

DENTAL HEALTH

VOLUME 65 | NO 5 OF 6

SEPTEMBER 2026



BSDHT.ORG.UK

THE JOURNAL OF THE BRITISH SOCIETY OF DENTAL HYGIENE AND THERAPY



BSDHT
FIRST SMILES
2026

ENDOCARDITIS
PREVENTION
**YOUR QUESTIONS
ANSWERED**

**INTERNATIONAL
SYMPOSIUM ON
DENTAL HYGIENE**
2026

Dental Prophylaxis

Professional dental prophylaxis solutions deliver effective plaque removal and support consistent clinical performance.

24%
OFF



SHOP NOW

Combi **SPECIAL OFFER** £4,450.00 Plus VAT

The most reliable and complete touchscreen prophylaxis unit on the market!

24%
OFF



SHOP NOW

Micropiezo **SPECIAL OFFER** £995.00 Plus VAT

Patients benefit from gentle ultrasound scaling in soft mode. Technology at its best.

20%
OFF



SHOP NOW

Labrida Starter Package

SPECIAL OFFER £2450.00 Plus VAT

Includes Mariotti motor and reciprocating handpiece plus 5 packs of brushes – enough for 25 patients.

Cover your investment.

The Labrida BioClean brush

PACK OF 5 £114.50 Plus VAT

An innovative single-use dental device for mechanically cleaning dental implants and compromised teeth. Best used with motor and reciprocating handpiece.

Dental Prophylaxis Supplied by General Medical



General Medical have been in the dental business for more than 40 years supplying high quality solutions for implant, perio and advanced surgical practices.

We are widely recognised for our exceptional customer service and support. We understand that our customers demand the best for their patients and fully subscribe to helping them achieve their goals. We are only happy when you are happy, try us out!



www.generalmedical.co.uk

info@generalmedical.co.uk

01380 734990



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



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

bsdht.org.uk

DENTAL HEALTH – ISSN 0011-8605

EDITOR

Heather L Lewis,
Bragborough Hall Business Centre, Welton Road,
Braunston NN11 7JG
Email: editor@bsdht.org.uk

BSDHT NATIONAL ENQUIRY LINE

Tel: 01788 575050
Email: enquiries@bsdht.org.uk

EXTERNAL RELATIONSHIPS & MARKETING LEAD

Kim Purdie
Email: Marketing@bsdht.org.uk

CLASSIFIEDS & JOBLINE

Tel: 01788 575050
Email: enquiries@bsdht.org.uk

PUBLICATIONS TEAM

Nick Collier
Harriet Elsworth
Marina Harris
Ali Lowe
Patricia Macpherson
Elaine Tilling

EDITORIAL BOARD

Susan Bissett
Bhupinder Dawett
Kenneth Eaton
Jeena Patel
Jeanie Suvan
Victoria Wilson

eCPD INDEPENDENT REVIEW PANEL

Marina Harris
Ali Lowe
Patricia Macpherson

Annual Subscriptions for non-members: £155.00 per annum
UK 6 issues including postage and packing. Air and Surface Mail upon request.

© Dental Health – The British Society of Dental Hygiene and Therapy 2026. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying or otherwise without the prior permission of Dental Health.

Views and opinions expressed in Dental Health are not necessarily those of the Editor or The British Society of Dental Hygiene and Therapy.

Warners Midlands plc
The Maltings, Manor Lane, Bourne,
Lincolnshire PE10 9PH
Telephone: 01778 391000
Email: helpdesk@warners.co.uk
Web: www.warners.co.uk



This journal is printed on paper
from an FSC® certified merchant

DENTAL HEALTH

23



ON THE COVER

Food glorious
food... or not?

- 05 Editorial
- 06 From the president
- 07 Dr Gerald Leatherman award 2026
- 08 BSDHT First Smiles 2026
- 10 Prizewinning dental hygienist of the first cohort to qualify in the UK
- 11 Up to 27 hours of available CPD for BSDHT members
- 14 International symposium on dental hygiene
- 17 BSDHT Suggestions Box
- 18 OHC 2026
- 20 Poster competition 2026
- 21 Behind the uniform my path into dental hygiene
- 22 Food glorious food... or not?
- 25 Endocarditis prevention - your questions answered
- 27 Lifestyle medicine in daily practice
- 33 Calming the intensivist
- 36 Did you know...?
- 37 A student's perspective
- 38 Interprofessional education - dental therapy and speech and language therapy
- 42 Global oral health leaders united in call for broader approach to preventing periodontal diseases
- 45 Small donations big impact
- 46 Clinical quiz
- 47 Oracle
- 49 Diary dates
- 50 BSDHT admin

THE ORAL HEALTH CONFERENCE

27-28 NOVEMBER 2026 ICC WALES.



**ILLUMINATING SMILES
INSPIRING CHANGE
IMPACTING COMMUNITIES**

**"I absolutely loved
the opportunity to
meet and connect
with others, and to
learn outside of the
practice setting."**

PREVIOUS DELEGATE

Join us to explore how oral health professionals can transform communities and create lasting impact.

Book now at bsdht.org.uk/ohc-2026 Save more than 15% until 15 September

What Do We Choose to Celebrate?



I have just read the editorial in the current issue of *Dental Update* by Professor Euan McColl and Mr Martin Kelleher and really could not agree with them more.¹ They share their reflections about the late, great Mr Kevin Lewis of whom our very own Professor Marina Harris wrote a year ago.² They inspired me to write this.

Within every profession there are individuals whose contribution extends far beyond their own clinical practice. They are the colleagues who encourage others, share their knowledge generously, support professional development and consistently advocate for the value of what we do. They may not always seek recognition, but their influence can be felt across the profession.

The BSDHT's Dr Leatherman Award holds a particularly special place within our profession. It is held in the highest regard and, importantly, recognises more than a single achievement or moment in time. Previous recipients have demonstrated dedication, professionalism and sustained support for the profession of dental hygiene and therapy and for our organisation. That distinction feels increasingly important in a professional landscape where recognition can sometimes be measured very differently.

Across the dental profession and industry, there is no shortage of awards. Some recognise genuine clinical excellence, research, education and contribution to the profession. Others, however, can feel increasingly connected to personal profile, commercial visibility, self-promotion or the ability to generate attention. Winning an award can undoubtedly be valuable, but perhaps we should occasionally pause and ask what the award is actually recognising. Is it achievement, or visibility? Is it sustained contribution, or personal branding? Is it influence based upon evidence and experience, or simply the size and engagement of an online following?

These questions become particularly relevant in an era where social media has become such a powerful part of professional life. Platforms such as Instagram, TikTok and LinkedIn can be enormously positive. They enable clinicians to share knowledge, communicate with patients, promote education and connect with colleagues across geographical boundaries. There is undoubtedly considerable value in that.

But visibility should not be confused with expertise. The person with the largest following is not necessarily the person with the strongest evidence base. The most polished presentation

does not necessarily represent the most appropriate clinical advice. And an influencer's ability to generate engagement should never replace professional judgement, critical appraisal or consideration of the individual patient sitting in front of us.

As dental hygienists and dental therapists, our professional credibility is built on something much more substantial than social-media metrics. It is built on education, competence, ethical practice, evidence-informed decision-making and the relationships we establish with our patients. It is demonstrated in the conversations we have, the care we provide, the outcomes we seek and the way we support our colleagues and our profession.

That does not mean that clinicians should avoid social media or personal promotion. Quite the opposite. We have an opportunity to occupy these spaces with credible, evidence-informed voices and to demonstrate the value of our profession to a much wider audience. However, perhaps we should be asking ourselves what message we are sending when we celebrate visibility above contribution.

This is where the Dr Leatherman Award feels particularly significant. Its value lies not simply in the prestige associated with receiving it, but in what it represents. It recognises people who have demonstrated commitment over time. People who have contributed when there was no guarantee of recognition. People who have supported colleagues, shared knowledge, advanced education, represented the profession and contributed to BSDHT because they believed in something bigger than themselves.

That kind of contribution may not always be particularly visible. It may not generate thousands of likes. It may not produce a carefully curated professional profile. But it matters. Indeed, perhaps these are precisely the contributions we should be celebrating more loudly.

As we anticipate the worthy recipient of the next Dr Leatherman Award, I would encourage us to think carefully about what we value as a profession. Let us celebrate innovation, research, education and leadership, but let us also recognise consistency, integrity, generosity and service. Our greatest measure of professional success cannot be how many people are watching us. In a world increasingly driven by visibility, perhaps the Dr Leatherman Award offers a welcome reminder that professional influence and social influence are not necessarily the same thing.

Perhaps that is something worth celebrating.

Heather
Heather Lewis

References

1. McColl E, Kelleher M. Standing on the shoulder of giants. *Dental Update* 2026; **53**(7):465-466. <https://www.dental-update.co.uk/content/comment/standing-on-the-shoulders-of-giants>
2. Harris M. Obituary: Kevin Lewis. *Dental Health* 2025; **64**(5):9.

FROM THE PRESIDENT

BY RHIANNON JONES

It has been an exceptionally busy period, so it is lovely to have the opportunity to pause and reflect on the work that has taken place since my last update, in July.

Financial Recovery Group

Firstly, I am delighted to share that the Financial Recovery Group (FRG) has presented its findings. The recommendations are designed to support our ongoing work to build a stronger, more sustainable and secure future for the Society. I am pleased to say that they have been accepted by Executive Committee and will shortly be presented to Council for consideration and support.

I would like to extend my sincere thanks to every member of the FRG for the considerable time, energy and commitment they have given to this work. It has undoubtedly been a significant undertaking, but will deliver long-term benefits and help ensure that BSDHT can operate efficiently, with a renewed sense of purpose, well into the future.

I also want to take this opportunity to acknowledge the incredible support I have received from our President-Elect, Simone. The role of president during my term has involved far more than I could ever have anticipated, and Simone's constant support and encouragement have been invaluable. Others have also supported me throughout my term, and I am immensely grateful to you all.

When Simone takes over as president in November, the Society will be in very capable hands. This is an exciting time to be a member of BSDHT and to be part of shaping its future.

Ahead of the AGM, we will be holding a webinar open to all members. This

will provide an opportunity to hear more about the internal review process and our plans for the future, as well as to ask questions. Please look out for your invitation and join us if you can. It is important to us that members understand what is happening within their Society and have the opportunity to be involved. It is your Society, and we want you to be part of its future.

International Federation of Dental Hygienists

I was also privileged to represent the UK at the International Federation of Dental Hygienists (IFDH) House of Delegates meeting and subsequent symposia in Italy this summer.

It is always inspiring to meet colleagues from around the world who share our profession but work within very different governance structures. The UK has come a long way, and it is rewarding to be able to share our experience and support colleagues in countries where dental hygienists and therapists are still working hard to have their voices heard.

Simone and I were fortunate to secure support to attend the event through our presentations, for which we are extremely grateful. It was also wonderful to hear that our Dental Health Matters podcast is being listened to by colleagues internationally. We have received some lovely feedback from those who find the episodes useful and appreciate that they are freely accessible. If you have not listened yet, please do take a look. It is a great way for us to support members while also generating valuable income for the Society. I am also delighted to congratulate Miranda on her re-election as IFDH Treasurer.

Looking forward

As I enter the final months of my presidency, my focus remains firmly on ensuring that the Society I hand

over to Simone and her new team is as strong, resilient and well positioned for the future as possible.

These are challenging times for any organisation, but I remain confident that BSDHT has something incredibly valuable: passionate members, dedicated people and a clear purpose.

Thank you, as always, for your continued support.

Rhiannon

Rhiannon Jones



THE DR GERALD LEATHERMAN AWARD

NOMINATIONS ARE NOW OPEN



The first recipient was Jean Bailey in 1994. Jean had been BDHA President between 1980-1982. The most recent recipient was Mike Wheeler BEM, BSDHT President 2006-2008.

Nominations need to be received no later than 5.00pm on Friday 2nd October 2026

ONLINE: <https://forms.cloud.microsoft/e/PiS6vpcbqC>

Email: enquiries@bsdht.org.uk



Background

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

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

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

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

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

Nomination Criteria

Nominations must demonstrate how the nominee has shown:

- Consistent support to our profession

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

Self-nominations will not be considered.

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

Submission Documentation

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

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

Eligible Nominators

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

FIRST SMILES 2026 BSDHT

This summer, BSDHT members were out in force visiting schools and nurseries across the four nations. These passionate volunteers engaged with children to promote oral health and establish healthy dietary habits. Once again, we are grateful to Oral B for generously supporting this initiative by supplying tooth brushes and toothpaste for the children.



**YASHANA
BYFIELD**

visited

**HARRIS GERRARD ACADEMY
(ERITH, KENT)**



**DEIRDRE
CANAVAN**

visited

**ST. PATRICK'S PRIMARY
SCHOOL (BALLYNAHINCH)**



**RUTH
MORRISON**

visited

**FANE STREET PRIMARY
SCHOOL (BELFAST)**



UDITA PATEL

visited

**RUISLIP STARS
NURSERY (RUISLIP)**



**KATE
PEYSNER**

visited

**BROOMHILL INFANT
SCHOOL (SHEFFIELD)**



PRIZEWINNING DENTAL HYGIENIST OF THE FIRST COHORT TO QUALIFY IN THE UK

A Mancunian by birth, Una Stanley (nee Allison, 12 December 1925 – 23 March 2021) took her School Certificate during the second world war, passing with flying colours. This was despite missing school for the best part of her final year. Although she had won a scholarship, her father kept her from school as he disputed whether the scholarship covered the cost of the school uniform! In 1941 she started work in a clerical role at Manchester Dental School, where she continued until the end of the war. This was her first proper job and she loved it, making good friends both amongst the administrative staff and the lecturers.

Quite quickly, her aptitude and potential was recognised by the Dental School, and she was promoted to working as an assistant to one of the professors, not as a formal dental nurse, but with more than solely administrative duties.

■ Alison Stanley, Una's daughter, presenting the cup to President Rhiannon Jones and President elect Simone Ruzario.

After the war, Una moved to Leeds to work at the Dental Hospital there. Her potential was recognised by the senior staff, and in 1949 she was encouraged to take the new course in Dental Hygiene. The idea for specialist dental hygienists



■ Una Stanley (nee Allison) receiving the W G Senior Cup from Alan Deverell and Guy Poynton.



came from the USA and she spoke of it as being linked with the creation of the NHS and the clear need to get children's teeth cared for properly. Una said that the first course for dental hygienists was created by dentists in the UK and was very taxing. One of the course tutors was Vera Creaton who went on to become the first President of the British Dental Hygienists' Association, formed in 1949, the predecessor organisation of the British Society of Dental Hygiene and Therapy. Vera and Una became fast friends, a friendship that lasted all their lives.

The course meant that she moved to the Eastman Dental Hospital in London. Living as a student in Kilburn, London at the age of 24 was exhilarating. But despite the distractions of London student life, Una excelled in her studies, coming top in the qualifying examination in 1950. She was awarded a silver cup to commemorate this, presented by W G Senior

Esq. The cup, which we are pleased to present to the BSDHT in her memory, is now slightly battered due to its illicit use in play by her daughters, but Una would have been honoured to know that her achievements were being recognised by her professional peers.

Following qualification, Una worked at the Eastman Dental Hospital in London. She married Charles Stanley in October 1951 and they moved to Calcutta (now Kolkata), returning in 1954. The couple had three daughters - Julie, Alison and Dodie. Una was a housewife until 1965 when she returned to work part-time as a dental hygienist for a couple of years in Edenbridge, Kent.

Una spoke of her student days fondly and enjoyed her work. She was always proud of her achievements as part of the first cohort of qualified dental hygienists in the UK.

