Prison for dental thief

A woman who stole £15,000 from the dental surgery where she worked as practice manager has been sentenced to six months in prison. Victoria Moore, 28, pleaded guilty to stealing the money from the practice in Ehbw Vale. The court heard how Moore, who was responsible for banking the money at the practice, took the cash between 2007 and 2009. The court heard how Moore and her husband took out a loan on their home in 2005 to carry out improvements but their debts increased.

Clinic visit ahead of review

A £4.6m community clinic in Lanarkshire has been visited by the public health minister before she chairs the local NHS board’s annual review. Public Health Minister Shona Robison visited the Douglas Street community health clinic in Hamilton, which provides NHS services including dentistry, together under one roof. Ms Robison said it was important that local people took part in the review of healthcare services. She added: “Our NHS should always strive to provide the best possible care, so holding those who manage our NHS boards to account is the right thing to do.” NHS Lanarkshire chairman Ken Corsar said: “Last year, sound progress was achieved across NHS Lanarkshire.” He added: “The annual review gives us the opportunity to reflect on the extensive range of activity which has been undertaken, the delivery of which could only have been achieved through the dedication and commitment from our staff.”

New Lerwick dental clinic

A new dental clinic is likely to be set up in Lerwick, Shetland within the next two years. The new practice could house up to four dentists and greatly improve access to NHS dentistry in the region. The new clinic aims to remedy the problem of some non-urgent dental patients being on waiting lists for several years, as current NHS dental facilities are overstretched. The project, whose whereabouts of which has not been decided upon, is part of the Scottish government’s new health targets. When the clinic is fully functional, there will be a total of 15 dentists in Shetland.

‘Tide is turning’ says CDO after latest NHS IC statistics

Recent report indicates increase in both UDAs and patients during 2009

The latest NHS Dental Statistics for England have been published by the NHS Information Centre for Health and Social Care.

The report, which evaluates data under the new contract from April 1, 2006, was published on November 26. The latest information on ‘activity’ relates to the first quarter of 2008/09, up to June 30, 2009. Patients seen to receive treatment amounted to 30.9 million - 0.6 million - on the final figures for last year’s first quarter.

The number of patients seen in the period ending Sept 30, 2009, was 279 million - 54.2 per cent of the population, a decrease of 0.5 million - 1.0 per cent - on the 28.1 million patients seen in the two-year period ending March 51, 2008.

This is, however, an increase of 0.2 million - 0.8 per cent - from the previous 24-month period ending June 30, 2009.

Chief Dental Officer for England, Dr Barry Cockcroft said: “We have invested more than £2 billion in NHS dentistry, resulting in more dental practices expanding and opening all the time. The tide is turning and access to NHS dentistry has been increasing steadily for over a year with more than 930,000 patients now seeing an NHS dentist in the last five quarters.

“Dentists working in the NHS treat around 250,000 patients every working day and our aim is to ensure that everyone who wants to see an NHS dentist can do so by March 2011.”

But Dental Practitioners Association chief executive, Derek Watson, thinks differently.

Watson commented “The Department of Health said that the very few dentists resigned in April 2009 represented very little capacity. They are missing the point. The new contract was supposed to correct supply problems and it has had the opposite effect. Fewer patients are now seeing NHS dentists as a result of the NHS contract, despite the fact the DH has been spraying the money hose around for two years in an attempt to disguise their bungling antics!"

Dr Watson said that in April 2008, 55.8 per cent of the population was seen on the NHS in the previous 24 months. Following the introduction of new terms of service on April 1, this fell to 52.7 per cent in June 2008, from which point it was thought to be recovering. However he said the newly-released adjusted figures to September 2009, demonstrated that it was struggling to reach pre-contract levels.


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Dental complaints concerns

A healthcare barrister has revealed his reservations about the Dental Complaints Service (DCS) and its lack of independence.

Angus McCullough, whose city of London practice deals with public, regulatory and disciplinary law, was speaking at a meeting of the Dental Law and Ethics Forum (DLEF) on Topical Issues in Dental Regulation.

At the recent meeting, which had a live link-up with members and Cardiff and Leeds, Mr McCullough acknowledged that the DCS had successfully resolved minor complaints about private dental treatment and reduced the load of the council’s disciplinary department. He said a survey of both dentists and patients who had experienced the service, of both dentists and patients, had produced the load of the council’s disciplinary department. He said a survey of both dentists and patients, who had experienced the service, reported that nine out of ten gave feedback that it was good or excellent.

But he added: “The DCS is a creature of the General Dental Council (GDC) and its procedures are neither independent nor confidential. It uses itself as ‘independent’ on its website, but, currently, no longer does so.”

He said the structure of the DCS and its relationship with the GDC made it possible for a dentist to be helped and transparent in responding to patient complaints, but in so doing, could provide the DCS with the grounds for a referral to the GDC’s Fitness to Practice procedures.

He observed that it was also questionable that the DCS now claimed to be “run operationally at arm’s length” but, has advisory board that took half its membership from the GDC and whose remit included advice on “day to day operational performance”.

He added that while the DCS had no powers to enforce its recommendations and dentists were not “obliged” to co-operate in the resolution of a complaint, a dentist could still find themselves facing a misconduct charge if the DCS decided to refer them to the GDC for a refusal to engage or cooperate.

He considered the complaint to be indicative of a broader problem.

A spokesman for the DCS said The DCS is an impartial, expert, free and fair service that can help solve complaints about private dental care. It is supported by more than 160 trained volunteerpanelists from across the UK. When a panel is convened it is made up of two members of the public and one dental professional. The decision making process regarding complaints is therefore completely impartial and this is considered an important part of the service – which the staff takes seriously.

The service is open to the public and registrants and doesn’t charge for its services. It has a local rate helpline, which is 08453 120 340. It gets its funding from the GDC, which means all registered dentists pay for the service through their Annual Retention Fee.

The service can look into complaints about private dental services provided by dental practices in the UK. It can’t look at complaints about NHS treatment. It also can’t look at staff matters - such as recruitment, pay and discipline - or at commercial or contractual issues.

Until recently the service had been part of the General Dental Council Board which made up of GDC council members - both registrant and lay members - as well as a number of independent individuals. However, since the restructuring of the Council of the GDC this year, the role of the Advisory Board is under review.

Full details of the DCS and what it can offer can be found on its website www.dentalcomplaints.org.uk.

BDA dentistry honours

The 2009 British Association of Dental Nurses’ award for outstanding contribution to dental nursing: Janet Goodwin

John Tomes Medal for scientific eminence and outstanding service to the dental profession: Richard van Noort and Geoff Craig

The Orthodontic National Group award (ONG) for outstanding contribution to orthodontic nursing and disadvantaged service to the ONG: Fiona Grist

BDA Fellowship for outstanding service to the Association and the dental profession: David Lester

The Dental Technologists Association Fellowship award for outstanding contribution to dental technology: Brian Gordon

The BDA Certificate of Merit for Services to the Association: Mike Hill

The BJTA Award for outstanding contribution to the dental industry: Martin Mills

The BDA Certificate of Merit for Services to the Profession: Jacqueline Armitage, Bridget Ashion, Glenys Bridges, Jo Eisenberg, Ashiq Ghaeri, Eric Nash, Malcolm Prideaux and Kenneth in the (on retirement awarded and received by his wife)

The Clinical Dental Technicians Association Roll of Distinction achievement: Kevin Manners

The British Association of Dental Therapists Roll of Distinction: Irene Ellis.
Editorial comment

Farewell from 2009

Well, doesn’t time fly when you’re having fun! It doesn’t seem five minutes ago since I was penning my first comment back in August, and here we are at the end of the year – thanks Dental Tribune – we will be taking a break now until January 2010, but don’t think it will all be mulled wine and Christmas shopping (that she will only take up four days of the week);

GDC on Vetting and Barring

Following the introduction of the Government’s new Vetting and Barring Scheme, the General Dental Council (GDC) would like to clarify its current stance and obligations in relation to the change in the law.

Within the meaning of the Safeguarding Vulnerable Groups Act 2006, the delivery of dental care is a ‘regulated activity’; therefore all those delivering care must be registered with the GSA in the long term. Registrants already employed and not changing jobs will be included in the scheme over time, with everyone needing to be included by 2015.

As of 12 October 2009, it became a criminal offence for people barred by the ISA to work or apply to work with children or vulnerable adults in a wide range of posts. It is also now a criminal offence for an employer to knowingly employ a barred person in a regulated activity.

The Council now has a legal obligation to share information about GDC registrants with the ISA. It is waiting to be advised as to exactly what information it will have to share, but it is likely to be anything which could indicate that a registrant poses a risk to children or vulnerable adults. The GDC may also receive information about its registrants from the ISA. It has already been decided by Council that such information should not result in automatic erasure from the Register, but should be considered as an allegation of impaired fitness to practise through the usual channels.

The GDC is looking carefully at how the Vetting and Barring Scheme will affect registrants and what role the Council will play. It is liaising with other regulators and working out how best to share relevant information alongside existing guidance on protecting patients.

A company selling dental implants for almost half the price of other suppliers are giving dentists the opportunity to pass this saving on to their patients, potentially dropping the price of dental implants in Britain.

DIO implant of South Korea is now operating in the UK after recently identifying a gap in the UK market. DIO UK is offering dental implants at prices less than half that of the most established UK brands (e.g. DIO titanium and RIM fixtures for under £90.00). The company has been around for over 25 years and is one of the largest implant manufacturers in Asia.

One dentist who has been able to drop his prices by 50% after switching to DIO implants is Dr. David Fairclough, who’s prime interests are dental implants and cosmetic dentistry. He believes that using implants of this kind could lead to them becoming cheaper for patients across Britain, currently one of the most expensive places in Europe for dental implants.

“One of my big criticisms of implant companies is that they sell you the implants and then you get very little from them again. There’s poor back-up. This hasn’t been the case with DIO!”

