

## South West Regional Group

The inaugural meeting was held at Bristol Dental Hospital on the 28th March 2000.

A programme is enclosed of the meeting which was split between a "business" section which covered mainly the future role of the group and a clinical session relating to the management of missing incisor teeth.

The conclusions of the business section were:-

1. It was proposed that the regional group leader would be in post for a 3 year period.
2. Room hire costs for the day meeting would be limited to £100.00 maximum (if any costs were payable).
3. Clarification was required with regards to additional invitations being extended to members of mono speciality lists or associate specialists.
4. The next meeting will be held on 27th March 2001 at Birmingham Dental Hospital.
5. The topic of the above meeting would be "Managing the Discoloured Tooth".
6. Some discussion centred around aspects of peer review and apparently there is a scheme running at Chichester with regards to Maxillofacial Surgical peer review and it was felt it might be worthwhile investigating this.
7. It was decided that a record would be kept of all presentations so that these would be available for future reference if necessary. These would be provided by the presenters themselves and would include a summary of the presentation including its outline and conclusions. Since a number of these presentations are now digitally based they would probably include a print out of the slide presentation data including photographs. A summary of any discussion following the presentation would also be included.

### CLINICAL SECTIONS

There were four major presentations by:-

1. **Mr Alexander Baxter, Specialist Registrar in Restorative Dentistry, Birmingham Dental Hospital.**

The main direction of the presentation centred on the problem of epilepsy and possible inhalation of dental prosthesis. There appeared to be only a remote chance of inhalation on dental derived objects during an epileptic attack. Published reviews/audits of hospital departments showed inhaled objects of dental origin do occur but no evidence could be found of this occurring during an epileptic seizure. Swallowing of objects appears to be far more common. In the English published literature there was only one case support of a denture clasp being inhaled during a epileptic attack. References were included.

2. **Mr C Butterworth, Specialist Registrar in Restorative Dentistry, Birmingham Dental Hospital.**

This presentation centred on the management of missing central incisors with orthodontics and resin bonded bridges. The summary points of the presentation/discussion are below:-

2.1 Good communication with Orthodontists is very important with full consideration of all treatment options especially if one option includes the removal of sound teeth.

2.2 Building up teeth with composite can be done before/during the orthodontic treatment to aid the orthodontic tooth positioning.

2.3 Resin bonded bridges were discussed in detail including a lively debate on whether any preparation should be undertaken.

It was decided that the jury is still out on this matter as there is no good evidence long term on which approach is best although several members indicated that they did not routinely prepare teeth. The preparers of the group felt that preparation gave some advantages in cementing and in occlusal adjustment before cementing as they often have a positive fit if the tooth is prepared.

2.4 Two Unit-cantilevered bridges were preferred by the group as they fell off in the retainer debonded. It was felt that rotation of a previously derotated abutment tooth could be prevented by carefully designing the contact area between the pontic tooth and its neighbours. Removable retainers were also used by some clinicians.

2.5 Panavia was the commonest cement used for cementing resin-retained bridges and many members of the group have used the newer opaque version. This can give shade-matching problems. A tip was given by Mr P King regarding the use of white putty on the palatal surface of the potential abutment tooth during shade taking.

2.6 Many members of the group were often cementing RBB's in place high using them as Dahl appliances.

### **3. Mr M Woodhead, Consultant in Restorative Dentistry, Bristol Dental Hospital**

This presentation centred on a case report involving a placement of two single titanium dental implants in the upper right and upper left central incisor regions. The main point of the presentation/discussion were as follows:-

3.1 The necessity of reducing the partial denture so that it became an overlay denture without actually applying pressure to the underlying implants.

3.2 The use of plastic cover screws which easily become swollen with saliva over a long period of time so that the internal hexagon strips and can make removal very difficult.

3.3 The importance of checking mucosal thickness and the necessity of placing the implants where the bone is rather than where aesthetically might be best.