UP TO 27 HOURS OF AVAILABLE CPD FOR BSDHT MEMBERS

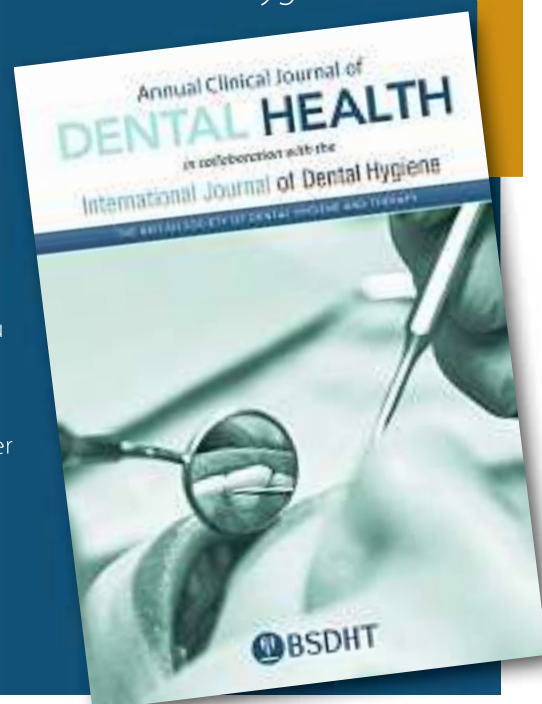
The editor is happy to report that the final paper submitted to the collaborative UK Special Issue of the *International Journal of Dental Hygiene* (IJDH), has now been published online.

The majority of papers (14 of 18) are published 'open access'. If you subscribe to the IJDH you can read all 18 on the IJDH website. If you do not subscribe to the IJDH, you can still gain access to read the 14 that are published open access. However, BSDHT members can log on to the BSDHT website and read all 18 there in our *Annual Clinical Journal of Dental Health* and obtain up to 27 hours of CPD in our unique programme!

Four standard questions have been set for each paper. Having read the paper, you are asked to demonstrate current and future learning, reflect on what you have learnt and explain how you will apply this knowledge to patient care.

All four questions have a minimum word count which must be adhered to in order to receive a CPD certificate, and will be reviewed by an internal review panel. You are advised to copy and paste your responses into a word document before you submit on survey monkey. It is important that you retain your responses until you receive your certificate.

Your submissions can also be copied and pasted directly into your Professional Development Plan, as required by the GDC.



UNSUBSCRIBED?

You may be missing out on regular updates from BSDHT!

Contact: enquiries@bsdht.org.uk





Colgate® Duraphat®, the only fluoride varnish that carries the weight of clinical evidence*

Colgate® Duraphat® is the only fluoride varnish
licensed for caries control in the UK†

- Fast and easy application
- Temporary visual tint to aid application
- Raspberry flavour



22,600 ppm Fluoride



Protect your patients, your team and your dental practitioners' prescribing responsibilities with Colgate® Duraphat® Fluoride Varnish¹⁻⁵

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk. Adverse events should also be reported to Colgate-Palmolive (U.K.) by calling **00-800-321-321-32**.



^{*}For caries control. [†]Colgate® Duraphat® Fluoride varnish for patients 3 years of age and over. **References:** 1. Delivering better oral health - an evidence-based toolkit for prevention, Office for Health Improvement and Disparities' 2021. 2. Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews 2013. 3. The use of fluoride varnish by dental nurses to control caries. NHS. Primary Care Commissioning, 2009. 4. <https://www.england.nhs.uk/long-read/supply-and-administration-of-medicines-by-dental-hygienists-and-dental-therapists/> 5. <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/avoidance-doubt-v4-1.pdf>.

Name of the medicinal product: Colgate® Duraphat® 50mg/ml Dental Suspension. **Active ingredients:** 1ml of suspension contains 50mg Sodium Fluoride equivalent to 22.6mg of Fluoride (22,600 ppm F⁻) **Indications:** For the prevention of caries in children and adults as part of a comprehensive control programme, desensitisation of hypersensitive teeth. **Dosage and administration:** Recommended dosage for single application: for milk teeth: up to 0.25ml (~5.65mg Fluoride), for mixed dentition: up to 0.40ml (~9.04 Fluoride), for permanent dentition: up to 0.75ml (~16.95 Fluoride). For caries prophylaxis the application is usually repeated every 6 months but more frequent applications (every 3 months) may be made. For hypersensitivity, 2 or 3 applications should be made within a few days. **Contraindications:** Hypersensitivity to colophony and/or any other constituents. Ulcerative gingivitis. Stomatitis. Bronchial asthma. **Special warnings and special precautions for use:** If the whole dentition is being treated the application should not be carried out on an empty stomach. On the day of application other high fluoride preparations such as a fluoride gel should be avoided. Fluoride supplements should be suspended for several days after applying Duraphat®. **Interactions with other medicines:** The presence of alcohol in the Duraphat® formula should be considered. **Undesirable effects:** Oedematous swelling has been observed in subjects with tendency to allergic reactions. The dental suspension layer can easily be removed from the mouth by brushing and rinsing. In rare cases, asthma attacks may occur in patients who have bronchial asthma. **Legal classification:** POM. **Product licence number:** PL 00049/0042. **Product licence holder:** Colgate-Palmolive (U.K.) Limited, Goldsworth Place, 1 Forge End, Woking, Surrey, GU21 6DB. **Price:** £22.70 excl VAT (10ml tube) **Date of revision of text:** June 2024.

PROFESSIONAL
— ORAL HEALTH —

BY HARRIET ELSWORTHY

INTERNATIONAL SYMPOSIUM ON DENTAL HYGIENE 2026

Anyone who knows me knows that I love a conference! Last year, a few colleagues and I discussed the opportunity to attend the International Symposium on Dental Hygiene (ISDH) in Milan, held in July this year. For a mother with three children under five, the thought of going away without thinking for three other people seemed like an opportunity I could not refuse. This turned out to be a good

decision because, alongside some other delegates from the UK, I was subsequently asked if I would serve as a member or moderator of the scientific poster award jury. I had submitted a poster in the past for another event but had never been part of the judging process before. I was delighted to accept and to become further involved.

The process of poster presentation and marking scheme were explained during online meetings we had with the ISDH

INTERNATIONAL ON DENTAL

9-11 July 2026, M



scientific committee prior to the event. This also highlighted the scale of organisation involved in the poster event: 183 poster submissions, divided into nine award categories, each with a moderator and three jury members!

Milan

We were greeted in Milan in 38-degree heat (not long after the heatwave here), and fitted in some sightseeing and pizza before heading to our accommodation. We registered early to avoid the queues on the first day of the conference - something we were glad we had done when we walked past the registration queue the next day. The ISDH is always impressive. This year there were more than 1000 delegates (55 from the UK), a mass of exhibitor trade stands and an excellent scientific programme. It was a pleasure to experience the opening ceremony, watching our President, Rhiannon, and President elect, Simone, carry the Union Jack down the aisle to the stage was unexpectedly moving!

I spent some of the following day judging the posters. I am familiar with peer reviewing and critical analysis through editorial and publications work, which is usually a slow process with time allocated to carefully consider each aspect of a manuscript. However, when it comes to judging a poster, it has to be done within five minutes sharp! This was slightly

overwhelming when you are used to having as much time as you like. It was also reassuring to see so many familiar faces from the UK taking part in the moderating and jury process at the same time; I even squeezed in a quick chat with Alison, our SWSW Treasurer, who was moderating.

Despite the pressure, I felt honoured to be a part of the process and confident in the decisions we made as a panel. It was wonderful to see the calibre of work displayed in the posters and oral presentations.

Downtime

During the the time we spent in Milan, we all managed to catch up with friends and colleagues - something that usually would not happen unless at an event like this - and have some important discussions regarding career opportunities. Away from the symposium we had time to go out for dinner, watch a storm over the mountains at Lake Como and sample the Aperol and gelato. It was a brilliant few days.

I am really looking forward to the OHC in November for similar opportunities to expand horizons and network, although perhaps with less gelato!



ChloroStay

7-Day Mouthwash

7-Day
Protection

What is the Benefit of ChloroStay 7-Day Mouthwash?

ChloroStay 7-Day Mouthwash is a weekly mouthwash which helps prevent plaque build-up, keep breath fresh and promotes and maintains oral hygiene for up to a week after use – especially in difficult to clean areas, such as between teeth and around orthodontic appliances.

NEW

**For once
a week use**

**Stand
15 OHC**

**27th & 28th
November**



How does ChloroStay 7-Day Mouthwash Work?

ChloroStay 7-Day Mouthwash consists of two solutions. When combined, tiny crystals of encapsulated calcium chloride chlorhexidine spheres are formed. These crystals adhere to the surfaces of the teeth and slowly release the chlorhexidine in a low but clinically effective dose over a period of up to 7 days.



What makes ChloroStay 7-Day Mouthwash different?

ChloroStay 7-Day Mouthwash is a unique mouthwash, developed by a multi-disciplinary team at Queen Mary University of London. Unlike traditional mouthwashes that have a high initial chlorhexidine concentration but are quickly washed away in the mouth, ChloroStay provides low and sustained chlorhexidine release for up to a week.

When should patients use ChloroStay 7-Day Mouthwash?

To provide added protection in difficult to clean areas such as between teeth and around orthodontic appliances. Whenever compliance with a once-a-week regime is easier to achieve or supervise than a regime carried out daily, and for patients who have difficulty in effectively brushing their teeth.



For further information, and advice on when to recommend or offer ChloroStay 7-Day Mouthwash to your patients, please call Schottlander on freephone 0800 97 000 79, visit schottlander.com or chlorostay.com

schoTtlander

BSDHT SUGGESTIONS BOX

As part of our commitment to ensuring that the British Society of Dental Hygiene and Therapy continues to evolve and meet the needs of our members, we are pleased to introduce the new **BSDHT Suggestions Box**.

The Suggestions Box is open to all BSDHT members. It provides a simple way for anyone to: share ideas; make suggestions; give feedback; or share opportunities that they believe could help improve the Society and benefit our members.

You can submit a suggestion here:

BSDHT - SUGGESTIONS BOX

There no need to login. You can give your name or remain anonymous.

We welcome suggestions on any aspect of the Society, including (but not limited to):

- Member services and benefits
- Events and education
- Communications
- Governance and operations
- Partnerships and collaborations
- New initiatives or campaigns
- Any ideas that could help us better support the profession and our members

Every suggestion received will be reviewed and assessed by the appropriate members of the Head Office team. Whilst we may not be able to implement every idea, each submission will be considered carefully and fairly.



To ensure transparency and keep everyone informed:

- A monthly summary of suggestions received, together with their status and any actions taken, will be shared with Council.
- A member-friendly update will also be published each month in Dental Health, BITES and on the Members' Portal, so that members can see how their feedback is helping to shape the future of the Society.

We encourage you to help promote the Suggestions Box whenever you have the opportunity. The more ideas we receive, the better we can continue to develop BSDHT for the benefit of our members and the wider profession.

Thank you in advance for your support and for helping us build an even stronger Society.

Scan me



BSDHT FINANCIAL REVIEW GROUP

An update on the progress made towards addressing the Society's future financial stability will be delivered via a webinar, well in advance of the BSDHT AGM. Please look out for a letter via email from the BSDHT President advising all members of the details for joining this webinar and the opportunity to submit questions. Subsequently, there will be a link to the recorded webinar, which will be hosted in the members' area of the BSDHT website.



The British Society of Dental Hygiene & Therapy

THE ORAL HEALTH CONFERENCE

ILLUMINATING SMILES • INSPIRING CHANGE • IMPACTING COMMUNITIES

27-28 NOVEMBER 2026 ICC WALES

Join us to explore how oral health professionals can transform communities and create lasting impact.



The Oral Health Conference (OHC) is the BSDHT's flagship must-attend annual event for dental hygienists and dental therapists. Each year, we put together the conference with you in mind – to provide our members with clinical education, CPD hours, a forum to hear from leading speakers, and receive updates from the profession, as well as the chance to network with colleagues, experts and industry. This year we are taking the OHC back to the ICC Wales.

A programme aimed at enhancing your career and relevant to your day-to-day practice

Amongst many other benefits, the conference provides a two-day programme that is designed to be clinically-applicable and professionally relevant, with take-away learning points you can apply the very next day at work.

"We have worked hard to create a programme that is engaging, evidence-based and immediately relevant to clinical practice. Covering everything from the latest clinical guidance and emerging science, to teamwork, leadership and advocacy, the programme reflects the breadth of

our profession and offers something for every delegate. Alongside hearing from respected experts, I am particularly excited that this year's programme provides a platform for new voices within our profession to share their expertise and research. I would also like to thank our valued trade partners for their continued support in helping us deliver such a strong educational programme. As the conference draws closer, I am very much looking forward to seeing colleagues come together to learn, share ideas and inspire one another."

Simone Ruzario,
President Elect, BSDHT

The range of topics and calibre of speakers is always one of the most highly-rated aspects of the OHC by our delegates. This year's programme will be as cutting-edge and diverse as always:

Consultant Paediatric Dentist, National Lead for Mini Mouth Care Matters, and Immediate Past President for the British Society of Paediatric

Dentistry - **Dr Urshla Devalia** – will open the conference with a keynote presentation **Addressing health inequalities for children and young people with disabilities in the UK.**

Also on the plenary programme is **Professor Aylin Baysan**, Professor in Cariology in Minimally Invasive (MI) Dentistry at Queen Mary University of London, discussing **Minimally invasive and patient-centred management of dentine hypersensitivity – a sustainable clinical workflow;** **Professor Tara Renton**, OBE, Emeritus Professor Oral Surgery at King's College London with **An update on local anaesthesia;** and closing the conference will be a fireside chat with Professor **Iain Chapple and Professor Avijit Banerjee** – hosted by Past President, Miranda Steeples.

Between the impressive plenary sessions, is a full stream of concurrent sessions and workshops to choose from, allowing you to tailor a programme that best suits your needs – check out the full programme at bsdht.org.uk/ohc-2026.



Be inspired by each other and help shape the profession

OHC is not just CPD! Feedback shows us that it is the key opportunity of the year to come together as a profession, to meet and share ideas and best practice, to celebrate our work, and be inspired by each other. There will be lots of opportunities to network with other delegates, speakers and trade representatives, as well as meet the BSDHT Executive team and members involved in the various working groups.

The social element is a big part of the OHC, and the legendary Friday Night Party is back this year! Add a ticket to your conference booking and join us for dinner, drinks and dancing at the Coldra Court Hotel at the end of the first day.

"What excites me most about this year's OHC is the opportunity for our profession to come together, share knowledge and inspire one another. With a programme that combines leading clinical expertise, emerging research and practical learning, delegates will leave with fresh ideas and renewed enthusiasm for their practice. I am especially looking forward to connecting with colleagues, celebrating our achievements and supporting the next generation of voices shaping the future of dental hygiene and therapy."

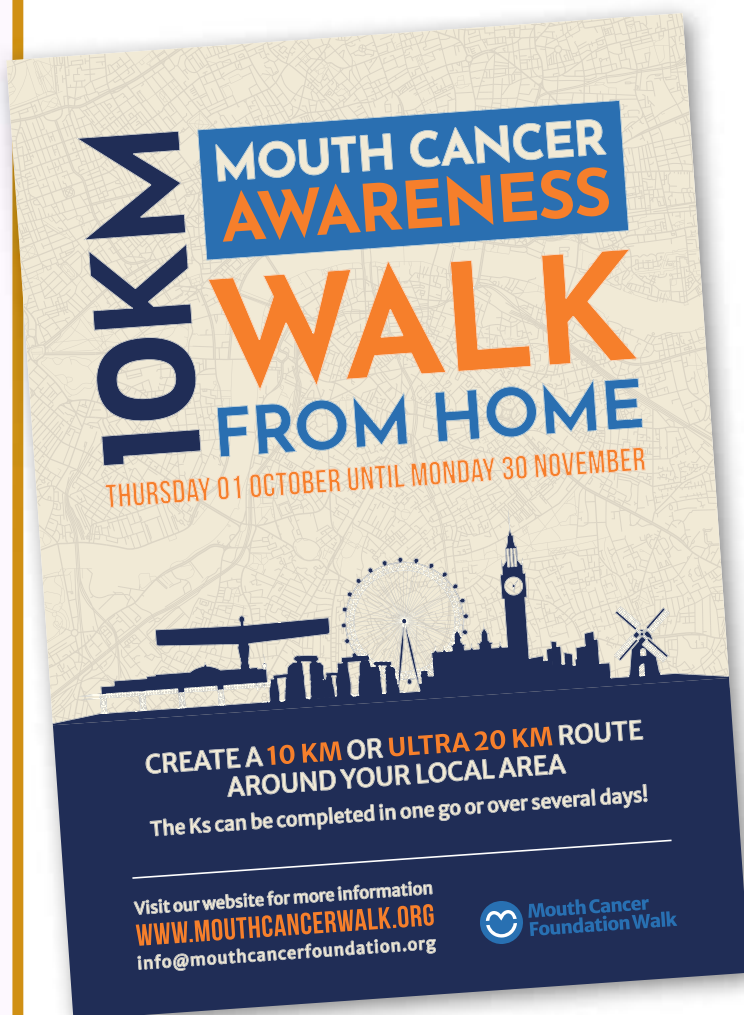
Rhiannon Jones,
President, BSDHT

10 great reasons to attend OHC

Still not sure? There are many great reasons to attend:

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

Join us at the conference – book your place at bsdht.org.uk/ohc-2026. Earlybird fees are available until Monday 15 September – book now to save more than 15%





CALL FOR SUBMISSIONS



The British Society of Dental Hygiene and Therapy invites members, dental hygiene or dental therapy students, and other GDC registrants to submit posters for the Annual Poster Competition 2026. The poster could be highlighting an interesting clinical case, an aspect of research that you have undertaken, or a service or quality improvement initiative. Outstanding work will be considered for publication in Dental Health.



