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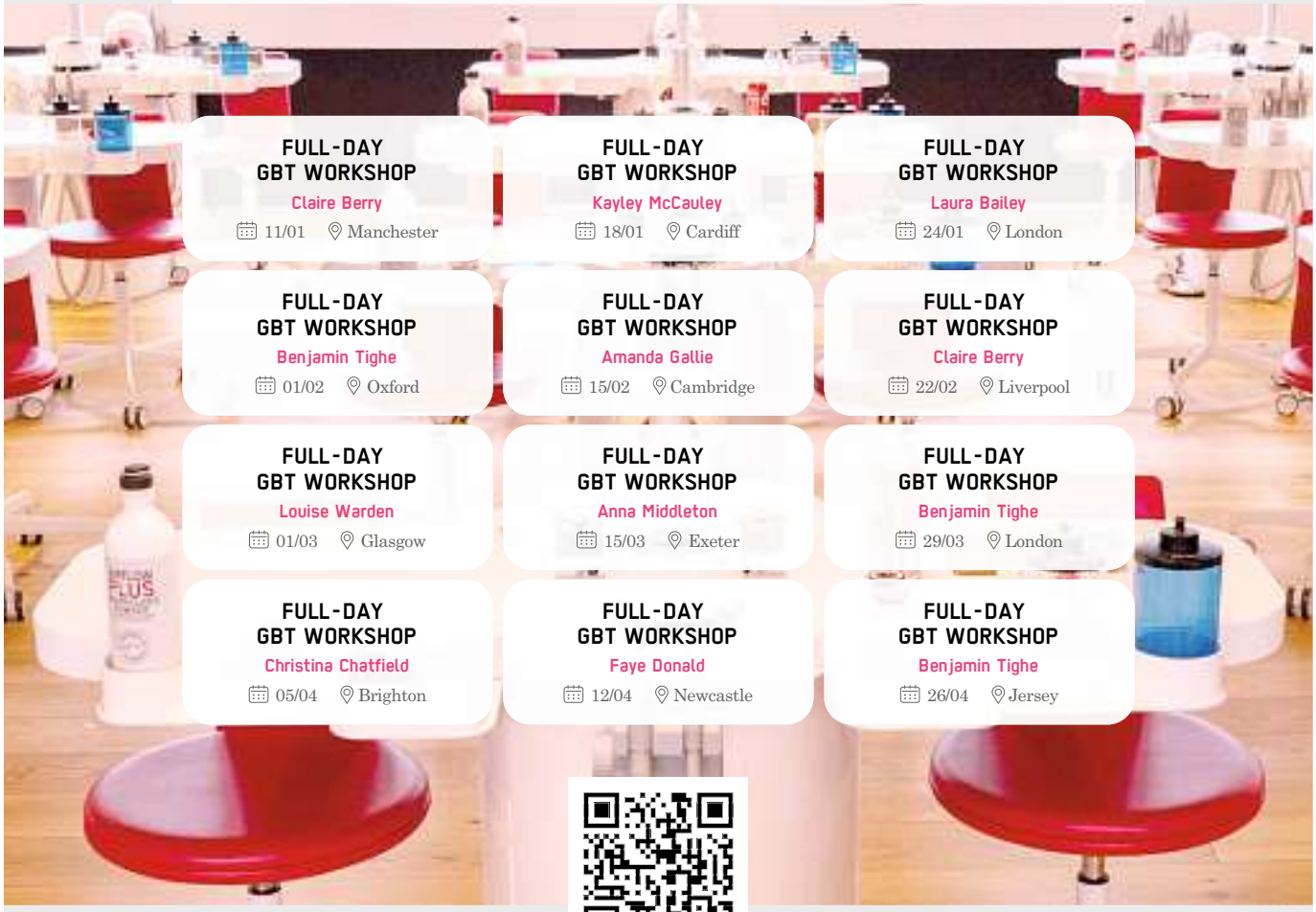

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BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY
Promoting health, preventing disease, providing skills

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A Healthier you in 2025

As the new year unfolds, the promise of a 'fresh start' is irresistible. For many of us, this means resolving to improve our health. But all too often, grand declarations of regular gym sessions or sugar-free perfection falter by February. It seems that the key to lasting change is crafting realistic, meaningful goals that enhance our well-being without feeling like punishment. We are good at our jobs because we care about the health and well-being of our patients and loved ones. I suggest that in 2025, we resolve to prioritise taking better care of ourselves. Let's aim to adopt personal, sustainable, health habits that nurture both our bodies and minds. Here are my suggestions:

Embrace all Movement

As clinicians, we spend many hours seated, treating our patients. Some of us work under such time constraints and full lists that we move very little in our working day. We all know that we should exercise more but often, at the end of yet another exhausting day, this is just too hard! This year, let's shift our mindset: think of movement as a celebration of what our bodies can do, not a tool to punish it. If the gym is not your happy place, then explore activities that bring you joy. Dance, swim, find a great yoga or Pilates class or simply get out into the fresh air for a twenty-minute walk. Aiming for 150 minutes of moderate-intensity movement per week – that's just under 25 mins a day! - is a great benchmark, but how we meet it should reflect our interests. Movement isn't just about burning calories - it's a cornerstone of physical and mental health.

Rethink our Relationship with Food

The diet industry would have us believe that health hinges on deprivation! In 2025, let's forget fad diets. A healthy relationship with food starts with the principle that all foods can fit into a balanced diet. We all know that we need to avoid ultra-processed foods (more about that in this issue) and instead incorporate plenty of fruits, vegetables, whole grains and lean proteins. The occasional treats should be part of this. Mindful eating - savouring our meals without distractions - can help us tune into our body's hunger and fullness cues, making it easier to eat in a way that feels nourishing and satisfying.

Prioritise Mental Health

Physical health resolutions often overshadow mental wellness, but they are deeply intertwined. This year, let's make our mental health a priority by incorporating habits that promote our own emotional well-being. Remember that rest is a form of productivity - getting enough sleep is crucial for both mental clarity and physical health. It is also worth protecting our peace by setting boundaries with work, social commitments and technology. Switch off that phone in the evening!

Cultivate Social Connections

Human beings thrive on connection, yet our increasingly digital lives can sometimes leave us feeling isolated. Let's prioritise our social health by nurturing meaningful relationships. These interactions boost emotional resilience and even have measurable effects on physical health. A strong social network is as vital to longevity as drinking less alcohol or staying physically active. (Regional group events in the spring anyone?)

Reduce Stress, One Step at a Time

Daily life often feels like a juggling act, and stress is a common denominator. While we can't eliminate stress entirely, we can build resilience to it. Techniques like deep breathing, yoga, and spending time in nature have proven benefits. Let's aim to simplify our commitments where possible, and learn to say no without guilt. Our worth is not defined by how busy we are.

Make time for fun

Last, but definitely not least, is laughing daily! Laughter lowers stress hormones and boosts immunity so let's all resolve to spend as much time as we can with those who make us happy.

I wish you all a happy and healthy New Year.

Heather

Heather Lewis

FROM THE PRESIDENT

I am so honoured to be writing my first article for Dental Health as your new president. I have been a member of the BSDHT (formally BDHA) since becoming a student in 1997. I remember that you used to receive a card with your membership number and an enamel badge to be proudly worn on your uniform. In those days there was no internet or social media so the only way I could find out what was happening in the world of dentistry was to read journals and attend meetings. Some of you reading this will recall that time and some of you may find it hard to imagine a time when you had to wait for the post or go to a library to find information. To think that I am now writing in our journal as your president is a 'pinch me' moment. In this world where we can access almost anything online, or ask an AI assistant without even having to type, I am so proud that we still produce and enjoy our own publication. Many of you may not be aware that it is read by many in the dental world, including our colleagues abroad, and that it is our way of preserving our history and supporting our future for another 75 years.

Reflecting on how things have changed during the 75 years since our incredible profession was born has made me appreciate all that being a member of a professional organisation can and, indeed should, offer. An organisation such as ours should be involved at every level from supporting those who wish to train to be a dental hygienist or dental therapist, to our undergraduate and post-graduate students and those who are working hard every day to care for the nation's mouths. We should be involved in consultations that affect our profession and be invited to collaborate on guidelines and standards that affect our daily work. Any government should want to hear from us and be aware of what we can offer the dental profession and wider population. We should be encouraged and supported to be involved in important research and have obvious career pathways where we can contribute valuable input and experience to promote health and prevent disease.

I am pleased to say that in my first few weeks, I have seen this in action.

I recently represented us at a round table event where a White Paper on 'The Future of Dentistry' was launched with the support of Denplan and Helen Morgan MP. The following week, our new president elect, Simone Ruzario, represented us all at the 'All Party Parliamentary Group' (APPG) in the House of Commons. On each occasion, we both felt 'heard' and that our ideas and concerns were

were taken seriously. Many of the guidelines that we work with every day, such as the BSP S3 guidance, consulted the BSDHT to ensure that there was representation for us. It is vital to consider our profession and the important part we play in the correct assessment, diagnosis and care planning for those fortunate to attend our practices or care settings. We also need to be at these events and tables to speak up for those who are not able to access mouth care due to disabilities, financial constraints or fear. We are here to support the profession to find ways to reach out to those who can't come, don't come or won't come for care. With the WHO Global Strategy[1] aiming to improve access by 2030, we have five years to make a change and provide fair access to dental care for all. How this looks and who will be involved is being discussed right now. We have to be involved and your Society will make it a priority to use the respected position it has in the dental world to promote health and prevent disease at every opportunity. You can also make a difference on an individual level by educating anyone who will listen, from your colleagues to your patients. They don't know what they don't know, so be the person who informs them. Let's start a new pandemic, one of passion for prevention!

Returning to my role as your president, I have to say that this is not something I imagined I would ever do and yet, here I am. Like so many things in life, there is no 'good time' for many of our life decisions. I think it was when I attended Parliament in my first week in term that I realised that I had made the right choice to stand for president elect. A friend called me that evening on my journey home and was surprised to hear where I had spent the day. When they asked how nervous I was, I realised that I hadn't been. Reflecting on the long journey home that day was when I truly realised the honour of representing us all, the passionate and hard-working dental hygienists and dental therapists of the UK. I wasn't nervous because I knew my purpose clearly, I had all of the facts ready and was full of passion and ideas for how we can better serve our patients and communities. I know that this was a big meeting to be part of in my first week in post but it served to demonstrate to me the enormity of the role and the responsibility that comes with it. I know that I won't always get it right and thankfully we have an incredible team of dedicated people in our executive, council, staff, working groups and our regional groups who will support our efforts. I know that I have a network of people from various backgrounds who will have thoughts, ideas and suggestions on how we can drive our profession forward. If you think that you work in a setting that is underserved, please email me so that I can direct you to a working group who would love to be able to hear from you and include your issues on the main agenda.

As a dental therapist who has worked for over 17 years in a cleft lip and palate team, I know that there are some settings that are far from common, and yet, that allowed me to 'see' the need in our country. Every person affected by cleft should have access to appropriate care. The fact that I could go from caring for a child with parents who cannot read or write and share a toothbrush, to someone who has never been able to find a dentist who would 'take them on' has given me the fuel and fire in my belly to try to make a difference. I'm sure you all have the same passion and direction.

I return to a word I used in my acceptance speech, 'purpose'. A dictionary definition[2] being, 'the reason for which something is done or created or for which something exists'. Our Society has a clear purpose. We are there to **promote health, prevent disease and support the profession**. Our strategy has and will remain driven and guided by this purpose and, in this shameful time where a child cannot see a dentist or a person has to suffer in pain as they cannot afford or access the necessary clinician, supporting efforts to find solutions will be a main priority. I thank all of those who came before for the challenges they overcame in their time and for their ongoing dedication to the cause. Ours is a healthcare profession. We are super heroes of the medical world. The diseases we prevent go so much further than dental caries and periodontal diseases. In treating dental disease, we reduce the likelihood of so many other, life-limiting diseases. Never forget how important you have been and continue to be in improving the health of the nation. Now, the challenge will be to make that fair and accessible to all. I'm ready for that challenge and welcome support and encouragement from you. This role will be challenging and difficult decisions will have to be made but with your voice and support, it is entirely possible to elevate and improve our standing in the dental world for our patients' best interests.

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PROFESSIONAL ORAL HEALTH

BY **ELAINE TILLING**

DENTAL LEADERSHIP NETWORK
HOW MANY PROFESSIONALS ARE ENOUGH?

The topic of the 9th annual meeting of the Dental Leadership Network held in London on 12th November focused the minds of those present on the current workforce crisis in dentistry in the UK.

Attended by key leaders within our profession, Jason Wong CDO England set the scene for the day by providing an overview of the challenges facing the profession from both a UK and global perspective. These were described as predominantly workforce issues:

- Workforce levels and distribution
- Access to oral health care – particularly for certain groups
- Dental tourism and illegal practice
- Waning job satisfaction – cognitive dissonance
- A culture of fear and anxiety – defensive dentistry

The challenges that we face are similar to those of the wider health care sector. People are leaving dentistry, thus adding to the 'dental deserts' in rural and coastal communities. The reasons for the mass exodus of the profession will not come as a surprise to any of us, with working conditions, work life balance, lack of professional support, patient and team safety, all discussed.

The department of the CDO England is working on policy for staff support and wellbeing and is considering different models for the provision of dentistry for coastal and rural areas. Consideration is also being given to the geographic reorganisation of training establishments; data supports the argument that students tend to stay in around areas where they train, in most cases.

The collaboration with other regulatory departments on subjects such as AI within healthcare is going ahead, as are proposals to extend the current pilots in NHS practices where hypertension and diabetes are being monitored.

Working Patterns

Stefan Czerniawski from the GDC presented some high-level insights from the dentists' and other dental care professionals' data, including the changing nature of the register. The 'feminisation' of the workforce was discussed (not a term with which I am comfortable!). Data presented showed that currently 2/3rds of dental students are female and that those dental professionals most likely to be working in the NHS are:

- Female
- Qualified less than 5 years
- Living in Scotland

Overall, the data showed that we are working less hours in both private and NHS practices. This is of course an observation of working practices across much of the UK workforce – not just in health care.

