DENTAL HEALTH

VOLUME 61 | NO 5 OF 6 SEPTEMBER 2022

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

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

bsdht.org.uk

DENTAL HEALTH – ISSN 0011-8605

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Annual Subscriptions for non-members: £128.00 per annum
UK 6 issues including postage and packing. Air and Surface Mail upon request.

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DENTAL HEALTH

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GUEST EDITORIAL

Brett Duane Associate Professor in Dental Public Health Dublin Dental University Hospital

Sustainability is mainstreaming…

I can see this everywhere: the growing interest in speaking events; requests for education; the increase in the creation of oral health research groups; and the daily emails. Academic colleagues normally interested in 'traditional' research, e.g. dental caries, are now realising that sustainability in dentistry is an important subject.

Regulatory bodies are also realising the need for education within our profession to fulfil our obligations as dental care professionals. Representative bodies, like the BSDHT, are also beginning to reflect this shift and are developing sustainability policies and frameworks to help guide their members. In a really positive move, the FDI sustainability group has been working with industry partners in an attempt to elicit change.

Within this editorial I would like to focus on a couple of areas of low hanging fruit: travel; prevention; decontamination; and product choice.

Avid readers in this area will note that, from a sustainability perspective, travel to dental appointments is the largest contributor to health care CO_2 emissions in our field. Indeed, in almost every one of our publications since the PHE report, travel is the highest contribution; from its impact in single fluoride varnish applications, to its influence within the environmental footprint of six month examinations.[1] Many within our profession would argue that "we are where we are!" and there is little we can do to change how our patients travel. The cheap availability of fossil fuels has allowed us to create a society where we can commute quickly and easily in and out of urban structures to access commodities such as healthcare. Unfortunately, our reliance on fossil fuels is also becoming a curse. There is little infrastructure accessible without a car. As Carlos Morenos and others would argue, we need a city that is human friendly - a 15 minute city.[2]

As healthcare providers we need to ensure we are adaptable to providing locally based services which link with public transport, or locate our practices close to people's residences. We should be doing everything possible to reduce travel. Our recent paper calculated the environmental advantage of community prevention programmes where only the nurse, and his/her team travel to deliver prevention to a large group of patients. Twenty four month check-ups for low risk patients are another way of reducing unnecessary travel.

We need to do everything we can to prevent disease, but do it in a low travel way. We need to balance carefully the ethical considerations of a routine appointment against its evidence for efficacy and its environmental footprint. The Economists research paper provided a societal and economic insight into periodontal diseases. The evidence suggests the need to support patients in understanding and preventing disease through home based care.[3,4]

However, we all know the disease process is much more complicated than just lack of knowledge. We need to tackle tobacco consumption. We need to ensure our patients are part of a comprehensive diabetes pathway. We need to be political, support a low sugar culture and support water fluoridation; and if water fluoridation is not possible, support subsidised fluoride delivery mechanisms.

We need as a society, and as dental care professionals, not only to advocate for climate action but for better socio economic factors for our vulnerable populations.[5]

We are faced with an ever increasing burdensome decontamination agenda. I urge you to question guidance, question the evidence base and choose the option that is both low risk for the patient but also environmentally sound. I strongly agree that we need to protect our patients, but the protection inside our dental facilities cannot be outweighed by the environmental harm of some of these processes.[6]

And be smart. When you are implementing a potentially new sustainable product, think about where the product comes from, and where it will end up. If it is compostable, what products were used to make it? If you are using it a lot, will it need a lot of land to grow the product? And if it is biodegradable/compostable is this relevant if it goes into domestic land waste, or into a yellow bag?

Create a culture of sustainability in your practice. Initiate conversations with patients and staff that build a sustainable practice that suits this need: educate; have a policy; normalise.

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FROM THE PRESIDENT

What a summer of sporting success it has been for the UK! Cameron Norrie reached the Wimbledon men's singles semi-finals and Heather Watson played her first quarter-finals in the ladies singles; the England ladies won the European (Ladies) Football Championships; and the home nations achieved great success at the Commonwealth Games, winning medals in the athletics, gymnastics and swimming, to name but a few sports that participated in Birmingham. Achieving this kind of success is a combination of individual talent, hard work, dedication, and *teamwork*. Athletes always thank their teams in post-match/competition interviews.

Similar to our sporting heroes, BSDHT is all about teams. Without teamwork we could not represent members and the profession and achieve the successful outcomes that we do.

BSDHT Strategic Plan

With teamwork in mind, the Executive met in July to produce a strategic plan for BSDHT *'that is fit for purpose and that will continue to meet the needs of current members, student members and encourage new membership to assure growth and longevity of the Society'.*

In preparation the Regional Group teams and the Executive were asked to consider 'two big things' that BSDHT has achieved over the past two years and 'one big thing' that we need to deliver as part of the strategy that can impact (positively) for members. The feedback was wide ranging und unsurprisingly, the main three issues that we continue to work on were mentioned: dental nurse chairside support; exemptions; and overseas dentists registering as dental hygienists and dental therapists. Other issues included: establishing career pathways; a range of continuing education; attracting new members whilst retaining members throughout their entire careers; and promoting the value of Regional Groups.

Joining the Executive team to assist in directing the strategy were Debbie Reed, Hon Vice President, and Gemma Barker, Barker PR. Debbie chaired the sessions, keeping the team on track and focusing on the many and creative ideas that were flowing, whilst Gemma added a PR perspective. Both Debbie and Gemma were integral to the work and we now have five main themes to work on over the next three years: membership; career pathways; regional groups; communications and PR; and financial and succession planning - all with short, medium and long-term goals.

An analogy that was used throughout the strategy was a quote from a book called *Good to Great* by Jim Collins. He writes about "having the right people on the bus and the right people in the right seats on the bus" in order to make the shift from being a 'good' organisation to a 'great' organisation! The bus analogy is applicable to all the BSDHT teams and really starts at grass roots with the regional groups.

Regional Groups Study Days

September and October is regional group study day season when members come together to learn from the many fantastic speakers that are invited to share their knowledge with you on a variety of topics. These events are designed to enhance and evolve your clinical practice. Please check the BSDHT website for dates, venues, speakers and their topics.

The regional groups also hold their *Annual General Meetings* and elect a new team. This is your opportunity to become part of a BSDHT team and contribute to arranging the study days, develop some new skills, make new connections and friends along the way, and have a seat on the bus! The regional groups are integral to the continuing success of BSDHT.

The Commonwealth Games are widely known as the 'friendly games'. As an avid viewer of the swimming, I was impressed that commentators frequently mentioned that the competitors are great friends out of the pool, which was evident throughout and a major contributing factor in their success. It is definitely my experience that working as part of a BSDHT team often creates lasting friendships and support as we move through our careers.

AGM and Nominations

BSDHT will once again hold the Annual General Meeting online on Thursday 17th November at 7.30pm. Please add the date to your diary.

Nominations are open for:

- President Elect - I will hand over the BSDHT Presidency to Miranda Steeples in November
- Honorary Treasurer - Laura McClune has completed her initial two-year term
- Student Representative Coordinator - Claire Bennett has worked to establish this role over the past fifteen months and it is now an electable post on Council and Executive
- Three Members Elected to Council - members who would like to become involved at national level are welcome to be nominated for a position on Council

Nomination papers have been emailed too you and are also

available on the BSDHT website. The closing date for nominations is 5pm on Friday 7th October 2022.

BSDHT Oral Health Conference

Planning for the OHC on 25th & 26th November in Manchester continues. Following on from the many positive responses from members who attended the OHC in Glasgow last November, we are all very excited and anticipate a really successful conference. If you are planning to attend and have not yet booked, please note that the early bird delegate fees end on Monday 19th September.

In other news…

NHS contract for dental services

On the 19th July, the Chief Dental Officer for England, Sara Hurley and Ali Spark, Director of Dentistry, Community Pharmacy and Optometry NHS England, announced the initial set of changes to the NHS contract for dental services, the first in sixteen years. Whilst BSDHT support these initial changes, there is still need for further clarification on remuneration for dental therapists working to their full scope. The news that the administrative barrier will be removed, for clinicians other than our dentist colleagues, to open a course of treatment, is a positive step and will allow patients to see a dental hygienist or dental therapist directly, without the need to see a dentist first. To ensure these changes are effective in widening access to care for patients, education of both the public and the wider profession is needed so they understand the role of a dental therapist, what their scope of practice is and how they can work effectively within the dental team.

EuroPerio10

The President elect and I travelled to Copenhagen to attend EuroPerio 10 last June. We were joined by BSDHT members Louise Baguley and Anna Fyodorov, who won the infographic competition sponsored by Colgate. There is more about the event from Anna and Louise in this edition of *Dental Health*. I would like to take this opportunity to thank Gail Vernon and all at Colgate for their support.

As I write this I am heading to Dublin, for the International Federation of Dental Hygienists (IFDH) House of Delegates meeting, where we will be representing BSDHT and the UK during two days of business meetings. This will be followed by the three-day International Symposium for Dental Hygienists (ISDH). There will be more news of our time in Dublin in the November edition of *Dental Health*.

Diane

Diane Rochford

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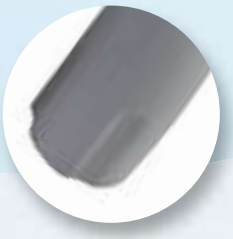

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Left to right: **Emma van Eyssen (Colgate), Miranda Steeples, Louise Baguley, Anna Fyodorova, Diane Rochford and Lone Lenes (Colgate).**

BSDHT AND COLGATE INFOGRAPHIC COMPETITION WINNERS ATTEND EUROPERIO 10

Louise Baguley and Anna Fyodorova were the lucky winners of the BSDHT & Colgate infographic competition to attend the EuroPerio10 Congress in Copenhagen in June.

The competition asked members to design an infographic on the topic: 'What is gum disease?', to be presented in layman's terms to help educate patients in practice.

The EuroPerio Congress is the world's leading congress in periodontology and implant dentistry. The programme included more than 120 speakers from around the world, all experts in their field. A rich and varied scientific programme featured interactive sessions, live surgeries and dental exhibitions showcasing the latest products and technologies in the industry.

Louise and Anna were accompanied by Diane Rochford (President) and Miranda Steeples (President Elect), who also attended representing the BSDHT.

Louise and Anna's winning infographics will be available to dental practices to help educate patients to understand 'What is gum disease?' and open conversations with their clinicians. The infographic will also be a downloadable

resource on the British Society of Dental Hygiene & Therapy website (**https://www.bsdht.org.uk/downloadable-resources/**) for dental hygienists and dental therapists to access and use with their patients.

The aim, and stated purpose, of The European Federation of Periodontology (EFP), is to provide global leadership in the promotion of periodontology and peri-implant health. By reducing the impact of these two common and debilitating oral diseases, it is hoped that the oral and general systemic health of society will also improve.

The scientific programme offered a wealth of latest research in periodontology and implantology - current treatment decisions, future approaches and new insights. The array of fabulous speakers made it challenging to decide which lecture, workshop, breakout session or poster discussion to attend, with the choice of up to six rooms simultaneously enlightening delegates with the latest information and approaches! As a bonus, the EFP have given a post conference 'access online programme' so that delegates can visit and revisit their favourite moments. Additionally, 111 dental companies offered new product launches and patient and personal use samples.

Louise commented: *'As a dental hygienist of 38 years, I loved attending Europerio! It's great to keep the brain cells working and I come back motivated and energised, particularly after the challenging last few years. It was lovely to meet Anna, newly graduated from Portsmouth University, and we had great fun together! Diane and Miranda were marvellous and a massive thank you for looking after us.*

This was a fantastic opportunity. This collaboration between BSDHT and Colgate was a great opportunity and particular thanks to Colgate for their support of our profession'.

Left to right: **Diane Rochford, Louise Baguley and Anna Fyodorova at the BSP social event.**

Similarly, Anna said: *'I felt very fortunate to have won the BSDHT and Colgate infographic competition. I am extremely proud my work will be used as an educational tool for clinicians and patients. Having only qualified a year ago, I was unsure which events were worth investing in due to commitments and a busy lifestyle. EuroPerio10 has been an eye opener for me and it turned out to be so much more than I had ever thought it would be. There was never a dull moment and so much choice - fantastic lectures to attend, connecting with the exhibitors and the socials in the evenings. I met some incredible people and I went away from the event with masses of new information and ideas to implement in my day-to-day practice to better myself as a clinician and to be able to educate patients better.*

My experience, of course, would not be the same without my new friend and fellow winner, Louise. We bonded very quickly from the start and are still in touch. I would like to thank BSDHT and Colgate once again for such a fantastic opportunity and I will be sure to attend every EuroPerio going forward."

