Prison for dental thief
A woman who stole £4,500 from the dental surgery where she worked as practice nurse has been sentenced to six months in prison. Victoria Moore, 28, pleaded guilty to stealing the money from the practice in Ebbw Vale, where she had worked for six years, before she used the cash to pay debts and to fund her cocaine use. Newport Crown Court heard how Moore, who was responsible for banking the money at the practice, took the cash between 2007 and 2009. The court heard how Moore and her husband took out a loan on their home in 2005 to carry out improvements but their debts increased.

Clinic visit ahead of review
A £4.6m community clinic in Lanarkshire has been visited by the public health minister before she chairs the local NHS board’s annual review. Public Health Minister Shona Robison visited the Douglas Street community health clinic in Hamilton, which is one of the local NHS services including dentistry, together under one roof. Ms Robison said it was important that local people took part in the review of healthcare services. She added: “Our NHS should always strive to provide the best possible care, so holding those who manage our NHS boards to account in public is the right thing to do.”

New Lerwick dental clinic
A new dental clinic is likely to be set up in Lerwick, Shetland, within the next two years. The new practice could house up to four dentists and greatly improve access to NHS dentistry in the region. The new clinic aims to remedy the problem of some non-urgent dental patients being on waiting lists for several years, as current NHS dental facilities are overstretched. The project, the whereabouts of which has not been decided upon, is part of the Scottish government’s new health targets. When the clinic is fully functional, there will be a total of 15 dentists in Shetland.

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‘Tide is turning’ says CDO after latest NHS IC statistics
Recent report indicates increase in both UDAs and patients during 2009

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The latest NHS Dental Statistics for England have been published by the NHS Information Centre for Health and Social Care.

The report, which evaluates data under the new contract from April 1, 2006, was published on November 26. The latest information on ‘activity’ relates to the first quarter of 2009/10, up to June 30, 2009. Patients seen ‘on activity’ data is reported to the end of the second quarter, up to September 30, 2009.

Quarterly activity information for 2009/10 is provisional and will be revised upwards to the final figure for the equivalent quarter last year.

This equates to 20.5 million UDAs, a 5.2 per cent increase on the final figures for last year’s first quarter.

The number of patients seen in the period ending Sept 30, 2009, was 279 million - 54.2 per cent of the population - a decrease of 0.3 million (-1.0 per cent) on the 28.1 million patients seen in the two-year period ending March 31, 2008.

This is, however, an increase of 0.2 million - 0.8 per cent - from the previous 24-month period ending June 30, 2009.

Chief Dental Officer for England, Dr Barry Cockcroft said: “We have invested more than £2 billion in NHS dentistry, resulting in more dental practices expanding and opening all the time. The tide is turning and access to NHS dentistry has been increasing steadily for over a year with more than 950,000 more people seeing an NHS dentist in the last five quarters.

“Dentists working in the NHS treat around 250,000 patients every working day and our aim is to ensure that everyone who wants to see an NHS dentist can by March 2011.”

But Dental Practitioners Association chief executive, Derek Watson, thinks differently.

Watson commented “The Department of Health said that the very few dentists resigned in April 2009 represented very little capacity. They are missing the point. The new contract was supposed to correct supply problems and it has had the opposite effect. Fewer patients are now seeing NHS dentists as a result of the NHS contract, despite the fact the DH has been spraying the money hose around for two years in an attempt to disguise their bungling antics.”

Dr Watson said that in April 2006, 55.8 per cent of the population was seen on the NHS in the previous 24 months. Following the introduction of new terms of service on April 1, this fell to 52.7 per cent in June 2008, from which point it was thought to be recovering. However he said the newly-released adjusted figures to September 2009, demonstrated that it was struggling to reach pre-contract levels.


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Dental complaints concerns

A healthcare barrister has called for his reservations about the Dental Complaints Service (DCS) and its lack of independence.

Angus McCulloch, whose city of London practice deals with public, regulatory and disciplinary law, was speaking at a meeting of the Dental Law and Ethics Forum (DLEF) on Topical Issues in Dental Regulation.

At the recent meeting, which had a live link-up with members and Cardiff and Leeds, Mr McCulloch acknowledged that the DCS had successfully resolved minor complaints about private dental treatment and reduced the load of the council's bers and Cardiff and Leeds, Mr McCulloch acknowledged that the DCS had successfully resolved minor complaints about private dental treatment and reduced the load of the council's disciplinary department. He said a survey, of both dentists and patients who had experienced the service, reported that nine out of ten gave feedback that it was good or excellent.

But he added: "The DCS is a creature of the General Dental Council (GDC) and its procedures are neither independent nor con- fidential. It uses itself as its 'independent' on its website, but, currently, no longer does so."

He said the structure of the DCS and its relationship with the GDC made it possible for a dentist to be helpful and transparent in responding to patient complaints, but in so doing, could provide the DCS with the grounds for a referral to the GDC's Fitness to Practice, procedures.

He observed that it was also questionable that the DCS now claimed to be "run operationally at arm's length" but, has advisory board that took half its membership from the GDC and whose remit included advice on "day to day operational performance".

He added that while the DCS had no powers to enforce its rec- ommendations and dentists were not "obliged" to co-operate in the resolution of a complaint, a dentist could still find themselves facing a misconduct charge if the DCS decided to refer them to the GDC for a refusal to engage or co-operate. He considered the complaint to be indicative of a broader problem.

A spokesman for the DCS said:

"The DCS is an impartial, expert, free and fair service that can help solve complaints about private dental care. It is supported by more than 160 trained volunteer pan- elists from across the UK. When a panel is convened it is made up of two members of the public and one dental professional. The deci- sion making process regarding complaints is therefore completely independent of the General Dental Council (GDC)."

Complaints about the com- plementary conduct or behaviour of clinical staff that raise questions of patient safety come to the GDC from a wide range of sources. The DCS can recommend that the complaint acompanhages the GDC with this type of issue. DCS staff may also sometimes refer cases to the Fitness to Practice team (FIP) if they feel it's seri- ous enough. Similarly, the FIP team may refer complainers to the DCS if they feel the service would be better placed to handle the issue.

Before 2006 if a private den- tal patient had a complaint and their dentist showed them the door, they had virtually nowhere to go. A critical report from the Office of Fair Trading provided the catalyst, and the Government called for action. The General Dental Council stepped in to set up and fund the DCS to operate at arm's length.

The aim of the DCS is to re- solve complaints fairly, efficient- ly, transparently and quickly by working with the patient and dental professional involved. It is completely impartial and this is considered an important part of the service – which the staff takes seriously.

The service is open to the pub- lic and registrants and doesn’t charge for its services. It has a hot- line, which is 08436 120 340. It gets its funding from the GDC, which means all regis- tered dental professionals pay for the service through their Annual Retention Fee.

The service can look into com- plaints about private dental serv- ices provided by dental practices in the UK. It can’t look at com- plaints about NHS treatment. It also can’t look at staff matters – such as recruitment, pay and discipline - or at commercial or contractual issues.

Until recently the service had been overseen by an Advisory Board made up of GDC council members - both registrant and lay members - as well as a number of independent individuals. How- ever since the restructuring of the Council of the GDC this year, the role of the Advisory Board is un- der review.

Full details of the DCS and what it can offer can be found on its website www.dentalcom- plaints.org.uk.

Dental technician advisory board chair

The Faculty of General Den- tal Practice (UK) has ap- pointed a leading dental technician to become chairman of its Dental Care Professional (DCP) advisory board.

A former president of the Dental Technicians Associa- tion and founder member of the FGDP(UK) DCP advisory board, Tony Griffin has been active more than 30 years in supporting train- ing courses for the dental team. He takes over the post from Janet Goodwin, who stepped down after helping to establish the General Dental Council. (GDC)

Mr Griffin’s achievements in- clude playing a key role in devel- oping a route to registration for dental technicians enabling a technician to become chairman of the FGDP (UK)’s initiatives to support the board that took half its membership from the GDC and whose remit included advice on “day to day operational performance”.

He added that while the DCS had no powers to enforce its rec- ommendations and dentists were not “obliged” to co-operate in the resolution of a complaint, a dentist could still find themselves facing a misconduct charge if the DCS decided to refer them to the GDC.

The post of vice-chairman of the DCP advisory board has been given to John Stanfield, who has represented dental hygienists on the board since 2006 and is also an assessor for the DCP’s, Key Skills Assessment. Both Mr Griffin and Mr Stanfield are also members of the editorial board for the FGDP (UK)’s DCP journal, Team in Practice.

Mr Griffin commented: “Along with John as vice-chairman and the DCP advisory board as a whole, I am looking for- ward to working with Tony, John and members of the board to ex- pand the FGDP (UK)’s educational and training opportunities for DCPs. I also hope to see the board develop beyond its ‘advisory’ status to become a more integral part of the faculty.”

BDA dentistry honours

The Peterborough Den- tal Access Centre was named as the third winner of the British Dental Association (BDA) Good Prac- tice Scheme Practice of the Year Award.

The 20-strong team received the award at the fourth annual BDA Honours and Awards Dinner in London, which is supported by the British Dental Trade Asso- ciation (BTTA). The evening also featured presentations to individ- uals by the BDA in recognition of service to dentistry and the BDA, along with a range of awards pre- sented by the BDTA and dental care professional associations.

The President of the British Dental Association John Drum- mond said: “This event has be- come a true celebration of the dental team, giving recognition to the commitment and talent of so many very special individuals. We were delighted to be joined by so many friends and colleagues from across dentistry to mark these achievements.

“The Good Practice Scheme is recognised as a benchmark for excellence with 1,250 members who have successfully completed the programme, with a further 2,000 working practises working towards membership.”

The honours and awards pre- sented were as follows:

■ BDA life membership to Ri- chard Beardon, David Evans, Tony Glenn, Robin Graham, Ri- chard Kendrick, Philip Lang, John Muir, James Robertson and Jim Watson.

■ The 2009 British Association of Dental Nurses’ award for out- standing contribution to dentistry nursing: Janet Van Noort and Geoff Craig

■ The Orthodontic Nation- al Group award (ONG) for outstanding contribution to orthodontic nursing and dis- tinguished service to the ONG: Fiona Grist

■ BDA Fellowship for outstanding service to the Association and the dental profession: David Lester

■ The Dental Technologists As- sociation Fellowship award for outstanding contribution to dental technology: Brian Gordon

■ The BDA Certificate of Merit for Services to the Association: Mike Hill

■ The BDHA Award for outstand- ing contribution to the dental in- dustry: Martin Mills

■ The BDA Certificate of Merit for Services to the Profession: Jane Armitage, Bridget Ashion, Glenys Bridges, Jo Eisenberg, Ashiq Ghaoui, Eric Nash, Malcolm Prideaux and Kenneth in the year of his award (stated above and received by his wife)

■ The Clinical Dental Technicians Award for outstanding achieve- ment: Kevin Manners

■ The British Association of Den- tal Therapists BDA of Distinction Award: Irene Ellis.
GDC on Vetting and Barring

Following the introduction of the Government's new Vetting and Barring Scheme, the General Dental Council (GDC) would like to clarify its current stance and obligations in relation to the change in the law.

Within the meaning of the Safeguarding Vulnerable Groups Act 2006, the delivery of dental care is a "regulated activity", therefore all those delivering care must be registered with the GDC in the long term. Registrants already employed and not changes jobs will be included in the scheme over time, with everyone needing to be included by 2015.

