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 commutation” 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 practice 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.

Regulator decreases fees for some location bands

A sweet diet...
A new study has identified that people who eat chocolate regularly are slimmer than those who do not. Although due findings do not state that eating chocolate will help you lose weight, lead author Dr Beatrice Golomb, an associate professor at the University of California, San Diego, said in a report that she hopes, through further research, to better understand what’s going on. In the study, Golomb and colleagues reviewed food questionnaires filled out by nearly 1,000 people who were asked about how often they ate chocolate. The researchers then tried to find any connections between chocolate consumption and the body mass index (BMI) of the participants. The study found that those participants who regularly ate chocolate had a lower BMI than the other participants. The results were even the same when the researchers adjusted their statistics, so the participants were not affected by age. Although due fruit and vegetable consumption, the study does not say that chocolate consumption will help people lose weight.

One smiley school
With National Smile Month only a matter of weeks away, St Marie’s Catholic Primary School and Nursery are showing off their ‘Smileys’ as part of the campaign, organised by the British Dental Health Foundation. On Friday 50 March the school had a dental theme for the day, “It is always a pleasure to hear about schools taking part in National Smile Month, and St Marie’s is no exception”, Dr Carter said. With around eight or nine children in every class already suffering from tooth decay in primary schools across the UK, National Smile Month is the perfect opportunity to discuss and promote oral health.

Born in 1977, National Smile Month has coincided with some major improvements in oral health levels in the UK. Taking place from 20 May to 20 June 2012, it is the UK’s largest and most successful oral health campaign. With the help of more organisations raising the importance of oral health, Chief Executive of the Foundation, Dr Nigel Carter, believes further advances can be made. To register for your free ‘Smileys’ visit www.smileymonth.org.uk for further tips and ideas of how to get involved.

www.dental-tribune.co.uk
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 £47bn 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 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, as 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 U.K. 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, develop 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.

NASDAL comments on the Budget

High earning dentists will be required to contribute following the announcement by Chancellor George Osborne that the 50 per cent income tax rate on earnings over £150,000 will reduce to 45 per cent from April 2013. This could be off-set, however, if they are buying or selling very high earning dentists will have reason to celebrate following the announcement by Chancellor George Osborne that the 50 per cent income tax rate on earnings over £150,000 will reduce to 45 per cent from April 2013.

The main rate of corporation tax is going to come down which will also benefit higher earning dentists who have incorporated and who earn more than £500,000. For most of the profession, however, the tax position will remain unchanged in the years ahead.

Alan Suggett, Chartered Accountant of UNW LLP media office for NASDAL, welcomed the announcement that the Chancellor is going to introduce tax avoidance legislation – known as an anti-abuse rules - in next year’s finance bill: “Dentists will be aware of tempting schemes for reducing tax which sound too good to be true and are usually to be avoided. The new legislation will stop the ultra-aggressive and contrived arrangements, eliminating the temptations which will prove to be a good thing as they usually come to regret having entered into them.”

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!

George Osborne’s third budget speech, which took 58 minutes, two minutes longer than the previous year, was the second shortest in 150 years.

Key changes:
• The top rate of income tax of 50 per cent on over £150,000 will reduce to 45 per cent from April 2013
• The main rate of corporation tax will be cut to 24 per cent next year and will fall 22 per cent from 1 April 2014. The small company rate remaining at 20 per cent
• The personal allowance (PA) will rise to £9,205 from 6 April 2015, and age related allowances for pensioners will be phased out over time as the PA increases
• A cap will be introduced on unlimited income tax reliefs for anyone claiming more than £5,000 of relief. The cap on a variety of different reliefs will be restricted to the higher of 25 per cent of income or £5000

ADT implant courses for dental nurses

Due to the resounding success following the launch of the ADT Dental Nurses’ Course last year, the ADT is continuing the Original Dental Nurses’ Course for 2012 and has created an Advanced Dental Nurses’ Course.

The Original One-Day Course on Dental Implants for Dental Nurses aims to increase the understanding of dental implantology to dental nurses. The course caters for the inexperienced dental nurse, offering nurses the knowledge and confidence to support the operator with surgical implant placement and subsequent restorative appointments.