In a recent interview Dr. Fairclough said, “There is no reason why it can’t be as cheap here as it is abroad, when you factor in travel and accommodation expenses. The savings I am making have meant that I’ve been able to reduce my prices by 50%, so it has made a huge difference. It means that those people who are thinking about going abroad for implants may consider staying in Britain and those who thought they couldn’t afford implants can now consider it an option.”

Dr. Fairclough was initially drawn to DIO because of implant companies is that they sell you the implants and then you get very little from them again. There’s poor back-up. This hasn’t been the case with DIO! DIO.

Dentists drop the price of dental implants

Dr. David Fairclough explains how DIO make implants more accessible for UK patients

“Dr. Fairclough said, “I’ve been doing dental implants for over 20 years now and I’ve tried most systems. When I came across DIO’s system it seemed to be the easiest to use at an affordable price. The implants are very easy to place and they have very good primary stability which is important.”

This increased primary stability comes from the multi-platform design and the double-threaded base which offers high stability in low bone density. Alongside this, the stability offered by the root form design reduces the possibility of interference with other teeth.

DIO UK aims to assist all of its dentists during the integration stages in understanding the implant system. Rather than hosting clinical days attended by large numbers of dentists, DIO involves new clients in live implant placements alongside an existing user, without a DIO representative being present. This allows the session to be very open between the two dentists meaning they are free to discuss the implants candidly. It also means that the dentists new to the system benefits from one-on-one tutoring.

“The back-up service I have been given has been invaluable” said Dr Fairclough, “One of my big criticisms of implant companies is that they sell you the implants and then you get very little from them again. There’s poor back-up. This hasn’t been the case with DIO!”

Dr. David Fairclough BDS(Lond.) LDS RCS (Eng.) qualified at University College Hospital, London in 1973 and has since received post graduate training in the UK, France, USA, and the Arabian Gulf. He has been involved in implants since 1977 and is a founder member of the Association of Dental Implantology. He has also lectured and run courses both in England and abroad on implant procedures.

Dr. David Fairclough

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A new dental trial in Northern Ireland aimed at reducing tooth decay in the under fives has been launched. Health Minister Michael McGimpsey, who launched, The Northern Ireland Caries Prevention in Practice, trial in November, said the trial would investigate the effectiveness of preventing tooth decay in youngsters by applying fluoride varnish to their teeth, as well as using fluoride toothpaste.

Nearly 2,500 children will be involved in the trial, with each child monitored over a period of three years. Mr McGimpsey said: “It is vitally important that we look at new approaches to tackling tooth decay as, unfortunately, young people in Northern Ireland have some of the worst oral health in western Europe.

“Last year, for example, 26,500 teeth were extracted from children who underwent a general anaesthetic in hospital for dental extraction. While this figure is a marked improvement over previous years, it is still way too high and unacceptable.

“Investing in preventive care now will provide dividends for the next generation.”

The trial has been developed through a partnership with bodies including Manchester University, the Department of Health and the British Dental Association.

At ESCD’s Autumn meeting, Professor Edward Lynch talked about minimal intervention in cosmetic surgery, placing emphasis on the use of ozone and ozonated water.

He told the audience that the powerful disinfectant properties of ozone are useful for a range of dental procedures and ozonated water can be used in hand washing, root canal disinfection, full mouth disinfection, in ultrasonic scalers, for dental water line disinfection, during the placement of implants, for cavity disinfection and the disinfection of deep lesions to reduce the need for root canal therapy.

Earlier that same day, Dr Irfan Ahmad presented an overview of caries pathogenesis and the role of biofilm. He went on to challenge existing paradigms and suggested that treatment should be based on risk assessment.

The session also included input from Dr Michael Karlsten on predictable bite registration with implant-supported bridges, while Dr Ajay Kakar demonstrated aesthetic splinting techniques for compromised teeth using quartz glass materials, which are easy to place and adapt.

During the day, ESCD members were invited to present clinical cosmetic dentistry cases and other evidence for scrutiny by a panel of experts, with success-

A new dental surgery is set to open at Malmesbury primary care centre in Wiltshire in the new year.

The opening of the practice, which will serve 3,000 new patients from about the middle of January, follows an investment programme of £5.1 million to set up new dentistry contracts in five Wiltshire towns.

The scheme’s overall aim is to increase the amount of people who have NHS dental treatment in Wiltshire.

Other new dental practices are being set up in Amesbury, Tidworth, Warminster and Westbury. In addition, existing dentists in Calne, Chippenham, Devizes, Marlborough, Melksham, Pewsey, Trowbridge and Woottton Bassett will be extending their NHS provision.

New Practice

Irish Tooth Decay Trial

A new dental trial in Northern Ireland aimed at reducing tooth decay in the under fives has been launched.

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Sustainable service piloted for the homeless

The recent Steele review acknowledged that although NHS dental services were generally available, communication and publicity about these services could be much improved. Last month Chief Dental Officer for England, Dr Barry Cockcroft, launched an initiative at East London homeless charity the Whitechapel Mission to enable London’s homeless to better access dental services.

A mobile dental unit serving the homeless has been set up as a pilot project in Tower Hamlets, which runs until May 2010. Homeless people can access it at the Whitechapel Mission, as well as nearby residential homeless unit Booth House and Dellow House day centre.

Leaflet

As part of the pilot, Dr Cockcroft launched a newly-published leaflet – Free NHS Dental Services for Homeless People in London - which gives information on dental services for homeless people, as well as details about emergency dental services and tips on oral health.

The leaflets are being distributed at homeless organisations and through the Department of Health-funded existing mobile tuberculosis screening service, which reaches thousands of homeless people annually. The TB service has been on the road for three years, after a successful pilot.

The mobile dental service for homeless people is modelled on the TB unit. Its director, Stephen Trilvas said homeless people were more comfortable if services were available overall, but that communication about services was the key to reducing inequalities.

“This pilot is a microcosm of improvements needed across the UK. It is not enough just to commission services for homeless people if they cannot find them. So taking services to them is the key to reducing inequalities.

“That’s why we are working with existing services for homeless people to give them information on where they can go for treatment.

Pro-active

“Tackling inequality means encouraging people to access services which are already there, which is a more pro-active way for them to get dental care.”

Whitechapel Mission’s director, Tony Miller said: “We work with chaotic people who are hard to pin down and are excluded. The TB mobile service saw 1.905 homeless people last year. The next chapter is the dental service, from which we are hoping for big things.”

The Mission has set up an innovative programme of its own, by donating 500,000 fluoride-preloaded toothbrushes annually to homeless people, at a cost to the mission of 1p each. This means homeless people who attend the centre can have a new toothbrush every day, for a cost to the mission of only £3.65 a year.

Dentist Dr Cyril Brazil treats homeless people two days a week at the community dental services for homeless people at Great Chapel Street medical centre, in central London.

Make a difference

He said: “It is very rewarding work. If I can go home and feel I have made some difference to help homeless people survive the day and not suffer from dental pain, then it has been worthwhile.

“The treatment won’t change their world, it just means at least they will not have to suffer dental pain.”

Project development officer for the homeless, Rebecc Bailey, who designed the oral health leaflet for the homeless, said:

“Although most people have access to NHS dental services the DH has identified a need for helping hard-to-reach client groups including the homeless and those living in hostels.

“The aim for this project is to put a system in place to manage a clear pathway for homeless and vulnerable people to access dental care.

“The leaflet on oral health is specifically targeted at the hard-to-reach. It stresses the importance of oral health and signs people to individuals to community dental services in London.”

Usuala Bennett, head of dentistry at Tower Hamlets PCT, said homeless people were now being reached who never had access to dental care before.

Extending relationships

She said: “The key to improving access is building networks of relationships. This pilot is an example of extending relationships with other services. We will all learn from working together.”

She said experience showed that what worked was to offer dental check-ups to the homeless attending breakfast at the Mission, which could be followed up by treatment in the afternoon.

In 1876, the forerunner of Whitechapel Mission opened, serving more than 11,000 breakfasts to the homeless in its first year. The Mission took over in 1896 and now serves breakfast for up to 150 daily.

Mr Miller said: “We have kept to the promise not to preach, but to demonstrate through action.”

The pilot mobile oral health programme is a step towards the Mission’s goal to empower excluded people.

The pilot’s impact will be evaluated by analysing the data of people receiving dental treatment at the community dental services, which it is anticipated will provide information on the scale of oral health problems among London’s homeless.

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CDO Dr Barry Cockcroft holding a fluoride toothpaste pre-loaded brush with Whitechapel Mission director, Tony Miller

A homeless dental patient being treated at the mobile dental unit in Whitechapel

A mobile dental unit outside the Whitechapel Mission

DT
BADN president Sue Bruckel has thanked all the sponsors of the 2009 National Dental Nursing Conference for helping to make it such a resounding success.

Ms Bruckel said that delegates would have had to pay up to three times the current conference fee without sponsorship, which paid for speakers’ fees and travel costs for the majority of the presentations, while the remaining speakers were local experts who gave their time for free.

The actual conference delegate rate charged by the venue was sponsored by the British Dental Trade Association, which also sponsored Sonicare; the provision of speakers by the British Chiropractic Association, Colgate, the General Dental Council, Nobel Biocare, Philips Sonicare, Schuelke, the University of Kent, WR Berkley Insurance (Europe) Ltd, 2gether NHS Foundation Trust and NHS Gloucestershire; and the generous donation of their time and expertise by the remaining speakers, conference registration fees would have had to start at over £200 each for BADN members and consequently £270 for non-members to cover the cost of staging the conference. And this doesn’t even take into account the administrative costs or the many hundreds of hours which the chief executive and staff put into the organization of the event.

“The on behalf of the BADN council, members and the delegates to the 2009 National Dental Nursing Conference, I should therefore like to thank all the sponsors, and speakers, for their generous support of dental nurses in the U.K.”

