BDJ Team
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DENTAL ANXIETY in children

BDA
British Dental Association

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January 2017

Highlights

Regulars

In this issue

Ed's letter

Still stumbling around after two weeks of Christmas merriment and New Year cheer? Then maintaining a calm, peaceful atmosphere in your practice is bound to be very welcome this month. Nobody wants anxious, stressed out patients, and that includes little ones. In her cover feature in this issue of *BDJ Team*, Zoe Marshman says that dental anxiety affects people of all ages and tends to develop in childhood and adolescence. Zoe writes about the new self-help CBT guide she helped develop, aimed at reducing dental anxiety in children. A child who is happy to come into the practice for their treatment should continue to return as they grow into adults - which can only be good news for oral health.

We are also pleased to feature dental hygienist Jocelyn Harding's guide for the dental care of cancer patients before, during and after their treatment - including a look at what treatment these patients might receive and the side effects it can have on the oral cavity.

Rosalyn Davies takes us on her journey from being a trainee dental nurse in the early 80s to making history as the first DCP President of the British Society of Gerodontology this year. This is strong evidence that dental nurses have the potential to do so much with their careers, despite one lady who commented on our Facebook page last year that she left the profession to become an HGV driver... While probing further into this individual's career path is not in our remit (although I am sure it would make a great story!) we do include her view among many others as we reflect on the dental nurse salary features we included in 2016.

Perhaps climbing the career ladder in dentistry isn't really your thing and instead you have an idea for an innovation that will do for dentistry what Sir James Dyson did for the vacuum. If so, make sure you read Ben Underwood's tips; Ben himself invented the award-winning Brush DJ app, which has been approved by the NHS and downloaded in 188 countries.

When you've read this issue, make sure you pop along to our CPD hub to complete your first hour of verifiable CPD for this year http://bit.ly/2e3G0sv.

Happy New Year!

Kate

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THE TEAM

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BSDHT SUPPORT CALL FOR FOOD MANUFACTURERS TO CUT SUGAR CONTENT

The British Society of Dental Hygiene and Therapy (BSDHT) have given their full support to Action on Sugar following their call on 26 October for UK food manufacturers to cut the amount of sugar in their products with immediate effect.

Following new research which shows significant differences in levels of sugar in similar everyday food products, Action on Sugar has urged food manufacturers to fall in line with Public Health England's voluntary reformulation programme to help tackle the health crisis caused by unnecessarily high levels of sugar in our food and drink.[1]

Action on Sugar has discovered that some companies put far less sugar in their products compared to other similar products on the market and believe that the Government's reformulation target of a 20% reduction in sugar can be easily achieved well before 2020 if companies make changes as a result.

The research looked at foods commonly consumed by children including: breakfast cereals, yoghurts, biscuits, cakes, confectionery, pastries, ice creams and chocolate spreads. They found that that product comparisons with less sugar already exist on the market, for example: ASDA Smart Price Vanilla Flavour Ice Cream (7.9 g) contains 46% less sugars compared to Waitrose Duchy Organic Vanilla Ice Cream (14.5 g sugars per 100 g) and Organix Goodies Gingerbread Men Biscuits (18.8 g) contains 38% less sugars versus McVitie's Mini Gingerbread Men (30.4 g sugars per 100 g) – demonstrating that reducing sugar is possible for manufacturers.

Speaking on the announcement, Michaela ONeill, President of the BSDHT, said: 'It is absolutely heart breaking to see that more than 33,000 children were admitted to hospital last year to have their rotten teeth removed under general anaesthetic.

'By coming in line with Public Health England's voluntary reformation programme food manufacturers have a vital opportunity to do something to help reduce this figure'.

The BSDHT have recognised that reformulation, whereby the sugar and sweetness in products are gradually reduced, is an important measure to help reduce the impact of tooth decay in the UK by making people more aware of how often they are consuming sugary foods and drinks by drawing attention to which products have sugar in.

1. Public Health England. PHE-led programme asks industry to remove 20% of the sugar from food eaten by most children. 29 September 2016. Available at: https://www.gov.uk/government/news/industry-attends-phe-briefing-on-reduction-and-reformulation (accessed November 2016).

Do you know an outstanding dental nurse?

The British Association of Dental Nurses (BADN) is requesting nominations for its 2017 Outstanding Contribution to Dental Nursing Award.

The Award, which will be presented in May at the Honours and Awards Dinner at the British Dental Conference and Exhibition, is given to a person deemed by the BADN Executive Committee to have made an outstanding contribution to the development and/or support of the dental nursing profession.

Anyone may nominate – all nominations must be on the official nomination form and all nominations must reach the Chief Executive by midday on 20 January 2017.The person nominated should be a Registered Dental Nurse.

The Award is for an outstanding contribution to the dental nursing profession, which should have had a notable impact nationwide (either UK-wide, or across one of the home countries, eg England, Scotland, Wales, Northern Ireland), have been to the benefit of the dental nursing profession and have been outside the remit of the nominee's paid employment. Nominators are asked to write a short narrative on the impact they believe their nominee's contribution has made, showing how their contribution has advanced dental nursing, at what level, who has benefitted in terms of: individuals, including both peers as well as patients; organisations; the profession; or more widely in terms of the whole dental community (nationally and internationally) and how the group(s) have benefitted.

The guidelines for nominating and the nomination form are available at www.badn.org.uk.

FULL TIME STUDENTS INVITED TO ENTER ESSAY COMPETITION

The Committee of the Association of Basic Science Teachers in Dentistry (ABSTD) is holding an essay prize competition for all students in full time programmes related to dentistry and oral health, with a first prize equivalent to €1,000.

The competition is to encourage interest in and engagement with basic sciences. The title of the essay for the competition, which has been chosen by the committee, is: 'Discuss how new technology is paving the way for personalised dentistry'.

Entries should be a reflective analysis of the topic within the scope of the basic and applied sciences which underpin dentistry. Entries should demonstrate integration of knowledge from across a range of relevant scientific disciplines, must reflect an understanding of contemporary scientific advances and be supported by reference to the appropriate literature.

Entries should be submitted to Jon Bennett, President of ABSTD, as a Word document to jon.bennett@plymouth.ac.uk, by Friday 31 March 2017.

Entrants are advised to read the competition regulations at www.abstd.org.

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FIRST INSURANCE SPECIFICALLY FOR DENTAL HYGIENISTS AND THERAPISTS LAUNCHED

The British Society of Dental Hygiene and Therapy (BSDHT) has launched BSDHT Indemnity, a new insurance policy developed especially for dental hygienists and dental therapists.

This product is unique in the market as it is the only policy in the UK specifically for hygienists and therapists. Usually insurance policies include dentists, who typically have a higher exposure of risk and therefore increase the chances of a higher premium.

BSDHT Indemnity is an exclusive offering for BSDHT members and can be purchased at any point in the year. This bespoke policy has been designed by the BSDHT and Howden, a Chartered insurance broker with a specialist Care and Medical team.

Helen Minnery, President of BSDHT, said: 'Indemnity is such an important requirement within healthcare and dentistry, but to be truly effective that protection must be tailored to an individual's needs. The BSDHT have a long-standing reputation for representing the best interests of practising dental hygienists and those dually qualified in dental hygiene and therapy; by launching this bespoke insurance plan we want our members to feel both confident and reassured that there is policy that is specifically built for them.

'Being a low exposure and low risk group, it's unfair for dental hygienists and dental therapists to have to incur the higher premiums of typical insurance policies and BSDHT Indemnity seeks to correct this.'

Visit www.bsdht.org.uk for more information.

Dental nurse spots fake dental device

Dental nurse Lizzie Boon was the winner of the 'Spot the Fake' competition held at BDIA Dental Showcase at ExCeL London in October.

The competition challenged members of the dental team to correctly identify genuine and counterfeit dental devices as part of the BDIA's award winning Counterfeit and Substandard Instruments and Devices Initiative (CSIDI), which has recently partnered with the Medicines and Healthcare products Regulatory Agency (MHRA) to help stamp out counterfeit and non-compliant equipment.

Lizzie, who is also a Quality Assurance Auditor for the National Examining Board of Dental Nurses (NEBDN), was awarded £500 to spend with a BDIA member of her choice. She commented: 'Seeing the fake equipment next to the real thing definitely makes you think about where the products come from and how important it is to purchase quality equipment from a reputable supplier in order to safely protect users and patients'.

The CSIDI campaign continues to highlight the danger of counterfeit and non-compliant dental equipment and the risk involved in purchasing from unknown sources.


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‘I left dental nursing to become an HGV driver’

BDJ Team’s features on dental nurse wages caused a storm on our Facebook page in 2016. Salary is a topic that is close to many dental nurses’ hearts. Here we present a selection of comments made by DCPs on our Facebook posts during the course of last year. If you didn’t see the original *BDJ Team* content on dental nurse wages, links are included at the end of this article.

