Bad teeth among athletes

Athletes at the London 2012 Olympic Games had ‘strik- ing’ levels of bad teeth, say researchers. A team at Universi- ty College London says where competitors had bad dental problems, with large amounts of carbohydrates and sugary energy drinks consumed regu- larly causing the damage. The study, published in the British Journal of Sports Medicine, looked at competitors visiting the dental clinic at the Games. Of the 562 athletes examined, 55 per cent had evidence of cavities, 45 per cent had tooth erosion and 76 per cent had gum disease. One in three said their oral health affected their quality of life and one in five said it affected training or ath- letic performance. Stress on the immune system from int- ense training may also leave athletes at risk of oral disease.

Cigarette health warnings

Barely a third (35 per cent) of teenagers in the South East are deterred from smoking by curr- ent cigarette packs, compared to nearly half (48 per cent) of teenagers in Australia, where packs are almost entirely cov- ered by graphic warnings, a survey has revealed. The Brit- ish Heart Foundation’s (BHF) poll found that 73 per cent of teenagers in the South East think the UK should introduce standardised cigarette packs. It was also found that 59 per cent of teens in Australia think graphic images on packaging deter people their age from smoking. The European Parlia- ment is set to vote on key leg- islation tomorrow (8 October 2013) that would see cigarette packs across the EU feature larger graphic health warnings on both sides of the box.

Guilty beautician

A beautician has pleaded guilty to unlawfully practising den- tistry by carrying out tooth whitening treatment. Ms Elaine Taylor-Valles is the first person to be prosecuted by the Gen- eral Dental Council (GDC) since the High Court upheld the view that tooth whitening is the practise of dentistry and should only be carried out by dentists, dental hygienists and dental therapists, working on the prescription of a dentist. Ms Taylor-Valles has been given a nine month conditional discharge and ordered to pay £350 towards the GDC’s costs. During sentencing at Preston Magistrates’ Court, District Judge Goodwin said: “I accept that Ms Taylor-Valles had done a tooth whitening course, how- ever she did not do the Gen- eral Dental Council to confirm whether she was allowed to do tooth whitening.”

News in Brief

The BDA’s General Den- tal Practice Committee (GDPC) met on Oct 4. The meeting was dominated by an angry discussion about the disastrous financial impact on the BDA that the new member- ship structure has had.

GDPC members received a presentation from Richard Shil- ling, the BDA’s Financial Direc- tor, at which he stated: “We have to cut staff, services and other costs, in order to enable us to make the savings needed under our proposed recovery plan”.

Whilst taking questions from Committee members, the Fi- nance Director admitted that 25 whole time or equivalent posts have been put at risk of redundancy already, represent- ing nearly 20% of the total BDA staff capacity across the UK, and management continue to invite further voluntary redundan- cies from across the staff. The Finance Director also admitted that the BDA may well need to look at a further round of redun- dancies, as part of a deeper cost- savings exercise.

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Feature

Senior BDA executive tells boss to quit

BDA crisis deepens after angry GDPC meeting

The BDA’s Finance Director told the meeting that there is currently a recurring shortfall in subscriptions of about £2.5m and a projected ‘worst case’ deficit of £5.4m. One GDPC member, who wished to remain anonymous, commented: “Simple maths tells me that the BDA needs to recruit about 8,500 new members at the ‘Essential’ level of BDA mem- bership, in order to make up a £2.5m shortfall in this first year. And even that would still leave the organisation with no finan- cial reserves unless savings are made from other areas.

“Surely this model should have been more carefully consid- ered by the management team and by the Principle Executive Committee? I gather less than 10% of the membership was lost during the transition to this new structure. It is clear to me that this is not a problem with mem- ber loyalty, this is about manage- ment incompetence.”

The BDA is now in the pro- cess of convening an Emerg- ency General Meeting of the UK Council. Under the BDA’s Arti- cles of Association, the UK Coun- cil has the power to dismiss the Principle Executive Committee and to call new elections.

Speaking with a member of the Smile-on News team, one senior BDA executive has raised the question of the viability of some members of the PEC and the CEO’s position and suggest- ed that now may be the time for some to ‘fall on their swords’.

Martin Fallowfield, Chair, BDA Principal Executive Com- mittee, said: “The BDA’s mem- bership structure needed to change. It was not financially viable and it was not fair to members; some were paying for services they seldom required while others were heavily using services for which their mem- bership fees did not pay.

“The new system is fair be- cause it links services received to membership fee paid. Mem- bers choose the membership package that is appropriate for them and they pay for it. It also establishes a sustainable finan-
3D printed toothbrush cleans teeth in six seconds

A new 3D printed toothbrush tailor-made to fit a person’s mouth is claimed to completely clean teeth in six seconds.

To make the ‘Blizzident’, dentists take a digital scan of a person’s teeth and use that to determine the optimal placement of 600 bristles by simulating biting and chewing movements. The bristles resemble normal toothbrush bristles but are much finer and tapered to reach the gum line better.

The scan is used to create a computer aided design (CAD) model of the brush, which is converted into a 3D object using stereolithography, a method in which liquid plastic is cured into a shape with an ultraviolet laser. The bristles are then attached.

To use the Blizzident, a person bites down on it and grinds their teeth for about six seconds. The brush’s makers say this is sufficient time to clean teeth completely, although independent studies have yet to verify this.

Anna Jefferson cleared over CQC cover up

Anna Jefferson, CQC’s current Head of Medi- cine, has been cleared of wrong-doing in an internal enquiry.

As previously reported, a report revealed that the CQC ‘covered up’ knowledge of its failings over a series of baby deaths at a Cumbria hospital. Anna Jefferson, along with Cynthia Bower and Jill Finney, were blamed in a follow-up report. They were all said to be present at a meeting where deletion of a critical report was allegedly discussed.

Ms Jefferson is alleged to have said of the report: “Are you kidding me? This can never be in a public domain.”

However, the CQC has now released a statement that says: “Anna Jefferson had not used ‘any inappropriate phrases’ as attributed to her by one witness quoted in the Grant Thornton report” and that “Anna Jefferson had not sup-
ported any instruction to delete and internal report prepared by a colleague - Louise Dineley.”

It added: “The CQC regrets any distress Anna Jefferson has suffered as a consequence of this matter and is pleased to welcome Anna back to the organisation following a period of maternity leave. She is currently undertaking a course of postgraduate study with CQC’s support.”

