Tooth decay highest amongst England’s most deprived

New figures on hospital admissions for dental procedures reveal higher rates for patients from the most deprived sectors of the population when the primary diagnosis is tooth decay

Aimost one fifth of such admissions were for patients from the most deprived ten per cent of the population. However, those from the least deprived ten per cent of the population accounted for only four per cent of admissions with a primary diagnosis of dental caries.

Health and Social Care Information Centre (HSCIC) Chief Executive Tim Straughan said: “These figures show a correlation between rates of hospital dental procedures caused by tooth decay and the patient’s level of deprivation. This report has implications for the public’s dental health and for hospital trusts in England that perform dental services, in particular those that serve England’s most deprived areas.”

Professor Damien Walmsley, the Scientific Adviser to the British Dental Association, said: “The striking and persistent correlation which exists between those with the best and worst oral health and their social backgrounds, particularly among children and young people, has long been apparent.

“Dentists working in Britain’s poorest communities are working with fundamental problems such as children not being taken to see a dentist, not being provided with toothbrushes and fluoride toothpaste and being fed irregular diets heavy with sugary and acidic food and drink. As a result, sadly, we see many children with significant levels of decay, some of whom have to be referred to hospitals for multiple extractions before they are even ten years old.

“Tackling these problems and the social determinants that underlie them needs to be part of government’s wider public health strategies across the UK, as the BDA continues to stress.”

Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, said: “Although the findings of the report are nothing new, the scale of the problem is a worry. Social inequalities have a great bearing on oral health, both in adults and children.

“While there have been major improvements in oral health in the last 30 years, with research leading to advances in the prevention and treatment of disease, inequalities remain and a marked social gradient in oral health is seen in those that areailer.

“Recognition of the common risks shared between chronic diseases such as cardiovascular diseases, cancers, obesity and oral diseases has facilitated more oral health organisations to work with health disciplines to educate and inform patients about the risks.

“There’s a lower social economic status tend to have an unbalanced diet containing little or no fresh fruit and vegetables. The entire profession should take every opportunity to discuss their patient’s diet to assess their risk and give them as much information on how to reduce their risk.”

Further research shows that more than 50 per cent of children in the UK will have dental decay by the time they are five. The Infant & Toddler Forum (ITF) is also calling for a focus on public health education in order to make a difference, with the aim to help families instil healthier attitudes in their children for lifelong health, through a programme of everyday tips on which foods to offer and which behaviours to encourage as early as possible.”
Funding uplift places extra pressure on GDPs, BDA warns

A government decision to award general dental practitioners in England an uplift to their funding of 1.5 per cent for 2015/14 will do little to relieve the increasing pressure on high street dentists, the British Dental Association (BDA) has warned.

The Department of Health’s decision has this year been made without a recommendation from the Doctors’ and Dentists’ Review Body, following its decision to suspend DDB’s role in determining pay settlements.

The Department of Health has also signalled that it intends to consult on the way that dental contracts are managed at the end of the 2015/16 financial year, although details of these changes are yet to be published.

Dr John Mihe, Chair of the BDA’s General Dental Practice Committee, said: “While dentists understand the financial challenges facing the public purse that sit behind this decision, they also know that their practice expenses are continuing to escalate and that their professional lives are becoming ever more challenging.

“Dentistry in England is facing an uncertain time with new commissioning arrangements being implemented in just a few weeks and new contractual arrangements being piloted.

“Dentists are working hard not only to care for their patients today, but also to make these reforms work to build a better future.

“That future will also depend on the funding short-falls that are being endured by practices now being recouped in future years. The BDA will continue to remind Government of this and look to the DDB for future recommendations to more effectively support dentists’ hard work caring for patients.

“We will also press for the full details of the changes to contract management that have been announced alongside today’s announcement. Inevitably, the devil will be in the detail of these changes and we will be looking very closely at them.”

Salaried dentists will receive a one per cent pay uplift, in line with the award given to other NHS employees.

Thousands encouraged to use internet to improve health

The NHS Commissioning Board has announced plans to help up to 100,000 more people to use the internet to improve their health.

The Board is forming a new partnership with the Online Centres Foundation to fund existing UK Online Centres to train and support people in public places to use the internet.

The funding will support the Online Centres Foundation to fund the NHS Commissioning Board’s new commissioning arrangements to pilot innovative approaches to getting involved in online healthcare.

These hubs will provide training and support to help people go online for the first time so they can start using websites such as NHS Choices. As people become more confident they will also be encouraged to do more online, such as provide comments on their use of the NHS or order repeat prescriptions online.

In addition to the health hubs, the programme will also establish a new network of larger NHS digital projects working in health locations (including hospitals and GP surgeries) to pilot innovative approaches to getting involved in online healthcare.

The NHS Commissioning Board is concerned that those who experience the greatest health inequalities – and who have the greatest need of NHS services - are least likely to be online.

Professor Bryn Bridges, chairman of AGBP, said: “Smoking may well be important when considering future risks in exposed people. It is an important priority to start to consider how knowledge of lifestyle factors such as smoking might be incorporated into occupational, medical and public radiation protection.”

Another risk from smoking

Britons fear tooth loss more than weight gain

A new survey from dental brand Corsodyl has revealed that permanent tooth loss is the nation’s biggest confidence killer.

Out of the adults surveyed, 51 per cent said that losing a tooth would be the worst blow to their confidence, compared to 19 per cent who cited changes in weight, and ten per cent bad skin.

Despite these findings, 48 per cent of those surveyed said that healthy looking gums are not as important as other aspects of their oral health, and only 18 per cent said they would visit the dentist if they had gum problems.

Dentist Amit Rai commented: “Gum disease is preventable. Britain and this new report highlights what I see in my practice on a daily basis - that some British adults seem to know little about the health of their gums. Although most patients nowadays understand the importance of brushing twice daily, they don’t often realise that the bugs, which cause gum disease, love to hide within the spaces in-between their teeth.

A build-up of bugs causes the gums to become inflamed commonly resulting in red, swollen gums which may bleed upon flossing or brushing. Over time gums could pull away from teeth and, if left untreated, gum disease could result in the scary reality of tooth loss. There are many products available to treat gum disease. Where appropriate, I often recommend a medicated mouthwash, containing chlorhexidine, for short term use to treat the signs of gum disease, as well as a good oral care routine.”

Smoking increases lung cancer risk after radiation exposure

The risk of developing cancer or tissue damage after exposure to ionising radiation varies among people because of genetic and lifestyle factors, according to the Health Protection Agency’sindependent Advisory Group on Ionising Radiation (AGIR).

An AGIR report concludes that there is strong evidence that smoking substantially increases the risk of developing lung cancer after exposure to ionising radiation; an effect particularly marked in people exposed to radon gas. There is also evidence that genetic factors affect the way people react to ionising radiation, although further research is needed to confirm this and identify all the genes responsible.

The conclusions raise ethical issues that will need careful consideration and could have implications for advice given to smokers who undergo radiotherapy, work with ionising radiation or are accidentally exposed.

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BDA warns of fiscal pressure

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Britons fear tooth loss more than weight gain
Editorial comment

Last week saw the sixth World Oral Health Day. Organised by the FDI, World Oral Health Day is celebrated every year on 20 March and was created to remind the global population that healthy teeth, gums and mouth play a crucial role in our ability to work or study without constant, nagging and painful toothache, in our self-confidence and in the health of our whole body.

This year’s theme is ‘Healthy Teeth for Healthy Life’. It reflects the major contribution oral health makes to our lives. The event provided a fantastic opportunity for FDI member associations to organise events locally to raise oral health in the public’s awareness.

Although the day is not widely marked in the UK, the opportunity for focusing on oral health should never go begging. I made sure that our social media was on the case, I hope your was too!

If you’d like to see more about World Oral Health Day so you can plan for next year, go to http://www.fdiworldoralhealth.org/events/world-oral-health-day/world-oral-health-day-2013.aspx.

Tooth loss? Rather have the flu!

Americans are more afraid of losing a natural tooth than they are of getting the flu, according to a January survey by the American Association of Endodontists. Despite an especially bad flu season that taxed hospital emergency rooms nationwide and led some cities to declare a public health emergency, more survey respondents hoped to avoid losing a permanent tooth (74 per cent) than avoid getting the flu (73 per cent).

Also, 70 per cent of respondents say they want to avoid getting a root canal, and 60 per cent were more anxious about root canal treatment than getting a tooth pulled (57 per cent), or receiving a dental implant (54 per cent). The underlying factor of these numbers could be connected to outdated concerns about root canal treatment.

During the seventh annual Root Canal Awareness Week, March 17–23, the AAE wants to dispel myths that root canals are painful and encourages patients who need a root canal to see an endodontist to save their natural teeth.