Our dental nurses showed the largest shift in working practices, with childcare during school holidays causing a transient drop out from the workplace. Making provision for more flexible working was discussed and is being trialled within the corporate sector to help address this.

The underutilisation of the full scope of practice for dental therapists was a common topic throughout the day – both during presentations and in the stake holder discussions. Fiona Sandom of the BADT gave a clear response to how this data could be used to promote the full scope of practice for dental therapy, given the growing clinical need. However, the correct and supported use of the perio and oral health focus of dental hygienists was not given the time it really deserved in this session.

Needs based workforce planning

Paul Brocklehurst, a consultant in dental public health and an epidemiologist, offered an inspired overview of how the pockets of clinical needs could be managed. Introducing a dynamic systems approach to workforce planning, and utilising all the team members to their full scope of practice, greatly improves the productivity of the workforce – change happens and we need to be adaptive to those needs. Change has happened but we are trying to address this with 'old school thinking' - more of the same is not working!

So, how many dental professionals are enough?

The 15-minutes table discussions generated questions to the panel and came up with some interesting and innovative suggestions. The one element that prevents any suggested move to increase or diversify the professional mix was the lack of clinical need data – the Adult Dental Survey is now 9 years overdue! With our new government currently going through a major overhaul, and clearly no money set aside for dentistry per se, the one light at the end of the tunnel is that this government does agree that the public needs to invest in our health care workforce. So watch this space!

What action can leaders take to inform the workforce?

Miranda Steeples spoke on the need to go beyond working with government and to have patient forums with focus groups to establish what patients want, and to highlight the treatment options that can deliver the care they need. The mindful and measured responses to questions from the floor were handled well – congratulations to our outgoing President and surely this is confirmation of the important role of the BSDHT in formulating policy as we move forwards.

The elephant in the room when it comes to leadership in dentistry is the significant lack of dental care professionals on the leadership teams. Given that together we form the majority of the total workforce, the time for talking on our behalf should end. Workforce transformation can only happen with compassionate leadership and we need to establish what that would look like now. This theme was certainly championed by several of the panel members.

My take on the proceedings of the day?

As a member of the profession for over 43 years, I find it hugely frustrating to be hearing the same dentist-led charge to address the clinical needs of our patients. The current model of care that we have is not working and a rethink is urgently needed. That rethink needs to be undertaken with full and equal participation of the team members that will be delivering that care.

Overall, this was an event brilliantly hosted by the GDC – and a step in the right direction.

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Safeguarding dental therapy training

I was alarmed to read in *Dental Health* that, due to funding issues, the four-year BSc Oral Health Science course at Edinburgh will cease to exist.

This is now the second dental therapy course to close its doors in the United Kingdom. I am aware that two new courses, namely those at Bangor University and University of Suffolk have started training dental hygienists and dental therapists. Huddersfield University is developing a new dental therapy course pending General Dental Council validation however, I fear for the survival of dental therapy courses that are not co-located within a dental school that trains dentists.

The NHS Long-Term Workforce Plan 2023 highlighted the need to invest in dental education, and the Dental Schools Council has called for an increase in both dentistry and dental therapy training places as a key priority. It is my understanding that training providers receive more funding for a Bachelor of Dental Surgery student than for a Dental Hygiene or Dental Therapy student. This large disparity will, of course, impact training providers and the financial viability of such courses in an increasingly competitive higher education market.

It is crucial that we invest in dental therapy academics who have academic parity with other dental occupations and are able to undertake research to evidence the impact of dental therapy practice and its contributions to improving the nation's oral health. It is paramount that we have dental therapist academics to ensure the development of a long-term workforce, rather than becoming overly reliant on dentists to produce research on our behalf, and educate future dental therapists.

I feel we are in uncertain times and believe that BSDHT should be involved in conversations regarding the future of our academic dental therapy workforce to secure our future.

Leon Bassi MSc, Dip Paed Dent (DT) RCS Edin, Dip DTh, FHEA, FDTFEd (RCS Ed)

BY CLAIRE BENNETT

BARIATRIC SURGERY AND ORAL HEALTH

Bariatric surgery is a transformative treatment for severe obesity that may significantly improve physical health, and quality of life, and has systemic implications that extend to oral health. As dental professionals, it is important to recognise the prevalence of bariatric surgery in the UK and its unique oral health challenges. This article explores the effects of bariatric surgery on oral health and highlights strategies dental hygienists and therapists can implement to provide practical, personalised care for this expanding patient population.

Prevalence of Bariatric Surgery in the UK

According to the National Bariatric Surgery Registry (NBSR) report, between 6,000 and 7,000 primary bariatric surgeries are performed annually in the UK, with approximately three-quarters funded by the NHS.[1] Despite the high prevalence of severe obesity - affecting around 28% of adults in England - only a fraction of eligible individuals receive surgery.[2] The growing popularity of medical tourism has also led some patients to seek bariatric procedures abroad, often with inadequate follow-up care.[3]

With the increasing prevalence of bariatric surgery, dental hygienists and dental therapists are more likely to encounter patients who have undergone bariatric surgery. Therefore, it is important to understand their oral health needs and the importance of tailored care.

Impact on Oral Health

Bariatric surgery, particularly gastric bypass and sleeve gastrectomy, significantly alters the gastrointestinal system, which can affect oral health in several ways:

Nutritional Deficiencies

Malabsorption of essential nutrients such as calcium, vitamin D, vitamin B12, and iron is common after bariatric surgery.[4] These deficiencies have specific oral manifestations:

- Calcium and Vitamin D: Deficiencies may lead to jawbone resorption, increasing the risk of periodontal diseases and tooth loss.
- Vitamin B12: Deficiency can cause glossitis, burning mouth syndrome, and mucosal atrophy. [5]
- Iron: Iron deficiency anaemia may present as angular cheilitis, pale oral mucosa and a sore or burning tongue.[6]

Xerostomia

Many patients experience xerostomia post-surgery due to reduced fluid intake, dietary changes or medications. A dry mouth increases the risk of:

- Dental caries due to reduced salivary flow.
- Oral infections, such as candidiasis.
- Discomfort when eating or speaking.

Gastroesophageal Reflux Disease (GERD)

GERD, exacerbated by bariatric surgery, exposes teeth to stomach acid, which could lead to enamel erosion. This can cause:

- Tooth sensitivity.
- Discoloration and thinning of teeth.
- Increased susceptibility to caries.

Dietary Adjustments

Following bariatric surgery, patients are advised to adopt specific dietary changes to ensure proper healing, maintain nutritional balance and support long-term weight loss. A liquid diet is initially recommended during recovery, gradually transitioning to pureed and soft foods over several weeks.[7] Patients are encouraged to prioritise high-protein, low-fat, and low-sugar foods to preserve muscle mass and support metabolic health.[8] Small, frequent meals (typically 4–6 per day) are advised to prevent overeating and accommodate reduced stomach capacity.[9] Drinking fluids is essential to stay hydrated, but fluids should not be consumed 30 minutes before or after meals to optimise digestion.[10] Patients should avoid foods high in sugar and refined carbohydrates to reduce the risk of dumping syndrome - a condition where food moves too quickly through the digestive tract.[11] Additionally, bariatric patients require lifelong supplementation with vitamins and minerals, such as calcium, vitamin D, vitamin B12 and iron, to address the malabsorption of nutrients resulting from the surgery.[12] These dietary adjustments are critical for overall health and preventing complications, including oral health issues.

Continued on page 17

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The Role of Dental Hygienists and Therapists

As frontline oral health professionals, dental hygienists and therapists are crucial in supporting bariatric patients through preventive care and education. Their expertise and guidance are invaluable in optimising these patients' oral health and overall well-being.

Pre-Surgery Assessment

- Conduct comprehensive oral examinations to identify and address any pre-existing dental issues.
- Provide tailored oral hygiene instructions and stress the importance of maintaining excellent oral care habits post-surgery.

Post-Surgery Care

- Frequent recall appointments: Schedule regular check-ups (e.g., every 3–4 months) to monitor for issues such as enamel erosion, dry mouth or periodontal diseases.
- Nutritional counselling: To minimise oral health complications, dental hygienists and dental therapists may have to collaborate with dietitians or medical providers when necessary. Reinforce the importance of nutritional supplements, such as calcium, vitamin D and vitamin B12.

Preventing Dental Caries and Erosion

- High-fluoride toothpaste and fluoride varnish applications are recommended to strengthen enamel.
- Advise patients to rinse with water after meals and to neutralise acids during GERD episodes.
- Educate patients on choosing low-sugar, less cariogenic foods and avoiding acidic beverages.

Managing Dry Mouth

- Suggest saliva substitutes, sugar-free chewing gum with xylitol, or increased water intake to combat xerostomia.
- Advise against alcohol-based mouthwashes, which can exacerbate dryness.

Empathy and Communication

Bariatric patients often face psychological challenges, including stigma. Therefore, it is essential to approach conversations with empathy and create a supportive environment where patients feel comfortable discussing their concerns.

Summary

Bariatric surgery is life-altering for patients, but it comes with unique oral health challenges. As dental hygienists and therapists, we play a vital role in mitigating these risks by offering preventive care, personalised advice and regular monitoring. By collaborating with medical professionals and staying informed about the systemic effects of bariatric surgery, we can ensure these patients achieve not only improved general health but also optimal oral health outcomes.

Author: Claire graduated in dental hygiene and dental therapy from Cardiff University in 2020, and has been working to her full scope of practice in a mixed dental practice. Claire currently serves as BSDHT Honorary Treasurer and previously held the position of Student Representative Coordinator. She is now channelling her extensive experience into a new business venture with her husband, demonstrating her commitment to innovation and excellence in dental care.

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BY JULIETTE REEVES

THE IMPACT OF ULTRA PROCESSED FOODS ON ORAL HEALTH

A COMMON RISK FACTOR APPROACH

The term Ultra Processed Foods (UPF) is becoming an increasingly important topic in public health research. Evidence shows that UPFs are associated with obesity, cardiovascular disease, type 2 diabetes and mental health disorders.[1] UPFs are defined by the NOVA food classification as industrial formulations made entirely or mostly from substances extracted from foods (oils, fats, sugar, starch, and proteins), derived from food constituents (hydrogenated fats and modified starch), or synthesized in laboratories from food substrates or other organic sources (flavour enhancers, colours, and several food additives used to make the product hyper-palatable).[2] These foods encompass a wide range of ready-made products including packaged snacks, instant noodles and ready-made meals. The UK is the second biggest consumer of UPFs globally[3] with 57% of daily energy intake in UK adults derived from UPFs and 66% of energy intake in adolescents.[4] School lunches of UK children contain almost 80% UPFs.[5] The most commonly consumed UPFs in the United Kingdom are identified as fine bakery wares, sugar sweetened beverages, and sausages.[6]

Link with non-communicable diseases

There is an increasing correlation between non communicable diseases (NCDs) globally and the intake of UPFs, prompting the inclusion of dietary intervention and reduction of UPFs as public health strategies in the common risk factor approach to the reduction of NCDs. [7]

It is therefore appropriate, in an oral healthcare setting, to provide dietary advice that includes the removal of UPFs as part of oral health promotion and periodontal diseases and caries prevention.

NCDs are considered to be mainly cardiovascular diseases, cancers, chronic respiratory diseases, osteoporosis and diabetes, however, in 2011 the FDI World Dental Federation succeeded in obtaining a specific reference to oral diseases in a declaration from the UN High Level Meeting on Non-

Communicable Diseases.[8] As a consequence, oral health has been increasingly promoted as a part of the spectrum of the NCDs.

The common risk factor approach (CRA) is based on the principal that controlling a small number of risk factors has an impact on a large number of diseases at a lower cost.[9] It is acknowledged that oral diseases all share common risk factors with NCDs and can benefit from common responses to NCDs.[10] The primary risk factors are identified as poor diet, poor hygiene, smoking, injuries, stress and sedentary lifestyle. Periodontal diseases are a component of the global burden of chronic disease, and chronic disease and periodontal diseases have the same essential risk factors.[11]

There is a considerable body of evidence linking frequent consumption of ultra-processed foods and sugar-sweetened beverages (SSBs) to dental caries.[12,13,14] In addition, there is an increasing body of evidence linking the consumption of refined carbohydrates and sugar to increased gingival inflammation and increased severity of periodontal diseases.[15,16] Providing our patients with dietary advice that includes the effects of UPFs constitutes an important part of oral healthcare messaging.

Oral health conditions have several risk factors in common with numerous important chronic diseases. Delivering targeted intervention for individual diseases along with a common risk factor approach, provides opportunities for dental health professionals to engage with patients as part of the wider healthcare community and the delivery of health care promotion programmes.

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DR LEATHERMAN AWARD 2024

Last November, at the OHC 2024 in Harrogate, Mike Wheeler BEM was celebrated as this year's recipient of this prestigious award, bestowed on him by newly elected BSDHT President, Rhiannon Jones. The origin of the Dr Leatherman award goes back to BDHA in 1994, as the association's way of recognising individuals that demonstrated a commitment and support for the dental hygienist profession. When BSDHT formed in 2006, that same commitment transferred to both the dental hygienist and dental therapy professions.

Mike qualified as a dental hygienist from the Royal Airforce Institute of Dental Health and Training in 1978 and immediately joined BDHA. Since that time, he has held a wide variety of professional roles, from 20 years in the RAF, championing the career framework, then for the next 25 years in a variety of NHS and education management appointments, as well as working in general dental practice and the salaried dental services. In 2023, Mike was recognised in the first Birthday Honours List of King Charles III, for services to oral health in the Southwest of England, by becoming a medallist of the Order of the British Empire (BEM).

Mike has been a proactive member of BSDHT for 46 years holding a wide variety of roles both regionally and nationally.

In 1997, he was elected honorary treasurer of BDHA, beginning a six-year journey as a member of the Executive. He led the review and updating of the financial management and assurance processes, culminating in BDHA becoming a company limited by guarantee in 2001. This protected the title of our organisation and membership assets and for the first time provided true legal status.