The registration fee for the 2009 National Dental Nursing Conference was £120 for BADN members and £190 for non-members. The current annual BADN full membership fee is £70.

Premier Award Winners 2009

An audit to assess the cleanliness and storage of decontaminated dental instruments.

2nd Richard Holiday
Dental record keeping and the role of oral cancer screening in the dental access centre.

DCP prize
1st Michelle Mitchell
Ethical considerations in 21st century dental hygiene.

2nd Amy Wilkins
Extending the role of the dental nurse in the orthodontic practice: the patients’ perspective.

This year’s winners were of a very high calibre, and even though Sheffield Dental School was predominant amongst the winning entries, Kathy Harley, Chair of Dental Protection, who presented the awards took time to encourage dentists and DCPs from all regions of the U.K to participate again next year.

Thank you also to the sponsors of the Premier Symposium, Smile-on and Henry Schein, who helped to make the day possible.

An oral health improvement programme for young children in Wales is to be extended.

Designed to Smile is being expanded, following two successful pilot schemes in north and south Wales.

In the scheme, which is delivered by the community dental service, dental health support workers deliver a supervised tooth-brushing programme in schools and provide toothbrushes and toothpaste to schoolchildren along with oral health advice. Part of the service is carried out via mobile dental health units, which provide specialist preventive care and treatment to schools.

The funding for this project has been doubled to £5.1 million for 2009/10 and rising to more than £5.8 million for 2010/11. As well as rolling out the scheme beyond the existing pilot areas to specifically target, ‘communities first’ schools in the rest of Wales, the additional funding will allow the scheme to be extended within the existing pilot areas. This means that six and seven year olds as well as three to five year-olds will be included, as well as a nursery-based programme for very young children under the age of three.

Compared to the rest of the UK, the dental health of children in Wales is poor, with a direct correlation between poor oral health and social/economic deprivation.

Health Minister, Edwina Hart said: “The rates of tooth decay in parts of Wales are too high and are something which needs to be tackled. Additional funding for the Designed to Smile, scheme will carry on and enhance the good work done in the pilot areas to extend it across the whole of Wales. There is a significant role for parents to play, but we know that for many children at the greatest risk of dental decay, cleaning their teeth or having their teeth cleaned does not form part of their daily routine.

“lt is clear that more direct and also more innovative methods of delivering preventive care are necessary if advances in child oral health are to be made.

“By teaching children the importance of good oral health at an early age, they will develop good habits which they can carry on into adulthood.”

User generated programme for young children under the age of three.

Designed to Smile is being expanded, following two successful pilot schemes in north and south Wales.

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News & Opinions
GDPUK round-up

Tony Jacobs shares the most recent snippets of conversation from his ever-growing GDPUK online community

The diversity of topics on GDPUK can be mind-boggling. What’s more, the site has been at its busiest ever during October and November, with contributions from many new members as well as older ones. GDPUK readership is now at a staggering 10,000 hours per month, which equates to 40,000 15-minute visits a month.

Recent discussions have raged about the various communications regarding HTM 01-05, including letters in the British Dental Journal and Parliamentary answers. The Chief Dental Officer wrote that the Department of Health (DH) will produce scientific references to support the decontamination document “if required”, which Ann Keen told the House of Commons would be arriving soon. Colleagues on GDPUK cannot believe the situation surrounding the scientific references; surely they would be ready at the touch of a button or the click of a mouse if they were the true basis of this derided document? In the meantime, a further letter was drafted by Tony Kilcoyne with 15 references all countering the edicts of HTM 01-05.

When the PDS Plus contract was published soon after BDTA Showcase (where GDPUK members met up all three days) in many ways there was only a minor response on the site as the access contract with all its pitfalls had been dissected previously when the draft document and spreadsheet were leaked.

Among other topics discussed were clinical ones, as well as more general and non-dental ones – how to repair a wrecked dentition; advice sought on cementing all porcelain restorations; should the profession take up the flu vaccine; abfraction; strategies against key performance indicators; weight training as well as James Hull news coverage to name a few.

It was suggested that practices should carry out a risk assessment for latex allergies. Someone pointed out this was called a medical history. Others report they have tried to remove latex products completely, gloves, LA cartridges and dam, to name a few.

Recent discussions have raged about the various communications regarding HTM 01-05

During the month, there were some polls of GDPUK membership; about 80 per cent responding were male, and 75 per cent practice owners. When asked about source of income, practitioners are polarised – very few earn 50 per cent of their income from NHS, the large majority of respondents earn either mostly from NHS, or mostly private fees.

The polls on the GDPUK forum software only allow one vote per member per poll, so they cannot be manipulated.

A kind soul had posted some video footage on YouTube immediately after the recent Manchester United v Chelsea football match, a young man could be clearly seen in the crowd, chewing on a toothbrush during the match. This was linked from the forum, and there was much surprise, even from a group of dentists, at this behaviour.

About the author

Tony Jacobs, 52 is a GDP in the suburbs of Manchester, in practice with partner Steve Lazurus at 406 Dental (www.406dental.com). He has had roles in his LDC, local BDA and with the annual conference of LDCs, and is a local dental adviser for Dental Protection. Nowadays, he concentrates on GDPUK, the web group for UK dentists to discuss their profession online, www.gdpuk.com. Tony founded this group in 1997 which now has around 7,000 unique visitors per month, who make 7,000 visits per month, who make 30,000 visits and generate more than a million pages on the site per month. Tony is also GDPUK.com’s in-box editor and most topical UK dental website.
Dealing with stress in the 21st century - a perspective for the dental profession

Ros Edlin looks at the issue of stress in the lives and careers of busy dental professionals and how you can help to minimise stress in your day.

Ask the average man in the street for his opinion as to whether or not dentists experience stress, and your query will, in all probability, be met with a look of incredulity and a snort of derision. After all, isn’t stress in the domain of the poor patient rather than the high-earning, fast-living, Porsche-driving dentist?! A media-fuelled opinion such as this may be true for a minority of dentists, but for the majority this is an entirely inaccurate assessment of dentistry today.

What is true, however, is that dentistry has been identified as one of the most stressful of the health professions.

A recent study by HL Myers and LB Myers conducted using an anonymous cross-section of 2,441 UK GDPs, found that 60 per cent of GDPs reported being nervous, tense or depressed, 58.3 per cent reported headaches, 60 per cent reported difficulty sleeping and 48.2 per cent reported feeling tired for no apparent reason – all signs possibly related to work related stress.

So why are dentists so susceptible to stress? Not only are they required to work in an intricate manner in a sensitive and intimate part of the body, sitting in the same position for long periods of time, but they also have to be responsible for the smooth running of the practice with regard to both staff and patients, as well as managing the financial aspect. Added to this are the ever-increasing demands and expectations of patients and the constant awareness of running behind schedule. As if this wasn’t enough, they have to ensure that they maintain clinical excellence in the eyes of a Regulatory Body.

Faced with all these factors, and for the most part, not having received any particular training in, for example, people skills or financial management, it is little wonder that many dentists fall victim to stress-related illnesses, either mental, physical or both.

Stress itself is not an illness but is, according to the Health and Safety Executive (HSE) definition, ‘the adverse reaction people have to excessive personal attributes. This could also include the responsibility of the welfare of both patients and staff. As is often the case however, the bureaucracy of the NHS mitigates against this feeling of control which could result in work-related stress.

The recent NHS Dental Contract is a prime example where it can be argued that dentists have a loss of control of their own destinies. It also illustrates the importance of involvement in the process of change for the best results to be achieved. Today’s dental environment is not going to change to accommodate the individual. It’s the individual who needs to learn to accommodate to the environment if he or she does not want to pay the price of chronic stress.

There is no doubt that we all need pressures and challenges in our lives to get us up in the morning and to keep us going. These can galvanise us into achieving great things; to work at our most productive level, but we have to be aware that having unrealistic goals or expectations can possibly result in the ‘law of diminishing returns’ ie the more we push ourselves to reach that elusive goal, the less well we can sometimes perform. This is not to underestimate the thrill of achievement, but it is worth paying heed to the warning signs.

‘Stress itself is not an illness but is the adverse reaction people have to excessive pressure or other types of demand placed upon them.’

These warning signs are like traffic lights in our lives. Green means that everything (or nearly everything) is going well with us. We are enjoying our work; the practice is flourishing; we have a great team and the patients are appreciative. Home and social life is good; the children are behaving themselves and the sun is shining. Then perhaps things start to go slightly awry - your valued nurse leaves, creating extra work for the rest of the staff, and leaving you feeling if you’ve lost your right arm. You find yourself staying later at the surgery to catch up and you are aware that you are feeling more tired than usual. At the surgery you feel your concentration slipping slightly and you are becoming tense and irritable. This situation may carry on for a while with perhaps other events occurring to add to the mix – a complaint or family illness for example. At home, your evening glass of wine is turning into two or three. You are sleeping badly, relationships are suffering and you are starting to feel that you can’t cope. The red light is beckoning! If the symptoms continue to intensify to the extent of absolute exhaustion, ill health and the inability to cope, it could be advisable to seek help.

Personality can also have a bearing on the dentist’s ability to cope with stressful situations. A study carried out by Professor Cary Cooper et al suggested that dentists had a tendency to exhibit ‘Type A’ behaviour. People with ‘Type A’ personalities tend to be driven, highly ambitious, impatient, aggressive and intolerant. They have high expectations of themselves and those around them. ‘Type B’ personalities although they may be equally ambitious and successful, are able to perform in a calmer and more relaxed manner. People can fluctuate between these two behaviours which are said to be on a continuum.

A successful practice is one where effective stress management strategies are firmly in place. This contributes to the atmosphere of well-being and competence within the practice. Its positive effect emanates through-out the staff feel valued and motivated and the patients feel more relaxed and welcome. A ‘win-win’ situation for all concerned.

