February 2026

Dentistry

More than 1 in 4 present with active caries[1-4]

Are you aware of your patients' caries risk factors?

Anna, 61

Exposed roots

Mason, 6

Frequent snacking

Josh, 15

Orthodontic appliances

Carole, 28

Prescription medications

Assess their caries risk, and consider prescribing high fluoride to increase caries control[5]

22,600 ppm Fluoride

0.619% Sodium Fluoride

1.1% Sodium Fluoride

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*Colgate® Duraphat® 5000 fluoride toothpaste for patients 16 years of age and over at increased caries risk. †Colgate® Duraphat® 2800 ppm high fluoride toothpaste for patients 10 years of age and over at increased caries risk ^YouGov Omnibus for Colgate® UK, data on file June 2015. Claim applies only to the Colgate® brand. **References: 1.** Oral Health Survey of Adults attending dental practices, 2018. Public Health England, published 2020. **2.**National Dental Epidemiology Programme for England, Oral health survey of 3-year-old children 2020: a report on the prevalence and severity of dental decay, Public Health England. **3.** National Dental Epidemiology Programme for England, Oral health survey of 5-year-olds 2022, Office for Health Improvement & Disparities. **4.** Child Dental Health Survey 2013, England, Wales and Northern Ireland National statistics, published 2015. **5.** Tavss et al. Am J Dent 2003;16(6):369-374.

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

Name of the medicinal product: Duraphat® 2800 ppm Fluoride Toothpaste. **Active ingredient:** Sodium Fluoride 0.619 %w/w (2800 ppm F-). **Indications:** For the prevention and treatment of dental caries (coronal and root) in adults and children 10 years of age and over. **Dosage and administration:** Adults and children 10 years of age and over: Use daily instead of normal toothpaste. Apply a 1cm line of paste across the head of a toothbrush and brush the teeth thoroughly for one minute morning and evening. Spit out after use; for best results do not drink or rinse for 30 minutes. **Contraindications:** Individuals with known sensitivities should consult their dentist before using. Not to be used in children under 10 years old. **Special warnings and precautions for use:** Not to be swallowed. **Undesirable effects:** When used as recommended there are no side effects. **Legal classification:** POM. **Marketing authorisation number:** PL00049/0039. **Marketing authorisation holder:** Colgate-Palmolive (U.K.) Limited, Goldsworth Place, 1 Forge End, Woking, Surrey, GU21 6DB. **Recommended retail price:** £5.10 (75ml tube). **Date of revision of text:** July 2024.

Name of the medicinal product: Duraphat® 5000 ppm Fluoride Toothpaste. **Active ingredient:** Sodium Fluoride 1.1%w/w (5000 ppm F^-). 1g of toothpaste contains 5mg fluoride (as sodium fluoride), corresponding to 5000ppm fluoride. **Indications:** For the prevention of dental caries in adolescents and adults 16 years of age and over, particularly amongst patients at risk from multiple caries (coronal and/or root caries). **Dosage and administration:** Brush carefully on a daily basis applying a 2cm ribbon onto the toothbrush for each brushing. 3 times daily, after each meal. **Contraindications:** This medicinal product must not be used in cases of hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions for use:** An increased number of potential fluoride sources may lead to fluorosis. Before using fluoride medicines such as Duraphat, an assessment of overall fluoride intake (i.e. drinking water, fluoridated salt, other fluoride medicines - tablets, drops, gum or toothpaste) should be done. Fluoride tablets, drops, chewing gum, gels or varnishes and fluoridated water or salt should be avoided during use of Duraphat Toothpaste. When carrying out overall calculations of the recommended fluoride ion intake, which is 0.05mg/kg per day from all sources, not exceeding 1mg per day, allowance must be made for possible ingestion of toothpaste (each tube of Duraphat 500mg/100g Toothpaste contains 255mg of fluoride ions). This product contains Sodium Benzoate. Sodium Benzoate is a mild irritant to the skin, eyes and mucous membrane. **Undesirable effects:** Gastrointestinal disorders: Frequency not known (cannot be estimated from the available data): Burning oral sensation. Immune system disorders: Rare (≥ 1/10,000 to <1/1,000): Hypersensitivity reactions. **Legal classification:** POM. **Marketing authorisation number:** PL00049/0050. **Marketing authorisation holder:** Colgate-Palmolive (U.K.) Limited, Goldsworth Place, 1 Forge End, Woking, Surrey, GU21 6DB. **Recommended retail price:** £7.99 (51g tube). **Date of revision of text:** July 2024.

February 2026

Dentistry

NHS DENTISTS TO DELIVER MINIMUM LEVEL OF URGENT CARE

NHS dental contract holders will have to deliver 8.2% of their contract value as urgent or unscheduled activity in 2026/27, the government has confirmed.

Announced on 22 January, the change means that NHS dentists will need to provide 11 urgent or unscheduled care treatment courses per £10,000 of contract value.

For example, 33 urgent courses of treatment would be required for a contract worth £30,000. At the increased remuneration level of £75 per unscheduled course of treatment, this would result in a payment of £2,475.

The government said the new measure would 'support wide geographical access to and more equitable distribution of unscheduled care capacity across practices'.

'The wrong approach'

However, the British Dental Association (BDA) said forcing practices to deliver a minimum amount of urgent care was 'wrong in principle'.

The association highlighted that practices could face financial penalties when not meeting urgent care targets because local demand does not exist.

Shiv Pabary, chair of the BDA General Dental Practice Committee, said: 'Mandating a minimum level of urgent care on practices is overreach. By their very nature these treatments are demand-led. Your dentist has no control over when the next patient breaks a tooth or develops an abscess, and if demand isn't there, they could pay the price.

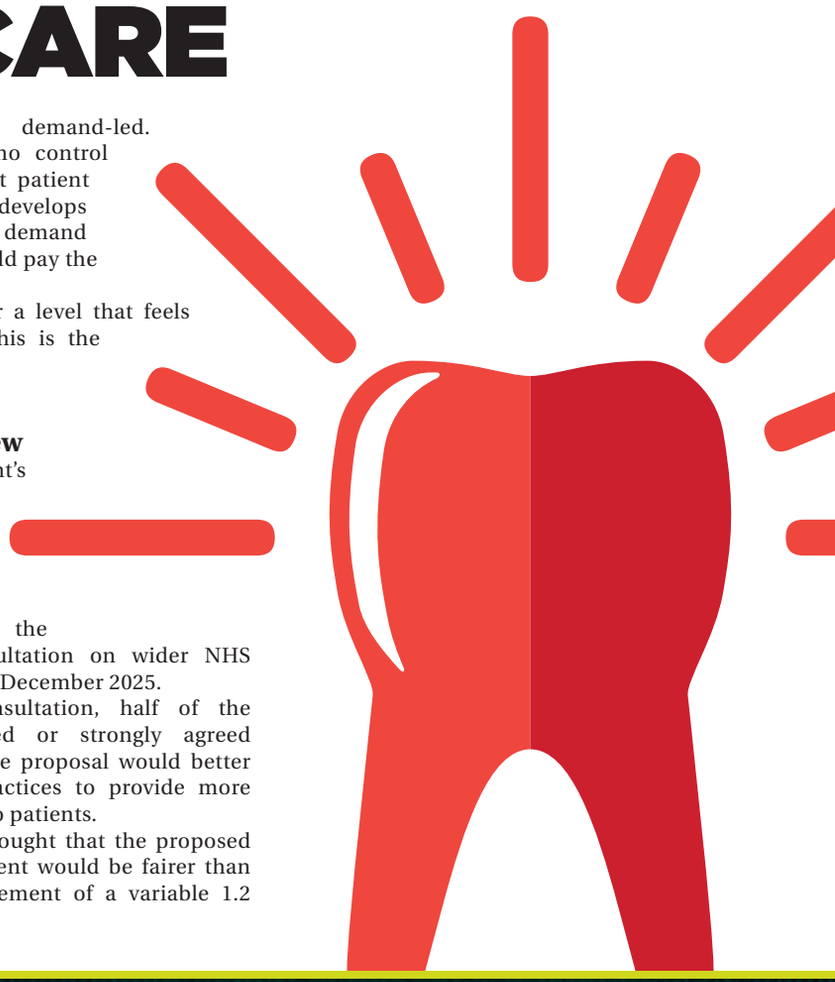
'We've fought for a level that feels manageable, but this is the wrong approach.'

The dental profession's view

The government's confirmation of the minimum urgent care threshold follows its announcement of the results of a consultation on wider NHS contract reforms in December 2025.

During the consultation, half of the respondents agreed or strongly agreed that the urgent care proposal would better support dental practices to provide more unscheduled care to patients.

A further 68% thought that the proposed payment arrangement would be fairer than the current arrangement of a variable 1.2 UDA value.



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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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Best intentions and imperfect fits

Guy Hiscott
Editor's view

Read it and weep, all you naysayers. The NHS dental reform train is well and truly rolling, and I challenge even the most staunch critic to argue otherwise… although whether you like where it's heading may be another thing entirely.

The latest move, to formalise urgent and unscheduled care within the NHS dental contract, is another step forward in what's fast becoming a tradition of this administration. It's steady, measured change.

As intentions go, it's hard to argue with. A system that responds more reliably to patients in acute need? Fewer headlines about DIY dentistry and self-inflicted extractions (hopefully)? Sign me up.

But you know what they say about good intentions (and even the best of them don't always translate into easy delivery).

Because it's easy to parcel up in a contract, but urgent care is a lot messier when it presents in practice. Unexpected needs and patients in pain, colliding with diaries and teams already stretched thin – it doesn't always make for plain sailing. So, for a lot of practices, I suspect this feels less like a philosophical victory and more like another plate to spin.

Mandating it into the contract is tricky. Emergency care is, by definition, demand-led. You can plan capacity for it, you can build systems around it, but you can't click your fingers and have it appear on demand. Which begs the question: should practices be penalised if the emergencies simply do not walk through their doors?

As ever, it's a question of location. High-need urban sprawls might see urgent cases every day. Coastal communities or rural regions with limited access to care might see their fair share – albeit less regularly. But practices serving more stable, affluent or better-served populations might find an uphill battle on their hands through no fault of their own. The dental needs of the UK aren't uniform – so why should the benchmark for urgent care be?

With that said, there's genuine opportunity here too, for those open to it. Some practices are already structured to accommodate urgent care more comfortably. For them, formal recognition and clearer remuneration is an easy win.

But consider too more imaginative local working. Stronger links with GP surgeries, pharmacies, care homes and community health services could help practices position themselves as part of a broader front line for urgent care, rather than a standalone endpoint. In the right hands, this new wrinkle to the contract can tee up the sort of collaboration with wider healthcare that benefits everyone.

As ever, the challenge is the use of a blunt instrument to tackle local problems – it's the nettle that the national contract has failed to grasp for 20 years. It's not a new tension. In many ways, making peace with it has been the compromise at the heart of modern NHS dentistry since the old 'new' contract was first introduced.

The urgent care question is another step along that same path: an attempt to standardise access in a system built on local delivery. It will help some practices, challenge others, and inevitably fall short of fitting everyone perfectly.

Perhaps the real test of this ongoing reform is not whether it removes those imperfections, but manages to keep moving forward in spite of them – only time will tell.

Government dentistry underspend falls by 91%

Unused government budget for NHS dentistry has fallen from £392 million in 2023/24 to just £36 million, the care minister has announced.

Minister of state for care Stephen Kinnock told parliament on 13 January that underspending on NHS dentistry had dramatically reduced in the past year.

The large underspend in dentistry has previously been cited as evidence of ample funding available for NHS dentistry. However, the British Dental Association (BDA) said it was likely due to practices being unable to fill vacancies or commit to delivering NHS appointments at a loss. The association stressed that the reduction in unused budget means there are 'now no excuses for government not to invest in easing the access crisis'.

Shiv Pabary, chair of the BDA General Dental Practice Committee, said: 'Ministers have used the vast underspends in NHS dentistry as an excuse not to invest. Underspends have now all but vanished, yet we still have an access crisis. We have practices delivering NHS care at a loss. Without sustainable funding there is no way to restore care to millions.'

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900 dentists removed from GDC register

The number of dentists removed from the General Dental Council (GDC) register increased to 900 this year, up from 793 in 2025. Despite this, the overall number of registered dentists after removals stood at more than 47,000. This was a 3% increase on the previous year's figure of 45,580.

Removal from the register might be due to voluntary removal, non-payment of the annual retention fee (ARF), retirement or notifications of death.

The GDC released data on the number of registered dentists on 19 January following the annual renewal period.

The registration numbers have increased continually over the years. For the past five years, the number of registered dentists and the percentage increase has been as follows:

- 2025: 47,022 (+3.2%)
- 2025: 45,580 (+3.1%)
- 2024: 44,209 (+2.5%)
- 2023: 43,130 (+2.2%)
- 2022: 42,215 (+0.8%).

'A useful benchmark'

The GDC said: 'The figures provide a useful benchmark for the total number of dentists registered in the UK, and while we recognise there are important issues of concern, including access to NHS dental services, it is important to note that the renewal data does not provide insight into the number of professionals working in different settings or the hours they work.

'However, we have again gathered working patterns data on dentists including the type of work they do, the number of hours they work, and whether they are working in the NHS or privately, which we intend to publish later in Q1 once the analysis has been completed.

'We expect that the working patterns data will provide further insights to inform workforce discussions and planning.'

The regulator also acknowledged that the annual retention fee has been increased for 2026, having remained the same since 2024. It said this reflects its 'ongoing commitment to maintaining professional standards while ensuring financial sustainability'.

The ARF now stands at £698 for dentists and £108 for dental care professionals (DCPs).

New synthetic sweetener is 'as sweet as sugar without dental harm'

A rare natural sweetener that 'delivers the taste of sugar without its drawbacks' has been synthetically reproduced by researchers.

Tagatose is a sugar that occurs naturally in dairy products, but in very small amounts compared to others such as glucose, fructose and sucrose. It is produced when lactose is broken down by heat or enzymes, such as when making yoghurt, cheese or kefir. Tagatose is 92% as sweet as table sugar with 60% fewer calories.

Instead of fuelling the growth of cavity-causing bacteria similarly to sucrose, tagatose has been found to reduce bacterial growth. Evidence has also suggested that it may have probiotic properties, helping to support a healthy microbiome.

Bacteria as 'tiny sweetener factories'

As tagatose accounts for just 0.2% of naturally occurring sugars, it is usually manufactured rather than extracted. Established processes for synthesising the sweetener were described as 'inefficient and expensive' by researcher Nik Nair, associate professor of chemical and biological engineering at Tufts.

He continued: 'We developed a way to produce tagatose by engineering the bacteria Escherichia coli to work as tiny factories, loaded with the right enzymes to process abundant amounts of glucose into tagatose. This is much more economically feasible than our previous approach, which used less abundant and expensive galactose to make tagatose.'

The yield of tagatose from this process is up to 95% compared to the 40-77% that is typical of conventional manufacturing.

In addition to reproducing the sweet taste of table sugar, tagatose adds a similar bulk texture in cooking. It also lacks some of the other major health drawbacks of sucrose, such as heightened risk for obesity, insulin resistance and diabetes.

As tagatose is only partially absorbed in the small intestine, its impact on blood glucose and insulin is greatly reduced compared to conventional sugar.

Clinical negligence found to cost the government £3.6 billion a year

A lack of 'any meaningful action' on clinical negligence has allowed its cost to the government to soar to £3.6 billion, according to a new report by the Public Accounts Committee (PAC).

Released on 30 January, the report criticises the Department of Health and Social Care (DHSC) and NHS England for failure to act on 24 years of warnings. This is despite four PAC reports on the rising impact of clinical negligence that have been released since 2002.

The report estimated that the government's liability for clinical negligence has quadrupled in real terms since 2006/7. The PAC called for the following measures to be implemented within two months of the report's release:

- A national system for sharing data between NHS trusts
- An operational plan from the government to tackle clinical negligence
- A national framework for improving patient safety with clear annual improvement targets.

'Profound suffering'

PAC chair Sir Geoffrey Clifton-Brown said: 'Clinical negligence is the second largest financial liability across government, but represents to our committee a different matter entirely from other large items like nuclear decommissioning or pensions.

'This is a swelling accounting of profound suffering. Each case can represent unspeakable devastation for the victims involved, and the overall picture is of a system struggling to keep its patients safe from avoidable harm.

'Indeed, the rising costs of such claims are diverting resources away from frontline care badly in need of them. That is why it feels impossible to accept that, despite two decades' worth of warnings, we still appear to be worlds away from government or NHS engaging with the underlying causes of this issue.'

He concluded: 'Government must move at pace towards a less adversarial system, reducing costs and ensuring that claims are paid more quickly for the benefit of families involved.

'Whatever happens next, government has been in unacceptable stasis on the issue of clinical negligence for the majority of my political life, as numbers have continued to creep up.'

Care leavers to receive extended access to free NHS dentistry

Care leavers will now receive free NHS dental care, prescriptions and eye care up to the age of 25 as part of a new package of government changes.

The government said care leavers often lack support after the age of 18, leaving them 'isolated, separated from their families or siblings, and struggling to get going as young adults'. The new measures aim to reduce the inequalities and barriers to opportunity this causes.

For example, the government found that many adults leaving care face barriers to accessing health services, with one quarter not told how to get health support, including registering with a dentist.

It also said that care leavers have a higher risk of mental health issues such as depression, anxiety and PTSD, and a higher chance of homelessness and unemployment.

'Break down those barriers to stop care leavers being held back'

In addition to extended access to free health services, care leavers will receive additional career support linked to the NHS. This will include a pilot scheme to trial paid internships for care leavers and a guaranteed interview scheme for NHS roles.

Health and social care secretary Wes Streeting said: 'Those in care face the toughest start in life and as a result suffer from a barrage of health inequalities, hampering their chances of going on to lead a happy, successful and fulfilling life.

'I'm proud that this government and the work Josh MacAlister did in my department will help break down those barriers to stop care leavers being held back.

'I am determined to give all children the best start in life, and this boost to healthcare and career opportunities for care leavers is a concrete step towards that goal.'

Entitlement versus access

Dr Nigel Carter, chief executive of the Oral Health Foundation, said: 'This is about dignity as much as dentistry. Extending free dental care to 25 is a hugely positive step for young people leaving care, many of whom have grown up facing real barriers to accessing dental services at a critical time in their lives.

'It removes a barrier that never should have existed and recognises the heightened risk of poor oral health among care leavers. The priority now is making sure this commitment translates into real access on the ground, so every eligible young person can actually secure the care they need as they build independent lives.'

The British Dental Association (BDA) also 'strongly supported' the move to extend the cutoff for free dental care for care leavers. However, it said this would be an 'empty gesture' without action to improve access to NHS dental services.

The association made a comparison to those who are pregnant, who are currently entitled to free dental care but often struggle to access NHS dentistry nonetheless due to a lack of available appointments.

BDA chair Eddie Crouch said: 'Extending exemptions to young people leaving the care system makes perfect sense.

'Charges remain a tangible barrier to vulnerable patients, encouraging millions to delay or avoid care. But to ensure this isn't an empty gesture government must ensure they can actually get an appointment.'

For the latest dental news, visit **dentistry.co.uk**.

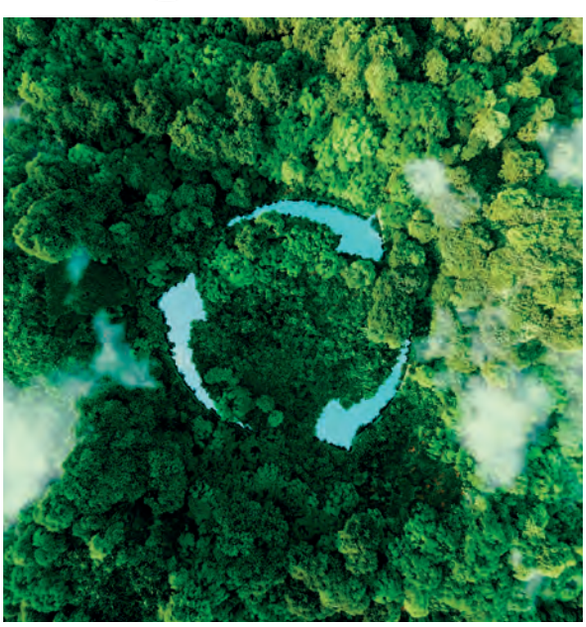
New recycling scheme introduced to target dental aligner waste

A new recycling programme has been launched to address dental aligner waste within the orthodontic sector.

In partnership with recycling specialist Terracycle, the Angel Aligner Recycling Programme offers dental practices a structured way to recycle used aligners that would otherwise be sent to landfill.

An estimated 25 million aligners are disposed of each year, largely because their multi-layered plastic composition prevents recycling through standard kerbside schemes.

The new programme uses Terracycle's Zero Waste Box system, designed for collecting and processing hard-to-recycle materials. Through this approach, aligners are collected in practice and returned to Terracycle, where they are sorted, shredded and converted into recycled plastic pellets for use in new products.



Available directly from Angel Aligner, each Zero Waste Box costs £140 (taxes and shipping included) and holds approximately 2,500 aligners. Once full, the box is returned using a prepaid label and replaced as needed.

According to Angel Aligner, the initiative is intended to support more sustainable waste management practices in orthodontics.

Julien Tremblin, general manager of Terracycle Europe said: 'We are excited to partner with Angel Aligner to bring this turnkey recycling solution to the orthodontic industry. By offering an easily accessible and effective recycling solution for aligners, we are empowering orthodontic practices and patients alike to become active participants in building a more sustainable future.'

Patients are encouraged to return used aligners to participating practices to take part in the programme.

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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.** Araujo MWB, Charles CA, Weinstein RB, McGuire JA, Parikh-Das AM, Du Q, Zhang J, Berlin JA, Gunsolley JC. Meta-analysis of the effect of an essential oil-containing mouthrinse on gingivitis and plaque. J Am Dent Assoc. 2015;146(8):610-622. doi:10.1016/j.adaj.2015.02.011 **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/

North of England Dentistry Show: bold ideas and exclusive offers

This year's North of England Dentistry Show is fast approaching – here's why you can't afford to miss it

Are you ready to challenge old ideas, share what's working and explore what's next? Then this year's North of England Dentistry Show is the event for you!

Taking place on 13 February at Manchester's AO Arena, the show 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.

Set your alarm

The aim of this year's North of England Dentistry Show is to present one day where the clinical, business and tech sides of dentistry collide – not to sell, but to solve.

Registration opens at 9:30am – and it'll pay to get there early as there are several first come, first served opportunities to take advantage of. Head to the exhibitor stands ahead of the sessions to check out all the early bird offers, while stocks last, including:

- Enlighten whitening kits. The first 300 visitors to the Enlighten stand can pick up a free whitening kit
- Suri electric toothbrushes. The first 350 visitors to the Suri stand will receive a free electric toothbrush
- Colgate Sensitive goody bags. Visitors to the Colgate stand can register for the new Colgate Professional Oral Health Hub and collect an exclusive goody bag!

The future won't be built on polite lectures or polished sales pitches. It needs bold ideas, open debate, and fearless voices. And across three stages, the North of England Dentistry Show is set to rewrite the rulebook. Here's what visitors can expect on each of the stages.

Clinical Horizons Stage

- Dentistry in 2030 – cracking the code of digital – Robbie Hughes and Jameel Gardee
- No half smiles: the future of comprehensive and ethical dentistry – Miguel Stanley
- Where did it all go wrong? Digital workflows for dentistry – Ian Buckle. – Iae.

Future Health Stage

- A new dawn for diagnostics – James Goolnik, Naz Kazemiga, Muy-Teck Teh and Victoria Sampson
- No half smiles: the future of comprehensive and ethical dentistry (live streamed) – Miguel Stanley
- The new frontier of prevention – Avi Banerjee, Cat Edney, Ben Atkins and Jason Wong.

Progressive Practice Stage

- Harnessing AI and technology to empower dental practice – Jin Vaghela and Kish Patel
- No half smiles: the future of comprehensive and ethical dentistry (live streamed) – Miguel Stanley
- Driving practice efficiencies and better outcomes through technology – Martina Hodgson.

An experiential event

In addition to the unmissable discussions taking place, attendees can:

- See live 3D printing in action with Sprintray in a dedicated restorative revolution theatre
- Get hands-on with AI tools shaping real clinical workflows, powered by Pearl, Inc
- Take a mindful break in Bupa's calm, tranquil space where you can go to relax and recharge
- Join the Weekend Warm Up – from 4-6pm, enjoy relaxed networking with back-to-back DJ sets and complimentary drinks
- Tune in to the hottest topics in dentistry with our live podcast sessions being held on the day. D

Visit www.dentistry.co.uk/noe to register your free place and be part of the conversation that goes off script.

