Satisfied, but not enough

Office of Fair Trading (OFT) report makes recommendations to free patients from restriction of dentist referral

Evidence gathered in the recent Office of Fair Trading report, has suggested “that dental patients are largely satisfied with the services provided by their dentist.” However, the report has also highlighted some areas for improvement.

The OFT study found that patients have insufficient information to make informed decisions about their choice of dentist and the dental treatments they receive; it also stated the complexity of the complaints process for patients, instances of potential pressure selling by dentists of dental payment plans and the need for accurate and timely information for patients. The OFT is calling on NHS commissioning bodies, the General Dental Council and the Care Quality Commission to be proactive in enforces rules which require dentists and dental practices to provide timely, clear and accurate information to patients about prices and available dental treatments.

The report also raised significant concerns about continued restrictions preventing patients from directly accessing dental care professionals, such as hygienists, without a referral from a dentist. The report considered these restrictions to be highly unjustified, and the OFT have responded by urging the General Dental Council (GDC) to remove restrictions preventing patients from making appointments to see dental hygienists, dental therapists and clinical dental technicians directly, as soon as possible.

The OFT report also highlighted concerns with the current NHS dental contracts in England and stated how it is extremely difficult for new dental practices to be established and how successful dental practices, which offer a higher quality of service to NHS patients, are prevented from expanding.

As a result, the OFT has urged the Department of Health to review the NHS dental contract to facilitate easier entry into the market by new dental practices and allow successful practices to expand.

"Also crucial is the development of a new dental contract which is already under way in England. In piloting and design ing those new arrangements Government must ensure that it provides clarity about what the NHS offers and properly supports practitioners in providing the kind of modern, preventive care that our patients deserve."

Dr Nigel Carter Chief Executive of the British Dental Health Foundation (BDHF) said in response to the OFT report: “Whilst we welcome the report and the fact it recognises the need for change in certain areas, some of the findings are extremely difficult for new dental practices to be established and how successful dental practices, which offer a higher quality of service to NHS patients, are prevented from expanding.”

"This study has also highlighted that the current NHS dental contract in England may well not be working in the best interests of patients, and that regulations unjustifiably restrict patients from getting direct access to dental care professionals like hygienists. Reform in both these areas is needed without delay."

In response to the report, Dr Susie Sanderson, Chair of the BDA’s Executive Board,

"Where patients do have concerns about their care, it is clearly important that they have an effective complaints process. This is helpful for dentists and patients alike and dentists support the goal of making the process as simple as possible."

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From strength to strength – Clinical Innovations Conference 2012

The ninth annual Clinical Innovations Conference has been hailed a ‘fantastic success’ from delegates and organisers alike. Dental Tribune was there...

Delegates and exhibitors mingle

The Clinical Innovations Conference 2012, organised by Smile-on and the AOG and in association with The Dental Directory, was a fantastic success, boasting world-class speakers, cutting edge topics and practical advice for the many dental professionals in attendance.

Held last month at the Millennium Gloucester Hotel in London, the event saw more than 400 visitors from across the country come together for the two-day event.

As befits one of the leading aesthetic and restorative conferences held in the UK, delegates were able to expand and develop their understanding of ideas and techniques with help from some of the top names in the field. For the first time, the event included a London Deanery DFT Conference, running alongside the Clinical Innovations Conference, providing more variety and attracting a number of additional practitioners.

The event began on the Friday, with world-renowned Dr Nasser Barghi speaking on ‘All-Ceramic and CAD/CAM Restorations in 2012: Clinical Steps’, to a highly attentive audience. Always a popular speaker, Dr Barghi’s look at restorative materials and the best indication for each was both practical and entertaining.

After the coffee break the conference split into two streams: Dr Wyman Chan and Dr Anthony Roberts. Dr Chan gave a lecture on ‘Modern Bleaching Techniques’. As a dedicated tooth-whitening dentist, Dr Chan focused on bleaching techniques and the science behind the products he uses, as well as running a live demonstration alongside his lecture, with his dental nurse.

Simultaneously, Anthony Roberts spoke about ‘The Periodontal Jigsaw: Putting it all Together’. Looking at what a measure of success in periodontal treatment might mean for both clinicians and patients, Dr Roberts discussed PPE charting and the journey of diagnosis. He also explained the clinician’s role as motivator, communicator and educator in addition to their clinical capacity for the best treatment for patients.

The afternoon continued the high standard of speakers, with Richard Kahan giving an enthusiastic talk on ‘New Horizons in Endodontic Diagnosis and Treatment Planning’.

Comparing the dental and medical industries, Richard highlighted the issue that dentistry has a far smaller range of tests to use when diagnosing a patient’s complaint. In fact, the only truly objective test is an X-Ray. This is not however, a totally reliable tool, as its limitations can affect the results shown. If an X-Ray does not show a specific problem that does not necessarily mean there is nothing wrong – if a lesion for example is limited to cancellous bone, an X-Ray will not show it at all.

In effect, an X-Ray gives a ‘shadow’ of the tooth structure, so a 2nd and 3rd dimension is needed for an accurate diagnosis. The Limited Volume Cone Beam Computed Tomography (CBCT) gives this, and allows for a reliable and immediate diagnosis; preventing the possibility of working on the wrong tooth and causing more problems than existed originally.

Nasser Barghi, Mhari Coxon and Fraser McCord then separated the conference into three streams, speaking on ‘Bonded All Ceramic Restorations in 2012’, ‘Effective Biofilm Management’ and ‘Diagnosis of Complete Denture Problems’ respectively.

Fraser McCord took over the lectures to discuss the best techniques for diagnosing problems with complete dentures. He was quick to establish five main areas where problems arise; • Support (resistance to movement towards the tissues)

• Retention (resistance to movement away from the tissues)

• Stability (resistance to movement horizontal forces)

• Appearance

• Miscellaneous

To diagnose each, Dr McCord recommended a hands-on approach, tracing the dentures while in the patients’ mouths to find where problems could be occurring.

Dr McCord concluded his lecture with a few pointers to aid success with complete dentures. The first was that practitioners should ensure they use the suitable diagnostic treatment with confidence and competency. Patients’ expectations should also be kept realistic and the dentures should be age appropriate, helping them to look as natural as possible. Finally, good communication with the tech.

Visitors receive their passes and day programmes
achieved if the most appropri-

dant treatment can only be
showed that success of endo-
dicates instrumentation’, he
believer that the ‘Anatomy

dontic problems. As a great
looked at techniques to treat

Techniques’. Discussing the
Endodontics: Concepts and
Gambarini lecturing on ‘3D
ed with Professor Gianluca

Dr Wyman Chan during his live demonstration

Dr ’s lecture was ‘An

update on recent research
into biofilm, Ms Coxon illus-
trated the four stages of bio-
film development and showed
5-D images of biofilm in its
various stages of attachment,
growth, maturity and dispers-
al. She then went on to dis-
cuss the methods of removing
biofilm and the evidence to
support their use.

The first day conclud-
ed with Professor Gianluca
Gambarrini lecturing on ‘3D
Endodontics: Concepts and
Techniques’. Discussing the
benefits of cone beam tech-
nology, he illustrated the im-
portance of working with 3D
images to diagnose patients’
complaints.

Professor Gambarrini then
looked at techniques to treat
a variety of complicated en-
dodontic problems. As a great
believer that the ‘Anatomy
dictates instrumentation’, he
showed that success of endo-
donc treatment can only be
achieved if the most appropri-
ate tools and techniques are
adopted for each case.

The London Deanery DFT
Conference was for London
Deanery Foundation dentist
attendees only, and proved to
be a popular addition. The
exciting new programme fea-
tured captivating lectures from
Richard Kahan, Nasser
Barghi, Martyn Cobourne,
Stephen Henderson and Dr
Wyman Chan.

As the Conference split
into three sessions again, Pro-
fessor Gambarini returned to
speak about ‘Improving Root
Canal Preparation and Obtu-
ration’. Simultaneously, Ajay
Kakar lectured on ‘Non Surgi-
cal Management of Periodon-
tal Disease’, Sandeep Sengh-
era discussed ‘Treating Your
Patients and Business to the
Latest in Technology’ and Dr
Nasser Barghi spoke about
CAD/CAM Zirconia to MSc
students.

Dr ’s presenta-
tion was a practical look at
marketing your practice to
new and existing patients us-
ing the technology that many
use daily in their personal
lives – smartphones, social
media etc. Likening the pa-
tient base to a bath with water
running in and out, he emphasised the need to
ensure patients are retained
with smart recall processes and
timesaving strategies for
patients such as online ap-
pointment booking.

John Moore then took
over the speaking to explore
‘Digital Dentistry and the Ad-
vantages for Cosmetic Treat-
mants’. Primarily discussing
how his practice is using the
CEREC system to their advan-
tage, Dr Moore showed how
clinicians can use CAD/CAM
in their practices to fulfil pa-

tients’ requirements.

Dr Barghi returned again
in the afternoon to repeat his

The London
Deanery DFT
Conference proved
to be a popular
edition’

In the evening, the event
hosted its third annual Char-
ity Ball, where hundreds of
dellegates dressed to impress.
Attendees were greeted by a
champagne reception, and
were able to relax and enjoy a
sumptuous three-course meal,
live entertainment in the form
of dentist-turned-magician Dr
Raj Rattan and fantastic com-
pany. As part of the evening,
the brand new Clinical Inno-

vations Award was launched,
designed to showcase the
best, most innovative products
currently on the market (see
pages 48&5 about the award).
Dinner was then followed by
dancing and a fabulous party
into the night.

The morning after the
night before is always a tough
start, but with speakers such
as Basil Mizrahi and Ajay
Kakar to look forward to del-
egates were fired up for the
Saturday programme.

Dr Mizrahi discussed ‘Clin-
ical Tips and Techniques to
improve the aesthetic and
biochemical precision of your
dentistry’. A very practical-
based lecture, Dr Mizrahi
looked at ways to make the
preparation of teeth easier;
from the use of loupes for bet-
ter vision to the type of hand-

piece used for prepping teeth.
Various issues surrounding

restorations were discussed;
from dealing with microleak-
age to the problem of bonding
to dentine.

The Clinical Innovations
Conference 2012 came to a
close on the Saturday after-
noon, with Dr Amit Patel
speaking on ‘Peri-implantitis –
a Future Timebomb’. With
the growing trend of placing
dental implants, cases of peri-
implantitis and peri-mucositis
will inevitably increase.

Dr Patel discussed the
process of the inflammation
and the reasons for it, look-
ing at prosthesis design. He
discussed his preferences for
screw-retained restorations and
looked at therapies for
managing the inflammation.

One of the many strengths
of the Clinical Innovations
Conference is that it com-
bines lectures with live work-
shops, demonstrations and a
trade exhibition, to cater to
practitioners’ every need.
Between lectures, delegates
were able to browse the exhi-
bition stands, accessing some
of the latest technologies in
the world of aesthetic and
restorative dentistry, and put
their questions directly to
the experts at each company.

