New reports spark debate on refined sugars in savoury foods

AFTER a much desired Easter break, with plenty of chocolate consumed in a more than average quantity, sugar has become the hot topic of debate to hit the headlines; but it’s not the chocolate that has highlighted this fresh concern.

A controversial New York Times Sunday magazine cover story ‘Sugar Triangle’ has proposed that sugar, in all its sweetness, may actually be toxic, and there are even suggestions that it could be as dangerous as cigarettes and alcohol.

But how much is too much? And is the source of the sugar important? Figures demonstrate that sugar consumption in the UK has increased by more than a third since the 1980s and even though people are consciously putting less sugar on their cereals or in their tea, many are being caught unaware in the secret sugars that are hidden in even the most savoury of foods.

The extent of the secret sugar problem has recently been discovered by BBC Scotland Health Correspondent Eleanor Bradford, who after giving up refined sugar for Lent became increasingly aware of the hidden sugar content in almost every food; including bread, mayonnaise and even crumpets.

Dentists are becoming increasingly concerned about the amount of sugar people are consuming, and dentist Kieran Falloon, a spokesman for the British Dental Association, expressed his concerns about the effect of sugar consumption: “As dental students we were always made aware of hidden sugars. People should look at the breakdown of percentages per serving: Putting it in perspective five grams = one teaspoon of sugar.

“For an alternative snack eat whole fruit, not pulped fruit as this releases sugars. Also giving dried fruit to children between mealtimes can be just as bad because when fruit is dried the sugar becomes concentrated. Whole cheese, not processed cheeses (especially those that are aimed at children because these contain sugars), can also be recommended.

“With regards to there being hidden sugars in foods I absolutely agree that there is too much. Manufacture’s believe that they have to add flavourings, such as salt and sugar, to their products to make them attractive. Even cooking sauces have sugar, which means that what you are eating isn’t as healthy as you think.”

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, said: “For many years dentists have recognised the large amounts of sugar in many foods where it is often added as a cheap bulking agent.

“Looking for hidden sugars often listed as sucrose, maltose, glucose, fructose etc can help the public cut down on how often they have sugary foods and drinks and help with both dental health and obesity.”

A spokesperson from The Sugar Bureau said: “A reanalysis of data from two dietary surveys of British school children, 1985 (Department of Health) and 1997 (National Diet and Nutrition Survey), found while BMI increased 2-3kg, there was no significant change in total sugars intake over that period.

“In this study key sources of sugars in the diet did change with a marked shift away from table sugar and milk, biscuits and cakes, counterbalanced by a significant increase in soft drinks and, to a lesser extent, fruit juice and breakfast cereals.

“The authors of this paper concluded that reduced energy expenditure, rather than dietary factors, is more likely to be a cause of increased BMI’s recorded in children over this time.

“The amount of sugars consumed is not considered the primary dietary factor associated with carries development. According to the most recent review of the scientific evidence by EFSA (2010).”

“Sugar does not depend only on the amount of sugar consumed, but is also influenced by oral hygiene, exposure to fluoride, frequency of consumption, and various other factors.”
MRSA discovered on braces

A recent study has revealed some of the bacteria found on orthodontic retainers, research after orthodontic treatment is completed, can be associated with the hospital superbug MRSA, a condition which can lead to blood poisoning.

The research, carried out by the UCL Eastman Dental Institute in London, also found a further two thirds of retainers examined contained a type of yeast connected with fungal infections, with both types of organism found potentially harmful to the population.

According to the British Orthodontic Society, nearly one million people in the UK began orthodontic treatment last year, and with more adults than ever before wanting treatment, Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, took the opportunity to encourage those who wear removable braces or retainers to develop high standards of oral hygiene.

Dr Carter said: “If you wear a removable appliance, it's important you take the time and effort needed to keep your teeth and braces clean. If you have good oral hygiene while wearing a brace, this will help avoid developing problems such as dental decay, gum disease and tooth decalcification, and can often be the difference between a successful course of treatment or otherwise. Removable appliances should be cleaned with a brush soak brush method of cleaning using an effervescent denture cleaner to help remove the bacteria and other organisms from the surface of the appliance. Simple things such as washing your hands before touching anything that can come into contact with your mouth can go a long way to reduce the risk of infection.”

Living with a brace can, at first, also feel a lot more. However, there are many more.

Responding to the Red-Tape Challenge

The British Dental Association (BDA) is calling on the profession to join in the government’s Red Tape Challenge by drawing attention to the myriad rules and regulations that distract them from providing patient care. An example is the disproportionate and duplicative regulatory requirements imposed by the Care Quality Commission, but there are many more.

The BDA welcomes this initiative, which government ministers say not only offers the public an opportunity to say what they really think of unnecessary regulation, but also commits them to repealing legislation that cannot be justified.

In a new pledge to get rid of unnecessary red tape, government departments will have to justify every single set of the 21,000 statutory rules and regulations in force today. Taxation, national security, and EU laws, are the only areas exempt from this scrutiny which will take place over the next two years. The exercise will apply to legislation in Northern Ireland, Scotland and Wales, where the government has jurisdiction.

Commenting on the Red Tape Challenge, Dr Susie Sanderson, Chair of the British Dental Association’s Executive Board, said: “This initiative chimes in well with the BDA’s long running campaign against red-tape in dental practice. Specifically, we will be asking members to suggest removing dental providers from regulation by the Care Quality Commission and from licensing by the new healthcare economic regulator, Monitor.

“Our members have also told us that they are fed up with the ever burgeoning, and costly legislation that falls into the realm of ‘law box-ticking’, rather than an evidence base for the need for compliance by dental practitioners.

“It’s vital though that this red-tape initiative is not just window dressing and that we see some real reduction in the unnecessary and unjustified regulatory burden that hampers dentistry.”

Substance-dependent individuals report poor oral health

Researchers from Boston University have found that the majority of individuals with substance dependence problems report having poor oral health. The researchers also found that over the period of a year opioid users in particular showed a decline in oral health. The findings appear online in the Journal of Substance Abuse Treatment.

According to reports, public health, dental medicine and internal medicine faculty from Boston University investigated the effects of different substances on oral health among a sample of substance-dependent individuals. Alcohol, stimulant, opioid and marijuana users were included. The subjects were asked to self-report their oral health status on a five-point scale ranging from poor to excellent.

Statistical analysis of the patients’ reports found no significant associations between the types of substances used and oral health status. The results did show, however, that 60 per cent of all subjects reported fair or poor oral health. Opioid users in the sample also exhibited worse oral health compared to one year ago.

“We found that the majority of our sample reported fair or poor oral health,” said Meredith D’Amore, MPH, a researcher in the Health Care Disparities Research Program at Boston University School of Medicine and Boston Medical Center. “Thus, oral health should be considered a significant health problem among individuals with substance dependence and providers should be aware of potential oral health issues.”

The researchers hope that their findings prompt more oral health interventions targeted toward individuals with substance dependence in the future. They also suggest that engaging addiction treatment or otherwise. Removable appliances should be cleaned with a brush soak method of cleaning using an effervescent denture cleaner to help remove the bacteria and other organisms from the surface of the appliance. Simple things such as washing your hands before touching anything that can come into contact with your mouth can go a long way to reduce the risk of infection.”

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Dentist defrauded NHS

It has been reported in a local newspaper that a dentist who defrauded the NHS in order to treat deprived patients has been suspended for two years and handed a 12-month jail term.

It was reported that Bristol Crown Court heard that Dr Jonathan Hunt had a £323,000-false accounting between March 2005 and October 2007. The fraud was uncovered as a banking officer asked members to suggest exempt from this scrutiny which will take place over the next two years. The exercise will apply to legislation in Northern Ireland, Scotland and Wales, where the government has jurisdiction.

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As I write this the sun is shining, it's getting too warm to work indoors and in a couple of days the Easter Bunny will be delivering a large pile of delicious chocolatey treats for my already hyperactive kids (not from me I hasten to add, they have two competitive, sorry, doting grandmothers...).

Renewal of Brunei agreement

King’s College London Dental Institute can look forward to three more years of collaboration aimed at the development of the dental workforce in Brunei Darussalam after the renewal of the agreement with the Government of Brunei. Professor Stephen Dunne, Head of Dental Practice & Policy at the Dental Institute and Mrs Mabel Slater, Head of Dental Care Professionals Centre for Education and Learning will take this collaboration forward.

In welcoming the news of the signing of the renewal of the agreement, Professor Dunne said: “I am delighted that we are continuing this highly successful collaboration. It is a great pleasure to work with Ministers and colleagues in Brunei Darussalam. Much has been achieved during the past three years, in particular, the establishment of a Brunei Diploma in Dental Hygiene and Therapy Programme.

“In addition, foundations have been laid for other areas of workforce development, including Dental Technology and a Dental Hygiene Therapy Conversion Programme. Discussions are also underway to establish a National Survey of Oral Health Brunei Darussalam to fully inform dental workforce requirements for the future. Thus, I am confident that the next three years of our collaboration will be just as successful as the last.”

In the meantime, discussions, being led by the Dean, continue with the University of Brunei Darussalam in respect of the possibility of collaboration in respect of BBS (Bachelor of Dental Surgery) training.