Diane and Miranda commented: *'We wish Anna and Louise all the best in their careers and as a Society, we are very pleased that they got so much out of the experience'.*

It's all about prevention! Novel strategies for prevention of peri-implant biological complications - Giorgio Pagni, Florence, Italy.

Supporting patients' daily challenges with plaque management

Up to half of the population suffers from periodontitis[1] and at-home daily dental plaque control between dental visits is key to maintaining oral health.[2] Gingivitis and periodontitis are a continuum of the same inflammatory disease; however, it does not follow that gingivitis will always progress to periodontitis. Evidence also indicates that interrupting the plaque colonisation process may well offer the most appropriate approach in helping to prevent the progression of periodontal diseases.[3]

Limitations in the oral care routines of patients include:

- The average brushing time is 46 seconds[5]
- Only 31% of people claim to clean between their teeth with floss,[6] despite agreement that flossing is necessary to protect oral health[7,8]
- Patients can lack the manual dexterity, the time or find flossing painful.[9,10]

When to take action

Offering insight into the reality of patients' situation, speaking at the launch of Oral Health Month earlier this year, Professor Iain Chapple*, commented on the fact that periodontal disease prevalence has changed very little in the last 20 years, despite advancements in the understanding of, and approach to, periodontal disease.

Referencing the Economist Intelligence Unit's White Paper on the societal and economic impact of periodontitis (2021), Professor Chapple asked: 'What happens if we could eliminate incident gingivitis? The cost of doing that by empowering patients to look after for themselves at home more than halves the amount of money spent delivering that care.'[11]

He continued: 'The cost, however, of diagnosing and treating 90% of periodontitis, that is enormous. The costs of care tripled, and in some cases almost quadrupled because that's a big dental workforce demand to get periodontitis managed.'[11]

He added that if you neglect gingivitis, then the cost of care increases significantly, because more disease develops and healthy life years reduce, resulting in more time off work, etc. Offering further insight into what is needed going forward, he stated a focus on oral health, not disease, was needed.

Attack plaque from every angle

It is widely accepted that the bacteria present in dental plaque are a major cause of caries and periodontal disease, and that prevention of these conditions requires removal of that plaque.[12]

Reinforcing this idea, Boyle and colleagues (2014) wrote: 'Dental plaque is the main cause of oral diseases and can be removed mechanically by 'effective' brushing and flossing.'[13]

Whilst the standard recommendation is to brush the teeth and clean interdentally, evidence suggests that the adjunctive use of a mouthwash may provide benefits beyond mechanical cleaning.[14]

Rinsing reaches virtually 100% of the mouth[15] and LISTERINE® penetrates the plaque biofilm, kills 99.9% of germs and helps reduce the repopulation rate of bacteria.[16-19]

New published data reveals how to tackle interproximal plaque with essential oils-based LISTERINE®

For patients who brush and floss, adding LISTERINE® reduces interproximal plaque by 28.4% versus brushing and flossing alone.**[20] And, for those who don't floss, LISTERINE® is shown to reduce interproximal plaque above the gumline by 4.6x versus floss.***[21] Of course, not all patients are the same - attack plaque from every angle. Make an evidence-based recommendation with LISTERINE®.

To view the full peer reviewed papers visit:

https://jdh.adha.org/content/96/3/8 - Bosma ML et al. Efficacy of flossing and mouthrinsing regimens on plaque and gingivitis: a randomized clinical trial. Journal of Dental Hygiene 2022; 96(3): 8-20

https://jdh.adha.org/content/96/3/21 - Milleman J et al. Comparative effectiveness of toothbrushing, flossing and mouthrinse regimens on plaque and gingivitis: a 12-week virtually supervised clinical trial. Journal of Dental Hygiene 2022; 96(3): 21-34

** Director of Research within the Institute of Clinical Sciences, College of Medical and Dental Sciences, The University of Birmingham.*

*** Sustained plaque reduction above the gumline with continual twice daily use for 12 weeks after a dental cleaning. Flossing underwent once daily supervision on weekdays. Use LISTERINE® as part of a 3-step routine.*

**** 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.*

NOTE: Full references available:
https://www.bsdht.org.uk/dh-contact-news/

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25-26 November 2022, Manchester Central, Manchester

The Oral Health Conference (OHC) is the BSDHT's flagship member conference and the must-attend annual event for dental hygienists and dental therapists. Put together entirely with you in mind it offers: education; CPD hours; leading speakers; updates from the profession; the chance to network with colleagues, experts, and industry.

We were so excited to be back to an in-person event in Glasgow last year, and we're even more excited to be together again this year in the in the lively city of Manchester on 25-26 November!

Enhancing our members' careers and patient care

The two-day programme is designed to be clinically-applicable and professionally relevant, with lots of top tips you can apply at work the next day, both to improve your patient outcomes and to grow as a dental professional.

"Meeting in Manchester for the OHC this year will build upon the success of Glasgow 2021 and will offer delegates a wide-range of speakers, hands-on sessions, and educational interaction with our colleagues in the dental trade. Whether you are starting out in your career, developing yourself as a business, or you are looking for motivation and options later on in your career, this year's OHC programme has something for everyone".

Miranda Steeples,
President Elect of the BSDHT and programme lead

The breadth of topics and quality of speakers are always two of our delegates' most highly-rated benefits of attending. The 2022 speaker faculty is as high-profile and diverse as ever, covering themes from the clinical to the professional:

Louis Mackenzie will give a talk on **MI materials - posterior restorations for dental therapists**, providing you with an update on contemporary materials, equipment and clinical techniques for the direct restoration of posterior teeth. By the end of the session, you'll be able to demonstrate an understanding of how to optimise all clinical stages of direct posterior sealants and restorations using resin-based materials, glass ionomer, and amalgam - helping you to enhance your patient care by selecting appropriate materials and equipment and optimising clinical techniques.

Back by popular demand, **Tim Ives** will be joined by **Juliette Reeves** to present on **Sugar - are we sweet enough?** This session will give you an overview of sugar and the disease process and how - based on research findings - you can persuade your patients to reduce consumption.

Don't miss **Peter Clarke's** keynote address on **Periodontal health - perception vs reality**, which will discuss the role of dental professionals in changing patients' perceptions of periodontal diseases and explore how we can encourage patients' active behaviour to aid their adherence to an at-home care regime to achieve and maintain periodontal health.

These are just a few of the speakers you'll see at the conference - you can view the full extensive programme at **bsdht.org.uk/ohc-2022**

Tailor the programme to your learning needs

As always, alongside the plenary sessions of keynote speakers you'll find breakfast workshops and three concurrent streams to choose from, allowing you to tailor a programme that best suits your needs.

Meet old friends and new

While the educational content of the conference is extremely important, the OHC is also the perfect way to come together as a profession, to meet and share ideas and best practice, and to celebrate our work. It's the perfect place to network and make valuable career contacts. Previous delegates always rate this as one of the most important aspects of the conference, with lots of opportunities to network informally and formally with other delegates, speakers and trade representatives. You'll also be able to meet the BSDHT Executive team and members involved in the various

working and advisory groups that are helping to shape BSDHT and our strategy.

And, of course, there are opportunities to relax and have fun with your friends and colleagues as well – not least at the Friday night party at the Marriott Victoria and Albert Hotel. Add a ticket to your conference booking and join us for food, drinks and dancing.

Following the excitement of being back face to face in Glasgow for the OHC last year, I am even more excited that the OHC2022 is going to be in my home city of Manchester. Miranda (President Elect) has worked hard to put a fantastic programme together, so this year's conference will really be 'the business'. Once again not only does the conference offer the opportunity to learn and enhance our skills as clinicians, but to celebrate our profession with friends and colleagues. I am looking forward to welcoming you to the marvellous city of Manchester in November.

Diane Rochford,
President, BSDHT

The OHC is the perfect place to make important contacts across the industry and profession.

Annual poster competition

Did you know you can be part of the OHC's educational content by submitting your work to be considered for poster presentation? We are pleased to provide those who have been involved in research projects, as part of their employment or continuing education and training, with the opportunity to submit their research for review and consideration by our Scientific Committee. The submission deadline is **5pm on Friday 23 September** – find full details at **bsdht.org.uk/ohc-2022**. Successful abstracts will be presented as part of a poster display at the OHC and prizes will be awarded.

The BSDHT would like to thank BioMin for their sponsorship of the poster competition.

10 great reasons to attend

This is just a taste of what you'll experience at the conference – there are many great reasons to attend:

1. Learn from educational sessions designed to be applicable to your day-to-day work.
2. Gain up to 9 hours of CPD.
3. Hear from leading speakers from clinical practice, academia, and industry.
4. Learn from your peers' research in the poster sessions.
5. Submit your work for the poster competition.
6. Help inform the BSDHT's work.
7. Share and learn from best practice.
8. Learn about latest products and services in the exhibition.
9. Network with colleagues and key players in dentistry in relaxed settings.
10. Celebrate the profession at the Friday night party.

Join us at the conference – book your place at **bsdht.org.uk/ohc-2022**. Earlybird fees are available until Monday 19 September

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COVID-19 INQUIRY LAUNCHED

The Covid-19 Public Inquiry has now been officially launched!

The Chair of the Inquiry has released her opening statement, which provides a breakdown of the first three modules of the Inquiry, and the protocol for becoming a Core Participant. The purpose of the Inquiry is to provide a factual account of what happened across the whole of the UK during the Covid-19 Pandemic, with health inequalities being a key theme throughout the Inquiry.

Inquiry Modules

The Inquiry will be divided into modules, each of which will reflect a different area of the Terms of Reference. The modules will then be heard in turn with the preliminary hearing for module 1 being held in September 2022, and the full hearings being held in Spring 2023.

Module 1 will consider the extent to which the risk of a coronavirus pandemic was properly identified and planned for, and whether the UK was ready for such an eventuality. It will also scrutinise Government decision-making in relation to planning and will seek to identify lessons from earlier incidents and simulations.

Module 2 will be split into two parts: the first considering core political and administrative governance and decision-making for the UK. The second considering the same for Scotland, Wales and Northern Ireland. Module 2 will also consider the decision-making for non-pharmaceutical interventions, such as national lockdowns and work from home provisions. The preliminary hearing for this module will be held in Autumn 2022, with further hearings being held in Summer 2023.

Lastly, module 3 will detail the impact of Covid, and of the governmental and societal responses to it, on healthcare systems generally and on patients, hospitals and other healthcare workers. It will examine healthcare systems and governance, primary care such as GPs and dentists, and the impact Covid had on NHS backlogs and non-Covid treatment.

Baroness Heather Hallett has stated that reports will be released at the end of each module, to ensure key findings and recommendations are made available to the public as they come to light.

Dental Alliance

FTA Law has launched the Dental Alliance to allow the opportunity for professionals from across the dental sector to be given a voice in the Inquiry. The

Image courtesy of:
PIRO4D from Pixabay

purpose is to demand answers and shape policy for the future to prevent mistakes from being repeated.

The Alliance will act as a single point of contact to co-ordinate the views of the many across the sector, whose voices may otherwise not be heard.

The Alliance is led by Sarah Buxton and Lindsay Dixon of FTA Law, Solicitors specialising in the dental sector, and leading public law barrister, Sam Karim QC of Kings Chambers. We are supported by a Steering Committee of individuals representing the interests of various areas of the sector – Diane Rochford, President BSDHT is a member of the committee. Their role will be to liaise with the members of their respective associations to gather evidence and provide a platform for their views to be expressed.

We are applying to become Core Participants to the Inquiry; initially to module 1. This will allow us to participate in the Inquiry and to put across the views of the sector on the impact of the pandemic and lessons that can be learned for the future. This means that we would be provided with electronic disclosure of evidence in relation to the module, we would have the right to make opening and closing statements at any of the hearings and suggest lines of questioning to be undertaken by Counsel. Core participants also gain the right to apply to ask questions of witnesses in the hearings.

How can you help?

1. Spread the word – the more people aware of and involved with what we are doing, the better. Direct people to our website **www.dental-alliance.co.uk** where they can sign-up to receive updates.
2. Gather your thoughts – the pandemic has had a wide-reaching effect and we are aware of many issues particularly affecting the dental sector. In due course we will be asking for your input via structured questionnaires so it would be helpful if you could start thinking about the types of issues you want to see raised at the Inquiry.
3. Show your support –having a seat at the table at the Inquiry will benefit everyone in the sector. We are seeking donations to cover the cost of this via our crowdfunding site at **www.crowdjustice.com/case/cida/** and would greatly welcome your contribution
4. Follow us on social media – we are on Facebook The Dental Alliance | Facebook and LinkedIn The Dental Alliance: Company Page Admin | LinkedIn

PART 2

ARE YOU COVERED?