‘Love the job. Hate the pay. All other dental professionals receive higher salaries. Dentists can’t practise without us therefore we should be paid accordingly.’
Janet

‘It’s sad we don’t get paid more. I don’t expect millions but we work hard to qualify. We train all year round to keep up to date with CPD to stay registered. (We are just as responsible for the patients’ welfare as dentists in the eyes of the GDC.) We’re trained in CPR. The dentist cannot work without us. In most cases it’s the nurse who keeps the surgeries running. And yet we get paid poorly; in my case it’s pence over living wage. But to think I could get a job where I don’t need any qualifications and be paid more is ridiculous.’
Lauren

‘Dentists can’t practise without us’

‘We used to have a pay scale...’

‘I love being a dental nurse, have done for years, but it’s true we are underpaid. I get paid 1p above living wage. I have a total of 15 years’ experience. I work part time - well 3/4 time as have young family, so I earn below the tax band. So when I pay my registration I cannot claim it back. Put it on my tax code ... therefore I work out I get paid under living wage.

The reason I’m still there is because one, I love what I do, two, it’s near where I live, and finally three it’s better the devil you know I think.’
Sarah

‘Wages will have to change or all qualified nurses will just work for agencies; in the old days we had the Whitley scale - pay depended on experience and qualifications - it was a much fairer system and it was black and white.’
Sue

‘I’m sorry, why are receptionists earning more than qualified registered professionals? Most nurses end up doing a lot of reception work as well as nursing so why exactly are we training, taking exams, paying registration, keeping updated on CPD, and working our backsides off for less money than the rest of the team? It’s absolutely disgraceful!’
Jodie

‘As said above we used to have a pay scale, that was BEFORE registration, CPD, CQC etc ... now there is nothing even though we are ‘professionals’. I haven’t had a pay rise for four years ... guess what, my rent alone has more than doubled in that time. I’m poorer than I was as my wages are the same ... they can’t stretch much further! Oh but the fees for a large composite filling have gone from £95 to £140, not bad for 40 minutes’ work!’
Verne

‘Paid more to clean the toilets’

‘I left the profession after 25 years this July. I was earning £8.35 an hour at age 41! I had worked at this particular practice for seven years and despite having a huge amount of responsibility (I also dealt with the majority of policies etc) the practice just didn’t pay any more. Fortunately I went back to college/uni and I now earn £25.69 an hour as a lecturer in Health & Social Care, I am paid when I do CPD and I have far less responsibility. The inequality dental nurses face will never change because the dentists will always have a “them and us” mentality; we are there to serve them and we are not worthy in their eyes. It’s a sad state of affairs.’
Lynsey

‘A couple of years back at our practice we (nurses) were on National Minimum Wage which was around £6.20 and the cleaner was on £7 a hour. Paid more to clean the toilets. Such a joke.’
Lauren

‘Absolutely shocking how little we are paid considering our qualifications! Dental nurses should all be banded as they are within the hospitals and community! And now as well as our registration fee we now have to stump up for indemnity insurance! No wonder more and more nurses are leaving the profession! Some nurses are still paid minimum wage! How? I’ve been in dentistry for 25 years and slowly watched dental nurses wages go down, but their responsibilities go up.’
Lynsey

‘I work as a locum dental nurse whilst at uni; I charge more than double and then some to what a nurse gets. If everyone did that then every dental practice would have to increase what they paid. It’s absolutely disgusting how bad nurses get treated!’
Rebecca

‘I was in dentistry for over 30 years. Manager for ten. I didn’t even crack £9 an hour. It really isn’t enough for the roles and responsibilities. Fantastic profession though!’
Charlotte

‘Wages down but responsibilities up’

‘I find it absolutely ridiculous that we often get paid less than a starting salary for someone who works on a checkout. Considering everything we have to put up with: infectious substances, bad attitudes and back breaking positions to name a few. Plus we have to pay for registration, CPD, etc just to be allowed to do the job. It’s not right.’
Lisa

‘This is why I left dental nursing to become an HGV driver. Pay is a lot more and I don’t have to pay for a registration either.’
Carolyn

‘Dental nurses have always been paid poorly - it’s time to acknowledge their professionalism, skills and commitment to their work.’
Bronwen

‘Well it has never been a well-paid job and still isn’t but it’s a worthwhile one in a caring profession. I still enjoy it after over 40 years; it just depends how much you enjoy it, you could go into management or hygiene or specialise!’
Heather

‘Perhaps don’t blame the profession blame the employer. I have been in the dental industry since 1998 and have always been paid well (I’ve worked for three different people). I have lots of friends who regard themselves as receiving an appropriate wage. My current employer pays our GDC as well as our indemnity. We’re perhaps luckier in our area with appreciative employers.’
Mel

‘A worthwhile job in a caring profession’

'But what is a fair wage?'

'I'm a part-owner of a practice and my main role is managing the business aspects and developing the team. As I came from a non-dental background, I'm training as a dental nurse just now. Our practice is based in central Scotland and is mixed NHS/private. We contribute towards our team ARF and help to provide some of their CPD with pensions on the way.

My question is, what would you (as dental nurses) genuinely see as a 'fair' hourly rate? I find this quite difficult as the costs of running a practice are constantly increasing and it's proving harder and harder, particularly under NHS, to be sustainable. I can, therefore, see both sides of the argument here.

Having taken on the role of the dental nurse myself (purely to understand and know how it feels!) I fully appreciate everything nurses contribute but no-one (dental nurses I've spoken to about it) can tell me what they think would be a "fair wage".

Regardless of which jobs I've been in previously, I find that people always want more money (naturally) but they often find it hard to quantify and justify. I think that's actually quite an important aspect here.

It's definitely interesting to see the differences in how practices utilise, treat and pay their staff ... often, finding a great environment also helps tip the balance - a bit of appreciation goes a long way for a dental nurse!'
Linsey

'Very disheartened and disgruntled that dental nurse wage is what it is. I believe it should be banded just like hospitals and community. Thriving practices need to realise they are thriving because of the TEAM behind them and need to pay accordingly. I know of dental nurses that are paid less than their reception colleagues even though they now have outlays such as indemnity. I have often thought about throwing the towel in and going to work for a supermarket that pays better but I love my job and the people I work closely with so I just keep doing what I do.'
Amy

'I love my job and the people I work with'

'It's a shame so many dental nurses are leaving the profession'

'I think it's a shame as so many dental nurses are leaving the profession for an easy life/job in retail etc without any CPD requirements and where they can go in and out of work without any other attachment/responsibility. Unfortunately for those of us with many years' experience and further qualifications the pay is not reflected accordingly. When I qualified in 2003 and moved into my first job, the pay was more than acceptable but fast forward 13 years (15 since I began in this career) radiography, FV application, progressing with sedation nursing and extra responsibilities that have naturally fallen upon us all with multiple changes to our role in this time and actually just over £2 pay increase in 13 years... then something has to be done. We do have responsibilities and we do have an element of liability in the increasing litigious culture we live in. Bring back the Whitley scale and get us all earning what we rightly deserve. The onus is entirely on the practice owner which I deem unfair as a lot of us (not all, I know, as I have been there) have empathetic bosses that appreciate what we do but I think more reward is required from higher up. The NHS certainly should provide those of us in NHS practice with an NHS pension if nothing else. I am very passionate about the job I do and want to better myself at every opportunity; however the adverts in Aldi offering very good pay are sometimes a temptation.'
Amy

'I've literally just finished training as a dental nurse and it's my biggest regret now realising the shoddy pay scale. It's so insulting to have to put so much hard work into something and get minimum wage while you run around for dentists earning a bomb! Looking to stop it already unfortunately, which is a shame because I love the actual job.'
Kaye

Relevant *BDJ Team* content

Dental nurses are paid no more than shop assistants
http://www.nature.com/articles/bdjteam2016115

Why are dental nurse salaries so low?
http://www.nature.com/articles/bdjteam2016152

The profession does not acknowledge the progress dental nurses have made
http://www.nature.com/articles/bdjteam2016162

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Dental care of cancer patients *before, during* and *after* treatment

By **Jocelyn Harding** RDH CEB Dip DH (RADC)[1]

According to Cancer Research UK there were 352,197 new cases of cancer diagnosed in 2013. So the question arises, how can we, as dental health professionals, best look after and advise these patients before, during and after treatment? If our mouths are the 'window to the body' it is important we treat the body holistically, not solely the area of cancer that is affected.

The difference between chemotherapy and radiotherapy

Chemotherapy

According to Macmillan Cancer Support (www.macmillan.org.uk):

'Chemotherapy uses anti-cancer (cytotoxic) drugs to destroy cancer cells. The drugs also affect healthy cells, causing side effects such as feeling sick or an increased risk of infection. Unlike cancer cells these cells usually repair themselves. Most side effects improve when treatment is finished.

Chemotherapy can be given as a main treatment or after other treatments to reduce the risk of the cancer coming back. Or, you may have it to shrink a cancer before surgery or radiotherapy. It is sometimes combined with radiotherapy (chemoradiation). Chemotherapy is also given to control cancer that has spread and to relieve symptoms.

The chemotherapy you have will depend on different things, such as the cancer type, the risk of it coming back, or whether it has spread. Some people have tests during treatment to check if the cancer is responding to chemotherapy.

You usually have chemotherapy by injection or a 'drip' into a vein, or as tablets. Sometimes, it's given in other ways, such as into the spine or into the bladder, depending on the type of cancer.'

