X-ray warning of unsafe scanners

Handheld scanners found to be dangerously faulty

Bruce Petrie, of the MHRA's Medical Devices Enforcement Team, said: “It’s vital that dentists and dental staff do not buy these dental X-ray machines from eBay or other websites because they are not approved and not safe for dentists or patients.

“We have seized 15 of these X-ray machines from the distributor and we are working with eBay and other governments to ensure dentists and patients are protected. We urge anyone who has bought one of these machines to contact us on the MHRA’s hotline on 020 580 6701 or at counterfeit@mhra.gsi.gov.uk.”

The Tianjie Dental Falcon Scanners

A cut-price X-ray machine thought to be being used at some dental practices has been found to be ‘potentially lethal’.

This is according to a report splashed across the front page of last Monday’s (5 December) Daily Mirror under the headline ‘Lethal X-ray machine at dentists’, which describes how a series of imported hand-held x-ray scanners could be lethal to both users and patients.

The Tianjie Dental Falcon scanners, which are for sale on various websites for as little as £200, were tested at King’s College Hospital said: “When we tested the X-ray machine, we found it did not properly protect either a potential patient, or the person operating it.

“Over time someone operating this machine, such as a dental assistant, would be exposed to unacceptable levels of accumulated radiation and this would have an increased risk to their health. I certainly wouldn’t want someone to use this piece of equipment to take an X-ray of me.”

The scanners were found to expose users and patients to 10 times the normal level of radiation – dramatically increasing the risks of cancer and organ damage”, said the report in the Daily Mirror. Investigators also found that the scanners had botched wiring and a lack of lead insulation to protect patients and users against radiation leakage.

At least one dentist in the UK is known to have used the device, and many others have said to have been interested in buying one.
Government crackdown on binge drinking

Ministers are proposing a minimum price of 45p per unit of alcohol sold in England and Wales as part of a package of measures aimed at reducing problem drinking and its associated risks for health and society as a whole.

In addition to the introduction of minimum pricing, the Home Office wants a ban on multi-buy promotions, such as two-for-one offers, and a new health-related objective for alcohol licensing.

“This latter measure would mean licensing authorities would be able to consider alcohol-related health harms when managing problems relating to the number of premises selling alcohol in their area.

Damian Green, the government's policing minister, commented: ‘The evidence is clear that availability of cheap alcohol contributes to harmful levels of drinking.

‘It can’t be right that it is possible to purchase a can of beer for as little as 20p.

Figures suggest irresponsible drinking costs the taxpayer £21 billion per year, with hospitals admitting 1.2 million patients with alcohol-related problems last year alone.

Australian example should be followed, charity urges

On Saturday 1 December, Australia became the first country to strip all tobacco products of branding and replace them with graphic health warnings of the consequences of smoking.

The new law means all cigarettes will now be sold in olive green packets containing graphic images warning of the consequences of smoking, legislation that organisers of Mouth Cancer Action Month believe should be enforced in the UK.

The news comes on the final day of the campaign, and is welcomed by Chief Executive of the British Dental Health Foundation, Dr Nigel Carter OBE.

Dr Carter said: “Any legislation designed to put people off smoking, particularly young people taking up the habit, is one the Foundation fully supports.

“These particular images are extremely graphic. If people continue to turn a blind eye to the dangers posed by smoking, they are putting themselves at real risk from a number of diseases and should see what damage smoking does.”

Examples of the new packaging

Aspire Academy shapes ‘leaders of tomorrow’ at The Dentistry Show

The all new ‘Aspire Academy’ will be running its first conference for newly qualified dentists on Friday 1st March at the 2013 Dentistry Show.

Hosted by Raj Bhatia, the free to attend conference will offer clinical and professional insight into being a modern dentist and a future practice owner, with presentations from Nilesh Parmar and Prem-Pal Sehmi, Kevin Lewis, Elaine Halley and Daz Singh.

Five sessions, each with a mini-ipad up for grabs, together with a host of online content and offers from Smile-On will be available for delegates who attend, followed by networking drinks and access to a discounted after dinner ticket for the “The Big Heart Party” in aid of Heart Your Smile.

Dentists who qualified between 2007 and 2011 can register to access a free delegate place at www.thedentistryshow.co.uk/aspire

Chair of Public Health England’s Advisory Board announced

Professor David Heymann has been confirmed as Chair of Public Health England’s Advisory Board.

He is currently Chairman of the Health Protection Agency and in his new role will Chair the Advisory Board that supports the Chief Executive of Public Health England in delivering its mission to protect and improve the nation’s health, address inequalities and improve the health of the poorest fastest.

Health Secretary Jeremy Hunt said: “I am delighted to confirm Professor David Heymann as Chair of Public Health England’s Advisory Board. He brings a wealth of experience to the role as a public health scientist and doctor at both national and international level.”

Professor David Heymann said: “I feel very privileged to be appointed as Chair of Public Health England’s Advisory Board. Public Health England offers an unrivalled opportunity to make a real difference to the health and wellbeing of the nation.

“I am looking forward to continuing to work with Duncan and his team and am confident that we have the expertise to support local government as they take on their new responsibility for improving and protecting the public’s health, as well as working in partnership with the NHS and other stakeholders locally and nationally.”

Chief Executive of Public Health England Duncan Selbie said: “I am greatly looking forward to working with David in pursuit of our mission and ambition.”

Professor Heymann will take up post formally as Chair of Public Health England’s Advisory Board on 1 April 2013, when Public Health England becomes fully operational.
Following an open and rigorous recruitment exercise, David Prior has emerged as the Government’s preferred candidate for the post of Chair of the Care Quality Commission.

The Secretary of State for Health has today invited the Health Select Committee to hold a public pre-appointment scrutiny hearing and report on the candidate’s suitability for the post, in line with proposals for scrutiny of key positions in which Parliament has an interest.

After a hearing, the Committee will set out its views on the candidate’s suitability for this post. The Secretary of State will then consider the conclusions of the Committee’s report carefully before deciding whether or not to proceed with the appointment.

David Prior is Chairman of Norfolk and Norwich University Hospitals Foundation Trust and Chair of an Academy School. David qualified as a barrister and spent ten years in the Steel Industry. Between 1995-2002 he served in a number of political roles, including as MP for North Norfolk, Deputy Chairman and Chief Executive of the Conservative Party and a member of the Trade and Industry Select Committee. He has been Chair of a wide range of private companies.
Vitamin D could prevent tooth decay

A new review shows that vitamin D could help prevent dental caries or tooth decay. The review, published in the December issue of Nutrition Reviews, encompassed 24 controlled clinical trials, spanning the 1920s to the 1980s, on approximately 5,000 children in several countries.

“My main goal was to summarise the clinical trial database so that we could take a fresh look at this vitamin D question,” said Dr. Philippe Hujoel of the University of Washington, who conducted the review.

The clinical trials he reviewed were conducted in the United States, Great Britain, Canada, Austria, New Zealand and Sweden. Trials were conducted in institutional settings, schools, medical and dental practices, or hospitals. The subjects were children or young adults between the ages of two and 16 years, with a weighted mean age of 10 years.

The vitamin D question takes on greater importance in the light of current public health trends. Vitamin D levels in many populations are decreasing while dental caries levels in young children are increasing.

“Whether this is more than just a coincidence is open to debate,” Hujoel said. “In the meantime, pregnant women or young mothers can do little harm by realising that vitamin D is essential to their offspring’s health. Vitamin D does lead to teeth and bones that are better mineralised.”

Hujoel added a note of caution to his findings: “One has to be careful with the interpretation of this systematic review. The trials had weaknesses which could have biased the result, and most of the trial participants lived in an era that differs profoundly from today’s environment.”

Microcracks in jawbone can lead to stronger bones

A recent article in the Journal of Oral Implantology suggests that introducing microcracks in the jawbone can stimulate bone growth.

The article describes an approach to oral implant surgery for patients with severely atrophic jaws that stimulates bone activation of the future implant location.

Dental patients with severely atrophic jaws have poor quality and quantity of bone in which to place an implant. Using the Osteotensor, a purpose-designed instrument, a series of microcracks are created in the jawbone. A biological response then takes place: proteins, stem cells, and other growth factors work to regenerate the bone.

After 45 to 90 days, implant surgery can take place. Solid titanium disks are implanted into the bone bed and covered by biomaterial. A rigid, screw-fixed prosthesis can then be immediately loaded and become functional.

The authors of the article report the case of a 74-year-old woman treated with this technique after she declined to undergo a bone grafting procedure. Forty-five days after microcracks induced bone activation, the same Osteotensor instrument could no longer penetrate bone at 23 of 42 impact sites. After 90 days, none of the sites could be penetrated. Softer, type IV bone had been transformed to harder, type II bone, and it was safe to proceed with implant surgery.

Two years later, the patient’s implants were osseointegrated, and the regenerated bone had become functional.

Glasgow Dental School gets £2.5m makeover

D ental services and teaching at the Glasgow Dental Hospital and School have completed a £2.5m refurbishment programme.

