**News in Brief**

**Dentists reach end of cycle**

More than 11,000 dentist registrants came to the end of their five year cycle on 31 December 2011 and must ensure that they have declared their CPD hours by 28 January 2012. All dentist registrants (except those whose cycle didn’t start until 1 January 2010) should have recently received a letter reminding them about their end of year declaration. The easiest way for you to make an end of year declaration is by logging on to www.gdc-uk.org. If you haven’t got an eGDC account you can register using your ID verification code, which is included in the declaration letter. Otherwise you can complete the form enclosed with the letter, returning it to the GDC in the freepost envelope by 28 January 2012. Any forms received after this date will not be processed.

**Experts call drink warnings**

Researchers in Australia have called for a new health warning on energy drinks after the number of people reporting medical problems after drinking rose last year. In 2004 Health professionals from the University of Sydney’s Medical School and the New South Wales Poisons Information Centre said there were just 12 reported incidents where people had suffered from an adverse reaction to energy drinks; in 2010 this figure jumped up to 65. Further figures reveal that since 2004, 207 calls for assistance have been recorded and at least 128 people have been hospitalised after drinking the highly caffeinated drinks. According to reports 20 people were recorded having seizures and hallucinations. The study was published in the *Medical Journal of Australia.*

**Liqueur fights tooth decay**

A recent report has stated that scientists have identified two substances in liqueur that kill bacteria which causes tooth decay and gum disease. The study, published in the ACS Journal of Natural Products suggests that the substances the scientists have found could play a major role in both treating and preventing gum disease. According to the report, they found that two of the licorice compounds, licirucmid and liciriscollavan A, were the most effective antibacterial substances and killed two of the major bacteria responsible for dental cavities and two of the bacteria that promote gum disease.

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**It’s time to Face the Facts**

Radio 4 programme highlights major concerns about the General Dental Council (GDC) and its FtP procedures

**B**BC reporter John Waite recently presented a Radio 4 *Face the Facts* broadcast on the GDC and its fitness to regulate the dental profession; interviewing a number of ex-GDC workers, patients and the new Chief Executive and Registrar of the GDC, Evlyne Gilvarry along the way.

Criticised for its complaint handling, admin problems (which have resulted in a serious backlog of cases), problems arising due to upheavals in management and a public resignation from former GDC chair Alison Lockyer over issues “that caused her concern”, it can be fair to say that it hasn’t been an easy time for the GDC these last few years; but as Waite discovered, there seems to be little room for excuse.

The problems surround the GDC’s complaints procedures. In 2010 there were 1,400 complaints, and although this sounds relatively small in comparison to the approx 100,000 dental professionals registered with the GDC, many of these complaints are in a backlog. Although the GDC are fully aware of the problem and have plans to deal with the issue Harry Cayton, CE Council for Healthcare Regulatory Excellence, who was interviewed for the broadcast, explained that complaints are not being dealt with “quickly and effectively” and in some cases decisions go against common sense.

One such incident involved dentist Mohammed Siddique, who was found guilty of re-using disposable instruments and gloves, and failing to sterilise equipment; he was also found guilty of not using water whilst drilling. After immediately being suspended by his PCT, the complaint was handed over to the GDC, who after taking two years to go through the complaints process, decided that he was fit to practise, even though they had originally concluded that there had been “serious breaches of the standards expected.”

When confronted about the case, Ms Gilvarry said: “The GDC’s role is not to punish the practitioner; it is to say ‘how can patients be protected here?’”

So why is it taking so long for the GDC to investigate complaints? Although the GDC have stated that there has been an 11 per cent decrease in the time taken to get a case to the investigating committee and out of the cases that had been awaiting a hearing for longer than nine months, there had been a 20 per cent decrease these figures, as Waite uncovered, do not include cases that have yet to reach the Fitness to Practise panel.

With examples such as this and concerns that the regulator was favouring dentists over patients in case complaints, it is no wonder that people have been questioning whether the regulator is putting patient safety first. Mr Cayton did express that “overall all [GDC] are protecting the public.” However, he also stated that: “The GDC need to refocus all its energy and its attention on patient safety and the quality of dentistry.”

The GDC have said they welcomed the opportunity to take part in the programme and a raft of changes they have introduced to improve the handling of complaints against dental professionals is, they believe, already having a positive impact.

Ms Gilvarry explained that the organisation has turned the corner with a much improved FtP process, which sees the fast-tracking of the most serious cases, additional and better trained staff, seeking of clinical advice at the outset of particular cases and an increase in the number of daily hearings and decision meetings to help clear the backlog of cases. She said: “The measures we have introduced to improve our Fitness to Practise processes are aimed at enhancing patient protection. We have made significant progress in the last 12 months and further reforms planned will see a continued improvement in 2012.”

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What a year!

2011 proved to be a memorable year for Dr Zaki Kanaan, (pictured), during which he was honoured by his peers on four separate occasions.

At the beginning of the year he was elected President of The London Dental Fellowship (membership of this highly respected group is by invitation only when a vacancy occurs) and he was then elected Vice-President of the British Academy of Cosmetic Dentistry (BACD) in addition to his role as Scientific Director.

Later in the year he was invited to join an Expert Panel for Guy’s, King’s and St Thomas’ Dental Institutes, which interviews potential students for both the undergraduate and graduate programmes.

Finally, on New Year’s Eve, Zaki discovered he had been voted into second place in the UK poll of Private Dentistry’s Elite 20 Dentists.

What a year!

Wellness Trust granted charitable status

The Dental Wellness Trust (DWT) has been granted official charitable status and will now launch a fundraising campaign to raise revenue for its exciting array of programmes, designed to help the underprivileged with their oral health care.

Founder of the charity, Dr Linda Greenwall, who is also Chair of the British Dental Bleaching Society, is thrilled to see the fulfilment of her long-term goal to help those in need with their dental health. She has worked tirelessly to set up the new charity as a way to give something back to the profession that has given her so much.

The London-based charity has identified a number of exemplary projects, both in the UK and abroad, and will work with partners organisations already on the ground to deliver programmes that will help people who have little or no access to basic oral healthcare.

The DWT has put together an innovative preventative-orientated educational programme, which will empower people to take control of their oral health.

The charity also offers pro-bono treatment to those in desperate need.

To find out more about the work of the Dental Wellness Trust, or how you can help, please visit www.dentalwellnesstrust.org or call 020 7267 7070.

Host a dinner party and save a village!

This Valentine’s Day, instead of jumping out of a plane, climbing a mountain or running a marathon, Bridge2Aid are encouraging people to host a Valentine’s Dinner.

During the month of February, the charity, which raises money for dental services in Tanzania, is asking you to invite your friends over for a dinner party to help support a Tanzanian village. The money can be raised by your friends donating money to Bridge2Aid in return for your hospitality.

Supporting a village means that the money you raise at your dinner party will be put towards the training of a Tanzanian medical officer in Emergency Dentistry. These medical officers will then be able to treat people in their rural village, relieving them of dental pain.

The charity will supply you with dinner mail cards explaining what their money will do and a video clip to play for your guests. All guests who support your event will be entered in a draw to win great prizes.

Please contact fundraising@bridge2aid.org for more information on hosting a dinner to sponsor a village or visit our website to find out more.

Coughing up cancer

A 57-year-old mother has miraculously saved her own life by coughing up a cancerous tumour.

According to reports, Claire Osborn, from Coventry, had two coughing fits, both of which produced pieces of the tumour. She didn’t think much of it until after the second coughing session that produced a 2cm lump that alarmed bells started ringing and Claire took the “heart-shaped lump” to the doctors.

“I knew something was very wrong so I went straight to my GP,” Mrs Osborn was reported saying.

Mrs Osborn was right to be concerned, as scans showed that the tissue was in fact an aggressive throat and mouth cancer; she was then informed that there was a chance that the tumour may not be the only one in her body.

