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 £1,000,000 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 55.8 per cent in 2009/10.

- 1.1 per cent (240 dentists) earned a taxable income of at least £50,000 in 2010/11, compared to 510 (1.5 per cent) in 2009/10.

"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."
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 to highlight 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 Ilfracombe. Danielle said “neither of us are long-distance walkers but we have been training hard and we are hoping that the weather remains favourable, particularly for the Dartmoor stretch. Fortunately we are doing this over eight days. We are paying for our own accommodation and every penny we receive in support goes to the Mouth Cancer Foundation”.

They are also working on their navigation skills as part of the route is described as “unwaymarked” or open moorland. Fortunately Paul has done some navigation before, but he still feels the need to practice in the field with a compass and an ordnance survey map.

He said: “We have read blogs of others who have done this walk and had nothing but rain day after day. We hope that doesn’t happen to us”.

Paul said: “We are taking seriously the requirement to upgrade our fitness levels”. Paul used to be a keen sportsman and badminton player but he said that it had been too easy to let these activities slip by the wayside as years passed. Danielle used to enjoy cycling and tennis and she says that she is really enjoying discovering a level of fitness that she thought she had lost. They have had support from a local radio station, set up for the period of the 2012 Olympic events in Weymouth and Portland, that has been playing recordings of an interview with Paul to raise awareness about mouth cancer.

Paul stated that the aim of the walk was not only to raise funds but also to raise awareness in the population regarding mouth cancer. He will be emphasising the importance of early diagnosis, attention to risk factors, and the changing demographics, with more young people being affected.

For anyone who wishes to donate visit http://www.mycharitypage.com/paulkelly

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

A n 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 25,000 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.

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:

• 20.8 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 children as in the 24 months to March 2006

• The number of courses of treatment performed on the NHS increased by 126,080 (0.8 per cent) in a year to reach 39.6 million in 2011/12. This number has been increasing each year since the courses of treatment measure was first introduced in 2006/07

HSCIC chief executive Tim Straughan said: “Today’s figures come hot on the heels of two more HSCIC reports that show dentists’ working hours have gradually increased. Primary care dentists have also seen a drop in their taxable income. Together, these dentistry reports offer a broad picture of what is happening within the dental profession and its patients.”

September is Colgate Oral Health Month

T his 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’re 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

This 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 subjected, 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 subjected 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.

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.

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:
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Researchers identify markers of oral cancer

A group of molecular markers have 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 give clinicians confidence that not everyone with a low-grade oral premalignant lesion will progress to cancer,” said Amir 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 rate, but would 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-risk, intermediate-risk 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 296 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 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.”
Making Digital Dentistry Happen

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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 which has been announced this week.

BDA Fellowship, which is awarded in recognition of outstanding and distinguished service to the dental profession, 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 Chesire 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 Commumity 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 Eastern Regions 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 of the BDA, has been awarded the Certificate of Merit for Administration and the Dental Journal has been awarded the Certificate of Merit for Services to the Profession.

Mr Allan Fyfe, an ex-Member of the BDA’s West of Scotland Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Bob Jenkins, a general dental practitioner and former figure in the BDA’s Metropolitan Branch, has been awarded the Certificate of Merit for Administration.

Mr Tony Dishington, a general dental practitioner and former Chair of the BDA’s West Yorkshire Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Dan Sealy, a general dental practitioner and former Chair of the BDA’s Yorkshire Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Andy Searle, a general dental practitioner and former Chair of the BDA’s South West and Wales Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Mike Batey, a general dental practitioner and former Chair of the BDA’s South West and Wales Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Simon Hirst, a general dental practitioner and former Chair of the BDA’s East Midlands Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr John Hall, a general dental practitioner and former Chair of the BDA’s West Midlands Branch, has been awarded the Certificate of Merit for Services to the BDA.

Mr Julian James, a general dental practitioner and former Chair of the BDA’s North of England Branch, has been awarded the Certificate of Merit for Services to the BDA.

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Be on your guard against oral health problems!

As part of Dental Focus’s commitment to enhancing the oral health awareness of the public, they are launching a new workshop on mouthguards and their importance in preventing dental injuries.