Achieving this ideal situation does not come naturally to many practitioners who may require guidance. It may be necessary to consider what your goals and aspirations are in relation to both yourself and your practice. Hopefully some of the coping strategies that follow will be of assistance.
In terms of individual stress, try take a step back and assess where the stress is coming from. Writing a list of causes from the most stressful down to the least will help you gain some perspective on the problem and may inspire you to tackle some of the issues raised. It is even possible that you could be the cause of issues raised. It is even possible for calming you down. (A prerequisite would have to be a competent receptionist who would not fill your appointment book so full that you do not have time to breathe, let alone try some deep breathing (which is excellent for calming you down.) Take a deep breath (don’t hold it) and count one, two three as you exhale slowly.

For the individual, relaxation techniques are also recommended. Although it is often thought that relaxation is not compatible with working in a dental surgery, with organisation and planning it is feasible. (Some European countries manage successfully to incorporate this into their working day.) A prerequisite would have to be a competent receptionist who would not fill your appointment book so full that you do not have time to breathe, let alone try some deep breathing (which is excellent for calming you down.) Take a deep breath (don’t hold it) and count one, two three as you exhale slowly.

In your every day life having a period of relaxation is vital. It could be as basic as taking breaks in the day or going out at lunchtime to listening to music or having a relaxing bath. The importance of relaxation is that it enables you to switch off and recharge your batteries!

Equally important is physical exercise. Exercise burns up the excess adrenaline resulting from stress, allowing the body to return to a steady state. It can also increase energy and efficiency. Do find an exercise which you enjoy that will motivate you to continue doing it.

Balance your diet. Eat breakfast, drink sensibly and include lots of water to rehydrate the system. Include complex carbohydrates (wholemeal bread, jacket potatoes) in your diet, to counteract mood swings, and fruit and vegetables to provide vitamin C to support the immune system.

Manage your time (and yourself) efficiently. Again, taking a step back and reviewing your working practice is essential. Do you have an allotted time for dealing with emergencies and administration? Are you constantly running behind schedule causing your stress levels to escalate? Developing leadership and organisational skills will enable you to feel more in control of your working environment.

Ensure that your staff are properly trained and aware of their individual roles and responsibilities. Encourage a culture of mutual support, whereby asking for help is not viewed as weakness. Talking over your problems with someone you trust can be such a help!

As mentioned previously, some dentists may be excellent practitioners but sadly lacking in interpersonal skills. An ability to listen is a gift. If you feel you need some training in communication, there are plenty of courses available.

By incorporating at least some of these strategies into your everyday life and your working life, you could create an environment which is stress-free and an environment in which it is a pleasure to work. It could make the difference between a good practice and an outstanding one. Who wouldn’t want that?

About the author

Ros Edlin is a freelance stress consultant. Her background is in social work and counselling. She lives in the North West and travels throughout the U.K. giving presentations and facilitating workshops on stress awareness and management to the dental team. Ros tries to practise what she preaches and relaxes by walking the dog, yoga and playing the piano (badly!)

Email: ros@stresswatch.co.uk


*Mark Hildman, Ph.D, Artistic Stress and Dentistry: Better Practice Through Control


Access over quality?

Although high-need patients can be seen for dental treatment, Neel Kothari thinks the jury is out as to whether they are getting the treatment that best meets their needs.

Over the last few days, I witnessed a miraculous cure to my writer’s block when a patient I recently treated brought to my attention some of the issues that can still be seen within NHS dentistry.

This patient is a young lady of around 25 who presented in a great deal of pain from a lower abscessed molar tooth, as well as rampant caries elsewhere. I asked her when she had last seen a dentist and she replied: ‘Only last week, I hooked in to see a dentist under the NHS, but at the end of my session I was told that this was only an emergency visit and they did not have the time to see me for treatment’. She was told to find another dentist and was given a prescription for antibiotics, but still could not sleep or eat.

Funnily enough, this is not the first time this has happened and I am sure that many of you may have encountered something similar. The problem here in my opinion cannot purely be put down to the new contract, but when any system is based solely on ‘improving NHS patient numbers’ rather than ‘improving quality’, surely the architects of the new contract must accept some culpability for introducing a system that, through a lack of proper piloting, has effectively prescribed neglect across the nation.

The good news for the Department of Health (DH) is that this patient will now probably count twice in the access figures! Leading me to question, just how exactly does the Government collate access figures?

Meeting bottom line

While I have some sympathy for dentists having to provide an unlimited mass of dental treatment for a fixed level of remuneration, surely there can be no excuse for kicking out patients in pain and agony while cherry picking those patients who help to better meet the bottom line.

While they all agreed that it was unacceptable to leave a patient in pain, I’m afraid across the nation, many dentists are apparently still working in different ways and it is clear that we still all have different interpretations of exactly how the new dental contract should be implemented. One problem still remains: when one dentist chooses to cherry pick patients, this leaves others to unfairly pick up the pieces.

Disastrous consequences

Ten years ago, in September 1999, Tony Blair told the Labour Party Conference: ‘Everyone will have access to an NHS dentist within one course of treatment’, to treating some of the major problems, stabilising the patient and spreading the treatment over multiple courses.

Twenty years later the driver (still) try and achieve this has clearly had disastrous consequences. Rather than improve quality, access to better meet the bottom line.’

The promises made at the recent Labour Party Conference should really be measured up against Labour’s own record. This in fact shows loss of access. After the introduction of the new contract, the number of people accessing NHS dentistry fell by one million. Some 7.5 million people are not going to an NHS dentist, because it is hard to find one. Fewer children are accessing NHS dentistry – more than 100,000 fewer than before the new dental contract and dental caries is now the third most common reason for children’s admission to hospital.

A key driver?

Regardless of how the Government dresses up various new schemes and initiatives to improve NHS dentistry, it does not take long to realise that ‘improving access’ tends to be the key driver. But how sensible is this aim? Of course everyone who needs a dentist should be able to get one, especially as it’s called a National Health Service, but exactly what are they getting?

In Hampshire and the Isle of Wight, access figures are clearly well below average. Regardless of how much investment into dentistry has been made here in recent years, according to prospective Parliamentary candidate Terry Scrivener, thousands of people across the New Forest still have no access to an NHS dentist.

One of the problems here is that any new practice commissioned by the PCT would be measured up against the current best practice. Immediately post introduction, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes through. Thirteen years on from the introduction of the new NHS system. Like many other dentists, he has concerns for the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.

About the author

Neel Kothari qualified as a dentist from Barts and the London School of Medicine in 2001, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate course in implantology at UCL Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice. Immediately post graduation, he was able to work in the older NHS system and see the changes through. Thirteen years on from the introduction of the new NHS system. Like many other dentists, he has concerns for the future holds within the NHS and as an NHS dentist, appreciates some of the difficulties in providing dental healthcare within this widely criticised system.
Cross-infection collapse?

Bruce Nell looks at the HTM01-05 guidance, its implications for those in dental practice and how the Department of Health intends to enforce it.

With the publication of the Department of Health’s Decontamination Health Technical Memorandum (HTM 01-05) earlier this year, the Government has signalled its determination to affect a change in practice within the dental profession. Within its introduction, it states the desire to ‘deliver the standard of decontamination that our patients have a right to expect’ through ‘a programme of continuously improving decontamination performance at a local level’.

The way in which the authorities will ensure dental practices are adhering to the guidelines is through the Care Quality Commission (CQC). Over the next two years all healthcare providers (including NHS and private dentists) will have to be registered with the CQC and the ‘provision of a safe, clean environment and appropriate decontamination of dental equipment’ will be a requirement. Demonstrating compliance will involve a self-audit of a practice’s procedures, with supporting evidence to show decontamination management is in effect.

The focus of the guidance is to impel a progression from the current ‘essential’ quality requirements for every practice to have instruments which are sterilised after the decontamination (reprocessing) cycle, to a state of ‘best practice’ comprising of three areas, summarised as:

- Separate decontamination facilities
- Use of a validated automated washer-disinfector
- Controlled storage of reprocessed instruments.

Many practitioners may well feel a degree of affront at the suggestion that their procedures for decontamination are not up to standard or, at worst, hazardous to the health of patients and staff. However, the ‘we’ve had no problems’ retort, coupled with the side effects of a repetitive process could lead to problems, as its not just contempt that is bred by familiarity when dealing with infection control.

The HTM 01-05 makes reference to a survey conducted in 2004 of the decontamination in general practices in Scotland, and it makes for some interesting reading. For instance, 42 per cent of surgeries did not have a dedicated area for decontamination, with the space also being used for activities such as food and beverage preparation or housing the compression unit; 52 per cent did not have a dedicated sink for cleaning contaminated instruments.

Consider for a moment the potential ramifications to the health of staff and patients of having a compression unit in with contaminated instruments. At least the Department of Health recognises that there needs to be time to institute the shift towards best practice of the separation of instrument reprocessing from other (clinical or otherwise) practices. It’s understood that sterilisation may well be taking place within surgical areas. At least if it’s using a bench-top machine, transplanting it to the separate facilities (once the necessary refurbishments have taken place) won’t be a difficult task.
to clean, sterilise and store re-
processed instruments, with the
necessary record keeping fre-
cently incomplete.

An important element of achieving compliance will be
having an assessment of the changes needed within the prac-
tice to meet ‘best practice’ re-
requirements. It’s an opportunity
for managers to re-evaluate cur-
rent procedures and to establish
a clear framework within which
the Infection Control Policy will
take a critical role in ensur-
ing the CQC’s requirements are
met. Being able to demonstrate
records are being kept in regards
to decontamination equipment
will be a significant element
within that so any system that
has been designed to facilitate
will be of valuable service.

To demonstrate best prac-
tice; ‘a cleaning process should
be carried out using a validated
automatic washer-disinfector’. A
dental practice needs a machine
that can reliably and consistently
produce the same high stand-
ard in cleaning and disinfection
which is required to minimise the
risk of cross contamination.