“We want patients to know that there is no reason to be anxious about receiving a root canal,” said AAE President Dr. James C. Kulild. “With today’s advanced technologies, root canals are painful and encourage patients who need a root canal to see an endodontist to save their natural teeth.”

Advanced Defence Sensitive blocks 92% of dentine tubules in just 6 rinses in vitro

Introducing the first in a new expert range from LISTERINE® – a twice-daily mouthwash built on potassium oxalate crystal technology that blocks dentine tubules deeply for lasting protection from sensitivity. In just six rinses Advanced Defence Sensitive blocks 92% of dentine tubules; twice as many as the leading recommended pastes.

It can be used alone for lasting protection, or in combination with the most recommended paste from the leading sensitivity brand, to significantly increase the number of tubules the paste blocks in vitro.

* Based on % hydraulic conductance reduction.

Reference:
1. Dentine Tubule Occlusion, DOF 1 – 2012.
6. Advanced Defence Sensitive

Do not recommend this product if patients have a history of kidney disease, hyperoxaluria, kidney stones or malabsorption syndrome, or take high doses of vitamin C (1000mg or more per day).
**New drug treats oral mucositis**

Mouse model studies show that administering genetically or topically, protein Smad7 protects against or heals mouth sores commonly associated with cancer treatment.

In some cancer patients treated with radiation, the mouth sores known as oral mucositis become so severe that feeding tubes are required for nutrition and narcotics are needed for pain. In fact, 40-70 per cent of patients treated with upper-body radiation develop the condition to some degree. Currently, there is no FDA approved treatment. A University of Colorado Cancer Center study published this week in the journal *Nature Medicine* takes an important step toward changing that.

“We developed a genetically engineered mouse that produces a protein called Smad7 in the surface layers of its mouth. With this protein expressed, mouse models were dramatically more resistant to oral mucositis than were controls,” says Xiao-Jing Wang, PhD, CU Cancer Center investigator.

Wang and collaborators including Qionghong Zhang, PhD, Yosef Refaeli, PhD, and radiation oncologist David Raben, MD, are pursuing further research with the goal of developing Smad7 as a therapeutic agent for human oral mucositis.

**Stub it out for the children’s sake!**

Smokers are most likely to kick the habit due to the effect it has on children, according to the results of a new survey.

Almost a third (30 per cent) of those surveyed by the British Dental Health Foundation said they would stop smoking due to the effects it has on children. More than one in four (26 per cent) said the danger of developing mouth cancer would be the reason they quit, while less than one in five (19 per cent) said the risk of lung cancer.

Children are often exposed to second-hand smoke in the home and particularly cars.

Tobacco use is a major killer worldwide, and Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, hopes the one in three smokers in the UK that want to quit do so sooner rather than later.

Dr Carter said: “The research is clear-cut – smoking in any environment is harmful to you and those around you. Around one in six adults in the UK still smoke, and if they are doing so around their children it could have a catastrophic effect on their future health.

“Children see their parents as role models. If they are smoking, children are more likely to take up the habit. By stubbing out cigarettes now, not only will you stop damaging your body, you will stop damaging those around you.”

**National award for Tyneside dental project**

A ground-breaking project which delivers a dedicated dental service for children in care in North Tyneside has won a national award.

Northumbria Healthcare NHS Foundation Trust’s initiative for looked after children in the borough won the ‘continuity of care’ award at the Patient Experience Network (PEN) awards.

The scheme, which operates in partnership with professionals responsible for the children’s welfare and wellbeing, ensures there is no interruption in dental care for children entering care and has resulted in improvements in their oral health.

“The project, run by the Trust’s Northumbria Dental Service, started as a 12-month pilot in conjunction with North Tyneside Council in 2010, however due to its success, has continued. Community dental officer Dr Alex Rushworth, who co-ordinates the project alongside senior oral health promotion officer Jo Macintosh, said: “We are really excited and proud to have won this award. This service was designed for the looked after children of North Tyneside with the help of the children, young people and carers themselves.

“Although Northumbria Dental Service already assessed and treated looked after children, this service means we have more robust links with everyone involved in the care of these patients. It means that more children are able to access our service and benefit from a project specifically designed to deliver health benefits to them.”

There are plans to extend the service into Northumberland.

**BDA launches major changes to membership**

For the first time, the British Dental Association (BDA) will offer dentists a choice of membership packages that reflect individuals’ different needs.

Following extensive research, the BDA is launching a new membership scheme and from 1 June 2015 the current ‘one size fits all’ membership will be replaced with three different packages, offering a range of benefits.

At the same time, the BDA is also launching a new online CPD ‘Hub’ which will be available to all members.

The new membership packages are:

• **Essential** (£205) – covering trade union support, access to online advice, subscriptions to the *BDA Journal* and *BDA News*, access to the brand new online CPD system

- Extra (£795) – covering everything in Essential membership plus, tailored support and advice via phone or email, and a VIP three-day ticket to the British Dental Conference and Exhibition
- **Expert** (£1,095) – covering everything in Essential and Extra memberships plus exclusive access to BDA Expert (including over 170 model policies and protocols); two three-day DCP tickets to the British Dental Conference and Exhibition; and a BDA Clinical Guide

Concessional rates will also be available:

• **Students** (£24 a year while at university) – covering a range of benefits including access to e-books, BDA publications and free entry to the Conference and Exhibition
- **Those over 65 (£195)** – for access to the Essential membership package.
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Work in Burma with Burmadent

Founded by practice owners Sharon Bierer and her husband, dentist Henrik Overgaard-Nielsen, together with fellow Trustees, Brian Weathery and Lesley Naismith from Software of Excellence, Burmadent has been established to provide dental care and promote oral health education in Burma.

Initially a holiday in March 2012 took Sharon and Henrik to Inle Lake in Burma where they were granted access to the Mein Thauk orphanage. The levels of caries and decay they found in the mouths of such young children was shocking and motivated the couple to organise a return trip to the area in November last year, with the aim of providing a programme of dental care to the orphans.

The couple were joined on the trip by the head nurse at their London practice, Zar Ni, and his wife Myat Myan San as well as Support Manager at Software of Excellence and trained dental nurse, Lesley Naismith.

Burdent aims to arrange for dentists to work in Burma with an English speaking nurse. Dentists will pay for their own flights and hotel (at £15pp per night). Burmadent will facilitate this by providing information on useful contacts, advice on precautions that should be taken, how to get a visa, necessary vaccinations, hotel details, travel arrangements etc. – in fact every resource needed to make your trip a reality.

Burdent has a number of events planned for the coming year and has a programme of presentations to local BDA groups already arranged. In addition, a Burma Day was being held at Software of Excellence on 22nd March and don’t forget the Burmaball on 12th October at “Eight” – the private members’ club in London.

BDTA Dental Showcase launches new website

Registration for BDTA Dental Showcase, the UK’s largest dental exhibition, is now officially open for 2013.

Whatever your reason for attending the UK’s largest dental exhibition – to see the very latest technology, gain insight on the newest treatments to see the very latest technology, gain insight on the newest treatments or to learn more and gain CPD – the new BDTA Dental Showcase website is the hub for everything you need!

The online portal of the UK’s largest dental exhibition has a whole host of practical features, designed to ensure you maximise your visit to BDTA Dental Showcase.

Visit www.dentalshowcase.com now to:

• Register for free to benefit from BDTA Dental Showcase 2013 See what’s new in the world of dentistry
• Find out the latest news and updates about the exhibition
• Use the new ‘My Dental Showcase’ section, where visitors can plan their day, see who will be exhibiting and research travel options
• Use the ‘Save The Date’ facility which will automatically add BDTA Dental Showcase to your online calendar
• Download your CPD from 2012 (if you have not already done so)
• View highlights from last year’s BDTA Dental Showcase
• Personalise your experience visit the ‘Save The Date’ facility which will automatically add BDTA Dental Showcase to your online calendar

The latest news and updates in the build up to the show are also available direct to you by following @dentalshowcase on Twitter or by liking the ‘BDTA Dental Showcase’ Facebook page.

This year, the exhibition will be held at Birmingham NEC from 17-19th October.

To find out more about Dental Showcase 2013, register for tickets and personalise your experience visit: www.dentalshowcase.com now!

Word of mouth strengthens oral health

More than 28 million people in the UK chose their current dentist through word of mouth, according to new research.

In a poll conducted by Bray Leino, half of people questioned (44.7 per cent) used friends and family recommendations for choosing their current dentist, while only 7.5 per cent of people used the internet. Almost two thirds (65.7 per cent) would rely on recommendations from friends and family to choose a new dentist.

The trust people have in their dentist was also highlighted as the survey found that two in every three people (66.3 per cent) would prefer to see the same dentist every time they visit.