Natural teeth last longer than dental implants

Patients should hang onto problem teeth as long as possible rather than getting dental implants, a new literature review suggests.

The review, published in the Journal of the American Dental Association, found that 15-year tooth loss rates range from 5.6 per cent to 13.4 per cent, whereas implant loss rates range from nought per cent to 33 per cent.

Some clinicians recommend dental implants as an alternative to treating severely diseased teeth, however the researchers note that even teeth classified as ‘hopeless’ may survive, especially if periodontal treatment address the underly-
ing problem.

“The results of this systematic review show that implant survival rates do not exceed those of compromised but adequately treated and maintained teeth, supporting the notion that the decision to extract a tooth and place a dental implant should be made cautiously,” the authors write.

It was found that more conical implants had higher stresses than did cylindrical and screw-shaped implants, and textured implants had better outcomes than those with machined sur-
faces. Implants were more likely to fail in patients with periodon-
titis-related tooth loss, in those who smoked, and in those with diabetes mellitus, a history of radiotherapy, or impaired bone quality.

“In light of the above review, the decision to retain properly treated and maintained teeth for as long as possible seems to provide an overall so-

olution that can reduce the treat-
ment risks over the long term,” they conclude.

Tooth restores man’s sight

A man has had his sight restored after one of his teeth was implanted in his eye.

More than two decades ago, former factory worker Ian Tibbetts began to lose his sight after suffering an industrial accident. According to the Independent, as he was re-
moving a piece of scrap metal from an oven it struck him in the right eye, ripping his cor-
nea in six places. By 1998 he had lost all sight in his right eye, followed a decade later by nearly all the remaining vision in his left.

Now thanks to an operation in which one of his teeth was implanted in his eye socket to act as a cradle for a false lens, his sight has been restored. The procedure, known as os-
teo-odonto-keratoprosthesis (OOKP) was carried out by surgeon Professor Christopher Liu at the Sussex Eye Hospital in Brighton.

When the two-stage surgery in-
volves the removal of a piece of tooth and bone from the pa-
tient’s mouth, and then stitched into the eye socket.

“The technical success rate is close to 100 per cent. The number of people who will see well for a very long time is two-thirds to three-quarters. If I am a bit more pessimistic I will say half to two-thirds. But for the major-
ity of people it will work,” says Professor Liu.
H ello and welcome to this month’s issue of Dental Tribune.

This month profession and industry alike are gearing up for one of the biggest events in the dental calendar – BDTA Dental Showcase.

I think we know one stand which may be extremely popular this year – that would be the BDA’s stand (K04). With all the news, rumours and rhetoric that has been circulating the organisation since the announcement of the new three tier membership system and the seeming failure of that system to ignite the interest of the profession, no doubt many members and non-members alike will be flocking to speak with the team.

We will be based on Stand H01 – do come and say hello.

Editorial comment

The changes were made after years of research and engagement with members. The new membership packages respond to what dentists have told us they want.

“They are also flexible. Members can trade up to a higher package if they realise they need a higher level of service and we see them doing exactly that.

“The implementation of a new business model brings challenges for any business and the BDA is no exception. The BDA’s senior management team has looked at the out turn and thought carefully about what changes are needed to respond to members’ decisions. It has moved quickly to implement a new financial model and is also consulting on changes to the deployment and headcount of its staff resource. Unfortunately, that will mean redundancies in some areas. Members can be assured that services will be protected.

“The changes were necessary and have been made after thorough research, careful consideration and dialogue with members. The BDA’s elected representatives – including the Executive Board and Representative Body; the bodies superseded by the PEC in 2012, and latterly the PEC itself – endorsed the changes.

“Like any democratic organisation the BDA is a crucible for different opinions and interests and has formal decision-making mechanisms through which they are debated and reconciled. Inevitably, with an issue as important as the operation of the Association, views come to the fore.

“One of the mechanisms for the exchange of views is the BDA committees and councils representing dentists working in different dental crafts and the four UK countries and we are committed to ensuring these bodies are kept fully informed. Many of them are scheduled to meet during the autumn and are being updated as they do, but contrary to reports, no EGM of the UK Council has been scheduled.”
CQC given more independence

The Care Quality Commission is to be given greater independence, Health Secretary Jeremy Hunt has announced.

Under the proposals, the Health Secretary will relinquish a range of powers to intervene in the operational decisions of the CQC. The CQC will no longer need to ask for Secretary of State approval to carry out an investigation into a hospital or care home, and the Secretary of State will no longer have the power to direct the CQC on the content of its annual report.

In addition, the newly created positions of Chief Inspector of Hospitals, General Practice and Adult Social Care, will be enshrined in law. They will lead CQC’s inspections and regulate providers of health or social care services across the public, private and independent sectors.

Health Secretary Jeremy Hunt said: “The Chief Inspector must be the nation’s whistleblower in chief. We will legislate in the Care Bill to give the CQC statutory independence, rather like the Bank of England has over interest rates. The welfare of patients is too important for political meddling and our new legislation will make sure Ministers always put patients first.”

Dentist jailed for filming female staff

A dentist has been jailed in Germany for secretly filming his female staff while they were changing clothes.

The 52-year-old had installed a video camera in the changing room of his practice which was used by his female hygienists and receptionists. After staff discovered the camera, investigators found almost 7,500 video files on the defendant’s computer going back six years, showing eight victims in their underwear or naked.

He has been convicted of 211 counts of violation of privacy using a recording device and jailed for two years and four months.

‘Pressure wash’ your teeth and gums

A dentist has invented a device that will replace the traditional toothbrush, toothpaste, floss and mouth rinse, and now he is trying to raise money to develop it.

The CLEARsmile device is a ‘pressure wash’ for teeth and gums that hits every angle simultaneously, says inventor Dr Igor Reizenson. He came up with the idea while working in the Veterans Hospital and seeing elderly bed-ridden patients unable to clean their teeth, and nurses not able to do it for them.

He also did community dentistry on mobile buses for underprivileged children across the state of Georgia, US, and came to the conclusion that an oral hygiene device that is quick, easy and effective, is needed.

Dr Reizenson now needs to create a prototype and it was found that $750,000 is needed to do this. His campaign can be found at the crowd funding site indiegogo.com.

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Interview: ‘The patient should be told the truth’

Dental Tribune Online spoke with Prof Stephen Porter from the UCL Eastman Dental Institute about new risk factors and prevention strategies for oral cancer

Undoubtedly, it will increase. When a celebrity announces that he or she has a particular disorder, there is often an upsurge of referrals by concerned individuals. In the UK, this was perhaps best illustrated when Freddie Mercury declared that he had HIV. There was a substantial rise in the number of persons seeking advice and/or testing for the disease in the aftermath.

