Tug of war between dentists’ associations

Power struggle developing between CODE and DPA: claims of ‘illegal activity’ darken situation

In a move that had tongues wagging at the recent Dentistry Show, dental association CODE has assumed the management of the Dental Professionals Association (DPA).

In a recent press release, Paul Mendllosohn, the Chief Executive of CODE, confirmed that the Council of the DPA has in fact accepted in principle a proposal by CODE to manage the DPA. Reasons behind DPA’s decision to ‘join forces with CODE’ were stated as ‘a result of falling membership levels’ and ‘concerns over declining finances’.

Despite the positive noises coming from the joint relationship, it would seem that everything is not quite clear cut. Some DPA members are garnering support against the agreement, claiming illegal activity on the part of the DPA Council and not allowing DPA members a vote on the decision. As displayed on the DPA website www.uk-dentistry.org, there is a backlash against the move and many are prepared to resign and withdraw their subscriptions if the decision goes ahead.

A statement from DPA has stated how the new joint working relationship would mean that DPA members would receive ‘greater benefits’ such as access to CODE’s management skills and ‘free services’ including CODE Infection Control Prevention kits and access to the employment legal helpline with First Assist.

The DPA press release also states that the new venture ‘means that members of CODE and the DPA will both benefit from the increased resources that joining forces will bring’ however, it does stress that ‘both organisations will remain as completely separate entities with their own unique goals and objectives.’

Dental Tribune spoke to ex-Treasurer Neville Bainbridge, who said: ‘Under the disputed CODE Association Management Agreement, CODE has been running the DPA on a day-to-day basis since 1st March. Therefore the press releases put out by the ‘DPA’ and CODE have been written by the same person. It was only when I decided to go public and the story broke on internet forums that the members found out what was actually happening behind their backs.

‘Obviously it is difficult to communicate with DPA members if they are being told ‘officially’ that the merger is going ahead, however I hope we are succeeding in communicating to members what happened on 21st January (when a meeting was held to vote on the possibility of a working agreement).’

“I would like to emphasise that whatever the outcome, our only motivation is to act in an open and transparent way in line with the wishes of the members.”

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www.dental-tribune.co.uk
Does your dental practice website meet new GDC criteria?

Dentists are urged to review their practice websites to ensure they comply with strict new GDC guidance.

UK-wide dental defence organisation MDDUS is advising every dental practice to check their website includes all relevant and up-to-date information as detailed in the GDC’s Principles of Ethical Advertising.

Under the new rules, practice websites must include a range of information including the dentist’s professional qualification and GDC number, the GDC’s address and contact details, details of the practice’s complaints procedure and the date the website was last updated.

MDDUS welcomes the clarity of the GDC’s website criteria – which came into force on March 1 – in an age where an increasing amount of information is accessed via the web.

The use of a website can help a dental practice communicate with and inform their patients for primary care. It aims to ensure all practice websites are accurate and do not display misleading information, in line with European regulation. The guidance sets out a clear breakdown of what websites should display to ensure they are accurate and accessible.

MDDUS dental adviser Rachael Bell believes the guidance benefits both patients and dentists. She says: “While a website is no substitute for face-to-face contact with patients, the new guidance will help patients as it ensures they are given clear and accurate information that is easy to access.

“For dentists, a website is a useful tool to communicate with their patients as information is now so readily available online and patients are ever more interested in being a great marketing tool, but exactly what is being offered and to whom needs to be clear and accurate if dentists are to keep themselves in line with the GDC’s guidance.”

“Most practices that have websites will already have most of the information that the GDC are asking them to display but it would be beneficial for practices to re-check their websites in light of the new guidance.”

“If dental practices are exploring setting up their own website they will now know from the GDC what information must be included.”

The guidance asks for a dentist’s registration number to be clearly displayed as well as their professional qualification and the country from which that qualification is derived.

Other information that must be displayed is the name and address of the practice, contact details including an email address and the GDC’s address or a link to their website. There also needs to be a section giving details of the practice complaints procedure which should include details of who patients can contact if they are not satisfied with the response.

“The guidance also states a dental practice website must not display information comparing skills or qualifications with other dental professionals and that all information on the website is up-to-date as possible as patients have a right to assume all information on the website is accurate,” adds Bell.

As well as websites, the guidance covers advertising services, the use of specialist titles and states all information or publicity material regarding dental services should be legal, decent, honest and truthful.

For full details of the GDC guidance entitled Principles of Ethical Advertising, visit www.gdc-uk.org.

Goodbye to tobacco displays

On 6 April 2012, all large shops in England will have to hide tobacco products from view in a drive to cut the number of smokers and protect young people who are often the target of tobacco promotion.

Sainsbury’s, The Co-operative and Waitrose have already been trialling hiding tobacco displays. Other shops have just one month to find out if they are classified as a large shop, to plan how they are going to cover up their tobacco displays and to train their counter staff on the new law.

Cigarettes and tobacco products are to be hidden from view except when staff are serving customers or carrying out other day-to-day tasks such as restocking.

Ending open cigarette displays will also help people trying to quit smoking and help to change attitudes and social norms around smoking.

Chief Medical Officer, Professor Dame Sally Davies said: “More than eight million people in England still smoke – it is our biggest preventable killer and causes more than 80,000 deaths each year.

“Nearly two-thirds of current and ex-smokers say that they started smoking before they were 18, with 39 per cent saying that they were smoking regularly before the age of 16.

“With only one month to go until large shops need to cover up their tobacco displays, we will soon start protecting children and young people from the unsolicited promotion of tobacco products in shops, helping them to resist the temptation to start smoking. This will also help and support adults who are trying to quit.”

Jean King, Cancer Research UK’s Director of Tobacco Control, said: “With one month to go before tobacco displays are removed from large shops, we look forward to cigarettes being less visible to children and young people.

“Around 80 per cent of smokers start before they turn 18, so it’s vital that cigarettes are not seen as normal, harmless products instead of the deadly and addictive drugs they really are. Preventing young people from starting to smoke is vital and putting tobacco out of sight is a step towards putting them out of mind for the next generation.”

Deborah Arnott, Chief Executive of ASH, said: “Despite the scare stories put out by the tobacco industry in the past, the countdown to implementation is going smoothly. Indeed many retailers have already covered up their displays and manufacturers are meeting the cost of adapting tobacco garments with incentive covers, just as we said they would. In Canada and Ireland retailers found no short term impact on tobacco sales and no growth in smuggling. There’s no reason why it should be any different here.”

Large shops are defined as having a relevant floor space of more than 280 square metres, as used in the current Sunday Trading law. When serving customers or actively carrying out one of the other tasks allowed, each temporary tobacco display must not exceed 1.5 square meters. Guidance on the new law is available on Businesslink or through local authority trading standards departments.

Retailers wanting to find out more about the end of tobacco displays can contact their local authority trading standards for more information.

New tools launched for healthcare professionals

The East Midlands Adult Safeguarding Board has developed four new tools designed to be used at all levels across services that have a responsibility for promoting and ensuring the protection of vulnerable adults.

From research there seemed a vast disparity in levels of understanding of the Mental Capacity Act, its associated Code of Practice and the Deprivation of Liberty Safeguards (DoLS) across those health and social care professionals that come into contact with vulnerable people. To help address this, two versions of a Mental Capacity Act e-learning tool have been devised; one for primary care workers, and the other for social care, which also provides flexibility and ownership for the end user.

