Meet the new CQC boss

David Behan takes over as Chief Executive in July

Dame Jo Williams, Chair of the Care Quality Commission (CQC) recently announced the appointment of David Behan as the Commission’s new Chief Executive.

David is currently Director General for Social Care, Local Government and Care Partnerships at the Department of Health, prior to which he was Chief Inspector of the Commission for Social Care Inspection. He has served as President of the Association of Directors of Social Services and as Director of Social Services for Greenwich, Middlesbrough and Cleveland Councils.

David joined the Department in 2006. For the last six years, he has made a major contribution to the work of the Department as a member of the Departmental Board and the NHS Management Board. He has led on work to reform adult social care, and has worked closely with local government to deliver the system reforms set out in the Health and Social Care Act 2011.

In his previous role, he was the first Chief Inspector of the Commission for Social Care Inspection. Before that, David held a number of leadership and senior roles in the social care and health sector, building on the frontline experience he gained at the start of his career in 1978. His contribution to social care was recognised in 2004 by a CBE for services to social care.

He will replace Cynthia Bower, who announced her resignation in February.

Dame Jo said: “I am delighted to confirm David as our new Chief Executive. The quality of applicants was exceptionally strong, but David’s combination of frontline and regulatory experience, coupled with his commitment to making a difference for people who use services, made him an outstanding candidate.

“His clarity of vision and strong track record on delivery will be crucial to driving forward the next stage of CQC’s development - as we continue to build on the progress already made, delivering increasing benefits to the health and social care system through our essential role in tackling poor care. I and my Board very much look forward to working with him.”

Commenting on his appointment David said: “I am greatly looking forward to my next challenge of working with the CQC Board, staff and stakeholders. I am delighted to have been given this opportunity to lead the organisation that takes action where services are poor and unsafe, whilst providing assurance that our health and care services are fit to achieve quality and outcomes for people which are amongst the best in the world.”

Health Secretary Andrew Lansley said: “I would like to thank David for his dedication and professionalism. He has made a huge contribution, both in designing the reform of the social care system so it is fit for the future, but also securing much better integration of health and social care.

“David will take his wealth of experience of health and social care to a vital role - making sure that not only are patients and service users getting high quality care, but that their dignity and experience is as important as their treatment and care. I wish David the best in his new role.”

Permanent Secretary Una O’Brien said: “David has made an outstanding contribution, not only to the Department of Health, but to the entire social care sector. I wish him all the best for the future.”

Robotic operation in UK
A minimally invasive treatment of oropharynx cancer is now available at the Welling- ton Hospital in London. The one-hour technique known as Transoral Robotic Surgery allows a surgeon to remove the cancer without splitting the jaw or taking tissue from other parts of the body. It in- volves the use of the Da Vinci robot to access the tonsils through the mouth and unlike a traditional surgery carried out by two surgical teams, it has less complications. Pa- tients are in hospital for just a week and do not need long- term feeding tubes as they are able to swallow normally soon after the surgery.

Sleep deprivation
Three studies being present- ed at Sleep 2012 conclude that obesity and depression are the two main culprits making us excessively sleepy while awake. Researchers at Penn State examined a random population sample of 1,741 adults and determined that obesity and emotional stress are the main causes of the current “epidemic” of sleepi- ness and fatigue plaguing the country. Insufficient sleep and obstructive sleep apnoea also play a role; both have been linked to high blood pres- sure, heart disease, stroke, depression, diabetes, obesity and accidents. In the Penn State cohort study, 222 adults reporting excessive daytime sleepiness (EDS) were fol- lowed up seven years later. For those whose EDS per- sisted, weight gain was the main cause of the EDS.

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Smile for the camera?

A recent story run by a national newspaper of images showing children coming round from anaesthetic after having their teeth pulled out has caused unrest in the dental world.

The before and after shots, which were taken in an effort to dispel patients' fears of the dentist, show the faces of several children before and after they are put under general anaesthetic.

The images show the children at Sheffield's Children Hospital looking cheerful, alert and happy before they underwent the procedure and then confused, scared and covered in blood in the photos after they had their teeth pulled out.

According to the report, photographer Andy Brown decided to create the series to show the young patients' bravery during what can be a singularly traumatic childhood experience.

However, the exhibition is seemingly having the opposite effect: The first picture is of a six-year-old boy, who reportedly told his mother he 'wouldn't be able to smile because his teeth hurt'; the second picture is of a little girl who looks scared and disoriented after having been unconscious for more than an hour; the third child looks dazed and confused, whilst the fourth child looks exhausted and worn down.

According to the report, after their first portraits were captured, the children were put under general anaesthetic for tooth extraction and remained unconscious until just before the second pictures were taken in the recovery room hours later.

Sheffield-based photographer Mr Brown said in the report: "In recovery, children were disoriented, woozy from the general anaesthetic and often upset. Their bravery in posing for a portrait despite this can be clearly seen."

"I chose to document the procedure in this manner to reflect the experience of the patient. They have no memory of the procedure; they are unconscious between the two time points recorded here."

According to the report, the hospital opened its doors to three professional photographers last autumn, with the idea that they would capture the essence of daily life on the wards for a ground-breaking exhibition.

The pictures, which have been described as 'fascinating' are part of the exhibition which is called You Are Not Alone; it aims to reassure children and parents who are intimidated by hospitals.

However, dentists across the country believe it is having the opposite effect: "I think it is a sad reflection on the state of UK dentistry when some people think children can be put at ease by showing them the blood smeared faces of post-GA patients" one disgusted dentist told Dental Tribune.

The hospital's website reads: "We recognise that coming to hospital can be an anxious time and that this can come from an uncertainty of what to expect."

A dentist is being forced out of his practice in Bransholme, Hull because of a 'ridiculous' rent charge at a new health centre.

According to a news report on the This is Hull & East Rid- ing news site, Russell Davies has been located at the centre for 16 years. However, the current centre is making way for a new £14.7m build competed in August and the rent for rooms will shoot up to £80,000 a year.

Mr Davies said: "It's increasing about seven times and I can't afford that out of my pay packet. I am not happy about it at all. It is a ridiculous amount to rent empty rooms."

"I'm the only dentist at the centre so there will no longer be a practice when the new building goes up. We treat about 2,500 patients and they will all have to find somewhere else to go."

Dental Outreach prize winner for Cardiff

This year the Cardiff University Outreach Prize for Dentistry was awarded to Kristian Davies. Each year a BDS undergradu- ate student from Cardiff is selected to receive this award in recognition of outstanding achievement in the final year of the course.

W&H supported the event again this year and kindly donated an engraved handpiece, which was presented to Kristian at the University's newly opened Primary Dental Care Unit in Mountain Ash.

The prize winner is selected for the possession of a number of attributes in addition to displaying a high level of clinical skill. Kristian was a well-deserved winner of this year’s award, his kind and caring nature was greatly appreciated by all his patients.

A popular member of his year, his “upbeat” manner, dedication and high standards made him the firm favourite for the award. Kristian served as year representative and achieved the 17th highest mark in last November’s national DFI interviews.

Known for being an extremely organised person with excellent social skills, Kristian was highly regarded and well liked by both the clinical and nursing staff.

He has chosen to take a DFI place near his home town in South Wales and he takes with him the best wishes of all the staff for his future career.

"This exhibition aims to break down some of these barriers by showing some aspects and characters of the hospital which are not normally seen."

"By sharing patients', parents' and staff experiences, we hope to demonstrate that we are not alone in our anxieties and wish to provide view- ers time to reflect on and even celebrate what makes their own experiences of The Children's Hospital so unique."

"Through these stories, we aim to share a glimpse of the bravery, care, dedication and even humour that exists at the hospital every day."

Editorial comment

This week sees the end of National Smile Month for another year. There has been lots to talk about this year within the profession, not least of which the use of the campaign by illegal tooth whiteners to promote their services, and the resistance this has caused within the profession about making sure the right messages are getting across to patients and consumers.

