CQC announces regulatory fees update
Regulator decreases fees for some location bands

Following two consecutive consultations on the fees that it charges to health and social care providers, the Care Quality Commission (CQC) has announced changes to its fee structure and the amounts that certain providers have to pay under the Health and Social Care Act 2008. These have been approved by the Secretary of State for Health.

The fees reflect government guidance to CQC that it must recover the costs of regulation from providers.

The responses received to both consultations have led to the following changes in the fees that CQC charges providers. These included:

- Bringing providers of out-of-hours services, who will be registered from 1 April 2012, into the scheme using the same bandings and fees scale as for “Dental and Independent Ambulance Services” providers.
- Reducing the lowest banding for the category “Adult Social Care providers without a commodation” from £1,000 to £720.
- Reducing the charges for the third and fourth bandings for the category “Dental and Independent Ambulance Services” providers.

Later this year the CQC will be launching another consultation about its longer-term fees strategy from 2015/16, which will include specific proposals for fees for 2015/14.

These proposals will be for providers of NHS general and other primary medical services who will be registered with CQC from 1 April 2013, as well as potential changes to fees for independent healthcare providers.

F

The banding and fees scale for services that provide dental services, independent ambulance services or out of hour’s services are determined with reference to the number of locations at or from which those services are provided. The fees are as follows:

Number of locations - Fee payable

<table>
<thead>
<tr>
<th>Number of locations</th>
<th>Fee payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>£800</td>
</tr>
<tr>
<td>2 to 3</td>
<td>£1,600</td>
</tr>
<tr>
<td>4 to 10</td>
<td>£4,000</td>
</tr>
<tr>
<td>11 to 50</td>
<td>£10,000</td>
</tr>
<tr>
<td>51 to 100</td>
<td>£24,000</td>
</tr>
<tr>
<td>More than 100</td>
<td>£48,000</td>
</tr>
</tbody>
</table>

CQC chief executive Cynthia Bower said: “Our approach to fees is based on fairness and on raising only as much income as we need to cover the costs of regulation. We have listened to what providers have told us during both these consultations and have made changes to address concerns and make the fees that we charge transparent and as proportionate as possible.”

CQC announces regulatory fees update
Regulator decreases fees for some location bands

F

The banding and fees scale for services that provide dental services, independent ambulance services or out of hour’s services are determined with reference to the number of locations at or from which those services are provided. The fees are as follows:

Number of locations - Fee payable

<table>
<thead>
<tr>
<th>Number of locations</th>
<th>Fee payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>£800</td>
</tr>
<tr>
<td>2 to 3</td>
<td>£1,600</td>
</tr>
<tr>
<td>4 to 10</td>
<td>£4,000</td>
</tr>
<tr>
<td>11 to 50</td>
<td>£10,000</td>
</tr>
<tr>
<td>51 to 100</td>
<td>£24,000</td>
</tr>
<tr>
<td>More than 100</td>
<td>£48,000</td>
</tr>
</tbody>
</table>

CQC chief executive Cynthia Bower said: “Our approach to fees is based on fairness and on raising only as much income as we need to cover the costs of regulation. We have listened to what providers have told us during both these consultations and have made changes to address concerns and make the fees that we charge transparent and as proportionate as possible.”
**NASDAL comments on the Budget**

The government has announced up to £4m of funding for businesses to develop ideas to address some of the biggest health problems of our time.

The Department of Health has opened two new competitions with up to £2 million of funding each to develop technological and innovative solutions that can:

- Improve the number of patients taking their medication as prescribed
- Obesity and alcohol related diseases and patients not taking their medication as prescribed are major health challenges. Alcohol and obesity related diseases cost the NHS over £17bn each year and between 6-10 per cent of all hospital admissions could be preventable if prescription medication was taken correctly.

Businesses are invited to come up with innovative solutions to these challenges. This could be anything from a device which helps people monitor what they eat or drink or a personalised care package used to help people take their medication as prescribed.

Health Minister, Lord Howe said: "Technology and innovation have an important role to play in helping to address the healthcare challenges facing the NHS. That is why we are investing £20 million in new and existing projects which can make a difference to patients’ lives."

"Today’s competitions provide an opportunity to develop innovative solutions for some of the biggest health problems of our time and we look forward to seeing the results."

Sir David Nicholson, Chief Executive of the NHS said: "Investing in innovation is vital for a modern and efficient NHS. It will benefit the patient, the taxpayer and UK plc."

The Small Business Research Initiative (SBRI) is a key part of the Innovation, Health and Wealth agenda, which aims to spread innovation throughout the NHS.

"These competitions provide vital funding for businesses to explore and test new technology before it becomes commercially available. Organisations are invited to submit their ideas which could have a real impact on patients and the NHS."

The competitions will be run through the Small Business Research Initiative (SBRI) process and are open to all organisations not just those in the health sector.

**Overweight students are risking losing their teeth**

A study, undertaken in Japan, has looked at the oral health and eating habits of more than 800 university undergraduates, and compared the levels of gum disease between students who were classed as underweight, normal weight and overweight.

The study found that students classed as overweight, that regularly eat fatty foods and rarely eat vegetables, were at an increased risk of gum disease compared to those who were underweight or normal weight.

The main rate of corpora
tion tax is going to come down from five per cent.

Of all George Osborne’s announcements, the increase in tax on tobacco by 5p is most potentially divisive, celebrated by non-smokers and the medical and dental professions, which support smoking cessation, and reviled by smokers with no intention of giving up.

Sir David Nicholson, Chief Executive of the NHS said: "Investing in innovation is vital for a modern and efficient NHS. It will benefit the patient, the taxpayer and UK plc."

The Small Business Research Initiative (SBRI) is a key part of the Innovation, Health and Wealth agenda, which aims to spread innovation throughout the NHS. That is why we are investing £20 million in new and existing projects which can make a difference to patients’ lives.

"Today’s competitions provide an opportunity to develop innovative solutions for some of the biggest health problems of our time and we look forward to seeing the results."

Sir David Nicholson, Chief Executive of the NHS said: "Investing in innovation is vital for a modern and efficient NHS. It will benefit the patient, the taxpayer and UK plc."

The Small Business Research Initiative (SBRI) is a key part of the Innovation, Health and Wealth agenda, which aims to spread innovation throughout the NHS. That is why we are investing £20 million in new and existing projects which can make a difference to patients’ lives.

"Today’s competitions provide an opportunity to develop innovative solutions for some of the biggest health problems of our time and we look forward to seeing the results."

Sir David Nicholson, Chief Executive of the NHS said: "Investing in innovation is vital for a modern and efficient NHS. It will benefit the patient, the taxpayer and UK plc."

The Small Business Research Initiative (SBRI) is a key part of the Innovation, Health and Wealth agenda, which aims to spread innovation throughout the NHS. That is why we are investing £20 million in new and existing projects which can make a difference to patients’ lives.
Editorial comment

Time really does fly when you are having fun! Here we are, mid April already and conference season is rapidly approaching. I will basically be living from a suitcase over the next few weeks as trips to Manchester et al beckons.

A bit closer to home, 18-19th May sees the much anticipated Clinical Innovations Conference, held at the fabulous Millennium Gloucester Hotel in London. With a top line-up of speakers such as Nasser Barghi and DT contributor Mhari Coxon, attendees are assured of a lively thought-provoking conference and plenty of networking opportunities.

Of course no self respecting conference would be complete without a party, and the Clinical Innovations Conference is no exception! The organisers have teamed up with charitable association the AOG to present a charity ball with all the glitz and glamour you’d expect. Proceeds from the event go towards the AOG Chitrakoot Project, providing dental care to families in the Indian village of Chitrakoot and its surrounds.

For more about the Clinical Innovations Conference, go to www.clinicalinnovations.co.uk or call 02074008989.

Cradle to grave

The 2nd John McLean Honorary Symposium has been organised in order to increase the funding of The John McLean Fellowship, which was formed in May 2010 to not only fund academic and clinical research, but also to honour John for his contribution to dentistry.

During his lifetime John achieved international renown as a highly regarded dental practitioner, scientist, author and keynote lecturer. His work was underpinned by a passion for science and astute insight of trends in dentistry and it is without doubt that his contribution to his fields of special interest and expertise in dentistry cannot be underestimated.

The theme of this year’s meeting is “Dental Health: Cradle to Grave” and will be held in the new seminar suite at Castle View Dental in Windsor on Friday May 4, 2012. The suite can seat a maximum of 55 delegates so early booking is advised to avoid disappointment.

Speakers include Edwina Kidd; Jim Page; Cheryl Butz; Ian Needleman; Tim Watson; Mike Wise; John Besford and David Winkler.

The goal is to raise a minimum of £15,000 for the McLean Fellowship.

A minimum donation of £500 to the John McLean Fellowship is suggested to secure your place for this unique event. Your donation will help promote and nurture student research in dental materials and enhance the opportunities available to those beginning their career in this vital aspect of dentistry.

Contact David Winkler at david@castleviewdental.net for more details.

Two ingredients that make Colgate Total one of a kind.

Clinically proven non-stop 12-hour antibacterial protection

www.colgateprofessional.co.uk
Alcohol industry sheds a billion units

Health Secretary Andrew Lansley announced recently that a billion units of alcohol will be shed by the alcohol industry through an ambitious plan to help customers drink within guidelines.

The initiative, which is part of the Responsibility Deal, is being spearheaded by 34 leading companies behind brands such as Echo Falls, First Cape and Heineken and will see a greater choice of lower strength alcohol products and smaller measures by 2015.

Market intelligence suggests consumers are increasingly looking for lower strength wines. In the past year, demand for lower and non-alcoholic beer has soared by 40 per cent across all retailers.

Key commitments include new and lighter products, innovating through existing brands and removing products from sale. They include:

- Sainsbury’s have pledged to double the sales of lighter alcoholic wine and reduce the average alcohol content of own brand wine and beer by 2020
- £25 million units will be gradually removed from Accolade Wines including Echo Falls Rosé and Echo Falls White Zinfandel
- Brand Phoenix - have committed to taking 50 million units of alcohol out of their wines - by reducing 0.8 per cent ABV on all FirstCape full strength red wines
- Molson Coors, the UK’s largest brewer, has committed to remove 50 million units by December 2015
- 100 million units will be removed by Heineken
- Own brand super-strength lager will be removed from sale by wholesaler Makro
- Tesco, the leading retailer for low alcohol drinks, will reduce the alcohol content of its own-label beer and cider and expand its range of lower alcohol beers and ciders

Health Secretary Andrew Lansley said: “The Responsibility Deal shows what can be achieved for individuals and families and work together with industry. We know it is an ambitious challenge to work in this way but our successes so far have shown we can make it work. We will work hard to engage even more businesses and get bigger results.