The Advanced One-Day Course entitled ‘Surgical Dental Implant Procedures for Dental Nurses’ has been created for dental nurses who are experienced in assisting with implant placement or have completed the Original One-Day Course.

The course aims to examine the dental nurses’ role in assisting with advanced surgical procedures in implant dentistry. Upon completion, nurses will recognise the instruments required, the process and the indications for each of the procedures.

The courses are located in London and Edinburgh. Both courses are booking up fast, with the first 2012 London date for the Original Nurses’ Course already full. For more information visit www.adt.org.uk or call the ADT on 020 8487 5555.

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 under graduates, and compared the levels of gum disease between students who were classified as overweight, normal weight and overweight.

The study found that students classified as overweight, that regularly ate fatty foods and rarely ate vegetables, were at an increased risk of gum disease likely to result in tooth loss. Students classified as overweight or normal weight were not exposed to the same risk. The study also suggested that young people who were overweight, but frequently ate vegetables were less likely to suffer from severe gum disease.

The findings are food for thought for around 450,000 students who start university in the UK each year. Current estimates suggest that over one in four young people aged 16-24 are classified as overweight in the UK, and potentially at greater risk of gum disease and tooth loss.

Chief Executive of the Foundation, Dr Nigel Carter, said: “Starting University is an exciting time for every student, but perhaps not for their oral health.

“One of the key ingredients to good oral health is a balanced diet, something which many people who have gone through university will admit to foregoing.

The myth about the higher cost of healthy eating is one the RDHF believes must be overcome in order for good habits to become the norm. Carter believes there’s a perfect opportunity around the corner to do just that.

“National Smile Month is an ideal opportunity for colleges and universities to urge students to think about what they’ve eaten throughout the semester and how they can put it right not just during the campaign, but ensure that a good, balanced diet remains part of their lifestyle.

“Whether it’s a healthy can of beans on campus grounds or an initiative from one of the many dental schools, promoting a better diet to combat weight problems and improve oral health can make a difference.”

National Smile Month, which runs from 20 May to 20 June this year, has an annual reminder to look after their oral health. The campaign encourages everyone to brush their teeth twice a day with a fluoride toothpaste, cut down on how often they have sugary foods and drinks and to visit their dentist regularly - as often as they recommend.

£4m for innovative solutions to tackle healthcare problems

Innovators are being invited to enter one of two 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

Overweight students are at risk of severe gum disease likely to result in tooth loss according to a recent study. The campaign encourages everyone to brush their teeth twice a day with a fluoride toothpaste, cut down on how often they have sugary foods and drinks and to visit their dentist regularly - as often as they recommend.
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.

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.
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 alcohol 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
- Asda, Morrisons, Sainsbury’s, Tesco, Waitrose, Coca-Cola Great Britain, Kerry Foods, Kraft, Mars, Nestlé, PepsiCo, Premier Foods, Unilever, Beekeeper (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 in 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, Marks & Spencer, Morrisons, Sainsbury’s, Tesco, Waitrose, Coca-Cola Great Britain, Kerry Foods, Kraft, Mars, Nestlé, PepsiCo, Premier Foods, Unilever, Beekeeper (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.

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.

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 staphylococci 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 on 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

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 Wimbslow Half Marathon in a bid to raise money for Smile Train.

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.

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 Oldham - has set his sights on running the Wimbslow Half Marathon in a bid to raise money for Smile Train.

To contribute visit: www.justgiving.com/GregPaysden

Formed in 1999, 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 80 of the world’s leading doctors and medical professionals in one third of their sales by the end of 2013

Heath Secretary Andrew Lansley said: “Eating and drinking makes it easier for shoppers to make the switch to 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

Talk 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.”
National Conference on CPD in dentistry

The General Dental Council (GDC), is holding a national conference 17 April 2012 focusing on the role of Continuing Professional Development (CPD) in dentistry.

Bringing together a wide range of speakers from across the four countries of the UK, the event will consider the themes of:

- CPD and professionalism
- Effectiveness of CPD in dentistry

KwickScreen wins prestigious prize

KwickScreen has won the best start-up business at the Lloyds TSB enterprise awards. In their newsletter, a spokesperson for KwickScreen said: “It really is a great honour to win such a prestigious prize and we are grateful for everyone’s support along the way. We only started selling the KwickScreen just under two years ago and now we have been adopted by more than 40 NHS trusts.

