered by the Primary Care Trust are Oscott, Perry Barr, Handsworth Wood, Lozells and East Handsworth, Aston, Nechells, Soto, Ladywood, Sparkbrook and Springfield.

Meeting healthcare needs

Seven out of 10 of the people in the area are black or Asian and the Heart of Birmingham Teaching Primary Care Trust aims to meet the challenges of fulfilling the healthcare needs of the diverse population they serve. As the population served by dentists in the area is diverse in terms of skills and approaches to address the needs of the local community are required. The major scheme’s component is a collaborative approach to transferring skills and ideas, which fits well into this context.

Six dental practices have been selected to take part in the new scheme. The Dental Tribune interviewed dentists from two of the pilot practices to find out more about the challenges they face and what they hope to achieve from being a pilot practice on the scheme.

Busy city practice

Sukhvidya Atthi runs the Hillbrook Dental Health Centre in Ladywood Road in the Balsall Heath area of Birmingham – a busy through-road with links to the city centre and many other parts of Birmingham. The health centre has over 6,000 patients and provides treatment that includes domiciliary, orthodontic and sedation services. Their income is entirely derived from the NHS, as 98.3 per cent of patients are exempt from payment. The centre is also treating an increasing number of asylum seekers.

Sukhvidya says, ‘Our books are filled with casual patients who just want one course of treatment and are not concerned with sustaining their oral health. We need to target these people with oral health promotion and prevention advice. We have already given oral health products – samples of tooth brushes and toothpastes with information leaflets to local school children.’

Focus on quality

Achieving quality management in terms of how dental practices operate is the main objective of the scheme. The pilot dental practices will also need to demonstrate how they are engaging with their patients to improve dental care in order to reach accreditation status.

The scheme is carefully structured and requires each dental practice to take part in a range of activities including a SWOT analysis of the practice, a record keeping audit, a review of training and career development for the practice team, significant event analysis, case studies and health promotion activities. It demonstrates how the dental practice is operating and how it’s promoting good general health within the community it serves. A review of evidence and a presentation before peers will also take place before the pilot dental practices can reach accreditation status.

Communication is key

Sandeep Kumar runs the Birchfield Dental Practice in Perry Barr. His team of 20 run five practices, treating 18,000 mainly NHS patients. The major scheme’s component is ensuring that the Asian community in the area do not speak English and the Practice’s main challenge is ensuring patients understand the importance of good oral hygiene and maintaining their overall health.

Encouraging patients to visit their dentist regularly to avoid problems with their teeth and mouth, however, is proving difficult.

Sandeep says, ‘We want to become an accredited practice to ensure that our patients are aware that we are providing a good quality service. We also want to be recognised as a practice that improves quality of life for our staff and patients. The financial benefits associated with the scheme will help improve services within the practice. In addition to this, we want the scheme to contribute to improving the working life of the team, so that they can be proud of their profession.’

A popular scheme

Eddie Crouch from the Birmingham Local Dental Committee comments, ‘The recent Health Select Committee report calls upon innovation from PCTs to commission quality NHS services and the Heart of Birmingham Teaching Primary Care Trust are leading the way. The launch of this report release by enrolling six dental practices to work with them to develop patient-focused care. The NHS Dental Contracts were fiercely opposed by NHS dentists in Birmingham. Indeed, almost 10 per cent of them left the NHS by April 1 2006. However, the enthusiasm for this scheme has been such that the PCT were unable to accept all those interested in being pilot sites.’

Addressing important issues

Neil Lockwood, project director for DPAS about why he wanted to get involved. He says, ‘The NHS has always tried to walk the tightrope between encouraging efficiency and focusing on consistent quality improvement. Having returned to the NHS (as a chairman) after a gap of a few years from retiring (as a Health Authority chief executive), I noticed how little the agenda had changed, particularly with regard to the question of constantly moving towards best practice.

‘I was personally speculating that the NHS tended to under-invest in support for this type of activity when the opportunity to be involved was put to me. It was clear that the scheme aimed to address some of the issues I had been thinking about.

