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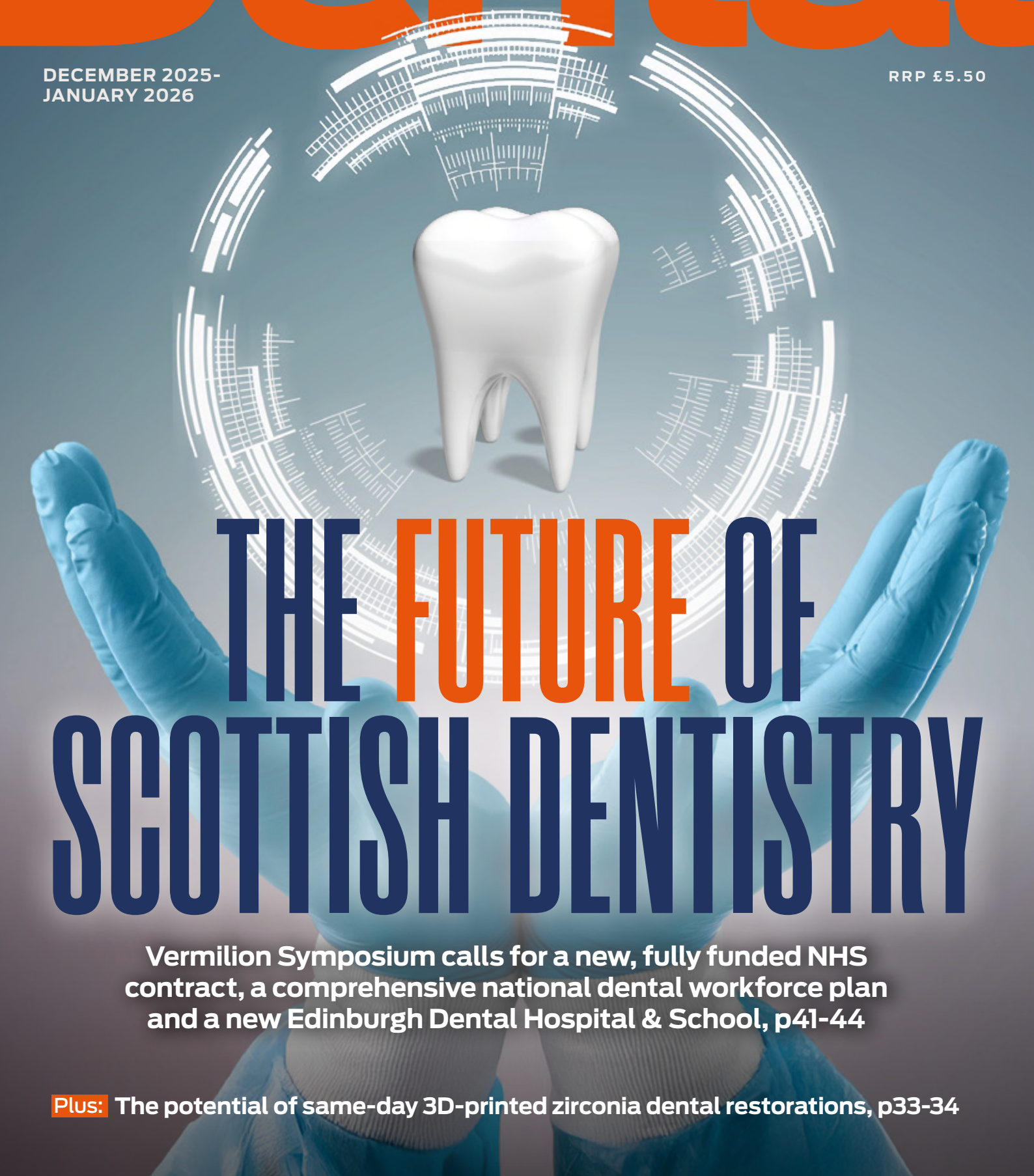

THE FUTURE OF SCOTTISH DENTISTRY

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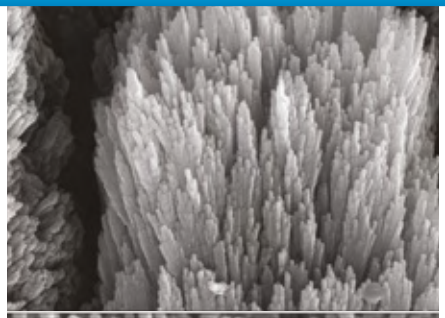

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Cautious optimism

The next three years will determine whether the GDC can transition to being trusted, effective ... and respected

The General Dental Council's (GDC) corporate strategy for 2026–2028, *'Trusted and effective,'* is arguably its most significant statement in a generation, seeking to pivot the regulator's role from being a source of anxiety to being a partner in public health and professional development.

For the dental profession, facing workforce shortages, high costs and systemic pressures within NHS dentistry, the reaction will be complex, a mix of entrenched scepticism, cautious optimism and a demand for tangible results.

The strategy's success rests entirely on the GDC's ability to turn its stated intentions regarding Fitness to Practise (FtP) reform and financial transparency into demonstrated, observable cultural change.

The most immediate and emotional reaction from dental professionals will likely be towards the GDC's commitment to reduce the "negative unintended impacts" of the FtP process and tackle the widely reported existence, and now acknowledged by the GDC, "climate of fear."

This is the core issue that has historically alienated registrants. The promise of streamlining investigations, making them timely and proportionate and prioritising non-adversarial methods, such as remediation, will be met with relief.

The dental profession has long argued that the drawn-out and punitive nature of FtP cases significantly harms mental health and drives experienced professionals out of practice.

However, this relief will be heavily tempered by deep-seated scepticism. The profession understands that the GDC is often constrained by outdated legislation, and changing the culture of an organisation requires far more than a revised mission statement.

Professionals will be watching closely for two things: a measurable reduction in the duration of cases, and tangible evidence that minor, isolated clinical errors are indeed being diverted towards educational remediation rather than formal disciplinary proceedings.

A second critical point of contention is the increase in the annual retention fee (ARF) for 2026. While the GDC justifies the increase by linking it to the investment needed for strategic modernisation, including digital-first services and efficiency savings, fee-payers, particularly through representative bodies such as the British Dental Association (BDA), will understandably react negatively.

Professionals, already facing mounting cost pressures, view the ARF as a compulsory tax, and any increase is a point of acute financial pressure.

The GDC has attempted to mitigate this backlash by capping future increases at the consumer price index (CPI) and committing to deliver 7% efficiency savings over five years.

The profession's reaction will, therefore, be transactional; it has paid the price for reform, and now it will, justifiably, demand transparency and delivery. It will expect regular, detailed reporting that demonstrates where the investment is going and that is not simply funding an expanded bureaucratic structure.

The success of the digital-first registration service, planned for early 2026, will be an early and high-profile test of whether the GDC can deliver efficiency for the new cost.

The strategy's focus on the dental workforce introduces both welcome relief and new anxieties. The commitment to streamline international registration and significantly increase the number of overseas professionals entering the register via the Overseas Registration Examination (ORE) addresses the critical UK workforce crisis, particularly in NHS primary care.

Practitioners facing burnout and excessive patient demand will welcome any initiative that brings qualified colleagues into the system faster.

Conversely, this focus raises two related concerns. First, the maintenance of standards. Professionals will insist that while the pathway is made more accessible, it must not become easier in a way that compromises patient safety or clinical equivalence with UK-trained graduates.

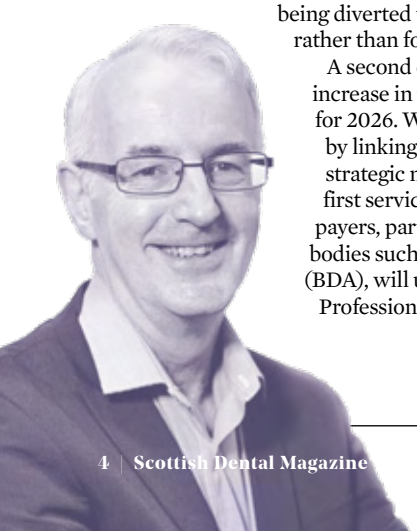
Second, the GDC's pledge to work collaboratively to influence wider issues, such as access to NHS dentistry, is ambitious.

While the profession is desperate for meaningful structural change, many will question the regulator's authority and efficacy in influencing deep-seated governmental policy on health funding and provision, a field traditionally outside the GDC's direct remit.

The GDC's *'Trusted and Effective'* strategy is fundamentally a contract with the profession. It recognises the deep frustration and existential fear felt by registrants and offers meaningful reform, particularly around FtP proportionality and digital modernisation.

The profession's reaction will probably be best described as one of cautious optimism; it is willing to believe in the promised culture change, but it will be diligent; scrutinising every ARF expenditure, every FtP outcome and every modernisation milestone.

The next three years will determine whether the GDC can successfully transition from a feared overseer to a truly trusted, effective and respected partner in the UK's oral health landscape.



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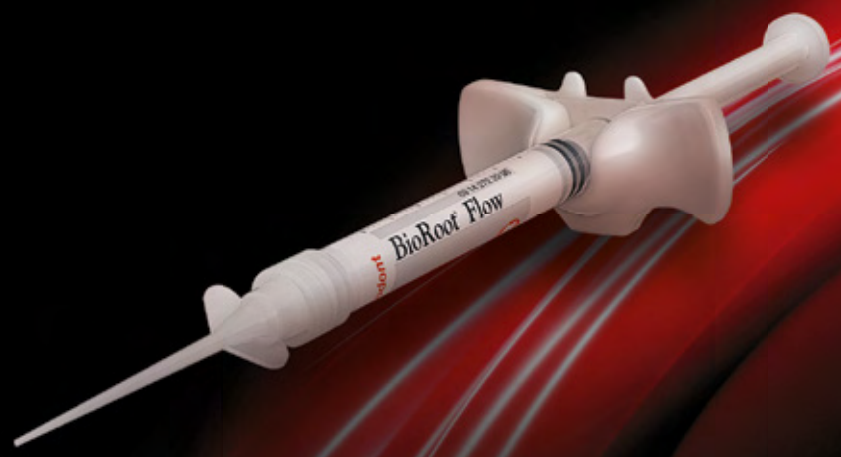

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Arthur Dent is a practising NHS dentist in Scotland
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Today's work world seems to focus on advancing technology, scaling and growth, founders and entrepreneurs and building your 'brand'. Other than the scaling, pun intended, what has that to do with dentistry? I'd suggest absolutely everything, but nothing particularly new.

Throughout my career, there have been huge changes in the technologies involved in dentistry. For example, the rise of digital X-rays, OPTs and CBCT and the advent of artificial intelligence (AI) products, such as Pearl, to enhance our assessment abilities. This speeds up processes and sharpens our diagnostic wit, benefitting our patients with treatment plans in seconds. Although, we should not be pressurised into making snap decisions, especially on complex plans or where diagnoses are not clear and obvious. Sometimes, having a good think, getting a second or third opinion and considering all the options is the smart play.

By the same token, we still only do direct and indirect restorations, prostheses, endo, oral surgery and perio. Most of these treatments are fundamentally unchanged; I can't remember which incarnation of resin bonding systems we are on? They work in the same way, just better and I'm very grateful for it. However, that incremental progress has happened without so much as an ounce of my effort. The cost of that change has not altered significantly either; it may be cheaper in real terms. The manufacturers alter materials, improve equipment design, chairs get more advanced – but that change is not driven by average dentists.

As to scaling and growth, the standard career arc, be it NHS, private or a healthy mix of the two, tends to look pretty much the same. Start small and simple and build skills and patient lists as you go. Inheriting a big list may give you a head start but it's a double-edged sword; the capitation/insurance payments are great, but can you service the patients? What are their demands and how well are they looked after or managed? Can you keep them happy while avoiding squeezed emergencies and expanding wait times?
A slow burn of patient numbers is much more likely to allow a young practitioner to build their experience and talent while maintaining quality and improve their confidence and decision-making abilities.

That is the definition of sustainable, scalable growth. It is the same with practices. Whether you start with a squat or buy an existing practice or even a group, the standard rules for managing growth apply. Supply and demand on one side and the ability to maintain your service quality and reputation on the other. The current situation in many practices is to protect the latter by limiting the former i.e. "we've stopped taking on patients" is code for we can't sustain growth. This is both heartening (someone in the practice has realised that their reputation is on the line and if we load our staff beyond their tolerance, we will lose it) and disappointing that a business struggles to grow and provide the service the population needs.

This leads us on to the entrepreneur/founder process. This was the main reason I chose dentistry over medicine as a career. I was always interested in running a business. I know that is not for everyone, but it seems to be popular to label yourself this way these days. Dentistry has always had a bit of this. The whole model relies on small business owners taking on risk, buying or setting up practices and putting themselves well outside their dental comfort zone and undergraduate training. It is not easy being a practice owner. It is incredibly difficult starting from scratch, even more so if you are on your own. The scale and range of legislation and compliance to learn and satisfy is enormous. But once you've done it and mastered it you deserve to call yourself an entrepreneur.

And finally... branding. It seems everyone is building their 'brand'. Social media is awash with people telling you how to do it. I saw a short video recently with a dental 'disruptor' weighing in on this. I agreed wholeheartedly with their thought. Making yourself out to be some kind of special dentist that exists only in a tiny niche in our profession is, in my not so humble opinion, most likely untrue. If you are a reasonable generalist, you can do pretty much everything they need and a course on invisible aligners does not make you an orthodontist.

This influencer's take was: "No-one wants to spend longer at the dentist than they have to and listening to you talk yourself up is a waste of their time." Spend that time finding out what their needs are. Talk about them, take them on their dental journey doing what you can, referring well for what you cannot and keep their oral health your top priority. Build the relationship, not your sales pitch. If you do that, then they will be happy to use you for their grand plan. That is how you build your brand, your reputation and enhance your marketing. The single best sustainable practice builder is word of mouth from happy patients. Not posts of footballers with composite bonding on Instagram. Build your skills through continuing professional development (CPD) and practice. Build relationships through knowledge of your patients, long-term care and results. Know your own abilities by seeing your failures, managing difficult patients and exude the confidence brought by experience. Stop 'building your brand' and just build your brand. That will lead to a well-cared for cohort that look after you, let you scale and grow and lead a satisfying professional life as a dental entrepreneur.

New Chief Dental Officer for Scotland announced

Gillian Leslie takes over from Tom Ferris who retires at the end of December

DR GILLIAN LESLIE has been appointed Chief Dental Officer (CDO) for Scotland. She takes up the post on 1 January 2026, following the retirement of the current CDO for Scotland Dr Tom Ferris.

Dr Leslie is the Principal Dentist and Practice Owner of Bridge Dental Care in Tranent. She graduated in 1998 from the University of Glasgow and joined the Commando Logistics Regiment of the Royal Marines, serving with them in Iraq during the second Gulf War.

She was posted to the US Navy to complete a year's training in exodontia and then to Germany to treat military personnel and their families, before returning to the UK to work in the Maxillofacial Unit at Queen Alexandra Hospital in Portsmouth.

During this time, Dr Leslie studied to gain her Membership of the Faculty of Dental Surgeons of England. In 2021, she was appointed as one of three deputy CDOs for Scotland.

In a letter to NHS staff, Tim Mcdonnell, Director of Primary Care in Scotland, said that Dr Leslie had been "instrumental in our delivery of NHS dental reform from November 2023, bringing in her experience as a practising dentist and business owner to deliver sustainable change for the profession."

He added: "I am delighted that Gillian will now have the opportunity to build on this successful programme to deliver further, meaningful action for oral health and dental care in Scotland, working in partnership with you and your teams.

"In her new role as CDO, Gillian will be responsible for overseeing all aspects of NHS dental policy and clinical leadership to ensure that we continue to deliver safe, effective and sustainable care to the communities that we serve.

"Please join me both in congratulating Gillian on her appointment, and in wishing Tom all the best for his well-deserved retirement."

A spokesperson for the British Dental Association (BDA) congratulated Dr Leslie on her appointment, adding: "Gillian is already well known by many of the dental profession in Scotland.

"She was heavily involved in the delivery of NHS payment reform, in her current role as Deputy CDO which she has held since 2021. BDA Scotland and its elected representatives look forward to continuing to work with Gillian in her new role as CDO."

Countries agree to end mercury fillings by 2034

MORE than 150 countries, including the United Kingdom, have agreed to phase out the use of mercury-based amalgam in fillings by 2034.

At a conference in Geneva in November, signatories to a treaty aimed at protecting human health and the environment from mercury pollution agreed "to end the use of dental amalgam by 2034, marking a historic milestone in reducing mercury pollution".

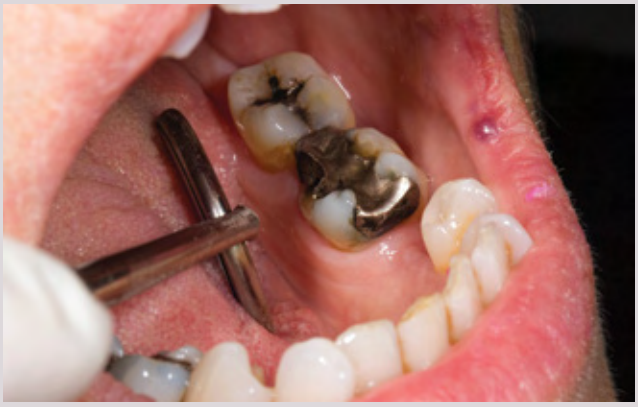
The Minamata Convention on Mercury is an international treaty to protect human health and the environment from the adverse effects of mercury and mercury compounds.

"This science-based, time-bound agreement marks a decisive step toward the total elimination of mercury use in dentistry," the signatories said in a statement.

Some countries have already banned its use in dental amalgam, a common filling material used for more than 175 years. But it remains the most common material for NHS permanent fillings across the UK.

Its use does come with regulations; it must only be used in pre-dosed encapsulated form; it must not be used for the dental treatment of deciduous teeth of children under 15 years, or for pregnant or breastfeeding women; and all dental practices must be equipped with an amalgam separator.

In November, the West of Scotland branch of the British Dental Association (BDA) hosted an in-person event, *'After amalgam, the battle of the bulk fills'*.



It focussed on the context of dental amalgam's use and reduction of its use; alternatives to amalgam, where and when each type can be used; and learning about Glass Ionomer Cement (GIC) and its variants.

Post-event, the BDA signposted resources for the profession:
Minamata Convention decision: tinyurl.com/wnnka9d2
Using dental amalgam in the UK: tinyurl.com/4p2pc4my

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Profession must 'reclaim the narrative' over teeth whitening

Regulation exists to prevent adverse incidents but investigation claims it is being ignored

THE BBC's recent investigation into illegal tooth-whitening is an opportunity to "show patients what legal whitening looks like," according to Dr Ben Atkins, past President of the Oral Health Foundation.

Dr Atkins described the findings of the investigation as "terrifying but sadly unsurprising. Whitening gels at 53% peroxide aren't aesthetic, they're chemical assaults on living tissue."

He said dental professionals see the aftermath; burned gingivae, pulpitis, enamel fracture and hypersensitivity so severe patients cannot drink cold water.

"These are preventable harms from products that should never be in unregulated hands," he said. "Regulation exists to prevent adverse incidents such as this but is clearly being ignored.

"Ensuring patients are dentally fit before whitening is a fundamental safeguard built into UK dental regulation. Under UK law, whitening above 0.1% hydrogen peroxide is a dental procedure and must only be prescribed or carried out by GDC-registered dental professionals using products up to 6%.

"This legal framework, underpinned by the Dentists Act 1984, GDC Standards for the Dental Team, and UK Cosmetic Products Safety Regulations, exists to protect patients through mandatory clinical assessment, consent and supervision."