NHS Greater Glasgow and Clyde (NHSGGC) have invested almost £2m on a significant project to modernise the hospital’s restorative dental clinics and expand the central instrument decontamination unit.

To complete the package of enhancements at the hospital The University of Glasgow have also invested £500,000 in transforming a traditional biochemistry laboratory into a multi-media teaching facility.

The new teaching suite is to be named the Dorothy Geddes Multi-media Facility in memory of the late Professor Geddes, who was a pioneering dental surgeon and oral biologist and the first woman to hold a professorship in dentistry at a UK university.

At a special event to officially open the new facilities NHSGGC Chairman Andrew Robertson said: “The benefit of these investments will reach many thousands of dental patients treated each year. The newly refurbished and expanded decontamination unit will serve not only the dental hospital but also 17 community dental clinics in and around Glasgow offering the very highest standard of instrument decontamination available.

The refurbishment includes a newly expanded central decontamination unit, new restorative dentistry clinics, a full 3D projection system, and a virtual microscopy suite.

Patients put off dentist due to cost

A ccording to a new survey, almost one third of people are putting off going to the dentist because of the cost.

The survey, carried out on behalf of the Irish Dental Association, found that there has been an increase in the number of patients who wait until they experience pain to visit a dentist.

Three quarters of dentists surveyed said they have seen an increase in the number of patients who arrive at a surgery in pain while 95 per cent of dentists have seen a marked increase in the number of extractions performed. Significantly, 91 per cent of dentists have seen a decrease in patient attendance.

Dr Peter Gannon of the IDA said the results were alarming. “The simple preventive treatments that were available were key to maintaining good dental health for many people. It is worrying to see such problems so soon and I am concerned that we are returning to the days of extractions and dentures” he said.
Aspire Academy - for tomorrow’s leaders
Friday 1st March at the Dentistry Show

Free to attend
www.thedentistryshow.co.uk/leaders

Offering newly qualified dentists a clinical and professional insight into being a modern dentist and a future practice owner. If you qualified between 2007 and 2011 then this is for you - it’s what you don’t get taught at dental school.

- Free to attend
- Membership to the Aspire Academy
- A mini-ipad up for grabs in each of the 5 sessions
- A host of online content and special offers from Smile-on
- Networking drinks after the Show
- Discounted party ticket for the Heart Your Smile Ball

Hosted by Raj Rattan with presentations from Nilesh Parmar & Prem-Pal Sehmi, Kevin Lewis, Elaine Halley and Daz Singh

Register for free by 18th January and book your place alongside the leaders of tomorrow.
**Lack of fixtures review could drive down value of practice**

Changes to the Capital Allowances Act could affect practice owners wishing to sell up.

“You could benefit from a tax refund now as well as laying important groundwork in advance of selling your practice. The earlier one of these claims is done the better because as well as a potential tax refund, it provides additional capital allowances going forward”, said NASDAL member Nick Hancock of specialist dental accountants Albert Goodman.

Until now, he explained, the ‘qualifying fixtures’ have normally been left as part of the freehold acquisition price. For a commercial property being sold after 5 April 2014, one of these reviews must be undertaken as part of the sales process. After that date, the vendor and the purchaser will need to specifically agree the sales price of those fixtures, usually by making a joint election under Section 108 of the CAA 2001 to achieve the capital allowance position.

Failure to carry out a fixtures review could drive down the value of the practice. Nick explained: “If qualifying assets are not identified with a Section 108 election being agreed, then effectively the buyer and all subsequent owners will have no opportunity to make a capital allowance claim on qualifying fixtures going forward. This could well have a detrimental effect on the sale proceeds figure when you try and sell your property.”

**All change for Careers Day 2013**

A number of new features including a CV clinic, business room and hands-on demonstrations will be on offer alongside the regular mix of practical advice, lectures, and exhibition at next year’s BDA UCL Eastman Careers Day, the newly-published programme reveals.

The annual event, which takes place on 8 February at London’s Hotel Russell, gives young dentists the chance to explore a range of career options and specialisms. Each of the eight rooms at the event will offer a full programme centred around a particular theme such as general practice, specialties, business and finance, experience building, and hospitals and special care.

For the first time in 2013 the day will also include a special programme of guidance sessions for those who are studying or have passed their OBE exam and a dedicated hands-on demonstration programme where a range of experts will demonstrate new clinical techniques on phantom head simulators. There will also be a dedicated CV Clinic offering delegates the chance to get one-to-one advice with the speakers.

There will also be a panel discussion looking at the organisation of dentistry in the future. The panel will include Chief Dental Officer Barry Cockcroft alongside Professor Andrew Eder, Professor of Restorative Dentistry and Dental Education at the Eastman Dental Institute, Elizabeth Jones, Dean of Postgraduate Dentistry for the London Deanery, and Peter Ward, Chief Executive at the BDA. The discussion will be chaired by Dr Judith Husband, Chair of Education and Ethics for the BDA’s Principal Executive Committee.

Speaking ahead of the event, Dr Judith Husband, said: ‘Those starting out on their career in dentistry will find, at the Careers Day, everything they need to help them take those essential first steps. I am pleased that we are once again working with the UCL Eastman Dental Institute to host this event’.

A full programme for the day and booking information is available on the dedicated event page on the BDA website.

**Tooth agenesis linked to family history of cancer**

Individuals with tooth agenesis have an increased risk of having a family history of cancer, a new study in the Journal of Dental Research has found.

Researchers from the University of Pittsburgh School of Dental Medicine recruited 82 individuals with no birth defect from the same institution to carry out the study.

Tooth agenesis was assessed in permanent teeth and was defined based on the age of the participants and when initial tooth formation should be radiographically visible.

The results showed that individuals with tooth agenesis had an increased risk of having a family history of cancer (p = 0.00006). Despite this, the researchers concluded that prospective studies are needed to confirm if tooth agenesis can be used as a risk marker for cancer.

**White night for CRISIS**

Members of the dental community braved the cold to gather for a fundraiser with a difference!

Aply named the Ice White party, the event saw more than 200 guests come together at the swanky Holborn House club in central London for an evening of dancing and entertainment to raise money for the homeless charity CRISIS.

Organiser of the event, dentist Nilesh Parmar commented: ‘The Ice White party was a huge success and I am overwhelmed by the support of the entire dental community. It was an overwhelming event to organise but with help from Louise (Mann M Ltd) and Raj Bhandot (owner of the Ice White party), we were able to really impress our guests. So far we have raised £5,261 for CRISIS with donations coming in through the justgiving page on a daily basis. I would like to thank all my sponsors for their financial support and help with the Ice White party, and look forward to working with them again next year’.

To donate to CRISIS via the Ice White page, go to www.justgiving.com/thecrises-white-xmasparty.
**Wrigley oral healthcare programme appoints new global manager**

Matthew Kent as the new Global Manager. Wrigley has hired the senior health communications specialist to drive the further development of the Programme which is focused on helping dental care professionals and patients better understand the role of sugarfree gum in their oral care routine. Matthew will be based in Wrigley’s UK headquarters putting the spotlight on the UK as leading the way in better oral health. WOPH operates in 47 countries around the world and is grounded in more than two decades of clinical research.

Matthew has a wealth of experience in both the UK and internationally. Previously Associate Director of London-based healthcare agency 90TEN, Matthew was responsible for delivering innovative solutions in public relations, medical education and treatment adherence through smart healthcare communications with a creative edge. Prior to 90TEN, Matthew held a senior management role in communications in New York where he specialised in delivering high impact programmes for brands and companies in pharmaceutical and consumer health.

Commenting on the appointment, Louisa Bowstreet, Communications Manager of the UK Oral Health Programme, said: “Matthew has great strategic and planning skills coupled with a track record of delivering well executed healthcare communications. His international background will be key to delivering the Programme’s oral health messages globally as well as promoting the great work the Programme is doing in the UK.”

Matthew added: “This is an exciting time for Wrigley in oral care and I’m delighted to be driving the global Wrigley Oral Healthcare Programme from here in the UK. Much of what happens in the UK informs and inspires our activities across the world, from educational resources to public policy outreach. I’m looking forward to providing new creative and strategic insight, to further engage dental professionals and their patients on the benefits of chewing sugar-free gum as part of an oral care routine.”

The benefits of chewing sugarfree gum are well documented and it is a clinically proven way to look after oral health whilst ‘on the go’. The science behind chewing is simple - chewing sugarfree gum after eating and drinking stimulates the flow of saliva which washes away food debris, helps neutralises damaging plaque acids and remineralises tooth enamel. The proven benefits of chewing sugarfree gum provide a strong reason for dental professionals to recommend chewing to their patients.

**IDH to launch dental academy**

Integrated Dental Holdings (IDH) has announced the creation of a Dental Academy, providing leading edge clinical training for its dentists, which will launch in Spring 2013.

