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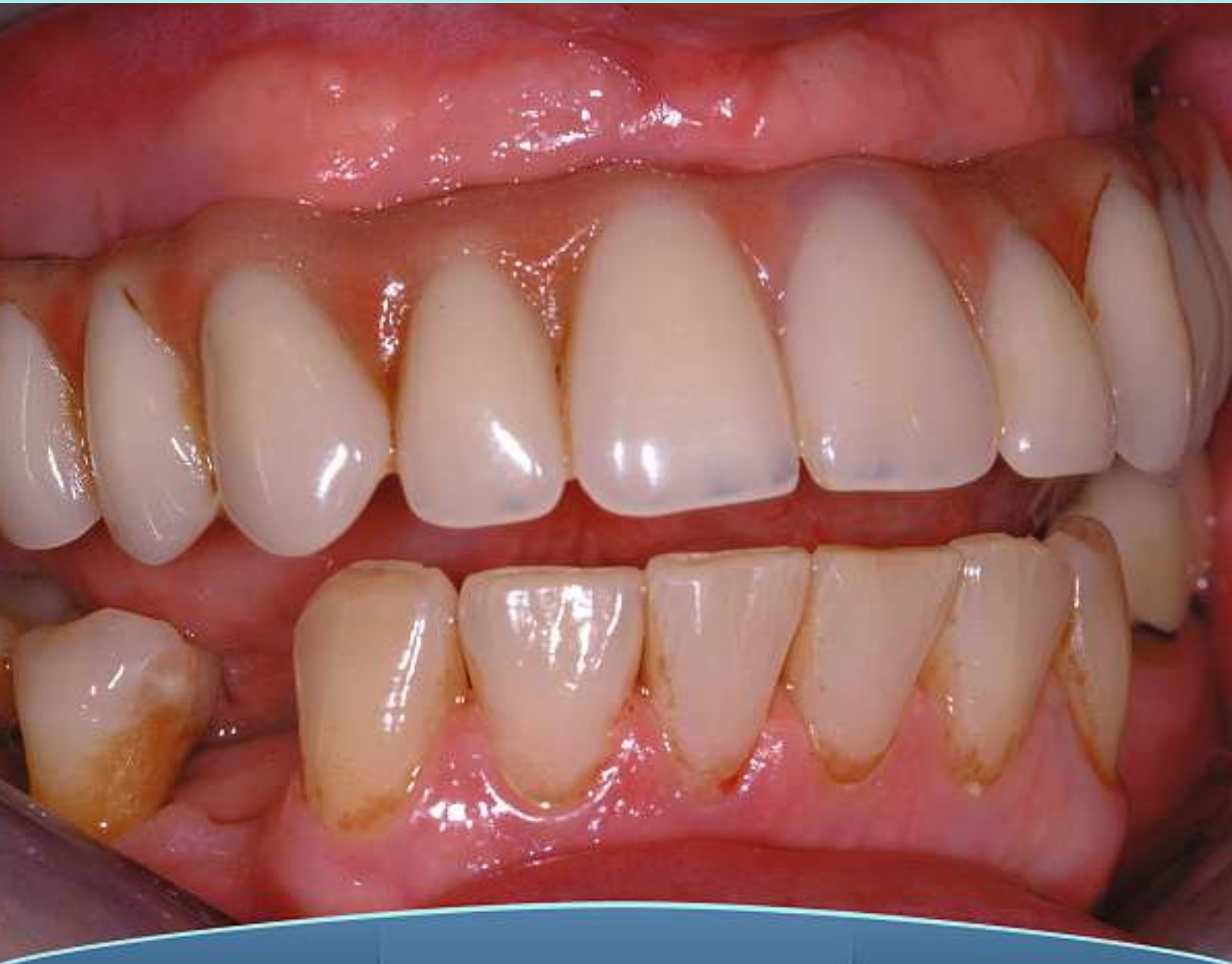

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The mission of BSDHT is to represent the interests of members and to provide a consultative body for public and private organisations on all matters relating to dental hygiene and therapy. We aim to work with other professional and regulatory groups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

BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
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Editorial

Ultra Processed Foods and Oral Health

A recent article in *The Times* caught my eye this week. It focussed on seven ultra-processed foods (UPFs) that nutritionists generally agree are, "actually good for us". These are: marmite; baked beans; sliced bread; plant milk; hummus; shop bought orange juice; and ready-made tomato sauce for pasta, which all contain vitamins, fibre and micro-nutrients essential to our diets. The nutritionists contributing to the article did qualify their choices by advising readers to choose no sugar varieties whenever possible.

UPFs are defined by the NOVA classification as industrially manufactured products that often contain multiple additives and minimal whole food content.[1] High in refined sugars, fats and additives, which tend to make them tasty and addictive, and low in essential nutrients, they now make up a substantial proportion of our daily caloric intake.[2] Their effects on our general health and well-being have been widely documented and the impact on oral health is increasingly recognised.[3]

The incidence of oral diseases - particularly dental caries and periodontal conditions - remains high, posing significant burdens to our healthcare systems.[4] Rich in fermentable carbohydrates and free sugars (such as sucrose and glucose), frequent snacking on UPFs maintains an acidic oral environment, enhancing the risk of enamel demineralisation and caries development. Moreover, the acidic nature of some UPFs, especially fortified beverages and soft drinks, is likely to contribute to dental erosion with the associated loss of hard tissue and increased dentine sensitivity.

Beyond caries, diets high in UPFs are often deficient in nutrients critical for periodontal health, including vitamins C and D, calcium, and omega 3 fatty acids. Nutrient inadequacy may impair collagen synthesis, immune defence and bone remodelling, thereby exacerbating gingivitis and periodontitis.[5]

Our paediatric patients are of course particularly vulnerable. Manufacturers' advertising campaigns are often designed to target children and young adults. Their enamel is less mineralised, and early exposure to UPFs can establish detrimental dietary habits. Studies demonstrate that high UPF intake during childhood is linked to increased caries in adolescence.[6]

UPFs are an ongoing challenge to the oral health of our patients. Dental hygienists and dental therapists must continue to play a proactive role in dietary counselling, integrating dietary risk assessment into routine care and support our patients with healthy eating behaviours.

The bigger question is: should we also be advocating much more for systems level interventions and lobbying to reduce UPFs consumption to improve the oral health of the nation? I welcome your thoughts.

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Heather

Heather Lewis

FROM THE PRESIDENT

BY RHIANNON JONES

I hope that you have all been able to enjoy the weather and have a found good work v life balance, doing something you enjoy. My personal reset always involves being outdoors, filling my senses with the wonders of nature.

Our job is so rewarding but sometimes involves a degree of personal sacrifice. It could be a patient sharing some sad news; or that our day was more challenging than we anticipated; or being involved in the training of a new nurse; or the boss was away and we are the only clinician available. There are so many stressors in our daily work but we often lack the time to sit and discuss them with colleagues, or management, and seek effective solutions. Has anyone asked you what would make your day more enjoyable? Sometimes it's the simplest of things, such as a drink waiting for you or your day list already prepared with notes.

Support for members

If you find that you are experiencing more tough days than rewarding days, please let us help you. Your Society exists for its members and we strive to support you in every part of your job. If you need some guidance on your career direction, or you feel like you are being 'left behind', our coaching and mentoring team has the training required to help you locate the doors that are open and waiting for you.

If you are having work related issues, such as a new contract or unsatisfactory working conditions, please email us and allow the team to direct you to someone with the expertise to help. We are usually able to respond quickly and if necessary, forward your issue to the legal helpline for further advice.

If you are worried about your eCPD and compliance, did you know that all of the BSDHT's lectures, webinars and journal eCPD are aligned with the GDC's learning outcomes and are peer reviewed? If you were to attend your regional group meetings, the Oral Health Conference and a few webinars, or make a submission to the journal's CPD programme, you would have over 20 hours a year and your certificates would be saved and easy to locate.

We are dedicated to providing you with the skills you need to give your patients the very best care. Please do let us know if there are any topics you would like us to consider. I will take this opportunity to remind you that your annual GDC renewal will be due by the end of July.

EuroPerio15

I recently represented the Society at EuroPerio15 in Vienna. My sincere thanks go to Colgate for supporting my attendance and helping us to be a part of this incredible event. With 10,000 delegates over three days, there was never a dull moment! From the variety of topics and sessions available to the networking opportunities, I was impressed with how respected this event is in Europe. It made me realise how important collaboration and collegiality are and why the Oral Health Summit is the right choice for 2025. We work together daily, but we rarely learn together. Working alongside the BSP, we bring you a varied and exciting programme with something for everyone. Edinburgh is a fabulous city and people always leave with great memories.

Let's make some lasting memories by joining our friends and colleagues in Scotland this November. See you there.

Rhiannon

Rhiannon Jones

THE DR GERALD LEATHERMAN AWARD

Nominations are now open for the Dr Gerald Leatherman Award – the first one was presented to Jean Bailey in 1994. Jean had been BDHA President for the period 1980-1982. Last year it was awarded to Mike Wheeler BEM, BSDHT President 2006-2008.

Nominations need to be received no later than later than 5.00pm on Friday 12th September 2025.

Email: enquiries@bsdht.org.uk

Background

The late Dr Gerald Leatherman played a very important part in promoting the role of the dental hygienist as one of the pioneers of preventive dentistry in the UK. Described as 'The Father of World Dentistry' by the late Dame Margaret Seward, he dedicated his professional life to raising the profile of both the dental hygienist and dental health promotion. He was actively involved with the British Dental Hygienists' Association (BDHA) and from the start played a leading role in the establishment of the first dental hygiene training school in England. Following his retirement from the office as President of the BDHA in 1957 he was appointed Honorary Vice President until his death in 1991.

It was during his early professional years, whilst working in the United States, that he first experienced the 'new profession' of the dental hygienist and oral health clinics. Being the visionary that he was, Dr Leatherman could see the potential benefits of such a group of dental auxiliaries. He brought his ideas back to the UK and began the crusade with like-minded colleagues which led to the recognition of the dental hygienist as an integral member of the dental team.

The 'Dr Gerald Leatherman Award' was established in 1994 to perpetuate and honour his name.

The Dr Leatherman Award is held in the highest regard by the profession, with past recipients having demonstrated dedication, professionalism, and consistent support of the profession and the BSDHT. (Formally BDHA).

The Award is in the form of a lapel pin bearing the words: 'Dr Leatherman Award' and a certificate to commemorate the date that the presentation was made.

Nomination Criteria

Nominations must demonstrate how the nominee has shown:

- Consistent support to our profession
- Consistent support to BSDHT (Formally BDHA)
- Altruistic traits in achieving their goals

Self-nominations will not be considered.

The nominee does not need to be a dental hygienist or dental therapist.

Submission Documentation

To remain open to the various ways in which the qualities of a nominee may be conveyed, the Dr Gerald Leatherman Committee recommend the nomination should include:

- The name, address, and a contact telephone number of the nominee.
- A citation demonstrating why the nominee should be considered as a worthy recipient of the Dr Gerald Leatherman award, including:
    - how the nominee fulfils the criteria
    - a brief CV of the nominee.
- The name, title and academic or professional affiliation of the **proposer**, their contact details, BSDHT number (if applicable) and length of time the individual is known to them:
- The name, title and academic or professional affiliation of the **seconder**, their contact details, BSDHT number (if applicable) and length of time the individual is known to them.

Eligible Nominators

- All BSDHT members can propose or second a nomination.
- Nominations by a non-BSDHT member must be seconded by a full BSDHT member.
- The nomination form must be signed by the proposer and seconder and accompanied by synopsis and brief CV.

CALL FOR **SUBMISSIONS**

The BSP and BSDHT Outstanding Clinical Team Case Report Prize

The BSP and BSDHT are delighted to announce a joint prize to be awarded at The Oral Health Summit in Edinburgh in November to the team of oral healthcare professionals who demonstrate excellence in the planning and treatment of a patient through a whole team approach. The prize will take the form of a cash award of £500, together with a certificate for the winning team.

To find full details on submission requirements and how to apply, visit the OHS website for more details: **profile.eventsair.com/oral-health-summit-2025**

Robin Davies DCP
RESEARCH AWARDS 2025

■ **L to R: Dr Susan Bissett, Prof. Emma Bingham, Mr. Mike Wheeler BEM, Ms Heather Lewis and Ms Simone Ruzario.**

The annual Robin Davies DCP Research Awards luncheon was held in May to celebrate this year's award winners. The celebration was held at Linden House, London and was attended by the leaders of dentistry across the UK. The Oral and Dental Research Trust (ODRT) partner with Colgate annually to offer a research grant to award winners, exclusively DCPs.

This year, we took the opportunity to explore the legacy, the impact and the exciting future of these awards. David Davies, Robin Davies' brother, attended the celebration to share his personal view of Robin's legacy as well as his profound impact on the dental profession: "He was enthusiastic about helping young researchers, including those in the wider dental team. He would have been very humbled by the honour you do him today".

Iain Chapple, Chair of the ODRT, welcomed the guests to lunch and invited the 2025 awardees to share their research proposals with the audience:

Morag Powell, dental hygienist and dental therapist, aims to investigate the impact of using a wellbeing app on student wellbeing.

Sian Cooper and Alison Crisp, dental therapists, will focus on developing the dental care pathway for children with Autism Spectrum Disorder (ASD) in the Derbyshire Community Dental Service.

Bal Chana, dental hygienist and dental therapist aims to increase awareness of minimum intervention oral care (MIOC) in patient management for dental therapists.

Amy Rawsthorne, dental nurse research practitioner, is exploring dental nurses' perceptions of their role in oral health prevention, along with the barriers and facilitators they encounter.

Colgate and the ODRT are pleased to be hosting this event once again, with the next celebration being held in Spring 2026. The call for papers will open on 1st October 2025. Applications for these awards must be received by Friday 6th February 2026.