Radiotherapy

According to Macmillan Cancer Support (www.macmillan.org.uk):

'Radiotherapy uses high-energy rays to treat disease. It can be given both externally and internally.

- External radiotherapy aims high-energy x-rays at the affected area using a large machine.
- Internal radiotherapy involves having radioactive material placed inside the body.

Radiotherapy works by destroying cancer cells in the area that's being treated. Normal cells can also be damaged by radiotherapy, which may

[1]*Jocelyn qualified as a dental hygienist at RADC Aldershot in 1992 whilst serving in the Royal Navy and has been fortunate to have the opportunity to work in many locations including Gibraltar, Hong Kong and Hawaii. Jocelyn has been part of the lovely team working for Dr Ewa Rozwadowska and Dr Colin Neil at Confident Dental Care in Stroud for nearly nine years.*

cause side effects. Cancer cells cannot repair themselves after radiotherapy, but normal cells usually can.

You can be given radiotherapy for different reasons. Doctors can give radiotherapy to try and destroy a tumour and cure the cancer. This is called curative treatment. It may be used with other treatments, such as surgery or chemotherapy.

If it's not possible to cure the cancer, doctors may give you radiotherapy to help relieve symptoms you have. This is called palliative treatment.

The type of radiotherapy you're given will depend on the type of cancer you have and your individual situation.'

Preparing patients

So how do we prepare patients before treatment starts? The priority is to help the patient to reach the end of their treatment with as little damage to the oral cavity as possible. It is important at this early stage of diagnosis that we are mindful of our patients' thoughts and feelings. We also have to understand that some patients may be reluctant to take advice as they may be psychologically affected and overawed.

The risks of the side effect of treatments need to be explained to patients, and although not all these can be avoided, they can be minimised by following advice that can be given by the dental team. The added complication to also consider is the individual reactivity of each patient to the chemicals and therapies and must be taken into account.

Xerostomia

Xerostomia or dry mouth affects mastication, speech and swallowing. Saliva contains the enzymes lipase and amylase for balancing the mouth and breakdown of lipids.

Infection

Oral mucositis is caused by the imbalance of the mouth allowing candida albicans to proliferate due to the weakened patient's immunity.

Burning, swelling or peeling of the tongue

This may be more common in patients who have been treated for a head and/or neck cancer. It is a nasty side effect as nerve endings can be damaged through treatment. Burning mouth can be a long term issue for the patient to manage. Hot and spicy foods will need to be avoided.

Change of taste

This may also be more common in patients who have been treated for a head and/or neck cancer. Due to destruction of the patient's taste buds this may or may not be a long term effect of treatment.

Decay

There is a high risk of caries with these patients, especially root caries. These surfaces are tricky to treat in a routine patient so for this category of patients we must take extra care and use as many preventative measures as possible.

Dental treatment options to be considered before patient treatment starts

Dental professionals have a real opportunity to help patients with a 'belt and braces' approach. There are many products to recommend, prescribe and ultimately help patients. Promoting a good controlled diet is the ideal. However, the priority for many patients is the consumption of any nutrients without considering the damaging effects of sugar. This especially applies to patients being treated for oral cancer. Extractions of vulnerable teeth should be completed before radiotherapy as extractions after treatment may result in bone necrosis, especially after oral radiotherapy.

Two weeks before treatment patients should be encouraged to reduce their oral bacterial load. Patients have a choice of Corsodyl or Curasept mouthwashes containing the active ingredient chlorhexidine gluconate. For effectiveness, patients should check which toothpaste to use, whether SLS (sodium lauryl sulphate) free or not, and also check how soon after brushing these mouthwashes may be used.

Patients will need to be warned of the damaging effects of high calorie drinks which may be recommended to them due to their lack of appetite. Patients should be encouraged to consume these rapidly because these drinks are high in sugar and will cause decay if drunk over long periods of time. Patients should be advised to mainly drink water, sugar free drinks, or suck ice chips. If patients wish to have other drinks encourage them to be sugar free and to alternate with water as far as possible. Some patients may be recommended pineapple, fresh or tinned, as it contains the enzyme Bromelain that helps to break down proteins and can also help with a metallic taste some patients complain of after chemotherapy, but these may also cause caries and erosion.

Examples of beneficial products

Fluoride toothpaste

1. Public Health England (PHE) – *Delivering better oral health: an evidence-based toolkit for prevention*, third edition, 2014 recommends high fluoride toothpastes. Duraphat 5000 toothpaste, for patients over 16; Duraphat 2800 toothpaste for patients over ten-years-old. These are prescription high fluoride toothpastes which only require a pea size amount on the toothbrush ideally twice per day. Cancer patients with a lack of saliva are categorised as high risk of coronal caries and root caries because of the lack of saliva. For head and neck cancer patients, fluoride toothpastes can be applied to the teeth overnight in custom made dental trays to increase the efficacy.
2. Oranurse supply toothpaste which is a non-flavoured and SLS free fluoride toothpaste. This contains sodium monofluorophosphate 1450 ppm fluoride. The use of SLS free toothpastes may reduce the incidence of oral ulcers.
3. Bioxtra toothpaste market a toothpaste which contains sodium monofluorophosphate 1500 ppm fluoride, natural enzymes and xylitol and is also SLS free.

Fluoride varnish treatment

For high risk patients Public Health England recommend a high fluoride varnish to be applied professionally to the teeth and any exposed root surfaces at six monthly intervals. There are a few choices of varnishes becoming available but currently PHE recommend Duraphat varnish containing calcium fluoride 22,600 ppm. Contraindications should be observed.

'THE RISKS OF THE SIDE EFFECT OF TREATMENTS NEED TO BE EXPLAINED TO PATIENTS … THEY CAN BE MINIMISED BY FOLLOWING ADVICE THAT CAN BE GIVEN BY THE DENTAL TEAM'

Toothbrush

A patient may or may not be able to manage a toothbrush. An electric toothbrush is ideal but anything in the mouth may be too tender. To help a patient achieve good plaque control we need to find a brush which a patient can manage in their mouth.

Curaprox market a soft headed surgical toothbrush, which is useful as the head is small and the filaments are very soft.

Mouth rinses

If a patient is not able to tolerate a toothbrush or toothpaste, then another option is a fluoride containing mouth rinse. PHE recommend using a fluoride mouthwash (0.05%) at a different time to brushing as rinsing straight after brushing reduces the beneficial effect of the toothpaste.

Dry mouth products

Some patients develop a very dry mouth and require mouthwashes and gels purely for lubrication.

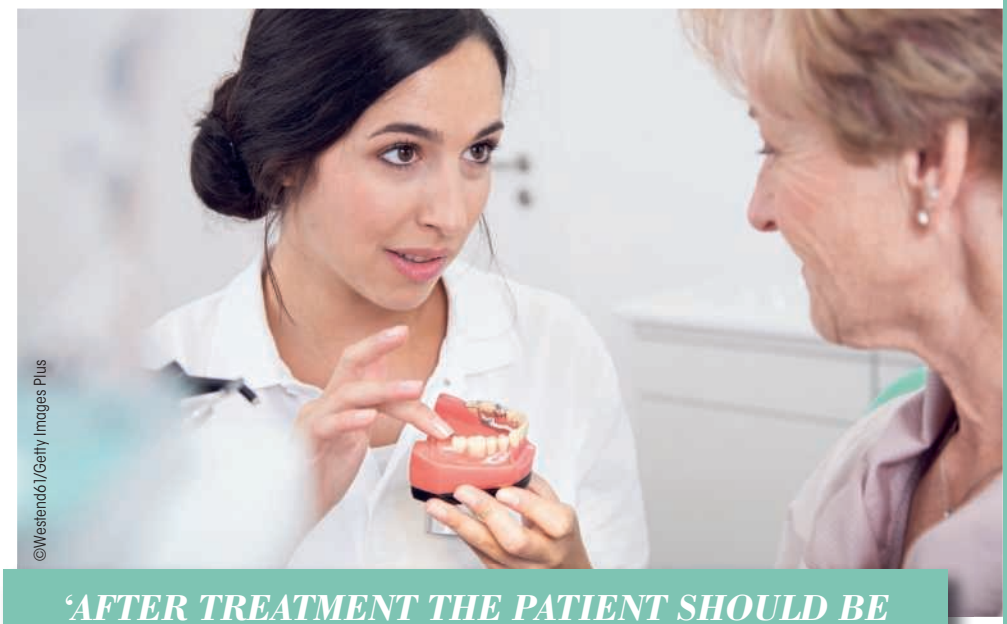
1. Bioxtra mouth rinse, gel and gel mouth spray contain lactoperoxidase, lysozyme and lactoferrin enzymes. The mouthwash is alcohol free without menthol or foaming agents. Bioxtra mouth gel can provide lubrication for many hours. For longevity, a small pea size of gel should be placed on the back of the hand, then rubbed between finger and thumb and applied around the oral tissues. Bioxtra mouth rinse and Bioxtra gel mouth spray contain xylitol and fluoride. Bioxtra gel and Bioxtra gel mouth spray are contraindicated for patients with lactose intolerance and egg allergies.
2. Gelclair is available on prescription or online and can be used either in dilution or straight onto the tissues to help lubrication and protection of the mucosa by producing a protective barrier.
3. Benzydamine (Difflam) mouthwash or spray are available to purchase or on prescription and act as an analgesic, anaesthetic and anti-inflammatory. Contraindications – age restrictions and allergies to ethanol (mouthwash) and glycerol (mouthwash and gel).
4. Gengigel is a natural product available to buy and comes in a gel and mouthwash and has no contraindications. Gengigel contains the active ingredient hyaluronan and some patients find this very soothing especially for oral ulceration.
5. Oracoat's XyliMelts lozenges are all natural and are made from xylitol and a gum lubricant. With their adhering and fully dissolving disc technology they are able to stay *in situ* and promote saliva, day or night, whilst helping to inhibit decay.