Take on the NOE Scan Challenge

If you needed one more reason to attend this year's North of England Dentistry Show in February, here it is!

The NOE Scan Challenge* gives you the chance to win over £10,000 worth of prizes – curated into one practice growth hamper designed to genuinely move the needle for your practice. As you make your way around the exhibition, visit participating exhibitors, complete the activation, and scan the codes. Every completed stop boosts your chances of winning!

From cutting-edge scanners and digital tech to lab credit, training and tools, this isn't one prize. It's a bundle built for how modern practices grow.

What's inside?

The combined value of the prize is more than £10,000. It currently includes:

- A 3D dental printer, courtesy of Shining 3D
- Ariana Grande concert tickets, courtesy of Denplan
- An intraoral scanner, courtesy of Dandy
- £500 lab credit and free Avant Garde training.

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N.O.E. Dentistry SHOW 2026

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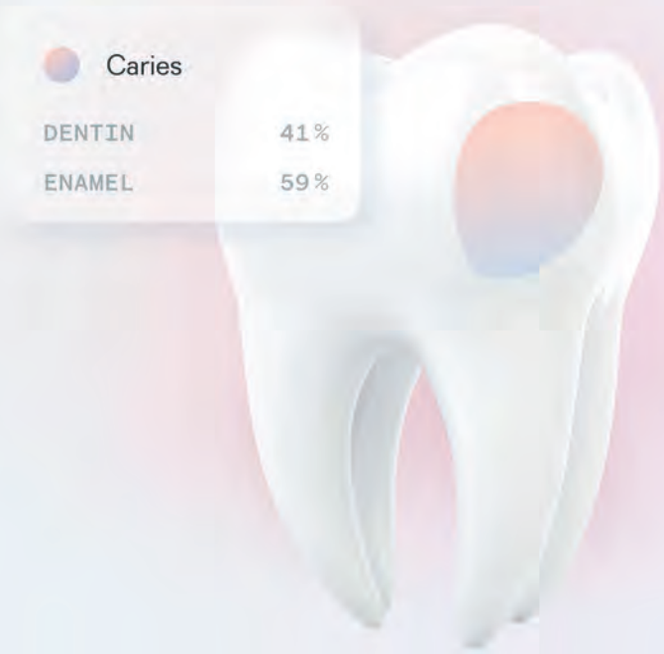

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Dr. Kunal Rai, Dentist

Dental industry movers and shakers revealed

Announcing the winners of the 2025 Dental Industry Awards

The Dental Industry Awards shine a light on the UK dental industry, recognising the achievements, projects and the high quality of work the companies, teams and individuals are dedicated to delivering to the profession.

The 2025 Dental Industry Awards took place on 11 December at Wembley Stadium in London and celebrated the very best in the dental industry.

Presenting the 2025 Dental Industry Award winners and highly commended.

Advertisement of the Year
Winner: The Orthodontic Clinic – Can't resist a perfect smile?
Highly commended: Boutique Whitening – We don't care. Just Smile
Highly commended: Kana Health Group – Go to Directory

App of the Year
Winner: Jawspace
Highly commended: Damira Dental Studios

Excellent use of PR
Winner: Association of Dental Groups
Highly commended: Tooth Club

Website of the Year
Winner: Breathe Dental Wellness
Highly commended: Damira Dental Studios
Highly commended: Mydentist

Excellent use of Social Media
Winner: Suri
Highly commended: Tooth Club

Corporate Social Responsibility
Winner: Connect My Marketing

Dental Practice Corporate Group
Winner: Bupa Dental Care
Highly commended: Kana Health Group

Servicing and Repair Company
Winner: Hague Dental Supplies
Highly commended: Dental Directory

Dental Industry Employee of the Year
Winner: Ben Fryer – The Dental Team Group
Highly commended: Jesse Frost – Kana Health Group
Highly commended: Jane Walker – Community Dental Services

Business Leader of the Year
Dental Industry Company
Winner: Ezgi Demir – Solventum
Highly commended: Cally Walker – Connect My Marketing
Highly commended: Sandeep Kumar – Mismile

Dental Practice Corporate Group
Winner: Lisa McKinnon – Todays Dental
Highly commended: Kunal Thakker – Tooth Club

Sustainable Business Award
Winner: Suri
Highly commended: Treeline Dental Group

Customer Service Provider of the Year – fewer than 25 employees
Winner: Connect My Marketing
Highly commended: Zima Dental

Customer Service Provider of the Year – more than 25 employees
Winner: Hague Dental Supplies
Highly commended: Bupa Dental Care

UK Exporter of the Year
Winner: Boutique Whitening
Highly commended: Kemdent

Dental Brand of the Year
Dental Industry Company – fewer than 25 employees
Winner: Suri
Highly commended: Icy Bear Dental Care
Highly commended: Sonic Dental

Dental Industry Company – more than 25 employees
Winner: Practice Plan

Dental Practice Corporate Group
Winner: Damira Dental Studios
Highly commended: Kana Health Group

Dental Industry Event of the Year
Dental Industry Company
Winner: Invisalign Live 2025 Align Technology
Highly commended: Dentorama 2024 – The Story Behind the Worst Dental Team Ever
Highly commended: We are Next – The Mismile Network Annual Conference and Charity Gala Dinner

Dental Practice Corporate Group
Winner: Bupa Dental Care's Dental Health is… Live

Funder of the Year
Winner: Performance Finance
Highly commended: Christie Finance

New Product/Service Launch of the Year – fewer than 25 employees
Winner: Breathe Dental Wellness
Highly commended: Natch

New Product/Service Launch of the Year – more than 25 employees
Winner: SDI Stela: Next Generation Self-Cure Composite
Highly commended: Solventum Clinpro Clear Fluoride

Product/Service of the Year
Winner: The Dental Pod by Zima Dental
Highly commended: Sonic Pro Ultrasonic + UV-C Cleaner

Marketing Campaign of the Year
Winner: Damira Dental Studios – The Summer Whitening Campaign
Highly commended: 3Shape – Product Marketing & Global Events
Highly commended: Tooth Club – Summer Campaign

Short-Term Postgraduate Course of the Year
Winner: The Modern Therapist – Anterior and Posterior Composites
Highly commended: Smile Dental Academy – PG Diploma Restorative and Aesthetic Dentistry

Team of the Year
Dental Industry Company
Winner: Smile Dental Academy
Highly commended: Mismile

Dental Corporate Group
Winner: Love Teeth Dental
Highly commended: Smile Dental Care
Highly commended: The Dental Team Group

Outstanding Business of the Year
Dental Industry Company
Winner: Boutique Whitening
Highly commended: Zima Dental

Dental Practice Corporate Group
Winner: Tooth Club
Highly commended: Bright Orthodontics. D

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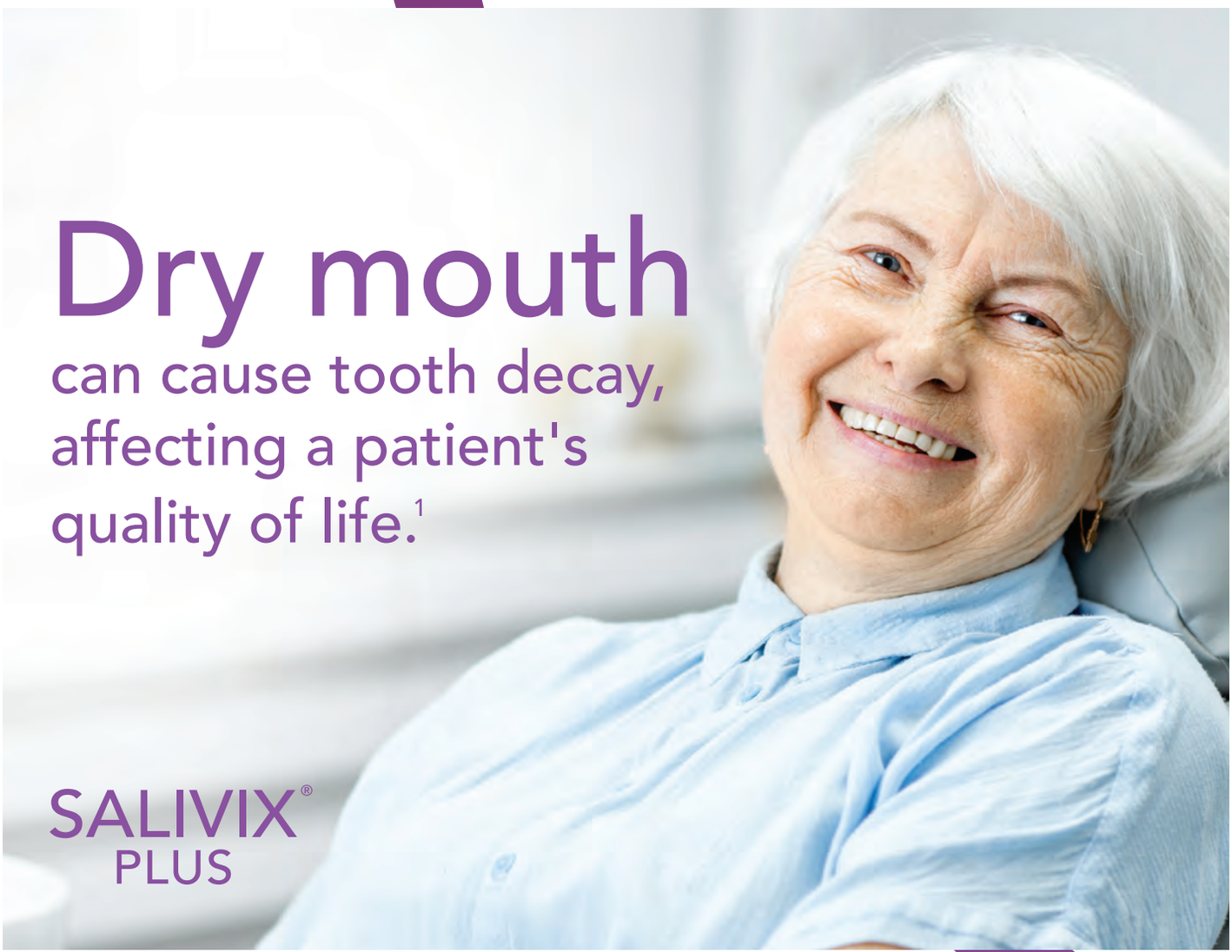

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Date of preparation: January 2026
MAT-SALX-UK-000260

GALEN

Hopes and wishes for dentistry in 2026

The ideal of a community of dental professionals has never felt more important, argues John Makin

It's frustrating that many of the things that I want to see happen in 2026 are echoes of last year. I won't be alone in that but I'm optimistic that we aren't set for a 'groundhog year' and will see progress in several policy areas.

The government has acknowledged that the system is broken and introduced some intermediate fixes last year while negotiations continue. However, measures like tweaks to bands, mandating unscheduled care and increasing intervals between check-ups still fall short of the wholesale reform that the BDA wants to see.

Historically, the DDU has not commented on contractual matters, but the current system has dentolegal implications, affecting professional wellbeing and helping to drive up patient complaints.

John Makin
Head of the DDU

We want to see fair remuneration and relieve the pressure on our members and, at the same time, we want to preserve what is of value.

Family dental practices have always given their patients a feeling of continuity, familiarity and confidence. It would be a shame if the government's plans for dentistry, not least the introduction of Neighbourhood Health Centres, undermined this and we will continue to champion family dentistry's place at the heart of the service.

Fresh movement

We're hopeful that the government will consult on clinical negligence reform once it has had the chance to study David Lock KC's advice on the rising legal costs of clinical negligence claims. It is also under pressure from the Public Accounts Committee (PAC), which is currently looking into the issue.

The DDU would particularly welcome the revival of plans to limit legal costs in clinical negligence claims and for this to be extended to claims valued up to £250,000. This would have a material effect on dental claims where the payments to lawyers often exceed the level of compensation paid to patients.

Dentistry wasn't mentioned last May when the government announced it would modernise the legislative frameworks of three professional healthcare regulators in this parliament. This is disappointing because the General Dental Council (GDC) has some of the oldest governing legislation of any UK-wide healthcare professional regulators and its fitness to practise process is ripe for reform.

Even if there is no finding of fact against them or their practice is found not to be impaired, GDC investigations cause real emotional strain for dental professionals, many of whom find they have to put their careers and lives on hold for many months while the process unwinds.

While the fitness to practise process itself is not supposed to be punitive, the cumulative effect of all the pressure, tortuous delays and sometimes financial hardship is a punishing ordeal for those under scrutiny.

Solid commitments

The GDC is limited in what it can do without new legal powers, which is why we hope the government will commit to a timetable for reform this year. In the meantime, it has gone some way to acknowledging the 'climate of fear' surrounding fitness to practise with its new Corporate Strategy for 2026-28, which says it wants to 'explore less adversarial ways of handling and resolving concerns'.

In 2026, the GDC says it will develop options for closing cases earlier, launch enhanced wellbeing support services and review quality assurance processes.

This is a positive step and the DDU will respond constructively when the GDC sets out its proposals. We'd also like to see the GDC improve the timeliness of the fitness to practise process, particularly after the assessment stage. Its most recent statistical report showed that a decision was reached in just 4% of cases within the 13 working week target in Q4 2024 and the median time from case examiner decision to initial hearing in 2024 was 10 months and six days, overshooting the nine-month target.

With everything we know about the mental health toll of the fitness to practise process, it was disappointing to discover that registrants are the source of an increasing number of concerns raised with the GDC (now 9% compared with 6% in 2022), according to its statistical report.

Of course, there will be cases where dental professionals have no choice – maybe their colleague ignored the issue or presents a real risk to patient safety. But given the GDC is obliged to assess every report, we hope they wouldn't subject a fellow dental professional to months of uncertainty and stress in bad faith.

These 'blue on blue' attacks are counterproductive when professional isolation is an issue for many and the dental service has been in permacrisis for some time. That's why the final item on our wish list is for colleagues to look out for and support each other in 2026. The ideal of a community of dental professionals has never felt more important. D

NHS dental contract changes

Nigel Jones considers the implications of the changes to the NHS dental contract in both England and Wales

We are rapidly approaching the start of a new financial year, and many dentists in England and, particularly, Wales will be steeling themselves to wrap their heads around the latest minor/modest/major/futile (delete as appropriate) changes to their contractual arrangements with the NHS.

Of course, the devil will be in the detail and considering the consequences of the changes, intended and otherwise, will take time; time that will be in short supply given the lateness of the hour that said detail is being provided.

Some will find themselves staring at the same page blankly, feeling none the wiser and thinking that this isn't what they signed up for when they chose dentistry as a career. Which begs the question: what did you hope you were signing up for?

That's not as trite a question as it might at first sound. Many might say something like 'the opportunity to have a tangible, positive impact on people's lives and developing skills while being appropriately rewarded in a way that allows for the right blend of work and play'. Sounds plausible, sensible and laudable.

But what impact? Pain relief or improved self-confidence? Which people? The advantaged or disadvantaged? Which skills? Clinical, interpersonal or small print interpretation?

I realise that the above is an oversimplification of what should be a many faceted answer to the question. However, the point remains that now is a good moment to reflect on what drew you to dentistry in the first place and not to simply adapt, yet again, to the ever-rising temperature of the NHS waters (check out the boiling frog analogy if you are unsure about that reference!).

This isn't just a binary point about private dentistry being good and NHS dentistry being bad. Reducing oral health inequality will be a huge motivator for many involved in UK dentistry and the NHS has a vital role to play in achieving that aim. It follows therefore that, for some, it is vital to thoroughly understand those new contractual arrangements to avoid being unnecessarily constrained by a lack of confidence or inaccurate assumptions.

Emergency care

Of similar importance will be the need to think through the long-term implications of the changes. Take, for example, the priority being attached in England to ensuring the whole population has access to a dentist... in an emergency. To this observer, it feels that those last three words are increasingly politically important.

Compelling a practice with an NHS contract to dedicate an agreed proportion of time to strangers directed to it by NHS 111 might be entirely in keeping with the vision of the owners in respect of the active role they seek to play in the local community.

At the other end of the scale, knowing so many practices use private income to subsidise NHS care for pre-2006 selected patient groups, this could be akin to allowing a pop-up McDonalds in the middle of The Ivy.

If the intent behind the new care pathways in England is to reduce barriers for high needs patients, that is to be applauded, and some practices will undoubtedly benefit financially. However, the sense of robbing Peter's practice to pay Paul's is hard to escape given the unused dental budget for 24/25 fell to £36m and there will be no additional funding.

Nice to see you

The impact of the renewed focus on NICE guidelines in respect of recall intervals will be interesting. The appeal of creating additional capacity by eliminating unnecessary appointments is understandable although the maths may be more challenging in reality than in a spreadsheet.

In Wales, some practice owners have suggested it amounts to the creation of a core service by stealth as it disadvantages practices with a stable, regularly attending patient base with a higher average socioeconomic status. The result, they anticipate, will be more contracts being handed back.

Others are viewing the publicity and strengthened enforcement of NICE guidelines as an opportunity to persuade motivated patients to pay privately for additional appointments. That's unlikely to be a problem financially for the NHS, but what will it mean for clinical capacity?

Those private appointments are still occupying surgery time, and the shortage of FTE clinicians means extending opening hours is rarely an option.

Make a choice

With these contractual changes in England and Wales comes a lot to think about. There will undoubtedly be those who, by taking the time to get fully immersed in the details, will make the new-look NHS contracts work better for them than others. For some, this could also involve compromises to patient care or, more likely, to their personal health and wellbeing. However, such compromises may be viewed as a price worth paying in pursuit of that goal of reduced oral health inequality.

For others, too much energy has already been wasted on the intricacies of contract interpretation, the management of legal risks and skewing their personal career vision to fit with the requirements of the NHS.

The important thing to remember is that the current imbalance between the supply of clinical time and patient demand for dentistry means that, in most scenarios, dental professionals in England and Wales have choices and don't need to feel bounced into a decision.

As Jake Abel has said: 'No choice is the wrong choice as long as you make a choice. The only wrong choice is choosing not to make one.' D

Nigel Jones
Director, Practice Plan

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*Azeez, A. A., Sheri f, S., & Franca, R. (2021). Statistical estimation of wear in permanent teeth: a systematic review. Dentistry Review, 1(1), 100001.

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1.BOCOUTURE Summary of Product Characteristics. Merz Pharmaceuticals GmbH: https://www.medicines.org.uk/emc/product/600/smpc (Last accessed January 2026).

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The whitening shift

Chinwe Akuonu explores tooth whitening and presents a selection of cases that highlight the importance of taking the starting stage and expected outcomes into consideration

Chinwe Akuonu
General and cosmetic dentist

When my patients initiate a conversation about how they have proudly cut down their coffee or tea consumption and that they brush and floss more regularly, I can't help smiling.

We all know how challenging it is to gain patients' trust and encourage them to take control of their oral hygiene. So, when something clicks and you sense they are fully on board with your recommendations, it gives you quite a buzz.

I have found that some of my most motivated patients are the ones who have had tooth whitening. These individuals not only seem to come and see me more regularly, they also demonstrate greater engagement with lots of questions about maintaining their improved oral health.

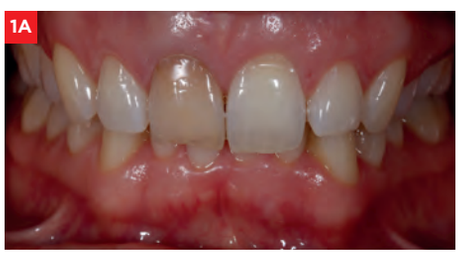
In my practice, tooth whitening is now requested by an increasing number of people across all ages and socio-economic backgrounds. I find that if a patient had been putting off going to the dentist, whitening seems to break that barrier for them. The fact that there is a minimally invasive, visible transformation within a couple of weeks is, without a doubt, a huge motivator.

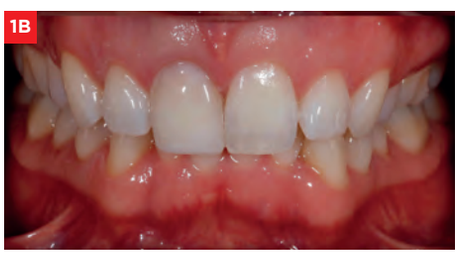
Business and education

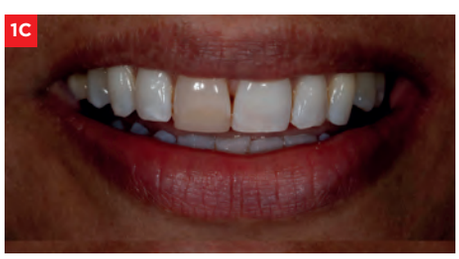
For me, the business of tooth whitening provides a great opportunity to showcase our expertise treatments and build rapport with patients. It empowers teams and improves patient communication.

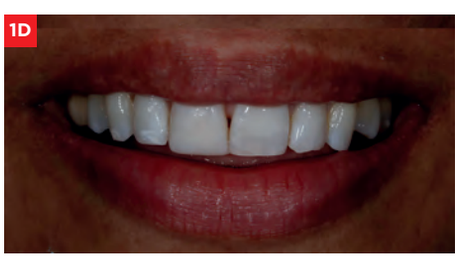
We have also seen many of our patients consider more complex restorative treatments after undergoing whitening. There are so many positives both for patients and the practice.

During my patient consultations prior to whitening, education plays an important role.