I don’t know if dental professionals love or loathe this time of year – all that sugar and chocolate and gooey things just waiting to be scoffed against every bit of advice given at dental appointments, or the kind of cariogenic situation that gives fuel for the oral health instruction! (and I bet you thought I was ‘going down the more work for me’ route...)

Needless to say I hope that everyone enjoyed a peaceful time during the Easter break and are looking forward to the mayhem that will be the Royal Wedding and May Day!

Of course it would be remiss of me not to mention the upcoming Clinical Innovations Conference, just two weeks away. To be held May 6-7 at the Royal college of Physicians in Regent’s Park, London. Not only will some of the world’s top speakers be there, but you’ll also have a chance to see me as I will be attending! For more information about the event go to pages eight, nine and 50 of this issue.
Dentist sees the future with optician partnership

A joint venture partnership in dental business is opening its first practice in a high street optician in Dundee, Scotland.

A.S. Optometrists has bought an Ideal Dental Care franchise and has set up the fully branded concession within its practice offering both NHS and private treatments.

It’s a ground-breaking move for Ideal Dental Care and owner Peter Thompson is keen to demonstrate the success of the new model — both in terms of the wider range of healthcare provision available to patients under one roof and also the potential business opportunities for optical companies looking at innovative ways to expand their service proposition.

“There is an immense amount of synergy between dental and optical businesses and it’s a fantastic opportunity for A.S. Optometrists to further enhance the range and scope of healthcare treatments it can offer its patients,” said Peter.

“In a competitive marketplace it’s important that businesses such as opticians have a point of difference and having a complementary service such as a dental practice can only be a good thing in retaining existing patients and attracting new ones.”

A.S. Optometrists has its first dentist in place ready for its mid-April opening and owner Ameen Sattar already has a large number of customers who have joined the waiting list to become patients.

“We are acutely aware of the needs of our patients and one thing that came through loud and clear was the demand to have a range of healthcare professions under one roof,” Ameen Sattar said.

“Franchising is common place within optometry but is still in its infancy in the dental industry — which really surprised me. But it’s good to see that there are forward thinking business people in dentistry such as Peter Thompson who is making it work both as a standalone and concessionary practice.”

Go ‘Absolutely Dental!’

The British Dental Health Foundation wants dental and health professionals to go ‘Absolutely Dental’ during NationaSmile Month by helping to plot hundreds of street and place names with fun dental themes.

The Foundation has published the first ever UK Dental Place Map, and it is hoped that everyone involved in dentistry and the health professions will add to the map and join in the fun in time for the start of National Smile Month on 15 May 2011.

Some of the many addresses and locations plotted on the map so far include Floss Street (London), Drill Lane (Cambridge), Bristle Avenue (Gwent), Mooth Lane (Wisbech), Canal Street (Leeds), Surgery Lane (Hartlepool), Wisdom Drive (Hertford), Tartar Road (London), Smiley Court (Northen Ireland), Bearcebridge Street (Nuneaton).

IGNITE YOUR PASSION FOR DENTISTRY

Would you like to boost your clinical knowledge, skills and career prospects with the help of some of the leading thinkers in the dental profession?

How about being one of the first to discover some of the most advanced pieces of technology currently on the market.

And how about topping it all off with a night on the tiles in Manchester’s vibrant town centre? The British Dental Conference and Exhibition 2011 19th-21st May 2011 offers dental care professionals all this and more.

In collaboration with Oral B, the event team of organiser has put together a series of sessions specifically designed for dental professionals. For the first time the BDA is providing a DCP theatre within the exhibition, offering a series of 21 bite-sized lectures on a variety of inspiring topics, all absolutely free!

On 19th May speakers will cover subjects including:
• Fear-free dentistry
• Medical emergencies — allergies and allergic reactions
• How to integrate prevention into your daily practice
• Periodontal health
• A-Z of running a successful practice
• The dental nurse as a registered professional
• The prevention of oral cancer

On 20th May speakers will cover subjects including:
• Good record keeping
• Peridontal health
• Boost your profitability with business planning
• How social networking can help promote your practice
• Smoking cessation

Places are available on a first-come, first-served basis throughout the day, enabling you to drop in and out as you please. This year’s exciting programme of lectures and seminars in the main hall is not to be missed.

Featuring a variety of leading speakers from around the world, dental care professionals will be spoilt for choice.

For more information visit www.bda.org.uk/conference or call 0207 955 0875.

Four practices win £500 each

Dental practices across England and Wales have been participating in the BDTA’s ‘Kick out the sweets, bring the treats’ Change4Life campaign for the past six months; displaying posters, encouraging patients to complete questionnaires and delighting their young patients with colourful stickers.

More than 2000 completed questionnaires have now been returned by the general public and four practices responsible for generating some of these responses have been selected at random as winners of the BDTA member gift voucher prizes.

The lucky winners were:
• The Robert Wakefield Dental Surgery, Driffield
• Ghylilmount Dental, Penrith
• Nabil & Nabil Dental Care, Essex
• The Dental Care Centre, London

Tony Reed, (pictured), Executive Director at the BDTA, commented: “Many dental practices were keen to be actively involved with the BDTA’s Change4Life campaign which was very encouraging as it was a perfect way to get children interested in dental health. Thank you to all the practices who promoted the campaign and congratulations to the winners!”

The winners were:
• Nabil & Nabil Dental Care, Essex
• Ghylilmount Dental, Penrith
• The Robert Wakefield Dental Surgery, Driffield
• The Dental Care Centre, London
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**Happy the Hippo here to help**

Happy the Hippo has been recruited by the British Dental Health Foundation to help teach young children how to look after their teeth. Around one third of children under the age of 12 in the UK continue to suffer from dental decay. Happy will be joining the Foundation in May to help lead the 55th National Smile Month campaign.

Despite major improvements in children’s oral health over the past 40 years, many children are still being affected by dental decay. The most recent data suggests that around a third (31 per cent) of five year olds starting primary school will have dental decay. The picture is slightly worse for children aged 12 in secondary schools – one third of children in every classroom will have signs of visible dental decay.

The theme of this year’s National Smile Month campaign is the ‘Smile Factor’. In adulthood peoples’ mouth, teeth and smiles are fundamental to all aspects of their life – whether career, personality, relationships, attraction or all-round good health. Creating good oral health habits from an early age are especially important to help children keep their smile factors throughout their lives.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, says: “Over the past 40 years we have made great improvements in children’s oral health. In 1975, nine out of every ten children aged twelve showed signs of visible dental decay. However, the incidence of dental decay still remains too high and we hope that Happy the Hippo will show more children how to look after their teeth better.”

**Enzyme could fight caries**

DTI. The bacterium Streptococcus salivarius, a harmless inhabitant of the human mouth, inhibits the formation of dental biofilms (plaque). Japanese researchers have discovered that the bacterium produces the FruA enzyme, which inhibits the development of plaque.

In their study the scientists separated a couple of substances produced by Streptococcus salivarius and tested their impact on Streptococcus mutans, the primary species of bacteria inhabiting the mouth and main factor for the formation of plaque. The authors suggest that FruA may actually regulate microbial pathogenicity in the oral cavity.

“We show that FruA produced by Streptococcus salivarius inhibited Streptococcus mutans biofilm formation completely in the in vitro assay supplemented with sucrose,” the researchers state in their study, which was published in the March 2011 issue of the journal Applied and Environmental Microbiology.

The researchers say the activity of the inhibitors was elevated in the presence of sucrose, and the inhibitory effects were dependent on the sucrose concentration in the biofilm formation assay medium.

FruA is produced not only by Streptococcus salivarius, but by other oral streptococci. Much of the oral microbial flora consists of beneficial species of bacteria. They help maintain oral health and control the progression of oral disease.

According to the science portal wissenschaft.de, a major step in fighting caries could be taken if the researchers find a method to implement FruA into a dental health product.

**New Appointments at James Hull Associates**

James Hull Associates is delighted to announce two new senior appointments as it further strengthens its board.

Current CEO Robin Pugh, (pictured left), will step up to Chairman after successfully guiding the business through its recent refinancing. Robin will take up the role of Chairman leaving vacant since the departure of Graham Hutton of Hutton Collins. Robin said “This is an exciting point in the development of the Group and I look forward to working with the team to take the business forward as the UK’s leading provider of specialist dental services.”

Robin will be replaced as CEO by Bryan Magrath, (pictured right), who joins James Hull Associates after a long and successful career with some of the UKs leading blue chip retailers. Bryan’s experience in customer facing organisations will be vital in helping James Hull Associates become the UK’s dentist of choice both for general and specialist care. Bryan said “I’m delighted to be joining James Hull Associates and the world of dentistry. The sector is changing rapidly and JHA is ideally positioned to take advantage of the developing market. I look forward to learning from the team around me and being part of the next phase in the development of JHA.”

JHA is a UK provider of specialist and general dental care with 74 practices nationwide, all dedicated to providing the highest standards of clinical care and customer service.
Pilots designed to test the proposed changes to the new dental contract have been delayed from an initial start date of April until sometime during the summer. This hold up has been the result of delays in the implementation of necessary software and IT training.

Mid-summer

Also, regulations for the governance of the pilots need drafting. In a letter to participating practices from David Lye, Assistant Director, Dental and Eye Care Services, Department of Health, he reports that suppliers expect software and IT training by mid-summer.