For additional information, please scan the QR code or visit: **https://colgate-experience.co.uk/robin-davies/**

PHILIPS' MOST ADVANCED SONIC TOOTHBRUSH FEATURES REVOLUTIONARY ADAPTIVE TECHNOLOGY

Philips' most innovative new Sonicare toothbrush features adaptive brushing technology, 62,000 gentle sonic movements per minute and patented optical sensing capability. Studies show that it can achieve up to 20 times more biofilm removal ,and up to 30 times more plaque removal in hard to reach areas , compared with a manual toothbrush.

The three brushes in the range feature new adaptive technology ensuring an optimal clean regardless of patient technique. A new drivetrain automatically adjusts brushing around the posterior teeth where brushing can be compromised due to interference with the buccal mucosa. This offers precision feedback when there is resistance to the head, regulating movement to ensure an optimal performance.

This is coupled with dynamic optimal sensors which 'regulate' amplitude when pressure is applied on the brush head. This self-regulation minimises any brush movements.

The new Sonicare has patented optical pressure sensing technology which improves pressure sensing capability, accurately measuring applied brushing force. The brush captures immediate measurements, lighting up and vibrating, encouraging patients to adjust their brushing technique. The pressure sensing technology assesses light reflection, with less light indicating more force. It is also Philips' quietest Sonicare yet. The R&D team counterbalanced the spring motion inside the drivetrain to reduce vibration and noise.

Sustainability remains a key focus and the brush has been created using innovative laser welding, ensuing additional strength and durability. The handles can be disassembled for repair, and batteries are replaceable. They are also more energy efficient, with a high-performance battery charge lasting 21 days . Packaging is paper-based and fully recyclable, while brushheads contain 70% bio-based plastic. They are tested for durability and reliability using a rigorous 30-day run time trial.

The 6500 and 7100 models connect to the Sonicare App with a timer feature, visual progress tracker and personalised brushing trend dashboard. The 5300 model offers superior plaque removal and whiter teeth , while the 6500 has three modes and intensities, and is suitable for patients with sensitive teeth and gums – achieving up to 200% better gum health in two weeks. The top of the range 7100 has four modes offering most options for patients - it removes ten times more plaque compared with a manual toothbrush.

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PRINCIPLES FOR ORAL HEALTH REPORT SIMPLIFYING EVIDENCE-BASED APPROACHES TO PERIODONTAL HEALTH

The Principles for Oral Health Report, is a global initiative aimed at simplifying evidence-based approaches to support periodontal health.

Developed through collaboration with world-renowned oral health experts during a 2024 round table summit, the report distils key scientific literature and clinical practice guidelines into practical strategies for dental professionals worldwide.

With over 1 billion people affected by periodontal disease globally,[1] the report highlights prevention-focused interventions as essential for mitigating oral biofilm and gingival inflammation levels. Beyond mechanical biofilm control, it underscores the potential role of adjunctive antiseptic mouthwashes in improving patient outcomes, particularly for those at heightened risk due to systemic or local factors.

Aligned with the EFP S3-level Clinical Practice Guideline,[2] the report provides clear protocols for diagnosis, prevention and treatment, enabling dental teams to deliver consistent, high-quality care.

Dr. Paula Matesanz, vice president of SEPA and initiative lead, explains:

"The Principles for Oral Health initiative empowers professionals and patients with simplified, evidence-based tools to improve oral health outcomes globally."

To read the full report, visit
https://principlesfororalhealth.com

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PREVENTION AND MANAGEMENT OF **DENTAL CARIES IN CHILDREN**

The Scottish Dental Clinical Effectiveness Programme (SDCEP) has recently published the third edition of its *Prevention and Management of Dental Caries in Children* guidance.

The guidance aims to support dental teams to improve and maintain the oral health of their younger patients through the delivery of preventive care and, where necessary, effective management of dental caries. This third edition is widely endorsed by BSDHT, national and international organisations as a source of reliable, high quality, professional advice that promotes the provision of safe and effective oral health care for patients.

The full guidance is presented within a dedicated website (**www.childcaries.sdcep.org.uk**) with a downloadable summary 'Guidance in Brief' also provided.

INTERNATIONAL COALITION **FOR DENTAL NURSES**

As part of its celebrations, the Society is launching 10 of the hugely successful initiatives up until October 2025; this is the fourth one. Did you know that the Society was responsible for designing and bringing together an international group that contributed to the COP26 Sustainability in Healthcare and Education initiative? Those who were involved contributed to the presentation, which was delivered on a worldwide platform and was recorded. It also led to 'dental nurses' being named in the WHO Oral Health Strategy. The focus of the presentation was on designing and delivering sustainable oral care at the community and local level. All participants received certificates from the University of Glasgow and the University of Berlin.

The Society is exceptionally proud of this project and the one that followed. These projects allow dental nurses/oral health practitioners to showcase their skills and abilities, and they encourage creative and courageous conversations. Many of those involved were shocked to discover that some of the richest countries provide the least care to the most vulnerable and in need. It was a privilege to work collaboratively and to have a Society member deliver the presentation with such passion and conviction. In a world of inequalities, oral care should not be neglected, knowing that the mouth is the gateway to the body and human health and life. Supported by the wider countries' perceptions and realities certainly fostered much interest. This not only celebrates the broader skills and abilities of the profession but also reminds dental nurses that international work brings powerful opportunities. The Society is a founder of the International Federation of Dental Assistants and Dental Nurses.

GDC OPENS RENEWAL PERIOD FOR **DENTAL CARE PROFESSIONALS**

The GDC has now opened its annual renewal period for dental care professionals.

To complete your annual renewal, you must complete three essential steps by the respective deadlines:

- Pay the Annual Retention Fee (ARF) of £96 by 31 July - you can pay online via eGDC or by Direct Debit.
- Make an indemnity declaration by 31 July – confirming you have the appropriate indemnity or insurance cover in place by the time you start practising.
- Submit a CPD statement by 28 August. The CPD year runs from 1 August to 31 July.

Following some changes introduced in March 2025, the GDC has simplified several aspects of the CPD scheme to reduce the administrative burden for clinicians. Key changes include:

- Simplified documentation requirements, with GDC registration numbers no longer mandatory on CPD certificates
- Electronic confirmations now accepted for CPD mapping documents
- More flexible approaches to quality assurance verification, allowing digital confirmations alongside traditional signatures
- Clearer guidance on grace periods and restoration processes.

DH and DT in the final year of their five-year CPD cycle who need additional time can apply for a grace period via their eGDC account. For those who registered within the last 12 months, you begin your first CPD cycle on 1 August 2025.

Around 480 DCPs failed to meet the minimum 10-hour CPD requirement over two years in September 2024. Whilst this represents a decrease from 2023 figures, the GDC emphasises that meeting CPD requirements remains essential for maintaining registration.

Anthony McNally, Head of Customer Services at the GDC, said: "We've listened to feedback from the dental professions and made significant improvements to our CPD processes, whilst maintaining professional standards. We encourage all DCPs to complete the working patterns survey, which provides crucial data to help the sector understand workforce challenges and plan for the future.

"The annual renewal process ensures that DCPs remain on the UK register and continue to provide essential dental care to patients."

For the second year running, the GDC is inviting DCPs to complete its voluntary working patterns survey as part of their renewal process. The five-minute survey gathers data on where DCPs work, the type of care they provide, and their weekly working hours.

To date, 43,692 dental care professionals (58% of the DCP register) have completed the survey, providing valuable workforce intelligence. This builds on strong participation from dentists; 66% (30,066) completed the survey over its two-year operation.

The renewal period runs until 31 July for ARF payments and indemnity declarations, with CPD statements due by 28 August.

For any queries, contact the GDC's customer services team on **020 7167 6000** or **information@gdc-uk.org**.

BY RHIANNON JONES

EUROPERIO 15

As your President, it is my duty to represent our members and our profession at numerous events throughout the year. Attending meetings and conferences at home has an obvious purpose when decisions are made that affect us - or those we care for - but international conferences have a less obvious purpose, or so I thought.

EuroPerio 15 was held in Vienna in May and it was important that BSDHT had a presence. It is never assumed that we will be able to attend, but it is worth considering what would happen if we did not.

In a climate of financial constraints, many societies and organisations must look carefully at their return on investment for certain events and engagements in the calendar. BSDHT is no different and certainly not exempt from financial restrictions: I assure you that your membership fee is respected and protected. It is part of the role of being a director to protect the future of this organisation and carefully manage the finances. We constantly explore affordable methods of attending important conferences to ensure that those of us living and working in the UK are represented and play a role in professional developments.

I am delighted that Colgate offered their kind support once again this year and we continue to be grateful for this ongoing generous investment in our profession.

I would like to share with you what I believe are the most important reasons for our attendance at these sorts of events. I did not realise until I began my term of office as president elect, how important it was that BSDHT is involved in dentistry at an international level.

Collaboration and support

This month, the profession of dental hygiene has been an important aspect of preventive dentistry in the UK for 76 years. There are very few countries with such a history who have also come as far as us. I know that some days it feels like we have not progressed or achieved as much as we would like but when you spend time with emerging associations and societies, and compare BSDHT, you realise how much work they still have ahead of them. It is our honour to help and mentor these newer organisations and in return they are very appreciative of our support. There are also opportunities for collaboration with the different organisations that represent dentists at large events such as this. Moreover, these are ideal occasions to showcase our skillset and to learn alongside each other. How can we possibly work together effectively and efficiently every day without learning together?

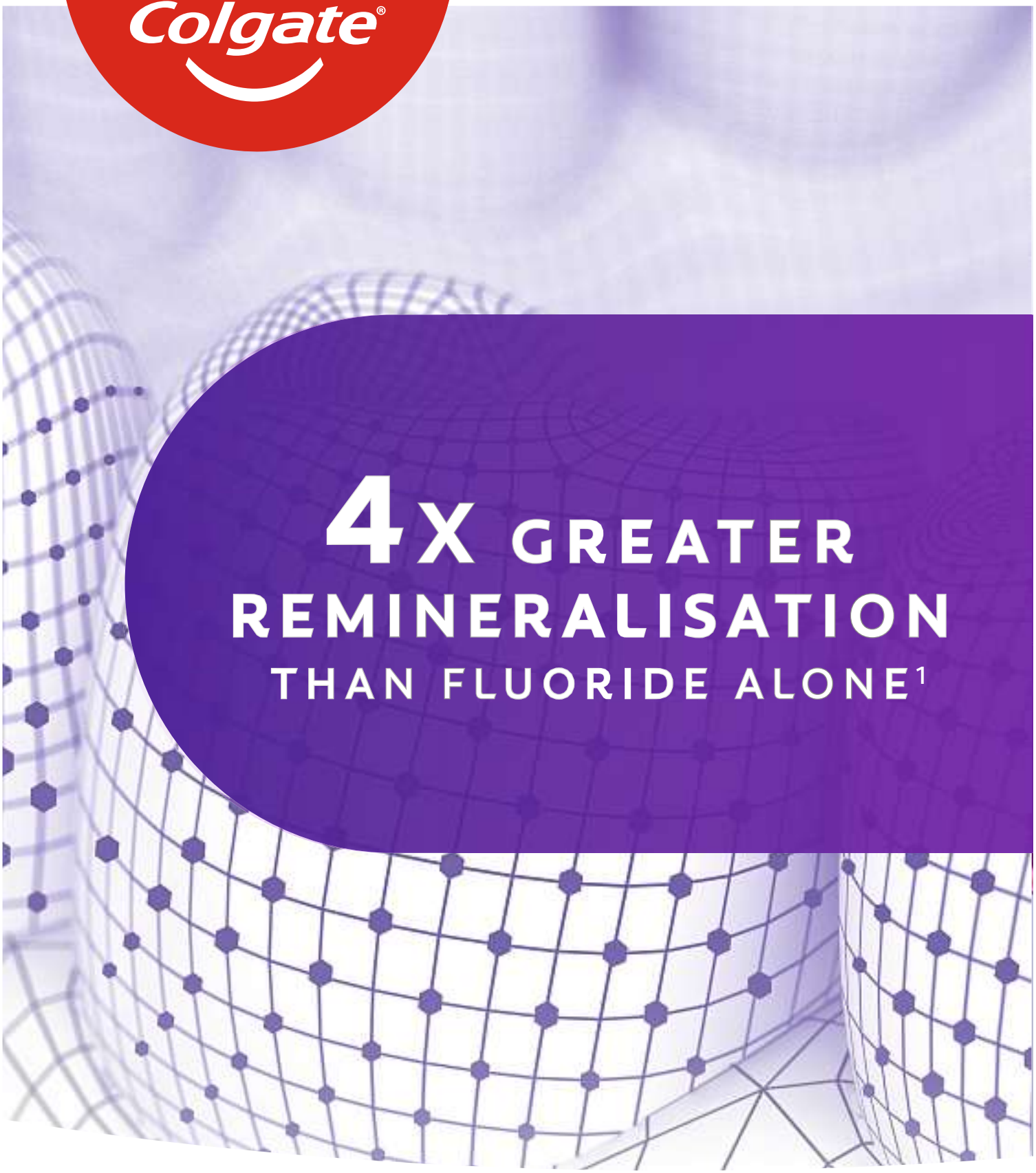
Throughout the conference, I was able to attend events where open discussions were encouraged and it was fantastic to see sessions hosted by dental hygienists. There is never any content specifically for dental therapists, as we are one of the few countries who are lucky enough to have them, but I was always welcomed to the

restorative sessions and they love to hear about dental therapy.

The trade exhibition was one of the largest I have ever attended and it took me three days to get around the whole space! I was pleased to see the newer, smaller companies and hope that they found the event helpful as they launch their products and innovations. It is always good to visit the commercial stands, particularly those companies with whom we have great working relationships. There were opportunities to sit and chat honestly about the direction of BSDHT and explore potential ways to work together more closely in the future. We were able to share with our colleagues in the dental trade our plans for our new podcast 'Dental Health Matters', which launches later this year. They were really receptive to this and all keen to be part of this exciting initiative.

The meetings and new relationships created from this event will help elevate our professional standing, not just in the UK but worldwide. If you have never attended a EuroPerio, please consider the next one in 2028 in Munich.

