Pay down, hours up

New figures make for bad reading for dental professionals...

ew figures show that the average pay for self-employed dentists who hold a primary care contract fell by £1,000 to £117,200 in 2010/11.

The decrease is detailed in one of two new reports published by the Health and Social Care Information Centre (HSCIC). The other report, on dentists’ working hours to 2011/12, suggests their average weekly hours have gradually increased.

Dental Earnings and Expenses, England and Wales, 2010/11 reported that in 2010/11 taxable income (gross earnings minus average expenses) from NHS and private dentistry was:

- £117,200 for self-employed primary care dentists who held a contract with their primary care trust (England) or local health board (Wales) – known as providing-performer dentists (who make up about 28 per cent of the primary care dental workforce). This is an 8.5 per cent decrease from £128,000 in 2009/10.
- £62,900 for self-employed primary care dentists who work in a practice but do not hold a contract – known as performer only dentists and who make up the majority (about 72 per cent) of the primary care dental workforce. This is a 4.2 per cent decrease from £65,600 in 2009/10.

The report also showed that when both groups were considered together:

- 59.8 per cent earned a taxable income of less than £75,000 in 2010/11 compared to 55.9 per cent in 2009/10.
- 1.1 per cent (240 dentists) earned a taxable income of at least £500,000 in 2010/11, compared to 510 (1.5 per cent) in 2009/10.

“Dental Working Hours, England and Wales, 2010/11 and 2011/12, also published recently, is based on a survey sample of both full and part time providing-performer and performer only dentists carrying out NHS work in primary care. It provides context to the earnings figures and suggests:

- Between 2006/07 and 2011/12 there were gradual increases in average weekly hours. For providing-performer dentists hours increased from 59.6 to 41.9 hours (smaller increase for performer only dentists), the main factor being a gradual increase in the proportion of time spent on non-clinical work (25.8 per cent in 2011-12).
- In 2011/12, providing-performer and performer only dentists reported working an overall average of 51.7 hours per week in dentistry, of which 28.1 hours (47.8 per cent) were devoted to NHS dental services. The remainder, 23.5 per cent, was accounted for by private dentistry.

HSCIC chief executive Tim Straughan said: “These figures show dentists on average have seen a drop in their income, with those that hold a contract with a Primary Care Trust or Local Health Board seeing a fall in 2010/11 of over £10,000. “This information will of course be of use to dentists but also other groups including the public and policy makers. Coupled with today’s other report that suggests a gradual increase in dental working hours, this information highlights changes taking place to the working lives of primary care dentists.”

Dental Earnings and Expenses, England and Wales, 2010/11 presents earnings and expenses results by Strategic Health Authority in England, age and gender. It is at www.ic.nhs.uk/pubs/dentalearn-exp1011

Dental Working Hours, England and Wales, 2010/11 and 2011/12 can be found at www.ic.nhs.uk/pubs/dentalworking-hours1012
Dentist walks the Two Moors in aid of Mouth Cancer Foundation

A dentist from Weymouth, Dorset and his partner Danielle Wootton, a university lecturer, are walking the Two Moors Way in Devon this September in aid of the Mouth Cancer Foundation. Paul Kelly said: “We decided to do something more to fundraise to help the consequences of mouth cancer and Danielle has had a relative die from this condition. Figures for mouth cancer are on the increase”. The Two Moors Way is just over 100 miles and goes over both Exmoor and Dartmoor to finish in Hythebridge. Danielle said “neither of us are long-distance walkers but we have been training hard and we are hoping that the weather remains favourable”. The report, NHS Dental Statistics for England: 2011/12 brings together information on different aspects of NHS dentistry in England, from the number of dentists working for the NHS and the amount of activity they perform, to the number of patients seen by an NHS dentist.

Key facts include:
- 29.0 million patients (56.6 per cent of the population, including children and adults) were seen by an NHS dentist in the 24 months to June 2012; a 0.4 million increase on the 24 months to June 2011 (55.8 per cent of the population) and a 1.4 million increase on the 24 months to March 2006, immediately prior to the introduction of the current dental contract when 55.8 per cent of the population were seen by an NHS dentist.
- 7.8 million child patients, or 70.7 per cent of children, were seen by an NHS dentist in the 24 months to June 2012; 0.4 per cent of the population were seen by an NHS dentist in the 24 months to June 2011 when 70.4 per cent of children saw a dentist but the same number and percentage of children as in the 24 months to March 2006.
- The number of courses of treatment performed on the NHS increased by 126,000 (0.9 per cent) in a year to reach 30.6 million in 2011/12. This number has been increasing each year since the courses of treatment measure was first introduced in 2006/07.
- The percentage of the population, including children, who were seen by a dental professional: Deliverable CPD Programme for all dental professionals: Deliverable CPD Programme for all dental professionals.

Rise in young female dentists working for the NHS, says new report

Another increasing number of female dentists are working for the NHS, with the gap between male and female numbers narrowing, a new Health and Social Care Information Centre (HSCIC) report shows.

Of the almost 23,000 high street dentists who performed NHS activity in 2011/12, 44.5 per cent were female. This is up from 43.5 per cent on the previous year and from 38.8 per cent in 2006/07.

There has been a gradual increase in the number of female dentists making up the under-55 age group; which is now 55.4 per cent compared to 55.2 per cent in the previous year and 51.8 per cent in 2006/07.

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- The percentage of the population, including children, who were seen by a dental professional: Deliverable CPD Programme for all dental professionals: Deliverable CPD Programme for all dental professionals.

September is Colgate Oral Health Month

This September, The British Dental Association and Colgate are partnering to raise awareness of oral health as part of overall health. Colgate Oral Health Month, now in its 10th year, aims to inform and educate the general public on the importance of good oral health, and to encourage communication between dental professionals and patients. The theme for the 2012 campaign is “Oral Health as Part of Overall Health” with the following messages:
- Brush your teeth twice a day with fluoride toothpaste.
- Avoid sugary snacks and drinks between meals.
- Visit the dentist regularly.

To help raise awareness and engage with the entire population, Colgate is running a national radio advertising campaign, focusing on the three key messages above. Additionally Colgate is hosting a Q&A event on their Facebook page during the month of September inviting the general public to have their oral care questions answered by a dentist.

Dental professional participation is key to the success of this campaign, Colgate will provide all registered practices with Colgate Oral Health Month practice packs containing educational materials to help your team create a practice display. Colgate Oral Health Month is an opportunity to reinforce the benefits of improving oral health as part of a national campaign, and your entire dental team can play a key role, as part of your on-going delivery of care.

A national Colgate Oral Health Month road show will provide oral health information to the general public throughout the month of September. Venues include Croydon, Cardiff, Kingston, Reading, Bath, Islington, Birmingham, Liverpool, Manchester, Sheffield, Leeds, Newcastle and Glasgow. Dental hygienists and therapists will provide oral care advice and raise awareness of oral health as part of overall health. If you are interested in attending one of the road shows, full details of the venues can be found at www.colgateprofessional.co.uk.

Colgate will provide a verifiable CPD Programme for all dental professionals: Delivering Better Oral Health – Promoting Prevention in Adults. This will be available to download from 1st September at www.colgateprofessional.co.uk.

For further information please contact the Colgate Oral Health Month registration line on 0161 665 5881.
Editorial comment

T

his week sees the start of Colgate Oral Health Month (COHM) - a dental public health campaign now in its tenth year.

Aiming to inform and educate the general public on the importance of good oral health, and to encourage communication between dental professionals and patients, COHM is a partnership between the BDA and Colgate with activities such as roadshows and a social media campaign to get the message across to the public that oral health is a fundamental part of overall health.

Get involved with the campaign - contact the Colgate Oral Health Month registration line on 0161 665 5881 for a registration pack and more information about the campaign’s events.

As I write, the Paralympics are now in full swing so please join me in wishing all competitors (but especially Team GB) the best of luck!

BDA welcomes Monitor licensing exemption proposal

The British Dental Association (BDA) has welcomed a proposal that providers of primary dental services in England will not be subject to licensing by Monitor. The proposal, which is outlined in a Department of Health consultation published today (15 August 2012), follows extensive lobbying by the BDA.

The BDA has made the case against the need for Monitor to license dentistry since the possibility was raised by the publication of the Health and Social Care Bill in 2010. BDA campaigning has stressed to politicians and the Department of Health the extensive regulatory regime to which primary care dentistry is already subject, and has seen BDA officers regularly pressing for confirmation that Monitor’s regime would not be applied to the sector.

Dr John Milne, Chair of the BDA’s General Dental Practice Committee, said: “Dentistry is already subject to extensive regulation. Adding another, unnecessary layer to the many that already sit across our practices would serve only to tie dentistry up in even more red tape. That’s why the BDA has lobbied hard against the possibility of Monitor licensing dental practice.

“We are pleased to see that our campaigning appears to have borne fruit and welcome today’s proposal that primary care dentistry will not be subject to Monitor’s regime. This is a sensible recommendation and good news for dental practice.”

The consultation document, Protecting and promoting patients’ interests – licensing providers of NHS services, considers who will be licensed by Monitor, how licensing will operate and the financial penalties that Monitor will be able to impose for breaches of its licensing conditions. The BDA will be reinforcing its view that what has been recommended is appropriate in a formal response to the consultation.

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

Oral Health as Part of Overall Health

This year, Colgate and the British Dental Association are partnering to raise awareness of oral health as part of overall health. As part of your on-going delivery of care, the entire dental team can get involved to reinforce the benefits of improving oral health.

Visit www.colgateprofessional.co.uk to download the 2012 verifiable CPD programme ‘Delivering Prevention in Adults’.

If your practice has not previously been involved in Colgate Oral Health Month, please call 0161 665 5881 to register.
Major review into cosmetic procedures launched

Expert panel to look at the worst way to protect patients having cosmetic interventions

The cosmetic surgery industry is under scrutiny and could find itself operating under tighter restrictions following a major review into cosmetic surgery and procedures launched today by the Department of Health.

The review, requested by Health Secretary Andrew Lansley and led by the NHS Medical Director, Professor Sir Bruce Keogh, is in response to concerns raised about the industry following problems with PIP breast implants.

It will look at many issues including whether the right amount of regulation is in place, if people have the right amount of information before going through with surgery and how to make sure patients get the right aftercare.