A fair number of famous people have had oral cancer, including Sigmund Freud, Ulysses S. Grant and TV producer Aaron Spelling to name but a few. In the UK, journalist and first husband of TV cook Nigella Lawson John Diamond wrote a series of articles detailing the progress of his disease and its treatment that informed many of the impact this disease can have on an individual and his or her family.

Unfortunately, the Michael Douglas situation has perhaps confused the exact role of the human papillomavirus (HPV) in mouth cancer. Certainly, it can cause mouth cancer and it can be acquired through orogenital contact, but there is no evidence that such contact will lessen any subsequent risk of contracting mouth cancer.

Oroflaccus figures are rising worldwide. What are the reasons for this, and does it fulfill the criteria for an epidemic, as it has been called in some media reports?

An epidemic is defined as a new case of a disease in a given human population over a particular period. It often has an emotive element to it. Oral cancer certainly is on the increase in the developed world, although the number of new cases is falling in some parts of the globe, notably parts of India.

The rise in some countries is gradual but sustained. Smoking tobacco and/or drinking alcohol are the two factors that traditionally have given rise to mouth cancer. In addition, individuals are now acquiring cancer-causing (oncogenic) types of HPV, probably via orogenital contact. This burst of infectious disease, or indeed sexually transmitted infection, is not a new phenomenon, but it has become much more manifest in the last 50 years. So, what is new is probably that oncogenic types of HPV are just more common in the sexually active population than in the past.

The exact risk that it carries is unclear but it has been suggested that the risk of HPV-related mouth and/or throat cancer climbs when someone has had more than nine different sexual partners.

What other factors besides smoking, drinking and HPV are currently being investigated, and what is their malignant potential?

People chew betel nut preparations (eg paan masal and gutka) in parts of India, Pakistan, Bangladesh and surrounding areas. These cause initial fibrosis of the oral tissue, termed “submucous fibrosis”, which carries a high risk of causing oral cancer of possibly 50 per cent. Submucous fibrosis can arise even in young individuals and is irreversible, and thus patients are likely to have a lifelong risk of mouth cancer, even if they stop the causative habit. The nightmare scenario is that when examining a patient with submucous fibrosis the mouth opening can be so small that a clinician may be unable to see the cancer.

Mouth cancer can also arise in patients who have rare genetic disorders, such as Fanconi anaemia and dyskeratosis congenita, but the most common oral disorder that is considered to be potentially malignant is oral lichen planus. This is a global disorder that typically occurs in middle-aged and older women. It is a chronic immune disorder that may cause painless white patches (lichen planus) on the mouth mucosa. It affects about one to two per cent of the population and is the most common disorder to affect the lining of the mouth (the oral mucosa).

It has been suggested that one-two per cent of patients with oral lichen planus will develop mouth cancer, but this risk is highly unpredictable because it does not appear to be consistently associated with the duration or type of treatment of the lichen planus, nor the age or sex of the patients, nor their alcohol or tobacco habits. The good news, perhaps, is that 98 to 99 per cent of patients with oral lichen planus will not contract mouth cancer.

Isolated white or red patches on the oral mucosa (sometimes termed “leukoplakia” and “erythroplakia”) have malignant potential as well, but these are actually uncommon, particularly the latter, compared with oral lichen planus.

Besides new treatment concepts, prevention remains the most effective strategy against oral cancer. Why do so many dentists still appear to overlook obvious signs of the disease, and do current screening procedures have shortcomings?

The great majority of patients ultimately found to have mouth cancer will have been referred to a specialist service because a dentist or other dental professional will have noticed something abnormal. He or she might not have known what it was, but they did the correct thing by referring the patient to a specialist.

Screening for possible mouth cancer is straightforward. It is just a matter of examining the neck and mouth carefully. However sometimes dentists do not know what to look for, as they have probably never seen more than one type of oral cancer in their professional lives.

Similarly, mouth cancer is
more likely in socio-economically deprived groups than the wealthy. Socially disadvantaged people have a tendency not to attend health care providers, including dentists, on a regular basis nor to take up possible screening opportunities for common diseases and therefore have a variable awareness and practice of disease prevention strategies, whether concerning oral health or general health.

Clearly, the best option for screening would be opportunistic screening, where health care staff examine patients in risk groups for a particular disease, but this requires people to want to attend a clinic and to appreciate the possible benefits of such attendance for their health and well-being.

Is there any evidence that regular screenings could help prevent oral cancer?

There is no evidence that a particular frequency of dental examination will lessen the risk of mouth cancer. However, the more regularly a person is examined, the greater the chance that emerging malignant or potentially malignant disease will be detected and that any lesion present will be small.

However, overzealous review is likely to be wasteful and thus all patients should be advised that if they become aware of a change in their gingivae or oral mucosa that persists for more than three weeks and has no obvious local cause, or example a sharp tooth or filling, they should seek advice from their dentist.

In its 2008 policy statement, the FDI stresses the important role of dental professionals in the detection of oral cancer and patient education. To what extent are dental professionals fulfilling this role?

The majority of patients ultimately found to have oral cancer will have been identified by a dentist or other dental professional; thus, dental professionals are fulfilling this role to a great extent. However, dental professionals should also be able to provide advice about oral cancer prevention, for example tobacco and alcohol cessation, and information on where additional advice can be obtained, for example tobacco cessation services.

The current rule of thumb is that the more people smoke and the longer that habit the greater the risk of mouth cancer. The same applies to alcohol. There are some nuances as regards the type of tobacco or alcohol that may affect risk but these are really not of notable concern when communicating a disease prevention message. Of significance is that the risk of cancer developing if someone smokes and drinks is much higher than if someone smokes or drinks (i.e. there is a synergistic rather than additive effect).

Of course, many dentists will indicate that they have no experience of having seen oral cancer or having managed any patient who has previously had such disease. However, there are some simple rules. If a lesion is solitary, has been present for more than three weeks and has no local cause, the patient should be referred. Any lesion that strikes a dental professional as odd and/or destructive warrants referral.

Dentists should always keep an accurate and contemporaneous record of what is observed during clinical examination and be familiar with the contact details of local oral cancer specialists (typically oral and maxillofacial surgery or oral medicine).

