January 2026

Dentistry

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HELP PATIENTS CARE FOR SENSITIVE TEETH

BEFORE, DURING AND AFTER PROFESSIONAL WHITENING*

Recommend to help keep teeth
free from stains post professional whitening*

* Start using at least 2 weeks before the whitening procedure

HALEON

PATIENTS WANT WHITER TEETH, DESPITE THEIR SENSITIVE TEETH[1,2]

86%

of people with sensitive teeth wish they had whiter teeth.[2]

50%

of people experience sensitive teeth when whitening but still want whiter teeth.[2]

Request samples

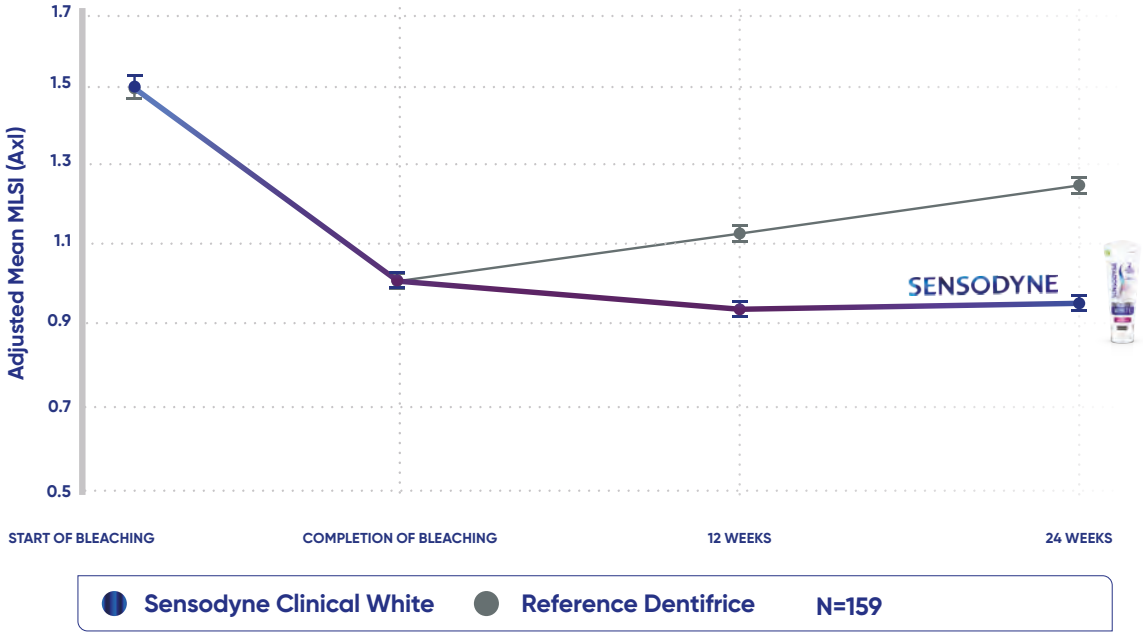
SENSODYNE

SENSODYNE CLINICAL WHITE: CLINICALLY PROVEN WHITENING TECHNOLOGY

Helps maintain the whiteness of teeth[4] following professional whitening procedures†

Effectively prevents stain build-up for up to 24 weeks post whitening procedure†

Extrinsic tooth stain change over time[3]



†After a professional whitening procedure. After 3 months vs a regular toothpaste, with twice daily brushing

References: 1. Haleon Data on File; Ipsos report OH Foundational Research in USA/Spain/Japan; 1420 adults; 2021. **2.** Haleon Data on File; Ipsos report "Sensodyne. US Whitening Fast Facts"; 2021. **3.** Haleon Data on File; 300109; 2024.

PM-GB-SENO-25-00251

January 2026

Dentistry

NHS DENTAL CONTRACT REFORMS ANNOUNCED

The government has revealed the latest overhaul of the NHS dental contract, with prioritisation given to patients with the most urgent dental needs. Dubbed 'the most significant modernisation of the NHS dental contract in years' by the government, the changes follow a consultation with the sector and the public. The reforms – which will be introduced from April 2026 – will include incentives for dentists to provide emergency and complex treatments through the introduction of a standardised payment package.

The changes include:

- A new, time-limited care pathway for patients with more complex dental needs
- Better payments for more complex treatment, which is often poorly paid under the current contract
- Payments linked to activity that helps reduce dental disease, rather than just treating problems once they occur
- New funding to support clinical audits and peer review within dental practices
- A requirement for practices to provide a set level of urgent dental care, with improved pay for this work.

'This marks the first step towards a new era for NHS dentistry' – Stephen Kinnock, minister of state for care

Minister of state for care Stephen Kinnock said: 'We inherited a broken NHS dental system and have worked at pace to start fixing it – rolling out urgent and emergency appointments and bringing in supervised toothbrushing for young children in the most deprived areas.

'Now we are tackling the deep-rooted problems so patients can have faith in NHS dentistry – these changes will make it easier for anyone with urgent dental needs to get NHS treatment, preventing painful conditions from spiralling into avoidable hospital admissions.

'This is about putting patients first and supporting those with the greatest need, while backing our NHS dentists, making the contract more attractive, and giving them the resources to deliver more.

'This marks the first step towards a new era for NHS dentistry after a decade of decline, one that delivers for patients and our dedicated dental professionals.'

The profession's response

Dr Nigel Carter, chief executive of the Oral Health Foundation, said: 'The proposed reforms acknowledge some of the pressures within NHS dentistry, particularly for patients with complex needs, but they stop short of the fundamental change the system requires. Adjusting contractual mechanisms may improve continuity of care for a small cohort of patients, but it does not resolve the structural problems that limit access or drive dentists away from NHS provision.

'Without sustained investment in prevention, early intervention and population-level public health measures, demand will continue to exceed capacity. A model that remains weighted towards managing disease rather than preventing it risks perpetuating the very pressures these reforms are meant to address.'

Jason Wong, chief dental officer for England, shares his view on page eight.

Shiv Pabary, chair of the British Dental Association's (BDA) General Dental Practice Committee, said: 'These are the biggest tweaks this failed contract has seen in its history. We do hope changes can make things easier for practices and patients in the interim, but this cannot be the end of road. We need a response proportionate to the challenges we face, to give NHS dentistry a sustainable future.'

The public consultation ran for six weeks from 8 July to 19 August 2025, with 60% from individuals sharing personal views, 33% from individuals sharing professional views, and 7% from organisations.

North of England Dentistry Show promises to bring a fresh perspective

Global pioneers and dental experts will be starting a new conversation on 13 February at the North of England Dentistry Show.

Taking place at Manchester's AO Arena, the event aims to hit one key goal across its three stages: to rewrite the rulebook and shake dentistry up. Through high-impact sessions, speakers including Miguel Stanley, Robbie Hughes, Martina Hodgson, Cat Edney and Avijit Banerjee will rethink assumptions to dismantle everything you think you know about modern dental practice.

Push beyond the expected – and discover the thinking behind the themes that are truly biting right now.

Turn to page 17 for *Dentistry*'s spotlight on the 2026 North of England Dentistry Show.

N.O.E. Dentistry SHOW 2026

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Mission statement

Dentistry magazine's unparalleled coverage of current affairs, new developments and the latest thinking keeps the dental sector on top of the issues that matter. For further information and to get in touch, email guy.hiscott@fmc.co.uk.

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Thank you, next

Guy Hiscott
Editor's view

As a rule, I'm not someone who enjoys complaining – although you'd be forgiven for thinking otherwise, given the thousands of words I've dedicated to taking issue with the NHS dental contract.

Given all that moaning, it would feel ungrateful if I didn't recognise the significance of last month's announcement from the Department of Health.

Urgent care is prioritised, complexity is better recognised, and quality is finally being talked about as something worth paying for. All those things are important. This is genuine movement in the right direction. It also speaks of promises being kept by the government, and a willingness to listen and respond rather than simply defend the status quo.

Considering how long we've spent locked in the inertia of pilots and empty assurances, this actually feels like momentum. So my hat goes off to Jason Wong, and to Stephen Kinnock for what they have done.

There is, of course, a 'but' coming.

Because it's also important to recognise that these reforms stretch the existing contract about as far as it can reasonably be taken.

They correct some of its most damaging incentives and soften its sharpest edges, but they do so within a framework that remains fundamentally unchanged. This is not a new contract. It's a sophisticated adaptation of an old one – and there is a difference.

That distinction is an important one because it defines what comes next. The 2006 UDA-based architecture is still doing a lot of heavy lifting here, even as new payments and priorities are bolted on around it.

The direction of travel is a more positive one but it's not a brand new road: it's the limit of what can be achieved without starting again.

So the risk now is not that these reforms are insufficient. Again, let me say that they are genuinely welcome.

Rather, it's that they are allowed to become the endpoint rather than an interim measure. We've seen a pattern of incremental improvement over structural change before, and this must not happen here.

(I might not think of myself as a complainer but I will happily admit to being a cynic.)

The most recent adult oral health survey underlines precisely why this momentum needs to be kept up. The findings are as timely as they are uncomfortable – and while there is no quick fix for problems that have been years in the making, any system that struggles to retain clinicians, reward prevention or support complex treatment is going to carry on contributing to this decline in oral health.

Which brings me to the uncomfortable question: what does 'next' actually mean?

At some point, NHS dentistry needs a genuinely new contract – one designed around prevention rather than repair, realistic workforce models rather than goodwill, and funding that reflects the scale of the challenge.

That doesn't mean discarding what has already been taken into consideration with these changes, but at some point the underlying structure needs replacing.

The government has promised to do this before its current tenure expires, and I want to see these recent reforms as proof of its commitment, but change comes fast in politics, and it takes no prisoners. (Did I mention that I'm a cynic?)

Handled properly, this moment could be remembered as the point at which NHS dentistry stopped treading water and began preparing for renewal. But that will only be true if the government can stick the landing – and the hardest work is still ahead.

Oral health award launches

The 2026 NASDAL Dental Check by One (DCby1) Practice of the Year award has been launched. Now in its eighth year, the award seeks to recognise a dental practice that has been successfully implementing and supporting the British Society of Paediatric Dentistry (BSPD) Dental Check by One (DCby1). The aim of the campaign is to increase the number of children who access dental care aged zero to two years.

The 2026 award will be presented by Jason Wong, chief dental officer for England, at the BDIA Dental Showcase at Excel London, on Friday 13 March.

Commenting on the launch, chair of the National Association of Dental Accountants and Lawyers (NASDAL) Heidi Marshall said: 'This award continues to highlight what is being done by so many practices across the UK. Each year we are genuinely inspired by the creativity, innovation and dedication shown by entrants as they find new ways to engage with their communities and promote good oral health from the earliest age.'

President of the BSPD, Dr Urshla (Oosh) Devalia commented: 'At BSPD we know how important a prevention approach to children's oral health is. The society is inspired by the many creative approaches we see up and down the country to encourage parents and carers to bring infants with them when they come for their own appointment.'

Entries can be submitted via nasdal.org.uk/award, by 5pm on Friday 6 February 2026. The winning practice will receive £1,000, a trophy, and the right to use the NASDAL Dental Check by One Practice of the Year 2026 title.

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Previous improvement to adult oral health has 'almost reversed' since 2009

More than one fifth of adults in England have a tooth with obvious decay, marking a 'reversal' of previous improvement, according to the latest adult oral health survey.

When those with at least one tooth with non-cavitated decay affecting the inner dentine were included, however, this increases to two fifths (41%) of dentate adults with obvious decay affecting at least one tooth.

The proportion of dentate adults with obvious decay reduced considerably between 1998 and 2009. However, there has been a 13% increase in the prevalence of the disease between 2009 and 2023.

'This is almost a reversal of the previous improvement, bringing the 2023 estimate closer to the one of 1998 rather than 2000,' the report reads.

Published on 9 December 2025, the adult oral health survey 2023 was carried out from June 2023 to April 2024, with a representative sample of adults in England aged 16 and older.

Key findings

Key findings from the latest oral health survey include:

- Almost two thirds of adults reported going to the dentist at least once in a two-year period (65%). One third (35%) reported going less frequently, or only when they had trouble with their teeth or dentures
- The majority of dentate adults (71%) had some tooth wear somewhere in the mouth
- More than three in five adults (65%) reported that their oral health was good or very good, 24% reported their oral health as fair, and 11% reported bad or very bad oral health
- Large proportions of adults reported that their oral health negatively impacted on their quality of life – 49% reported that they had experienced an occasional or more frequent oral impact, while 43% reported that their oral health had negatively impacted on their daily life. Additionally, 22% experienced a severe oral impact.

What does the profession say?

British Dental Association chair Eddie Crouch said: 'Hard won gains on oral health are going into reverse. Government needs to double down – and deliver promised reforms and vital investment.

'Without real commitment, NHS dentistry won't have a future and the nation's oral health gap will widen further.'

Nigel Carter, chief executive of the Oral Health Foundation, said: 'These figures are a stark warning that England is heading backwards on oral health. To see levels of decay returning to those last recorded in the late 1990s is simply unacceptable and entirely preventable.

'We urgently need national action to make healthier choices easier, improve access to dental care, and address the widening inequalities that are leaving millions behind. Unless we act now, we risk a generation living with worse oral health than their parents and grandparents.' D

New specialist progression route announced in Scotland

Specialty dentists in Scotland who are able to demonstrate they possess and have been applying the skills and experience for the specialist grade will now be able to progress to a specialist title.

These skills and experience must meet the capability framework requirements for the specialist grade and there must be a service need for a specialist grade post.

For candidates who successfully apply before 31 January 2026, pay will be backdated to 1 August 2025. It will not replace the existing process for recruitment into a vacant role, for example when an associate specialist leaves or when a new role is created.

The Scottish Government acknowledged that a clear commitment to career development is needed for specialty dentists to create opportunities for progression. It said this would in turn improve patient care and access to services.

Specialist progression route process

1. Specialty dentist requests a meeting with their line manager to discuss regrading, including evidence they are working at specialist level
2. Line manager considers evidence and discusses the service need for a specialist with the clinical director
3. If the line manager supports the application, the specialty dentist submits an application form to the medical workforce team
4. If the line manager does not support the application, they must tell the applicant why in writing, explaining which of the eligibility criteria were not met. Where the applicant's level of experience, skill or autonomous practice is the reason, a development plan should be identified with the applicant
5. Even where the line manager does not support the application, the specialty dentist can still apply to the medical workforce team if they disagree with the decision
6. The medical workforce team forms a panel to consider the application. The panel may request additional information
7. The panel decides whether to accept or reject the application. Before rejecting, the applicant must be invited to a discussion with the panel
8. If the panel accepts the application, the applicant is regraded with effect from date of application and informed in writing. Where needed, an updated job plan should be agreed between the applicant and line manager
9. If the panel rejects the application the applicant should receive detailed feedback
10. If rejected, the applicant may submit an appeal to the medical director. A new panel will hear the appeal, and the applicant must be advised in writing of the outcome.

Government orders investigation into costs and practices of private dentistry

Chancellor Rachel Reeves has ordered a market study into private dentistry amidst concerns of 'hidden costs', reports suggest.

The minister has written to the Competition and Markets Authority (CMA), urging it to investigate the costs and practices of private dentistry. In a statement, Reeves said 'hidden costs, lack of transparency and overtreatment' has impacted families in need of dental treatment. As a result, she wants to see 'urgent action' to help reduce prices, the Mirror said.

BDA chair Eddie Crouch said: 'This call for an investigation is utterly perverse. The chancellor is singling out private dentists for doing what any business does: covering their costs, some of which are of the chancellor's own making. At the same time, she's very happy to starve NHS services of vital funding.

'We'd remind her that profits from private care are all that are keeping NHS dentistry afloat.'

Nigel Jones, strategy director at Practice Plan, said: 'This feels like a desperate attempt to distract attention from the supervised neglect of NHS dentistry by successive governments. It could well backfire because a properly conducted review should shine a spotlight on NHS under funding and the failure in effective workforce planning.'

Simon Thackeray, of the British Association of Private Dentistry (BAPD), added: 'The proposal for the CMA to investigate private dentistry fees is deeply misguided.

Private dentistry has not caused the access crisis, inflationary pressure or workforce shortages. The root cause is decades of political neglect of NHS dentistry.'

GDC publishes updated guidance to 'reduce fear and stress' in dentistry

The General Dental Council (GDC) has published updated decision-making guidance in a bid to reduce fear among registrants. The regulator said it comes as part of its ongoing work to improve fitness to practise processes and increase transparency.

Coming into effect from 6 January 2026, it follows a 12-week consultation held by the GDC.

The updated guidance includes improvements to the impairment sections – particularly public interest impairment findings – and instances where practice committees may consider findings on the grounds of public interest. The conflict of interest section now includes bias and the difference between the two.

New sections have been added covering discrimination and harassment, special measures to support vulnerable witnesses, and reasonable adjustments for registrants and witnesses involved in hearings.

The guidance also places greater emphasis on the seriousness of sexual misconduct and discrimination cases, and makes clear that sexual misconduct involving members of the dental team is as serious as cases involving patients.

Fitness to practise

Independent panellists on practice committees – which include the professional conduct committee, professional performance committee and health committee – decide whether a dental professional's fitness to practise is currently impaired.

Although primarily for practice committee panellists who make decisions on whether a dental professional's fitness to practise is currently impaired, the guidance is also relevant for registrants and their representatives at fitness to practise hearings, the regulator says.

Tom Whiting, chief executive and registrar at the GDC, said: 'We know that fitness to practise investigations can take too long and feel overly complex, often leading to a fear of the process and of the GDC. As a result, it can negatively impact the mental health and wellbeing of those involved.

'By supporting consistent, transparent and proportionate decision-making through this updated guidance, we aim to reduce some of the negative impacts of fitness to practise investigations.'

The guidance can be viewed at bit.ly/4533E3r.

Dental amalgam: agreement sets global 'phase-out date' for 2034

A 'global phase-out date' of 2034 has been set after which the manufacture, import or export of dental amalgam will no longer be permitted.

The landmark decision was reached at the Sixth Conference of the Parties (COP6) to the Minamata Convention on Mercury, led by FDI World Dental Federation (FDI) and the International Association for Dental, Oral and Craniofacial Research (IADR).

The agreement includes an exemption that supports the joint advocacy by FDI and IADR, which ensures that even after the phase-out of dental amalgam it can be used 'when its use is considered necessary by the dental practitioner based on the needs of the patient'.

This provision ensures that patient care remains at the centre of decision-making, safeguarding access to essential restorative treatments where alternatives are not yet available or viable.

Over four days of deliberation, both organisations delivered individual and joint statements reinforcing the continued relevance of dental amalgam in restorative dentistry as well as the importance of prevention.

They called for research into 'affordable, effective and sustainable' alternative materials and emphasised that waste management should be compulsory to reinforce the convention's broader objective of reducing environmental mercury exposure.

The efforts helped to extend the final phase-out timeline beyond 2030 – the date originally proposed.

The European Parliament voted to ban dental amalgam in January 2024, resulting in a total phase-out in the European Union (EU) from 1 January 2025. D

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NHS dental contract reforms: 'a positive step'

Chief dental officer (CDO) for England Jason Wong introduces the newly-announced changes to the NHS dental contract and the motivations behind them

Jason Wong
Chief dental officer for England

NHS dentistry plays a vital role in supporting the health of communities across England, and I want to thank you and your teams for the work you do every day.

The reforms announced by the government in December 2025 aim to support you and improve patient experience. They are the results of the consultation on reforms to the NHS dental contract that ran over last summer – guided by the insights shared by dental teams across the country.

We know there is much more to do, and that these reforms are just the start, but these changes are a positive step for dental professionals and patients.

A need for change

I know you've faced increased pressures in recent years, reflecting changes in demand, workforce patterns and the growing importance of prevention and long-term care. This has highlighted the need to update how NHS dentistry supports you to deliver care effectively and sustainably, while also continuing to improve patient experience.

That is why the government has pushed forward these reforms, which better reflect the realities of modern dental practice and respond directly to what the profession has told us.

We listened closely to dentists and your teams, as well as to patients and the public, to shape these reforms. You were clear about what would help you provide better care, and those views have been central to the approach we are taking.

Remuneration

A key focus has been to better remunerate you for the care you provide, particularly for patients who require more complex or longer-term treatment.

The reforms also place greater emphasis on longer-term treatment for patients with complex needs, helping you manage conditions such as advanced decay or gum disease more effectively. This supports improved outcomes for patients and gives appropriate weight to your clinical judgement.

The changes recognise the breadth of skills within dental teams. By making better use of the skills of dental nurses and other professionals you can focus on the care that most needs your expertise.

This helps ensure care is delivered by the right person at the right time and strengthens the focus on prevention, particularly for children's oral health.

Prevention remains central to these reforms and expanding the scope of practice for dental nurses will allow more preventive care to be delivered efficiently. Alongside initiatives like community water fluoridation, this puts a clear focus on children's oral health and embeds prevention across NHS dentistry.

