Top tips for team working – effective utilisation of dental therapists

By Morag Powell[1] and Ewen McColl[2]

Introduction

The relatively recent publication of Health Education England's (HEE's) Advancing Dental Care Review highlighted the underutilisation of dental therapists in general dental practice:[1]

- 'HEE wants to create opportunities across each of its regions to optimise the skills of Dental Therapists and facilitate the profession to undertake more simple dental treatments. The London Economics study found that potential net economic benefits and, consequently, service benefits would be associated with a greater flexibility in the use of skill mix by creating an environment where Dental Therapists could undertake more Band 1 and simple Band 2 treatments, which would free up dentists to undertake more complex treatments
- They frequently find themselves unable to exploit their full Scope of Practice – often for historic or contractual reasons. The potential for dentists – particularly in primary care – to share workload with DCPs in line with their Scope of Practice and experience is greatly under-utilised. This opens opportunities for securing an adaptive workforce, particularly in rural and coastal areas, where dental access is a challenge.
- One of the consistent issues identified by patient engagement events was a lack of understanding among patients of the roles of the whole dental workforce, which has contributed to the situation.'

Aims and objectives

In this paper, we will discuss six top tips for optimising team working with a dental therapist in order to optimise outcomes for patients.

1. Understand your colleagues' scope and how to utilise it

In May 2013, the General Dental Council (GDC) clarified the scope of practice (SoP)[2] for members of the dental team including dental therapists (DThs). This guidance is a way of describing what individual team members are trained and competent to do in practising their profession. It describes the knowledge, skills and experience team members can utilise to practise safely and effectively in the best interests of patients. This is currently under review by the GDC with the hope that this will further increase utility of DThs, particularly in primary care.

> 'By optimising the full scope of practice of dental therapists, this would allow dentists to focus on more complex treatments unique to their scope.'

This review is based on recent evidence commissioned by the GDC indicating there was a lack of understanding around the SoP document in some registrant groups.[3] This research demonstrated that nine in ten DThs (91%) and orthodontic therapists (88%) and eight in ten hygienists (84%) felt that they knew a great deal or fair amount about the SoP guidance document. In comparison, only around six in ten dentists (61%) and dental nurses (59%) stated that they knew a great deal or fair amount about the SoP guidance document.

The aspiration in Advancing Dental Care is that by optimising the full SoP of DThs, this would allow dentists to focus on more complex treatments unique to their scope such as endodontics or fixed prosthodontics, facilitating holistic patient care in a well-defined manner, with primary disease control at the centre of patient care. Below, we discuss and clarify some issues that in our experience there is still some confusion relating to DThs' scope.

Prevention

Prevention is the cornerstone to everything that we do within dentistry. All members of the dental team are trained in this, and all undergraduate dental therapy students are familiar with the standards detailed in *Delivering better oral health: an evidence-based toolkit for prevention*.[4] Preventive advice should be patient-specific, include written information for the patient, and be followed up at subsequent appointments. Details of disclosing, plaque and bleeding scores, risk assessment, specific oral hygiene instruction and reinforcement of this should be detailed in the patient record.

Radiographs

DThs are trained to justify, prescribe, take and report on radiographs within their scope. Teamworking is essential in this area and where reporting falls outside the scope of a DTh then consultation will need to occur with a dentist registrant (ie endodontic radiographic interpretation).

Clinical examination

DThs are trained to complete a full clinical examination, working to the level of competence they are trained and indemnified to do so. This is completed as standard practice. They are similarly trained to diagnose and treatment plan within their

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competence, in line with their training and level of indemnity.

Treatment of periodontal disease

DThs are trained to meet the current British Society of Periodontology S3 guidance[5] and are aware of the evidence base supporting this guidance. They are trained in a range of equipment: power, ultrasonics and piezon, and manual instrumentation.

Paediatric restorations and extractions

DThs are trained to complete paediatric restorations and Hall crowns. They are also trained to complete pulpotomies, though in our experience this is of limited utility in modern paediatric practice and they are not trained to complete pulpectomy as it is not in their SoP. DThs' scope covers paediatric extractions and many have an interest in paediatric care.