“Cutting alcohol by a billion units will help more people drink sensibly and within the guidelines. This pledge forms a key part of the shared responsibility we will encourage as part of the alcohol strategy.”

Estimate suggest that in a decade, removing one billion units of sales would result in almost 1,000 fewer alcohol related deaths per year; thousands of fewer hospital admissions and alcohol related crimes, as well as substantial savings to health services and crime costs each year.

Chief Medical Officer Professor Dame Sally Davis said: “Drinking too much is a major public health issue. By cutting out units from many of our best-known brands, this initiative will help people to continue to enjoy a sensible drink while lowering their unit consumption.”

Researchers find bacteria on dental bib holders

The sterilisation protocol for dental bib holders is inconsistent and can result in the presence of bacteria such as pseudomonas and micro-organisms, researchers from Germany have proved. In a study, they found bacteria on more than two-thirds of reusable bib holders.

The researchers at the Witten/Herdecke University in Witten, Germany, examined 50 metal and plastic bib holders.

“The analyses of the bacterial load showed that 70 per cent of all reusable bib holders were contaminated with bacteria. The predominant colony types identified were staphylococcus and streptococci. On several bib chains, we also found various bacterial rods, pseudomonas, fungi and other types of cocci,” said Prof Stefan Zimmer, lead investigator of the study and scientific director at the Witten/Herdecke University. “Although the bacteria found in this study were all non-pathogenic, in principle reusable bib holders can cross-contaminate dental patients.”

The bacteria found on the bib holders do not usually cause disease in healthy people, but can be a threat to immunosuppressed patients, as well as young children and the elderly, who often have compromised immune systems. Bacteria from an unsterilised bib holder can enter the body when a patient touches the bib holder or neck after a dental visit and then rubs an eye or touches the mouth.

Cross-contamination can also occur when a bib chain is splattered with saliva, plaque, blood and spray from the mouth, when it catches onto hair and accumulates the wearer’s sweat, make-up or discharge from neck acne, and if the dental worker applies a dirty bib chain with gloved hands before the examination or cleaning.

Several other studies have found similar results. Three US studies found unacceptable levels of microbial contamination on dental bib holders, including pseudomonas, E. coli and S. aureus, the most common cause of staph infection.

All aboard the Smile Train

is the world’s leading cleft charity providing free cleft lip and palate surgery to children in developing countries. It also provides free cleft-related training for doctors and medical professionals. To date, it has helped more than 725,000 individuals across more than 80 of the world’s poorest nations.

Speaking of his efforts to raise funds that will help Smile Train in its invaluable work, Dr Paysden said: “A lot of children affected by clefts are considered outcasts by society. This can mean they are excluded from education and overlooked for job opportunities. In worse case scenarios, some are even killed or abandoned at birth.

“It’s hard to believe that children are being treated in this way over something that isn’t their fault and can be fixed so easily. By running the Wilmslow Half Marathon in a bid to raise money for Smile Train.

Formed in 1999, Smile Train

Calories to be capped and cut

The country’s biggest supermarket markets, food manufacturers, caterers and food outlets are joining forces to help cut five billion calories from the nation’s daily diet, the Health Secretary Andrew Lansley recently announced.

Auda, Marks & Spencer, Morrisons, Sainsbury’s, Tesco, Waitrose, Coca-Cola Great Britain, Kerry Foods, Kraft, Mars, Nestle, PepsiCo, Premier Foods, Unilever, Beechuter (Whitebread), Subway and contract caterer Compass have all joined the fight against obesity and are leading the way in signing up to the Responsibility Deal’s calorie reduction pledge.

England has one of the highest rates of obesity in Europe and some of the highest rates of the developed world. More than 60 per cent of adults and a third of 10 and 11 year olds are overweight or obese. Consuming too many calories is at the heart of the problem.

Making commitments today to cut and cap calories are some of the world’s biggest food and drink manufacturers and best known brands. More than three-quarters of the retail market has signed up. The following examples highlight some of the initiatives being taken:

- Auda will develop a new reduced calorie brand across a wide range of products that will contain at least 50 per cent fewer calories than their core Chosen by you brand
- Coca-Cola Great Britain will reduce the caloric content of some of their soft drinks brands by at least 50 per cent by 2014
- Mars will cap the calories of their chocolate items to 250 calories per portion by the end of 2015
- Morrisons will launch a range of healthier products developed by their chefs and nutritionists
- Premier Foods will reduce calories in one third of their sales by the end of 2014
- The Subway brand has committed to offer five out of their nine low Fat Range Subs
- Tesco is on track to remove 1.8 billion calories from its soft drinks, will expand its Eat, Live and Enjoy range of low-calorie meals and is making it easier for shoppers to spot low-calorie options

Health Secretary, Andrew Lansley said: “Eating and drinking too many calories is at the heart of the nation’s obesity problem.

“We all have a role to play – from individuals to public, private and non-governmental organisations – if we are going to cut five billion calories from our national diet. It is an ambitious challenge but the Responsibility Deal has made a great start.”

4 News


A kind hearted dentist is going the extra mile for a children’s charity. Dr Greg Paysden, pictured, who runs two dental practices - one in North Manchester and another in Saleford - has set his sights on running the Wilmslow Half Marathon in a bid to raise money for Smile Train.

To contribute visit: www.justgiving.com/GregPaysden

A"
The regime that
shows plaque bacteria
no mercy

Brushing and flossing/interdental cleaning are pivotal to oral hygiene. They displace and dislodge dental plaque bacteria that can cause gingivitis and periodontal disease. But bacteria from other areas of the mouth can recolonize on teeth quickly.¹

Using LISTERINE® after mechanical cleaning destroys oral bacteria effectively, killing up to 97% in vivo.² This lowers the bacterial burden in the mouth and in plaque that reforms.³ And when used for 6 months, LISTERINE® can reduce plaque levels by up to 52% more than brushing and flossing alone.⁴ In addition, LISTERINE® Total Care products offer various levels of fluoride and other benefits to suit patients’ needs.

So recommend LISTERINE® as the final step in your patient’s daily regime, to finish the job started by mechanical cleaning.

References:
2. Data on file, OL689/06/29, McNeil PPC.

ID:UK/LI/12-0084

Brushing and flossing/interdental cleaning are pivotal to oral hygiene. They displace and dislodge dental plaque bacteria that can cause gingivitis and periodontal disease. But bacteria from other areas of the mouth can recolonize on teeth quickly.

Using LISTERINE® after mechanical cleaning destroys oral bacteria effectively, killing up to 97% in vivo.² This lowers the bacterial burden in the mouth and in plaque that reforms.³ And when used for 6 months, LISTERINE® can reduce plaque levels by up to 52% more than brushing and flossing alone.⁴ In addition, LISTERINE® Total Care products offer various levels of fluoride and other benefits to suit patients’ needs.

So recommend LISTERINE® as the final step in your patient’s daily regime, to finish the job started by mechanical cleaning.

References:
2. Data on file, OL689/06/29, McNeil PPC.
Planmeca appoints South West distributor

S&S Dental Services has been awarded sole south west-based distributor status for Planmeca dental equipment.

The Planmeca tie-up means S&S Dental is now the only dealer based in Devon, Cornwall, Dorset and Somerset who can deal directly with the Planmeca factory to get the best prices for these award-winning pieces of equipment.

Paul Sutcliffe, owner S&S Dental Services said: “We are delighted to be an official distributor for Planmeca. We’re a great match as they specialise in the design and manufacture of high tech dental equipment and we are known for our excellent service and extensive product knowledge.

“Dentists chose Planmeca products because they are cutting edge, not only in terms of technology, but also in terms of design. Gone are the days when surgeries look sparse and somewhat frightening. Planmeca products are very stylish and play a key role in helping to make visiting and working in the practice a more enjoyable experience for patient and dentists.”

Plymouth-based S&S Dental Services provides a one-stop sales and service shop to more than 1000 practices throughout the south west. They have been awarded the Planmeca contract because of its established reputation in the dental field. The south west enjoys a high concentration of dental surgeries using Planmeca, so S&S Dental will be able to provide a local service to these dental clinics and practices using, as well as introduce these fantastic high-tech products to those who are looking to invest in new equipment.

For more information about S&S Dental and Planmeca, call 0844 272 4561.

Profits down, costs up in NASDAL stats for 2010-2011

The annual benchmarking statistics just issued by NASDAL reflect the wider economy in 2010-2011, the most recent year for which figures are available. Fee income is down for both the NHS and private sectors, profits are generally down, whilst costs have increased.

The statistics reflect the fee income of both NHS and private practices. To fit in either category, you must have a greater than 80 per cent commitment. In NHS practices, fee income has fallen by three per cent, whilst profits fell by nearly 10 per cent compared to the previous year and are now back down to 2005/06 levels.

Private practice fee income has remained static but rising costs have led to a seven per cent drop in net profit. The average UDA rate paid to practices appears to have remained static at around £25 over the last three years. While the highest UDA rate paid to a practice was £71,000 in the previous year and are now back down to 2005/06 levels.

Private practice fee income has remained static but rising costs have led to a seven per cent drop in net profit. The average UDA rate paid to practices appears to have remained static at around £25 over the last three years. While the highest UDA rate paid to a practice was £71,000 in the previous year and are now back down to 2005/06 levels.

The profit of Associates has continued to fall and in 2010-2011 stood at around £88,000 compared to £71,000 in the previous year. The majority of associates still enjoy a 50 per cent agreement with their principal

but this is not always 50 per cent of the full UDA rate agreed with the Primary Care Trust.

Ian Simpson, Chartered Accountant and Specialist Dental Advisor, said that while private practice appeared to be surviving reasonably well despite the economy in 2010-11, mixed practices had suffered. He added, larger practices had experienced the greatest impact on profit.

Nick Ledingham, NASDAL chairman, of Specialist Dental Accountants Morris and Co, speaking at the press conference, said the figures provided an interesting insight into how dentists and their patients responded to an economy in the doldrums. He believes the NHS fee income has dropped because fewer non-exempt patients were going for treatment and some dentists were opting not to fulfil or were unable to fulfil their NHS contract. He believes mixed practices which have fared least well are best placed to prosper as the economy recovers.

