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THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY

ROBIN DAVIES RESEARCH **AWARDS 2026**

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Promoting health, preventing disease, providing skills

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EDITORIAL

The Tobacco and Vapes Act

The Tobacco and Vapes Act, which received Royal Assent on 29 April 2026, represents one of the most significant public health interventions of a generation. However, this landmark decision appeared to get lost in the daily news feeds in the days following. In my opinion, it absolutely did not get the coverage in the UK media that it deserved!

For dental hygienists and dental therapists, whose work is rooted in prevention, health promotion and behaviour change, this legislation is welcomed as a major opportunity to improve the nation's oral health and protect future generations from the harms of nicotine addiction.

Smoking remains the leading preventable cause of death in the UK, responsible for approximately 80,000 deaths every year.[1,2] Despite decades of public health campaigning, around 5.3 million adults in the UK continue to smoke. Perhaps most tellingly, around three-quarters of smokers report wishing they had never started.[3] These figures highlight a stark reality: tobacco addiction often begins in youth, yet its consequences can last a lifetime.

The Act introduces a historic measure that will make it illegal to sell tobacco products to anyone born on or after 1 January 2009. This 'smoke-free generation' approach aims to gradually phase out smoking and prevent future generations from becoming addicted to tobacco. From an oral health perspective, the potential benefits are profound. Smoking is a major risk factor for periodontal diseases, delayed wound healing, tooth loss, oral mucosal abnormalities and mouth cancer.[4-7] Every young person prevented from taking up smoking is potentially spared decades of avoidable oral disease and treatment needs.

Equally important are the provisions relating to vaping and nicotine products. While vaping has often been positioned as a smoking cessation aid for adults, the rapid rise in youth vaping has raised serious concerns among healthcare professionals. The Act seeks to protect children and young people by banning advertising and sponsorship of vapes and nicotine products, while also granting powers to regulate packaging, flavours and product displays.

For dental teams, these measures are particularly significant. Increasing numbers of young patients report vaping, often perceiving it as harmless. Yet emerging evidence suggests vaping may contribute to oral health problems, including dry mouth, irritation of oral tissues, increased plaque accumulation and changes to the oral microbiome.[8-9] While research continues to develop, the precautionary approach adopted by the legislation reflects a growing recognition that nicotine addiction in any form carries risks, particularly for developing adolescents.

The Act also strengthens enforcement mechanisms. New powers will enable Trading Standards to issue fixed penalty notices for underage sales and other offences, while provisions for a retail licensing scheme for tobacco, vape and nicotine products could improve accountability across the supply chain. Effective enforcement is essential if legislation is to translate into meaningful public health gains.

Dental hygienists and dental therapists are uniquely placed to support the aims of the Act. Every patient interaction presents an opportunity to discuss tobacco use, vaping and nicotine dependence. Through preventive advice, brief interventions and signposting to smoking cessation services, we can play a pivotal role in reducing nicotine addiction and supporting healthier lifestyles.

The government's commitment to investing in expanded smoking cessation services is therefore especially welcome. Legislative change alone cannot eliminate tobacco-related harm; it must be accompanied by accessible support for those who wish to quit. The combination of prevention, regulation, enforcement and cessation support offers the strongest chance yet of creating lasting change.

As further regulations and implementation guidance are developed, we should continue to advocate for evidence-based prevention strategies and remain engaged in public health discussions. The Tobacco and Vapes Act is more than a piece of legislation; it is an investment in the health of future generations. For oral health professionals committed to prevention, it marks an important step towards a future where fewer people experience the devastating effects of tobacco and nicotine addiction, and where children and young people can grow up healthier, free from the burden of preventable disease.

Heather

Heather Lewis

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FROM THE President

BY RHIANNON JONES

I hope you are enjoying the summer and that have planned a well-deserved break from your varied roles. I had a milestone birthday in June and was able to enjoy some rest and a good hiking holiday. It is so important that we take time out from our work to properly rest and recharge. Our jobs are very demanding; from time pressures, financial pressures, maintaining clinical skills and CPD to fitting in a family and social life too. No one teaches us effective time management at university and we can feel the pressure to see as many patients as possible, and work maximum hours, often to our own detriment.

Podcast

There are two podcast episodes where these issues are covered and I urge you to listen. 'Beating Burnout' and 'The Whole Patient Approach' focus on us and how we can look after ourselves. As your president, I admit that I have struggled to manage sometimes and I have learned that having a supportive and caring team around you makes the difference between breaking or taking a break. I have to thank the people I work with in the BSDHT for their support through some challenging personal issues and the challenges we currently face within the Society.

Recruitment

I am pleased to report that we are doing well with our recruitment and by the time of printing, we expect to have received some recommendations from the Financial Review Group (FRG). Having a new head office team is exciting and a great opportunity to look at our current structure, identify areas for growth and work towards a sustainable future.

OHC 2026

The preparation for the Oral Health Conference is going well and we encourage you to look at the programme and book your place as we don't want to turn people away from such an exciting and well-planned event. ICC Wales is a great resort and I urge you to consider looking at the additional options of the spa and various restaurants. They make a great effort to decorate it for Christmas too. Grinches be warned!

Financial Review Group

Since my last contact, you will have received a letter regarding the FRG and the work they are doing to support Executive and Council to ensure a robust financial structure for the future. The team will also look at current contracts, internal governance and make recommendations. The Society is yours. You have a right to decide what happens within the organisation and a voice that we want to hear. Please use the route of your Regional Council Representative (email in back of journal) and let us know if you can identify areas for growth and development. We are also keen to hear of any concerns you may have. Please be assured that we are working tirelessly to strengthen and build a Society for the future. We really want to hear from you.

International Symposium Milan

Simone and I are travelling to the International Symposium in Dental Hygiene in July and look forward to representing you all at an international level. I co-chair the membership group and was thrilled to see a motion passed at the last IFDH House of Delegates meeting at ISDH where it was agreed that dental therapists, and therapy organisations, could now be members. I find this part of the role very rewarding and, in particular, sharing the knowledge we have gained in the UK with our neighbours who still do not have professional autonomy in their country.

GDC

Don't forget the July 31st deadline for your GDC registration. If you have any questions regarding the eCPD requirements, there is an excellent 'myth-busting' document written by the Dental Professionals Alliance (DPA) that answers most questions well. You will find this on the GDC website.

I know we are working through some challenging financial and structural issues at present but please be assured of our dedication and commitment to making this a great Society for our members. Your patience and support is so appreciated and never taken for granted.

OBITUARY

SUE LLOYD
1947-2025

It is with great sadness that we share news of Sue Lloyd, Past President of BDHA 1990-1992

Sue was born on 9th October 1947 and lived in Deptford, South East London. From a very tender age she wanted to have a career in dentistry, which she said was the result of a traumatic visit to the 'school dentist'!

Sue qualified at the Royal Dental Hospital (RDH) in 1975 as a dental hygienist and worked in private practice before training as a dental therapist at New Cross, qualifying in 1979. She held the position of senior tutor at the RDH School of Dental Hygiene, St George's Hospital, London for five years before being recruited as the dental health education adviser to Gibbs Oral Hygiene Service. Sue worked part time as a tutor at King's Dental Institute, London and was staff hygienist in the Primary Care Department, specialising in treating high risk patients. She ran her own small business in oral health promotion called Pearly Whites.

A member of BDHA since 1974, Sue was editor of *Dental Health* from 1980-1989 and BDHA president 1990-1992. She was an active member of several BDHA committees and was also an elected member of the Dental Auxiliaries Committee of the General Dental Council from 1983 -1996. She was a member of the Consultant Editorial Board of *Dental Health* and served on the editorial board of *Dental Practice* and *European Dentistry*. She was BDHA's representative to the British Dental Health Foundation and to the Institute of Health Education.

From 1990-1992 she was one of BDHA's UK directors/ delegate to the International Federation of Dental Hygienists. From 1992 to 1998 she served as secretary of IFDH and then was appointed administrator of IFDH until her retirement in 2003. Sue became an honorary life member of IFDH in 2004. At that time, the House of Delegates acknowledged her valuable contribution to the growth and development of the Federation.

In 1997 BDHA honoured her with the prestigious Dr Leatherman Award.

In her spare time, Sue was fond of reading, gardening and absorbing, "useless pieces of information". She absolutely adored all members of the feline family and all three of her cats were spoilt rotten. Sue also admitted to having an obsession with horoscopes!

As she and Bill approached retirement, and their move to the Lake District, Sue fondly reflected that she had achieved an enormous amount of job satisfaction in a caring profession as well as building a large network of professional colleagues and friends worldwide.

Past president and editor, Caroline Clitter reflects: "Sue took responsibility for the 'BDHA Newsletter' and made it into a journal. That basic format subsequent editors have built upon still stands.

Sue was generous with her time with me as I took over the reins as editor when she became the president of BDHA. Communication with other organisations flourished under her guidance and leadership. I will always remember her brilliant sense of humour!'

Past BDHA Administrator Ann Craddock reflects: "Sue was an excellent and well-respected president, always highly professional and very good at dealing with people on every level. She always treated everyone, with whom she came into contact, respectfully."

Sue is missed by all those who knew her. We send our condolences to her husband Bill Crothers.

BSDHT NORTH EAST SPRING MEETING

Date: Saturday 25th April 2026

Venue: The Marriott Hotel, York

Speakers: Professor St John Crean and Dr Tim Ives

The BSDHT North East Spring Meeting provided an excellent opportunity for delegates to come together, share knowledge, and engage in a day of high-quality clinical education.

We woke up in the lovely Marriott Hotel in York to beautiful sunshine rising over the racecourse — such a perfect start to an exciting day ahead.

After a visit to the stands of our colleagues in the dental trade, the programme began with our first speaker, **Tim Ives**.

Tim focused on **the link between nutrition, behaviour, and modern food environments,** particularly how changes since the 1940s have shaped what and how we eat.

Sugar is considered one of the most addictive substances globally and Tim discussed the impact of ultra-processed foods (UPFs) on health and behaviour. A key theme in his teaching was the *NOVA classification system*, where foods are categorised by level of processing, with UPFs being identified as particularly problematic due to their ability to encourage overeating and poor health outcomes.

Tim also explored the *constrained energy model,* suggesting that calorie intake and expenditure are influenced by biological regulation rather than simple willpower alone. If an ingredient is not typically found in a home kitchen, it is likely to be a processed product.

A strong message throughout Tim's work is that fat has historically been wrongly blamed for heart disease, and that added sugars may play a significant role. Healthier fat sources, such as olive oil rich in polyunsaturated fats, may help to reduce cardiovascular risk.

Behavioural and environmental factors are also central to his teaching. Fast food is often cheaper than healthy options, and food industry practices—such as the use of over 75 different names for sugar—can make it difficult for consumers to identify what they are eating.

Some practical dietary changes include:

- Focusing on whole foods
- Avoiding products with long ingredient lists (e.g., more than 5 ingredients)
- Swapping ultra-processed foods for whole food alternatives
- Following NHS guidance on daily sugar intake
- Stevia is a good sugar substitute and xylitol has potential oral health benefits.

A key health theme was chronic inflammation, linking it to factors such as sugar, smoking, alcohol, stress, and its effects on the body including gingival irritation.

Tim referenced a 28-day no sugar challenge, where participants (including healthcare professionals) reported such benefits as:

- Reduced brain fog
- Weight loss
- Improved anxiety levels

However, he also acknowledged common reasons for failure, including alcohol consumption and social pressure from friends and family.

Overall, Tim's message centred on the idea that modern food systems are engineered to encourage overconsumption, and that many health struggles related to diet are not purely individual failings. As he put it: *"This isn't your fault — these foods are designed to make you buy more."*

The afternoon session, led by Professor **St John Crean,** explored the growing challenge of **managing medically complex patients in modern dental practice.**

With patients living longer and retaining more of their natural dentition, clinicians are increasingly required to navigate complex medical histories and medication regimes.