People are being asked to give their views on, and share their experiences of, the cosmetic surgery industry and cosmetic procedures. The call for evidence, issued today, which can be found at www.dh.gov.uk/publichealth, is asking for people’s views on:

- the regulation and safety of products used in cosmetic interventions
- how best to ensure that the people who go through procedures have the necessary skills and qualifications
- how to ensure that organisations have the systems in place to look after their patients both during their treatment and afterwards
- how to ensure that people considering cosmetic surgery and procedures are given the information, advice and time for reflection to make an informed choice
- what improvements are needed in dealing with complaints so they are listened to and acted upon

This comes as a survey shows that many people consider the cost of surgery more important than the qualifications of the people doing it, or how they will be looked after. The survey of 1,762 people shows that:

- Two thirds (67 per cent) of those questioned consider cost as a factor when deciding whether or not to have cosmetic surgery (66 per cent for non-surgical procedures)
- Only half (54 per cent for surgery, 50 per cent for non-surgical procedures) take the qualifications of their practitioner into consideration
- Less than half (44 per cent for surgery, 56 per cent for non-surgical procedures) consider the qualifications of their aftercare.

It also shows that, as a result of the recent PIP breast implant problems, almost half of women (45 per cent) who said they would have considered cosmetic surgery before, say that they are now less likely to have it. This compares to a quarter (24 per cent) of men.

Professor Sir Bruce Keogh said: “The recent problems with PIP breast implants have shone a light on the cosmetic surgery industry. Many questions have been raised, particularly around the regulation of clinicians, whether all practitioners are adequately qualified, how well people are advised when money is changing hands, aggressive marketing techniques, and what protection is available when things go wrong.”

“I am concerned that too many people do not realise how serious cosmetic surgery is and do not consider the life-long implications – and potential complications – it can have. That’s why I have put together this Review Committee to advise me in making recommendations to Government on how we can better protect people who choose to have surgery or cosmetic interventions.

“We want to hear views from everyone, particularly people who have experience of the cosmetic surgery industry or of other cosmetic interventions – good and bad – so we can learn what works best.”

A team of experts will assist Sir Bruce Keogh to gather evidence and make recommendations to the Government by next March. The members are:

- Andrew Vallance-Owen, former Medical Director of BUPA
- Catherine Kydd, campaigner on PIP implants
- Professor Sir Ian Kennedy, Emeritus Professor of Health Law, Ethics and Policy at University College London
- Trudy Halpin, Editor of Marie-Claire magazine
- Dr Rosemary Leonard, GP and media doctor
- Professor Shirley Pearce, clinical psychologist and former Vice Chancellor of Loughborough University
- Simon Wither, plastic surgeon
- Vivienne Parry, writer and broadcaster

The Secretary of State for Health has also requested that the review considers a national implant register, for products such as breast implants and other medical devices. The information could include the date and place of the operation, the clinical outcome as well as a method of identifying the patients who received the product.

Researchers identify markers of oral cancer

A group of molecular markers has been identified that can help clinicians determine which patients with low-grade oral premalignant lesions are at high risk for progression to oral cancer, according to data from the Oral Cancer Prediction Longitudinal Study published in Cancer Prevention Research, a journal of the American Association for Cancer Research.

“The results of our study should help clinicians to identify patients that not everyone with a low-grade oral premalignant lesion will progress to cancer,” said Marnam Rosin, Ph.D., director of the Oral Cancer Prevention Program at the BC Cancer Agency in Vancouver, British Columbia, Canada. “However, they should also begin to give clinicians a better idea of which patients need closer follow-up.”

Oral cancers are a global public health problem with close to 300,000 new cases identified worldwide each year. Many of these cancers are preceded by premalignant lesions. Severe lesions are associated with a high progression risk and should be treated definitively. However, the challenge within the field has been to distinguish which low-grade lesions are the most likely to progress to cancer.

In 2000, Rosin and colleagues used samples of oral premalignant lesions where progression to cancer was known to have subsequently occurred in order to develop a method for grouping patients into low, intermediate or high-risk categories based on differences in their DNA. In their current population-based study, they confirmed that this approach was able to correctly categorize patients as less or more likely to progress to cancer.

They analysed samples from 286 patients with mild or moderate oral dysplasia identified and followed over years by the BC Oral Biopsy Service, which receives biopsies from dentists and ENT surgeons across the province. Patients classified as high-risk had an almost 23-fold increased risk for progression.

Next, two additional DNA molecular risk markers called loss of heterozygosity were added to the analysis in an attempt to better differentiate patients’ risks. They used the disease samples from the prospective study, and categorised patients into low-, intermediate- and high-risk groups.

“Compared with the low-risk group, intermediate-risk patients had an 11-fold increased risk for progression and the high-risk group had a 52-fold increase in risk for progression,” Rosin said.

Of patients categorised as low-risk, only 5.1 percent had disease that progressed to cancer within five years. In contrast, intermediate-risk patients had a 16.5 percent five-year progression rate and high-risk patients had a 65.1 percent five-year progression rate.

“That means that out of every three high-risk cases are progressing,” Rosin said. “Identifying lesions that are more likely to progress may give clinicians a chance to intervene in high-risk cases, and may help to prevent unnecessary treatment in low-risk cases.”
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BDA celebrates individual contributions to dentistry

Fourteen individuals who have made outstanding contributions to dentistry have been honoured by the British Dental Association (BDA) in the organisation’s 2012 Honours and Awards it has been announced this week.

BDA Fellowship, which is awarded in recognition of outstanding and distinguished service in general dental practice, has been conferred on three individuals: Dr Mike Arthur, a general dental practitioner in Lanarkshire and former Chair of the BDA’s Scottish Council; Dr Lester Ellman, a general dental practitioner and former Chair of the BDA’s General Dental Practice Committee (GDPC); and Dr Raj Joshi, a consultant in restorative dentistry who has represented hospital dentists at a national level for many years and served as both Chairman and President of the South Yorkshire Branch.

BDA Life Membership was conferred on three individuals: Dr John Mooney, the current Chair and former President of the BDA’s East Lancashire Cheshire Branch who has served as a Vice Chair of GDPC and member of the BDA’s Executive Board;

Mr Jackie Morrison who has served both the BDA’s Community Dental Services Group and its West of Scotland Branch in roles including President; and former Consultant in Dental Public Health Dr Richard Ward, a former Chair of the BDA’s Central Committee and former Consultant in Community Dental Services (now Salaried Dentists Committee).

Three individuals’ names will be entered on the BDA’s Roll of Distinction: British Dental Trade Association Executive Director Tony Reed, Emeritus Professor Philip Sutcliffe and BDA Director Linda Wallace.

Dr Malcolm Heath of the BDA’s Eastern Counties Branch, and Dr John Herrick, who has played a leading role on the BDA’s Scottish Salaried Services Committee, have been awarded the BDA’s Certificate of Merit for Services to the Association. Dr David Crosier, Communications Manager, has been awarded the Certificate of Merit for Promotion and a leading figure in the campaign to allow dentists living with HIV to practise, and Dr Mervyn Drain, a leading figure in the BDA’s Metropolitan Branch, have been awarded the BDA’s Certificate of Merit for Services to the Profession.

BDA President Dr Frank Holloway said: “The BDA is extremely proud to be honouring these fourteen individuals, whose outstanding commitment and professionalism have illuminated dentistry. Each has served the dental family and the patients it treats with dedication and professionalism and we know that the BDA’s Certificate of Merit for Services to the Profession can be proud that it counts amongst its ranks so many individuals of such calibre.”

A ceremony to present the winners with their awards will be held in London in November.

MyFaceMyBody Awards - the shortlist is announced

On Saturday 3rd November 2012 dental, aesthetic and beauty professionals will be attending the party of the year at the MyFaceMyBody awards. The theme is a masquerade ball, and with entertainment from the West End, a drinks reception and a three-course-meal, the evening promises to be a great night out.

The aesthetic and dental business is one of the most forward-looking industries in the world. It is constantly pushing the boundaries of what is possible to achieve and matches technological advances with human endeavour to create stunning solutions which change people’s lives for the better.

To recognise this, The MyFaceMyBody Awards, which is the first aesthetic and dental consumer awards, has been organised to celebrate and award those who have made a difference in the cosmetic sphere.

The prestigious awards, which are sponsored by handi…MEDIA and will be televised and consumers will be involved in the voting process.

The awards are promising to be a fantastic chance to promote company products and services and with special sponsorship packages and the knowledge that MyFaceMyBody will reach 10 million consumers during the run up to the awards through various media channels.

What’s more, the awards will be supporting Bridge2Aid, a charity set up to help bring dental pain relief to East Africa, an area where people have no access to pain relief, leaving millions in pain. The charity helps to train local healthcare workers in basic extractions techniques. Focussing on sustainability, and with the help of dentists and nurses from the UK, they train more than 48 health workers each year with plans for expansion. Because of this work, an estimated 1.7 million people now live within reach of someone who can help them when they have dental pain.

Along with a whole host of entries, from body reshaping treatments to non-surgical procedures, best clinics and community teams, those shortlisted from the dental world are:

Best Tooth Whitening
Enlighten
Zoon Whitespeed – Phillips
Pearl Branston ice and coffee
Hollywood smile
Arm & Hammer Advanced
White Max Booster
Arm & Hammer Advanced Whitening

Best Dental Hygiene
Sonicare Airflow – Phillips
Sonicare Diamond Clean – Philips
Molar Lid Tepe – Angle Brush
Molar Lid Implant Care toothbrush
Arm and Hammer SONIC Spinbrush
Pearldrops Whitening mouthwash

Most Innovative Dental Prestige Dental – bruxism
TePe Clip Strip
Smile in a day implants
Clearstep

Win a trip for two to GNYDM

To mark Colgate Oral Health Month, Colgate is offering the chance to win a fantastic week-long trip for two to New York to take in the Greater New York Dental Meeting, which runs from 24th to 27th November 2012.

The Greater New York Dental Meeting is one of the largest dental congresses in the world, attracting more than 50,000 delegates from 152 countries. Featuring some of the most highly regarded authorities on dentistry, the event at the Jacob K. Javits Convention Center in Manhattan, will be an unrivalled opportunity to expand your knowledge by exploring the latest industry innovations and practices. And after the congress, there will be plenty of time to hit the shops, take in a show on Broadway, or just sample the very best that the Big Apple has to offer.

