DENTAL HEALTH

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THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

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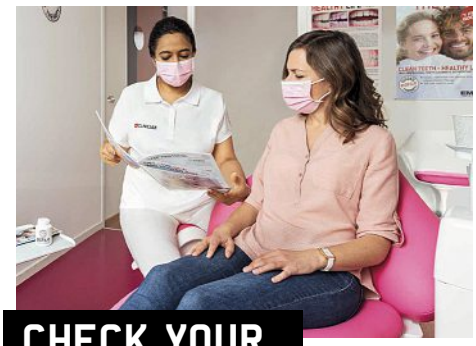

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The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups to provide the highest level of information to our members as well as to the general public. The Society seeks to increase the range of benefits offered to members and to support this with a clear business and financial strategy. The Society will continue to work to increase membership for the benefit of the profession.

BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
Promoting health, preventing disease, providing skills

bsdht.org.uk

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EDITORIAL

Mandatory vaccination

As I write this, in December, the UK government has just announced that all front-line NHS staff in England with direct patient contact must be vaccinated against COVID-19 by 1st April 2022.

So, for any member to whom this applies, who may be still hesitating, this means that you will need to have your first dose by the 3rd February, otherwise you will not be eligible to get your second dose by the April deadline.

Reassuringly, it appears that the voluntary uptake of vaccinations by health care workers is going well. According to the British Dental Association, 90% of NHS dental staff in England have had two doses of the vaccine. In Scotland, the chief medical officer stated that rates for vaccine uptake by NHS and social care staff are very high. Currently, in Wales there is no plan to introduce a compulsory vaccination programme. Hopefully, dental teams in Wales are also complying. However, in Northern Ireland a public consultation is underway about the compulsory vaccination of new staff.

Obviously, there are dental care professionals who, for personal reasons, do not wish to be vaccinated. In Italy, where vaccination is compulsory, a dentist presented for his inoculation wearing a fake arm. According to news reports, he is now facing criminal charges. There was also the news of another individual who was wearing a half body suit made of silicone in a desperate attempt to avoid being vaccinated.

Mandatory vaccination programmes are divisive and contentious and, quite rightly, ethical concerns are hotly debated. Last November it became compulsory for all care home staff, excluding individuals who were medically exempt, to be vaccinated. This policy resulted in a large number of care workers leaving the profession and the inevitable impact on their lively hood. Whatever your views about mandatory vaccination, an exodus of essential front-line care home staff is alarming.

Until the government's announcement, vaccination against COVID-19 was not an absolute requirement for dental registrants. The General Dental Council (GDC) acknowledges that there are sometimes legitimate reasons for an individual not to partake of a vaccination programme. However, the GDC Standards for the Dental Team[1] do require us to provide a safe environment for patients and to manage the risks to our own health. Vaccination programmes are a recognised form of protection.

In dentistry, some viruses pose a risk to staff and patients and therefore employers will often request evidence that we have immunity. We may be referred to our local occupational health unit to be tested for the presence of Hepatitis B and Hepatitis C antigen. We also may need to prove that we are HIV antibody negative. Although not compulsory, those working in the NHS are also encouraged to have the annual flu vaccination.

The various regulations that require us to be vaccinated align with our duty of care towards our patients. In situations where, for medical or ethical reasons, a team member cannot be vaccinated then clinical guidelines must be closely adhered to. It is our duty to protect our patients from communicable diseases wherever possible including vaccine preventable transmissible diseases.[2]

Ultimately, it will be the recommendations of each of the devolved nations to decide whether or not all healthcare staff must be vaccinated against COVID-19.

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1. General Dental Council. Standards for the dental team. 2013.
2. Department of Health. Immunisation against infectious disease. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf (accessed December 2021).

Heather Lewis

FROM THE PRESIDENT

The year since my first 'from the president' has passed by in the blink of an eye! For many, the start of a new year can be a time for reflection. However, this is often accompanied by a feeling of excitement as we plan for the year ahead.

The theme for the OHC2021 was *See and be Seen - shining a spotlight on our profession.* SEE represented Skills, Evolve and Engagement. As I mentioned in my welcome speech at the conference, I could never have known back in the summer of 2019 how important 'engagement' would be - engaging with our patients, the teams we work with and each other has never been more vital. Promoting renewed enthusiasm for our profession is high on the agenda for 2022.

Annual General Meeting

BSDHT held the AGM online, for the second time, on the 11th November 2021. We dealt with the business of the day, answering questions relating to reports previously sent out to all members and approved changes to the Rules and Articles of the Society.

The election of the new honorary secretary was put to a vote with Jolene Pinder and Sarah Rohan receiving over 300 votes between them. The closely contested election saw Jolene being elected as the new honorary secretary. Three nominations were received for the three members elected to council positions: We welcome Stephanie Leyland, Claire McCarthy and Simone Ruzario. We also welcome Emma Hornby as coaching and mentoring representative and Claire Bennett as student representative co-ordinator to Council, Claire will also be the student members voice on the executive team this year.

The recipient of the Dr Gerald Leatherman award was also announced. For the first time this was awarded posthumously to Kay Cullen. Jolene read an emotional citation dedicated to her friend Kay.

Coaching & Mentoring

The coaching and mentoring programme launched at the AGM, offers another fantastic member benefit. Engaging the services of a coach or mentor can be costly, so please take advantage of the programme. The mentors can help you to channel all your plans for the new year and help you achieve some goals for your personal and professional development. Please contact **enquiries@bsdht.org.uk** for an expression of interest form.

Ambassadors

The applications where plentiful and to a very high standard making it a difficult decision for the selection panel. I would like to introduce the BSDHT ambassadors for 2022-23:

Lauren Barry; Nancy Bentley; Martha Branch; Joseph Burchell; Abbie Eades; Dominika Jaslikowska; Aaron Kinsey; Asma Matloob; Lynn McCartin; Robiha Nazir; Vishwal Patel; Kate Reading; and Claire Stott.

The BSDHT teams are looking forward to working with the ambassadors to spread the word about the good work of the Society and the dental hygiene and therapy profession.

Oral Health Conference

A year later than planned and challenges throughout 2021, made the OHC2021 extra special for all those involved. The theme of *See and be Seen,* shining a spotlight on our profession, has never been more apt. In the days and weeks following the conference, social media was flooded with praise and expressions of delight about the event. I have received so many messages of congratulations!

Not only has the spotlight been shone on our profession, but it also shines brightly on BSDHT.

The programme reflected the title, with a variety of topics and hands-on workshops throughout the two days and the conference dinner at the Grand Central Hotel on Friday night was the perfect opportunity to celebrate all that we have achieved and overcome since our last OHC in Newport in 2019.

I would like to once again thank all the teams involved in making the OHC happen: the trade for their support; the many speakers for sharing their knowledge, skills, and wisdom; but most importantly the biggest thank you goes to the delegates. Without you OHC2021 would not have been possible.

Planning for Manchester 2022 is underway, so please add to your diary *OHC2022 Manchester, Friday 25th and Saturday 26th November* and join us for what is sure to be a fantastic two days.

Infographic Competition

During the conference the BSDHT Infographic Competition was launched. If you have a creative flare and would like the opportunity to promote dental hygiene and therapy far and wide, then this is your chance. The idea is that the winning entries, can be used in dental settings across the country to highlight our roles within the dental team.

The closing date for submissions is Monday 28th February 2022.

New Home

Bragborough Hall Business Centre is the new home of BSDHT. The administration team has a dedicated office providing a safe environment and in beautiful surroundings. Sustainability is at the forefront of this development, which enhances and aligns with the Society's sustainability policy. Another added benefit is that BSDHT has the use of the conference facilities for Council meetings, training days and other educational opportunities. The location is ideal being close to a train station and motorway network making it easy for members and guests to visit.

Flossuary

BSDHT member Elizabeth Matthews is busy preparing for Flossuary again this February. Her fantastic initiative proved very popular last year and she is hoping to reach more dental teams and patients again this year. Liz's initiative is designed to motivate and create a behaviour change in patients with a fun 28 day flossing challenge. If you would like to be involved, then please contact Liz directly: **enquiries@flossuary.com**

Study Days

The regional group teams are busy planning for the Spring study days, so please save the date. Venues have covid safe policies in place and the teams will do whatever it takes to make sure members are as safe as can be. The face-to-face Autumn study days received positive feedback, and while online learning has its place, there is nothing quite like being back in the same room with our friends and colleagues, not only to learn, but to share experiences and catch up on all the news. Let's make sure the Spring study days create the same buzz, excitement, and enthusiasm as the OHC and keep shining that spotlight!

Diane Rochford

KAY CULLEN IS POSTHUMOUSLY BESTOWED THE DR LEATHERMAN AWARD

The Dr Leatherman Award has long been widely regarded among the profession as a symbol of excellence, dedication and determination to usher in real change.

This year, the perfect candidate could be none other than Kay Cullen, a lifelong pro-active devotee to the Society who sadly passed away from breast cancer in 2019.

Her friend and colleague Jolene Pinder posthumously nominated Kay for the award.

Kay qualified as a dental hygienist from Glasgow Dental School in 1982 under the close tutelage of Bill Collins. She was a committed and very proud dental hygienist. Her reputation preceded her wherever she went. Her passion for oral health was exhibited in her daily working practice as well as on many dental committees at both national and regional level.

Having known Kay for only 16 years before her very premature and sad passing I can honestly say she was a true model of what every dental hygienist would hope to be.

Clinically excellent and precise, her work with her patients is still exhibited in my practice every day. I covered for her sick leave when her breast cancer was first diagnosed and her patients are still with me now. Kay was at the 'coal face' of dental hygiene for more than 30 years and her reputation locally was second to none. Patients travelled for miles to see her on recommendations from colleagues and other patients.

Kay was a huge advocate of choice for patients and a massive supporter of direct access. She believed that the dental hygienist was at the centre of any ethical and successful practice. Her foresight before direct access came into being showed how successful and clinically beneficial to the patients a 'business within a business' could be. She was a true pioneer in a challenging demographic.

She was involved with the BSDHT from qualification and worked for over 30 years in both a regional and national capacity. She held every role possible at a regional level. She encouraged new members constantly and was the gregarious and welcoming face for newbies at every meeting. She was inclusive and would never have anyone attending solo sitting that way for long - whether they liked it or not! Kay would have had them on the committee before they knew it. She constantly sought out new and exciting speakers for the regional meetings and before social media, used every means possible to ensure good attendance. The glass of wine at lunch was always a welcome addition.

In the dental practice where Kay was based, she was the lead on nurturing and training dental nurses. Many of these nurses were encouraged to gain further qualifications and move careers into dental hygiene. She was respected for being the human resources department when dealing with many challenging situations. She demonstrated exactly how career progression within the profession could work and was an inspiration for those nurses who worked alongside her.

She advocated chairside assistance for the dental hygienist long before the rest of the profession caught up. Her forward thinking in this area was uncompromising, she knew we could only work at our best, and at capacity, when assisted. She saw this from both a clinical and patient perspective. She also advised and consulted with other dental professionals to forge better working conditions.

She implemented a local schools' programme utilising trained nurses within the practice to cover primary and secondary schools. A team from the practice would also be found at every secondary school's careers evening with Kay leading the charge to ensure the young adults knew what opportunities lay at their feet if they chose a career in dentistry.

Kay was a highly valued member of the direct access working group within the Scottish government health department, advising on the practical implementation of this groundbreaking change in the delivery of primary dental care within general dental practice in Scotland. She was also a member of the Scottish Intercollegiate Guidelines Network (SIGN) that established formal procedures for the prevention of dental caries in children. Kay continued to be active in both these prominent groups with her usual drive, determination and good humour, despite her illness.