As of 12 October 2009, it became a criminal offence for people barred by the ISA to work with children or vulnerable adults in a wide range of posts. It is now a criminal offence for an employer to knowingly employ a barred person in a regulated activity.

The Council now has a legal obligation to share information about GDC registrants with the ISA. It is waiting to be advised about GDC registrants with the obligation to share information on protecting patients.

The GDC is looking carefully at how the Vetting and Barring Scheme will affect registrants and what role the Council will play. It is liaising with other regulators and working out how best to share relevant information alongside existing guidance on protecting patients.

A company selling dental implants for almost half the price of other suppliers are giving dentists the opportunity to pass this saving on to their patients, potentially dropping the price of dental implants in Britain.

DIO Implant of South Korea is now operating in the UK after recently identifying a gap in the UK market. DIO UK is offering dental implants at prices less than half that of the most established UK brands (e.g. DIO titanium R&BM fixtures for under £900). The company has been around for over 25 years and is one of the largest implant manufacturers in Asia.

One dentist who has been able to drop his prices by 50% after switching to DIO implants is Dr. David Fairclough, who's prime interest are dental implants and cosmetic dentistry. He believes that using implants of this kind could lead to them becoming cheaper for patients across Britain, currently one of the most expensive places in Europe for dental implants.

“One of my big criticisms of implant companies is that they sell you the implants and then you get very little from them again. There's poor back-up. This hasn't been the case with DIO!”

In a recent interview Dr. Fairclough said, “There is no reason why it can’t be as cheap here as it is abroad, when you factor in travel and accommodation expenses. The savings I am making have meant that I’ve been able to reduce my prices by 50%, so it has made a huge difference. It means that those people who are thinking about going abroad for implants may consider staying in Britain and those who thought they couldn't afford implants can now consider it an option.”

Dr. Fairclough was initially drawn to DIO’s systems by cost. He made it a very easy transition for him and what role the Council will play.

“Farewell from 2009”

Well, doesn’t time fly when you’re having fun! It doesn’t seem five minutes ago since I was penning my first comment back in August, and here we are at the end of the year - thanks Dental Tribune - we will be taking a break now until January 2010, but don’t think it will all be mulled wine and Christmas shopping (that should only take up four days of the week!)

The team here will be looking forward to 2010 and planning to make DT even better for the New Year!

With that in mind, here is a call to readers to get involved. For 2010 we are looking for case presentations from dental professionals covering all aspects of dental treatment. E-mail Lisa@dentaltribuneuk.com if you’re interested in seeing one of your cases in print!

Just one thing remains for me to say to all our contributors and corporate partners for all of your support over 2009 and in particular since I’ve been editing DT - you have made it a very easy transition for me. Hope you all have a peaceful Christmas, a prosperous New Year and see you on January 18 for Issue 1, 2010.
**Cosmetic Dentist Gives Parisian Lecture**

A dentist, who lectures at Smile-On’s annual Clinical Innovations conference, addressed delegates at the sixth annual meeting of the, European Society of Cosmetic Dentistry, (ESCD) held in Paris.

At ESCD’s Autumn meeting, Professor Edward Lynch talked about minimal intervention in cosmetic surgery, placing emphasis on the use of ozone and ozonated water.

He told the audience that the powerful disinfectant properties of ozone are useful for a range of dental procedures and ozonated water can be used in hand washing, root canal disinfection, full mouth disinfection, in ultrasonic scalers, for dental water line disinfection, during the placement of implants, for cavity disinfection and the disinfection of deep lesions to reduce the need for root canal therapy.

Earlier that same day, Dr Irfan Ahmad presented an overview of caries pathogenesis and the role of biofilm. He went on to challenge existing paradigms and suggested that treatment should be based on risk assessment.

The session also included input from Dr Michael Karlstén on predictable bite registration with implant-supported bridges, while Dr Ajay Kakar demonstrated aesthetic splinting techniques for compromised teeth using quartz glass materials, which are easy to place and adapt.

During the day, ESCD members were invited to present clinical cosmetic dentistry cases and other evidence for scrutiny by a panel of experts, with success-

**New Practice**

A new dental surgery is set to open at Malmesbury primary care centre in Wiltshire in the new year.

The opening of the practice, which will serve 3,000 new patients from about the middle of January, follows an investment programme of £5.1 million to set up new dentistry contracts in five Wiltshire towns.

The scheme’s overall aim is to increase the amount of people who have NHS dental treatment in Wiltshire.

Other new dental practices are being set up in Amesbury, Tidworth, Warminster and Westbury. In addition, existing dentists in Calne, Chippenham, Devizes, Marlborough, Melksham, Pewsey, Trowbridge and Wootten Bassett will be extending their NHS provision.

**Irish Tooth Decay Trial**

A new dental trial in Northern Ireland aimed at reducing tooth decay in the under fives has been launched.

Health Minister Michael McGimpsey, who launched, The Northern Ireland Caries Prevention in Practice, trial in November, said the trial would investigate the effectiveness of preventing tooth decay in youngsters by applying fluoride varnish to their teeth, as well as using fluoride toothpaste.

Nearly 2,500 children will be involved in the trial, with each child monitored over a period of three years.

Mr McGimpsey said: “It is vitally important that we look at new approaches to tackling tooth decay as, unfortunately, young people in Northern Ireland have some of the worst oral health in western Europe.

“Last year, for example, 26,500 teeth were extracted from children who underwent a general anaesthetic in hospital for dental extraction. While this figure is a marked improvement over previous years, it is still way too high and unacceptable.

“Investing in preventive care now will provide dividends for the next generation.”

The trial has been developed through a partnership with bodies including Manchester University, the Department of Health and the British Dental Association.
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Sustainable service piloted for the homeless

The recent Steele review acknowledged that although NHS dental services were generally available, communication and publicity about these services could be much improved. Last month Chief Dental Officer for England, Dr Barry Cockcroft, launched an initiative at East London homeless charity the Whitechapel Mission to enable London’s homeless to better access dental services.

A mobile dental unit serving the homeless has been set up as a pilot project in Tower Hamlets, which runs until May 2010. Homeless people can access it at the Whitechapel Mission, as well as nearby residential homeless units, Booth House and Dellow House day centre.

Leaflet

As part of the pilot, Dr Cockcroft launched a newly-published leaflet - Free NHS Dental Services for Homeless People in London - which gives information on dental services for homeless people, as well as details about emergency dental services and tips on oral health.

The leaflets are being distributed at homeless organisations and through the Department of Health-funded existing mobile tuberculosis screening service, which reaches thousands of homeless people annually. The TB service has been on the road for three years, after a successful pilot.

The mobile dental service for homeless people is modelled on the TB unit. Its director, Stephen Trilvas said homeless people were more comfortable if services were taken to them, which could act like a bridge. He said: “NHS services are not geared up for people with challenging health needs. As we got better at working with outreach workers in the TB project, we started to discover that there were parallels for other health interventions.”

Mainstream services

“The oral health project is being piloted along the same pattern, of plugging people into mainstream services who hadn’t previously accessed them successfully,” said Dr Cockcroft. “The Steele review said dental services were available overall, but that communication about this was not good enough.

“We are trying to communicate the fact that there are dental services available for homeless people.

“Oral health is generally good in England, but there is a need to reduce inequality.”

The pilot is a microcosm of improvements needed across the UK. It is not enough just to commission services for homeless people if they cannot find them. So taking services to them is the key to reducing inequalities.

“That’s why we are working with existing services for homeless people to give them information on where they can go for treatment.

“Tackling inequality means encouraging people to access services which are already there, which is a more pro-active way for them to get dental care.”

Whitechapel Mission’s director, Tony Miller said: “We work with chaotic people who are hard to pin down and are excluded. The TB mobile service saw 1,905 homeless people last year. The next chapter is the dental service, from which we are hoping for big things.”

The mission has set up an innovative programme of its own, by donating 500,000 fluoride-preloaded toothbrushes annually to homeless people, at a cost to the mission of £3.65 a year. The aim for this project is to put a system in place to manage a clear pathway for homeless and vulnerable people to access dental care.

“Tackling inequality means making it specifically targeted at the hard-to-reach. It stresses the importance of oral health and signposts individuals to community dental services in London.”

Leaflet

Ursula Bennett, head of dentistry at Tower Hamlets PCT, said people were now being reached who never had access to dental care before.

Project development officer for the homeless, Bellette Bailey, who designed the oral health leaflet for the homeless, said: “Although most people have access to NHS dental services the DH has identified a need for helping hard-to-reach client groups including the homeless and those living in hostels.”

Dentist Dr Cyril Brazil treats homeless people two days a week at the community dental services for homeless people at Great Chapel Street medical centre, in central London. He said: “It is very rewarding work. If I can go home and feel I have made some difference to help homeless people survive the day and not suffer from dental pain, then it has been worthwhile.

“The treatment won’t change their world, it just means at least they won’t have to suffer dental pain.”

Project development officer for the homeless, Bellette Bailey, who designed the oral health leaflet for the homeless, said: “Although most people have access to NHS dental services the DH has identified a need for helping hard-to-reach client groups including the homeless and those living in hostels.”

The treatment won’t change their world, it just means at least they won’t have to suffer dental pain.”

Mr Miller said: “We have kept the promise not to preach, but to demonstrate through action.”

The pilot mobile oral health programme is a step towards the Mission’s goal to empower excluded people.

The pilot’s impact will be evaluated by analysing the data of people receiving dental treatment at the community dental services, which it is anticipated will provide information on the scale of oral health problems among London’s homeless.

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BADN president Sue Bruckel has thanked all the sponsors of the 2009 National Dental Nursing Conference for helping to make it such a resounding success.

Ms Bruckel said that delegates would have had to pay up to three times the current conference fee without sponsorship, which paid for speakers’ fees and travel costs for the majority of the presentations, while the remaining speakers were local experts who gave their time for free.

The actual conference delegate rate charged by the venue was sponsored by the British Dental Trade Association (BDTA) with conference handbooks sponsored by Philips Sonicare, which also sponsored books sponsored by Philips (BDTA) with conference handbooks sponsored by Philips Sonicare, which also sponsored additional costs along with NHS Direct. In addition, the BDTA provided delegate bags, supplemented by washbags and USB pens from Colgate and the British Cheese Board provided the luncheon cheeseboard.

Ms Bruckel said: “Our chief executive, Pam Swain, has calculated that without the direct financial contributions from the BDTA, NHS Direct and Philips Sonicare, the provision of speakers by the British Chiropractic Association, Colgate, the General Dental Council, Nobel Biocare, Philips Sonicare, Schuelke, the University of Kent, WR Berkley Insurance (Europe) Ltd, Zedher NHS Foundation Trust and NHS Gloucestershire; and the generous donation of their time and expertise by the remaining speakers, conference registration fees would have had to start at over £200 each for BADN members and consequently £270 for non-members to cover the cost of staging the conference. And this doesn’t even take into account the administrative costs or the many hundreds of hours which the chief executive and staff put into the organization of the event.

“One on behalf of the BADN council, members and the delegates to and the National Dental Nursing Conference, I should therefore like to thank all the sponsors, and speakers, for their generous support of dental nurses in the U.K.”