Undoubtedly a great deal has
been done to raise the stand-
ards of decontamination in den-
tal practices since 2004. A simi-
lar survey of practices in Eng-
land conducted in 2008/9 will
return its findings in the near
future and its results will be of
great interest.

HTM 01-05 states that ‘prac-
tices should plan for the intro-
duction of a washer-disinfector’
primarily because hand washing
cannot be guaranteed of main-
taining controlled conditions
(often two per cent of surgeries
in the 2004 survey were using
detergent specifically formu-
lated for the manual washing of
surgical instruments; some were
using kitchen cleaning agents).

Using a washer-disinfector is
the preferred method for cleaning
dental instruments because it
provides the best option for con-
trol and reproducibility of clean-
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which is an important aspect of
establishing compliance.

In response to the HTM 01-
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cifically designed to meet the
requirement for maintaining
correct functioning of the machine. By incorpor-
at ing an in-built microprocessor,
which controls and records the
pressure and temperature used
during the cycle, an independ-
ent monitor with printer then
creates a printed copy as evi-
dence so that a record showing
compliance is created; Since
this needs to be completed eve-
ry day, having an automated system really is a time-efficient
solution. Practices will have to
maintain such records for at
least two years.

The washer-disinfector also
has to be easily dismantled to al-
low each part to be adequately
cleaned. By having a water res-
ervoir that is completely detach-
able from the machine means a
practice can easily ensure they
remain confident in minimising
cross contamination from bacte-
rial or chemical agents within
water supplies.

The third element of achiev-
ing best practice is the storage
of instruments. The HTM 01-05
recommends that: “the storage
of instruments does not exceed 21
days for instruments sterilised in
a non-vacuum (type A) steriliser
or 10 days if sterilised in a vacu-
um (type B or S).”

The 2004 survey found there
were flaws in the methods used
that have been designed to facil-
tate will be of valuable service.

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Streamlining operations
Jo Banks discusses how to simplify the day-to-day running of your practice and ensure your appointment systems are working smoothly

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Dealing with problems

It's not the problem that's the problem; it's how you deal with it. Unfortunately, given the underlying issues of relationships and prior personal history that invariably accompany any difficult problem, it is not appropriate to treat problems in the same way you would with problems that are never easy. It therefore seems to make sense to set out some basic ground rules on how to be an effective problem solver.

1 Bite-sized chunks: A few years ago, there was a bestselling book by Kristine and Richard Carlson called Don't sweat the small stuff... and it's all small stuff. All too often, individuals refer to a series of inter-related problems instead of tackling the specific problem at hand. If you can take what appears to be a large problem and break it down into several sub-components, and then deal with each component part individually, you are much more likely to find a solution than trying to sort out the problem in its entirety.

2 Control: Define and clarify the issue – does it warrant action? If so, how? Is the matter urgent, important, or both? Are you able, in a clear and rational manner, to identify the problem and the obstacles that the problem presents? Clearly state the problem and what obstacles the problem presents to you. Once you have done this, you need to understand what you have control over and what you don't. Your efforts to resolve the problem must focus on, and be within, the areas over which you have control.

3 Reality and perception: Which components of the problem are real, which are perceived? You may contribute to the problem by magnifying it out of proportion, thereby turning a small issue into a very large one. Check the realities! Take the example of a patient who promised to send a cheque, which had not yet been received. You might think the patient had simply forgotten, and send a gentle postal reminder, or you could become incensed that you had done so much for the patient which had gone unappreciated, pick up the phone, ask the patient how they expect you to run a business if people don't pay on time and demand immediate payment. Guess which is the reality and which is the perception. Guess which way your patient will lose a patient to the practice.

4 Information: Do you have all the information you need? Solving problems is often like becoming involved in investigations. Have you thoroughly researched why the problem exists? Do you have all the information you need? If not, be persistent and seek out all information before tackling the problem. Gather all the facts and understand their causes.

5 Non-emotion: Are you able to see issues clearly, objectively and with emotional detachment? Are you able to discuss points of contention without becoming angry or emotional? We all have 'buttons' which, when pushed, cause us to react in a predictable but unfortunately irrational way. For example, when a partner says: 'You always do this', chances are you will respond with a retort that is as unreasonable as the very statement itself.

6 Negative energy: Working toward your goal without the interference of negative mental energy makes any job more manageable – you should not allow another person who is critical of you, rather than having your best interests at heart, to be part of the solution – they are more likely part of the problem.

7 Options: How many options for solutions do you have? Generate a list of different options for solving the problem. Are some better than others? Why? Which options seem reasonable? Some are practical, others rooted in fantasy. Have you weighed the pros and cons, advantages and disadvantages of your options? Are there any limitations to your options? Are they affordable? Avoid vagueness or 'foot in both camps' compromise. As Aneurin Bevan once said, 'We know what happens to people who stay in the middle of the road. They get run down.' Think about, or brainstorm with others, possible options and solutions. Select the best option. Explain your decision to those involved and affected, and follow up to ensure proper and effective implementation.

8 Is it you? Could it be that you are the problem? Your personal belief and value systems may be contributing to the problem, and may equally be getting in the way of a solution – 'I'm not going to let a nurse tell me what to do!' Don't jump to conclusions. Once you have all your information, analyse it carefully and look at it from various viewpoints. Be as objective as possible and don’t be quick to judge. Remain judgment-free as much as possible; it gives you the freedom for you to use your critical thinking skills.

9 Take a break: When you are beset by what appears to be an insoluble problem, take a break. Failure to take regular breaks not only wears you down, but also makes you less productive. While you may not feel it at the time, slowly but surely, burnout will sneak up on you. You’ll become less patient and less attentive. Over time, you’ll burn out more quickly and your creativity and insights will slowly fade away. Breaks don’t have to be disruptive or last very long. Usually all we need is a few minutes to clear our heads, stretch our arms and get some air. It’s like pressing the reset button and providing ourselves with a fresh start. Furthermore, a week or two away doesn’t hurt either.

10 Buying a solution: Some decisions and challenges are difficult because you don't have the necessary knowledge or experience. Could it be beneficial to buy a solution, for example, by calling in a coach, consultant or an accountant? How often does a pair of eyes that is not emotion-ally involved in a tricky situation see the reality of the situation with absolute clarity?

Problem-solving and decision-making are closely linked, and each requires creativity in identifying and developing options, for which the brainstorming technique is particularly useful. Good decision-making requires a mixture of skills: identification and creative develop-ment of options, clarity of judgment, firmness of decision, and effective implementation. Once your solution is in place, it is important to monitor and evaluate the outcome regularly.

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About the authors

Adrienne Morris is a highly-trained licensed coach whose aim is to help people from where they are now to where they want to be, in clear measured steps.

Ed Bonner has owned many practices, worked as a management consultant with a number of dental practices and their staff to achieve their potential. For a free consultation, or a complimentary copy of The Power of 10 e-zine, email Adrienne at adliple coach@yahoo.com or Ed on bonner. edwin@gmail.com.
A good team is for life, not just Christmas

It’s a good idea to treat staff little and often throughout the year, says Sharon Holmes, as a way of showing appreciation.

Moving into a new year is like starting afresh. It gives you a chance to forget how busy you’ve been and move on to new things.

When I joined our first practice as manager, we used to celebrate at the end of the year by going out for to a restaurant with practice owners, Dr Malhan and Dr Solanki. Once we moved into the corporate environment, arranging this became a bit more complex, and celebrations too many. None of us in upper management wanted to eat four expensive meals in a space of one week – this would surely increase our waistlines before Christmas Day even arrived – so on our first year, I decided to ask individual staff members how they best liked to celebrate the Christmas period.

As it turned out, most staff chose to have individual dinners with their own staff and associates and to receive gift vouchers from the Dental Arts Studio. So out I went to buy M&S vouchers, which I sent to all the staff with a Christmas card, thanking them for their contribution throughout the year. We did this for two years running.

Now we have been established for nearly six years to become a mini corporate group of four practices and a low level of staff and associate turnover, we all know each other very well, so have chosen to have one huge Christmas bash at the end of the year with staff and their partners from all the practices combined. We’ve successfully done this for three years now with staff talking about it for weeks afterwards.

Our first joint Christmas Party – the “Pink Party” – was affiliated to a charity event where the Dental Arts Studio raised £5,000 from ticket sales and a further £1,000 from raffles and prize draws on the night, for Breast Cancer Awareness. Not only did we have a lot of fun on a Thames River Boat, we were also able to contribute to a worthy cause.

Last year, we hosted a party at the Hilton Hotel in London’s Docklands, which was also a success, and once again this year we will return to the Hilton Hotel, but this time in Mayfair.

I am starting to feel the buzz in the surgery and the ladies are already talking about finding the perfect outfit for the occasion. These are the moments we all look forward to, and for a short while we can all forget about root canals and pain and realise that life does not have to always be fast and furious.

We don’t only celebrate at Christmas time here at the Dental Arts Studio. Recently, we’ve started having regular social get-togethers on Saturday evenings at either one of our principal dentists’ homes.

We also have staff member of the month award where the highest performer is rewarded for doing more than is required of them, a lot of the time in difficult situations that may arise in the practice. Let’s not forget “Fatty Friday”, which involves buying sweet treats every Friday.

Each practice has its own Secret Santa event at Christmas, and we always make sure we carry out collections for birthday presents.

As Albert Einstein once said: ‘A hundred times every day I remind myself that my inner and outer life depend on the labours of other men, living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving.’
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First-time sellers - seeking the right advice

If you’re about to embark on selling your dental practice for the first time, careful consideration should be taken when seeking legal advice. Andy Acton offers some useful advice to those looking to make that first sale.

Selling your practice is certainly not a task you want to put in the hands of someone who has little experience. It’s also something you don’t want to enter into lightly, because it could well represent your life’s work or create a lump sum for retirement or investment in a new project. You deserve the very best advice available from someone with good pedigree and a proven track record.