Throughout her illness, whilst trying to continue to work, her dedication to raising money for charity was phenomenal. She organised a fashion show with breast cancer survivors to raise money for Breast Cancer Care and raised £20,000. She also tirelessly supported the local hospice, which went on to provide care for her just before she died.

Kay continued to support the BSDHT throughout her illness and never missed a meeting. Her presence was always a joy and her laugh unforgettable!

I felt it was important to nominate Kay for this award as she was the 'perfect' example of a dental hygienist: involved in the community; at the forefront of change in the profession; trailblazing; and a true motivator.

So, here's to Kay – a trailblazer and an incredible woman who is deeply missed by all who knew her.

THE BSDHT WELCOMES TWO NEW POSITIONS TO THE COUNCIL

Following this year's Annual General Meeting, we are excited to welcome two new positions to the Council – Student Representative Coordinator and Coaching & Mentoring Representative.

Claire Bennett will be taking on the role of Student Representative Coordinator. In this role she will provide ongoing support for students who are currently studying dental hygiene and therapy in the UK.

Emma Hornby has been elected as the Society's Coaching & Mentoring Representative.
This position will provide a two-way link between mentors and the BSDHT Council.

Congratulations ladies and welcome to the Council! We can't wait to see what you bring to the table.

THE BSDHT WELCOMES DEBBIE REED!

The society is thrilled to announce the election of Dr Debbie Reed as our latest Honorary Vice President.

A passionate educator who is currently the Head of Department for Digital & Lifelong Learning at the University of Kent, Debbie is a welcome addition to the BSDHT and hopes to bring her unique insight, extensive experience and passion for education and development to the role.

Upon her new position being announced in the BSDHT Annual General Meeting Debbie said:

"I am so delighted to be invited and accept one of the BSDHT's prestigious Honorary Vice President roles. I'm honoured to be considered by such an esteemed organisation and my eagerness for the role knows no bounds! I'm looking forward to working closely with all of the BSDHT who so admirably represent dental hygienists and dental therapists across the nation."

Debbie joins our current Honorary Vice Presidents, Dr. Simon Hearnshaw and Dr. Stacey Clough.

Welcome to the Society, Debbie!

CONGRATULATIONS TO THIS YEAR'S WINNERS!

BSDHT

BSDHT wants to extend a huge congratulations to this year's winners of the annual Poster Competition and the Student of the Year Award.

Both coveted accolades, the competition for these awards was fierce this year with a wealth of talent showcasing exactly how dedicated the current and next generation of dental hygienists and dental therapists are to the profession.

Student of the Year Award

Aaron Kinsey from the University of Plymouth was named the Student of the Year for his positive attitude, talent and commitment to the profession – well done Aaron!

Unfortunately, Aaron was not at the OHC in person to accept the award, but he did send a pre-recorded message to thank the Society for all its support.

Poster Competition

With a number of excellent entries, the annual poster competition was another highlight. Winner of this year's first prize was Lauren Barry, with her case study of successful use of dental therapy skills in special care dentistry – a highly informative and helpful piece of work!

A big congratulations again to all of our winners!

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LOGGING ON TO THE MEMBERS' AREA:

Complete the boxes using the following information:
User name: your full name, no addreviations, no spaces, all in lower case
eg. dianamarysmith. Password: your BSDHT membership number.

If you need clarification of the details we have on file– first name, middle name (if provided) and membership number – please contact BSDHT on **01788 575050**

CPD AND LIFELONG LEARNING STRATEGY EVENT

Reported by
ALI LOWE

5TH OCTOBER 2021

Health Education and Improvement Wales (HEIW) is a special health authority within NHS Wales sitting alongside other health boards and trusts. It plays a leading role in the education, training, development, shaping and transformation of the healthcare workforce in order to ensure high quality care for the people of Wales.

This event took place remotely with the aim of determining HEIW contribution to a strategy that will work towards an equitable approach across professions based on the specific needs of their roles.

The attendees represented a wide range of professions and included providers, regulators and consumers of CPD. Speakers included, Professors Push Mangat, Alison Bullock and Nichola Ashby.

The focus was on barriers to continuing professional development (CPD), CPD formats/providers, outcomes, and quality assurance. During the event, attendees were divided into breakout rooms to discuss the potential strategy: there was a general consensus that HEIW is already doing an excellent job and there was emphasis on the role HEIW plays in influencing change, providing CPD, implementing the strategy and influencing organisations.

Factors for consideration included:

- A need to clarify roles including links between HEIW and professional bodies along with health and social care;
- The fact that several new roles are currently under development;
- The need to incorporate nonclinical team members (traditionally there has been emphasis on clinical CPD);
- Team members aspirations and the support they need to fulfil them;
- Potential career ladders;
- The role of patients in staff development;
- Quality assurance and risk assessment;
- The need to create a multi-professional workforce and multidisciplinary CPD opportunities;
- The need for interprofessional working.

It was concluded that whilst online learning has been beneficial during the pandemic blended learning is advantageous for those working in isolation e.g., some pharmacists and dental professionals, thus effective communication between all those involved is essential.

The event ended with everyone contemplating the next steps in the development of this strategy.

Watch this space…!

IN CASE YOU MISSED IT...

The fourth edition of Delivering Better Oral: an evidence-based toolkit for prevention was published in September.

You can access it here:
https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention.

ANTIBIOTICS DO NOT CURE TOOTHACHE!

National dental and medical organisations have come together again to support the World Health Organisation's Antimicrobial Awareness Week.

The Association of Clinical Oral Microbiologists and College of General Dentistry, supported by the Association of Dental Hospitals, British Dental Association, Healthcare Improvement Scotland, British Association of Oral Surgery, British Society for Antimicrobial Chemotherapy, British and Irish Society for Oral Medicine, Faculty of Dental Surgery of the Royal College of Surgeons of England, Faculty of Dental Surgery of the Royal College of Surgeons of Edinburgh, and the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow, reminded patients that, *"antibiotics do not cure toothache",* and encouraged the dental team to adhere to best practice and only prescribe antibiotics as an adjunct to definitive clinical management of the cause when indicated, according to national guidelines.

Prudent prescribing of antimicrobials can slow down the development of antimicrobial resistance, and all healthcare prescribers play a vital role. The dental profession has shown its commitment to addressing antimicrobial resistance by significantly reducing the use of antibiotics over the last decade, both in dental practice and a hospital setting.

Dental hospitals in the UK and Ireland reduced antibiotic prescriptions by 22% and 30% for therapeutic and prophylactic indications respectively between 2018 and 2020 (prior to the COVID-19 pandemic).

It has been reported that COVID-19 had a negative effect on the profession's endeavours in improving antibiotic prescribing patterns. The organisations therefore encourage dental teams in both general practice and hospital settings to re-start auditing their practice of antibiotic prescribing against the recently updated national guidelines, as this will help to reduce the use of antimicrobials and improve patient outcomes.

The successful management of acute dental infections requires accurate diagnosis and definitive treatment, and patients who have prompt access to emergency dental services have a much-reduced risk of developing life-threatening sepsis. Dental teams are encouraged to use the following resources to update their knowledge on the latest national recommendations on the use of antimicrobial agents in dentistry, and to audit their practice:

- **Guidelines for antimicrobial prescribing in dentistry are available at: https://cgdent.uk/standards-guidance/ and https://bnf.nice.org.uk**
- **Guidance for antimicrobials in dentistry in Scotland are available at: https://www.sdcep.org.uk/published-guidance/drug-prescribing/and https://www.sapg.scot/media/5473/statement-on-pen-v-in-dental-infections.pdf**
- **Antimicrobial prescribing audit tools are available at: https://cgdent.uk/standards-guidance/ and https://heiw.nhs.wales/education-and-training/dental/quality-improvement/national-audit-projects/antimicrobial-prescribing/**
- **Other resources, including the Dental Antimicrobial Stewardship Toolkit, are available via: https://cgdent.uk/standards-guidance/ and https://bda.org/amr**
- **Other Toolkit, are available via: https://cgdent.uk/standards-guidance/ and https://bda.org/amr resources, including the Dental Antimicrobial Stewardship infections.pdf**

BSDHT Infographic Competition

Call for infographics

The British Society of Dental Hygiene and Therapy (BSDHT) would like to invite colleagues to submit designs to be considered for an Infographic Competition.

This infographic ties in with 2021 Oral Health Conference theme of 'See and Be Seen'. The infographic should be designed to be displayed in dental waiting rooms and inform members of the public of the role of the dental hygienist or dental therapist, and how they are a valuable part of the dental team.

All designs will be judged by the BSDHT Judging Committee, and the winner will receive Amazon vouchers along with an Award Certificate. The infographic must use the BSDHT corporate colours, as a primary base/source.

BSDHT

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Prizes will be awarded to 1 Dental Hygienist and 1 Dental Therapist entry (each will receive a £400 Amazon Gift Voucher), and there will also be some prizes for the runners up.

Terms and conditions

The competition is open to all BSDHT members.

An individual may submit two infographics - one depicting the role and benefits of seeing a dental hygienist and one for a dental therapist; however, you are not obliged to submit two.

Persons submitting an image for the Infographic Competition are doing so with the understanding that they abide by the terms and conditions, deadline policies, and the decisions of the BSDHT Judging Committee.

By submitting your infographic, you are agreeing that it is published in a future BSDHT publication and have it available as a download from the BSDHT website for BSDHT members.

Successful designs will be produced with sponsorship from BSDHT. Infographics will be circulated to the BSDHT Judging Committee for review following the closing date. Closing Date for submissions is Mon, 28th Feb 2022.

For more information and a submission form, please contact BSDHT at enquiries@bsdht.org.uk

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COACHING AND MENTORING ANOTHER MEMBER BENEFIT

by LAURA McCLUNE

Coaching and mentoring are terms often used interchangeably, particularly in the context of business and healthcare as both disciplines offer an individualised approach to personal, professional and career development. Coaches and mentors use their own experience to ask questions that lead learners to their own insight and conclusion, therefore helping them to develop their own wisdom and experience.[1] Additionally, commentators believe that coaching and mentoring can play a key role to support organisations.[2] In some respects, all dental professionals can be seen as being part of a larger organisation, albeit within smaller individual practices. Fundamentally, this support can be beneficial as it provides a ready, impartial and trusted source of advice from someone who understands the professional requirements and expectations.[3]

BSDHT's Coaching and Mentoring Programme

The BSDHT's Coaching and Mentoring Programme is finally set to be launched, which is incredibly exciting if a little nerve wracking: it has been no mean feat to get this vital member benefit off the ground. Although personally I am fortunate to have the support of some like-minded and knowledgeable individuals who I can lean on when I am experiencing any challenges, as a Society we are fully aware that this is not currently available to everyone. It was our forward thinking former president Julie Deverick who first set the wheels in motion for a members' mentoring service, and under the direction of our current president, Diane Rochford, it has now evolved to a Coaching and Mentoring Programme.

Although there are many similarities between coaching and mentoring there are multiple differences too.

If we look back to the height of the pandemic, the Society was inundated with members' enquiries from those who were desperately trying to navigate such a difficult time. However, on reflection, I think that we have known for quite some time that this was a particular support service that was always in demand.

In BSDHT we are lucky to have a small number of already qualified coaches and mentors amongst our membership but ultimately we required more. Therefore, in the summer of 2021, on the two hottest weekends of the year, a large group of enthusiastic BSDHT members virtually attended a training event hosted by the University of Kent. We were joined by UMD professional's lead Fiona Stuart-Wilson and tutor Sandy Horvath who delivered a jam packed few days of an "introduction to coaching and mentoring". I was lucky enough to be one of these individuals taking part and all I can say is that I was not prepared for the level of knowledge relating to delivering coaching and mentoring! Thankfully, I was hooked!

