DENTAL HEALTH

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THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

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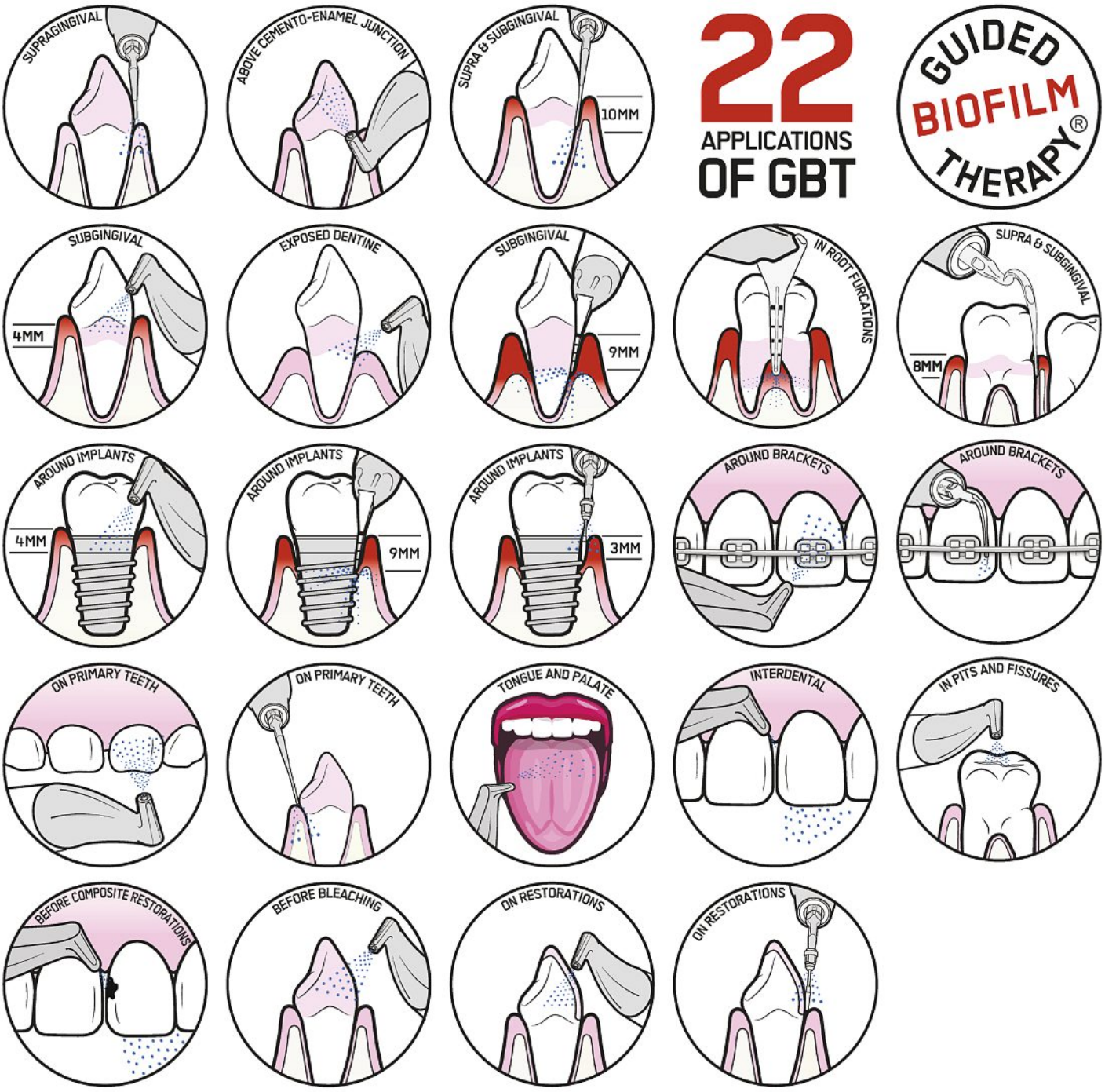

EMS

DENTAL HEALTH

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

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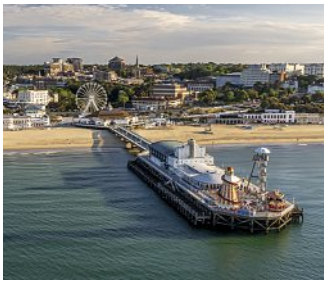

ON THE COVER
All in the same boat – OHC 2023 – Bournemouth international centre

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EDITORIAL

Let's celebrate…

Welcome to the July issue of *Dental Health*. Just as I was editing content for the journal, I was alerted to some wonderful news that I would like to share with you. Two of my dear friends, both BSDHT colleagues and dedicated dental hygienists, have been recognised for their professional achievements.

Mike Wheeler, BSDHT past president 2006-2008, has been awarded the British Empire Medal (BEM) in the King's Birthday Honours. The BEM is awarded for a 'hands-on' service to the local community. This is usually a charitable or voluntary activity that has made a significant difference. Mike's award is in recognition of his services to oral health in South West England. Mike was a practising dental hygienist and dental workforce lead tutor, Health Education England, and has been a member of BSDHT for 45 years!

Marina Harris, BSDHT past president 2008-2010, has been promoted to associate professor at the University of Portsmouth. Marina is a dental hygienist and a member of the BSDHT publications team. Alongside her practice and teaching career, Marina gained a Bachelor of Science in social sciences, a Master of Laws in legal aspects of medical practice, the Post Graduate Certificate in Teaching and Learning in Higher Education and a PhD!

Congratulations to both and definitely well deserved. You will be able to read more about these inspiring individuals in September's issue.

BSDHT must also congratulate the class of 2023! The next generation of dental hygienists and dental therapists has completed their undergraduate studies, passed their examinations and are now hopefully celebrating the outcome of their years of hard work. Welcome to our profession! As you begin your clinical practice, please remember that BSDHT provides a whole raft of services to help guide you on the next stage of your career.

As editor, I would like to remind you that the publications team is here to support you towards publication in our journals. Don't let that dissertation languish on a shelf! Your work can be edited and shared within the pages of the journal. Do get in touch and we can get started!

In other news…

Work has been continuing throughout spring to update *The Prevention and Treatment of Periodontal Diseases in Primary Care:* dental clinical guidance, which was published in 2014 by the Scottish Dental Clinical Effectiveness Programme (SDCEP). A number of supporting tools to assist clinicians in the management of periodontal diseases are also being developed for inclusion in the guidance. SDCEP will now open a consultation draft of the second edition. The consultation will last for six weeks starting on **6 July** and ending on **17 August 2023**. You can read more by visiting: **www.sdcep.org.uk**

Last month, the British Society of Paediatric Dentistry (BSPD) launched an initiative to raise awareness of children's rights: *Rights from the Start*. Throughout this year, the BSPD has focussed on highlighting the importance of ensuring that the wellbeing of our most vulnerable children is prioritised and protected. All professionals working in dentistry should be aware of the rights of children. A fact sheet outlines these rights according to The United Nations Convention on the Rights of the Child (UNCRC). BSDHT is supporting this initiative and members are encouraged to download the factsheet to display in their work place.
Visit: **www.bspd.co.uk**

Just a thought…

I hope you enjoy reading Nick Coller's excellent paper on head and neck skin cancer, pages 30-34 – so pertinent at this time of year! Thinking of the sunshine brings to mind the naïve individuals travelling to Turkey for dental work. As a wise young man pointed out to me… forensic dentistry may become redundant with all these cloned teeth, everyone will be the same!

Heather Lewis

FROM THE PRESIDENT

BY **MIRANDA STEEPLES**

If you don't use it, you lose it!

I hear this a lot! I also find myself saying and thinking this a lot! An example is to my patients with reducing mobility when I find myself encouraging them to just take a walk each day to try to maintain what muscle use they still have.

The same could be said for our Regional Group study days. Numbers of attendees have been falling for some time. I often hear: *"I can't make this one, but I'll definitely come to the next one".* While BSDHT is a 'not-for-profit' organisation, the groups cannot run at a loss. Prior to September 2022, an average of 14% of people who *could* attend a Regional Group study day in their area, actually did! Even before the pandemic, it was only 26%, which is sad for the local teams and the head office team, who all put so much work into arranging these days.

We did consider ending the study days, and changing the structure of the teams, but as one Regional Group Representative said to me: *"This fear of losing the study days has galvanised my area, they really stepped up their attendance this last time".* The teams overall have given strong positive responses for wanting to continue with their team structures the way they are, and with the study days. Following discussion at the Executive and Council meetings in 2022, and consultation with the Regional Group teams, it has been decided to keep things as they are and then review in a year or so.

It's up to you! Please support your local Regional Group study days. If you don't use them, you will lose them. Along with all the opportunities for face-to-face CPD and connection with your colleagues in the trade and friends in your local area.

Regarding the Society, as a whole, I hear and read questions asking: *"What does the Society do for me?"* To current members: we respond to enquiries with evidence-based answers; sign post you to legal advice; provide CPD in the journals, webinars, at study days and the OHC; provide a coaching and mentoring service; offer a very good deal on your income protection and indemnity cover; offer access to a Benevolent Fund that you can call upon if you are in financial difficulty; and in addition, we provide a sense of community and support.

I know we have members who will remember a time of working with no gloves, no dental nurse support and when a dentist had to be onsite so you could give local anaesthetic via an IDB. A time when as a dental therapist you could only work in the community services, and not general practice. A time before direct access. A time when there was no BSc for dental hygiene and no postgraduate educational opportunities.

It is the professional organisations that have lobbied and changed this. We are still working toward exemptions and striving to ensure equity within the NHS for our colleagues who deliver this care. There are some that will say: *"Why should I pay to be a member because the work is happening anyway whether I pay to support it or not."* But ask yourself: is that the voice of a professional? Is it not for the greater good, the team-working within our registrant groups, that we all pull together to make things better for our professions, and not work in isolation regardless of anyone else? We need to pull together now more than ever, for it is a time of change.

The same could be said for the provision of postgraduate study, which I understand is not for everyone. I know that currently undertaking this won't necessarily lead to any more remuneration, or greater pay banding in the NHS, but these courses may open doors to opportunities you don't even know about yet. If these programmes are not utilised they will close and that potential opportunity for profession-wide growth and development as an individual, and as a profession, will stall. Further education can instil us with confidence to take on positions of influence and get involved with making the decisions that shape our own professional destinies.

As an example, by the time you read this I will have attended a listening tour with my local Integrated Care Board where we will discuss the NHS contract amendments and what we think is necessary to make this work, for us working in it, as well as patients receiving care within it. I will be representing dental hygienists and dental therapists at this event, speaking for both.

The first Refresh and Refine events will also have been held in Edinburgh and Bristol to support those in practice who feel the need for this training. Thank you to those who have booked for these courses, I know they will be a success and I am confident we will hold even more of them in the future.

In the meantime, bookings are open for the OHC in Bournemouth and President elect, Rhiannon Jones, has curated a superb programme with something for everyone, for all our members, for our BSDHT family. I look forward to seeing you all there!

TIME TO START THINKING ABOUT CPD

Continuing Professional Development (CPD) is a compulsory part of being a member of the dental team and is something we all must do – but why is it so important?

CPD is a vital part of demonstrating your commitment to professionalism. It ensures confidence in your practice, knowing that you are providing the highest quality care for your patients, and it allows you to stay up-to-date with the latest developments, technologies and treatments.

We also know that good employers are increasingly looking for dental hygienists and dental therapists who are committed to their professional development and who have a wide range of skills and knowledge that will benefit their practice.

We understand that finding the time for CPD is hard. You may have demanding work schedules or not have the help or support from your employer to develop a meaningful personal development plan or complete your CPD. You may also have family commitments or other obligations to attend to that mean completing your required CPD is a real challenge.

Most dental hygienists and dental therapists are meeting their professional responsibilities when it comes to CPD. However, the number not meeting the minimum requirements has increased in recent years, and the GDC is concerned that if this continues there will be an increase in the numbers who fail to meet their CPD requirement.

What do you need to do each year?

As a registered dental professional there are several things you need to by 31 July to maintain your registration:

1. **Make your annual CPD statement:** As a dental therapist or dental hygienist, you need to complete at least 75 hours of verifiable CPD during each five year CPD cycle, and complete at least 10 hours CPD in each two-year period.
2. **Keep a personal development plan:** You need to maintain a personal development plan, which you can use to inform your CPD priorities
3. **Pay your annual retention fee of £114:** You need to do this before the deadline of 31 July.
4. **Make your indemnity declaration:** You must have appropriate indemnity arrangements in place so that if things do go wrong, patients are protected.

There may be some years when you are unable to complete any CPD. That's fine, but you need to remember to complete a zero-hours CPD statement when you are doing your annual renewal.

Remember, you can make your CPD declaration at any time throughout the year and you can check how much CPD you need to complete this year by accessing your online account on eGDC.

In your final year and need a bit more time?

The number of hygienists and therapists who are in the final year of their five-year CPD cycle in the 2023 ARF period is significantly higher than other years. So, please check now if you are in the final year of your cycle.

And if you are in the final year of cycle and need a little more time to complete your required CPD hours, you can apply for a grace period. This will give you an additional 8 weeks to complete any outstanding CPD.

However, you need to apply for this grace period by 31 July.

What to do next…

- Make sure you know what CPD you need to complete this year before your renewal in July, by checking on eGDC.
- If you are unsure of your CPD requirements you can check these on the GDC website: **www.gdc-uk.org/education-cpd/cpd**

If you need additional support or have any questions, please get in touch with the GDC now, rather than waiting until renewal.

BSDHT Member of the Year

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BSDHT

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POSTER COMPETITION
OHC 2023

BSDHT's Annual Oral Health Conference will be held over two days on the 24th and 25th November. Once again, a poster competition is included as part of the programme.

This is a fantastic opportunity for members to showcase their work. Posters will be on display throughout the conference.

Judging will take place on Saturday 25th November 2023 and the prizes for the winning entries will be awarded during the last session at the conference.

Visit the BSDHT website for details on:

- **Guidelines for the preparation of abstracts**
- **Submission Form & Terms and Conditions**

BSDHT EASTERN REGIONAL GROUP

SPRING STUDY DAY 2023

Date: Saturday the 18th of March 2023

Venue: Huntingdon Marriott hotel

Speakers: Gulab Singh, Hiten Halai

Sponsors: thanks to: CTS dental; Curaprox; Haleon; Oral B; Oralieve; Stoddard; Swallow; TePe; and Wisdom.

We had an exciting Spring study day this year in a new venue, due to a last-minute cancellation by the original hotel. The committee members were up at the crack of dawn to be in Huntingdon by 7.30 am, ready to meet the trade companies and organise the day.