This was undoubtedly an event to inspire and enthuse all delegates and a great prelude to the Oral Health Summit in Edinburgh later this year. Thank you, Colgate, for the opportunity to be a part of EuroPerio 15.



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BY JENNA BENNS

PRE-PREPARATORY INFORMATION FOR PAEDIATRIC PATIENTS

Imagine walking into a huge room with loud, scary sounds, bright lights and equipment you've never seen before. Many people dressed differently to how you are used to, and a strange smell in the air. Our paediatric patients, especially first-time attendees, have to go through this experience and are still expected to be cooperative and allow strangers into their personal space.

This piece is a reflection on my experience as a final year student dental therapist (DTh) on our paediatric outreach clinic.

As a student DTh, we see many paediatric patients who have never attended the dental surgery, despite being past the recommended age for their first dental check-up. These patients can have varied reactions to the dental environment. For some, the unknown is interesting and they relish in the attention and inquisitive nature we put forward, wanting to ask question after question and being informed of step-by-step procedure, the 'monitors'. Others, 'blunters', manage and cope with stressful environments by minimising or avoiding their exposure to it. This can often present as quietness, crying, withdrawn

body language, or what may seem like ignoring behaviour. They prefer distractions to help them 'tune out' the stressors. The monitors and blunters theory from Miller (1981;1987)[1] helped us to understand the different techniques with which children will better interact, depending on their coping style.

We had learnt about behaviour management techniques, and pre-preparatory material in lectures but I had never realised the true power and difference it can make until I saw a 2-year-old patient for the second time. At the first appointment, they were very upset, confused and a language barrier increased the complexity of the situation. After settling, at most the patient would smile, but no mirror could be used or examination undertaken. The parent was given some ideas for what to do before the next appointment: to read and watch Peppa Pig's dentist episodes, watch Bluey's dentist episode, and role play with tooth counting and mouth opening. The parent was determined.

I had to make the distinction between cognitive development of a 2-year-old child, their mental growth, versus the coping abilities, their emotional regulation, that they may possess. The knowledge and understanding that at 2 years old, we're typically in Piaget's Sensorimotor to the Early Pre-operational stage. Piaget also described how infants must process information by weighing up both assimilation and accommodation. Assimilation, the process by which new information is taken in and allocated into a previously understood mental framework, while accommodation, requires the alteration and adaptation of a previously understood framework to fit the new information.[2]

In a 2-year-old, this presents as a limited ability to predict or reason with actions, limited understanding of cause and effect, inability to differentiate between imagined or real threat and a reliance on their immediate sensory experiences. As a result, these verbal explanations, even in child friendly language, are largely ineffective: the child is unlikely to understand why they need to see a dentist or what they are doing and if they are in danger or not. Reasoning is not applied, so sensory information is processed as it is received.

Their coping abilities, how they handle the feelings and emotions described above, are lacking due to inexperience and their inability to regulate emotions or articulate the need for reassurance. The understanding of these two elements further strengthens the idea that we must listen and observe our patients to be able to provide them with the techniques best suited to them.[3]

I could not have predicted the different child I saw just 3 months later. Smiling, happy, excited! A bubbly and comfortable child who recognised me and was eager to show me all of their teeth to chart. It was upon reflection of this that I truly understood the power of preparation and appreciated the work of children's cartoon animators, providing us and our patients with the vital material needed for observational learning and social modelling.

I began to think deeper about how this could improve my practice, and formulated an 'introduction pack' which could be given to parents/guardians of first-time attending children. Contents include: welcoming and friendly images of key staff whom they would see; a cut out activity of common dental instruments; links and suggestions of children's shows with episodes about the dentist; and recommendations to parents to address common preparation problems. These common issues include tricking the patient into coming, or attending with a parent/guardian who is anxious of the dentist themselves.

I determined that information regarding the effectiveness of preparation rather than surprise would be a key area I would like to explore further during my career while finding my feet treating my own paediatric patients and their families at the family run dental practice, I am set to begin work in.

My experiences while in my university paediatric clinic have been priceless, challenging, and incredibly insightful, fueling my desire to follow the path I have chosen. From my experiences as an anxious patient myself, to qualified dental nurse, to graduating dental hygienist and therapist, I discover with every patient that there is always more to learn and ways to improve both myself, and my patients' experiences. My goal is to make dental experiences comfortable and welcoming for my paediatric patients, in hope of reducing the number of anxious and dental-phobic adults in the future.

Jenna is happy to share her resources with BSDHT members. Please contact her directly: **jbennsdental@gmail.com**

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BY GAMINI DAS

RETHINKING LOCAL ANAESTHETIC AND BEHAVIOUR MANAGEMENT IN PAEDIATRIC CARE

Worldwide, dental caries remains the most prevalent chronic disease in children, contributing to pain, infection, difficulty eating and speaking and an overall reduced quality of life.[1] In the UK, it is the leading cause of hospital admissions among children.[2] Alarming recent data from official statistics shows that between 2022 and 2023, 47,581 tooth extractions were carried out on 0-19-year-olds, with 66% of those cases caused by dental caries, a 17% rise from the previous year.[3] Despite being entirely preventable, dental caries contributes to missed school days, disrupted routines and significant costs to the NHS.[4]

General anaesthetic (GA) is often used to manage severe cases, particularly when a child is highly anxious or has special needs. While sometimes necessary, GA carries risks such as postoperative complications, heightened anxiety in future dental visits, and significant financial strain on the NHS.[5] For example, in the same year, tooth extractions under GA cost the NHS £64.3 million, with £40.7 million directly linked to caries-related procedures.[3]

Without effective prevention and early intervention strategies, including better training in paediatric care and behaviour management, this avoidable disease continues to impact thousands of children and overstretch public health resources.

The Key to Pain-Free Paediatric Dentistry

Effective pain management is a fundamental principle of modern dentistry, ensuring patient comfort and facilitating successful treatment outcomes. For clinicians, administering local anaesthetic (LA) is a critical skill that underpins safe and effective pain control. LA agents work by temporarily binding to sodium channels, blocking sodium's entry into nerve cells and thereby halting the transmission of pain signals to the brain. This process enables patients to undergo procedures extractions and cavity preparation without discomfort, significantly improving their experience.

However, while the fundamental mechanism of LA is well understood, its application can present unique challenges, particularly in paediatric dentistry. Administering LA to children involves not only technical proficiency but also understanding the psychological factors at play, especially since young patients often have heightened fears or anxieties about dental procedures.

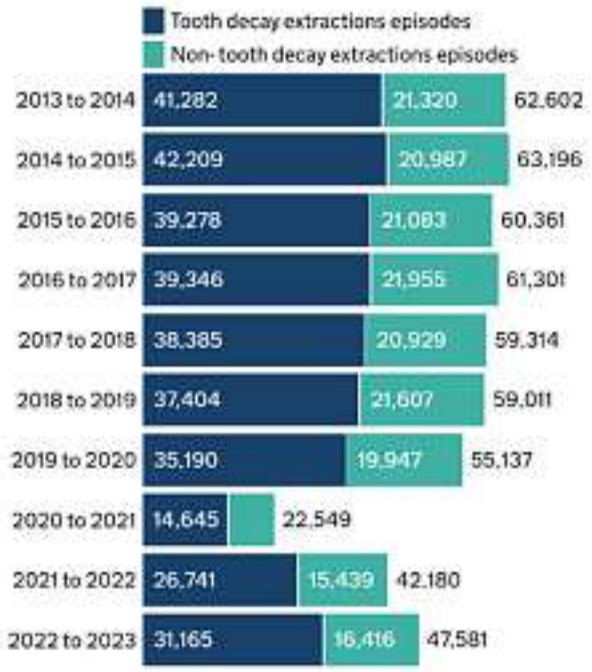

Figure 1: **Number of tooth extraction episodes in the last 10 year by extraction category (Gov.uk. 2024).**

The Challenge of Behaviour Management in Paediatric Dentistry

While the technical aspects of administering LA are essential, behaviour management is often the make-or-break factor in paediatric dental care. A child's fear, anxiety, or lack of understanding can turn even the simplest procedure into a high-stress situation for both the patient and the clinician. In these moments, a practitioner's ability to communicate clearly, build trust and respond empathetically is just as important as their clinical skill.

Techniques such as 'tell-show-do', distraction, desensitisation and positive reinforcement are widely recommended.[6] yet they are not always effectively taught or consistently applied. Many dental professionals, particularly students and newly qualified clinicians, report feeling underprepared for the behavioural aspects of treatment, especially when delivering LA to younger patients.[7]

Bridging the Training Gap

This was reflected in my research, which explored the perceptions of final-year dental hygiene and therapy

students regarding the administration of LA to paediatric patients. Although students had a sound understanding of LA techniques, many lacked confidence when it came to behaviour management. A recurring theme was the need for more hands-on experience, particularly with younger, less cooperative patients. Students highlighted gaps in training, especially around communication strategies and real-life exposure to anxious children in clinical settings.

These findings point to a broader issue within dental education: clinical competence must go hand-in-hand with behavioural confidence. Without it, we risk undermining a child's early dental experiences, potentially shaping their attitudes to oral health for years to come.

Better Training, Brighter Smiles

To reduce unnecessary referrals for GA and improve outcomes in paediatric dental care, more emphasis must be placed on comprehensive training that integrates behaviour management with clinical instruction. While many dental curricula teach the theoretical aspects of LA administration, they often underplay the psychological and emotional dynamics at play in the paediatric setting.

Evidence-based behaviour management techniques, such as 'tell-show-do', positive reinforcement, distraction techniques, modelling, and positive behaviour reinforcement, should be reinforced through interactive learning, not just lecture-based teaching. Role-playing, video demonstrations, and supervised clinical simulations that reflect real-world scenarios (e.g., treating an anxious or neurodiverse child) allow students to build confidence in how they communicate, not just how they inject.

Moreover, multi-disciplinary collaboration, working alongside child psychologists or paediatric nurses, could also enhance understanding of developmental behaviour, helping dental students better anticipate and respond to children's needs.

By embedding these approaches early in training and maintaining them throughout clinical placements, we can equip future dental professionals to deliver not just pain-free treatments but also true child-centred care. This shift won't just benefit patients; it will also foster more confident clinicians, better prepared for the realities of modern paediatric practice.

Conclusion

Local anaesthetic may be a routine, everyday task for a clinician but its impact is profound, especially in the care of children. When delivered with skill, confidence, and compassion, LA can prevent pain, reduce fear, and lay the groundwork for a lifetime of positive dental experiences. But to achieve this, we must treat behavioural training not as an optional add-on, but as a core component of paediatric dental education as the real impact lies not in the procedure itself, but in the trust and comfort built long before the needle is even needed.

Author: Gamini is a dental hygiene and therapy student at the University of Portsmouth, about to graduate. While having a broad interest in many areas of dentistry, she has a particular passion for paediatric care believing that delivering compassionate, patient-centred treatment is key to making a positive impact and a gateway to improving people's lives.

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BY LAURA KING

POSTGRADUATE TRAINING FOR DENTAL THERAPISTS A FOUNDATION FOR THE FUTURE

Leaving university and training is exciting! Exam and assessment stresses are finally over and the days of living on a student budget are coming to a much-anticipated end. Working as a dental therapist is finally on the horizon! Or is it…?

The reality

Deskilling is a sad reality for many. Frequently, our professional forums are populated with queries about courses and job opportunities with people often sharing their frustration about the lack of opportunity, or undesirable working conditions. There are many well researched barriers to finding dental therapist opportunities: we know that some dentists 'don't like handing the work over'; we understand that the current NHS contract is not fit for purpose (despite changes); and that therapy can be difficult to implement under the units of dental activity (UDA) system. It can be challenging to establish yourself in private practice straight out of training.

Overall, the transition from university to practice is hard. Gone is the cushioning of our friends and peers on clinic, with a tutor nearby to monitor, advise and assess. Suddenly we are out in practice. We are navigating self-employment versus employment, going over contracts with a fine-tooth comb, wondering if the offer is fair. And this is before we have even thought about the clinical aspect! At university, we may hear about earning potential, opportunities, exciting stories of lovely private practices, and nursing support. Unfortunately, this is not a real-life experience for everyone.

This profession has come an awfully long way since the 1960s. We have so much more opportunity than our predecessors, thanks to our professional societies and associations who continue to lobby tirelessly for our rights and working conditions. We are no longer bound to working in hospital, community, or school services. We can deliver inferior dental blocks. We have direct access and exemptions… the list goes on.[1] Despite all the positive changes and hard graft, therapists frequently encounter barriers when looking for opportunities, and often feel we are not treated fairly or equitably to our dentist colleagues. But what if there was a way to make the transition from student training to professional working life easier…?

Opportunity

Dental therapist foundation training (DTFT) schemes are currently running across the country alongside dentist foundation training (DFT).

Region	Website
North West	https://www.nwpgmd.nhs.uk/dental-therapist-foundation-training-scheme
North East and Cumbria	https://madeinheene.hee.nhs.uk/dental_training/Dental-Therapists/Recruitment
Yorkshire and the Humber	https://www.yorksandhumberdeanery.nhs.uk/dentistry/programme/dental_therapy_foundation_training
Midlands	https://eastmidlandsdeanery.nhs.uk/dental/dental_foundation_training2/therapy-foundation-training-midlands
East of England	https://heeoe.hee.nhs.uk/dental/eoe-dental/dental-therapist-foundation-training
London and KSS	https://london.hee.nhs.uk/dental/dental-foundation-therapy
Thames Valley and Wessex	https://thamesvalley.hee.nhs.uk/dental-directorate-thames-valley-and-wessex/therapist-training/
Southwest	https://dental.southwest.hee.nhs.uk/about-us/dental-foundation-therapist-programme/dental-foundation-therapy-applications/
Scotland	https://www.nes.scot.nhs.uk/our-work/therapy-vocational-training-dental/
Wales	https://heiw.nhs.wales/education-and-training/dental/training-programmes/wales-dental-therapy-foundation-training-wdtft-programme/

Table 1: **Current providers of DTFT**

Completion of DFT is an expected part of training for dental graduates, and ensures that they receive their NHS performer number so that they can work in NHS practices and services.[2] In that respect, it could be considered 'mandatory'. Of course, some might choose not to do DFT (or not be allocated a space), but this means a future working in only private practice and no opportunity to progress on to dental core training (DCT).