To enter visit http://www.colgateprofessional.co.uk before midnight on 30th September.

Terms and conditions apply. See website for details.

Help us reach 25,000 registrations and unlock £10,000 for dental charities

This year, BDTA Dental Showcase is switching to e-ticketing, which means big savings in postage costs. To encourage delegates to register online, the BDTA will be donating up to £10,000 to dental charities chosen by you. All you need to do is to go to dentalshowcase.com, register for your e-ticket and vote for the dental charity of your choice. When registrations reach 20,000, we will donate £5,000, shared out between the charities in accordance with your vote at dentalshowcase.com. Once registrations reach 25,000 we will add another £5,000 to be shared between them in the same way. £10,000 really can make a difference to people’s lives, so every registration counts. Registering in advance also means that you get free entry to the show, so don’t delay.

Once you have registered, don’t forget to choose your favourite dental charity to decide how the money is shared by voting at: www.dentalshowcase.com/charity

This year’s BDTA Dental Showcase takes place from 4th-6th October at ExCeL London, the biggest exhibition on the UK dental calendar. Featuring over 500 exhibitors with knowledgeable on-stand experts displaying their full product range and more than 10,000 delegates, BDTA Dental Showcase is the premier event of the year. Register online now, if you want to get first-hand experience of the latest innovations the dental industry has to offer, all at this year’s BDTA Dental Showcase.

With mini-lectures, live theatre demonstrations and opportunities for CPD, there is something for every member of the dental team. Don’t miss out!

Remember, your online registration can make a difference! If, for any reason, you are unable to access the internet, then you can still obtain free entry to the show by contacting our pre-registration hotline on 01494 729959.
Be on your guard against oral health problems!

As part of Dental Focus’s commitment to awareness of all head and neck cancers, while also working to raise much-needed funds for the Mouth Cancer Foundation, Dental Focus® will be sponsoring the Mouth Cancer Foundation 10km Awareness Walk which will take place on Saturday 22nd September at Hyde Park in London. The event will raise funds for the Mouth Cancer Foundation, while also working to raise awareness of all head and neck cancers.

Among the many sponsors of the event is Dental Focus® Web Design – an award-winning team of online marketing experts, with more than 500 dental websites to their name. As part of Dental Focus’s commitment to community and issues affecting dentistry, Dental Focus® won’t just be sponsoring the Mouth Cancer Foundation Awareness Walk – members of the team will also be taking part in the walk as well! With last year’s event a fantastic success, this year’s event aims to be even bigger and better than ever before.

To join the Dental Focus® team on the walk, you can register for free at www.mouthcancerwalk.org.

On the day of the event, from 1pm, you will be able to collect your participant bib, t-shirt and refreshments for the walk that will start at 2pm. Once the walk is complete you can look forward to receiving your very own goodie bag packed with freebies, with prizes awarded to the highest individual and team fundraisers.

For more information visit www.mouthcancerwalk.org.

Dental Protection launches new workshop

The third workshop in Dental Protection’s communication and risk management series will be launched on 28 August in Hong Kong during the FDI Annual World Dental Congress. Key stakeholders from a variety of countries have been invited to attend the inaugural workshop that will be introduced by Kevin Lewis (Dental Director) and facilitated by John Tiernan (Director of Educational Services DPL/MPS).

Like other workshops in the series, Mastering Difficult Interactions is a three-hour interactive workshop that is available to members free of charge and to non-members at a charge.

Mastering Difficult Interactions provides a solution-focused approach to enhancing effectiveness and ease when dealing with difficult interactions.

By attending this workshop delegates will:
- Understand the choices available when faced with a difficult interaction
- Learn techniques to minimise conflict and deal with challenging scenarios
- Build the skills to effectively “diagnose” the problem
- Learn personal “survival” skills to reduce stress
- Improve the clinical outcomes of these complex situations

The workshop will run in the UK and Ireland later this year when early booking is advised. Full details are available online http://bit.ly/O2KVre.

Planmeca signs record-breaking Saudi contracts

Finnish dental equipment manufacturer Planmeca delivers three fully digital teaching environments to King Saud University College of Dentistry and the National Guard of Saudi Arabia Health Affairs as part of an extensive local health care development and investment to education.

This substantial delivery agreement includes a turnkey solution with more than 1,000 dental units, simulation units, 2D and 3D X-ray systems combined with a dental teaching software platform, which seamlessly incorporates the devices and partner solutions into a high-tech, attractive learning concept. A similar solution with 127 dental units and a complete imaging and teaching system will also be delivered to the University of Eastern Finland in Kuopio.

The government of Saudi Arabia has given high priority to health care services development. With these projects, the Saudi Arabian Ministry of Higher Education is investing in the new facilities of the female dental college and builds a new dental hospital on the male college campus. At the same time, the National Guard of Saudi Arabia invests in top level teaching environment for the educational and research purposes of the King Saud bin Abdulaziz University for Health Sciences College of Dentistry.

In co-operation with its local distributor Care Ltd., Planmeca delivers the complete digital university installations including 990 Planmeca Compact i and Planmeca Sovereign dental units and 100 simulation units as well as a complete imaging system consisting of 19 Planmeca ProMax 3D dental X-ray units, 545 Planmeca ProX digital intraoral imaging systems all interconnected with Planmeca Romexis software. The installations will be completed in fall 2012.

Lennon tooth sculpture

According to a recent report, a piece of John Lennon's tooth has been used in a sculpture.

The sculpture has been created by artist Kirsten Zuk, whose brother, dentist Dr Michael Zuk, won the tooth at an auction in Stockport for £19,500 last year.

According to reports, Kirsten Zuk has incorporated the small piece of the molar in her clay model of the singer as a tribute to the Beatles icon.

Speaking about the sculpture, which will be on display during Edmonton's Fringe Festival, Kirsten said: "I love John Lennon – I've been a huge fan all my life. This is like a time capsule. It will contain his DNA."

Donations made at the viewing will go towards the children’s charity Smile Train, as Dr Michael Zuk explained: “Lennon gave his tooth to a fan in good spirit so I wanted to do a few things that would raise awareness of the charity Smile Train, so we are asking people that come to view the sculpture at Kirsten’s Art Show this weekend in Edmonton to consider making a donation which helps children with cleft lip and palate.”

The tooth was originally given to Lennon’s housekeeper Dorothy Jarlet, who worked for the singer at his home in Weybridge between 1964 and 1968.
Mercy ships: Changing lives

Neel Kothari looks at the volunteer work taking place in West Africa

In West Africa, the severity and extent of osteomyelitis is more widespread and persistent than those seen in the UK. Apart from poor nutrition and a compromised immune system against infection, the lack of basic health care including dental treatment and antibiotics leads to uncontrolled periapical abscesses and subsequent extensive osteomyelitis in West African patients. Acute medullary bone ischaemia and irreversible bony necrosis lead to chronic suppurative osteomyelitis.

Agbekanne’s case

In West Africa, the severity and extent of osteomyelitis itself is not particularly painful given the lack of nerve endings in bone, however she did have mild discomfort due to the mucosal infection. Specialist Oral and Maxillofacial surgeon Leo Cheng reports that patients with osteomyelitis who remain untreated risk suffering from pathological fracture of the mandible and oro-antral/oro-nasal fistula for maxillary osteomyelitis. Mr Cheng also reports that very often patients presented with facial swelling and pus discharge and some have single and multiple extraoral sinususes. Some patients were tested to be HIV positive, sickle cell crisis, Hepatitis B and actinomycosis.

Although this is a severe case and rarely seen in the UK, an important message for dentists is to be aware of the increased risk of osteomyelitis that is posed by minor oral surgery procedures and bisphosphonate usage. Bisphosphonates adversely affect osteoclasts, which are the cells responsible for bone resorption and thereby act to increase bone density. The literature shows that intravenous bisphosphonate usage carries a higher risk of osteomyelitis compared with oral bisphosphonate usage.

Guanue’s case (before and after)

The uses of bisphosphonates include the prevention and treatment of osteoporosis, osteitis deformans (“Paget’s disease of bone”), bone metastasis (with or without hypercalcaemia), multiple myeloma, primary hyperparathyroidism, osteogenesis imperfecta, and other conditions that feature bone fragility.

Guane’s case local functional deficits including poor speech and overflowing of tears due to defective drainage of tears.

In Guane’s case local functional deficits including poor speech and overflowing of tears due to defective drainage of tears.

For uneducated village chief and witch doctors, babies with clefting deformities are often treated as devil's children

The second case is that of two-year-old boy Guanue, who presented with a rare bilateral facal cleft. Thankfully Guanue was lucky enough to receive treatment that managed to close his facial clefts.

Poor speech and overflowing of tears due to defective drainage of tears.

Poverty in this part of the world the outcomes for those who are sick are very poor many of the conditions that are considered treatable in developed countries often result in fatalities in the third world.

Due to extreme levels of poverty in this part of the world the outcomes for those who are sick are very poor and many of the conditions that are considered treatable in developed countries often result in fatalities in the third world.

This article tells the stories of three people who have had life changing operations thanks to the work of the all of the volunteers at Mercy Ships and discusses the impact that treatment has had on these patients.

The first case is that of Agbekanne, a 40-year old lady who presented with severe mandibular osteomyelitis as seen in the accompanying photos.

Agbekanne’s case

Specialist Oral and Maxillofacial surgeon Leo Cheng reports that patients with osteomyelitis who remain untreated risk suffering from pathological fracture of the mandible and oro-antral/oro-nasal fistula for maxillary osteomyelitis. Mr Cheng also reports that very often patients presented with facial swelling and pus discharge and some have single and multiple extraoral sinususes. Some patients were tested to be HIV positive, sickle cell crisis, Hepatitis B and actinomycosis.

Although this is a severe case and rarely seen in the UK, an important message for dentists is to be aware of the increased risk of osteomyelitis that is posed by minor oral surgery procedures and bisphosphonate usage. Bisphosphonates adversely affect osteoclasts, which are the cells responsible for bone resorption and thereby act to increase bone density. The literature shows that intravenous bisphosphonate usage carries a higher risk of osteomyelitis compared with oral bisphosphonate usage.

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Alimou’s case

Our third and final case is that of 22-year old Alimou who presented with a large multicystic ameloblastoma of the mandible.

