Tobacco not displayed
After much deliberation regard-
ing the display of tobacco in shops it has now been proposed that tobacco will no longer be displayed in shops.

The new legislation, which is better known as the Health Act 2009, will come into force for large stores on April 6 2012 and on April 6 2015 for all other shops. Accord-
ing to a statement from the
Department of Health only temporary displays in “cer-
table” circumstances will be allowed, with the rules phased in to minimise the impact on businesses. With regards to plain pack-
ing for cigarettes and other tobacco products, the Gov-
ernment is keeping an “open mind” and is planning a con-
sultation on different options before the end of this year.

Frogs have teeth!
According to new research, frogs have re-evolved “lost” bottom teeth after more than 200 million years. Tree-
dwelling Gastrotheca guentheri are the only known frogs in the world with teeth on both their upper and lower jaw. The reappearance of these lower teeth after such a long time identifies a “loop-
hole” in previous theories in evolution and ultimately fu-
el the debate about the perma-
nent loss of complex traits in evolution. Commonly known as “mysterious frogs” the Gastrotheca genus carry have other unusual traits be-
cause they carry their eggs in pouches on their backs. Dr John Wiens led a team of sci-
entists from Stony Brook Univ-
ersity, New York to investi-
gate this exceptional feature. Their findings are reported in the journal Evolution.

Sweet tooth
Scientists have discovered that taste cells have several addition sugar detectors on top of the previously known sweet receptor. This sweet re-
ceptor is the primary mecha-
nism in recognising sugars such as glucose and sucrose and also artificial sweeten-
ers. Margolskee has suggested that this molecule has a role in evolution. Commonly believed to be a temporary loss of complex traits in evolution, scientists debate about the perma-
nent loss of complex traits in evolution. This new research serves to integrate taste sen-
sation with digestive process-
s. “Margolskee was quoted as saying, the study suggests that different sugar taste sensors have varied roles.

Can’t Quite Complete
Regulator admits to backlog in registration process

T he Care Quality Commis-
sion (CQC) has admitted that it will not have com-
pleted the registration process for a significant proportion of den-
tal practices who have submit-
ted their forms to the regulator.

In an email sent to practices the CQC stated: We have received approximately 7,400 valid applica-
tions from primary dental care and independent ambulance medicine. We are working hard to have those providers fully registered as soon as possible and some providers have already begun to receive their no-
tices of decision (NoDs) and certifi-
cates of registration.

On 1 April, there will be some providers who are still in the final stages of registering. We would like to reassure any provider who has submitted a valid application to us, but has not received their NoD or certificate, that we will consider them to be ‘in process’.

Some dentists have been upset by this news, calling for the CQC to put back or even abandon its endorsement to many and that it can appear daunt-
ling. However, providers should be reassured that this system will be an endorsement to many and that it both dentists and patients will ul-
timately benefit from the process.

The spokeswoman continued: “Providers who have applied for registration within their given timeframes can continue to pro-
vide services after 1 April. If a pro-
vider’s enhanced CRB check is not finalised, and the provider is not registered by 1 April, we would only bring proceedings against them if they were in the public interest to do so. We do not seek to penalise any provider who has genuinely attempted to register.”

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Editorial comment

This week sees the D-Day for registration with the Care Quality Commission and the new dawn of regulation. The process has been a turbulent one, which to be honest shows no sign of stopping. This is shown in the news front page, where by the CQC’s own admission to providers stated that it was not going to get through all of the applications submitted by this week’s deadline.

Even as we go to press, it is still unclear as to the fee structure practices will have to pay to be registered. Practitioners are feeling increasingly frustrated with the lack of information and are calling for the delay or abandonment of CQC registration for dentistry.

I am not against the principles of CQC. I am a firm believer in monitoring of standards and provision of a high quality service. However those who are being regulated need to have the highest confidence in those applying the rules. This currently is not the case. I can only see more discontent from both providers and the CQC if the situation continues the way it is going. I am calling on both parties to make this work in a way that is of benefit to patients, providers and the CQC. Am I naive? I really hope not.

Not good news for oral health

The Public Health Responsibility Deal published this week sends mixed messages on the Government’s commitment to improving public health and is unlikely to force the pace of change needed to tackle alcohol abuse in particular. According to an oral health charity, the British Dental Health Foundation is concerned that the voluntary nature of the pledges to improve public health are soft options and likely to be overlooked in favour of commercial considerations.

Studies in Scotland have shown that the alcohol industry completely flouts the ban on encouraging young people to drink and has sophisticated and costly campaigns to snare the young and encourage binge drinking. The industry simply has too much at stake and cannot be trusted on these issues with the nation’s health.

The BDHF points to the Government’s own statistics on alcohol abuse to justify a different approach to improving public health. In its recent White Paper – Healthy Lives, Healthy People: Our strategy for public health in England – the Government estimated that alcohol abuse costs the NHS £2.7 billion each year.

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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Students kick the habit

In the first known scheme of its kind in London, student volunteers from Thames Valley University (TVU) in West London have qualified as Smoking Cessation Advisors to help fellow students in Ealing, quit the habit.

Ealing Stop Smoking Service has trained 11 Psychology students at TVU to a professional standard so that they can help their peers quit smoking through a free personalised six week programme.

TVU and Ealing Stop Smoking Service found that students could save £1,000 a year if they stopped smoking ten cigarettes a day, which is equivalent to almost a third of a basic student loan. Research has shown that 65 per cent of smokers in Great Britain want to give up smoking and 22 per cent of people in London smoke, which is the second highest rate in the country*.

Clinics, located at St Mary’s Road in Ealing, run on Monday afternoons, Tuesday evenings and Friday lunchtimes so that full-time and part-time students are able to attend them. Student Advisors offer confidential advice and free recommendations on everything from stop smoking medication to nicotine replacement therapy.

Pauline Fox, Health Psychologist and Principal Psychology Lecturer at Thames Valley University, said: ‘The University is very proud to be working with Ealing Stop Smoking Service to give students the support they need to quit smoking so they don’t need to “go it alone”. Students are four times more likely to stop smoking if they use our service and as Student Advisors can recommend stop smoking medication at prescription rates, they can do it on a tight budget.’

Rachael Davis, Stop Smoking Facilitator at Ealing Stop Smoking Service said: ‘We are delighted to have trained Thames Valley University’s hardworking and enthusiastic students as Stop Smoking Advisors. Peer support is really effective in changing behaviour, especially amongst students; this was the catalyst for the project. We are very proud to be working in partnership with Thames Valley University on this project which puts student wellbeing at the heart of the education service that it provides.’

TVU student Caroline Laffarge has been trained by Ealing Stop Smoking Service as an a Stop Smoking Advisor and said: ‘As a student myself I understand how stressful exams can be and what it is like being away from home for the first time so to quit smoking can be a big challenge. The training I received from Ealing Stop Smoking Service and the support from TVU has been excellent and I am thrilled to be involved in this exciting project. When a student comes to see me and wants to give up smoking I ask them about their smoking behaviour history, I take a carbon monoxide reading from a detector and set a quit date’

* Figures from General Household Survey 2009

‘Smile Factor’ for NSM

The British Dental Health Foundation (BDHF) is delighted to announce the theme for this year’s National Smile Month, the ‘Smile Factor’, running from 15 May – 15 June. The aim of the campaign is to put the smile back on peoples’ faces and help them display their full personalities through the ‘Smile Factor’ theme.

Now into its 53rd year, National Smile Month remains an integral part of the Foundation’s work in promoting greater oral health. As in previous years, the Foundation will also be raising the awareness of a healthy diet and the link between good oral health and good overall body health and promoting the three key messages of brush for overall body health and promoting the three key messages of brush for two minutes twice a day using a fluoride toothpaste, visit the dentist regularly, as often as they recommend and cut down on how often you have sugary foods and drinks.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, described the thinking behind this year’s campaign, Dr Carter said: “A smile can be a very powerful show of emotion, yet not everyone has the confidence to do so. They say you can hide behind a smile if you are not happy or are self-conscious about your teeth, so many people are missing out on showing their very own ‘Smile Factor’. Others are being held back by poor oral well-being and its impact on their general health. This year’s campaign is designed to challenge those perceptions and get you smiling again.”

Every year the Foundation encourages local communities, practices and individuals up and down the country to take part and get involved in National Smile Month, and as ever, there will be a wide range of different ways in which people can do just that. There will be many family and community events throughout the campaign – all of which need your support.

If you’d like to find out more about National Smile Month, wish to take part in an event or organise one, all campaign material is now available. Please call the Foundation’s PR Department on 01788 559079 to request a copy.

Network with other professionals with a commitment to improving Dental Nurse Education

For further information and an application pack please visit our website www.nedbn.org or contact sarah@nedbn.org. Full training and support will be provided. Successful applicants will be invited to an assessment day in May 2011.