The vision behind the Dental Academy is to deliver world-class training programmes initially for IDH staff, as part of IDH’s commitment to the development of its people and the highest standards of dental care across the UK. Once established, The Academy will also open its doors to the wider profession and offer high-quality development for non-IDH dentists. As part of IDH’s commitment initially for IDH programmes, The Dental Academy is to deliver world-class training programmes, which will launch in Spring 2013.

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**Denplan announces new life presidents**

Following its acquisition by Simplyhealth, Denplan has announced that its former Chairman, David Phillips and former Non-Executive Director, Meredyth Bell, have accepted roles as Life Presidents at Denplan.

The Life President role has been created to recognise David and Meredyth’s commitment to Denplan over the years and their ongoing involvement and support for the dental profession.

Denplan Managing Director, Steve Gates commented: “I’m thrilled that we have been able to secure the services of David and Meredyth in their new roles as Life Presidents they will continue to play a key role in a number of Denplan activities and remain ambassadors for the business. They have both been instrumental in the success of Denplan and their experience will be warmly received, alongside our other expert advisors.”

**ADI appoints official DCP Committee Member**

The Association of Dental Implantology (ADI) has elected Juliette Reeves as their first official Dental Care Professional Committee Member. Juliette, a hygienist, will represent dental care professional (DCP) members on the ADI Committee over the next two years, as announced at the ADI’s annual general meeting on Monday 19 November.

The ADI Committee, which comprises 15 clinicians and one technician representative from around the UK, meets on a quarterly basis to direct the future of the organisation on behalf of its 2,000 members. Juliette will be involved in liaising with and representing the ADI’s DCP members, ensuring that their interests are being met.

Juliette Reeves is a successful hygienist and nutritionist with more than 30 years’ experience. Her main areas of interest are nutritional influences in periodontal disease, stress and bone density. Juliette has received training in implant maintenance from master class academies in Geneva, Liechtenstein and more recently in the US.

Juliette says, “I am delighted to have been given the opportunity to work with the ADI Committee on behalf of my fellow DCP’s. As the field of implant dentistry develops and the number of implant placements increases, it is critical that the dental team also progresses.”

Juliette Reeves
The Minimally Invasive Dentistry Show!
Ken Harris talks MI and the MSc in Restorative and Aesthetic Dentistry

The media and certain groups within our own profession seem intent upon exposing “the unpleasant and unacceptable face of cosmetic dentistry” to paraphrase our former premier, Ted Heath.

The media have been on this tack since the dawn of time (or at least the dawn of the TIMES) and it goes something like this. Dentist butchers perfectly healthy teeth in the name of cosmetic improvement, shock horror!!!

The profession responds with alarm and a new philosophy is hastily trotted out to pacify the indignant Daily Mail readership. Attraumatic extraction anybody? Perhaps a no-prep veneer?

Yes folks, it’s the Minimally Invasive Dentistry Show, the art of fighting without fighting. A very laudable ideal, but many of us actually practice “Realistic Dentistry” driven by real patients who demand real results and not some faddish, here today, gone tomorrow solution. Furthermore many patients (at least my patients) just want their teeth to look good, and are not too concerned about how it happens.

However, few patients can resist the oleaginous charms of the current heavy-weight champion of the minimally invasive movement when correctly presented; put your hands together for tooth whitening, ladies and gentlemen!!

An excellent module has us all fully spammed-up about tooth whitening. The science has been comprehensively covered, check. We know our Carbamides from our pure peroxides, check. Even internal bleaching of single teeth has been blitzed, checkitty check!! That should hit any media objections clear out of the park, surely?

Now don’t get me wrong, tooth bleaching should be the first offering of any self-respecting dentist when the evil cosmetic dental devil comes a-callin’, but it will not straighten teeth or replace lost tooth tissue ... which is where it all gets a little messy.

Let’s quickly rewind back to the heady days of spring when our anterior aesthetics module began. As well...

**Today’s patient wants a beautiful smile with far less invasive dentistry.**

**Minimal** tooth reduction & clinically **Superior** outcomes transform smiles

That’s exactly what LUMINEERS® is all about.

Bring LUMINEERS® to your practice....

....give your patients something to smile about!

Come and learn the LUMINEERS® technique at one of our one day courses.

You will:

- Learn about the versatility of Ultra-thin Veneers
- Realise minimally invasive options with prep vs no prep considerations for aesthetic dentistry.
- Increase patient acceptance and gain practice growth.

**Objectives:**

- Diagnosis and Case Selection
- Treatment Planning & Smile Design
- Case Presentations
- Step-by-Step Procedure

Impression taking ‘Live’ Demo

Hands-On simulated step by step procedures.

Bring models or photos of prospective cases for discussion with our clinician.

**Bonus feature...**

An introduction to the Ultimate provisional....

**Friday 15th February 2013**

Cardiff

May 2013 tbc

London

For information or to book your place

08451 301611

lumineers@dkap.co.uk www.dkap.co.uk

A non-refundable deposit is required to reserve a place. Course content subject to change without notice. DKAP reserve the right to cancel.
as tooth whitening, we have also touched upon the minimally invasive miracle that is “rapid orthodontics to teeth the teeth look their fad?”. On a more traditional note, we have been lifted to celestial heights of ecstasy watching the prodigious Dr Gregory Brambilla in action. I would suggest there are few better exponents of the art of direct resin, and we are so fortunate to have him lead the direct composite resin module.

The latest minimally invasive offering, the concept of “Pragmatic Aesthetics” was also introduced during this module by the ever likeable Professor Trevor Burke, but I do wonder just where we are allowed to draw the line with “pragmatic”. I’m equally not convinced my patients would compromise aesthetics for tooth preservation to the degree as was suggested. Furthermore, it takes real skill to convincingly rebuild teeth with composite resin, and I’m sure Trevor would agree he’s no Gregory Brambilla, I know I’m not.

Equally, boiling down aesthetic dentistry to just stick- ing bits of composite to teeth, admirable though it is, seems just a teensy bit reductive I feel, and a truly excellent module concerning the restoration of root filled teeth suggests a tacit agreement by our tutors that we should not put our drills away just yet.

However, for now we have been asked to demonstrate just our minimally invasive credentials by providing two simple aesthetic case reports to test our progress. As a card carrying Manchester University student, I was looking forward to the traditional long summer break, and we were duly rewarded for all our hard work with all of August off; hurrah for the holidays!! The holiday smile was soon wiped from my face however, when the case report deadline was announced as early September; hold the Ambre Solaire!

Nothing too complex said our tutor, it’s not about showing off, but more about learning your limitations, Hmmmmm! My first case involved whitening and direct composite resin to restore a traumatised upper central incisor. Think I managed that one OK (thank you Dr Brambilla). The other, a case of replacing two old PFM crowns with all ceramic alternatives. Unfortunately case reports are not as simple as they sound when you have to back up your decision making with academic references from the literature. I guess that’s what being an academic is really about, and why I am doing the MSc after all.

Fast forward to an early September evening in London with the lethargic city nursing a post-Olympic hangover; it’s the eve of our second residential course. Speaking of hangovers, many of us are meeting at a local hostelry to trade MSc stories and reignite old friendships. This is what the MSc is really about, socialising with like-minded colleagues.

However, when the child of morning, rosie-fingered Dawn, appears we begin four days of intense teaching starting with the excellent Professor Burke on posterior aesthetics followed by two whole days with the awe-inspiring Prof Nasser Barghi keeping the Anterior end up. Bring it on!

I’ve just discovered there is also the little matter of another essay, and this time it’s a big one. A whopping 2,500 words is required. I’m hiding behind the settee!!

About the author

Ken Harris graduated from the dental school of the University of Newcastle upon Tyne in 1982 and passed MFDS (UK) in 1986. He maintains a fully private practice, specialising in complex dental reconstruction cases based upon sound treatment planning protocols. He is one of only two Accredited Fellows of BACD, holds membership of BAOD and remains a sustaining member of LCDG. He is currently UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Member of the Kois Center in Seattle.
What is the personal-ity of your Facebook Business Page? Is it friendly, fun, positive, cheerful, inspiring, serious, gross, depressing, or boring? Whether you set an intention for what you want your Page to deliver—or not—at some point it will say a lot about you.

If one of your goals is to keep your practice name and face in front of patients and potential new patients, consider what most people want from Facebook. There is no dislike button for a reason. People are socializing, liking things, and sharing meaningful photos with friends, family and colleagues.

So, think twice the next time you want to post a nasty peri-odontal mouth photo, root canal video, or bare implant abutment. While we in the dental industry may find that fascinating, for the most part the general consumer does not.

Take a look at your Page right now. What sort of photos do people see when they visit? Are there smiling faces, pictures of real people, and pleasant or interesting things to look at? If your Page is dominated by clinical information and photos of teeth, hopefully you are catering to a clinical audience. The good news is you can easily change your posting strategy and makeover your Page at any time.

If you are interested in making genuine connections with patients and potential new patients in social media, you will need to get comfortable sharing some personality. Why? According to Google research (zeromomentsoftruth.com) people are visiting on average ten traditional and online forms of information to learn about businesses in depth. Not only will potential new patients visit your website, they will also likely want to watch videos about you, read reviews, and see what Facebook has to show about you.