The event ran on a slightly different format to usual, as we introduced hands-on sessions. We had parallel sessions to allow for a greater number of delegates and filled our capacity of 40 places. A sell out! Our thanks go to our colleagues in the trade who joined us between 8am and 10am and again during our morning refreshment break.

The hands-on sessions were chosen and organised based on delegate feedback at our

AGM in October 2022. The sessions were all chosen to be of benefit to everyone - newly qualified as well as experienced clinicians.

Our speakers were Dr Hiten Halai, a periodontist, and Mr Gulab Singh, dental therapist and chairman of our regional group

Gulab's 90 minutes session was entitled, 'Hands on Piezo Ultrasonics with various tips, and air-polishing techniques and powders. ' He was supported by Amanda Harbrow-Harris (dental hygienist) and Francois Faro (NSK) in delivering this session.

For some of us, the air-polishing element of this session was a refresher, and for others it was an introduction into air-polishing. We learnt about the different powders and their uses, as well as air-polishing and implants. Gulab explained

considerations and contraindications when offering this treatment to patients.

Halai 's 90 minutes session was entitled: 'Hands-on instrumentation made easy',

This session started with a discussion about the clinician's goals when providing non-surgical periodontal therapy, as well as the patient's perspective and what they want. Then we quickly moved onto the characteristics and functions of curettes and how to carry out effective hand instrumentation using the correct techniques. We were able to test different Gracey curettes on study models as well as hone our sharpening techniques.

After lunch, short presentations were delivered by Rachel (Oral B) and Andrea (Eastern regional group rep).

The dental company representatives provided us with quiz questions, and some prizes earlier in the day. Once the questionnaires were answered, the delegates were entered into the raffle which we drew at the end of the day. We had many exciting prizes and lots of winners.

This was a successful day, despite the last-minute changes and the very early start, and we look forward to seeing you all again at our next study day on Saturday the 14th October 2023.

Nancy Gieson

BSDHT LONDON REGIONAL GROUP

STUDY EVENING

Date: Thursday 20th April 2023

Venue: Bupa Dental Care, Bank London

Speakers: Cat Edney, Anna Middleton, Marukh Khawaja

Sponsors: Thanks to: BlancOne; Curaprox; Haleon Healthcare Partners; Kin Dental; Optim; Oral B; TePe; and Trycare.

The London team undertook a survey monkey of our members to discover what they wanted from our meetings. It became clear that an evening event would fit best with their needs. Happily, BSDHT London Regional Group returned in 2023 with a sold-out spring study CPD evening! We very much appreciated that Bupa Dental Care, Bank London was happy to sponsor the venue.

At registration our delegates and trade were welcomed with a choice of a glass of prosecco or juice and a registration gift of either a Waterpik or hand instrument. We also sold raffle tickets raising money for The British Red Cross to support the Turkey Earthquakes. We were further delighted by all our donated raffle prizes: a surprise bag from Anna Middleton; a Waterpik from Waterpik; a toothbrush kindly donated by Curaprox; a whitening box from BlancOne; and set of interdental brushes from Optim. TePe generously donated

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Delegates visited our mini trade exhibition with fabulous trade stands. Having our colleagues in the dental industry support our regional events provides a personalised and one two one interaction so that our delegates can find the right products and services to fit the needs of their patients and practice.

A light refreshment was provided, and as it was the last night of Ramadan, those fasting were also provided with Ramadan bags to break their fast.

Regional group meetings are great ways to engage with people, meet old friends, network, and find new friends and colleagues as well as increase your knowledge and confidence, often learning from others. We were spoiled with our award-winning speakers delivering some exceptional inspiring and motivational methods to change mindsets and working practices all in accordance with the CPD guidelines providing verifiable CPD.

Oral B kindly commenced the first set of lectures of the evening with a presentation entitled, 'Your role beyond the chair ' delivered by Lindsay Austria, Territory Manager for Oral B. There were three further inspirational presentations: dental therapy, direct access and mindfulness and wellbeing.

Cat Edney, an award-winning dental therapist focussed on, 'Putting therapy into practice' sharing her journey and a day in the life of a dental therapist. Award winning dental hygienist, Anna Middleton, shared her story of building her brand and offering 'Direct access with confidence'. Marukh Khawaja, CEO of Mind Ninja, suggested, 'Small steps to skyrocket well-being' and shared some content from her book - Resilience and wellbeing for dental professionals.

A short update from BSDHT council brought the evening to a close.

Aside from a few AV hiccups, we had all spent a beautiful evening networking and learning in the heart of London before it was time for the London committee to sit down and think about the next one! If you would like to contact the London group or are keen for us to cover a particular subject, please contact Sakina on londonregionalrep@bsdht.org.uk

Keep updated with all events and information by following us on Instagram **@bsdhtlondon**

Sakina Syed

ALL IN THE SAME BOAT

OHC 2023 - BOURNEMOUTH INTERNATIONAL CENTRE

OHC 2022 was held in Manchester and it was better than ever! A whopping 90% of you told us you'd be back next year. So, on 24-25 November will see you in Bournemouth! And as we will spend a weekend at the seaside, what better theme than **'All in the same boat'** – recognising our role in working across healthcare for the benefit of our patients, supporting one another while working together and alongside other professionals. The full conference programme is available at **bsdht.org.uk/ohc-2023**, and as an insert to this copy of the journal – take a look to see how you could benefit from a programme that's packed with sessions designed to enhance and elevate your clinical practice, whilst providing two days of quality CPD.

A programme by members, for members

The conference programme has been developed by Rhiannon Jones, the BSDHT's President Elect, from member and past delegate feedback and with you in mind:

"I am so excited about this year's OHC in Bournemouth. The venue is excellent and one I have always looked forward to revisiting. The theme this year is designed with support and collegiality in mind. We are 'all in the same boat' and yet our experiences of the journey can differ. With this in mind, I have worked hard to design a programme which provides a variety of CPD from clinical skills to medical conditions linked to our work. I have also selected speakers who wish to support and reinvigorate us as they value our work and strive to help us to stay well.

I really hope to see some familiar faces but also some new ones. Please share the programme with your team as it is a conference for anyone with a passion for oral health and the wellbeing of the dental team."

More CPD hours than ever before and an expert panel of speakers

This year's OHC will offer more than 10 hours of CPD. Here are just a few of the highlights:

- Oral health starts in the mind and connects to the mouth - Theodora Little, dental therapist
- Propel your career with teeth whitening treatments - Megan Fairhall, dental therapist
- New therapeutic strategies for dental enamel management - Fabia Profili, dental hygienist and tutor
- Sustainability in general dental practice - Tracy Doole, dental hygienist
- Periodontitis and the 3 Is – inter-professional collaborations, integrated care, and individualised treatment - Varka Rattu, dentist

Submit your work to the annual poster competition

The BSDHT is currently accepting submissions of abstracts to be considered for the annual poster competition. Prizes for best posters will be awarded at the conference and successful abstracts will be presented in a poster display onsite. Submit your abstract by 5pm on 22 September 2023. Full details can be found at bsdht.org.uk/ohc-2023. The poster competition is kindly sponsored by Colgate.

And so much more…

There are many reasons to attend the conference, not least 10+ hours of quality CPD, the exhibition, and the social and networking aspect. BSDHT President, Miranda Steeples sums up why you should attend:

"If the last few years have taught us anything, it is that we are all in the same boat, navigating our way through each day, and this applies to us in dentistry, as well as wider healthcare teams. The BSDHT strategy considers how a dental hygienist or dental therapist might utilise their skills alongside other healthcare professionals and contribute to holistic patient care. Rhiannon has created a fantastic programme which has something for everyone at all stages of their career. We are excited to welcome you to the sunny south coast and look forward to seeing you there!"

Save more than 25% before 18 September and pay in instalments

Registration is open and early-bird fees are available until 18 September 2023. **Book your place online at bsdht.org.uk/ohc-2023**. Once again, we're pleased to offer payment by instalments to make the cost easier to manage. And furthermore, we've fixed full attendance fees at 2022 prices to recognise that the rising cost of living is squeezing everybody's budgets.

The special rates for newly-qualified and student members will also run again. BSDHT student members and members who qualified in 2021, 2022 and 2023 are eligible to register at less than 40% of the standard member rate – prices start from just £53.

SOCIAL MEDIA AND ORAL HEALTH

BY CAMERON KEIR

Social media can be an excellent data-sharing tool and undoubtedly impacts and influences many people. However, the validity of the content and information shared is often open to question!

We are all aware that many patients are experiencing difficulty accessing NHS dental care. For these people in need, social media has a role to play in communicating oral health messages, help and advice. Many clinicians utilise social media platforms as tools to reach a wide audience and to increase oral health literacy. Those of us who do this, aim to give evidenced based messages and help patients to make informed health decisions.

The General Dental Council (GDC) has published guidance on the use of social media and states: 'Social networking sites and other social media are effective ways of communicating with others on both a personal and professional level.'[1] Using social media to reach those who cannot access professional help could significantly improve how individuals care for themselves at home. We can share techniques and tips to teach people how to implement an effective daily oral hygiene routine and check their own mouths for disease.

Such social media interventions may improve early diagnosis of diseases and facilitate behaviour change techniques, providing support and emphasising the consequences of health issues. Social media can serve as a collaborative dissemination platform to reach and influence a target audience and some early research has revealed a significant positive influence of social media on public health. By providing efficient, ubiquitous, and user-friendly approaches we can attract large numbers of viewers and demonstrate a certain level of engagement with health-related messages. With engagement and effective use, behaviour change around health can be implemented.[2]

However, there is also misinformation being disseminated. Currently, there is no legislative guidance and the content of posts is frequently subjective. Individuals searching for reliable advice have to navigate a minefield of conflicting ideas. Evidence-based toolkits such as Delivering Better Oral Health[3] offer researched and practiced guidance whereas instruction gained online does not have to adhere to the same level of professional scrutiny.

Misinformation spread by brands is common in the dental world where content is product-focused instead of patient-focused. This seems obvious to dental professionals but for others it can be easy to believe wonderous claims of teeth whitening over the prioritisation of oral health.

If the dental hygienists and dental therapists using social media could challenge the false information impacting oral health promotion, social media would be an even more powerful tool for education.

Although it is not something that is necessarily within the control of the profession it's an interesting subject of discussion nevertheless. I believe we ought to be asking questions. Is social media influencing oral health awareness positively? Or does the subjectivity of social media have no place in health promotion?

Author: Cameron is a final year student studying Oral Health Science at the University of Essex. She looks forward to getting into practice and continuing her education and working towards her masters.

Email: ck21627@essex.ac.uk

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NOT A DENTIST! WHY NOT?

BY LIAM HOLLANDS

When I was a dental nurse, people often asked me: "Are you going to study to be a dentist afterwards?" As a dental hygiene student at university, people often ask me: "Why aren't you studying to be a dentist?" (Let's call these people Gavin.)

Though I don't particularly mind these questions, or let them bother me, it does make me think that dental professionals (other than dentists) are undervalued and misunderstood. The public should know that all dental professionals are valuable members of the dental team. We all have different roles to play, and we all contribute to the overall goal of providing our patients with the best possible care.

I chose to do dental hygiene because I want to make a difference in people's lives and help to improve their oral health, and overall health. Yes, I know Gavin would say that dentists do that too, but I like to think that hygienists do it with more passion! It seems obvious that the public needs to be told that dental hygienists and therapists are not just 'backup dancers' for dentists but clinicians in their own right. As a dental hygienist, I have the opportunity to provide preventive care, diagnose and treat oral diseases and educate my patients about oral health while helping them to develop healthy habits. All of this, by the way, can be done through direct access, so no need for those meddling dentists that Gavin loves so much (only joking, dentists!).

Being proud to be a dental hygienist should be normalised. I know the difference hygienists make to patients, and I am grateful that I will have the opportunity to do so as well. I have witnessed dental phobic patients arrive with extremely poor dental hygiene and a determination to not see their dentist. Then, after seeing a dental hygienist for a few appointments, they leave with good breath, a happy, healthy smile and understanding that dental professionals are not so bad after all! The fact that dental hygienists aren't dentists is one of our biggest strengths. It enables us to be less intimidating to those who fear dental treatment and slowly introduce a new and improved perception of dentistry to the patient, allowing them to ease back into the dental chair at their own pace.

So, does all of this knowledge change my answer when Gavin asks, *"Why aren't you studying to be a dentist?"* Well, probably not, but I can smile behind my mask knowing that I am exactly where I need to be.

Author: Liam is a soon-to-be second-year dental hygiene student at Teesside University. He is originally from Eastbourne where he worked as a dental nurse. He feels lucky to be studying alongside his wife, who is also on the course at Teesside!

Email: liamhollandsuk@gmail.com

THE BEST TIME TO SUBMIT YOUR SELF ASSESSMENT TAX RETURN IS NOW!

You might be thinking, 'now why would I want to do that, the deadline is not until 31 January'? No one particularly enjoys organising their taxes, many find it a daunting task, and so of course it's tempting to put it off while you can. But why not make this the year that you change your approach, and discover the benefits of early filing?

HMRC has recently revealed that the number of Self Assessment customers who choose to file their tax return on the first day of the tax year (6 April 2023) has more than doubled since 2018, with 77,500 customers submitting their 2022 to 2023 tax return this year compared to almost 37,000 customers on 6 April 2018. Here's why they're doing it.

Early filing does not mean early payment

Choosing to file your tax return early does not mean you have to pay HMRC any money early. The 31 January deadline for payment remains unchanged. If you choose to pay your tax bill earlier for your own convenience, that's fine, but it's entirely up to you. When you file early, you get to know what your tax bill is going to be, which can help you plan ahead.

Know what you owe

Knowing what you owe means you can arrange your finances appropriately before the Self Assessment deadline on 31 January. It puts you in control so you can plan how you'll make the payments to cover the bill, whether you choose to spread the costs over time or just stick with lump sum payments.

Get any refund faster

If you've paid too much tax during 2022-2023, HMRC will let you know as soon as your tax return has been processed and arrange for any overpayment to be refunded. That's money in your pocket months before you'd get it if you put off filing your return until nearer the deadline.

Set up a budget plan

HMRC offers a Budget Payment Plan facility. Customers can

choose how much and how often they want to pay by Direct Debit – putting you in full control of managing your bill. You can find out more here: https://www.gov.uk/pay-self-assessment-tax-bill/pay-weekly-monthly

Have time to understand if you need help and to get that help

The cost of living crisis means many people are experiencing financial pressures right now and if you're feeling the pinch, your tax bill will probably be a further source of worry. However, putting off filing your return isn't the best idea. Filing early will mean you have more time to look into your payment options if you're unable to pay in full by the deadline. HMRC is keen to help customers explore these options, which may include paying your tax bill in instalments through a Time to Pay arrangement , many customers can set this up online. See if this could work for you here: https://www.gov.uk/difficulties-paying-hmrc/pay-in-instalments

Goodbye to last minute stress

There's absolutely nothing worse than the panic that sets in with an impending and important deadline, which only gets worse when you realise you've made a mistake or have forgotten something that you need for your tax return.