Wanted: NEDBN exam panel members

The National Examining Board for Dental Nurses (NDBN) is seeking to recruit new members to its Panel of Examiners in order to deliver a new assessment of the National Certificate in Dental Nursing qualification in 2011.

Featuring Objective Structured Clinical Examinations (OSCEs), NEDBN has completely revised the format of the qualification in order to provide a more modern approach to the assessment of dental nurses.

To become an Examiner with NEDBN you must:
- Have previous experience of assessing OSCEs within dental training
- Be registered with the General Dental Council
- Be currently practicing as a dental surgeon or dental care professional
- Have two years’ experience since qualification
- Be well organised and able to maintain high quality standards
- Be passionate about Dental Nurse Education and helping people reach their full potential

Becoming an Examiner will help you to:
- Network with other professionals

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Dental archive bequeathed by estate

A bequest from former BDA president, John Walker-M-Lean OBE, is to be used to fund work on an archive documenting the history of dentistry since the start of the National Health Service. Being developed in conjunction with King's College London Dental Institute's (KCLDI's) Unit for the History of Dentistry, the recently launched John McLean Archive: A Living History of Dentistry, will fill a void in the dental profession's recorded history.

Members of the McLean family presented the BDA Trust Fund with a cheque in support of dental research, which will be used to fund the archive, at a reception held at BDA headquarters in London. The reception was attended by trustees of the Fund, representatives of KCLDI and the BDA, and members of the project's team, including Professor Stanley Goller and Dr Steve Simmons from KCLDI’s Unit for the History of Dentistry, and BDA museum staff members Rachel Bairisto, Melanie Parker and Sophie Riches.

Head of BDA Museum Services, Rachel Bairisto said: “In time, this archive will provide an essential record of the significant evolution of the dental profession from 1948 onwards. This will be invaluable for generations of professionals to come. We are honoured to be given the opportunity to realise this project through the generosity of one of the most highly-regarded leaders in the profession, John McLean, whose legacy will long be remembered.”

The project will comprise a series of witness seminars and individual oral history interviews, encompassing the full breadth of dentistry in the UK.

Wesleyan warns dentists of under insurance risk

Wesleyan has launched a new service for its dental clients to help ensure that they have the correct level of home insurance cover. Wesleyan’s Private Clients Insurance service now includes a free ‘walk-through’ home valuation for dentists after new statistics show that up to 70 per cent of professionals have inadequate cover levels.

According to the Birming-ham-based mutual, a leading provider of tailored financial advice and products to the dental profession, the majority of dentists fail to appreciate the value of their home contents and sometimes forget to re-assess cover levels to include valuable new purchases.

Wesleyan believes that its insurance service is the first in the UK to offer personal valuations for free to dentists regardless of the level of sums insured.**

Mark Lee, Business Development Manager for Wesleyan’s Private Clients Insurance, said: “Our dental customers are time poor and don’t always have the time to review their insurance cover. As a result they are often underinsured and leave themselves exposed if something should happen to their home. This service takes away the hassle of calculating contents cover by leaving it to an independent valuation professional who will visit at a time that suits the client.

“Private Clients Insurance is designed specifically with our customers in mind. For example, they can delegate authority for dealing with their policy to another person so they don’t have to handle any of the administration involved. Private Clients Insurance customers also get a dedicated personal client manager who looks after their needs.”

The new valuation service has been launched following the successful first year for Wesleyan’s Private Clients Insurance, which has seen an eight-fold increase in demand since re-launching in 2010. [ ]

* Statistics provided by Wesleyan
** terms and conditions apply

Dental charges rise

J ust days after it was revealed that dental charges will be frozen in Wales and prescription charges will be scrapped in Scotland, Ministers have confirmed that prescription fees and dental charges will increase in England.

The announcement has unsurprisingly been greeted with anger prompting people to question the equality of a different fee scale for different parts of the UK.

Ministers have confirmed that dental charges will increase by the following: band 1 treatments will go up to £17, band 2 treatments will increase to £47 and band 5 treatments will be raised to £204.

Along with this rise in den-tal fees prescription charges will also increase by 20p to £7.40 per item from the 1st April.

Dental charges in England are the highest in the UK and now England remains the only country in the UK where prescriptions aren’t free.

The British Medical Association has criticised the price increase, claiming that the increase amounts to a tax on the sick. Sue Sharpe, from the Pharmacuetical Services Negotiating Committee, also condemned the news, saying that people from low income families may struggle to get the medication they need.

Katherine Murphy, Chief Executive Patients Association said: “At a time when many patients are struggling to make ends meet, another increase on charges they must pay is not acceptable.

“It is essential all patients feel they can access healthcare when they need it and not be deterred by costs.”

A spokeswoman from the Department of Health said that the government was investing an additional 10.7 billion pounds in the NHS and claimed that abolishing prescription charges in England would leave a shortfall in NHS funding of 450 million pounds per year. [ ]

Fellowship for Dental Dean

P rof Elizabeth Kay, Dean of the Peninsula Dental School, has been awarded Fellowship Ad Eundem of the Faculty of General Dental Practice (UK) (FGDP(UK)) at The Royal College of Surgeons of England. She received her award at the Annual Faculty of GDPs (UK) Diplomates Ceremony in London.

The award of Fellowship is the highest accolade a member of the FGDP(UK) can achieve. It is a mark of achievement for those who have made a contribution to patient care or the profession of primary dental care, significantly over and above what might be reasonably expected of a member of the FGDP(UK).

Russ Ladwa, Dean of the FGDP(UK), commented: “It is obvious to all to see that Professor Kay has an exceptional enthusiasm for her profession, and a willingness to help others along their chosen path. Her tireless work and support for dental practitioners to provide an improved quality of care for their patients is well known and I thank Prof Kay for that.”

Prof Elizabeth Kay

Prof Kay added: “I am of course delighted to have been awarded such a prestigious accolade. While it is me who has been made a Fellow, it is an achievement that reflects the hard work and dedication of my colleagues and our students at the Peninsula Dental School, as much as it does me personally.”

Gone with the wind

M a tthew Walton, the dentist who repeatedly broke wind and belched in front of patients and staff has been struck off.

Along with a string of allegations to his name, Walton was reported to have made derogatory comments about certain patients’ unemployment, disabilities, age and ethnic origin.

Other charges included Walton being routinely brusque, abrupt and sarcastic; not allowing dental nurses to communicate with patients; not allowing his dental nurse sufficient time to clean the clinical area in surgery between patients and routinely not warning his dental nurse that he was about to take x-rays of patients when she was in the room.

Walton, worked at the practice in Wiltshire, Shropshire, between August 2006 and December 2007.

The committee in London told Walton it had taken into account his “lack of insight and lack of remediation.” [ ]
A visit by the All-Party Parliamentary Group (APPG) for Dentistry allowed a group of MPs and Peers to see the work of a busy dental school, including its research, teaching and clinical activities. Guests were able to visit KCL-DI’s craniofacial development and stem cell research laboratories, tour facilities for the care of vulnerable and anxious patients, and see the state-of-the-art haptTEL technology used in teaching students. The visit was led by Professor Nairn Wilson, Professor of Restorative Dentistry and Dean and Head of KCGI.

Parliamentarians learnt about the evolution of dental academia, including the opening of new dental schools, expansion of student numbers and the contribution many general dental practitioners are playing in educating dental students. The development of shorter courses for graduates from related disciplines and the development of training for dental care professionals were also highlighted.

The Parliamentarians also heard from Lauren Holmes, the President of the institution’s Dental Society and a fourth-year student. She highlighted the experience of dental students and stressed the importance of the reforms currently being undertaken in dentistry engaging the next generation of practitioners who will deliver care in the system that is created.

A retainer and a whole lot of bacteria

Researchers at the UCL Eastman Dental Institute have found that insufficient cleaning could allow a build-up of microbes on orthodontic retainers.

Dr Jonathan Pratten and colleagues looked at the types of microbes which live on retainers and found that potentially pathogenic microbes were growing on at least 50 per cent of the retainers that were conducted ion the study.

The results of the study, which was published in the Society for Applied Microbiology’s journal Letters in Applied Microbiology, has indicated that there is possibly a need for the development of improved cleaning products for orthodontic retainers. According to reports, Dr Pratten and his team took samples from the mouths of people without retainers and those wearing either of the two most widely used types of retainers and searched for microbes which are not normally found in the oral cavity.

The researchers were particularly interested in two species of microbes; Candida, a type of yeast, and Staphylococcus, including MRSA. The results of the study showed that species of these microorganisms were present on 66.7 per cent and 50 per cent of retainers respectively, regardless of the retainer type. Reports stated that these microbes were also present on the interior cheeks and tongue of retainer wearers.

Living in communities, otherwise known as biofilms, the bacteria can be very difficult to remove, and although they pose no real threat to healthy individuals, both Candida and Staphylococcus can be potentially dangerous to people with a low immune system.