Currently, postgraduate foundation training schemes for dental therapists are not mandatory and do not result in an NHS performer number. Regardless of the acquisition of a performer number, it is the process and experience of DTFT itself that is important and of value, especially in terms of transitioning from education to work, and to ease into the flow of practice. Despite DTFT not being mandatory, most healthcare education teams (previously known as deaneries) are now offering spaces.

Table 1 shows the current health education teams providing DTFT.

Benefits

There are many benefits to completing a DTFT scheme and they should not be dismissed as being for only those who 'lack confidence'. In fact, the interview process is competency based which therefore ensures that applicants are assigned places based on performance at interview (the same as a dentist applying for DFT). Recent research has shown that, at one-year post-graduation, dental therapists who complete DTFT are more confident than those who did not.[3] As well as increased confidence, foundation dental therapists can benefit from:

- Frequent study days which are well matched to learning needs
- Study days alongside trainee dentists
- Continuing professional development (CPD) hours
- Support from a dedicated educational supervisor in practice
- Integration into a mixed-skill team and a supportive working environment
- Working alongside a foundation dentist
- Nurse support
- Completion of learning portfolios to monitor progression and competence
- Tutorials and study time
- Opportunity to complete audits and develop non-clinical skills
- Consolidation of therapy skills in the first year post-graduation
- Opportunity to enhance clinical skills
- Development of knowledge, critical thinking and evidence-based practice skills
- An employed, salaried role (NHS band 6) with the perks of employment such as holiday entitlement, pension contributions, sick pay etc.
- Part-time working which leaves time for another position elsewhere if desired
- Time to learn the NHS contract and how to work within NHS and mixed practices
- Networking opportunities at study days and social events
- A smoother transition from training to working practice

This is not an exhaustive list, of course, and others who have been through the process will have their personal opinion. It is also important to consider the pitfalls and downsides to a DTFT year: the practices may not be well placed geographically; there may not be enough places on the schemes; the pay may not be deemed attractive; or the extra academic opportunities are not desired.[3]

There is also an argument that graduates deem themselves to be confident enough to get going in practice. Phrases like, "I don't need a foundation year; I am confident enough" or "…foundation schemes are for the under-confident or those who struggled at university"[3] may be encountered. However, these opinions do not necessarily match the reality. Firstly, whilst confidence is important, it should not be confused with competence; confidence is self-measured whilst competence is externally assessed.[4] The two go together, but a confident clinician does not always equate to a competent clinician. As previously mentioned, the interview process is competency based which suggests that a level of understanding, skill and knowledge is required to gain entry on the scheme, the opposite of a candidate who may have struggled during training. And finally, dentists and other professionals - for example, pharmacists and doctors - are required to complete a foundation year or equivalent as part of their training pathway.

Negatives

Despite all the positive aspects, there are also some negative points to consider. Recent research reports that some postgraduate trainees experienced the following:

- A lack of support from their trainers or that their trainers required more training
- Study days that were too advanced
- Remuneration too low
- Not enough spaces on the scheme
- Needed more hands-on therapy focussed study days

Although some therapists reported negative experiences, they still conveyed high levels of satisfaction. Overall, DTFT was beneficial to them as they felt more confident, supported and had a range of learning opportunities. When asked, many would recommend DTFT to their peers and strongly felt that it should be mandatory.[3]

Going forward

As a profession, dental therapists are keen to use and maintain their restorative skills. After all, why go through all the training to use only some of your skill set? Despite DTFT being an option, dental therapists frequently encounter barriers when seeking suitable roles. These include: a lack of understanding of the scope of a therapist; poor pay; a lack of trust from dentists; contractual issues with NHS and UDAs; limited therapy; lack of nurse support; inadequate appointment times; and deskilling.[3,5,6,7]

Hopefully, with publication of the Advancing Dental Care (ADC) Report, devised as a 'blueprint for change' to develop a future dental education and training infrastructure, we will see progress and improvements to DTFT to ensure high quality training. ADC also places emphasis on a multi-skilled professional workforce with the aptitude and competencies to support and meet the oral health needs of patients and communities, and makes the following statements:

- Increase the scope and range of training opportunities for dental therapists
- Review how dentists, dental therapists and dental hygienists can be better prepared for clinical practice
- Work towards a standardised dental therapist foundation training model for all newly qualified dental therapists
- Enable dental therapists to utilise their full scope of practice.[8]

With so much strain currently on NHS dental services, surely fewer barriers for the implementation of dental therapists can only be a good thing?

Summary

So, is postgraduate foundation training a foundation for the future? Well, recent research suggests so, with those who completed DTFT reporting higher confidence levels, more opportunity and time spent on restorative procedures, and gaining therapist positions because of their postgraduate experience.[3] Obviously, the job opportunities are the same whether you have undertaken DTFT or not. However, those who have completed DTFT are more likely to be working in community, hospital, prison, NHS, and university settings, therefore experiencing more diverse patient groups and achieving career variety and scope.[3]

Overall, DTFT is a valuable educational experience! What a great foundation for a wonderful career choice.

Author: Laura qualified as a dental therapist from the University of Portsmouth in 2016. Following this she undertook a foundation year with the Thames Valley and Wessex Deanery, and since then she has worked for the Ministry of Defence. In 2022 she completed a Master of Research degree in Oral and Dental Health sciences with the University of Portsmouth. The subject of the research was postgraduate foundation training for dental therapists and its impact on career progression; the manuscript produced from this has since been published. Her career goal is to eventually get into teaching and academia.

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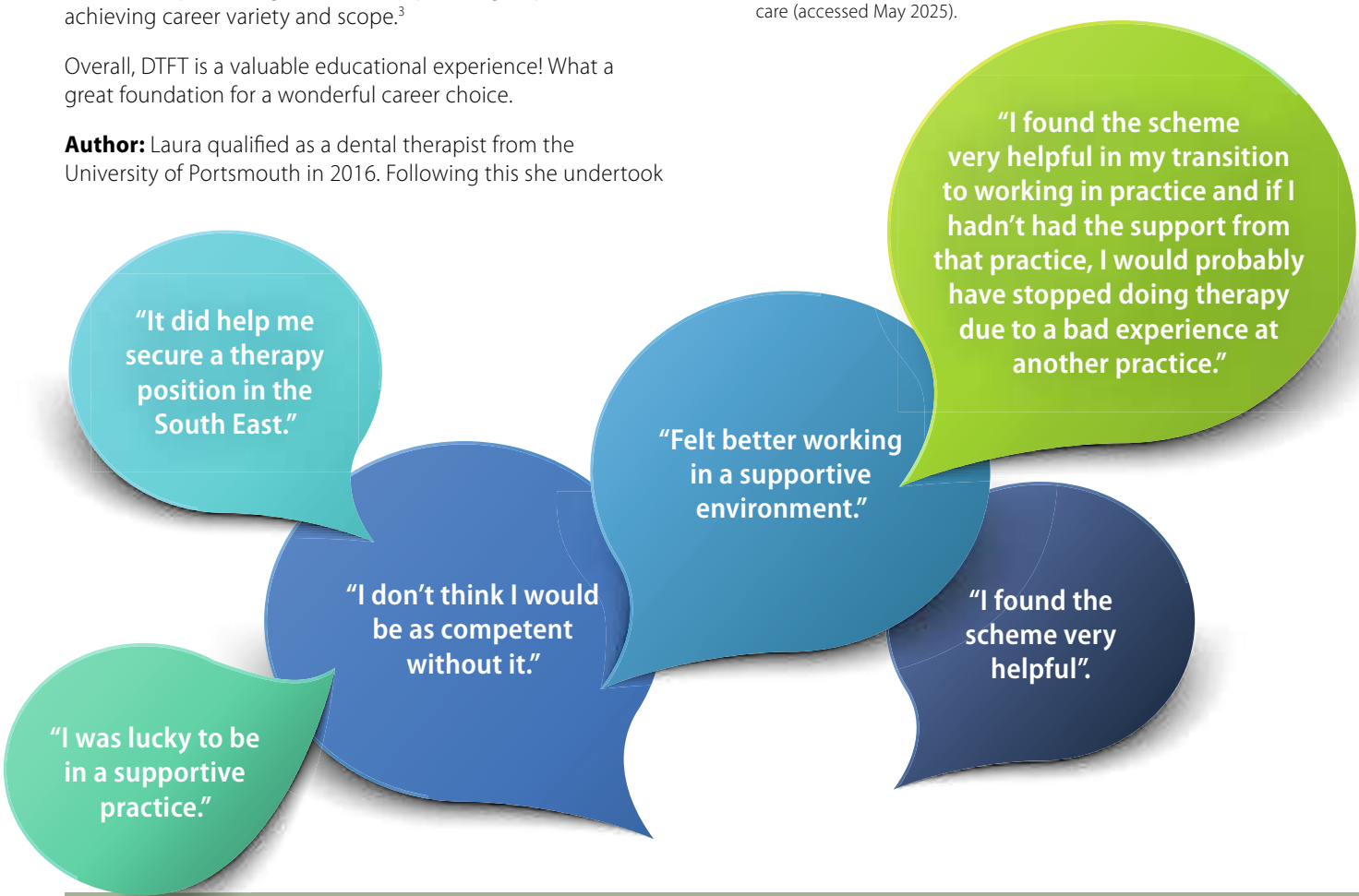

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JEANIE SUVAN

SPOTLIGHT ON...

Jeanie Suvan is a dental hygienist with an impressive clinical and academic record. She holds an MSc in Evidence Based Healthcare, an LLM in Medical Law and Ethics and a PhD in Clinical Dentistry. For many years Jeanie has been involved in post-graduate teaching and clinical research, including the role of Associate Professor and Director of the MSc Dental Hygiene Programme at UCL Eastman Dental Institute. Jeanie is currently a Clinical University Lecturer at University of Glasgow Dental School, Honorary Clinical Lecturer at University of Siena, Italy and co-Editor-in-Chief of the IJDH. Jeanie is also a member of the BSDHT Editorial Board.

Today we hear more about what has driven Jeanie through to this stage in her career, and what developments she would like to see for dental hygienists and dental therapists in the future.

DH: Where did you qualify as a dental hygienist and what motivated you to pursue this as a career?

JS: I qualified at the University of Alberta in Western Canada. By the time I was 16 years old I had decided that I wanted to become a hygienist - I had already determined when I was very young that I wanted to pursue a career in healthcare. I

remember, very clearly, deciding that I would find it boring to be in an office environment; the biggest motivator for me to be a hygienist was the thought of having contact with different people every day.

DH: What prompted you to embark on further education and what was your first post-graduate degree?

JS: The programme to qualify as a hygienist was a diploma at that time. I was looking at further studies as a kind of degree completion. When I was working in Switzerland I had the chance to become involved a little in research, just treating patients and helping with logistics for the study as an extra pair of hands. I then had the chance to take part in a summer programme in clinical research methods at the University of Washington in Seattle and this was at Master's level. When I completed this I realised that I really wanted to pursue a Masters, particularly in something research related, to enhance my skills in that field. It wasn't until I was back in an English speaking country that I completed an MSc in evidence-based healthcare; this focused on research design. At this stage - dare I say it- I was around twenty years into my career. It wasn't just the academic knowledge I was gaining through doing postgraduate study though, I underestimated how much I would learn about myself whilst completing them. It surprised me how much I took away from these experiences.

DH: While you were working clinically as a hygienist, what was your first exposure to the idea of working non-clinically in academia or research and where did this lead you?

JS: It was a nudge from people I worked with - particularly Trisha O'Hehir. When Trisha came to the city I was in to teach a course, she got in touch with a colleague of mine and said she needed some extra people to help teach the hands-on and so my colleague enlisted me to help. I had no idea what I was getting into. Then they decided that this was something I should be doing more and kept prompting me to help. Looking back, I hesitated a lot about this. I think that's something if I were to say I made mistakes in my career, it would be thinking too much about taking such opportunities. Now I tell people, don't think about it so much - just jump in, what's the worst that can happen?

That was my first taste of teaching. I formed a familiarity with the university through becoming involved in CPD courses there, then I was involved with interviewing for the intake of dental hygienist students every year. This experience empowered me to accept an opportunity to go to Switzerland to work at a university. It felt like a natural progression.

DH: Your non-clinical roles encompass both teaching and research. What came first and did one lead to the other?

JS: Teaching led to research. I was fortunate when I was teaching to be around people who were very science based, this was before we had any evidence-based guidelines. I was accustomed to reading journal articles early on in my career; this drove my curiosity to become involved in research.

DH: What were your first experiences in published research?

JS: My first hands-on research experience was study co-ordination and being a study examiner. It didn't even turn into a publication. We actually showed that the product we were testing didn't work, and so the study didn't progress further.

One of the first publications I was involved in was a study that Trish O'Hehir and I did together. We were both convinced that people ignored their lingual surfaces and so our study investigated this. The study showed that brushing lingual surfaces without toothpaste improved oral health outcomes. It wasn't going to change the world but it was a great experience.

DH: Did you have involvement in the profession outside of the workplace?

JS: I was involved both with volunteering and with the professional society back in Canada - I was president of the Alberta Dental Hygienists' Association during a critical time when we were becoming self-regulating with more independent practice. We were one of the first in North America to become self-regulating. I think our associations nurture passion for the profession and they are so important for that reason, and to feel part of a community. It made me feel energised and motivated to be involved with something important.

One of my first volunteer projects was working in the local children's hospital. I went down and asked around, and found that they had a dental chair that wasn't being used, so I started providing dental care for the children - either the children in the hospital, or outpatients with special needs. We didn't have a system at that time for community care and I enjoyed doing something so different.