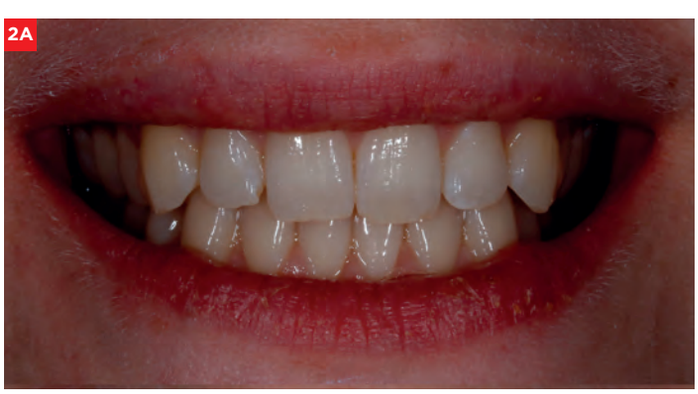


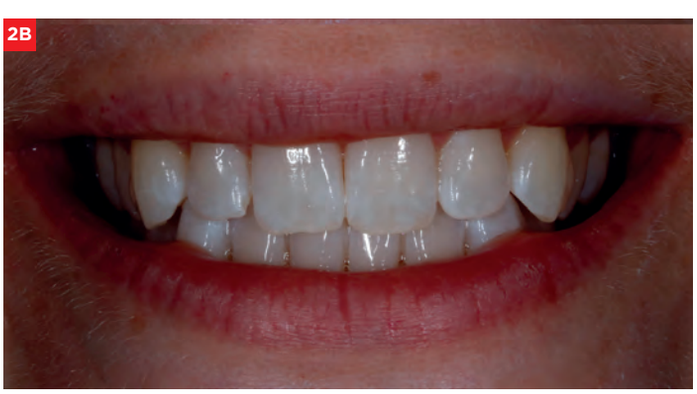


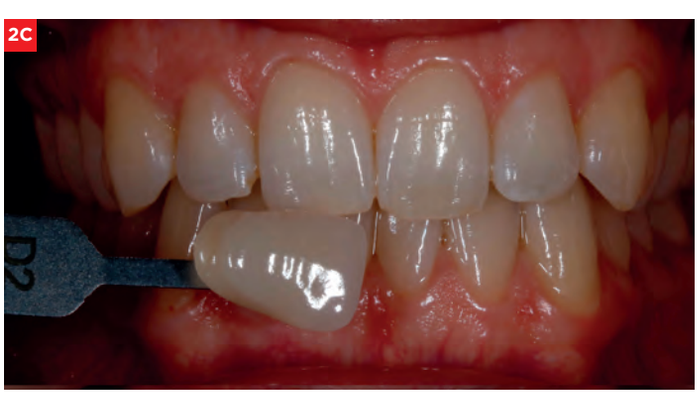


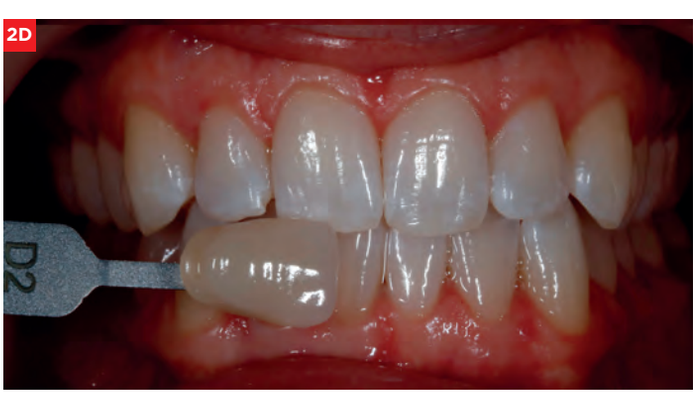


Figures 1a-1d: This patient presented dark upper right teeth. Previous non-professional methods (including whitening toothpaste) proved unsuccessful. Following internal and external tooth whitening, achieved after three weeks, the patient was happy with their results

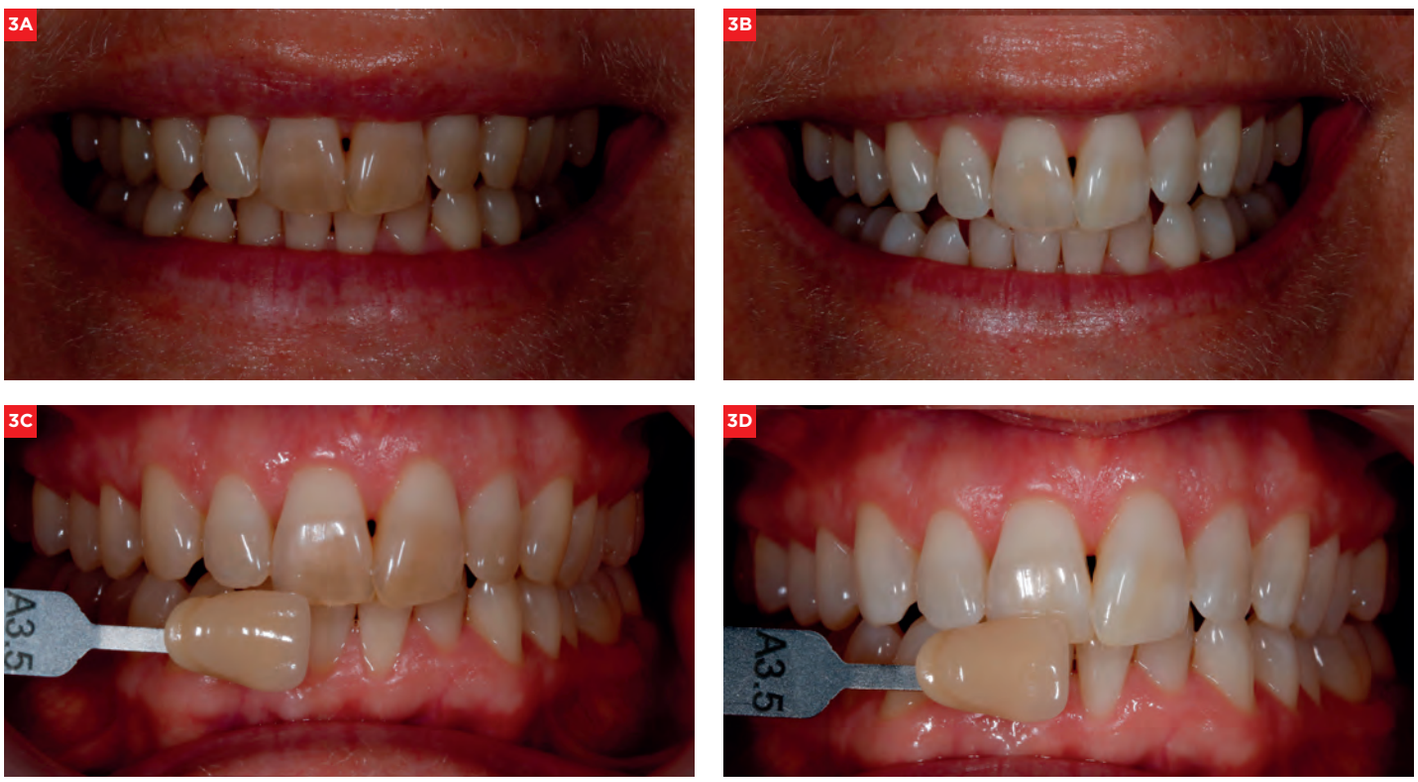




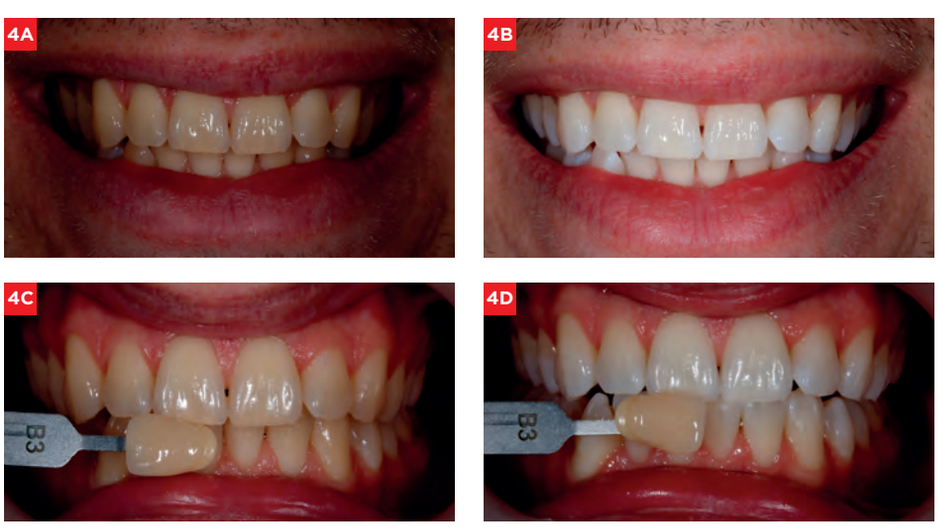




Figures 2a-2d: In this case, whitening after four weeks showed minimal improvement. We had pre-empted the issue and the patient was therefore comfortable whitening her teeth for longer. She has been happy with the results, reinforcing that managing patients' expectations is key to success in whitening cases



Figures 3a-3d: This patient presented some discolouration of the teeth showing as a light banding. Surprisingly, the patient assured us that she had not taken any antibiotics that would have been the cause of this. In this case, the recommended length of the whitening treatment was eight weeks with more gel top up. The patient is happy with the initial results and is continuing with treatment



Figures 4a-4d: The results of this patient's whitening motivated him to have his teeth aligned. Whitening is also an integral part of larger treatment plans: I always recommend integrating whitening with other dental treatments

I explain the science of whitening and how it is essentially about changing the internal structure of the stain molecules; the difference between extrinsic and intrinsic staining; why thousands of products on the market are not only ineffective but can also be dangerous and cause further problems longer term.

Once we confirm their suitability for tooth whitening, I also explain the importance of compliance.

I explain that younger patients typically tend to have thicker and more porous enamel, and they may respond more rapidly to whitening. Older patients tend to have thinner enamel and more prominent dentine. This affects shade perception and sensitivity levels (and dictates the gel concentration and gel waiting times too).

Top whitening tips

One of my biggest recommendations is to arrange shade tabs according to value and not hue with the Vita shade guide. This way, it's easier to record a patient's shade when they come into the practice.

Stains to look out for are those caused by tetracycline, antibiotics, sclerosis or hypocalcification, as they may not respond well to whitening.

As for sensitivity, I tend to incorporate desensitising agents like fluoride varnish or desensitising toothpaste to provide additional relief and improve compliance, besides recommending limited tray wear time and lowering of the gel concentration.

Arrange shade tabs according to value and not hue with the shade guide

Certain teeth do not respond to whitening due to variations in the amount of enamel thickness, mineral composition and, sometimes, presence of microcracks. This is also important to bear in mind.

In addition, to successfully implement tooth whitening, practices need to select a brand they can trust. I personally chose Philips Zoom! and am very happy with the results I achieve, as well as the support provided by the company.

As Philips Zoom Whitening Gel contains amorphous calcium phosphate (ACP), the lustre of the teeth is improved and enhances the overall cosmetic result.

Sodium fluoride has also been added on to protect the enamel, while potassium nitrates reduce sensitivity. The combination of all these ingredients contributes to the total health of the tooth and the compliance of the patient.

The company also recently collaborated with a number of dental professionals (including myself) to put together a 'whitening playbook', which covers every aspect of tooth whitening and offers guidance on treatment protocols. D

Request the Philips Zoom whitening playbook at **bit.ly/3N8cWFt**.

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Boosting confidence with aligner support

In this complex orthodontic case, Sanaa Kader explains how collaboration gave her the confidence to plan predictably, manage refinements smoothly and grow her skills for future aligner cases

Dr Sanaa Kader
Principal dentist and owner, Indigo Dental

Treating with clear aligners is becoming increasingly common in general practice, but when it comes to more complex cases, many dentists hesitate. Uncertainty around staging, rotations or loss of tracking can make clinicians cautious about expanding their scope.

For me, guidance from Aligner Intelligence provided the reassurance I needed to manage a challenging crowding case while also building confidence for future treatments.

Significant crowding

My patient, a 26-year-old male, was unhappy with the appearance of his misaligned teeth and wanted a straighter, more balanced smile. Clinical records showed a class III skeletal pattern with a class I dental malocclusion. His overjet was 2mm, overbite 3mm, and his lower midline was shifted 2mm to the right.

No extractions were required, but there was clear mandibular crowding and several teeth flagged for rotation. The lower incisors were slightly retroclined, and the buccal corridors were narrow. Functionally, he had a mild deep bite, but his lips were competent and his oral hygiene excellent – both positive indicators for aligner success.

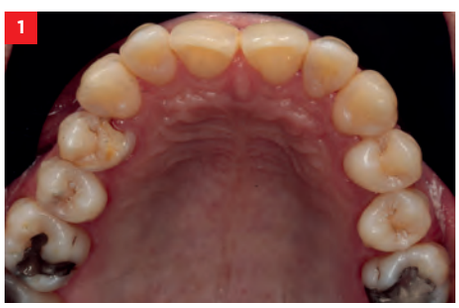
My treatment goals were to relieve crowding, align both arches, correct the overjet and improve the overall smile aesthetics. Once the teeth were aligned, I planned to complete whitening and composite edge bonding to refine the proportions of the anterior teeth.

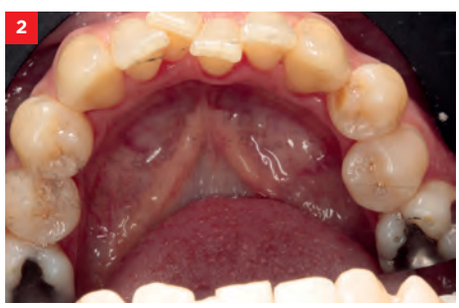
The case was more complex than the straightforward alignment cases I had managed before, which is why I chose to involve Aligner Intelligence.

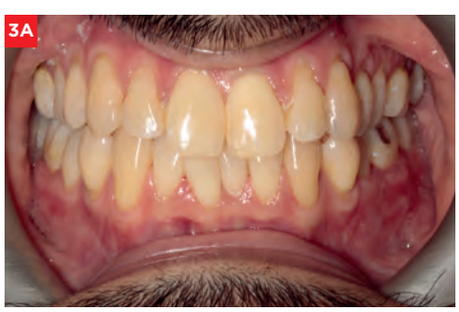
Planning with specialist input

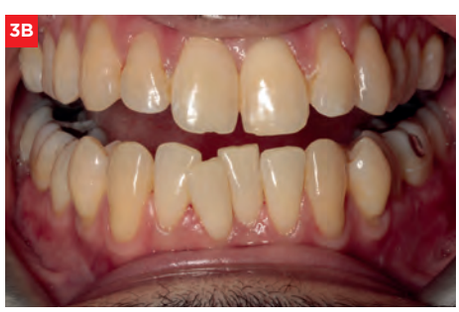
Working through the Clearcorrect portal, I gave Aligner Intelligence access to the patient's digital scans, photographs and clinical notes so that Dr Richard Jones, the specialist orthodontist allocated to my case, could review the details. Together, we discussed treatment aims and potential biomechanical challenges.

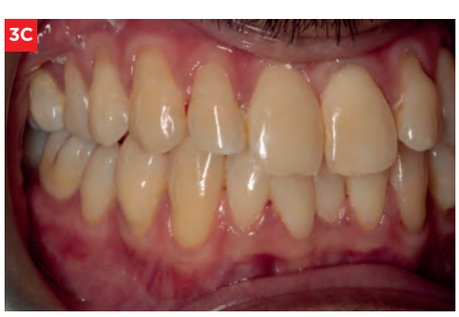
Dr Jones identified that crowding in the lower arch could be addressed conservatively through staged interproximal reduction (IPR) and buccal expansion of the upper arch to maintain arch coordination.

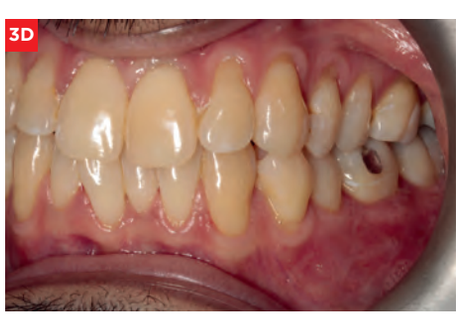












Figures 1-3: Pre-treatment intraoral images

We used Clearcorrect's virtual setup to visualise the sequence and refine the staging plan.

The key difference in this process was being guided by orthodontists who understand the biological and mechanical limitations of tooth movement from real clinical experience. That guidance gave me greater confidence when presenting the plan to the patient.

The treatment was designed as a full-arch correction with 45 aligners on a weekly wear schedule, using the 'unlimited' treatment option to allow for refinements. In total, the planned treatment time was just over 14 months.

Buccal expansion provided space in the upper arch, while 4.5mm of staged IPR was performed across the lower arch between contact points LL3 to LR3.

Anterior bite ramps were applied to the upper six anterior teeth to assist in intruding the lower incisors and correcting the overjet.

Engagers were placed on all teeth showing yellow and red rotation flags. Importantly, the plan incorporated overcorrection aligners, anticipating the natural tendency for relapse.

A smoother journey and fewer refinements

Active treatment began in April 2024. I instructed the patient to wear each aligner for seven days, ensuring at least 22 hours of daily wear. The patient was highly compliant, which made the journey straightforward.

At aligner six, I noted loss of tracking on UL2, which is common in cases with multiple rotations.

A revision was planned with additional anchorage engagers on the posterior ▶

teeth (UR6, UL6, LL6, LR6) to improve control. These small refinements were simple to manage, thanks to clear guidance from Dr Jones and his team.

Midway through the sequence, I observed that rotations were still slightly lagging, so we planned a second revision after aligner 25. This phase focused on detailing and improving incisor inclination.

The third and final revision, aligners 35 to 45, addressed a mild bilateral posterior open bite that developed as a result of the anterior intrusion.

By the end of treatment in June 2025, all movements had tracked well, with excellent arch coordination and symmetry. The occlusion was balanced, and the patient was thrilled with his new smile. For retention, we fitted bonded fixed retainers upper and lower, supported by Essix retainers worn full-time initially, tapering to night-time wear.

Even with these three revisions, the case felt much smoother than others I had planned alone. My mentor had anticipated potential issues such as anchorage loss and staged rotations, which helped avoid more extensive mid-treatment corrections. It also reduced chairside time and the number of rescans required.

Learning through mentoring

While the clinical support was invaluable, the most significant outcome of working with Aligner Intelligence for me was the mentoring experience.

The team doesn't simply produce a finished plan; it walks you through the reasoning behind each stage. Every suggested change from rotation sequencing to engager design came with a clear explanation of why.

This complex crowding case was my first collaboration with the organisation and it completely shaped how I now approach aligner treatment planning.

The team took the time to understand my background and level of experience, tailoring the discussion accordingly. The tone was collegial rather than prescriptive, and the advice felt practical and relevant. It never felt overwhelming – just supportive.

That mentoring element is what distinguishes Aligner Intelligence for me. Many planning services can provide a setup, but few teach you how to interpret the biomechanics, anticipate potential tracking issues or understand the limits of what aligners can achieve. Having an orthodontist walk you through those decisions gave me insight I now apply in every new case.

Reflection and discussion

Several lessons stand out from this case. Staged IPR was invaluable in creating space safely while maintaining contact tightness and enamel integrity. The use of bite ramps and overcorrection aligners helped prevent incomplete intrusion and relapse of the lower incisors, ensuring the deep bite was corrected predictably.

The collaboration also reinforced the importance of anchorage control. Adding posterior engagers early in the revision improved tracking and reduced the need for further refinements.

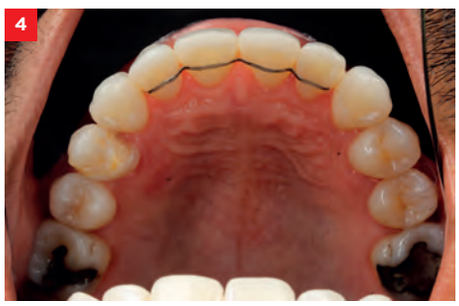
From a patient-management perspective, involving a specialist orthodontist increased trust and compliance, which greatly influenced the outcome.

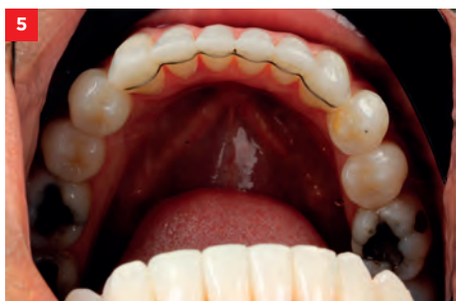
If I were to refine anything, I would have scheduled interim checks slightly earlier to identify tracking issues sooner. Overall, the treatment was predictable, the patient was delighted, and the mentored approach proved both educational and confidence building.

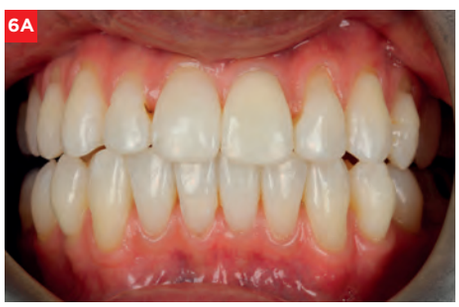
What's ahead?

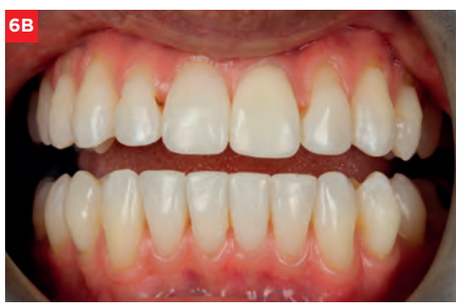
Since completing this case, I have continued to treat aligner patients independently. I still find value in returning to Aligner Intelligence for more demanding cases or when time is limited.

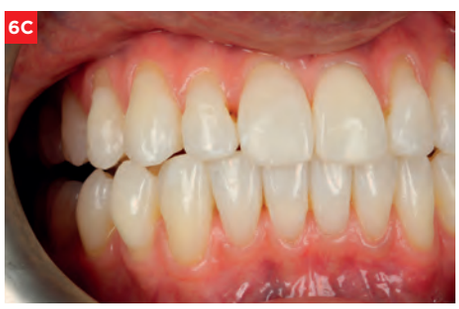
For clinicians balancing multiple practices or managing a growing aligner portfolio, having a service that combines treatment planning and mentorship can be a real asset.

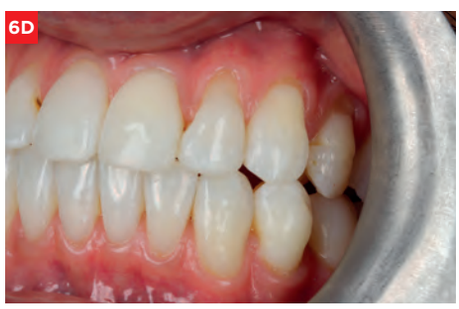












Knowing that the treatment plan is both achievable and evidence-based offers peace of mind for both practitioner and patient

Figures 4-7: Post-treatment intraoral images

The collaboration has made me more conscious of biomechanics and patient communication. It has also reaffirmed that high-quality aligner treatment is not just about straightening teeth, but about predictable, biologically sound movement that respects long-term stability.

Ultimately, the greatest benefit lies in achieving predictability for the patient while continuing to grow professionally as a clinician. Knowing that the treatment plan is both achievable and evidence-based offers peace of mind for both practitioner and patient.

For me, this case marked the start of a new level of confidence in aligner therapy, proof that with the right guidance, even complex cases can become manageable, rewarding and educational experiences. D

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Injection moulding restorations in the aesthetic zone

Dimitrios Spagopoulos discusses high-precision injection moulding restorations in the aesthetic zone

Dr Dimitrios Spagopoulos
Clinical instructor, School of Dentistry, University of Athens

Advancements in dental techniques often benefit from innovations across industries. Injection moulding – originally developed as an industrial process involving the injection of molten material into a mould to form precise components – has been successfully adapted in dentistry to facilitate accurate and minimally invasive restorative procedures.

This additive technique allows for accurate replication of natural tooth anatomy, making it especially valuable in conservative aesthetic dentistry.

The following case illustrates its clinical application in anterior rehabilitation.

Case report

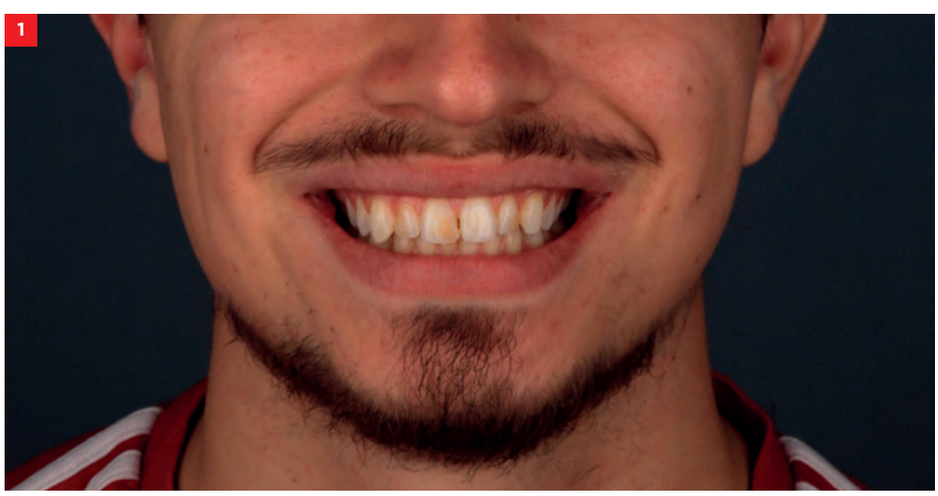
A 24-year-old male patient presented with concerns regarding the aesthetic appearance of the anterior dentition, specifically involving minor incisal wear and aged composite restorations on the central and lateral incisors (Figures 1 to 3).

Although orthodontic treatment was proposed, the patient declined. A minimally invasive strategy was prioritised to preserve tooth structure and ensure a conservative rehabilitation.

Following comprehensive clinical evaluation and consensus on the desired aesthetic outcome, the injection moulding technique was selected to facilitate a precise and predictable restoration of the natural dental anatomy.

An initial smile design and diagnostic wax-up were made to establish the desired aesthetic and functional outcome. First, a rigid bite registration vinyl polysiloxane (VPS) material (Shore A90 hardness) was applied to the palatal side of the wax-up, ensuring it did not extend beyond the incisal edges of the teeth.