Tony Reed, Executive Director of the British Dental Trade Association (BDTA) said: “New technologies have transformed the whole experience of visiting the dentist. There are now a wide range of largely non-invasive treatments including laser treatments, to target decay and disease, and digital scanning technology which allows dentists to make replacement teeth and crowns without taking silicon impressions.

“Dental treatments have advanced significantly helping to make a visit to the dentist a much more relaxed experience and encouraging more patients to take care of their oral health which, in turn, benefits their overall health.”

GDC’s Chair and Chief Executive speak at BDA Conference

The General Dental Council’s (GDC) Chair, Kevin O’Brien and Chief Executive, Evlyanne Gilvary will be appearing at this year’s BDA Conference, taking place at London ExCeL on 25-27 April 2015.

Together they will present a session on Friday 26 April in Theatre 4 at 2.15pm, entitled Radical changes ahead – the GDC prepares for the future. In the session they will be discussing the GDC’s work, future aims and strategy; cost effective regulation; and the importance of contributing to the GDC’s work.

Kevin O’Brien will also be presenting the session Working to deliver dentistry in line with patient expectations on Friday in the Training essentials theatre at 11am. In the session, Kevin will be exploring the aims and objectives of the GDC’s corporate strategy; the role of patient expectations and safety; and how progress in key projects such as direct access, the review of standards and CPD will impact dental professionals.

For more information about the conference and to book a place, please go to: http://conference.bda.org/
Where are you on the management skills ladder?
Glenys Bridges requests your help...

The CASPER campaign began in June 2012 with a meeting of 12 interested parties at Aston University Business School. The aim of the meeting was to form a Steering Group to highlight the need for clear guidance on the standards of professional education required to enable dental professionals to meet regulatory standards for quality of care and patient safety.

With the enactment of the Health and Social Care Act 2008 and the creation of the regulatory bodies appointed to ensure compliance with its regulations we have been approached by an ever increasing number of practice teams struggling with the requirements. It is clear to us that many of the employers—Registered Providers do not have the training required to make the regulations into an effective tool for ensuring consistent standards of patient-focused care. Frequently, they employ a practice manager who does not have the required skills either.

The CASPER working group is made up of managers, communicators and trainers who understand the skills required at each level of practice management. Whether your management role is at the strategic level where managers are often Registered Providers and are responsible for business planning, or at the operational level at which managers are responsible for designing practical procedures, or the supervisory level at which managers supervise the work of colleagues, having the appropriate knowledge, skills and understanding of management principles is advisable, especially during adverse economic times.

Registering your interest
We are inviting interested dental professionals to register their interest in the CASPER project by completing the questionnaire below, you can do this on paper and post your response with your name and postal or email address to: 24 Farnworth Grove, Castle Bromwich, Birmingham B36 9JA or email us asking for an electronic version for the questionnaire at casper.campaign@gmail.com

Completing the questionnaire
Identify the level of your management contribution by simply referring to the ‘Management Function’ column as follows:

1. Refers to Strategic Management or
2. Refers to Operational Management or
3. Refers to Supervisory Management

When you have identified your current level of management contribution, 1 or 2 or 3, complete all four functions; Planning, Organising, Leading/Directing and Controlling then do the same for the Training Needs column by completing the corresponding horizontal row.

When we have registered your interest through either the receipt of your request for an electronic survey, or your paper (by post), we will send you a second skills gap survey directly, relevant to your management level showing you the recognised skills and outlining relevant training opportunities for you.

We are inviting interested dental professionals to register their interest in the CASPER project by completing the questionnaire below:

**About the author**

Glenys Bridges is an experienced management trainer and assessor with 20 years experience of working with General Dental Practitioners and their teams. In addition, she has expertise and qualifications in Counselling and Life Coaching. Her first book Dental Practice Management and Reception was published in 2006 her second book: Dental Management in Practice was published during 2012.
Tooth whitening update, better late than never
Neel Kothari looks at the situation around whitening


Prior to this time the majority of the profession carried out tooth whitening procedures in breach of the law; in the absence of any political will to enforce it a messy situation ensued. The problem was that despite its illegality, tooth whitening was a treatment which in many cases offered a cheaper, less damaging and less risky approach to improving patients’ smiles compared with conventionally carrying out veneers or crowns.

However the current amendment completely changes this. The vast majority of tooth whitening procedures can now comfortably be carried out with concentrations of six per cent or less Hydrogen Peroxide, rendering the need to use greater concentrations almost obsolete. Accordingly, it is now incredibly difficult for dentists to provide a clinical justification to break the law.

The regulations set out that products containing or releasing up to six per cent hydrogen peroxide can be used, subject to the following conditions:

- It is only to be sold to dental practitioners
- For each cycle of use, the first use is to be by a dental practitioner, or under their direct supervision, if an equivalent level of safety can be ensured
- After the first cycle of use, the product may be provided by the dental practitioner to the consumer to complete the cycle or use
- It is not to be used on a person under 18 years of age

The General Dental Council (GDC) position statement on tooth whitening further expands on this legislation stating that if they receive information or a complaint that a registrant is using a product for cosmetic purposes in excess of six per cent they may face fitness to practise proceedings and can expect to have the matter referred to the relevant trading standards department.

The Dental Defence Union (DDU) advises its members that in the worst case scenario ‘dental professionals who use bleaching products containing or releasing over six per cent hydrogen peroxide could be imprisoned and/or fined up to £5,000 under the Consumer Protection Act 1987.’ The DDU
also states ‘the six per cent hydrogen peroxide limit applies to any compound whether used externally or internally e.g. on a root canal treated tooth’ and that ‘it remains illegal to use tooth bleaching compounds containing or releasing more than six per cent hydrogen peroxide’.

Dental Protection also states that ‘the use of products containing or releasing more than six per cent hydrogen peroxide is a breach of the Regulations’ and ‘members may consider, for example, the extensive published evidence that products containing or releasing more than six per cent hydrogen peroxide may lead to a higher incidence of side effects including sensitivity, which in turn are respon-

meant to work in practice, so if I ever find out I will do my best to update you on this position. Alternatively if there is anyone out there who knows please email me at neel@saw-stodontist.com.

In what may seem as a somewhat contradictory position The Department of Business, Innovation & Skills (BIS), who oversee consumer safety and trading standards, have advised that the Consumer Protection Act 1987 and the cosmetic Products (Safety) (Amendment) Regulations 2012 do not cover the final ‘use’ of the product, therefore these specific regulations do not prevent the direct application of any whitening product of any concentration to the teeth.

This suggests that it is not illegal under these regulations for anyone to apply whitening products of any strength directly to the teeth of patients, however it is difficult to see how this can work if dentists are restricted from purchasing HP products over six per cent and are not supported by their dental defence unions.

Essentially, the need to use stronger concentration whitening products has always been debatable given that similar results can easily be achieved using ‘weak’ or ‘strong’ products. Those advocates of ‘power whitening’ may ultimately feel disheartened by the ruling, however really have no choice but to abide by it. Over the past year I personally noticed seemingly excellent deals in a number of power whitening lamps – I am now extremely glad that I wasn’t tempted to buy one.

‘Dental Protection also states that ‘the use of products containing or releasing more than six per cent hydrogen peroxide is a breach of the Regulations’ sensible for a significant number of complaints relating to these procedures. Furthermore, this evidence suggests that the use of these higher concentrations, whether administered in the surgery or at home, may ultimately confer no long-term benefits in aesthetic terms when compared to the alternative products that remain within the proposed six per cent limit.’ If a member considers that it is in a patient’s best interests to use a product containing or releasing more than six per cent hydrogen peroxide and a member chooses to use this product they may be challenged on the use of the product by Trading Standards Officers.

As part of the agreement to change the directive the EU demanded that there should be reporting of any adverse effects from the use of HP products up to six per cent. At the time of writing I am not entirely sure as to how this is
Creating a successful and profitable practice in the recession

Ash Parmar details steps you can take to be successful in today’s economic climate

The world is in economic turmoil at present. If you watch the news, we are constantly being reminded of doom and gloom. Have you wondered how this may affect your dental practice? This article will look at the fundamental concepts that every practice owner needs to really focus on in 2013, not just to survive, but hopefully to thrive in. Remember, a practice cannot just stay where it is. If you do nothing, your business will probably decline. By taking positive action and working hard, the business will grow.

1 The Law of Attraction (pic 1)

The Law of Attraction says that you are a living magnet. Any thought you have, combined with an emotion, positive or negative, radiates out from you and attracts back into your life the people, circumstances, ideas and opportunities consistent with it.

The Law says that if you have a very clear idea in your mind of your desired goal (eg having a successful private practice), and you can hold that idea in your mind on a continuing basis, you will draw into your life the resources that you need in order to achieve it. So whatever type of new patients you want to attract, have a positive focus and attitude, and this will happen. I successfully used this concept in setting up a state-of-the-art private cosmetic and implants practice two years ago (www.smiledesignbyash.co.uk).