He reports that suppliers expect services from David Lye, Assistant Director, Dental and Eye Care Services, Department of Health, Director, Dental and Eye Care Services, Department of Health, to receive IT training by mid-summer.

The new software being implemented across the pilot sites will support the Dental Quality and Outcomes Framework (DQOF) underpinning the trials, which will assess the quality of the work being carried out and the clinical outcomes used to calculate remuneration; for the first time this will be based on patient care rather than on the number of procedures being carried out.

The software being implemented will allow efficient data collection and reporting. Support and training will be provided to pilot sites, which will include clear clinical definitions, for example active decay and BPE (basic periodontal examination). Training will also be provided on the use of the oral health assessment.

According to the Department of Health, monitoring and evaluation will be a continuous process throughout the life of the pilots, which will help to inform the utility of the proposed measures and their subsequent development for inclusion in the new contract.

Continuity of care

The pilots have been designed to improve the quality of patient care and increase access to NHS dental services, with the added objective of improving the oral health of children. The contract aims to reward dentists for the continuity and quality of care provided to patients, instead of the number of treatments undertaken.

In December 2010 it was announced that the trials would start in April 2011, however last week the Department of Health announced that the pilots will begin in the summer across 62 practices in England which have been selected to participate. According to Ben Atkins, Clinical Director of participating practice Revive Dental Care, the delay in the pilots has not resulted in an inconvenience: “The proposals of these pilots mean a change in mindset as it is a totally new system. However, we have received full support over the training issues. I can understand why the Department of Health would want to delay the start date as they won’t want to get it wrong.”

Get it right

Health Minister Lord Howe commented: “It is important that we take our time to get this absolutely right. We want our reforms to give dentists the encouragement they are looking for to provide a service that meets the needs of today’s population, and which fosters positive habits from an early age.”

“This approach is not only better for patients, but also a better use of NHS resources.” He added.

Each model being piloted will be slightly different in order to provide information and evidence on various aspects of the proposals; this will help inform better the development of the new national contract. Months of preparation have gone into the pilots.

Professor Jimmy Steele, who was a member of the National Steering Group that developed the proposals, said: “The Adult Dental Health Survey showed further improvements in oral health in England. We now need an NHS dental service to match; one that maintains good oral health as well as providing appropriate treatment. The dental contract pilots will explore how best to make this a reality but it is important to get it right, so time spent setting this up properly is time well spent.”

The British Dental Association has indicated their approval of the proposed changes and hope that problems created by the current arrangements will be addressed. They also stress the importance of making sure that all areas are covered before starting the pilots.

John Milne, Chair of the BDA’s general Dental Practice Committee, said: “The profession is working closely with the Department of Health and we are pleased to see that progress towards beginning the pilots is being made. Dentists who have been selected to participate and primary care trusts are being kept up to date with developments and training on aspects of the pilots including IT arranged.

Taking opportunity

“It’s important that this training, and indeed the whole process, is given the time it needs. These pilots must not be rushed. They are an opportunity to get NHS dentistry back on track. That opportunity must be taken.”

Software and IT training delays postpone contract pilot start

Dental Tribune’s Maria Anguita looks closer at the delay to the start of the pilot schemes which aim to reform NHS dentistry.

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What went wrong?

Eddie Scher previews his forthcoming lecture

“You should always learn from other people’s mistakes, especially in surgery.” This was a favourite saying of my father’s, and it is just as true today. In my lecture at the Clinical Innovations Conference, I will share some of the problems that have been seen in my practice. Most of these were in patients referred to me when things have gone wrong – as of course they sometimes will. From these problem cases, I will show in my lecture first, what could be done to help the patient and solve the problem, and secondly, the lessons to be learned that will improve our own practices and help us avoid making the same mistakes. This will be in three key areas: treatment planning, surgery, and prosthetic restoration.

In this article, I set out some of the questions that will be answered in my lecture.

Errors in treatment planning
The best way to avoid making errors in treatment planning is to know when to say ‘no’. There are some cases where implants simply are not the right solution.

Errors in surgery
Errors in surgery are the most difficult to manage. However, even when guided surgery is inappropriate, a CT scan can be used. This may show, for example, serious difficulties such as when the inferior dental nerve is at the crest of the ridge (Fig 5). As I will show, guided surgery and/or a CT scan should be combined with a detailed protocol of other steps to best manage risk when operating in the posterior mandible.

Another nightmare scenario is losing an implant during surgery. This happened to the operating surgeon in Figure 4. With a careful look at the x-ray you will see where the lost implant ended up: I will explain in the lecture how to get it back out.

Flapless surgery can also be problematic. The patient in Figure 5 was referred to me as having had a simple extraction but you will have to come to my lecture to see how.

Errors in prosthetics
Figure 1 might be one such example. This young lady was referred to me with a special request. Something has obviously gone wrong with the implant placement. Can her smile be recovered in time for her wedding? The answer will be yes (Fig 2), but you will have to come to my lecture to see how.

Errors in prosthodontics
Placing implants too close together is an error we will all see: Figure 12 for example is obviously a difficult clinical situation. How, though, can we take an impression of two posts so close together?

Another extraordinary case is in Figure 15. What could have caused this patient’s pattern of damage?

I look forward to sharing the answer will be yes (Fig 2), but you will have to come to my lecture to see how.

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*England only.
answers to these questions with you at the lecture. I would also end with this final word of caution: proper training and experience in implant placement is exceptionally important to avoid mistakes and accusations.

I would invite any aspiring implant surgeon to attend my six-day course, or another course with proper accreditation.

About the author

Dr Scher graduated from University College Hospital, London, UK in 1973. He is registered on the GDC Specialist List in Oral Surgery and Prosthodontics. He is a Visiting Clinical Professor at the Prosthodontic and Implant Department, Temple University, Philadelphia, USA. He is also a Member of Faculty at Lyon University, France, and an Honorary Senior Lecturer in Dental Implantology, School of Health Care Professions, University of Salford, UK. He is also Honorary Lecturer at the Eastman Dental Hospital. Dr Scher is a Fellow and Diplomate of the ICOI, a Director on its Board. He is also a founder member and past President of the Association of Dental Implantology, I.K., and still serves as an elected board member. He also holds a Diploma from the American Society of Osseointegration. He is the Director of the Osseointegrated Implant Course (now in its 20th year), and is the chairman of the editorial board of Implant Dentistry Today. He is published extensively in refereed journals. Dr Scher was Scientific Chair of the ADI International Symposia in 1989 and 1991, and was Host Chairman of the ICOI World Congress XI, 1992. He has also been Scientific Chair of ICOI World Congress August 2003 and 2004; Scientific Chair of ADI International Congress in May 2005; Scientific Chair of Nobel Biocare Conference in September 2006; and Scientific Chair of ADI International Congress in May 2007. He is President of Alpha Omega UK 2008/9.
The litigation arising from the change in dental contract continues to be a significant issue in the United Kingdom. The recent High Court Judicial Review in Ex p Ikhtlaq Hussein and two others v Secretary of State for Health v Warwickshire Primary Care Trust [2010] EWCA Civ 3551 (see www.bailii.org) could have some financial implications for some GDS contractors. The NHSLA's decision to set aside the matter back to the NHSLA was potentially includable within the employer's GDS Contract.

The facts

There were three claimants, with essentially, parallel cases. In April 2006, PCTs issued GDS Contracts, which came into effect in 2006, and there have been some financial implications for some GDS contractors. The PCT was potentially includable within the employer's GDS Contract. The NHSLA's decision to set aside the matter back to the NHSLA was potentially includable within the employer's GDS Contract. The High Court has referred the matter back to the NHSLA for further consideration of the appropriate activity level/contract value of such employees in the principal's GDS Contract.

Implications for General Dental Practitioners

Other general dental practitioners may have been similarly affected in 2006, by their PCTs issuing GDS Contracts to employed dentists, and not including the baseline activity/contract value of such employees in the principal's GDS Contract.

Can any such aggrieved contractor bring a claim at this stage or is it too late?

What might the value of such a claim be? Both issues may be dependent on the NHSLA's decision following the remission back to them of the Hussain case, for further consideration of the appropriate activity level/contract value and, no doubt, the NHSLA will report the outcome in due course.

The rationale behind the legislation was that the size and value of the practice was to be protected, to ensure funding was in place for the number of patients serviced by the practice, including its employed dentists. When a particular employee left the practice, it was to be able to replace the departing employee with another dentist, so as to continue to honour the demands of its patients.

If the departing employee effectively took "his" NHS funding with him, the employer's practice was being diverted. The intention of the legislation could not have been to encourage employed dentists to leave their employer, taking with them goodwill, which the employer had built up.

High Court Review

In a nutshell the High Court concluded that the adjudicator's decision must be set aside for error of law. Where work had been undertaken during the baseline period, by employee or assistant dentists, such activity and contract value was potentially includable within the employer's GDS Contract.

Where to Now

The High Court has referred the matter back to the NHSLA for further consideration of the appropriate activity level/contract value and, no doubt, the NHSLA will report the outcome in due course.

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For potentially affected contractors reading this article, it is clearly too late to refer the matter to the NHSLA. There is a three year "limitation" period in disputes to the NHSLA, the time running from the date of the claim (likely to be March 2006, or at the latest 1st April 2008).
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Actions for breach of contract must be brought within six years

'The general rule is that damages for breach of contract are such losses as may have been reasonably foreseeable when the breach took place'.

