BDJ Team
MAY 2016

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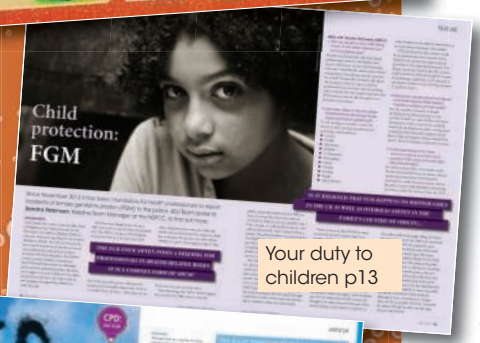
HTM 01-05 p22

Ed's letter

SUGAR is everywhere you look at the moment: breakfast, lunch, snacks… I mean, everywhere in the media. Every day there seems to be a new story about children going to hospital to have their rotten teeth removed under general anaesthetic, a comparison of sugar content in everyday products like breakfast cereal or 'child-friendly' drinks, or of course the role of sugar in the 'obesity epidemic'. I myself have a sweet tooth (a whole mouth full of them) but take the greatest care to look after them, armed with the advice of the many dental articles I have read over the years. But will a tax on the quantity of sugar in soft drinks make a difference to the levels of decay in children's teeth? Led by Sharif Islam, known for his strong, sometimes controversial opinions, this issue of *BDJ Team* collates the views of dental professionals and associations on George Osborne's planned tax on sugar in fizzy drinks.

Will the tax make a difference? p17

We are keen to present as wide a range of articles as possible here at *BDJ Team*, which is why this issue includes a focus on child protection in relation to Female Genital Mutilation (FGM). While you might at first think 'what has that got to do with dentistry?', by reading our article you will learn that all health professionals have a responsibility to report suspected incidents of FGM, and what to do if you are concerned about a patient who comes to your practice.



Your duty to children p13

Our CPD article for May is all about what sort of waste is generated by dental practices and how we can help the environment by processing it correctly. We also include *BDJ Team*'s first article by Emma Male, practice manager and highly experienced dental nurse: an introduction on handling HTM 01-05.

This month sees the highlight of the dental calendar take place up north: the British Dental Conference and Exhibition, so be sure to check out our advice piece on preparing for a CQC inspection, and how you can learn more on this topic in Manchester.

We also unveil a brand new competition: should you be named our first DCP of the month?! Don't be shy, nominate yourself.

What's in a bin? p7

Kate

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THE TEAM

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WHY SHOULD YOU BE **DCP** OF THE MONTH?

WIN!

BDJ Team, in collaboration with the Oral Health Foundation, is running a competition to showcase one dental care professional (DCP) each month both on the *BDJ Team* website and on the *BDJ Team* Facebook page (www.facebook.com/bdjteam).

The July winner of DCP of the month will win instant fame (!) and a Little Bear demonstration puppet (pictured): the ideal tool for teaching younger patients good oral hygiene habits.

To be in with a chance of winning and becoming DCP of the Month, just **email us** your name, job title, workplace, age, and town, and tell us why you should be DCP of the Month. Perhaps you have just completed a qualification or postgraduate certificate, raised money for charity, organised a practice open day or special campaign for patients, gone into the community to educate people about oral health, or anything else you would like to tell *BDJ Team* readers and the dental community about.

Email bdjteam@nature.com by **30 May 2016**. **All entries must include a photo. ENTER TODAY TO BE IN WITH A CHANCE OF WINNING!**

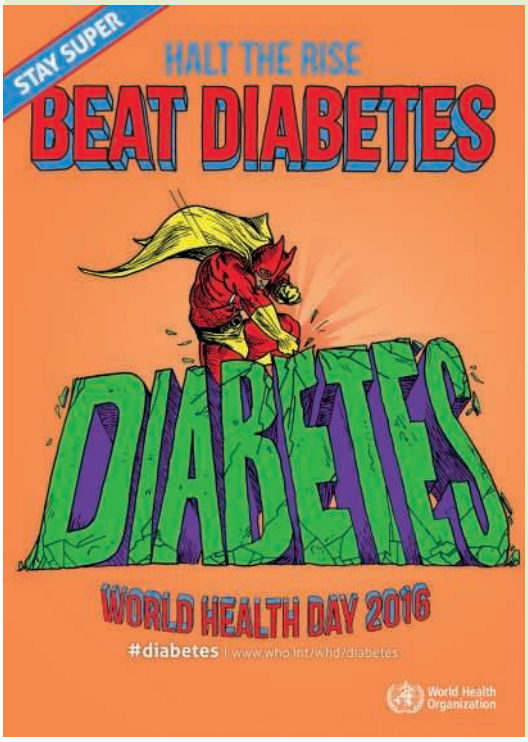
The Little Bear and a range of other demonstration products, models and downloads can be purchased from the Oral Health Foundation shop at https://www.educatingsmiles.org/.

Entry to the competition indicates that you are happy for your details and photograph to be used on the BDJ Team *website, Facebook page and Twitter account (@Editorkate2).*

DENTAL TEAMS SHOULD TEST FOR **DIABETES**

In the run up to World Health Day on 7 April, the British Association of Dental Therapy (BADT) said that dental teams should screen for diabetes and offer dietary advice in the global battle to control the onslaught of the disease.

This year's World Health Day campaign focused on the growing epidemic of the disease, looking at the causes, the costs and the need for prevention.



Some 350 million people around the world have diabetes and this figure is set to more than double in the next 20 years.

In a bid to halt the rise in cases of Type 2 diabetes, in particular, Amanda Gallie, president-elect of BADT, is suggesting dental practices could and should expand their health remit to include blood glucose testing, diet and wellbeing advice and motivating patients to better health habits, thereby minimising the risk of diabetes.

Amanda said: 'Preventive health care lies at the very heart of the role of the dental profession and, in primary care, we are better placed than most health providers to alert patients to the early signs of health-threatening behaviours as we see patients so regularly.

'Offering in-practice screening for diabetes, in the form of blood glucose testing, not only adds value to the patient's dental experience but also acts as a key marker regarding risk for pre-diabetics and can be a catalyst to discussions about the importance of good dental hygiene and other preventive measures.

'When we consider the current financial restraints within the NHS – and the seemingly unstoppable increase in chronic conditions such as diabetes – the role of dentistry has never been so important in an overall health care. The Government should consider funding these diabetes tests as an investment in the future health of a nation because, with regular screening, and education about preventive measures we can draw attention to this disease and keep the associated health risks at bay.'

This year, Philip Preshaw, professor of periodontology and consultant in restorative dentistry at Newcastle University, is the keynote speaker at the BADT's annual conference – *From Cradle to Grey: Developing 21st century strategies for age-related oral care* – taking place in Manchester on 23 and 24 September.

He will be addressing the clinical challenges presented by diabetic patients, will look at how the disease increases the risk for periodontitis and will offer an insight into the links between periodontal disease, diabetes and heart disease.

For more information, visit www.badt.org.uk.

For more on World Health Day, visit http://www.who.int/campaigns/world-health-day/2016/en/.

President's Column

Jane Dalgarno BSc, *BADN President*

March has been another busy month in my role as BADN President. Plans are well under way for the forthcoming Dentistry Show and BADN's involvement with the Dental Nurse Forum, which I will be chairing. I am looking forward to meeting as many dental nurses as possible there this month [April].

I attended meetings with a number of awarding bodies for dental nurse education. I am keen to ensure BADN is influential in this sector and the routes that dental nurses can take both pre and post registration. These awarding bodies will have promotional stands at BADN Conference in October and will have a series of articles in the *British Dental Nurses' Journal*.

It was with interest that I met with John Milne, National Dental Advisor for the Care Quality Commission (CQC) to discuss issues facing dental nurses in their role as CQC Registered Managers. The CQC will randomly inspect 10% of dental practices, but also those where concerns have been expressed. A Provider Handbook is available to advise practices before inspections. Safeguarding and cross infection appear to be the main areas of non-compliance. The CQC welcome both good and bad feedback, following inspection. Further information on the CQC can be found at http://www.cqc.org.uk/ and www.badn.org.uk.

I was delighted to have been approached by the British Society of Periodontology (BSP) seeking support for their upcoming campaign and their National Gum Awareness Day on 12 May. The Society recognises the important role the dental nurse plays in prevention and will have resources available for promoting this campaign with patients and colleagues. The BADN will feature this in the Spring *British Dental Nurses' Journal*, on our website and in other promotional material.

Finally, if I could remind you to participate in the survey that the BADN is conducting in relation to the demographic profile of the dental nurse. This is available at: www.badn.org.uk.

BADN OUTSTANDING CONTRIBUTION

RAF Warrant Office Pam Daley has been awarded the 2016 BADN Outstanding Contribution to Dental Nursing Award.

Pam joined the Royal Air Force (RAF) in 1986 and has been a clinical dental nurse, practice manager, regional practice manager and Head of Dental Nurse training for Defence. She also founded, and was the first Secretary of, the BADN Armed Forces Group.

In 2010 she was appointed as a NEBDN examiner and became a Trustee in 2015. Pam has been a presiding examiner for the Board and is also a member of the NEBDN Quality Assurance committee.

Pam is currently a serving Warrant Officer and is the lead dental nurse of the RAF, looking after the welfare and careers of all RAF dental nurses.

The award will be presented to Pam at the BDA Honours and Award Gala Dinner on 28 May at the Midland Hotel, Manchester.

NEW BSDHT WEBSITE HAS PATIENT CENTRIC APPROACH

The British Society of Dental Hygiene and Therapy (BSDHT) has unveiled their new website which makes it easier for the public to find a member in their area.

Patients are now able to search from BSDHT members practising near them through the 'Find a Dental Hygienist/Therapist' feature which is central to the new website.

Michaela ONeill, President of the BSDHT, said: 'This is a brand new feature, and one which we are encouraging everyone to get involved with. By becoming part of the BSDHT members have an incredible opportunity to grow their public presence and boost their patient lists.

'One of the biggest issues affecting oral health in the UK today is the ability for the public to access services; by giving our website a patient centric approach we hope to address this and make people more comfortable about visiting their dental team.'

The new website also offers many other benefits to members including access to the latest goings on in dentistry through the improved news section; a live Twitter feed; and information about the upcoming Oral Health Conference and Exhibition in Belfast later this year.

