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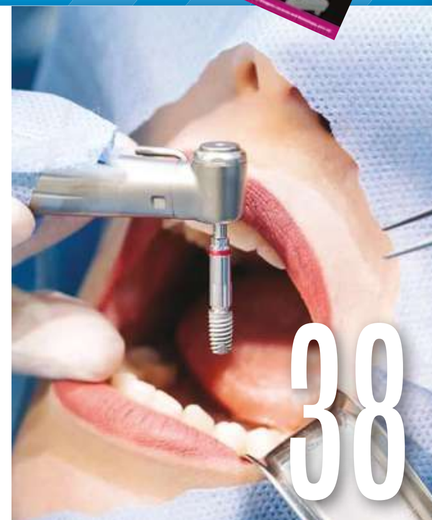

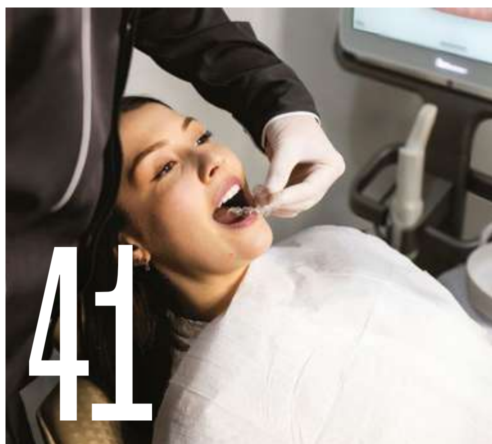

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Teething problems

What can Scotland learn from Westminster's overhaul of NHS dentistry?

The crisis in public dental care is a painful reality across the United Kingdom. From 'dental deserts' to patients driven to desperate acts of 'DIY dentistry', the traditional model of state-subsidised oral health is under pressure.

Against this backdrop, Westminster recently announced sweeping reforms to the NHS dental contract in England, aiming to prioritise urgent care and dismantle long-standing bureaucratic barriers. As Scotland grapples with its own chronic shortages and a growing exodus of practitioners to the private sector, its policymakers could potentially assess whether England's new blueprint offers some lessons.

The centrepiece is a fundamental shift in how dental contracts operate. By embedding urgent and emergency care directly into core contract requirements and standardising payment packages, the reforms aim to incentivise longer-term, complex treatments for conditions such as progressive gum disease and severe tooth decay. Crucially, rather than penalising dentists for multiple, time-consuming appointments under rigid unit-of-dental-activity caps, the new system offers financial stability for holistic packages of care.

For Scotland, this structural pivot contains valuable lessons. In late 2023, the Scottish Government introduced its own payment reform system, moving toward a more streamlined fee-per-item model. While this initially stabilised the sector, many Scottish dentists argue that the fee structure still fails to adequately reflect the complex, time-intensive realities of high-needs patients.

Scotland could possibly learn from England's explicit strategy of tying standardised financial incentives to complex care pathways. By ensuring that treating a patient with extensive oral health issues is financially viable, the Government could prevent practitioners from turning away vulnerable individuals in favour of simpler, more lucrative private work.

Furthermore, England's aggressive focus on workforce diversification offers an instructive model. The English reforms formally empower dental nurses, hygienists and therapists to work to the full scope of their practice; incentivising dental nurses to apply fluoride varnish and restructuring fees for fissure sealants.

Scotland has long pioneered community-led public health through its acclaimed Childsmile programme, yet its high street practices remain bottlenecked by a traditional, dentist-centric delivery model. Embracing a more integrated, team-led approach in Scotland could dramatically unlock capacity, freeing up fully qualified dentists to tackle complex surgical procedures while allied professionals manage routine prevention.

THE TRUE VALUE OF ENGLAND'S REFORMS FOR SCOTLAND LIES NOT IN THE SPECIFIC MONETARY INCENTIVES, BUT IN THE WILLINGNESS TO REWRITE THE UNDERLYING CONTRACT"

However, Scotland must exercise caution before giving into the temptation of duplicating Westminster's playbook. A closer look at the trajectory of English dental policy reveals significant pitfalls. Earlier iterations of England's strategy relied heavily on short-term 'new patient premiums' and 'golden hello' recruitment bonuses to plug regional gaps; measures that independent reviews, including data from the National Audit Office, revealed largely failed to generate sustainable, long-term access for adults.

Ultimately, the true value of England's reforms for Scotland lies not in the specific monetary incentives, but in the willingness to rewrite the underlying contract. Scotland's distinct advantage is its strong baseline in early-years preventive care.

If Scotland can marry its existing public health strengths with England's structural willingness to properly remunerate complex, urgent care and diversify the workforce, it could forge a sustainable path forward. To support NHS dentistry, Scotland does not need to copy England entirely, but it could match its neighbour's appetite for structural reform.

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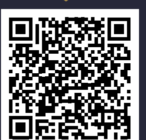

Arthur Dent is a practising NHS dentist in Scotland
Got a comment or question for Arthur? Email **arthurdent@sdmag.co.uk**

Losing control

Along with myriad complications and opportunities afforded by the current shift in the NHS/private balance, there is an insipid and potentially calamitous situation afoot. Control and negotiation in Scotland are in danger of being upset significantly or even lost. The BDA is vociferous about NHS England dental problems and yet the UK Government has done little about it. In Scotland, Statement of Dental Renumeration (SDR) changes have improved things but there is less NHS activity than pre-COVID-19. The deeper issue is the potential for a representation vacuum.

Dental politics has never been the most thrilling prospect for most practitioners. However, we are directly affected in every way by those who help, administer and advance the profession on our behalf. In the different nations, this works in slightly different ways. In Scotland, politicians interact with the profession through the Chief Dental Officer's (CDO) office and the Scottish Dental Practice Committee (SDPC). While they are a British Dental Association (BDA) supported and controlled committee, their representatives are paid by Scottish Dental Fund (SDF), which is, in turn, supported by a quarterly levy based on the NHS earnings of all the dentists in each Local Dental Committee (LDC). Our professional control is sponsored by those earning in the NHS only. There is currently no other pathway to negotiate with the Scottish Government and influence payment and organisational structures.

That only affects the NHS work, I hear you say. Yes, it does, and the mechanism used to work pretty well. It does not allow for private dentists to influence the system and the actions of the CDO. Perhaps it should not. However, if you take that view, who is controlling and monitoring what goes on in wider dentistry? Not private practitioners. The GDC? They do not inspect practices. They do not have regular checks on dentists. Does the Care Quality Commission (CQC) get involved, as happens in England? Health Improvement Scotland (HIS) works in concert with governmental structures to inspect private practices. Academia and its products are not influenced or controlled by private individuals or corporates.

Apathy towards dental politics has always existed; which is why it is the same people involved now as were involved when I started nearly three decades ago. There are some new faces, but they are few and far between. What had been constant was enough funding to keep paying for our negotiators because enough people contributed through their NHS earnings to keep LDC and SDF coffers full. That is rapidly changing. A combination of greater apathy and higher private earnings mean LDCs across the country are feeling the pinch. Reduced values due to NHS reduction and reduced numbers of levy payers. The SDF will start to feel that too and our ability to pay our negotiators will diminish, if not vanish, within a few, short years.

If you are a private dentist or one working for a corporate, then why should you care? Well, I would argue that Scotland is unlikely to be able to support a fully private model. The finance is not there. If that were to be the case, then there may end up a huge disconnect between the governmental control of dentistry, practices and the profession. Said vacuum. This could lead to politicians taking significant advantage of that lack of representation and forcing through policies which make it very difficult for independent practitioners to operate out with the purview of governmental control of legislation, inspection and operational control. I also do not believe that the BDA has enough members, and therefore funds, to support this on their own.

Perhaps the corporates may club together to have some representation? Would this be likely to serve the profession or push for greater profits? When clinical and quality control is left up to any group without checks and balances, the providers and patients will suffer. The profession (NHS or private) benefits significantly from strong and vocal representation to ensure practitioners are supported in their work. Quality control is essential and there are reasonable systems in place to support this. What I do not wish to see is a 'wild west' style of control where each individual or practice has to look after themselves in terms of inspection, quality assurance, working systems etc.

