Grinding teeth
The credit crunch is causing people in the UK to grind their teeth more.

Dentists are finding that the number of patients who grind their teeth has increased over the past two months – at the same time as recent hikes in petrol, energy bills, food and mortgage costs.

Keith Cohen, a dentist practising in Harley Street and the City, noticed the change two months ago and is blaming it on stress, one of the factors most commonly linked with people grinding their teeth.

Alexander Jones, a Yorkshire dentist, has also seen an increase in people with pain around the jaw and snapping the corners off teeth, probably around 10-15 per cent since the summer – both symptoms are an indication of grinding teeth.

 Grinding teeth can lead to gum and nerve damage and can also cause jaw and muscle problems.

Top school
The University of Manchester’s School of Dentistry has been ranked top of all dental schools in the UK for student satisfaction.

It is a double triumph for the school, which made history in June, by becoming the first ever to achieve a 100 per cent pass rate in the final examination of its Bachelor of Dentistry Surgery degrees.

Dr Nick Grey, head of the school said: The excellent performance of our students in achieving a 100 per cent pass rate and our top ranking for student satisfaction reflects the school’s commitment to placing student feedback high on the agenda.

He added: ‘These successes are a credit to both our staff and students.’

DLA ceremony
The Dental Laboratories Association is to hold its 2009 Chairman’s Dinner on 31 January. Awards will be given out at the event. These will include Dental Technology Student of the Year, Dental Technician of the Year, DLA Member of the Year and Outstanding Contribution to Dental Technology.

New Chairman Jonathan Bill will celebrate his inauguration at the new awards ceremony hosted by Dominic Holland of Never Mind the Buzzcocks and Who’s Line is it Anyway. The event will be held at the National Space Centre in Leicester.

Cumbria fluoridation
NHS North-West is looking at extending water fluoridation into more areas in line with the government’s fluoridation plans

Dr Cockcroft
Barry Cockcroft tells Dental Tribune why he followed the path into dentistry and how he became England’s CDO

PCTs talk
After two years under the new contract what do the PCT managers really think about it? The truth is revealed

Adhesive dentistry
Patient demand for better aestheticics has been met with an amazing spectrum of new materials and techniques

‘Back-up accusations’ says BDA

The British Dental Association is calling on the Department of Health to come up with evidence to substantiate its accusations that dentists are exploiting patients by calling them in for more check-ups than they need.

Current guidelines by the National Institute for Health and Clinical Excellence (NICE) say healthy patients do not need check-ups more than once every two years.

However chief dental officer Dr Barry Cockcroft claims some dentists are asking patients to return every six months.

He has also accused them of maximising their profits by splitting treatments which could be done in a single session, leading to more check-ups.

Dr Cockcroft said he is talking to primary care trusts (PCTs) to work out how to stop dentists spreading treatments across different appointments so they can make more money.

Responding to the accusations, Susie Sanderson, chair of the British Dental Association’s (BDA) executive board said: The British Dental Association does not have the necessary data to comment on these suggestions. If the Department of Health does, it should share that information so that it can be investigated and better understood.

The interval between recalls is, according to NICE guidelines published in 2004 and supported by the BDA, a matter for a practitioner’s clinical judgement in consultation with the patient. For adult patients, that interval is required to be between three and 24 months.

She added: ‘The significant problems with the new dental contract have been recognised this year by the House of Commons’ Health Select Committee.'
More fluoridation for the North West

NHS North West is looking at extending water fluoridation into more areas in Cumbria - as part of a push by the government to fluoridate more of England.

Around 150,000 people in West Cumbria receive fluoridated water. Now NHS North West is consulting with the county’s primary care trust, NHS Cumbria, over whether they should draw up preliminary plans to extend its reach. The plans would be subject to a public consultation.

Barry Cockcroft, the government’s CDO, said: “Areas with high levels of caries are considering it. We only need to fluoridate 40 per cent of the country.

The main part of our policy is preventing disease and so we are looking at fluoridation. We are making progress for the first time in 20 years.”

Southampton is the first area to hold a consultation on the issue and this is already underway.

Fluoridation was first introduced into Cumbria in 1960s when areas in and around Birminghham and Newcastle were fluoridated, along with the Republic of Ireland.

The government has set aside £4.2m over three years to strategic health authorities who decide after consultation to introduce fluoridation schemes.

Critics such as the National Pure Water Association and the Green Party are opposed to the plan and link it with diseases such as cancer and Alzheimer’s disease.

However Dr Cockcroft dismissed the ‘scare mongering that says it causes cancer’ and said: ‘All the water in this country contains some fluoride. So we have had it for generations and there is no evidence linking fluoride with systemic disease. The only thing that is connected with fluoridation is dental fluorosis and that only occurs in a tiny minority of children.’

Eric Rooney, a consultant in dental public health at NHS Cumbria said: “Water fluoridation is one possible intervention to improve dental health and we already have fluoridation schemes in the West Cumbria area. Any eventual scheme for Cumbria would be subject to a public consultation by NHS Northwest.”

Currently, about 10 per cent of England’s water is fluoridated - mainly in the north-east and the West Midlands. The government wants to fluoridate nearly half of England, according to the Chief Dental Officer (CDO).

The plans would be subject to a public consultation, According to the Chief Dental Officer (CDO).

First orthodontic therapists graduate

British patients left unprotected

The UK is in danger of being one of the last countries in the EU to persist with an outmoded system that can mean dental patients who are harmed by a negligent dentist do not get any compensation, warns the Dental Defense Union.

In the large EU member states such as France and Germany, it is already a requirement that practising dentists have professional indemnity insurance in order to protect patients where they are negligently harmed.

However in the UK, while there is insurance, there is also discretionary indemnity which offers only the right for a dental professional to request assistance and have the request considered.

Rupert Hoppenbrouwers, head of the Dental Defence Union said: “In this current dento-legal and economic climate, we cannot understand why the UK still allows unregulated indemnity.

The UK has fallen far behind other EU states on this. A German patient who was treated in the UK and negligently harmed by a dentist who was reliant on discretionary indemnity might not be compensated if the indemnifier decided not to assist with the claim. Of course, a German patient who was treated and harmed at home by an insured dentist would receive insured compensation. There is now an opportunity to resolve this anomaly.”

The European Commission is currently developing a directive to safeguard patients’ rights in cross-border healthcare, including the need for appropriate ‘systems of professional liability insurance or a guarantee or similar arrangement appropriate to the nature and the extent of the risk’.

Mr Hoppenbrouwers wants to see the European directive amended to ensure that indemnity must be provided only by the state or a regulated insurer. This would make discretionary indemnity unacceptable in the EU.

He added: “In the current volatile economic climate it is particularly important that professional indemnity is regulated as this provides a high degree of protection. When damages are awarded in negligence cases it is imperative that patients know they will receive the compensation due to them. The UK has some of the most forward-thinking and technically advanced dental professionals in the EU but discretionary indemnity is distinctly last century.”

Drop-in dental centre

Patients in Basingsope are to get a drop-in dental centre in what is believed to be the first of its kind in the country. A proposed new health centre is to have 20,000 booked and drop-in ‘units of treatment’ per year of dentistry.

Minor surgery, contraceptive and sexual health services and a cardiovascular risk and case-finding unit are other services the trust is hoping to offer. The health centre will be open to registered and non-registered patients seven days a week, between 8am and 8pm.

Smile-on offers latest in clinical dentistry

Smile-on has joined forces with Alpha Omega and is holding a conference on the very latest in clinical dentistry.

Dr Devorah Schwartz-Arad and Professor Nitzan Bichac will present Success factors in dental implantation: a multi-disciplinary approach between the surgeon and the prosthodontist at next year’s Clinical Innovations Conference and Annenberg Lecture at the Royal College of Physicians. Dr Schwartz-Arad is a specialist in oral and maxillofacial surgery.

Professor Bichacu is a leading authority in many fields including dental implant therapy and fixed prosthodontics. During this all-day event on 15 May 2009, dental professionals can explore the team’s role in treatment planning, the benefits and drawbacks of immediate implantation and loading, and how prosthodontist and surgeon can work together to determine the best treatment approach.

For more information, or to book your place at the 2009 Clinical Innovations Conference, call 020 7400 8989 or e-mail info@smile-on.com

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Published by Dental Tribune UK Ltd

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Dental Tribune UK Ltd

· October 27–November 2, 2008

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Is now the right time to contemplate moving from the NHS into the private sector? This is a question that I frequently hear asked, and the thought process behind the question is also quite common: ‘do I really want change and upheaval?’ and ‘do I want it now?’

However, there has, quite seriously, never been a better time to contemplate change. Those who are comfortable with above-average UDA rates must now be aware that the possibilities of ‘harmonisation’ are looming and in some cases already happening. Recent media stories, which look to blame dentists for the failings of the new dental contract, are also too familiar.

Access (volume) is the declared goal of the reforms, and it is the profession who will take all the risks involved, while their goodwill and business assets are valued entirely at the whim of their local NHS management.

To quote one colleague, the ideal time to make the move out of the NHS is always a little while before you actually do it. This was certainly true in the last days of the ‘old contract’ when dentists were queuing up for a last-minute conversion. There were inevitably problems with this approach, since plans were rushed, communications brief and objectives not always fully thought through.

Some colleagues on the other hand, have an unquenchable belief that all will turn out well. That’s understandable, as no-one likes to think about the hangover when the party is in full swing. But history does not support this prospect. Every major Governmental reform of dental healthcare has had an uncomfortable outcome for dentists.

Interestingly, dentists are very clear about why they seek relief from managed healthcare. Their reasons, according to Denplan research are: to spend more time with patients; to reduce workplace stress; to offer good quality clinical care; to have clinical freedom; to run their practice without outside constraint, and (in about sixth place) to have appropriate financial reward.