The researchers are now looking at developing effective methods of cleaning retainers; however, for the meantime it is hygiene that is the key to reduce the bacteria.

Consultant appointed Vice President RCPSG

A female consultant has become the first woman to be given the job of Vice President of the Royal College of Physicians and Surgeons of Glasgow.

The institution was established more than 400 years ago in 1599 and a woman has never been given the position, until now. Dr Alyson Wray, a consultant in paediatric dentistry at the Royal Hospital for Sick Children and Glasgow Dental Hospital, has been awarded the prestigious title.

Dr Wray said that the appointment was a “huge thing” for the organisation; she said that she has spent many years being the only woman in the room at conferences and meetings, but claimed that in recent years, things have started to change and women are being given more opportunities.

America’s Toothfairy

Dental manufacture KaVo Group has made a leadership commitment to the health of the nation’s children as the newest National Children’s Oral Health Foundation: America’s Toothfairy (NCOHF) underwriting partner. In just five years, NCOHF affiliates have reached more than one million children with preventive, restorative, and educational oral-health services. NCOHF underwriters include leading national and international dental corporations that fund Foundation operating and program expenses to help ensure that 100 per cent of every additional dollar donated to NCOHF provides underserved children with the care they deserve.

“We are thrilled to have become an underwriter and advocate for NCOHF,” said Henk van Duijshoven, president and global group executive, KaVo Group.

“The core values of the NCOHF and the KaVo Group are very similar. We use innovative ideas, the best team, and spirit of continuous improvement to drive awareness and access to comprehensive pediatric oral health services to eliminate this epidemic.”

“We are honored that KaVo has joined us in our mission to eliminate children’s needless suffering from America’s number one chronic childhood illness,” said Fern Ingher, NCOHF president and CEO. “Their laudable philanthropy makes it possible for NCOHF to respond to the escalating number of children in critical need of services in 2011.”

SO WHY DON’T THEY MENTION THIS?
New plans to stub out smoking

New FpT panel members

Fake drugs arrest

HM Government

Healthy Lives, Healthy People: Our strategy for public health in England

News


New plans to stub out smoking

N ew ambitions to tackle the substantial public health harms from tobacco were announced on No Smoking Day by Health Secretary Andrew Lansley.

The Government has published Healthy Lives, Healthy People: A Tobacco Control Plan for England which sets out how tobacco control will be delivered over the next five years.

Local communities will take a leading role in reducing smoking rates. The plan confirms action to end eye catching tobacco displays in shops which encourage young people to start smoking.

Andrew Lansley said: “Smoking is undeniably one of the biggest and most stubborn challenges in public health. Over eight million people in England still smoke and it causes more than 80,000 deaths each year.

“Smoking affects the health of smokers and their families. My ambition is to reduce smoking rates faster over the next five years than has been achieved in the past five years.

“We want to do everything we can to help people to choose to stop smoking and encourage young people not to start smoking in the first place.

We will help local communities to take a comprehensive approach to reducing smoking so we can change social attitudes to smoking.”

The Tobacco Control Plan has three national ambitions to reduce smoking rates in England by the end of 2015:

- From 21.2 per cent to 18.5 per cent or less among adults
- From 15 per cent to 12 per cent or less among 15 year olds
- From 14 per cent to 11 per cent or less among pregnant mothers

These ambitions represent reductions in smoking rates that exceed the reductions we have seen in the past five years. The Government has set out key actions in the following six areas:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Effective communications for tobacco control

Within the plan, the Government sets out actions to maximise the use of information and intelligence to support tobacco control activities. It also explains how tobacco control policies will be protected from vested interests.

HM Government

Healthy Lives, Healthy People: Our strategy for public health in England

New FpT panel members

La st year the General Den tal Council (GDC) agreed a Corporate Plan for 2011-2015 that stated it will efficiently manage hearings capacity and productivity. As part of that promise, and following a successful and competitive recruitment campaign last year, 51 new Fitness to Practise panel members have now joined the GDC.

The new panel members were recruited by the Appointment Committee, and those who were successful at interview underwent a two-day pre-induction training programme at the end of last year. They’ve been slowly introduced since the end of January this year and will sit on the Interim Orders, Professional Conduct, Health, Performance and Registration Appeals Committees. No more than two new panelists will be used on a five-person panel during their induction period.

Ten dental care professionals (DCPs) were appointed along with 19 dentists and 22 lay members.

Neil Marshall, Director of Regulation at the GDC, said: “We have seen an increase in complaints in recent years and are working hard to clear a backlog of cases. In addition to the new panel members we have also invested in more hearings staff and additional legal advisers in order to increase our hearings capacity. We’re also reviewing our fitness to practise processes and procedures across the board in order to be sure that we are dealing with these matters as swiftly, effectively and efficiently as possible.”

The GDC’s key purpose is to protect patients and regulate the dental team. It supports the quality of practice and reputation of the profession by setting standards, promoting them and taking action when they are not met.

The GDC aims to deliver regulation which is proportionate, targeted, consistent, transparent and accountable. It is committed to managing its resources effectively, efficiently and sustainably and to ensuring decision making is collective, robust and accountable.

Fake drugs arrest

T hree men were arrested and more than £1m worth of suspect ed counterfeit and unlicensed medicines were seized yesterday as part of a simultaneous raid on three residential locations, and a secure storage unit, in north and east London.

The operation targeted the gang, with eastern European connections, for alleged supply of vast amounts of counterfeit medicines internationally including many customers within the UK. The drugs were alleged to have originated from the Far East.

The trio, who have been released on bail, are believed to be linked to numerous illegal online pharmacies selling fake prescription only medicines and other unlicensed drugs online. Their website “Aladdin’s Cave of fake medicine” included Viagra, Cialis and Levitra, and was designed to “trick unsuspecting customers that they were getting the real deal.”

“These illegal online pharmacies have been supplying a massive amount of medicines, mostly to treat erectile dysfunction, hair loss and weight loss, to many people around the world,” he said.

“What we seized yesterday is estimated to have a street value of more than £1 million but the business these men were running could have generated a turnover well in excess of that.”

Counterfeit medicines have been supplied to both UK and international customers

Wedding day?

T he Royal Wedding on April 29th has been declared a Bank Holiday. But are employers obliged to give their staff the day off? Dominic Tomkins of Bowling Law, a member of NAS-DA Lawyers Group, says the answer lies in the staff contract and the practice’s normal policy. If staff normally work bank holidays then it’ll be business as usual.

For practices that want to close for the wedding, says Dominic, the question of whether they have to give their staff paid holiday for the 29th will depend on the individual staff contract. If the contract allows the staff member a fixed number of days’ annual leave per year inclusive of public holidays the wedding won’t increase the staff member’s annual leave entitlement, and the practice could just insist that the staff member uses up one day of their outstanding annual leave entitlement on the 29th.

However, if the contract says the staff member is entitled to a fixed number of days’ annual leave exclusive of public holidays, then that staff member (if they are full-time) will be entitled to take the 29th as an additional day of paid annual leave. Part-time staff on such a contract will have the right to their relevant pro-rata annual leave entitlement of 9 bank holidays per year, rather than the usual 8.

As the wedding is sandwiched between Easter and May Day, it will be and remain to remember these holiday requests in good time and fairly (be that on first-come first-served basis or some other reasonable basis).

Dominic is a lawyer with Bowling Law, members of NAS-DA Lawyers’ Group and can be contacted on 020 8221 8056 or email Dominic.Tomkins@bowlinglaw.com.

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## Outstanding Value from Kent Express

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Scams, smirks and skin
Tony Jacobs discusses the latest hot topics on GDPUK.com

So much has occurred in the time since my last column, and as always I can only convey a smidgeon of the flavour of discussions that have taken place on GDPUK.com. This column is like the précised version of the edited part of the digest!

To begin, the hearts and minds of GDPUK readers were lifted by news that the end of the “no win no fee” method of paying litigation by patients is in sight. Will this finish off certain law firms, dentists were asking?

There were also conversations where thoughts often kept private were put out in public; once one colleague admitted the practice was not as busy as they would like, many joined in to discuss the facts. At local meetings, and perhaps all face to face events, there is a bravado which prevents colleagues admitting this, despite the economic climate which stare us in the face and is heavily promoted by the media. The media forgets that Sky TV, the supermarkets and mobile phone companies all seem to have growing revenues, but it seems the discretionary spend on cosmetic dentistry is suffering a hull at present.

It was also discussed that when the troubles in North Africa started, a dentist cared for a patient who had returned from Tunisia after escaping the situation. She had prepared teeth but the crowns would follow in the post [due to the emergency situation there]. So, would the UK dentist please fit them? This opened a can of worms and although there was sympathy for the patient and her plight, it seems the crowns fitted in the European Community must comply with EC regulations. In addition, it was pointed out that if something did subsequently go wrong with the crowns, the solicitor’s letter would land on the desk of the UK dentist who fitted them. It was generally agreed that this would not have been a problem 20 years ago – a dentist would inspect the crowns, try them in, and cement.