DH: You have been invited to lecture all over the world. How does this fit into your career?

JS: I am naturally an introvert and speaking in front of people is something that makes me nervous. I have to say that when I first lectured, I thought 'why am I doing this?' I only agreed so that people would stop asking me to do it! I thought if I finally caved then they will finally see that I can't do it and they won't ask me again. Unfortunately, that backfired! It still makes me nervous speaking in front of people and that's something I have had to work at to overcome - it's been a bit of a process. What motivates me to continue and overcome this is that it doesn't really matter what they think about me, I just truly love it and want others to have the enjoyment I have found in the profession. Speaking gives the opportunity to be involved and to energise other people, to expand their knowledge in a certain area. My motivation was never to enhance my

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Continued SPOTLIGHT ON...

own career - it was to have an impact on the advancement of our profession.

DH: You have been involved in many large-scale, high-impact pieces of research; is there any work that you are most proud of and if so, why?

JS: I love them all for different reasons. Any of the studies I did as part of my PhD around obesity and periodontitis - I experienced a whole different perspective on people who struggle with their weight. Others I love, particularly the larger studies where we were investigating the oral-systemic link - mainly because of the memories of the teamwork and what it took to do some of those large studies. It's great when you see they have impact. More recently I have to say some of the systematic reviews because there's so much evidence available now that I find it a challenge to take it and synthesise it. I think the jewel for me is probably the guidelines paper on non-surgical therapy - because of the team that was involved but also it's an important paper for dental hygiene and shows the power of non-surgical therapy. It highlights how important our role is as dental hygienists.

DH: Has there been a moment that you feel was pivotal and changed the course of your career?

JS: Probably a few, because the course of my career has changed a few times. But if I were to say what really accelerated change, it would be every post graduate degree I've done. They each brought different things to my career.

I am a great advocate for further education of any kind. It doesn't have to be a PhD. Its about the experience, the people you meet when you learn, and how you develop - it's the process. It stretches us and forces us to discover and discuss. I've taught for many years and have seen over and over how students come into a programme one person and leave a different person. I absolutely believe that education is life changing. It's the key to the professionalisation of our profession - as we grow individually, our profession also benefits and advances.

DH: You have achieved a great deal over the course of your career, you are also a parent. Did this change how you made decisions or pursued opportunities opened to you?

JS: Yes. I would say my family always came first, and if I'm honest, I probably could have accomplished more sooner. At first, I thought my career was taking away from my home life, but I slowly realised that actually my family were very proud of what I was doing. It also encouraged a shared responsibility within the family - everyone had to chip in a little, everyone had a job, so it wasn't all just falling on me. I admit it, there were days where I felt pretty stretched and I felt like maybe I was making a mess of everything, there were a few nights short of sleep. But looking back I have no regrets. I definitely think you have to compromise a little, but those compromises don't mean that you can't accomplish a lot on both sides.

DH: What development would you like to see in terms of further opportunities for dental hygienists and therapists?

JS: I think it would be great to find ways to have more hygienist and therapist interface with research. I would love to see curiosity nurtured; opportunities and support provided to those who want to become involved. We are a healthcare field based on science, and an important part of that is critical thinking and being able to consume information, assimilate it in our mind and make decisions and judgements. I would love to see it flow through our profession more, I would love to see research more in every part of our profession from our education through to our everyday clinical practice. Our involvement in it, reading it, producing it, synthesising it in every aspect. I think we're at the point in the UK now where I think it would be the right time to engage and empower more hygienists and therapists in research - not to gain some kind of recognition or power, it's about being able to provide the best care and being the best version of yourself

We are in a position to do much more than provide treatment to each individual patient, as we look at our challenge of chronic disease management in today's world - and I think there's a role for us in this: how can we broaden our scope to spread our message of oral health beyond the dental chair?

DH: What advice would you give a hygienist or therapist interested in pursuing a career in research? Is postgraduate education necessary?

JS: I would say make sure you're reading research. It starts there: learn as much as you can about it. For those with postgraduate education I would say look for ways to partner with others to get involved - either through university or a network - find others who share your interest and work together, because research is something you don't do alone.

BY CAROL RAFFERTY

FROM DENTAL HYGIENIST TO CEO

Almost two years ago I found myself preparing to address delegates at The American Academy of Arts and Science in Cambridge, Massachusetts. Dentherapy Ltd, the R&D company I co-founded, had been selected by the ADA Forsyth Institute to present at their Dentech Conference: one of 17 global companies asked to showcase their innovative technologies. Being from Edinburgh, I was inspired to note that fellow Scot, namely Alexander Graham Bell, had presented his own innovation at the Academy: the first public demonstration of the telephone in 1876.

Dentech is a leading oral health technology and innovation conference and as I descended the stairs to the auditorium and stepped onto the stage I was met with a sea of expectant faces: leading researchers, industry figures, academics and venture capitalists. I had previously decided not to present my slide deck from the podium, as I didn't think I'd need to refer to my 'memorised' notes but, at that moment, I forgot my opening line. My mind was blank! How did I get here?

A Career in Dentistry

My career in dentistry began as a dental nurse in the community dental service. I subsequently trained as a dental hygienist at Edinburgh Dental School. I then worked in general practice and the community dental service, where I took part in the early roll-out of Childsmile in Scotland, the dental public health initiative that introduced daily toothbrushing in nursery and school settings. During this period, I obtained an MSc in Health Promotion.

In 2006 I was appointed senior dental nurse tutor by NHS Education for Scotland for Grampian and Tayside. Alongside seven tutors we delivered the NEBDN training programme for our large first cohort of 150 trainee dental nurses.

Throughtout this period I continued to work as a dental hygienist but as my daughters approached the transition from school to university, I began to contemplate my own career transition.

An Innovative Idea

In my clinical role, I was only too aware of the changing needs of my patients: those whose medications result in dry mouth; others with increased sensitivity due to worn dentition, tooth whitening or frequent consumption of acid foods and drinks.

Tailored oral care advice includes recommending products, toothpastes or mouthwashes, to help prevent, stabilise or treat oral conditions. However, these products tend to require access to a sink and are often restricted to morning

and evening routines. I began to question why there were no therapeutic products I could recommend to my patients to use between brushing, when their mouths are most vulnerable post frequent acidic episodes.

This was the prompt to consider whether I could develop an oral care product to be used directly after snacks, food and drinks, delivering 'just in time' remineralisation, effectively boosting care between brushing.

However, I did not know where to start. What did I know about formulation and product development? Nothing! I had no idea of the challenges that lay ahead and the skills I would have to acquire. Had I known a fraction of the work involved, or the timescale for developing new therapeutic oral care products, I would not have been brave enough to have started!

The Quest

My first step was to test my product concept idea with a family friend. Dr Howard Marriage was Entrepreneur in Residence at Edinburgh University at that time and subsequently went on to set up the Translation Department at the Francis Crick Institute. Howard opened his extensive contacts book, which included Scottish Enterprise (SE). This organisation provides start-up companies with research and development grants, supporting feasibility studies for high risk, ambitious projects.

Having secured a SE feasibility grant, we began formulation development and consumer discovery. Approaching people in shopping centers and train stations, we asked a range of open questions, related to their oral health priorities or concerns and what products they currently used. At this point I had to take off my 'white coat' as it was critical not to 'sell' our product concept, but rather to establish if there was a specific problem our product could help alleviate or resolve - our value proposition.

Idea becomes reality

At this early stage, we began to assemble our team of formulation specialists, biochemists, patent attorneys and regulatory advisers. Dr Richard Willson, our Chief Scientific Officer, was previously senior formulator with GSK and part of the team that developed Pronamel and other Sensodyne products. Richard joined our team and led development of 'Toothboost Technology', our unique glycoprotein-based formulation for delivery in a range of products. Our lead product, Toothboost Oral Mist, is an easy to use, no-rinse spray, formulated to boosts the saliva's remineralising and buffering function, enabling consumers to protect their teeth directly after food, snacks and drinks, without the need to find a sink!

Our product portfolio has now grown to include mouthwash, toothpaste and dissolving strip technology. In-vitro studies confirm our proprietary formulation's multifunctional application: remineralising early carious and erosive lesions; pH buffering, supporting healthy oral microbiome; hypersensitivity; stain prevention. Consumer trial feedback highlighted Oral Mist's lasting freshness and 'just brushed' smooth mouth feel.

Collaboration and Networking

Throughout the ten-year period of establishing the company, assembling our team, and engaging with dental professionals, patients and consumers, we could not have achieved any of this without the generosity and support of the life science community. Dr. Howard Marriage, our dear friend and mentor who was instrumental in supporting and guiding our project, sadly died in 2020. This was an extremely difficult period for the team, which coincided with the COVID 19 pandemic.

Opportunity North East's (ONE) Life Science sector, an organisation in Aberdeen, has provided pivotal support to Dentherapy. In 2023, ONE opened the BioHub innovative space, supporting the entrepreneurial ecosystem of researchers and innovators to translate world-leading science to the marketplace. We now have co-working space in the BioHub, working alongside researchers and companies developing diagnostic and therapeutic products in areas of Alzheimer's, diabetes, cardiovascular disease and oncology.

Collaborating and networking with this unique community creates an opportunity to discuss the link between oral, metabolic and systemic health. This offers additional ways to engage dental and medical professionals in communicating the importance of oral health in our overall health.

Back to the conference

Finally on stage, I took a deep breath, reflecting that each step in my dental career had given me the tools to create this company and present our innovative technology. Did it go smoothly? Not exactly! However I was both memorable and entertaining by default, and am happy to share the full story with BSDHT members at the BSDHT Oral Health Summit in Edinburgh later this year.

Interestingly, the keynote speakers also focused on the connection between oral health and systemic health and highlighted the importance of user-driven research. The need to translate research into new technologies and products that have real-world application for patients, consumers and communities.

Listening to the panel discussions, I reflected that Toothboost Oral Mist is a user-driven product, with the potential to support both oral and systemic health of patient groups, consumers, with possible application in community settings.

I am happy to report that Toothboost attracted a lot of interest from the delegates, resulting in new connections, friendships and collaborations. Indeed, we were invited to present Toothboost at ADA Smilecon 2024, in New Orleans as part of Forsyth Institute's 'Innovation Hub' under the heading, "the future of dentistry."

Our plan is to manufacture and launch our initial product Toothboost Oral Mist later this year. This is currently in progress, with a number of dental practices looking to take part in our initial launch programme.

Contact: c.rafferty@dentherapy.com

QUIET EROSION
COERCIVE CONTROL IN DENTAL PRACTICE

When you train and qualify as a dental hygienist or therapist, you expect to work hard. You prepare for clinical challenges, time pressure, patient demands and your role within a broader team. What you don't expect is to feel emotionally worn down, not by patients or workload, but by the behaviour of those in leadership roles.

Abuse in the workplace is not always accompanied by shouting or overt aggression. Sometimes, it's quiet. Insidious. Difficult to name. That's what makes coercive control so damaging: it is a pattern of behaviour that gradually erodes a person's confidence, independence and sense of safety, often without the realisation that it is happening!

Coercive Control

Originally described in domestic abuse contexts, coercive control is now recognised as a pattern of psychological manipulation that can appear in many environments, including workplaces. It involves dominating another person through a series of small, ongoing actions designed to undermine, isolate and control them.

In a dental setting, it may look like this:

- Micromanagement: You are constantly monitored and corrected, even in areas where you are highly competent
- Exclusion: You are left out of conversations about your own work or about patients
- Double standards: You are praised to your face but undermined behind your back
- Manipulation: Your words or actions are misrepresented and used against you
- Isolation: Team members are quietly turned against each other through gossip or favouritism

Each act may seem small on its own but together creates a climate where people feel anxious, uncertain and powerless.

What makes coercive control even harder to recognise is that it often comes wrapped in charm, warmth, attentiveness, even generosity. The person in charge may seem kind, supportive and invested in your success. In the beginning, you might feel encouraged, included, or even lucky to be part of their team. That positive attention builds trust and lowers your guard. But that same charm can later be used to excuse controlling behaviour or to create confusion when boundaries are crossed. By the time subtle manipulation begins, you may already feel too invested, too unsure, or too isolated to speak up.

The Signs of a Coercive Environment

In a coercive workplace, control is not enforced overtly; it is enforced subtly. You may slowly begin to notice:

- Frequently rewriting clinical notes or emails to avoid criticism
- Feeling watched or judged rather than supported
- Colleagues becoming guarded or withdrawn
- Gossip and unspoken power dynamics dividing the team

These environments often claim to value 'high standards' or 'professionalism', but they function through fear, not mutual respect.

Gaslighting: Doubting Your Own Reality

Gaslighting is a specific form of psychological manipulation where someone makes you question your memory, perception or sanity. It is named after the 1944 film Gaslight, where a man manipulates his wife into thinking she is losing her mind.

In the dental workplace, gaslighting might look like:

- Being promised something then being told, "That was never said!"
- Raising a concern and being told you are, "Overreacting."
- Noticing unethical behaviour, but being made to feel like you are the problem

Over time, you lose trust in your instincts. You second-guess your perceptions. You start believing that maybe you are difficult, or sensitive, or wrong.

Micromanagement Is Not Leadership

Dental hygienists and dental therapists are qualified, skilled professionals. Many of us work under our own initiative, managing our own patient lists, delivering direct treatment, and making clinical decisions every day. But in some practices, that autonomy is constantly undermined, not through formal rules but through subtle, persistent control.

Micromanagement does not always come in the form of direct instructions. You might be given responsibility for supervising other staff, or running your own diary, yet feel constantly checked up on. You are asked where your colleagues are, what they're doing, or whether they're "pulling their weight." You may be expected to manage others while also being managed yourself! You are told to be efficient but questioned for stepping out during your unpaid break. You are asked to be flexible, but penalised for saying, "No!"

Your clinical judgement is often second-guessed. You may

feel pressured to squeeze in additional patients, to shorten appointments, or to deliver care in ways that compromise your standards. You might even find yourself justifying decisions to people who are not clinically trained. And all the while, you are expected to smile, stay professional, and not make a fuss.