“I was devastated. I just thought I was going to die,” Mrs Osborn was reported saying.

Oral care of older patients remains a challenge, says BDA

The quality and availability of oral healthcare for older adults remains an issue, and insufficient priority in being given to making improvements, the British Dental Association (BDA) has warned in a new report.

The report says that many older adults’ health and well-being is under-served and that concerns remain about provision in the future. It also argues that oral health is often not properly considered in wider healthcare provision and, as a result, that many patients simply don’t get the care they need. Furthermore, the report warns, the aging demographic of the population of Britain means that new challenges will emerge, including a significant increase in demand for restorative dental treatment.

The report provides a progress check on 21 recommendations for improving oral care for older adults made in a BDA report of 2005. Just six of those recommendations have been met in full, today’s report says. Amongst the challenges yet to be confronted are inadequate information about patient charge exemptions, the inability of dentists to prescribe artificial saliva except in certain circumstances, and the continued absence of a commissioning framework that properly takes account of older patients’ needs.

Today’s report sets out twelve priorities for reform including the provision of free, comprehensive oral health assessments for over-60s, better integration of health and social services, and the establishment of basic standards for care with which care homes should be obliged to comply.

“This report reminds us that many older adults simply aren’t receiving the oral healthcare they need. That is unacceptable. Although progress has been made against the priorities highlighted by the BDA in 2005, notable challenges remain and new ones are emerging. This is a problem that won’t go away. The BDA will be pushing hard for the twelve new priorities this report sets out to be addressed.”
Editorial comment

The British Dental Association is this week making history after it has called for dentists’ views on the possibility of balloting for strike action over the proposed changes to NHS pensions and the impact it could have on dental professionals.

In an attempt to gather opinion on the pension reforms and industrial action in time for its Representative Body meeting in early Feb, the BDA launched a survey which was sent to members for completion.

The idea of strike action does not seem to sit well with dental professionals, and in essence I agree with them. Not that I am against large scale protest or that dentists shouldn’t show solidarity in highlighting a particular issue, I just think that NHS pension reform isn’t the best issue!

Why not look at other issues that affect dentistry and make a rallying call to members over those? I’m sure we can all think of a few...

Let me know what you think about the pension issue and whether the BDA should call for strike action. Email me at lisa@dentaltribuneuk.com

100 miles in 50 days for the Ben Fund

Tony Chivers, MBE, has rowed 100 miles to raise much-needed funds for the BDA Ben Fund and the Dentist’s Health Support Trust.

“It would be tragic if the work of both charities ceased through lack of finance,” says Tony, who is Vice President of the Ben Fund.

Rowing at an average speed of 6mph on a concept rowing machine for more than 18 hours in November, Tony has so far raised £2,180 towards his £10,000 target. “A hundred miles in 50 days may not sound much,” he says, “but at 91 years old, it was quite a challenge!”

The Dentists’ Health Support Programme is a confidential alcohol and drug programme offering advice, counselling and treatment where necessary. The Ben Fund has a much wider role, helping all UK dentists and their families in times of need.

“Please join me to ensure that the work of these charities continues,” says Tony. “There is still a long way to go, so please make it a real team effort.”

To give a donation, please go to: www.justgiving.com/bunchiversrow100. For more information about the BDA Benevolent Fund call 020 7486 4994, email dentistshelp@btconnect.com or go to bdabenevolentfund.org.uk. All enquiries are considered in confidence. The BDA Benevolent Fund is a registered charity no. 208146

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

If so don’t hesitate to write to: The Editor, Dental Tribune UK Ltd, 4th Floor, Treasure House, 19-21 Hatton Garden, London, EC1 8BA
Or email: lisa@dentaltribuneuk.com
ADAM Conference has practice management at its heart

A low reading level below could potentially harm a person’s oral health

A new report looking into literacy levels in the UK has uncovered more than five million adults having a reading level below that expected of an 11-year-old – which could potentially harm their oral health.

The 2011 Skills for Life Survey, published in December by the Department for Business and Innovation found that one in six (15 per cent) of adults aged 16-65 achieved literacy skills at or below entry Level 3 – the equivalent expected by the National Curriculum of those leaving Primary School.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, says the profession needs to make sure those who lack basic reading skills get the right information in a form that is more easily understood.

Dr Carter said: “Millions of people in the UK suffer from poor literacy skills and this can have a troubling impact on their oral health. Regrettably, this will ultimately have an effect on a patient’s ability to read, understand and use oral healthcare information to make decisions and follow instructions for treatment, often leaving them wondering where to go and what to do next.

“Patients are not expected to understand medical jargon and dental professionals must consider carefully how effective their communication is verbally, online and in print.”

The British Dental Health Foundation offer a series of more than 50 easy to read information leaflets, ranging on a variety of dental topics. Over one million leaflets were sold to dental practices and oral health educators in 2011, while a further million visited online versions on the Foundation’s website.

Dr Carter added: “We have a strict policy on plain English underlining written advice.

The report also found that patients with such difficulties cannot give informed consent to the proposed treatment, often leaving them unable to make decisions about their oral care.

“Patients might struggle completing forms, could struggle completing forms, could struggle completing forms, could struggle completing forms...”

The nationwide survey investigating literacy levels throughout the UK also found that an estimated 1.1 million adults fit into entry Level 1 – the equivalent of National Curriculum for 5-7 year-olds. This figure has increased by a third since the pre-2001 study in 2003 (from 3.4 per cent to 5 per cent).

Poor literacy may be a widespread problem but dentists can only act if they know they exist, but there are several tell-tale signs to look out for. Patients could struggle completing forms, having problems replying to recall letters or having difficulty following written advice.

Patients with such difficulties should report them to their dentist so they can receive the information in a format that is easy to understand.

The Foundation’s Dental Helpline, manned by trained dental nurses and oral health educators, is open between 9am and 5pm, Monday to Friday on 0845 0861188. Alternatively the team respond to enquiries from the website.

Team up for Three Peaks challenge

Do you work in a great team? If so, this is the ideal event for you and your colleagues. Bridge2Aid, (B2A) the dental and community development charity working in the Mwanza region of North West Tanzania, has arranged a fantastic fundraising event for teams of three to six people. Your team is challenged to walk the Yorkshire Three Peaks in under 12 hours. The spectacular route is roughly 24 miles long, taking in the summits of Pen-y-ghent (894 metres), Whernside (756 metres) and Ingleborough (725 metres). That makes approximately 1,600 metres of ascent and descent.

The event takes place on Saturday 5th March and is being run by B2A by Eight Point Two, a specialised organiser of challenging events who will provide qualified instructors, marshals for the mountains, communication systems and full support.

Completing the Yorkshire Three Peaks challenge in 12 hours is no easy task and will require the right preparation, support and lots of determination. Participants should do some pre-event training – walking, of course, as well as swimming or cycling. The cost of registration is £20 per person and teams must commit to raise at least £200 per person before the event. Practice Plan and IDH have already entered two teams each and there have been verbal commitments from several other companies in the dental industry.

Why not enter your team to tackle the physical challenge while enjoying spectacular Yorkshire scenery – as well as raising vital funds to help Bridge2Aid’s essential work in Tanzania?

For more information about the Yorkshire Three Peaks go to www.eightpointtwo.co.uk/YorkshireThreePeaks. To find out more about the B2A challenge and to register your team go to www.bridge2aid.org or contact Kerry at fundraising@bridge2aid.org.
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**Working for a greater good**

You have worked hard, time for a big break. Time for the 5 Cs. Charity, conference and congeniality. In February you have the opportunity to travel to Cape Town in South Africa for an Innovation Conference and tour in association with Smile-On and the AOG.

The AOG is well known for its packed dinner dates, fun family days, international trips and worldwide charitable projects. Last year’s trip to India was a rewarding success; if you missed then this year’s trip to South Africa is a must.