Finally, the patient should be told the truth, i.e. that the dental professional has concerns that a lesion is possibly malignant or premalignant, and is thus referring the patient for further investigation.

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THE DENTAL PRACTICE MANAGEMENT SPECIALISTS
With all that was going on with the transition of PCTs to NHS England, the DH’s 2013 update of HTM 01-05 has gone relatively unnoticed. Maybe this is because it was resentfully received on account of wrapped instruments now being able to be stored for six times longer than before, which in turn questions the previous 21- or 60-day guidelines along with the practice costs associated.

This got me thinking about guidelines. I’m not sure why, but people don’t always like to follow guidance and direction. In fact a study has shown that when people are asked to plan a journey they don’t tend to follow their own directions, because the scene, as it unfolds in real-time, presents various opportunities to reduce the journey time through taking short-cuts. Maybe it’s because we think we know better or we are too pragmatic to be wasting our time on “reading” and would rather be “doing”. Either way, when it comes to professional guidelines the risks of not following them could be more serious.

A guideline is considered to be a statement by which to determine a course of action, and clinical guidelines are published by a number of bodies, including the National Institute of Health and Clinical Excellence (NICE) who assert that “good clinical guidelines aim to improve the quality of healthcare”. Are guidelines mandatory to follow? Well, the case of JAC Richards v Swansea NHS Trust [2007] EWHC 487 (QB) demonstrates how the judiciary has held professional guidelines as the legal standard in which to find negligence.

In this particular case, the time taken to deliver a baby by emergency caesarean section exceeded that recommended in the NICE and Royal College of Gynaecologists and Obstetricians guidelines on caesarean section. As this delay was found to have led to the claimant’s cerebral palsy Field J found the NHS Trust to be negligent. This reliance on guidelines represents a judicial shift away from the Bolam standard of a competent body of professional opinion because, unlike experts, guidelines are evidenced-based and objective. Guidelines can therefore be relied on as a tool to reduce clinical error and promote consistency in the provision of care.

Examples of guidelines within the dental sphere include NICE Guidance on the Extraction of Wisdom Teeth (2000) and FGDP Adult Antimicrobial Prescribing in Primary Dental Care for General Dental Practitioners (2012).

Use of clinical guidelines does however present concerns to the practise of dentistry including the growth of ‘cookbook dentistry’ where dentists are at risk of practicing prescriptively, even when it is justified to use clinical discretion in the patient’s best interests. Fear of litigation could perhaps give rise to defensive dentistry. As inferred from Plato, the imposition of guidelines threaten the autonomy of our profession, which prides itself on being truly imprecise insofar that patients are unique and no disease manifests in the same way. Samanta et al contend that it is important that the courts use guidelines that are credible. This credibility could be determined on the basis of evidence-based standards, ie authorship by esteemed professional bodies and the guidelines themselves being systematically developed on the basis of evidence.

Guidelines are just that – guides. However, beware of likening them to futile instructions. This is because they are valued by the judiciary to help identify what is legally expected, offering a framework which can be used by the courts in order to assess the reasonableness of decisions in the arena of clinical negligence.

• References are available upon request. The views expressed are those of the author and do not necessarily reflect the views of, and should not be attributed to, any organisation or institute that he works for.

About the author
Amit Rai is a General Dental Practitioner, Dental Educator and Advisor with a Dental-Legal background.
The Resuscitation Council (U.K.), the medical charity that produces official UK guidelines for CPR, has launched an app as a way to learn CPR in the 21st century. Together with production company UNIT9, the Resuscitation Council has created LIFESAVER, a free app that is available on your computer, smartphone or tablet.

An estimated 60,000 people each year in the U.K. have an out-of-hospital cardiac arrest and less than 10 per cent of these survive; this means that it's more likely that the person suffering the arrest will be known to the rescuer. The Resuscitation Council built this app as an attempt to let people learn CPR easily, have the confidence to do it, and ultimately, save lives.

With almost everyone having access to a computer, smartphone or tablet and wanting to receive information in a quick condensed manner, this is the first effective way of learning CPR available to everyone.

LIFESAVER is an interactive short film that is played like a game. The user is put into the situation and asked questions about what you would do each step of the way; if you pick the wrong answer, you're told why it's wrong and what should be done instead. Playing the game is quite pressured - you're given a time limit to answer the questions so have to react quickly, just as you would if you were in a real-life situation. The interactivity really puts you in the situation and makes you feel as if you are experiencing it.

Being involved in the game provides a more vivid experience than practising on a dummy like traditional CPR classes.

There are three different scenarios to go through, giving you advice in what to learn in each situation. There is also the opportunity to hear expert advice on CPR and real-life accounts of cardiac arrest.

Viv Cummins talks about her experience when her husband had a cardiac arrest. Viv phoned the ambulance and the responder talked her through what to do. She'd done a CPR course a few months earlier and says it all came back to her - her panic went and she got into practical mode.

"I already knew it was too late at this point but I had to do what I could and got on with what I'd been trained to do. It was nothing like carrying it out on the mannequin in the training", she says.

Viv knows that she had done everything she could to try and save him. Her husband dying wasn't as a result of her not knowing what to do, and she says this has given her great comfort since his death.

LIFESAVER is available from both the Android and Apple app stores, and can be played online at www.life-saver.org.uk.

"Paul is a passionate and charismatic speaker
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It's BDTA Dental Showcase time!

Dental Tribute details all you need to know about this year's event...

BDTA Dental Showcase is renowned as the UK’s biggest and most important dental exhibition.

Organised by the British Dental Trade Association (BDTA), Dental Showcase is the longest established and best attended show in the dental calendar annually attracting thousands of dentists, practice managers, hygienists, therapists, dental nurses, lab owners, dental technicians and dental receptionists.

In 2012 more than 15,000 members of the profession and trade attended the exhibition, attendance numbers are always independently audited by the BPA.

Manufacturers and suppliers invest considerable resources in developing innovations that are specially designed to meet your needs, save time, improve productivity, reduce long term costs and generally make your life easier. Dental Showcase provides the perfect opportunity for forward-looking members of the dental team to see what’s new, gain technical and business information, make informed purchasing decisions and take advantage of special offers.

BDTA Dental Showcase 2013 will once again offer a diverse range of free, informative mini lecture sessions providing verifiable CPD and for those who prefer a more practical learning experience there will be a new and exciting line-up of Live Theatre demonstrations throughout the three days.