Mike worked on a number of initiatives including laying down the pathways for direct access and ensuring the full role and value of dental hygienists was recognised, especially with other dental membership organisations and members of the wider health care teams. He was also involved in the innovation that was the BDHA CPD portfolio, well before CPD was mandated!

He became President elect in 2004 and led the discussion in England to ensure that the move to dental therapy programmes of learning still represented a strong focus on oral health improvement and the management of periodontal diseases. Between 2006-2008 he was BDHA President and then inaugural president of BSDHT. During his presidency , Mike defined the budget and worked with a wide range of industry partners as symposium director of the International Symposium of Dental Hygiene and Therapy on behalf of the International Federation of Dental Hygienists, which BSDHT hosted in Glasgow in 2010.

Mike was the only non-dentist to serve on the initial Medical Education England Dental Programme Board. As a trustee of the then British Dental Health Foundation, he worked to define the pathways of learning for DCPs with the Faculty of General Dental Practice of the Royal College of Surgeons England. He has lectured widely on the utilisation of all team members in the delivery of oral health care.

Mike contributed to the NICE Guidelines and initiated the Southwest Mouth Matters care programme funded, by Health Education England (HEE) which built upon Kent Surrey and Sussex's Improving Oral Health of Older People project, which subsequently became Mouth Care Matters. Mike led the discussions with the Care Quality Commission on their vital role in improving oral health for adults in the care sector, which laid the pathway of opportunity for dental hygienists and therapists to become CQC inspectors.

As dental workforce advisor for HEE (now NHS England) he led the development of a number of apprenticeships which will provide improved opportunities for our dental nurse colleagues. A pathway to dental hygienist training, through dental hygienist apprenticeships, is in development. The development of apprenticeships will also provide an opportunity for funded training pathways at levels 6 and 7 for dental hygienists and therapists at enhanced and advanced clinical practitioner levels.

When delivering a presentation focussing on utilising the whole dental team, at a BDA conference, he was introduced to the audience as an individual widely respected across the dental profession having achieved a number of firsts: first male president of BDHA; inaugural president of BSDHT; first dental care professional to sit on the medical education dental programme board; the only dental hygienist to lead in dental commissioning when the 2006 contract was introduced; first joint appointment between the NHS and a university managing both a dental hospital and school coupled with being the director of a community service. In addition, Mike was the first dental hygienist to be a NICE external expert on oral health as well as the oral health adviser to OFQUAL.

All who know him will agree that after nearly 46 years he is still as enthusiastic about being a dental hygienist and supporting BSDHT.

Congratulations Mike! You really are a true ambassador for our profession.

BY JULIE BISSETT

INNOVATIVE APPROACHES TO ORAL HEALTH EDUCATION

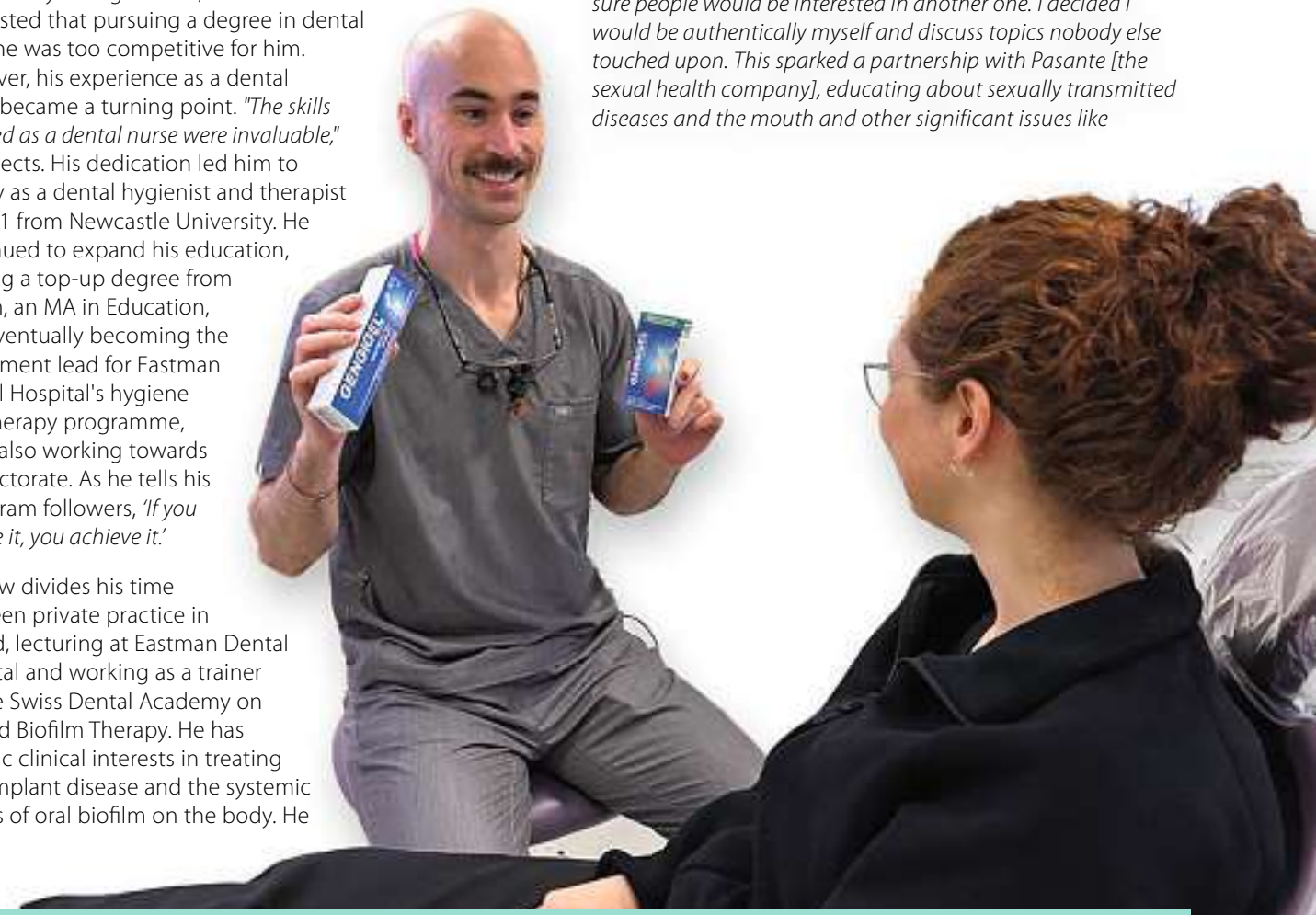
Education comes in a myriad of guises. One might wonder what an animated SpongeBob SquarePants has to do with HPV advice or what four-lane motorways have to do with systemic health? Yet for dental therapist and educator, Benjamin Tighe, better known as @thegumsguy on Instagram, he blends creativity with his clinical expertise, whether he is teaching students, mentoring colleagues, or educating patients, both in practice and online.

Ben began his career as a dental nurse – thanks partly to his dental hygienist sister helping him secure a trainee role. Initially facing doubts, a careers advisor once suggested that pursuing a degree in dental hygiene was too competitive for him. However, his experience as a dental nurse became a turning point. *"The skills I gained as a dental nurse were invaluable,"* he reflects. His dedication led him to qualify as a dental hygienist and therapist in 2011 from Newcastle University. He continued to expand his education, earning a top-up degree from UCLan, an MA in Education, and eventually becoming the assessment lead for Eastman Dental Hospital's hygiene and therapy programme, while also working towards his doctorate. As he tells his Instagram followers, *'If you believe it, you achieve it.'*

He now divides his time between private practice in Oxford, lecturing at Eastman Dental Hospital and working as a trainer for the Swiss Dental Academy on Guided Biofilm Therapy. He has specific clinical interests in treating peri-implant disease and the systemic effects of oral biofilm on the body. He embarks on any course that broadens his understanding. A self-confessed workaholic, dental education (teaching and learning) is simply part of his 'every day'.

Ben launched his Instagram account amid the COVID-19 lockdowns to provide patients with online access to dental advice. He shares professional posts, too, and the account is a homage to all things oral health and a testament to his innate skills at educating, whatever form it takes. He covers topics as far-reaching as tobacco staining and dental photography to more sensitive issues like unprotected oral sex and HPV (using tongue-in-cheek emojis and the aforementioned SpongeBob to get across his messaging), breaking taboos to promote comprehensive oral health awareness.

'@thegumsguy was my Covid-19 baby,' he explains. 'I had the account but didn't know what to do with it. There are so many outstanding dental accounts out there, and I wasn't sure people would be interested in another one. I decided I would be authentically myself and discuss topics nobody else touched upon. This sparked a partnership with Pasante [the sexual health company], educating about sexually transmitted diseases and the mouth and other significant issues like



menopause. I also discuss clinical cases and general day-to-day life. I had no idea it would be so popular, but if someone takes even one thing away from one of my posts, I'm happy.'

However, the real magic happens in his face-to-face daily encounters with his patients. He maintains that optimal care comes from bespoke care and strongly advocates for his profession to boldly shift away from a template approach. He says, *'Education should be tailored to individual needs rather than following a one-size-fits-all approach.'*

Here, Benjamin shares his thoughts on the power of personalised care – and how he is helping patients achieve optimum at-home hygiene practices.

Back to basics

I was determined to change everyone's oral hygiene habits when I first graduated. I would provide a rainbow of interdental brushes and floss recommendations and suggest an electric toothbrush. However, experience has taught me that while this is the ultimate goal, change does not happen overnight. It requires a gradual shift in behaviour. I ask the patient about their lifestyle and any concerns, barriers or resistance to implementing good oral hygiene habits. It may be that I go over the correct toothbrushing technique at the initial appointment, and that's it. I've found disclosing and giving patients a plaque score is a massive motivational tool – they're engaged and want to do better. As I see the patient more frequently, I'll slowly introduce things to their daily routine. Next might be a specific-sized interdental brush for them to use while the kettle is boiling. By doing this, compliance shoots up, as does longevity in their behaviours.

Patients often normalise bleeding

Gingivitis is a disease and needs to be treated as such. I take bleeding scores on every patient. Much like plaque scores, this is tangible and understandable. I will explain that whilst it is best not to have any bleeding, guidelines state anything over 10% is classed as a disease, and because of this, we may need further appointments. This is an ideal opportunity to skills mix with oral health educators if they're available in your practice. I often use analogies, as getting lost in dental jargon is easy. I explain that the bacteria in the mouth form biofilm, which can lead to inflammation. Now, inflammation in the mouth is like a road to the rest of the body; the more inflammation, the wider the road. We want a narrow country lane at best. If a plaque score is 100%, then they have a four-lane motorway for the bacteria to enter the bloodstream and travel around the body, often resting in other areas. I explain that the biofilm continues to cause inflammation, so if their gums are puffy and red, the likelihood is that so too are these different areas. This leads me perfectly to the topic of systemic disease, of which I am passionate!

Link between oral and systemic health

This is becoming more common knowledge among the public, but there is still a long way to go. I'm a firm believer in the tell-show-do model. We must show the patient intraorally and then ask them to demonstrate back to ensure the correct techniques are taught. Every patient is different and will have different needs. My 'go-to' recommendations include a rotating-oscillating electric toothbrush, disclosing tablets, interdental brushes and certain mouthwashes. I have been using Gengigel for a long time and find it exceptional for promoting healing after subgingival PMPR, implant surgery and treating ulcers and trauma. Its solid evidence base is crucial, especially when aligning with S3 guidelines [the evidence-based clinical practice guidelines established through a systematic review process]. My clinical outcomes with this particular product have been excellent, particularly with the hyaluronic acid which is highly effective in managing gingival tissues in peri- and post-menopausal women. As a dental nurse, I initially worked with a dentist who placed implants. Now, at a practice in Oxford, I am responsible for maintaining them. I am committed to providing the best care for my patients, so I have completed nearly every implant maintenance course available to ensure I deliver the highest standards of care.

A lighter approach to dentistry

I have recently teamed up with award-winning dental hygienist Claire Berry to launch a podcast. It can be an isolating profession, and with the rising mental health challenges, increasing numbers leaving the profession and the constant pressures we face, it can be challenging. Unless you're in it, it's hard to grasp the reality of working in this field. That's why Claire and I created @yourdentalbesties. It was borne from an acute awareness of all these challenges and a desire to take proactive action. We tackle the conversations many people shy away from, but we also laugh, share stories and exchange experiences. It's a light-hearted show, perfect for keeping you company during your morning commute or helping you unwind on your way home.

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BY VICTORIA WILSON

IF YOUR WAY DOES NOT WORK, ISN'T IT TIME TO **CONSIDER A NEW STRATEGY?**

In a report published in December 2023 which focused on the potential of personalised neurofeedback for meditation, the authors explained that the ability to foster mindfulness had been empirically reported to decrease mood disorders, anxiety, anger, depression and fatigue. They also referenced some studies suggesting that mindful meditation could enhance attention and cognitive performance, as well as help with emotional regulation.[1]

Let's stop for a moment though. Meditation is increasingly touted as a solution for many social and structural stressors, but how realistic is its practise for dental professionals whose diaries are always full and who have not got time to breathe, either in the workplace or at home? Besides, how can meditation be considered an option if individuals' personalities do not inherently easily lend themselves to the idea of slowing down and developing meditation?

Busy dental professionals often express a common challenge: the perception that meditation is not for them because they struggle to sit still and quieten their racing minds. With constant thoughts of impending deadlines and endless to-do lists, the effort to simply 'do nothing' can feel more stressful than relaxing. Meditation might seem almost antithetical to being a suitable solution for individuals used to handling daily complex multitasking and always undertaking responsibilities at speed.

No wonder that retreating to a peaceful setting to meditate might feel completely counterproductive and even make individuals worry about disengaging from tangible problems instead of tackling them!

Work-life balance

I have recently conducted wellbeing roundtables with Claire Frisby and our findings confirmed that promoting well-being among dental professionals should be at the core of every dental practice.

Dental professionals have reported: feeling pressurised to constantly deliver; having concerns about professional regulation; fear of litigation from patients; and working in a high-stress environment with relentless challenges along the way.[2,3] This often results in individuals feeling overwhelmed, reaching a state of toxic resilience. We work in such a rewarding profession and it feels so unfair and tragic that some individuals gradually lose that perspective. It does not have to be that way!