“Thank you everyone for your continued support, it really means a lot to us.”

A KwickScreen helps provide infection isolation, improve privacy and dignity and can be even be personalised thanks to a method which means any design can be printed on the screen. According to the KwickScreen newsletter, several hospitals have brought the screens to hide unsightly equipment and to brighten up the hospital environment for both patients and staff.

The Lloyds TSB Enterprise Award was set up to show that Lloyds TSB is committed to the small and medium sized business market. It is also a way of helping to encourage new start-ups and enterprises.

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.

Using LISTERINE® after mechanical cleaning destroys oral bacteria effectively, killing up to 97% in vivo. This lowers the bacterial burden in the mouth and in plaque that reforms. And when used for 6 months, LISTERINE® can reduce plaque levels by up to 52% more than brushing and flossing alone. 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:
1. Barnett ML. JADA 2006; 137: 16S-21S.
2. Data on file FCLGBP0023+28, McNeil PPC.
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The Kwikscreen

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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 80 per cent of dental surgeries across the country over 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.

The statistics reflect the fee income of both NHS and private practices. To fit in either category, you must have a greater commitment in the dental field. The statistics are gathered from a sample of practices across the UK to provide average ‘state-of-the-nation’ figures. They are used by NASDAL accountants to help dentists and dental practices benchmark their figures. A limited version of the statistics is made public at an annual press conference to produce a snapshot of dental practice finances across the country over recent years.

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 2005/0 levels.

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 2005/0 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 £23 over the last three years. While the highest UDA rate paid to a practice was around £44, the highest to an associate was £55.50.

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.

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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

18th and 19th May 2012
Millennium Gloucester Hotel & Conference Centre, London Kensington
info@smile-on.com | www.clinicalinnovations.co.uk | 020 7400 8989

EARLY BOOKING DISCOUNT
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 (£9205 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 staggering seven per cent. On a purchase of £2 million the amount of Stamp Duty paid will be roughly equivalent to the average UK house price (£140,000). Whilst relatively few dentists will be affected by this it may set a precedent for future increases to stamp duty at a lower threshold.

The Personal Allowance will increase to £9,205 from April 2015, benefiting those with income under £100,000. If you pay your spouse and have previously set their salary in line with the personal allowance you should revisit this. However the level of income at which National Insurance is paid should also be considered. The increase to the personal allowance will unfortunately be partially offset by the decrease in the threshold for income tax rate levied on the slice of income between £300,000 and £1.5 million, known as the ‘marginal rate’, will fall. Practices considering incorporating contrived or artificial schemes. Dentists considering non-standard ways to avoid income tax should exercise caution as such schemes may well be subject to future legislation. If you are part way through a tax avoidance scheme when the loophole closes this can be hugely problematic.

There was a slight softening of the proposed Child Benefit reduction, with the much vaunted ‘cliff edge’ being raised to £60,000 from January 2015 and a phasing in of the cut for those with income more than £350,000. As many dentists earn in excess of £60,000 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. The ‘smaller profits’ rate has already fallen (as per previous budgets) to 20 per cent, for companies with profits under £300,000. It is this rate that will be applicable to many incorporated dental practices. The good news is that corpora
tion tax rate levied on the slice of profits between £300,000 and £1.5 million, known as the ‘marginal rate’, will fall. Practices considering incorporation should discuss the impact of this with their accountant.
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 raise 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, whoever 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
- A ‘poor performance’

The World’s First Online
MSc in Restorative & Aesthetic Dentistry

Two of the UK’s most respected education and academic organisations have joined forces to provide an innovative, technology driven MSc in Restorative and Aesthetic Dentistry. Smile-on, the UK’s pre-eminent healthcare education provider and the University of Manchester; one of the top twenty-five universities in the world, have had the prescience to collaborate in providing students with the best of everything – lecturers, online technology, live sessions and support.

Convenience
The majority of the learning resources on this programme will be online. The masters will combine interactive distance learning, webinars, live learning and print.

Ownership
The programme is designed to encourage the student to take responsibility for his/her own learning. The emphasis is on a self-directed learning approach.