In the current climate, there is a lot of scurrying about for business and many firms are extending their range of services beyond their core in an attempt to generate new income streams. I am a great advocate of innovation and we should all be looking to evolve and develop – it’s what makes business fun.

That said, would you buy a car from a company that specialises in selling trucks? However, from the service recipient’s viewpoint this requires some consideration.

Pay special attention
Selling dental practices is a complex business and while there is a core underlying transaction, even through the thousands that we have had an involvement in, there is always a unique element that requires some special attention. Take your pick – the list goes on:

- How do I protect my UDA value?
- Is it a problem that I don’t have contracts with my associates?
- I am planning to incorporate, how does this affect my sale?
- My property value has dropped and I don’t want to sell it with my practice, what are my options?
- I have someone who is interested but they won’t make a commitment.

As well as an experienced sales agent, the need for a specialist should be considered when seeking legal advice. You could use a local firm who have quoted a relatively low fee, compared to a specialist firm. However, I would want a firm that understands the need for dental-specific covenants and warranties to ensure I was protected and the contract was fit for purpose.

I had a client many years ago that bought a practice and (against my advice) chose to use a local law firm. This firm failed to ensure that all the leases outstanding on the equipment in each surgery were repaid from the sale proceeds at completion. This error resulted in the finance company repossessing the equipment from each surgery because lease payments were not being made (the seller was enjoying retirement in another country?). The practice survived – just – but it had to be fully re-equipped by the new owner and the impact on business was catastrophic. The client saved a couple of thousand pounds on their legal bill and nearly went bust in the process.

Choose wisely
There is no guarantee that working with those of good pedigree and a wealth of experience means that everything will go smoothly. However, carefully selecting firms that know what they are doing, and are backed-up by real and current-market experience should make for a safer transaction.
Immediate single-tooth replacement and provisionalisation in the aesthetic zone

As immediate implant placement gains momentum, Dr Graham Magee gives an example of how this high-risk treatment leads to success

With more than 40 years of clinical evidence, Titanium Endosseous implants have become an acceptable (evidence-based) form of treatment to replace natural teeth and should be considered as an alternative to either a partial denture or bridge.

Immediate implant placement with simultaneous immediate function or immediate loading has been gaining momentum over recent years and can be a very predictable method in providing implant treatment for our patients. There have been various timeframes used for the definition of immediate implant placement. Hammerle et al (2004) suggested that immediate implant placement was when an implant was placed following tooth extraction and as part of the same surgical procedure.

In the same paper, the consensus statements say “implants should not be placed at the time of tooth extraction if the residual tooth morphology precludes attainment of primary stability.” It also states that, “If buccal plate integrity is lost, implant placement is not recommended at the time of tooth removal. Rather augmentation therapy is performed.” The implant is then placed after healing, that being 12-16 weeks or even longer than 16 weeks. It has also been reported that infection adversely affects immediate implant placement (Rosenquist & Grenthe 1996; Grunder et al. 1999) and is a contraindication for immediate placement of an implant into an extraction socket.

Predicatable treatment concept
Immediate implant placement and provisionalisation is a predictable treatment concept (De Rouck et al 2008). The success rate is at least comparable to data published for single-tooth implant placement using standard protocols in healed sites. This happens providing careful appropriate patient selection is used and the surgeon is familiar with the techniques that differ from the standard two-stage protocol for implant placement.

For the patient, the main advantage for immediate replacement and provisionalisation is fewer surgical visits as well as providing immediate aesthetics that are virtually indistinguishable to the original tooth. Sometimes if the tooth being replaced is discoloured due to non-vitality, the aesthetics will provide an immediate improvement.

For the clinician, immediate replacement allows for minimal disruption of the soft tissue providing immediate peri-implant support through careful manufacture and design of the provisional restoration. This helps to maintain the stability of the gin-
gival marginal tissues, which is necessary for a successful aesthetic outcome.

Root-filling failure

The following is a case study of a 50-year-old female with a history of a failing root-filled, upper-left central incisor. The root filling had been present for approximately 25 years and this had been apicected approximately 15 months before the tooth became problematic (Figure 1). The patient did not want another apicectomy and requested that the tooth should be extracted. The various options for restorations were discussed and as the neighbouring central incisor was root filled and restored with a post crown, the lateral incisor was restored with a veneer due to microdontia, a bridge was not a viable option. The patient was adamant that she did not want a partial denture.

As the tooth was not infected and investigation had shown that the buccal plate was still intact, it was decided that the tooth could be extracted and immediately replaced with an implant fixture. This was to be utilised to support a Nobel Biocare immediate temporary abutment and a provisional crown.

What the treatment involved

Under local anaesthesia, a crescentic incision was made and no flap reflection. The upper left central incisor was extracted using a very careful (atraumatic) technique with a periosteum to preserve the buccal plate of bone and careful manipulation of the gingival tissues.

Once the tooth was removed, the socket walls were curteted to remove any remnants of periodontal fibres or granulation tissue. The socket was inspected to ensure that the buccal plate was still intact (Figure 5). Using the standard protocol, the bone was first prepared by penetrating the palatal wall at the apical third. Great care needs to be taken in the osteotomy preparation as the palatal wall of the extraction socket is commonly very dense and difficult to prepare which can cause ‘run-off’ of the drill tip.

To achieve the initial perforation, the drill is held at an angle of approximately 45° to the palatal wall. Once the drill has penetrated the palatal wall, the angle is changed to then run more-or-less parallel to the an-

![Figure 1: Radiograph of failing upper left central incisor](image1)

![Figure 2: Pre-operative view of UL1](image2)

![Figure 3: Extraction of UL1](image3)

![Figure 4: Immediate Provisional Abutment (IPA)](image4)

![Figure 5: Provisional crown being manufactured on IPA](image5)

![Figure 6: Internal hex which has been created by curing flowable composite over the IPA](image6)

![Figure 7: Immediate Provisional Abutment (IPA)](image7)

![Figure 8: Provisional crown being manufactured on IPA](image8)

![Figure 9: Internal hex which has been created by curing flowable composite over the IPA](image9)

gle produced by the buccal plate. In the anterior maxilla, implant placement is typically toward the palatal aspect of the socket. Ideally there should be a space of 0.5mm-1mm between the buccal plate and the anterior surface of the fixture.

The site was further prepared using the standard drill sequence. A Nobel Speedy Replace regular platform fixture (ø4mm x 15mm) was then placed which stopped at a torque value of 55Ncm. It is recommended that if a torque value of 55Ncm cannot be achieved the implant should not be brought into immediate function. A cover screw should be used and the implant submerged; therefore some other temporary measure such as a Maryland Bridge should be used. In these conditions the root could even be sectioned from the extracted tooth and the crown bonded to the adjacent tooth.

Primary stability is very important in this procedure as the bone support needs to be strong enough to support the fixture and prevent micromotion from exceeding the threshold above which fibrous encapsulation prevails over osseointegration (Szmukler-Moncler et al. 1998).

An Immediate Provisional Abutment (IPA) (Figure 4) was fitted to the implant and fastened down to 20Ncm. The abutment is non-engaging, screw-retained and inserted using a multi-unit abutment driver. The abutment has a 1.5mm depth of shoulder and comes with a plastic coating, which can be used with acrylic provisional materials. I find however, that when using composite materials it is better to discard the coping and cement the composite to the IPA.

A provisional composite crown was pre-manufactured by the laboratory. A small amount of Tetric Flow composite (any flowable composite would also work) was placed in the provisional crown. A sufficient amount was used to engage with the metal of the IPA but not spill out and touch the tissues. This was then light cured whilst the provisional was supported in the correct position. The provisional was then removed and placed on another IPA connected to a protection analogue. The voids were then filled with more Tetric Flow. The margins were then shaped
and polished to ensure a smooth shoulder with no ledges or deficiencies against the IPA. (Figures 5 and 6). The provisional crown was then cemented to the IPA with a very small amount of Tempbond, ensuring that no cement extrudes into the tissues. **Adjusting the provisional crown**

It is important at this stage to ensure that the provisional crown is adjusted to ensure that there is no contact with the lower teeth in centric occlusion (Figure 7) and no contact in any protractive or excursive movements (for example, not immediate loading). The patient was advised to try and avoid the provisional crown and not to apply any forces with eating for the first four weeks.

The provisional crown was left in situ for six months (it is recommended that an absolute minimum of three months should be allowed for osseointegration before disturbing the immediately placed implant). The provisional crown was removed and a fixturehead impression taken of the implant. The adjacent post crown (upper right central incisor) was also prepared for a new crown to ensure a good match for both central incisors. A Procera Zirconium abutment was connected to the fixture (Figure 8). The abutment screw was fastened down at the recommended torque of 35Ncm. Procera porcelain crowns were fitted to both central incisors (Figure 9). The implant-retained crown was cemented with Tempbond. It is recommended that the definitive restorations on implants should be cemented with temporary cement as this allows access to the implant if necessary.

**Immediate implant placement is gaining momentum.** Clinicians should be aware however that this is a higher-risk procedure and should only be attempted by those surgeons with experience in dental implant surgery particularly when dealing with the aesthetic zone.

References


Figure 10: Final restorations 18 months after fitting.

**About the author**

Dr Graham Ma gee qualified at Liverpool University in 1978 and in 1993 Graham created the Chester Dental Implant Centre within the general practice where he was a partner. Finally in 1998 needing more space for the Implant Centre he relocated the Clinic to the present building. Graham has undergone extensive postgraduate training to develop his skills in Dental Implant Surgery and Cosmetic Dentistry including a Masters Degree in Dental Implantology from Sheffield University. He continues with his postgraduate education regularly attending courses in Britain, Sweden, France and America and also gives lectures on the aspects of Dental Implantology and CT Scanning and 3D Planning in Advanced Dental Implant Therapy. Graham also runs postgraduate training for dental practitioners in his practice and is a member of the Association of Dental Implantology and of the American Academy of Osseointegration. To refer to Graham or for further information on Chester Dental Implant Centre, call 01244 540 177.
In a world where most things we purchase are ready-made rather than bespoke, we are protected by a money-back returns policy in case we don’t like something after we’ve paid for it. However, dentists spend the majority of their time creating custom-made items which makes such an approach expensive and best avoided if possible.