He added: “NASDAL clients will benefit hugely from the statistics as their accountants will be able to benchmark their results and work with them to ensure they are well placed to maximise their potential.”
Switch on to new ideas

Speakers:

Prof Nasser Barghi
Dr Richard Kahan
Prof Gianluca Gambarini
Dr Wyman Chan
Dr John Moore
Dr Ajay Kakar
Ms Jackie Coventry
Dr Mona Kakar
Basil Mizrahi
Fraser McCord
Mhari Coxon
Amit Patel
Anthony Roberts
A budget summary for dentists
Jeff Williamson highlights the areas affecting dentists in the recent Budget

Some dentists may be able to breathe a sigh of relief following George Osborne’s 3rd Budget on Wednesday 21st March. There were no big surprises, not least because The Budget was widely leaked to journalists beforehand. In general, the effect of The Budget is likely to be neutral or even positive for many dentists, although it highlights the need for careful tax planning over the next few years.

What didn’t happen...
Contrary to rumours the Chancellor didn’t remove higher rate tax relief on pension contributions. Those dentists making pension contributions in any shape or form can hang onto this generous tax perk for at least foreseeable future.

Despite the Liberal Democrats pushing for the loss of tax free cash from pensions, this hasn’t happened. This particularly benefits those close to retirement, especially those with significant NHS Pension benefit or large personal pension funds.

‘High earners’ have avoided further raids on income or capital taxes. There were no negative changes to the rate of tax paid by higher rate taxpayers, although the loss of the increased personal allowance (£250 in 2013/14) for those with income in excess of £100,000, is likely to be widespread amongst dentists. This shouldn’t be ignored and can be mitigated with pension contributions.

The headlines...
The highest rate of Income Tax will be reduced to 45 per cent from the current 50 per cent for those earning in excess of £150,000, from April 2015. Some careful planning may be required to time the withdrawal of income (salary/dividends/drawings) to ensure the reduction has maximum personal impact. We advise dentists reassess their business year end timing with their accountant as this may be critical to saving tax.

Stamp Duty on house purchases over £2 million is to be increased to a staggered 25 per cent. On a purchase of £2 million the amount of Stamp Duty paid will be increased to £600,000 from January 2014. The ‘smaller profits’ rate of corporation tax levied on the slice of profits between £300,000 and £5 million for incorporated dental practices over the next three years. However most will fall outside the main corporation tax reduction to 22 per cent in 2014. The ‘smaller profits’ rate has already fallen (as per previous budgets) to 20 per cent, for companies with profits under £500,000. It is this rate that will be applicable to many incorporated dental practices. The good news is that corporation tax rate levied on the slice of profits between £500,000 and £1.5 million, known as the ‘marginal rate’, will fall. Practices considering incorporation should discuss the impact of this with their accountant.

There was a slight softening of the proposed Child Benefit reduction, with the much vaunted ‘nilth edge’ being raised to £30,000 from January 2013 and a phasing in of the cut for those with income more than £50,000. As many dentists earn in excess of £60,000 the loss of Child Benefit is likely to be widespread in the dental community.

Corporation Tax reductions are likely to benefit incorporated practices over the next three years. However most will fall outside the main corporation tax reduction to 22 per cent in 2014. There was a slight softening of the proposed Child Benefit reduction, with the much vaunted ‘nilth edge’ being raised to £30,000 from January 2013 and a phasing in of the cut for those with income more than £50,000. As many dentists earn in excess of £60,000 the loss of Child Benefit is likely to be widespread in the dental community.

The effect of The Budget is likely to be neutral or even positive for many dentists.
Improving practice performance

Amanda Atkin considers what you should do when things go awry

We have multi-skilled healthcare professionals in this country who provide dental health care to the population. Dedicated, committed and highly skilled dental teams are focused on offering high quality care for patients within and without the NHS. However, sometimes things can go a little awry and their professional integrity is called into question.

If this happens the overriding concern is always for patient safety but professionals also need support and sensitively to ensure they are treated fairly by the organisation employing them. After all, for the majority, an episode of sub-standard performance will not spell the end of a career.

With the right support and management of the situation most professionals will continue with their work and the treatment of patients. Quick and effective intervention regarding performance concerns should result in the desired outcomes – which must always include support for the practitioner. Importantly, all concerns must be treated in a fair and consistent manner.

Consider these questions:

• What constitutes a performance concern?

• Who could/should raises concerns?

• Do those who could or should raise concerns know how to do so?

• Who should manage a performance concern once it has been raised?

• Do you know the answers to these questions?

A ‘poor performance’ reporting system should be simple enough to follow so that everyone knows who to speak to and what will be done, whichever the concern involves. Sometimes it is difficult to voice concerns especially if it relates to your boss, however, it is important to remember your reasons for raising a concern at this point. Your in-house process and procedure will have identified individuals who will be able to help at this point.

Performance concerns may relate to:

• Standard of work – for example frequent mistakes

• An inability to handle a reasonable volume of work to a

page 10
required standard

- Unacceptable attitudes towards patients
- Unacceptable attitudes towards work or colleagues – for example, uncooperative behaviour, poor communication, poor teamwork, lack of commitment and drive etc
- Poor punctuality and unexplained absences
- Lack of skills in tasks/methods of work required
- Lack of awareness of required standards
- Consistently failing to achieve agreed objectives
- Acting outside limits of competence
- Poor supervision of the work of others when this is a requirement of the post
- A health problem

If you have one of the above concerns, what comes next? Below are some important thoughts you may have and actions you may take:
- Consider the risk to patient safety
- Consider what your options are
- Ensure you are fully aware of the process you need to follow
- Ensure you know how to inform the individual
- Ensure you know that the systems are in place to support the individual
- Know if this concern needs to be dealt with formally or informally
- Decide what to do

What the GDC says you should do regarding performance concerns is contained in its code of behaviour Standards for dental professionals. Its guidance can be summarised as follows:

- The duty to put patients’ interests first and act to protect them must override personal and professional loyalties
- You have a duty to work within your knowledge, professional competence and physical abilities

This responsibility includes making sure that you:
- Get and follow medical advice if you know that you have a serious condition which you could pass on to patients, or that your judgement or performance could be seriously affected by a condition or illness
- Get help if you have any other problems which are affecting or may affect your professional performance
- Only carry out a task or type of treatment if you are sure that you have been trained and are competent to do it
- Do not put anyone off raising a concern about your health, behaviour or professional performance
- Co-operate fully with any procedure for investigating concerns which applies to your work

In my next article, I’ll discuss turning around poor performance.
Excellence in endodontics

Daniel Flynn discusses endodontic microsurgery

1 Root canal retreatment through the crown
2 Endodontic microsurgery
3 Extraction +/- prosthetic replacement

‘Endodontic surgery has evolved to become a technically accurate, highly predictable procedure with remarkable success rates’
There are significant differences between the above microsurgical techniques and traditional surgery approaches.

1. Osteotomy size
The use of smaller instruments, magnification and illumination allows access to the root tip, often without removing any additional buccal bone should the plate be already perforated. Staining

Prove it to Yourself - Whiter Teeth in 1 Minute
just leave toothpaste on teeth for up to 1 minute before brushing

We’re confident you’ll love Beverly Hills Formula toothpaste we offer 100% money back guarantee

The use of smaller instruments, magnification and illumination allows access to the root tip, often without removing any additional buccal bone should the plate be already perforated.

Need advice?
Ask the stain removal experts:
www.beverlyhillsformula.com sales@beverlyhillsformula.com

Fig 3 Hemostasis achieved, parallel resection of root tip and retro-preparation sealed with MTA

Fig 4 Soft tissue removed

Fig 5 Haemostasis achieved, parallel resection of root tip and retro-preparation sealed with MTA

Fig 6 Soft tissue sent for histological investigation

greater amount of dentinal tubules and may not remove enough of the apical anatomy lingually. Modern techniques using a cut perpendicular to the long axis of the tooth result in exposure of far fewer tubules, enables a smaller osteotomy, retention of more buccal bone and no periodontal communication. There is less chance of a lingual perforation in the retro-preparation and it is easier to identify the apices of
the roots.

3. Root end resection
It is recommended to remove 3 mm of the root tip. At this level 85 per cent of apical ramification and 95 per cent of lateral canals are removed (5). Following resection it is critical that the root end is inspected under high power visualisation, stained and viewed with micro-mirrors. Identification of isthmuses, cracks and lateral canals may be treated at this stage.

4. Retropreparation
Micro-hand pieces and burs are no longer the ideal treatment for retro-preparation. Instead, diamond coated ultra-sonic tips are excellent for allowing the operator to clean along the original canal, the isthmus and minimise microcrack formation.

The use of MTA as a root end filling material is another improvement. Superior to amalgam in terms of sealability and biocompatibility, it is more difficult to place and doesn’t give an aesthetically pleasing result when viewed on a radiograph post-operatively. Critically MTA results in regeneration of periodontal ligament and cementum cells and appears to have inductive effects on bone and tissue cells. Super-ERA has also shown favourable results using microsurgical techniques.

Endodontic microsurgery is a great option to keep in mind when planning treatment and has an added bonus for patients being the least expensive intervention when compared to endodontic retreatment and crown, extraction and fixed partial denture, or extraction.

For more information about EndoCare please call 020 7224 0999 or visit www.endocare.co.uk

Fig 7 Examining a resected root tip with a micro-mirror and implant (4)

Fig 8 Post-operative radiograph

Fig 9 Four-month review (Almost complete healing and asymptomatic)

‘Endodontic microsurgery is a great option to keep in mind when planning treatment’

Comply with CQC and let MediMatch collect your models.
DO NOT throw your models away!

Let MediMatch organise collection of your gypsum waste.

Gypsum plaster cast is prohibited from landfill as per giving off hydrogen sulphide gas (HTM 07 01 Safe Management of Healthcare Waste, DH 2010) and therefore, cannot be disposed of as domestic waste. The material must be separated into an appropriate container and sent for gypsum recycling arranged through a specific contractor.

Order your collection bags today and let us deal with the model disposal for you powered by Gypsumwaste Ltd.

12 month contract = £200 (12 Collection Bags) or £20 per individual Collection Bag (minimum of 3 bags per order)

T: 08 444 993 888

MediMatch Dental Laboratory
Your -Private- Dental Lab

Terms and conditions apply. Price is correct on day of going to press. MediMatch has the right to amend or terminate this promotion at any time. The promotion is on behalf of Gypsumwaste Ltd.

About the author
Dr Daniel Flynn BDS hon BChD RCS(Eng) MiADent RCSI qualified from the Dublin Dental Hospital, Trinity College, Dublin in 2002. Daniel has recently joined the EndoCare team headed by Dr Michael Sultan. Daniel lectures and provides hands-on courses for general practitioners. He also teaches Endodontics at the Eastman Dental Institute for Oral Healthcare Sciences.


powered by Gypsumwaste Ltd.
Do we treat patients based on radiolucency?

Dr Sander Loos provides a case report

Just after Christmas, on 26 December 2010, a 76-year-old male patient, who was in great pain, consulted the emergency dentist. The patient indicated that he felt a throbbing pain in his lower left jaw. The pain was unbearable and had kept him awake all night. The dentist took radiographs of teeth #36 and #37 and an orthopantomogram (OPG; Figs 1 & 2).