Another conversation was – was this colleague the subject of a scam? A practice website received an email from a nudist; it attached a photo and asked if the patient could have treatment in the nude – does the practice accept nudist patients? Wind up or true test? The offending photo was not uploaded to GDPUK; it might not have been a pretty sight!

One PCT wrote to their dentists expressing the need for them to wear long sleeves when working, this being contrary to HTM01-05 advice to be bare below the elbow. One wag suggested clinical wear with one long sleeve, one short to satisfy both masters.

A news item which gained a few smirks was a practice in Munich trying a new marketing ploy; the principal and team were all dressed in traditional Alpine garb. Much skin was on display and the comments from colleagues were all concerned with Health and Safety and of course HT!

About the author

Tony Jacobs, 54, is a GDP in Manchester, in practice with partner Steve Lazauskas at 406 Dental. Tony founded GDPUK in 1997, and the website now has over 11,500 unique visitors each month, who make 50,000 visits and create over 2m pages on the site every month.
Interview with the Care Quality Commission
Neel Kothari speaks to the CQC’s Linda Hutchinson

Neel Kothari (NK): There has been a lot of speculation around the remit of the CQC; can you help sort out fact from fiction?

Lind Hutchinson (LH): The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England. Our aim is to ensure the quality and safety of care, wherever it is provided. We also seek to protect the interests of people whose rights are restricted under the Mental Health Act. We promote the rights and interests of people who use services and have a wide range of enforcement powers to take action on their behalf if services are unacceptable poor.

We are introducing a new registration system that brings the NHS, independent healthcare and adult social care under a single set of essential standards of quality and safety for the first time. Registration is a legal license to operate. We register health and adult social care services if they meet essential standards and we continuously monitor them to make sure they continue to do so as part of a dynamic system of regulation which places the views and experiences of people who use services at its centre.

NK: How justifiable are the CQC fees, given that the profession already pay for GDC regulation - and what sort of future increases do you envisage?

LH: Registration with CQC is the law and the fees are calculated on the estimated cost of regulation. They were based on a similar provider type, independent GPs, although the fees could change over time once we have a clearer idea of how much authority is required for this sector in terms of compliance monitoring.

NK: If it is shown that over-regulation directly or indirectly has a detrimental effect on patient care, how would you as a regulator feel about it and would you recommend to the DH that your remit is scaled back?

LH: Regulation is in the best interests of patients and providers. In fact, registration will be an enforcement to providers who meet the standards. Regulation is based around providers meeting the essential standards, which are based on outcomes, the experiences people have. This system puts patients at the centre of care.

NK: Why has CQC only focused on practice policies and protocols and not actual clinical care at the point of delivery?

LH: The system of registration focuses on outcomes, which are based on the experiences patients have, rather than inputs, and we make no apologies for this.

We only normally inspect policies and protocols if we are looking for answers about questions that we have identified about outcomes for people. Our system of checks and inspection is driven by monitoring outcomes, through quality and risk profiles. We define outcomes broadly so as to include both clinical outcomes and people’s experiences.

NK: How will CQC monitor compliance after 1 April?

LH: All providers will have a planned review at least once every two years and can have a responsive review at any time. Responsive reviews will happen if we have specific concerns about a provider. If you are registered with conditions on your registration, you will be subject to review more than if you have no conditions. This is a risk-based regulatory system.

So there we have it guys, did it help? Is there anything else anyone wants answered? If so please email me at neelkothari@hotmail.com and I will do my best to raise it with the CQC.

About the author

Neel Kothari qualified as a dentist from Bristol University Dental School in 2005, and currently works in Cambridge as an associate within the NHS. He has completed a year-long postgraduate certificate in implantology at UCL’s Eastman Dental Institute, and regularly attends postgraduate courses to keep up-to-date with current best practice.
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Continuing the Care That Starts in Your Chair
For dental practices these days, one of the main concerns is concentrating on how many new patients come in to the practice; however, the ones that leave are usually pushed to the back of the dentists’ mind.

As a dentist you may want to keep hold of as many patients as you can, so for your information here are some of the top reasons why people decide to change to a new dental practice.

1. The practice doesn’t offer the patient what they want. Patients who require special treatments, no matter what area it is in, may decide to look somewhere else for their dental treatment if their current practice does not offer or specialise in that area.

2. Patients are not aware of what the practice offers. Patients haven’t done the mind reading course. If you don’t advertise what special treatments and facilities the practice has to offer the patients aren’t going to know, and as a result, they may go elsewhere for treatment that YOU can offer them. As one source said: “The reality is that patients spend most of their time in your office looking at the ceiling: So unless it’s written there, your patients most likely haven’t read about it.” Maybe this is the way forward for advertising?

3. The treatment doesn’t meet the patient’s expectations. For many patients, if the treatment that they receive fails to meet their expectations they may look elsewhere for future dental work. Communicate with your patients to find out what they’re really thinking. Also, if a patient is made to feel uncomfortable by their dentist they may consider leaving and taking their business elsewhere.

4. Quality of service. It’s not just dental work that can leave a lasting impression on a patient; the level of friendliness and service from all members of staff, such as the receptionist, will leave an impression, and could decide for a patient if they stay or leave. This is also true for the level of care that is provided – it only takes a moment to take notice and talk to a patient to cover any fears that they may have. Treat them as an individual with needs, and not just as a form of income.

5. Patients are worried about how long they have left it since their last visit. According to sources, people would rather go to an entirely new dentist rather than face a dentist they’ve avoided for a long time. To avoid this from happening simply let the patient know that you will be there to treat them when they are ready. You could even find out how you could make it more convenient for them.

6. Prices are not made clear or explained. One of the most common complaints about visiting the dentist is the cost; however, explaining the cost of various treatments to your patients could make a huge difference to how they feel about paying for treatment, and less hesitant about paying for treatment in the future. Remember, people will tend to
Quick Guide

1. The practice doesn’t offer the patient what they want
2. Patients are not aware of what the practice does
3. The treatment doesn’t meet the patient’s expectations
4. Quality of service
5. Patients are worried about how long they have left it since their last visit
6. Prices are not made clear or explained
7. Relocation, relocation
8. Change of staff
9. New practice opens up
10. Opening hours

Business Management Tribune DENTAL TRIBUNE United Kingdom Edition · March 28–April 5, 2011

Explaining the role of various treatments could make a huge difference in how they feel about paying.
All in a day’s work
Amelia Bray calls some friends for instant answers

At the BDA Conference in May the BDPMA will host a seminar or, rather, a panel of experts (it’s on Saturday 21st May thanks for asking). We’re loosely modeling it on the BBC TV programme Question Time but without the politics and panel member sniping. I’ll be doing my best David Dimbleby impression as chairman and the rest of the panel will comprise four experts.

For me, their range of expertise illustrates the developing role of today’s practice managers. We have the proprietor of a business services and support consultancy, a social media guru, a marketing expert and a dental business consultant. We could have had more experts – a team development coach maybe, a personal development advisor perhaps, an accountant, an IT systems guru, a PR person and so on.

We’ve bravely (perhaps recklessly) entitled it Everything you ever wanted to know about dental management – all your questions answered. But will we be able to answer all the questions posed? I believe so, but to be absolutely certain, I’d like the opportunity to call a friend – many friends indeed.

Ironically, perhaps, there will be no doubt be members of the audience capable of providing solutions to problems that catch out the panel members. I say this confidently because of the BDPMA’s experience with Twitter. Not only do practice managers need to have a vast range of skills these days, they need instant answers to problems. What sort of ultrasonic bath do I need to comply with HTM01-05? How do I track referrals to the practice website? Who offers good CQC training?

Twitter provides the answers or, rather, is the conduit to a raft of instant expertise. Add in the Facebook page and our website and we can probably claim an active network of more than 1,000 people directly or indirectly involved with dental practice management. I suppose the BDPMA could say that while we don’t necessarily know the answer, the chances are somebody who knows us will.

I know what the cynical among you are thinking – that and if you’re a dentist principal now feeling sorry for your manager or a practice manager feeling overworked I recommend visiting the BDPMA website (www.bdpma.org.uk) and looking on the News & Events page for the Practice Managers’ Training Retreat, which is being organised by BDPMA member, Joanna Taylor. Regular de-stressing should also be part of the modern practice managers’ role.

What’s Missing?
Three global titles from the Dental Tribune International portfolio are coming to the UK. Published quarterly, each of these glossy, clinically-focused titles aims to bring you the latest developments in the fields of implantology, endodontics and cosmetic dentistry in a clear, easy to read format.