While social media is a newer communication tool, an important old rule of business still applies—people do business with people they like.
get to know you via photos or links to the non-profit you support or hobbies you or your team enjoy. Then 20 per cent of the time you can pass along a story about dentistry. Let others get to know, trust, and like you and your team by stretching a bit outside of your comfort zone. If you find your temptation to sell dentistry overwhelming, consider a Facebook ad. The great thing about a social media ad is you don’t have to commit to anything long term. Explore some new ideas and see how they work.

When it comes to making emotional connections with people, there is no greater opportunity than with your Facebook cover photo. One of the biggest visual additions of the 2012 Timeline redesign was that of the cover photo. The cover photo is the landscape at the top of your Facebook Business Page. It is the first and most powerful message you share about your practice. And it’s your best opportunity to immediately emotionally connect with visitors.

Facebook recommends your cover photo tell a story about your practice. Note: let your cover photo tell your story literally means illustrate your story—with photographs, not text. Let a rich and engaging photograph illustrate what your practice is all about. Some practices create graphics and add text details like the doctor’s name, practice name, or some of the same information that is already located in the page title or “About” section located immediately below their cover photo. Perplexing why some clutter up a great photo with text? Let a rich and engaging story literally mean illustrate your practice story in a photograph that best represents your practice. Your cover photo might be a photo of your entire team, the dentists, your beautiful practice interior, or a montage of several photos. Brainstorm with your team and choose your photo as a group. Know that it is as easy as the click of a button to change out your cover photo.

Remember that photos of teeth, while great to showcase your dentistry, will likely not lead to human connections or stronger relationships. Don’t let opportunities to make connections with prospects new with existing patients slip away. Human connections lead to trust, and trust results in increased word of mouth, greater referrals, higher case acceptance and strong loyalty. What does your Facebook Page say about you? Do you like what you see?

The Wolf light curing light is a high-performance light source for polymerization of dental materials. It consists of a charger and a cordless handpiece powered by a rechargeable battery. The unit is designed for use on a table and cannot be wall-mounted. The light source is a high-performance light-emitting diode (LED).

In contrast to halogen lights, the emitted light specifically covers the light wavelength between 430 and 480nm. The polymerization performance is so high that the exposure times can be reduced by 50% in comparison with a conventional halogen light (with light intensity typically ranging from 600 to 800W/cm²).

Selected filling composites can be cured in as little as 5 seconds if the light guide can be placed in close proximity to increment. Selected filling composites can be cured in as little as 5 seconds if the light guide can be placed in close proximity to increment.

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American psychologist Abraham Maslow once said, “If you only have a hammer, you tend to see every problem as a nail.” I think as a profession, it can be very easy to develop “tunnel vision”, especially if you happen to work exclusively in one area of the profession, or your special interests lead you down a very particular way of thinking. This can be quite a dangerous trap to fall into in my mind, and can ultimately undermine the level of care we can provide to patients – both in terms of forming accurate diagnoses, and also in terms of our patients’ wider oral health.

If you want to be a Specialist in any discipline, you really should aim to get as much experience in general dentistry as you can before embarking on the Specialist route. Not only will this make you a better Specialist, it will also make you a better dentist in the broadest sense of the word, and you will find yourself far better equipped to deal with complex cases and referrals.

Going back to my time spent working under Professor Pitt Ford, it wasn’t long before I soon recognised the benefit that my extra experience brought me as an Endodontist. When it came to treating people whose teeth had a good prognosis, technically as students we could all do the root fillings, but we were encouraged to apply the knowledge and experience we had gained in general dentistry. It wasn’t good enough then, just to complete the root filling – we also had to consider the practical factors that would impact upon our GDP colleagues. We’d then have to put on our restorative dentistry hats and consider how our treatment planning would fit with other areas of dentistry beyond just the RCT itself.

Of course this is all well and good, but when the patient’s teeth have a good prognosis, but when the prognosis is not so good, we have to think very carefully indeed. Suppose for example the tooth was...
lost. Is the patient suitable for a bridge or an implant, or should we attempt “herodontics” to try and save a tooth because if we don’t, the alternative is far worse?

**Tunnel Vision**

Rather than having “tunnel vision”, and seeing everything just through our eyes as Endodontists, a crucial part of Specialist practise is the treatment planning and diagnosis. We have to bring together a very broad knowledge of general dentistry and Specialist dentistry before we do our treatment. With so many different facets to modern dentistry, this approach is more important today than it’s ever been.

For example, it’s becoming increasingly common that a lot of people who haven’t been to the dentist in a long time decide to have orthodontics. They may have some sort of short-term orthodontic appliance, and the first thing their dentist does is send them for a full mouth scan. Lesions and poor root fillings are picked up at this stage, and we often have many Orthodontists coming to us and asking whether root fillings are required, or what the best solution is, taking into account the current state of the patient’s overall oral health. We then have to work in conjunction with our Orthodontist colleagues to form a sort of “compromise” solution that leaves the patient with the best overall prognosis for their long-term oral health. This may include suggesting alternative treatment plans based on a thorough assessment of all the various health risks, as well as practical and cosmetic factors.

**Holistic approach**

To be a good Specialist – especially in this day and age – you really can’t have “tunnel vision” and just think about your own narrow field of dentistry.
Okay...so this is my last column for 2012. And I decided to indulge myself. I am putting out a request to you all to make one small change in your practice for a huge impact on the oral health of the nation. Many of you will know of my slightly obsessive desire for every practice to disclose every patient at every oral health visit. The impact of the clear visual for the patient is such an important way to improve someone’s home care routine and help them to maintain the motivation that they require. Take a picture and print it out for them, or even use their own phone, and you have a reference for them to return to during the gaps between visits. Keep score simply so they can see a record of years of scores and use it to motivate and monitor them throughout their life. One simple thing has so many positive results.

It still frustrates me that I see patients in their 50s who when I explain I will use a dye to show where they find hard to clean say “Oh yes, I had that done at school.” How can we be getting it so wrong? What happens when we get out in practice that stops us from remembering the basics for patient care?

So...I thought I would give you some solutions to the common barriers that stop people from implementing this powerful motivational tool in their practice.

Patients don’t want it
Like anything new you are bound to meet a little resistance. The longer the patient has been coming, the more resistance is likely. It is quite easy to defuse this.

Write to them – send a letter saying how much you are looking forward to seeing them at their next hygiene session. Explain that to help you help them better you will be putting a simple dye on the teeth (reinforce – don’t worry it all comes off when we polish you at the end of the session) to show where they find hard to clean. It would be really helpful if they bring what...
they normally clean with with them too so you can help them get the best out of their home routine. Feedback from patients in practices where this has been implemented has been very positive.

**Lack of time**

Time is the most common reason people give for not being able to disclose. I am glad to say that I can provide a solution even for someone who is restricted heavily by appointment times.

Get the patient to do it – have some of the cotton bud disclosing solution and a laminated instruction card at reception then send them off to the rest room to do the job for you. The patient will have a look for certain while there so you end up with a patient in the chair ready to listen about advice in your short appointment.

**It costs too much**

It is actually a very inexpensive thing to implement and the patient will start to view their healthy mouth differently. In fact, in practices where we implemented this, we saw an increase in the uptake of non essential dentistry. It seems the patient was much more interested in their oral health. So, for a very small investment the long term ROI is high.

I don’t have a hygienist in my practice
That is not a barrier to this. This type of interaction can be carried out with great results by a dental nurse trained to deliver oral hygiene advice. Patients actually quite like that the dental nurse can’t put anything sharp near them and find it easier to be honest about their habits, or lack of them, with a dental nurse. What is interesting is the amount of job satisfaction the dental nurse carrying out the disclosing and advice feels from providing this service which can be charged for where appropriate to bring more profit in to the practice and a better wage for the trained nurse.

**The other benefits**

The other benefits we have seen in practices that have added this as a standard service is an improvement in oral health product sales, increased recommendation of friends to the practice and more positive feedback in the patient questionnaires.

Patients are often more open to longer sessions of periodontal treatment and the costs involved when they have more awareness of their health. Referring to a specialist can be easier to recommend and more accepted.

Furthermore, CQC will like you for it and the worrying trend for periodontal related litigation cases will not be a worry for you and your practice.

Go on, try making a small change in your practice and measuring the bigger impact it will have on your patients. You won’t be disappointed.