The injection moulding technique was selected to facilitate a precise and predictable restoration of the natural dental anatomy



Figures 1-3: Initial situation, showing old, discoloured composite restoration in the upper front

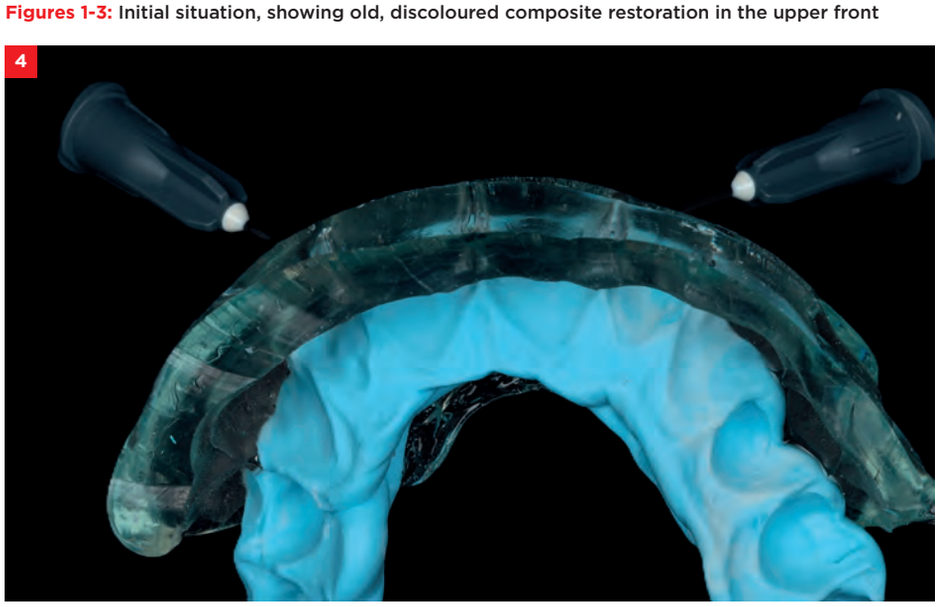


Figure 4: Mould for the injection. The palatal part was made of a vinyl polysiloxane (VPS) bite registration material with high rigidity (Shore A90), while the buccal part was made of clear VPS

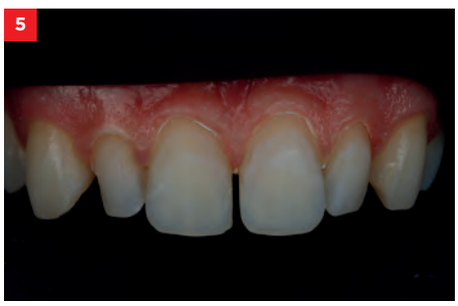


Figure 5: The old composite restorations were carefully removed

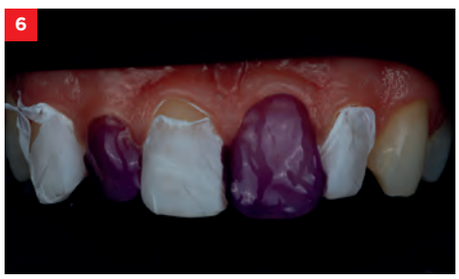


Figure 6: A split-dam isolation combined with Teflon tape was used prior to the start of the adhesive procedure with G2-Bond Universal

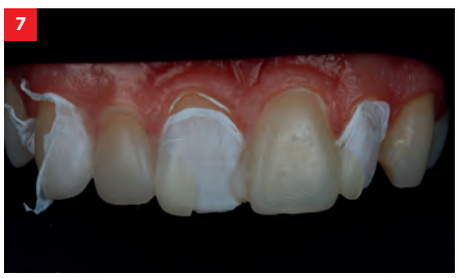


Figure 7: The composite (G-aenial Universal Injectable, A1 shade) excess after injection could be carefully removed with a number 12 blade

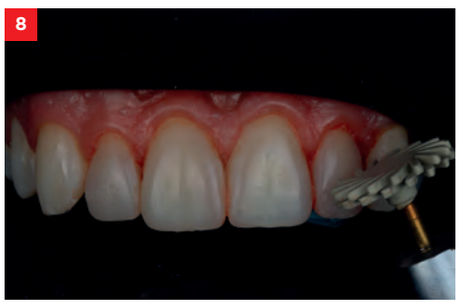
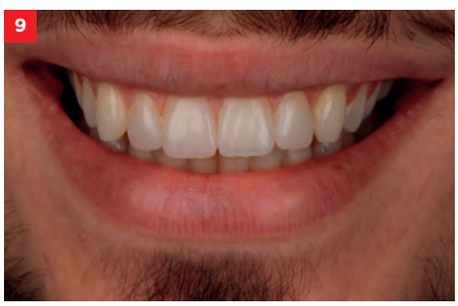
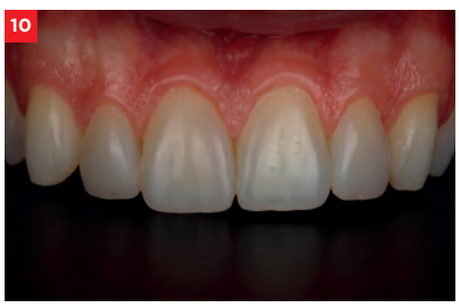


Figure 8: Only minimal finishing and polishing were required





Figures 9-11: Treatment result. With the injection moulding technique, the right shape and symmetry of the teeth are more easily obtained

The patient was highly satisfied with both the aesthetic outcome and the natural biomimetic appearance of the restoration

Without waiting for this material to polymerise, a clear VPS (Exaclear, GC) was immediately applied to the buccal side of the model.

This simultaneous application allowed both silicones to co-polymerise, forming a unified silicone index (Figure 4).

The combination allowed for the creation of a stable and dimensionally accurate index, minimising the risk of discrepancies relative to the planned wax-up.

Prior to the restoration, the old composites and irregularities were removed (Figure 5). For isolation, a split dam technique was used in conjunction with Teflon cords placed in the sulcus to prevent moisture contamination at the restoration margins.

In the first phase, teeth UR3, UR1 and UL2 were restored. The other teeth were covered with Teflon tape. Enamel surfaces were etched with 37% orthophosphoric acid for 30 seconds (Figure 6), followed by the application of G2-Bond Universal (GC) adhesive in accordance with the manufacturer's instructions.

The flowable composite (G-aenial Universal Injectable, A1 shade, GC) was injected through the buccal portion of the silicone index in two separate phases (Figure 7).

Excess resin was carefully removed using a number 12 scalpel and Sof-Lex discs.

When using a single mould for multiple restorations, it is advisable to begin with the teeth requiring the greatest volume of composite addition.

Particular attention was given to thorough light curing – initially through the transparent matrix and subsequently after its removal – to ensure complete polymerisation of the composite material.

The same protocol was followed for teeth UR2, UL1 and UL3.

Final finishing and polishing were kept to a minimum and at light pressure in order to preserve the surface texture imparted by the clear silicone matrix, avoiding unnecessary removal of material (Figure 8).

Final result

The patient was highly satisfied with both the aesthetic outcome and the natural biomimetic appearance of the restoration (Figures 9 to 11).

In summary, the injection moulding technique – combined with the right materials – allowed for anatomically precise, immediately predictable and durable restorations. D

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The perio-systemic link

Crystal Marruganti explains why periodontal care is essential to supporting whole-body health

Crystal Marruganti
Dentist

For years, periodontitis has been considered an isolated oral infection that was limited to the mouth. We now know it is far more complex.

Periodontitis is a chronic inflammatory condition triggered by a dysbiosis within the oral microbiome in a susceptible individual. The inflammatory mediators released in the gums – cytokines, prostaglandins and C-reactive proteins – circulate through the bloodstream, influencing distant organs and metabolic pathways. This suggests their potential role in systemic inflammatory and infectious processes.

It also explains the close association between periodontal diseases and other conditions such as diabetes, cardiovascular diseases and metabolic syndrome. The relationship is bidirectional: uncontrolled systemic inflammation worsens periodontal breakdown, while untreated periodontitis can significantly increase the systemic inflammatory load. Understanding this connection changes how we approach our patients. Managing periodontal health means managing inflammation at a systemic level – and this requires us, as oral healthcare providers, to consider more than just the plaque.

Lifestyle: the forgotten determinant

Lifestyle is one of the most powerful, and often overlooked, determinants of periodontal health. Our most recent research has focused on how daily lifestyle behaviours – such as nutrition, stress levels, sleep quality and physical activity – influence both oral and systemic health.

Nutrition is a fundamental part of everyone's life. Diets that are high in refined carbohydrates and ultra-processed foods, and low in fibre and fresh fruits and vegetable, may fuel pathogenic oral bacteria and eventually increase oxidative stress and systemic inflammation. By contrast, diets rich in antioxidants, omega-3 fatty acids and polyphenols support microbial balance and reduce gingival (as well as systemic) inflammation.

While smoking remains the most destructive modifiable risk factor for periodontal diseases, high stress levels and poor sleep quality are increasingly recognised as key contributors to the disease. Elevated cortisol levels impair immune regulation, while chronic fatigue alters inflammatory thresholds, making individuals more prone to infections and more vulnerable to the microbial challenge.

Physical inactivity also plays a role, and our research identified what we called the 'physical activity paradox' whereby leisure-time physical activity was identified as a protective indicator for periodontitis, while occupational physical activity was identified as a risk indicator for the disease, as it maintains the low-grade systemic inflammation that quietly accelerates periodontal breakdown.

Privileged position

Given the strong links between lifestyle behaviours and systemic conditions such as diabetes, hypertension, cardiovascular diseases and periodontitis, the lifestyle changes we foster our patients to adopt can bring about dramatic benefits extending beyond the oral cavity.

These improvements may include reduced blood pressure, improved glycaemic control, and overall improved systemic health and wellbeing.

In fact, because oral healthcare providers maintain frequent contact with the general public, we are in the privileged position to be able to promote holistic wellbeing and thus play a pivotal role in preventing chronic diseases, starting right from the dental chair.

Highlighting the broader public health implications of this approach, I was deeply honoured to be featured in the Forbes 30 Under 30 list for science and healthcare, which highlights the growing appreciation of oral health as a cornerstone of overall health and wellbeing.

In my clinical practice at Harley Street Dental Studio, I work to implement the daily application of this research. An essential part of this process is also educating our patients to understand why the disease appeared in the first place and what to do to prevent any further periodontal breakdown or tooth loss.

For this reason, we now routinely integrate systemic screening into periodontal assessments – for example, by measuring HbA1c levels and assessing for lifestyles such as diet quality, frequency of physical activity, perceived stress levels and sleep quality. These indicators help identify patients whose oral inflammation may be a symptom of wider metabolic imbalance.

Treatment plans include not only specific periodontal non-surgical or surgical care but also tailored tips on anti-inflammatory nutrition, smoking cessation, stress management and microbiome-friendly habits. When patients begin to view their oral health as part of their overall wellbeing, the results are transformative – not only for their gums, but for their general health.

The future of periodontology

The field of periodontology is moving rapidly towards precision and integration. Advances in microbiome mapping, salivary diagnostics and personalised medicine will allow us to predict disease risk and speed of progression with greater accuracy. But, given the multifactorial nature of periodontitis, technology alone will not give us all the answers we may need.

The greatest progress will come from behavioural change – in both patients and professionals. Dental professionals have an opportunity to act as early detectors of systemic conditions and as advocates for healthier lifestyles.

By embracing a truly integrative model of care, we move from treating the disease to promoting wellness, that could revolutionise our patients' lives. Ultimately, periodontal care is not just about treating the gums – it's also about supporting whole-body health, and to treat the mouth as the gateway to systemic wellbeing. D

Utilising dental nurses in hygiene work

Ayesha Akhter reveals why dental nursing support for dental hygienists is the link to an elevated patient experience and sustained practice growth

Ayesha Akhter
Dental therapist

After relocating to the south of England, I was surprised by how normalised it has become for dental hygienists to work without nursing support – and even more shocked that some practices offer higher pay to do so.

This raises questions about how we value hygienists' work and the standard of care we deliver. Working without a dental nurse isn't simply about convenience; it affects accuracy, safety, mental health, and professionalism across the board. Working without a dental nurse isn't a logistical issue – it's a patient safety and professional respect issue.

Professional standard

Having a dental nurse present enables more detailed and accurate work. With assistance, dental hygienists can carry out full periodontal charting, record indices and provide more effective non-surgical periodontal therapy.

Without support, appointments can unintentionally shift focus towards plaque removal rather than disease management and prevention.

Hygienists perform radiographs, oral cancer screenings and monitor periodontal health – all of which deserve the same level of support as any other dental procedure.

According to GDC standard 6.2.2, clinicians should 'work with another appropriately trained member of the dental team at all times when treating patients in a dental setting'.

A dental nurse's role extends far beyond suctioning. They act as a witness in incidents, support during medical emergencies, and ensure rapid access to drugs or a defibrillator – while the clinician remains with the patient.

In short, having nursing support isn't optional; it's a professional standard that safeguards both patients and clinicians.

A streamlined approach

Expecting dental hygienists to handle suction, charting and sterilisation alone increases the risk of repetitive strain injury and musculoskeletal strain. It also compromises aerosol management and infection control, not to mention the unprofessional look of patients holding their own suction.

Working unsupported also adds mental pressure. With a dental nurse, the clinician can fully focus on treatment, improving accuracy and flow. Feeling supported increases confidence, reduces stress, and boosts job satisfaction – all essential for retention and wellbeing.

A supported hygienist is a confident hygienist, and confident clinicians deliver the best care.

A skilled dental nurse streamlines every part of the appointment. Surgery turnaround is quicker, charting becomes more accurate and patients are seen on time.

Efficient appointments improve the experience for everyone. Patients feel cared for, clinicians work calmly, and practices see higher consistency in output – all without compromising quality.

Furthermore, collaboration with a dental nurse strengthens communication across the practice. Dental nurses often remember patient details that enhance rapport and continuity of care.

Shared learning also happens naturally – dental hygienists can mentor dental nurses in preventive and periodontal techniques, helping the whole team grow together.

Practice growth and recruitment

From a business standpoint, full nursing support is a smart investment. Patients notice when a clinician is well-supported – it reflects positively on the practice's professionalism.

Job adverts that clearly state 'full nursing support provided' instantly attract more applicants. Skilled hygienists are drawn to progressive workplaces that value comprehensive care and teamwork.

Dental nursing support for dental hygienists is not a luxury, it's a necessity

Happier clinicians mean better patient outcomes, more rebookings, and glowing Google reviews – all contributing to sustained practice growth.

Driving change through reflection and audit

This topic has been discussed for years, but meaningful change comes from data and dialogue. Post-COVID-19, we've seen a renewed appreciation for the role of dental nurses in infection control – it's time to extend that to hygiene support too.

Dental hygienists can start by raising the issue with practice owners or managers. Hold a staff meeting to discuss the practical benefits of support, from ergonomics to patient outcomes.

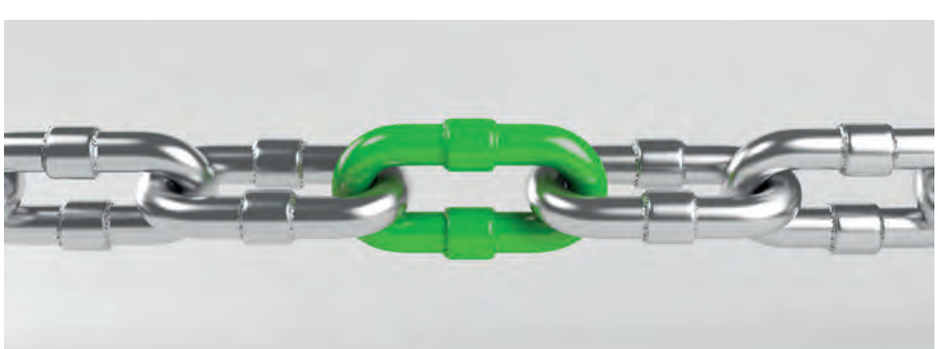
A practical next step is to run in-practice audits comparing what can be achieved solo versus with a dental nurse:

- Record keeping accuracy
- Appointment timing and efficiency
- Missed or deprioritised charting
- Ergonomic strain or fatigue/stress levels.

These audits provide measurable, objective data that highlight the difference support makes. A trial day with a dental nurse can also help visualise the benefits instantly, often more convincing than words.

Audits turn conversations into evidence – and evidence into change.

Even in job interviews, raising the subject can plant a seed for awareness. These small discussions move the profession closer to universal support for hygienists.



A win-win situation

Dental nursing support for dental hygienists is not a luxury, it's a necessity. It enhances safety, accuracy and efficiency while protecting clinician wellbeing and elevating the patient experience.

Recognising the importance of teamwork and full support is how we uphold the standards our patients and our profession deserve.

When hygienists are supported, everyone wins – the clinician, the patient and the practice. D

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Rebuilding life after a brain aneurysm

Marium Riaz shares her experience with brain aneurysm, stroke and rediscovering her career path in dentistry in the aftermath

Marium Riaz
Dentist with MBA in global healthcare management

Dentistry has always been more than a profession to me – it has been a source of joy, purpose, and identity. After 11 years practising in Riyadh, Saudi Arabia, I made a life-changing decision to move to the UK with my seven-year-old son in 2022. I wanted to expand my career by pursuing an MBA in global healthcare management and also be closer to my sister.

I never imagined that within two years, my life would change in ways I could never have prepared for.

Warning signs

Before my aneurysm ruptured, I experienced a series of symptoms that, in hindsight, were warning signs. I frequently saw double and suffered from persistent headaches. I visited several doctors – general practitioners and even an ophthalmologist – but no one could pinpoint the cause.

On 13 April 2024, my brother-in-law noticed something alarming: the right side of my face looked different from the left. He was worried it might be the beginning of a stroke.

We rushed to A&E, waited for hours, and finally saw a doctor. Despite my concerns and my request for a CT scan, I was reassured that everything was fine. I left feeling uneasy but tried to trust the medical advice.

The next day, everything changed. I became unconscious, and an ambulance took me to hospital. By the time I arrived, my aneurysm had already ruptured. It was a devastating diagnosis – an aneurysmal rupture followed by three strokes.

Brain aneurysm 101

A brain aneurysm is a swelling in a blood vessel in the brain. While rare, if the aneurysm bursts it can cause a bleed on the brain, called a subarachnoid haemorrhage.

Most brain aneurysms are small and do not cause symptoms. However, larger aneurysms can cause symptoms such as:

- Headaches
- Pain above or around the eye
- Changes in vision, such as double vision
- Dizziness and balance problems
- Numbness or weakness on one side of the face
- Difficulty concentrating and speaking
- Problems with short-term memory.

Source: NHS

I remained unconscious for over a month. When I finally woke up, nothing felt the same. My speech was heavily slurred, I couldn't walk, and I had lost the use of my right side – my dominant side as a dentist.

Life after the rupture

Coming back to consciousness was both a relief and a shock. I had to relearn the most basic parts of daily life. Mobility, speech and even recognising myself was a struggle.

I still remember the frustration of wanting to speak clearly but hearing only slurred words come out. The feeling of helplessness was overwhelming at times.

It has been more than 18 months since my aneurysm ruptured, and although I am much better, the recovery has been far from linear. I walk with the help of a stick, and while my speech is still slower than before, it is much clearer.

My right hand remains weaker, which means returning to clinical dentistry is no longer possible. Accepting that reality was one of the hardest parts of my journey.

People often ask me about the recovery process, but the truth is, I am still figuring it out. There is no clear handbook, no predictable timeline, and no definite endpoint. Instead, recovery feels like a series of tiny victories – getting through a conversation without struggling for words, managing steps without fear, or simply recognising how far I've come.

This experience has forced me to slow down, recalibrate and appreciate progress in all its forms

I've had to learn patience with myself, something I was never good at before.

This experience has forced me to slow down, recalibrate, and appreciate progress in all its forms.

Rebuilding my career

Despite the physical limitations, my passion for dentistry hasn't faded. I passed the license in dentistry (LDS) Part 1 exam before my surgery, and I'm actively looking for remote opportunities that allow me to stay connected to the profession.

I believe I still have so much to contribute – whether through administrative roles, case coordination, consultancy, patient support or practice management.

Looking ahead, I dream of opening my own clinic one day, one that I can manage even if I cannot practise clinically. I want to create a space that reflects my values, my resilience, and my love for the profession.

If I could offer one piece of advice to anyone going through something similar, it would be this: pay attention to your symptoms and trust your instincts. You know your body better than anyone else. And if life does take an unexpected turn, don't lose hope. This journey can be long, painful, and incredibly challenging – but improvement is possible. You can still rebuild your life, even if it looks different from before.

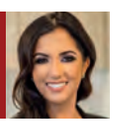
Before my aneurysm, I wasn't working in the UK yet, so I did not have an established workplace to rely on. However, since beginning my recovery, I've found the dental community to be encouraging and welcoming. Still, I believe more can be done – especially in raising awareness of invisible disabilities, offering flexible or remote roles, and creating pathways for clinicians who, like me, can no longer practise clinically but still have immense knowledge and value to bring.

Today, I am ready to return to work in a new capacity. My journey has changed me, but it has not taken away my determination or my connection to dentistry. I am proud of how far I've come, and I am hopeful for what lies ahead. D

Reflections at the halfway point

Dentistry's Next Top Digital Dentist winner, **Sheena Tanna**, shares her stand-out moments, pain points and unexpected lessons of the last six months

Sheena Tanna
Principal dentist,
Billericay Dental Care



Last year, *Dentistry* revealed Dr Sheena Tanna as the winner of 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.

Here, Sheena details how the first half of her journey has gone.

How would you describe your journey in the competition so far?

Demanding, fast-paced and genuinely eye-opening! I thought the competition would mainly be about showcasing digital dentistry, but it's highlighted every part of my clinical workflow, leadership style, and team culture – in a very positive way.

It hasn't been a smooth upward curve. It's been iterative, thought-provoking and incredibly real. I've moved from early momentum to reflection and then to clarity.

What have been the stand-out moments for you?

The Itero Lumina bootcamp was a pivotal moment. It highlighted not just how powerful the scanner is, but how easily its full diagnostic potential can be underused without a clear, repeatable workflow. That experience shifted how I approach scanning – moving it from a technical step to a central part of diagnosis and patient communication.

Another key moment was working with the Aligner Dental Academy (ADA) and spending time at Align HQ with mentors and judges. This provided valuable insight into how Align Technology supports the integration of digital workflows into everyday clinical practice. It also reinforced the importance of embedding digital systems across a multi-clinician practice, rather than centring them on one individual.

It reaffirmed the value of consistency – ensuring associates feel confident using scanners diagnostically, not just for aligner records. ADA has supported this by sending Bhavin and Michael into the practice to train our associates, helping build confidence with scanning and reinforcing its role as a meaningful diagnostic tool.

How has this competition changed your clinical workflow day to day?

My workflow is now more intentional. Scanning is used as a considered part of the diagnostic process, where it adds genuine clinical and communication value rather than functioning as a tick-box exercise. It supports clearer diagnosis and helps patients better understand what's happening in their mouth.

I remain closely involved in key consultations, particularly for Invisalign treatments and restorative cases, working alongside our TCO to ensure clinical clarity and continuity. While I have always been confident in these conversations, the competition has helped refine how we structure them as a team, improving consistency, patient confidence, and the flow from diagnosis through to treatment acceptance.

Systems don't implement themselves. Introducing scanning required clear structure, team involvement and tracking to ensure consistency. Digital dentistry is most effective when it is measurable, supported, and embedded across the entire practice.

Have there been any unexpected insights?

The biggest lesson has been that technology alone doesn't change behaviour – leadership does. It's easy to assume that understanding the benefits of scanning and AI tools naturally leads to adoption, but in practice too much change at once can slow progress.

Breaking implementation into small, achievable steps – such as focusing on a limited number of scans each day, reviewing outcomes and then gradually layering complexity – has proven far more effective. That insight has reshaped how I now introduce any innovation across the practice.

The competition has also reinforced my belief that digital dentistry is less about speed and more about clarity. When patients can clearly see and understand what's happening, trust builds naturally and conversations become more meaningful.

What challenges have you encountered?

One of the key challenges has been ensuring consistent team engagement while introducing new digital workflows. Even with training and access to excellent tools, it became clear that adoption doesn't happen automatically in a busy clinical environment.

With support from mentors, I recognised that the issue wasn't reluctance, but cognitive overload. Addressing this meant simplifying expectations, introducing changes in clearly defined phases, and focusing on removing barriers rather than adding pressure.

Another challenge has been balancing ambition with practicality. The competition opens so many opportunities that it's tempting to progress everything at once. Developing a clear, phased plan helped maintain focus, prioritise what would deliver the most impact, and ensure momentum was sustainable rather than rushed.

What's the plan for the next six months?

My priority over the next phase is consistency across the team, with a clear focus on sustainability.

Clinically, I want to continue refining how digital scanning informs restorative and orthodontic diagnosis, using it to enhance clinical judgement, predictability and patient understanding. From a leadership perspective, my focus is on developing associates who are confident and capable decision-makers with digital tools, using technology thoughtfully and consistently.

I'm also keen to use data more intelligently – analysing refinements, treatment outcomes and growth trends – so that the practice continues to evolve through insight, with decisions that are increasingly evidence-led, strategic, and future-focused.

I'm excited about attending Invisalign live events and visiting the Align manufacturing facility in Poland. The support and access provided by Align Technology have been instrumental in deepening my understanding of how digital workflows operate at every level. That insight will directly strengthen how we communicate, plan and deliver treatment at Billericay Dental Care.