Professor Crean highlighted the importance of recognising key systemic conditions and understanding how they can influence dental care, particularly in relation to bleeding risk, healing and treatment planning.

A key message was the need to work in line with current guidance, such as SDCEP, and to ensure thorough medical history taking, risk assessment, and clear patient communication. The session also reinforced the importance of recognising signs that may indicate more serious underlying conditions and the need for appropriate referral.

Overall, the lecture provided a valuable reminder of the essential role dental professionals play in delivering safe, holistic care to an increasingly complex patient population.

The day was a great success, leaving delegates feeling informed, inspired, and confident in applying their learning to everyday practice. We hope to see you all again next year!

Cara Hills-Smith,
Regional Group Representative

Sarah Hunter,
North East Regional Group Secretary

ROBIN DAVIES DCP RESEARCH AWARDS 2026

The annual Colgate Robin Davies DCP Research Awards luncheon was held on Wednesday 13th May in London. Simone Ruzario, BSDHT President elect, and Heather Lewis, Editor BSDHT publications, were present to learn about the innovative research undertaken by dental hygienists, dental therapists and dental nurses that will be supported by these generous awards.

Michael Wheeler and Marina Harris, past presidents, Emma Bigham, from the BSDHT education team and Frances Robinson from the BSDHT DIB team were also present along with Susan Bissett and Bhupinder Dawett who support us on the BSDHT editorial Board.

The editor encouraged the recipients to submit to future publications of our journals and disseminate the results of their research to BSDHT members.

The successful applicants share their experiences:

Alicia Rutherford & Emma Wilkinson

Role: Dental Hygiene Therapist & Dental Nurse.

Employer: Hafren House Dental Practice.

Project Name: PEARL study (Perinatal and Early childhood Access to Reliable Lifelong oral health care).

Supervisor: Sarah Young.

I was first attracted to apply for the Robin Davies award because:

We've been involved in other studies throughout our time working at HHDP and thought it would be a great opportunity to further our research skills and learn how to build and present our own study in something we feel is important to oral health.

What will the Robin Davies award enable you to do?

This award will provide paid time and resources to design and deliver a study exploring how services and activities can be improved within perinatal care.

This work will help us understand how oral health activities can be safely delivered by non-dental professionals. It will identify barriers to providing oral health education and prevention and highlight existing gaps. The findings will support further research on integrating oral health into perinatal care for a primordial approach to caries prevention.

Chaitali Mehta Daud

Role: Coach mentor with Dental mentors UK, Dental Hygienist and Dental Therapist (qualified as a Dental Technician).

Employer: Fareham Road Surgery & Chequers Dental.

Project Name: Introduce and Evaluate "Preventative Coaching Mentoring" to Early Career Dental professionals.

Supervisor: Professor Chris Louca, alongside Professor David Radford, Dr Phil Gowers, Dr Mabel Saw, Dr Jessica Patel-Barnes and Dr Shilpa Chitnis.

I was first attracted to apply for the Robin Davies award because:

Professor Louca advised me to do so! I had first seen this award in a dental magazine when I was a dental hygiene and dental therapy student and since then I knew it is a very prestigious award to be affiliated with, as it encourages DCP's to get into the field of research. Never in my wildest of dreams thought I would apply for this award and actually my research project got selected for it.

What will the Robin Davies award enable you to do?

Firstly I am so grateful to receive this award. It just feels like a turning point for me, as it will help me bridge the gap between my dreams and my reality by alleviating some of the financial burdens allowing me to fully focus on my passion and make a tangible impact through this project.

■ **The winners**

The BSDHT Team

Avril Ware

Role: Clinical Tutor in Dental Hygiene and Dental Therapy.

Employer: University of Sheffield.

Project Name: Improving the implementation of Evidence- Based Prevention Guidance in a Student Clinical Teaching Environment.

Supervisor: Zoe Marshman.

I was first attracted to apply for the Robin Davies award because:

My application follows a University of Sheffield clinical audit revealing inconsistent student compliance with DBOH guidelines on caries and alcohol advice. Researching this implementation gap is vital, as prevention is a fundamental pillar of dental health. This project aligns with the Robin Davies Award's core values and criteria.

What will the Robin Davies award enable you to do?

This award will facilitate research into student perspectives on clinical guidelines, enabling collaboration with other dental schools. By identifying implementation barriers, we can refine our teaching strategies to ensure future dental professionals effectively prioritise preventative care in their clinical practice.

Charlotte Wake

Role: Dental Hygienists and Therapist, Visiting Lecturer at the University of Bedfordshire and PhD Candidate.

Employer: I am a self-employed DCP and self-funded PhD student.

Project Name: Using a collaborative approach to create a mentorship model for use in UK Dental Practice.

Supervisor: Associate Professor Dr Hoda Wassif & Professor Dr Yannis Pappas.

I was first attracted to apply for the Robin Davies award because:

It is such a prestigious award and solely supports the work of DCP's. As an under-represented part of the dental community, it is important to undertake research involving this population. It was a clear application process, and it encourages equality and inclusivity in our profession.

What will the Robin Davies award enable you to do?

This award lifts the financial pressures of undertaking research and makes this a viable career pathway. This funding will cover advertising and data collection software costs and allow for attendance at conferences to share the findings. This funding impacts the success of this project; I am grateful as an awardee.

Amanda Bloomfield-Gallie

Role: Doctoral Researcher at the University of Lincoln.

Employer: University of Lincoln, Lincoln Institute of Rural and Coastal Health.

Project Name: Active research- Investigating the working practices of non-dental health and social care professionals in the delivery of oral health.

Supervisor: Prof Mark Gussy.

I was first attracted to apply for the Robin Davies award because:

My MSc supervisor encouraged me to apply for an award. Robin himself and the wider family of Robin Davies had created a unique research legacy and the opportunity to help broaden participation in research among dental care professionals. As a DCP, I want to help disseminate the message that research in practice is achievable and that there is support and funding for small projects to increase our body of work. Getting an award and documenting my journey on social media helps draw attention to these aims. Robin taught me prevention and public health needs as a hygiene student in Manchester, and I also wanted to honour that.

What will the Robin Davies award enable you to do?

My first award has helped me to grow and has enabled me to complete my first research project, disseminate my findings at an international conference and a UK conference, and has provided additional funding for IT equipment, gifts of thanks, travel, and professional membership fees. The award has also given me experience in grant writing and networking within the research community.

My second award will enable me to have some extra time to conduct my focus group research, complete the write-up, and disseminate my work at an international conference. I received my ethical clearance for the project on Friday, 1st May, so recruitment can now begin and the research can take shape.

GDC CONSULTS ON NEW PROFESSIONALISM FRAMEWORK

The General Dental Council has launched a consultation on proposals to replace the Standards for the Dental Team with a new Framework for Professionalism.

The Framework for Professionalism will make a major contribution to the delivery of the GDC's 2026-2028 strategy, particularly its first objective to support dental professionals to provide safe and effective care for their patients. It would be one of the primary means by which that commitment is being put into practice.

Based on extensive research and stakeholder engagement, the current Standards document, introduced in 2013 and known as the 'silver book', was considered to be overly prescriptive, potentially limiting dental professionals' ability to use their judgement in real-world clinical situations. Designed to make it easier for dental professionals to apply professional judgement confidently in practice, the proposed framework aims to fix that.

The new approach replaces the Standards for the Dental Team with four Principles of Professionalism, supported by expectations, statutory professional guidance, and practical resources such as case studies, blogs and videos. Unlike the current model, the supporting material will support dental professionals to apply the framework to practice and can be updated quickly to respond to changing needs.

The GDC is clear that the proposals are not about changing the expectations on dental professionals to ensure patient safety and public confidence in the professions. The aim is to make it easier to apply professional judgement confidently in practice, in patients' best interests.

The Framework has been developed through research, testing and engagement with dental professionals, patients, professional associations, educators and indemnifiers. Legal and operational testing has also been carried out to confirm it would align with existing Fitness to Practise processes.

If approved, the GDC will work with stakeholders to develop supporting material to help dental professionals understand the new framework and apply it in day-to-day practice. Responses to the consultation will play a central role in shaping the final model.

The GDC will host engagement sessions for dental professionals and stakeholder organisations throughout the consultation period.

The **consultation is available on the GDC's website** in English and Welsh as an online survey, with downloadable versions for those who prefer to respond by e-mail or post. The consultation is open to dental professionals, patients and the wider public across the UK, and runs until **31 August 2026.**

DENTAL THERAPIST ROLES IN GENERAL ANAESTHETIC SETTINGS

GDC. Dental Therapist Roles in General Anaesthetic Settings. Available at **https://www.gdc-uk.org/standards-guidance/standards-and-guidance/gdc-guidance-for-dental-professionals/dental-therapist-roles-in-general-anaesthetic-settings**

GDC PUBLISHES MOST DETAILED FITNESS TO PRACTISE REPORT TO DATE

For the first time, the report covers all four stages of the fitness to practise process: initial assessment, assessment, case examiners, and hearings. It includes comparison data from previous years and breaks down cases by informant type, country, registrant type, sex, time on the register, region of qualification, and ethnicity.

Key findings at a glance

The GDC received 1,766 concerns in 2025, a 26% rise on the previous year. Of every 100 cases received, on average 81 progressed to assessment, 34 to case examiners, and 15 to a Practice Committee hearing.

The regulator completed 1,293 assessments in 2025, almost identical to the 1,294 completed in 2024, and held 110 Practice Committee hearings, a 50% increase on the 73 held in 2024. It removed 18 dental professionals from the register, the same number as in 2024, representing 0.01% of all registered dental professionals.

In 2025, the GDC closed 19% of new concerns at the initial assessment stage, more than at any point in the previous four years.

Completion times fall to five-year low

The assessment caseload rose by 35% to 761 open cases by year end, a direct result of the surge in concerns received. The number of case examiner decisions rose by 9% on 2024, yet the GDC still reduced the time it took to complete cases at every stage of the FtP process.

The average time to complete the assessment stage increased from 76 working weeks in 2024 to 78 in 2025. However, the average time from assessment decision to final case examiner decision dropped from 50 working weeks to 36. The time from final case examiner decision to an initial Practice Committee hearing dropped from 81 working weeks to 57, its lowest in five years.

A streamlined approach for single patient clinical concerns has almost halved the time to complete the assessment stage for these cases, from 30 to 16 weeks. The average time from the decision to refer to an initial Interim Orders Committee hearing rose slightly, from 16 to 19 working days.

Sources and types of concerns

- Patients: remain the largest single source of concerns, (45%) of all concerns received in 2025, though that proportion dropped from 51% in 2024 despite the actual number of patient concerns rising by 86. Those acting in a public capacity, including employers and NHS bodies, raised 54 more concerns in 2025 than in 2024. Whistleblower referrals almost doubled, rising from 3% to 5% of all concerns received.
- Dentists: made up 77% of all concerns
- Dental care professionals: made up the remaining 23%.
- New registrants: concerns about dental professionals who had been on the register for less than five years grew from 19% in 2024 to 22% in 2025.

The proportion of concerns relating to UK-qualified dentists dropped below 60% for the first time, to 57.5%, reflecting the growing number of internationally qualified dentists joining the register. Concerns relating to EEA-qualified dentists increased by 36%, the sharpest rise of any group, while those relating to overseas-qualified dentists increased by 32% compared to 2024.

Interim Orders Committee

The GDC referred 149 registrants to the Interim Orders Committee in 2025, more than in any of the last three years. Of those, 70% resulted in an order being placed on the registrant's registration, up from 62% in 2024. Cases combining clinical and conduct issues were the most common type referred, with 83% resulting in an order.

Equality, Diversity and Inclusion

Asian or Asian British dentists make up 31% of the register but made up 36% of new concerns received in 2025.