He urged dental teams to embed whitening within auditable pathways; pre-treatment screening, signed consent, product traceability, post-treatment review and documented sensitivity management. Partnerships with industry and professional bodies can support the profession, he said.

"Companies like Philips, with its Zoom Whitening portfolio, and organisations such as the Oral Health Foundation have the credibility to amplify safety messages, supply patient-facing materials and lobby digital platforms to remove illegal listings. When manufacturers back research-led, compliant systems, they give clinicians confidence and protect patients."

Dr Atkins added: "This investigation is our chance to reclaim the narrative. Show patients what legal whitening looks like.

"Offer patients a safety-check consultation to assess kits they have purchased online. Make infection control and consent visible.

"When patients see the rigour involved, they can understand the significance of a legal, professional treatment – rather than defining their search by price.

"By underlining what is involved to protect them, ensuring they are not damaged, and that they get a good result, they can appreciate our added value."

AI speech tools could revolutionise dental record-keeping

ARTIFICIAL intelligence (AI) automatic speech recognition (ASR) tools could dramatically improve how dental professionals record patient information, according to a study by King's College London.

But the study[1], published in the *Journal of Dental Research*, added that while the transcriptional accuracy of these tools is high, they can struggle with more technical language and their reliability is not currently sufficient to support unreviewed use.

Researchers tested ten different ASR systems to see how well they could transcribe spoken orthodontic clinical records into written text.

The best-performing system was an experimental pipeline combining OpenAI's GPT-4o transcription with a large language model for error correction, closely followed by the Heidi Health digital scribe and the GPT4-oTranscribe speech-to-text application programming interface.

While the technology is promising, researchers warn that clinically significant errors - such as misidentifying teeth or treatment plans - can still occur. They recommend a 'human-in-the-loop' approach, where clinicians review and edit transcripts rather than relying on them blindly.

"AI speech tools can streamline documentation and improve efficiency, but we must remain vigilant," said Ruairi O'Kane, the lead author. "Even subtle transcription errors can potentially impact patient care."

[1]*kclpure.kcl.ac.uk/ws/portalfiles/portal/352269625/Final_manuscript.pdf*

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SCAN TO REFER

Turkish dental clinics target Scotland

Global value of dental tourism is set to increase by £40bn over the next 10 years

PERSONNEL from dental clinics based in Antalya, Türkiye, were scheduled to be in Scotland throughout the autumn and winter offering consultations, treatment plans and "transparent pricing" to potential patients.

The revelation comes as a new report puts the global value of dental tourism in 2025 at £7.95bn, with that figure set to rise to £47.80bn over the next 10 years.

The report[1] says that the growth of the market is driven by "the high cost of dental care in developed nations, increased awareness of affordable options abroad and the appeal of combining medical treatment with tourism".

Dental tourism is said to be worth £600m[2], annually, to the Turkish economy. Now, Turkish practices are targeting Scotland specifically with events in Edinburgh, Glasgow and Aberdeen.

> "A NEW REPORT PUTS THE GLOBAL VALUE OF DENTAL TOURISM IN 2025 AT £7.95BN, WITH THAT FIGURE SET TO RISE TO £47.80BN OVER THE NEXT 10 YEARS"

They include HB Dental Clinic. Its team page features biographies of its dentists[3], two of which display dummy text. One says: "Override the digital divide with additional clickthroughs from DevOps. Nanotechnology immersion along the information highway will close the loop on focusing solely on the bottom line".

Another says: "The Big Oxmox advised her not to do so, because there were thousands of bad Commasand devious Semikoli, but the Little Blind Text didn't listen."

A spokesperson for the British Dental Association said: "We are aware that these operators are rapidly innovating, with unregistered dentists providing what appears to be a diagnosis in hotels and now on the high street.

"We have concerns that the authorities are not stepping up to challenge what appear to be material breaches of the Dentists Act 1984. We are continuing to actively campaign on these issues."

[1]*tinyurl.com/3p9xx65t*
[2]*www.uksmiles.co.uk/turkey-dental-statistics*
[3]*hbdentalclinic.com/doctors/*

Scotland's child oral health gap set to widen

DECADES of progress in children's dental health risk going into reverse – with gains at best plateauing – according to the British Dental Association (BDA).

The latest report[1] of the National Dental Inspection Programme indicates that stark and persistent inequalities are widening between Scotland's most deprived and most affluent communities.

Just 68.2% of P7 children in the 10 most deprived areas were found to be decay free – compared with 91.5% in the 10 least deprived – a gap of 23.3%, up from 20.1% in 2019. The report acknowledges that since 2005 obvious decay experience has declined, but this downward trend appears to have flattened out since the COVID-19 pandemic.

Reform to the way NHS dentists are paid was rolled out in November 2023, but the BDA said there remain question marks over whether the level of change is sufficient to keep practices sustainable and narrow inequalities of both access and outcomes. The BDA is advocating a fully funded workforce plan "to ensure Scotland has the dental professionals it needs."

Gillian Lennox, Chair of the BDA's Scottish Dental Practice Committee, said: "Vital progress tackling deep oral health inequalities has at best plateaued, and at worst gone into reverse. As we head into an election year, it's a stark reminder that there can be no complacency when it comes to dentistry. Our children will pay the price for any indifference."

[1]*tinyurl.com/3wbp8kuj*

Merry Christmas

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Inequalities in dental education report published

Calls for coordinated action to address regional inequalities in access to dental careers

A REPORT on widening participation in dental education in the UK, calling for coordinated action to address regional inequalities in access to dental careers, has been published by the Dental Schools Council.

The report identifies persistent 'cold spots' with far fewer applicants than other areas and outlines a series of targeted recommendations to expand opportunities for students from under-represented and under-served areas.

The council said that with oral health inequalities on the rise, particularly in areas with limited access to care, it is essential to implement measures to recruit more students from regions most in need of oral healthcare professionals.

Drawing on internal research and data from UCAS on applicant trends, the council has published schools' progress in improving representation in student cohorts. The report outlines key recommendations to address geographical inequalities:

- Target outreach and recruitment efforts towards regions with low application rates and outside existing university target spots
- Scope mutual recognition of widening participation schemes among universities
- Use national data and tracking systems to map inequalities in real-time.

Professor Ewen McColl, the council's chair, said: "To meet the UK's growing oral health needs and reduce persistent inequalities in oral healthcare across the country, we must draw on the widest possible pool of talent.

"Widening access to future oral healthcare teams from all communities is not only about fairness, though that is important, it is essential for building a dental workforce that is equipped to serve all communities across the country through research and service.

"Nationally, [the council] will explore reaching beyond our traditional catchment areas for our outreach and recruitment efforts towards regions with low application rates. This must be a collaborative effort to ensure that all communities are able to send people to train at dental school.

"Students from under-represented backgrounds bring lived experience, insight and commitment that enrich both the learning environment and the profession. Supporting these students to access and thrive dental education is critical to building a workforce that reflects and understands the population it serves.

"Dental schools cannot act alone. Dentistry remains one of the most oversubscribed courses in UK higher education, with many highly capable applicants unable to secure a place.

"If we are to close workforce gaps and ensure equitable access to care, we urgently need government investment to increase the number of funded places in dental schools. Without this, we risk exacerbating health inequalities and turning away the very future dentists who could make all the difference."

BDIA partners with BREATHE to champion wellbeing

THE British Dental Industry Association (BDIA) has partnered with BREATHE, a new initiative aimed at improving mental health and wellbeing across the whole UK dental sector.

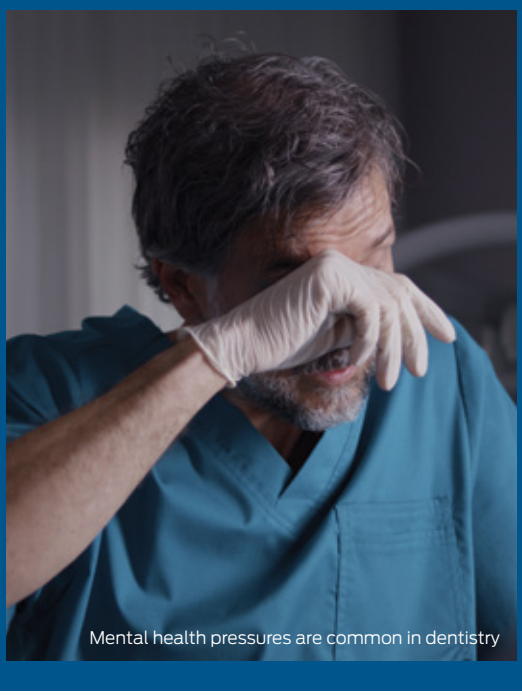
BREATHE offers practical advice, useful resources and signposts to professional support for anyone in the dental community, from dentists, technicians, nurses, receptionists and practice managers.

Mental health pressures are something many people in dentistry experience, not just clinicians. Long hours, demanding workloads and the emotional pressures of patient care can all take their toll. BREATHE aims to make it easier for people to talk about these challenges and find the help they need.

Edmund Proffitt, Chief Executive of the BDIA, said: "We're really pleased to be working with BREATHE. It's a brilliant initiative that highlights an issue affecting so many people across the dental world. Wellbeing isn't just a nice-to-have; it's essential to keeping our teams healthy, motivated and able to deliver great patient care."

Dr Rana Al-Falaki, Co-Founder of BREATHE, added: "BREATHE was created because we saw how much the dental community needed a safe space to talk about mental health and to find genuine support. Partnering with the BDIA helps us reach more people and keep wellbeing at the heart of the conversation in dentistry."

To learn more or access the BREATHE platform, visit **www.breathedentalwellness.org**



Mental health pressures are common in dentistry

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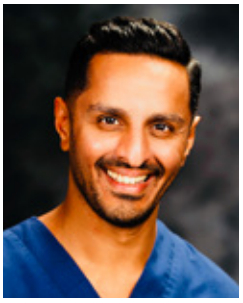
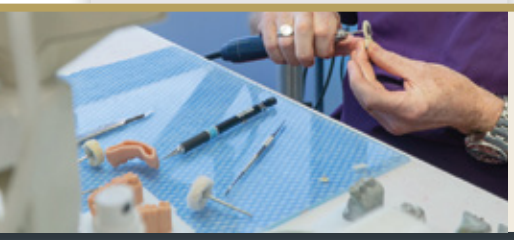


GDC No. 75815 | BDS (Glas, 1999) | MFDS RCS (Edin, 2002) | MSc MedSci (Glas, 2003) | Dip Imp Dent (RCS Edin, 2011)

Abid is a graduate of the Glasgow Dental School. He has a master's degree at Glasgow University and a Diploma in Implant Dentistry from The Royal College of Surgeons in Edinburgh. He is a member of their Faculty of Dental Surgery, and he is the immediate past president of the Association of Dental Implantology. Abid limits his practice to implants and the management of complex restorative cases with a special focus on immediate loading – having placed in excess of 5,000 implants. He utilises digital dentistry, implants and smile design for the management of complex restorative cases.



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Revised standards for dental education released

Five new areas introduced to address demands of modern practice

THE General Dental Council (GDC) has published its revised Standards for Education, marking the first comprehensive update to the framework since 2015.

Following a 12-week public consultation, the new standards – which define the requirements for all UK dental programmes leading to GDC registration – will come into effect for the 2026/27 academic year. They form the core framework for the regulator's quality assurance of dental education across the UK.

Designed to reflect the evolution of dentistry, demographic shifts and the wider healthcare ecosystem over the last decade, the revised Standards are intended to be used in conjunction with the Safe Practitioner Framework, published in 2023.

After extensive engagement with education providers, professional bodies, students and Chief Dental Officers, the GDC has made structural improvements and introduced five new areas to address the demands of modern dental practice:

• Student and Staff Wellbeing: Directly addresses the importance of mental health and robust pastoral support systems within training institutions.

• Admissions: Focuses on establishing fair, inclusive and transparent processes for programme entry.

• Monitoring of Behaviours: Strengthens requirements for professional development and maintenance of standards throughout training.

• Technological Advances: Ensures programmes keep pace with the rapid developments in dental technology and digital education methods.

• Differential Attainment: Commits to actively addressing inequalities and providing dedicated support for diverse learners.

Stakeholders, who provided 42 responses to the consultation (from November 2024 to February 2025), praised the changes for their clearer structure and the addition of topics relevant to modern dental education.

Manjula Das, Head of Education Quality Assurance at the GDC, commented: "We're delighted with the positive response to our revised Standards for Education.

"These updates ensure our regulatory framework keeps pace with the evolving needs of dental education whilst maintaining our primary focus on protecting patients.

"The new requirements around wellbeing, inclusive admissions, and differential attainment demonstrate our commitment to supporting students and trainees. We look forward to working closely with education providers over the coming year to ensure a smooth transition to these revised standards."

The core structure maintains the four key regulatory areas – patient protection and safety, student development and support, quality assurance of programmes and examination and assessment – but breaks down complex areas into clearer, stakeholder-specific requirements.

Education providers will be supported by the GDC with guidance, engagement sessions and resources to adapt their processes and transition confidently to the revised Standards by August 2026. The full Consultation Outcome Report[1] and the Revised Standards for Education[2] are available on the GDC website.

[1] *tinyurl.com/8rkj8u8k*
[2] *tinyurl.com/23utnu4w*

Smartphone system shows promise for early detection of oral cancer

A LOW-COST, smartphone-based imaging system called mDOC (mobile Detection of Oral Cancer) has been developed and tested by researchers at Rice University in Houston, Texas. Their study[1], published in *Biophotonics Discovery*, evaluates how well the system can help dental professionals decide when to refer patients to oral cancer specialists.

The mDOC device combines white light and autofluorescence imaging with machine learning to assess oral lesions. Autofluorescence imaging uses blue light to detect changes in tissue fluorescence, which can signal abnormal growth. However, this method alone can be misleading, as benign conditions like inflammation also reduce fluorescence.

To improve accuracy, the mDOC system uses a deep learning algorithm that analyses both image data and patient risk factors, such as age, smoking habits and anatomic location, to make referral recommendations.

In the study, researchers collected data from 50 patients at two community dental clinics in Houston. Each patient underwent imaging of up to five oral sites using the mDOC device. The images were reviewed by expert clinicians and their referral decisions served as the 'ground truth' for training and testing the algorithm.

The team used a rehearsal training method, combining new data with previously collected images from high-prevalence and healthy populations to improve the model's performance in typical dental settings, where suspicious lesions are rare.

The final model was tested on a holdout dataset representing a low-prevalence population. The system correctly identified 60% of the sites that experts recommended for referral, while avoiding unnecessary referrals in most cases. Notably, the mDOC algorithm outperformed dental care providers, who missed all cases that required referral.

Future improvements may include collecting more detailed patient history and refining the algorithm to reduce false positives.

[1] *tinyurl.com/5ndkh6u6*

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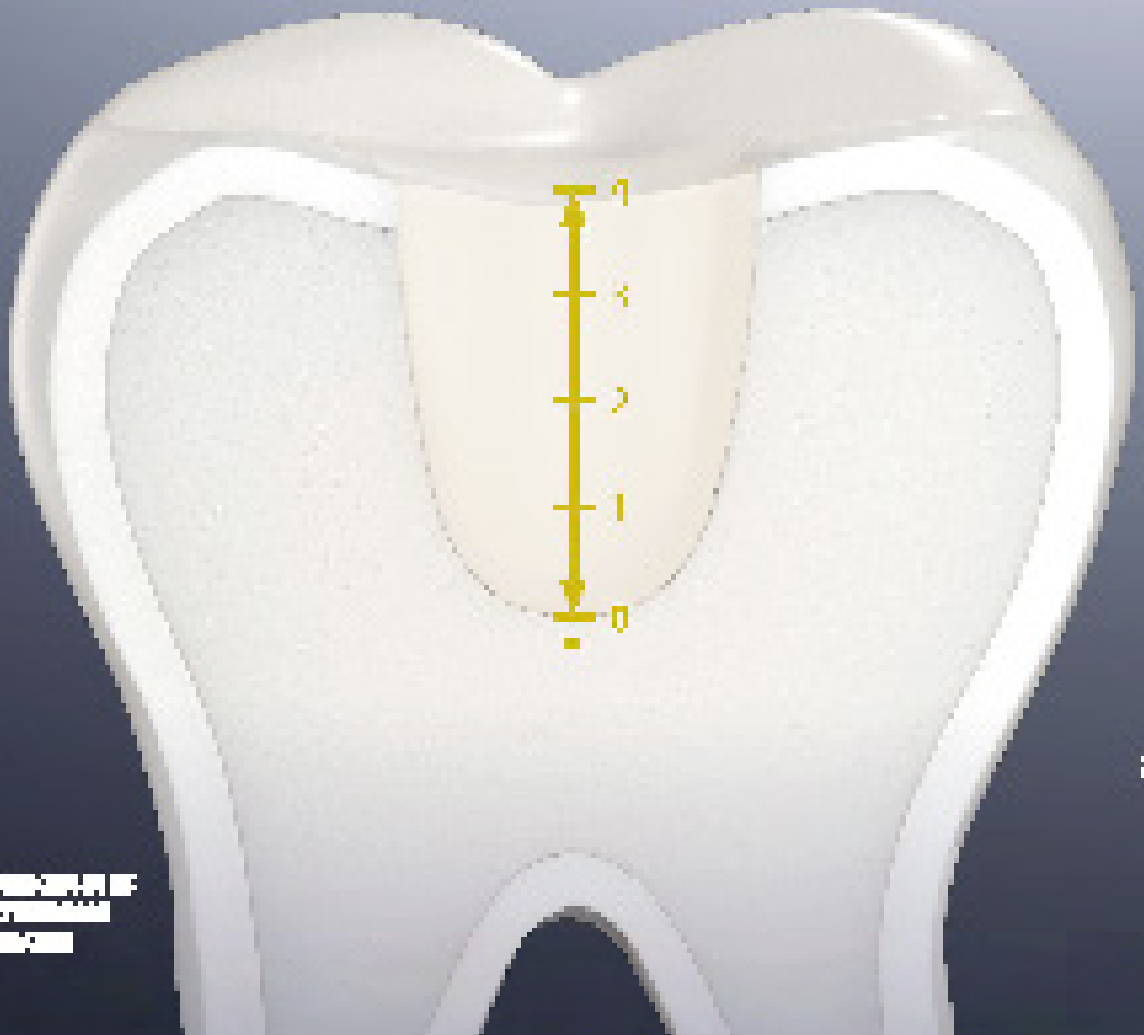

Strong support for suicide awareness teaching

Dental students say there is also scope for a unified approach to teaching

THERE is strong support for increased suicide awareness teaching at undergraduate level and scope for a unified approach to teaching in the United Kingdom, a study[1] by students at Dundee Dental Hospital and Research School has found.

There are more than 6,000 deaths by suicide each year in the United Kingdom. National suicide prevention strategies seek to improve the way services assess those who are suicidal.

The Dundee study highlighted that undergraduate dental students lack confidence when assessing individuals for suicide risk and that there is an appetite for education on this topic.

The aim of the study was to design, deliver and evaluate a brief teaching intervention on suicide awareness for undergraduate dental students using the NHS Model for Improvement methodology. A scoping literature search found no formal framework or evaluation on suicide awareness teaching for undergraduate dental students.

Following the development and delivery of a pilot teaching intervention, an anonymised questionnaire was distributed with free-text boxes to capture qualitative feedback. Analysis informed subsequent improvement cycles and teaching.

"The vast majority of students felt the teaching was relevant, useful and reported increased confidence and awareness of how to signpost following disclosures of suicidal ideation," said the study's authors.

"Qualitative feedback was overall very positive, with the importance and universal impact of the topic highlighted. In total, 98% of students felt this topic should continue to be taught at undergraduate level and an appetite was expressed for further teaching."

