DENTAL HEALTH

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

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

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GUEST EDITORIAL

25 years of Google, 75 years of BSDHT and 3.5 billion people…

Sergey Brin and Larry Page met in Stanford University's computer science programme in the late '90s. Together they quickly learned they shared a similar vision: to make the World Wide Web a more accessible place. On September 27, 1998, Google Inc. was officially born. Think how much has changed since 1998 societally and in the world of technology overall. However, through that change, the mission of Google has remained the same: to organize the world's information and make it universally accessible and useful. Billions of people from all over the globe use Google to search, connect, work, play, and so much more. And don't we know it, as I shout at my smart speaker to tell me the News headlines!

As we approach the 75th year of our organisation, I believe it is also a chance to reflect on what has been done and achieved in the last 75 years. It is a time to celebrate the successes of those dedicated members who have given so much to the profession. However, it is also critical to look towards the future asking ourselves what the next 75 years looks like and where we as a profession will stand. We need to consider what technology will be supporting us in our roles and with what information our patients will be armed when they make their routine dental visits. Similar to Sergey Brin and Larry Page, but arguably more so than ever, there is a requirement for a shared vision across the dental profession. Henry Ford once said, 'Coming together is a beginning; keeping together is progress; working together is success.'

The World Health Organisation in its recent Global Oral Health Action Plan (2023-2030) talks of a strategic objective/target to have an Innovative workforce model for oral health. The existence of an operational national health workforce strategy that includes a workforce trained to respond to population oral health needs.

What are those population needs, today, tomorrow and 75 years from now? In fact, what are the workforce needs of today, tomorrow and 75 years from now?

As I sit here today reflecting on the untold level of achievement by the world's largest technology companies, I am conscious that never have we lived in a world of such extremes. There is a huge dichotomy of oral health needs. The industrialised world is hanging off the next iteration of the smart phone, with capabilities beyond that of its everyday users but at some point, soon, will be an integral part of millions of people's daily oral health routine if it isn't already. Yet 3.5 billion people worldwide are still suffering from oral diseases and conditions, all of which could be preventable.

Toothbrushing is still not a daily practice of the entire global population. These combined conditions have an estimated global prevalence of 45%, which is higher than the prevalence of any other noncommunicable diseases. Noncommunicable diseases (NCDs), such as heart disease, cancer, chronic respiratory disease and diabetes, are the leading cause of death worldwide and represent an emerging global health threat. And we as a profession know that when you receive fluoride toothpaste twice a day, every day of your life, the reduction in dental diseases such as dental caries is significant.

So, as we come toward the OHC 2023 where we can be together as a society, I as a dental healthcare professional, we as a profession, the 'creators' of the innovative workforce model for oral health of the future, and BSDHT should all be in the same boat. Each of us needs to pick up an oar because rowing individually sees you going round in circles, but mass movement together will create true motion. Motion that can effect change, no matter how big or how small and not just here in the UK, but globally.

Alastair Lomax

Alastair Lomax is a medical affairs director with Haleon. He holds a degree in psychology and is a dental hygienist and therapist. He has worked at the Eastman Dental Hospital, NHS dental services and private practice. He transitioned into industry holding several roles in the medical affairs, education and clinical research disciplines. Alastair is a member of BSDHT publications team.

FROM THE PRESIDENT

BY MIRANDA STEEPLES

The year has flown by since our OHC in Manchester. I am delighted to report that registration numbers for this year's OHC have already surpassed those for 2022 but there is still time to secure your place. Join us at OHC2023 in Bournemouth where we will be 'All in the same boat'.

The AGM will be held at conference this year, face-to-face, and we will be looking to welcome a new Honorary Secretary, and ratifying other BSDHT Council members such as: the Regional Group Representatives; the Coaching and Mentoring Representative; the Student Representative Co-ordinator; and 3 new Elected Members to Council. I am excited to see who will be joining the team for the forthcoming year.

At our last AGM, we welcomed a new group of people to the Executive Team and further new additions in January at the Council meeting. I would like to thank my excellent Council members for their support this year, and especially those who will still be in post for 2024, with particular thanks to Sarah Murray for stepping in as Acting Honorary Secretary.

Our Working and Advisory Groups are still going strong and, in the future, I hope to welcome a representative from each of these groups to a position on the BSDHT Council. The Regional Groups are a way of engaging with your Society at local level and I am grateful to all those who volunteer their time with the groups, and with other activities within the Society – we could not do it without you! Another indispensable team is at Head Office - Selina, Louisa and Tracey, all led by Sharon - they are all brilliantly talented in their fields and we could not run as we do without them.

The last 12 months have been busy with the day-to-day business of the Society; our regular Executive and Council meetings, the webinars we host, the Regional Group study days, and our new venture, 'Refresh and Refine', which was very well-received. There will be more of these to come, so if you have ideas for a topic you would like to see covered, or a venue where we could host such an event, do please get in touch.

BSDHT works with other stakeholder groups in the UK, either within or overseeing dentistry, to ensure that dental hygiene and dental therapy stay at the forefront of discussions. We maintain close relationships with other UK dental organisations to support this and ensure our work is aligned. We maintain a presence at trade shows and conferences, we submit speakers to present on our behalf: all of this we do across the four nations. BSDHT continues to be YOUR voice at these meetings and when responding to consultations. We are stronger together with one voice, and without you, our members, we would have limited strength and reduced purpose. Thank YOU for your continued support.

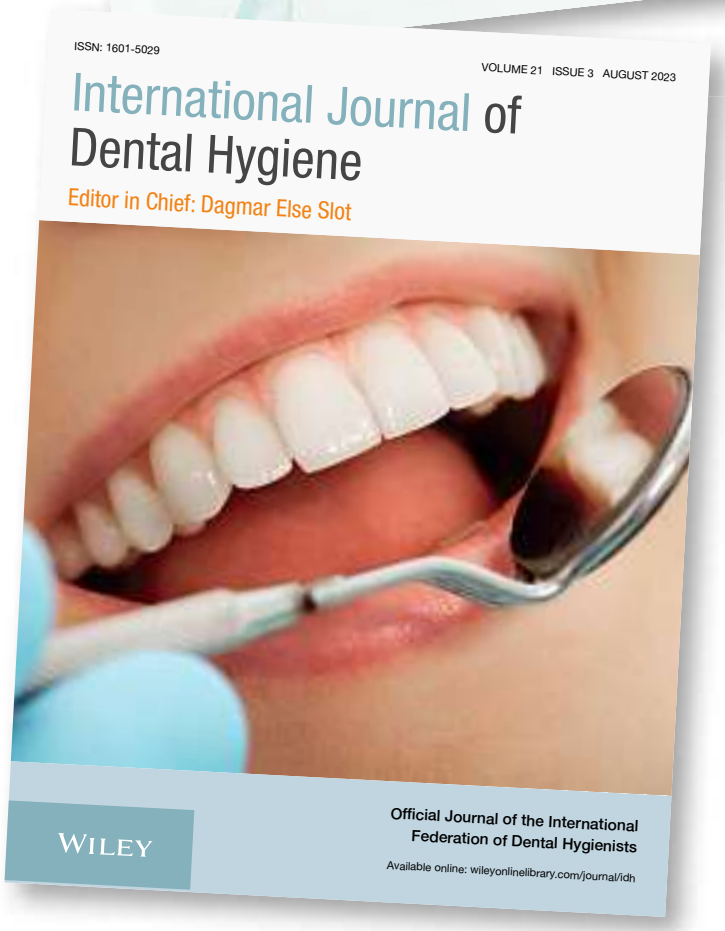
As the Society goes from strength to strength, we look forward to celebrating 75 years since our inception as the British Dental Hygienists' Association (BDHA). Our birthday party will be in London on 6 July 2024 and details will be available soon as to how you can secure a place. I hope that there will be an event to mark this day in each of the four nations. As part of the celebratory year, I would like to have 75 trees planted in various locations in the name of BSDHT as a way of marking the magnitude of our achievement and of ensuring a positive legacy.

Additionally, I would like each Regional Group, and the members within the region, to commit to 75 hours of voluntary work within their communities. This does not need to be dentally related, and I am aware that many members already offer their time in this way. The idea behind this is to raise the profile of the BSDHT and of our professions, to those outside of dentistry, and to demonstrate that there is so much more to us than just teeth and gums! Of course, this will also spread goodwill and good deeds throughout the country during our year of celebration.

Looking ahead to the OHC in Bournemouth, I am delighted to be presenting the prize for our very first Member of the Year competition, alongside our Student of the Year, the Poster Prize winners, and the Gerald Leatherman award. Encouraging our members to excel personally and professionally should be acknowledged, and excellence rewarded. These awards are a highlight of the OHC each year and I am very much looking forward to seeing you there.

This is the last Dental Health for 2023 and I would like to thank you once again for your ongoing support of the Society, to wish you and your loved ones well for the new year, and I will look forward to taking BSDHT onwards and upwards with you all by my side.

CALL FOR **PAPERS**



Dear Colleagues,

In 2024 the British Society of Dental Hygiene and Therapy (BSDHT), originally the British Dental Hygienists' Association (BDHA), will celebrate its 75th anniversary. The editors of the **Annual Clinical Journal of Dental Health** (*ACJ*) and the **International Journal of Dental Hygiene** (*IJDH*), Heather Lewis and Dagmar Else Slot, are delighted to announce a collaboration to produce combined issues of the journals to showcase the scientific advances made within the dental profession by UK dental hygienists and dental therapists.

The special anniversary issues will be of direct interest to all oral health care providers since they will highlight the growth and development of our profession.

Submission Guidelines

Research reports with a structured methodology should be submitted for consideration. Submissions must support the general aims of the *ACJ* or the *IJDH* and at least one of the authors must be a dental hygienist or dental therapist based, affiliated or trained in the United Kingdom. Submitted manuscripts will be subject to peer-review. All accepted papers will be published in the November 2024 issues of both journals.

How to Submit

- All papers must be submitted through the **Wiley manuscript processing platform for the IJDH**.
- Authors should follow the **submission guidelines for the IJDH journal**
- Adjustments to conform to the *ACJ* style guidelines will be made if the manuscript is accepted for publication.
- Authors should include a statement in their cover letter that their paper is being submitted for consideration for inclusion in the special issue to celebrate 75 years of the BDHA and the BSDHT.

The deadline for submissions is **1st March 2024.**

Please contact Heather Lewis regarding the logistics in the first instance. (**editor@bsdht.org.uk**)

Questions regarding submissions should be directed to Heather Lewis (**editor@bsdht.org.uk**) or Dagmar Else Slot (**d.slot@acta.nl**)

We look forward to working with you to highlight this celebration of 75 years of our professional organisations.

Heather Lewis RDH, BA (Hons)
Dagmar Else Slot RDH, PhD

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GETTING INTO RESEARCH

BY SUSAN BISSETT

Interested in research? Don't know where to start? Then listen to this podcast by an inspirational fellow dental hygienist: Oral & Dental Research - Podcast Series - Newcastle School of Dental Sciences.

I am passionate about career development for dental hygienists and dental therapists, and I am frequently invited to talk about career opportunities that involve research. I qualified as a dental hygienist in 1994 and worked in dental practice and Newcastle Dental Hospital for many years, before starting my career in research in 2009. I began by being employed on a fixed term contract to provide periodontal care for patients enrolled on a clinical research study; and then later I became the manager of a Dental Clinical Research Facility, that was newly built in the Dental Hospital. Consequently, I have worked with many researchers, ranging from those just starting out with their first research project, to experienced professors running multicentre trials.

Research is not for everybody. There are those who dip their toe into research and don't like it, but I love the variety! Research is a step into the unknown. It starts with a hypothesis or question, and quantitative (numbers) or qualitative (words) methods are used to gather data that are analysed, interpreted and brought together in a discussion. An academic writing style is used to present the findings in scientific meetings, conferences or journals, and whilst that is entirely appropriate, it does not allow us to hear of the trials and tribulations of day-to-day research.

When I was studying for my Masters and PhD, I was frequently visited by imposter syndrome. At times I felt very uncomfortable with what I was doing, fearing that I would fail, and feeling like I did not belong. Often this was based on assumptions about those around me: assumptions that they were intellectually more capable than I was.

The idea for the podcasts came from my love of listening to people talking about their lives, and my curiosity to know more about the untold life of a researcher. The official aim of the podcasts is to showcase the variety of research conducted at our dental school, and to enable networking and knowledge mobilisation; but I also wanted to support early career researchers, by letting them see the person behind the research and be inspired by their story.

I try to keep the podcast content varied, so I speak to researchers at different stages of their career, and we discuss a variety of topics. For example, there is Zella who talks about her study looking at the effects of novel nicotine products on oral cells and tissues; but she also shares her experiences of finding a way to balance the demands of studying and conducting her research in order to maintain health and wellbeing. One of my favourites is a conversation with Lydia Austin, a dental therapist, who completed a foundation training research module at Newcastle University and went on to take up a Fellowship with Health Education England, North-East and Cumbria.

The podcasts are available to listen to via:
https://podcasts.ncl.ac.uk/oralanddentalresearch/

I hope you enjoy listening to them, and maybe find inspiration to consider different opportunities for your own career development.

Author: Dr Susan Bissett PhD, MClinRes, AdDipFET, DipDH is an academic dental hygienist working full time as a Lecturer at Newcastle School of Dental Sciences, where she is involved in both teaching and research. She is Deputy Degree Programme Director for the BSc in Oral & Dental Health Sciences (dental therapy course) and she is the National Institute for Health Research (NIHR) Oral & Dental Specialty Group lead for the North East and Cumbria region. Her research interests are in health screening in dental settings; interprofessional collaboration for conditions that crosscut medicine and dentistry; and the development and implementation of interventions to improve oral and systemic health. She is also a member of the BSDHT editorial board.

Contact: s.m.bissett@ncl.ac.uk

READERS FORUM

ANN SCHOFIELD (née ROUND)

It has come to our attention that Ann Schofield (née Round) (President of BDHA 1976-1978) has recently had health problems and is now in residential care in Brighton. We send her our very best wishes.

Should anyone wish to write direct to Ann, I have an address for her nephew who will pass on any post to her or alternatively you can contact Elizabeth Riding, one of our Past Presidents, who is in touch with Ann: email **elizabethriding789@btinternet.com**

Patricia Macpherson
email: pubs@bsdht.org.uk

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"First Smiles CLASS

Clare Payne visited
DRINGHOUSES PRIMARY SCHOOL (YORK)

Christina Pope visited
MODBURY PRE-SCHOOL (SOUTH DEVON)

Katy Bennett visited
EMMER GREEN PRE-SCHOOL (READING)

BSDHT

Jo Martin visited
TITHE BARN PRE-SCHOOL (CHELTENHAM)

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Campaign" OF 2023

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First Smiles

Improving oral health for children everywhere

in partnership with Oral-B

Laura Wilson visited HOLY TRINITY PRIMARY (HAYWARDS HEATH)

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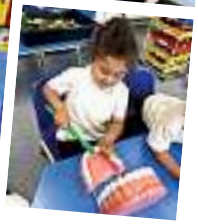
Ruth Morrison visited FANE STREET PRIMARY SCHOOL (BELFAST)

Toyin Akala visited ST. JOHN OF JERUSALEM PRIMARY SCHOOL (LONDON)



BSDHT REFRESH AND REFINE 2023

BY DIANE ROCHFORD

Last summer, BSDHT held the first of its innovative Refresh and Refine educational events in Edinburgh and Bristol.

Recognising the steady decline in members attending regional group study days, despite the teams' best efforts, Miranda Steeples and I, in our respective roles at the time as President Elect and President, had discussed alternative options to providing our members with quality BSDHT continuing education, in line with the Society's strategic plan.

Taking on board members' feedback from those attending regional group study days, and the Oral Health Conferences, we produced a plan that combined theory and hands-on sessions for members to update their knowledge and clinical skills.