Registrant Category

GDC Registrants & BSDHT Members



Student Category

UK Dental hygiene or dental therapy students, or work undertaken when an undergraduate student (within last 2 years)

KEY DATES



ABSTRACT DEADLINE

14 September 2026

5pm - complete online submission form



ACCEPTANCE NOTIFICATION

30 September 2026

5pm - all entrants



FINAL POSTER DUE

30 October 2026

PDF to BSDHT office

ABSTRACT REQUIREMENTS

- ✓ Maximum 300 words, narrative text only; standard font size (10 pitch)
- ✓ No graphs, tables or references at abstract stage
- ✓ Full names of authors, credentials and affiliations; if several authors have a mutual affiliation, list the names and credentials of all authors, then list the affiliation.
- ✓ Funding must be identified in the last sentence, i.e. *Funding for this project was through ...*
- ✓ Asterisk (*) in front of presenting author
- ✓ Ethical approval statement if required

SPECIFICATIONS FOR POSTER

SIZE

A0 Portrait

FORMAT

High resolution PDF

RESOLUTION

300 ppi min

PHOTO

Presenter photo required

PRIZES:

1ST PRIZE

Free 2-day delegate pass for the BSDHT Oral Health Conference 2027,
(including travel and one night's accommodation)

Free attendance at a BSDHT Regional Group event
(either Spring/Autumn 2027)

1 years free BSDHT membership

2ND PRIZE

Free 2-day delegate pass for the BSDHT Oral Health Conference 2027,
(including travel and one night's accommodation)

3RD PRIZE

Free 2-day delegate pass for the BSDHT Oral Health Conference 2027

STUDENT PRIZE

Free 2-day delegate pass for the BSDHT Oral Health Conference 2027



TO ENTER: Submit your abstracts using the online [Submission Form](#) by **14th September 2026.**

Incomplete or incorrectly formatted submissions will be returned without review.

The poster content must match the submitted abstract.

All posters will be judged by the BSDHT Judging Panel.

Outstanding entries will be considered for publication in Dental Health or the Annual Clinical Journal.

BY JULIE KUJUR

BEHIND THE UNIFORM MY PATH INTO DENTAL HYGIENE

As I enter the final term of my dental hygiene degree, reflecting on my journey has shown me how unpredictable career paths can be. I hope my experience encourages others facing similar setbacks or uncertainties.

Finding a career that felt right

By the time I began studying for my A-levels, I already knew that I wanted to work in dentistry. However, it was only when I attended an open day at King's College London that I discovered dental hygiene as a career.

I subsequently threw myself into the application process — UCAS, personal statement, interviews — only to be met with rejection after rejection! I had not realised just how competitive entry into our profession was going to be!

Watching my friends receive university offers while I had none was isolating. I felt stuck and unsure of what to do next. I considered backup options, including nursing and law. But none of these felt right. I did not want to take a gap year, but I also could not imagine committing to a course about which I was not passionate.

Then, just as I was losing hope, I received an unexpected email from the University of Portsmouth offering me a place on a one-year dental nursing course. I hesitated at first, questioning whether it was worth it. Looking back now, it was one of the best decisions I could have made.

The detour that changed everything

That year in dental nursing gave me far more than I expected. What started as a backup plan became a turning point: I gained independence, built life-long friendships and, most importantly, grew in confidence and self-belief. When application season came around again, I approached it with a completely different mindset. I understood the profession. I understood the competition. And this time, I understood my own capability.

After months of interviews, preparation and waiting, I received three offers, including one from the University of Essex.

Dental Hygiene School

Dental hygiene was a leap into the unknown. One of my biggest concerns was being one of the youngest in the cohort. Many of my peers had years of dental nursing experience, whilst I had not even worked a day in a dental practice. I questioned whether I would fit in, whether I would keep up, whether I would find my place.

Thankfully, those fears quickly disappeared. The people I met, and the environment I stepped into, made all the difference. Over the past two years, I have learned that growth does not come from being the most experienced person in the room, it comes from being willing to learn, adapt and keep on going.

Rejection is redirection

If I had not accepted that alternative offer, I would have missed experiences that helped shape who I am today.

It is never too late to fulfil your dream! On this course, I have met students aged 19 through to their 40s, each with different paths but all arriving at the same goal. There is no deadline on pursuing what matters to you.

For A-level students struggling to secure dental hygiene offers, remember that you are not alone. Connecting with current students or platforms like The Student Room can be incredibly reassuring. Support and advice are always out there.

Looking back, I realise that not getting in the first time was not the end of the road, just a different route to the same goal. Every setback and unexpected opportunity helped shape my confidence, experience and perspective, ultimately leading me to where I was meant to be.

Author: Julie Kujur is a final-year dental hygiene student at the University of Essex, having previously studied dental nursing at the University of Portsmouth. She is passionate about oral health education and encouraging others to pursue their goals within dentistry.

Contact: dentallyjulie@gmail.com



BY ELAINE TILLING

FOOD GLORIOUS FOOD... OR NOT?

The impact of diet on our lives, and the status of our overall health and well-being, is rarely out of the news. We are, therefore, all too aware that there are complex issues related to the food that we eat: affordability, accessibility, nutritional value and sustainability, to name but a few.

We are what we eat

As advocates of oral and general health our role in supporting patients with nutritional advice has never been more important, nor complex. Government advice is not only often out of date but also, in some cases, contested between health care providers.

It begs the question: is anyone out there doing anything positive about clearing the fog? Fortunately, the answer to this is, yes! Let's start this first information piece considering arguably the most important group of all – our children. Getting nutrition wrong from the start, is a poor start.

Children's food campaigns in the UK aim to ensure all children have access to healthy, sustainable and affordable food, while tackling food insecurity and promoting better nutrition in schools and communities. Below are some current key campaigns and initiatives:



Children's Food Campaign

This campaign unites over 100 organisations, including health charities, school food experts, and environmental groups, to advocate for policy changes that improve children's diets. Key achievements include securing legislation to restrict outdoor unhealthy food advertising, promoting School Food Standards, and supporting Universal Infant Free School Meals. The campaign also engages parents through a manifesto and hosts events like the Children's Food Summit to influence government policy and local authorities. You can visit their website here: sustainweb.org



Children's Right2Food

Led by Young Food Ambassadors, this initiative focuses on ensuring every child in the UK can access and afford

nutritious food. It evolved from the Children's Future Food Inquiry, which gathered insights from children and young people about food insecurity and its impact. The campaign promotes the Right2Food Charter, advocating for government action to reduce hunger, tackle inequalities in obesity, and protect children's right to food. Visit the website: foodfoundation.org.uk



Bite Back 2030

Bite Back 2030 empowers students to improve their school food environment through assemblies, student-led clubs, and advocacy projects. The campaign highlights the prevalence of unhealthy, low-nutrition options in school canteens and encourages young people to push for healthier choices. It also supports policy changes, such as the ban on junk food advertising online and on TV before 9pm, while emphasising the need for stronger measures. Visit the website: biteback2030.com



Save the Children UK

This international charity addresses child food insecurity both globally and in the UK. In response to COVID-19, it provided emergency grants, food vouchers and early-learning packs to support children in poverty. The organisation works in schools, nurseries and communities to ensure children are



fed, learning and treated fairly, while also responding to crises worldwide. Visit the website: savethechildren.org.uk



Feed London

Focused on London, Feed London supports children and families during school holidays when food insecurity is most acute. The initiative targets boroughs with the highest child poverty rates, providing food boxes and family support, while advocating for legal and policy changes to achieve fairness and equality in access to nutritious food. Visit the website: feedlondon.org

Goals and Impact

These campaigns collectively aim to:

- Ensure **all children have access to healthy, affordable food.**
- Reduce **childhood obesity and food insecurity.**
- Improve **school food standards** and limit exposure to unhealthy advertising.
- Engage **children, parents and communities** in advocacy and education.
- Influence **government policy** to create sustainable, long-term solutions for child nutrition.

By combining grassroots activism, policy advocacy and direct support, these campaigns are working to create a healthier food environment for children across the UK.

This is not a call for BSDHT members to 'march on Parliament (where things are a bit busy at the moment) but a call to help include and raise the awareness of the impact of poor diet on the oral health of our children.

Perhaps members could consider checking out one of these campaigns and adding your voice and expertise to these groups...?





PREVENTION RE-IMAGINED: HORMONES, BIOFILM, AI AND THE MODERN DENTAL PRACTICE

OUR SPEAKERS

HEADLINER

DR
ARIF



BEN
TIGHE



CLAIRE
BERRY



LOUISE
WARDEN



DR.
DEVAN
RAINDI



CHARITY
PARTNER



DR
PAYVAND
MENHADJI



DR.
SIMON
CHARD



HARRY
MORRIS



GBT
SUMMIT



DR
CHRISTIAN
LEONHART



CELSDA
COSTA



FRIDAY 2ND OCTOBER
8:15AM - 5:30PM
30 EUSTON SQUARE, LONDON



£125.00 GENERAL
ADMISSION
6 HOURS CPD

BOOK
YOUR PLACE



ENDOCARDITIS PREVENTION YOUR QUESTIONS ANSWERED

In the last issue of Dental Health, we published a paper by Professor Martin Thornhill: A major change in NICE guidance puts endocarditis prevention back in the spotlight for all dental professionals (*Dental Health* 2026;**65(4)**: 36-42. <https://doi.org/10.59489/bsdht188>).

This paper was well received by readers and several of you took the time to write and pose some further questions. The author has kindly responded to the two most commonly asked by you, our members.

Question: *Who is expected to prescribe the antibiotic cover now if needed - I believe it used to be the patient's cardiologist? Is it now the patient's dentist? What happens with Direct Access patients?*

Response: There are three parts to this question:

(i) Who is expected to prescribe antibiotic cover now if needed?

The dentist is responsible for this.

The updated NICE guidelines direct clinicians to the implementation advice on antibiotic prophylaxis (AP) against infective endocarditis (IE) produced by the Scottish Dental Clinical Effectiveness Programme (SDCEP) for detailed advice on AP for people at high-risk of IE undergoing dental procedures. The SDCEP advice makes clear that if AP is needed, it is the responsibility of the patient's dentist to prescribe the AP. It is also the dentist's responsibility if they fail to prescribe AP.

In October 2024, a high-risk patient (with a prosthetic heart valve and a previous history of IE) won one of the largest ever negligence claims against a dentist when he developed IE following a dental extraction. This was despite NICE guidance at that time saying: "Antibiotic prophylaxis against infective endocarditis is not recommended routinely for people undergoing dental procedures." The court found that the dentist should have been aware of research evidence demonstrating the benefit of AP and the recommendations of other guideline committees around the world-wide, that meant this patient was at high-risk for IE and should be considered for AP cover. The court considered this was not a routine situation, and the dentist should have given (or at least offered) AP to the patient. The court was also highly critical of the ambiguity of the wording of the NICE guidance. This criticism may have been a factor in persuading NICE to change the wording of its guidance and more clearly direct clinicians to the SDCEP for advice.

(ii) I believe it used to be the patient's cardiologist?

It has never been the cardiologist's responsibility to prescribe AP cover for dental procedures. That is a myth that has gained

traction among some dental professionals, in part due to the ambiguity of the NICE wording. Some have used this myth to deflect responsibility when patients have questioned why they will not prescribe AP – but it is not true. Although many cardiologists disagreed with the NICE guidance (as did many dentists) they were subject to it just like dentists. It should be noted, however, that the guidelines are not rules, they are guidelines. NICE has always made clear that it is not mandatory to apply their recommendations: "...the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individuals, in consultation with them and their families and carers or guardians". In that regard, it is notable that prescribing data shows that many dentists have continued to prescribe AP to high-risk patients undergoing invasive dental procedures. On a few occasions when dentists have refused to provide AP to patients at particularly high-risk, some cardiologists have also gone against NICE guidance and prescribed AP in a bid to protect their patients. But it was never their responsibility, or a requirement for them, to do so.

(iii) Direct access patients

I am not an expert on Direct Access. For clarification, therefore, dental professionals should consult the GDC, the legal requirements pertaining to Direct Access and their indemnity insurance providers. However, it is my understanding that although the Human Medicine Regulations 2012 were amended in 2024 to permit registered dental hygienists and therapists, with appropriate extra training and qualification, to prescribe some medicines including local anaesthetics and fluorides (Schedule 17, part 2 paragraph 13 of the regulations lists those medicines that can be prescribed), this did not extend to permitting the prescribing of antibiotics. This means that if a patient requests or requires AP, they will need to be referred to a dentist to prescribe this.

Question: *How do you perceive the guidance's suggestion that the dentist is to have the discussion with the patient and inform them. I feel the documents mention the dentist not the dental care professional. Am I to hand this to my dentist? How does this work under direct access? Also, I am by no means an expert in cardiovascular conditions and would always feel I'd want the patient's cardiologist's input.*

Response: Some of this is covered in the responses above. All healthcare workers involved in providing care should be involved in the shared decision-making process. It is the cardiologist's responsibility to determine if a patient is at high-risk for IE. Most will explain this to their patient and advise them that if they require dental treatment, they may require AP. Most cardiologists will tell patients to bring their high-risk status to the attention of any dental professional treating them so that that they can evaluate the risk posed by any dental treatment and explain this to the patient along with the risks and benefits of AP.

Most patients are therefore aware of their risk status, or dental professionals can easily ascertain this from the medical history e.g. history of having had a prosthetic valve inserted or of having had a previous episode of IE. Some patients now carry a card with them to show other healthcare providers what their IE-risk status is. If there is any doubt about the patient's status, however, most cardiologists are happy to be contacted to provide this information. Doing so may take time and delay treatment, however.

It is then for the dental professional (dentist, dental hygienist or dental therapist) to determine what dental treatment is required and if this involves an invasive procedure that could put the patient at risk of IE. If an 'at-risk' dental procedure is needed, the dental professional should explain the risk posed by that procedure, and the potential risks and benefits of AP cover, before obtaining informed consent to go ahead. The outcome of these discussions should be recorded in the clinical notes. If the patient decides they want AP cover, then arrangements need to be made for that to be provided. If the patient is being treated by a hygienist or therapist under Direct Access, this currently means they will need to be referred to a dentist for the prescription. In that situation, the dentist should also confirm the need for the treatment and the appropriateness of the AP cover i.e. obtain the patient's informed consent, before prescribing the AP, regardless of whether the procedure is then performed by the dentist or another dental professional. Both the prescriber and the person performing the procedure should go through the shared-decision making process and confirm that the patient is happy to proceed with the proposed dental treatment under AP

cover. For further advice consult with your indemnity insurance provider.