The authors concluded: "There is strong support for further suicide awareness teaching at undergraduate level and scope for a unified approach to suicide prevention teaching in the United Kingdom.

"Consideration of the lived or living experience of those who have been affected by suicide, alongside input from national experts and charities, will be crucial in the development and delivery of this educational material."

[1] *www.nature.com/articles/s41415-025-8720-5*

BOS launches pro bono scheme for conflict zone refugees

THE British Orthodontic Society (BOS) is creating a database of members willing to treat patients arriving as refugees from conflicts.

"Refugees continue to arrive in the UK, with recent conflicts in Gaza, the Middle East and Ukraine adding to the figures," said a spokesperson. "To help provide practical help and support, the BOS would like to be able to create a database of members who would be willing to treat patients arriving as refugees in their locality.

"We appreciate that this work will need to be done on a pro bono basis, but the BOS Board believes that it is for a worthy cause. Some of those entering our country will, of course, need urgent medical attention and orthodontics may not be their focus but for those who need our help, we think that as orthodontists we should be able to 'step in' and assist."

If practitioners would like to add their name to this register, they can email Gemma at the BOS office on executiveSec@bos.org.uk. The list would be circulated to those in need who would contact practitioners directly and it would be for them to then liaise with the patient.

When consenting to be placed on the list, the BOS said it would helpful if members could indicate whether, among their team, there are individuals who speak other languages and who may be able to help those refugees with limited English.

"We know that the thoughts of our members are with all those affected by the devastating effects of conflict and we hope that this scheme will allow BOS members and our specialty to help in small ways," said the spokesperson.

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Ukrainian dentist creates robot receptionist

Kyiv startup is aiming to support digitalisation of the service sector

A ROBOT that combines artificial intelligence and business process automation has been created by a Ukrainian dentist.

VUZOLL, a startup founded by Kyiv-based Roman Niskhodovskiy, is taking on the digitalisation of the service sector, creating intelligent robot assistants capable of replacing a business's reception and automating routine business processes.

The robot, its first product, can meet patients, recognise faces, conduct consultations and make appointments. It is currently in use at Niskhodovskiy's clinic. He said the aim was to reduce workload on staff and improve service.

"I wanted to create a smart assistant that would help both the clinician and the patient – quickly, accurately and humanely," he said.

"We don't just build robots; we create a new culture of human-machine interaction. Our robot can meet customers, recognise faces, speak natural language, provide advice, record in CRM and even respond to emotions."

The company is preparing to deploy 10 robots at partner businesses to test their effectiveness, followed by mass production. The price per robot is expected to be around £4,000, plus around £100 per month for a subscription which includes AI module updates, CRM integration and technical support.

College publishes portfolio requirements for restorative dentistry

Associate Fellowship acts as a stepping stone to Fellowship, recognising enhanced knowledge and skills

DETAILED requirements for portfolio submissions in restorative dentistry have been published by the College of General Dentistry (CGDent). It follows the recent launch of CGDent's portfolio-based route to Associate Fellowship and the Clinical & Technical domain of Fellowship.

Those with a wealth of clinical experience and expertise in restorative dentistry, and not just advanced qualifications in the field, can now apply for Associate Fellowship of the College. If successful, they will also have satisfied the Clinical & Technical domain of College Fellowship and will be able to add their portfolio to the College's Register of Members and Fellows as a recognised qualification.

Associate Fellowship acts as a stepping stone to Fellowship, recognising enhanced knowledge and skills. Associate Fellows are eligible to attend the College's prestigious Fellows' Receptions, have the opportunity of ceremonial admission by the College President and may use the postnominal 'AssocFCGDent'.

Fellowship is the most distinguished membership of the College and is recognised with the postnominal designation 'FCGDent'. A mark of excellence, it requires satisfaction of at least three of the College's five Fellowship domains.

> "ASSOCIATE FELLOWSHIP ACTS AS A STEPPING STONE TO FELLOWSHIP, RECOGNISING ENHANCED KNOWLEDGE AND SKILLS"

Those applying via the new portfolio-based route must submit a training log and details of clinical cases. They must also supply a comprehensive CV detailing at least five years' post-qualification experience in roles with the appropriate responsibilities and clinical environment to meet the expected standard of patient care.

For full details see www.sdmag.co.uk/college-publishes-restorative-portfolio-requirements

Scottish Orthodontic Conference 2026

THE annual Scottish Orthodontic Conference takes on Friday 30 January 2026 at the Royal College of Physicians and Surgeons of Glasgow or online.

The in-person and online event will provide delegates with updates on current practice and contemporary topics, with a mix of engaging speakers, clinical pearls and panel sessions.

The conference will be of interest to those based in both primary and secondary care and is intended to engage the whole orthodontic team and those with an interest in orthodontics.

The conference is aimed at:

- Orthodontists
- Orthodontic trainees
- Orthodontic therapists
- Orthodontic nurses
- Dentists with an interest in orthodontics

Learning outcomes

- Improve clinical photography
- Recognise clinical indications for composite restorations when finishing cases
- Updated knowledge on craniofacial abnormalities and their treatment
- Improve clinical efficiency with aligner treatment
- Understand how the British Orthodontic Society is helping the specialty.

Poster competition

Entries for the Scottish Orthodontic Conference poster competition are currently being accepted. The top submissions will be invited to present their entry as part of the conference with the winner announced at the end. All other accepted abstracts will feature as part of a digital showcase. Full submission guidelines can be found in the downloadable documents on the RCPSG webpage.

For full details of the conference and to book your place, visit www.rcpsg.ac.uk/education/scottish-orthodontic-conference

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MPhil MClinDent (Prosthodontics)
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Fears raised over 3D printing in dental clinics

Equipment has potential to emit ultra-fine particles and volatile organic compounds

SAFETY concerns are emerging over the increased use of 3D printing in dental clinics.

The rapid integration of 3D printing into dental practice has transformed workflows by enabling the in-house fabrication of appliances, dental models and surgical guides.

Many clinics now routinely have 3D printers on site, reducing dependence on labs, and costs, while improving turnaround times.

"However, alongside these benefits, safety concerns are emerging," said Dr Prasad Nalabothu, a research scientist at the Oral and Maxillofacial Surgery Clinic, University Hospital Basel, in a *British Dental Journal* report[1].

"Research has demonstrated that desktop 3D printers have the potential to emit ultrafine particles (UFPs) and volatile organic compounds (VOCs) during operation, which have consequences for air quality and occupational health."

Recent data from NHS trusts demonstrate an expansion in the adoption of 3D printing, but approaches to regulation and safety remain inconsistent, added Dr Nalabothu.

"While some organisations may adhere to ISO 13485, MDR (Medical Devices Regulation), or MHRA (Medicines and Healthcare Products Regulatory Agency) processes, numerous reports indicate the absence of specific standards being implemented," he said.

Dr Nalabothu said that the adoption of practical measures such as enclosed printers, adequate ventilation and local extraction has the potential to reduce the associated risks.

"However," he added, "it must be noted that without more robust and comprehensive guidance, the implementation of such measures may remain inconsistent and uneven.

"A coordinated approach from the General Dental Council, dental associations, and occupational health authorities could provide much-needed direction.

"It is imperative that future research also incorporates the consideration of emissions, material safety and environmental impact, thereby ensuring that innovation is embraced without compromising health."

[1] *www.nature.com/articles/s41415-025-9267-1*

GDC publishes whistleblowing disclosures report

All 79 disclosures triggered Fitness to Practise action

EVERY whistleblowing disclosure the General Dental Council (GDC)received in the past year resulted in immediate regulatory action, according to the regulator's Annual Whistleblowing Disclosures Report 2025.

Published alongside those of eight other UK healthcare regulators, the report covers the period from 1 April 2024 to 31 March 2025, demonstrating a coordinated effort across the sector to maintain transparency and address serious concerns raised by insiders.

For the GDC, the key statistics show a steady volume of disclosures, but a "robust" regulatory response:

- 79 whistleblowing disclosures were received, matching the total from the previous year.
- Crucially, all 79 disclosures resulted in regulatory action being taken, specifically the opening of a Fitness to Practise (FtP) case.
- 54 of the 79 disclosures featured concerns related to conduct.

Most concerns came from within the profession, underscoring the vital role dental professionals play in patient protection:

- 51 concerns originated from dental professionals (registrants).
- 22 came from non-registrants employed in dentistry.
- Six were submitted anonymously.

Of the initial 79 cases opened, 46 proceeded with active regulatory consideration, while 32 were closed due to insufficient information, despite the regulator's efforts to follow up. At the close of the reporting period, 29 cases remained under assessment and may yet be referred to Case Examiners for further action.

In response to the importance of these disclosures, the GDC has focused on strengthening its internal processes. The regulator completed additional quarterly reviews in 2024-25 to ensure the appropriate verification and status of individuals raising concerns.

The GDC confirmed it has enhanced its approach to identifying and supporting whistleblowers, implementing additional verification processes to ensure that those raising issues receive the support they need throughout the regulatory process.

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*Source: YouGov Survey 2023

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Gum disease and cavities increase risk of stroke by 86%

Study tracked 5,986 adults, with an average age of 63, for two decades

PEOPLE with cavities and gum disease may face a higher risk of ischaemic stroke, according to a study[1] published in the *Journal Neurology*.

Ischemic strokes are the most common type of stroke and occur when a clot or blockage reduces blood flow to the brain, depriving it of oxygen and nutrients.

"We found that people with both cavities and gum disease had almost twice the risk of stroke when compared to people with good oral health, even after controlling for cardiovascular risk factors," said Souvik Sen, of the University of South Carolina and the study's lead author.

"These findings suggest that improving oral health may be an important part of stroke prevention efforts."

Researchers analysed data from 5,986 adults with an average age of 63 who had no prior history of stroke at the start of the study. All participants completed dental exams that assessed whether they had gum disease, cavities or both. They were then placed in three groups: having a healthy mouth, gum disease only or gum disease with cavities.

The participants were tracked by the researchers for two decades, using phone contact and medical records to determine which people had a stroke. Of 1,640 people with healthy mouths, 4% had a stroke, of 3,151 people with gum disease only, 7% had a stroke and of 1,195 people with gum disease and cavities, 10% had a stroke.

After adjusting for factors such as age, body mass index and smoking status, researchers found that when compared with people with healthy mouths, those with both gum disease and cavities had an 86% higher risk of stroke. Those with gum disease alone had a 44% increased risk.

The study also found that people with both gum disease and cavities had a 36% higher risk of experiencing a major cardiovascular event, such as a heart attack, fatal heart disease or stroke when compared with people with healthy mouths. Participants who reported visiting the dentist regularly had an 81% lower chance of having both gum disease and cavities and 29% lower odds of having gum disease alone.

A limitation of the study is that participants' oral health was assessed only once, at the start of the study, so changes in dental health over time were not captured. It is also possible that other unmeasured health factors contributed to the findings. The researchers said the study does not prove that poor oral health causes strokes; it only shows an association.

[1]*www.neurology.org/doi/10.1212/WN9.0000000000000036*

Stem cell studies pave the way for regenerating lost teeth

TWO stem cell lineages that drive tooth root and alveolar bone formation have been identified by researchers.

Using genetically modified mice and lineage-tracing techniques, the team has revealed more about the cell signalling mechanisms guiding differentiation in stem cells in developing teeth, offering insights into future regenerative dental therapies.

The ability to regenerate lost teeth and their surrounding bones is considered a holy grail in the field of dentistry. Currently, the gold standard for replacing a lost tooth is to use a foreign object – such as an implant or a denture.

While both are considered effective, they cannot perfectly replicate a natural tooth's structure, function or feel. This has prompted many researchers to conduct studies on tooth development in a bid to open new avenues for regenerative therapies.

"Our findings provide a mechanistic framework for tooth root formation and pave the way for innovative stem cell-based regenerative therapies for dental pulp, periodontal tissues and bone," said Mizuki Nagata, Assistant Professor at Science Tokyo.

The researchers' papers[1,2] were published in *Nature Communications*.

[1]*www.nature.com/articles/s41467-025-61048-x*
[2]*www.nature.com/articles/s41467-025-61050-3*

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Scottish practice to the rescue

McManus and Scott Dental Surgeries step up after The Christians' lead singer loses tooth

GARY Christian, lead singer of The Christians, was treated by a Motherwell dental practice – hours before the band was due to play a gig in Glasgow. One of his teeth had fallen out after a show in Gateshead in October.

"It [was] the tooth next to his front tooth," said Emma Roberts, the band's manager. "When he started singing, it was whistling because of the gap."

She said they were "beyond thankful" that McManus and Scott Dental Surgeries squeezed the 70-year-old singer into a busy Monday morning schedule at short notice.

"I phoned at 9am expecting them to get rid of me, but they were really helpful. Luckily the woman remembered the band too," said Roberts. "I was amazed. They've really saved our life, so we'll have to find a good way to thank them."

> "I PHONED AT 9AM EXPECTING THEM TO GET RID OF ME, BUT THEY WERE REALLY HELPFUL. LUCKILY THE WOMAN REMEMBERED THE BAND TOO"

The Christians had a series of international chart hits in the late 1980s and early 1990s, including *Ideal World*, *Hooverville*, *Forgotten Town* and *Harvest for the World*.

DATES FOR YOUR DIARY

2026

30 JANUARY
Scottish Orthodontic Conference
Royal College of Physicians and Surgeons of Glasgow
rcpsg.ac.uk/education/scottish-orthodontic-conference

5 FEBRUARY
Lilian Lindsay memorial lecture
The Court Room, Cutlers' Hall, London
cgdent.uk/2025/01/15/lilian-lindsay-memorial-lecture

10 FEBRUARY
BDIA Symposium
Nexus - University of Leeds Campus
bdia.org.uk/events/bdia-symposium

24 APRIL
Conference of Scottish LDCs
Stirling Court Hotel
scot-ldc.co.uk/2026-agenda

12-13 JUNE
The Scottish Dental Show
Braehead Arena, Glasgow
sdshow.co.uk

4-7 SEPTEMBER
FDI World Dental Congress
Prague
2026.world-dental-congress.org

Note: Where possible this list includes rescheduled events, but some dates may still be subject to change.

NEW BIOINSPIRED GEL RESTORES AND REGENERATES DENTAL ENAMEL

WORDS
WILL PEAKIN

Breakthrough opens up the possibility of effective, long-lasting preventive and restorative treatment

Bioinspired describes the process of developing novel materials, devices, structures or methods by abstracting and applying the functional principles found in biological systems.

It is a design approach that looks to the natural world, which has optimised solutions through billions of years of evolution, for ideas to solve human problems in technology, engineering and architecture.

Examples in medicine include:

• **Cell membrane-coated nanoparticles:** Inspired by natural cell membranes, scientists coat drug-carrying nanoparticles with material taken from red blood cells or cancer cells. This 'cloaking' helps the drug-carrying particle evade the immune system and specifically target tumours.

• **Silkworm silk for tissue scaffolds:** The natural protein silk fibroin, from silkworm cocoons, is used as a biomaterial in regenerative medicine. Its strength, biocompatibility and slow degradation rate make it an excellent scaffold for growing new tissues or for use in advanced wound healing patches.

Now a new bioinspired material has been used to create a gel that can repair and regenerate tooth enamel, opening up new possibilities for effective and long-lasting preventive and restorative dental treatment.

Scientists from the University of Nottingham's School of Pharmacy and Department of Chemical and Environmental Engineering, in collaboration with an international team of researchers, have developed a material that has the potential to regenerate demineralised or eroded enamel, strengthen healthy enamel and prevent future decay.

Tooth enamel is characterised by an intricate hierarchical organisation of apatite nanocrystals that bestows high stiffness, hardness and fracture toughness. However, enamel does

not possess the ability to regenerate, and achieving the artificial restoration of its microstructure and mechanical properties in clinical settings has proved challenging.

To tackle this issue, the Nottingham team engineered a tuneable and resilient supramolecular matrix based on elastin-like recombinamers (ELRs) that imitates the structure and function of the enamel-developing matrix.

When applied as a coating on the surface of teeth exhibiting different levels of erosion, the matrix is stable and can trigger epitaxial growth of apatite nanocrystals, recreating the microarchitecture of the different anatomical regions of enamel and restoring the mechanical properties.

Their study, published in *Nature Communications*[1], demonstrates the translational potential of their mineralising technology for treating loss of enamel in clinical settings, such as the treatment of enamel erosion and dental hypersensitivity.

The gel can be rapidly applied to teeth in the same way dentists currently apply standard fluoride treatments. However, this new protein-based gel is fluoride free and works by mimicking key features of the natural proteins that guide the growth of dental enamel in infancy.

When applied, the gel creates a thin and robust layer that impregnates teeth, filling holes and cracks in them. It then functions as a scaffold that takes calcium and phosphate ions from saliva and promotes the controlled growth of new mineral in a process called epitaxial mineralisation.

This enables the new mineral to be organised and integrated to the underlying natural tissue while recovering both the structure and properties of natural healthy enamel.

The new material can also be applied on top of exposed dentine, growing an enamel-like layer on top of dentine, which has many benefits including treating hypersensitivity or enhancing the bonding of dental restorations.

Enamel degradation is a major contributor to tooth decay and is associated to dental problems affecting almost 50% of the world's population. These problems can lead to infections and tooth loss and can also be associated with conditions such as diabetes and cardiovascular disease.

Enamel does not naturally regenerate; once lost it is gone forever. There is currently no solution available that can effectively regrow enamel. Current treatments such as fluoride varnishes and remineralisation solutions only alleviate the symptoms of lost enamel.

Dr Abshar Hasan, a Postdoctoral Fellow and lead author of the study, said: "Dental enamel has a unique structure, which gives enamel its remarkable properties that protect our teeth throughout life against physical, chemical and thermal insults.

"When our material is applied to demineralised or eroded enamel, or exposed dentine, the material promotes the growth of crystals in an integrated and organised manner, recovering the architecture of our natural healthy enamel.

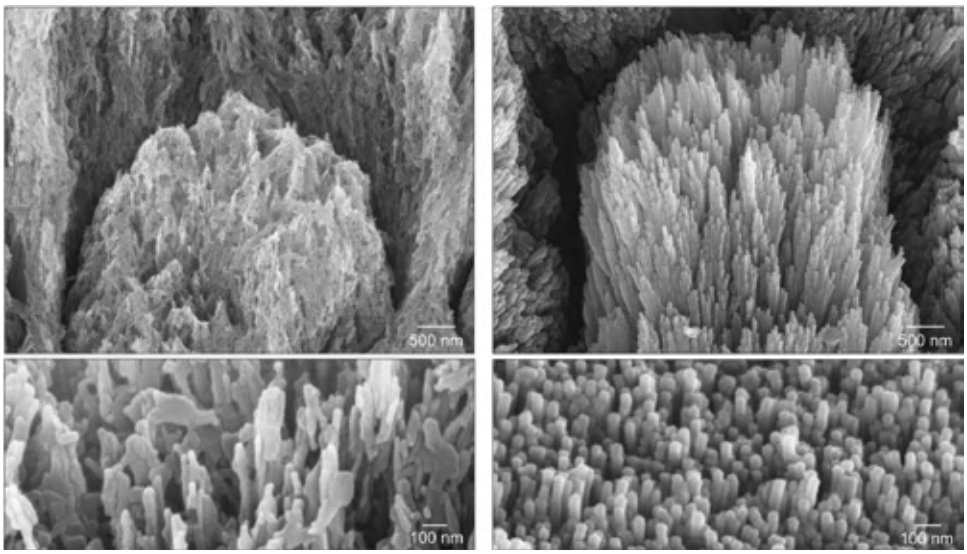
"We have tested the mechanical properties of these regenerated tissues under conditions simulating 'real-life situations', such as tooth brushing, chewing and exposure to acidic foods, and found that the regenerated enamel behaves just like healthy enamel."