The timing of the amendments to the *NHS Dental Contract*, announced by NHS England in July 2022 - which included dental hygienists and dental therapists working to their full scope of practice, with the ability to open a course of treatment - meant that this educational opportunity was timely. These changes formed the theme for these first two *Refresh and Refine* events.

The format

BSDHT Vice President, Nishma Sharma, presented a pre-recorded webinar on oral health assessments, diagnosing and oral care planning (within scope), which the delegates watched in advance of the face-to-face event. The presenters of the hands-on sessions created and shared short theory webinars to support and prepare delegates for the hands-on aspects. These pre-records were sent to delegates during the week leading up to the event and were available for a week following the event.

Delegates had the opportunity to practise four out of the five skills they had pre-booked. They were assigned a group dependent on which of the skills they had chosen and followed a rotation format, moving from table to table. Skills on offer were: dental dam placement; placing and polishing anterior composite restorations; temporary dressings; re-cementing crowns temporarily; applying fissure sealants; and impression taking. The sessions lasted 45 minutes, with a 15-minute break for the delegates, while the presenters and helpers cleared and prepared the tables for the next session.

The events were a hive of activity as each group, listened, learned, discussed and practised their chosen skills, all of which was reflected in the feedback gathered before CPD certificates were issued. Overall, the feedback was positive, with many describing how *'this was a fun and social event as well as being informative'* and that the small groups gave it a *'very personal feel.'* Some members felt that they left feeling more confident in their abilities and that these events were so timely and necessary!

One member wrote before the event to say: *'I just wanted to say how much I'm enjoying this format for the refresh course. I like the videos being sent in advance to be watched when it is convenient. Thank you.'*

Our supporters

What started as an idea Miranda and

I had last summer, came to fruition with the help and support of many. We could not have wished for two better events, with a wonderful team of presenters: Avijit Banerjee; Amanda Gallie; James Hyde; Edward Longbottom; Petros Mylonas; Melody Schwartz; and Nishma Sharma.

The events were generously supported by the teams at FMC: Leanna Ellis and Charlotte Knight; GC: John Maloney, Paul Keeley, Gillian Wylie and Wayne John; Optident: Rebecca Haworth-Johnson, Balraj Chand, Lyndsay Beaumont, Chris Hardy and Richard Dunne; BSDHT: Sharon Broom, Fay Higgin and Selina Vegad, and not forgetting, the volunteer helpers: Emma Hutchison and Yasmin Sutherland (BSDHT Scottish Regional Group Committee members) Rhiannon Jones (President -Elect), Rachel White and Harriett Elsworthy (BSDHT South West & South Wales Regional Group Committee members), and, last but by no means least, the delegates who attended the events, their readiness to learn, engage, and interact was wonderful to see.

The BSDHT team met recently to review all the feedback and reflect, recognising what worked well, and what can be improved on for future dates. Planning for Refresh and Refine 2024 events has already begun, with various topics that have been shared by members in their feedback from webinars, regional group study days, the Oral Health Conferences, member enquiries and the wider profession on social media.

If you didn't have the opportunity to attend this summer, why not give it a go in 2024!

OBITUARY

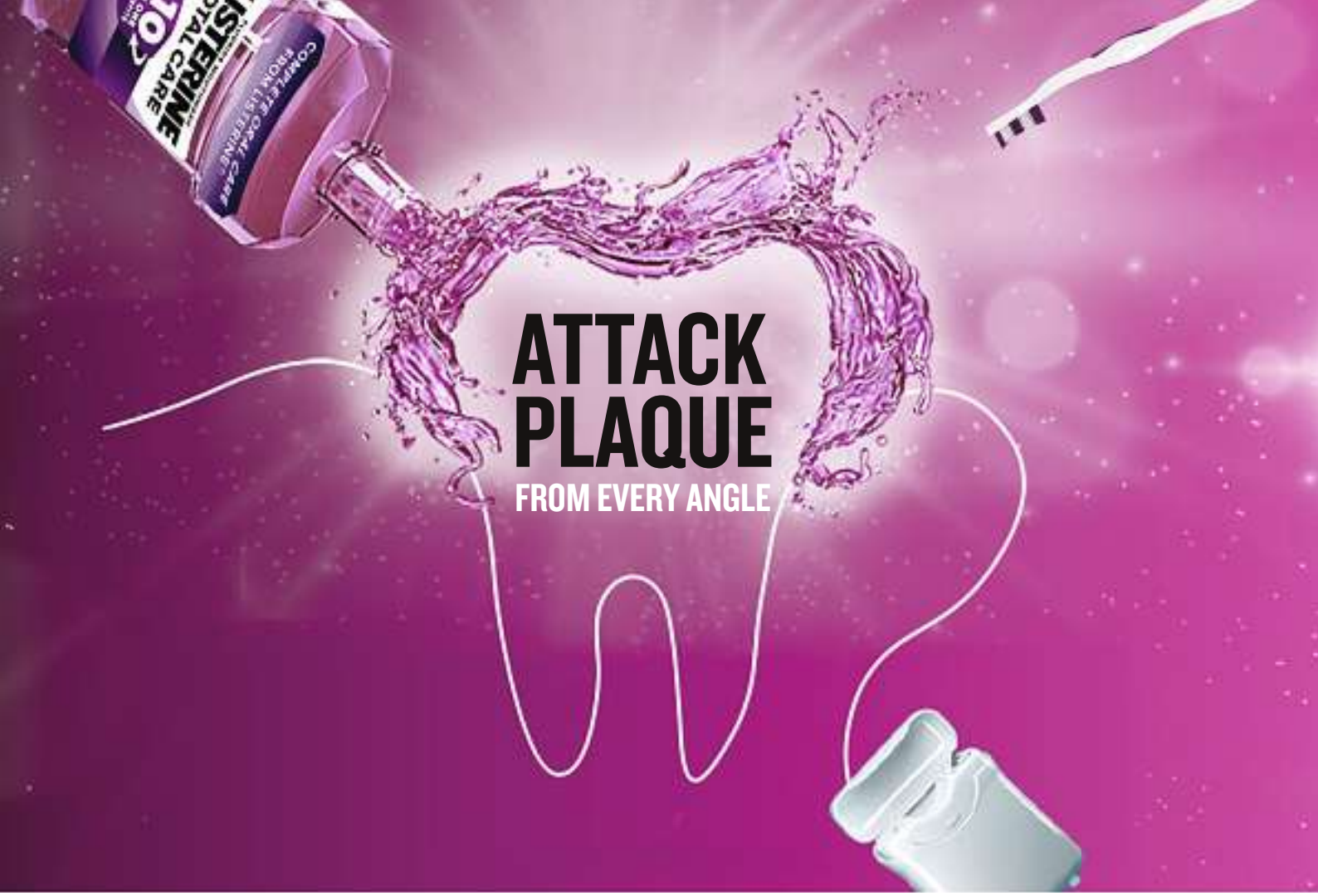
CATHERINE CLARKE
21:04:1958 – 09:08:2023

Cath Clarke was a force of nature; full of life, bristling with professional pride and commitment.

Cath qualified first as a dental nurse at Manchester before studying to become a dental hygienist. Cath worked in and around Manchester throughout her career. She was respected by patients and colleagues alike, always cheerful and always available.

Cath left us too early and too young. Sharp as a tack to the very end she succumbed to cancer not far from her cherished home surrounded by close friends and family. She loved her job and her patients. All of us who were fortunate enough to have known Cath will miss her smile, laughter and friendship.

Simon Hearnshaw – colleague and friend.



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** Sustained plaque reduction above the gumline with continual twice daily use for 12 weeks after a dental cleaning. Flossing was performed by a dental hygienist.

Scan for clinical studies

1. Milleman J, et al. Journal of Dental Hygiene. 2022;96(3):21-34.
2. Bosma ML, et al. Journal of Dental Hygiene. 2022;96(3):8-20.

UK-LI-2200277

COVID-19 UNIVERSITY AND ME

BY HAYLEY COKAYNE

We are constantly reminded of the importance of looking after our mental health. This seems ever more prevalent, with a spike in cases during, and since, the COVID-19 pandemic. The Higher Education Statistics Agency (2022) found that 119,500 students reported having a mental health condition in 2021/2022 - a 3.5 increase compared with data from 2014/2015.[1]

A study in China reported that over 50% of participants showed signs of significant psychological distress triggered by the pandemic.[2] Furthermore, National Office for Statistics (2022)[3] data revealed concerning results, with students reporting lower levels of happiness and higher levels of anxiety than the general UK population. Sadly, 17% of students admitted feeling lonely 'all or most of the time', whereas 7% of the general population reported feeling this way.[4] Was this perhaps in part due to students moving away from home, having to make new friends, or needing to isolate during periods of lockdown?[5] Despite the extensive wellbeing services and safeguarding protocols in place to protect students, not everyone would have felt comfortable asking for help.

Currently, two years on, I feel it important to share my experience to help others and shed light on the difficulties some of us faced undertaking a BSc during the height of the pandemic.

The decline

The first hint that COVID-19 would have any impact on my degree was during the entry interview process when we were told that we would not be able to shake hands with any of the interviewers. At the time, it seemed a little overcautious. Little did we know the devastation ahead. It was not until after I had accepted my unconditional offer that I started to worry.

It was inevitable that COVID-19 had an enormous impact on how university courses were operated throughout the UK. Lectures and tutorials were moved online with minimal live interaction, in line with government restrictions.[5] Universities did their best to adapt to this unfamiliar way of working. I worked out that in the first academic year I attended campus eight times for short sessions and met a handful of people: only one student from the dental therapy programme. Although this format was hard for me personally, it is important to recognise that for some, the online format was preferrable and advantageous particularly for those who needed to commute long distances or were parents.

The transition from working as a dental nurse full time to then, suddenly, being alone to study was difficult. I had not previously appreciated the benefit I gained from everyday interactions with colleagues, until they were gone. During the height of the pandemic, libraries, coffee shops and gyms closed which meant fundamental activities that improved wellbeing were unavailable. Most days were spent in front of my laptop, working through pre-recorded lectures without the opportunity to ask questions, clarify understanding and have discussions. It was often an arduous task to get students to turn on their webcam. No one wanted to be the odd one out with their camera on, which must have been demotivating for the facilitators. We were helpfully provided with the option of asking questions online but getting a response could take days, which was not ideal if you had an immediate problem.

I have since come to realise that, for me, being virtually combined with BDS students in our first year but only having

been able to actually meet one BSc student had a negative impact. For example, while many BSc students, had come from varied educational backgrounds, such as access courses and dental nursing, the vast majority of BDS students were fresh from A-levels, in which they had excelled. A much larger proportion of BDS students lived near to campus whereas it was the opposite with BSc students - most of us commuted. The combination of commuting and covid related restrictions made establishing friendships difficult. Although, of course, I appreciated why the courses had been merged, and the advantages, this did fuel my feelings of loneliness and inadequacy.

With the start of year two came an increase in simulation clinical skills sessions and closer support from specific dental therapy and hygiene tutors, which was brilliant! Before we knew it, our first day of treating real patients arrived. Despite feeling underprepared and battling increasing anxiety, I held it together. Unfortunately, the anxiety had been for nothing as the patient failed to attend. For the following two weeks, the same thing kept repeating; either my patient would not turn up or they would cancel, in part due to COVID-19 lingering.

Experiencing this emotional rollercoaster of mentally building myself up, only to be let down again, was exhausting. I felt like I was falling behind, but had not even started! It was difficult to not compare myself to students from other universities on social media who all appeared to be way ahead of me and having the time of their lives. I also had family, friends and former colleagues messaging asking what I had been up to. Rather than admit the truth, I lied and said I had been seeing patients. This was easier and less embarrassing than the reality.

The feeling of having so much to learn but so little time was unbelievably overwhelming. Ultimately, it became too much and after arriving early to clinic one morning, only to discover my patient had once again cancelled, I broke down and had a panic attack. The first of what would turn out to be many. My tutors and head nurse were brilliant, going out of their way to support me and with help from my family, GP and personal tutor, I returned to clinic.

Top tips

- **Ask yourself: 'Is what I am feeling rational and how do I manage it?'**

  We sometimes catastrophise situations beyond what is realistic and often, the 'worst' situation can be managed easily. For example, I would worry about not knowing the answer to a patient's question. Instead of automatically feeling like I would look stupid and inadequate, I would remind myself that the patient is aware they are seeing a student and would not expect me to know everything. Instead, when introducing myself I would remind the patient that I was a student and that I may need to ask for support.

- **Exposure to the trigger**

  As impossible as it may sound, the key to overcoming your fear is by exposing yourself to it. The longer you avoid it, the harder it becomes. With slow exposure, you will come to see the situation for what it really is - manageable.

- **Preparation**

  It is common knowledge and somewhat of a joke that I am always ridiculously early. However, this is my choice and I do it for my own benefit. By leaving earlier, I do not have to rush and have flexibility if a train is delayed. I have time to finish my coffee or grab a snack before heading up to clinic. When I get to clinic, I have time to read the patients notes and make sure the bay is set up in exactly the way I like. If I notice anything in the patient's history that I am unsure of, I have time to do some reading. If there are forms to complete, I prefill as much information as possible so that the appointment is not delayed. I also spent a weekend creating a planner that I kept with me on clinic everyday which contained vital information and 'cheat sheets' for procedures.

- **Get outside**

  Fresh air does wonders for mental health and wellbeing. I am lucky that I live in a green area with lots of woodland so I would regularly take myself out for a walk. Something about being out amongst nature is relaxing, motivating, and inspiring.

- **Open up**

  I am lucky to have a great relationship with my mum and am comfortable speaking to her. I was later surprised by just how many others within my student group were also struggling and we ended up being a good support to each other. After all, let's face it, we often spend more hours of our days with them than our families! My personal tutor was brilliant, and I will be forever thankful for her support and kindness. She went far beyond her professional duties, and I am pleased to be able to call her a friend. My eventual career aim is to get into teaching, if I manage this, I hope to be able to support students the way she did with me. It does not matter who you talk to, whether it be family, friends, a helpline, or someone trained in mental health, the important thing is that you reach out. Doing so is surprisingly cathartic and the motto is true - a problem shared is a problem halved!

- **Engage with services**

  After being initially reluctant, at my personal tutor's persistence, I gave in and spoke to the wellbeing team, who were great. They are able to provide services such as cognitive behavioural therapy and counselling. Speaking to someone who does not know you personally, is surprisingly helpful.

- **Sleep**

  Get quality sleep for the recommended hours. Being physically energised will help with being able to cope mentally and help you think more clearly.

- **Mindfulness and meaningful activities**

  Make time for activities you enjoy and be kind to yourself. I love to read but had got to a point of only ever reading for educational purposes rather than enjoyment. Therefore, I dedicated time each day to read and once I returned to clinics, I would use my train journey for reading. I made sure to get out of the house at weekends, even if it was just for a long walk or to have a quick cup of tea with a friend.

- **Avoid comparing yourself to others**

  I cannot stress this enough: social media can be deceptive and inaccurate! Let's be honest, if you have two photos of a restoration, which one would you post? The pretty one or the not so pretty one? I try to be transparent with my posts, but the truth is it is hard to expose your flaws. Furthermore, quantity is not more important than quality – just because a clinician says they have done 10 restorations more than you, does not mean they are better skilled.

Today

My mental health is stable and managed. I have the occasional moment when those bad feelings threaten to resurface but I use my coping skills to keep them at bay. I managed to successfully pass the BSc with great grades and began a foundation scheme in September. I aim to use my personal experience to help others, fight stigma and advocate for mental health wellbeing.

For anyone struggling, please believe in yourself, you can do it. There are brighter days ahead and people who can help you, just talk to them!

Author: Hayley graduated with a BSc in dental hygiene and therapy from Kings College London earlier this year. She currently works as a dental therapist at a practice in Hertfordshire as part of the East of England's Dental Therapist Foundation Training Scheme. Hayley uses her own lived experiences to advocate and educate about the importance of mental health.