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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 summed up as follows:

• The duty to put patients’ interests first and to 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

‘Endodontic surgery has evolved to become a technically accurate, highly predictable procedure with remarkable success rates’

1 Root canal retreatment through the crown

2 Endodontic microsurgery

3 Extraction +/- prosthetic replacement

None are the days of the clumsy apicectomy and amalgam retrograde fillings. Endodontic surgery has evolved to become a technically accurate, highly predictable procedure with remarkable success rates.

Implant technology has meant many teeth of questionable prognosis are extracted in the name of future predictability. While implants have been a wonderful adjunct in the dental armature, our primary role as dentists is to try and conserve the existing dentition that have good long term prognosis.

Classically an apicectomy was a treatment of last resort, using large bulky instruments, rough approximations and excess amounts of amalgam. The biological ramifications of additional canals, cracks, apical deltas and poor initial root canal treatments may have been overlooked resulting in poor success rates. This has understandably resulted in a negative perception of apical surgery amongst the dental profession who erroneously believe success rates to be around 60 per cent when the actual figure for endodontic microsurgery is over 91 per cent after five to seven years (1).

Modern techniques and equipment have transformed the procedure. Using CBCT scans from the outset we can plan surgery exactly; three dimensional picture of bone loss is clear as is the position of anatomically sensitive structures; lengths can be accurately measured and existing treatment such as posts and MB2s assessed.

Radiographic examination (Fig 1) revealed a large radiolucency associated with the UL5. There was an initial root canal treatment and subsequent retreatment provided by a competent GDP using rubber dam and sodium hypochlorite irrigation. There was a well-fitting new crown placed and no associated periodontal pocketing greater than 5mm.

A provisional diagnosis of acute exacerbation of chronic apical periodontitis was made and treatment options discussed with the patient (who had just paid for and was satisfied with a new crown.)

A mucoperiosteal flap was raised with micro-blades that produce neat, precise incisions as they cut in multiple directions. Once the flap was raised, the perforation in the buccal plate was identified and root tip located. The granulation tissue was curettaged and haemostasis achieved.

Following resection of 3mm of the root tip perpendicular to the long axis of the tooth a retropreparation was completed with ultrasonics, then sealed with MTA. The tissues were compressed and the flap closed with 5/0 monofilament sutures that were removed painlessly after 72 hours as reattachment had taken place.

At the four-month review the buccal swelling had completely resolved and radiographically there was significant healing present.

The patient was delighted with the outcome of treatment.
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 the PDL makes it easier to differentiate between bone and root tip. The smaller the size of the osteotomy, the quicker the healing (2).

2. Bevel Angle
Traditionally the root was resected at 45 degrees for access, visualisation and sealing purposes. But, this method results in the exposure of a 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 root.

Fig 4 Soft tissue removed

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

Fig 6 Soft tissue sent for histological investigation

‘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’

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the roots.

3. Root end resection
It is recommended to remove 3mm of the root tip. At this level 88 per cent of apical ramifications and 95 per cent of lateral canals are removed (5). Following resection it is critical that the root end is 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-EBA 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)

About the author
Dr Daniel Flynn BDS, MDent Sc, 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.

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

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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 57 and an orthopantomogram (OPG; Figs 1 & 2).

Although the radiograph did not show the full anatomy of tooth #57 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 #57.

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 nervus 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 37 functioning as cantilevers.

Tra-oral examination showed a well-restored dentition with a cantilever bridge on teeth #35 to 37, with #36 and 37 functioning as cantilevers.

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 #57.

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As previously mentioned, the mesial canals were filled with silver cones rather than 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 #37 owing to poor oral hygiene
3. Vertical root fracture (VRF) of the distal root of #37

As diagnosis 1 and 3 would require a more invasive therapy (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 radiolucenty 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

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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.

Today, 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.

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...
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 it was then time to reshape the canals and retreat the distal canal (Fig. 3). 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 55.04 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 Vo-robeyeva, interpreter and translator, for her help with this article.

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Rubber dam hazards?
Dr Kenneth Serota gives his opinion

The September issue of Oral Health included an article by Dr Ellis Neuburger 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).

Design systematic: Review of randomised controlled trials. Data sources: Medline, Web of Science, Embase, and the Cochrane Library databases; appropriate Internet sites and citation lists.

Study selection: Studies showing 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.

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.