3.4 The importance of the maxillofacial surgeons/restorative dentist interface to ensure that the implants are placed in the ideal position.

3.5 Discussion of the use of a "passport" which can be given to the patient and which will allow them to pass on information to dentists even many years in the future with the precise details of the manufacturer, the precise type of implant and superstructure used, and the artificial shade and type of bridge or crown used.

### **4. Mr A Watts, Specialist Registrar in Restorative Dentistry, Bristol Dental Hospital**

This case report involved the multi disciplinary management of traumatised upper incisor teeth. The patient has suffered horizontal root fracture to both 1/1. Root canal treatment had been carried out to both teeth but it was evident that /1 was fractured a few millimetres sub gingivally and therefore restoration (if possible) would be difficult. Subsequent treatment provided included:-

- 4.1 Extrusion of the fractured /1 root with a removable orthodontic appliance.
- 4.2 Pre restorative periodontal crown lengthening surgery.
- 4.3 Restoration with posts and crowns.

Discussion ensued about the amount of treatment involved and whether that would be justified with our current knowledge of dental implants particularly in relation to longer term prognosis. Management of adjacent soft tissues was also discussed.

It was evident that this meeting was much appreciated by the members present and they felt it was a worthwhile exercise. It is hoped that these meeting will continue and prosper.

**East London Regional Group**

**Eastman Dental Hospital**

**25 April 2000**

In attendance: P D Cheshire (Convenor)  
Professor J Hobkirk  
D Setchell  
L Searson  
R Welfare  
J Howlett  
A McDonald  
U Darbar  
J Wickens

Apologies: K Hemmings  
R Heath  
A Leon  
G Pearson  
M Barsby  
P Wright

At the Annual General Meeting of the Consultants and Specialists in Restorative Dentistry Group, it was decided that East London Region would examine the consultation process as part of the Clinical Effectiveness Assessment.

It was considered that the consultation process begins when the dentist makes a decision to refer the patient or when the patient initially asks for a referral. It extends through the referral letter, the patient attendance and from the consultant's point of view terminates when the written report is sent back to the general dental practitioner. From the patient's and general dental practitioner's point of view, the referral does not terminate until there has been some discussion of the written report by the general dental practitioner and the patient. Occasionally the process may be elongated by the need for diagnostic work to be carried out prior to the written report.

Whilst the report back to the general dental practitioner may represent the end process, the benefit of the consultation will not become truly apparent till the general dental practitioner has carried out any treatment.

All present felt that an important aspect of the consultation process would be to assess whether the advice given in the report was actually followed or not. It was felt that identifying the reasons why treatment was undertaken or disregarded was fundamental to the process. However, concern was expressed at the general dental practitioner's willingness to participate in an assessment of this process. Concern was also raised whereby the practitioner may interpret any assessment as a form of policing of the general dental practitioner.

It became clear that it would not be possible to examine the whole consultation process. The overarching National Performance Framework of Clinical Effectiveness Indicators include:

1. Health improvement
2. Fair access

3. Effective delivery
4. Efficiency
5. Patient/carer experience
6. Health outcomes

Factors such as health improvement and health outcome could not really be assessed without involving the general dental practitioners and the treatment that they provide so it was felt that these aspects would not be examined in the first instance. Great difficulty was expressed when trying to identify measurable indicators and evidence based criteria. After much discussion it was decided to examine the early stages of the consultation process, specifically from the initiation of the referral by the general dental practitioner to receipt of the letter by the consultant. It was felt that the following aspects could be assessed as part of a pilot study, with a view to identifying effectiveness indicators.

1. The fairness of access
2. The effectiveness of delivery
3. The efficiency

Please find enclosed some thoughts about potential questions which should appear on an Assessment Form. This is by no means comprehensive and your feedback is obviously required and greatly appreciated. You will see that they are broken down into two general categories revolving around the general dental practitioner factors and the hospital factors. For the purposes of this exercise the patient/carer experience has been ignored.