What the LDCs, SDF, SDPC, the BDA and the Government need to do is to ensure that the vacuum does not happen. They must engage with younger professionals to create enough interest and concern that they first put in some money. The funding system is likely to require change to facilitate this. Then, hopefully, some of those younger professionals may want to do more than simply fund the system. I strongly believe that the job of a professional is to leave that profession in a better state than when the entered it. That does not have to involve all your time or effort. However, it would be much easier if everyone did their bit, from funding to effort and influence.

With the shift towards private models and the possible downturn in NHS dentistry, there is a chance that our support structures quietly wither and die. If not fostered, the administrative and political control may leave our grasp. If that were to happen, our profession may lose that status. We become simple providers without influence of our control or payment structures. Many working for corporates may already be on that path. I do not have anything against the corporates; however, I would like to have more control of my destiny rather than less. I would like to believe that those who do have control are constantly reminded of other points of view and forced to do the best for all, not simply serve their own ends. This view may appear to be bleak, but I am concerned...

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SURGICAL PRINCIPLES	MON 22ND FEBRUARY 2027
	TUES 23RD FEBRUARY 2027
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AI and virtual tech take centre stage at dental conference

Royal College of Surgeons of Edinburgh unveils expert speaker programme for 2026 Dental Triennial Conferences

THE Royal College of Surgeons of Edinburgh's (RCSEd) Faculty of Dental Surgery has unveiled the programme for its 2026 Dental Triennial Conference, Digital Intelligence in Dentistry: From innovation to clinical impact.

Held at the RCSEd campus on 22-23 October, the event will bring together leading voices in dentistry to explore the digital technologies, treatments and training methods transforming the profession.

The programme will explore the promise of AI in education and diagnostic imaging, the latest in digitally guided implant surgery and the role of virtual reality in training the next generation of dental professionals.

With world-renowned speakers, including Professor James Field, Professor Shakeel Shahdad and Professor Mutlu Özcan, delegates can expect cutting-edge insights combined with practical applications to improve patient care.

The conference is designed to benefit a wide range of professionals, from specialist trainees and early-career dentists to consultants and general dental practitioners seeking to stay informed about transformative developments across all areas of dentistry.

Professor Grant McIntyre, Dean of The Royal College of Surgeons of Edinburgh's Faculty of Dental Surgery, said: "The Dental Triennial Conference is a cornerstone event for professionals in the sector, and this year's focus on technological innovation is particularly timely.

"The rise of artificial intelligence and virtual technology has the potential to fundamentally reshape our field in the coming years, and this year's conference will serve as a vital platform for exploring how these advancements will enhance our diagnostic capabilities, revolutionise treatment planning, and ultimately transform the patient experience for the better.

"We are proud to host a discussion where leading experts can share the developments that will define the future of dentistry."

For more information on the programme and to register for the event, visit: www.rcsed.ac.uk/dentaltriennial

Drop-in sessions to find out more about new dental exams

FOLLOWING the launch of a new generation of dental examinations, the Dental Examinations Executive will be hosting online drop-in sessions.

They will enable prospective candidates to ask questions about the new tri-collegiate MFDS and Dental Specialty Fellowship examinations commencing in October. Part 1 applications are open and will close on Thursday 16 July, or earlier if capacity is reached.

The Dental Examinations Executive is a tri collegiate body responsible for the development and delivery of postgraduate dental examinations on behalf of the three UK Surgical Royal Colleges - the Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England and the Royal College of Physicians and Surgeons of Glasgow.

The new generation of examinations comprises of the membership examination, designed to assess the competence of a General Dental Council (GDC) registered dentist practising at the level of a Dental Core Trainee completing the third year of training, and provides a recognised gateway for entry into dental specialty training.

The specialty fellowship examinations assess competence at the standard expected of a dental specialist seeking entry to the GDC Specialist List. These new examinations replace a range of specialty membership and fellowship examinations delivered by individual colleges or groupings of colleges.

By bringing the three UK Surgical Royal Colleges together, the Dental Examinations Executive delivers a consistent examination experience for all candidates, irrespective of location, training pathway or College of affiliation.

The examinations form one key part of the UK dental career journey, with the examinations providing independent evidence of progression, mapped to the GDC curricula, and used alongside other evidence, such as workplace-based assessments, in determining career progression.

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[1] Work-in-progress, optional features available for sale starting Q3 2025

BADN to merge with Community

President-elect Carolyn Roberts will become Chairman of the BADN Community Committee

MEMBERS of the British Association of Dental Nurses (BADN) have voted overwhelmingly to approve a merger with Community, the trade union representing workers in a diverse range of sectors.

Ahead of the launch of the ballot on a merger, the BADN's Chair and General Secretary Ruth Garrity RDN said that joining forces with Community would allow the organisation to "extend its influence, expand its membership and enhance the offer it provides to its members."

After the result of the vote was announced Pam Swain MBE, BADN's Chief Executive, said: "We are delighted to be moving forward, supporting dental nurses and promoting the dental nursing profession, together with Community; an organisation which shares BADN's aims and values.

"We look forward to the future as part of a strong and effective partnership. I am personally delighted that, when I retire next year, I shall be leaving the Association in safe hands capable of continuing to support, promote and benefit dental nurses and the dental nursing profession."

Following the vote Preetee Hylton, the BADN's President, announced her resignation. In an email, Ms Hylton said it had been a "considered decision following reflection during my tenure".

She added: "It has been a privilege to work alongside colleagues and stakeholders across the dental profession, and I remain sincerely grateful for the support, collaboration, and professional relationships developed during my time in office."

Ms Hylton will be succeeded by the President-elect, Carolyn Roberts RDN, Senior Dental Nurse for Anglesey and Gwynedd CDS clinics within Betsi Cadwaladr University Health Board. Following the merger, Ms Roberts will take over as Chairman of the BADN Community Committee.

Dentists shift towards private care

AN Inverness-based dental plan provider company has seen the number of dentists using its services rise by 77% and says practices across Scotland are adapting rapidly to major changes within the profession.

IndepenDent Care Plans (ICP), established in 1995 by a team of dentists, supports dental practices throughout Scotland. The company says increasing demand for private treatment is prompting many practices to move towards private or mixed models in response to growing financial and operational pressures.

The trend reflects wider findings from the latest UK Dental Market Review, which highlights rising patient demand for private care alongside increasing concern around the long-term sustainability of NHS dentistry.

ICP says the number of dentists using its plans increased by 77% between January 2019 and December 2025, underlining both the company's growth and the scale of change taking place across the Scottish dental sector.

Dr Robert Donald with some of the ICP staff

The business works with practices throughout Scotland, helping clinics develop more sustainable financial models while continuing to support patient care.

Dr Robert Donald, Marketing Director of ICP, said the move towards private provision is not simply about increasing revenue, but about creating more stable and resilient businesses. "Practices are having to think differently about how they operate," he said. "There is a growing need to balance patient affordability with the long-term viability of the business."

Payment plans are becoming an increasingly important part of that approach, allowing patients to spread the cost of care while giving practices more predictable income.

The changes come at a time when confidence is beginning to return to parts of the UK dental sector, with increased activity in practice sales and investment following a challenging period in recent years.

Dr Donald added: "What we're seeing is a sector that is adapting. Practices are looking for practical solutions that work for both the business and the patient, and that's where structured approaches such as dental plans can play a role."

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New fellowships launched

Representing a significant advance in professional recognition of the whole dental team

THE College of General Dentistry (CGDent) has launched fellowships for each role in the wider dental team.