About the author
Amelia Bray joined the industry as a dental nurse in 1994, having previously worked as a veterinary and chiropractic clinic. In 2000 she assisted her boss (now husband) to relocate the dental practice from a town centre premises to a converted barn in the middle of an apple orchard in the Tamar Valley and at this point assumed the role of practice manager. Amelia completed the Diploma in Professional Practice Management in 2004 and has been involved with the BDPMA since 2005, starting out as Treasurer of the Devon & Cornwall Region before joining the National Executive as Assistant Secretary, Secretary then Treasurer and now Chairman.
Out of hours...out of mind?
Julia Dawson looks at top-quality care for patients, even when the practice is closed

So, the practice is looking great, your team couldn’t be better and your patients seem delighted with the services you’re providing - during practice hours of course. But, what if one of your valued patients has an accident and needs urgent dental treatment? Can you ensure that they will be treated with the same care and attention when you’re off duty? What happens in the evening or on a Sunday while you’re enjoying some well-deserved down time?

We all understand that patient’s dental emergencies don’t always occur during normal working hours. By ensuring that your out of hours services are both clinically excellent and convenient you’re going to engender trust, loyalty and word of mouth recommendations from your patients. The tips below are designed to show that with a little planning and team spirit you can ensure your patients enjoy top-quality care, whatever the time of day or night.

Emergency services
Patients don’t realistically expect you to be available 24 hours a day, seven days a week. But they also don’t want to have to battle over out-of-hours appointments or deal with a complex dental emergency service when they are in pain – especially if they have already paid for high-quality, private treatment.

Most accident and emergency service staff are there to preserve life and cannot be expected to prioritise saving a tooth over an urgent medical condition. In the majority of cases, all that the A&E staff are able to do is patch a patient up, temporarily alleviate pain and refer them back to your practice when it reopens. Their role, after all, is to preserve life where possible and diagnose any urgent medical conditions; access to suitable care in the first place.

Other common out-of-hours cases include pain from possible abscesses, lost fillings, fractured cusps and dry sockets following a recent extraction, as well as facial injuries. Since most emergencies occur

What do your patients do when they need out of hours care?

‘Patients don’t realistically expect you to be available 24-hours a day, seven days a week’

Smaller or single-handed practices can join an inter-practice rota, or indeed set one up where none already
‘Getting your out-of-hours communication right is really important for retaining the loyalty and retention of your patients and can often go a long way to attracting new ones and growing your business’

exist. This involves a group of practices joining together to create an out-of-hours service for the patients of those practices. Getting together with your fellow dentists, settling on the ground rules for your particular rota and sharing the responsibility for your patients’ emergency care, ultimately results in greater patient loyalty for every practice involved, not to mention the satisfaction of knowing that you are providing the best possible round-the-clock care – without chaining yourself to the surgery!

Go the extra mile
One of the things that often come up when discussing poor call-centre experiences is being left to listen to a ringing phone. Most people will hang up after four or five rings during the day, but if you don’t have an out of hours answer-phone message in place the patient can often feel abandoned with nowhere to turn. An appropriate message with concise instructions can really make the difference to patients – often at a time of extreme pain and stress.

It may sound silly to undertake training on something that occurs when you’re not working, but getting your out-of-hours communication right is really important for retaining the loyalty and retention of your patients and can often go a long way to attracting new ones and growing your business. Some payment plan specialists offer a range of training courses on topics such as Improving Communication and Customer Care, not to mention how to get access to the clearest and most helpful out of hours information on your website. Many of these courses also offer verifiable CPD and can be invaluable in improving the patient journey and ensuring the very best care.

So, hopefully the information here has shown you that providing an effective out-of-hours service is incredibly important, not only to ensure that your patients are looked after in an emergency, but also to secure their loyalty and open up communication with other practices in your area. It’s a win-win situation!

Patients should always have access to top quality care whatever the time.

About the author
Julia Dawson joined Denplan in 1990, running the Administration department. Now as Director of Customer Services, Julia has overall responsibility for the Practice Support Advisors, Customer Advisors, Registration and Administration Services, Insurances and Helpline, Corporate Customer Service teams and the Out-of-Hours Helpline team. Working closely with the other divisions across the company, Julia and her team are constantly looking for ways in which they can improve and diversify their service offering.

Clinical Governance including Patient Quality Measures
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Are you waiting to find out when the Care Quality Commission* inspect your practice?
Have you addressed all 28 CQC outcomes?

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Would you like to know how you would fare when your practice is inspected and have the opportunity to take corrective action?
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- Your premises including access, facilities, security, fire precautions, third party and business continuity plans.
- Information governance including Freedom of Information Act, manual and computerised records, Data Protection and security.
- Training, documentation and certificates.
- Radiography including IR/99 and IR(ME)2000 compliance.
- Cross infection and decontamination including HTM 01-05 compliance and surgery audits.
- Medical emergencies including resuscitation, drugs, equipments and protocols.
- Training, documentation and certificates.
- Waste disposal and documentation and storage.
- Practice policies and written procedures.
- Clinical audit and patient outcomes including quality measures.

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Progress not perfection

Ernestine Wright discusses how to systemise your practice to make your life easier

Over the past few months, most private practices in the UK have been spending a lot of time preparing for compliance under the Care Quality Commission. Principals, practice managers and their teams have employed many precious man-hours on everything from completing the paperwork to revisiting aspects of their practice to ensure compliance, and many of the discussions in surgery about GDPs’ frustrations with the CQC!

I frequently hear dental practices saying that they would prefer to be spending their time treating existing patients or attracting new ones to their practice, rather than completing paperwork or documenting systems to ensure the smooth running of the business. That being the case, systems may not be the most popular things to discuss, but they are vital to the success of your practice. If you do want to attract new patients and ensure that your existing ones keep coming back, then having systems in place is more likely to help ensure that you have a healthy appointment book and a profitable practice.

There are literally hundreds of systems that you need. For example, with regards to compliance for the CQC, a series of well-run systems make it much easier to implement, and keep the right side of CQC regulations in important areas such as:

- Clinical Compliance
- Health and Safety
- Staff Discipline
- Staff Interviewing and Recruitment
- Induction of new staff
- Appraisals
- The principles of clinical governance
- Documentation of all these systems can seem overwhelming.

A never-ending task reminiscent of the painting of the Forth Bridge! So, at this point I am going to recommend that you make your mantra “Progress not Perfection” when considering the systems you need to have in place to effectively run a dental practice. Start with the priority areas and know that you will constantly have to review/ amend as you develop your practice.

So what would I recommend as the priority areas for systemising your practice? My top three are:

1. **Conforming to Regulations**
   - So that you can practise dentistry and continue to run a business.
   - To include, most importantly:
     - a. Clinical Standards and Protocols
     - b. Health and Safety

2. **Client Experience**
   - So that you can attract new patients, ensure your existing patients keep coming back and recommending you, and maintain a profitable business.
   - To include, most importantly:
     - a. New Patient Enquiry By Phone Process (and scripts)
     - b. Client Experience Checklist
     - c. Appointment Booking Procedures

3. **Managing your Team**
   - So that you have the right support team to help you grow your business.
   - To include, most importantly:
     - a. Robust interview process
     - b. Contracts and job descriptions
     - c. Regular team meetings and individual performance appraisals

In many ways the most important systems are not the back-office, hidden systems that help your administration run well (although they are, of course, important), but the systems that you are patient-facing, which enable your team to give a consistent message that truly represents the standards for which you and your practice stand.

Most dental practices want to deliver a fantastic customer service for their patients but some are frustrated with the reality of achieving this. What typically happens on a day-to-day basis is that their team finds a way of doing things that (with or without the principal’s agreement) they have decided are effective. They may vary these ad-hoc systems for the benefit of the patient, or to make their own day easier to manage. This can work reasonably effectively until somebody new joins the team. At this stage the team member who best knows the system will verbally pass it on to the newcomer and nothing gets written down. In situations where even this is impossible, the new team member may find themselves having to create a new system all of their own. So without systems your team can be very flexible to suit the patients and themselves and exhibit a ‘can do’ attitude towards patients, but can end up delivering a different message every time. However, with systems your team can deliver a consistent and accurate message and feel confident that the message they are giving is the right one.

In addition to this your team can promote a message that is congruent with your brand.

Let’s look at a possible system for a “New Patient Enquiry by Phone”. I believe this is one of the most important things to get right in these challenging economic times. In other words, you want to ensure that you make the most of the phone enquiries you receive by turning as many of them as possible into new patient consultations.

**Procedure for new patient enquiry by phone:**

The process needs to include:

- Rules regarding how many rings the phone is an-

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**Dental Tribune** United Kingdom Edition - March 28-April 5, 2011
Most dental practices want to deliver a fantastic customer service for their patients but some are frustrated with the reality of achieving this.