Feedback from the event
has been fantastic, with many
delegates already penning the
2015 date in their diary. next
year’s event, the tenth anni-
versary of the Clinical Innova-
tions Conference, will be held
17-18th May 2015. See you
there!
Rewarding innovation

*Dental Tribune* looks at the first Clinical Innovation Award finalists

The first ever Clinical Innovations Award, a fantastic new prize designed to showcase the best, most innovative products on the market today, was held this year at the Clinical Innovations Conference Charity Ball.

The Clinical Innovations Conference, now in its ninth year, has become one of the leading conferences in aesthetic and restorative dentistry in the UK. The conference itself brings together top international thinkers who present the very latest developments in dentistry.

In keeping with the theme of the lectures, these conferences have become the backdrop for companies to expose the genius of their innovative products. Smile-on and the AOG invited the dental industry to nominate their most innovative product to be judged by a panel of experts.

There was a fantastic range of entries, some of which were described as “breathtakingly brilliant”, others of which were defined as “superbly practical”; all were distinguished as having innovation at the heart of their solutions.

The judging panel consisted of a number of esteemed dental professionals, as well as members of a number of key journal editorial boards. As the award ceremony got underway, the judges were keen to comment on the variety and excellence of all the products short-listed, which had given the panel “great admiration” for all the companies involved. With such a strong short-list, picking a final three was tough, and the judges were particularly interested to examine innovation for dentistry as a profession – not just in the product itself.

With such a strong line-up of potential winners, the winner of the inaugural Clinical Innovations Award really had to stand out above the rest and after much careful deliberation, Dean of the London Deanery Mrs Elizabeth Jones announced the winners.

The winner was the Morita Veraviewepocs 3D R100 X-ray machine and according to the judges it was a cut above the rest:

"This is an amazing development. No one thought anyone could achieve it. The field of vision in the right trough providing accurate information has been almost impossible with rotational devices. This is a technological breakthrough of increasing an 80mm diameter cylindrical field of vision to 100mm triangulated field of vision – to simulate the shape of the triangulated mandible, now includes the missing anatomy without exposing other tissue. This improves accurate detailing and will enhance patient safety when diagnosis and treatment planning is undertaken."

Launched in March 2012 the Veraviewepocs 3D R100 is the latest model in the Veraviewepocs 3D series of combination panoramic, cephal & cone beam CT devices. It re-defines the concept of 3D imaging with a unique Reuleaux Triangular FOV which more accurately matches the shape of the patients’ jaw. The R100 FOV in-
cludes relevant anatomy that would be imaged with a 100mm circular diameter cross section but excludes irrelevant tissues outside the jawline. Not only was it previously considered impossible to achieve anything other than a circular cross section, but by achieving this, the X-ray dose to the patient is comparatively lower by around 15 per cent. With such powerful implications for enhanced patient safety, the R100 is the deserving winner of the first ever Clinical Innovations Award.

The highly commended award went to W&H with its entry the Proface light probe. Despite all the years of research in the field, detecting caries remains difficult. Where previous caries detection devices have generally been chemical based leaving stains, the Proface light probe was commended for its innovative approach that, while not perfect, provides the right approach to ‘evidence’ in knowing when to stop treating.

This new innovation allows direct visual identification of the caries-infected areas, thereby enabling selective treatment during caries excavation due to the ease of detecting the caries. Proface enables simple identification of the extent of a carious lesion allowing the clinician to ensure that subsequent excavation is minimally invasive and leaves healthy tooth structure intact. It also allows the clinician the confidence of knowing that they have eradicated the entire caries.

The commended award went to NSK S-MAX PICO HANDPIECE. In the modern era of micro cutting and magnification, this handpiece reduces the size of its head to allow wider visibility and better access to the posterior regions of the mouth where mouth opening is restricted, or in children and patients where mouth opening is limited. This handpiece has the smallest neck and head size yet developed in dentistry and the NSK’s S-Max pico ultra-mini turbine has been specifically developed for minimally invasive (MI) procedures. The technical specification of this handpiece’s cutting ability for such a small head is impressive. This is minimalistic functional art in action.

Finalists for the award were:
- The Carestream CS7600, the world’s first Intelligent Image Plate System
- COMPONEER from Coltene/Whaledent, Direct Composite Shells that represent a completely new class of veneers
- Tri Plaque ID Gel from GC UK, a gel that allows you and your patient to identify areas of plaque in three easy steps
- Propoints from Smart Seal,
flawed and out of date. The Steele Review, which was commissioned by the last government, has already addressed the concerns raised around the 2006 NHS Contracts and a replacement proposal is already being pilot. The results of this will be used to help shape the future of the way NHS dentistry is delivered.

“The recommendation for the GDC to require that private contracts should be open to public scrutiny is irrelevant. A dentist should provide a patient with a treatment plan, and as each patient’s plan is different, fixed pricing will lead to confusion and the possibility of disappointed patient expectations.

“The report suggests that patients should be given direct access to dental hygienist and therapists. And whilst supporting this recommendation, as we believe it may facilitate a better understanding of oral health and encourage new patients and more referrals to the dentist, it must be done under caution.

“This report should not be taken as final and it may set the future of dentistry in the UK and if taken in isolation it does not deliver a satisfactory solution for the patients or the dental health profession. The findings of the OFT report need to be included and reviewed as a part of the education, research and change which needs to happen to deliver the best quality dental care.”

David Worskett, Chair of the Association of Dental Groups (ADG) said: “The Association of Dental Groups, which represents the larger corporate providers of dentistry and Dental Groups, welcomes the OFT’s market study of dentistry in the UK and supports many of its key conclusions.

“In particular, ADG members, who account for some 10 per cent of NHS dentistry, support provision of clearer pricing information and are pleased to have been able to reach agreement with the OFT on ways of extending and improving this.

“The ADG supports the OFT’s emphasis on choice and competition in dentistry. Members welcome the emphasis in the report on improving entry to the market for new providers and the support the OFT gives to increasing tendering. Long-term contracts facilitate investment and continuity of patient care but must not prevent commissioners from tackling poor quality. The OFT’s recommendation to the sector and to the Department of Health have the potential to improve quality for patients and help to drive up standards, particularly when taken in conjunction with the new NHS dental contract, which addresses many of the worst problems identified by the OFT in the current arrangements.

“Clinical opinion in the UK remains divided over the issue of direct access to some dental services and the ADG believes that it is clinical considerations that should determine whether to go down this route. The ADG therefore awaits with interest the work already being undertaken by the GDC on this.

“It is of course vital that im

GPs draw the line at CQC reg fee payment

A

ccording to a recent report, it has been agreed by the local medical committee’s conference that GP practices should not have to pay for CQC (Care Quality Commis- sion) registration.

North Yorkshire GP Brian McGregor said in the report that GP practices were “already sub- jected to oversight from 28 or- ganisations and the CQC would become the twenty-ninth as of next April.”

Dr McGregor won support for his demand that registration should not impose any expense on practices.

He said: “It’s a bit like medi- eval times, giving a piece of sil- ver to the axe-man to ensure the sweep was sure. The ultimate cost of registration should not fall on GPs.”

The report also quoted Gloucestershire GP Steve Avis, who said he did not want his GP practice to become a stark envi-

ment Award.

“...the best quality dental care.”

According to the report, the conference called on the CQC to take “as cure-all for the future of the way NHS dentistry and the OFT is completely right to draw attention to the worst types of abuse. ADG members already have very high standards of clini- cal and corporate governance designed to prevent abuse and protect patients.

“However it is welcome news that the level of abusive practices is put into perspec- tive by the very high levels of complaints and in practice there is already con- siderable choice and com- petition on the high street, bringing real benefits to pa- tients. The ADG agrees with the OFT that the overall assessment of the market does not require or justify a referral to the Competition Commission.”

All smiles as professor scoops Lifetime Achievement Award

The former dean of Dundee Dental School and chair of the Dental Schools Council, Professor William Saunders has received the first ever Scottish Dental Life- time Achievement Award par- ing tribute to his commitment to the dental industry in Scotland.

Professor Saunders has made a substantial contribution to dentistry in Scotland over many years and has been pivotal in the development of both undergraduate and postgraduate teaching. He also sits as a council member of the Royal College of Surgeons of Edinburgh.

Four of Scotland’s top dental professionals were nominated for the award - Professor Saun- ders was up against Dr Graham McKirdy from Glasgow, Edin- burgh’s Dr Jim Rennie CBE and Dr Hew Mathewson CBE. Fel- low industry professionals voted online making Professor Saun- ders the clear winner.

He received the accolade at an evening drinks reception dur- ing the inaugural Scottish Den- tal Show at Glasgow’s Hampden Park on Thursday 24 May. BBC sports pundit Chic Young, who entertained guests with dental tales and football anecdotes, pre- sented the trophy.

Bruce Osborne, editor of Scot- tish Dental magazine, organis- ers of the Scottish Dental Show and Scottish Dental Lifetime Achievement Award 2012, said: “Professor Saunders fellow pro- fessionals admired his continued commitment and his exceptional academic work making him a worthy winner of the first Scot- tish Dental Lifetime Achieve- ment Award.

“Employing more than 10,000 professionals in Scotland, dentistry is a significant industry and Professor Saunders influ- ential work can ensure that the country continues to produce the very finest graduates.”

The award was one of the highlights of the Scottish Dental Show, where more than 100 ex- hibitors representing the cream of the UK dental trade have been showcasing the latest innova- tions, product developments, services and laboratories.

Created by the Connect Pub- lications a subsidiary of Scot- tland’s largest contract publisher Connect Communications and the publishers of Scottish Den- tal magazine, the free event is providing up to 12 hours of veri- fiable CPD through speaker ses- sions and hands-on workshops. The Minister for Public Health, Michael Matheson MSP officially opened the show. ■

It has been agreed that GP’s should be spared the fee to register with CQC.

According to the report, which GP practices to inspect and reiterated its belief that reg- istration was a bridge too far.

Richard Howarth, a 45-year-old dentist from East Kilbride, is tak- ing up a fund-raising challenge to dive in a shark-infested tank!

Richard, who has been invit- ed to do the charity event at the Blue Planet Aquarium, Manches- ter, will be cleaning the teeth of a shark named Storm, an 11.5ft Sand Tiger Shark who weighs in at a staggering 50 stone!

For the challenge Richard, who is taking specialist training before spending half an hour in the chilly shark infested tank, will be equipped with a tooth- brush so he can clean Storm’s 46 razor-like teeth!

Richard hopes to raise £2,000 through this challenge for the charity Dental Mavericks and their work to end the daily den- tal pain for Moroccan kids. The money will help buy a solar powered dental chair so that more conventional dental care can be provided rather than just extractions and fillings for the charity Dental Mavericks and their work to end the daily den- tal pain for Moroccan kids.