Although the radiograph did not show the full anatomy of tooth #37 and its surrounding structures, the dentist diagnosed apical periodontitis (AP) and advised an endodontic retreatment or extraction and an implant. To make the patient comfortable for the time being, he prescribed 500 mg Amoxicillin and Ibuprofen.

After another sleepless night, the patient consulted a different emergency dentist on 27 December. The analgesics did not give him pain relief and he was starting to become desperate. The second dentist confirmed the original diagnosis and referred the patient to an oral surgeon because an endodontist was not available at short notice. He requested apical surgery on tooth #37.

The following day, the oral surgeon took another OPG and concluded that surgery was not the best treatment option in this case because the apex was located too close to the nerve alveolaris inferior and access to the apices of tooth #57 was difficult.

He also confirmed the diagnosis of an AP and suggested extraction or endodontic retreatment.

On 5 January 2011, the patient visited my office for the first time. The pain had diminished but not disappeared. Intra-oral examination showed a well-restored dentition with a cantilever bridge on teeth #35 to #37, with #36 and 57 func-...
diong as abutments. Tooth #37 showed an occlusal filling in the crown. Palpation of the buccal fold was not painful and there was no mobility of teeth #36 and 37. The pockets of #36 were within normal limits. However, periodontal probing distal of #37 provoked strong pain and extreme bleeding. The distal pocket measured approximately 6mm.

As the previously taken radiographs were not available and the OPT was considered unsuitable for proper diagnosis, a peri-apical radiograph (Fig. 5) was taken. The radiograph showed that tooth #37 had previously been treated endodontically. The mesial canals were filled with silver cones rather too short of the apex. There also appeared to be some gutta-percha and a large metal post in the distal canal. Additionally, radiolucency was noticeable around the apex of the mesial root. According to the patient, he had received endodontic treatment about 15 years ago owing to pain following bridge cementation. The tooth had been without symptoms since then.

Considering the history and my clinical and radiographic findings, my differential diagnosis was:

1. painful AP owing to reinfection or leakage
2. painful marginal periodontitis distal of tooth #37 owing to poor oral hygiene
3. vertical root fracture (VRF) of the distal root of tooth #37

As diagnosis 1 and 3 would have required rather invasive therapies (re-treatment or extraction), we opted to rule out the local marginal periodontitis first. Under local anaesthesia, the distal pocket was thoroughly cleaned and the patient was instructed to use dental floss distal of tooth #37 on a daily basis.

On 31 January, three weeks after initial treatment, the patient returned for evaluation and appeared free of complaints. There was no bleeding on probing and pain could not be provoked.

It should be noted that by selecting this strategy, neither an AP nor a VRF was definitively excluded as a cause of pain. It should be taken into account that owing to the patient being on antibiotics, the symptoms of the AP may have temporarily disappeared and returned at a later stage. Nevertheless, at that point we treated the patient based on history, a radiograph and patient complaints rather than merely on the basis of the radiolucent or leakage evident on the radiograph.

In May 2011, the patient returned to our office once again. He was free of complaints, pockets were within normal limits and there was no bleeding on probing.

“The radiographic picture is only one means of diagnosis... the picture may show a lot of rarefaction, but to use it as the sole means of diagnosis is unwise.” Thomas Philip Hinman, 1921

---

**Introducing the Laser-Lok® 3.0 implant**

Laser-Lok 3.0 is the first 3mm implant that incorporates Laser-Lok technology to create a biologic seal and maintain crestal bone on the implant collar. Designed specifically for limited spaces in the aesthetic zone, the Laser-Lok 3.0 comes with a broad array of prosthetic options making it the perfect choice for high profile cases.

- Two-piece 3mm design offers restorative flexibility in narrow spaces
- Implant design is more than 20% stronger than competitor implant
- 3mm threadform shown to be effective when immediately loaded
- Laser-Lok microchannels create a physical connective tissue attachment (unlike Sharpey fibers)

---

2. Implant strength & fatigue testing done in accordance with ISO standard 14801.
Root-canal retreatment is a very common procedure that endodontists and general practitioners are faced with on almost a daily basis. The biggest challenge here is to re-establish the initial pathway of the canal and its original exit or apex. During the past decade, several techniques required that gutta-percha be used to fill the root canals. Sometimes and for many reasons, such as leakage or short preparation and/or obturation, the gutta-percha needs to be removed and the canal re-negotiated.

Generally, NiTi rotary files were used in such cases in order to facilitate and expedite our task. However, the files used to accomplish this task faced additional challenges, that is, the debris coming from the previous obturation and the density of the obturation material. The first difficulty is piercing the mass of the obturation material. Here, our choice of file should focus on a strong tip that can take the pressure and engage the mass of the gutta-percha, break it down and push it back into the access cavity. The second challenge is to select an instrument that can enter the root-canal structure and engage the obturation material, pushing it out coronally, while offering enough flexibility to go around curves and shape the root-canal surface safely.

The slight modification in their structure gives these files much-needed flexibility, while preserving their very high safety levels. The clinical applications are very simple. My favourite sequence of the K3 system is the G-pack, which allows me to do crown-down using the taper of the files and keeping the tip stable at ISO 0.25. This sequence allows for a very nice start, removing the obturation material from the coronal third with relatively short files, such as orifice openers, and doing so in a relatively short time. The deeper we go, the more we need to decrease the taper, especially when curves are present inside the canals and smaller taper files are needed.

It is at this particular moment that the flexibility of the heat-treated alloy gives the files the ability to negotiate the curves without any distortion of the canal or macro-damage to the file structure (as has been demonstrated in research and clinically).

Clinical cases
The first clinical case could be described as a very bad day in a dental office. Two files had been trapped and separated in the mesial canals and the patient was referred to the clinic but had to drive for more than two hours to attend the clinic. Thanks to heat treatment that has changed the world of rotary NiTi files, allowing us to modify the crystalline structure of the metal, we have been able to obtain several types of the alloy to give us different files, from the Twisted File to the latest modification of the K5 system, the K3XF (SybronEndo; Fig. 1). The K5 system files are known to be robust yet very safe.
get to our clinic. When I first saw the X-rays (Fig. 2), I remembered a very similar case from several years ago with practically the same location of file separation. The separated files in the mesial canals were clearly visible. It was also noticeable that the distal canal had not been treated to full length. Ultrasonic tips and the use of an operating microscope allowed me to retrieve the separated files and then time to reshape the canals and retreat the distal canal (Fig. 5). Owing to the combination of requirements for the treatment of this case—shaping and retreatment in one tooth—my instruments of choice were K3XF files. I started with 25.08, followed by 28.06 and concluded crown-down with 25.04.

This gave access to the apical part, which was enlarged to 53.04 in the mesial and distal canals in order to prepare the apical portion of the root-canal system. The speed of the micro-motor for the shaping procedure was 500rpm and a sequence of push-and-pull movements—four to five strokes per canal—with each file was used in order to reach full working length. Figure 4 shows the obturation of the canals, which was performed with RealSeal (SybronEndo) after both separated files had been removed and the root-canal system reshaped.

The second case came as another referral. The patient was suffering from pain in her lower molar and was sent to the office in order to check the case and give the necessary treatment. The preoperative X-ray (Fig. 5) showed an apical lesion with an incomplete root-canal treatment. Because diagnostics found no sign of a root-canal crack, retreatment was my choice. However, we had to overcome two obstacles: the crown placed on the tooth and the fibre post inside the distal canal. I decided to go through the crown without removing it in order not to place any tension on the distal canal. When analysing the anatomy, it appeared that the roots were fused. In such cases, avoiding any tension is recommended in order to avoid any cracks.

Under the microscope and through the crown, I managed to remove the filling surrounding the post. With the use of the ultrasonic WHAT, I managed to remove the fibre post itself together with the previous filling from the access cavity. Using the K3XF after removal of the fibre post was a great help in reshaping the root-canal system, which appeared very convergent.

The files displayed no sign of metal fatigue and the 25.06 was taken deeper into the canal compared with the standard K5 files. The extra flexibility and strength of the K3XF allowed me to perform crown-down and final apical shaping. Obturation of the root-canal system was performed with the Elements Obturation Unit (SybronEndo) and RealSeal material. The post-operative X-ray (Fig. 6) shows that the merging canals had been cleaned, shaped and filled; and the same had been done for the fibre-post space.

Conclusion
In the two clinical cases presented here—both rather a challenge for root-canal retreatments—the final results were an endodontic success. This lends support to the fact that each challenge needs to be treated separately without fear or tremor from the initial pre-operative X-rays. Our fear shall control neither our judgment nor our choices!

I would like to thank Yulia Voryeva, interpreter and translator, for her help with this article.

About the author
Dr Philippe Stolman, Dubai Sky Clinic, Jumeirah Business Tower, Level 25, Trade Center Street, Bar Dubai, Dubai, UAE.

phil2stolman@hotmail.com

Great new features
Dental System™ 2012 - the future proof solution

Model Builder
Create lab models directly from TRIOS® and 3rd party intraoral scans. Support for implant models.

TRIOS® integration
Receive TRIOS® digital impressions instantly from dentists and start designing right away.

3Shape Communicate™
Upload 3D design visualizations with a single click. Share and discuss your cases with dentists.

2nd Generation Removable Partial Design
Intuitively mimics the familiar workflow while significantly reducing production time.

Digital Temporaries
Create cost-effective temporaries without pouring a model using Virtual Preparation and Virtual Gingiva.

D500 3D scanner
3Shape’s new D500 model with Dental System Standard provides the market’s best entry-level CAD/CAM solution for small to medium labs and can later be upgraded to extend the range of available indications.

D800 3D scanner
Two 5.0 MP cameras. Scans a single-die in 25 seconds, captures texture and scans impressions.

Backing our users with technology, care and expertise

New Dynamic Virtual Articulation
Like using your physical articulator. Support for Occlusion Compass, KaVo PROTAR® evo, Whip Mix Dentaray Mark 330, SAM® Z2P, Artex® compatible and more to come.

Next Generation Telescopes
Full freedom for designing telescopic crowns. Support for attachment crowns and open telescopes. Add multiple bands, parametric attachments, and customized attachments.

Scan the QR code & sign up for our newsletter

Meet us at Dentistry Show in March 2-3, Birmingham UK, NEC Booth M3
Rubber dam hazards?
Dr Kenneth Serota gives his opinion

The September issue of Oral Health included an article by Dr Ellis Neiburger entitled Rubber dam hazards. The contextual inaccuracy, skewed perspective and postulatory bias of the author was disingenuous at best and horrifying at its worst.