Consider the case of a young male patient in his early twenties who requested his dentist to close his midline diastema. The patient was soon to be married and wanted the work done before the wedding day. It was quite a large gap of some 4mm between the upper central incisors, but the dentist confidently assured the young man that he could close the gap and produce ‘a perfect smile’ ready for the wedding photos.

When the patient returned for the preparation to be done, he asked the dentist to prepare the two lateral incisors as well as the centrals. This was duly done and an impression was taken before the patient rebooked to return a week later.

At the fitting appointment, the two central veneers were tried in. The patient agreed they looked fine and he was pleased with the way they closed the diastema. To save time, the dentist did not try in the two other veneers and went ahead and cemented all four of them. When he now looked in the mirror, the patient was surprised at the result and not at all happy with the size of the central incisors. He also felt the veneers were quite bulky under his lip. The dentist reassured him and asked him to try them for a couple of weeks.

A tricky situation

The patient phoned the next day saying that both he and his fiancée were very upset with the result and that the teeth were now far too prominent. With the wedding taking place in less than a fortnight the dentist agreed to replace them at his own cost. The patient had lost confidence in the dentist by now and instead went to another dentist who replaced the veneers for a considerably higher fee, which the patient now demanded from the original dentist.

Whenever aesthetics are involved in dentistry, it is wise to obtain the patient’s consent on the complete final appearance before finishing the case, particularly if it will be difficult or expensive to redo the treatment once it has been cemented or bonded in place.

Look out for another Learning Curve feature from Dental Protection in future editions of Dental Tribune UK.

**Learning Curve**

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

The patient had lost confidence in the dentist by now and instead went to another dentist who replaced the veneers for a higher fee.
Pride of dentistry in rural Devon

The Devon Centre of Dental Excellence is achieving outstanding business success and going from strength to strength. So what is the secret to his success? Centre owner Dr Badiani reveals all.

The ancient stannary town of Ashburton, on the slopes of Dartmoor, is hardly the place you’d think you’d find the leading referral dental centre in the West Country, but you’d be wrong. And Dr Mitesh Badiani, who bought the place in 1995, has more than demonstrated what a wise decision it was.

Today, the Devon Centre of Dental Excellence is the flagship practice for a group of practices including Plymouth, Bovey Tracey and Portland. More are in the pipeline and dentists are queuing up to join. So what is Dr Badiani doing that is having such an impact and how is he achieving it in what, at face value, is a sleepy rural community?

The answer is deceptively simple. Dr Badiani makes no decisions without carefully considering them. When he does, his commitment is total and his business acumen sure-footed. And above all, he ensures that the patient experience exceeds expectations. It’s worth taking a closer look at how these values translate themselves into action.

Developing your product

The ‘marketing’ advice given generally to dentists by any number of ‘experts’ is seemingly endless with the majority of it simply being statements of the obvious. It does not take a genius to work out that there are established ways of communicating with patients, all of which are relevant and applicable to almost every practice. The genius comes, not describing and defining your market, but in developing a product that satisfies its needs.

In this respect, Dr Badiani’s philosophy and skill are clear. It is not about creating a practice that simply flaunts its capability. It is about creating a practice that shows that it listens to and cares about what patients want.

A few examples highlights this point:

- The reception team greet everyone with a welcome that says ‘we’re glad you’re here’. The smile endorses this greeting and is genuine. It isn’t just a ‘skin-deep’ gesture. This can only happen in a practice where the staff are happy and is aware that patients recognise and take notice of body language.

- There are a variety of places (other than reception) through-out the practice in which patients may wait and relax. This provides personal ‘space’, encourages a greater affinity with the practice and builds the patient/dental team relationship.

- There is a delightful, spacious and calming garden, which, on a summer day, is a haven of calm and tranquillity. Patients are free to sit and relax there before and/or after treatment. Again it enhances the relationship.

- The toilets are spotless and stocked with supplies of toilet-tries for patients to use. These make a nicer touch than a bottle of disinfectant.

Dealing with anxiety

It is a sad fact that many people fear dental treatment. Dr Badiani, who mentors and trains dentists all over the country, says: ‘We have for many years treated a great number of patients who are extremely nervous of dental treatment and...
where a local anaesthetic is re-
quired, there are various meth-
ods we will consider. One of
my favoured techniques is the
WAND system, which is amaz-
ingly effective when used by a
skilled, well-trained dentist. It
reduces anxiety and is literally
pain free. It is particularly help-
ful when treating children or
those with needle phobia who
we find often don’t even realise
they’ve had an injection!

Another concern of some pa-
tients is radiation dosage. In real-
ity, the risk to the patient may be
minimal, but this does not neces-
arily allay fears and anxiety.

‘Low radiation dosage was
one of the criteria I had in mind
when seeking to upgrade to 3D
digital imaging. I was worried
that, by referring to the hospital,
I was increasing patient concern
and in many instances the diag-
nosis did not warrant the radia-
tion dosage’, says Dr Badiani, ‘so
I decided to see what the market
had to offer.’

An exhaustive look at CT
scanners ended with Dr Badiani
choosing the Picasso Trio from
Vatech and E-Woo. ‘Quite sim-
ply the quality, the software, the
service and product knowledge
are the best,’ he says, ‘and the
Picasso is already enhancing our
diagnostic capabilities across
the range of specialist treatments
we offer!’

Working as a team
Dr Badiani’s choice of the Pic-
asso Trio exemplifies the policies
of the Devon Dental Centre of
Excellence to put quality above
cost. He has surrounded him-
self with something of a “dream
team” in the way of specialist cli-
nicians and knows that they, too,
want the best.

Dr Badiani himself concen-
trates on dental implants, IV se-
dation and cosmetic dentistry. He
also mentors for Osteo-Ti and
Ankylos. Andrew Pickering, Lin-
da Blakely, Carol Robinson and
Anna-Marie Smith offer general
dental treatment and specialists
include Professor Nico Louw
(Endo), St John Crean (Oral and
Maxillo facial), Amelia Jerreat
(Ortho) and Matthew Jerreat
(Perio and Restorative dentistry).

It is Dr Badiani’s view that
individually and collectively
we will benefit from 3D imag-
ing. ‘While most treatments are
straightforward, careful plan-
ing is always required and the
exceptional quality of the Picasso
images is second-to-none. I also
value the information it provides
for more complex cases where
we need to work and assess as
a team.’

Building referral business
A further benefit of investing in
3D imaging is that it adds to the
service that the Devon Dental
Centre of Excellence can provide
to referring dentists.

Dr Badiani is very conscious
of the trust that other dentists
place in him. He recognises
the concerns that any dentist has
when he or she refers a patient:
“When you build a referral prac-
tice, you have to do so clearly
understanding that your role
is to support and advise, never
compete, be it consciously or un-
consciously. You must strive to
exceed the expectations of your
colleagues in the same way as
you do with your patients, always
keeping in mind that they are
all clients.”

In this way, referring den-
tists are seen as almost part of
the team. They have access to
the technology and share in
the knowledge, facilities and
skills available in Ashburton.
Specialist training facilities are
available and procedures can
be watched at the viewing thea-
tre as they take place and then
discussed in a comfortable and
relaxed atmosphere.

For more information, con-
tact Devon Dental Centre of Ex-
cellence at Croydon House, 28
East Street, Ashburton, Devon
TQ13 7AX; call 01564 652 255 or
email info@devondental.co.uk or
visit www.devondental.co.uk

For more information on E-
Woo Technology, call 020 8851
1660, email info@e-wootech.co.uk
or visit www.e-wootech.co.uk.

About the author
Dr Mitesh Badiani
is a prac-
titioner of high
standing and ex-
pertise. Qualified
from Newcastle
Dental Hospital
in 1991, and has
been a Clini-
cal Director of a
number of suc-
cessful primary
care practices since 1995. He aims
to provide a comprehensive range
of pain-free dentistry for patients as well
as mentoring and training dentists
from all over the world.
Chlorhexidine Without The Drawbacks!

Curasept is a chlorhexidine mouthwash whose unique formulation helps prevent changes in patient's taste perception as well as reducing the occurrence of discoloration of the teeth.

Chlorhexidine-based mouthwashes are considered the gold standard for plaque control and inhibition, including in orthodontic patients. The latest Contin products include HTM 01-05 compliant sugar free, Curasept protects gums and teeth against attack from harmful bacteria and the build-up of plaque.

Now all the benefits of Curasept mouthwash are available in a gel form, allowing for specific application to the gums or even the periodontal pockets.

There will be: - No staining - No alcohol - No aftertaste

Studies have shown that alcohol provides no extra benefit to the antiplaque effect of chlorhexidine, and may be linked with oral cancer. Both alcohol and sugar free, Curasept prove prophylactic and teeth against attack from harmful bacteria and the build-up of plaque.

For more information please contact Suzy Rowlands on 0208 241 8526 or email info@bacd.com

New Dowsy Ovindo Visito Intra-oral Digital X-Ray System

Visilex are proud to announce a new Digital Intra-Ora System featuring unique USB connectivity and both side and 1 and 2 CMOS sensors. Both sensors have an exact number of pixel and the USB removable cable is clipped on to the back of the sensor for easy ergonomic positioning in the mouth. The USB system comes with a unique interface positioning device which the sensor can be clipped into.

The package includes: - Dowsy “Quotation” Software - Interface Modem - Storage box - Integral Postioning device-cable - Scanner - Full Instructions - Interface Modem - 24 Months Warranty

USB connection between modem box and computer

This USB connected system comes with a 560 pixel cable length between sensor and software interface. The USB removable cable is clipped on to the back of the sensor for easy ergonomic positioning in the mouth. The USB system comes with a unique interface positioning device which the sensor can be clipped into.