Calcium repair mousse

GC produce two calcium repair products - tooth mousse and MI paste - available in a choice of flavours. Tooth mousse is safe for babies and pregnant women and can be used with Duraphat 2800/5000 toothpaste. MI paste, safe for children over six years, can only be used with Duraphat 2800 toothpaste. This product has the benefit of pushing calcium and phosphate ions back into the tooth surface. Apply a small pea size amount on the end of the tongue and then lick it around the teeth or apply it on the end of a clean finger and wipe around. Contraindications - lactose intolerance.

Peppersmith produce a range of xylitol sweets and gum in a variety of flavours so helping with the change in taste and helping to reduce decay.

After treatment the patient should be encouraged to attend regularly for examinations and ongoing care with their dentist and hygienist for preventive advice and treatment, and to give patients reassurance about their recovery process. The optimal timing of this will be decided by the specialist and will depend on the patient's type of treatment and how they have responded. The specialist may recommend a prescription mouthwash such as Calphosol or MuGard, to help alleviate the patient's mucositis.



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'AFTER TREATMENT THE PATIENT SHOULD BE ENCOURAGED TO ATTEND REGULARLY FOR EXAMINATIONS AND ONGOING CARE…'

Interdental cleaning

Controlling biofilm in these inaccessible areas is difficult, but should be attempted by patients. If it is possible there are many choices of TePe interdental brushes, Wisdom Clean Between brushes and OralB Glide Floss picks. A Waterpik Ultra Water Flosser or Philips Sonicare Airfloss or Airfloss Pro may be an easier option to consider. These can be used with warm water to make the cleaning more comfortable. They are ideally to be used before tooth brushing to not wash away the benefits of the fluoride toothpaste.

Chewing gum and sweets

It has been found that saliva production can be stimulated when chewing gum so encouraging the use of sugar free gum and ideally versions that contain xylitol can help with lubricating and reducing decay.

For some head and neck cancer patients (HNC) the severe problem of osteoradionecrosis (ORN) cannot be avoided. Regular dental visits for checking oral health and helping to prevent infections and caries, especially root caries, are of utmost importance for this type of patient. These patients must continue using a high fluoride toothpaste and tooth mousse/MI paste long term as a good regular daily preventative routine is paramount for these high caries risk patients.

Dentistry is an ongoing science, based on evidence and communication, so why not build up a rapport with your local oncology department and team, perhaps arranging a visit to them as they will be more than happy to help with current guidelines and answer any questions.

Good luck!

bdjteam20178

DCPs in the spotlight

To kick off 2017 we meet a selection of lovely DCPs who may be working in a practice somewhere near you. If you would like to appear in a future issue, drop us an email any time to bdjteam@nature.com.

Mary Moss,
Dental hygienist

Age: 40

Job title: Dental hygienist

Town: Preston, Lancashire

Workplace: Kirkham Dental Care

Marital status: Married

Partner's name and job: Martin, Security Engineer

Children and names: Harry (14) and Savannah (10)

How long have you worked in dentistry? Since I was 17! As a dental nurse. I went to Birmingham Dental Hospital in 1997-1999.

Why did you choose dentistry for your career? Well I originally I wanted to be a police woman, but decided dentistry was maybe safer! I guess both help people.

Do you have any special responsibilities within your dental practice? Yes I am lead child protection and I write/produce the practice newsletters. I love this as I get to say all the things I sometimes don't get time to say in a normal appointment.

What do you like best about your job? Helping patients make a difference and understand how to prevent gum disease and decay.

What is the most challenging part of your job? Thinking of new ways to try to engage those patients who don't take on board the messages we give to prevent disease.

Do you have any ambitions that you would like to share with us? So many! I have an ever-growing bucket list. I recently ticked off a sky dive and hopefully in 2017 will do a half marathon.

What are your other plans for 2017? This year (2016) I did an impression course, to be able to provide whitening trays under prescription from the dentist, so hopefully I will do more added duties at work like this. I would love to help expand our oral health services we offer at work, with children's sessions etc.

What do you like to do outside work? I recently started running. We do lots of walking with the dog and kids.

Tell us a secret. Oooh! No! Can't possibly!

What do you like about BDJ Team? That it's for the whole team! Full of facts and need-to-know information.

What three things could you not live without (besides people)? My dog Daisy, music, and a beach ... any beach (preferably hot!).

Christine Smethurst,
Auxiliary dental tutor

Age: 36

Job title: Auxiliary dental tutor

Town: Leeds

Workplace: Leeds University

Marital status: Married

Partner's name and job: Mark, works in market research

Children and names: One child called Seb

How long have you worked in dentistry? 13 +

Why did you choose dentistry for your career? Firstly I wanted to go into general nursing and I wanted on the job training and dental nursing seemed to cover both care and on the job training. Going to uni when I was younger was not on my radar.

Do you have any special responsibilities at your workplace? I lead a module called Clinical Practice 1 at the dental school. I also teach international students the language of dentistry.

What do you like best about your job? I like marking assignments and facilitating communication skills workshops. These workshops have actors pretending to be patients; it's great fun and excellent learning for the students.

What is the most challenging part of your job? Trying to please everyone.

Do you have any ambitions that you would like to share with us? I hope to become a Social Media Manager so I can work my career in and around children. I'm currently studying to achieve this goal.

What are your plans for 2017? I am hoping to start my own business in digital marketing, and specialising in dentistry. I would love also to take my little boy to Thailand.

What do you like to do outside work? I love to visit National Trust sites with my little boy, spend time with my family and friends and eat out.

Tell us a secret. When I was younger I was really good at running 800 metres and 1,500 metres and was told I had the potential to be professional runner. However, due to my family not having much money and no car, I struggled to keep up with the demands of competing.

What do you like about BDJ Team*?* Friendly staff and great online presence.

What three things could you not live without (besides people)? Eyebrow pencil, mascara and water.

Loraine Lee,

Oral health educator/ dental nurse

Age: 51

Job title: Oral health educator/dental nurse

Workplace: Redhill Hospital

Marital status: Divorced

Children and names: Gemma (dentist), 27; Oli (recruitment), 26; Emily (hospitality), 23 and Alice (hospitality), 18

How long have you worked in dentistry? I qualified as an RDN in 1984 and have worked part time and full time over the years. I have several post qualifications and ten years' experience in maxillofacial.

I fell into dentistry after I dropped out of A-levels at school and my mother told me to go find a job! I went for a trainee dental nurse job in Croydon , with over 100 candidates I didn't think I would get the job. I had the most amazing year with a young postgrad dentist who really inspired me and we learnt so much together. I always knew he would do well; he is now a consultant restorative dentist and he looked after my dentist daughter during her work experience at his hospital in Chichester.

I am now part of an amazing pilot project at my hospital to improve the oral health of hospitalised patients, and it has been so successful that we are being funded to roll the project out to other trusts with the backing of the Chief Dental Officer for England, Sara Hurley.

My dental experience from early implants in practice, maxillofacial and orthodontics with radiography, oral surgery and being a part time ambulance responder has given me so much to pass on, that my role now as oral health educator in hospital has been a natural and rewarding progression.

I like the fact we are improving patients' oral health in hospital as the mouth seems to have been left out of the body for a few years.

The job can be challenging at times, especially training doctors to look in the mouth!

I would like to see a dental nurse/oral health educator in every hospital in the future to ensure patients get top to toe care from staff, especially as patients are living longer with more complex oral and health needs.

What are your plans for 2017? I hope 2017 is better for me personally outside of work but dentally I hope the project is recognised as important as hand washing!

What do you like to do outside work? I love meeting up and relaxing with friends and family.

Tell us a secret. My secret wish is to retire to France or Italy one day with a kind and genuine person.

What do you like about BDJ Team*?* I love to read the articles and recognise faces from over the years.

What three things could you not live without (besides people)? My hair straighteners, my phone and my heels.

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CPD: ONE HOUR

'Your teeth you are in control'

CPD questions

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Dr Zoe Marshman[1] writes about the new self-help Cognitive Behavioural Therapy (CBT) guide to reduce dental anxiety in children.