Richard Howarth, who is a member of the Dental Mavericks Charity, is travelling to Morocco in September for eight days to treat children in severe dental pain with no access to dental care. Richard said: “The idea for this crazy dive came from a pa- tient of mine, I think they find it funny that I spend my life help- ing patients who are anxious and fearful. And for me to im- mense myself in the tank then the tables would be turned.”

Richard has been invited to do the charity event at the Blue Planet Aquarium, Manchester from 10.30pm to 1.30pm on 8 June 2012. ■

Dentist to clean shark’s teeth

Richard Howarth, a 45-year-old dentist from East Kilbride, is tak- ing up a fund-raising challenge to dive in a shark-infested tank!

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Editorial comment

The news today has been dominated by the Office of Fair Trading’s report into dentistry and the recommendations that they have made. People from all areas of the profession have been making their cases in a variety of media – radio, TV, newspapers etc – aiming to downplay what many have called the sensationalising of the report.

Yet again the drum of evil dentist misleading patients has been banged, trying to drown out the fact that the majority of those who responded (and that was 3450 people) are actually satisfied with the dental care they receive.

Statistics, as we all know, can be twisted to prove anything. In my post-graduate days as a green and grateful marketing assistant for a firm selling telephone systems, I had to ring local businesses to find out about their systems for a university-based project. Treated as a loathsome cold calling salesperson, I had to take the figures from the nine companies who bothered to talk to me and make a presentation out of them. With the use of the times by five principal and some lovely pie charts, I made a fantastic presentation that bore no resemblance to the true situation of the telephone system usage of the city’s local businesses.

Sound familiar? Thought so.

Dental training needs ‘urgent consideration’

The recent Health Select Committee report on Education, Training and Workforce Planning highlights a failure to adequately consider the dental issues that must be tackled, the British Dental Association (BDA) has said. This must be addressed urgently, the BDA believes, by proper consideration of how changes might affect dentistry and what must be done to support dental training.

The report, which notes a lack of vital detail in plans for the reform of the training and education of healthcare workers, has nonetheless failed to pick up properly on warnings in the BDA’s submission to the Health Select Committee inquiry, meaning that the issue of how the training of dentists and their teams will be paid for is still unclear. Detailed assurances that dental practices will not be expected to pay for training, a scenario that would be completely unacceptable, are urgently required, the BDA believes.

Dr Judith Husband, Chair of the BDA’s Education and Standards Committee, said: “This report reminds us that the Government’s plans are still lacking in important detail and require significant further development. Disappointingly, differences between medical and dental training remain unacknowledged and dental-specific issues have not been addressed.

“The BDA has been pressing for clarity on these issues. That they continue to be unresolved is a source of frustration and anxiety for dental practice owners. Dentists need to see a bold, unambiguous statement from Government that confirms that they are not to be landed with a huge financial burden for training future generations of the profession.”

References:
1. Barnett ML. JADA 2006;137:16S-21S.
2. Data on file FCLGBP0023+28, McNeil PPC.
Buying smarter could save NHS £1.2bn

Traditionally, the NHS has struggled to make the most of its buying power as there was very little knowledge between local hospitals about their equipment needs. This fund allows the NHS to benefit from the savings of bulk buying expensive medical equipment via NHS Supply Chain.

Health Minister Simon Burns said: “This is a golden opportunity when we know where there are simple solutions. That is why the NHS needs to buy smarter and get the best value for the taxpayer for every penny spent.

“We know that at least £1.2 billion could be saved over the next four years if the NHS innovatively changes the way it buys goods and services.

“Already, over £11 million has been saved through bulk buy discounts on the cash fund. This is the first step to better, smarter procurement in the NHS and we will be working closely with hospital trusts over the next six months to help them save even more money that can be reinvested in patient care.”

The recommended life of the majority of equipment, such as CT and MRI scanners is ten years, after which it either needs updating or replacing because of wear and tear. There are over 200 of these large-scale items that need replacing over the next four years. The NHS Supply Chain are able to secure better bulk buys deals for the NHS with suppliers. As equipment is purchased by trusts, payment for it will go back into the fund, effectively replenishing it for future use.

Andy Brown Managing Director of Business Solutions for NHS Supply Chain said: “This important development will allow NHS Supply Chain to group together the purchasing power of the NHS for this vital equipment, make large commitments to suppliers and bring improved planning to the management and replacement of this equipment across the NHS and with suppliers.”

Procurement plays a valuable role in driving improvement in so many ways. Better procurement means these savings can be reinvested to benefit patients. Our ambition is to put in place a world-class procurement system in the NHS that is responsive to modern suppliers. This will enable the NHS to adopt existing innovations and stimulate new ones that will benefit patients and taxpayers.

In addition, hospitals are now being asked to drive forward improvements through a series of actions, from more transparent and assessing how they buy equipment and services, including:

- Publish the details of all contracts over £10,000
- Appoint a board executive to be accountable for procurement performance
- Regularly audit procurement

These actions in Raising Our Game will be taken forward immediately, whilst the strategy for developing world-class procurement will be published later this year.

It is vital that we have procurement that is not only better, but is world class. As a first step, Raising Our Game sets out the actions that the NHS must take immediately. It should be focused on outcomes, not just cost, and must be responsive to creative ideas from suppliers, procurement specialists, clinicians and managers.

Transformation procuring in the NHS could enhance quality and value and we shall be focusing on the development of the strategy for delivering this which will be published later this year.

Trade a smile for a ‘smiley’

Smile Month. All you need to do is make us smile!“Smileys” to aid their event, simulations the chance to win 300 in the Somerset Primary Care District currently working for the Somerset Primary Care District. She plans to celebrate her retirement in June with a ‘Grand Tour’, in aid of Dentaid, visiting each of the county’s ten clinics in turn – about 200 miles – backpacking with a lightweight tent.

Starting on June 28th, the route will take her from her home in the Mendips to Frome, Yeovil, Chard, Taunton, Wellington, Minehead, Bridgwater, Burnham-on-Sea, Wells, Glastonbury and home, covering about 25 miles per day, using many of the long distance footpaths in Somerset.

She writes: “Dentaid's aims sum up many of the areas of dentistry in which I have been involved – the wider aspects of delivery of care to populations; issues of access and reaching out to the more vulnerable; prevention and education.”

Sponsorship donations to benefit Dentaid will be much appreciated and can be made at www.justgiving.com/elizabeth-may1.

“Grand Tour” to benefit Dentaid

Trade a smile for a ‘smiley’

W

ant to take part in Na
tional Smile Month? Struggling for ideas? Budget too tight? Make the BDHF smile and they can help.

Campaign organisers the British Dental Health Foundation are offering five organisations the chance to win 500 ‘smileys’ to aid their event, simply by making them smile.

So how does it work? Well, you can post your idea on their website, Facebook fan page, on Twitter or email them. They’ll pick out your favourite and voila – free ‘smileys’. The contact details you will need can be found below.

Dr Nigel Carter, Chief Executive of the Foundation, said: “So far the campaign has generated an excellent response. It is extremely pleasing to see such a variety of organisations taking part in this year’s campaign.

“We hope by making so many ‘smileys’ available free of charge that more organisations will come forward and help us spread the messages of National Smile Month. All you need to do is make us smile!”

Submit your attempts to make the BDHF smile by 5pm on Friday 8 June at the following places to be in with a chance of winning:

- www.smilemonth.org/page/competition
- Facebook fan page – National Smile Month
- Twitter – @smilemonth, @DAVIDB_DHF
- Email – pd@bdhf.org.uk

For further information please visit www.smilemonth.org or call 01478 539762.

Starting on June 28th, the route will take her from her home in the Mendips to Frome, Yeovil, Chard, Taunton, Wellington, Minehead, Bridgwater, Burnham-on-Sea, Wells, Glastonbury and home, cover-

Fiona Caldcott, Chairwoman of the independent Information Governance Review Panel, has selected the members of the panel who will conduct the review. The aim of the Review is to advise on how to achieve a better balance between protecting and sharing confidential personal information.

The members of the Review, entitled ‘Information: to share or not to share?’ have been drawn from patient and voluntary groups, clinical and local government professionals. Further information is available at www.Caldcott2.dbh.gov.uk

Dame Fiona Caldcott, Chair of the Review, said: “I am delighted that the individuals who we invited to participate in this work have accepted enthusiastically. They will play a crucial role in ensuring we have effective connections with groups or individuals whose support we need if our recommendations are to be realistic and likely to lead to constructive and acceptable improvement. The breadth of panel members’ experience will guarantee us the necessary insights to identify the appropriate balance between sharing and protecting information.”

The full list of panel members is:

Dame Fiona Caldcott, Chair
John Carvel, former Social Af-
cations and Education, Head of Policy and Faculty of Public Health

Terry Dafer, Director of Adult Social Care, Stockport Council and ADASS
Janet Davies, Director of Nursing, RCN
Professor David Haslam, President BMA
Dr Alan Hassey, GP, clinician Academy of Medical Royal Colleges
Dawn Monaghan, Strategic Liaison Group Manager, Informa-
tion Commissioner’s Office
Terry Parkin, Director Peoples Services, Bright and Hove City Council
Sir Nick Partridge, Chief Ex-
ecutive Terence Higgins Trust
Professor Martin Servers, Ger-
iatrictian, University of Ports-
smouth
Caroline Tapster, Former Chief Executive Hertfordshire Country Council
Jeremy Taylor, Chief Executive National Voices
Sir Mark Walport, Director Wellcome Trust
Dr David Wrigley, GP from

Membership of Information Governance Review Panel announced

News
The key to a healthy smile lies in the infant and toddler years

Leading experts in toddler feeding and dental health have united to highlight the importance of diet, positive feeding habits and good oral health routines in the early years, as part of National Smile Month (20 May-20 June).

Around a quarter of a million children starting primary school across the UK will already have tooth decay and the Infant & Toddler Forum (ITF) and British Dental Health Foundation are working together to raise awareness about how to avoid this wholly preventable problem.

Those who learn good habits from an early age are more likely to carry them into adulthood, and the ITF – specialists in food and feeding in the under threes – has produced a sheet of simple tips to help families take positive steps towards their toddlers’ good dental health. Endorsed by the Foundation, the practical, evidence-based advice includes tips on how to care for children’s teeth – including diet, bottle-feeding, tooth brushing, fluoride and medicines.

Advice around what and what not to eat can also be confusing; the UK Royal College of Surgeons Dental Faculty recently reported that half of five year olds show signs of enamel erosion caused by fruit, particularly citrus fruits and encouraged schools to ban fruit juice and to offer milk and water instead.

Judy More, paediatric dietician and member of the ITF, says: “It is important to give young children the opportunity to learn to like water as a drink by offering it. Fruit juice, like other sweet drinks, causes tooth decay when drunk frequently throughout the day. If fruit juice is given as a drink it should be well diluted; for example one part juice to about six to ten parts water and served in a glass, cup or beaker, not a bottle.