Dental Focus® Web Design supports the Mouth Cancer Foundation 10km Awareness Walk

The 7th annual FREE Mouth Cancer Foundation 10km Awareness Walk will take place on Saturday, 22nd September at Hyde Park in London. The event will raise much-needed 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 improving awareness of oral health issues and assisting practices in communicating to their patients, they have created a turnkey software platform, the Devices and Plans (DPL/MPS) system, which has been incorporated into the new Dental Focus website.

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 and team survival skills to reduce stress
- Improve the clinical outcomes of these complex situations

The new workshop will run in the UK and Ireland later this year when early booking is advised. Full details are available online http://bit.ly/Q2Kvce.

Lennon tooth sculpture

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

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 the purchasing 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.

Don't put the tooth in ice

Don't clean the tooth with disinfectant or water or let it dry out

Don't put aspirin or clove oil on the wound

If you have any further advice please visit the Foundation's ‘Tell Me About’ section to find out more about cracked teeth and mouthguards.
Mercy ships: Changing lives

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

It has now been over two years since the Dental Tribune first reported on the work carried out in West Africa by volunteering healthcare professionals for the charity Mercy Ships. 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 all of the volunteers at Mercy Ships and discusses the impact that treatment has had on these patients.

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

Agbekanme's case

In West Africa, the severity and extent of osteomyelitis is more wide spread and persistent than those seen in the UK. Apart from poor nutrition and a compromised immune system against infection, the lack of basic healthcare including dental treatment and antibiotic usage leads to uncontrolled perialpal abscesses and subsequent extensive osteomyelitis in West African patients. Acute medullary bone ischaemia and irreversible bone necrosis lead to chronic supplicative osteomyelitis.

Agbekanme was not in extreme pain as 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/oronasal 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 extrarot sinuses. 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 reabsorption 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.

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.

Guuane's case (before and after)

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.

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

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 reabsorption 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.

In Guuane's case local faciul skin flaps (interdigitating and transposition flaps) were used to close the clefts and closure of the lower eyelid conjunctiva was also required.

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

In some villages in West Africa bury babies alive with clefting deformities. They are often rejected by their own parents, relatives and villagers because they feel that they are cursed. Some babies with birth deformities are even left in the forest for wild animals.
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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**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**
Colourful perception and 50 shades of grey

Ken Harris provides a colourful update on the MSc

W
ell, six months have passed in the blink of an eye... and I don't feel a day older. Howev-
er, 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 get-
ing 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 communication and manage-
ment issues, and galloping ever onwards towards treat-
ment planning, with a neces-
sary genuflection at the altar of informed consent and legal matters. Consequently we've landed with an almighty bump

at the conclusion of module two, hot, moist and breathless (yuck!) but allegedly tooled up and ready for anything that might come our way.

We have had six months of serious teaching and learned reading to keep us all occu-
pied, and we are now ready to come out swinging as lean, mean aesthetic dental ma-
achines.

The phoney war is over, and now it's time to get down and dirty with the hand piec-
ea; I do love the smell of burn-
ing dentine in the morning! The upcoming module has us showing off our clinical skills in the shape of our first clini-
cal case reports, and there is nowhere to hide; especially with our new found dental photography skills.

However, before the dia-
mond hits the enamel, I must tell you that as a finale to module two we have had to write our first proper essay. It's been 50 years since I last penned 1,500 words to this standard, and I must admit that I have felt the ominous spectre of "academic writ-
ing." seeking me like the eye of Mordor, since I began this course. I faced the task with much trepidation, but I was determined not to let it devour me whole. Yes, perhaps I have been reading a little too much epic poetry of late; apologies folks! Anyway after numer-
ous false starts, I managed to stop eating the lotus flowers and began upon my own epic essay. After avoiding Scylla & Charybdis, sidestepping the Cyclops, and getting an earful of the Sirens' seductive song along the way, I finally made it home to Ithaca. Thankful-
ly, my own personal Odyssey (odd essay?) did not take me 10 years, but it certainly took me a lot longer than I expect-
ed. We had to send in our com-
pleted manuscripts via the in-
ternet, and I suspect I was not the only one sweating over a hot laptop at two minutes to midnight on deadline day!