It has been heartening to see the galvanising of some of the profession behind stopping this menace to patient safety. Continued communication to the companies via their Facebook pages, Twitter feeds, press, consumer boards, letters to companies supplying their services, letters to Trading Standards etc; it has caused much trouble for some of the larger illegal whitening services.

Of course it is a small stone dropped in a large pond, even the most passionate of supporters would admit to that!

But still, the ripples of this stone could have far reaching consequences. I hope that these efforts made over the last month continue and more add their voice.

Grant for new device

A North East team who have developed a device which will help monitor gum disease has been awarded more than £1,000,000 of Government funding.

Scientists at Newcastle University, working with biotechnology companies OJ-Bio Ltd and Orla Protein Technologies, are developing a novel device which has great potential in rapidly detecting the early signs of gum disease and monitoring improvement as the condition is treated. The government-backed Technology Strategy Board and the Engineering and Physical Sciences Research Council (EPSRC) have awarded the grant funding to the £1.3m project to help the consortium develop the prototype into a commercial product.

The project will deliver a device that will enable patients and dentists to monitor gum disease accurately, simply and cost effectively, by identifying signs of the disease in saliva.

The funding allows OJ-Bio and Orla to work with scientists Dr John Taylor and Professor Philip Preshaw, from the Institute of Cellular Medicine (ICM) & Centre for Oral Health Research (COHR) at Newcastle University.

OJ-Bio was created to develop a new generation of hand-held, real-time diagnostic devices that combine biotechnology processes with electronics manufacturing.

OJ-Bio had already performed an initial study for the Technology Strategy Board, which demonstrated the feasibility of a nanobiosensor device for the detection of proteins called matrix metalloproteinases, which are involved in a variety of diseases.

The project brings together a multi-disciplinary effort of UK excellence in nanoscale science.

New lighter tint

Colgate®
Duraphat®
Dental Suspension Fluoride Varnish

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• Clinically proven caries efficacy!
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  – 46% reduction in DMFT
• Quick and easy application
• Temporary light tint for visual control

Applying fluoride varnish containing 22,600ppm F is a recommended intervention in ‘Delivering Better Oral Health – An evidence-based toolkit for prevention’.

Duraphat 50 mg/ml Dental Suspension. Active ingredients: 1ml of suspension contains 50mg Sodium Fluoride equivalent to 22.6mg of Fluoride (22,600ppm F).

Indications: Prevention of caries, desensitisation of hypersensitive teeth. Dosage and administration: Recommended dosage for single application for milk teeth: up to 0.25ml (13.6mg Fluoride), for mixed dentition: up to 0.40ml (9.04mg Fluoride), for permanent dentition: up to 0.75ml (16.95mg Fluoride). For caries prophylaxis the application is usually repeated every 6 months but more frequent applications (every 3 months) may be made. For hypersensitivity 2 or 3 applications should be made within a few days.

Contraindications: Sensitivity to colophony and/or any other constituents. Ulcerative gingivitis. Stomatitis. Bronchial asthma. If the whole dentition is being treated the application should not be carried out on an empty stomach. On the day of application other high fluoride preparations such as fluoride gel should be avoided. Fluoride supplements should be suspended for several days after applying Duraphat. Interactions with other medicines: None known.

Legal class: POM. Product licence number: PL 00049/0042. Colgate-Palmolive (U.K.) Ltd. Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. Tel: 01483 333000. Fax: 01483 333002. Email: info@colgate.co.uk. Website: www.colgate.co.uk. Product licence holder: Colgate-Palmolive (U.K.) Ltd. Guildford Business Park, Middleton Road, Guildford, Surrey GU2 8JZ. Price: £22.70 excl VAT (10ml tube).

Application form: The form should be completed by a dental practitioner

The new collaboration between Tempdent and Smile-on has developed the Dental Nurse Education Zone, an online portal of information and education for dental nurses at any stage in their career. Alison Doherty, Head Tutor at Tempdent and Kirstie McCallie, General Manager – Qualifications at Smile-on spoke to Dental Tribune and explained how the two companies have come together to provide Dental Nurse Education Zone.

Kirstie explained: “Combining our healthcare educational expertise with the UK’s leading specialist dental training provider to deliver a better and more flexible approach to dental nurse education is a natural synergy.

“Collaborative partnerships are fundamental to Smile-on’s philosophy and our partnership with Tempdent is another step forward in providing innovative blended learning offerings for every registered dental professional, this includes dental nurses.”

Alison said: “As the head tutor at Temp Dent, I have used some of the services offered by Smile-on and found them to be high quality, very user-friendly resources. As a training provider that has been delivering the primary qualifications for more than 10 years, we have accreditation for both City and Guilds and the National Examining Board and a substantial knowledge and expertise to ensure students can qualify as easily and quickly as possible.

“We can now combine these two high quality expert companies to deliver a new style of learning across the United Kingdom to reach areas where there are very few training providers.”

This combining of expertise has led to the development of the Dental Nurse Education Zone. The UK’s first blended learning website for dental nurse education, it has been developed to cover areas such as Primary Qualifications; Online Registration for the National Diploma in Dental Nursing; Online Registration for the Advanced Apprenticeship in Dental Nursing NVQ; Postgraduate Qualifications; eRecord of Experience and Online Extended Duties.

The Zone will also include sections for CPD and Specialist Career Advice & Job Search; as well as access to the latest news and information relevant to dental nurses. Alison explained: “The students will be able to access the underpinning knowledge through a website. They can log on and work through material such as reading matter, audio PowerPoint presentations, webinars, pre recorded webcast material and a discussion board. We are trying to use a wide variety of materials to ensure that the students will find it easy to watch, interact and learn.

“There are also parts of the qualifications that will be difficult to learn in this way and so we have added regional workshops. The learners will know where and when these are running so the more practical techniques needed to pass an exam can be tried, tested and perfected before the exam.

“As I mentioned, we have full capability of helping the students to meet the standards needed for the qualifications and have had an excellent success rate in delivering both primary Dental Nursing qualifications in a classroom based manner. As an example, we have just received our first results for the brand new National Diploma for Dental Nurses written exam that was sat last month. Fifty-three of the 56 students have passed the written exam. This is a pass rate of 95 per cent! Together with Smile-on’s online expertise we can bring our highly successful and quality assured Dental Nurse training programmes online to every Dental Nurse across the UK.”

Kirstie added: “Innovation is one of our guiding principles and using integrated technology solutions creatively to provide qualifications that are now woven into the long term interests of dentistry is at our core.”

Smile-on are leaders in the field of blended learning for dental professionals; in 2010 the company launched in partnership with the University of Manchester the first two-year online MSc in Restorative and Aesthetic Dentistry. Now in its third year, the course accommodates between 60-70 students in each cohort from around the world. Kirstie said: “We are entering into a new age of integrating new technology based learning into the educational sector. Learners and employers want the ability to fit educational needs around commercial commitments, whilst also minimising the financial and time impacts traditional methods sometimes dictate.

“There is so much more choice now in how we access and deliver content, the question is not ‘why’ we should be doing it, but ‘what’ is the best way to deliver a particular component to meet the needs of the recipients. Whether it is through webinars, e-Learning, podcasts or more traditional face-to-face methods, we need to ensure we take all aspects of the participants’ learning styles into account and be far more customer centric in the approaches we adopt.”

Alison added: “Dentistry has changed so much in the last few years. Education has changed in the last few years. There is a need to be able to offer different methods of learning to students at a time that is convenient to them in the workplace. Many of the students now find that they learn faster and more easily through their computer than going into a classroom situation. They prefer to be able to learn at their own pace instead of the pace set by a class. Also, many cannot access a classroom based lesson at a convenient time or location for them. IT seems like the perfect solution for many.