Alvaro Mata, Professor in Biomedical Engineering and Biomaterials, added: "We are very excited because the technology has been designed with the clinician and patient in mind. It is safe, can be easily and rapidly applied, and it is scalable.

"Also, the technology is versatile, which opens the opportunity to be translated into multiple types of products to help patients of all ages suffering from a variety of dental problems associated with loss of enamel and exposed dentine.

"We have started this process with our start-up company Mintech-Bio (www.mintech.bio) and hope to have a first product out next year. This innovation could soon be helping patients worldwide."

Paul Hatton, a professor of biomaterials science at the school of clinical dentistry in Sheffield and member of the British Dental Association's health and science committee, told the BBC: "Recreating natural enamel to repair teeth has been something of a 'Holy Grail' for dental materials scientists for many years [and] this paper suggests an exciting breakthrough has been made."



[1] ***www.nature.com/articles/s41467-025-64982-y***

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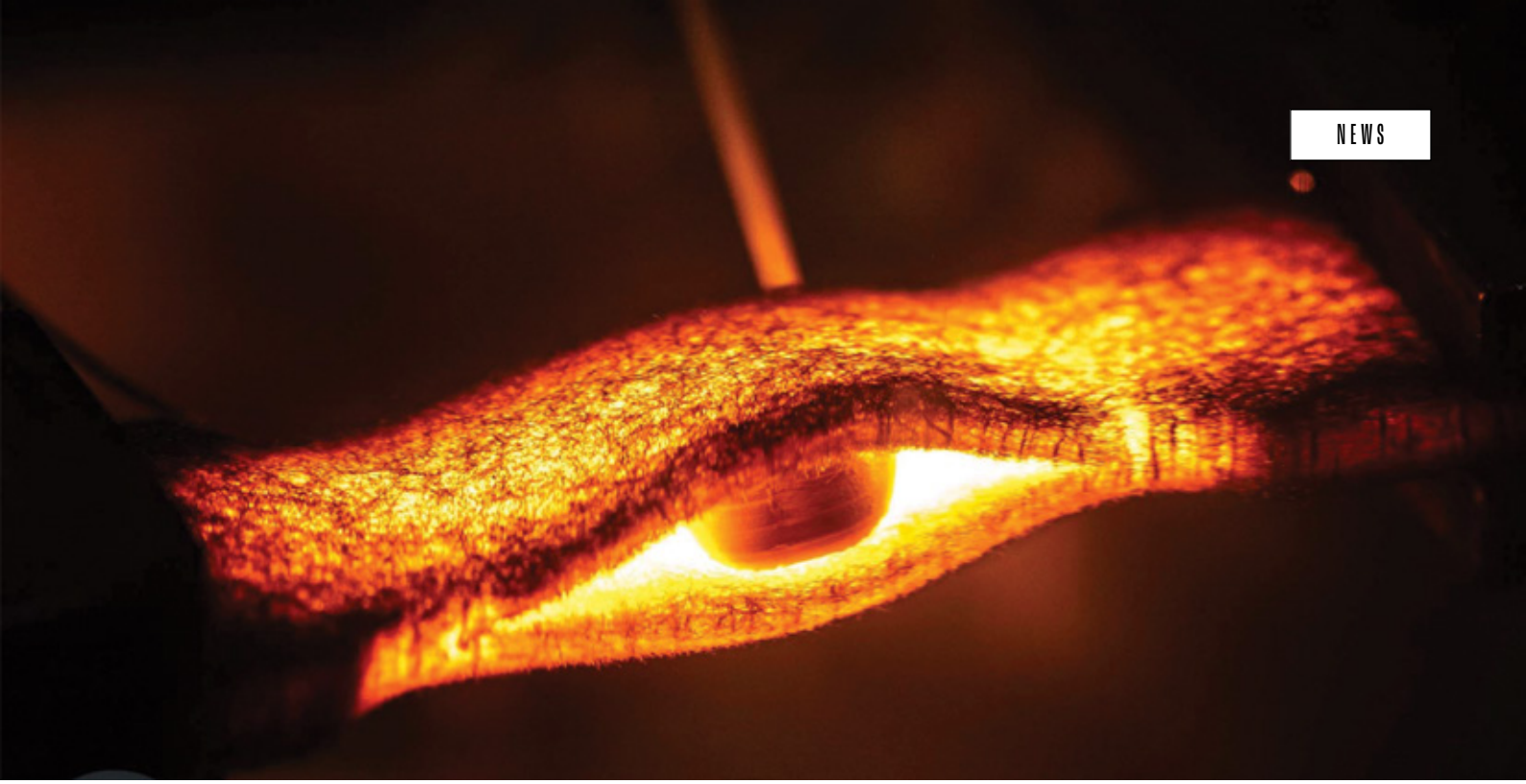

CROWN JEWEL OF DENTAL RESTORATION IN SIGHT

Researchers say the technology enables same-day, 3D-printed dental restorations made of zirconia

A technology that enables same-day, 3D-printed dental restorations made of zirconia, the gold-standard material for permanent dental work, has been developed by researchers at the University of Texas at Dallas (UT Dallas), *writes Kim Horner.*

The team is working to make the technology, which could be used for crowns, bridges, veneers and other restorations, commercially available.

Above: A dental crown is produced by combining enhanced heat transfer with the use of porous graphite felt, which can reach temperatures above 2,550 degrees Fahrenheit

"We are excited to be advancing the commercialisation of chair-side 3D-printed, all-ceramic zirconia permanent dental restorations," said Dr Majid Minary, professor of mechanical engineering at the Erik Jonsson School of Engineering and Computer Science.

"Because the crowns can be custom printed for each patient on the same day, this approach offers greater personalisation, faster treatment and the convenience of receiving a permanent restoration in a single visit."

Dental crowns are caps that are placed over damaged or decaying teeth. They can also serve as supports in a dental bridge, which replaces a missing tooth. 3D-printed restorations have emerged as an option that offers better customisation and colour-matching, as well as a more efficient manufacturing process that could reduce cost and waste.

However, the currently available same-day, 3D-printed crowns are made of ceramic resins that are not as strong as zirconia. While same-day zirconia crowns are also available, they are not 3D-printed; rather, they are milled, a process that involves carving the crown from a block of zirconia. These zirconia restorations face challenges and limitations in design complexity and the risk of micro-cracking during milling or sintering.

The UT Dallas researchers and their collaborators have solved a challenge in producing 3D-printed zirconia restorations by significantly reducing the time involved in processing a zirconia restoration after it is 3D-printed.

The researchers explained their approach in the September print

Dr Majid Minary (left) and mechanical engineering doctoral student Mahdi Mosadeg

edition of the journal *Ceramics International*[1]. The method will require clinical validation and regulatory approval before it becomes commercially available.

After a zirconia crown is 3D-printed, it must undergo two key steps: debinding and sintering. In the debinding stage, heat is applied gradually to burn off the resin that held the zirconia particles in place during printing. This process can take from 20 to 100 hours.

Once the resin is removed, the crown undergoes sintering, a high-temperature firing process similar to baking clay in a kiln, which fuses the zirconia particles together into a dense, hardened solid.

"Debinding has been the bottleneck in the process," said Minary, corresponding author of the article. "It must be done very slowly. If you speed it up, the polymer being burned off turns into gas, and if that gas cannot escape, the crown may crack or fracture.

"A debinding time of 20 to 100 hours is not practical for same-day dental service. As a result, 3D-printed permanent zirconia restorations are not yet commercially available."

The team's technology reduces debinding time to less than 30 minutes; a breakthrough that could make same-day permanent dental restorations possible.

Their approach combines enhanced heat transfer with the use of porous graphite felt, which can reach temperatures above 2,550 degrees Fahrenheit. The felt covers the 3D-printed restoration, allowing gas released from the resin to escape, while a vacuum system simultaneously removes the gas.

"The combination of all of these features is what makes it work," said Minary. "With our technology, if a practitioner wants to offer a 3D-printed zirconia crown chair-side, they could provide it to a patient within just a few hours."

The UT Dallas team led by Minary, in collaboration with Pan-AM Dental Laboratory, recently received a $550,000 award through the NSF's Partnerships for Innovation – Technology Translation project to support commercialisation of the technology.

> "THEIR APPROACH COMBINES ENHANCED HEAT TRANSFER WITH THE USE OF POROUS GRAPHITE FELT, WHICH CAN REACH TEMPERATURES ABOVE 2,550 DEGREES FAHRENHEIT"

The commercialisation project also involves 3DCeram Sinto Inc. in Grand Ledge, Michigan; and Dr Amirali Zandinejad, a prosthodontist in Arlington, Texas, and former associate professor at the Texas A&M University College of Dentistry.

Other UT Dallas-affiliated contributors include Mahdi Mosadegh, first author and mechanical engineering doctoral student; modelling engineer Moein Khakzad; chemistry doctoral student Zahra Sepasi; mechanical engineering graduate student Kalyan Nandigama; and Dr. Golden Kumar, Associate Professor of Mechanical Engineering.

In addition to the NSF, the research in the paper was also supported by the US Air Force Office of Scientific Research.

A finished dental crown created by the UT Dallas researchers' technology

Kim Horner is Communications Manager at UT Dallas.

[1] ***www.sciencedirect.com/science/article/abs/pii/S0272884225023417***

Single-step thermal debinding for ceramics vat photopolymerization in less than 30 minutes

The following is an abstract from the authors' paper published in Ceramics International.

Vat photopolymerization (VPP) 3D printing of ceramics is known for producing high-resolution, high-quality ceramic parts, particularly in the dental industry.

However, the thermal debinding (TD) process in ceramic VPP is time- and energy-intensive due to the large binder content (40–60 vol%), limiting its widespread adoption. The TD step often takes 20–100 h, significantly increasing manufacturing costs and preventing the use of VPP for processes requiring fast turnaround times.

Here, we demonstrate an ultrafast thermal debinding (UFTD) process for zirconia parts fabricated by VPP, achieving complete binder removal in under 30 min. By utilising the unique advantages of vacuum debinding and rapid heating with porous graphite felts, we accelerate binder removal while maintaining the structural integrity of the ceramic parts.

Our results show a 40-200-fold reduction in processing time and a 3,500-fold decrease in energy consumption compared to conventional thermal debinding, with the UFTD-processed samples exhibiting properties comparable to conventionally processed 3D-printed zirconia.

This approach provides a promising method for faster, energy-efficient production of zirconia parts, while the findings also offer valuable insights into the mechanisms of UFTD, paving the way for its application in other ceramic-based additive manufacturing processes.

www.sciencedirect.com/science/article/abs/pii/S0272884225023417

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Lyall graduated from the University of Glasgow in 2013 and spent many years in general dental practice in the West of Scotland, building a strong base in general dentistry skills.

He became a member of the Royal College of Physicians and Surgeons of Glasgow in 2018 and gained a Master of Science degree with Distinction in Restorative Dentistry from the University of Birmingham in 2024.

Since 2022, he has worked part time as a Specialty Dentist in restorative dentistry at the Glasgow Dental Hospital providing complex endodontic treatment for patients referred by their general dental practitioners.

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REVERSE EVIDENCE-BASED DENTISTRY

WORDS
ANDREA MASCOLO, OANA DINCULESCU, MARIA MEZETTI, GILBERT MERCIECA AND FRANCESCA BUSUTTIL

An innovative approach to dental education and clinical practice

Evidence-Based Dentistry (EBD) involves the integration and interpretation of the most current research evidence with personal experience. First cited in professional dental literature in 1995[1], EBD allows dentists, as well as academic researchers, to keep abreast of new developments and make decisions that improve clinical practice. Today, most dentists are familiar with EBD and generally support its implementation[2].

However, despite its benefits, barriers to EBD implementation remain, including insufficient time, inadequate training and a perceived lack of relevance of the evidence to everyday practice[3]. Dentists often rely on colleagues, key opinion leaders, company sales representatives or social media forums to gain new information.

However, these sources are not always up to date or correct and may provide financially motivated advice. Social media forums lack quality control, and yet due to the visibility of cases posted they are likely to have an overinflated effect on practice[4]. Busy clinicians need access to selective, efficient and patient-driven research. It is crucial for clinicians to be able to assess the level of evidence of publications to formulate an evidence-based treatment plan and provide patients with accurate, current, and trustworthy information.

In light of these challenges, this commentary introduces the concept of Reverse Evidence-Based Dentistry (Reverse EBD), defined as a structured analytical process that inverts the conventional EBD sequence. Unlike traditional EBD, which begins with published evidence to inform clinical decisions, Reverse EBD starts from real-world clinical practices or historical observations and systematically traces backward to identify and evaluate the supporting scientific evidence. This approach not only clarifies the evidence base behind established protocols but also trains learners to discern gaps between practice and research, fostering reflective, critical and evidence-aware clinical reasoning.

EBD has a significant influence on oral healthcare, yet persistent barriers – such as limited time, perceived complexity, and insufficient translation of evidence into practice – continue to hinder its consistent adoption. Reverse EBD is proposed as a complementary framework

designed to address these limitations. Unlike conventional EBD, which follows a top-down model that begins with published evidence and applies it to clinical settings, Reverse EBD starts from real-world clinical practices and works backward to identify and evaluate the supporting scientific rationale.

This inversion of the evidence pathway promotes active engagement, contextual understanding and reflective inquiry, helping clinicians and students critically assess both established and emerging treatment protocols. By fostering a dynamic link between observation and evidence, Reverse EBD bridges the gap between theory and practice, making evidence-based reasoning more accessible and applicable to everyday clinical decision-making.

At the European Institute of Medical Studies (EIMS) in Malta, Reverse EBD has been integrated into undergraduate teaching within a neutral, non-promotional pedagogical framework aimed at developing analytical and reflective competencies. This educational implementation demonstrates how Reverse EBD can strengthen evidence-based thinking while preserving academic independence and methodological rigor.

Additionally, EIMS has introduced the concept of Reverse EBD through an engaging and easily reproducible process that builds on foundational clinical skills. By readapting the concept of reverse engineering to dentistry, Reverse EBD is defined as a structured analytical process through which one seeks to understand, by means of deductive reasoning, how an established clinical or educational procedure has been developed and supported by scientific evidence. This perspective enables learners to reconstruct the rationale behind existing practices and critically evaluate their evidence base.

Undergraduate students at EIMS received foundation training in EBD principles and then applied Reverse EBD to a foundational unit of their curriculum: History of Medicine. As part of this exercise, students virtually examined Mayan human skulls exhibited at the Peabody Museum at Harvard University, questioning how three shell fragments were integrated into the mandible.

Additionally, they also considered archaeological evidence from other cultures. They explored how the Etruscans in Italy and the Ancient Egyptians used cast iron, copper and even oxen bone to create the first tooth substitutes. This exercise allowed students to link different units and develop a critical assessment of their learning. By examining historical practices through the lens of modern evidence-based principles, students gained insights into the evolution of dental practices and the importance of EBD in modern dentistry.

> “REVERSE EBD BRIDGES THE GAP BETWEEN THEORY AND PRACTICE, MAKING EVIDENCE-BASED REASONING MORE ACCESSIBLE”

The Reverse EBD approach can also be applied to clinical protocols beyond historical contexts. For instance, while laser protocols have been strongly promoted for the treatment of periodontal disease and peri-implantitis, students applying the Reverse EBD process discovered differing recommendations. In fact, the S3 Level Clinical Practice Guideline for the treatment of Stage I-III periodontitis[5], published by the American and European Academies of Periodontology, does not recommend use of lasers. This critical reverse process stimulates learners to adopt a more conscious and evidence-based approach to clinical practice, encouraging them to evaluate and validate current protocols against the best available evidence.

Another example of the Reverse EBD process applied to clinical protocols is for the use of platelet-rich fibrin (PRF). PRF, used alone or in combination with grafts or other biomaterials, has shown regenerative effectiveness in different clinical fields[6]. The Reverse EBD exercise allowed students to assess higher levels of evidence related to specific procedures.

For instance, a meta-analysis on the effectiveness of PRF as an adjunctive material to bone graft in maxillary sinus augmentation demonstrated no clear advantage or disadvantage in using PRF preparations or their by-products alongside bone graft materials[7]. This exercise helps students critically evaluate evidence, understand the complexities of clinical protocols, and identify alternative protocols equally supported by evidence.

In forensic dentistry, it has been noted that EBD is sometimes employed to justify procedures rather than to genuinely guide best practices. This misuse of EBD is a concern that is acknowledged within both forensic and general dental literature[8]. In this context, as well as in clinical dentistry, the Reverse EBD process could be a valuable tool for critically evaluating evidence and proposed protocols.

By encouraging a more thorough examination of clinical practices, the Reverse EBD approach may result in an improved understanding and application of evidence-based practices in clinical settings. Furthermore, through Reverse EBD, clinicians may identify procedures that may be more compatible with variables such as their level of clinical experience.

Over the past 30 years, the contents, methods and assessment of EBD education have been widely studied and discussed. A recent scoping review revealed that the current literature focuses mainly on teaching of critical appraisal skills, traditional teaching methods and short-term outcome assessments. To address these gaps, future research should explore comprehensive educational models, multifaceted teaching approaches and validated outcome assessment tools[9].

Among the strategies described for effectively teaching EBD in undergraduate courses, the following have been highlighted: designing continuing and frequent dental education courses; establishing collaborative student research groups; utilising online tools for EBD education; and dividing EBD courses into shorter modules[10].

Teaching strategies that incorporate clinical experiences tend to be more effective in fostering critical thinking and application of EBD principles. Implementing EBD in the foundational years of dental education, even when students have limited prior dental knowledge, can encourage early development of analytical and reflective skills essential for evidence-based practice.

Furthermore, the concept of Reverse EBD has been formally incorporated into the newly accredited Bachelor of Science (Honours) in Dental Science (180 ECTS, Malta Qualifications Framework (MQF) Level 6) at EIMS. The programme adopts an interdisciplinary curriculum combining dental science with biomedical engineering, health IT and research methodology, offering a neutral pedagogical framework that integrates Reverse EBD as both a theoretical and practical approach to developing analytical and reflective competencies.

This programme combines dental science with biomedical engineering, health IT and advanced research methodologies, preparing graduates for careers at the intersection of clinical practice, research and healthcare innovation[11],[12]. Within this curriculum, Reverse EBD is applied not only as a theoretical framework but also as a practical pedagogical tool, enabling students to critically analyse both historical practices and contemporary protocols.

This integration illustrates how Reverse EBD supports the development of innovative educational approaches and the enhancement of critical appraisal competencies among future dental professionals.

The introduction of Reverse EBD encourages clinicians to critically assess the level of evidence in publications and to differentiate between evidence-based guidelines and market-driven protocols. By focusing on protocols supported by robust evidence, and using a hierarchical pyramid for initial evaluation, clinicians can ensure that they are applying the most appropriate and effective treatments based on solid research and critical assessment of their own knowledge and skills.

The Reverse EBD framework enhances the understanding and practical application of evidence-based practices by promoting a systematic, reflective approach to evaluating existing protocols and identifying the scientific rationale behind them.

Reverse EBD represents a complementary approach to traditional EBD, fostering critical appraisal of both historical and contemporary protocols. Its integration into the innovative BSc (Hons) Dental Science programme demonstrates its potential as both a pedagogical strategy and a clinical mindset, supporting the development of critically minded, research-driven dental professionals.

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MUST IT BE THIS WAY?

Vermilion's biennial event outlined a vision for the future of Scottish dentistry

WORDS
WILL PEAKIN


Dr David Offord

Ever heard of SNIP? It stands for: 'Situation, Need, Ideas, Plan'. It is a structured approach used for problem-solving, decision-making and communication.