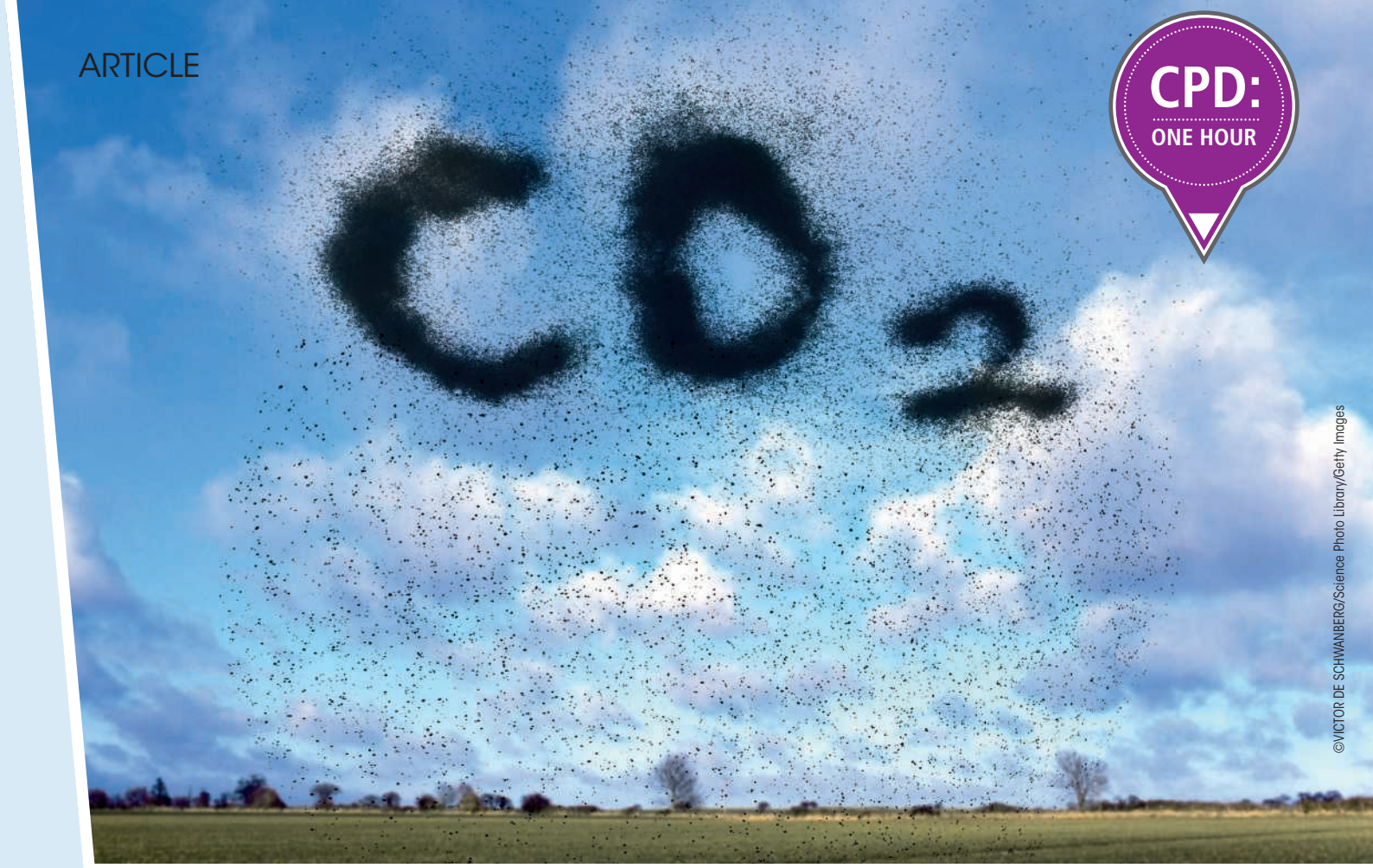
Go to www.bshdt.org.uk to visit the new website and find out more about the conference.

DIARY DATES

Event: 7th DCP Symposium
Host: Dental Postgraduate Section of the Wales Deanery in collaboration with The Royal College of Surgeons Edinburgh
Date: 27 May 2016
Location: Marriott Hotel, Cardiff
Further details: email liddingtonke@cf.ac.uk or hayeskj@cardiff.ac.uk

Event: 2nd Dental Practice Manager Conference
Host: Forum Training
Date: 22 June 2016
Location: Thistle City Barbican, London
Further details: http://www.forumbusinesstraining.co.uk/education/event/339-dental-practice-manager-conference-2016-london-22ndjune

CPD: ONE HOUR



What's in a bin?

A case study of dental clinical waste composition and potential greenhouse gas emission savings, by **J. Richardson**,[1] **J. Grose**,[2] **S. Manzi**,[3] **I. Mills**,[4] **D. R. Moles**,[5] **R. Mukonoweshuro**,[6] **M. Nasser**[7] and **A. Nichols**.[8]

Introduction

The impact of high levels of carbon on the environment has been well documented.[1,2] Healthcare services are responsible for a significant percentage of these emissions[3] and need to review where services and activities can make reductions. Due to relatively large carbon dioxide (CO2) emissions, the use of toxic materials and the production of vast amounts of waste, healthcare is compromising public health and damaging the ability of future generations to meet their needs.[4] In the EU, the health sector creates at least 5% of total CO2 emissions.[5] Furthermore, improving energy and resource efficiency and the development of sustainable procurement policies and waste management are vital for the health sector.[3] Although a small number of studies of waste management have been conducted in health and social care waste management,[6-10] studies on waste management in dentistry are limited.

Of equal concern is the variety of materials used in healthcare and dentistry (for example, plastics, cotton and rare metals) that are subject to the influences of climate change and geopolitical unrest.[11-13] Since 2009 a number of guidance documents have been developed which enable health service providers to begin to embed sustainability principles into policy and practice.[2,14] The NHS has begun to reduce carbon output while at the same time managing to increase productivity.[15] There is still a long way to go to embed sustainability across all departments and to ensure that items used in healthcare come from sustainable sources. Items should be purchased with reuse in mind and methods of disposal chosen with environmental protection as a core purpose. As the climate changes and affects accessibility to some raw materials, prices of these raw materials will rise and choices will need to be made about what is essential and whether or not alternatives can be found. Furthermore, to reduce the impact of carbon produced from long supply chains, the manufacture and disposal of items used in healthcare will need to be closer to the end user.

[1]Professor of Health Service Research, [2]Senior Research Fellow, [3]Associate Researcher, [8]Lecturer, Faculty of Health and Human Science, [6]Lecturer in Accounting, Faculty of Business, Plymouth University; [4]Academic Clinical Fellow, [5]Professor of Oral Health Services Research, [7]Clinical Lecturer in Evidence Based Dentistry, Plymouth University Peninsula Dental School

Rationale

Although there are a number of articles exploring the quality and quantity of waste in dental practices, there are no studies on organisational, educational or behavioural strategies to decrease unnecessary waste.[16] Dental practices have a unique position as staff use a high number of dental materials and instruments on a daily basis (unlike medical practices). It is unclear how dentists' and dental care professionals' (DCPs') choices and behaviours around selecting and using materials impact on the amount of unnecessary waste production. Much of the current environmental discussion in dentistry is focused around the use and disposal of dental amalgam, and several European countries have banned its use due to the negative environmental impact. This may be a highly relevant issue, but it would appear to have deflected the focus from other environmental considerations including the impact of clinical waste management in dental practices.

Farmer *et al.*[17] undertook a waste audit of dental practices in Australia and reported that materials used to support infection control constituted up to 91% of total waste produced. Although individual dentists generate a relatively small amount of environmentally unfriendly wastes, the accumulated waste produced by the profession may have a significant environmental impact. Dental waste not only has negative effects on the environment, but the cost of its removal falls heavily on dental practice budgets. In 2009 new infection control guidance was introduced within England and Wales (Scottish guidance contains variations) under the Health Technical Memorandum HTM 01-05.[18] This was subsequently revised in 2013. This has impacted significantly on dental practices and is considered to have had a deleterious effect on environmental sustainability in dentistry.

This study seeks to investigate clinical waste production in a single dental practice as a case study, building on the evidence gap by using methods previously developed through healthcare waste and procurement studies[9,10,12,19] and the rapid evidence review undertaken by Nasser.[16]

AIM

This study aims to measure the nature and quantity of clinical dental waste, and assess the feasibility of measuring the potential financial and carbon savings of appropriate segregation and recycling.

OBJECTIVES

1. To measure the nature and quantity of clinical dental waste
2. To assess the feasibility of measuring the financial cost of dental clinical waste
3. To measure the extent to which waste is incorrectly segregated in order to estimate the potential greenhouse gas (GHG) savings that might be achieved through better waste management.

> *'THE WASTE PRODUCED BY THE PROFESSION MAY HAVE A SIGNIFICANT ENVIRONMENTAL IMPACT.'*

METHODS

Rationale for data collection process:

Evidence suggests that inappropriate healthcare waste segregation can lead to non-clinical waste being disposed of in the clinical waste stream.[17] The consequence of this is the unnecessary incineration of non-clinical waste at high financial cost and excessive GHG emissions. In order to examine the extent of non-clinical waste being allocated to the clinical waste stream an audit approach was designed to weigh and categorise the clinical waste of one dental practice. The audit approach used in this study has been tested in recent research by the Sustainability Society and Health Research Group (SSHRG) at Plymouth University in a study of waste management in health and social care in Cornwall.[10,19]

Sample

The site for the study was a mixed NHS/private dental practice in North Devon. The clinical waste generated during treatment sessions over a specified period in this practice was audited by the research team.

Data collection

Clinical waste at the study practice is collected weekly by a waste management company and collection is always scheduled for a Friday. A decision was made to carry out the waste audit on two separate occasions: Thursday, 28 August 2014 (session 1) and Wednesday, 10 September (session 2). This would ensure that a sufficiently large amount of waste was available from which to select a sample. In addition to examining the contents of the waste bags from the two data collection sessions, the total clinical waste for session 2 was weighed to provide an estimate of the mass of waste produced. Since the waste that was weighed on session 2 had accumulated over a four day period, its mass was inflated by a factor of 25% in the analyses in order to estimate the amount of waste produced in a working week (five days). Waste was recorded and classified according to the type of material and the frequency with which it was found. A range of the most common items used in each treatment session was photographed. Each item was identified, weighed, and the amount of waste recorded (frequency and mass).

Minimising the risk of bias

The clinical waste audit was conducted on days of the week shortly before collection was due, and on two occasions separated by a five week interval. This allowed for some variation in clinicians and in working practices and treatments. Ultimately, the focus of the study is the use and disposal of dental consumables and not an examination of treatment so the potential for bias is reduced. All data entry has been quality assured by: (i) a sample of quantitative data entry that was audited by a member of the audit team not involved in entry; (ii) an audit trail that has been kept for all aspects of the project.

Ethical approval safety and study conduct in relation to normal working of the practice

Activities took place using the code of practice for research developed through Plymouth University's Faculty of Health and Human Sciences Research Ethics Committee. All data collected were anonymised to protect the participants and maintain confidentiality.

Table 1 The independent variables:

Clinical waste items	Variable
Sterile wrapping	Recyclable waste variable (IV1): Within each dental clinical waste bag (Percentage of [mass of recyclable clinical waste items per / total mass per bag])
Tissues, gloves, bibs, 3 in 1 tips, other clinical items	Non-recyclable waste variable (IV2): Within each dental clinical waste bag (Percentage of [mass of non-recyclable waste items per bag / total mass per bag])

Patients were aware of a researcher in the building. The practice used an electronic notice board and information about the study was made available as part of the daily notices. A reflective log noting any issues that impact on study design or practical issues of data collection was maintained throughout the study period. This was used to make any necessary revisions to inform a possible larger study involving diverse dental practices. Relevant and appropriate protective clothing and face shields were used during the data collection process.

Data analysis

Descriptive statistics describing the composition of the clinical waste at the participating dental practice were obtained from the raw data using the statistics package SPSS version 21. Further analyses were undertaken to explore whether simple linear relationships exist between the possible recyclable waste (sterile wrapping packaging) and the total mass of waste within each dental clinical waste bag. In order to undertake this linear regression analysis, the data for each clinical waste bag were uploaded onto Microsoft Excel. The clinical wastes of these bags were divided into two groups namely recyclable waste (sterile wrapping packaging) and the non-recyclable waste (all other clinical waste items). These data formed the independent variables respectively of the simple regression analysis as reflected in Table 1. The 'Y' variable of the simple linear regression analysis were the natural logarithm of the total mass of each dental clinical waste bag recorded during the dental waste audit by this research study and of each simulated clinical waste bag. The identified coefficients associated with the recyclable and non-recyclable waste within the dental clinical waste bags indicate whether there are any minimum immediate potential financial cost savings (recyclable waste) that can be made on dental clinical waste disposal.

RESULTS

The summary composition of waste bags from the clinical waste stream at the participating dental practice is described in Table 2.

Waste bags contained a median of 25 different types of item and a median of 174.50 items in total. Items were composed of seven different materials and each bag had a mean weight mass of 0.6724 g.

The most frequently disposed of items during clinic sessions can be seen in Figure 1. Tissues were the most frequently found item in the clinical waste. Gloves were the second most frequently disposed of item during dental clinic sessions; the different colours of gloves reflect size and were analysed separately due to their different weights. The sterile wrapping, in which re-usable dental instruments were brought to the treatment rooms post sterilisation and before use, were the third most frequently disposed of item type.