Coaching and mentoring really does have the ability to help people. I see it as a way of assisting individuals to problem solve, or to develop their own solutions, with a little guidance and a sympathetic ear to sound things out. In many ways, as professionals, we already carry out informal coaching and mentoring, not only to our patients but more than likely to other members of our dental team or peers. I have definitely received some coaching from the majority of the BSDHT executive team at some point!

If you would like to find out more or you wish to sign up then please contact the BSDHT office on **enquiries@bsdht.org.uk**

Author: Laura is BSDHT honorary treasurer and a BSDHT coach and mentor

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DENTAL HYGIENIST TO VACCINATOR

by JOANNA BROWN

"Hi, my name is Joanna, and I will be your vaccinator today. Is this your first, second or booster dose? Also, which hand do you normally write with?"

So, not my normal speech to my dental patients but I suppose that's the pandemic for you! Who would have thought, nearly 18 months ago, that dental hygienists and therapists would be eligible to train as vaccinators?

It was a hot and sunny day last June when my dental nurse mentioned that she had applied to work at the Greater Manchester Mass Vaccination Centre, and I should think of applying. My initial reaction was that although I am competent to give patients an injection in the mouth, an injection in the arm is totally different. Growing up, I was always the one at the back of the queue for injections at school and I have even been known to faint in my local sandwich shop following an injection at my GP surgery! This seemed like a big step to me. Still, I hesitantly asked her for the link to the application form and I suppose the rest is history. The offer for the position was one of the fastest I have ever had: I sent my application form in on a Thursday evening and by Friday lunch, an offer came in via email.

The training

The process to become a vaccinator was not an easy one and did involve long hours studying the mandatory topics on 'e-learning'. I then had an induction by Microsoft Teams. Finally, I nervously arrived at Tameside Hospital to go through the face-to-face training to become a vaccinator.

My trainers were great at putting me at ease and it was at this point I met some fellow vaccinators. Several of my colleagues were pilots and cabin crew who were unable to fly due to

the restrictions in place. We practised our skills vaccinating a rubberised piece of 'arm' filled with a sponge to collect the water we placed in the syringes. Once this session was complete it was time to move over to the centre to begin my time as a vaccinator.

Let me just explain at this stage the fun of gaining a shift. We used a system called 'Allocate Me' which allows you to see a list of shifts available. To secure a shift you have to act fast! They are snapped up quickly so when they appear you need to 'double tap' your mobile phone/tablet screen to gain one. I was very lucky to get a shift in a relatively short time after my training. My first shift was last July in the middle of a heatwave. I was fortunate to have a colleague from one of my workplaces there that day to guide me. It was so hot I distinctly remember the little igloos with 'ice blocks' we had to build to keep the vaccine vials cool!

At my centre we had pods split into five rooms. Each pod consists of a pod leader to supervise, five vaccinators each with an admin person to do the paperwork, a health care assistant who monitors our waiting area and two people to draw up the vaccine. A pod is dedicated to one vaccine, Pfizer, Moderna or AstraZeneca. Separately, we had a row of assessment desks to allow the patient to go through the initial consent process first.

It is all very well organised and this impressed me from day one. When you arrive for your first shift you must go through a competency assessment to be able to vaccinate unsupervised and I was fortunate to be placed with a paediatrician oncologist helping that day to show me the ropes. I was naturally nervous, but he soon put me at ease. One of the patients that attended on that day was a young man. As it was a warm day his arm bled slightly afterwards to which I reassured him was because he was hot. To which he replied, "No-one has said that to me in a while." Oops! I soon learnt how to better phrase my expressions after that. I have now done over 200 vaccinations to date, and I must say that I really look forward to each shift.

So, what have I learnt from this experience?

My skill set as a dental hygienist has been so useful especially with patient management and current PPE requirements - as vaccinators we are often in level 2 PPE. Sometimes there can be a consent issue and my experience dealing with complex treatment plans and liaising with team members is an asset. Instead of talking to a principal dentist or consultant I often find myself liaising with the pod lead and pharmacist to deliver excellent patient care instead.

I feel privileged to have stepped forward in this time of need and taken part in the Vaccine Deployment Programme, helping lots of people in the Greater Manchester area receive their immunisations. I hope in the future these skills may come in useful again during the winter immunisation programme.

Author: Joanna graduated from the Greater Manchester School of Dental Care Professionals in 2009. She now works at Manchester Dental Hospital as the staff hygienist and Rusholme Dental Practice.

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PROFESSIONAL ORAL HEALTH

IN PRACTICE

The president elect, Miranda Steeples, responds to member enquiries. This month's round up sees a great variety of questions. Thank you for getting in touch and please keep them coming! Do keep these pages, they are written to be a reminder for you to use in the future as well.

Q *If a Dentist is not in the practice, as a dental hygienist, am I allowed to give a patient an inferior dental nerve block or infiltration injection, if I am competent so to do?*

A Yes! Both a dental hygienist and dental therapist may utilise local anaesthetic as appropriate. It is within the scope of practice for both roles and a dentist does not need to be present in the practice. So long as a prescription, or patient group directive, is in place, the patient has consented, and the medical history does not preclude this course of action, then you may proceed.

Q *I am a self-employed dental hygienist working in multiple practices. I am about to hand my notice in to one of my practices where I have worked for 10 years and would like some guidance on the rules of informing my patients. Am I allowed to tell them the other practices I work at if they ask because they want to follow me? There is nothing in my contract about this.*

A There is not any rigid guidance on this and it is an ethical dilemma. We focus a lot on what is and is not in contracts, and if you have signed a contract with this clause in, you would be professionally obliged to follow this.

Many people work across multiple practices and it does come up in conversation, *"…you only work here on a Wednesday, do you work elsewhere on other days?"* Then it naturally comes out in conversation, *"Well yes, I work at XYZ on other days…"* and so on.

This is quite different to actively soliciting patients to follow you elsewhere.

The difficulty is when a patient says that they will, *"See you in six months"* and you cannot really say *"yes"*, because you won't be seeing them. At that point you would say that you are leaving and they may surprise you by saying, *"Oh, good luck then"* and happily book in with your successor, or they may ask if you will be working elsewhere. At that point, I would probably say, *"Yes, and if you wanted to you could look me up on Google, but there will be someone taking over my list when I am gone, so if you want to continue your care here, you can, or if you want to follow me, I can see you under direct access".* It is then up to the patient to decide what they want to do.

You just cannot be seen to be actively recruiting patients to come with you. It is possibly best to have a conversation with the practice owner for how they want you to manage these conversations with patients. As you are leaving on good terms, I presume, this should be quite easy.

Q *I have started working as a dental therapist and I am seeing patients after they have been treated by a dentist for restorative and periodontal treatments. Neither dentist has worked with a dental therapist before and we are all not sure if I can see patients with a broken or lost filling for an emergency appointment. If so, can I open a course of treatment and send NHS claims under my name?*

A No! When working under the NHS system, a dental therapist may only treat patients after they have been assessed by the referring dentist, who will open the treatment plan and detail what treatment they would like you to perform.

REACHING BEYOND THE PRACTICE

by **JOLENE PINDER**

How a series of unfortunate events helped a dental hygienist fall back in love with dentistry.

While dentistry can be a fulfilling and stimulating vocation, even the most passionate in the profession must surely have had their commitment tested of late. It can often prove challenging to see a way forward during times of turmoil, which may cause a rethink on career choices.

Jolene Pinder understands this only too well. A dental hygienist who qualified in 2001 whilst serving in the Royal Navy, she now runs Flossbar, a direct access hygiene clinic in Troon, in Scotland. She also happens to be BSDHT's newly elected honorary secretary.

Jolene set up her squat practice to deliver oral hygiene care to those struggling to access NHS dentistry. Launching just one week before COVID-19 hit our shores, she was almost immediately forced to shut down.

Once practices in Scotland got the green light to reopen, however, the hiatus in care ironically provided a springboard to quickly establish her business that now busily accommodates hygiene patients, often working as a referral centre for neighbouring dental practices. Troon is a small town caring for a tight community, so Jolene has been perfectly placed to help with the inevitable backlog of patients.

But she was not always this enthused, and her ambivalence towards her dental career came long before the pandemic wreaked havoc.

Crisis

Roll back a decade, and Jolene believes it was a series of unfortunate events that helped her to fall back in love with dentistry, forcing her to reassess her work/life balance and find her 'happy place'.

She recalls: 'A while back, I was feeling disillusioned. As a clinical dental hygienist, it can often feel like we are on a merry-go-round of one patient after another, trying to provide the best care, and that is not healthy.'

Around the same time as this crisis in her career choice, she was diagnosed with breast cancer. But strangely this terrible blow not only helped her to refocus and find a complementary career path, it also ultimately led to rekindling her passion for dentistry.

She recalls: 'Ten years ago, aged 34, I was diagnosed with breast cancer. I underwent surgery reconstruction and physiotherapy following chemotherapy and, as a keen runner, I was devastated to discover I did not have the same energy levels. My physiotherapist suggested Pilates, which I was able to do every day throughout treatment.'

Caring Beyond the Practice

This advice provided impetus to reset her career journey towards where she is now. But, throughout that time period, the support she received from the people in her classes was just as important, with many of them becoming firm friends.

Time to reset

'It was an eclectic mix of people who were extremely supportive and they took me out of myself and away from everything else. I had little time to think about my health or work. Their company offered a reset.'

And so enthusiastic was she that her Pilates teacher suggested she'd be perfectly suited to lead her own classes.

Jolene recalls: 'So, I become a Pilates teacher. It was challenging but I really enjoyed it.

'In Pilates there is lots to think about when it comes to movement, position and control. Everything centres on you and requires a huge amount of focus. Pilates helped me get away from the surgery. I built a studio within my house and taught four hours of Pilates classes a day as well as one-to-one sessions.

'As a Pilates teacher, people often come to you with injuries, or are referred. Similar to dentistry, I was helping them on their journey to better health and enjoying seeing the progression they made.'

Having almost given up on 20 years of dentistry, Jolene became re-enthused with her role. She was also invited to be a key opinion leader for an oral health company and, she says, 'it was a game changer. These events merged to give me a new enthusiasm for my profession.'

During the first lockdown, she not only continued to teach Pilates online ¬but also temporarily relocated for a number of weeks to East Sussex to help Christina Chatfield clear the backlog of patients at her practice, Dental Health Spa in Brighton.

Firm friends, the duo are keen supporters of Moveit4smiles, a charity that raises money to help tackle mouth cancer and raise awareness about the HPV vaccination. The charity's fund-raising efforts have included walking 500 miles from Scotland to Brighton, climbing to the summits of various mountains in Great Britain and embarking on the long and arduous Camino de Santiago, taking them across the Pyrenees from France to Santiago de Compestella in Spain.

September marked their latest venture when the group took on Bla Bheinn on the Isle of Skye, an 8km walk with an ascent of 990m. In fact, Jolene is now taking the lead with next year's task when the team will walk the Appian Way, the ancient Roman road running from Rome to Campania in southern Italy.

Her bonding with dental colleagues doesn't stop there and, during lockdown, she was among several dental hygienists who set up an online forum for colleagues isolated because of the pandemic.

She says: 'My colleagues Faye Donald, Amanda Gallie, Christina and I were meeting up via Zoom and it suddenly struck us that if it was good for us, it could be good for others. So, we came up with the Dental Ninjas. Colleagues interacted by joining our discussions, sending in questions or adding something in the chat box. Initially, we were limited to Zoom's 40 minutes and 100 people, but this soon expanded. What started as a weekly informal chat, led to deeper discussions about common challenges.