In 2012, more than 100 free business and clinical CPD sessions offered visitors more than 60 hours of verifiable CPD. In total, the dental team enjoyed 5,000 verifiable CPD sessions!

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  • Don’t miss Philips’ Showcase giveaway! Lucky delegates each day can try the Sonicare Airfloss at one of the brushing stations on Philips’ stand (P06) and can take it away with them for free.
  • kemdent’s range of exclusive special offers at this year’s show: Amazing half price sale on 5L disinfectants, plus spend up to £175.00 on kemdent products and get a PracticeSafe Hand Disinfectant Gel Dispenser FREE OF CHARGE! Don’t forget to ask about the FREE gun and activator when you purchase 100 Diamond Rapid Set Capsules at the Offer Price: £167.25 + VAT.
  • Visit NSK on stand G21 and get three cans of Pana Spray Plus free of charge with every handpiece order, saving £95.58 incl VAT.
  • Qudent’s special deal of 10% discount on orders placed at the show for all Support Design and D-Tec products. Visit stands J18 and J19 to find out more!

BDTA Dental Showcase takes place at the NEC in Birmingham October 17-19. See you there!
Journey through an MSc in Restorative & Aesthetic Dentistry with Oliver Harman

Dr Oliver Harman is now coming to the end of his two-year MSc in Restorative & Aesthetic Dentistry, with only a couple of weeks before the dissertation section of the course. Designed to advance practitioner’s skills in this area, the course is provided by renowned education provider Healthcare Learning: Smile-on in collaboration with the University of Manchester.

The second half of the MSc course has provided everything I have come to expect. The latest modules have taught me a lot about how much I still have to learn, and it has been an exciting and at times challenging journey.

Module four was an introduction to the research and evidence-base behind everything we do. This was completely new to me as such an area was not included in my initial training to become a dentist, and with this came my greatest challenge from the MSc course. While it was extremely interesting to delve into all the research associated with the practical work I do, it was a real eye-opener – for all the things I didn’t know! When I first qualified, I was told how things worked, shown how to do them and that’s what I did; so this was a whole new way of thinking. The test for this module was a particularly rude awakening, as I realised just how much there still was to learn. I am however pleased to report that I did pass the module after some hard work.

Having considered myself a fairly experienced clinician, I was surprised to find sections of this course quite so challenging. That said, I think it was invaluable to go back to basics and to be able to form my own opinions directly from the evidence-base available. I experienced a different style of teaching here as well – it was clear the course instructors were training us for bigger things. This module in particular encouraged a high level of thinking and reasoning, which has already had a huge influence over the way I practice dentistry.

Highly aesthetic

By the time we reached module five, I was somewhat relieved to return to the wet-fingered...
dentistry I am reasonably comfortable with. In this section we looked at how to perform back fillings correctly and how to achieve highly aesthetic results.

Module 6 then covered more advanced techniques and involved a lot of implant work. This I found exception- ally useful as it forced me to go beyond the basic understanding I already had and it gave me a really good grounding in implantology, as well as covering complex restorative areas too. For the first time, I think I can now honestly say that I actually understand occlusion – if anyone can!

Strengthening foundations

While I appreciate the Manchester University’s methods of teaching are not the only ones, this MSc course has been superb, especially when it came to occlusion. The course strengthened my clinical foundations, covering all types of treatments and providing practical advice for day-to-day procedures. Patient communication was an especially helpful area to go over, and covering the potential risk factors has helped strengthen my treatment plans.

I have also been thoroughly impressed with all the academics leading the course, who really know their stuff and have been fantastic instructors. A good balance between the research, hospital and general dentistry has also been presented.

Now nearing the end of the MSc, I am keen to take a much more minimally invasive approach to cases wherever possible. This has been reflected in my practice and we have started to focus on providing more advanced cosmetic and restorative treatments, with enhanced treatment planning procedures. We also now have an in-house implantologist, and the MSc has certainly helped me build

this relationship.

For any professionals thinking of undergoing a Masters course, I think it is important to evaluate your personal situation before you start. I have found that running a busy practice while taking on the extra workload from the MSc difficult at times, so I would say such an endeavour would be best suited to those running more established practices, or to associate dentists with fewer responsibilities. I also take my hat off to the clinicians on my course juggling a busy family life as well, particularly those with young children!

Finding the balance

A good support system is vital when undertaking this type of course – designed to test you and develop your skills, the workload can understandably put you under pressure. I am fortunate enough to have a very understanding wife, who has stepped in to help with the daily goings-on of my practice, and I can’t thank her enough for her support. It’s all about finding the balance between your personal and professional responsibilities. I do not know'. As I come to the end of the formal training of the MSc and look towards my dissertation, I can say without a doubt that it has changed the way I practice for good. It has been an excellent course and I have thoroughly enjoyed the journey.

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Going Private

Roger Matthews reveals how making the transition to private practice does not have to be an ‘all or nothing’ decision for dental practices and looks at some of the private options which allow you to retain your NHS contract

In the current economic climate, the idea of ‘going private’ will leave many principals feeling a little nervous to say the least. After all, the NHS at least provides a relative, or perceived, level of security, so why would you want to put an entirely new funding option in place for your patients? What are my options? Because a full transition to private practice is such a daunting prospect, it’s really important to look closely at the problems you currently face in your practice and what options are available to you. The good news is that, in this day and age, the transition to private practice is not an ‘all or nothing’ choice and there are plenty of options available. The overwhelming majority of Denplan practices, for example, offer a mixed service of both NHS and private care and we’re able to guide them through the process one step at a time.

And, with so much change on the horizon once again with the NHS, it makes good business sense to look at the available options and the ways in which you can secure your practice’s success long into the future. What is it specifically that you want to achieve or change as a result of offering private care; which provider will offer you the best support; and do their values and aspirations mirror your own? Once you have the answers to these questions you can see whether a full or partial transfer is the best option for you or whether a slower transition to offering private care is the way to go.

You can, for example, undertake a principal only transition whereby the NHS contractual obligations are delivered by associates within the practice, and the principal focuses on private patients. As a result, the principal gains freedom from UDA targets and can benefit from the additional time spent with patients. The practice also benefits from increased revenue while retaining its NHS contract and offering patients a greater degree of choice.