Figure 2 shows that paper comprised the most frequent material proportion of waste

Table 2 Waste composition minimum, maximum, sum, mean and standard deviation (N = 10 bags of clinical waste)

	Minimum	Maximum	Sum (10 bags)	Median	Mean	SD
Unique items	6	28	206	25	20.60	7.95
Item frequency	44	286	1841	174.5	184.10	78.11
Materials	4	10	67	7	6.70	1.70
Mass (g)	150	1270	6720	6118	672.4	322.6

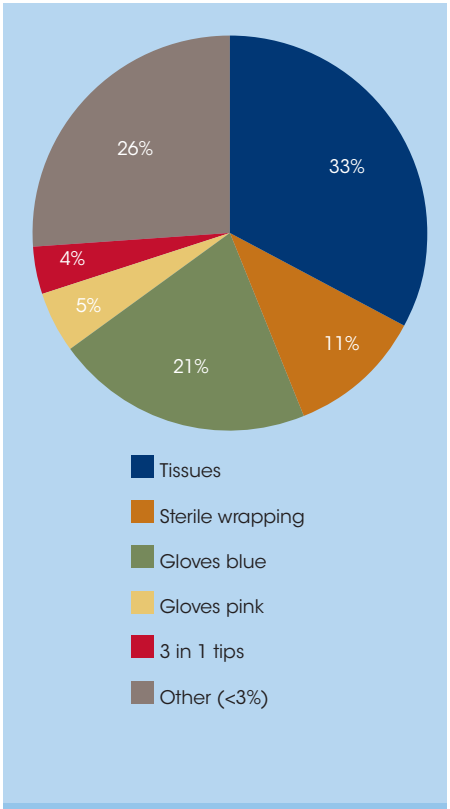


Fig. 1 Item type frequency occurrence in dental waste audit (%)

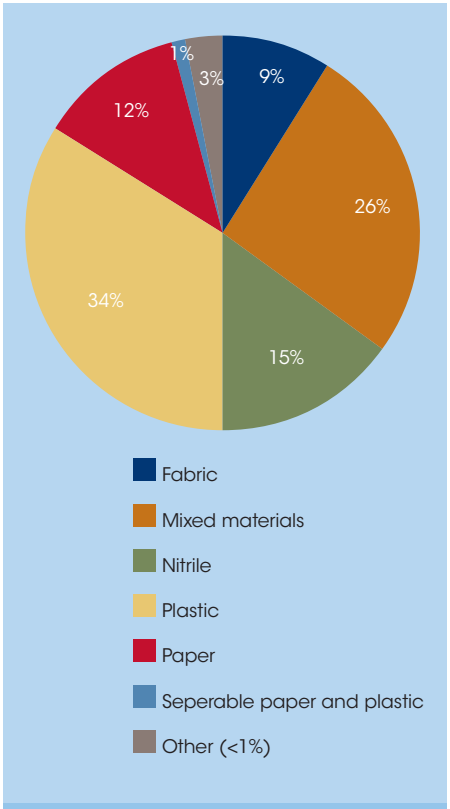


Fig. 2 Material frequency occurrence in dental waste audit (%)

Table 3 The possible coefficients associated with recyclable and non-recyclable waste within clinical waste bags

Model	Constant	Recyclable waste	Non-recyclable waste	ADJ R^2	F-STAT
Simple linear regression model: 1	1.209***	-0.012***		0.684	1082.530
Simple linear regression model: 2	1.058*		0.013***	0.706	1197.4

Note: The table reports the possible coefficients associated with recyclable and non-recyclable waste within clinical waste bags. In the simple linear regression model 1 and model 2, the natural logarithm of the total weight of each simulated clinical waste bag has been used as the dependent variable. Additionally, in model 1: for each simulated clinical waste bag, the mass of recyclable waste items over the total mass of each bag expressed as a percentage forms the independent variable, and in model 2, for each simulated clinical waste bag, the mass of non-recyclable waste items over the total mass of each bag expressed as a percentage forms the independent variable. Additionally, ADJ R^2 reports the Adjusted R^2, F-STAT is the F-statistic. ***, ** and * denotes statistical significance at the 99%, 95% and 90% levels respectively.

from the dental clinic sessions. The material nitrile, from which the gloves are made, was the second most frequently disposed of material. Plastic was the third most frequently disposed of material. The sterile wrapping, which was the third most commonly disposed of item, was comprised of separable paper and plastic material components. Separable paper and plastic was the fourth most frequently disposed of material type.

The total mass of items disposed of during the dental clinic sessions sampled can be seen in Figure 3. Almost 3,000 g of the total 6,720 g waste audited was tissues, and almost 1,800 g of waste was comprised of nitrile gloves (blue and pink). Overall the third heaviest material type was the sterile wrapping.

Figure 4 shows that paper constituted over 3,000 g of the total audited waste and Nitrile waste had the second highest overall mass (1,800 g). Mixed materials, plastic and separable paper and plastic material types all had similar overall masses of just over 500 g each.

The findings of the waste audit showed that the most common items in dental waste by frequency were also the most frequent items by mass. The material type frequency and mass findings were similarly consistent. The item type and material type findings were also fairly consistent with each other. Paper tissues and nitrile gloves were the two most commonly disposed of item and material types during dental clinic sessions.

Sterile wrapping was the third most frequently disposed of waste item. Although by weight sterile wrapping only contributed less than one third of the mass that nitrile gloves did, it is a highly recyclable piece of waste. More effective separation of sterile wrapping (for recycling) before it comes into contact with any form of contamination could potentially reduce waste amounts by up to 5 kg per week at this practice.

Table 3 shows that at 99% significant level, the weights of the recyclable waste (weight of sterile wrapping) have a negative linear relationship to the total mass of the clinical waste bags. The negative linear relationship is due to the fluctuations that exist in the weights of sterile wrapping within the clinical waste bags. The sterile wrapping fluctuates between 5% and 10% per waste bag, depending on the quantity of sterile wrapping disposed of by the dental practice during the given time period. The masses of the recyclable clinical waste (for example, mass of sterile wrapping), indicate where potential immediate minimum financial cost savings can be realised by the dental practice when, for example, sterile wrappings are not included within the dental clinical waste bags.

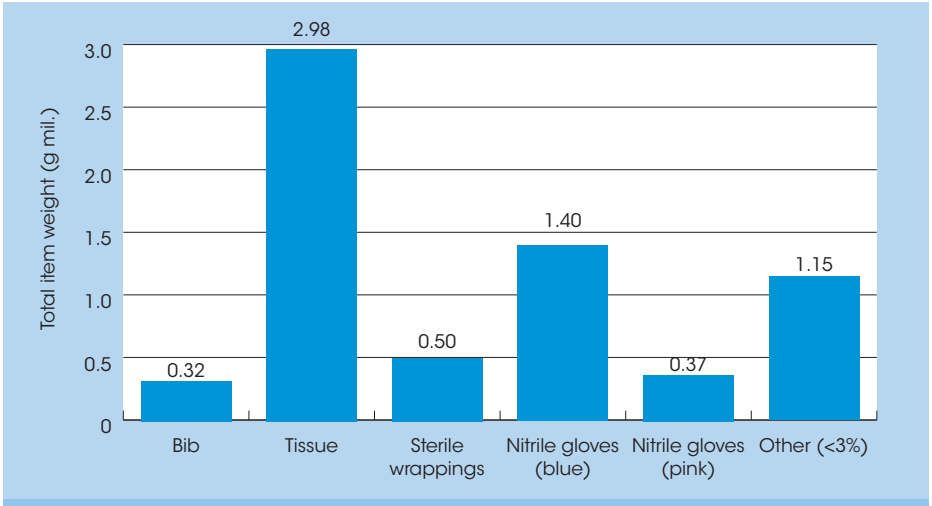


Fig. 3 Total mass for item types (grams)

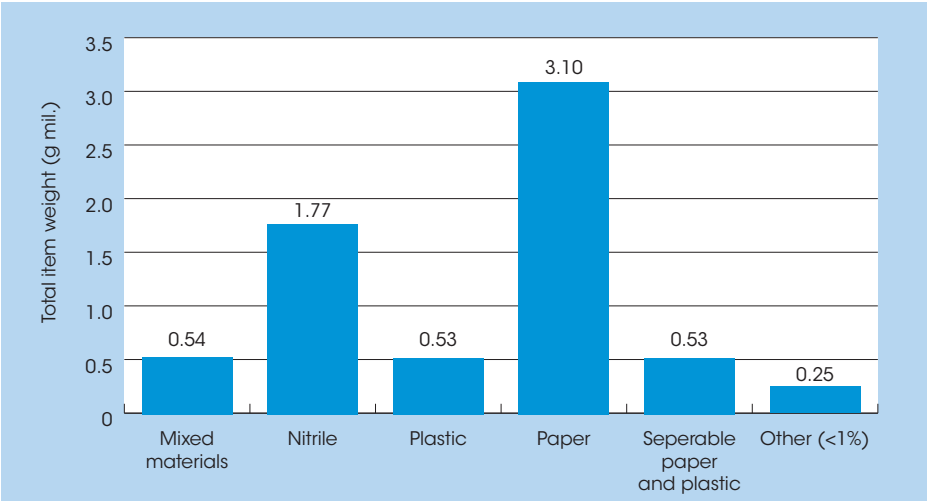


Fig. 4 Total mass for material types (grams)

'PAPER TISSUES AND NITRILE GLOVES WERE THE TWO MOST COMMONLY DISPOSED OF ITEM AND MATERIAL TYPES DURING CLINIC SESSIONS.'

At 99% significance level, the mass of the non-recyclable waste (mass of all other clinical waste items excluding sterile wrapping) have a positive linear relationship to the total mass of the clinical waste bags. This shows that an increase in the total mass of dental clinical waste will result in an increase in the weight of non-recyclable waste. In order to explore the potential GHG savings we conducted further analysis of the data related to sterile wrapping. GHG conversion factors for waste disposal were obtained from the 2011 Guidelines to Defra/ DECC's GHG Conversion Factors for Company Reporting (Table 9d).[14] The GHG for incineration of clinical waste was taken as 1,833 kg CO2e emitted per tonne of waste. This is a lifecycle conversion factor accounting for the entire product cycle from material extraction to final disposal. Defra emissions factors for incineration do not specifically account for clinical waste, which is commonly undertaken at higher temperatures. To reflect the increased emissions that are likely to result from the incineration of clinical waste, the highest available emissions factor for incineration was applied. In this audit we have about 5 kg per week of sterile wrapping = 0.005 tonnes, resulting in the following calculations:

- GHG emissions from using and disposing of sterile wrapping as clinical waste per week: 0.005 tonnes × 1,833 kg CO2e per tonne = 9.165kg CO2e
- GHG emissions from using and disposing of sterile wrapping as clinical waste per year: 9.165 kg CO2e per week × 52 weeks = 476.58 kg CO2e
- GHG emissions for using and disposing of sterile wrapping as recycled waste per week: 0.005 × 302 kg CO2 per tonnes = 1.51 kg CO2e per week
- GHG emissions from using and disposing of sterile wrapping as recycled waste per year: 1.51 kg CO2e per week × 52 = 78.52 kg CO2e per year
- GHG savings per year are: 476.58 kg CO2e – (78.52 kg CO2e) = 555.1 kg CO2e
- GHG savings per year: 0.5551 tonne CO2e savings per year.

These calculations are based on the waste in the dental practice we audited and the fact that this waste stream is always sent for incineration.

DISCUSSION

The three Rs (reduce, reuse, recycle) are commonly referred to in managing environmental sustainability. This tends to be given fairly low priority within NHS dental practices, where the focus is predominantly on patient safety, NHS targets and financial stability. Environmental sustainability in dentistry is challenging, and certainly became all the more so following the introduction of revised infection control guidelines in 2009 (HTM 01-05).[18] The guidelines encourage single use instruments, materials and consumables and reuse is discouraged wherever possible. Sterile wrapping and storage of instruments is advocated, which has had an impact on the amount of plastic and paper disposed of through the increased use of sterilisation bags.

It is difficult to argue against implementation of best practice infection control guidelines if this results in improved patient care. However, the increased use of plastic and paper wrapping is considerable and this has led to increased production of waste and cost. The practice in which this study was conducted incurred a 58% increase in waste management costs over a four-year period following the introduction of HTM 0105.[18] Reuse of materials and instruments may have limited potential in view of safety concerns, and the focus must therefore be on reduce and recycle.