The webinars have still been coming fast and loose. Some good, and some not so good, but all have to be watched and inwardly di-
gested as our "attendance" at these virtual lectures is strictly monitored by our tu-
itors, and rightly so. Never-
theless, the sheer volume of work has made it tempting to perhaps cut a few corners and maybe miss out some lectures along the way. However, I can still hear the stern words of my old schoolmasters ringing in my ears; “remember, when you cheat you are only cheating yourself... now bend over Harriss... Somebody wake me, please!!!

Dr Gregoury Brambilla is a clinician whose work has made it tempting to come out swinging as lean, mean aesthetic dental ma-
achines. He is one of only two Accredited Fel-
ders of BACD, holds full membership of BDA and remains a sustaining member of AACD. He is currently UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Ken Center in Seattle.

About the author

Ken Harris gradu-
ated from the den-
tal school of the University of New-
castle upon Tyne in 1982 and passed MFGDP(UK) in 1996. He maintains a fully private prac-
tice with branches in Sunderland and Newcastle upon Tyne specialising in complex den-
tal reconstruction cases based upon sound treatment planning protocols. He is one of only two accredited Fel-
ders of BACD, holds full membership of BDA and remains a sustaining member of AACD. He is currently UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Ken Center in Seattle.

Having trouble with 50 shade of root grey?
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.

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 be in place and followed by all staff and the patients should feel able to discuss issues and concerns with the practice.

TIP 2 - have a complaints procedure and policy in place

Complaints procedures should be readily followed by all staff and should be in place to ensure patients feel safe and secure in the practice. A complaints policy should be readily followed by all staff and more importantly the patients should feel they are able to discuss issues with the practice.

TIP 3 - have a complaints procedure and policy in place

A complaints policy should be readily followed by all staff and more importantly the patients should feel they are able to discuss issues with the practice.

TIP 4 - have a complaints procedure and policy in place

A complaints policy should be readily followed by all staff and more importantly the patients should feel they are able to discuss issues with the practice.

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.

The staff focus

The staff should be confident 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.

The clinician focus

The clinicians should be confident 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.

The practice management focus

The practice management should 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.

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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 like:
• That your practice has a child protection policy, a policy on man rights policy, a policy on aggression and violence etc.
• 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.
Restrains policies are rare in dentistry where restraints have been asking for them. There are very few situations to the patients. It will be individual to that practice.

As with all management areas, these are not the only policies relating to this subject. You may want to have other policies in place too for example a Human rights policy, a policy on aggression and violence etc.

Holding various staff meetings and communicating with your staff will help to achieve continuity of practice procedures and policies. Audits too are a way of improving our services to patients and regular audits carried out may help to demonstrate our compliance to CQC. There are many ways to show your compliance of this outcome and the tips above are only a few of them. The method of compliance for each practice will be individual to that practice.

What is your commitment to safeguarding children?

‘It is useful to have a policy which clearly outlines the procedures for staff members to follow and states their responsibilities to the patients’
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.

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.

For someone who has been practising for 20 years it has been extremely useful, and it gives a really good overall picture. 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.

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".

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".

“Within 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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4: Case Studies - Providing first hand experiences of examining, making referrals and living with oral cancer

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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.

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*The Dental Advisor, Vol 23, No. 3, p 2-5
costs. Questions 5, 4, 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.
The cost efficiency of 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 creation of the first European university, the

"Today however things seem to be changing with a move from the “Bricks” of the university campus to the “Clicks” of mobile learning"

University of Bologna 1088, universities have been accepted as the societal hub for knowledge and learning. For a millennium the ways in which universities have offered learning, knowledge and student assessment has to a large extent 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?

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 an 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

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**About the author**

Dr Ken Nicholson BDS, MSc Dr Nicholson graduated from Queen’s University Belfast in 1982 winning the Ash prize in restorative dentistry. After several years in general practice he joined the Royal Arms Dental Corps where he remained until 1998 when he returned to N. Ireland to establish a successful general practice. After a decade in general practice he opened and ran a dedicated implant referral centre, where he was instrumental in the development of the MSc course in Implant Dentistry at the University of Warwick where, until April 2012, he was an Associate Professor in the faculty of Clinical Education. He is the founder of the British Society of Oral Implantologists, the co-founder of the European Journal of Oral Implantology, the International Congress of Oral Implantologists, a member of the Faculty of Examiners at BDS Edinburgh and sits on the editorial board of the European Journal of Implant Dentistry. The International Journal of Implant Dentistry and Related Research, Implant Dentistry Today and The Irish Journal of Dental Education. He is currently studying for his Doctorate in Education, looking at the role of e-learning in postgraduate dental education and devotes the majority of his time to SmileTube.tv and clinical implant practice.
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 wide 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

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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, failure to complete treatment plans and returning in pain at regular intervals

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 significant emotional or physical harm.”