Are there any other causes of action?

There may be two possibilities.

1. Firstly there may be an action for "breach of statutory duty". The framework for calculating the level of activity and contract value is a statutory framework. If the PCT failed to carry out such calculations properly they have failed in their statutory duty, enabling a claim to be brought.

2. Secondly there may be a claim for breach of warranty under clause 23 of the GDS Contract. By those warranties the PCT promised that "all information in writing which is provided to the contractor specifically to assist the contractor to become a party to this Contract was, when given, true and accurate in all material respects". Under clause 25 are further warranties, for example, that no relevant information has been omitted.

Under the provisions of the 2005 Transitional Provisions Order (which sets out the framework for the transition from the "old" section 35 arrangements to the "new" arrangements), the responsibility for analysing the baseline year data, was specifically given to PCTs. "It might be arguable that if incorrect calculations had been made to the contractor's baseline UDAs and contract value, the relevant PCT had been in breach of warranty." This could lead to a claim for damages for breach of contract.

Actions for breach of contract must usually be brought within six years from the date of the breach in question, so care needs to be taken with limitation periods.

A contractor contemplating action should also ensure that they had not elected, in their Contract to be regarded as a health service body (clause 14) restricting action only to the NHSLA (with the three year limitation period problem). It might be sensible to seek an early "opt out" of clause 14, which is possible under Regulation 9 of the National Health Service (General Dental Services Contract) Regulations (Regulation 9(4)). A contractor may, "at any time" request a variation of the Contract to remove the election from health service body status.

Any such opt out should be in place before any proceedings were commenced.

What might a claim be worth?

Firstly how much might a claim be worth? The general rule is that damages for breach of contract are such losses as may have been reasonably foreseeable when the breach took place. An aggrieved contractor might argue that had their GDS Contract been at the appropriate higher level of activity and the higher contract rate, the contractor would have had to pay, say, 50 per cent of each "UDA value" to that relevant employee.

The remaining 50 per cent balance would have been part of their gross annual profits. They might go on to argue that such increased profits would have been the "top slice", that the practice overheads would already have been provided for by the "lower slice", and that their net loss was therefore 50 per cent of the value of each UDA lost as a result of the PCT's breach of contract/breach of statutory duty, on an annual and charging basis. Such loss might amount to a substantial sum.

About the author
Young & Lee’s litigation team, headed by Chris Leek, acted for the claimants before the High Court, and before that in the NHSLA but were not the solicitors, who originally acted for the claimants.

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The dawn of a new tax year
Richard Lishman discusses planned changes in Tax Year 2011/12

As a new tax year dawns, it is essential that dental practitioners familiarise themselves with the proposed changes that the Coalition Government are going to introduce to the financial system this year and next. This holds particular significance where pensions are concerned as practitioners are among those professions with high pensionable earnings and will therefore be particularly affected.

Included in these changes is the elimination of the ‘default’ retirement age as from October 2011, making employers unable to force someone to retire at 65. The basic state pension itself will rise by whichever gives the highest amount from either:
- the average wage increase in earnings for that year
- the cost of living increases for that year x 2.5 per cent

Other elements of the State Pension will continue to rise in line with prices. The Government is referring to this plan as their ‘triple guarantee’.

Annual Allowance
As from April 6, the yearly amount that can be saved into a pension through tax relief will be reduced from £255k to £150k. This change to the annual allowance will include the increase in the NHS Pension Scheme benefits and contributions to any other pensions. In addition, those with enhanced protection will no longer be able to be exempt from the annual allowance.

If a pension contribution exceeds the annual allowance, the tax relief received by the pension needs to be repaid in full at the highest marginal rate at which relief was received. For example, if a practitioner pays £60k in their pension, £10k above the limit, the rate of tax relief is 50 per cent: (£60,000 - £50,000) x 50 per cent = £5,000. In the event that part of the tax relief was received at 20 per cent and another at 40 per cent, the tax due would still reflect this.

However, also introduced will be a three-year carry forward rule that allows unused annual allowance from the last three tax years to be brought forward if pension savings have been made in those years. This could indicate that if a pensions saving is more than £50k, it may be worth taking full advantage of the annual allowance charge meaning there is some optimism to be seen in these changes, as only tax relief already received has to be repaid. However, as the pension will be taxed in full, this results in a more problematic outcome in the long term.

In addition to this, the value of pension benefits in a defined benefit pension scheme, such as the NHS Pension Scheme, will also increase, resulting in a greater risk of exceeding the annual allowance and incurring tax charges.

The annual contribution is calculated based on growth in value of benefits and this method is likely to increase the number of practitioners caught out as even relatively modest NHS Earnings may exceed the annual allowance limit. This exact calculation is reasonably complex, requiring the NHS statements of the previous two years.

Individuals are held solely responsible for working out if they incur an annual allowance charge and need to report this on their self-assessment tax return. However, they need to obtain information from their pension scheme administrators as to the increase in value of their pension savings for the tax year. Pension schemes can only provide this information if requested by the scheme member or if the individual has pension savings greater than the annual allowance. Information cannot be provided any earlier than six months after the end of the tax year to which the information pertains, however for the first year (2011-12) schemes will be given an extra 12 months to provide this information.

Lifeline Allowance
The standard Lifeline Allowance (LTA) is the total amount of pension savings you can build up tax efficiently over your lifetime and as of April 6 2012, the Coalition plans to reduce this from its current £1.8 million down to £1.5 million. As with the annual allowance, any amount over the LTA in a pension will be taxed according to how the excess is received. As a lump sum, any excess will incur a tax charge of 55 per cent: as regular income, the tax charge of 25 per cent will apply to the excess. The charge for lump sum is higher as it will not be taxed later, whereas the pension income will be taxed at the practitioner’s highest marginal rate.

With these changes in mind, individuals should know that the Government has not released any plans to review this cap until 2016, and such a review would not necessarily lead to the limit being raised. With the rise in inflation, many more dentists could be affected by these excess charges. Furthermore, younger dentists should begin to consider pension planning now to avoid unnecessary tax charges in the future, especially as these alterations are making the process more complex.

Alternative forms
Despite these proposed changes, there are ways that practitioners can keep their excess savings free of tax, by looking at alternative forms of long-term saving alongside their current pension plans. For instance, the amount that can be saved, tax free, into an Individual Savings Account (ISA) is increasing annually with inflation and as of April 2011 the saveable amount will have increased to £10,680.

It is the responsibility of the individual to ensure that they stay within the new limits that the Coalition Government has proposed for April 2011/12, and currently, there is no system in place to prevent the overfunding of pensions when the annual allowance is reduced. Practitioners are advised to acquire guidance from an independent financial adviser, who are one step ahead and can already offer an analytical formula that can help determine whether the practitioner will be in this position in the current year.

About the author
Richard T Lishman of money-lifestyle.com, which are a specialist firm of Independent Financial Advisers who help dentists across the UK manage their money and achieve their financial and lifestyle goals. For more information call 0845 355 5000 or email info@money-lifestyle.com.
Looking to buy a practice?
David Brewer provides a guide for buying your own practice in today’s world

The majority of the associates that I speak with aspire to ultimately become practice owners – possibly as a result of logical career progression or simply to protect their own position and to be in control as they can often see their income share percentage reducing.

How they must look enviously at their colleagues who purchased practices in the early to mid 2000’s when it seemed the banks would lend to anyone simply because they were a dentist; asking very few questions and making available the full asking purchase price by way of loan quite often at rock bottom rates!

As we all know the financial world has now changed somewhat...

The banks are now taking a much more critical approach to any finance requests and will review in depth all aspects of any proposal.

The banks main focus nowadays is on the individual(s) who is looking to buy the practice and it is essential therefore to ensure you present yourself in the best possible terms to the bank in question – with particular attention given to three areas:

1. **Your CV**
   - The bank WILL ask for this. Ensure your CV is fully up to date – include all positions worked from VT onwards and try to avoid any gaps in employment/working history. Include any specialism/additional qualifications and having worked both privately and NHS at a number of practices will be viewed as a good thing. Also, highlight any managerial or staff responsibilities you may have undertaken, especially if you have any separate business qualifications and/or family friends who do.
   - “It is a big jump from being an associate to practice owner and the bank will need to be confident that you can take this step.”

2. **Track Record/Earnings**
   - Most banks would now expect any applicant to have worked for at least TWO years as an associate in the UK before any lending for practice purchase will be considered.
   - It is essential that your financial accounts are kept as up to date as possible as these will form a key part of any lending assessment - with the banks looking closely at prior GROSS earning (before current principal) as a guide to what you could achieve as practice owner, i.e. if your gross £100k as associate (take home say £40k) but are looking to acquire a practice where the current owner grosses £250k, this may be considered too big a jump – unless you can reasonably explain why.
   - The banks would prefer cash but WILL consider equity in property as quasi contribution – but be prepared as it may not be worth as much in the bank’s eyes as you think (see below as to the value banks place on such property).
   - As a rule of thumb, a 20 per cent contribution is needed; however in certain cases 10 per cent can be considered (and the banks ARE quite often happy to include a contribution – cash or property - that is gifted from family – which is a common way for clients to get on the practice-owning ladder).