It is always tempting to think that ‘it won’t work for me’ or ‘it won’t work for my patients’, but time and again, over more than 20 years of experience tells us otherwise. A careful analysis, using expert systems and experienced advisors, will reveal what is possible in any practice circumstance, in any location.

And once a realistic goal has been set, and crucially, all the practice team are committed to its achievement, the outcome is entirely predictable. As dentists we are perhaps more likely to be ‘control freaks’ rather than merely swept along by the tide, but this is one time when to have knowledgeable, outside advice is essential. Dentists who have moved into the private sector always have one saying in common: ‘I wish I’d done it years ago’.

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The late Sir John Harvey-Jones, ICI Chairman and Troubleshooter said: ‘in business, there are only forward and reverse gears; there is no ‘park’ option.’ In the turbulent world that is UK dentistry today, this is the very best time to be selecting ‘forward’.

Roger Matthews, CDO for Denplan

Guest comment
The time is right to go private…
£11m funding boost for dental training

The government has announced an extra £11m of funding for dental hospitals in England to fund new IT systems to support the training of dental students.

The funding is part of a joint initiative by the Department of Health, NHS Connecting for Health and the Dental IT programme board.

Deputy Chief Dental Officer, Tony Jenner said: 'This extra funding reinforces the government’s commitment to supporting dental hospitals and expanding the dental workforce.

The NHS now has over 4,000 more dentists than it did in 1997 and we have increased the number of undergraduate training places by 25 per cent to ensure we have more dentists in the areas of the country that need them the most.'

The £11m will be divided between each of the 10 trusts that applied for funding.

The trusts will have responsibility for using the money to train dental students in the use of clinical computer programmes that they will use in practice.

This includes core applications under the National Programme for Technology, such as Patient Administration Systems, N3, Choose and Book, Picture Archiving and Communication Systems and access to the NHS Care Record Service, clinical dental systems, resource management and support for the teaching of students. As well as training future dental care professionals, NHS dental hospitals and associated dental schools research ways to improve oral and dental health and provide specialist clinical services for patients.

The 10 trusts receiving allocations include South Birmingham PCT, University College London Hospitals NHS Foundation Trust, Guy’s & St Thomas’s Hospital and Dentaid, which is responsible for funding for dental hospitals and asso- ciated dental schools research ways to improve oral and dental health and provide specialist clinical services for patients.

Infant Oral Mutilation campaign

The oral health charity, Dentaid, has launched a campaign to stop the practice of Infant Oral Mutilation carried out in countries such as Uganda, where baby teeth are gouged out with knives, bicycle spokes and finger nails.

The teeth are removed because the people believe the soft white buds of the new teeth are actually worms in the mouth of the infant. These ‘mouth worms’ are believed to be parasitic and fever causing so if the child has an illness, the baby teeth are blamed.

A spokeswoman for Dentaid said: ‘A primitive technique is usually employed to gouge out the baby teeth involving un-sterile knives, bicycle spokes, finger nails or other bizarre and inappropriate instruments.

The practice is often carried out by village healers for a fee. It is also performed by parents, community elders and even midwives.

The consequences of this Infant Oral Mutilation (IOM) can be severe pain, serious oral health complications and, not infrequently, death.

Infants often suffer from future facial disfigurement, damage to the gums and the permanent teeth following the removal of their health deciduous teeth.

In one region of Uganda, infant deaths due to septicaemia and other infectious diseases, following IOM, are reported to be second only to malaria as a cause of infant mortality, according to Dentaid.

Another problem is that when ‘mouth worms’ are diagnosed, often the real illness is left undiagnosed and untreated.

Dentaid wants to make the public more aware of what is going on and has created an IOM action group to focus on implementing a strategy to combat this practice.

Dentaid has devised a trial community based approach to educate people about the practice of IOM in the countries in which it takes place.

A group of volunteers in association with Christian Relief Uganda, went out to Uganda in September 2008.

They carried out dental screenings, basic treatments and training. They also conducted interviews with health workers, community leaders and parents to gather anecdotal evidence of how IOM is perceived in Uganda. This information will assist in the strategic development of the Dentaid project to combat IOM.

If you are interested in getting involved with this campaign please contact Nicky Triance on 01794 325146 or email nicky@dentaid.org. Detailed information can also be found at www.dentaid.org.

More preventative work for Sheffield

NHS dentists in Sheffield will be asked to sign a new contract next year that encourages them to carry out more preventative work.

The change, when the current three-year contract comes to an end next March, is part of NHS Sheffield’s Dental Health Commissioning Strategy.

The Primary Care Trust wants to reduce the proportion of the contract that focuses on the delivery of EBAs (Units of Dental Activity) and develop a framework aimed at encouraging a preventative approach to practice whilst improving access to high quality dental services, according to the strategy.

The director of dental public health for Sheffield, John Green, said the current dental contract was very ‘activity focused’. He added: ‘There would still be recognisance for carrying out treatment such as extractions and fillings, but dentists would also get rewarded for preventive work.’

Preventive work will therefore focus on deprived areas in Sheffield as statistics have shown this is where children are more likely to develop dental problems. This will include increasing access to dental care, improving children’s diet and targeting oral health promotion at young children.

Fluoride is currently added to children’s milk in 42 primary schools in the city and this will continue under the new strategy.

Dentists wanted for revalidation views

The General Dental Council is asking dental professionals for their views on its proposals for the revalidation of dentists.

Hew Mathewson, president of the GDC said: ‘Revalidation is about ensuring dentists continue to meet the standards expected of them throughout their careers. Patients can have even more confidence that their dentist is performing to a high standard and that those standards are being set and overseen by a regulatory authority – the GDC.’

We want revalidation to be as simple and flexible as possible, so we are committed to using existing and current quality assurance systems and locally gathered evidence. The first cycle of revalidation for dentists is not expected to start until 2011. By that time we should have thoroughly tested the system that is finally introduced.’

Under the proposals, dentists will need to provide evidence in four key areas – professionalism, clinical, management and leadership, and communications. Evidence might include clinical audit, significant event analysis, patient surveys, and personal and practice development plans.

Once revalidation is up and running for dentists, the GDC will look at introducing a system for other groups of dental professionals on its registers.

For more information and to download the current proposals visit www.gdc-uk.org/revalidation. The GDC website will be updated as revalidation is developed.
“Sometimes people think that big companies aren’t interested in NHS dental practices, my experience of Henry Schein Minerva is just the opposite. They have encouraged and supported us in many ways, providing an excellent staff training programme which has really helped develop our personnel. We now have an established facility that provides outstanding care for our patients, all made possible by the first class service we receive from Henry Schein Minerva.”

Yemi Opaleye – Tetbury Dental Practice, Tetbury

Me & Henry Schein

Partnership in Practice

To develop your partnership

email: me@henryschein.co.uk
www.henryschein.co.uk
Location, location, location!
Alex & Abby – Michael Dental Care, Cheltenham

I t the future’s bright for a certain well-known mobile phone company, then the same can be said of a fairly recently qualified couple who have opened their first practice on the outskirts of Cheltenham. Alex and Abby Michael are everything that the future of UK dentistry is founded on; young, enthusiastic and with a heartfelt commitment to providing patients with great dental care.

“...we’ve been very fortunate in the help we’ve received in all these areas from Henry Schein Minerva and our local rep Sally Dawson, who is just an amazing person.”

and excellent treatment when required.

Alex and Abbey met at Cardiff Dental School from where they qualified in 2002, they each completed VT training in Swanssea and Bromsgrove respectively and were awarded their MFGDP qualifications in 2004, marrying later the same year. When the opportunity to take over the Cheltenham practice arose they realised it was too good to miss and took over in October 2005.

Location, location, location – it’s a key factor in the success of any business and one thing is certain, Michael Dental Care is perfectly situated. On the outskirts of Cheltenham, the practice is easy to reach, has parking facilities on its doorstep and is 5 minutes from the M5, meaning it draws from a very wide catchment area that includes most of Gloucestershire, Worcestershire and Herefordshire. Some patients even come from as far as Cornwall in the West and London in the East.

So why do patients travel quite so far to get their dentistry at Michael Dental Care, - well Alex and Abby have a very simple but very powerful approach to dentistry and to life in general and have built up respect and credibility even winning over the patients of the previous owners, who were using most regular suppliers, but by her explaining the ways in which she and Henry Schein Minerva would be able to help in their new venture, - not just by supplying consumables, but by her helping them on a consultancy route.

Part of this role was to complete an audit to give Alex and Abby an insight into which products they were using most regularly - information that Alex has found invaluable.

“As we were starting a new practice, obviously cashflow was and remains a key priority for us and we operate a ‘just in time’ ordering process so that we don’t have money tied up in stock we don’t need. Sally’s audit made this much easier – I now order everything on-line, my previous orders are listed which speeds the process up and because we know we can rely on next-day delivery we can maximise our cash flow and credit terms.”

Sally has also provided staff training in sterilisation procedures, helped with marketing ideas and in short has been there to help solve problems they have faced in their early days. And their relationship remains as strong as ever.

“Sally has just been fantastic. Nothing is ever too much trouble for her and we have really come to rely on her expertise and advice.”

Michael Dental Care has attracted around 1000 new patients in their first 18 months of being open and attribute a lot of their marketing activity to encouraging referrals from existing patients – a strategy that has so far proved very successful.

“Our belief is that nice people know other nice people, so we ask our patients to pass our details on to their family and friends – so far, 80% of our new patients have come via this route.”

Alex and Abby have a dynamic, efficient and very welcoming practice which reflects their personalities and enables them to practice a style of dentistry they are comfortable with. This enthusiasm and zest for life not only hoes well for Michael Dental Care but also for the future of dentistry itself.

For more information email: me@henryschein.co.uk
When we opened our new practice, cashflow was a key priority for us. We operate a “just in time” ordering system so that we don’t have too much money tied up in stock and Henry Schein Minerva’s stock audit makes this much easier. We regularly order on-line and because we know we can rely on Henry Schein Minerva’s excellent service and delivery, we can maximise our cashflow and credit terms.”