Further reading

Antibiotic prophylaxis | Scottish Dental Clinical Programme

Dental antimicrobial stewardship: toolkit - GOV.UK

<https://www.gov.uk/guidance/dental-antimicrobial-stewardship-toolkit>

<https://www.sdcep.org.uk/published-guidance/antibiotic-prophylaxis/>

COPY DATES FOR

DENTAL HEALTH

1ST OCTOBER FOR NOVEMBER ISSUE

The Editor would appreciate items sent ahead of these dates when possible

Email: editor@bsdht.org.uk

SEE US ON:
**STAND
23
AT THE
OHC**

WE PROTECT YOUR INCOME

Should you ever become ill and unable to work, our aim is to ensure that your family remains financially secure



0121 452 1066

www.dgmutual.co.uk

info@dgmutual.co.uk

50%
DISCOUNT OFFER*
FOR FIRST 2 YEARS
CODE: **BSDHT 2026**

dg mutual Income Protection
Insurance Specialists

'Peace of mind may cost less than you think. Let dg mutual create a bespoke income protection plan for you'

'If being off work due to illness or injury means you could not pay your bills, consider income protection insurance from dg mutual'



- A mutual friendly society established in 1927 to help our members and share our profits



- Over 99% of all claims paid
- Over 77% claims paid within a week
- No penalty for frequent claims or limit on the number of claims



- Up to £1200 benefit tax free p/week
- Payable from day one or deferred
- An option of a tax free lump sum on retirement

LIFESTYLE MEDICINE IN DAILY PRACTICE

Dentistry today is prevention-focused, holistic and connected to overall systemic health.

It requires highly skilled clinicians playing a crucial role in delivering the patient-centred care that modern dentistry requires. Dental hygienists and dental therapists (DH and DT) must be recognised as much more than just providers of a “scale and polish!”

A dental hygiene appointment may include personalised oral hygiene instruction, risk factor assessment and behaviour change counselling to support oral health, prevent disease and protect long-term outcomes. These versatile, transferable skills uniquely position DH and DT to incorporate evidence-based lifestyle medicine approaches in managing patients' behaviours related to oral disease.

The Case for Change

We should therefore embrace this significant and promising period of opportunity for our profession. The interrelationship between oral health and overall health is established. Oral health is increasingly recognised as an essential component of an individual's well-being. As affirmed in the World Health Organisation (WHO) Global Status Report, “There is no health without oral health.”¹

The rising prevalence of chronic conditions like cardiovascular disease (CVD) and diabetes, linked to periodontal diseases, pose a global challenge with heavy economic implications. Overburdened healthcare systems cannot rely solely on treatment; root causes must be addressed to prevent escalation.² A multidisciplinary approach and collaboration with allied health professionals is therefore essential. An individual's self-care and prevention strategies are key to quality of life and dental professionals are well placed to educate patients about shared risk factors for oral and systemic health by addressing lifestyle behaviours at their roots.³

The Oral Systemic Connection

It is widely accepted that oral health is a fundamental component of overall health. The World Health Organisation (WHO) estimates that oral diseases - recognised as noncommunicable diseases (NCDs), including dental caries, periodontal diseases and mouth cancer⁴ - affect more than 3.5 billion individuals globally, surpassing the burden of all other NCDs combined.⁵ In response to these alarming figures, the WHO Global Oral Health Status Report (2022) advocated expanding the current 5x5 NCD framework, which focuses on five diseases and five risk factors, to a 6x6 model that

incorporates oral diseases and sugar, aiming to address the shared risk factors associated with NCDs.⁶

Approximately 9% of UK adults show signs of severe periodontal disease.⁷ Increasing awareness of oral-systemic health links highlights associations between periodontal diseases and conditions like CVD, diabetes, obesity, Alzheimer's, and rheumatoid arthritis, some of which are bidirectional. This underscores the need to address shared risk factors across these NCDs.⁸

Lifestyle Medicine

Lifestyle Medicine (LM) is an evidence-based discipline grounded in six pillars, based on preventing, treating and reversing chronic disease. It is a natural fit for preventive dentistry. By addressing the root causes of NCD's through behaviour change, it seeks to lessen the burden of chronic conditions through primordial, primary, secondary, and tertiary prevention.

At its core, LM acknowledges that individuals actively participate in managing their own health through the decisions and behaviours that impact chronic conditions. The discipline emphasises shared care, education, knowledge and informed decision-making, operating as an interconnected, partnership-based approach to management.⁹

Applying Lifestyle Medicine in Practice

The six pillars of LM are important for both oral health and the risk factors linked to all NCDs. Their significance and clinical importance should be included in every dental appointment. The pillars function independently and interact within a dynamic cycle.

The British Society of Periodontology's adoption of the S3 guidelines emphasises the importance of discussing periodontal disease risk factors as the initial step in treatment.¹⁰ Integrating LM into appointments offers a structured approach to explore lifestyle behaviours and supports a more detailed assessment of factors such as pre-diabetes, CVD, stress and obesity. Its comprehensive framework also helps identify less commonly addressed but related factors, including sleep, social connection and substance misuse, which can reveal behaviours that might otherwise remain undisclosed or feel too sensitive to discuss.

1. Physical Inactivity

Physical inactivity is estimated to be responsible for over five million deaths per year, arguably a significant global problem. Inactive lifestyles are risk factors for many chronic diseases such as CVD, strokes, type 2 diabetes and depression. Physical

IT'S A MATCH!

LONG-TERM MATERIAL



FALL IN LOVE

duerrdental.com/system-hygiene

For the love of hygiene: ID 212 instrument disinfection preserves the value of your instruments for longer. Because it is gentle on materials, the product is a perfect match for instruments with rubber and silicone components. The System Hygiene from Dürr Dental is the perfect partner for all your practice hygiene needs.
duerrdental.com/system-hygiene



Scan for more information

**DÜRR
DENTAL**
THE BEST, BY DESIGN

inactivity and increased abdominal adiposity are associated with persistent low-grade inflammation and may predispose to obesity.¹¹

LM recommends at least 150 minutes of aerobic activity per week plus strength training to help reduce the risk of chronic disease. By encouraging our patients to become more physically active, we may help lower levels of inflammatory biological markers, thereby improving immune function, which is linked to better oral health.¹² Strength training also improves cardiovascular health and reduces the risk of type 2 diabetes and obesity.¹¹

2. Minimising Harmful Substances

Unlike the other pillars, this one focuses on stopping behaviour - the effects of toxic substances like smoking and alcohol are well known. Acknowledgement of the damaging effects of such behaviours is just the start; the challenge is achieving positive change in reduction or cessation.

Approximately 5.3 million UK adults smoke, and 5.4 million use e-cigarettes. We often educate patients on smoking harms like mouth cancer and periodontal diseases. However, how often do we discuss their alcohol intake? Approximately 24% of UK adults regularly exceed alcohol intake guidelines, with higher rates among professionals. Excessive drinking is linked to liver and heart disease, cancers, including mouth cancer, of which alcohol is linked with a third of cases. Reducing alcohol improves saliva, lowering caries and mouth cancer risk.¹³

3. Social Connection

Although often overlooked, this particular pillar is highly relevant in dental settings. Humans are inherently social and connection, purpose and meaning are central to our mental and physical health. Loneliness can be as harmful as smoking 15 cigarettes a day, or harmful alcohol use, and is linked to

illness and premature death. Social relationships are also closely associated with the risk of heart disease, obesity, certain cancers, and depression. In contrast, supportive relationships strengthen immunity and resistance to disease.¹⁴

Social disconnection may reduce motivation for self-care, including oral hygiene. Poor oral health, such as caries and tooth loss, can lower quality of life and contribute to psychological and social issues. Concerns about appearance, or having bad breath, may discourage smiling, laughter and social participation, especially involving eating. The connection between social connection and oral health is mutual and significant in dental practice.¹²

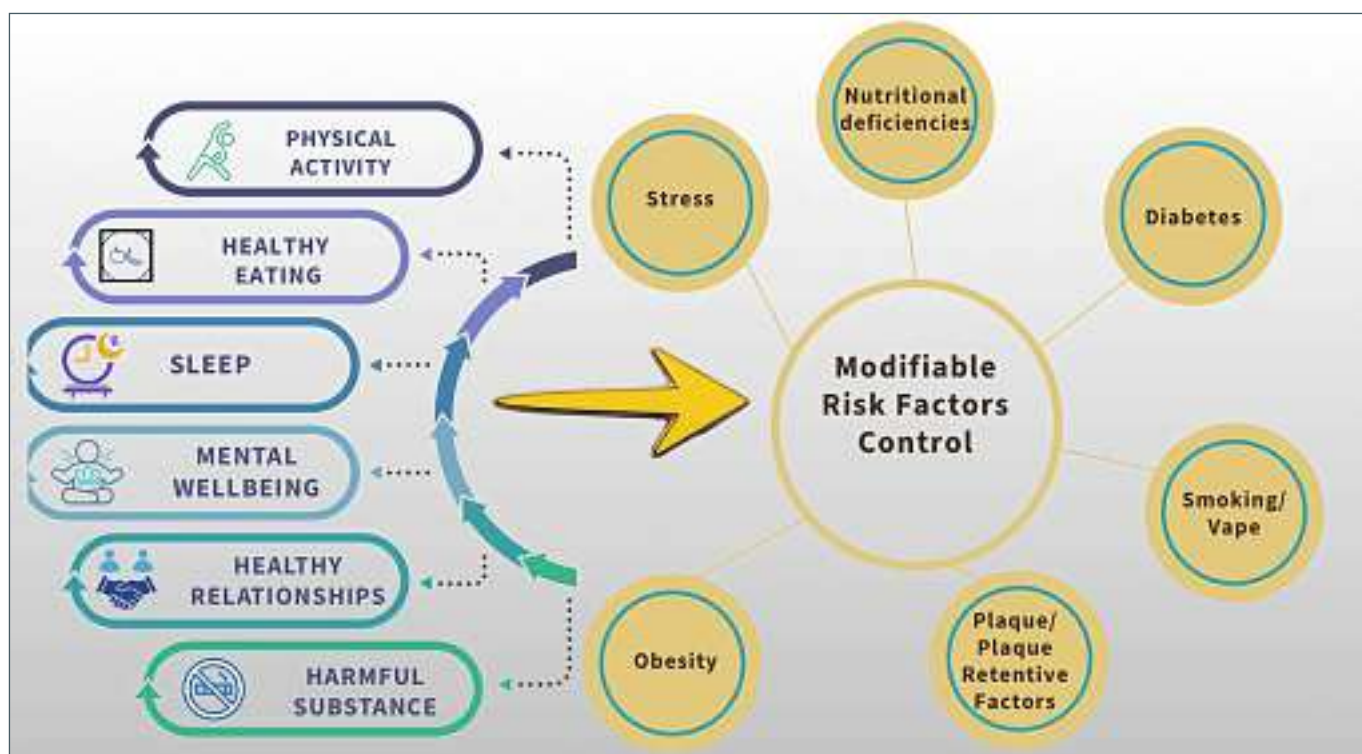
4. Nutrition

Nutrition plays a central role in oral and systemic health, influencing caries, erosion, and periodontal diseases. Frequent sugar intake drives demineralisation, while ultra-processed, pro-inflammatory dietary patterns contribute to chronic inflammation and periodontal breakdown. In contrast, nutrient-dense, anti-inflammatory diets rich in fibre, micronutrients, and healthy fats support periodontal stability and immune function. Within the UK Biobank cohort, a high micronutrient and fibre dietary pattern was associated with a lower risk of self-reported periodontal diseases, underscoring the importance of overall diet quality rather than single nutrients.

Clinically, brief, non-judgemental dietary assessment can focus on sugar frequency, ultra-processed food intake and specific erosive risks, such as acidic sports drinks in athletes. Healthy teeth and gums are also fundamental to a positive relationship with food and nutrition, whereas pain, tooth loss or impaired chewing can restrict food choice and compromise diet quality.¹⁵

5. Sleep

Sleep is a critical yet often under-recognised determinant



■ **Figure 1:** Applying the pillars of Lifestyle Medicine to address modifiable risk factors

of oral health. Inadequate or poor-quality sleep impairs immune function, delays healing, and increases systemic inflammation, all of which can negatively affect periodontal treatment outcomes. Sleep disturbances are closely linked with bruxism, xerostomia, and higher caries risk and often co-exist with obesity and cardiometabolic disease. Simple screening questions about sleep quality, snoring, nocturnal awakenings, daytime fatigue or jaw pain can be incorporated into routine dental assessments, enabling timely signposting for further evaluation of possible sleep-disordered breathing. A large analysis of adults from the United States and the United Kingdom showed that a healthy lifestyle score including ideal sleep duration, alongside diet, smoking and physical activity, was associated with a lower prevalence of periodontal diseases, partly mediated by reduced systemic inflammation. This emerging evidence supports the inclusion of sleep as a core pillar in preventive dental practice.¹⁶

6. Mental Wellbeing

Stress management is also highly relevant in periodontal care, acting through both behavioural and biological pathways. Chronic psychological stress increases cortisol levels, disrupts immune function and promotes a pro-inflammatory state that can accelerate periodontal disease progression and delay healing. Stress is strongly associated with bruxism and other parafunctional habits, as well as coping behaviours such as tobacco use, harmful alcohol consumption and recreational drug use, all of which further damage periodontal and oral mucosal health. Recognising the clinical signs of stress such as tooth wear, fluctuating plaque control, mucosal trauma or recurrent acute periodontal episodes, creates opportunities for supportive, non-stigmatising conversations and brief interventions. A recent systematic review reported that psychological stress and stress-related disorders may negatively

influence periodontitis treatment outcomes through both behavioural factors and altered immune and inflammatory responses.^{17,18}

A unique opportunity

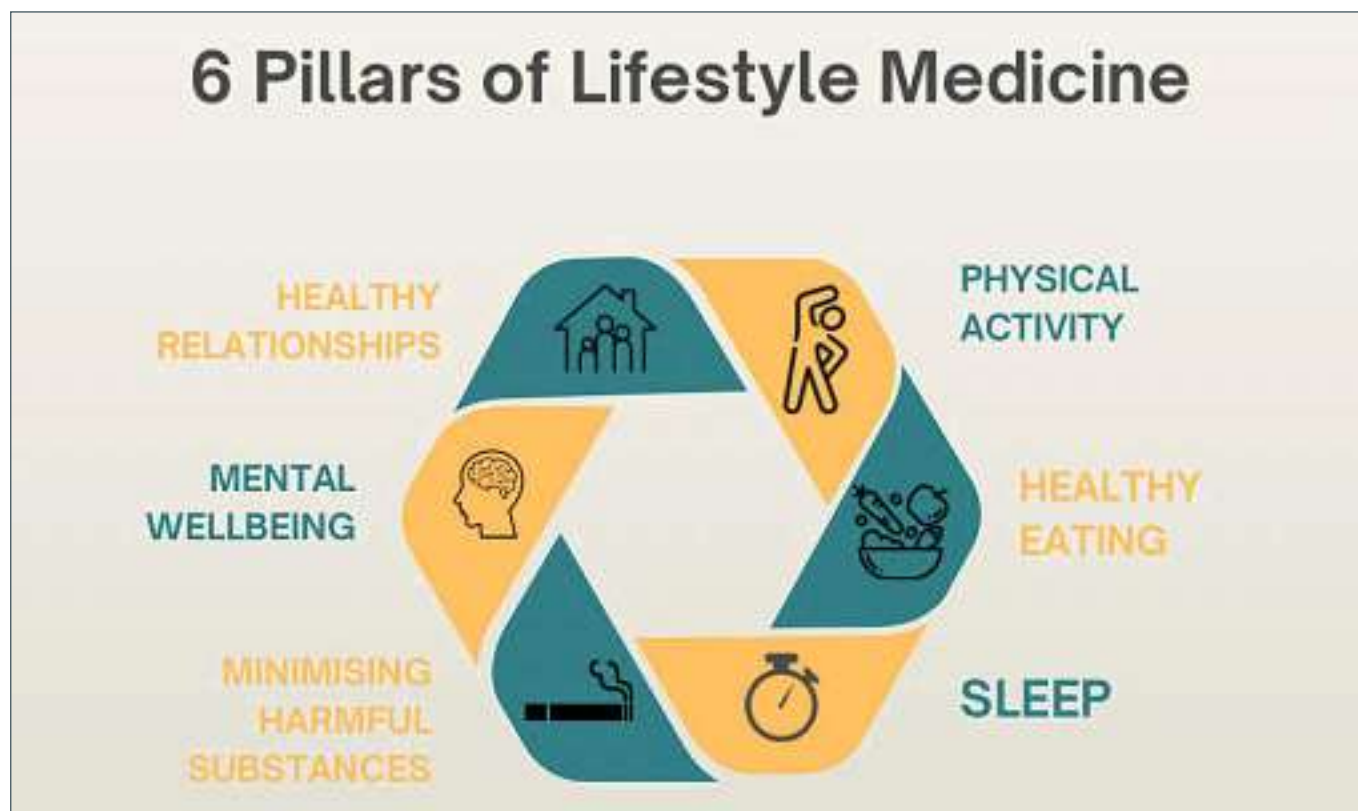
Dental hygienists and dental therapists see patients regularly, building long-term relationships. This continuity supports monitoring, reinforces healthy behaviours and allows early detection and identification of concerns. Patients often view us as prevention-focused practitioners and expect advice on avoiding future problems while managing current ones.