To ensure theoretical learning can be reinforced at the frontline of health and social care, the NHS East Midlands has produced Prompt Cards that clinicians and practitioners can easily refer to in practice. The need for a simple-to-use and accessible tool to help adult safeguarding was identified following the pilot use of the Safeguarding Self-assessment and Assurance Framework (SAAF) in 2010.

This initiative was developed by a small working group of safeguarding health leads from across the region, in consultation with the East Midlands Adult Safeguarding Network. The colour coded cards ensure that the relevant information can be accessed quickly to support good practice and help the user identify vulnerable individuals.

Finally, the Valuing People Team in Leicestershire has developing a number of new resources to help keep people in the community safe, particularly people who may have a learning disability or a learning difficulty.
Editorial comment

This week I’d like to make an apology to all our readers of Dental Tribune.

It’s not something editors like to do, being practically perfect in every way, but on this occasion it is necessary!

The last issue of Dental Tribune saw an unacceptable lapse in our usually high editorial standards in the form of some glaring mistakes on the front page.

Readers have written in and given me feedback, and thanks for that – it is good to know that readers care about what we do and keep us on our toes so to speak.

We very much want to make sure this is an isolated occurrence so I’d like to assure readers we have looked into what went wrong and we are putting it right.

English poet Alexander Pope said: “To err is human; to forgive, divine.” So please forgive our human errors, and we promise to learn by our mistakes.

FDI launches Guide

During a session on NCDs, hosted by the American Dental Association (ADA), the FDI launched its publication “Oral health and the United Nations Political Declaration on NCDs: a guide to advocacy.”

The guide provides FDI national dental associations with the necessary information and tools to follow up their government’s commitments on NCD prevention and control. It further provides a timetable for their exchanges and developing a political declaration.

FDI Executive Director Dr Jean-Luc Eiselé characterised the guide as a means for NDAs to demonstrate their understanding of the Political Declaration, their commitment on NCD prevention and their policy and monitoring plans.

Applying fluoride varnish containing 22,600ppm F is a recommended intervention in ‘Delivering Better Oral Health – An evidence-based toolkit for prevention’. This year’s guide also contains no stated policy.

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Recommended dosage for single application: for milk teeth: up to 0.25ml; for mixed dentition: up to 0.40ml; for permanent dentition: up to 0.75ml. For cases prophylaxis the application is usually repeated every 6 months but more frequent applications (every 3 months) may be made. For hypersensitivity 2 or 3 applications should be made within a few days.

Contraindications: Hypersensitivity to colophony and/or any other constituents. Ulcerative gingivitis. Stomatitis. Bronchial asthma. Special warnings and special precautions for use: If the whole dentition is being treated the application should not be carried out on an empty stomach. Interactions with other medicines: If the whole dentition is being treated the application should not be carried out on an empty stomach. On the day of application other high fluoride preparations such as a fluoride gel should be avoided. Fluoride supplements should be suspended for several days after applying Duraphat. Interactions with other medicines: The presence of alcohol in the Duraphat formula should be considered.

Desensitisation of teeth duraphat can be achieved by simultaneous application of a desensitising agent. Undesirable effects: Oedematous swelling has been observed in subjects with tendency to allergic reactions. In rare cases, asthma attacks may occur in patients who have bronchial asthma.


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Text service could cut three million missed appointments

Research carried out by the British Dental Association discovered that at least three and a half million dental appointments are missed in England each year, and is a common problem across the whole of the health sector. But new research from overseas has shown that text message reminders could be a solution to improve attendance rates.

In a recent trial, dentists in India who sent their patients a text reminder found that four in every five people attended their appointment on time. Although text messaging is used by many dental practices in the UK, it is not widespread and with an estimated 91 per cent of adults in the UK owning or using a mobile phone it is the most ubiquitous form of communication.

While it remains to be seen whether the system would eradicate missed dental appointments in the UK, it is a solution that should be given further consideration, according to Chief Executive of the British Dental Health Foundation, Dr Nigel Carter. Dr Carter said: “At present individual practices are responsible for how they communicate with their patients. However, with such a large number of people not attending dental appointments, it’s obvious better communication is needed.

“A text message is a very simple, efficient and cost effective way of communicating in modern society. With so many mobile phones in use, it could be the answer to the problem.”

The cost of NHS dental treatment, allied with dental anxiety within the population, accounts for the reason three in every four people think twice about looking after their oral health. With basic NHS dental charges due to increase on 1 April 2012, Dr Carter believes now more than ever patients need to be informed about how important their oral health is.

Dr Carter said: “While patients may have genuine reasons for not attending dental check-ups, the Foundation has previously reported on other factors, particularly financial constraints, influencing dental treatment choices.

“The general public need greater access to information to educate them on how important their oral health is. It has been proven that looking after your oral health can reduce the risk of getting infections which in turn can spread to other parts of the body. For instance, heart disease, strokes, diabetes, pneumonia, pancreatic and colon cancer are all problems made worse or even caused by poor dental health, particularly gum disease.

“If people realised that dental care is not a luxury that should be overlooked, regular check-ups can identify early signs of gum disease. The cost of not doing so has health implications, not to mention more extensive cost implications.”

The research, carried out on 206 people attending outpatient clinics at the I.T.S Centre for Dental Studies and Research (ITS-CDSR), Muradnagar, Ghaziabad, Uttar Pradesh, India, found the rate of attendance on time was found to be significantly higher in the test group (79.2 per cent) than in the control group (55.5 per cent). (ITS-CDSR)

Study reveals causes of ‘meth mouth’

A study in Quintessence International (March 2012, Vol. 45, 5, pp. 229-257) has revealed how dental researchers are trying to reveal the factors that contribute to a condition known as ‘meth mouth’.

The disorder, which develops in the oral cavities of methamphetamine (MA) abusers, can lead to a series of problems, such as extensive tooth decay, caries and severe periodontal disease.

The study came about after it was identified that there had been few in depth studies on ‘meth mouth’ and the authors wished to characterise the oral health of subjects with a history of meth abuse as compared to non-abusing control subjects.

“A small number of studies published had been describing ‘meth mouth,’ but most were limited in their design or were conducted by non-dental personnel,” lead author Michele Ravencel, DMD, associate professor at the Medical University of South Carolina’s College of Dental Medicine, said to reporters.

Could collagen ‘matrix’ be the cure for receding gums

New research could help cover exposed roots that have been caused by receding gums

Research carried out by Dr Shahram Ghanaati and dentists Dr Markus Schlie, who together with a team of researchers from Germany and Switzerland, investigated how collagen could be used to form a support frame to help mend receding gums and exposed roots.

The study was led by Dr Shahram Ghanaati and dentist Dr Markus Schlie, who together with a team of researchers from Germany and Switzerland, investigated how collagen could be used to form a support frame to help mend receding gums and exposed roots.

To extract the collagen, reports stated that various processes, such as oxidative and alkaline treatments, were used to ensure that bacteria, viruses and other pathogens were removed and that the cell walls were broken down.

The study focused on 14 patients who had more than 60 cases of gum recession between them. The participants’ teeth were cleaned before collagen implants were placed in place on the infected teeth with loops of surgical thread. Two weeks later the sutures were removed and it was reported that none of the patients needed antibiotics. It is believed that the collagen acted as a ‘scaffold’ for the body to repair the damage caused by gum recession.

Speaking in a report after the participants had been re-examined six months later, Dr Schlie described the results: “In all cases the healed-over implant improved the look and severity of the recession, and, in over half of all treatments, resulted in total coverage of the exposed root. We would not have expected any of these patients to get better without surgery.”