The AOG trip to South Africa is not the only option for a fundraising awareness visit, it is a chance to see some outstanding sights. During the last 40 years all AOG activities have led to a charitable contribution as a matter of habit. As well as supporting a cleft lip and palate treatment centre that provides facilities for 500 villages with respect to dental care, the

**Surveys recognise Wesleyan as top industry performer**

Wesleyan Assurance Society, the Birmingham-based financial services specialist for doctors, dentists, teachers and lawyers, has again topped a leading industry survey for the performance of its with profits bond.

The bond was named top performer in a Money Management survey* published earlier this month giving Wesleyan savers the best payouts on their investments and out-performing similar products from larger firms such as LV= and Prudential.

The survey looked at the ‘cash in’ value for a £10,000 initial investment over one to 10 years. Wesleyan took the top spot not only for ten years – which saw a return of £16,805, with an AGR (Annual Growth Rate) of 5.5 per cent, compared to the 1 per cent net from an average 90 day deposit account over the same period – but also over six, seven, eight and nine years.

These results come on the back of Wesleyan being rated a ‘rock solid 10 out of 10’ in an independent survey of with profits offices by Cazalet Consulting, making it the only life office to achieve this feat for seven successive years.

The report said: ‘Wesleyan continues to top the charts with regard to impressiveness with profits financial strength, good investment flexibility and relatively very strong underlying investment performance, added to which the Society has managed the rare feat, compared to the sector as a whole, of attracting more in premium income than it has been paying out in claims during the past couple of years.’

* Results taken from Money Management magazine study published 01.01.2012 ‘With profits bonds: latest results’.

**UKloupes donates £500 to keep children smiling**

A young entrepreneur based in Cardiff has donated £500 to Smiling Train a charity that provides free cleft surgery to hundreds of thousands of poor children in developing countries.

Clefts are currently a major problem in developing countries where millions of children are suffering with uncorrected clefts. Most cannot eat or speak properly, aren’t allowed to attend school or hold a job. They face incredibly difficult lives and their clefts usually go untreated because they are poor – too poor to pay for a simple surgery that has been around for decades.

UKloupes donates £5 from every sale to Smiling Train and have, through other fundraising events, donated more than £15000 to the charity.

Dave Stone, founder of UKloupes and a newly qualified dentist, comments: “In such a tough economic climate, it’s easy to forget about others in the world who may be suffering more than just financial difficulties.”

The UKloupes donations will have provided cleft lip and palate surgery for 10 children as well as training surgeons and providing medications and equipment.
Laugh 'Til It Heals: Notes from the World's Funniest Cancer Mailbox, has been described as the book that offers healing humour for cancer survivors and brings funny cancer stories to life.

Written by bestselling author Christine K Clifford, Laugh 'Til It Heals: Notes from the World’s Funniest Cancer Mailbox is a compilation of touching cancer stories from men and women who sent letters to The Cancer Club®, an online forum for people with cancer.

The book explores the humorous side of cancer while also providing information on how to support someone who has cancer, and giving advice regarding beneficial nutrition. The book is also practical in citing resources created by cancer patients worldwide.

As you read these touching stories, you will laugh out loud with the storyteller. Laugh at the story of a woman chancing tumbleweed (her wig) across the parking lot on a windy day, or the woman who suffered the side effect of a process 

Laughter and humor can help you get past the unpleasant, manage the unbearable and cope with the unexpected. Christine firmly believes laughter saved something as important as her life during cancer: her spirit. All too often our sense of humour escapes us in times of trouble, yet Christine believes laughter has many therapeutic effects and can assist in fighting illness.

One of Christine’s members had been very depressed since her mastectomy. One day all that changed and she appeared to be much more back to her “old self”. A good friend noticed and asked her friend what the difference was. Her reply encapsulates the essence of the book: “Last Tuesday I just woke up and I realised that my sense of humour wasn’t in my left breast!”

Laughter ‘til it heals. Notes from the World’s Funniest Cancer Mailbox, by Christine K Clifford.

Address: The Cancer Club®, and giving advice regarding beneficial nutrition. The book is also practical in citing resources created by cancer patients worldwide.

As you read these touching stories, you will laugh out loud with the storyteller. Laugh at the story of a woman chancing tumbleweed (her wig) across the parking lot on a windy day, or the woman who suffered the side effect of a process.
The Direct Access debate

In our look at the two sides of the debate surrounding Direct Access (DA) for hygienists and therapists, Shaun Howe argues that DA can only be a good thing...

I
t's an old profession; I'll grant you it's not the oldest but we do have to thank Dr Alfred C Foxes who in 1911 decided to train his dental assistant in how to carry out prophylaxis in the mouth, in the knowledge that good oral hygiene would prevent future disease. We have come an awful long way since then; being enrolled (1958), having the ability to work in general dental practice (1974) and the rest as they say, is history.

Patient wants vs. Patient needs

We work in a patient-led profession; despite what we say or tell our patients, they have the right to choose what they have done to them. We tell them the effects of not treating disease and they still choose not to have treatment(s) carried out. It is their body and it is their choice, and we respect that. In this scenario how could it not be argued that direct access is a good thing?

If we were ethically obliged to treat disease regardless of their choice, we may have a very different discussion here but that has never been the case (with the very rare exception of those unable to make decisions for themselves). However, the reality is that we have to let patients make their own choices. If a new patient attended a practice and was told by the GDP that they needed x fillings and not treatments and treatment for advanced periodontal disease, yet all they sought was removal of stain, then we are powerless to stop that and have to respect their wishes and do what they want (providing the treatment does not harm them, in this case we may refuse to treat them).

We have to explain the consequences of not having the prescribed treatment but it still remains their choice. The GDP tells us this is so and that we have to respect dignity and choice.

Patient safety

The biggest concern for all involved has to be patient safety; this I cannot argue against. It is imperative that patients are protected and cared for. There are some that will argue that patients will use direct access because of direct access and have suggested that this is because the GDP will screen for disease that we may miss. I know what a hole in a tooth looks like and sometimes have to get the GDP in to confirm that yes, it is a hole and it needs treatment; this is despite the fact that the patient has just (or recent- ly) had an examination. This is not a dentist bashing; far from it. I often feel that in the team I work in that this protects the patient, the GDP and myself from potential problems; the more eyes the better as far as the patient is concerned.

The FGDP recently asked for DCPs who have spotted a cancer made a difference to patients' wellbeing because of this, all as part of Oral Cancer Awareness Month; hang on a moment, surely the GDP should have spotted the lesion? Just a thought. But this was perhaps naughtily of me using this because I do not know the ins and outs, but to suggest that I (or any other hygienist) would ignore a lesion is somewhat surprising in the least. I will always ask my dentist colleagues to look at anything I don't like the look of and sometimes I refer onwards because that is the right thing to do. I do not believe that with direct access patients are anymore at risk than they are now.

Protectionism

There is, I am afraid to say, a whiff of protectionism about the whole anti direct access argument. This is somewhat of a lame argument as there are very few hygienists who will work with an associate-type contract rather than the current models out there. I know very little about being self-employed (being wholly employed in the practices I work in) and I see no reason why this could not continue with direct access as the patient goodwill will still belong to the practice and not the hygienist in question.

Qualification and experience

I think there is some confusion amongst many about who will get direct access and under what rules. Many of us feel that there is a very real need for not only qualification but some recognised course that will enhance those skills learnt in hygiene school, and with experience; perhaps after gaining this qualification working with a periodontologist mentor that would be available for advice if necessary.

This would be an absolute pre-requisite and not negotia- ble. This would allow those that do not want the added responsibility of direct access not to have it. Let us not forget that this is not for all; it would allow the indemnifiers to differentiate between those that have added responsibility and those that don't and have proportionate fees that reflect this.

The very real world

Ok, it is a fact that many of us work in the absence of a diagnosis or a correctly completed prescription. I have spent 18 years working with “feel IYg” in notes as have a great number of hygienists and therapists, Shaun Howe argues that DA can only be a good thing...
of my colleagues. We carry out diagnosis by proxy on a daily basis and in many cases will be the first person to mention to a patient that there is pocketing and inflammation (notice the subtle difference here; we tend not to tell them they have a periodontitis).