**Vulnerable Patients**

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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 states that it is up to 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 interests
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.

About the author

Dr Henry Clover - Deputy Chief Dental Officer, Denplan. Henry is a former general dental practitioner who converted his own practice to private practice in 1995. He joined Denplan’s dental policy team in 1998 and is responsible for Denplan’s Professional Services team, providing professional guidance and support for all member dentists.
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 Dental Training Facility at LonDEC and respond to your questions. 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 scenario as possible.

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 facilities with LonDEC’s Simulation Suite Supervisor and Training Co-ordinator Kemi Bakare.

- **Saturday 6th October 2012 – 6 hours CPD** - **Course Fee £299**
  - **Gorgeous Gums - Aesthetics in the Pink Zone**
    - Develop an understanding of current concepts in the management of soft tissue defects, the biological principal and evidence supporting various techniques.
    - Hands-on surgical element covering soft tissue grafting techniques on animal jaws.

- **Saturday 10th - Monday 12th November 2012 – 21 hours CPD**
  - **Course Fee £1050**
  - **3-Day Aesthetic & Restorative Masterclass**
    - **Day 1:** Shape, Shade and Colour
    - **Day 2:** Creating the Perfect Smile
    - **Day 3:** Aesthetic Indirect Restorations
  - 3 Days of hands-on training on iStan’s world class dental training room

- **Saturday 17th November 2012 – 6 hours CPD**
  - **Course Fee £349**
  - **Perfect Preps in the Aesthetic Zone**
  - Hands on anterior prep cutting for indirect aesthetic restorative options, designed to restore function & aesthetics using MI & conventional designs

- **Wednesday 2nd November 2012 – 6 hours CPD**
  - **Course Fee £275**
  - **Aesthetic Indirect Restorations**
  - Choosing the correct aesthetic materials for indirect restorations & hands-on sessions on making small & large span temporary & provisional restorations, impression taking, & lab communication

- **Friday 23rd – Sunday 25th November 2012 – 18 hours CPD**
  - **Course Fee £1200**
  - **3-Day Modern Endodontics Masterclass**
    - **Day 1:** Contemporary endodontics techniques & hands-on operation on iStan:
      - Preparation, Irrigation & Obturation
    - **Day 2:** Root canal retreatment & removal of root canal filling materials (inc. hands-on):
    - **Day 3:** Endodontics hands-on including use of posts and restorative techniques

- **Tuesday 27th November 2012 – 6 hours CPD**
  - **Course Fee £175**
  - **An MI Approach to Tooth Wear in General Dental Practice**
  - Restorative management protocols for predictable clinical outcomes. Developing an understanding of the latest technology in dental adhesive materials and the principles behind simple care planning of tooth wear cases.

- **Saturday 1st December 2012 – 6 hours CPD**
  - **Course Fee £299**
  - **All White on the Night**
  - Tooth whitening practical sessions on available techniques, including in-surgery procedures as well as “take home” whitening options. Discussion on minimally invasive options for smile design such as composite addition

*Please contact us to take advantage of our limited early bird course fees. All courses include refreshments, lunch & CPD certificate.

For further details & to book a place please visit: www.londec.co.uk
Alternatively, please call or email: 0207 848 4570 / info@londec.co.uk

Looking for a suitable venue to deliver first-rate dentistry postgraduate training? Or for a meeting or trade display events? LonDEC facilities are flexible spaces that adapt to meet your needs. Contact us to find out how we can help you.

www.londec.co.uk
The learning experience has changed the way basic life support is being taught. Delegates have expressed overwhelming gratitude for the experience, not only to learn the technical way 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 dental professionals to understand what needs to be done to achieve the best quality service for our patients.