HMRC offers the following additional advice for those interested in getting started with their tax return right now:

- If this is your first time completing Self Assessment, you'll need to register and get your Unique Taxpayer Reference (UTR). Allow yourself time to sort this out into your plans. You can find out more here: https://www.gov.uk/register-for-self-assessment
- Think digital first. Last year, 97% of customers filed their Self Assessment tax returns online, and many even used the app. HMRC has lots of helpful advice on how to complete your Self Assessment on GOV.UK.
- Beware of scammers. Tax scams come in many forms. Some offer a rebate while others threaten arrest for tax evasion. If someone contacts you saying they're from HMRC, never let yourself be rushed, especially if they want you to urgently transfer money or give personal information. HMRC will never ring up threatening arrest. Make sure to take your time and if you're unsure, check HMRC scams advice on GOV.UK: https://www.gov.uk/topic/dealing-with-hmrc/phishing-scams
- Protect your login details. Your HMRC account contains your personal information such as your bank account details. So don't share your HMRC login with anyone, including your tax agent, if you use one.

Hopefully you are now convinced you that there are only positives to filing a Self Assessment early. So why not make a start today?

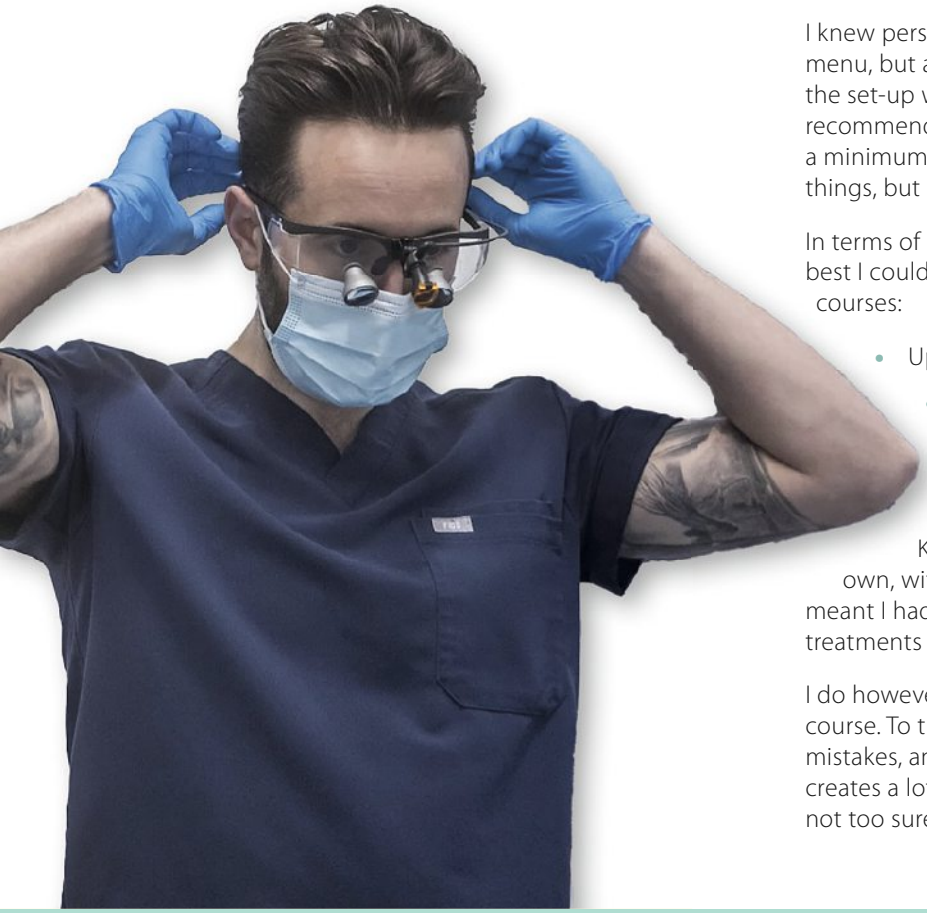
BY LUKE SNELLING

CELEBRATING 10 YEARS OF DIRECT ACCESS

LUKE SNELLING OPENED HIS BUSINESS, DENTAL HEALTH & AESTHETICS BELFAIRS CLINIC, ON 29TH NOVEMBER 2019

DH: At what point in your career did you decide to start your own business and why?

LS: I have always wanted to own my own practice. The initial drive originated from my uncle, who was a successful practice owner. From a 'selfish' (perhaps naive!) point of view, I liked the look of the lifestyle and being my own boss. But the distinct moment arose in May 2013 when we were allowed to work under Direct Access. I had done research into being a practice owner as a dental therapist prior to this and knew how difficult it would be, especially with the prescription issues and remit constraints. However, when direct access was passed, I knew the barriers were lowered significantly, which meant we could function and run a clinical practice in a much better way.



DH: How did you work out what aspects you needed to consider before taking the plunge?

LS: In truth, I did not! Well, not enough! I knew roughly how much I needed in terms of costs (I had a business partner at that time). I certainly wouldn't have had enough to start the project on my own. Once we had spoken with the builders and architects, we knew what we would need to get the business off the ground. We had several meetings with a business manager early on who had worked out what our daily running costs would be and projections, and what each room could potentially earn, considering our outgoings. This allowed us to work out profit margins and helped planned the treatment menu. I would highly recommend this type of help, albeit a very expensive investment.

I knew personally what I wanted to offer in my treatment menu, but a lot of the issues that we came across during the set-up we generally dealt with at the time. I would not recommend this if you want to keep the stress levels to a minimum. Sometimes it is impossible to plan for these things, but in truth we needed to be better prepared.

In terms of self-development, I knew I needed to be the best I could be before going into this, so I took the following courses:

- Updated radiograph prescribing course
- Periodontal update
- Advanced aesthetics refresher
- Cosmetic composite course

Knowing that, clinically, I was effectively on my own, with only mentors to lean on for remote support, meant I had to be 100% committed and confident in the treatments I was offering.

I do however wish I had taken a business management course. To this day I am still learning and still making mistakes, and it is a huge element of the day to day, which creates a lot of stress. Without my practice manager I am not too sure I would be able to cope.

DH: What were the most important elements for you and why?

LS: Well firstly, I always wanted to be my own boss. But from a selfish point of view, I wanted to be recognised for being a good dental therapist. I had seen a good few examples of hygienists and therapists on social media who had become very successful by utilising their remit and working independently (either as an LTD company or marketing themselves separately to their practice). I was very jealous of this, to be perfectly honest. I had gotten myself into a bit of a rut with the constant hygiene maintenance cleans, the revolving door of hygiene being 80-90% of my working week. I only had a small amount of therapy thrown into the mix. I had started to become very busy with facial aesthetics, which was something I never planned to do, but I happened to be good at and enjoy doing. It was nice to offer something different to dental hygiene. However, I knew I had the skills to be good at cosmetic dentistry and loved the idea of composite bonding. The only way I knew how to utilise all these skills was to be my own boss and so realising this could be achieved after direct access was granted, I jumped at the chance to start my own clinic.

DH: Who helped you along the way and what did they do?

LS: Originally, I shared the burden with a business partner. This unfortunately did not work out (I could write a whole essay on that part!). It was the push I needed however so I won't bemoan the decision to have a business partner in the first place, it certainly spread the load of responsibility and stress during the set up.

I had help from family members, my uncle being a retired dentist and mum being a dental nurse and practice manager. The support from my partner, now wife, was major.

Regarding setting up and sourcing advice, I utilised my then employers who were more than happy to help with the million questions I had about being a clinic owner. I built a fantastic rapport with the dental company who provided and fitted all the dental equipment, which allowed me to amalgamise this alongside the builders. Looking back, I should have gone with more specialist builders who maybe had dealt with dental operations before. We did come across a lot of issues which cost us regarding design and time delays, however we managed to get through it all on the tight budget we had set.

Finally, I had help from a friend who supports clinics setting up with CQC, which was crucial. Without her, I think I would have had a CQC meltdown! There are professional bodies who help with this, and I would strongly recommend you get this sort of help.

DH: What have you learned on this journey that you can share to help others?

LS: Do not take this lightly! The one thing I have learned is it really is not as glamorous as it looks from the outside. I think there are fantastic job opportunities out there now for dental hygienists and therapists to utilise their skills. This doesn't necessarily mean you need to have your own business to be utilising them. The stress, costs and level of self-development required to run a clinic are intense. If you have the option to work for someone who can carry that burden, whilst you still work and utilise your skill set, then I would take that every day of the week. If not, and you need that change, and can't see it happening whilst working for other people, then go for it.

DH: Can you give 3 top tips for success?

LS: These are:

- If you just work hard, you will always be successful. I know people say 'work smart, not hard' but honestly, if you are a grafter, people will always respect that, and the success will follow.
- Don't be a massive push over! You need to be a bit cut throat to be in business.
- Invest in yourself. Whether it be courses or speaking to someone about stressful situations. It's the best investment you will ever make.

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BY WENDY CASSAR

CELEBRATING 10 YEARS OF DIRECT ACCESS

WENDY CASSAR OPENED HER BUSINESS, THE DENTAL HYGIENE CENTRE, ON 12TH OCTOBER 2015

DH: At what point in your career did you decide to start your own business and why?

WC: In 1988 I qualified from Guys hospital and began a career which I continue to love. At some point along the way, I recognised there was a need to create a space where dental hygienists could work to their best abilities in their own environment. The change in law on 1st May 2013 prompted me to create my vision for my business, The Dental Hygiene Centre, or the Pink Palace as we are now known.

At that time, my husband owned The Grange Dental Surgery in Chichester and luckily premises became available next door. This additional space allowed us to offer our patients more availability but, importantly, also hygienist services under direct access. The plan was that more patients could access dental hygiene services, with the back-up of an onsite dental surgery if needed.

Mike Maberley, head of Dental Hygiene at Guys Hospital when I trained, had always fought for and promoted the independence of dental hygienists. It gave me great joy when Mike agreed to open my practice on 12th October 2015.

DH: How did you work out what aspects you needed to consider before taking the plunge?

WC: An important consideration was how I could promote independent dental hygiene services without

upsetting local dentists! I wanted to open a practice to help local dental surgeries and orthodontists that may have been struggling to support their patients with dental hygiene services. It was important to me to be seen to be an adjunct to local dental services, to help and to promote dental hygiene without taking away from their own services. I did my best to become acquainted, and build relationships, with the local dentists and orthodontists.

Before taking the plunge, we had to work out the finances to justify the cost of setting up a new surgery. We managed to get a second surgery in the building, which enabled us to have two full time hygienists with nursing support. This local, unique service soon resulted in our clinics becoming full. Our primary feed was from The Grange Dental Surgery, but it soon came to light that there was a massive gap for direct access patients, although it took some time for patients to realise they could just come for treatment without a dentist's referral. A bonus was that I always felt safe in the knowledge that dental back up, and radiographs if needed, was available next door.

The initial cost was high. However now, 7 years later, we have full clinics daily and a waiting list. We also have a happy accountant and are covering all our costs!

Due to our set up, we were able to open very quickly again during the pandemic and continued our services without compromising our level of care. I would like to think we were an oasis of normality during those strange and difficult times.

DH: What were the most important elements for you and why?

WC: It was important for me to create an environment that was calm, peaceful and caring for patients, particularly if this was their first dental experience in a long time. It was important to create a space where dental hygienists could work and show our profession at its best; to showcase the range of skills that we can offer without being compromised by the usual constraints and restrictions of a dental practice. My favourite colour is PINK and also, of course the colour of healthy gums. So, I felt the two worked in harmony in our chosen colour scheme!

DH: Who helped you along the way and what did they do?

WC: Despite being my husband, Paul Cassar the principle dentist at The Grange, had faith in my abilities as a dental hygienist and in the profession itself to create a unique set up rarely seen in dentistry.

A friend and colleague, Heather, started as my receptionist and helped market the practice. She shared my passion and encouraged me from the first day of opening. All the amazing staff at The Grange and Dental Hygiene Centre who embraced change and shared my vision.

The dental hygienists, past and present that I have worked with - I could not have done it without you.

DH: What have you learned on this journey that you could share to help others?

WC: Caring and kindness are the most important assets to every business and always remembering how much of a privilege it is to share and build trust with new patients.

Looking after your staff - creating a happy team creates a happy work environment, which transmits across to patients. Without each other we cannot do our job.

Do not be frightened of Direct Access. We may be the first step for patients, but Direct Access is a giant leap for dentistry!

DH: Can you give 3 top tips for success?

WC: This is easy!

- Believe in our profession, we do make a difference.
- Always remember that the patient is the reason we are here.
- You can never have too much pink in your life!