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

Results: We were unable to identify any randomised controlled trials. The abstract reads:

"Objectives: To determine whether parachutes are effective in preventing death and major trauma related to gravitational challenge."

The abstract reads:

Study selection: Studies showing 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.

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Not wishing to misjudge nor malign the author, I searched the many publications attributed to Dr Neuburger in the literature using Google Scholar. My personal favourite was Similar encephalitis oseous lesions in Tyrannosaurus Rex and man, followed closely by Voodoo Barbie and the dental office?

Fig 2

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 plausible 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 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 the hazards of clamp placement, phobias, material residue in pockets anon... even providing a rebuttal to the text gives it a undeserved credibility.
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 marketing showed the fact that even amongst those whose focus is narrowed by a specialty, a segment can be castigated through market forces to recognize 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 paucity of instruments to achieve 100 percent 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 depending upon whether you are a frequentist, a subjectivist or an objectivist, the theorem suggests that if we assign some a priori probabilities and then compute a posteriori probabilities, the degree of confidence those hypotheses can be conditioned by the new data that becomes available. For example, the Venn diagram (Fig. 2) relates to a population, the number expected to have a type of cancer, the number that are indeed positive for that cancer and the number that show a false positive by virtue of a test for markers. After the variable, consider the efficacy of lasers by way of example, the degree of penetration into the dental profession, the advocacy of those that use them and the perception of the value inherent based 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 HealO-zone. 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 maintain 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 replicated 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 floodgates 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
An in-vitro study

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

**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 ultrasounds 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. 1983), straightened canals (Chenail & Teplitsky 1985, 1988) and ledged simulated root canals (Al Jadaa et al. 2009).

IrriSafe™ (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

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

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- 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 any 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 a 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’s light either with high-tech micro-instruments, it is now possible to treat the entire root canal.

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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 5.8 per cent. Linear regression analysis of the data from Groups 1, 2 and 4 revealed that canal dimensions were significantly affected by irrigant regime (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 irrigant agitation (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). Irritant choice and combination, duration of agitation and coronal-apical level all had a significant effect on the dimensions of the artificial root canal.
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Safeguarding pensionable pay and the ARR
David Paul discusses the Annual Reconciliation Report for pensions

In early April, every practice 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 cornerstone in the process of identifying 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 accurate in asportioning the pensionable 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 transferred the responsibility for pensionable pay from the Business Services at Eastbourne 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 dental profession endeavoured to complete the ARR as best it could. No unified approach was adopted and many diverse, mainly incorrect, completions occurred.

The Pensions Agency, Business Services at Eastbourne, the BDA and NASDAL (National Association of Specialist Dental Accountants and Lawyers) became aware of the escalating 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 problem 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 associate’s pensionable pay
- In the case of a practice that had incorporated what constituted the pensionable pay of the director/shareholders, particularly in a limited company with mixed (NH and private) income

As a result of the discussions, the Guidance Notes to 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 exceeded 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
- Associates who are incorporated and who cannot pension their income with effect from 7 November 2011

Step 3

Sole practitioner or partnership

The pensionable income allocation to the dentists at the practice is as follows:
- Following Step 1 calculate 45.9 per cent of the achieved GDS/PDS contract value. This is 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 deducted from the pensionable pay ceiling. If the practice has any dentists identified in Step 2 their earnings are also deducted from the ceiling
- In the case of a sole practitioner 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 balance working at the practice cannot exceed the ceiling identified in Step 1. If there is working at the practice a non-pensionable dentist identified in Step 2 then the declared pensionable pay on the ARR will fall short of the ceiling by the amount earned by the non-pensionable dentist. It is unlawful for this shortfall to be allocated to other pensionable dentists at the practice.

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

Limited company

Where a practice has incorporated and the limited company holds the GDS contract or PDS agreement, the limited company is required to complete an ARR as the provider. The process involved for the company is exactly the same as occurs for a sole practitioner or partnership up to the point that the balance of the pensionable ceilings has been determined. At this point the pensionable pay of the director/shareholders who are active NHS members or PDS holders will be added to those director/shareholders in the year to 51 March, the NHS pension year.

It is often the case that where a practice has incorporated the limited company receives mixed dental income (ie NHS and private). In these circumstances there is no need to apportion salary/dividends between NHS and private income for NHSPS purposes. All salary/dividends paid to dentist/associates are available for allocation as NHS pensionable income.