Ultimately, this competition has reinforced my belief that while every smile may be a masterpiece, the best outcomes are achieved when people, systems and technology move forward together – with patients firmly at the centre of it all. D

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

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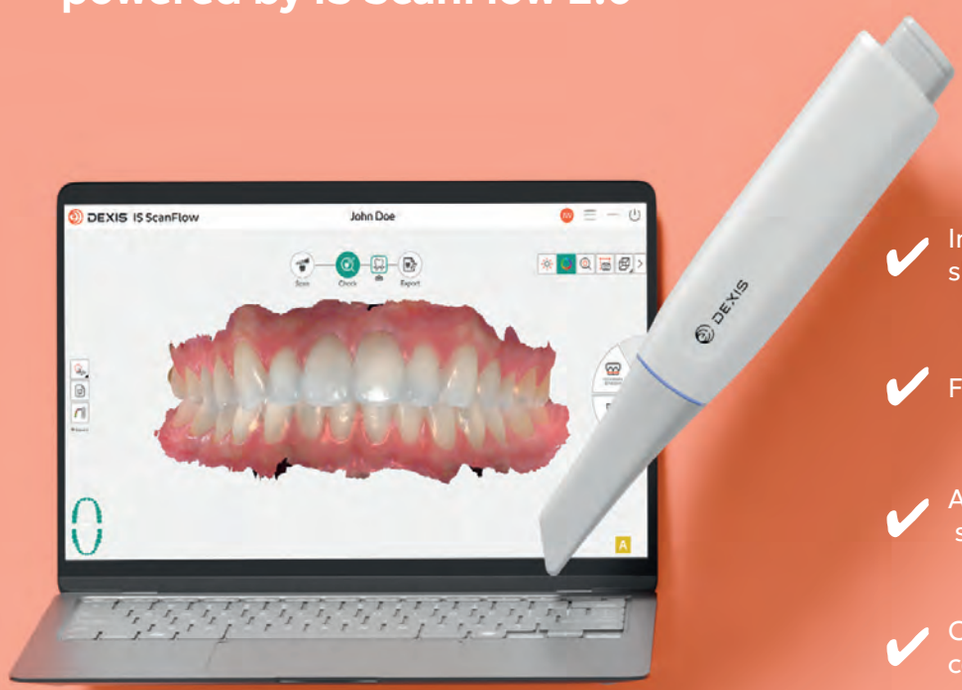

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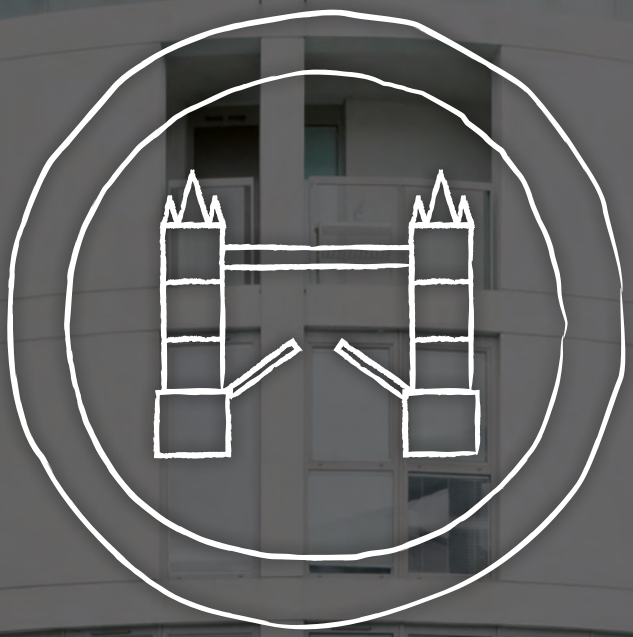

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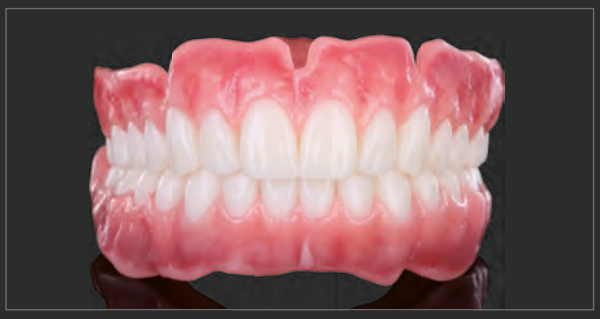

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Tune in: creating conversational space

Rhiannon Jones considers why shared conversation, connection and leadership are essential for the future of dental hygiene and dental therapy

Rhiannon Jones
President, BSDHT

Dentistry is changing. Expectations are rising, patient needs are becoming more complex and prevention is increasingly recognised as central to long-term oral health outcomes. Within that landscape, dental hygienists and dental therapists are stepping into a more visible and influential role. Yet even as responsibility grows, opportunities to pause, reflect and engage in meaningful professional dialogue can be hard to find.

Much of professional life is focused on delivery. Clinics are busy, diaries are full and the pressure to keep moving forward leaves little time to step back and take stock.

While education and CPD remain essential, they do not always capture the nuance of modern practice or the emotional and professional demands that sit alongside clinical care.

What is often missing is space for honest, profession-led conversation that reflects real experience as well as evidence.

Finding the space

Creating that space matters. When clinicians are able to share experience, challenge assumptions and reflect together, confidence grows and standards rise. Prevention becomes embedded rather than aspirational, and professional identity strengthens. Conversation, when grounded in practice and purpose, becomes a driver of progress.

Dental hygienists and dental therapists are central to this shift. Their work spans prevention, early detection, patient education and long-term behaviour change. They often spend more time with patients than any other member of the dental team and are well placed to notice subtle changes, both clinically and emotionally.

With that closeness comes insight, with insight comes responsibility, and those perspectives deserve to be heard.

For the British Society of Dental Hygiene and Therapy (BSDHT), supporting the profession has always meant more than advocacy alone. It means listening, responding and creating opportunities for members to engage with the issues shaping their working lives.

As the profession evolves, so too must the ways in which those conversations happen.

The conversation is unfolding

It was in response to this need that the BSDHT introduced a new podcast – Dental Health Matters. Now a couple of weeks into its launch, the podcast is beginning to take shape as a platform for thoughtful, profession-led discussion, bringing together voices from across dentistry, healthcare and professional wellbeing.

Rather than focusing on a single topic, the series reflects the breadth of issues facing dental hygienists and dental therapists today. Initial episodes explore sustainable approaches to wellbeing and resilience, recognising that burnout and emotional fatigue are not personal failings but predictable responses to sustained pressure. Addressing these challenges early is part of responsible professional practice and essential to delivering high-quality patient care.

Prevention and early detection are also central themes. Conversations around mouth cancer, risk recognition and confident patient communication reinforce the critical role dental hygienists and dental therapists play in safeguarding health beyond teeth alone.

When clinicians are able to share experience, challenge assumptions and reflect together, confidence grows

These discussions highlight prevention as a shared professional responsibility, underpinned by clinical skill, confidence and clear communication.

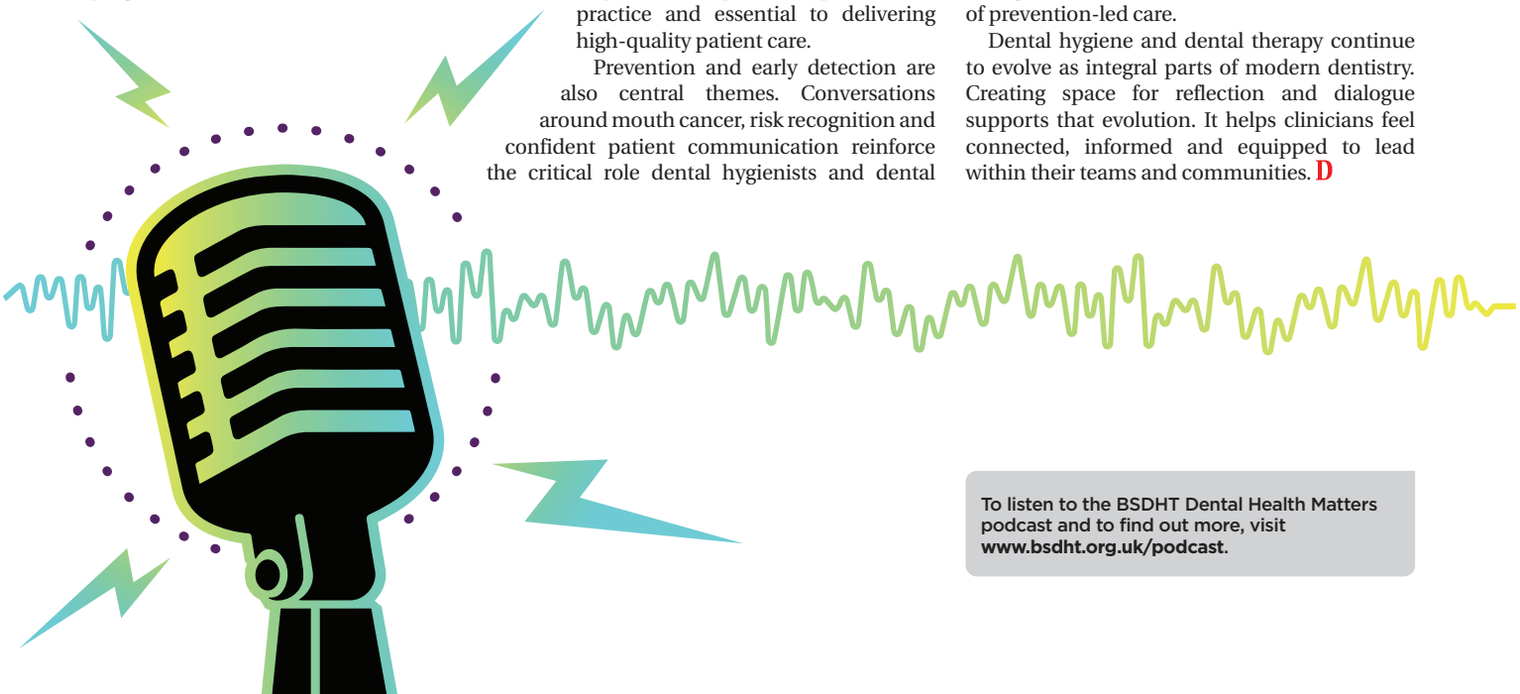
Looking ahead, the series also creates space to reflect on the future of the profession. Policy change, evolving scope of practice and shifting models of care demand adaptability and leadership. Engaging openly with these topics helps clinicians feel prepared rather than reactive and supports a stronger sense of professional agency.

Why listening matters

The podcast has so far been supported by the BSDHT's corporate friends: EMS, Oral-B and Tepe. Their involvement reflects a shared commitment to prevention and education, and has helped ensure the series remains freely accessible to the profession.

However, importantly, the content itself is independent, evidence-informed and shaped by the realities of practice. Taking time to hear different perspectives, reflect on shared challenges and consider new approaches strengthens confidence and reinforces the value of prevention-led care.

Dental hygiene and dental therapy continue to evolve as integral parts of modern dentistry. Creating space for reflection and dialogue supports that evolution. It helps clinicians feel connected, informed and equipped to lead within their teams and communities. D



To listen to the BSDHT Dental Health Matters podcast and to find out more, visit **www.bsdht.org.uk/podcast**.

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Pathways, challenges and opportunities

Robert Leigh on the highs and the lows of pursuing a doctorate as a dental therapist

Robert Leigh
Dental therapist, and London and south east BADT representative

Can you tell us a little about your background in dentistry and how you came to qualify as a dental therapist?
I started out in dentistry after work experience by working as a dental nurse. From there, I trained as a dental therapist and hygienist at the Eastman Dental Hospital. I moved through roles fairly quickly, working in general practice, specialist settings, and later within NHS oral health promotion.

Alongside clinical work, I was always interested in things outside of the mouth. Even during training, I found myself drawn to how dentistry connects with education, prevention, and wider health and social care systems, not just what happens in the surgery. Public health became a huge interest of mine.

What first sparked your interest in research, and when did pursuing a doctorate start to feel realistic?
The real turning point came during my BSc top-up degree in management and leadership in health and social care. I specifically chose not to do a dental focused degree. I wanted to step outside dentistry and see how other parts of healthcare work and lead.

Initially for my dissertation, I chose a topic around career progression and workforce development for dental therapists and hygienists. In my first supervisory meeting I was told that this was a flat out no – there simply was not enough current literature to make this a viable BSc topic at the time, and the scope went well beyond undergraduate level. I was told: 'This is more of a doctorate level question.' So, naturally, with this in mind, the only possible step for me was to do a doctorate.

Can you explain the route you took from clinical practice into doctoral study?
My route took a lot of exploration outside the box. Like many, I qualified through diploma routes, which can limit access to postgraduate study. Completing a BSc top-up degree was an important step, to make me both eligible for higher education but also confident.

At the same time, moving into NHS oral health promotion played a huge role. It shifted my work to population level and helped me realise that the questions I had sat in social care and public health as well as dentistry.

After the BSc, I applied to the doctor of professional practice in community and social care at the University of Lancashire. Professional doctorates focus on applied, practice-based research, which made far more sense for me, than a traditional PhD would have done. However, it is completely equal to a PhD.

Were there any barriers or assumptions you had to challenge along the way?
The biggest assumption I had to challenge was that career progression must mean more clinical courses. For myself, I also questioned where I belonged academically.

It feels like learning how to be professionally nosey and question everything

As the only dental professional on my course, surrounded by wider social care professionals, I initially felt different. However, it quickly became clear that the thing we have in common is not our professional background, but learning how to think as a researcher.

What does studying for a doctorate involve day to day, and how does it differ from other forms of dental education?
At the beginning much of the teaching is to prepare you to became a researcher and develop the skills normally taught on a master's programme.

As you progress, the focus is on developing your research programme approval, ethics application and literature review rather than collecting data straight away.

You're constantly asked to justify your decisions. Why this question? Why this method? Why this group? There's a lot of reading, drafting, feedback, and rewriting.

In many ways, it feels like learning how to be professionally nosey and question everything, which I've come to really enjoy.

Do you feel dental therapists are underrepresented in research and academia?
Yes, dental therapists and hygienists are underrepresented in research and academia, due to much previous research being dentist led research and limited academic pathways for us.

Without their voices, research can overlook our practice, leadership roles and innovation, reinforcing the idea that these we are purely clinical rather than contributors to knowledge, research and academic leadership.

What advice would you give to a dental therapist who is curious about research or academia but unsure whether it's for them?
The biggest thing I'd say is look outside dentistry. Don't automatically assume your next step has to be a dental course. There's a huge amount of flexibility in higher education if you're willing to explore it.

Contact course leads directly and talk through your ideas and thoughts and explore whether your interests or potential research questions fit their programme. A lot of doors only open once you ask and sometimes the correct door isn't labelled, you have to knock and ask!

Higher education doesn't have to mean leaving dentistry behind. For many of us, it's about expanding how we contribute and shaping where the profession goes next. D

For details about the British Association of Dental Therapists, visit **badt.org.uk**.

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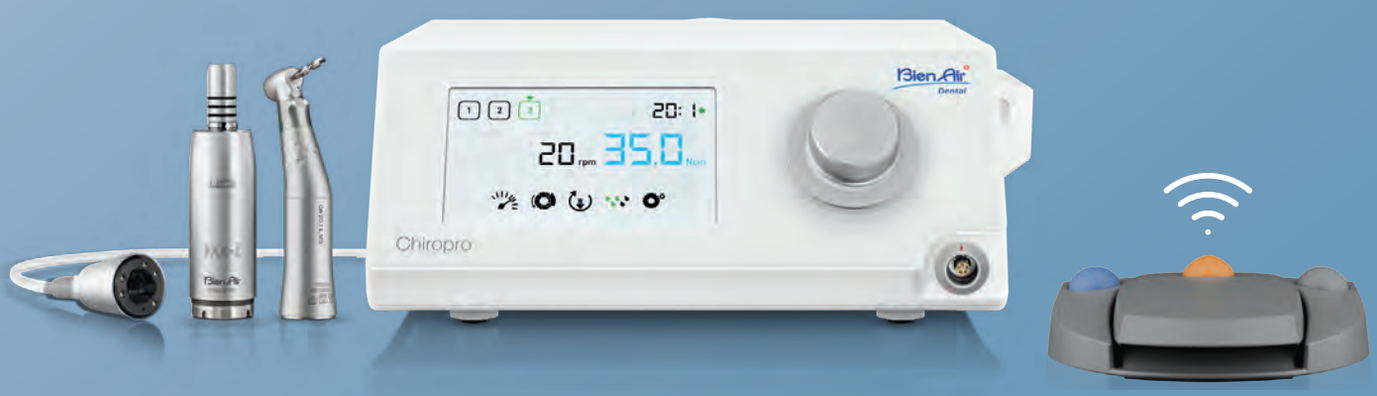

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NHS dentistry and workforce planning

Nigel Jones speaks to **Eddie Crouch** about workforce planning and the chancellor's call for an investigation by the Competition and Market Authority into private dentistry

Nigel Jones
Director, Practice Plan

Eddie Crouch
Chair, British Dental Association

Nigel Jones (NJ): When it comes to working less than full-time, what seems to be uppermost in people's mind is the desire to avoid burnout and that they're accepting of their current income levels and preferring a reduction in work pressure over and above earning more, which is quite an insight. What is your take on the GDC strategy, and in particular the elements concerned with workforce and overseas registration?

Eddie Crouch (EC): It's been interesting because Toby Harris announced that he was leaving as chair of the GDC at the time when it was consulting on the new strategy. Helen Phillips is the new chair, and I have been encouraged by her positive approach and her desire to do something about elements that she sees from that strategy, which was about turning around the fear within the profession of regulation and making it a regulator that's less aggressive. So that's encouraging.

It started off at a time when the government had not made a decision about things like provisional registration. So, we were extremely disappointed that the ARF rose by so much at a time when incomes are not rising anywhere near the same level. The GDC argues that it has been eating into its reserves. All regulators have huge amounts of reserves, but do you need that level of reserves when you know you're getting large amounts of money coming in twice a year and you can dictate what that money is depending on the number of people who are registering? I'm not sure.

Moving on to general points about the workforce, it took the GDC an inordinate length of time to procure a new provider of the ORE. Something must have happened because the process was completely delayed. However, it has now announced that it has awarded that contract. But is it going to be enough to cope with the backlog of people? Once you cut off the avenue of overseas dentists registering as therapists, inevitably the number of people waiting to sit the ORE exam is going to shoot up. And that's exactly what's happened.

According to the GDC and our friends at the ADG, this number might be as many as 8,000 people waiting to sit the ORE exam. Even if you double the capacity of it that's hardly going to make a significant dent. The process is completely unfair, and we've made that argument to the GDC.

There must be a fair way of accessing the exam. You can't have a Glastonbury ticket sale-type system when you open availability for the exam and someone who's just applied to take the ORE has the same chance as someone who's been waiting three to four years for it. It just makes no sense at all.

NJ: Regarding the workforce issues, it's no wonder that it took the GDC so long to think about the FTE issue when it came to workforce related matters, as its revenue is not driven by whether you work part-time or full-time. It's just driven by the number of people on the register. So, perhaps it overlooked it because its business model doesn't require it, but it's a big factor for people and I think the reason why it's such a big driver of change is the scarcity of clinical resource. That applies if they're working part-time, let alone the headcount point, it is driving up the cost of securing clinical resource. That then adds to the financial pressures of running a dental practice. It's particularly difficult in an NHS practice where it's not so easy to pass on those increased costs and it gets harder for you to compete with private practices that can. That then links me to Rachel Reeves' call for the Competition and Market Authority (CMA) to look at private dentistry. What's your take on that?

EC: Following the press release we issued, I've had quite a lot of feedback from across the profession about how pleased they were to see how strong we were on it. We said it's perverse. A chancellor that's starving some elements of dental provision and then those who can, as you rightly say, alter their charges based on the financial decisions of the treasury such as taxation and national insurance, which relate to the costs of running businesses these days.

With the flexibility you have outside of the NHS, it's inevitable that some of those charges have risen significantly and they've probably just done that to keep their heads above water. I sense that there may be a very small element of abuse of fees, but I don't sense that it's widespread and I'm sure any investigation will not turn that up either.

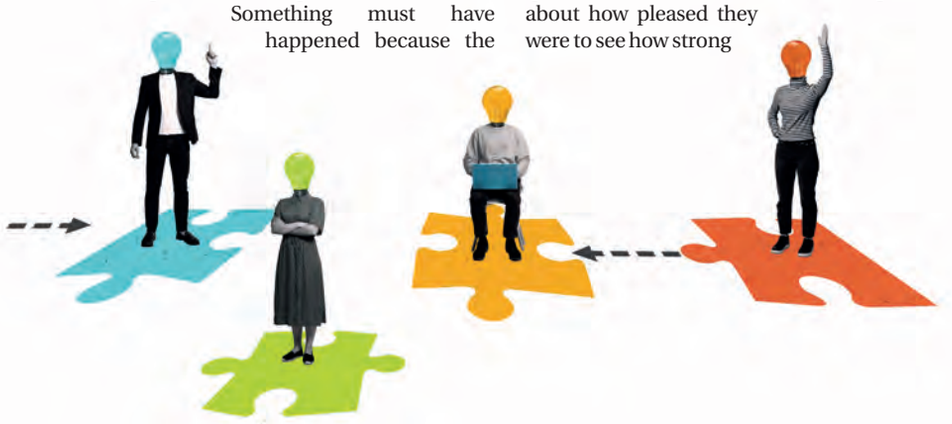
With regards to the workforce, the previous government had a plan to grow the home workforce with 40% more dentists and 40% more therapists. The current government came in and looked at the figures and said: 'these don't add up and we're going to stall that for a minute'.

There are calls in parliament for dental schools in the east of England and the south coast and everywhere else and we've only just started consulting again on a new 10-year workforce plan, but we need to be in a position where we can create our own workforce. I really think workforce planning for dentistry has been appalling for a long period of time and I sense that it's going to be even more difficult to do with all those factors about working patterns. At least we have the data to look at and work with.

I spoke to Chris Louca, director of the University of Portsmouth Dental Academy. He's pleased that the GDC has given them approval to create a dental school. Now all he's waiting for is the Office of Students to give them some money to create an undergraduate curriculum.

Stephen Kinnock has been questioned in parliament by MPs about when these resources will be given to these two new schools because the University of East Anglia has had the same situation. He didn't really give a clear idea of where this money would come from or when they were going to get it.

But we must look at the workforce issue because historically, the BDA has said: 'We have enough dentists, we just haven't got enough who want to do NHS dentistry'. That's worked for us politically, but I don't think that's ringing true as we go forward. The more people who leave NHS dentistry and go private and see fewer patients, then workforce planning must be much more accurate than it is now. D



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Tackling difficult conversations

Is there a conversation you've been putting off? Mark Topley explains how to build a culture of open communication

Mark Topley
Founder, Great Boss Academy

You know that conversation you've been putting off for three weeks? The one about the receptionist who keeps undermining the triage system. Or the associate who's consistently running late. Or the dental nurse whose attitude is starting to affect the whole team. It's still there. And it's getting louder.

Spend some time with this: how many difficult conversations are you currently not having?

Not the ones you've scheduled and keep postponing. The ones you've quietly decided aren't worth the risk. The feedback you're holding back because you don't want to upset someone. The tension you're hoping will just settle on its own.

I ask because this is the most common leadership struggle I see in dental practices. Not strategy. Not systems. Communication. Specifically, the ability to say what needs saying when it feels uncomfortable to do so.

The cost of staying quiet is higher than most leaders realise.

What actually breaks down

When difficult conversations don't happen, stress builds on both sides. The leader carries the weight of unresolved issues. The team member continues a behaviour they might not even know is a problem. Everyone else watches and draws their own conclusions about what's acceptable.

Eventually, something gives. What could have been a calm, contained conversation becomes heated and messy. The kind where emotions run high, defences go up and trust takes a big hit. The 'showdown at the OK Corral' – and that's exactly what it feels like when avoidance reaches breaking point.

But here's the other cost: your good people notice. They see that certain behaviours aren't being addressed, and they realise nothing's going to change. And quietly, over time, they start looking elsewhere.

The real block

When I ask leaders why they're not having these conversations, the answer is almost always the same: 'I don't want to upset them'.

That sentence sounds kind and feels protective, but it's not. Because what you're actually saying is: 'I would rather tolerate ongoing stress, erosion of standards, and the risk of losing my best people than sit through 20 minutes of discomfort'.

I understand it. These conversations are hard. Especially in small teams where relationships matter. Especially across generational divides where communication styles differ. Especially when you genuinely care about your people.