“Sweet food, sweet drinks and fruit juices should only be given at four occasions throughout the day (e.g. three meals and one snack) to minimise the times teeth are exposed to sugar and acid. Water and milk are the only drinks that should be offered between meals and snacks.”

Dr Nigel Carter, Chief Executive of the Foundation says, “Educating children from an early age can reap huge benefits, as the development of a good oral healthcare routine begins at a young age.”

For more information on protecting toddlers from tooth decay, download the ITF’s free ‘Protecting Toddlers from Tooth Decay’ Guidance & Tips sheet for families or Factsheet for professionals working with parents.

For further information about National Smile Month and to view resources supporting the campaign visit: www.smilemonth.org

Honigum. Overcoming opposites.

Often times, compromises have to be made when developing impression materials. Because normally the rheological properties of stability and good flow characteristics would stand in each other’s way. DMG’s Honigum overcomes these contradictions. Thanks to its unique rheological active matrix, Honigum yields highest ratings in both disciplines. We are very pleased to see that even the noted test institute «The Dental Advisor» values that fact: Among 50 VPS Honigum received the best «clinical ratings»

www.dmg-dental.com

*The Dental Advisor, Vol. 23, No. 3, p 2-5
A long career dedicated to the dental nursing profession- Jean Smith

Diana Wincott MBE pays tribute to M Jean Smith MBE: Following the Second World War there was great difficulty in recruiting suitable dental chairside staff. There was no formal training available, pay was poor and the term ‘Attendant’ often deterred suitable applicants from entering the work.

The Dental Nurses and Assistants Society of Great Britain and Northern Ireland, established in 1940, sought to influence and attract secure proper training and pay for their members and protect the character and status of dental nurses. It was in this environment that the young Jean Smith found herself.

Jean passed the National Examination in 1945 at the Leeds centre. At that time the Panel of Examiners consisted of six dentists.

In 1948 Jean replied to an advertisement for a Secretary to the Dental Nurses and Assistants Society who urgently needed a new secretary; the advertisement stated that, unless someone came forward at once, the society would cease to function. Fortunately Jean Smith was appointed!

Jean made a huge commitment to her work and succeeded in increasing the numbers of courses, candidates and examiners, ensuring that the professional status of dental nurses was promoted. She became widely recognised as the figurehead of the profession.

Then in January 1954 the British Dental Association and the British Dental Nurses Association agreed to form a Joint Committee.

Recommendations on pay and conditions for dental nurses in General Dental Practice were issued in an advice sheet and in 1964 a National Voluntary Register was established. Jean Smith administered the register and became the first registrar.

Succeeding years were occupied with ever increasing workloads and emerging issues of fluoridation, dental health education and post qualification courses. It became clear that there was a need to look at creating an improved career structure for dental nurses within the dental team; this was pursued with the BDA and representatives from Area Health Authorities and the Department of Health.

Jean’s style was always calm and considered. She was able to read a situation and make timely judgements for the benefit of the profession and it is through Jean’s considerable contribution that we now call ourselves a profession. This service to dentistry was recognised in 1975 when Jean was awarded the MBE in the Queen’s Birthday Honours. (pictured)

In 1978 the Association was officially entered on the records as a Trade Union. Pay negotiations continued with the BDA and through the Whiteley Council. In 1985 a campaign was launched and MPs approached to support a fair wages resolution. Jean prepared the submission made to the Nuffield Foundations research into the Training and Future Role of Dental Nurses.

Jean was determined to get proper recognition for Dental Nurses and in 1980 approaches were made to the GDC to set up a group of stakeholders to standardise their training and education. The Dental Nurse Standards and Training Advisory Board was set up in 1981 and the National Voluntary Register was taken under the auspices of the GDC.

A report was prepared and published in 1984 outlining, for the first time, the role and training objectives for dental nurses. It is widely acknowledged that much of the work in developing this document was undertaken by Jean and three other dental nurse representatives.

Jean Smith retired from the Association on 51st December 1985 but continued to work for the Examining Board and in the development of Occupational Standards.

Jean Smith’s impact on the Dental Nursing Profession is without equal. She leaves a daugther Jennifer, grandchidren Diane and Joel and great grandchildren Natalie, Hannah, Isobel and Alexandra.

BDA PEC membership announced

The results of the elections for seats on the British Dental Association’s Principal Executive Committee (PEC) have been announced. Voting for the elections finished on Wednesday 25 May and has been followed by the counting of ballot papers.

The successful candidates and the geographical constituencies they have been elected to represent are:

- Dr Martin Fallowfield (England, East)
- Dr Judith Husband (England, East Midlands)
- Dr Russ Ladwa (England, London)
- Dr Paul Blaylock (England, North)
- Dr Victor Chan (England, South East)
- Dr Nigel Jones (England, South West)
- Dr Eddie Crouch (England, West Midlands)
- Dr Mick Armstrong (England, Yorkshire and Humberside)
- Dr Philip Henderson (Northern Ireland)

BDA website.

BDA website.

BSHDDT announce first accreditation awards

The British Society of Dental Hygiene and Therapy (BSDHT) have announced the first awards under their new education Accreditation Scheme, which was launched at the Oral Health Conference & Exhibition at Bournemouth in November 2011.

The scheme aims to ensure a consistency of quality and standard for Continuous Professional Development educational material used by its members.

- Dr Robert Kinloch (Scotland)
- Dr Stuart Johnston (Wales)

A by-election will take place in the England, North West constituency, with no representative having been elected to represent the seat during these elections.

Members have also been elected for three seats that will represent dentists across the whole of the UK. The successful candidates for the UK-wide seats are:

- Dr Alison Lockyer
- Dr Susie Sanderson
- Dr Graham Stokes

The senior officers of the PEC, including the Chair, will be elected in June, ahead of the body formally taking responsibility for the governance of the BDA on 1 July. The results of those elections will also be announced on the BDA website.

Exciting volunteering opportunities with B2A

Bridge2Aid are delighted to offer a new and exciting opportunity for volunteers in Dodoma, Tanzania. This is a new area for our Dental Volunteer Programme and after successfully piloting in January, they are now filling spaces for a second trip on the 2nd-12th October 2012.

Dodoma, as illustrated on the map, is located inland and the geographical difference to Mwanza will offer returning volunteers the chance to experience something completely new. Even as the capital city of Tanzania, Dodoma is under resourced and under developed with great dental needs within a long distance of the city centre.

Government officials in Dodoma requested our assistance, and following the pilot, we are confident that DVP will continue to work well in this location.

At the moment Bridge2Aid have a limited number of places left available for this trip so if you are interested in joining them, please contact the visits team for more information visits@bridge2aid.org.
No longer a sensitive subject
Eric Peterson discusses sensitivity and whitening

The popular accessory nowadays is not just the handbag, the shoes, or the Chihuahua; it’s the pearly white smile to boost appearance and self-esteem. In fact, tooth whitening is one of the fastest growing in the dental market, boasting an estimated value of £600 million according to the Academy of General Dentistry.

This growth has allowed teeth whitening to become more accessible for patients and there’s a solution to suit all budgets; in-office procedures, dentist-prescribed at-home treatments, strips and gels. But a common factor of this cosmetic procedure is that the patient will almost certainly experience some level of discomfort through sensitivity. This pain can often be so excruciating that the patient either stops treatment halfway through or dismisses this procedure altogether in search for a less painful option.

And it’s not just after teeth whitening, dentine hypersensitivity affects one third of the adult population at some point in their lives. This can be anything from a mild twinge to having severe discomfort that lasts for several hours or even days. Be it a result of teeth whitening or if they are simply sensitive to heat, cold, sweetness, acidity or brushing, by educating patients on how to deal with dentine hypersensitivity you can help them achieve a whiter, brighter, “pain-free” smile.

Explaining the causes and symptoms of sensitive teeth
Many people can be confused about the causes of their sensitive teeth so it’s important to make them aware of all the common factors and put them at ease. Generally, when the hard enamel is worn down or gums recede the dentine tubules become exposed; the causes and symptoms will differ for every patient, from eating or drinking foods and hot or cold beverages to touching teeth or exposing them to cold air.

The pain associated with dentine hypersensitivity can affect the eating, drinking, and breathing habits of patients, so it’s ideal to start by informing them that sensitive teeth are relatively common and not usually a health concern.

• Check which toothpaste they use – Highly abrasive ingredients found in toothpastes can add to the discomfort, as they continue to wear away the enamel. Patients should steer clear of highly abrasive toothpastes, especially after in-surgery treatment, as they can damage the teeth and gums, removing the lustre of the teeth and dulling an otherwise beautiful smile.

By educating patients on how to deal with dentine hypersensitivity you can help them achieve a whiter, brighter, “pain-free” future’
to minimise the effects of sensitivity, easing the pain and protecting sensitive teeth by sealing exposed, open dentine tubules.

- Check the patient’s five senses – A study which appeared in the General Dentisty journal (2002) confirmed that people who are sensitive to bright lights, loud noises, pungent perfumes and itchy clothing, are most likely to avoid hot and cold foods and drinks because they have sensitive teeth. The study found a direct relationship between sensitive teeth and other sensitivities, finding that patients with sensitive teeth expressed a need to wear sunglasses when outdoors.

Helping patients overcome sensitive teeth
As a dental professional your expert advice and recommendation carries considerable weight. Openly discussing sensitive teeth with patients will enable you to identify how much of a concern it is for them and recommend a solution to help eliminate the discomfort. Put their mind at rest by confirming that sensitive teeth can be easily addressed by following some simple oral care procedures; avoid brushing teeth too hard or too much, avoid grinding or clenching teeth and avoid acidic foods and drinks.

Patients should also be advised to use a low abrasion, desensitising, whitening toothpaste which contains the ingredient Potassium Citrate. This desensitising agent will help relieve tooth sensitivity by effectively blocking the transmission of pain sensation between the nerve cells rapidly and effectively, so that tooth whitening is no longer a sensitive subject! Ultimately, by switching to a low-abrasive whitening toothpaste patients can reduce the risk of suffering from dentine hypersensitivity from the outset.

In a study recently performed by Missouri Analytical Laboratories (July 2011), a range of whitening toothpastes were tested to compare and evaluate their levels of abrasion. The results confirmed that Beverly Hills Formula whitening toothpaste is proven to be less abrasive than other leading brands of both whitening and regular toothpastes, scoring as low as 95 on the RDA table whilst some leading competitors have levels as high as 147.

Raising awareness of sensitive teeth
By helping your patient’s combat sensitive teeth you will be making a dramatic improvement to their life, enabling them to enjoy hot and cold foods and drinks again.

Nominate a “sensitive teeth” expert in the practice or hold a “sensitive teeth” day/week/month; you’ll be surprised at how many patients will come forward to end their fight against sensitive teeth. Leave flyers/brochures on sensitive teeth around the practice, in reception or in the waiting room, and patients will feel more inclined to tackle the subject.

Eric Peterson is founder of the whitening toothpaste Beverly Hills Formula. For more information on the Beverly Hills Formula products please call +353 1842 6611, email info@beverlyhillsformula.com or visit www.beverlyhillsformula.com.