The registration fee for the 2009 National Dental Nursing Conference was £120 for BADN members and £190 for non-members. The current annual BADN full membership fee is £70.

This year’s Premier Symposium, organised by Dental Protection and Schülke, saw the winners of the Premier Awards 2009 announced. The annual risk management competition has a total prize fund of £6,000 and accepts entries from projects which recognise the importance of patient safety.

Congratulations to this year’s winners:

Undergraduate prize
1st Richard Beckwith
Difficulties in obtaining valid consent in clinical dentistry.

2nd Rachel Ingle
A comparison of HTM01-05 guidance with the sterilisation of reusable instruments in the Dental Practice Unit, University of Sheffield.

Postgraduate prize
1st James Roberts
An audit to assess the cleanliness and storage of decontaminated dental instruments.

2nd Richard Holliday
Dental record keeping and the role of oral cancer screening in the dental access centre.

DCP prize
1st Michelle Mitchell
Ethical considerations in 21st century dental hygiene.

2nd Amy Wilkins
Extending the role of the dental nurse in the orthodontic practice: the patients’ perspective.

This year’s winners were of a very high calibre, and even though Sheffield Dental School was predominant amongst the winning entries, Kathy Harley, Chair of Dental Protection, who presented the awards took time to encourage dentists and DCPs from all regions of the U.K to participate again next year.

Thank you also to the sponsors of the Premier Symposium, Smile-on and Henry Schein, who helped to make the day possible.

If you would like to receive details of next year’s Awards you can register your interest by emailing sarah.garry@mps.org.uk.★

Premier Award Winners 2009

An oral health improvement programme for young children in Wales is to be extended.

Designed to Smile is being expanded, following two successful pilot schemes in north and south Wales.

In the scheme, which is delivered by the community dental service, dental health support workers deliver a supervised tooth-brushing programme in schools and provide toothbrushes and toothpaste to schoolchildren along with oral health advice. Part of the service is carried out via mobile dental health units, which provide specialist preventive care and treatment to schools.

Funding for the scheme is doubling to £1.5 million for 2009/10 and rising to more than £5.8 million for 2010/11. As well as rolling out the scheme beyond the existing pilot areas to specifically targeted, ‘communities first’ schools in the rest of Wales, the additional funding will allow the scheme to be extended within the existing pilot areas. This means that six and seven year olds as well as three to five-year-olds will be included, as well as a nursery-based programme for very young children under the age of three.

Compared to the rest of the UK, the dental health of children in Wales is poor, with a direct correlation between poor oral health and social/economic deprivation.

Health Minister, Edwina Hart said: “The rates of tooth decay in parts of Wales are too high and are something which needs to be tackled. This additional funding for the, Designed to Smile, scheme will carry on and enhance the good work done in the pilot areas to extend it across the whole of Wales. There is a significant role for parents to play, but we know that for many children at the greatest risk of dental decay, cleaning their teeth or having their teeth cleaned does not form part of their daily routine.

“It is clear that more direct and also more innovative methods of delivering preventive care are necessary if advances in child oral health are to be made.

“By teaching children the importance of good oral health at an early age, they will develop good habits which they can carry on into adulthood.”★

New GDC chair

D entist Alison Lockyer (picture left) has been elected as chair of the new look General Dental Council. Alison was born in Leeds and is now based in Leicestershire, but also works in Oxfordshire.

Alison was a returning Reg- istrant member to the Council of the GDC which she has been in volved with for more than eight years.

She qualified in Edinburgh in 1980 and works full-time as a primary care dentist with five private and NHS practices in Ox fordshire and Leicestershire. She’s also provided dentistry within prisons and in an industrial setting (BMW factory).

The current Chair Hew Math ewson and the Chair Elect Alison Lockyer will discuss and agree the detailed handover timetable. The Chair Elect will take office as Chair on either 1 January 2010 or on the date on which the current Chair resigns, by agreement, whichever is earlier.

Alison commented: “I would like to thank Hew for his excellent Presidency, he will be a hard act to follow, but has been an excellent example of how to Chair. I am really looking forward to leading this multi-skilled and talented Council in public protection.”★
GDPUK round-up

Tony Jacobs shares the most recent snippets of conversation from his ever-growing GDPUK online community

The diversity of topics on GDPUK can be mind-boggling. What’s more, the site has been at its busiest ever during October and November with contributions from many new members as well as older ones. GDPUK readership is now at a staggering 10,000 hours per month, which equates to 40,000 15-minute visits a month.

Recent discussions have raged about the various communications regarding HTM 01-05, including letters in the British Dental Journal and Parliamentary answers. The Chief Dental Officer wrote that the Department of Health (DH) will produce scientific references to support the decontamination document “if required”, which Ann Keen told the House of Commons would be arriving soon. Colleagues on GDPUK cannot believe the situation surrounding the scientific references; surely they would be ready at the touch of a button or the click of a mouse if they were the true basis of this derided document? In the meantime, a further letter was drafted by Tony Kilcoyne with 15 references all countering the edicts of HTM 01-05.

When the PDS Plus contract was published soon after BDTA Showcase (where GDPUK members met up all three days) in many ways there was only a minor response on the site as the access contract with all its pitfalls had been dissected previously when the draft document and spreadsheet were leaked.

Among other topics discussed were clinical ones, as well as more general and non-dental ones – how to repair a wrecked dentition; advice sought on cementing all porcelain restorations; should the profession take up the flu vaccine; abfraction; strategies against key performance indicators; weight training as well as James Hull news coverage to name a few.

It was suggested that practices should carry out a risk assessment for latex allergies. Someone pointed out this was called a medical history. Others report they have tried to remove latex products completely, gloves, LA cartridges and dam, to name a few.

A kind soul had posted some video footage on YouTube immediately after the recent Manchester United v Chelsea football match, a young man could be clearly seen in the crowd, chewing on a toothbrush during the match. This was linked from the forum, and there was much surprise, even from a group of dentists, at this behaviour.

Recent discussions have raged about the various communications regarding HTM 01-05

During the month, there were some polls of GDPUK membership; about 80 per cent responding were male, and 75 per cent practice owners. When asked about source of income, practitioners are polarised – very few earn 50 per cent of their income from NHS, the large majority of respondents earn either mostly from NHS, or mostly private fees. The polls on the GDPUK forum software only allow one vote per member per poll, so they cannot be manipulated.

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Tony Jacobs, 52 is a GDP in the suburbs of Manchester, in practice with partner Steve Lazurus at 406 Dental (www.406dental.com). He has had roles in his LDC, local BDA and with the annual conference of LDCs, and is a local dental adviser for Dental Protection. Nowadays, he concentrates on GDPUK, the web group for UK dentists to discuss their profession online, www.gdpuk.com. Tony founded this group in 1997 which now has around 7,000 unique visitors per month, who make 7,000 visits and generate more than a million pages on the site per month. Tony is sure GDPUK.com is the liveliest and most topical UK dental website.
Dealing with stress in the 21st century - a perspective for the dental profession

Ros Edlin looks at the issue of stress in the lives and careers of busy dental professionals and how you can help to minimise stress in your day

A sk the average man in the street for his opinion as to whether or not dentists experience stress, and your query will, in all probability, be met with a look of incredulity and a snort of derision. After all, isn’t stress in the domain of the poor patient rather than the high-earning, fast-living, ‘Porsche-driving dentist’?

A media-fuelled opinion such as this may be true for a minority of dentists, but for the majority this is an entirely inaccurate assessment of dentistry today.

What is true, however, is that dentistry has been identified as one of the most stressful of the health professions.

A recent study by HL Myers and LB Myers conducted using an anonymous cross-section of 2,441 UK GDPs, found that 60 per cent of GDPs reported being nervy, tense or depressed, 58.3 per cent reported being nervous, tense or depressed, 58.3 per cent of GDPs reported being nervous, tense or depressed, and 48.2 per cent reported difficulty sleeping. 60 per cent reported difficulty sleeping and 48.2 per cent reported feeling tired for no apparent reason – all signs possibly related to work related stress.

So why are dentists so susceptible to stress? Not only are they required to work in an intricate manner in a sensitive and intimate part of the body, sitting in the same position for long periods of time, but they also have to be responsible for the smooth running of the practice with regard to both staff and patients, as well as managing the financial aspect. Added to this are the ever-increasing demands and expectations of patients and the constant awareness of running behind schedule. As if this wasn’t enough, they have to ensure that they maintain clinical excellence in the eyes of a Regulatory Body, faced with all these factors, and for the most part, not having received any particular training in, for example, people skills or financial management, it is little wonder that many dentists fall victim to stress – related illnesses, either mental, physical or both.

Stress itself is not an illness but is, according to the Health and Safety Executive (HSE) definition, ‘the adverse reaction people have to excessive pressure or other types of demand placed upon them’. The HSE also ‘makes an important distinction between the beneficial effects of reasonable pressure and challenge (which can be stimulating, motivating and can give a ‘buzz’) and work- related stress, which is the natural but distressing reaction to demands or pressures that the person perceives they cannot cope with at a given time’. The concept of perception is particularly relevant in that, faced with the same situation, a difficult procedure or a demanding patient, one dentist may relish the challenge and yet the other be trembling in their shoes!

Also pertaining to the definition of stress are the notions of control and change.

It is clear that we function best when we are in control of our circumstances; when we feel we are responsible for our successes or failures due to our own personal attributes. This could also include the responsibility of the welfare of both patients and staff. As is often the case however, the bureaucracy of the NHS mitigate against this feeling of control which could result in work-related stress.

The recent NHS Dental Contract is a prime example where it can be argued that dentists have a loss of control of their own destinies. It also illustrates the importance of involvement in the process of change for the best results to be achieved. ‘Today’s dental environment is not going to change to accommodate the individual. It’s the individual who needs to learn to accommodate to the environment if he or she does not want to pay the price of chronic stress.’

There is no doubt that we all need pressures and challenges in our lives to get us up in the morning and to keep us going. These can galvanise us into achieving great things; to work at our most productive level, but we have to be aware that having unrealistic goals or expectations can possibly result in the ‘law of diminishing returns’ ie the more we push ourselves to reach that elusive goal, the less well we can sometimes perform. This is not to underestimate the thrill of achievement, but it is worth paying heed to the warning signs. ‘Stress itself is not an illness but is ‘the adverse reaction people have to excessive pressure or other types of demand placed upon them’.”

These warning signs are like traffic lights in our lives. Green means that everything (or nearly everything) is going well with us. We are enjoying our work; the practice is flourishing; we have a great team and the patients feel more relaxed and welcome. A ‘win-win’ situation for all concerned.

A successful practice is one where effective stress management strategies are firmly in place. This contributes to the atmosphere of well-being and competence within the practice. Its positive effect emanates throughout – the staff feel valued and motivated and the patients feel more relaxed and welcome. A ‘win-win’ situation for all concerned.

Achieving this ideal situation does not come naturally to many practitioners who may require guidance. It may be necessary to consider what your goals and aspirations are in relation to both yourself and your practice. Hopefully some of the coping strategies that follow will be of assistance.

What are you doing now?
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In terms of individual stress, try take a step back and assess where the stress is coming from. Writing a list of causes from the most stressful down to the least will help you gain some perspective on the problem and may inspire you to tackle some of the issues raised. It is even possible that you could be the cause of the stress! You may need help dealing with some of these issues. Try not to let pride stand in the way of getting the help you need.