But avoidance isn't kindness. Clarity is.

Understanding open communication

Open communication isn't about being blunt or harsh. It's not about 'radical honesty' or airing every frustration. It's about trusting each other enough to speak uncomfortable truths in a respectful, constructive way. It's about being willing to push through the discomfort those conversations cause in order to reach an outcome where everyone can move forward together.

That's the skill. Not the speaking itself, but the ability to tolerate discomfort without backing down, without softening the message into meaninglessness, without making it everyone else's problem.

Great leaders train themselves to move through discomfort gracefully. They breathe. They choose who they want to be in the middle of stress. They don't settle for dissatisfactory compromises that let everyone off the hook. They push through conflict to get to real collaboration.

The one thing to do differently

If you're recognising yourself in this, here's what I'd suggest you do on Monday morning.

Don't start by having the difficult conversation you've been avoiding. Start by naming the pattern.

Call a team meeting. Keep it short and say something like this: 'I want to talk about how we handle difficult conversations as a team. I've realised I sometimes avoid raising things because I don't want to upset people. And I'm wondering – is it just me, or does everyone find this difficult?'

That's it. You're not solving it yet, you're simply opening the door.

What you'll likely find is that your team has been feeling the same way. That your team members have been holding back too. That the culture of avoidance isn't serving anyone.

From there, you can start building something different. A team where feedback flows more freely. Where issues get raised early, when they're still small. Where people trust that difficult doesn't mean hostile.

Building the muscle

This won't change overnight, but you can get better at it.

You can practise staying present when a conversation gets tense. You can learn to breathe and choose your response instead of reacting. You can build the muscle that lets you sit with someone's disappointment without immediately backing down.

Because if you develop only one leadership skill this year, make it this one: the ability to tolerate discomfort without throwing a tantrum, without looking for an easy way out, without pretending everything's fine when it's not.

Your team doesn't need you to be perfect. But it does need you to be honest. It needs you to care enough to have the conversations that matter, even when they're hard.

So, start with the question: is it just me, or does everyone find this difficult? And see where the conversation takes you. D

Improving communication and collaboration

Ashley Byrne highlights some common issues that crop up in communication between dentists and dental technicians and looks at ways to overcome them

Ashley Byrne
Associate director, Byrnes Dental Laboratory

Every dental technician has seen it. The dreaded lab ticket with two little words: 'Call me.'

No details, no prescription, no hint of what's needed, just a vague message that sends a ripple of frustration through the lab. It's become the universal signal for 'something's gone wrong' or perhaps 'I haven't quite decided yet'.

But as every technician knows, a 'call me' request is rarely simple. It means stopping work, picking up the phone, waiting for a dentist who's in surgery, then playing a round of voicemail ping-pong before getting an answer that could have been sorted in two sentences by email.

Why we still struggle to communicate

Dentists are busier than ever. Back-to-back patients, staffing challenges, admin, compliance – it's no wonder that returning lab calls slips down the priority list. But from the lab's side, a lack of communication can stop production dead in its tracks.

We can't make assumptions or fill in the blanks; we're bound by the prescription, by law. Every adjustment, every material choice, every shade tweak needs to be clear and documented. That's not just good practice – it's a legal necessity.

A written prescription is required by the MHRA, and while a Whatsapp message can help clarify details, it can't replace the official instruction.

Traditionally, the solution has been simple: chase the dentist. Ring the practice, leave a message, try again later. But in 2026, with the technology available to us, that approach feels more like firefighting than communication.

Meeting people where they are

Modern communication means thinking beyond the phone. Some prefer email threads that can be traced and archived. Others rely on Whatsapp for speed and photo sharing.

For some, practice management systems provide secure messaging between clinic and lab. However, the real trick is finding out what works best for each practice.

Sometimes, the right person to speak to isn't the dentist at all. It could be the dental nurse who books appointments, the practice manager who oversees logistics, or the treatment coordinator who handles the patient's journey.

At the start of every new working relationship, technicians should ask the practice:

- Who should we contact for what?
- What's the best communication method – phone, email, Whatsapp or something else?
- Who covers messages when someone's on holiday?

Once you've agreed the process, document it. Having a clear, traceable system not only saves time but also protects everyone if things go wrong.

When technology makes things harder

Ironically, as communication tools have evolved, so have the barriers. Many large dental companies have developed their own closed communication systems, often tied to their scanners, implant platforms, or CAD/CAM workflows.

In theory, these systems are designed to streamline case management. In practice, for labs, they've made life far more complicated.

We're now expected to use multiple platforms, one for intraoral scans, another for implant cases, another for aligners, another for digital dentures. Each one has its own logins, file types, messaging systems, and update quirks. Instead of simplifying communication, it's fragmented it.

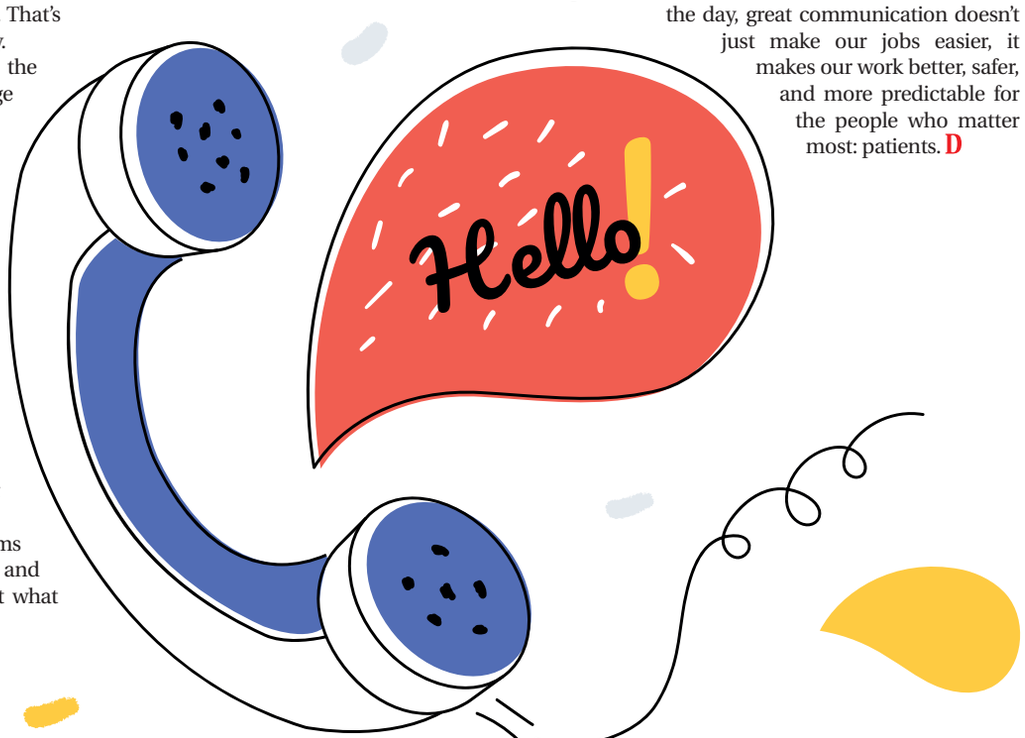
For a busy lab working with dozens of clinics, each loyal to different systems, this patchwork of software has turned what should be simple collaboration into digital chaos. We've become software managers as much as technicians, juggling updates, passwords, and proprietary portals just to keep cases moving.

The way forward

We need to find a middle ground between old-fashioned phone chasing and the overcomplicated digital maze. Communication should be consistent, efficient and accessible, regardless of which scanner or implant system is being used.

That starts with mutual understanding. Dentists can help by clarifying how and when they prefer to be contacted, and by ensuring written prescriptions are complete and compliant. Labs can help by modernising their communication habits, using clear channels, and keeping records of every interaction.

If both sides commit to structured, respectful and traceable communication, we can replace the 'call me' lab ticket with something far more powerful: collaboration. Because, at the end of the day, great communication doesn't just make our jobs easier, it makes our work better, safer, and more predictable for the people who matter most: patients. D



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Tax year-end: time to review

Are you leaving money on the table, asks Iain Stevenson

Iain Stevenson
Head of dental, Wesleyan Financial Services

As we approach the end of the tax year, it's worth taking a moment to reflect on whether you've made full use of the allowances available to you.

For many dentists, a well-timed review can make a meaningful difference to both short-term tax bills and long-term financial security.

Pension contributions remain one of the most tax-efficient ways to save. With an annual allowance of up to £60,000 (or 100% of relevant earnings), plus the ability to carry forward unused allowances from the previous three tax years, there may be scope to boost contributions before 5 April.

This is relatively straightforward for personal pensions, but those in the NHS Pension Scheme should be aware that allowances are based on complex growth calculations rather than contributions alone – an area where specialist guidance can be invaluable.

A well-timed review can make a meaningful difference to both short-term tax bills and long-term financial security

Use it or lose it

ISAs are another key consideration. The £20,000 annual allowance is strictly 'use it or lose it', and planning is becoming increasingly important ahead of announced changes to cash ISA limits from 2027. Don't forget to consider your spouse or partner's allowance too, as well as the £9,000 limit on junior ISAs for children or grandchildren.

Elsewhere, gift allowances, charitable donations, dividend planning for limited company owners and the £3,000 capital gains tax allowance can all play a role in reducing your overall tax exposure.

One step ahead

With further changes on the horizon following the 2025 autumn budget, staying one step ahead at tax year-end could help ensure more of your hard-earned income stays where it belongs – with you.

Remember, the value of your investments can go down as well as up, and you may get back less than you put in. Tax treatment depends on individual circumstances and may be subject to change in future. D

For more information about Wesleyan Financial Services, visit **wesleyan.co.uk/dental.**

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Delivering a six-star patient experience

Carol Somerville Roberts suggests ways to give patients an outstanding, personable experience that creates a story worth sharing with others

Carol Somerville Roberts
BACD president and clinical director, Evolve Dentistry

For a cosmetic dental treatment, the journey is as important as the destination. Clinical excellence can provide a patient with their desired final outcome, but delivering a six-star experience begins before they have even entered the dental practice, and is vital to word of mouth success.

The patient journey starts from the initial demand for a dental treatment or interaction at your dental practice.

Before the patient has even made contact, clinicians should consider their branding and online presence: what does the brand say about them and who does it attract?

A well-designed, professional website or social media page is an immediate reflection on the quality of work delivered in a dental practice. Once you have a patient's interest, there should be a smooth process in which they can easily find out more information or get in contact with the team.

First impressions matter

How the patient is greeted upon arrival at the dental practice makes a major first impression. Team members should consider if the patient is getting the right answers for the questions they are asking and how they are welcomed.

It is recommended that all members of the dental team take the time to walk into their practice as if they were a first-time patient. As you enter and interact with the reception team, ask yourself: 'What stands out?'.

It can be easy for us to head to work every day and become desensitised to our surroundings, so paying attention to things like the paint work, the interior design, the toilets and the overall cleanliness of the place will help find ways to improve the patient experience – everything must be to a high aesthetic standard.

It is also worth sitting in the dental chair to take in the sensory details from the patient's perspective.

Making a connection

Patients want to feel like a person too. They should be greeted by each member of the dental team with warmth; a patient must feel valued, and the clinician should thank them for attending and create a welcoming environment for their care.

Furthermore, identifying why the patient wants a cosmetic dental treatment and why they chose your practice builds a relationship of mutual trust from the get-go, making them feel like they are in safe hands and helping the team understand the patient's expectations.

Simple and satisfying

Every part of the patient's journey should be simple and clear, from booking an appointment to understanding treatment plans, from payment to post-treatment maintenance.

Being authentic and genuinely interested in each step the patient takes with your practice ensures that they leave feeling satisfied.

Patients won't tell their friends and family about composite resins or their margin lines – giving them an outstanding personable experience instead creates a story worth sharing, strengthening your brand and turning those five stars into sixes. D

Being authentic and genuinely interested in each step the patient takes with your practice ensures that they leave feeling satisfied

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Zirkonzahn's UK lecture tour 2026

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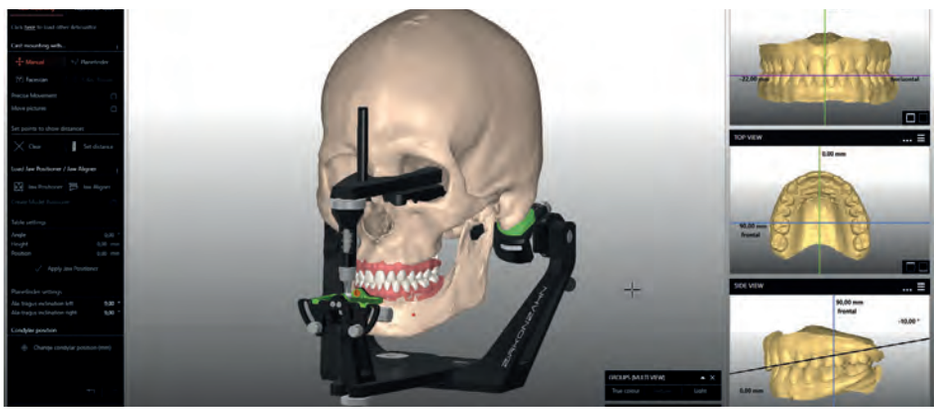

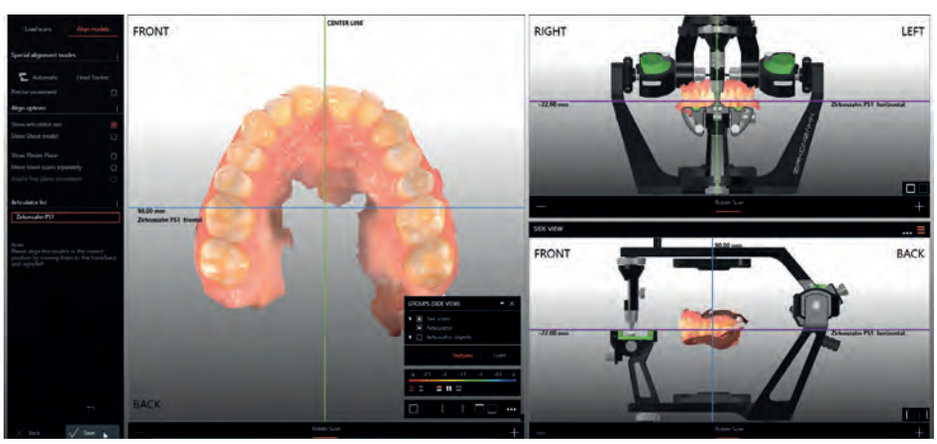

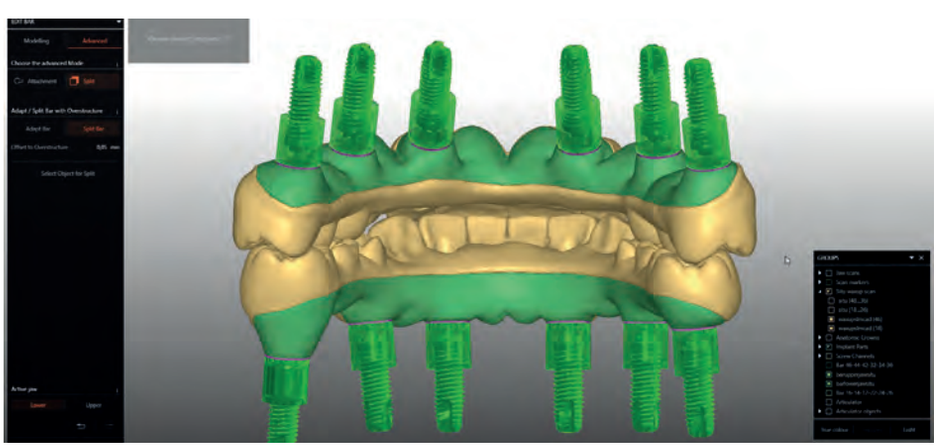

With the title 'The Full Power of Zirkonzahn.Modifier – Digital Design Advantages', Zirkonzahn has announced a new lecture tour in the UK for 2026.

The first tour will take place from 10 to 12 March in Brighton, London and Milton Keynes, with MDT Alexader Lichtmannegger as lecturer. This year's topic will explore the company's advanced design software, Zirkonzahn.Modifier, illustrating its latest features and seamless integration within the treatment workflows.

Digital dental technology

Zirkonzahn.Modifier was developed specifically for digital dental technology: by presenting two real patient cases, the lecturer will highlight how the software opens up entirely new pathways for digital designs, offering an intuitive and modular workflow that does not bind dental technicians to rigid project structures, but leaves them maximum flexibility.

Following the cases step-by-step, participants will be able to observe, amongst others, how the software's cutting-edge algorithms offer exceptionally natural and functional tooth setups that go far beyond standard solutions. They will also gain insight into the high level of automation and flexibility in data processing and editing. The lecturer will explain, for example, how intraoral and laboratory scans can be automatically positioned in digital articulators, allowing occlusion and function to be evaluated directly during the design process. He will also illustrate how changes can be applied immediately within the ongoing project, and how models, constructions and scan data can be edited and adjusted in real time.

As part of the case workflows, some of the software's powerful modules with their functions will also be outlined, such as the 'Boolean Operations' function, allowing to cut or connect individual elements for maximum design freedom, and the 'JawAligner' function, for the plaster-free articulation of digitally created models. The new 'Bone Doctor' module will also be shown, which enables the user to analyse the various skull bones by importing the patient's DICOM data and obtain 3D files out of them. The presentation also includes the new Zirkonzahn.Archive add-on module and the Zirkonzahn.App – working in synchronisation with the intraoral scanner and the new Head Tracker digital facebow, as well as the new Colour Liquids Prettau® Aquarell Boost®.

The two-hour lecture is open to both dental technicians and dentists and meets the criteria for the GDC's development outcomes C. Participation is free, but registration is mandatory. Places are limited.

For more details and registration, scan the QR code or contact Carmen Ausserhofer **(+39 0474 066 662, carmen.ausserhofer@zirkonzahn.com)** or Jasmin Oberstaller **(+39 0474 066 735, jasmin.oberstaller@zirkonzahn.com)**.

You can also find Zirkonzahn at the CDTA CPD Day and AGM 2026 on Saturday 14 March in Nottingham. Join its conference about digital full dentures!

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A collaborative approach

Oral-B explores how dental professionals can drive transformation to help achieve healthier smiles for children

For many years, UK statistics on children's oral health have made for a disheartening read. The link to socioeconomic status is especially significant, with the cost-of-living crisis (BDA, 2023) and poor access to NHS dentists intensifying the challenges. Put simply, many children in low-income households lack a dental home.

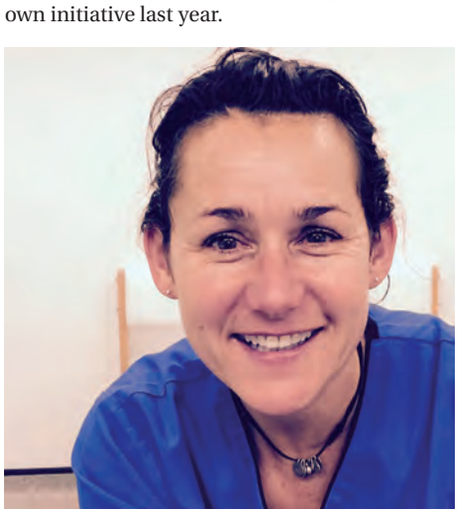
The stark disparities between different groups highlight the urgent need for targeted action. Poor dental health can cause pain, disrupt sleep and make it difficult to eat. For children, this has long-term implications for their confidence, mental health, academic performance and overall wellbeing.

With a government pledge to rebuild dentistry, is that tide about to turn?

Cautious optimisim

The Oral health survey of 5-year-old schoolchildren 2024 revealed that those in the most deprived areas of England were more than twice as likely to have experienced dentinal decay (32.2%) as those living in the least deprived areas (13.6%) (Office for Health Improvement and Disparities, 2025). Whilst inequalities in the prevalence of dentinal decay in five-year-olds significantly decreased from 2008 to 2015, there has been little change in inequalities since then. Commenting at the time, Dr Charlotte Eckhardt, dean of the Faculty of Dental Surgery at the Royal College of Surgeons, said that whilst the numbers were 'still too high', supervised toothbrushing programmes offered 'a glimmer of hope'.

Evidence-based interventions and patient education, both at national and local levels, are crucial in addressing the issues. The Welsh government's flagship Designed to Smile programme, launched in 2009 to tackle significant inequalities in childhood tooth decay among disadvantaged communities, served as an inspiration for the UK government's own initiative last year.



Launching a fully funded national voluntary programme in March 2025, it is targeting early years settings in the most deprived areas. Early analysis by the Child of the North initiative has offered further grounds for 'cautious optimism' – although its authors stressed the need for schemes to be scaled up and strengthened if they are to meet needs (N8, 2025).

Caregiver involvement

However, for clinicians providing dental care in primary care settings, what steps can they take to help address oral health inequalities? And what tools are available to support their efforts?

Caregiver involvement remains crucial to the effort, with daily habits entrenched early, making a significant difference to long-term oral health status. According to the authors of one study: 'Caregivers must be placed in the epicentre of efforts to promote optimal oral health behaviours, including early preventive dental visits' (Divaris et al, 2014). While another showed that collaborative efforts are essential in promoting effective oral health practices among young populations (Wang et al, 2024).

A recent small but significant feasibility study also highlights the essential role they play in supporting children's oral health. The study examined the Oral-B iO Kids 6+, a child-friendly electric toothbrush that uses clinically proven oscillating-rotating technology. Its purpose was to evaluate its practicality and effectiveness in real-world settings.

Participants were recruited from an NHS dental practice in North Wales that caters to a high-need paediatric population. Children aged 6 to 10 years without contraindications were invited to try out the electric toothbrush. Caregivers were instructed on how often to use it, ideally twice daily – in the morning and at night – and shown how to monitor brushing duration and pressure using a mouth model. They were asked to use the toothbrush regularly for four weeks, maintaining their usual oral care routines without making any other changes.

Caregivers maintained logs to monitor compliance and participated in follow-up interviews, while the children completed questionnaires.

Although the sample size was small (four participants), which limits the ability to generalise findings, strong engagement and caregiver satisfaction were evident. Trends indicated overall improvement in plaque and gingival health after four weeks. Notably, three out of four children consistently achieved the recommended two or more brushing sessions per day.

Changing the status quo

It is this collaborative approach to children's oral hygiene that Dr Fiona Sandom believes is fundamental to changing the status quo on child oral health statistics.

A dental hygienist and dental therapist, Fiona was awarded an MBE in the King's Birthday Honours List 2025 for her outstanding services to dental therapy and the NHS in Wales. She now works part-time in a busy NHS practice, serving as the DPSU Lead and North Wales Regional Lead for Health Education and Improvement Wales (HEIW).

She explains: 'Health inequalities remain a major concern for oral health. Ensuring there is enough food on the table and getting children to school on time are usually the priorities for many families – and they often lack the time or energy to supervise their children's toothbrushing. Yet, it is often those same individuals who need our help the most. Promoting equity within the home environment is therefore crucial. Many programmes already effectively tackle these inequalities by offering access to toothbrushes, fluoride toothpaste and educating children in schools, for example.'

She adds: 'However, we all have a part to play in supporting these initiatives at a local level. For those of us in primary care dental settings, we can utilise tooth models to educate parents on proper toothbrushing habits (using an electric toothbrush if possible), reinforce healthy food and drink choices and provide tailored support with clear guidance – all key aspects of preventive care. Additionally, the Oral-B Professional website offers numerous resources for distribution. I suggest visiting www.oralbprofessional.co.uk for more information.'

Improved quality of life

Many believe that only by completely eradicating childhood poverty will children's dental health and wellbeing be reflected positively in the UK's health statistics. In the meantime, the dental profession bears a responsibility to reduce oral health inequalities.

Equipping carers with the correct knowledge, skills and tools is therefore highly beneficial. Promoting a collaborative approach, where carers understand the significance of oral health and know how to support their children, can lead to healthier smiles and an improved quality of life for young patients.

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

From ‘probably fine’ to provably compliant

What dental practices learned in 2025, and what inspectors are focusing on in 2026

Dental practices entered 2025 under more pressure than ever. Time was tighter. Expectations were higher. And compliance increasingly sat in the background until something brought it sharply into focus.

Across the year, our compliance advisers worked closely with practices of all sizes. Looking back, clear patterns emerged – not just about where practices struggled, but about the quiet gaps that caused the most stress when scrutiny increased.

What we repeatedly saw across practices in 2025

Most practices weren’t struggling because they didn’t care about compliance. They were struggling because the way compliance lived inside the practice hadn’t kept pace with how it’s now being assessed.