Dentists who identified as White make up 46% of the register and made up 35% of new concerns. Since 2022, the proportion of assessment stage cases closed for dentists who identified as White dropped from 42% to 35%, while the proportion closed for dentists who identified as Asian or Asian British increased from 26% to 36% over the same period.

The full report is available here: **https://www.gdc-uk.org/docs/default-source/reports-and-publications/fitness-to-practise-statistical-report-2025---accessible.pdf**

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The NIHR-supported incubator aims to build capacity and develop research careers in oral health research, with an emphasis on informing policy across the UK.

The steering group is currently investigating barriers and enablers into oral health professionals building a research career. The team is keen to talk to dental hygienists and dental therapists who have either started a career in research, are established in research or who have tried to take part/lead research but been unsuccessful.

For more information:
https://sheffield.ac.uk/dentalschool/research/themes/transforming-oral-health/incubator

Expression of interest form:
https://docs.google.com/forms/d/e/1FAIpQLSdmYf7yqvq3unCPNq4cCSxXfLs-JIPPiPH9DbySP4qIZNS_XQ/viewform?pli=1

IMAGE COURTESY OF PIQSELS

READERS FORUM

A CALL TO ACTION!

An article in the February edition of Dentistry recently caught my eye. Written by a dental therapist it is entitled, Utilising dental nurses in hygiene work. **https://dentistry.co.uk/app/uploads/2026/02/DM_FEB_26.pdf**

I think the article makes some good points about the need for dental hygienists to work with nursing support. Perhaps it might be time to for the BSDHT to raise the issue once again...?

On a positive note, I think that the issue of nursing support is raised more frequently now, as there are many more dually qualified hygienists/therapists working in general practice. However, while these clinicians do seem to get support when carrying out dental therapy treatment this is not always available when they carry out dental hygiene treatment.

Furthermore, the GDC is currently requiring that the time a dental nurse can work without undertaking training be reduced from two years to one year. This of course could result in even less support for dental hygienists as, more often than not, it is the most recent and most junior member of the team who is allocated to assist us, assuming that we are lucky enough to get assistance in the first place.

I think BSDHT with the valuable help of *Dental Health* has achieved some good outcomes recently especially with some issues that were 'hanging' and a long time in coming to fruition.

I continue to be impressed by *Dental Health*; I think it is a great journal and of value to BSDHT members as well as being a very good example of a highly professional journal.

Thank you so much for all your efforts on behalf of the profession and BSDHT members.

Rosemarie Khan OBE,
Past President 1984-1986

Congratulations on the Editorial in the March issue of Dental Health: A system on the brink – dental hygienists and therapists as agents of change.

I believe that the President and President-elect were aiming to meet the Secretary of State for Health, Wes Streeting. I eagerly await an update.

Before the election it was said that newly qualified dentists would be required to work for two years undertaking NHS work. I suggest that the Society holds them to account! As per your editorial: it is all too true. The government should be advising the BDA to encourage their members to widely and routinely utilise dental therapists' skill sets. I was employed by a dentist because I was a dental therapist as well as a dental hygienist. However, the reality was that he referred very little work to me and when he did it was beyond my scope e.g., a cavity that needed pins. Dental therapists absolutely know their limitations but also know their strengths. It is still thought that we treat only children. NOT the case at all which should be empathised to everyone! Dentists and politicians alike.

I also think that your comments about Direct Access should be lobbied for by the members and that your conclusion is so apt. Let us hope that it reaches a wide audience (and is acted upon). We live in hope!

Caroline Clitter,
Past President 2000-2002

Thank you to the BSDHT for the work they continue to undertake in maintaining high standards for our profession. The effort that was put into ensuring the GDC brings an end to recruiting overseas dentists as dental therapists and hygienists has made a great difference: important in light of the number of dentists from other parts of the world migrating to the UK to work.

I would like to express my concern about dental hygienists and therapists who are gaining qualifications from Eastern Europe, and other European countries, within a year of studying part time at weekends and being allowed to register with the GDC.

In this country we have to go through years of rigorous education to finally qualify for registration with the GDC. It undermines our profession, and the years of training, if our colleagues from overseas can study for a year and then be entered on the register.

I have recently met two dental nurses who are training abroad at weekends, once a month, and will qualify within a year.

Please kindly advise how the BSDHT intends to address this.

Koleh Agatha Rees

BY **DIANE ROCHFORD**

BSDHT REGIONAL GROUPS
THE KEY TO BSDHT'S LONGEVITY AND SUCCESS

BSDHT has twelve regional groups: Eastern; London; Midlands; North East; North West; Northern Ireland; Scotland (Scottish); South East; South West & South Wales; South West Peninsula; Southern; and Thames Valley. When you become a member of the society you are directed to a regional group, which is generally the region in which you live.

Each regional group has a committee of elected members, who volunteer their time and skills. The primary role of the committee is to arrange two study days during the year, in Spring and Autumn. Each year, at the regional group AGM, members are elected to the five committee roles – chair, secretary, treasurer, trade liaison officer and regional group representative on Council.

The study days have been, and continue to be, an opportunity for members to expand their knowledge and skills, gain valuable CPD, connect with other members and often forge lasting friendships.

Our trade partners, support the study days by sponsoring speakers, and their local representatives attend to introduce themselves, share information and provide samples of new and established products for you to share with your patients.

Study days, attract a variety of different speakers and topics that are relevant to daily clinical practice for dental hygienists and dental therapists at all stages of their careers. Speakers range from those who are well established within the profession to those who are emerging as the next generation of educators, all sharing their knowledge and experiences in a variety of ways, including interactive lectures and hands-on workshops.

Alongside, the education and local connections, the study days provide an insight to the Society as a whole, from the structure of BSDHT to the various teams and working groups and more broadly the role the Society plays in the wider dental profession.

But, why are BSDHT Regional Groups so important?

A regional group meeting is where it all began for many members of the BSDHT Council and Executive. The members, professionalism and activity, of the groups contribute to the succession and longevity of BSDHT.

As a past president of BSDHT, regional group study days have been a significant part of my career, firstly when I attended the London and North West study days as a delegate, and then later when I was invited to present at many other groups' study days. I was also elected North West Regional Group Representative on Council, a role I held for four years and thoroughly enjoyed, before I was asked to consider standing as president elect, having previously being elected on to the executive team. My experience is just one of countless Council and Executive members who would gladly tell you about their progression.

Looking head

Online learning and an abundance of free webinars have changed how we learn and connect with others. These and other changes have impacted on members' decisions to attend study days, creating more challenges for the regional group committees.

President elect Simone Ruzario is very much aware of the importance of the regional groups and the challenges the committees are facing. With this in mind, Simone has arranged a series of online meetings with each of the committees to allow them time and space to offer ideas and solutions to these challenges. I have had the pleasure of joining Simone and the committees to act as a liaison and offer support as they plan and prepare for their study days.

Our collective goal is to attract more members to attend study days. There is real value in face-to-face learning. We hope to inspire some of you to take on an active role within your regional group - a wonderful opportunity to learn and develop new skills and build a supportive network.

There is further work to be done and along with Simone, I look forward to seeing what we can achieve.

The Regional Groups really are key to the success of BSDHT.

Author: Diane is a Past President of BSDHT and currently a member of the BSDHT Education Group.

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We are looking forward to welcoming many of you this November as we take the OHC back to Wales for OHC 2026 - illuminating smiles, inspiring change, impacting communities - to explore together how oral health professionals can transform communities and make lasting impact.

The full conference programme is available as an insert to this copy of the journal – take a look to see how you could benefit from a programme that is packed with sessions designed to enhance and elevate your clinical practice, whilst providing two days of quality CPD.

"It has been a privilege to work with the team on this year's OHC programme. We have listened carefully to feedback from previous delegates and created a programme that reflects the topics, challenges and opportunities that matter most to dental hygienists and dental therapists today.

We have an outstanding line-up of speakers who will share their expertise, insights and practical knowledge over the two days.

I encourage you to block out the dates in your diary, take advantage of the early-bird rates and join us for what I hope will be an inspiring and valuable conference experience."

Simone Ruzario,
President Elect, BSDHT

11 CPD hours and an expert panel of speakers

This year's OHC will offer up to 11 hours of CPD and will be delivered by some of the best speakers in the field, including:

- Addressing health inequalities for children and young people with disabilities in the UK - Dr Urshla Devalia, Consultant Paediatric Dentist
- The myths and facts of prescribing and interpreting radiographs for the dental hygienist and the dental therapist - Dr Jimmy Makdissi, Consultant Dental and Maxillofacial Radiologist and Senior Clinical Lecturer
- Minimally invasive and patient-centred management of dentine hypersensitivity - Professor Aylin Baysan, Professor in Cariology in Minimally Invasive (MI) Dentistry
- Implants - hands-on workshop - Dr Claire McCarthy, Clinical Research Fellow and Clinical Teacher Periodontology
- Gingivitis guidelines - Dr Jeanie Suvan, Clinical Lecturer
- Comfortably numb - an update on local anaesthesia - Professor Tara Renton, OBE, Emeritus Professor Oral Surgery
- Clinical imaging in periodontics - Dr Jumoke Adeyemi, Senior Clinical Lecturer and Honorary Consultant in Periodontology
- Holes and pockets - oral health perspectives from The Two Profs - Professor Iain Chapple, Clinical Professor of Periodontology, and Professor Avijit Banerjee, Professor of Cariology & Operative Dentistry

SAVE 15% until 15th September and pay in instalments

Submit your work to the annual poster competition

You could also feature your own work at the conference. The BSDHT is accepting submissions of abstracts to be considered for the annual poster competition. Prizes for best posters will be awarded at the conference and successful abstracts will be presented in a poster display onsite. Look out for details soon at bsdht.org.uk/ohc-2026.

Come together as a profession

CPD is just one aspect of the OHC – the exhibition, networking, and the social aspects also make it the must-attend event for the profession. **BSDHT President, Rhiannon Jones** tells us why you should attend:

"The OHC returns this year to my homeland of Wales. The ICC is close to the Severn Bridges and is located at the impressive Celtic Manor Resort. Arrive and leave your car and cares behind for the weekend. There are a range of hotels onsite and an excellent spa should you wish to relax after a day of learning. You will be surrounded by beautiful countryside and no doubt a variety of Welsh weather to sample.

Please come and let us inspire you, educate you and let's learn together for the best interest of the profession and the patients we care for."

Save 15% until 15 September and pay in instalments

Registration is open and early-bird fees are available until **15 September 2026**. Book your place at: **bsdht.org.uk/ohc-2026.**

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PROFESSIONAL
ORAL HEALTH

BY **GYAN KAUR RAJA**

EDUCATIONAL RESOURCE FOR PATIENTS

My poster focuses on oral health risks in athletes and how these can be prevented, from a dental student's perspective. This topic stems directly from my dissertation, which explored how the dental team can effectively manage dental erosion and caries associated with sports drink consumption in athletes. As part of disseminating my findings, I wanted to translate the evidence into a clear, engaging visual resource that could be easily understood by patients and the wider public.

The idea developed from recognising a gap between knowledge and awareness. While evidence shows athletes may be at increased risk of dental erosion, many patients are unaware of the impact of behaviours such as frequent sports drink consumption and sip-based hydration. This contrast inspired me to create a poster that not only highlights the risks but also provides practical, preventive advice.

When designing the poster, I considered what a viewer could realistically take away in a short amount of time. This led to a simple, structured layout with three key sections: why athletes are at greater risk; research insight; and how athletes can protect their teeth. Presenting information in concise, clear statements ensures it is accessible without overwhelming the reader.

The poster highlights key risk factors including: frequent sports drink use; prolonged acid exposure through sip-based hydration; high training volumes; and reduced saliva during exercise. It also includes a research insight demonstrating that dental erosion prevalence in athletes can range from 19–55%, reinforcing the significance of the issue.

Prevention is a central focus, reflecting the role of the dental team. Advice such as: using fluoride toothpaste; avoiding rinsing after brushing; delaying brushing after acidic drinks; limiting sports drink frequency; and attending regular risk-based dental screenings, provides patients with clear, actionable steps.