Urgent care access

Improving access to urgent care is another important element. Patients should be able to receive timely support when problems arise, while also benefiting from care that supports their longer-term oral health. Integrated care boards will be supported to implement the reforms in close partnership with you and your teams.

These reforms represent a positive step forward for NHS dentistry. They are designed to support you as professionals, improve patient experience and help build a service that is fit for the future.

By working together, we can build on what already works well and support a system that remains sustainable for both patients and the profession.

We will continue to work with you in developing further reforms and improving the working environment for dental teams. D

Background information

The consultation, which ran for six weeks from 8 July to 19 August 2025, received 2,289 completed responses – 60% from individuals sharing personal views, 33% from individuals sharing professional views and 7% from organisations.

More than half of respondents to the consultation agreed the proposals would improve the current NHS dental contract and support practices to prioritise care for those who need it most.

The changes will require legislative amendments, which the government plans to introduce from April 2026.

NHS England will work with integrated care boards and clinical experts to produce detailed implementation guidance.

The key measures being taken forward from the consultation are:

- Embedding urgent treatment in the NHS dental contract so patients have access to urgent dental care when they need it
- New treatment pathways for complex needs such as serious tooth decay and progressive gum disease
- Delivering effective, evidence-based care, making greater use of dental expertise and knowledge
- Enhanced support for dental professionals' learning and development, benefiting patients from an enhanced skill set
- Strengthening the NHS dental workforce by supporting retention.

Source: Department of Health and Social Care and Stephen Kinnock MP

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Reframing the debate

Andrew Dickenson discusses how the Welsh dental contract reform addresses patients' needs and supports sustainable care

Andrew Dickenson
Chief dental officer for Wales and Welsh Government deputy director

The reform of the Welsh NHS dental contract represents the most significant structural change since 2006. In developing the new contract, in tandem with dental representatives and the NHS, the Welsh Government has prioritised needs-led care, prevention, equity and improved access.

Reform purpose: population health, not optics

The reform's central aim is to shift from activity-driven delivery to a needs-led, prevention-first model, which directs resources to where they achieve the greatest health gain. This is not cosmetic. Prioritising clinical risk, expanding preventive interventions and deploying a broader skill mix are designed to reduce avoidable disease and free capacity for those with the greatest need.

Public consultation highlighted access and clarity, while professional negotiation has shaped clinical and operational details. The resulting policy seeks to balance public expectations and clinical priorities with the budget available.

Risk-based recalls safeguard continuity

Concerns about moving away from the routine of six-monthly recalls are understandable. But risk-based recall is evidence-informed – many low-risk patients derive limited benefit from fixed six-monthly reviews, while higher-risk patients require closer surveillance.

The reform provides clinicians with a framework to record risk status, set personalised care plans, and justify interval decisions.

Safeguards are built in – for moderate-risk patients, recent treatment episodes, or those with complex comorbidity – through clear guidance and review checkpoints. Implemented in line with NICE guidelines, risk-based recall preserves continuity for those who need it most while redistributing capacity to untreated high-need cohorts.

The amber cohort: recognised and addressed

Patients who fall between categories – neither new nor acutely high-need – pose an operational challenge. The reform's emphasis on prioritising new and high-need patients tackles longstanding inequities in access, but moderate-need patients are not overlooked. Safeguards include:

- Defined care packages to support ongoing management
- Regular audit and review of care plans to ensure timely intervention
- Local contract flexibility where population profiles show significant numbers of medium-need patients.

Together, these measures maintain continuity for moderate-need patients while enabling practices to reduce backlog and concentrate preventive resources where they have greatest impact.

Funding: transparency and calibration

Financial stability is a legitimate concern. Offering a time-based contract with uplift in hourly allocation is important but sits within a broader funding architecture: capitated payments, adaptive commissioning to reflect local population need, and guaranteed funding for urgent access.

The capitated prevention element also aims to reduce high-cost downstream activity by preventing disease progression through timely intervention.

Contract flexibility: refinements to reduce stress

The policy aim is to safeguard continuity of NHS services and protect public funding, but these rules are not immutable. Practical refinements – such as aligning contractual notice periods with standard NHS termination timelines – can support both service delivery and business stability.

Such adjustments reduce unnecessary stress without altering the reform's core objectives.

Regional variation: a solvable challenge

Variation between health boards in rebasing and local negotiation is a reasonable worry, but not an argument against reform.

National standardisation is intended to provide consistency while allowing local discretion for demographic and workforce differences.

Safeguards include publishing minimum national standards, requiring equity-sensitive adjustments in deprived areas, and creating oversight routes to review outlier decisions quickly. These steps retain the benefits of local responsiveness without creating postcode inequity.

Mixed models and ethics: clarity preserves trust

Concerns about private membership plans and the NHS/private boundary are critical to maintaining public trust. The reform's ethical stance is clear: patient entitlements must be transparent; professional guidance should delineate acceptable mixed-model communications; and monitoring must identify practices that create unfair tiers of access.

Practices may offer private services, but transparency ensures choices are genuine and not the product of disguised necessity.

Workforce and skill mix: an opportunity to build capacity

Better use of the wider dental team offers an opportunity to increase capacity and career progression – this mirrors the successful approach we have adopted in reforms across other branches of primary care.

With clear scope of practice guidance, investment in training and appropriate supervision, expanded skill mix can free dentists from lower-value tasks, enabling them to concentrate on complex care and preventive leadership.

Properly supported, this change enhances clinical effectiveness and local service resilience.

Implementation levers and measuring success

For reform to be judged by outcomes, delivery must be transparent and adaptive. Key levers include:

- Maintaining multi-stakeholder engagement
- Rolling finance models with published assumptions
- Clinician-facing guidance on recall and prevention
- Dashboards tracking access, preventive uptake, continuity, and sustainability.

Balanced, public-facing metrics should report timely access for high-need cohorts, preventive intervention coverage, stability in moderate-risk indicators, and workforce participation trends.

Reform with realistic safeguards

In the November/December issue of *Dentistry*, Louise Anderson described the new contract as optics-driven, financially unsustainable, and professionally alienating. However, this fundamentally underestimates the evidence base and the safeguards inherent in the contract.

Professional concerns are practical and must continue to shape delivery. The right path is not to pause reform but to proceed with transparent, pragmatic measures – calibrated finance, clinical safeguards for recall, defined provision for medium-need patients, adaptive commissioning based on local population need, and consistent application across health boards.

Implemented in this spirit, contract reform will deliver improved population oral health and a sustainable NHS dental service in Wales. Fair in principle and feasible in practice. D

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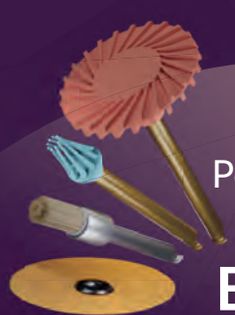

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Dentistry and fiscal drag

Iain Stevenson uncovers the hidden cost of the 2025 autumn budget

Iain Stevenson
Head of dental,
Wesleyan Financial Services

The 2025 autumn budget may have avoided any dramatic changes to income tax rates – but that doesn't mean dentists are shielded from its impact. In fact, the government's decision to extend the freeze on personal income tax and national insurance thresholds until April 2031 is likely to be a significant challenge for dentists over the coming years.

On paper, maintaining current tax rates sounds reassuring. In practice, the opposite is true. With inflation pushing earnings upwards, more dentists will find themselves dragged into higher tax bands despite no rise in headline rates – a classic case of fiscal drag.

On paper, maintaining current tax rates sounds reassuring. In practice, the opposite is true

For many practitioners already operating in the 40% or 45% brackets, even the most modest income growth could see a greater share of their earnings taxed at higher rates.

Those earning above £100,000 face an additional headache: the tapering of the personal allowance. This well-known tax trap pushes the marginal tax rate even higher and can substantially erode take-home pay.

Practice owners aren't exempt from the squeeze either. Rising minimum wage levels will increase staffing costs at a time when margins are already tight. Balancing recruitment, retention and profitability will become even more challenging as operational expenses rise faster than income.

Ultimately, the freeze may be politically convenient, but for the dental profession it's anything but neutral. Without careful planning, the silent creep of fiscal drag could leave many dentists paying significantly more tax – despite nothing changing on the surface. D

Workforce issues: still the biggest challenge

Nigel Jones discusses what he believes to be the biggest driver of change in UK dentistry as well as the biggest threat to any efforts to reduce oral health inequality

Nigel Jones
Director, Practice Plan

From budgets to potential Competition and Markets Authority (CMA) inquiries and from General Dental Council (GDC) strategies to consumer media appearances, it's clear we still need to talk seriously about workforce issues in UK dentistry.

It's been in the spotlight for many years, so there is at least a superficial understanding. However, a little knowledge can be a dangerous thing, and there is a continuing obsession with headcount while placing insufficient emphasis on other factors such as productivity, patient throughput or the trend for part-time working. This matters. Workforce issues are, in my opinion, the biggest driver of change in UK dentistry and the biggest threat to any efforts to reduce oral health inequality.

The myth of 'enough dentists'

Take, for example, the oft-repeated claim that we have more than enough dentists in the UK, just not enough willing to work in the NHS. According to Professor Chris Whitty, this situation arises because it is more 'lucrative' to work in the private sector.

Whether or not you agree with Professor Whitty could depend on which definition of 'lucrative' you think he meant. If it's the traditional view about producing a great deal of profit, then that's a massive oversimplification of why dentists turn to the private sector.

If, however, you take the civil law definition – that something is lucrative if it is 'acquired without accepting burdensome conditions' – then I agree. Nearly all the hundreds of dentists I've helped in the last three decades to 'go private' have done so not to increase taxable income, but to escape what they viewed as the burdensome conditions of working in the NHS.

Why dentists leave the NHS

Many cited NHS administration, bureaucracy and contract management as contributory factors. However, of greater significance is that nearly all wanted to lengthen appointments and see fewer patients per clinical session.

A fear of complaints, litigation and the GDC lies beneath this desire, as the perception is that longer appointments mitigate risks of misunderstandings and clinical errors. When appearing before MPs last year, the CDO for England, Jason Wong, highlighted that the NHS dental workforce needs to feel able to provide safe care and feel safe doing so. Most of the dentists I have helped did not feel sufficiently safe within the NHS, so opted for the private sector and a less intense way of working.

Burnout and the rise of part-time working

Safety concerns and NHS intensity have further implications because there is also the risk of burnout. Mitigation of that risk is part of what leads so many dentists to go part-time.

There are wider drivers than mental health behind the trend for part-time work. Society responded to the pandemic by re-evaluating the part work plays in our lives. The ability to blend career and family differently is part of the attraction of dentistry for many. With frozen tax thresholds extended to 2031, the temptation to reduce clinical hours rather than increase a tax bill is likely to endure for years.

The supply-demand imbalance

The implications are obvious. If a private dentist sees fewer patients, the more dentists that go private, the more we need.

Likewise, with dentists going part-time. Increases in headcount – whether homegrown dentists, overseas dentists, therapists or hygienists – will struggle to keep pace with reductions in clinical hours and patient throughput.

The result will be continuing restrictions in the supply of clinical services to meet patient demand.

That demand will almost certainly soften as the cost of living crisis affects spending decisions and attendance patterns. However, that softening could well be less than reductions in supply and is also likely to be temporary.

Given priority attached to health and appearance by an ageing population, demand looks set to outstrip supply for many years.

CMA inquiry: a political chess game?

Perhaps it's that imbalance that brings us to the potential inquiry into private dentistry by the CMA. The basic law of supply and demand dictates that prices rise when supply decreases, so it's no surprise this is what we have seen in private dentistry.

In a world where providers can become price makers rather than price takers, a question for the CMA will be whether this position of strength is being abused. However, while there will inevitably be exceptions, the BDA's response to the Chancellor's call for an inquiry evidenced that increases in private fees over the last four years have averaged 13.8%, while cumulative inflation over the same period stands at 24.5%.

Although the chancellor of the exchequer outlined her motivation for requesting an inquiry, it is hard to escape the feeling that this is the first of a sequence of moves in the political game of chess in which NHS dentistry is embroiled. Trying to guess the endgame could be a waste of energy.

What happens next?

Perhaps it is a genuine response to consumer concern, fuelled by isolated incidents of unfairness. Maybe it's a prelude to rapid expansion in the private dental market following promised NHS contract reform greater than the recent tweaks.

Whether intended or unintended, such an inquiry should bring into sharp focus the supply issues caused by decades of inadequate workforce planning by successive governments.

If, as many believe, we are moving towards a core service for NHS dentistry – and with it, an exacerbation of part-time work and reduced patient throughput – that can only be a good thing. D

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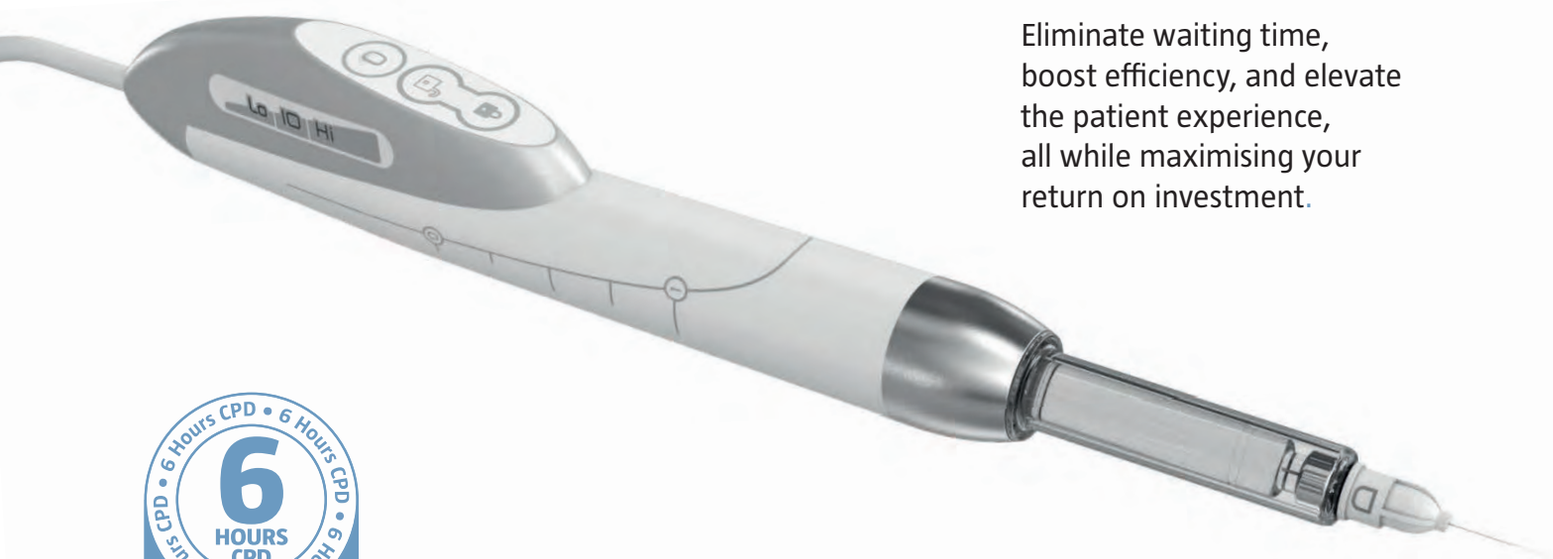

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SWALLOW

Are you ready for a new conversation?

The 2026 North of England Dentistry Show is coming to Manchester – find out why it's the dental event everyone will be talking about

The rate of change in dentistry has never been higher – which is why the 2026 North of England Dentistry Show (NOE) has been revamped to help clinicians navigate what comes next.

With technology, patient expectations and the pace of innovation accelerating faster by the day, dentistry is at a crossroads. NOE 26 will bring those conversations together under one roof.

Stepping beyond the boundaries of a traditional exhibition, this year's event will help the profession navigate rapid change and explore the innovations, mindsets and models shaping its future.

On 13 February in Manchester's AO Arena, global leaders, hands-on innovators and practitioners driving progress will take to the stage – all united by the belief that dentistry is ready for a new conversation.

Miguel Stanley: the future starts with 'no shortcuts'

At the heart of the day sits keynote speaker Dr Miguel Stanley – one of global dentistry's most respected and recognisable voices.

Founder and clinical director of the White Clinic in Lisbon, Miguel has spent more than two decades championing a simple but uncompromising principle: that there are no shortcuts to exceptional care.

His clinic has built a reputation for ethical, precision-led dentistry, attracting some of the world's most discerning patients and inspiring colleagues across five continents.

At NOE 26, he will deliver a keynote that feels particularly resonant for the UK. Miguel will explore the dangers of cutting corners and the rising need for 'revision dentistry' – correcting outdated or harmful work to restore health, trust and long-lasting aesthetics.

He will then chart how digital technologies, advanced biomaterials and AI, when applied with responsibility and purpose, can elevate clinical outcomes and transform the patient experience. The result will offer a candid, aspirational roadmap for clinicians who want to practise dentistry that is genuinely future-proof.

Progress without repetition

Across the day, other sessions will examine what it really means to move dentistry forwards.

Robbie Hughes will offer a visionary glimpse ahead of dentistry in five years' time – where new technologies and materials make patient expectations easier to meet than ever before.

His unflinchingly future-facing view will be underpinned by the teachings of comprehensive dentistry being shared elsewhere.

Ian Buckle will explore how high-quality digital dentistry still relies on timeless fundamentals: occlusion, function and the discipline of getting the basics right.

Digital workflows continue to dominate the conversation, with Martina Hodgson showing how digital orthodontics elevates communication, predictability and patient experience.

Elsewhere, a more holistic approach will come to the fore. James Goolnik will lead a panel made up of some of the leading lights in diagnostics discussing new models of personalised healthcare.

Meanwhile Professor Avijit Banerjee's panel session will champion a shift towards prevention, team-based practice and a more expansive role for therapists and hygienists.

The programme aims to make the argument that dentistry cannot meet tomorrow's demands with yesterday's thinking. It will bring the fresh perspectives, new models of care and willingness to rethink long-held assumption needed for progress.

Experience and education

NOE 26 will also contain dedicated experiential zones that let delegates test, feel and explore the innovations shaping modern practice.

- Feel At Ease with Bupa Dental Care: a space to decompress and reset: expect space to focus, practical wellness sessions and fluffy blue chairs
- AI Lounge powered by Pearl: hands-on access to the AI tools already influencing diagnostic decisions worldwide, with expert walkthroughs to illustrate how AI is already integrating into everyday care
- Restorative Revolution Theatre powered by Midas: live 3D printing, showcasing next-generation restorative materials, new workflows and the future of same-day treatment.

Smile Clinic Group's Jin and Kish will bring the day to a close by hosting the 'weekend warm-up' – where the lights go down, the music goes up and delegates can usher in the weekend while unwinding together. A reminder that professional development can be social, memorable and fun.

Why attend?

Dentistry needs a new conversation – and NOE 26 is built to start it.

It aims to offer clarity on the technologies worth adopting, the skills worth investing in and the mindset shifts that will define the next decade of practice.

The day blends global insight, targeted expertise and practical demonstrations that speak directly to the challenges dentistry faces now.

Whether you're looking to strengthen clinical decision-making, explore emerging technologies, rethink your business model or simply reconnect with colleagues and your own motivation, Manchester is the place to be. D

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The final frontier?

Mastering prevention is dentistry's next great challenge – but meeting it needs unity and inspiration, Cat Edney and Avijit Banerjee tell Guy Hiscott

For all the talk of innovation, the most critical transformation facing dentistry might not be a new material, a shiny digital workflow or even the latest AI diagnostic.

Instead, it's a mindset shift. One that reframes oral healthcare as a long-term investment in wellbeing, instead of a reaction to disease.

Few people explain that better than dental therapist Cat Edney and Professor Avijit Banerjee, who paint a picture of a profession on the brink of dramatic change – if it can only seize the opportunity.

'In the last five to 10 years we've seen huge innovations in oral care,' Cat begins. 'My hope is that the next decade brings that impact to the grassroots: fewer children in hospital for extractions, earlier intervention, and an entire dental team taking an active role in prevention.'

Avijit agrees, and stresses that the shift is already underway. 'The way we deliver oral healthcare needs to adapt,' he says.

'We have a framework for this: minimum intervention oral care. It's being taught to new graduates and increasingly embedded in primary care. But it needs to permeate the whole profession so teams are empowered to help patients change behaviour.'

For this to happen, prevention must move beyond technique and into culture. As Avijit puts it, the goal is to go from asking 'what is the matter with you?' to 'what matters to you?'

It's a model endorsed by the World Health Organization and widely adopted in general healthcare. But dentistry is behind the curve.

Avijit continues: 'What happens in your mouth affects your body – your general health, your mental health, your wellbeing. The evidence is there. The challenge is making the system catch up.'

Understanding the barriers

If prevention is the frontier, then education – for both patients and professionals – is the foundation.

Cat is unequivocal about this: 'There's a huge number of people in the UK who have very limited understanding of oral health. We need to start education early, from primary-age families to older patients who still see tooth loss as inevitable. It's a wider societal issue, not just a dental workforce issue. Policy has to address it too.'

