Implementation ball gets rolling with announcement of pilots

Call for participants in Steele review pilots circulated by the Department of Health as implementation programme gets into action

The implementation of the recommendations put forward last year by the Steele Review into NHS dental provision has gathered momentum with a call for interested parties to take part in pilot schemes and the formation of an implementation group to oversee the delivery of the recommendations.

In a letter sent out to dental professionals and Primary Care Trusts, CDO Dr Barry Cockcroft called for expressions of interest to come forward for participation in two phases of piloting.

We are now asking for expressions of interest in taking part in piloting. Piloting will initially take place in two waves. We are designing a number of “whole system” options, which we aim to pilot from this autumn. We are also looking to launch a small first wave of pioneer pilots – to begin this April.

The whole system pilots will involve practice or PCT-level pilot schemes that will run for two years. They will use a range of blended contracts, each with a different mix of remuneration for capitatisation, quality and activity, which is at the heart of the Steele recommendations. The pilots will be monitored and evaluated centrally to assess the impact on the quality of patient care, the flow of money for PCTs and providers, the impact on the skill mix and the relative effectiveness of each of the contract options.

More immediately, we are looking to identify pioneer pilots to begin at the start of the coming financial year. We are aware that many PCTs are already operating blended contracts, along the lines envisaged in the Steele review, or are testing, or planning to test in contracts, discrete aspects of the thinking set out in the review. We are inviting expressions of interest from PCTs with such schemes in taking part in a “pioneer” wave.

Expressions of interest for piloting will need to be co-ordinated and approved by PCTs. We have written today to invite volunteers from PCTs in being part of the first wave of pilots. If you are a contract holder and would like your practice to be considered for piloting the first step is to contact your PCT and, if they are content, they will put forward an expression of interest to the Department.

PCTs have been given a deadline for initial expressions of interest for the autumn pilots of 19 March 2010.

The deadline for the first wave of pilots passed last week; however those who wish to find out more about the second wave of piloting are requested to contact their PCT to register interest.

In more news, it has been announced that Prof Steele has joined the implementation group which will oversee the delivery of the recommendations he proposed in the review.

Prof Steele will join Dr Cockcroft and John Milne, Chair of the General Dental Practice Committee on the board.

Commenting on the news of his involvement, Prof Steele said: “During the Review of NHS Dental Services I worked extensively with patients, dental professionals and the wider NHS to identify ways in which the NHS could improve and offer all patients the highest standard of care. The pilots will test the recommendations are important to ensure any changes made work for both patients and the NHS. "I am pleased to have the opportunity to see through the recommendations of my final report as they are rolled out across the NHS. It is important that we improve preventive services to keep people healthy as well as making sure they have access to the best possible care when they need it.”

Tuition fees hike

Students has criticised the recommendations could mean that they would earn more for ‘prestige’ degrees including dentistry, law and medicine. The report, carried out by the Institute for Employment Studies, which was submitted to ministers, suggested that many students would prefer to pay more for their education in order to prevent students from poorer backgrounds doing these degrees. The National Union of Students has criticised the report, saying that higher fees would lead to more students relying on their parents for financial support.

Commissioned UDA rise

The number of commissioned Units of Dental Activity (UDAs) has risen over the last quarter. Statistics released by the Department of Health reveal that the number of UDAs commissioned as of 31 December 2009 had risen to 88.5m. This represents an increase of 1.4m (1.6 per cent) on the number of UDAs commissioned at 30 September 2009. All 152 Commissioners (Primary Care Trusts) took part in the survey.

www.dental-tribune.co.uk
BDA calls for ‘detailed engagement’ on pilots

Continued and detailed engagement with the dental profession is vital to the success of the Steele Review pilots, according to the British Dental Association (BDA).

Dr John Milne (pictured, right), chair of the BDA’s General Dental Practice Committee (GDPC) said that there has been a promising start to the evolution of high street dentistry, including good engagement with dentists on the development of care pathways and a pledge that pilots will be given time to work and be properly evaluated.

However he warned against complacency, stressing that the process will only deliver a better system for dentists and their patients, if there is continued engagement.

Speaking after the GDPC’s first meeting of 2010 which was held in London, Dr Milne commented: “Good progress has been made on the process of taking forward the recommendations of Professor Steele’s Review with the establishment of working groups to consider different aspects of the reforms.

“The Department of Health (DH) has a chance to create a system that really works and the profession is keen to help them do that. The way to achieve that is continued and detailed dialogue. Importantly, the process must also be given the time it needs.”

Dr Milne also reiterated the importance of dealing with the problems arising from the current contract, citing the still unresolved difficulties with the sale of practices and transfer of contracts as an outstanding issue.

He also warned that the problems that are still arising as a result of the Universal Dental Activity (UDA) system will soon be in the spotlight again.

He added: “Many dentists across England and Wales will soon be having difficult conversations with their primary care organisations about UDA targets.

“Practitioners urge PCTs to take a constructive approach to those conversations that recognises the issues dentists face and the hard work they do providing care to patients.”

I’ll have veneers and a foot massage please!

Patients at a new dental surgery in Edinburgh are having free foot massages and watching films while they have their dental treatment.

Dr Elaine Halley, who has just opened the £1m Cherrybank Dental Spa in Scotland’s capital, wants patients to be able to relax while they have their treatment.

So patients are given DVD glasses so they can watch films and TV shows such as Friends or Sex and the City.

Dr Halley, the first female president of the British Academy of Cosmetic Dentistry, has found that most people tend to prefer watching comedies to distracting themselves while they have their treatment.

She added: “It was good that he was so relaxed, but not ideal for his treatment.”

When patients arrive at the dental surgery, they are welcomed by the smell of freshly baked bread, which is made by staff in the building, in order to get rid of any of the normal dental smells.

They can also have hand and feet massages while they are getting their dental treatment.

Dr Halley has taken many of her ideas from America in order to make going to the dentist a much more enjoyable experience.

Death closes practice

An NHS dental practice in Worcester has been forced to close, after the dentist who set it up died in a motorbike accident.

John Roe, set up the Green Dental Practice in 2002 and died last June in a motorbike crash.

As yet, no one has come forward to take over the practice.

However NHS Worcestershire, has said it will continue to look for someone to take over the running of the practice or open a new dental surgery in Dines Green.

The surgery in Dines Green has more than 7,000 patients on its books and employs eight people, including four part-time dentists.
Editors' Comment
Affecting change in dentistry

After months of seeming inactivity, the implementation of the Steele Review is gathering momentum with the announcement of the pilot programme and calls for participants from the dental community. I say seeming inactivity, because as we all know after the flurry of announcements and presentations it was always going to take some time before the profession saw any kind of progress with the establishment of pilots.

In my opinion this process is a little like watching a new building go up from behind a protective wall. There is the initial excitement as the machinery moves in, then frustration as you hear a lot of noise but nothing concrete seems to be happening; then whoosh – suddenly there is a structure in place and you can see what the builders have been up to all this time.

At the 2010 Career Opportunities in U.K. Dentistry conference held recently, Prof Steele commented on the fact that there are many people who are willing to criticise NHS dentistry and say they have no control over what happens, but that this is a chance to be in control of what happens and be engaged in the process of decision making for the future of NHS Dentistry.

Whether you believe this to be political rhetoric or an honest chance to make a difference is up to you and your opinion of how robust you think NHS dentistry is. But maybe it is worth giving the pilot process a chance and seeing how you fit in – you can either make a difference or be able to say you tried.

DT

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Or email: lisa@dentaltribuneuk.com

Premier Awards

Dental Protection and Schülke are celebrating the 10th anniversary of the Premier Awards.

The Premier Awards were set up to reward dental professionals who recognise the importance of patient safety within the dental practice.

With a total prize fund of £6,000, the Premier Awards offer one of the largest cash prizes for dental risk management projects in the U.K.

There are now six subject areas available in the competition:

- Ethics and professionalism
- Record keeping
- Cross-infection control
- Teamworking and Skillsmix
- Consent and communication
- Health and Safety

All members of the dental team are eligible to enter, whatever stage of their career they have reached.

The event will recognise individual achievements in developing awareness and the effective management of risk within clinical dentistry.

This year’s awards will be presented during The Premier Symposium to be held at Kings College, London on 4 December.

To request an application, or for more information on the Premier Awards visit: www.dentalprotection.org or contact Sarah Garry on 020 7399 1339 or by emailing sarah.garry@mps.org.uk

The closing date for entries to this year’s Premier Awards is 3 September.

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Audit report highlights ‘worsening’ child dental health says BDHF

The dental health of five-year-olds has ‘worsened’ over the last decade, according to a recent report.

The report by the Audit Commission found that dental health has worsened and obesity rates have risen.

The average five-year-old in 2005/06 had 1.47 decayed, missing and filled teeth, compared with 1.65 in 1999/00.

Childhood obesity rose from one in 10 to one in seven between 1995 and 2008, although the rate of growth may now be slowing, the report said.

The report – Giving Children a Healthy Start – said an estimated £10.9bn has been spent, directly or indirectly, on improving the health of under-fives in England since 1999.

Of this, £2.7bn has been spent on Sure Start, a programme to improve services for young children.

It includes children’s centres, maternity grants to cover essentials and family lessons on areas such as dental health and nutrition.

Some parents are not using Sure Start children’s centres because they are unaware of them, or they dislike the ‘judgmental nature of health professionals’, the report said.

It found the investments have ‘not produced widespread improvements in health outcomes’.

The report said: ‘Some health indicators have indeed worsened – for example, obesity and dental health.’

The report showed the gap between disadvantaged areas and those in better areas had in fact grown and that a child in a deprived area is 19 per cent more likely to have unhealthy teeth than the average child.

The health inequalities are one of the major goals of the Sure Start programmes.

Steve Bundred, chief executive of the Audit Commission, called the findings ‘disappointing’ and said: ‘The under-fives rarely seem a priority locally.’

The Audit Commission wants local authorities and the NHS to be clear about how much they are spending on the under-fives.

The cash needs to be targeted at improving the lives of the most vulnerable and progress must be monitored, it said.

The British Dental Health Foundation is urging the government to focus on the prevention of dental decay in under fives, following the report.