Background to dental anxiety

Dental anxiety is common, affects people of all ages and tends to develop in childhood and adolescence.[1,2] The Child Dental Health survey in 2013 found 14% of 12-year-olds and 10% of 15-year-olds were classified as having extreme dental anxiety.[3]

Impact on children

Children with high levels of dental anxiety have more decayed and extracted teeth with unmet need for dental care.[4] Up to one in five young people report not visiting the dentist regularly because of fear[5] or not completing dental treatment.[6] Children themselves when describing their experiences of dental anxiety report making negative predictions about what could happen (eg suffering pain or harm, clinical error, being powerless); reliving traumatic dental experiences; avoiding dental care by using deceptive or negotiation strategies; experiencing negative affective states (eg fear, anxiety, anger, shame, embarrassment), and physical symptoms of sweating and shaking.[7]

Impact on parents

Child dental anxiety also has an impact on parents. Hallberg and colleagues found that parents experienced difficulties trying to persuade their dentally-anxious children to go to their appointments and lacked strategies to handle their child's level of fear and effectively manage the situation.[8]

Impact on dental services

Dental anxiety in young people also has a significant impact on dental services. Providing dental treatment for anxious patients is time consuming, demanding and a cause of occupational stress.[9] Patients typically end up being referred to paediatric dentistry services, having to wait longer for dental treatment and at increased costs to the NHS.[10]

Traditionally, dental anxiety has been managed using pharmacological techniques including inhalational sedation and general anaesthetic (GA). However, such approaches only manage rather than reduce children's dental anxiety.[11] The cost per case for inhalational sedation or GA for dental treatment has been estimated at £273 and £720 respectively.[12] Indeed, dental anxiety remains unchanged in those children who receive dental treatment under general anaesthetic[13] with anxious children becoming adults with a long-term reliance on expensive pharmacological techniques.

Ways to reduce anxiety

Over recent years it has been recognised that greater effort should be directed towards behaviour management and psychological interventions which can reduce patients'

[1]*Reader in Dental Public Health, School of Clinical Dentistry, University of Sheffield*

anxiety long-term.[14,15] Cognitive Behavioural Therapy (CBT) is a goal-orientated talking therapy which aims to help people manage their problems by changing how they think and behave in relation to their problems. CBT incorporates a variety of different cognitive and behavioural strategies which aim to help the patient modify the unhelpful behaviours or thoughts maintaining their anxiety.[16] A review of meta-analyses revealed that CBT is highly effective in treating a range of general anxiety disorders in both children and adults.[17]

Ways to reduce dental anxiety in children

CBT interventions have shown promising results in reducing dental anxiety in adults in terms of effectiveness, acceptability and benefits enduring over time.[18-21] While strategies such as providing information, 'tell-show-do', stop signalling, graded exposure, systematic desensitisation and modelling interventions are regularly employed by dentists and dental care professionals with children there is a paucity of research about the effectiveness of CBT for reducing children's dental anxiety.[22]

'Your teeth you are in control'

Recently, a self-help guide and accompanying resources, based on the principles of CBT, has been developed for use with children aged 9-16 years and delivered by dental practitioners and dental care professionals.[23] Experts in paediatric dentistry, child clinical psychology, health psychology, dental public health and CBT led the process with children, parents, dental team members and Patient and Public Involvement representatives all involved. A person-centred approach was used based on the Five Areas™ model of CBT.[24]

The guide 'Your teeth you are in control' includes information on the dental team and basic procedures; describes tools children can use to help them feel less anxious; contains activities children can complete to feel more in control including a 'message to dentist' and a stop signal signed agreement; and prompts them to reflect on what went well about each visit. The step-by-step process of using the guide is described in Figure 1. The guide is suitable for children with mild to moderate dental anxiety who require a course of treatment but have no urgent dental treatment needs.

'Your teeth you are in control' was used with a sample of new patients who attended the community dental service in Derbyshire or the paediatric dentistry department of Charles Clifford Dental Hospital in Sheffield. Overall, 56 children were consented to take part in the study with 48 children completing three treatment visits and questionnaires before and after treatment. Of these 48 children, 33 were female (69%), 25 lived in deprived areas (52%) and 36 were referred for the management of dental caries (75%). There was a statistically significant reduction in child self-reported dental anxiety and improvements in quality of life with nearly two-thirds (60%) indicating they felt 'a lot

Fig.1 How to use the Cognitive Behavioural Therapy self-help resources with dentally anxious children (9-16 years)

Prior to using the guide:

- Register on website www.llttf.com/dental
- Visit the 'dental team' section of the site, view the training videos and read the dental team guide - it might be helpful for other members of the team to do this too.
- Think about how you are going to assess child dental anxiety: clinical impression or self-reported measure
- Obtain hard copy guides for patients or print flyers which signpost them to the online self-help guides. Available from the Sheffield School of Clinical Dentistry online shop.
- Download spare patient worksheets (eg 'Message to the dentist') and have these available on the clinic.

Identify patients where self-help CBT is indicated:

- Patient is assessed as having dental anxiety
- No urgent treatment needed
- Course of treatment required
- Child and family interested in self-help approach

Guide is introduced by dental professional who will be providing the course of dental treatment:

- Describe as 'self-help' guide, avoiding any descriptions of need to do work or books!
- Explain paper guide and online versions available for child and parent
- Highlight was developed with teenagers to increase credibility
- Ask child to have a look through and complete 'Message to the dentist' for their next visit

At the start of each visit:

- Read or review 'Message to the dentist'
- Recognise their past achievements
- Discuss worry/pain score
- Agree tools and stop signal

At the end of each visit:

- Provide specific praise for what they have achieved in the visit
- Complete post-treatment worry/pain score (remind of successes)
- Plan for next appointment (let them know what the procedures will involve and signpost them to the guide as appropriate)

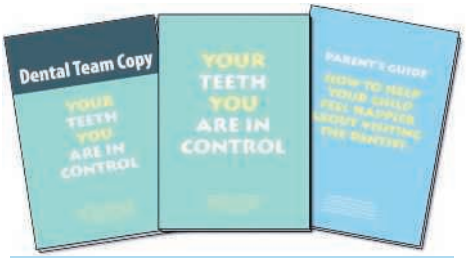

Fig. 2 Self-help CBT guide for the reduction of dental anxiety in children with accompanying resources for parents and dental professionals

less worried' about going to the dentist since using the guide. The guide was found to be acceptable to children, parents and dental professionals. Further research was recommended to evaluate this self-help guide in a randomised controlled trial[23] and its further use in both secondary and primary dental care is encouraged.

'Your teeth you are in control' is available as a paper guide http://tinyurl.com/hc998fl or online at www.llttf.com/dental. There are also accompanying resources for parents (Fig. 2) and online training for dental professionals.

Summary

- Child dental anxiety is common and has significant impacts on children, parents and dental professionals
- Traditional pharmacological approaches only manage, rather than reduce dental anxiety
- Psychological interventions such as CBT have been found to be effective at reducing dental anxiety in adults
- The use of a new guide 'Your teeth you are in control' based on the principles of CBT reduced dental anxiety and improved the quality of life of children who used it in paediatric dentistry clinics.

For more information contact Z.Marshman@sheffield.ac.uk.

'THERE WAS A STATISTICALLY SIGNIFICANT REDUCTION IN CHILD SELF-REPORTED DENTAL ANXIETY AND IMPROVEMENTS IN QUALITY OF LIFE'

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CPD questions

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‘Life is about lifelong learning’

Rosalyn Davies explains to *BDJ Team* how she progressed from being a trainee dental nurse in 1983 to being the first DCP President of the British Society of Gerodontology (BSG) in 2017.

Name: Rosalyn Davies

Age: 51

Marital status: Married for 24 years with a son and a daughter

Job title: Service Improvement & Operations Manager, ABMU Health Board Community Dental Service/ Dental Programme Manager 1000 Lives Service Improvement, Public Health Wales, Swansea

Town: Swansea

Qualifications: Certificate in Dental Surgery Assisting NEBDSA 1985
MSc Public Health & Health Promotion
IQT Bronze and Silver

Hobbies: Dog show exhibitor

How did you first get into dental nursing?

I almost fell into dental nursing! I had left school and was planning on a career to become a nurse. I was studying a 'pre-nursing course' in college (as it was called in the Dark Ages) when I undertook a placement

'IT IS SO VARIED AND INTERESTING, THERE IS NEVER A DULL MOMENT, WHICH IS WHY I CAN HONESTLY SAY I LOVE MY JOB.'

in a Geriatric Hospital (as it was called in those days). Being rather naive and fresh out of school aged only 17 I felt I couldn't cope with the huge responsibility of caring for older patients. I was offered a job as a trainee dental nurse in a local general dental practice and the rest is history. My career in dentistry began. I am so grateful to the clinicians I trained with who inspired my training and gave me the experiences and foundation of general dental services: four handed dentistry, apicoectomy and gingivectomy spring to mind every time I think about my early training days – I loved it. The pre-preparation, during treatment, and patient after care... it was exciting!

How has your career developed since completing your dental nurse training in 1985?

Very soon after completing my training I applied for a position with the Community Dental Service in Abertawe Bro Morgannwg Health Board (ABMU HB). This role was very different from general practice and I suppose at the time I was already looking to develop my career and gain other experiences in dentistry. I worked on a mobile dental unit in areas of deprivation in the Swansea and Neath Valleys and participated in school screening, epidemiology and oral health improvement programmes.

I have worked for AMBU HB, Community Dental Service for 31 years and to some this may be viewed as a non-developing career, however, during that time my role was and is still continually changing. I have been on a rollercoaster of learning and developing not only in a professional sense but personally as well. I have been part of a considerable change of service for community dentistry and I am particularly proud to be a part of that change.