FEATURES OF R4
- R4 Mobile
- Direct link to PIN pad
- Patient Check-in Kiosk
- Care Pathways
- Communicator
- Steritrak
- E-Forms
- Patient Journey
- On-line Appointment Booking
- Text Message and Email reminders
- Clinical Notes
- Appointment Book
- Digital X-Ray
- Managed Service
- Practice Accounts

About the author
Eric Peterson is founder of the whitening toothpaste Beverly Hills Formula. For more information on the Beverly Hills Formula products please call +353 1842 6611, email info@beverlyhillsformula.com or visit www.beverlyhillsformula.com.
How hand hygiene impacts hospital infection rates

A study published in BMJ, which coincided with the World Health Organization SAVE LIVES: Clean Your Hands campaign on the 5 May 2012, reveals that the campaign played a significant role in reducing rates of some healthcare associated infections in hospitals across England and Wales.

The purpose of the study was to evaluate the impact of the Clean your hands campaign on the 5 May 2012, which coincided with the Clean Your Hands campaign on rates of hospital procurement of alcohol hand rub and soap, and report trends in selected healthcare associated infections, and investigate the association between infections and procurement.

Bedside alcohol hand rub, materials promoting hand hygiene and institutional engagement, regular hand hygiene audits, were installed from 1 December 2004 and rates for each trust of hospital procurement of alcohol hand rub and liquid soap and levels of Staphylococcus aureus bacteraemia (meticillin resistant (MRSA) and meticillin sensitive (MSSA)) and Clostridium difficile infection for each trust was obtained.

The results found that combined procurement of soap and alcohol hand rub tripled from 21.8 to 59.8 mL per patient bed day; procurement rose in association with each phase of the campaign. Rates fell for MRSA bacteraemia (1.88 to 0.91 cases per 10,000 bed days) and C difficile infection (16.75 to 9.40 cases); however, MSSA bacteraemia rates did not fall.

Increased procurement of alcohol hand rub was independently associated with reduced MRSA bacteraemia, but only in the last four quarters of the study and the publication of the Health Act 2006 was strongly associated with reduced MRSA bacteraemia.

The study concluded that the Clean your hands campaign was associated with sustained increases in hospital procurement of alcohol rub and soap, which the results suggest has an important role in reducing rates of some healthcare associated infections.

National interventions for infection control undertaken in the context of a high profile political drive can reduce selected healthcare associated infections.

Patients contacted over infection concerns at dental practice

Nearly 1,000 patients at a dental practice in Aberdeen have been contacted by NHS Grampian due to concerns regarding their infection control procedures.

According to a report, the patients at the Bridge of Don Dental Clinic and Research Centre in Silverburn Crescent, Bridge of Don have been sent advisory letters after an inspection in March found that infection control procedures at the practice, including those for instrument decontamination, did not meet national standards.

A spokeswoman for NHS Grampian said in a report: “The letter reassures patients that the risk of infection is low. However, any patient who remains concerned can contact NHS 24 helpline 08000 28 28 16 between 8.00am and 10.00pm where they can get further advice about health concerns including for blood borne viruses such as hepatitis B, C and HIV.

“Letters have been sent to patients registered at the independent practice between January, when it opened, and 10 April, the date of a follow up inspection which found infection control procedures were satisfactory and now followed national standards.”

She added: “Dr Xenofon Giouzis is the only dentist now working in the practice. He is registered in the UK with the General Dental Council and is authorised to treat NHS patients in Grampian. This incident is not related to him.”

Dr Maria Rossi, consultant in Public Health Medicine at NHS Grampian, said: “We are working closely with local and national experts and have concluded there is a low risk of infection to patients. As our priority is always for the safety and welfare of patients, we felt it was important to write to inform them of this incident. The letter emphasises that no action is required by the patient, but tests will be available if anyone remains concerned having read the letter and after calling the helpline.”

Ray Watkins is Consultant in Dental Public Health at NHS Grampian. He added: “While this is an independent practice, it is expected to comply with national infection control standards. We are unable to confirm that these standards were adhered to prior to April 10 when at a follow-up visit, procedures were found to be satisfactory.

“The practice has co-operated with the investigation, and will continue to be monitored.”
By now, all dental practices must comply with the essential requirements of Health Technical Memorandum 01-05 Decontamination in Dental Practice (aka HTM 01-05). If they do not, they are in breach of CQC Regulation 12, Outcome 8. HTM 01-05 was produced (in the words of the Department of Health) “in response to emerging evidence around the effectiveness of decontamination in primary care dental practices and the possibility of prion transmission through protein contamination of dental instruments.”

In brief, the essential requirements of HTM 01-05 are that:

- Regardless of the technology used, the cleaned instruments, prior to sterilisation, should be free of visible contaminants when inspected with a magnification device. Instruments should be reprocessed using a validated decontamination cycle including: cleaning/washing (in terms of manual cleaning, this includes having a written protocol, a validated steam steriliser, and at the end of the reprocessing cycle they should be in a sterilised state).
- Reprocessed dental instruments should be stored in such a way as to ensure restraint of microbiological re-colonisation. These measures should be backed by careful controls on the storage times to which instruments that are less frequently used are subject.
- Practices should audit their decontamination processes quarterly using an audit tool (the use of the Infection Prevention Society/DH audit tool that accompanied the document was strongly recommended).
- Practices should have in place a detailed action plan on how the provision of decontamination services will move towards best practice.

Amanda Atkin explains on-going clinical governance Considering that last bullet point in more detail, it is implicit in the guidance that merely meeting the essential requirements of HTM 01-05 is not an end in itself. Instead, practices should continue moving forward with decontamination and aim towards best practice – effectively shooting at ever narrowing goalposts.

By definition, I cannot tell you in detail what best practice is. It will continue to evolve over time as more effective processes are discovered and as better decontamination equipment is produced. Also, you may be close to achieving best practice now or you could be a long way off it.

In moving towards best practice, you may wish to consider some or all of the following upgrades to your practice:

- The use of an automated (HTM 01-05) washer-disinfector
- Separate facilities for decontamination clearly separated from the clinical treatment area. This implies the use of a separate room or rooms which should be used for the purpose of decontamination only and to which access should be restricted to those staff perform-
ing decontamination duties

- Organisation of the reprocessing area into a dirty/clean workflow system with best practice being dirty and clean areas as separate rooms, each with a door and individual air supply and extraction

- Provide suitable storage for instruments, which reduces exposure to air and a possible risk of further contamination

- Minimise worktops – which means less clutter and less to clean – and replace them with glass, so that patients can see immediately that the surgery is clean

To keep abreast of decontamination best practice, I suggest you link up with your PCT, that you always read Dental Tribune and Infection Control Tribune and that you keep an eye on dentistry websites. Also, check out the decontamination equipment manufacturers for new products, liaise with dentistry colleagues and visit the appropriate trade and association stands at shows.

An action plan for best practice

Decontamination best practice cannot simply be a wish list – you need to draw up an action plan for achieving it. At the moment, no timescales have been set for practices to achieve best practice. This makes developing an action plan with targets as to when things will be achieved rather tricky. Bear in mind that you will, at some stage, need to show this action plan to a member of your PCT and talk through it – so it needs to be based on sound thinking, not guess work.

Let’s take the example of separating decontamination rooms. There are many dental practices that use the same room for patient treatment and decontamination and this meets HTM 01-05 essential requirements at this time. The principals or owners of these practices need to decide how they can work towards a separate and controlled decontamination room (or clean/dirty rooms). If it’s merely a question of utilising an unused room or erecting partitions, the timescale for achieving it could be relatively short and will depend on when the finance is likely to be available.

In, for example, a listed building or premises where you are already short of space, the only solutions may be to move or rent/purchase additional premises. Clearly, this will likely be a longer-term aim.

For something a little easier to build into your action plan, consider the purchase of washer-disinfector. You will need to investigate what models are available, which will be most suitable, how much it will cost and what the installation requirements area. You will also need to consider how, where and when your staff can be trained to use it and how much this will cost. They may well also need training in the use of instrument rotation systems and working in a designated decontamination room.

Although you should check whether your PCT has funds available for the purchase of washer-disinfectors, in England there was no central funding for meeting HTM 01-05 essential requirements and there is certainly none at this time for moving towards decontamination best practice. By contrast, the Scottish Government has made funds available for decontamination improvements, for the maintenance of decontamination equipment and even provided grants for when a practice needs to relocate.

Sample test processes and procedures to evidence the level of compliance

Finally, don’t forget to maintain the daily and weekly checks of equipment and the quarterly checks specified in the Infection Prevention Society/DH audit tool.
**“Sterile” does not mean clean and safe**

Dr Mikael Zimmerman discusses disinfection

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Most equipment-associated infection is due to inadequate cleaning and disinfection. The most effective stage of any decontamination procedure is thorough cleaning.

Medical devices heavily loaded with microbiological material will be more difficult to sterilise than one lightly contaminated and must therefore be thoroughly cleaned to reduce organic material or bio burden before disinfection and sterilisation. Washer-disinfectors are the safest and most reliable option.

Automated processors, eg washer disinfectors and ultrasonic cleaners, improve the quality of the decontamination process and offer the safest, most reliable option for decontamination. The most reliable medium, known as the ‘safe and sure’ is by far the quickest, safest and most efficient and money at the same time as quality will be improved.

Decontamination is done most simply in a disinfectant which both cleans and disinfects in one stage. In a washer-disinfector the items are first cleaned by rinsing in cold water and then washed in water at less than +70°C. The water temperature then increases to between +85°C and +95°C, for one to three minutes, providing thermal disinfection of the load. At the temperature range of +85°C - +95°C, pathogenic bacteria are inactivated or killed, but bacterial spores survive. In order to ensure inactivation of viruses, particularly hepatitis virus which is relatively heat tolerant, it is now recommended that the water temperature during the disinfection phase should be just over +90°C.

Disinfection is generally a less lethal process than sterilisation. It eliminates virtually all recognised pathogenic microorganisms but not necessarily all microbial forms (eg bacterial endospores) on manmade objects. Disinfection does not ensure overkill, and therefore disinfection processes lack the margin of safety achieved by sterilisation procedures.

Cleaning and disinfection of instruments should be carried out as soon as possible after use. Dried biological material is much more difficult to remove than fresh deposits. Blood, with its content of iron, acid and sodium chloride, is corrosive.

**The type B-cycle**

Sterilisation is defined as the use of a physical or chemical procedure to destroy all microbial life, including large numbers of highly resistant bacterial endospores. The sterility requirement for medical products means that the theoretical probability that a living organism will be present on an object after the sterilising process is equal to or less than one in a million, so-called Sterility Assurance Level (SAL) = 10⁻⁶. Sterility may be achieved by various methods: heat, chemical and ionising radiation. The simplest method is heat sterilisation. There are two methods: dry heat sterilisation, ie use of dry heat usually a hot air oven or autoclaving, in which most heat (steam) is used.