INTERVIEW WITH TOM CHASTON OF ALL MED PRO

by FAY HIGGIN

This article is intended to be of general interest to all dental hygienist and dental therapist colleagues, no matter who you currently indemnify with. The professional indemnity landscape is constantly changing and it's a good idea to keep yourself informed and up to date.

Q If I am employed, rather than self-employed, do I need my own policy?

A If you are employed there is a chance that you are covered under your employer's policy however if you are not then you will need to buy your own indemnity cover. If you are covered under your employer's policy but work at multiple practices you will need to check that the cover extends to your activities at the other practices. If it does not then you will need to buy your own indemnity cover for work not picked up by your employer's policy. It is your responsibility, not that of your employer, to ensure that there is a correct policy in place according to the GDC regulations.

It is good practice to request a copy of the employer's policy and have a copy for your records so that you can see whether or not you have cover.

If you work for more than one employer, e.g. for locum work, I would advise taking out your own policy.

Q A patient letter of complaint has been received by the practice where I work. What should I do?

A Assuming the practice has given you a copy – and they do not always – get in touch with your indemnity provider straight away. It is important that you receive the advice you need from the outset so that a policy claim can be avoided from the outset. The sooner you can get dento-legal advice the better - they should guide you through the procedure.

For example, you may receive a letter from the patient complaining that they are unhappy with their treatment or from, for example, Dental Law Partnership asking for treatment records – you have to provide a copy of the patient record by law. You cannot charge for this. The patient owns the data. Several months later, if there is a potential case of negligence, there will be a follow up letter with more detailed allegations. We classify that as a letter of claim.

Some insurers operate differently, some policies specify that you only have to notify if there is something that is 'likely' to give rise to a claim and others specify you notify if it 'may' result in a claim. There is a fundamental difference between the two. We prefer to deal with issues at an early stage and it does not impact on your premium. It is important to get things right at the outset, so we can ensure there are no issues further down the line.

These days it is possible to get a claim for almost anything. For example, the way the clinician spoke to the patient or their family or a dispute about fees. It is not a negligence case but when you speak to us we can advise, and may suggest '…perhaps respond in this way'.

Q How do you support members at a GDC hearing?

A In much the same way as supporting a policyholder through a claim. Give us a call and we will provide dento-legal help straight away. You will be guided and supported through the process. AMP picks up the cost of the hearing and appeals process. The timeframe to respond to the communications can sometimes be very short so you should call us straight away.

Q What about prescriptions, if a dentist is not at the practice that day?

A In the case of antibiotics, this is outside your scope of practice. You would have to refer the patient to someone who can prescribe that day. It would be a matter for the practice to ensure there is adequate cover in place.

Q People moving from 'claims made' to 'claims occurring', do they have to notify their old insurer of anything in particular?

A Any new insurance policy will exclude anything that you are already aware of. If, for instance, a BSDHT member is moving from the BGP policy to All Med Pro (or any other provider), and then tried to make a claim for something it transpires they were aware of, say six months earlier, any provider would reject that.

It is important to look at the policy wording: if you have to notify anything which 'may' lead to a claim – you have to notify everything to ensure you are covered.

Q A What about a patient in pain or in need of a prescription?

I would normally defer to our dento-legal advisers on that in real-time to make the decision. If we get the same kind of query a lot, we make a note and all learn from it. A big part of what we do is bring together the best dento-legal advisers, insurers, brokers and claims people so we have the best hybrid solutions for our clients.

Q A Do you cover the use of lasers?

As long as it is within your scope of practice, and you are trained and competent, then you will be indemnified for what you do.

Q A Do you only cover people if treatment is undertaken in surgery premises?

Yes, it must be a clinical setting. However, there is a qualification to that, in relation to care undertaken in care homes; these are CQC registered premises and are covered. So, members can undertake domiciliary care and know that they are covered. A bit more challenging is providing care within a patient's home. The risk is with infection control so we would need to look carefully at what was actually being provided to patients in their own home.

For a quotation on indemnity cover, go to:
https://quote.allmedpro.co.uk/product/bsdht/

THE DENTAL THERAPIST AT SEA

by LYNN HARRIS, JANICE HEARNE, GRAEME BRYCE

The Royal Naval Dental Service (RNDS) was founded over a 100 years ago to deliver dental care to its military population. Dental hygienists (DH) and, more recently, dental therapists (DT) are integral to care provision for the management of primary dental disease to reduce the risk of dental emergency (DE) within the operational environment. The RNDS provides dental care shore-side via primary healthcare dental centres, on land-based operations with the Royal Marines and afloat whilst deployed at sea.

Deployed clinical working environment

Shore-side DPHC (Defence Primary Healthcare) dental centres offer modern equipment and services to provide all levels of care. The capital (larger) royal naval ships, such as the aircraft carriers and amphibious landing platforms, have fully equipped designated dental surgeries (Fig. 1) that allow comprehensive dental care to be provided. Portable dental modules, including operating units (Fig. 2) and radiographic equipment, allow dentistry to be provided within smaller vessels by converting the ship's sickbay (medical department) into a dental treatment area. One of the advantages of these portable modules is that they provide agility for the deployed dental team (DDT) to transfer between vessels, enabling dental support for a larger fleet.

Clinical delivery

Ships' companies often work in high stress environments for extended time periods and this predisposes the individual to dental disease and increased risk of DE. DE include pericoronitis, periodontal disease, endodontic disease and fractured restorations. Left untreated, the DE has a substantial impact on both the individual and the effectiveness of that individual in performing their normal role.[1,2,3] The DDT aims to provide dental care that both treats and reduces the future risk of DE without removing the patient from their deployed role. If a member of the ship's company had to be removed from duty, or the ship, this may have an impact on operational capability and could affect its ongoing taskings. The DDT, comprising a dental officer (DO), dental nurse (DN) and either a dental hygienist (DH) or dental therapist (DT), forms a tight-knit, multi-disciplinary team that provides a broad range of mixed complexity primary dental care including oral surgery and a full range of restorative treatments.

The RNDS aim to deploy DNs with enhanced skills – these include oral health education (OHE), dietary advice or the application of fluoride for high caries risk patients. Subsequently, the DN compliments the DT to deliver an extensive range of treatments for patients with RIOTN (Restorative Index of Treatment Need) Tier 1 complexity dental disease. The DT is integral to improving the ship's population's dental health, providing supportive periodontal therapy, treating dental caries and fractured restorations and treating tooth surface loss. DT delivery of Tier 1 care also increases the DO capacity to undertake more complex treatments.

An example of this integrated approach to treating complexity was a recent deployment on HMS Albion, when the DDT included a restorative consultant which allowed care provision to include both Tier 2 and 3 treatments.

Figures 3a, 3b and 3c present a Tier 2 complexity case. Severe tooth surface loss affecting UR3 – UL3 on 23-year-old male. Case completed with restored localised UR3 – UL3 composites at increased vertical dimension.

Figure 1: **Working in the dental department onboard HMS Albion**

Figure 2: **Working with the portable dental unit (PDU) on board HMS Albion (seen to the right of clinician)**

To register your interest in joining the RN please visit:
www.royalnavy.mod.uk/careers/roles-and-specialisations/services/surface-fleet/dental-hygienist or scan the QR code

Life on board

DDTs join a ship for a defined period, ranging from several weeks to several months, dependent on the ship's operational programme and patient treatment need.

If you enjoy structure, you will love life on board. Daily life begins with "Call the Hands," where the ship's main broadcast is used as the ship's alarm clock. The option of early morning circuit training with the physical training instructor (affectionately known as Clubz) is available should you wish to have a workout before breakfast, otherwise you can use the fully equipped gym at any time during the day or attend late afternoon circuit training.

Life in the mess decks is focused on the work hard play hard ethos. When the working day ends you can find yourself with your friends (or Oppos) playing card or board games, watching a film, holding mess deck quiz nights or making a fancy-dress outfit for the next theme night. Food is served in the galley where we dine with our peers. It is home to some of our favourites such as fish Friday, steak Saturday and the good old Sunday roast.

Opportunities

The RN deploys to all areas around the globe and is a fantastic way to see the world. During my military life I have been fortunate to visit many different countries including: Cape Verde; Bahrain; South Africa; the Falkland Islands; and Norway. I also elected to spend six years based overseas in RN Gibraltar. The working environment is both diverse and challenging but you will be supported by a military family with an ethos that encourages success and aspires to excellence.

Alongside life at sea and delivering shore-side clinical care, the RN provides additional opportunities such as: participation in representative sport; stewarding tennis at Wimbledon and cricket at Lords; and even an invite to Buckingham Palace. Adventurous training and serving as part of the dental forensics team are other aspects of RNDS life that are rewarding and add to the tapestry of service live.

The package

The RN provides job and income-security, with additional 'My Navy The Offer' benefits including: non-contributory pension; funded GDC registration; free medical and dental care; gym facilities; training; maternity support; high quality subsidised military accommodation; and a help to buy your first house scheme. Whilst funded professional development is available, there is also scope to develop in areas not related to dentistry and broaden your professional portfolio.

If you have enthusiasm for working in challenging environments, are professional and have a real sense of adventure, then joining the Royal Navy is for you!

Author: Lynn qualified as a dental hygienist from Newcastle University in 2002 and completed the dental therapist conversion in 2007 at Cardiff University. She has served in the Royal Navy for over 19 years and is based at HMS Collingwood, Portsmouth. She is also the current BSDHT Scottish Treasurer and Military Ambassador.

Email: Lynn.Harris976@mod.gov.uk

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Figure 3a: **Upper incisors and lateral incisors prepped with rubber dam**

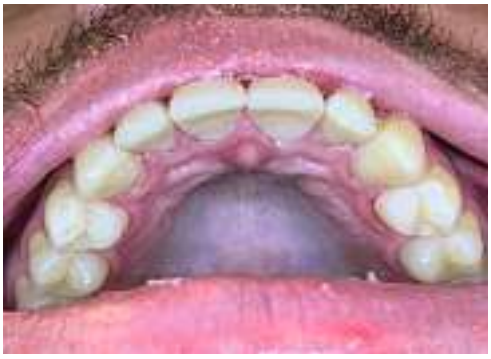

Figure 3b: **Palatal view of completed UR3-UL3 composite restorations**

Figure 3c: **Patient happy with treatment and overall outcome**

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A DAY IN THE LIFE OF A STUDENT DENTAL THERAPIST

by HOLLIE FIDDLER

In 2011 I began my career in dentistry as a trainee nurse and very quickly realised that my goal was to become a dental therapist. It appealed to me that no two days were likely to be the same, whether that was the various treatments carried out or the individual patients and their needs. Forward to 2020 and that goal became my reality as a student on the Oral and Dental Health Sciences course at Newcastle University. No two days are ever the same but here is a flavour of my daily routine:

8:00am: I always set an alarm Monday to Friday to make sure I keep in a routine and stay productive. I like to get up before clinic and make time for a coffee and breakfast to set me up for the day.

9.30am: I arrive at university, change into scrubs and make my way to clinic. Two of the most important things I take to clinic are my loupes - I cannot work without them now – and my course competency booklet. This is filled with assessments which we have to complete throughout the duration of the course. Once on the clinic, I collect my patients notes and begin setting up for the session.

11.15am: Time for treatment! Before calling my patient through I always:

- read through my notes to remind myself of what I did last visit and the plan for this visit
- ensure I am current with the patient's medical history noting any issues or medications
- check for any other entries from other colleagues since last visit with me
- check any radiographs that are available
- review the prescription and make sure it is current

Once my patient is comfortably settled in the chair, I will update their medical history if there have been any changes since last visit. At this point I will offer the patient a chance to raise any concerns they may have about their treatment. We will then together agree the plan for that day's treatment.

A dental therapist's scope of practice is extensive and my appointments usually consist of: tailored oral hygiene education; complete periodontal examination; sub- and supragingival professional mechanical plaque removal (PMPR); administering local anaesthetic; caries management; and direct restorations on primary and secondary teeth. Once the appointment is complete, and the patient has left, I write my notes and receive feedback from the tutors.

1:00pm: At this point I tend to leave clinic and head for the library where I meet my friends for lunch before lectures or a revision session. We usually have a debrief of what we learnt on clinic and it helps us all to share our knowledge.