If we are to work to a prescription then this in itself is somewhat of a quandary; the GDC in its Standards Guidance tells us that a treatment plan from a dentist could be “outline” or “detailed”. Again this presents problems on a daily basis because I am then left to decide the direction of treatment and to decide what treatment the patient needs without any clue from the GDP. Perhaps this is a trust issue and the GDPs I work for trust my judgement, skill and abilities? I’m not sure if this is true because I have walked into practices as a new member of the team and still had the same issue!

There is plenty of anecdotal evidence that this is wanted by patients; the GDC regularly has patients contacting them wanting to know why they have to see a dentist first as do the practices I work in. Reception at one practice receives on average three or four telephone calls a month from patients wanting to book in for a hygienist appointment, only to be told they cannot as there is no valid prescription in the notes and to get that they must have an examination with their GDP; frustrating for all involved I’m sure you would agree?

I do not think direct access is quite the issue many are making it. There are so few that want to open their own practice and the vast majority perhaps just want the ability to see a long standing patient without having to go through the rigmarole intimiated to previously? They will screen for disease and advise the patient appropriately because to not do so would be unethical. Whilst this piece does not allow me to explore the whole “pro” argument in any great detail, I do hope it has made many think?

There are lots of issues and there are those that perhaps could present this argument in a much better way. The above is my opinion only; I choose not to be a member of the various representative bodies but that does not make my opinion any less valid and I thank Dental Tribune for giving me a forum in which to do so.
Direct Access: Against
Debbie Withers discusses the arguments against Direct Access for hygienists and therapists

I would like to make it clear that the views stated are my personal views as a working therapist in general dental practice and do not represent the views of any organisation or professional body.

I wish to make my views on the direct access proposal public as there are two sides to every story – yet only one opinion has been widely represented in the majority of the dental press. I am, to put it bluntly, against direct access to therapists and hygienists from the general public, without an examination from a registered dentist. Whilst this may go against the grain of many in the profession(s) it is perhaps about time that someone who is against the proposal represents the view of the very silent minority?

In his article, Shaun manages to present his views in an articulate way and approaches many of the fears that I have in a logical and sound fashion, but he does not cover every aspect. I certainly believe that the vast majority of therapists and hygienists have the ability to take on further study to enable them to provide an excellent service – I know we do – I just don’t understand why we would want to.

I wholly embrace the fact that two pairs of eyes are looking at a patient’s mouth; I also really appreciate that the final decision on most aspects of patient care are not weighing on my shoulders, this should be approached in a fashion that allows me to perhaps question what has been proposed, but also that I am not the final arbiter in the choice of care for the patient. If I wanted this, I would apply to dental school and train to complete my BDS!

One of my main concerns is that a hierarchy of therapists and hygienists could be then measures can be put in place. A dentist very rarely works alone, so is in a safer position to see a brand new patient; this protects the patient, and also the DCP from unproven allegations.

It is also important to be aware of financial considerations. Obviously, with increased responsibility for patient care, then indemnity costs should increase and perhaps significantly? Will registration with the GDC increase to satisfy the potential risk of appearing in front of the PCC in future years? Will our salary increase to reflect our increased responsibility? Will employers be willing to embrace change to their previous practice and embrace the costs that come along-side? I accept that there are those that embrace this potential future, but I do wonder if this is being driven by some so vigorously that people like me may be left out in the cold with our views not being heard. There are many questions that I am unable to answer but I can certainly speculate on.

I look forward to finding out the results of the proposals for dental hygienists and therapists and would suggest that a thorough and wide ranging consultation, covering all the aspects I have outlined, that may or may not address these concerns, should be completed prior to any decisions being made; that would allow us all to see the impact they could have on dental team working.

‘If a patient has seen a dentist first we have some guidance as to the patient’s attitude towards dental treatment; if they are phobic, or occasionally unstable then measures can be put in place’

Debbie Withers: I wholly embrace the fact that two pairs of eyes are looking at a patient’s mouth

Debbie Withers

Debbie Withers qualified as a dental therapist and dental hygienist from the University of Portsmouth in 2009, and currently works in private & NHS practice. She has a particular interest in paediatric dentistry & anterior composite restorations.
Are they all out to get you?
Stephen Hudson delivers part one looks at the situations we can change

I want you to imagine, for a moment, that there is a great conspiracy (this is a fictional conspiracy of course, I am not suggesting such a thing exists). The conspiracy has one goal: To create anger and indignation within YOU

Dark agents lurk in the fetid bowels of corporations, council and government agencies, traffic planning offices as well as lurking beneath the desk of the country’s newspaper editors. They whisper vile plots, twist and scheme and manipulate those whose morals are corroded, and whose hearts and souls have died. Let us see how this conspiracy might manifest:

• On your drive to work you always turn right at a certain junction. One day you reach the junction and find a no right turn sign has appeared, sending you down an intricate one way system.

• You bust a tyre on your road that is riddled with potholes. But said road has just been invaded by sleeping policemen and “nobby” pavements.

• You email customer support via a secure part of the company’s website which can only be accessed by your password, which only you have. You ask a question and are informed that you will need to ring customer service to get your answer for “security reasons”.

• Your local council spends hundreds of thousands on “fast finding” trips abroad, whilst threatening hundreds of cuts to front line services due to austerity.

• The government cut the budget by £7b, only to then give that £7b saved to “help” the Irish banks.

• You buy something form a shop, “would you like to join up for our blimblam card?”. You say no, “are you sure, you get 10 per cent off badgers entrails when the sun is eclipsing Orion”. You say no, “But you get a free Wall’s polishing kit”. Repeat until you walk out of the shop without saying no, “But you get a free Wall’s polishing kit”. Repeat until you say yes.

• You are walking past a peaceful window to see the sun shining through the paper down and look out the window to see the sun shining and children playing.

• You are told you must apply for an eCRB check, for a job you have been doing for 50 years.

• You open the newspaper and are assaulted by how terrible life is. War, famine, death, kids, recession, depression… You put the paper down and look out the window to see the sun shining and children playing.

• Your car renewal insurance comes through, 40 per cent higher than last year, even though you haven’t had an accident that was your fault in more than 10 years.

• You are told you cannot have breakfast because, “it’s all been put away”. It’s there, in the feckin’ kitchen.
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Have you got Critical Illness Cover?

Dino Charalambous discusses Critical Illness Cover for dentists

Life insurance is by far the most popular form of protection taken out by dentists to cover their dental loans, mortgages and to protect their families. Critical Illness Cover (CIC) is sometimes mentioned briefly or not at all by some advisers, due to their increased premiums.

Critical Illness Cover is normally a ‘bolt on’ to life insurance and provides a one-off lump sum if you are diagnosed with one of the critical illnesses covered by the policy. Most critical illness policies will cover between 25 and 40 critical illnesses.

The lump sum payment can provide financial assistance to a family when they need it most; a dentist that has a critical illness may be the main breadwinner, if they do not work then income will not come into the household, financial worries will also not help them to get better. On top of all of this, they may need to see specialist doctors or get private treatment. Income protection policies may go some way in providing income to the household; however this will be a limited amount on a monthly basis or after a deferred period and may not be sufficient to cover all the expenses in the event of a critical illness. There is no limit on the amount of critical illness cover you can take out.

You can also have a combination of cover between life insurance and critical illness cover; for example you could have £50,000 of life insurance and £250,000 in critical illness cover on the same policy, so the most popular policy for dentists is the cover you require to fit into your budget for protection.

Not all critical illness policies are the same; an article in the London Metro edition dated the 27 July 2011, illustrates a prime example of this. A bus driver took out a critical illness policy 12 years ago for £500,000, unfortunately he had to have a leg removed recently, he thought he would be covered and contacted his insurer, to find to his horror, for the policy to pay out he would have needed to have BOTH legs removed/ampu­tated.