Contact: wendycassar21@yahoo.co.uk

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Facebook: The Dental Hygiene Centre

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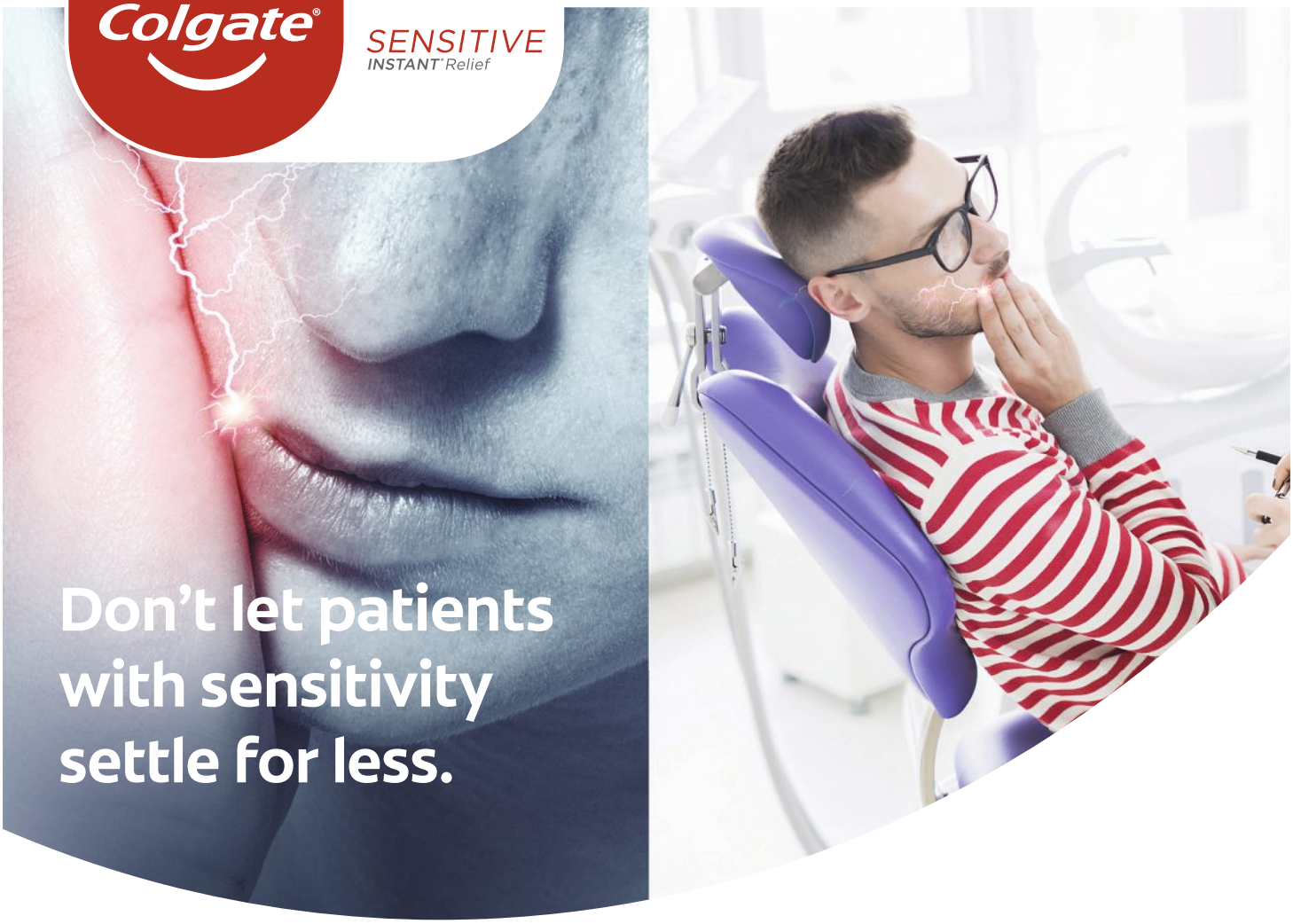

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References: 1. Nathoo S, Delgado E, Zhang YP, et al. Comparing the efficacy in providing instant relief of dentine hypersensitivity of a new toothpaste containing 8.0% arginine, calcium carbonate, and 1450 ppm fluoride relative to a benchmark desensitising toothpaste containing 2% potassium ion and 1450 ppm fluoride, and to a control toothpaste with 1450 ppm fluoride: a three-day clinical study in New Jersey, USA. *J Clin Dent.* 2009;20(Spec Iss):123 -130. **2.** Docimo R, Montesani L, Maturo P, et al. Comparing the Efficacy in Reducing Dentin Hypersensitivity of a New Toothpaste Containing 8.0% Arginine, Calcium Carbonate, and 1450 ppm Fluoride to a Commercial Sensitive Toothpaste Containing 2% Potassium Ion: An Eight-Week Clinical Study in Rome, Italy. *J Clin Dent.* 2009;20(Spec Iss):17- 22.

BY JULES FISHER

CELEBRATING 10 YEARS OF DIRECT ACCESS

JULES FISHER OPENED HER BUSINESS THE DENTAL HYGIENE STUDIO LTD ON 24TH AUGUST 2019

DH: At what point in your career did you decide to start your own business and why?

JS: I qualified as a dental hygienist at the Royal Army Dental Corps in 1996 - something that I had always wanted to do. When Direct Access came into being in 2013, I started to think about it more seriously, from a business perspective. I was already working under DA in the practices where I was employed so it just felt like a natural progression. I was fortunate to work alongside a brilliant GDP for over 20 years and when she sold her practice to retire in 2017, I realized it was 'now or never'! She encouraged me and was instrumental in giving me the confidence to believe it was achievable. At that point I was in my forties and knew I still had a few good years left in me. My sons were both at high school so it was a good time to take the leap. So, with the help of my husband, we started actively looking for suitable premises and began our journey. When we had located suitable premises, and secured the funding we finally started planning.

DH: How did you work out what aspects you needed to consider before taking the plunge?

JS: I'm a bit of a control freak, so I needed to know everything in detail!

As I was planning to set up a private squat, I knew that I'd be starting off with zero patients. I asked myself lots of questions and researched carefully: why would patients choose to come and see me? ; how would I raise the finance? Was my business plan feasible? How would it be received by local GDP's, would there be lots of negativity or suspicion? As the first independent DA practice owned by a dental hygienist in the local area, would patients even understand the concept of DA? Would I be taken seriously?

Thankfully, the practice has been very well received in the local area. Since the COVID-19 pandemic, a number of local GDP's now recommend us to their patients, and 'officially' refer them for treatment, which was something I never expected.

DH: What were the most important elements for you and why?

JS: Having worked in private practice for most of my career, I had been frustrated by the constraints of short appointment times and being bound by 'practice policy' which prevented me from treating patients in the way I wanted to. Additionally, the lack of full-time nursing support and feeling like an undervalued member of the team, are just two important elements which helped me make this decision. A patient centered approach is super important

to me and achieving excellent patient outcomes is what I strive hard to achieve.

DH: Who helped you along the way and what did they do?

JS: You know that saying, 'it takes a village to raise a child' - that's how it felt when I was setting up the practice! Lots of people gave me help and advice. I found that people really want to help, you just need to learn how to ask. Benji Blum from Dental Directives was especially helpful setting up the PGDs I needed, and his knowledge and support was invaluable. I managed to access free business start-up advice from a local charity, The Women's Organisation, who specialise in helping women set up in business. I had no previous business experience, never managed staff, never had to deal with compliance etc. so, all of this help was imperative. I am lucky to be very close friends with other dental hygienists with whom I qualified and respect them greatly, so with their experience, knowledge, and support I eventually felt ready. We talked through different scenarios, potential pitfalls and bounced around lots of ideas. Without them, I doubt I would have the courage to go through with it all! (Thank you to Lee White, Lorraine Webb, and Vicky Harris for not laughing when I first told you my ideas). My family and friends have also been amazing in supporting me, owning a practice can involve long working days, so having their support has been essential.

DH: What have you learned on this journey that you could share to help others?

JS: I think the most important thing to understand is that it is a process. There are no short cuts, no fast track and that is for good reason. The process requires lots of reading and frequent late nights researching. However, I now know my business inside out, back to front, and upside down! A pragmatic approach really helped me to just simply work through it one step at a time. My business, The Dental Hygiene Studio, opened to patients in 2019 and just a few short months later closed for 6 months due to the global pandemic. Not ideal business planning! However, no one could have foreseen this. Subsequently, having to navigate extortionate PPE costs, fallow times, furloughing staff and wondering whether or not I'd still have a business to re-open, certainly tested my resolve. It was a stressful, uncertain time but I learned a lot from it. Resilience and positivity as well as grit, determination and believing in what I was trying to achieve really got me through. Keeping focused was hard, but fortunately I managed to navigate through and almost four years later we are busier and stronger than ever.

DH: Can you share your three top tips for success?

JS: In my opinion the most important are:

- Spend lots of time researching, reading and asking questions. Do not be afraid to ask for help.
- Get business start-up advice if, like me, you have no prior experience of running a business.
- Trust in the process. It is a scary concept initially but take a deep breath and just do it!

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READERS FORUM

DIRECT ACCESS

Having just opened my May 2023 copy of Dental Health, I just wanted to say what a great article 'Reflection 10 Years On' is!

Beautifully and honestly written - it refers very professionally to the struggles we had - especially for the likes of Sally Simpson, Marina Harris, Mike Wheeler and Margaret Ross, who were all in post as President in the formative years of the proposal.

It is very important that the newer members of the profession are reminded of how contentious this piece of legislation was, so thank you for that.

Julie Rosse,
BSDHT Past President 2012-2014

Orotol Plus

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MEETING THE STUDENTS

BY SAKINA SYED

I recently had the pleasure of visiting the Eastman Dental Hospital Education Centre and meeting with first year dental therapy students. What a delightful group! Despite having a long day of visits from other dental companies they were all really engaging.

The aim of my visit was to promote our professional organisation, BSDHT, and highlight the huge raft of support and opportunities we offer to students throughout their years of study, and subsequently their professional careers. This is available to all dental hygiene, dental therapy and BSc. oral health science students in the UK.

The students at the Eastman shared their relief at finishing their end of year exams and excitement about embarking on the next phase of clinical sessions. They were particularly interested to hear our plans for this year's Oral Health Conference in Bournemouth, in November. BSDHT regional study days and the opportunity to showcase their work in *Dental Health* also provoked excited discussion!

BSDHT looks forward to welcoming new student members and wishes them all good luck with their exams.

My thanks to Debbie Hemmington, Tutor, for facilitating my visit at the Eastman Dental Hospital.

Sakina Syed
REGIONAL REPRESENTATIVE AND
ACTING CHAIR BSDHT LONDON

HEAD AND NECK SKIN CANCER: CAUSES, IDENTIFICATION, REFERRAL AND PREVENTION

BY NICK COLLER

AIM

To raise awareness of the causes and types of skin cancer affecting the head and neck

LEARNING OBJECTIVES

An enhanced knowledge of skin cancer of the head and neck, including its prevention, causes and appropriate referral pathways

LEARNING OUTCOMES

Dental hygienists and therapists should feel confident to:

- Raise the matter of skin cancer with patients
- Give appropriate advice about risk factors and prevention of skin cancer
- Manage appropriate referrals

Aligned to GDC development outcomes: A,C,D

To take the CPD please follow the link or scan the code:
HTTPS://WWW.SURVEYMONKEY.CO.UK/R/DH-JULY-2023

Deadline for submissions: 28 August 2023

ABSTRACT

Overexposure to ultraviolent (UV) radiation is the main risk factor for developing skin cancer.[1] All skin types, at any age, can be damaged by UV radiation, however for some individuals the risk is greater.

Currently there is no national screening programme for skin cancer in the UK.[2] Dental hygienists and dental therapists are ideally placed to be on the front line for early detection and identification of potential skin cancers, especially of the head, face and neck. Thorough knowledge of potential skin cancer susceptibility, identification and referral process is therefore essential.

It is beyond the scope of this article to examine the many types of skin cancer. Rather, this article focuses on the most common skin cancers of the head and neck – a key domain of the dental hygienist and therapist's extra oral soft tissue examination.

KEY WORDS

skin cancer, basal cell carcinoma, squamous cell carcinoma, melanoma

Causes of skin cancer

Almost all melanoma and non-melanoma skin cancers are caused by prolonged or repeated exposure to UV radiation from the sun or sunbeds.[3] People of all skin colours can be susceptible to skin cancer and it is unknown why an individual would develop one type of skin cancer over another, outside of the predisposing factors listed below. The following groups are at greater risk of developing the disease:[4]

1. Individuals with a particular skin type
   - Fairer skin types that do not tan easily due to less of the protective pigment melanin
2. Sunbed users
   - Sunbeds emit UVA and UVB radiation, both of which damage the skin
   - The International Agency for Research on Cancer classifies sunbeds as a Group 1 carcinogen[5]
3. Individuals who are at an increased risk of sunburn
   - People who work outdoors or who spend prolonged periods of time outdoors
   - Those with a previous history of sunburn
4. Individuals with an increased number of moles on the body

- People with more than 100 moles
- People with large or unusually shaped moles

5. Individuals with a family history of skin cancer or melanoma
6. Individuals who have a condition that lowers immunity (such as diabetes) and those people taking immunosuppressants. All immunosuppressive treatments, either pharmacological or physical, have the potential to impair the skin's immune system network of cells and cytokines, thus leading to an increased incidence of skin cancer.[6]

Types of ultraviolet radiation

UV radiation can both damage cell DNA and cause rapid cell growth which encourages tumour development. There are three types of UV rays of different wavelengths.[3]

1. UVA: long wavelength
   - Linked to long-term skin damage
   - Able to penetrate the skin to the hypodermis, causing redness and soreness
   - Can cause skin cancers, but not the most common cause compared to UVB[3]
2. UVB: medium wavelength
   - Able to penetrate the skin to the epidermis
   - Directly causes changes in cell DNA
   - Main form of UV radiation which causes skin cancer[3]
3. UVC: short wavelength
   - The most dangerous form of UV radiation
   - Blocked by the ozone layer

Types of skin cancer

The most common types of skin cancer of the head, face and neck are:[7]

Keratinocyte carcinomas, in particular:

- Basal cell carcinoma
- Squamous cell carcinoma

Melanomas, in particular:

- Superficial spreading melanoma
- Nodular melanoma
- Lentigo maligna melanoma

Non-melanoma skin cancer is significantly more common than melanoma, with more than 156,000 new cases reported in the UK last year compared to approximately 16,700 cases of melanoma.[8] Melanoma has a much poorer 5-year survival than non-melanoma cancer and unfortunately the incidence rate of melanoma has risen faster in the last 25 years than any other type of skin cancer.[8]

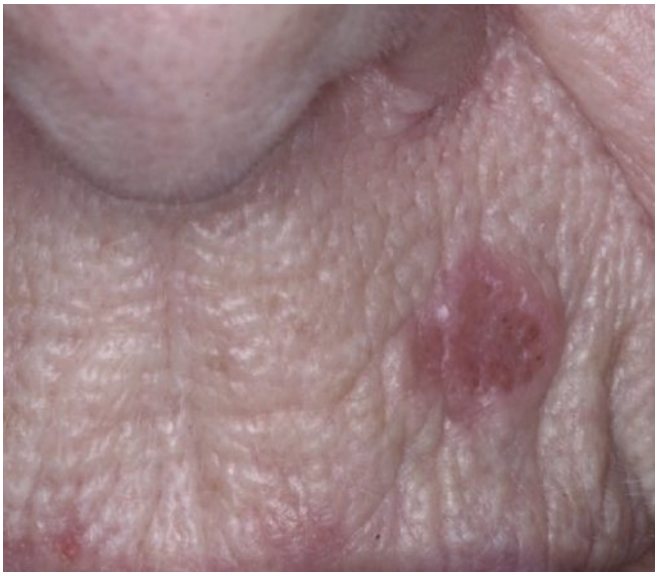

Figure 1: **Basal cell carcinoma on the upper lip**

Skin cancer in people of colour

Skin cancers occur less often in people of colour, but when they do, they tend to be diagnosed at a later stage, meaning the prognosis is worse.[9] It has been found that late-stage melanoma diagnoses are more common in Hispanic and Black patients than in non-Hispanic white patients.[10] This could be the case for a number of reasons:

- Low public awareness of the risk of skin cancer among people of colour (people of colour might present less often to medical professionals for skin checks)
- The places on the body where skin cancers tend to occur in people of colour are often in less sun-exposed areas , making detection more difficult (for example, the most common location for melanoma in patients of colour is the soles of the feet)[9]

Basal cell carcinoma

Basal cell carcinoma (BCC) is the most common form of skin cancer and occurs in sun exposed areas, especially the face, top of the head, neck and ears (Figure 1). The tumour is caused by uncontrolled growth of basal cells in the epidermis. Since BCC grows slowly and rarely spreads, it is essentially curable and causes minimal long-term damage, if treated early.[11,12]

Signs and symptoms[11,12]

- Pink, red or white shiny bump
- Pigmented brown or black bump especially in those with darker skin
- Red scaly patch with or without discomfort
- Flat white, yellow or waxy patch
- Ulcer which opens up, bleeds and crusts over only to reopen again
- Pink growth with elevated border and depression in the middle

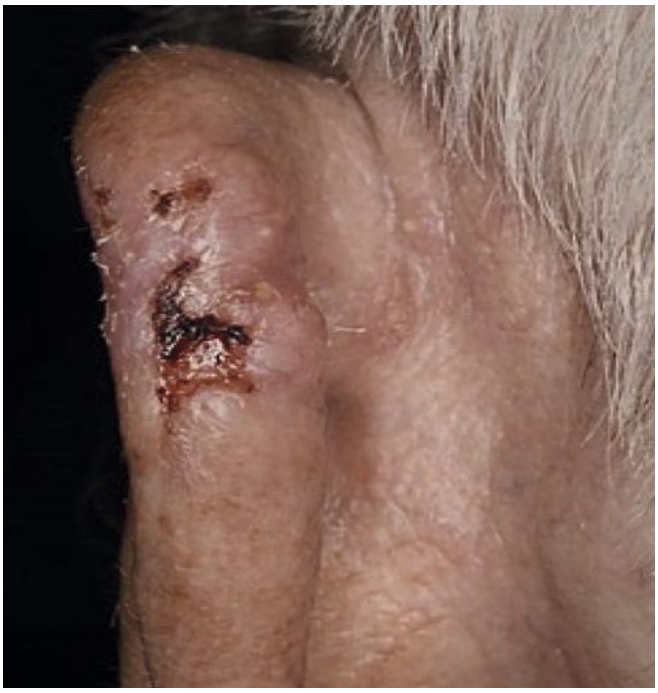

Figure 2: **Squamous cell carcinoma on the ear**

Asymmetry

Melanoma is likely to be an irregular shape whilst a mole is usually symmetrical

Border

Melanoma is likely to have a blurred or irregular border compared to the well-defined border of a mole

Colour

Melanoma tends to be more than one colour (brown mixed with a black, red, pink, white or blue tint) in contrast to the one brown shade of a mole

Diameter

Melanoma is usually more than 6mm in diameter, while a mole is smaller (not bigger than the blunt end of a pencil)

Evolving

Change in shape, in particular becoming raised, is a sign of a melanoma

Figure 3: **Comparison of ABCDE for melanoma and benign mole**

Squamous cell carcinoma

Overall, squamous cell carcinoma (SCC) is the second most common type of non-melanoma skin cancer but is also the most frequent form of skin cancer in people of colour.[9] The majority of cases of SCC occur on sun exposed areas like the face, neck, ears, lips and forearms (Figure 2). Skin SCC is often accompanied by pain and tenderness.[13]

Signs and symptoms[13]

- A firm lump with a rough or crusted surface; there can be a lot of surface scale and sometimes even a spiky horn sticking up from the surface
- Red, violet, purple, grey or dark brown patch in pigmented skin
- Scaly patch with irregular borders that sometimes crusts or bleeds
- An elevated growth with a central depression that occasionally bleeds
- An open sore that bleeds or crusts and persists for weeks
- A wart-like growth that crusts and occasionally bleeds

Melanoma

Melanoma arises in melanocytes (melanin producing cells) and the moles produced. Unlike other forms of skin cancer, melanoma can metastasise quickly to other areas of the body, such as lymph, bone and brain. In women, melanoma is most commonly found on the lower legs, while in men, it usually develops on the head, neck, chest and back.[14] This variation is thought to be partly due to genetics, and in part to do with differences in the way that men and women are exposed to sunlight.[14]

Melanoma identification

It can be difficult to tell the difference between a melanoma and a benign mole but the ABCDE list is a useful method of differentiation (Figure 3). In addition, any skin abnormality that does not look like other changes on the patient's skin should be treated with suspicion. This is called the 'Ugly Duckling Sign.'[16]

Superficial spreading melanoma

Superficial spreading melanoma normally grows outwards rather than downwards into the skin (Figure 4). It is the most common type of melanoma, accounting for 60% - 70% of cases and is most often seen in fair skinned people aged between 30 - 50 years.[8]

Signs and symptoms[17]

- Flat or slightly elevated, especially as they grow
- Dark brown with different shades, including black, blue or pink
- Asymmetrical with irregular borders
- Greater than 6 mm in diameter

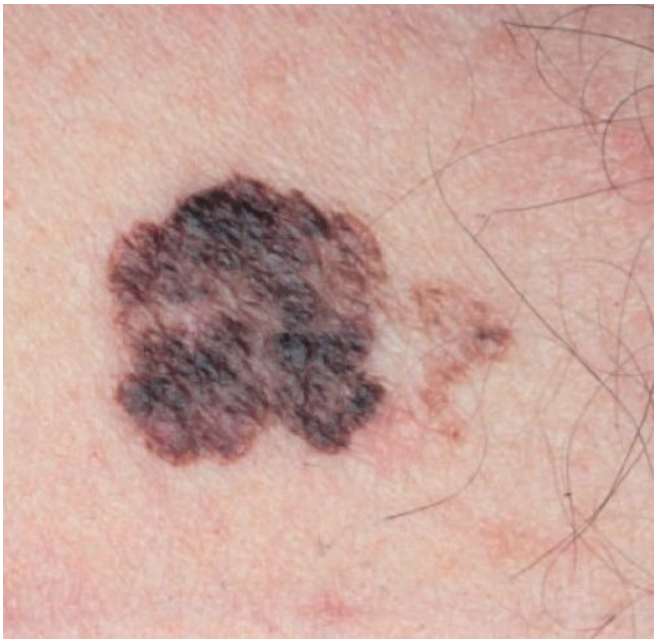

Figure 4: **Superficial spreading malignant melanoma**

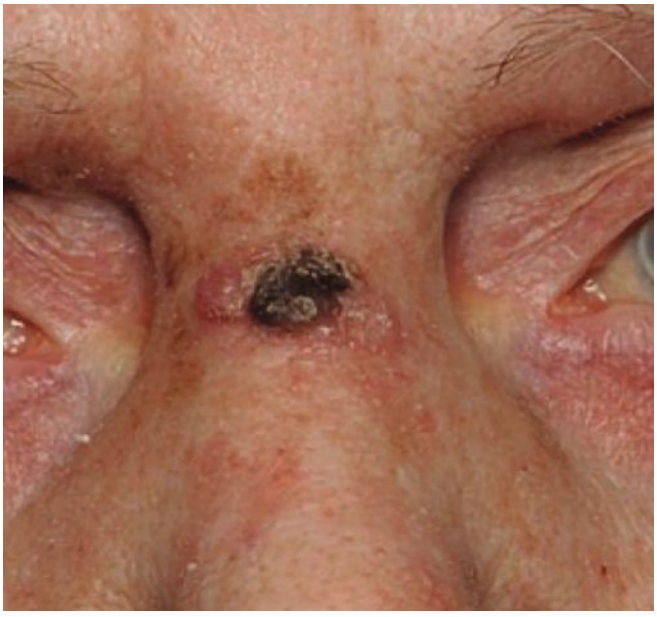

Figure 5: **Nodular malignant melanoma**

Nodular melanoma

Nodular melanoma is the most aggressive and fastest growing form of melanoma which can quickly grow downwards into deep layers of the skin (Figure 5).[1]

Signs and symptoms[8,18]

- Black in colour (occasionally blue-grey in pigmented skin)
- Can also be white, brown, tan, red or skin colour
- Firm
- Raised or elevated
- Bleeding or oozing
- Fast growing

It may be differentiated from other types of melanoma using the EFG rule[19]: **E**levated in nature, **F**irm to touch and **G**rowing.

Lentigo maligna melanoma

Rare in pigmented skin, lentigo maligna melanoma develops from slow-growing, coloured patches of skin called lentigo maligna or Hutchinson's melanotic freckles. If it starts to invade deeper layers of the skin and form lumps (nodules), it becomes lentigo maligna melanoma.[8]

Signs and symptoms

- At least 6mm wide and can grow several centimetres (larger than other forms of melanoma)
- Smooth surface
- Brown patch but can also be pink, red or white
- Rare in black or brown skin

The referral process

It is important not to unduly alarm a patient when a skin abnormality is detected since in the vast majority of cases it will represent a benign condition. However, it is equally important that a specialist opinion is obtained. An explanation of what has been found should be given and the patient advised to see their general medical practitioner (GMP) relatively urgently. The clinician can also back up the need to see the GMP by requesting their patient's doctor's details and writing to them directly. If necessary, the GMP can then refer the patient to a dermatologist using the correct pathway following the National Institute for Health and Care Excellence (NICE) guidelines.[20]

1. **Basal cell carcinoma:** Routine referral should be made unless there is a particular concern about the skin abnormality, such as large size, which would suggest the need for a suspected cancer pathway referral and an appointment to see a dermatologist within two weeks.
2. **Squamous cell carcinoma:** Referral is always made via suspected cancer pathway.
3. **Melanoma:** All patients with suspected melanoma should be seen by a specialist within two weeks of assessment by their GMP.

This suspected cancer pathway should be followed for all pigmented skin lesions scoring three or more against the following weighted checklist:[20]

- Major features of the lesion (scoring two points each):
  - Change in size
  - Irregular shape
  - Irregular colour
- Minor features of the lesions (scoring one point each):
  - Largest diameter 7mm or more
  - Inflammation
  - Oozing
  - Change in sensation

Additionally, all suspected cases of nodular melanoma qualify for a suspected cancer pathway referral.

In the case of suspected skin cancer on the head and neck, then referral to a local oral and maxillofacial (OMFS) department is also an option. The referral should be made using the appropriate OMFS suspected cancer pathway.

Educating patients

All clinicians should make a careful clinical record of the exact location and nature of any detected skin abnormality, taking clinical photographs, if possible. Photography is an extremely helpful way of detecting changes in appearance over time. Any skin change noted should be brought to the patient's attention. Often simply highlighting the abnormality to the patient and garnering their response can be enough to allay any suspicions.

Dental hygienists and therapists have a key role in educating patients about how to avoid potential skin cancer. Whilst the public is more aware than ever before of the danger posed by overexposure to UV radiation, some misconceptions still exist. Particular focus on the use of sunscreens and the danger of sunbeds is vital. For instance, SPF 30 or above needs to be applied at least 30 minutes before sun exposure to offer adequate protection, and sunscreen needs to be re-applied at least every two hours, regardless of marketing claims of all day protection, and always directly after swimming.[21]

Lastly, patients should be encouraged to examine their own bodies for any abnormal area of skin which might not be observed in the dental surgery. Dental care professionals can advise that the best time to do this is before or after a shower or bathing, using a handheld mirror to see hard-to-reach areas. Promoting a skin health message, particularly of the head and neck, should be regarded as an integral component of the provision of holistic dental health care.

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BY KATE AMBER

THE IMPACT ON THE PSYCHOLOGICAL WELLBEING OF A SAMPLE GROUP OF BSDHT MEMBERS PROVIDING CLINICAL CARE DURING THE COVID-19 PANDEMIC

ABSTRACT

Aim

To explore the effect on the psychological wellbeing of a sample of dental hygienist and therapist members of the BSDHT who provided patient care during the COVID-19 pandemic.

Methods

An electronic questionnaire was sent to members of the BSDHT in December 2021 (n=2780). Focused questions allowed for an understanding of an individual's perceptions of anxiety, safety and effectiveness of current coping strategies.

Results

The study population revealed widespread anxiety on returning to work following a national lockdown. Those respondents who felt safer and more supported expressed less anxiety than those who did not have positive experiences of safety and support. The latter group stated that they were more likely to consider leaving the profession. Providing clinical care during the COVID-19 pandemic also had negative effects on relationships outside of work. Furthermore, many respondents felt that current coping strategies aimed at improving psychological wellbeing were inadequate.

Conclusion

Gathering this data and insight will inform knowledge of the psychological wellbeing of the study population and allow for appropriate recommendations to the wider workplace health and safety to be made, if indicated. Recommendations and research implications include improved health and safety within the workplace with a focus on the Health and Safety Executive's management standards for stress.

KEY WORDS

COVID-19, dental hygienists, dental therapists, stress, anxiety

Background

In the year 2020 to 2021, stress, depression or anxiety accounted for 50% of all work-related ill health cases with statistically higher levels noted in healthcare professionals.[1] Dentistry has long been recognised as inherently stressful, with research exploring psychological impacts dating back six decades.[2] Common stressors include: running behind schedule; coping with difficult or uncooperative patients; constant time pressure constraints; and NHS working constraints.[3] The impact of COVID-19 to care provision arguably exacerbated an already stressed workforce.

With obvious cross-infection risks to the workforce,[4] changes to dental care provision were observed on a global scale. The eventual re-opening of dental care within the UK accompanied a major change in dental care provision with the four nations observing new standard operating procedures (SOP) and enhanced infection control. These new SOP and their impact on the workforce were explored by the General Dental Council's (GDC) publication: *The impact of COVID-19 on oral health and dentistry*.[5] The report documented many professionals' concerns including: economic impacts; operating implications; and access to care. Correspondingly, research has shown that changes to clinical care are likely to have increased mental health problems amongst members of the profession[6]: 92% of dentists reported that they felt stressed because of the impacts of COVID-19 on clinical care provision.[7]

Methodology

A questionnaire was piloted on six dental hygienists and therapists and the questions subsequently adjusted in light of their responses. The pilot questionnaire confirmed the need for a qualitative aspect. The adjusted questionnaire was sent with a single email request via the BSDHT administration to all members (n=2780). The survey was

open between Thursday 2nd and Wednesday 15th December 2021. A convenience sample included 43 past students at Bristol Dental Hospital.