The charity has called for more awareness in spearhead areas.

Figures produced by the independent watchdog show around 150,000 more children have decayed, missing and filled teeth in spearhead areas compared with the rest of the country. This is a gap which has increased dramatically over the last ten years.

Children living in disadvantaged areas are 54 per cent more likely to live in workless households and face poorer health conditions than under five’s living in less deprived areas.

Out of these children, one in five has poor dental health.

Evidence clearly shows establishing good oral health during a child’s early years may play a vital role in regards to better health in later life, with diminished levels of heart disease, strokes and diabetes.

The report also showed that children from minority groups have poorer health levels, and their parents are less likely to take advantage of mainstream health services due to lack of awareness or cultural preferences.
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Mouth cancer campaign-ers have called for the new HPV test to be intro-
duced in Britain, to help diagnose mouth cancer in its early stages.

The British Dental Health Foundation (BDHF), organisers of the well respected Mouth Cancer Action Month, wants the screening procedure, which detects a virus strongly linked to oral and throat cancer, to be used on patients in the UK. The test is already widely available in America.

The BDHF believes the test would cut the current number of mouth cancer deaths.

The test is for the sexually transmitted oral human papilloma virus (HPV), which can be carried out in the dentist’s chair.

The test identifies one of two exceptionally dangerous forms of HPV – known as 16 and 18 – long before the virus develops into cancer and creates lesions.

Chief executive of the BDHF, Dr Nigel Carter, claims that early diagnosis of the disease is vital. He said: “Currently the best chance of beating the cancer comes from early detection, improving survival rates to more than 90 per cent, so it is important to follow the slogan of the Mouth Cancer Action Month campaign: ‘If in doubt, get checked out.’

Mouth cancer is a potentially fatal condition that is taking more lives each year. Without early diagnosis, chances of survival could plummet down to 50 per cent.”

Mouth cancer has previously been found to be more common in men than women and people over the age of 40, though an increasing number of men and young people are developing the condition.

Research now suggests the human papilloma virus (HPV) could soon rival smoking and drinking as a main cause of mouth cancer.

Indemnity costs for injectable, non-permanent cosmetic procedures such as botox are now available at a lower rate at the dental indemnity organisation, Dental Protection.

Injectable, non-permanent cosmetic procedures such as botulinum toxin and non-permanent dermal fillers in any part of the face (excluding the neck) can now be indemnified within normal subscription categories.

Kevin Lewis, dental director said: “We took a cautious view when we first introduced categories for cosmetic and adjunctive procedures six years ago, and their cost was significantly higher than for our normal subscription categories. At that time we promised a detailed review of our claims experience and these changes are the result of that process.

“Members who have been properly trained in these procedures and who adhere to the new Standards for Cosmetic Injectables will, we believe, be no more of a risk when carrying out these procedures than when they are providing many other types of dental care and treatment.”

Previously, it was necessary either to transfer to a Dental Cosmetic membership category at significantly higher subscriptions, or to buy a separate indemnity for these cosmetic procedures from a third party (usually a commercial insurance provider) at an additional cost.

The Independent Healthcare Advisory Services (IHAS) recently announced the imminent launch of a third party (voluntary) Registration and Inspection Scheme for providers of these procedures, incorporating the IHAS (Quality Mark, which is designed to demonstrate to patients and third parties that the provider has received appropriate training in the use of these procedures, and is committed to the Standards for Cosmetic Injectables under the auspices of IHAS.

The new scheme includes the inspection of the facilities in which these procedures are to be provided.

Caspe Healthcare Knowledge Systems (CHKS) is to be the third party registration, quality assurance and inspection agency.

The procedures carried out in the immediate peri-oral area, nasalabial folds and elsewhere in the face are all included, but the neck is specifically excluded.

Hygienists, therapists and other DCPs are not yet included in the IHAS-CHKS Registration and Inspection scheme, although this is being kept under review by the IHAS.

Indemnity costs cut for botox

‘Screen for HPV’ calls charity

...
Help when you need it most

_Dental Tribune_ looks at the NHS Practitioner Health Programme and its benefits for dentists

**Chief Medical Officer for England, (CMO) Sir Liam Donaldson,** has hailed the just-published report on the first year of operation of the Department of Health-funded NHS Practitioner Health Programme (PHP) as a ‘resounding success’.

The free, confidential PHP service was set up for dentists, doctors and other health professionals (HCPs) with health concerns – especially mental health problems and addiction – which could hinder their ability to function well at work and thus potentially harm patients.

The report – *Invisible Patients* – emphasised that dentists work in unsupported, pressured environments for long hours, responsible for both staff and patients and financially accountable for their practices.

The number of dentists assessed during the PHP’s first quarter was 17 per cent of the total, dropping to eight per cent by September. Greater awareness-raising was initiated as a result.

Scheme director Dr Clare Gerada said: “Dentists as a whole are at the far end of sickness treatment. So they can become very unwell when they present for treatment, with severe alcohol and depression problems. They work in a more isolated manner and have more pressure on them as they are the boss of the team. They are a more isolated and sicker group than doctors.”

Sir Liam added: “Previously, dentists and dentists affected by physical or mental illness found it extremely difficult to access appropriate and confidential care. The PHP service offers specialised support to clinicians, allowing them to get the help they need so that we can ensure that they remain able to offer safe, high quality care to their patients.

“From the number of practitioners-patients accessing the PHP during its first year of operation, it is clear that there is a need for this highly specialised service.”

The project, set up as a general practice with a referrals service, reported good outcomes with patient-practitioners demonstrating improvements in mental health and social functioning, as well as in the numbers returning to work and the reduction in potential risk to patients and the public. The report revealed that nearly 80 per cent of patient-practitioners were able to remain in or return to work after treatment.

Dr Gerada commented: “It had been an enormous privilege to do this work.”

She said: “Looking after sick health practitioners is an eye-opener as it is not easy to manage. We noticed how troubled and ill some were. We didn’t realise the complexity of the problems.

“Dentists and doctors are one of the most unattended patient groups in health care. Their health needs can be as bad as those of homeless patients.

“Health practitioners don’t get sick they erect self-inflicted barriers.” The PHP project is a way to address their needs. Dentists and doctors also have to look after others which can do harm if they are untreated themselves.

“The scheme was set up to give practitioners the space to tell their story and get treatment.”

Sir Liam said his 12 years as CMO heralded the success of a project he had long wished to see. He said: “One of the key proposals was the establishment of an environment for dentists, doctors and other HCPs with health problems to be seen. This has been very effective”

Prof Alistair Scotland, who chaired a recent working group on practitioner health, commented that suicidal thoughts were significantly higher in dentists, doctors, nurses and pharmacists who could find it hard to get help.

“He is keen that PHP-type facilities are made available to all health professionals across the country because, at more than one million, NHS staff make up the biggest single group of patients for the NHS but they often struggle to access the same standard of services as others.

“We need three or four of these services across England, backed up by a panel of GPs and occupational physicians with extra training to treat health professionals.”

Any medical or dental practitioner can use the service, where they have: a mental health or adduction concern at any level of severity and/or a physical health concern which may impact on the practitioner’s performance. Practitioners might not access mainstream services because they do not want to admit ill-health, have concerns about confidentiality or choose to self-medicate.

In the PHP scheme, a GP heads up an integrated treatment-planning team. Problems presented during the programme – which has seen 184 patients in 12 months – included finance, housing, work and relationships. About two-thirds had health problems and one-third addiction problems. More men tended to exhibit alcohol and substance abuse, while more women exhibited mental health problems on the whole. Mental health problems affected 114 patients - 62 per cent of the total - while addiction problems affected 67 patients - 56 per cent of the total. The remaining two per cent presented with physical health problems.

Dr Gerada said although dentists and doctors presented late with illness, they did very well when treated. Although other supportive services existed, such as the Dentists Health Support Programme and British Doctors and Dentists Group, the PHP offered the most comprehensive assessment and treatment package.

She said: “Dentists and doctors tend to treat themselves and write prescriptions. Self-management can get them into trouble. They have a higher rate of depression and suicide and only tend to present for treatment when there is a crisis.

“Doctors and dentists like everyone else are only human and suffer from conditions and illnesses like the rest of us. We have found that the sooner they access the service when they are experiencing a health problem, the speedier their recovery will be.”

Programmes are being developed to look at enhanced skills for GPs to treat other health professionals, with plans to extend the PHP to Avon and Newcastle.

For more information or to contact the Practitioner Health Programme, please ring 0203 049 4505.
Whose practice is it anyway?

Quentin Skinner discusses the issue of control - control of your practice and the organisations with a potential interest in your business...

How funny life is, in that sometimes certain of its fundamental tenets change over a relatively short period of time without any one noticing. Consider how the mindset of the dental profession has changed over the last two decades....

Then....

Back in the early '90s, when BUPA DentalCover was launched in an effort to compete with Denplan Care, both brand-ed schemes felt the need to introduce ‘quality’ measures as part of the procedures necessary to help protect the national delivery of the brand promise. From a businessman’s point of view, this was a perfectly sensible proposition, as it would help to reduce the risk of many custom- ers operating under the same banner getting tarred with the brush created by the actions (or inaction) of a smaller number of miscreant customers.

However, at the time, the profession took a very different view. I remember well from my time at Denplan, whenever we raised the subject of “quality” at semi-nars, dentists would invariably round on us, saying that clinical quality was a matter for the profession and its representative bodies, and certainly not a mat- ter for third party commercial ventures to get involved with.

It was also in the early 1990’s that the BDA started waving the red flag to its members, warn- ing of the dangers of third party control if they got involved with the ‘dental plan administra-tors’. The basis for the BDA’s argument was almost entirely framed around the situation in America – this was quite differ- ent to the UK, with an oversupply of dentists and funding levels controlled by the combination of employers who were in con- tract directly with the dental plan administrators/insurers for the provision of employee dental benefits. Granted, a few aspects of the BDAs warnings could indeed have been relevant to the nationally-branded dental schemes, but they just did not apply to the operation of dentists’ own practice-branded plans where the administration was sub-contracted to back-office ad- ministrative agents.