5:00pm: The end of the working day and time to relax with a gym class or home to watch some trashy TV with a yummy dinner. I find that it is really important to wind down properly after a day at university as some days can be really intense.

Although this is just a brief overview of a 'typical' day as a student dental therapist, I am so happy that I pursued my goal. Each day is full of variety. Every patient has their own unique concerns and challenges which in return makes it one of the most rewarding careers. Being able to help and support patients with their oral health whilst having the skill to give them a beautiful smile is my dream job.

Author: Hollie is about to enter her final year of study at Newcastle University.

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USING AI TO IMPROVE PATIENT ORAL HYGIENE BETWEEN APPOINTMENTS

by JAMES RUSS
JENNIFER RUSS
JAMES THOMAS

Dental hygienists and dental therapists have an essential role in improving patients' oral health but patient compliance is often challenging. Although patients receive demonstrations on best oral hygiene practices, it is difficult to know how effectively they are being implemented between appointments. Artificial intelligence (AI) presents an affordable and scalable solution to delivering tailored oral hygiene guidance to patients between dental visits.

Oral Hygiene Support for Patients

Dental diseases remain the fourth most expensive conditions to treat in most industrialised countries and are estimated to impact 3.5 billion people globally.[1] Oral diseases are a significant public health concern and can cause pain, discomfort, loss of function and a reduced quality of life.[2] These conditions are often preventable, including dental caries and periodontal diseases, and tend to be associated with plaque accumulation and poor oral hygiene. The burden of dental diseases can be reduced through good oral hygiene, maintaining a balanced, low-sugar diet and sufficient exposure to fluoride. In addition, regular dental professional interventions are crucial to educate patients and manage reversible conditions before they progress.[3]

Dental hygienists and therapists regularly provide the primary clinical response to plaque and calculus deposits, as well as delivering tailored oral hygiene instruction to patients. This detailed educational advice can prevent pathology from developing and empowers patients to take responsibility for their own oral health.

With ever increasing pressures on public services, health care priorities have moved towards a more prevention-focused approach. If oral disease can be prevented, and slowed, then this can reduce necessary appointment times and improve overall patient access to the limited care resources available.

Whilst healthcare professionals are working hard to tackle oral disease, 39% of adults do not see a dental professional regularly.[4] Many patients delay seeing dental professionals until they are in pain, due to the limited accessibility, inconvenience and high cost of traditional in-person appointments.[5] As a result, 23% of these adults suffer from untreated and unrestorable decay.[6]

Although 75% of adults brush their teeth twice a day, patients rarely receive any insight between appointments into how effectively they are removing plaque.[7] The Delivering Better Oral Health toolkit for prevention advises that all adults should remove plaque daily using effective techniques as advised by dental professionals.[4] 'Daily, effective plaque removal is more important to periodontal health than tooth scaling and polishing by the clinical team'.[8] However, how can patients access tailored advice regarding oral hygiene methods between appointments? Once patients have received demonstrations on best oral hygiene practices, they need a way to know how effectively they are being implemented. Why should tailored oral health guidance be limited only to dental appointments?

With ever increasing access to technology and with mobile phones always within arm's reach, it is worth considering how technology can play a key role in supporting patient's oral care and hygiene habits.

Artificial Intelligence

Artificial intelligence (AI) is increasingly used to deliver targeted and efficient products, such as filtering out spam emails, answering questions in smart voice assistants and is even used to deliver self-driving cars. This raises the question, could it be used to compliment the expertise of dental professionals in helping patients to improve their oral hygiene between appointments? At Testmyteeth we believe that it definitely can!

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James Russ - Founder of Testmyteeth

The App

Testmyteeth is an affordable dental app that uses the high-quality cameras available on modern smartphones, combined with the power of AI to highlight where patients have missed when brushing their teeth. The app works by analysing images of the patient's maxillary and mandibular arches, taken at home after chewing a low-cost, two-tone plaque disclosing tablet.

The app then provides detailed insights about the type, quantity, and location where plaque has been found within the captured image. This allows patients to track improvements in their brushing technique over time. Using the generated insights, Testmyteeth can then deliver tailored educational guides between dental appointments, helping patients to manage and improve their own oral health.

The Plan

Having completed development of our prototype app we are excited to announce that we are looking for beta testers. We would love to invite BSDHT members to test the platform, provide feedback on the personalised insights we deliver, and help shape future app features that will motivate patients to improve their oral hygiene.

If you are interested in participating in our beta program, please sign up on our website at **www.testmyteeth.com**.

Authors

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2. Jennifer Russ BDS MFDS RCPS Glasg. Dental Core Trainee, Liverpool University Dental Hospital.
3. James Thomas BSc University of Bath. Dental student Kings College London.

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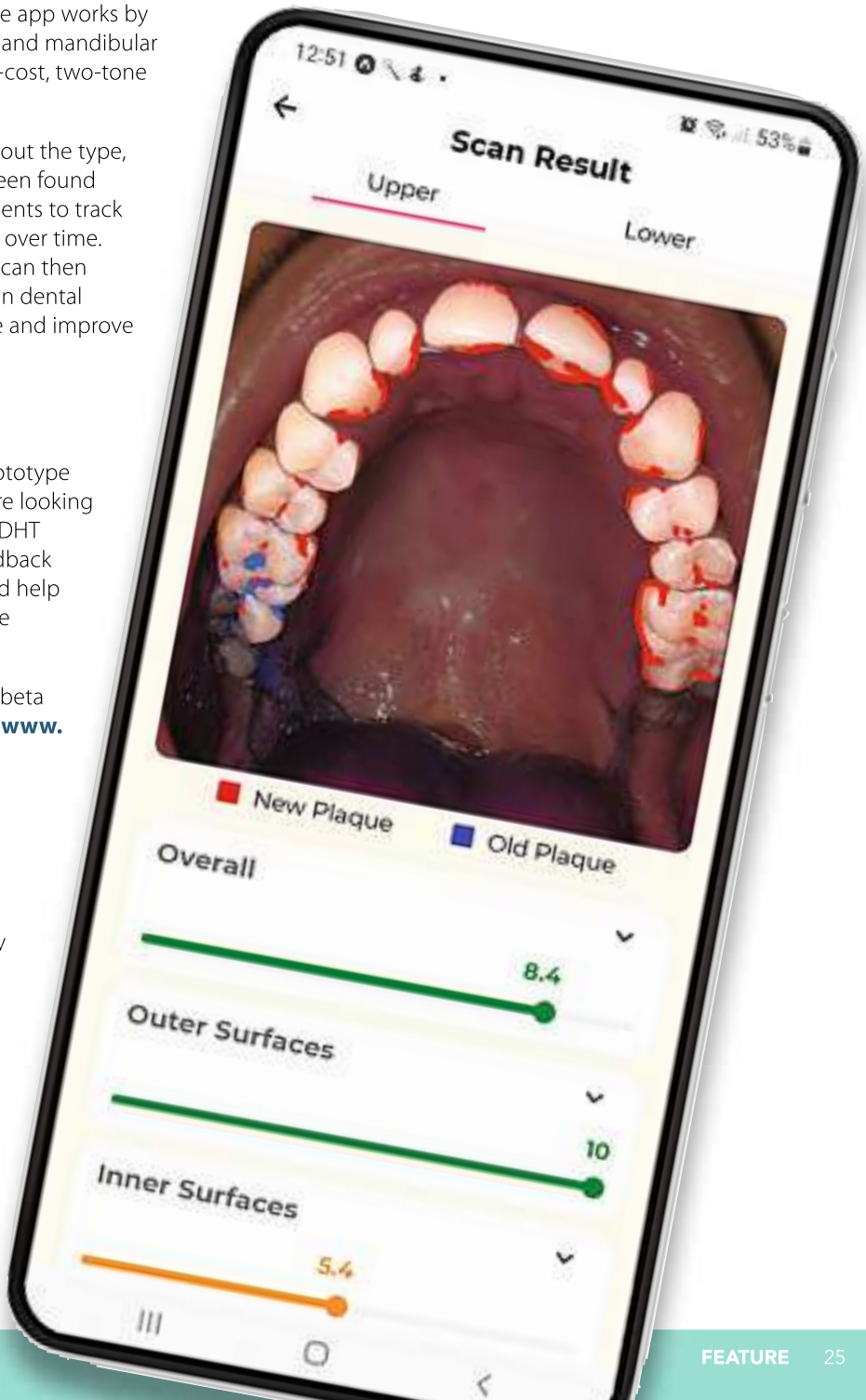

THE CLASS OF 1992

by SAMANTHA EUSTACE (NEE JOHNSON)

Thirty years ago, as a shy 21-year-old, I glanced around the classroom at my eight fellow students, all dressed in the same navy-blue trousers, jumpers, socks and shoes with the Birmingham School of Hygiene logo proudly displayed. Just as I noticed a pair of brightly patterned socks peeking out, one exception to this uniformity of dress code, Mrs Noble arrived making us quiver in our boots as, over the top of her glasses, she fixed my class mate with her stern glare, and announced: "Good morning ladies and welcome! You, Miss Heron, please go and change your socks immediately!" Yikes! What had I let myself in for? Little did I know that this was the start of a wild year that would change my life forever, both professionally and personally.

Becoming friends

As a mixed bag of females - four Canadians, four English and one Irish - we quickly united as one. Our common thread was that we were all qualified dental nurses and wished to further our training and treat patients. The course was intense straight from the off with two essays assigned to us that very first day. The student groups rolled on a six-monthly basis: we were the 'juniors' and our 'seniors,' who were six months ahead of us, were already treating 'live' patients.

I lived at home with my parents, and as we were only six miles from the city I travelled by bus to and from school each day. The girls from both groups all lived on the top floor of Musson House - a nurses' accommodation linked to the general hospital next door. Each room had a wash basin and then

there was a shared toilet and shower area at one end of the hall with the kitchen at the other end. One of the bedrooms had been turned in a 'TV' room with old sofas and a rented TV/Video machine. (No social media back in the day!) A couple of weeks into the course, one of the girls invited me back to Musson for a coffee. I very quickly realised that I was missing out when I saw how the girls all lived together! Fortunately, my luck was in as another Canadian girl had not managed to travel to the UK to join our course and her room was spare. The girls marched me to the office and I signed myself up for the last remaining room there and then - I announced to my parents that evening that I would be moving out!

Work hard play hard

We were quickly let loose on phantom heads with teeth covered in green paint. Perfecting our hand scaling techniques involved painstakingly removing all the paint. I was left-handed and was assigned to a 'senior' girl called Emma, also left-handed, who kindly guided me through my first six months with patience and love. (Ten years later she became Godmother to my first born.) Our tutors, the wonderful Mr Gibbs and Mrs Jones, were fabulous.

We were swept along with coursework and clinical sessions and bonded very quickly as a unit. Our tutors commented that they hadn't seen a group before as tight as we were. My parents were rewarded every weekend with a houseful of girls all wanting a home cooked meal where they swopped stories of family life. Sometimes the girls would even visit my parents' house without me!

Downtime would be a 'pint' in the infamous Gen Den where we chatted about our day's events and what we had learned that day. I found this to be a great revision method and would later recall these conversations during exams!

We practised our various new skills on one another. Before we knew it, we were treating patients and it was amazing how quickly we adapted to 'real life' plaque and calculus! Every three months we sat a written exam/viva/practical to carry us through to the next three months. It all seemed so fast and furious that there was little time for outside life and consequently these girls became my family over the next year.

Too soon, the seniors (our safety net) qualified and left us and the juniors arrived. It was our turn to become the 'Mother Hens' to the newbies. Work, play, patients rolled around for the next six months and suddenly we were facing our final exams!

A week later we found ourselves surreally sitting in a classroom waiting to be called in one by one to be given our results. In celebratory mood, we all rushed off to the Gen Den where the pints flowed and future plans were made. After results a few of us went on a trip to Lanzarote before I moved back home and settled into working life. Oh, but how I missed those girls…!

Real life beckoned and some of the girls returned to Canada, two moved to London together and others returned to their respective homes. However, over the years there have been numerous weekends spent together again, at various homes. My parents visited Canada and stayed with two of the girls twice before I had the chance to get across that pond!

The years have rolled by. I am married (the girls all came to my wedding) and have two children. I still work as a dental hygienist between two practices, one where I have been for 34 years (I started there as a 17 year-old nurse). We are still a strong unit and still all practising. We have been through marriages (my Dad even gave one of the girls away) births of children, loss of loved ones, divorces and cancer – it is an unbreakable bond.