Recognising professional accomplishment in clinical and other areas of practice, the new fellowships are:

- Fellowship in Dental Nursing – FDN (CGDent)
- Fellowship in Orthodontic Therapy – FOT (CGDent)
- Fellowship in Dental Hygiene – FDH (CGDent)
- Fellowship in Dental Therapy – FDTher (CGDent)
- Fellowship in Dental Technology – FDTech (CGDent)
- Fellowship in Clinical Dental Technology – FCDT (CGDent)

The launch of the new fellowships represents a significant advance in the professional recognition available to members of the wider dental team.

It is also the latest stage in the fulfilment of the College's founding ambition to promote and develop the whole team. It follows the recent inauguration of Deans to lead its Faculty of Dental Nursing & Orthodontic Therapy, Faculty of Dental Hygiene & Dental Therapy and Faculty of Clinical Dental Technology & Dental Technology.

Every registered Dental Care Professional is eligible to join the College as an Associate Member. Those holding a recognised and relevant Postgraduate Certificate may join as –or upgrade to become – a Full Member (MCGDent), and those satisfying any one of the College's five fellowship domains can qualify as an Associate Fellow (AssocFCGDent).

The six new fellowships are open to dental professionals with at least ten years' experience in practice who fulfil the requirements of any two of the College's fellowship domains. Full details of the College's fellowship domains, and a link to apply for the relevant Fellowship, are available here **cgdent.uk/fellowship-domains**

Dental team completes London to Paris cycle challenge

TWO dental professionals have completed a London to Paris cycling challenge raising more than £6,500 for charity.

Suzanne Ord and Karen Smart, of SMile Hygiene in Comrie, successfully completed the cycle in just 24 hours, raising money for two charities close to their hearts; Scotland's Charity Air Ambulance and Dyslexia Scotland.

Suzanne and Karen, who provide mobile dental hygiene service covering north-east Scotland, took on the endurance event despite only starting serious cycling around 18 months ago. Joining more than 80 riders, they set off from Blackheath on Saturday 2 May and arrived in Paris late afternoon the next day.

TAKING ON LONDON TO PARIS IN 24 HOURS WAS SOMETHING COMPLETELY OUTSIDE OUR COMFORT ZONE"

Suzanne told *Grampian Online*[1]: "Taking on London to Paris in 24 hours was something completely outside our comfort zone. We came into this as novice cyclists, so it was both physically and mentally challenging, but knowing we were raising money for two incredible charities kept us going every mile of the journey."

[1]*www.grampianonline.co.uk/news/north-east-dental-team-completes-24-hour-london-to-paris-cyc-434726*

Link between diabetes and periodontal disease 'not discussed'

THE majority of primary and secondary healthcare professionals do not discuss the link between diabetes and periodontal disease with their diabetic patients, according to a study[1]. The also tend not to refer patients with diabetes to a dentist or inform their dentist of the diagnosis.

The study set out to identify current practice, knowledge and beliefs of medical healthcare professionals working in Scotland, related to the link between periodontal disease and diabetes. A cross-sectional observational study was undertaken in 2021 with endocrinology consultants and registrars, general practitioners, diabetes specialist nurses, practice nurses and healthcare assistants involved in the care of people with diabetes across the country.

Exploratory interviews were used to inform the development of an online self-report questionnaire. In total, 128 medical healthcare professionals completed the questionnaire. Quantitative data were subjected to frequency calculations. Qualitative data were analysed using thematic analysis.

The questionnaire revealed that most participants did not discuss the link with their diabetic patients with diabetes, did not refer patients with diabetes to a dentist or inform the dentist of the diagnosis. Participants reported a lack of awareness of the link, insufficient time to discuss this with patients and unclear referral pathways.

The study's authors said that it had highlighted the need to strengthen education and patient communication by raising awareness, developing resources and improving referral pathways between medicine and dentistry.

[1]*www.nature.com/articles/s41415-026-9625-7*

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A new generation of dental exams is coming

It's part of a new approach to assessment which will also see changes to the MFDS qualification

APPLICATIONS are now open for 10 new, tri-collegiate Dental Specialty Fellowship Examinations, with the first diets scheduled for October.

They are part of a new, joined-up approach to assessment which will also see changes to the MFDS (Membership of the Faculty of Dental Surgery) qualification. Currently, most dental specialties have multiple versions of the specialty exam, administered by individual royal colleges, or a combination of colleges.

The Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England and the Royal College of Physicians and Surgeons of Glasgow, will introduce a new, tri-collegiate approach to assessment to cover 10 specialties. Assessment of the remaining dental specialties will remain with the relevant bodies. Having a single exam for each specialty will enable consistency for trainees and will provide a clearer training pathway for all specialties, while continuing to support patient safety.

The first examinations for Part 1, the single best answer exams, will take place this October in various locations in the United Kingdom. Part 2, the clinical structured orals, will take place from February to April 2027. International exam dates will be planned for 2027.

Professor Sondos Albadri, Chair of the Dental Specialty Fellowship Examinations Board, said "This new framework broadens access and provides more opportunities for dentists to have their specialist knowledge, skills, and experience formally recognised through the award of a Fellowship in their chosen specialty by one of the UK's surgical Royal Colleges. We hope this provides a clear and flexible pathways for all specialties."

Changes to MFDS

The MFDS (Membership of the Faculty of Dental Surgery) qualification will also be changing over 2026 and 2027.

The Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England and the Royal College of Physicians and Surgeons of Glasgow have announced the launch of the new tri-collegiate MFDS examination. Delivered and recognised internationally, the MFDS is a marker of advanced clinical knowledge, professionalism and communication across a wide range of dental disciplines.

Ahead of the opening date for applications for the new examinations, dentists are encouraged to visit the website www.dsfe.org.uk to find out more about the changes, eligibility criteria and exam dates.

List of specialties to be covered by the new approach:

- Dental Public Health
- Endodontics
- Oral Medicine
- Oral Surgery
- Orthodontics
- Paediatric Dentistry
- Periodontics
- Prosthodontics
- Restorative Dentistry
- Special Care Dentistry

List of specialties not covered:

- Dental and Maxillofacial Radiology
- Oral and Maxillofacial Pathology
- Oral Microbiology

Neanderthals used stone drills to treat cavities

NEANDERTHALS used stone drills to treat cavities 59,000 years ago, in what is the earliest known evidence of dental treatment. The single molar, which was unearthed in a cave in southern Siberia, features a deep hole that appears to have been created using a sharp, thin stone tool.

The hole extends into the pulp chamber. The researchers found microscopic signs of decay as well as scratches and grooves. In a study published in the journal *PLOS1*, they explain these marks are consistent with deliberate drilling using a pointed stone tool.

A dental professor, who reviewed images of the tooth but was not part of the research, rated the Neanderthal's work as "a decent job".

"If I was marking this for a dental student, I wouldn't give it an A, but given the circumstances it's pretty impressive," said Justin Durham, a professor of orofacial pain at Newcastle University and the British Dental Association's chief scientific adviser.

The smoothed edges of the drilled cavity, and wear patterns inside it, suggest the individual survived and continued to chew with the tooth for some time after the procedure. The find pushes back the known evidence for tooth-drilling by about 50,000 years and marks the first time it has been seen outside our species, Homo sapiens.

The study included a series of experiments. Using sharp stone points similar to tools found at Chagyrskaya Cave, the researchers drilled holes into three modern human teeth. They then compared the results with

the Neanderthal molar. The marks they had made closely matched the shape and microscopic grooves seen on the ancient tooth.

Neanderthals occupied the Altai region of Russia, where the tooth was found, until about 45,000 years ago, hunting wild bison and horses. Until now, the oldest widely accepted evidence of drilled teeth came from Neolithic humans at Mehrgarh, in what is now Pakistan, where molars dating to roughly 9,000 years ago had been bored with flint tools.

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New toothpaste stops periodontal pathogens

It contains a substance that selectively inhibits only those bacteria that cause periodontitis

RESEARCHERS have identified a substance that selectively inhibits only those bacteria that cause periodontitis, thereby preserving the natural balance of the oral microbiome.

Pathogenic bacteria are killed by conventional oral care products such as alcohol-based mouthwashes and products containing the antiseptic chlorhexidine, but these also eliminate beneficial microorganisms.