The study was published in BioMed Central’s open access journal Head & Face Medicine.

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NI Executive funds cut to ‘hit dental services’

The British Dental Association has warned that dental services in Northern Ireland could deteriorate if plans to cut funds are carried out.

According to Claudette Christie, national director of the BDA in Northern Ireland, the proposed cuts would result in a six per cent reduction in dental service funding and with the vast majority of people dependent on National Health Service dentists, the proposal is causing concern.

“The cuts would reduce some of the treatments available to the patients, most notably how frequently you could have your teeth cleaned at the dentist,” Ms Christie said.

“That would go back to once a year from four times a year. That’s a very significant change... and it’s important that you do that to manage and maintain your oral health.”

New research could help cover exposed roots that have been caused by receding gums

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Switch on to new ideas

Speakers:

- Prof Nasser Barghi
- Dr Richard Kahan
- Prof Gianluca Gambarini
- Dr Wyman Chan
- Dr John Moore
- Dr Ajay Kakar
- Ms Jackie Coventry
- Dr Mona Kakar
- Basil Mizrahi
- Mhari Coxon
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EARLY BOOKING DISCOUNT
Rainforest remedy could spell end of dental pain

The Amazonian rainforest plant used in the remedy

A n ancient Incan toothache remedy – for centuries handed down among an indigenous people in the rainforests of Peru – could be on the cusp of revolutionising worldwide dental practice. The remedy, made from an Amazonian plant species from varieties of Acmella Oblancea and turned into a gel for medical use, has proved hugely successful during the first two phases of clinical trials and may hasten the end of current reliance on local anaesthetics in dental use and Non-Steroid Anti-Inflammatory Drugs (NSAIDs) in specific applications.

Cambridge University anthropologist Dr Françoise Barbiera Freedman, the first westerner to be invited to live with the Keshwa Lamas in Amazonian Peru, is leading efforts to bring this wholly natural painkiller to the global marketplace as an organic alternative to synthetic painkillers.

In doing so, the company she founded, Ampika Ltd (a spin-out from Cambridge Enterprise, the University’s commercialisation arm) will be run according to strict ethical guidelines, and will be able to channel a percentage of any future profits back to the Keshwa Lamas community who agreed to share their expertise with her.

With no known side-effects and dentists are leading efforts to help stop the use of smokeless tobacco by people of South Asian Origin. Dentists, dental nurses and dental hygienists may be asked to play a leading role as part of new proposals to stop the use of smokeless tobacco in the UK. The National Institute for Health and Clinical Excellence (NICE) has published a consultation on their proposals, which recommends a key intervention and education role for dental professionals.

NICE is also recommending more training for dental professionals to help them gain a greater understanding of smokeless tobacco including terminology, symptoms and approaches to successful intervention.

Smokeless tobacco is associated with a number of health problems including nicotine addiction, mouth and oral cancer, periodontal disease, heart attacks and strokes, problems in pregnancy and following childbirth and late diagnosis of dental problems as smokeless tobacco products can often mask pain.

Smokeless tobacco is mainly used by ‘people of South Asian origin’, which includes people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

The draft guidance recommends that dental professionals take specific actions including:
• Asking patients about their smokeless tobacco use and record the outcome in their patient notes
• Making users aware of the potential health risks and advise them to stop, using a brief intervention
• Referring users who want to quit the habit to tobacco cessation services that use counselors trained in behaviour support
• Recording, the person’s response to any attempts to encourage or help them to stop using smokeless tobacco in the patient notes

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “Smokeless tobacco – are approaching four times more likely to suffer from mouth cancer. Quite rightly dental professionals have been identified as major players to help reduce these risks and prevent the serious health conditions caused by smokeless tobacco.

“The British Dental Health Foundation supports NICE’s draft proposals and encourages all dental professionals to include the intervention of smokeless tobacco usage as part of their continuing professional development.”

NICE identifies key role for dentists to help smokeless tobacco cessation

The consultation is open to comments until 25 April 2012.

Killing Candida with mouthwash

S cientists have discovered that silver nanoparticles can kill yeasts which cause hard-to-treat mouth infections.

As a result of the discovery, Professor Mariana Henriques, University of Minho, and her colleagues hope to test silver nanoparticles in mouthwash and dentures as an aid to help prevent yeast infections.

According to a recent report, the team of researchers looked at the use of different sizes of silver nanoparticles to determine their anti-fungal properties against yeasts such as Candida albicans and Candida glabrata, which cause oral thrush and dental stomatitis, a painful infection which affects a reported 70 per cent of denture wearers.

Infections such as oral thrush and dental stomatitis are particularly difficult to treat because the microorganisms involved form biofilms. However, during the study the scientists discovered that by adding different sizes and concentrations of silver nanoparticles the different sizes of nanoparticles were effective at killing the yeasts.

Although the authors have stressed that more research is required at this early stage, the researchers hope that the study will enable the nanoparticles to be used in many different applications.

The research was published in the Society for Applied Microbiology’s journal Letters in Applied Microbiology.

Scientists have discovered that silver nanoparticles found in mouthwash can kill yeasts.
Dental records must be delivered in a timely manner to improve continuity of care for prisoners when they move from one secure setting to another, the British Dental Association (BDA) warns in a series of reports on oral healthcare in prisons and secure settings.

This would assist prison dentists in providing continuity of care to a population that has complex, high needs, and tends to access care only in emergencies. The high turnover of prisoners, particularly in short stay institutions, means that many courses of dental treatment go unfinished, the reports suggest.

The challenge of delivering effective dental services to prisoners is often compounded by a history of substance abuse with many prisoners only recognising a need for dental care when they are undergoing detox from drug and alcohol addictions. It is also well recognised that the prison population has a higher incidence of mental health conditions than the general population.

The reports highlight that national IT systems were installed in England and Wales last year to improve the transfer of prisoners’ medical records but not dental records, a missed opportunity to enhance the delivery of dental services. They also draw attention to gaps in training for prison dentists in the handling of personal threats to security, and the specific clinical challenges of treating prison populations.

The BDA began collecting evidence from prison dentists about the challenges of working in the prison environment in 2010, culminating in the current reports. This included a survey of prison dentists which revealed that 64 per cent of respondents said they wanted more training, particularly around issues connected to security and treating patients with substance abuse.

Reflecting on her 11 years’ experience of delivering dental care for prisoners, the Deputy Chair of the BDA’s Executive Board, Judith Husband, said: “Providing good quality continuing care in prisons is obviously challenging, but too often the provision of such care is hampered by the failure to transfer dental records with the patients when they move between establishments.

“This increases the workload for dentists, and the cost to the NHS of commencing a new treatment plan each time the patient is relocated.

“The delivery of medical care has undoubtedly been improved by the electronic transfer of records; surely this system can be emulated in dental services?”

“It’s also essential that dentists new to the prison environment receive mandatory training in diffusing threats to general and personal security, as well as clinical training appropriate to the needs of prisoners.”

Precious Cells International (PCi) has now opened subsidiary offices in the UK and will be expanding into many different types of tissue. Deciduous teeth, healthy wisdom teeth and permanent teeth extracted for orthodontic purposes all contain stem cells that have the ability to develop into many different types of tissue (skin, nerve, muscle, fat, cartilage and tendon) and can potentially help to replace diseased and damaged tissues in the body without rejection.

Precious Cells International welcomes visitors to their central stem cell processing and storage facility at Brunel Science Park. This would assist prison dentists in providing continuity of care to a population that has complex, high needs, and tends to access care only in emergencies. The high turnover of prisoners, particularly in short stay institutions, means that many courses of dental treatment go unfinished, the reports suggest.