Participants were invited to read an information sheet which detailed how their data would be securely managed, the benefits of taking part and contact details of the investigator for any participants requiring further support during the process. Informed consent was requested before answering 15 questions. Data were collected electronically with respondents (n=209) receiving a survey link to Qualtrics XM. The information was anonymised and stored on the University's secure OneDrive system to which only the investigator and supervisor had access in accordance with the Data Protection Act 2018 and General Data Protection Regulation requirements.

Ethics approval was granted by UWE in November 2021.

Analysis took place within IBM SPSS, a statistical package specifically aimed at the social sciences. Data analysis involved two phases of description and interpretation. Whilst quantitative data were described with visuals including graphs, it was then cross tabulated and correlations between categorical variables investigated with Chi Squared analysis. Qualitative responses were thematically arranged providing context to the empirical research.

Figure 1: **General practice was the primary work setting of the majority of respondents.**

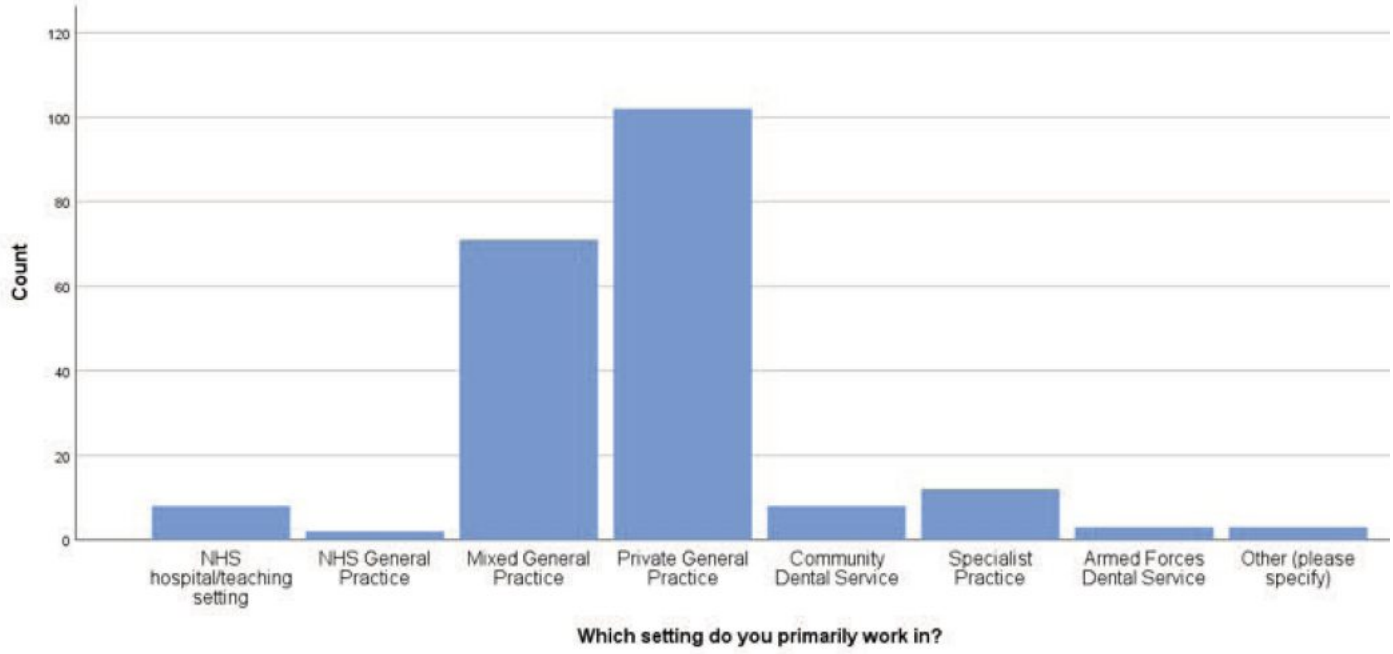
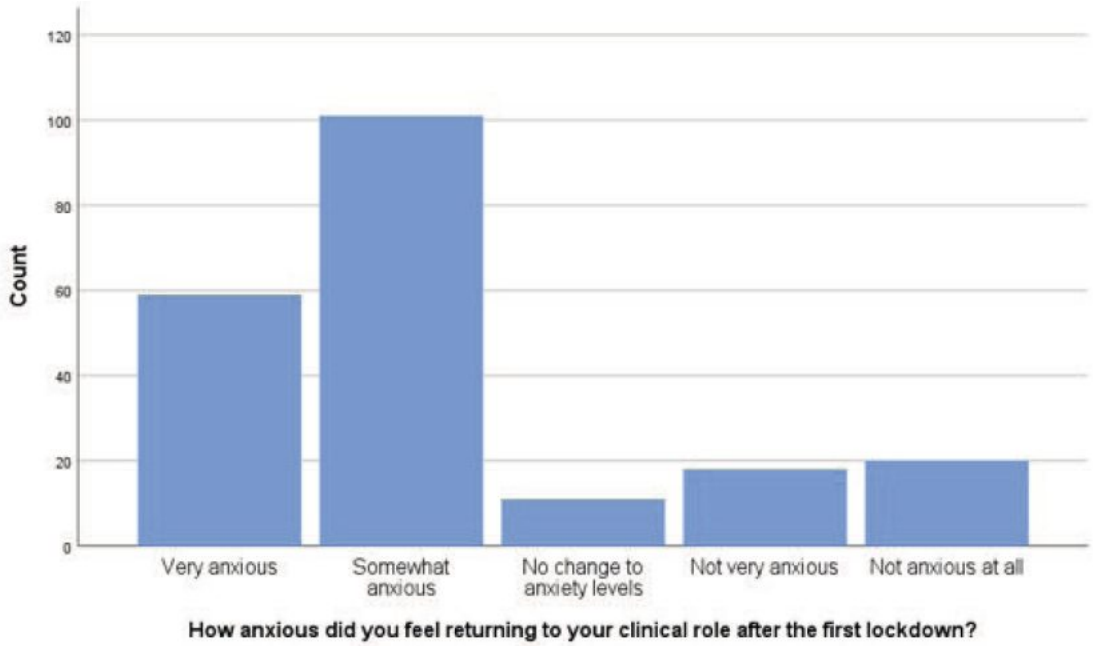


Figure 2: **Following the lifting of lockdown, the vast majority of respondents felt a degree of anxiety in relation to their return to work.**



Results

There were 209 full responses to every question: the responses of participants who had not answered every question were discarded. The main results are presented as infographics below. Although not statistically significant, as less than 10% (n= 278) of the membership responded, the results offer an interesting flavour of this sample of BSDHT members' feelings at that point in time.

Discussion

Variables contributing to a return-to-work anxiety

Higher levels of return-to-work anxiety were found in those from Northern Ireland, the North East and South West England. This aligns with published data that showed an increased infection rate in Northern Ireland around the time

Figure 3: **At the time of the survey, most respondents felt that their anxiety had improved.**

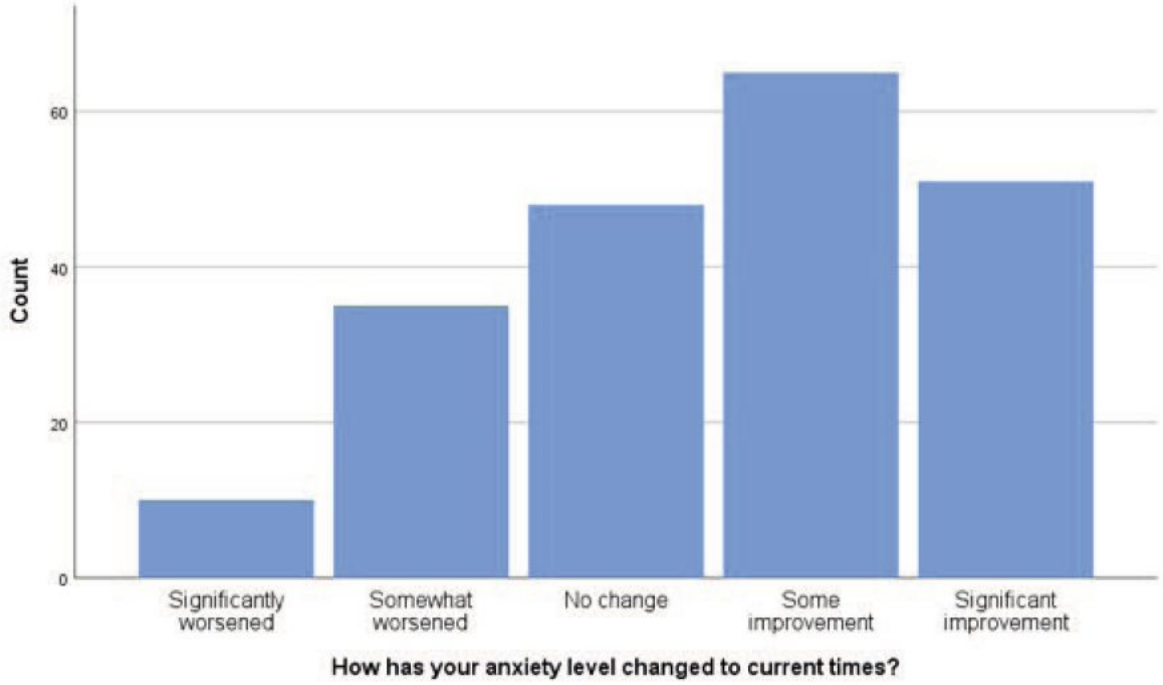


Figure 4: **Encouragingly, the vast majority of respondents felt supported by their place of work during the pandemic.**

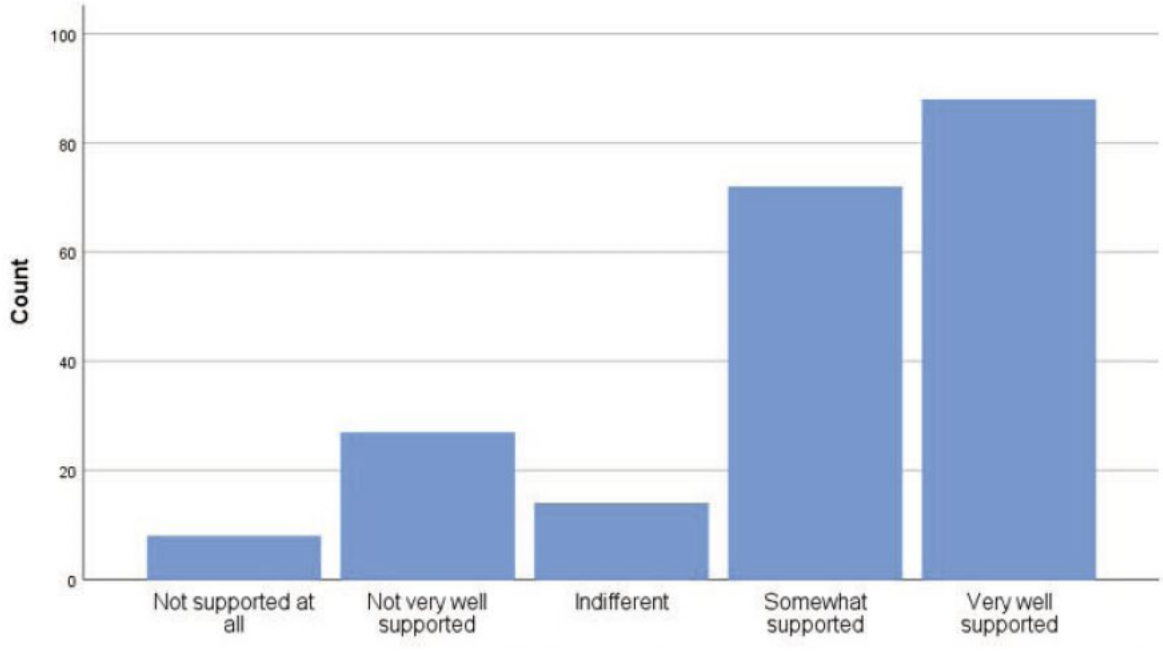


Figure 5: **Reassuringly, the majority of respondents felt safe at work.**

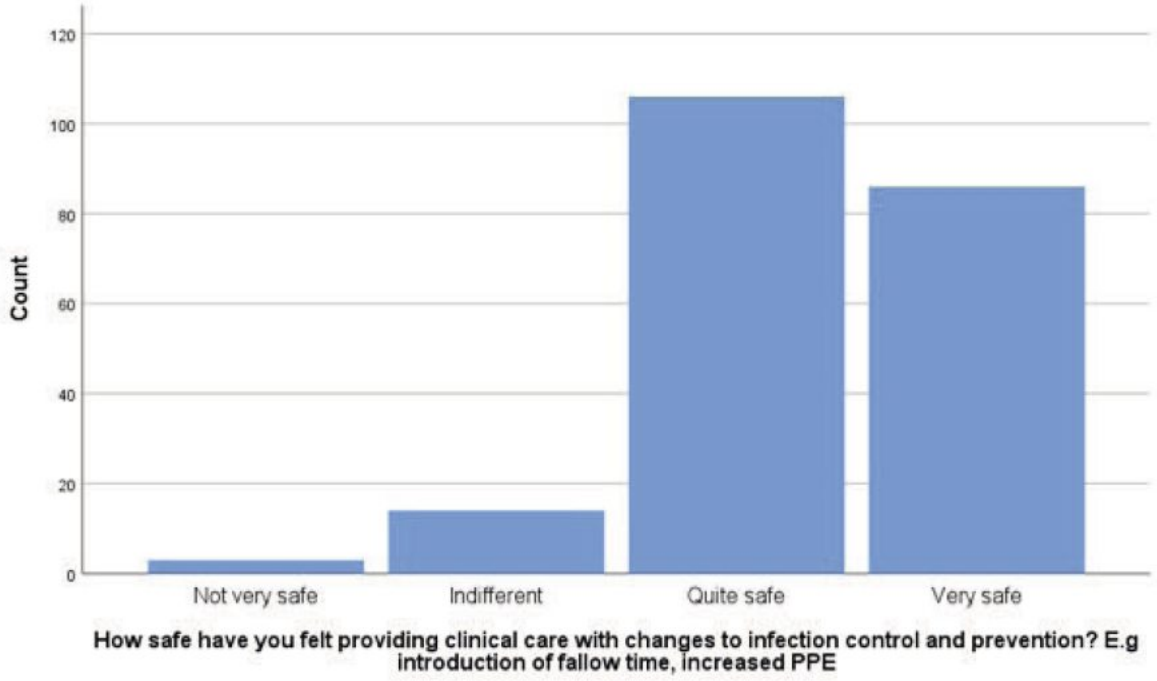
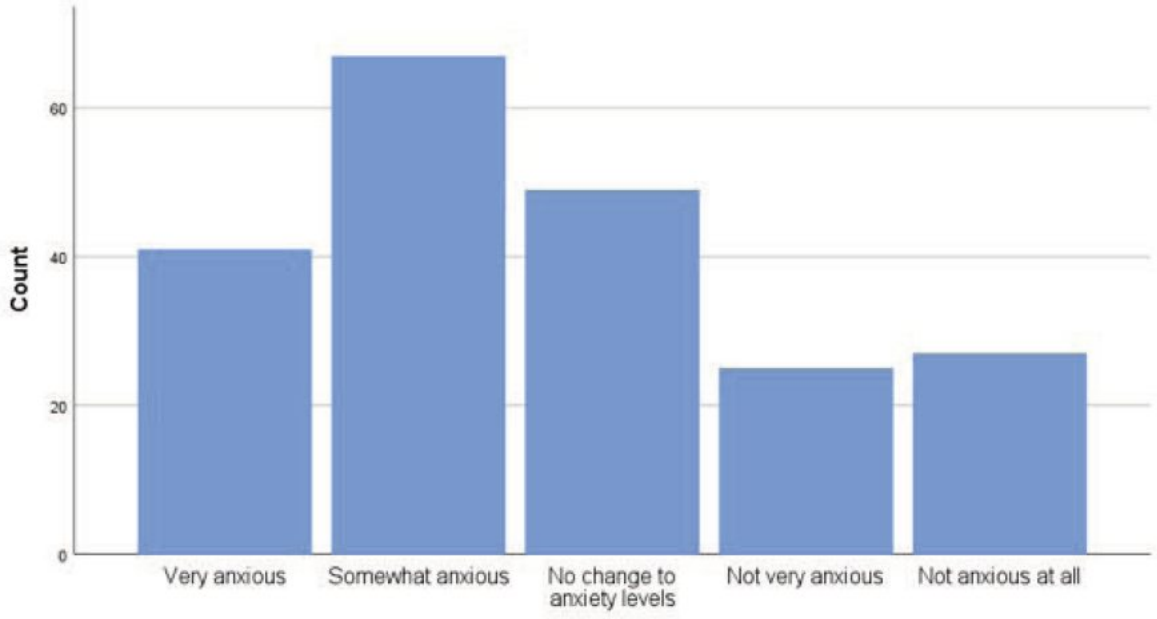