When the oral microbiome re-establishes itself after treatment, pathogenic bacteria such as Porphyromonas gingivalis gain an early advantage because they proliferate particularly well in inflamed gum tissue. Beneficial bacteria grow more slowly, and the oral microbiome quickly shifts back from its natural balance into dysbiosis, allowing the disease to recur.

Researchers at the Fraunhofer Institute for Cell Therapy and Immunology IZI have identified a substance, known as guanidinoethylbenzylamino imidazopyridine acetate, that selectively blocks harmful pathogens such as

Porphyromonas gingivalis without affecting other bacteria[1].

"Rather than simply killing gingivitis pathogens, it inhibits their growth," said Stephan Schilling, Head of the Fraunhofer IZI branch Molecular Drug Biochemistry and Therapy Development. "They are unable to exert their toxic effects, so beneficial bacteria can occupy niches that would otherwise be inaccessible to them. In this way, the substance works in harmony with healthy bacteria to gently rebuild and stabilise the microbial balance in the mouth."

The basis for this technology originated from an EU-funded project involving numerous international partners. The spin-off company Periotrap Pharmaceuticals GmbH was founded in Halle in 2018 with the aim of developing innovative oral care products.

PerioTrap created its microbiome-friendly toothpaste in close collaboration with Fraunhofer IZI and the Fraunhofer Institute for Microstructure of Materials and Systems IMWS. "The product is designed to prevent periodontitis. Like conventional toothpaste, it also contains abrasives and fluoride to prevent tooth decay," said Mirko Buchholz, one of the spin-off's founders.

[1] ***www.fraunhofer.de/en/press/research-news/2026/january-2026/new-toothpaste-stops-periodontal-pathogens.html***

Artificial saliva protects teeth from acid and decay

SCIENTISTS have created an artificial saliva using a sugarcane protein that can protect teeth and fight bacteria. The key ingredient, CANECPI-5, binds directly to enamel, forming a shield against acids that cause decay.

Early tests show it works even better when paired with fluoride and xylitol, significantly reducing damage to teeth. The innovation could be especially life-changing for cancer patients who lose saliva production after treatment.

Researchers at the Bauru School of Dentistry, University of São Paulo, found that CANECPI-5 creates a protective 'shield' over teeth. This layer helps defend enamel from acids found in beverages such as juice and alcohol, as well as acids from the stomach. The findings were published in the *Journal of Dentistry*[1].

Professor Marília Afonso Rabelo Buzalaf, lead author, said: "We tested the mouthwash developed with CANECPI-5 by applying this solution to small pieces of animal teeth once a day for one minute. Based on these results, we'll conduct further research so that we can think about applications of this product.

"This is the first product that uses the concept of acquired pellicle [a thin protective layer that quickly forms on the tooth surface] to treat xerostomia, which is the sensation of a dry mouth caused by a lack of saliva. We use substances that will reformulate the composition of the proteins that bind to the teeth. We've developed a process in which CANECPI-5 binds directly to tooth enamel, helping to make teeth more resistant to the action of acids produced by bacteria."

[1] ***www.sciencedirect.com/science/article/abs/pii/S0300571225006220***

Truly Dental enters Scotland with purchase of private Glasgow practice

SPECIALIST business property adviser Christie & Co has announced the sale of dental implant clinic 3 Step Smiles, in Glasgow.

3 Step Smiles is a four surgery, private dental implant clinic located within a modern retail unit. The practice occupies a prominent position on Dunlop Street in the heart of Glasgow, just a short walk from key transport hubs, including Glasgow Central Station.

Eduardo Crooke Gonzalez de Aguilar started the practice in 2017, alongside Dr Blanca Crooke, who has been the principal dentist at the clinic for many years. Dr Crooke has been central to the practice's success; building strong, long-term patient relationships.

Following a confidential sales process with Christie & Co, the practice has been purchased by Dr Mo Shirin, founder of Truly Dental, an Irish-founded dental group with ten practices in Ireland, three in England and one in Dubai. The acquisition marks the group's first practice in Scotland with the vision to further expand across the UK.

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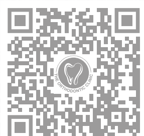

College opens four new routes to Associate Fellowship

This widens eligibility to those with accomplishments and experience in teaching, leadership, research or dento-legal matters

FOUR new routes to Associate Fellowship have been opened by the The College of General Dentistry (CGDent), significantly widening eligibility to those with accomplishments and experience in teaching, leadership, research or dento-legal matters.

A stepping stone to Fellowship, Associate Fellowship was introduced by the College at its inception to increase the standing of those dental professionals who have significantly developed their knowledge and skills. Open to those in all dental team roles, it bridges the large gap between Membership and Fellowship which previously offered no further recognition of these individuals' achievements.

To date, Associate Fellowship has only been open to those holding particular qualifications, broadly aligning it to the requirements of the old Clinical domain of College Fellowship. To widen relevance across different aspects of professional achievement, and to further recognise the diversity of contributions made to the profession in the service of patients, Associate Fellowship is now open to any dental professional meeting the requirements of any one of the College's five Fellowship domains.

Clinical and Technical

This domain requires the applicant either to hold an eligible award or to submit a clinical portfolio demonstrating equivalent training and capability. Qualifying awards include a relevant Postgraduate Diploma, Master's degree or PhD from a recognised UK or EHEA higher education institution or an accredited UK provider; the CGDent Diploma in Primary Care Orthodontics or Certified Practitioner status; specialty membership of a UK Royal College or Royal College faculty; a diploma in a specific dental discipline from RCS England, RCS Edinburgh or the former FGDP; the MGDS, MAGDS, MDS or MRACDS; and Accredited Full Membership of the British Academy of Cosmetic Dentistry.

Alternatively, applications by clinical portfolio are currently open in Restorative Dentistry, with specifications for Implant Dentistry and Orthodontics due to be published soon.

Teaching and Assessment

This requires applicants to either be recognised by an authoritative body in this field, to have a relevant Postgraduate Certificate together with three years' qualifying experience, or to have eight years' qualifying experience plus verified training.

For example, applicants can qualify if they have eight years' service as an NHS Educational Supervisor (for at least 200 hours per year), together with either 27 hours' relevant and recent CPD or Fellowship of the Faculty of Dental Trainers of the Royal College of Surgeons of Edinburgh.

Leadership, Management and Clinical Governance

Applicants under this domain should either hold an eligible diploma-level leadership qualification, or a certificate-level leadership qualification together with three years' service in a relevant leadership role, or have three years' experience in a defined senior leadership role together with 10 hours' relevant and recent CPD. For example, applicants qualify if they have three years'

experience of leadership, oversight and accountability as principal or partner of a multi-chair practice with a minimum of six registrants, together with a relevant Level 7 Postgraduate Certificate or ILM Level 5 diploma.

Research and Publications

Applicants should either have completed a relevant Doctorate or Master's degree including a research dissertation, or have had at least five peer-reviewed articles published in MEDLINE-indexed publications (such as the *Primary Dental Journal*) or *Dental Update*.

Law and Ethics

This domain requires applicants to have either five years' experience in a qualifying role together with 10 hours' relevant and recent CPD, or to have a law degree or relevant postgraduate qualification together with a year's experience in a relevant role.

Associate Fellows are senior members of the College who are advancing their journey towards Fellowship. Recognised as 'Enhanced Practitioners' on the College's Career Pathway, their professional standing is marked out by the use of the postnominal AssocFCGDent.

Full details of the domains, and a link to apply, are available at cgdent.uk/fellowship-domains

BDIA and BADN announce partnership

THE British Dental Industry Association (BDIA) has partnered with the British Association of Dental Nurses (BADN) in a bid to better support the dental sector.

Both organisations share a common goal; to support the people and businesses that keep dentistry moving forward, while maintaining high standards of patient care.

By working together, the BDIA and BADN say they can offer greater support, share knowledge and create new opportunities for their members.

The partnership connects dental suppliers with dental nurses, helping both sides better understand each other and work more effectively together.