Anyway, suffice it to say that the natural self-regulatory in- stincts of the profession were to an extent encouraged by the third party control warnings, and life proceeded accordingly.

Who is in control of your practice?

This is most important, even for those dentists who feel that things might just carry on as they are under their existing nGDS contract. Any of the ex- tra funds for dentistry promised by the Government will only be released in conjunction with this new contract. PCT staff are currently being trained up to be able to crack the control- ling whip much more effectively in order to try to squeeze a better outcome (access) out of a tight- er and tighter budget, and no change of Government will alter this.

In the new Decade of Aus- terity, any change of ownership, any under-delivery, any need for contract variation – any chance to move more NHS funding into this web of control will be seized upon, because otherwise the PCT staff will not be doing their jobs...

andi, of course, merely by submitting notice but without giving any reason, PCT staff will be at liberty to enter the practice premises and thor- oughly check up on all aspects of the business. Acceptance of this situation is a far cry from those feelings not 20 years ago that quality is a matter of the profession and the profession alone.

4th, 5th, 6th party control...

Oh, and interference and con- trol by PCT staff is not all, not by a long way. In addition, the PDS Plus template contract al- lows for entry and inspection of the practice premises by:

• NICE: an organisation appar- ently directed to help manage and control the costs of NHS care, and one that is not even represented by a dentist

• The Care Quality Commission: which, whilst retaining a promi- nent dentist as its advisor, repres- ents yet another swathe of bu- reaucratic regulation, the need for which would be hugely ques- tionable if the GDC was properly empowered to do what it was al- ways previously responsible for doing in the past.

• Local Involvement Network Representatives: doubtless, someone will come up with a more positive explanation of the need for LINks, but to me this conjures up an unsanitary visit by the People’s Party Representa- tive in Stalin’s Russia, who cer- tainly will not have the well-be- ing of the dentist in mind...

Whose practice is it, anyway?

So, there will always be those in life who will succumb to control by others, even when this points towards an ongoing squeeze on their personal circumstances. However, many others sooner or later find that such oppre- sive restrictions on the freedom to act as they have been brought up or trained to do force them to look for a newer, independent way forward.

I would therefore encourage dentists who wish to operate in a working environment as free from third party control as possi- ble to sit up and do some careful analysis of the alternative fund- ing structures for the delivery of their dentistry, and choose the route that best ensures that they remain in control of their own practice.

Who is in control of your practice?

Seeing that both parts of the new contract have been released in conjunction with the Government will only be doing in the past.

About the author

Quentin Skinner is Chairman of DPAS. He is one of UK dentistry’s most influential thinkers. DPAS is a adminis- trator of practice-branded private dental plans. For more information, contact DPAS on 01747 870 870 or visit www.dpas.co.uk.
Managing periodontal diseases

Peter Galgut discusses different adjuncts to periodontal treatment to help dental professionals achieve the best outcome for patients

Periodontal treatment is no longer based on good oral hygiene maintenance and professional root surface debridement alone. Although periodontal diseases are primarily caused by bacteria in plaque biofilm, several cofactors are also necessarily. Cofactors include genetically inherited tendencies, social factors such as smoking, environmental factors such as stress, and the presence of other diseases such as diabetes. This understanding has led to important changes in how periodontal diseases are managed clinically.

A number of studies have shown that even thorough root surface debridement (ie scaling and rootplaning) is insufficient to eliminate subgingival plaque bacteria (1), even in the presence of good oral hygiene. Increasingly, sophisticated strategies for management of periodontal diseases are being developed.

Pharmacological Adjuncts to Periodontal Treatment

A whole range of new products are now available to manage periodontal diseases more effectively in clinical practice. The best known products are topically applied antimicrobials and anti-inflammatory adjunctive aids to mechanical cleansing.

Antimicrobial mouthwashes and topical slow release antimicrobials, and healing anti-inflammatory products are being increasingly being used clinically to control periodontal diseases more effectively as powerful adjuncts to meticulous mechanical root surface debridement and good oral hygiene maintenance. They are used to maximise the healing process after mechanical cleaning, and to manage those patients who respond poorly to debridement alone.

Being able to place topical antimicrobials and anti-inflammatory products into areas of infection such as periodontal pockets is a major advance in managing periodontal diseases.

New Products to Manage Periodontitis more Effectively

A new range of innovative anti-inflammatory products have recently become available. A topical gel (Trade name Gengigel) is based on hyaluronic acid (a natural ingredient of ground substance in which tissue cells grow). This product has been shown to promote healing and reduce inflammation (2,3,4). More recently a systemic anti-inflammatory product (Trade name Periostat) has become available. This product is taken systemically for up to three months at a time to dampen down the over-active inflammatory response to periodontal pathogens, and characterizedly respond poorly to debridement alone (5,6).

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‘Being able to place topical antimicrobials and anti-inflammatory products into areas of infection is a major advance in managing periodontal diseases.’
The DPAS family, are you part of it?

"I am Richard Fretwell, Guidepost Dental Practice, and this is my DPAS family."

DPAS is more than a dental plan provider; it’s a family. A family of experts and a family of dentists, offering a family of products. We like to believe we’re different by offering a professional service at a competitive rate, whilst maintaining a friendly and cooperative relationship with your practice.

We have set-up and run dental plans, with Supplementary Insurance, for over 1,200 dentists from over 550 dental practices nationwide. Our competitively priced service attracts many practices from other dental plan providers and we use our expertise and experience to facilitate these transfers.

Key members of the DPAS team were instrumental in developing the original concept of conversion from the NHS to independence and DPAS has continued to help dental practices with this transition.

DPAS offers a range of services to suit every practice, including Payment Plans, Children’s Plans, Membership Plans and a newly launched Dental Implant Accident Protection Policy. Additional services from DPAS also include an exclusive online Marketing Toolbox, an interactive children’s website and an online Web Portal allowing dentists to access and modify their patient information 24 hours a day.

For more information on DPAS, our practice-branded plans or any of our other products and services, visit www.dpas.co.uk, or call 01747 870910. You can also e-mail DPAS at enquiries@dpas.co.uk, or follow us on iTunes, Twitter and Facebook.
Facing the judge and the jury

Allegations have been made against you to the GDC and your career’s hanging in the balance. What do you do next? Get a good lawyer, says John Goodwin

All of a sudden, your busy professional life is interrupted. You receive a letter from a caseworker in the Fitness to Practise Department at the General Dental Council (GDC). It says that your case has been referred to the Investigating Committee, and to the Registrar who has in turn decided to refer it to the Interim Orders Committee. This is to decide whether an order for interim suspension of your registration should be made, or whether it should be made subject to certain conditions.

Your initial reaction may well be one approaching panic. After all, you could be suspended from your practice. Not only this, you do not have very long to act. You are not likely to get more than up to two weeks’ notice of the hearing and it would be difficult to agree an adjournment with the GDC caseworker.

You might also have been told previously that allegations against you have been received and that you, or someone on your behalf, have responded to these allegations. For example, you may already have filed your representations in response to the allegations on record.

When you receive a referral to the Interim Orders Committee you will be told when and where the hearing will be and that you have a right to be represented by Counsel or solicitor or “some other person”.

You will be given information on the Dentists’ Act, what can happen if you do not attend the hearing (the Committee can proceed in your absence) and a very brief outline as to what the Interim Orders Committee can take into account. You will receive a copy of the relevant rules. What you will not receive at first is a copy of the papers that will be placed before the Interim Orders Committee. You may only receive these two or three days before the hearing.

So, in short, your whole professional career may be on the line. If you are suspended from practice there is no guarantee that you will ever actually be able to practice again, depending on how the investigation pans out in the future. Assuming that very few dentists in this position will wish suddenly to retire, the issue then is how to prepare and, in particular, you must be aware of the rules, regulations and guidance under which the General Dental Council will be acting.

Take legal advice

You must seriously consider taking immediate legal advice. You may be entitled to representation by your defence Union or you may wish to instruct a firm of solicitors privately. An experienced lawyer will know what guidance documents will be considered by the GDC and that the Committee will be comprised of members, some of who are practising dentists.

The first document that should be considered is one entitled, “Guidance for the Professional Conduct Committee”, the latest version of which was published in October 2009. This sets out the fact that the Professional Conduct Committee has to balance public protection and proportionality. They decide whether your fitness to practise is impaired by reason of your conduct, while at the same time aiming to protect patients and colleagues from the risk of harm and safeguarding public confidence in registered dental professionals.

In an Interim Orders Committee, the members will know, and in any event will be reminded by their legal adviser, that it is not a “fact-finding hearing”. This is a very complicated concept with which to come to terms and it cannot be stressed too highly that you will need an experienced solicitor/Counsel to guide you through this.

Presenting your case

The next step is to consider on a practical basis how to present your case. Of course there may be circumstances where a dental professional’s behaviour has been so extreme all hope is lost, but assuming this isn’t true, one has to adopt a practical and speedy approach to preparing the hearing. The following are guidelines, although not extensive, as to what can be done:

1. Prepare a detailed statement giving details of your professional history to date including where you trained and qualified, where you have worked since qualification, where you currently work, the status of your employment, your job description, and title, your responsibilities and any information which will give a full picture of your professional history and current professional life to the Committee. They need to know who you are and what you do. It may well be relevant (for example in cases where there is concern about prescription practice) for them to know whether your practice is private, NHS or a mixture.

The bundle of documents is likely to contain details of any previous appearances before the various committees of the General Dental Council but, in any event, it is imperative that, if there are any such matters, you give as full a history as possible of these to the Committee and therefore in the first instance to your solicitor.

2. References. When the Committee is looking at protection of the public and the proportionality that might be involved if you were suspended, it can only help your case to provide as many references as possible from patients and professional colleagues. Many dentists will have collected these over the years as a matter of course or will have comments and suggestion books, which contain references. However, what you should really be seeking to do is to obtain references, including personal references, as a matter of urgency. Anyone providing a reference should be told the purpose of it and the allegations which are made. It is much better to have a reference which contains words to the effect of “I know that Dr X has been accused of serious professional issues…” than one which does not make it clear that the referee knows of this.