Regularly checking in with colleagues must become a daily routine within these settings.[4] It is essential to recognise that caring for individual well-being is a shared responsibility among all dental professionals, and access to support resources should be clearly signposted. Furthermore, establishing systemic approaches within dental settings to promote well-being is vital and represents a significant opportunity for future growth and enhancement.

Regardless of whether meditation is on anyone's agenda, I

would really like to encourage my peers to stop and reflect for as little as two minutes, about whether their current life prioritises their physical and mental health and aligns with their vision 10 years ahead, if asked to look into the future. What do you envision for yourself? Does your current work-life balance support this ideal for the future? If the answer is yes, that's wonderful! However, if the answer is no, this presents an opportunity to pause and reflect on the small, cost-effective adjustments that can be made now to realistically achieve a future vision and aspiration.

A favourite quote from *Sadhguru*, which I often share with my colleagues is: "Pain is a part of being human. Suffering is optional." [5]

Professional reflection among dental professionals is an ongoing process. However, incorporating additional reflection that prioritises our well-being should also be a daily consideration. This approach aligns with the need for primary prevention in the realm of mental health for dental professionals.[6]

If we are all aspiring to operate consistently at peak performance, experiencing greater well-being and better job satisfaction, surely the idea of putting new strategies in place should start to make sense?

I would like to reassure everyone that cultivating a meditation practice does not need to encroach on the time one does not have. During a class I delivered recently, a participant commented, *'It is when we feel we don't have the time that we must* ***find the time****, to do something for ourselves'.*

Meditation is one of the most disciplined practices for enhancing focus and minimising distractions. It has been shown to increase the ability to reframe how we interpret stressors and our responses. Meditation is about training your mind to increase your ability to solve insight-related problems, and having a favourable impact on key workplace outcomes, including performance, relationships, and well-being.

From the rapid evidence-based review commissioned by the GDC[7] one thing recently highlighted was that dental professionals would potentially be more receptive to adopt something specifically tailored to their needs. This would mean looking into the challenges they commonly face; like the fear of litigation, the need for perfectionism, time constraints, the constant pressure of high expectations on themselves, phobic patients, writing comprehensive notes, the fear of whistleblowing, the fear of not being competent or confident, to name but a few.

If meditation could be tailored to be more meaningful to the profession, in a configuration that made sense to individuals, amongst a community of like-minded professionals, then I think people would be a lot keener to engage and at least give it a go. I have also observed this over the last four years from delivering mindful movement and meditation classes online on a weekly basis.

Philips has supported me for years as the company recognises the importance of helping practices which place an emphasis on individual and collective growth to ensure they thrive in clinic and maintain high value to patients, whilst making personal happiness a priority.

I am thrilled the company wholeheartedly agreed to work collaboratively with me to raise awareness of my recent wellbeing roundtables, and now with my meditation initiatives tailored specifically to dental professionals to help the profession deal with the challenges of daily life.

With this in mind, we would like dental professionals to take ownership of their well-being, reflect upon what meditation could mean to them, and question how and if this could serve them and address their needs. It is about helping them acknowledge and interpret stressors in their lives and find ways to help them function as optimally as they can. If individuals constantly feel overwhelmed, this naturally dilutes their ability to focus, excel and reach their full potential, so how can they possibly deliver the highest levels of care for their patients?

Primary prevention can prevent the need for full-on interventional support and starts by recognising what our bodies interpret as stress, and how it shows up in our body, and when one is stressed, and learning how one can skilfully manage pressures. Engaging in meditation can take as little time as three minutes a day and can be incorporated into established habits (like time taken to brush one's teeth!). [6]

I would like to highlight that practising meditation should be part of a multi-pronged strategy to help individuals.

A series of complimentary meditation mindfulness videos to prepare for a New Year, New You will soon be available on my Smile Revolution platform. For more information: **Victoria - info@smile-revolution.net www.smile-revolution.net/yoga**

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BY DANIELA SCHÄDLER

PROFITABILITY IN PRACTICE

Many dental hygienists and therapists feel the pressure of constrained, rigid appointment times that can result in job dissatisfaction, constant feelings of stress and even burnout. The relentless back-to-back 20, or 30, minute appointment times often leave us feeling like we are on an endless treadmill, with little to no control over our diaries.[1] In addition, there is a further threat of litigation if we fail to inform and treat appropriately.

This reality starkly contrasts with our training, where we were taught to manage patients holistically and adjust appointment lengths based on treatment complexity. However, training often overlooks the business models driving dental practices. While rigid appointment timings might suit some in our profession, they do not work for everyone. It is encouraging that many practices are starting to move away from this approach, giving us more autonomy over our workload.[2]

The volume-based model is familiar in dentistry, where high numbers of patients are treated within set times with minimal flexibility. These time constraints create pressure on a clinician's expertise, potentially overshadowing acquired and honed skills. These 20, or 30, minute appointments, with fees based on time rather than the skills required, are misaligned with holistic care. Patients' needs vary significantly, and skilled treatments demand time, a commodity this business model does not often provide. Whilst profitability is crucial for dental practices, this model prioritises quantity over quality, potentially compromising patient care. It can lead to inadequate care for those who need it most and place a heavy burden on clinicians, risking burnout and reducing overall service quality. Although NHS appointments are typically constrained by funding, private treatments should have the flexibility to suit individual needs.

Finding myself on this 'treadmill', I soon lost both motivation and passion for a career I had worked so hard to build. The back-to-back appointments were intense, leaving no room for longer treatments, never mind finding time to rehydrate or use the toilet. Realising that the appointment structure was contributing to my dissatisfaction, I knew I had to make a change. After multiple failed attempts, my voice was finally heard. I learnt something from each attempt, which improved my negotiating skills. Here are some factors I had to consider when negotiating change.

Understanding costs

To propose any business plan, it is essential to understand current costs, how changes will implicate the practice and any associated risks. By identifying current profitability, it becomes easier to demonstrate how change can have a positive financial impact.[3] With longer appointments, a patient's oral health can stabilise quicker, improving patient satisfaction and health, whilst gradually increasing the patient base. Practices that emphasise quality over quantity can enhance their reputation, attracting a loyal patient base that values thorough, expert care. In addition, the way the appointments are described influences a patient's understanding of what their specific appointment entails.

Below is an example of how longer appointments based on clinical need, requiring advanced skills, can follow a skill-based business model.

Current		Proposed	
Treatment	Patient charge	Treatment	Patient charge
20 minutes (scale & polish)	£50	30 minutes (routine hygienist visit)	£75
30 minutes (scale & polish)	£75	60 minutes (advanced periodontal treatment)	£185
40 minutes (deep clean)	£100	90 minutes (advanced periodontal treatment)	£278

Barriers

There are multiple barriers to consider before presenting a case, and where possible it is prudent to identify how to overcome them. The following should be considered, including how to solve them:

- **Patient perception** Patients may resist changes, especially fee increases. It is crucial to comprehensively explain the benefits of having adequate time for high-quality care. Transparent communication about the value of enhanced care and flexible payment options can ease this transition. Often, once a patient has attended a longer appointment, they experience the benefit of having the extra time spent on them. Additionally, appointments are advertised using the dated "scale and polish" terminology. Removing this label also moves patients away from believing they are attending just for a "clean". It also makes it clearer to implement the BSP S3 Guidelines.[4]
- **Over-subscribed diaries** Many dental hygienists and therapists are booked months in advance, often due to the volume of patients or pre-booked appointments. Zoning the diary well in advance can reserve times for specific treatments, allowing patients to be seen sooner. If a zone has not been booked up a week or so before, the reception team can fill it with patients on the 'waiting list' to ensure the space is utilised.
- **Practice tradition** Changing long-standing practices can be challenging. Emphasising the positive impact over care can overcome this resistance.
- **Team understanding** It is essential that the whole team understands and supports the 'new role' of the dental hygienist and therapist. This includes training the reception team, so they understand and are fully on board with the need for longer appointments and can discuss why they are so much more beneficial for the patient.
- **Decision-maker's understanding** It is vital that we educate the decision-makers about the dental hygienist

PERIODONTAL WORKFLOW

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and therapist's roles and skills. Practices that fully utilise us, and empower us to use our full scope of practice, typically see improved patient outcomes and greater team satisfaction.

- **Cost considerations** Transitioning to a skill-based model requires careful consideration of costs. While running a dental practice involves significant expenses, from salaries to equipment maintenance and upgrades, explaining the benefits of the new model and how business costs will be covered can strengthen the proposal.
- **Patient 'DNA' risk** Patients failing to attend appointments has the potential to be more detrimental to profit under the skill-based business model due to longer times being blocked out in the diary. Introducing a deposit system can mitigate this risk, by ensuring the deposit covers the basic running costs.
- **'Plan' patients** Whilst dental payment plans are beneficial to both parties - bringing in a steady income for practices, helping patients spread the cost and encouraging them to attend regularly - they can also result in higher cases of failures in attendance, which can be costly to practices. These can be more difficult to manage, but practices may decide to implement deposits for longer appointments to reduce this risk. Equally, the type of payment plan will impact whether the treatment is included in the plan or not, and if it is, it can be more challenging to implement a deposit in this case.
- **Working to the scope of practice** Many dental hygienists and therapists still do not have the opportunity to work to their full scope of practice. Often the barrier for this is having appointment availability, or the dentist having a clear understanding of their role. Educating the dental team and building trust regarding your ability is key to success in this.[1]

Implementing change

Changing the appointment structure can disrupt an already booked schedule. Implementing a phased approach, gradually adjusting appointment lengths and fees can help patients and team members adapt smoothly. By zoning the appointment diary, dental hygienists and therapists can avoid multiple back-to-back intense treatments, reducing physical and mental fatigue. It also provides opportunity to provide additional treatments within our scope of practice, such as tooth whitening.

If the change results in having occasional short gaps in the diary, we can be further utilised by the undertaking fluoride application, fissure sealants, or taking dental impressions – all within our scope of practice. Alternatively, this time could be used to carry out clinical audit and drive other improvements in the practice.

Conclusion

The volume-based model in UK dental practices, while financially appealing, can fall short in providing holistic, patient-centred care. Shifting to a skill-based fee structure prioritises quality over quantity, ensuring each patient receives the time and attention they need. This approach enhances patient satisfaction, improves clinical outcomes and adopts a sustainable, rewarding work environment for clinicians.

Proposing change requires careful planning, patient education and strategic scheduling, but the long-term benefits make it a worthy endeavour. In a landscape where patient expectations are ever-evolving, practices that prioritise skilled, personalised care will stand out, setting a new standard for the profession.

Speaking up can also be daunting, especially if the decision makers seem unapproachable. Developing a strategy that considers the benefits and risks of change, as well as clearly outlining the positive operational and financial impacts, is key to being heard.

I hope this article resonates with practices and those feeling this strain, inspiring a rethink of how we approach our work.

Author: Daniela Schädler qualified as a dental therapist in 2019. Previously, she worked as a qualified dental nurse for many years in primary and secondary care dentistry. Currently, she works clinically as a dental therapist and as a dental compliance analyst for Agilio Software.

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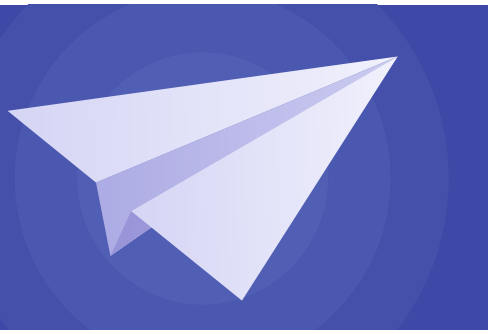


BY MAGGIE JACKSON

TURNING PASSION INTO LEGACY

Maggie's story charts the development of the VisionPerio brush. She worked with periodontists for 40 years until a stroke in 2019. Convinced by the relevance and success of the VisionPerio brush, she now shares her experience with other clinicians.

Discovering my passion

My love of dentistry began in the WRAF in 1961 – dental hygienists at that time trained for one year. Oral hygiene instruction (OHI) was given by teaching the 'Bass technique' with bristle toothbrushes and wood sticks to compress soggy interdental gum tissue, all gloveless. At that time, we laughed at the idea of an electric toothbrush.

My RAF practices had empty diaries to fill, so a patient's second or third appointments took place quickly, often within a few days, and I witnessed tremendous change when my patients actually followed advice and focussed on their posterior, lingual and interdental cleaning.

I encouraged them on their improvements and continued to remove calculus and cigarette stain with only hand instruments, bristle brushes and polishing paste.

Identifying the problem

In 1967, I started working part time in NHS practice and loved it. I was treated like an associate and paid 50% of the scale and polish (S&P) fees. I was often gently told to: 'Just do a 'clean-up of the stain' or 'Don't try too hard' or 'You don't have to do too much'. At the universal six-monthly S&P some patients had improved, but many others had not. This begged two questions: Why were some patients different? Why did some present with less plaque, better OH and less bleeding? For others, at each and every visit their teeth were scaled, revealing copious bleeding, often interdentally. When floss became available in the UK in the 70s, I then spent time teaching my patients how to use it. Frustratingly, however much I enthused, I could still see little evidence of improved OH or reduction in bleeding.

Incredibly, I knew nothing about periodontal diseases until 1979 when I worked with a GDP called Roy Higson. I realised that there was more to learn about improving my patients' oral health than S&P, cleaning teeth and basic toothbrushing! However, it was several more years before I understood 'host factors were likely to be of overriding importance for the most severe forms of periodontal diseases.'[1,2] It needs recognition even today, 'A common error in clinical management, is to place patients into a 3-monthly maintenance schedule without delivering definitive treatment in the first place.'[3] 'Three monthly controls may be maintained with professional prophylaxis and OH reinforcement, less, would fail to prevent deterioration.'[4,5] I was desperate to learn more…

Revelation

In 1981, I discovered interdental brushes – a revelation! I subsequently introduced them to my patients where a toothbrush, floss or interspace brush did not adequately reach. I often adapted them for my patients by curving them to compress tissue, which ensured the bristles reached deep into the interdental space without the wire catching lingual margins of pockets.