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**About the author**

Mhari Coxon has 20 years’ experience in dentistry, working as a nurse, receptionist, oral health advisor and ultimately hygienist in a variety of practice environments. She is passionate about her profession. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist in central London. From Chairing the London BSDHT for 5 years, and working as an MSc, Mhari excels at motivating and co-ordinating a team and utilizing skills, decentralising leadership and developing self-efficacy in members. Throughout her career Mhari has developed hygiene protocols and plans in practices which have continued to be used with great success. Mhari is Clinical Director for CPD4DCP Ltd, a training company offering motivational and interactive development courses to the dental team. As a keen writer, Mhari is on the Publications Committee of the British Society of Dental Hygiene and Therapy, the British Society of Hygienists and Therapists (BSDHT) Journal, has a conversational column in Dental Tribune and writes articles for many other publications and online sites. As a speaker, Mhari has presented regionally, nationally and internationally for many groups including Talking Points in Dentistry, the British Orthodontic Society Specialist group, the BSDHT, the BDA, the British Society of Dental Hygiene, the dentistry show and many others. In 2006 she was the Probe Hygienist of the year, and was highly commended in 2010. 2011 saw her placed 15 in the Dentistry Top 50 most influential people in the UK.
This is probably the time of year to look back at what we’ve covered in my series of articles – the journey so far, if you like. We’ve considered telephone conversations with patients and how to make sure enquirers become clients. Following this I discussed the look and atmosphere within and without a practice – and the impression this creates. Then we spent some time discussing various ways of gathering feedback from patients and what to do with the information collected. Marketing and dealing with complaints were the next topics – with an emphasis on the role of your front of house team in each of these.

Quite a journey but I did write in the first sentence that it was only ‘the journey so far’. There’s more – much more – to come. Just as clinical dentistry is becoming less about drills and wet fingers and more about intraoral cameras and dental lasers, so developing a dental practice is constantly changing too.

Here, I’ll give you a taste of what I’ll cover in my new series of articles beginning in 2013 and suggest some (Christmas holiday?) research and reading you can do.

The editor and I have not firmed up the title of the new series but something along the lines of ‘The Z to A of dental practice development’ is favourite. No, I haven’t mis-typed that – I do mean Z to A, not the other way around. Perhaps ‘Bottom to Top’ would be a more accurate way of describing the approach I’ll be taking.

For me, the development (and the ongoing journey towards perfection) of a dental practice begins not with the dentist principal securing another qualification but with the recently recruited receptionist picking up a discarded sweet wrapper as he or she enters the practice in the morning. Too esoteric? Let me explain.

If a culture of seeking perfection in all things is embedded deep within the psyche of a practice team, a new member will automatically adopt the same approach and, aware of the poor impression it may give patients and potential patients, will pick up the wrapper.

As preparation for what I shall write about next year and because I’m sure that, like me, you’ll get bored over the Christmas break here’s some suggested reading.

I would visit your local library and get out a load of books on marketing, business development and market
research. You needn’t read all of each one or them all – just ‘skim read’ through to store key phrases and terminology in your mind.

One book I do recommend reading all through is The Jelly Effect: How to Make Your Communication Stick, by Andy Bounds. It’s been out a couple of years so secondhand copies are available via the Internet if you don’t want to spend the RRP of £18.99 for the paperback version (it’s also available as an eBook). I’m happy to quote part of the description of the book from the publisher’s (Capstone) website: Like throwing jelly at a wall, poor communication never sticks.

Too much information and not enough relevance is a problem that pervades almost all business communication. So what’s the answer? More relevance and a lot less jelly.

I won’t spoil your enjoyment of the book by saying much more about it but the key to his well-argued contention is the word relevance. What you, your staff, your website and your marketing say about your practice must be relevant to what patients and prospective patients want. So forget listing your qualifications and say instead how by straightening their teeth you will make a person look younger.

The other area I suggest you bone up on is training and personal development – particularly for your front of house staff and manager(s). If I can draw a parallel with the Olympics, these members of your team are like the lead runners in a relay squad and patients are the batons. If they make a poor start with a patient or, worse still, metaphorically drop the baton there’s no chance of you, as anchor woman or man winning. That’s why I constantly advocate having a well-trained, highly motivated front of house team – they are, in effect, your ‘shop window’ to the public and patients. They can also be your marketeers and market researchers.

Before you rush off to do a course on, say, cosmetic dentistry, check with your reception staff that it’s something patients or prospective patients are enquiring about. And once you are trained, it will be your front of house team who will initiate the process of selling your cosmetic dentistry skills to patients.

There is also the Campaign for Administrative Standards and Professional Education for Receptionists and Practice Managers (CASPER) – being led by Glenys and Jane Armitage (another Dental Tribune contributor). Back in April they circulated a statement that ‘when it comes to the non-clinical aspects of dental care there is a massive black hole in terms of training and ongoing development requirements’.

Their statement went on to say: ‘to consistently achieve an excellent dental experience for patients, a range of quality management skills are required, such as planning services, auditing performance, creating, implementing and evaluating SMART objectives and gathering feedback on clinical and non-clinical aspects of care’.

I wholeheartedly agree and was delighted to be one of the dental professionals they invited to work with them to urge the GDC and CQC to formalise a non-clinical curricular framework. The work is ongoing and you should keep an eye open for more news.

That’s about it for 2012. I’ll leave you with a story about President Kennedy (quoted by Andy Bounds). The President asked a NASA janitor who was sweeping the floor: “What do you do here?” The janitor replied: “I’m helping to put a man on the moon.”


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About the author

A proven manager of change and driver of dramatic business growth, Jacqui Goss is the managing partner of Yes!RESULTS. By Yes!RESULTS dental practices see an increase in treatment plan uptake, improved patient satisfaction and more appointments resulting from general enquiries. Yes!RESULTS turnaround and practices into great practices.

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The Missing Business Plan

The second in our series about Pia Mint

Having started her new job at the Endeavour and Hope dental practice with enthusiasm, by the end of her first week there Pia Mint was feeling anxious. She wondered how she could ever settle in and make this practice run as well as her previous practice had done. When she was appointed the partners convinced her that their practice was well organised and compliant. They had certainly ‘talked the talk’ about how their practice ran but now she had discovered that they were most definitely not ‘walking the walk.’

On Monday she kept thinking, “I can’t be looking at this correctly, I must be missing something, I’ll look again!” By Tuesday she was angry because what she was discovering was not what she was promised about how the practice operates. By Wednesday Pia was worried. Her spirits were at rock bottom. She kept thinking about conversations she had heard between practice managers at the local practice managers’ group. They had said on more than one occasion that they felt like they were just used as scapegoats when things went wrong. Pia had come to realise that a great deal ‘went wrong’ in this practice. In fact, it would be more surprising if things ever went right, based on the lack of structure and low team morale she had discovered.

By Thursday she was starting to think about how she could reconcile herself and just keep going in her new job role. The thought, “I could just fit in and do my best, at least I will get paid at the end of the month. I just need to be able to show that I have done my job. Just as the practice has staggered on in the past, I am sure it can continue moving forward in the same way. However, this is not what I wanted from this work role, but perhaps it’s what I will need to settle for?”

Pia did not sleep well on Thursday night and was tired when she arrived for work on Friday morning. When she arrived she found the front door was unlocked, because the last person to leave on Thursday night had forgotten to lock up. Then when she opened her email she discovered that she had received a strongly worded complaint from a patient who had attended a review on Monday. The patient had settled her account before leaving. Then on Wednesday she had received a letter from the practice saying she had been undercharged and needed to pay an additional £25.00.

Heavy hearted she continued to scan down her emails and saw one from Kate, a practice manager with whom she had become friendly at the local managers’ group. The subject bar read ‘Congratulations on your new job!’ Pia opened the mail.

Kate ran a large local practice with an excellent reputation. She was always very upbeat and her practice was well known for running like a well oiled machine. In that moment, feeling tired, overwhelmed and hopeless she clicked on ‘reply’ and typed ‘Oh Kate, what have I done?’ then she clicked on send.

Before long Kate responded and said that she felt worn out. Kate said on more than one occasion that they felt like they were just used as scapegoats when things went wrong. Kate had come to realise that a great deal ‘went wrong’ in this practice. In fact, it would be more surprising if things ever went right, based on the lack of structure and low team morale she had discovered.

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Pia nodded her head and Kate went on to say, “Don’t tell me anything about the problems you are having. Just let’s accept that there are problems and rather than getting bogged down in them, I strongly advise you to direct that time and energy toward creating solutions. In my experience it’s always a case of cause and effect. One cause will result in multiple effects; so when the single cause is managed so too are the multiple effects.”

Pia sipped at her cappuccino and looked at Kate who continued: “Effective businesses management begins with a definition of the purpose of the business. You need to be clear about what the practice wants to achieve. This definition will be the practice’s objectives. Then based upon this definition, you can determine the most effective ways to bring those objectives to fruition. This will involve creating clear, agreed policies and procedures”.

Pia thought for a while and said, “It sounds like a plan.”

“Yes”, said Kate, “It’s a business plan, does the practice have a practice business plan?”

“They said they have one, but I have not seen it”, replied Pia.

Kate continued: “In my mind the business plan is the most essential document for practice management. The role of a practice manager is to progress the practice smoothly and effectively to secure the objectives set out for the next one, three, and five years”.

Pia decided that when she got back to work she would ask the partners for a copy of the business plan and see what they came up with.