3. It might go without saying, but you will often find in all types of committee and court hearings that the person accused has not dealt with all the allegations in detail. You must prepare a sentence by sentence/paragraph by paragraph response to all the allegations against you. Bearing in mind that these hearings have to be dealt with quickly, you may have to burn the midnight oil to do this properly.

You must consider carefully whether you accept the allegations against you. If, for example, a prescription issue arises, do you accept that the writing on the prescription is yours? Is the signature yours? If there is an allegation that you treated a young person without your nurse being present and allegations have arisen from this, do you really accept this?

An Interim Orders Committee is not a fact-finding hearing. In my extensive experience of representing people in front of all types of tribunals and courts it is surprising how many people make admissions or concessions without really considering the allegations properly.

When they later realise that they may have been too hasty in doing this, they become a hostage to their own admission/concession. Great care and caution must therefore be exercised. Of course you should never seek to mislead a committee but it must be borne in mind that all this is being done as a rush and may be in something of a panic, and careful reflection must take place before nailing any colours to the mast.

4. Documentary exhibits. If allegations are made which concern the keeping of records you should seek urgently to gather those records, review them and prepare them and
You should also prepare a bundle for the shorthand writer who will be present at such a hearing to assist.

6. The Committee has power to suspend but it also has power to impose conditions to be placed on your registration. The Committee will have a bundle in front of them entitled, GDC Conditions Bank. These are extensive but you will not be limited to the standard sets of conditions. The current conditions bank used by the GDC includes a total of 71 conditions. It is divided into different areas to help the panel choose which conditions might be appropriate. As just a few examples, if you have a problem with alcohol misuse a condition might be imposed for you to abstain completely from the consumption of alcohol. If there are personal drug issues, you may have condition to take drugs only as prescribed to you by your medical or dental practitioner.

7. Undertakings. The Director of Hearings sent a letter to Defence organisations in June 2006 explaining that undertakings can be offered to a committee about your future conduct and how it can be monitored. An undertaking does not have to be offered and the Committee does not have to accept one if it is. It is a defence (dental professionals) responsibility to offer an undertaking and not the duty of the Committee to request them. The offer of a suitable undertaking therefore is also something that might be considered.

This article is very much an outline and not intended to be a full and detailed description of all the procedures and all the potential ways of dealing with allegations.

What I particularly wish to draw to your attention to however is that, if you find yourself in the unenviable position of facing an Interim Orders Committee, you have to act quickly, and you have to take proper advice, you have to try not to panic and you have to deal with all preparation and paperwork to be placed before the Committee, as a matter of urgency and applying general principles of good legal practice, for example:

1. What is mischief alleged against you; and
2. How can you best put together a case, quickly, to prevent the potentially career-threatening sanction of suspension?

As a final point, I would also urge anyone appearing before the Committee to consider obtaining advice from an expert dental practitioner to assist their lawyer in connection with specific practice issues. I have not dealt with the appeal procedure that is available to the High Court, although that is something which would need to be considered if you are unhappy with the decision.

About the author

John Goodwin is a solicitor advocate. He has been in practice for 27 years. He represents dental professionals in connection with any enquiries into their conduct and working practices as a member of the Dental Team at Cohen Cramer Solicitors. He also represents dental professionals concerning their regulatory practices. To contact Cohen Cramer Solicitors, call 0113 2440597, email dental.team@cohen cramers.co.uk or visit www.co hemcranerm.co.uk.

For more information, please contact Molar Ltd on 01934 710022 or visit www.molarld.co.uk.
Chlorhexidine is a tried and tested and highly effective anti-septic used in the oral cavity to treat minor oral infections, and has been available for many years in a sustained release form (trade name Periosol). Another two-stage chlorhexidine product (trade name Closite) is based on two forms of chlorhexidine. Chlorhexidine digluconate (0.5%) is a small molecule and therefore it is released in high concentrations immediately after placement. Chlorhexidine dichloride (1%) is a larger and more complex molecule that is released over a period in excess of 7 to 8 days, at a consistent to maintain its anti microbial properties.

Other anti microbial gels are based on antibiotics such as Minocycline (Trade name Den-tomycin) and Metronidazole (Trade name Elyzol). A completely new concept in periodontal pocket disinfection is now available that uses the well-known property of the light (Trade name Periowave) to kill bacteria in the same way as those who suffer from acne find that their spots disappear after sitting in sunlight. A photosensitive gel which bonds to Gram negative bacterial proteins is introduced into periodontal pockets and activated by directing the intense light from a non-thermal soft laser into the pockets, disrupting the toxic substances to which the dye has adhered, and potentiating the oxidative burst from the host cellular inflammatory response that is used to destroy pathogenic bacteria. This system is showing the great potential to maximise periodontal pocket disinfection and post operative healing as well as attachment gain after treatment.

Products such as these are highly effective treatments for periodontal disease. Other innovative products that are now available use ozone. Ozone is a bioactive oxygen molecule that attaches to and destroys bacterial walls. A recently developed machine (Trade name Ozotop) uses micro-capillary tips to introduce the ozone gas into periodontal pockets and root canals. Because ozone is a gas it permeates this tissue and inaccessible niches it potentially achieves instant total disinfection.

Such dramatic innovations present major potential to improve healing during the active phase of treatment, to manage recurrent bouts of active disease and to maintain tissue stability, and also to improve the potential for maintaining long-term periodontal health.

Conclusions

It must be emphasised that these products are all complementary and adjunctive to mechanical root surface debridement by means of scaling and rootplaning. It is crucial that as much foreign material by way of plaque, food debris, and subgingival calculus, is physically removed from the root surfaces prior to using these products. Mechanical root surface debridement gives good results and remains the mainstay of periodontal therapy. Adjunctive topical and systemic antimicrobial and anti inflammatory products, photo disinfection, ozone and other treatment methods may give good treatment outcomes, but the best results are universally achieved when several different techniques adjunctive to root surface debridement are used together to complement each other.

Therefore modern periodontal therapy requires thorough and meticulous mechanical root surface debridement, together with the use of other adjunctive therapies to achieve the enhanced results that individual treatment techniques cannot achieve alone.

About the author

Dr. Peter Galgut is a long-standing clinical periodontist practicing in North West London (www.periodontal.co.uk). He has recently launched a website offering help and advice in the management of periodontal conditions for colleagues who do not have a local periodontist. This site address is www.periodontal-diagnosis.com.

3) Galgut Peter N: The Role in Hyaluronic Acid in Managing inflammation in Periodontal Diseases: Dental Health 2002: 42: 4: 3-5
9) 7-8 at The Royal College of Physicians London. For more information go to www.clinicalinnovations.co.uk.

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References

3) Galgut Peter N: The Role in Hyaluronic Acid in Managing inflammation in Periodontal Diseases: Dental Health 2002: 42: 4; 3-5
TREATING A PERI-RADICULAR ABSCESSES

Dentist Nicolai Orsteen presents a clinical case study looking at the treatment of a maxillary left lateral front tooth

**Diagnosis**
The extra-oral examination on 30 January 2008 was within normal limits, shown in Figures 2 and 3.

However, as is visible in Table one, the intra-oral examination revealed gingival bleeding on probing, no sinus tract and fluctuant swelling of the palate mucosa in the area of teeth 21, 22 and 23. The periodontal pockets however, were within normal limits.

Following the investigations, the diagnosis showed that a peri-radicular abscess was related to non-vital tooth 22. The problems associated with the diagnosis were a wide root canal, and an open apex with large apical lesion.

The structured treatment plan involved conventional root canal treatment, and to be assessed for surgery after six months.

**The treatment plan**

Treatment commenced on 5 April 2008. Following an initial clinical examination, the tooth was diagnosed with and apical abscess (no sinus present). Access was gained under a rubber dam and the canal was filled with exudate.

The root canal length was determined both by apex locator (RootZX) and a periapical radiograph. The root canal disinfection was completed mechanically using Hedstrom files (size 25/00 mm/incisal edge).

Particular care was taken during irrigation due to the open apex, and ultrasonics were used for the further cleaning of the canal. A formula of one per cent NaOCl, two per cent CHX and 17 per cent EDTA were used for chemical root canal disinfection. The canal was dressed with Ca(OH)2 and IRM was applied as a temporary filling.

Following the surgery, on May 29, tooth 22 was asymptomatic and still sensitive to percussion.

**Preparation for root treatment**
The patient missed the following three appointments, but returned on October 14. On this date the tooth was still sensitive to percussion and palpation. As there were no real signs of improvement, it was decided that the tooth should be root filled and an appointment for apical surgery was made. To ease discomfort, the root canal was filled with an 8mm length of white MTA, and a wet cotton pellet was placed over the MTA. On top of the cotton pellet, a temporary filling with IRM was placed.

The re-operative procedure was carried out on November 6. A marginal incision from the mesial aspect of tooth 21 and to the distal aspect of tooth 23 was made, followed by 5mm vertical releasing incisions at the mesial aspect of tooth 21, and a length of 10mm at the distal aspect of tooth 23. The mucoperiosteal flap was elevated (see Figure 10), and a pathologic fenestration of the cortical buccal bone was evident, approximately 3mm from the marginal bone crest between teeth 22 and 23. An ostectomy was performed after which the lesion was treated by curettage. The palatal cortical bone also had a pathologic perforation, a root-end resection of about three millimeters of the root. The root end was inspected through the operating microscope, and no fracture was found.

The adaptation of the white MTA to the root canal was
judged as good and the operation site was inspected and rinsed with sterile saline, before being sutured with five 6-0 silk sutures.

The patient was informed about the prognosis of the tooth and given post-operative instructions. Six 400mg Ibuprofen tablets were dispensed, and the patient was instructed to take one every four hours in the first day following surgery. A prescription of Penicillin V tablets (qds 660 mg *4) for seven days was also given.

The sutures were removed on November 13, and there was evidence of good soft tissue healing. The patient experienced no discomfort from the surgical site.

The temporary filling and cotton pellet were removed during the post-treatment restorative procedure, and replaced by a composite restoration (35 per cent phosphoric acid, Adper, Scotchbond, Filtek Flow (A5) in the apical part, Filtek Supreme (A3D and A2B) in the coronal part). Teeth 21 and 25 maintained vitality. The histological report of the lesion showed a partial epithelium lined cystic wall with intense chronic to acute inflammation, consistent with a radicular cyst.