I was fired up and inevitably needed to know more, so I regularly attended periodontology conferences and travelled to Europerio meetings. I was also invited to Gothenburg for private study twice between 1981 and 1983. I observed surgery, learnt about research, implant placement and met a top clinical dental hygienist. I asked her my burning question: which floss did she use? She looked at me and said: 'I don't ask them to floss – they can't use it. I use these long brushes in many sizes'.

It was this further education that equipped me to make better practice choices and negotiate better pay, and in 1983 Philip Green, the first private specialist referral periodontist in UK outside Harley Street, asked me to help build his Manchester practice. Later, I then contacted Nick Pandya in Colchester requesting sessions in his specialist practice. Nick also taught postgraduate students at The London. Like Philip, he acknowledged comprehensive non- surgical periodontal treatment is fundamental to success before specialist surgery.

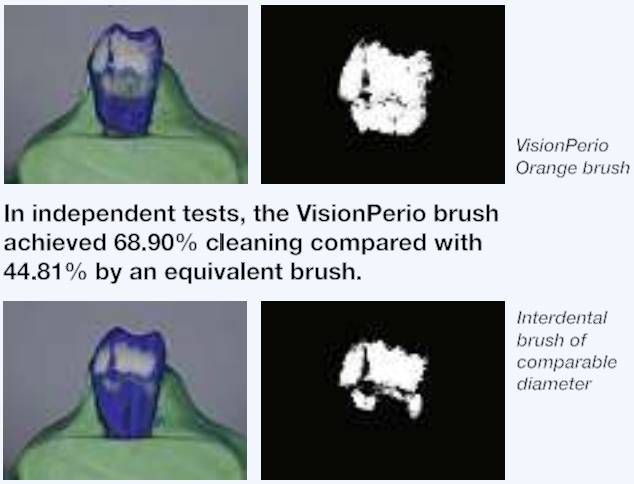
Research

Studies recognised that: 'Effective use of interdental brushes achieved a superior plaque removal than floss and can reach 2.5 mm into the gingival crevice'.[6] Subjects should 'remove as much supragingival, and if possible, subgingival plaque, to disrupt and prevent re-colonisation of subgingival areas to prevent further breakdown.'[7,8] However, other studies came to various conclusions without specific indications of how, or which, interdental brushes should be used. Generally, 'TePe' was adopted as the generic name within the profession for all interdental brushes.

My clinical results seemed to indicate that patients using curved brushes with a snug fit, just once a day achieved very good results. Based on this, I was accepted at Leeds to test my method with curved interdental brushes compared to floss. The study was supplemented by a detailed questionnaire on use and preference.[9] The data indicated that brushes improved clinical parameters and proved highly acceptable to patients. This research earned me an MPhil and publication in one of the top two world periodontal journals.[10]

Innovation

At that time, there were a limited variety of brushes available for my research, so I decided to design one and, later, a colleague and I consulted a brush manufacturer in the UK. The 'research' brush is not to be confused with VisionPerio brushes which were subsequently developed based on research data, from clinical parameters and patient compliance.[10] In order to design the unique characteristics of the VisionPerio brush, unavailable for my research, a colleague and I met a UK brush manufacturer. The brief was to make six brushes, graded in size, with machinable wire, flaring bristle and strong colour fibre. The colour made it easier to identify and show up plaque after the bleeding had come under control. Through self-funding – big marketing budgets have never been available – personal recommendation and trial packs, we have found a route to acceptance via dental therapists and dental hygienists.



VisionPerio Orange brush

Interdental brush of comparable diameter

One of the first to adopt VisionPerio brushes was Birmingham Dental Hospital, led by our 'periodontal hero' Professor Iain Chapple and his team, who have endorsed the brushes as first choice for patients in clinic and for after care.

Author: Maggie's story is written within that of the VisionPerio brush. Maggie worked periodontists for 40 years until her stroke in 2019 and now shares her experience with other clinicians.

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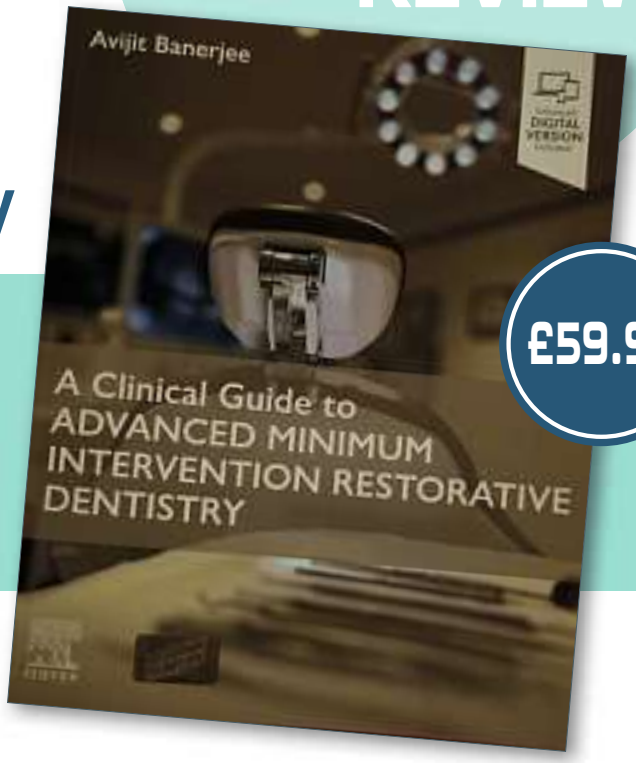
BOOK REVIEW

A Clinical Guide to Advanced Minimum Intervention Restorative Dentistry



Author: Professor Avijit Banerjee
Publisher: Elsevier
ISBN: 9780443109713
Cost: £59.99

Reviewed by Miranda Steeples

This is a must-have book for all dental therapists and dental hygienists. In fact, this book would be a useful addition to any workplace staff room for all team members to read. Even those who do not diagnose or treat caries will find this a useful guide for understanding caries progression and prevention, and for motivating patients. Additionally, for those who prefer to read on the move, there is a digital copy provided with every purchase.

Many will recall that 'Pickards' was essential reading during university for generations, but the last edition was published by Prof. Banerjee in 2015 under the title of 'Pickard's Guide to Minimally Invasive Operative Dentistry' (10th Edition). It was also released by a different publishing house (OUP), hence the new title for this new edition.

However, this is much more than just a new title. It elevates operative dentistry and offers the reader a definitive guide to holistic, person-focused, restorative dentistry and cariology for all members of the oral healthcare team. This is a step-change in working in primary dental care and it supports the reader in working with a new phased-care approach, with a strong emphasis on preventive oral healthcare, the role that patients must play, and brings all oral healthcare team members into this mindset.

The reader is walked through the patient journey and is guided by clinical and scientific evidence-based protocols, with the opportunity for self- testing provided throughout the book to check knowledge.

Every type of learner is considered here. There are flowcharts and tables for easy reference and the text is enhanced by a variety of high-quality clinical photographs. The use of case studies brings the philosophy of minimum intervention oral care (MIOC) to life, with sequential chapters exploring each stage of the protocol from an initial refresher of hard tissue pathologies; through each MIOC stage of Identifying Clinical Problems considering Diagnosis, Prognosis and phased Personalised Care Planning; Disease Control and Lesion Prevention; Minimally Invasive Operative Dentistry; and finally, how to establish a Risk Based Recall for Active Surveillance.

The foreword is written by Professor Sir Nairn Wilson, who declares that the book is 'a pleasure to read' and that it 'supersedes existing textbooks on operative and conservative dentistry'. I wholeheartedly agree that this book is a valuable resource for those who wish to take their patient care to the next level, and would recommend purchasing this guide in order to take advantage of learning from the author.

	Dental Hygienist	Dental Therapist	Student
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Key: *Average **Good ***Excellent ****Absolute must!

eCPD PAPER

BY JOHN STANFIELD

THEN – NOW – WHERE NOW?

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AIM

To explore the parallel evolution of nursing, dental hygiene, and dental therapy in the UK, highlighting shared milestones, unique challenges and future growth opportunities.

LEARNING OBJECTIVES

1. Examine historical and contemporary advancements in nursing, dental hygiene and dental therapy.
2. Understand the role of education, legislation and professional autonomy in these professions.
3. Explore future opportunities for leadership, research and integration within healthcare.

LEARNING OUTCOMES

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

- Compare the development of nursing, dental hygiene and dental therapy in the UK.
- Identify key milestones that influenced their autonomy and scope of practice.
- Discuss future trends in these professions and their impact on healthcare.

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ABSTRACT

This article examines the parallel journeys of nursing, dental hygiene and dental therapy in the UK, recognising the shared milestones and unique challenges faced by each profession. It explores how these professions have expanded their scope of practice, embraced academic opportunities and adapted to an increasingly complex healthcare landscape. By comparing their historical and contemporary developments, we gain a deeper understanding of the interrelated yet distinct paths that have shaped their roles in modern healthcare, alongside their potential for future growth.

KEY WORDS

TEL, Education, Technology

Background

The healthcare professions in the UK have undergone remarkable transformations over the past century, marked by a significant shift from strictly supervised, task-oriented roles to ones characterised by autonomy, advanced clinical expertise and academic leadership. Nursing and dental hygiene/therapy exemplify this progression, with both professions evolving to meet the changing demands of healthcare systems, public expectations and workforce needs. However, while nursing has often been at the forefront of professional advancement, dental hygiene and therapy have followed a similar trajectory, albeit with a notable lag in the pace and extent of progress.

In both fields, pivotal reforms in education, legislation and clinical practice have driven a transition towards greater professional independence and specialisation. These reforms have not only redefined the scope of practice but also elevated the status of nurses, dental hygienists and dental therapists as integral contributors to healthcare. Educational advancements, including the transition to higher education

and postgraduate opportunities, have empowered professionals in both domains to enhance their clinical, academic and leadership capabilities.

Historical Development of Nursing in the UK

Early 20th Century

At the beginning of the 20th century, nursing in the UK was largely a subordinate role. The profession was regarded primarily as an extension of the domestic sphere, with nurses providing bedside care under the strict supervision of physicians.[1] The focus was on tasks such as bathing patients, changing dressings and other basic care duties. Training at that time was largely apprenticeship-based, with nurses learning through hands-on experience in hospitals. This model of training, while practical, limited the professional growth and autonomy of nurses, as their roles were confined to routine, task-oriented responsibilities.

Post-WWII Reforms

The establishment of the National Health Service (NHS) in 1948 marked a turning point for the nursing profession. The creation of the NHS brought about a significant increase in healthcare needs and workforce demand. Nurses were required to take on more responsibilities, and there was growing recognition of the need for a more formal and structured approach to nursing education. Nursing schools were established in the years following the war, and the profession began to shift from the traditional apprenticeship model to a more academic form of education. Nurses started to receive formal classroom instruction, in addition to their practical training, allowing for a deeper understanding of healthcare's scientific and theoretical foundations.

1970s and 1980s

The professionalisation of nursing marked the 1970s and 1980s, as nurses began to take on more specialised roles within the healthcare system. The introduction of nurse specialists, particularly in fields such as cardiac care, oncology, and paediatrics, allowed nurses to focus on specific areas of healthcare, thereby increasing their clinical expertise. This period also saw the publication of the Briggs Report in 1972, which called for a major overhaul of nursing education in the UK.[2] The report emphasised the need for nurses to acquire academic credentials and recommended that nursing education be aligned with higher education institutions. This was a significant shift, as it placed greater emphasis on academic qualifications, marking a departure from the purely practical training model of earlier years.

1990s: The Move to Higher Education and Nurse Prescribing

The 1990s brought further significant changes to the nursing profession in the UK, particularly with the integration of nursing education into universities. By the end of the decade, a university degree had become the standard for entry-level nursing, reflecting the profession's move towards greater intellectual and clinical autonomy. This shift helped elevate the status of nursing, as it placed nurses on a more equal footing with other healthcare professionals who required university-level education.

One of the most important developments during this period was the introduction of nurse prescribing. Initially, nurses were only permitted to prescribe a limited range of medications under specific circumstances. However, over time, the scope of nurse prescribing expanded significantly. By the early 2000s, nurses in certain roles were able to prescribe a wide range of medications independently, without the need for a doctor's oversight. This development represented a major milestone in the professionalisation of nursing, as it allowed nurses to take on more complex clinical responsibilities and provided them with a greater degree of professional autonomy.

21st Century: Advanced Practice and Leadership

In the 21st century, nursing in the UK has continued to evolve, with the rise of advanced practice roles such as nurse practitioners, advanced clinical practitioners and consultant nurses. These roles involve expanded scopes of practice, allowing nurses to undertake activities traditionally reserved for doctors, such as diagnosing conditions, developing treatment plans and prescribing medications. The emergence of these roles has significantly enhanced the professional standing of nurses, as they are now recognised as clinical experts capable of independently providing high-quality, patient-centred care.

The introduction of professorships in nursing has also contributed to the profession's development. Nursing academics have played a key role in advancing the evidence base for clinical practice, conducting research that informs healthcare policy and improves patient outcomes. The establishment of professorial roles in nursing reflects the increasing recognition of the importance of research and academic leadership within the profession.

Today, nurses in the UK play critical roles in both clinical practice and academia, with expanded autonomy and a broad scope of practice that rivals that of other healthcare professionals. Nurses are no longer confined to subordinate, task-oriented roles; instead, they are valued as independent professionals who contribute to patient care, healthcare policy and academic research.

Historical Development of Dental Hygienists and Therapists in the UK

Early 20th Century

The profession of dental hygiene in the UK has its origins in the early 20th century, with the first formal training programme for dental hygienists established in 1921 at the Eastman Dental Hospital in London. Dental hygienists were initially introduced to provide preventive care, such as scaling and polishing teeth, under the supervision of dentists. Their primary role was to promote oral hygiene and prevent dental disease, focusing on educating patients about proper oral care. However, like nurses during this period, dental hygienists had limited autonomy and

were required to work under the direct supervision of dentists.