As a dentist, put yourself in his situation. If you lost an arm/limb would your critical illness insurer pay out?

There is only one provider of critical illness cover which would provide the correct cover for dentists: are you with them or not?

Most critical illness policies also provide other benefits like children’s cover and Total and Permanent Disability. These policies can be arranged with guaranteed premiums, which mean that the premium won’t change over the term of the policy; or reviewable, the premiums would be reviewed in line with the current market, generally every five years.

Dental loan cover

Life and critical illness cover can be used to cover a dental loan, in the event of a critical illness the bank loan would be cleared and the dentist would earn income from the associates. If the dentist died, then the loan would also be paid off so this in effect provides a two-fold protection for the dentists and their estate.

Family and mortgage cover

Life and critical illness cover can be used to cover a house mortgage. The mortgage can be paid off if the life and critical illness policy is taken out for the outstanding mortgage amount. The policy is normally arranged whereby it can pay out on first death or first diagnosis of a critical illness.

Family protection can pro­vide a lump sum to the family in the event of a critical illness or death. A family Life and Critical illness policy can be taken out in addition to mortgage cover.

Evolution of Critical Illness Policies?

There is one provider of life and critical illness cover which has a unique proposition. They call it Serious Illness Cover, which would cover up to 16 critical illnesses. This is based on the severity of the illness/condition and would pay out between 10 per cent and 100 per cent of the insured amount. This is unique in the market, so in the event of a serious illness that meets their criteria you would still get a pay out, it’s not an all or nothing policy. This may be the way forward for future critical illness policies.

If you have an existing critical illness policy it is best to get advice before replacing it, as some of the older policies may cover more critical illness definitions than newer ones.

Critical Illness Cover should not be taken as an alternative to income protection and vice versa, they are separate policies and cover different situations. Critical illness cover pays out a lump sum payment whereas income protection would pay out a monthly income.

About the author

Dino Charalambous has been a mortgage and protection broker for over seven years and provides a personal service for his clients in mortgages, life insurance, critical illness cover, income protection and general insurance. Where possible, he likes to provide face to face interviews so he gains a full understanding of his clients’ requirements. Dino will take charge of any applications and follow it through to the end so that there are less potential hassles for clients. This also ensures his clients have the appropriate cover for their needs. The dental sector is his main focus and he has worked with many dentists over the past seven years and many of his friends are dentists! For an informal chat, please call Dino Charalambous on 07939 457589/08456 121 424 or get in contact by email dino.charalambous@ft associates.com. FTA Finance Ltd is an appointed representative of IN Partnership the trading name of The On-Line Partnership Limited which is authorised and regulated by the Financial Services Authority.

‘Critical Illness Cover should not be taken as an alternative to income protection and vice versa, they are separate policies and cover different situations’
With the New Year upon us millions of people across the world will be pausing to take stock of their lives, consider their New Year’s resolutions and plan for the year ahead. For businesses the New Year is an important time. By considering both the successes and the failures of the previous year, a successful business will be one that takes pride in its successes but also learns from its mistakes to become stronger for having made them. These same principles apply just as well to the large multinational corporations as they do to businesses such as local retailers and dental practices.

For recently opened practices, the New Year can be particularly exciting, with each week providing new challenges and new potential patients. For longer-established businesses too, the New Year should be equally exciting as it is a good opportunity to take positive action for the benefit of the business. The biggest trap any business can fall into is getting stuck in a “rut”. Each and every day is, after all, a new opportunity and for this reason businesses should always look forward and so seek a positive outcome from any challenge they encounter.

In the spirit of forward thinking and positive thinking for the year ahead, one of the best things any dentist or practice owner can do is formulate a plan, both in a general sense, and also, importantly, in regards to finance.

Too often people leave their tax planning until April (which can limit the options available to you when the time comes to fill in your tax return) and you can find you might be parting with more of your hard-earned money than you might like.

Instead of leaving your financial matters to the last minute, the New Year is the perfect time to seize control of your finances and ensure both you and your business make the right choices for the year ahead.

With pensions such a hot topic for public debate and with the lifetime allowance set to drop to £1.5m in April 2012, there has never been a more critical time to start considering your options. It can certainly pay high earners to consider options beyond those associated directly with pension schemes when thinking about their plans for the future.

Beyond pensions, dental professionals and practice owners would be wise to undertake a review of the tax efficiency of their current investments. Another factor that needs to be considered is the impending reduction in the level of capital allowance, which is due to fall in April 2012. This in turn can potentially impact upon the size and timing of any planned capital expenditure or investment. If you are unsure about capital allowances, or need advice in this area, you are recommended to consult an IFA for the best impartial advice.

An IFA can advise you on any number of ways to maximise both your personal, and your business tax efficiency. Be it a question of tax-efficient savings or even the best means to save money by providing employees with tax-free benefits in lieu of salary, an Independent Financial Advisor will be able to offer you honest, impartial advice in order that you might make the best decision for you and your business.

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A media ghost town or a potential boomtown?

Rita Zamora questions whether Google+ pages are the latest “must have” in social media, or a waste of time?

Is your practice on board with Google+ Pages yet? If not, grab your stake... Perhaps you are thinking: “Not another social platform to manage! My team barely has time to keep up with Facebook”. Or you may be thinking: “Why set up shop there, Google Plus (Google+) is a social media ghost town”. If this sounds like you, this article is a must read.

It’s no question that Google is still the king of search. Although Facebook has passed Google with the amount of time people spend on the site per visit, Google still leads the pack when it comes to search. This means that Google+ Pages have great potential to become search powerhouses for your practice. The added significance of this is that Google pages will become another valuable piece of what I like to call “online real estate” for you. In the past I’ve touted how important multiple pieces of online real estate are, and so does Google ...

In Google’s new ebook, Zero Moment of Truth, they make a few key points about the shift of the consumer search:

1 What was once a message is now a conversation. Shoppers today find and share their own information about products, in their own way, on their own time.

This means that instead of your potential patient finding you in the Yellow pages, they’re much more likely to find you because they searched “dentist London” in the Google search bar of their smartphone or laptop.

2 Word of mouth is stronger than ever. For the first time in human history, word of mouth is a digitally archived medium.

This day in age, an ad in the Sunday paper probably won’t yield a slew of new patients. What will? A great review on an online review site or a Facebook post by one of your patients sing-
down to? Simply this... The world of online search continues to evolve. If having your practice found on Google matters to you, then Google+ Pages should matter to you. Will Google reach Facebook’s popularity as a social platform? In my opinion, no (at least not at this point). Too many people have made Facebook their “home” filled with friends, photos, and memories. And, in some cases, baby boomers got dragged, kicking and screaming, to Facebook (so they aren’t going anywhere). With that said, having a Google+ business page for your practice is still another valuable piece of online real estate that can improve your search results and build your practice brand. If you have ever invested money for search engine optimisation, then joining Google+ pages is a no brainer, and could potentially return similar benefit ie getting found on Google.

So how do you set up a business profile on Google+? It’s easy! Just follow these simple steps below and your practice will be online ready to engage.

1. First things first, you do need to have a Google account (email). If you do, simply log in. If you don’t, creating one is simple. Visit https://plus.google.com

2. Once you’re logged in, go to the Google+ Business Page and click the blue “Create Your Google+ Page” button.

3. On the next page, choose a business category and add your practice name, web address, what kind of business you are. Then click “Create”.

4. Upload a business photo and add a tagline that sums up your practice on the next page and then you’re all set! Your practice now has a Google+ Business Page.

At this time don’t worry yourself about implementing a posting schedule to match your practices’ Facebook efforts. In the coming weeks or months we should know more about how Plus Page updates will play a part in Google’s grand search plan. From there, we’ll be able to better strategise the most beneficial post content and frequency for your page.