Result

The patient’s long-term prognosis is uncertain, due to the thin root canal walls and risk of fracture.

Follow-up

On November 13 for a twelve-month post-surgery appointment, the patient was still asymptomatic. Teeth 21 and 23 were sensitive to ice-test, and there were no periodontal probing depths over four millimetres around tooth 22.

The radiograph showed evidence of healing.

About the author

Dr Nicolai Orsteen graduated from the University of Oslo in January 2002, completing his specialist training in endodontics in June 2009. He then worked in general practice in Oslo from February 2002 was also a secretary on the regional dental board in Norway from 2004 to 2008. From August 2008, Nicolai worked at a specialist practice in Oslo before joining the specialist team at Endocare Richmond and Harley Street. For more information please call 020 7224 0999 email reception@endocare.co.uk or visit www.endocare.co.uk
Achieving the impossible

Dr Jacob Krikor discusses what to do if you’re faced with having to improve the appearance of a tooth that looks beyond salvage

You know the feeling. The patient had a root filling on the central incisor 10 years and five dentists ago. The tooth went dark and now after all these years with a dark tooth the patient chooses you to pose the question to that you dread to hear: ‘Can you do something to make this tooth look better?’

I usually look at the tooth and look again and again from this angle and that angle, playing with my goatee pretending to be smart, studying the tooth while in fact I am crying inside remembering the times when I tried with a single veneer, indirect ceramic or direct composite and failed to match the next door tooth.

On a few occasions I have been lucky when the neighbouring tooth was a crown and with a triumphant smile I suggest to have that crown replaced at the same time as we are crowning the dark tooth. This will ensure the best aesthetic results. But what if the neighbouring tooth is a nice untouched big lovely incisor? Do I cut it?

Achieving better results

Here are some steps I use to help:

1. I take a picture of the front teeth before preparation.

2. I take a picture of the tooth after preparation to give my technician as much information as possible.

Before 1

After 1

Before 2

After 2

Before 3

After 3

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3. I send the patient to the local technician for shade and shape taking. The technician is then able to add those tiny but crucial characteristics to the tooth that make it look natural.

4. I use multi-shade cement, such as Variolink Veneer Cement that has the try-in paste and the different cement shades.

**Learning from the experts**

I recently attended a hands-on course about direct composite restorations arranged by Ivoclar Vivadent and presented by Dr Ron Jackson (USA). Dr Jackson has extensive experience in comprehensive restorative and cosmetic dentistry as well as being an active lecturer internationally.

The focus of the course was on restoring front teeth whether as a single tooth or multiple teeth. I was really inspired and amazed by how much we can do with today’s composites. During the day, Dr Jackson demonstrated how to restore a tooth with the help of the multi-layer system Empress Direct and the results were really impressive.

Of course, it is a learning curve in that the more you use it, the more you master it.

In the images included in this article courtesy of Dr Ron Jackson we can see the results that can be achieved by this technique. As for me, I now can’t wait for the question to pop up again: ‘Can you do something to make this tooth look better?’ And the answer is: ‘You bet I can.’

If you have similar cases with satisfactory results either by using a direct or indirect technique and want to share your experience I would be more than happy to hear from you.

To see more of Dr Jackson’s clinical cases, visit www.ronjacksondds.com. Dr Jackson is also lecturing at the seminar entitled: *Giving Your Patients Something to Smile About: Composite Artistry*, on June 24-25 2010 at the London Dental Education Centre (LonDEC). Go to www.odonti.com and click on the link ‘courses’ or contact Ivoclar Vivadent for course details.

**UK Clinician:** Dr W.E. Jenkins BDS (Wales) (PD)DS

Wyn Jenkins graduated from The Welsh National School of Medicine, in 1987. He has published numerous articles for Dental journals and has lectured extensively throughout the UK, Ireland and the U.S.A. Dr Jenkins joined DKAP in 2006 as the registered Lumineers UK Lecturer.

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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

Difficult economic times impact upon the clinician and the patient. People tend to assess their own situation and consider the financial implications. Any purchase that may be perceived as unnecessary will usually be the first to go.

In addition, it is well-recognised that healthcare complaints and litigation tend to increase in times of recession or economic downturn, perhaps because patients are less willing to accept and tolerate sub-optimal outcome for which they have paid money, that (in their view) could have been put to better use.

Possibly now more than ever the practice owner should consider carefully the explanations given by patients who are slow in settling their account for treatment provided earlier. It is important to distinguish between the patient's situation and the party's difficulty in paying and the one who is reluctant to pay for treatment that is not satisfactory.

Payment overdue
Consider the case of a dentist who wrote to a patient demanding payment on account overdue by one month. The patient had ignored a previous request, but had also indicated on the phone to the practice manager, that she was unhappy with treatment.

The dentist, who was of the view that his treatment was beyond criticism, considered this complaint to be a delaying tactic on the part of the patient. He instructed the practice manager to inform the patient that she would be taken to Court within seven days if the payment was not received. He also refused to talk to the patient about her concerns until the debt was cleared. A summons was issued in a Small Claims Court.

The patient counter-claimed for damages and also complained to the General Dental Council. Subsequently, the dentist was reprimanded for failing to deal with the patient’s complaint and to keep the patient informed. In addition, an expert report was provided during the hearing, which criticised the standard of care that had been provided by the dentist.

Disputes about payment are frustrating, but it is important to explore the situation carefully to ensure that the patient has not lodged a complaint that needs investigation and formulate a suitable response before pursuing the financial side of things.

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

Company Feature
Selling your dental practice - Who is your buyer?

It is widely acknowledged that the open-market approach to selling a dental practice often generates the most interest and therefore the highest price paid.

However this is not always the case, especially when you intend to sell to:
- Dentists within the practice
- Body Corporates

Price setting, negotiating and managing the sales process are equally important to practice owners who don’t go for the full open-market option. PFM offer support in this instance, helping to avoid numerous potential complications arising from the practice sale. Sales agencies such as PFM deal with the sale of dental practices day in day out, whereas the majority of practice owners sell a practice once in their career.

Our experience and skills have allowed us to develop and launch two new services for dentists who have already identified a buyer for their practice.

Selling to existing associates or partners
We have come across a number of dentists over the last 12 months experiencing difficulties with the internal sale of their practice. Common problems include uncertainty on how to price goodwill and resolving contractual intricacies as the sales process evolves.

PFM now offers a service to remove this burden and the potential problems from practice owners. The service includes:
- A goodwill and equipment valuation
- Negotiation handling until completion.

The aim of this service is to promote a smooth sales process.

By offering this third party element, PFM can reduce potential problems in the relationship between the purchaser and seller.

This is a comprehensive service which includes a meeting at the practice, valuation report and advice on the partnership structure as well as negotiation handling. A fixed fee is charged for this service.

Corporate Sales
Body Corporates regularly employ a scattergun approach, sending indiscriminate mailings to practices with enticements to sell. PFM have experienced cases where a practice owner has accepted a much lower direct offer from a Corporate Body than could have been achieved with the help of a professional agent.

The experience and skills of an agent will identify which Body Corporate will be most suited for the practice, what price could be achieved and deal with all important tie-ins and terms. PFM are proud to be independent and will consider all Corporate Bodies to ensure the best sales terms are achieved.

In addition, the majority of Corporate Bodies will pay the agent’s costs as part of the offer - cited as the key factor in some sales (proceeds you receive). A better price and expert advice can therefore be gained at no additional cost.

About the author
Martyn Bradshaw, BA (Hons) Dip PFS, is a director of Practice Financial Management Ltd (PFML), one of the UK’s leading dental practice sales agents. Further information about PFML’s practice valuations and sales services can be found at www.pfmdental.co.uk.

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The instrument itself doesn’t cause the problems. It’s the fact that it will block the canal and preclude further shaping and cleaning which is mandatory in endodontics. It is therefore essential to know when the file separated and how clean the canal was before this happened.

Why does it happen?
The actual reasons for instrument fracture are multi factorial and are mostly dependent on clinicians’ experience and the numbers of times the file has been used. Hopefully with the new Government recommendations to discard files after a single use rather than to sterilise them, the incidence of separation will reduce.

However, one study into file separations unsurprisingly found an increased incidence of NiTi rotary file separations (1.68 per cent) compared with stainless steel file systems (0.25 per cent) approximately seven times as many. In addition, the probability of separating a file in the apical third was 35 times more than in the coronal third. The highest percentage of instrument separation occurs in mandibular molars (55 per cent, usually in mesial roots) followed by maxillary molars (35 per cent, usually in buccal roots).

File separation may even occur in the hands of highly skilled professionals. As Louis Grossman, one of the founding fathers of endodontics once reported: “A dentist who has not separated a tip of a file, or a broach, has not done enough root canals.”

Once a file has separated, a decision needs to be taken as to whether to accept the situation, obturate as best as possible and monitor or to attempt to either bypass the instrument to attempt retrieval.

Steps to take
As frustrating as it may be when a file separates, not every separation must be removed and the astute clinician would determine steps to be taken according to the specific clinical conditions presented:

1. Was the tooth vital or necrotic (and probably infected) before treatment? If the tooth is not infected and copious amounts of irrigants had been used before the separation and the instrument itself cannot be bypassed, it is best to leave it there with the obturation and simply follow up.

2. In infected teeth, has the file separated at the beginning of the preparation or at the end, when the canals are “clean”? If there is preoperative periapical radiolucency and the tooth is infected, every effort is made to first bypass the separation (especially if two canals share the same apex). Generally removing the instrument by tumbling around it leaves to a loss of tooth tissue and a weakening of the root. If too much tooth is removed, there is a procedural risk of perforation, therefore bypassing using fine stainless steel instruments and enlarging by hand is preferable. Once bypassed, the obvious temptation is to go back in with a NiTi instrument, but it’s advised not to, as it is more than likely that it too will break.

Removing a file that is located beyond the curvature (when we can not see it after a straight line access) really increases procedural risks as inevitably a lot of tooth is removed and this reduces the root resistance to fracture.