1989

In 1989 I completed the Diploma in Health Promotion at Swansea University. Following this course I was fortunate to lead on a specific oral health improvement project in the valley communities of both ABM and Hywel Dda Health Boards. It was funded for three years. This role involved joint working with health and education. I developed a school education teaching programme. This was a six week teaching programme implemented into the education curriculum of year 3 and 6 primary school children. In addition I started the school tooth brushing programme in schools. This programme was delivered to areas of high deprivation. This piece of work significantly changed the way we worked in educating children and parents. Previously health promotion consisted of a one off visit to schools and providing children with a colouring sheet and a badge. This new way of inter-professional working meant developing a whole system approach in the curriculum to enhance children's learning around oral health and hygiene. Children were provided with work books, homework to complete as well as participating in practical based learning. It was very successful.

1992

I applied for an oral health promotion role within the community dental service and was successful. This role was purely educational: no clinical component. Whilst I was saddened at leaving my clinical role, I was at this point really questioning the 'why' of dental disease. What is it that leads so many children to have a general anaesthetic for tooth extractions when dental decay is largely preventable? I spent a considerable amount of time during this phase of developing oral health programmes for a wide range of people, from birth to older people services. It was during these years that I married (1992) and had my children (1995 and 1997). Juggling a full-time career (which I was passionate about), managing home life and bringing up two children was a challenge. I took a full 12 months' maternity leave for each of my children but otherwise have not had a career break. I have always been one to embrace a challenge and went on to be chair of the Parent-Teacher Association and a Governor at my children's school for a considerable number of years. Ironically both of these roles helped in my work with multi professional development.

'BY DEVELOPING THE ROLE OF DENTAL NURSES THERE IS THE POTENTIAL FOR DENTAL PROVIDERS TO BE ABLE TO WORK MORE EFFICIENTLY, PROVIDE BETTER PREVENTIVE CARE AND GIVE BETTER ACCESS FOR PATIENTS.'

2005

I embarked on an MSc course at Swansea University – Public Health & Health Promotion. What a journey and an amazing learning experience. This course totally changed the way I worked, thought, practised. It opened my eyes to the wonderful world of learning. I constantly preach to my children – life is about lifelong learning and it is not a one off event. We need to embrace it as much as possible.

2008

I graduated from my MSc course with a Distinction. Inevitably, embarking on a research study intrudes on family life and involved many sacrifices. However, this will have all been worthwhile if my study helps keep alive the underpinnings of what individuals consider health to be and for others to think more creatively about oral health promotion and improvement.

Later in 2008 my role in the CDS changed considerably to developing care pathways for people with learning disabilities, complex medical problems, older people and patients in hospital. This role most certainly took me out of my comfort zone and was yet again another challenge. However, as the role developed the service saw a significant increase in the number of special care patients being referred to the CDS.

It was this change in my role from children's service to older people that most likely kept me in my job today.

2012 onwards

In 2012 I was seconded to 1000 Lives Improvement unit, Public Health Wales to lead on the national work for Improving Mouth Care for Patients in Hospital. This work stream focused on adopting the national improvement methodology for service improvement in NHS services in Wales – IQT (improving quality together). I developed an all-Wales mouth care risk assessment and care plan for use in secondary care, bringing nursing and dental colleagues together to work in a multi collaborative way. The mantra for this programme was – 'Nurse led and supported by dental teams'.

In 2013 I became the secretary for the All Wales Special Care Interest Group/Oral Health Care and was also nominated to be part of the British Society of Gerodontology (BSG).

In 2014 I was invited to present the 1000 lives work in Geneva at the FDI World Dental Federation and in Phoenix, Arizona at the Sonntag Dental Care Conference.

Then of course this year [2016] I became President-elect for BSG.

I have been on a roller coaster of a learning experience and I feel privileged to have worked with such talented clinicians and passionate colleagues over the years. But of course for me the main driver in my work is 'our patients'. At the heart of everything I do I never lose sight of the patient. I want to improve the patient journey, from referral (to whatever setting, be it in community - care homes to secondary care – hospitals). I know it sounds a bit like an old cliché but by the time I retire I want to have 'made a difference' and contributed to the world of oral health care.

What are the most common oral health problems for older patients generally?

I think this question is a difficult one, however what I would say is the most common oral health problem that are not recognised by other health and care professionals are:

- Xerostomia which can lead to significant oral health problems
- A coated tongue
- Poor oral hygiene – plaque control and gum disease
- Levels of support for carrying out oral hygiene (tooth brushing).

Do you think that access to dental care is a big problem for older people in this country?

Yes I do; as the population is living longer it is not only the type of complex dentistry maintenance that has to be provided but access to dental services. By that I mean not

only in terms of finding a dentist but physical access. How many service providers have a hoist or a wheelchair platform so a patient can be treated in their wheelchair? As the population's weight is increasing how many service providers have bariatric facilities? The demand for Special Care Dentistry is growing and the NHS needs to support that growth in terms of specialist training for the dental team (clinicians, hygienist, therapist and dental nurses).

Can you outline a typical day in your working week?

In a nutshell a typical day for me is busy busy busy!

I like to keep my feet firmly on the ground. My day can go from attending a high level meeting with Welsh Government colleagues or ABMU Health Board, planning national/local learning events for 1000 Lives, working with nursing colleagues on the hospital programme, developing an e-learning resource for non-registered staff in care homes to listening to a patient about their experience of attending a dental service. I call it juggling many balls - it is so varied and interesting, there is never a dull moment, which is why I can honestly say I love my job.

What is the All Wales Mouth Care Tools?

This work is underpinned by what was once called the Fundamentals of Care 2003 (now called Health and Care Standards for Wales 2015). The principles are that when a patient is admitted to hospital they are fully supported to carry out mouth care. So in essence on admission a mouth care risk assessment is carried out by a registered nurse and will lead onto a bespoke mouth care plan if required. This care plan is then carried out by a health care support worker. Utilising a single risk assessment across Wales ensures consistency and evidence based oral care if staff and patients move from one area to another. Building on the hospital programme, in 2012 Welsh Government launched a programme to improve the Oral Health of Older People Living in Care Homes. So at present I am involved with trying to develop a single risk assessment and care plan that can be used across both primary and secondary care. This means a smooth transition in oral care for patients if they move, for example, from a care home into hospital and then back to a care home. Part of this work involves working with the all Wales procurement team to ensure staff have the right resources and of course considerable staff training for both students and existing staff teams.

'I ALSO WISH TO SHARE MY JOURNEY TO ENCOURAGE MORE DENTAL NURSES THAT THERE IS A WHOLE CAREER PATHWAY WAITING FOR THEM IF THEY REACH BEYOND THE CHAIRSIDE.'

Do you think dental nurses could play a greater role in providing oral care to older patients?

Absolutely, it's all about utilising prudent health care approaches in dentistry. For example, an important area for development is the use of dental nurses with enhanced qualifications. Oral health educators have an important role to play in providing dietary advice, oral hygiene instruction, administrating high-concentration fluoride varnish and smoking cessation. It no longer makes economic sense to pay highly-trained and expensive dentists to deliver these non-clinical aspects of dental care. By developing the role of dental nurses there is the potential for dental providers to be able to work more efficiently, provide better preventive care and give better access for patients. In a well-developed skill-mix team responsibility can be devolved from dentists and therapists to dental nurses with enhanced training. This downward cascade of responsibility frees time, is more cost effective and is very good for team morale helping to retain good quality staff.

How did it feel to be named President-elect of BSG and what will the role involve?

To be honest I am honoured as I understand this is the first time a DCP has been nominated for this position. However, it is important to point out that I am only in this position because of the 'fantastic teams' that I have been given the opportunity to work alongside. I am just one of many, many wonderful enthusiastic and devoted dental colleagues who would be more worthy of this position than I am.

The role will mostly involve organising two study days and encouraging more DCPs to become part of BSG. I also wish to share my journey to encourage more dental nurses that there is a whole career pathway waiting for them if they reach beyond the chairside.

What are your plans for your time as President?

The focus for 2017 will be on Improving Oral Health Care for Older People in Care Homes. Twenty or 30 years ago staff working in a care home by and large cleaned dentures, as the majority of residents wore dentures. Due to the changing pattern in older people's oral health this is no longer the case. Staff in care homes need to be adequately trained and have the competencies to be able to clean not only residents' teeth, mouth and dentures but also to be aware of 'over dentures' and 'implants'. Raising the awareness and highlighting the need of older people's access to dentistry will be key.

What do you like to do outside work?

I have always been a besotted dog lover and in 2002 we brought home our lovely, lovely Tilly – a soft coated wheaten terrier. We waited almost 18 months for her and I agreed that I would enter some dog shows. Well the rest is history: I went on to be an exhibitor at Crufts and other dog shows travelling the length and breadth of the country, I bred a litter of puppies and have bred a champion. I have met some wonderful lifelong friends through the dog world. Sadly Tilly died in February of this year and so we now only have Daisy, her daughter. Who knows, maybe it's time for another patter of tiny paws!

Do you have any other goals or ambitions you'd like to share with readers?