And Avijit believes the gap is structural as much as cultural. 'We have a brilliant NHS at its core,' he says. 'But dentistry often sits at the periphery of its mechanisms.

'Policymakers talk about change, but delivering it requires appetite and alignment. The barriers aren't clinical – they're systemic.'

And one of the largest of those barriers is financial. Cat points out: 'In dentistry, we've historically rewarded treatment rather than prevention.

'If you've not done something physical, you're not paid for it. So why would practices invest time, money and training in prevention?'

It's a sentiment Avijit echoes: 'Antiquated remuneration systems have created a "watch and wait" culture that makes no sense clinically.

'You wouldn't tell a patient with high blood pressure to watch and wait. You wouldn't tell a pre-diabetic to come back in six months. Yet that's what we've done for decades.'

Both Avijit and Cat believe that change is coming – the problem is that it's happening very slowly.

'There is movement,' Avijit says, 'but it's incremental. The key is updating our messaging to the public.

'People don't go to the doctor only when something hurts; they go to stay healthy. Dentistry needs the same shift.'

Skill mix, industry and the power of working together

But that shift is bigger than any one person. Indeed, it's bigger than any one clinical role working on its own, argues Cat.

'Dental nurses who are oral health educators, dental hygienists, dental therapists – they all have enormous potential in minimally invasive care,' she says. 'But that's only possible if the system values what they do.'

Industry, too, must have a seat at this table. 'The innovations we've seen over the last 20 years have been incredible,' Cat continues. 'But we need industry partners working together to show how these technologies integrate to deliver personalised care.'

For Avijit, this alignment is long overdue. 'If all stakeholders used the same language and pushed towards the same outcomes, policymakers would have no choice but to respond,' he says.

'Medicine has achieved this unity; dentistry is catching up. The stars are aligning, but we must accelerate.'

This unity is not just philosophical. It has practical benefits: clearer patient communication, stronger delegation, better adherence to evidence-based care and more consistent outcomes.

Above all, it creates the conditions for system reform – and without this, prevention cannot scale.

Dentistry needs a new conversation. Not scripted, not filtered. Raw conversations that reflect the reality of practice, the evidence, and the passion people feel for making things better

The technology horizon

There's one further silver lining, agree the pair. Despite all the structural issues dentistry needs to address, technology is already reshaping prevention.

'AI is helping us educate patients about their radiographs in ways we couldn't before,' Cat explains.

'With that knowledge, patients are much more open to treating early carious lesions. They're not asking us to watch and wait any more: they're asking what they can do.'

This is part of a bigger shift in patient expectations. 'Future generations value their health and expect personalised, transactional care,' Avijit adds.

'Shared decision-making, environmental sustainability, the phasing out of mercury – all of this fits into minimum intervention care. It's not about overtreatment; it's about wellbeing.'

And we're not done yet, he adds. 'The tech will only get more exciting,' Avijit says. 'The way dental teams learn and deliver care will change dramatically. And that's positive – as long as we temper innovation with common sense.'

A profession ready for new conversations

Both Cat and Avijit believe the next step is to bring these discussions into the open with energy, unity and honesty.

'Dentistry needs a new conversation,' Avijit says. 'Not scripted, not filtered. Raw conversations that reflect the reality of practice, the evidence, and the passion people feel for making things better.'

Cat agrees: 'It's all about innovation, but also action. Prevention is the direction of travel – now we need the system to support it.' D

Explore the solutions shaping prevention's future at the North of England Dentistry Show on 13 February at AO Arena, Manchester. Join Cat, Avi and a panel of leading clinicians, policymakers, researchers and industry innovators as they unpack practical solutions, from minimum intervention care and skill mix to system reform and the technologies reshaping prevention. Sign up for free at **dentistry.co.uk/noe** to join the conversation – and help shape the next frontier in oral health.

‘Scan everything’

Martina Hodgson delves into how digital dentistry is transforming patient trust, team engagement and practice efficiency

For Yorkshire dentist Martina Hodgson, digital dentistry isn’t a technical upgrade – it’s a fundamental rethink of how a practice functions.

A general dentist with a strong orthodontic focus, Martina runs two practices in Wakefield and Leeds. She describes digital workflows as central to the way she delivers care.

‘For me, digital dentistry is a way to elevate the patient journey,’ she explains. ‘It enhances communication, speeds up treatment, increases revenue, and engages the team. It’s not just a way of taking impressions – it’s a game-changer in how the practice runs and how dentistry is delivered.’

Moving past the fear factor

However, despite the benefits, Martina still sees hesitance across the profession.

‘People are scared to invest. They’re scared to step out of their comfort zones,’ she says. ‘And I’m not going to lie – the learning curve can be steep. You’re investing money, but you’re also investing time and effort.’

But for her, the returns speak for themselves.

‘Digital dentistry gives you the most powerful communication tool we’ve ever had. When you show a patient a scan in full 3D colour, it builds instant trust. Years ago, we were trying to explain cracked teeth or recession with mirrors and clunky little cameras. Now they can see exactly what’s happening for themselves.’

That clarity changes conversations – and decisions. ‘If all it did was improve relationships and create that instant trust, it would be worth it,’ she says. ‘But you’re also upskilling your team, involving them in the patient journey, and increasing revenue because patients understand their problems and ask how to fix them.’

The most common mistake

Martina’s bluntest observation is that most dental practices fail to get full value from the tech they already own.

‘The biggest mistake is under-utilising the scanner,’ she says. ‘People spend thousands of pounds on a piece of kit and then use it like a glorified impression machine. It sits in a corner gathering dust.’

In her practices, the scanner is a core clinical tool – used for every new patient and at every check-up. ‘A scan should be an education tool and a communication tool. There’s nothing more powerful than a patient seeing their mouth in 3D for the first time.’

It also reframes treatment discussions. ‘If you say they need a filling or that a tooth is broken, they can see it instantly,’ she says. ‘It means you can ethically explain treatment options, and they’re far more likely to take them up because they understand the consequences of doing nothing.’

Unlocking digital efficiency

For practices looking to get more from digital – or finally dust the scanner off – Martina suggests three practical steps:

1. Upskill your team. ‘The first thing you need to do is train your team,’ she says. ‘Your dental nurses and treatment coordinators should be able to scan. It’s great for them – and it frees you up’
2. Make scanning routine. ‘Most patients have never seen anything like it. The trust, understanding and engagement you get from scanning every patient is unbelievable. It’s a big shift, but absolutely worth the effort’
3. Bring production in-house. Explore in-house workflows in a controlled, progressive way. ‘Once you’re scanning properly, think about whether making certain items in-house could be more efficient and more profitable. Start small – a simple 3D printer for models, Essex retainers or bleaching trays is enough.’

Strengthening the human side of care

For Martina, the most important point is that digital dentistry doesn’t replace the human element – it enhances it.

‘Sometimes it feels like AI is taking things away from us. I don’t feel that at all. Digital dentistry elevates how we educate and communicate with patients. And it involves the whole team in delivering care.’

She sees it as fundamentally inclusive. ‘When I fit a retainer or 3D-printed veneers that my dental nurse has printed and glazed, I tell the patient: “Katie did this”. They think it’s incredible. It brings everyone closer together.’

As far as Martina is concerned, digital dentistry fulfils the reason most clinicians entered the profession in the first place. She says: ‘It allows us to elevate the human involvement in dentistry – not replace it.’ D

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1. Bosma, M.L., McGuire, J.A., DelSasso, A. et al. Efficacy of flossing and mouth rinsing regimens on plaque and gingivitis: a randomized clinical trial. BMC Oral Health 24, 178 (2024). https://doi.org/10.1186/s12903-024-0 3924-4 **2.** Figuero, E., S. Roldan, J. Serrano, M. Escribano, C. Martin and P. Preshaw (2020). "Efficacy of adjunctive therapy in patients with gingival inflammation. A systematic review and meta-analysis." J Clin Periodontol" **3.** EFP: Guidelines for effective prevention of periodontal diseases (2014). Available at: https://www.efp.org/news-events/perio-workshop/past-workshops/perio-workshop-2014/

What's old is new again

Ian Buckle explains why digital dentistry needs a new mindset

Digital dentistry is unlocking possibilities that were unthinkable even a decade ago – faster workflows, richer diagnostics, more predictable outcomes. But if you believe Ian Buckle, we're still a long way from realising the true potential of digital dental workflows. Not because the tools aren't good enough, but because the dental profession is coming at them from the wrong angle.

'We're still seeing digital in a very procedural way,' Ian explains. 'We look at how to mill a crown or print a veneer – the single tooth jobs – instead of asking: how does this help us look after the whole patient?'

It's a point grounded in decades of experience. Ian has worked across cosmetic, restorative, functional and now airway-aware dentistry long enough to see techniques rise, fall and mature. And his message is not nostalgic; it is simply that every technological leap only becomes valuable when paired with sound principles.

'There's really no obstruction today to being a good dentist,' he says. 'Digital takes the strain out of so many difficult parts of diagnosis and planning. But if we use it with the wrong mindset, we'll just make the same old mistakes – only faster.'

Stop thinking procedure-first

Ian's central concern is that dentistry risks being seduced by convenience. Digital tools are astonishingly capable, but the profession's default approach has been to use them as direct replacements for analogue steps – rather than as catalysts for rethinking workflows entirely.

'It's like when electricity replaced steam,' he says. 'At first, everyone tried to get electricity to do what steam used to do. But its real power was that it could be used differently – distributed, flexible, efficient. Digital dentistry is the same.'

He offers the example of the facebow – a familiar analogue tool that many clinicians initially tried to recreate digitally.

'I spent five years trying to make a digital facebow,' he admits. 'Then one day you realise: what is the facebow actually doing? And how do our digital tools achieve that better, faster, more precisely? That's the shift we need.'

The problem, he believes, is that dentistry has become trapped in a single tooth mindset. Procedures are refined; workflows are tightened. However, there is a fundamental question not being asked often enough, which is: what does this patient truly need and how does digital help me deliver that?

Complete dentistry

Digital dentistry's real promise, Ian argues, is not efficiency but completeness.

'Instead of looking at one tooth and thinking "how do I fix it?", we need to look at the whole human being,' he says. 'Digital makes it incredibly easy to assess, diagnose and treatment plan at a much higher level than most of us could manage with analogue tools.'

For Ian, that higher level is what he calls complete dentistry – an integrated approach that considers: teeth and restoration requirements; periodontal health; soft tissues; the masticatory system (muscles, joints and functional patterns); airway and breathing; posture – and only then the smile.

'The smile is the decorating,' he says. 'It's the bit everyone sees. But it only lasts if the foundations underneath are sound.'

Where analogue complete dentistry could be slow, technique-sensitive and riddled with inaccuracy, digital dentistry has removed those barriers entirely.

'Mounting models used to take me half a day,' Ian says. 'Now it takes two minutes. You can create a diagnostic digital model, design a trial, and plan a whole case with extraordinary precision. There really is no excuse now not to practise good dentistry.'

The shift, then, is not technological – it's philosophical. Digital makes complete dentistry easier, but only if clinicians choose to use it for that purpose.

Speed is not synonymous with progress

Digital workflows are often marketed on speed: instant scans, same-day crowns, rapid trial smiles. But Ian cautions that speed can be both seductive and dangerous.

'Pete Dawson once said digital could just get you into trouble quicker,' he recalls. 'And he wasn't wrong. If you use it with the wrong mindset, you can do the wrong thing faster – and more convincingly – than ever.'

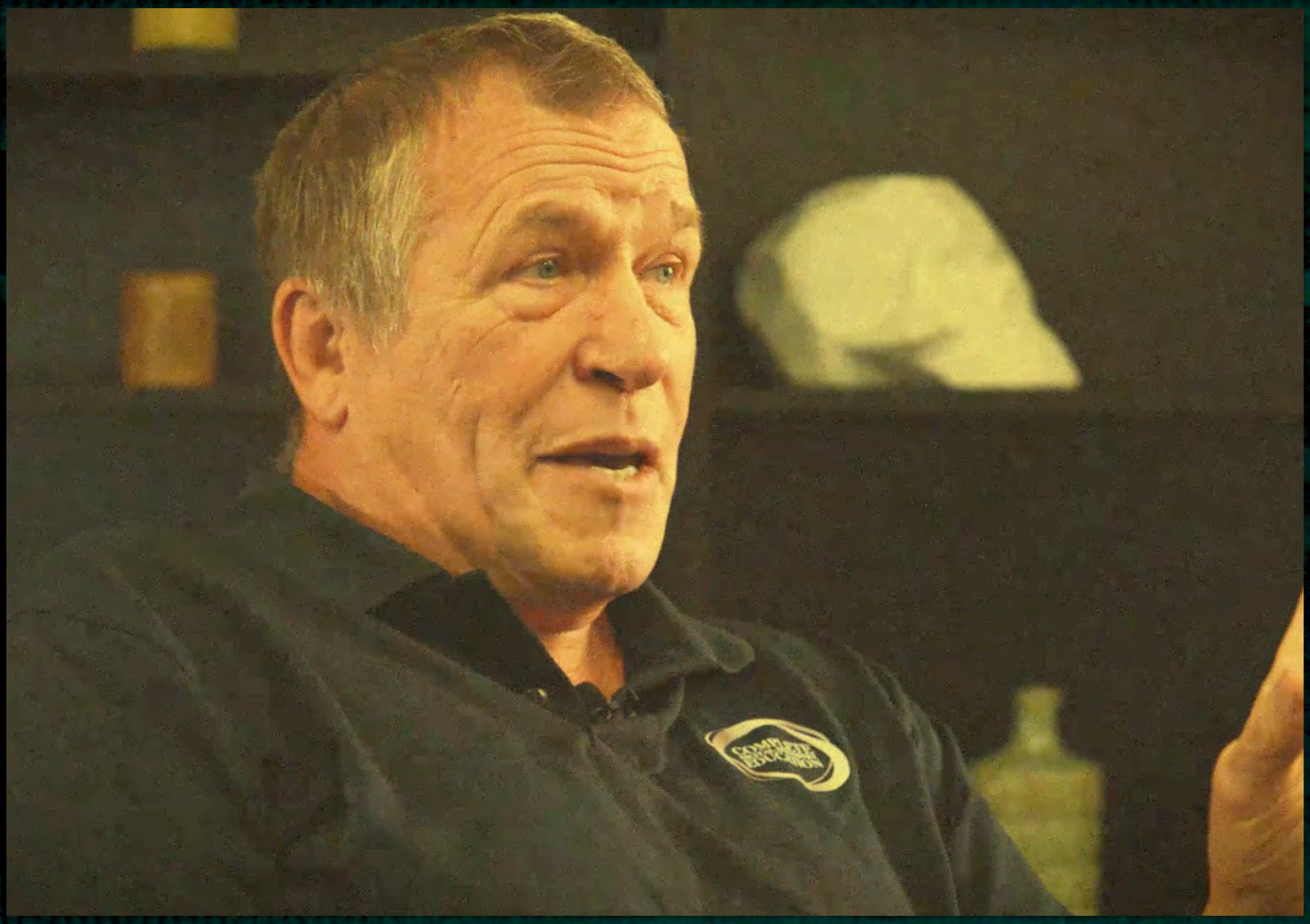
He has seen it first-hand. A beautifully designed same-day smile trial that collapses under scrutiny the moment the patient goes home. A case rushed from scan to cementation with no opportunity for patient feedback. Materials selected for convenience rather than longevity.

For Ian, the provisional phase remains the dividing line between success and failure.

'You design something, the patient takes it home, they try it out, their family sees it. You tweak the bite, tweak the aesthetics. And now digital means you can scan that provisional and reproduce it exactly. That's where digital is transformative. But it doesn't mean you skip the process.'

Similarly, printed materials – while increasingly impressive – demand discernment.

'I love printing,' he says. 'But if my pal walks in and needs a simple onlay, I'm probably milling lithium disilicate because I know its long-term strength. Convenience isn't a substitute for evidence.'



Digital takes the strain out of so many difficult parts of diagnosis and planning. But if we use it with the wrong mindset, we'll just make the same old mistakes – only faster

Do the right thing

Ian is clear-eyed about what digital should and shouldn't be used for. Its value, he argues, is in enabling ethical, thoughtful dentistry that endures.

'Most of my patients aren't looking for quick fixes,' he says. 'They want to stay well, look good and keep their teeth working for the rest of their lives. Digital makes it so much easier to diagnose properly, plan properly and deliver something that lasts.'

Longevity, trust and fulfilment matter to him. He has treated some patients for more than 25 years – and he wants to be proud of the work that sits in their mouths.

'Economical solutions still need to last,' he says. 'I'm from the back end of Liverpool – I know what "buy cheap, buy twice" means. Digital helps us give more people good, durable dentistry. But you've got to understand the foundations, not just the tools.'

It is this, he says, that keeps his own career exciting: the ability to do meaningful work at a higher level, with greater predictability, than ever before.

'The biggest thing about digital dentistry today is that it really makes it so much easier to be a good dentist,' he says. 'But only if we use it to look after people properly – not just to do the same old jobs a bit faster.'

Offering a hand up

Ian's philosophy is deeply informed by mentors across cosmetic, functional, restorative and occlusal disciplines – from Larry Rosenthal and Galip Gürel to Pascal Magne, Henry Gremion and the FACE group.

What they all had in common, he says, is an insistence on principles. On looking beyond the procedure. On understanding systems, not just steps.

'Sometimes it takes 10 or 20 years before you go "now I get it",' he says. 'If I can help someone learn that in a year or two, it eases my pain a bit.'

That, ultimately, is why he continues to teach – and why he believes digital dentistry is the most exciting moment of his career.

'Digital makes it so much easier to be a great complete dentist,' he says. 'If we take the lessons of the past and apply them with the tools of today, we can do extraordinary things – predictable things, long-lasting things. But we've got to think bigger than single teeth.' D

Ian will be exploring how diagnostics, digital workflows and complete dentistry can work together to deliver long-lasting results at the North of England Dentistry Show on 13 February at AO Arena, Manchester. Sign up for free at **www.dentistry.co.uk/noe**.

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Porcelain veneers: effortless aesthetics

Manrina Rhode shares the treatment provided for a patient who wanted a handcrafted, natural-looking smile and a plan that suited his demanding international career

Dr Manrina Rhode
Aesthetic dentist

When a patient expects cosmetic treatment to look as real and effortless as possible, the clinician has to carefully select the optimum combination of products, techniques and protocols to deliver the desired outcome. Patient compliance with any required aftercare is also of paramount importance.

The patient in this case had conducted extensive research into clinics around the world for a dental treatment plan that was just right for him. The search led him to my Instagram page, @drmanrinarhode, which prompted him to make an appointment at DRMR in London. We subsequently provided him with a bespoke set of Ivoclar IPS Emax Press veneers to enhance his natural features without overpowering them.

Initial consultation

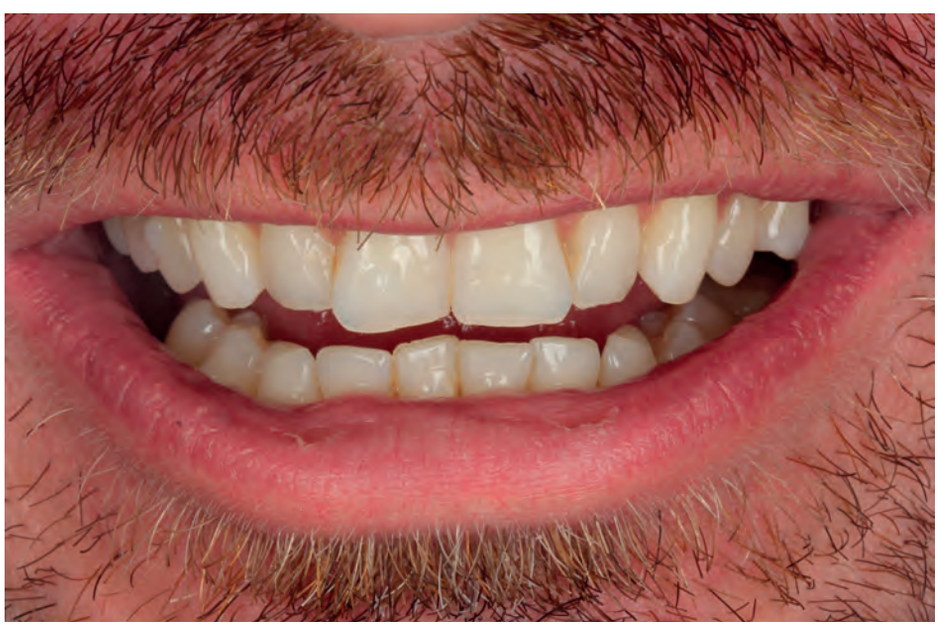
The patient, a male in his mid-30s, lives in Zurich and travels frequently with his work as an investor. He had been searching for the right clinic to provide him with natural-looking veneers having previously tried tooth whitening and straightening with clear aligners for six months. He had paused treatment as he was not certain it would achieve his goals.