During appointments, many aspects of LM, including diet, smoking, alcohol use, stress, physical inactivity, and sleep, are often discussed. Extending these discussions to include prevention and management of NCDs is a logical, clinically relevant expansion of current practice. It may also improve practitioner and patient satisfaction and lead to better consultation and treatment outcomes.

As information about the link between oral and systemic health becomes more accessible through social and mainstream media, patient expectations are evolving, reinforcing the need for a modern, wellbeing-focused approach.

Practical Implementation in practice

LM should be seamlessly integrated into clinical consultations. This can be achieved during medical history taking by asking about new medications, health conditions, alcohol consumption, or smoking status. It can also be addressed when assessing periodontal inflammation, gingival bleeding, caries risk or xerostomia by connecting the discussion to the patient's oral health.



■ **Figure 2:** Six pillars of Lifestyle medicine

During time-limited appointments, it may be most practical to introduce one or two pillars at a time. Alternatively, a comprehensive assessment can address all pillars and link the patient's current oral health status to systemic inflammation and its impact on oral health. Whatever the approach, it should be delivered sensitively, without judgment, and supported by active listening, SMART goal setting, and a non-directive, non-prescriptive style.¹⁹

Challenges and Constraints

Although more than 80% of chronic diseases may be preventable through healthy lifestyle behaviours, long-term adoption remains challenging. Addressing root causes requires a comprehensive strategy to halt and reverse disease progression. LM is designed not to increase workload, but to make practice more effective.²⁰

Prevention relies on patients making behaviour changes that are sustainable when goals are self-determined. However, assessing readiness for change and setting appropriate goals and priorities takes time within an already demanding appointment schedule.

Effective lifestyle medicine coaching helps ensure staff are trained and competent, supports clear team communication about its purpose and benefits, and aids integration of these discussions into patient consultations. This may also improve job satisfaction across the team.¹⁹

Summary

The role of dental hygienists and dental therapists is evolving. We not only treat disease but also advocate for prevention, educate and promote lasting behavioural change.

Every clinical interaction and effort to empower patients or promote positive lifestyle changes contributes to improved health outcomes. Oral health is integral to overall health, and healthcare systems must recognise this connection. Dental professionals are excellently positioned to bridge this divide, impacting both oral health and broader systemic wellbeing.

Lifestyle medicine is not separate from dentistry; it is a natural extension. By targeting underlying causes of disease, the profession can shift from maintenance to meaningful transformation. This enhances opportunities for professional growth, collaboration with other healthcare providers and prioritises prevention in patient care.

The future of care is clear: longer, whole-health-focused appointments, focusing on whole-person health, including HbA1c testing, blood pressure, BMI, nutrition, and discussions about diet, with onward referrals where needed. Patients should be informed, motivated, and actively engaged in their wellbeing. This is an achievable, evidence-based progression, not just an aspiration.

The real question now is not if we can join this change, but if we are prepared to lead it....?

Authors: Lisa Knowles qualified as a dental therapist in 2007.

Kate Reading qualified as a dental hygienist in 2004 and serves as Chair of the Northwest BSHDT Committee.

Having become colleagues at a referral practice in Wilmslow, Lisa and Kate further advanced their shared interest in preventive care by obtaining Certificates in Lifestyle Medicine Coaching. Together, they co-founded PeriLife Align, a social media platform dedicated to educating both patients and professionals on the links between chronic conditions such as diabetes, obesity, and cardiovascular disease and oral health, through the application of evidence-based lifestyle medicine principles.

Contact: Katereading.rdh@gmail.com

Lisa@clinic334.co.uk

References

1. World Health Organization. Global strategy and action plan on oral health 2023–2030. 2024. <https://www.who.int/publications/i/item/9789240090538>
2. Freihat O, Sipos D, Aamir M, Kovacs A. Global burden and future projections of non-communicable diseases (2000–2050): Progress toward SDG 3.4 and disparities across regions and risk factors. *PLoS ONE* 2025;**20(12)**:e0336036–6. <https://pmc.ncbi.nlm.nih.gov/articles/PMC12694828/>
3. NCDs. Management of noncommunicable diseases in primary health care. World Health Organization - Regional Office for the Eastern Mediterranean. <https://www.emro.who.int/noncommunicable-diseases/publications/questions-and-answers-on-management-of-noncommunicable-diseases-in-primary-health-care.html>
4. Chapple ILC. The global burden of oral disease - what is the fuss? *BDJ Team* 2025;**12(8)**:364–367. <https://www.nature.com/articles/s41407-025-3105-9>
5. World Health Organization.. Oral Health 2023. https://www.who.int/health-topics/oral-health#tab=tab_1
6. Benizian H, Daar A, Naidoo S. Redefining the non-communicable disease framework to a 6 × 6 approach: incorporating oral diseases and sugars. *Lancet Publ Health*. 2023;**8(11)**: e899–e904. DOI: 10.1016/S2468-2667(23)00205-0
7. Oral Health Foundation. UK oral health statistics. 2026. <https://www.dentalhealth.org/uk-oral-health-statistics>
8. Kapila YL. Oral health's inextricable connection to systemic health: Special populations bring to bear multimodal relationships and factors connecting periodontal disease to systemic diseases and conditions. *Periodontol*. 2000. 2021;**87(1)**:11–16. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8457130/>
9. British Society of Lifestyle Medicine. What is Lifestyle Medicine?. 2025 <https://bslm.org.uk/lifestyle-medicine/what-is-lifestyle-medicine/>
10. British Society of Periodontology. BSP UK Version of the S3 Treatment Guidelines for Periodontitis. <https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis>
11. British Society of Lifestyle Medicine. Lifestyle Medicine – The Facts. Physical Activity. <https://bslm.org.uk/physical-activity/>
12. Ciantelli NM, Menezes M, Yoong J, Deschamps J, Jaqua EE. exploring the interplay between lifestyle medicine and oral health: a bidirectional relationship. *Am J Lifestyle Med*. 2024;**18(3)**:425–430. <https://doi.org/10.1177/15598276231213339>
13. British Society of Lifestyle Medicine. Lifestyle medicine. The Facts. Avoiding Toxic Substances and Harmful Behaviours. <https://bslm.org.uk/harmful-substances/>
14. British Society of Lifestyle Medicine. Lifestyle medicine. The Facts. Healthy Relationships and Social Connection. <https://bslm.org.uk/healthy-relationships-and-social-connections/>
15. Watson S, Woodside JV, Winning L, Wright DM, Srinivasan M, McKenna G. Associations between self-reported periodontal disease and nutrient intakes and nutrient-based dietary patterns in the UK Biobank. *J Clin Periodontol*. 2022;**49(5)**:428–438. <https://doi.org/10.1111/jcpe.13604>
16. Marruganti C, Luthra S, Hussain SB, Suvan J, D'Aiuto F. Healthy lifestyles

and better periodontal health: Results from two large population-based surveys. *J Periodont Res.* 2025;**60(2)**:144-153. <https://doi.org/10.1111/jre.13320>

17. Macri M, D'Albis G, D'Albis V, Antonacci A, Abbinante A, Stefanelli R, et al. Periodontal health and its relationship with psychological stress: a cross-sectional study. *J Clin Med.* 2024;**13(10)**:2942-2. <https://doi.org/10.3390/jcm13102942>
18. Mauland EK, Neupane SP. The influence of psychological stress and stress-related disorders in the treatment outcome of periodontitis: a systematic review and meta-analysis. *J Clin Periodontol.* 2025;**52(12)**:1760-1778. <https://pubmed.ncbi.nlm.nih.gov/40855968/>

19. Conn S, Curtain S. Health coaching as a lifestyle medicine process in primary care. *Austral J Gen Pract.* 2019;**48(10)**:677-680. <https://search.informit.org/doi/10.3316/informit.677929098103677>
20. Bodai BI, Nakata TE, Wong WT, Clark DR, Lawenda S, Tsou C et al. Lifestyle medicine: a brief review of its dramatic impact on health and survival. *Permanente J.* 2017;**22(22)**:17-25. <https://doi.org/10.7812/TPP/17-025>

Cite this article:

Reading K, Knowles L. Lifestyle Medicine In Daily Practice. *Dental Health* 2026;**65(5)**:27-32. <https://doi.org/10.59489/bsdht189>

INVITATION TO BECOME BSDHT COUNCIL OBSERVERS



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 Monday 28th September 9.30pm - 15.30 ONLINE

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

Don't let enjoyment



be spoilt by dry mouth

NEW
look,
SAME
formulation



Oralieve Moisturising Mouth Gel and Spray help relieve the symptoms of a dry mouth, leaving your patients free to get on with enjoying life more fully.

The No. 1 most recommended brand by dental professionals for dry mouth relief*

*Data collected online. Contact hello@oralieve.co.uk for verification.

Earn 2.5 hours of
FREE verifiable CPD



www.oralieve.co.uk

Oralieve®

BY HAFEEZ AHMED
& LISA DEVINE

CALMING THE INTENSITY

With rising burnout among oral health professionals, a new perspective on anxiety may offer a path toward resilience, balance, and long-term wellbeing.

Dentistry has long been recognised as a high-stress profession, but the scope of that stress is broader and more complex than many may realise. Research consistently shows that dentists experience higher rates of burnout, anxiety, and depression compared to many other professions.¹ Alarmingly, studies in the United States have also identified elevated suicide mortality rates among dentists, with a steady increase over recent decades.²

What is perhaps even more concerning is that this trend persists despite decades of research, awareness campaigns, and well-established coping strategies.³ Traditional approaches to managing stress in dentistry, while valuable, have not fully addressed the root of the problem.⁴ And increasingly, evidence suggests that dental hygienists and other members of the dental team are experiencing similar levels of psychological distress.^{5,6}

A 2025 study expanded the conversation beyond dentists alone, highlighting that the entire dental team is vulnerable to burnout.⁷ This shift is significant. It underscores the need for a more inclusive, systemic approach to mental health; one that recognises shared workplace pressures, interpersonal dynamics and the emotional demands of patient care.

A Different Way to Understand Anxiety

An alternative perspective was born out of The Philosophy Fridge experience⁸ and challenges the way oral health professionals think about anxiety itself. Rather than viewing anxiety solely as a negative condition to suppress or eliminate, this approach considers it a natural and potentially useful function; an internal signal designed to guide perception, decision-making and action.

At its most basic level, anxiety exists to protect us. It helps identify potential threats, prepares the body for action and sharpens awareness. But in modern professional environments, especially high-pressure ones like dentistry, this system can become overwhelmed or misinterpreted.

Anxiety operates as part of a two-stage process. The first stage is instinctive and physical—often described as a “gut feeling.” This immediate response is rapid and automatic. The second stage involves the mind, which interprets, filters, and decides how to respond to those initial signals. Ideally, these two systems work in harmony.

Problems arise when there is a disconnect; when the mind repeatedly overrides or ignores the signals from the body. Over time, this mismatch can lead to chronic stress, emotional exhaustion and the sense of being overwhelmed that many dental professionals report.

From Fear to Function

A key insight in this framework is that anxiety itself is not inherently harmful; it is the interpretation of anxiety that determines its impact. When anxiety is viewed through a lens of fear, it can feel paralyzing. It becomes something to avoid, suppress, or escape. But when the same physiological response is reframed through a lens of opportunity or ambition, it can become energising and motivating.

For oral health professionals, this shift in perspective can be powerful. The same heightened awareness that contributes to stress can also enhance clinical performance, improve decision-making and support patient care, if it is understood and managed effectively.

The Role of Conditioning

Another important factor is how individuals learn to process anxiety over time. Early experiences, whether supportive or adverse, shape how people respond to stress later in life. Overprotective environments, neglect, or chronic pressure can all contribute to maladaptive patterns.⁹

In the context of dentistry, this conditioning may be reinforced by the demands of education and clinical training. High expectations, perfectionism and fear of error can create a foundation where anxiety is consistently interpreted as a threat rather than a tool.

This is particularly relevant for students and early-career professionals. Studies have shown that a significant percentage of dental and dental hygiene students already meet criteria for burnout before entering the workforce.¹⁰ Without intervention, these patterns can persist and intensify throughout their careers.

Why Traditional Approaches Fall Short

Conventional mental health strategies often focus on reducing or eliminating symptoms: controlling negative thoughts, minimising stress, and promoting relaxation. While these approaches can be helpful, they may not fully address the underlying dynamics of anxiety.

Cognitive behavioral therapy (CBT), for example, emphasises the relationship between thoughts, feelings, and behaviors.¹¹

The stand-out performance patients need.
The name professionals recommend.



Not all water flossers are equal. Recommend by name.



Industry leader

Recognised as the #1 selling water flosser brand in the UK and in the world.

Recommended by experts

The most recommended water flosser brand by dental professionals* and the only one approved by the Oral Health Foundation.

*Based on 2025 independent survey of Dental Professionals; among those who recommended branded water flossers

Backed by science

Supported by over 80+ clinical research studies. Clinically proven to remove up to 99.9% of plaque bacteria in treated areas* and be 2X as effective as string floss for improving gum health.

*in vitro, data on file

Standing the test of time

With 60 years of innovation, Waterpik™ has been committed to a professional-level clean for over half a century.



Bring premium flossing to centre stage.
Sign up on our website for **the advocacy programme**
www.waterpik.co.uk

waterpik™
waterflosser

It provides tools for reframing negative thinking and developing healthier responses. However, even with these tools, many professionals continue to struggle.

One reason is that anxiety dysfunction can make it difficult to see a way forward. When someone is deeply entrenched in stress or burnout, solutions can feel out of reach. This creates a cycle where the very condition that needs to be addressed also limits the ability to address it.

Practical Steps Toward Change

A more effective approach may involve redefining the relationship with anxiety rather than attempting to eliminate it. It may be useful to employ a series of mindset shifts:

- Recognise that anxiety serves a natural purpose and is not inherently harmful.
- Accept that feelings of uncertainty or discomfort are a normal part of growth and professional development.
- Distinguish between stress caused by external factors (such as workplace conditions) and internal patterns that can be adjusted.
- Acknowledge that some level of emotional fluctuation is unavoidable and even necessary for resilience.
- Avoid the tendency to withdraw or isolate, as engagement with others is essential for both personal and professional wellbeing.
- Practice self-compassion, particularly during setbacks or periods of difficulty.
- Understand that mental health support, whether therapy or medication, often involves trial and adjustment rather than immediate solutions.

These shifts are not quick fixes. They require consistent effort and reinforcement over time. But they offer a pathway toward greater balance and adaptability.

Implications for the Dental Team

For dental practices, these insights have practical implications. Addressing burnout is not just an individual responsibility; it is a collective one. Creating a supportive work environment, encouraging open communication, and recognising the emotional demands of the profession are all critical steps.

Leaders within dental teams can play a key role by fostering a culture where mental health is prioritised alongside clinical excellence. This includes normalising conversations about stress, providing access to resources, and promoting realistic expectations.

Importantly, these efforts should extend to all members of the team. Dentists, dental hygienists, dental therapists, dental nurses and administrative staff each face unique pressures, and their wellbeing is equally essential to the overall function of the practice.

Finding Balance in a Demanding Profession

Ultimately, the goal is not to eliminate stress entirely, but rather to develop the capacity to navigate it effectively. This requires a balanced perspective, one that acknowledges both the challenges and the opportunities inherent in dental practice.

Avoiding negative emotions altogether can lead to what some describe as “emotional fragility,” where even minor stressors become overwhelming. In contrast, embracing a full range of experiences can build resilience and adaptability.

The Role of Hope

While systemic changes in the profession are important, they take time. In the meantime, individual coping strategies remain essential. Hope, in this context, is not about expecting the external environment to change overnight. It is about maintaining internal stability and preventing emotional collapse in the face of ongoing challenges.