I am not a big achiever and very happy with the simple things in life. I don't need an exotic holiday or glittering lifestyle. I suppose it would be nice if I could win best of breed at Crufts - now that would be an achievement.

Would you recommend your career path to other dental nurses?

Absolutely – it has been a whirlwind romance with a dental twist.

bdjteam201711

The *snakes and ladders* of innovation in dentistry

Do you have an idea that you think would really make a difference in dentistry? Then **Ben Underwood**,[1] a dentist and NHS Innovation Accelerator Fellow, can help.

Innovation

One of the best examples of a recent innovation is the smartphone. This has revolutionised the way people communicate, for example with WhatsApp, and how people find love, with apps such as Tinder. An innovation is a significant positive change from what existed before. It is important to distinguish that to be an innovation, rather than an invention, something needs to be widely adopted.

In dentistry there have been a number of revolutionary innovations – one example is the ability to bond to enamel and dentine, which allows material to be attached rather than just be passively held in or on teeth. Bonding also revolutionised orthodontics, allowing the use of brackets. Another example is the air turbine, which replaced the electric and pedal drills.

An innovation can be a new way of working as well as a physical or digital product.

Snakes and Ladders

Snakes and Ladders is a board game that most people will have played as a child. Players start at the bottom of the board and the victor is the one who gets to the top first. On the way to the top are a number of snakes and ladders connecting two squares.

The snakes can hinder progress, sending the player down the board, and the ladders can help, allowing the player to skip a number of squares to move higher up the board. This journey to the top makes Snakes and Ladders a good analogy for innovation. The inventor, whether that is an individual or organisation, wants their invention to be the one that gets to the top of the board before its competitors. In the case of dental innovations, to be the invention that gets widely used either by dental professionals or patients or the public: becoming an innovation. Whilst luck plays a part in any successful innovation there are a number of other helps (ladders) and hindrances (snakes) that can be encountered on the journey.

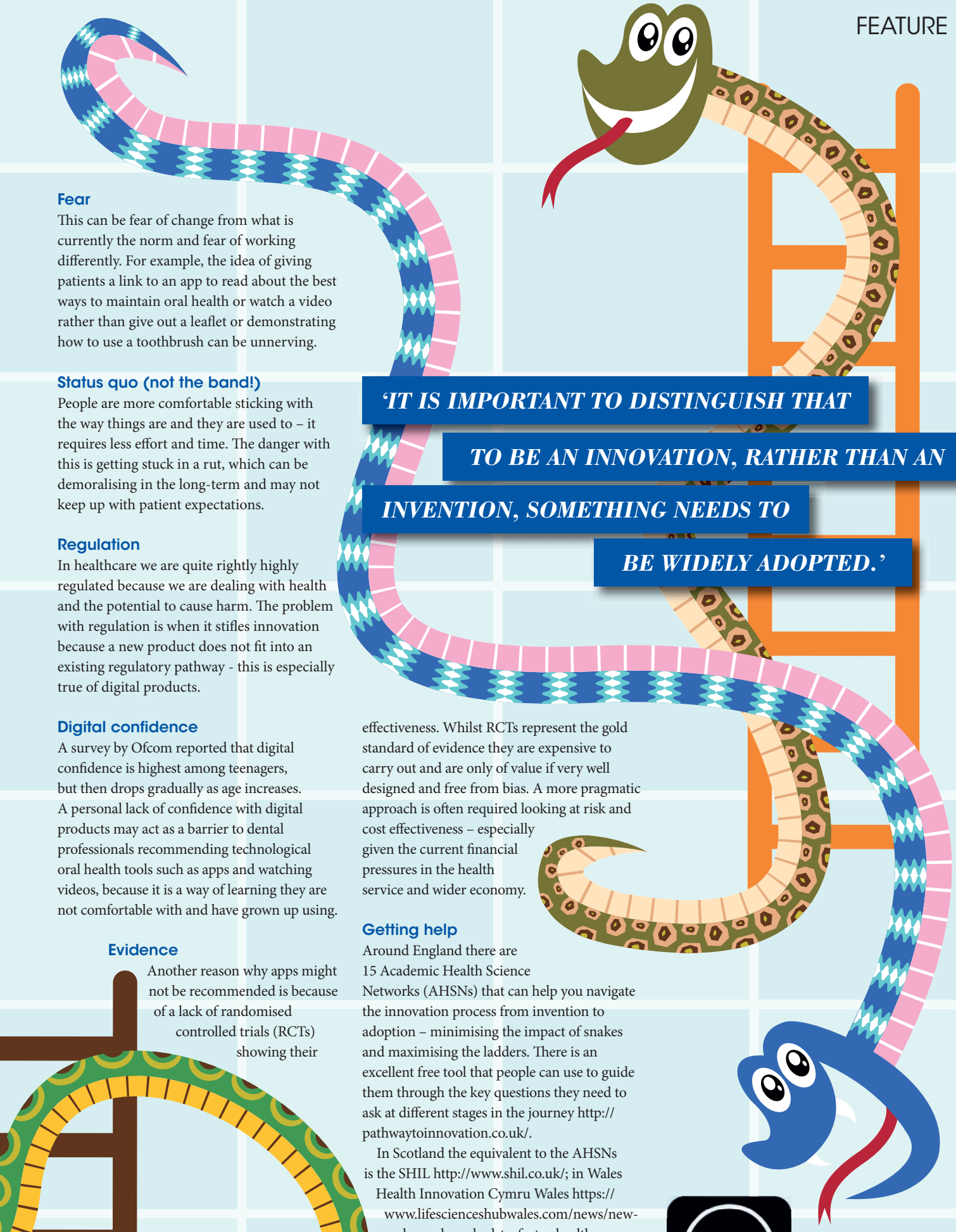
The path from invention to innovation

I will give a few examples of the snakes and ladders I have encountered during the development of the Brush DJ app. This app plays two minutes of music to motivate people, especially children, to brush for an effective length of time. The app also communicates via text and animated video the information for patients given in the Public Health England toolkit *Delivering better oral health*. To date the app has had over a quarter of a million downloads in 193 countries.

People

People are in my opinion the most important factor in helping or hindering an invention becoming an innovation. On my journey I have encountered both snakes and champions who will not only supply the ladders, but also hold them. The reason why some people will hinder is often due to fear.

[1]*Ben is an NHS dentist in York. His main areas of interest are preventative and minimally invasive dentistry. He began developing the Brush DJ app and videos in 2011 and has gone on to win a number of awards, becoming one of the inaugural fellows on the NHS Innovation Accelerator programme. The programme supports exceptional individuals with a passion for learning and a commitment to share their learnings widely, scaling evidence-based innovations for greater patient benefit https://www.england.nhs.uk/ourwork/innovation/nia/.*



Fear

This can be fear of change from what is currently the norm and fear of working differently. For example, the idea of giving patients a link to an app to read about the best ways to maintain oral health or watch a video rather than give out a leaflet or demonstrating how to use a toothbrush can be unnerving.

Status quo (not the band!)

People are more comfortable sticking with the way things are and they are used to – it requires less effort and time. The danger with this is getting stuck in a rut, which can be demoralising in the long-term and may not keep up with patient expectations.

Regulation

In healthcare we are quite rightly highly regulated because we are dealing with health and the potential to cause harm. The problem with regulation is when it stifles innovation because a new product does not fit into an existing regulatory pathway - this is especially true of digital products.

Digital confidence

A survey by Ofcom reported that digital confidence is highest among teenagers, but then drops gradually as age increases. A personal lack of confidence with digital products may act as a barrier to dental professionals recommending technological oral health tools such as apps and watching videos, because it is a way of learning they are not comfortable with and have grown up using.

Evidence

Another reason why apps might not be recommended is because of a lack of randomised controlled trials (RCTs) showing their effectiveness. Whilst RCTs represent the gold standard of evidence they are expensive to carry out and are only of value if very well designed and free from bias. A more pragmatic approach is often required looking at risk and cost effectiveness – especially given the current financial pressures in the health service and wider economy.

'IT IS IMPORTANT TO DISTINGUISH THAT TO BE AN INNOVATION, RATHER THAN AN INVENTION, SOMETHING NEEDS TO BE WIDELY ADOPTED.'

Getting help

Around England there are 15 Academic Health Science Networks (AHSNs) that can help you navigate the innovation process from invention to adoption – minimising the impact of snakes and maximising the ladders. There is an excellent free tool that people can use to guide them through the key questions they need to ask at different stages in the journey http://pathwaytoinnovation.co.uk/.

In Scotland the equivalent to the AHSNs is the SHIL http://www.shil.co.uk/; in Wales Health Innovation Cymru Wales https://www.lifesciencesshubwales.com/news/new-scheme-launched-to-foster-healthcare-innovation-in-wales/ and in Northern Ireland The Technology Transfer Office for Health and Social Care in Northern Ireland http://www.innovations.hscni.net/.

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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.

WIN A DESIGNER TONGUE CLEANSER

The Italian made AMANO tongue cleanser is designed to add elegance to the 2,000-year-old ritual of tongue scraping. Tongue cleansing was particularly in vogue in the eighteenth and nineteenth centuries, with George Washington and Victorian aristocracy firm advocates of the routine.