He was also convinced that bonding would not give him the smile he wanted. More recently, the patient had consulted clinics in Turkey but had been told that he would require 24 crowns.

By the time the patient attended the first consultation at DRMR, he had already decided that veneers were a more suitable option for him as he particularly wanted a handcrafted smile delivered within a short timeframe, to fit with his business travel plans (Figures 1 to 3).

We explained that wax-ups would be produced from the scans and photographs taken at the consultation, and that veneer preparation could be carried out within a week, with the first review shortly after.

The fitting of permanent veneers from the UR5 to UL5 would take place two weeks later followed by a final review. Treatment would therefore be concluded within the same month. The patient was pleased to learn that the veneers would be custom made and, if looked after properly, would last for around 20 years.



Figures 1-3: **The patient wanted a natural-looking, handcrafted smile to address his aesthetic concerns**

Clinical assessment

A thorough intraoral and extraoral assessment was carried out and radiographs and photographs were taken. The patient's medical history was clear, although he is an occasional smoker. The gentleman had previously received root canal treatment on his posterior teeth.

The incisal relationship was class I with a normal overbite and overjet. Group function was recorded for the righthand and lefthand excursions. The molar relationship was class I on the left. The righthand side was not recorded due to a missing lower right molar (LR6).

Crowding was apparent in the upper centrals and lower 3-3. Incisal wear was also visible on the upper and lower 3-3. The patient's upper and lower midline was 2mm to the lefthand side. His masseter and temporalis muscles were hypertrophic and lip seal was competent.

Tooth shade was recorded as B1.

Oral hygiene

The patient's treatment plan included a visit to our hygienist. He brushes his teeth twice a day but his interdental cleaning was irregular. His diet was high in acidic foods although low in sugar. Our findings revealed generalised gingivitis with a good prognosis if the patient adhered to an optimised oral hygiene regime.

We discussed the need for maintenance to treat the gingivitis and prevent further, more serious conditions and demonstrated good brushing technique for cleaning ▶

the gingival margins. The importance of interdental and interproximal cleaning was emphasised, including the use of a wide-fitting toothbrush for optimum plaque control.

Case planning

The patient felt his mouth was too narrow and he wanted to achieve better facial symmetry with a larger, whiter smile. His canines were rather pointed but he was happy with their appearance.

Ivoclar IPS Emax Press veneers were chosen for the case for their ability to mimic nature. I recommended the use of a nightguard to protect the temporary and final veneers, particularly as the patient's previous night-time bruxism habit had already worn his teeth.

I explained the benefits of adding 1mm to the edge of the upper anterior teeth to reveal 2mm when his lips were at rest. It was agreed we would wait to finalise the build-up until the review after preparation and fitting of the temporary veneers, to make adjustments after any lip swelling had subsided. We also discussed broadening the patient's smile with characterisation or by introducing some slight imperfections on the veneers to make them look as natural as possible.

Composite bonding to the lower 3-3 was also recommended to help minimise the risk of further wear or damage due to grinding. Had there been damage to his temporaries, it would not have been advisable to fit the permanent veneers.

Abfractions were charted and recession was shown to the patient on the intraoral scan. He was advised composite fillings would be needed to treat the abfractions. The problem was likely to be caused by an incorrect brushing technique at the margins.

Bone loss was also present at the site of the missing LR6. We discussed the options of a denture, bridge or implant and suggested that an implant to fill the gap might provide the optimum functional and aesthetic value in the longer term.

The patient was also advised that some of his deeper fillings would need removing during the preparation phase and be replaced with porcelain veneer onlays to reduce the risk of flare-up.

Preparation and temporary veneers

To prepare for placement of the set of 10 veneers in the upper jaw, an intraoral scan was taken and sent to the laboratory, Precision Dental Studio, for fabrication of the wax-up, which would be delivered within three days (Figure 4). The temporary stent would also be made within the same timeframe (Figure 5). A full series of photographs was also sent to the laboratory with instructions for restoration of canine guidance.

At the preparation appointment, both UR5 and UR4 fillings were removed to prepare them for replacement with a veneer onlay on the UR5 and veneer inlay on the UR4. Buttons remaining on the LR3, UR4 and ▶

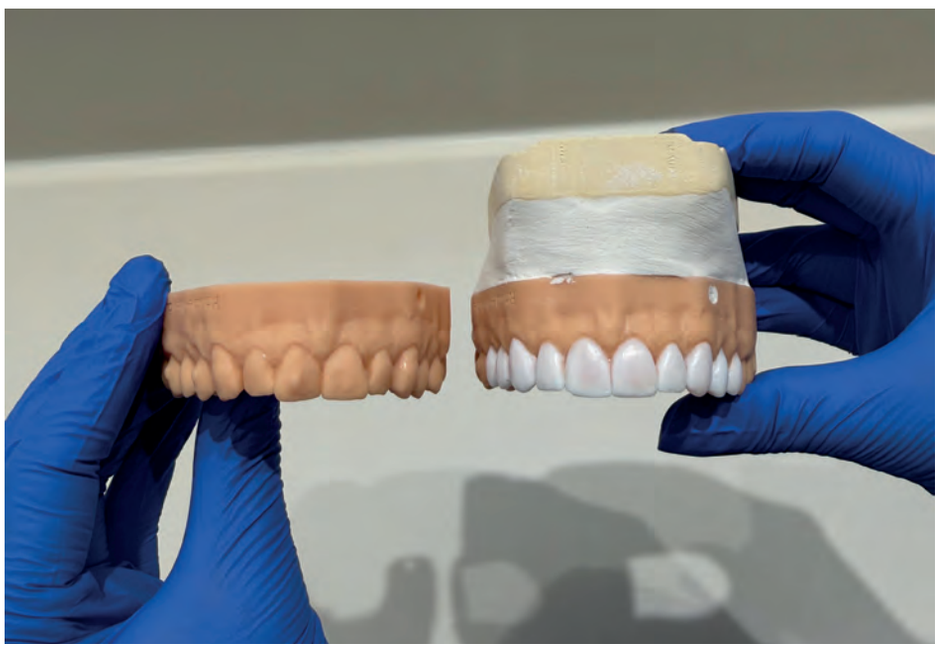


Figure 4: An intraoral scan was taken and sent to the laboratory for fabrication of the wax-up

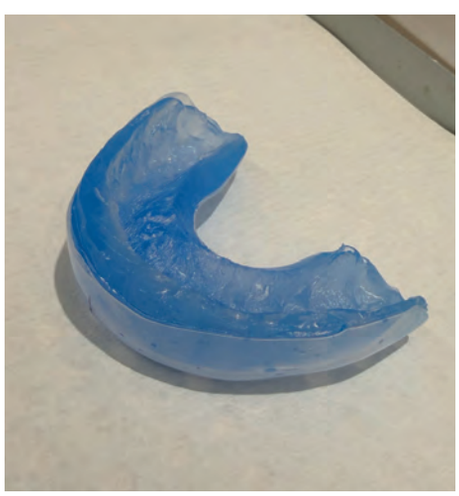


Figure 5: The temporary stent needed to be made within a short timeframe

Figure 6: The patient's teeth were isolated and prepared using the putty stent as a guide

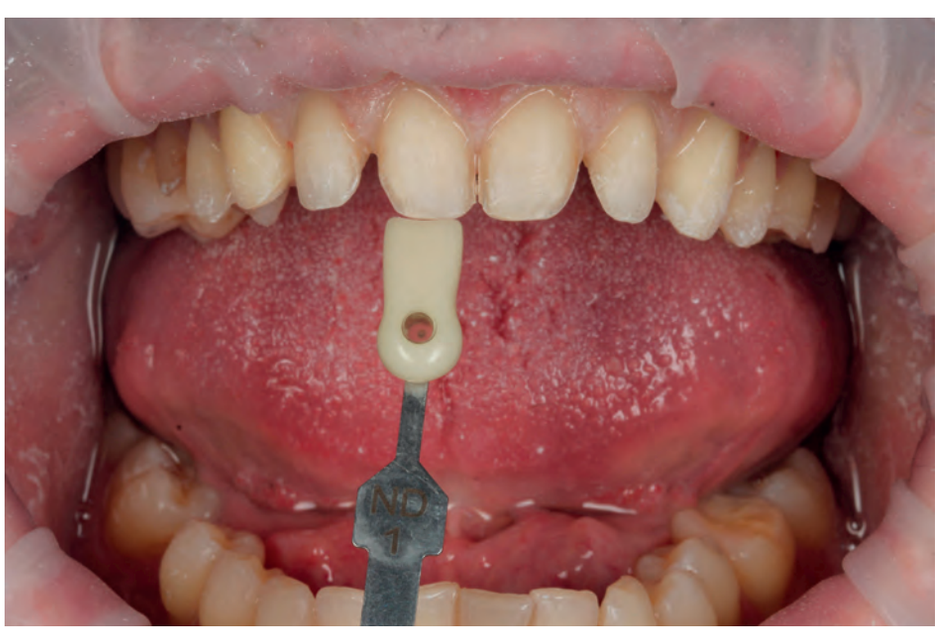


Figure 7: A stump shade guide was used to determine the correct shade for the veneers

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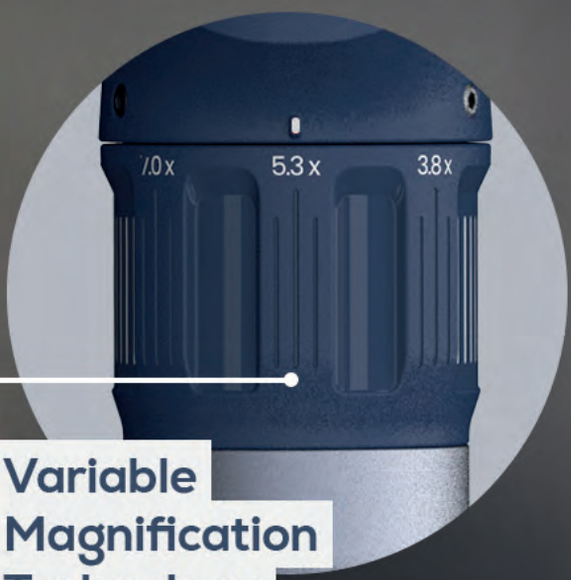

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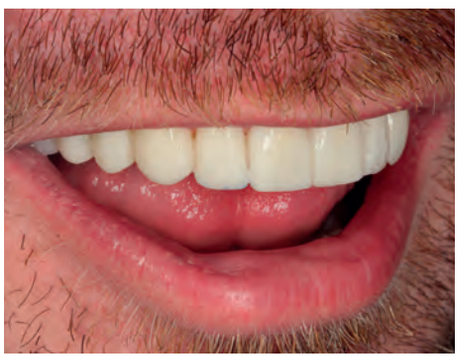
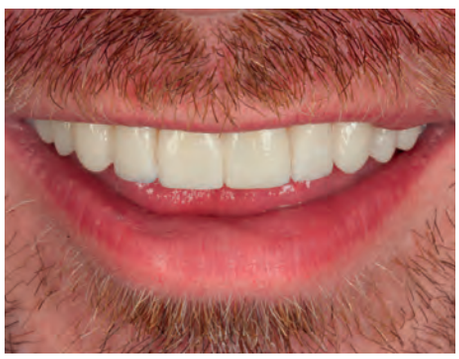
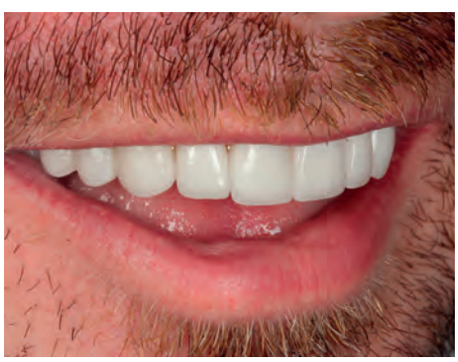
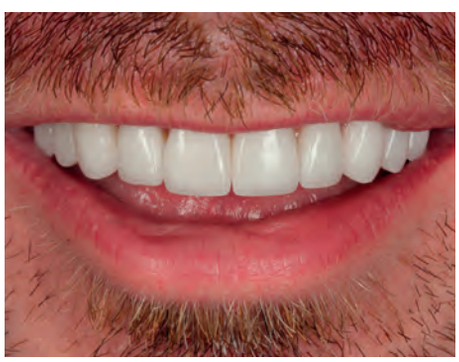
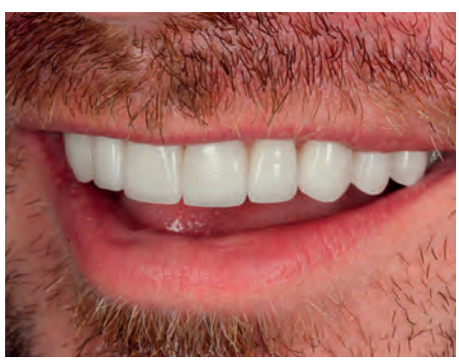




Figures 8-10: Temporary veneers were placed, excess material was cleared and occlusion checked and refined in all excursions

Figures 11-13: The final veneers enhance the patient's natural features without overpowering them

UR6 from the previous orthodontic treatment were removed. The patient's dentition was checked with a blue light to confirm the absence of residual composite. His teeth were isolated and prepared using the putty stent as a guide (Figure 6) and burs for a minimally invasive approach.

A stump shade guide was used to determine the correct shade for the restorations (Figure 7). Impressions were taken with Ivoclar Virtual Putty with Light Body. I have found this vinyl polysiloxane material provides exceptional accuracy. The bite registration was then completed for precise fabrication of the permanent veneers.

The teeth were spot etched, bonded and cured. Temporary veneers were created using the stent filled with the bis-acrylic composite material, Luxatemp, in B1 shade, and placed into the patient's mouth over the prepared teeth. Excess material was cleared and the matrix was removed with the 10 veneers bonded to the prepared teeth. Occlusion was checked and refined in all excursions (Figures 8 to 10).

Care instructions were provided to the patient and he was shown how to clean his temporary veneers with a pink Tepe interdental brush.

At the review appointment, photographs were taken and the patient's hygiene and cleaning routine was checked. The final veneer shade, a mix of BL2 and BL3, was confirmed in natural light.

Anterior teeth shapes were adjusted. The UR1 was shortened to match the UL1, and the length was increased on the lateral incisors and mesial aspect of UL3. Scans and further photographs were taken of the alterations and were relayed to the laboratory.

Fitting of permanent veneers

The patient returned two weeks later for fitting of the custom-made, porcelain veneers. Local anaesthetic was administered and the temporaries were removed. The definitive veneers were tried in. The patient and I were delighted with the natural-looking aesthetics and perfect colour selection.

An Ivoclar Optragate latex-free lip and cheek retractor was used to retract the lips evenly and gently, and gauze was placed on the tongue. The teeth were etched using 37% phosphoric acid and Ivoclar Monobond Etch & Prime ceramic primer was applied to the inner surface of the veneers using a microbrush for 20 seconds and then left for 40 seconds before being washed. Bond was applied to the prepared teeth.

Ivoclar Variolink Esthetic neutral shade was used for the adhesive cementation of the veneers. The material's consistency makes it easy to use and produces predictable results with a highly reliable bond. Each veneer was placed, spot-cured, cleaned and flossed. The veneers were then light-cured for 40 seconds with a layer of glycerine over the margins, and polished.

Scans were taken and occlusion checked in all excursions. The patient was given postoperative care instructions and a review date was set.

Follow-up appointment

At the review, we determined that the tips of the upper central incisors needed to be slightly more level and the shape of UR1 could be a little more rounded. Accordingly, adjustments were made with a black finishing and polishing disc. The bite was checked and the patient confirmed it was comfortable. Excursions and canine guidance were also checked, and the patient was reminded about the risk of damaging the lateral veneers by grinding if he did not wear his nightguard. In-surgery photographs and studio shots were taken.

The patient was given a tray for home whitening treatment for the lower teeth. Production of the final nightguard was also brought forward so the patient could leave the clinic with it before he embarked once more on his travels.

Case reflection

This patient had previously tried using clear removable aligners and tooth whitening to address his aesthetic concerns but felt it was not the right approach for him and therefore stopped the treatment. What he really desired was a handcrafted smile that looked effortlessly natural.

With a bespoke set of 10 upper veneers, expertly crafted by our master ceramicist, the patient's mouth has been transformed by his new smile, which has enhanced his existing natural features without overpowering them (Figures 11 to 13).

I have been providing my patients with Emax veneers for more than 20 years and I am always confident of a predictable, durable and natural-looking result. Patient compliance with rigorous oral hygiene, good brushing and interdental cleaning technique, and the use of the nightguard, will also be required to enhance the resilience of these veneers and their enduring aesthetics. D

To learn more about Manrina's smile makeover veneer course, email **academy@drmr.co.uk** or visit **www.designingsmiles.co.uk**.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Wisdom tooth nerve injuries: considerations

Raj Kumar discusses wisdom tooth surgery trigeminal nerve complications

Raj Kumar
Examiner, Royal College of Surgeons Edinburgh

Wisdom teeth – also known as terminal molars, third molars or eights – usually erupt between the ages of 17 and 24 years. According to the World Health Organization, in about 25% of worldwide cases, the teeth become impacted against the second molars or the sevens.

Impacted mandibular third molars (M3M) tend to suffer future problems such as decay, soft tissue infection and inflammation and commonly cause secondary decay against the sevens.

The instance of decay on the sevens can range from 24 to 80%, depending on the age of the patient. This decay can lead to gross destruction of the sevens, the need for root canal treatment or even the removal of the tooth.

Wisdom tooth impaction occurs as the wisdom tooth is developing (and the roots are growing) but the angulation prevents a full eruption. Impaction generally means that the wisdom tooth is stuck either horizontally, vertically or at an angle against the seven or the body of the mandible behind the wisdom tooth.

Prophylactic removal

Prophylactic removal of the eights is uncommon but can occur in patients that are planned to undergo:

- Bisphosphonates, antiangiogenics, chemotherapy
- Radiotherapy of the head and neck
- Immunosuppressive therapy
- Reduction of mandibular fractures
- Orthognathic surgery around the angle of the mandible
- Resection of benign and malignant lesions
- Military personnel about to be deployed (Pepper et al, 2016).

Primary dental treatment

On initial presentation, with soft tissue inflammation, the patient may complain of pain, swelling, reduced opening, halitosis and/or food impaction.

The general term for wisdom tooth soft tissue infection/inflammation is pericoronitis. To treat pericoronitis, clean the periodontal soft tissue area around the eight and advise a saltwater rinse or prescribe antibiotics.