Alimou Camara is from Conakry, the capital of Guinea in West Africa. At 16 while in the 11th grade, Alimou had to stop school as the tumour was growing in size and becoming an unsightly spectacle. His siblings supported him, but his friends abandoned him. “People laughed at me and rejected me,” he said.

He was unable to work, eat, and began losing weight. Alimou lived with one of his parents because they feel that they are cursed. Some babies with birth deformities are even left in the forest for wild animals.

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married brothers whose kids grew afraid of him. His sister-in-law feared contamination and ordered her children not to drink from the same cup. His life slowly became one of seclusion as he kept himself inside hidden away from a judgmental world.

After eight years his tumour, which hung from his lower jaw, had grown to equal the size of his head. It was a huge strain on his neck. His bottom teeth were embedded and displaced as the mass enlarged. He experienced headaches and a continual watering of his eyes.

There was a constant leaking of pus that seeped from his mouth where the fungating tumour protruded. Alimou would wipe it away, but the smell was overpowering.

For the last several years he has been unable to chew and forced to push the food to the back of his throat to swallow.

Without medical attention, these benign tumours slowly cut off a person’s airway as they grow and in many cases no longer allow the passage of food through the mouth. The eight-hour surgery involved removing the three-kilogram (6.6 pound) tumour, his lower jaw, and all his lower teeth. The tumour was removed and he was fitted with a titanium lower jaw by surgeons Gary Parker and Mark Shrime.

The day finally came when Alimou awoke without a mass on his face for the first time. Handed a small mirror, he examined his face quietly, in awe, as tears slid down his cheeks. He was unable to speak due to the tracheotomy.

Cosmetically, he looked normal again and his face felt much lighter. He was planning to go back to school as his aim was to become an accountant.

On behalf of Dental Tribune I would like to give a special thanks to Mr Leo Cheng for providing the information and photos for these cases.

For those of you who wish to learn more about the work carried out by Mercy Ships, please visit www.mercyships.org.uk for further information.

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About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Sawston, Cambridge as a principal and owner at High Street Dental Practice. He has completed a year-long postgraduate certificate in implantology and is currently undertaking the Diploma in Implantology at UCL’s Eastman Dental Institute.
Colourful perception and 50 shades of grey
Ken Harris provides a colourful update on the MSc

Well, six months have passed in the blink of an eye... and I don't feel a day older. However, I have recently been forced to face up to reality as Smile-on has posted mug shots of all the MSc delegates on the website. I'm told you are getting older when the policemen look young, but what about the dentists, they all look so young! Wonder what they think of me?

Anyway, we've picked up speed since first embarking upon the joys of dental anatomy back in January, sprinting headlong through patient issues, and galloping ever onwards towards treatment planning, with a necessary genuflection at the altar of dental photography skills. Having trouble with 50 shade of root grey?

The phoney war is over, the real war has begun! The upcoming module has us showing off our clinical skills; I do love the smell of burning dentine in the morning! The next live webinar promises to be a real crack-up with Dr Brambilla talking about “Advanced Anterior composite Techniques”. Does it get much better than this? Except perhaps a week in Brazil... (apologies Newton!!)

Anyway, tomorrow morning I have to place an all-ceramic crown on a root filled upper central incisor. The problem is with the root shade exhibiting 30 shades of grey, my nurse has suggested I need to be seriously disciplined, ooh-er missus! I don't think she’s been reading Greek epic!

Having trouble with 50 shade of root grey?

About the author
Ken Harris graduated from the dental school of the University of Newcastle upon Tyne in 1982 and passed MFGDP(UK) in 1986. He maintains a fully private practice with offices in Sunderland and Newcastle upon Tyne specialising in complex dental reconstruction cases based upon sound treatment planning protocols. He is one of only two Accredited Fellows of BADG, holds full membership of BAD and remains a sustaining member of AAGD. He is currently UK Clinical Director for the California Center for Advanced Dentistry and the only UK Graduate and Mentor of the Ken Center in Seattle.

Having trouble with 50 shade of root grey?
Five easy ways to help achieve smoother CQC compliance
Shilla Taliti provides some advice on Outcome 7

As it dawns on us all, we will all be faced with an inspector calling from CQC (if you haven’t had one already). The question is: Are you Prepared?

In this series of articles, I will be writing tips on achieving compliance based on the several outcomes CQC are looking at.

As a reminder of the tips in part 1 - they included confidentiality, patient records, complaints procedures etc.

As a reminder of the tips in part 2 - they included Good patient communication, emergency protocols, Safe practice environments etc.

This article will be based on: OUTCOME 7; Safeguarding patients from abuse.

The regulations of Outcome 7 look at things like the way in which we protect our patients against the risk of abuse and that we do not tolerate any abusive behaviour should it occur. This can be measured in the way we make arrangements within our individual practices to ensure the patients are safe by means of having correct policies and procedures in place. Patients who come to our practices should feel they are protected and that their human rights are respected and upheld.

Although my tips cover only a few areas of this outcome, I hope you find them useful in complying with CQC. This is a very important topic and for ease I have categorised it.

The four main areas in practice include: The patient focus, The staff focus, The clinician focus and The practice management focus.

The patient focus
The patients should benefit from the fact that the practice works in collaboration with other services, teams and individuals in relation to safeguarding matters; and that these procedures link up with local authorities. They should feel confident that their children are treated by a team who understands their responsibilities in line with the Children’s act 2004.

TIP 1 - have a complaints procedure and policy in place
Patients should know that if they have any concerns, they can speak to somebody about it. A complaints procedure should be readily followed by all staff and more importantly the patients should feel they are able to discuss issues with the practice. A complaints policy should

‘Patients who come to our practices should feel they are protected and that their human rights are respected and upheld’

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be displayed somewhere for the patients to see it easily, for example in the waiting room.

The incidents raised by patients, their concerns and what their actual complaint is should be logged, monitored and responded to within the normal requirements set out in your policy.

The clinician focus
There are two aspects to the clinician’s duty. One to protect the patient from abuse and secondly to heed any warning signs that may be evident from the patient of abuse. This could be, in the form of emotional or physical abuse etc.

If you suspect any of the dentists/hygienists to be in the direct line of abusing the patient, then this is a breach of our duty and the correct measures should be followed by staff in order to protect the patient. See Tip 3 on whistle-blowing.

The staff focus
TIP 2 - All clinical staff should have and enhanced CRB check done
All members of the dental team should have an enhanced CRB check done. The only time you may want to carry out a comprehensive risk assessment.

TIP 5 - have a whistle-blowing policy in place
The practice staff should have the confidence to report concerns without worrying about the consequences and they should know their rights under The Public Disclosure Act 1998 for whistle blowing. These concerns may be in the form of abuse (verbal, physical etc).

The staff should feel that they can disclose something and are protected when doing so. The disclosure should be made to the appropriate body like the practice manager, partner, PCT or the health and safety executive.

The practice management focus
All members of our dental team should have a personal responsibility for safeguarding patients. The staff should understand the signs of abuse and know who to go to, if they have any concerns.

Tip 4 - have a vulnerable adult’s policy and staff training on it
This is mostly where a patient is 18 years of age or over and they are not able to look after themselves or protect themselves from harm or being exploited. This can include the elderly, people with mental illnesses, physical disabilities etc.

It is useful to have a policy which clearly outlines the procedures for staff members to follow and states their responsibilities to the patients. It is always useful to have the local contacts for adult safeguarding board near you, on the policy.

Staff should be regularly trained on this aspect and they should all be aware of what to do if they suspected misconduct. A training log is useful to show compliance in this area.

Tip 5 - have a child protection policy and staff training
The policy could have things such as:
• What your commitment is to safeguard children
• How you will endeavour to safeguard children
• All staff are all trained on child protection

• That you may share information about concerns with other agencies who need to know
• That you will follow appropriate management to supervision, support and training

It may be useful to have a nominated lead for safeguarding issues within the practice so that all staff and patients know who to raise a concern with.

Extra tip - restraints in dental practice
Restraints policies are rare in dentistry but some CQC inspectors have been asking for them. There are very few situations in dentistry where restraints would ever be appropriate. Examples include:
• A staff member holds a patient’s hand, to reassure them, if they are especially fearful of local anaesthetic injections. Whilst the primary purpose of such an action would be to reassure the patient, there is the possibility that the patient may want to grab the dentists hand whilst they were using the drill

The act requires two condi-
Expand your “Cosmetic” Dentistry

Oliver Harman discusses expanding horizons with an MSC in Restorative and Aesthetic Dentistry from The University of Manchester and Smile-on

In the dental industry today, there are many interpretations of the term “cosmetic dentistry”. Some practitioners would define it as a branch of dentistry that focuses solely on the appearance of the smile, as opposed to the health of the teeth. However these are not two mutually exclusive entities.

In an attempt to reconcile “aesthetics” with “cosmetics”, many practitioners are now enrolling in educational courses to help develop their knowledge and understanding within the area of “cosmetic” dentistry. In today’s society, there is a high demand for aesthetically pleasing smiles amongst the general public. As this demand increases, it is important that clinicians enhance their skills within this field, and produce the results expected by patients.

Innovative

Smile-on is currently working with the University of Manchester to provide the innovative MSc in Restorative and Aesthetic Dentistry. The distance-learning course is designed to enhance clinicians’ existing knowledge and skills, providing a combination of both instructor-led units and self-paced eLearning modules. The aim of the MSc is to develop practitioners’ confidence and ability to offer the highest standard of aesthetic restorative dentistry to their patients.

Dr Oliver Harman from The Harman Dental Clinic in Royal Tunbridge Wells, is one of the two dentists in the UK to pass the BACD Fellowship Examination, and began the MSc course at the beginning of the year.

Excellent

“I have just completed the introduction to the MSc course, and have so far found it to be an excellent grounding in 21st century dentistry,” he says. Offers a very up-to-date and progressive set of lectures, at the cutting-edge of the dental industry.

Webinars

When discussing what features of the course he found most beneficial, Dr Harman is finding the eLearning approach to be very positive. “I definitely prefer the webinars live, as I feel it adds something to the lecture. Generally the format works very well and is a realistic method of learning for busy dental professionals. The online aspect provides the fantastic privilege of allowing me to continue working while studying. This is particularly relevant to dental professionals fairly advanced in their careers, as it is more challenging to attend traditional courses regularly with great commitments to their families and practices. The online format allows for more mature clinicians to revisit mainstream education and training without making too many sacrifices.