Trial and error

Initially, the new accreditation scheme is expected to run for 12 months. However, there is huge interest among dental practices and a possibility that the scheme could be rolled out throughout the Heart of Birmingham area. The other two PCTs in Birmingham are watching the scheme in the hope of following suit.

‘The greatest achievement would be for the scheme to be sustained over a long term period, allowing the participants to work together to continue to improve until all practices are accredited. This will ensure that the local community in the Heart of Birmingham have access to a range of high quality dental practices,’ says Neil.
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Of even greater importance was the message being received as to the importance the dentists were placing on the value of the comprehensive help and advice Eschmann are able to provide, particularly in respect of compliance to the new dental guidance document HTM 01-05. An example of this was how to implement an effective ‘flow process’ for instrument decontamination within the confines of the technology and equipment, presenting complianced with HTM 01-05.

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For further information please call 01480 862080, email enquiries@oraldent.co.uk or visit www.oraldent.co.uk

Astra Tech Appoints New Dental Head

Astra Tech Dental, a world leading dental implant company, is pleased to announce a new head for the dental division, George Black. George has spent over 15 years working in the healthcare industry and most recently has worked for the German multi-national company, Draeger Medical.

He comments, “I was attracted by Astra Tech Dental’s many reasons, none more important to me than others. The strong Astra Tech brand has been the ‘gold standard’ for many dental practitioners and individual esthetics and long-term reliability. For the clinician and patient this technology means reduced chairside time, the precision of the abutments eliminates the need for the dentist to make further adjustments. Atlantic’s method makes it possible to fabricate individual abutments for most of the major implant systems on the market. The technology also allows for increased efficiency and profitability for the dental laboratory.”

For further information, please contact: Delin, Business Unit Director, Dental, Astra Tech AB Phone +46 705 76 26 60 Kerstin Wettby, Head of Market Communication, Dental, Astra Tech AB Phone +46 705 16 52 02 Visit Astra Tech www.astratechtal.com

Incorporating three important enzymes, Enzycal’s activity is targeted against harmful micro-organisms in the mouth works by enhancing the body’s natural antibacterial system. Fluorides in Enzycal reenriches mineral nutrients from the saliva into the enamel on a natural basis. The consequent remineralisation can balance or even reverse the loss of minerals in the early demineralisation process, restoring the surface to its former strength and adding to its future resistance.

Sold in dozens, the 75ml tubes contain 1450ppm Fluoride and Enzycal is SLS free.

Dürr Dental (Products) UK LTD

Dürr Dental’s huge choice of digital technology was defined...
Aquatoc Quatro fluid abrasion unit in Tanzania

Mwanza, in Tanzania, is now firmly on the map as far as Fluid Abrasion is concerned! Velopex have provided an Aquatoc Quatro which has been installed at the busy Bridge2Aid Hope Dental Centre in Mwanza.

Dr Ian Wilson commented: “The Donation of the Velopex Aquatoc “Quatro” allows us to provide more patients in the area with restorative treatments. Using the Fluid abrasion technique with the Aquatoc Quatro, our patients have access to conservative techniques where minimal tooth tissue removal is confined”.

The Velopex Aquatoc Quatro contains two chambers, which can accommodate any combination of the 5 Cleaning and Treating media available. The 5p Treatment powder allows the clinician to ablate hard tissue (Composite, enamel and dentine) creating a relatively smooth surface, which is ideal for the latest bonding and restorative materials. The 2p Hydrating powder gives the clinician a much smoother cut for finer work. For Cleaning, the Bicarbonate of Soda allows smoking stains to be removed as well as carious dentine. The combination of these powders, in a single unit, provides the modern dental practice with a unit that can cover a wide range of dental treatment applications. Dr Wilson is excited about this development saying “Having a new piece of equipment we can clean, dry and polish or cut! It’s invaluable in the adhesive techniques we use.”