3. **Deposit / Contribution**
   - The banks will certainly be looking for any prospective purchaser to put a deposit down towards any new purchase. The banks would prefer cash but WILL consider equity in property as quasi contribution – but be prepared as it may not be worth as much in the bank’s eyes as you think (see below as to the value banks place on such property).
   - As a rule of thumb, a 20 per cent contribution is needed; however in certain cases 10 per cent can be considered (and the banks ARE quite often happy to include a contribution – cash or property - that is gifted from family – which is a common way for clients to get on the practice-owning ladder).
   - For most though, the key here is to build up your cash savings and if your dream is practice ownership, DO NOT BUY YOUR HOUSE FIRST! So many
associates put their hard earned savings as deposit towards a house purchase (as mortgage providers also now need 20 per cent) with nothing left for the practice purchase.

**Equity**

With house prices static at present, once you have put your deposit towards the house, it simply cannot be claimed back. Whilst the banks can consider your house as security, they will tend to place a ‘security’ value of 70 per cent of open market value on the property – so once discounted by this figure, less existing mortgage, there tends to be no equity left.

For example, a house of £500,000 value with a £300,000 mortgage. Banks would value at 70 per cent of £500,000 less the mortgage leaving ‘security’ value of £50,000 (somewhat less than the true equity of £200,000).

**BUY YOUR PRACTICE FIRST AND YOUR HOUSE SECOND** - your deposit can be put towards the practice purchase. Once you have the practice you would expect to earn more than you would as an associate - you should then accumulate savings at a faster rate to then enable you to put a deposit down for a larger house close to where the practice is.

In most cases you would earn more pound for pound purchasing a dental practice than investing in property.

The banks ARE still lending for practice purchase and the dental sector is viewed by them as relatively low risk - which is great news for prospective purchasers.

**The right result**

However, it is essential that your application is presented in the right manner to the right person at the right bank. Simply walking in to your local branch will not achieve the right result, and could go against you if the local manager does not understand the profession and says ‘no’. Once you receive a ‘no’ it is then extremely difficult to overcome this.

**Always** engage the services of an independent specialist to work on your behalf (we currently have access to SEVEN banks who are actively lending to the dental market), who will package the proposal in a manner which will satisfy the banks credit criteria (all banks have slightly different requirements) and ensure you are personally introduced to a number of the specialist dental divisions of these banks. By involving more than one bank, a degree of competition can also be generated to ensure that more competitive terms are secured.

Remember that you only get one chance to make a first impression with the bank - make sure you get it right.

‘Remember that you only get one chance to make a first impression with the bank - make sure you get it right’

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**About the author**

David Brewer has worked for the dental profession for more than 15 years helping more than 1000 clients secure funding for practice purchase and start up. With his banking background and friendly pro-active approach, he is ideally placed to provide advice and guidance to clients who are looking to purchase a practice or simply review their existing arrangements. David works with Frank Taylor and Associates and can be contacted on 08456 12344 or david.brewer@ft-associates.com

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Keeping Google in mind
Cathy Johnson looks at how to make your practice website really work

Hit the spot with your website requires thought and careful planning. The web is an interactive, dynamic and rapidly changing communications medium and a great website is one that gives the visitor exactly what they want.

So what are your patients looking for? It may come as a shock to learn that it’s not so much your treatments they’re most interested in, it’s the solution to their particular problem. You need to ask yourself what their biggest problems might be and then solve them. In order to have a popular site, you’ve got to get inside the mind of the user. “How can I help my patients?” is the best place to start.

At the outset, be sure to employ an experienced web designer, preferably one with knowledge of dentistry, and discuss your main objectives in depth. It is also worth doing some research of your own and making a shortlist of sites you like, noting what appeals to you and why. What grabs your attention, what keeps you there, what looks good, what works well, what are you most impressed by? Also, look out for any really bad sites and make a list of potential pitfalls such as what makes it hard to navigate, what looks unprofessional or confusing, what takes too long to load and so on.

What brings you back to any of the websites you visit? Generally, you will come back for a few reasons: visual appeal, ease of use, clarity and usefulness of content and optimum functionality. You will be able to discuss your observations with your chosen designer and plan the navigation based on all the elements you decide to include.

Visually your site must look clean, inviting, and be interesting and easy to navigate. A clear layout, legible text and logical navigation will always have the edge over flashy gimmicks and information overload. Avoid Flash animation as people are likely to go elsewhere rather than wait for anything that takes time to load – the ‘skip intro’ button has to be the most clicked on option on the internet.

A survey by Akamai Technologies of 1,000 web users showed that if a shopping site took longer than four seconds to load, 75 per cent of the participants would not return. Around 50 per cent of respondents formed a ‘negative perception’ of a company with a badly performing website and a third would abandon a site if it was difficult to navigate. So it is wise to either eliminate animation altogether or opt for alternative compatible animation such as JavaScript.

Always keep Google in mind. Achieving high rankings on Google is an ever-changing minefield, so take expert advice on search engine optimisation and let function take priority over form where it is beneficial to do so. Unlike printed literature, there are limitations with regard to fonts when it comes to website design and functionality. Make sure you use a Google-friendly font so your site can be read on any system, including the iPad and iPhone.

It goes without saying that your practice logo must be prominent and the colour scheme consistent with your brand. This is a perfect opportunity to reinforce your brand image and continuity is key. The dental team and the practice on the home page will add a personal touch and differentiate you from those that open with the same old stock images of smiling models. Keep the look fresh, simple and uncluttered and make sure your menu is concise. Don’t fall into the trap of bombarding patients with information overload. Avoid flash animation as people are likely to go elsewhere rather than wait for anything that takes time to load – the ‘skip intro’ button has to be the most clicked on option on the internet.
so much information at the outset that they are put off and log off.

Make sure content is easy to find and in a variety of ways. A top navigation, side navigation, search and home button are great players in this field. No matter how good your website is, always assume there will be users who get lost along the way and cater for their needs. The bottom line is if a user can’t find the information they are looking for, they have no reason to be on your site. A call to action ‘contact’ button must be accessible on every page – after all, the main purpose is that your viewers contact you.

Visitors don’t want to have to think too hard when viewing your web pages, they want answers to the questions they are asking and to be fascinated by anything else they come across. Increasingly, web surfers show a maddening unwillingness to stay put on any one website, so make sure you stir their emotions to keep them hooked. People talk about this in terms of ‘stickiness’, meaning that your site must keep your viewer’s attention glued rather than let them click on someone else’s. Remember, your rival practice website is just one click away.

‘Hot’ buttons will grab viewers’ attention on the home page. Not too many, perhaps three or four, which identify common problems and present a solution. An example problem might be ‘Dental Implants – the solution to unsightly gaps’. Hot buttons are also a great way of capturing attention via incentives, discounts or instant access to details of payment plans. Just take care to limit the number of these buttons so as not to overwhelm the user.

The language you use should always be uncomplicated and patient centered. When explaining treatments remember that although patients are interested in the techniques, their primary concern focus is more likely the outcome for themselves. Patients will also be looking for evidence of your reputation and checking out testimonials. Before and after photo galleries show the remarkable transformations that can be achieved, so make sure your photo galleries scroll to show how much experience you have. Include plenty of written, or preferably video, testimonials, but do remember to ask for patient consent.

All in all, make sure you take every step you can to ensure the user experience is a good one by giving them what they want as quickly as possible. The fundamental features that make a website work can be elusive, but the underlying trick is to know your target market and design your site to serve their needs. Well organised, edited, and timely original content set in an attractive, memorable, interactive, Google-friendly and consistent format are some key traits of great websites – and when you have a great website, marketing becomes a much easier walk in the park.

Examples of websites

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About the author

Cathy Johnson specialises in design for dentists and will design your practice image, stationery, welcome packs, referral packs, external signage and website to raise the profile of your practice and attract the patients you are looking for. She also writes and produces a biannual patient newsletter, branded for you to send to your patients. Cathy’s success is built on more than 25 years of experience as a graphic designer combined with in-depth understanding of the needs of the dental profession. She and her team are based in London and work with practices across the U.K. and abroad. Working with single practitioners through to large dental groups, all services are tailor-made to suit each individual practice. Cathy Johnson Design Tel: 020 7289 1215 Email: cathy@cathyjohnsondesign.com  www.cathyjohnsondesign.com
Amelia Bray tells why association membership can be vital to a practice manager

Being a practice manager can be a lonely business. There is only one of you within a practice and your day is often spent fire fighting problems that crop up and require your immediate attention. You must be versatile, a great person, an excellent time solver and all-round super star.

While almost every other member of your team must be registered with the GDC, there is no such regulatory body representing dental practice managers. There is no legal requirement to register with an organisation, meaning there is no official regulation or standard to uphold.

On the plus side, this can amount to more freedom for the practice manager. But what it often means in real life is that practice managers across Britain are reinventing the wheel on a daily basis. They face the same problems, such as CQC and ensuring the implementation of clinical governance, they deal with the same staff issues, such as training, appraisals and sickness, and many do this alone, without much support.

The GDC outlines what it requires from its members and lists what they must achieve in order to maintain their registration. This includes completing CPD, meeting certain standards that are clearly set out by the GDC, and working within a ‘Scope of Practice’. Tick the boxes and you’ve met the criteria. It’s a different world for the practice manager. You have to earn the respect of your team, which chances are has a list of qualifications as long as your arm – without a helpful checklist!