Across practices, we repeatedly saw:

- Evidence that existed, but wasn’t easy to find, review or explain
- Actions logged, but not clearly followed up or communicated
- Compliance knowledge sitting with one person, creating pressure and risk
- Assumptions that things were ‘probably fine’, until something triggered closer scrutiny.

These weren’t dramatic failures. They were gaps that built over time, and often where inspectors, advisors and practice teams spent the most time.

What confident practices did differently

One of the clearest lessons from 2025 was that confidence didn’t come from doing more compliance. It came from doing it differently.

Practices that felt calmer and better prepared moved away from relying on memory and last-minute fixes. Instead, they leaned into clearer systems, shared responsibility and visibility.

When teams understood why something mattered, not just what they needed to do, engagement improved and responsibility was shared. Compliance became part of everyday working, rather than something saved for inspection preparation.

Common compliance pressures seen in 2025

- CPD gaps across employed and self-employed team members
- Audits completed, but actions not clearly communicated
- Tasks done, but not evidenced or signed off
- Limited oversight of how compliance was being maintained day to day
- Difficulty evidencing team understanding of compliance responsibilities

What inspectors are focusing on now

As we move into 2026, expectations around governance, evidence and accountability continue to rise. In many cases, the rules haven’t changed – but how compliance is being assessed has.

Inspectors are spending less time asking whether something exists, and more time exploring how it’s used, reviewed and improved. Across the sector, there is increased focus on:

- Clear audit trails and follow-through
- Real-time evidence, not retrospective explanations
- Consistency across multi-site practices
- Demonstrating learning, not just recording training.

Having policies and records in place is no longer enough. Inspectors want to see how they’re used in practice.

Why support still matters

Looking ahead, the most confident practices aren’t trying to fix everything at once. They’re making small, steady shifts – moving compliance into shared systems, building simple routines, and asking questions early.

Compliance can feel isolating if teams think they’re expected to know everything. The right combination of clear systems and experienced support helps practices feel calmer, more organised and better prepared.

If any of these pressure points feel familiar, book a demo to see how Dentistry Compliance can help your practice move from ‘probably fine’ to confidently compliant.

Dentistry Compliance

‘It won’t be me’ ... until it is

Probably fine.
(Until it isn’t.)

As this year begins, we still might say,
“It won’t be me. Well not today.”

That policy waits. The file’s nearby.
Reviewed last year… or so we tried.

The team all nod. There’s quiet trust.
Things feel in place. Enough for us.

No drama here. No raised alarm.
Compliance works best when it’s all calm.

It’s steady habits, clear and sound.
Not last-minute fixes rushed around.

So for this year, we pause, review.
We tidy. Check. We follow through.

Not from fear or mounting stress,
But because being ready just takes less.

With the right support, steady and known,
We don’t have to carry it alone.

Amrita Bhambra Nijjar

Compliance Manager at Dentistry Compliance

Building confidence in implant dentistry

Introducing the Dental Implant Course with Dr Anthony James

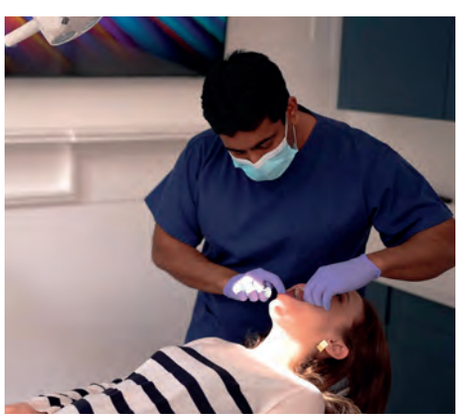
Implant dentistry continues to be one of the most rewarding and in-demand areas of modern clinical practice. For clinicians looking to enter this field with confidence and a structured pathway, The Dental Implant Course with Dr Anthony James offers a comprehensive, mentor-led programme designed specifically for beginners and dentists with no prior implant experience.

This dental implant course is aimed at clinicians who are new to implant dentistry, including those with limited surgical experience, provided they have at least two years of postgraduation clinical experience.

The overarching goal of the course is ambitious yet clearly defined: to train dentists to competently tackle approximately 90 to 95% of implant cases independently within their own practices upon successful completion. Central to achieving this aim is the provision of ongoing, structured mentor support with cases both during and after the course, ensuring learning is consolidated in real clinical settings.

The course is supported by Nobel Biocare, reinforcing its focus on contemporary, evidence-based implant solutions.

Teaching is delivered over 20 face-to-face study days, providing a total of 120 hours of verifiable CPD. The course takes place primarily at the Harley Street Implant Centre, 46 Harley Street, London W1G 9PT – a state-of-the-art clinical facility designed to support both theoretical learning and hands-on training. Selected study days are also held at St Paul's Cathedral and the Royal Albert Hall, offering an inspiring backdrop for focused professional development.



Structured learning

The course structure balances theory and practice. The theoretical component covers implant science, anatomy, CBCT level 1 and 2 training, treatment planning and patient selection, marketing, and medicolegal considerations. This ensures delegates gain not only the clinical knowledge required for implant dentistry but also an understanding of compliance, risk management, and the business aspects of implementing implant treatment in practice.

Practical training forms a substantial part of the programme. Delegates undertake implant placement on study models, develop anatomy and suturing skills using pig's heads, and receive comprehensive asepsis training.

A key feature is mentored implant placement on delegates' own patients, allowing clinicians to apply their learning directly to their everyday practice under supervision. Training also includes digital implant dentistry, with intraoral scanner training integrated into the curriculum.

Both surgical and restorative aspects of implant dentistry are covered, providing a complete clinical workflow. Delegates present cases to the cohort for critical appraisal, fostering reflective learning and peer discussion.

An optional additional week in Egypt offers the opportunity to place 15 implants, further enhancing clinical exposure.

By the end of the course, delegates can expect a solid foundation in implant dentistry and the confidence to provide implant treatment independently. The programme is designed to allow progression onto further training in advanced implant techniques and includes hands-on clinical training with direct supervision.

Importantly, the course is designed to meet the curriculum of the Membership in Implant Dentistry examination at the Royal College of Surgeons of Edinburgh (MImpDent RCS (Ed)), and upon successful completion, delegates should feel confident to sit this examination.

The course fee is £9,950, with a discounted rate of £8,950 available for those who sign up by 1 April 2026. Course benefits include:

- Five mentored cases
- Two live surgery observations
- Exclusive Nobel Biocare discounts
- 12 months of free Nobel Biocare DTX planning software.

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Digital occlusion analysis

José Suárez Feito discusses digital occlusion analysis in adhesive rehabilitation of tooth wear patients

Accurate occlusal assessment is essential in the adhesive rehabilitation of patients with tooth wear. Conventional methods using articulating paper are limited and subjective, as they record only static end contacts without information on force magnitude or contact sequence. Digital occlusion analysis systems overcome these limitations by capturing timing and relative force distribution throughout the entire closure process.

This article presents the clinical application of the OccluSense digital occlusion analyzer, recent improvements in recording accuracy, and a practical protocol for its use in occlusal splints and full adhesive rehabilitations.

Introduction

Ideal occlusion is classically defined as simultaneous bilateral contacts of equal intensity in maximum intercuspation (MI). Clinically, articulating paper is used to assess this condition, assuming uniform mark size reflects balanced occlusion. However, articulating paper provides only a static snapshot and fails to represent the dynamic sequence of occlusal contact. True simultaneity is biomechanically impossible, and studies report error rates exceeding 80% when occlusion is assessed visually alone.

Digital occlusion analyzers address these shortcomings by recording contact location, timing, and relative force distribution during closure. Among these systems, OccluSense (Bausch, Germany) offers a clinically reliable and cost-effective solution suitable for daily practice.

The OccluSense system

OccluSense comprises a wireless handpiece and a thin (60µm) pressure-sensitive sensor with over 1,000 sensing cells, capable of recording up to 256 relative pressure levels. Data are transmitted wirelessly to an iPad application, where occlusal contacts are displayed in two- and three-dimensional formats. The sensor measures changes in electrical resistance rather than absolute force values. Its minimal thickness allows reliable detection of both static and dynamic contacts while simultaneously marking contact points in red. A key recent innovation is the CenterFix accessory, which aligns the sensor with the maxillary interincisal line. This standardization significantly improves reproducibility between recordings and facilitates inter-arch comparison.

Recording protocol

After a daily functionality test, recordings are taken in MI and during lateral and protrusive movements. MI recordings of approximately four seconds are sufficient, while excursive movements require longer recordings. A recording frequency of 50Hz enables smooth real-time playback.

Patients are positioned upright for restorative cases and receive brief training to reduce movement artifacts. Each movement – MI, right laterality, left laterality, and protrusion – is recorded separately to ensure precise analysis.

Figure 1: The OccluSense digital occlusion analyzer

Data interpretation

The occlusion data is evaluated simultaneously in 2D and 3D views. In 3D mode, the bar height represents the relative pressure, while the color coding reflects the pressure distribution: green indicates flat contacts, red indicates pinpoint pressure. Red markings alone do not indicate pathology; clinical relevance depends on timing, duration, and distribution.

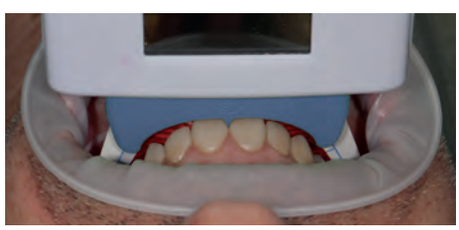
Frame-by-frame playback allows analysis from first contact to MI. A vertical filtering slider helps isolate clinically relevant overloads by excluding low-level noise. Contacts that persist across multiple frames and remain visible at higher filter thresholds are considered significant.

Clinical applications

In occlusal splint therapy, OccluSense is primarily used to verify adjustments made with articulating paper. Due to the flat posterior splint surface, posterior interferences are rare, and digital analysis mainly confirms balanced force distribution and immediate posterior disocclusion during excursions. In full adhesive rehabilitations, digital analysis is particularly valuable because complex cusp–fossa relationships increase the risk of force concentration and false-positive markings. While meticulous adjustment with articulating paper remains essential, OccluSense serves as an objective quality-control tool to confirm occlusal stability.

Discussion

Clinical experience and in vitro studies demonstrate that OccluSense provides reliable and reproducible occlusal data, especially when used with the CenterFix alignment system. Although it does not replace conventional occlusal indicators, it significantly enhances diagnostic accuracy by revealing contact timing and force distribution.



Figures 2a and 2b: The correct placement of the CenterFix tip in the interincisal line between the two upper central incisors can be seen

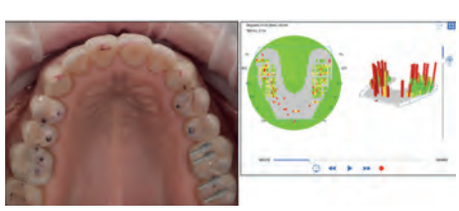


Figure 3: The occlusal adjustment made especially at level 3.7 and also at 3.6 is shown. After several adjustments and checks with OccluSense, we confirm the correct distribution of pressures as shown in the MI registration frame

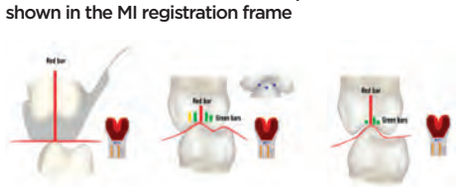


Figure 4: Illustrations showing different types of posterior occlusal contacts a) Occlusal splint (single point contact) b) Cusp-fossa relationship with multiple point contact on slopes c) Cusp tip to marginal or triangular ridge relationship

Conclusion

Structured occlusal concepts and adjustment protocols enable predictable outcomes in adhesive rehabilitation of tooth wear. Digital occlusion analysis with OccluSense represents a logical extension of these principles, providing objective verification of occlusal balance at reasonable cost. Its application in occlusal splints offers an effective learning platform prior to use in complex restorative treatments.

Download the full article at **www.occlusense.link/fte**. For further information about Dr Jean Bausch GmbH & Co KG, call **+49 221 709 360**, email **info@occlusense.com** or visit **www.occlusense.com** and **www.occlusense-shop.com**.

The role of mouthwash in periodontal care

Professor Iain Chapple explains how updated clinical guidance clarifies when and how mouthwash can enhance periodontal care

Iain Chapple
Professor of periodontology and director of research, Institute of Clinical Sciences

The British Society of Periodontology (BSP) steps of care flowchart is widely used when implementing the S3 clinical guideline in day-to-day clinical practice, and it provides a key summary of recommendations from the BSP adolopment of the European Federation of Periodontology (EFP) S3 level clinical guidelines for managing stages one to three periodontitis.

Now, 'adolopment' is an odd word. What it really means is that the BSP had a separate workshop and updated any evidence from the EFP workshop, which was in 2019, and they either adopted or they adapted each recommendation according to the UK healthcare system.

The stakeholder group was broader than the EFP group, and it included representatives from organisations like the General Dental Council (GDC), the office of the chief dental officer (OCDO), the Royal Colleges, the College of General Dentistry, and also specialist societies other than the BSP.

But perhaps most importantly, it included patient representatives, and they are critical because they provide us with vital insights and input to ensure whatever the recommendation is that is being made has meaning for patients.

Working together

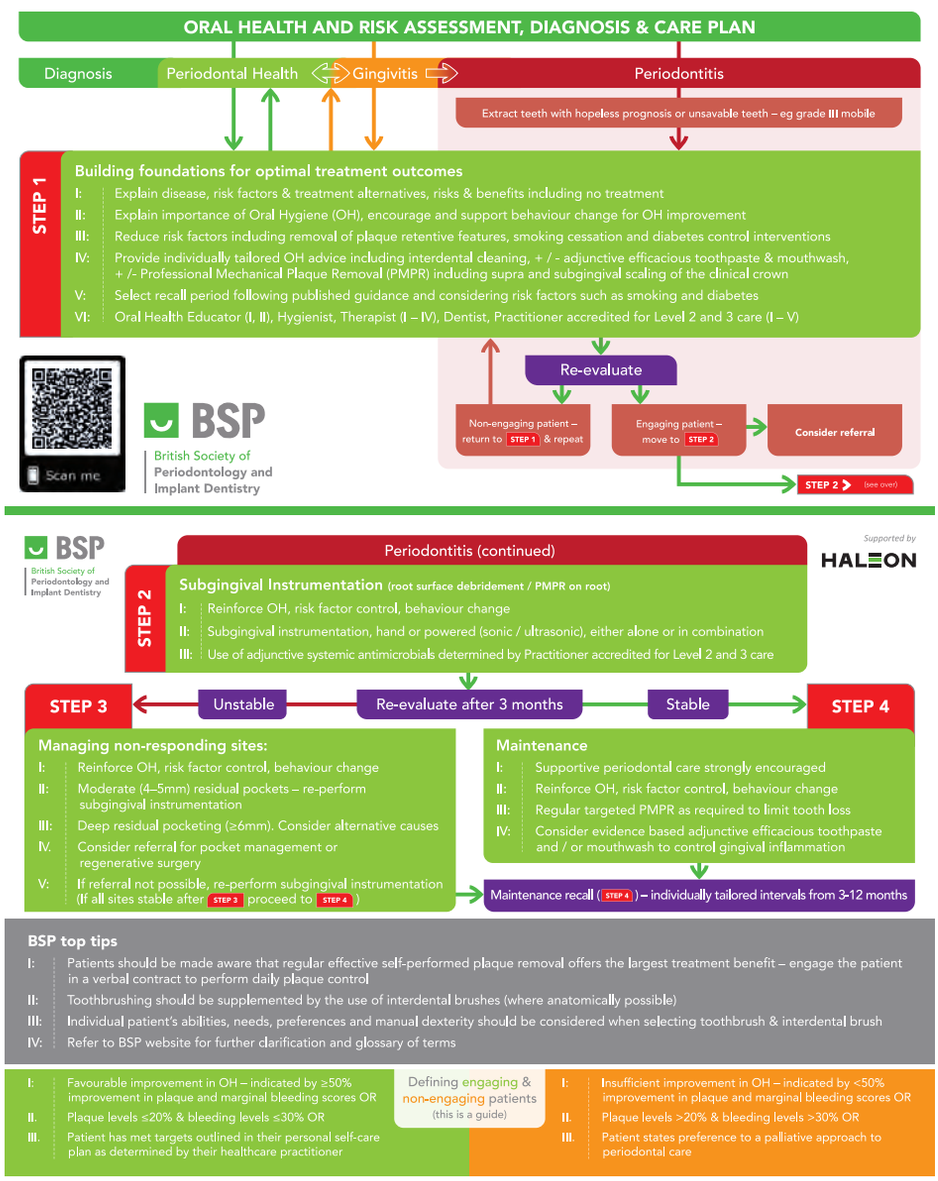
The S3 level process doesn't just use the evidence base. It's important to recognise this. It also takes into account things like:

- The cost of an intervention
- The impact on the environment
- Ethical issues
- Access – whether it be physical or financial – to treatment.

You'll see that the use of chemical adjuncts to mechanical plaque control is referred to both in step one, which is for prevention of periodontal diseases, but also in step four, for supportive periodontal care (SPC).

The guideline actually downgrades the evidence from strong, which is what the systematic reviews told us, to an 'open recommendation' for chemical adjuncts. And it does this to account for things such as cost, access and environmental issues.

So, despite the evidence base supporting significant adjunctive benefit in reducing plaque and gingival inflammation, the open recommendation essentially leaves it open to us as oral health care professionals, along with our patients, working together to decide on the best regime for that individual patient.



Flowchart: BSP UK Clinical Practice Guidelines for the treatment of periodontal diseases

Are adjunctive agents beneficial?

Now, it's not shown in the flowchart, but in the document itself, recommendation R4.13 actually goes as far as naming adjunctive agents that have been proven to offer benefit in randomised, controlled trials that have been systematically reviewed (West, 2021).

It states that 'if an antiseptic mouth rinse formulation is going to be adjunctively used, we suggest products containing either chlorhexidine, essential oils or cetylpyridinium chloride (CPC) for the control of gingival inflammation in periodontitis patients during supportive care.'

Note, this only refers to during supportive periodontal care because that's what the systematic review addressed, and that's what the focus question looked at. And so, we can only limit the conclusion to exactly what was written on the tin, if you like.

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Restorative treatment: full dentures

Alexander Lichtmannegger illustrates the workflow for a patient who was treated with full dentures in Abro Basic Multistratum and Denture Gingiva Basic Mono Pink resins from Zirkonzahn

Alexander Lichtmannegger
Master dental technician

Although minimally invasive procedures are becoming increasingly important and their basic idea to preserve as much tooth structure as possible is undisputed among experts, there are still patients who need a complete restoration after total tooth loss. In addition to implant-supported restorations, full dentures are still a tried-and-tested method, especially among the elder demographic.

In the following case, master dental technician Alexander Lichtmannegger explains how he created upper and lower full dentures made of Abro Basic Multistratum and Denture Gingiva Basic Mono Pink resins with Florence Totalprox Denture System.

Initial patient situation

The following real case illustrates the workflow for a patient who was treated with full dentures in Abro Basic Multistratum and Denture Gingiva Basic Mono Pink resins (Zirkonzahn). Due to their poor condition, the patient had all her upper teeth removed at the age of 25; over the years, the remaining natural teeth in her lower jaw were also extracted.

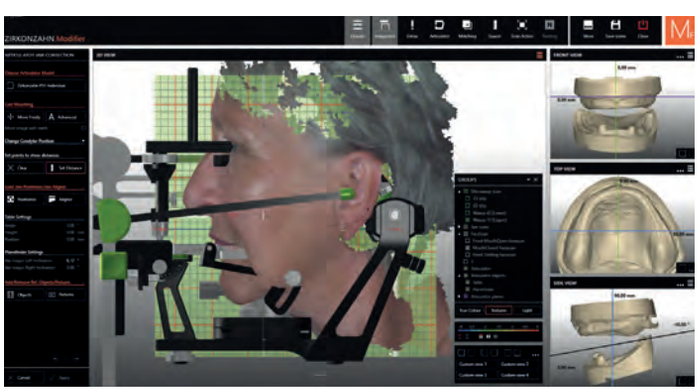
A conventional denture in the lower jaw did not meet her functional requirements, which led to the placement of two implants and a new prosthesis supported by locators. However, the patient was consistently unhappy with the aesthetics, so she returned to the practice, requesting new prostheses with functional and aesthetic improvements.

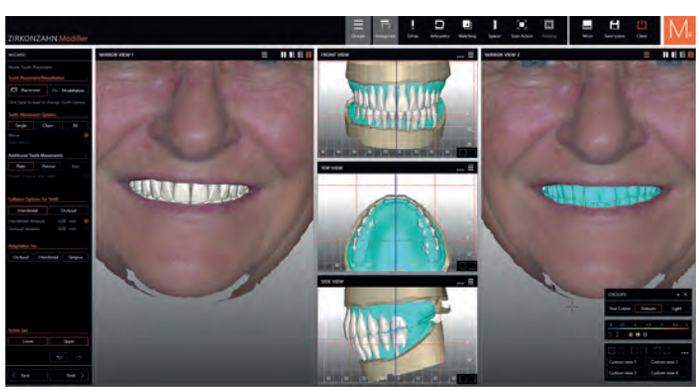
Case realisation

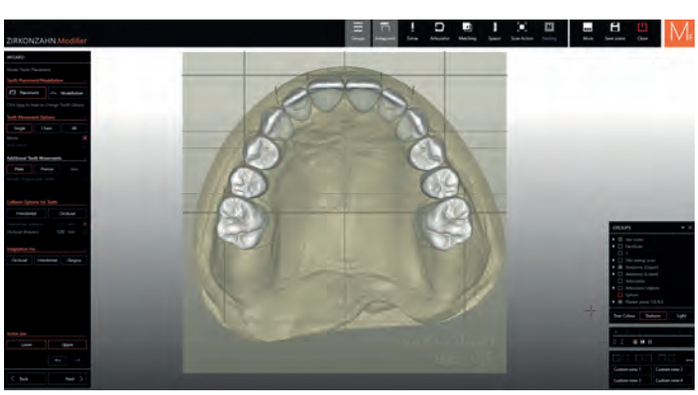
The treatment was performed using Zirkonzahn's digital workflow and the new Florence Totalprox Denture System. A comprehensive set of data was collected to create the restorations, including patient photos, 3D facial scan data, digital impressions of the oral situation and the dentures previously used by the patient.