Alex & Abby – Michael Dental Care, Cheltenham
BDHF backs sugary drinks ban

The British Dental Health Foundation is urging NHS hospitals to ban sugary drinks from their vending machines.

Schools are expected to fill their vending machines with water, fruit juices and healthy snacks. Now the BDHF is calling on hospitals and GP surgeries to do the same.

NHS Tayside in Scotland is one trust which has been quick to take action by banning sugary drinks in vending machines at some of its hospitals.

The BDHF’s chief executive Nigel Carter said: ‘The foundation not only backs the NHS Tayside decision, but calls for a UK-side ban on sugar drinks and snacks in hospitals, surgeries and health centres. Sugary products taken between meals are the main cause of tooth decay, which can lead to fillings and extractions.’

He added that banning unhealthy food and drink was important in protecting people against a range of other health conditions, such as heart disease and diabetes. The Scottish Government has backed NHS Tayside’s move and is calling on other trusts to follow suit, while the Department of Health said it wanted to see a similar approach in England.

A Department of Health spokesman said: ‘We have stated in the new obesity strategy that we expect the public sector to lead by example. The NHS is responsible for promoting and procuring healthy and nutritious food for staff, patients and visitors.’

The National Institute for Health and Clinical Excellence, which produces guidance for the health service in England and Wales, has also recommended the promotion of healthier food in surgeries and hospitals.

Smile-on and Dentsply launch new webinars

Smile-on and Dentsply are offering dental professionals a chance to take part in a new series of Dental Webinars.

During the Webinars, dentists will be able to ask questions just as they would in a normal lecture.

They can also visit the website and watch the Webinar again, to cover points they might have missed.

Dr Julian Webber’s two-part series takes place on the 4 and 10 December and looks at endodontics and includes re-treatment.

Dr Webber was the first UK dentist to receive an MSc in endodontics. He has held teaching positions at Guys Hospital and is a former president of the British Endodontic Society.

This new series of Webinars counts towards the participant’s continuing professional development.

For more information, visit www.dentalwebinars.co.uk

Further guidance for Botox

The General Dental Council has opened its new Specialist List in special care dentistry. The GDC currently holds 15 Specialist Lists.

The purpose of them is to reassure the public that those using the title ‘Specialist’ have demonstrated they have met standards approved by the GDC for entry to the lists. Only dentists on the lists are entitled to use the title ‘Specialist’.

During a two-year ‘transitional period’ which runs up to 50 September 2010, dentists can apply to join the list on the basis of their specialist training, qualifications and experience.

Dr Vinod Joshi is to launch hygiene talk

The founder of the Mouth Cancer Foundation is giving a talk on how to improve oral hygiene amongst patients with oral cancer.

The lecture by Dr Vinod Joshi is at the British Association of Dental Nurses’ Annual Conference on 1 November is supported by Philips Oral Healthcare.

A key to the early detection and prevention of mouth cancer is identifying patients who are at risk, factoring in age, gender, racial group, smoking and alcohol use, diet and even oral cleanliness.

Only 1.7 per cent of all cancers diagnosed each year in the UK are related to the mouth. These cancers have a higher ratio of deaths than cases of breast or cervical cancers or skin melanoma.
"Henry Schein Minerva’s philosophy is to help practitioners maximise profitability by helping them run successful businesses. From the outset, they encouraged us to think about where we could improve productivity and efficiency, providing practical advice and marketing ideas based on our individual circumstances. Working with Henry Schein Minerva in this way has been nothing short of a revelation."

Mike & Helen - Briercliffe Road Dental Practice, Burnley

Partnership in Practice

To develop your partnership
email: me@henryschein.co.uk
www.henryschein.co.uk
When it comes to what is good for the public mind and body, the choice is a fairly simple one: mass values vs elitism. Let’s give some examples: Big Brother vs Mastermind; Hollywood blockbuster vs art-house cinema. Former head of the BBC, Lord Reith, stated unequivocally that, ‘to apply broadcasting to the dissemination of the shoddy, the vulgar and the sensational would be a blasphemy against human nature’. Yet, that is precisely what broadcasting has done in the bid to attract ever-increasing numbers of listeners and viewers. But is this necessarily blasphemous? Was Lord Reith not just simply being elitist, condescending and paternalistic to oppose sensationalism, shoddiness and vulgarity, or was he foreseeing the dumbing down of morality, education and civility?

Who sets the agenda?
The fundamental question really is who actually sets up the agenda. Does the mass of mankind determine what it wants to do and how it should behave and then expect the media to follow suit, or does the media exert the pressure, which dictates the way the masses will react? Does the intelligent minority come into the picture at all nowadays, or are they a relic of the past? Is it the British way to cut down the tall poppies, just as they did in the French Revolution. One view is in hell with elitism, the elite are pompous, pretentious and an anachronism – let the masses decide! Yet, others think not; is this not a dereliction of duty, a case of the inmates running the asylum?

How does this affect the practice of dentistry?
One way that this has affected the profession is in the realm of fitness to practise, where we are no longer judged solely by our peers, but now by at least an equal number of lay people, who intelligent though they may be, tend to be the voice of prevailing mass opinion rather than the dental elite, possessors of expert knowledge. We would not want the passengers to be flying the plane when pilots are on board. Another is that we spend at least five to six years learning anatomy, pathology, physiology, pharmacology and a few other ‘ologies’ in order to be purveyors of dental health and healers of pain. Dentistry as a noble vocation practiced by an elite minority who are elite because they have paid their dues by their diligence. Yet this is not what the masses seem to want from us today. What they want is straight white. Straight white is not the main thrust of what we learn in dental schools, but it is undoubt-edly the main thrust of Extreme Makeover and the like. People who resent paying private fees for preventative, reparative and restorative dentistry will unhesitatingly fork out greater sums so that can look like the movie or television star of the moment.

Yes, one could and perhaps should say thank heaven for that, because we have become too good at the old preventive game and are cutting our own throats in the process. As long as mass values determine the agenda we should just take the money while we can be- The fundamental question re- ally is who actually sets up the agenda. Does the mass of mankind determine what it wants to do and how it should behave and then expect the media to follow suit, or does the media exert the pressure, which dictates the way the masses will react? Does the intelligent minority come into the picture at all nowadays, or are they a relic of the past? Is it the British way to cut down the tall poppies, just as they did in the French Revolution. One view is in hell with elitism, the elite are pompous, pretentious and an anachronism – let the masses decide! Yet, others think not; is this not a dereliction of duty, a case of the inmates running the asylum?

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When it comes to what is good for the public mind and body, the choice is a fairly simple one: mass values vs elitism. Let’s give some examples: Big Brother vs Mastermind; Hollywood blockbuster vs art-house cinema. Former head of the BBC, Lord Reith, stated unequivocally that, ‘to apply broadcasting to the dissemination of the shoddy, the vulgar and the sensational would be a blasphemy against human nature’. Yet, that is precisely what broadcasting has done in the bid to attract ever-increasing numbers of listeners and viewers. But is this necessarily blasphemous? Was Lord Reith not just simply being elitist, condescending and paternalistic to oppose sensationalism, shoddiness and vulgarity, or was he foreseeing the dumbing down of morality, education and civility?

Who sets the agenda?
The fundamental question really is who actually sets up the agenda. Does the mass of mankind determine what it wants to do and how it should behave and then expect the media to follow suit, or does the media exert the pressure, which dictates the way the masses will react? Does the intelligent minority come into the picture at all nowadays, or are they a relic of the past? Is it the British way to cut down the tall poppies, just as they did in the French Revolution. One view is in hell with elitism, the elite are pompous, pretentious and an anachronism – let the masses decide! Yet, others think not; is this not a dereliction of duty, a case of the inmates running the asylum?

How does this affect the practice of dentistry?
One way that this has affected the profession is in the realm of fitness to practise, where we are no longer judged solely by our peers, but now by at least an equal number of lay people, who intelligent though they may be, tend to be the voice of prevailing mass opinion rather than the dental elite, possessors of expert knowledge. We would not want the passengers to be flying the plane when pilots are on board. Another is that we spend at least five to six years learning anatomy, pathology, physiology, pharmacology and a few other ‘ologies’ in order to be purveyors of dental health and healers of pain. Dentistry as a noble vocation practiced by an elite minority who are elite because they have paid their dues by their diligence. Yet this is not what the masses seem to want from us today. What they want is straight white. Straight white is not the main thrust of what we learn in dental schools, but it is undoubt-edly the main thrust of Extreme Makeover and the like. People who resent paying private fees for preventative, reparative and restorative dentistry will unhesitatingly fork out greater sums so that can look like the movie or television star of the moment.

Yes, one could and perhaps should say thank heaven for that, because we have become too good at the old preventive game and are cutting our own throats in the process. As long as mass values determine the agenda we should just take the money while we can be-
Walking the talk

In an exclusive interview England’s Chief Dental Officer tells Dental Tribune how he fell into dentistry, his plans for fluoridation and why dentists have nothing to worry about post 2009. Penny Palmer reports

It is always raining when I’m scheduled to interview England’s CDO for dentistry. This August day is no exception – except there is a gale. But London’s view from the eleventh floor from New Kings Beam House is always breathtaking whatever the weather.

Barry Cockcroft greets me in his clutter-free office and we have tea. Suiited and booted he is smarter than I am, but he is so easy to talk to it doesn’t matter. He is a ‘people’ man without a doubt, as mannerisms honed clearly from life as a dentist shine through.

You can label some people and fit them into boxes but not Barry – this is a man much ‘darker’ than you might expect when you meet him in the flesh. Quietly spoken, with a Bolton lilt, he is interesting, engaging, sensitive and quirky, but above all is passionate on all things dentistry.