It could also be useful to employ this technique with your staff by asking them to identify the sources of stress. ‘By airing and discussing grievances, concerns and new strategies, the various members will feel part of the dental team and provide mutual support in time of stress.’

For the individual, relaxation techniques are also recommended. Although it is often thought that relaxation is not compatible with working in a dental surgery, with organisation and planning it is feasible. (Some European countries manage successfully to incorporate this into their working day.) A prerequisite would have to be a competent receptionist who would not fill your appointment book so full that you do not have time to breathe, let alone try some deep breathing (which is excellent for calming you down.) Take a deep breath (don’t hold it) and count one, two three as you exhale slowly.

In your every day life having a period of relaxation is vital. It could be as basic as taking breaks in the day or going out at lunchtime to listening to music or having a relaxing bath. The importance of relaxation is that it enables you to switch off and recharge your batteries!

Equally important is physical exercise. Exercise burns up the excess adrenaline resulting from stress, allowing the body to return to a steady state. It can also increase energy and efficiency. Do find an exercise which you enjoy that will motivate you to continue doing it.

Manage your time (and yourself) efficiently. Again, taking a step back and reviewing your working practice is essential. Do you have an allotted time for dealing with emergencies and administration? Are you constantly running behind schedule causing your stress levels to escalate? Developing leadership and organisational skills will enable you to feel more in control of your working environment.

Ensure that your staff are properly trained and aware of their individual roles and responsibilities. Encourage a culture of mutual support, whereby asking for help is not viewed as weakness. Talking over your problems with someone you trust can be such a help!

As mentioned previously, some dentists may be excellent practitioners but sadly lacking in interpersonal skills. An ability to listen is a gift. If you feel you need some training in communication, there are plenty of courses available.

By incorporating at least some of these strategies into your everyday life and your working life, you could create an environment which is stress-free and an environment in which it is a pleasure to work. It could make the difference between a good practice and an outstanding one. Who wouldn’t want that?

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About the author

Ros Edlin is a freelance stress consultant. Her background is in social work and counselling. She lives in the North West and travels throughout the UK giving presentations and facilitating workshops on stress awareness and management in the dental team. Ros tries to practise what she preaches and relaxes by walking the dog, yoga and playing the piano (badly!).

Email: ros@stresswatch.co.uk


2. Mark Killman, Ph.D., Artistic Stress and Dentistry: Better Practice Through Control


Access over quality?

Although high-need patients can be seen for dental treatment, Neel Kothari thinks the jury is out as to whether they are getting the treatment that best meets their needs

Over the last few years, I have witnessed an miraculous cure to my writer's block when a patient I recently treated brought to my attention some of the issues that can still be seen within NHS dentistry.

This patient is a young lady of around 25 who presented in a great deal of pain from a lower abscessed molar tooth, as well as rampant caries elsewhere. I asked her when she had last seen a dentist and she replied: 'Only last week, I booked in to see a dentist under the NHS, but at the end of my session, I was told that this was only an emergency visit and they did not have the time to see me for treatment.' She was told to find another dentist and was given a prescription for antibiotics, but still could not sleep or eat.

Funnily enough, this is not the first time this has happened and I am sure that many of you may have encountered something similar. The problem here in my opinion cannot purely be put down to the new contract, but when any system is based solely on 'improving NHS dentistry' and people are not going to an NHS dentist, because it is hard to find one, especially as it's called a National Health Service, but exactly what are they getting?

In Hampshire and the Isle of Wight, access figures are clearly well below average. Regardless of how much investment into dentistry has been made here in recent years, according to prospective Parliamentary candidate Terry Scrivener, thousands of people across the New Forest still have no access to an NHS dentist.

One of the problems here is that any new practice commissioned by the PCT would be subjected to a massive number of patients, many of whom may require treatment for years of dental neglect. That's great, you may say? Surely that's exactly what a new dental practice needs, isn't it? Well, yes and no; we hear a lot about NHS efficiency savings and getting more for less, but there comes a point where less is definitely less and if PCTs choose to fund new services based around improving access rather than quality, just exactly who are they accountable to? And at what point does this transgress from governing to influencing clinical decisions?

Of course since the inception of the NHS, dentistry has always been used as a political football where successive governments have incentivised clinical choices they deem favourable. However in incentivising access over quality, while high-need patients are able to be seen for dental treatment (according to the DH), for me the jury is out as to whether they are getting the treatment that best meets their needs.

The promises made at the recent Labour Party Conference should really be measured up against Labour's own record. This in fact shows loss of access. After the introduction of the new contract, the number of people accessing NHS dentistry fell by one million. Some 7.5 million people are not going to an NHS dentist, because it is hard to find one. Fewer children are accessing NHS dentistry – more than 100,000 fewer than before the new dental contract and dental caries is now the third most common reason for children’s admission to hospital.

A key driver?

Regardless of how the Government dresses up various new schemes and initiatives to improve NHS dentistry, it does not take long to realise that ‘improving access’ tends to be the key driver. But how sensible is this aim? Of course everyone who needs a dentist should be able to get one, especially as it's called a National Health Service, but exactly what are they getting?

The promises made at the recent Labour Party Conference should really be measured up against Labour's own record. This in fact shows loss of access. After the introduction of the new contract, the number of people accessing NHS dentistry fell by one million. Some 7.5 million people are not going to an NHS dentist, because it is hard to find one. Fewer children are accessing NHS dentistry - more than 100,000 fewer than before the new dental contract and dental caries is now the third most common reason for children's admission to hospital.

Disastrous consequences

Ten years ago, in September 1999, Tony Blair told the Labour Party Conference: 'Everyone will have access to an NHS dentist within two years.' Ten years later the drive to (still) try and achieve this has clearly had disastrous consequences. Rather than improve quality, access to treating some of the major problems, stabilising the patient and spreading the treatment over multiple courses.

While they all agreed that it was unacceptable to leave a patient in pain, I'm afraid across the nation, many dentists are apparently still working in different ways and it is clear that we still all have different interpretations of exactly how the new dental contract should be implemented. One problem still remains: when one dentist chooses to cherry pick patients, this leaves others to unfairly pick up the pieces.

Meeting bottom line

While I have some sympathy for dentists having to provide an unlimited mass of dental treatment for a fixed level of remuneration, surely there can be no excuse for kicking out patients in pain and agony while cherry picking those patients who help to better meet the bottom line?

Cases like these do raise important questions as to how the profession deals with those patients needing much restorative intervention. When trying to find out what the ‘powers that be’ (various PCTs and dental unions) seem to think, I was not surprisingly bombarded with a myriad of different opinions ranging from treating all dental disease within one course of treatment, to treating some of the major problems, stabilising the patient and spreading the treatment over multiple courses.
Cross-infection collapse?

Bruce Nell looks at the HTM01-05 guidance, its implications for those in dental practice and how the Department of Health intends to enforce it

With the publication of the Department of Health’s Decontamination Health Technical Memorandum (HTM 01-05) earlier this year, the Government has signalled its determination to affect a change in practice within the dental profession. Within its introduction, it states the desire to ‘deliver the standard of decontamination that our patients have a right to expect’ through ‘a programme of continuously improving decontamination performance at a local level’.

The way in which the authorities will ensure dental practices are adhering to the guidelines is through the Care Quality Commission (CQC). Over the next two years all healthcare providers (including NHS and private dentists) will have to be registered with the CQC and the ‘provision of a safe, clean environment and appropriate decontamination of dental equipment’ will be a requirement. Demonstrating compliance will involve a self-audit of a practice’s procedures, with supporting evidence to show decontamination management is in effect.

The focus of the guidance is to impel a progression from the current ‘essential’ quality requirements for every practice to have instruments which are sterilised after the decontamination (reprocessing) cycle, to a state of ‘best practice’ comprising of three areas, summarised as:

- Separate decontamination facilities
- Use of a validated automated washer-disinfector
- Controlled storage of reprocessed instruments.

Many practitioners may well feel a degree of affront at the suggestion that their procedures for decontamination are not up to standard or, at worst, hazardous to the health of patients and staff. However, the ‘we’ve had no problems’ retort, coupled with the side effects of a repetitive process could lead to problems, as its not just contempt that is bred by familiarity when dealing with infection control.

The HTM 01-05 makes reference to a survey conducted in 2004 of the decontamination in general practices in Scotland, and it makes for some interesting reading. For instance, 42 per cent of surgeries did not have a dedicated area for decontamination, with the space also being used for activities such as food and beverage preparation or housing the compression unit; 52 per cent did not have a dedicated sink for cleaning contaminated instruments.

Consider for a moment the potential ramifications to the health of staff and patients of having a compression unit in with contaminated instruments. At least the Department of Health recognises that there needs to be time to institute the shift towards best practice of the separation of instrument reprocessing from other (clinical or otherwise) practices. It’s understood that sterilisation may well be taking place within surgical areas. At least if it’s using a bench-top machine, transplanting it to the separate facilities (once the necessary refurbishments have taken place) won’t be a difficult task.
The second aspect of achieving the state of compliance is the use of a validated automated washer-disinfector. In the 2004 survey, 96 per cent of surgeries used manual washing as either the sole method, or part of the cleaning process. 45 per cent of surgeries had a designated sink purely for re-processing instruments, which means that more than half of the surgeries were using a washing method for other purposes, such as hand washing. Can anyone confidently say they can guarantee the same is not happening in their practice?

HTM 01-05 states that ‘practices should plan for the introduction of a washer-disinfector’ primarily because hand washing cannot be guaranteed of maintaining controlled conditions (only two per cent of surgeries in the 2004 survey were using a detergent specifically formulated for the manual washing of surgical instruments; some were using kitchen cleaning agents). Using a washer-disinfector is the preferred method for cleaning dental instruments because it provides the best option for control and reproducibility of cleaning; the process can be validated which is an important aspect of establishing compliance.

In response to the HTM 01-05 companies are manufacturing washer-disinvertors specifically designed to meet the requirement for maintaining records of correct functioning of the machine. By incorporating an in-built microprocessor, which controls and records the pressure and temperature used during the cycle, an independent monitor with printer then creates a printed copy as evidence so that a record showing compliance is created. Since this needs to be completed every day, having an automated system really is a time-efficient solution. Practices will have to maintain such records for at least two years.

The washer-disinfector also has to be easily dismantled to allow each part to be adequately cleaned. By having a water reservoir that is completely detachable from the machine means a practice can easily ensure they remain confident in minimising cross contamination from bacterial or chemical agents within water supplies.

The third element of achieving best practice is the storage of instruments. The HTM 01-05 recommends that: “the storage of instruments does not exceed 21 days for instruments sterilised in a non-vacuum (type N) steriliser, or 10 days if sterilised in a vacuum (type B or S).”

The 2004 survey found there were flaws in the methods used to clean, sterilise and store re-processed instruments, with the necessary record keeping frequently incomplete.

An important element of achieving compliance will be to have an assessment of the changes needed within the practice to meet ‘best practice’ requirements. It’s an opportunity for managers to re-evaluate current procedures and to establish a clear framework within which the Infection Control Policy will take a critical role in ensuring the CQC’s requirements are met. Being able to demonstrate records are being kept in regards to decontamination equipment will be a significant element within that so any system that has been designed to facilitate will be of valuable service.