“Technology has developed dramatically in the past few years, and the course offers a very up-to-date and progressive set of lectures, at the cutting-edge of the dental industry.”

Passionate

When talking about why he wanted to take the MSc in Restorative and Aesthetic Dentistry, Dr Harman is very passionate about the controversies surrounding the concept of ‘cosmetic dentistry’.

“In the dental industry at the moment, there are some very conflicting views about what the term ‘cosmetic dentistry’ covers. Unfortunately, I think many practitioners have formed their opinions based on some of the pretty terrible examples of so-called ‘cosmetic’ work in the past.

“As far as I’m concerned, ‘cosmetic dentistry’ is not a separate entity in practice. In all my work I aim to complete...
Approximately 6,000 people in the UK annually are diagnosed with oral cancer - with an estimated 2,000 deaths every year
(Source: British Dental Health Foundation, www.mouthcancer.org)

Oral Cancer – prevention, examination, referral has been designed to support all health professionals by updating their knowledge, highlighting the importance of oral cancer screening, and providing practical tools for communicating with patients and colleagues.

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2. Team Approach - Looking at all aspects of communication both within the team and with patients
3. Screening Examination - Practical advice on improving the opportunistic screening procedure in practice
4. Case Studies - Providing first hand experiences of examining, making referrals and living with oral cancer

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Enhancing
“The MSc in Restorative and Aesthetic Dentistry enhances my mainstream knowledge of modern techniques, providing an updated platform for my work. I put a lot of emphasis on keeping up with new advances within the field worldwide, but I think it is very important to have an understanding of the progress within the UK. “Along with a few colleagues, I wish to help bridge the gap between the widespread views of ‘cosmetic’ dentistry. Though I have just begun the course, I think it will be a tremendous help to knowing and fully understanding the literature and evidence-base behind the work I do – an invaluable benefit both in practice and for the clinical case studies and articles I frequently write.

“With so many contradictory ideas of ‘cosmetic dentistry’ within the dental community, it is no wonder the general public don’t really understand the term. In order for patients to know what we mean, we need to define the term ourselves first. We need to ensure what we’re teaching, learning and trying to achieve is the same for everyone – hospital workers, general practitioners and members of the public.”

The MSc course from Smile-on and the University of Manchester is split into seven units, incorporating webinars, lectures, residential sessions and a dissertation to end. The online resources can be accessed repeatedly, at a convenient time to the practitioner, and from a familiar environment. Including access to advice and guidance from some of the experts at the forefront of aesthetic dentistry, the course provides a solid framework for dental professionals to develop and improve the standard of service they offer their patients.

Smile-on: inspiring better care.

For more information about the online MSc in Restorative and Aesthetic Dentistry go to www.smile-on.com/msc, email info@smile-on.com or call 020 7400 8989
Implant Training Options, from “Bricks” to “Clicks”

Ken Nicholson discusses how to invest in your career and boost your practice income

No-one, but absolutely no-one, can have missed the fact that there is a global economic crisis. Perhaps this may have directly affected your practice – fewer patients, fewer referrals, decreased uptake of elective or advanced treatment.

One way of off-setting this situation is to offer something new in your practice perhaps dental implants but this requires training, so what are your options? Let’s take some time to consider these options or different approaches and tailor this article to answer the ten questions most commonly asked of me during my 12 or so years of teaching implant dentistry;

1. Does the course comply with current guidelines?
2. Will I need to spend a lot of time away from my practice?
3. How much hands-on training is provided?
4. Are patients provided?
5. Must I provide patients for treatment?
6. What recognition do I get at the end of this course?
7. Can I offer my patients a discount if treated on the course?
8. Who is ultimately responsible for the treatment (medico-legally)?
9. What happens if my patient’s treatment is not completed before the end of the course?
10. How much does it all cost?

If you look at the questions above you will see there is an underlying theme – economics. Not surprising really when one considers that the majority of people asking the questions are busy General Dental Practitioners. Question 2 for example, “Will I need to spend a lot of time away from my Practice?” – time away from practice costs money in lost revenue, travel and accommodation.

Honigum. Overcoming opposites.

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costs. Questions 5, 4, 5, 7 and 10 also have an economic theme. Think about it, what’s the point of the training? By the end of the programme you want to be able to place and restore implants in a safe and predictable manner in your General Dental Practice environment (The Goal) and get a return on your investment. Without a significant amount of hands-on training it is unlikely that you will realise this goal. An implant programme should deliver two things, knowledge and skills. Many implant courses offer the knowledge component but most struggle when it comes to skills training.

What, then, might the criteria be for the ideal implant training programme?

- Cost effective and cost efficient i.e. value for money - minimising the time you need to take out of your practice thereby being cost efficient and having low course fees, thereby being cost effective in allowing you to more readily see a return on your investment.

- Adequate skills training - Patients provided for hands-on (skills) training

- A significant amount of skills training

- A recognised qualification - That shows you are trained to a certain standard that meets the required guidelines

- That will help with marketing your new found skills

Looking at the last of these criteria first what exactly is a “recognised” qualification. This is usually taken as a degree inferred by an academic institution or a qualification inferred by a Royal College. One needs to be very wary of private courses promoting a “Certificate” or “Diploma” at the end of their programme. At best such courses can only offer verifiable CPD or a certificate of course completion.

Of course a recognised qualification is not an essential requirement but the ideal course would at least offer the option.

So what are the current pathways to meeting the ideal course criteria and what are the advantages and disadvantages of each?

The GDC supported FGDP implant training standards document updated in June this year (http://www.fgdp.org.uk/assets/pdf/publications/policy documents/implant training stds jun 12.pdf) clearly indicates that appropriate training can be delivered by a wide variety of providers ranging from universities to individuals. The important point is that the course you enrol on should, as a bare minimum, meet these standards.

The majority of UK universities now offer part-time MSc programmes in implant dentistry but this is probably the most costly route to obtaining a qualification in implant dentistry with average fees for a three year programme in the region of £25k. Furthermore the hands-on (skills) training offered on university programmes varies greatly from one university to the next.

One slightly unusual pathway to a qualification in implant dentistry is the Diploma at the Royal College of Surgeons of Edinburgh. With the right course geared towards the examination this can be the most cost effective and cost efficient route.

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The cost efficiency to both the student and the course provider can be hugely increased by the use of e-learning. This is where the situation becomes very interesting. Ever since the first European university, the University of Bologna 1088, universities have been accepted as the societal hub for knowledge and learning. For a millennium the ways in which knowledge and learning were delivered has gone unchanged through the huge societal changes created by technology. Today however things seem to be changing with a move from the “Bricks” of the university campus to the “Clicks” of mobile learning.

Change in universities to embrace the technology that can enhance learning and reduce the cost of education tends to come at a snail’s pace - Richard Holeton, director of academic computing services at Stanford University Libraries, has said “Change in higher education, as they say, is like turning an aircraft carrier. In eight or nine years we will continue to see incremental changes, but not the more radical transformations described.”

From the point of view of the GDP looking for a cost efficient and cost effective course e-learning cannot be ignored. A course on which the delivery of the knowledge component is through an e-learning platform means that the practitioner will not need to take expensive time out of practice to attend lectures. Furthermore, a well structured e-learning course can enhance the learning experience through the use of interactive presentations that you can return to time and time again as opposed to the one off lecture with a pretty pointless pdf handout. The structure of the e-learning content is of paramount importance. Web based learning should be exactly that and not just a means of disseminating lifeless information. Combine e-learning with “hybrid” or “blended” delivery and we are suddenly now well on our way to meeting the criteria set earlier for the ideal implant programme.

With the use of regular live Webinars, an online discussion forum, on-line assessment, mock examinations geared towards the Diploma in Implant Dentistry at the Royal College of Surgeons of Edinburgh and the provision of patients to treat under supervision we have now perhaps arrived at the ideal implant training programme.

The distillation of years of teaching and clinical experience combined with a knowledge and enthusiasm for IT in education has allowed Dr Ken Nicholson the director of ProfiVision Ltd. to produce such a course hosted on the e-learning platform at http://www.SmileTube.tv

University of Bologna 1088, universities have been accepted as the societal hub for knowledge and learning. For a millennium the ways in which knowledge and learning were delivered has gone unchanged through the huge societal changes created by technology. Today however things seem to be changing with a move from the “Bricks” of the university campus to the “Clicks” of mobile learning. How can the business of higher education possibly avoid the influence of technology that has transformed other information centric industries such as news media, magazines, music and television?

For further information: 01480 477307

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Children and Vulnerable Adults

Denplan’s Deputy Chief Dental Officer, Henry Clover, looks at the sensitive issue of caring for children and vulnerable adults in the modern dental practice

The vast majority of regulation inspectors will have significant experience of inspecting providers across a whole range of services – most with a background in nursing or social care. Therefore, it’s unsurprising that their enquiries to date have concentrated on aspects relating to these fields.

Denplan has been receiving a steady stream of reports from members about their recent inspections and questions that any member of staff can be asked have included:

- How do you respect and involve patients?
- Who is responsible for safeguarding vulnerable adults in the practice and how is this achieved?
- How do you ensure the safety of child patients at your practice?
- Tell me about local arrangements for safeguarding children?

There are no right or wrong answers to these questions, so it’s best to be as honest and detailed as possible – a ‘stock’ answer may not reflect exactly what happens in a specific practice and could lead to further probing questions. The Inspector wants to see how your policies and protocols translate into safe and effective care and whether the whole team can show that they work together to achieve this, so it’s a good idea to get the whole team involved from the outset.

Safeguarding vulnerable adults and children

Children

One child per 1,000 under four years of age suffer severe physical abuse and an estimated one-two children die each week in England and Wales as a result of abuse. Every member of the public has a responsibility to report their concerns about the welfare of children and vulnerable adults, but the dental team is in a position to observe these groups more frequently and your observations can be crucial when trying to prevent abuse or neglect.

Abuse is classified into the following categories:

- Physical – hitting, shaking, biting, poisoning, burning etc
- Signs of this abuse include orofacial trauma, which occurs in at least 50 per cent of...
children diagnosed with physical abuse. Also be aware that accidental injuries typically involve bony prominences such as the nose, chin, knees etc, so document injuries seen on both sides of the body, on soft tissue and any history of similar or untreated injuries. Black eyes and injuries to the cheeks, intra-oral, ears and neck are also an indicator.