This is not guidance… it is erosion! You begin to doubt your own instincts, not because you lack skill, but because you are made to feel as though your autonomy is conditional. That the right to lead your sessions, manage your time, or speak up is something that can be quietly taken away.

True leadership recognises clinical skill and respects professional boundaries. It supports growth and collaboration. Micromanagement does the opposite: it reduces a clinician to a pair of hands, not a thinking, capable practitioner.

When Work Invades Your Life

Another common sign of coercive control is the blurring of boundaries between work and personal time. In many practices, WhatsApp becomes the default form of communication, popping up late at night, during weekends, or even when you are on holiday.

You might be added to multiple groups: one for reception, another for nurses, another for operations or marketing. At first, it feels efficient. But over time, it creates a culture of constant availability. You feel guilty for muting the group; you are expected to read, reply and act no matter the time or context. The practice never switches off. It lives in your pocket, pinging through moments of rest, family time, or recovery. Eventually, you stop switching off too.

Divide and Conquer: The Power of Gossip

Workplace triangulation - when a leader passes information between colleagues to create tension - is a key tool of coercive control. It breaks down trust and keeps people in line.

You hear that someone said something about you. You're told you have caused upset but not given clear details. Conversations you thought were private reappear with someone else. Slowly, people stop confiding in each other. You do not know who to trust. But that's the point!

When the team is fractured, leadership goes unchallenged. New staff are quickly absorbed into the culture, unaware of the dynamics beneath the surface. Long-standing friendships fade. The atmosphere changes and you begin to feel alone even in a full building.

When You Stop Feeling Safe

These things do not happen all at once. The culture creeps in gradually, until the abnormal feels normal.

You go home anxious. You lose sleep. You dread seeing the rota. Work no longer feels fulfilling, it feels like survival. You stop suggesting new ideas. You reduce your effort not because you do not care, but because you are trying to protect yourself. And then you feel guilty for doing 'the bare minimum'.

You start to censor your conversations. You lower your voice. You worry that even a chat might be overheard, or worse, watched back on CCTV. You feel constantly on edge, even when nothing has happened yet. That is not vigilance. It is survival mode.

That guilt and fear keeps you stuck. But the longer you stay, the more your confidence fades and the harder it becomes to imagine anything different.

Why Hygienists and Therapists Are Especially Vulnerable

Dental hygienists and therapists are often self-employed, working in roles that do not include access to HR support or formal grievance routes. That vulnerability can be exploited.

Despite being central to prevention-led care, we are sometimes treated as peripheral: expected to be flexible, grateful, silent. Our kindness, empathy and desire to be team players can be manipulated to keep us compliant.

Working with support staff does not guarantee feeling supported especially when the environment is governed by fear or manipulation. When those who speak up are quietly pushed out and those who comply are rewarded, the message becomes clear: shrink yourself or leave.

When Something Feels Off

You might be in a coercive work place if:

- You feel anxious even when things seem "fine"
- You doubt your clinical judgement, despite experience
- You avoid speaking openly with colleagues
- You are expected to be available 24/7
- You feel exhausted even after rest days
- You are afraid to raise concerns

What You Can Do

If you recognise aspects of your own experience in this article, you are not alone and it is not your fault. Coercive control is subtle but harmful, and acknowledging it is an important first step.

Here are some practical steps you can take:

- Document everything: Keep a written record of incidents, including dates, times, and what was said or done. Even informal or verbal comments can be important.
- Communicate in writing: Try to move important conversations to email or written platforms where a record is kept. This can help protect you and clarify expectations.
- Contact BSDHT: As your professional body, the British Society of Dental Hygiene and Therapy can offer support, guidance and resources. You do not need to face this alone.
- Reach out to someone you trust: Whether it is a colleague, mentor, or friend, speaking to someone can help you process and evaluate the situation with greater clarity.

- Know your value: If the environment is affecting your wellbeing, it is not a reflection of your competence. Leaving a toxic workplace is not giving up it is protecting your health and your future.

A Final Thought

This article is not about blame. It is about awareness.

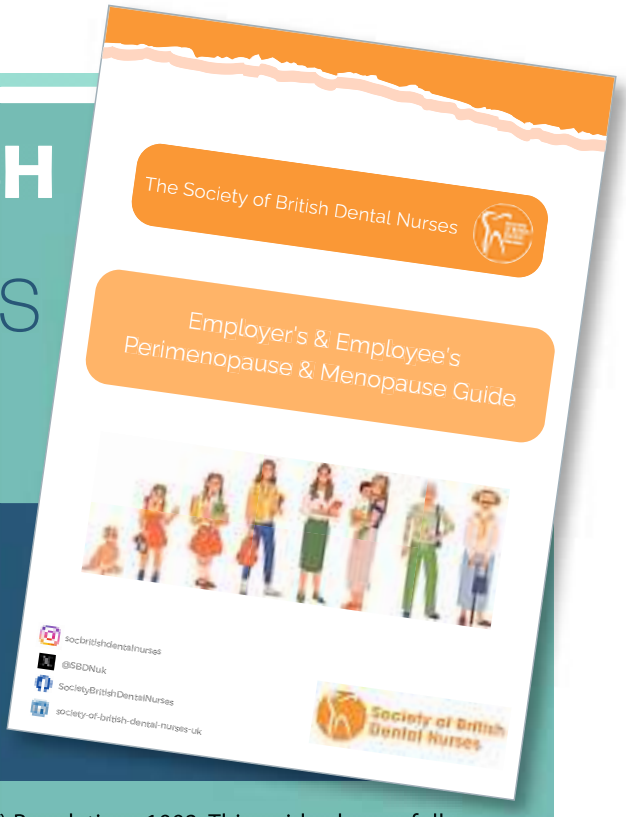
Coercive control thrives in silence and ambiguity. Naming it is the first step toward change not just for individuals, but for our profession.

If you have experienced a workplace like this, please know it does not reflect your ability or worth. There are excellent leaders and supportive practices. There are environments where you can grow, contribute and be respected.

Do not let one toxic setting define your career. You deserve better. We all do.

Author: The author is a dental therapist who wishes to remain anonymous.

THE SOCIETY OF BRITISH DENTAL NURSES: EMPLOYER'S & EMPLOYEE'S PERIMENOPAUSE & MENOPAUSE GUIDE



Author: Info@sbdn.org.uk
Publisher: https sbdn.org.uk
Produced by: Nicola Sherlock, NatCert.DN, MSBDN, SBDN Executive Secretary
Reviewed by: Elaine Tilling

Women make up nearly half of the UK workforce, yet many feel forced to reduce their hours, pass up promotions, or even leave their jobs due to lack of menopause support. Wellbeing of Women is a charity that saves and changes the lives of women, girls and babies and instigators of The Menopause Workplace Pledge with the Civil Service, the largest employer now signed up. The impetus built up since its launch in 2019 is going some way to facilitating workplace support for women going through what can be an extremely challenging time in their lives.

The DCP cadre is predominantly female and so is good to see representative organisations such as the SBDN producing this accessible guide for both employees and employers. The guide lists symptoms and symptom support for the individuals and outlines the legislation and regulations that protect women in the workplace under both The Health and Safety at Work Act (1974) and The Workplace (Health, Safety and Welfare) Regulations 1992. This guide also usefully explains the roles and responsibilities of employers.

SBDN further supports its membership with regard to setting up local policy in the workplace by providing downloadable templates for Risk Assessment that help their employees identify and develop supportive policies and systems.

This guide attests to the SBDN's commitment to supporting its members in the workplace and sharing best practice with the wider team within the dental workforce.

To view and download a PDF copy of the document visit:
https://sbdn.org.uk/wp-content/uploads/2025/05/employers-employees-menopause-guide-3.pd

BOOK REVIEW

Putting health at the heart of your practice

Author: Sheila Scott
Publisher: Dental Protection
Cost: £20.00

Reviewed by Ali Lowe

I was lucky enough to meet Sheila Scott several years ago when she was engaged as a consultant at a practice where I worked. She was both dynamic and inspiring. Following her visit, I clearly remember pulling together as a team and acting upon her many findings. I can certainly vouch for her coaching skills! She is mostly retired now (although she delivered a series of workshops in conjunction with Chris Barrow earlier this year). However, in the absence of a practice visit her book is the next best thing.

What this compact book lacks in size it more than makes up for in content including a foreword by Kevin Lewis who wholeheartedly endorses Sheila's mantra that it's, *'Not about the dentistry.'* The book is the epitome of Sheila's advice and reinforces just what a 'health centred practice' should be doing - offering a straightforward achievable plan to help us achieve better health for our patients.

In chapters 1-4 Sheila reinforces the importance of good communication in getting patients on our side - after all they judge us much more for our chairside manner than our clinical skills. Obviously, we need to be able *provide* good treatment, but our patients will trust us depending on *how* we deliver treatment. In order to manage their expectations better we need to deliver what our patients really want from us rather than what we think they need.

The book goes on to explain the importance of both the 'Dental Health Check' ('check-up' is so outdated!) and membership plan. Chapters 7 & 8 consider 'what' is important regarding a hygienist referral and the crucial role of the hygienist in maintaining the patient's health ('*just*' and '*scale polish*' are very negative words). Indeed, the Hygiene Protocol is a must read for all the team but especially those who define and implement protocols. And although the topic is not addressed directly, this book is in fact, a communications road map for the dental therapist moving to deliver their full scope of practice in a way that wins the hearts and souls of the patients.

I particularly liked the 'Opening Conversation' section in chapter 3, the Importance of discussing sterilisation and patient protection together with the action points in each chapter.

I have no hesitation in recommending this book to all members of the dental team - after all, 'putting health at the heart of the practice' requires a combined effort. In her conclusion Sheila urges us to 'demonstrate with pride just how much we care' and with the help of this book we can do just that.

You can buy your copy at **www.sheilascottdental.co.uk** for £20 plus postage – or by emailing Sheila directly on **sheilascotthaha@gmail.com** (especially for multiple copies - 4 copies or more attracts a 25% discount).

	Dental Hygienist	Dental Therapist	Student
Usefulness in practice	****	****	****
Revision Tool	****	****	****

Key: *Average **Good ***Excellent ****Absolute must!

eCPD PAPER

BY JOHN STANFIELD

THE OVERPRODUCTION OF DENTAL THERAPISTS IN THE UK
A WORKFORCE MISMATCH AND POTENTIAL SOLUTIONS

1½ Hours eCPD PER PAPER

AIM

To critically examine the mismatch between the growing number of qualified dental therapists in the UK and their underutilisation in practice, and to explore workforce, contractual, and systemic reforms necessary to enable full integration of dental therapists into NHS dentistry.

LEARNING OBJECTIVES

1. Understand the factors contributing to the overproduction of dental therapists in the UK.
2. Analyse the impact of NHS funding structures - particularly the UDA system - on the utilisation of dental therapists.
3. Compare the integration of dental therapists in NHS dentistry with the more successful integration of nurse practitioners in general medical practice.
4. Evaluate proposed solutions, such as therapist-led clinics and contract reform, to improve workforce efficiency and access to care.

LEARNING OUTCOMES

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

1. Identify and describe key reasons behind the workforce imbalance of dental therapists in the UK, including educational and policy-driven factors.
2. Critically assess the limitations imposed by the current NHS dental contract system on the full utilisation of dental therapists' skillsets.
3. Compare and contrast the workforce integration strategies of dental therapists and nurse practitioners, drawing out lessons applicable to UK dentistry.
4. Propose evidence-based solutions—such as contract reform and therapist-led clinics—that could enhance the role of dental therapists in improving NHS dental service delivery.

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ABSTRACT

In recent years, there has been a marked increase in the number of dental therapists qualifying in the United Kingdom, driven in part by efforts to modernise the dental workforce and expand access to preventive and minimally invasive care. However, this shift has not been matched by a proportional increase in employment opportunities within the NHS or private sectors. As a result, newly qualified dental therapists are facing significant barriers to employment, often struggling to find roles that make full use of their skills and scope of practice.

This article explores the current oversupply of dental therapists in the UK, examining the contributing factors behind this workforce imbalance. It considers the policy and educational drivers that have led to an increase in training places and evaluates the consequences for both the profession and the wider dental workforce. Particular focus is placed on the mismatch between workforce planning and employment realities, the limitations of NHS contract structures, and the persistent underutilisation of dental therapists in clinical settings.

The overproduction of dental therapists presents a challenge not only to individual practitioners, but also to the sustainability and effectiveness of workforce reform within UK dentistry. Without significant changes to commissioning structures, practice models, and stakeholder attitudes, the profession risks producing a highly skilled but underemployed workforce. Urgent action is required from policymakers, educators, and professional bodies to address these imbalances and to ensure that dental therapists can contribute meaningfully to the delivery of oral healthcare across the UK.

KEY WORDS

Dental therapist, workforce, planning, prevention

Table 1: Registration Statistical Report 2023[1]

Year	Dental Nurse	Dentist	Dental Hygienist	Dental Technician	Dental Therapist	Orthodontic Therapist	Clinical Dental Technician
2019	58,882	42,471	7,562	5,776	3,620	696	375
2020	58,978	43,053	7,824	5,533	3,947	735	368
2021	59,480	43,292	8,312	5,319	4,408	829	390
2022	59,021	44,123	8,832	5,153	5,013	914	401
2023	61,774	45,204	9,572	5,092	5,961	1,021	428

Introduction

In recent years, the UK has significantly increased the training of dental therapists. Currently, there are about 6000 dental therapists on the register, which is an increase of nearly 1000 from the previous year (between 2022-23) (Table 1).[1] However, despite their broader scope of practice compared to dental hygienists, many therapists find themselves working solely in hygiene roles. This raises concerns that successive governments are using therapists as a cost-effective alternative to dentists in the struggling NHS, while failing to provide them with enough opportunities to work to their full potential.