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Precious Cells International welcomes visitors to their central stem cell processing and storage facility at Brunel Science Park. This would assist prison dentists in providing continuity of care to a population that has complex, high needs, and tends to access care only in emergencies. The high turnover of prisoners, particularly in short stay institutions, means that many courses of dental treatment go unfinished, the reports suggest.

The challenge of delivering effective dental services to prisoners is often compounded by a history of substance abuse with many prisoners only recognising a need for dental care when they are undergoing detox from drug and alcohol addictions. It is also well recognised that the prison population has a higher incidence of mental health conditions than the general population.

The reports highlight that national IT systems were installed in England and Wales last year to improve the transfer of prisoners’ medical records but not dental records, a missed opportunity to enhance the delivery of dental services. They also draw attention to gaps in training for prison dentists in the handling of personal threats to security, and the specific clinical challenges of treating prison populations.

The BDA began collecting evidence from prison dentists about the challenges of working in the prison environment in 2010, culminating in the current reports. This included a survey of prison dentists which revealed that 64 per cent of respondents said they wanted more training, particularly around issues connected to security and treating patients with substance abuse.

Reflecting on her 11 years’ experience of delivering dental care for prisoners, the Deputy Chair of the BDA’s Executive Board, Judith Husband, said: “Providing good quality continuing care in prisons is obviously challenging, but too often the provision of such care is hampered by the failure to transfer dental records with the patients when they move between establishments.

“This increases the workload for dentists, and the cost to the NHS of commencing a new treatment plan each time the patient is relocated.

“The delivery of medical care has undoubtedly been improved by the electronic transfer of records; surely this system can be emulated in dental services?”

“It’s also essential that dentists new to the prison environment receive mandatory training in diffusing threats to general and personal security, as well as clinical training appropriate to the needs of prisoners.”
Neel Kothari interviews Dr Susie Sanderson OBE

In the first part of this four-part series, Neel Kothari talks to Chair of the BDA Exec Board Susie Sanderson about the future of NHS dentistry

NK: What does the BDA hope to see from the current new NHS contract pilots?

SS: I think we have a unique opportunity to influence re-form this time around. The 2006 contract is disastrous in two main areas – disastrous for dentists and disastrous for patients. It’s also been disastrous for the government. As a result of our lobbying, the Health Select Committee carried out an enquiry into the 2006 contract and found very little that was acceptable about it. That resulted in the review, so we then had a recipe if you like, a template, for looking forwards. The key thing at that point, having done all that work making compelling stories, making sure that everyone knew that the contract was disastrous, was to make it survive through the change in government – and through significant efforts we managed to achieve that.

The pilots are a pretty unique opportunity to test what should happen in the new contract. They’re not a testing a prototype contract, but they’re testing parts of it, looking at things like remu-neration models, oral health assessments and care pathways. What we want to see is something which satisfies the three stakeholders.

Patients come first
Patients always come first. The patients want a contract which provides them with care when they want it and need it that’s affordable, good value for money and a quality that they can rely on. They want to improve their oral health and actually, those who think about it deeply enough will also want the public health to improve. They’ll want their children’s health to have improved and they’ll want a situation where that will continue.

The dentists want all of that, but they also want to be able to do it in an environment where they can sustain their businesses and where they can have a decent work-life balance and they’re not run ragged, running round in circles being anxious about how they’re going to pay their next set of bills. So they want to be able to have a system where they can deliver everything that’s needed to improve oral health, and that includes prevention, restorative interventions and taking in all the new technologies that come along; the NHS shouldn’t be an area where you can’t do things because it’s the NHS. The NHS should be able to sustain financially and from a support point of view any innovation that comes along as well. So the dentists want all that, but primarily dentists want to be able to carry on doing that, so they want the financial challenge to fade away and they want to be able to do it in an environment which is sustainable.

And then the government want to be able to afford it; they want access, they want to be able to say that anybody who wants dental treatment can get it. That’s not the same as saying everybody in the whole country can get comprehensive care; it’s that those that want it can access it when they need it. But they also want to be able to control it. So they want to be able to continue with the 2006 notion - a capped, funded service. That was the fundamental change which made it so difficult. There’s no way that’s going to go away again. The government want to continue to control what they spend on dentistry.

The important thing is for everybody to hold their nerve as we go through the testing process. The practices that are involved are NHS practices are used to running themselves ragged and being constrained in what they can do and the time that they can do it in. Now, holding their nerve and actually working through these contracts in a way that they will want to do in the new contract, with enough time, enough resources, being able to sustain it, doing the right things for the patients, imple-menting prevention, improving oral health; all of those things they’ve got to do in these tests. Whether or not it’s not what normally happens, they’ve got to hold their nerve and do that.

No going back
The Department of Health have got to hold their nerve, because intuitively you and I as dentists will think at some point they’re going to realise that they can’t afford this.

The Department of Health have got to hold their nerve, because intuitively you and I as dentists will think at some point they’re going to realise that they can’t afford this

NK: When the new contract is eventually rolled out, what criteria do you think are needed to judge whether it is successful?

SS: It’s again to do with the needs and the aspirations of the three stakeholders. Are we improving oral health? Does everybody who wants it, needs it, have access to it, within the structures that it is, within whatever the NHS of-fer turns out to be? Are den-tists able to make a living, sustain their practices, invest, educate, keep patients safe, still have some interest in what they’re doing on a day-to-day basis, still be inspired to go to work? Are they able to build their teams so that everybody grows in self-worth, self-esteem and their part in delivering the care? The most important thing is that it has to be sustain-able. It has to be affordable for a practice to be able to do this. You can’t expect a practice for example that’s been in a two-up two-down since 1948 not to be needing to put some investment into their building, or relocate, or do something, to get to the point where they can improve the situation they’re working in.

NK: So is there government funding for this?

SS: Not at the moment. But there has to be within those contracts enough for dentists to say, ‘I can provide that care and I can set something aside to plan for investment. In fact, I can make sure I’ve trained my staff, I can fulfil sensible, propor-tionate regulatory requirements’ – it all has to be cov-ered and you’ve got to make a living. You have to have some headroom for investment. My personal view is that that headroom, that flexibility for every practice to invest if they need to, is not there at the moment.

NK: Is it fair for any profes-
sional to enter into a situation where they're being paid a certain sum of money without having an idea of how much work they potentially need to do? Does that not introduce a perverse incentive? Is that fair for the patient?

SS: Of course it does. No, it isn’t. And that’s absolutely the fundamental flaw in the contract. Whoever you are, whether you’re an associate or a practice owner, that’s absolutely the basis of the flaw, and it’s what the Health Select Committee, when they finally understood how it worked, agreed as well. This is why we’ve got to carry on the testing for long enough so that the valuation is real and credible and gives some meaning to proper funding and proper structure in the future.

Sustainability
The difference in the treatment volumes between patients in the very high deprived areas and other areas is just phenomenal and as an associate I would want to know what it looked like before I went there. I mean we’re all up for doing some high needs, because it’s actually very rewarding turning people around. But you can’t do it on every patient every day for the average UDA value. It’s just not sustainable.

NK: UDA values are kept confidential between practice owners and the PCTs and often not passed on to associates in full. Why is this information, which really is the only true measure, although not an accurate one, of patient need being kept secret?