- **Emotional** – being made to feel worthless, unloved, bullied etc
- Emotional abuse is often harder to recognise but signs include clingy or agitated behaviour and distress when a parent or carer is not present, self harm, abuse of drugs and alcohol, delinquent behaviour and educational problems

- **Sexual** – Including the witnessing of sexual acts or pornography etc
- Signs of this abuse can include erythema, physical damage to the mouth, ulceration and vesicle formation arising from an STD, inappropriate sexual behaviour or knowledge, anxiety or depression, delayed development, or pregnancy

- **Neglect** – failure to provide adequate food, clothing, shelter, supervision, emotional neglect etc
- Signs of this neglect can often include failure to comply with professional advice, a child being under or malnourished, have inappropriate clothing for the weather, ingrained dirt or head lice, withdrawn or attention seeking behaviour. There is also the issue of dental neglect which includes severe caries, irregular dental attendance and missed appointments,

In all these cases, you must be prepared to exercise your judgement - failure to pass on information that might prevent a tragedy could expose you to criticism. Your patient is the most important person, so don’t think ‘what if I’m wrong?’, but instead think ‘what if I’m right?’ Documenting and reporting potential abuse is essential and you must follow your LSCB guidelines. Sample child protection referral flowcharts are also available from Denplan, which you can modify to fit with your local guidelines. You should also bear in mind that members of the dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately.

**Vulnerable adults**

Vulnerable adults are at risk of all of the same abuse as children, but with the added risk of financial abuse too. A vulnerable adult is classified as someone “who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against signifi-

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*Abuse occurs in many forms including physical*
In both children and vulnerable adults, therefore, it is important to note down your observations if you suspect abuse and document any injuries including the type, extent, pattern and location, as well as the overall appearance of the person and anything else you feel may be relevant. In child cases you should consult your child protection lead in your practice in the first instance and then potentially liaise with other agencies such as your LSCB, your defence union, other health care agencies and social services. In adult cases, the LSCB is substituted by your Adult Safeguarding Board and, dependent on the case, it might be appropriate to involve the police.

If a child or vulnerable adult discloses abuse to you, it is important to remain calm and not to be judgemental. You should avoid asking leading questions, but listen carefully and ask open questions. Follow your child protection policy and record your notes using their own words wherever possible. It’s also important not to promise confidentiality as it is your duty to report your concerns.

Judging mental capacity in vulnerable adults

Some people may lack the capacity to make appropriate decisions for themselves due to age, illness, disability, substance abuse or medication. The Mental Capacity Act 2005 (MCA) covers England and Wales and is designed to protect health carers and can help you make a decision about treatment options. The MCA places it upon the treating clinician to consider the capacity of the patient and which treatment is in their best interest. It is not for the relative, spouse or carer to make this decision, which can be a difficult relationship to manage for the practice team.

Five principles of MCA 2005:
1. A person must be assumed to have capacity unless it is established that they lack capacity
2. A person is not treated as unable to make a decision unless practicable steps to help him/her to do so have been taken without success
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise or eccentric decision
4. An act on, or decision made under this act for, or on behalf of, a person who lacks capacity must be done or made in their best interest
5. Could the decision be made in a way that interferes less with their rights and freedom of action

The care and treatment of children and vulnerable adults is an integral part of every dental practice. Policies and training involving the whole dental team is essential to protect these groups and help act appropriately on any concerns encountered. It’s up to you to ensure that your practice team is up to date on all legal and legislative requirements, but knowing and applying best practice will not only improve your chances of an excellent regulatory report but will improve your business model and systems.
A centre for excellence

Dental Tribune looks at the dental training facility at LonDEC

For the past three years LonDEC has been a centre of excellence in its provision of post qualification education and training courses for Dental Professionals. These courses have principally focused on advancing existing skills and learning new skills via high-end hands-on training. The majority of courses held at LonDEC make use of the state of the art clinical skills training room that hosts the latest phantom head simulators, video operating microscopes and even a CAD teaching aid called PrepAssistant that can scan a single tooth preparation in a matter of minutes and generate reports relating to how it compares to an “ideal” tooth preparation. Visitors and users of the dedicated dental education centre report that facilities within LonDEC are better than any they have seen locally, nationally or internationally.

As well as having the 26 delegate capacity clinical skills training room LonDEC has a 65 seat lecture room, two seminar rooms that can seat 10 in each and a dental surgery set up for medical emergency simulation training as well as dental decontamination training suite.

This article will look closely at the Medical Emergency and Decontamination training suite, which has been highly acclaimed by many that have attended a course.

Medical Emergency Suite
This is LonDEC’s jewel in the crown and is home to the infamous iStan. iStan shares the facility with LonDEC’s Simulation Suite Supervisor and Training Co-ordinator Kemi Bakare.

For those who are unaware of this existing technology, iStan is a “living” manikin. He breathes, has a pulse, will speak to you and respond to your questions. Most importantly, if not cared for, should an emergency scenario occur, iStan will suffer the full consequences of an medical emergency crisis – would you and your colleagues really know what to do if iStan had an anaphylactic attack, fit, simple faint or even a heart attack whilst you carried out his dental check-up?

Controlled by computer software iStan is a life size Human Patient Simulator. Using iStan’s truly life-like behaviour enables delegates attending courses at LonDEC to see how they would actually behave in an as close to real life situation as possible.

LonDEC provides all required course materials and each delegate will receive a certificate and verifiable CPD hours. Lunch and refreshments will also be provided to all those attending a LonDEC course.

For further details & to book a place please visit: www.londec.co.uk

For any further information please email info@londec.co.uk or call +44 (0) 207 848 4570

www.londec.co.uk
of carrying out CPR but also to have the emotions and urgency that comes with a real life crisis situation.

Delegates are able to review the way they carried out the management of the crisis by watching the automatic recordings that are created. This review process is carried out in a neighbouring classroom and is where most of the learning is carried out. Seeing oneself in action and performing a task well (or less well) is a great way of seeing, and of course believing, what to do better next time or indeed, what had been done correctly and well at the time. Students can self-reflect on their practice against the theory learnt. Discussions can be held amongst the students and the Tutor is able to facilitate their learning by also giving feedback.

Decontamination Suite
Designed as a fully compliant, highly specified Sterilisation room
The aim was to demonstrate what could be achieved in a dental practice, with all the legislations and guidelines to consider.

The suite has enabled, not only dental nurses, but also other dental professionals to understand what needs to be done to achieve the best quality service for our patients.

It also demonstrates the workload required from dental nurses before or after each patient.

The Decontamination suite is an eye opener to working practice and the knowledge gained will benefit all dental professionals.

For anyone looking to design a dental decontamination suite in their own clinic it is a must see facility.

Teaching and training in this important core CPD area takes place on a weekly basis, as it does for medical emergency training. LonDEC is fortunate to have expert tutors for its own courses and for London Deanery courses held at the centre.

LonDEC can provide tailor made solutions for the full dental team and when the whole team do come along they are always surprised by what a great learning experience they have had, what a great team bonding exercise it has been and also they often go away and re-write sterilisation and medical emergency protocols. LonDEC is located a short walk from London Waterloo station in a building that is open 24 hours a day, 7 days a week. Courses can be put on at a time that suits individuals and practices. Why not make a day of it and carry out true-to-life hands-on medical emergency training in the morning, infection control training in the afternoon and then wander across Waterloo Bridge in to Covent Garden for all that the West End of London has to offer by way of shops, restaurants and theatre. The LonDEC staff will happily arrange the whole event, just let us know what you need and it will happen.

Please visit the LonDEC website for more information about the centre and the courses we offer and please feel free to contact us with any enquiries.

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Employment law: know where you stand

Michael Sultan looks at the potential minefield of employment law

Dentistry has always been a challenging profession, and now, with regulation and competition between practices at an all-time high, it is perhaps more challenging than it’s ever been. Be it the CQC, the GDC, PCTs, or even the HMRC, there are just so many hurdles for us to cross, and hoops for us to jump through, it’s staggering that we have any time for our patients at all!

Cause for concern
But while as a profession we have had to get used to the likes of CQC inspections and the need to fulfil regular quotas of CPD, there is one particular aspect to our role as employers that has given me great cause for concern in recent months. That is, employment law.

As a regular visitor to dentistry shows and conferences throughout the year I am always keen to attend lectures and listen to speakers share their thoughts on dentistry. I am especially interested to learn from our international colleagues, many of whom offer a different perspective to what we are used to here in the UK.

Our American colleagues in particular will often speak passionately on the subject of branding. According to the US philosophy, in order to run a successful practice – or indeed a successful business – staff should always reflect the nature of the organisation.

Time and time again, any speaker on branding will always say the same thing: if your staff aren’t ‘on brand’ then find staff who want to work for you!

In a British room, this message often leaves the audience feeling somewhat perplexed. This is because in the UK our labour laws very much favour the employee. As an employer then, if ever we were to employ someone who just wasn’t ‘doing it’ for us anymore, then we’d sorely struggle to part company with that employee on any grounds other than the most serious.

Labour laws
I fully understand the need for employment laws, and the need to protect employees’ rights. What I don’t agree with however is the completely debilitating and sometimes catastrophic consequences that some of these employment laws can have.

How is a dental practice expected to survive if an employee is required to be suspended on full pay during an investigation? Not only must the practice meet the cost of the suspended staff member’s pay, but they must also cover the cost of the replacement, and the loss of working efficiency experienced as a result. With employment laws as they stand even the smallest matter can potentially cripple a practice and run it into the ground.

Window
There’s been some coverage in the press recently surrounding an amendment to employment law that is supposed to work in employers’ favour. Essentially it gives employers a two-year window in which they can legally still ask an employee to leave. While this might be a slight change to our benefit, I still can’t help but think this doesn’t address a number of the fundamental issues.

As an employer, if you have a grievance with a member of staff there will be an informal and formal grievance procedure, a disciplinary and even an appeal process. With the rise in unionism within...
certain areas of the profession, we are also now finding a number of unscrupulous individuals and organisations taking advantage of dentists’ ignorance of labour law. This has led to more people than ever pushing for the likes of unfair dismissal or constructive dismissal. Very often this doesn’t leave the dentist with a leg to stand on, and the practice will fast be out of pocket if they haven’t followed the correct procedure.