Our plan to travel to Dublin and attend the ISDH will be the first time in 30 years that the most of us will all be together at one time. I am so excited! We may all be a little bit older, and wider, but when we are together, we feel just like those 21 year-old students again, ready to work hard and play hard.

So, to these wonderful girls, in the words of our graduation song (with thanks to Whitney Houston)…I will always love you. Thank you for being still in my life.

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by MIRANDA STEEPLES, SIMONE RUZARIO

A REPORT ON THE FINDINGS OF THE BSDHT DIVERSITY, INCLUSION & BELONGING SURVEY 2021

Introduction

A few months into the catastrophic pandemic of 2020, George Floyd was murdered in the US. Shining a spotlight on the true reality of racial discrimination and racial inequality, many occupations, both in the private and public sector, were prompted to reflect and draw on the importance of education and awareness around ethnic diversity. In dentistry, we asked ourselves some searching questions and took brave steps to engage in the conversation and look at the areas that needed to be focused on within our profession. Unfortunately, for many years we thought that racial biases and inequalities were something that only happened 'somewhere else'.

As a Society that represents dental hygienists and dental therapists, BSDHT wanted to take this conversation seriously and the Executive team at that time thought it would be best placed to put a call out to its members for those who had interest in this work and who would participate in a diversity, inclusion and belonging (DIB) working group. The group was formed in September 2020 and in order to formulate a strategy, it was decided to carry out a 'pulse check' and engage the membership. The aims were: to explore if issues of DIB were a problem for the membership; to understand the level of awareness of the problem; to ascertain if anyone had experience of being discriminated against in any way in the workplace; and could BSDHT do better?

As a Society, we are fully aware that equality and inclusion is not limited to just racial aspects, and that people may experience discrimination due to any of the protected characteristics.[1,2,3] We wanted to learn how diversity was represented within the profession and encourage those from diverse backgrounds to share their experiences. When we talk about diversity it is important to talk about inclusion, because it is fine being invited to the party, because we can all be invited to the party, but once there do we actually feel included?

Methodology

The DIB working group met regularly during 2020 to discuss and explore how the BSDHT could best represent its membership in the space of diversity, inclusion and belonging. It was agreed that we would survey the members by means of a questionnaire to gather some rudimental facts and figures and then leave adequate space for more full qualitative style responses to add depth and richness to members' stories.

The group considered what information it wanted to know about the membership and worked on the questions that could be included in the survey, both closed and open questions, to allow for the respondents to share their various lived experiences.

The survey aimed to gain insight into members' experiences surrounding diversity, inclusion and belonging, and their thoughts around how they felt their workplaces, and BSDHT delivered in these areas.

The survey design allowed for respondents to provide greater insight into individuals' experiences both at work and within the BSDHT. The survey was designed to collect both qualitative and quantitative data to aid future recommendations, and become part of the BSDHT Strategy, and perhaps the broader dental professions.

Survey Monkey was used to host and share the survey, and it was piloted with the then Executive Team of 10 individuals in May 2021 to test the flow and wording of the questions. It was approved with no amendments and was subsequently sent to the broader membership.

To ensure accessibility for all members to have the opportunity to complete the survey, it was distributed via email with the link to the survey embedded in the email. This allowed the survey to be completed on a mobile phone device, or on a laptop, which also ensured cost effectiveness to the BSDHT.

No ethical approval process was conducted for this online survey as this was an internal report, surveying our own membership. The authors of the article have no declaration of interest to report that would have relevance to the survey.

Results

The survey collected data both quantitatively and qualitatively to establish a brief overview of members' experiences and then open questions to gain deeper insight into their experiences in the workplace and with the BSDHT.

In May 2021, there were 2900 members and 279 responses were received, a response rate of almost 10%. Not all responses were complete, some questions had not been answered, and it was not clear why. Incomplete responses may offer some workable data, and full responses can give a more representative picture.

The first five questions were designed to be answered yes or no and all respondents answered these questions (Fig.1).

Figure 1

QUESTION	YES	NO
1. Has your age ever been a barrier to you being the best dental professional you can be?	28 (10%)	251 (90%)
2. Has your gender/gender identity been a barrier to you being the best dental professional you can be?	11 (4%)	268 (96%)
3. Has your marital/relationship status been used against you in the workplace?	14 (5%)	265 (95%)
4. Has disability been used against you in your life as a dental professional?	6 (2%)	273 (98%)

5. Has any of the following been a barrier to you being the best dental professional you can be?

	YES	NO
Pregnancy	33 (12%)	246 (88%)
Race	22 (8%)	257 (92%)
Religion	6 (2%)	273 (98%)
Gender/Sex at birth	8 (3%)	271 (97%)
Sexual orientation	3 (1%)	276 (99%)

Some questions had missing responses, the results are presented below (Fig.2).

The total of completed surveys was 279 and none of the questions in Figure 2 elicited a full response, all had missing answers, even though there was an option for 'don't know' or 'maybe'. The percentages of 'yes', 'no', 'maybe' or 'don't know' answers were derived from the number of answered responses with the skipped number excluded.

There were two questions that gave respondents the opportunity to provide a more detailed answer: one related to the individual's workplace; and the other about what more BSDHT could do.

Q11: What does your employer do to ensure staff feel included and part of the team?

Of the responses to this survey, 107 skipped this question, and 172 gave a response. Following analysis using a process of coding, categorising and theming[4,5] the following three main themes were derived from the data – the employer either: does nothing; utilises communication; or uses inclusive behaviours and actions.

With regards to employers that utilise communication, this took several forms: written policies; team meetings; digital messaging (emails, texts, WhatsApp messaging); one-to-one conversations; group huddles; and general communication.

Some employers use inclusive behaviours and actions to make their team members feel included, and this may take the form of the giving of a gift, or arranging a team social event.

Figure 2: **Some questions had missing responses, the results are presented below**

QUESTION	SKIPPED	ANSWERED	YES	NO	MAYBE	DON'T KNOW
6. Do you worry about disclosing any protected characteristics?	101	178	27 (15%)	151 (85%)	0	0
7. Do any of your employers have policies or procedures around EDI?	22	257	149 (58%)	18 (7%)	0	90 (35%)
8. Do you worry about identifying your sexual orientation to organisations?	24	255	5 (2%)	250 (98%)	0	0
9. Would you consider further training or CPD to better understand EDI?	95	184	92 (50%)	28 (15%)	64 (35%)	0
10. Do you feel individuals like yourself are well represented by BSDHT?	40	239	217 (91%)	22 (9%)	0	0

Q12: How can the Society best serve its members in the space of Equality, Diversity and Inclusion?

From the responses received, 113 answered this question, while 166 skipped it. A number of themes can be derived from the responses given to this question. There are four themes that can be grouped together because they are non-specific and not offering a suggestion for action: not sure how to answer this; already are; no need for any changes; could do better. With regards to what actions the Society could take to best serve its members, respondents requested additional mentoring/support; education; wider representation; and requested that the BSDHT uses its platform/voice.

One respondent said that there were, 'too many male speakers for a profession mostly made up of women'. Also offered was the request that we 'ensure the best person for speakers at meetings, not chosen because of race or gender', with a similar request for contributors to the journal, 'to ensure the best person for writer of articles is used, not chosen because of race or gender'.

Regarding wider representation respondents suggested: 'reflecting and supporting cultural diversity'; 'having diverse representation'; 'making sure its board members and positions of office are diverse and more inclusive of people from the black and ethnic minorities'; 'representatives from all areas of society'. BSDHT should continue to strive to provide representation for all to have: 'more people of colour included in the organisation'; to have 'ambassadors from all ethnicity and religious belief systems'; 'I have never seen a mixed race or black ambassador'.

Discussion

The vast majority of respondents did not indicate that they had experienced discrimination, which is encouraging. Some of the protected characteristics can be hidden and may not be disclosed by individuals, and it is not clear if the respondents had disclosed any of these characteristics to those in the workplace.

Age discrimination is something that may be experienced by all of us, regardless of any other distinguishing features, and was reported by 28 (10%) respondents, which is unsettling. Although gender/gender identity/sex at birth did not seem to affect anybody, being pregnant had been a barrier for 33 (12%) respondents in being the best dental professional they could be. Racial discrimination was the next highest result with regards to why people had felt discriminated against, followed by marital or relationship status, 22 (8%). The smallest numbers of reported discrimination, <4%, was reported with regards to gender/gender identity, disability, religion, gender/sex at birth, and sexual orientation.

There is the suggestion that some workplaces do not communicate what they do to ensure staff feel included and part of the team, because some respondents stated they were: 'unsure'; 'unaware of any policies'; 'not much history of such employers'; and 'I don't know, but it has never been a problem'. Perhaps they in fact, actually do nothing?

Examples of written documents included: having leaflets; written policies; protocols; in-house newsletter; and team training and courses provided. Worryingly though was the comment, 'in reality the policies are written and then forgotten about', and more so, 'my thoughts are that these policies are more about protecting staff from patient's prejudices and about protecting patients from any discrimination'.

Many respondents spoke of having team meetings as a means of making people feel included, either using the phrase 'team meetings', 'practice meetings', 'staff meetings', or 'feedback meetings' and one response stated, 'Some don't work together so staff meetings are less inclusive, although the minutes get distributed to all'.

Digital media were utilised as a means to communicate with team members, either via email, text, or WhatsApp messages, to ensure that people were 'included in all communications', and to 'ensure everyone was kept informed'.

Many encouraging comments were provided including how all new members are introduced to the team, that staff are 'kept informed and updated', that 'everyone is aware of practice protocols and how things are run', and importantly, 'everyone's opinion is listened to and valued with any concerns or ideas acted on properly' and that their employer 'maintains and promotes open honest dialogue in a safe space'.

Other verbal communication is utilised by some employers including staff appraisals, one-to-one meetings and peer review sessions. Team members can 'raise any concerns privately' and there is 'an open-door policy where any concerns can be easily raised'. Some employers utilise team huddles and weekly appreciation sessions, while others do not quite hit the mark with their morning huddles because in doing this they are 'making us hate them so we band together'.

Numerous responses stated that they are: 'all treated equally'; 'all treated the same'; or 'treated as part of the team'; and that they are treated with 'care and respect'. Some responses suggested inclusivity was not always in a positive way: 'treat all the same, shout at everyone so we all feel equally bad'; and that 'time off is accepted for religious reasons so long as it is taken as annual leave'.

The employers are: 'approachable'; they regularly 'ask employees if they are ok or need any support'; there is a culture of 'collaboration, openness and transparency'; there is 'consultation' before decisions are made; and 'every person is involved and has the choice to be involved'. These practices arrange: 'staff lunches'; 'social events'; 'staff nights out'; 'group CPD events'; and 'team building exercises and activities. Other practices show appreciation by means of gifts and personally saying thank you.

BSDHT

It was reassuring to see that some respondents think that BSDHT is already serving our members in the space of equality, diversity and inclusion, specifically noting that, 'the Society already does so much across the board. I'm not sure how it can be improved. Keep up the good work', and another comment that came with an important caveat, 'you already do a great job, but we need to start where the universities end. All students are aware of equality and it should not end when they leave'. Others felt that BSDHT was 'doing a very good job', 'it is already achieving it' and 'I think it already does serve its members in equality and inclusion'. 'When I first joined, I was discriminated against because I am male. I decided to leave due to this back in the 90's. However recently I believe BSDHT has greatly improved and is far less discriminating'.

The theme of no need for any changes was supported by a small selection of quotes: 'by staying out of politics'; 'not to make a huge thing of it unless there is a problem'; 'only consider their qualification to carry out role'; and 'the BSDHT should serve us best as professional hygienists/therapists and whatever our ethnicity/sexual orientation/religion should not be the organisation's concern. It should not be prioritised; it should not affect the way we work or conduct ourselves as professionals'.

Then those who thought BSDHT could do better because they: 'do not know what is done already'; that BSDHT should, 'be fully transparent and open to ideas, criticism and feedback and demonstrate examples where they haven't been equal/inclusive and what is being done'; and finally, 'ask opinions of all its members and demonstrate the end results of these interactions, not just that they have asked a question'.

Themes were offered which gave constructive suggestions as to how BSDHT could better support its members in the space of equality, diversity and inclusion, starting with offering mentoring and support which was suggested by numerous respondents and to provide facilities to support members. Another suggestion was that BSDHT should have 'support groups should you need someone there to talk to', that we should 'support everyone as equals' and to 'continue offering

contacts for mental support and financial advice'. At the time of the survey the need for mentoring and support was already identified, and in November 2021, BSDHT launched a coaching and mentoring programme for members.