The BDIA and the BADN will work together to provide useful updates, training and insights to help dental nurses stay up to date with the latest products and best practices, and to help suppliers understand and appreciate the important role of the dental nurse in the dental team.

Members will benefit from access to more resources, ideas and opportunities through this collaboration. "We're really pleased to be working with the BADN," said Edmund Proffitt, the BDIA's Chief Executive.

"Dental nurses are at the heart of patient care, and this partnership helps us build a stronger connection between the industry and the people using the products every day."

Carolyn Roberts RDN, President-elect of the BADN, said: "Working with BDIA means our members can feel more connected to what's happening across the industry and better supported in their roles. We're excited about what we can achieve together."

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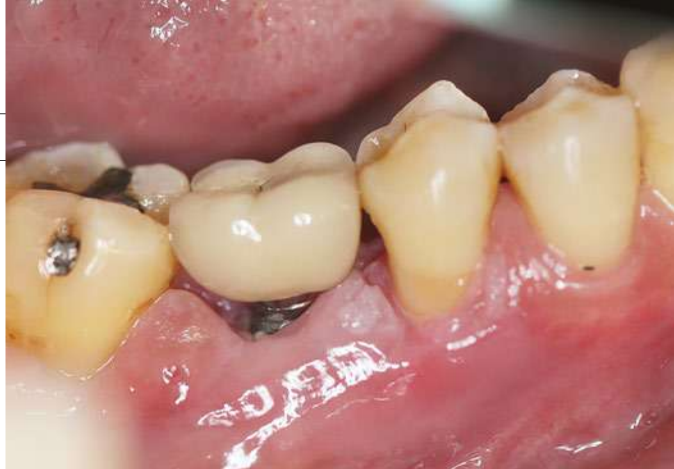

Peri-implantitis finding offers hope of new treatment

Antibiotics usually fail to stop the infection for reasons that researchers have not understood until now

WHILE dental implants have given tens of millions of people something dentures never could – a full set of fixed and fully functioning teeth – 10% to 20% of implant patients eventually experience the aggressive jawbone infection, peri-implantitis. Antibiotics usually fail to stop the infection for reasons that researchers have not understood until now.

A recent study1 in PNAS Nexus by researchers with the Rutgers School of Dental Medicine has found that bacteria corrode implants, causing them to shed microscopic titanium particles into the surrounding tissue. Those particles hijack the immune cells sent to clear the infection and lock them into a state of inflammation that destroys the jawbone they are supposed to protect.

Peri-implantitis has long been a puzzle because it initially looks like its counterpart in natural teeth, periodontitis, and begins with the same oral bacteria. In patients with natural teeth, antibiotics and routine cleaning resolve the infection. In patients with implants, the same drugs against the same bacteria succeed less than half the time, while the bone underneath continues to disappear.

Working with human tissue samples, cultured human immune cells and a genetically engineered mouse model, the team pinpointed a specific calcium channel in the body's bacteria-eating macrophages that the titanium particles activate. Switching that channel off in mice prevented the disease. The result is the first credible drug target for a condition that affects up to one in five implant recipients and costs the global health system more than a billion dollars a year.

"For the first time, we show why all the antibiotic treatments that work around teeth do not work around implants," said Georgios Kotsakis, the study's senior author and the assistant dean for clinical research at the dental school. "Now that we know the cause, we can start developing therapeutics."

[1]*www.academic.oup.com/pnasnexus/article/5/4/pgag081/8533976*

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Two important SDCEP resources updated

Both resources are acknowledged as having UK-wide relevance

NHS Education for Scotland's (NES's) Scottish Dental Clinical Effectiveness Programme (SDCEP) has published new editions of two of its resources: Antibiotic Prophylaxis Against Infective Endocarditis and Management of Acute Dental Problems.

The updated SDCEP antibiotic prophylaxis against infective endocarditis implementation advice supports dental teams to identify and manage the dental care of patients at increased risk of infective endocarditis, with a focus on shared decision-making. The implementation advice is presented within a dedicated website (**www.antibioticprophylaxis.sdcep.org.uk**), with supporting tools also provided, and is endorsed by several UK cardiac societies.

Key messages are:

• Antibiotic prophylaxis is recommended or should be considered for patients with high-risk cardiac conditions
• Antibiotic prophylaxis is not recommended for patients with moderate risk cardiac conditions
• All patients at increased risk of infective endocarditis should be given advice about prevention
• Dental teams must make a shared decision with their patients about antibiotic prophylaxis for 'at-risk' dental procedures
• Dental teams should explain the potential benefits and harms of antibiotic prophylaxis so that patients can make an informed decision about whether prophylaxis is appropriate for their individual situation.

The updated SDCEP management of acute dental problems guidance provides decision support to identify any immediate advice or attention to give a patient presenting with an acute dental problem, and to determine the appropriate provider of subsequent care.

The guidance is intended for use by a range of healthcare staff such as general medical practice, emergency department and pharmacy staff, as well as members of the dental team.
The updated guidance is available via a dedicated website (**www.acutedentalproblems.sdcep.org.uk**).

Both resources are acknowledged by the National Institute for Health and Care Excellence (NICE) and the four UK Chief Dental Officers as having UK-wide relevance. The dental faculties of the UK Royal Surgical Colleges also endorse these resources as providing reliable, high-quality professional advice.

Fighting oral cancer with bioengineered chewing gum

RESEARCHERS have shown[1] that extracts from bioengineered chewing gum reduce the levels of three microbes known to be associated with head and neck squamous cell cancer (HNSCC), paving the way for more effective and affordable therapies.

HNSCC is a common cancer that develops in the lining of the mouth and throat. It can be aggressive and often has poor outcomes, especially when diagnosed at advanced stages.

Building on previous work using a chewing gum made from lablab beans (bean gum) containing the naturally antiviral protein FRIL, researchers at the University of Pennsylvania's School of Dentistry examined the levels of three microbes linked to cancer; human papilloma virus, or HPV, and two species of bacteria, Porphyromonas gingivalis (Pg) and Fusobacterium nucleatum (Fn) – in oral samples from patients with HNSCC.

"The global increase in oropharyngeal cancer is linked to HPV infection," said lead researcher Henry Daniell. "And Pg and Fn infections worsen survival rates of untreated recurrent or metastatic oral cancer, even after surgery and risk-adjusted adjuvant, or supplemental, therapies."

They found that bean gum extracts reduced HPV levels by 93% in saliva samples and by 80% in oral rinse samples.

Bioengineered bean gum was found to reduce levels of three microbes associated with head and neck squamous cell cancer to almost zero

When they bioengineered the bean gum to also contain protegrin, an antimicrobial peptide that can kill harmful bacteria, they found that a single dose reduced the levels of Pg and Fn to almost zero without affecting the beneficial bacteria normally found in the mouth.

This contrasts with radiation therapy, which both reduces beneficial bacteria and increases disease-causing yeast (Candida albicans).

"Lip and oral cavity cancer was the seventh leading cancer type in cancer incidence and mortality rate worldwide in adolescents, young adults, and middle-aged adults in 2022," said Daniell. "Our findings support the value of advancing these therapies to clinical trials as adjuvants with current treatments or as prophylaxis to prevent infection and transmission."

[1] ***www.nature.com/articles/s41598-026-39062-w***

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Archaeological evidence of ancient gold ligature discovered

Researchers say the rationale for undergoing the procedure went beyond retaining oral function

THE earliest known example of restorative dentistry in Scotland has been outlined[1] by researchers at the University of Aberdeen.

A middle-aged adult male, who lived between 1460–1670 CE in Aberdeen and was buried in the East Kirk of the parish church of St Nicholas, was observed to have a gold ligature fixed to the right lateral and left central mandibular incisors, forming a bridge for the potentially missing right central incisor.

As he lived before the establishment of dentistry as a profession during the 19th century, the ligature was likely placed by a semi-skilled practitioner, known as a dentatore, such as a jeweller or barber.