The first step involves defining and understanding the problem. Next, the specific need or goal is identified. Then come the ideas; this step encourages creative thinking and exploring various possibilities without immediate judgment. Finally, agree a plan; evaluate the ideas, select the most appropriate and create a concrete, actionable plan.

SNIP was the approach taken by Dr David Offord in his talk at the Vermilion Biennial Symposium in Edinburgh at the beginning of October. The symposium's title? *The Future of Scottish Dentistry and Career Pathways in Primary Care*. As well as Dr Offord, Vermilion's Practice Principle, speakers included Jim Hall, founder and Chief Executive of Clyde Munro, Professor Ewen McColl, Head of Peninsula Dental School, Professor Richard Ibbetson, Emeritus Professor, University of Aberdeen and University of Lancashire, Dr Ian Mills, Honorary Associate Professor at the Peninsula Dental School, and Anas Sarwar MSP, BDS, leader of the Scottish Labour Party.

The context had been set out by Dr Offord in the run-up to the symposium; Scotland, he said, is confronting a deepening dental crisis with workforce contraction and patient access barriers across the country. The landscape is marked by a dual problem; a severe decline in NHS primary care provision, manifesting as practice closures and limited patient access, particularly in rural and non-city areas, such as Fife, Moray and Dumfries and Galloway, and a critical erosion of NHS secondary care capability, notably within the Lothian region. As revealed by *Scottish Dental* magazine, Edinburgh University has withdrawn its funding from the Edinburgh Dental Institute (EDI). Recruitment to its undergraduate and postgraduate dental education programmes had been "paused", a spokesperson confirmed.

Nationally, statistics reflect a public health crisis with severe consequences for Scotland's most vulnerable populations. The gap in dental participation rates between children from the most and least deprived areas has widened dramatically from 7% in 2010 to 20% in 2022, creating a two-tier system that abandons those who need care most.

"We're seeing patients resort to dangerous DIY dentistry, travelling hundreds of miles for treatment or going without care entirely," Dr Offord told *Scottish Dental*. "This isn't just about oral health. Untreated dental problems can lead to serious systemic health issues, emergency hospital admissions and, in extreme cases, life-threatening infections."

The symposium challenged political leaders to deliver concrete solutions to the crisis. It called for:

- A new, fully funded NHS contract making primary care dentistry an attractive career option, thus improving patient care
- A comprehensive national dental workforce plan with long-term funding commitments
- The establishment of a new Edinburgh Dental Hospital and School to provide integrated training of dentists, specialists and dental care professionals.

Addressing the audience for his

talk, titled *Must it be this way? A vision for the future of Scottish dentistry*, Dr Offord said: "We need to be bold, unconventional, demanding. We need to turn Scottish dentistry around. What is the situation? What do we need? Let's generate some ideas and then agree a plan.

"What is the situation? We have NHS dentists leaving the workforce for private practice. They see better remuneration. They see better work/life balance. A three-and-a-half day working week. They see the opportunity to offer complex treatments outwith NHS parameters.

"Health inequalities are stark. There is a frightening gap developing in participation rates of the least and most deprived children. We hear reports of people resorting to DIY dentistry or switching to private care due to lack of NHS access.

"We have seen a decrease in graduate numbers due to COVID-19 disruption. There have been shortfalls in VT recruitment in 2024-25. This is a particular issue in rural areas. Systemic financial pressures are very real. The increase in operating costs has created a critical landscape for practice owners who, because of the increase in National Insurance, cannot give their staff pay rises."

Dr Offord also highlighted the situation in Lothian, which is experiencing a significant growth in population at the same time as the supply of dentists is expected to fall short of the number required to maintain the current registration rate. "We have to talk about 'the Edinburgh problem'," he said.

Dr Offord referred to the closure of the Edinburgh Dental School and Hospital in 1994. The closure was accompanied by plans to replace the school and hospital with the Postgraduate Dental Institute, which became the EDI in 1997.

However, significant concerns were expressed at the time regarding the EDI's potential effectiveness and viability; concerns which have come to pass. "The current challenges faced by secondary care in Lothian are not recent phenomena, but rather a long-term consequence of historic political and financial decisions that have had a ripple effect spanning decades," said Dr Offord.

Waiting times for Lothian dental services reveal a severe and deteriorating access crisis, he said. It holds the Scottish record for a patient's waiting time; 169 weeks. The longest wait for a child's tooth extraction was 70 weeks and for an adult, two years. The average waiting time for oral and orthodontic surgery has increased by 320% in the past five years. "These waiting times are significantly longer than NHS Scotland's national target of 18 weeks from referral to treatment," said Dr Offord.

"This profound disparity represents a severe and deteriorating crisis in secondary care access, a fundamental inability of the system to provide timely and necessary specialist treatment, leading to prolonged patient suffering. This contrast between stated standards and the lived experience of patients in Lothian hides a critical failure in service delivery."

Dr Offord added: "Scotland, as a country, cannot afford to continue to underinvest in oral health. The health economics of inaction are frightening." He pointed to two reports commissioned by the European Federation of Periodontology; *Time to take gum disease seriously*, published in 2021, and *Time to put your money where your mouth is*, published in 2024.

The first argues that periodontitis is a major, yet preventable, public health crisis across Western Europe with severe societal and economic consequences. Despite advanced healthcare systems, the prevalence of periodontitis has remained largely unchanged for the past 25 years. Crucially, the report highlights that periodontitis is associated with more than 50 non-communicable systemic diseases, including diabetes and cardiovascular disease. The report called for an urgent shift in focus, from treating advanced disease to preventative care and improving access to care.

The second analysed the profound and unequal global burden of dental caries and severe periodontitis, which collectively affect nearly half the world's population, surpassing the prevalence of the five most common non-communicable diseases (NCDs). The report highlights that the most deprived populations experience a disproportionately high disease burden and face major barriers to accessing care, often resulting in invasive, costly treatments such as tooth extraction rather than prevention or restoration.

Its core argument is that oral health is critical to overall systemic health and policy must pivot from an expensive, reactive 'restorative' model to a proactive, preventive approach to tackle deep socioeconomic inequalities.

"We have poured all of our resources into treating the consequences of caries and perio with ever more complex, expensive treatments," said Dr Offord, "while ignoring the fact that these diseases are largely preventable.

"We need to understand the value of oral health in overall health and wellbeing. We need funding, long-term funding; we need a fundamental shift to understand that investing in oral health, and achieving a paradigm shift to primary prevention, will yield a net saving for the National Health Service."

Dr Offord cited the example of Japan which, in 1989, initiated the *8020 Campaign* aimed at ensuring that people still have 20 of their original adult teeth when they reach the age of 80. Over the course of the campaign, the percentage of people achieving that 80/20 goal has grown fivefold, from around 10% to around 50%. It has not only improved their quality of life but is also linked to better overall physical and mental health.

In terms of the workforce, Dr Offord said there needs to be a "comprehensive national dental workforce plan with a long-term

Anas Sarwar

"SARWAR STRESSED THE CRITICAL NEED FOR A "LONG TERM, PARTNERED THOUGHT THROUGH FULLY FUNDED MODERN WORKFORCE PLAN"

funding commitment. We need dentists, nurses, therapists, technicians." It is clear, he said, that there is a need for a new, fully funded NHS contract and a complete overhaul of the Statement of Dental Remuneration, placing prevention at the centre. "We need to make NHS dentistry an attractive career option and show the possibility of career progression within NHS care," he said.

Having covered the 'situation' and 'needs', Dr Offered moved to 'ideas' and 'a plan'. He conceded that there were many more people more capable than him in advising politicians on the best way to develop a new contract, but he said he wanted to suggest one idea; that is, a core service. "Think of it like a menu in a restaurant," he said, showing a slide with treatments available under an NHS core service on one side and private treatments on the other.

NHS Core Service	Private Treatments
Check-ups	Crowns
Periodontal assessments	Veneers
Professional mechanical plaque removal	Bridges
Fissure sealants	Molar RCT
Fillings	Implants
Extractions	Aligners
RCT for incisors, canines and premolars only	Composite bonding
Acrylic dentures	Orthodontics

"It's about saying as a country we can no longer afford for patients to have the full *a la Carte* on the NHS. Crucially, public funds that are currently being spent on crowns, bridges and so on should be redirected into preventative care," said Dr Offord.

"We can see a symbiosis of NHS and private dentistry resulting in two income streams and a fulfilling, varied practice requiring skills progression."

He cited Professor Nicola Innes, head of Cardiff Dental School, who put forward ideas that could effect change and be sustainable; fully deploy dental therapists and hygienists; reform the NHS contract without losing continuity of care; align training to the model of care; and back the Dental Schools Council's call for an increase in dental training places.

Dr Offord also outlined his proposal for a new Edinburgh Dental Hospital and School, with a community-based learning approach as pioneered by the University of Plymouth's Peninsula Dental School and recently adopted by the RCSI University of Medicine and Health Sciences for its new undergraduate Bachelor of Dental Surgery (BDS) degree programme. Dr Offord said the new Edinburgh Hospital and School could, for example, be based at the Easter Bush Campus, south of the city centre, which currently incorporates The Royal (Dick) School of Veterinary Studies, the Roslin Institute, and several other research institutes and laboratories. It could also have hubs in Glenrothes, Bathgate and Galashiels; areas suffering a lack of access to dental care.

He called on Mr Sarwar, if elected as First Minister next year, to create a task force to devise a "radical prevention-based contract for primary care". In his speech, Sarwar shared a powerful anecdote from his time as a dentist in Paisley, which at the time had the worst oral health record in Scotland. He linked this poor health to "deep, deep, generational inequality and deep, deep generational poverty".

He recalled having to perform numerous full dental clearances, extracting all teeth and fitting acrylic dentures, on patients as young as 18 and 19 years-old. He highlighted the need for greater connectivity in healthcare, linking drug prevention with oral and wider health.

Sawar said that NHS dentistry in Scotland in its current form will not survive. He outlined three broad areas for reform:

1 Stripping back bureaucracy

Sarwar argued that the NHS has a "bureaucracy and management headache" for a population of five and a half million, with 14 territorial boards, six specialist boards, and 30 integrated joint boards. The goal would be to strip back bureaucracy and empower frontline staff. It would mean fewer chief executives, finance directors and managers, and more dentists, nurses, doctors and clinicians.

2 Modernising the NHS

The current NHS system is viewed as being stuck in the 20th century, he said, and the system needs to be brought into the 21st century, addressing issues like the continued use of fax machines.

This involves embracing technology for accessing care and information, and integrating digital and AI into the health and social care system.

3 A credible workforce plan

Sarwar stressed the critical need for a "long-term, partnered and thought through fully-funded modern workforce plan," which Scotland has lacked for more than a decade. The plan must match skills, colleges and universities with the workforce pathway. It must ensure talent is attracted and retained in all parts of the country, including the south of Scotland and rural areas, by providing training places and educational opportunities outside of the central belt.

He said he believes fundamental reform of NHS dentistry is required, which should also be part of a broader reform of the entire NHS. He wholeheartedly agreed with Dr Offord that the balance must shift toward preventative care, so the NHS becomes a "national health service" rather than a "national sickness service".

The system must be led by dentists, as those currently proposing solutions often "don't understand or haven't experienced or lived NHS dentistry". Any new NHS contract and new model for NHS dentistry must include remuneration as a central part of the discussion and negotiation, he said.

Sarwar identified two "false measures of success" that need to be addressed:

- The proportion of the population registered with an NHS dentist. This is misleading because patients may remain on the register long after they have last been seen.
- Age groups eligible for free dentistry. This is irrelevant if there is no dentist available to deliver the care. Sarwar likened it to giving someone a free bus pass but having "no bus for you to take."

The overall goal must be a system that is accessible in every part of the country. Sarwar noted that more practices are taking fewer NHS patients, and more parts of the country are not allowing people to register for NHS treatment.

Reform needs to result in more graduate dentists staying in dentistry and making the job more attractive, providing both personal value and a feeling of giving back.

Sarwar concluded by stating that his team is committed to doing the necessary "thinking and modelling" before the election to build a credible and deliverable programme, which includes pulling together "key thinkers and delivery agents" if Labour is elected to government.

Vermilion Biennial Symposium 2025
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TOGETHER WE ARE STRONGER

A new, unified voice for Scotland's dental practice owners has taken a significant step forward

The Scottish Dental Practice Owners group (SDPO) group held its inaugural Annual General Meeting in October; a landmark moment for practice owners.

The atmosphere was one of palpable energy and shared purpose. For too long, dental practice owners in Scotland have navigated a challenging landscape of mounting regulation, financial pressures and legislative hurdles, often feeling isolated in their struggles. The SDPO AGM served as a powerful antidote to that isolation, forging a collective front dedicated to advocacy, support and tangible change.

The day began with Atif Bashir from the SDPO committee summarising the group's origins. He reminded attendees that the SDPO was in the crucible of the COVID-19 pandemic. "SDPO was originally formed as a help group for practice owners during the COVID lockdown to help navigate Government policy related to practice closure," Bashir explained.

But the group's mission quickly expanded beyond self-preservation. In a moving moment, Bashir highlighted the community spirit that has always been at the group's core. "In addition, I am proud to say together we raised £10,000 and used it to buy and deliver PPE to care homes. To everyone involved in that effort, thank you."

This grassroots, collective action demonstrated the latent power of a unified practice owners group. Recognising this potential, the group formally constituted as a limited company in August 2020, laying the groundwork for the body it is becoming today. "Those attending in person and those joining us online," Bashir addressed the room, "welcome to our first AGM."

The formal presentations provided a stark, data-driven analysis of the current environment while charting a course for a more secure future.

Kevin Strain from Christie & Co opened the session with a detailed discussion on practice values, offering crucial insights into the factors that drive market perception and financial worth in today's volatile climate. This was followed by a vital presentation from Victoria Forbes of Scottish Dental Accountants, who dissected the financial health of dental practices, offering clarity and strategies for navigating the complex economic pressures facing the sector.

The morning session was rounded off by Girish Bharadwaj from the SDPO committee, who delivered a critically important update on the group's strategic advocacy work, focusing specifically on Regulation 22.

For those unfamiliar, Regulation 22 of the National Health Service (General Dental Services) (Scotland) Regulations 2010 empowers the Scottish Ministers to make and amend Statements of Dental Remuneration (SDRs) – the very lifeblood of NHS practice finances – but only after consulting "with such organisations as appear to them to be representative of persons providing general dental services."

Bharadwaj explained the SDPO's strategic position: as a newly established but rapidly growing entity, the group is on a clear trajectory. If it continues to thrive and grow, any future refusal by the Scottish Ministers to consult with the SDPO for the purposes of Regulation 22 could be challenged by way of judicial review. The grounds would be that such a refusal was wholly unreasonable, given that the SDPO had demonstrably grown into a truly representative organisation. This is a bold and calculated legal stance, based on advocate opinion signalling the SDPO's intent to secure a permanent seat at the table where the most critical financial decisions are made.

Following a break where attendees networked with sponsors over light refreshments, the event transitioned into its formal AGM. It was here that Atif Bashir laid out the compelling, overarching vision for the SDPO with crystal clarity. "We are all having the same problems," he stated. "We cannot solve those problems as individual practice owners."

He pinpointed a key issue resonating with every owner in the room: "Currently, anyone anywhere can open an NHS Dental Practice if they pass a practice inspection, irrespective of whether it's right next door to you." This unsustainable model, he argued, has a direct precedent. "These are all the same problems pharmacy owners faced in the 1980s. We want to follow their road map. They formed a unified owners' group and together they forced the Government to change legislation that stopped that happening."

This historical analogy forms the bedrock of the SDPO's strategy. By building a single, powerful and unified body, the group believes it can achieve what is impossible for individual practices:

- Advocate for change to legislation to introduce a 'necessity' test for new NHS contract awards.
- Advocate for practice owners to own the patient list, providing business stability and asset value.
- Negotiate better NHS terms directly with the government from a position of collective strength.
- Negotiate better deals with suppliers, finance, and insurance companies, leveraging the purchasing power of hundreds of practices.
- Lower practice overheads across the board, allowing owners to reinvest savings into their teams, technology and patient care.

"Our next step is simple," Bashir concluded, "every dental practice owner in Scotland must sign up on the website, creating a unified owners' group that will be impossible for the Scottish Government to ignore."

www.sdpo.org.uk

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A novel aesthetic technique for restoring dental implant access holes

Keisuke Seki, Koji Shiratsuchi, Arata Toki, Atsushi Kamimoto and Yoshiyuki Hagiwara

Good dental implant outcomes require not only functionality but also excellent aesthetics[1,2]. Successful implant treatment is achieved not only by the absence of pain, signs of peri-implant tissue inflammation and bone resorption over time, but also by the satisfaction of the surgeon and patient with the outcome of the treatment[3].

The special mechanism of fastening the superstructure to the implant body via abutment screws, which is unique to implant superstructures, protects the implant body from the damage caused by excessive occlusal forces[4,5,6]. Additionally, the risk of local infection caused by biofilm adhesion is reduced by the ability to remove the implant for cleaning. This mechanism also allows for removal and repair against the chipping or fracture of the superstructure.

In contrast to these advantages, screw-retained implant superstructures have the disadvantage of poor aesthetics. If the access hole is dark, the aesthetics of the prosthetic treatment of the anterior region, which is visible when smiling, as well as the molar region, can be compromised, leading to a reduction in the patient's expected treatment outcome[7]. Even if there are no functional problems, the true success of implant treatment cannot be considered if the patient is not satisfied with the aesthetic aspect. Although this problem can be solved by cementing the superstructure, residual cement can cause peri-implantitis[8,9].

Furthermore, a decline in the long-term sustainability of cement is also a concern and discussion regarding the fabrication of an ideal superstructure and management methods is ongoing[10,11]. Studies on sealing techniques for occlusal screws have been reported by many researchers since about 2000[12,13,14,15].

Currently, a light-cured composite resin with excellent sealing and wear resistance is often used as the final repair method for access holes. However, an opaque composite resin that can completely shield the metallic colour in the access hole has not yet been developed. In addition, a light-cured composite resin that shrinks is also problematic for the microleakage of saliva and oral bacteria, as well as cotton pellets and silicone materials[16,17]. Salivary contamination from the access hole is thought to influence the development of peri-implantitis if it extends into the implant–abutment connection[18].

Despite their poor aesthetics, porcelain-fused-to-metal crowns that seal access holes have been commonly used as the primary implant superstructure, but a combination of titanium-based abutments and zirconia crowns has now become the dominant structure[19,20]. Although zirconia crowns appear to have solved the aesthetic problem because of their greater strength and lighter colour[21,22], microleakage through the access hole remains a problem. Complications after the placement of implant superstructures can be divided into mechanical complications, such as a crown or abutment screw fractures, and biological complications, such as peri-implant mucositis or peri-implantitis[23,24,25].

Even if the superstructure functions without problems immediately after placement, there will inevitably be some cost and effort to maintain it over 10 years[26]. The longer the period of maintenance treatment, the greater the incidence of both complications and in many cases, the superstructure must be removed to deal with these problems. Therefore, unlike natural tooth crown prosthetics, removability is an important factor for implant superstructures. Unfortunately, no superstructure has yet emerged that would solve all these problems.

To meet the conflicting requirements of aesthetics, functionality, and removability, we have devised a new method of restoring implant superstructures that we term the inlay-covering aesthetic technique (ICE technique). In this technique, the conventional superstructure fabrication process is augmented with an inlay body covering the access hole of the crown. We undertook a case in which the inlay was fabricated using computer-aided design/computer-aided manufacture and then cemented, and good results were obtained. The purpose of this case report was to present the details of a novel fabrication method and to report progress in its use.