Providing education in this area was a popular recommendation with the suggestion that the journal *Dental Health* could be well-positioned to help BSDHT support its members by printing 'articles from a variety of professionals', that articles are written that offer 'help/support for any equality/inclusion issues', and the suggestion that there is 'continued representation in the journal'. Another suggestion was given to 'perhaps give option of having publication in different languages', that we should 'reach out to students/old/young members [with] social media updates and emailing', and that BSDHT should 'listen to the members and raise issues that are brought to them in articles so that those members that can't speak out can get advice'.

Within this theme was education that could be provided outside of the journal, including: 'presentations from a variety of professionals'; 'webinars from a variety of backgrounds'; 'discussion and bias training CPD'; with the request to 'continue to keep us all informed and educated'; to 'encourage equality and diversity training/workshops'; 'to continue offering CPD topics to support members with learning more about this'; and to 'cover a wide range of subjects which will include everyone'.

The theme which attracted the largest number of respondents mentioned BSDHT having wider representation by: 'reflecting and supporting cultural diversity'; 'having diverse representation'; 'by making sure its board members and positions of office are diverse and more inclusive of people from the black and ethnic minorities'; 'representatives from all areas of society'.

And as before it was encouraged: 'to ensure the best person for whichever post, not chosen because of race or gender'. Pictures of genders and ethnicities in publications, proportional representation on different groups including Council and Executive Teams must be based on the best person for the role, not to tick a box exercise'.

The final theme was the suggestion that BSDHT should better use our platform/voice/status and ensure we: 'treat everyone the same/equally'; to 'understand the viewpoint of as wide a diversity as possible in order to feel all are appropriately represented'; to 'continue to give people the opportunity to speak out about their opinions and how they feel'; to maintain a 'collective voice' and 'keep raising awareness of our capabilities'. BSDHT should: 'get advice from those with lived experience'; 'keep members informed of any issues that arise'; 'encourage members to speak out if they see or have personal experience of discrimination'; 'to look at an individual's circumstances and backgrounds and treat all equally, but respect any differences that may arise whether they be gender, race etc.,' and perhaps most importantly, 'to continue the conversation and dialogue between all.'

The survey asked questions and presented us with even more questions – how do we encourage more diversity within our executive and council teams, or ambassador groups? How do we ensure our members feel that we are behaving in an inclusive way, and ensure that all members feel they belong to this Society and also our profession?

Conclusion

The results show that diversity, inclusion and belonging is an area which BSDHT should continue to make a priority and incorporate into the Society's ongoing strategy. BSDHT must ensure that its activity - from publications, through education to all individuals who represent the organisation in the profession and in the public domain - are fully cognizant and abreast of the importance of being equitable and inclusive.

The Society wants to continue to work closely with its membership to ensure that it continues to build on its strengths and opportunities that were shared during the survey.

Recommendations

Following the results and discussion, it has been decided that the BSDHT needs to continue with this work. The Society is keen to keep working within the space of equality, diversity, and inclusion and to keep partnering with other organisations, including the College of General Dentistry (CGDent) and Diversity in Dentistry Action Group (DDAG).

BSDHT needs to ensure we regularly have these pulse checks with the membership to ensure that the voices of all members of the professions are heard. It could also be suggested that the DIB working group occasionally put out spot check questions via social media that can allow for those individuals who are not members of the Society to be active in our work and to have a say. It is equally important to explore why people from more diverse backgrounds are not members of BSDHT and ways in which the Society can feel more inclusive.

In future surveys, the BSDHT will ensure that demographic data are captured from respondents because it is not known 'who' completed this questionnaire – was it completed by groups who were likely, or not, to experience discrimination?

Additionally, following the survey, the DIB group has thought of other ways to circulate online questionnaires. QR codes may be a useful option for individuals to access a survey.

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Treating a patient with non-verbal autism in general practice

by CLAIRE DEWSHI

AIM

To provide some background to autism and its management in primary care and document an example of treating a non-verbal autistic child in a general practice.

LEARNING OBJECTIVES

- To discuss how autism can lead to dental and oral health challenges.
- To examine how these challenges can be tackled with the help of all members of the dental team and the child's own social support network.
- To consider how best to plan and structure dental appointments for children with autism to ensure they have a positive dental experience.

LEARNING OUTCOMES

Following this article, the reader will be able to:

- Describe key characteristics of autism and how they may present in a dental environment.
- Evaluate different methods of managing patients with autism in primary care.

Aligned with GDC development outcomes: A,D

To obtain 1 hour of CPD for this paper follow the link or scan the QR code:
HTTPS://WWW.SURVEYMONKEY.CO.UK/R/DHSEPT2022

ABSTRACT

Autism is a developmental condition where patients exhibit a decrease in understanding of social situations, impaired communication skills, and unpredictable reactions to external stimuli.[1]

Autistic patients may have poor oral care due to difficulty tolerating regular brushing, sensory differences, behaviour challenges, and communication barriers, especially in a dental surgery.

This article hopes to increase awareness of the challenges facing autistic children and parents, and outline measures which can be taken by the dental team to provide appropriate dental care. Furthermore, it will highlight the importance of involving the patient's family for continued support at home, alongside care by dental professionals.

KEY WORDS

Autism Spectrum Disorder, Preventative Dentistry, Paediatrics and Special Care

Introduction

Autism affects at least 1% of the population with many children still undiagnosed. Around 30-40% of autistic people are non-speaking.[2] It is likely that, at some point during clinical practice, we will encounter a patient who is autistic and although there is an option to refer to special care or community dental services, in some instances it may not be possible or appropriate. Referrals to secondary care often have extensive waiting lists and the pandemic has only strained the situation further. By providing care in general practice, not only are we able to identify and tackle oral disease sooner, but also strengthen the main pillar of clinical dentistry - prevention.

What is Autism?

Autism is a lifelong developmental condition which can affect how someone perceives and interacts with the world. It can make dental visits stressful and intimidating for the child and their parent or guardian, who may worry their child will not be understood, or cared for.[3]

Autism may present through:

- Communication and social interaction challenges
- Heightened or reduced sensitivity to stimuli
- Repetitive or obsessive behaviour
- Extreme anxiety which could lead to distressing events e.g. shutdown or meltdown[4]

Oral Impacts

Reports suggest that only half of children with autism brush their teeth twice a day, and nearly two-thirds of parents admit that tooth brushing is difficult. It is generally thought this is attributed to sensory processing difficulties (the strong taste of

the toothpaste and its texture if it foams in the mouth can be upsetting for the patient); even the feel of the bristles of the toothbrush may be too much for the child. Interdental cleaning is even more difficult due to lack of motor co-ordination.[5]

Diet

Autistic patients may prefer soft, sweet, sticky food and hold the bolus in the buccal sulcus, known as 'pouching'.[6] They have also been reported to snack more between meals and have an affiliation to eating only certain food substances (which are often highly cariogenic), again predisposing them to a dental caries.[7]

Medication

Some patients are prescribed antipsychotics or antiepileptics which can contribute to gingival enlargement and reduced salivary flow rate.[7] Some medication is also sweetened to make it more appealing for the child, but of course, worse for their teeth.

Habit and Malocclusion

Autistic patients may exhibit some elements of compulsive and even self-harmful behaviours including bruxism, tongue thrusting, lip biting and gingival pricking.[6]

There has also been research suggesting a higher prevalence of anterior open bite, narrow and high-arched palate, and dental crowding in patients on the autistic spectrum.[8]

Dental Management

This initial visit should be short and remain as non-clinical as possible. The purpose of this visit is to help the patient comfortably acclimatise to the dental environment: it is not to treat any dental disease. Ideally, the patient should not be kept waiting as this can trigger anxiety, and any subsequent appointments should be at the same time, in the same surgery, with the same clinician to create a routine.[6]

It is helpful to show the patient dental items to help 'desensitise' them. Also known as 'exposure therapy', it has three main components: discussion, teaching, exposure.

The first step is to learn which aspects of dental care cause the greatest anxiety and ask the patient to list them in order of increasing phobia. Secondly, teach the patient relaxation techniques (often mindful breathing where the deepened inhalations and exhalations provide more oxygen to the body and decrease the heart rate). Finally, expose the patient to the stimuli starting with the least anxiety-provoking, then moving up the ladder over several visits.

By controlling when the child is exposed to the stimuli and ensuring they are either relaxed, or in the presence of positive stimuli, the child will feel calmer in the dental setting and is more likely to co-operate.[9,10]

Adapted Environment

Autistic children may find external stimuli distressing and the lights, noise, and smells of the dental surgery are no exception. Studies have shown that adapting these stimuli can reduce anxiety in children with developmental disabilities. The adapted environment can include use of an LED headlight instead of a dental lamp, projected calming colours in the surgery, and rhythmic music for audio-stimulation.[11] Although not all of this may be easily available in general practice, small considerations like closing windows to reduce noise from the external environment and dimming the lights may be helpful.

Communication and Tell-Show-Do

Good communication is essential to build trust with the patient. Autistic children may find it difficult to express themselves and this may lead to crying and frustration. In cases of little or no verbal expression, a Picture Exchange Communication System (PECS) can be used for the patient to help them express their feelings and concerns. As they are unable to express their emotions verbally, they may point to a picture of their emotion to relay how they feel.[12] There have also been studies using PECS for oral hygiene education and tooth brushing instruction which report improvements in plaque control and a decrease in anxiety in patients.[13]

'Tell-Show-Do' is a commonly used technique where communication plays a central role. It puts the patient at the centre of their care as the dental team explains what will happen in the examination or treatment. They are then shown how it will be done (either given an instrument to hold, or shown in the mirror what will happen). Finally, the procedure is carried out as explained.[9]

The purpose of this is to mentally prepare the patient so there are no unexpected surprises. The session must therefore be carried out exactly as described and you can use positive verbal communication (such as, "thank you for keeping nice and still") or non-verbal techniques like smiling to encourage the patient throughout.

Information for parents

As dental professionals, we will see the patient perhaps every three months; the rest of the year, the patient will be with their family, so it is vital oral health messages are conveyed in a clear and concise manner to make every contact count. Advice should include:

- ### Brushing at a young age

This will help desensitise the patient to brushing, and get them used to having foreign items in their mouth. It will also create routine and structure which removes some of the unpredictability and confusion from the day. Tooth brushing should be supervised and carried out twice a day using a fluoride toothpaste and a spit-don't-rinse technique.[14]

- ### Brushing with water

This may be a good step in getting the child used to the bristles without the added discomfort of strong smells or tastes from toothpaste. Sometimes it is the flavour of the toothpaste, or the fact it foams that causes the child to dislike brushing their teeth. If that is so, products which are SLS free, or Tooth Mousse GC ™ can be trialled. Tooth Mousse GC™ has the added benefit of increasing remineralisation of the enamel. Studies have

shown up to a 24.6% reduction in enamel demineralisation and an 11.1% reduction in lesion depth[15] although other studies highlight that is it the repeat application of the agent which is needed to show the benefits.[16]

• Diet

A healthy, balanced diet may be challenging for autistic children as they often like to eat the same foods, or will only eat foods of a certain colour. It is important to try and encourage savoury snacks where possible, and limit drinks between meals to water or milk. This will help protect the teeth from decay and encourage a healthy lifestyle.[14]

• Education and Social Story

Social stories are a way to help autistic children learn about the wider community and appreciate appropriate responses to social situations. They were first developed in 1990 and are now an evidence-based method of helping autistic patients. The goal is to ensure the child understands the new social situation for a given setting and primes them for when they have to manage it in real life.

The social story uses simple text and visual aids and may be written as a physical book, or an e-book which has been suggested also helps increase the child's interest in reading the story independently.[17]

The key messages from the story should be reinforced with gentle questioning such as, "What does the story tell us to do?" until the child understands the story and acts appropriately without prompting.

Case Study

A 9-year-old boy attended the dental practice with his mother; his medical history highlighted that he was non-verbal autistic, and that this was his first dental visit.

Before he was brought into the surgery, the radio was turned off in case he was overly-sensitive to sound, the PC screen was off, and the blinds were tilted to avoid too much light entering the surgery. The dental nurse was present throughout as a chaperone and support.

When the patient first came into the surgery with his mother, he was reluctant to sit in the dental chair so the initial part of the examination was done informally on a regular chair. Since he was non-verbal, the discussion was only with his mother and she reiterated that this was the first time he was seeing a dentist.

His mother's presenting concern was of the "yellow stuff" on his lower front teeth. She said she usually brushed his teeth twice a day, using a fluoride toothpaste and manual toothbrush. He did not rinse with water after brushing and his diet was varied including foods from all major food groups. He only drank water between meals, but may have juice in the mornings, or as a treat.