2 Goal Setting (pic 2)

Goal setting is essential for success. Goals must be written with clear deadlines. Only the top three per cent of the most successful business owners have clearly defined WRITTEN goals! For example, to convert an NHS practice to a private practice may require a one - two year game plan with clearly defined and management monthly goals. This makes the task easier and minimizes financial risks in the transition. The entire team needs to understand the journey of change, and support the business in the new vision and direction that the practice will take.

3 Improving your Practice (pics 3a, b)

The first important and practical thing is have a close look at your practice. To improve it need not cost that much money! Dentists spend thousands of pounds on equipment and fancy gadgets, but often fail to understand that patients will NOT really perceive these differences. They will however notice the aesthetic ambience of the practice, the nice aromatherapy vapour as they enter the premises, the beautiful music playing in the background, the smiling and smartly dressed professional team members. They will also notice the totally clutter free environment, the beautifully appointed bathroom, and the freshly made tea and coffee. They will also enjoy the classy hardback books in your reception lounge, the nice works of art and makeover pictures of your clients on the wall.

In summary, set a budget, have a team meeting and brainstorm the ideas of change you want to consider in your practice. Review what nice hotels and restaurants look and feel like. You CANNOT have a successful private Practice if you “don’t look the part”! This is obvious, but often ignored.

4 Review your Finances (pic 4)

It is vital to go back to basics and rethink your strategy going forward. The current economic climate is very unusual; even estate agents cannot predict what exactly will happen in the next twelve months! As dentists, we need to be clear of the following:-

- Monthly turnover target
- Monthly expenses
- Cost to run each treatment room
- Profit made by the hygienist or associate working for you
- Marketing plan and budget
- Number of new patients you would like to sustain the practice

Once you are offering a superior service, increase your fees by 10 per cent. This will have the effect of increasing your profit by 28 per cent if your expenses are held at 65 per cent! In addition, review all expenses and tighten up wherever you can, and certainly avoid any major capital expenses. If you intend to do more cosmetic dentistry, then purchase important pieces of equipment or technology (eg a digital SLR camera or a soft tissue diode laser), ie things that have a very good return on investment.

5 Marketing the Practice

Allow a budget of five – eight per cent of the annual turnover for marketing your practice. You should then have a detailed marketing plan for the year, which will actually change as time goes on. This is because you need to monitor your marketing strategies and evaluate what is working and what is not. Some examples of successful and low cost marketing strategies are:-

- Develop a website, and optimise it
- Network with local businesses
- By clearly defining your vision, you will automatically decide on the type of patients you wish to attract to the practice

Finance Plans for patients (pic 6)

If you do not already work with a financing company that offers finance plans for dental patients, then it is vital to immediately set this up. A company such as Medenta (www.medenta.com) can come and train up your treatment coordinator, including help with verbal skills. For a larger investment, most patients will want to spread payments over an extended period of time, and if possible enjoy the benefit of extended period of time, and if possible enjoy the benefit of...
an interest free loan over 12-24 months.

7 Team Meetings (pic 7)
By having regular monthly team meetings where EVERY-ONE is present will give the team an excellent opportunity to discuss, co-discover and role-play verbal skills. Someone will need to create the agenda, which is approved by the principal, and also take minutes.

The team should also have a daily morning meeting where the treatment coordinator has pre-planned everything. This important 15-minute discussion will ensure a smoother day and reduced stress!

8 Education and Team Training (pics 8-11)
To make successful change, you will need the following:

- Excellent clinical skills. Go on postgraduate courses to learn additional skills. Hands-on courses are the best way to learn (e.g. Smile Design, Occlusion, and Photography).
- Learn the Art of Selling. How can you quickly learn the skills to successfully get your patients to say “Yes” to larger treatment plans? How good are you and your team at communication skills?
- An excellent treatment coordinator. Dentists find it hard to delegate. However, a highly trained and skilled treatment coordinator will drive your business to levels of success.

Learn more about Luxatemp and other DMG milestones at www.dmg-dental.com/20-years
you would not have dreamed of. Dentists should mainly focus on actually doing the dentistry! It is likely that there is a team member you have that will have the requirements for being a great treatment coordinator. You simply need to identify this person and nurture them. I recommend Laura Horton to any dentist that wants their team trained to a very high standard (visit www.horton-consulting.com).

9 Exceptional Customer Service (pic 12)
Patients (ie customers!) are very discerning nowadays. There is no room for complacency. The new patient experience has to be seamless from the minute the initial phone call enquiry comes. The team needs to be trained in adding value to everything that is said and done at work. The language between colleagues needs to be courteous and professional at all times. Many small touches in caring for the patient will add up to the overall experience being positive and totally comfortable. Having satisfied customers will create “raving fans” that will then refer more new clients. In this current economic climate the need to really look after people is even greater!

10 Bonus System (pic 13)
Having a fair bonus system based on practice turnover and team performance is a great way to appreciate hard work that is done by staff. The system needs to be simple, with clarity in everyone’s mind as to how it works. Bonus should be calculated on an average of three months turnover, and paid monthly (if applicable for that period) separate from the monthly pay cheque. It goes without saying that appreciation and compliments are equally important as financial rewards when it comes to motivating team members!

Summary
“Knowledge is Power” and the more you learn, the more you find out that you do not know. As human beings, we only use about three per cent of our true potential! Imagine what you will become and the practice success you will enjoy if you put your mind to it, and discover the right mentors…
Long-term care vs. short-term gain

Michael Sultan highlights the importance of thinking long-term...

The one thing I always remember about my first employer was his favourite lesson. ‘Michael,’ he would say, ‘always remember: a fast buck is your last buck.’ Of course, he was right, but I don’t think my younger self quite realised the significance of those words. Now, looking back, I am much better placed to understand exactly what he meant. He wasn’t just telling me about the need to be honest and open with my patients – he was telling me to always think in terms of long-term care.

When we’re young I don’t think we appreciate the passage of time, but as we grow older we soon wonder where the time’s gone. As dentists we’re in a fairly unique position as if we continue to work at the same practice, we get the chance to assess the outcome of our work over a number of years. It’s lessons such as this that really push the point home.

Whereas 20 years ago a patient may have sat in my chair and said ‘I’m 60, is it worth it?’ today I’m more likely to have someone say ‘I’m 80, is it worth it?’ If you’ve got a toothache then it doesn’t matter how old you are. The oldest person we’ve treated here at EndoCare was 100. Did she want to keep her teeth? Very much so!

What this reminds us then is that with an aging population, looking to the long-term is even more important than ever. If people want to look good at 70 then rather than patching up teeth one tooth at a time we need to be thinking about the overall big picture, and not constantly fire-fighting each separate problem as it occurs.

So now, more than ever, ‘short-term gain’ is very short, especially when we consider the longevity of patients. But it’s a fine balancing act. Of course we should always endeavour as a dentist that the work we do now can have a profound impact upon a patient’s life and will hopefully be with them for many years to come.

What this teaches us then is that we always have to have our eyes on the future and the ‘real health journey’ our patients will take. It’s no good for example seeing a tooth with a broken filling and putting a crown on it without thinking that six months down the line the patient would have opted for a bridge for the adjacent gap.

One factor that’s had a significant impact upon the way we treat our patients nowadays is the aging population. I remember back when I was a schoolboy, the woman who used to run the chip shop near our school died. Ok, so she was 60, overweight and a smoker, but a generation or so back, 60 wasn’t too bad an age. Nowadays, it’s a completely different story.
to focus on the long-term but at the same time we have to give patients what they want. As we all know, very often patients don’t know what they want, or they think they know what they want, and don’t necessarily have all of the facts and evidence to hand. Financially some patients may have only short-term goals. Students for example may not be able to afford major treatments until a later date. We should always endeavour to provide a solution with as little harm to the long-term prospects as possible. With treatment discussions, ‘no’ sometimes means ‘no not now’ rather than ‘no not ever’. If a student came to you who needed an implant but couldn’t afford it, it would be very wrong to cut down their adjacent teeth and make a bridge (short-term gain) when in the long-term they would be better off having an implant and just waiting for it. If the problem short-term is financial then we should always do something that’s reversible and non-damaging.

But there’s also another element to this short-term gain discussion that we haven’t yet considered. How does taking the long-term perspective benefit our practices as businesses? Someone once told me that the biggest practice builder is emergency patients. If you really help someone out, then more often than not, they will stay with you for life. That’s because people don’t forget the great service provided. They don’t forget if you go out of your way to help them out in a difficult situation. If you’ve got an emergency in and you’ve been punitive with fees and ‘fast buck’ culture, yes you’ve got them out of pain, but no, they’re not going to come back. For the sake of a few hundred pounds you’ve soured a relationship for a lifetime. If the problem short-term is financial then we should always do something that’s reversible and non-damaging. But there’s also another element to this short-term gain discussion that we haven’t yet considered. How does taking the long-term perspective benefit our practices as businesses?