Regardless of the method, the result of sterilising procedures depends on the number of microorganisms and other biological material present on the article before inactivation and the resistance of microorganisms to the sterilisation process. The result of steam sterilisation is also influenced partly by the kind of material the items are made of, and partly by the shape of the items. It is important to note that packaging material itself is a porous load (paper, textiles and should be handled as such. All packaged/wrapped goods require sterilisation in steam-autoclave processes with pre- and post-vacuum cycles.

Another factor which influences the result of the sterilising procedure is the way in which the chamber is loaded as well as whether the items are packaged and the shape of the package. The goods should not be tightly packed: the steam must be allowed to penetrate all parts of the goods. Residual moisture in the packaging material after sterilisation will act as a potential pathway for microorganisms to penetrate the package.

Steam sterilisation Saturated steam under pressure is by far the quickest, safest and most efficient and most reliable medium, known for the destruction of all forms of microbial life. The brief exposure to steam destroys the most resistant bacterial species and heat is rapidly achieved because of mass heat transfer as the steam condenses.

In order for the steam to condensate within the whole load to be sterilised, virtually all air must be evacuated during pre-treatment. This can only be achieved with several (at least three (3)) pre-vacuum cycles. So called B-cycle in accordance with EN 13060.

In steam sterilisers with pre- and post-vacuum processes (ie B-cycle), the sterilisation process is composed by three main phases: pre-treatment, sterilisation and post-treatment. During pre-treatment the air is expelled by a number of pulses of vacuum and the introduction of steam. The temperature increases successively, up to the degree at which sterilising is to take place. The actual sterilisation period, which is called holding time, starts when the temperature in all parts of the autoclave chamber and its contents (the load) have reached the sterilising...
temperature. The tempera-
ture should then remain con-
stant, within specified tem-
perature band, throughout the whole sterilisation phase (plateau/holding time). In the post-treatment phase, either the steam or the re-vapourised
(plateau/holding time). In the whole sterilisation phase, throughout
sterilisation, temperature should then remain con-
temperature. The tempera-

Steam sterilisation of hol-
low instruments (with long, narrow lumina) and porous objects always requires sev-
eral (at least three (3)) pre-
vacuum pulses to a defined, pre-set, vacuum level.

Fewer instruments, better control
The type of equipment and the type of procedures in use at
the clinic will to a very high extent determine the safety margin of decontamination. A very important issue, that is often foreseen, is the logis-
tics of instruments. A com-
mon problem in many dental
offices is an overload of in-
struments, which will con-
tribute to a more difficult and time
and demand procedure to
keep track of all instruments and to make sure that storage
and sterile as well as packag-
ing/wrapping conditions are
maintained.

An area of contact will not be
properly cleaned and disin-
fected.

Two different metals will
cause corrosion.

Corrosion is a common prob-
lem. When in the same fluid, instruments and other articles made of different metals may
corrode, and corrosion de-
struys sharp and delicate in-
struments. Corrosion pits will
also make the surface rough, which increases the possi-
bilities of microorganisms to
attach themselves to the in-
struments. Mixing different
types of metal in a liquid solu-
tion will result in an electro-
chemical cell and cause cor-
rosion – this is often the case
during cleaning, ultrasonic
bath and washer disinfectors
when using aluminium trays and instruments in stainless
steel or when cleaning carbon
burs and burs made of stain-
less steel in the same liquid
container. However, in daily
dentistry we call this rust
and blame the manufacturer
for poor material – the actual
problem is clinical routines!

Don’t make it too heavy
Metallic weight is another de-
cisive in decontamination and
sterilisation. The heat energy
from the ultrasonic waves in the
ultrasonic bath and/or
the water in a dishwasher or
washer disinfecter as well as the saturated steam from the
steriliser shall be concentra-
ed on the instruments that are
to be processed. A load that is
too heavy lessens the effect of
disinfection and sterilisation.

The steam sterilisers that are
most frequently used in den-
tal clinics are adapted to loads
of 4.0–4.5 kilos. A stainless
steel tray with instruments
for endodontic procedures
has a weight of approximately
1.5–1.7 kilos! This will be an
important issue to consider
when using trays made out
of 4.0–4.5 kilos. A stainless
steel tray with instruments
for endodontic procedures
has a weight of approximately
1.5–1.7 kilos! This will be an
important issue to consider
when using trays made out
of stainless steel.

Fastened but free
Instruments should be free and
fastened on trays so that
ultrasonic waves, water jets
and steam can reach every
part to clean and inactivate
efficiently during the whole
procedure of disinfection and
sterilisation. Even if fastened
the instruments must be free
and have no contact points/
areas with the locking device.

Steam sterilisation of hol-
low instruments (with long, narrow lumina) and porous objects always requires sev-
eral (at least three (3)) pre-
vacuum pulses to a defined, pre-set, vacuum level.

Fewer instruments, better control
The type of equipment and the type of procedures in use at
the clinic will to a very high extent determine the safety margin of decontamination. A very important issue, that is often foreseen, is the logis-
tics of instruments. A com-
mon problem in many dental
offices is an overload of in-
struments, which will con-
tribute to a more difficult and time
and demand procedure to
keep track of all instruments and to make sure that storage
and sterile as well as packag-
ing/wrapping conditions are
maintained.

An item heavily loaded with microbiological mate-
rial will be more difficult to
sterilise than one lightly con-
laminated. The most effective
stage of any decontamination
procedure is thorough clean-
ing and this should accom-
pany or precede all disinfec-
tion procedures. The effect
of cleaning, disinfection and
sterilisation is affected by the
design of the cassettes/trays
being used. Shadow ef-
fects may easily emerge from
the use of solid cassettes so
that instruments are not be-
ing properly cleaned, neither
in washer disinfecters nor in
ultrasonic bath.

Fastened but free
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Luxator Extraction Instruments are now the preferred method of performing extractions.

Fig 11 Evaluation of the handling of instruments with effective tray systems has shown substantially reduced time.

Fig 12 Rationalisation of the handling of instruments is a good way to improve practice economy and quality.

Dental metal instruments are for the most made by stainless steel which are heavier than trays made out of aluminium.

The most efficient trays, from disinfection and sterilisation standpoint will be trays/cassettes made out of a non-heat absorbing, non-heavy and non-corrosion causing material.

Tray-prep increases efficiency and security

To organise the logistics and handling of instruments requires a lot of time, and unfortunately few clinics take that time to go through these processes.

To obtain a flow of instruments as secure and efficient as possible, the use of a system as complete as possible is recommended.

The first thing to do to ameliorate the logistics of instruments and materials in the clinic is to minimise the number of instruments in the treatment area. Tray systems facilitate the flow of instruments and goods the whole way between treatments, via sterile area, to storing. With a carefully planned tray system you can handle the tray, the accessories and the instruments (products) as one unit throughout the whole process of work.

Tray systems and “tray-prep-stations” facilitate the handling of goods. A good tray system with practical tray accessories and carefully planned hygiene routines facilitates the flow of materials. Unstructured handling of instruments results in losing valuable time and heightens the risk of reducing security and disregarding aseptics.

Secure handling of instruments also leads to minimising prick and puncture wounds, at the same time as simplifying the inspection of instruments. It also means that single use materials and hazardous waste can be easily removed and thrown into a lidded waste bin, if using a tray-prep-station in the surgery.

Stands for burs and endofiles – a hidden problem

Stands for burs and endofiles are very often a hidden problem in the clinic. A simple solution to the problem is to use one standard kit that is in use during the whole process of work and the whole hygiene circle. Pre-prepared trays with all instruments in place also minimises the process time between patients.

Stainless steel is not forever

Dental metal instruments are for the most made by high quality stainless steel with high elasticity and high stretch. The material has high resistance against wear and corrosion. All of these capacities can be negatively influenced by erroneous handling of the instruments, particularly in connection with cleaning, disinfection and sterilisation.

If the instruments are not used in an aseptic manner, cross-contamination can be the consequence, and本文 is a member of the subgroup for dental professionals within Strama – the Swedish strategic programme against antibiotic resistance.

It is important to maintain the tenability of the instruments with careful handling. They are not to be thrown in the process of decontamination. The instruments should be processed in trays, holders or stands so as not to clash against each other. They should also be in contact with each other as little as possible when washed, disinfected and sterilised.

Reduce the number of articles and save time and money

To have fewer instruments in use means that it will be easier and safer to locate goods that should be re-sterilised and re-disinfected and that there will always be current information on which instruments that are needed in the surgery.

Higher security will be a result from always having the right materials and instruments in the treatment area.

The time in need for handling sterile goods can be reduced, usually to half the time.

Good control of and minimising the number of instruments and materials result in less costs and gives the conditions of safer handling, decontamination and disinfection.

A tray system should facilitate the handling of instruments through the whole hygienic circle. Evaluations of effective tray systems have shown reduced time for handling the instruments at disinfection and sterilisation.

Rationalisation of the handling of instruments during all parts of work - from preparation to sterile keeping - gives the staff liberty to work with quality improvement and to take a greater part in the treatment of patients. Rationalisation of the handling of instruments is thereby a good way to improve practice economy.

Often instruments made of stainless steel are supposed to be extremely strong and fit for using for almost any amount of time. But the truth is that all kinds of instruments can be harmed both by mechanical, thermal and chemical influences. Dental instruments often consist of different parts and of different kinds of metals and alloys, even in the same instrument.

Dr Mikael Zimmerman is one of the founding members of AESSA, a Foundation in Europe for Safety and Infection Control in Dentistry. He is also a member of the subgroup for dental professionals within Strama – the Swedish strategic programme against antibiotic resistance.

About the author
Infection control is continually neglected in dental education

DTT’s Ben Adriaanse interviews Dr Hans de Soet, microbiologist and expert in infection control

In 2009, a group of microbiologists established the Association for European Safety & Infection Control in Dentistry (AESIC), an organisation that promotes European collaboration for shared knowledge and uniform legislation on infection control and dental hygiene. This March, AESIC and ACTA, an academic centre for dental education in the Netherlands, organised a conference in Amsterdam with the theme ‘Harmonising dental infection prevention guidelines in Europe’. During the conference, steps were taken towards establishing a collaborative working group to collect and share dental infection control guidelines in Europe.

Dr Hans de Soet, microbiologist and expert in infection control at ACTA, and chairperson of the event, shared his thoughts on the conference in Amsterdam:

Dental Tribune Netherlands: Dr De Soet, what are your thoughts on the conference in Amsterdam?
Dr Hans de Soet: It was a successful conference. At last year’s European Oral Microbiology workshop, we sensed a need for harmonisation in dental hygiene and infection control. Apparently, there are substantial regulation differences among European countries: in some, these regulations are set up as laws, while in other countries they are merely stipulations. The way in which these guidelines are enforced also varies.