Delivering on its promises

A survey reveals why the new Sonicare FlexCare is so successful and it’s search is on to find new trialers

A year after its launch Philips has released figures to show that its new technology platform, which has spawned both FlexCare white and FlexCare White sonic toothbrushes, has generated sales of over £150,000 power toothbrushes.

Early users evaluated the new Sonicare FlexCare after brushing with it for a month. Of the 260 UK dental professionals who assessed it, 75% claimed that dental health was excellent, yet in as little as 28 days, a quarter of the evaluators believed that their overall dental health had improved after using FlexCare—what they felt was a “long-lasting, effective and cost effective (a real winner)”.

Whether early trialers used manual or power toothbrush before the evaluation they believed that their overall dental health was improved after using FlexCare and the 260 UK dental professionals who assessed it, 75% claimed that their dental health was excellent, yet in as little as 28 days, a quarter of the evaluators believed that their overall dental health had improved after using FlexCare—what they felt was a “long-lasting, effective and cost effective (a real winner)”.

For more information or to ask any questions, please contact: Mark Chapman, Customer Service Instruments Ltd Barretts Green Road LONDON NW10 1AP
Tel 07734 048877
Bridge2Aid can be contacted via their website http://www.bridge2aid.org

Oral probiotic found to help Xerostomia symptoms

Xerostomia is defined as dry mouth resulting from reduced or absent saliva flow. It can be a disease, rather a symptom of a variety of health conditions or a side effect brought on by medical treatment. The condition may be a sign of an underlying disease, such as Sjögren’s syndrome, which is caused by the body’s immune system attacking and destroying healthy glands, or diabetes and other causes of insufficient saliva include anxiety, medication and consumption of alcoholic beverages, physical trauma to the salivary glands, their ducts or nerves, excessive breathing through the mouth or radiation therapy to the head and neck. Patients who have endured chemotherapy usually suffer from the condition. Treatment may also come about as a result of ageing and it is thought that about 20% of the elderly will suffer Xerostomia to some degree. Xerostomia is a common side-effect of various drugs, such as cannabis, amphetamines, antihistamines and some antidepressants.

Treatment for Xerostomia involves finding and treating any correctable causes such as dental treatment and smoking. However in many cases it is not possible to correct the Xerostomia itself. So patients are advised to relieve the symptoms and preventing damage to the gums and teeth. So patients with Xerostomia are advised to avoid the use of decongestants and antihistamines and pay careful attention to their oral hygiene. Drinking water may bring little relief and can even make the dry mouth more uncomfortable however frequently siping sugarless fluids, chewing xylitol gum and using saliva substitutes as a mouthwash have been found to help.

PerioBalance hits the streets

Following hot on the heels of the success Sunstar enjoyed at the BDTA with the burgeoning interest and successful case studies, the high performance software diagnostic tool which actively-feedback which active caries appears in red and healthy enamel in green. In contrast to other screening systems it also shows caries that was not previously diagnosed so it can be used to monitor the progression of various conditions over a period of time.

The Velopex Aquatoc Quatro which has been installed at the busy Bridge2Aid Hope Dental Centre in Mwanza.

Now there is another ad-junct which sufferers have re-port ed helps tackle some of the problems associated with Xerostomia. Sunstar’s PerioBalance is a unique oral health probiotic containing Lactobacillus reuteri Prodentis which has been documented in clinical studies to assist in the restoration of the natural balance of the mouth and contribute to a healthy oral health in a number of studies and as a result is accredited by The British Dental Health Foundation.

To obtain a free PerioBalance sample please visit www. sunstar.com and search for PerioBalance.

If you want more information about embarking on a trial with Sonicare FlexCare and the UV Sanitiser or recommending them, visit www.sonicare.co.uk or call 0800 0567 222.

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Earlier this year, 50 determined individuals raised thousands of pounds for Bridge2Aid, by taking part in the Yorkshire Three-Peaks Challenge. This involved ‘topping out’ on Pen-Y-Ghent, Whernside and Ingleborough, a 25-mile route, in under 12 hours. It was an exhausting day, which started at 4.30am, but this was all forgotten against the massive sense of achievement felt at the end (as well as the blisters) when the climb was completed and money was raised.