Third molar surgery

Due to the impaction, the wisdom tooth generally flares up on a regular basis – at least

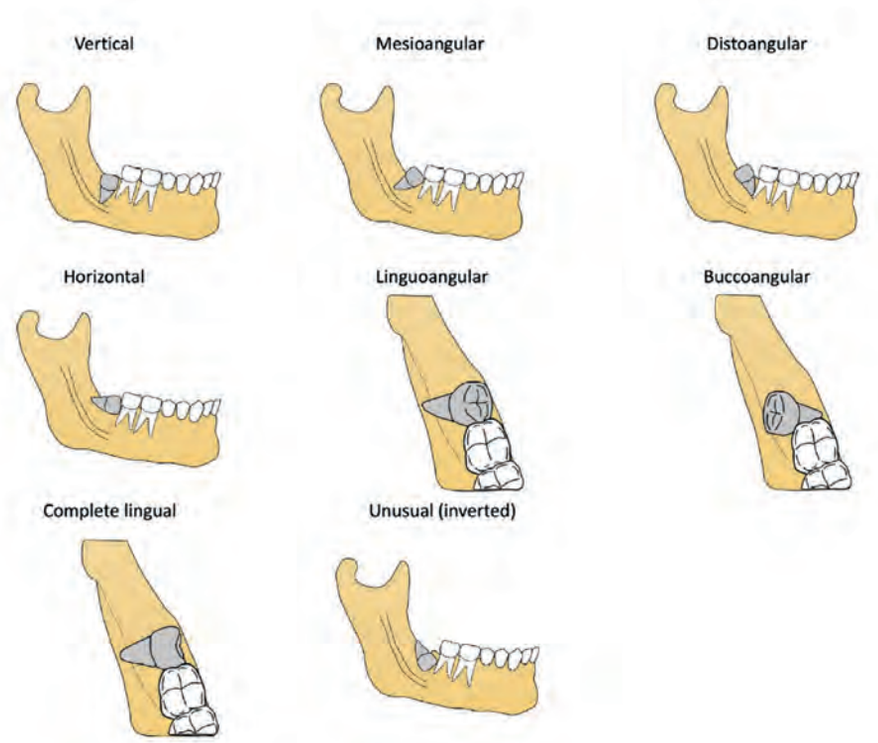

Figure 1: Winter's classification of impaction (Iwanaga et al, 2021)

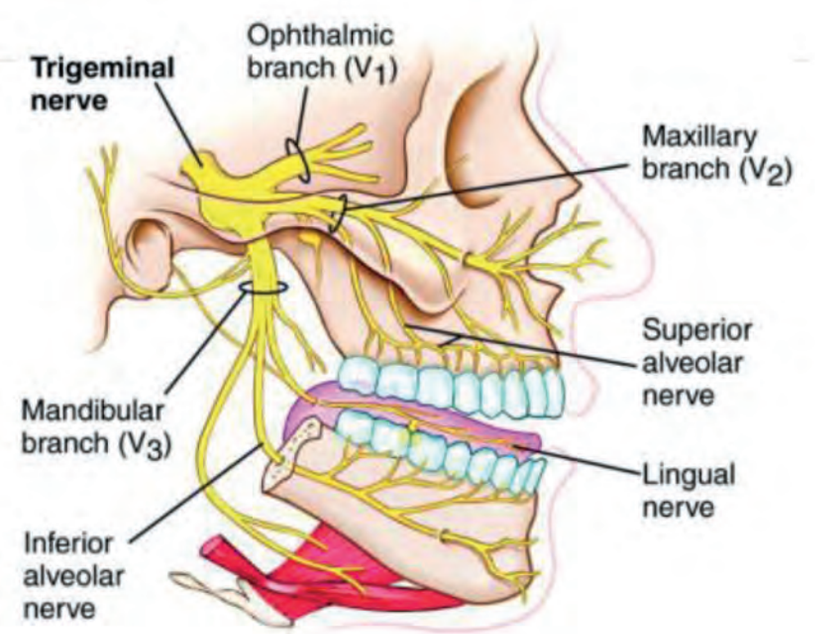

Figure 2: Mandibular nerve anatomy

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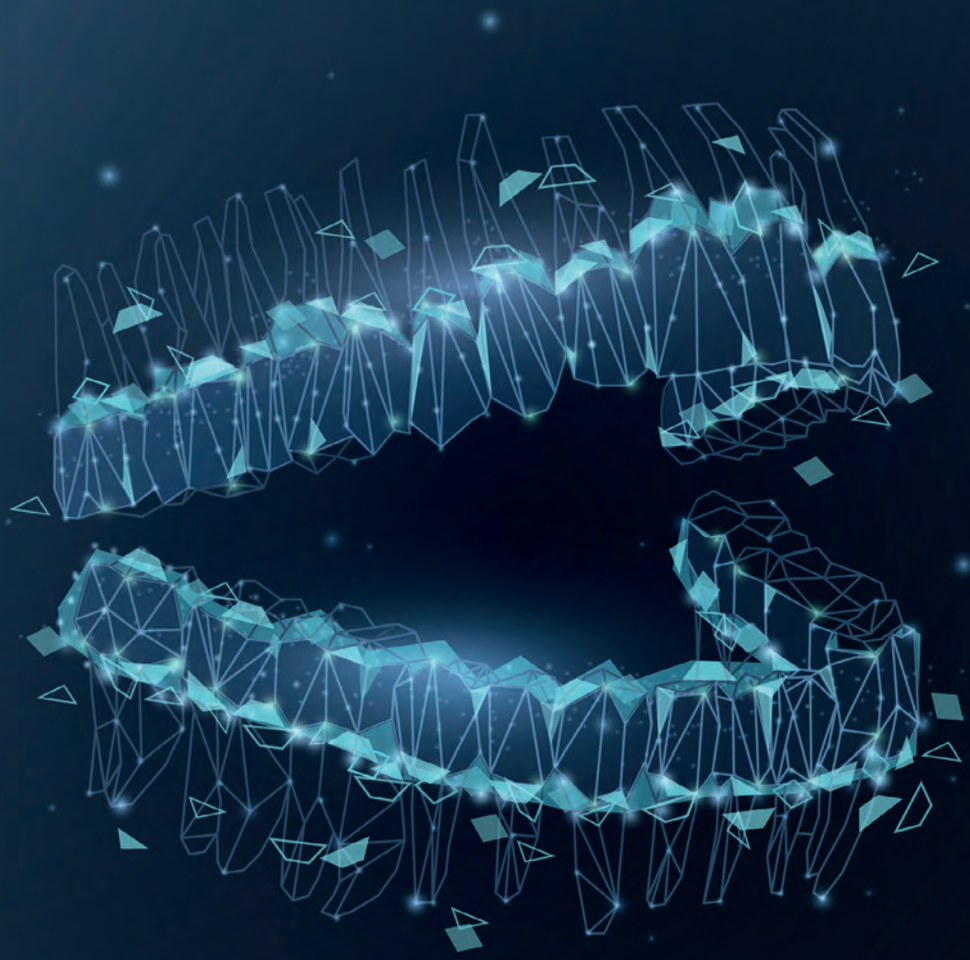

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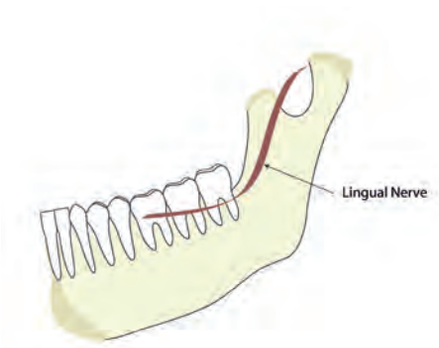

Figure 3: Lingual nerve

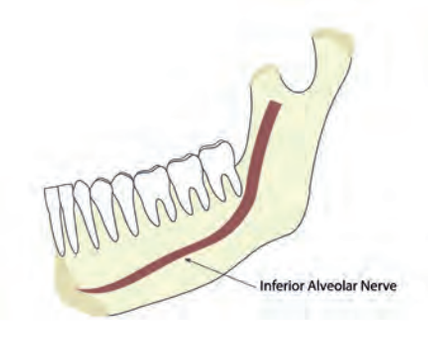

Figure 4: Inferior alveolar nerve

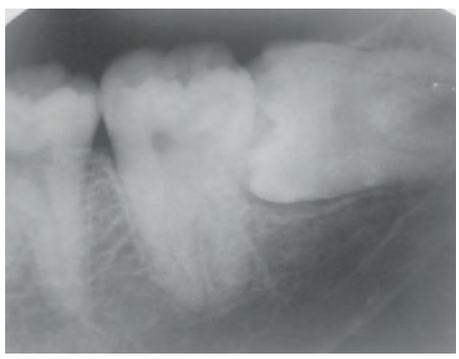

Figure 5a: In most cases, the IAN canal is visible on radiographs

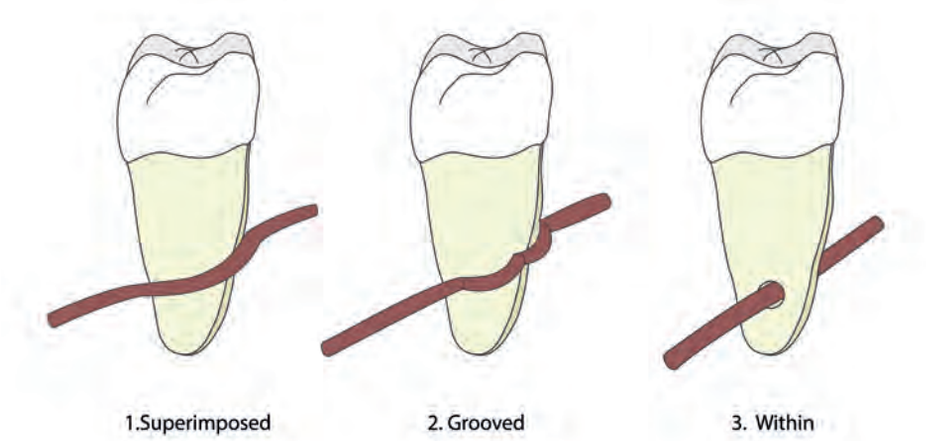

Figure 5b: The inferior alveolar nerve and terminal mandibular molar

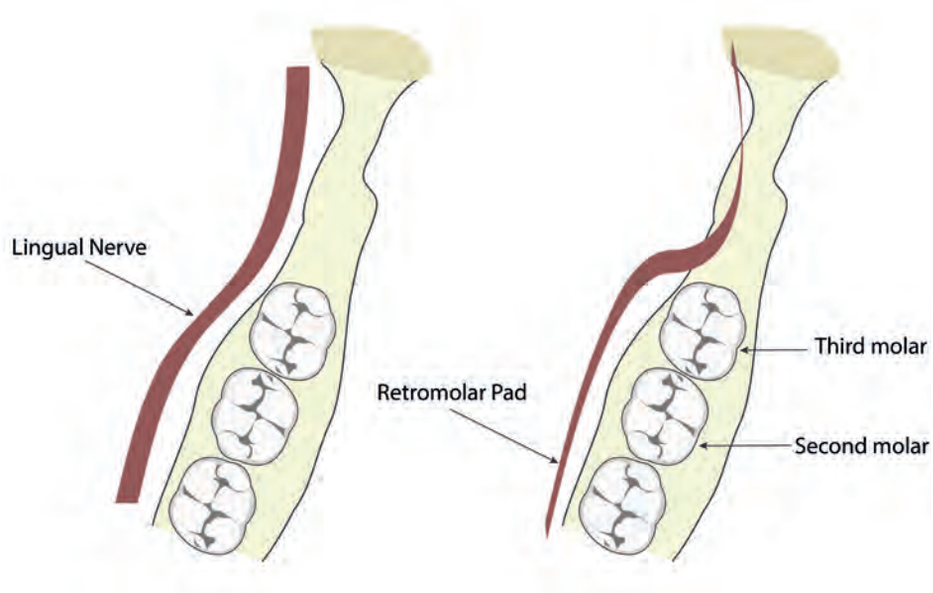

Figure 6: The lingual nerve and M3M

once or twice a year – and eventually the soft tissue infection is so severe that the patient requests the removal of the impacted tooth.

Ventä, Turtola and Ylipaavalniemi (1999) reported follow-up data on Finnish students confirming that, by the age of 38 years, most impacted mandibular molars required removal.

However, there is increasing evidence that mandibular eights should be removed before permanent symptoms or additional damage to the sevens occurs (Huang et al, 2014).

Third molar surgery is one of the most common surgical procedures performed in secondary care in the NHS (McArdle and Renton, 2012).

M3M surgery is usually carried out in a surgical setting, such as a dental practice or an oral surgery hospital setting, and typically performed by a dentist with experience in oral surgery tooth extractions or an oral surgeon.

M3M general post-surgery risks

During the surgical removal of the eight, a surgical flap is usually raised, cortical bone is removed and the tooth is then elevated completely. The flap is then closed and sutured and the patient is usually given analgesics and, on occasion, antibiotics.

Those at risk of postoperative infection include:

- Smokers
- Patients with poor oral hygiene
- Diabetics
- Patients on immunosuppressants
- Patients on bisphosphonate drugs.

There is little evidence that patients who are prescribed antibiotics after surgery have a reduced risk of complications. The more serious risk is damage to the mandibular nerve branches during surgery.

Nerve damage could result in:

- Paraesthesia (the sensation of tingling, burning, pricking or prickling, skin-crawling, itching, 'pins and needles' or numbness on or just underneath the skin)
- Anaesthesia
- Dysesthesia (unusual touch-based symptoms)
- Hyperesthesia
- Ageusia (loss of taste)
- Dysgeusia (altered taste).

Nerve injury may be temporary and/or subside after six months. If longer, the injury is considered permanent (Iwanaga ▶

et al, 2021). Patients should be warned of these risks, if they apply.

Mandibular nerve anatomy

The trigeminal nerve constitutes the largest sensory cortex representation in the brain compared with other sensory nerves, this is because the trigeminal nerve provides sensory innovation to sight, smell, taste, hearing and speech (Figure 2).

Damage to the branches of the trigeminal nerve during molar surgery can cause significant psychological morbidity (Caissie et al, 2005).

The trigeminal nerve branches into the ophthalmic, maxillary and mandibular nerves.

The mandibular nerve is the only branch that contains motor fibres and innervates:

Anterior division

- Motor innervation – muscles of mastication
- Sensory innervation – buccal nerve (buccal mucosa).

Posterior division

- Auriculotemporal – sensory nerve to skin and area around the TMJ and ear.

The lingual nerve runs in the mucosa below and behind the M3M and the tongue side mucosa (Figure 3):

- Supplying the anterior two-thirds of the tongue
- Floor of the mouth
- Lingual mucosa and gingivae
- Submandibular and sublingual glands
- Carries the chorda tympani nerve carrying taste sensation to the anterior two-thirds of the tongue.

The inferior alveolar nerve enters the mandible body at the ramus and sits within the inferior alveolar canal along with the inferior alveolar artery (Figure 4).

- Motor: mylohyoid and anterior belly of the digastric muscle
- Sensory:
  - Sensation to all the teeth
  - Sensation to the skin and mucosa of the lower lip.

The IAC and M3M

The radiographic presentation on a panoramic X-ray can show the inferior alveolar nerve (IAN) canal superimposing the roots and, in most cases, the canal is visible on radiographs (Figures 5a and 5b).

The inferior alveolar canal (IAC) can sit away from the M3M, in close vicinity or within the roots of the tooth (Iwanaga et al, 2021).

The lingual nerve and M3M

The lingual nerve can enter the oral cavity behind the M3M over the bone crest (Tojyo et al, 2019) but commonly it is further forward and below the alveolar crest.

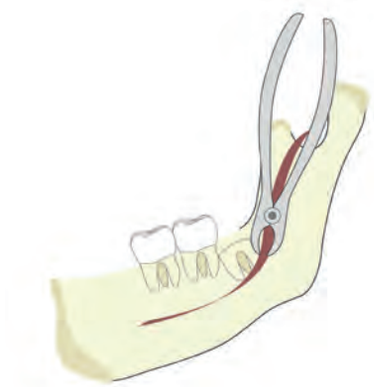

Figure 7: Wisdom tooth extraction and lingual nerve damage

The lingual nerve sits in the lingual mucosa but cannot be seen radiographically as it is not housed within a canal.

M3M extractions and radiographs

When a surgical procedure is planned for the removal of a M3M, the common radiograph taken is a panoramic or OPG. This is a two-dimensional image with some distortion.

It is recommended that, when the root apices are in a close relationship with the IAN, a CT scan is taken to ascertain the relationship.

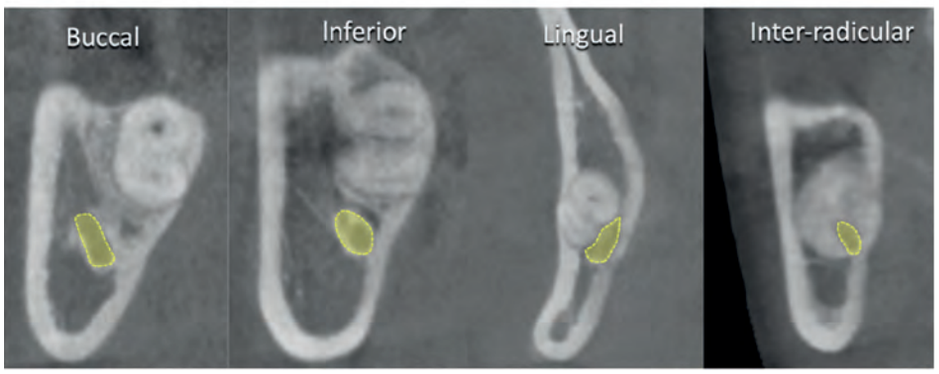

Figure 8: CT scan images of root/IAC relationships

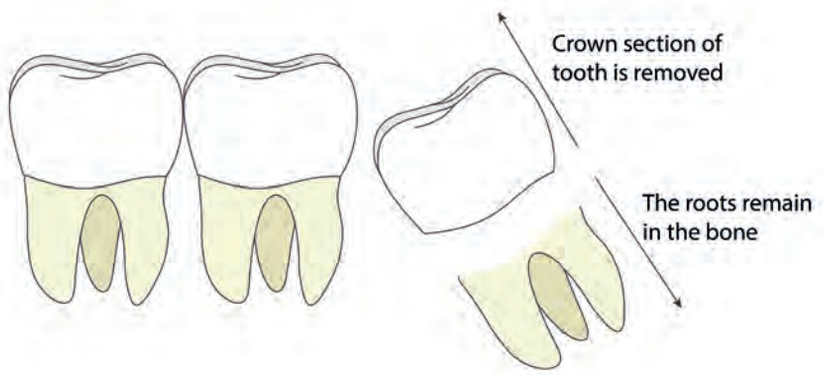

Figure 9: Coronectomy

M3M extractions and lingual nerve damage

During a surgical procedure for removal of the M3M, the surgeon will normally raise a soft tissue flap buccally and lingually to the M3M. This is to gain exposure and a better perspective of the impacted molar.

However, on raising a lingual flap, the surgeon may either make an incision to release the flap (thereby being at risk of severing the lingual nerve) or may use a lingual flap retractor (however, the pressure of the retractor may also cause compression or damage to the lingual nerve).

Where the M3M is impacted distally, the surgeon may create a larger flap and remove cortical bone behind the tooth. This runs the risk of damage to the lingual nerve in cases of an abnormal nerve pathway (Tojyo et al, 2019).

The incidence of lingual nerve injury is up to 2% of M3M extractions (Tojyo et al, 2019).

M3M extractions and IAN damage

There is a heightened risk of neurosensory damage when the canal shows radiographic narrowing, direct contact with the roots, a lingual course with or without cortical plate perforation and an intraroot course of the canal.

The IAN can become damaged, severed or compressed while the roots are elevated. The reported incidence rate of injury ranges from 0.35 to 19% when the roots are close to the IAN (Iwanaga et al, 2021).

Minimising nerve damage risks

If an impacted M3M needs removal, then a surgeon has two options:

- Remove the whole tooth and the risk nerve damage
- Remove the crown and leave the roots in situ, coronectomy.

To reduce the risks of nerve damage, avoid:

- Raising a lingual flap
- Removing bone distally to the M3M
- Applying pressure on the IAN during elevation
- Applying a pulling force on the IAN during elevation
- Trying to remove the roots.

Coronectomy

Coronectomy or partial odontectomy involves:

- Buccal mucoperiosteal flap
- Buccal bone removal
- Crown sectioned horizontally or vertically at the root level
- Partial horizontal sectioning and levering the crown off (lower risk of lingual plate damage)
- Crown elevate buccally.

The advantages include:

- Minimal risk to the nerves
- Smaller surgical field
- Less trauma to the mandible
- Faster surgical procedure (30 minutes)
- Faster healing
- Resolution of pericoronitis
- Less bone resorption distal to the seven.

However, disadvantages include:

- If roots are loosened, they may migrate upwards
- If the roots are loosened then they may need to be removed at the same time, risking damage to the IAN
- If the nerve pulp is left behind and become necrotic, it may become infected
- A second surgical procedure may be required at a later date.

Legal issues

Winterbotham v Sharak

This case was heard between 16-19 July 2024 and involved lingual nerve damage to Mrs Winterbotham during the elevation of a distoangular impacted LR8 by Mr Sharak, a specialist oral surgeon.

It was argued that the risks of LN injury were not explained to the claimant. The claimant was not offered a coronectomy procedure. Mr Sharak did not undertake coronectomies.

The defendant argued that even if the risks had been explained the claimant would still have gone ahead with the procedure.

The claimant was a speech and language therapist and claimed that her employment had been taken from her because of the injury.

Presiding over the case, Neil Moody KC started his introduction with a summary of the basic anatomy around M3Ms. He correctly identified the LN and the IAN as being at risk of damage.

He included the defendant's risk sheet, warning of damage to the surrounding nerves, but Mrs Winterbotham denied ever seeing the sheet. Mrs Winterbotham thought that the risk to the LN did not apply to her as the defendant had not pointed it out to her.

The defendant was criticised for his lack of record keeping and failure to gain informed consent.

It was put forward by the KC that a coronectomy would have:

- Reduced risk to both nerves
- Removed the source of the pericoronitis.

The claimant had altered speech and sensation and won substantial damages.

Summary

In my experience, when a M3M is within 2mm of the IAN canal, I always suggest a coronectomy, as it rarely involves taking a CT scan and healing is much quicker.

I still raise a buccal flap but once I have access, cutting the crown in a horizontal fashion is quite easy to do, but I stop before full sectioning. I then use a luxator to lever off the crown.

Even a distoangular molar can be elevated buccally without the need for distal bone removal.

More surgeons should offer a coronectomy approach when there is a risk to the lingual nerve and/or the IAN.

Patients should be made aware that coronectomy is not without complications, but the risk to the nerves is minimal when performed by experienced hands. D

For references, email newsdesk@fmc.co.uk.

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Making the right move

After leaving her life as a dental hygienist in New Zealand, Lauren Ward set her sights on improving the oral health of the UK

Lauren Ward
Education manager, Philips

When I left New Zealand, I had mixed feelings. Travelling to the UK has certainly been a longstanding rite of cultural passage between the two countries and I was delighted to hear that so many people back home had loved the whole experience.

For me, the hard part was not the unknown, the difficulty was leaving my patients behind knowing that my absence could compromise everything I had worked for with them.