To demonstrate best practice; ‘a cleaning process should be carried out using a validated automatic washer-disinfector’. A dental practice needs a machine that can reliably and consistently produce the same high standard in cleaning and disinfection which is required to minimise the risk of cross contamination.

Undoubtedly a great deal has been done to raise the standards of decontamination in dental practices since 2004. A similar survey of practices in England conducted in 2008/9 will return its findings in the near future and its results will be of great interest.

**About the author**

Bruce Nell worked on Equipment and Surgery Design for Wrights Millners in South Africa. Trained in Dental Ergonomics at GICE in the USA before going on to lecture extensively in South African Universities on Sterilisation and Advancements in Dental Equipment. Bruce is now the Sales Director of Xenos Dental Supplies. He also lectures at local PCT Dental Forums on HTM 01-05 LDE Design and Considerations.
Streamlining operations

Jo Banks discusses how to simplify the day-to-day running of your practice and ensure your appointment systems are working smoothly

Use correctly, the appointment book can be the practice team’s greatest ally. Not only can it that the reception room is not become a waiting room, but it is also the cornerstone of a smooth-running practice.

However, the appointment book is also one of the tools we use day-to-day without really utilising it effectively and it is easy to take it for granted. By following the top tips below, you can get your appointment system working seamlessly and ensure that you are taking full advantage of this valuable tool.

Manage new patients

It is important to make sure every new patient feels valued, as choosing a dentist is a significant decision and requires a feeling of trust in both the dentist and the practice. Therefore, when a new patient contacts the practice by telephone to make an appointment - why not send them a practice information leaflet, directions to the practice and a medical history questionnaire, together with their appointment card? By doing this you are not only reminding the patient of their appointment, but you are also reducing the time they have to wait in reception by saving them completing any forms when they arrive.

Book at short notice

If a patient calls for an appointment time which is not available, or they have to wait for a number of weeks for their appointment, you could ask them if they would like to be notified of any cancellations. By retaining and using an up-to-date list of patients who are willing to attend at short notice you can help ensure that cancelled appointments are filled and the appointment list is used efficiently.

It is also a great idea to give patients a courtesy call around one to two days before their appointment. This can help them feel relaxed and appreciated to ensure that they know which member of the team they will be seeing at each appointment. If your patient visits a particular dentist regularly, be sure to let them know, before their appointment, if their dentist is unable to see them, and the name of the replacement dentist who is seeing them.

This is particularly important for nervous patients, as they may have built up a level of trust with their regular dentist and may not feel comfortable seeing anyone else. If you leave it until they are time to record the relevant details, such as the date, time and who they will be seeing at their appointment, in their diaries. This not only reduces the risk of missed appointments but also provides them the opportunity to explain any problems or concerns, which will put them at their ease and also help the dentist.

Be clear on charges

Appointment time is precious in any practice, so it is essential to make sure patients, especially new ones, understand the practice’s policy on failed appointment charges. This will discourage last minute cancellations and no-shows, while also helping to keep the appointment book up-to-date, with more opportunity to fill cancellations with last minute appointments.

Give patients time

Be sure to allow sufficient time for patients to make their appointments, either in person or on the phone, and not to rush them. This is an effective and easy way of making patients feel valued; it also gives them appointment charges. This will discourage last minute cancellations and no-shows, while also helping to keep the appointment book up-to-date, with more opportunity to fill cancellations with last minute appointments.

You could also put this in your patient information leaflet or welcome packs to new patients. This may have a cost, but this expenditure can often pay dividends when it comes to cancelled appointments. Other options include a patient newsletter or adding this information to your practice website.

Keep it legible

As the appointment book will be read by most of the practice staff, ensure that your writing is neat and legible. This may sound obvious, but some of the most common mistakes in practice are often down to poor written communication. It is also important to use only recognised abbreviations, not your own version of shorthand, to ensure that entries can be understood by everyone.

A lot of practices are now computerised, so why not promote the benefits of computerised appointment books? This will be an effective solution if you have trouble reading other team members’ handwriting, or even if you just want to make your appointment book more secure. Though this may reduce illegibility issues, you will still need to be clear about abbreviations and shorthanded notes.

Zoning the appointment book

It is a really good idea to have allocated slots every day for emergency patients. This means that your scheduled patients do not have to wait for their appointment in the event of an emergency and your practice is far more likely to run more effectively.

Another effective management tool is to see nervous patients first thing in the morning before the practice gets too busy, in order to reduce their anxiety and reduce the risk of them having to wait. You could also aim to see them at the end of the day so they do not have to have time out of school. And, mixing them with your more nervous patients could release the potential for anxiety in both parties.

Children’s days

Many practices have found it really useful to clear a day in the appointment book in the school holidays and have a children’s day. You can provide fun activities such as face painting and use the opportunity to educate children on how to brush their teeth and what foods they should avoid. It also works well if the dentist spends the whole day doing examinations only, building future appointments should a child require further treatment. This is an excellent way of seeing your children in one block, encouraging more regular check-ups and reducing the fear factor for children who may see the dentist as a scary place!

These tips are designed to give you a starting point, but if you wish to learn more about how you can streamline the running of your practice there are a number of handbooks and guides available, which can even be personalised to suit your particular practice’s needs.

Alternatively, why not look into attending a training course to target any areas of improvement? Some dental payment plan specialists not only offer a range of structured training courses, but can also provide bespoke training for your practice to take place at a venue that suits you.

About the author

Jo Banks is Sales Trainer Manager at Joining Denplan in 1993, providing training to dentists and their practice teams on a wide range of subject areas. She has also provided bespoke training courses, which can even be personalised to suit your particular practice needs.

She has a range of experience in all aspects of dental practice management, having joined Denplan as a Sales Trainer in 1993, working with clients to provide bespoke training to suit their specific needs. She has also provided bespoke training courses, which can be personalised to suit your particular practice needs.
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The 10th Dimension…
the power of 10

In part two of this two-part series, Ed Bonner and Adrianne Morris discuss the art of problem solving.

Dealing with problems

It’s not the problem that’s the problem; it’s how you deal with it. Unfortunately, given the underlying issues of relationships and prior personal history that invariably accompany any difficult situation, it’s all too easy to approach problems in an inappropriate way.

1 Bite-sized chunks: A few years ago, there was a best-selling book by Kristine and Richard Carlson called Don’t sweat the small stuff… and it’s all small stuff. All too often, individuals refer to a series of inter-related problems instead of tackling the specific problem at hand. If you can take what appears to be a large problem and break it down into several sub-components, and then deal with each component individually, you are much more likely to find a solution than trying to sort out the problem in its entirety.

2 Control: Define and clarify the issue – does it warrant action? If so, now? Is the matter urgent, important, or both? Are you able, in a clear and rational manner, to identify the problem and the obstacles that the problem presents? Clearly state the problem and what obstacles the problem presents to you. Once you have done this, you need to understand what you have control over and what you don’t. Your efforts to resolve the problem must focus on, and be within, the areas over which you have control.

3 Reality and perception: Which components of the problem are real, which are perceived? You may contribute to the problem by magnifying it out of proportion, thereby turning a small issue into a very large one. Check the realities! Take the problem in its entirety. Are you able to discuss points of contention without becoming angry or emotional? We all have ‘buttons’ which, when pushed, cause us to react in a predictable but unfortunately irrational way. For example, when a partner says: ‘You are doing this’, chances are you will respond with a retort that is as unreasonable as the very statement itself.

4 Information: Do you have all the information you need? Solving problems is often like being in a mystery novel or investi-gating. Have you thoroughly researched why the problem exists? Do you have all the information you need? If not, be persistent and seek out all information before tackling the problem. Gather all the facts and understand their causes.

5 Non-emotion: Are you able to see issues clearly, objectively and with emotional detachment? Are you able to discuss points of contention without becoming angry or emotional? We all have ‘buttons’ which, when pushed, cause us to react in a predictable but unfortunately irrational way. For example, when a partner says: ‘You are doing this’, chances are you will respond with a retort that is as unreasonable as the very statement itself.

6 Negative energy: Working towards your goal without the interference of negative mental energy makes any job more manageable – you should not allow another person who is critical of you, rather than having your best interests at heart, to be part of the solution – they are more likely part of the problem.

7 Options: How many options for solutions do you have? Generate a list of different options for solving the problem. Are some better than others? Why? Which options seem reasonable? Some are practical, others rooted in fantasy. Have you weighed the pros and cons, advantages and disadvantages of your options? Are there any limitations to your options? Are they affordable? Avoid vagueness or ‘foot in both camps’ compromise. As Aneurin Bevan once said, ‘We know what happens to people who stay in the middle of the road. They get run down.’ Think about, or brainstorm with others, possible options and solutions. Select the best option. Explain your decision to those involved and affected, and follow up to ensure proper and effective implementation.

8 Is it you? Could it be that you are the problem? Your personal belief and value systems may be contributing to the problem, and may equally be getting in the way of a solution – ‘I’m not going to let a nurse tell me what to do!’ Don’t jump to conclusions. Once you have all of your information, analyse it carefully and look at it from various viewpoints. Be as objective as possible and don’t be quick to judge. Remain judgment-free as much as possible, allowing you to use your critical thinking skills.

9 Take a break: When you are beseated by what appears to be an insoluble problem, take a break. Failure to take regular breaks not only wears you down, but also makes you less productive. While you may not feel it at the time, slowly but surely, exhaustion will sneak up on you. You’ll become less patient and less attentive. Over time, you’ll burn out more quickly and your creativity and insights will slowly fade away. Breaks don’t have to be disruptive or last very long. Usually all we need is a few minutes to get away from it all, clear our heads, stretch our arms and get some air. It’s like pressing the reset button and providing ourselves with a fresh start. Furthermore, a week or two away doesn’t harm either.

10 Buying a solution: Some decisions and challenges are difficult because you don’t have the necessary knowledge or experience. Could it be beneficial to buy a solution, for example, by calling in a coach, consultant or an accountant? How often does a pair of eyes that is not emotionally involved in a tricky situation see the reality of the situation with absolute clarity?

Problem-solving and decision-making are closely linked, and each requires creativity in identifying and developing options, for which the brainstorming technique is particularly useful. Good decision-making requires a mixture of skills: identification and creative development of options, clarity of judgment, firmness of decision, and effective implementation. Once your solution is in place, it is important to monitor and evaluate the outcome regularly.

www.thepowerof10.co.uk

About the authors

Adrianne Morris is a highly-trained executive coach whose mission is to help people from where they are now to where they want to be, in clear measured steps.

Ed Bonner has owned many practices, and now consults with a wide range of dentists and their staff to achieve their potential. For a free consultation, or a complimentary copy of The Power of Ten e-zine, email Adrianne at alplife@coaching.co.uk or Ed on bonner.edwin@gmail.com.
A good team is for life, not just Christmas

It's a good idea to treat staff little and often throughout the year, says Sharon Holmes, as a way of showing appreciation

Moving into a new year is like starting afresh. It gives you a chance to forget how busy you've been and move on to new things.

When I joined our first practice as manager, we used to celebrate at the end of the year by going out for to a restaurant with practice owners, Dr Malhan and Dr Solanki. Once we moved into the corporate environment, arranging this became a bit more complex, and celebrations too many. None of us in upper management wanted to eat four expensive meals in a space of one week – this would surely increase our waistlines before Christmas Day even arrived – so on our first year, I decided to ask individual staff members how they best liked to celebrate the Christmas period.