'It became a regular fixture throughout lockdown. We had guests, including a dental hygienist who was working in Germany during lockdown and a counsellor who offered advice on how to keep mentally well, as well as the presidents of BSDHT and BADT. We kept it informal and averaged around 80 people each week. It was very successful and opened up conversations that really resonated with people.'

A lot of time, energy and money are invested in establishing a dental career. But what if you suddenly find yourself struggling with all the challenges that this brings? Moreover, what if the pandemic has proved so overwhelming that you feel trapped in a role you no longer enjoy? Jolene firmly believes extracurricular activities not only aid mental and physical health, but often reignite enthusiasm as well.

Having undergone her own transformation, she is now enjoying the latest chapter of her career. As a member of the BSDHT executive, she joins a movement that aims to raise awareness of our role looking at how best to progress in a profession that is ever changing.

She explains: 'COVID-19 created change that was harder and faster than we were all ready for. We now have to rethink what members want and how we can facilitate members needs via study days, regional meetings, conference and so on. We are about to go through some challenging times to get our approach right for younger people and now is the time to reconnect with our professional peers, especially as this was curtailed during the pandemic.'

This article has been brought to you in partnership with Oral-B who will be making a donation to Move it 4 Smiles https://www.dentalhealth.org/donate/moveit4smiles on Jolene's behalf

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TREATING MY FIRST PATIENT

by SOPHIE JACKSON

From the first day at university, I have dreamt about the day I treat my very first patient!

How do I feel about this? Well to be honest, I feel slightly apprehensive, I go to bed most nights rehearsing a spiel of the words that I will say to my first patient. Do I feel ready? The answer would be yes, and no! However, I do believe that when the time comes, I will be prepared and raring to go.

I have practised my clinical skills on phantom heads, and on my clinical partner (thank you, Catrin). We have been administering local anaesthetic on each other (Yikes!) which to be fair, was not so bad. I can now confidently give an ID block and buccal infiltration anaesthesia. I am so grateful for the experience to give and receive local anaesthetic: it will all serve me well when it comes to showing empathy and providing reassurance to my patients.

Preparation is key

Being proactive about my learning is essential in my preparation to treat my first patient. I have written up several notes in my clinic folder, which I can glance at as a prompt if my nerves get the better of me. I have begun to realise that the roles of a dental hygienist and therapist are complex. It is not just about a quick PMPR appointment, there are a vast number of things that need to be achieved in a relatively short appointment time. I take my hat off to all dental hygienists and therapists who achieve this day in, day out. You are amazing!

What I have included in my clinic folder:

- Patients note templates
- Patient questions with prompts
- Medical history questions
- Extra and intra oral exam guide
- BSP guidelines for periodontal disease (2017)
- The Challacombe Scale of Clinical Oral Dryness (Kings College London)
- Delivering Better Oral Health Toolkit tables
- Patient information leaflets
- Photos in a table with oral abnormalities
- List of medications and oral manifestations
- Administering LA crib sheets

Grateful for the opportunity

University is tough, especially second year. We are completely left to our own learning. The self-directed learning element is something that I struggled with initially. However, I am thrilled to be living in Manchester and having support from my university friends. (Although I am in second year, I feel like a first year on campus!) To have the opportunity to be able to study together is great - we all learn from each other. I know that it is so important to be motivated and set time each day to study.

One step at a time

The saying, 'it's a marathon, not a sprint' is a good analogy for university life. I chose this career route as I will be forever learning and gaining in experience along the way. This can only make me a better clinician for the future. There are so many amazing people in this profession that I look up to and aspire to one day be like them. But, right now gaining as much experience and passing my university exams is my priority.

Top tips for seeing your first patient

- Prepare - read through the patients notes beforehand
- Have a wipeable folder with information that you can take onto clinic with you
- Rehearse what you want to say either with friends/family or recording
- Ask the tutor about any concerns you have prior to treating your first patient
- Afterwards, keep a diary and reflect on your experience

Good luck to those who are treating patients soon, you have got this!

Author: Sophie Jackson is a second-year oral health science student at the University of Manchester.

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OHC 2021 GLASGOW

This year's Oral Health Conference (OHC) was everything we hoped for and more!

Our time in Glasgow was filled with learning, laughter and lots of chances for delegates to acquire new skills. Plus, the show gave everyone a much-needed chance to reconnect with colleagues, make new friends and, most importantly, see once again why the profession is such an exciting and important part of modern dentistry.

Make sure you don't miss out this year!

Date for your diary: 26-27 November 2022, Manchester. See you there!


Loch Ness
3
DENTAL HEALTH
SEE BE SEEN

TRANSFORMING ORAL HEALTH

by FRANCES ROBINSON

Health Education England's (HEE) purpose is to support the delivery of excellent healthcare to patients, by ensuring that the workforce of today, and tomorrow, has the right numbers, skills, values and behaviours. Nine months ago I became the first dental hygienist to be appointed Clinical Oral Health Transformation Fellow for HEE.

I applied for the role because it offered the potential to gain experience working in the public health sector, whilst allowing me to work clinically at the same time. Gaining my MSc in dental public health in 2017, and spurred on by my interests in oral health promotion and health inequalities research, I felt this position would be an excellent opportunity for me to develop my career.

Career development

A fellowship is a position, often combined with clinical work, with an emphasis on an individual's learning and development. It focusses on expanding opportunities for aspiring leaders for them to gain the necessary experience and skills for future system leadership roles. As such, there are opportunities to be involved with projects, programmes and in settings outside a health professional's normal clinical exposure. There may also be specific goals included such as writing, submitting and publishing papers, attending scientific meetings and conferences and working on particular projects, as well as networking. The balance of all these is dependent on your host organisation and your line manager.

During a fellowship there is flexibility to align the projects that you work on to individual interests, whilst working for the greater aims of the organisation. This means there is a real opportunity to tailor a fellowship role to where you feel you could be of most benefit, or where you would like to gain more experience. I found that this helped to shape the year to ensure I am getting the maximum benefit. The aims for my year with HEE are to work on projects aligning to my areas of interest: oral health inequalities; oral health education; empowerment; promotion; increasing skill mix; and multidisciplinary team working in primary care.

A clinical fellow may also have the opportunity to attend courses and gain qualifications that are not directly linked to their clinical work, for example leadership and management qualifications and attend clinical leadership conferences.

There are other fellows across the country with HEE and in other organisations for example, the Office of the Chief Dental Officer (England), General Dental Council and the Care Quality Commission. There is a clinical fellows' networking group where collaborations across work streams can be facilitated and a journal club takes place. This has given me the chance to network with new professionals across medicine and dentistry, which has been really enjoyable.

It has been an interesting year working from home. It can take longer to settle into not working in the surgery all the time. Getting to know colleagues is harder when you don't sit with them at a desk every day but the team at HEE has been very supportive.

I have had the opportunity to evaluate some of the programmes and pilots taking place in the dental office at HEE. I am currently writing a paper evaluating the success of a pilot that has aimed to reduce the number of paediatric patients being sent to secondary care. A subsequent paper will evaluate the success of the 'return to work' therapy scheme, a programme aimed to get those dental therapists that have not been using their full scope of practice back into therapy work by providing them with training opportunities, supervisor support and a practice placement.

The clinical fellows at HEE also support projects involving the foundation dentists and foundation dental therapists. Furthermore, there is the chance to sit on various working groups and interact with external organisations like Public Health England and local councils.

Dental hygiene preceptorship

The most exciting project I have been working on is the creation of the dental hygiene preceptorship. It will be a little like a foundation year, similar

to that for newly graduated dentists. Clinicians will work under the NHS and receive high quality training. Subsequently, they will be ambassadors for oral health in the wider health field. However, it will also be suitable for clinicians with more experience owing to the outreach element.

Clinicians will spend one day a week in primary practice treating periodontal diseases and one day in outreach. It aims to bridge the gap between dentistry and medicine creating more efficient referrals through the two. Dental hygienists are appropriately skilled to hold these roles in communities, as they are trained with exemplary communication skills and have a preventative mind set.

The aims of the preceptorship are to:

- Increase awareness, perceptions and education of oral and periodontal health in populations;
- Improve access to periodontal care in NHS primary dental care especially for vulnerable and hard to reach populations;
- Increase awareness of periodontal disease - risk factors, treatment, consequences etc. - in other health professionals, through multi-disciplinary team working and outreach in the wider NHS;
- Reduce numbers of referrals and improve the quality of the referrals into NHS secondary care for non-surgical periodontal therapy;
- Reduce inequalities in oral health, particularly periodontal diseases within the NHS.

It is a wonderful opportunity to be able to help create, work on and lead a project I am passionate about with the support of an organisation like HEE.

I am the first fellow at HEE to be a dental hygienist rather than a dentist. As I am in this unique position, I advocate for dental hygienists and dental therapists and work hard to make our voices heard across a variety of internal and external groups. For example, I sit on a routine dental care managed clinical network (MCN) where I am the only clinician that is not a dentist.

It can be intimidating applying for a role that is so different from the one you have now, or even one that is aimed more at dentists than dental hygienists or other oral health professionals. My advice in these cases would be to email and ask for more details. Advise that you would excel at the role and bring something different to the table. For example, I used my interview with HEE to propose the idea that they needed someone with a different skill set. I put my case forward, I did not apologise for not being a dentist and I was subsequently successful in getting the role!

Throughout our career we must be proactive and make a space for where we want to be!

Author: Frances is a dental hygienist working in London. Her interests lie in oral health promotion, education and empowerment, as well as multi-disciplinary teams in primary care. Frances also chairs the dental hygienists' working group of the College of General Dentistry and is volunteer officer for the dental charity Dental Mavericks.

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Minimal intervention dentistry for the child patient
The current landscape

by CASSANDRA LEWIS AND LEON BASSI

AIM

This article aims to provide an overview of best practice in minimum intervention strategies for caries management in primary care.

LEARNING OUTCOMES

1. Application of best practice in evidence-based caries management for paediatric dental patients.
2. To gain an understanding of minimally invasive techniques for use in paediatric dentistry in aid of dental care planning using minimum intervention principles.
3. Appreciation of the role of the dental team in adopting a minimum intervention strategy in primary care settings.

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ABSTRACT

In the wake of the COVID-19 pandemic the UK dental workforce is facing a national health crisis as we address the vast amount of untreated dental disease. This is ever more pressing for our child dental patients for whom early detection and intervention is key to maintaining quality of life. A pragmatic, cost-effective, dental team-based approach, grounded in the philosophy of Minimal Intervention Dentistry (MID) is needed to address the increasing burden of disease and the worsening of health inequalities. Although not exhaustive, this article offers a brief overview of evidence relating to minimally invasive techniques for the management of dental caries in paediatric dentistry.