It is proposed that the first 30 letters received by each Consultant should be assessed and then the data pooled. It is anticipated that an assessment form will need to be sent to the referring GDP on receipt of the referral in order to acquire relevant information which is not normally included in a referral letter. It will still be important to identify each sample as the returns will be coming from a homogenous environment, namely postgraduate teaching hospital, undergraduate teaching and district general hospitals. It will be relevant to compare the experiences of the different units.

### **General Dental Practitioner Factors**

- a) Fairness of access. This will involve assessment of the patient age group, sex, ethnic group. Socio economic status can be assessed from the post code.
- b) Initiation of referral. It might be valuable to know who actually initiates the referral, whether this is the general dental practitioner, the patient or another group such as the general medical practitioner.
- c) Reason for referral. Has the patient been referred for advice or treatment, on economic grounds or for other reasons, eg, management problems.
- d) Reason for referring to a particular Consultant. This will include factors such as is the Consultant known personally to the GDP, whether the general dental practitioner is aware of the Consultant's particular interests; he or she may have recently attended a postgraduate course given by the Consultant, the decision may be related to the waiting list; the general dental practitioner may be aware of the Consultant's particular referral criteria. There may be other factors or the patient may be referred to a Department in general and not to a specific Consultant.
- e) Reasons for referral to a particular Hospital or Unit. This may be closely connected to factors outlined in d), however, where there are a number of units within relatively short distances of

one another, it may be interesting to know why a particular hospital is chosen. Factors may include: proximity, waiting list factors, the relative ease with which patients are accepted for treatment.

- f) Referral criteria. It is the practitioner aware of the referral criteria for the Department or Consultant that the patient is referred to.
- g) Is the patient normally treated under the NHS or privately.

### **Hospital Factors**

- a) Has the patient been referred to a specific Department or individual.
- b) Does the letter fulfil the minimum set of referral criteria, for example: patient's name, address, date of birth, telephone number, a specific medical history, a statement of the problem, a clear request for treatment or advice, is a tentative diagnosis offered? Is any information included which would enable the Consultant to prioritise the case in terms of urgency from the point of view of pain or disease severity. The minimum set of data would be different for different referral categories, for example the Period Department may consider it essential that probing depths etc, are included.
- c) Does the Department or specific individual publish their referral criteria and if so where?
- d) How are referrals to unnamed consultants allocated.
- e) Is an acknowledgement of the letter of referral sent to (i) general dental practitioner, (ii) the patient, and what is the timescale.
- f) What is the approximate distance that the patient would have to travel from the home address to the hospital. (This may give a skewed perspective bearing in mind patients may travel some distance to work and the hospital may be local to their work rather than home.)
- g) Does the Consultant operate a selection criteria for patient's accepted for treatment. Is this criteria made available and is it different to the referral criteria.
- h) There must be some detailing of the type of Unit that the patient has been referred to, namely postgraduate teaching hospital, undergraduate teaching hospital, an outreach clinic, a regional unit and also the speciality, ie Restorative Dentistry, removable prosthodontics, fixed prosthodontics, periodontics, endodontics.

### **CLINICAL GOVERNANCE – APPROACH**

The purpose of clinical governance is to critically examine the treatment we provide and ensure that it is of the best standard that can be provided within the constraints of the service.

Such a process should be efficient, educational and non-threatening.

The following is a scheme for carrying this out:

1. Regular (weekly, bi-weekly or monthly) departmental case conferences.

2. Chaired by audit lead for department.
3. Two cases discussed: one chosen randomly, one selected for interest.
4. An audit sheet is complete per case – appendix 1.
5. A quarterly review by the audit lead of audit sheets to be presented to the Clinical Audit Committee.

## AUDIT SHEET

Patient: \_\_\_\_\_ No. \_\_\_\_\_

Consultant(s) in charge of case \_\_\_\_\_

### Diagnosis

#### 1

(i) Were guidelines of examination and diagnosis followed? **Y/N**

(ii) If not which aspects were not carried out?