1960s to 1980s: The Introduction of Dental Therapists

During the 1960s and 1970s, the UK faced a shortage of dentists, particularly in the public sector, prompting the introduction of dental therapists. These professionals were trained to perform basic restorative treatments, such as fillings and extractions of deciduous teeth in children, under the supervision of dentists. Dental therapists played an important role in addressing the oral health needs of children, especially in school dental services. During this period, dental hygienists continued to focus on preventive care, but both professions operated under strict dentist supervision, with limited autonomy

1992: Local Anaesthesia and Expanded Clinical Roles

A pivotal moment in the development of the dental hygiene and therapy professions came in 1992, when dental hygienists were granted the ability to administer local anaesthesia for the first time. This marked the beginning of a shift towards more advanced clinical roles and greater autonomy for dental hygienists. The ability to administer local anaesthesia allowed dental hygienists to perform more complex procedures, such as 'deep scaling' and 'root planning', without the need for direct dentist supervision. This development was significant, as it signalled a move towards expanding the clinical responsibilities of dental hygienists and recognising their potential to play a greater role in patient care.

2000s: Further Expansion of Scope and Direct Access

The 2000s brought significant advancements in the roles of dental hygienists and therapists in the UK. In 2002, both professionals saw changes to their scope of practice:

Dental therapists were allowed to work in general dental practice for the first time. Previously limited to community and hospital settings, this change by the General Dental Council enabled them to provide a broader range of treatments, including restorative care for both adults and children. This expanded access to dental care and increased their role in general dental practice.[3]

Dental hygienists no longer needed to work under the direct supervision of a dentist. Instead, they could operate under a dentist's prescription, meaning the dentist did not need to be physically present during treatment.

Both changes gave these professionals greater independence and flexibility while maintaining collaboration with dentists for more complex cases. Additionally, dental hygienists and therapists gained the ability to take radiographs and provide more advanced restorative care under general supervision, further enhancing their contributions to patient care. One of the most significant changes occurred in May 2013, when the General Dental Council (GDC) introduced direct access for dental hygienists and therapists.[4] This reform allowed these professionals to see patients without a prior prescription or examination by a dentist. Direct access greatly enhanced the autonomy of dental hygienists and therapists, enabling them to provide preventive and some restorative treatments independently. While we still refer patients to dentists for more complex care, the ability to offer services without direct dentist oversight has positioned us as key members of the dental care team, capable of delivering high-quality, patient-centred care.

June 2024: Medicine Exemptions and Expanded Autonomy

In June 2024, a ground breaking policy change empowered dental hygienists and therapists in the UK to administer and supply certain medicines without requiring a dentist's prescription. This exemption covers critical treatments such as local anaesthetics (e.g., lidocaine and prilocaine), fluoride varnish, minocycline periodontal gel, and nystatin oral suspension. By granting these professionals the authority to deliver these treatments independently, the change streamlines patient care, reducing delays and enhancing access to timely interventions.

This milestone marks a significant recognition of the advanced clinical expertise and professional competence of dental hygienists and therapists. It reinforces our essential role in delivering high-quality, autonomous care, particularly in preventative and minimally invasive dentistry.

The shift did not occur overnight; it was the result of prolonged advocacy by the British Society of Dental Hygiene and Therapy (BSDHT) and the British Association of Dental Therapists (BADT). These professional bodies tirelessly campaigned for legislative reform, demonstrating the safety, efficacy, and necessity of expanding the scope of practice for our profession.

However, the timing of this reform cannot be divorced from the broader political and systemic challenges facing NHS dentistry. The growing shortage of dentists within the NHS - exacerbated by workforce pressures and declining dentist retention - has heightened political scrutiny. Policymakers appear to be looking to dental hygienists and therapists as a partial solution to address gaps in patient access and alleviate mounting pressure on the system. While this reform undoubtedly expands the autonomy of dental hygienists and therapists, it also aligns with a pragmatic response to workforce shortages, highlighting the political influence of healthcare reform on professional roles.[5]

As the dental sector continues to evolve, this change underscores the critical balance between clinical autonomy, professional advocacy and political pressures shaping healthcare policy in the UK.

Educational Advancements in Dental Hygiene and Therapy

Educational advancements have played a crucial role in the growth and professionalisation of the dental hygiene

and therapy professions. Historically, dental hygienists and therapists were trained at the diploma level, but over time, the standard of education has shifted, with Bachelor's degrees becoming the mainstay of most training programmes. This move towards higher education has helped to raise the status of the profession, as it places greater emphasis on the scientific and theoretical foundations of oral healthcare.

In recent years, many dental hygienists and therapists have pursued further education, obtaining Master's degrees and PhDs. Traditionally, most of these advanced qualifications have been in fields outside of dental hygiene and therapy, such as public health, healthcare management or education. However, specialised Master's programmes tailored specifically to dental hygiene and therapy have now been developed, reflecting the growing recognition of the need for advanced clinical training and leadership development within the profession.

The increasing availability of PhD programmes, particularly in oral health research, has further contributed to the academic development of the profession. Notably, the University of Portsmouth offers a PhD programme in oral health, providing dental hygienists and therapists with the opportunity to engage in high-level research and contribute to the academic foundation of the profession. These educational opportunities have opened doors to academia, research, and leadership roles for dental hygienists and therapists, allowing us to play a key role in shaping the future of dental care.

Conclusion: The Evolution of Nursing and Dental Hygiene/Therapy

The evolution of nursing, dental hygiene and dental therapy in the UK highlights the increasing recognition of these professions as critical components of the healthcare system. Reforms in education, legislation, and clinical practice have expanded the scope of practice for both nurses, dental hygienists and dental therapists, allowing us to take on more autonomous and complex roles. The development of advanced practice roles, such as nurse practitioners and consultant nurses, has transformed nursing into a profession characterised by clinical expertise, leadership, and academic contribution.

Similarly, dental hygienists and dental therapists have seen their scope of practice expand significantly, particularly with the introduction of direct access and medicine exemptions. Educational advancements, from undergraduate to postgraduate qualifications, have empowered these professionals to contribute to research, policy development, and evidence-based practice.

Today, nursing, dental hygiene and dental therapy professionals are well-prepared to meet the growing demands of modern healthcare, providing high-quality, patient-centred care and contributing to the ongoing development of their respective fields. Their contributions to clinical care, research, and leadership ensure that they play an integral role in shaping the future of healthcare in the UK.

Where Next for Dental Hygienists and Therapists?

Leadership in Clinical and Educational Spheres

- **Shaping Educational Curricula:** As the scope of practice for dental hygienists and therapists continues to evolve, these professionals are poised to play an influential role in shaping the educational frameworks that guide future generations. With increasing emphasis on advanced practice, clinical innovation and research, dental hygienists and therapists could actively contribute to the development of educational programmes that reflect these changes. This could include the creation of specialised Master's and PhD programmes tailored specifically to the needs of dental hygiene and therapy. These programmes would focus on not only advancing clinical expertise but also fostering leadership and research skills. In doing so, dental hygienists and therapists can help ensure that the curriculum aligns with the latest developments in oral healthcare, offering a forward-thinking approach to training that supports the growth of the profession.
- **Driving Research in Preventive Care:** Many dental hygienists and therapists are already engaged in research, particularly in the realm of preventive care. In the future, their involvement in research is likely to expand, with a growing focus on evidence-based practices that promote long-term oral health and prevent chronic oral diseases. Our expertise in preventive care and patient education uniquely positions us to lead initiatives aimed at improving public health outcomes. As leaders in oral health research, we will play a crucial role in developing innovative strategies for disease prevention, early detection and management of conditions such as periodontal diseases and dental caries. By contributing to the scientific foundation of preventive care, dental hygienists and therapists will help shape the next generation of oral health policies and practices.
- **Specialist Roles:** Much like the evolution of nurse specialists in the healthcare system, there is significant potential for dental hygienists and therapists to step into specialised roles that address the growing demand for specialist dental services within the NHS. As shortages of specialist dentists continue, specialist dental care professionals could fill critical gaps, offering more advanced care in areas where expertise is particularly needed. One promising area is non-surgical periodontology, where dental hygienists could lead efforts in managing periodontal diseases using advanced non-invasive techniques. By expanding into these specialist roles, dental hygienists and therapists could contribute significantly to alleviating pressure on the NHS, providing patients with high-quality care while broadening the range of services available within the public system.

These developments illustrate the increasing leadership and influence of dental hygienists and therapists in both clinical and educational spheres. As our roles continue to expand, we are set to make essential contributions not only to the

direct delivery of care but also to the shaping of future oral health policies, education, and research.

Public Health Advocacy and Policy Development

Dental hygienists and therapists are well-positioned to influence oral health policy. Future developments could see them become more involved in:

- **National health campaigns:** As advocates for preventive care, dental hygienists and therapists could take on leadership roles in national oral health campaigns, focusing on reducing the incidence of dental caries, periodontal diseases and mouth cancer. Our expertise in prevention would be invaluable in shaping public health policies and initiatives aimed at improving the nation's oral health.
- **Health equality initiatives:** Dental hygienists and therapists may lead efforts to reduce disparities in oral healthcare access, particularly in underserved or rural communities. This would involve advocating for policy changes that improve access to preventive services and early treatment, ensuring that all populations benefit from high-quality oral health care.[6]

Further Integration into General Healthcare

Given the current recognition of the link between oral health and systemic health, the profession is likely to see even greater integration with general healthcare services. This could manifest in:

- **Oral health in general medical settings:** Dental hygienists and therapists could work more closely with general medical practitioners to integrate oral health assessments into regular medical check-ups, particularly for patients with chronic conditions like diabetes or heart disease. This would ensure that oral health is prioritised as a key component of overall health.
- **Collaborative care in hospital settings:** Dental hygienists and therapists might expand their roles within hospitals, especially in departments that manage conditions related to oral health, such as oncology or cardiology. Our involvement could range from providing oral health assessments for inpatients to working with medical teams to prevent oral complications related to treatments like chemotherapy.

Technological Innovation and Patient-Centred Care

Building on the current use of digital scanners and radiography, future developments might include (subject to changes in Scope of Practice):

- **AI-driven diagnostics and treatment planning:** While digital tools are already in use, the integration of artificial intelligence (AI) could further enhance the role of dental hygienists and therapists. AI could assist in diagnosing periodontal diseases or predicting the progression of oral health conditions, enabling dental hygienists and therapists to provide more targeted and personalised care.
- **3D printing for customised care:** In the future, dental hygienists and therapists may utilise 3D printing technologies to produce customised oral appliances, such as mouthguards or splints, directly within the practice. This could streamline care delivery and offer patients more personalised preventive and therapeutic solutions.

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eCPD PAPER

BY HARRIET ELSWORTHY

INFANT FORMULA WHAT DENTAL PROFESSIONALS NEED TO KNOW

1½ Hours eCPD PER PAPER

AIM

To familiarise dental professionals with types of infant formula and current guidelines surrounding their consumption.

LEARNING OBJECTIVES

To assimilate evidence surrounding formula consumption in order to understand current recommendations.

LEARNING OUTCOMES

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

- Describe and understand the roles and availability of different types of infant formula on the UK market.
- Be able to give evidence-based advice to patients regarding infant formula and choice of drink..

Aligned to GDC development outcome: *A and C*

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ABSTRACT

Infant feeding is not as straightforward as it seems; feeding a new baby is often a challenging endeavour and when feeding does not go to plan it can be stressful and traumatic for both caregivers and infants. First infant formula is essential to babies who are not exclusively breastfed. However, contrary to NHS guidance, infants are being unnecessarily exposed to expensive and processed follow-on and toddler formula milks which may contribute to long-term dental and systemic consequences.

A basic knowledge of the market and what drives it is helpful to us as dental professionals. As healthcare professionals, it is our duty to help signpost and guide patients towards making well-informed choices, and away from the plethora of misinformation, to which tired new parents may be particularly vulnerable amongst the fog of uncertainty that comes with parenting.

KEY WORDS

Infant formula, milk formulas, milk, breastfeeding, infant nutrition

Follow-on and toddler milks are the leading single food source of free sugars in the diets of children aged 12-18 months old in the UK. Parents are led to believe by well-placed marketing that progression onto these milks will be beneficial – indeed, 'growing up' and 'toddler milks' are the fastest growing global category of commercial milk formula.[1]

Why is formula milk required?

In the UK, although data shows that most mothers would prefer to breastfeed, most do not do so for as long as they had planned.[2] Catalysts for stopping breastfeeding are complex and multi-faceted and include:

- Lack of breastfeeding support from both family and healthcare professionals [3]
- Inadequate workplace maternity policies
- Inadequate laws preventing misleading marketing of commercial milk formula, bottles, teats [4,5]

The Office for Health Improvement and Disparities (OHID) breastfeeding data from England in 2022-2023 showed approximately 51% of infants were fully formula-fed at their

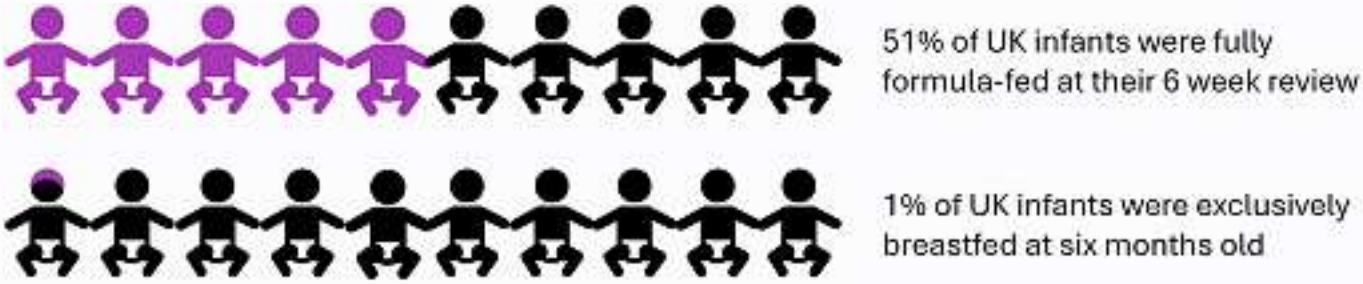

Figure 1: **Graphic showing percentages of infant feeding methods**

6-8 week review.[6] The most recent UK-wide Infant Feeding Survey was carried out in 2010 and showed that only 1% of infants were exclusively breastfed at six months of age[2] (Fig. 1).