Adult restorations

They are trained to provide permanent and temporary direct restorations. This includes extensive caries removal and stepwise techniques and includes all dental materials including Biodentine. In cases where it is suspected clinically and radiographically that the caries removal will affect the pulp, therapists should discuss with a dentist registrant as to the best management of this case. Should endodontic intervention be needed, this is outside the DTh's scope; therefore, discussion and case planning with a dental registrant is essential.

DThs can carry out composite build-ups of teeth but not in cases where vertical dimension is altered in any way.

DThs' scope does not include Nayyar Core type restorations (ie that involves placement of a restoration which involves invading the root canal complex and the purpose of which is to act as a core for the construction of a crown).

Occlusal alteration

Further to the above with regards to composite build-ups and composite restorations, reconfiguring occlusion is out of scope of the DTh and any restorations should involve a conformative approach. DThs are trained (Table 1)[6] to assess and manage existing occlusion as part of the placement of restorations. In cases where there is any concern around altering occlusion, this needs to be discussed with a dental registrant who should take over this element of the care. Shared care is essential in such cases.

2. Wider scope considerations

DThs are trained to take impressions and can take an impression as appropriate to scope and competence. However, DThs may only be trained to take alginate impressions as a baseline and further training may be required on appropriately quality-assured postgraduate courses.

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They can complete tooth whitening procedures on prescription from a dentist registrant; however, the first cycle of this must be completed with the dental registrant on the premises. They can take the impressions for bleaching trays and they can fit them, as this is deemed within scope.

The non-surgical treatment of peri-implantitis is within scope; however, removal of any implant-retained superstructure to gain better access to implants is not within the SoP and shared care is essential. For example, if the implant-retained superstructure needs removing to facilitate maintenance, this can be done by the dental registrant. This will then allow the therapist to carry out the professional mechanical plaque removal (PMPR) including scaling with appropriate implant-specific instruments.

Orthodontics including Invisalign is not within the scope of a DTh, and indemnifiers differentiate between the fitting of bleaching trays, which is in scope, from fitting Invisalign trays, which is out of scope. In addition, a grey area is the placement of composite 'buttons' for the Invisalign trays, which is currently deemed in scope. However, guidance on this may change when the new SoP is published.

Periodontal splinting is another grey area of the scope; however, it is the authors' view that this is within scope when completed as shared care, and the teeth have been assessed by the dental registrant prior to referring to DTh for composite-type splints in periodontal patients. However, it would be prudent for registrants to confirm the exact position of their indemnifiers in relation to this procedure before completing it on a patient.

3. Written treatment plans

If patients are being treated under shared care then written treatment plans are required to be in place for the DTh, for all aspects of their scope. The SoP is clear that a DTh cannot change the direction of a treatment plan, but they can change the detail. An example of this would be a written prescription for a paediatric restoration can have the details of surfaces and/or materials changed by the DTh; however, the direction of this cannot be changed from filling to extraction. It is therefore helpful, if there is question over the restorability of the tooth, to include a statement advising to extract if necessary, if indeed the tooth is unrestorable.

Table 1 Preparing for practice. Dental therapy restorative undergraduate learning outcomes[6]

1.14	Restoration of teeth
1.14.1	Assess and manage caries, occlusion, and tooth wear, and, where appropriate, restore the dentition using the principle of minimal intervention, maintaining function and aesthetics
1.14.2	Restore teeth using a wide range of treatments and materials appropriate to the patient including permanent and temporary direct restorations, maintaining function and aesthetics
1.14.3	Provide pulp treatment for deciduous teeth
1.14.4	Restore deciduous teeth using preformed crowns
1.14.5	Explain the role of the dental therapist in the restoration of teeth

Table 2 Example of written prescription for local anaesthetic	
Patient's name	xxxxxxxxxx
Anaesthetic	Lignospan Special 2% 2.2 ml
Max cartridges	4
Route of administration	IDB and infiltration

The amount of detail included in the written treatment plan is determined by the dental registrant and can vary depending on the complexity of treatment proposed. Treatment plans should be patient-specific based on the findings of a clinical examination and give sufficient detail to allow the DTh to know what treatment they are expected to provide.

Taking time to develop a practice treatment protocol with the clinical team can be advantageous for standardisation, particularly if the practice employs a number of DThs and associates, as this allows for standardisation of treatments in appointments. This allows both the dentist and the therapist to know what is expected at each appointment, in line with appropriate scope.