For the sake of a few hundred pounds you’ve soured a relationship for a lifetime. If you think about the cost of patient acquisition and how much a patient is worth to a practice these days (especially taking patient longevity into account), sometimes it’s even worth just shrugging your shoulders and waiving a fee if that means you might be able to keep hold of someone for 10, 20, 30 years or more.

So there’s a lot more to my old mentor’s advice than meets the eye. Yes, a fast buck certainly nearly always is your last buck, but this simple statement means so much more than that, and has an impact on all of our working lives’

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Dr Michael Sultan BDS MSc DFO FICD is a Specialist in Endodontics and the Clinical Director of EndoCare. Michael qualified at Bristol University in 1986. He worked as a general dental practitioner for 5 years before commencing specialist studies at Guy’s hospital, London. He completed his MSc in Endodontics in 1995 and worked as an in-house Endodontist in various practices before setting up in Harley St, London in 2000. He was admitted onto the specialist register in Endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on Endodontic courses at Eastman CPD, University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008 he became clinical director of EndoCare, a group of specialist practices.
Keeping up with the industry

Dr Richard Kahan gears up for Clinical Innovations Conference 2013

Designed specifically to help dental practitioners keep up-to-date with the industry, Healthcare Learning: Smile-on is proud to host the 10th Clinical Innovations Conference (CIC) on 17th and 18th May at the Millennium Gloucester Hotel in Kensington, London. Presented in collaboration with The Dental Directory, the event will provide a unique opportunity for dental professionals to attend a variety of clinical lectures and workshops, learning and applying the latest techniques and products in the industry.

Running alongside the main lecture programme this year will be the London Deanery DFT Conference, designed specifically to introduce London Deanery Foundation students into the modern dental industry.

Amongst the confirmed line-up of highly respected speakers will be Endodontic Specialist, Dr Richard Kahan. Richard is a specialist endodontist working in Harley Street, London and the former Director of Endodontic Courses at UCL Eastman CPD. He has lectured widely on endodon-

cic and technology and has recently set up the Academy of Advanced Endodontics to teach the fundamentals of endodontics to GDPs through extended mentoring within his practice. With five years’ experience of endodontic CBCTs, his clinic has become a referral centre for complex cases used by both endodontists and GDPs.

“After speaking at the CIC last year, I found the event to be very well organised while providing a wide range of education to suit all delegates,” he says. “I found audience participation to be great, and really felt that delegates were responding to what I was saying.

“I will be giving a similar lecture this year, looking into cone beam CT technology, and how it can be used to diagnose and treat endodontic cases effectively. I will use various case studies to illustrate my points.

“My lecture will also apply to all members of the dental team, as I hope to aid the general progressive awareness of cone beam technology within the modern profession. I aim for delegates attending my talk to realise the potential for this technology to enhance their clinical work, even if they have not undergone any training specifically within the area of endodontics. I also hope to offer support and guidance on how delegates can utilise this knowledge and understanding to raise the standard of their treatment range. The latest imaging equipment can save the practitioner and their patient.

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both time and money, which could have a great affect on the overall success of treatment and the reputation of the dental practice."

In order to provide a diverse learning experience for delegates, the CIC 2013 will present several additional features over the course of the two days. The trade exhibition for example, will host a range of high profile suppliers and manufacturers, demonstrating the latest equipment and innovations in UK dentistry.

“Dentistry is a very fast-paced profession, and techniques and equipment can evolve very quickly,” adds Richard. “As a result, I think it can be very difficult for practising clinicians to keep on top of the latest developments, particularly if they are also trying to run a dental practice and raise a family at the same time. Information has also become more accessible to patients, so they are always demanding new or more complex treatments on top of everything else. If the clinicians get behind, so does the practice, and in such uncertain economic times, this can be a huge worry.

“In order to keep up, I think it is important that clinicians employ a variety of learning methods, and one of these should definitely be attending events such as the CIC. I believe this to be a very useful way for practitioners to update their knowledge and skills, as the events encourage face-to-face interaction between professionals. Dentistry can be a lonely profession at times, particularly for principle dentists. By speaking to people they otherwise may not have had the opportunity to speak to, attendees to such events can gain a wealth of new ideas and different perspectives to help them and their practice thrive.

“As well as offering a relaxed and friendly atmosphere for networking, the trade exhibition also enables delegates to meet the experts behind new products, allowing them to gain a better understanding of the techniques. From the trade’s point of view it also provides feedback on where they could improve their products or services, so everybody gains.”

Another opportunity to meet both old friends and new will be presented at the Clinical Innovations Awards Ball on the evening of 17th May, when you can relax and enjoy a luscious gala meal with live entertainment. The evening will also celebrate the latest developments in the industry, and the deserving winner of the Clinical Innovations Award will be announced.

Speakers include:
Nasser Barghi
Irfan Ahmad
Louis MacKenzie
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Delegates at CIC 2012

About the author

As well as working in his specialist practice in Harley Street, Richard is also Senior Clinical Part-time lecturer in Endodontology at the prestigious Eastman Dental Institute, University College London teaching endodontics to both postgraduate specialist students and general practitioners. He has lectured nationally and has written many research papers for refereed journals. Richard’s other interest is Information Technology and he is a consultant in dental IT integration. He has recently finished writing a clinical software programme called EndoBiz which is currently undergoing beta testing.

To make sure you don’t miss Richard or any of our renowned speakers, book early and avoid disappointment. To find out more or to book your place, please email info@healthcare-learning.com or call 020 7400 8989 Follow us on Twitter @smileonnews and @hlc_smileon for the latest news.
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continuing the care that starts in your chair
Blowing the whistle and protecting patients

Dilhani Silva details who to contact when you’re concerned about a colleague.

The government guidelines Support Scheme (PASS) can recommend advice and support and guidance. PASS can recommend additional training, courses or mentoring etc.

Practitioner Advice and Support Scheme (PASS) The government guidelines for PASS are as follows:

- The PCOs will work with the Local Dental Committee to help develop a system for identification, assessment and remediation in general dental practice.
- The process must be clear in distinguishing concerns from complaints. Concerns can come from anyone, and can lead to an investigation of the allegation.
- The PCOs will work with the Local Dental Committee to help develop a system for identification, assessment and remediation in general dental practice.
- The process must be clear in distinguishing concerns from complaints. Concerns can come from anyone, and can lead to an investigation of the allegations.
- Clinical and professional - Patients and the wider public - Management - Finance

General Dental Council The GDC has a three-stage complaints procedure for dealing with allegations about the registrant’s performance. At stage one the allegations are considered by a caseworker. If they need further investigation the information is passed on to the Investigating Committee (IC).

- The IC decides whether to refer the case to full public enquiry (stage three) or not to refer it for a public inquiry and take no further action or issue advice or warning. If the case is referred for a full public enquiry it is forwarded to one of the practice committees - the Professional Conduct Committee, the Professional Performance Committee or the Health Committee.

At stage two the IC considers the allegations, comments from the dental professional, any additional comments from the individual who made the allegations. All parties receive a complete copy of the paperwork (excluding any sensitive health information). The IC decides whether to refer the case to full public enquiry (stage three) or not to refer it for a public inquiry and take no further action or issue advice or warning. If the case is referred for a full public enquiry it is forwarded to one of the practice committees - the Professional Conduct Committee, the Professional Performance Committee or the Health Committee.

- The IC decides whether to refer the allegations for an enquiry, they can refer the dental professional to the Interim Orders Committee (IOC) to consider whether to impose conditions or interim suspend until the enquiry has been held.

At stage three (full public inquiry) the relevant Committee hears evidence and investigates facts. If any allegations are proven, the Committee can impose conditions on registration, prohibiting them, for example, from working in a particular area of practice or issue a reprimand. See the GDC guidelines Principles for raising concerns.

The National Clinical Assessment Service (NCAS) The PCO or GDC may decide to involve NCAS for the more complex or serious cases. NCAS has dealt with over 5000 cases of underperformance in doctors and dentists and brings great experience towards helping practitioners to improve standards and keep working.

NCAS works in a number of different ways and for complex cases may carry out an assessment and can recommend further training or mentoring.

Dentists’ Health Support Programme The Dentists’ Health Support Programme was launched by the British Dental Association in January 1986 under the title ‘The Sick Dentist Scheme’. The DHSP title was adopted in 2001. The objects of the programme are to identify and support dentists who may be impaired by dependency/alcohol or other drugs. Through a system of investigation, verification, intervention, referral for treatment, post-treatment support and monitoring the dentist can overcome his/her impairment and is supported in return to satisfactory, safe practice.