“I have spoken to many students who have met at various exhibitions and other networking events who have voiced a desire to learn as an online course, together with the knowledge of knowing that there was always a dedicated tutor who is available to speak to in times when they need support. This is where our programme differs as we believe students can complete these primary qualifications with full support of a tutor who can be on the end of a phone or at a workshop.”

Over the next six months Tempdent & Smile-on will also be starting delivery of online Dental Nurse Post Registration Qualifications – Oral Health Education, Dental Radiography & Dental Nurse Sedation, as well as Dental Receptionist & Practice Management qualifications, all of which Tempdent have been successfully delivering for a number of years & have achieved outstanding success rates. A number of the qualifications that will be delivered by the Dental Nursing Education Zone are either fully government funded or heavily government subsidised.
Smile-on and Tempdent understand the need for flexible learning to fit around the busy lifestyles of dental nurses and practices.

This blended learning website provides everything you need from the start of your dental career through to your postgraduate qualifications and even helps you find the right job:

- Primary Qualifications
- Online Registration for the National Diploma in Dental Nursing
- Postgraduate Qualifications
- eRecord of Experience
- Online Extended Duties
- Specialist Career Advice & Job Search
- CPD
- Latest News & Information

Contact us for more details on 020 7400 8989 or email info@smile-on.com
Experts from King’s College London have warned that cases of permanent nerve damage caused by dental implants could rise further if steps are not taken to address risks and prevent injury.

Researchers from the King’s College London Institute of Dentistry carried out a case review of 50 dental implant patients who were referred to a specialist nerve injury clinic at King’s College Hospital, part of King’s Health Partners Academic Health Sciences Centre. The findings, published today in the British Dental Journal, reveal that patient consent and information, pre-operative planning and appropriate post-operative referral were inadequate in this patient group. The team has used these findings to make recommendations for clinicians to improve practice.

Incidence of injury to the inferior alveolar nerve (IAN) has increased as a result of a rise in dental implant surgery over recent years. There are approximately 10,000 mandibular (lower jaw) dental implant procedures carried out each year in the UK, and an estimated 100 reported chronic nerve injuries resulting from these procedures per year.

This type of injury can cause severe pain and altered sensation in the face, affecting everyday activities such as speaking, eating, kissing, shaving and brushing teeth. These injuries can have a significant effect on a patient’s quality of life, and can lead to depression and other mental health problems.

In 1997, approximately 10 per cent of all nerve injuries caused by dental work were associated with implants and this increased to 30 per cent in 2007. Several hundred complaints about dental implants were made to the General Dental Council last year.

Researchers reviewed 50 patients whose nerve injuries were caused by dental implants. A detailed history was taken, alongside a clinical examination and assessment of pain levels. They found that:

- Only 11 of the 50 patients were aware of signing consent forms for the implant surgery and of those eight felt they were not explicitly warned about nerve injury. Sixty-four per cent of patients did not recall providing written consent.
- Two with significant depression and two with significant depression and suicidal thoughts.
- Thirty per cent of the implant surgery patients had problems with eating, drinking and brushing teeth due to pain. Psychological problems were reported by 30 per cent. This included four patients out of the 50 with diagnosed depression and two with significant depression and suicidal thoughts.

The study showed that some of the patients experienced problems associated with dental implant surgery, such as severe bleeding, constant pain and/or discomfort, numbness and speech problems.

Barriers to cleft care

When a child is born with an orofacial cleft, a family may face medical, financial, and cultural trials. Knowing how parents perceive their ability to access needed care for a child born with birth defects can help formulate solutions. A survey of North Carolina mothers examines barriers to support and services.

Cleft Palate–Craniofacial Journal reports findings from this survey in the May issue. Mothers responded to questions about barriers to care, including an open-ended question to offer further insight. This study is a qualitative analysis of this population, based on a state-wide birth defects registry.

Almost 250 mothers of children born from birth to six years of age with orofacial clefts responded to the survey. Almost 40 per cent of the mothers reported problems accessing primary craniofacial care. Geographical factors, lack of referrals, experiences with stigmatisation, and concerns about confidentiality are some of the barriers that these mothers perceived.

The themes that emerged in this study were financial, structural, and personal barriers to care. Lack of health insurance or Medicaid reimbursement rates can create financial obstacles to care. The structure of the health care system or psychosocial problems can be defined as structural and personal barriers.

To address these issues and help parents to achieve a positive view of their experiences, the authors recommend well-coordinated care and communication between service providers and families. Training and continuing education for healthcare professionals could help them understand patient perceptions and needs. Health insurance companies, health departments, craniofacial and cleft teams and centres, and birth defect registries can collaborate with families and existing health care systems to offer identification and assessment of these children to the services that can best meet their needs.

Getting greener

As part of its commitment to lessening its impact on the environment, Denplan held a special Green Action Day on 25th May 2012.

In support of its ISO14001 environmental management accreditation, Denplan’s Green Action Day included lots of ‘green’ activities and prizes. Not only did staff wear green clothing for the day, but many avoided using their cars in favour of walking, running and cycling into work. There was a ‘trash fashion’ competition, quizzes, a themed cake sale and a raffle in aid of Denplan’s chosen charity, Macmillan Cancer Support. The ‘Monitor Monitor’ was also on patrol, giving out seeds and plant pots to all employees who turned off their computer monitors the evening before.

Business Services Manager, Kevin Muldoon, said: “Denplan takes its environmental management very seriously and although the Green Action Day was a great deal of fun, it also had a serious message behind it. Everyone really got into the spirit of things and we not only raised awareness of green issues, but hopefully made people think about where they can reduce their impact on the environment at home and at work. Even something small, like turning off monitors every night, can save you money, reduce your energy usage and ultimately your carbon footprint – it’s these small things that will make a huge difference if everyone does their bit.”

For more information about Denplan, visit www.denplan.co.uk or call 0800 401 402.
A growing number of people are cutting back on their oral healthcare as household budgets continue to be squeezed. The UK’s current economic problems are proving bad news for the nation’s teeth as many people are looking for ways to save money. The British Dental Health Foundation is warning that any cut-backs to spending on oral health is a false economy and will cost more in the long run – physically and financially.

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The warnings have been prompted by a new survey commissioned by the Foundation which suggests that more than a third of adults (36 per cent) are more likely to delay any dental treatment needed due to cost and over a quarter say they are visiting their dentist less often as a result of the current economic problems. Approaching one in five (17 per cent) people say they are spending less on their oral care and over a quarter (27 per cent) are buying cheaper oral care products including toothpaste, mouthwash and toothbrushes.

Not surprisingly, people on lower incomes are most at risk of deteriorating oral health in the current economic climate. One in four people (24 per cent) on lower incomes are likely to refuse dental treatment and approaching four out of every ten people are more likely to delay treatment.

Chief Executive of the British Dental Health Foundation, Dr Nigel Carter, is hoping to remind anyone thinking of over-looking their oral health, to think again.

Dr Carter said: “Our findings show that oral health is not recession-proof and that too many people are willing to gamble with their oral health. Unfortunately, they are running the risk of storing up a wide range of health problems and even bigger costs in the future. Many people are entitled to free dental treatment on the NHS and it’s always worth checking, especially if your circumstances change.

The findings have been published as part of National Smile Month, which runs from 20 May to 20 June and is the UK’s biggest annual reminder to look after their oral health. The campaign encourages everyone to brush their teeth for two minutes 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.

More than a third of adults are more likely to delay any dental treatment needed due to cost.
Living like a rock star

Ken Harris reveals all from the first MSc residential in Manchester

The MSc cohort gather for a group photo at the Manchester residential

What a hectic few months it has been. What with trips to Copenhagen to teach occlusion, and to Warsaw to present a lecture at the Polish Academy of Cosmetic Dentistry to say nothing of a day spent in a day teaching colleagues in Nottingham, and a lecture at the 2012 Dentistry Show at the NEC, I have had little time for anything else. I suppose I do spend rather too much time preparing my lectures, but when colleagues take time away from their practices, I do feel a big responsibility to deliver. I really must juggle my time better.