The archaeological and documentary evidence indicates he was a relatively wealthy member of the community, based on his prestigious burial location, and that he was able to afford this type of dental work.

Researchers say that given the social importance of an individual's appearance during the Late Medieval and Early Modern era as an outward expression of their moral character, it is likely the rationale for undergoing this procedure extended beyond retaining masticatory abilities and oral function.

The most likely purpose for the gold wire ligature, they said, was to attempt to either retain the right lateral incisor or to provide a bridging scaffold to sustain a prosthetic tooth.

[1]www.pmc.ncbi.nlm.nih.gov/articles/PMC13109052

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GDC confirms first ORE sittings and fees under new contract

Increasing capacity forms part of a collaborative approach to supporting the workforce and improving access to care for patients

THE General Dental Council (GDC) has announced the confirmed sittings, expanded capacity and revised fee structure for the Overseas Registration Examination (ORE) in the first year of its new contract.

Following a competitive procurement process, the GDC signed contracts with UCL Consultants Ltd in March, with the first exams under the new contract scheduled to take place from August.

Exam sittings for 2026/27

The first contract year runs from 31 May 2026 to 30 May 2027. Confirmed Part 1 sittings are as follows:

- 25-26 August 2026 (600 places)
- 14-15 October 2026 (600 places)
- 2-3 February 2027 (600 places)
- 6–7 April 2027 (600 places)

Part 2 sittings:

- 10–13 September 2026 (144 places)
- 26–29 November 2026 (200 places)
- 21–24 January 2027 (200 places)
- 4–7 March 2027 (200 places)
- 15–18 April 2027 (200 places)

Capacity

In the first year, the GDC will provide 2,400 Part 1 exam places and 944 Part 2 exam places. The focus will be on establishing delivery, including systems, processes and day-to-day operations, safely and sustainably ahead of planned growth in years two and three. Part 2 capacity is set to increase to 1,500 places per year by year three of the contract. Demand for ORE sittings remains high and places are not expected to meet demand in the short term.

Fees for 2026/27

ORE fees have been updated for 2026/27 to reflect the cost of delivering the examination under the new contract. The revised fees are as follows:

- Application processing fee: £115 (increased by 20% from £96)
- Part 1 fee: £485 (reduced by 17%, from £584)
- Part 2 fee: £6,967 (increased by 65%, from £4,235)

Booking

For the first time, candidates will book their ORE sittings through their MyGDC account. The booking window for the August Part 1 sitting will open on 30 June. Candidates are encouraged to ensure they can log in to MyGDC in advance of that date, including resetting their password if required.

Candidates nearing the five-year limit for Part 2 and those with refugee status will be those offered priority access to exam places. A new candidate portal, including a revised booking system, is being developed as part of the new contract. The new portal should be in place for exams scheduled in 2027.

Mothers' prenatal immunity shapes lifelong resistance to gum disease

MOTHERS provide a hidden immune legacy that protects their children's teeth long after weaning is over, according to a new study[1]. Maternal antibodies act as "early life architects", programming the mouth to resist aggressive bacteria and prevent the bone loss associated with adult gum disease.

Research by the Hebrew University of Jerusalem focused on the transition period after birth when the oral cavity is first exposed to a surge of microbes. To navigate this vulnerable stage, mothers provide their offspring with essential immune tools through two distinct pathways: in utero transfer and breastfeeding.

The study found that antibodies transferred during pregnancy, known as in utero-derived IgG, act as a primary architect for the mouth's immune landscape. These antibodies reach the neonatal salivary glands and are secreted into the saliva. Their presence is crucial for maintaining a healthy balance, as they essentially teach the immune system to remain calm in the presence of friendly bacteria while preparing it for future threats.

In laboratory models, offspring that lacked these prenatal antibodies exhibited hyper-activated immune cells and higher bacterial loads in their salivary glands and gums. This lack of early instruction led to significant changes in adulthood, specifically an increased susceptibility to periodontitis, a condition characterised by destructive inflammation and bone loss around the teeth.

While prenatal antibodies focus on internal immune 'tone', those delivered through breast milk serve a different purpose. The research indicates that breast milk antibodies are essential for the proper physical maturation of the oral epithelium, which is the protective lining of the mouth.

These postnatal antibodies help regulate the timing of 'barrier sealing', ensuring that the mouth's protective lining becomes a sturdy defence at just the right moment. This process is highly sensitive to the microbial environment. The study noted that when these antibodies were absent or their effects were disrupted by antibiotics, the physical integrity of the oral barrier was compromised.

The findings offer a new perspective on the origin of oral diseases. The team identified that maternal IgG specifically recognises and binds to certain oral pathobionts, such as the Pasteurellaceae family, which are known to drive aggressive forms of gum disease.

This discovery opens the door for potential preventive strategies, such as maternal immunisation. By vaccinating mothers during pregnancy, it may be possible to enhance the specific antibodies passed to the child, effectively pre-programming their immune system to resist chronic oral infections later in life.

[1] *www.doi.org/10.1038/s41467-026-71704-5*

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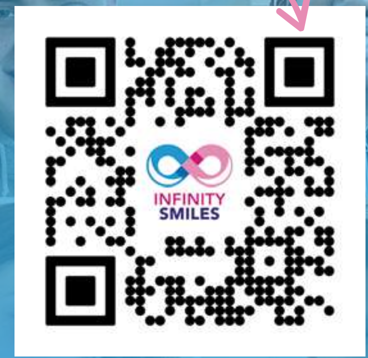

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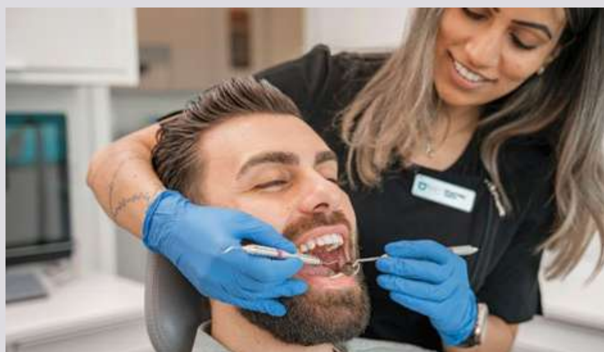
International dentists outnumber UK dentists joining GDC register



Supporting a diverse and growing dental workforce is one of the regulator's core commitments

THERE has been a 4.7% increase in the number of registered dental professionals in the UK over the past year, the General Dental Council (GDC) has disclosed.

As of December 2025, 131,680 dental professionals were registered with the GDC. The number of dentists increased by 3.4% to 47,916, and dental care professionals (DCP) by 5.5% to 83,764.

The report includes comparison data from previous years to show trends and changes. For the first time, internationally qualified dentists now outnumber UK-qualified dentists joining the register, 53% compared with 47%.

The number of dental nurses increased by 6,473 (5.4%) to 68,472. Dental nurses now make up more than 50% of all those registered with the GDC, with 96% of those who joined the register in 2025 being female.

The number of registered dental therapists grew by 21% to 8,661, while the number of dental hygienists increased by 11% to 11,292. Meanwhile, 71% (1,044) of new dental therapist registrations and 55% (591) of dental hygienist registrations were from internationally qualified dentists who joined the register with DCP titles, a route that has now closed.

Despite overall growth, the number of dental technicians dropped for the sixth consecutive year, falling below 5,000 for the first time. Only 143 dental technicians joined the register in 2025. In total, there were 9,332 additions to the register in 2025, down from 9,888 in 2024.

Theresa Thorp, Executive Director of Regulation at the GDC, said: "This report provides important insights into the dental workforce, the people who make up our register, and dental professions that are growing and changing.

"Supporting a diverse and growing dental workforce is one of the core commitments in our strategy, Trusted and Effective, for 2026 to 2028, and we're committed to ensuring our registration processes are as straightforward as possible for those joining our register."

The Association of Dental Groups (ADG), the UK's leading representative body for dental groups across NHS, private and community-based Services, welcomed the announcement. The ADG has long called for a more predictable, better resourced ORE system to help address the UK's chronic dental workforce shortages.