- Reassuring them that you will provide them with a private emergency appointment at xxxhrs today and that Dr X will attend to their pain.
- The amount they can expect to pay

If they wish to go ahead with the appointment:
- How/when the fee is payable to book the appointment
- What information must be recorded for practice computer
- Giving address/direction/parking information
- Information on arriving for the appointment what happens/timings
- Asking them if they have any questions about today’s appointment
- Information/Advise on what they need to bring/do/eat before they attend the appointment
- Telling the patient that you are meeting your customer’s expectations
- Give a consistent message
- Make the patient feel very well looked after
- Appear confident and capable
- Potential clients are therefore much more likely to say yes to coming to your practice.
- Systems will also make the practice manager’s job a lot easier, helping them to focus on creating and managing the systems and the team, rather than juggling managing with actually ‘doing’. By ensuring that the practice has systems, principals are freed up to focus on running the business and carrying out top quality dentistry, rather than feeling they have to do everything in the practice from reviewing the appointment book to changing the light bulbs!

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About the author
Ernestine Wright is a founding partner and managing director of Breathe Business. Ernest joined Breathe from Reuters where she was a senior director. Her principal responsibilities at Reuters were largely concerned with people and process. Her last major project at Reuters was as lead director setting up a joint venture with Dow Jones, which involved bringing together teams from two very different companies and cultures running their UK business. With a background in results and marketing as well as building high performing teams, Ernest specialises in coaching dentists and their teams on leadership, sales and marketing as well as building high performing teams.

Most dental practices want to deliver a fantastic customer service for their patients but some are frustrated with the reality of achieving this.
Looking for opportunity
Sharon Holmes discusses options for recruitment of staff

I would, in all probability, say that one of the hardest tasks is recruiting for the right candidate to join your team. Over the years we have used different methods of recruitment to try and select the best possible candidates. Due to this task being an extremely important role, we have streamlined our group policy and procedures on recruitment.

We have used various methods for recruitment, such as recruitment agencies, word of mouth amongst our own staff, internal promotions and outside recruitment for replacement of the post and the internet. We also have potential candidates who either email or post us their CVs.

Out of all of the above methods I have come to rely on using the internet the most. We place our adverts on various websites; we source the best CVs that have been submitted and after careful screening of the CV we then contact the potential candidates and offer them interviews.

Once the interviewee arrives at the practice they are given a questionnaire to fill in so that I have a guideline to start from. The practice manager carries out the first interview, from this a short list is created and a second interview process is put in place with the selections where I then carry out the interview or either Dr Malhan or Dr Solanki to make that all-important final choice.

This can be time consuming, but I find it most effective as I am thorough with my screening process as well as knowing what I will require from the potential candidate once I have elected them. Does mean more work as once you have made your selection it is important to collect all the necessary essential documents as well as following up on at least two character references.

This can be testing as at times it is difficult to get a character reference in a short space of time, which means you have to make the request several times, which means you are unable to make the job offer as soon as you may want to. To get around this issue we now ask the potential candidates to provide written references at the time of their interview.

I find that going through the process yourself instead of using a recruitment agency the process becomes a personal one due to the fact that the potential candidate has not been coached on what to say during the interview process. You can also negotiate your fee as to what you feel the candidate and their experience is worth and their interview. Written references at the time of interview allows us to be able to send screening and recruitments with a government sponsored Recruitment Company to offer apprenticeships to school leavers. They do all the screening and recruitments and pay for the candidates to receive training. It is our responsibility to mentor and direct them all other levels of employment. Their tutor comes to the practice to carry out assessments and so forth.

This is cost effective as you can either pay the student the minimum fee of £2.50 per hour or more if you wish to do so. This is an ideal opportunity to help someone young to get into the market place and have an opportunity to develop and as it is affordable you are able to have an extra member of staff as part of your contingency plan for avoiding disaster when it comes to functionality on a day to day basis.

As Winston Churchill once said: “A pessimist sees the difficulty in every opportunity an optimist sees the opportunity in every difficulty.”

About the author

Originally from South Africa, Maron Holmes has worked in the field of dental practice management since 1992. In 2005, she moved to London City Dental Practice where after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is now part of a mini co-operative group called the Dental Arts Studio, of which she has been instrumental in its creation.

Every employer wants a new member of staff to fit in with their team

Sharon Holmes, originally from South Africa, is responsible for dental practice management in the London City Dental Practice. She has worked in the field of dental practice management since 1992. In 2005, she moved to London City Dental Practice where after 18 months, was responsible for managing four practices in the group. Holmes is responsible for dental practice management at the London City Dental Practice, which is now part of a mini co-operative group called the Dental Arts Studio, of which she has been instrumental in its creation.
A question of being safe or sorry

David Hands and Neil Photay discuss nickel restorations and metal allergies

It is estimated that one in every three people in the UK will suffer from some kind of allergy in their lifetime and this has inevitable consequences for health care professionals who know they must take any relevant history of allergy into consideration before embarking on a treatment plan. From latex allergy to an allergy to the ingredients in sedatives, dental professionals must be constantly aware of how to spot, and treat, allergic reactions. One often unconsidered problem is an allergy to nickel, which can be a problem for people with fillings and restorations. Whilst the dangers of mercury in amalgam fillings has been making news for years, nickel has been somewhat overlooked, but the potential for allergic reaction should not be underestimated by patient or dentist.

Solid understanding

In the dental field, a solid understanding of allergies will allow the dentist to treat patients suffering from metal allergies and to select appropriate restorative materials for them. With approximately 10 per cent of women and six per cent of men thought to suffer from the condition, metal allergies are a growing concern, and can represent a small but significant proportion of the practitioner’s patient base.

So how do we know if a patient has a metal allergy? The short answer, unfortunately, is that we don’t. Medical records will sometimes provide details of previous allergic reactions and some patients may even have had a patch test to confirm this, but many people are unaware that they have an allergy to nickel at all. Sensitivity to jewellery that contains nickel is not necessarily a precursor to an intra-oral reaction as research has shown that people with a positive skin reaction to nickel are not necessarily allergic to nickel containing alloys intra-orally, and vice-versa. Indeed, sensitivity to a nickel-containing alloy may well be due to its iridium and indium content instead, which all share similar chemical properties. However, many patients with a nickel allergy also have

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When it comes to the health of patients, it is always best to err on the side of caution and so, if any intolerance to alloys is suspected, the best option is to choose all-ceramic materials'
an intolerance to gold; so as a general rule of thumb, if a patient has a known history of a nickel or gold allergy or intolerance, metal restorations should be avoided altogether. Dentists should also be aware of the symptoms of an intra-oral metal allergy, which usually include local irritations and inflammation of the mucous tissue of the mouth, predominantly in the form of gingivitis and stomatitis. In extreme cases patients can present with discoloration of the gums and some deterioration of the gingiva.

Other metals
Along with iridium, palladium can also cause sensitivity in patients with nickel allergies. It is estimated that between 54 and 65.5 per cent of patients with nickel allergies also suffer reactions to palladium, and bonding alloys containing this should also be avoided if a history of nickel allergies is known.

Thankfully, with many all-ceramic restorations available both privately and on the NHS, patients at risk of an allergic reaction now have a range of safe solutions from which to choose. Composite inlays are a particularly affordable option and also boast superior aesthetic benefits to their metal counterparts. If all-ceramic restorations on posterior teeth are not viable due to their strength, biocompatible alloys such as cobalt-chrome are also a safe option.

Err on the side of caution
When it comes to the health of patients, it is always best to err on the side of caution and so, if any intolerance to alloys is suspected, the best option is to choose all-ceramic materials. Many patients will be pleased to be offered the more aesthetically pleasing option, and few will disagree that it is better to be safe than sorry.

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About the author

Neil Photay
BSc (Hons) GDC Reg. Technician
Neil proudly carries his family tradition of working in the dental industry and creating and manufacturing dental innovations and technologies. Working at both the CosTech Laboratory and family dental surgeries from the age of 16, Neil completed a BSc(hons) in Computer Science, specialising in project and team management at Brunel University before returning to the CosTech Elite laboratory in 2005.

David Hands
MDT GDC Reg. Technician
David has a Master Technician status.

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At the end of January, Dentaid welcomed four final year students from the School of Dentistry at Cardiff University, all of who, with the end of their studies in sight, were looking forward to embarking on their careers.

During the trip, Mike Phil-lips, one of Dentaid’s volunteer retired dentists, showed the students some of the tools which had been donated to the charity. He explained how even old equipment, once cleaned and refurbished, is invaluable in countries where even second-hand kit is beyond the means of most health providers.

The students also had a tour of the workshop where all the donated equipment is stored and refurbished. They were particularly impressed by manager Dave Effamy’s incredible practical ability. Dave is able to take three non-working pieces of equipment and transform them into two working pieces of equipment; by mixing and matching the working parts he can produce two pieces of equipment that are perfectly viable and ready for shipping.

Another skill Dave has is that he can strip out the more complex sections of electronic equipment and make it useable in countries where there is an unstable electrical supply.

The students learned a lot from their day and by the end of it they recommend other students to visit Dentaid. Any students interested in visiting should contact rob@dentaid.org.