For dentists and dental hygienists and therapists alike, this perspective offers a practical and empowering approach. By reframing anxiety, understanding its function, and developing healthier responses, it is possible to move beyond burnout and toward a more sustainable, fulfilling career.

Authors: Hafeez Ahmed is a periodontist in private practice in Royal Leamington Spa, Warwickshire, England, with more than 30 years of experience. He is author of the book *The Philosophy Fridge: Bad Apples, Soggy Gums, Rotting Teeth*.

Lisa Devine has over 25 years of experience in holistic therapies and sports massage with a keen interest in anxiety, fibromyalgia, burnout, and chronic fatigue syndrome. She works in Royal Leamington Spa, Warwickshire, England. Lisa's vision is to get everyone healthy, living mindful of their brains and bodies.

The authors have recently published a book called *The Anxiety Bureau*, it's available to buy on Amazon. The forward to the book is by Dr Sami Timimi who is a Consultant Psychiatrist specialising in teenage and adolescent psychiatry. The book is aimed at teenagers and presents the psychological concepts which support the perspective of anxiety presented in this article in an easy-to-understand format.

Contact: binswoodhousedentalpractice@btinternet.com.

References

- 1 Kulkarni S, Dagli N, Duraiswamy P, Desai H, Vyas H, Baroudi K. Stress and professional burnout among newly graduated dentists. *J Int Soc Prev Comm Dent*. 2016;**6**(6):535–541. doi: 10.4103/2231-0762.195509
- 2 Tomasi SE, Lipman R, Bloom F, Nett RJ, Cox-Ganser JM, Fechter-Leggett ED. Suicide deaths among dentists in the United States. *J Am Dent Assoc*. 2005;**156**(12):1024-1033. <https://doi.org/10.1016/j.adaj.2025.08.016>
- 3 Meyerson J, Gelkopf M, Eli I, Uziel N. Stress coping strategies, burnout, secondary traumatic stress, and compassion satisfaction amongst

- Israeli dentists: a cross-sectional study. *Int Dent J*. 2022;**72**(4):476–483. 10.1016/j.identj.2021.09.006
- 4 Plessas A, Paisi M, Bryce M, Burns L, O'Brien T, Hanoch Y, et al Mental health and wellbeing interventions in the dental sector: a systematic review. *Evid Based Dent*. 2022;**7**:1–8. <https://doi.org/10.1038/s41432-022-0831-0>
 - 5 Harris M, Wilson JC, Holmes S, Radford DR. Perceived stress and well-being among dental hygiene and dental therapy students. *Brit Dent J*. 2017;**222**(2):101–106. <https://doi.org/10.1038/sj.bdj.2017.76>
 - 6 Harris M, Eaton K. Exploring dental professionals' perceptions of resilience to dental environment stress: a qualitative study: Exploring dental professionals' perceptions of resilience to dental environment stress: a qualitative study. *Brit Dent J*. 2025;**238**(6):395–402. <https://doi.org/10.1038/s41415-024-7953-z>
 - 7 Durkin J, Mumford C. Burnout, stress, and wellbeing: the rising mental health crisis in UK dentistry in dental care professionals. A quantitative Perspective. *Int J Dent Hyg*. Feb 2025. <https://doi.org/10.1111/idh.12906>
 - 8 Dr Hafeez Ahmed, The Philosophy Fridge - Bad Apples, Soggy Gums, Rotting Teeth. Independent, Amazon.
 - 9 Lieb R, Wittchen HU, Höfler M, Fuetsch M, Stein MB, Merikangas KR. Parental psychopathy, parenting styles, and the risk of social phobia in offspring. A prospective-longitudinal community study. *Arch Gen Psychiatry*. 2000;**57**(9):859–866. doi:10.1001/archpsyc.57.9.859
 - 10 Deeb RG, Braun S, Carrico C, Kinser P, Laskin D, Golob Deeb J. Burnout, depression and suicidal ideation in dental and dental hygiene students. *Eur J Dent Educ*. 2018;**22**(1):e70–e74. <https://doi.org/10.1111/eje.12259>
 - 11 Glenn D, Golinelli D, Rose RD, Roy-Byrne P, Stein MB, Sullivan G, et al. Who gets the most out of cognitive behavioural therapy for anxiety disorders? The role of treatment dose and patient engagement. *J Consult Clin Psychol*. 2013;**81**(4):639–649. <https://doi.org/10.1037/a0033403>

Cite this article:

Ahmed H, Devine L. Calming the Intensity. *Dental Health* 2026; **65**(5):33–36. <https://doi.org/10.59489/bsdht190>

DID YOU KNOW...?

The International Federation of Dental Hygienists (IFDH) has developed a series of evidence-based White Papers, published over a three-year period, to provide its international associate members with accessible, relevant information to support the advancement of oral health.

These papers are valuable resources for dental hygienists, dental therapists and oral health therapists, particularly when advocating for the profession, informing policy and education, and working collaboratively with colleagues and stakeholders across dentistry, medicine and education.

Importantly, the series highlights the contribution that dental hygienists, dental therapists and oral health therapists can make to improving population oral health and supporting

the World Health Organization's Global Strategy on Oral Health. It also provides an opportunity to demonstrate how prevention-focused care and behavioural approaches can contribute to better health outcomes.

The White Paper series covers a broad range of contemporary issues, including:

- Oral health during pregnancy
- The impact of sustainability
- The cost-effectiveness of prevention
- Ageing and oral care
- Behavioural change
- Oral health for medically challenged patients

Together, these topics reflect many of the issues that are increasingly relevant to everyday clinical practice, public health and the future development of the dental hygiene and therapy professions.

As a member of the IFDH through BSDHT, members can access the latest White Paper, **Behavioural Change**, written by Jeanie Suvan and Claire McCarthy. It provides an opportunity to explore the evidence surrounding behaviour change and consider how this can be applied to patient communication, prevention and clinical practice.

The White Paper can be accessed here:

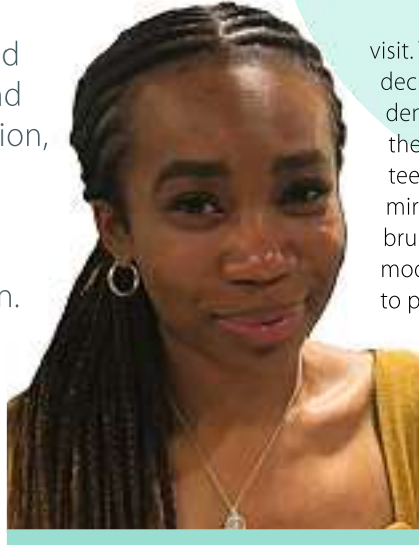


Scan me



A STUDENT'S PERSPECTIVE

The role of the dental hygienist and dental therapist extends far beyond the dental surgery. Health promotion, education and community engagement are fundamental components of improving oral health, particularly among children. Prevention underpins modern dental care and remains one of the most effective strategies for reducing the burden of oral disease, especially beginning in childhood and continuing into adulthood.¹ One way this is achieved is through community oral health promotion, particularly school visits, which provide an opportunity to reach large groups of children at an age when oral health behaviours begin to develop.



visit. Two dinosaur models, one demonstrating deciduous dentition and the other permanent dentition, provided an engaging way of explaining the difference between primary and permanent teeth. Using giant toothbrushes and mouth mirrors, the children eagerly demonstrated brushing techniques on an oversized mouth model. This hands-on activity enabled them to practise effective brushing techniques in an engaging and memorable way. The sessions finished with an interactive quiz that encouraged the children to apply what they had learnt while providing an enjoyable opportunity to consolidate the key messages. The enthusiasm shown by the children emphasised how interactive learning can make oral health education enjoyable, memorable and accessible.

Reflection

Delivering these sessions strengthened my confidence in communicating with children and demonstrated that many children already had a good understanding of basic oral health principles. The experience reinforced that effective prevention extends beyond the dental practice, with schools providing valuable opportunities to establish lifelong healthy behaviours. Community outreach initiatives benefit not only the children receiving oral health education but also the students delivering it, providing valuable opportunities to develop communication skills, confidence and professionalism, while contributing meaningfully to community oral health before qualification. As I prepare to qualify, this experience has reinforced the rewarding role dental hygienists and dental therapists play in improving children's oral health through education, long before a patient enters the dental surgery.

Author: Natalie is a BSDHT Student Representative and 3rd year dental hygiene and therapy student at the University of Portsmouth.

Contact: natalie.o.dental@gmail.com

Prevention in the community

As part of this wider commitment to prevention, I recently participated in an oral health promotion visit to a local primary school. The visit involved delivering sessions to year 1 and year 2 pupils, with the aim of promoting positive oral health behaviours through interactive age-appropriate education. The sessions began with a simple presentation designed to encourage active participation rather than passive listening, helping to reinforce key oral health messages. The children were invited to share what they already knew about teeth, oral hygiene and healthy eating choices. This stimulated conversation and helped tailor discussions to their level of understanding. The use of practical resources enhanced engagement and was a particularly valuable aspect of the

References

- 1 Bhaskar V, McGraw KA, Divaris K. The importance of preventative dental visits from a young age: systemic review and current perspectives. *Clin Cosmet Investigat Dent*. 2014;**6**:21-27. <https://doi.org/10.2147/CCIDE.S41499>
- 2 Office for Health Improvement and Disparities. (2024). National Dental Epidemiology Programme (NDEP) for England: Oral health survey of 5-year-old children 2022. GOV.UK. <https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022/national-dental-epidemiology-programme-ndep-for-england-oral-health-survey-of-5-year-old-children-2022>
- 3 National Institute for Health and Care Excellence. (2016). *Oral health promotion in the community (Quality Standard No. QS139)*. <https://www.nice.org.uk/guidance/qs139>

BY FERN BRIDGES,
NAJIYAH ISLAM, EVA TOMALIN-
REEVES, TATIANA TOPOR

INTERPROFESSIONAL EDUCATION

DENTAL THERAPY AND SPEECH AND LANGUAGE THERAPY

Oral health is an important part of general health and wellbeing, yet it is often overlooked outside of dentistry. Poor oral health can affect an individual's comfort, nutrition, communication, confidence and overall quality of life. It has also been linked to wider health conditions such as cardiovascular disease, diabetes and respiratory infections.¹⁻³ Despite this, oral health promotion is still often viewed primarily as part of dental care. In reality, many patients regularly interact with a range of healthcare professionals who may have opportunities to reinforce key oral health messages. However, many non-dental health and social care professionals receive little formal education in oral health, which can limit their confidence and ability to recognise problems, provide appropriate advice or make timely referrals. This is particularly important given that barriers to accessing NHS dental services, including limited availability, cost and services that are not commissioned to meet local needs, mean some patients may have more frequent contact with other healthcare professionals than with a dental professional.⁴ Although NICE recommends that caregivers support residents with their oral health, there is currently no mandatory requirement for oral health training in care settings. While the proportion of care staff receiving specific oral health training increased from around 30% in 2019 to approximately 60% in 2022, high staff turnover means these skills are frequently lost, highlighting the need for ongoing education and training.⁵

Dental caries continues to be one of the most common non-communicable chronic diseases nationally and globally.⁶ In the UK, oral disease remains highly prevalent despite being largely preventable. Recent surveys in England found that around 23% of 5-year-old children experience dental decay, with children in more deprived areas significantly more affected.⁷ In addition, dental caries remains the leading cause of hospital admissions among children aged 5 - 9 years.⁸ These figures highlight not only the prevalence of preventable oral disease, but also the ongoing oral health inequalities that continue to affect vulnerable populations. Alongside the impact on patients and families, oral diseases also place a considerable financial burden on the healthcare system, reinforcing the need for a broader and more preventative approach to oral health promotion.

Greater awareness of oral health among wider healthcare

teams may help support earlier intervention and improve patient outcomes, as patients are often seen more regularly by healthcare professionals outside of dental services, particularly those with complex medical or additional care needs. This can create opportunities for earlier recognition of oral health concerns and support prevention.

Speech and Language Therapists (SLTs) are one professional group where this collaboration is particularly relevant. SLTs commonly work with patients with dysphagia, neurological conditions, learning disabilities, communication difficulties and complex care needs. Many of these patients are at increased risk of oral health problems due to factors such as reduced dexterity, xerostomia, difficulty maintaining oral hygiene or modified diets.⁹ For example, patients requiring thickened fluids or soft diets may experience prolonged oral clearance times and increased caries risk. In some cases, communication difficulties may also make it harder for patients to express dental pain or discomfort. In such circumstances, oral disease may remain undetected. Due to their ongoing involvement in patient care, SLTs are in a valuable position to support prevention and recognise oral health concerns early.

Collaboration

There is clear overlap between SLTs and dental professionals in areas such as communication, oral function, diet modification and long-term prevention. Working collaboratively may therefore help provide more holistic, patient-centred care and improve understanding of the challenges faced by these patient groups.¹⁰ These factors formed the basis of a collaborative project with first-year speech and language therapy students at Marjon University.

As part of this collaborative opportunity, the dental therapist (DTs) authors were given the opportunity to deliver a teaching session to speech and language therapy students at Plymouth Marjon University on the subjects of dysphagia, dysgeusia and xerostomia, as well as advising on mouth care for these patients. This was followed by a presentation delivered by a SLT tutor focused on the assessment and management of dysphagia. The afternoon concluded with collaborative case-based discussions, allowing both DTs and SLTs to discuss cases as a group and explore how

each discipline would approach patient management. It also provided an opportunity to explore future practical collaboration to promote a more holistic management of these cases.

Interdisciplinary learning

This experience created a unique opportunity for wider health and social care colleagues to engage in a form of interdisciplinary learning. Undergraduate healthcare education often occurs in isolation from the wider healthcare professions. This learning model tends to result in limited understanding of one another's roles, responsibilities and scope of practice and an ignorance of other teams' potential to be involved in the multidisciplinary management of a patient. The session conducted allowed for the DTs to gain an understanding of how SLTs approach patient management. Similarly, the SLTs gained an awareness of how DTs approach patient care, highlighting both similarities and differences in advice provided.

Working as part of a multidisciplinary team (MDT) requires clear and effective communication. The various specialties need to liaise closely. Planning and timing treatment and allocating tasks and responsibilities amongst the team ensures everyone understands their role. During the interprofessional engagement (IPE) project it became apparent that, as healthcare workers, we face a huge barrier: lack of awareness and knowledge surrounding other health care professional roles and their scope of practice. Considering this, it is likely that we are not utilising the whole team to its full potential and therefore face limitations and longer waiting periods for patients when providing appropriate care. It is important therefore, to participate in IPE projects and raise awareness of different roles within health care and join the dots between different professionals' scope of practice.

As a group of four DTs based across the South West the authors agreed the best approach to work collaboratively and efficiently together, whilst balancing contrasting work schedules and economic concerns, would be to work remotely as a team. Subsequently, meetings via online video calls were arranged to discuss aims and objectives, assign tasks and delegate topics of research, with findings stored on a shared Word document. Once the information had been collated, it was agreed to produce a PowerPoint presentation with each member completing the slides relevant to the topics they had researched. This approach ensured that each team member understood their role and what was expected of them throughout. It also allowed the team to complete the work at their convenience to suit their work/life schedule.

This did however, cause some barriers during the preparation of the IPE project and whilst delivering the presentation. Due to working remotely, and work schedules not aligning, there was no opportunity to rehearse prior to presenting to the SLT students.

The presentation

The team delivered the presentation focusing on oral health topics relevant to SLTs, including periodontal diseases, xerostomia, caries, diet and mouth care. As dysphagia was the

SLTs focus topic for the week, the session helped highlight the important link between oral health and patients with swallowing difficulties. This collaborative approach enabled SLTs and DTs to present their approach to care for patients and helped both professions gain a better understanding of each others' responsibilities and areas of overlap. During the mixed group case study discussions, both teams worked collaboratively to analyse patient scenarios, and consider appropriate management approaches. This structure was effective, because it encouraged shared learning, while also creating opportunities for discussion, collaboration and practical application of knowledge.