I'm not certain how it managed to secret itself into our beloved centenarian journal, but it did. Before I comment on the text, I'd like to share a scientific article with you published by Smith and Pell in the British Medical Journal in 2003 (entitled Parachute use to prevent death and major trauma related to gravitational challenge).

**Objective:** To determine whether parachutes are effective in preventing major trauma related to gravitational challenge.

**Design:** Single-centre, randomised controlled trial. Data sources: Medline, Web of Science, Embase, and the Cochrane Library databases; appropriate internet sites and citation lists.

**Study selection:** Studies showing the effects of using a parachute during free fall.

Main outcome measure: Death or major trauma, defined as an injury severity score > 15.

Results: We were unable to identify any randomised controlled trials of parachute intervention.

Conclusions: As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials. Advocates of evidence-based medicine have criticised the adoption of interventions evaluated by using only observational data. We think that everyone might benefit if the most radical protagonists of evidence-based medicine organised a cross-over trial of the parachute.

Not wishing to misjudge nor malign the author, I searched the many publications attributed to Dr Neiburger in the literature using Google Scholar. My personal favourite was *Simulacrum and Parachute* (Fig 1); the issues pertaining to time and the dental office, not to be outdone by Water line bioluminescence dangers—*A Tempest in a Teapot!* Of note, none of the references pertaining to the hazards were dated beyond 1990.

As to the inaccuracies, rather than repeating the text, I'll answer the “factoids”: rubber dam is routinely used in the vast majority of endodontic and restorative procedures by contemporary dentists; sterilisation of the rubber dam can be done readily; reuse is the most scurrilous of the factoids proposed; colour is not an issue, in fact it can be used to enhance photographic documentation; the physical and chemical properties of the dam enable it to be used with most if not all dental materials and its strength cannot be in dispute, as the average endodontic clamp cannot be in dispute, as the average endodontic procedure does not require multiple replacement; damage from clamps occurs because of improper placement; the sheer enormity of clamp sizes and design allows for literally any clinical situation with tissue injury essentially non-existent; there are a raft of alternatives to clamp placement (Fig 1); the issues pertaining to time for placement, phobias, material residue in pockets anon … even providing a rebuttal to the text gives it a undeserved credibility.

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---

**Rubber dam hazards?**

**Dr Kenneth Serota gives his opinion**

---
Dentistry is perched on a slippery slope. In North America alone, it represents a silo of approximately $60 billion. Evidence-based science has been replaced by marketing science and the concept of “nondiagnostic advocacy” has been lost in the ether. I wish I possessed Randy Lang’s erudition and Will Rogers’ wit. His recent editorial on a specific orthodontic band of dubious value beyond the strength of its market ing showcased the fact that even amongst those whose focus is narrow rowed by a specialty, a segment can be catalysed through market forces to recognise something as the holy grail, when another faction sees the same product as having the value of a Gwyneth Paltrow GOOP-substantiated cleanse.

In my own area of interest, a recent article by one of the better-known clinicians questioned the value of the wealth of new endodontic products coming to market, especially the latest NiTi iteration that reintroduced reciprocation. The essence of the article was, “if it ain’t broke, don’t fix it”, which then included the take away message that the product long associated with the reputation of the author had served the discipline well and it too required only a purdity of instruments to achieve 100 per cent predictable clinical success.

To bring this to a purposeful conclusion, I would encourage you to Google Bayes’ theorem. It is in essence an equation and dependent upon whether you are a objectivist, the theorem suggests that if we assign some a priori probabilities and then compute the degree of confidence in some hypothesis can be conditioned upon their need to see viable applications and substantiated results. It is a technology that will inevitably prove to be an invaluable tool, albeit currently in its infancy.

Read all publications with extreme caution – think HealOzone. Dentistry is getting very complicated as technology and innovation alter its construct. The one essential aspect that must never be overlooked is the need to sustain biological fundamentalism through assiduously conceived investigations and authorship that follows the Cochrane Collaborative principles. We are about to enter a decade wherein it is manifestly conceivable that teeth can be regenerated or replicat ed and achieve morphological and functional integration into the gnathostomatic apparatus. While it may not impact on the $4 billion a year whitening arena of oral services, it will impact on many others. The number of rubber dam hazard articles may well breach the levees and flood gates and overwhelm the profession, decimating the landscape and relocating the populace. It is Oral Health’s job to stand on guard:

“Oh Canada, to stand on guard for thee”.

References

About the author
Dr Kenneth S. Serota graduated from the University of Toronto in 1975 and was awarded the George W. Sterner Memorial Key for Excellence in Prosthodontics. He received his Certificate in Endodontics and Master of Medical Sciences degree from the Harvard-Forsyth Dental Center in Boston. A recipient of the American Association of Endodontists Memorial Research Award for his work in nuclear medicine screening procedures related to dental pathology, his passion is education, and most recently e-learning, and rich media. Dr Serota presently interview, endodontic programme for the Ontario Dental Association from 1985 to 1997 and was awarded the ODA Award of Merit for his efforts in the provision of continu ing education. The author of more than 80 publications, Dr Serota is on the editorial board of Endodontic Practice, Endo Tribune and Implant Tribune. He founded ROOTS, an on line educational forum for dentists from around the world who wish to learn cutting-edge endodontic therapy, and recently launched IMPLANTS (www.implants.com) and www.id -sntail.org in order to provide dentists with a clear understanding of the endodontic-implant algorithm as foundational dentistry.

R4 Practice Management Software 
GIVES YOU MORE
AND KEEPS ON GIVING
CONSTANTLY IMPROVING
CONSTANTLY DEVELOPING
CONSTANTLY DELIVERING

More features, More benefits, More time, More support, all of which can help you achieve More patients and More profits

...and there’s still more to come

For more information or to place an order please call 0800 169 9692
email sales.uk.csdi@carestream.com or visit www.carestreamdental.co.uk
Carestream Dental
© Carestream Dental Ltd., 2012.

0800 169 9692

email sales.uk.csdi@carestream.com

carestreamdental.co.uk

FEATUReS OF R4
R4 Mobile
Direct link to PIN pad
Patient Check-in Kiosk
Care Pathways
Communicator
Steritrak
E-Forms
Patient Journey
On-line Appointment Booking
Text Message and Email reminders
Clinical Notes
Appointment Book
Digital X-Ray
Managed Service
Practice Accounts
Biodentine™

... is the first all-in-one, biocompatible and bioactive material to use wherever dentine is damaged

![Biodentine Probe](image)

For crown and root indications
Helps the remineralisation of dentine
Preserves pulp vitality and promotes pulp healing
Replaces natural dentine with the same mechanical properties


## An in-vitro study

James Prichard discusses the effect of ultrasonic irrigation variables on the dimensions of artificial root canals

**Fig 1**

**Fig 2**

**Fig 3**

**Aim:** To investigate the effects of power setting, type of irrigant and duration of ultrasonic irrigant agitation with Irrisafe™ on the mean percentage change in the cross-sectional area and diameter of artificial root canals in an in-vitro model.

**Methodology:** Twenty-five extracted anterior human teeth were collected and split into two halves, each of which was embedded in epoxy resin. The external root surfaces were polished to produce flat, smooth dentine surfaces. A pilot score was used as a guide to prepare an artificial canal using rotary instruments to a size 30/.06. The root canals were randomly assigned to five groups. Group 1: irrigation with 2.5 per cent NaOCl, ultrasonic agitation at power setting 7 (n=5); Group 2: irrigation with 17 per cent EDTA, ultrasonic agitation at power setting 7 (n=5); Groups 3, 4, and 5 were irrigated with 2.5 per cent NaOCl, 17 per cent EDTA, 2.5 per cent NaOCl, with ultrasonic agitation at power setting 4 (n=5), 7 (n=5) and 10 (n=5) respectively. Irrigant was delivered with a syringe and ultrasonically agitated with a P5 Satelec® and Irrisafe™ tips. Canal area and depth were measured at 17, 16 and 9mm from the canal orifice at baseline and after one, two and five minutes of ultrasonic agitation.

This study came about as a result of a presentation that Chris Stock, Godfrey Cutts and I made to Prof Kish Gulabivala. We showed him a protocol for shaping and then cleaning root canals using Irrisafe. He announced that all steel instruments and tips remove dentine and cut root canals, so I set out to prove him wrong!

I would like to express my thanks to Prof Gulabivala for the idea behind this project and the incredible opportunity he afforded me.

**Contemporary endodontics falls into three distinct categories:**

1. **Preparation** (mechanical shaping)
2. **Irrigation** (syringe flushing and adjunctive cleaning)
3. **Obturation** (sealing the root canals in three dimensions)

The existence of several morphologically different microorganisms was shown to be associated with necrotic pulps as early as 1984 by W.D. Millar. Bacteria in the root canal system has been shown to cause apical periodontitis in gnotobiotic rats (Kakehashi et al. 1965). Sundqvist demonstrated that 18 out of 19 traumatised but intact teeth associated with periapical radiolucencies gave positive bacterial cultures (Sundqvist 1975).

Schilder (1967) suggested that the root canal be cleaned and then shaped to allow for three-dimensional obturation. However, at least 58 per cent of the root canal surface could remain uninstrumented during root canal treatment (Peters et al. 2001) and 70 per cent more debris remained following instrumentation when compared with instrumentation and irrigation (Baker et al. 1975). Furthermore the landmark studies of Byström and Sundqvist (1981, 1983) demonstrated a 100-1000 fold decrease in bacterial counts when 0.5 per cent Sodium Hypochlorite (NaOCl) was introduced instead of saline. Therefore it has generally been accepted that a chemo-mechanical approach to root canal debridement is required to significantly reduce the bacterial load that may encourage more...
predictable healing.

The role of root canal preparation has therefore undergone a shift from one primarily fulfilling a debriding function to one regarded more as establishing radicular access to the complex root canal system, for irrigation and obturation (Gulabivala et al. 2005).

Root canal irrigants should be biologically compatible, chemically able to remove both organic and inorganic substrates, be antibacterial, demonstrate good surface wetting, have no adverse effects on remaining tooth structure and be easy to use and effective within clinical parameters (Gulabivala et. al 2005).

Penetration of irrigants into the root canal is a function of irrigating needle diameter in relation to preparation size (Ram 1977), and placement of the needle closer to the working length increased the efficiency of irrigation (Abou-Rass & Piccinino 1982, Sedgeley et al. 2005).

Improvement of the efficiency of irrigation especially in the apical third of the root canal system has been attempted by agitating the irrigant. The use of hand-files, pumping of well adapted GP cones (manual dynamic), continuous irrigation during rotary instrumentation and sonic and passive ultrasonic devices have all been described (Gu et al. 2009).