3. Taking the right approach could hugely increase prognosis and tooth survival. One should not try to remove a separation without such knowledge, skill and suitable equipment. Adequate visualisation is essential either using loups and a light source or ideally a microscope.

Whenever the file separates, it is important that the patient is made aware of the problem and the prognosis. It is not negligent breaking a file. With their narrow pathways and multiple curvatures, canals are difficult spaces to get to. Instruments can fracture even in the best of hands.

Should treatment fail and the tooth remains symptomatic or without healing, an endodontic surgical approach or extraction may be necessary.

About the author
Dr Michael Sultan BDS MSc DFO is a specialist in endodontics and the clinical director of Endocare, a body representing a specialist group of practitioners Michael Sultan qualified at Bristol University in 1986 and worked as a general dental practitioner for five years before commencing specialist studies at Guy’s hospital, London. He completed his MSc and in endodontics in 1995 and worked as an in-house endodontist in various practices before setting up in London’s Harley Street in 2000. He was admitted onto the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on endodontic courses at the Eastman University in London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. To talk to a member of the Endocare team, call 020 7224 0999, email reception@endocare.co.uk, or visit www.endocare.co.uk.
Confirming treatment cases

Patients are far more likely to sign up to a treatment plan if a team member is able to answer all of their questions and explain clearly what’s involved, says Sharon Holmes

Most dentists do exceptionally well when it comes to monitoring their own UDA performance, as well as offering patients private dentistry. However, at the Dental Arts Studio, we have systems in place throughout our group of practices to help us identify when someone is not doing as well as we think.

This is great for business because once we’ve identified problem areas, we can formulate an action plan to assist them with self-development when it comes to treatment planning. To do this, we hold regular one-to-one meetings with them to discuss potential causes for their underperformance. Most of the time, they will say they don’t know what they are doing wrong as they are offering patients treatments. But it’s important we identify the reasons because the Dental Arts Studio has two NHS practices within its group, so we have to ensure that our associates are following all the guidelines with regards to treatments that patients can receive on the NHS. The private treatments on offer are more of the cosmetic type as well as implants and adult orthodontics.

When I was a dental nurse in South Africa, I sat in on all case discussions and I was not allowed to leave the surgery at all unless asked to prepare for study models or X-rays. I witnessed many successful cases being taken up by our patients which in some cases involved a two-year treatment plan which lead to extensive costs – I worked for a prosthodontist which meant many patients had to see a periodontist prior to crown and bridge work.

Guaranteed success

The success of following through on case acceptance relates to presentation, education, allowing the patient to ask questions and the dentist taking the time to be patient to explain the treatment to the patients until they feel comfortable and fully informed.

Initially patients would attend for a general examination. During their first visit, a full-mouth examination was carried out. X-rays were taken, as well as an OPG and impressions for study models. The patient was made aware that this was carried out in order to produce tools to assist with the creation of the most effective treatment plan for their oral care, thus building trust. The more you explain to patients the reason behind your care, the more they will believe its not just about making money.

The next step

Once the first consultation was over, the patient was asked to book a second-hour-long consultation to discuss other aspects of the treatment plan. It was free and a time to go through the patient’s charting, notes, X-rays and study models. The treatment plan was typed up descriptively, including clear details of costs and appointments required from start to finish of the advised treatment. This included any referrals. The fees were broken down so that there could be no misunderstanding with regards to costs.

During this discussion, the treatment plan, X-ray's and study models and any other educational charts were on hand to assist in any necessary explanations. Treatments that were discussed were addressed as medical issues and not cosmetic. The up-side of the medical treatment is that at the end of the full-mouth rehabilitation, the patient completed with a fully restored mouth and a wonderful smile.

Money talk

When the issue of cost was discussed, the patient was informed of the practice policy with regards to payment of fees. The initial outlay for filling restorations and oral hygiene appointments were to be paid after each course of treatment, as we did not run an accounting system. Secondly, when the treatment involved laboratory work, the patient had to pay a 50 per cent deposit on the start of the prep work. When the laboratory work was at the biscuit-bake stage, the patient would be required to pay a further percentage of costs, and by the time the crowns or bridges where fitted the patient would have settled their fees in full. Patients were given a substantial discount if they paid cash up front for the whole agreed treatment plan.

During this session, the patient was given time once again to discuss availability of their attendance as it was a commitment to the treatment as well as the funding of their dental care.

A second opinion

Treatment cases can be successful, but it comes down to the dentist or treatment care coordinator as to how confident you make the patient feel. Patients worry about commut ing to long and regular dental appointments, as well as parting with their hard earned cash so you need to make them confident. Bear in mind patients can be very cautious and do not take your treatment plan and go to another practice for a second opinion if they don't feel confident or comfortable with what you are advising them. Honesty, clarity and fully informed consent and a written treatment plan are an advantage to a practice when it comes to case acceptance.

If after a case discussion the patients do not book to go ahead with treatment, it is worth making a follow-up call to the patient to see if they want to go ahead with treatment. We ask all our associates to keep a book with a record of all treatment plans issued and encourage them to either call the patients themselves or to ask their designated personal assistant/receptionist to make the follow-up call. This has proven to be effective.

Once a patient accepts a treatment plan, it is imperative that the patient signs it to say that they understand what treatment is being offered and that they are happy to go ahead with it. A copy is then placed in their folder. All aspects of dentistry involve administration and it can prove costly if you do not follow a practice procedure to ensure all aspect of treatment cases is covered.

About the author

Originally from South Africa, Sharon Holmes has worked in dental practice management since 1982. She received hands-on training from the first dentist who employed her in 1982, which gave her a breadth of experience in knowing what’s involved in providing dental treatment. Arriving in the U.K. in 2002, she took a post in a mixed NHS and private practice in Wimblington, eventually taking over its management, converting it to a fully private practice. In 2003, she moved to London City Dental Practice where after 18 months, was responsible for managing four practices in the group. The London City Dental Practice is now part of a mini co-operative group called the Dental Arts Studio, in which she has been instrumental in its creation. She holds the position of operations director and manages every aspect of the group along side her principal dentists.
A number of changes introduced by the 2009 Finance Act could have a significant effect on the amount of tax payable by dentists and as a consequence careful consideration is required if a practitioner is to minimise liabilities to both income tax and class 4 national insurance contributions.

**Capital expenditure**

In addition to the 100% allowance for the first £50,000 spent on plant and machinery, known as the Annual Investment Allowance (AIA), there is a new first year allowance (FYA) of 40%. This does not have a monetary limit but is available only for qualifying expenditure incurred in the 2009/10 tax year, so time is fast running out!

Qualifying expenditure of £150,000 incurred on or before 5 April 2010 will attract an AIA of 100% on £50,000 and a FYA of 40% on £80,000, effectively doubling the tax reduction. If you are considering major expenditure later this year, it may be worth bringing it forward to the current tax year ending on April 5th.

The same amount of capital expenditure incurred on or after 6 April 2010 for an unincorporated practitioner would only generate a writing down allowance, initially of 20% on £80,000. This new FYA could create a loss which could be carried back for up to a maximum of 3 tax years.

**Reduction of the personal allowance with effect from 2010/11**

An individual is entitled to a full amount of personal allowance provided that individual’s adjusted net income (ANI) is £100,000 or less. If the ANI exceeds £100,000 the personal allowance (PA) is reduced by £1 for every £2 of the excess. Consequently if an individual’s ANI amounts to £104,450 the PA allowance is £6,500 for the 2010/11 tax year, the PA will be reduced by ½ x £4,450 ie £2,225. If a dentist’s ANI amounts to £113,000 no PA would be claimable.

Dentists should be aware that the effect of this restriction is to create a marginal rate of income tax of a massive 60% for a short band of taxable income just below or just over £100,000.

50% higher rate of tax for 2010/11

A 50% tax rate is payable on taxable income in excess £150,000 for 2010/11 and subsequent years consequently dentists should consider the importance of deductions such as Gift Aid payments in order to reduced the amount of their taxable incomes.

**Limitations in relief for pension contributions**

With effect from 2011/12 relief for pension contributions will be reduced for those with incomes between £150,000-£180,000 and those with incomes in excess of £180,000 will only be entitled to relief at the basic rate of income tax. To prevent taxpayers circumnavigating the new rules by manipulating their income and pension contributions in advance of the new rules, anti-forecasting provisions were introduced with effect from 22 April 2009.

Tax relief on pension contributions made after 8 December 2009 will be reduced only where the dentist has changed their existing pattern of pension contributions and total contributions in the tax year exceed £20,000.

The reduction in tax relief is effected by way of a Special Annual Allowance charge which in 2009/10 charges tax at 20% on pension contributions to which it applies and in 2010/11 charges tax at a rate such that the tax relief is reduced to, rather than by, 20%. This tax will be collected via the normal self-assessment system.

Far from simplifying the tax system these changes only serve to complicate a dentist’s tax affairs.

On a positive note, however, if you are incurring capital expenditure act swiftly, you still have the option to reduce your tax bill significantly in the current financial year.

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Try a little tenderness...

Getting patients to feel comfortable and to comply when it comes to maintaining a high level of oral hygiene at home can be tricky, says Alison Lowe who reveals how a new product and a stern example might just help

I’m sure we all get days when at least one patient presents with either raging tooth-ache or a localised gum infec-
tion. And, without wanting to sound unsympathetic, although it’s distressing for the patient, it can also be time consuming for the hygienist. This is mainly be-
cause the appointment is likely to involve a discussion of the problem and finding a free slot with the dentist. Not to mention the fact that they still want their scale and polish.

Now, imagine if next time this happened you could simply pop a little medicine-filled ‘cap’ on
the tooth and send them on their way. No, I’m not dreaming. This little idea could soon be a reality, with research being carried out on a product called ‘Denticap’ – a topo-
ical treatment aimed at treat-
ing localised dental problems.

Traditionally, patients would either be prescribed painkillers or antibiotics, which although are extremely effective, often have side effects. For example, some painkillers produce hy-
peracidity and gastric irritation when taken orally and antibiot-
ics can be slow to work and un-
dergo hepatic ‘first pass’ effect. And liquid dental formulations don’t last for long after they’ve applied before being washed away by saliva. However, it is hoped that Denticap will coun-
truct these problems.