Overall, this poster aims to bridge the gap between research and practice. By disseminating my dissertation findings in a visual and accessible format, I hope to increase awareness, support behaviour change, and reinforce the role of dental professionals in preventive care.

Author: Gyan is a final year dental hygiene and therapy student at the University of Portsmouth. She is passionate about the relationship between oral health and athletic performance, and the prevention of oral disease in athletes.

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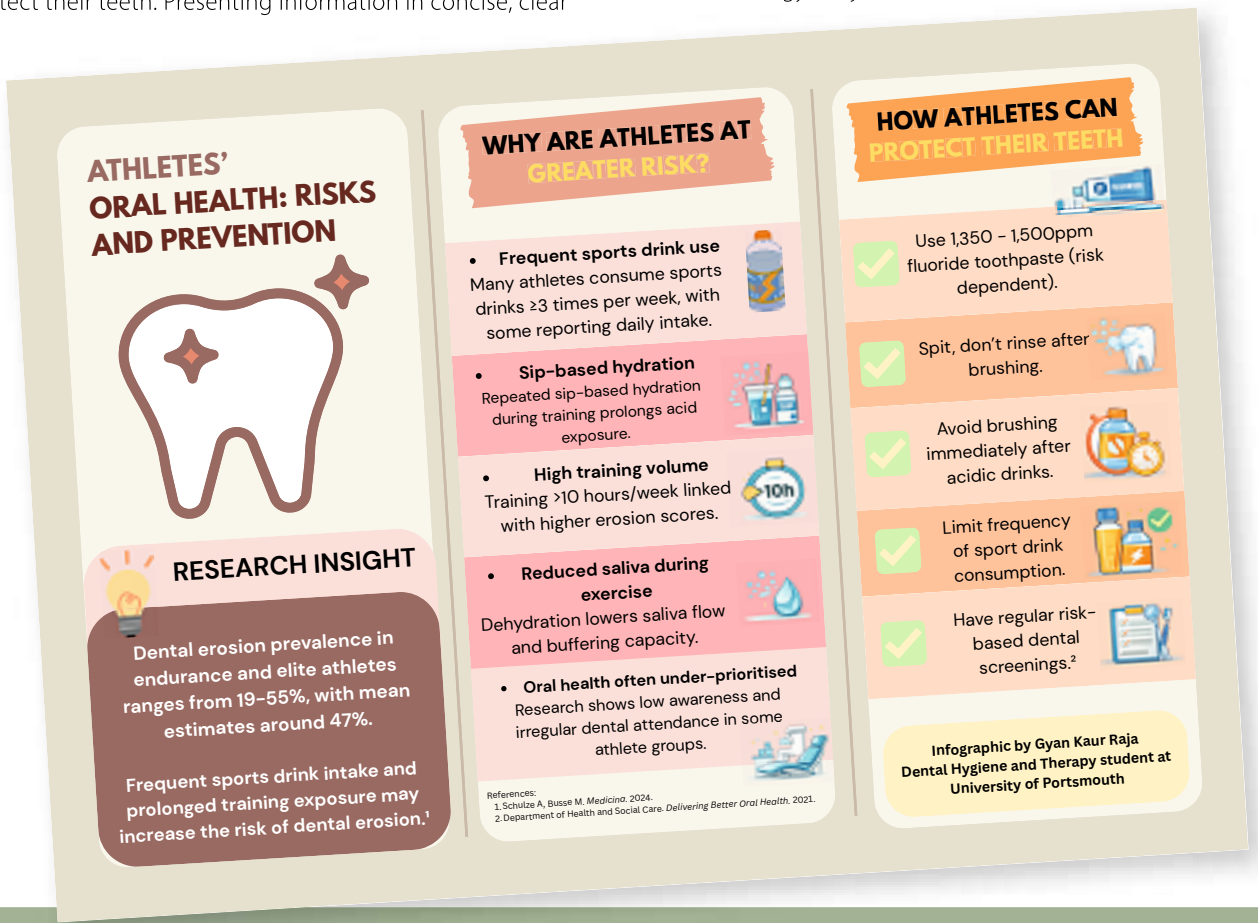

BY **MOLLY HUME**

SUPPORTING ADULT PATIENTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

As dental health professionals, we meet patients from all walks of life, each of whom presents with their own challenges, routines and priorities. Over time, I have supported individuals with complex medical histories, anxious or disengaged patients, and some living in difficult circumstances. These experiences have shaped how I approach initiating patient behaviour change. Recently, one particular patient made me pause and reflect more deeply on my practice.

An adult patient with Attention Deficit Hyperactivity Disorder (ADHD) presented for treatment. They had chosen not to take medication for their condition. They were honest about their struggles, especially when it came to maintaining a consistent oral hygiene routine. Despite understanding the importance of brushing twice daily and cleaning interdentally, they found it difficult to remember or stay focused long enough to follow through. I realised quite quickly that this was not about motivation or lack of knowledge - it involved something deeper.

After that appointment, I spent some time learning more about ADHD. I wanted to move beyond a surface level understanding so I could better support patients like this in a meaningful way. ADHD affects around 3-4% of adults in the UK and can impact memory, organisation, and the ability to form consistent routines. Reflecting on this, I began to recognise how easily our standard oral health advice, something that may seem simple to us, can feel overwhelming or unrealistic for some patients.

At the next visit, I approached things differently. Instead of focusing on what the patient 'should' be doing, we worked together to find what might realistically fit into their daily life. We talked about using visual prompts, like notes on the bathroom mirror, to act as immediate reminders. We also discussed linking toothbrushing to an existing habit, helping to reduce the reliance on memory alone. I found myself shifting my focus from perfection to progress. Rather than introducing multiple changes at once, we prioritised building one small, consistent habit. Once that felt manageable, we would then look at gradually introducing interdental cleaning. This felt more achievable for the patient and, importantly, less overwhelming.

What stood out most to me from this experience was the importance of truly listening. As clinicians, it can be easy to fall into the routine of giving advice, but real impact often comes from understanding the person in front of you. It reminded me that our role is not to diagnose or label, but to support, adapt and meet patients where they are.

This experience also challenged me to reflect on my own learning. There will always be moments in practice where we feel unsure or out of our depth, but those are often the moments that lead to the most growth. Taking the time to learn, reflect and adapt is what allows us to continue providing compassionate, patient-centred care.

Looking back, it was not only my patient who benefited from the support I offered: I benefited too. It reminded me why I chose this profession. Prevention is not just about reducing disease it is about empowering people in a way that works for them. Sometimes the smallest changes, such as a note on a mirror, can make the biggest difference. If there is one thing that I have taken from this experience, it is that behaviour change does not come about by telling patients what to do. It comes from working with them, understanding their world, and helping them find a way forward that feels achievable. In doing so, we not only help our patients improve their oral health but, importantly, we earn their trust, build confidence and create a lasting impact.

Author: Molly is a final-year dental hygiene and therapy student at the University of Leeds.

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BY **HEATHER LEWIS**

NHS TO PRIVATE CONVERSION

WHAT THE DATA TELLS US, AND WHAT IT MEANS FOR YOUR TEAM

NHS dentistry is at one of the most consequential crossroads in its history. The pressures are not new - rising costs, punishing UDA targets, workforce gaps and a growing access crisis have been building for years - but 2026 has brought them to a point where many practices are no longer quietly wondering what comes next. They are actively deciding.

A BBC investigation published in March 2026 revealed that £900 million of NHS dental funding had been returned to government as clawback over two years - roughly one pound in every seven paid to NHS dentists.[1]

The British Dental Association described the situation as reflecting 'the perversity of the broken contract dentists are working within',[2] noting that the clawback was the result of chronic underfunding rather than a lack of demand.

Against this backdrop, NHS contract reforms in England took effect in April 2026 - adding further impetus to a conversation that many in the profession have been having for some time. And a major new report, published in May 2026, gives us the clearest data yet on how that conversation is translating into action.[3]

The scale of the shift

The State of NHS Conversion 2026, produced by Patient Plan Direct and drawing on 16 years of real conversion outcomes across hundreds of UK practices, found that 65% of practice principals are actively considering, planning or exploring NHS to private conversion in 2026.[3]

A separate finding reported that 63% of respondents said the current NHS landscape had made them more open to conversion or accelerated their thinking. Only 3% said it had strengthened their commitment to remaining within the NHS.[3]

These are not marginal figures. For BSDHT members working in NHS and mixed practices, the message is clear: this conversation is happening in a significant proportion of practices right now.

What the evidence shows about the process itself

One of the report's most important contributions is the data it provides on what conversion actually involves - as distinct from what practice owners fear it will involve.[3]

The biggest concern among practice principals considering conversion is financial risk, cited by 35% - not patient retention, which is the assumption most commonly made.[3]

On the question of viability, the report found that practices typically need to retain only around 40% of their active NHS patient base on a private plan for the model to be commercially sustainable - considerably lower than most anticipate.[3]

Timelines are also shorter than expected. Practices now reach their target plan patient numbers in an average of seven weeks - down from 11 weeks three years ago.[3]

Implications for the whole dental team

For dental hygienists, therapists and nurses, a practice conversion is not an abstract business decision. It changes the clinical environment, the patient base, the appointment structure and the daily working experience.

The evidence suggests that the transition period - managed well - can offer significant professional benefits. Private models typically provide longer appointment times, greater clinical autonomy and the opportunity to practise in ways that align more closely with professional values. Many team members report that the change, once completed, improves working conditions considerably.

What the research also makes clear is that the quality of communication throughout the process is critical - both to the practice team and to patients.[3]

For those working in practices where this conversation is beginning, asking questions early, seeking clarity on the timeline and what each stage will involve, and engaging with the process rather than waiting for decisions to be handed down, is likely to lead to better outcomes for everyone.

The full report is freely available and provides a useful, evidence-based resource for any dental professional navigating this landscape.[3]

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BY **CLAIRE BENNETT**

CONSTANT CONNECTION

Digital communication apps, such as the widely used WhatsApp, were designed to make communication easier, and in many dental practices they undoubtedly have.

WhatsApp enables faster team updates, rotas can be adjusted instantly, clinical queries can be answered quickly, and individuals often feel more connected throughout increasingly busy working weeks. However, I increasingly question whether dentistry has fully recognised the emotional impact WhatsApp culture is beginning to have within teams.

In many workplaces, WhatsApp is no longer simply a communication tool. It has quietly become part of the culture of the practice itself — shaping relationships, influencing atmosphere, and extending workplace dynamics far beyond the walls of the surgery. Work no longer ends when people physically leave the building: notifications continue late into the evening; conversations drift into weekends; team tensions can follow people home. Many professionals now remain psychologically connected to work almost all the time, even during personal time.

What makes WhatsApp particularly complicated is that it removes many of the things that help communication feel balanced and emotionally safe in real life: tone of voice, facial expression, body language, timing and context. The meaning in a message typed quickly may be interpreted very differently by somebody reading it late at night after an exhausting day.

Within high-pressure healthcare environments, that matters enormously. A rushed message can feel abrupt. A public disagreement can shift the atmosphere of an entire team. Silence within a group chat can feel loaded with meaning.

Even seemingly minor exchanges can alter workplace relationships the following day.

Unlike face-to-face conversations, digital communication also offers very little emotional closure. Historically, difficult workplace moments often ended when people left work. Now they can continue indefinitely through phones carried in pockets, bags and beside beds. Over time, that level of constant emotional accessibility becomes exhausting.

I also think WhatsApp has fundamentally changed professional boundaries within dentistry. Increasingly, personal and professional lives overlap within the same digital spaces. Colleagues become woven into each other's everyday lives far beyond clinical work itself. Whilst this can strengthen friendships and team cohesion, it can also make conflict feel far more personal, public and emotionally consuming when difficulties arise.