So are Google+ pages the latest “must have” social marketing tool for your dental practice? From a networking and “social” standpoint, at least at this point, it is a bit of a ghost town. However from a search standpoint (being found on the number one search engine in the US and the UK) it could be a hugely powerful potential boomtown – a benefit you could reap with the initial investment of 30 minutes of your time to get set up and familiarise yourself enough.

Will your practice stake a claim on Google+ Pages? If search and being found matters to you, I hope to see you there!

Rita Zamora is an international social media marketing consultant and speaker. She and her team actively re-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the ADAM.

Learn more at www.DentalRelationshipMarketing.com or email RitaZamora.com.

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**About the author**

Rita Zamora is an international social media marketing consultant and speaker. She and her team actively re-manage dozens of dental practices’ social media programs. Her clients are located across the United States and internationally. She has been published in many professional publications. Rita is also Honorary Vice President to the ADAM.

Learn more at www.DentalRelationshipMarketing.com or email RitaZamora.com.
You do like my articles don't you? Nobody has ever rung me up and said they don't and all my friends think I write brilliantly. Surely, feedback is only important if the mic is too near the speaker?

Apparently not. On the GDC website is a revealing research report entitled General Dental Council Patient and Public Attitudes to Standards for Dental Professionals, Ethical Guidance and Use of the Term Doctor. It was issued in November 2010 so is quite current.

In case you've not read it, here are a few points from the report:

- A large proportion of respondents within the focus groups reported a mistrust of dentists in the UK
- A prevailing concern leading to this mistrust is the view held by some participants that dentists are not seen as just healthcare professionals but rather as businessmen
- Ineffective communication contributed to a majority of respondents' negative experiences

This article is not the vehicle for debating the report and I've only referred to it to highlight how feedback, if conducted correctly, can produce some surprising outcomes. I too have had patients tell me negative things about dentists and dental staff – things they were completely unaware of.

Here's one example: the patient had not liked the way she had been treated by the reception staff whom she found to be somewhat indifferent and unfriendly. She had expected a much better service and felt her experience did not live up to expectations and would not be returning.

Unless you know, you can't do anything about it. Equally, if you get positive feedback you know you're doing well in that area and can concentrate on improvements elsewhere.

There are many ways to get feedback and I'll write about patient consultation groups (PCGs) in my next article. Here, I want to deal with one-to-one patient surveys. Just before a patient rushes out after an appointment, a member of staff can try engaging them to answer a full clipboard of questions. I wish you luck if you try this approach (ie don't). You can pass the patient a written questionnaire to complete. Again, I wish you luck if you're seeking honest and comprehensive answers (ie you won't get both).

In terms of garnering on-the-spot feedback, the best you can do, and I believe this is worthwhile, is for the front of house (FOH) staff to pose a straightforward ques-

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tion. Consider: “Is there anything that would have made your visit more pleasant?” or “Do you prefer our new text appointment reminder service?” This ‘soft’ information can usefully be discussed at team meetings and may help focus proper patient surveys, which I’m coming to now.

In my experience, telephoning patients is a much better method and indicates that the practice has an active interest in them as an individual. A patient’s responses will be far more detailed, and hence be invaluable business intelligence, during a telephone ‘chat’. I use the word deliberately to suggest informality.

The best time to contact a patient is straight after an appointment and certainly within seven days – a period I describe as the ‘golden time’. In my experience, seven days is the maximum period patients will retain a clear recollection of their visit, what they experienced and what was said to them.

I have found the greatest success by telephoning patients on a landline (if you call their mobile, they could be anywhere doing anything) at home in the evenings or at weekends. Most recently, I have learned when doing patient surveys and remote patient coordination that a surprising number of people who are too busy at the time to get involved in a conversation ask that I call back on a Saturday or even a Sunday morning.

You should always ask whether the patient you are calling is happy to spend some time giving feedback about their recent visit to the dental practice. Since you should do a few trial runs with colleagues or friends of the questions you intend to ask, you should have some idea of how long the conversation will last. Most people will agree to give up 10 minutes (and quite often stretch the conversation to longer) whereas suggesting at the outset it could last 20 minutes or more is likely to result in a refusal to participate.

You should have questions written down and they should be open questions – ones that cannot simply be answered by yes or no. You may wish to focus the questions toward a particular aspect of the practice – reception arrangements if you have recently recruited new front of house staff, for example. Do not, however, follow your script slavishly. Although you want to ask similar questions of a number of patients so you can compare the answers, you also wish to give patients a platform to mention virtually anything they may like or dislike about your practice and the staff.

I say virtually, because if the conversation turns to a complaint of a clinical nature the interviewer will need to cut the patient short to avoid compromising your procedure for dealing with these.

I mentioned earlier a negative comment made about reception staff. When carrying out surveys you won’t be asking patients directly about members of staff but you can pose questions that allow them to make observations. For example: “How would you describe the way you were dealt with at the reception desk?” or “What comments would you make about communication with the dentist and dental nurse?”

Aside from the dentist or hygienist they saw, patients are unlikely to know names (full marks if your patients/dental team communication is so good that they do know the names of nurses and reception staff and/or they wear name badges) so you will have to research who a patient saw if they make specific negative (or positive) comments.

You should also be prepared for a patient survey call to turn into a treatment co-ordination exercise – where the focus is more on discussing a patient’s treatment plan and resolving any questions and concerns they have.

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Caveat Emptor (or do you believe in love at first sight?)

Alun Rees provides some tips for buying a practice

Caveat Emptor is Latin for “Let the buyer beware.” The idea that buyers take responsibility for the condition of the items they purchase and should examine them before purchase. This is especially true for items that are not covered under a strict warranty.

But 12 months on and you’re sinking. The reason the accounts were so healthy and the bank was happy to lend is because they covered the years when the previous owner had discovered crowns but chosen to forget periods, especially in the plan patients.

The receptionist and practice manager had been described as the heart of the practice. She knows all the patients because she has been there for so long and is now busy telling everyone she meets that you’re full of these new-fangled ideas that are OK in the future.

So what do they do? Scour the adverts in the BDJ, ask the agents to be placed on their mailing lists, smile at the manufacturers’ reps and ask if they have any knowledge? Eventually something turns up; they inspect, get the accounts and show them to their bankers (and lest we forget a banker can sometimes be a person who lends you an umbrella when the sun shines and demands its return when it starts to rain).

Oh the excitement! (Scenario) “This is it, this is love, and this is the one for me.” The banker says they’ll lend me the money! It took them a couple of weeks to make the decision but obviously saving for the deposit was worthwhile and the seller’s accounts look good. Fantastico let’s get the offer in quickly, we’ve heard that practices are being snapped up at the three months fly by, whack, hand your notice in, and get the new equipment on lease; than the asking price? OK, we can get a banker can sometimes be a person who lends you an umbrella when the sun shines and demands its return when it starts to rain.

For further details and to book your place please visit... www.businessofdentistry.co.uk or call: 0845 003 0048

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"My clinical confidence has grown immensely and my case assessment feels stress free now. The uptake for work, and therefore my income, has increased massively. I had easily recouped my investment in the course fees plus a lot more in just six weeks."
Tim Earl, East Sussex

"Great atmosphere, a lot of fun!"
Thomas Mistrman, Sweden

"Ian Buckle is incredibly knowledgeable, approachable and realistic."
Jacqueline Fergus, Aberdeen

"I felt the pace of theory and hands on was spot on, clearly understandable processes to take back to my own practice."
Stevens Bass, Buckinghamshire

"Life-changing (dentally!) every dentist should attend."
Neeta Shah, Middlesex

Hands On

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Will the teams that work together succeed together?

Mhari Coxon

Things are a bit tight for many of us just now and with the economy in such a mess it may well get worse before it gets better. Many of the profession agree with me when I say we all have to run twice as fast to stay in the same place. There is a real temptation to moan and point fingers at this stage. Someone has to be to blame right?