I guess I initially underestimated the sheer amount of reading this MSc course would involve and probably allowed it to build up to a sizeable backlog. However, I have knuckled down and finally completed Module 1... just in time to start Module 2!

The first module began with the basic science which has lain deep in my undergraduate subconscious for well over 50 years. Sharpey’s fibres, the prickle cell layer and of course the Hunter-Shreger bands have once again become old friends. I feel like an 18 year old again!

The latter stages of Module 1 has been restoratively based with examination and diagnosis well in the fore as they should be, but up to now there has been very little emphasis upon aesthetic aspects. I guess this is how it should be initially, but did I perceive the slightest bat’s squeak of animosity towards the whole concept of cosmetic dental treatment from the academic staff? I wonder if they have become so used to teaching restorative dentistry over the years that the cosmetic outcome may well still be of a secondary concern. Let’s see how they shape up during the coming modules shall we?

As well as a comprehensive reading list, much of our teaching is also provided by live online webinar lectures. This format allows direct access to the lecturer and we are all encouraged to type in questions and comments as the lectures unfold. It makes for a lively interactive format, and I’m starting to see who the troublemakers are already!

It seems there are 70 or so delegates from around the world with a large contingent (perhaps 20 or so) from Bombay, so we really are a cosmopolitan bunch. I’m expecting full and frank exchanges of views over the next two years from such a talented group.

Initially only names, I can now put faces to names following the first four day residential course in Manchester where we all finally got to meet up. I am always humbled the way other nationalities speak English so well, and a few beers with delegates from Croatia and Bulgaria in particular have only reinforced my linguistic shortcomings.

Being amongst the shortlisted candidates in the Smile Awards this year, my team (sensing a few free drinks!) felt we might win something and decided we should attend; no excuses! The fly in the ointment was that the presentation ceremony clashed with the MSc residential. My staff of course just saw this as an opportunity to be celebrated with celebratory drinks I was “forced” to buy (London prices, wow!).

The news of our win was getting down to London for the Friday evening awards ceremony and back to Manchester early Saturday morning before my absence was noticed.

However, the news of our success was revealed via Twitter within minutes of the presentation, so the game was up, and I could not hide my Saturday morning “celebratory hangever”. I tried to blame it all on the 6am train from Easton, but news of the huge round of celebratory drinks I was “forced” to buy (London prices, wow!) had also travelled ahead of me, and my limp excuses were met with smirks and superior looks by the “teacher’s pet” contingent. All I can say is that my staff were a lot worse for wear than I was, which is no real surprise I suppose, but their powers of recovery are startling. Ah, the joys of youth.

Few things polarise the profession as much as cosmetic dentistry except perhaps occlusion. “I’ve never seen a good veneer!” say our colleagues, usually when they happen to see a particularly bad example of a veneer in their practices. Equally, I’ve lost count of the times I’ve been told occlusion does not matter or equally that it matters too much. It seems ignorance and personal prejudice drives dental opinion in both of these contentious fields. However, as we have just completed a comprehensive occlusion module, and are embarking upon the anterior aesthetic module, I’m expecting my MSc studies will be able to give me some definitive answers over the next two years.

With all this studying I must not neglect my other career as a rock star, although I have been spending lots of time with the Hunter-Shreger band!

The MSC cohort gather for a group photo at the Manchester residential

Students enjoy one of the hands on sessions.

About the author

Ken Har ris graduated from the dental school of the University of Newcastle upon Tyne in 1982 and passed his FDSRCS (Eng) in 1988. He maintains a fully private practice with branches in Sunderland and Newcastle upon Tyne specialising in complex dental reconstruction cases based upon sound treatment planning principles. He is one of only two Accredited Fellows of BACD, holds full membership of BAAD and remains a sustaining member of AAMD. He is currently the UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Kois Center in Seattle.

Ken Harris was a member of the UK Clinical Director for the California Center for Advanced Dental Studies and the only UK Graduate and Mentor of the Kois Center in Seattle.
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At the end of last month the Office of Fair Trading (OFT) published its report on the UK dentistry market; in summary it declared that dental patients were largely satisfied with the services provided by their dentist. But even though the report started off on a high note, there were significant concerns regarding the past and the future of dentistry, and there were several recommendations that went hand in hand with these concerns.

One concern highlighted by the OFT was how the existing NHS dental contract in England acts as a barrier to entry and expansion in the dentistry market (a market who’s growth is valued at an estimated £5.73bn a year). The report stated that:

potential new, innovative dental practices trying to enter the dentistry market face limited opportunities, good practices offering higher quality services to patients face high barriers to expansion, and poor performing dental practices face more limited incentives to improve in order to retain and attract new patients. Even on paper it doesn’t sound too good.

Vital step
In the OFT’s view, it is a vital step for the Department of Health to progress with the redesign of the NHS dental contract and introduce a system in which ‘any qualified provider’ may deliver NHS services to dental patients and where NHS dental payments follow the patient; it was also strongly recommended that the Department of Health bring an end to non-time-limited NHS dental contracts and that NHS dental contracts in England should be ‘streamlined and standardised’ to facilitate entry into the market by new dental practices.

The proposed moves by the OFT didn’t seem to come as a shock to most practitioners, as practice principal Neel Kothari explained: “Unsurprisingly the 2006 dental contract was slated by the OFT report. A core concern for the OFT is that the existing NHS dental contract in England acts as a barrier to entry and expansion in the dentistry market and that reform of the NHS dental contract is needed to facilitate greater competition’.

‘A core concern for the OFT is that the existing NHS dental contract in England acts as a barrier to entry and expansion in the dentistry market and that reform of the NHS dental contract is needed to facilitate greater competition’

The Dental Tribune looks at what the recent OFT report on dentistry will mean.

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This leads onto the obvious ‘elephant in the room’ as Neel explains: “What exactly should be available on the NHS? Co-Cr dentures, implants, fixed bridge work, or simply a core service centred on fillings and dentures? Assuming that the OFT report is accurate in that 500,000 patients a year are actually being misled this is more than just a perverse incentive built within a flawed system; it’s confirmation that things have gone horribly wrong.”

Other worries highlighted in the report surrounded issues of dental payments plans, and concerns that patients are being pressured into joining a dental payment plan as a means of paying for private dental treatment. Along with these discoveries there were further matters regarding the complaints process and how the current complexity and costs impose unnecessary burdens on patients and dentists.

As a result, the OFT stated that they strongly recommended that either a single body should be responsible for dealing with such complaints, or a single patient-facing portal for the reporting of such complaints should be developed to ensure a more effective, efficient and consistent complaints system. So far all the findings from the OFT report, from insufficient patient information to the complexity of the complaints process for patients, makes the question surrounding patient care beg for some serious deliberation. But the question on patient care was made even more prominent when the OFT announced that they had called upon the GDC to review and urgently remove restrictions on direct patient access to dental care professionals.

Currently, dental patients are unable to access dental hygienists, dentists and therapists (except for patients without any teeth) clinical dental technicians without first receiving a referral from a dentist; however, the OFT stated that they do not consider that there is any compelling, objective justification for the current restrictions.

Benefits
The OFT believe there are a number of benefits that Direct Access may deliver for patients, such as the chance to provide patients with greater choice and a chance to allow DCPs direct interaction with patients; the OFT also believes that the removal of restrictions on patients’ Direct Access to DCPs could also create competition and enable the development of more efficient models of service in the dentistry market that may be more responsive to patients’ needs.

The report states: “On the ba-

Mixed emotions
The statement has caused mixed emotions in the dental sphere. The GDC and the BDA have raised concerns around patient safety if patients are allowed Direct Access to DCPs, with the BDA stating that direct patient access to DCPs would introduce risks to patient safety because ‘DCPs are not trained to diagnose significant early stage oral disease.’ However, these views are not shared by all.