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This is an entirely personal reflective account – all views are my own and not representative of the university or my peers.

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NEGOTIATING EMPLOYMENT

BY GEMMA COWEN

As a new graduate, seeking employment can be exciting but also daunting! I felt lucky that my work as a locum dental nurse, over a period of nine years, had provided me with some insight into what I was looking for when I started working as a dental therapist in practice.

Preparation

During my final year as a student, I reflected on my skill set and updated my CV with a cover letter, stating what I was hoping to achieve in a clinical role, along with the scope of practice of a dental therapist, and how this could benefit the practice.

I started applying for jobs before my finals last May and was invited for interviews. It had been a while since I had an interview - three years ago, and that was for a university - so this enabled me to build my confidence.

Market research

Before applying for any positions, I explored online recruitment sites. This enabled me to have a good understanding of the salary range for the area where I live, and the benefits offered. This information helped me to negotiate a fair salary: I was fully prepared to justify my salary request based on my qualification, certifications and experience.

The salaries offered varied significantly so it was important to carefully read the job specifications. Happily, I noted a common trend; most roles wished to utilise and incorporate a dental therapy-led model.

I applied for the jobs that matched my interests and appeared to value the skill set of a dental therapist. While I waited, I decided to experience dental therapy as a locum, just days after my registration, and worked in both NHS and private practices. This proved to be beyond insightful! I practised my skills in some great dental therapy clinics utilising the reforms of directly opening a course of treatment. I developed additional skills to add to my CV and even numerous offers of a job!

Accepting offers

Not all applications made resulted in an interview. Some practices did not even follow up post-interview, even though I later contacted them thanking them for the opportunity!

Nonetheless, one of the positions I accepted followed my time as their locum. The practice aligned with so many of my values: it had a wealth of experienced clinicians; it was a referral practice; the patients were well-managed from an oral disease perspective; they had a vision to develop the sister practice into a dental therapy-led clinic; the team was established; and the practice invested in staff training. Although they were looking for a full-time dental therapist, I negotiated three days as an employee. This opportunity felt too good to miss, even though it involved a daily two hours commute! In these circumstances, I thought travelling every day would be too demanding.

The second role that I secured was one day a week on a self-employed basis, in a direct access one chair therapy-led practice. It was closer to my home but as a squat practice (brand new) it presented some challenges: no established diary or a mentor for support. I welcomed the challenge!

I had also secured further work covering a dentist's role short term. This mainly involved carrying out examinations in an NHS practice. This was exciting! This has finally become achievable only this year as the NHS recognises the wider scope of the dental team.

One month on, I am enjoying getting to know my patients, and the dental teams. I feel settled, supported and, importantly, valued! I am looking forward to developing my professional skills and have recently just become a certified guided biofilm therapy (GBT) provider.

Post-university life has been hectic and somewhat of a whirlwind. It literally feels surreal! I have achieved so much in the last six months. I am embracing my privileged position as a dental therapist, supporting patient oral health with education and treatment.

Top tips

Do your market research. It is invaluable and will enable you to negotiate and set your rate.

Dress to impress. First impressions do count. It is a competitive market and you are one of many new graduates seeking employment.

Ask for the proposal. One particular full-time position in a mixed practice (NHS and private) sounded amazing!

However, taking in to account holidays and the cost of a postgraduate qualification they were prepared to fund, the hourly rate worked out less than I could earn as a locum dental nurse. I did ask the practice to consider increasing the rate and be more competitive within the market. Unfortunately, they could not compete.

Hourly rate or percentage? This is a common question which you will be asked, and warrants an article in itself! Be mindful that 'hourly rate' does not always equate to the employed rate or allow for white space (diary gaps). You will also need to know how many patients they will expect you to treat within an hour. If you choose to be paid a percentage of the work you undertake, you will need to ask questions of the variety of work you will be expected to carry out and what the practice charges per treatment. Only armed with the facts will you be able to assess which model is right for you.

Take your time. My experience of this process took more than eight weeks from interview to my first working day. It is important not to rush or feel pressured to accept offers. Ensure they are right for you! Negotiation is a two-way process and both parties must be satisfied with the final arrangements.

Good luck!

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BY HANNAH MOORE

HOW TO SUCCEED AT UNIVERSITY THROUGH FIRST YEAR AND BEYOND

The start of a university degree course can be challenging in so many ways, from moving away from home for the first time to learning to work independently, as well as getting to grips with academic writing. With my third and final year now underway, I have been reflecting on all I have learnt that has helped me succeed at university, so far. In this article I share, in no particular order, my top tips on what has worked for me. I hope that it will help other students.

Routine

Studies show that adequate sleep aids the retention and consolidation of newly acquired information and increases our ability to focus and cope with stress. Thus, a regular wake-up and bed time can impact positively on a student's academic performance. As well as maintaining a good sleep routine, I have found that limiting study time to 'office hours,' wherever possible, has allowed me to dedicate myself to my course without it completely taking over my life.

Study habits

To keep on top of a demanding workload, I would advise creating a study plan at the beginning of each semester. This could include calculating the amount of work required each week to meet assessment deadlines, including end-of-year submissions. It is helpful to find a revision technique that works for you early in your course: experiment with flashcards, mind maps, or the blurting method - writing down everything you know about a topic, then comparing it to your notes until you can recall all the information successfully. To help you focus, I would suggest having a dedicated workspace with minimal distractions. You could also try the Pomodoro tecnique which involves working for 25 minutes, then having a 5-minute break. Engaging with a variety of resources, such as CPD courses, webinars, and dental events, including BSDHT regional group study days, helps to widen your knowledge and help prepare for life after graduation.

Exercise and diet

Regular exercise not only improves our physical health but also our mental health and academic performance too. Studies show that exercise can improve energy levels, concentration and memory. It also helps to reduce 'brain fog' and feelings of anxiety and depression. NHS guidelines recommend at least 150 minutes of moderate, or 75 minutes of vigorous-intensity, activity a week.[1] To help combat work-related aches and pains, incorporate stretching and core-strengthening activities like yoga or Pilates into your routine.

The benefits of exercise - improved cognitive function, energy levels and mood - are enhanced by also following a healthy, balanced diet with adequate water intake. I find that meal planning, only buying what food I need (plus

a treat or two) and batch cooking or meal prepping is a fantastic way to save time and money – see if this works for you too!

Support

University isn't always easy, but there are things you can do if you are struggling. For help with general topics, such as referencing or researching, investigate resources or workshops offered by your library. Don't be afraid to approach your lecturers for course-specific queries and take advantage of practical sessions to gain valuable feedback. To help with exam revision, consider forming a study group - I've found this a great way to improve information recall and highlight areas for further study. Finally, make time to see friends. Having fun activities planned is a good motivational tool when life gets stressful, and regular social contact can reduce any feelings of loneliness.

Undertaking a degree requires hard work and dedication, but by developing your own effective study habits and seeking support where necessary, you will be more likely to succeed academically. By developing healthy routines and learning beyond the course syllabus along the way, you will be ready to embark on a successful career in dental hygiene or therapy.

Author: Hannah qualified as a dental nurse in 2015, then undertook post-qualifications in plaque indices, fluoride varnish application and radiography in preparation for undertaking a degree in dental hygiene. She continues to work as a locum dental nurse alongside her current studies in her final year.

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BY LOUISE MCATASNEY

CELEBRATING 10 YEARS OF DIRECT ACCESS

LOUISE MCATASNEY OPENED HER BUSINESS, ML DENTAL HYGIENE CLINIC, IN MARCH 2019

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

LM: I had worked in the dental industry for twenty years, spending ten of these as a dental hygienist providing bespoke hygienist treatment and advice in dental practices. I was lucky to have worked in both specialist and general dental practices. The experiences had allowed me to hone and maintain my skillset and provide the full spectrum of hygienist treatments. When the law changed in 2013, I knew that, at some point, I would love to set up my own clinic and treat patients independently, offering them a service that was both affordable and easily accessible.

After 10 years working as a dental hygienist, I felt that the time was right. Having gained enough experience and knowledge I was excited to start planning my own clinic.

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

LM: This was definitely challenging, to say the least! My clinic was the first of its kind to be set up in Northern Ireland, so it was difficult to know just where to begin! After composing a solid business plan, I got help and guidance from my professional bodies including the GDC and, of course, the BSDHT. I made contact with the RQIA and began the process from there. A special thanks has to go the dentists that I worked alongside on the months leading up to opening my business. I will be forever grateful for their help and guidance.

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

LM: When starting out in business as a clinic owner, I wanted to get it right from the outset. Patient education, safety and welfare were my top priorities. I dreamt of a clinic where I could build relationships with my patients, resulting in them trusting me to educate them on the importance of oral health and returning regularly. Having all the necessary policies and procedures in place was vital to ensure the highest standards of patient care. A very important element for me was giving patients a service that was easily accessible and at the same time affordable.

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

LM: There are many people that have helped me along the way, including professional bodies and former colleagues - all provided guidance throughout the whole process. I am thankful still for their ongoing

support. A special thanks goes to my friends and family, especially my mother and father for always encouraging me and always being there. Last but not least, my favourite person, my husband! All of this would not have been possible without him - with three young children, setting up a new business is particularly hard work.

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

LM: It is essential to remain positive and remember why you started in the first place.

Always keep focused on your goals and utilise any help available to you from professional bodies and colleagues. Most importantly, ensure you have some downtime with family and friends, so you don't burnout!

DH: DH: Can you give 3 top tips for success?

LM: For me, the most important are:

- Do your research! This is essential for your financial well-being. Research the varying interest rates on borrowing and check for any grants that may be available to you.
- Ensure you have plenty of support networks both personally and professionally.
- Cultivate and protect your relationships with those work colleagues that help keep you positive and to whom you can turn to for advice and guidance as your business grows.

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BY CHRISTINA CHATFIELD

CELEBRATING 10 YEARS OF DIRECT ACCESS

CHRISTINA CHATFIELD OPENED HER BUSINESS, DENTAL HEALTH SPA, ON 17TH SEPTEMBER, 2007

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

CC: I had retired from clinical work to embark on a new career in the corporate world, with no intention of ever returning to working clinically as a dental hygienist. I was 43 years old when the idea of owning my own business came to me, prompted by the Office of Fair Trading (OFT) upholding the super-complaint about the dental industry. The trouble was that no matter what the OFT said, they did not have the power to change the law. Nevertheless, their ruling inspired the idea that Dental Health Spa was a possibility. Also, despite all our best efforts, as clinicians, there was a lot of dental disease out there. This was evident at every BSDHT, BSP, BDA, BADT local, national and international meeting I attended.

Dental Health Spa came to fruition in 2007 when a change in the law allowed other dental health care professionals, in addition to dentists, to own and run dental practices. I became one of the first dental hygienists in the UK to do just that. My vision was, and continues to be, to encourage an alternative route into dental care, especially for those who are not accessing it because they are apprehensive of treatment, or struggling with the cost. According to the The National Dental Survey 2011, of a population of 1.4 million in Sussex, more than 350,000 had not accessed dental care in the previous two years (i.e., more than 25% of the population). Of that number 25% identified anxiety, and 50% the cost as the reason for their non-attendance.

Fundamental to my business model was a further change in the law to allow patients to access oral hygiene services without the need for a "prescription" from a dentist. I became involved in the National Working Party for Direct Access in achieving this important change. The General Dental Council approved the measure in March 2013, and on May 1st along with other dental hygienists in the UK, I

was finally able to treat patients 'off the street'. A great day for me, for Dental Health Spa, but more importantly for patients who are now empowered to make more choices.

The Dental Health Spa aimed to remove those factors identified as barriers to access to dental care, and to build a robust, caring, sustainable business, which in time can be replicated across the UK. As dental hygienists, we grasped the changes in law and fought to deliver better health outcomes.

The Dental Health Spa recognises the vital role that oral hygiene plays in general health, with growing evidence that gum health is directly linked to heart disease, lung disease, low birth weights, diabetes and erectile dysfunction. We also know that dental hygienists, along with dentists, are often the first to spot abnormalities which turn out to be mouth cancers: relatively easy to treat if diagnosed early, but result in more deaths than either testicular or cervical cancer if not. We therefore encourage our customers back into regular dental care via a 'softer route'.

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

CC: I had analysed the scale of opportunity using statistics from the British Dental Health Foundation, that helped break it down to a local level. Stats from the Adult Health Survey showed disease levels and, combining those from the Office of National Statistics, it appeared that for every dental hygienist or therapist in the UK, there were approximately 4000 patients with moderate to severe gum disease. At least 20% of those individuals were not accessing care, and those that were, were not accessing the right periodontal care.

Location was a key driver. People have to be able to easily locate you. We absolutely had to be visible (whether that's location or marketing). We had to ensure that our potential patients were aware of what we had to offer. We positioned ourselves on the High Street in Brighton because accessibility is important. We were flexible and aligned ourselves with the surrounding shops' and businesses' trading hours. It is essential to care for your patients outside of normal working hours.

However, it was no easy feat to open my new business on a high street location. This was further complicated by the legalities of converting the premises from a retail business.

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

CC: As I have said, location is key, but so also is the right environment, the team, software and equipment.

It is fundamental that you build trust. What makes a person feel comfortable in our care is the level of trust they have in us. Being able to choose who treats you is a big part in building that trust!

We provide information with our very consumer friendly brand: 100% kissable! We use social media platforms: Facebook, X (formerly twitter) and Instagram. Our website clearly sets out our prices and unambiguous explanations: information is up front and honest. We also write articles and give interviews for the local press and are involved with local radio. We listen to our patients. The knock-

on effect of all this means that means we grow by recommendation.

We dared to be different! We put our head above the parapet, marketed ourselves as such, and are winning over the Brighton market despite there being, on average, 70 dental business in and around the locality, (it's rather like a coffee shop on every corner). We started with zero patients and, to date, over 15,000 people have walked through our door. We continue to evaluate our service and tweak, update and evolve what we have. We continue to educate ourselves and keep ahead of the changes in the market - never resting on our laurels.

Without the right software, building and growing is virtually impossible. I wanted to offer something different so started with cheesy radio adverts on air polishing. Even I grew tired of hearing them but, crucially, Brighton heard! I am always looking for innovative ways to deliver exceptional pain free care.

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

CC: Calculations showed that setting up a functioning dental hygiene practice in a prime high street location required a £200,000 cash injection. But how do you obtain funding when your business idea aims to challenge the status quo within a massive industry like dentistry, with laws and industry bodies against you? Not easy!

The original funding was achieved by setting up a three-way partnership, one being my original manager from my Oral B days.

The sheer scale of the challenge to make our business a success, despite all the challenges, proved too much for my partners. Three became two, then two became one as they suffered cold feet and withdrew. In fact, even the bank got cold feet at one point!

Thanks to financial support from friends and family I bought out my fleeing partners and kept the business afloat. Despite so much negativity I never lost faith in the business model. I knew that the law could be changed and that the model would succeed, which it did in 2013.

Why was I so determined and so willing to take on this risk? The scale of opportunity was vast. Up to 50% of the adult population is not under the regular care of a dentist, and society, the NHS and employers are all suffering the consequences of the increasingly neglected oral health of our population.

However, I was not prepared for the recession that hit in 2008/9, just one year after launching. Also, when I initially set up, I did not realise it would take a further six years for DA to be granted! Furthermore, no-one could have foreseen the catastrophic effects the pandemic in 2020.

Carol, my sister-in-law, became my business partner. She had to guarantee all the leases because of my credit rating and took on a £16k loan to clear them. Additional funding was needed and her husband Phil, who became my IT manager, took on two further £15k loans to support the business in the early years. Other monies came from friends and family without which DHS would not be where it is today. Sarah Murray, Elaine Tilling and Margaret Ross, Jolene Pinder, Debbie Hemmington, BSDHT, BADT and BDHF became my council along the way, to name but a few. Elaine taught me so much about how to correspond. It is almost impossible to articulate the depth of support I was given. However, I was never frightened to ask for help and advice - no one had all the knowledge to do what I did, and continued to do, me included!