The package includes:

- Dowsy “Quotation” Software - Interface Modem - Storage box - Integral Postioning device-cable - Scanner - Full Instructions - Interface Modem - 24 Months Warranty

USB connection between modem box and computer

North of the Sixth Annual BACD Conference

Delegates at the 2009 BACD Conference were delighted with the remarkable technology available from Nieuwex, including the OPG Pro dental microscopes, designed by world leader leader, Carl Zeiss, and the EyeMag/loupes range such as the EyeMag Smart, with 2.5x magnification and 30% increase in working distances.

Nieuwex delivers an extensive range of equipment solutions, offering a comprehensive service including:

- In-depth equipment surveys to ascertain the client's specific needs
- Helping clients find the ideal equipment
- Training - Aftersales

Also on display was the Swiss-designed Exterucer, the first dental mirror that self-deploys for continuous clear vision, together with Nieuwex Contour Alcohol Free disinfectants. The latest Contour products include HTM 01-05 compliant solutions such as sealed disposable cartridges, a 2 in 1 surface cleaner disinfectant that incorporates a mild detergent and an alginate mix to disinfect impressions at source (think to sponsor the 2009 BACD Conference). Nieuwex has delighted with the success of the Sixth Annual Conference.

For more information please call Nieuwex on 01453 758519, email info@nieuwex.co.uk or visit www.nieuwex.co.uk

Predictable Diagnosis and Treatment Planning

The most recent Study Club event organised by The British Academy of Cosmetic Dentistry took place at the Costa Court Hotel on Friday 25th September, and saw one of the leading authorities in cosmetic dentistry give a presentation on Records for Predictable Diagnosis and Treatment Planning.

With over 20 years’ experience in both private and public health sector, Dr Buckle is an accomplished practitioner, recognized through his membership to both the British and American Cosmetic Dentistry Academies.

Attendees were also taken through issues concerning the use of articulators and the way to decide which type to use as well as the arguments in favour of utilising a ‘fandango’ as an aid to planning treatment. His scoliosis on the most appropriately used equipment in the BACD Advanced. Relation between AIB and sea also extremely helpful.

The British Academy of Cosmetic Dentistry would like to extend its thanks to Dr Buckle for a most informative evening.

For information on future Study Events, please contact: Suzy Rowlands on 0208 241 8526 or email info@bacd.com

New Year, New Job

As 2010 starts will you be looking for a change of job? A New Year is a chance to change many aspects of our lives, and employment is no different.

Maybe you want to see what jobs are out there, and don’t want to spend any money? Wouldn’t it be good if you could post your CV and details to a website for FREE?

Receive email alerts when a relevant vacancy is listed:
Visit www.practicestory.com and post your CV’s details and even a video, absolutely FREE.

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Visit www.practicestory.com and register your details for FREE today.

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If you have second-hand equipment that you no longer need, what is your best course of action? Advertise? Sell your colleagues?

Why not list it for FREE on www.secondhandtools.com? You can reach a huge potential audience in just a few clicks and you only pay anything when you sell it.

Hundreds of dentists have already registered for FREE on the site since it launched so why not just try them?

Takara Belmont

Takara Belmont launched their latest treatment centre, the Clois, at Dental Show West last month.

This remarkable treatment centre combines good looks with incredible functionality, not to say easy when you argue already hard the most ergonomic treatment centre on the market. However, even with great beauty there is room for enhancement.

Takara Belmont is confident that the Clois II will not disappoint.

Enhanced aesthetics can often be at the expense of functionality, reliability and cost. Takara Belmont is confident that the Clois II will not disappoint on any of these accounts.
**Improve aesthetics in cases with compromised bone**

A one-day course for implant dentists who wish to improve the aesthetic outcomes in compromised bone cases. The course will provide an introduction to the concept of guided bone regeneration, an overview of the latest innovations in hard and soft tissue management, and practical hands-on exercises. Attendees will receive a comprehensive learning pack that includes all the materials used during the course.

**Implied inductive learning**

This course is designed to help implant dentists improve their aesthetic outcomes in compromised bone cases. Attendees will learn about the latest techniques in guided bone regeneration, hard and soft tissue management, and practical hands-on exercises. The course is suitable for experienced implant dentists who wish to enhance their aesthetic outcomes and provide a better patient experience.

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Chemical disinfection – an integral part of endodontic treatment

Endodontic treatment aims to resolve periapical and radicular periodontitis as well as intracanal infection caused by microorganisms. This can be considered a three part process involving shaping and cleaning the canal, chemical disinfection and finally root canal obturation followed by coronal restoration of the tooth.

Shaping and cleaning involves enlarging the canal in order to allow for chemical disinfection. This is an important next step for ensuring complete eradication of remaining bacteria, which will facilitate healing and help prevent recontamination.

Chemical disinfection involves the use of irrigants to eliminate any remaining pathogens. It is important to use the correct irrigant sequence and concentration. A lack of awareness of any limitations could still result in endodontic failure and periapical disease.

For example, the golden standard irrigant is sodium hypochlorite, often used in conjunction with EDTA. Recently, new irrigation sequences involving the addition of other solutions have proven to raise predictability rates.

Canals can have complex internal anatomy with various fins and cul-de-sacs so it is also important to use energising techniques. These techniques will help loosen adhesion of biofilm to the dentinal substrate.

It is also important to remember that killing endodontic pathogens present in teeth is more difficult than in laboratory exercises.

A new MSc in Endodontics

The University of Warwick will launch a new MSc in Endodontics in January 2010. The programme will be delivered by leading professionals, academics and researchers in the field of endodontic dentistry, and supported by respected academics from the field of continuing professional development.

As a part-time course, it has been designed to offer a flexible training pathway tailored to individual requirements and circumstances. The programme will allow students to improve and increase the scope of endodontic treatment in their practices through the study of a wide range of topics, such as tooth morphology, mechanical shaping, chemical disinfection and pain management in endodontics.

Learning will take place through traditional seminars and practical work, performed in labs and at regional training centres. Students will gain a thorough understanding of modern technologies, using materials and instruments such as surgical microscopes and cone beam CT.

Applications are being accepted now and further information about the course can be found at www.warwick.ac.uk/go/dentistry.
A BADN do to remember

The 2009 National Dental Nursing Conference, held at the Cheltenham Chase Hotel in October was the biggest and most successful to date

This year’s BADN conference saw a record number of delegates in attendance at the event sponsored by the British Dental Trade Association, NHS Direct and Philips Sonicare. As well as the opportunity to network, delegates watched as outgoing President Angie McBain handed over the Chain of Office to Sue Bruckel who became BADN’s 2009 to 2011 President at the Opening Ceremony, and listened to a presentation from keynote speaker GDC President Hew Mathewson. The lecture programme, which offered up to seven hours of verifiable CPD, covered cross-infection control, introducing preventive practice, law and ethics, back care for dental nurses, risk assessment, prosthetics, oral and maxillofacial surgery, implants, medical emergencies and resuscitation, the new BSC for DCPs, forensic dentistry and accessibility for people with learning disabilities. Delegates were able to choose which presentations they wished to attend in advance, through BADN’s new CVENT online registration facility. Schuelke, Colgate, WR Berkley, the British Chiropractic Association, Nobel Biocare, Philips Sonicare, the University of Kent, Gloucestershire PCT and the 2gether NHS Foundation Trust provided speakers.

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How to enter
To win, register at www.dentalghar.com and submit a piece of work that highlights the difficulties of communicating as a dental health professional across barriers of language, culture, faith and other aspects of diversity. The entry can take the form of articles, projects, research reports and other written work over 2000 words.

Finally, visit Dentalghar to hear Prof. Damle, Vice Chancellor of the Maharshi Markandeshwar University’s latest thoughts on dentistry, in his interview filmed at the FDI World Dental Congress, 2009.

To find out more go to www.dentalghar.com

Delegates watched as outgoing President Angie McBain handed over the Chain of Office to Sue Bruckel

Extra curricular activities
Outside the lecture theatre, delegates were able to talk to representatives of NHS Direct, the General Dental Council and Parliament Hill, providers of the BADN Benefits Scheme. At lunch, delegates were treated to a selection of specially chosen British cheeses, courtesy of the British Cheese Board.

Master of Ceremonies at the black tie Presidential Dinner was Peterborough GDP Martin Fallowfield. Entertainment was provided by swing tribute act Swing Thru a Lens, whose repertoire of rat pack classics and modern swing favourites proved a big hit with delegates.

At the Closing Ceremony, sponsored by Philips Sonicare, President Sue Bruckel presented four new BADN Fellows with their certificates, introduced new members and first-time delegates and congratulated delegates on recent qualifications and achievements.

Photos, taken by local photographer Sally Burford, will be available shortly on the BADN website and the BADN Facebook Group.

Next year’s National Dental Nursing Conference will be held at the Blackpool Hilton on 26 and 27 November 2010.
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NEW EVIDENCE FOR THE BENEFITS OF INCREASING BRUSHING TIME

To motivate behavioural change, it helps if patients understand the benefits of brushing for at least 2 minutes twice a day with fluoride toothpaste, compared to an average brushing time of around 46 seconds.¹

New research results from Aquafresh show that increasing brushing time:

**Significantly increases plaque removal**

*26% more plaque removal was observed with brushing for 120 seconds compared with 45 seconds*²

**Significantly increases fluoride uptake and enamel strengthening**

*Surface microhardness (SMH) increased in a linear fashion over the period 30–180 seconds*²

References


* AQUAFRESH is a registered trade mark of the GlaxoSmithKline group of companies.

Recommend a great tasting fluoride dentifrice to encourage your patients to brush for longer, for increased fluoride protection and plaque removal.