In order to be successful, respected leaders, practice managers need to enhance their ability to do their job effectively and need to adhere to an ethical code.

The professional body for practice managers is the British Dental Practice Managers’ Association. Ours is the only association that represents dental practice managers and we aim to provide networking, forums and tools for the continual professional development of our members, promote training and development, and work with industry-leading partners to promote best practice. We also strive to keep our members updated with information that will help their practices be more successful and profitable.

Why face the task alone, when there is a professional organisation that will help you speed up your road to success by putting you in contact with like-minded individuals? Why navigate the transition from NHS to private singlehandedly when there are scores of practice managers within our organisation who have gone through this process and have plenty of advice and help to offer? Why spend hours setting up in-house recruitment procedures when there are advice sheets and templates already written and ready to download in the Members’ Area of our website?

BDPMA member Seema Sharma says: “As a dentist with a strong interest in practice management, I find the BDPMA an incredibly valuable resource for contacts and networks. I learn best by discussion and the BDPMA gives me a fantastically rewarding group of practice management challenges with.”

The BDPMA was formed in 1995 and now has more than 800 members. We aim to be the organisation of choice for dental team members representing the majority of dental practices in the UK. As well as providing expert advice on all aspects of dental management, this year and in the future we will offer free training events.

As an extra incentive to new members we offer first year introductory e-membership for just £25, with full membership costing £85 a year. You can join us by visiting www.bdpma.org.uk and filling in a simple registration form.

About the author

Amelia Bray joined the industry as a dental nurse back in 1994, having previously worked in veterinary and chiropractic clinics. In 2000 she assisted her boss (now husband) to relocate the dental practice from a town centre premises to a converted barn in the middle of an apple orchard in the Tamar Valley and at this point assumed the role of practice manager. Amelia completed the Diploma in Professional Practice Management in 2004 and has been involved with the BDPMA since 2000, starting out as Treasurer of the Devon & Cornwall Region before joining the National Executive as Assistant Secretary, Secretary, then Treasurer and now Chairman. Away from work she’s a busy mum and step-mum who enjoys cake making and decorating, watching the mighty Green Army (that’s Plymouth Argyle to the uninitiated) and relaxing on her old Looe fishing boat with gin and tonic!
It is no use saying: ‘We are doing our best’
Sharon Homes discusses the recruitment and selection process

I have always been responsible for the recruitment of staff throughout dental arts studio. It was as simple as placing an advert in whichever source you chose, receiving and reading through the applicant’s curriculum vitae and then inviting them to an interview. When the potential candidate arrived at the practice we would hand them a questionnaire to fill in, which had general questions on it such as, why would you like to work for us etc.

Once I had completed all the interviews I would shorten the list down to the top three and arrange for a second interview to take place with either Dr Solanki or Dr Malhan. We would then select from these three the person we thought was best suited to the role after a reference check had been carried out. This has always worked out well up until now.

With CQC being one of the tasks that I have been dealing with for the past six months it’s been like having a spring clean of my administration folders! One of the outcomes we have to deal with is the suitability of staffing, which lead me into refreshing our recruitment policy with the help of the Code ADP website.

The Code website has been a massive help in enabling me to update all our practice procedures and policies. On a whole we were very much in line with requirements, but like many other practices there were a few policies not in place, as well as a couple being outdated.

One of our newly updated policies is to have a clearly defined outline for recruitment. Success after all is in the preparation of any task or challenge undertaken.

The advice that Code gave is outlined as follows:

1. Identify the specific job related criteria using a job description
2. Match these criteria with those detailed in the CV or application form
3. Use this list to select which candidates will be interviewed if appropriate

Once a list has been created it is much easier to choose which candidates to interview. Once your selection has been made you then invite your potential candidate to present themselves for an interview. A job description should be sent out to the candidate before hand to ensure a successful application and interview as the candidate has already had the opportunity to decide whether they are the correct person for the role being advertised.

Preparing for a recruitment interview is just as important for you as it is the interview preparation for the applicant. To have a successful interview...

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Use the same line of questioning for each interviewee.

April 25-May 1, 2011
United Kingdom Edition

The second opinion is valuable in making a recruitment decision. It’s also important to be able to sit back and watch your colleague interview while you have the opportunity to observe the candidate’s body language and facial expressions. It’s also helpful in your own development as your colleague can also give you feedback on your own interviewing technique.

Interviews should be confirmed in writing. Now days this is easily achieved as most of us now have access to the internet. If this is not possible then a letter confirming the interview should be sent.

When preparing for the interview you should identify any areas on the CV that do not appear clearly laid out and do not define the experience and qualifications required for the job role being advertised. Look where there are unexplained gaps and make notes to ask specific questions to these areas. Also pay attention to short span employment in short periods of time. Also validate statements of achievement.

Create questions to be covered in the interview process and ensure that the interviewee is able to answer your questions decisively and constructively.

**Conducting the interview**

1. Use the same line of questioning with each candidate. Keep it simple; do not ask for any personal information as this is not relevant to the job and it could be considered discriminatory.
2. Do not accept partial or unclear answers to any of your questions.
3. Keep the questions open for example; do not ask simple questions that require a simple yes or no answer.
4. Take notes of the candidate’s answers and note down your own comments.
5. The candidate should be talking for 80 per cent of the interview and you should only be talking for 20 per cent of the interview.

**After the interview**

1. Read carefully through the notes that you had taken about each candidate and complete Code ADP’s assessment form or you could create your own if you are able to. Your reasons for your selection are important in case your final decision is challenged by the interviewed candidates, eg under the Sex, Age, Race or Disability Discrimination Acts.
2. Compare each candidate using the information you have against the requirements of the job being advertised.
3. Make an assessment for each candidate as to whether...
they have met the criteria for the role. Make sure that they fit in with the culture of your team; however make sure that you do not discriminate. Be sure to make the correct choice as an error in judgement can be costly and time consuming should it not pan out.

An offer of employment should be made verbally upon the receipt of two professional references which are satisfactory. These two references should be from a previous and current employer. In the case of a school leaver a reference from a teacher is acceptable. These references should be in writing, although details may be clarified by telephone if necessary. If the references are not produced in a reasonable amount of time then it may be necessary to retract the offer of employment.

Once you are happy with the character references an offer of employment must be sent to the potential candidate to confirm the offer of employment and the conditions thereof. Once the job has been accepted then a contract of employment should be sent out.

Make sure to ask the candidate to present all necessary documents for eg qualification certificates, work permits, Hep B, personal information with regards to next of kin etc. All the essential documents must be placed in a personnel folder and placed in a secure environment only accessible to the practice manager or principal dentist.

As Winston Churchill once said: “It is no use saying, ‘We are doing our best.’ You have got to succeed in doing what is necessary.”

About the author

Originally from South Africa, Sha¬
ron Holmes has worked in the field of dental practice management since 1992. In 2003, she moved to London City Dental Prac¬
tice where after 18 months, was re¬
sponsible for managing four prac¬
tices 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 crea¬
tion.

‘Make an assess¬
ment for each can¬
didate as to whether they have met the criteria for the role. Make sure that they fit in with the cul¬
ture of your team; however make sure that you do not dis¬
criminate’
Don’t be stationary over stationery

David Mills provides a quick guide to getting it right

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DENTAL TRIBUNE United Kingdom Edition - April 25-May 1, 2011

the competitive world of dentistry, it can be hard to keep up with the Joneses’ as practitioners offer an increasing array of options and treatments. While the extremely high standards set for dentists, by governing bodies and by the clinicians themselves, the quality of work is rarely called into question in any reputable practice, so how do you set yourself ahead of the game? One of the best options is effective advertising, and this can be achieved even by small and cost effective means such as business cards and stationery.

High impact, quality stationery can help you to successfully convey your practice philosophy to both the public and the local business community. The image that you project to the public is of utmost importance both with regards to finding new patients, and preserving your existing client base. Patients are only too pleased to give repeat business to a dentist whom they trust to offer them the best possible service, and their loyalty and ‘word of mouth’ advertising are essential to the maintenance of a thriving practice.

So what next?

In order to establish an effective range of stationery, your first port of call must be a reliable printer. This can be a confusing and daunting experience however, as the printing industry has, over the years, developed into such a complex trade that people outside the business are frequently baffled by its intricate and seemingly bizarre vocabulary. Reputable printing firms will provide you with an expert representative to help you overcome this unexpected language barrier, and specialist companies, dealing with the health sector, can cater to your specific needs as a dental practitioner.

You should also speak to other people regarding printing costs, as it is a good idea to have a budget in mind when speaking to a printer. The printing industry can be just as competitive as dentistry and so is always in the printer's best interest to offer you the optimal deal. If a printer in recalcitrant with regards to offering you a better, cheaper solution, it may be that you should take your business elsewhere.

Your vision of what you want from your stationery is what really matters and it is the job of the printer to take your ideas and requirements and turn them into a viable technical solution that suits your business and your budget. However, while your printer possesses the array of options and treatments that you need, the buck should never stop with them. It’s your job to see that everything is going to plan at every step of the way and to this end it is essential that you carefully proof everything before it is sent to print. Even specialist printers can be unfamiliar with some technical terminology but by submitting copy electronically, you can ensure that any necessary changes can be made quickly and easily.