By 2pm Pia was back at her desk. Following her chat with Kate she felt much more positive and was beginning to see the way forward. When she had the business plan to work from she would be able to grapple with what she needed to do.

At the end of the afternoon session she asked one of the partners, Hugo Hope, if she could have a word with him before he left. He agreed and entered her office (which was also the staff room). “I wonder if I could have a copy of the practice business plan” said Pia.

“Well”, he replied, “The thing is that although Jon-Luke and I have discussed business plan type stuff, we have never actually gone so far as to commit it to paper. In short, I guess the plan is to survive.”

What do you think Pia should do?

Pia was disappointed, yet hopeful. She was beginning to see how she could improve the practice. Her next project would be to get the practice’s business plan up and running as the basis for making sweeping improvements.

At home that night she searched the Internet and found a range of proformas. But how could she create a business plan without the required skills and know how?

She decided to call Kate, to ask her how she had produced her first business plan and Kate explained that she had professional help from a company who came into the practice and in a practice meeting to help them to produce the initial plan, from then on they were able to keep up-to-date by conducting regular reviews. Pia now needs to convince her employers that the cost of engaging a dental consultant, to help them to develop their first business plan would be an excellent investment which would see an excellent return.

On Monday morning Pia spoke to the partners, who gave her the green light to research the market and seek out the most appropriate service provider to work with them to develop their business plan. The one provider that stood out to her was MINT Nationwide, who would spend the morning with the management team and the afternoon engaging the team to play their individual roles in the success of their practice.
Local Healthwatch: what will it mean to you?

Amanda Atkin explains about Healthwatch and how local Healthwatch will affect dentists

The Health and Social Care Act 2012 is a weighty document running to more than 450 pages. As the Health and Social Care Bill it had a bumpy passage through Parliament being given up for lost. When it did not receive Royal Assent until March 2012, Shadow health secretary, Andy Burnham, committed to repealing it at the recent Labour Party Conference. Billed (excuse the pun) as the most extensive reorganisation of the structure of the NHS in England to date, the Act abolishes PCTs and Strategic Health Authorities. Here, I’ll concentrate on Part 5 of the Act – Public Involvement and Local Government.

Paragraph 181 amends the Health and Social Care Act 2008 as follows: A committee of the [Care Quality] Commission known as “the Healthwatch England committee” is to be appointed in accordance with regulations. Further on, under a heading of Local Healthwatch organisations, the Act makes amendments to the Local Government and Public Involvement in Health Act 2007.

Essentially, these changes flow from the Coalition Government’s desire to give more power and control over public services to members of the public – often categorised as ‘no decision about me without me’. The White Paper Equity and excellence: Liberating the NHS said that the NHS would be ‘genuinely centred on patients and carers’ and give citizens a greater say in how the NHS is run’. Hence Healthwatch – to strengthen the collective voice of local people.

Healthwatch England

Launched on 1 October 2012, this organisation styles itself as ‘your national spotlight on local services’. It is an ‘independent consumer champion for health and social care in England’. Healthwatch England is an independent committee of the CQC and the Chair of Healthwatch England, Anna Bradley, formerly Chief Executive of The National Consumer Council, also sits on the board of the CQC. This is recognised as a potential conflict of interest but we are assured that ‘robust governance’ is in place to deal with this.

Essentially, Healthwatch England is a national body which will coordinate feedback from a network of local organisations and use the information to influence national policy. It promises that the voices of people who use health and social care services will be ‘heard’ by the Secretary of State, the CQC, the NHS Commissioning Board, Monitor (the independent regulator of NHS trusts) and every English local authority.

Healthwatch England will also help local Healthwatch organisations to be set up in every local authority.

Local Healthwatch bodies

There must be local Healthwatch organisations in every English local authority area able to start on 1 April 2013. These Healthwatch organisations are to be commissioned by local authorities with help and advice from Healthwatch England. Local Healthwatch organisations will have a number of the following roles and responsibilities. They will have a seat on local health and wellbeing boards – which were also set up under the Health and Social Care Act 2012. These boards, which are already working in ‘shadow’ form, also get going in earnest from April 2013.

As well as having a seat for a representative of the local Healthwatch organisation, these boards must include a local elected representative, a representative of each local clinical commissioning group, the local authority director for adult social services, the local authority director for children’s services and the director of public health for the local authority. Their remit is to ‘improve the health and wellbeing of their local population and reduce health inequalities.’ The local Healthwatch is expected to influence how health services are commissioned and set up.

Local Healthwatch organisations will also provide information, advice and support about local services and pass recommendations to Healthwatch England and the Care Quality Commission. Of critical concern to dentists in my view is the bullet point on the Healthwatch website which states that local Healthwatch organisations will:

- have the power to enter and view services.

Turning to the DH document Local Healthwatch: A strong voice for people – the policy explained, the above statement is nuanced somewhat. It states that the legislation will allow for, and in some cases require, regulations to be made covering [among other things]:

- the duties on services-providing organisations to allow entry to authorised representatives of local Healthwatch.

In many ways Local Involvement Networks – LINks – (see below) are the forerunner of local Healthwatch organisations. LINks represent what is commonly called ‘enter and view’ authority in terms of visiting premises where health and social care activities are carried out. The use of this authority has been mixed across the country. In some cases the CQC and LINks have coordinated inspections and ‘enter and view’ visits. It is anticipated that Healthwatch England will produce advice for local Healthwatch organisations and the CQC to maintain similar liaison.

Importantly, the 2007 Health and Social Care Act stated that only the following services-providing organisations are required to allow entry:

- A National Health Service trust;
- An NHS Foundation trust;
- A Primary Care Trust;
- A local authority;
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In many ways Local Involvement Networks – LINks – (see below) are the forerunner of local Healthwatch organisations. LINks represent what is commonly called ‘enter and view’ authority in terms of visiting premises where health and social care activities are carried out. The use of this authority has been mixed across the country. In some cases the CQC and LINks have coordinated inspections and ‘enter and view’ visits. It is anticipated that Healthwatch England will produce advice for local Healthwatch organisations and the CQC to maintain similar liaison.

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- have the power to enter and view services.
LIINKs representatives - have no right of 'enter and view' to dental practices.

Seventy-five local authorities were chosen to be 'pathfinders' for local Healthwatch. In one exercise, nine of these were surveyed for their experiences. Some stated that before April 2015 they intend to build a profile for local Healthwatch within their local authority and NHS organisations to embed local Healthwatch as a significant partner in the planning and commissioning processes for health and social care. It was also thought that local Healthwatch organisations might develop a quality certification mark.

The Local Government Organisation has published a document entitled Supporting Healthwatch Pathfinders – Building successful Healthwatch organisations. This includes 15 case studies for pathfinder local authorities with the broad finding that many intend transitioning from LIINKs to local Healthwatch. Indeed, back in March 2011 the DH produced a HealthWatch (before it became Healthwatch) Transition Plan explaining how the work, community and structures of LIINKs could be built up.

LIINKs

If local Healthwatch organisations sound familiar, you may be thinking of Local Involvement Networks (LIINKs). These are local individuals and community groups who work together to improve health and social care services. There have been problems with LIINKs which is why they're being replaced by local Healthwatch organisations. LIINKs have rarely involved a wide cross-section of their local communities, few people know about them and they are not brought together under a national umbrella.

While local Healthwatch organisations will be commissioned by their local authority and accountable to them, Healthwatch England will provide consistent advice and information from a national viewpoint. It will also develop partnerships with other national bodies to raise awareness of local Healthwatch and hopefully increase involvement by a wide range of local people.

I should also mention Local Professional Networks (LPNs), which will be an integral part of the national NHS Commissioning Board (NHS CB) and the 27 local NHS CB teams (called Local Area Teams (LATs)) – also due to come into effect from 1 April 2013. LPNs will be embedded into LATs to provide local intelligence and expertise as part of the local commissioning infrastructure and into the quality improvement work for primary care.

How will Healthwatch affect you?

You could, if you choose, have nothing to do with local Healthwatch and may never be directly affected by it. I suggest this would be a mistake. More so than LIINKs, local Healthwatch organisations will likely have considerable influence over local health and social care provision. As (an independent) part of the CQC, Healthwatch England will also have influence at national level - informed by feedback from local Healthwatch organisations. Particularly active local Healthwatch organisations may, in time, arrange with the CQC to visit yours and other local dental practices to 'enter and view'. And who's to say they won't develop local health service quality standard marks?

I believe you should look out in the coming months for news of the development of your local Healthwatch organisation. The Local Government Association is leading the implementation of local Healthwatch and there is much useful information, including briefings, publications and events on its website www.local.gov.uk (search for 'healthwatch').

Healthwatch is less 'Big Brother' and more vox populi (voice of the people).

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About the author

Amanda Atkin runs Atkinspire Ltd and offers practice support, training and consultancy on information governance, CQC compliance, National Minimum Standards and more. She is the author of HTM 01-05. Her bespoke service supports practices in the NHS and the independent sector to meet national standards within their daily routines – to ensure a high quality service and patient safety at all times. 