2. Case presentation

2.1. Problems to date

Access holes designed on the occlusal surface are highly removable, but there is no gold standard for sealing methods, which are often associated with poor aesthetics (Figure 1). Especially in the

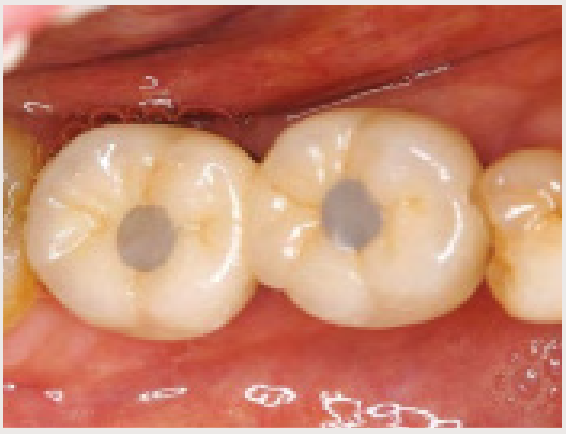


Figure 1: A typical example of unaesthetic access holes in the teeth of a 61-year-old man. The access hole in the superstructure of the porcelain-fused-to-metal crown is sealed with composite resin. The colour tone is poor because it reflects the metal colour of the inner surface, and the filling surface is flat.

case of porcelain fused to metal crown superstructures, the interior of the access hole is made of metal and often suffers from dark tones. Because the inlay covering aesthetic technique has particularly excellent aesthetic performance, the procedure will be explained with case examples.

2.2. Case report using the ICE Technique

A 72-year-old female patient visited our hospital for the treatment of severe periodontitis (Figure 2a–c). After initial periodontal treatment, implants (Straumann® Bone Level SLActive® Φ4.1 × 10, Straumann, Basel, Switzerland) were placed in the mandibular molar region (#46). The surgery was performed in a two-stage procedure, where an acrylic resin provisional crown was placed, and the patient was followed up for three months. Because there were no problems with occlusal function and the peri-implant mucosa was stable, a precise impression was made.

2.3. Impression taking

First, the provisional crown is removed to confirm that the mucosal morphology of the subgingival contour is adequately scalloped. As in the conventional method, impressions are taken with silicone impression material using an implant-specific impression coping. Even when optical impressions were made at the implant level, the following procedure remained the same, so the surgeon could choose either impression method (Figure 3).

Figure 2: (a) A 72-year-old woman with severe periodontal disease (2022). (b) Right lateral view at initial examination. The occlusal plane is greatly distorted because of the posterior bite collapse. (c) Left lateral view.

Figure 3: After comprehensive periodontal treatment, implants were placed in both mandibular molars in a two-stage procedure. Scalloping of the subgingival contour was achieved with a provisional crown at #46. No inflammation of the peri-implant mucosa was observed.

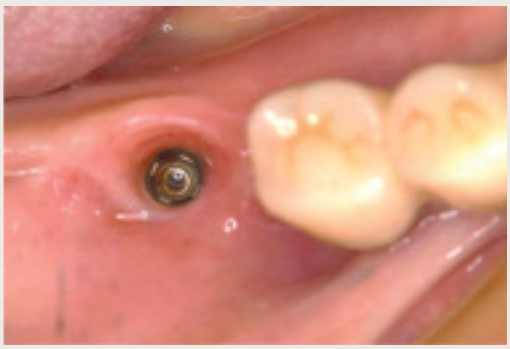
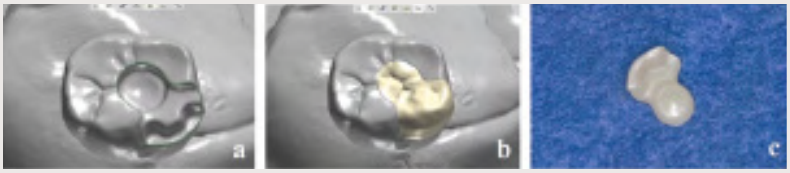


Figure 4: (a) The dental technician marks the inlay cavity on the semi-sintered crown. (b) Semi-sintered zirconia crown machined from a zirconium oxide disc and cavity preparation before sintering. (c) Sintered crown (main body).

Figure 5: (a) The inlay cavity in the crown scanned with the laboratory scanner. (b) New inlay body designed with software (Dental System® Ver.2.23.1.1, 3Shape, Copenhagen, Denmark). (c) Completed highly translucent partially stabilized zirconia inlay body.



> “IF THE INLAY BODY IS BROKEN BECAUSE OF OCCLUSAL FORCES, A NEW REPLICA CAN EASILY BE FABRICATED FROM COMPUTER-AIDED DESIGN DATA”

2.4. Fabrication of superstructure (main body)

The screw-retained superstructure with highly translucent partially stabilised zirconia discs (Sakura Zr. Disk ML, Straumann Japan, Tokyo, Japan) was fabricated by computer-aided design/computer-aided manufacture (D2000, 3Shape, Copenhagen, Denmark). After milling, the inlay cavity was prepared by a dental technician in a semi-sintered state for easy grinding, and then sintering was performed (Figure 4a–c).

2.5. Scanning of the main body and fabrication of the inlay body

The superstructure was then scanned with a laboratory scanner, and the inlay body (Sakura Zr. Disk ML, Straumann Japan, Tokyo, Japan) was fabricated separately (Figure 5a–c). In addition to covering the access hole, the cavity was given a retention form and a resistance form. The margin of the cavity is different from that of an ordinary inlay restoration and requires special processing. The inlay body must be removed when the abutment screw is fastened for maintenance.

After maintenance, the removed inlays can be placed again. For this purpose, the apical margin of the inlay cavity in the crown body should be prepared and an undercut should be made. This makes it easier to remove the inlay body with an inlay crown remover. Although the occlusal inlay has excellent aesthetics, it was designed as an on-lay rather than an occlusal inlay because there was no place on the side of the body to hook pliers. If the inlay body is broken because of occlusal forces, a new replica can easily be fabricated from computer-aided design data. If an occlusal approach is required, occlusal adjustments can be made directly in the oral cavity.

2.6. Completion of the superstructure components

All components were characterised, and the superstructure was completed (Figure 6).

2.7. The superstructure placement and maintenance treatment

After the abutment screws were tightened to the torque indicated by the manufacturer, the inlay body was luted with glass polyaluminate cement (IP Temp Cement, Shofu, Kyoto, Japan) (Figure 7). The left molars (#35, 36) were also fabricated using the same technique (Figure 8a–d), and maintenance treatment was started (Figure 9a–d). Maintenance was continued for one year, and no problems, such as fracture of the main body, detachment of the inlay body, or loosening of the abutment screw, were observed.

Plaque control was well maintained, and there was no redness, pus discharge, or swelling of the peri-implant mucosa. The comprehensive treatment of severe periodontitis resulted in an improvement in the disorder of the occlusal plane, harmonisation of the dentition and improvement of the occlusal function. The patient was aesthetically satisfied and will continue to receive implant-supported therapy.

3. Discussion

This case report presents a new technique to solve the problems associated with access holes in conventional implant superstructures. This method is a simple way to aesthetically seal the access hole by fabricating a zirconia crown and inlay with excellent mechanical strength and minimal negative impact on peri-implant tissue[27]. The fixation of the superstructure by occlusal screws requires the tight sealing of the access hole. Several disadvantages associated with access hole sealing methods have been identified. Previous studies have reported that it is difficult to achieve good functional and aesthetic access hole filling using screw-retained implant prosthetics[28].

In addition to colour discordance, these disadvantages are presumably related to filling operation difficulties, poor sealing because of composite resin shrinkage and wear resistance. Patient visits for frequent access hole repair have a significant impact on the patient's quality of life. Currently, cotton pellets, gutta-percha, silicone sealing material and vinyl polysiloxane are used as buffers in the access holes[29,30,31]. However, more research is needed to identify a material that does not degrade, is easy to remove and meets hygienic requirements. There is currently no gold standard for occlusal surface screw sealing methods[32].

Although composite resin has excellent sealing properties, it is difficult to hide the metallic colour of the inner surface of the access hole, even with the use of a sealant with an opaque colour.

In addition, it is difficult to provide proper occlusal contact with the composite resin because of incorrect manipulation and wear during filling. We think that our method can solve this problem because the inlay body can be designed in advance by a computer. It can be inferred that the incidence of prosthetic complications increases with a prolonged maintenance period.

The method also has an advantage in that the inlay body is easily removed for maintenance, and even if the inlay body is damaged, it can be easily remanufactured using the data from the scanning process[33]. Specifically, it is assumed that this is a case of retightening a loose abutment screw. Additionally, it has the biological advantage of maintaining healthy peri-implant tissue because it avoids the problem of residual cement in the subgingival area, as in the case of the conventional cement retention method. Additionally, the restriction of the implant placement direction is reduced, allowing for a wider range of indications.

With these advantages, we consider that the ICE technique might allow implant treatment to become more predictable. However, a small inlay body may impair retentive force and resistance and may easily drop out of the cavity. Therefore, the direction of transmission of occlusal force should be considered when designing the crown shape[34,35]. Care should be taken to ensure that the area covered by the inlay body does not contain a functional cusp and that the inlay body is not subjected to harmful lateral occlusal forces. In addition, a sufficient area in the lateral chambers contributes to the stability of the inlay body.

Of note, the degradation of the cement over time is a problem because it can damage the body of the inlay, leading to impaired aesthetics. This problem needs to be solved in the future. In addition, detailed studies on luting materials, including glass ionomer cement and resin cement, are also required. Achieving an optimal marginal adaptation of restorative materials is essential to prevent microleakage, improve restoration

Figure 6: Completed stained and characterised superstructure.

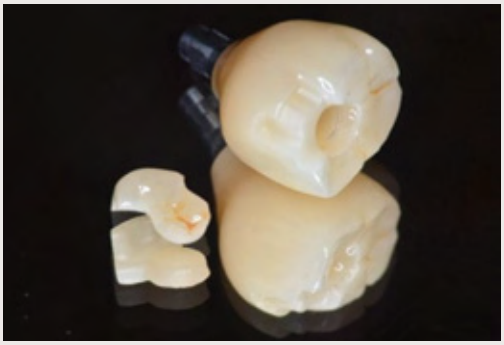


Figure 7: Excellent aesthetics with the superstructure placed after the abutment screw was fastened at 20 N/cm. The removal instrument is hooked into the notch at the bottom of the inlay when access to the abutment screw is required.

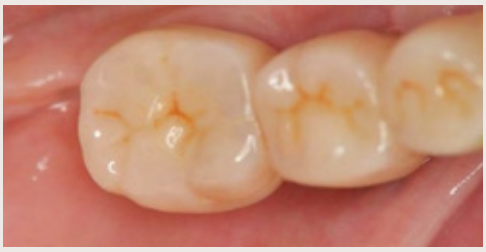


Figure 8: The superstructure of the left molars (#35, #36) fabricated using the same technique. (a) After sintering. (b) Completed superstructure. (c) High esthetic value was achieved. (d) Occlusal view.

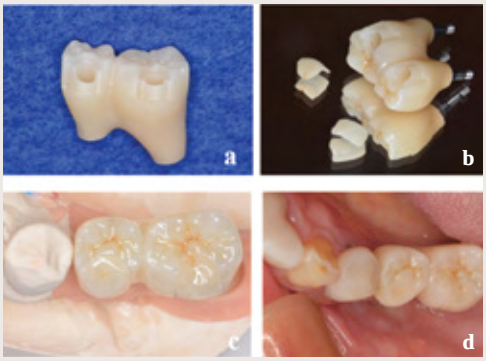
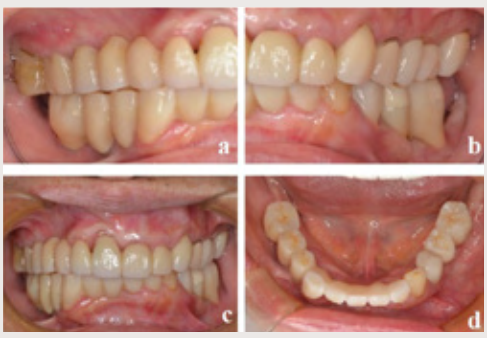


Figure 9: Images taken during maintenance treatment. (a) Left lateral view. (b) Frontal view. (c) Right lateral view. (d) Mandibular occlusal view.



longevity and maintain periodontal health. Therefore, it is important for clinicians to select materials such as lithium disilicate, zirconia or other advanced ceramics that offer superior adaptation to the tooth structure to ensure durable and biocompatible restoration[36].

The aesthetic restorative technique presented here is most suitable for molars with a wide occlusal surface because of the importance of the stability of the inlay body. The application of this technique to canine and anterior teeth is a subject for future study. Although the new technique reported here provided good results, a limitation of this study is that it is only a case report with an insufficient follow-up period.

This technique is not suitable for full arch rehabilitation, and it can complicate the eventual retrievability of the access hole in the case of implant prosthetic complications. In addition, the ability to maintain good adhesion of the inlay body is an important issue for future study.

> **IF THE PROCESS OF IMPLANT SUPERSTRUCTURE FABRICATION INTRODUCED IN THIS CASE REPORT RESOLVES ALL THE PREVIOUS PROBLEMS RELATED TO AESTHETICS, FUNCTIONALITY AND CLEANABILITY"**

Future studies should include a large number and variety of samples and cases with long-term observation to validate the true effectiveness of this method and obtain generalisable results.

4. Conclusions

The process of implant superstructure fabrication introduced in this case report resolves all the previous problems related to aesthetics, functionality and cleanability.

This novel restorative technique compensates for the shortcomings of conventional screw-retained and cement-retained superstructures and leads to improved outcomes for dental implant treatment, contributing to an improvement in oral quality of life.

For references see: www.sdmag.co.uk/restoring-dental-implant-access-holes-references

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THOUGHTS ON SUCCESS

"Sometimes I think I have read and listened to so many people that I may have lost my own sense of who I am and why I do what I do"

THESE are not my words but those of a youngish dental client. Increasingly, I find myself helping people not just with the business of dentistry, but also with far more fundamental issues. A common problem is the sheer overload of information.

So distracting are some of the issues that I recently considered changing the business name away from *The Dental Business Coach* to address the fundamentals of business *and* the rest of life. But my imagination failed me.

The phrase "change is the only constant in life" or "Life is flux" is attributed to Heraclitus and his view that, "we can never step in the same river twice". Heraclitus wrote but a single book, on papyrus, which unsurprisingly has not survived through more than two millennia. Like much of what we take as wisdom will have been distorted by the hearsay and opinion of others.

With now more than 50 years studying, working and reflecting on the practice and business of dentistry, I have come to see, to accept or reject, a variety of theories and alleged facts. So, as the year-end rolls around, here are a few of my thoughts on success.

WORDS
ALUN K REES

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

alunrees@mac.com

Start with the end in mind

Steven Covey's book, *The Seven Habits of Highly Effective People*, came into my life from three sources in the space of a month when it was part of the recommended reading. Firstly, via a retreat at a Church in Cheltenham.

Next up was Mike Wise's year-long postgrad course in restorative dentistry in Wimpole Street. Finally it was the suggestion of my tutor on the Open University MBA course.

Habit #2, 'Begin with the end in Mind' includes the instruction to imagine yourself at your own funeral; what would you want to hear people say about you in their eulogy?

Write it out in detail, do not miss a thing and go deep. Next, ask yourself, how are you going to get from here to there? What are your long- and short-term plans? What is your first step? Then steps two, three and so on.

No matter how slowly you start, momentum is the thing

Seth Godin quotes Mark Twain who said: "The secret of getting ahead is getting started. And the secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, and starting at the first one."

This latter 'secret' is sometimes referred to as 'baby steps' and helps to prevent burn out, often a significant problem in dentists, especially, but not exclusively, owners of small to medium-sized practices.

Gather a good posse

Surround yourself with people who can help you achieve what you have set out to do.

From lawyers and accountants, through clinical and administrative support staff, from laboratories to cleaners, and, of course, patients (or customers if you wish) who *will* become your most important sales force and will refer you "people like them".

This latter group will save you tens of thousands in marketing costs because they are easy to recruit, do not charge you and know exactly what you are like.

Set clear expectations of everyone and make sure they know what they are to expect from you. Be prepared to have difficult conversations when they are required.

Avoiding clear expectations and conversations is tempting but will result in confusion and resentment.

Take the best care of yourself

It is not easy, nothing worthwhile is, but it will be rewarding in every measure if you know what you want, are ambitious and honest with yourself and others; are not tempted to break your own rules or make demands on yourself that you cannot keep. Build and maintain a small circle of true friends with whom you can be truthful, are able to share problems when they arise and whom you can support in your turn.

Dentistry, especially as a practice owner, can feel like a solitary life. So beware what can be called a 'silo' existence; the risks of this have been well described by Gillian Tett of Kings College, Cambridge in her book *The Silo Effect*.

Briefly, teams or groups within businesses or businesses within communities focus on their own goals without considering the wider picture. The results are isolation, little or no collaboration, conflicting goals and negative consequences.

Dentists are often lonely; they and their practices can develop an isolationist mentality resulting in a distorted world view.

To keep your mind healthy, remain curious, stay in touch with developments in your profession, talk and listen to others. Join study groups, support your local BDA or other organisation section, limit social media.

Every day, mentally wipe your feet on leaving the practice. Do not take work home; it will grind you down and you will not complete it.

Take holidays and down time. A cardinal rule, not an original of mine but one that was a lifesaver, is "never come back from a holiday without the next one already in the appointment book".

Grow up, be not afraid

Choose courage over comfort. Professional maturity is realising, accepting and embracing that you are on your own.

Mentors, wise friends and a coach can help you but nobody else can walk your chosen path for you.

Finally, to return to Covey's "Habits #2". In the final analysis after your life is done, the only question you will be asked is: "Did you make the most of your gifts?" That all depends on you and your choices; be wise.

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BUILDING STRONG FINANCIAL FOUNDATIONS FOR YOUR DENTAL PRACTICE

Whether you are opening a new dental practice, stepping into ownership, or looking to enhance profitability in an established business, understanding and managing your finances – as well as clinical excellence – is essential for long-term growth and success.

Managing your accounts, taxes and cash flow can feel overwhelming, but with the right approach and a clearer picture, you will feel more in control and confident to make business decisions.

EMBRACE DIGITAL TRANSFORMATION

Digital-based accounting tools provide real-time access to your financial data, whether you are in the practice, at home or on the move. This flexibility means tasks like invoicing, bank reconciliation and payment tracking can be handled quickly and efficiently in streamlined processes.

Many solutions integrate seamlessly with clinical systems, creating efficiency and freeing up time for patient care.

For practices that haven't yet made the switch, this is an opportunity to simplify processes and gain better visibility over your business.

MANAGING COMPLIANCE OBLIGATIONS

Bookkeeping is not just administration; it is a strategic control mechanism that provides vital insights for sound decision-making, while ensuring compliance. Limited companies must file annual accounts with Companies House within nine months of the year-end, while sole traders and partnerships must make tax payments twice a year.

FORECAST YOUR CASH FLOW

A robust cash flow forecast will help you plan for growth, manage expenses and avoid shortfalls. It is worth reviewing your costs regularly, planning ahead for at least six months – factoring in income patterns, tax deadlines and supplier costs – and keeping a cash buffer for unexpected commitments.

Jayne Clifford,
Partner
Armstrong Watson
E: jayne.clifford@armstrongwatson.co.uk
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KNOWING YOUR NUMBERS

Financial leadership means understanding the metrics that matter. For dental practices this might include, monthly NHS income, payroll-to-income ratio, gross profit percentage and return on capital and assets.

Tracking these figures will help you to benchmark performance, spot trends and make informed decisions that support long-term growth. Financial leadership is not just about compliance; it is about creating a future-ready practice. By embracing digital tools, you can unlock efficiency, reduce stress and focus on what matters most: your patients and your future.