Life became extremely difficult during the COVID-19 pandemic. My daughter Lori was tenacious in her support and managed to get essential publicity for us. She never gave up. All of the much-needed press coverage that really raised our profile came from her persistence – SKY, national BBC, national and local TV, The Huffington Post and so many more. Thankfully, our Brighton patients did not forget us or give up on us during that very difficult time.

We survived the pandemic and have flourished! We are currently a team of 5 hygienists and therapists and 3 dentists: a fully functioning dental business because that's what our patients wanted!

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

CC: Be prepared to sacrifice time and money, but never give up. Cash is King, so cashflow is so important. However, a good credit score is essential. Get the right location and know your software inside out before you launch. Invest in your team and equipment. Invest time in evolving a good social media presence. Stay healthy!

DH: DH: Can you give 3 top tips for success?

CC: This is a tough one, but essentially:

- Think outside the box
- Be prepared to take calculated risks
- Ultimately you have to believe you can do it

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BY ANNETTE MATTHEWS

CELEBRATING 10 YEARS OF DIRECT ACCESS

ANNETTE MATTHEWS OPENED HER BUSINESS IN AUGUST 2019

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

AM: I opened my skin (soon to be smile) clinic just before the Covid-19 pandemic in 2020.

As a 3-storey clinic, my end goal is, and has always been, to implement a multifaceted 'one stop shop'. I wanted my own business in order to deliver the services that I wanted to offer, in my own unique and niche way. I enjoy being my own boss and being able to provide options to my patients that I can deliver confidently in my way on my terms. I have had a few professional and personal challenges along the way, but I refuse to let this affect my vision and long-term goal.

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

AM: In all honesty, I didn't! I tend to live for the moment and roll with what feels right. I know that's not the best way to do business but it is a good way to end up loving what you do. In the midst of chaos and uncertainty, you have to make it work once you take the leap!

At the time I made the decision to set up and invest in my own business, I really was not ready! I had only eight regular clients. My father said to me: "Annette, do you have enough clients to pay the rent?" My answer was: "No, not really, but I have to find them now, don't I?"

That was a bold move, to say the least! Of course, I should have planned and prepared more, but for me it worked and gave me the incentive to master my marketing and build a client base.

The great thing was that I found a locality where I would have little or no competition. Not that I think that is essential: I have had so many positive experiences working with colleagues delivering

similar treatments. Cheerleading others and tagging/recommending clinics local to me has always been my thing.

The reality is that clients will choose who they want to do their treatment based on first impressions. I am confident that what I offer is an experience they will tell others about. Word of mouth is the best form of advertisement.

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

AM: Freedom! Doing things my way and being inventive with solutions. Choosing the treatments, I wanted to offer.

I honestly believe that you can make anything happen if you want it enough and I have applied this mindset both professionally, and personally very recently, with positive results.

Every day is however a school day and running your business means you need to be pretty much

available 24/7. However, the benefits are well and truly worth it in the long run.

My next big goal is completing my direct access dental surgery space. I currently work in a dental practice local to me 1-2 days a week and sometimes do locum work to build up my business funds in order for me to plough this back into my future goals.

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

AM: Christina Chatfield and Jolene Pinder. The Dental Health Spa in Brighton is a truly inspirational business model and these ladies are super approachable. I often help out with locum shifts there and being in this environment is empowering and inspiring. I have learnt many useful nuggets from Christina's business model and continue to look to her for help with my own career and business development.

My father: I am a daddy's girl and all I want to do is make him proud! This always incentivises me to keep going even on the bad days - which can come at any time - but helps to build my resilience along the way.

Yvonne Wood who had a dental practice in Wales has also been an inspiration to me. Regularly attending conferences and meetings with likeminded individuals has been, and continues to be, a positive influence and helps keep me focused on my end goals and aspirations. This is my chance to give a little shout out as well to Heather Lewis, Michaela ONeill, Claire Bennet, Simone Ruzario, Sharon Broom and some past and current executive team members of the BSDHT who have supported me in my endeavours.

I am confident that I have pretty much nailed the skin and aesthetic side of my business. My next and rather large addition will be that potentially 'leopard print' dental chair – I will continue to do things my way, always with my patients best interests at heart!

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

AM: I have learned to be independent and that I have greater strength and resilience than I ever thought possible.

I have embraced change and often taken gambles, which in turn have manifested so many positive outcomes.

When things don't go your way, you take a deep breath and simply change direction.

Self care is ESSENTIAL and despite long demanding working hours I always put time aside to make sure I look after my own mental health, spending time with my loved ones.

I am lucky enough to live in the Peak District and have a beautiful landscape to enjoy around me.

My daughter (pictured) is also pivotal in my choices, I wanted to show her just what anyone is capable of.

My family situation has changed recently: it's now just my daughter and me. This drives and empowers me all the more!

DH: DH: Can you give 3 top tips for success?

AM: I think it is really important to:

- Set small goals and smash them – celebrate EVERY win!
- Be supportive of others around you and embrace the unknown.
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SPOTLIGHT ON...
CHARLOTTE CARLING

In December 2022 Julia Brewin approached me to participate in series three of the Eastman Dental Podcast. Apart from being surprised and honoured to have been asked, I was also delighted. Reflecting can often have mixed emotions. However, as I reminisced, I concluded that I have been immensely privileged to have a varied and exciting working life and feel honoured to be part of the dental profession. This is my professional journey.

A life changing decision

I initially trained as a dental nurse before embarking on a dental hygiene programme, where I gained the certificate in dental hygiene. The extended duties followed and I completed all additional training. For readers unfamiliar with this term, it comprised training in: administering local anaesthetic; radiography; temporary dressings; impression taking; and tooth whitening. Five years after qualifying, I had an opportune conversation with a colleague who had worked in Saudi Arabia. She encouraged me to apply for a hygiene position. That phone call to the recruitment agency was a life changing decision, one that I value to this day.

The Kingdom of Saudi Arabia

In the late nineties, Saudi Arabia was unlike most countries. It was defined by what was forbidden rather than what was allowed. Women could not drive, there was no social mixing of the sexes, no public entertainment and no alcohol. TV and radio were strictly controlled and censored, and the morality police (Mutawah) ruled the streets. Mutawah were specialist religious police that enforced strict religious customs of Sharia law. Wearing an all-encompassing black abaya and headscarf was obligatory when leaving the residential compound.

Initially, it was a culture shock. Acquainting myself and adapting to a new way of working and living required acceptance and perseverance. I slowly adjusted and learned to appreciate the Kingdom. More importantly, I wanted to succeed. I worked for the Armed Forces Hospital, with my first posting in Al Kharja (a small community village), approximately 90 km from Riyadh. Periodontal disease was highly prevalent. There had also been a significant increase in type 2 diabetes due to a substantial diet change. How interesting would researching the link between the two diseases have been in 1997? A golden opportunity missed!

Treatment mainly consisted of non-surgical therapy. Even though I had taken over from an existing dental hygienist, limited treatment had been the norm. I therefore started from scratch and readdressed the approach to treatment and oral hygiene instruction, as hygiene treatment was still a new concept. Predominantly, the patients were Bedouins and were only familiar with miswaks (a tooth cleaning stick). Toothbrushes and interdental aids were a novelty; many were reluctant to change their habits.

To encourage behavioural change, being accepted was critical. I gradually achieved this by learning essential Arabic, thanks to the help of my interpreter, Mohammed. His insight into the Saudi way of life was crucial to understanding Saudi culture and mindset. The word Insha'Allah (God willing) was widely employed. When I eventually understood its relevance, I included the phrase when giving oral hygiene instruction, acknowledging their willingness to try. In addition, I re-examined my original approach regarding the miswaks as they were part of their custom. It mainly applied to male Saudis who always seemed to have one handy, sitting conveniently in the top pocket of their thobe. They did have some benefits, primarily cleaning the labial surfaces. I, therefore, incorporated them as an adjunct to using toothbrushes, encouraging gradual behavioural change.

After eight months, I was posted to the main hospital in

Riyadh and became their lead hygienist. I went from treating Bedouins to royalty. In addition to daily clinical sessions, I would be requested to treat high-ranking royals late at night; 10.00 pm would be the usual time. Waiting over an hour for them to attend their appointment was a regular occurrence. During Ramadan, you worked mainly night shifts from 8:00pm to 2:00 am and then went shopping, which added novelty to a working day!

I was once part of a team requisitioned to treat the King hunting in the desert near the Iraqi borders. We flew across some outstanding desert scenery. I still consider it to be the most spectacular experience. On arrival, we stepped off the plane onto a red carpet! The hospital was new but very close to the Iraqi border and appeared to be in the middle of nowhere. After hours of waiting, soldiers lined up at the entrance; the King cancelled at about 10.00pm! Disappointed and slightly bemused at being flown to this remote destination to find we had been cancelled, we dined Saudi style in a beautiful majlis. It was indeed a consolation!

Saudi taught me resilience: I learned to value and admire cultural differences; appreciate working in an international environment; and, notably, what my colleagues offered. The Saudis were very welcoming, and the ones I helped were grateful. As a sign of affirmation, the Saudis would address me as a sister - a term of endearment I greatly valued.

Ex-pats provided a close community where camping in the desert was the highlight. Although war with Iraq was a threat, and the gas masks out of date, it did not deter us. The overall experience heightened my appreciation and excitement of working abroad. I felt humbled to have had the opportunity.

Hello Dubai!

I was honoured to become Emirates Airline's first dental hygienist. Life was very different to Saudi Arabia with the sexes mixing, public entertainment and authentic gin and tonics. Airline crew, general managers and engineers were entitled to free healthcare. The airline had set up a clinic with medicine and dentistry working side by side. As with Saudi, periodontal disease was rife. The days were long, a patient every half an hour, but not long enough to treat extensive periodontitis. With most staff allowed only two visits a year, I was anxious that I was merely touching the surface of the problem! I focused heavily on oral hygiene instruction, including prepared educational material, which was favourably received. To guarantee the patients could buy the dental aids recommended, I set up a shop within the pharmacy. The best seller was the new Oral B electric travel toothbrush; the travel box provided was ideal. I won an innovation award for the success of my ideas.

Emirates Airlines is a multicultural international organisation and a patient's perception of their oral health could be a sensitive issue. Being aware of this required careful management. My contribution was small in the grand scheme but, however minimal, every patient I helped was an accomplishment. In addition, it was a missed opportunity that medicine and dentistry did not amalgamate. The departments, although on the same floor, were treated as separate entities; the crucial oral systemic link had eluded us.

Working for the airline had its perks, with heavily discounted fares providing an opportunity to travel. My parents and grandmother benefited from the discounted fares and hotels in Dubai. They could enjoy dining in the desert, dune bashing, camel racing, unspoiled beaches and duty-free shopping. Dubai was very different from today's skyscrapers; the Burj Al Arab was still under construction. It was easy to get around and there were public beaches. The Middle East had been a phenomenal experience; I had set the motion rolling for my successors. However, I decided it was time to return. I needed to earn a decent income and progress my career.

Return to the UK

Adapting back to cold, wet and sunless days was tough. It was an abysmal summer and I longed for a continuous blue

sky, something I had particularly relished living in the Middle East. On returning, I worked for The Fresh Breath Clinic in the west end of London before joining a general practice which, after several years, I co-owned. It's great overseeing a team, the practice's general running and having autonomy buying equipment.

During this period, I went to Bristol University, undertook a two-year part-time course in dental therapy and gained a diploma. Sadly, my marriage ended, and as a single mother, the survival skills I learned from my time abroad came into play. It was exceptionally tough to start again, approaching 50. I joined a specialist referral practice in Harley Street and have been there ever since. I have been fortunate to work with excellent clinicians and practice teams who have supported me. After the split from the business, I felt the need to reinvent myself and pursue other avenues. Not having a degree, I focused on searching for courses to enhance my professional standing.

MSc Dental Hygiene

My online search brought me to the three-year part time UCL/Eastman MSc in dental hygiene. Having been accepted, even though I felt I was underqualified, I began my new journey. I am indebted to my tutors, Jeanie Suvan and Ruth Glover, and my cohort for their patience when I struggled with numerous IT aspects. With persistence and plenty of YouTube videos, I taught myself and learned skills that I thought were impossible. Fundamentally, my competencies have expanded inordinately. Academic writing is an area I particularly enjoy, critiquing papers and learning to interpret statistical analysis. Many aspects of the course were challenging, but with each hurdle, my confidence increased. As Ruth Glover once said, the course is a personal journey. She is correct; an enhanced skill set and renewed confidence have led me to pursue other avenues.

Fitness to practice panellist for GDC

During the first lockdown, I read the GDC advertisement for the fitness to practice application. Equipped with confidence that the MSc had given me, I applied. I spent considerable time on the application and was subsequently offered an interview. In my third year as a panellist, I feel privileged to be part of the team. The work is fascinating and has provided me with broader competencies to continue to move forward, adding diversity. What has been particularly interesting is understanding the legal framework behind each hearing and the court process. The GDC treat all panellist members as equals, creating a positive and fair environment in which to work.

In conclusion

The Eastman podcast aims to be accessible to the dental team, with its goal being to inspire, motivate, and educate from individual experiences. I would never have sat down to reflect if Julia had not contacted me. No journey is without its challenges, but having the strength to strive continuously is what has ultimately pushed me forward. Maintaining professionalism is essential, and creating opportunities is pivotal in staying focused. Learning is lifelong, and making new friends is a marvellous bonus. Dentistry was the right decision; dental hygiene and therapy have opened unexpected doors.

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Readers can find the podcast:

- by following the link https://linktr.ee/edhec
- scanning the QR code

or searching for 'The Eastman Dental Podcast' wherever you get your podcasts.

BY SIMONE RUZARIO

THE DENTAL THERAPIST RETURN TO PRACTICE

As the New Year approached, I asked myself what I wanted to achieve in 2022.

I have been a dental hygienist and dental therapist for nearly 20 years and for most of this time I have worked as a dental hygienist. I love being a dental hygienist, but after about 14 years of clinical practice I was ready to try something different.

I have been a volunteer for Dentaid for around six years and found this sector an area that I wanted to transition into. Unfortunately, at the time, I did not have enough managerial exposure to make the transition easy.

I joined Proctor and Gamble (P&G) in 2018, in the Global Oral Health Team, working with Oral-B. My time at P&G was great! I learnt so much and was encouraged to develop and enhance my management and leadership skills. Four years later, in January 2022, I was ready to try something new. My time with Oral-B was coming to an end and I needed to continue to evolve. I joined the Product Research team at P&G that year and was excited to use the research skills I had gained studying for my MSc in Public Health. However, something was still niggling, and I realised that this was not the transition for me.

During my time at P&G I never stopped being a clinician. I continued to practise as dental hygienist at weekends and remained continually active within BSDHT. I was an elected council member and integral in founding the Diversity, Inclusion and Belonging (DIB) working group. I am currently also honorary treasurer.

As I was exploring my options the changes to the NHS reform were coming through and opportunities for dental therapists in general practice were becoming more available. As I write this, I am aware that there are colleagues who were fortunate to use their dental therapy skills straight from university, but the majority went into community settings or worked in the private sector.

When I was approached to consider working as a dental therapist, it was within the NHS setting providing dental care to communities that would not be able to access private care. The thought of returning to dental therapy was terrifying at first. I had not practised for so many years.

Simone with one of her nurses

Simone with one of her referring dentists

The Obex Dental Group were so supportive and the clinicians that I work with have been so encouraging and wonderful mentors. In my early days, being back in practice, I only wanted the periodontal cases. This was my comfort zone. My managers laugh now, because if I have a day of periodontal cases I am the one complaining! I have so much more confidence in utilising my full scope of practice as a dental therapist.