Richman first described the use of ultrasonics in endodontics in 1957. Endosonics was a term first described by Martin and Cunningham (1984) and referred to the simultaneous preparation and irrigation of root canals. Passive ultrasonic irrigation (PUI) was first described by Weller et al. (1980) and relates to the non-cutting action of the ultrasonically activated file. The free movement of the file or wire allowed irrigant to penetrate more easily into the apical part of the root canal (Krell et al. 1988).

However significant problems were encountered with k-files as they produce irregular shapes and apical perforations (Stock 1991, Lamley et al. 1989). Straighten canals (Chenail & Teplitsky 1985, 1988) and ledge simulated root canals (Al Jadaa et al. 2009).

IrrisafeTM (from Acteon UK) is a stainless steel instrument that is non-cutting, parallel sided and available in two lengths (21 and 25 mm) and two tip sizes (ISO 20 and 25) and designed to be used after root canal shaping is complete to agitate freshly delivered irrigants.

It can be pre-bent in curved canals and introduced to 1mm short of the working length. It should fit loosely within the prepared canal shape so that the movement of the irrigant around the tip is uninhibited and the tip can vibrate freely. Once inserted, the power is activated and the violent movement of the irrigant “scrubs” the walls of the canal thereby implying the effective removal of dentine debris, micro-organisms (biofilm and planktonic bacteria) and organic tissue from the root canal (van der Sluis 2007).

The technique requires that the NaOCl irrigant is delivered in...
Key features of IrriSafe

- Driven by the Newton® range of piezoelectric generators, IrriSafeTM generates micro-cavitation and micro-currents that spread through the canal system. It is the best instrument for the passive ultrasonic irrigation currently available.

- The irrigant effect is amplified not only by the mechanical activation provided by the vibration, but also by the heating effect of the ultrasonics, that intensifies the sodium hypochlorite solution and debridement properties.

- Non-cutting edges to prevent any damage to the root canal anatomy.

- IrriSafe is more efficient than smooth wires, because its loops generate turbulences and optimize the irrigant activation.

- The blunt-end prevents perforation to the apex or to the canal walls.

- The special steel benefits from a specific surface treatment that provides the instrument with a better resistance and transmission of the ultrasonic vibrations and a complete compatibility with sodium hypochlorite, versus nickel-titanium ultrasonic wires.

Godfrey Cutts and I run an annual two-day endodontic re-treatment course, throughout which we also use Acteon’s Endo Success Kit. This ultrasonic tips kit has been designed as solution for the problems most often encountered during non-surgical endodontic treatments. The new titanium-niobium alloy allows optimum use of ultrasound in the trickiest situations.

The current trend in surgical techniques is to offer minimally - or even non- invasive protocols. By using an operating microscope, together with high-tech micro-instruments, it is now possible to treat the entire root canal.

5ml bolus via a syringe fitted with a side vented needle and then IrriSafe™ is inserted and activated for 20 seconds. This is repeated three times. In oval canals the tip can be moved towards the walls (avoiding contact dampening) to encourage fluid movement into these areas.

Ideally EDTA liquid is then inserted and agitated for a further 20 seconds before a final flush of NaOCl is performed.

The canal(s) can then be dried and obturation carried out according to preference.

The results of the study. The mean percentage change in cross-sectional area and diameter in descending order were: Group 2 - 52.7 per cent and 26.2 per cent; Group 5 - 42.6 per cent and 25.8 per cent; Group 4 - 25.2 per cent and 9.4 per cent; Group 3 - 14.8 per cent and 5.1 per cent; Group 1 - 6.5 per cent and 3.8 per cent. Linear regression analysis of the data from Groups 1, 2, 4 and 5 revealed that canal dimensions were significantly affected by irrigation regime (p=0.009), coronal-apical level (p=0.009) and duration of irrigant agitation (p=0.0001). Analysis of the data from Groups 5, 4 and 5 revealed that both coronal-apical level (p=0.009) and duration of agitation of the irrigant (p=0.0001) significantly affected the increase in canal dimensions.

Conclusions: The test model established that there is a clinically insignificant change in root canal dimensions when manufacturer’s instructions were followed (Group 4). Irrigant choice and combination, duration of agitation and coronal-apical level all had a significant effect on the dimensions of the artificial root canal.
You’ll never look at toothpaste the same way again...

Introducing Oral-B PRO-EXPERT
One toothpaste with the benefits of many.

The first and only toothpaste with a breakthrough formulation of stabilised stannous fluoride and polyphosphate. The combination amplifies its antimicrobial, anti-sensitivity and acid erosion benefits. 15 years of research and over 70 clinical studies have helped validate this latest toothpaste innovation.

To learn more, visit us at www.oralb.co.uk/professional
I n early April, every prac-
tice in England and Wales
with a GDS contract or a
PDS agreement receives its
Annual Reconciliation Report
(ARR). It is a statutory duty of
the contract holder to submit
a completed ARR to the PCT/
LHB by 51 May.

The ARR is the corner-
stone in the process of iden-
tifying the pensionable pay of
the dentists at the practice. It
is this pensionable pay that
will eventually determine the
amount of the NHS pension
for each dentist. It is therefore
essential that the ARR is accu-
rately apportioning the pen-
sionable pay available at the
practice amongst its dentists
who are members of the NHS
Pension Scheme (NHSPS).

The ARR requirements
were introduced in 2006. The
new dental contract trans-
ferred the responsibility for
pensionable pay from the
Business Services at East-
bourne to the individual
practice. It is fair to say that
both the pension regulations
and the guidance given by
Business Services in relation
to the ARR were not fit for
purpose. As a result the den-
tal profession endeavoured
to complete the ARR as best
it could. No unified approach
was adopted and many dif-
verse, mainly incorrect, com-
plications occurred.

The Pensions Agency, Busi-
ness Services at Eastbourne,
the BDA and NASDAL (Na-
tional Association of Specialist
Dental Accountants and Law-
yers) became aware of the es-
calating problems arising with
the ARR. Over many months,
discussions have taken place
between the organisations, which have resulted in clearer
Guidance Notes to accompany
the 2011/12 ARR.

The main issues and prob-
lem areas that were identified related to
• The adoption of a common procedure of ARR completion
• The correct allocation of the practice’s pensionable pay amongst the dentists at the practice
• What constituted an associ-
ate’s pensionable pay
• In the case of a practice that had incorporated what con-
stituted the pensionable pay of the director/shareholders, particularly in a limited company with mixed (NH and private) income

As a result of the discus-
sions, the Guidance Notes
for the 2011/12 ARR now give
much more comprehensive
guidance as to the correct
completion of this year’s ARR.

The correct procedure for
completing the ARR and the
allocation of pensionable pay
is now as follows
Step 1
Calculate 45.9 per cent of the achieved GDS/PDS contract value. This identifies the maximum pensionable pay available to the practice and is a ceiling that cannot be ex-
ceeded when the pensionable
pay is distributed amongst the
dentists at the practice who
are members of the NHSPS.
Step 2
Identify any dentists at the
practice who are not members
of the NHSPS such as
• Dentists already in receipt
of their NHS pension
• Dentists who have opted out of
the NHSPS

Step 3
Calculate 43.9 per cent of the achieved GDS/PDS contract value. This identifies the pensionable earnings ceiling
• Declare the pensionable pay of the associates. This is the actual net amount paid for GDS/PDS work undertaken in the pension year ending at 51 March
• The declared pensionable pay of the associates is de-
donated from the pensionable pay ceiling. If the practice has
any dentists identified in Step 2 their earnings are also de-
donated from the ceiling
• In the case of a sole prac-
titioner the balance remaining represents the pensionable pay of that sole practitioner
• In the case of a partnership the balance remaining can be allocated between the partners in any proportions provided by the partnership agreement

The total pensionable pay
allocated to the dentists work-
ing at the practice cannot ac-
ceed the pensionable pay ceil-
ing identified in Step 1. If there
is working at the practice a
non-pensionable dentist iden-
tified in Step 2 then the de-
dered pensionable pay on the
ARR will fall short of the ceil-
ing by the amount earned by
the non-pensionable dentist. It
is unlawful for this shortfall to
be allocated to other pension-
able dentists at the practice.

If the practice employs a
dentist then the amount of
that dentist’s basic NHS salary
constitutes its NHS pension-
able pay and must be deducted
from the pensionable earnings ceiling to arrive at the balance available to the sole practi-
tioner or partners.

Limited company
Where a practice has incor-
porated and the limited comp-
y company holds the GDS contract
or PDS agreement, the limited company is required to com-
plete an ARR as the provider. The process involved for the
company is exactly the same
as for a sole practi-
tioner or partnership. The point
that the balance of the pen-
sionable earnings ceil-
ing has been determined. At
this point the pensionable pay
of the director/shareholders
who are active NHSPS mem-
ers is the amount that
is eventually paid under that
guidance as to the correct
completion of this year’s ARR.

The Pensions Agency had
identified that one of the main
problem areas with earlier
ARRs was the underestimation
of the pensionable pay of some
5,000 associates. The Guid-
ance Notes with the 2011/12
ARR now clarifies the position in that any associate’s pension-
able pay is the amount paid
to the associate for GDS/PDS work undertaken. It there-
fore does not matter about the
terms of the individual associ-
ations.

In November 2011 new
legislation was enacted. As a
result of this legislation, it is
likely that there will be ma-
jor changes in the 2012/13
ARR which will further safe-
guard the pensionable pay
position of associates. In the
meantime, the 2011/12 ARR
and its guidance notes are a
considerable improvement
upon earlier versions and should ensure a more accu-
rately pensionable pay alloca-
tion to dentists involved.

About the author
David Paul is a Chartered Account-
ant and a member of the National
Association of Specialist Dental Ac-
countants and Lawyers. He is on
the editorial panel of NASDAL’s
supremacy committee and has played a key role in resolving
issues associated with the ARR. He
can be contacted on 01204 779000, or
d.paul@grahampaul.com. Or to find a
NASDAL member in your area, go to
www.nasdal.org.uk.

‘It is fair to say that both the pension regulations and the guidance given by Business Services at Eastbourne in relation to the ARR were not fit for purpose’

Safeguarding pensionable pay and the ARR
David Paul discusses the Annual Reconciliation Report for pensions

Failure to meet necessary requirements may result in a void dividend with unwelcome tax consequences
The Ninth Clinical Innovations Conference 2012
Preparing your practice for the future

The Clinical Innovations Conference has become a major event in the dentistry calendar. Now in its ninth year, this established event gives participants a chance to hear from world-class speakers from around the globe who will be presenting a host of lectures and live workshops. The event looks set to be inspirational and motivating for all involved.