WhatsApp encourages immediacy rather than reflection

People often respond emotionally before processing properly. Frustrations are shared impulsively. Tense conversations happen publicly within groups rather than calmly and privately. In healthcare settings, where stress levels and emotional fatigue are already high, this can gradually create cultures of emotional overstimulation and hypervigilance that teams may not consciously recognise until relationships begin deteriorating.

There is also often an unspoken pressure within workplace WhatsApp groups to remain constantly engaged, available and responsive. Choosing not to reply can feel socially noticeable. Muting conversations can create guilt. Stepping back from communication may even be interpreted negatively by others, despite somebody simply trying to protect their own wellbeing.

Constant connection is not always healthy

As dental professionals, we rightly speak more openly about burnout, resilience, psychological safety and workplace wellbeing than ever before. Yet digital communication is still rarely included properly within those conversations, despite

IMAGE COURTESY OF PIQSELS

now playing such a significant role in daily professional life.

Healthy communication is not simply frequent communication. It also requires boundaries, emotional regulation, professionalism and respect for personal space. Not every frustration needs an immediate audience. Not every emotional reaction belongs in a group chat. Not every message requires an instant response.

I do not believe WhatsApp itself is the problem. In many ways, it has transformed teamwork positively within dentistry. But I do believe the profession is still learning how to use constant communication without allowing it to quietly erode emotional wellbeing, professional relationships and workplace culture underneath the surface.

Perhaps the real challenge for modern healthcare teams is not learning how to communicate more, but learning when to pause, when to step away, and when certain conversations are better held face-to-face rather than through a screen.

Because sometimes professionalism is not found in sending the message quickly. Sometimes it is found in recognising that not every thought, frustration or emotion needs to be communicated immediately at all.

Author: Claire has worked for almost 30 years in dentistry and qualified as dental therapist in 2020. she is passionate about prevention, patient care and supporting positive workplace cultures within the profession.

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INVITATION TO BECOME BSDHT

COUNCIL OBSERVERS

BSDHT

BSDHT Council would like to invite any interested BSDHT members to apply for the role of council observer.

It has been agreed that the work of the BSDHT Council would be more transparent to members if meetings were open to invited observers.

A number of members of the Society may attend full Council meetings purely as observers. Applicants will be accepted on a first come basis and no expenses will be paid.

Council will meet on Tuesday 28th July 7-9pm

ONLINE

To register your interest please email enquiries@bsdht.org.uk

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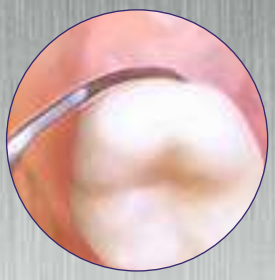

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OPINION

BY HAFEEZ AHMED

THE THERAPY IS IN THE FLOSSING NOT THE FLOSS

The most effective way to achieve and maintain a healthy mouth and smile is education and prevention – specifically primordial and primary prevention. Primordial prevention aims to stop people developing risk factors before the disease starts and primary prevention aims to correct risk factors that have developed before disease starts.

In respect to oral hygiene, the current recommendations state that the precise regime should be tailored to individuals based upon risk factors and their current oral health status. This includes brushing for two minutes twice daily supplemented with interdental cleaning.[1] It is also known that a lifestyle which incorporates interdental cleaning improves the fabric of a person's health profile.[2,3]

As a clinician, I am strongly biased towards prevention and flossing. I have always felt that floss is a winner - it embodies the perfect properties for implementing and realising primary prevention. The patient in figure 1 has followed my advice and uses tape floss alone for interdental cleaning. I prefer tape over string to avoid 'flossing clefts'.[4] My experience and knowledge of floss and the ways of using it has evolved over the years, to the point where I have innovated a 'flossing system' I am proud of. The purpose of this article is to encourage more people to embrace flossing.

Figure 1: **Healthy mouth and smile**

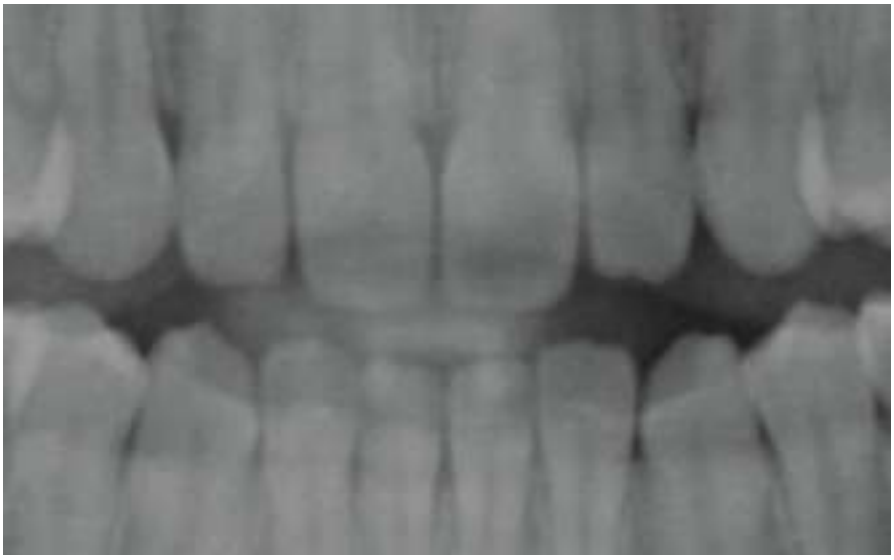

Figure 2: **Radiograph of smile in fig. 1**

Point to note – a differentiation

When primary prevention is not successful and bone is lost there is a shift to secondary and tertiary prevention. The aim of secondary prevention is to stop the disease recurring after successful treatment and the aim of tertiary prevention is to stop the complications of the disease, such as tooth loss. As a rule, when the bone loss is minimal, I coach patients to supplement flossing with a round ended toothpick at the specific site or sites. The patient in figures 3 and 4 uses tape

Figure 3: **Inflamed papillae between teeth 42 and 43**

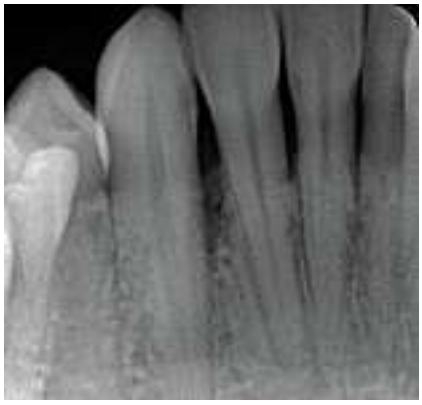

Figure 4: **Bone loss mesial tooth 43**

Figure 5: **Significant bone loss**

floss for interdental cleaning, this is supplemented with the use of a round ended toothpick on the mesial surface of tooth 43.

When the bone loss is significant (Fig. 5) I coach patients to further supplement flossing and toothpicks with interdental brushes.

Caution

Every oral hygiene aid has the potential to work well but they also have the potential to cause damage. Avoiding abrasion is one of the main reasons floss has remained at the top of my list. I am wary of a complete reliance on brushes as, in my experience, the bleeding often stops when the abrasion starts. The patient in figure 6 relied exclusively on interdental brushes because she has upper and lower fixed orthodontic retainers. 'Bleeding stops when abrasions starts' is the adage I associate with brushes, like the adage some of my colleagues associate with chlorhexidine mouthwash: 'if it isn't staining it probably isn't working.'[5]

Evidence

Evidence based healthcare is essential – the evidence provides an insight upon which we develop treatment strategies. It also stimulates innovation. But often, frustratingly, the studies lack the details for us to fully understand the precise circumstances faced by the patients they feature. It is also important to note that the studies only explain what has happened for some patients in some settings, and not all patients.

Over the last 10 years the evidence has been helpful and informative although it has also created some controversy around flossing.[6] The controversy is that some professionals, patients and journalists think the evidence is saying 'flossing is waste of time.'[7]

Figure 6: **Gingival recession and tooth surface abrasion**

To clarify, this is not true. There is not a conflict over the value of flossing. When done well, as part of an overall care regime, it is beneficial.[8-12] There are, however, known situations which hamper it, for example, residual calculus and imperfect margins on restorations. For me, the evidence confirmed what I have observed in some of my patients – but it is not true for them all. I can, however, understand the confusion: in some studies, at first glance, it is not always obvious if the evidence is about the value of flossing or if it is about how some patients are struggling to use current products to their benefit.

"Flossing cannot be recommended other than for sites of gingival and periodontal health, where inter-dental brushes (IDBs) will not pass through the interproximal area without trauma. Otherwise, IDBs are the device of choice for interproximal plaque removal." [13]

My approach works within the frame of this statement in that I recommend flossing for prevention. Where I differ is when prevention fails, I do not move directly to interdental brushes. I recommend a round ended toothpick as an adjunct to flossing in sites with minimal bone loss. I add interdental brushes to the regime for sites where the bone loss is significant.

"The working group opinion and overall consensus was that flossing could not be recommended where interdental spaces were large enough to accommodate interdental brushes, but it may have a role where spaces were too tight to accommodate interdental brushes." [14]

At first glance the above statement (and many like it) seem to say that flossing cannot be recommended. This is not what it says. It says that flossing cannot be recommended in sites where prevention has failed. Looking back at figure 5, my recommendation is to use dental floss in the healthy sites and to supplement the floss with round ended toothpicks in specific sites where minimal bone loss has occurred and to consider using interdental brushes in specific sites where the bone loss is more significant.

World Health Organisation

The World Health Organisation urged

oral health providers (in the resolution of its 74th Assembly) to focus more on a *"…health-centered preventive approach and less on a pathology-driven treatment approach."* [15]

To this end, flossing fits the realm of 'preventative approach' and inter-dental brushes fit the realm of 'pathology-driven treatment approach'.

Lifestyle

In my experience, when oral hygiene aids fail it has less to do with the aid itself and more to do with the patient's lifestyle – it is usually inadequate time dedicated to the task. Lifestyle covers belief, desire, motivation, attitude, ambition and these things influence a person's engagement in preventive measures (and bad habits). In a very small number of people the aids fail due to high genetic susceptibility.

A lifestyle which incorporates interdental cleaning improves the fabric of a person's health profile.[2,3] On the other hand, poor oral health and periodontal disease has been linked to 57 serious systemic conditions.[16] Science has not been able to show whether individuals who engage in interdental cleaning also engage in other healthy habits or if the interdental cleaning alone can convey such a benefit by reducing risks of periodontitis, tooth decay, and tooth loss.

It makes sense to me that the type of person who spends 8-10 minutes per evening on the intricacies of interdental cleaning is the same person to engage in other beneficial habits.

Thus, 'the therapy' is in the act of making the time to floss regularly. The therapy is taking place alongside the reduction in interdental plaque and the gingival inflammation. The therapy is in reflecting over the food debris that can easily be seen on the floss as it does its job. The therapy is in the confidence of fresh breath in the morning. The therapy is in the silence, the concentration, the discipline and in slowing yourself down to spend some moments in your own mind – alone. The planning, the concentration, the discipline, the distraction, the desire, the execution, all contribute to the therapy. Most of all, the therapy lies in the mindset (and the act) of taking personal responsibility for one's oral health.

Frustrations

It is hard enough to persuade patients to floss in the first place. It is also well recognised that they are generally resistant to change and need constant support and encouragement for it to happen. These are issues that are likely to persist. So, of course it is frustrating when additional doubt and confusion is wrongfully planted upon them. It makes prevention a more difficult proposition.

Another frustration is that some patients lie about using floss.[17] I am afraid, in my experience, practically everyone gives a fake answer. Usually, to avoid the cognitive dissonance of admitting to not having done something beneficial. In addition, trust in society is low and patients lie to protect themselves against unnecessary treatment and falsely elevated charges. The truth is a person's best attempt at it and cannot be measured by science.