SS: Because it’s a business contract. Any business contract would need to be kept confidential. It is the head contract, which is completely different to the sub contract. As a practice owner your contract is with the PCT and that’s confidential. But if you were going into a practice as an associate where your contract is with the practice owner, not the PCT, you would want to know the sort of spread of work that you were going to be expected to do for £9 a UDA, or whatever it is you’re going to be paid – that’s good business sense in any sort of case. If you wanted me to paint all the garage doors down Wimpole Street Mews, I’d want to know what you are going to pay me per garage door. If I got £9 per garage door in the last job, and you offered me the same, I’d say that’s fine. But it might turn out they’re three storeys high and 60 foot wide! It’s the same in dentistry – we need to be very careful to check what it is we’re taking on.

In the next article, Susie Sanderson answers questions on dental regulation.
Build a layer of protection with Sensodyne

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The rise of the “smile makeover”

Rupert Hoppenbrouwers asks to what extent should cosmetic treatments be offered in dental practices

The term “smile makeover”, now used to describe a range of cosmetic treatments, some dental and some non-dental, has gathered a lot of press interest and, as a result, created increasing demand for these types of treatment.

Tooth whitening hit the headlines recently when the GDC brought a successful prosecution against a non-registered for carrying out tooth whitening. With this renewed attention, the perceived “quick fix” cosmetic treatment is back in the spotlight. The DDU sometimes receives calls from its members raising concerns about the number of beauty salons now offering tooth whitening, usually carried out by beauty therapists, so prompting some dental professionals to ask whether the law or the GDC’s stance has changed.

Practice of dentistry
Not at all. The GDC states that:

“The practice of dentistry is limited to GDC registrants. It is the Council’s view that applying materials and carrying out procedures designed to improve the aesthetic appearance of teeth amounts to the practice of dentistry. So too does the giving of clinical advice about such procedures. Therefore all tooth whitening procedures, including bleaching and laser treatment are seen as the practice of dentistry by the General Dental Council.”

The GDC requires that tooth whitening treatments should only be carried out by registered dental practitioners acting within the GDC’s Scope of Practice. The GDC has recently published guidance for the principle of cosmetic advertising which sets out the regulatory requirements for dental professionals advertising their services. The guidance states that:

“If you wish to offer services which your training as a dental professional does not qualify you to provide, make sure you undertake appropriate additional training to attain the necessary competence. Do not mislead patients into believing that you are trained and competent to provide other services purely by virtue of your primary qualification as a healthcare professional, but make clear that you have undertaken extra training to achieve competence.”

Dental professionals need to ensure that all work they undertake is within their Scope of Practice. This sets out the core activities of each group of registrant, the additional skills each group might develop during their careers, and the types of work that groups other than dentists do not undertake. Most relevant in this context is the point that registered dentists are the only members of the dental team who can diagnose and can draw up a treatment plan (save for clinical dental technicians treating edentulous patients for the provision of complete dentures). They are also alone in the dental team in having general prescribing rights (botulinum toxin is a prescription-only medicine in the UK). It is also important to bear in mind that the GDC expects any dental professional undertaking any type of treatment to be not only appropriately trained, but to have adequate and appropriate indemnity for that work.

Pros and Cons
The undertaking of cosmetic procedures should be approached in the same way as any other type of dental treatment. Care should be taken to ensure that patients properly understand the options, the pros and cons of those options, including the material risks, and give valid informed consent. Dental professionals should ensure that they are appropriately trained, their scope of practice permits them to carry out the treatment proposed and that they have the necessary indemnity. Ultimately, any work carried out should be line with the ethical obligation of all dental professionals to put patient’s interests first, which means they should refuse to provide any treatment which goes against their clinical judgment and which they consider will not be in the patient’s best interest.

About the author
Rupert Hoppenbrouwers is head of the DDU. He is a former general dental practitioner and was Director of the School of Dental Hygiene at University College Hospital, London from 1980 to 1986. He has lectured and written widely on risk management and dento-legal matter and has a particular interest in clinical negligence and dental care professionals. He is currently Chairman of the UK Dental Law and Ethics Forum.

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The administration of botulinum toxin and dermal fillers in dental practices is an area that continues to raise ethical and legal concerns. The administration of botulinum toxin and dermal fillers in dental practices is an area that continues to raise ethical and legal concerns.
School split
Doctors have called for a rethink of plans to split the Plymouth-based Peninsula College of Medicine and Dentistry (PCMD) after concerns emerged that the split would cause disruption to research. The proposed plans would mean a medical and dental school at Plymouth and a new medical school at Exeter; however, according to BBC report a letter from the Devon Local Medical Committee (DLMC) has called the move by PCMD founders University of Exeter and Plymouth University a “disaster”. The DLMC, which represents Devon GPs, said in a letter to Plymouth University Vice Chancellor Wendy Purcell that the announcement in January was a “momentous shock to all students and staff involved with the medical school across the peninsula”. A spokesperson representing both universities said: “We remain convinced that this is in the best interests of students and patients in the South West.”

UCL research poster comp
Congratulations to PhD student Prasad Sawadkar and research associate Dr Kris Gellynck on each winning a prize at first year’s UCL Graduate School Research Poster Competition. The two Institute scientists were awarded in the category of Medical Sciences & Population Health Sciences. Prasad Sawadkar, working under the supervision of Dr Vivek Muderia from UCL Institute of Orthopaedics (Division of Surgery and Interventional Sciences) and Dr Laurent Bozec from UCL Eastman Dental Institute, was awarded Second Prize. Their work aims to surgically optimise the graft insertion technique in tendon to take the load off the repair construct. To date, this work has focussed on testing of a modified suture technique to accommodate a tissue engineered tendon in vivo. Prasad Sawadkar is a first year PhD student registered at UCL jointly between Institute of Orthopaedics (Division of Surgery and Interventional Sciences) and Eastman Dental Institute. Dr Kris Gellynck, working together with Dr Rishma Shah and Professor Nigel Hunt at the Institute, was awarded a runner-up prize. Their work focuses on the engineering of a contiguous muscle, tendon, bone structure for implantation in areas of deficit within the craniofacial region. The work is funded by a Fellowship awarded to Dr Shah by the Royal College of Surgeons, England.

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The importance of training
Alison Doherty discusses the high profile subject

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Barry Musikant discusses critical thinking

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After years of teaching endodontic programmes around the country, I can say with strong conviction that the process of critical thinking has not been applied to the mechanics of endodontics. Not for one moment am I critical of a programme’s emphasis on diagnosis, histology and pathology. The incorporation of microscopes has vastly improved dentists’ abilities to seek out fine structure that can be the difference between success and failure.

Where critical thinking is missing is in the selection of the design and utilisation of the instruments used to shape the canals. For the most part, K-files are the instruments recommended for the initial shaping of canals. I have never detected any evidence that the decision to use K-files resulted from an analysis of what works best. It is simply a tool that has been handed down from generation to generation either to perform the entire shaping procedure...
or to create a glide path for the subsequent use of rotary NiTi files.

If K-files had been chosen as the most appropriate instrument to use after critical analysis, we would expect these instruments at least initially to shape canals more easily than other instruments. We would expect that such problems as loss of length because of the apical impaction of debris, distortion to the outside wall, elbowing and frank perforation would be less inclined to occur because of superior design and method of usage. Yet K-files are associated with all the above problems, whereas their counterpart, K-reamers, is far less likely to produce such issues. In fact, critical thinking was not applied to the choice of instruments. Tradition, inertia and simple prejudice take the place of effective analysis.