This year the conference will be held in the Millennium Gloucester, Kensington in London on Friday 18th and Saturday 19th of March 2012. With a varied schedule throughout the conference, participants will have an opportunity to understand and learn how to apply the latest aesthetic developments through practical experience, and to attain treatment tips that can immediately be introduced to everyday practice.

The conference meets the GDC’s educational criteria and delegates who attend both days will gain 14 hours of verifiable CPD certified by Smile-On Ltd. The event is not just an opportunity to gain priceless experience but a chance to encounter experienced speakers. Confirmed speakers for the conference are:

Professor Barghi is head of the aesthetic dentistry division in the Department of Restorative Dentistry at the University of Texas, San Antonio. He has presented over 650 educational courses and empiric workshops in more than 30 countries and written over 250 articles. He is a member of the American Academies of both Esthetic Dentistry and Fixed Prosthodontics, and the International Association for Dental Research.

Dr Chan is a teeth whitening specialist who has conducted research which has led to the granting of five UK patents. He has developed protocols that improve the safety, predictability and efficacy of teeth whitening procedures. A prolific author on this subject, he is responsible for a chapter in the new Quintessence manual “The Art of Treatment Planning.”

Dr Kahan is a Harley Street specialist and the senior visiting lecturer on endodontology at the Eastman Dental Institute. A highly regarded lecturer nationwide, his other interest is dental IT integration, and he has recently created EndoBiz, a clinical software programme.

Professor Gambarini has lectured in universities all over the world and is the author of or has contributed to hundreds of books and articles. He has been the keynote speaker at major national and international endodontic congresses, including...

---

Dental Web Design • Bespoke Web Development • Search Engine Optimization
(+44) 08 444 993 888
MediMatch Media Solutions, Unit A, Orion Business Park, West Ealing, London, W13 9SJ, www.medimatch.co.uk
SOPRO LIFE
DIAGNOSIS & TREATMENT

A patented new fluorescence technology which allows you to ‘see the invisible’ – detection of occlusal or interproximal decay, even in its earliest stages, which is often missed by X-rays. The fluorescence images produced in treatment mode show a differentiation between healthy and diseased tissue, while images can be compared under white light in daylight mode. All images can be evaluated with magnification of 30x to 100x and work seamlessly with Sopro Imaging software.

For a limited time only, get the USB Dock Station (shown right) absolutely FREE when you purchase the SoproLife.

For further information:
01480 477307

info@acteongroup.co.uk | sales@acteongroup.co.uk | www.acteongroup.com

EVENTS

Dr John Moore is a private GDP from Plymouth in Devon who uses Cerec for all his cosmetic smile makeovers. For eight years John has developed Cerec techniques and taught other dentists how to benefit from Digital dentistry. John became an BCD Cerec Trainer in Dubai in 2007 and with his brother Dr Paul Moore in Galway, has had articles published.

Dr Ajay Kakar, Periodontist and Implantologist, in private practice in Mumbai is the current Secretary of the IAACD and the Vice President of the International Academy of Periodontology and a member of the IDO, his creations created a decade ago are the forerunners of the internet and Indian dentistry.

Basil Mizrahi graduated from the University of the Witwatersrand, South Africa. After qualifying with an MSc in Dentistry, he left South Africa to specialise in prosthodontics and Implant dentistry at Louisiana State University, USA. Basil is fully recognised by the General Dental Council as a Specialist in Prosthodontics and Restorative dentistry. He operates a full time referral private practice as well as running hands-on “Advanced Aesthetic and Restorative Dentistry” courses. Basil publishes and lectures extensively both nationally and internationally.

Fraser McCord graduated from Edinburgh and spent ten years in a busy general dental practice. He bagged BDS and Part 1 FDS while in practice and then migrated to be a Registrar in Restorative in Edinburgh Dental Hospital for two years when, after passing RDS Part 2. Fraser retired in 2010 but continues to lecture for fun.

Mhari Coxon has 20 years’ experience in dentistry in the UK, in a variety of practice and hospital environments. At present, she works as Senior Professional Relations Manager for Philips Oral Healthcare and clinically as a hygienist. Mhari is a keen writer and is a sought after speaker who has lectured extensively in the UK and overseas.

Apart from the opportunity to listen to experts in the field, there is a chance to debate, participate in question and answer sessions and attend the AOI Clinical Innovations Charity Ball, a great opportunity to relax and network. The AOI Clinical Innovations Charity ball will be held on the Friday evening for the third year running. In 2011 more than 200 people attended and enjoyed a festive occasion of wonderful food and entertainment.

The Clinical Innovations Conference is always well attended. Now it is firmly established, it is valuable for dentists seeking to improve their own practice and performance. Delegates can also be kept well-informed on endodontic progress, enjoying and varied and enlightening event.

For information and to book a place call Smile-on 020 7400 8989 or visit www.clinicalinnovations.co.uk.

Basil Mizrahi
Periodontist and Implantologist
Mumbai

Dr John Moore
Private Dentist
Plymouth

Dr Ajay Kakar
Periodontist and Implantologist
Mumbai

Fraser McCord
Registrar in Restorative Dentistry
Edinburgh

Mhari Coxon
Senior Professional Relations Manager
Philips Oral Healthcare
Professional standards

Glenys Bridges provides a guide to work

Applying the qualities and attributes of professionalism are an essential requirement for all healthcare professionals. In the dental profession standards of professionalism stem from regulations set out in the Dentist Act and Health and Social Care Act. I often meet dental professionals who are aware that they do not wholly meet some aspects of these requirements. Such shortfalls can stem from the practical pressures encountered in day-to-day workplace situations, or from a lack of knowledge and understanding, or from unassertive, unproductive behaviour which fails to focus on goals. This article provides a guide for DCPs who want to become more assertive at work.

Most people are aware that assertiveness is an attribute which enables those who are shy or lack confidence to become more involved. Assertiveness also helps the more extrovert or volatile people to fine tune their interactions with patients, suppliers and colleagues. An assertive person is a positive, resourceful presence in dental team. Therefore an important aspect of professional and personal development should be to avoid unproductive behaviour patterns, in favour of focusing on goals, solving problems and feeling at ease at work.

So how can you start to develop more assertive behaviour patterns? From the outset it is essential to recognise that assertiveness is not about getting your way at the expense of others. Professional assertiveness is about feeling at ease when setting your standards and maintaining them, without violating the rights of others. Here are three basic and essential steps to help you to achieve this.

Listen and show understanding - productive assertiveness is based on good communication skills. This means taking enough time to understand all points of view and vested interests. You may not agree with other people’s views, but goals are most easily met when information gathering clarifies matters and leads to consensus.

Say what you want, how you feel or what you think - this can be more difficult. Manage your state of mind so that it supports you in being assertive. When communicating state the facts, rather than relying on personal opinions alone. Describe your thoughts and feelings about the situation (for example, determined, confident), then go on to clarify your needs (say what you want the other person to do). Always close the conversation by summarising your main points. Finally ensure your make sure you maintain assertive non-verbally communications with steady eye contact, a serious expression and a firm voice with a moderate rate of speech.

Say what you want or what action you want taken - having set the scene you are now at the point where you need to make a clear request. This should be based on the facts, regulations or requirements of the situation. Being assertive is no guarantee that you will achieve the desired outcome, but it dramatically increases the chances.

Recognising the need to develop assertiveness skills is just the beginning. If assertiveness is not naturally part of your character a first step is to model on someone whose assertiveness you admire. To do this think of someone whose assertiveness underpins high professional standards, without unduly antagonising others. This person would make an ideal coach or mentor able to direct and support you by sharing their philosophy, strategies, techniques and thinking patterns.

Register & More Information at:
Contact In Athens:
Tel: +30 210 213 2084, +30 210 222 2637
E-mail: info@omnicongresses.gr
Web: www.omnicongresses.gr
Contact in the US:
www.gide.com
Tel: +1 310 696 9025
E-mail: nena@gidedental.com
website: www.gidedental.com
Media Partner: DENTAL TRIBUNE

www.gide.com

DT

ESTHETIC CURRICULUM
Program Chairs:
Dr. Ed McLaren & Dr. Sascha Jovanovic
Session Chairs:
Dr. Didier Dietschi, Dr. Daniel Edelhoff, Dr. Mauro Fradeani

YOU CAN START FROM THE
2ND SESSION & MAKE UP THE 1ST SESSION
NEXT YEAR IN GENEVA

SESSION I - FEBRUARY 24 - 27, 2012 IN GENEVA, SWITZERLAND
DIRECT RESTORATIONS AND ADHESIVES with Dr. Didier Dietschi and others

SESSION II - MAY 24 -27, 2012 IN ATHENS, GREECE
INDIRECT RESTORATIONS, FULL CERAMIC CROWNS AND VENEERS with Dr Daniel Edelhoff and others

SESSION III - OCTOBER 9 - 12, 2012 IN ATHENS, GREECE
ALL CERAMIC RESTORATIONS AND FIXED PROSTHODONTICS with Drs Mauro Fradeani & Egon Elwe

SESSION IV - DECEMBER 3 - 7, 2012 IN LOS ANGELES, CALIFORNIA
GRADUATING WEEK AT UCLA with Drs. Ed McLaren, Sascha Jovanovic, Brian Lesage Todd Schoenbaum, Pascal & Michel Magne

PROGRAM FEATURES
CLASSROOM EDUCATION
LIVE PATIENT TREATMENTS
CASE PRESENTATIONS
HANDS-ON
90 HOURS SELF-STUDY
217 HOURS CE
2 CERTIFICATES from gIDE and UCLA

Program Fee: 11.900€
Initial deposit payable upon registration EUR 1.000€
1st payment EUR 4.900€, before 5th Jan ’12
2nd payment EUR 3.000€, before 5th May ’12
3rd payment EUR 3.000€, before 25th Aug ’12

About the author
Glenys Bridges is an independent dental team trainer. She can be contacted at glenys.bridges@gmail.com
Continual Disinfection: Alkazyme® continually disinfects the contaminated ‘wash water’ as created within the ultrasonic cleaner.

Economical: Just five grams of Alkazyme® with ordinary tap water makes one liter of enzymic cleaning/disinfecting solution.

Choice of user format: Available from all dental sundry suppliers in both 750g loose powder tub and tubs of 100 easy dose water soluble sachets.

For comprehensive product information visit: www.alkazyme.com

Practise Plan makes a further climb in the Sunday Times Top 100 Best Companies to Work For! For the second year running, and in the second year running, another Bath in the ranking was achieved!