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The Power to Create
Posterior Composites in General Practice

Trevor Bigg gives an overview of restorative composites

For the majority of dentists, general practice has changed beyond recognition over the past decade. Minimal Invasive Dentistry, digital imaging and the computerisation of records, amongst many other changes, have altered the way dentists practise in their surgeries throughout the country.

But, although this is hardly ever mentioned, the greatest change that has occurred in the day-to-day running of a general practice has been the increasing use of composite filling materials in the restoration of posterior teeth.

Amalgam or Composite?
Dental amalgam has been the material of choice for restoring posterior teeth during the past 160 years. Despite repeated attempts to prove the dangers to the patient of using this material no significant link has been shown and, on July 28, 2009 the US Food and Drug Administration stated that unless the patient is allergic to mercury “the levels (of mercury) released by dental amalgam and batteries, as next to chlor-alkali production for batteries (to be phased out by 2020), dental amalgam will be the largest mercury use in the EU.”

In June this year, a joint DoH and DEFRA meeting issued a statement that the UK

1. Poor moisture control
2. Difficult cavity accessibility
3. Large cavities
4. Large interdental spaces to be bridged.

It is at this point that some readers may be thinking that the banning of amalgam is long overdue, but it must not be forgotten that amalgam, for all its faults, is a very forgiving material and even the EU is aware that there are situations indicating that over one-third of an American’s mercury exposure is from dental amalgam. Even though there are many other sources of mercury in the environment, the continued action from pressure groups in Europe led to the European Union (EU) commissioning the BIO Intelligence Service (BIOS) to review the potential for reducing mercury pollution from dental amalgam and batteries, as next to chlor-alkali production for batteries (to be phased out by 2020), dental amalgam will be the largest mercury use in the EU.

Over the past 10 years, techniques, materials and aids have improved so that Opdam’s study published in 2007 showed that survival rates for amalgam restorations as a routine procedure. In the long term our patients may be better served by the placement of posterior composites as:

- The placement of posterior composites in Class II cavities is successful and predictable. Using composite and not amalgam increases the lifespan of a tooth.
- Composite is the ‘material of choice’ for initial posterior cavities. Amalgam should only be used in already heavily restored dentitions in older patients.

Why is composite resin better than amalgam at increasing the lifespan of a tooth?

- Less sound tooth needs removal during preparation
- Adhesive bonding means that non-retentive preparations can be used (Figs 1, 2, 5 & 4)
- Adhesive bonding improves the marginal seal and reduces ingress of oral fluids and bacteria into the cavity, which is the commonest cause of pulpal damage and death

There are situations where amalgam is considered to be only 0.1 per cent of the worldwide burden and the result of a recent study showed support the EU strategy to reduce the environmental impact of mercury, and should, subject to certain exemptions, support a ban on the use of dental amalgam from 2016.

The exemptions, which would be reviewed after five years to identify if they were still required, would allow amalgam to be used under the following conditions:

‘The greatest change that has occurred in the day-to-day running of a general practice has been the increasing use of composite filling materials in the restoration of posterior teeth’
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Moisture control is essential, but a rubber dam is not mandatory!
Rubber dam is mandatory for root canal treatment and strongly advised in areas of difficult access and for certain procedures, such as the placement of posterior Resin Bonded Bridges. However, the financial cost of rubber dam precludes its use for routine restorative work in most NHS practices.

Does this affect the longevity of the subsequent restoration?
One study has shown that rubber dam incorrectly applied affected the proximal contact strengths of posterior composites leading to food impaction and periodontal problems. So rubber dam is no sub-

What’s more, because porcelain is applied directly to the Atlantis crown abutment, it can be easily retrieved, if needed, and the time and cost of preparing a separate coping is recaptured.

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Experience the freedom of unlimited possibilities. Experience Atlantis™.
Matrix techniques: On the advice of the Chief Dental Officer, all dentists should be using single-use, disposable matrix bands, as it is impossible to clean assembled conventional bands such as Silvexand adequately. 14

The use of disposable products such as Omni-Matrix (Ultradent) and AutoMatrix (Dentsply) provide affordable, well-fitting matrix bands that act as a mini-dam in keeping oral fluids out of the prepared cavity. The band must be shaped so that the correct contact area is produced on the proximate tooth to reduce the risk of food packing and drifting. A sectional matrix, such as Falodent (Dentsply) is excellent at producing a good contact, but care should be taken in older patients as the wide contact area produced by wear over time is not reproduced by most sectional systems.

Bulk fillers: Returning to the original scenario, already 5-10 minutes of the half-hour appointment has been used. To enable the rapid placement of a composite restoration a new generation of flowable composites has been developed to use as a liner or bulk filler, such as SDR (Dentsply), Venus Bulk Fill (Heraeus) and Tetric EvoCeram Bulk Fill (Ivoclar Vivadent). These generally overcome the problem of light-activated composites loading the tooth-restoration interface. To avoid the preparation of the cavity floor and may increase marginal adaptation in the gingival margin area. It also acts to stabilize the matrix band, preventing slippage if little tooth is left supra-gingivally. (Fig. 7)

Finishing techniques: Good finishing techniques reduce the failure rate caused by secondary caries in composite restorations:

1. Place a 0.5 mm liner at first, as the base of a thicker layer may be further than the maximum depth of 4 mm when a matrix band has been fitted or a deep cavity is present. The initial thin layer is self-leveling as it flows into the irregularities of the cavity floor and may increase marginal adaptation in the gingival margin area. It also acts to stabilize the matrix band, preventing slippage if little tooth is left supra-gingivally. (Fig. 7)

2. Place a further layer of liner, or bulk fill if the cavity is deep, allowing a minimum of 2 mm of conventional composite occlusally to improve wear resistance and appearance. Adaptation of the second layer of flowable or conventional composite is enhanced by the smooth surface left by the initial lining.

Although the manufacturer's state that it is possible to bulk fill using these materials in 4 mm increments, anecdotal evidence suggests the following protocol:

- Direct the bur from the tooth to the filling to reduce iatrogenic damage
- Remove ‘high-spots’ and contacts on the tooth-restoration junction
- Do not ‘over-carve’ the surface, as deep fissures can make cleaning more difficult in some cases and could predispose towards fracture
- Etch and wash the finished restoration and use the remaining bonding agent to re-seal the margins and repair surface micro-cracks

Conclusion: Posterior composite restorations are ‘technique sensitive’ and do require training and experience if a good restoration is to be placed in the limited time available in general practice.

Materials research is slowly improving the outcome of these restorations and part of a dentist’s Continuing Professional Development should be in engaging in these advances so that a long lasting, functional and aesthetically pleasing restoration can be provided in a realistic time-scale, to the benefit of the dental health of our patients and the financial health of our practices.
Dentine hypersensitivity: Simplified

Dr Fay Goldstep looks at treatments to ease this sensitive subject

All dental practices have patients with dentine hypersensitivity. Many patients avoid dental treatment because of their hypersensitivity. Surprisingly, most practices do not have a systematic approach for diagnosing and treating this condition. This is simply because it seems too complicated. There is a multitude of products. What works? Why does it work? Many practitioners have had poor success in the past with sensitivity treatments and are reluctant to try again. Today’s products are effective and easy to use. The following discussion will attempt to bring simplicity and clarity to the subject of diagnosis and treatment of dentine hypersensitivity.

Definition
Dentine hypersensitivity is defined as a short sharp pain arising from exposed dentine in response to:

• thermal change
• evaporation of air
• tactile stimulus
• osmotic pressure
• chemical stimulus

...and cannot be ascribed to any defect or pathology.¹

The three essential components of dentine hypersensitivity are (Fig. 1):²

1. exposed dentine surfaces
2. open tubule orifices on the exposed dentine surfaces
3. patent tubules leading to vital pulp

Dentine hypersensitivity has been reported to affect up to 57 per cent of the general population.³–10 It occurs most frequently in patients of 30 to 40 years of age.¹¹ All teeth are susceptible but canines and premolars are the most affected.¹², ¹³

A 2002 international survey of 11,000 adults revealed that only half of the affected individuals had talked to their dentist about their sensitivity and only half of this group actually received treatment recommendations.¹⁴ Many patients do not wish to burden the dentist with this problem, or they may feel that it may not be taken seriously.