During my working week, I split my time among three of our practices in Bedfordshire and Hertfordshire and provide NHS dental therapy. I have various referring dentist colleagues who usually work the same days, which enables us to easily connect and discuss cases if I need their advice. I do work to a prescription from the dentist, however, we do respect each other's clinical skills. For example, if a dental material has been prescribed but, when it comes to placing that material, I deem it not appropriate, they are happy to change the prescription and update the treatment plan.

Due to such a supportive environment, my confidence as a dental therapist has grown so much in the past year. When I consider that one year ago, I would have been so nervous to think about doing an extraction or restoring a tooth, I am so thrilled that I took on this challenge. I genuinely believe my years of experience as a dental hygienist brings an enhanced spin on my daily practice, as oral hygiene advice and prevention are at the heart of all my patient care.

In January 2022, I was looking for a new challenge, something that would stimulate me, something that would bring satisfaction and have lasting impact. That is exactly what dental therapy has done for me.

Author: Simone Ruzario graduated from Barts and The London Dental School in 2004 and practises as a dental hygienist and dental therapist in Bedfordshire and Hertfordshire. Simone is the Honorary Treasurer for the BSDHT and is an active member of the Diversity, Inclusion and Belonging Group.

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DENTISTRY IN THE MEDIA

BY NICOLLE HARRISON

There has long been portrayals of dental professionals in film and television programmes, often either humorous or scary in their representation. Some examples of these are: Charlie and the Chocolate Factory (2005); Little Shop of Horrors (1986); and The Carol Burnett Show with George Carlin (1969). In the children's film, Finding Nemo (2003), a dental scene focuses on the patient's fear and anxiety whilst sitting in the waiting room. Such scenes do not promote dentistry in a positive light. In fact, it is a concern that negative portrayals of dentistry, and dental professionals, may influence and conflate the fears of potential patients, while also being detrimental to clinicians and their treatments.

The perfect smile

Currently, there appears to be a focus in the media on perfectly aligned, gleaming white teeth, evident in so many individuals on our television screens and social media platforms. This is particularly ubiquitous in such popular UK television programmes as Love Island, Geordie Shore, Made in Chelsea and RuPaul's Drag Race. Sometimes it appears that considerable transformations of the participants' dental appearance takes place over a series of episodes. Could these amazing transformations influence viewers to aspire to replicate that perfect smile? It is of concern that this will appeal to the younger demographic of viewers of these programmes. Additionally, it is not often transparent that these same individuals are often monetised as influencers.

In a recent BBC documentary (Turkey Teeth: Bargain smiles or big mistake?)[1]

The documentary makers approached 150 cosmetic dental clinics in Turkey and 50 in the UK. The clinicians in each practice were presented with a set of clinical photos of one 'potential patient' and asked what, if any, treatment they would advise was required.

In the dental clinics in Turkey, 70 of 120 dentists asked would suggest crowns and veneers for that patient. Some of the respondents suggested up to 28 crowns were needed, only one respondent stated crowns and veneers would be the 'wrong intervention'. In contrast, none of the UK respondent dentists suggested that crowns or veneers were required for the patient in the photograph.

Furthermore, 1000 dentist members of the British Dental Association were surveyed. A large proportion of this sample reported that they had treated patients with complications following 'turkey teeth' procedures.

Social media

Social media can be a really useful marketing tool in dentistry: it can be used as a portfolio for dental professionals to promote their services and showcase their skills. Social media can also be used to educate patients by providing explanations and examples of dental procedures, demonstrations of cleaning techniques and tools, and help ease anxiety regarding dental appointments and treatments. It can widen your reach to potential new patients. Consider the online presence a dental professional may have, for example, the 'Singing Dentist' (Instagram: 376,000 followers).

However, we need to be acutely aware of the impact of influential celebrities on our younger patients: Justin Bieber (293 million), Post Malone (24.8 million) and Lil Wayne (18.4 million) have a combined online following of 336 million (Instagram). Instagram is full of images of young girls with a certain look (Kim Kardashian has 364 million followers).

There has been a rise in cosmetic treatments since social media platforms have been used to advertise dentistry: 63% of those individuals considering treatments are aged between 18-34. Up to 35,000 British and Irish citizens have travelled abroad to destinations, such as Turkey, for cheaper cosmetic dental procedures.[1]

In that same documentary, 95% of the dentists surveyed by the BBC, reported that they had examined patients that had travelled abroad for these cosmetics treatments and 86% stated that the cases they had treated were due to complications developed from these procedures.

An influencer named Jack Fincham (1.7 million followers), gained fame on Love Island 2018. He also appeared on the BBC documentary. On camera, he reflected that if he had been better informed at the time, he would have chosen to have composite bonding treatment rather than the extensive treatment he actually had in Turkey. He advised that any individual considering travelling abroad does need to do their research if they want to undergo similar cosmetic procedures.

Ethical and GDPR

The GDC has developed guidance regarding social media in maintaining professional standards and general data protection regulations (GDPR). There are strict boundaries to be followed. These include, ensuring patient confidentiality and obtaining consent before uploading any images of them. The GDC states:

"If we are tempted to go online and challenge incorrect views and information portrayed in the media, we must

ensure that we follow the GDC guidance. 4.2.3 of the Standards for the Dental Team states:

'You must not post any information or comments about patients on social networking or blogging sites. If you use professional social media to discuss anonymised cases for the purpose of discussing best practice you must be careful that the patient or patients cannot be identified.'

The standards expected of dental professionals do not change because they are communicating through social media, rather than face to face or by other traditional media. As a dental professional you have a responsibility to behave professionally and responsibly both online and offline.

However, because anything that is said on social media is instantly made public, it creates new circumstances in which the standards apply. Your professional responsibilities, such as patient confidentiality and professional courtesy, are still fundamental when you use social media."[2]

Personal viewpoints must be avoided: ensure that evidenced based facts, statistics and data are given instead.

It is also worth bearing in mind that there are laws in place to prevent misleading advertisements, such as the code rule 3.3.[3]

Conclusion

As dental professionals we have a duty of care to our patients. An awareness of current trends on social media are an important part of that care.

Author: Nicolle Harrison graduated as a dental hygienist from Cardiff University earlier this year.

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EXCITING DEVELOPMENTS IN TRAINING AND EDUCATION

NHS England: Workforce, Training and Education (WT&E) - formerly HEE - in the Midlands are pleased to announce the launch this Autumn of a new virtual learning environment for the whole dental team.

Developed by Shima Chundoo, Postgraduate Virtual Learning Environment (PGVLE) Fellow in the Midlands, along with Jennie Ross, Associate Dean for Dental Workforce Development, the platform will be a place for all professionals working in the Midlands region to find out about training developments and opportunities.

This is an exciting clinician driven platform, which currently hosts education and training for medicine, surgery, pharmacy and now dentistry.

Mike Foster, Dental Dean, comments:

"My mantra for dental education has always been 'inclusion for all' and the new PGVLE is the perfect platform to enable postgraduate training and education to be extended to all dental registrants across the Midlands.

The PGVLE is in its infancy, and I am excited to see where it grows as it hosts a huge library of resources. The system can host meetings and courses as well as educational resources that are relevant to all. The success of such a programme relies on its users so please support us and help us develop the content by suggesting new areas that we can expand into or new courses that we can advertise or host for the benefit of all."

There will be a dedicated section on the platform to make it easy to see at a glance what courses are relevant to dental hygienists and dental therapists, as well as a forum to engage regarding future training you would like to see offered. As it develops, it is hoped the site will become a 'one stop shop' for education in the Midlands where training from other providers will be also be advertised.

Leadership opportunities

In addition to the new platform, WT&E in the Midlands are incredibly excited to share a leadership opportunity for dental therapists or dental hygienists that will become available in 2024.

The part time employed post will give the successful applicant the chance to spend two days a week working on projects and issues relating to your profession, for example, successfully implementing skill mix in NHS practice, as well as developing your own leadership skills.

Under the supervision of Fleur Kellet, Associate Dean for Fellows, and mentors from across the region, previous fellows have completed projects ranging from the creation of a Dental Care Professional Network in the East Midlands to development of a work experience programme, as well as more clinically related projects.

To keep up to date with information about the application process please log onto the PGVLE for updates.

To register for access, use this MS form: **https://forms.office.com/r/Ax3taLpNTa** or scan the QR code.

SUPPORTING ANXIOUS CHILDREN THROUGH DENTAL CARE

Maria Langridge[1], Jasmin Meehan[2], Jessica Roberts[3], Cassandra Lewis[4], Amrisha Ondhia[5]

AIM

The aim of this paper is to augment existing understanding around non-pharmacological behaviour management of children in a dental setting with a focus on Trauma Informed Care.

LEARNING OBJECTIVES

Readers should be able to:

- Discuss the factors contributing to dental anxiety in children.
- State the strategies for engaging children and their guardians in the dental care process.
- Explain the principles of Trauma Informed Care (TIC) and how it can be applied in a dental context to support healing and reduce re-traumatisation.
- Identify non-verbal and behavioural cues indicating increased distress in children and describe techniques for de-escalating distress and maintaining a positive patient-clinician relationship.

LEARNING OUTCOMES

By the end of this article, readers will be able to:

- Explain the relationship between dental anxiety and avoidance of dental care.
- Recognise signs of distress in children during dental consultations and apply appropriate strategies for de-escalation.
- Evaluate their skills to engage both guardians and children effectively for successful interventions in paediatric dentistry.
- Apply the principles of Trauma Informed Care (TIC) with an understanding of its relevance in paediatric dentistry.

Aligned to GDC development outcomes: *A,C,D*

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HTTPS://WWW.SURVEYMONKEY.CO.UK/R/DH-NOVEMBER-2023
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ABSTRACT

The causes of child dental anxiety are likely to be complex and multi-factorial, including previous medical/dental experience and environmental/situational factors. Dental clinicians working in paediatrics, particularly dental therapists, require the dual skills of engaging both guardians and the child for successful interventions. Should the dental team be successful in providing prevention and chairside management for these children, this could have long lasting dental and psychological benefits.

Background

Dental caries is a serious concern for children within the United Kingdom, most severely affecting those living in deprivation and from minority backgrounds. The Oral Health Survey of five-year-olds 2022 found the prevalence of caries in England to be 29.3% nationally, rising to 38.7% in the Northwest[1]. The interaction between dental caries and anxiety is well-established with children more likely to experience dental anxiety compared to adults[2]. Moderate anxiety affects 63% of 12-year-olds and 54% of 15-year-olds, with self-rated anxiety higher in girls than boys[3].

Dental anxiety

The causes of child dental anxiety are likely to be complex and multi-factorial, including previous medical/dental experiences[4] and environmental/situational factors[5]. The 'vicious cycle' of dental anxiety and avoidance of the dental surgery often prevents engagement with routine care, thereby reducing access[6]. Delayed appointments allow dental caries to progress, therefore when treatment is finally sought, this is likely to be more invasive. Providing treatment to an anxious child in pain can reinforce and perpetuate anxiety if not managed carefully. It is likely that guardians[7] and dental clinicians[8,9] impact on the development and management of support in children developing dental fears. As such, it is vital for dental clinicians to have skills to address dental distress early in the child's dental journey to reduce the chance of this vicious cycle. If this anxiety is not addressed early, it can be carried into adulthood and subsequently impact on lifelong dental health[10].

Dental clinicians working in paediatrics, particularly dental therapists[7], require the dual skills of engaging both guardians and the child for successful interventions[11]. Should the dental team be successful in providing prevention and chairside management for these children, this could have long lasting dental and psychological benefits.

Trauma informed care

Trauma Informed Care (TIC) involves the design and delivery of services to support healing and reduce the chance that engaging with health services is re-traumatising for children[12,13]. TIC is highly relevant in a dental context due to some of the inherent factors which could impact on a child's sense of powerlessness and safety[12,14]. The ideas and suggestions in this paper are informed by TIC as they position child and guardians' reactions in the context of the dental system, thereby encouraging changes in practice by dental clinicians[15].

The aim of this paper is to augment existing understanding around non-pharmacological behaviour management of children in a dental setting with a focus on TIC. The authors represent experience across both paediatric dentistry and dental psychology in tentatively providing suggestions for choosing different interventions to reduce the chance of distress and de-escalate distress if it occurs.

It is important to keep in mind that highly anxious, neurodiverse, or pre-cooperative children may need further input and should be referred onto specialist services appropriately to prevent a negative experience and the development of further anxiety[16].

Linking psychological theory to child dental distress

Figure 1 graphically depicts distress within a dental consultation, showing a process of escalation and de-escalation over time. It suggests strategies that can be used by clinicians aiming to reduce the escalation of emotions, and as a basis to inform clinical decision making around dental anxiety interventions before and during a child's dental visit.

Part One: Approaches to help reduce the development of distress

1. Preparation and information giving

Studies highlight that giving children information preparing them for dental treatment can help to reduce distress and increase engagement[17]. Information is often categorised as either procedural or sensory[18] and can include sending information in appointment letters to detail what to expect, and helpful behaviours or language to use when speaking to the child[19]. This could include links to video walkthroughs of the practice or explaining we will be "counting their teeth".

Sensory information is likely to be most helpful if it explains physical sensations positively, so children do not anticipate unpleasant sensations, such as "you will feel something cool", rather than you will feel a "sharp scratch". Videos of children undergoing examinations or simple treatment (modelling) have also been shown to improve behaviour at initial and subsequent dental visits [19,20]. In line with more technology-driven approaches, utilising virtual reality (VR) has been demonstrated as effective in reducing anxiety preoperatively in children when used as a preparation and distraction tool, and has a significant role in exposure-based acclimatisation[21].

However, other research has found that giving preparation information increases anticipatory anxiety, especially in younger children who are already cautious about visiting the dental surgery[22]. As outlined in Table 1, guardians and children are the best sources to aid clinicians' decisions when enquiring how much preparation information to provide[23]. Furthermore, asking a guardian's perspective can help contain and reassure them regarding their role in the process, reducing their anxiety[24].

A good rapport with patients is key for preventing the escalation of distress. Using age-appropriate vocabulary and humour can be beneficial in developing the patient-

Figure 1: Graph depicting the distress curve and appropriate timings for specific anxiety reduction and soothing strategies.