KEY WORDS

Minimal intervention dentistry, minimally invasive techniques, paediatric dentistry, biological approach, dental therapist, MIOC

Photo by **Artem Podrez** from Pexels

Table 1: Key Definitions

Term	Definitions
Minimal Intervention Dentistry (MID)	MID is a "concept of patient care that deals with the causes of dental disease and not just tlhe symptoms"[14]
Minimally Invasive Dentistry	A component of MID (also known as ultraconservative or micro-invasive) which refers to operative procedures which preserve sound tooth tissue and tissue which has the potential to remineralise[14] Micro-invasive techniques refer to sealling or infiltration of lesions[16].
Minimum-intervention Oral Care (MIOC)	MIOC is the concept of prevention-based minimum-intervention oral care[1].
Biological Approach	The use of techniques which alter the environment of the biofilm, disrupt the carious process and aim to halt caries progression[17].
Hall Technique (HT)	A biological approach for managing primary molars where caries is sealed beneath a preformed metal crown (PMC). This avoids local anaesthesia, tooth preparation and caries removal[18].
Resin Infiltration (RI)	An approach to the management of non-cavitated carious lesions on proximal and smooth surfaces of primary and permanent teeth. It involves resin perfusion of 'porous' caries-afffected enamel by capillary action to halt caries progression[19].
Non-restorative Cavity Control (NRCC)	This approach involves increasing access to carious cavities to improve cleanability and permit removal or disorganisation of the biofilm to halt caries progression[20,21].
Atraumatic Restorative Technique (ART)	ART involves the use of hand instruments to remove infected carious dentine followed by restoration with a high viscosity glass ionomer cement[22].
Silver Diamine Fluoride (SDF)	SDF is a clear, odourless liquid currently licenced for use in the UK as a desensitisation agent for non-carious, lesions and teeth affected by molar incisor hypomineralisation[23]. It also has cariostatic properties.

Introduction

Dental caries was recently defined in 2020 by the European Organization for Caries Research (ORCA) and the International Association for Dental Research (IADR) as:

"A biofilm-mediated, diet modulated, multifactorial, non-communicable, dynamic disease resulting in net mineral loss of dental hard tissues. It is determined by biological, behavioral, psychosocial, and environmental factors. As a consequence of this process, a caries lesion develops." [1]

The management of dental caries is a major global public health challenge. The results from the Global Burden of Diseases, Injuries, and Risk Factors Study 2017[3] highlight that there has been little improvement in oral health worldwide over the last three decades.[4] It estimates up to one-third of the world's population (2.3 billion) are affected by untreated dental disease, with untreated caries in deciduous teeth affecting 530 million children. This makes untreated dental caries in deciduous teeth the 10th most prevalent health condition alongside other non-communicable diseases (NCD). The global situation has only worsened during the COVID-19 pandemic, following closures, restrictions and regulations placed on dental services around the world.[5,6]

According to the UK Child Oral Health Survey (2019)[7], the prevalence of dental decay in 5-year-olds stands at 23.4%, with highest rates in the North West of England (31.7%). The management of this disease in young children is essential to preserving quality of life[8,9] and instilling positive attitudes towards lifelong oral health without dental anxiety.[5,10] In England, over half of children report moderate levels of dental anxiety, with severe anxiety reported in 10-14% in the Children's Dental Health Survey (2013).[11] A pragmatic, empathic and cost-effective solution is needed to address the increasing burden of disease and the worsening of health inequalities.[5,12]

Following advances in cariology, approaches to caries management have been changing[2,13], and alongside these new techniques comes the responsibility to maintain an evidence-based approach to our clinical practice. Although not exhaustive, this article offers a brief overview of evidence relating to Minimal Intervention Dentistry (MID)[2,14,15] for the management of dental caries in paediatric dentistry. Table 1 outlines some key definitions relevant to this article.

Minimal intervention dentistry for paediatric dentistry

Minimal Intervention Dentistry (MID) is concerned with the process of disease, and with respect to caries this is the imbalance between demineralisation and remineralisation of tooth tissue.[24] First introduced in the 1990s[25] it promotes a holistic caries management phisosophy[15] (Table 2), which moves away from the principles of complete caries removal

Table 2: Principles of MID[15]

1. **Early caries detection and risk assessment**
2. **Remineralisation of demineralised enamel and dentine**
3. **Optimal caries preventive measures**
4. **Minimally invasive operative interventions**
5. **Repair rather than replacement of restorations**

(G.V Black's extension for prevention) and advocates repair over replacement of existing restorations.

It is inherently child-friendly in its approach focusing on: tooth tissue preservation through early caries detection and risk assessment; remineralisation of tooth tissue; use of preventative measures; and non-operative or minimally invasive restorative treatment only when necessary.[26,27] Evidence suggests these techniques show improved health outcomes, patient satisfaction and cost-effectiveness in the long-term.[28,29]

It is therefore understandable why this approach underpins the recent Global Consensus 2021 from the Alliance for a Cavity-free Future[12] and Caries Care International (CCI) system derived from the ICCMS™ for dental practice.[30] Both documents emphasise the shifting focus of caries management towards individualised risk assessment, tailored oral-health behaviour improvement and tooth preservation.

In 2013, Professor Avijit Banerjee proposed the concept of 'MIOC' (Minimum-Intervention Oral Care).[31] This work further emphasised the need for a paradigm shift in caries management, but also introduced a MIOC team-delivery framework to assist dental teams in managing patients in the primary care setting.[2] It outlines the roles and responsibilities of the dental therapist within the domains of disease 'identification', 'prevention/control', 'minimally invasive treatment' and 'recall' (Figure 1). Indeed, the scope of practice of the dental therapist affords a key role across all domains of patient management. A coordinated team-based approach to paediatric dentistry is much needed to bolster future service provision in the primary care setting.[32]

Early diagnosis and caries risk assessment

Early caries diagnosis is key to a successful MID preventative strategy[33] and clinicians should adopt a systematic approach to their clinical and radiographic assessments.[33] It follows that the earlier disease is detected and managed, the less risk there is of a child experiencing dental pain or needing to cope with invasive dental procedures.

Paediatric dentistry notwithstanding, any caries management plan should be tailored to the individual health needs of the patient. This is ideally guided by a caries risk assessment[34,35], which permits a greater understanding of the multifactorial nature of the carious disease process. From this perspective an appreciation of the imbalance between caries risk and protective factors can be appropriately managed for that specific patient. Caries risk assessment should be reviewed at regular interviews as a child's caries risk can change over time. Indeed, the outcome of the risk assessment will dictate the appropriate recall intervals as per NICE guidelines.[36]

There is no evidence in favour of one specific caries risk assessment system or protocol over another[37], and many tools (e.g. CAMBRA[38]) and guidelines exist to aid clinicians in a thorough assessment e.g. those from the American Dental Association (ADA)[39] and European Academy of Paediatric Dentistry (EAPD).[34]

Prevention strategy

A preventative focus is the cornerstone of MID[38], and strategies may be adopted at a local, regional or national level.

On a national scale, water fluoridation has been shown to reduce caries prevalence by 50%.[40] A recent joint statement from the Chief Medical Officers of the UK in September 2021 affirmed that water fluoridation can reduce the prevalence and severity of dental caries, but an in-depth discussion of national policy is outwith the scope of this article. School fluoride programmes e.g. Childsmile (Scotland) is a further example of prevention-based interventions on a national level which aim to

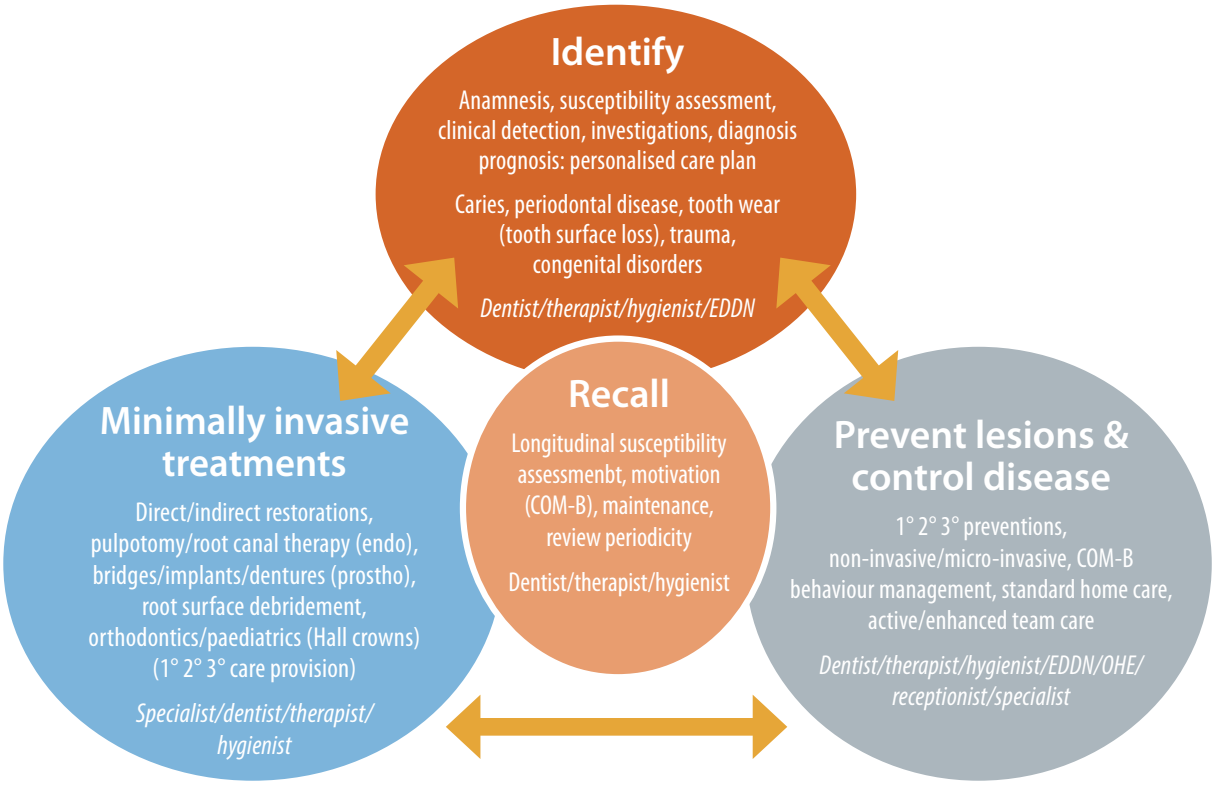

Figure 1: **MIOC dental team-delivery framework. Reproduced with permission from Professor Averjit Banergeee[1]**

improve oral health and reduce health inequality in accessing dental care services.

Locally, a key challenge to a preventative approach is behaviour change on the part of the patient/parent. The use of motivational interviewing[35] and tools such as COM-B[41] are invaluable for tackling ambivalence, tailoring of appropriate advice to individual family circumstances, and establishing a partnership with the transfer of oral care responsibility to the child/carer/parent.[42]

Public Health England recently updated their Delivering Better Oral Health Toolkit 2021 (DBOH) to better reflect the levels of evidence for each oral health prevention intervention. The success of topical fluorides (varnishes, mouthrinses and prescription toothpastes) are well documented.[43] Based upon a caries risk assessment and the child's age, a tailored oral health plan can be created to encompass appropriate preventative interventions and recall frequency.

Minimally invasive techniques

The biological approach permits a shift in focus from invasive operative procedure in line with MID principles, and its application to paediatric dentistry is well supported in the literature.[13,42] The FiCTION Trial demonstrated that although the biological approach with prevention showed little improvement in outcomes (episodes of pain or infection) over conventional techniques, it is suggested to be more cost-effective.[44] A similar result was concluded by BaniHani et al. (2018)[17] who compared outcomes from conventional and biological approaches in the paediatric departments at two different UK dental schools.

Several dental interventions harness the principles of the biological approach, and some key techniques are explored below. As minimally invasive techniques, these fit the MID philosophy and are generally well accepted by child patients and their carers/parents. However, as with all interventions informed consent and case selection must underpin clinical decision making.

Atraumatic restorative technique (ART)

ART was one of the first promoted MID technniques.[22,45] Although initially intended for adoption in remote areas and developing countries, ART is establishing its place in the developed world. Owing to its minimally invasive technique[22], it is well accepted by children and patients with dental anxiety or additional special needs. It has also been invaluable during the COVID-!9 pandemic as a non-aerosol generating procedure.