Flawed
One striking example here is that if you sack someone and don’t tell them they’ve got a right to appeal then the industrial tribunal will always find for that employee, no matter what the problem was originally as the issue is a flaw in the procedure! Furthermore, dental practices will also find that if they don’t have the relevant documentation, policies or disciplinary procedures in place to protect themselves and their staff then they will find that they are themselves vulnerable to a successful complaint from a disgruntled prospective, present or even past employee.

With employment law such a tricky and potentially troublesome issue for dental practices, it really does pay to have an advisor on your side

Troublesome issue
With employment law such a tricky and potentially troublesome issue for dental practices, it really does pay to have an advisor on your side. This is why I heartily recommend all colleagues outsource to a HR department that has all the relevant skills and expertise to deal with any employment issues that may arise. In this modern and increasingly challenging world, we just can’t afford to make these kinds of mistakes. I urge you then, to protect yourselves now – you never know what might be round the corner.

About the author
Dr Michael Sul- tan BDS MSc DFO FICD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in Endodontics in 1993 and worked as an in-house Endodontist in various practices before setting up at Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPE, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practitioners. For further information please call EndoCare on 020 7224 0999 or visit www.endocare.co.uk.
Simply the best
Chris Dakin discusses the UK Dawson Academy...

I qualified as a dentist in 2002, and like many spent my early career completing vocational training, working within the NHS, and paying off my student debt! With the treatment constraints of certain areas of NHS funding, I was keen to push my career forwards the independent/private sector, and wanted a skill-set to enable me to do this. In 2006 I completed a year-long, one day a month restorative dentistry course amongst other CPD courses, and was considering what to spend my money on next!

In 2008, I heard Glenn DuPont from the Dawson Academy lecture on Solving Anterior Wear Problems, and then did the break-out session taught by Glenn and Ian Buckle. Several dentists I’d spoken to had recommended the Dawson Academy and I was considering going to Florida to complete the courses. Fortunately, Ian was in the process of bringing the core curriculum to the UK, and having liked what I’d heard, decided it was something that I’d like to do. I phoned Sally-Ann (Ian’s wife and course administrator), and re-served my place. I was to be one of the first dentists to pass through the (UK style!) Dawson Academy continuous.

May 2009, and I’m checking into a hotel at for the initial Dawson Academy lecture: Functional Occlusion – From TMJ to Smile Design. The usual questions featured in my mind; Would it be worth the cost? Would I learn things that would improve my dentistry? Would they be applicable to my practice and relevant to me?

Over the next six months I completed the remainder of the core curriculum, including Dental Examinations and Records, Aesthetics, Treatment Planning, Occlusal Equilibration, and Restoring Anterior Teeth. The small-group nature of the hands-on sessions encouraged discussion and the opportunity to ask questions, and seeing the familiar faces of participants at each of the courses led to group camaraderie and a heightened sense of learning together. Without exception, the lecturers always wanted to give as much information as possible, and many class-sessions had timings extended at their insistence to enable this. This added lots of value and made the courses excellent value for money.

Mention must also be made of the venue – I attended the hands-on classes at Ian’s practice in the Wirral. The facility is lovely, but it is the friendliness and support of his staff that really make the courses run well. They also provide an excellent social program, so it’s not all just learning!

So, the benefits of studying with the Dawson Academy? It is simply the best post-graduate course I’ve taken. So much so, that when Ian set up some advanced courses I readily signed up. It has given me a set of clinical principles and a framework in which to apply them. It has made my work more successful and predictable and has increased my enjoyment of dentistry. Furthermore, the lectures and course material forms a collection (along with Pete Dawson’s textbook) which I frequently refer. I have a part-time teaching position at The University of Birmingham, and I would like to think that it has helped me to teach some occlusion concepts to my undergraduate students.

In short, I feel that it is an excellent course, the continuum has also given me the chance to meet like-minded dentists, many of whom have become good friends. I’m sure many of them would agree with my thoughts.

About the author
Chris Dakin qualified in 2002 and works as an associate dentist in private practice in Shipston-on-Stour, and Coventry, enjoying all aspects of aesthetic restorative dentistry. He is also a part-time clinical lecturer at The University of Birmingham School of Dentistry, and has lectured on occlusion in restorative dentistry both locally and nationally.

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A career path change and discovering my passion

My first experience of the Dawson academy was a BDA lecture in Birmingham, where I first met Ian Buckle and was impressed with both his knowledge and enthusiasm. I had studied previously under well respected speakers, Bill Cornowicz and Roy Higson, so my knowledge of occlusion was already at a respectable level.

The Dawson academy however brought something very new to my career progression. In 2009 I undertook the first set of four modules for the core curriculum and found that importantly all the fragmented pieces of knowledge that I had were able to come together so that I could finally start to implement the concepts of complete dentistry into the practice. The course offers a pragmatic and systematic approach from carrying out a comprehensive examination through to treatment planning and implementation. From 2010 onwards I have successfully completed a significant number of cases, from full mouth rehabilitations to complex implant work.

To change a career path is no easy task. Having worked for many years I struggled to apply the principles that I had learnt. Focusing on the approach of a systematic diagnostic and treatment plan I began to approach my treatment decision making in a different way. I used the three dimensional approaches taught by Dr Buckle and started to visualise and create plans in the diagnostic wax up phase myself rather than expect a technician to guess where the teeth should go and what they should look like. This alone improves clinical and diagnostic skills and coupled with the additional modules of anterior restoration and equilibration helps to make important treatment making decisions in the planning phase rather than start treatment with no concept of how it will conclude– an unfortunate error many of our profession have made and are still making.

At this transitional time, Dr Buckle is there to help. He encourages bringing models and helping with the treatment making decisions, while always insisting that the all the records are as accurate as possible. Poor records mean all further stages are compromised. Unlike many of the restorative gurus out there, Dr Buckle is always approachable.

This course has truly changed my practicing career and I am now doing the kind of dentistry I could only have imagined a few years ago. I have since gone on to the advanced set of modules and slowly have gained the confidence to tackle complex and difficult cases.

The Philosophy of the Dawson approach really emanates from Peter Dawson himself, possibly the most important figure in the advancement of complete dentistry, and Ian Buckle, along with John Cranham, Glenn Dupont, Dewitt Wilkinson and Andrew Cobb(ito name a few) have brought this philosophy forward. They teach with a passion and desire to spread their knowledge as Peter Dawson would have wished when the academy was first set up.

For further information on this introductory course, basic Core Curriculum of learning and team events, please contact:

info@bdseminars.com +44 (0)151 342 0410

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www.dental-tribune.com
A key(boards) question

As a dentist you want to ensure CQC compliance; keeping your computer keyboards clean and germ free, what are your options...

Plastic Wrap - this means you keep ‘clingfilm’ around the exterior of a keyboard. This works; it’s cheap and does the job, it’s difficult and time consuming to replace a between treating patients, it looks very unprofessional.

- Silicone Rubber Covers - moulded removables covers that fit directly over the keyboard. Covers must be removed and washed in a sink with soapy water, presenting a barrier to compliance. The rubber material and deep crevices between keys become a reservoir for pathogens - making them worse than the keyboard without a covering, if they aren’t cleaned regularly. They can look extremely unprofessional when they are not cared for.

- Keyboard keys - the entire keyboard is made of rubber, with keys that move within the enclosure. Must be washed in a sink with soapy water, presenting a barrier to compliance. Rubber material and deep crevices between keys become a reservoir for pathogens - making them worse than a regular keyboard, if not cleaned regularly. Lack of tactile feel make these keyboard harder to use. Generally these keyboards are more unreliable and the rubber breaks down.

- Sealed Membrane - tactile keys are covered with a sealed membrane typically made of vinyl or similar. Can be cleaned in place. However, the tactile keys require more force than a regular key-board, making them impractical for quick, repetitive typing and crevices are an issue.

- Sealed Rubber over Mechanical Keys - a thin silicone rubber membrane is stretched over regular mechanical keys. They can be cleaned in place. Porous rubber material can attract dirt and pathogens. The thin cover is easily damaged and can break down with some cleaning agents.

- Anti-Microbial Plasctics & Coatings - incorporating a coating or plastic additive with anti-microbial properties. Looks and feels like a regular keyboard. Difficult to clean down in the cracks. Even if it’s anti-microbial, you still have to wipe off residue. This presents a barrier to compliance.

- Solid-Surface Touch - a glass or acrylic top with touch sensitive keys. Smooth polished surface makes cleaning fast and effective. Can be cleaned in place. Is waterproof. Lack of tactile feel of the keys can slow typing speed. No moving parts and completely sealed means very durable.

The solid surface solution seems to tick all the right boxes.

The highly-polished surface of a solid surface keyboard eliminates any crevices in which dirt and microbes can gather.

With no moving parts, the solid-surface keyboard can be very slim and also very reliable. All these factors combine to produce a favourable rating in every category for the solid-surface solution.

Traditionally usability of solid-surfaced keyboards has been a drawback. The keys are not mechanical, so the user is unable to tactile feel the keys and unable to press them to get the keyboard ‘click’ feedback users expect.

Furthermore, because the surface is touch-sensitive, the user is unable to rest their fingers on the keys without causing them to type. This means slower typing for 10-finger typists who are used to resting their fingers on the home row keys. The problem is seemingly paradoxical: how can a touch-sensitive keyboard allow the user to rest their fingers on it and feel the keys without typing?

When a user types on a solid-surfaced keyboard, they usually tap on the desired key causing a “thumping” noise, or vibration. Conversely, when they are resting their fingers on a key, no tap occurs. By adding a vibration sensor to the keyboard and correlating its input to that of the touch sensors, the paradox is solved; the keyboard simply doesn’t output text unless a tap has coincided with a touch. This approach would allow the user to rest their fingers on the touch-sensitive surface, solving the problem described above. Further, shallow indentations could be moulded over each key, forming “key-wells” on the solid surface that allow the user to tacitly feel the location of each key. With these enhancements, the usability of the solid-surfaced keyboard is dramatically improved.

Solid surfaced keyboards are quicker to clean because they are made with a solid, sealed surface; they can be cleaned in a fraction of the time it takes to clean a regular keyboard and are easier to clean. It’s just as easy as wiping a countertop just wipe the keyboard in place with a disinfectant.