Several oral health topics were especially relevant to the SLT students. Xerostomia was discussed in relation to swallowing difficulties, patient comfort, oral disease and infection risk. Dysphagia was a key topic that clearly demonstrated the overlap between the two professions, particularly regarding oral hygiene management and aspiration pneumonia prevention. The inclusion of *Mouth Care Matters*¹¹ principles reinforced the significance of maintaining oral health within hospital and care home settings. The discussions highlighted the fact that oral health is not separate from general health. The presentation successfully covered a range of oral diseases and linked them clearly to SLT practice. However, on reflection, mouth cancer should have been included.

The authors' presentation, included Delivering Better Oral Health⁶ guidelines, alongside diet advice, oral hygiene tools and correct techniques for maintaining good oral and denture hygiene. Included was slide outlining different modified oral hygiene aids for patients who struggle with manual dexterity. In addition, the NICE NG48 guidance¹² for adults in care homes, as well as the Smiling Matters¹³ review published by the Care Quality Commission, were referenced.

Outcome

From this IPE project, an understanding of the role of a SLT informed the DT authors as to when it is appropriate to refer patients into their care. In return, educating SLTs on the role and scope of a DT has helped them to recognise when a referral to a DT is appropriate. These SLTs now have an awareness of when a patient requires oral health advice and care that falls into the scope of a DT and can confidently refer directly to a dental therapist. This type of referral may expediate care in circumstances where access to a dentist is difficult. Overall, by expanding our knowledge on scope of practice we can utilise the whole health care team effectively, streamline appointments and ensure patients are seen efficiently by an appropriate member of the team. However, a lack of awareness of how to refer directly to a DT across the South West is still a barrier.

To further improve the awareness of health care professionals and their role in oral health it would be ideal to have the training provided at an undergraduate level. IPE should be made mandatory across all universities as working as a MDT is essential for providing safe, individualised, holistic treatment for patients.

Reflections

After discussing different IPE projects with colleagues, it is

Unrivalled Ergonomics



Our exclusive TrueFit[®] Technology analyses your unique facial features and working posture to deliver comfort, perfect visual alignment, and lasting ergonomic support.



CUSTOM MEASURED • CUSTOM FITTED • CUSTOM MADE



Back 0°-5°



Elbow +/- 90°



Hip 105°-125°



Neck 0°-15°

Q-Optics loupes bring your work into sharp, precise focus, reducing physical strain and supporting lasting comfort

535 656 312

VALLOWDENTAL.CO.UK

LES@SWALLOWDENTAL.CO.UK

BOOK YOUR
FREE DEMO



= SWALLOW

clear that it would be beneficial to both the dental team and the wider healthcare team to have an oral health champion in all departments within a general hospital. They should be provided with contact details of a nominated dental professional who will act as a point of contact and can be reached if healthcare providers have any queries. The nominated member of the dental team can provide oral health advice, liaise with the hospital and arrange further training if the department feels it is required for their team. This communication would benefit professionals on a bi-directional basis as the oral health care team can contact wider health care professionals for advice and also training. However, lack of knowledge, contact, time constraints, access and funding all remain barriers to IPE projects.

A key learning point is the importance of adapting terminology during the presentation for a non-dental audience. Certain dental terms such as 'periodontitis' and 'caries' are familiar within dentistry but may not be fully understood by SLT students without explanation. It is important to use clear, accessible language when communicating with other healthcare professionals or patients. This is an essential skill in clinical practice, particularly in multidisciplinary settings where effective communication supports patient-centred care.

The use of practical resources enhanced audience engagement. During both the presentation and case study sessions, MouthEzes, toothbrush samples, dry mouth gel samples, and foam mouth sponges were incorporated. These resources helped demonstrate what can be used for mouth care. While practical resources were used, incorporating more hands-on activities throughout the presentation, particularly using phantom heads, may have increased engagement further. Additionally, introducing more interactive elements, such as quizzes or Kahoot activities, could have encouraged greater discussion and participation rather than passive listening.

The collaborative case study discussions were one of the most successful aspects of the day. Working in mixed groups allowed both professions to contribute different perspectives to patient management. There was significant crossover between dentistry and SLT, particularly when discussing patients with complex medical needs. Referral pathways between dental professionals and SLTs were also discussed, helping to clarify when interprofessional referrals may be beneficial. This activity demonstrated the value of teamwork, and how collaborative approaches can improve patient outcomes.

Authors: Fern, Eva, Tatiana and Najiyah were the 2025-2026 Dental Therapy Foundation Trainees in the South West.

Special thanks to Flora Wisdom and the team from Plymouth Marion university for their support in this collaboration.

Contact: tatiana.topor.contact@gmail.com

fern.bridges@outlook.com

najiyahislam2002@gmail.com

evatreeves2003@gmail.com

References

1. Sabbah W, Folayan MO, El Tantawi M. The link between oral and general health. *Int J Dent*. 2019;2019:7862923. <https://pmc.ncbi.nlm.nih.gov/articles/PMC6560319/>
2. Tonetti MS, Jepsen S, Jin L, Otomo-Corgel J. Impact of the global burden of periodontal diseases on health, nutrition and wellbeing of mankind: A call for global action. *J Clin Periodontol*. 2017;44(5):456-462. <https://doi.org/10.1111/jcpe.12732>
3. Hashim NT, Babiker R, Padmanabhan V, Ahmed AT, Chaitanya NC, Mohammed R et al. The global burden of periodontal disease: a narrative review on unveiling socioeconomic and health challenges. *Int. J. Environ. Res. Public Health* 2025; 22(4): 624. <https://doi.org/10.3390/ijerph22040624>
4. Public Health England (2021). Inequalities in oral health in England: Summary. <https://www.gov.uk/government/publications/inequalities-in-oral-health-in-england>
5. Care Quality Commission (2025). Smiling matters: Oral health in care homes – progress report. <https://www.cqc.org.uk/publications/smiling-matters-oral-health-care-homes-progress-report/progress-recommendation-3>
6. Department of Health and Social Care, Welsh Government, Department of Health Northern Ireland and NHS England (2021). Delivering better oral health: An evidence-based toolkit for prevention. Chapter 4: Dental caries. <https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-4-dental-caries>
7. Gov.UK National Dental Epidemiology Programme (NDEP) for England. Oral health survey of 5-year-old children 2022. at: <https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-children-2022/national-dental-epidemiology-programme-ndep-for-england-oral-health-survey-of-5-year-old-children-2022>
8. Royal College of Surgeons of England (2025). Tooth decay leading cause of hospital admissions among young children. <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/dental-stats-sept-25/>
9. Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (2020). Role of the Speech and Language Therapist. <https://www.wvl.nhs.uk/media/leaflets/5ff57bfa4a4aa6.82565432.pdf>
10. Royal College of Speech and Language Therapists (2025). Eating, drinking and swallowing guidance. <https://www.rcslt.org/members/clinical-guidance/eating-drinking-and-swallowing/eating-drinking-and-swallowing-guidance>
11. National Institute for Health and Care Excellence (2016). Oral health for adults in care homes. NICE guideline NG48. <https://www.nice.org.uk/guidance/ng48>
12. National Institute for Health and Care Excellence (2016). Oral health for adults in care homes. NICE guideline NG48. <https://www.nice.org.uk/guidance/ng48>
13. Care Quality Commission (2019) Smiling matters: oral health in care homes. https://www.cqc.org.uk/sites/default/files/20190624_smiling_matters_full_report.pdf

Cite this article:

Bridges F, Islam N, Tomalin-Reeves E, Topor T. Interprofessional education. dental therapy and speech and language therapy. *Dental Health* 2026;**65(5)**: 38-41. Doi: <https://doi.org/10.59489/bsdht191>

GLOBAL ORAL HEALTH LEADERS UNITED IN CALL FOR BROADER APPROACH TO PREVENTING PERIODONTAL DISEASES

Global leaders met at ISDH 2026, the International Symposium on Dental Hygiene, in Milan to review two landmark oral health reports from Europe and the US, built on the same global evidence base, and to discuss the role of clinically proven mouthrinse in the prevention of periodontal diseases.

Periodontal diseases affects more than 1 billion people worldwide and are a major global public health challenge.¹ Despite being largely preventable, its burden continues to rise.¹ At a press briefing during the International Symposium on Dental Hygiene (ISDH) in Milan, hosted by Kenvue, experts highlighted how two independently developed reports, from Europe and North America, reached remarkably similar conclusions on how prevention strategies should evolve, and on the role of a clinically proven mouthrinse alongside mechanical cleaning.

The two reports are the American Dental Hygienists' Association (ADHA) white paper on redefining the management and prevention of periodontal diseases,² and the Principles for Oral Health report convened by the SEPA Foundation.³

Independent reports, same conclusion

What makes this notable is how the two reports came about. They were developed separately, by different organisations, in different parts of the world, yet they draw on the same underlying evidence base and reach the same broad conclusions. Both rest on a shared scientific foundation, including the European Federation of Periodontology (EFP) S3-level clinical practice guidelines⁴, alongside guidance from the American Dental Association and the American Academy of Periodontology.

Across all of it, the finding is consistent. Whilst mechanical cleaning remains the foundation, mouthrinse may be considered to control gingival inflammation as part of a personalised treatment approach for specific cases, with essential oils formulations among the best supported by the available evidence. Both reports position mouthrinse as an adjunct to mechanical cleaning (toothbrushing), never a replacement, to be recommended according to each patient's risk.^{2,3}

The voices behind the alignment

The briefing brought four expert voices together to deliver that single message. Professor Luigi Nibali (King's College London) set the scientific ground, on why a preventable disease is still rising and why gingivitis must be taken seriously. Dr Ana Molina (SEPA) explained the Principles for Oral Health report and how it turns guideline evidence into advice a busy clinician can use. Dr JoAnn Gurenlian (ADHA) set out the white paper's conclusion that the dental hygienist is the front line of prevention, and why the profession made that recommendation itself. Simone Ruzario (President-Elect, BSDHT) brought it back to the chairside, and discussed how the evidence impacts dental hygienists and dental therapists in everyday practice the world over.

The role of a mouthrinse, in the words of the reports

Each presentation landed the same point in its own words. From the European evidence, the EFP S3-level guidelines recognise specific antiseptics, with essential oils among the most efficacious, as personalised adjuncts to patient's oral hygiene to help control gingival inflammation⁴ while the Principles for Oral Health report concludes that the use of specific antiseptics, as adjuncts to mechanical biofilm control, is recommended in certain group of patients, where either local or systemic factors make mechanical biofilm control insufficient to achieve and maintain periodontal health.³ From the US, the ADHA white paper reports that a mouthrinse with a fixed combination of four essential oils, added to brushing and flossing, significantly reduced whole-mouth plaque, gingivitis and bleeding compared with brushing alone, and positions adjunctive antiseptic mouthrinse as a simple, affordable and widely available addition to daily home care.²

When and how to recommend it

The practical message for dental professionals is consistent across both reports. Twice-daily brushing with a fluoride toothpaste and daily cleaning between the teeth remains the foundation. A daily antiseptic mouthrinse, used as an adjunct rather than a replacement, should be recommended for those patients where mechanical cleaning alone is unlikely to be sufficient. This includes patients with persistent gingival inflammation, those with biofilm-

retentive features such as crowding, restorations, implants or orthodontic appliances, and those whose general circumstances, reduced dexterity, frailty, or conditions such as diabetes, make effective plaque control and inflammation control harder to achieve. The recommendation should be tailored to the individual, explained in plain language, and revisited at each visit, with flavour and intensity options used to support adherence.^{2,3}

Quotes

"The evidence base is clear and consistent enough for guidelines and reports across different regions to consider a clinically proven mouthrinse for some patients. While brushing and cleaning between the teeth is essential, the number of patients with periodontal diseases is growing and the evidence supports a clinically proven adjunctive mouthrinse to help support and maintain gum health for specific patients."

Dr Ana Molina, Vice-President, SEPA

"It is unusual to see organisations working in different healthcare systems and professional environments review the evidence separately and arrive at such similar conclusions. That level of alignment gives clinicians confidence that the recommendations are grounded in a robust and consistent body of evidence."

Dr Simon Arnold, Medical Affairs Lead for EMEA, Kenvue

Find out more

Dental professionals can explore the science and the practical guidance behind these findings at **kenvuepro.com**. To read the reports in full, visit the Principles for Oral Health report at **principlesfororalhealth.com**, or view the ADHA white paper, Redefining the Management and Prevention of Periodontal Disease, at **adha.org**.

References

1. Hu M, Zhang R, Wang R, Wang Y, Guo J. Global, regional, and national burden of periodontal diseases from 1990 to 2021 and predictions to 2040: an analysis of the Global Burden of Disease Study 2021. *Front Oral Health*. 2025;**6**:1627746. <https://doi.org/10.3389/froh.2025.1627746>
2. American Dental Hygienists' Association. Redefining the Management and Prevention of Periodontal Disease: Practical Guidance for the Practicing Hygienist in Navigating Clinical Decision-Making and Patient Engagement [White Paper]. 2026. Available at: <https://www.adha.org/rinse-resource-center/white-paper-highlights/> Accessed 24 June 2026
3. SEPA. Principles for Oral Health Report. Sponsored by LISTERINE®. 2025. Available at: <https://principlesfororalhealth.com/> Accessed 24 June 2026
4. Sanz M, Herrera D, Kebschull M, Chapple I, Jepsen S, Berglundh T, et al. Treatment of stage I–III periodontitis—The EFP S3 level clinical practice guideline. *J Clin Periodontol*. 2020; **47**(Suppl 22): 4–60. <https://doi.org/10.1111/jcpe.13290>



32
reasons
to buy the
Varios Combi Pro2



Register now

27th - 28th November 2026

Join us on stand 29-31 at
The BSDHT Oral Health Conference



See the Varios Combi Pro2 in action! On-stand, hands-on
Workshops for dentists, hygienists and therapists

Varios Combi Pro2

Say hello to an evolution in ultrasonic and powder therapy.

Gentle yet powerful, reliable and exceptionally durable, Varios Combi Pro2 has a host of advanced features designed to improve efficiency, control and enhance patient comfort.

Engineered with meticulous attention to detail, Varios Combi Pro2 is an investment in clinical excellence and in the health of your patients.



Find out more
Varios Combi Pro2



Contact your local
Product Specialist

WATER HEATER • TITANIUM SCALER HANDPIECE • JET NOZZLE FOR PERIO HANDPIECE • AUTO CLEANING • REMOVABLE POWDER CHAMBERS

BY POPPY IRVINE

SMALL DONATIONS BIG IMPACT

As dental professionals, we understand that oral health is closely linked to overall health, confidence, wellbeing, and quality of life. Every day, dental hygienists and therapists work to educate, motivate and support patients in achieving better oral health. However, for many people, accessing even the most basic oral hygiene products can be a challenge.

This is why I have made a commitment to donate oral health products on a regular basis to support those in my local community. Each month, I donate essential items to The Hygiene Bank, as well as supporting local food banks and outreach programmes across West and North Yorkshire. These donations include everyday essentials such as toothbrushes, toothpaste, floss, and other oral care products that many of us may take for granted

Essential healthcare items

The need for these services highlights an important reality: oral hygiene products are essential healthcare items, not luxury products! For individuals and families experiencing financial hardship, choosing between purchasing food, paying bills or buying toiletries can be a difficult decision. By donating oral health products, we can help remove one barrier to maintaining good oral health.

As dental professionals, we are in a unique position to recognise the wider social factors that influence oral health. We see first-hand how inequalities, access to resources and life circumstances can affect a person's ability to care for their teeth and gums. Supporting community initiatives is one way we can extend our impact beyond the clinical setting.

The response from local organisations has been incredibly positive. A simple donation of toothpaste or a toothbrush can provide dignity, reassurance and practical support to someone who may otherwise go without. It also reinforces the message that oral health matters for everyone, regardless of circumstances.

I would encourage colleagues across the dental profession to consider how they might support similar initiatives within their own communities. Whether it is donating surplus oral health products, organising a collection point within a practice, or partnering with a local charity, small actions can create meaningful change.

Brush It Forward

Prevention is at the heart of what we do as dental professionals. By sharing our knowledge and resources beyond the dental chair, we can help improve access to oral healthcare and contribute to reducing health inequalities.