Figure 6: **Respondents' anxiety levels varied in relation to infection and prevention control measures.**



of a phased return to work.[8] It is unclear why respondents from these particular areas of England were more anxious.

Studies have shown that workers with previous experience of public health episodes were likely to be more resilient during the COVID-19 pandemic,[9] whereas younger workers exhibited greater fear whilst providing clinical care.[10] The respondents in this study all reported feeling 'some anxiety'.

Similar proportions of those workers identifying as 'very anxious' were found across different dental settings. A quarter of respondents working in either a mixed practice, private practice, community dental service or specialist practice, felt 'very anxious'. Given that a phased return to work and national guidance were imposed on all of those sectors in England and Scotland, irrespective of working environment, this may account for data similarities.

It has been reported that an individual's COVID-19 infection history attributes a weak association between COVID-19 infection and poorer psychological wellbeing, especially in those over the age of 40.[11] Furthermore, fluctuating wellbeing was felt across England during the pandemic with periods of exacerbation and quiescence.[12,13] Therefore, unpredictable levels of stress and anxiety within the UK are not exclusive to this study population, which may explain dissimilarities and discrepancies between empirical research findings and the wider literature.

Variables contributing to feelings of support

It has been shown that individuals with lower levels of anxiety are more likely to show increased resilience.[14] Respondents who felt supported reported feeling 'less anxious' about a return to work. Feelings of support arose alongside access to resources: personal protective equipment (PPE) was cited as a reason for this.

Nine professionals felt 'very well supported' and were less likely to be planning a career change compared with 36 respondents who felt 'not supported at all'. It has been shown that professionals who intended to leave their role were doing so due to feeling 'undervalued' and 'under too much pressure'.[15] Furthermore, additional pressures on female healthcare workers which may impact on those leaving their roles have also been explored including, 'having to care for older relatives'.[16] Aside from age, medical history or caring duties, intentions to change careers have been widespread and not exclusive to those in dental care provision with more than 25% of surveyed workers planning to change jobs.[17] In which case, to attribute this intention solely to the provision of clinical care during the COVID-19 pandemic may be challenging.

Variables affecting strategy effectiveness

When considering how the perception of strategy effectiveness correlated with experience, the results showed a generalised sway towards apathetic or ineffective. Yet those with greater experience (25 years and more) were more likely to consider coping strategies to be somewhat effective. One such possibility for this increase in considered effectiveness is that those more experienced workers may have a heightened resilience. Additionally, those with greater experience may have a more established peer support network, developed selfcare tactics, greater financial security, increased control over their work or they may hold more senior positions within the profession increasing networking and an expectation to cope.

The study findings suggested that those working longer hours were more likely to consider coping strategies as ineffective. However, one potential cause may be that those respondents with less free time may have less opportunity to partake in suggested strategies. One respondent's perception of strategies included 'yoga' whilst another answered, 'plenty rest at home.' Arguably, those who do work long hours are in greater need of appropriate strategies to reduce stress and anxiety.

Variables impacting relationships

Interestingly, none of the respondents felt that relationships outside of work had improved. Moreover, of those 121 respondents who were feeling 'very anxious' about a return to clinical care, the majority felt relations outside of work had deteriorated.

One such reason for those with greater anxiety suffering deteriorating relations may be based around a concern of transmission. It has been found that clinical staff have shown greater concern for the health of colleagues, family, and friends.[18] Dentists and dental hygienists in committed relationships have previously been found to experience higher self-efficacy and lower anxiety levels.[19] The respondents who reported feeling 'less anxious' and 'more supported' may have attributed this in part to a secure home life.

Research limitations

The study was undertaken in December 2021, eighteen months after most UK nations had introduced a return to practice. It must be noted therefore that the findings are open to recall bias by the participants.

Non-response bias may also potentiate a limitation with those who were either lesser affected or more profoundly affected not taking part in the survey. Additionally, a disproportionate number of responses were obtained from those in the South-West region. Distribution of the survey by the University of Bristol, investigator location and local peers may have influenced this figure.

Confounding factors should also be accounted for. There may be many contributory factors to psychological health status of the study population. Mental health has declined at various points throughout the pandemic, on a national level, therefore differentiating whether psychological wellbeing truly has been influenced by the workplace alone or external factors becomes challenging.

Research implications and recommendations

Further research

Research has shown that poor psychological wellbeing amongst dental care providers working during the COVID-19 pandemic has extended for months.[20] It has been shown that two years after the onset of COVID-19, three-quarters of respondents in one study have gone to work despite not feeling mentally well enough.[21]

HSE collaboration

Given the apparent gaps in health and safety, a collaboration with the HSE is indicated. Under the Health and Safety and Welfare Act 1974 employers have a legal duty of care to protect the health, safety, and welfare of their employees. Self-employed status is commonplace amongst dental hygienists and dental therapists and this was highlighted as an area of concern amongst qualitative text. Respondents who reflected on their self-employment shared experiences of being unsupported. However, the HSE states that employers must still protect '…other people who might be affected by their business'. By proactive engagement from

the HSE, health and safety improvements may produce a more sustainable, heathier, and happier workforce. Such improvements may simply include the adoption of the HSE Management Standards as many of the named six stressors were demonstrated amongst research findings.[22]

Action from organisational bodies and professionals

Within the free text responses, many respondents recalled how online communication had promoted a supportive experience. Similarly, those who had received a poorer support experience identified communication as a tool for improvement. Participants reflected on counselling, webinars, and meetings to improve their coping mechanisms.

Respondents attributed positive experiences of 'support' and 'coping' to chairside assistance with many respondents calling for mandatory nursing support in line with GDC standard 6.2.2: 'You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting'.[23] Therefore, a call to action from organistional bodies to enforce such a standard should improve psychological wellbeing of dental hygienists and dental therapists.

Conclusion

The findings demonstrated a mix of fragility and resilience amongst this sample group providing clinical care during the COVID-19 pandemic. The study found that those who felt more supported and safer were more likely to remain in the profession and has demonstrated that strategies aimed at reducing occupational stress and anxiety are sub-standard. Along with this, the empirical research has shown a gap in workplace health and safety.

The importance of relationships was demonstrated throughout the study. Prior to analysis, the expectation was that respondents who never, or rarely, worked with a fellow dental hygienist or dental therapist peer would be prone to greater anxiety. However, this was not found to be the case. With detail from qualitative data, it was found that all clinicians regardless of role appeared to show similar concerns.

In addition, the importance of PPE and infection control was established during the questionnaire findings as not only a protective factor but one to promote wellbeing. Given that most respondents identified with a positive perception of safety, this may demonstrate faith in PPE and infection control guidelines, both latterly being listed as suitable coping strategies to reduce stress and anxiety.

The study participants, as a majority, experienced a positive degree of support from senior colleagues, thereby again showing the importance of 'teamwork' and 'communication'. Similarly, these two aspects are suggested as methods to improve support perception and coping mechanisms.

Interestingly, even those participants who reported feelings of apathy about coping strategies provided free text responses for improvements. With so many feeling that coping strategies were neither effective nor ineffective, this is perhaps demonstrable of the seemingly accepted stressful nature of dentistry. During a period when sound health and wellbeing seem to be more important than ever before, now may be an opportune time to change and improve the way we work.

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BY CINDY TUER

THE REPORTED EXPERIENCES OF EDUCATORS FROM ONE UK DENTAL INSTITUTE TEACHING UNDERGRADUATE DENTAL STUDENTS REMOTELY ONLINE DURING THE CORONAVIRUS PANDEMIC

ABSTRACT

Aim

To explore the experiences of educators from one UK dental institute teaching undergraduate dental students remotely online during the coronavirus pandemic.

Methods

Between September and December 2021 a small-scale qualitative study was conducted at the University of Central Lancashire (UCLan). A purposeful sample of 50 educators currently teaching dental undergraduate students was invited to take part. Data were collected from an open-ended research questionnaire and one-to-one interviews. Both the data from the questionnaires and interviews were then triangulated to generate a thematic analysis and a report to reflect the participants' lived experiences.

Results

From the 50 participants invited to take part, six consented and completed both the online questionnaire and one-to-one interview. The analysis of the answers to the questionnaire and one-to-one interviews generated a total of five major and one minor theme. They were: time management; flexibility; student participation; emotional well-being; change in teaching practice; and regulatory body preferences.

Conclusion

The educators preferred the remote online teaching and learning environment. Overall, they felt happier and had a better work-life balance. However, they did not consider it a replacement for previous professional practice and preferred a blended approach to the future of dental education.

KEY WORDS

Educators, undergraduate dental students, remote online teaching and learning, coronavirus.

Background

In late 2019 the recently discovered severe acute respiratory syndrome coronavirus (SARS CoV-2) emerged in Wuhan, China and proliferated worldwide with catastrophic consequences.[1] The virus spread rapidly through discharge of the nose or in saliva. Three stages of severity were identified: initial inflammatory markers; pulmonary involvement; and organ failure.[2] Consequently, the World Health Organisation (WHO) proclaimed coronavirus to be a pandemic in the Spring of 2020. A year later, on the 15 February 2022, key statistics reported a total of 418,650,474 recorded cases, inclusive of 5,856,224 deaths.[3] To minimise the number of coronavirus cases worldwide the WHO advised the entire population to regularly wash hands, wear a face mask, get vaccinated and socially distance.[4]

Implications for education and professional practice

The impact of the coronavirus on the delivery of dental education was profound.[5] Traditionally, an effective problem-based learning environment[6] was characterised by shared interactions between educator, student learning, and clinical skills.[7] However, within dentistry the risk of transmission of the virus through an aerosol generating procedure (AGP) remained high.[8] Research identified that in the initial stages of the coronavirus, every single patient could transmit the virus to a further two to four people.[9] Consequently, a decision was made to facilitate remote online teaching within dental schools. At UCLan, the curriculum was modified to include: online video conferencing; podcasts; demonstrations; pre-

recorded lectures; static PowerPoint presentations; and on-site teaching activities using phantom heads.[10]

Rationale

The development of computers and the world wide web have already been shown to positively impact on higher education to establish a collaborative and cooperative learning experience, regardless of distance.[11] Nonetheless, since the outbreak of the pandemic, a study carried out in Pakistan amongst students of both medicine and dentistry identified approximately 77% of medical and dental students had a negative perception toward remote online learning.[12] It was found that students still favoured face-to-face teaching during the lockdown period and did not feel ready for remote online learning. Furthermore, with increased fear of infection and reduced communication[13] little has been reported of the dental educators' own experiences to facilitate an effective remote online learning experience. Consequently, to understand what effective online learning is from the educators' own experiences, may not only enable students to acquire the appropriate knowledge, skills and character to meet the General Dental Council's (GDC) requirements for students to become safe practitioners,[14] but also provide best patient care.

Methodology

A small-scale qualitative study using a phenomenological approach[15] was conducted from September to December 2021. Ethical approval was granted through the UCLan Ethics Committee (HEALTH 0204). Subsequently, a purposeful sampling[16] of 50 UCLan educators who were teaching undergraduate dental students remotely online, were emailed an invitation to participate in the study. Attached to the invitation email was a study information sheet. It was made clear that involvement was voluntary and that the study would be carried out remotely through the Microsoft Teams online collaboration platform. This multiple communication method was chosen for being both flexible and a platform with which the participants would be already familiar.

Written consent from the study participants was obtained and initial data were collected from an open-ended self-reported research questionnaire (Figure 1) which they answered prior to the interview. In addition, an interview schedule was constructed to facilitate the conduction of one-to-one interviews, with a duration of approximately 20 minutes to create a deeper understanding of the educators' teaching experiences. Subsequently, the Braun and Clarke (2006)[17] reflexive thematic analysis was adopted to identify, analyse, and record themes from both the questionnaires and interviews to triangulate and generate a report that accurately reflected the participants' experiences.

Results

The findings were reported in chronological order from commencement of data collection in September 2021 to May 2022 when the narrative ended. Six educators consented to participate in the study and completed both the open-ended questionnaire and the one-to-one interview. Both male and female educators were equally represented with an age range of 41- 64 years. The participants comprised of: one dental therapist; one dental technician; and four dentists with a broad range of teaching experience ranging from one to twenty years. There was no reason given from the remaining 44 participants as to why they chose not to take part.

Open-ended questionnaire

From the six open-ended questionnaires, a total of 15 phrases were identified and generated into five codes: hours affected; positive experiences; negative experiences; impact on students' learning; and change in teaching practice.