Holland identified waste management as an aspect of dental practice for which it would be worth developing practice-based eco guidelines in an attempt to 'save money and minimise impact on the environment.'[20] In discussions with waste management organisations she acknowledged that 'poor waste segregation was an issue'. This has also been recognised in the NHS and long-term care sites studied by Manzi *et al.*[19] However, in this feasibility study, although some items were wrongly segregated, the majority of waste contained tissues, sterile packaging and gloves used in treatment, and was appropriately disposed of. We therefore concluded that those items appropriately discarded need to be reduced to enable both financial and environmental savings.

The British Medical Association (BMA) has also begun to raise awareness about climate change and the need to manage resources more efficiently. In the report 'Doctors taking action on climate change,'[21] the BMA looked to its own premises and identified areas where it can reduce carbon emissions, serving as an example to doctors to enable changes in practice, for example, in terms of the amount of waste produced.

A recent report by the Academy of Royal Medical Colleges[22] recognised the need for clinicians to be 'innovative in order to tackle the huge financial challenges we are facing'. The report identified a range of behaviours to achieve this, among which were highlighted the need for a 'change in culture – where doctors resolve to eradicate waste'.

To our knowledge, GHG and efficiency savings through waste reduction has not been explored within NHS dentistry. The recycling of wrapping used on sterile equipment would probably be the easiest change to implement which could result in considerable waste savings. Based on our results, the financial efficiency savings would be relatively modest due to the significant charges for removal of domestic waste and the practical difficulties in recycling commercial paper and plastic. It is questionable whether small projected savings for a six surgery practice would be sufficient incentive to influence change. This does not take into consideration a potential reduction in glove and tissue use which would also result in considerable waste reductions and equi valent cost savings. Our GHG savings are tentative, and this approach needs further development with larger data sets in order to determine suitable strategies to achieve both reduction of the GHG contribution of dental practices and make financial savings without compromising practices and care.

'STERILE WRAPPING AND STORAGE OF INSTRUMENTS IS ADVOCATED, WHICH HAS HAD AN IMPACT ON THE AMOUNT OF PLASTIC AND PAPER DISPOSED OF...'

The collection of data from a greater range of dental practices and over a greater period of time would provide a more representative data set. Using detailed data about the waste composition it would also be possible to provide more accurate estimations of dental waste production across the country and estimate cost and carbon footprint figures for any size and type of dental practice. This information could then be used to inform strategic planning for the reduction of the cost and the carbon footprint associated with dental activities and monitor changes over time.

Healthcare is under increasing pressure in terms of demands on services and the spiralling cost of providing care to an ageing population. The need to maximise efficiency has been a key feature of recent healthcare reforms with £20 billion worth of efficiency savings targeted over the last four years in the NHS. Dentistry has not been immune to these efficiency savings and has been tasked with

CONCLUSIONS

In a recent article for the *British Dental Journal*[20] Caroline Holland asks 'can a dental practice go green and increase profits?' She concludes that it is 'possible to operate an eco-friendly practice and make a difference to the bottom line'.

Holland's opinion, and the system changes recommended by the BMA and the ARMC are recent, but mark a change in attitude towards sustainable practice in clinical care.

There are significant benefits in reducing waste production within the NHS, both in terms of cost and the impact on the environment. The data from our study

would appear to support the view that it is possible to reduce carbon emissions and increase profitability, although this is likely to require a degree of reorganisation within the practice. Successful implementation of an environmentally sustainable approach to waste management will be dependent on the practicalities involved and the financial incentives for adopting such practices. It is therefore unlikely that significant change will be affected without the influence of government.

STUDY LIMITATIONS

This feasibility study was carried out in one dental practice so the data must be treated with caution and should not be generalised. However, the study achieved its aim of providing valuable data for a larger study to further explore the findings. The waste audit only included 9% of the clinical waste in a specific time-frame and didn't include domestic waste or observations of practice.

Benefits to NHS dentistry:

- Reduction of NHS carbon emissions through reduce, re-use and recycle approaches
- Income generation from viewing waste as resource/recycling
- Reduced waste management costs
- More data is required, but this approach has the potential to inform strategic planning in dentistry.

Benefits to patients

- Potential efficiency savings within NHS dentistry
- Supports greater choice for patients who are concerned about sustainability and the impact of healthcare on the environment
- Limiting the environmental burden of dentistry will have a positive impact on patients' general health and wellbeing (for example, reduced respiratory disease, allergies etc).

We would like to thank the Institute for Sustainability Solutions Research at Plymouth University for funding this study, and staff in the practice for their time, patience and support during data collection.

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Child protection: FGM

Since November 2015 it has been mandatory for health professionals to report incidents of female genital mutilation (FGM) to the police. *BDJ Team* spoke to **Sandra Robinson**, Helpline Team Manager at the NSPCC, to find out more.

Introduction

In November 2015, John Cameron OBE, Head of Helplines at the National Society for the Prevention of Cruelty to Children (NSPCC), released a statement regarding Female Genital Mutilation (FGM). The UK Government has now made it mandatory for health and social care professionals and teachers to report incidents of FGM to the police. The NSPCC is keen is ensure children are protected from FGM and that victims are identified, protected and supported and that offenders are brought to account. It believes that adults and professionals have a key role to play in encouraging and supporting children to come forward.

FGM has been illegal in the UK since 1985, but as yet no one has been found guilty of it. The NSPCC set up an FGM helpline in summer 2013 as it became aware that other child protection concerns within the family and a professional who suspects a child has undergone the practice can often debate whether to report what's happened given they think harm has already been done.

'THE FGM ISSUE OFTEN POSES A DILEMMA FOR PROFESSIONALS IN HEALTH RELATED ROLES. IT IS A COMPLEX FORM OF ABUSE'

the FGM issue often poses a dilemma for professionals in health related roles. FGM is a complex form of abuse – often there are no

Since launching, the NSPCC FGM helpline has received over 900 contacts from the

Q&A with Sandra Robinson, NSPCC

1. Are you aware of any calls being made to the FGM helpline from dental professionals?

We have not had specific calls from dental professionals; however, the helpline does receive calls from a variety of professionals who have wanted further information, advice and guidance or to discuss specific concerns for a child. This has also included calls about the Mandatory Duty to report and from professional such as nurses who are meeting with a woman who they suspect may have had FGM and just want to talk through how to have that conversation.

2. Are there areas of the UK where FGM practices are known to be more commonly carried out?

FGM can happen anywhere in the UK. However, there are large populations of practising communities in:

- London
- Cardiff
- Manchester
- Sheffield
- Northampton
- Birmingham
- Oxford
- Crawley
- Reading
- Slough
- Milton Keynes.[1]

3. In the UK where is FGM usually carried out?

It is believed that FGM happens to British girls in the UK as well as overseas (often in the family's country of origin). Girls of school age who are subjected to FGM overseas are thought to be taken abroad at the start of the school holidays, particularly in summer, in order for there to be sufficient time for her to recover before returning to her studies.

FGM performed in this country would be in private home environments and is therefore not carried out under medical procedure or by trained professionals. It is illegal to perform FGM in the UK, to assist a girl to perform FGM on herself or to assist in facilitating a child who is UK national or permanent resident to have FGM performed in another country.

4. Would you recommend that dental practices display FGM posters/ helpline numbers on their walls?

Yes, for a number of reasons. It should be displayed in professional areas so any member of staff can contact if they want more information or have a concern for a child. It should also be displayed in public waiting areas so anybody who attends the surgery is aware there is help and support out there should they need it. The FGM helpline is there for everyone.

5. If dental professionals have concerns about a patient and suspect FGM, what is the first step they should take?

If a child discloses (this is any female under 18) they have had FGM or, on routine clinical examination you believe FGM has been practised on a child, then you need to inform the police as part of the Mandatory Reporting procedures under the Serious Crime Act 2015. This will usually be through calling 101 but if the injury is recent or the child is in imminent danger then use 999. Be prepared to give your name, contact details and professional role; you will also need to give the name, date of birth and address details for the child. Remember to contact the safeguarding lead for your organisation in addition to reporting to the police, and take the police reference number so you can share this with them also. The duty is an individual duty and must be reported by the person who has identified the issue. Timescale should be as soon as possible but should certainly be within 24 hours although in some circumstances a longer delay may be acceptable, however, remember the safety of the girl or others at risk must always be the priority.

'IS IT BELIEVED THAT FGM HAPPENS TO BRITISH GIRLS IN THE UK AS WELL AS OVERSEAS (OFTEN IN THE FAMILY'S COUNTRY OF ORIGIN)…'

public and professionals and over 300 have been so serious they have been referred onwards to children's services and the police. One example of a call involved a doctor who called anonymously with a concern about a patient. The patient's father was preparing for his daughter to visit Somalia, but wouldn't give the doctor any details about why she was going there. The patient and family's details were then passed on to local children's services to follow up.

The NSPCC believes that any parent who has allowed FGM to happen to their child needs not only to be brought to account for their action but their attitudes and beliefs need to challenged. FGM is traumatic for every victim and it is essential that the NSPCC provides psychological support for the women and girls who have gone through it and that it works to best assess any further risks to children within the same family.

Girls are more at risk if FGM has been carried out on their mother, sister or a member of their extended family.[2]

A study in 2015 reported that no local authority area in England and Wales is likely to be free from FGM entirely and that women and girls from affected communities in areas with lower known cases may be more isolated and in need of targeted support.

If you have concerns the FGM may have taken place or been told by someone other than the child then you would follow your organisation's normal safeguarding procedures and consider a report to children's services and/or police. This is the same as you would do for any safeguarding concern.

In general it is always good to keep families informed and involved when you are addressing concerns for a child, however, if in doing this you are putting that child or other siblings at risk do not discuss with the family and take advice from your designated safeguarding lead.

Information on what could be included in local procedures can be found in new statutory multi-agency guidance on FGM published (1 April 2016) on page 50, section D2.2.[3]

6. If you want to know more about FGM are there any free resources available?

e-Learning for all professionals (including teachers, police, border force staff, and health visitors), developed by the Home Office, is available at www.fgmelearning.co.uk.

Health Education England offer e-learning, free to access by health and social care professionals, at www.e-lfh.org.uk/programmes/female-genital-mutilation/.

7. Do you have any other general advice for dental professionals working in communities with a high proportion of residents from countries where FGM is common?

As well as the FGM helpline the NSPCC helpline 0808 800 5000 is available 24/7 to discuss concerns for a child on any issue. There is also an email address help@nspcc.org.uk.

I would also recommend the NSPCC website www.nspcc.org.uk this has loads of really good information on FGM and a range of other issues such as Underwear Rule Campaign (how to talk to children about their privates staying private), Share Aware and Net Aware (raising awareness of online safety, information about apps used by children and how you can talk to your child about staying safe online).

You can also sign up to the NSPCC Library service and get regular safeguarding updates. You can do this through the NSPCC website >Research and Resources > Sign up for CASPAR.

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If you think someone is potentially at risk of FGM or you want to report a concern/need advice please contact the NSPCC helpline on 0800 028 3550 or email **fgmhelp@nspcc.org.uk** – you can remain anonymous if you wish. Alternatively if you know a child who is concerned about FGM - please encourage them to call ChildLine on 0800 1111 anytime.