(iii) State reasons for this if known.

2. Was the diagnosis appropriate? **Y/N**

### Treatment

#### 1.

(i) Was the treatment appropriate? **Y/N**

(ii) Were guidelines on treatment followed? **Y/N**

(iii) If treatment was not appropriate, why not?

#### 2.

(i) Were there any adverse outcomes? **Y/N**

(ii) Were these managed effectively? **Y/N**

(iii) How could this have been avoided?

### Outcome

#### 1.

(i) Was the outcome satisfactory? **Y/N**

(ii) If not, why?

Recommendations for future management \_\_\_\_\_

## South London Regional Group

21 September 2000

Present: R Saravanamuttu (Chairman)  
B J Smith (Report writer)  
N L Fisher  
M Woolford  
D Bartlett  
T Watson  
J D Walter  
C Morgan (SpR guest)  
S Safiullah (SpR guest)  
K Harper (SpR guest)

The Chairman welcomed members and guests and explained the concept of clinical governance. He said that this meeting was to explore accountability and, to avoid defensiveness, set out the rules which were that comments were non attributable and the results were to be non threatening. Three patients were to be presented and the group were to consider the approach to managing the patients and were to complete question sheets.

Patient 1 was presented by Mr Safiullah with clinical slides, casts and photographs and was a 54 yr old man referred for restoration of this worn anterior teeth. His main complaint was of repeated fracture of restorations from the anterior teeth over at least a five year period and he was concerned about his appearance. His history revealed acid regurgitation and a high fruit intake. His teeth exhibited moderate tooth surface loss from erosion and attrition and a Class II div 2 anterior occlusion. The dentition was heavily restored with amalgam restorations posteriorly and composites anteriorly.

Patient 2 was presented by Mr Saravanamuttu with clinical slides, casts and photographs and was a 35 yr old woman whose main complaint was of repeated periodontal abscesses especially in the UL23 region and a poor appearance of these teeth. At the initial consultation, there was a 9mm probing depth midfacially to UL2 and there was pus exuding from the area. There were also deep probing areas associated with UR4 and UL6.

Patient 3 was also presented by Mr Saravanamuttu and was a 17 year old man whose main complaint was of the poor appearance of his anterior teeth. He had congenitally missing UR2 and UL3, the UL2 was small and pointed in appearance.

The clinical details of each patient were presented over a 5 minute period and then the group had 30 minutes to look at photographs and casts and to complete questionnaires on each patient.

The questions were:

1. Do you regularly treat cases such as this?
2. What do you feel are the general principles one should follow in treating a case like this?
3. If you treat or oversee treatment of such cases, what approach do you usually take in managing such cases?
4. What alternative treatments might you consider?

5. How much do cost/facilities affect the approach you take?
6. If the patient wished to have the best treatment available and could self fund this, would you change your approach to managing such a case?

After a break, the group discussed each patient.

Patient 1. The role of occlusal analysis, possible loss of occlusal vertical dimension, what the patient wanted, causes of erosion, concepts and principles of restoration were all discussed. It was concluded that many factors affected the treatment planning but some principles emerged.

Patient 2. There was discussion on use of antibiotics and the concept of full mouth disinfection.

Patient 3. There was discussion on various methods of restoration including orthodontics and the use of implants.

There then followed a discussion on clinical guidelines with a series of five questions:

1. Is there a correct way to treat a specific condition – should there be guidelines for management of each diagnosis?
2. What is the role of the literature and scientific evidence in formulating guidelines?
3. Should guidelines govern our clinical practice?
4. Who should formulate these guidelines?
5. How do economic factors influence guidelines?

All members of the group felt that the exercise had been very worthwhile and looked forward to more similar meetings.