It also demonstrates the work load 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 that 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.

We look forward to hearing from you.

www.LonDEC.co.uk
http://twitter.com/LonDEC
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2012. It’s no time to be fitting your patients with 1960’s lab work.

MaxiDent is the brand new lab created to meet the needs of today’s NHS and independent dentists and their patients.

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You’ll get 50% off the cost of the first standard crown unit, MaxiFlex flexible dentures or unbreakable ZiRock crown you order from us.

Or, if you’ll give us an extended try out, we’ll give you 25% off your entire bill in the first month in which you order 10 or more jobs from us.

There’s lots more information overleaf, as well as inside the front cover flap.

Or take a look at our website.

It’s totally free to open your account.
The Dual Wavelength waterlase® iPlus™
Advancing Laser Technology to Its Ultimate

INTUITIVE & INTELLIGENT GRAPHICAL USER INTERFACE

For example, performing a Class I Cavity Prep with the iPlus® is as easy as 1,2,3...

Step 1  Select "Restorative" from the first screen
Step 2  Choose "Class I" from the next screen that appears automatically
Step 3  Specify any other concerns such as patient sensitivity or bond strength
That’s it! Step on the foot pedal, and start working.

BREAKS THE SPEED BARRIER

- iLASE™ powered laser delivers 100 pulses/sec. for superior soft-tissue cutting
- Patented laser technology delivers 10 watts of power
- Enables multi-quadrant same-day procedures

ENABLES BIOLOGICALLY FRIENDLY DENTISTRY

- No micro-fractures or thermal damage
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iLASE™ 940nm DIODE LASER DOCKING STATION

- Adds dual wavelength versatility and convenience
- First totally wireless dental laser
- 5 Watts peak power with ComfortPulse™
- Battery operated with finger switch activation
- Exclusive bendable tips in many diameters & lengths

PROVIDES GREAT RETURN ON INVESTMENT

- Increases treatment acceptance of day-to-day restorative cases
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- Increases productivity and enables new procedures

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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.

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

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 indus-
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 towards the independent/private sector, and wanted a skill-set to enable me to do this. In 2006 I completed a year-long, one 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 was served my place. I was to be one of the first dentists to pass through the (UK style) Dawson Academy continuum.

May 2009, and I’m checking into a hotel at for the initial Daw-son Academy lecture: Functional Occlusion – From TMJ to Smile De-sign. 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, attended co-vered Examination and Records, Aesthetics, Treatment Planning, Occlusal Equilibration, and Re-storing Anterior Teeth. The small-group nature of the hands-on ses-sions encouraged discussion and the opportunity to ask questions, and seeing the familiar faces of participants at each of the cours-es 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 tim-ings 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 pro-vide 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 princi-ples and a framework in which to apply them. It has made my work more predictable, and has increased my enjoyment of dentistry. Furthermore, the lec-tures and course material forms a collection (along with Pete Daw-son’s textbook) to which I fre-quently refer. I have a part-time teaching position at The Univer-sity 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 me.

About the author

Chris Dakin qualified in 2002 and works as an associate dentist in pri- vate 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 occlu-sion in restorative dentistry both locally and nationally.

Chris Dakin discusses the UK Dawson Academy...
**A key(board) 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 can wrap ‘clingfilm’ around the exterior of a keyboard. This works; it’s cheap and does the job, it’s difficult and time consuming to replace between treating patients, it looks very unprofessional.

- Silicone Rubber Covers - moulded removable 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.

- Rubber Keyboards - the entire keyboard is made of rubber, with keys that move within the rubber encasement. 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 makes 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, 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. The whole keyboard 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 Plastics & 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 tactically 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 occurred 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 tactfully 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 tap-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-mike.hensman@cleankeys.com www.cleankeys.com
As 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 look at roles with a ‘fresh pair of eyes’. We’ve moved on from the days of ‘time and motion’ studies but similar principles still apply – somebody new to a task can often suggest more efficient ways to do it. There are other good reasons why you should take a turn on the reception desk, why your practice manager should sit in (with the patient’s agreement) on a treatment and why your nurses should see how 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, I sometimes ‘hold the fort’ at reception while somebody is on lunch break or has a hospital appointment etc.