Sally Simpson, President of BSDHIT said: “We firmly believe that Direct Access will not be detrimental to patients as suggested by the General Dental Council and British Dental Association; rather that Direct Access will help dentistry move forward and embrace the successful model of care as employed in medicine allowing patients greater accessibility.”

Sally Reid, Secretary of BADT said: “BADT are in favour of the OFT report regarding Direct Access for dental therapists and hygienists and support their recommendation. Patients should have more freedom of access and choice on who can deliver their dental care. This will improve the system and enable dental care professionals to practice dentistry within their competency without the need for treatment planning and referral from the dentist.”

Speaking on the subject, Neel said: “Whilst this could potentially be a good thing for patients, I am concerned that a government body responsible for making sure markets work well for consumers is making recommendations that have a clinical impact on patient care. On top of this, what evidence does the OFT have that suggests that allowing Direct Access to DCPs will actually save money and be better for consumers?”

Insatiable demand
Even still, as Neel explained, there remains to be some good points about UK dentistry, as Neel explained: “Whilst the OFT report highlighted flaws within the UK dentistry market, it fails to note the contribution that NHS dentistry has played in meeting the insatiable demand for high output en masse dentistry whilst working in a budget limited system.”

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A well-earned break!

Dentist Clive Jones looks back at selling his last practice

Dentist Clive Jones had had a long and varied career in UK dentistry. After qualifying in 1974, he worked in hospital for two years carrying out oral surgery before moving to general practice as an associate in Huntingdon in the long, but summer of 1976. By 1984 he had purchased his own practice in Histon (Cambridgeshire) and this was sold in 2005.

But he wasn’t done yet! He then worked at a dental practice within a GP practice in Somersham (Cambs) before starting a bridge) in 2008. This was a massive challenge but one that he attacked with vigour. Clive had nearly passed the squat premises and had thought they would be an ideal site for a practice – so he took his chance. Through know-how, targeted marketing and of course decent dentistry, the practice had grown to almost 5000 patients with a 65:35 NHS:Private split by 2010 – impressive.

The plan had always been to sell within three years or so and Clive was looking forward to a well-earned retirement! The practice needed to be sold and Clive approached Frank Taylor and Associates without hesitation. “I had a valuation with them when I sold my Histon practice in 2005 but for one reason or another had not sold it through them and had always regretted it”, remarked Clive. That was settled – the practice was on the market.

“I expected a large number of responses”, commented Clive, “and we got them!” Within 10 days of responses”, commented Clive, “and we got them!” Within 10 days of the sale of a dental practice even if relatively straightforward, can be a very stressful time and getting away for a well-earned break.

An offer was accepted from a dentist who, although very charming in the first instance, seemed more and more indifferent once the price was agreed. There seemed to be a lack of excitement and the purchaser almost ‘stumbled’ through the finance process. There were three completion dates and finally the offer was withdrawn in January 2011 – the day before exchange.

The whole process had to be started again. Clive was introduced to the eventual buyer by his accountant – they got on like a house on fire.

Clive continued to use Frank Taylor and Associates as an agent, even though his accountant had introduced the new buyer. There was no legal demand to use Frank Taylor and to pay their fees but they had been so useful during the previous attempt at sale that Clive was more than happy to employ them and receive their support.

That may surprise some but that shines a light on a common misconception. The agent’s job is not just to find a buyer (or it shouldn’t be!). As the sales process becomes ever more complex, they are a negotiator, mediator, confidant, shoulder to cry on – the list goes on. Even in the first, aborted sale, Clive found the support and assistance that he received from Frank Taylor and Associates to be invaluable.

Anyway, back to the well-earned break of the title. Frank Taylor and Associates offer a week’s break in a Florida villa to ALL their vendors on the completion of the sale. The sale of a dental practice even if relatively straightforward, can be a very stressful time and getting away from it all once the ink is dry, is a great way to unwind and put the sale behind you.

Clive took them up on their offer even though he wasn’t sure that Florida was really ‘his thing’. However, he and his wife had a fantastic time! Clive said: “A friend of ours had bought a place out there about 15 minutes up the road and that helped us get some local knowledge. We felt that we were not quite the target demographic for Disney, but we did do SeaWorld and my highlight was definitely the Kennedy Space Centre. The scale of it was simply awe-inspiring!”

“I found the ‘dynamic relaxation’ of golf, the everglades etc to be just what I needed post-sale. I am quite sure that the bed in the villa is the biggest that I have ever slept in! The only disappointment was that we had to come home – I would suggest a minimum of three weeks to anyone.”

“Upon reflection, I think that the villa is really symptomatic of the way that Frank Taylor and Associates approach and undertake business. It is clearly not a necessity but that extra thought and consideration makes all the difference and leaves one, as a client, with a warm glow (and tan in this case?)”

“So many retired people come up with the phrase “I can’t see how I found time to work.” This is absolutely true, and not based on watching day time TV either, God forbid. Our garden is controlled, long needed painting in the house has been done, long term financial planning is being done, and most importantly my golf handicap is coming down. We are creating time to do things that we did not have time to do previously, such as cookery courses, photography courses, learning Spanish, and frequent visits to London theatres and galleries.”

“We are also in the process of obtaining planning permission to build a dream house in the garden which is a great challenge. I did find time last year to do the London to Paris lake ride which did take up a great deal of time getting fit enough to do 100 miles a day.”

“As you can gather, I love retirement and the opportunity it gives to travel as well as the previously mentioned things. We aim to be on “holiday” at least every six to eight weeks, usually out of the country.”

Retirement has given Clive the opportunity to unlock a door that was impossible to open whilst working and he sums up: “I have to say that Frank Taylor and Associates, as well as giving us key to open the door, also made the journey manageable.”
Peer to Peer and Pier to Pier
News about the British Orthodontic Society Conference 23rd-25th September 2012

The first joint meeting of the BAO (British Association of Orthodontists) and BSSO (British Society for the Study of Orthodontics) took place in Bournemouth 26 years ago, and it is to the very same sandy shores that 2012’s conference returns. Whilst much has changed in clinical and academic practice, there is no doubting the inexorable ascent of the British Orthodontic Conference to become the UK’s most prestigious specialist conference – attracting in excess of 1,000 delegates to hear a unique blend of homegrown and international speakers.

One of the main attractions for this year’s conference is sure to be Dr Ben Goldacre. Known to many as a best-selling author, broadcaster and journalist as well as a psychiatrist and statistician, Ben is to address the Conference on the Sunday afternoon and by all measures should not be missed as he gives his unique take on the relationship between medicine and the media as well as the darker side of research and its relationship with business-objectives and big pharma.

For the main programme, the emphasis at BOC has always been to schedule presenters with a keen eye on the scientific basis for sound clinical decisions. With this in mind international speakers such as Sebastian Baumgartal will present on mini-screw anchorage solutions, Prof CH Kau will discuss the integration of cutting edge technology into clinical practice.

‘One of the main attractions for this years’ conference is sure to be Dr Ben Goldacre’
The emphasis at BOC has always been to schedule presenters with a keen eye on the scientific basis for sound clinical decisions.
Attracting innovation to BOC

Three pioneering innovations showcased for the first time at the British Orthodontic Conference by Philips

Philips believes technological advances will bring about the clinical effectiveness which is key to improving the future of oral health. It is this guiding principle which drives the Company to perpetually innovate.