4. Prescription-only medicines

Both injections of local anaesthetic or the provision of high-concentration fluoride products are procedures that are controlled by the Medicines Act 1968 because they involve the use of prescription-only medicines (POMs).[7] If patients are being treated in a practice setting under shared care and not under direct access, then various prescriptions are required to be put in place for the DTh to allow them to complete the required treatment.

For local anaesthetics, either a Patient Group Direction (PGD) is required to be in place or a written prescription needs to be provided by the dental registrant for the anaesthetic. The Human Medicines Regulations 2012 allow independent hospitals, clinics and medical agencies to authorise their own PGDs. The regulations also allow dental practices and clinics which are registered with the CQC (or the HIW in Wales or the RQIA in NI) for the treatment of disease, disorder or injury and/or diagnostic and screening procedures to authorise PGDs.[7] If providing a patient-specific written prescription, in order to meet legal requirements on prescribing, the dental registrant must have completed a recent clinical examination of the patient. If a written prescription is required then this must include the name of the drug, the amount to be administered, the maximum number of cartridges that can be administered and the method of administration, as demonstrated in Table 2. In addition to local anaesthetic, high-concentration fluorides also require a similar detailed prescription or PGD in place.

> 'The scope of practice is clear that a dental therapist cannot change the direction of a treatment plan, but they can change the detail.'

Work is currently being undertaken by the British Association of Dental Therapists (BADT) and British Society of Dental Hygienists and Therapists (BSDHT) on Exemptions of the Human Medicines Act. The Department of Health has recently consulted on the exemption from the act for DTh specifically for the exemption of local anaesthetics, fluorides and topical antimicrobials. Once these relevant changes are approved and are in place, there will no longer be a need to provide a written prescription or a PGD for these items.

5. Chairside assistance

Much work is currently being undertaken on the subject of chairside assistance by BSDHT, who would like to further promote chairside dental nurse support for all clinicians as part of their ongoing work. A recent survey of BSDHT members identified 30% (145) of dental hygienist respondents were rarely or never provided with chairside support.[8]

The CQC have published that they feel there are two aspects to lone working,[9] which include:

- Having someone else on the premises so there is support in a medical emergency
- Whether a clinician needs chairside support from a dental nurse when treating patients.

The CQC currently judge whether lone working is safe by considering:

- The view of the General Dental Council (GDC) professional guidelines: General Dental Council *Standards for the dental team* Principle Six: 'Work with colleagues in a way that is in patients' best interests'
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 (staffing) and regulation 12 (safe care and treatment).

The guidance provided by the CQC is that DCPs should assess the circumstances and make a clinical judgement about the level of appropriate support required to treat a patient safely.

It is the authors' view that both the employer and the DTh should also consider the safety and wellbeing of the DTh within this clinical judgement. A judgement needs to be taken on whether they regard it as safe practice for the DTh to not have a chaperone and what the potential impact would be on the wellbeing of the DTh if they are lone working. The BSDHT survey found that 49% of respondents agreed that work pressures affected the quality and safety of dental care delivery, with 82% attributing time pressures as the main causative factor in errors made. In addition to this, 77% of respondents reported suffering from stress and 66% from anxiety. Recent evidence published in a rapid review,[10] commissioned by the GDC, into the mental health and wellbeing of the dental profession acknowledged that there are significant issues with the wellbeing of members of the dental team.

Taking this into account, the question to consider here is: is it feasible for a DTh to complete the majority of their scope without chairside assistance? This question is not only limited to DThs but is relevant to DCPs including dental hygienists,

therapists, orthodontic therapists and clinical dental technicians. Patient comfort should be considered, along with the need for acceptable levels of cross-infection control with high-volume suction.

In addition to this, from an equality perspective, employers need to consider the fairness of any decision for a DCP to work as a clinician without chairside assistance. Any such decision would exclude the DCP from having a chaperone present in the surgery with them, which is below the accepted standard that a dentist colleague working as an associate would be expected to accept.

Additionally, in order to optimise outcomes for patients, the quality of work provided in Figure 1 would in our opinion not be possible without chairside assistance, so we believe this is essential for the clinician and the patient.