First infant, Follow-on and Toddler formula milk- what's the difference?

Infant formula is recommended and essential for non-breastfed or mixed-fed infants up to one year of age; for the first six months formula will be the means by which an infant will consume its nutritional requirements; from six months to one year it can be offered alongside complementary foods. Nutritional composition of infant formula is heavily regulated to ensure that all available brands are safe and will provide sufficient support for infant growth over the first few months in the absence of breast milk. Formulas are available either as a powdered product or ready-to-feed liquid.

First infant formula

- The nutritional composition is heavily regulated; ingredients found to be beneficial are required to be added by law. Ingredients can differ with brands but composition must comply with legal requirements.

Follow-on formula

- These are formulas marketed to feeding healthy infants from six months to one year. Follow-on contains slightly higher levels of protein, micronutrients and iron than infant formula. These should never be fed to babies under six months old. [7]

Toddler/ Growing-up milk

- These are marketed as alternatives to cow's milk for children over one year old. The main constituents are powdered milk/ milk components, carbohydrate and vegetable oils. There are no UK regulations governing their composition or labelling.

Why are follow on milks not recommended by the NHS?

There is a plethora of evidence and subsequent guidelines demonstrating that follow-on formula offers no health or nutritional advantage over first infant formula. [4,8-10]

Figure 2: **Chart showing infant feeding recommendations**

If an infant is drinking formula milk, the NHS recommends that first infant formula is used alongside breastfeeding, or exclusively for the first six months, and then alongside complementary foods until the age of one year (Fig. 2). From this point, either breast milk or cow's milk is recommended alongside a nutritious diet. This eliminates the requirement for any formula other than first infant formula, rendering follow-on and toddler milks as entirely discretionary.

Follow-on formula is often marketed as providing a necessary source of iron for older infants and toddlers however the UK infant feeding guidelines recommend that after six months of age additional nutritional requirements, especially iron, are instead met by introducing a varied and nutritious diet of complementary foods. Furthermore, most first infant formulas available in the UK already meet the higher target for iron required by guidelines in follow-on formula (Fig. 3) and are therefore recommended until an infant is one year old.

Why are Growing-Up and Toddler milks not recommended by the NHS?

From the age of one year, either breast milk or cow's milk are recommended as a child's main milk drink.[11] Public health guidance clearly states: "'Formula milks (including infant formula, follow-on formula, 'growing up' or other 'toddler' milks) are not required by children aged 1 to 5 years.'[1]

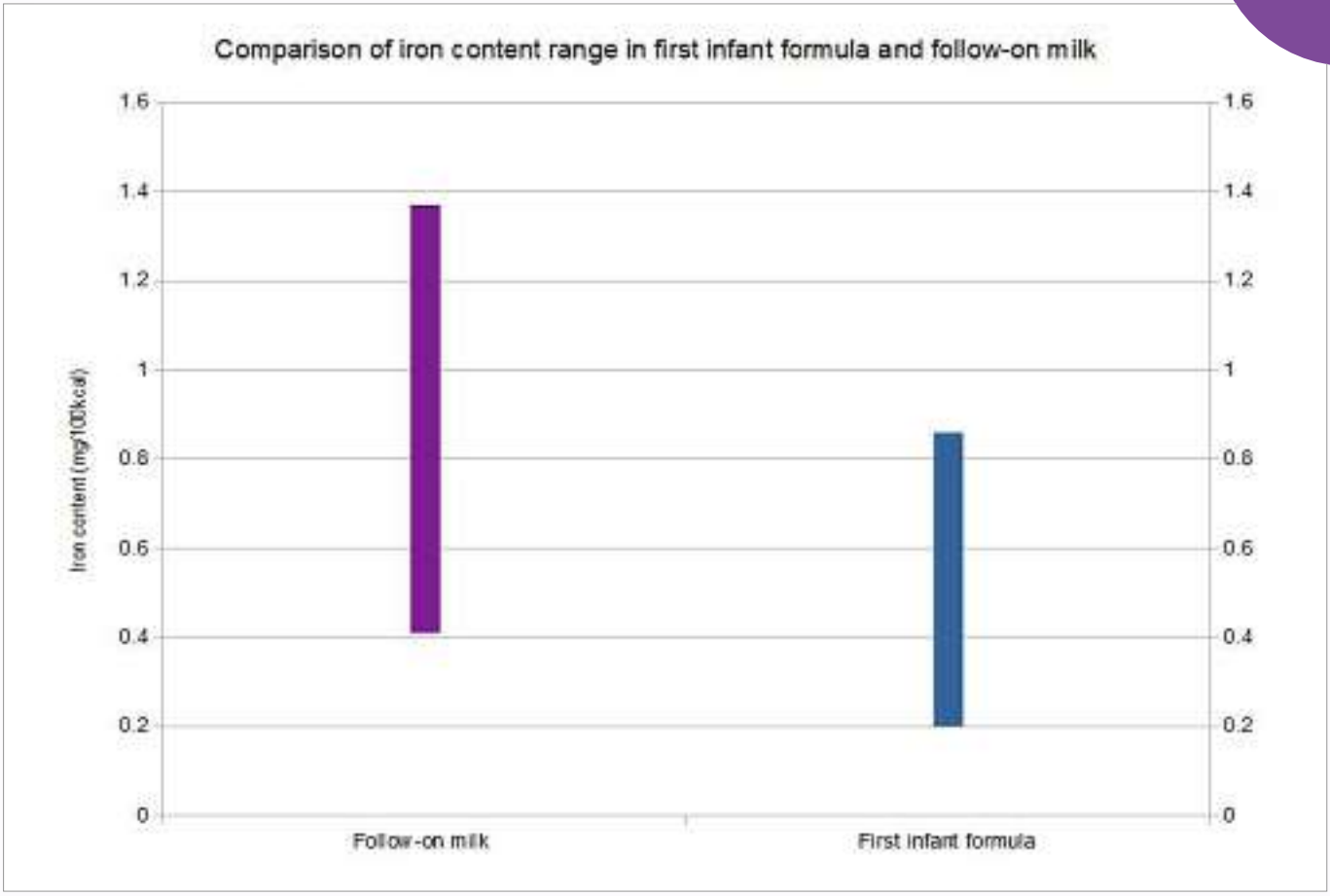

Figure 3: **Infant formula. What dental professionals need to know. Why does infant formula affect us as dental professionals**

Most toddler milks do not have a nutritional composition which aligns with recommended nutrient intakes for this age group, particularly for sugar; for the children who do consume formula between the ages of 12-18 months, half of their total free sugar intake and almost a third of their dietary energy intake comes from these products.[1] As such, consumption of toddler milks poses a number of problems:

- Provides energy without essential micronutrients
- Displaces nutrient-rich, whole foods in favour of ultra-processed, sweetened drinks
- Encourages a sweet taste profile
- Additives have an effect on gut microbiota

This contributes toward the potential for longer term consequences linked with consumption of excess free sugars, particularly in the first 1000 days of an infant's life: increased risk of overweight, obesity and associated non-communicable disease, including dental caries.[1,12,13]

Redefining non-milk extrinsic sugars

Following recommendation by the Scientific Advisory Committee on Nutrition in 2015[14] Public Health England adopted the definition of 'free sugars' in place of 'non-milk extrinsic sugars' upon which recommendations had been previously been based.[15] Table 1 summarises classification of sugars in their various forms:

Table 1: **Classification of free sugars**

Free sugars	Not free sugars
All **added** sugar in any form (monosaccharides and disaccharides) Honey, syrups, nectars including malt extract	Maltodextrins, oligofructose, sugar substitutes such as polyols
Lactose **when added as an ingredient**	Lactose and galactose **when naturally present in milk and dairy products,** including milk powder
All sugars naturally present in fruit/vegetables **that have been blended, pulped, pureed, extruded or powdered**	Sugars present in **fresh** and most types of processed fruit and vegetables – **canned, dried, stewed, frozen**
All sugars in drinks except dairy-based drinks	All sugars naturally present in cereal grains, nuts and seeds; except in drink form

Labels of all toddler milks display the total sugar content – this includes all monosaccharide and disaccharides within the formula. However, these do not include maltodextrins as, according to UK guidelines, they are not classified as a sugar; this is misleading because maltodextrins are so rapidly digested by the body that it has a higher glycemic index than glucose, and may also have cariogenic potential,

although evidence surrounding this is contradictory.[16] The two companies owning the majority of the UK market share for infant milks both have maltodextrin as a constituent of their toddler milks.

Marketing regulations

Infant formula:

- Advertising is restricted to either scientific or specific baby care publications, which must only provide factual scientific information.
- Nutritional and health claims are not permitted.
- Advertising must not imply that bottle-feeding formula is equivalent or superior to breastfeeding;
- Specific terms such as 'humanised', 'maternalised' are not allowed.
- Must carry a clearly stated 'important notice' concerning the superiority of breastfeeding and that the product should only be used on the advice of an independent and qualified person.

Follow-on formula has far fewer marketing restrictions:

- Specific terms such as 'humanised' and 'maternalised' not allowed.
- All necessary information must be provided so as not to discourage breastfeeding.
- Labelling and presentation must show a clear distinction between follow-on and first infant formula to avoid confusion between the two.

Toddler and Growing-up milks currently have no marketing regulations at all in the UK.

Despite regulations stipulating clear differences must be made between follow-on and first infant formula, branding and appearance remains very similar between them; there are no specific nutritional composition, marketing or labelling regulations for these products. The wide array of different formula milks on display can be very confusing and misleading, especially to tired new parents.

Toddler and Growing-up milks were created by the industry to extend infant formula product ranges into the second and third year of life. They have increasingly generated more substantial income to commercial milk companies as birth rates have declined and breastfeeding rates increased.[5,17,18]

Relaxed marketing regulations and allowance of nutritional claims on follow-on milk, and complete lack of regulation for toddler milks, facilitates companies to cross-brand these with first infant formula; this allows indirect marketing of first infant formula brands through their follow-on and toddler products. Current UK guidance pertaining to regulating marketing of these products does not align with global guidance. The World Health Assembly concluded that any beverage marketed for children under three years old is considered a breast milk substitute and should not be advertised or promoted.[19]

Research conducted by Swansea University in 2019 showed that almost 60% of parents under 25 years old thought they had seen adverts for first infant formula, despite this being illegal in the UK – this demonstrates how effective cross-branding of formula actually is.[20] These perceptions are partly driving purchase decisions, from which, research has shown, parents are unlikely to diverge once they have made the decision to feed their child a specific formula. [21]

The Competition and Markets Authority (CMA) was so concerned about this that they commissioned a report which is due to be published in February 2025. Their primary concern was that parents may not have sufficient information to make well-informed choices when choosing a formula due to cross-brand marketing, but their interim report, published on 8th November 2024 has also found[21]:

- Formula prices increased by 25% from 2021-2023 while maintaining high profit margins
- Two brands owned 85% of the UK market share in 2023
- Suppliers may not have incentives to offer formula at competitive prices
- Parents often choose a formula brand for the first time in vulnerable situations without access to information to enable a well-informed decision (just after birth, in hospital); as such brand reputation plays an outsized role in decision-making
- Advertising for follow-on formula has been supporting sales of first infant formula
- Branding across different types of formula milks are not clearly differentiated

Suggested recommendations based on these findings include strengthening marketing regulations and improving access to accurate information to enable more evidence-based decisions to be made by parents and carers.[21]

Why is cow's milk is recommended for infants?

In the absence of continued breastfeeding, full-fat cow's milk is recommended as an infant's main milk drink from the age of one year, with a guide of 350ml per day.[11,22] At this point foods, rather than milk, make up the majority of a child's diet and therefore can provide the necessary iron intake. It is also important to note that very high consumption of animal milks has been associated with iron deficiency in young children, due to subsequent poorer appetite for food where excessive milk has been consumed, and the lack of iron present in animal milk. [23,24] This is why 350ml intake per day has been recommended to avoid excessive consumption.

Animal milks provide a significant proportion of many important nutrients to an infant's diet, particularly high-quality protein and highly bioavailable calcium; consumption of 350ml of full-fat cow's milk a day provides a 1-2 year old with 82% of their recommended daily protein intake and over 100% of their recommended calcium, riboflavin and iodine.[22]

Table 2: Recommendations of plant-based alternatives to milk

If advised to drink plant-based	**Unsweetened and fortified:** • Soya-based • Pea-based
Safe but not as highly recommended	**Unsweetened and fortified:** • Nut-based & coconut-based (both low in energy and protein) • Oat-based (high in free sugars)
Not advised for children under 5 years of age	Rice-based (high arsenic levels)

Its composition may be protective against development of insulin resistance [25]; the calcium and phosphate also aid buffering capacity and protect against caries.[26]

For those who cannot, or chose not, to consume animal milk, there are many plant-based alternatives available. Current advice recommends unsweetened and fortified plant-based milks as summarised in Table 2.[27]

Summary of current guidance

It is important we give accurate dental health advice to parents regarding infant milk consumption. A summary of current available guidance[11,27,28]:

- Current WHO guidance recommends breastfeeding an infant **up to the age of two years and beyond**
- **Breast milk is the only food or drink babies need for around the first 6 months** of their life; **first infant formula milk is the only suitable alternative** to breast milk
- Either **breast milk or first infant formula should be used for the first six months;** from **6-12 months this can be combined with complementary foods;** from 12 months either breastmilk or animal milk should be an infant's main source of milk alongside a varied diet
- From a dental standpoint, **breastfeeding up to the age of 12 months has been found to be associated with a decreased risk of dental caries in infants;** evidence surrounding infants breastfed beyond 12 months is contradictory
- Bottle-fed babies should be introduced to drinking from a free-flow cup from the age of 6 months and **bottle feeding should be discouraged from 12 months old**
- **Only breast or formula milk or cooled, boiled water should be given in bottles**
- **Only animal milk or water** should be drunk between meals and adding sugar to foods or drinks should be avoided

First Infant Nutrition Trust provides detailed, evidence-based advice for parents/ carers and healthcare professionals, with detailed rationale behind recommendations made by the Trust with a view to influencing public health policy. The website can be accessed at **https://www.firststepsnutrition.org/**.