I am excited to be part of a national initiative called 'Brush It Forward'. This is a community-led UK oral health project founded by dentist Dr. Kev Chavda. It delivers free toothbrushes and practical hygiene education directly into primary schools. The programme aims to prevent severe tooth decay by teaching children healthy daily habits early. Local dental professionals volunteer their time to deliver essential oral health lessons within schools whilst donating a toothbrush to every child within that school. You can learn more here: <https://www.brushitforward.co.uk>

Together, through small acts of kindness and professional responsibility, we can make a lasting difference — one toothbrush at a time.

Author: Poppy is a dental therapist working across Yorkshire. She is passionate about public health promotion and outreach initiatives.

Contact: Poppyirvine@hotmail.com

[@thehygienebankleeds](#)

[@brushitforward](#)



CLINICAL QUIZ

A 52-year-old female patient reports that her gums “always bleed”, despite brushing twice daily and using interdental brushes. She is not currently experiencing pain but is concerned that her gums have become increasingly sensitive. The patient has not attended regularly for periodontal care for the past three years. She stopped smoking five years ago and has recently been diagnosed with type 2 diabetes. She asks whether she should simply brush harder to “get rid of the bleeding”. Clinical examination reveals generalised bleeding on probing, with depths of 5–6 mm at several sites and localised gingival recession.

- Q1. Which clinical finding is most important when determining whether this patient may have periodontitis rather than gingivitis?
- Q2. What is the most appropriate response when the patient asks if she should brush harder to stop the bleeding?
- Q3. Which aspect of this patient's medical history is particularly relevant to your periodontal assessment?
- Q4. What should be your next step if the clinical assessment indicates periodontitis?

SEND YOUR ANSWERS TO THE EDITOR BY 30TH SEPTEMBER. 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 THE NEW NEXT-GENERATION PHILIPS SONICARE DIAMONDCLEAN 9900

Experience Philips Sonicare's most intelligent toothbrush yet.

Designed to help patients brush more effectively through real-time AI guidance, the Next-Generation DiamondClean 9900 provides personalised feedback exactly when it matters most.

Key Features

- See every area as you brush: AI-powered Mouth Map technology tracks brushing coverage across 12 zones of the mouth in real time, helping patients identify areas they've missed.
- Never miss a spot: Smart Coverage Feedback guides users towards a more complete clean and highlights areas that need additional attention.
- Personalised pressure coaching: Smart Pressure Feedback provides light and vibration cues when brushing pressure is too hard, too soft, or just right, helping protect teeth and gums.
- Powerful Sonicare cleaning: Sonicare Fluid Action drives fluid deep between teeth and along the gumline to help remove plaque from hard-to-reach areas.
- Supports better brushing habits: Real-time guidance helps patients improve their brushing technique every day, extending oral care support between dental appointments.

ANSWERS TO CLINICAL QUIZ JULY 2026

The winner is: **Agnieszka Modhwadia**

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

A1. Lay the patient flat with legs elevated to improve cerebral blood flow (recovery position if recovery is delayed), loosen tight clothing and ensure an open airway. Reassure the patient and administer oxygen if available. Most episodes resolve quickly once circulation normalises. Do not continue treatment until full recovery.

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

A2. Stop treatment immediately and assist the patient to use their salbutamol inhaler (2 puffs). Reassure and monitor

them closely. If oxygen saturation or breathing does not improve, administer oxygen (15 L/min) and call emergency services. If an inhaler is unavailable or ineffective, refer to the practice's emergency protocol and use a spacer or nebuliser if present.

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

A3. Call for help, activate emergency services (999), and begin CPR immediately following Resuscitation Council UK guidelines — 30 compressions to 2 rescue breaths. Attach an automated external defibrillator (AED) as soon as possible and follow the prompts. Continue CPR until professional help arrives or the patient recovers.

ORACLE

Labrida BioClean

An innovative, single-use dental device for the mechanical debridement of dental implants and periodontally compromised teeth. Used by dental professionals, its unique bristles are made of chitosan, a biocompatible and naturally derived biopolymer with bacteriostatic properties.

Combi Touch

Combining ultrasound and air polishing in one unit - it allows complete prophylaxis treatment, from removal of supragingival and subgingival calculus, to gently removing stain and biofilm and even implant cleaning. Some characteristics are:

Air polishing supra and subgingival - You can simply switch during the treatment between supra and subgingival air polishing by pressing Prophy or Perio button.

Clogging protection - Once switched on, the tubing is cleaned by a permanent light air stream.

Ergonomic touch panel - Due to the ergonomic touch panel, you control every function as fast and intuitive as never before, and at the same time clean and disinfect the device.



generalmedical

Refill function - Thanks to the exclusive "refill" function, you can remove the powder chambers without switching the unit off, for fast and efficient maintenance.

Mariotti

The latest Mariotti MiniUniko motor is the ideal companion to Labrida brushes in tandem with an NSK reciprocating handpiece.

This combination (see outside back cover of journal) provides the perfect setup for effective cleaning of roots and implants. The gentle reciprocating

action cleans root and implant surfaces more efficiently and faster than manual cleaning and start up costs are extremely low.

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



TePe

EasyFit™

New

Helps patients make interdental brushing a routine that sticks.

The innovative conical brush head glides smoothly between a range of interdental spaces to remove plaque effectively – making it easy and comfortable for patients who are just starting out.

Available in sizes S/M and M/L.





OPTIM™

Great Quality

Great Price

Made in Great Britain



OPTIM Interdental brushes are precision **made in the UK**, using high tensile strength, plastic-coated, stainless-steel wire at the core, which helps to prevent the brushes from buckling, **even on the smallest sizes**. They are the same colour coded sizes that practices/patients are already familiar with and are very competitively priced.



For more information or to request a sample, simply speak to your dealer, scan the QR code or visit **www.optim-idb.uk**

DIARY DATES

AUTUMN 2026 BSDHT REGIONAL GROUP STUDY DAYS

Contact: enquiries@bsdht.org.uk

Regional Group	Date	Details	Contact (Group Secretary)	Contact Details
Eastern	17th October 2026	Park Inn by Radisson Palace, SOUTHERN-ON-SEA	Amanda Kestell	easternsecretary@bsdht.org.uk
London	24th September 2026	ONLINE AGM Only	Udita Patel	londonsecretary@bsdht.org.uk
Midlands	3rd October 2026	Voco St Johns Solihull, 651 Warwick Road, SOLIHULL, Birmingham B91 1AT	Joanna Ericson	midlandssecretary@bsdht.org.uk
North East	9th September 2026	ONLINE AGM Only	Sarah Hunter	northeastsecretary@bsdht.org.uk
North West	21st October 2026	ONLINE AGM + Guest Speaker NINA FARMER 'Stress & Gut Health'	Jessica McGenn	northwestsecretary@bsdht.org.uk
Northern Ireland	20th October 2026	ONLINE AGM + Guest Speaker DR PAUL REANEY 'Sleep Solutions'	Gill Lemon	northernirelandsecretary@bsdht.org.uk
Scottish	8th September 2026	ONLINE AGM Only	Kirsty Sim	scottishsecretary@bsdht.org.uk
South East	6th October 202	ONLINE AGM + Guest Speaker JOCELYN HARDING 'Oral Cancer'	Sam Doyle	southeastsecretary@bsdht.org.uk
Southern	24th October 2026	Voco Winchester Hotel & Spa, Telegraph Way, WINCHESTER, SO21 1HZ	Karen Poulter	southernsecretary@bsdht.org.uk
South West & South Wales	27th October 2026	ONLINE AGM Only	Lynn Chalinder	swswsecretary@bsdht.org.uk
South West Peninsula	To be confirmed	ONLINE AGM Only	VACANT	southwestsecretary@bsdht.org.uk
Thames Valley	13th October 2026	ONLINE AGM Only	Keileigh Ireston	thamesvalleysecretary@bsdht.org.uk



BSDHT.ORG.UK

VISIT THE BSDHT ONLINE

LOGGING INTO THE MEMBER ONLY PORTAL:

1. Select the **'Member Login'** button in the top right of the BSDHT website <https://www.bsdht.org.uk/>
2. Enter your email address and password and **'Log In'** button

If you cannot remember your password, please click the **'Reset it'** link (this will initiate an email allowing you to reset your password).

If you need clarification of the details we have on file, please contact BSDHT via enquiries@bsdht.org.uk or call **01788 575050** (lines are open Mon-Fri, 9am-5pm)

ADMINISTRATION

President: **Rhiannon Jones** - president@bsdht.org.uk

President Elect:
Simone Ruzario - presidentelect@bsdht.org.uk

Acting Honorary Treasurer:
Leon Bassi - treasurer@bsdht.org.uk

Honorary Secretary:
Juliette Reeves - honsec@bsdht.org.uk

Honorary Vice Presidents:
Iain Chapple, Aylin Baysan, Mike Lewis

Elected Council Members:
Leon Bassi, Emma Bingham, Claire McCarthy
ecm1@bsdht.org.uk

Elected Council Members to Executive Team:
Tracy Doole - ecm2@bsdht.org.uk
Cara Hills-Smith - ecm3@bsdht.org.uk

BSDHT Representative Health Education
England Advisory Group (HEEAG): **Diane Hunter**

BSDHT Representatives Institute of Health Promotion
and Education: **Elaine Tilling**

Coaching and Mentoring Representative:
Emma Slade-Jones - MC1@bsdht.org.uk

Diversity, Inclusion and Belonging Representative:
Anna Charters - DIB5@bsdht.org.uk

Education Group Representative:
Sarah Murray - Ed2@bsdht.org.uk

Student Representative Coordinator:
Amie Kavanagh - studentrep@bsdht.org.uk

Student Representative to Council:
Paige Busby - studentrep1@bsdht.org.uk
Lonika Manektalla - studentrep2@bsdht.org.uk

Tutor Representative:
VACANT - tutorrep@bsdht.org.uk

Publications Editor representative:
Patricia Macpherson - pubs@bsdht.org.uk

UK Representative to the IFDH:
Rhiannon Jones, Simone Ruzario

REGIONAL GROUP REPRESENTATIVES ON COUNCIL

Eastern: **Laura Hobbs**
easternregionalrep@bsdht.org.uk

London: **Sakina Syed**
londonregionalrep@bsdht.org.uk

Midlands: **Tiffani Hutchinson**
midlandsregionalrep@bsdht.org.uk

North East: **Cara Hills-Smith**
northeastregionalrep@bsdht.org.uk

North West: **Victoria Griffiths**
northwestregionalrep@bsdht.org.uk

Northern Ireland: **Tracy Doole**
northernirelandregionalrep@bsdht.org.uk

Scotland: **Lynn Harris**
scottishregionalrep@bsdht.org.uk

South East: **Casey Duncan**
southeastregionalrep@bsdht.org.uk

Southern: **Anna Wahlberg**
southernregionalrep@bsdht.org.uk

South West and South Wales: **Adam Taylor**
swswregionalrep@bsdht.org.uk

South West Peninsula: **Sabina Camber**
southwestregionalrep@bsdht.org.uk

Thames Valley: **Kirsty Ierston**
thamesvalleyregionalrep@bsdht.org.uk

ADMINISTRATION

EASTERN

Chair: **Amanda Harbrow-Harris**
easternchair@bsdht.org.uk

Secretary: **Amanda Kestell**
easternsecretary@bsdht.org.uk

Treasurer: **Jenny Griffiths**
easterntreasurer@bsdht.org.uk

Trade Liaison: **Jess Gridley**
Easterntlo@bsdht.org.uk

LONDON

Chair: **Sakina Syed**
londonchair@bsdht.org.uk

Secretary: **Udita Patel**
londonsecretary@bsdht.org.uk

Treasurer: **Sandeep Thandi (Samra) (Acting)**
londontreasurer@bsdht.org.uk

Trade Liaison: **Naomi Pascall (Acting)**
londontlo@bsdht.org.uk

MIDLANDS

Chair: **Eleanor Cowlam**
midlandschair@bsdht.org.uk

Secretary: **Joanna Ericson**
midlandssecretary@bsdht.org.uk

Treasurer: **Hannah Moore**
midlandstreasure@bsdht.org.uk

Trade Liaison: **Jenny Whittaker**
midlandstlo@bsdht.org.uk

NORTH EAST

Chair: **Julie Rosse**
northeastchair@bsdht.org.uk

Secretary: **Sarah Hunter**
northeastsecretary@bsdht.org.uk

Treasurer: **Sarah Warwick**
northeasttreasurer@bsdht.org.uk

Trade Liaison: **Liz Powell and Elizabeth (Beth) Pooley**
northeasttlo@bsdht.org.uk

NORTH WEST

Chair: **Kate Reading**
northwestchair@bsdht.org.uk

Secretary: **Jessica McGenn**
northwestsecretary@bsdht.org.uk

Treasurer: **Alison Edisbury**
northwesttreasurer@bsdht.org.uk

Trade Liaison: **Kathryn Mayo**
northwesttlo@bsdht.org.uk

NORTHERN IRELAND

Chair: **Rachael Lilley**
northernirelandchair@bsdht.org.uk

Secretary: **Gill Lemon**
northernirelandsecretary@bsdht.org.uk

Treasurer: **Jordan McCrea**
northernirelandtreasurer@bsdht.org.uk

Trade Liaison: **Niamh Adair**
northernirelandtlo@bsdht.org.uk

SCOTTISH

Chair: **Lynn Harris**
scottishchair@bsdht.org.uk

Secretary: **Kirsty Sim**
scottishsecretary@bsdht.org.uk

Treasurer: **Sandra Morgan**
scottishtreasurer@bsdht.org.uk

Trade Liaison: **Emma Hutchison**
scottishtlo@bsdht.org.uk

SOUTH EAST

Chair: **Jo Downs**
southeastchair@bsdht.org.uk

Secretary: **Sam Doyle**
southeastsecretary@bsdht.org.uk

Treasurer: **Adelle Cager**
southeasttreasurer@bsdht.org.uk

Trade Liaison: **Sarah Breslin**
southeasttlo@bsdht.org.uk

SOUTH WEST AND SOUTH WALES

Chair: **Harriet Elsworthy**
swswchair@bsdht.org.uk

Secretary: **Lynn Chalinder**
swswsecretary@bsdht.org.uk

Treasurer: **Alison Brown**
swswtreasurer@bsdht.org.uk

Trade Liaison: **Jennifer Jenkins**
swswtlo@bsdht.org.uk

Social Media: **Paige Busby**
southernsecretary@bsdht.org.uk

SOUTH WEST PENINSULA

Chair: **Sabina Camber**
southwestchair@bsdht.org.uk

Secretary: **VACANT**
southwestsecretary@bsdht.org.uk

Treasurer: **VACANT**
southwesttreasurer@bsdht.org.uk

Trade Liaison: **Jill Hetherington**
southwesttlo@bsdht.org.uk

SOUTHERN

Chair: **Lauren Pink and Laura King**
southernchair@bsdht.org.uk

Secretary: **Karen Poulter**
southernsecretary@bsdht.org.uk

Treasurer: **Karenn Helmrichne-Davila**
southerntrreasurer@bsdht.org.uk

Trade Liaison: **Ashley Ingram**
southernrtlo@bsdht.org.uk

THAMES VALLEY

Chair: **Keleigh Ireston**
thamesvalleychair@bsdht.org.uk

Secretary: **Keleigh Ireston**
thamesvalleysecretary@bsdht.org.uk

Treasurer: **Sarah Turnbull**
thamesvalleytreasurer@bsdht.org.uk

Trade Liaison: **Sarah Turnbull**
thamesvalleytlo@bsdht.org.uk

Re-Evaluate Rinse®

Evidence-Based. Patient-Focused.



NEW

Range of tastes tailored
to help with patient compliance.

While every patient's mouthwash preference is unique, recommendations should always be evidence-based. Recommend the 3rd essential step, formulated with 4 **Essential Oils**.

It's Time For An Evidence-Based Recommendation.

LISTERINE®

UK-LIS-2025-268193



FIND OUT
MORE

MCRepairs.



Repairs Professionals Can Rely On.

Trust MC Repairs with expert repairs & servicing for ultrasonic scalers, air polishing systems and much more oral hygiene equipment!

acteon

DTE

DÜRR
DENTAL

EMS

KAVO

MK-DENT

NSK

WOODPECKER



Visit: www.mc repairs.co.uk

Telephone: 01253 404 774

Email: repairs@mc repairs.co.uk