I am imploring us as a dental profession to stop the bickering, back biting and moaning (especially in public and on forums) and work in a united manner to survive this tricky time. Recently I have witnessed real aggression towards fellow professionals who are not in your field. Dental nurses bemoaning the fact that hygienists, therapists and dentists are not supporting them enough; hygienists are whining that dentists do not appreciate them; hygienists and therapists feeling disgruntled that no-one knows what they do; dentists whinging that their staff members are not motivated enough; and the dental technicians, clinical and non-clinical, working quietly and politely for the most part and being segregated slightly by other groups. Everybody is blaming everyone else for their dissatisfaction with their chosen career. I really doubt that any profession is without its frustrations and although I applaud our drive for change and solution I am saddened and embarrassed when we turn on our fellow professionals and team members in an attempt at solutions.

If we are to change as a profession, and change the way the public perceives us, then our attitude has to change. Yes, we all have issues that are important to our individual roles. Yes, we all want respect and recognition for what we do. But, do you really think that moaning, whinging and attacking others is the way to do this? Isn’t it just a bit playground bully like? A wonderful friend once said to me “you catch more bees with honey than you do with vinegar” She was completely correct. If we can unite in our problem solving, be it political or in practice, and work hard to earn the respect and recognition we all feel we deserve then things can only get better. Too many of us feel...
we are owed our living without working hard for it.

Let leaders be leaders
I implore the leaders of our practices and societies and associations to lead by example and show respect to your fellow professionals regardless of their role. This profession would be nothing without great decommitment nurses and dental therapists who deserve the respect of us all, in the same way one of our academic researchers should be held in reverie. A leader needs to provide the vision, communicate that vision and inspire their team to work towards that vision. They have to take responsibility for their actions when things go right and, more importantly, when things go wrong.

Remember who the most important team member is
When we are feeling the pressure and strain of a heavy workload it is understandable that we start to think about our situation and sometimes feel a bit hard done by. We can lose sight of the good things in our day to day jobs and find fault with everyone around us. It is vital that we remember that there is really only one person in the team who gets to be more important than the others and must always be supported and cared for. That team member is the patient.

Without excellent patient care we are nothing and we all fail in our duty. Focusing on our oral health and hygiene protocols and plans in practice will stand each team and inspire their team to work towards that vision. They have to take responsibility for their actions when things go right and, more importantly, when things go wrong.

Get creative in your thinking and ask your team to contribute
Some of the best strategic thinking I have had the pleasure of doing recently was with a panel of dental professionals. It was such a great opportunity to see the patient’s journey from so many different perspectives. Using reflection and working in a respectful manner to everyone on that panel, from the dental nurse to the dentist, we were able to develop successful strategies. This is just as doable in practice with your team and every member will have something worthwhile to contribute if the leaders of the team can be patient and respectful and encourage staff to feel they can contribute.

Keep calm and carry on
I know this is a soap box moment for me but I am indulging myself as I hope that at least one person will read this and decide to stop talking and acting in a negative, disrespectful manner and aim to work in a positive, respectful way. If we all decide to be positive, respectful and caring in our nature then it is not only the patients who will benefit but the rest of the team and ultimately us ourselves as those that pay it forward, and keep going and work hard tend to talk about the good luck that befalls them. And in our heart of hearts we know this is not luck but a case of reaping what you sow. So let’s get working towards what is going to be a fantastic future in dentistry and support each other in the process.

About the author
Mhari Coxon has 20 years experience in dentistry, working as a nurse, hygiene and oral health adviser 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 MSc, Mhari excels at motivating and re-orienting a team and utilising skills, developing leadership and developing self efficacy in members. Throughout her career Mhari has developed hygiene protocols and plans in practices which have continued to be used with great success. Mhari is Clinical Director for CPDforDCP Ltd, a training company offering motivational and interactive development courses to the dental team. A keen writer, Mhari is on the Publications Committee of Oral 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, the BSDHT, the BDA and the International Symposium of Dental Hygienists, the dentistry show and many others. In 2006 she was the Probe Hygienist of the Year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50. She has presented at the UK. 2012

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ENTRY DEADLINE
3rd February 2012

Special care dentistry
Margaret Martin provides an insight into the ethos of special care dentistry

Special care dentistry provides the greatest provision of care for patients with specific medical needs. It includes screening and domiciliary visits, preventive and treatment programmes tailored to meet the specific needs of groups or individuals. People who need special care dentistry largely fall within the definition of disability as defined in the Equality Act of 2010, formerly known as the Disability Discrimination Act. The DDA gives disabled people the right to equal access to services including dental treatment. Under the DDA reasonable measures should be taken to make dental premises more accessible to disabled people. The other act relevant to special care dentistry is the Mental Capacity Act 2005 which has five statutory principles to protect and support people with learning disabilities. These principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
3. A person is not to be treated as unable to make a decision unless all practical steps to help them to do so have been taken without success.
4. An act done or decision made under this act for or on behalf of a person who lacks capacity must be done in their best interest.
5. Before act is done or decision is made on behalf of a person who lacks capacity should be done in the least restrictive manner of the person’s basic rights and freedoms.

As a dental nurse it is not compulsory to have any post qualification experience before you can work with Special Care patients but the NEBIN do a post qualification certificate in Special Care Dental Nursing. To be a special care dental nurse you need to show empathy, understanding and patience at all times, giving every patient the dignity, respect and confidentiality they deserve. For anyone wishing to complete the post qualification certificate in Special Care Dental Nursing the course involves several study days; you must complete 20 log sheets and three expanded case studies meeting the required elements, ie different disabilities/care needs. The exam is a three section written paper, first is a multiple choice, then a long answer care plan and finally three short answer questions.

About the author
Margaret began her career in dental nursing in 1988 working in a multi-surgery NHS general dental practice in Stockport as a nurse, receptionist and practice manager. She gained her NEBDN certificate in 2004. In 2005 she completed and passed post qualification in Oral Health Education in Manchester Community Dental Service and has gained the NEBDN certificate in conscious sedation in 2007. Initially working in a single surgery with a Dental Officer, new in a multi-surgery teaching clinic, she assists students from Manchester University at outreach for Paediatrics and the Senior Dental Officer, a specialist in Special Care Dentistry treating children and adults with varying degrees of special needs on a daily basis. In 2011 she gained the NEBDN certificate in Special Care Dental Nursing. She hopes to do the extended clinical duties for dental nurses in Flowerdale application and impression taking.
After your three days at the BDTA Showcase, what do you see are the biggest differences between UK and Danish/European Dentistry?

The biggest difference seems to be that UK dentists mainly work with the dental unit instruments (delivery system, as you call it) placed at the right side of the patient. This is far away from the working field in the patient’s mouth. This position is analogous to placing a car’s gearstick behind the driver, in between the backseats.

What are the disadvantages of using an instrument delivery system on the right side of the patient?

The disadvantages become obvious when you understand that our work needs both concentration and precision; disturbances to this should be avoided.

The objective of a dentist’s work should be to work with undisturbed concentration on the working field, without having to look or reach away. This is not possible with an instrument delivery system on the right side of the patient.

First, when the dentist is working in the 9 o’clock position, looking at the patient’s teeth from the right side, the unit’s instruments are placed almost behind them. Secondly, the unit’s instruments cannot be reached by the assistant in order to be prepared and transferred by them to the dentist. The assistance is therefore “amputated” and the dentist has to look and reach away to pick up and place the instruments back – regardless of the dentist’s working position.

Where should the units’ instruments be placed?

The units’ instruments should be placed centrally in a balanced delivery system over the patient, between the assistant and dentist, allowing the workflow to be improved.

Then, from any sitting position (9, 10, 11, 12 o’clock), the dentist can pick up the unit’s instruments with a finger using their peripheral vision, without having to look away from the patient’s mouth.