A colleague may be referred to this programme either personally or from one of the other bodies referred to above.

GDC principles for raising concerns Ensure that staff members have familiarised themselves with the GDC principles of raising concerns and clarify any issues and questions at a practice meeting.

Adapt a policy on raising concerns and provide staff members with the relevant training to ensure that they are aware of who they need to notify in the relevant circumstances.

Provide relevant information to the new staff members during their induction programme.

For more details about the Practitioner Advice and Support Scheme (PASS), carry out a Google Search and you should find details of your local scheme.

Government has scrapped the draconian confidentiality clauses aimed at silencing whistle-blowers, in the NHS. This is assuredly the best news in the NHS opposite to its negative press. It is time to put things right by ending the blame culture. We all are adults, not children who work in the profession, and should be able to take responsibility to raise concerns of our poor performance to protect the public, which simply could be our family. Staff should be encouraged regularly and should be alerted by the systems in place not only by the government but by our own working environment. There should not be a fear to report any wrong doing, misconduct or any poor performance as it will elevate the profession and the surgery performance. It has proven that ‘Non-disclosing’ clause in contracts has silenced the profession for some time.

Towards April each year we (most of us) chase the UDAs, that is a fact. Some might say we are forced by the system to do so. Are we doing this ethically? Meeting targets, ticking the boxes and endless bureaucracy has brought this upon us! Many of you may agree but I leave this to my intelligent readers.
Turn your good practice into a great one – part three

Jacqui Goss continues with your journey toward practice perfection!

The way your calls are answered is crucial

Attention dentists, hygienists and all other wet finger operatives. Imagine if you will that you have no appointment system. People turn up when they feel like it and bang repeatedly on the door of your treatment room, regardless of how busy you are. As more people arrive they also start banging on the door. When you let one of them in you discover they’re not a patient and you have no notes on them. Nevertheless they sit themselves in your chair and demand attention. They may be there for five minutes or half an hour. Meanwhile, the banging on the door is getting louder...

A nightmare scenario? Nooo… just a typical working day for a receptionist through the prism of being a dentist. For front of house staff, answering the phone is just one of their many routine tasks yet the way they do it and what they say can significantly affect practice profits. I’m amazed that some practices spend time and money attracting potential patients (read part two to find out how) and then don’t ‘close the deal’ by overlooking the training and on-going development of their reception staff.

I’ve been on both ends of the telephone. Practice owners employ me to play the role of potential new patients to assess how well the telephone is answered. As extreme examples, reception staff can be ‘captured spies’ – persistent questioning is required to elicit any information – or they can be ‘monologue-ists’ – they emit a continuous stream of words, often repeating themselves rather than pausing for breath!

I exaggerate for effect, not to imply criticism. Answering the phone in a practice is hard work. I’ve done it when clients have been suddenly left short-handed and judge it as akin to running a mental marathon with the added hazard of random hurdles to leap over. Oh, and the occasional wayward mobile ‘banana’ to trip over.

When you answer the phone you have no idea who is calling. Within a few seconds you may determine their gender from the sound of their voice. You don’t know their name, age, mood or their reason for calling. They may be in a hurry or relaxed. They could be warm and dry or getting cold and wet. They may have good or poor hearing and there could be little or lots of background noise.

Okay, let’s start considering what mistakes can be made when answering the telephone and how they can be avoided. The usual advice is to first confirm the business name and then identify yourself (I’m making up the names): “Good morning. Sunny Smiles Dental Practice. Jacqui speaking and I can help you”

The problem comes when somebody answers the telephone in this way 10, 20, 50 times a day. Before the week is out they’re answering: “G’morning. Sunny Smiles – an insight into goodwill valuations from leading practice valuers PFM Dental. A specialist dental solicitor will cover legal issues including: NHS contract transfers, sale agreements and employment law. Dental accountants PFM Townends will present on tax reliefs and independent financial advisers will focus on the NHS Pension and wealth management.

Buying a Practice – financing a practice purchase and presenting your case to the banks. Lloyds TSB Healthcare will cover finance applications and PFM Dental’s practice valuers will offer guidance on goodwill values. A specialist dental solicitor will cover sale/purchase agreements and common pitfalls.

To book your place on one of PFM Dental’s verifiable CPD courses please email mandy.wraige@pfmdental.co.uk or call Mandy on 0845 2414480.
properly heard what was said. The tendency to speak rapidly (sometimes in a frenzied way) is called pressured speech. In other circumstances, it can be a symptom of certain mental health conditions such as schizophrenia. I won’t get sucked into the whole world of psycholinguistics but I can tell you that it’s a topic which has evoked considerable study – not least by Heidi Biggenbach from California who has written several books on the subject.

There are accepted rates of speech, measured as words per minute (wpm). Fewer than 110wpm is slow whereas conversational speech is somewhere around 150wpm or more (some experts say 180-200wpm is ideal, others consider this fast). There are free audiosbooks available via the Internet (www.booksshouldbefree.com is one website) and these can help you gauge a rate of speech that can be readily understood. You can also find rate of speech tests online. For example, The Public Speaker podcast, offers one here: http://www.lisabmarshall.com/unategorized/how-fast-do-i-speak.

Bear in mind that research has shown older people tend to perform more poorly (although there can be considerable variation) when speech is deliberately speeded up.

Ways of giving a ‘smiley’ greeting on the telephone include speaking clearly and naturally and perhaps with a deeper voice, Oh, and smile genuinely while you do so. Colleagues should occasionally listen to how practice team members use the telephone to ensure they haven’t reverted to an Olympic pace greeting! The other thing to be checked regularly is that your telephone system has good audio clarity – unless a colleague makes a trial call every so often, you may never know. They should also check that receptionists are not starting to speak before the line is properly connected – resulting in a “...ternoon, Sunny Smiles Dental Practice” etc.

Finally, how does your answerphone message sound to callers? Check for clarity, background noise, pace of speech and good intonation.

Why have I used most of this article concentrating on just the first few seconds of a telephone call? It’s because those first seconds are critical – it is oft quoted that research shows that people form first impressions of others in just a very few seconds. Unfortunately, I can’t refer you to specific research to verify this. I can, however, give you a great reading recommendation. It’s Drop the Pink Elephant by Broadcasting Business Managing Director, Bill McFarlan. The book is about ways to speak to people without getting them focused on the opposite of what you are saying. Eg if someone says: “Don’t think about a pink elephant,” then, of course, that is exactly what you think about. So, if you say: “Don’t worry, we are really good with nervous patients,” all the patient hears is that they should worry!

About the author

Jacqui Goss is the managing partner of YesResults dental practice management consultancy. Many practice owners value her knowledge and expertise to considerably improve their patients’ journeys.

Email: jacqui@yesresults.co.uk

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

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All change on the NHS contracts front

Amanda Atkin relates the ongoing saga of NHS dental contracts and advises on good housekeeping you should undertake

Who remembers the General Dental Services (GDS) contracts? Yes, for some people the painful memories are still there! These were introduced to take effect from April 2006 and heralded the new local commissioning arrangements for NHS primary dental care services. There were also new contracts for dentists in Personal Dental Services (PDS) pilots making the transition to GDS contracts. For those providing services such as orthodontics, there were substantive time-limited agreements – normally a five-year PDS Agreement.

Towards the end of 2009, the DH introduced a new model contract called the PDS+ Agreement. Many dentists and dental associations were concerned that this new agreement was a shorter-term contract than previously, that it favoured the PCTs and required management systems likely to be beyond the resources of small practices and even larger corporate ones. Updates to this draft agreement followed in early 2010 – most notably to the payment bands for key performance indicators (KPIs).

Since their introduction in 2006, dental contracts have often been criticised. Some dentists claim they encourage an ethos of ‘drill and fill’ in order to claim the Units of Dental Activity (UDAs) required under the contract. Some even suggest that it has encouraged ‘informed neglect’ – which are not words to be used lightly. However, when an investigation by NHS Protect subsequently uncovered £70m a year of fraudulent claims it was the death knell for these contracts.

In 2010 the government announced it would pilot three different models to help develop a new national NHS dental contract. Dental practices with existing GDS contracts or PDS agreements were invited to apply to become a pilot in December 2010. From the applications who met the criteria, a selection was made in order to reflect the diverse range of the practices across England, in terms of ‘rurality’, size, population demographics, and so forth. There was also a mix between corporate, independent and single-handed practices.

Seventy pilot practices went live in the summer of 2011, although not all at the same time – a staggered approach allowed flexibility to resolve any details with the PCT and the practice before signing the agreements, and gave the national team the capacity to support them through this process.