Three of its latest innovations will be on show when the Company makes its debut at the British Orthodontic Society Conference in Bournemouth this September. Sonicare Airfloss is an electronic hand held device which dispenses rapid bursts of air laden with microdroplets of water to flush out debris around fixed brackets and permeate the interproximal spaces. The water is propelled between the teeth at 45 miles per hour, dislodging plaque biofilm, while leaving the gums unscathed. What's more, it requires only a teaspoon of water every tooth in a minute and permeates the interproximal debris around fixed brackets without the brush is as clinically effective than oral irrigation systems and encourages greater patient choice and clinical trials show it is more effective than string floss.1

For patients at the conclusion of their treatment the Company has also just launched Zoom WhiteSpeed, its most advanced tooth whitening system which is proven to whiten teeth up to eight shades in just 45 minutes and delivers 40 per cent better results than a comparable non light-enhanced whitening system. Of the 35 dental professionals who participated in testing the new system, 85 per cent indicated that the results were equal to or greater than previous Zoom models but technological advances meant that patients experienced less tooth sensitivity.3

A list of references is available from the publisher.

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For more information or details on special offers please visit the Philips stand at the BOS Conference or www.philipsoralhealthcare.com. Please call 0800 032 3005 or 0800 0567 222.

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Sheffield, 2012

Philips Airfloss


Fourteen questions about Invisalign for teens

Dr Peter Ilori discusses patient preference

In this interview Orthodontic Specialist Dr Peter Ilori explains why his teenage patients are expressing a preference for invisible aligners rather than metal brackets.

1. Align Technology launched Invisalign Teen with features which are specifically designed for teenagers (such as the compliance indicators, eruptions tabs and compensators as well as free replacement aligners). As a practitioner, which of these features do you appreciate the most?

Dr Ilori: It is undoubtedly the combination of these features which makes this product well supported and effective in tackling most malocclusions. However it is also the free replacement aligners which give confidence to parents who might worry about additional costs.

2. How long have you been treating teenagers with Invisalign?

Since the day Invisalign Teen was launched in 2008, so I have four years of experience using this system with my younger patients.

3. What is the benefit of Invisalign compared with traditional fixed brace treatment?

The advantages of Invisalign can be seen from both a patient and clinical perspective. Teenage patients are very appearance conscious and they report that it is truly invisible, easy to wear and is generally more comfortable (and less painful) than traditional fixed braces. Teenagers tend to cope better with oral care instructions and there is less interference with their dietary habits (so no need to abandon pizza habits). For patients who have confidence or social problems, the product has been very successful in reducing teasing and bullying in school and social environments. Parents find it easier and feel more confident to monitor and supervise their children’s treatment because the system has built in compliance indicators.

4. What are the clinical benefits of Invisalign compared with traditional fixed brace treatment?

From a clinical perspective it is easy to start a case and there are additional benefits of reduced clinical time and no emergencies. There is a high level of patient acceptance of this product so it sells itself. The Clincheck feature helps me plan, visualise and explain clearly what the end result is likely to be. I have received a lot of positive comments from parents and children who feel they are a part of a new wave of cutting-edge technology in orthodontics.

5. Which Invisalign products do you use for the treatment of teenagers?

We mainly use Invisalign Teen but in a few instances we will use Invisalign Lite or even the adult version depending on the complexity of the case.

6. As it is not always possible to predict the eruption path of the canines, 2nd premolars and 2nd molars, an orthodontist might need to change the final position or stage of these teeth. This change is not regarded a mid-course correction by Align Technology and will not be charged. How valuable is this to you?

This is very valuable because ectopic teeth are common and any practitioner will need to capture and align these teeth as they come through. Also, from a cost perspective, patients would not be happy if additional charges were applied during the treatment.

7. According to your experience, what is the most crucial benefit for parents who are considering Invisalign for their children?

Most parents would do anything to prevent their children being unhappy about wearing braces. Traditional braces tend to trigger battles relating to eating as well as the frequency of toothbrushing and regular visits to repair broken braces.

8. What is the most crucial benefit for the teenagers?

The crucial benefit is that teenagers get their teeth straightened without compromising their self-image, confidence or appearance.

9. How commercially interesting is it for you as an Orthodontist to offer Invisalign to your teenage patients?

Selecting the right cases and completing and achieving treatment goals is rewarding. Invisalign Teen is also profitable because we make savings on materials, chairside or clinical time and repairs.

10. What kind of marketing activities do you use when promoting Invisalign to your teenage patients?

We use our website and social media as well as internal marketing using posters and brochures. We also get a lot of our referrals involved by sharing the benefits of the teen products.

11. What role do you think Invisalign plays in your practice when it comes to teenage patients?

The most valuable and virulent driver is Invisalign Teen. This is because of its high acceptability within this age group.

12. What is your top tip to other Orthodontists who are considering treating teenagers with Invisalign?

If you share the benefits and advantages of this treatment you can expect an increase uptake. Invisalign Teen treatments require detailed knowledge of dental eruption patterns, jaw growth and experience in planning, treating and managing young children and teenagers which Orthodontists are ideally placed to manage.

13. What is your orthodontic experience?

I am a Specialist in Orthodontics with 27-years of experience in dentistry. In 2001, I was awarded the MBA with distinction from Brunel University in Uxbridge. I am the founder/owner of Octagon Orthodontics with branches in London, High Wycombe, Denham and Beaconsfield. I am actively involved in the development of orthodontic, aesthetic and cosmetic enhancement protocols for clients of all ages using Invisalign, Invisalign Lite and Invisalign Teen. I am also a Platinum Elite Practitioner and Clinical Speaker/Trainer.

14. Where can I get more information about Invisalign – Teen and otherwise?

You can find out more about Invisalign by visiting: www.aligntechnstitute.com/international/pages/english.html

15. What is your orthodontic experience?

Dr Peter Ilori

Invisalign with embedded compliance indicator
Improving smiles with removable orthodontic appliances

Dr Sunil Chudasama discusses his first Inman Aligner case

After successfully treating patients with clear aligner systems, veneers or bonding to improve my patients’ smiles, I was attracted to the Inman Aligner due to it being a very simple, cost-effective solution for patients. I found it very easy getting my first case and quickly completed the user-friendly online training by Straight Talk Seminars.

My first case with the Inman Aligner was on a 28-year old male, who I will refer to as JB. His main aesthetic concern was his anterior crowding, primarily with his lower teeth. After in-depth discussion with JB about his priorities, it became clear that he was mainly concerned with his lower incisors and would consider some improvement to his upper incisors. He was happy with the shape and shade of his teeth.

The options we talked about were veneers (direct/indirect) and adult orthodontics via clear aligners (Invisalign or Clearstep) or a removable device (Inman Aligner). As JB was happy with the shape and shade of his teeth we agreed that the healthiest and best option long term would be to orthodontically improve his smile. JB had mild crowding with his upper anteriors, and mild-moderate crowding with his lower anteriors, so I felt it was important to raise the issue about the rotated lower canines, as it would not be possible to predictably align these teeth without the use of fixed orthodontics.

The choice between the options became clearer after discussing the advantages of the Inman Aligner. Firstly, it is a cheaper treatment option in comparison to clear aligners; and secondly, it works much faster – this proved useful, as we had limited time, as JB was planning a year of travelling in the near future. Fixed orthodontics would not be a suitable option due to aesthetic concerns.

On agreement that the Inman Aligner was the best product to use for his case, we then planned the logistics. Initially JB was only concerned with his lower teeth. However, after identifying that he had limited space to move the teeth around between the upper and lower teeth, we planned to align and open up the upper anterior teeth with slight proclination, which would then give us plenty of room to move the lower teeth.
of space to correct and align the lower incisors.

The patient was medically fit and well. An examination revealed that he was dentally healthy and maintained excellent oral hygiene.

On the first appointment we:
- took the necessary photos
- got him to read and sign the consent form
- obtained a bite registration
- took upper and lower impressions (two-stage)

I then designed the appliance and sent off the impressions to Nimro Dental for case analysis, and construction of the upper aligner. I informed the lab that up to 0.25mm of IPR could be performed between contacts.

On receipt of the aligner from Nimro Dental I confirmed the design and mock up model, as well as accepted their diagnosis that 0.2mm IPR was needed to achieve the final result.