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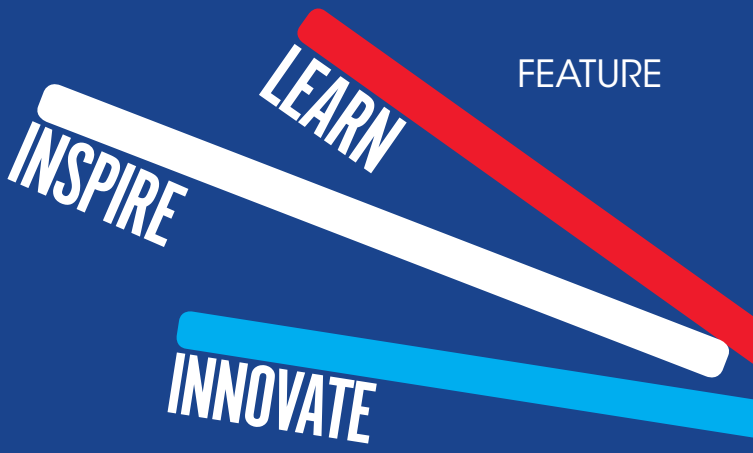
CQC what you need to know



Richard Harris[1] at the British Dental Association sets out all you need to know about CQC inspections

Just over a year ago, the CQC changed the way in which they assess dental practices. Can you briefly outline what the main changes were?

Essentially, I think it is important to realise that under the new system the CQC is still looking at more or less the same subjects as it did previously. There used to be 16 (of the 28) outcomes which could be inspected during a visit and these have now been compacted into 11 new fundamental standards. However, that's not all. These fundamental standards have then been grouped into five key questions and it is these questions that the inspectors need answers to, to establish whether a practice is compliant or not.

What are these five key questions?

These five key questions ask if the service provided is safe, effective, caring, responsive and well-led. In order to secure answers to these questions, there are Key Lines of Enquiry (KLOE) which should give answers to satisfy the key questions.

Lost? Well, let's walk through one. Under the 'Is it safe?' key question, one of the KLOEs is 'What systems/processes are in place to ensure that all care and treatment is carried out safely?' Now, we think – and it can only be an opinion – that you might look at 'managing risk', where staff know what actions to take in the event of an emergency, and 'controlling/preventing infection', where all clinical staff are aware of the infection control and decontamination requirements.

How can a practice best prepare for an inspection?

We have an advice publication, *CQC – safe, effective, caring, responsive and well-led*, available to all BDA members (check with your principal), which breaks the key questions down into manageable chunks and lets you establish to what extent you meet them.

Although the advice publication is accessible to all BDA members, the 170 associated editable policies and procedures are exclusively available for BDA Expert members. These allow you to change a template to fit your practice's circumstances and are updated whenever legislation or regulations change.

We also produce a 'What to expect from an inspection' booklet, again available to all members, which details the timescales and what might happen on the day. There will, more than likely, be two inspectors and the visits seem to be lasting around four to five hours.

Reading through the booklet and checking whether you do most of what we suggest would certainly stand you in good stead ahead of any inspection.

If any issues are identified by an inspection, what should the practice do?

After the inspection you will be given feedback on what was found; it is an idea to listen carefully, as you may be told to do something which – if you do as instructed – might not necessarily appear in the final report.

If there has been a breach of the regulations, you will be told and, hopefully, given a steer as to how you might rectify it, although the CQC says that is not its role; it checks for compliance, but does not give advice on how to do it.

You will normally be sent the draft report within three weeks and this is the opportunity to check it for factual accuracy and to challenge anything you do not agree with.

Unfortunately, issues cannot be unseen, so if it happened on the day, but does not normally, the CQC cannot remove it from the report, as it is a snapshot of the practice on the day the inspection was undertaken.

Bearing in mind there will be two people in the surgery for about five hours each, they are probably going to find something; most practices have been given something they 'should' do. This will appear in the report and should be done 'over time'. However, if there is a 'must' in the summary, this means you have breached a regulation and that has to be done within the next few weeks normally (there are a few that are so serious that practices must address them immediately).

BDA Extra and Expert members can talk to our Compliance Team on 0207 7563 4567 or email compliance@bda.org if they have any queries with, or want a comment on, their draft reports.

bdjteam201682

BRITISH DENTAL CONFERENCE & EXHIBITION 2016

26 - 28 May | Manchester

Richard will be available to talk to BDA members and non-members about compliance issues in the Advice Zone at the British Dental Conference and Exhibition (www.bda.org/conference), Manchester, 26-28 May. You can also listen to his talk on 'CQC: what is it up to?' at Speaker's Corner on Thursday, 11.30.

You may also be interested in John Milne's (National Dental Advisor for the CQC) talk about the 'CQC: what to expect when we inspect', in the Personal Development Theatre at the Exhibition on Thursday, 11.00.

[1] *Richard has worked at the BDA for more than 16 years in total. For many years he worked with the General Dental Practice Committee and, after a brief stint elsewhere, as the first point of contact for members with Care Quality Commission (CQC) issues*

The fizzy drinks tax

Will a tax on sugary drinks have an impact on levels of dental caries or obesity? We present a selection of views from individuals and associations within the dental industry.

Introduction

In his budget on 16 March 2016, Chancellor George Osborne said that he will impose a levy on soft drinks with total sugar content above 5 g per 100 ml, with a higher rate to be paid on drinks with more than 8 g per 100 ml. The levy will not apply to milk-based drinks or fruit juices. The Government says that the levy, which will be imposed on producers and importers, will raise around £520 million each year, and the English share of the proceeds will be earmarked for increasing sport and extracurricular activities in schools.

With a single can of pop containing more than a child's recommended daily intake of sugar, the Government's emphasis is on incentivising manufacturers to reformulate their products.

'A naïve way of dealing with a complex issue'

Sharif Islam, dentist

Sharif's letter 'Pillaging from dental hygienists' caused a stir in the March issue of BDJ Team' (http://bit.ly/1Qupkt5)

I can actually hear them cheering. Jamie Oliver is jumping around and gesticulating even more wildly than usual; the Left are toasting each other because, let's face it, it's another tax and, to paraphrase Will Rogers, they never met a tax they didn't like. The headlines are claiming it's a victory in the fight against obesity, especially amongst children. The dental profession is clasping their hands in glee saying it's about bally time. The Government is patting itself on the back for being so progressive while simultaneously deflecting from the grand larceny in its budget.

But a sweetener on the deal this ain't. Because they're all wrong.

A sugar tax is probably one of the most pernicious, punitive and pointless taxes in a generation, and there have been lots of those. To think that punishing consumers for buying sugary drinks is instantly going to change their behaviour and reduce obesity (and decay) rates suggests that the Government has been inhaling too much of its own product.

Sugar is bad. We know. Added sugar in the diet has no nutritional value to human biology whatsoever. All the excess sugar you consume simply spikes your insulin and gets shunted into storage around your belly and thighs. Coupled to a sedentary lifestyle and voila, obesity. To say nothing of the rampant caries it cultivates in your teeth.

Unfortunately adding a levy to certain drinks based on their sugar content is lacking in both logic and science. Fruit juices will be exempt owing to their apparent nutritional value. Really? Fruit juice is nutritious? A glass of freshly squeezed orange juice is simply the accumulated sugary water from about six oranges and probably spikes your insulin as much as a glass of soft drink. But wait, it's full of vitamin C, right? Yep, that's the added ingredient. Whereas an actual single orange has just enough natural sugar coated in fibre, B and C vitamins and precious phytochemicals. Try one; you might like it.

To say nothing of diet soft drinks, apparently better because they're sugar-free. Unfortunately their acid content will still honeycomb your enamel and dentine into Swiss cheese, especially when they become a more popular option exempt from the levy. The critical pH for enamel to demineralise is 5.5. Cola is around 2.5. You can do the chemistry.

To say nothing of the vanilla soy cinnamon latte the lady sitting next to me is drinking. I wish I could maintain a physique that svelte while drinking a Styrofoam cupful of sugar. But rather than discouraging food companies from putting sugar in their products in the first place let's penalise people for consuming it at the other end (!) It's a bit like when tobacco companies deliberately made their cigarettes more addictive but the smoker got hit with a higher tax on purchase. Of course, the Government won't dare antagonise the food industry. After all, if we all made healthier choices, the food, drug and diet industry would all lose considerable stock.

Public awareness about sugar is higher than ever and overall consumption is decreasing. We even have traffic lights on our food labels to inform us. So who is actually going to suffer this tax? It's the people at the poorer end of the economic spectrum that can't afford the healthier choices in the produce aisle and rely on multi-buy deals on junk food to feed their kids. In other words, the people who can least afford it.

'PEOPLE WILL SIMPLY BUY DIFFERENT BRANDS OR UNLEVIED DRINKS TO GET THEIR SUGAR FIX.'

But is it even going to generate any significant income? Can anyone be genuinely taxed out of their behaviour or choices? Nope. People will simply buy different brands or select unlevied drinks to get their sugar fix. Companies will substitute sugar with chemicals like aspartame and saccharin, the latter of which is known to spike insulin in the same way as sugar. Worse still, they may resort to using high-fructose corn syrup like the Americans, an ingredient even more insidious than sugar for increasing obesity. In Colorado last year a friend took great pleasure in showing me random items from their supermarket shelves to demonstrate its ubiquity. They even put it in hummus!

The Government wants to use the income from this sugar tax to fund sport at schools, an idea roughly as noble as taxing guns to fund the gurneys after we've shot each other. Something about a horse bolting and a stable door comes to mind. If they were serious about this issue they could simply mandate more physical activity in state education, preferably at the start of each day, which would lead to more enthusiastic learning, better exam results and fitter students by the end of it.

In fact, it always staggers me that nutrition is not a mandatory part of the school syllabus. Not every human being smokes, drinks, takes drugs or has regular exercise, but every single organism on the planet has to feed on something to stay alive. So given that it's the primary lifestyle factor affecting human health by a large margin why in the name of muffin tops is it not an essential part of our education? It would take a mere generation to arrive at better choices, leading to a reduction in rates of chronic and costly diseases like obesity and diabetes.

Proponents of this tax argue that it is simply one cog in the overall mechanism to increase awareness and reduce obesity rates. That's a conveniently naïve way of dealing with a complex issue. Societal attitudes to nutrition and lifestyle probably need to change but they change slowly and a tax won't help them get there any sooner. People are still smoking and drinking despite the huge levies on cigarettes and booze.

All dental professionals, from dentists to hygienists to oral health educators, need to play their part in discouraging excessive sugar consumption. A well-articulated conversation with our patient can be far more effective than a punitive tax. But as HM Government invents ever more ways to send our money on a futile chase after the spiralling demands of a chronically indebted budget it may not be long before something else is stolen. And not to fund someone's need to snort coke but their need to drink Coke.

Good luck with that.

'ALL sugar should have a tax'

Shaun Howe RDH, *BDJ Team* reader panel

Ask yourself, what is the point? A small levy on fizzy drinks will not really address the problem of obesity but from our perspective we have the potential of maybe reducing tooth decay. I am not convinced we will notice any significant difference and either way, it may take a generation to show any effect. Fruit and milk-based drinks will be exempt and these are notoriously high in sugar and any dental nurse, hygienist or therapist knows that the natural sugars in fruit are released and become cariogenic the moment you blitz them in the smoothie maker, not to mention the natural acids already present.

This is another stealth tax that helps future governments provide 'health promotion' by taxing us. Okay, it is a step in the right direction but ALL sugar should have a tax and the Government needs to really decide what are foods (no VAT) and what are true luxuries so that VAT can be put on high sugar foods such as cakes. The problem is not necessarily what we eat, but more about how we move (in obesity terms). A drop in tooth decay? Not that I can see and it is probably almost impossible to monitor even over generations.

'I AM NOT CONVINCED WE WILL NOTICE ANY SIGNIFICANT DIFFERENCE [IN TOOTH DECAY].'

'1 g, 4 g or 10.6 g of sugar causes an acid attack regardless'

Nicola Sherlock RDN, *BDJ Team* reader panel

The recently announced sugary drinks tax will require companies to pay a levy according to the amount of sugar in drinks. Manufacturers are expected to pass that charge onto the consumers via higher prices in the shops although the industry has been quoted to state that [the tax] 'is more likely to cause job losses rather than make children less obese'.

Jamie Oliver believes it will not only reduce consumption but force the soft drinks industry to 'reformulate more quickly'. However, when the levy is looked at more closely, the first 4 g of sugar in 100 g is not taxed so if the industry does choose to revise their recipes rather than pass the price on to the consumer, surely a reduction to 4 g will be the most likely revision, which may reduce childhood obesity but it won't make a big impact in the dental world in reducing the decay rate: 1 g, 4 g or 10.6 g of sugar causes an acid attack regardless.