Trek with a purpose

Dentaid, a well-known dental charity, collects unwanted equipment from surgeries and hospitals for refurbishment and shipping to the developing world to equip clinics and teaching hospitals.

Like all charities, Dentaid needs funds and one way of raising cash is to organise sponsored treks. Last year’s expedition took 12 people to Vietnam; six were dental professionals, the other six included a beautician, a roofer and a chartered surveyor.

This year’s trek from 1-14 October is to North East India. The opportunity offered by this expedition is one you simply won’t find anywhere else. The first two days are spent assisting at a dental clinic in a home for disabled children in Calcutta, and gives the chance to see at first hand the difference that our work makes. This is followed by a 60km trek through West Bengal’s mountains, forests and villages and a visit to a Buddhist monastery. Apart from hotels at the start and end of the trip, accommodation is in mountain huts or tents, so this is a unique chance to get close to the country and the people and see village life at first hand.

The all-inclusive cost is £2,450 which you can either pay yourself or raise from sponsorship. Intimate contact with the people we meet is what makes our trips completely different from commercial operations, so we restrict numbers to a dozen and we’re always booked up early.

If you want to find out more contact Dentaid’s head of fundraising, Diane Platt on 01794 524249, email diane@dentaid.org or visit our website www.dentaid.org.
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Mhari Coxon discusses the four E’s of selling

I have recently applauded the teams that have got business savvy and work together to make a profitable, growing practice. We need to try as professionals to marry the business of dentistry to providing ethical care for our patients.

I have often been asked how I feel about selling by hygienists, therapists and nurses, who sometimes feel they are being forced to sell in a way which makes them uncomfortable. Some see it as unethical and not part of their job. I say that it is what we do every day and, when done well, doesn’t feel like selling or being sold to at all.

Ethical duty
It is primarily the role of the dental health professional (DHP) to assist patients to attain and maintain their oral health. This should always be at the forefront of everything we do. And selling, in this capacity, is simple and effective; it is also what we do every day. Recognising how and why will help us to succeed in increasing treatment uptake.

The Four Es
When working with our patients, using the four Es will produce a great, motivational, productive relationship. This relationship will give the base to sell the patients what they want. These are:

• Engagement
• Empathy
• Education
• Enlistment

Engagement
Engagement is a connection between the clinician and patient that continues throughout the encounter and sets the stage for the establishment of a partnership.

Barriers to engagement by the clinician include a failure to introduce oneself, inquisition-type questioning, and the biggest no no – interruption of the patient’s story.

Techniques for successful engagement include, showing interest in the patient as a person, empathy which is sincere and successful when a patient acknowledges that he or she has been seen, heard, and accepted as a person.

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front, negotiating and prioritising the agenda for the visit and using the patient's language rather than medical jargon. You are effectively finding out what it is you can sell to the patient in terms of their wants and needs.

Empathy
Empathy is sincere and successful when a patient acknowledges that he or she has been seen, heard, and accepted as a person.

Barriers to empathy often include using medical terminology, confusing sympathy with empathy and feeling that it takes too much time.

Effective empathy can be exhibited by:

• Greeting the client on neutral territory; ie the waiting room
• Keep on an even eye level with maintained eye contact
• Avoid physical barriers
• Reflective speech - Repeat information in patients' own language
• Share experiences/anecdotes
• Accept patients' thoughts and feelings
• Use 'hear' 'see' 'told' when talking after listening to show you are thinking of what they said

Education
To effectively communicate education first assess what the patient already knows and then ask questions to determine what he or she might be wondering. Not all patients will be forthcoming with questions, so be prepared to probe empathetically to discover their most basic concerns and fears.

Common questions from patients include:

• What has happened to me?
• Why has this happened to me?
• What will be done to me?
• Can they fix it?
• Why will they do this rather than that?
• Will it hurt?
• When will I have the results?
• How much will this cost?
• Why bother with all this?

Be prepared for these questions and have good answers prepared as a team.

Enlistment
Enlistment is an invitation by the clinician to the patient to collaborate in decision-making regarding the problem and the treatment plan. It is a challenge to the dental team to create a plan of treatment that the patient will accept and to which he or she will adhere.

As all practitioners know, patient non-adherence is a tremendous problem – loss of earnings, resources wasted, waste of time.

This form of enlistment is a necessity and seen as best practice. CQC will smile on this kind of communication.

Why bother with all this?

By incorporating effective communication techniques into daily patient interactions, clinicians can decrease their medical practice risk. More importantly, clinicians can positively and effectively impact patient health outcomes without increasing the length of visits - a win-win situation for both parties, and indeed the goal of health care.

Put yourself in the patient’s shoes

If you follow the four Es then creating that acceptance of treatment can be enjoyable for both you and the patient and give the principle something to smile about too.

Paul Howe, who is a sales advisor, quotes five foundations for successful selling. These are:

• Nobody cares how much you know until they know how much you care
• We all love to buy but hate being sold
• Clients are happy to be led but never pushed
• Leave them better than you found them – regardless
• Deliver what you promise, always, on time, first time, every time

I genuinely try to follow these ideals with every patient and actually, these can be applied to general life as well with great effect.

In conclusion

Selling is simply exchanging a product or service for money and everyone in a dental practice does this daily, even if the patient is exempt from payment. Reactive selling, (this is when you are approached for your product and you respond) is the easiest and most effective form of selling, and again, something we do every day. Proactive selling, (this is when you approach someone to try and enter a dialogue with them to discover if they would benefit from your product or services) is also a suitable form of selling providing you abide by the four Es rule. Asking if someone is interested in a service is not pushy-selling, unless you do not listen to or respect the answer the patients give.

About the author
Mhari Coxon is a dental therapist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDforDCP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@paulfordcp.co.uk.

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Chris Townsend

Early bird Booking Discounts
As we arrived at the Dentistry Show we had a really nice greeting from all the staff. It really makes a difference when a warm welcome is received from everyone.

There was a fantastic programme for dental nurses this year, mainly due to the efforts of organiser Jillian Eastmond.

She did an incredible job selecting the speakers. My favourite was Dr Freddie Martin, as his lecture on forensics was fascinating. Other delegates agreed; the talk from the room was good as they all said what an interesting lecture this was. All the lectures were excellent. Other great speakers were Kimberly Wingrove who gave valuable advice about the role dental nurses can play in oral health instruction and Avi Banerjee who really hit home on why minimal intervention is so important. I’ve heard lectures about this before at the British Academy of Cosmetic Dentistry and it’s certainly the way I’d like to be treated myself!

The exhibition was also great, a large amount of stands with generally a good response from all the exhibitors, although I couldn’t help but feel some discrimination from some of the exhibitors when they realised they were talking to a dental nurse and not a dentist! Their attitude seemed to change quickly and instead of carrying on talking they just pushed leaflets into my hands which was obviously my cue to leave!

I think it’s important for exhibitors to realise that we as dental nurses have a big input as to what materials we have and use in the practice. We often persuade our dentists to buy products and they often ask us to find out information on different products for them, so I can’t help but feel that maybe some exhibitors lost out from business from practices purely because of the lesser attention we received.

Having said that; this was still a really enjoyable event. At the end of the first day there was a drinks reception which gave delegates a chance to mingle with each other over a glass of wine or a cold beer before getting ready for the second day’s busy programme.

All in all it was a fantastic couple of days and I really cannot wait to see what they can provide for us next year!

About the author
Chloe Lewis is a qualified dental nurse at Avenue Road Dental Practice on the Isle of Wight. Her extended duties include clinical photography, tooth whitening procedures and patient counselling. Chloe can be reached at: info@wightdental.com. Jillian Eastmond CPS both chaired and lectured at the event. Dr. Freddie Martin, Forensic Odontologist. Kimberly Wingrove discussed oral health education. Minimal intervention must be the way of the future in dentistry. Avi Banerjee gave a great overview.
What’s good for the patient is good for the dentist

Javier M. de Pisón discusses a Vedic Smile approach to dentistry

A n extremely skilled clinician with more than 17 years of experience in cosmetic dentistry, Dr Su- shil Koirala says that technology should work to improve health, never to compromise it. His Minimally Invasive Cosmetic Dentistry (MiCD) treatment protocol is based on conscious- ness, nature and evidence-based technology that really respects the patient’s long-term health and needs.

Koirala, who is the founder and president of the Nepalese Academy of Cosmetic Dentistry and of the South Asian Academy of Aesthetic Dentistry, combines in his MiCD protocol philosophy and ethics, scientific research, and what can be described as a Vedic Smile or holistic approach to dentistry.

Concerned about the rapid ad- vance in aesthetic procedures, Koirala began to question if the aim of many dental techniques was to improve health or just to offer the patient a quick makeo- ver, regardless of their long- term consequences.