As it turned out, most staff chose to have individual dinners with their own staff and associates and to receive gift vouchers from the Dental Arts Studio. So out I went to buy M&S vouchers, which I sent to all the staff with a Christmas card, thanking them for their contribution throughout the year. We did this for two years running.

Now we have been established for nearly six years to become a mini corporate group of four practices and a low level of staff and associate turnover, we all know each other very well, so we have chosen to have one huge Christmas bash at the end of the year with staff and their partners from all the practices combined. We’ve successfully done this for three years now with staff talking about it for weeks afterwards.

Our first joint Christmas Party – the “Pink Party” – was affiliated to a charity event where the Dental Arts Studio raised £5,000 from ticket sales and a further £1,000 from raffles and prize draws on the night, for Breast Cancer Awareness. Not only did we have a lot of fun on a Thames River Boat, we were also able to contribute to a worthy cause.

Last year, we hosted a party at the Hilton Hotel in London’s Docklands, which was also a success, and once again this year we will return to the Hilton Hotel, but this time in Mayfair.

I am starting to feel the buzz in the surgery and the ladies are already talking about finding the perfect outfit for the occasion. These are the moments we all look forward to, and for a short while we can all forget about root canals and pain and realise that life does not have to always be fast and furious.

We don’t only celebrate at Christmas time here at the Dental Arts Studio. Recently, we’ve started having regular social get-togethers on Saturday evenings at either one of our principal dentists’ homes.

We also have staff member of the month award where the highest performer is rewarded for doing more than is required of them, a lot of the time in difficult situations that may arise in the practice. Let’s not forget “Fatty Friday”, which involves buying sweet treats every Friday.

Each practice has its own Secret Santa event at Christmas, and we always make sure we carry out collections for birthday presents.

As Albert Einstein once said: ‘A hundred times every day I remind myself that my inner and outer life depend on the labour of other men, living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving.’

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First-time sellers - seeking the right advice

If you’re about to embark on selling your dental practice for the first time, careful consideration should be taken when seeking legal advice. Andy Acton offers some useful advice to those looking to make that first sale

Selling your practice is certainly not a task you want to put in the hands of someone who has little experience. It’s also something you don’t want to enter into lightly, because it could well represent your life’s work or create a lump sum for retirement or investment in a new project. You deserve the very best advice available from someone with good pedigree and a proven track record.

In the current climate, there is a lot of scurrying about for business and many firms are extending their range of services beyond their core in an attempt to generate new income streams. I am a great advocate of innovation and we should all be looking to evolve and develop – it’s what makes business fun. That said, would you buy a car from a company that specialises in selling trucks? However, from the service recipient’s viewpoint this requires some consideration.

Pay special attention
Selling dental practices is a complex business and while there is a core underlying transaction, even through the thousands that we have had an involvement in, there is always a unique element that requires some special attention. Take your pick – the list goes on:

■ How do I protect my UDA value?
■ Is it a problem that I don’t have contracts with my associates?
■ I am planning to incorporate, how does this affect my sale?
■ My property value has dropped and I don’t want to sell it with my practice, what are my options?
■ I have someone who is interested but they won’t make a commitment.

As well as an experienced sales agent, the need for a specialist should be considered when seeking legal advice. You could use a local firm who have quoted a relatively low fee, compared to a specialist firm. However, I would want a firm that understands the need for dental-specific covenants and warranties to ensure I was protected and the contract was fit for purpose.

I had a client many years ago that bought a practice and (against my advice) chose to use a local law firm. This firm failed to ensure that all the leases outstanding on the equipment in each surgery were repaid from the sale proceeds at completion. This error resulted in the finance company repossessing the equipment from each surgery because lease payments were not being made (the seller was enjoying retirement in another country!). The practice survived – just – but it had to be fully re-equipped by the new owner and the impact on business was catastrophic. The client saved a couple of thousand pounds on their legal bill and nearly went bust in the process.

Choose wisely
There is no guarantee that working with those of good pedigree and a wealth of experience means that everything will go smoothly. However, carefully selecting firms that know what they are doing, and are backed-up by real and current-market experience should make for a safer transaction.

About the author
Andy Acton is director of Frank Taylor & Associates, independent valuers and consultants to the dental profession. Andy has helped a number of dental specialist banks develop their services to the dental profession, including NatWest and Bank of Ireland. For more information, call 08456 123454, email team@ft-associates.com or visit www.ft-associates.com.
Immediate single-tooth replacement and provisionalisation in the aesthetic zone

As immediate implant placement gains momentum, Dr Graham Magee gives an example of how this high-risk treatment leads to success.

With more than 40 years of clinical evidence, Titanium Endosseous Implants have become an acceptable (evidence based) form of treatment to replace natural teeth and should be considered as an alternative to either a partial denture or bridge. Immediate implant placement with simultaneous immediate function or immediate loading has been gaining momentum over recent years and can be a very predictable method in providing implant treatment for our patients. There have been various timeframes used for the definition of immediate implant placement. Hammerle et al (2004) suggested that immediate implant placement was when an implant was placed following tooth extraction and as part of the same surgical procedure.

In the same paper, the consensus statements say “implants should not be placed at the time of tooth extraction if the residual tooth morphology precludes attainment of primary stability.” It also states that, “If buccal plate integrity is lost, implant placement is not recommended at the time of tooth removal. Rather augmentation therapy is performed.” The implant is then placed after healing, that being 12-16 weeks or even longer than 16 weeks. It has also been reported that infection adversely affects immediate implant placement (Rosenquist & Grenthe 1996; Grunder et al. 1999), and is a contraindication for immediate placement of an implant into an extraction socket.

Predictable treatment concept

Immediate implant placement and provisionalisation is a predictable treatment concept (De Rouck et al 2008). The success rate is at least comparable to data published for single-tooth implant placement using standard protocols in healed sites. This happens providing careful appropriate patient selection is used and the surgeon is familiar with the techniques that differ from the standard two-stage protocol for implant placement.

For the patient, the main advantage for immediate replacement and provisionalisation is fewer surgical visits as well as providing immediate aesthetics that are virtually indistinguishable to the original tooth. Sometimes if the tooth being replaced is discoloured due to non-vitality, the aesthetics will provide an immediate improvement.

For the clinician, immediate replacement allows for minimal disruption of the soft tissue providing immediate peri-implant support through careful manufacture and design of the provisional restoration. This helps to maintain the stability of the gingiva.
gival marginal tissues, which is necessary for a successful aesthetic outcome.

Root-filling failure
The following is a case study of a 50-year-old female with a history of a failing root-filled, upper-left central incisor. The root filling had been present for approximately 25 years and this had been apicected approximately 15 months before the tooth became problematic (Figure 1). The patient did not want another apicectomy and requested that the tooth should be extracted. The various options for restorations were discussed and as the neighbouring central incisor was root filled and restored with a post crown, the lateral incisor was restored with a veneer due to microdontia, a bridge was not a viable option. The patient was adamant that she did not want a partial denture.

As the tooth was not infected and investigation had shown that the buccal plate was still intact, it was decided that the tooth could be extracted and immediately replaced with an implant fixture. This was to be utilised to support a Nobel Biocare immediate temporary abutment and a provisional crown.

What the treatment involved
Under local anaesthesia, a cervico-incision was used and no flap reflection. The upper left central incisor was extracted using a very careful (atraumatic) technique with a periosteum to preserve the buccal plate of bone and careful manipulation of the gingival tissues.

Once the tooth was removed, the socket walls were curved to remove any remnants of periodontal fibres or granulation tissue. The socket was inspected to ensure that the buccal plate was still intact (Figure 5). Using the standard protocol, the bone was first prepared by penetrating the palatal wall at the apical third. Great care needs to be taken in the ostotomy preparation as the palatal wall of the extraction socket is commonly very dense and difficult to prepare which can cause “run-off” of the drill tip.

To achieve the initial perforation, the drill is held at an angle of approximately 45° to the palatal wall. Once the drill has penetrated the palatal wall, the angle is changed to then run more-or-less parallel to the an-
and polished to ensure a smooth shoulder with no ledges or deficiencies against the IPA. (Figures 5 and 6). The provisional crown was then cemented to the IPA with a very small amount of Tempbond, ensuring that no cement extrudes into the tissues.

Adjusting the provisional crown

It is important at this stage to ensure that the provisional crown is adjusted to ensure that there is no contact with the lower teeth in centric occlusion (Figure 7) and no contact in any prognathic or excursive movements (for example, not immediate loading). The patient was advised to try and avoid the provisional crown and not to apply any forces with eating for the first four weeks.

The provisional crown was left in situ for six months (it is recommended that an absolute minimum of three months should be allowed for osseointegration before disturbing the immediately placed implant). The provisional crown was removed and a fixturehead impression taken of the implant. The adjacent post crown (upper right central incisor) was also prepared for a new crown to ensure a good match for both central incisors.

A Procera Zirconium abutment was connected to the fixture (Figure 8). The abutment screw was fastened down at the recommended torque of 35Ncm. Procera porcelain crowns were fitted to both central incisors (Figure 9). The implant-retained crown was cemented with Tempbond. It is recommended that the definitive restorations on implants should be cemented with temporary cement as this allows access to the implant if necessary.

Immediate implant placement is gaining momentum. Clinicians should be aware however that this is a higher-risk procedure and should only be attempted by those surgeons with experience in dental implant surgery particularly when dealing with the aesthetic zone.

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References

About the author
Dr Graham Magee qualified at Liverpool University in 1978 and in 1993 Graham created the Chester Dental Implant Centre within the general practice where he was a partner. Finally in 1999 needing more space for the Implant Centre he relocated the Clinic to the present building. Graham has undergone extensive postgraduate training to develop his skills in Dental Implant Surgery and Cosmetic Dentistry including a Masters Degree in Dental Implantology from Sheffield University. He continues with his postgraduate education regularly attending courses in Britain, Sweden, France and America and also gives lectures on the aspects of Dental Implantology and CT Scanning and 3D Planning in Advanced Dental Implant Therapy. Graham also runs postgraduate training courses for dental practitioners in his practice and is a member of the Association of Dental Implantology and of the American Academy of Osseointegration. To refer to Graham or for further information on Chester Dental Implant Centre, call 01244 540 177.
Learning Curve

With more than 4,500 new cases opened every year there is a wealth of experience within Dental Protection from which all of us can learn

In a world where most things we purchase are ready-made rather than bespoke, we are protected by a money-back returns policy in case we don’t like something after we’ve paid for it. However, dentists spend the majority of their time creating custom-made items which makes such an approach expensive and best avoided if possible.

Consider the case of a young male patient in his early twenties who requested his dentist to close his midline diastema. The patient was soon to be married and wanted the work done before the wedding day. It was quite a large gap of some 4mm between the upper central incisors, but the dentist confidently assured the young man that he could close the gap and produce ‘a perfect smile’ ready for the wedding photos.

When the patient returned for the preparation to be done, he asked the dentist to prepare the two lateral incisors as well as the centrals. This was duly done and an impression was taken before the patient rebooked to return a week later.

At the fitting appointment, the two central veneers were tried in. The patient agreed they looked fine and he was pleased with the way they closed the diastema. To save time, the dentist did not try in the two other veneers and went ahead and cemented all four of them. When he now looked in the mirror, the patient was surprised at the result and not at all happy with the size of the central incisors. He also felt the veneers were quite bulky under his lip. The dentist reassured him and asked him to try them for a couple of weeks.