Support is provided via a national team that includes the Department of Health, NHS Dental Services and others. Clinical training for dental teams on the care pathways and support on implementing and using the software have been provided, as well as a range of events for both PCTs and practices, a dedicated regional support lead and an online helpdesk and resource network.

While the agreements make changes to the way dentists work and what they’re paid to do, they continue to receive payments and contract information from NHS Dental Services, and PCTs remain as the commissioner and contract holder with the practice for the next few months until they transition to the NHS Commissioning Board.

The new agreement would be designed to reward dentists for the ‘continuity and quality of care provided to patients, promotion of oral health and preventative measures as opposed to the number of units of dental activity undertaken’. At the same time, the dental outcomes and quality framework (DOOF) was launched to measure the quality of work carried out under the proposed new contract.

According to the DH: ‘It will be underpinned by the use of a standardised oral health assessment and the development of a comprehensive set of accredited clinical pathways.’ At the time of writing, the DH has just added 29 new practices to join the 70 already on the pilot scheme.

Following assessment of the experiences of the practices on the pilot scheme and a period of consultation, legislation will be brought before Parliament and, if approved, the new dental contracts are proposed to commence from April 2014.

Core pathways for patients form part of the pilots

‘In 2010 the government announced it would pilot three different models to help develop a new national NHS dental contract’
for Government Update published earlier this year, against the commitment to introduce a new dentistry contract the ‘What we have done’ comment was: We have established the pilot programme to test out elements of a new dental contract, and published initial findings in the autumn of 2012. We will continue to work closely with the NHS Commissioning Board to develop a new dental contract.

Meanwhile, a new health and care system in England will be in place from April of this year and Clinical Commissioning Groups (CCGs) will replace PCTs. CCGs will commission many of the services for their local community such as services provided by GPs, A&E, maternity services and so on. However, a new independent body, set up on 1 October 2012, called the NHS Commissioning Board (NHSCB) will commission all dental services (including primary, community and secondary care hospital dental services) and urgent and emergency dental care. The NHSCB will also commission a wide range of other health and care services such as primary ophthalmic services and pharmacy services. This is so-called Direct Commissioning.

The NHSCB takes up its full statutory duties from 1 April 2013 and terms itself a ‘special health authority’. It comprises a number of directorates, with Barry Cockerst, Chief Dental Officer, a member of the Medical Directorate. In addition, it has regional and area teams.

The NHSCB will draw upon the knowledge and expertise of local professional networks (LPNs) to secure local dental services. LPNs should be multi-disciplinary and include a local eye health network, a local pharmacy and, of most interest to us, a local dental network.

Local dental networks will have a wide ranging role – supporting practices, developing integrated care pathways, ensuring high quality standards are maintained and so on.

At the time of writing, NHSCB area teams are drawing up plans and budgets on the basis of them commissioning all dental services. However, the NHSCB document Supporting planning for 2013/14 for Direct Commissioning, dated 24 January, states (paragraph 7): ‘Discussions are continuing as to whether secondary dental care is better commissioned from a centre of expertise, this has not been finalised’.

For primary care the NHSCB currently has a number of priorities including the ‘safe’, ‘steady state’ transfer of dental (and other) PCT contracts to the NHSCB on 1 April 2015.

Following the anticipated publication of Securing excellence in commissioning NHS dental services in February 2015, the NHSCB will begin to develop national care pathways across all dental specialties in line with the outcomes of the new national NHS dental contract pilots. It will continue to support the dental contract piloting programme and plans to implement a new dental contract by 2014-2015 or even 2016!

The work PCTs are currently undertaking is predominantly to ensure that all independent contractors, including dentists, have a contract in place which is current, has all the relevant paperwork attached and is uploaded electronically onto the NHS secure server. It is advisable for dentists with an NHS contract to ensure such paperwork is in place, it is current, signed and dated, that the statements you receive from the NHS DS include the correct contract value, the correct amount of activity, your UDA value is what it should be and any outstanding variations to contracts such as partnerships etc. are in place as PCTs start to novate contracts to the NHSCB.
Health & Safety is a big issue in the present time. As a manager it is essential that you are ahead of the game and any changes affecting the Health & Safety of your staff should be implemented straight away, with regular reviews of policies. It’s also of little use having a policy and having no staff involvement. Each and every member should be aware of what is included in your policy and how it involves them. An ideal way is to ensure during induction you give all employees copies of what I consider to be the most important policies you should have, Grievance, Confidentiality, Health & Safety etc, certainly make sure that time is set aside for new employees to read through them plus all the other policies in place, obtain a signature of understanding and maybe during staff meetings it would be an idea to look at different policies and how it affects the employee and employer. Most importantly is to ensure that policies are reviewed at regular intervals and acted upon if necessary.

Today I am going to concentrate on New and Expectant Mothers in the Workplace and what is required by law to be implemented.

I don’t want to sound discriminative but as the majority of DCPs are women, this is one area in practice management that I can safely say one day you will come across the need for ensuring the legislation affecting New & Expectant Mothers is in place, not only to protect the staff but to protect you as an employer.

Legally a pregnant employee is required to give her employer three pieces of information:

- Prior to or on the 15th week before her estimated date she must inform you that she is pregnant.
- She must notify the confirmed date.
- The date she intends to start her maternity leave.

This should be given in writing and a form MAT B1 obtained by the employee and given to the Employer.

So as a manager I would like to think that I wouldn’t necessarily hold any pregnant employee to terms and conditions where pregnancy is concerned. Once you have been informed of a pregnancy you must acknowledge the notification of maternity leave within 28 days.
Where Health & Safety is concerned employers have a duty of care to protect the health and safety of their employees and pregnant employees, and nursing mothers have special duties that apply to them. It is therefore most important that any issues regarding health and safety should already be in place to cover those within this category.

A full risk assessment is required covering pregnant and nursing mothers. It is a good idea to already have a risk assessment for expectant and nursing mothers in place as you would be ready should it occur, however you would have to take into fact that all pregnancies are different and should the individual’s GP or Midwife give the employee medical advice that may interfere with their daily working life you would have to take this into consideration and adapt the risk assessment. However if the risks cannot be removed you would have to offer suitable alternative work.

When looking at a risk assessment for expectant or new Mums you would need to consider factors that would normally not cause a potential problem until pregnancy occurs.

In a dental practice exposure to Radiation would be a problem so that would be the first thing I would not allow the employee to do. Also:

- Lifting, bending and carrying.
- Standing, sitting in the same position for long periods.

Pregnant employees have legal rights - including paid time off for antenatal care, maternity leave and maternity pay. Pregnant employees have four rights:

- paid time off for antenatal care
- maternity leave
- maternity pay
- protection against unfair treatment, discrimination or dismissal

This includes any parenting classes recommended by a Midwife or GP. It is illegal to refuse time off for antenatal care, however fathers are not allowed time off to accompany.

Employers can’t change a pregnant employee’s contract terms and conditions without agreement - if they do they are in breach of contract.

Pregnancy-related illnesses

If the employee is off work for a pregnancy-related illness in the four weeks before the baby is due, maternity leave and Statutory Maternity Pay will start automatically - it doesn’t matter what has been previously agreed.

Should there be no other suitable work, which in hindsight if trained in Reception this could always be an alternative, however legally if no other suitable alternative work is available the employee has a right to be placed on maternity suspension and her wages remain as normal; this is only the case if alternative work has been offered and refused. The suspension can last up to four weeks before the expected date of arrival, when ordinary maternity leave starts.

All the employee’s employment rights are protected whilst on maternity leave:

- Pay rises
- Accrued annual leave

Statutory Maternity Leave

The employee can take up to 52 weeks of Statutory Maternity Leave providing the Employer is given the correct notice. You don’t have to take all of your statutory maternity leave but you must take two weeks compulsory leave before your baby is born.

Eligible employees can take up to 52 weeks maternity leave. The first 26 weeks is known as ‘Ordinary Maternity Leave’, the last 26 weeks as ‘Additional Maternity Leave’.

The earliest leave can be taken is 11 weeks before the expected week of childbirth.

About the author

Jane Armitage
Practice Manager of the Year 2005, 06, 07, 09.

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City & Guilds Dental Nurse Qualifications

Janet Goodwin highlights dental nurse education

In October 2005, Peter Mathias from City & Guilds and Stephen Lambert-Humble from NEBDN signed an agreement between the two organisations to develop and deliver dental nurse qualifications. After a short period of time the Scottish Qualifications Authority in Scotland also became part of this new tripartite agreement.

City & Guilds, who hold awarding body status with Ofqual and who are part of the National Qualifications Framework, would lead on the delivery of the theoretical and work based assessment aspects of the qualifications. NEBDN would deliver the final assessment/examination.