Decisions, decisions

There are several factors to consider when ordering, for example, business cards. Firstly, if your logo is coloured, you will need to decide whether one, two, three or four colour options are appropriate. Having four colours is the most expensive and can be used to create photo quality images, but simpler logos may require only one or two colours, saving you money.

The next step is to decide upon the finish of your cards. Finishes come in two types - coated or uncoated. Uncoated is basic card and lends not to wear as well as coated, but it is cheaper to produce and makes great appointments cards, as the surface can be written on. Coated card is not as good for writing on but is more durable and can look more ‘up market’. It also comes in matt or gloss finish and is most people’s preference for business cards, but your printer will be able to advise you on this.

The weight of the card (how thick it is) is also something to consider as, while heavier card can be more expensive, it is also generally better quality and can have a ‘classier’ feel. You may wish to think about postage costs in making this decision as well as whether you think your cards are likely to be used to convey information and immediately disposed of, or kept for long periods of time. Along with the weight of the card, you will need to decide upon a size. You can pick virtually any size for your cards but the most popular option is 85x5cm, the standard size of a credit card and therefore ideal for keeping in a purse or pocket. However appointment cards may need to be bigger, in order to fit in more information and complex or photo-quality graphics can look squashed on smaller media (artwork can also incur an extra charge so check with your printer).

When considering your budget and you will need to assess how many business cards you think you will need as the quantity or ‘print run’ is the main factor in fixing a price. Most businesses give discounts on large orders and, as the majority of the cost comes from the initial set up of the design; it is economical to place the largest order you can. However, if you rarely give out business cards, or your information/contact details are liable to change, you run the risk of being left with unused stock that will then be wasted.

When your card is ready to go to print, you will be sent a proof, which you will need to sign off. This is the most important stage of the process, as any mistakes now will necessitate a reprint of the entire stock and, whilst most reliable companies will give you a reduction on reprints (accidents do happen) this kind of generosity cannot be relied upon, and can prove an expensive and time-consuming error.

It can be a good idea at this point to check the document, walk away, and then check it again with fresh eyes to make sure you haven’t missed anything. You can also get another member of staff to check it, or even ask a patient what they think of the design, as it is ultimately their opinion that counts.

Remember that high impact, quality stationery is, quite literally, your ‘calling card’ and the product that you present to the public will reflect your ethos as a practitioner. So, do your research before committing to buy, consider your design carefully before submitting it to your printer, and check your proofs before printing to ensure that you have a company image that can really turn heads.

Quick Tips

• Speak to colleagues to get a ‘word-of-mouth’ recommended Printer with specialist knowledge of your industry.

• Remember, black still counts as one of your colours.

• Checking twice means printing once!

About the author

David Mills is the General Manager for Admor. For more information contact Admor at Support@admor.co.uk or by calling 01903 858910.

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

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The International Association for the Study of Pain (IASP) selects a different, pain-related issue to study each year. 2011 has been designated as the ‘Global Year Against Acute Pain’ with the focus on raising the levels of understanding and the quality of treatment for acute pain in all its forms.

A natural consequence of medical advances in the control or subjugation of previously life-ending diseases and trauma repair is greater longevity for the victims. With average life expectancy for all of us rising, the importance of research into pain management and its effects on the individual’s quality of life is axiomatic. While few people actually die of pain, many lives are blighted by a failure to reduce or understand its debilitating effects and how destructive it can be for the individual, particularly over an extended period.

Acute pain should not be confused with chronic pain. Acute pain, by definition, is spasmodic in nature and relatively short lived, while chronic pain, however intense, is continuous. Acute pain develops when the brain receives sudden notice of tissue damage, and the nerve signals are amplified by sensitisation in the central and peripheral nervous systems. Although the incidence may be brief, repeated occurrences quickly disrupt the quality of daily life and without treatment can develop into a condition of chronic pain.

Pain by its very nature is subjective; pain ‘thresholds’ vary hugely between genders, ages and cultures, and the intensity of physical pain can also be affected by psychological and emotional factors. Comparisons between individuals suffering from very similar conditions are therefore rarely of any value and can be offensive to the sufferers.

The priority for every clinician should be the immediate reduction of acute pain, both to relieve the sufferer and to prevent the onset of chronic pain. However, the situation is often not as simple as it seems. An IASP report has found that many healthcare professionals have a tendency to downplay the importance of acute pain management for a variety of reasons. Reasons include a belief that pain relief medication may mask symptoms or impede curative medication, or that the patient should in any event expect, and therefore tolerate, a certain amount of discomfort. This lack of education in the practitioner may be mirrored in the patient, who fears becoming addicted to pain killers, or that taking pain killers may have side-effects, or perhaps delay recovery. With many patients experiencing uncertainty, acute pain is all too often under assessed and under treated.

It is my own contention that as healthcare professionals compassion is integral to our responsibilities and we have a duty to be fully aware of the nature, treatment methodology and potential consequences of acute pain. Within dentistry, endodontics is an area where practitioners should pay particular attention to this aspect of patient care by keeping up to date with the latest information and techniques for pain management. The problem needs to be addressed on three fronts – by individual practitioners, their colleagues and by the patients.

Traditionally, dental and endodontic practices’ professional promises of intent have been altruistic, vague, and expressions of the obvious in bland, Quixotic language. Announcing a goal of delivering the best possible care in the best possible environment is neither binding on the clinician nor reassuring for the patient. I suggest that our mission statements should be rewritten to imply a greater sense of imperative, obligation and urgency – for example:

It is the absolute right of every patient to be free from pain, and we as endodontists will take every possible measure to protect and promote a higher quality of life for all our patients.

Once we have made our own commitment to expand our knowledge, we can progress to spreading the word amongst our colleagues about the optimum application of anaesthesia and analgesics in the resolution of the pain associated with extraoral dental disease or tooth restoration. Increased awareness among practitioners will in turn enable more patients to be properly advised on the appropriate control of post-treatment pain, and so overall standards of care will rise.

A key issue in endodontics today is the cost of treatment, which was recently highlighted by the Steele report. The relief of pain by tooth preservation or root canal treatment is becoming the means of many, with a huge, less well-off demographic obliged under the NHS to accept extractions or removable prosthesics as the only alternative.

Dr Michael Sultan discusses pain control

About the author

Dr Michael Sultan BDS MSc DFO FCDI is a specialist in Endodontics and the Clinical Director of EndoCare, a group of specialist practices. For further information please call EndoCare on 0844 855 2020 or visit www.endocare.co.uk
Scanning the Spectrum

The A-Dec dealer sales meeting was the perfect occasion to launch a series of new products and brand positioning to the UK market. Dental Tribune was there.

S
o, what do you call a group of dental dealers? This was the question that occupied me as I made my way to a hotel in Hinckley, just a few miles from the Nuneaton HQ of our hosts for the next two days, dental equipment manufacturer A-dec.

General Manager Karl O’Higgins and his team were on hand to welcome a full house of attendees to the A-dec Dealer Sales Meeting. This was an intense event, ranging from presentations aimed at informing the dealer network about A-dec’s current position and future plans, to guest speaker Chris Barrow who gave his thoughts on the ‘state of the nation’ for the dental industry.

Product launch
You may be surprised at the thought of a gaggle (yes, that is my collective term) of dental press people at a dealer meeting, but invited we were and we were able to see the launch of two new product offerings as well as see more about the A-dec Spectrum of dental chair solutions.

First to be unveiled was the A-dec 200, a complete system packed with features for added accessibility and comfort - all at great value and within a neat compact package. Developed in conjunction with dental professionals around the world to offer a solution for the wide range of practice styles found in global markets. General Manager for A-dec UK, Karl O’ Higgins said: “As the new point-of-entry to the A-dec family of dental chairs and delivery systems, we knew that A-dec 200 would have big shoes to fill. Our systems have always been known for reliability. Even our entry-level systems have the reputation for durable performance with minimal down-time.”

‘Designed for success’
Fitting into the A-dec range of systems between Performer and A-dec 300, the A-dec 200 was launched with the tagline ‘Designed for Success’. Features include: four preset positions; double-articulating headrest; seamless upholstery; telescopic assistant's arm and oversized tray; multi-axis light.

Karl added: “A-dec manages the full manufacturing process to provide dentists with the most reliable equipment possible. Just like our A-dec 500® and A-dec 3000® systems, A-dec 200 allows every practice to enjoy the same quality and performance that dentists, dental schools, and healthcare institutions in more than 75 countries rely on day-after-day and year-after-year. It really is the right product at the right time and at the right price.”

Cabinetry
Another offering to be unveiled was a new range of cabinetry solutions. A-dec teamed up with cabinet manufacturers DentalStyle to create a range of ergonomic and versatile cabinetry designed to be used with the Zirc colour coded trays (see below). Ciaran Hynes, A-dec’s Operations Manager, discussed the company’s thought process behind the new range and...
the importance of taking into account the working environment of the whole dental team to reduce the rates of occupational Repetitive Strain Injury (RSI).

After a very intense morning of presentations, the post-lunch sessions were organised, and the attendees were separated into groups to attend each session.