When asked to give me an example on his typical day he cannot tell me because there is no typical day. It is a career many would envy. On average he deals with at least 100 emails a day, as well as attending internal and external meetings home and abroad. He is also inundated with invites to practice openings and evening launches – no one can deny that this man has a heavy schedule to deal with.

Nevertheless, it goes with the territory and Barry is not complaining. In fact, he knows his subject so well he answers the questions before you’ve even finished asking them, albeit in a roundabout way.

On how and why he chose dentistry for a career he says: ‘I originally wanted to be a vet and had a place to study veterinary medicine straight after my A Levels, but after doing his research on the veterinary world he quickly changed his mind. Did he consider medicine? ‘It didn’t appeal,’ he says matter of factly, ‘but liked the fact you could see a problem and put it right with dentistry.’ Any regrets? ‘Not one, and I would do it all again if I had to choose again.

Yet the concept of becoming CDO back in 1990 couldn’t have been further from Barry’s mind. ‘When you have 50,000 dentists with the career option of being the CDO it’s a pretty narrow window’. It all began when the BDA balloted their members against the Tory contract. ‘I had joined the LDC just as a local thing but the ballot stimulated me to stand for the GDSC committee – I just found it interesting.’

Always committed to NHS dentistry, Barry loathed the item for service concept. ‘I did see some abuse of the old system going on around me so when the PDS pilots were about to launch I was hanging on the health authority door asking “was this a great idea?”’

It wasn’t long before Barry became involved on a national scale, and in 2000 Options for Change came to life. ‘The then CDO Margaret Seward approached me and asked if I would be involved and I said yes.’ As the new deputy CDO it was a ‘massive jump’ from working in his practice in Rugby for the last 20 years. ‘I started the new job November 4, 2002, at 9am, and found out about the health and social care act at 9.20am.’

On what he missed most from life as a dentist he comments: ‘I had enjoyed the clinical aspect and the patients, but it was the interaction with lots of people that I really missed.’

The ‘F-word’

Meanwhile, first-hand experience of fluoridation in Rugby stayed firmly in his mind, and remains top of his CDO achievement list. ‘We enabled the first consultation to deliver a new fluoridation scheme in 20 years, it’s all down to the NHS now.’

However, the ‘tremendously complicated’ issue comes with many challenges, including a ‘small but very well organised opposition.’ So what does he think about it?

‘People have a right to express a view but if you’re going to do something to stop others from benefiting, you have to have the evidence to support it. On why he passionately supports fluoridation Barry is unstoppable. ‘60-70 per cent of our children are decay-free in England; this is down to a good diet, fluoride toothpaste and education, while evidence supports that deprivation and poverty is linked to decay.’

Citing research evidence from the US Barry continues; ‘In the States fluoridation reduces decay in older people by 27 per cent, and as the most literate country in the world, people would be sving if there was a fluoridation link to any of these health issues.’

He continues: ‘The York Review looked at 700 papers and there was not one link between fluoridation and general health issues – there really is no evidence that any damage is done and that is a fact.’

When asked why 70 per cent of children with healthy teeth should drink fluoridated water to benefit the 50 per cent with decay he is honest. ‘Would you stop treating people for lung cancer if they smoke? Would you stop treating people because they are obese?’

‘Everyone benefits from fluoridation. Those with higher levels of decay benefit the most, but even decay-free people can develop it without fluoride.

‘This is a process that has no discernable effect on any health condition and dental disease.
does not heal – if you lose your teeth at ten-years-old you are stuck with that for the rest of your life.’

He continues: ‘I don’t have the right to impose fluoridation and neither does anyone have the right to stop it happening; it’s not the only thing that is added to improve people’s health - we add folic acid to bread, and iodine to salt, so what’s the difference?’

On fluorosis Barry says: ‘I spent 20 years working as a dentist in a fluoridated area and I never had to do a cosmetic procedure related to it - you would have to drink loads and loads of water to get it anyway.’

At this point Barry points out the evidence in the form of UK NHS dental surveys statistics from the World Health Organisation (WHO). According to one study, the results clearly highlight that five-year-old children do have more filled, missing or decayed teeth in unfluoridated areas such as the North West, Scotland and Wales.

Similarly, the WHO global database shows that England’s 12-year-old children have the best oral health – with an average number of just 0.6 filled, missing or decayed teeth (it used to be five in 1975). And adults with no teeth have fallen by a whopping 50 per cent from 1968 to 1998.

When asked whether dental access could be the reason for those suffering from oral health diseases Barry is resolute. ‘Access is completely unrelated to dental disease; it is education, smoking cessation, sugar, obesity and diet that affect it.

‘It is also the availability of fluoride toothpaste and water fluoridation, coupled with sugar consumption.’

Moving on to how he deals with criticism Barry has an innate ability to divert away from the subject, but when pushed further he says: ‘Some criticism is ill-founded, but there is always another side to it but it is rarely personal.

‘I’ve always listened because you learn from it, but when it is so vitriolic about what you are doing from people with a vested interest in dentistry outside the NHS, it means you are doing something right - you’ve got to meet the real people to hear what’s really going on.’

As for barriers blocking the way for a smoother ride Barry says: ‘Perception has always bothered me with media coverage sending out the wrong message.

He continues: ‘Dentists are advertising for NHS patients and we now get mostly good coverage in local media.’

While the fluoridation scheme is close to the finishing line, the profession just needs to get past 2009. ‘The contracts do not simply end in 2009, they are open-ended and do not need to be renegotiated,’ explains Barry. Dentists, he says, must keep in touch with their PCTs, but the DH will be issuing guidance for post 2009 shortly.

For now though, Barry sees no reason to move on from his post as England’s CDO for dentistry. So how long does he see himself doing the job? ‘When I’m not enjoying it anymore I know that it’s time to move on’ he concludes.
A system under duress?

In the first of a new series, Neel Kothari looks at how the recent changes in NHS dentistry have affected the way the service now operates, and asks whether reforms have actually helped solve the problems they set out to achieve.

Since April 2006, the new dental contract has been widely criticised by the press and dentists alike, and despite protests from the profession, the new contracts were implemented nonetheless. As a result, we now live in a new age, where people’s dental problems fall neatly into one of three categories for which we receive a certain level of reimbursement, depending on the care we’ve provided.

We no longer provide items of treatment; instead we are providing courses of treatment. If these courses happen to be short, such as a simple filling or a single crown, life tends to be stress-free, but what happens when we have to do more? And why do some dentists complain more than others?

Common complaints

The variety of treatment available in general dentistry practice today can be staggering. Sure, some procedures can be challenging, but there are now more reliable ways to save or replace teeth than in the past, and dental materials have also come a long way, and are far more reliable and predictable. So why, according to the parliamentary Health Select Committee (HSC), are dental practitioners now complaining that they have less work and why are dentists pulling out more teeth and saving fewer?

Over the past few decades, since the start of the NHS in 1948, the oral health of the nation has improved significantly, and for a while time stood still. The NHS continued to tick along with dentists generally choosing to work in more affluent areas, leaving many areas of the country with a poor supply of NHS dentists. In addition, there was a growing concern that the NHS offered too many incentives to provide complex courses of treatment, rather than preventative care.

Poorer areas suffering

Since the care principal of the NHS, to be available to all, was being seriously eroded, many were asking why poorer areas were suffering, while wealthier areas were able to enjoy the benefits of the NHS. In April 2006, the Department of Health (DH) made vast reforms to the NHS, giving more power to the PCTs and simplifying a complex charging system into three broad categories. While dentists protested against these changes, we nevertheless succumbed to the will of the Government and accepted that as a way of providing health care.

A recent HSC report criticised much of the new contract. Its conclusions have not come as a surprise to most of those working within it. Although this contract was introduced without piloting, we now know that any further changes must now need vigorous testing; so, like it or not, this contract is here to stay at least for the time being.

Targets too rigid

The HSC has recognised that the contract’s new remuneration system based on units of dental activity (UDAs) has proved extremely unpopular with dentists and many PCTs have set unrealistic UDA targets and have applied these targets too rigidly. The new challenges of working in the NHS now involve managing these targets, or else facing financial penalties. Those dentists who manage to finish their targets early may not automatically receive further funding and as a result, may be forced to either work privately or not at all. The fundamental problem here is the lack of clarity and uncertainty in terms of what the future holds. While PCTs expect UDA targets to be appropriately rationed throughout the year, in practice, for many dentists this is not always possible. Those dentists who are struggling to meet their UDA requirements face having to repay the PCT for uncompleted UDAs, regardless of the amount of work they have provided per course of treatment.

While the remuneration system is based on historical data, many younger practitioners either do not have a reference period or may have changed the way they have practised since then. Those seeing new patients, often have to provide more restorative care per course of treatment, compared with practitioners seeing patients on a continuous basis. This leaves many younger dentists having to cope with unrealistic and unrepresentative targets in an untested system.

A bleak future?

Although one of the primary aims of the new dental contract was to improve access, the HSC reports that fewer patients are visiting an NHS dentist than before April 2006 and access to dental care in many areas so far shows no sign of improvement. As a profession, we now face the difficult task of learning to cope with a challenging system without knowing what the future really holds in store. Dentists have argued that these difficulties make working in the NHS unfavourable, but little has been done to ease dentists’ working lives, with many in the profession now questioning whether it is feasible to carry on in the NHS.

Moving forward

So what can be done to rebuild the burnt bridges of trust between dentists and the PCTs? Well, to start with we must know the direction we as a profession are heading in before we get there. We still have no clear idea of what to expect after April 2009, which makes financial planning (such as investing in further staff or investing in equipment) a logistical nightmare.

Like it or not, this contract is here to stay at least for the time being.
Philippa Coleman is a part-time dental health commissioner for Worcestershire PCT, which has 70 new dental contracts in urban and rural areas. Alongside colleague, Daphne O'Connor, she is forging links with local NHS dental practices. She is pleased there is 11 per cent more UDA funding this current financial year.