It is important to ensure that where dividends are paid in a limited company that all the company’s work and tax rules are followed when a dividend is paid. Failure to meet the necessary requirements may result in a void dividend with unwelcomed tax consequences. Where salary and dividends paid to director/shareholders exceed the pensionable pay ceiling the unused balance cannot be carried forward to future pension years and it is unlawful to allocate the shortfall to any other pensionable dentist at the practice.

The Pension Agency had identified that one of the main problems areas with earlier ARRs was the understatement of the pensionable pay of some 5,000 associates. The Guidance Notes with the 2011/12 ARR now clarifies the position that in any associate’s pensionable pay is the amount paid to the associate for GDS/PDS work undertaken. It therefore does not matter about the terms of the individual associ-
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...
those of the AAE, IFEA and ESE. He is currently working with manufacturers to develop new technologies and clinical procedures for root canal treatment.

Matt McColley, Group Corporate Business Manager for Software of Excellence, joined the company in April 2010, taking guru from virtually an unknown product to the first choice for patient education software and making sales in

the UK, Holland, Italy, Germany, Australia and Dubai. Matt will be discussing how implementing guru within the practice can help educate patients and increase treatment plan acceptance.

Anthony Roberts qualified from Birmingham Dental School having also completed an Intercollegiate Bachelor of Science Honours Degree in Physiology. Anthony worked in general practice as a VDP and then in a variety of SHO positions. He completed his Fellowship in Dental Surgery in 1999. Anthony’s main interest in restorative dentistry is periodontology.

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 BDC 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 ISCD. Dr Kakar is a Specialist in Restorative and Periodontal Dentistry. John became an ISCD Cerec Trainer in Dubai in 2007 and with his brother Dr Paul Moore in Galway, has had articles published.

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 FDS 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 AOG Clinical Innovations Charity Ball, a great opportunity to relax and network. The AOG 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 wonderment and music.

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 keep 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.
Professional standards

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 teams. 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 mean, 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.

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Practise Plan makes a further climb in the Sunday Times Times Top 100 Best Companies to Work For!

The company announced last year, that the team at Practise Plan were all keen to find out where they would be positioned in the Sunday Times Times Top 100 Best Companies to Work For 2012; and for the second year running, another Bib in the ranking was achieved! The company attained 38th place in the list for the second year in a row. The company officially competed against thousands of organisations on the Sunday Times Top 100 Best Companies list.

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 last 12 months, set against a backdrop of a tough competition from hundreds of selected organisations, all battling to collect the company’s award. Nick Dilworth gives his thoughts on the achievement. Nick Dilworth.

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Stroma wins process of patent infringement Benham/Salibody, 26 March 2012

Stroma, the dental technology leader, has won a first instance patent infringement lawsuit against Bien-Air Dental Technology. Stroma’s claim in the regional court of Mannheim granted an injunction against sales of Bien-Air’s products with infringing ALGA technology and unspecified damages for the use of Stroma’s IP

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

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New software update supports the hands-free operation of the SIREndo endodontic treatment system.

When you place the file the reaches the apex of the root canal the dentist can now direct the injection via the rotation of the foot switch.

Version 2.0 of Stroma Dental Systems SIREndo allows the practitioner to move the footswitch to more effective and convenient root canal treatment. As soon as the dentist reaches the apex he can reverse the rotation of the footswitch via the foot control. Just one brief touch is enough to change from clockwise to counterclockwise rotation and vice versa.

In more than 6 months, the new Footswitch operator keeps the user informed at all times. The exponential progress box now consists of 18 blocks as opposed to 9 in previous versions. The new Footswitch access the apex the file tip moves beyond the apex and the apex. When the file tip reaches the apex and it’s “A” is displayed. The message “A” is shown as soon as the top 2 contra-angle tips are used.

A series of short beeps can be heard as the file approaches the apex. This changes to a continuous tone when the file tip goes beyond the apex. Since the launch of SIREndo at IDS 2005 we have continuously developed the software,” said Anja Wedemeyer, Product Manager in the Instruments Development.

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Sirona is a leading creator of intellectual property in the dental industry and it will continue protecting its intellectual property rights globally.

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