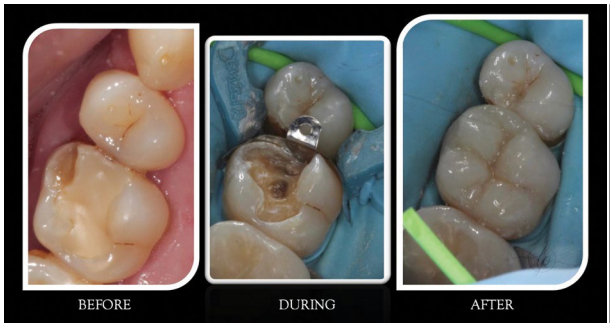


Fig. 1 Replacement of a failing composite by a dental therapy student (images courtesy of Lorena Pivoda, now GDC-registered dental therapist)

Fig. 2 Image courtesy of BSDHT and infographic winner 2022, Kim Chambers

6. Promotion of the dental therapist role to patients

There is a lack of understanding in the general public of the role of a DTh and further work is needed to educate the public on the different roles of the dental team.[3]

Recent research, commissioned by the GDC, demonstrated that the public were least likely to be aware of the role of a DTh.[3] They were variously thought of as providing advice, exercises or post-surgery recuperation (like a physiotherapist) or assisting those with phobias of visiting a dentist (like a counsellor). People were unsure about their remit and only guessed at the tasks they might undertake. When explained, people were particularly surprised about the extent of tasks a DTh could undertake.[3]

Therefore, when referring patients to the DTh, it is important to explain to the patient that a DTh will be carrying out the treatment as part of shared care. It is also imperative that as part of the introduction to the patient in the surgery, the DTh identifies themselves as a DTh, so it is clear to the patient what their role is within the team.

An infographic has recently been created by a member of the BSDHT to help promote the role of the DTh specifically aimed at educating patients on the skillset of the DTh (Fig. 2). This would be an excellent addition to any practice wishing to promote the role of the DTh within the team.

Conclusion

DThs have a wide skill set often underutilised in practice. Full utilisation of a DTh in primary care will inevitably optimise outcomes for patients, and consideration of the above top tips will hopefully go some way to facilitate change or stimulate innovative team working to optimise clinical outcomes. ■

References

1. Health Education England. HEE's Advancing Dental Care Review: Final report. 2021. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Advancing%20Dental%20Care%20Report%20Sept%2021.pdf (accessed May 2022).
2. General Dental Council. *Scope of practice*. London: GDC, 2013.
3. IFF Research. Scope of Practice Review: Final report. 28 May 2020. Available at: https://www.gdc-uk.org/docs/default-source/research/scope-of-practice-guidance.pdf?sfvrsn=7b3d8e58_4 (accessed May 2022).
4. Department of Health. *Delivering better oral health: An evidence-based toolkit*. 2021. Available at: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention (accessed May 2022).
5. British Society of Periodontology. UK version of S3 Treatment Guidelines. 2021. Available at: https://www.bsperio.org.uk/professionals/bsp-uk-clinical-practice-guidelines-for-the-treatment-of-periodontitis (accessed May 2022).
6. General Dental Council. *Preparing for practice: Dental team learning outcomes for registration*. 2015. Available at: https://www.gdc-uk.org/docs/default-source/registration-for-dcps-qualified-overseas/preparing-for-practice-(revised-2015)-(3)9cfe2565e7814f6b89ff98149f436bc7.pdf (accessed May 2022).
7. Dental Protection. Use of anaesthetics and fluorides by dental hygienist. 2015. Available at: https://www.dentalprotection.org/uk/articles/use-of-local-anaesthetic-and-fluoride-by-dental-hygienists-and-therapists (accessed June 2022).
8. Stratford D. The perceived impact on performance and patient safety of work-related stress and mental health disorders experienced by dental hygienists and dental therapist members of the British Society of Dental Hygiene and Therapy. *Ann Clin J Dent Health* 2022; 44–49.
9. Care Quality Commission. Dental mythbuster 13: Lone working in a dental practice setting. 2022. Available at: https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-13-lone-working-dental-practice-setting (accessed May 2022).
10. Plessas A, Paisi M, Bryce M *et al.* Mental health and wellbeing in dentistry: A rapid evidence assessment. June 2021. Available at: https://www.gdc-uk.org/docs/default-source/research/mental-health-and-wellbeing-in-dentistry27973e06-eb0f-4ee2-b92f-7fee3d2baf5b.pdf (accessed May 2022).