I did not observe any fundamental differences. There are, of course, some minor variations. For example, in some countries gloves can be used more than once. Generally though, the regulations are quite similar. In Scandinavia, dentists are obligated to record their activities concerning infection control according to 10 stipulations. Each requires a separate record, such as “equipment validation”.

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ONE wipe does it all!

Biocleanse Ultra is an alcohol-free wide spectrum microbiocide that cuts through contaminants, lifting them from surfaces and leaving a physically clean and disinfected surface in a single operation.

- Cleans & disinfects in a single wipe
- Alcohol free
- pH neutral
- Ultra-low residue
- Broad surface compatibility
- Proven efficacy
- HTM 01-05 compliant

HTM 01-05: 6.57
“Care should be taken in the use of alcohol wipes, which – though effective against viruses on clean surfaces – may fix protein and biofilm.”

Protein contamination in the dental surgery
Peter Bacon discusses surface cleaning and disinfection

As the dental profession is only too well aware, both cleaning and disinfection processes within the dental practice are of paramount concern, not only in relation to CQC and HTM01-05 compliance, but also with regard to staff and patient well-being – which the compliance guidelines are there to ensure and protect.

Protein contamination in the dental surgery is an obvious area for serious concern, since residual protein on surfaces can harbour pathogens.

Blood has the potential to carry and transmit viruses such as HIV, HBV and HCV. The risk of transmission of communicable bloodborne viruses might be considered to come only from high risk areas such as accidental sharps injuries, but greater research and advances in the sphere of microbiology now provides evidence that many micro-organisms can survive on a variety of surfaces, making the danger of disease transmission from contaminated surgery surfaces or equipment a genuine threat to patients and staff. In addition, an increasingly mobile population including greatly increased economic migration has resulted in a resurgence of diseases such as TB, which are associated with overcrowding and poor standards of general health.

In order to overcome the potential issue of surface decontamination and the prevention of transmission of pathogens, dental practices must have rigorous infection control policies which establish clear protocols for cleaning and disinfection and document the practice’s adherence to the procedures laid down.

Decontamination is defined as a reduction in the risk of contamination to a level that is acceptable, ie controlling the number of microbes in an environment. Within a dental surgery, both cleaning and disinfection are required but although the terms are often confused they are not the same thing. Cleaning involves physical removal of soil matter from surfaces while disinfection is inactivation of pathogens. Cleaning must take place before disinfection to ensure that bacteria, proteins and other contaminants are removed from surfaces before disinfection takes place, unless a suitable single stage process is in use.

Decontamination of a specific area is aided by the use of commercially available products and many of these agents are based on alcohol. In dentistry, alcohol has been widely adopted as a disinfectant for many years and its efficacy in this role is well documented.

The widespread use of alcohol as a disinfectant in dentistry has been largely driven by its low cost and quick drying properties, where its rapid drying is perceived as a major factor in achieving a short turn-round time between patients. However, rapid evaporation of alcohol based products also means that by the time the treatment of a surface has been completed, most of the alcohol has evaporated from the wipe or surface, so the areas wiped at the end of the process will be neither cleaned nor effectively disinfect.

A fact frequently overlooked, but one that is highlighted by the HTM 01-05 guidelines, is that alcohol is not effective as a cleaner, particularly where protein based soils are present as is likely to be the case in medical and dental environments.

Section 6.57 of HTM01-05 states: Evidence suggests that the use of commercial bactericidal cleaning agents and wipes is helpful in maintaining cleanliness and may also reduce viral contamination of surfaces. Care should be taken in the use of alcohol wipes, which – though effective against viruses on clean surfaces – may fix protein and biofilm. However, the careful use of water with suitable detergents, including those CE marked for clinical use, is satisfactory provided the surface is dried after such cleaning.

NOTE: Alcohol has been shown to bind blood and protein to stainless steel. The use of alcohol with dental instruments should therefore be avoided.

Some of the limitations of alcohol are as follows:
- Protein fixation
- Materials incompatibility (particularly PMMA)
- Rapid evaporation
- Flammability

If we consider the ideal properties of a combined disinfectant and cleaning agent, most “experts” would agree that the following would be a reasonable, though not exhaustive list:

- Excellent cleaning action
- Broad spectrum microbicalidal action – some microbes present may be more challenging than others, for example TB
- Non-toxic – or at least selectively toxic
- Short contact time – driven by time pressure and the need for short turnaround between patients
- Stability – some agents have a very short shelf life
- Ease of use – no complicated making-up requirements
- Competitively priced

As stated in HTM 01-05, alcohol does not clean effectively but will disinfect clean surfaces, therefore, a two-stage process is required when using an alcohol based disinfectant.

1. Clean to remove physical土壤
2. Disinfect with alcohol to inactivate pathogens

This process however is less than desirable from an operational point of view due to the additional time required to carry out two procedures between each patient as well as the additional cost of buying two products and the additional inventory required.

Therefore we have seen in recent years a growing demand for water based combined cleaners and disinfectants. The ideal solution is a carefully formulated water based product that can both remove soil and disinfect in a single process, greatly reducing the time taken and providing an effective solution.

The properties required in such a combined cleaner and disinfectant would be:

- Broad spectrum efficacy
- Wide surface compatibility
- Effective cleaning
- CE marked Class 2a (required if a product is to be used to disinfect medical devices)
- pH neutral
- Two-year shelf life
- Low residue
- Supplied in all formats (ready to use, concentrate and wipes)

The ability to deliver all the required features and their associated benefits in a single product will answer the demands of the market and provide a means of ensuring complete compliance with current guidelines.
Treatment of gingival hyperpigmentation

Drs Prabhuji, S Madhupreetha and V Archana discuss using the diode laser for aesthetic purposes

The colour of the gingiva is various among different individuals and it is thought to be associated with cutaneous pigmentation. It depends on the vascular supply of the gingiva, epithelial thickness, degree of keratinisation of the epithelium and the presence of pigmented cells.

Oral pigmentation is the discolouration of the mucosa or gingiva. It can be either due to physiological or pathological conditions. Melanin, a brown pigment, is the most common pigment associated with the etiology of oral pigmentation.

Gingiva is the most common site of pigmentation in the oral cavity. This hyperpigmentation is seen as a genetic variation in some populations independent of their age and sex. Hence it is termed as physiological or racial gingival pigmentation. Melanosis of the gingiva is frequently present in dark skinned ethnic groups as well as in different medical conditions. Although pigmentation of the gingival is completely a benign condition, it is an aesthetic problem in many individuals.

Gingival depigmentation is a periodontal surgical procedure in which the gingival hyperpigmentation is eliminated or reduced by different techniques.

Gingival depigmentation

Various depigmentation techniques have been employed with similar results. Selection of a technique should be based on clinical experience and individual preferences.

The various methods include gingivectomy, gingivectomy with free gingival autografting, electrosurgery, cryosurgery, radiosurgery, chemical agents such as 90 per cent phenol and 85 per cent alcohol, abrasion with diamond bur, Nd:YAG laser, semiconductor diode laser and CO2 laser.

One of the most common techniques for depigmentation is the surgical removal of undesirable pigmentation using scalpels. In this procedure, gingival epithelium is removed surgically along with a layer of underlying connective tissue. The denuded connective tissue then heals by secondary intention.

Laser ablation of gingival depigmentation has been recognised as one of the effective techniques. Different lasers have been used for gingival depigmentation including carbon dioxide (10.600nm), diode (810nm), Neodymium: Yttrium Aluminium garnet (1.064nm) and Erbium: YAG (2.940nm) lasers.

The diode laser was introduced in dentistry a few years back. The diode laser is a solid-state semiconductor laser that typically uses a combination of Gallium (Ga), Arsenide (As), and other elements, such as Aluminium (Al) and Indium (In), to change electrical energy into light energy. It can also be delivered through a flexible quartz fibre optic handpiece and has a wavelength of 810nm. This energy level is absorbed by pigmentation in the soft tissues and makes the diode laser an excellent hemostatic agent. It is used for soft tissue removal in a contact mode. The power output for dental use is generally around two to 10 watts. It can be either pulsed or continuous mode.

The present case series describes simple and effective depigmentation techniques.
using A.R.C. Fox™ (semiconductor diode laser), which have produced good results with patient satisfaction.

Case report one
A 22 year old female patient visited the department of Periodontics, Krishnadavary College of Dental sciences, Bangalore with the chief complaint of “blackish gum”. The medical history was non-contributory. Intra-oral examination revealed generalised blackish pigmentation of the gingiva, however it was healthy and completely free of any inflammation.

Considering the patient’s concern, a laser depigmentation procedure was planned.

Procedure
Diode Laser (A.R.C. Fox™) with wavelength of 810nm was selected for the procedure. No topical or local anaesthesia was given to the patient. Melanin pigmented gingiva were ablated by diode laser vaporization with a flexible hollow-fibre delivery system with a non-contact, air cooling hand-piece, under standard protective measures. The procedure was performed on all pigmented areas. Remnants of the ablated tissue were removed using sterile gauze damped with saline. This procedure was repeated until the desired depth of tissue removal was achieved. Analgesics and chlorhexidine 0.2 per cent mouthwash were prescribed.

Results
No post-operative pain, haemorrhage, infection or scarring occurred in first and subsequent visits. Healing was uneventful. Patient’s acceptance of the procedure was good and results were excellent as perceived by the patient.

Case report two
A 24 year old female patient visited the department of Periodontics, Krishnadavary College of Dental sciences, Bangalore with the chief complaint of “blackish gum”. The medical history was non-contributory. Intra-oral examination revealed generalised blackish pigmentation of the gingiva, however it was healthy and completely free of any inflammation.

Considering the patient’s concern, a laser depigmentation procedure was planned.

Procedure
The depigmentation was performed identically to the first case. Analgesics and chlorhexidine 0.2 per cent mouthwash were prescribed.

Results
No post-operative pain, haemorrhage, infection or scarring occurred in first and subsequent visits. Healing was uneventful. Patient’s acceptance of the procedure was good and results were excellent as perceived by the patient.

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**‘The diode laser is a solid-state semiconductor laser that typically uses a combination of Gallium, Arsenide and other elements’**
Why improving your practice is a mystery – part nine
Jacqui Goss asks: Who are you?

Okay, pop quiz time! In July 1978 a single was released which was an edited version of the album track of the same name and reached number 18 in the record charts. The title of the single was the same as the album released a month later and included part of the name of the band. That’s correct, it’s Who Are You by The Who. My point? Well, here I want to discuss why and how you should make yourself as visible and memorable as you can. Don’t worry, I won’t advocate you donning fancy dress and parading down the high street – which must surely be banned by GDC rules. And, in any case, I’m using the ‘royal’ you – your practice, your practice team and you.

Patient journey
I’ve written before about how your team should work to ensure each person enjoys a ‘wow’ patient journey. But the benefits of that great experience in terms of the opportunity for patients to share it with friends and family, will be lost if they can’t remember who you are. You may think you’re memorable but believe me you’re eminently forgettable! Don’t take it personally. As soon as patients have their foot out of the door they’ll probably begin forgetting the name of your practice, most likely failing to recall the name of the dentist or hygienist they saw and certainly putting out of their minds the names of nurses and front of house (FoH) staff. I offer no science to support this, only empirical evidence based on making telephone calls to patients when I’m commissioned to undertake satisfaction surveys.