Neil Carmichael, Executive Chair, Association of Dental Groups, said: "For too long, the ORE bottleneck has prevented highly trained international dentists already living in the UK from contributing to patient care. The GDC's commitment to a more stable, better planned examination schedule and registration process is exactly the kind of practical reform the sector has been urging."

DATES FOR YOUR DIARY

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

24 JULY
Annual Sports Dentistry Conference
Royal College of Physicians & Surgeons of Glasgow
www.sportsdentistryuk.com/scientific-conferences

4-7 SEPTEMBER
FDI World Dental Congress
O2 universum Congress Centre, Prague
2026.world-dental-congress.org

22-23 OCTOBER
Dental Triennial Conference
RCSEd, Edinburgh
tinyurl.com/56sm5p84

30 OCTOBER
RCSPG Annual Dental Conference: AI in 2026 and Beyond
Royal College and Online
rcpsg.ac.uk/education/annual-dental-conference

30 OCTOBER
NHS Dental Symposium hosted by GG&C LDC
200 St Vincent Street, Glasgow
ggc-ldc.scot/events

6-7 NOVEMBER
ADG Annual Conference
De Vere Cotswold Water Park Hotel, South Cerney
www.theadg.co.uk/what-we-do/annual-conference

4 DECEMBER
CGDent Scotland Study Day 2026
Glasgow Science Centre
cgdentscot.org.uk/glasgow-study-day/speakers

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

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DENTAL CONNECT

Springing back to the Boomerang Community Spring Festival

WORDS
MADELEINE WATT AND RACHEL MCLEOD

Community engagement is a fundamental aspect of preventative dentistry, offering opportunities to promote oral health awareness and education beyond the clinical setting.

As part of our involvement with Dental Connect, a Dundee Dental School initiative focused on improving oral health within the Dundee and Tayside community, we organised and delivered a family-orientated outreach event at the Boomerang Community Hub[1] in Dundee on 4 April.

The event was organised through collaboration with community event leader Alison Carr from the Boomerang Community Hub, alongside several students who had been appropriately trained to deliver curated resources to the public. Part of this organisation process involved liaison with members of the Dental Connect committee to ensure that adequate supplies were available for the anticipated quantity of visiting public.

The event was designed as a spring-themed session aimed at engaging families in oral health education through interactive learning. Three stations were developed to facilitate this: an oral hygiene and dental trauma education station, a dietary advice station, and a "dress as a dentist" activity. The latter encouraged children to role-play using colourful scrubs, gloves and glasses, creating a relaxed and enjoyable environment in which interactive learning could take place, forming a positive attitude towards dentistry (Figure 1).

The trauma station

The trauma station focused on two main topics: prevention of tooth avulsion and management of permanent tooth avulsion. Delivery of this information was aided through use of a 'Pick it, Lick it, Stick it' educational poster provided by Dental Trauma UK.[2] Further discussion with participants included the use of milk as an appropriate storage medium where immediate re-implantation of the avulsed tooth is not possible. All advice given was in accordance with current International Association of Dental Trauma guidelines and Dental Trauma UK resources.[2,3] A mixture of dentate models with removable teeth and mouthguards were used at this station to further participants' understanding (Figure 2).

Figure 1 (left): Dental Connect stations delivered at the Boomerang Community Spring Festival (featuring Madeleine Watt)

Figure 2 (right): Dentate models with removable teeth and mouthguards used at the trauma station

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THIS OUTREACH INITIATIVE WAS A REWARDING EXPERIENCE THAT DEMONSTRATED THE IMPACT OF PREVENTIVE EDUCATION WITHIN THE COMMUNITY"

Figure 3 (top left): Dentate models and unicorn puppet used to administer toothbrushing instruction (featuring Rachel McLeod)

Figure 4 (top right): Dietary advice station

The oral hygiene station

Toothbrushing technique and frequency were the main topics discussed at the oral hygiene station which aimed to improve participant knowledge and to instil beneficial habits from a young age.

Individuals were queried on their existing knowledge of the following questions: do they know the recommended frequency and duration of toothbrushing each day, and could they demonstrate their current technique using a large dentate model and toothbrush? Following this, students demonstrated and explained the Bass technique using the same dentate model and toothbrush. Dentate puppets were also used for children to demonstrate their understanding after receiving instruction, with this practical aspect allowing for immediate correction to improve execution (Figure 3).

Within the dietary advice station (Figure 4), there were again two focuses: to identify foods which are 'friendly' and 'non-friendly' to the dentition, as well as to educate on the sugar content of common food and drink through visualisation with plastic resembling sugar cubes. Through this, students were able to discuss the importance of reduced snacking and restricting soft drinks to mealtimes, illustrating the potential negative effects on oral health.

The 'dress as a dentist' station

We found that the younger attendees especially enjoyed the 'dress as a dentist' station, where they chose from a range of patterned scrub tops and wore safety glasses, gloves, and masks. This exercise aimed to help reduce apprehension and normalise dental visits, hopefully increasing willingness to attend future appointments and prevent development of dental anxiety.

Main takeaways

The event was well attended, with engagement from countless families and 39 children, with ages ranging from infants to teenagers. The interactive nature of the stations proved effective in facilitating communication of key oral health messages. Feedback from the event organisers was highly positive, with appreciation expressed for both the educational content and our approach to delivery. Importantly, this led to an invitation to participate to participate in future initiatives, including a mother and infant class, highlighting the value of sustained community engagement.

This experience underscored the importance of flexibility when delivering outreach initiatives, particularly in the face of limited resources. It also reinforced the effectiveness of interactive, child-friendly approaches in promoting oral health education. From a professional perspective, the event contributed to the development of communication skills, confidence in public engagement, and an appreciation of the role of dentistry in addressing community health needs. This outreach initiative was a rewarding experience that demonstrated the impact of preventive education within the community. Despite the challenges faced, the event was successful in engaging families and delivering key oral health messages, while also strengthening our commitment to continued involvement in community-based dental initiatives.

References

[1]Boomerang Community Hub. [2]Dental Trauma UK. Save a knocked out tooth (Pick it, Lick it, Stick it poster). 2022. Available at: www.dentaltrauma.co.uk/File.ashx?id=15302 (accessed 15 April 2026).

[3]Fouad AF, Abbott PV, Tsilingaridis G, Cohenca N, Lauridsen E, Bourguignon C, et al. International Association of Dental Traumatology guidelines for the management of traumatic dental injuries: 2. Avulsion of permanent teeth. Dental Traumatology. 2020;36(4):331-42.

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ORTHODONTICS

BUILDING A SUSTAINABLE RURAL WORKFORCE

Orthodontic Therapists programme is strengthening the resilience and long-term sustainability of dental services

WORDS
CAROLINE TAYLOR

significant milestone has been reached in strengthening orthodontic services across Scotland's rural and island communities, helping to address challenges in access to NHS Scotland orthodontic care.

An 'Earn as You Learn' Orthodontic Therapy Training Programme, delivered by Public Services Delivery Scotland (PSD Scotland) prepares registered Dental Care Professionals (DCPs) for the Royal College of Surgeons of Edinburgh (RCSEd) Diploma in Orthodontic Therapy.

The blended learning programme being led by PSD Scotland – a new organisation bringing together NHS Education for Scotland (NES) and NHS National Services Scotland (NSS), designed to speed up modernisation across Scotland's health, care, and wider public services – supports structured career development while directly expanding local capacity and access to NHS orthodontic services. This begins with a four-week core programme, followed by monthly study days delivered online and in person at Edinburgh Dental Education Centre.

Workplace based clinical training forms a vital component of the programme and is conducted under the direct supervision of a General Dental Council (GDC) registered specialist orthodontist. On successful completion, participants are eligible to change their GDC registration and practice as Orthodontic Therapists.

Enhancing equity and access to training

In partnership with NHS Boards, the GDC and RCSEd, PSD Scotland has adapted the Orthodontic Therapy Training Programme to support participation from DCPs employed in Scotland's rural and island communities.