The company attained 30th place in the 100 Best Companies list, which is an improvement of 28 places facing tough competition from hundreds of selected organisations, all battling to gain a high placing in the rankings. To support the company’s appearance in the 100 Best Companies list, the company launched a month long competition to win five family holidays from across the business, including Managing Director Nick Dilworth, down to London to enjoy the black tie awards ceremony at Battersea Evolution and to collect the company’s award. Nick Dilworth gives his thoughts on the climb in the ranking was achieved!

And, as a further cause for celebration, Practise Plan was one of only 113 organisations out of 1082 entrants to successfully achieve Three Star Status in the Sunday Times Top 100 Best Companies accreditation.

The route to successful endodontics

NSK understands that successful endodontic treatment requires precision and attention to detail. NSK range of endodontic handpieces, microtomes, ultrasonic scalers and apex locator, provide clinicians with a superior level of technology, leading to more predictable treatment outcomes. NSK’s ENDO-MATE T2C endodontic microtome is specifically designed for use with 54/61 tips from all major suppliers. This unique, lightweight endodontic microtome delivers consistent torque, reduced vibrations and enhanced memory. It allows you to store up to nine speed and torque settings. NSK’s ENDO-MATE TC2 ultrasonic handpiece has a large tip chamber and delivers a lightweight, economical ultrasonic handpiece and a simple, key less operation ensuring it is easy to use during even the most delicate endodontic procedures. The NBE Ventures NBE (Ultrasonic scalers) provides a patient-friendly and efficient way to meet the challenges of endodontic therapy. And, with a choice of 54/61 tips, it’s tip on and an autoclavable container. Those looking for a more compact and would benefit from either the VARIS 570, or the VARES 370 specifically designed as a portable control unit for easy installation into any dental unit. In addition, the VARIS 370 is available as a wall unit, where all its functions can be controlled via the built-in touch screen.

Contact details for further information: Sirona Dental Systems 0845 071 5040 info@sironadental.co.uk

Stoma wins process of patient infringement Benchim/Baldwin, 26 March 2012

Stoma, the dental technology leader, has won a first instance patent infringement lawsuit against Alera Technologies, LLC. Stoma manufactures the regional centre of Barmstedt granted an injunction against sales of Vahan’s products with infringing ALX technology and unspecified damages for the use of Stoma’s IP.

Stoma is a leading company in the dental industry and it will continue protecting its intellectual property rights globally.

Contact details for further information: Stoma Dental Systems 0845 071 5040 info@sironadental.co.uk

Quality Endodontic Distributors Ltd has launched a new B&L beta and alpha II OEDs® Superb B&L beta and alpha II control obturation devices from the perfect combination

The new B&L beta enables fast and easy delivery of warm sealer material with an endodontic backfill technique, facilitating rapid obturation of even the most difficult root canals. With its new sealer delivery system, compact and easy to handle, it features variable temperature settings, a rechargeable lithium ion battery which supports hours of use from a single charge, and a choice of 25g and 250g cartridges for smooth or improved access. Supplied with three tips, the Superb B&L-alpha II is the ultimate in accuracy and versatility combined with a high-speed contra-angle handpiece and a refurbished cable machine. It features multiple temperature settings (15°C, 25°C and 35°C) to accommodate the dental unit, and a quick heating tip that reaches temperature within 10 seconds. It incorporates a built-in thermocouple that registers the first charge and allows the operator to complete many cases without the need to recharge. Finally it comes complete with a tip, so it is immediately ready to use, with a full range of optional tips available separately. For further information contact: telephone Quality Endodontic Distributors Ltd on 01733 449499, email sales@qedendo.co.uk, fax 01733 561342, visit www.qedendo.co.uk or contact your local QED Salesperson.
Superior digital imaging exclusively from Carestream Dental

The true revolution of digital imaging in dentistry has just begun. Carestream Dental has made the digital revolution available to all. Superior digital imaging, provided exclusively from Carestream Dental, makes digital x-ray systems affordable to practices large and small. The Carestream CS 5300 series provides a breakthrough in ultra low radiation, patient-friendly software and the highest quality and the highest image resolution in the industry (true resolution superior to 400 lines mm – that’s not just a high claim, it’s an industry standard). State-of-the-art WiFi technology allows the user the freedom to operate anywhere in practice, liberty of movement around the chair. With data uploaded within seconds, the practitioner gets the data they need almost instantaneously, saving treatment time.

True revolution of digital imaging allows practitioners to move from the process of taking an X-ray to the process of taking the decision - whether it’s to provide treatment or to refer to a specialist. By allowing the “right” decision to be made, a practitioner is saving time, money and data. And, perhaps most importantly, saving the most important thing of all: lives. The livelihood of an individual can be transformed from one day to the next. The quality and the speed in which an image is captured and sent to the screen is critical to patient outcomes and treatment success. Just imagine the impact that Carestream Digital Imaging can make in your practice.

For more information, please contact Richard Banks, Programme Administrator on 01202 724 942 or visit our website at carestreamdental.co.uk

CPO – UCL Eastman Certificate in Advanced Aesthetic Dentistry
Dr Anna Turo is an associate dentist at Pudsey Dental Practice in Leeds and she recently completed a Postgraduate Certificate in Advanced Aesthetic Dentistry with the UCL Eastman Dental Institute.
“I decided to do the course because I lacked the knowledge to take on more complex cases and I wanted to offer my patients a better smile. It was a huge breakthrough in utilising wireless technology. Direct transfer of data to iPod devices without the need for a computer and thanks to its protective silicone layer. State-of-the-art WiFi technology allows the user the freedom to operate anywhere in practice, liberty of movement around the chair. With data uploaded within seconds, the practitioner gets the data they need almost instantaneously, saving treatment time.

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

The LRP appliance training course
The LRP appliance was born out of the understanding that many patients become acutely conscious that their appearance was not worthy of improvement. This is where the LRP comes in. It is a fixed orthodontic appliance that straightens anterior teeth with minimal discomfort and minimal treatment time. 

For more information, please contact Richard Banks, Programme Administrator on 01202 724 942 or visit our website at carestreamdental.co.uk

Annamay Ga Enorinwe – Teeth Speaker
Annamay Ga Enorinwe is a Ugandan dentist to give oral health education and treatment to Ugandan patients. Dental is working with a team of dentists to set up a dental plantation to travel to rural villages in Uganda. 

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

Annamay Ga Enorinwe – Teeth Speaker
Annamay Ga Enorinwe is a Ugandan dentist to give oral health education and treatment to Ugandan patients. Dental is working with a team of dentists to set up a dental plantation to travel to rural villages in Uganda. 

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

Annamay Ga Enorinwe – Teeth Speaker
Annamay Ga Enorinwe is a Ugandan dentist to give oral health education and treatment to Ugandan patients. Dental is working with a team of dentists to set up a dental plantation to travel to rural villages in Uganda. 

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

Annamay Ga Enorinwe – Teeth Speaker
Annamay Ga Enorinwe is a Ugandan dentist to give oral health education and treatment to Ugandan patients. Dental is working with a team of dentists to set up a dental plantation to travel to rural villages in Uganda. 

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.

For information on admission contact Dr Lester Elson on 07973 875 553 or email: lester@oralige.co.uk Web: www.oralige.co.uk

Annamay Ga Enorinwe – Teeth Speaker
Annamay Ga Enorinwe is a Ugandan dentist to give oral health education and treatment to Ugandan patients. Dental is working with a team of dentists to set up a dental plantation to travel to rural villages in Uganda. 

Amie Mawson – validity of the University’s approach
to oral health education

To carry out general oral health education (DHE) - to enable communities on the dangers and prevention of caries and oral malnutrition (ODM) - to screen children and establish their oral health status - to provide a pain relief service of emergency extraction and atraumatic restorative treatment A sponsored position has been made available for a dentist who wishes to give of his time and expertise.
Something to Smile about...

SmileGuard is part of the QFD Group, internationally renowned for revolutionising the world of custom-fitted mouthguards. Our team is to support the dental professional with the very latest and best protection and thermoformed products available today.

- Full-Fit Mouthguard - the best protection for teeth against sporting and trauma.
- QFDNight - a self-fit guard enabling patients to sleep comfortably.
- NightGuard - the most comfortable and effective way to protect teeth from wear.
- Bracing Way - the simplest and best method for retaining teeth.
- Snoreguard - a totally fitting appliance to improve snoring.
- QFDSafety - mouthguard and tray cleaning tablets.

In 2007 QFDs was awarded the BS 5750:1996 under the QFD's business management system.

Contact to advertise call Joe Ackah on 0207 400 8964

Dental Practice Valuations and Sales

Are you considering selling your practice?

- Independent Valuations
- Professional Sales Agency

Experts in Sales - Body Corporations | Associates | Partnerships

Speak to one of PM's experienced valuers to find out how experience, independence and a personal service can achieve the highest price for your practice and help you with your exit strategy.

For more information contact Marijn Beekhuis or Paul Newman.
T: 01904 672832
E: Marijn.Beechhuis@pmtdental.co.uk or Paul.Newman@pmtdental.co.uk

Website: www.pmtdental.co.uk

STAND OUT FROM THE CROWD

Choose a first class dental specialist accountant, with unrivalled expertise and over 30 years’ experience dealing with:

- Tax Savings – Chartered Tax Advisor
- Buying and Selling a Practice
- Incorporations
- NHS Superannuation
- HMRC Investigations

FREE CONSULTATION

Book your free initial meeting at our Thame office.

WWW.DBS.ORG.UK
01844 260111

Whatever your management role.....

you can find a qualification to benefit you and your practice. UMD Professional’s range of qualification courses are accredited by the Institute of Leadership and Management and provide a practical management training pathway for dentists, DCPs and practice managers.

ILM Level 3 Certificate in Management
designed for senior nurses and receptionists and new managers taking their first steps in management

ILM Level 5 Diploma in Management
for existing practice managers and dentists

ILM Level 7 Executive Diploma in Management
designed for practice managers and business managers, and accredited by the Faculty of General Dental Practice as part of the FGDP Career Pathway

For full details, course dates and venues contact Penny Parry on:
020 8265 2070 penny@umdprofessional.co.uk

www.umdprofessional.co.uk

To advertise call Joe Ackah on 0207 400 8964
Build a layer of protection with Sensodyne

With Sensodyne Repair & Protect you can go further than treating the pain of dentine hypersensitivity. Sensodyne Repair & Protect contains NovaMin® calcium phosphate technology which builds a reparative hydroxyapatite-like layer over exposed dentine and within the tubules\(^1\)-\(^5\).

Starting to form from the first use\(^5\), this reparative layer creates an effective and lasting barrier to the pain of dentine hypersensitivity\(^6\)-\(^8\), with twice-daily brushing.


SENSODYNE, NOVAMIN and the rings device are registered trade marks of the GlaxoSmithKline group of companies.