‘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.’

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!

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/lin’) 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
Jacqui Goss is the Managing Partner of Yes!RESULTS. She is using the language of key words to express what the business does.

A proven manager of change and driver of dynamic business growth, Jacqui Goss is the managing partner of Yes!RESULTS. By using the language of key words the business can express what it is capable of.
**New Alginite Micer from Qudent**

Qudent have introduced a new alginite micer to their product range. The Palux MX300 alginite mixer features a modern, bullet less design with a lightweight metalwork making it more resistible. The powerful motor is capable of operating at a maximum of 2000rpm and creates a smooth bubble free mix in under 15 seconds. The MX300's memory settings (10 & 12 minutes) make it easy to use and ensure a good quality mixture. The Palux MX300 is complete with four mixing cups, spatula and magnetic mixing rod. The unit is competitively priced and is supplied with a two year warranty.

**Dentures demonstrated**

The makers of Palux® are delighted to announce the winner of a restaurant meal for two in the Palux® Support Kit 2011-2012 prize draw at a York House dental practice, Chesham.

The prize draw was open to all patients receiving a Palux® Denture Support Kit. These support kits include top tips, advice and information to help denture wearers adjust to their new teeth, a denture bath and brush, and a money off coupon for any product in the Palux® range.

Support Kits are available free of charge to denture patients, clinics and labs, and can be requested by calling 01296 494 470.

The maken of Palux® produce products for denture wearers, including denture features to help block food particles getting trapped between the denture and the gums, making eating more comfortable, and denture cleansers to help maintain good oral hygiene.

**New generation of 3D CBCT**

The UK’s first R100 was installed at Parkdale Dental Clinic in Walsall and Dr Jonathan Hough enthused ‘The ability to undertake 3D scans in-house speeds up the treatment planning process, and avoids the expense and inconvenience of sending patients abroad. I believe this investment will more than pay for itself in higher acceptance rates for treatment plans’.

Capable of posterior dentistry in a 10mm diameter field of view (FOV), the R100 field includes relevant anatomy equivalent to a 100mm cylindrical scan. The Morta Veranovecent’s 3D R100 won the Innovation Award at this year’s Clinical Innovations Conference in London. A panel of eminent dentists and members of journal editorial boards decided that this breakthrough had ‘potential implications for enhanced patient safety’.

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**Kemdent Hat Trick**

Craig Mayhew, General Manager at Kemdent beat over 20 golfers to win the GBDF Golf Tournament 2012 at the House of Golf in Aldershot.

Craig has competed in this tournament for the last six years but has never been lucky enough to win. His father Graham Mayhew, had won the GBDF golf tournament in 2009.

Craig completed a Mayhew hat-trick and collected the prize for longest drive.

Well done to everyone who took part!

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

**R&G Professional**

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**New Alginite Micer from Qudent**

Qudent have introduced a new alginite micer to their product range. The Palux MX300 alginite mixer features a modern, bullet less design with a lightweight metalwork making it more resistible. The powerful motor is capable of operating at a maximum of 2000rpm and creates a smooth bubble free mix in under 15 seconds. The MX300's memory settings (10 & 12 minutes) make it easy to use and ensure a good quality mixture. The Palux MX300 is complete with four mixing cups, spatula and magnetic mixing rod. The unit is competitively priced and is supplied with a two year warranty.

**Dentures demonstrated**

The makers of Palux® are delighted to announce the winner of a restaurant meal for two in the Palux® Support Kit 2011-2012 prize draw at a York House dental practice, Chesham.

The prize draw was open to all patients receiving a Palux® Denture Support Kit. These support kits include top tips, advice and information to help denture wearers adjust to their new teeth, a denture bath and brush, and a money off coupon for any product in the Palux® range.

Support Kits are available free of charge to denture patients, clinics and labs, and can be requested by calling 01296 494 470.

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COURSE ANNOUNCEMENT
MULTI-SYSTEM IMPLANTOLOGY CERTIFICATE COURSE AT
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Recognised by University of Salford

Applications are invited for a hospital based “certificate” year course (one day a month) starting on 7th November 2012.
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For further information:
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