What about the extra cost of a solid surface keyboard? Well let’s look at that; assuming just six cleanings per day, solid surface keyboards can save up to 50 hours per year in cleaning time, per keyboard. Any way you look at it, solid surfaced keyboards can pay for themselves in far less than a year. Cost savings also result from fewer disposable gloves and wipes used per treatment and the return on investment is immediate and significant: up to 10 times in the first year alone! An amazing investment, considering the expected life span of these keyboards is up to five years. What’s the side-effect of all those savings? Well a far more aseptic computing environment.

So in conclusion a solid-surface touch-sensitive keyboard provides an effective solution to the problem of the spread of infection caused by keyboards. By making the cleaning and disinfecting processes both effective and easy, compliance to cleaning protocols are more likely to be followed with this type of keyboard. The additional features of a touch-sensor help overcome the traditional drawback of usability of these keyboards, making it an ideal solution for infection control.

If you would like a copy of this white paper please email dr.hensmanwhitepaper@cleankeys.com
Why improving your practice is a mystery – part 1

Jacqui Goss says: don’t forget to stop and smell the roses

Taking time to ‘smell the roses’ can be an eye opening experience for practice managers

A s a practice management consultant I have a range of daily rates depending on what I’m asked to do – consulting, training, mentoring, an audit, patient coordination and so on. Compared to some others in this business, my rates are modest and clients have even told me this. This allows more practices to be able to afford me, which broadens my experience, and means I’m quite often asked to stand in for an absent team member or members. Not clinical staff but practice managers, business development managers and patient coordinators, for example. In doing this, I sometimes ‘hold the fort’ at reception while somebody is on lunch break or has a hospital appointment etc.

Fresh eyes
I enjoy doing so and in this article I shall explain why you should facilitate and take part in job swaps within your practice as well as occasionally bringing in outsiders to act on some of the monthly management reports are run off and analysed.

I can’t recall their names just now but some bosses of large retail companies are well known for rarely being in their offices. Instead, they are constantly touring their shops, often turning up unannounced. They monitor activity, talk to shoppers, meet their staff and generally keep abreast of what’s happening. Such an approach is impossible within dental practices. For maximal turnover dentists and hygienists need to be encouraged in their treatment rooms from dawn until dusk and only let out at weekends if they’re lucky! The practice manager is rarely seen as they bat- tle continuously with new compliance requirements and the front of house (FoH) staff can barely cope with the phones ringing ‘off the hook’. I exaggerate for effect, of course.

Opportunity
However, patients do fail to arrive and there are sometimes gaps in appointment schedules. Practice managers and patient coordinators do

‘We’re looking at having sheets of smiley face symbols so that staff can simply tick eg happy face, surprised face, angry face and so on’

though it was a business in which I’ve consulted quite frequently and know well, I gained an even better understanding of the dynamics of the practice – the hectic and less hectic periods, the frequency of telephone calls and the movements and changing priorities of the staff.

I now understand better why FoH staff can sometimes struggle to interpret correctly and act speedily upon messages that come from team members in the treatment rooms. A hastily scribbled note or brief telephone message can have a perfectly clear meaning to a dentist or nurse totally involved with a complex treatment but seems out of context to a receptionist dealing with a patient asking about the dental plan, a courier unloading deliveries and a member of the public wanting directions to the post office!

Ambience
Sat at a reception desk with in-sight and earshot of the patients’ lounge, as I was, I learned that you don’t have to actively eavesdrop to get a feel for the (constantly changing) collective mood and atmosphere. Silence ‘says’ a lot as, on the other hand, does animated conversation and laughter. Sometimes, I collected valuable feedback from patients either without asking or just by posing a simple enquiry such as: “Is there anything that would have made your visit more pleasant?”

I’ve written previously about how FoH staff can gather useful patient feedback and market your practice (you can view my articles on www.dental-tribune.com or my LinkedIn profile at http://uk.linkedin.com/in/jacquigoss). My session on the reception desk reinforced just how worthwhile this can be. From my spell on reception the learning points for the practice I was in were:}

- Additional resources need to be available at the front of house at two or three particular times of the day to cope with increased telephone and in-person patient activity.
- A common language of key words needs to be agreed between FoH and clinical staff for messages together with a priority rating system (such as one to five or ‘hi/med/hn’) instead of everything being classed ‘ASAP’.• FoH staff need a quick and easy way of noting comments and feedback from patients so that they can subsequently be discussed at team meetings. We’re looking at having sheets of smiley face symbols so that staff can simply tick eg happy face, surprised face, angry face and so on – including some we’ll make up (such as a ‘would welcome SMS appointment reminders’ face and a ‘liked the new website’ face).

You, of course, will have different experiences when you job swap and discover different learning points to be solved. However, if you take a turn on reception, as I did, I’m sure you’ll be reminded what a difficult and demanding role it is. Oh, and that you need a strong bladder, because ‘comfort breaks’ can be few and far between!

About the author
A proven manager of change and deliver of dynamic business growth, Jacqui Goss is the managing partner of Yes!RESULTS and is using the company’s professional practices to increase in treatment plan take-up, improve patient satisfaction and more appointments resulting from fewer no-shows. Yes!RESULTS turns good practices into great practices.

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New Alginite Miser from Qudent

Qudent have introduced a new alginite miser to their product range. The Palau MX100 alginite miser features a modern, button less design with a lightweight weightless mix, making it more resistant to spillage. The powerful motor is capable of generating a maximum of 3,000rpm and creates a smooth bubble-free mix in under 15 seconds. The MX100’s memory retention (9 hours & 12 minutes) is easy to mix and use and ensures a good quality mixture. The Palau Miser is compatible with all mixing cups, spatulas and magnetic mixers. The unit is competitively priced and is available to order at £120.00 (ex VAT) (STP £139.00). If you require any additional information on our Alginite mixes, please contact Qudent on 01903 211377, or visit www.qudent.co.uk

Dining out with dentures:

The makers of Polgrip® are delighted to announce the winner of a restaurant meal for two in the Polgrip Support Kit 2011/12 prize draw at a York house dental practice, Chiswick.

The prize draw was open to all patients receiving a Polgrip Dental Support Kit. These support kits include information about how to help denture wearers adapt to their new teeth, a denture bath brush and a money off coupon for any product in the Polgrip range.

Support Kits are available free of charge to dental surgeons, clinics and labs, and can be requested by calling 0800 0567 222.

The makers of Polgrip produce products for denture wearers, including denture adhesives to help block food particles getting trapped between the denture and the gums, making it easier to chew and drink more in comfort and denture cleanser to help maintain good oral hygiene.

www.polgrip.co.uk

Part-funded for 2013 by UMD professional dental business management course in London and Leeds

UMD Professional has announced that dentists and senior practice managers can benefit from part-funding towards one of the most comprehensive business management course which starts in London, and, for the first time, Leeds in the early autumn.

This unique course, which leads to the EMAS Level 7 Diploma in Executive Management, offers a blend of practical workshops, webinars and one to one management mentoring, and aims to help dentists and senior management understand how to increase the quality of life for denture wearers, including denture adhesives to help block food particles getting trapped between the denture and the gums, making it easier to chew and drink more in comfort and denture cleanser to help maintain good oral hygiene.

For more information on the Polgrip stand, visit www.polgrip.co.uk or www.philipsoralhealthcare.com

www.kemdent.co.uk

News of 3D CBCT

The UK R100 was ‘an amazing development’ . Jonathan Pugh found the interactive ‘powerful implications for enhanced patient safety’ . Their verdict was that the R100 was ‘an amazing development’ . Jonathan Pugh found the interactive panoramic and bi-directional scout positioning particularly useful when operating the equipment. Monte R100 standard features ‘high speed, high quality, line draw image’ . The field of view options (40mm diameter up to R100) ‘very fast and accurate automatic scout positioning’ . 

www.monte-dental.co.uk

Well done to everyone who took part in the CT competition! Congratulations to the winners of the prize for longest drive!

The latest multi award winning innovation being showcased at the BDMA show in the UK. Mcrepair Ltd is pleased to announce the launch of their new website.

www.mcrepair.co.uk

For further information on UMD products visit our website www.kemdent.co.uk

Kemdent Hat Trick

Craig Mayhew, General Manager at Kemdent beat over 20 golfers to win the BDMA Golf Tournament 2012 at the Foxhills Golf Club Surrey.

Craig has competed in this tournament for the last six years but has never been lucky enough to win. His father Graham Mayhew, had gone to the BDMA golf tournament in 2015 & 2011. Craig completed a Mayhew hat-trick and collected the prize for longest drive!

Well done to everyone who took part!

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For full details, course dates and venues contact Penny Parry on: 020 8255 2070 pers@umdprofessional.co.uk

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COURSE ANNOUNCEMENT
MULTI-SYSTEM IMPLANTOLOGY CERTIFICATE COURSE AT TRAFFORD GENERAL HOSPITAL, MANCHESTER
Recognised by University of Salford

Applications are invited for a hospital based “certificate” year course (one day a month) starting on 7th November 2012. This unbiased multi system clinical course in its 20th year is designed to teach practitioners how to incorporate implant treatment to their practices safely with the back up of three most documented implant systems according to the FGDP GDC Training Guidelines. Astra, Nobel Biocare and ITI/Straumann, the market leaders in implantology for their unique indications, predictability, research and documentation, are taught step-by-step during the year course. Each participant will have the opportunity to place implants in their patients under supervision. The course has been granted approval by the FGDP (UK) for accreditation towards its Career Pathway.

COURSE CONTENTS AND BENEFIT
- Keynote consultant/specialist speakers from UK and abroad
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- Benefit from extensive network of accredited UK Mentors
- Clinical practice support and advisory service
- Implant team with highly proven 20 years’ clinical research and teaching experience
- Become an ITI member (with complimentary 1st year’s subscription) (worth £200)
- Receive complimentary editions of five ITI Treatment Guides (worth £350)

For further information: Professor T.C. Ucer, BDS, MSc, PhD, Oral Surgeon, Oaklands Hospital, 19 Lancaster Road, Manchester M6 8AQ.
Tel: 0161 237 1842 Fax: 0161 237 1844 Email: ucer@oral-implants.com www.oral-implants.com

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