As for the frustrations of sensational headlines in journalistic articles, unfortunately, criticising a small part of the process, like flossing, whilst not committing to the full preventative requirement is common (and lazy). Some people do not appreciate that dental flossing is not a skill one is born with, it needs to be learnt. This is essential for it to be effective. The training is usually provided by a dental therapist, a dental hygienist or a dental oral health educator.

Innovation

My interpretation and perception of the science have evolved over my career through experience, and continues to do so. My knowledge of floss and the ways of using it has evolved over the same time. In addition to this, I am privileged in that I spend, on average, 75 minutes with a single patient for simple supragingival PMPR including oral hygiene instructions.

As an undergraduate student when my teachers explained flossing to me, it made perfect sense. It became obvious in patients who flossed that the response was beneficial - but, watching other patients doing it explained why many studies have found otherwise. Back then, I coached my patients to take floss from a dispenser and to wrap it around their fingers to use it. Most of them found controlling its insertion between their teeth difficult. Reliance on fingers also made adapting the floss to the tooth surface difficult. After qualifying, I moved forward and coached my patients in a technique called 'loop flossing'.

The loop in Fig. 7 was made using Glide dental Tape taken from a traditional dispenser. I would make it chair side as part of the oral hygiene demonstration and then patients would make their own at home. It made flossing easier but was still heavily reliant on finger dexterity, plus we found that it takes 10 small knots for the overall knot to hold without slipping!

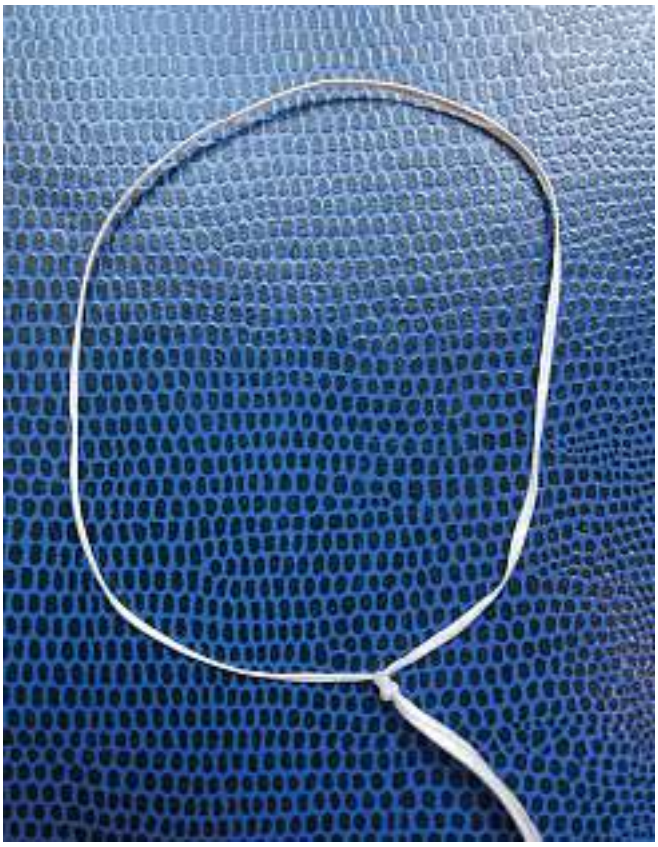

Figure 7: **A Loop made using Glide dental tape**

During the late 1990's single-use disposable floss picks became very popular. I tried them but did not like them. The handles bent easily, the floss lacked tension and I could not reach my posterior teeth with them. Thereafter, for a while, I recommended The Hummingbird, the powered flosser made by Oral-B but, suddenly, it was no longer available.

From about 2000 onwards, my preference shifted to a rigid handle the length of a toothbrush, like the one in figures 8 and 9 I could reach my molars, and it was reassuringly stiff.

In 2013, I made a video 'oral hygiene instructions with gum specialist Dr Hafeez Ahmed' and uploaded it to YouTube. The video is comprehensive and it includes the loading and use of the handle. **https://www.youtube.com/watch?v=NeTzFLjALXM&t=2s**

Most of my patients found it tricky to load the tape to the handle and once they did, it slowly unwound. They also found the arms on the handle fractured after only a small number of loadings.

The handle in figure 9 is what I am currently recommending to patients. I have taken what worked best and developed it into a system with a rigid long-lasting handle onto which a prefabricated tape loop can be loaded. It is ideal in-surgery for checking the smoothness of root surfaces after calculus removal – although sharp spicules reduce the lifespan of the loop.

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Figure 8: **Dental tape looped around a rigid handle**

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Figure 9: **A rigid handle the length of a toothbrush onto which a prefabricated loop of dental tape can be loaded creating the perfect tension.**

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A summary of this article will be on display at The International Symposium of Dental Hygiene in Milan Italy 2026 in the Innovation/Project section.

How often do you feel the floss loop should be replaced? To assist in the innovation: Scan the QR code to take the survey.

BY **SAKINA SYED**

UNDERSTANDING HOW TO **MANAGE PERI-IMPLANT DISEASE**

Dental implants have become the standard method for replacing missing teeth, in selected patients. However, inadequate monitoring and maintenance, combined with additional risk factors, can increase the likelihood of implant failure. Each time an implant is placed, there is a real risk of peri-implant complications developing.[1]

Working as part of a multidisciplinary team, across 20 surgeries, I am involved in all the different stages of implant placement and, subsequently, the management and maintenance of implants, in health and disease.

It was while working in a practice that I observed that clinicians managed patients' dental implants in a number of different ways.

This realisation prompted my colleague and I to conduct an audit[2] to assess how our fellow clinicians managed peri-implant health and disease in practice. The findings confirmed that there were great variations in how clinicians - dentists, specialists, dental hygienists and dental therapists - monitored and treated peri-implant disease.

Although the problem of peri-implantitis is generally understood by the profession, the depth of understanding and confidence to identify and treat patients with signs of peri-implant disease depends on experience, exposure, support and training.[3] There is no standardisation or set protocol in disease management, and when exactly to refer, but there are guidelines set by the British Society of Periodontology (BSP), Association for Dental Implantology (ADI) and the European Federation of Periodontology (EFP) that we can follow.

Some clinicians encounter uncertainties regarding the appropriate instruments for cleaning around implants; what types of toothbrushes (manual or electric) and which interdental aids are really effective. My oral hygiene advice and routines are customised for each patient, using only evidence-based products proven safe and effective thanks to rigorous scientific research. I do recommend an electric toothbrush, such as the Sonicare 7100, along with special small manual single brushes and either implant floss or interdental brushes. Water flossers like the Philips Power Flosser are especially effective for patients with multiple implants or bridges. They make plaque biofilm management simpler and less dependent on technique and are useful for cleaning around super structures and exposed threads or metal work.

Dental professionals should carefully consider the intricate bi-directional relationship of chronic infections and systemic diseases such as diabetes, heart disease, chronic respiratory disease, dementia and oral health, as it may increase the risks of peri-implantitis and periodontal diseases.[4] I believe overlooked factors, rather than new ones, can also contribute to disease progression and severity. Bruxism, soft tissue thickness phenotype, lack of professional hygiene maintenance, implant structure and design, change in medications and significant medical complications i.e., radiation, chemotherapy are also important factors to consider. This becomes particularly relevant when patients are managed through direct access, as you might not be involved with their care from the beginning of the implant process.

While most patients are aware that smoking is detrimental to their general health (lungs and heart), a significant number still do not really appreciate the fact that smoking and vaping can harm their teeth,

gums and overall oral health.[5] As a result, smoking still needs to be highlighted as a risk factor for peri-implantitis and implant failure.

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eCPD PAPER

A major change in NICE guidance puts endocarditis prevention back in the spotlight for all dental professionals

1½ Hours eCPD PAPER

AIM

To inform dental health professionals about the very important change in guidance on how patients at risk of infective endocarditis should be managed when undergoing dental care. In particular, the change from recommending against all use of antibiotic prophylaxis for endocarditis prevention to recommending it for all high-risk individuals undergoing extractions and oral surgery procedures and recommending it should be considered for all other dental procedures involving manipulation of the gingival or periapical region of the teeth.

LEARNING OBJECTIVES:

The author will:

1. Explain the background and reasons for the change in guidance.
2. Identify the types of patients who are at increased risk of endocarditis, for whom the guidance changes apply.
3. Describe the types of dental procedure for which antibiotic prophylaxis will need to be considered.
4. Explain the antibiotic prophylaxis regimens to use.
5. Identify the risks posed by different dental procedures to those at increased risk of endocarditis and the risks and benefits of antibiotic prophylaxis.

LEARNING OUTCOMES:

Having read this paper, the reader will be able to:

1. Identify patients at increased risk of infective endocarditis for whom antibiotic prophylaxis should be considered.
2. Identify those dental procedures that should be considered for antibiotic prophylaxis cover.
3. Discuss with individual patients the risk of infective endocarditis posed by different dental procedures and the potential risks and benefits of antibiotic prophylaxis.
4. For patients at increased risk of endocarditis, discuss other measures to reduce the likelihood of them developing infective endocarditis or of having a poor outcome should it occur.
5. Identify the most appropriate antibiotic prophylaxis regimen to prescribe.

Aligned with General Dental Council (GDC) development outcomes: *A&C*

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DEADLINE FOR SUBMISSIONS 31ST AUGUST 2026

KEY WORDS

Endocarditis, antibiotic prophylaxis, prevention, guidelines.

Background

IE is a serious infection of the heart, particularly the heart valves. Thirty percent of patients die within one year of diagnosis and survivors have serious long-term health problems.[1] Oral bacteria are implicated in 35-45% of IE cases.[2] Prior to 2008, UK guidelines recommended antibiotic prophylaxis (AP) before invasive dental procedures for all patients at increased IE-risk. In 2008, however, NICE made the highly controversial decision to recommend against all use of AP for IE prevention: *"Antibiotic prophylaxis against infective endocarditis is not recommended for people undergoing dental procedures."* The Chief Dental Officers (CDOs) wrote to all dentists telling them to follow the NICE guidance and pointing out that it was a condition of the NHS service agreements in England and Wales that they do so. Indemnity insurers also wrote to dentists telling them to follow the NICE guidance and informing them that if a patient was prescribed AP and subsequently developed an adverse reaction, their insurance would not cover them. Not surprisingly, compliance with the 2008 guidance to stop AP was very high.[3]

The UK was unique, however, in recommending against AP. All other major guideline committees world-wide recommended that individuals at high risk of IE (Table 1) should receive AP before at-risk dental procedures – any procedure involving manipulation of the gingival or periapical region of the teeth.[4,5] This included the European Society for Cardiology (ESC) guideline committee – who provide guidance for the rest of Europe,[4] and American Heart Association (AHA) guideline committees – who provide guidance for the whole of the Americas.[5]

Table 1: Individuals at high- and moderate-risk of infective endocarditis (IE)

High Risk Patients
Antibiotic prophylaxis is recommended in patients with:
• A previous episode of infective endocarditis • Surgically implanted prosthetic valves and with any material used for surgical cardiac valve repair • Transcatheter implanted aortic and pulmonary valve prostheses • Untreated cyanotic congenital heart disease (CHD) • CHD treated with surgery or transcatheter procedures with post-operative palliative shunts, conduits or other prostheses • After surgical repair, in the absence of residual defects or valve prostheses, antibiotic prophylaxis is recommended only for the first 6 months after the procedure • Ventricular assist devices
Antibiotic prophylaxis should be considered in patients with:
• Transcatheter mitral and tricuspid valve repair
Antibiotic prophylaxis may be considered in:
• Recipients of heart transplants
Moderate or Intermediate Risk Patients
Antibiotic prophylaxis is not recommended routinely* in patients with:
• Rheumatic heart disease • Non-rheumatic degenerative valve disease, e.g., mitral valve prolapse • Congenital valve abnormalities including bicuspid aortic valve disease • Hypertrophic cardiomyopathy • Cardiovascular implanted electronic devices (CIEDs) e.g. implanted pacemakers and defibrillators

Adapted from the 2nd Edition of the SDCEP implementation advice,[9] and the 2023 European Society for Cardiology (ESC) guidelines[4] for the management of infective endocarditis on which the SDCEP advice is based. *While not recommending AP routinely for moderate-risk individuals, AP may be considered for an individual patient when a cardiologist feels this is appropriate, e.g. complex cardiac risk factors, or comorbidities such as diabetes or immune suppression. Where there is uncertainty about a patient's risk status, the patient's cardiologist should be consulted.