Throughout the initial conversation, questions were directed at both the patient and the parent to involve the child in his care. Their oral hygiene routine and diet was congratulated, and evidence-based advice from Delivering Better Oral Health reiterated.[14]

Figure 1: **An example of a Picture Exchange Communication System (PECS). Displayed at the main entrance of Morriston Hospital, Swansea.**

Figure 2: **An example of a social story kindly reproduced from iroqsea.org**

After this, the patient was encouraged to sit in the dental chair, but was very reluctant. Eventually, his mother picked him up and put him on the chair. The second challenge was reclining the chair as this unsettled the patient and led to tears and screaming.

His mother reassured him, and expressed her wish for the dental exam to continue. Again, this was a struggle as he refused to open his mouth long enough for a full examination. Even just showing the patient the mouth mirror and explaining what was going to happen in a Tell-Show-Do approach brought no luck.

His mother helped push his lips apart which allowed a quick glance at the dentition revealing substantial amounts of plaque and calculus present across the lower anterior teeth.

By this point, the patient was distressed and a decision was made to end the appointment. Once the patient sat on the normal chair in the surgery, he stopped crying and returned to being calm.

To try and get the patient desensitised to objects in his mouth, a dry microbrush was used to brush over his teeth while he was sitting on his mother's lap. He tolerated this well, so the same motion was repeated with fluoride varnish on the microbrush (he did recoil at the taste but his mother placated him). His mother was also given some microbrushes to take home so when he saw them again in the surgery, he would be more comfortable.

The dental care advice mentioned in this article was explained to his mother to lay some foundations to improve his tolerance of the next dental visit. The patient was then booked for a review appointment in three months.

Visit 2

This second visit was much easier - the patient sat in the dental chair without crying, opened his mouth and allowed an examination with a dental mouth mirror. The change in attitude was surprising, and his mother explained that she had been working with him at home on a regular basis, watching videos about going to the dentist, reading social stories and practising with micro brushes and a toy dental exam kit she bought online.

On examination, there was significant amounts of lingual and labial calculus on his lower anterior teeth which needed to be removed professionally. A hand scaler was used as an ultrasonic would have produced too much noise, water and vibration which would unsettle the patient. Initially hand scaling prompted further tears and screaming, however with his mother standing in front of him, her hand could be placed on top of the scaler so it appeared that only she was cleaning his teeth. This meant that the patient remained calm enough to grossly remove the supragingival calculus. Constant reassuring words and positive verbal reinforcement further relaxed the patient.

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The visit was concluded with another quick fluoride varnish application and he was booked again for an appointment in three months time to maintain routine and structure.

Visit 3

This was perhaps where the most progress could be seen as the patient willingly sat in the dental chair, did not kick or scream, and allowed full removal of supragingival calculus with a hand scaler.

The change in attitude was dramatic and it was pleasing to see that the patient had grown comfortable in the dental environment.

Since examination and PMPR had now been achieved, the next step would be to desensitise the patient to further dental situations including dental radiography, and (if necessary) restorative work in the future.

Reflection

This young patient highlights the importance of social interaction, verbal and non-verbal communication and the necessity to work with a child's support network.

On reflection, it would have been better to plan his visits in a series of structured appointments to initially have a non-clinical visit, followed by a treatment visit as this would also have allowed more time for systematic desensitisation. However, the patient's mother was hesitant and declined this intervention. She had struggled to get her son into a dental practice and worried that further delays would allow his oral health to deteriorate further.

His mother was very motivated to take the time to teach her son about the importance of dental visits, purchase dental items to show him what was to be expected, and to brush his teeth twice a day, every day, despite difficulties. It is only though a co-ordinated effort by the dental team and the parent that oral health can be safeguarded in vulnerable children who, especially since the pandemic, too often slip through the system.

A referral to Paediatrics, or the Community Dental Service was offered, but his mother did not want to travel far, or to remain on a waiting list for several months. It was only with her continued support and reassurance that we managed to reduce this child's anxiety around dental care.

Conclusion

The care of patients with autism needs to be taught more in the undergraduate curriculum to prepare students for challenging patients in practice. It is a subject which is only briefly covered during training, and there is the assumption that there will always be an alternative pathway for those patients.

Following the Covid-19 pandemic, and the mounting pressures on hospitals, alongside the NHS secondary care backlog, primary care is where clinicians will tackle not only the simple cases, but also less routine care. Knowledge of simple behaviour management techniques and relaying the importance of oral care at home can make a huge impact on a child's dentition and hopefully prevent them entering a lifetime cycle of restorative dentistry. Especially for children with non-verbal autism, who will find it difficult to express when they are in pain, prevention of dental disease is imperative, and regular dental care must be included at every stage of their lives.

Utilising the skills of the dental team and the patient's wider medical network will support the holistic care of vulnerable children and ensure their social, developmental and oral health needs are met.

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The BSP S3 Treatment Guidelines: A blueprint for periodontal treatment success

by SHAUN HODGE

The British Society of Periodontology (BSP) has certainly been busy these past few years. After delivering a UK version of the 2017 Classification of Periodontal Diseases, in 2020 it released its implementation of the EFP 'S3 Treatment Guidelines'.[1] Work such as this can sometimes divide members of the dental profession: either you are super excited to settle down with 70-odd pages of periodontal goodness on a Sunday morning, or you are slightly frustrated at having yet another set of guidance to try and get to grips with.

Although as a certified perio nerd, I am very much in the 'excited' camp, I can absolutely sympathise with those that are a little less enthusiastic. After all, our personal and professional lives are busy enough without the added task of firstly reading, and then attempting to implement new classifications and guidelines. In this article I will try and reduce some of the stress this might cause by summarising the guidance, and then explaining some of the impacts the S3 Guidance might have on the management of periodontitis in practice.

The S3 Guidelines in Brief

The BSP S3 Guidelines were designed to establish a blueprint of how to manage periodontitis in practice. It has been adapted from the S3 Guidelines produced by the European Federation of Periodontology (EFP) to be workable within the UK healthcare system. It complements the 2017 Classification of Periodontal Diseases, and as an 'S3' guideline it is one that has been produced to the highest standards by reviewing the latest scientific evidence base, in addition to considering expert opinion.

In its 70 or so pages there is nothing particularly revolutionary. But it is a fantastically useful piece of work in how it delivers

a 'recipe' of how to treat periodontitis in practice, referencing the very best evidence we have. This is important, as it ensures our clinical practice is 'gold-standard', while at the same time improving outcomes for our patients. There are four key steps set out in the guidance:

1. Building Foundations for Optimal Care

The main aim here is to educate and motivate the patient to instigate behaviour change. The focus is on reducing risk factors such as poor plaque control, poorly managed or undiagnosed diabetes, smoking and possibly even lifestyle factors such as poor diet and obesity. It can include supra gingival Professional Mechanical Plaque Control (PMPR) and adjunctive therapies for reducing gingival inflammation, such as chlorhexidine mouth rinse.

2. Sub-Gingival Debridement

Now termed 'sub-gingival PMPR', this is to be carried out when the patient's risk factors are under control. If the patient cannot control their risks factors, such as plaque control, step 1 may be repeated on a regular basis. It is important to continue to provide the patient with education and motivation regarding periodontitis, perhaps attempting to describe the problem in different ways to enable progression on the next step of care.

3. Management of Non-Responding Sites

Following non-surgical periodontal therapy there may be persistent deep pocketing, particularly in moderate-severe cases. These pockets can be treated again non-surgically, or deeper pockets may be suitable for periodontal surgery (such as pocket reduction or regenerative procedures).

4. Supportive Periodontal Therapy

Aimed at maintaining patient motivation and oral hygiene standards the supportive care step includes PMPR and monitoring of the patient's periodontal condition with bleeding on probing scores and six-point pocket charting at regular intervals.

Do we need a new set of guidelines?

At first glance there is nothing revolutionary about these four steps. They lay out in a clear, methodical way what we were all taught in our training. But, when looked at in conjunction with the 2017 Classification the guideline is nudging us towards a more holistic, evidence based and effective approach to care.

With any new set of guidelines, a sensible question to ask is: 'what's the point - weren't things working just fine before all of this?' It is a question worth asking, but if we look at the evidence the answer is no – currently there is certainly room for improvement in periodontal care in the UK and beyond.

Severe periodontitis is the 6th most common disease in humankind.[2] As well as leading to tooth loss, which can be devastating and life changing for many patients, chronic periodontitis has been associated with numerous serious conditions such as diabetes, dementia, cardiovascular disease, and complications of pregnancy.[3,4,5,6] Global trends suggest that the incidence of periodontal diseases is increasing, and this is despite it being readily preventable and treatable in most cases.[2] The reasons for this are multi-factorial and complex, but one aspect we as dental professionals have some control over are the methods we use in managing the disease.

Avoiding the Periodontal Treadmill

We are all far too familiar with the long-term periodontitis patient who attends every three months without ever really improving their condition. This has been referred to as the 'periodontal treadmill', and as well as leading to reduced outcomes for the patient, it can also be demoralising for us as clinicians when we see no real improvement or impact despite our efforts. The S3 Guidelines offer a clear pathway away from this treadmill.

A chronic disease like periodontitis cannot be successfully treated without thorough understanding and cooperation from the patient. This is quite unique in dentistry. Although a restoration or crown might fail quicker in someone who continues to consume high amounts of sugar in their diet, the treatment will be successful for a short while at least. But in periodontitis, this is not the case.

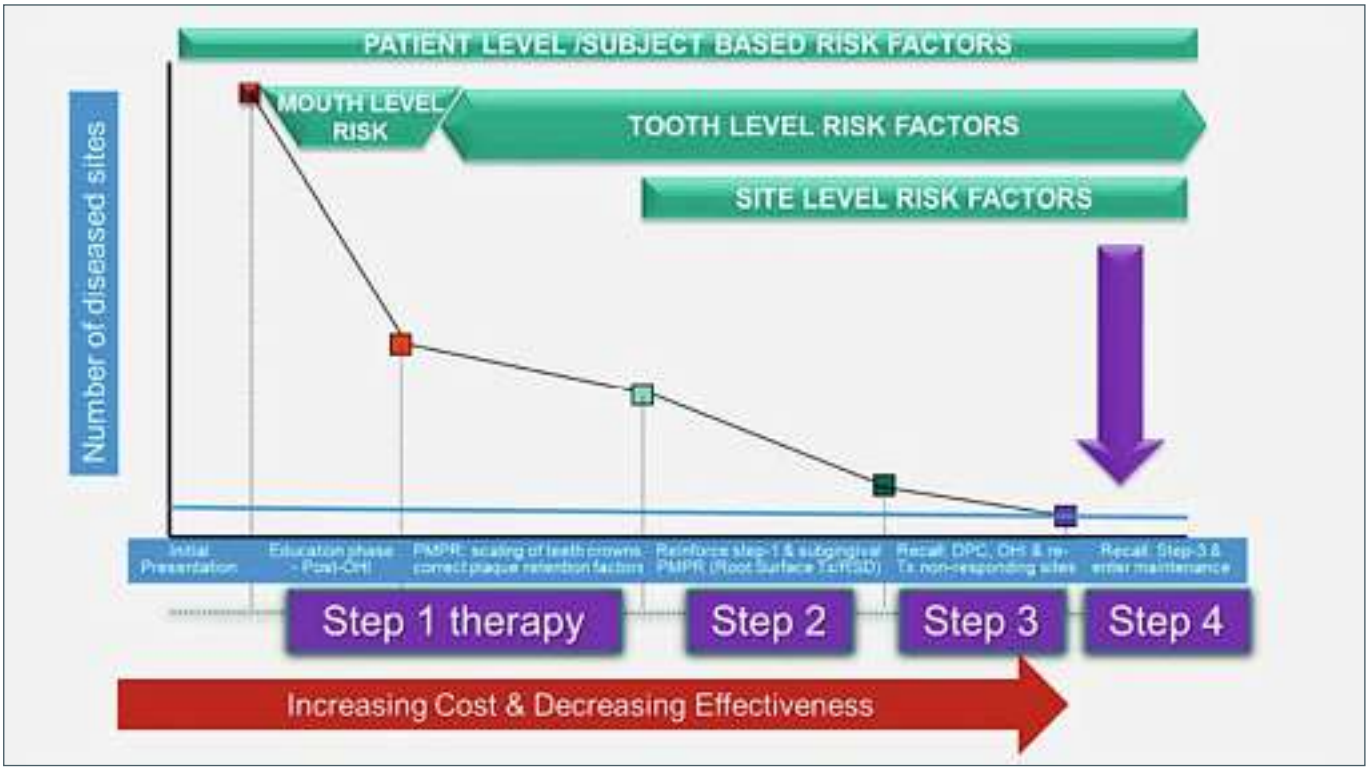
Diabetes is very similar. A serious and potentially deadly disease, diabetes is difficult to control unless the patient actively participates in their care. Diabetes specialists know this, and it is why upon diagnosis a great deal of time is spent counselling the patient about the disease and what steps they can take at home to help control it. This is seen very much as a vital part of the management plan.