In the early 2020s, the New Zealand Dental Association reported a sharp increase in dental costs, leading to approximately half of the population forgoing essential dental care (Gage et al, 2025).

In Taranaki, where I practised as a hygienist, we didn't have a periodontist, and the closest one meant a three-hour drive. A lot of patients didn't have the money or time to visit them, so uptake of referrals was limited, which put a lot of pressure on me.

This led me to study at RW Perio School for a postgraduate diploma in periodontics for dental hygienists.

I am proud to say that my time there made a difference: initially, the eight-chair clinic did not have a hygienist, but once I set this up, appointments kept coming in and I was always fully booked week after week.

Sadly, the fact that we didn't have any further study opportunities available for hygienists in New Zealand was frustrating for me and became the catalyst for my move.

Oral health challenges remain the same wherever you are in the world

Making a difference

Eight months prior my trip, I had handed in my resignation and already started the search to find my replacement to ensure there was some continuity of care for my patients. I was fully booked with months of appointments, and I absolutely wanted to keep the momentum going. After despairing at the lack of applicants, I decided to approach dental universities to offer months of training and mentoring. That didn't work either and it was heartbreaking. My position has tragically remained vacant ever since.

Moving to the UK has, however, been extraordinary and I have no regrets. My ambition is to study and increase my learning skills for when I go back to New Zealand to provide additional services (like advanced periodontal treatment) to my patients to tackle a lack of provision and dental deserts. No contribution is a small contribution – and, collectively, we can and do make a difference.

A change of outlook

When I was in New Zealand, I had convinced myself that working in a clinical setting was the right and only way to further myself and help patients. I was so mistaken.

Since I have been working as the interim professional relations and education manager for UK and Ireland here in the UK for Philips, my outlook has completely changed. The role is allowing me to regularly meet so many inspiring and knowledgeable dental professionals who share clinical insights about their patients. These learnings have been considerable in developing my thinking in ways I could have only ever dreamt about.

Interestingly, oral health challenges remain the same wherever you are in the world. However, I'd say I hear more stories here about people being time poor. UK is a linear-active monochronic culture, so time is viewed as a limited resource and people always feel in a rush. As a result, oral health often ends up at the bottom of the priority list, as we know.

I still feel encouraged and positive though. Recent surveys show that individuals will increasingly make time for what they really value: a 2024/25 UK fitness report from Puregym found that 76% of people aspire to be healthy, with 48% of people currently exercising in the UK (up 3% from last year).

A 2025 Innova Market Insights report on Health and Wellness Trends in the UK highlights that 64% of British consumers are taking action to live healthily. On a more 'everyday' level, people show how they want to look and feel good, with make-up routines in the UK estimated between 15 and 30 minutes on a regular day.

So how come oral health is still not at the top of people's priorities? As I see it, we can observe two kinds of compliance.

We have patients who hear that their oral hygiene needs to be improved and will subsequently show some level of compliance to align with our values and expectations. Their motivation, however, remains extrinsic and mainly driven by the dental professional. In other words, without us, the chance of this new oral health regime lapsing is high.

Other patients will become more intrinsically driven and highly engaged, and that is where motivation takes a different path. If it comes from them, compliance has more chance to endure.

For this, patients need to really understand what is going on in their mouths. I had a patient who was convinced he had perfect teeth because he had no fillings and was adhering to a strict oral health routine. Unfortunately, I found periodontal probing depth up to 7mm. Another patient was rigorously looking after his teeth but would stay clear of the gums due to the immediate bleeding that occurred when he brushed them.

Both of these patients' poor health conditions were a result of lack of education regarding their gingival health and reinforces why the role of educators is so important.

Shaping behaviour change

As a Philips education manager, my ambition is to help shape oral health behaviours and gain patient compliance through motivational strategies. When I was in New Zealand, I found it upsetting to see adult patients coming for their first visit seeing a hygienist and finding periodontal disease. However, I recognised it was part of our culture; once access to free dental appointments stop at the age of 18, a large portion of the population just won't visit the dental practice until they have an emergency. Therefore, we can't diagnose dental diseases at their early stages where treatment is less invasive and cheaper for the patient.

People should be made aware of technologies that can help with their oral health regimes, and this is another reason I love working for Philips. We offer a demo in-mouth trial unit, which allows patients to try a Sonicare brush when they are ready to consider an upgrade from a manual approach or are looking for new tools to improve their oral hygiene.

As dental professionals, we can teach patients how to use correct tools and increase their chance of becoming compliant when it comes to daily oral hygiene routines.

I am confident about the future. My patients in New Zealand trusted me and I believe I made a positive impact on their health, largely through education. They did not just align with my expectations; they shared them and became as motivated as me to improve their oral health. That is the beauty of this sector and the rewards are huge. D

For references, email newsdesk@fmc.co.uk.

Clarity, systems and connection in dentistry

Andrea Ubhi shares eight key lessons learned from her recent study day in York

Andrea Ubhi
Director, Andrea Ubhi Dentistry

When clinicians gather under one roof, something happens that can't be replicated online. The questions, the laughter, the shared honesty – they become the real learning.

The Andrea Ubhi Study Day, held in York, brought together clinicians, therapists, hygienists and managers for a day of practical teaching and reflection.

From implant rescue to managing burnout, one theme ran through every session: modern private dentistry demands both precision and humanity.

Here are eight lessons that delegates took back to their practices.

1. Nine revolutions

Opening the day, Chris Barrow mapped out the 'nine revolutions' transforming dentistry – a fast-moving landscape shaped by AI, 3D printing and intraoral scanning. These advances are now routine tools, streamlining workflows and improving consistency.

But amid the excitement, Chris reminded delegates that one revolution can't be led by machines: human connection.

'AI can design your aligners and 3D-print your restorations,' he said, 'but it can't read a patient's face, ease their fear, or make them feel seen.'

Lesson: embrace technology for efficiency and precision, but remember the most valuable part of dentistry is still the human one.

2. Creating space for restoring wear

Tim Steel's lecture tackled one of restorative dentistry's persistent challenges: how to create space in worn dentitions while preserving the tooth tissue.

Through clear case examples, he demonstrated how diagnostic wax-ups, provisionalisation and digital planning can restore form and function conservatively.

This approach utilises extrusion/intrusion, distalisation, or rehabilitating in centric relation, amongst other methods, to avoid cutting down teeth.

His advice was simple but powerful: 'There's an art to restraint. Sometimes the best dentistry you do is the millimetre you choose not to take.'

Lesson: when managing tooth wear cases, focus on phased planning, accurate records, and minimal intervention. Predictability is key.

3. Managing periodontics

Faye Donald refocused the room on the fundamentals with a discussion on managing periodontics in practice and biofilm management in periodontal and implant maintenance.

Her message was practical and uncompromising: long-term restorative and implant success depends on consistent hygiene systems. She emphasised measurable maintenance schedules, written home-care plans, and clinician-therapist collaboration.

'Hygiene maintenance isn't the aftercare,' she said. 'It's the real care.'

Lesson: build structured maintenance protocols. Prevention isn't an optional extra, it's the foundation of every successful treatment plan.

4. Complexity requires clarity

Elena Bonciu presented complex root canal treatments with 3D imaging and printed tooth models that brought anatomy to life. Delegates saw how visualising canal morphology before starting treatment saves time and improves outcomes.

Her focus was on deliberate planning and case selection. 'Every tooth has its own personality and story,' she said. 'Our job is to uncover it.'

Lesson: use 3D imaging and planning tools to improve accuracy – but don't skip the basics: access, irrigation and patience remain the keys to success.

5. Precision in motion

Adam Glassford's video presentation took delegates through every stage of a real implant placement – from diagnostics to immediate loading and final restoration.

Seeing the full case unfold highlighted how meticulous sequencing, clear communication and multidisciplinary collaboration lead to predictable results. 'Implant dentistry isn't about speed,' Adam said. 'It's about consistency – repeated with care, every time.'

Lesson: follow structured protocols from planning to delivery. Predictability is built through process, not shortcuts.

6. Fixed orthodontics versus clear aligners

Tarun Mittal tackled the hot topic of fixed braces versus clear aligners. His message: both systems have their place – the skill lies in case selection.

For complex rotations, root torque or vertical discrepancies, fixed appliances remain the gold standard. Aligners work brilliantly for simpler movements and motivated patients.

According to Tarun: 'True expertise isn't loyalty to a system. It's loyalty to the patient's best outcome.'

Lesson: use clear clinical criteria for appliance choice. Let evidence and biomechanics – not marketing – guide your recommendation.

7. The practice manager's side room

In the Chairman's Suite, practice managers and non-clinical leaders met for practical discussions on how to sustain calm, focus and effective communication.

Two topics dominated: managing overwhelm and understanding patient personalities.

Managers shared common pressures – compliance, HR, marketing and constant firefighting – and discussed how to regain control using simple systems such as structured diaries, task delegation, and protected thinking time.

The second session explored using DISC profiling to better understand both patients and team members. Recognising whether someone is decisive, cautious, sociable, or analytical helps tailor communication and prevent conflict.

Lesson: managing people well requires self-awareness and systems. Understand personality types to reduce friction and build trust.

8. Purpose beyond profit

The day paused for a powerful video message from Smriti Khadka, country director of Asha Nepal, the charity supported by Andrea Ubhi Dentistry.

Smriti shared stories of women and children rebuilding their lives after trafficking and abuse, showing how the profession's generosity translates into real-world change. Her closing words: 'Your help really changes lives.'

Lesson: a purpose beyond profit brings meaning to the work. Integrate giving into your practice – it motivates teams and builds culture.

Final reflections

By day's end, one theme connected every session – from business strategy to implant dentistry: excellence is built on clarity, systems and connection.

Modern dental practice success depends on technical mastery and calm leadership – and on remembering that every piece of technology still serves one ultimate goal: patient trust. D

For updates about future events, follow Andrea on Instagram **@andreaubhi**.

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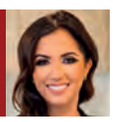
The journey so far

Sheena Tanna, winner of *Dentistry*'s Next Top Digital Dentist, shares how her journey has 'exceeded expectations' and caught the attention of national media

Sheena Tanna
Principal dentist, Billericay Dental Care



Being named *Dentistry*'s Next Top Digital Dentist 2025 was 'nothing short of surreal' for winner Sheena Tanna. 'It was a real pinch-me moment,' she admits. 'I couldn't actually believe it. It felt like a credit, not just to me, but to my team as well, because we've been on this digital journey for such a long time now, and it's a major part of what we do, so it just felt so lovely to be recognised for that.'

That sense of team effort is central to everything Sheena does. As principal dentist and owner of Billericay Dental Care, she's spent years building a practice where innovation, collaboration and patient experience go hand-in-hand.

Building Billericay Dental Care

Sheena qualified from the University of Leeds in 2009. The early years were about refining her general dentistry skills before moving into smile design, which became a key focus.

'When I bought my practice,' she explains, 'I used the background knowledge I'd built up – I'd spent a lot of time learning the science of dentistry – and I combined it with what I believe is an art. That's how I formed Billericay Dental Care, and that's when I created our motto, "every smile is a masterpiece". I feel that if you combine the science and the art together, that's when you create amazing results.'

That philosophy continues to guide the practice's approach today – combining artistry, precision and, most importantly, technology, to enhance patient outcomes.

Gaining clarity and confidence

More than anything, dentistry is about improving communication and the overall patient experience as far as Sheena is concerned.

She explains: 'Digital dentistry has lots of different aspects to it. For me, my passion has always been about patient experience and alleviating anxiety, and it's one of the main ways I use digital dentistry.'

One of her favourite examples is using 3D scans obtained from her Align Itero Lumina to help patients visualise what's happening in their mouths. 'We go from what traditionally would have been, "you need a filling" to now, "let me show you this 3D scan of your teeth." I can point out the brown area, and they instantly understand what needs to be done. They can see it for themselves.'

'Suddenly you're collaborating. Your patient is on the journey with you. You're no longer telling them what they need.'

That same approach extends to cosmetic work too. Using the digital smile design software Invisalign Smile Architect, Sheena can show patients their proposed new smile before treatment begins.

'Our communication is so much better,' she says. 'We alleviate anxiety for the patient, but also as the clinician my anxiety is down, because I know exactly what the patient wants and what I'm going to create.'

For her, digital tools are about clarity and confidence, for both the dentist and patient.

It was a real pinch-me moment. I couldn't actually believe it. It felt like a credit, not just to me, but to my team as well

The digital journey

When the competition opened for 2025, Sheena saw it as an opportunity to use Align Technology's expertise to take her digital journey to the next level.

'I entered *Dentistry*'s Next Top Digital Dentist was because it was something I was already very passionate about. I had renovated the practice, we doubled our size, and I had planned the practice to accommodate digital dentistry. So when I saw this award, it wasn't just the fact that I was being named *Dentistry*'s Next Top Digital Dentist, it was about what it was offering me.

'I thought, well, all of these things are going to help me be better, and upskill me, and as a result, I'm going to be a better leader, which means I'm going to be able to educate my team better, which means my practice is going to do better.

'We were on a digital journey. We were always going to take that journey, but this prize was going to help me elevate us much quicker and grow on a much bigger scale faster, and that's why I entered.'

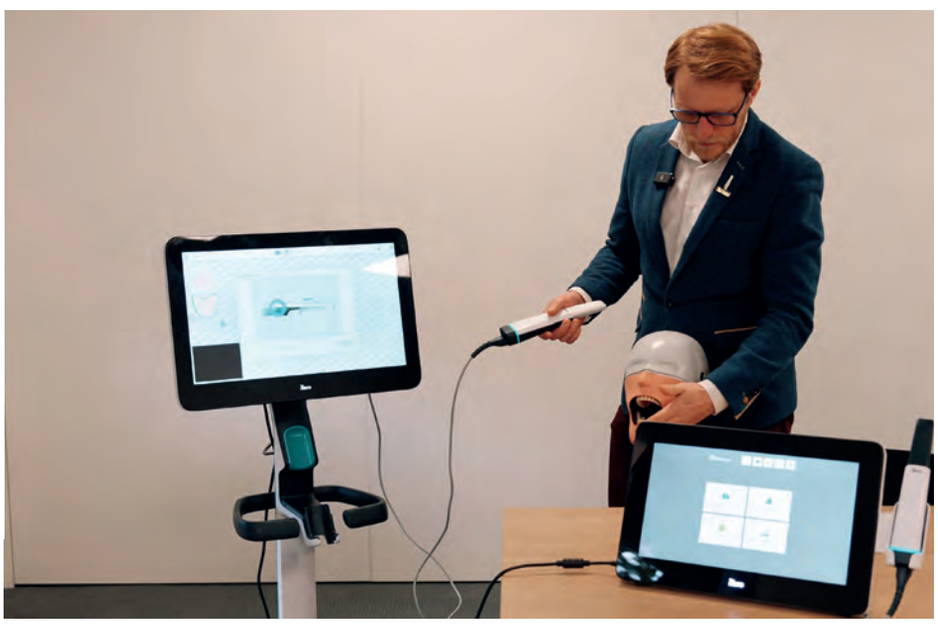
The more knowledge I can absorb, the better leader I'm going to be for my team, and the more my practice is going to progress

Exceeding expectations

Winning the award has already been a transformative experience – and one that's gone well beyond what she anticipated.

'It's completely exceeded expectations. I don't think I could ever have imagined so much input, so much attention to detail from everyone, especially from the Align team. How amazing everyone's been with me, and how much they are really paying attention to what I'm doing, and then tweaking me and making it better, and then trying to personalise that experience so that we get the most out of it, has been amazing.'

The recognition has also created a wave of interest outside the profession. 'What's been really amazing is how much it's already resonating with the wider population,' she explains. 'I've already been on national radio – Heart, BBC – and featured in my local newspaper. It feels amazing to be part of



Last year, *Dentistry* revealed Dr Sheena Tanna as the winner its Next Top Digital Dentist competition – an initiative created to champion dentists embracing a digital transformation.

Run in collaboration with Align Technology, the programme offers an opportunity to embark on a year-long journey of mentoring, coaching and access to cutting-edge digital tools designed to drive clinical excellence and practice growth. With Align's support shaping the experience, the initiative helps one dentist unlock the full potential of digital workflows.

something that's getting digital dentistry out there and getting both patients and colleagues involved on that journey.'

Managing growth and balance

As both a mother of two and a principal dentist, Sheena acknowledges that the next phase of her digital expansion will come with challenges.

'I think whenever you're implementing change or growing a business, there's always the work-life balance to think about,' she says. 'I'm going into my systems and changing the journey so we can be bigger and better, but that involves education – not just for me, but for the team. Balancing that alongside home life will probably be the biggest challenge.'

But already, the process has brought unexpected positives. 'One of the amazing things that's come from it is that I've had to delegate more because I'm busier,' she explains. 'And what we've found is that individual team members are shining because of that. I've given them new titles and responsibilities, and they've really risen to it.'

For Sheena, that's a sign that growth doesn't just come from new technology – it comes from empowering people too. 'It's a really good thing for Billericay Dental Care. Individuals are upskilling, they're taking ownership, and that's what it's all about.'

Looking ahead

Over the coming months, Sheena has clear goals for what she hopes to achieve – personally, clinically and professionally.

On a personal level, she says it's about learning and growth. 'I've always believed knowledge is power. The more knowledge I can absorb, the better leader I'm going to be for my team, and the more my practice is going to progress.'

Clinically, she aims to fine-tune her techniques and patient journey so that care is always of the highest standard. 'Once again, the better I am, the better mentor I'm going to be for my associates,' she adds.

And professionally, she wants Billericay Dental Care to become a benchmark for how digital dentistry can transform the patient experience. 'I want my practice to be a digital backbone – something other practices can aspire to, that shows how it can impact patient experience and alleviate anxiety.'

Encouraging others to take the leap

Sheena's advice to others considering investing in digital dentistry is simple: 'You just need to start. Stop thinking about it, just start. Buy one piece of equipment and master it and read about it and use the resources around you, because there are so many other people out there who are happy to help you, and there are so many amazing courses.'

She says once you step into it, the technology quickly becomes intuitive. 'You realise how easy and user-friendly it is, and how much it alleviates anxiety – both for your patient and yourself. It makes things like patient consent and treatment planning so much smoother.

'AI and digital dentistry are developing month on month, day on day. It's getting better and better, and it's now time to embrace it and get on board. It's not scary, and you're going to be just fine.'

A buzz across the practice

Winning has already had a ripple effect throughout the team. 'It's created a real buzz winning the award already, and that has really boosted morale and made everyone even more driven towards the patient journey and making sure we're providing an amazing experience,' Sheena says.

'But also this award came with courses and learning points for the entire team, and there's been a lot of time and effort put into helping educate individual team members, and I think that's going to be really amazing to help create an amazing patient experience when people come to our surgery.'

As she continues her journey as *Dentistry*'s Next Top Digital Dentist 2025, her focus remains on developing her team, refining patient experiences and showing how digital tools can make dentistry more effective for everyone involved. D

Dentistry's Next Top Digital Dentist competition is run in collaboration with Align Technology, empowering the next generation of digital clinicians and supporting the advancement of digital workflows.

Being part of the conversation

Debbie Hemington, Joanne Bowles, Lauren Long and Ibrahim Numan review 2025 from the perspective of the British Association of Dental Therapists

Debbie Hemington, Joanne Bowles, Lauren Long and Ibrahim Numan
BADT executive council

With another busy year at the British Association of Dental Therapists (BADT) wrapped up, we wanted to take a moment to pause and reflect on just how much ground we've covered on behalf of our members.

What stands out most is how often we've found ourselves in the rooms where decisions are being shaped – ensuring dental therapists and dental hygienists are represented, respected and included in every discussion that affects our profession.

One of our highlights came last December, when Fiona, Debbie and Ibrahim travelled to the Indian Dental Association Conference in London as guest speakers. They were invited specifically to help colleagues who have qualified abroad, often as dentists, better understand the scope of practice frameworks of a dental therapist, and the importance of working safely within their remit. We have been invited back this year and look forward to contributing again.

At the GDC Leadership Network, Joanne and Debbie continued to fly the BADT flag, where skill mix was a hot topic in every meeting. Of course, the real challenge is turning those conversations into action; that's where having consistent BADT presence really matters. By being there throughout the year, we've ensured that dental therapists and dental hygienists voices are not lost in the process.

A joined-up approach

Our involvement with the Dental Professionals Alliance (DPA) has also been incredibly meaningful. It's a forum that brings together the wider dental community, and one that really amplifies shared concerns. Through the DPA, we were invited to London in July to meet Stephen Kinnock with the chief dental officer – an opportunity we used to raise issues that directly impact our members: the ongoing shortage of dental nurses, the limitations of the NHS contract, and the lack of parity in pensions or NHS benefits for those providing direct access.

We also emphasised how supervised toothbrushing and increased NHS appointments won't deliver their full benefit unless they sit within a joined-up approach to oral health from birth, involving midwives, health visitors and others. It was important to highlight, again, that dental caries remains the leading cause of children being admitted for general anaesthetic, despite being almost entirely preventable. Public education must be part of the solution.