Substantial evidence underpins this approach for selective caries removal which shows reduced post-operative signs and symptoms of pulpal disease in children.[46,47] Further evidence also demonstrates remineralisation of affected dentine under well-sealed restorations.[48,49] Herein enters the concept of the "seal is the deal". However, while ART shows high success rates in the management of single-surface carious lesions, when compared to multiple-surface lesions the success rates of ART restorations in deciduous teeth over two years dropped from 93% to 62% according to a recent meta-analysis.[50]

It is noteworthy that in deciduous teeth outcomes were improved with indirect pulp capping compared to pulpotomy (94.4% success rate compared to 82.6% at two years[51]). This further emphasises the rationale for selective caries removal.

Fissure sealants

A 2017 Cochrane review[52] concluded that resin-based sealants placed on pit and fissure surfaces are effective at preventing caries occurrence in high-risk individuals (11% reduction in caries compared to 51% for no sealant at 24 months). There is also evidence that sealants can reduce caries progression in non-cavitated carious lesions.[47] More research is needed to determine the effectiveness of glass ionomer cements (GIC)[52], but there is evidence to suggest their suitability for partially erupted or sensitive compromised first permanent molars.[53]

There are some differences in the UK recommendations on the preventative use of fissure sealants on first permanent molars. The Scottish Dental Clinical Effectiveness Programme (SDCEP)[35] advocate placement for all children as early as possible after eruption, while the DBOH Toolkit (2021) recommends this approach for high-risk children.

Interestingly, a more recent 2020 Cochrane review[54] concluded insufficient evidence when comparing the effectiveness of topical fluoride varnish and resin-based fissure sealants. Clearly this is an area where we may see changes in future guidelines.

The Hall Technique

Evidence of remineralisation of carious dentine under well-sealed restorations (without caries removal) underpins the rationale of the Hall Technique (HT), and advocates for its use have grown in recent years.[16,35,55] It is a straightforward and effective procedure for deciduous molar teeth which can benefit children who might otherwise be unable to cope with conventional techniques.

A recent systematic review concluded success rates five times that of conventional plastic restorations[56], and no significant improvement was found when the HT was compared to the more invasive conventional technique for placement of preformed metal crowns.[57,58] Interestingly, acceptance in the US is also growing[59], as reflected in guidance by the American Academy of Pediatric Dentistry (AAPD).[60]

The potential for discomfort following immediate placement of a HT crown, and parental acceptance due to aesthetics, are important clinical considerations with this technique.[61] ART is perhaps more favourable in this regard, but HT crowns have demonstrated almost three times higher survival rates (93.4%) compared to ART (32.7%) at 36 months for class II cavities.[62]

The University of Dundee produces a thorough and informative user manual[18] to support clinicians in adopting this technique, and increasingly the HT is being taught at dental schools worldwide.

Silver Diamine Fluoride (SDF)

SDF provides a minimally invasive and potentially cost-effective approach to managing dental caries in deciduous teeth. The synergistic effects of silver and fluoride inhibit collagen degradation and enhance tooth tissue remineralisation however, it is extremely caustic and does permanently stain tooth tissue.

Although it was cleared for use by the Food and Drug Administration in the US in 2014[63], SDF is currently unlicensed for use as a cariostatic agent in the UK. However, advocacy

for its use is growing.[23,64] The British Society for Paediatric Dentistry website provides resources to support SDF use in the UK, including standard operating procedures and consent forms.

The process of application is similar to that of topical fluoride varnish, and is suitable for young and cooperative children, or as a holding measure for children awaiting a general anaesthetic. Biannual application of 38% SDF showed a significant increase in caries arrest in deciduous teeth, particularly anterior teeth with smooth surface lesions.[65] It is noteworthy that this arresting effect was most evident for children with reduced plaque scores, emphasising the importance of an established oral hygiene regime. Interestingly, evidence suggests it may be a more effective caries management option compared to topical fluoride varnish.[66] More research is needed to better understand the effects of SDF at the level of the oral and gut microbiome, and investigate the longevity of placing GIC over SDF lesions (a technique referred to a silver-modified ART or 'SMART').

Resin Infiltration

Resin infiltration (RI) is another minimally invasive approach[19] which aims to stabilise demineralised tooth tissue in non-cavitated approximal carious lesions through selective perfusion with a resin.[19] The Icon® system is well recognised in the UK and the technique can be performed in one visit through separating teeth with a wooden wedge (or two-visits with the use of orthodontic separators).

A recent randomised controlled trial demonstrated a reduction in caries progression of non-cavitated lesions (2.2% compared to 20%) at one year.[67] Again, the success was dependent on an established oral hygiene regime, but it provides an adjunctive minimally invasive approach for the management of young permanent molars.

In addition to its application for approximal lesions, RI shows promise for improving the appearance of white spot lesions.[47]

Non-restorative Cavity Control (NRCC)

NRCC adopts the biological approach for arresting carious lesions. The rationale is to open the carious lesion, therefore making it accessible to home biofilm management. NRCC is advocated in the SDCEP[35] for children who may find more invasive options challenging. The procedure may take more than one visit if the child is potentially cooperative.

However, success relies heavily on active home management of the oral biofilm by engaged patients/parents.[21] Indeed, evidence from a recent RCT study protocol[20] suggests that the control of the biofilm is the most crucial aspect of dental caries management. As such, case selection and identification and education of key stakeholders (especially the care giver) is essential.

The dental team should be cognisant with the consent process for NRCC and the active monitoring of the dynamic caries process.

When intervention is necessary

Determining appropriate intervention thresholds requires considered clinical judgement with respect to carious lesion activity, cleanability and cavitation, alongside the 'Golden Triangle' of factors contributing to the success of adhesive MI restorations (histopathology, materials science and clinical handling).[31] Shared decision and engagement from the parent/carer is also essential.

A recent DELPHI consensus statement[27] advocates MID principles in the management of active lesions:

- Non-cavitated and cavitated cleanable lesions should be managed through non- or micro-invasive techniques, as should non-cavitated lesions with radiographic caries extending into the outer third of dentine (D1) and caries restricted to the enamel.
- All cavitated (non-cleanable) lesions and those presumed to be cavitated (D2/3) require minimally invasive management e.g. selective caries removal or stepwise excavation.[46] The Hall Technique is an exception to this rule.

Conclusion

The future of MID within paediatric dentistry seems clear. MID offers a holistic, evidence-based, minimally invasive and cost-effective approach which benefits both patients and clinicians. Although it is not without its challenges (Table 3), the advantages of adopting a MID strategy reach beyond those afforded to individual dental teams or practices, to provide a possible solution to the current national health services crisis.

The pressure now placed on the dental profession to meet the increasing dental needs of our paediatric patients requires a coordinated and strategic approach which harnesses the full scope of practice of all members of the dental team, specifically dental therapists. Indeed, a recent publication by the Chief Dental Officer for England corroborates the use of the MIOC framework in the post-pandemic era.[68] Ultimately, to meet this demand, there is also the requirement for higher education institutions to promote the MID philosophy within their curricula[5,10], and prepare clinicians for the delivery of modern evidence-based dentistry.

Table 3: **Benefits and challenges of adopting MID**

Benefits	Challenges
• **Preservation of tooth tissue** • **Maintenance of tooth vitality and function** • **Minimal discomfort** • **Improved health outcome** • **Improved patient satisfaction** • **Reduced risk of dental anxiety** • **Evidence-based**	• Patient attitdue towards MID philosophy • Transfer of responsibility to the carer/parent (self-care) • More frequent recalls/time-consuming • Concerns over perceptions of supervised neglect • Technique sensitivity (training) • Aesthetics e.g., staining (SDF) or non-tooth-coloured restorations (PMC)

MID – Minimal Intervention Dentistry, SDF – silver diamine fluoride, PMC – performed mental crown

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eCPD PAPER

The oral health needs of residents in young offender institutions: how can we create an appropriate health promotion plan to manage these needs?

by KATHERINE BROCK

AIM

To explore the specific oral health needs of young offenders.

OBJECTIVE

To evaluate how to appropriately manage the oral health needs of young offenders.

LEARNING OUTCOMES

Readers will be able to appreciate the different oral health needs of young offenders and will be able to consider methods of promoting oral health within secure environments and the problems that may arise.

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ABSTRACT

Young offenders tend to have significantly poorer oral health, come from more deprived backgrounds and access care much less frequently than the general population. They are also much more likely to have habits prior to incarceration that are damaging to their oral health, including smoking and taking drugs. Health promotion in prisons is a key concept laid out by Her Majesty's Prison Services (HMPS). However, interventions are often overambitious and complex. There are also practical challenges to promoting oral health in prisons.

KEY WORDS

Young offender, barriers, specific oral health needs, intervention

Introduction

Young offenders (YO) have different needs to other members of the general population and young offender institutions (YOI) often provide a unique opportunity to improve their lives. Coming from predominately deprived, low socioeconomic backgrounds, these young people have a variety of risk factors and often suffer from significantly poorer oral health than the general population. They often experience a higher rate of decay but much lower rate of treatment and a number of barriers to accessing dental care.[1]

Research suggests that lower socio-economic status, poverty, and lower educational attainment all contribute to an increased likelihood of diseases.[2] The availability of good healthcare and resources varies inversely with the population served,[3] so that areas of greater population, often including areas of deprivation, are underserviced and the occupants will suffer more from health inequalities.

When delivering an intervention, the specific group's determinants of health must be considered. For YO, socio-economic status plays an important role: most YO come from acutely disadvantaged backgrounds, with low educational attainment, unemployment, poverty and poor physical health.[4] This is likely to result in a greater chance of illness and disease, even before they enter prison.

The unemployment rate of both YO and general prison populations[1,4-7] is much greater than the average of general and youth populations. At least 50% of the prison population have no educational qualifications (GCSE level or level 2) with this rising to over 60% having no vocational or professional qualifications.[9-11] In the UK, the percentage of YO who were

Table 1: Percentages of different demographics in YO compared to general populations. (NEET – not in education, employment or training).

Data area	Scottish cross-sectional study of a maximum-security prison, a women's prison and a YOI[1]	Overview of UK prison population[4]	Prisoners 20 – 35 years old in North East England (HMP Doncaster, Lindholme and Moorland)[5]	Scottish study in HMP & YOI Cornton Vale, HMP Shott and HMP & OI Polmont[6]	Scottish Mediation model study[7]	British Medical Journal Data[8]	General population (UK)	General youth population
Unemployment	66%	–	63.9%	67%	68%	68%	3.9%[9]	NEET – 11.2%[10]
No educational qualifications	–	50%	60.2%	–	–	47%	7.5%[11]	NEET – 11.2%[10]
No professional qualifications	–	–	62.8%	–	–	–	7.5%[11]	NEET – 11.2%[10]
Suspended from school at least once	–	–	–	–	–	42%	–	5.18%[12-13]
In care at least once	–	–	–	47%	35%	24%	–	0.56%[13-14]
Parent ever in prison	–	–	–	–	–	–	–	2.2-2.3%[13-15]

suspended from schooling at least once is 42%[9], compared with around 5% of the general youth population[12,13], which will inevitably disrupt social and health education (PSHE) as well as formal academic attainment.

Although specific percentages vary, the probability of being in care prior to being a YO is evidently high.[6-8] Likewise, more than 42% of YO had at least one parent in prison at some point prior to, or during, their own stay in a YOI. If representative, this indicates difficult and unstable home lives for most YO compared to the general population[13-15], leading to a host of other problems when incarcerated, including general and oral health.