Can a payment plan help? Offering a dental payment plan to patients wishing to benefit from private care can increase the practice’s stable, regular income, while providing a way for patients to budget for their dental care. It’s not uncommon to assume that patients will be unwilling or unable to afford such a service, but Denplan’s own research, undertaken by YouGov, has indicated that 15 per cent of regular attenders without a payment or cash plan, and over 23 per cent of Private Fee Per Item patients would consider buying a payment plan to help them budget for their dental care and treatment. Those who would consider buying a dental payment plan also said they would be willing to pay around £14.90 per month for it [Denplan / YouGov survey, January 2013 – total sample size was 4116 adults surveyed online. Figures have been weighted and are representative of all UK]

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Providing your patients with a range of options to pay for their treatment ensures their loyalty and can mean the difference between attendance and a depleted appointment book due to cancellations or postponed treatment in the current financial climate. It can also help you to differentiate yourself from the competition, increasing the success of your practice. Some payment plan specialists can also provide a wide range of value added services worth thousands of pounds as part of your membership and can provide the help and advice you need to ensure that, whatever your individual goals and aspirations may be, the transition runs smoothly and is as stress free as possible. This allows you to get back to the kind of dentistry you trained to deliver without worrying about the future. It sounds simple and, in the right circumstances, it can be.

Why now?
The current target-driven approach favoured by the NHs is believed by many to be at odds with the patient-focused approach that is at the foundation of professional training. This was cited by many as one of the main reasons for practices moving away from the NHs when the last new NHS contract was introduced in 2006. However, the Department of Health seems to have learned from these experiences and the piloting of new approaches to fund NHS dental care is well under way, although the confirmed details of such a new contract remain unknown.

The next version of the NHS contract does, therefore, need to learn and build from its past experiences, but it does so against a predicted future of flat healthcare spending and further budgetary constraints. It will also be at least another year before the evaluation of the NHS pilot outcomes is sufficient to inform a new contract. And, with a general election in May 2015, it would seem that the coalition’s commitment to introduce a new contract before then may be a tall order.

That said, it’s interesting to note the intention of introducing a new NHS dental contract based on registration, capitalisation and quality, with a focus on preventive care. This is a system that payment plan specialists such as Denplan have been operating and developing for more than a quarter of a century, with a rich history of helping practices achieve and sustain financial stability while being able to truly focus on helping patients to achieve optimal oral health.

With such a significant amount of turbulence inevitably on the cards for NHS dental care, it seems that, now more than ever, the question of making at least a partial transition to private practice is a viable one and a very real way of securing your practice income and future success.

- Denplan will be exhibiting at BD&A Dental Showcase in Birmingham. Visit Stand F10 to discuss what Denplan could do for your practice.

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The perfect answer to gagging

Dr Manuel Kalo presents a simple solution to help patients prone to gagging during the impression taking process

A 46 year old patient required the replacement of defective composite and amalgam restorations in teeth 14 and 15 with existing distal (14) and mesial (15) approximal carries (fig. 1).

The teeth were to be restored with ceramic restorations. A special challenge was the patient's pronounced gagging reflex.

In order to take an accurate impression of any cavity prepared according to minimally-invasive principles, the impression material must exhibit specific properties.

The wash material should be applicable without bubbles, remain in situ on the preparation without slumping, have optimal flow characteristics under pressure, and provide precise detail reproduction. The tray material should support the properties of the wash material. The preferred tray material should be one with a true putty consistency and with optimal resistance when positioned, in order not to trigger the patient's gagging reflex. Both materials should be suitable for the double-mixing technique with matching setting times.

For the double-mixing technique, DMG’s Honigum-MixStar Putty and Honigum-Light were used because these materials fulfilled all the above conditions. The materials were mixed in the MixStar-eMotion automatic mixing unit, which is programmable for working time and setting time in the mouth.

In order to guarantee stability of the impression material upon removal from the mouth, a non-perforated impression tray, coated with DMG Tray-

Fig. 1 Initial situation
Fig. 2 Preparing the cavities
Fig. 3 Applying DMG Tray-Adhesive
Fig. 4 Hygienic filling of the impression tray, using Honigum-MixStar Putty

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NEW!
Adhesive, was used.

**Procedure**

After removal of the defective restorations, excavation of the cavities, and preparation of the cavities (fig. 2), an impression was taken using the double-mixing technique.

For this purpose, the impression tray was first coated with Tray-Adhesive (fig. 3). While the assistant filled the impression tray with Honigum-MixStar Putty (fig. 4), the dentist filled the cavities and covered the occlusal surfaces of the adjacent teeth with bubble-free Honigum-Light (fig. 5). During the wash material’s 1:45 minute working time the impression tray was inserted in the patient’s mouth using light pressure and left in situ for at least 5:15 minutes. The acoustic signals of the MixStar-eMotion’s timer are very helpful for the clinician’s time management. After the setting time had elapsed, the impression was removed from the patient’s mouth, which, particularly in the area of the prepared teeth, must be done parallel to the axis of the teeth. The material’s putty consistency, which remains in that state even after hardening, makes this process significantly easier. After drying the impression, the result was inspected and the impression stored at a maximum temperature of 25°C.

*In order to take an accurate impression of any cavity prepared according to minimal-invasive principles, the impression material must exhibit specific properties."

The material properties of Honigum-MixStar Putty and Honigum-Light provided optimal results. The impression was a bubble-free, finely detailed reproduction of the entire preparation, including any difficult to access areas and preparation lines.

Thanks to the rheologically active matrix of Honigum-Light, which delivers excellent stability yet very good flow characteristics, and putty-like characteristics of Honigum-Mixstar Putty, which provides patient-friendly resistance, there was no irritation of the sensitive areas in the patient’s mouth due to overflowing or running impression material. Consequently no gagging occurred.

The precise reproduction of the preparations, by means of combining the two impression materials, was demonstrated impressively by the perfect fit of the final restorations (fig. 7).

**About the author**

Dr. Manuel Kalo - Winterhuder Weg 76A 22085 Hamburg Tel. +49 40 2279842 The complete DMG range, including Honigum, is distributed in the U.K and Ireland by DMG Dental Products (U.K) Ltd. For further information contact your local dealer or DMG Dental Products (UK) Ltd on 0044 1656 790601, fax 0044 1656 360100, email info@dmg-dental.co.uk or visit www.dmg-dental.com

**Fig. 5** Homogeneous and bubble-free syringing of the preparation, using Honigum-Light

**Fig. 6** Perfect impression result

**Fig. 7** Perfectly fitting final restorations

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On the fifth day of Stuart Hazell’s trial in May of this year he pleaded guilty for murdering 12-year-old Tia Sharp. He is someone who never had any record as a paedophile. A huge amount of people have said that she was better off leaving this world as it was a dysfunctional family. They lived with this person day in, day out and this was the mother and the grandmother. The law expects us, the professionals, to protect children, we have a huge responsibility; a moral obligation. I wonder how we do this when most cases of child abuse and neglect do not come to the notice of professionals. The above case is a classic example, which means that children like Tia (and more recently, four-year-old Daniel Pelka) continue to be harmed.