Patient Engagement: The Key to Treatment Success

When talking about the S3 Guidelines, a common query is that is it not unfair to the patient if we deny them treatment if they are smoking, or if their oral hygiene is still poor? This is a good question, and it clearly shows our mindset as dental professionals. We do not see 'Building Foundations for Optimal Care' as a true and meaningful treatment intervention. We do not see behavioural modification, oral hygiene instruction, patient motivation and education regarding the disease process as 'real' treatment. We have been conditioned to feel like we need to pick up our instruments to provide meaningful treatment, and as a result many of our patients feel this way too. The systems we work within also further this sort of thinking, with very little incentive for preventive dentistry and far more emphasis on clinical intervention. In dental school we spend hundreds of hours practising our clinical skills, and gaining important knowledge of anatomy, physiology, and biochemistry. But comparatively little time was spent learning how to effectively communicate with our patients, particularly in the complex field of behaviour change.

The ability to explain a complex disease process, the risks, and benefits of treatment, to present a tailored oral hygiene regime for the patient in a digestible and implementable manner - these things take a great amount of skill and practice. This does not even take into consideration that each patient is an individual, who will need these ideas expressed in very different ways for them to be engaged. That nice doodle of the periodontium won't work for everyone!

Figure 1: **Risk-driven prevention delivers the greatest periodontal health improvement in Step-1 of care, with deceasing return on investment (time & money) towards Step-2 amd 3.**



The great thing about the S3 guidance, is that it sets out 'Building the Foundations' as the key element in all further care. It allows us to inform the patients that the 'scale and polish' they have grown accustomed to is not what is going to improve their gum health. It is their self-care that is going to be the real deciding factor. The evidence backs this up. Figure 1 shows how the greatest improvement in the patient's periodontal status is gained in Step 1 therapy.[7] Furthermore, it is this stage which is the most cost effective.

A Medical Model of Dentistry

This model of care is more often seen in the world of medicine - which has been rather artificially separated from dentistry for as long as anyone can remember. But we know that dentistry is essentially a speciality of medicine, and we are increasingly aware that the impact of poor oral health, and especially periodontal health, does not stop in the mouth.

Many of our patients do not realise this. Part of the problem is that we offer far more services which are commodities compared to our medical colleagues - cosmetic treatments such as whitening, orthodontics and composite bonding or veneers. The fact that we work in a very visible area - and as a result always need to have form and aesthetics at the forefront of our minds, as well as function and health - is part of what makes our careers so rewarding. But it is important to remember that the foundation of everything we do is ensuring our patients are healthy and absent of disease.

We are all part of the healthcare team, and excellent periodontal outcomes can only be achieved through excellent teamwork between dentist, specialist, dental hygienists and therapists, and oral health educators. Implementing the S3 guidance as a team, with a health-first approach can certainly lead to improved outcomes. Periodontitis is rapidly being better understood as a serious, chronic disease with far reaching economic and systemic consequences. Our medical colleagues in a range of specialities are beginning to realise this, and it is important that we as a profession are ready to step up and lead the integration of oral health into the mainstream of medicine. The S3 Guidelines offer a blueprint that reflects medical management of complex chronic diseases such as diabetes. Management is grounded in patient engagement and education, and thanks to the 2017 Classification, we have clear therapeutic goals to aim for in terms of bleeding on probing percentage and pocket depths.

S3 Guidelines in Practice

Where I work in practice, we made great efforts in implementing the S3 Guidelines by developing our own periodontal pathway based upon the guidance. It has not been easy, in part due to the culture of patients attending for a 'scale and polish', and therefore expecting just that. A more accurate name for these sessions would be 'Periodontal Therapy Sessions'. This would more accurately describe an appointment which may include oral hygiene instruction and behavioural modification advice including smoking cessation and diabetes management as well as PMPR.

Patients were often a little annoyed at first when they were informed that a great deal of the session was going to be taken up with oral hygiene instruction, motivation and behaviour modification. Although this has always been provided, the emphasis of the session, and what the patient perceived most value from, was usually the actual scaling/debridement. But what we have found is that with excellent communication, and clear consistent messaging from everyone in the practice, the vast majority of patients engaged with the programme.

Following engagement, we have found outcomes of PMPR to be improved and more stable for the long term.

The pathway set out in the S3 Guidelines can also be readily implemented in an NHS setting. The 'Healthy Gums Do Matter' toolkit reflects the guidance, with an emphasis on patient education and engagement.[8] It includes numerous patient agreements and consent forms which are useful not only for patients but also from a medico-legal standpoint. This along with the BSP 'Delivery of Care' document, offers clear guidance on when to claim UDAs for each part of the S3 treatment algorithm.

Conclusion

The BSP S3 Guidelines not only offer a pathway to improved periodontal outcomes, but also present an opportunity for us as dental professionals to build more rewarding working lives. It can be easy to get stuck focussing on the processes, rather than the outcomes of our day-to-day work. Far from robots designed to fill and scale teeth, by following the spirit of the S3 Guidance we can work to our potential as healthcare professionals, building the foundations for lasting change with our patients.

Author: Shaun is a general dental practitioner with an interest in periodontology. He works in private practice at The Pines Dental Surgery in Cardiff, and alongside his clinical work he has established The Perio Club, a monthly study club for all members of the dental team. He is also involved with clinical research and teaching at the University of Bristol.

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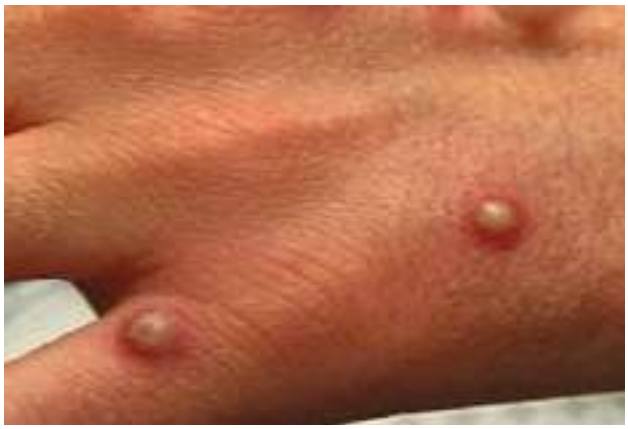
Q2. What viral infection that presents in this way has recently been reported in UK?

Q3. How is the infection spread?

Q4. Should you provide routine dental treatment at this visit?



SEND YOUR ANSWERS TO THE EDITOR BY 30TH SEPTEMBER

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

ANSWERS TO CLINICAL QUIZ JULY 2022

The winner is: **Rita Matukaitiene**

Q1. Is this a freckle or a malignant melanoma?

A1. Malignant melanoma.

Q2. Give one clinical feature of the abnormality that influenced your decision?

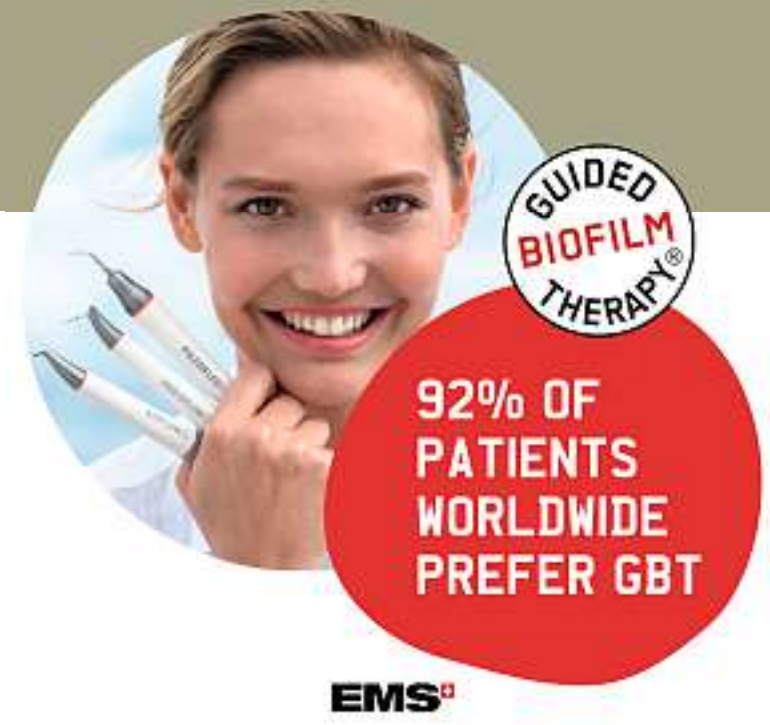
*A2. **Asymmetry** of colour, **Border** is ragged, **Colour** is variable black/brown or **Diameter** is greater than 6mm.*

Q3. What question could you ask the patient to support your diagnosis?

*A3. Is the appearance changing in size, colour or shape? **Evolving**.*

Note the A, B, C, D, E for melanoma.

92 % of patients worldwide prefer Guided Biofilm Therapy (GBT)



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AUTUMN 2022 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 15th October 2022	Bar Hill Hotel, Cambridge	Nancy Gieson	easternsecretary@bsdht.org.uk
London	N/A		Simona Kilioke	londonsecretary@bsdht.org.uk
Midlands	Sat, 15th October 2022	Woodlands Grange Hotel , Milverton Road, Leamington Spa	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Weds, 5th October 2022 (EVE)	Dental Protection Offices, 2 Victoria Place, Holbeck, Leeds, LS11 5AE	Julie Rosse	northeastsecretary@bsdht.org.uk
North West	Sat, 1st October 2022	Online only	Karen McBarrons	northwestsecretary@bsdht.org.uk
Northern Ireland	Sat, 24th September 2022	Radisson Blu Hotel, Belfast The Gasworks, 3 Cromac Place, Ormeau Road, Belfast BT7 2JB	Joanne Cregan	northernirelandsecretary@bsdht.org.uk
Scottish	Sat, 1st October 2022	Peebles Hydro Hotel, Innerleithen Road, Peebles, EH45 8LX	Samantha Byrne	scottishsecretary@bsdht.org.uk
South East	Sat, 10th September 2022	The Village Hotel, Castle View Forstal Road, Sandling, Maidstone, ME14 3AQ	Louisa Clarke	southeastsecretary@bsdht.org.uk
Southern	Sat, 24th September 2022	Stones Hotel, Highpost, Salisbury, SP4 6AT	John Murray	southernsecretary@bsdht.org.uk
South West & South Wales	Sat, 1st October 2022	Double Tree North Bristol, Bradley Stoke BS32 4JF	Rachel White	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 8th October 2022	Online only	Jade Campbell	southwestsecretary@bsdht.org.uk
Thames Valley	Sat, 10th September 2022	Best Western, Buckingham	Vacant	thamesvalleysecretary@bsdht.org.uk

BSDHT member-only webinar, advance notice:

"Boosting mental wellbeing in dentistry: a toolkit to help you thrive"

Register in advance using link: **https://bit.ly/3CnOF6y**

Speaker: Dr Marukh Kwaja
Date: 6 October 2022
Time: 7.30pm

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BSDHT member-only webinar, advance notice:

"Saliva: a vital bodily fluid. Oral and systemic health implications"

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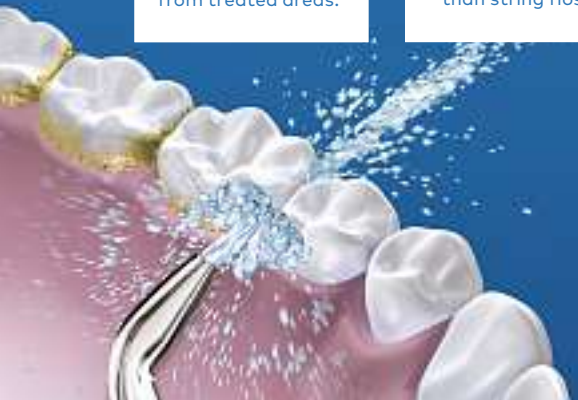

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