One-to-one interview

The interviews lasted between eight and 32 minutes and were conducted, recorded and transcribed verbatim by the investigator. From the six interviews, a total of 235 phrases were identified and generated into 10 codes: positive experiences; negative experiences; benefits; barriers; educators' preferences; educators' expectations; students' feelings; change; future support; and educators' feelings. The interview questions are set out in Figure 2.

Triangulation of the data

In January 2021, the five codes from the open-ended questionnaires were triangulated with the 10 codes from the one-to-one interviews to identify five overarching major and one minor theme.

Major themes

Time management

Questionnaires

Data from the questionnaires showed that four of the six participants reported that their working hours had changed. Their shared view was that these positive experiences were because of *"a change in teaching practice"* and *"better time management."* Participant 1 reported: "*saving time" had been a "positive experience" with a "better work-life balance."*

One-to-one interviews

Responses in the interviews provided deeper insight and communicated a more holistic[16] picture of the participants' experiences. Participant 1 discussed this

Figure 1: **Open-ended questionnaire**

1. Have you been teaching remotely online since the outbreak of the coronavirus pandemic in the United Kingdom?

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2. Have the hours that you teach been affected by remote online teaching? If yes, please provide details.

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3. Have you had any positive experiences? If yes, please provide details.

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4. Have you had any negative experiences? If yes, please provide details.

.....
.....
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5. Have your current experiences of remote online teaching and learning changed your teaching strategies? If yes, please provide details.

.....
.....
.....

6. Do you feel the need for further training in information and communication technology to facilitate the move to remote online teaching and learning?

.....
.....

7. Have your experiences of remote online teaching and learning changed since the reopening of universities? If yes, please provide details.

.....
.....

8. Do you feel the move to remote online teaching and learning has influenced your teaching practice? If yes, please provide details.

.....
.....

9. Has the move to remote online learning had a positive or negative impact on your current teaching practice and if so, how?

.....
.....

10. Do you feel that the current remote online teaching and learning has had a positive or negative impact on your students and if so, how?

.....
.....

Figure 2: **Interview schedule - questions asked to the participants in the one-to-one interviews**

QUESTIONS

1. Do you feel the move to remote online teaching and learning impacted on the hours that you teach?
2. Has managing the work life balance with remote online teaching and learning been stressful for you?
3. Have you needed to undertake or wish to undertake any further training to facilitate this new learning environment?
4. Do you feel any of your students may have had the need to undertake any further training?
5. Do you feel this relatively new teaching environment encourages or discourages student interaction?
6. Do you think this experience has created more of a student-centred approach to education?
7. Has the move to remote online teaching influenced your own teaching practice?
8. Do you think it is the technology that has changed your teaching practice rather than the knowledge base?
9. Do you have any future concerns regarding the delivery of teaching and learning within this remote educational environment?
10. If you could make any changes, what would they be?

positive experience: *"I think I'm saving quite a bit of time there, I'm happy with the timing so I can do other things. I have more time for the extra bits that you usually do when you get in at 7:30 / 8 o'clock."* Additionally, concerns were raised regarding the: *"...time spent and risk management of unnecessary travel to work."*

Flexibility

Questionnaires

The key words and phrases recorded from the questionnaires were "accessibility" and "less travel." Participant 6 noted that the flexibility of remote online teaching enabled: *"a wider range of resource platforms, developing outside of the box of thinking of how to deliver."*

One-to-one interviews

Participants discussed their positive experiences with regard to the flexibility of the remote online teaching and learning environment. Participant 6 elaborated on the questionnaire

and gave an example of how they could use the flexibility of the online platform Teams to share the students work and actively engage with them to: *"show them where they were going wrong."* As a result, they felt that: *"it worked really well and it is great for increased communication and student collaboration."*

Student participation

Questionnaires

From the responses, only two participants reported their experiences. Participant 3 noted that it was: "neither a positive nor negative" experience, *"The students didn't turn on their cameras, so it was hard to assess engagement or understanding."* Additionally, participant 4 reported: "lack of student interaction" and would therefore *"flip the lecture"* in future.

One-to-one interviews

All participants discussed: *"active student participation."* While the educators were seen as the facilitators of the learning process, the students themselves actively engaged with the technological learning material. Participant 5 felt pre-recorded lectures enabled the quieter students to participate: *"I get the feeling students don't like speaking so easily on a virtual platform. So, where its being recorded people are more confident to speak out."* Not all students turned on their cameras, which created a barrier with communication.

Emotional well-being

Questionnaires

From the questionnaires, only two participants reported on emotional well-being. Participant 1 reported a positive experience and now had: *"a better work-life balance."* Additionally, participant 5 noted that the current remote online teaching and learning environment had also: *"positively impacted on the students' emotional well-being."*

One-to-one interviews

The participants suggested that the remote online teaching environment had a positive impact on both the educators and students' emotional well-being. Participant 3 felt: *"happier"* as they no longer had the *"bundle race"*. Initially, participant 2 felt: *"awkward"* teaching students *"with all their worldly goods in the background"* but had *"got used to it and got over it."*

Change in teaching practice

Questionnaires

Participants in the study were equally divided as to whether or not their teaching practice had solely changed because of the move to remote online teaching and learning. Participant 1 noted that they were now: *"more likely to teach one-to-one"*, whereas participant 2 reported: *"clinical cases are clinical cases whether on-line or in a face-to-face tutorial."*

One-to-one interviews

The consensus of all participants across the different fields was that they preferred a blended approach to the future of teaching and learning. Participant 2 felt that: *"we need to hang on to some of the positive experiences."* All participants commented that the future of dental education should include face-to-face teaching, integrated with online technology. Participant 5 commented on: *"cost being a potential barrier"* for the students and that they were *"not familiar"* with all *"software"* packages and *"would require future support."*

Minor theme

Regulatory body preferences, although minor, was considered to be significant and was therefore included in the study.

From the questionnaires, participant 2 reported: *"Abiding by the GDPR* (General Data Protection Guidelines[18]) *… to circulate cases online"* had *"influenced their teaching practice."* Whereas, from the one-to-one interview, participant 2 discussed regulatory body preferences' in more detail: *"If sending out a case report for the students to work through, I had to be very careful that I cropped all the radiographs to take the patient's name out of the top of it but left the relevant information so, it could all be anonymised."*

Additionally, participant 2 raised concerns regarding students': *"competencies"* and the reluctance of the National Health Service to return to "*how things were*" pre COVID-19: *"I think we've probably got another academic year where students are going to be having reduced clinical experience."*

Discussion

It is of interest that although the participants worked the same number of hours, time management and flexibility were the most positive experiences. Although loss of clinical sessions was perceived as a *"future concern"* for competency development, all participants had successfully adapted their teaching practice to include case-based scenarios, phantom heads or quizzes to better support their students remotely. Albeit this was outside of their normal working hours, they did not feel *"under pressure."* This supports the findings of previous research[11] on how time management and flexibility can positively impact on higher education by helping both students and educators to free up time within a busy schedule. As a result, the participants generally felt happier with a better work-life balance that not only supported the undergraduate dental students but also their own emotional well-being.

Although student participation and attendance were found to have increased, not all students switched on their cameras. Even if the reason may have been because of a weak internet connection, all the participants from this study perceived this as a barrier to developing effective communication.

Additionally, although the participants had access to training at the university to overcome the newly appointed technological infrastructure, often family members were asked instead for additional support.

On reflection, the participants' experiences may have been better supported through structured peer mentoring. Research[19] has shown peer mentoring to successfully

support undergraduate dental students reach their personal and professional developmental goals since the outbreak of the coronavirus pandemic. It could be argued that the participants from this study may have benefited from the same developmental support. As a result, this study identified the importance for future research to focus on teachers' and participants' own learning preferences to utilise online technological platforms to support the remote online teaching and learning environment.

Limitations

A limitation to this study is the low response rate which was part of a dissertation for a MSc in Dental Education. Additionally, there was only one investigator who was also coder and author. Intercoder reliability has been previously shown to improve transparency of the coding and trustworthiness of the analysis process.[20]

Conclusion

Prior to the coronavirus pandemic, 12 years earlier an opinion paper identified the constant threat of opportunistic pathogens. The authors highlighted the importance of establishing suitably qualified faculties with sufficient resources within remote online learning in dentistry.[21] However, recent literature suggests little has changed within dental education. The authors concluded the sudden paradigm shift from traditional teaching and learning methods did not allow sufficient time for adaption.[22]

The findings from this study support these views and showed the participants felt unprepared for the sudden move to remote online teaching and *"learnt as they went along".* Although the participants preferred remote online teaching, they did not consider it to be a replacement for previous professional practice and discussed their preference to change to a blended approach to the learning environment. Some had already embraced this change in academic practice and had introduced different teaching strategies using phantom heads and resumed face-to-face contact with their students.

This approach might better support the participants to not only meet their own professional standards[23] but also their students' needs to practice as safe beginners.[24]

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Author: Cindy is a dental hygienist who graduated from The Royal London Auxiliary School in 1996 when she was awarded the Old Londoner's Prize. She has a keen interest in teaching and has continued her studies obtaining her BSc in dental studies with first class honours. Most recently Cindy completed her MSc in dental education with distinction.

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CLINICAL QUIZ

Perioral Dermatitis

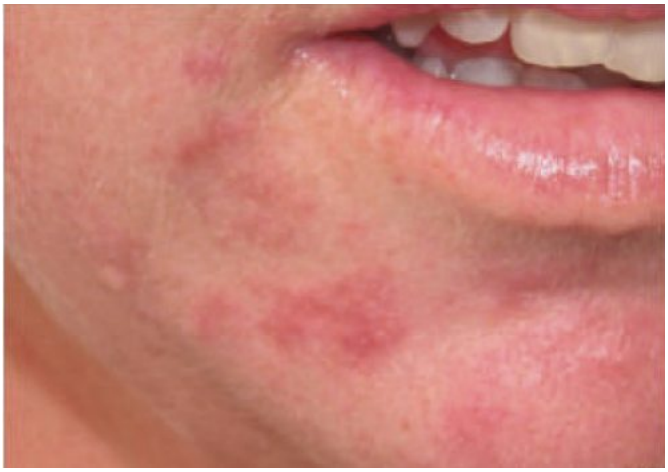
Perioral dermatitis is an acne-like condition that typically occurs around the mouth, nose, and/or around the eyes (also known as periorbital dermatitis).

The rash often looks like small, red, acne-like breakouts in people with light coloured skin and skin-coloured breakouts in people who have skin of colour.

The exact cause, and triggers, of this condition vary and include the use of certain cosmetic products.

Q1. What commonly used oral hygiene product is thought to trigger perioral dermatitis?

Q2. What ingredients in oral hygiene products are thought to be the main triggers of this condition?



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SEND YOUR ANSWERS TO THE EDITOR BY 31TH JULY. PLEASE INCLUDE YOUR ADDRESS.

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

ANSWERS TO CLINICAL QUIZ MAY 2023

The winner is: **Michelle Glover (student dental therapist)**

Q1. What type of bacteria are spirochaetes?

A1. Strict anaerobes.

Q2. What is the diagnosis?

A2. Necrotising gingivitis.

Q3. What antimicrobial agent should be prescribed?

A3. Metronidazole .

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AUTUMN 2023 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 14th October 2023	Huntingdon Marriott Hotel, Hinchingbrooke Business Park Kingfisher Way, Huntingdon PE29 6FL	Nancy Gieson	easternsecretary@bsdht.org.uk
London	Thurs, 14th September 2023 (17:30-21:15)	BDA Offices, 64 Wimpole Street, London W1	Simona Kilioke	londonsecretary@bsdht.org.uk
Midlands	Sat, 23rd September 2023	Bragborough Hall Braunston, Daventry, NN11 7JG	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	TBC	TBC	Julie Rosse	northeastsecretary@bsdht.org.uk
North West	TBC	TBC	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	Tues, 19th September 2023 (18:30 - 21:30)	Marlborough Clinic Belfast, 1 Marlborough Park, Belfast, BT9 6XS	Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	Tues, 26th September 2023	ONLINE AGM + guest speaker Barbara Lamb	Ana Malove	scottishsecretary@bsdht.org.uk
South East	Sat, 30th September 2023	TBC	Sam Davidson (Acting)	southeastsecretary@bsdht.org.uk
Southern		No event - OHC instead	Ellie-May Ayling	southernsecretary@bsdht.org.uk
South West & South Wales	Sat, 7th October 2023	TBC	Alison Trinh	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 7th October 2023	Crown Plaza Hotel, Plymouth	Lauren Binns	southwestsecretary@bsdht.org.uk
Thames Valley	Sat, 16th September 2023	Small group HANDS On - details TBC - W&H Offices, St Albans NO Trade	Vacant	thamesvalleysecretary@bsdht.org.uk

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Rachel White
Dental Hygienist,
Stoke-Bishop Dental Centre

Prophy-Mate neo

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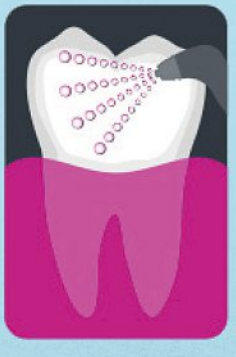

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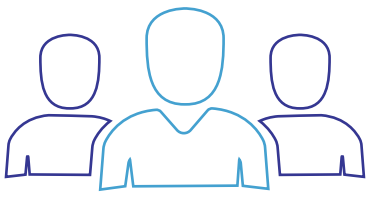
DO YOUR PATIENTS REALISE THEY HAVE **DENTINE HYPERSENSITIVITY?**

DO YOUR PATIENTS AVOID HOT OR COLD FOOD, CHEW ONLY ON ONE SIDE, OR COVER THEIR MOUTH ON COLD DAYS?
THEY MAY NOT EVEN REALISE THEY HAVE A PROBLEM.

A SIMPLE PROBLEM

1 in 3 adults suffer from dentine hypersensitivity.[1] However, they may dismiss or attempt to rationalise the behaviours they've had to change to avoid twinges.[2]



A SIMPLE CONVERSATION

As a dental health professional, **you have the opportunity to talk to your patients** and help them recognise the problem.[3]

A SIMPLE SOLUTION

Scan the QR code to go to our Psychology of Sensitivity page. Here you will learn more about the ways patients deal with sensitivity, and find a free questionnaire you can use to help them understand their condition.

References:
1. Addy M. Int Dent J 2002; 52:367–375.
2. Gibson B, *et al.* The everyday impact of dentine sensitivity: personal and functional aspects. In: Robinson PG, editors. Dentine hypersensitivity: Developing a person-centred approach to oral health. London: Elsevier Inc, 2015, Chapter 6.
3. Communicating with Patients. Pocket Dentistry. Available at: https://pocketdentistry.com/communicating-with-patients/

SENSODYNE HALEON