Years of practice led him to develop his guidelines for MiCD, a set of principles that stress early diagnosis, disease intervention, selection of minimally invasive treatment procedures, and use of evidence-based materials, taking into account as well the psycholog- ical aspects, ethnic background, and actual health needs of the pa- tient.

A Pioneer Paper
In a groundbreaking article entitled “Minimally Invasive Cosmetic Dentistry: Concept and Treatment Protocol,” Dr Koirala offered a much needed guide to minimally invasive cosmetic dentistry, a discipline that up to now has been more concerned with appearances than with clinical evidence.

The article, published in Cosmetic Dentistry magazine, was translated in many languages and attracted many followers eager to at last have a clini- cal protocol for many dental cosmetic procedures that stressed something that while obvious was not widely fol- lowed—preserving as much nat- ural tissue as possible.

The ability to differentiate between what a patient wants and what he or she actually needs is a large ethical ques- tion in cosmetic dentistry. In order to address this issue Koi- rala has developed what he calls a simple self-conscious pre-treatment test, “whereby I ask myself four simple yet hon- est questions”:

• How would I treat my own family members?
• Will the treatment plan remain the same regardless of who the patient is?
• Am I competent and happy enough to take up the case?
• Is the patient happy with the Biological, Financial and Time (BFT) cost estimation of the treatment?

Koirala explains that “what a patient wants and what a patient needs are two different things. The needs are the basic treat- ments a dentist can provide. But the wants are of a different variety, like choosing clothes in a store: you choose the colour of the teeth, the texture of the teeth, the shape of the smile.”

What is Beauty?
Since the definition of beauty is different in each culture, it also affects cosmetic procedures.

“For Western-style contem- porary smile aesthetics, beauty is long teeth and a straight smile, but the same parameters don’t apply in Asia,” he ex- plains. “In fact, Asian patients don’t mind having a little bit of overlapping teeth, which they see as natural. So we cannot use the same formula globally in cosmetic dentistry.”

Studies have shown that the dental pulp of Asian patient is generally wider, in comparison to the pulp of Asian patient. “For Western-style contem- porary smile aesthetics, beauty is long teeth and a straight smile, but the same parameters don’t apply in Asia,” he ex- plains. “In fact, Asian patients don’t mind having a little bit of overlapping teeth, which they see as natural. So we cannot use the same formula globally in cosmetic dentistry.”

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• Will the treatment plan remain the same regardless of who the patient is?

Koirala warns that “you need clear consciousness while choosing the right technology for your practice, technology may not always be health-ori- ented”. As a sample, he thinks that CAD/CAM restoration tech- nology still has to be refined in order to be adopted fully in re- storative dentistry. “CAD/CAM presently demands extension for insertion, strength and aes- thetics,” thus, “we are compro- mising health for technology.”

“Clinicians still believe that articulating paper mark gives them ideal force component in occlusal adjustment,” contin- ues Koirala. “The ‘big mark big force, small mark small force’ concept has no scientific evi- dence, but most cosmetic den- sists rely on articulating paper marks to do occlusal force ad-

“The eyes, teeth and skin tone should be in harmony. If the teeth are too white, it may look awkward and unnatural.”

Changing the Mindset
While the principles of MiCD may seem complicated, the protocol is easy to follow and very practical. The reason is that it doesn’t require chang- ing clinical techniques, but us- ing them in a consciousness way beneficial for both the pa- tient and the dentist.

“We don’t say, ‘Don’t cut the tooth this way’, we say, ‘Cut less’,” explains Dr Koirala. In fact, the MiCD protocol does not reject any contemporary proce- dure, including full crowns or bridges; it just asks the dentist to use their consciousness prop- erly to think if invasive options can be avoided, and to use them only as a last resort.

In other words, the only thing a dentist has to do to comply with MiCD is to change the priorities for a given procedure, to alter his or her mind-set. The framework of MiCD establishes five golden principles:

1. “Sooner the Better” – early exploration of diseases and de- fects to minimise possible inva- sive treatment in future.
2. “Smile Design Wheel” – follow these principles (see image), and respect the psy- chology, health, function and aesthetics of the patient.
3. “Do no Harm” – select...
treatment procedures that maximise preservation of healthy tissue.

4. “Evidence-Based Approach” – selection of materials and equipment must be based on science.

5. “Keep in Touch” – focus more on regular maintenance, timely repair and strict evaluation, which should be understood by the patient.

As Dr Koirala says, they are simple guidelines to accommodate every treatment in a dynamic protocol because science constantly changes.

“A good protocol should incorporate changes based on scientific evidence,” he continues. “The philosophical part may be the most difficult because it’s subjective, which is why we give a questionnaire to the patient whereby he decides what he wants. We give him the science and inform him about the technique, but he decides what type of aesthetics he wants.”

High-quality materials

When Koirala published his MiCD protocol in 2009 he not only gained a following among dentists, but also the respect of high-quality dental manufacturers. 

“I met with Mr Patrick Loke,” Koirala says referring to Shofu’s Asia-Pacific Marketing Director, “who told me he liked the concept of MiCD because his company is concerned with the health of the patient, and with developing bio-aesthetic products in dentistry.”

In Shofu he seems to have met his match and you can detect his dedication and conviction when he says, “I’m very happy using Giomers (a bio-aesthetic restorative material), so much so that it inspired me to write a book,” he adds referring to a new type of restorative materials whose name is a hybrid of the words “glass ionomer” and “composite.”

Koirala is now conducting long-term trials using various dental materials, with a focus on the MiCD protocol and its acceptance as a way to accomplish clinical results.

He believes he has developed a concept that is good for the patient, good for the dentist, and good for society. The MiCD protocol is in its preliminary stage worldwide, but the conferences he gave in South East Asia and South Asia have been widely accepted. “This is the right time to come out with this new philosophy,” he explains, “so that in four or five years a new generation can start talking about the preservation of health in the long run.”

Non-Invasive Health

The medical sciences are moving towards non-invasive procedures, and adequate ways of health promotion to avoid oral diseases. In dentistry, however, minimally invasive procedures are being used routinely only in caries management.

“In the medical sciences it is inherent not to cut tissue,” Koirala continues. “If patients knew that to place a crown you need to cut the tooth’s enamel, they probably would not accept the treatment.”

“You need to start at an early age, like six or seven, in order to detect various smile defects like orthodontic problems,” Koirala says. “Everything that can affect oral health, including cosmetics, should be thought about at an early age.”

“Dentists may use MiCD or not,” Koirala adds, “but they all agree it’s the right approach. I want to encourage everybody to join the MiCD mission. Our MiCD Global Network (a web-based organisation) is a group of dedicated professionals who wish to improve the knowledge of the clinician and the patient. Information technology can help promote these ideas through networks of dentists, people, and like-minded companies. We need to change our mind-set.”

Koirala plans to change the mind-set through more international lectures, collaborating with like-minded clinicians and academicians, creating study clubs to exchange knowledge, and providing internet-based educational seminars.

“We are changing protocols for the health of the patient, and ultimately, dentists will win too, because it saves time on procedures and provides aesthetics and function. The type of material used is secondary to me, as long as it preserves health, a harmonious function (the force component), and promotes aesthetics. We are not promoting a company here, but promoting health. And that is our first responsibility as clinicians. It is something that can be the pride of the profession.”

Resources

• MiCD Website: www.MiCDglobalnetwork.org
• MiCD Protocol in “Cosmetic Dentistry”: www.dentaltribune.com/articles/content/id/1749/scope/specialities/regional/international

SIDEBAR 1

Preserving Health, Enhancing Smiles

This advanced second generation material is a Giomer ideal for anterior and posterior restorations.

Patients today are much more educated and demanding regarding dental treatments. Amalgam is a perfect example. A high-percentage of patients demand not to have amalgam fillings for cavities, but request a tooth-colour material. In the past, a restoration with amalgam required cutting a lot of tissue, but the new direct tooth-coloured restorative materials cause less damage to the tooth and provide better aesthetics.”

The developer of the MiCD protocol during the interview with Dental Tribune

The trend is growing.

The goal now is achieving good aesthetics with minimally invasive treatment with the support of MiCD instruments and bio-aesthetic materials,” adds Loke.

“We are the official partner of the MiCD movement, Loke adds, which motto is ‘Preserving Health Enhancing Smiles.’ “We are fully committed to support their educational events for both public and dental professionals, such as workshops, lectures and symposia.”

Shofu’s advanced restorative materials use S-PRG Technology (Surface Pre-Reacted Glass
Ionomer), which provides predictable aesthetics and better function. These are bio-aesthetic materials that allow fluoride release and recharge. You can restore a small cavity removing only the affected area because the S-PRG fillers help re-mineralise the tooth structure.

S-PRG Technology is effective and is based on eight years of clinical trials. The new ongoing studies use MiCD protocols and newly developed materials. They were introduced in 2010 at the main dental research venue, the congress of the International Association for Dental Research (IADR) in Barcelona, Spain.

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