It's been a particularly active first 10 months for Joanne as chair, with work spanning everything from scope of practice documentation and GDC professionalism frameworks to supporting conversations around referral pathways.

Joanne represented the BADT at a British Society of Periodontology workshop, looking at the S3 guidelines around dentine hypersensitivity. She has also attended events to support campaigns like National Smile Month and spoke at the Robert Ireland Lecture on leadership. Every one of these moments has been another chance to ensure dental therapists and dental hygienists are part of the bigger picture.

Representation

The updated scope of practice guidance, which came into effect on 1 November, has been a major focus for us in recent months. Joanne and Debbie have been closely involved in supporting the GDC throughout the rollout, helping to clarify the questions from registrants and working to ensure the messaging was as clear and practical as possible. We're proud to have played a part in shaping clearer communication and helping make sure members feel confident in understanding what the changes mean day to day.

But representation isn't just about policy and strategy – it's about celebrating our profession, too. As a dental awards judge, Debbie was struck by the quiet, dedicated individuals making enormous differences in their communities.

Regional representatives visited schools – presenting to students and offering graduation prizes – highlighting the support we provide for the future generation of dental therapists and dental hygienists.

Throughout all of this, the BADT executive council has continued to regularly meet to respond to consultations and emerging issues. Whether it's scope of practice, GDC curriculum updates or other tasks that arise, often with little notice, we're always ready to act quickly for our members and the profession.

The BADT has an excellent group of individuals within its council, and it has been exciting to welcome some new and very talented dental therapists into our already dedicated and passionate team. We thank them all for their hard work and dedication.

Looking back, last year has been defined by visibility, collaboration and dedication. Whether in policy meetings or clinical workshops, at award panels or advisory groups, the BADT has been there – making sure your voice is part of every conversation that shapes the future of our profession.

Here's to another year of working together, representing you, and continuing to champion the vital role of dental therapists and dental hygienists across the UK. D

For more information about the BADT, visit **www.badt.org.uk**.

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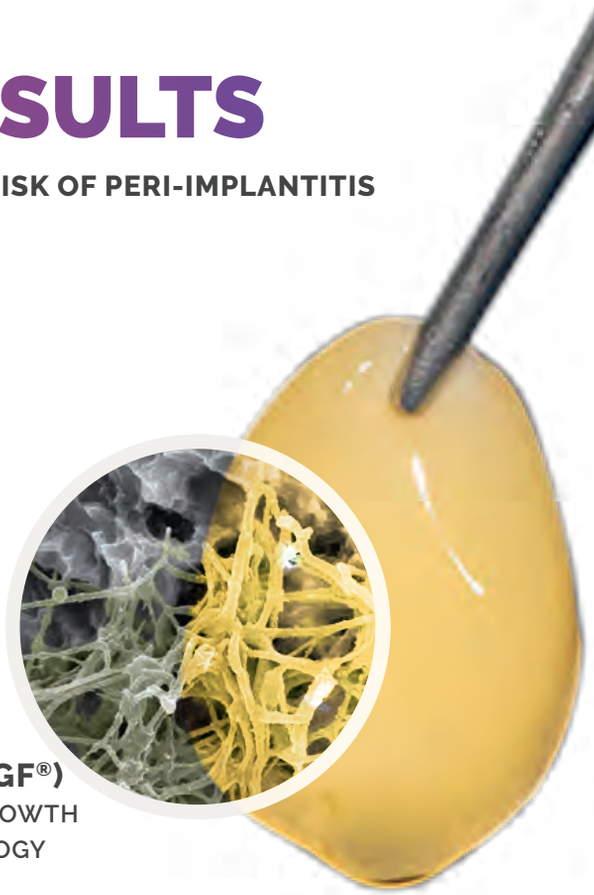

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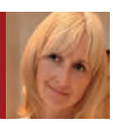
Building a healthier future together

Rhiannon Jones reflects on 2025 – a year of progress, collaboration and purpose

Rhiannon Jones
President, BSDHT



Looking back on 2025, I am struck by the sense of momentum within our profession and the renewed collaboration across UK dentistry. There is growing recognition of what dental hygienists and dental therapists contribute to national oral health.

Whether through engagement with government, partnerships with professional societies or grassroots member activities, 2025 has demonstrated what can be achieved when the profession works together with clarity and purpose. One of the defining moments of the year was the British Society of Dental Hygiene and Therapy's (BSDHT) involvement in discussions with the Department of Health and Social Care about the government's 10-year health plan. For the first time, the contribution of dental hygiene and dental therapy was recognised in long-term national planning, giving the society a platform to keep prevention at the heart of oral health strategy.

The revised Scope of Practice also opened the door to new opportunities and responsibilities. It reminds us that prevention is everyone's business and that patients deserve access to the right care from the right professional. It also challenges us to be ready for change and to ensure that training and support evolve alongside new expectations.

Prevention has remained the common thread through every BSDHT initiative, from First Smiles to the Oral Health Summit delivered with the British Society of Periodontology and Implant Dentistry (BSP). These collaborations demonstrate what can happen when education, research and clinical practice align. They reinforce that good oral health depends not only on what happens in the surgery but also on our ability to advocate, educate and lead.

Support through change

Behind every policy discussion and professional event is a society built on connection. The BSDHT has continued to be a home for learning, growth and support. Regional study days, mentoring programmes and CPD remain central to what we offer. Our regional groups listen to members and create events that meet local needs, from evening sessions to conferences and informal gatherings. These moments of contact strengthen the community and remind members they are part of something bigger.

We also recognise that professional life can be isolating. Many colleagues work independently, often as the only dental hygienist or dental therapist in their practice. That is why the BSDHT continues to invest in communication and accessibility.

Last year also saw the development of the Dental Health Matters podcast, created to reach people wherever they are. It will offer a new way to share ideas, clinical insight and personal stories that reflect the breadth of our profession once it goes live.

Wellbeing and peer connection will remain priorities in 2026. The dental profession has faced significant change in recent years, and it is vital that we continue to look after one another and to celebrate collective progress.

Supporting wellbeing is not just about individual resilience but also about creating the conditions where professionals feel valued, listened to and empowered to thrive.

Preparing for the future

The year ahead will be about readiness and opportunity. As the NHS explores new community-based models of care, there is huge potential for dental hygienists and dental therapists to play a leading role. Prevention is our area of expertise, and these evolving models could transform access to care if they are properly supported and resourced.

The BSDHT is already preparing for this future by reviewing its structure and ensuring that our committees and council remain fit for purpose. We are also identifying new ways to make the society sustainable for generations to come. Council meetings will take place more often to encourage greater member involvement, and partnerships will continue to grow across education, policy and practice.

These efforts reflect our role both nationally and beyond. What we do here in the UK often informs wider professional dialogue, and in turn we continue to learn from the experiences of colleagues around the world.

Internationally, the BSDHT represents the UK profession on the global stage. With 76 years of experience, we are among the world's longest-standing dental hygiene and dental therapy organisations, a legacy that brings both pride and responsibility. Seeing how our profession is developing in other countries is always a reminder of how far we have come and how important it is to keep building on that foundation.

A promising year ahead

As we step into 2026, there is a real sense of optimism. The profession is ready to embrace new opportunities, strengthen its voice and keep prevention at the centre of care.

Together we can build on last year's progress, support one another and continue to lead through example.

If we stay true to our shared purpose of promoting health and preventing disease, 2026 will be a defining year for our profession and for the patients we help. D

For more information about the BSDHT, visit **www.bsdht.org.uk**.

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The merits of mentoring

Carol Somerville Roberts explains how finding the right mentor or mentee at the right time in your life can be a true game-changer and the key to unlock success

Carol Somerville Roberts
President, British Academy of Cosmetic Dentistry (BACD)

'If I have seen further it is by standing on the shoulders of giants', claimed Sir Isaac Newton. He's right, of course – having a mentor is a gateway to help career progression; the chance to hear from someone more experienced about how you can achieve your professional goals.

Similarly, connecting with a mentee is a fantastic way of giving back; to be the shoulders for someone to stand on and to help preserve and spread invaluable knowledge and skills for the future.

Transformative support

Finding the right mentor or mentee at the right time in your life can be a true game-changer. Whether looking for advice on juggling parenthood with practice management or evolving your clinical skills to take on more advanced cosmetic dental treatments, having someone to turn to provides comfort and confidence.

A mentoring relationship does not have to be formal either: connecting with a peer at an event or seeking out a renowned expert in a particular field could be the start of a long-lasting friendship, where a quick text, email, call or coffee can pose questions, air concerns and overcome challenges.

Failure is a vital teacher, and to hear that successful dentists are open in admitting the things they wished they had done better is a huge reassurance

The knowledge and skills to be gained from a mentorship do not have to reinvent the wheel; it's unlikely that you will learn a radical new technique or be shown an under-the-radar technology that streamlines the daily workflow. Instead, a mentor can guide you through complex cases, listen to personal problems, and support you in a number of ways.

The advantage of experience is hindsight, and mentors can share the choices they made at the same point in their career, and the lessons learned from them.

For the next generation, hearing something like: 'I have done x, y and z, but I wish I had done it like this…' from a senior clinician can improve their confidence because it emphasises the value of perspective and learning from mistakes.

Failure is a vital teacher, and to hear that successful dentists are open in admitting the things they wished they had done better is a huge reassurance in an industry as intense as dentistry.

A win-win approach

Mentoring is a two-way process too. While the expectation is that the younger mentee will gain more knowledge, there is also considerable room for the mentor to enhance their learning.

The next generation of dentists are bursting with talent, harnessing new technologies and demonstrating that the future of cosmetic dentistry is in capable hands.

I've noticed in particular how much focus younger dentists give to a good work-life balance – a concept that may have emerged in the 1970s, but feels like it has only recently taken the world by storm. This sees fewer hours worked, and more time dedicated to home life, hobbies, CPD and much more. The impact is reflected in improved productivity, bolstered focus and an upbeat morale. Older mentors may take notice of this approach to enhance their own lives, both professional and personal.

For cosmetic dentists, surrounding ourselves with people who we can ask questions to – in complete confidence and without feeling judged – is a powerful educational tool.

This is why the British Academy of Cosmetic Dentistry (BACD) champions in-person events as a conduit for networking; physical interactions can give you a better understanding of who a great mentor or mentee could be, while growing a strong community of like-minded dental professionals.

The perfect supplement to CPD, becoming one half of a mentoring relationship pushes us towards a gold standard in clinical excellence; a pathway built on tried and tested experience. D

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‘Do or die’

From the brink of closure to thriving private practice, Ant Davies shares how he built a successful dental group

Three years on from a successful conversion from NHS to private dentistry, practice owner Ant Davies shares how he went from being on the brink of closing a site to now owning three thriving practices in West Cumbria.

Ant’s circumstances three years ago will be familiar to many practice owners across the UK. Still suffering from the effects of the pandemic and unable to recruit associates to help him deliver his large NHS contract, his business was struggling. Despite being on the edge of the Lake District and all its attractions, his vacancies went unfilled for so long that he faced having to close one of the two sites he had bought a few years earlier.

‘We weren’t really able to deliver the NHS contract anymore,’ Ant recalls. ‘It wasn’t working. We couldn’t recruit, especially rurally.’ Ant made the decision to convert both sites to private dentistry with support from Jayne Gibson, his Practice Plan regional support manager.

A leap of faith

However, converting to private practice wasn’t without risk. One site had long-standing associates, making the transition smoother. The other, however, had three new dentists unfamiliar to patients. ‘It was a bit do or die really,’ Ant says. ‘We didn’t really have anything to lose at that point either.’ Despite everything, both practices successfully converted. ‘It was a bit of a leap of faith,’ he admits. ‘You’re trusting someone else’s advice, stepping into the unknown. But it worked out well.’

Ant attributes this in part to the shifting landscape of dentistry and patient expectations. His experience challenged the conventional wisdom that, to be successful, private conversions need well-established dentist-patient relationships. His success suggests that patients may be more open to change than previously thought, especially when NHS services are stretched thin and patients are unable to gain access to a dentist.

Growth and expansion

With two successful conversions under his belt, Ant was happy to consolidate and was not actively seeking to expand. However, when a practice located within a mile of his own came up for sale, he saw an opportunity. ‘It wasn’t part of a big master plan,’ he says. ‘It was more from a consideration as to how that sale might affect the other practices, rather than necessarily wanting to add another practice to the group,’ he explains. ‘It was more a case of if we don’t do it, then there may be other implications. But I don’t tend to shy away from opportunity.’ The third practice has brought new capabilities, including an in-house lab, a clinical dental technician and services like sedation and endodontics. This allowed Ant to begin integrating services across the group, offering patients more comprehensive care and creating internal referral pathways.

A new way of working

The shift to private dentistry has transformed the way Ant and his team operate. ‘We’re able to offer all treatments now,’ he explains. ‘There are no shackles on what we can provide.’

Dentists in the group have more time to apply advanced techniques, improve outcomes and pursue areas of interest. Ant also ensures he makes better use of skill mix, allowing therapists and specialists to work to their full scope of practice.

Free from the restrictions of NHS dentistry, the atmosphere in practice has changed for the better. ‘It’s completely different.’ Ant says. ‘I almost don’t remember that previous life. It’s gone. It certainly is less stressful. There’s a freedom to it,’ he continues. ‘We’re not tied to targets or bureaucracy. We make our own decisions.’

One of the key pillars of Ant’s success has been the introduction of patient dental membership plans. The regular income from plan fees has helped give Ant a sense of financial security. ‘That consistent regular monthly income from plan patients is a game changer really.’

It also encourages regular attendance from patients, which is not always the case with fee-per-item models. ‘Plan patients are committed,’ Ant notes. ‘They come in regularly, which gives us consistent points of contact and financial security.’

Lessons learned

Ant’s experience of practice ownership has had its share of stress. From the pandemic to the pressures of ownership, he’s faced a number of challenges. Although it took a degree of courage to step away from the NHS, he feels perceptions of its security are misplaced.

‘NHS contracts are a funny thing really,’ he muses. ‘You’re told that there’s a lot of security in it but since leaving I disagree with it a lot. I think people get a little bit brainwashed into thinking that there’s this security that is false really. I don’t feel now that I have less security than I did when I had the NHS contract. I think if anything, I feel more secure in the fact that I know that I can do what I need to do for my business rather than being tied to something.’

He credits much of his success to the support of Practice Plan and Jayne, who has remained a trusted adviser throughout. ‘She’s been incredibly valuable to the business from the start of the conversion to even now,’ he explains. ‘There are still times where I’ll pick up the phone and run something by her to get her feel for something or see how it would work alongside the plan. So, she’s very much still present. She’s almost part of the team now,’ he says.

Looking ahead

Ant’s focus now is on integrating the three practices, growing specialist services and maintaining the personal, independent feel of each site while streamlining processes in the background. He has no desire to build a corporate empire and sees himself as more of an ‘accidental’ group owner.

He has no regrets about making the move away from NHS to private dentistry. ‘I wouldn’t change it for the world,’ he says. ‘We’re not just treading water anymore, we’re swimming.’

At the time Ant made the move, his conversion bucked the trend. However, three years on, stories such as his are becoming more common, but no less heartening.

For dentists considering a move to private practice, Ant’s story is a powerful reminder that with the right support, strategic thinking and a willingness to take risks, it’s possible to turn uncertainty into opportunity. D

For support, call Practice Plan on **01691 684165** or visit **www.practiceplan.co.uk/nhs**.

Autumn budget: implications for dentistry

Simon Cosgrove explores how the autumn budget will affect dentists in 2026

Simon Cosgrove
Dental regional manager,
Wesleyan Financial Services

The 2025 autumn budget unveiled a number of reforms that will have far-reaching implications for dentists – from income tax thresholds to pensions, dividends and ISA rules.

For high-earning dentists and practice owners, understanding how these measures will impact your personal and business finances is essential for making informed steps to protect your income, manage rising costs and plan efficiently for the future.

Frozen income tax thresholds

One of the headline announcements from the budget was the decision to extend the freeze on personal income tax and national insurance thresholds until April 2031.

While thresholds will remain unchanged until then, rising earnings due to inflation can cause what is known as 'fiscal drag' – meaning more of your income is gradually pulled into higher tax bands, even though official tax rates haven't increased.

For high-earning dentists, the extended freeze creates a more direct personal tax challenge. Many already fall into the 40-45% tax brackets, and with thresholds fixed until 2031, even modest income growth could push more earnings into higher-rate bands.

What's more, if you earn over £100,000, you may also be caught by the tapering of the personal allowance – effectively pushing the marginal tax rate even higher. This 'tax trap' can significantly reduce take-home pay, even when headline rates remain unchanged.

Practice owners will also feel the impact of fiscal drag through rising operational costs. With minimum wage rates continuing to increase, staffing expenses are likely to climb, adding pressure to already tight margins. These higher costs could affect profitability, as well as decisions around staff recruitment and retention.

Tax treatment depends on your individual circumstances and may be subject to change in future.

Pension savings and the new salary sacrifice cap

From April 2029, only the first £2,000 per year of pension contributions made via salary sacrifice will be exempt from national insurance contributions (NICs). Any amount above this will be subject to both employer and employee NICs – in other words, treated as a standard pension contribution.

While many dentists are self-employed and won't typically use salary sacrifice themselves, some practice owners do offer it to employed staff. If this is the case, it's important to be aware that the NIC benefit for your employees will diminish for contributions above £2,000 a year.

Higher taxes on dividends, savings and property income

For many dentists, income doesn't just come from salary or self-employment. Dividends, retained profits, property income and returns from savings or investments often form a significant part of overall earnings.

Changes announced in the budget affect these income streams directly:

- Dividend tax rates will rise by 2% from April 2026. The basic rate will rise from 8.75% to 10.75%, and the higher rate from 33.75% to 35.75%
- From April 2027, tax on savings and property income will also increase by 2% across all bands.

If you take profits as dividends or rely on rental or investment income, these increases will reduce net returns. This means that taking profits personally or investing outside of tax-efficient wrappers (such as ISAs or pensions) may be less appealing.

For dentists operating limited companies, the increase in dividend tax also makes withdrawing profits from the practice less attractive. As a result, practice owners may now prefer to keep more profits inside the company, where funds can be used or invested more efficiently – through commercial investments, for example.

Although investment returns within a company are still taxable, retained capital has the potential to grow faster than if it were withdrawn and taxed at higher personal rates. This makes the way you use retained profits a key financial planning consideration.

Remember, the value of your investments can go down as well as up, and you may get back less than you put in.

ISA reforms and savings strategy

The budget also introduced changes to the structure of individual savings accounts (ISAs). While the overall annual ISA allowance remains at £20,000, from April 2027 the amount that can be held in a cash ISA will be capped at £12,000 for savers under the age of 65.

To use the full allowance, the remaining £8,000 must be placed into other ISA types (most commonly stocks and shares ISAs), as part of the government's efforts to encourage greater long-term investment in the wider economy. Importantly, savers aged 65 and over are exempt from the new cash-ISA cap and retain the full £20,000 cash allowance.

For dentists who have traditionally used cash ISAs as a low-risk place to hold funds for equipment purchases, practice upgrades or future tax liabilities, these reforms may require a change in approach.

With the new restrictions – and with taxes on dividends, savings and rental income continuing to rise – it may be an appropriate moment to reassess your savings plans and consider whether incorporating a longer-term investment strategy could offer better resilience and tax efficiency. D

Putting mouthwash myths to bed

Iain Chapple and **Elena Figuero** take a deep dive into the evidence supporting the use of adjunctive chemical agents

Iain Chapple
Professor of periodontology and lead for Birmingham's NIHR BRC in the inflammation theme of oral, intestinal and systemic health

Elena Figuero
Professor of periodontology and associate dean of quality assurance and international affairs at University Complutense of Madrid

When we talk about chemical biofilm control, there are two main ways of application: either local application, such as subgingival delivery into the periodontal pocket (a professional treatment), or topical application, such as toothpaste or rinses (Figuero et al, 2023).

Mouth rinses are ideal from many points of view. They have more favourable pharmacokinetics, they are independent of the patient's ability to perform toothbrushing, they can reach areas that are difficult to access, and they are generally well accepted by patients (Figuero et al, 2023).

What the evidence shows

We were able to demonstrate evidence from 70 randomised clinical trials, each with at least six months of follow-up, assessing the efficacy of antiseptics as coadjutants of mechanical biofilm control.

That represents more than 6,000 participants in either test or control groups. However, nearly no evidence was found relating to agents other than antiseptics (Figuero et al, 2020).

All combinations of active antiseptic agents were shown to reduce gingival inflammation to a statistically significant degree compared with the placebo. Importantly, there were no statistically significant differences between patients with gingivitis and those in supportive periodontal care (Figuero et al, 2020).

Taken together, this evidence makes it clear that antiseptic rinses can play a useful role. But mouthwash is only one part of the picture. To put these findings into context, we also need to look at other aspects of oral hygiene and adjunctive treatments (Figuero et al, 2020; 2023).