Mechanism of action
The most widely accepted theory for the mechanism that causes dentine hypersensitivity is the hydrodynamic theory first proposed by Brännström in 1963.¹⁵ When dentinal tubules in vital teeth are exposed and open, the fluid in the tubules flows in an inward or outward direction, depending on pressure differences in the surrounding tissue. This fluid shift activates pain receptors in the intra-tubular nerves or superficial pulp and the patient feels pain (Fig. 2).²

Diagnosis
Prior to establishing the diagnosis of dentine hypersensitivity, one must first rule out other conditions that exhibit similar symptoms:²

• caries
• pulpitis
• marginal leakage

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• restoration fracture
• cracked tooth
• polymerisation shrinkage

It is important to use specific clinical descriptors with the patient (like brief, sharp, localised) to differentiate dentine hypersensitivity from pulpal pain (which is prolonged, dull, aching, poorly localised and longer lasting).2

Risk factors for dentine hypersensitivity include:27

• periodontal disease
• gingival recession
• para-function (abstractions)
• acidic diet
• xerostomia
• bleaching

These factors predispose the patient to the essential components of dentine hypersensitivity: exposed and open dentinal tubules leading to vital pulp. There may also be passage of fluids through the enamel. The enamel may be thought of as a semi-permeable membrane that allows passage of fluids and small molecules through the organic defects between the enamel crystals. With time, the organic channels become plugged owing to the formation of organic biofilm. When this occurs, the bidirectional flow of fluids stops and so does the pain. During bleaching, the organic plugs may be dissolved, reopening the enamel channels and causing sensitivity.27

Treatment

The first line of treatment for dentine hypersensitivity is of course prevention. All of the predisposing factors must be dealt with first. This may not be an easy task. Periodontal disease, recession, occlusal forces and diet present many challenges. The treatment of sensitivity is much simpler in comparison.

If we review the mechanism of action of dentine hypersensitivity, it is easy to understand the wide range of products available for treatment. The product must either block the movement of fluid in the tubules or stop the transmission of the pain response to the brain. For added simplification, it is important to focus on the active ingredient, and not on the multitude of products (Table I).

Products are available for in-office or at-home application. Treatment should not be restricted to one option only. This is not a one-size-fits-all solution. Different treatments may be tried and modified based on the patient’s response.

The first group of products works by occluding the open tubules and decreasing pulpal fluid flow. This group includes flurides, fluorides, tissue fixatives, oxalates, remineralising agents and Pro-Argin Technology. The second group of products work by deproteinising the nerve so that it cannot transmit the pain response.

Occlusion of dentinal tubules

Fluorides - Fluoride application is believed to work through a reaction between the fluoride ion and ionised calcium in the tubular fluid. This reaction forms an insoluble calcium fluoride precipitate in the tubule.25 Different fluorides show differing effectiveness. Stannous fluoride is more effective than sodium fluoride in occluding dentinal tubules (Fig. 3a & b).20

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Fluorides - Fluoride varnishes, tissue fixatives, oxalates, remineralising agents and Pro-Argin Technology. The second group of products work by deproteinising the nerve so that it cannot transmit the pain response.
This technology is available for in-office application, through a paste that is delivered by prophylaxis cup. There is also toothpaste for at-home use. The in-office paste has been found to provide immediate and lasting relief of hypersensitivity for four weeks when it is applied as the final polishing step of a professional cleaning. It has also been found to decrease dental prophylaxis discomfort when used prior to the procedure. The second major group of desensitisation products works by depolarising the nerve that transmits the pain response. After the nerve has been depolarised, it cannot re-polarise and this diminishes its excitability. The ingredient that produces this effect is potassium nitrate. According to the FDA, for a potassium nitrate toothpaste to claim to be desensitising, it must contain five per cent of the ingredient. Potassium nitrate penetrates the enamel and dentine to travel to the pulp and exerts a calming effect on the nerve. This effect can be thought of as anesthetic-like. Potassium nitrate products are ideal for whitening sensitivity. Whitening sensitivity occurs due to the easy passage of peroxide through the enamel (a semi-permeable membrane) and dentine to the pulp. Desensitisation products that work by occluding the dentinal tubules are ineffective in preventing the passage of the tiny peroxide molecule, which can travel in the interstitial spaces between the tubules.

Potassium nitrate can be delivered in several effective ways to counteract whitening sensitivity:

1. Pre-brushing with five per cent potassium nitrate toothpaste for two weeks pre-whitening and during whitening: It takes approximately two weeks for the potassium nitrate to be at peak desensitisation efficacy.

2. Whitening tray delivery of a potassium nitrate toothpaste for ten to 30 minutes during whitening treatment: This appears to be very effective for more acute sensitivity. It is preferable to use a toothpaste without sodium lauryl sulphate, which is the primary ingredient in most toothpastes, and creates the effect of foaming. Sodium lauryl sulphate has been associated with increased gingival irritation, especially on prolonged contact.

3. Syringe delivery of potassium nitrate and fluoride: The material is applied as needed for specific areas of sensitivity.

Potassium nitrate incorporation into the whitening gel itself: Bleaching efficacy does not appear to be affected by this addition.

Conclusion: Treatment of dentine hypersensitivity is a simple, clear process. It starts with a differential diagnosis, ruling out other possible aetiologies like caries, pulpitis, cracks, marginal leakage, etc. Next, an attempt is made to eliminate predisposing factors such as periodontal disease, parafunction, acidic diet and xerostomia.

At the same time, the patient is evaluated with respect to the potpourri of potential desensitisation ingredients and the products that contain them. It is essential for the dental practitioner to be familiar with these ingredients, their mechanisms of action, benefits and indications. Some patients may require more than one type of treatment. The treatment is fine-tuned until a successful solution is found. There is no longer a reason for any patient to endure dentine hypersensitivity. Simple answers have been found to this long-time problem, and the dentist has gained a patient for life. 

Editorial note: A complete list of references is available from the publisher.

About the author
Dr Fay Goldstep has been a featured speaker in the ADA Seminar Series, and has lectured at the American Dental Association, Toronto, American Academy of Cosmetic Dentistry, Academy of General Dentistry, and the Big Apple dental conferences. She has been a contributing author to three textbooks and has published more than 20 articles. She is a fellow of the American College of Dentists, International Academy for Dental-Facial Esthetics and Academy of Dentistry International. Dr Goldstep is a consultant to a number of dental companies and maintains a private practice in Toronto, Canada.

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Fig. 4. The Pro-argin formulation attracts a calcium-rich layer from the saliva to infill and block the dentinal tubules. (Courtesy of Colgate)

Fig. 5a & b. ACP forms a mineral barrier of hydroxyapatite, which occludes the exposed dentinal tubules. (Courtesy of GC)
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The larger Tri-Scaler Aqua benefits from the same features as the Compact with the added benefit of built-in water reservoir allowing you to add other clinical solutions, such as saline etc. making the unit very flexible in its applications. With 5 scaler tips included the Tri-Scaler Aqua represents excellent value for money.

For further details or to place your order please contact Dental Sky directly on 0800 294 4700.

Medical emergencies: are you prepared?
Medical emergencies can happen at any time. That’s why it’s essential your staff are up-to-date on the latest procedures for emergency situations, so they can react swiftly and effectively to any foreseeable occurrence.

At dbw we have over 20 years experience working closely with dental practices, providing bespoke training solutions that are both informative and engaging.

Our foreseeable medical emergencies training course includes:

- In-house practice specific training.
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- Hands-on practical session for all the team including the use and application of automatic external defibrillators to build confidence.
- Advice and recommendation on your existing practice emergency response kit and the treatments you produce with a demonstration of our unique track & rescue emergency drugs with tamperproof seal.

For more information call dbw on 01206 861 950, Or visit www.dbw.co.uk
Get ahead with a project manager says Roger Gullidge

Dentists who are building their own new practice should always use an independent project manager says Roger Gullidge of Roger Gullidge Design.

"It is possible to project manage a practice without using a project manager," says Roger Gullidge. "All you need to do is employ someone with experience of such projects and can afford to do so!" However, with more than 20 years of experience in building dental practices, Roger Gullidge says, his experience can come at a cost. "With every practice you build you buy Sirona Equipment from Sirona Systems, the UK’s only Specialist Supplier of Siemens/Tridenta equipment.

Sirona Specialties, Sirona Systems offer the choice from the complete range of Sirona Teeth Whitening, Sirona 9000 3D Extraoral Imaging System, MX20 Handpiece System and Sirona Cerec CAD/CAM System.

Virofex: Perfection in Global Disinfection

Virofex is the comprehensive and versatile disinfectant, which doesn’t harbour the complications associated with alcohol-based products.

Virofex cleans and disinfects to the highest levels. It’s effective and on a wide range of surgery surfaces, from glass and metal, to plastics including enamel, porcelain, chair upholstery, soft furnishings and all other non-porous medical devices.

Virofex comes in small cartridges which ensure:
• No staff contact with chemicals
• No spills and no waste
• The correct amount will always be used
• It is easy and quick for the whole team to use

The Virofex cartridge is simply inserted into the neck of a Virofex bottle, which is filled with 500ml of tap water. The bottle then needs a gentle shake to activate the release system in the trigger spray bottle. This reduces packaging by 72% and eliminates waste.

"Ingenious" and "Brilliant". Virofex is a high level alcohol-free disinfectant, which doesn’t harbour the complications associated with alcohol-based products.

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BDS, MFDP, MSc
General Dental Practitioner

Mr Amit Patel
BDS MSc MClindent MFDS RCsed MRD RCSEng
Specialist in Periodontics & Implant Dentist Associate Specialist Birmingham Dental Hospital

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