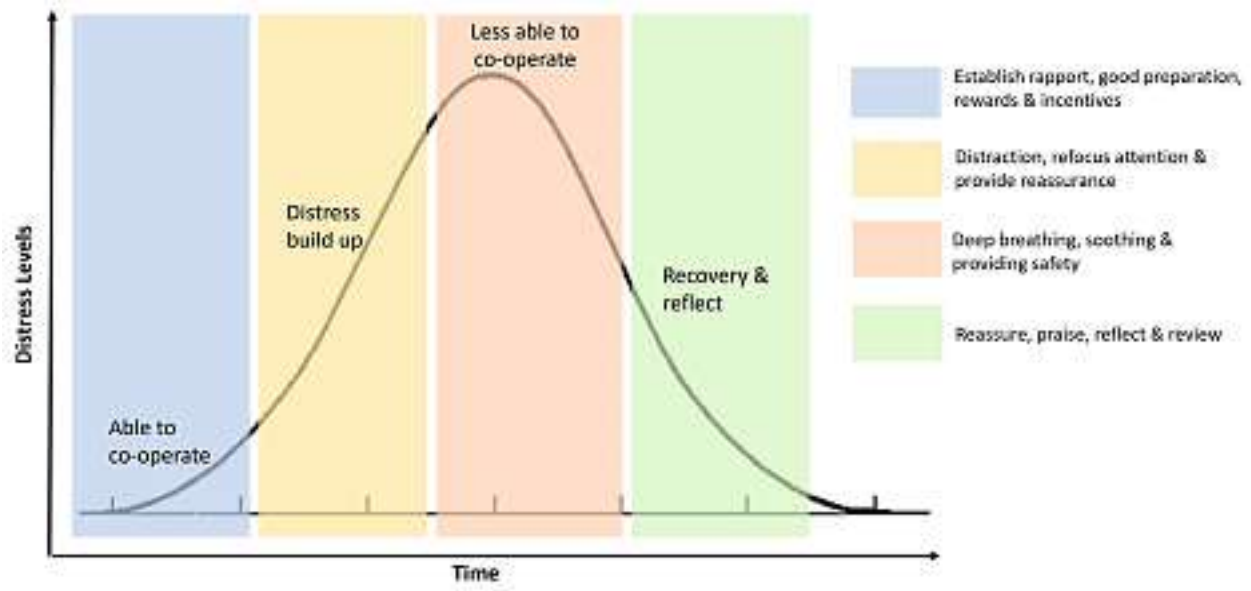

Table 1: Decision-making on information-giving for child patients

	Example questions
Amount of preparation advice to give	• Would you like to know more about what we hope to do today? • When you have been to the dentist before, was it helpful to find out what was going to happen? • Does finding out what we will do make a difference to you?
Learning from previous experience	• When you have been to the dentist before, did they do anything that was helpful? • Did they do anything that was less helpful?
Review at the end	• Is there anything I did today that was helpful? • Is there anything I did you would prefer me to do differently? • What did you do today that helped you do so well?

clinician relationship; simple techniques such as 'peek-a-boo' or guessing games, through to plays on words and jokes for older children[19,25]. Preparation information is also beneficial within the appointment using techniques such as 'Tell Show Do'. Here the procedure is explained in age-appropriate terms, demonstrated on an inanimate object or the patient's hand, before being performed to allow the experience of sensations in a more controlled manner. Children may also benefit from watching in a patient mirror[19].

2. Increasing sense of control

Research demonstrates the importance of helping children to feel in control during medical procedures[26]. This can be achieved by asking children about how they want the consultation to progress (Table 1). Asking this directly may be difficult to answer, therefore, asking about previous relevant experiences can create a helpful template with which to support the child to feel more confident.

The use of stop signals including raising a hand can be practised before the procedure, possibly as part of 'Tell Show Do'. Defined breaks from dental treatment after a set length of time have been shown to reduce less cooperative behaviour[27]. This could involve setting a timer or simply counting out loud. Allowing the child to choose the length of time will increase their autonomy and perception of control. Incorporating other choices can help with this, for example, "do you want to do the left or right today?".

At the end of the consultation, making time to review can help the clinician develop a personalised understanding of the child and family, help with future preparation and increase the child's self-efficacy (Table 1).

3. Praise/Rewards/Incentives

Focus on rewards can be used to help motivate children during treatment before they become emotionally distressed.

Rewards can be provided by dental teams and families, but whoever provides this should make verbal rewards behaviourally specific, for example praise for opening wide or staying still as opposed to more generic comments such as "you did really well today"[28]. It should also be given in the moment, as close to the desirable behaviour as possible as part of intermittent reinforcement. It is important to tailor this reward to the child and what they value.

Behavioural shaping, where progressively more desirable behaviours are rewarded and reinforced, can be used over a number of consultations to support a child to engage with dental care[29].

Instead of offering rewards for completing treatment, a contracting approach can be adopted to avoid the dilemma of offering a reward but treatment not being completed. For instance, the development of a fear hierarchy starting with the dental behaviours where the child is most confident and getting progressively more challenging. It is acceptable to pause, or stop, if the child is demonstrating levels of distress that could result in longer-term emotional harm.

Part Two: Approaches when distress is building up/progressing

Emotions, including fear and anxiety, are defined as brief states which include physiological, expressive and subjective experiences. These have multiple functions including the avoidance of pain or harm[30,31]. Research suggests emotional intensity escalates in the context of specific triggers, these can be external such as seeing dental equipment, or internal such as anticipating pain. When someone feels threatened, they experience a high level of emotion which impacts on their ability to listen, think or soothe[32]. Figure 1 indicates alternative strategies for supporting a child may be required if they become distressed. Importantly, research regarding emotions of threat, including anxiety, would suggest that strategies including rational and clear thinking are helpful prior to an escalation of emotion, however, soothing and validating strategies are helpful when emotion is higher[33].

1. Detecting changes in emotion: the build-up

Alongside the strategies mentioned above, it can be helpful to have awareness of non-verbal/behavioural cues to indicate distress (anxiety, fear or disgust)[31]. Table 2 outlines some changes in behaviour that could indicate increased distress. However, it is important to acknowledge individual differences when working with young people, in the context of how they demonstrate specific emotions. For example, some children may feel anxious, but act angry. In line with principles of TIC, talking about any of these changes with a child and their guardians may give the clinician useful feedback and help encourage a shift in communication to better manage distress before it reaches 'crisis point'.

2. Escalation of distress

As clinicians notice increases in distress, they may encourage a change of focus for the child using distraction techniques. Distraction techniques can be very helpful, especially if discussed prior with the family so that the child's preferred distraction resources are brought to the appointment and

Table 2: Non-verbal cues as they relate to increase in negative emotions[34]

Emotion	Typical behaviours
Anxiety / Fear	• Wide eyes • Eyebrows raised and pulled together • Raised upper eyelids, tensed lower eyelids • Jaw dropped open and lips stretched horizontally backwards • Hand wringing
Disgust	• Eyes screwed up • Lowered eyebrows • Wrinkling on the side and bridge of the nose • Upper lip is raised into an inverted 'U' • Lower lip raised and slightly protruding

are easily available. Audio and audio-visual distraction techniques, as detailed in Table 3, have been demonstrated as effective in reducing distress during dental treatment, are clinically feasible, safe and do not introduce significant training needs.

Awareness of the accompanying adult's reactions to their child's escalating distress can be beneficial to the clinician[29]. Guardians may be attuned to previous difficult experiences, and this could influence their reactions in the moment. The use of reassurance and modelling to both parties may help. For example, offering the child a break, engaging the guardians and child in a conversation or being curious about whether there is anything the guardians or child would find helpful at this moment. Noticing how children respond to these distractions can guide the clinician in whether they can proceed. If the child appears able to 'make sense' of the discussion, the clinician may want to return to preparatory information.

3. High distress/escalated emotions

If distress increases, these earlier interventions may become less effective. As symptoms of distress become physiological, it is helpful to use interventions that target physiological arousal. Strategies used should be tailored to the child. Therefore, we recommend asking guardians what soothes and de-escalates increasing distress.

Unlike adults, children typically express emotion behaviourally. Therefore, clinicians can identify increases in anxiety through behaviours such as becoming tearful, irritable, or 'clingy', stomach and/or headaches. Deep breathing exercises, such as diaphragmatic breathing could be beneficial, but can be abstract concepts for children. Therefore, if this is the preferred technique, it can be tailored to meet the cognitive needs of the young person; for example, "hot chocolate breaths" and "balloon belly breathing" use more developmentally appropriate language and concepts[37,38].

Table 3: Examples of audio and audio-visual distraction techniques[35,36]

Type of Distraction	Examples of Distractions
Audio	• Listening to music; to include headphones to allow a deeper immersion • Listening to stories
Audio-visual	• VR Technology • Watching cartoons, or other videos such as YouTube videos

Integrating relaxation techniques may be more appropriate, considering the child's preference. This could include progressive muscle relaxation, guided visual relaxation and safe place imagery. Visual imagery is a useful technique in children as they often have a more active imagination[38]. It is an easy way to tailor approaches to the child by incorporating the experiences they enjoy most such as playing with a pet or visiting a specific location[19]. It may be preferential for children who struggle with nasal breathing, as difficulties breathing through one's nose during deep breathing exercises can increase anxiety.

Part Three: Approaches to recovery and reflection

It is helpful for clinicians to be assured that feelings of distress and anxiety return to baseline levels, as demonstrated in Figure 1. Regardless of the dental outcome, time should be given to allow the child's and guardian's emotions to de-escalate; on a neuropsychological level, this would mean that their threat system becomes less triggered, allowing them to be able to think more clearly again[22]. Clinicians can allow the child and guardian to reflect on this experience by using questions mentioned in Table 1.

Considering our language and labels is important when asking families any questions, and when having discussions about the child's experiences in the dental chair. For example, saying "they are an anxious person", or "they never do what they are told" is negative. Putting the child's emotional reactions into context of what has happened that day may be more beneficial, such as rephrasing to "today you noticed feeling nervous, what made that worse?", or "today we agreed to stop, what do you think about trying again next time?".

Conclusions

The preceding discussion demonstrates that there is an array of non-pharmacological techniques which can be utilised to manage varying levels of paediatric distress in the dental setting. Ideally, these approaches should be integrated into a broad and comprehensive approach to patient management. Children demonstrating higher levels of distress may need more time and may require the dental team to utilise a combination of techniques and preparation to manage their distress. Of course, what works for one child may not work for another. Therefore, there is a need for flexibility when dealing with distressed children due to their unique individual needs and historical experiences.

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BY DIANE ROCHFORD

WORKING TO FULL SCOPE OF PRACTICE IN GENERAL DENTAL PRACTICE: A REPORT PRESENTING THE RESULTS OF A BSDHT MEMBER SURVEY

The General Dental Council (GDC), defined Scope of Practice as: "Activities that you carry out as part of your professional role. These are activities that you have the knowledge, skills, and abilities to perform safely and effectively…Your scope of practice is personal to you. The activities you carry out will partly be defined by the setting in which you practice, the needs of your patients, and the knowledge and skills of yourself and your team. Your scope of practice is also likely to change over time as you develop and expand your knowledge, skills, and experience (within the defined boundaries of your registered title)." [1]

In its current format, a prescriptive list of duties is laid out for each registrant group in line with their pre-registration training, and the boundaries of their current practice. In the GDC Scope of Practice Review 2020 document,[2] it is widely accepted that working as part of a team is vital to providing the highest standards of care; to ensure that patients receive their dental care from the most suitable and appropriately trained member of the dental team. [3]

Initial changes were introduced for NHS dentistry in England in July 2022. This allowed dental hygienists and dental therapists to provide NHS care within their scope directly to patients, and aimed to increase much needed access to care for patients.

The perceived benefits for dental hygienists and dental therapists having the opportunity to utilise their full range of skills includes: greater clinical autonomy; reduces the likelihood of de-skilling in duties that are not regularly utilised; and promotes greater professional fulfilment.

Anecdotally, it is currently accepted that many BSDHT members are not routinely undertaking all aspects of their Scope of Practice. To establish whether or not BSDHT members are working to full their scope of practice, as set out in the current GDC Scope of Practice 2013 document, a questionnaire was designed and circulated in March 2022 to members of the British Society of Dental Hygiene and Therapy (BSDHT).

In this context the full scope of practice is deemed as the duties listed in the GDC Scope of Practice (2013) document.[4]

Materials and methods

An online anonymous questionnaire was deemed the most applicable format to collect data. The aim was to capture quantitative data and the qualitative views at a point in time specific to the members taking part. A quantitative and qualitative questionnaire was subsequently designed and piloted via Survey Monkey by two representative dental hygienist and dental therapist members of the BSDHT Executive team. Amendments were made following feedback.

An email was sent to all members of the BSDHT in March 2022. It included: a brief explanation of the rationale for the questionnaire; clear instructions to complete all the questions to ensure meaningful data is collected; and a link to the Survey Monkey anonymous questionnaire. Participation was taken as consent. There was a short window of opportunity of two days to complete the questionnaire.

The aim was to identify whether or not BSDHT dental hygienist and dental therapist members, in dental practice settings, were working to their full scope, how often this occurred and which skills were being utilised in addition to their 'usual' daily practice.

The questionnaire also captured: the members' demographic information; gender; date of qualification; region(s) in which they worked as defined by the twelve BSDHT UK regional group areas; in what capacity they were practising - as a dental hygienist or dental therapist; the clinical setting(s) in which they worked - NHS, private or mixed NHS and private settings.

All eight questions were quantitative, except for the final question, which was qualitative and required the member respondents to comment and give their reason for their response to the final question. This response was limited to fifty words.

The data collected from the Survey Monkey were transferred to an Excel spreadsheet: one page displayed the data collected from members registered as dental hygienists; a second page contained data from members registered as dental therapists. The master spreadsheet was subsequently duplicated multiple times to enable easy retrieval and analysis of the data. The master Excel spreadsheet containing the data was stored on a password protected BSDHT computer by the investigator. The investigator retains the master copy on a password protected personal laptop. The intention is to use the data collected in a larger follow up survey and publish the results.

Ethics

The primary intention of the questionnaire was to gather data to formulate a report for BSDHT and in preparation for a

meeting with another professional membership organisation therefore ethics approval was not considered.

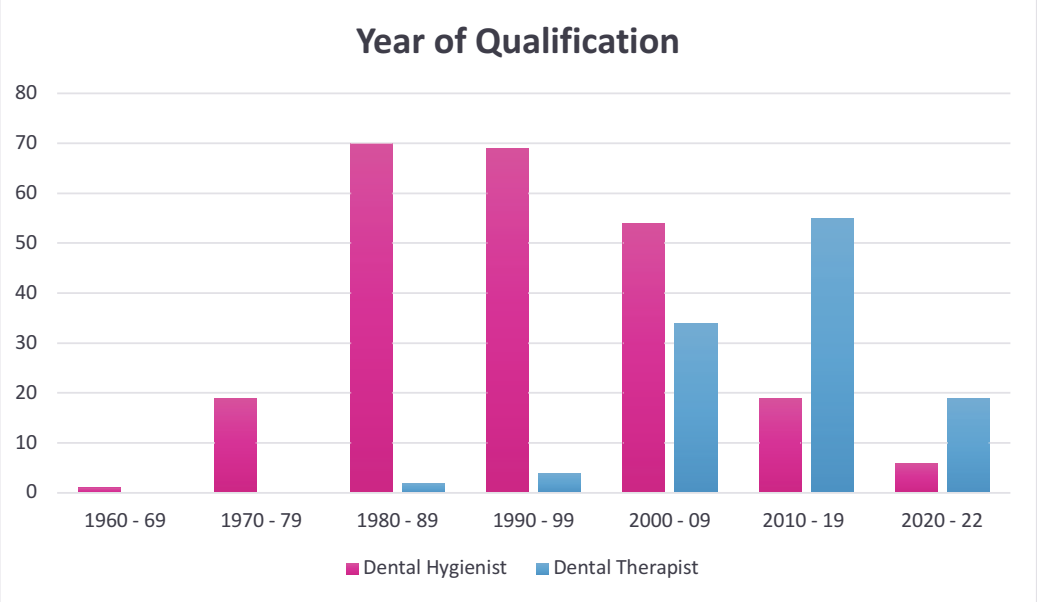
Results

The survey collected primarily quantitative data with the final question collecting qualitative data.

In April 2022, there were 2785 members of BSDHT. The survey returned 353 responses - a 12% response rate. Although, 65 respondents did not answer all the questions, this 10% response rate this was considered to be meaningful data.