At the second appointment we:
- checked the fit of the aligner
- confirmed the patient was happy with the proposed final result
- activated the aligner and placed the necessary composite buttons
- performed the first stage of IPR (0.1mm), polished the interdental spaces and applied duraphat
- discussed post operative instructions, demonstrated insertions/removal of the aligner, aftercare, oral hygiene and provided the patient with a written document, explaining what had been discussed

At the 1st review appointment (four weeks later) we:
- checked progress: things were moving along as planned
- ensured the appliance was still engaging the teeth and ‘tight’
- repeated the final IPR stage (0.1mm), polished the interdental spaces and applied duraphat

At the 2nd review appointment (four weeks later) we:
- checked progress: we were 95 per cent of the way there, but the upper central incisors were still not ideally aligned
- ensured the appliance was active: the appliance was still engaging the teeth and ‘tight’

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- Care Quality Commission Outcome 4 Care and welfare of people who use services
- Care Quality Commission Outcome 7 Safeguarding people who use services from abuse
- GDC statement on Child Protection and Vulnerable Adults, (expansion of standards for Dental Professionals principle 1.8)

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- "Delivering Better Oral Health" for older patients

SPEAKERS
Sue Gregory
Anousheh Alavi
Graham Gilmour
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B was very impressed with his result, as you can see in the photos and we are currently mid treatment on his lower arch, which I am pleased to say is progressing well!

Conclusion
Overall the Inman Aligner is a safe and easy appliance for any GDP to confidently use. It needs to be used wisely and appropriately, but I can safely say it has completely changed the way I treat my patients – I would now much rather offer an aligner and place direct composites to improve a smile, as opposed to cutting into perfectly healthy teeth for veneers. In cases where veneers are required, the invasiveness of the procedure can be greatly reduced by some quick pre-alignment.

The Straight Talk online course was a fantastic and convenient way for me to gain my accreditation as I already had a good idea of techniques and approaches with regards to adult orthodontics and I have been recommending the product to patients and dentists since!

Author Info
Sunil Chudasama
BDS (Lon) qualified at King’s College London in 2008 and currently work as an associate dental surgeon in two practices based in Essex. He provides a variety of treatments and has an interest in cosmetic and restorative dentistry. He strongly believes in postgraduate training and since qualifying has successfully completed the Chris Orr Cosmetic Dentistry & Aesthetic Restorative Dentistry course, trained in several orthodontic systems and completed MJDF parts I & II. He will soon commence the Restorative Dentistry MSc at the renowned Eastman Dental Institute. Sunil’s vision and aim has always been to provide quality and ethical dental care for his patients.
The Clearstep System is a comprehensive invisible orthodontic system designed to provide bespoke orthodontic solutions that are “invisible” and efficient. At the core of the system are clear positioner braces which are designed to align your teeth in incremental steps and offered to patients as an alternative to traditional metal wires and brackets.

The most obvious benefit to patients is the discretion that the System offers. This makes the System particularly popular with adult patients who want a naturally beautiful smile without anyone realising they are undergoing orthodontic treatment, unlike the alternative of fixed train track braces.

The clear positioners at the heart of the system are removable, which allows the patient to fit their orthodontic treatment around the needs of their daily routine. They are removed to eat, drink and clean your teeth, but otherwise are worn all of the time. After a two week period the patient progresses onto the next positioner in their sequence. This sequence of positioners will gently guide the patient’s teeth into their desired position.

Positioners are provided to the patient in sequences of eight positioners. Once this sequence is completed, the patient returns to their Clearstep practitioner for a new impression of their teeth. This impression is then sent to Clearstep for assessment and the next sequence of eight positioners is produced. This approach ensures that the treatment progresses according to plan and allows Clearstep to continually capture new data as the teeth are moving providing the patient with the most accurate and efficient treatment possible.

**The Solution**

A practitioner begins by gathering the patient’s records to assess their case. A General Dental Practitioner sends them to Clearstep and will receive a diagnosis and treatment plan devised by a specialist orthodontist detailing the options that are available, which is then discussed with the patient. A specialist orthodontist will devise their own treatment plan and have a similar discussion with the patient regarding their options. Once the patient’s decision has been made, the practitioner will instruct Clearstep to produce the first sequence of eight positioners.

The impressions of the patient are turned into plaster models of the patient’s teeth which are then digitally scanned so that a 3D model can be created. Specialist orthodontic technicians then plan out each individual movement of the teeth according to the treatment plan as prescribed by the orthodontist.

A 3D model is then printed by Objet’s Eden 500V for each of the eight steps in the sequence from which the clear positioner brace is then manufactured. The sequence is then sent to the Clearstep practitioner who will guide the patient through the treatment.

**The Results**

Treatment with clear positioner braces...
by the technicians, the production of the models is initiated by the Objet Eden500V, allowing the technician to proceed to the next patient’s case. Consequently the daily production yield per technician has increased within a short time frame and further time savings are forecast.

The switch to a digital production process has provided the company with a scalable solution needed for continued growth.

The Objet Eden500V is also pivotal to Clearstep’s digital study model storage strategy, as they can quickly and easily print any stored files. Clearstep could additionally provide orthodontists with tools for virtual treatment planning and assessment without the need for a physical model. This has opened a potential new market whilst crucially solving storage issues.

Digital storage made it easier to streamline their appliance replacement services, reduce administration costs and store models in a safe, controlled environment. With the system’s intuitive search functions, rapid case retrieval could be handled by the front line staff, leaving Clearstep’s technicians free to focus on the core manufacturing.

Clearstep’s approach to incorporating CAD/CAM technology is expected to show a return through the faster more streamlined manufacturing process, giving them the ability to improve the service to their clients and drive forward the company’s continued growth and development.

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Chronic pain management

Michael Sultan discusses the bigger picture

Chronic pain is an awful, debilitating condition and can seriously impact upon patients’ quality of life. With insufficient systems in place for the management of chronic pain, thousands of patients are left to suffer in silence, either unaware that help is out there, or left feeling helpless after the healthcare system has failed address their pressing needs. I was deeply saddened to read a story in the news about a man who took his own life after suffering from excruciating toothache. The man in question, Dorian Thomson, a 44-year-old model from Maida Vale, suffered from Ehlers-Danlos Syndrome (EDS), an inherited collagen disorder that causes weakened joints and can force sufferers to live in an enormous amount of pain. According to reports, Mr Thomson had previously received failed orthodontic treatment that had in fact exacerbated his condition, leading him to suffer for almost a decade before he finally took his own life.

As soon as I read this story, my first thought was how could we, as a caring profession have let down somebody in so much pain that they eventually committed suicide? Naturally it would seem Mr Thomson’s relatives are calling for an investigation into this matter, although I do suspect that the orthodontic treatment is something of a red herring. What this story does highlight however is the very poor availability of access to chronic pain centres.

As a specialist endodontist, I treat pain on a daily basis and am very much aware of the debilitating impact pain can have on my patients’ lives. Strange-ly, at EndoCare we did actually treat a similar case to Mr Thomson’s a little while back. Like Mr Thomson, the patient was a tall, thin model and also

Ehlers-Danlos Syndrome (EDS) can force sufferers to live in pain.
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What strikes me more than anything from this story is that in this modern age, people such as Mr Thomson are still slipping through the net. As a profession we have let him down and he has paid the ultimate price as a result. It disappoints me that in the year 2012 we still have such poor systems in place to help people deal with chronic pain, and there are hundreds if not thousands of people out there still suffering.

What we need is what the old political spin-doctors would describe as ‘joined up thinking’. Chronic pain is not something that can be treated in isolation. With a great deal of experience as an endodontist, I know from my own work that there are many facets to chronic pain beyond dealing with the site of infection.