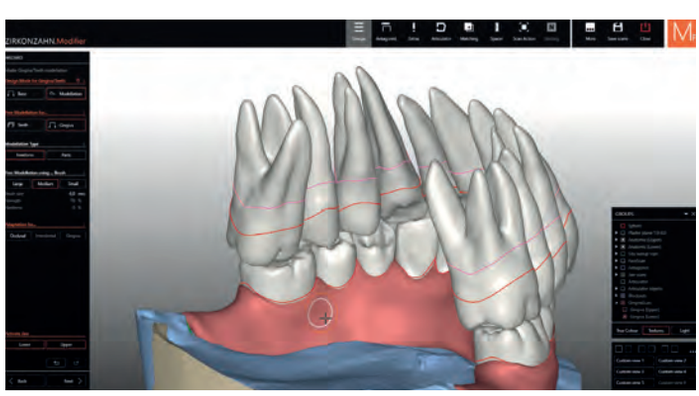
The step-by-step workflow is as follows:

- Digital acquisition of the oral situation with the Face Hunter 3D facial scanner and the Planesystem
- Data matching and digital articulation using the PS1 virtual articulator in the Zirkonzahn.modifier software (Figure 1)
- Virtual tooth setup and individualisation of the tooth shapes with selection from the Heroes Collection rooted tooth library (Figure 2)
- Correct tooth scaling and positioning in occlusion using the Plaster Plate (Figure 3); automatic generation of the gingival area (Figure 4)
- Nesting and milling the try-in structures in a Try-In Rigid resin blank
- Assessment of aesthetic, functional and phonetic aspects in the patient's mouth with the try-ins, which were then used as functional trays for taking the final impression (Figure 5)
- Digitisation of the new denture impressions and the new aesthetically and functionally adapted situation. Adaptation of the digital tooth setup to the new denture impressions
- Nesting both denture bases and teeth respectively in a Denture Gingiva Basic Mono Pink resin blank (diameter 125mm) and in an Abro Basic Multistratum resin blank (diameter 95mm)

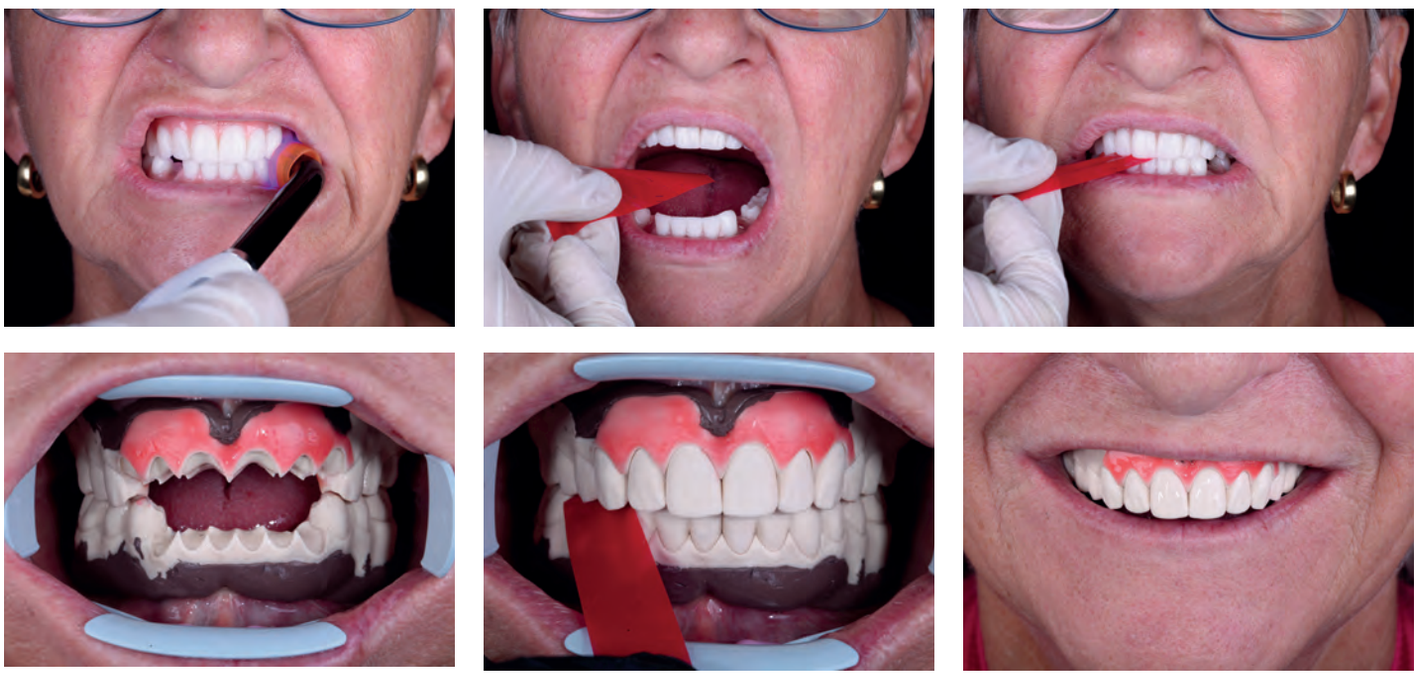








Figures 1-4: Digital workflow



Figures 5a-5f: Try-in assessment

Figure 6: Abro Basic Multistratum and Denture Gingiva Basic Mono Pink resins

- Milling the structures in the M2 Dual Teleskoper milling unit and veneering the gingiva with Gingiva-Composites
- Bonding teeth to denture bases according to the innovative Polibond procedure, a bonding technique based on the principle of cold welding. Polibond perfectly bonds denture teeth to denture bases as it dries, creating a single, unified structure
- Final insertion of the upper and lower dentures in the patient's mouth.

About the resin materials used

With Abro Basic Multistratum and Denture Gingiva Basic Mono resins used for this patient case (Figure 6), Zirkonzahn introduces new PMMA-based materials, which are particularly biocompatible and health-friendly due to their low residual monomer concentration.

Abro Basic Multistratum shows a natural colour gradient from dentine to enamel and improved material properties in terms of translucency values, flexural strength as well as fracture and abrasion resistance, which make it particularly suited for the manufacture of denture teeth (not for partial dentures). However, it can also be used for long-term temporaries and various secondary and tertiary structures.

Figure 7: Initial situation

The gingiva was produced using Denture Gingiva Basic Mono, available in three different colours: pink, blue-pink and cherry-pink. This is a gingiva-coloured resin with high flexural strength and fracture resistance, which has been specifically developed for the production of denture bases.

Blanks are available in a diameter of 125mm, allowing dental technicians to manufacture up to two denture bases in a single milling process.

The material is also available as Denture Gingiva Pro Mono, which offers even higher performance: practically unbreakable, with outstanding fracture resistance and very high flexural strength – ideal for particularly demanding cases.

For a more individual result, the gingival area of the restorations can also be characterised with composites.

Figure 8: Final result

Summary

Despite the difficult initial situation (Figure 7), with the new Florence Totalprox Denture System the patient received new high-quality, long-term dentures (Figure 8). The restoration met the expectations of the patient both aesthetically and functionally, improving her self-confidence in everyday life. D

To learn more about Zirkonzahn's courses, visit **www.zirkonzahn-education.com** or contact Zirkonzahn's Education team: call **+39 0474 066 650** or email **education@zirkonzahn.com**.

Leadership in decontamination

New Aura Infection Control survey reveals the leadership reality for UK decontamination leads

Dental decontamination specialists Aura Infection Control, in partnership with FMC and supported by the Society of British Dental Nurses, has released the results of its nationwide survey, 'Leadership in decontamination – how are you leading the way?', revealing both encouraging confidence levels and clear areas where decontamination leads need greater support.

The survey gathered insight from decontamination leads across UK dental practices to explore leadership confidence, challenges, auditing outcomes, and professional development needs within this vital infection control role.

High confidence, even under pressure

Encouragingly, respondents reported a strong level of confidence in their leadership abilities. On average, decontamination leads rated their confidence at eight out of 10 when asked about maintaining consistent decontamination standards under pressure.

However, the results also highlighted that 10% of respondents did not feel confident, reinforcing the importance of continued leadership development and structured support.

Motivating teams remains the greatest challenge

When asked about the most challenging aspect of leadership, almost half of the respondents identified motivating team members to consistently follow processes as their primary difficulty. Managing time and workflow pressures followed closely behind, reflecting the operational and human challenges decontamination leads face alongside their technical responsibilities.

These findings underline that leadership in decontamination is as much about influencing behaviours and culture as it is about protocols and compliance.

Audits highlight mixed experiences

The survey also explored what happens when non-compliance is identified during audits. While 60% of respondents said issues are corrected immediately with full team cooperation, 40% reported delays, resistance, or actions not being followed through.

This suggests that although many practices respond positively to audit findings, there remains some inconsistency in how improvements are implemented and sustained.

Communication is identified as the cornerstone of effective leadership

One of the clearest messages from the survey was the importance of communication. When asked which leadership quality every decontamination lead should develop, effective communication emerged overwhelmingly as the defining capability.

Respondents described communication as multifaceted – encompassing clear instruction, confident explanation, active listening, empathy, and the ability to explain not just what needs to be done, but why it matters.

Strong communication was repeatedly linked to better compliance, improved patient safety, reduced resistance to change, and stronger teamwork.

Knowledge and credibility were also seen as essential, with respondents emphasising that communication is most effective when supported by up-to-date knowledge, evidence-based practice, and leading by example.

Overall, the analysis indicates that while many leadership qualities matter, effective communication acts as the central mechanism through which knowledge, compliance, motivation, teamwork and safety are achieved, making it the most critical capability for a dental decontamination lead to develop.

Training priorities reflect the results

Unsurprisingly, when asked which leadership skill they would most like to strengthen through training, communication and influence ranked highest, followed closely by coaching and developing others.

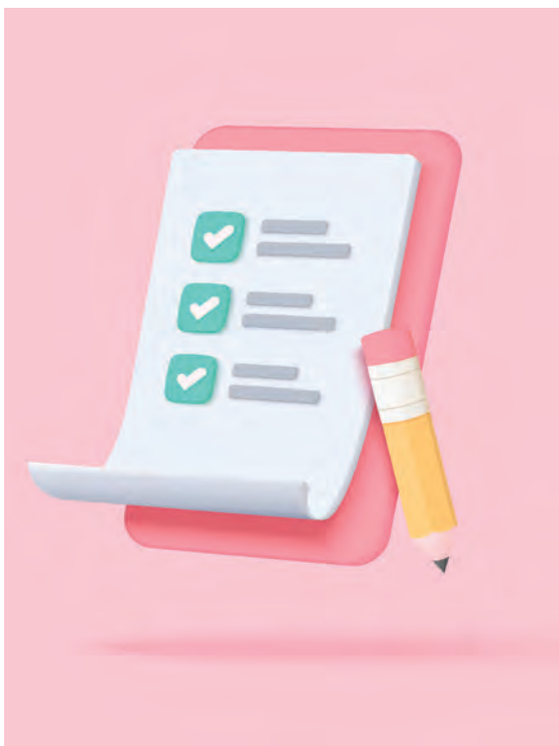
A third of respondents also highlighted leading audits, continuous improvement and building confidence as a leader as key development needs, while time management was seen as less of a priority.

Industry voices

Laura Edgar, managing director of Aura Infection Control, said: 'These results clearly show that decontamination leads are confident and committed, but they are also navigating complex leadership challenges.

'Communication sits at the heart of effective decontamination leadership – supporting compliance, consistency, and culture. The findings reinforce why leadership training must go beyond technical knowledge to include influence, confidence, and people management.'

Fiona Ellwood, executive director of the Society of British Dental Nurses, added: 'Decontamination leadership is fundamental to patient safety and quality assurance. This survey highlights the pressures decon leads face and the critical need to recognise, value, and support their leadership role within dental practices.'



Shaping the future of decontamination leadership

The 'Leadership in decontamination' survey results will help inform future training programmes, resources and industry initiatives aimed at strengthening leadership capability within dental decontamination.

By focusing on communication, influence, and team development, the profession can continue to raise standards, improve compliance, and protect both patients and staff.

Aura Infection Control and the SBDN remain committed to championing decontamination leads and supporting the leadership skills that underpin safe, effective and compliant dental practice across the UK. D

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Choosing the colour palette for your practice

Colour goes beyond just being a decorative element; it serves as a strategic and emotional tool in the design of dental practices, says A-dec

When designing the interior of a dental practice, colour goes beyond just decoration; it's a powerful design element that can shape the overall experience, affect how patients feel, and even boost staff performance.

In 2026, Dulux's 'rhythm of blues' collection introduces three shades of indigo that strike a perfect balance between modern and soothing. These colours are a natural choice for healthcare environments like dental practices, where building trust and creating a sense of calm are essential.

The psychology of colour: why blue works in dentistry

Blue is one of the most trusted colours for good reason. It radiates calmness, stability and confidence, qualities that help patients feel more at ease in a clinical setting.

Dulux's 2026 collection showcases three harmonious blues:

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- Slow Swing, a rich, meditative indigo designed to ground you
- Free Groove, a vibrant, energising blue that sparks creativity.

Each of these shades carries its own emotional significance and can be mixed and matched to embody 'your space, your pace', according to Dulux.

Walls: painting for calm and confidence

When choosing paint colours for walls in a dental practice, many designers will be turning to the Dulux 2026 indigo family. Using Mellow Flow on the main walls can create a soothing and spacious atmosphere, while Slow Swing makes for a lovely accent, which can span across an entire practice, from reception areas to treatment rooms.

You might consider using Free Groove more selectively, perhaps on feature walls in design or consultation rooms where fostering creativity and connection is key.

Combining these blues with fresh, neutral whites enhances the sense of cleanliness and simplicity. Dulux's spec guidance suggests that its 2026 collection is designed for both commercial and residential spaces, making it a great fit for professional settings.

Flooring: complementing your colour scheme

When it comes to creating a cohesive look in your practice, flooring plays a crucial role, just like the walls. You want your flooring materials to be hygienic, durable, and visually appealing.

If you're working with a blue-based colour palette, think about using lighter-toned vinyl or sheet flooring in cool greys, dove greys, or soft whites. These shades blend beautifully with Mellow Flow or Slow Swing without overshadowing them.

On the other hand, opting for wood-effect vinyl or high-quality laminate in pale ash or washed-oak finishes can add warmth and texture while maintaining a serene, natural vibe.

These choices lay down a calming foundation that complements the emotional atmosphere created by your walls and upholstery.

Dental chair upholstery: mix or match

Dental chairs serve more than just a purpose; they play a significant role in shaping your practice's visual identity. With options like formed and sewn upholstery, you have access to a wide range of colours, including various shades of blue. For instance, A-dec's upholstery collection features Indigo, Bayou, Poseidon, Diplomat Blue, Pacific, and Riviera, which all beautifully align with Dulux's Indigo story. For instance:

- Indigo upholstery reflects the richness of Slow Swing, creating a refined and cohesive atmosphere
- Bayou or Pacific can evoke the tranquillity of Mellow Flow
- Diplomat Blue or Riviera offer a slightly bolder tone, like Free Groove, yet still feel soft and inviting.

Choosing upholstery in these blue shades not only enhances the continuity of your design but also promotes a calming environment for patients, while projecting professionalism. For dental teams, working in a space with soothing upholstery can lessen visual fatigue and subtly foster patient trust.

Putting it all together: a harmonious design approach

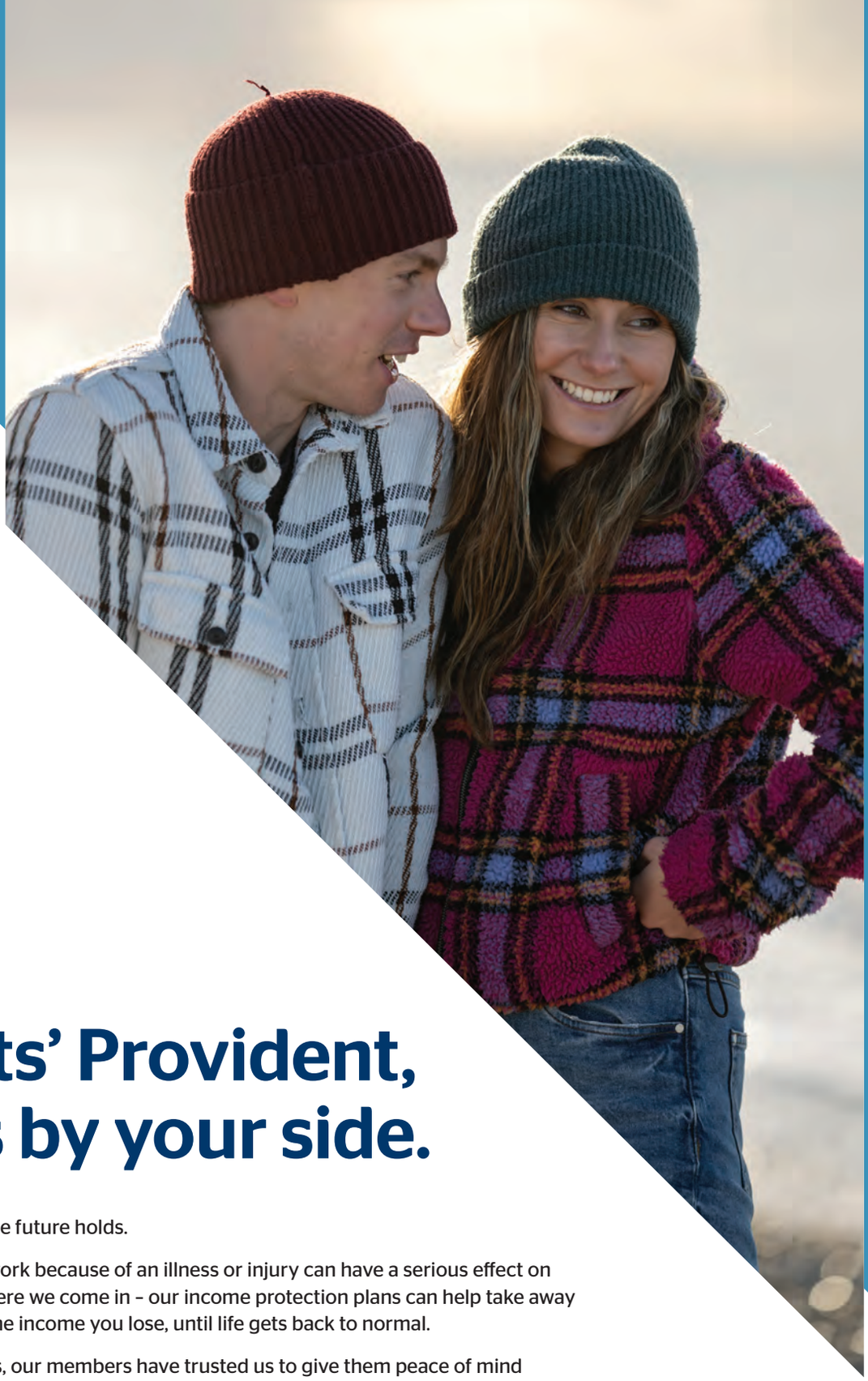
When it comes to designing or giving a fresh look to a dental practice, you don't have to stick with just sterile whites or clinical greys. By carefully combining the Dulux 2026 indigo blues with matching flooring and upholstery, you can create a space that feels truly inviting and contemporary.

While blue takes centre stage in 2026, a successful practice design doesn't depend solely on it. Neutral colours like beige and taupe are still crucial, especially for cabinetry, worktops, and secondary spaces. These subtle shades help maintain a professional, polished appearance without distracting from the main indigo palette.

Dulux's 2026 collection offers a versatile palette that complements the calming and trustworthy atmosphere we expect in clinical environments. When you pair these shades with matching flooring and upholstery, like A-dec's selection of blue chair finishes, you create a cohesive and comforting space for both patients and practitioners.

For practices looking to explore colour design in more depth, there are lots of useful tools and resources available. For instance, A-dec's augmented reality tool, Dream in 3D, can help you visualise different colour palettes with a click of a button – try it for yourself at a-dec.com/dream-in-3d. D

Request samples of A-dec's upholstery at https://unitedkingdom.a-dec.com/colour.



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The remarkable R4+

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R4+, a Sensei product, offers access to the strongest and most comprehensive workflow.

The system has been elevated further through the incorporation of cloud-thinking with the renowned Sensei solutions. From booking and scheduling to patient records, the R4+ offers multiple outstanding benefits. These include e-signatures and SMS messaging to ensure strong patient communication, online backup and recovery for peace of mind and security, and even enhanced imaging integration for a seamless workflow. The powerful system does not compromise ease of use, with clear and straightforward calendars plus stored patient information, medical tracking, and finances available in just a few clicks.

gosensei.co.uk

Zirkonzahn design software training Zirkonzahn

Zirkonzahn has announced the first dates for 2026 for its training on the Zirkonzahn.modifier design software on 23-24 and 26-27 March 2026 at the School of London.

This course provides a comprehensive overview of the Zirkonzahn.modifier design software. Participants explore the software's most relevant features and see live demonstrations of its use in combination with Zirkonzahn's newest products, such as the Jawaligners and the head tracker digital facebow.

Special attention is given to the enhanced virtual articulator, particularly its application with the splint and snoring bite functions. The instructor guides participants through the software advanced tools and workflows, such as Continue Working – which enables users to move seamlessly back and forth within the design process – as well as the integrated workflow for designing bars and overstructures in a single step.

The new Zirkonzahn.archive software and the Zirkonzahn.app are also presented, showing how they help to simplify the daily work. The training concludes with a practical session, allowing participants to apply and consolidate their newly acquired skills.

The course is open to dental technicians and dentists and meets the criteria for the GDC's development outcome C.

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Never-ending knowledge ADI

Improving one's knowledge is vital to stay ahead in the field of implant dentistry. As techniques, technologies and materials evolve, clinicians must too. Due to this, access to high-grade learning opportunities is crucial to maintain positive confidence and a strong, updated skill set.

The Association of Dental Implantology (ADI) enriches members with a huge array of educational resources. This includes reduced fees to its world-renowned implant dentistry conferences and £150 credit for use on the Osteocom Dental Education Platform. With webinars available too, an ADI membership encompasses every aspect of innovative learning.

Each attribute delivers practical, research-based information that is not only applicable to clinical performance, but also enhances decision-making and patient care.

www.adi.org.uk

AI-powered and accelerated implant planning Carestream Dental

Carestream Dental's latest innovation in digital implant planning is CS 3D Implant Premium, an advanced AI-powered software solution that streamlines workflows, improves case acceptance and simplifies case sharing between professionals.

Utilise CS 3D Imaging Premium and its AI capabilities to automate routine tasks, accelerating the implant planning process.

Once you merge a CBCT scan with digital impressions, the AI Auto Implant feature automatically identifies and numbers teeth. Then, select an implant from a digital library featuring more than 100 manufacturers, and the program calculates an appropriate crown position and the dimensions and position of the virtual implant, all while accounting for the present anatomy.

The case plan can be exported as STL files to labs, or exported directly into Smop or Blueskybio software for surgical guide creation.

The Share My Case service seamlessly enables sending CBCT data and implant planning files online without manually exporting the data.

All premium features are available through a new subscription plan, but you can experience them in a free 30-day trial.

www.carestreamdental.com/cs3dpremium

Digital dentistry at a time that suits you Planmeca

Planmeca's mobile showroom Plandemo is packed with the latest in cutting-edge technology and provides the perfect opportunity to explore the full product range at a time and location that suits you.

See the New Viso G1 CBCT imaging unit inside. Discover how easy it is to use first-hand, and the high-quality clinical images it produces.

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Experience the rich selection of tools and features available in Romexis with a software demonstration, and find out how same-day dentistry can be incorporated into your surgery with the Planmill 35 milling unit.

www.planmeca.com/plandemo

Industry innovations

Efficiency meets ergonomics Coltene

Coltene continues to lead endodontic innovation and efficiency with the Hyflex EDM OGSF Sequence – a simplified yet structured, four-file workflow created to improve the speed, accuracy and safety of endodontic care.

Developed using advanced electrical discharge machining (EDM) technology, each nickel titanium file offers outstanding flexibility, fracture resistance and durability. The intuitive sequence – including the Opener and Glider to open the glide path, and the Shaper and Finisher for the accurate shaping of the root canal over the full length – assists clinicians through optimised design.

Minimising instrument changes during treatment, the Hyflex EDM OGSF Sequence delivers high fracture resistance, long-term durability and enhanced torque control.

The result is a predictable workflow that enhances both clinical performance and patient comfort.

For practitioners seeking a system offering ergonomic, innovative design that streamlines their workflows, find out more today!

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Bulletproof your dentistry IAS Academy

If you've ever struggled with broken restorations, chipped bonding or unpredictable bite outcomes, IAS Academy's Bulletproof Dentistry course offers the clarity and confidence you need.

This two-day course is tailored for dentists who want to reduce stress and increase the longevity of their restorative work. Through a combination of theory and real-world applications, delegates will learn how to approach complex restorative challenges with precision and ease.

Overseen by expert ortho-restorative dentists Dr Jaz Gulati and Dr Mahamoud Ibrahim, the course will cover a range of useful topics including occlusal positions, restorative design, biomechanics and force management protocols, how to spot possible complications combined with various practical exercises.

New for 2026, participants gain access to 10 hours of online pre-course video content, allowing them to prepare at their own pace and revisit key concepts anytime.

Whether you're looking to refine your restorative approach or tackle more advanced cases with confidence, Bulletproof Dentistry equips you with the tools to succeed.

www.courses.iasortho.com/courses
01932 336470

A-dec raises the bar with new package A-dec

A-dec is shaking up the dental world with the A-dec 500 Pro Dental Package, a premium solution designed to enhance ergonomics, streamline workflows, and ensure long-term adaptability.

The A-dec 500 Pro pairs the flagship A-dec 500 chair with the cutting-edge 500 Pro delivery system, which includes the Dynamic 500 Pro touchscreen (DS7). This user-friendly seven-inch touchscreen simplifies daily tasks with customisable presets, first-out logic for safer procedures, and multi-user profiles that sync effortlessly across operatories. The outcome? A more efficient and personalised experience for every clinician.

At the core of this system is A-dec+, an updatable software platform that keeps your equipment up-to-date and connected. With the A-dec+ app, practices can easily monitor equipment performance, receive real-time alerts, apply software updates, and manage one or multiple locations without a hitch, leading to smoother operations and less downtime.

Built with adaptability in mind, the A-dec 500 Pro is designed to evolve alongside your practice, ensuring it remains relevant and ready for the future. This dedication to quality is backed by A-dec's impressive 10-year warranty, giving you peace of mind that the equipment is built to last and perform over the long haul.

a-dec.com/delivery-systems/a-dec-500
a-dec.com/find-a-dealer

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