Three bagger
First up was Chris Barrow who discussed the importance of customer service. Quoting the famous ‘three baggers’ concept from Walmart founder Sam Walton, Chris looked at his nine ‘cardinal rules’ for delivering exceptional customer service:

• Don’t pass the buck
• Develop a customer charter, and broadcast it
• Don’t try to hide mistakes
• Be very clear when communicating with clients/patients and follow it up in writing
• Don’t assume that clients/patients know as much as you do (even when they say they do!)
• Ask yourself if you’re delighted with your work. If you are not delighted, how can you expect patients to be?
• Walk the floor – be visible to your team and patients
• Surprise people with follow up calls

• Ask for word-of-mouth referrals, these are the most cost effective way to grow your business.

Next to present was Nicolle Folen, Vice-President for Sales & Marketing at Zac, a US-based company specialising in the organisation and sterilisation of dental instruments. The company’s colour-coded system for the different procedures in surgery is a concept being embraced by A-dec and was one of the concepts behind the new cabinetry range.

Anti-Microbial
Nicolle discussed in more detail why using colour-coded tubs and trays could help reduce stress and improve infection control measures within a dental practice. She then walked through some of the products, emphasising the use of the anti-microbial agent Microban® in the manufacture of their tubs and trays.

The third session was an overview of the A-dec spectrum, by Eugene O’Malley and Mark Harris (Territory Managers). This was a chance for the attendee to ask questions about each of the chair solutions and get a feel for the differences between each one.

The final session was split to give further insights into surgery design. Discussions centered on best practice for infection control and decontamination in practice, a closer look at the new cabinetry range and Karl O’Higgins giving a practical look at ergonomics in a dental surgery and how this can improve working conditions for the dental team and the experience of the patient.

Healthy competition
The day was then topped off by a fantastic meal and a chance to indulge in some healthy competition as a huge Scalextric track, racing simulator and two Nintendo Wii consoles were set up, as well as a set of casino tables for the more sedate competitors!

This event was a very intense and worthwhile day, and a big congratulations should go to the whole A-dec team for organising such a great event. Oh, and in case you were wondering, my collective term for a group of dental dealers is a busyness.
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Emerging trends
A look at the recent Philips Symposium in Cologne, Germany

The eighth Emerging Trends Symposium initiated by Philips took place in Cologne, Germany the day before the start of the IDS on 20-21 March 2011. It was attended by 50 key opinion leading dental professionals from across Europe, attracted by a roster of international speakers, each adding to the knowledge-base which is redefining oral hygiene intervention. By the close of the symposium the assembled delegates were left in no doubt about closing the gap between the science and art of dentistry.

As a precursor to the introduction of two new Philips products at the close of the symposium, the event kicked off with a lecture about peri-implantitis and what is known and can be done to tackle this condition which can lead to the body’s rejection of an implant.

According to the first speaker, Professor Hugo de Bruyn, peri-implantitis is an inflammatory process within the tissues surrounding the implant components, which in most cases is related to a bacterial infection.

It affects both soft and hard tissues around dental implants in a dramatic way because it leads to bone loss and is related to pocket formation and pus evacuation. This often reversibly affects the appearance as well as position of the gums and the interior zone of the maxilla, and has aesthetic consequences leading to patient dissatisfaction.

Central to the treatment of peri-implantitis is biofilm removal, however there are important differences between the gums around teeth and implants which should affect the approach to oral hygiene for those with implants. Surgical treatment is predominately based on implant surface decontamination and this is typically combined with pocket reduction and regenerative procedure’s to close the defect. The first option is a radical way to reduce the defect and improve accessibility for oral hygiene measures whilst the second option aims to avoid recurrence of disease and enhance the aesthetic outcome by defect closure.

Currently there are a very limited number of powerful clinical studies available which focus on etiology, pathogenesis and efficacy of peri-implantitis treatment. Yet Professor de Bruyn questioned whether the ‘alarming rise in the disease’ discussed in some papers is the reality of everyday clinical practice.

He also questioned whether it is related to changing treatment protocols or changed implant surfaces or designs which have been introduced.

His lecture concluded with an overview of the literature and treatment rationales and showed, by means of case reports, some clinical consequences, protocols and clinical guidelines related to disease prevention and treatment.

As we improve our detailed knowledge about these bacterial deposits and the pathways of periodontal breakdown, the improvement of the patient’s individual oral hygiene becomes pivotal to the goal of improved periodontal therapy.

Dr. Paul Stoodley took his theme ‘Biofilm Management beyond Plaque Removal’ and started by explaining that dental plaque biofilm is a living community of many different types of bacteria and microorganisms which attach and grow to tooth and gum surfaces.

The resilience of dental plaque biofilm is underlined by the ongoing management effort to prevent and maintain good oral health. Direct scrubbing using brush bristles is an established method of removing dental plaque biofilm, however there are many locations within the mouth, such as the interproximal spaces, gingival sulcus and pits and fissures in the occlusal grooves, which are difficult to access.

Biofilms can also be removed by fluid flow, if high enough shear forces are generated. Dr. Stoodley demonstrated that powered brushing using Philips Sonicare sonic toothbrushes, can remove biofilm formed from Streptococcus mutans, a common biofilm dental plaque cariogenic pathogen, from interproximal spaces and frontal tooth surfaces by the generated fluid flow alone.

In more inaccessible areas, where some biofilm remained, he demonstrated that fluid flow could act as a reservoir for fluoride, potentially having the beneficial effect of increasing contact time with the enamel surface.

Fluoride also reduces the degree of acidity at the tooth surface by reducing biofilm activity.

Building on the application of fluid flow for biofilm management, Dr Stoodley introduced the concept of the new Philips Sonicare AirFloss which utilises a small volume of high velocity liquid to create high shears and jet impingement pressures to remove biofilm from interproximal spaces.

By using a typodont model and artificial biofilms comprised from biopolymers produced by biofilms, he showed how he had captured the removal from interproximal spaces using high speed imaging. On impact the artificial biofilm in the interproximal space was immediately pushed back by the biofilm flow and the biofilm detached.

Finally Thomas Clos addressed the need to draw to more closely new toothbrush production methods with marketing requirements and beneficial performance for users. During his presentation he gave an overview of the evolution of industrial toothbrush production and demonstrated the state of the art methods used today.

The pros and cons of each method were highlighted and the presentation concluded with an insight into development and production methods used for the creation of a new Philips Sonicare DiamondClean brush head.

At the climax of the symposium the assembled delegates were given a preview and insight into the research and clinical effectiveness of two new Philips Sonicare products which were launched the following day at the IDS.

The new Philips Sonicare AirFloss is the first interdental cleaning device which uses microburst technology to clean interproximal areas and Philips Sonicare DiamondClean power toothbrush is considered the most sophisticated, high performance Sonicare toothbrush to date.
Dubbed as one of the most inspiring and informative conferences in the dental calendar, the Clinical Innovations Conference 2011, will be held for the eighth year on the Friday 6th and Saturday 7th May at the Royal College of Physicians in Regent’s Park, London.

The event’s organisers Smile-on are hosting this year’s event in conjunction with the AOG, the Dental Directory, the FGDP and the ESCD. They have put together a dental conference with a difference, bringing together a host of leading speakers in restorative and aesthetic dentistry, an unparalleled programme of lectures and a glittering charity ball for more than 500 lucky delegates.

The 2010 conference will host a line-up of highly prestigious international speakers alongside exhibitors offering the latest dental technologies from around the world. Confirmed speakers are: Nasser Barghi, Julian Webber, Eddie Scher, Wyman Chan, Julian Satterthwaite, Jason Smithson, Trevor Burke, Julian Webber, Bob McLelland, Eddie Lynch, Wolfgang Richter, Liviu Steier.

The conference holds opportunities where you can:
• Learn truly innovative solutions to achieve superior results
• Gain hands-on experience in the latest techniques
• Take away tips you can start putting into practice immediately
• Question and debate all ideas
• Receive your core subject ‘Medical Emergency’ certificate

This year the London Deanery will be hosting their DCP Conference on Friday 6th May in parallel to the Clinical Innovation programme. Dental professionals will be treated to sessions on subjects such as mentoring in the workplace, risk management and communication skills. The conference also featured fascinating sessions on infection control and a lively course on dealing with medical emergencies by Dr Joe Omar. This conference can be booked via the London Deanery eWisdom course booking system.

After the success of last year’s CIC, the Clinical Innovations Conference is growing and the 2011 conference is expecting delegate numbers in excess of 300 highly motivated dentists who are passionate about learning.

Dr Sara Abdullah Alnoor Aljily is a GDP from Madina Dental Centre in Doha, Qatar. She had this to say about last year’s event: “I heard about the Clinical Innovations Conference through Smile-on’s regular email updates. I decided to take part in this extraordinary gathering to widen my experiences and knowledge which I believed did really happen.”

“I have found the conference to be well organised and very professional with excellent speakers, which is of course the most important thing! Attending the conference has been a great experience and has helped update my skills. I’ll definitely be putting these skills to good use when I go back home.”

To accompany the event, Smile-on and the AOG are pleased to announce The Annual Clinical Innovations Conference Charity Ball, which will be held on Friday 6th May at 5-star Millennium Hotel in Mayfair.

With more than 300 people expected this promises to be a night to remember. Traditional dress is encouraged.

There are only a few places left at the Clinical Innovations Conference. To book your seat as a delegate or to reserve your table of 10 at the ball please call 020 7400 8989 or email info@smile-on.com. Alternatively you can go to www.clinicalinnovations.co.uk to view the full programme and book your place.

Contact us on 020 7400 8967 quoting DTUK10 to get your early booking discount.
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