If you would like to help raise money for Bridge2Aid, it’s major fundraising event approaching is the biennial Climb Kilimanjaro expedition; the extra-adventurous can sign up for the trip of a lifetime next year, August 20th to 30th 2009, and climb to the very top of Kilimanjaro, literally ‘Stand on the roof of Africa!’ It’s a tremendous experience, with last year’s participants rating it as a lifetime high.

However you want to help Bridge2Aid restore smiles and change lives, we will support you all the way and really value the efforts you go to. So whether you want to be sponsored for sitting in a bath of baked beans, want to organise a 1970s disco or get your team to come to work in outrageous wigs for the day, we want to hear from you!

Making a difference

£2 – pays for screening, pain relieving dental treatment and oral health education for a schoolchild in Mwanza. There is currently virtually no oral health education available to Tanzania’s children. 99 per cent have never visited a dentist and consequently suffer from rampant tooth decay. Your donation will relieve the pain and lay foundations for a positive future.

£4 – funds a filling at Hope Dental Centre for a child from one of Mwanza’s orphanages or HIV outreach projects. HDC offers a heavily subsidised service to these projects, and helps to maintain the children’s oral health, a vital part of their general wellbeing.

£10 – provides a microfinance loan to a member of the street community to help them establish a means of generating income. Our Community Development team works alongside each individual to assist them in getting started and making sure the money is used effectively.

£25 – funds dental treatment of 40 people who attend one of our rural ‘Tooth Camps’. These events serve to provide free treatment to the rural population (90 per cent of Tanzanians) and also train rural clinical officers in safe extraction techniques. Without this service and the training it provides, rural Tanzanians have virtually no access to safe dentistry, and can suffer dental pain for weeks, months or even years.

If you’re interested in climbing Mount Kilimanjaro or helping Bridge2Aid in any other way, more details visit www.bridge2aid.org or email kerry@bridge2aid.org.
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To place recruitment or Courses/Seminar ads please contact: Joseph Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com

WILL YOU SELL US YOUR PRACTICE?

SPADENTAL IS LOOKING TO ACQUIRE HIGH QUALITY DENTAL PRACTICES ACROSS ENGLAND AND WALES FOR ITS PRINCIPALS. If you are interested in selling your practice as a ‘whole’ practice, either immediately or in the not too distant future, we would very much like to hear from you.

It is our policy when we acquire and invest in a practice to ensure the healthy continuity of the services you provide both for your patients and staff. At the same time looking at ways of supporting and developing the future potential of the practice.

In absolute strictest confidence and without obligation, if you would like an informal discussion on your thoughts, ideas and options with us, with possibly an indication outlining a competitive offer for your practice from us, then please contact Paul Massey - Acquisitions Partner on 01600 891560 or 07836 701922 or by emailing paul.massey@spadental.co.uk

www.spadental.co.uk

Essential CPD for the dental team Saturday 15 November and Saturday 29 November 2008

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

Howard Cohen & Co, members of the ASPD, are proud to introduce new member of their Dental Team

Howard Cohen & Co are delighted to welcome Mr Sunil Abeyewickreme who is joining their busy and expanding Dental Division.

Mr Abeyewickreme qualified as a barrister in 2004. He has previously been employed by the BDA to advise their members on general legal issues but specialising in Employment Law. He is joining Howard Cohen & Co as part of their specialist team offering advice and assistance to dental practitioners on:

• Employment Law  • NHS Contracts  • Expense Sharing and Partnership issues
• Associates  • Industrial Disputes

Howard Cohen & Co, members of the ASPD, are a Leeds based national solicitors practice providing a comprehensive range of legal services to the Dental Profession in all parts of the Country.

ASPD members offer professional, objective and practical advice and services, based on expertise within the industry, to dental practices and other businesses within the dental sector. ASPD members include solicitors, accountants, banks, financial advisers, valuers and sales agencies, insurance brokers and leasing and finance companies.

For more information please contact: Sunil Abeyewickreme

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