When someone’s been suffering for a long period of time, or if they’re run down and tired, there’s an emotional component to their pain, especially where chronic pain is concerned. To deal with this element adequately systems should address the acute need for patients such as Mr Thomson to see professionals such as psychologists and counsellors to give him a comprehensive range of measures to help him alleviate some of his symptoms and improve his quality of life. From a clinician’s perspective, patient suffering in any form is inexcusable, and allowing our patients to suffer in silence is one of the worst things I can imagine.

This case should serve as a reminder of why it is we do what we do. As dentists we work for the common good – we work to relieve our patients’ pain and improve oral health. We should not be purely side-lined by beauty but should focus on health.

As clinicians then, we need to be more aware of the systems that are in place that can help people such as Mr Thomson. Chronic pain is a serious condition. Unless systems to deal with chronic pain are improved, I fear cases such as poor Mr Thomson’s will become all too common.

Chronic pain can have a negative impact on patient’s daily life
Get CPD and some Christmas shopping!
The BADN discusses the 2012 National Dental Nursing Conference

The 2012 National Dental Nursing Conference, which will be held at the Blackpool Hilton on Saturday 24 November, will be the last conference before the end of the first five-year CPD cycle in July 2013*. Dental nurses who still require CPD can take advantage of the fact that this year it is a one day Conference, which keeps costs down, and held on a Saturday, which allows more dental nurses to attend.

We’ve done away with the Presidential Dinner (something else most survey respondents wanted!), but anyone arriving on the Friday can join us at Harry Ramsden’s for an informal fish and chip supper. Because dental nurses are used to multi-tasking, we’ve arranged for delegates to start their Christmas shopping and have the car valeted during conference - as well as keep fit with a Zumba session, and those staying over on Saturday night can complete their Christmas shopping with a visit to the local Hounds Hill Centre and/or Fleetwood’s Freeport on the Sunday morning.

The Keynote Speaker will be new GDC Chairman Kevin O’Brien, who will be followed by the GDC’s Clare Herbert speaking on how to manage the end of the first CPD cycle. Barbara Lamb will then give a presentation on a subject much requested by respondents to our recent conference survey - Radiography.

After lunch we have presentations on Oral Cancer, Special Care and a return visit from Sharon Waxkirsh, whose hypnotherapy in dentistry proved so popular two years ago. We are also in the process of organising a second presentation stream for after lunch, so delegates will have a choice for each of the afternoon presentation sessions. The £50 Conference fee (that’s for current BADN® members - £120 for non-members) includes lunch and refreshments.

We have negotiated a special B&B rate at the Hilton, or there are hotels in all price ranges nearby. Conference registration will be on line (payment must be made at the time of registration by credit or debit card) and delegates to previous Conferences will get their priority invitation emails around the end of May. General registration will open at the beginning of June - if you are not yet, send your name and e mail address to conference@badn.org.uk and we’ll add you to it. There will also be a link, from the Conference page of the BADN® website www.badn.org.uk/conference.

If you are not yet a BADN® member but are interested in attending Conference, its worth becoming a member first, as it will save you £70 on the Conference fee! go to www.badn.org.uk/join-up to join online. If you registered with the GDC before 31 July 2008, your CPD cycle ends on 31 July 2013. If you registered after 31 July 2008, your CPD cycle started on 1 August after you registered, and ends five years later. For example, if you registered in August 2008, your CPD cycle started on 1 August 2008, and finished on 31 July 2014. For more information on CPD, visit http://www.gdc-uk.org/Dentalprofessionals/CPD/Pages/default.aspx

* If you registered with the GDC before 31 July 2008, your CPD cycle changes on 31 July 2013. If you registered after 31 July 2008, your CPD cycle started on 1 August after you registered, and ends five years later. For example, if you registered in August 2008, your CPD cycle started on 1 August 2009, and finished on 31 July 2014. For more information on CPD, visit http://www.gdc-uk.org/Dentalprofessionals/CPD/Pages/default.aspx

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Special Guest Speaker
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Safeguarding children
Glenys Bridges looks at the policies, procedures and regulations you need

Irrespective of the type of work you do, or the profession you are a part of, safeguarding is currently a top priority issue. Every so often a case comes to the public attention that is so appalling that rafts of new measures are introduced in an attempt to prevent a repetition. In 2007 the Department of Health provided clear guidance to dental teams on this highly emotive issue, when they published Child Protection and the Dental Team. (This can be downloaded from http://bit.ly/LFQk4).

Dental teams have responsibilities, both as healthcare professionals and as members of society. When any of us hear something about a child or vulnerable adult that concerns us we should report our concerns to someone who can help. In such circumstances, from the outset it’s important to realise that members of the dental team are not responsible for making a diagnosis of child abuse or neglect, just for sharing concerns appropriately. For this reason it is essential to agree as a practice upon the required response, and to set this out in the form of a written and well communicated policy and procedures document, which should be followed should concerns be aroused.

In these very difficult economic times, the stresses and strains are having a devastating effect on some families. Articles in the press frequently give examples of the suffering of some of the most vulnerable members of society. These serve to highlight the fact that record numbers of families are having court cases brought against them to remove their children because of factors like abuse and neglect. Most children who go into care do so as a result of concerns that they are being neglected, not that they are at risk of physical violence, or sexual abuse. As dental care professionals we are often in a position to recognise neglect, which in some cases can be resolved through education and support.
General Dentistry Programme for Professionals

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The guidance should follow this three-stage approach:

1. Evaluate the injury itself, its extent, site and any particular patterns
2. Take a history to understand how and why the injury occurred and whether the findings match the story given
3. Explore the broader picture (e.g. the child’s behaviour, the parent-child interaction, underlying risk factors or markers of emotional abuse or neglect)

Numerous reputable organisations provide a wide range of excellent written policies and procedures for dental businesses. Having selected such a policy, or better still developing a policy in-house, it is essential to follow through by embedding its content into the fabric of the practice. In this way you make your policies living documents for the quality and safety of care, rather than just documents gathering dust on a shelf.

References:
2. Implant strength & fatigue testing done in accordance with ISO standard 14801.

For more information, contact BioHorizons

About the author
Glynys Bridges is an independent dental team trainer. She can be contacted at glynys.bridges@gmail.com

Dental professionals are often in a position to spot neglect

Child Protection and the Dental Team states that:

- Abuse or neglect may present to the dental team in a number of different ways:
  - Through a direct allegation (sometimes termed a ‘disclosure’) made by the child, a parent or some other person
  - Through signs and symptoms which are suggestive of physical abuse or neglect
  - Or through observations of child behaviour or parent-child interaction

To ensure that the team is able to respond effectively should the need arise, it is highly recommended that a Child Protection Lead is appointed.

Child Protection Lead is appointed. This could be a registered provider, practice manager, or a senior dental nurse. This person should be the first port of call for their team if they have concerns about any individual. The Child Protection Lead should be ready and equipped to follow practice policy and procedures in response to those concerns. They are also responsible for ensuring that any actions investigated are followed through.

The practice policy should contain flow charts and checklists to guide the team both in the preparation for and the response to events. It should contain all of the required phone numbers and contact names, as well as team guidance for the assessment of any physical injury.

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**BioHorizons presents its European Symposium**

BioHorizons invites you to join an international group of well-respected experts for its European Symposium in Rome between 18 and 20 October 2012.

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The event will include presentations from Carl Misch, Michael Pikos, Jack Ricci, Sonia Loopy and Brian Miller.

Also, expanding on previous event offerings, the 2012 schedule incorporates a biologics forum on the Thursday afternoon (19th October).

To find out more about this exciting event, including details of the topics to be covered, please visit www.biohorizons.com/symposium-series-Italy-2012.aspx.

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The innovation aims to remove the financial burden of replacing disposable-day trays from dentists, and to ensure that they dispose of impression trays after using them. Reusing the trays carries a significant risk of cross-patient contamination.

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The Dental Directory is one of the best-known names in dentistry, but it never rests on its laurels, instead working tirelessly to provide knock-out value for its customers.

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