Brushing and flossing

Patients may use either a power toothbrush or manual brushing. The evidence base favours power toothbrushes, but the effect size – the actual difference – is not that large, and there are cost implications. Many patients cannot afford power brushes, so manual brushing remains perfectly acceptable (Sanz et al, 2020).

Flossing is another area of debate. We suggest not using floss as a form of interdental cleaning for periodontal maintenance patients. The reason is that in maintenance patients the gaps are often too wide, so floss is ineffective; interdental brushes should be used instead. However, this does not mean flossing has no role. If a patient has tight spaces where interdental brushes cannot fit, flossing can still be effective.

So, the flossing story is a little complicated: not recommended for maintenance patients with large gaps, but appropriate for prevention or where interdental brushes are not suitable (Sanz et al, 2020; Slot et al, 2020).

Antibiotics and periodontal care

When you look at systemic antibiotics, the evidence shows there can be some additional benefit when used alongside non-surgical periodontal therapy. However, these improvements are modest, and when the risks, costs and impact on antibiotic resistance are considered, routine use cannot be justified (Sanz et al, 2020).

We therefore make a very strong negative recommendation: systemic antibiotics should not be used for managing periodontitis in general dental practice. There is a small caveat – such as in young patients with generalised grade C periodontitis (previously called aggressive periodontitis) – where antibiotics may be considered. But these cases should be treated in level two or level three care settings in the UK. In other words, general practice should not prescribe systemic antibiotics for periodontitis; these patients should be referred to specialists. This is part of antimicrobial stewardship and the effort to reduce resistance (Sanz et al, 2020).

Returning to mouth rinses

The foundation of managing gingival inflammation is self-performed mechanical biofilm removal – this is the gold standard. If patients can do it effectively, that is all they need. But if they struggle, adjunctive measures, including antiseptics, may be considered in specific cases (Figuero et al, 2023).

For the first time, we have defined the three agents in mouth rinses for which there is the strongest evidence: chlorhexidine, essential oils, and CPC.

We do not name specific companies, and industry was not involved in this process, but cetylpiridinium chloride (CPC) are the agents most consistently supported by evidence (Figuero et al, 2023).

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Confident leadership starts here

Mark Topley shares the six foundations of confident leadership that every practice manager can use to create a thriving, motivated, and well-led team

Mark Topley
Founder, Great Boss Academy

Let's get one thing clear. If you're a practice manager, you are not just the practice manager.

You're the one juggling rotas, people problems, patient issues and last-minute emergencies – often all before 10am. Most days, you're the person everyone turns to when something goes wrong.

But here's the truth no one tells you early enough: running the practice and leading the practice aren't the same thing.

And if you've ever felt stuck in the middle – expected to lead but never actually shown how – you're not alone.

In my experience, confident leadership at practice manager level is one of the biggest indicators of long-term success, retention and growth. Not loud leadership. Not knowing all the answers. Just calm, grounded, consistent leadership that helps the whole team step up.

Let's explore the six foundations of confident leadership that every practice manager can use to create a thriving, motivated and well-led team.

1. Lead yourself first

Leadership starts with you – your energy, mindset and presence.

If you're constantly firefighting, reacting to everything and running on adrenaline, your team will feel it. But when you're calm, grounded, and intentional – even in tough moments – the team will mirror that energy.

Confident leaders build rhythms into their week that keep them balanced. They know what fuels them, what drains them, and where their time actually goes. They set boundaries and protect them. And they understand their emotional tone and the ripple effect it has on the whole practice.

Leading yourself also means being kind to yourself – celebrating progress, learning from mistakes, and choosing courage over criticism.

2. Unite and guide with a practice creed

Most team problems come down to one thing: people pulling in different directions.

That's why every team needs a shared story – a practice creed. Rather than a corporate mission statement, it's a simple, human way of defining what you stand for and how you work together.

Your practice creed should capture three things:

1. The problem you help your patients overcome
2. The destination you're working towards together
3. The behaviours that matter most along the way.

You don't need to be the principal to lead this. In fact, your daily presence makes you the perfect person to keep that story alive. The clearer your shared identity, the more pride, alignment and ownership you unlock across the team.

3. Create and protect culture

Culture isn't what's written in the handbook or printed on posters. It's how your team thinks, acts and feels – especially when no one's watching.

It rises or falls on leadership. Confident leaders define the attitudes and behaviours they expect and don't leave it to chance. They repeat what matters, address what doesn't and, most importantly, model the standards they want to see.

The strongest cultures are built by people who protect what's good and challenge what isn't – early, clearly and kindly.

4. Communicate what matters

The best leaders aren't the loudest – they're the clearest.

In a busy dental practice, there's no shortage of noise. Messages get diluted, instructions are misunderstood, and people fill in the gaps with their own assumptions.

Confident communication means stripping back the waffle and focusing on what really matters:

- Set expectations up front, not after things go wrong
- Give feedback that helps, not hurts
- Listen with the intent to understand, not just to reply.

A great practice manager is also a translator – making sure the principal's vision lands with the team, and the team's concerns are heard by the leadership. If your team's confused, it's rarely a people problem – it's a communication one. And that's something you can fix.

5. Balance challenge and support

This is where many practice managers quietly burn out – and where teams quietly disengage.

You care deeply about your people. You want to be approachable. But when you avoid challenge, you start carrying too much. Respect erodes, and underperformance becomes normal. On the other hand, if you lead only through pressure, your team shuts down and avoids accountability.

The secret lies in balance: high challenge and high support. Challenge without care feels like bullying. Support without challenge leads to enabling. Together, they create trust, growth, and loyalty. The best teams say: 'I know exactly what's expected – and I know they've got my back.' That's the culture worth aiming for.

6. Delegate to develop

Delegation isn't about getting stuff off your plate. It's about unlocking potential.

If you're still doing things someone else could do – not because you're best at it, but because it's quicker or easier – you're holding the team back and holding onto overwhelm.

Real delegation means letting go of perfectionism, trusting others and coaching them through the learning curve – not taking things back the moment they wobble. Confident leaders don't just hand over tasks; they hand over ownership. That's how you scale trust, performance and freedom.

You deserve to lead well

Remember, you're not 'just' the practice manager. You're the leader your team needs. With the right mindset, tools and support, you can lead with calm, clarity, and confidence – and transform how your whole practice runs. D

Join Mark's webinar on 20 January on **dentistry.co.uk**, where he'll explain how to apply these six foundations.

S4S UK and S4S London unite

Jinesh Patel and Matt Everatt embark on a new chapter that will take S4S into its next era of growth, innovation and clinical partnership

For both of us, this moment represents far more than the uniting of two respected dental laboratories. It represents two personal journeys built through hard work, deep commitment, and a shared belief in raising standards across UK dentistry – finally coming together under one united S4S.

A partnership rooted in personal history

For Jinesh, this merger is the culmination of a deeply personal journey that began in 2008 with a small, family-run laboratory in London – HM London.

What started in modest surroundings quickly became a mission driven by family values, ambition, and sheer perseverance.

Over the years, HM London grew into a respected, service-led laboratory, eventually evolving into S4S London. This partnership strengthened ties with S4S UK and opened the door to new opportunities, new technologies, and deeper collaboration.

Introducing the S4S board

Jinesh Patel – Director. With years of hands-on leadership and operational expertise, Jinesh brings a deep, personal understanding of the dental laboratory landscape. His vision and experience are shaping the future of S4S with innovation, collaboration, and a focus on delivering exceptional value to clinicians.

Matt Norie – Director. Matt is the driving force behind S4S's product development, overseeing the creation and market introduction of the lab's signature solutions. Matt has extensive technical knowledge and a proven leadership track record.

John Bevan – Director. John brings extensive experience in finance and commercial strategy, helping to shape and streamline S4S's operations. His focus on efficiency and client-centric processes ensures that working with S4S is seamless.

Ellis Bullement – Director. An operational expert, Ellis has leveraged his years of experience to develop, streamline, and grow S4S into one of the UK's leading dental laboratories.

Neil Bullement – Board Member. Co-founder alongside Matt Everatt, Neil has been a foundational figure in S4S's growth. His expertise in business development, internal structuring, and financial planning has been instrumental in shaping the lab's success.

Today, that journey reaches a defining milestone: S4S London becomes fully part of the S4S family – not just operationally, but in vision and purpose.

Matt's journey with S4S began long before there was a laboratory, a workbench or customers. It started with a clear idea: that dental technicians could contribute far more to clinical outcomes, innovation and education than the industry traditionally recognised. That belief became the foundation on which S4S was built.

As co-founder and the first technician involved, Matt helped define the lab's early direction, championing quality, hands-on expertise, and strong clinical partnerships. His work across snoring and sleep apnoea, bruxism, splint design, and education helped establish S4S as a trusted national leader.

Today, as Strategic Technical Consultant, Matt continues to guide the technical standards and clinical support that underpin S4S. This new chapter brings together the values he helped instil from the very start, strengthening S4S's commitment to innovation, quality and service across the UK.

Two labs, one shared vision

S4S UK has long been known for leadership across orthodontics, snoring and OSA, bruxism, splints, and whitening – supported by innovation, education, and collaboration.

S4S London has been recognised for precision, speed and premium service.

Together, these strengths form the foundation of a stronger, more connected S4S.

As part of that vision, we are creating a new digital education platform – a collection of short, practical, experience-led videos spanning appliance design, clinical insights, materials, and best practices. Our aim is to make decades of knowledge easily accessible to every clinician who wants to grow.

Evolving roles guided by respect and shared purpose

As Jinesh steps into the role of Director of S4S, he carries forward both the legacy of S4S London and the foundations built through years of running a family laboratory.

'Growing a lab from a small family business to being part of S4S is an emotional and incredibly

meaningful journey,' says Jinesh. 'Building on Matt's work, while bringing my own history and values into the future of S4S, is a privilege.'

Matt continues as Strategic Technical Consultant, ensuring continuity in quality, innovation, and clinician support. 'What makes this moment special is how naturally our paths align,' says Matt. 'Uniting our expertise and values only strengthens what we can offer dental professionals across the UK.'

The unified S4S offers clinicians:

- Expanded service capabilities across Sheffield and London
- Enhanced turnaround times
- Increased technical expertise
- Strengthened digital communication
- New education and training initiatives.

Both sites will continue operating as normal, now supported by aligned workflows and shared knowledge.

Looking ahead with gratitude and ambition

This merger represents years of dedication, sacrifice, and belief – from both sides. From a family-run London laboratory to a national organisation at the forefront of dental innovation, this moment marks a new chapter, built on everything that has come before.

'We are incredibly proud of our journeys,' says Jinesh. 'And now, together as one S4S, we're ready to deliver even more value - combining scale with personal service, experience with innovation, and national reach with family-driven values.'

Our mission remains the same: to empower dental professionals with world-class laboratory solutions, leading education, and unwavering support – helping them deliver excellence to every patient, every time.

Kickstart 2026 with peace of mind

Back to the practice after Christmas? There's a free gift waiting for you from Aura Infection Control

As dental teams across the UK return to their practices after the Christmas break, there's one area of infection control that deserves urgent attention – dental unit waterlines.

While surgeries may look immaculate after a deep clean, waterlines can be a hidden reservoir of microbial contamination.

Aura Infection Control is encouraging dental professionals to make dental unit waterline safety a priority this January, offering 50 free red waterline samplers to the first practitioners who want to check the quality of their unit water.

Laura Edgar, managing director of Aura Infection Control, stresses that appearances can be misleading. 'It's easy to assume that a spotless surgery means everything is safe,' she explains.

'But waterlines can hide unseen dangers. Biofilm can develop quickly, even in new systems, turning what looks like clean water into a potential source of contamination.'

Biofilm – the microbial layer that adheres to the internal surfaces of dental unit tubing – can escalate bacterial counts far beyond the accepted safe limit of 100 colony-forming units (CFUs) per millilitre. Research shows that even new, untreated waterlines can exceed 200,000 CFUs within days, demonstrating how rapidly microbial loading can occur.

Such levels present risks not only to patients but also to clinicians and support staff exposed during procedures involving aerosols.

Christmas closures create ideal conditions for biofilm proliferation.

When water sits stagnant in dark, narrow tubing for a few days, bacteria can flourish unchecked.

Dental teams returning in January may unknowingly begin the new year with water systems containing significantly elevated microbial loads.

Routine waterline treatment and regular testing remain essential components of safe dental practice.

For teams looking to start the year with confidence, Aura Infection Control's free sampler offer provides a simple opportunity to check water quality and ensure compliance with recommended standards. Visit aiconline.co.uk/free-sampler to claim one of the 50 free red samplers.

Kickstart 2026 with peace of mind – and make dental unit waterline safety part of your practice's routine infection control checks. D

To claim a free sampler, visit aiconline.co.uk/free-sampler. Book a free dental decontamination review at aiconline.co.uk/dental-decontamination-review. For more details, email orders@aiconline.co.uk.

Breaking down barriers

A-dec explains how to make the dental practice more inclusive and shares key features to look for in a dental chair to ensure it meets the needs of every patient

More than a billion people, equating to about 15% of the world's population, are living with some kind of disability (The Lancet Public Health, 2021). This can include long-term sensory, mental or physical challenges that impact their daily lives, access to healthcare, and the support they need. As our global population ages, we can also expect the number of people with disabilities to increase in the coming years.

Unfortunately, even with this growing number, individuals with disabilities often find themselves overlooked by health systems and face serious gaps in health and wellbeing outcomes. The public health sector has a crucial role in tackling these inequalities by advocating for inclusive policies, enhancing accessibility in services, and making sure that disability considerations are incorporated into every aspect of health planning and care delivery (The Lancet Public Health, 2021).

Accessibility in dental care extends from the reception area to the treatment room; every element of your space should be thoughtfully designed to ensure all patients, regardless of ability, feel welcome, safe and valued.

With careful planning and the right dental equipment, your practice can remove common barriers to care, creating a more inclusive environment that enhances the experience for both patients and the dental team.

Rethinking the patient journey: layout and flow

An accessible practice begins before the patient even enters the building. Consider your parking, for instance, are your spaces accommodating for a wide range of people?

In addition, features like step-free entrances, wide automatic doors, low-height reception counters, and accessible restrooms are all ways to help maintain a high quality of service for everyone.

Think about how you can ensure the layout inside the practice works for all your patients, including easy movement for wheelchair users, those with walking aids, or individuals with sensory sensitivities. This means:

- Corridors and doorways: all treatment room doors should ideally be at least 900mm wide and have corridors that are at least 1,200mm wide (Gov, 2024)
- Spacious treatment rooms: ideally, you would have at least 1.5m x 1.5m of clear floor space inside the treatment room for wheelchair users to turn safely. To help keep the floor space open, try and avoid clutter by building in vertical storage solutions
- Accessible toilets and hygiene areas: accessible toilets and hygiene areas are often overlooked areas of an inclusive dental practice. These spaces should feature step-free access, wide doorways (minimum 900mm), support rails, lever-style taps, and an easily reachable emergency pull cord. Where possible, baby changing tables should also be installed
- Clear signage: have all signage within the building displayed with large fonts, high-contrast colour and braille/tactile markers
- Lighting and acoustics: ensure spaces are well-lit, with adjustable lighting options to help patients with sensory sensitivities. Opt for indirect lighting to minimise glare and harsh reflections. Use sound-absorbing materials such as carpets or acoustic wall panels to help reduce background noise and create a calmer environment, which is always a bonus in a dental practice, which is commonly associated with being an unnerving environment to start with.

Dental chair considerations

Perhaps the most important aspect of ensuring an accessible dental practice is the dental chair. It's the hub of every practice, and for many patients, it can either represent a moment of dignity or distress.

For patients with mobility issues, traditional dental chairs can present significant challenges. Transferring into the chair can be awkward or physically unsafe. Hoisting can be undignified.

For wheelchair users, the expectation to leave their chair is often very challenging. This is where the right dental chair design can make all the difference.

If you're planning to purchase a new dental chair or upgrade an existing one, here are the key features to look for to ensure it supports accessibility and meets the needs of all your patients.

1. Dental chair weight capacity

A large proportion of dental chairs have a weight limit of 350lb (159kg), which can pose challenges in today's healthcare landscape, especially given that, as of 2024, 64.5% of adults aged 18 and over in England are classified as overweight or living with obesity (Gov, 2025). This highlights a critical gap in accommodating the diverse needs of modern patients.

To truly be inclusive, a dental chair must be designed to safely support individuals of all body types. The A-dec 500 dental chair addresses this need with a robust weight capacity of up to 500lb (227kg), ensuring that every patient can receive care safely.

2. Low base-down position

This feature is often overlooked, but how low a dental chair can go can make it easier for patients to transfer from wheelchairs or stand directly in front of the chair before being assisted.

A-dec dental chairs, for example, offer an exceptionally low base-down position, with all 500 chairs featuring a low point of 343mm.

3. Removable or reversible headrest

One of the most useful accessibility features a dental chair can have is a dual-articulating headrest. This feature enables dentists to completely remove the headrest from the chair and reposition it 180 degrees around to enable wheelchair users to remain in their own chair during treatment while still enabling dentists to access the oral cavity effectively.

4. Chair swivel function

To facilitate easier access, dental chairs should have a good range of radius, ideally 30-degree swivel left or right of swivel. The A-dec chairs can swivel 60° in total (30° each side of the centre). This helps dentists position the chair for the most comfortable patient entry and exit.

5. Ergonomic, slim design

Space efficiency is critical in both modern and older surgeries. A-dec chairs allow better access around the patient, reducing repositioning and strain for both the patient and the dentist. A-dec's slim chair design allows dentists to get closer to the patient, reducing the need for excessive repositioning or awkward movements. The A-dec chair baseplates are compact to help further facilitate movement around the chair and easy access for wheelchair users to get as close as possible to the dental chair. This not only benefits the patient but also helps protect dentists from repetitive strain or postural injuries.

6. Flexible delivery systems and lighting

The A-dec delivery system and A-dec LED lights offer an extensive range of motion, enabling tools and visibility to be repositioned as needed. This adaptability is essential when treating patients with varying mobility levels or who remain in their wheelchairs during procedures.

The value of thoughtful design

When it comes to thoughtful dental surgery design, it's not just about ticking boxes for regulations, it's about truly delivering compassionate, patient-centred care. With a strong emphasis on ergonomic excellence, intuitive functionality and inclusivity, A-dec helps to empower dental professionals to create accessible environments that never skimps on performance or style. D

For references, email newsdesk@fmc.co.uk.

Discover more at **unitedkingdom.a-dec.com**.

Industry innovations

Unveil new insights

Carestream Dental

Artificial intelligence (AI) can make a running start in your practice workflows with the introduction of CS 3D Imaging software from Carestream Dental in your practice.

Now powered by AI, routine tasks can be completed immediately and with high levels of accuracy throughout the programme. This automation saves clinician's time and minimises the risk of mistakes through human error.

Plus, if professionals want to make a change from an AI generated result, it is simple to do – ensuring they have complete control over treatment.

AI-powered features include panoramic curves and nerval canal mapping, CBCT scan and intraoral scan data matching, and virtual crown design and implant placement.

Available now, AI Insights from Carestream Dental is ready to make an effective difference in your workflows.

www.carestreamdental.co.uk

The seamless Sensei Cloud

Carestream Dental

Agility, and connection. Sensei Cloud from Sensei, the practice and patient management brand of Carestream Dental, offers all this plus peace of mind, so dental professionals can focus on what's important: delivering remarkable patient care.

Modern dental practices require modern workflows with minimal risk and resilience to change. The cloud-based platform offers this flexibility, while eliminating the need to update systems or worry about backups. Your data is stored and protected in Microsoft-managed data centres, enhancing its uninterrupted performance and reliability. On the note of seamless operation is the streamlined transition to Sensei software. Carestream Dental ensures undisrupted migration with additional guidance and support for future upgrades too. The innovative, user-friendly platform makes it the perfect addition to any modern practice, empowering you to optimise patient care and accelerate growth.

gosensei.co.uk

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Looking to upgrade your CBCT X-ray unit? You can now trade in your old extraoral device for the new Viso G1 3D CBCT at a very special price.

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One phone call away A-dec

A-dec is not only renowned for its exceptional quality dental equipment; it takes pride in providing customers with an exceptional personal customer service because, quite simply, A-dec cares.

Whether you get in touch with one of the team of regional territory managers covering the UK and Republic of Ireland, the special markets manager, David Miles, or an A-dec-approved dealer, you'll receive the same first-class experience.

With the team's experience in the dental sector spanning over 40 years, whether you are looking to set up a new practice, revamp your existing one, considering a new equipment installation, or need ongoing support, A-dec is just a call away.

The dedicated team will ensure you have all the support you need every step of the way so you can make an informed decision that will meet your business needs for today and for years to come.

A-dec's dedicated UK-based customer service team brings decades of combined experience and is ready to assist you.

A-dec believes that service should be as reliable as the equipment it produces. From initial conversations to after-sales support, you'll experience the same commitment to quality, honesty, and integrity that has made A-dec a trusted name in dentistry for more than 60 years.

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