The NHS Crisis and the Shift Towards Dental Therapists

The NHS dental workforce crisis is well-documented, with many dentists leaving the NHS due to poor working conditions and inadequate funding.[2] In response, policymakers have promoted the training of more dental therapists. However, without sufficient therapist-specific roles, many are forced into hygienist positions. This mismatch between training and employment wastes valuable skills and fails to address the root causes of NHS dental service shortages. To create a sustainable workforce, the government must rethink its approach to integrating therapists into NHS dentistry.

A well-functioning NHS dental workforce should make full use of the skills available within the system. Currently, however, therapists are being trained but not given the professional autonomy required to work to their full potential. A more strategic workforce plan that enables therapists to perform the duties for which they are trained could improve access to care, reduce NHS pressures, and make the profession more attractive to new entrants.

The Role of Dental Therapists vs. Dental Hygienists

Dental therapists and dental hygienists have overlapping skills but distinct roles. Hygienists focus on preventive care, including periodontal care (PMPR), and patient education. Additionally, therapists are trained to carry out a wider range of treatments, such as fillings, extraction of children's teeth, and, more recently, conducting dental examinations.[3] Importantly, both groups are now able to use the exemptions mechanism, allowing them to supply and administer certain prescription-only medicines without the need for a dentist's prescription, further enhancing their clinical autonomy and contribution to patient care.[4]

Historically, separate training pathways existed for dental hygienists and therapists. However, most current courses produce therapists rather than hygienists. This shift was intended to create a more versatile workforce, yet the reality is that many therapists find themselves underutilised. The lack of dedicated therapist positions forces them to accept hygienist roles, leading to skill attrition and dissatisfaction within the profession. A survey by the British Association of Dental Therapists (2021)[5] found that over 60% of dental therapists were unable to work to their full scope, demonstrating the systemic failure to integrate them properly into the workforce.

Therapists are trained in restorative procedures, caries management, simple deciduous extractions, and paediatric dental care. Yet, the rigid structure of many NHS contracts often prevents them from performing these duties.[6] As a result, the skills that could be used to alleviate NHS pressures remain underutilised, contributing to inefficiencies in service delivery.

Additionally, the limited use of dental therapists means that patients are often forced to wait longer for appointments, as dentists remain overburdened with cases that therapists could effectively handle. This is particularly problematic in underserved areas, where access to dental care remains a challenge. Expanding the role of therapists could help bridge this gap, improving overall patient care and reducing treatment delays.[7]

Why Are Therapists Working as Hygienists?

1. Lack of Therapist-Specific Roles

Despite the increasing number of dental therapists being trained, there are simply not enough positions that allow them to work within their full scope. Many NHS practices still rely on the traditional dentist-hygienist model, overlooking therapists as a viable solution for expanding routine dental care.

- **Practice Owners' Reluctance** – Many practice owners are unfamiliar with the therapist's role or see little financial incentive to employ them in their full capacity. Given that NHS contracts are structured around dentist-led care, practices are often hesitant to shift to a therapist-inclusive model.

- **Therapists as a 'Backup' Workforce** – Some practices employ therapists primarily for hygienist roles, occasionally allowing them to perform restorative work. This inconsistency limits their ability to maintain and develop their full skill set, leading to professional stagnation.[8]
- **Preference for Dentists in Key Roles** – Many practices still favour hiring dentists for examinations and restorative treatments rather than incorporating therapists effectively. Without policy-driven incentives, there is little motivation for practice owners to change their employment strategies.[2]

2. Dentist-Centred Contracts in the NHS and Their Impact on Dental Therapists

NHS Funding Structures and the UDA System

In England and Wales, NHS dental contracts are predominantly structured around the Units of Dental Activity (UDA) system, which was introduced on 1 April 2006 as part of wide-ranging NHS dental contract reforms. Under this system, dental practices receive funding based on the number of UDAs they deliver annually, with different treatments assigned specific UDA values. The system was designed to move away from the traditional item-of-service model, aiming to simplify funding and encourage a more preventive approach—though it has been subject to ongoing criticism and review. For example:

- A Band 1 course of treatment (e.g., an examination, diagnosis, and preventive care) is typically worth 1 UDA.
- A Band 2 treatment (e.g., fillings, extractions, and periodontal care) is worth 3 UDAs.
- A Band 3 treatment (e.g., crowns, dentures, and bridges) is worth 12 UDAs.

While the intention behind this system was to simplify funding and improve access to care, it has resulted in unintended consequences—one of the most significant being its dentist-centred nature.

Financial Disincentives for Utilising Dental Therapists

Although dental therapists are trained to carry out a range of treatments that fall under Band 2, including fillings and periodontal care, the UDA system does not differentiate between whether a dentist or a therapist performs the treatment. The remuneration for the practice remains the same, regardless of who provides the care. However, since dentists can offer a broader scope of treatments, including those in Band 3, they are often seen as more financially valuable under the contract system. This creates a financial disincentive for practices to utilise dental therapists fully.

As a result, many NHS practices prioritise having dentists deliver care even when a dental therapist could competently provide most of the treatment. This limits the role of dental therapists in NHS practice, despite their clinical competencies being well-suited to certain aspects of patient care.

Steele Review and Calls for Reform

The Steele Review (2009) examined NHS dental services and identified a need for a more preventive, team-based approach.[9] The report acknowledged that the UDA system was not adequately structured to encourage the best use of skill mix within dental teams. Despite this, substantial reforms to NHS dental contracts have been slow, and the funding model still largely favours a dentist-led approach.

Consequences for Workforce Utilisation and Access to Care

The current funding model affects dental therapists and the overall efficiency of NHS dental services in several ways:

- **Underutilisation of Therapists** – Many therapists find that NHS practices are reluctant to employ them due to financial constraints, despite their ability to provide essential treatments.
- **Access to Care Challenges** – With NHS dentists facing high workloads, more effective integration of therapists could improve patient access and reduce appointment wait times.
- **Private Sector Opportunities** – Many dental therapists move into private practice, where they can work more flexibly and be valued for their skill set, rather than being limited by restrictive NHS contracts.
- **Bureaucratic Barriers** – Although dental therapists can now be issued a PIN to open courses of treatment on the NHS, they must still work under a dentist's performer number. This dual-layered system continues to impose administrative burdens that may discourage practices from fully integrating therapists into NHS workflows.

What could be the solution?

Therapist-led clinics could provide a significant improvement to NHS dentistry by enhancing access to care, improving efficiency, and maximising the skills of the entire dental team. With increasing pressures on NHS dental services, particularly in terms of access and workforce shortages, shifting certain responsibilities to dental therapists could help alleviate these challenges. *"Skill mix must not be viewed as just a redistribution of roles and responsibilities within dentistry as it presently exists: it will apply across the entire spectrum of healthcare."* [10]

Several reforms could improve the situation, including:

- Activity-based remuneration that recognises therapists' contributions separately from dentists.
- A capitation-based system that focuses on overall patient care rather than individual treatment fees.
- Greater contractual flexibility to incentivise the full use of the dental workforce.

Until such changes occur, NHS dental contracts will likely continue to disincentivise the full utilisation of dental therapists, reinforcing the dominance of dentist-led care in the system.

1. Expanding Access to Care

One of the biggest issues in NHS dentistry is limited access, with many patients struggling to secure appointments. Therapist-led clinics could help by:

- **Providing routine care:** Dental therapists are trained to carry out examinations, fillings, periodontal care (PMPR), paediatric extractions, and preventive treatments, meaning they can manage a significant portion of NHS dental patients without the need for a dentist.[11]
- **Reducing waiting times:** By delegating appropriate treatments to therapists, dentists would be free to focus on complex cases, reducing bottlenecks in NHS dental services.
- **Addressing regional shortages:** Many areas, particularly rural and underserved communities, face a shortage of NHS dentists. Therapist-led clinics could provide a sustainable solution in these regions.

2. Improving Efficiency in NHS Dentistry

- **Optimising workforce utilisation:** The current model often underuses the skills of dental therapists, leading to inefficiencies. Therapist-led clinics would allow them to work to their full scope, reducing reliance on dentists for routine care.
- **Streamlining patient pathways:** Patients often see a dentist for treatments a therapist could provide. A direct-access model within therapist-led clinics would ensure patients are treated by the right professional at the right time.
- **Reducing unnecessary referrals**: By allowing therapists to manage their caseloads within NHS settings, unnecessary referrals to dentists for basic restorative and preventive work could be minimised.

3. Strengthening Preventive Care and Public Health Outcomes

- **Greater focus on prevention:** Therapist-led clinics could place a stronger emphasis on preventive dentistry, such as fluoride applications, oral hygiene education, and periodontal maintenance. This aligns with NHS England's aim of shifting towards preventive care.[12]
- **Managing periodontal diseases effectively**: Given the increasing burden of periodontal diseases, a system where therapists led clinics focused on PMPR and periodontal maintenance could improve long-term outcomes.
- **Better paediatric and community dental care:** Therapists are particularly well-placed to lead clinics that focus on children's oral health and outreach programmes, helping to reduce the incidence of dental decay in young patients.

4. Financial and Systemic Benefits

- **Cost-effectiveness:** Therapists can provide many treatments at a lower cost than dentists, meaning NHS resources could be allocated more efficiently.
- **Retention of workforce:** Many dental professionals leave the NHS due to workload pressures. By making better use of dental therapists, dentists could have a more manageable workload, improving job satisfaction and retention rates.
- **Improved integration with wider healthcare services:** Therapist-led clinics could work closely with other healthcare professionals (e.g., GPs, health visitors, and schools) to provide holistic care, particularly for vulnerable groups.

A Workforce in Need of Change

The UK has invested heavily in training dental therapists, yet poor workforce planning has left many underutilised. Instead of relying on outdated models, the NHS must integrate therapists more effectively to improve access to dental care. Therapist-led clinics could provide a lifeline to underserved communities, where access to dental care is often limited due to a shortage of NHS dentists.

By creating more therapist-led roles, reforming contracts, improving career progression, raising public awareness, and addressing pay concerns, the UK can build a more sustainable dental workforce. Without these changes, dental therapists will continue to be underutilised, while NHS patients struggle to access essential services.

Compare the workforce integration of dental therapists within NHS general dental practice to the integration of nurse practitioners and advanced nurse practitioners within general medical practice (Table 2).

Key Takeaways

1. **NPs/ANPs Have Been Better Integrated Than Dental Therapists:** Despite initial resistance, systemic changes in funding and practice models enabled NPs/ANPs to become essential in primary care. A similar approach could help dental therapists.
2. **Financial Incentives Are Crucial:** General practice adapted to NPs/ANPs partly due to funding models that recognised their contributions. NHS dentistry lacks a comparable structure to support therapist-led care.
3. **Public Awareness and Acceptance Matters:** Patients increasingly trust NPs/ANPs, while many still expect to see a dentist rather than a therapist. More education and systemic changes are needed in dentistry.
4. **Policy-Driven Change Is Necessary:** GP practices were incentivised to integrate NPs/ANPs, whereas NHS dentistry still prioritises a dentist-led model. Reforming contracts and workforce strategies could help integrate dental therapists more effectively.

Author: John Stanfield qualified as a dental hygienist in 1980 at RADC Aldershot and has since gained extensive experience working within HM Forces, military hospitals, the NHS, and private practice in the UK and internationally. He also served as the DCP Lead for NHS England. John was a Council Member of the College of General Dentistry and the inaugural Chair of the Faculty of Dental Hygiene & Therapy.

Table 2: Comparison of Workforce Integration: Dental Therapists vs. Nurse Practitioners

Aspect	Dental Therapists in NHS Dentistry	Nurse Practitioners in General Medical Practice
Reason for Expanded Workforce	Address NHS dental workforce shortages by training more dental therapists.	Address GP shortages and increasing patient demand by integrating NPs/ANPs.
Training and Scope of Practice	Trained in preventive care, restorations, simple extractions, and paediatric dentistry. However, often restricted to hygiene roles.	NPs/ANPs have postgraduate training, allowing them to diagnose, prescribe, and manage chronic conditions under supervision or independently.
Workforce Utilisation Issues	Many therapists are underemployed or forced into hygienist roles due to lack of therapist-specific positions and rigid NHS contracts.	NPs/ANPs have been more successfully integrated into GP practices, reducing the burden on GPs by handling routine cases, chronic disease management, and minor illnesses.
Barriers to Full Scope Practice	NHS contracts prioritise dentist-led care, making it financially unappealing for practices to employ therapists for restorative treatments.	Initially, some resistance from GPs and patients; however, policy changes and funding models facilitated better integration.
Impact on Access to Care	Underutilisation of dental therapists contributes to long waiting times and dentist shortages, particularly in underserved areas.	NPs/ANPs improve access to primary care by offering appointments for minor illnesses and chronic disease management, reducing GP workload.
Public and Professional Perception	Public and professional awareness of dental therapists' full capabilities remains limited, with many patients expecting a dentist.	Over time, public trust in NPs/ANPs has grown, especially in chronic disease management and urgent care.
Financial and Contractual Barriers	NHS UDA system does not incentivise therapist-led care; practices favour hiring dentists due to contract structures.	Funding models have evolved to reimburse GP practices for NP/ANP-led appointments, making their integration financially viable.
Proposed Solution	Create therapist-led clinics, revise NHS contracts to enable therapists to work to their full scope, and increase public awareness.	NPs/ANPs are already established in many GP practices, but further expansion in specialist areas (e.g., elderly care, minor surgeries) is ongoing.

Additionally, he worked as the editor of Team in Practice at the Faculty of General Dental Practice (FGDP).

Currently practising in Cheshire, John holds a PhD in Technology-Enhanced Learning from Lancaster University, an MSc in E-Learning Technology from the University of Portsmouth, and a Diploma in Computing from Oxford.