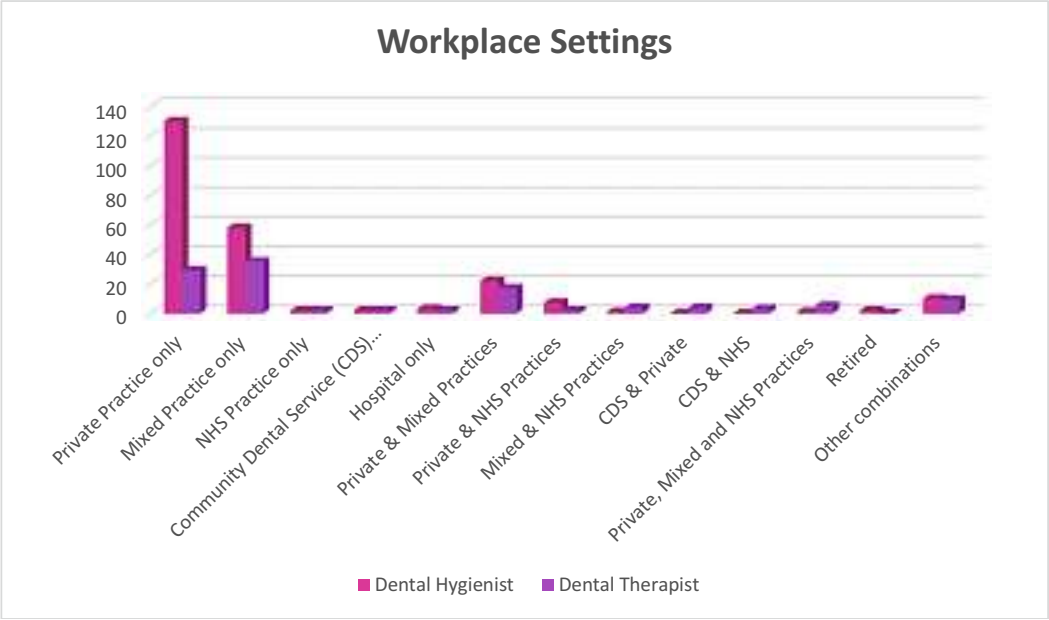
The majority of members completing the survey were female (97% ; n=343). The data revealed that 67% (n=238) of respondents were registered as dental hygienists and 33% (n=114) were registered as dental therapists.

Figure 1: In which year did you qualify?



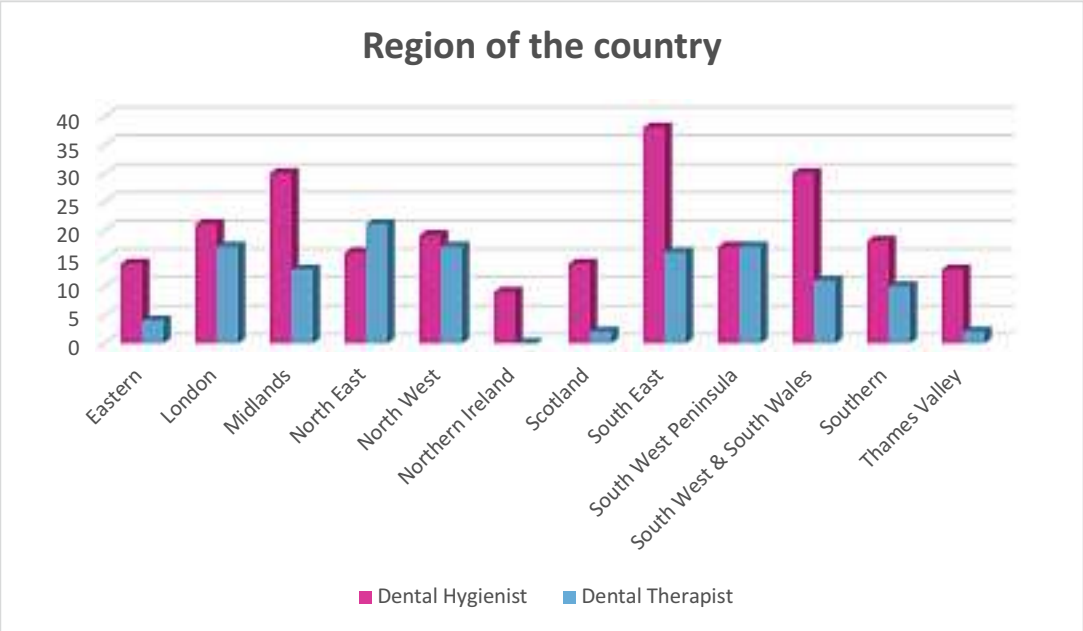
The data revealed: 29% (n= 70) of dental hygienists respondents qualified between 1980-1989 and 28% (n= 69) between 1990-1999; 48% (n=55) of dental therapist respondents qualified between 2010-2019.

Figure 2: Which of the following best describes your place of work?



Private practice was by far the most common workplace setting for 54% (n=130) of dental hygienists - 24% (n=58) worked in mixed practices and 0.8% (n=2) worked in NHS practices. However, 31% (n=35), of dental therapists worked in mixed practices (a combination of NHS and private), 25% (n=29) worked in private practices and 2% (n=2) worked in NHS practices. It is worth noting that since respondents could indicate all their workplace settings, multiple answers and variations of workplace setting were revealed on analysis of the data.

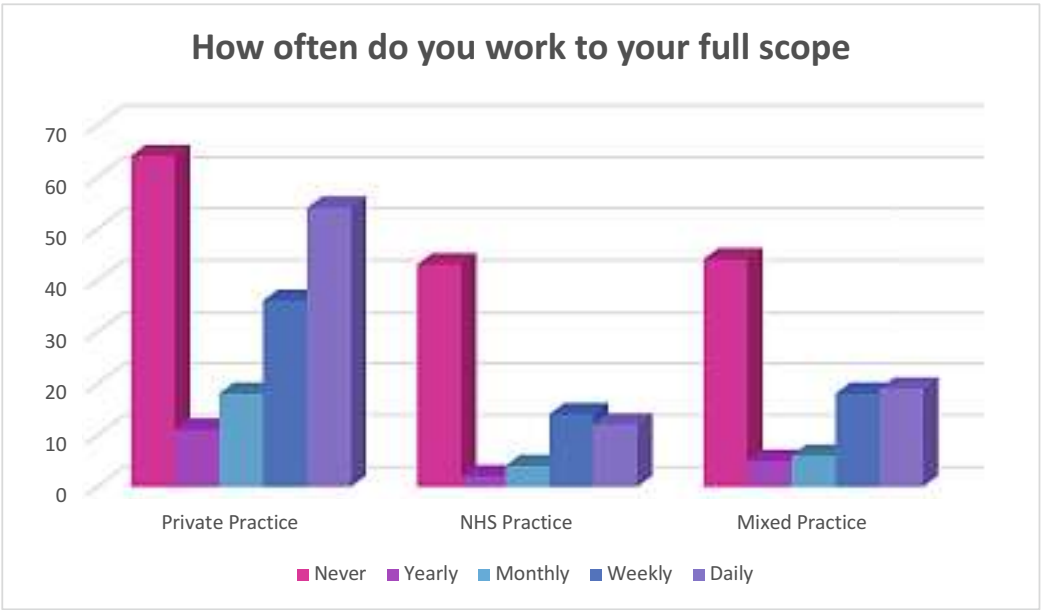
Figure 3: In which of the following regions of the country do you work?



The BSDHT regional groups were used to define the areas of the country where members worked, rather than where they lived: 15% (n=38) of dental hygienists worked in South East England; 16% (n=21) of dental therapists worked in North East England; 13% (n=17) worked in London; 13% (n=17) worked in North West England.

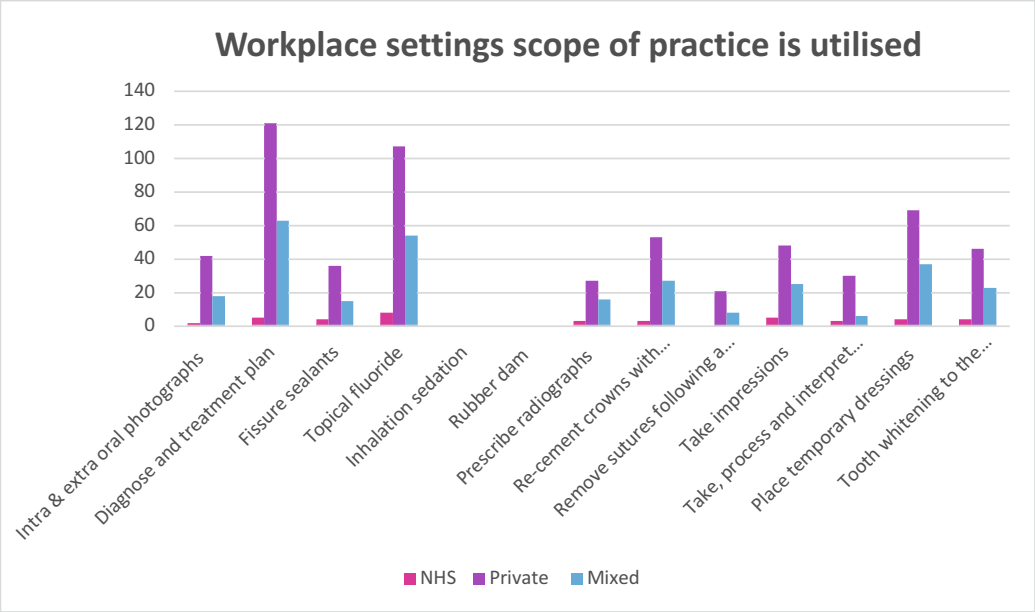
Dental Hygienists

Figure 4: How often on average do you work to your full scope of practice?



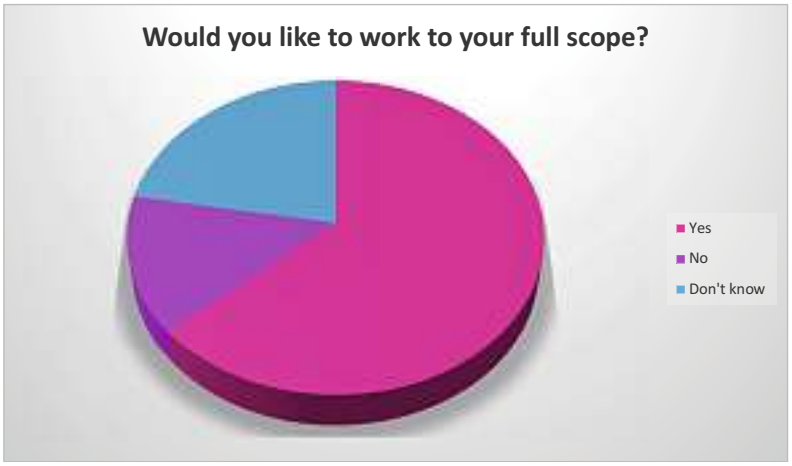
In private practices, 35% (n=64) of dental hygienists never worked to their full scope of practice. Of those members that did work consistently to their full scope, 29% (n=54) did so on a daily basis and 20% (n=36) did at some points on a weekly basis. Of those members who worked in NHS practices, and those who worked in mixed practices, 47% (n=44) and 57% (n=43) respectively, never worked to their full scope.

Figure 5: Which skills within the scope of practice of a dental hygienist do you have the opportunity to utilise and how often?



The results indicated that dental hygienists working in private practices had greater opportunity to carry out procedures within their scope of practice that are not seen as routine, daily procedures. NHS practices appeared to offer less opportunity at the time of the survey.

Figure 6: Would you like the opportunity to be able to work consistently to your full scope?



Of those members who were at the time of the survey not working to their full scope of practice, 64% (n=126) would have liked the opportunity to do so whilst 14% (n=28) answered 'no' and 22% (n=44) answered that they 'don't know'.

Dental Therapists

Figure 7: How often on average do you work to your full scope of practice?

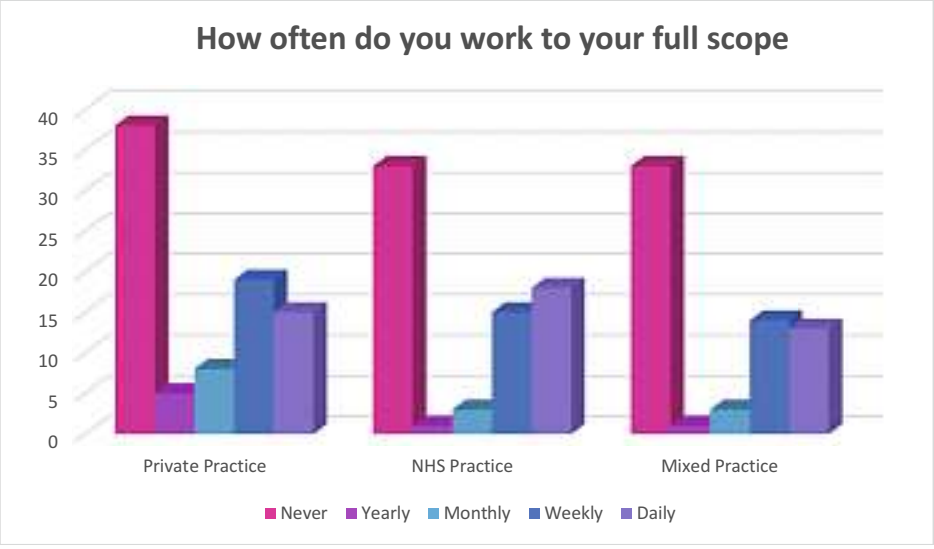
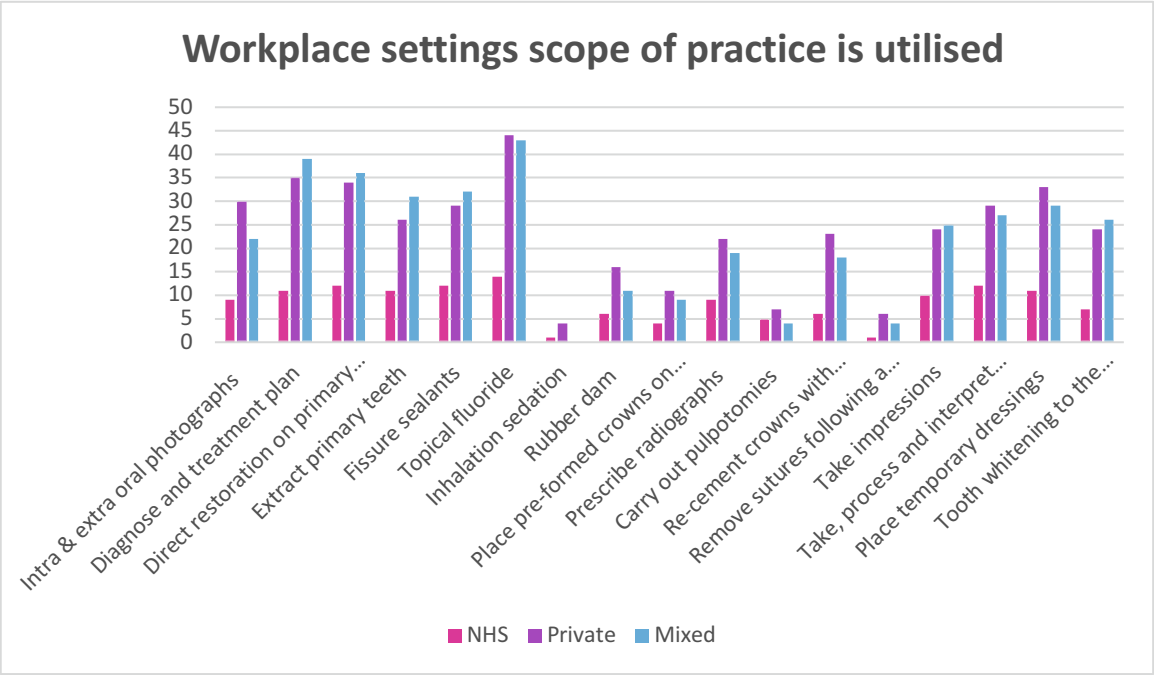


Figure 7

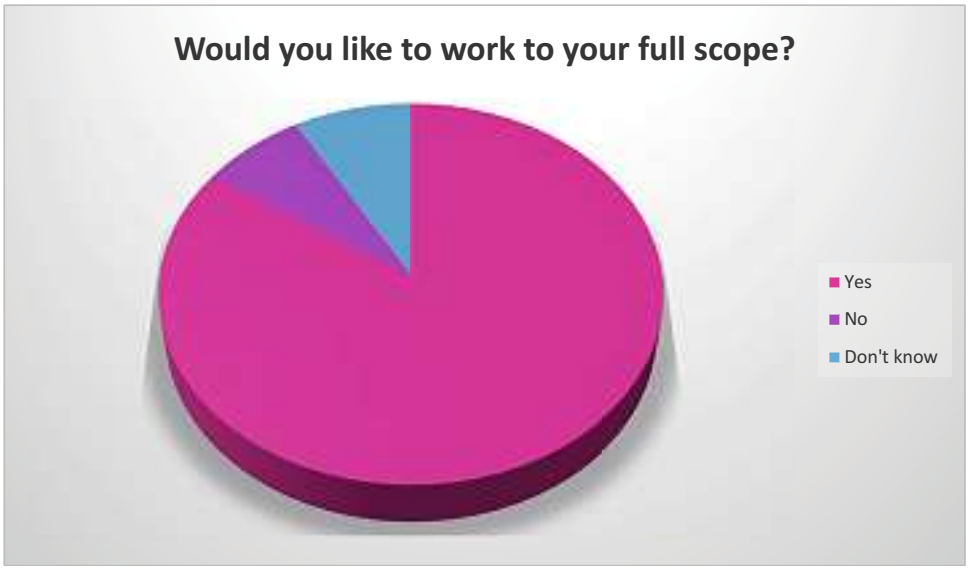
The results revealed that the following 'never' worked to their full scope of practice: 45% (n=38) in private practices; 47% (n=33) in NHS practices; and 51% (n=33) in mixed practices. When these dental therapists could utilise their full scope on a weekly or daily basis they did so: 17% (n=15) daily and 22% (n=19) weekly in private practices; 26% (n=18) daily and 21% (n=15) weekly in NHS practices; 20% (n=13) daily and 21% (n=14) weekly in mixed practices.