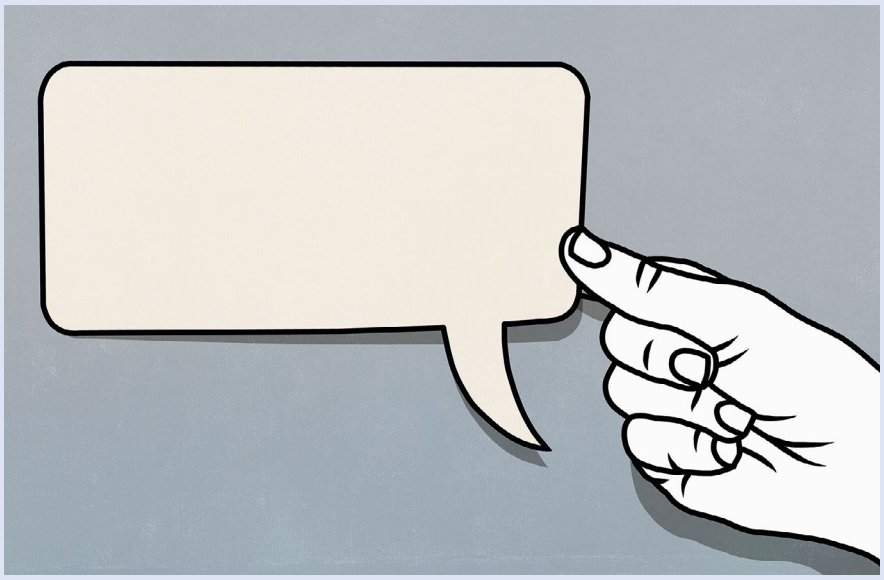
GDC opens consultation on corporate strategy

On 4 July, the General Dental Council (GDC) opened a consultation on its plans for the next three years. The regulator is seeking views on its proposed strategy which focuses on ways both to prevent patient harm and to be proportionate when handling the concerns it receives, progressing its ambition to shift the balance from enforcement to prevention.

The strategy includes plans to embed new principles of professionalism, providing the dental team the space needed to make informed judgements relevant to the situations faced in practice. There are also ongoing plans to focus investigations on the most serious concerns, such as those that raise issues of public safety or confidence.

The quality of the regulation the GDC can provide is closely linked to the quality of legislation it works under. This legislation has not been fundamentally updated for four decades and its weaknesses are becoming increasingly apparent while the timetable for reform gets less and less certain. The regulator says it will continue to press government for the reform it needs to become more agile and efficient – and be ready to respond should it arrive in the next three years – but it will also continue to focus on its core functions, and make improvements wherever it can, should reform not materialise.

This is a consultation on the regulator's plans and what those plans will cost to deliver. That does have an impact on the Annual Retention Fee (ARF) which the GDC expects will increase from the levels set in 2019 to around £730 (+7%) for dentists and around £120 (+5%) for dental care professionals (DCPs).



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A spokesperson for the General Dental Council said: 'This is a consultation on our strategic plans for the next three years and we look forward to hearing the views of everyone who holds an interest in our work, which of course includes dental professionals. Our target is to maintain a free reserve level equivalent to four and a half months of operating costs, and we believe the approach we've set out will maintain that level. If we are to continue ensuring patient safety and promoting the confidence that the public rightly have in dental professionals, the GDC must be financially sustainable and we are not immune to the inflation which is affecting everyone'.

In response to the GDC's plans to increase the ARF, the British Dental Association (BDA) said that such a move will undermine progress in rebuilding trust and confidence in the regulator among the dental profession. It stressed that this will place needless financial burdens on dental team members.

Shareena Ilyas, Chair of the BDA Ethics, Education and Dental Team Working Group said: 'Any hike in the ARF is impossible to justify while the GDC is sitting on vast reserves. The costs of providing care are spiralling, while the real incomes for all team members have collapsed. Further fee increases will only undermine any gains when it comes to restoring this profession's confidence in its regulator.'

The full plans are available on the GDC's website and the deadline to respond to the consultation is midnight, 6 September 2022: https://www.gdc-uk.org/about-us/what-we-do/consultations-and-responses/corporate-strategy-2023---2025.