Key Position
Members of the healthcare sector, especially dental teams, are in a key position to observe potential signs of mistreatment; like everyone, they have a responsibility to report any concerns. We have a duty of care. All of us share the responsibility to follow practice procedure, local procedure and the national procedure for child protection. We may observe, feel, or hear something that causes us to suspect that a child is at risk of neglect or abuse. It is our utmost responsibility to take action and make the whole team aware and follow the procedures. Sharing information and sharing concerns is the key.

As a civilised country we lament and screech about child soldiers in Syria and child labour in Bangladesh. Jimmy Savile has left us a memoir; his malicious activities were shielded by his niche success and charity efforts, now it has been exposed by his death. It is sad he is not alive to witness his shame and it is a shame on the people and authorities who turned a blind eye to all this - or should I say the system failed these children.

Four Types of Abuse
There are four types of abuse - Physical, Emotional, Sexual and Neglect. It is of paramount importance we do not ignore the vital signs of any abuse. Children may have physical marks on their body or they can portray emotions or behavioural changes, which may be worth further scrutiny. We should speak about these topics in our staff meetings and enlighten the whole team. We should not let the innocent childhood be taken away from children at risk or let them die before they have even lived their life. This is the extreme end of child abuse. In American paediatric dentistry circles ‘wilful failure of parent or guardian to seek and follow through with treatment as necessary to ensure a level of oral health essential

Child Protection – a huge responsibility, a moral obligation
Dilhani Silva discusses spotting abuse of children in a dental setting
for adequate function and freedom from pain and infection' is dental neglect. Participating in Oral Health Education days in schools has given me a vital insight, especially for primary school children. They tell me ‘Mummy brings me sweets when she picks me up’ or ‘I have a milkshake before bed with a movie’. Statements such as these are endemic in our culture. I must admit this is often due to a lack of knowledge. This all boils down to one thing, as Tony Blair famously said - ‘Education, Education, Education’.

Most of all we should endeavour to protect children in the dental setting, as well as ensure a level of protection for ourselves. We all need to follow the guidelines from organisations such as the GDC, CQC etc and carry out enhanced CRB (now Disclosure and Barring Service (DBS) checks).

The General Dental Council’s Standards for Dental Professionals states: You must maintain appropriate boundaries in the relationships you have with patients. You must not take advantage of your position as a dental professional in your relationships with patients’.

Every dental practice should follow best practice steps to put in place child protection procedures. These include:

• Nominating a member of staff as the ‘Lead on child protection’
• Having a written child protection policy with Local Child Protection Lead details included
• Following a step-by-step guide of what to do if you have concerns
• Following best practice in record keeping
• Undertaking regular team training and staff meetings on the subject of child protection and safeguarding
• Practising safe staff recruitment procedures

If you are concerned about a child you should act on it promptly; please do not think someone else will take action. Approach the child in a friendly manner, take a history, examine and talk to the child. Do not ask leading questions. Ask the child and the parent/carer about what caused any obvious injuries, and take into account the child’s past dental history, their medical history and the family and social circumstances. Please do not be judgemental. Speak to your Child Protection Lead or a senior member of staff and follow the local child protection guidelines.

Further guidance

• All Wales child protection procedures http://www.allwalesunit.gov.uk/index.cfm?articleid=298
• The British Society of Paediatric Dentistry and the Royal College of Paediatrics and Child Health’s Procedures to be adopted by the dental professional who suspects child abuse http://www.rcpch.ac.uk/publications/recent_publications/GDC/CFinalNovember.pdf http://www.scottishdental.org/docs/proce_suspabuse.pdf (version for practices in Scotland)
• Educare child protection distance learning resource, written by the NSPCC (the first two modules are available free of charge) and supporting its campaign http://www.debrus-educare.co.uk/talktilitstops/
• Healthcare Learning: Smile-on has produced an online resource looking at the treatment and support of vulnerable children. Access the course for free http://elearning.smile-onnews.com/
• Local safeguarding children boards (These organisations help key agencies to work together) http://www.everychildmatters.gov.uk/locb/
• Scottish Dental child protection and the dental team resources http://www.scottishdental.org/resources/child_protection

About the author

Dilhani Silva
Practice Manager
Orthodontic clinic, Orthoclinic Limited.
Practice finance made simple
Becky Barnett details finance issues

So things are looking up if you listen to the news and the papers, although on the ground some would argue that the resistance to spend is still there. Our practice sales team are still going into practices who say that they haven’t been materially affected the patient books are still a little quieter than they were and patients continue to postpone big treatment plans not through not having the money but through fear of not having it!

However, from a practice finance perspective in honesty the ground hasn’t really moved in the last two years. We have an exciting new entrant in the market with a further two banks who aren’t active in the market at the moment in the crux of writing new credit policies to offer lending to dentists, but talk is talk and actually drawing down money is something entirely different. The new entrant openly admit to being more expensive but seek to compete on the grounds of being a different service offering and more informed credit team which is undoubtedly a draw given some of the big names’ reputation. However, the days of 1 per cent above base are still sat in the past alongside petrol at 69p a litre!

I tend to find that when first approached by prospective buyers, they are in the main inquisitive about how much money they will be allowed to borrow and at what interest rate. Although these are difficult questions to answer specifically as lending decisions are based fundamentally on the target practice(s) so we enter a chicken and egg style scenario.

However, with the average goodwill and equipment transaction value on Dental Elite’s rostrum being £95,045 it is becoming more challenging for first time buyers as popular practices now rarely trade for less than £50,000. However, there are a number of government schemes, pro-active healthcare managers and ambitious banks who will often find a way to make a deal work if it is presented in the right way:

• Presentation is Key; when you are presented with a set of accounts for a practice everyone knows that these accounts have been subject to some legal manipulation to mitigate the annual sum paid to George Osborne! Motor Expenses / Spouse’s Salaries, I’m sure you know the drill but of course you shouldn’t rely on your Bank Manager to find these to make your proposal attractive to credit. If you want the practice we are going to have to demonstrate to the lenders that this deal works and that it is a good business with a good profit margin. Further if you are going to add additional services or reduce overheads in the business to improve the bottom line, build it into a cash flow forecast and a supporting business plan if appropriate.