Figure 8: Which skills within the scope of practice of a dental therapist do you have the opportunity to utilise and how often?



The dental therapists working in private practices or mixed practices had more opportunity than their colleagues who worked in NHS practices, to undertake procedures that are not considered routine, daily procedures and are specific to the scope of practice of a dental therapist.

Figure 9: Would you like the opportunity to be able to work consistently to your full scope?



Of those members who were currently not working to their full scope of practice, 71% (n=81) answered that they would like the opportunity to do so, whilst 6% (n=7) said 'no', and 7% (n=48) answered that they 'don't know'.

Figure 10: Developing Themes

Professional Development	Patient Care	Perceived Challenges	Recommendations for Implementation
Skill development	Improved access to care for patients	Loss of confidence	Skill set needs updating
Professional fulfilment	Treatment provided by the most appropriately trained dental professional	De-skilled	Support and appropriate referrals from dentist colleagues
Improved confidence	Patient diary full with existing scope	Chairside dental nurse support required	Longer appointments required to allow time for added scope
Clinical autonomy		Appropriate remuneration	Chairside dental nurse support
Utilising taught skills		Lack of awareness by other members of the dental team relating to a dental hygienist's scope of practice	
Variety throughout the day		Legislative changes required (exemptions)	
Remuneration		Patient diary full with existing scope	
		Referred all the problematic cases	

The final question also asked members to comment on the reason for their choice. Their responses were limited to 50 words.

Not all members provided comments. From those that did, four themes were identified: professional development; patient care; perceived challenges or barriers; and recommendations for implementation. The table above presents both dental hygienists' and dental therapists' responses, as they were very similar.

Discussion

The results of the survey revealed that the majority of these BSDHT respondent members were not working to their full scope of practice. When asked if they would like to practice to their full scope, the majority of dental hygienists and dental therapists answered that they would.

The four themes that emerged from the members' responses related to: *Professional Development; Patient Care; Perceived Challenges; and Recommendations for Implementation.*

Professional development

The dental therapists and dental hygienists surveyed, regardless of when they qualified, felt that they had de-skilled due to underutilisation of the skills they had been taught and had developed during their pre-registration training.

One dental therapist commented: *"I really enjoyed doing every procedure as a student at university and that's exactly what I would like to do in practice."*

Many dental hygienists were afraid and disappointed that they were viewed as *a "…scaling machine".* Some members considered themselves *"…fortunate to be working consistently."* One dental therapist commented: *"I have the privilege of working with an open-minded team and love it!"*

Working as a team, to deliver the highest standard of care for patients, with appropriate delegation, is referenced in the *GDC Standards for the dental team* document (Standard 6.1).[3] The members that were currently working to full scope, frequently referred to a feeling of *"belonging".* Teamwork and the opportunity to add variety to each working day often promotes confidence and leads to a feeling of professional fulfilment.

"I love all aspects of my job and by working to my full scope it keeps the interest and prevents me from de-skilling." Dental therapist, qualified 2021.

Patient care

Although included in some responses, patient care was not widely commented on in the responses. Those members that did comment generally felt that if the wider dental team worked consistently to their respective full scope of practice, it would widen patient access to care.

One dental therapist commented: *"If I could use my full scope, I could help patients more than I am at the moment."* Another member responded: *"I learned and worked hard for this qualification and would like to be able to use all my skills for the benefit of patients."*

Skill Mix is the term often used within NHS settings to describe all dental professionals working to their full scope of practice. To assist in widening access to care for patients, NHS England made some initial changes to the NHS Dental Contract (July 2022)[5] promoting skill mix within the dental team and removing administrative barriers to enable dental hygienists and dental therapists to be able to open a course of treatment.

In this survey, dental hygienists, more so than dental therapists, agreed that their patient diaries could not accommodate them providing additional treatments within their scope. They were too busy treating existing patients with periodontal maintenance pathways or providing initial non-surgical periodontal therapy. Many dental hygienists who trained in the

1980's and 1990's (the majority of the respondents) stated that this was what they were trained to do, and enjoyed.

Perceived challenges

A lack of confidence and underutilisation of clinical skills appeared to be a barrier for these dental hygienists and dental therapists. One dental hygienist explained: *"I would like to be able to do more of my scope of practice, but not all, due to lack of confidence and having de-skilled since qualification."*

Full time dental nurse chairside support would be required if additional duties and treatments were to be referred by dentists to dental hygienists and dental therapists in practice. BSDHT continues to promote the need for chairside nursing support with other stakeholders who can assist in influencing the change required.

Another perceived barrier was found to be related to remuneration. Some responses highlighted a potential negative impact on their income and many were concerned that patient referral and appropriate payment systems for dental hygienists and dental therapists was lacking.

In May 2020, the GDC published the *Scope of Practice Review: Final Report*.[2] Findings in the report reflect the responses to the BSDHT survey of members in April 2022 relating to a general lack of awareness amongst all members of the dental team and each individual team member's scope of practice. The GDC report stated that only 61% of dentists and 59% of dental nurses know a fair amount about the current Scope of Practice document, in comparison to 91% of dental therapists and 84% of dental hygienists.

Three respondents anonymously commented:

"It depends on the attitude of the dentists. Many of them don't seem to be taught about delegating services or cannot see how it will benefit the practice."

"I thoroughly enjoy being a dental therapist however sadly, practices are NOT supportive of utilising dental therapists in both NHS and private practice despite being potentially beneficial to our patients. "

"A better use of skill mix. More variety and interesting days. Improved experience for the patient as they are seeing the correct person for the treatment they require."

Recommendations for implementation

Member respondents shared suggestions that could assist them with delivering patient care by utilising their full scope of practice. Opportunities to update their skills, along with support from their practice teams with appropriate referrals would be welcomed. Several responses related to lengthening appointment times to allow for additional duties or treatments to be carried out. Many felt that they would be expected to continue within the constraints of their standard allocated appointments.

Conclusion

The survey established the extent to which this sample of BSDHT members were working to their full scope of practice, and how often. Generally, NHS practices appeared to be underutilising the wider skills of both dental hygienists and dental therapists. Since this survey took place before the initial changes to NHS dentistry in England, it would be interesting to know if this has changed in recent months. Whilst private practices and mixed practices seemed to be utilising skills, this is often inconsistent. This sample of BSDHT dental hygienist and dental therapist members welcomed the opportunity to work to their full scope.

There are many potential benefits to dental hygienists and dental therapists working consistently to their full scope of practice. For the individual professional, the opportunity to confidently practise their full range of clinical skills often leads to longer and more fulfilled careers. Practices enjoy a greater sense of teamwork and delegation amongst the team. Most importantly patients are more likely to receive the highest standard of care carried out by the most appropriate member of the dental team as efficiently as possible, ultimately widening patient access to care.

Limitations

The survey captured the views of a limited number of BSDHT members, which may or may not be reflective of the wider profession. The test questionnaire was piloted by two members of the BSDHT Executive team - a representative dental hygienist and a dental therapist. Ideally, a larger cohort of Executive team members would have been able to comment and offer recommendations.

As the investigator intended the results to be available for an imminent dental stake holder meeting, the time frame for responses and analysis was only two days. Longer availability could have probably achieved a greater response rate which could be deemed more reflective of the members and profession. A wider survey is planned to build on these results.

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CLINICAL QUIZ

A middle-aged female patient, whom you know from their medical history has previously suffered from a stroke, attends for an appointment with you. On response to your greeting, she tries to smile but one side of her face droops. You are aware that a stroke occurs when blood, carrying essential nutrients, is prevented from reaching the brain, causing cells to die and also that if you are at all suspicious it is important to act FAST: stroke is the 5th cause of death in the UK and a leading cause of disability.

Q1. Is facial drooping a sign of a stroke?

Q2. What does the acronym FAST stand for?

Q3. Should you give the patient aspirin?

Q4. Compared with a patient who has never had a stroke, how many times more likely is a patient who has a history of stroke to experience another?

Q5. What is the main treatable risk factor of a stroke?

Q6. What percentage of strokes are preventable?

THIS QUIZ WAS KINDLY SUBMITTED BY ALI LOWE. • **IMAGE COURTESY OF** PIQSELS.

SEND YOUR ANSWERS TO THE EDITOR BY 30TH NOVEMBER. 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 SEPTEMBER 2023

The winner is: **Hazel Cameron**

Q1. What condition may the patient be suffering from?

A1. Measles. This highly infectious disease kills up to 10% of individuals infected. The spread can only be controlled by vaccination. Whilst in 2017 the WHO declared that the UK had eliminated measles, unfortunately that status has not been maintained. It is known that cases of measles occur where vaccine uptake is sub-optimal and that young, unvaccinated adults who have missed childhood MMR vaccination are particularly vulnerable. The disease is characterised by a fever, cough, inflammation of mucous membranes and the appearance of a rash.

Q2. What are the spots called?

A2. Koplik's spots. Although rare, this viral symptom is characterised by clustered, white abnormalities of the buccal mucosa in the mouth of a patient suffering from measles. They manifest two to three days after the appearance of symptoms but before the measles rash and disappear as the rash appears.

Q3. What treatment is available for the condition?

A3. There are currently no anti-viral drugs available. Symptoms of fever and infection are treated with paracetamol and antibiotics, respectively. High dose Vitamin A may be administered to severe cases in young children.

Q4. Should treatment be deferred?

A4. Yes. The patient can be infectious for four days before the rash appears and remain infectious for up to four days after it dissipates.

ORACLE

Young Innovations launches international logistics center in Ireland

American dental company Young Innovations has opened a new logistics centre in Ireland. The Dungarvan site will become a hub for international trade and the European market. "The excellent infrastructure allows us to expand the product range and deliver faster, which are ideal conditions for optimal support of our customers," emphasised Frank Whyte, Vice President and Managing Director of Young International, at the opening ceremony. Cormac Johnston was introduced as the new General Manager of Young Microbrush Ireland.

The Group's Microbrush brand has been present locally for 25 years. The branch was initially used as a production facility and later as a warehouse. Since 2014, the premises have been steadily expanded and the portfolio continually added to, for example with the brands Young Dental, American Eagle Instruments, Pro-Matrix, Pro-Tip, Crystal Tips, Zooby and Denticator. The continuous growth required the expansion of capacity. The warehouse was enlarged and all buildings completely renovated.

Young Innovations' extensive portfolio can now be fully mapped and the diverse requirements for storing the high-quality goods are also easily met.

At the inauguration ceremony, Frank Whyte thanked the energetic team as well as the previous General Manager, Mary O'Keeffe, who had been with Microbrush since 1998 and has now retired. Cormac Johnston was introduced as the new General Manager. The senior professional brings to the position many years of experience in quality and process management at international companies in the healthcare and biotech industries.

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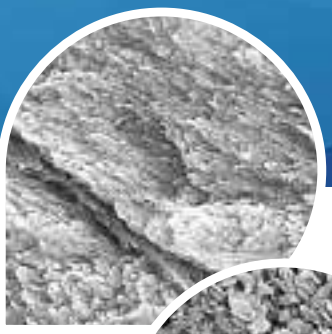
RECRUITMENT

Enamel Remineralisation based on

SCIENTIFIC EVIDENCE



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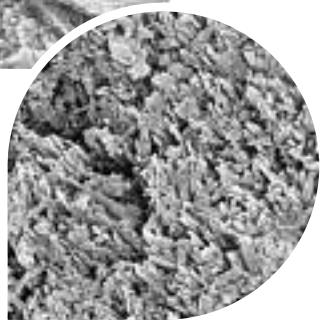

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The formation of S-HAp microcrystals was seen in a regular, compact appearance with the same structure and orientation as the existing natural enamel prisms.

This proven greater biomimicry is probably linked to the **benefits of Magnesium and Strontium; which were not contained in the other tested formulas.**

* Study on 'Biomimetic Mousses and Toothpastes for Enamel Remineralisation'. Authors: Ionescu Ac., Izzo D., Pulcini MG., Dian A., Brambilla E. University of Milan, Oral Microbiology and Biomaterials Laboratory. IRCCS Galeazzi Orthopaedic Institute, Dental Clinic. Academic Board, Naples. Journal of Osseointegration 2019.

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Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 16th March 2024		Nancy Gieson	easternsecretary@bsdht.org.uk
London	Thu, 18th April 2024	TBC	Simona Kilioke	londonsecretary@bsdht.org.uk
Midlands	Sat, 2nd March 2024	Hilton East Midlands Airport	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Sat, 20th April 2024	York (TBC)	Julie Rosse	northeastsecretary@bsdht.org.uk
North West	Sat, 9th March 2024	FMC North of England Show Manchester - Refresh & Refine (NO TRADE)	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	Sat, 23rd March 2024		Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	Sat, 20th April 2024	Minto Dental Care, 1 Liberton Gardens, Edinburgh EH16 6JX	Ana Malove	scottishsecretary@bsdht.org.uk
South East	Sat, 27th April 2024	One Warwick Park Hotel, Tunbridge Wells, TN2 5TA	Sam Davidson (Acting)	southeastsecretary@bsdht.org.uk
Southern	Sat, 16th March, 2024	Holiday Inn Winchester	Ellie-May Ayling	southernsecretary@bsdht.org.uk
South West & South Wales	Fri, 1st March 2024	Arnos Manor, 470 Bath Road Arno's Vale, Bristol BS4 3HQ.	Alison Trinh	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 9th March 2024	Crowne Plaza Plymouth	Lauren Binns	southwestsecretary@bsdht.org.uk
Thames Valley	TBC	TBC	Vacant	thamesvalleysecretary@bsdht.org.uk

Patricia Macpherson, BSDHT Publications Team, is trying to contact a recipient of the BSDHT Dr Gerald Leatherman Award. Namely, Christine Jones who received this prestigious award in 2001. Please contact Patricia on **pub@bsdht.org.uk** Alternatively, she would be grateful if any members who know Christine could pass on her request to her.

In addition, Patricia has been unable to contact our Past President Pat Gooderham and asks if she could get in touch on: **pubs@bsdht.org.uk**

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References: 1. Parkinson, CR *et al* BMC Oral Health 2020;20: 89-96.

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