A tricky situation

The patient phoned the next day saying that both he and his fiancée were very upset with the result and that the teeth were now far too prominent. With the wedding taking place in less than a fortnight the dentist agreed to replace them at his own cost. The patient had lost confidence in the dentist by now and instead went to another dentist who replaced the veneers for a considerably higher fee, which the patient now demanded from the original dentist.

Whenever aesthetics are involved in dentistry, it is wise to obtain the patient’s consent on the complete final appearance before finishing the case, particularly if it will be difficult or expensive to redo the treatment once it has been cemented or bonded in place.

Look out for another Learning Curve feature from Dental Protection in future editions of Dental Tribune UK.

ESTHETIC CURRICULUM

Master Program Chair: Dr. Ed McLaren & Dr. Sascha Jovanovic
Session Chairs: Drs. Didier Dietzchi, Mauro Fradeani & Stefan Paul

SESSION I - FEBRUARY 26- MARCH 1, 2010 IN ATHENS, GREECE
DIRECT RESTORATIONS AND ADHESIVES with DR. DIDIER DIETZCHI and others

SESSION II - JUNE 23- 26, 2010 IN ATHENS, GREECE
INDIRECT RESTORATIONS, FULL CERAMIC CROWNS AND VENEERS with DR. MAURO FRADEANI and others

SESSION III - OCTOBER 7 - 10, 2010 IN ATHENS, GREECE
ALL CERAMIC RESTORATIONS AND FIXED PROSTHODONTICS with DR. STEFAN PAUL and others

SESSION IV - NOV 29 - DEC 3, 2010 IN LOS ANGELES, CALIFORNIA
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Pride of dentistry in rural Devon

The Devon Centre of Dental Excellence is achieving outstanding business success and going from strength to strength. So what is the secret to his success? Centre owner Dr Badiani reveals all.

The ancient stannary town of Ashburton, on the slopes of Dartmoor, is hardly the place you’d think you’d find the leading referral dental centre in the West Country, but you’d be wrong. And Dr Mitesh Badiani, who bought the place in 1995, has more than demonstrated what a wise decision it was.

Today, the Devon Centre of Dental Excellence is the flagship practice for a group of practices including Plymouth, Bovey Tracey and Portland. More are in the pipeline and dentists are queuing up to join. So what is Dr Badiani doing that is having such an impact and how is he achieving it in what, at face value, is a sleepy rural community?

The answer is deceptively simple. Dr Badiani makes no decisions without carefully considering them. When he does, his commitment is total and his business acumen sure-footed.

And above all, he ensures that the patient experience exceeds expectations. It’s worth taking a closer look at how these values translate themselves into action.

Developing your product

The ‘marketing’ advice given generally to dentists by any number of ‘experts’ is seemingly endless with the majority of it simply being statements of the obvious. It does not take a genius to work out that there are established ways of communicating with patients, all of which are relevant and applicable to almost every practice. The genius comes, not describing and defining your market, but in developing a product that satisfies its needs.

In this respect, Dr Badiani’s philosophy and skill are clear. It is not about creating a practice that simply flaunts its capability. It is about creating a practice that shows that it listens to and cares about what patients want.

A few examples highlights this point:

■ The reception team greet everyone with a welcome that says ‘we’re glad you’re here’. The smile endorses this greeting and is genuine. It isn’t just a ‘skin-deep’ gesture. This can only happen in a practice where the staff are happy and is aware that patients recognise and take notice of body language.

■ There are a variety of places (other than reception) through-out the practice in which patients may wait and relax. This provides personal ‘space’, encourages a greater affinity with the practice and builds the patient/dental team relationship.

■ There is a delightful, spacious and calming garden, which, on a summer day, is a haven of calm and tranquillity. Patients are free to sit and relax there before and/or after treatment. Again it enhances the relationship.

■ The toilets are spotless and stocked with supplies of toiletries for patients to use. These make a nicer touch than a bottle of disinfectant.

Dealing with anxiety

It is a sad fact that many people fear dental treatment. Dr Badiani, who mentors and trains dentists all over the country, says: ‘We have for many years treated a great number of patients who are extremely nervous of dental treatment and

The Devon Centre of Dental Excellence is achieving outstanding business success and going from strength to strength. So what is the secret to his success? Centre owner Dr Badiani reveals all.
where a local anaesthetic is re-
quired, there are various meth-
ods we will consider. One of
my favoured techniques is the
WAND system, which is amaz-
ingly effective when used by a
skilled, well-trained dentist. It
reduces anxiety and is literally
pain free. It is particularly help-
ful when treating children or
those with needle phobia who
we find often don’t even realise
they’ve had an injection!“

Another concern of some pa-
tients is radiation dosage. In real-
ity, the risk to the patient may be
minimal, but this does not neces-
Sarily allay fears and anxiety.

‘Low radiation dosage was
one of the criteria I had in mind
when seeking to upgrade to 3D
digital imaging. I was worried
that, by referring to the hospital,
I was increasing patient concern
and in many instances the diag-
nosis did not warrant the radia-
tion dosage’, says Dr Badiani, ‘so
I decided to see what the market
had to offer!’

An exhaustive look at CT
scanners ended with Dr Badiani
choosing the Picasso Trio from
Vatech and E-WOO. ‘Quite sim-
ply the quality, the software, the
service and product knowledge
are the best,’ he says, ‘and the
Picasso is already enhancing our
diagnostic capabilities across
the range of specialist treatments
we offer!’

Working as a team
Dr Badiani’s choice of the Pic-
asso Trio exemplifies the policies
of the Devon Dental Centre of
Excellence to put quality above
cost. He has surrounded him-
self with something of a “dream
team’ in the way of specialist cli-
nicians and knows that they, too,
want the best.

Dr Badiani himself concen-
trates on dental implants, IV se-
dation and cosmetic dentistry. He
also mentors for Osteo-Ti and
Ankylos. Andrew Pickering, Lin-
da Blakely, Carol Robinson and
Anna-Marie Smith offer general
dental treatment and specialists
include Professor Nico Louw
(Endo), St John Crean (Oral and
Maxillo facial), Amelia Jerreat
(Ortho) and Matthew Jerreat
(Perio and Restorative dentistry).

It is Dr Badiani’s view that
individually and collectively
we will benefit from 3D imag-
ing. ‘While most treatments are
straightforward, careful plan-
ing is always required and the
exceptional quality of the Picasso
images is second-to-none. I also
value the information it provides
for more complex cases where
we need to work and assess as a
team.’

Building referral business
A further benefit of investing in
3D imaging is that it adds to the
service that the Devon Dental
Centre of Excellence can provide
to referring dentists.

Dr Badiani is very conscious
of the trust that other dentists
place in him. He recognises the
concerns that any dentist has
when he or she refers a patient:
“When you build a referral prac-
tice, you have to do so clearly
understanding that your role
is to support and advice, never
compete, be it consciously or un-
consciously. You must strive to
exceed the expectations of your
colleagues in the same way as
you do with your patients, always
keeping in mind that they are
all clients.”

In this way, referring den-
tists are seen as almost part of
the team. They have access to
the technology and share in
the knowledge, facilities and
skills available in Ashburton.
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available and procedures can
be watched at the viewing thea-
tre as they take place and then
discussed in a comfortable and
relaxed atmosphere.

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tact Devon Dental Centre of Ex-
cellence at Croydon House, 28
East Street, Ashburton, Devon
TQ13 7AX; call 01564 652 253 or
email info@devondental.co.uk or
visit www.devondental.co.uk

For more information on E-
Woo Technology, call 020 8851
1660, email info@e-wootech.co.uk
or visit www.e-wootech.co.uk.

About the author

Dr Mitesh Bada-
ni is a prac-
titioner of high
standing and ex-
pertise. Qualified
from Newcastle
Dental Hospital
in 1991, and has
been a Clin-
cal Director of a
number of suc-
cessful primary
care practices since 1995. He aims
to provide a comprehensive range
of pain-free dentistry for patients as well
as mentoring and training dentists
from all over the world.
Predictive Diagnosis and Treatment Planning

The most recent study Club event organised by The British Academy of Cosmetic Dentistry took place at the Costa Court Hotel on Friday 9th September, and saw one of the leading authorities in cosmetic dentistry give a presentation on Records for Predictable Diagnosis and Treatment Planning.

With over 20 years’ experience in both private and public health sector, Dr. Buckle is an accomplished practitioner, recognised throughout his work to both the British and American Cosmetic Dentist Academies. Attendees were also taken through issues concerning the use of articulators and the way to decide which type to use as well as the arguments in favour of using a Handy dental positioning device which the sensor can be clipped into. His elucidation on the most optimal usage of articulators was superb. Related to this, BioHorizons has continued to provide clinicians unique products supported by university-based research.

BioHorizons 2009 – 2010

BioHorizons have had an exciting year with the expansion of their biologics range, new Virtual Implant Planning (VIP) software and the introduction of some brand new implant courses which delivered a record number of delegates.

These new product developments in 2009 have confirmed BioHorizons’ place as one of the fastest growing oral reconstructive device companies in the world, as they also further demonstrated their commitment to providing the most comprehensive line of evidence-based, scientifically-proven dental implants and tissue regeneration solutions.

From the launch of the flagship External Implant System (Maxtak) in 1997, to the introduction of the tapered internal implants incorporating Laser-Lok technology, BioHorizons has continued to provide clinicians unique products supported by university-based research.

2010 is set to be even bigger for BioHorizons and will see a number of new product developments and launches on which information will soon be released. In further information for UK and further conferences and BioHorizons’ comprehensive range of implants and regeneration products please contact the UK office directly on 01344 752560, email: infouk@biohorizons.com or visit our website at www.biohorizons.com
Kemdent values the expertise of its customers and Kemdent is currently funding a project to take out further extensive research into Diamond GIC Dental materials. It is this support of Exeter University and Bristol Dental School. Kemdent have always been leaders in the contribution of experienced dentists to help them research their products.

For this reason Kemdent are encouraging new customers to evaluate their Glass Ionomer Capsules by providing them with 5 x A3 Diamond Rapid Set Capsules at this evaluation form. The completed evaluation forms will provide a valuable contribution to the project so Kemdent is offering an added incentive. Completed evaluation forms will be entered into a monthly prize draw with a chance to win £100.00 of Kemdent vouchers.

Diamond Rapid Set Capsules are packed in individual, easy to access foil. Diamond Capsules can be used for class 1, 2 and 5 abrasion cavities- for additional information please refer to the sample pack a web site of resistance to moisture and saliva which prevents any expansion of the restoration, providing a more reliable seal to the cavity wall.

For further information or to place orders call Jackie or Helen on 01793 770256 or visit our website www.kemdent.co.uk.

BACD Study Club: Impression Free Dentistry

The British Academy of Cosmetic Dentistry presents the latest in its series of Study Club Lectures, to be held at the British Dental Association, London on Tuesday 26th January 2010

Entitled Impression Free Dentistry: Are We There Yet? Dr Ian Preiss will explore how digital impressions can have a significant impact on the way dentists practise.