Let’s examine how critical analysis would prevent this widespread mistake that is perpetrated on our student bodies over the years. Take a look at a photograph of a K-file (Fig. 1). Please note that the shank is composed of 30 flutes along its 16mm of working length. The greater the number of flutes, the more horizontally oriented they are. Compare the 30 flutes on a K-file to the 16 that are present on the shank of a reamer (Fig. 2). Also, please note that with approximately half the flute number, each flute is significantly more vertically oriented along the length of the reamer shank. Fewer flutes lead to less engagement along length. Resistance in apical negotiation is directly related to the reduction in engagement.

A watch-winding motion is the recommended way to use both the reamers and the K-files. Yet, when a watch-winding motion is applied to the more horizontally oriented flutes of a K-file, the threads tend to embed themselves into the canal walls without shaving any of the dentine away in the process. Increasing the amount of engage-

‘In fact, critical thinking was not applied to the choice of instruments. Tradition, inertia and simple prejudice take the place of effective analysis’
ing the canal. Compare the action of these flutes with the more vertical orientation of the flutes on the reamer. Using the same watch-winding stroke applied to the K-files, the blades being more at right angles to the plane of motion will immediately start shaving dentine from the walls of the canal, further reducing the degree of engagement and the subsequent resistance encountered as the reamers negotiate apically.

Clinically, the dentist encounters less resistance when using reamers because there is less engagement along length, resulting from fewer flutes to begin with and their greater ability to shave dentine rather than embed into it. Embedment leads to increased resistance. Shaving dentine further reduces the smaller amount of engagement that was already present. The design and utilisation of the K-file works against the very goals it wants to attain. Reamers are designed and utilised in a way that is compatible with their goals. Critical thinking would make these basic points obvious. Controlled clinical testing of both designs would immediately demonstrate the superiority of reamers to K-files.

The comparison could easily stop at this point, and reamers would be the unquestioned winner, but there are other advantages that accrue to the user as well. With less engagement along length, a cutting blade more or less at right angles to the plane of motion that removes dentine rather than embeds into it, a more flexible instrument that is a consequence of fewer twists along the length of the shank, the reamer gives the dentists a superior tactile perception, giving him the ability to differentiate between the tip of the instrument hitting a solid wall or engaging within a tight canal. Both situations will ei-

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**Fig. 4 The Endo-Express reciprocating handpiece (Essential Dental Systems)**

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**Figs. 5-7 Radiographs showing clinical results achieved with relieved reamers in a reciprocating handpiece**

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ther stop or slow down apical progress.

However, if the tip of the instrument is hitting a wall, there will be no tug-back when the reamer is withdrawn, telling the dentist that he must not attempt to proceed further.

Rather, he must remove the reamer from the canal, place a 45° bend at the tip and, with a light peck-and-twist motion, attempt to manually negotiate around the obstacle. On the other hand, if tug-back is present from the outset, the dentist knows to continue apical negotiation using either the recommended watchwinding motion or a twist-and-pull motion until the apex is reached.

A K-file that is already so heavily engaged along length cannot make the distinction between a solid wall and a tight canal. The resistance along length obscures what the tip of the instrument is encountering. Using a K-file, all a dentist may know is that he is short of length. Using an aggressive twist-and-pull motion, the proper length can be regained even when employing a K-file with a non-cutting tip. However, too often the dentist will discover that the original anatomy has been lost with the apical third transported to the outside wall of a curved canal. This is the effect when a solid wall or impacted debris is encountered, but not recognised as such because of the excessive engagement of the K-file along length.

The absence of critical thinking is recapitulated by maintaining the continued use of K-files. First, we abdicate the use of reamers without making any comparisons. Worse, while not learning the benefits of reamers, we also lose our evolutionary potential to improve upon a tool that in its present state is superior to K-files.

Critical thinking demonstrates that reamers are superior to K-files for several reasons, one of the main reasons being reduced engagement along length. By placing a flat along the entire working length of the reamer, we now have a reamer that has even less engagement along its working length. The result is an instrument that is even more flexible because it is thinner in cross-section, includes two vertical columns of chisels that cut equally effectively in both the clockwise and counter-clockwise direction and is asymmetrical in crosssection, giving it the ability to differentiate between a round and oval canal.

No symmetric instrument can differentiate between a round and oval canal. The ability to make this distinction tells the dentist when to widen the canals to greater dimensions for superior mechanical cleansing and better chemical debridement via the irrigants (Fig. 5). Without critical thinking, no one knows that a reamer is

**Critically thinking demonstrates that reamers are superior to K-files for several reasons, one of the main reasons being reduced engagement along length**

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superior to a K-file and without that knowledge, no one knows that a reamer can be modified to further improve its functionality. Perhaps, most importantly, without the benefit of critical thinking, those designing instruments to eliminate the shortcomings of K-files do not eliminate them. They merely reduce them, still incorporating their use in the creation of the glide path, and then proceed to introduce rotary NiTi systems that, while overcoming the limitations of K-files, introduce significant new problems that add cost, anxiety and unpredictability to canal shaping.

In the meantime, critical thinking would clearly demonstrate that relieved reamers (Fig. 3) are not only good for glide path creation but work far more safely when used for the entire shaping procedure. Stainless steel relieved reamers are quite effective at recording the curvatures of a canal. Unlike NiTi, they do not snap back to the straight position, a property that increasingly distorts the apical end of curved canals as the tip-size and taper of the instruments increase.

The greater stiffness of stainless steel is compensated for by the relieved reamer design, never exceeding a .02 taper and routinely straightening the coronal curve prior to the use of larger-tipped instruments. Used either in a tight watch-winding stroke or in a 30° reciprocating handpiece (Fig. 4), the tip of the instrument confined to such a short arc of motion always stays centred in the canal. As long as patency is maintained, these relieved reamers will not deviate from the original pathway. Patency is maintained by going 0.5mm beyond the constriction through a 25 relieved reamer, a technique that is easy to master and is completely predictable in its results.

Unless one is exposed to this technology, they may not realize the benefits of relieved reamers. Stainless steel relieved reamers are not only good for glide path creation but work far more safely when used for the entire shaping procedure. Stainless steel relieved reamers are quite effective at recording the curvatures of a canal.
to the critical thinking needed to open one’s mind to better working alternatives, the entire cascade of learning is stopped before it starts.

Without critical thinking, one will never learn that reamers are safer, more efficient and more effective than K-files. Without learning the superiority of reamers, one will never learn that relieved reamers are superior to non-relieved reamers. If one does not use reamers, one will not be exposed to the advantages of non-distorted shaping using a 50° reciprocating handpiece. Without the exposure to a 50° reciprocating handpiece, one will never appreciate the absence of torsional stress and cyclic fatigue that plagues rotary NiTi, leading to unpredictable separation. And, without the appreciation that instruments will simply not break, one will not confidently shape canals to the larger dimensions that are often required to ensure proper debridement and irrigation.

Examples of cases done with relieved reamers in a reciprocating handpiece are shown in Figures 5–7.

We have been indoctrinating our students for too long. It is about time that we educate them. Critical thinking is the way for students to make rational decisions. They will become better dentists and serve the needs of their patients better when these skills are honed. There may be those out there who dispute the conclusions that critical thinking will produce, but I defy anyone who says this is not the proper way to educate.