Yo and Oral Health

It is well documented that YO have significantly poorer oral health than the rest of the population.[5,16-18] There are many reasons: not accessing preventive care or treatments; anxiety; detrimental habits including smoking, alcohol, and substance misuse; a poor, high-sugar, diet; mental health issues; and lack of knowledge and understanding.[1,4,5]

The high mean DMFT values shown in Table 2 support the general understanding that prisoners generally have poor oral health. However, the mean number of decayed teeth reported varies between studies, perhaps due to what was measured as decayed, and what scale was used. DMFT measures the number of teeth with decay, not number of separate sites with decay, so does not always show the extent of caries in a patient. In a study by Freeman and Richards (2019),[1] of 259 participants only 10 had no obvious signs of caries experience at all (presumably a 0 on ICDAS scale), meaning that over 95% of participants had some kind of obvious decay (1-6 on ICDAS scale). Furthermore, the mean filled teeth index is significantly lower in all the prison studies[1,4,5] than the general population, indicating that despite a higher caries experience, fewer teeth are being treated: prisons therefore have a much higher unmet treatment need than the wider population.

Risk Factors

There are numerous factors that can negatively affect oral health, including smoking, alcohol consumption, drug use and diet. In England, 14% of adults are smokers,[11] compared with at least three quarters of prisoners. Almost 10% of all adults have used illegal drugs in the last year, with this rising to 20% in 16 to 24-year-olds.[19] This compares to 90% of YO who admitted to using illegal drugs prior to incarceration.[6-7]

The habits of prisoners are significantly worse than those of the general population, increasing the risk of poor oral health. These habits are usually developed by the time an individual is incarcerated and so the problems associated may well have already occurred.[20,21]

Smoking is one of the biggest risk factors for mouth cancers. It also increases the risk of gingivitis or periodontitis. Oral

Table 2: The DMFT index details for various prison studies compared to the general UK population.

Data	Scottish cross-sectional study[1]	Overview of UK prison population' oral health[4]	Prisoners 20 – 35 years old in North East England[5]	General UK adult population
Mean DMFT	10.21	15.59	–	–
Mean Decayed Teeth	1.62	3.5-4.2	2.87	2.7[4]
Mean Missing Teeth	4.36	7.55	–	–
Mean Filled Teeth	4.23	5.12	–	–

Table 3: **The percentages of prisoners with habits that can worsen oral health across different studies.**

Data	Overview of UK prisoners' oral health[4]	Scottish mediation model study[7]	British Medical Journal data[8]	Overview of UK prison population[20]	Youth Justice Board Juvenile offender data[21]
Smoking	84% - remand 78% - sentenced	–	80%	89% juveniles	83%
Alcohol	–	–	–	67%	82%
Illegal drugs	–	79% 91.8% for YO	64% in 4 weeks prior to incarceration	69%	90%

candidiasis, halitosis and staining are also a likely effect of smoking.[22] A positive impact of incarceration is that YOI, are forbidden from consuming alcohol and drugs anywhere in the facilities.[23] Smoking is only permitted in very specific areas for detainees over 18 years old.[24]

However, diet can be difficult to control as the provision of meals and snacks is contracted to an outside company. Prisoners are able to buy snacks, but these are also often high in sugar and fat.[25]

Barriers

Many individuals, especially those in prison, only seek dental treatment in an emergency or when in pain. One of the biggest and most common barriers to accessing care and treatment is anxiety. Nearly 50% of adults experience some level of dental anxiety.[26] Prisoners reportedly experience higher levels of dental anxiety, often due to their mental health issues or drug habits[7], and they tend to delay seeking treatment more than most.

Prisoners access preventative health services and medical care much less than the general population.[20] Many do not access help, despite thinking that they have a need.[27] This contrasts with the long-held belief that prisoners do not care about their oral health. However, prisoners often lack the motivation needed to seek care or improve their oral health[20] and struggle to access care, even when understanding there is a need, due to long waiting lists, lack of services and staff.[5]

However, as the demographic data suggests, prisoners have low levels of educational attainment and thus low levels of literacy. This becomes a problem particularly in terms of health literacy.[1] Health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions".[27] For prisoners, this means they do not always understand the information given or are not able to process it to a sufficient degree to make decisions about seeking treatment. Often, this means they leave accessing care until in pain. It has been found that prison guards think that generally YO do not have much knowledge about their own oral health and hygiene.

This is also linked to a lack of resources. In one study, 80% of prisons surveyed had programmes in place to help stop smoking but less than 60% had a dedicated oral health programme.[17] There is an acute lack of funding to the UK prison system, especially for healthcare needs. A patient with access to dental care may still not receive it as there are not enough prison staff available either to take the prisoner, or dental professionals to actually treat them.[1,4,17] Prisoners are also moved between prisons frequently so are often moved before they have been able to access the care they need.[4]

Another positive impact of incarceration is that oral health treatment is free in prison, providing an opportunity to seek treatment that young offenders would otherwise have not had.

Principles of Intervention

There have been broad outlines of health promotion principles in prisons. In 2003, Her Majesty's Prison Service (HMPS) and the NHS released a Prison Service Order (PSO), detailing the requirement for prisons to have a whole system approach to health promotion in order to make sure prisoners receive care, prevent deterioration of their health and allow them to adopt their own healthy behaviours to be taken back into wider society. The Prison Service Order (PSO)[28] outlines five key areas, as a minimum, that prisons should be addressing in the health promotion plan. These areas are:

1. Mental health promotion and well being
2. Smoking
3. Healthy eating and nutrition
4. Health lifestyles, including sex and relationships and active living
5. Drug and substance misuse

Although oral health is not explicitly listed, it is relevant to all five categories. The PSO gives an idea of the aims of health promotion and equal service provision for prisoners. Health promotion programmes in prisons should aim to influence the determinants of health and tackle health inequalities, by working upstream, as well as providing acute care to those who need it.[29,30] de Viggiani (2012),[29] outlines specific examples on how to approach health promotion in a prison environment. While these will be used in the planning process, the concepts are idealistic and aimed at large scale interventions. The suggested major areas of focus are:

- Health improvement
- Participation and involvement
- Workforce development
- Ethical provision and accountability
- Supportive environments
- Institutional reorientation
- Flexible multidisciplinary provision

It is important for reasons of equity to be consistent across the whole prison system; ideally, a prison-wide approach to health promotion would allow equal service provision across all prisons. Equally, since health is a human right, there should be the same level of care inside prisons, as outside.[30-32] Likewise, a health promotion initiative should provide the prisoners with

empowerment and autonomy to make their own decisions in a safe, supportive, and secure environment. Policies that promote health should address cultural, environmental, social, economic, and political determinants of health, not just medical factors, to have a holistic approach.[30-31] Ideally, all staff would play a role in health promotion inside the prison, and understand their role.[16,30]

Within a prison environment, there should be an initial assessment of need in order to triage and understand the needs of each prisoner.[17,30] As well as upstream interventions, there should also be an educational approach, to teach prisoners the skills they require to make their own healthy choices; prisoners could also educate their peers.[16] This can help change behaviour patterns, prevent further deterioration and reduce the chances of reoffending. Vacca, (2004),[32] argues that prisoners who receive academic, social and vocational education are less likely to reoffend and return to prison. This not only helps the prisoners themselves but saves the prison system from further strain.

A prison health promotion initiative should also provide post-prison help, once the users leave and re-join wider society.[8,30] This requires a community outreach connection to allow continuation of care. Prisoners should also be enabled to reflect on the services provided and suggest future improvements to initiatives. This is crucial if the intervention is to benefit them and other prisoners in the future.

However, even in concept, there are issues with health promotion in the secure estate. There is a conflict between rehabilitation efforts within detention and the improvement ideals of health promotion programmes. These two contrasting systems can often be difficult to assimilate. In removing autonomy and free choice, prisons can undermine the values of health promotion, and this often reduces empowerment, creating self-esteem issues. There is also the overarching concern of security. While this is less of a problem in lower security prisons (Categories C and D), in high security prisons (Categories A and B), security concerns and prison lockdowns can disrupt prisoner schedules, meaning that prisoners often struggle to seek care, even if provided, and often do not receive the same level of education or care as in other prisons. Society often views prisoners as less worthy of care due to their crimes. This can make it difficult to justify the costs of programmes in the eyes of society and the government. Furthermore, some professionals refuse to work in the prison system due to negative perceptions of prisoners as antisocial and more difficult to work with.[32]

Previous Interventions

In theory, it may be more feasible to promote health to a YO: they are still at an age where they can be influenced and educated, enabling them to make their own health choices; the greater focus on rehabilitation can justify the expenditure of devoting resources to them. However, the most effective programmes are likely to be multifaceted and complex in nature in order to encompass all the individual needs of prisoners; an initial needs assessment is key, allowing information to be collected on what needs to be tackled. This information should be transferable, accompanying the prisoner should they move institutions.

Woodall & Freeman, (2020)[33] found that 40% of surveyed prisons had some kind of whole-system approach to health promotion, although the specifics of each programme differed. Prisons are successfully promoting quitting smoking programmes, 94% of prisons having a programme in place. At 88%, prisons are generally managing screening and prevention activities for various diseases very well. However, only 19% of prisons offer individual health promotion support on release. It is clear prisons are making attempts to promote health. However, it seems many still do not understand what is needed to have a system-wide approach to effective promotion. There are also often issues in creating new programmes and policies within prisons.

Problems can arise due to resources and funding, prisons are underfunded and under resourced, with low staff numbers. Prisons struggle to fund existing programmes without adding more programmes and policies. If health promotion could be integrated with existing services, this could help streamline the system, making it interdependent, without increasing costs. Again, training staff in health promotion initiatives is often deemed as extra work to an already challenging role. Having health promotion initiatives led by specialist teams or professionals would allow prison staff to do their jobs, though this would obviously entail additional costs.

Health promotion should continue after prison. However, as previously stated, only 19% of prisons have continuity of care outside prison.[8] This means that prisoners may revert back to their old and damaging habits and struggle to continue to make healthy choices. In order to prevent this, links should be made with the community and professionals within the community to continue to support prisoners.

Prisoners often move between prisons, and this can result in discontinuation of care and treatments.[34] To prevent this, information should be shared between institutions to allow for continuous care. Prisoners also struggle to access care, even when available. There can be long waiting lists and often the treatment is only for urgent circumstances. Accessing the dental service in prison is also instigated by the prisoner – they have to request to see the dentist – which encounters the barriers of knowledge and empowerment previously discussed. It is also essential that there is enough staff, both prison and dental professionals, to cope with the needs of the prisoners. Often there are insufficient staff to escort patients to their appointments, and so these appointments are lost.[1,16]

Prisoners can also suffer from a lack of motivation and commitment to their own health, even when services are in place. Marshman et al., (2014)[6] found that 69% of prisoners surveyed were not happy with the appearance of their teeth and 75% thought they needed treatment of some kind. MacDonald et al., (2013)[17] found that dental hygiene was one of the highest rated areas of health promotion need for YO. However, many prisoners still do not seek care due to a lack of motivation. It is not that they do not care about their health, but they do not necessarily always know what to do or possess the necessary motivation.

Although the Scottish Government published its Oral Health Improvement Plan (OHIP) in January 2018, it was not until November 2020 that the Scottish Government launched 'Mouth Matters'; an oral health promotion resource for dental and healthcare professionals and prison staff to support prisoners in their oral health needs, raise awareness and raise motivation for prisoners in regard to their oral health. The information in this resource is based on a study by Freeman *et al.*, (2019).[1] As this is a relatively new oral health promotion programme

there is, as yet, no data or reports to consider, but as it is based on extensive research into the specific needs of prisoners in relation to their oral health. It is expected to be successful although it may suffer still from the barriers and issues discussed in *Principles of Intervention*. This programme can be further reflected on in terms of effectiveness once it has been in place long enough to be able to evaluate both the problems and successes.