In 2015, a study published in the Lancet showed that AP prescribing in England fell by nearly 90% following the NICE guidelines but that IE incidence had increased in parallel.[3] Following this NICE changed the wording of its guidance in 2016. It became: *"Antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures."* The addition of the word 'routinely', however, simply caused confusion. It seemed to imply that AP might be recommended non-routinely for some people and situations but provided no guidance as to what those situations and who those people were.

NICE guidelines do not apply in Scotland in the same way they do in the rest of the UK and most doctors in Scotland followed the ESC guidance instead of NICE. Although the CDO for Scotland had advised Scottish dentists to follow the NICE guidance in 2008, they were not contractually required to in the same way as colleagues in England and Wales. Hence, the ambiguity caused by the addition of the word 'routinely' to the NICE guidelines permitted the Scottish Dental Clinical Effectiveness Programme (SDCEP) to produce implementation advice for dentists based on the 2015 ESC guidance. Like the ESC guidance, it recommended that AP should be considered for all high-risk individuals undergoing at-risk dental procedures. There were some notable differences, however, between the SDCEP advice and ESC guidance. The 2018 SDCEP advice said that supragingival scale and polish and the basic periodontal exam were not at-risk procedures and did not therefore need consideration for AP. This was contrary to what all other international guideline committees said. Although SDCEP claimed NICE endorsement of their implementation advice, NICE did not make this clear in their own guidelines. Hence most dental professionals in England and Wales considered they were still contractually required to follow the NICE guidelines and not to prescribe AP.

Recent research, however, has demonstrated a clear association between at-risk invasive dental procedures and subsequent IE in high-risk individuals,[2,6] and several studies have now shown that in high-risk individuals AP significantly reduces the incidence of IE following these procedures. In addition, a recent Coroner's case,[7] and a successful negligence claim against a dentist, both of which involved high-risk patients who developed IE after at-risk dental procedures performed without AP cover, may have persuaded NICE to change the wording of its guidance. In November 2024 it was changed to: *"Antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures. For advice on antibiotic prophylaxis for people at high risk of infective endocarditis undergoing dental procedures, and for relevant patient information, see the Scottish Dental Clinical Effectiveness Programme's (SDCEP) implementation advice on antibiotic prophylaxis against infective endocarditis."*[8]

For the first time, NICE has acknowledged the existence of high-risk individuals who may benefit from AP. It has also, for the first time, recommended that all dental professionals should use the SDCEP implementation advice, not just those in Scotland. However, the 2018 SDCEP advice was out of date. So SDCEP committed to updating it, and the updated 2nd edition was published on the 24th March. It is available at: www.antibioticprophylaxis.sdcep.org.uk

Together, the updated NICE guidelines and SDCEP implementation advice have completely transformed UK guidance. We have gone from recommending against all AP in 2008, to recommending in 2026 that AP should be offered to all high-risk individuals undergoing extractions and oral surgery procedures and should be considered for all other at-risk procedures involving manipulation of the gingival or periapical region of the teeth (see Box 1).

Box 1 : Main recommendation

For patients at high-risk of IE, AP is recommended for extractions and oral surgery procedures and should be considered for all other at-risk dental procedures

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Patient's Cardiac Risk Status

The SDCEP advice has adopted the cardiac risk status definitions used by the ESC. Patients who are considered at high-risk of IE and for whom AP is recommended are shown in Table 1. Although AP is not recommended for patients at moderate risk of IE (Table 1), there may be some individual situations, particularly when there are comorbidities present, where a cardiologist may feel it is appropriate for a patient to receive AP. If a cardiologist considers a moderate risk patient should receive AP, they should be managed as if they are at high-risk. Where there is any doubt about a patient's risk status, the patient's cardiologist should be consulted.

Table 2: At-risk dental procedures where SDCEP recommend antibiotic prophylaxis (AP)

At-Risk Dental Procedures Where AP is Recommended
Extractions and oral surgery procedures including:
• Dental extractions • Incision and drainage of abscess • All oral surgical procedures • Periodontal and endodontic surgery • Placement of dental implants including temporary anchorage devices and mini-implants • Uncovering implants and implant components that are sub-mucosal • Oral biopsies*
At-Risk Dental Procedures Where AP Should be Considered
Other procedures that involve manipulation of the gingival or periapical region of the teeth including:
• Professional mechanical plaque removal (PMPR). This includes supra- and subgingival scaling • Full periodontal examinations (including pocket charting) • Basic periodontal examination (BPE) • Plaque and bleeding indices • Subgingival restorations including fixed prosthodontics • Placement of preformed metal crowns • Placement of subgingival rubber dam clamps and subgingival matrix bands • Placement and removal of orthodontic separators and bands • Endodontic treatment before apical stop has been achieved
Procedures for which AP is not recommended
• Infiltration or block local anaesthetic injections in non-infected soft tissues • Supragingival restorations • Removal of sutures • Radiographs • Placement or adjustment of removable orthodontic or prosthodontic appliances • Adjustment of fixed orthodontic appliances which does not involve placement or removal of orthodontic separators and bands • Following exfoliation of primary teeth • Following trauma to the lips or oral mucosa

Adapted from the 2nd Edition of the SDCEP implementation advice,[9] and the 2023 ESC guidelines[4] for the management of infective endocarditis on which the SDCEP advice is based. *Although not specifically mentioned by SDCEP, oral biopsies are defined as an oral surgical procedure by the ESC guidelines.

At-Risk Dental Procedures

Most guideline committees define at-risk dental procedures as all invasive dental procedures that involve manipulation of the gingival or periapical region of the teeth. SDCEP has recommended AP for all dental extractions and oral surgery procedures and recommended AP for all other at-risk dental procedures involving manipulation of the gingival or periapical region of a tooth. In addition, SDCEP has produced lists of examples of these procedures (Table 2).

Importantly, the new SDCEP advice makes clear that all scaling procedures - including supragingival scale and polish, and the basic periodontal exam are now considered at-risk dental procedures for which AP cover should be considered in high-risk patients (previously SDCEP had said these were not at-risk procedures).[9]

Obtaining Informed Consent

SDCEP stresses the importance of informed consent discussions with all patients at increased IE risk (moderate and high-risk). The risks posed by any dental procedures should be discussed along with the potential risks and benefits of AP and the results of these discussions recorded in the patient's clinical record. Table 3 provides information on the relative risk of developing IE after different at-risk dental procedures for different risk-categories of patient, and how that risk may be altered by AP.[10-12] Information is also provided on the risk of developing an adverse drug reaction following a single 3g oral dose of amoxicillin for AP purposes.[10-13] It should be noted that although there are no recorded deaths from adverse reactions to amoxicillin AP, 30% of IE patients die within 12 months of diagnosis.

Table 3: Risk levels to aid discussions with patients

Patient risk level	Procedure Type	Without AP Cover		With AP Cover	
		Approximate risk of IE	Equivalent to	Approximate risk of IE	Equivalent to
High-risk	Oral surgery	1 in 40	1 person in a single decker bus	1 in 500	1 person in 12 single decker buses
High-risk	Extractions	1 in 100	1 person in a double decker bus	1 in 1,000	1 person in 10 double decker buses
High-risk	Other at-risk dental procedures	1 in 1,000	1 person in the largest jumbo jet	1 in 3,333	1 person in 3.3 jumbo jets
Moderate-risk	All at-risk dental procedures	1 in 40,000	2 people in a nearly full Wembley stadium	1 in 50,000	2 people in a maximum capacity Wembley stadium
Low-risk	All at-risk dental procedures	1 in 333,000	1 person in a city the size of Bradford	1 in 333,000	1 person in a city the size of Bradford
The risk of an adverse drug reaction with amoxicillin AP in someone with no history of penicillin allergy					
All patients	-	-	-	1 in 50,000*	2 people in a maximum capacity Wembley stadium*

Notes: AP= antibiotic prophylaxis, IE = infective endocarditis. *Although there is a ~1 in 50,000 risk of an adverse reaction with amoxicillin AP (in those with no history of penicillin allergy), there are no recorded deaths. In contrast, 30% of IE cases die within 12 months of diagnosis.

Table 4: Oral antibiotic prophylaxis (AP) regimens recommended by SDCEP

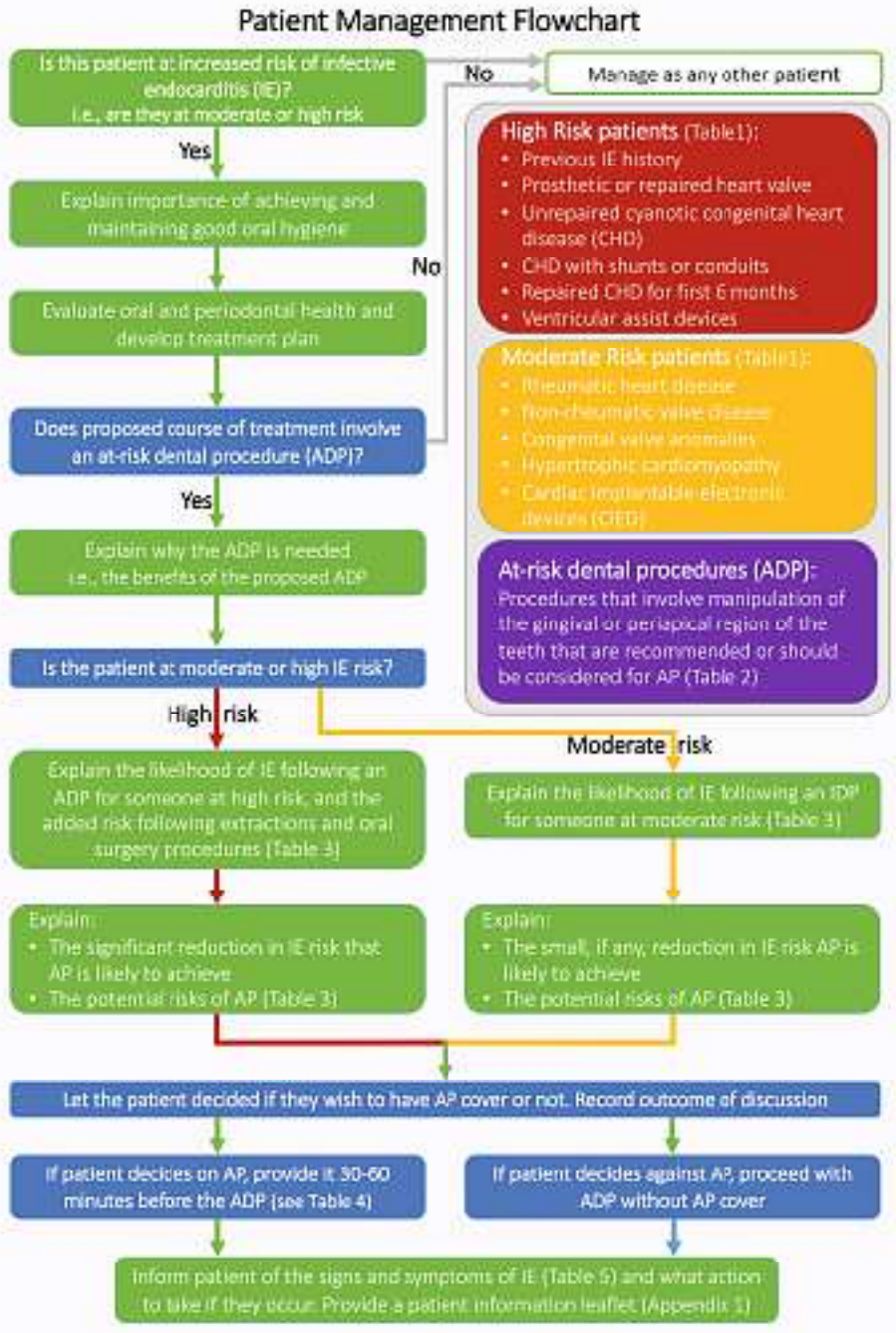
Oral AP Regimens for High-Risk Individuals Undergoing At-Risk Dental Procedures			
Situation	**Antibiotic**	**Single oral dose 30-60 minutes before procedure**	
		Adults	**Children**
No allergy to penicillin or ampicillin	Amoxicillin	2g (4 x 500mg capsules)	50mg/kg (maximum dose 2g)
		Or 3g (3g sachet of sugar free powder)	
Allergy to penicillin or ampicillin	Clarithromycin	500mg	15mg/kg (maximum dose 500mg)
	Azithromycin	500mg	15mg/kg (maximum dose 500mg)