If you have questions or would like to discuss strategies for strengthening your practice finances, we'd love to chat.

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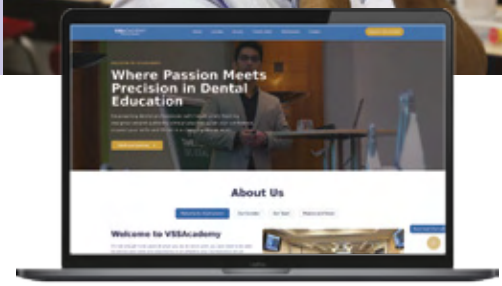

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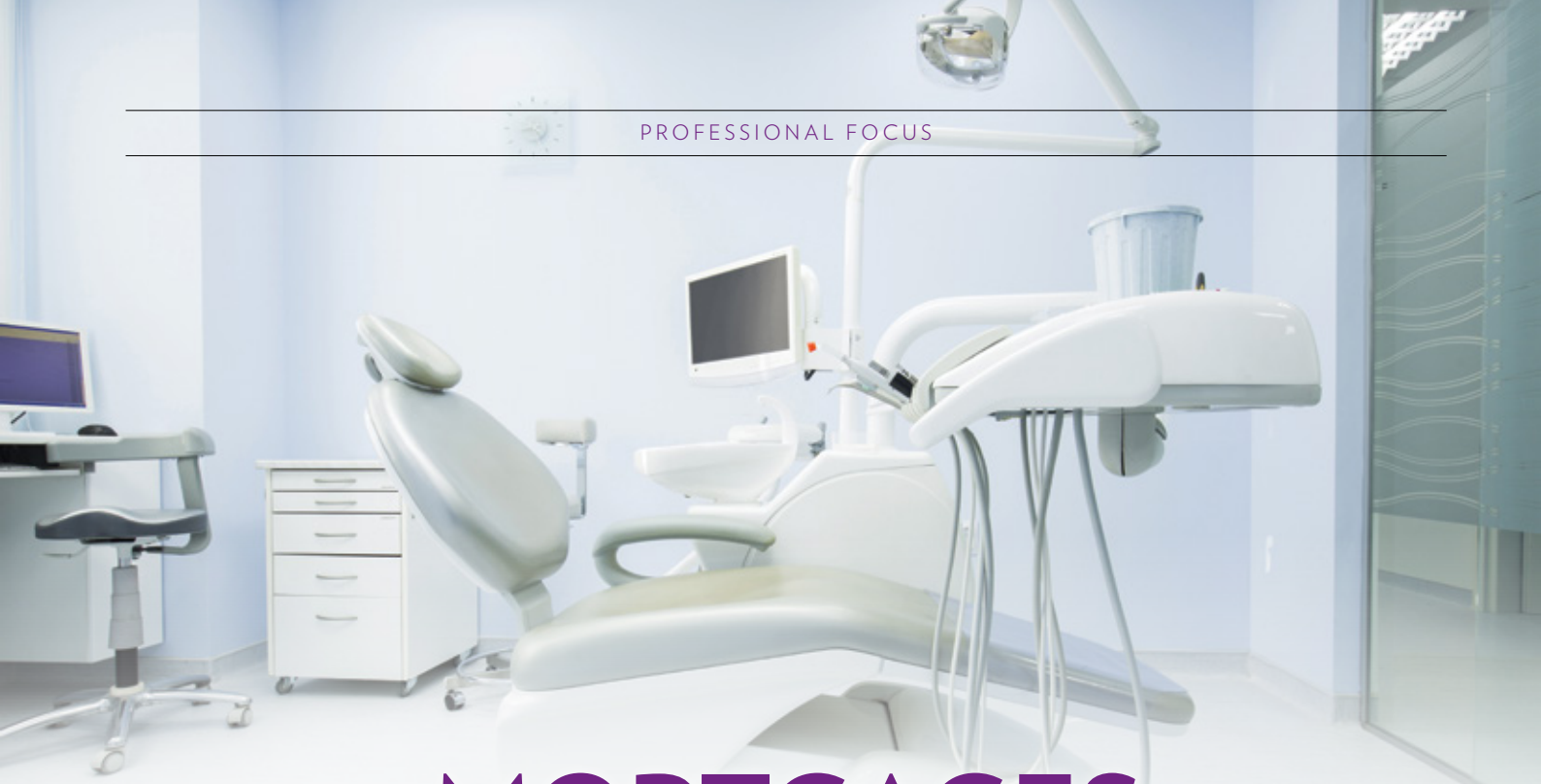

MORTGAGES FOR DENTISTS

Lyndsey Pickering from PFM Dental discusses the key to home ownership

Average house prices in Scotland, as measured by the UK House Price Index (HPI), increased by 4.9% in Q1 2025, the highest rate since late 2022, and the fifth consecutive quarter of positive annual growth. For many dentists, owning a home is a key personal milestone, but the journey to securing a mortgage can be more complicated than expected. Whether you have just completed your Dental Vocational Training (DVT), or have been practising as an associate for several years, navigating the mortgage market can present unique challenges.

UNDERSTANDING THE CHALLENGE

Income structures can be complex. Between mixed NHS and private income, varying associate agreements and self-employment transitions, lenders sometimes struggle to assess affordability accurately. This can result in unexpected hurdles when trying to get on the property ladder, even as high-earning professionals.

Many newly qualified dentists aim to buy their first home within months of completing their DVT position and moving into associate positions. As income typically grows quickly during these early years, wanting to maximise borrowing potential is understandable. However, most mainstream lenders require at least two full years of tax returns before considering a mortgage application.

FLEXIBLE OPTIONS FOR DENTISTS

Fortunately, some lenders take a more flexible approach. A number of specialist mortgage providers recognise the income of dental professionals prior to receiving two years tax calculations. Certain lenders may be willing to use your associate pay schedules (if you have them for several months) as proof of income. Others may accept just one year of accounts. Even experienced associates can face challenges. For example, if you have recently changed your trading structure. For instance, from sole trader to limited company, many lenders treat this as the start of a new business. This often resets the clock, requiring two years of trading under the new setup before you can reapply.

WHY SPECIALIST ADVICE MATTERS

This is where working with a mortgage broker who understands the dental profession can make all the difference. A specialist broker can interpret your income correctly, identify lenders with flexible underwriting criteria and present your application in the best possible light. They can also help you explore a range of products, from fixed-rate and tracker mortgages to offset and flexible options, to find a deal that suits your circumstances and long-term financial goals. Buying your first home, or moving up the property ladder, should not feel out of reach just because your career path does not fit the standard lending template. With the right advice and lender support, there are lenders offering borrowing, on competitive terms too. It is worth exploring your individual circumstances and reviewing your options to securing a mortgage.

> **“A SPECIALIST BROKER CAN INTERPRET YOUR INCOME CORRECTLY, IDENTIFY LENDERS WITH FLEXIBLE UNDERWRITING CRITERIA, AND PRESENT YOUR APPLICATION IN THE BEST POSSIBLE LIGHT”**

Lyndsey Pickering is an experienced financial adviser, with responsibility for PFM Dental's new associate dental clients. Lyndsey strives to keep her clients' needs at the forefront of her advice process, specialising in mortgages, income protection, regular pension and savings advice. ***pfmdental.co.uk***

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It is with great sadness that we bid farewell to our colleague who passed away on 2 October, writes Olaf Sauerbier

Since 2017, Andrew had served as Country Manager UK/Ireland/Malta at VOCO GmbH. During these years, he made a lasting impact on our company through his profound expertise, his wealth of experience and, above all, his honest, authentic and respectful manner.

Andrew's professional career was characterised by dedication, vision and determination. He assumed leadership responsibilities across international markets and earned great respect as an accomplished manager, coach and strategist. His ability to motivate people, foster strong relationships and unite teams behind shared goals was both inspiring and impactful.

Beyond his professional excellence, we will remember Andrew as a colleague who stood out for his integrity, openness and humanity. He was not only a manager or business partner but a valued companion. We are grateful to Andrew for his time with us, his tireless commitment and for the mark he has left on our company and in our hearts. Our deepest sympathy goes to his family and loved ones. Andrew will remain in our thoughts with the highest esteem.

Olaf Sauerbier is the Managing Director of VOCO GmbH.

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At his new clinic Dr Navid Saberi offers an exceptional patient experience

Saving Teeth is the first independent private specialist endodontic referral centre in Edinburgh. It focuses on saving teeth that might otherwise face extraction. This includes the effective diagnosis and management of dentoalveolar pain and trauma. Whether patients are dealing with a dental emergency or trauma, persistent toothache, undiagnosed dental pain or the need for intricate root canal therapy, the Saving Teeth team can deliver prompt, effective and compassionate care and treatment.

The practice was founded and is led by Dr Navid Saberi. A registered specialist in endodontics, Dr Saberi dedicates his skills exclusively to complex endodontic procedures. His mission is to save teeth, especially those requiring the most complex care, and avoid unnecessary extractions. He is a specialist member of the American Association of Endodontists and a member (and former officer) of the British Endodontic Society and European Society of Endodontology. Since 2009, he has been mentoring dental students and qualified dentists in the field of endodontology. He established Navid Saberi Endodontics in 2013, Edinburgh Endodontist in 2019 and has now relocated to Saving Teeth, at 23B Howe St, in a former blacksmith's, built in 1808. The contrast in look between its former use and now is incredible. Walking in, it does not feel like you are in a dental practice; more like a gallery. The reception's décor is luxurious, calm and welcoming.

Dr Saberi has been thinking about the clinic's creation for more than a decade. As well as clinical practice, design has long been a passion. Along with his flair for look and feel, with the building's listed status he also enjoyed paying respect to its history and design. Over the months of renovation, members of the public marvelled at the attention to detail shown. On completion, occupants of neighbouring buildings were queuing up to see the transformation inside.

"The practice is purpose built and the environment, along with the team's expertise and the investment we have made in advanced technology, provides the journey that I want patients to enjoy – from the moment they are referred, to when they arrive, undergo treatment and through to post-treatment," said Dr Saberi. The team does everything to put patients at ease; before, during and after treatment. Normally anxious patients report not noticing that they were undergoing a dental procedure. "It is a state-of-the-art service," he said. "And it's slow...in a good way. We allow about two hours per treatment. So, patients come in, they are welcomed, they relax, perhaps enjoy a refreshment. We have a chat. Then the treatment, recovery, another chat. Patients leave feeling revitalised." Saving Teeth is open for referrals. Dr Saberi has a long-established cohort of referring colleagues, but he welcomes new referring colleagues and collaborators. Looking to the future, Dr Saberi and his team, comprising a treatment coordinator and nurse, will be complemented by a periodontist.

> "THE TEAM DOES EVERYTHING TO PUT PATIENTS AT EASE; NORMALLY ANXIOUS PATIENTS REPORT NOT NOTICING THAT THEY WERE UNDERGOING A DENTAL PROCEDURE"

Saving Teeth
23B Howe St, Edinburgh, EH3 6TF
W: saving-teeth.co.uk
T: 0131 3818383
E: yourteam@saving-teeth.co.uk
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TURNKEY SURGERY DESIGN

Vermilion's stunning second floor expansion is a showcase for IWT's expertise and exceptional service

IWT Dental Services was the obvious choice, says Kay MacMillan, General Manager at Vermilion – The Smile Experts. "I have worked with Ian [Wilson] and Bruce [Deane] on two other clinic build projects for Vermilion and we have developed a good working relationship," she said.

Their latest collaboration has been on Vermilion's £800,000 second floor expansion at 24 St John's Road in Edinburgh.

"We were looking to expand our current offering by doubling our clinic capacity, offering our referring practitioners more specialist services and to reduce patient wait times," she said. "It was also an opportunity for us to bring our hygiene and admin team back under the one roof and condense the working week."

The expansion covers 3,500 square feet and comprises a swish reception and staff area, five beautifully executed surgeries, a high-end LDU and space for continuing professional development courses with capacity for live video links to the surgeries.

"IWT was involved in the early stages of planning to install all of our dental chairs, the LDU and X-ray equipment as well as the IT/AV offering," said Kay. "They collaborated with both our architect and builder throughout the project to ensure that nothing was a surprise along the way.

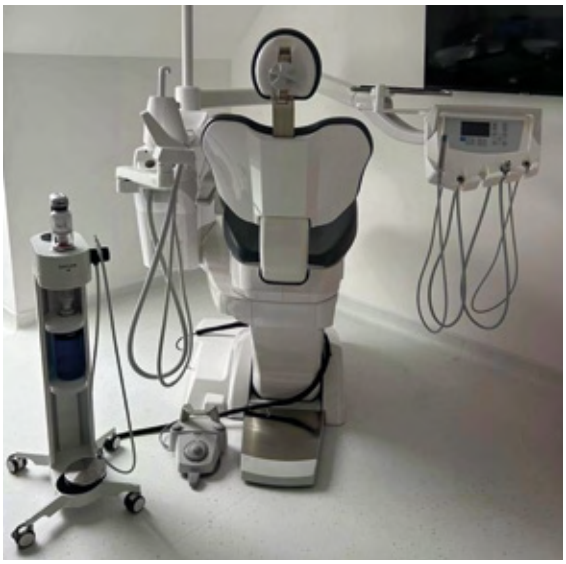
"Bruce also worked with a bespoke supplier to install their high-calibre dental cabinets in all of our surgeries and LDU. Ian was responsible for the IT and the AV equipment that we have in every area of the clinic."

HOW DID THE PROCESS WORK?

"They attended planning and site meetings – assisting me in the preparation of the new space, back when it was a blank canvas – working out the correct equipment for the practice's needs.

< Reception area

Surgery >



They also provided detailed schematic drawings to ensure that the equipment was installed accurately in the surgeries and LDU.

"The install was seamless, with minimal disruption in the clinic during this time. All of the technicians were professional and supportive throughout; the guys are a credit to both Bruce and Ian. There were challenges during the project – it's not surprising with a large team of people working on the build – but I feel we all worked together to achieve an amazing result overall."

WHAT QUALITIES DO IWT BRING TO A PROJECT?

Kay said: "They're personable and they have a hands-on approach, wanting to understand your business needs while offering their knowledge. Ian and Bruce are always there to help."

ABOUT IWT

IWT provides industry-leading solutions for dental practices of any size and at any stage in their development.

Their partnership philosophy offers full optimisation of your practice, equipment and workflow, enabling you to focus maximum attention on your patients.

From single-surgery installations to end-to-end managed services, including building works, plumbing, electrics, flooring, dental chairs and bespoke cabinets, IWT are experts in working with you and your team to identify your specific requirements and deliver your vision.

IWT has long-established relationships with leaders and vanguards of dental equipment supply, and their experience in delivering excellence throughout the industry allows them to offer you cutting-edge innovation and complete practicality, regardless of budget. They strive to provide your business with the right equipment, supported by their expert advice and exceptional customer service.

Their service covers IT and networking, dental chair supply, imaging supply and project management.

Their high client retention rate is a source of great pride to everyone at IWT and is testimony to their dedicated team of expert technicians and the exceptional service they provide.

www.iwtech.co.uk

HOW TO INCREASE YOUR PLAN MEMBERSHIP: GIVE THEM AN INCENTIVE

Practice Plan Regional Support Managers Selina Alexander and Louise Anderson share ways to encourage team members to promote your plan and get patients to join

As inflation and practice running costs continue to rise, a well-populated dental membership plan, with its predictable monthly income, can help ease some of a practice owner's worries.

As well as the income, plans also help encourage patient loyalty and regular attendance, opening further opportunities to generate revenue. That is why it is important to sign up as many patients as possible to become plan members. From cupcakes to air fryers, vouchers to spa days, incentives do not need to be extravagant; they just need to be meaningful. Pitched right, they can transform your team into enthusiastic ambassadors for your membership plan.

During her working life, Selina has visited dozens of practices across the UK and has witnessed firsthand how small, thoughtful rewards can drive big results. "An incentive doesn't always have to be monetary," she explains. "It can be time back, like a Friday afternoon off, or something fun like cupcakes when the team hits a milestone." One standout example she shares is of a practice in Belfast struggling to reach 1,000 patients. Selina asked the team what would motivate them, and their answer was simple: an air fryer for the staff kitchen. The owner agreed, and within months, the team hit their target. The moral of this story? Ask your team what would give them an incentive to promote your plan more widely.

CHART YOUR PROGRESS

Another effective strategy is to break down big goals into more easily achieved steps. If your aim is to add 2,000 new members to your plan, take it in stages. Reward team members when you hit 50 more, then 100 and so on until you reach your target. Track your progress to keep people motivated. "Seeing the numbers go up gives the team a sense of achievement," said Selina. "It's not just about hitting a huge target; it's also about celebrating the journey."

TEAM-BASED REWARDS WORK BEST

While offering individual incentives might seem appealing, they can sometimes be counterproductive. Encouraging patients to sign up is a whole team effort. "I don't encourage top-seller rewards," Louise explains. "It can create resentment. If someone's on reception and signs up ten patients, others might feel it's not worth trying as they don't have the same exposure to patients." Instead, focus on team-based incentives. Louise suggests starting with something simple like pizzas for lunch when the team hits 25 sign-ups. Then scale up: "For 50 patients, maybe a £5 voucher each. For 100, a £10 voucher. It builds momentum," said Louise. Vouchers are especially effective because they are flexible and personal.

TAILOR INCENTIVES TO YOUR TEAM

Not every team wants the same thing. Some love the idea of a spa day; others would rather not spend time with colleagues outside of work. Choose incentives that are inclusive and easy to distribute. Vouchers, time off or shared treats like lunch or snacks tend to work well across the board.

TRAINING + INCENTIVES = RESULTS

Both Selina and Louise emphasise the importance of refresher training alongside incentives. "I've done 27 refresher trainings this year," Selina shares. "It gives teams a boost and reminds them why the membership plan matters." Louise adds that after training, there is often a spike in sign-ups. However, activity can drop off if the team isn't continually engaged. That is where incentives come in. "Training gets them started, but incentives keep them going," she added.

OVERCOMING RESISTANCE

Sometimes, the challenge is more to do with mindset than motivation. Selina recalls working with a practice where the reception team had been with the previous NHS-focused owner for years. "They weren't interested in the plan," she said. "But GDC regulations are clear: communication is key. Patients need to be told about their options." In cases like this, Selina has even spent time on reception herself, modelling how to talk to patients about the plan. "It's about showing, not just telling."

Selina Alexander

Louise Anderson

SET CLEAR TARGETS AND CELEBRATE SUCCESSES

Louise works with her practice owners to set realistic monthly targets to help them achieve their end goal. "I advise using charts to track joiners, leavers and net growth," she said. "Practice Plan practices can monitor all these details on Supportal. The dashboard shows all this information in real time so you can monitor things easily. For example, you could set goals such as 15 new patients in January and reward the team when they hit them." Incentives are about more than just rewards; they are about recognition, motivation and creating a culture of growth. Whether it is cupcakes, vouchers, or an air fryer, the right incentive can transform a passive team into go-getters and passionate promoters of your membership plan. So, ask your team what they want. Set clear goals. Track progress. Celebrate wins and watch those numbers climb!

Selina Alexander is a Regional Support Manager at Practice Plan with three decades' experience. She began her career in dentistry as a trainee dental nurse and progressed to become Regional Manager for 10 practices, through to mergers and acquisitions manager.

Louise Anderson is a Regional Support Manager with Practice Plan. She began her career as a dental nurse in 1991 and is also a qualified NVQ Assessor. Before joining Practice Plan in 2022, she spent 15 years as a group manager for five dental practices in south west Wales.

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Ant Davies, Principal Dentist, in his surgery.