Ms Colman says: ‘Short-term it’s good we can offer additional UDAs until March 2009 to all NHS general dental practitioners working with the new contract. ‘Long-term, we are undertaking a needs’ assessment to target areas needing specific funding for additional dental activity.’

The PCT is setting up an Oral Health Strategy in 2009, with an emphasis on health education and to look at differing ways of awarding quality. Ms Colman sees the new contract as a positive challenge: ‘We are taking it as a good opportunity. But we realise the importance of working pro-actively with dental practitioners - because they are the interface with the patients - and the public to demonstrate that NHS dentistry is alive and well in Worcestershire.’

Looking ahead, she says: ‘Our aspiration is to develop the best dental services we can and the new contract is a tool towards this.’ Meanwhile, Mark Pulford is the primary care commissioning manager for Heart of Birmingham Teaching PCT with a special interest in dental services. He says the PCT stuck quite rigidly to the baseline UDAs based on the new contract’s test-period in 2004/05.

‘The different contract values reflect the different baseline-experiences and each contract is unique,’ Mr Pulford thinks the new contract has certain advantages: He says: ‘It is a much simpler system to get the same income each month.

‘Another positive aspect is that instead of being paid on a drill-fill-bill basis like before, which meant the more work dentists do the more money they get, practices now tend not to take on new patients

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Tradition with a modern twist...
Dr Crouch says it’s not just about how many UDAs are dispensed, but how they are utilised. He adds: ‘The DH is concerned that increasing UDAs doesn’t mean more patients are seen. More available dentistry does not necessarily mean more patients. In areas where PCTs understand dentistry better, UDAs can be used better.’

He thinks dental commissioning only works if the commissioner knows how to get things done and suggestions are given a speedy response. But in areas where managers are given several NHS responsibilities, dentistry is at the bottom of the list. He says: ‘If one person has too much responsibility over different areas, the results get so diluted that dentistry suffers.’

Dental surgeon, Anthony Lipschitz, from Great Northern Road dental clinic in Dunstable, Bedfordshire, says: ‘The problem is not with Bedfordshire PCT, but with the Government. The recent DH report states many clinics are opening, which is true. But they don’t offer extensive treatment and are usually just dental A & E units. What’s happening is a patch-up job.’

We have all seen the gradual demise of the NHS, but hardly anyone is prepared to speak out. We dentists are doing the best we can and will always get by, but it is the dental health of the public that is losing out.’

‘South Birmingham has been set a target to get 20,000 more NHS patients, but it’s struggling. However, in some areas the new system is work-
public is not getting the dental service it deserves.'

Corrine Manger, from Warwickshire PCT, says: ‘We have an open dialogue with all dental practitioners to ensure appropriate UDA s are allocated to meet patient needs. She adds that the PCT is really pleased it has enough capacity to increase NHS dental provision in line with its Oral Health Needs Assessment. ‘Within the national framework there are two specific periods when formal negotiations can take place - mid and end-of-year reviews - but we also have an open door arrangement where any practice can discuss their contract at any time.’

However she admits the new contract took time to settle down: ‘Like all PCTs, we faced difficult issues, but we now have a very good relationship with dental practices and the LDC.’

She thinks the new contract is a change for the better: ‘It has enabled us to clearly define what we need in Warwickshire and develop new initiatives for improved quality and access. We have a very positive view on NHS dentistry’s future and our ongoing partnership with practitioners.’

Sue Gregory, consultant on dental public health for Bedfordshire, Luton and Herts PCTs agrees, saying that the PCTs acknowledges the need for stability very seriously to provide dental care to meet the needs of the population and good results are emerging.

‘We believe the new contract is working quite well and were pleased we didn’t lose any NHS dental care in transition. In fact, NHS patients have increased over the two years. There is now the same volume of money available for dentists as in the fee-per-item days, so dentists should meet patients’ needs in the same way. Possibly there was a tendency for overtreatment in the old system.’

She understands dentists’ initial fears, but thinks any wrinkles can be ironed out through good communication. ‘Dentists were concerned because the new contract is cash limited. Beforehand, they entered claims for each treatment. Now it’s a fixed annual contract, which can be very frustrating. However, new UDA s can be negotiated for.

‘It’s important for us to be clear about our expectations from dentists and we are working hard locally to ensure that full NHS care includes endodontics and periodontics.’

At Luton PCT we are developing a Dental Skills Area for care professionals such as nurses and dental technicians to support practice.

But what about the future?

‘Maybe there could be a preventative dental health UDA, which is currently not covered, although patients can obtain an oral health tool-kit, which gives advice on dental self-help preventative techniques.

‘Ultimately, for the new contract to work, communication is the key.’

PCTs acknowledge some dentists were not over-the-moon about how the volume and value of work carried out by practices in the new contract’s test-year was translated into UDAs. They admit that for some dentists, it is daunting to change from a cash-per-item system to a cash-limited system. But the overall message rings out loud and clear. For the contract to work, good working relationships between PCTs, dentists and LDCs are absolutely crucial.'
Knocking opportunities

Since the revised dental contract in 2006, some dentists have gone private, but others are running successful NHS dental practices. But how well are they really doing? Yvonne Gordon investigates

Principal dentist, Dr Gurpram Singh Lidder opened his first practice in Dunstable in 2004 - the year of the new contract's test-scheme - and a second practice in Leighton Buzzard this August.

He says his success is because of regular communication with the PCT. Dr Lidder acknowledges the practice is doing fewer complex procedures, but thinks an advantage of the new contract is increased flexibility to use both NHS and private treatment. He says: 'Previously, dentists were either NHS or private, but the new system encourages mixing. A patient can have an NHS filling or crown for some teeth and private treatment for others. Dr Lidder says this compensates for financial losses from NHS treatments. A dentist can charge privately for restoring a root-filled tooth, with the root-canal treatment on the NHS. Therefore a patient can have a more aesthetic and durable restoration as an amalgam alternative. 'Once we explain to patients why we offer an additional private treatment option, most readily accept it,' he adds.

However, he thinks one of the new system’s disadvantages is there is no longer patient registration, which opens the floodgates for criticism. He says: ‘Lack of registration opens the door to give the Government flack that NHS patient figures are now hidden: under the old system, it was clear how many were registered.’ He thinks if patients were registered, surgeries with more NHS patients could be financially rewarded and patients could ask for their own dentist, rather than any available.

Although much of the motivation for the new system was simplification, Dr Lidder thinks it has become oversimplified. This can encourage some dentists to opt for tooth removal rather than longer treatment, because payment is the same. He says: ‘As an incentive, financial rewards should be given to dentists for more complex procedures.’

But he adds that technological advances like implants offer a very successful treatment outcome - an alternative to tooth removal and to other complex and statistically less successful procedures.
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Trust...
He says the new system makes it easier to budget, because income is predictable. Beforehand, income was dependent on how much work a dentist undertook, so investment was riskier.

All in all, Dr Lidder sees a bright future for dentistry. He says: ‘In Bedfordshire, the PCTs are doing very well. With the Leighton Buzzard practice, there is hardly anywhere with lack of NHS access. But I would suggest bringing back registration and rewarding those NHS practices with more NHS patients.’

And to any new dentist thinking of starting their own NHS practice, Dr Lidder advises: ‘Start small with something you can control and then expand after several years. Don’t go for big tenders, leave them to the corporates. Take a small tender with feasible UDA targets and build up slowly.’

Crude UDAs

General Dental practitioner, Shiv Pabary, is the principal of a large practice in Newcastle, running five other dental practices, two of which opened since the new contract. He is also part-time honorary clinical lecturer at Newcastle Dental School. He has always worked in the NHS, having his first practice in 1987. Alotted one of the original Personal Dental Service (PDS) contracts, he isn’t keen on Units of Dental Activity (UDAs). He says: ‘I am not a lover of UDAs, which are a crude, financial measure.’

It is not just about delivering UDAs, but the need to develop quality initiatives, such as preventative dental health.

Dr Pabary says the surgeries, which see up to 20 patients per day per dentist, have enough capacity to treat all NHS patients. For him, a downside of the new contract is the length of treatment for high-needs’ patients and the danger of running out of money if one expands, although it is possible to negotiate for more UDAs. Other gripes are treatment-costs, such as individual crowns, which have risen. A patient, who has three crowns at once, will pay the same as a patient who just has one. Dr Pabary has not changed his overall philosophy, - to cater for the needs of individual patients - but he does understand how some dentists could veer towards doing tooth extractions rather than conservation treatment, because payment is the same.

He says: ‘The average UDA for our practices is £22 with the same UDAs for a filling taking 10 minutes or a root-canal treatment, taking several hours.’

Dr Pabary has always offered private treatment to give patients’ all options. Under the new contract, NHS treatment must be a clinical necessity, so cosmetic crowns or bridges do not usually fall into this category.

As for the future, he thinks it bodes well for large practices. He said: ‘Practices of a certain size will survive, because it is easier for PCTs to commission with a large set-up. The single practitioner will become isolated. PCTs need to look at what quality means to patients, in terms of access, ease of ap-
pointments and explanation of options.

'We are working well with the PCTs and doing a good job, but part of the problem is lack of continuity. In Gateshead, two women lost their PCT positions, with whom we had built a relationship. So trust was built up and then lost. PCTs should have a dedicated dental lead person to maintain ongoing dialogue with dentists.'

'Whether local commissioning works will become clear when PDS ends in 2011.'

Challenging contracts

Meanwhile, Shalin Mehra is MD of a 21-practice dental corporate, with practices across several PCTs in Northamptonshire, Derbyshire, South Staffordshire, Gloucestershire, Leicestershire County and Rutland, Oxfordshire and Bucks.

He feels the new contract has some very definite advantages, while acknowledging initial problems. He says: 'Every new contract is challenging and one must be adaptable to change. One advantage is that, as a provider, it is easier because an accurate prediction can be made regarding annual income. This helps with business planning and is a big positive.'

He thinks the new contract is a great opportunity for PCTs to take control of local dental provision.