Adapted from the 2nd Edition of the SDCEP implementation advice.[9]

Table 5: Symptoms of Infective Endocarditis

Symptoms of infective endocarditis
Moderate- or high-risk patients should be advised to seek urgent medical attention if these symptoms develop within a few weeks of an at-risk dental procedure, whether the patient received AP cover or not.
Flu-like symptoms i.e. • **High temperature (38C or above)** • **Night sweats** • **Shortness of breath on exertion** • **Tiredness (fatigue)** • **Muscle and joint pains** • **Unexplained weight loss** • **Loss of appetite**
Other presentations:
• New or changing heart murmur • Spotty red skin rash (petechiae) • Narrow, reddish-brown streaks under the nails (splinter haemorrhages) • Red tender lesions on the fingers or toes (Osler's nodes) • Confusion • Stroke

Figure 1: Flow chart for the management of antibiotic prophylaxis in patients at high- and moderate-risk of infective endocarditis



Antibiotic Prophylaxis

SDCEP has also updated their recommendations on what AP regimens to use (see Table 4). For most patients, they recommend a single oral dose of amoxicillin 30-60 minutes before the procedure. They recommend the 3g sachet of sugar free amoxicillin powder, that is mixed with water to make a drink. Many dental professionals will be familiar with this preparation since it was previously recommended for AP in the UK (and is still available) and was popular with patients. However, in line with other international guidance, they alternatively recommend a 2g dose (4 x 500mg capsules). The main reason the 2g dose is recommended elsewhere is because the 3g sachet preparation is not available outside the UK and many patients do not tolerate the 3g dose when given as 6 x 500mg capsules. Notably, Clindamycin is no longer recommended for those with a history of penicillin allergy due to the risk of adverse reactions,[13] and a single 500mg oral dose of clarithromycin or azithromycin is recommended instead.

Other Aspects of Prevention

Maintenance of good oral hygiene is essential for all patients at increased risk of IE (both moderate- and high-risk). It not only reduces the need for invasive dental procedures but also reduces the risk of oral bacteria entering the circulation during normal

daily activities such as tooth brushing, flossing and chewing – particularly in those with poor oral hygiene and periodontal disease. Hence maintenance of good oral hygiene should be a priority for all patients at increased risk. SDCEP does not give specific advice about this, but the ESC guidelines recommend that patients at moderate IE-risk see a dental professional at least annually for professional cleaning and a dental exam, and patients at high-risk should do so twice yearly. Of course, the risks and benefits of scaling and polishing procedures should be discussed with these patients along with the potential risks and benefits of AP, particularly for patients at high-risk of IE. A suggested patient management flowchart is provided in Figure 1.

Early Detection of Endocarditis

IE is a serious disease with high morbidity and mortality. However, outcomes are significantly better the earlier the condition is diagnosed and treatment is started. Unfortunately, the presenting symptoms (Table 5) are often indistinguishable from flu and this can result in a delay in diagnosis. It is important, therefore, that all patients who are at increased IE-risk (both moderate- and high-risk) who undergo an at-risk dental procedure, whether or not they had AP cover, are advised of the symptoms of IE they should look out for and what action they should take if they arise. The symptoms can arise soon after the dental treatment (within 2 weeks) or may be delayed for a month or more. If flu-like symptoms arise within a few weeks of an at-risk dental procedure, patients should be advised to seek urgent medical attention and inform the doctor that they are concerned about the possibility of IE. The patient should tell the doctor about what moderate- or high-risk cardiac conditions they have, any invasive dental procedure they had (and when), and if it was covered by AP or not.

A patient information leaflet can be helpful in providing information for patients at increased IE risk and an example is provided in Appendix 1.

Finally

Finally, this change brings UK AP guidance into line with guidance in the rest of the world. It is essential all dental professionals are aware of this change and the huge implications for their clinical practice. To protect high-risk individuals from any unnecessary and preventable risk of developing this devastating disease, it is essential this change is implemented as quickly as possible.

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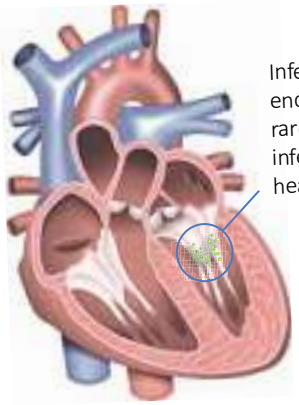
Appendix 1

Infective endocarditis and dental treatment

A patient information leaflet



Infective endocarditis is a rare but serious infection of the heart valves

It can affect anyone, but you are at increased risk of endocarditis if you have one of the following:

Higher-risk conditions:
- A replacement heart valve.
- A history of endocarditis.
- Some types of congenital heart disease.
- Other high-risk conditions advised by your cardiologist

Moderate-risk conditions:
- Unoperated heart valve disease.
- A leaking or narrowed heart valve.
- An implanted pacemaker or defibrillator.
- Hypertrophic cardiomyopathy.

If you have a high or moderate risk condition, there is a small risk of developing endocarditis after at-risk dental procedures.

At-risk dental procedures include:
- Oral surgery procedures (all types).
- Tooth extractions.
- Any procedure involving manipulation of the gums or periapical region (root tips) of the teeth (including scaling, root canal treatments and some restorative dental treatments).

If you need an invasive dental procedure your dentists will explain the risk and what can be done to prevent or minimise this.

Endocarditis prevention:

Oral Hygiene
- Maintenance of good oral hygiene is important in preventing endocarditis in those with moderate- and higher-risk conditions.
- Your dentists or hygienist will explain how this can be achieved.
- Patients with moderate-risk conditions should see their dentist or hygienist at least annually for professional cleaning and a dental exam
- Patients with higher-risk conditions should do so twice yearly

Antibiotic prophylaxis
- Your dentist will explain the potential risks and benefits of taking an antibiotic before an invasive dental procedure to reduce the subsequent risk of endocarditis (antibiotic prophylaxis).
- It can significantly reduce the endocarditis risk for patients with higher-risk conditions.
- The benefit for those with moderate-risk conditions is much smaller (but so is the risk) and the benefits may not outweigh the disadvantages.
- After explaining the risks and benefits your dentist will let you decide if you wish to have antibiotic prophylaxis or not.

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ANNUAL RENEWAL PERIOD OPEN

Registrants must complete the process on time to maintain their registration and continue practising in the UK.

Key dates

- 31 July 2026: Deadline to pay the ARF and declare indemnity, and the deadline to apply for a CPD grace period.
- 28 August 2026: Deadline to submit a CPD statement.

To complete your annual renewal:

- Pay your Annual Retention Fee (ARF) of £108 by 31 July 2026
- Declare you have, or will have, appropriate indemnity or insurance cover in place by the time they start practising, and no later than 31 July 2026
- Submit a CPD statement by 28 August 2026.

Registrants should complete their renewal on MyGDC, the online portal that replaced eGDC when it launched in March 2026.

Anthony McNally, Head of Customer Services at the GDC, said: "This year, dental care professionals are completing their annual renewal via MyGDC for the first time, and we want that experience to be as straightforward as possible. If you have not yet logged in, please do so and reset your password before you renew. It only takes a few minutes.

"We also want to encourage as many dental care professionals as possible to complete the working patterns survey alongside their renewal. The data is becoming increasingly valuable to the dental sector, and every additional response helps build a clearer picture of the workforce."

DCPs who do not meet the 31 July deadline for payment and the indemnity declaration, or the 28 August deadline for their CPD statement, risk being removed from the register and will no longer be able to legally practise in the UK.

CPD requirements

All dental care professionals must complete a minimum of 10 hours of CPD every two years and submit an annual CPD statement as part of their renewal, including those who have completed zero hours in the current year.

Dental hygienists and therapists in the final year of their five-year CPD cycle who do not expect to meet the minimum number of hours required, which varies by professional title, can apply for a grace period before 31 July 2026. If approved, this provides an additional eight weeks to complete the required hours. Applications can be made through the CPD section of MyGDC.

Dental hygienists and therapists who registered within the last 12 months will begin their first CPD cycle on 1 August 2026.

CLINICAL QUIZ

Medical emergencies, though infrequent in dental settings, can occur without warning and demand calm, swift, and competent management. All members of the team must be trained and prepared to act immediately. Familiarity with emergency drugs, equipment, and basic life support protocols is essential to safeguard patient safety and fulfil GDC professional standards

Q1. During treatment, a patient becomes pale, sweaty, and faints in the dental chair. What immediate action should you take?

Q2. A patient who is asthmatic experiences sudden wheezing and shortness of breath during treatment. What should you do?

Q3. A patient suddenly loses consciousness and has no signs of breathing or circulation. What is your immediate next step?

Key Learning Points:

- Review your medical emergency training at least annually, with updates in basic life support and AED use.
- Know the contents and location of your emergency drugs kit, oxygen cylinder, and defibrillator.
- Always carry out a thorough medical history check before every appointment.
- Maintain calm communication within the dental team during any emergency event.

IMAGE COURTESY OF PIQSELS.COM

SEND YOUR ANSWERS TO THE EDITOR BY 30TH JULY. PLEASE INCLUDE YOUR ADDRESS.

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

Win a Tahir Electric Flosser Starter Kit (£89.99 RRP)

Tahir Oral Care was founded after a life-threatening complication from Crohn's disease, when the founder required emergency surgery following a ruptured abscess. The surgeon who saved his life was named Tahir, which inspired the brand.

Alongside this, he experienced ongoing oral health challenges including mouth ulcers and inflamed gums. Despite being advised to floss, existing solutions were often difficult to use or uncomfortable, leading to poor compliance.The Tahir Electric Flosser was created to address this, focusing on simplicity, accessibility, and patient adherence. Designed for one-handed use without placing fingers in the mouth, it supports effective interdental cleaning with minimal effort. A sensitive mode helps improve comfort for patients with compromised gingival tissue.

A 1,000-patient clinical trial is currently underway with Barts and The London School of Medicine and Dentistry to further evaluate its impact. Exclusively stocked in Harrods.

Tahir aims to support long-term behaviour change and improve oral health outcomes.

ANSWERS TO CLINICAL QUIZ MAY 2026

The winner is: **Jennifer Jenkins**

Q1. What is your differential diagnosis?

A1. Although similar to a gingival epulis, infection is most likely due to a fragment of bone left in the socket following extraction.

Q2. What further investigations should be undertaken?

A2. X-ray in first instance.

Q3. The periapical radiograph shows a radiodensity which is most likely a retained bone fragment. What is the treatment of choice?

A3. Referral back to the dentist for removal.

ORACLE

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For more information visit: https://www.generalmedical.co.uk

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Southern	24th October 2026	Voco Winchester Hotel & Spa, Telegraph Way, Winchester, SO21 1HZ	Karen Poulter	southernsecretary@bsdht.org.uk
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