‘We have been indoctrinating our students for too long. It is about time that we educate them. Critical thinking is the way for students to make rational decisions’

K-files. Without learning the superiority of reamers, one will never learn that relieved reamers are superior to non-relieved reamers. If one does not use reamers, one will not be exposed to the advantages of non-distorted shaping using a 50° reciprocating handpiece. Without the exposure to a 50° reciprocating handpiece, one will never appreciate the absence of torsional stress and cyclic fatigue that plagues rotary NiTi, leading to unpredictable separation. And, without the appreciation that instruments will simply not break, one will not confidently shape canals to the larger dimensions that are often required to ensure proper debridement and irrigation.

First published in Roots (international version) Issue 4 2011
The importance of training for the dental team

Never before has training the dental team been such a topical and high profile subject

Over the last 10 years dentistry has witnessed a substantial change as the GDC legislated the need for compulsory CPD training for all the clinical dental team.

The most recent emphasis on the importance of training has been brought about by the CQC’s emergence into the dental profession.

According to practices that have always invested in staff training, with some of them having gone on to obtain the Investors in People (IIP) or BDA Good Practice standards, regular training of the entire dental team is invaluable to the practice in many ways:

1. Boosting of staff morale, knowledge and skills as staff will feel respected and valued
2. Longevity of staff employment as the team will be happy and confident with enhanced knowledge and skills
3. Greater patient satisfaction and fewer complaints will be evident as familiarity with all the team will in turn improve the reputation of a practice
4. Practice run in a more cost and time efficient manner when each team member understands their responsibilities and can carry out their duties efficiently
5. A more profitable and successful practice as patients will want to return and refer other people to a safe and positive experience of dentistry

Who do we mean by the dental team? The dental team is often thought to consist of the dentist, hygienist/therapist and dental nurse as these are the GDC registered professionals who need to complete CPD to uphold their registration. However, in order for a practice to work successfully the dental team also includes the dental receptionist, practice manager, administration staff, decontamination room assistants and even the cleaner!

A variety of CPD courses are available to the entire dental team through many different mediums. These range from the core subjects of Cross Infection and Decontamination, Radiography and CPR Medical Emergencies to topics such as Communication or Conflict Management.

Dentists and hygienists/therapists have always had to be professionally qualified in order to start their careers. There are a variety of different postgraduate specialist training qualifications that they can obtain. After completing their primary qualifications there are a number of post registration qualifications available.

The dental office team, namely the dental receptionists, administration managers and practice managers are usually the most overlooked members of the dental team as there are no formal dental qualifications available to them and they are not on the GDC register. There are government funded work-based management, customer service and business administration NVQs that fit with the job roles of these team members.

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Training is, therefore, a very important enhancement for all members of the dental team. We all strive for patient satisfaction as this leads to personal job satisfaction for each member of the team.

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Relishing the learning experience

Glenys Bridges discusses how to get maximum return for your continuous professional development investment

PD is now a fact of life for dental professionals. However, across the profession attitudes toward this obligation vary widely. In some cases it is viewed as another hurdle to be endured, whereas in other cases practice teams are reaping real benefits from their coordinated approach for the on-going development of their knowledge and skills. In this article I will share with you five tips for maximising the return from your teams CPD input.

Tip 1 - Within any given team there will be a spectrum of attitudes toward development and learning. At the extremes of that spectrum, people relish the learning experience and welcome each chance to up their skills and excel. At the other end of the same spectrum people do not feel the need to dedicate time and effort into developing their working practices, preferring to sleep walk through their career doing an OK job.

Managers need to take great care to address the needs of their people throughout the spectrum. To do this they need to ensure all learning experiences provided are stimulating and pragmatic. Even the most enthusiastic learners will lose interest if they cannot see any practical benefits from their learning. Whether the desired result is to get people going, or keep them on board, make sure learners recognise tangible personal and professional benefits from their learning.

Tip 2 - Many educational theories demonstrate the importance of cascading learning from one learner to another. For example, educational psychologist William Glasser advocates that we learn: 10 per cent from what we read, 20 per cent from what we hear, 30 per cent from what we see, 50 per cent from what we do and 70 per cent from what we discuss. 80 per cent from what we experience; 95 per cent from what we teach someone else. This being the case, sharing knowledge and skills gained from a CPD experience will benefit all parties.

In order to reach this stage practice goals should be shared with the team through appraisals and team meetings. Many practices demonstrate the importance of reflective practice when setting the team’s CPD activities. When the team are committed to reaching (and clearly understand) their part in securing those goals, all their CPD will be welcomed.

Tip 3 - For CPD to be meaningful it must contribute to the on-going process of securing the goals set out in the practice’s business plan. This plan should be the basis for decision making when selecting CPD activities. When the team are committed to reaching (and clearly understand) their part in securing those goals, all their CPD will be welcomed.

Although your team’s CPD is prescribed in GDC regulations, it is important to recognise that the GDC requirements are minimum standards. It is also important to use CPD as a tool for business development by ensuring each person uses their learning to contribute to a process of continuous improvements in the quality and safety of dental care provided at your practice.

Tip 4 - ‘Blended learning’ is a buzz word in the lifelong learning sector. This approach to learning takes into account the fact that each person has preferred ways of learning. Some are happy to immerse themselves into a book and will learn from reading, whereas others gain most from practical, applied learning experiences. There are many diagnostic tests available on the internet to analyse the preferred learning style of each team member and if you establish the learning preferences of each team member early on you can provide each person with stimulating learning opportunities.

Tip 5 - Development as a result of learning is a process that takes place over time. Many educationalist advocates that reflective practice is essential for ensuring that the cognitive processes that progress learning into measurable development require an input of reflective practice. Following each learning experience team members should be required to keep a learning log. This can be shared with colleagues and more importantly reviewed periodically to refresh learning.

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About the author

Glenys Bridges is an independent dental team trainer. She can be contacted at glenys.bridges@gmail.com.
Changes to the Lifetime Allowance and your pension

Brendan Coburn looks at financial planning for retirement

From the 6th April 2012, the total amount of pension savings you can build up over your career in a tax efficient manner is being reduced due to a reduction in the Lifetime Allowance.

The Lifetime Allowance (LA) is a limit on the total value of your pension savings that you can accrue over your career until retirement before a tax charge is levied.

Currently, the level of the LA stands at £1.8m but this is being reduced to £1.5m from the 6th April 2012.

As well as the value of your NHS pension, the value any private pensions you hold form part of your LA at retirement.

If you exceed your LA then any excess over the limit is subject to a tax charge of 25 per cent if taken as a pension (and the pension is then taxed as income) and 55 per cent if taken as a lump sum.

In real terms, this means a dentist at retirement could find themselves with a smaller pension and lump sum than they had expected.

Even though the new limit of £1.5m may seem quite high, this change will affect dentists who have accrued significant NHS benefits already during their career and/or who have made large contributions into a private pension, particularly if they are looking to retire and take their pensions in the next couple of years.

There is a window of opportunity for those affected to protect the higher level of LA by applying for Fixed Protection (FP).

Available until 6th April 2012, FP would preserve a dentist’s personal LA of £1.8m.

However, this solution is not a universal panacea since there are restrictions on the provision of FP. Most notably, any dentist with FP cannot accrue any further pension benefits from the 6th April 2012.

This effectively means that FP could be unsuitable for younger active NHS Pension Scheme members or those wishing to continue to contribute to private pensions. It is likely then, that FP will only be a consideration for those dentists who are about to leave the NHS Pension scheme and have not taken their benefits or who have already left the NHS Pension Scheme but who have not yet taken their benefits from a private pension scheme.

This is a highly complex area and any dentists who feel they may be affected by this change should seek professional advice from a financial consultant, ideally a dental specialist, who is well versed in the workings of the NHS Pension Scheme before making a decision that could have an impact on their retirement.