It is also disappointing that the extra revenue will not be used to reduce the price of fruit and vegetables to encourage healthier choices as suggested by the 'Food for thought' report by the British Medical Association[1] (of the £520 million expected, £160 million will fund sport in schools and £285 million will be put to use extending the school day).

Although if anyone had any gripes about the plastic bag tax, they are certainly bringing their neatly folded canvas bag to and from the supermarket now, so maybe it is a small step in the right direction.

1. British Medical Association. *Food for thought: promoting health diets among children and young people*. July 2015. Available at: http://bit.ly/1D1jtHF (accessed April 2016).

'IT IS DISAPPOINTING THAT THE EXTRA REVENUE WILL NOT BE USED TO REDUCE THE PRICE OF FRUIT AND VEGETABLES.'

'Dental caries is the one disease where evidence supports sugars having a contributory role'

Josie Beeley, Hon Senior Research Fellow, University of Glasgow

The British Dental Association (BDA) should congratulate George Osborne on imposing a tax on sugary drinks in the recent budget in an attempt to reduce the incidence of a major disease in the UK. Unfortunately he gave that disease the wrong name. It should have been dental caries rather than obesity! This is the one disease where evidence supports sugars having a contributory role.

Obesity however is not a disease, but a disorder with just one cause, calorie intake exceeding calorie expenditure.

Hopefully at the legislative stage, the tax will refer to 'non milk extrinsic sugars' and not just 'sugar'. An error then might result in a tax on milk!

Ed's note: this is due to be published as a letter to the editor of the British Dental Journal.

'HOPEFULLY THE TAX WILL REFER TO NON MILK EXTRINSIC SUGARS, NOT JUST SUGAR'

'Better education and a population motivated to be healthier is the answer'

Elaine Halley, cosmetic dentist, Cherrybank Dental Spa, Scotland

Sadly as a nation we do not have a good history when it comes to the amount of sugar in our diet. For children, this means that the number one cause for children having general anaesthetics is tooth decay – this is a shocking statistic that a preventable disease is causing so much harm.

I think the debate about the sugar tax is an interesting one. Regardless of the passing of this tax, better education as to what are truly healthy and unhealthy habits and a population motivated to be healthier is surely the answer. We have a culture of making unwise health decisions and the consequences of losing teeth early in life are serious and can lead to other problems such as a fear of the dentist or teeth not growing in correctly. That is not to mention the damage that a high sugar diet can do to the rest of the body. We do see children who have been told by other dentists that they need extractions of baby teeth due to decay – and often the parents come to us desperate for another opinion and another way. Generally whether the teeth can be saved or not depends upon the child's age and ability to sit in the chair. Sadly – we often see the problem too late – the damage is done.

'AS A NATION WE DO NOT HAVE A GOOD HISTORY WHEN IT COMES TO THE SUGAR IN OUR DIET.'

'There needs to be consistency and clarity in food labelling'

Fiona Sandom, president of the British Association of Dental Therapists (BADT)

The Chancellor's introduction of a sugary drinks tax is a positive step forward – and highlights the need for health education, especially about children's dental health – an issue which often gets overshadowed by the so-called childhood 'obesity crisis'. Because more serious health problems can result from poor dental health, I would have preferred to see a significant proportion of the revenue put towards improving access to preventative dental health care, particularly in the more deprived areas of the UK.

Moving forward, there now needs to be consistency and clarity in food labelling, as well as some robust measures taken to limit the strategies of drinks companies especially as tactical marketing ploys such as end-of aisle displays, price discounting and sponsorship were all cited as major influencers in the increased sales of carbonated drinks in last year's Public Health England study.

'CHILDREN'S DENTAL HEALTH OFTEN GETS OVERSHADOWED BY THE "OBESITY EPIDEMIC".'

'Industry finally has a reason to start cutting the dose'

Mick Armstrong, Chair of the BDA

Many were expecting half-measures from government on sugar, so today's announcement looks like progress.

Britain's sugar addiction is costing the health service billions, and it's only right the drinks companies should make a fair contribution. Health professionals are confronting a preventable epidemic, and parents, government and the food industry all need play their part.

Sugar is cheap, addictive and-nutrient free, and industry finally has a reason to start cutting the dose.

'HEALTH PROFESSIONALS ARE CONFRONTING A PREVENTABLE EPIDEMIC...'

'This is a step in the right direction'

Mick Horton, Dean of the Faculty of the General Dental Practice (UK (FGDP[UK])

This is definitely a step in the right direction. Sugary drinks are now children's biggest source of dietary sugar. In England, two in ten are obese by the time they leave primary school, and tooth extraction is the primary reason why children are admitted to hospital.

Whilst investing in school sport is laudable, there is a need to educate the public as to the dangers of a high sugar diet and the potential risks to health of childhood obesity, diabetes and avoidable dental extractions.

The Government could have used this levy to challenge the culture in which the average person drinks two litres of high sugar soft drinks every week, and we look forward to seeing further measures in the Childhood Obesity Strategy.

'WE NEED TO EDUCATE THE PUBLIC AS TO THE DANGERS OF A HIGH SUGAR DIET.'

'More pressure needs to be put on manufacturers'

Nigel Carter OBE, Chief Executive of the Oral Health Foundation

While welcoming what is obviously a positive step in addressing the current children's dental health crisis and 'obesity epidemic' we are facing in the UK we feel that the measures outlined do not go far enough and more pressure needs to be put on manufacturers.

By implementing the levy on manufacturers and not the consumer pressure is now on companies to change their products; we have to now make sure that they do just this and not continue with their current models and pass the cost onto the consumer through price raises.

Giving manufacturers two years to review their products and potentially reduce the amount of sugar in them is a positive move, and we now want to see food and drink manufacturers seriously evaluate their products with the aim of reducing their sugar content or make it more obvious the amount of sugar in them.

We are also happy to see the money raised by the levy go to towards school sports, but we feel some of these funds could have been used to educate the public about preventing oral health problems, which are some of the biggest health issues facing children in the UK.

What we have seen today with the sugar levy announcement is a very clear and effective statement from the Government that they are trying to tackle the nation's growing health problems but there is still so much more for them to do.

'SOME OF THESE FUNDS COULD HAVE BEEN USED TO EDUCATE THE PUBLIC ABOUT ORAL HEALTH.'

'It's imperative that the levy is at least 20%'

Professor Graham MacGregor, Chair of Action of Sugar

We are delighted to see in today's budget announcement that the Government will be introducing a new sugar levy on soft drinks which will be used to double the funding they dedicate to sport in every primary school.

However, for this to be effective it's imperative that the levy is at least 20% on all sugar-sweetened soft drinks and confectionery and escalate thereafter if companies do not comply to reformulation targets – and this must be implemented immediately.

The country is still eagerly awaiting for David Cameron to announce his long overdue childhood obesity strategy and he now has a unique opportunity to produce a coherent, structured evidence-based plan based on our six key recommendations, which includes food and drink reformulation, to prevent obesity, type 2 diabetes and tooth decay.

'DAVID CAMERON HAS A UNIQUE OPPORTUNITY TO PRODUCE A STRUCTURED PLAN TO PREVENT OBESITY, TYPE 2 DIABETES AND TOOTH DECAY.'

What do you think of the levy on sugary drinks? Email bdjteam@nature.com or comment at www.facebook.com/bdjteam.

bdjteam201683

HTM 01-05: *eating the elephant a bite at a time*

If managed efficiently, being nominated your practice's decontamination lead can be an empowering opportunity for you and your team. **Emma Male**[1] explores a practical, step by step approach to applying HTM 01-05 to your practice.

Eating the proverbial elephant

When I was asked by my employer in 2009 to convert 86 pages of a new decontamination guidance document into an efficiently functioning decontamination system for our busy, five-surgery dental practice, it felt like I had been asked to split an atom while summiting the north face of the Eiger. I could not envisage me, a newly promoted Clinical Manager with a purely dental nursing background, steering our practice ship through the seas of decontamination compliance. However, with a deep breath, a positive approach and with a practice principal who believed in me, I made a plan and broke down what seemed like a mammoth task into small manageable chunks.

[1] *Emma is Practice Manager at Martock Dental Practice and director at Elite Dental Nursing Ltd. She has worked in dentistry since 2003 and during that time has worked as an orthodontic nurse, dental implant nurse, practice manager, a dental nurse tutor on the National Diploma in Dental Nursing as well as providing in-house dental implant nurse and CPD training.*

'Start with why'

To quote leadership expert Simon Sinek, I needed to 'start with why' (https://www.startwithwhy.com/). Sinek believes that when you know why you are doing something, you then know the underlying value of doing it, thus you are more likely to complete the task well. If I was to get compliance from our team in operating new decontamination procedures then I needed to fully understand the 'the why' of HTM 01-05 guidance and importantly, ensure our team did too.

Why is HTM 01-05 guidance important?

- HTM 01-05 is a document designed to be used as guidance for decontamination in dental practice first published by the Department of Health in 2009 and updated in 2013[1]
- Its aim is to improve the standard of decontamination in primary care dental services by giving guidance on decontaminating reusable instruments and related measures taken to reduce cross infection, thus protecting patients and staff
- By adhering to the guidance, healthcare providers are complying with the Health and Social Care Act 2012 which they are legally and morally obliged to do.[2]

Team responsibility and accountability

Effective infection prevention control and compliance is achieved by ensuring that all team members who are involved in clinical and decontamination procedures and all management staff are adequately trained and knowledgeable of their roles and responsibilities.

All staff registered with the General Dental Council (GDC) must adhere to the GDC's *Standards for the dental team*.[3] It is each staff member's responsibility to complete verifiable continual professional development (CPD) in areas including cross infection control. It is also their responsibility to ensure they have received the mandatory and recommended vaccinations required to safely work in a clinical environment and to ensure anything which may affect their fitness to practise is declared and reviewed in the appropriate manner.

The GDC's standards relevant to infection prevention control are:

Standard 1 Put patients' interests first

Standard 6 Work with colleagues in a way that is in patients' best interests

Standard 7 Maintain, develop and work within your professional knowledge and skills

Standard 8 Raise concerns if patients are at risk.

Clear job descriptions documenting infection control roles and responsibilities can also ensure accountability of staff members carrying out decontamination.

How does HTM 01-05 fulfil its purpose?

The HTM 01-05 guidance document ensures compliance in decontamination in primary care dental practice by:

- Providing accessible online reference
- Ensuring practices have local policy in each area of cross infection control
- Ensuring regular auditing is carried out of all cross infection control procedures
- Ensuring practices have a local policy in place for each aspect of infection prevention
- Ensuring regular cross infection control training is undertaken by staff
- Setting two levels of compliance: Essential Quality and Best Practice
- Ensuring practices have a team member accountable for all decontamination procedures.

The guidance document is broken down into three sections:

1. Decontamination policy and foreword
2. Advice to dentists and practice staff (local decontamination)
3. Engineering, technology and standards.

Auditing

As well as providing primary care service with guidance HTM 01-05 stipulates that an audit of compliance must be carried out every six months. The Infection Prevention Society has a free downloadable audit tool available for use by all practices at the following link: http://www.ips.uk.net/professional-practice/resources1/dental-audit-tool/.[4]

When auditing compliance the decontamination lead in your practice or another trained staff member will check and initiate compliance in the following areas:

- Prevention of blood borne virus exposure
- Decontamination, environmental design and cleaning
- Hand hygiene
- Management of dental medical
- Personal protective equipment (PPE)
- Waste management and disposal
- Legionella risk management.

Local policy and staff training

The guidance document and audit tool will ensure that dental practices have a written local policy in each of the above infection prevention measures and that staff training is carried out at appropriate intervals (usually annually).