'If an NHS dentist decides to only offer private treatment, the local PCT can re-invest the money clawed back, which is good for patients.'

Mr Mehra takes on board comments from the Health Select Committee about fewer patients and decreased access, but thinks these issues are being resolved.

'We can work with the PCT to change and address local needs. I think that figures quoted about less patients having NHS dental access, are historic and that access is improving overall. The new contract is not perfect, but again I am hopeful that concerns aired by the profession are being taken on board.

The handing system needs to be refined and targets are hard to achieve in areas of high need.

'But most of all, one needs an open, honest and transparent relationship with the PCT, which is currently commissioning a lot more dental activity.'

He adds there is an ethical duty to give patients the choice of fit-for-purpose NHS treatment or cosmetic treatment which is a luxury. 'The range of options now is far wider and patients can mix and match NHS and private treatment.

'It is early days, but I am sure things will gradually stabilise under the new contract, with a greater emphasis on prevention in the future.'

Listening up

Dave Pulford, principal dentist of a large 25-year-old practice in Nuneaton, is local dental committee (LDA) chairman of Warwickshire PCT. He says there has always been good dialogue with his PCT, which carried over from his PDS contract to the new GDS contract. 'The PCT has listened since day one. I think PDS was a better system, because there was more emphasis on preventative dentistry.

'Before UDAs we were given a monthly sum so there was more clinical freedom. Now the monthly sum is tied into the number of UDAs on the three bands of examination, fillings and laboratory work.'

Mr Pulford says the most common treatments at his surgery are check-ups and advice, less crown and bridge work is being done. The practice also offers cosmetic dentistry. He thinks that overall the new contract is working well in Warwickshire.

But as for dentistry’s future, he sounds a warning note: 'The Government has what it wanted - to fix the cost of dental treatment. If that continues, there will still be an NHS. But what one gets for it, may well be diminished.'

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Ultrasonic surgery
Adhesive dentistry

Over the past few years patient demand for better aesthetics has been met with an amazing spectrum of new materials and techniques.

Nowhere has the revolution in dental materials been more apparent than in the field of adhesive dentistry. The attraction of minimal tooth preparation, coupled with highly aesthetic restorative materials is appealing to patient and dentist alike. However, there is often a price to be paid for these benefits, and one which may not be obvious to the patient unless the dentist takes the time to explain all the advantages and disadvantages of the various options.

Problems frequently arise in adhesive dentistry when the dentist has heavily emphasised the benefits of these materials and techniques without warning the patient of the limitations.

Composite restorations

Patients are demanding tooth-coloured fillings either for aesthetic reasons or because of their own concerns about mercury toxicity in amalgam restorations. In the first instance, there is no doubt that composites provide a more aesthetic solution than amalgams. However, where a patient is requesting the removal of amalgams to cure a medical problem e.g. multiple sclerosis or allergies, the dentist must be wary of representing the proposed composite restorations as a cure, since the evidence to substantiate these claims, is, at best, inconclusive.

The decision to restore a tooth with a composite restoration will be dependent on a number of factors, including:

- Patient preference
- Size and shape of the cavity
- Occlusion
- Ability to isolate the tooth to keep it moisture free
- Cost and time

The choice of a composite restoration by a patient should be on an informed basis and some of the problems previously encountered by dentists can serve to highlight areas that should be discussed with patients, perhaps with the help of a simple information leaflet.

Common problems with composite

Postoperative sensitivity

Amalgam is generally a well tolerated material and is less prone to cause postoperative sensitivity than directly placed composite fillings. Sensitivity can be caused by a variety of factors and a study of the literature will show a number of techniques that attempt to overcome the problem.

The risk of postoperative sensitivity is difficult to eliminate however. So it makes sense to warn a patient of the possibility, even if only to reassure them of its transitory nature. The patient should be advised to return if the sensitivity fails to resolve, and this should be recorded in the clinical notes.

Wear characteristics

Many composites have a wear characteristic that is poorer than amalgam especially in load-bearing areas. Where larger restorations are placed or when patients have a bruxing habit, particular care should be taken. In these cases consideration should be given to the use of alternate materials or even a fixed restoration – particularly when replacing more than one cusp on either premolar or molar teeth.

Discoloration

Unlike porcelain, most composites absorb stains and this can very quickly compromise the aesthetics of an otherwise
successful result. Patients should be warned of the potential for tobacco, red wine, coffee or tea to stain their new composite fillings. Other food substances (e.g. turmeric in Asian foods) can also stain the restorations, as can mouthwashes containing chlorhexidine. When planning anterior composite restorations, it is important that these factors are considered and the patient warned accordingly so that they can make informed choices about their dental care.

Debonding

To a patient, a filling is often considered to be a permanent solution. Where there is little tooth substance, heavy occlusal forces, or parafunctional activity/habits, a patient should be advised that their composites might fail. Incisal edges and corners of anterior teeth are often restored in composite and these can sometimes be problematic when the dentist is adopting a minimally invasive technique and relying on maximal retention from the adhesive bond and etch technique. The risk should be explained to the patient before placing the restoration because an informed patient is more likely to understand and accept an adverse outcome.

The above list of potential problems seems prohibitive but there is no doubt that composites are here to stay, are very effective when used appropriately, and are often an excellent aesthetic alternative to other more radical and invasive treatment options.

Common problems with adhesive bridges

Adhesive bridges or resin-bonded bridges have come a long way from the first Rochette bridge. The considerable advances in adhesive technology enabling metal to be bonded to teeth have made this technique a more realistic alternative to dentures or implants. Unfortunately they can also be unpredictable despite the research evidence on the longevity of the bond.

There are several factors to consider when planning treatment for a patient with a view to providing adhesive bridgework.

Location

The upper anterior part of the mouth is the most popular site for...
the placement of these bridges and often the most successful. Posterior bridges have a poorer long-term success.

Occlusion
When planning for the bridges ensure that there is a favourable occlusion both in static and dynamic relationships. This is best examined with the help of articulated study models.

To prepare or not prepare?
The decision to prepare teeth with a guide plane, rest seats or pins or to leave it unprepared is a clinical one and will reflect the clinician’s experience and training. It is essential to discuss the relative merits of both approaches with the patient. If the tooth is prepared in any way, it no longer becomes a ‘reversible’ option even if it is minimally prepared. It is important to establish this with the patient because if the bridge fails, the patient is automatically committed to remedial treatment of the prepared tooth or teeth. The patient should be aware of this before giving their consent to the procedure.

One wing or two?
When replacing a single anterior tooth research now seems to indicate that a single wing is the treatment of choice and a cantilever design should be planned. Sometimes there is differential movement of the teeth in occlusion so when two wings are used there is a distinct risk of one of them debonding. If this goes unnoticed, caries could develop behind the loosened wing. Clearly this is something that needs to be discussed with the patient and whichever design is chosen, the patient should be aware of the implications for its maintenance and the need for regular attendance to check it.

Common problems with veneers and dentine bonded crowns
These adhesive restorations have transformed millions of smiles around the globe and continue to do so successfully. However, they need careful planning and to be aesthetically successful, some tooth substance usually needs to be removed. Again they cannot be viewed as a ‘reversible’ option since their failure will always necessitate further treatment even if only to replace the porcelain veneers with composite facing.

There is a danger that veneers will be promoted to patients as an ideal alternative to crowns, and a quicker and cheaper route to a film star smile. It is easy to see how patients might view veneers as a win/win option, so it is vital that any dentist contemplating providing veneers or dentine bonded

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Aribex's NOMAD is a handheld intraoral x-ray system that is cordless, battery-powered, true DC, lightweight, and simple to use. It features an external backscatter shield and unique internal radiation shielding to ensure operator safety that exceeds regulatory requirements. NOMAD's portability doesn't compromise the diagnostic quality of the x-ray images but provides additional diagnostic information when it is needed with great speed and convenience.

For more information, call Clark Dental at 01270 613730 or Email sales@clarkdental.co.uk
Crowns for a patient should discuss their particular needs very carefully. Pre-operative photographs and study models are helpful in communicating with the patient, but they also form a vital part of the patient record. In addition a meticulous note of all the relevant conversations held with the patient should be entered in the record.

Case study
A young male patient in his early twenties requested a dentist to close his midline diastema. He was getting married the following month and wanted this done before the wedding day. It was quite a large gap of some 4mm between the upper central incisors but the dentist confidently assured the young man that he could close the gap and produce ‘a perfect smile’ ready for the wedding photos.

At the next visit the patient returned, asking the dentist to prepare the two lateral incisors as well as the centrals. This was duly done and an impression was taken before the patient re-booked to return in two weeks time.

At the fit appointment the two central veneers were tried in and the patient agreed they looked fine. However the dentist had not shown him all four veneers in place and had not tried them in using the try-in paste that came with the bonding kit.

The dentist went ahead anyway and cemented them in. When he looked in the mirror, the patient was surprised at the result and not at all happy with the size of the central incisors. He also felt the veneers were quite bulky under his lip. The dentist reassured him and asked him to return in a couple of weeks. The patient phoned the next day having shown the veneers to his fiancée. Both were very upset with the result as they felt the front teeth were far too prominent and dominated his smile too much. With the wedding taking place in less than a fortnight the dentist agreed to replace them at his own cost. The patient had lost confidence in the dentist by now and instead went to another dentist who replaced the veneers for a considerably higher fee.

Conclusion
The size of the diastema was quite large and to mimic the final effect of the veneers, composite applied to the teeth without etching would have given the patient and the dentist a quick and reversible guide as to the final result.

Diagnostic wax-ups in advance of treatment might also have allowed both patient and dentist to anticipate the likely size and shape of the finished veneers.

The patient should have been warned that the veneers would feel slightly bulky under their lip and that the sensation would soon pass.

The patient should have been warned about the possible changes in speech and the potential to lisp in the early days after the veneers were placed.