So, what exactly is Denticap?
Well, it’s a soft polymeric, cylindrical mould (a bit like a temporary crown) that attaches to the tooth surface. It contains both antibiotics and analgesics, which should spell double trou-
ble for any dental problems.

And now for the science! Denticap is prepared using a mixture of Eudragit, Carbopol, gum karaya powder and ethyl cellulose – don’t worry if this all sounds Greek to you, the main thing you need to know is that the active ingredients are lido-
caine hydrochloride and amoxi-
cillin trihydrate. And as would be expected, Denticap has been subject to several clinical trials including tests for:

- Macrodhesion
- Water absorption capacity
- Swelling index

So far, drug release studies have shown that Denticap is sticky enough to stay on the tooth un-
til it is levered off using a little extra force. However, further studies are needed before Den-
icap is widely available for use, but it’s a product that shows great promise.

Patient compliance
On another note, and returning to the present moment for now, if you attended GlaxoSmithKlein’s Talking Points in Dentistry con-
ference in the summer or were a delegate at the British Society of Dental Hygiene and Therapy conference in Bournemouth, you would probably have seen Phil Ower speak. He is a mine of information and his presen-
tations always remind me just how critical a high standard of oral hygiene is in the success of all forms of periodontal therapy, especially as a healthy periodon-
tum is essential if other forms of dental treatment are to succeed.

Conveying this message to patients isn’t always easy though and as we all know, lack of pa-
tient compliance is the key prob-
lem in the prevention of peri-
odontal problems – this is why it’s so important to explain the disease process in detail. One particular gem of information I learned from the lecture, relat-
ing to an article published in The Times back in 2004. It’s called ‘Bug the Builder’ and it describes the formation of biofilm and its role in the development of den-
tal disease in a way that is really easy for patients (and us) to un-
derstand. Here is a short extract from the article:

‘Dentists might be more suc-
cessful in getting you to brush your teeth and floss more if they told you what the consequen-
tes were. Bacteria are building evil smelling cities in and between your teeth – what we nicely call ‘plaque’.

Plaque is anchored to your teeth by a dense opaque slime about five micrometers (1/5,000 in) thick. Above this, colonies of different strains of bacteria, shaped like mushrooms or cones, soar to between 100 to 200 mi-
crometers. Each miniature met-
tropolis is permeated at all lev-
es by channels for transporting water, waste and oxygen. Mmm… tasty!’

Have you ever had a pa-
tient comment on the awful smell when you have flossed or TePe’d their teeth in the surgery? Well just think, now you can tell them that ‘bug’ and his bacterial buddies are busy build-
ing ‘evil smelling cities’ on their teeth. If this information does-

The

About the author

Alison Lowe is a dental hygienist based at The Orthodontic Centre in Cardiff, a private practice specialising in implants, cosmetic work and perio-
dontal and Cardiff Dental School. She has won several awards including Hygienist of the Year 2008 and is a columnist for the Western Mail. She thoroughly enjoys what she does and is delighted to be contributing to Dental Tribune UK.

References:
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It is a sad fact that in this age of recession, starting out on your own is a very risky prospect and the concept of a Unique Selling Point could be the difference between success and failure. Dr Jaz Kalsi, principal dentist at Aquila Dental, has not only a great USP for his recently-established practice but also a great business model to help ensure success.

Aquila Dental, situated in the High St in Billericay, Essex and conveniently located near to the rail station on one of Essex’s busiest commuter routes (2.84 million used this station according to the 2007/08 Office of Rail Regulation statistics), has made its home above Aquila Optometry. The optometrists has been established in Billericay for more than 25 years. The business was acquired by Jaz’s brother, and when they saw that there was space upstairs which was lying dormant, the idea for Aquila Dental was formed.

“Aquila Healthcare for the whole family, dental care and optometry combined,” says Jaz, “people can come and get their eye test done and their dental check up and be good to go for the next six months to a year!”

Jaz is primarily a GDP with an interest in the cosmetic side of dentistry. “We cater for most needs; we do general dentistry right up to the more complex cosmetic treatments, which is my speciality. We also do facial rejuvenation treatment – Botox, fillers etc – so we have quite an array of services available and it is nice to have that mix of patients so it isn’t just those who haven’t been to the dentist for a while. In addition, as I am the only dentist here, there is a degree of continuity for the patient – they know they are going to see the same guy and they get to know who their dental professional is”.

“I really do think we should make it as easy as possible for patients – that was the idea behind establishing Aquila Dental. The concept is not new – in the past it has been tried under a corporate brand with the availability of checkups for both eyes and teeth. But I think it wasn’t a success because it was so corporate and lacking in the personal touch or the family friendly atmosphere. It’s about patients being happy with the level of service and the practice going above and beyond; reminder calls about appointments, phoning patients after they’ve had tricky procedures to see if they’re okay; just trying to do as much as you can to fit in with the patient’s lifestyle”.

To fulfil this ambition, Jaz had specific ideas on what he wanted for his practice. The challenge was making these ideas into reality. To manage this he chose SPS Dental to do the fit out. “There
was a lot of mechanical work to be done, wiring, plumbing etc. We used a company called SPS Dental. I already knew the ‘head honcho’ Chris Knight (Managing Director of SPS), whom I got to know at a practice where I used to work in Bishop’s Stortford over a year ago. When I left there I kept Chris’ details and things just went from there. Chris and his team genuinely seem to enjoy what they do and care about the customer. Also he and his team have a long background in dentistry – many of these types of companies have one guy who knows a little bit about dentistry and how practices work etc, but the rest of the team don’t. The whole team at SPS have been involved in the dental field in some capacity for many years. This gives you confidence when you are about to spend a lot of money with someone”.

“The largest room that had to be gutted was the actual surgery, the electric and plumbing put in, new flooring and units...this was all sorted out through SPS. I basically told them what I wanted and they went through everything with me and made sure everything was high spec, including the cabinetry and the worktops.”

“For the dental chairs we chose the Clesta II from Takara Belmont. It’s one of the newer chairs, but based on my experience from previous practices, the thing you learn very quickly is that as a brand, Belmont chairs are reliable as anything. They are easy to look after, they look good, they feel good and are easy to work with. On some other brands of chair the design and ergonomics are a bit ‘arty-farty’ and can look a bit weird to be honest with you. They’re also prone to breakdown which is the last thing I wanted in my new business!”

“With the Clesta II we have an intra-oral camera integrated into the chair, which is fantastic as I often use it to show patients before and after shots. You also have the extra options on the chair, such as the ability to programme the handpieces to do specific things. The way I see it, if you are going to set up a surgery you are expecting to work there for 20-30 years, you need to be happy about the quality of equipment you are using. With the upholstery I went for a really funky kind of cyan blue colour which looks great.”

Jaz’s advice to anyone looking to set up on their own is, “Be realistic in what you are trying to achieve and have a five year plan – people think that to be successful you just have to open your practice and patients will come. But you have to work hard, especially in the recession. The one thing that worried me slightly was starting up this venture in the middle of a recession. But I think that I have created an environment in which I can work in the way that I want to work, use the materials that I want to use and just practise dentistry the way I want. The lure of that was far stronger than any financial insecurity.”
For more information please call Genus on 01582 840484 or email chris@genus.co.uk. Genus should be your first point of call for a stunning, ergonomic work place with a top-quality, bespoke service to suit the dentist’s individual needs. A-dec’s professional, highly trained, Equipment Specialists are available to visit your practice well in advance of the project commencing to listen to your needs and share in your vision. They will then offer advice and guidance to ensure the complete success of your project from start to finish.

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Industry News

Dental Tribune
United Kingdom Edition • February 22-28, 2010

Ergonomic Surgery Considerations

If you are planning a surgery refurbishment or are looking to expand your treatment room – consider building into your extensive network of Equipment Specialists. With a level of experience that generates over 400 new surgeries per year, A-dec can help you make the right choices. As a typical dental surgery in the UK is expected to be in service for around 14 years (on current replacement cycles), do not reinvest in a facility that suits the needs of the past. Understanding your goals, Lansdell & Rose uses tried and tested methodology and technology to inform their comprehensive advice. Lansdell & Rose are renowned for their ability to expertly design and plan a facility that will meet your needs for now and throughout the future.

For more information about the A-dec product line or to discuss your project ideas contact A-dec today:

Through Your Patients Eyes

Have you ever really thought about how your patients perceive your practice? First impressions count and chances are, what factors into your overall opinion may vary greatly to their own. However, it’s not just the reception that makes the initial impact but the surgery environment too. The Civic II offers modern and overall look that is not dissimilar to an armoire, obvious advantages to you are a smaller footprint and therefore easier surgery planning options.

The fact that the Civic II is available in either an arctic or electric options, the latter of which offers fibre optic, micro-motor, endodontic features and digital displays as standard, is not relevant to them. However, they’re likely to judge the treatment centre on what it looks and feels like. The Civic II will not disappoint. It’s curvilinearly impressive and its seamless piece seat combines with the newly designed backrest not only looks good but offers even greater comfort.

Good looks mean nothing if not matched with functionality, reliability and cost. Takara Belmont is confident that the Civic II will not disappoint on any of these accounts.

Ashbourne’s First Velopex Picasso Laser

Ashbourne, in the peak district, is now well and truly on top of the new world for dental equipment. First Ashbourne Picasso Laser has been installed at the Dental Practice in the Compton Street which can now offer all patients the availability of laser treatments as well as the high quality dentistry previously offered.

The Velopex Diode Laser contains two lasers, a 10 Watt Gallium Arsenide (GaAs) diode laser and a small laser pointer. The GaAs laser is ideal for soft tissue (gum) work – in a deed of course, with teeth.

The Velopex Diode Laser can also be used for Tooth Whitening. This allows superior results to be obtained in surgery, in relatively short times.

The Velopex Picasso Laser is so easy to operate with a user friendly, menu based, control system that is easy to navigate. The unit itself can be readily moved to any dental chair or on a trolley – the unit is the size of a large laptop.