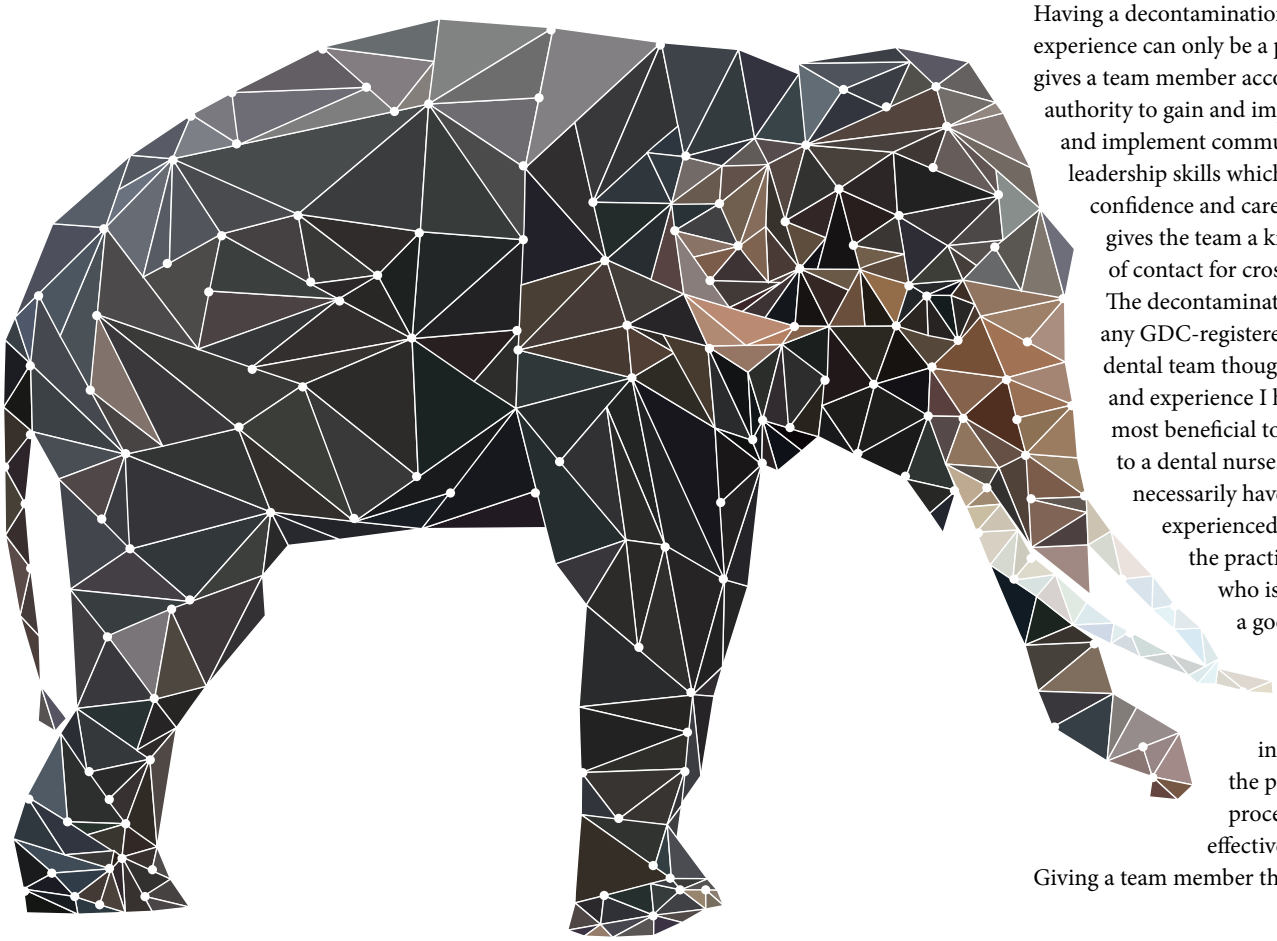
'HAVING A DECONTAMINATION LEAD GIVES A TEAM MEMBER ACCOUNTABILITY AND AUTHORITY TO GAIN AND IMPART KNOWLEDGE…'

Essential quality and best practice

The HTM 01-05 guidance document sets out two benchmarks of infection prevention compliance: Best Practice and Essential Quality. All dental practices have a legal obligation and moral duty to meet the Essential Quality standard in decontamination procedures. However, practices should have a plan in place showing that they are working towards best practice.

Decontamination lead

Having a decontamination lead in my experience can only be a positive thing. It gives a team member accountability and authority to gain and impart knowledge and implement communication and leadership skills which can encourage confidence and career progression. It gives the team a knowledgeable point of contact for cross infection control. The decontamination lead can be any GDC-registered member of the dental team though in my opinion and experience I have found it the most beneficial to allocate the role to a dental nurse. This does not necessarily have to be the most experienced dental nurse in the practice but someone who is solution focused, a good communicator and would thrive on the challenge and take pride in making sure that the practice team and procedures are efficient, effective and compliant. Giving a team member the responsibility



can be a fantastic opportunity to allow them to demonstrate their potential and credibility and lead onto gaining other areas of responsibility.

Steps to compliance

1) Familiarise yourself

Set aside some time ideally in a quiet office or surgery to familiarise yourself with the document. The document can seem daunting at first due to its size, however, once you get to know where to find information, the document becomes a valuable, easy to use tool.

2) Download the audit tool

Locate the Infection Prevention Society's audit tool which you can either download as a PDF version or download a program to your computer's desk top.[4]

3) Auditing

One section at a time, work though the audit tool to see if you are already compliant. Highlight actions to take should any areas need any attention.

4) Implementing changes

If there are non-compliant areas which are shown on the section of audit you are undertaking, you can immediately take action straight away if it is a simple task like booking a professional to come and carry out a Legionella risk assessment, for example. If it involves the way other team members work then you will need to consult, explain and possibly train them in any implemented changes in order to make sure that they understand how and why that particular action needs to be undertaken. Some actions may take a while; if this happens mark the action point on your audit point as pending and mark (if necessary) that you are currently non-compliant until you can take action.

5) Local practice policy

Once you have taken action to ensure you are compliant in the area of infection prevention which you are auditing, you will need to write a local policy. I find the easiest way to make sure I include everything into the local policy is to work through the audit and include all of the items which are appropriate to the policy. It is good practice to go through the policies at your team meetings to ensure the team know their roles and responsibilities, with them signing the policy to confirm this.

6) Ongoing audit and review

After six months of your initial audit you will need to re-audit and document any changes. Each policy should be reviewed and updated every 12 months or with any changes incurred before the annual review.

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4. Infection Prevention Society. Dental Audit Tool. V2 released June 2013. Available at: http://www.ips.uk.net/professional-practice/resources1/dental-audit-tool/ (accessed April 2016).

This is Emma Male's first article for BDJ Team *and we look forward to running further features from her in future issues.*

> ***'IT IS GOOD PRACTICE TO GO THROUGH THE POLICIES AT YOUR TEAM MEETINGS TO ENSURE THE TEAM KNOW THEIR ROLES AND RESPONSIBILITIES…'***

Key points

1. **See the role of decontamination lead as an opportunity** to develop yourself and career and include it on your CV
2. **Be wary of companies who claim that their products will make your practice compliant**; they want to sell their product rather than make your practice compliant. Always refer back to the official HTM 01-05 document if you are in any doubt
3. **Always keep your manufacturers' instructions.** They hold important information about the most effective way of decontaminating and maintaining your instruments and equipment.
4. **Not all team members will want to change the way they work. That's normal.**
   - Listen carefully to any team members who are struggling to adapt to change.
   - Reassure them by asking which aspects they are finding challenging
   - Explain why the changes are important along with benefits of any new systems
   - Ask them for their input in providing a solution which would be better suited to them and the team. Even if they cannot provide a solution, they will feel they have been listened to and will comply with the procedures you have put in place.
5. **Don't be confused by unreliable information.** In the age of social media, blogging and internet forums we are bombarded with information on a daily basis about compliance but not all of it is credible. If a practice manager in the next town keeps her patient records in an underground bunker 25 miles away from the practice because she believes that's the only way of truly being compliant with The Data Protection Act, it does not mean that this is the new national procedure we must all adapt. Take other people's interpretation of guidance lightly and always go to the correct authorities for information.

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The benefits of *mentorship* for the dental team

By **Joanne Brindley**[1] MA, FHEA, PGCLTHE, RDT, RDH

This article:

- Helps registrants to prepare for the enhanced CPD[1]
- Identifies the benefits of supporting one another in continued professional development
- Overviews the qualities required for an effective mentor
- Highlights the disadvantages of less formal online activities
- Suggests how mentorship can positively impact on the workplace.

Becoming a reflective practitioner

Becoming a reflective practitioner provides an opportunity to become an autonomous and self-directed professional. It facilitates the development of good quality care by stimulating personal and professional growth by addressing the gap between evidence-based theory and practice, underpinned by the prerequisite of insight in our past, current and future practice. In 2017 the General Dental Council (GDC) plans to transition to new Continued Professional Development rules which will change the CPD requirements for registrants, known as enhanced CPD.[1] Heralding the mantra of Rolfe[2] it is now no longer enough for professionals to know just 'what we do and how we do it', that a professional must be able to evidence the rational processes behind their decisions and judgements, to be able to demonstrate how they know. One way of addressing this is to ensure that professionals do not just have the skills, or indeed are able to demonstrate the skills to be reflective in action (show-how), but also develop a skill

[1] *Senior Dental Care Professional Teaching Fellow, The University of Portsmouth Dental Academy, William Beatty Building, Hampshire Terrace, PO1 2QG*

set that allows them to reflect on action (know-how) via an evidence-based approach which underpins their individual practice. In developing reflective skills registrants may find it useful to use another, perhaps more experienced, member of the dental team to act as a guide[3] or mentor. Schrubbe[4] describes mentors as people who are able to see more in you than you see in yourself. They assist you in creating a vision and development plan that maximises your own strengths, abilities and potential for growth. An effective mentor is able to inspire confidence in others, pushing them to their limits in order to facilitate them achieving their greatest potential. Mentorship can be viewed as an effective way of guiding fellow members of the dental team through their 'river of practice'.[5]

The skills of a mentor

The skills required by workplace mentors are: active listening skills, questioning and provision of information, feedback, facilitation of reflective skills and empathy.[6] It is interesting to note the inclusion of empathy, which is also a quality that is sought in dental undergraduates as part of values based recruitment of NHS students.[7] The relationship of mentor and mentee should be non-directive and non-judgemental, respecting the subjective world of the mentee,[6] with the caveat that they both (mentor and mentee) remain mindful of objective professional boundaries that are expected of a registrant. The positive benefits of clinical mentorship have been acknowledged by the Department of Health[8] who state that where these roles are embedded they have a 'flourishing and a demonstrable impact on patient care'. In the future new pathways could be explored with a view to creating supportive opportunities that triage those in more urgent need of mentorship support and foster opportunities to nurture the registrants who are floundering within their chosen profession.

Joanne Brindley

Dentistry has been part and parcel of my entire working life. I qualified as a dental nurse back in 1991 and I have been a GDC registrant since 1994, working in both primary and secondary care environments as a dental hygienist and therapist. I joined the University of Portsmouth Dental Academy in 2005 and I am currently a Senior Dental Care Professional Academic Tutor, where I co-ordinate the pre-clinical activities for the first year BSc students in addition to coordinating the final year students' research projects.

In 2012 I completed an MA in Learning and Teaching; my dissertation focused on the use of e-portfolios to aid in student learning. I am currently in the final stages of completing a Doctoral Thesis which is an illuminative evaluation of the use of reflection in undergraduate dental education.

I am passionate about enhancing DCP education, which is reflected in my current role as an Education Inspector for the General Dental Council.

'MENTORSHIP CAN BE VIEWED AS AN EFFECTIVE WAY OF GUIDING FELLOW DENTAL TEAM MEMBERS THROUGH THEIR "RIVER OF PRACTICE".'