• Be Comfortable with the Target Practice: Two of the modal lenders in the sector instruct a chartered valuation as a matter of course which seeks to confirm your offer for the practice. Eight times out of ten this valuation will come in at the level you have offered for the practice but there are occasions, especially on very popular practices that the value comes in below that, that you have offered. Whilst we work with the valuers to give them the most accurate information to support the value offered, annoyingly it is a fairly frequent occurrence that the value doesn’t marry up. Depending on the lender the amount

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Interested in endogenetics? To visit DB’s Stand N03 and N05 will hold the key to endogenetic therapy.

Chloe@totaldental.co.uk

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Phils launches recommended scheme for AirFloss and SuperEndo handpieces

In the run up to Christmas gifting period, Philips has launched a recommendation scheme for dental practices who prefer not to dispense products. Participating practices will be provided with vouchers which their patients can give to their in the right direction to buy a SuperEndo toothbrush or AirFloss. The vouchers will be redeemable in Boots stores and can be added incentive to encourage patients to purchase, they offer a £12.50 discount. This is in addition to any in store promotions which are running The vouchers are provided for practices to tear off from a freestanding stand on display unit for SoniCare – which is valid on all brushes in the counter top display unit; one for Sonicare – which is valid on all brushes in the bin. Lucky delegates each day can try the Sonicare AirFloss at one of the brushing stations on Philips’ stand (P06) at the BDTA Conference and can take it away with them for free. This follows a similar initiative at the product’s unveiling at the BDTA Conference earlier in the year when 100 delegates trialled an AirFloss. The early trialists evaluated their AirFloss for thirty days and results were beyond Philips expectations, 95 per cent would recommend it to their patients, friends or colleagues.

More than 95 per cent agree that AirFloss is easy to use (for their patients) and 80 per cent believe that AirFloss will be effective for use with orthodontic patients.

Other highlights of a stand visit will be a chance to see the new SoniCare FlexCare Platinum – the most innovative sonic toothbrush to be developed by Philips – and the new Sonicare AirFloss mini, which eliminates even more plaque from between the teeth than a manual and has a built-in pressure sensor to prevent patients from over brushing.

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Bupa and AXA PPP, with an astonishing 50% recognition rate*. As the only company direct on 0800 0567 222.

For further information on the complete range of Heka Dental equipment visit Stand N03 and N05, contact DB Dental on 01484 401015 or visit www.hekadal.com.

For further information about Denplan email info@dentalfacts.co.uk or visit www.denplan.com.

For further information please contact Chloe Booth on 01725 261657 email: chloe@totaldental.co.uk
Help your patients achieve the best Waterpik® Water Flosser to exhibit at the BDMA Dental Showcase 2013. Do you want to help your patients achieve excellent oral health? You have discovered the benefits of the Waterpik® Water Flosser. Exhibiting at this year's BDMA Dental Showcase, the team will be on hand to offer any information or advice you may need on the Waterpik® Water Flosser. Water Flosser, for example, has been proven to remove up to 99.9% of plaque and food debris. Waterpik® team will be on hand to provide any information or advice you may need on the Waterpik® Water Flosser.

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Constitc self-etching and adhesive flowable composite is a new 3-in-1 flowable composite combines etching gel, bonding agent and adhesive flowable composite. Available in six shades (A1, A2, A3, A3.5, B1 and Opaque-White), Constitc is a fast-setting, one-step adhesive system that is simple to apply and light-cured. Constitc can be used for a minimally invasive procedure and adhesive flowable composite eliminates both the etching and bonding steps and saves valuable time too. Post-operative sensitivity is also markedly reduced. Constitc is easier to use than traditional etchant-and-adhesive systems. DMG’s NEW Constitc self-etching and adhesive flowable composite is ideal for MID: When restoring teeth as part of a minimally invasive procedure such as direct white fillings, it is great to save another time too? DMG’s NEW Constitc self-etching and adhesive flowable composite is ideal for MID: When restoring teeth as part of a minimally invasive procedure such as direct white fillings, it is great to save another time too?

For further information please contact: Constance Chui, Constance.Dental@bupa.co.uk or visit: www.sparkle-dental.com or www.sparkle-dental-labs.com

Support the UK dental technician trade with Sparkle Dental Labs Sparkle Dental Labs is a Leeds-based dental laboratory that is looking to support the local UK dental technician trade, which has suffered in recent times due to work being outsourced to cheaper alternatives. Delegates attending this year’s BDMA Dental Showcase will have a chance to meet with a member of the Sparkle Dental Labs team about the array of services that they offer and the quality of the dental products that they produce. Sparkle Dental Labs has over 2,000 products from which to choose, with a range of cereals medium to high quality of dental products, enabling them as one of the UK’s leading suppliers.

To speak with a member of the Sparkle Dental Labs team you can find them on stand M9 at the year’s BDMA Dental Showcase, which takes place from October 17th-19th at the NEC in Birmingham.

For any additional information please call 01386 450902 or email customerservice@sparkledentallabs.com or visit: www.sparkle-dental-labs.com

Zesty is an online booking service that makes finding new patients simple. The service allows patients looking for cosmetic dentistry to find the right practice for them and book an appointment with only a few of clicks of a button. With enquiries about cosmetic treatments to your practice.

To find out more about the MSc in Restorative & Aesthetic Dentistry, please call 020 7400 9389 or email info@healthcare-learning.com

Journey through an MSc in Restorative & Aesthetic Dentistry With Dr Oiler Harman Dr Oiler Harman is now coming to the end of his two-year MSc in Restorative & Aesthetic Dentistry, with only a couple of weeks before the dissertation section of the course. Delegates to advance practitioners’ skills in this area, the course is provided by renowned education provider Healthcare Learning. Smile on in collaboration with the University of Manchester. This MSc course has been superb. I experienced a different style of teaching throughout this course – it was a real mix of theory and the things to do with patients. It was an exciting course to be involved in.
The CONELOG® Implant System offers a comprehensive prosthetic portfolio for all indications. The conical implant/abutment connection with its proven CAMLOG positioning through three grooves and cams provides maximum precision and user-friendliness. Rounding off its overall offer with an exceptional price-performance ratio, CAMLOG has become the trusted supplier of choice for numerous implant professionals. More information: www.camlog.com

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