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BY HAFEEZ AHMED

HIDDEN BEHIND THE SMILE

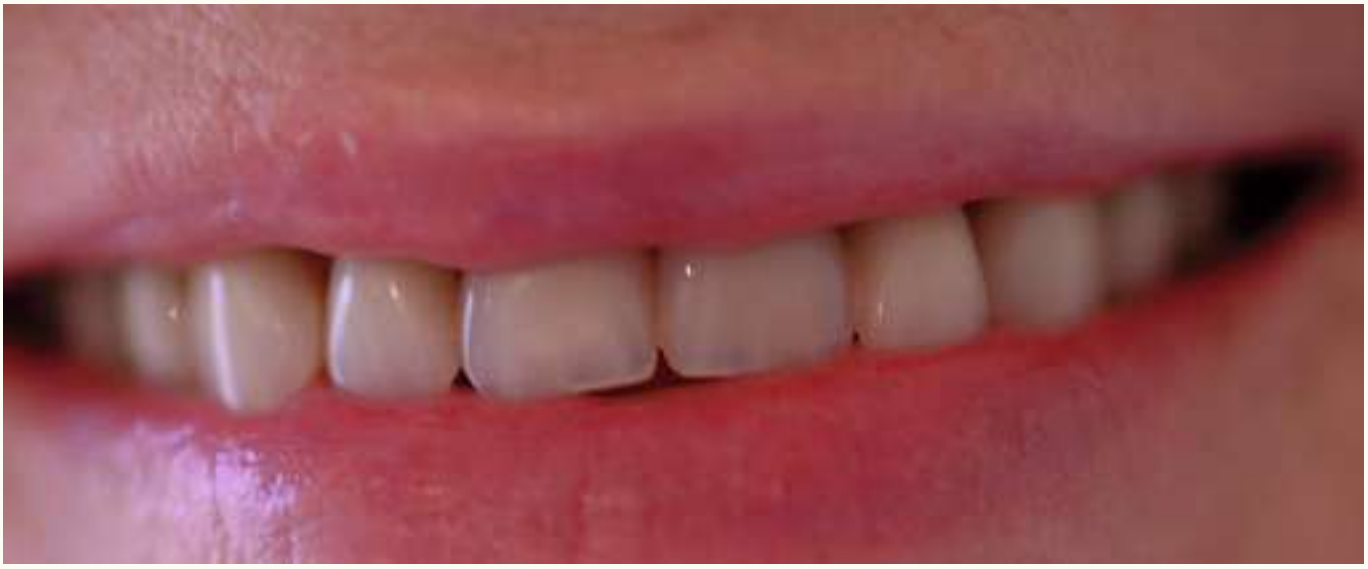


Figure 1: The Smile - 9 teeth peeping through lips

How old is the person in figure 1? Are they male or female? How much coffee do they drink, or are they a tea drinker? Looking at the translucency of the central incisors, perhaps they have a passion for orange juice or gin or both?

Context

As professionals, we are required to make judgements without being judgemental or personal. It is a skill that takes considerable development and each one of our many experiences contributes to the process. As an undergraduate student, along with seven of my colleagues, I fulfilled the entry requirements to take part in the Colgate-Palmolive Scholarship. We were required to submit an essay entitled, 'What can be gleaned about a person from the examination of a single tooth'. It was a fascinating project and I was amazed at what can be learnt about a person from the examination of a single tooth. I won the Scholarship, travelled to Adelaide in Australia to join a research team and investigated the association between *Fusobacterium Nucleatum* and periodontal diseases.

Reveal

The patient in figure 1 is 75 years old and is grateful for her smile. She is equally grateful that it does not look artificial.

Figure 2 reveals that the patient is partially dentate, her lower arch is her natural teeth and her upper is a full-arch implant retained bridge.

The treatment was completed in 2008 and over the years has been maintained with a combination of homecare and professional supportive

Figure 2: Upper arch implant retained bridge

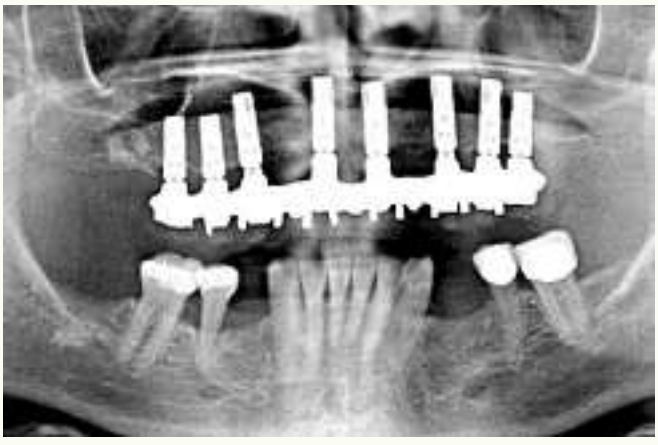
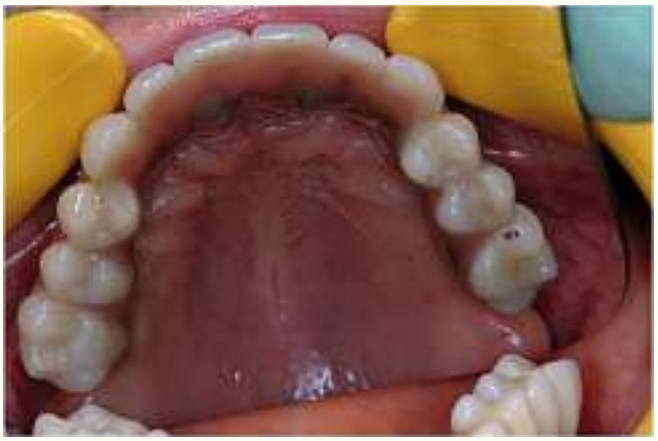


Figure 3: Radiographic appearance

Figure 4: The palatal surface of the upper arch bridge



periodontal therapy (SPT). The SPT has been provided at three month intervals. Maintenance has not been easy as access to the gingival crevice around the implants is almost impossible. Figure 4 shows the palatal surface of the bridge, access to the gingival crevice is largely concealed by the underside of the bridge.

A Brief History

The patient was referred in 2006; she was 56 years old, had never smoked and was not taking any medications at the time of referral. Figure 5 is a copy of the radiograph which accompanied the referral. The patient had already lost most of her upper teeth and what remained displayed all the classical signs of advanced untreated chronic adult periodontitis. During the post examination discussion, I aimed at managing her expectations and actually went as far as saying, "If you can't change your homecare don't bother considering fancy treatment". I was mindful that if the patient continued to lose bone at the same rate as prior to the referral, then the prognosis for a satisfactory outcome was bleak. I was also mindful of the scientific speculation on the matter of bone loss in untreated patients diagnosed with periodontitis. The average bone loss is speculated to be 0.3mm per year.[1,2] In patients treated surgically, with no supportive periodontal therapy, bone loss is speculated to be 1mm per year.[3] Ensuring the patient was able to provide informed consent was predicated on her understanding that the degree to which she complied with my oral hygiene instructions was more important than the choice of any particular treatment method.[4]

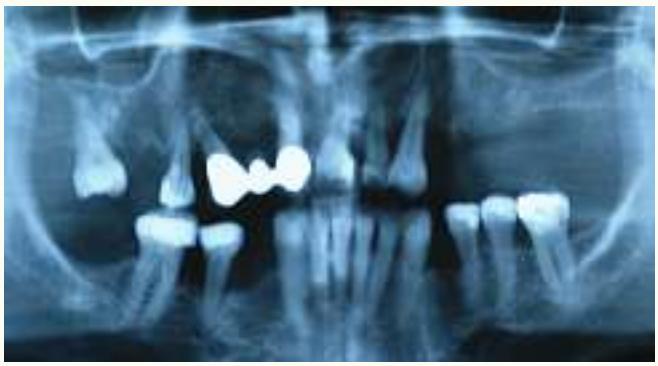


Figure 5: The radiographic appearance of the patient at initial consultation in 2006

Treatment in Brief

Broadly speaking the agreed treatment plan was divided into:

1. Cause related therapy
2. Review and revise
3. Corrective therapy
4. Review and revise
5. Restorative therapy
6. Review and revise
7. Maintenance therapy

During phase 3 of the treatment plan it became clear that her remaining upper natural teeth were beyond reasonable treatment. She was very upset to learn this and at the time, after some consideration, she insisted on having 'teeth in a day,' an emerging treatment option at that time. This is a dental implant procedure that aims to replace missing teeth with a full set of teeth in a single day, rather than the traditional multi-step process that can take months. The upper arch implant retained bridge was completed in 2008.

The original bridge has now been in function for 17 years; it had a significant refurbishment (replacement of the acrylic teeth) after 10 years and is currently due another. The patient has continued to attend SPT sessions at an interval of 3 months and although the bleeding score has always been around 90% her periodontal tissues have remained stable. She stopped attending SPT sessions during Covid lockdown and then continued to remain in self-isolation. Each time we contacted her she said, "I'm not ready to return to the real world just yet". She finally returned to the practice after an 18 month break with peri-implantitis around two of the eight implants. The inflammation was resolved with treatment, however periodontal pocketing has remained above 4mm. Since then, she has continued to attend for SPT sessions at an interval of three months.

Insight

From the outset I shared with her my concerns that, for her age, to have lost so many teeth and present with this degree of bone loss indicated a very high susceptibility to ongoing disease. I reiterated time and again that given her high susceptibility, periodontal therapy would be challenging and, that if it were successful, then maintenance was likely to be challenging. The risk of implant failure was high but if successful, then maintenance was equally likely to be challenging.

Shortly after the bridgework was completed in 2008 the patient confided in me, for the first time, that she had been diagnosed with Myalgic Encephalitis (ME) in her forties and during it she was practically bedridden for about five years. I simply said, "You didn't tell me that before". Some years later she jokingly confided in me that her first husband had nick-named her 'Road-Runner' after the Looney Tunes cartoon character because of her tendency to rush around.

Some years later she admitted that her homecare was inconsistent and that she had not really been able to make any significant improvement in her regime. Some years later, whilst in discomfort from her jaw joint and associated muscles, she confided in me that she wakes up most nights with her teeth clenched together. Some years later she confided in me that she tends to spend most of the time feeling frustrated. That when she has nothing to do, she gets frustrated through boredom and that when she has a task to complete, she becomes overwhelmed and frustrated. She also said, "I'm always stressed, it's my nature, I can't change it".

Over the years, in response to the patient's disclosures, I have jokingly said, "It's a wonder any of the treatment has worked" and I have advised her that, in my opinion, the entire success of her entire treatment is down to the SPT and that having it provided at three monthly intervals has proved to be the correct interval period for her.

This case highlights and reflects the fact that patient compliance is variable and challenging.[5,6] Furthermore, patients sometimes change what they disclose over time.[7]

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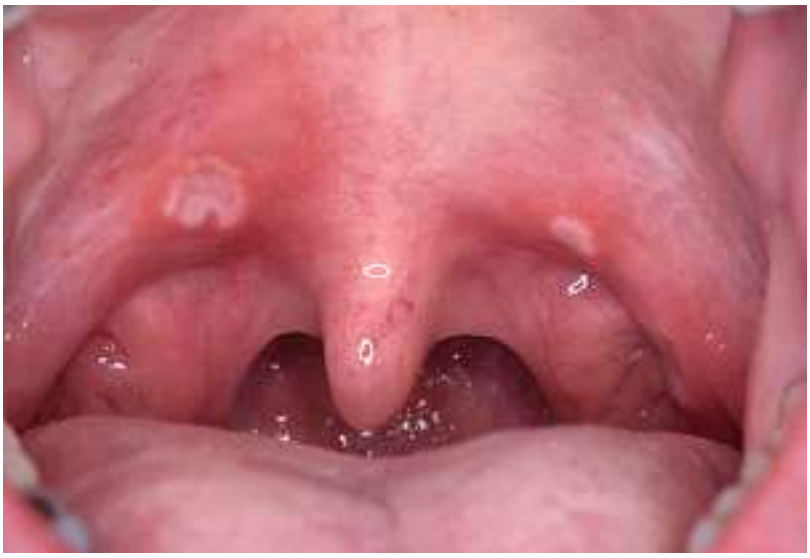
Q1. What is the diagnosis?

Q2. What question would you ask the patient about diet?

Q3. What haematinic deficiency is most frequently associated with this condition?



This quiz was kindly provided by Mike Lewis, Emeritus Professor Cardiff University

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ANSWERS TO CLINICAL QUIZ MAY 2025

The winner is: **Jovita Rumsiene**

Q1. What further investigations are required for a definitive diagnosis?

A1. *Radiographs to determine bone loss compared to radiographic evidence from 1 year post placement.*

Q2. What is the diagnosis?

A2. Peri-implantitis

Q3. What is the first approach to treatment?

A3. *Non-surgical therapy*

Q4. What is the end point for treatment success?

A4. *No probing depths greater than 5mm with no bleeding on probing at more than one point and no suppuration present*

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The Falkland Islands Government is seeking a Dental Therapist to join our team. This role is pivotal in delivering comprehensive dental care including dental hygiene and therapy activities, and supporting the oral health of our diverse community. Full nursing support is available.

Key Responsibilities:

- Equal split between dental hygiene and therapy procedures including examinations, prevention, periodontal treatments, direct restorations, and deciduous extractions.
- Participation in community-level oral health promotion and education activities, mentoring of trainee dental nurses, and clinical governance activities.

Qualifications:

- Degree in Dental Hygiene Therapy
- Registration with the UK General Dental Council as dental therapist and evidence of working in this role.

Package:

- 37.5 hours per week.
- 2-4 year contract.
- £40,668 base salary plus 25% gratuity and 25% market supplement on the base salary. Total package £61,002.
- Generous annual leave allowance, relocation and flights package.

For more information, or to apply see www.jobs.gov.fk

BSDHT.ORG.UK

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LOGGING ON TO THE MEMBERS' AREA:

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

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

THE ORAL HEALTH SUMMIT

28-29 NOVEMBER 2025

EDINBURGH INTERNATIONAL CONFERENCE CENTRE

2025 JOINT CONFERENCE HOSTED BY

BSDHT
The British Society of Dental Hygiene & Therapy

BSP
British Society of Periodontology and Implant Dentistry

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