Many veneer kits come with a try-in paste and where appropriate this could be used to establish how the final result would look, before finally cementing them.

The entire problem could have been prevented by more careful planning and better communication with the patient before the treatment started, about what to expect.
Ivoclar Competence in Composites

Holistic treatment concepts with accurately coordinated products from one manufacturer, UNIC com-bines aesthetics with function-ality. Because of its inviting appearance and optimised clinical results in less time. This enables them to meet both the growing demands of patients as well as the increasing economic pressures. Ivoclar Vivadent manufacture every-thing required to meet these de-mands.

Composites based on inno-vative nano-technology, Tetric EVO.Ceram and Tetric EVO.Flow, combine with adhesives, such as Adhe se One and Exci te which are both available in the unique VivaPen delivery system, to open up new restorative possi-bilities for Dentists. Excellent handling, chamferless edge, high marginal quality and wear resistance, as well as excellent polishing properties are only a few of their manifold benefits.

Finally, high-performance light-curing units, such as the award winning cordless Blue-phase light range, enable complete polymerization for opti-mised physical properties.

For further details contact your local Representative, visit www.ivoclarvivadent.com or telephone 0116 284 7800.

HEKA DENTAL EQUIPMENT... ...you're in safe hands!

The ultimate embodiment of feedback from patients, den-tists, dental technicians and service engineers, UNIC com-bines aesthetics with function-ality. Because of its inviting appear-ance, high performance light through functionality, it creates the perfect environment for a pleasant visit to the dentist.

Like all Heka Dental Treat-ment Centres, UNIC is electri-cally operated rather than hy-draulically driven. This means it can incorporate all the desir-able state-of-the-art features associated with top-of-the-range electrically operated units, features not necessarily possible with old fashioned hy-draulic units. As well as offering more features, it also means that UNIC offers more precise control and superior reliability.

Designed by David Lewis, UNIC is the epitome of er-gonomic design. Everything – instrument table, trays, light, x-ray unit etc – is within easy reach. Heka Dental call it intu-itive design and functionality – everything is exactly where you expect it to be. Heka Dental are one of the few with most complex clinical proce-dures easier, more efficient and comfortable for both the patient and dental team. Heka Dental equipment is available in the UK from Den-tal Services Direct, telephone 0158 267 2727, or visit www.heka-dental.dk for further in-formation.

CEREC Systems

CEREC® is a computer-aided method for creating pres-cision fitting all-ceramic restorations at the chairside. It enables Dentists to design and create precision fitting all-ce-ramic inlays, onlays, partial crowns, veneers and crowns for the anterior, premolar and mol-lar regions in one visit. Elimi-nating the need for messy and time consuming impressions, CEREC® utilises a digital im-pression taking technique to capture the data required to de-sign the restoration which is then milled from a solid block in the milling unit. The milling unit can be situated anywhere within the Practice, even as a fascinating eye-catcher in the waiting room.

For further information, contact Ceramic Systems Limited on 01952 582950, e-mail sales@ceramic systems.co.uk or visit www.ceramic systems.co.uk

Loupes, Lights at any age...

What was especially notice-able this year was that the aver-age age of dentists buying their first loupe at the Evident stand at this year’s Dental Showcase has dropped significantly demon-strating that loupes and concen-tric lights are necessary for den-tistry irrespective of age.

With a range wide enough to suit all tastes, even the most fashion conscious professional can experience the benefits of enhanced vision with Orascop-tic's new HiRes Elliptical Class III loupes and stylish Victory de-signer frames. A "must-see" was the unique through-the-flip Revolutions, combining TTL and flip-up in one loup. Evident's new Zeon Apollo LED light sys-tem was also available to view; the smallest, most lightweight headlamp on the market.

Danneville consumables exclu-sive to Evident were also on show including Accodale SRO, the super radiopaque composit-ite lining material and Accodale PV, the veneer cement, com-pete with its unique try-in paste. Finally, Prepstart, the versatile and powerful air abra-sion unit continued to create significant interest.

For more information on any Evident product, Freecall 0800 521111 or visit Evident's website at www.evident.co.uk

NEW Bluephase G2 LED....

Ivoclar Vivadent’s NEW Bluephase G2, cordless, high-powered LED light offers un-limited application within the surgery. It features an innova-tive polychromatic LED which emits a broad light spectrum of 580 to 515nm, similar to conventional halogen lights. This means it is suitable for use with any of the currently used photo-initiators. Conventional LED lights do not emit such a broad spectrum and so cannot do this. Consequently Bluephase G2 facilitates unre-stricted use – every material, every indication, every time!

Cordless for unlimited mo-bility, the NEW Bluephase G2 features a lithium polymer bat-tery with a 60 minute capacity. It delivers a high intensity 1,200 mW/cm2 output for reduced curing times starting at just 10 seconds, and three modes of op-eration – maximum, deep and stress-reduced polymerisation.

For further details contact your local Representative, visit www.ivoclarvivadent.com or telephone 0116 284 7800.

ASPD members line up at the BDTA Showcase

ASPD members were de-lighted with the response from delegates at the 2008 BDTA Dental Showcase in London.

The Association of Specialist Providers to Dentists is the first port of call for dentists seeking advice and support to overcome obstacles and achieve their goals. Members have proven that their services are valuable to dental professionals, and can also work together to deal with any of your issues that require more than one area of expertise.

With a range of professional services including solicitors, fi-nancial advisers, insurance brokers, accountants, banks, valuers & sales agencies, leasing & finance and more, the ASPD is a touchstone for den-tists requiring reliable guid-ance and services.

Several members exhibited at the BDTA Showcase, including:

- Dental Business Solutions
- Essential Money
- Howell Jones Solicitors
- Lloyds TSB
- NatWest Healthcare
- Money4dentists
- NHS Dental Systems
- NSUK
- Nationwide
- Northern Ireland
- Omnipost
- Premier Dental
- Scotland
- Speakman
- The Southern
- Total Care
- United Kingdom
- West End Dental
- Whitehead
- Yorkshire

For more information or to re-quest a copy of the 2008 ASPD Directory please call 0800 458 6773 or visit www.aspd.co.uk

NSK's Big Impact!

Wow! What a Dental Show-case...from the moment visitors arrived at the entrance NSK made a remarkable impact, with huge banners in the con-course area and a fantastic stand, just inside the exhibition hall.

Showcase proved to be an excellent opportunity for NSK to exhibit and demonstrate their complete product range, in-cluding, contra-angles, micro-motors, surgical and prophylagy systems. Proving that there is so much choice, NSK can provide all dental professionals with ex-cellent quality equipment to be use in restorative procedures, prosthetics, endodontics, or-thodontics, oral hygiene, labo-ratory and surgical procedures.

NSK’s BDTA Showcase Prize Drawing was a fantastic opportu-
nity to win a Ti-Max X turbine, Ti-Max X contra-angle and a Prophy-Mate neo, winners were announced on 31st October and are now successfully using their new products in practice.

If you were unable to attend this year's Showcase, but would like to see more of the NSK product range please contact Jane White at NSK on 0800 634 1909 or one of NSK’s Product Specialists, who will be more than happy to come and visit you.

NEW
Silamat S6 ....
... Form and function perfectly mixed

Ivoclar Vivadent’s NEW Silamat S6 is a modern universal mixing device for amalgam, glass ionomer cements and other predosed dental materials in capsules and injection capsules in various shapes and sizes.

Showcase
Success leads to Practice Success

Visitors to the Software of Excellence Stand at this year's BIjTA Dental Showcase were very interested to the new and exciting developments now available from the EXACT system.

The knowledgeable Software of Excellence staff gave "live demonstrations" of the software's capabilities, providing visitors with a fantastic opportunity to experience first hand all the exciting features the EXACT system delivers. These include the new and advanced Presentation Manager and Recall Manager. Software of Excellence also introduced practice staff to their new Computer Telephony Integration (CTI) system, which provides practices with patient caller recognition – this feature which is linked to the relevant patient record helps to significantly improve practice/patient relationships.

C2+ Treatment Centre
Ergonomically designed for efficiency and profitability

Ergonomic efficiency generates revenue and Sident Dental Systems' C2+ is the most ergonomically efficient Treatment Centre available.

It combines an intelligent, ergonomic control concept with proven design features to optimise productivity and profitability. This includes a choice of control concepts - "hands-on" using control keys or "hands-free" using a cursor and foot switch. The colour coded control keys are organised in blocks for chair adjustment and programming, handpiece function and speed.

"Partnership in Practice"

The success of Henry Schein Minerva's busy stand at this year's BIDTA Dental Showcase was testament to their ethos of "Partnership in Practice".

Visitors were particularly interested in the launch of the new CEREC MC XL system, boasting shorter milling time, unrivalled precision and complete ease of use, clinicians saw how straightforward it could be to mill first-class restorations. And getting hands-on proved to be a real attraction for clinicians, as they experienced cutting-edge laser technology with the Biolase Waterlase MD, delivering advanced features and SGG laser energy and water for easier, more effective procedures. Speaker presentations were also a big hit with passing visitors, who had the opportunity to stop and listen to a diverse range of topics from workshops with Bridgeway to more advanced discussions on facial aesthetics.

If you missed the 2008 BDTA Dental Showcase but would like to speak to a member of the Henry Schein Minerva team, please call 0870 10 20 45.

All-ceramic restorations from Ivoclar Vivadent

What better way to promote your Practice than by offering your patients the state-of-the-art in all-ceramic restorations. Ivoclar Vivadent offer a choice of all-ceramic options, enabling Dentists to provide their patients with the perfect all-ceramic restoration for every indication.

For further information call Sident Dental Systems on 01952 582900 or email j.colville@sident.co.uk.

Leading Lights
In Dentistry

The Dental Directory has launched an exciting new Orthodontic catalogue. Packed with a full range of support material for dental practices including educational leaflets, posters and clinical papers.