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BY WISAM A. ALDULAIMI

CHILD PATIENT PREPARATION

The sixth National Dental Epidemiology Programme 2022[1] survey of 5-year-old children in England, showed that 29.3% of children examined had enamel and/or dentinal decay. Regionally, this ranged from 23.3% in the South West to 38.7% in the North West of England. Overall, 23.7% of 5-year-old children in England had experience of dentinal decay. Poor oral health impacts on children and families. It affects a child's ability to eat, smile and socialise and causes pain and infection often resulting on days missed at school, despite this being a largely a preventable disease.

Older school children in year 6 were surveyed in mainstream, state-funded schools in England in the academic year 2022 to 2023. This was the first time this population group has been surveyed. The survey was carried out as part of the Office for Health Improvement and Disparities' National Dental Epidemiology Programme (NDEP). The main findings from the survey showed that: overall, 16% of year 6 schoolchildren in England, whose parents gave consent for participation in this survey, had experience of dental caries. Among this group, each child had, on average, two teeth with experience of decay.[2]

As dental hygienists and therapists, understanding the significance of these temporary teeth is vital in promoting effective dental care and educating families on maintaining good oral hygiene from an early age.

Foundation for Oral Health

Deciduous teeth serve as the foundation for a child's oral health. Parents and carers need to understand they are essential for:

- **Chewing and Nutrition:** These teeth allow children to chew food properly, which is crucial for proper digestion and nutrient absorption. A balanced diet supports growth and development.
- **Speech Development:** The proper alignment and structure of primary teeth aid in the development of clear speech. They help in the correct pronunciation of words, which is vital for effective communication and learning.
- **Facial Structure:** Deciduous teeth play a role in supporting the facial muscles and giving shape to a child's face. This support is important for aesthetic and functional development.
- **Guidance for Permanent Teeth:** Deciduous teeth maintain space in the jaws for permanent teeth. They act as guides for the eruption path of permanent teeth, helping to prevent malocclusions and overcrowding.

Importance in Preventing Oral Diseases

- **Caries and Infection Control:** Deciduous teeth are susceptible to caries, which, if left untreated, can lead to pain and infection affecting a child's quality of life. Early intervention and education by dental hygienists can prevent the progression of cavities.
- **Early Orthodontic Assessment:** Monitoring the growth and development of primary teeth allows for early detection of orthodontic issues. Early referrals to orthodontists can mitigate more severe problems in the future.

Educational Opportunities

Dental hygienists and therapists have a significant role in educating parents and children about the care of deciduous teeth:

- **Oral Hygiene Practices:** Teaching effective brushing and flossing techniques adapted for children's needs is crucial. This includes selecting age-appropriate toothbrushes and toothpastes.
- **Routine Dental Visits**: Encouraging regular dental check-ups from an early age helps inculcate a habit of preventive care, making children more comfortable with dental visits as they grow older.
- **Diet and Lifestyle Counseling:** Advising on a balanced diet low in sugar can help prevent decay. Educating families about the impact of bottle feeding and sippy cups on oral health is also valuable.

Psychological and Social Aspects

- **Reducing Anxiety:** Familiarising children with dental care reduces fear and anxiety about dental visits. A positive experience early on can influence their attitudes towards oral health throughout life.
- **Building Self-esteem:** Maintaining healthy primary teeth can boost a child's self-confidence. A beautiful smile can positively impact their social interactions.

Psychology of child development

The psychological development of children was originally viewed as a series of well-defined phases but is now seen as a continuum. The phases of development may well differ

Figure 1: **Children aged 7–11 years are able to consider another person's point of view.**

from child to child, so cannot be rigidly applied but, for clarity, are described as a series of psychological developmental milestones from infancy to adulthood.[3]

The most important theoretical perspective now influencing thinking about child development is John Bowlby's attachment theory. [4] Bowlby suggested that child development could best be understood within the framework of patterns of interaction between the infant and the primary caregiver. If there were problems in this interaction, the child was likely to develop insecure and/or anxious patterns that would affect their ability to form stable relationships with others, to develop a sense of self-worth, and to move towards independence. The other important concept to note is that development is a lifelong process - we do not switch off at 18 - nor is it an even process. Development is uneven, influenced by periods of rapid bodily change.

Children aged 6–7 years usually have sufficient coordination to brush their teeth reasonably well. Below that age many areas of the mouth will be missed and there is a tendency to swallow relatively large amounts of toothpaste; therefore preventive guidelines recommend parental involvement in brushing prior to age 7 years and supervision of brushing thereafter.

The Swiss psychologist Piaget formulated the 'stages view' of cognitive development on the basis of detailed observations of his own children and suggested that children pass through four broad stages of cognitive development (Table 1).[5]

Table 1: **Piaget's stages**

Sensorimotor	This stage lasts until about 2 years of age. The prime achievement is 'object permanence'. The infant can think of things as permanent - which continue to exist when out of sight - and can think of objects without having to see them directly.
Preoperational thought	This runs from 2 to 7 years of age. The sensorimotor stage is further developed, allowing the child to predict outcomes of behaviour. Language development facilitates these changes. Thought patterns are not well developed, being egocentric, unable to encompass another person's point of view, single-tracked, and inflexible. Typically, children in this age band are unable to understand that areas and volumes remain the same despite changes in position or shape.
Concrete operations	This is the stage of thinking that occurs from about 7 to 11 years of age. Children are able to apply logical reasoning, consider another person's point of view, and assess more than one aspect of a particular situation. Thinking is rooted in concrete objects; abstract thought is not well developed.
Formal operations	This is the last stage in the transition to adult thinking ability. It begins at about 11 years of age and results in the development of logical abstract thinking so that different possibilities for action can be considered.

We must be prepared for parents who do not agree with our perceived wisdom or do not understand the basic tenets of specific programs. Dentists, dental therapists and dental hygienists will lead less stressful practising lives if they remember that not all their patients will always agree with or follow oral health advice.

However, children do develop their selective attention, and by the age of 7 years can determine which messages merit attention and which can be ignored. Concentration skills also improve. Children must be involved in their treatment and some dental advice can be offered to children of this age but,

Figure 2: **Being good with patients is not necessarily an inborn art!**

Figure 3: **Be prepared for parents who don't agree.**

but, given the importance of the home environment, parents should be the main focus of any information given on oral healthcare.

With increasing age children become more efficient at discriminating between different visual patterns and reach adult proficiency by about 9 years of age.

The majority of perceptual development is a function of the growth of knowledge about the environment in which a child lives, hence the necessity to spend time explaining aspects of dental care to new child patients .

Children need to form good oral health habits from an early age to help avoid dental caries. Although largely preventable, it is still a serious problem among young children. The Office for Health Improvement and Disparities oral health survey of 5-year-old children 2022 and Public Health England oral health survey of 3-year-old children 2020 found that:[6]

- Nearly a quarter of 5-year-olds in England have tooth decay, affecting three to four teeth on average
- Children from more deprived backgrounds are more likely to have tooth decay
- 11% of 3-year-olds in England have visible tooth decay, affecting three teeth on average

Figure 4: **Spend time explaining the facts about dental care.**

Conclusion

The role of deciduous teeth in a child's life cannot be overstated. Dental hygienists and therapists play a pivotal role in maintaining the health of these teeth and, by extension, the child's overall well-being. Through education, preventive care, and early intervention, we can help ensure that children grow with healthy smiles leading to healthier futures. Emphasising the importance of deciduous teeth can transform how families approach dental care, fostering a culture of oral health awareness from an early age.

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He graduated with a BDS from Baghdad University College of Dentistry in 1999, and went on to obtain a Master's Degree in restorative dentistry in 2005. He worked as a restorative specialist in Saudi Arabia for 16 years. He qualified as a Dental Therapist in the UK in 2024.

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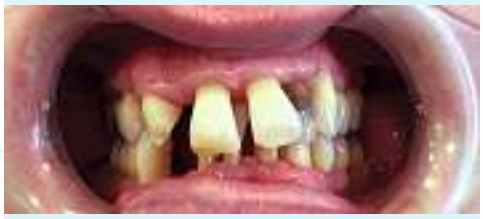

Recall at 12 months

Case study and photographs courtesy of **Pat Popat**
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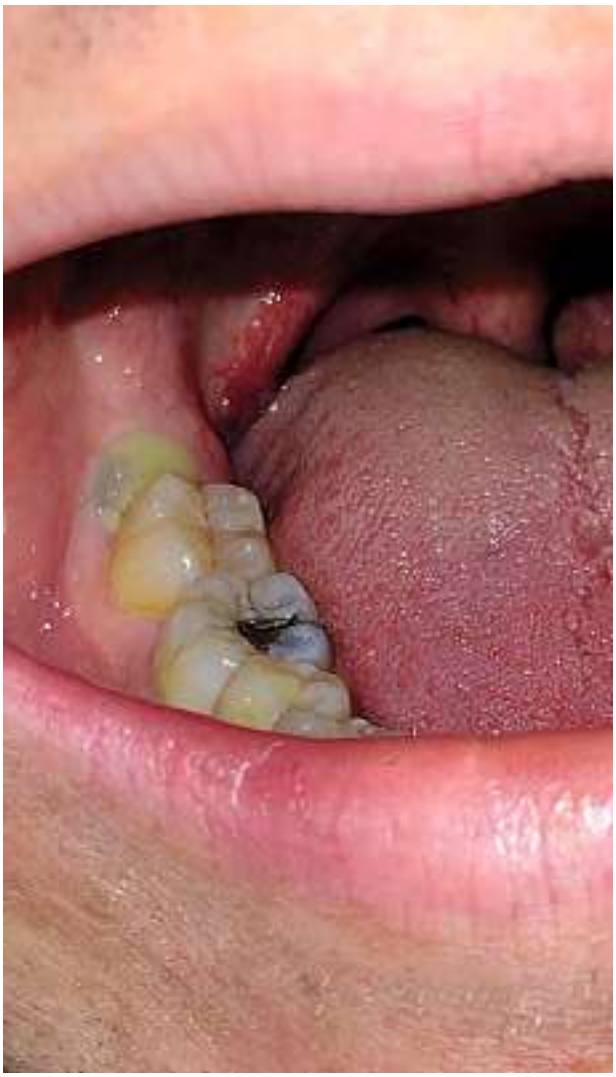
CLINICAL QUIZ

A 22 years old male patient presents as an emergency complaining of difficulty in opening his mouth and pain on the right side when chewing. The pain started as a dull ache three days ago and is increasing in intensity. He could not sleep last night and this morning the pain is continuous, a dull throbbing ache, which is severe when he tries to chew. He has taken paracetamol for pain relief with no benefit.

Extraoral examination reveals tenderness in the right submandibular region with lymph nodes slightly enlarged. He cannot open his mouth more than 2 centimetres. There is no extra-oral swelling and the skin in the area appears normal. The patient is not pyrexic. Intraoral examination reveals diffuse swelling in the right third molar area, extending buccally and lingually around the peri coronal flap over a partially erupting third molar. The area is very tender to touch with evidence of pus discharging from under the flap.



Q1. What further investigations are needed?

Q2. What are the differential causes for the pain and swelling that the patient is experiencing?

Q3. What is the short, and long term, management?

Quiz kindly provide by Dr Latha Davda, Editorial Board

ANSWERS TO QUIZ NOVEMBER 2024

A 55-year-old lady complains of a painless swelling on her lower lip, which has been slowly enlarging over four months. She thought it was a cold sore and has been applying aciclovir cream but not noticed any benefit.

The affected tissue is firm to palpation.

Q1. What two clinical features would not support the abnormality being a cold sore?

A1. *The swelling is painless and has been present for more than three weeks*

Q2. What type of referral is indicated?

A2. Urgent Suspected Cancer (USC)

Q3. What is the most likely diagnosis?

A3. *Squamous cell carcinoma*

Quiz kindly provided by Prof. Mike Lewis

DIARY DATES

SPRING 2025 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	Sat, 22nd March 2025	Holiday Inn Colchester Abbotts Lane, Eight Ash Green, **Colchester** CO6 3QL	Amanda Kestell	easternsecretary@bsdht.org.uk
London	Thurs, 27th March 2025	Neuron Pod, Queen Mary University of London, The Blizard Building, 4 Newark Street, **London** E1 2AT	Udita Patel	londonsecretary@bsdht.org.uk
Midlands	TBC		Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	Sat, 5th April 2025	Radisson Blu Hotel, Frankland Lane, **Durham** DH1 5TA	Sarah Hunter	northeastsecretary@bsdht.org.uk
North West	TBC		Jessica McGenn	northwestsecretary@bsdht.org.uk
Northern Ireland	Sat, 22nd March 2025	Marlborough Clinic Belfast, 1 Marlborough Park, **Belfast** BT9 6XS	Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	Sat, 21st June 2025	Scottish Dental Show, **Braehead** Arena (no trade)	Kirsty Sim	scottishsecretary@bsdht.org.uk
South East	Sat, 26th April 2025	Salomon's Estate Country House, **Tunbridge Wells** TN3 0TG	Sam Doyle	southeastsecretary@bsdht.org.uk
Southern	Saturday 15th March 2025	Voco Hotel (Holiday Inn), Telegraph Way, **Winchester** SO21 1HZ	Karen Poulter	southernsecretary@bsdht.org.uk
South West & South Wales	Sat, 22nd March 2025	St. Pierre Marriott Hotel & Country Club, St Pierre Park, **Chepstow** NP16 6YA	Lynn Chalinder	swswsecretary@bsdht.org.uk
South West Peninsula	Sat, 7th June 2025	China Fleet Country Club, Saltash, **Cornwall** PL12 6LJ	VACANT	southwestsecretary@bsdht.org.uk
Thames Valley	TBC		Keileigh Lerston	thamesvalleysecretary@bsdht.org.uk

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