So, how do you counter this collective and, presumably, selective amnesia? Quite simply, your name (by which I mean the practice name and appropriate team member names) should go everywhere. Logo and nameplate design is not my department but I do know they should be distinctive, memorable and repeatedly visible. I’ve quite often walked in to a dental practice (and other establishments) and seen nothing to reinforce the knowledge that I’m in the correct place. Look around your practice – does my comment ring true? There are, of course, many places to put your practice name and or logo – leaflets, posters, mugs, pens and so on.

Name calling
Turning to the FoH team, which is my department, there are several ways they can reinforce the name of the practice, the names of the clinical staff and their own names. The most obvious is for the information to be on their clothing. However, this may not be obviously visible to the patient as they approach the reception area (they may not be wearing their reading glasses) so have nice large nameplates on the desk or counter as well. FoH staff should get in the habit of introducing themselves. This is vital on the telephone but also useful in face-to-face contact. As well as the “who are you?” benefits I’m discussing...
here, it also prevents patients having to make awkward references such as: “The girl on reception said...” or “Can you lend me your pen, er, miss?”

Now for some clinical staff name reinforcement. Foll staff should say something similar to: “Right Mrs Goss, your appointment is with Doctor XXXXX in five minutes and her nurse, XXXXX, will collect you when she is ready.”

They can actually be a bit more sophisticated. If the dentist or hygienist in question is a recent addition to the prac-
tice team how about: “Okay, Mrs Goss, your appointment is with XXXXX our new hygienist, whom I’m sure you’ll like.”

If your practice offers, say, cosmetic treatments, what about: “Now Mrs Goss, your appointment is with our cosmetic dentist, Mrs XXXXX, and her nurse, XXXXX, will come for you in just a few minutes.” No harm in other patients overhearing that you have a cosmetic dentist!

Of course, XXXXX the nurse should subsequently say something like: “Hello Mrs Goss, I’m XXXXX and Mrs XXXXX is ready for you now.

Reminders
Don’t let patients leave without something reminding them where they’ve been and who they’ve seen. Even with SMS and email reminders, the old appointment reminder card system is still valid and should be used. You may also consider a system whereby patients get rewarded for recommending a friend. If so, you’ll need to give them something they can pass on – similar to a business card, perhaps.

There is an almost endless choice of corporate gifts as potential giveaways. I favour things that are likely to be re-
tained and, preferably, kept where they are easily visible. My noticeboard in the kitch-

en is so overcrowded that for this reason I suggest avoiding things that need to be pinned up. How about a fridge magnet, a branded pen or a mouse mat instead! For ideas ofgiveaways, I suggest you look at the British Dental Health Foundation shop (http://www.dental-health.org/shop). Anything you do give to patients must contain your practice name and contact details.

And finally, a few words about social media. If you set up a practice Twitter, Facebook or other social media account, do make your posts ‘social’ (ie not just oral health orientated) and do keep it going. A dormant account gives a poor impression – shut it down if you’re no longer going to use it. On LinkedIn, which is a showcase for your profes-
sional identity and a network-
ing opportunity, don’t be shy – include a profile image! You don’t really want people won-
dering:

Who are you?
Who, who, who, who?
Who are you?
Who, who, who, who?
In general practice we can often feel we don’t have time to listen to our patients. And can we really be bothered anyway? I mean, they do go on a bit don’t they?

And yet, if we don’t listen actively we run the risk of missing out on treatment and by default money. Yes, I said it, listening can make you money! Listening well can help you to identify the patient’s wants and needs and work these into the treatment options you offer them. And it can’t just be one team member that does this. For optimum results it needs to be the whole team.

Here are some simple tips that can get you listening actively quickly and simply.

Shut up!
No really, ask a question and then do not talk again until you are absolutely sure the other person is finished talking. It is amazing the extra insight you will gain by trying this. When we interrupt two things may happen. They will either perseverse and talk for a long time because of it, or they will clam up altogether.

Ask permission
When you want to discuss something with a patient, stopping smoking, changing diet, adding a new oral hygiene product to their routine, ask permission to start the conversation. Rarely the patient will say no. When they do, respect that. It is so hard to do but DON’T talk to them anyway. They will see the respect you gave their wishes and be much more receptive to you as a person, and in the long run, your advice.

Take note
A great way to show you are listening well is to write down what the patient is saying. It doesn’t have to be word for word but writing in their choice of words then repeating these back to them can really show the patient has been heard and understood. All of us, regardless of background or circumstances, value being listened to and understood.

Make a questionnaire with open questions on it
To help the whole team get into the swing of active listening make your questionnaire have open questions in it instead of closed. An open question requires more than a yes or no answer. For example: What was it that made you decide to book for your visit today? Open questions can help lead the pa-
Mhari Coxon discusses how using your ears can lead to success

Re-read those notes

It is not easy to remember each patient so always take a minute to re-read your notes. Remembering that their son was doing his driving test, that they hate the sound of the slow speed, dread the 5in1; these little touches mean so much to your patients and will keep them coming back.

Share - unless asked not to

Share the information received with all the team so there can be continuity in conversations with the patients. Obviously, if the patient tells you something in confidence and asks you not to share this again respect their wishes. The only time this does not stand is if the information could pose a risk to others.

Try it out a bit at a time

Learning any new skill can be tiring, and can make us run late! So, try out listening in this way to one patient in your morning list, then on one patient from your afternoon list.

That way you can compare how you communicate and listen now with the listening you will develop as a habit over time. The results should be pretty conclusive that this is the best way to work with patients for their patient centred care pathway.

Build it up one patient at a time per day over a week or so, then look back and reflect on the benefits as well as measuring which listening sessions went best.

We are all individuals so learning a way of doing this that works for you is important too.

Good luck and remember - we have two ears and only one mouth for a reason.

‘To help the whole team get into the swing of active listening make your questionnaires have open questions’

Mhari Coxon

Mhari Coxon has 20 years experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London. From Chairing the London BSDHT for 5 years, and working as an MD, Mhari excels at maintaining and co-ordinating a team and utilising skills, decentralising leadership and developing self efficacy in members. Throughout her career Mhari has developed hygiene protocols and plans in practices which have contributed to her success. Mhari is Clinical Director for CPD@DCP Ltd, a training company offering motivational and interactive development courses to the dental team. A keen writer, Mhari is an expert in Publications Committee of Dental Health, the British Society of Hygienists and Therapists (BSDHT) Journal, has a conversational column in Dental Tribune and writes articles for many other publications and online sites. As a speaker Mhari has presented regionally, nationally and internationally for many groups including Talking Points in Dentistry, the British Orthodontic Society Specialist group, the BSDHT, the ADA, the International Symposium of Dental Hygiene, the dentistry shows and many others. In 2006 she was the Probe Awards hygienist of the year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the UK.

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For optimum results it needs listening to and understanding. All of your patients will say no. When you get to a severe and talk for a long time happen. They will either perceive you are talking too much or circumstances, value being heard and understood. All of these back to them can reinforce your advice and be much more receptive to respect you gave their wishes. They will see the importance of your advice. You will gain extra insight by listening to your patients

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BH&H prepares for the journey ahead with new business development manager

Kate Taylor-Knight has joined the BH&H Group of Companies in the role of Business Development Manager. She joined the dental corporate on 20th May 2012 and is primarily responsible for acquisitions and integrations, as the business continues to grow and evolve.

“My career in dentistry started as a trainee nurse, which soon progressed into management. Kate has the energy and passion to lead most sectors in dentistry, from a single handed NHS practice to first class dentistry in Harley Street. We are currently working for the largest dental corporate in Europe.”

Card is delighted with her new appointment at BH&H, saying, “My passion is people... get the people right and the profit will follow! This is a core value of BH&H and look forward to the journey!”

For more information about BH&H please call 01363 84646 or email Ali Keating@bkh.co.uk. Chris Barrow at chris@bkh.co.uk or visit www.bkh.co.uk. Want to stay in touch with the Barrow Keating Group? Connect with us here: Facebook: www.facebook.com/barrowkeating. YouTube: www.youtube.com/company/barrow-keaving-group. Twitter: Chris Barrow (@ChrisBH&H), Dr Ali Keating (@AliBKH).

The Dental Directory supports 2012’s ninth annual Clinical Innovations Conference

The Dental Directory was pleased to be a sponsor of the Ninth Annual Clinical Innovations Conference, 2012, which took place on 18th June 10am-12.30pm at the Millennium Gloucester Hotel & Conference Centre in London’s Kensington.

The Ninth Annual Clinical Innovations Conference has become one of the leading events in the aesthetic and restorative dentistry sector in the UK. The educational nature of the event means it is representative of the cutting-edge and most recently developed technologies and products within the aesthetic and restorative dentistry sector in the UK.

Held for the third year and the first CIC Innovation Award. Delegates enjoyed a first look at the very best in food and entertainment.

The judging panel included a number of well respected dentists, as well as members of journal editorial boards. Judges needed to be on their toes to complete the CS 7600 for its unique ability to store patient information directly on the plate, which is of great benefit to busy practitioners. Judges also praised the brand new innovative “Scan & Go” technology, exclusive to the CS 7600 system.

With experience providing forward-looking imaging systems and practice management solutions across the globe, Cassante Dental’s products are used by 7 out of 10 practitioners to deliver exceptional patient care. Recognition with the CIC Innovation Award judging panel is yet further proof of Cassante Dental’s continued commitment to innovation and success.

For more information, contact The Dental Directory on 0800 585 566 or visit www.dentaldirectory.co.uk.

Carasante Dental and CIC 2012: Innovation at the forefront of dentistry

Carasante Dental was proud to sponsor the ninth annual Clinical Innovations Conference (CIC) on the 19th – 21st May 2012 held at the Millennium Gloucester Hotel and Conference Centre in London. The dynamic event celebrated all that is inspirational and pioneering and Cassante Dental was a fitting recipient of the award. With a broad portfolio of products and services to deliver exceptional patient care, the Cassante Dental stand was a popular destination for delegates.

On displays included CS 4D – Practice management software, which behaves as the hub of the practice, simplifying and speeding routine tasks and communication throughout the practice.

For innovative imaging systems, delegates discovered the CS 9300 all-in-one extracorporeal imaging system, which offers the widest range of clinical applications on the market. Also on show was the CS 7600 intraoral imaging plate system with its fully automated and secure e-ray workflow.

A leading conference attract- ing leading providers, and the cutting edge technology from Cassante Dental brings practice to the forefront of dentistry.

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Data last revised: September 2010.

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References
1. AB Data on file: Study No. NL0811.2010. Two Nuromol tablets compared with two tablets of Ibuprofen 200mg and Codeine 12.8mg.

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