The new qualifications:

a. NVQ level 2 award in dental nursing
b. NVQ level 3 in certificate dental nursing

were formed around the National Occupational Standards devised by the Learning Skills Council. They provided a staged process for a dental nurse in achieving level 2 initially, then moving on to level 3. The units were a mixture of practical competence and theoretical knowledge delivered in training centres and dental hospitals throughout the UK.

This new way of delivering professional dental nurse qualifications saw the development of new roles, and the introduction of funding for certain age groups of students. This concept saw the emergence of Youth Training Scheme and different types of registered and approved training centres.

The new roles consisted of:

a. Assessor – who confirms that the evidence provided by a student for assessment has been produced and authenticated in accordance with the requirements of the assessment specification.

b. Internal Verifier – who ensures that the assessors are consistent in their interpretation and application of the standards within the award, and the accuracy and consistency of assessment decisions between assessors is maintained.

c. External Verifier – who has a dual role – verifying the performance of the centre to ensure the quality and consistency of assessment against national requirements, and supporting and advising the centre on improving the effectiveness and quality of assessments.

The final examinations for the qualifications: ie the Vocationally Related Qualifications were available three times a year in March, June and December.

Present Day

In 2008, both the level 2 & 3 were due to be reviewed as they had reached their five year term; this review coincided with the introduction of statutory registration of dental nurses by the GDC.

The GDC had accepted that the registrable qualification would be the revised level 3 Diploma 4254 in dental nursing; therefore many centres found that the delivery of a level 3 Award 7393 now has little value for dental nurses and it is being withdrawn from December 2012.

The reformatted Level 3 Diploma qualification which has 46 credits and 291 guided learning hours consists of:

Unit 301 Ensure your own actions reduce risks to health and safety

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Unit 503 Emergency First Aid
Unit 504 Prepare and maintain environments
Unit 505 Offer information and support to individuals
Unit 506 Provide chairside support during the assessment of patients’ oral health
Unit 507 Contribute to the production of dental images
Unit 508 Provide chairside support during the prevention and control of periodontal disease and caries and the restoration of cavities
Unit 509 Provide chairside support during the provision of fixed and removable prostheses
Unit 510 Provide chairside support during non-surgical endodontic treatment
Unit 511 Provide chairside support during the extraction of teeth and minor oral surgery

The nine units above are focused on the practical aspect of the role of dental nursing and assessed by a work based portfolio.

Unit 512 Principles of Infection Control
Unit 513 Assessment of oral health and treatment planning
Unit 514 Dental Radiography
Unit 515 Scientific principles of oral health & dental procedures

The further four units are focused on the theoretical aspects, and are assessed via an hour and a half examination, which is taken at the student’s training centre in March, June and December.

The Level 3 qualification also moved into the Apprenticeship Framework, and along with the units above, students also have to complete:

a. Functional Skills in English, maths and ICT (if they do not possess GCSEs level C or above)
b. Employers’ rights and responsibilities

during the last year, the contract between the three parties has expired, and City & Guilds now set their own papers and have their own bank of markers, and Chief Examiner.

There are many centres around the UK delivering the qualification with between 500 – 700 candidates undertaking the assessment at each sitting.

Future
During late 2012-early 2013, City & Guilds have been working to move the examination to an electronic format - a working group has been building up a bank of questions around the four theoretical units, which will then form the basis of each paper.

The examination will be based on 60 questions over a 1 ½ hr examination. Centres will be able to let their students complete the examination on demand, as every paper will be unique.

The advantages of this system will be:
1. Flexibility
2. Cost effectiveness
3. That detailed results will be available immediately
4. That centres have more control on candidate assessments
5. That assessments are available on demand

Other changes that have been or are taking place include:

a. The National Occupational Standards for Dental Nurses were revised last year and are now published on the Learning Skills Website.
b. The GDC Learning Outcomes – Preparing for Practice, dental team learning outcomes for registration, have now been published.
c. The City & Guilds 4251 Diploma is due to expire and be reviewed at the end of December 2015

So where does this leave City & Guilds?
These changes give City & Guilds the opportunity to re-design and develop a Diploma in the future that is accessible, robust, and fit for purpose.

About the author
Janet Goodwin was born in Bradford in West Yorkshire. Janet now works in the Blackpool area and since 2005 she’s worked as qualifications manager for the National Examining Board for Dental Nurses. She is already involved in some work with the General Dental Council. Since 2002 as an invited professional, she’s been involved in working groups for dental nurse registration, overseas registration and DCP education. Janet is currently working with the Faculty of General Dental Practice to help develop ICP integration within their educational programmes.

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For more information call Dr Benshall on 01269 733 146, email info@brenalondental.com or visit www.brenalondental.com

Practice of the Year wins Urbania Award
Manchester Dental Care in the Broadwalk area of Manchester has recently been named British Dental Association (BDA) Good Practice of the Year 2013, according to an indication from Graham Gamble Ltd. With exceptionally high standards of patient care, a wide range of available treatments and an ongoing commitment to continuing development of staff, Manchester Dental Care received a high and modern image that reflected the ethos of the practice. Nicola Barard, Practice Manager says: “We are very proud of our practice, but more of a traditional boutique. We have had a significant amount of feedback from our patients, so using such a bold time line for our new design was a very brave step and we were initially very apprehensive. However, since the day one we opened the final image we have cultivated using Urbania, the selection of shades complement each other well to create a bright, clean and welcoming atmosphere. Staff wear white ties worn with pink, dentists wear all black and hygienists black with a pink trim. All gowns were supplied with the option of incorporating the Manchester City football logo. Manchester Dental Care were selected for this accolade from 1,800 members of the Good Practice Scheme, which Manchester Dental Care have been participating in for 10 years. Two practices were shortlisted and 300 patients were then judged on a number of criteria including patient communications, the care pathway and team training. For further information on Graham Gamble their products and services take a look at www.grahamgamble.co.uk or call 0161 205 6326.” For further information on this press release please contact 0116 208 1816, mobile or e-mail billy.ubr@btinternet.com

Pronamel reels in red dot design award for SIRIUS
SIRIUS naturally ranks among top 25 of over 4,500 design products - SIRIUS was presented with the award at the red dot gala. Patients notice the comfort and design of SIRIUS – but new research, conducted for Pronamel, throws light on just how often this condition is seen in practice.

In a survey of 200 dental professionals, conducted in January 2013, 83.5% said they had seen patients with this type of erosion in the last 1,000 patients, however 81% felt that the condition was on the increase. Patients are also aware of the problem. Nearly 60% of dentists reported that an increasing number of patients were expressing concern to them about Acid Wear. 89% of dentists agreed that Acid Wear posed a significant threat to patients’ oral health.

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- Worcester | Friday 15 March
- Belford | Friday 19 April
- Glasgow | Friday 16 May
- Wigton | Friday 7 June
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The ideal introduction to occlusion
Onset in Everyday Practice, organized by BDA and presented by Dr. Laurence Munns, provides the ideal introduction to the principles of occlusion and how they affect restorative, periodontal and orthodontic treatments. Practitioners will also be able to develop their understanding and management of headache cases. In addition, the seminar includes TMJ anatomy and function and the use of appliances. Faculty- and university-approved, worth 7 verifiable CPD hours, the course will also be able to develop their understanding and management of headache cases. The first 60 minutes of this session will be available online for those who are unable to attend the day course. Dr. Ricci will also be presenting a seminar on practical occlusion and a hands-on workshop in occlusion.

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Dr Richard Kahan at BDA 2013
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2 DAY INTENSIVE HANDS-ON
APICOECTOMY TRAINING UNDER MICROSCOPE

SUBJECTS COVERED
- treatment planning and considerations
- incision techniques and micro-suturing
- osteotomy window
- ultrasonic retrograde preparation and filling
- bone augmentation

This course is intended for the serious generalist, special interest dentist, specialist endodontist or oral surgeon who wishes to extend his/her knowledge and expertise. The hands-on training will forcibly and will positively impact the trainee’s confidence and skill for this challenging and important treatment option after failed root treatments.

The hands-on training will include preparing approaches on at least 6 extracted teeth set in phantom heads with the use of microscopes and more.

Please phone Dr Zolty BDS MSc:
0161 792 5223 or 07780 901 916
or email info@proendo.co.uk for more details.
Sessions are limited to 10 participants and are booked on a first-come-first-served basis.

£649.00 per day

🎯 AIMS: to advance the standard of surgical endodontics.
🎯 OBJECTIVES: to obtain a full and current knowledge and skill to perform microsurgical endodontics with confidence. The hands-on training will provide not only the necessary skill but ensure there is coherence in its implementation.
🎯 OUTCOME: the participant will obtain information for treatment planning and the necessary skill to perform the complex endodontic surgery.

14 hours cpd
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Highly precise transfer without transfer aid

Simple abutment positioning through three grooves and cams

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