Conclusion

YO clearly have significantly poorer oral health than the general population, often due to their deprived backgrounds, damaging habits, and less frequently accessing preventive care. Health promotion in prison settings is clearly an important concept but completely successful interventions are yet to be developed due to practical challenges of putting programmes in place as well as the complexity of the aims of an intervention. Some programmes have been launched, but it is still too early to evaluate their success so further analysis of effective methods of health promotion in prison will be needed in the future.

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TREATING THE UNDER-FIVES

by DOMINIQUE TILLEN

Children's dental health is reliant upon responsible adults understanding what needs to be done.

Nearly a quarter of England's 5-year-olds have tooth decay affecting, on average, three to four teeth.[1] A Public Health England report[2] noted that 10.7% of the children surveyed already had tooth decay, despite having erupted molars for only one or two years.

Confusion reigns

Sometimes it is not that parents do not want to give their child the best dental start in life, it is often that they are confused. A survey of 1,000 mothers in the UK revealed confusion about when and how to start a baby's oral health regime.[3] The results of mothers' habits and perceptions on a baby's oral care and teething showed lack of clarity about when a child should first visit a dentist:

- 13% believe they should first take their baby to the dentist at six months;
- A staggering 72% of mothers say that they have never seen any information on gum care for babies;
- Over half (53%) report turning to their mothers for information on managing their baby's teething pain;
- Only 10% said that they get this information from their dentist.

Where to begin?

Parenting skills as well as a good local social support network is crucial to the introduction of positive oral health behaviours. But many parents have a number of issues that prevent them from caring for their baby's teeth. Reasons given include: parents' tiredness; lack of confidence in their skills as a parent; finding the information confusing; the widespread availability of sugary foods and drinks; and their perception of the lack of local child-friendly dentists.

Access to information, resources and dental-care services

Parents need local support and consistent information and tools. However, there are often barriers to communication and in recent times, COVID-19 has been the main blocking mechanism. The familial and social restrictions introduced

Mums & Gums Survey Reveals Baby Oral Care Confusion

mums & gums

THE CONFUSION

72% say they have never seen any information on gum care for babies.

53% of mothers turn to their own mothers for advice on 'teething pain'.

...and only 10% of parents say that they get 'teething pain' information from their dentist.

Only 6% of mums are aware that keeping gums clean during teething is important.

THE SOLUTIONS

94% of mothers believe that either GPs, health visitors or dentists are best placed to provide baby oral care advice.

With 22% believing this should fall to health visitors.

Reassuringly 60% of mothers believe cleaning a baby's gums or mouth is a good idea.

With 34% of mums saying that they are already often cleaning their baby's gums.

Notes:

1. Brush-Baby Mums & Gums Survey carried out across 1,000 UK mothers of children aged 0-6 years by One-Poll
2. Brush-Baby is an oral care brand for babies from birth up to 6 years, providing specialist gum wipes, teether toothbrushes, brushes for toddlers and toothpastes. Visit www.brushbaby.co.uk for more information
3. The Brush-Baby Mums & Gums Survey contains ethnicity, socio-economic and regional breakdowns (available on request)
4. For more information, contact Kate Clark, KCPR KateClarkPR on 07990 525639 / kate@kateclarkpr.co.uk or Marian Greally, Brush-Baby on 0345 5202229 / marian@brushbaby.co.uk

brush-baby

in response to the COVID-19 pandemic have had a huge effect upon the dental health and welfare of children. These include:

- Different birth experiences therefore limited contact with health professionals for new parents;
- 'Shielding' and 'social bubbles'; preventing information gathering via habitual, familiar patterns of socialising;
- Inability of some people to access professional sources of information via websites and social networking forums;
- Lack of opportunity to see dental professionals;
- Disruption to family structures and routines.

Official statistics show a significant drop in the number of children who visited a dentist during the pandemic. In the year up to 31 March 2021, dental appointments fell from 58.7% to 23% meaning that nine million children have missed out on treatment! Twelve million cases of dental treatment were delivered in 2020-21; a drop of 69% compared to the year before. A total of 30 million dental treatment courses have been lost since the first national lockdown.[4,5]

Experience counts

Children have differing needs from adults and consideration must be given to developing manual dexterity, sensitive tastebuds and new experiences.

Children are social learners and they learn through experience, environment and imitation, which is why oral health education, establishing an early years toothbrushing routine and visiting the dentist from an early age for acclimatisation purposes, is so important.

Repetition… repetition…

It is vital to bear in mind that a child's perception is very different from that of an adult. We may need to repeat something or show an action a few times in order for the child to grasp it and this includes finding the right words. And obviously no two children or experiences are the same so we need patience in abundance!

An active and engaged child is at the core of the oral health of the future, which throws up its own set of challenges in providing child-friendly products and welcoming experiences.

Bathroom and bedtime

Imitation really is the sincerest form of flattery in the case of toothbrushing. Parents are the first and ideal role models for children. Carrying out their own thorough toothbrushing routine for two minutes two times day is the best example to set a child. Establishing a bath and bedtime routine including toothbrushing using tick charts to keep a track of progress and rewarding with a sticker or bedtime story is an ideal end to the day. It is usually and easier to maintain as opposed to the mornings when the hands on the clock seem to move quicker!

First time dental visits

The British Society of Paediatric Dentists national Dental Check by One scheme encourages parents and caregivers to take a

child for their first dental check-up before the age of one and dental hygienists have a key role to play in a children's oral health.

Top tips from practising dental hygienists and therapists (who are also mums!)

Greater Manchester Mouth Care Tool Kit

"In order to make the visit as smooth as possible, it would be great for parents to read books or watch programmes that involve visiting the dental clinic, so that the children have an idea of what to expect from their visit.

Also consider encouraging the child to come into the surgery on their own, so there is no confusion about which adult is in control. I personally find that from the age of 4 years upwards, young children respond better when Mum/Dad are not in the room."

Helene Schirmer – Lead Dental Therapist, Happy Kids Dental

"I believe the best method for treating under-fives is to take an innovative approach. In our practice we've created several methods, one of these is our 'Toothbrushing Academy' appointments which are engaging sessions aimed at starting healthy habits early, having fun learning about teeth and acclimatising young children to visiting the dental practice so that as they grow older they don't develop a fear of the dental team.

Having a positive patient relationship and making prevention fun and easy, is 'key' to being able to help with the transition to treatment."

Isabel Brandon – Dental Therapist, 4a Dental

I'm from the Greater Manchester area which, unfortunately, experiences significant amounts of tooth decay, even from before school age.

I believe a parent's involvement can have a hugely positive impact on not just their child's oral health. But their overall general health too. Less decay = less missed school in order to attend appointments, less sleepless nights due to pain."

As Natalie Wong concludes for the dental profession: *"The under 5s age group is so magical, and we, as dental professionals, can help build trust and good experiences from a young age."*

Early Years – *'The future is literally in our hands'*

From September 2021, the Early Years framework must explicitly include a new requirement to promote the good oral health of children in the existing requirement to promote good overall health. While it is up to individual providers to determine how they meet this requirement in a way that works best for their setting, all providers will need to take steps to find ways in which they can encourage children to care for their teeth and gums.[6]

Key points

- Non-dental health professionals have a key role in early years toothcare
- It must be recognised that infants, toddlers and young children have differing dental-care needs to adults
- Practices that reduce parent-to-baby transmission of decay-causing bacteria should be encouraged
- It is important to encourage care of gums before and during teething
- Alternatives such as chewable toothbrushes and Xylitol dental wipes for infant/toddler tooth and gum-care should be considered
- Flossing should be introduced as part of children's oral care routines
- The use of Xylitol in toothpastes,mouthwashes, sweets and chewing gum is recommended to improve dental health.

Author: Dominique is the founder and managing director of Brush-Baby Ltd.

Correspondence: marian@brushbaby.co.uk

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CLINICAL QUIZ

An 18-years-old patient presented concerned about the discolouration of his upper anterior teeth. He mentioned that he was often teased at school because of it.

The patient had no history of sensitivity. His diet was healthy and varied. On examination mottling of the first molars was evident. His history revealed that he had been prescribed antibiotics multiple times as a child and he believed his birth had complications.

Following a comprehensive oral evaluation, the treatment plan was agreed upon: initial treatment of dental hygiene visit(s) to improve his oral hygiene followed by tooth whitening, and ICON treatment.

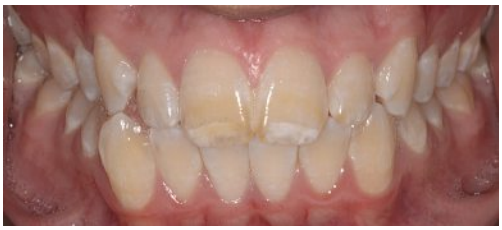
Q1. What could have caused the discolouration and mottling of his teeth?

Q2. What is the condition that often causes mottling or discolouration of the molars and anterior teeth?

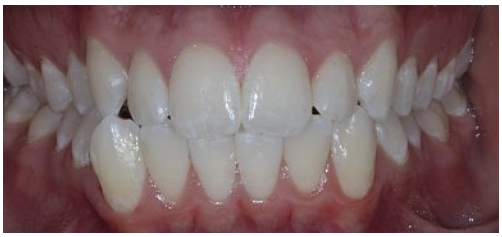
Q3. What would be the most appropriate tooth whitening treatment for this patient to ensure a predictable result?

Q4. For which types of enamel defects or discolouration could ICON be used?

Quiz courtesy of Diane Rochford



Before



After

SEND YOUR ANSWERS TO THE EDITOR BY 31ST JANUARY

Email: editor@bsdht.org.uk **Postal:** The Editor, Dental Health, BSDHT, Bragborough Hall Business Centre, Welton Road, Braunston NN11 7JG.

ANSWERS TO CLINICAL QUIZ NOVEMBER 2021

The winner is: **Dominika Jaslikowska**

When asking the patient to protrude their tongue during your soft tissue examination, it deviates to the left. On subsequent palpation, the tongue feels firm on that side.

Q1. What is the motor nerve supply to the tongue?
A1. Hypoglossal.

Q2. Why is the tongue deviating to the left?
A2. Lack of motor neural input to left side resulting in failure of the muscle on that side to contract.

Q3. What is the most likely diagnosis in this case?
A3. A malignant tumour within the left posterior third of the tongue most likely to be a squamous cell carcinoma.

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Contact: enquiries@bsdht.org.uk

DUE TO THE CORONA VIRUS PANDEMIC THESE MIGHT BE SUBJECT TO CHANGE, PLEASE CHECK THE WEBSITE

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Midlands	Saturday, 12th March 2022	Hilton East Midlands Airport, Derby DE74 2YZ	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Saturday, 19th March 2022	Holiday Inn, Garforth, Leeds	Jill Rushforth	northeastsecretary@bsdht.org.uk
North West	Saturday, 5th March 2022	Mandec, Manchester	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	Saturday 2nd April 2022	Agape Centre, Lisburn Road, Belfast *TBC	Joanne Cregan	northernirelandsecretary@bsdht.org.uk
Scottish	Saturday, 30th April 2022	Crowne Plaza Hotel, Glasgow	Laura Hempleman	scottishsecretary@bsdht.org.uk
South East	Saturday, 23rd April 2022	Holiday Inn Gatwick, Povey Cross Road, RH6 0BA	Louisa Clarke	southeastsecretary@bsdht.org.uk
Southern	Saturday, 12th March 2022	Holiday Inn, Winchester	John Murray	southernsecretary@bsdht.org.uk
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