For more information or to ask any questions, please contact:
Mark Chapman
Medivance Instruments Ltd, Barrets Green Road
LONDON W10 7AP
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Quality and unrivalled value

Kalin offers a complete range of equipment including dental units to meet the needs and budgets of the discerning dental professional, a full range of treatment units with its innovative suspended chair concept which can be optimally adapted to the everyday needs of the dental practice.

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As a typical dental surgery in the UK is expected to be in service for around 14 years (on current replacement cycles), at A-dec we recognise there is much to be done for average dental surgery refurbishment. As A-dec believe refurbishment is a must, and is an ideal time to make improvements.

A-dec’s professional, highly trained, Equipment Specialists are available to visit your practice well in advance of the project commencing to listen to your needs and share in your vision. They will then offer advice and guidance to ensure the complete success of your project from start to finish.

For more information please contact Paterson Health Group on 01594 833 599 or info@patersonhealthgroup.co.uk.
Clearing a View

Hoggen eyeguards are well known for its provision of uncompromised safety combined with stylish design. Now the Hoggen Plus Eyeguard range features some new improvements.

The high quality polycarbonate lenses, which are also fog resistant, are polished to a slight drip and can be removed for cleaning. The thin interlock band ensures the glasses stay in place even during the most intense procedures.

The lightweight eyeguards from Hoggen clearly offers the best protection for your eyes.

For more information please call John Jessop of Blackwell Supplies on 020 7224 1447 or fax 020 7224 1694.

Keen to Book a Course?

UCL Eastman CPD also offers short courses, CPD and core subjects for all the Dental Health Care profession. The courses can be taken individually or can form part of a Certificate, Diploma or a higher level qualification. UCL Eastman CPD also offers short courses, CPD and core subjects for all the Dental Health Care profession. The courses can be taken individually or can form part of a Certificate, Diploma or a higher level qualification. UCL Eastman CPD also offers short courses, CPD and core subjects for all the Dental Health Care profession. The courses can be taken individually or can form part of a Certificate, Diploma or a higher level qualification.

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For further information, contact the UCL Eastman Administration Team on 020 7950 1231, or email dismant@ucl.ac.uk.
How can you attract more patients without wasting marketing your practice to the wrong people?

Finding new patients is always difficult, especially for a single-practitioner, and is particularly tough in the present recession and competitive retail environment. But help is at hand! The team behind the most successful and wide-ranging US patient referral network is now working with UK practices to boost their patient base and increase their profitability. Nobel Biocare’s NobelGuide™ system has been designed by a dentist and his team with 30 years’ experience in providing solutions which enable practices to maximise cashflow and profitability.

The benefits to dentists are self-evident. The plans make it easier for patients to afford the treatments they need, and practices are marketed directly to these patients.

Dentists seeking to improve their practice’s cashflow and profitability, while offering cost-effective treatment to their patients, should contact a dental network provider like Munro Sutton and discuss their options. It may leave you laughing all the way to the bank!

For more information please call DDE 234 3558
or visit www.munro Sutton.co.uk

Kemdent value the expertise of their customers

Kemdent are currently funding a project to carry out extensive research into Diamond GIC Dental materials, with the support of University of Leeds and Bristol Dental School.

This is a season Kemdent are encouraging new customers to evaluate their Glass Ionomer Capsules by providing them with 5 x 53 Diamond Rapid Set Capsules and an 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 M & S vouchers.

Diamond Rapid Set Capsules are packed in individual, easy to access foil packs. Diamond Capsules are available for weekly and 3, 5 and 10 thousand packs for additional strength. Diamond’s early snap set creates a waterproof 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.

NuClay VIVADENT LICHTENTHOUNG COURSE & RESIDING SUCCESS

Volcanic Solid has made a huge impact on the dental industry, and is the leading system for implant dentistry. The company’s leading ceramic specialist, Mr Rob Lyncock, recently held a 4 day course in November at the company’s headquarters in Lithonsthoen.

The course concentrated on specialist areas including technical procedures for max press, max zirconia and a max core focusing on the necessary chairside and layering techniques required.

Using his extensive experience from within the industry, Mr Lyncock focused lectures over the four days on a full anterior case, from pre-proximal to final proximal, highlighting the differing capacities and transparencies of the max system.

As the courses throughout 2009 have proved a phenomenal success Mr Lyncock will be holding further international courses in Lithonsthoen throughout 2010 which will cater for all practitioners from the newly qualified to the very experienced. For further information please call 0116 284 7880.

Smile-on Newsletter

As the market leaders in innovative, flexible and inspirational education solutions, Smile-on offers easy access to outstanding training programmes for the entire dental team.

Smile-on is also at the forefront of the latest news information and education opportunities and offers busy professionals an easy way to keep their finger on the pulse, absolutely free.

The Smile-on newsletter will also advise on upcoming webinars. A breakthrough in education, a webinar is an interactive online tutorial from one of the most highly regarded dental professionals in their field.

Registered users on the Smile-on website can also track their CPD and explore the vast array of continuing education resources from Smile-on.

Smile-on is dedicated to the dental industry by promoting excellent patient care and career satisfaction through education and training. The expert team from Smile-on are also on hand to offer guidance on the learning material to busy professionals who can meet their industry obligations, build their CPD and advance their skills within dentistry.

For more information or to sign up, for the Smile-on newsletter email info@smile-on.com or visit www.smile-on.com

The Continu alcohol free DUWL disinfectant effectively strips away biofilm to achieve long term reduction in infection control so a weekly maintenance treatment is all that’s needed to maintain high levels of disinfection, making it very cost-effective.

With HTM 01-05 highlighting the limitations of alcohol based solutions, Continu is rapidly becoming the alcohol-free disinfectant of choice and the new Dental Unit Water Line Disinfectant completes a highly successful range that includes spray, swabs, liquid soap and hand cleansing foam, together with anti-microbial印象凝胶.

For more information please call Nuveen on 01453 872266, email info@nuveen.com or visit www.nuvecare.co.uk

Coltene Whaledent

SwissFlex – New from Coltene Whaledent

To enhance the popular DeltaX range Coltene Whaledent is pleased to launch a brand new product, SwissFlex discs which offer conturbing, finishing and polishing of composites, amalgam, glass ionomer and precious metals. With no slippage of the covered mandrel and super thin foil this disk allows higher efficiency and avoids over-erosion due to ideal contact with the tooth surface.

Available in coarse, medium, fine and ultra-fine the SwissFlex Introductory kit contains 200 discs, 40 finishing & polishing strips plus three mandrels for an introductory price of £24.05.

For more information on this new Danish product please call free phone 0500 395 454 exts 225/224 www.dentalirectory.com

Nuveen has launched a groundbreaking new water based DUWL, Disinfectant to deliver a safe, effective and economic solution for inhibiting bio-contamination of waterlines.

Some existing solutions are known to damage equipment, many are expensive, and HTM 01-05 states that “No currently available single method will completely eliminate bio-contamination of DUWLs or exclude the risk of cross infection” (A.80).

The Contenu alcohol free DUWL disinfectant effectively strips away biofilm to achieve long term reduction in infection control so a weekly maintenance treatment is all that’s needed to maintain high levels of disinfection, making it very cost-effective.

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For more information on this new Danish product please call free phone 0500 395 454 exts 225/224 www.dentalirectory.com

Coltene Whaledent

SwissFlex – New from Coltene Whaledent

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Supported by the British Orthodontic Society, this successful BDA Seminar is now in its thirteenth year and continues to be popular. It’s a great opportunity for those dentists who are considering setting out on their own for the first time and covers all aspects of either buying into an existing practice or the challenges faced when establishing a practice from scratch.

The one-day seminar endeavours to answer all your questions – from the philosophical ‘Is it right for me?’ to the more practical, day-to-day issues you are likely to face. Previous seminars have sold out very quickly and places will be limited, so book early to avoid disappointment.

What it includes
The programme begins with opening remarks from the chair Nilesh Patel, GDP Buckinghamshire, BDA Executive Board Member and covers issues such as, starting out and setting out on your own – initial considerations when setting up on your own, the different options open to you when setting up a new practice, buying an existing practice, setting up a squat practice, how the new contract will affect you and how to deal with the PCTs and 10 tips to setting up successfully.

It also cover setting up a specialist private practice; employing staff in 2009/10 – developing contracts, developing practice policies and procedures; financial implications of owning a practice; business plans and management; health and safety in dental practice and buying into an existing practice. There’s also an interactive panel session where there’s a chance to ask a panel of experts questions relating to your needs and experiences.

Speakers include leading orthodontist Neil Counihan; Maharashtra Hasnaini who runs a mini co-operative group of four specialist practices; managing partner at Dental Business Solutions George Manolescue; award-winning practice owner Gareth Mcleer and Senior Health and Safety Advisor with the British Dental Association’s Professional and Advisory Services Directorate Daniel McAlonan, to name a few.

The seminar meets the educational criteria set by the GDC for Verifiable CPD (six hours) and is certified by the British Dental Association.

Hotel accommodation
If you wish to stay overnight during the event please contact Virtuso, our appointed hotel booking agency, direct on 0845 310 3333 quoting reference “BDA – Setting up in practice”. Alternatively, you may email them at bda@virtuosoltd.com or book online at www.virtuosoltd.com.

For further information on the programme and to book your place on this seminar please contact Erica Sprigge, Events Officer, British Dental Association, 64 Wimpole Street, London, W1G 8YS, call 020 7563 4590 or email events@bda.org.
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Every dental surgery should be equipped to enable the dentist or trained DSA to administer resuscitation. The Tricodent Emergency Resuscitation Kit is easy to identify and put into immediate use. Patients in the surgery or waiting room who suffer cardiac arrest, cardiopulmonary collapse, respiratory arrest or an acute allergy condition may be given oxygen or an oxygen-enriched air supply to revive them using the self-reinflating bag.

The kit is supplied complete and ready to use with a fully charged 340 litre oxygen cylinder with multi-flow regulator, resuscitator bag and guedel airways.

All components can be purchased separately & the KEOxygen can be rented. Tricodent also provides a full servicing and re-filling package to ensure that your practice always has an appropriate level of emergency cover.

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