## North Midlands Regional Group

### Centres:

- ◆ Leeds
- ◆ Liverpool
- ◆ Manchester
- ◆ Sheffield
  
- ◆ Bradford
- ◆ Leicester
- ◆ Wakefield
- ◆ Wrexham

### **Membership:**

- ◆ 19 NHS Consultants
- ◆ 20 Honorary Consultants
- ◆ 13 NHS/Honorary SpRs

**Total:** 52 members

### **Regional Group Meeting:**

**Date:** Wednesday 28<sup>th</sup> June 2000 (10:00 a.m. to 4:00 p.m.)

**Venue:** **Charles Clifford Dental Hospital, Sheffield**

Programme:

- ◆ **morning:** Treatment planning....I teach that to GDP's!
- ◆ **afternoon:** Clinical audit: (why) are we so bad at it?

**Attendance:** 28/52 members (54%)

### **Treatment Planning ..... I teach that to GDPs!**

Whilst the above may be factually correct for most of us how often do we get the opportunity to discuss the tougher cases at a meaningful level with (hopefully sympathetic!!) colleagues.

### Aims

The aims of this session are:

- ◆ to generate discussion on treatment planning issues for selected cases;
- ◆ to exchange ideas on newer or contentious treatment planning options;
- ◆ to allow peer review of treatment planning decisions for challenging clinical cases.

### Format

- ◆ four cases;
- ◆ four groups – all see each case in turn;
- ◆ report back/group discussion.

## **Clinical audit: (why) are we so bad at it?**

- do you find audit activity at your base fulfilling and satisfying?
- do you have plenty of good audit projects underway?
- have you completed lots of audit loops, changed practice and re-audited?

If so, great, come and tell us about it. If not, you will be in good company!

### Aims

The session will try to identify:

- why clinical audit can be seen to be such hard work;
- reasons for lack of good audit projects;
- reasons for poor attendance at audit meetings;
- reasons for poor completion, implementation, re-audit of topics;
- reasons for poor compliance with National Audit Projects.

### Format

- ◆ four groups;
- ◆ brainstorm three questions;
- ◆ report back/group discussion;
- ◆ suggest strategies for improvement.

Clinical Audit - discussion questions:

1. Do you think clinical audit is worthwhile or a waste of time?  
Why?
2. What are the barriers to effective audit in Restorative Dentistry at your base?
3. How could the ACSRD (and its regional groups) help you to carry out better audit projects, locally?

### Audit session – results

**Problems:**

- ◆ difficulty identifying topics\*
- ◆ projects too ambitious
- ◆ lack of critical mass of participants\*
- ◆ failure to complete audit loops
- ◆ time pressures
- ◆ lack of support locally (IT/audit staff) \*
- ◆ no perceived changes following audit
- ◆ apathy (!)
- ◆ single handed consultants\*
- ◆ lack of clearly defined outcome measures\*
- ◆ lack of guidelines\*

## Suggestions:

- ◆ ACSRDR – facilitating/co-ordinating role
- ◆ regional/national audit projects
- ◆ ACSRDR – guidance on topics/methodology/guidelines
- ◆ ACSRDR – help with suitable outcome measures
- ◆ ACSRDR – formal training (audit methodology) + updating
- ◆ regional groups to provide critical mass

## How was it for you? / Debrief:

- ◆ very positive feedback
- ◆ enthusiastic
- ◆ suggestions for future meetings - rotate around the centres
  - regional audit project
  - formal audit training
  - measuring clinical outcomes
  - keep half day clinical/peer-review
  - failed cases
  - patient's complaints
  - multi-disciplinary cases
  - undecided treatment plans
  - clinical skills training
  - evaluating new/"high-risk" techniques

## Evaluation questionnaires

CPE approval: (4.5 hours CPE)

## Summary

### ACSRDR to provide:

- ◆ advice on involvement of Newcastle in N. Mids. group
- ◆ leadership and guidance on audit in the regions
- ◆ feedback on format/frequency of future meetings