The Dental Directory launches new Orthodontic Product Guide

The Dental Directory has launched an exciting new Orthodontic catalogue. Packed with a full range of products supplied by many of the world's leading orthodontic manufacturers the new range, although similar to the previous one is even better in quality and at very competitive prices.

While the line of products offered by The Dental Directory will be familiar, as it is the same catalogue offered by many of the orthodontic industry’s leading companies, the big difference is that the previous one is even better in quality and at very competitive prices.

The main focus of the GSK stand was Sensodyne Pronamel toothpaste. This provided the ideal platform on which to discuss the growing concern of acid erosion, Sensodyne Pronamel is a daily toothpaste with an optimised fluoride formulation, that helps protect against acid erosion by re-hardening softened enamel.

Visitors to the stand were given the opportunity to discuss Sensodyne Pronamel and were given a sample to try.

Visitors also had the opportunity to learn more about GSK's product portfolio, which includes Sensodyne, Poligrip, Corsodyl and Aquafresh. The stand featured a full range of support material for dental practices including educational leaflets, posters and clinical papers.

GSK’s oral care division is part of GSK Consumer Healthcare. A leading consumer healthcare company worldwide, GSK Consumer Healthcare is present in 150 markets.

The Dental Directory has launched an exciting new Orthodontic catalogue. Packed with a full range of products supplied by many of the world’s leading orthodontic manufacturers the new range, although similar to the previous one is even better in quality and at very competitive prices.

Included in the range are metal and aesthetic brackets, buccal tubes, bands, archwires, elastomers, adhesives, pliers, hand instruments and patients’ accessories. In addition to providing its customers with the well designed Orthodontic
Product Guide for maximum convenience in selecting and ordering, The Dental Directory also has a fully trained orthodontic team who can offer advice on any of the broad range of specialist products.

To take the aggravation out of ordering orthodontic materials call (0800 585586), fax (01576 500 581) or order electronically via the Internet (www.dentaldirectory.co.uk). Also, come and see us at the BOC in Brighton between 14-16 September, Stand no 28. ■

Practice more profitably with EXACT

With more than 20 years’ experience in UK dentistry, Software of Excellence has become a leading supplier of practice management systems, selling more than twice as many systems as their nearest competitors each year. By delivering excellent customer service, Software of Excellence ensures the smooth running of efficient and profitable practices, while also enhancing the patient experience.

EXACT is the most used dental practice management system in the UK, efficiently delivering the information necessary to manage a successful dental business. Offering document management, e-mail and SMS communication, 3D teeth charting and multi-column appointment book as well as many other features, EXACT helps you take control of your practice management so that it will run smoothly and efficiently, delivering time-saving features in surgery that allow you to spend more time with the patient.

Find out today how EXACT can improve your practice further by calling Software of Excellence today on 0845 5455767 and why not request an exact brochure while you’re there! ■

Dentsply

DENTSPLY is pleased to launch two new preventive discovery kits, Platinum and Gold, at the BDTA showcase in London; these kits will be available for a limited time only.

These complete kits enable you to start a periodontal procedure right away. If your surgery offers air polishing and teeth whitening as practice building initiatives, the Platinum Kit is recommended; however, your surgery offers scaling and root planing procedures, the Gold Discovery Kit is recommended.

On purchase of the Platinum kit, you get up to 25% discount Vs normal RRP and with the Gold kit, you get up to 5% discount Vs normal RRP. What’s more is that, with several delighted patients willing to pay that bit extra for air polishing and teeth whitening or for Oraqix during scaling and root planing procedures, the investment made into these kits can be recovered in no time.

For further information or to arrange for a Preventive sales specialist to visit your practice, please call DENTSPLY on 0800 072 5151. ■

750th Aquacut Quattro Installed

Bexleyheath, Kent, is now firmly on the map as far as Fluid Abrasion is concerned! The 750th Velopex Aquacut Quattro has been installed at Dr H. Shaffle’s busy practice, in The Broadway, Bexleyheath. This light and airy building provides a superb backdrop for this busy dental practice - which now offers all patients the availability of fluid abrasion: Cleaning and Treating, in a calm soothing environment. Dr Shaffle commented: “I’ve got the Velopex Colour Laser as well as the Aquacut Quattro it’s great! It’s an essential part of modern technology in a modern practice”!

The Velopex Aquacut Quattro contains two chambers, which can accommodate any combination of the 5 Cleaning and Treating media available. The 55µ Treating powder allows the clinician to ablate hard tissue (Composite, enamel and dentine) creating a relatively rough surface – which is ideal for the latest bonding and restorative materials.

For more information or to ask any questions, please contact: Mark Chapman Mediavance Instruments Ltd Tel 07734 048777 ■

NSK’s newly developed Dual Air Jet turbine system ensures that turbine noise is no longer a concern. Still delivering high levels of torque and powerful cutting, NSK’s Dual Air Jets ensure procedures are performed in virtual silence so that the patient is treated in a gentle and therapeutic environment.

Your comfort is just as important as that of the patient and NSK have ergonomically designed all their handpieces to rest comfortably in the hand. The Ti-Max X Series turbines boast an extremely lightweight Titanium body which is on average 30% lighter than the equivalent stainless steel version, so you’ll feel just as comfortable as your patients. What’s more, the Ti-Max X Series turbines are compatible with all major manufacturers’ couplings including Kavo®, W&H®, Bien-Air® and Sirona®, so you can enjoy the power, comfort and quality of NSK whichever system you’re currently using.

Practice in comfort! For more information please contact Jane White at NSK on 0800 654 1900 or your preferred dental supplier. ■

Celebrity Liz McClaron chooses Hejco ‘Pink’ at BDTA Dental Showcase

The Kent Express team were delighted when Liz McClaron, ex-Atomic Kitten star and winner of Celebrity Masterchef took time out of her busy schedule to view the latest range of Hejco Uniforms at BDTA Dental Showcase.

Liz commented that she was surprised to find such a wide selection of designs and colours available – and made a bee-line for her favourite colour - Pink.

The Kent Express team explained how Hejco’s beautifully designed clothing can make a real difference to the quality of life in practice - as a smart appearance will inspire confidence in dental practice employees, helping to make patients feel welcome and of course, knowing they look good will also do wonders for the team’s morale.

To find your favourite style and colour call 01654 878787 or visit www.kentexpress.co.uk ■

Must-Have Technology at Must-Have Prices

Why pay twice the price for an intraoral camera when you can pay much less and achieve the same results with the easy to use, lightweight Cammy. Capturing a clear image of your patient’s mouth, the advanced Cammy™ instantly enables the patient to see exactly what you see. In addition, its distinctive mini-head design enables you to access even the hardest to reach areas, helping identify cracks and find root canals. Capturing images of your patients’ mouths has never been easier with Cammy’s™ zoom toggle and freeze buttons.

With so many options it can be difficult to choose the best one for you. Therefore Burtons offer a fixed cost affordable rental service from just £70 per month. With no minimum hire period it offers a complete choice of models and options, upgrades at any time – without penalty, routine service visits, breakdown cover, pressure vessel inspection and certification. For some practices it is the permanent solution, for others it enables them to identify their precise requirements prior to purchasing their own Instaclave Series 5.

For further information contact Burtons on 01622 854500, email info@burtons.uk.com or visit www.burtons.uk.com ■

Instaclave Series 5

The Instaclave Series 5is the tried and trusted benchtop autoclave from Burtons. Supported by their nationwide team of Service Engineers it offers Practices everything they need for fast and reliable autoclaving functionality.

Simple to operate and with unsurpassed reliability, it is the most versatile and reliable benchtop autoclave available. It meets all the current British and European Standards, as well as the requirements of HTM 2010.

For further information contact Burtons on 01622 854500, email info@burtons.uk.com or visit www.burtons.uk.com ■

ART Plus CdtE-Sensor Panoramic X-ray

ART Plus represents a new generation of extra-oral dental X-ray imaging systems. The easy to use, affordable digital dental radiography system Digirex™ uses state-of-the-art CCD technology to provide you with high definition imaging for zero fog, enabling faster diagnosis and eliminating the cost of chemicals and film. Simply connect Digirex™ to your computer via a USB port and you can immediately begin to store, retrieve and transmit images electronically and even adjust or magnify images for optimum viewing.

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For further information, contact Ceramic Systems Limited on 01932 582930, e-mail sales@ceramicsystems.co.uk or visit www.ceramicsystems.co.uk

New OptraStick

It can be very difficult to pick up, position and precisely place small and fiddly indirect restorations. New OptraStick, from Ivoclar Vivadent, enables dentists to easily handle indirect restorations and other small items.

OptraStick is a plastic applicator instrument with a flexible, but strong adhesive tip and an easily adjustable shank which facilitates easier access. Even if only slight pressure is applied, it enables dentists and their support staff to easily take hold of, carry and precisely place indirect restorations made of various materials, such as ceramic inlays, onlays and crowns, as well as IPS Empress or IPS e.max veneers. Using OptraStick, will facilitate the ease and efficiency of many clinical procedures including try-ins, application of etching gels and final cementation.

Supplied in packs of 50 OptraStick is an exciting addition to the OptraLine range which includes the anatomically shaped OptraDam for acute isolation, OptraGate ExtraSoft for retentive isolation and a clearer clinical view, and OptraFine the highly efficient diamond polishing system.

For further details contact your local representative, Visit www.ivoclarvivadent.co.uk or telephone 0116 284 7880.
NHS Warwickshire are seeking to appoint a provider(s) to deliver a high quality Out of Hours Dental Service Provision.

Contract Start Date: 01/04/09 for 5yrs with a possible 2yr extension
Estimated Contract Value: £460,000
Expressions of interest: By 14/11/08
Contact: Carol Reece, 01926 495491 x 602,
Email: Carol.Reece@warkpct.nhs.uk

To place recruitment or Courses/Seminar ads please contact: Joseph Aspis on 020 7400 8969 or email joe@dentaltribuneuk.com

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