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BUYING A DENTAL PRACTICE

Samantha Hodgson looks at some of the factors that hinder a lending application

POV: you want to buy a dental practice and will need bank funding. What do you need to prepare in advance of a lending application? What do you need to avoid? Here are some of the main things to consider.

1. INCOME VS SPENDING

Lenders factor your monthly spending into their calculations; the more you spend, the more drawings they deem you will need from your target practice. If you declare that you require £60,000 p.a. to cover your spending but you are currently spending £80,000 p.a., the bank's credit team will not approve the lending application, unless you can provide strong evidence as to why you require less. Keep an eye on your spending and try to reduce unnecessary purchases to show a true reflection of your monthly costs. Aim to save as much cash as you can on the run up to a purchase. If you are a high earner, lenders will question where your money has gone if it is not in savings, property or business. Note the type of spending on your bank statements; regular gambling is a red flag for credit teams.

2. HIGH DEBT AND PAYMENT DEFAULTS

As with most loans, payment defaults or high levels of debt which cannot be repaid before you take out the loan can result in your application being rejected. High levels of personal or business debt indicate your finances are already strained. Spending on a credit card is fine, providing it can be cleared either monthly or in full prior to loan drawdown, and the level of spending is not outside of your current earnings.

3. INSUFFICIENT DEPOSIT PLUS POOR FINANCIAL STANDING

100% loans are possible, providing you have a good financial standing e.g., a good level of equity in property or existing businesses. However, it is more typical for lenders to require a minimum of 10%-20% deposit.

Lenders want to see commitment from a buyer. This could be in the form of a cash deposit and/or a charge over your property. If you don't have available cash to commit, lenders will view you as a riskier investment and are more likely to want a charge on your property. It is important to note that to calculate equity, most lenders will write the value of your property down to around 70% of its current on-market value and then deduct your current mortgage. So, while a £500,000 property with a £300,000 mortgage may look as though you have £200,000 equity, lenders will calculate this as:
£500,000 x 70% = £350,000 property value
£350,000 - £300,000 = £50,000 equity

The costs involved in buying a practice will also be factored into your current cash reserves, reducing the potential useable deposit. Buying costs are typically around £15,000 to £20,000.

4. LACK OF EXPERIENCE OR EXPERTISE

Lenders are hesitant to approve an application if you have less than three years' experience in the dental industry. They want to see that you are settled as a dentist and, hopefully, that you have some form of management experience. They will ask to see your CV to evidence this. You may want to consider partnering with a mentor or seeking additional training to strengthen your application. Being a good associate and being a good practice owner are two different challenges. You will need to provide a brief business plan for the practice; to show you have considered things you want to keep and things you want to do differently. Lenders like to see stability and any potential plans for future growth.

5. NO ACCOUNTING HISTORY AND UNPAID TAX

Lenders will want to see three years' associate accounts/tax returns, so keep on top of your accounts. Don't delay paying your tax bill – your accountant will be required to confirm that all tax is paid up to date.

6. UNCERTAIN PRACTICE REVENUE STAFFING

You will need to evidence that the target practice can generate sufficient income to cover expenses and loan repayments. Ensure you have full financial information for the practice plus details of any changes over the last few years. If practice income has not been stable or is growing, you will need to explain why and how and ensure that current income can be maintained.

More recently, lenders have started to factor in staff stability and recruitment. If additional dentists are needed at the practice, you will need to confirm how you plan to recruit and how income will be maintained.

7. POOR APPLICATION

Your initial lending application needs to be detailed and address any potential concerns early on. Failure to do so will result in your application being delayed or possibly rejected. If you are looking for guidance on how to prepare to buy a dental practice, please contact PFM Dental today for a free, no obligation chat.

Samantha Hodgson,
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E: Samantha.Hodgson@pfmdental.co.uk
T: 01904 670820
W: pfmdental.co.uk

> **"LENDERS WANT TO SEE COMMITMENT FROM A BUYER. THIS COULD BE IN THE FORM OF A CASH DEPOSIT AND/OR A CHARGE OVER YOUR PROPERTY"**

CELEBRATING 20 YEARS

Performance Finance and the dental evolution

Performance Finance's celebration of 20 years of dedicated support to the dental industry is more than just a timeline milestone; it reflects the sector's own evolution. Over two decades, they have cemented their role not simply as a lender, but as an integral financial partner that understands the unique pressures and opportunities facing dentists today.

The dental landscape has undergone a revolutionary shift since 2005, moving to an era defined by digital innovation. Performance Finance has been the engine driving this change, providing the specialist finance required for the adoption of game-changing technology. From funding the initial investment for CBCT scanners and CAD/CAM systems to facilitating the refurbishment of whole clinics, their expertise has enabled practices to upgrade, expand and deliver gold-standard patient care.

Beyond equipment, their commitment is most evident in practice acquisition.

They have guided countless associates to achieve their dream of practice ownership, structuring bespoke deals for first-time buyers and growing dental groups alike. Their ability to offer highly specialised solutions, like unsecured loans and tax-efficient asset finance, sets them apart from generic high-street lenders. Performance Finance's 20-year journey of trusted lending solutions is a testament to their deep sector knowledge, stability and focus on client success. Here's to their continued success in supporting the future of UK dentistry.

Buying or selling a dental practice?

Whether you're preparing to sell your practice or take your first steps into ownership, our team is here to guide you through the process with clarity, confidence, and care.

Thinking of buying? Set yourself up for a successful purchase.

What are you buying? Assets, goodwill or shares?

Buying alone or with others? Structure affects everything

Lender-ready? 3 years' accounts usually needed - we can help

Due diligence: NHS/private split, staff, contracts, premises

Smooth handover: Think TUPE, patient lists, insurance

Profit extraction: We'll help plan tax-efficient remuneration

Thinking of selling? Make your next move with clarity and confidence.

Valuation matters: Based on turnover or EBITDA, but ultimately down to what a buyer is willing to pay

Corporate buyers: May offer more but often come with conditions and deferred payments

Associate buyers: Flexible and familiar but may require more time and funding

Tax implications: Capital Gains, Income Tax and Inheritance Tax need careful planning

Legal support: Work with solicitors experienced in dental practice sales

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Taking care of **dental** business

For the outcome you're looking for – whether that is buying or selling your practice, advice on associate agreements, partnership agreements and/or shareholder agreements or specialist immigration advice, to property matters, employment law and data protection - speak to our expert Dental Team for **specialist legal advice**.

MAXIMISING YOUR RETURN

Lucy Hennessy outlines some of the key steps you can take to ensure an efficient sale process

Thinking about selling your dental practice? Selling a practice takes more time and involves more preparation than you would perhaps think, but planning ahead with the guidance of experienced experts (like the Thorntons Dental Team!) will ensure you maximise the return on your investment.This article summarises some of the key steps you can take to ensure an efficient sale process.

1 YOUR PROFESSIONAL TEAM

You should engage with a specialist dental accountant and lawyer as soon as possible in the sale process. A dental specialist will be able to give you an insight into common issues that can occur throughout a sale process (and help you navigate around these) and give you an idea of the type of documents and information you will be asked to provide to a prospective buyer.

2 SALES AGENTS

Some practices are sold privately and off-market and if you are fortunate enough to have an existing associate who is keen to buy in then great! Most practices however are sold via specialist sales agents, who specialise in the sale of dental practices and have extensive networks of contacts you can benefit from. We would always recommend that you register with one of them for marketing your practice and ensuring you are attracting the best offers.

3 HEADS OF TERMS

Heads of Terms are a document that sets out the key commercial terms of the deal, so that all parties have clear expectations on the transaction specifics from the outset. Importantly from a seller's perspective, they normally contain legally binding confidentiality provisions to ensure that any information you release to a buyer during the due diligence process is treated as confidential and cannot be disclosed by the buyer to any third parties, save in limited circumstances.

4 DUE DILIGENCE

Due diligence is a vital part of any practice sale, and its importance is often underestimated by sellers. The due diligence process normally comprises a list of queries/ requests for information provided by a buyer's solicitor – it covers things like financials, employees, pensions, regulatory compliance etc. and while it can take some time to work through, the more detailed and complete responses you can give the better. A well organised practice will sell much more easily and the sale process generally will progress much more efficiently if the due diligence responses can be provided in an orderly and efficient manner.

Lucy Hennessy
Solicitor
E: lhennessy@thorntons-law.co.uk
M: 0330 2368647

5 BUSINESS PURCHASE AGREEMENT / SHARE PURCHASE AGREEMENT

This is the legal contract for the sale of the practice. The first draft of it is usually prepared by the buyer's solicitor and, normally, it won't be circulated unless and until the legal due diligence process is largely completed (which is why it is important for sellers to respond promptly!) Its purpose is essentially to allocate transaction risk, and it will go backwards and forwards between the parties' solicitors until such time as it is in a form that is acceptable to both. Once agreed, it is time to complete the deal, sign the documents, receive payment and hand over keys – congratulations!

At Thorntons, we have a wide network of contacts within the dental sector in Scotland, from accountants to sales agents, and we would be happy to share these with you. So, if you are thinking of selling your dental practice, please give us a call on 03330 430350 and if you need any further persuasion, please see what some of our clients have said at **www.thorntons-law.co.uk/dental**

THE SCOTTISH DENTAL MARKET IN 2025

Joel Mannix, Director – Dental at Christie & Co, shares some key highlights

2025 was another key year for independent dental operators in Scotland. As corporate operators paused their acquisition strategies in the country, 100% of practices sold through Christie & Co were purchased by independent buyers.

KEY ACTIVITY AND CHALLENGES

Activity in Scotland was slow at the start of the year, with fully private practices and those with two or fewer surgeries gaining less interest and therefore proving more difficult to sell.

However, the market picked up significantly in the latter half of 2025, signalling renewed confidence, and local multi-site operators stepped up, offering attractive deals that would traditionally have been reserved for corporate buyers. Meanwhile, goodwill values remained resilient, with indications that they may be on the rise.

The challenges we have seen across the UK have been apparent in Scotland, too. For existing operators, rising operational costs, including essentials such as heating and lighting, have added further pressure, alongside persistent staffing issues, particularly in attracting and retaining Associates. Financial constraints have compounded these difficulties, with tighter budgets and tax rate increases impacting both buyers and sellers.

Joel Mannix, Director – Dental, Christie & Co

MARKET EXPECTATIONS IN 2026

- We expect to see new corporates entering the Scottish market, as they recognise the potential that the market has to offer
- There will continue to be a rise in interest from first-time buyers who want to jump into practice ownership
- We'll see more creative deal structures, including deferred consideration and earn-outs, as buyers look to manage risk and cash flow
- There will be a greater focus on mixed practices, as operators seek to balance NHS and private income streams for stability
- We expect to see clarity on tax and financial planning as a result of the Autumn Budget

THE YEAR OF DOING LESS, BUT BETTER

By Victoria Forbes, Director, Dental Accountants Scotland

As we near the end of 2025, many Scottish dental practices tell us the same thing: they feel stretched. Rising costs, full diaries, staffing pressures and the constant hum of operational noise can make it feel as though every day brings another demand on time and energy.

But the practices performing best in the current climate are not the ones doing more. They are the ones doing less, but better. There is strength in simplicity. When pressures mount, the instinct is to add new initiatives or expand services. Yet for many practices, the greatest gains come from pausing, stepping back and focusing on the activities that genuinely 'move the needle'.

For some this means reducing unprofitable treatments or limiting low-value appointments that drain chair time. For others it is about tightening admin processes, improving handovers or refining the way the diary is zoned. Small, thoughtful improvements, done well, often outperform grand reinventions that never fully take root.

Victoria Forbes
Director, Dental Accountants Scotland
E: victoria@dentalaccountantsscotland.co.uk

'Doing less' does not mean lowering ambition. It means choosing with intent. It means giving yourself permission to focus on patient care, team wellbeing and financial clarity rather than firefighting. It means identifying two or three areas that will truly improve your quality of life as a practice owner. 2026 will reward practices that prioritise capacity, calm and clarity. Those who simplify will find they create more space: space for patients, for the team, for clinical excellence and for owners to breathe again.

If you feel your practice has become too busy to function at its best, you are not alone. A conversation and a fresh pair of eyes can help you pinpoint where the biggest improvements lie. If you would like support to simplify, refocus and strengthen your practice, we would be very happy to help.

› ORALIEVE

ORALIEVE FLAVOUR FREE TOOTHPASTE SUPPORTS PATIENTS WITH SENSITIVE MOUTHS

Oralieve, the most recommended brand for dry mouth by healthcare professionals, is expanding its oral comfort range with the launch of a new Flavour Free Toothpaste, designed for patients who struggle with strong flavours; a common issue for those with dry or sensitive mouths.

Dry mouth affects a large proportion of the UK population, due to increased use of multi-medications, cancer treatments and conditions such as Sjögren's Syndrome, diabetes and Parkinson's.

For many people with autism, dementia, Burning Mouth Syndrome or sensory sensitivities, even mild flavours in toothpaste can cause irritation, discomfort or burning sensations. Mint might feel 'fresh' for some but for people with dry or damaged oral tissue, it can be anything but. That cool tingling sensation can often be a sign of irritation and not refreshment.

For many, the foaming agents (like SLS) found in traditional toothpastes make things even worse. They strip the mouth of moisture and increase the discomfort; due to their harsh foaming action and the way they aggravate already sensitive tissues.

Oralieve Flavour Free Toothpaste has been specially developed to help. Its gentle formulation contains 1450ppm fluoride to help protect against tooth decay, and is free from SLS, reducing the risk of further irritation. What is more it contains no added flavours, making it suitable for anyone with heightened oral sensitivity.

Oralieve Flavour Free Toothpaste is available from major dental and pharmacy wholesalers. Consumers can purchase directly from www.oralieve.co.uk or Amazon. Available in 12ml trial size and 75ml full size for £5.49.

For more information visit www.oralieve.co.uk

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It features excellent flow properties such as a flowable, non-heated gutta-percha that does not shrink, but rather expands slightly to increase adherence and facilitate simple yet precise placement in the canal.

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For more on COLTENE, visit www.colteneuk.com/GuttaFlow, email info.uk@coltene.com or call 0800 254 5115.

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RECORD-BREAKING MONTH FOR LOCUM!

Whether you are looking for a permanent or locum role, Dental Elite offers a comprehensive recruitment service that can quickly match to you your ideal position.

The Dental Elite locum recruitment dream team – Luke Arnold and Lisa McCusker – are now reunited and helping practices across the UK source locum dentists and dental hygienists.

They have had so much success recently that they have broken their own record for the largest number of locum shifts allocated in one month! A figure they look to break again this month...

For support you can rely on, whether you're looking for permanent or locum roles, contact Dental Elite today to find out more.

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› AGILIO

AGILIO LAUNCHES IGROW TO POWER GROWTH FOR INDEPENDENT DENTAL PRACTICES

Agilio has launched iGrow, a first-of-its-kind growth platform that gives independent practices the tools to compete with corporates, attract patients and build long-term value. At a time when independent dental practices are under growing pressure from corporates and large groups, iGrow provides a practical and proven way to compete more effectively. By bringing together three established Agilio solutions into one streamlined offering – Customer Relationship Management (CRM), specialist marketing services and a fully managed dental plan – iGrow enables practices to attract, convert and retain patients while freeing up valuable time for owners and teams to focus on care. The solutions within iGrow are:

- CRM (DenGro): an intuitive enquiry management system that helps teams capture, track and convert more patient leads, ensuring every opportunity is maximised
- Marketing Services (The Fresh): specialist dental marketing support that drives visibility, builds reputation and generates a consistent flow of new enquiries
- Dental Plan (iPlan): a fully managed membership plan that encourages loyalty, provides predictable income and strengthens long-term practice valuation.

Independent practices already using the elements of iGrow are reporting impressive outcomes:

- 98% increase in revenue
- 44.2% uplift in patient conversion rates
- 10x return on investment (ROI)
- 23% of pay-per-click (PPC) traffic converted directly into revenue
- 500% increase in ROI for digitally-driven practices.

iGROW

To learn more about iGrow and how it can support independent dental practices, visit agiliosoftware.com/igrow

› AGILIO

AGILIO STRENGTHENS LEADERSHIP TEAM

agilio SOFTWARE

Agilio Software, the UK's leading provider of healthcare operations software, has unveiled three senior appointments that will help propel its next phase of expansion.

The new hires mark a major investment in Agilio's growth strategy, focused on mergers and acquisitions (M&A), international expansion and continued organic growth.

The new appointments are:

- Tom Cornwell, Chief Financial Officer (CFO) – Tom brings more than a decade of financial leadership and growth expertise from The Access Group, where he helped scale the company from £60 million to £1.2 billion through strategic M&A and sustainable expansion
- Bruce Fair, Chief Revenue Officer (CRO) – following a successful consulting period, Bruce now joins permanently. With a strong track record in scaling SaaS (Software-as-a-Service) and digital platforms, and global experience across the UK, USA and Australia, he will accelerate Agilio's revenue growth and international reach
- Mike Osborn, Chief Customer Officer (CCO) – a seasoned leader in healthcare and technology, Mike is known for building high-performing teams and delivering exceptional customer experiences. At OneAdvanced, he drove significant organic growth through customer-centric innovation.

Agilio supports more than 8,000 dental practices and thousands of GP surgeries, pharmacies and veterinary practices across the UK. The company has grown rapidly through acquisitions, partnerships and product development, and its investment in leadership underscores its commitment to redefining healthcare operations and empowering professionals to deliver better care.

For more information visit www.agiliosoftware.com/directors

› MISMILE

MISMILE CELEBRATES 10 YEARS

On 12 September, more than 500 dental professionals gathered at the Leonardo Royal Hotel, London, for the MiSmile NEXT Conference and Gala – marking 10 years since Dr Sandeep Kumar founded the MiSmile Network.

What began with just 20 practices has grown into a thriving community of more than 500, delivering more than 60,000 Invisalign smiles and raising £350,000 for Operation Smile. NEXT combined world-class education with celebration, energy and connection, reflecting MiSmile's mission to give patients beautiful smiles while supporting members to grow their practices.

Highlights included sessions from futurist Amelia Kallman, entrepreneur Bejay Mulenga MBE, communication expert Nigel Risner, and MiSmile Clinical Directors Dr Bhumita Shah and Dr Oliver Smart. Align Technology's leaders also underlined their ongoing commitment to the network.

Dr Sandeep Kumar, Founder and CEO, said: "This milestone is not only a celebration of what we've achieved, but a launchpad for what comes next. MiSmile is evolving into the Home of Practice Growth, supporting our members with the tools, training and inspiration they need to thrive for the next decade and beyond."

To find out more about MiSmile, and how you could be part of this incredible community, visit join.mismile.co.uk

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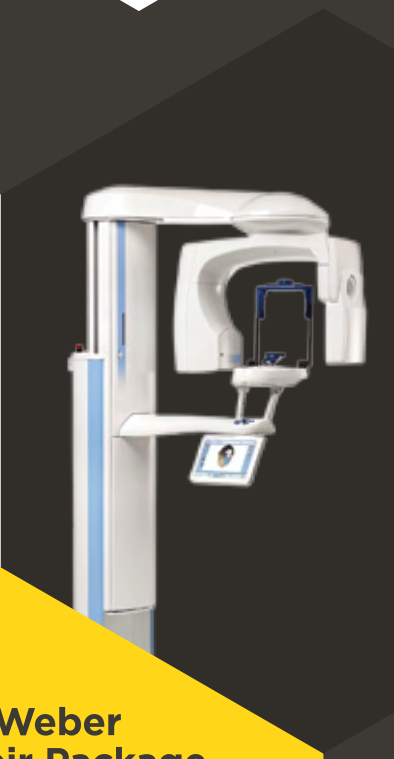

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Alastair Fraser, Principal Dentist, Greygables Dental

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