Enriching the development of skills

Another way of enriching the development of reflective skills may be to use online mentorship support by embedding reflective logs and activities online via a virtual learning environment. Dabbagh[9] has identified how 'Generation Xers' (those born 1960-80), have been replaced with the 'Generation Nexters' (those born 1980-2000), describing how learners are now being challenged with socially mediated online learning activities that de-emphasise independent learning and emphasise social interaction and collaboration. It is interesting that the 'classic' adult learner (independent, self-motivated, remote) now appears to have an increasing requirement to evolve and manage a personal online presence, as part of their professional development, which could include opportunities for sharing their reflections and collaborate online as part of a peer mentorship programme. If online mentorship support is developed in the future it could become the foundation for encapsulating an ever-evolving lifelong learning journey. However, the use of online resources should not be confused with the informal process of covertly or overtly sharing or extolling information with one another in the safety of online forums. These can have the seductive quality of allowing people to gather multiple sources of support and information (via professional social networking platforms, un-calibrated discussion forums and general online hearsay) which could be inadvertently implemented as part of a registrant's armamentarium, with the downside that the information may not necessarily be from a sound evidence-base. Davis[10] terms this information use as 'frag-mentoring', describing that the downside of this type of activity is that not all of the 'mentoring participants' are aware of their role. If genuine mentors had knowingly been formally recruited to nurture their mentees they may well have implemented a more cautious stance opposed to more anecdotal information sharing. There is a danger that it may become all too easy for a practitioner to piece together fragments of information, weaving aspects that they personally prefer into their own (and complimentary) value system, opposed to having a more formal professional discussion with a mentor, with a view to resolving an identified problem or issue. The use of a more formalised system of synchronous or asynchronous online support system may well be a good way to provide the much needed support to developing practitioners, cultivating a safe and progressive environment in which to develop and hone their professional skill set, providing that professional boundaries and expectations are set.

Professional reflection

There is a synergy that exists between the trust required and the 'collegiate climate'[11] which is just as important as the technique and models deployed when undertaking professional reflection. It is of paramount importance that the mentor and mentee relationship is as supportive as possible. There is a requirement for both parties to be mindful of the element of risk and vulnerability the participating mentees may face. It can be just

as embarrassing, or indeed empowering, for a colleague to be seen as a model of virtue to their peer, alongside the difficulties of exposing one's failures. A fine tightrope of balance must therefore be undertaken by a skilled mentor to ensure that the richness of this learning activity does not become a toxic environment leading to blame.

The prerequisites for mentorship to occur must be apparent in both stakeholders; the mentor must be keen to pursue, facilitate and support the needs of the mentee, and the mentee must be willing and keen to engage with this activity, which can become part of a much broader and effective development culture that encompasses the entire dental team, as demonstrated in Figure 1.

If the dental team, regardless of size, takes the time to listen to the views of one another (and their patients) via appreciative enquiry of ways to improve, this will allow them insight into their own individual strengths and weaknesses. If all of these positive aspects are developed within a culture that has a shared, safe and nurturing vision of practice, there is a tangible opportunity to lead to positive outcomes for all participants. Failure to integrate these positive attributes into the mentorship learning culture can lead to the development of a narrow view of the world,

Fig. 1 Positive mentorship culture for the dental team

'THE MENTOR MUST BE KEEN TO SUPPORT THE NEEDS OF THE MENTEE AND THE MENTEE KEEN TO ENGAGE WITH THIS ACTIVITY.'

which will ultimately limit the development of practical skills, suppress empathetic patient care and hamper emotional resilience.

Indeed, in these times of change it is important that we support one another, acknowledging, as the Berwick report[12] recommends, that everyone should be able to come to work knowing that 'they will be treated with respect, supported to do their work and expand their skills, and be appreciated for what they do'. Perhaps it is time for us, as a profession to show some self-compassion and empathy for one another, the same compassion that is afforded to patients up and down the country on a daily basis, by guiding and supporting one another as we sail down our 'river of practice'[5] as it meanders through our working lives.

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Product news

Product news is provided as a service to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ Team*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

VISIT STAND B03 AT THIS YEAR'S CONFERENCE

This year the GSK Consumer Healthcare team will be visiting the British Dental Conference and Exhibition to showcase Sensodyne and Pronamel.

New Sensodyne Repair & Protect – now with stronger repair – offers sensitivity sufferers the benefit of both advanced NovaMin technology and sodium fluoride in a single formulation. The immediate availability of sodium fluoride when brushing allows for greater fluoride uptake into the hydroxyapatite-like layer formed by NovaMin, over exposed dentine.

Pronamel toothpaste has an optimised fluoride formulation to help minerals penetrate deep into the tooth surface, actively strengthening and re-hardening acid-weakened enamel. Pronamel toothpaste delivers more fluoride deeper into enamel than other fluoride toothpaste helping to protect patients enamel from the effects of erosive tooth wear.

Visit stand B03 to try Sensodyne Repair & Protect and Pronamel toothpaste for yourself in GSK's tasting station. The stand will also feature an interactive lecture revealing the truth about patients with dentine hypersensitivity and erosive tooth wear.

GSK are pleased to be sponsoring two presentations at the conference:

'Burden of Oral Diseases in Ageing Populations and links with General Health' - Georgios Tsakos, Thursday 26 May, 14:30–15:30

The presentation will review the epidemiological evidence on the burden of older adults and highlight the issues around the impact on quality of life.

'How to Manage and Prevent Patient Tooth Wear Caused by Dietary Acids' – Rupert Austin, Friday 27 May, 11:45 – 12:45

The presentation will cover the clinical signs and symptoms of erosive tooth wear and dentine hypersensitivity as well as revealing the latest science on prevention and diagnosis of tooth wear and hypersensitivity.

For further information on Sensodyne and Pronamel visit stand B03 or www.gsk-dentalprofessionals.co.uk.

LEARN ABOUT SUSTAINABLE DENTISTRY

A new session on sustainable dentistry has been released on the award winning e-Learning for Healthcare (e-LfH) platform.

Released on NHS Sustainability Day 2016, the resource provides an introduction to climate change and explores the main principles of sustainable practice and their application in dentistry. It encourages clinicians and managers to make sustainable choices and identifies practical tools and resources to support this.

The material can be accessed by the dental team free of charge on the e-LfH website which provides 24/7 access to nationally quality-assured materials on a wide range of topics in health and social care including dentistry. These sessions use an engaging and interactive presentation style using images, video and animation as well as self assessment to help build knowledge and understanding.

The e-learning resource has been developed by dentists Dr Devika Vadher and Dr Divya Verma, working with the Centre for Sustainable Healthcare (CSH) as Sustainable Dentistry Scholars – part-time roles funded by Health Education Kent, Surrey and Sussex.

http://www.e-lfh.org.uk/programmes/dentistry/

www.sustainablehealthcare.org.uk

SUPPORT YOUR DENTURE PATIENTS

When patients hear the news that they need dentures, everything else you tell them is often unheard. At least 32% of patients don't know what questions to ask their dentist when getting their new denture fitted (based on a survey of 1,748 denture wearers in four countries).

To help support your patients on their denture journey, the Poligrip Partner Programme has been created in conjunction with dental professionals.

Ask your GSK representative today for further information on the Poligrip range and Partner Programme.

The Poligrip range includes:

- Poligrip Overnight Whitening Daily Cleanser
- Poligrip 3 Minute Daily Cleanser
- Poligrip Ultra Fixative Cream
- Poligrip Flavour Free Fixative Cream.

Recommend the Poligrip range to help your patients with dentures eat, speak and smile with confidence.

For additional support GSK have developed a distance learner module on the topic of 'Caring for Patients with Dentures'. The module has been designed to provide you with an insight into the patient experience of dentures as well as supporting you when providing practical advice.

For further information on the Poligrip range and to complete the distance learner module visit www.gsk-dentalprofessionals.co.uk. Completion of the module can contribute up to 1.5 hours towards your verifiable CPD

MENTORING FOR DENTAL NURSES

Mentoring for Dental Nurses is part of a wider group of Mentors in Dentistry that has been organised to offer mentorship and mentoring training for those directly and indirectly involved with dental nurses.

Mentoring in Dentistry is far from a new concept, but it hasn't been specifically designed for the purpose of dental nurses. Whilst mentoring is rarely allied to any one group the mechanism of mentoring is rarely provided for.

Mentoring for Dental Nurses is a proactive group always on the lookout for dental professionals to join the team. Everyone has had those moments or feelings of not knowing where to turn or how to make changes in either our careers or professional lives. This group can help make a difference.

The recent group to undertake mentoring training are now involved in a reach project looking at how mentoring has impacted on their group. That is what makes this a unique group. Over the last year the group has been working tirelessly training and supporting more mentors and some of the team have expanded their roles; some of the team are already out there facilitating mentor training.

More and more dental nurses are undertaking extended duties, additional studies and need support to overcome hurdles. This group can help.

The picture here shows mentor training in action at the Italian School of Cookery in London.

For more information about the Mentoring for Dental Nurses group, email info@dentallearningcurve.com or call 01530 224648.

HANDY ORAL HYGIENE TOOL WILL REMIND PATIENTS

'Hooked on Oral Hygiene' is a new tool designed to help dental professionals improve patients' oral hygiene by providing individually tailored advice on a handy door-hanger style hand-out. It features three boxes where dental professionals can write personalised tips on oral care as well as an illustration of the patient's mouth showing them which areas to focus on when brushing.

The tool was designed by dental hygienist Michelle Coles and was launched in March by the Wrigley Oral Healthcare Programme (WOHP) and the British Society of Dental Hygiene & Therapy (BSDHT). Miss Coles' idea won the Oral Hygiene By Design Award 2015, hosted by WOHP and BSDHT.

Printed on steam-proof paper, the Hooked hand-out can be hung on any bathroom door or cabinet as a visible reminder to patients to practise good oral hygiene in between dental check-ups. There's even space to write the time and date of their next check-up, helping to minimise the chance of missing appointments.

UNIQUE ADVERTISING IN YOUR COMMUNITY

Car Quids connects dental practices with their local communities by branding cars belonging to individuals who regularly drive in busy areas in the local town or city. It's a new form of advertising that sparks conversations and drives new patient registrations.

One dental practice, Dental Concepts, is working with Car Quids to engage with the local community and raise brand awareness in Andover – an area without many alternatives for outdoor advertising such as billboards. Practice Principal Manish Chitnis also had the idea to run a social media campaign alongside Car Quids so they can engage customers both online and in the real world along multiple touchpoints. By spotting a car, Andover residents can win prizes such as a free tooth whitening.

The cars can be booked easily using Car Quids' unique online dashboard which also instantly provides information such as estimated views, costs and availability by location.

From Land's End to John O'Groats and almost everywhere in between, Car Quids has cars in over 100 cities and towns in the UK. All of the major cities are well covered and they have a member fleet of close to 10,000 cars.

You can find out more, book a campaign or have a chat with the company at http://www.carquids.com/.

CPD questions May 2016

What's in a bin?

1. In the EU, the health sector creates at least _____ percent of the total CO2 emissions.
a) two
b) three
c) five
d) seven

2. Which of the following is regarded as being highly recyclable?
a) nitrile
b) paper
c) sterile wrapping
d) fabric

3. Which of the following is **correct**?
a) the introduction of HTM 01-05 has reduced waste management
b) NHS dentistry is fully aware of the efficiency savings to be made in waste reduction
c) the report indicates financial efficiency savings will be considerable
d) NHS dentistry is being required to reduce costs by 4% year on year

4. Which of the following has published identifiable areas on its premises that can reduce carbon emissions?
a) GDC
b) RSM
c) BDA
d) BMA

BDJ Team CPD

CPD: ONE HOUR

Missed **CPD**?

Don't worry! We know you can't always do our CPD when it arrives! That's why we make the last six CPD articles available for you to complete. Visit www.nature.com/bdjteam/cpd to get your verifiable CPD.

➤ April 2016: **Periodontitis:** a potential risk factor for Alzheimer's disease

➤ March 2016: **How to turn complaints into compliments**

BDJ Team is offering all readers **10 hours of free** CPD throughout 2016. Simply visit **www.nature.com/bdjteam/cpd** to take part!

➤ February 2016: **Infection prevention and control in your practice**

➤ January 2016: **The knowledge of dental nurses at one institution of the scope of practice of the dental team member**

➤ November 2015: **No turning back: posture in dental practice**