The focus is the new 3LSiwa Chairside Occlusal Scanner and the lecture will cover:

- An introduction to technology involved
- Clinical examples
- Computer software for capturing data
- Interpretation of data and communication between dentist and lab
- Clinical cases and proofs for onlays, veneers, and all-ceramic crowns

The lecture will also feature a practical element, allowing attendees to use the equipment.

Dr Ian Preiss is a member of the BACD, BACD and ADI Part of the Bow Lane Dentist Practica since 2000, he won the 2009 Restorative Smile of the Year Award at the prestigious Smile Awards.

Places are limited for this event and so booking early is recommended. For more information or a booking form please contact Suzy Rowlands on 0208 241 8130 or email easybacad@.

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A clean sweep for schülke at BDA Dental Showcase 2009

Schülke enjoyed a busy event, experiencing a huge amount of interest in both their brand new training programmes and infection control methods at this year’s BDA Dental Showcase.

A company with over 115 years of experience in infection control, schülke were a source of great interest from dental professionals keen to learn more about the new range of ‘v4dent’ training programmes available.

The v4dent in-practice sessions (developed with the BDA, DOH and COPEND) and the DVD and on-line training packages all ensure compliance with the latest regulations HTM 100, and provide a wealth of knowledge and ideas.

As well as the ongoing work in the European dental industry, schülke are also doing all they can for the developing world. schülke has been working with dental and community development charity BridgeAid for three years, and has already helped train two medical staff.

For more information on the training visit www.v4dent.com or contact schülke on 01482 545 950 or visit www.schulek-emp.co.uk.

Improved aesthetics in cases with compromised bone

A one course for implant dentists who wish to improve the aesthetic outcomes in compromised bone. A one course for implant dentists who wish to improve the aesthetic outcomes in compromised bone. This course is currently running a chance to take out further extensive research into Diamond GIC Dental materials. It is this support of Exeter University and Bristol Dental School. Kemdent have always been leaders in the contribution of experienced dentists to help them research their products.

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Practice Works presents Groundbreaking Technology at BDA 2009

PracticeWorks have always been at the forefront of innovation, and this year proved no exception. Amongst the range of impressive devices on display were:

• The newly unveiled Kodak 6500 wireless RVG sensor is a robust, waterproof device providing the highest image resolution in the industry. Using this new technology, information can be reviewed on iPad devices, offering a whole new level of convenience and accessibility.

• Alongside this comes the PERIS1 System, a simple yet powerful mobile solution to the problem of real-time control of patient information and financial records. Dental professionals liked how it provided access to essential data whilst away from the practice.

• With oral health on the agenda, Oralinsights was a popular model on display, with its fully interactive, 3D computer-generated imaging allowing children to develop effective brushing techniques.

With other innovative solutions for today’s dental professionals on display, PracticeWorks continues to demonstrate its dedication to supporting first-class oral healthcare.

For more information please call PracticeWorks on 0800 169 9692 or visit www. practiceworks.co.uk.

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For more information please call PracticeWorks on 0800 169 9692 or visit www. practiceworks.co.uk.

Access to More Patients with Munroe Sutton at the Sixth Annual BACD Conference

Delegates of the sixth annual BACD at the ECC in Edinburgh were introduced by Munroe Sutton to a truly world class Patient Referral Plan to successfully grow their patient base and encourage returning clients.

The Patient Referral Plan has been developed by dentists, for dentists, and proven successful in the US for three decades. Now tailored to the UK market, Munroe Sutton’s outstanding solution/fee practices:

• Increase cashflow with payment at time of service

• Reach out to more patients with FREE marketing solutions

• Offer a seamless service with an automated patient verification system

• Free MORE patients

Munroe Sutton was proud to sponsor the 2009 RADC and delighted with the success of the conference. Delegates to the Munroe Sutton stand were introduced to the first step towards growing their practice with full appointment books, cost-effective treatment plans, happy patients and the support of a world leader in highly effective patient referral plans.

For more information please call 0800 234 3558 or visit www.munroesutton.com.

The Complete Smile Academy

Introduction to Implants Day Course Nuneaton

On the 25th of February and the 21st of July 2010, the Complete Smile Academy will be offering an excellent opportunity for dental professionals to grow their practice by placing implants. The day course will see everything you need to know about giving you:

• Optimal personalised aesthetics for all indications and enhanced patient satisfaction.

The Implant Day Course will incorporate:

• A number of limited delegates in a fabulous venue - Surgical techniques • Implant occlusion – getting it right – Aspects of smile design • Prosthetic treatment – Predictable restorations • Planning your own case – a template for success • Implant videos, hands-on workshop opportunities

Learning the techniques of reducing chair time with one-stage and minimally invasive surgery, the Implant Day Course will also include hands-on activities to give you confidence and competence when offering implant treatment within your practice. Learn, practice, discuss and embrace the world of dental implants!

For more information call 0192 427 1202 or visit
UAE International Dental Conference & Arab Dental Exhibition

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Chemical disinfection – an integral part of endodontic treatment

Endodontic treatment aims to resolve periapical and radial periodontitis as well as intracanal infection caused by microorganisms. This can be considered a three part process involving shaping and cleaning the canal, chemical disinfection and finally root canal obturation followed by coronal restoration of the tooth.

Shaping and cleaning involves enlarging the canal in order to allow for chemical disinfection. This is an important next step for ensuring complete eradication of remaining bacteria, which will facilitate healing and help prevent recontamination.

Chemical disinfection involves the use of irrigants to eliminate any remaining pathogens. It is important to use the correct irrigant sequence and concentration. A lack of awareness of any limitations could still result in endodontic failure and periapical disease.

For example, the golden standard irrigant is sodium hypochlorite, often used in conjunction with EDTA. Recently, new irrigation sequences involving the addition of other solutions have proven to raise predictability rates.

Canals can have complex internal anatomy with various fins and cul-de-sacs so it is also important to use energising techniques. These techniques will help loosen adhesion of biofilm to the dentinal substrate.

It is also important to remember that killing endodontic pathogens present in teeth is more difficult than in laboratory exercises.

A new MSc in Endodontics
The University of Warwick will launch a new MSc in Endodontics in January 2010. The programme will be delivered by leading professionals, academics and researchers in the field of endodontic dentistry, and supported by respected academics from the field of continuing professional development.

As a part-time course, it has been designed to offer a flexible training pathway tailored to individual requirements and circumstances. The programme will allow students to improve and increase the scope of endodontic treatment in their practices through the study of a wide range of topics, such as tooth morphology, mechanical shaping, chemical disinfection and pain management in endodontics.

Learning will take place through traditional seminars and practical work, performed in labs and at regional training centres. Students will gain a thorough understanding of modern technologies, using materials and instruments such as surgical microscopes and cone beam CT.

Applications are being accepted now and further information about the course can be found at www.warwick.ac.uk/go/dentistry.

Postgraduate Dental Education
New Course
MSc in Endodontics

Endodontic treatment is one of the most technically demanding procedures in general dental practice. Growing demand from patients for teeth to be saved rather than extracted has presented a need for further training in this area. The Postgraduate Dental Education Unit at Warwick Medical School has developed a new MSc in Endodontics to deliver comprehensive and flexible endodontic education.

Our new MSc in Endodontics will develop your knowledge and confidence in this complex discipline, enabling you to deliver a high quality service.

As a part-time course spread over 3.5 years, it offers you the flexibility to continue working in clinical practice while studying. You will study a wide range of topics from sterilisation and disinfection procedures to tissue regeneration and preventing cross infections.

Applicants should be registered with the General Dental Council and have full professional indemnity insurance.

Contact us for further information, quoting reference code COS91F6

+44 (0) 24 7657 4640
dentists@warwick.ac.uk
www.warwick.ac.uk/go/dentistry
A BADN do to remember

The 2009 National Dental Nursing Conference, held at the Cheltenham Chase Hotel in October was the biggest and most successful to date

This year’s BADN conference saw a record number of delegates in attendance at the event sponsored by the British Dental Trade Association, NHS Direct and Philips Sonicare. As well as the opportunity to network, delegates watched as outgoing President Angie McBain handed over the Chain of Office to Sue Bruckel who became BADN’s 2009 to 2011 President at the Opening Ceremony, and listened to a presentation from keynote speaker GDC President Hew Mathewson.

The lecture programme, which offered up to seven hours of verifiable CPD, covered cross-infection control, introducing preventive practice, law and ethics, back care for dental nurses, risk assessment, prosthetics, oral and maxillofacial surgery, implants, medical emergencies and resuscitation, the new BSC for DCPs, forensic dentistry and accessibility for people with learning disabilities. Delegates were able to choose which presentations they wished to attend in advance, through BADN’s new CVENT online registration facility. Schuelke, Colgate, WR Berkley, the British Chiropractic Association, Nobel Biocare, Philips Sonicare, the University of Kent, Gloucestershire PCT and the 2gether NHS Foundation Trust provided speakers.

Extra curricular activities
Outside the lecture theatre, delegates were able to talk to representatives of NHS Direct, the General Dental Council and Parliament Hill, providers of the BADN Benefits Scheme. At lunch, delegates were treated to a selection of specially chosen British cheeses, courtesy of the British Cheese Board.

Master of Ceremonies at the black tie Presidential Dinner was Peterborough GDP Martin Fallowfield. Entertainment was provided by swing tribute act Swing Thru a Lens, whose repertoire of rat pack classics and modern swing favourites proved a big hit with delegates.

At the Closing Ceremony, sponsored by Philips Sonicare, President Sue Bruckel presented four new BADN Fellows with their certificates, introduced new members and first-time delegates and congratulated delegates on recent qualifications and achievements.

Photos, taken by local photographer Sally Burford, will be available shortly on the BADN website and the BADN Facebook Group.

Next year’s National Dental Nursing Conference will be held at the Blackpool Hilton on 26 and 27 November 2010.

‘Delegates watched as outgoing President Angie McBain handed over the Chain of Office to Sue Bruckel’

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Win
Dentalghar is proud to have launched an Educational Bursary Award in association with leading providers of interactive teaching and online courses for healthcare professionals, Smile-on Ltd and the worldwide protection organisation Dental Protection Ltd. The bursary is available to help students and clinicians fund their education, maximizing their potential to deliver better oral care.

How to enter
To win, register at www.dentalghar.com and submit a piece of work that highlights the difficulties of communicating as a dental health professional across barriers of language, culture, faith and other aspects of diversity. The entry can take the form of articles, projects, research reports and other written work over 2000 words.

Finally, visit Dentalghar to hear Prof. Damle, Vice Chancellor of the Maharishi Markandeshwar University’s latest thoughts on dentistry, in his interview filmed at the FDI World Dental Congress, 2009.

To find out more go to www.dentalghar.com
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NEW EVIDENCE FOR THE BENEFITS OF INCREASING BRUSHING TIME

To motivate behavioural change, it helps if patients understand the benefits of brushing for at least 2 minutes twice a day with fluoride toothpaste, compared to an average brushing time of around 46 seconds.¹

New research results from Aquafresh show that increasing brushing time:

**Significantly increases plaque removal**

- 26% more plaque removal was observed with brushing for 120 seconds compared with 45 seconds*²

**Significantly increases fluoride uptake and enamel strengthening**

- Surface microhardness (SMH) increased in a linear fashion over the period 30–180 seconds*³

Recommend a great tasting fluoride dentifrice to encourage your patients to brush for longer, for increased fluoride protection and plaque removal.

References


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