Secondly, the assistant can change contra-angles, mount burs and diamonds, use the 3-in-1 syringe and pass the unit’s instruments to the hand of the dentist.

Finally, the unit’s instruments can be supported balanced, so that the dentist’s hand is liberated from carrying all the instrument’s weight in his hand, thus aiding precision.

What is the reaction of the patient to a centralised instrument delivery system? When the patient is lying down the unit’s instruments cannot be seen by the patient.

However, the dentist’s head is very visible. When the dentist is working traditionally, their head and eyes will move back and forth more than 100 times while making a composite-filling, for example. The patient perceives this as disturbing and distracting, because it appears that the concentration cannot be held; this is not “calming” for the patient.

However, when working with a central instrument delivery system, the patient perceives the dentist’s head to be in a fixed position in front of the patient and their eyes stay focused on the working field in the patient’s mouth.

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Do you have a comment on why dentists in the UK use a delivery system on the right side? As there is no practical, ergonomical or psychological reason, the reason for using a side delivery system is historical, and probably because instrument holders for side delivery systems are more easily manufactured. Obviously this position has not been challenged and the value of alternatives demonstrated.

The cheap to produce side delivery systems were used in Scandinavia, too, until about 1975, when, among others, I became very active in promoting the benefits of using balanced centrally located instruments. As a result, the “old habits” were left behind and replaced by new “working systems”, which allow relaxed concentration on the patient.

These principles are now generally accepted in continental Europe, except in Germany, where the strong German dental industry still try to promote 50-year-old traditional habits in competition with “modern” ergonomics.

What do you consider are the most important benefits of working in a more ergonomic way for the dental team? The most important benefit is the enhanced ability to maintain undisturbed concentration on the work in the patient’s mouth. Plus the opportunity to relax and see your hands’ precise and fast movements more easily, and be much less tired.

I believe the less the dentist needs to do, and the more the clinical assistant can do, the more efficient and profitable the practice will be because it will save time. Time to either earn more money or enjoy more leisure time and, perhaps more importantly still, reduce stress. At the same time, the increased competence and importance of the assistant increases their interest and engagement too.

What is more, working with a more ergonomically efficient surgery layout will pay for itself, because time equals money!

What are the ergonomic benefits of working four-handed? Working successfully with an assistant, four-handed dentistry enables the dentist to operate with undisturbed concentration on the work at hand.

The assistant uses their left hand to take a hand instrument from the instrument tray, which is ideally positioned between the dentist and the assistant. The instrument is extended out toward the dentist, who does not need to look away from the patient’s mouth. The assistant then takes hold of the suction tip and simultaneously moves the three-in-one syringe forward for use by the dentist, if required. The cavity can now be rinsed and dried.

The assistant keeps the mirror dry and free from condensation by blowing air on it, allowing the dentist to see when working with the mirror and spray.

The dentist can easily switch between using the handpiece and hand instruments as appropriate. This enables the dentist to focus on the task at hand without looking or reaching away.

When the patient is lying down, visual access to the patient’s mouth is good for the dentist as well as the assistant. Instead of twisting themselves, dentists can work in the midline (mediolongitudinal plane) of their body and change working position between 9 and 12 o’clock according to the line of sight and orientation of the surface or cavity of the tooth on which they are working.

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A recent study showed that 61 per cent of users are unlikely to return to a website that they had trouble accessing and navigating on their phone. Of these, more than half suggested that the experience had negatively shaped their opinion of the business / brand.

Remember, just because you can see your website on a mobile phone doesn’t mean it’s mobile-friendly. Follow these best practices to help your practice connect with patients and drive conversions:

1. Keep it quick
   Mobile users are often short on time, squeezing in online tasks as they go about their day. They may also be low on data, depending on their data package. To help them, design your site to load quickly and make copy easy to scan. Prioritise the content that mobile users need most - use your desktop site analytics to see what mobile users are doing. Reduce large blocks of text and use bullet points for easy reading and compress images to keep them small for faster loading.

2. Simplify navigation
   No one likes to be confused. Clear navigation will help your customers easily find what they need. Minimise scrolling and help users navigate between pages with clear back and home buttons. Where possible, aim to use seven navigation links or fewer.

3. Be thumb-friendly
   People use their fingers to operate mobile devices – especially their thumbs. Use large buttons and give them breathing room to reduce accidental clicks, pad smaller buttons to increase the clickable area.

4. Design for visibility
   A mobile-friendly site needs to get its message across without causing eyestrain. Make it easy for your customers to read - remember, they maybe be in a place with low light. Create contrast between background and text and make sure content fits onscreen, and can be read without the need to zoom.

5. Make it accessible
   Ideally, your mobile site should work across all mobile devices and all handset orientations. Find alternatives to Flash - it does not work on some devices eg iPads and iPhones. Adapt your site for both vertical and horizontal orientations - keeping users in the same place when they change orientation.

6. Make it easy to convert
   No matter what your site's objective is, your customers need to be able to do it with a virtual keyboard and no mouse. Make it easy to for someone to contact you! Keep forms short using the fewest number of fields possible and use click-to-call functionality for all phone numbers.

7. Make it local
   Consumers look for local info on their phones all the time, from finding the nearest cinema to locating a dentist. Include functionality that helps people find and get to you. Have your address on the landing page and include maps and directions.

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**About the author**

Amy Rose-Jones is the Marketing Manager at Dental Design Ltd, the leading design and marketing agency for the dental profession. With more than 9 years of dental marketing experience, Amy has a passion for driving your business forward through a unique blend of creative and marketing skills.

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I have always found Admor an easy company to work with and find the catalogue a useful tool for our practice which is a large NHS practice with two surgeries in Hull. My main orders have recently been for surgery signage and I find the bespoke service Admor can provide, is excellent, and would like to thank them for their help in maintaining a well-presented, uniform dental practice. I ordered from Admor again this morning! Challenge Dental Centre, Hull.

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As part of the company’s on-going commitment to dental education and training, DENTSPLY organised a mini forum in Konstanz, Germany for GDPs interested in learning more about ChemFil® Rock. Guests at the two day event were offered the opportunity to try out the new material.

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For Keith, we provided a key alternative to traditional dentures and dental implant techniques, which help many more people like Keith transform their lives, one smile at a time.

For more information about Universal Smile Centres visit www.unitedsmilecentres.co.uk or call 03000 338459.
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For more information, please contact Communicare Dental on 0800 169 9992 or visit www.communicaredental.co.uk

ChairSafe products should be used for daily disinfection of surfaces close to patient’s mouth, adding an additional layer of security to any practice. HTM 01-05 a guidance published by the DOH, recommends that Dental Chairs and their surfaces should be disinfected after each patient treatment. ChairSafe is a solution which is easily applied and is quick to dry. ChairSafe adsorbs and penetrates into the cell wall of bacteria, fungi and viruses. With a shelf-life of 2 years and 100% biocidal, ChairSafe is a hygienic and cost-effective solution for disinfecting dental practice surfaces.

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For any other enquiries please email salc@topdental.co.uk

Cameron Day Conference 2012

Now celebrating its 12th year ‘Cancer Opportunities in UK Dentistry’ will take place on Friday 3rd February 2012 at London’s Hotel Russell.

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Arted at foundation dentists, young dentists, or anyone considering a change of career. To attend, please register by 28th January.

This year’s theme is ‘What Cancer Path is Right for You?’ and the event, which offers a full day of lectures, is supported by a generous memorial address by The Earl Howe, Parliamentary Under-Secretary of State.

Programme highlights include – financial planning for recent graduates – Working abroad – Tailed Primary Dental Care services – Hot tips for your job interview – Advice on private practice, NHS practice and branching into specialties. Delegates can also use a free membership to collect CPD points and be in with a chance of winning fantastic prizes.

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To book your place contact Ewan Milliby at UCL Eastman CPD on G70 7951261, or email d.milliby@eastman.ucl.ac.uk.

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Classified 31

Something to Smile about...

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