About the author

Brendan Coburn Dip PF I am a financial planner at Essential Money, one of the leading firms of specialist IFA’s for dentists and one of the few ASPD – Recognised Financial Planners.

I have worked in financial services for my entire career starting with Natwest. Following this I established my own brokerage in 2000 which I nurtured until its eventual sale. I then joined Royal Bank of Scotland to provide Independent Financial Advice to their commercial clients until the opportunity arose to join Essential Money.
The Q and A’s of recruiting

Lis Hughes provides some useful advice

Employment law has changed a lot over the years and there is now so much more to consider.

A t Frank Taylor and Associates we see a huge number of dental practices every month. As well as valuing and selling these practices, we also provide a full range of business services. This will very often lead to involved discussions about a wide range of aspects of dental practice management and associated issues. One item that comes up again and again is that of recruitment. ‘How do we get the right staff?’, ‘How do we keep the right staff?’, ‘Where should we look?’

This was becoming such a regular request that we decided to do something about it. We have formed a partnership with recruitment experts, MedicsPro. As the leading valuer and sales agents of dental practices in the UK, we are well aware of the importance of the right team members, and how this can make a massive difference to the success or failure of a dental business.

MedicsPro is a company founded on an adherence to best practice; hence why they are members of the Recruitment and Employment Confederation. This ensures that dental professionals can be confident of work ing with a respected and fully compliant dental staffing agency.

Our colleagues at Medics Pro have provided some top tips if you have, or will have a need for the right staff in the near future:

1. If you pay peanuts, you will get monkeys. It never fails to amaze me that some principals will complain about lack of staff loyalty and team members not ‘buying into’ the practice vision, only to find out that their staff would be better off working on the checkouts at Tesco’s! The right people don’t come cheap.

2. Remember that nursing and reception staff are as important to the practice as dentists and hygienists. They are very often the ‘face of the practice’ and need careful consideration – an excellent nurse may not be great on the front desk for instance.

3. Is it a permanent position? If it is for a locum or temporary position, it may be much easier to get someone else to take care of it for you.

4. Consider the costs of getting it wrong. As well as having to start the whole process again, there could be costs to your practice’s reputation and patients do not relish the idea of seeing someone different every time.

5. Do not be afraid to go to multiple interviews. If you are still not sure then don’t feel you have to make a decision. Take a step back and ask yourself why you are unsure?

6. Are you an expert in recruitment? Think very carefully about managing the process yourself. It is no longer just a case of putting an ad in the BDJ, seeing the responses flood in, and employing the candidate you struck up a rapport with in a brief meeting. Employment law has changed a lot over the years and there is now so much more to consider. Also, if you aren’t doing dentistry, you aren’t earning money.

7. When you are choosing an agency, ensure that their fees, whatever they may be, are open and transparent.

8. Once you have decided upon an agency to work with, before anything else is done, you should discuss openly and honestly what you are looking for in a candidate. This will save everybody’s time and effort!

9. Any agency should perform a rigorous candidate search along agreed themes and present you with the cream of the crop.

10. Consider the options of short-term contracts and ensure that where relevant, a probationary period is added.

‘Consider the costs of getting it wrong. As well as having to start the whole process again, there could be costs to your practice’s reputation and patients do not relish the idea of seeing someone different every time’

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Frankly Speaking

About the author

Lis Hughes is a Director of Frank Taylor and Associates and works specifically with clients as the transaction proceeds through the sale and purchase process. She is a recognised authority on what it is happening in the dental sector particularly in relation to CQC and compliance. Tel 08456 125158 Email: lis.hughes@ft-associates.com Frank Taylor and Associates

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Meet us at Dentistry Show in March 2-3, Birmingham UK, NEC Booth M3
Are you prepared for a medical emergency?

Sharon Holmes discusses some of the best ways to get your practice learning new tricks

Sometimes last year my principal dentist, Dr Malhan showed me an article about a dentist, who unfortunately suffered a fatality at his practice due to a patient having had an allergic reaction to a mouth rinse that contained chlorhexidine. The fortunate thing for this dentist was that he and his dental team dealt with the emergency in the correct manner even though it had a tragic ending. Even the paramedics who arrived within five minutes could not help the patient. The paramedics had nothing but praise for the dentist and his team.

We, like everyone else, have annual CPR training, but when you come to think of it how often do you actually deal with a real life threatening situation in a dental surgery? I have been in dentistry for 20 years and, fortunately, have only ever experienced patients who have fainted. This really drove home the message that you can never be overly prepared when it comes to dealing with medical emergencies. Having come from a medical background, it got me motivated in wanting to make sure that all our teams across the group would be readily prepared in dealing with an emergency.

So I set about creating a medical training program that stretches out across the year.

The plan that I created is simple and educational. Using the Resuscitation Council (UK) Standard for Clinical Practice and Training, I made sure that I had all the medical emergency scenarios covered.

The common medical emergencies that could happen in a dental practice are:
1. Asthma
2. Anaphylaxis
3. Cardiac emergencies
4. Myocardial infarction
5. Epileptic seizures
6. Hypoglycaemia
7. Syncope (fainting)
8. Chocking and aspiration
9. Adrenal insufficiency

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†Depending on geographic location. Prices quoted are for a limited time only and are subject to change.
a theory sheet showing a flow chart of how to deal with each emergency. The theory sheets are used for learning the signs and symptoms of the particular emergency.

I decided to include the training sessions in our monthly staff meetings, which are booked for a minimum of two hours. During the staff meeting half an hour is dedicated to learning about common medical emergencies and we discuss the chosen subject in depth and share incidents that we may have experienced over the years.

We then go through the emergency drug kit where we discuss each drug and what it is used for. To make the drugs easier to recognise during a stressful situation I have instructed my practice manager to have each drug clearly labelled (red ink on a white label) and a brief description of what it is used for. For example: Glyceryl Trinitrate spray (GTN) would be marked as CHEST PAIN – ANGINA ATTACK.

We then go through the procedure of the O2 Cylinder and make sure that we all know how to open the O2 cylinder and to close it, and learn how to ensure it is completely closed to avoid a disaster. We also make sure that we have the correct masks and tubing in place and that they are left in situ because the less time you need to spend trying to connect your tubing and mask, the sooner you can assist the patient.

Before ending the training session we go through the roles of the persons who have been nominated for dealing with each different step if an emergency was to occur. One person is nominated to call the ambulance, another is nominated to stand outside the practice and wait for the ambulance, and the dentist and nurse are then left to deal with the patient.

Each month a different person is nominated to lead the training so that each person gets a turn to prepare and teach.

My desire is for our teams to learn to be interactive and to enjoy the learning, but most importantly to become learned. The more they learn the less I stress.

In closing, my advice to you would be to review your medical health questionnaire to ensure that it covers all medical questions. Make sure to update your patient’s health status at each visit and make sure notes are made on the back of the questionnaire regarding any changes; these must be dated and then signed by the patient and dentist.

Finally, make sure that the nominated health and safety officer is completing all their weekly audits and checks. These can be done on different days, but I tend to do them randomly so that my staff don’t know when to expect them! I do this to ensure that they are always prepared and can’t work around my pending site visits.

As Winston Churchill once said: ‘I never worry about action, only inaction.’

My desire is for our teams to learn to be interactive and to enjoy the learning, but most importantly to become learned. The more they learn the less I stress.’

About the author
Originally from South Africa, Shannon Holmes has worked in the field of dental practice management since 1992. In 2003, 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.
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