Simple to use and with a range of eye-catching designs, the nickel and alloy head of the AMANO tongue cleanser is gently drawn down the tongue's surface, removing all debris in two to three strokes. Due to its precise design and weight, patients will not gag with an AMANO.

AMANO has three of its latest tongue cleansers to give away to *BDJ Team* readers. To be in with a chance of winning one, just answer the following question:

Q. Which American President is known to have used a tongue scraper (it can still be viewed in his museum)?

A. George Washington
B. Bill Clinton
C. Abraham Lincoln

The first three people to email the correct answer, A, B or C, to mano@amanotonguecleanser.com, by 3 February 2017, will win an AMANO tongue cleanser.

www.amanotonguecleanser.com

AMANO is available in Selfridges, Harrods and Planet Organic

MAKE A POINT OF CONTACT

Patient Connections from innovative dental software developers, Welltime, gives you the opportunity to communicate with your patients like never before.

An easy-to-use system that integrates seamlessly with your current digital facilities, Patient Connections allows you to send your patients comment forms and questionnaires after each appointment. The information you receive from these provides essential feedback with which you can improve your service.

Patient Connections also enables you to review and monitor this feedback in a simple manner – and then make use of it on your website. You will also be able to send patients pertinent articles and oral health tips through the programme, to offer them an even better service.

What's more, this eclectic programme allows you to send patients bespoke clinical advice and education, to support the advice you have given them in the surgery. This promotes better patient understanding and gives your patients the knowledge they need to take their own dental care into their hands.

To find out more about what Patient Connections could do for your practice and your patients, contact the expert team at Welltime today on 07999 991 337, email sales@welltime.co.uk or visit www.welltime.co.uk.

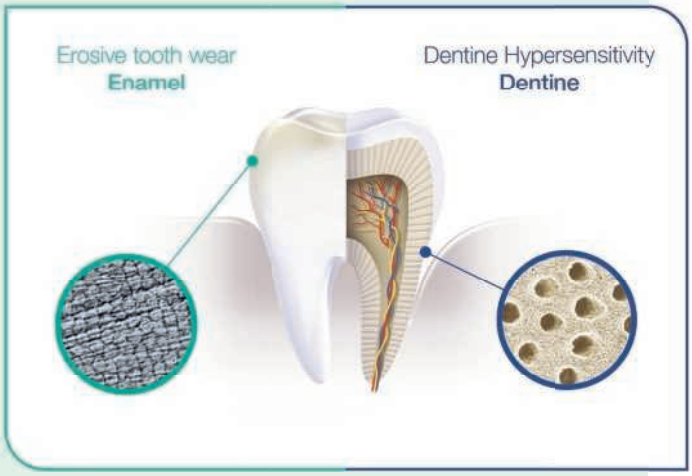
RAISING AWARENESS OF TOOTH WEAR AND DENTINE HYPERSENSITIVITY

GSK is leading a campaign to raise awareness among dentists, DCPs and patients about two common conditions: erosive tooth wear and dentine hypersensitivity (DH).

Seventy-seven percent of British adults exhibit signs of tooth wear.[1] You can now download the GSK BEWE app from the App Store for a comprehensive guide to erosive tooth wear diagnosis. Recommend Pronamel for daily protection from the effects of erosive tooth wear.

Dentine hypersensitivity is also widespread. 41.9% of adults have experienced it[2] and over 70% of sufferers consider the sensations to take pleasure out of eating and drinking.[3] Recommend Sensodyne Repair & Protect for daily repair from DH.

For more information on these conditions and other CPD materials, visit: https://www.gsk-dentalprofessionals.co.uk/.



1. Disease and related disorders – a report from the Adult Dental Health Survey 2009. The Information Centre for health and social care, 2011
2. Addy M. *Int Dent J* 2002; **52:** 367-375.
3. GSK Data on File RH02026.

AN INNOVATION IN MOUTH CLEANSING

The MC3 is an ergonomically designed Class 1 medical device for use in delivering safe mouth care. Unlike brushes, it cleans the tissues and collects debris simultaneously and unlike sponge swabs, the cleaning head of the MC3 will not detach and form a safety hazard.

The MC3 was developed following a medical safety alert from the Medicines and Healthcare Products Regulatory Agency involving the use of foam mouth swabs. A foam head had detached from the stick of an oral swab while a carer was providing mouth care to an elderly patient. The foam head could not be retrieved and the patient subsequently died. Over 800 patient safety incidents have been reported by The National Patient Safety Agency where the foam head had either become detached or pieces of the foam head were torn off and retained or lodged in the mouth. Foam mouth swabs have now been banned across Wales and many Healthcare Trusts across England.

The MC3 can be used safely with ventilated patients at risk of contracting ventilated associated pneumonia (VAP). MC3 is for those people who depend on or require assistance for mouth care and for people where conventional methods such as toothbrushes and sponge swabs are not suitable.

MC3 can be used to cleanse the soft tissues inside or around the mouth for a wide range of people, including the edentulous. It can be used wet or dry to lubricate and moisten the lips and mouth with water, water based gels and mouth rinses; clean a coated tongue; remove retained food and debris from the mouth; remove sticky tenacious secretions, crusty plugs on the palate and stringy saliva; and aid oral densensitisation for patients with special requirements and learning disabilities.

The MC3 is suitable for use by any healthcare professional in hospitals, care, nursing and residential homes, hospices, community health and social service teams and in dental practices.

For more details contact Linton Whyte on 07877 547762 or email lintonwhyte@live.co.uk.

IMPROVE RECALL EFFECTIVENESS

Patient recalls are often forgotten or sent only once in the hope the patient receives the message first time. Missed appointment patients are not contacted for re-booking and as a result end up in an 'idle' state with no activity in the practice. All of these issues lead to large lists of patients being registered but not being treated.

Understanding and reacting to the needs of patients is fundamental to proactive marketing. As a recognition of these issues, iSmile has a built-in Campaign Manager which can automatically generate up to three rounds of appointment reminders and up to eight rounds of recall reminders. Each message is set to be sent via any channel (SMS, email, letter or patient preference) and the message for each round of reminders can be customised. With all the activity happening automatically in the background it eases pressure on practice managers and receptionists and ensures the practice knows the state of each registered patient.

Furthermore, the iSmile system extends directly to the palm of your patients. The digital age has created a connected world with constant access to key information anywhere, anytime on any device. iSmile has an integrated Patient Portal, which can be accessed from any device and is branded to the practice's specifications. The secure Patient Portal enables the patient to complete their medical history ahead of their appointment, minimising surgery wait times and allowing the dentist to see more patients during the day.

The iSmile Patient Portal also captures patient feedback on their experience and includes a patient interest form. The feedback can then be analysed at the practice and interest specific campaigns can be setup.

For more information about iSmile call 0845 468 1287 or visit www.ismiledental.co.uk.

SPOT THE FIRST SIGNS OF CARIES

The CALCIVIS imaging system introduces revolutionary new technology to the dental profession.

By using a unique and highly specific recombitant, luminescent photoprotein, the CALCIVIS imaging system identifies free calcium ions with a distinct light signal. Calcium ions in solution are indicative of active demineralisation - the initial stages of dental caries - meaning that professionals now have an accurate way of identifying high-risk carious lesions.

The CALCIVIS imaging system is an innovative step forwards in the field of prventive dentistry. Patients can be given an opportunity to maintain the health of their natural teeth for longer.

Find out more at www.calcivis.com.

BDJ Team CPD

CPD questions: January 2017

CPD: ONE HOUR

'Your teeth you are in control'

1. Select the **incorrect** statement.

A) sedation and GA manage rather than reduce children's dental anxiety

B) GA for dental treatment costs the NHS about £720

C) the Child Dental Health survey in 2013 found that 14% of 15-year-olds were classified as having extreme dental anxiety

D) child dental anxiety also impacts on parents

2. Cognitive Behavioural Therapy:

A) aims to help the patient modify unhelpful behaviours or thoughts

B) incorporates a variety of different strategies

C) is a goal-orientated talking therapy

D) all of the above

3. Which of the following statements is made in this article?

A) 'tell-show-do' and stop signalling is rarely used by dental professionals

B) parents are usually best placed to handle their child's dental fear

C) there is a lot of research about the effectiveness of CBT for reducing children's dental anxiety

D) anxious children become adults with a long-term reliance on expensive pharmacological techniques

4. 'Your teeth you are in control' was used with a sample of new patients in Derbyshire and Sheffield. Select the correct result from the 48 children who completed three treatment visits.

A) over half were female

B) 36% were referred for the management of dental caries

C) 75% lived in deprived areas

D) nearly a third indicated they felt a lot less worried about going to the dentist since using the CBT guide

BDJ Team is offering all readers **10 hours of free** CPD on the BDA CPD hub! Simply visit **http://bit.ly/2e3G0sv** to take part!

How to take part in *BDJ Team* CPD

BDJ Team CPD is now on the BDA CPD hub! This site is user-friendly and easy to use. There are now **ten hours of free BDJ Team CPD** on the CPD hub.

To take part, just go to **http://bit.ly/2e3G0sv**

To send feedback, email **bdjteam@nature.com.**