Flexible 12- or 24-month learning routes are now available, enabling trainees to gain the required clinical competencies while remaining embedded within local services, aligned with GDC learning outcomes. Recognising the importance of addressing rural workforce sustainability, PSD Scotland prioritises a minimum of two programme places for trainees based within Scotland's rural NHS Boards, subject to meeting entry requirements.

In 2024, four trainees based in rural NHS Boards commenced the programme, one from NHS Western Isles, one from NHS Highland and two from NHS Shetland. All have now successfully completed training and achieved the RCSEd Diploma in Orthodontic Therapy.

Antony Visocchi, Director of Dentistry, NHS Shetland, said: "Like many rural services, NHS Shetland faces ongoing recruitment challenges, further compounded by geography. Developing a 'grow our own' workforce has proven to be an effective and sustainable solution, enabling people to progress without the need to relocate.

"This initiative builds on our existing career pathways and extends them further, strengthening the resilience and long-term sustainability of dental services for our island communities. When the right people come together with the right attitude, great things are possible."

In addition, three trainees based in NHS Highland and NHS Shetland completed the programme via the extended learning route. The trainee from NHS Western Isles temporarily relocated for a 12-month period to a specialist orthodontic practice in Inverness to undertake supervised clinical training. This approach ensured full exposure to specialist-led care and supervision while maintaining a clear pathway back to their local health board.

Reflecting on this experience, Lynsey Mackinnon, NHS Western Isles Orthodontic Therapist, said: "I feel very fortunate to have been given the opportunity to join the orthodontic team, contributing to the delivery of services for patients across the Western Isles while continuing my professional development. I was well supported throughout the programme, which was particularly important as I was living and working away from home."

Joanne Bark, Director of Dentistry, NHS Western Isles said: "I congratulate GDC-registered Dental Nurse Lynsey Mackinnon on becoming part of the clinical team as an Orthodontic Therapist. Her determination in, and commitment to, working off island to gain, bring back share clinical experience will help further strengthen and expand our patient services, particularly in our more remote clinics."

Kelly Webb, NHS Highland Orthodontic Therapist, also reflected on her experience: "Being part of the first rural cohort on the Orthodontic Therapy programme allowed me the opportunity to gain my Diploma qualification and achieve my professional development and career aspirations.

"The blended learning model and consistent support from my supervisor and PSD Scotland have strengthened my clinical knowledge and skills, and overall personal development, demonstrating how vital accessible training is for remote and rural NHS services."

Innovative solutions for remote supervision

One of the most significant advancements supporting rural orthodontic therapy training has been the introduction of a hybrid remote supervision model. This was implemented by NHS Shetland, supported by visiting specialist orthodontists from NHS Tayside and PSD Scotland.

Using a blended approach of in-person visits and digital solutions – including videoconferencing for new patient assessments, secure digital record sharing, remote case-based discussions, smartphone-based treatment monitoring and telehealth enabled progress reviews – clinical teams have established a safe, effective and robust supervisory framework.

This innovative approach has transformed both orthodontic therapy training and service delivery across many of Scotland's island communities. It has strengthened clinical oversight, improved service efficiency, and significantly enhanced patient access to care. Crucially, it has enabled mainland-based specialist supervisors to provide real time support for the trainees while maintaining high standards of quality and patient safety.

The blended learning programme supports structured career development while directly expanding local capacity and access to NHS orthodontic services

Grant McIntyre, Consultant and Honorary Professor in Orthodontics, NHS Tayside's Dundee Dental Hospital and Research School, said: "NHS Shetland enabled the clinical team to integrate a series of individual technological solutions into a service-level digital ecosystem. This technological convergence has been instrumental in delivering the innovative hybrid remote supervision model supporting both Orthodontic Therapist training and the transition into long-term team working.

"The key beneficiaries are the patient population who now have access to a predictable clinical service rather than the historical reliance on peripatetic fly-in and fly-out clinicians. With an increase in service capacity and a reduction in waiting times, the population of one of the most remote archipelagos in the UK has a robust service fit for the future."

Sumithra Hewage, Consultant Orthodontist, NHS Highland, sharing her reflections on the new programme model and implementation of remote supervision, said: "The introduction of Orthodontic Therapy training with remote supervision is a welcome development, creating equitable career opportunities for motivated DCPs in rural areas.

"This model also strengthens local access to specialist-level care and supports sustainable service delivery, especially where specialist recruitment is difficult. Its success depends on strong trust between trainer and trainee. On a personal level, it has been hugely rewarding to help someone realise a career ambition that once felt out of reach."

Building skill mix and career progression pathways

The Orthodontic Therapy Training Programme illustrates the impact that effective skill mix can have in expanding service capacity and building sustainable workforce models across NHS Scotland.

For DCPs, the programme provides a clear and attractive progression pathway, enabling extended clinical responsibilities while retaining experienced staff within local services. For patients, it means improved access to timely orthodontic care within their community.

Miriam Moar and Ingrid Couper, NHS Shetland, who have successfully completed the programme, reflected on the opportunities it has created:

"We both feel incredibly lucky and privileged to have been given the opportunity to train as Orthodontic Therapists. These successful outcomes show that, with the right support, barriers can be overcome to help remote and rural communities build the skills they need for a sustainable and resilient workforce."

Together, these achievements demonstrate how targeted investment in training, flexible learning pathways, and innovative service models can deliver meaningful change for remote and rural orthodontic services. By supporting Dental Care Professionals to develop advanced skills within their own communities, PSD Scotland and NHS Boards are strengthening local capacity, improving equity of access to care, and building a resilient orthodontic workforce fit for the future.

This collaborative, sustainable approach offers a powerful model for addressing workforce challenges and ensuring high quality orthodontic care for patients across Scotland's most remote and island communities.

Caroline Taylor is Associate Postgraduate Dental Dean (DCP) at Public Services Delivery Scotland.

Find out more:

› Further information on the Orthodontic Therapy programme can be accessed via TURAS: Orthodontic Therapy - Turas Learn

› Public Services Delivery Scotland (PSD Scotland): ***www.publicservicesdelivery.scot***

Introducing Dr Lyall Dominick

Dentist with an interest in endodontics

BDS MFDS RCPSG MSc | GDC No. 243639

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.

Lyall accepts referrals for most aspects of non-surgical endodontics at Clifton Dental & Implant Clinic including:

- Treatment of teeth with wide or open apices
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- Assessment of teeth with questionable restorability
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- Crown and post removal
- Location of canals

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PSD SCOTLAND'S DENTAL DIRECTORATE ACHIEVES TOP RATINGS

Modern Apprenticeship in Dental Nursing programme recognised as excellent by HMIE

Public Services Delivery (PSD) Scotland is celebrating excellence across all categories following His Majesty's Inspectorate of Education (HMIE) inspection in March.

At the time of the inspection, the Dental Directorate formed part of NHS Education for Scotland (NES) and is now part of PSD Scotland following its establishment on 1 April 2026.

The Modern Apprenticeship in Dental Nursing programme was recognised for 'Excellent: Outstanding and Sector Leading' across all HMIE quality indicators:

- Leadership and Management
- Quality of Training
- Progress and Outcomes

Inspectors also identified the team's digitally enabled delivery model and innovative assessment approaches as 'Highly Effective Practice', recognising their positive national impact on quality, sustainability and learner experience.

The Modern Apprenticeship in Dental Nursing is delivered by PSD Scotland's Dental Care Professionals (DCP) Workstream. The team was established in 2006 to strengthen and advance dental nurse education in Scotland. At that time, the Scottish Government's Action Plan for Improving Oral Health and Modernising Dental Services highlighted the need to expand both the availability and quality of dental nurse education ahead of compulsory General Dental Council registration. It also called for improved access to post registration education to support career progression and high quality patient care.

Twenty years on, the DCP Workstream delivers a wide range of high quality, blended learning programmes that support dental nurses, orthodontic therapists, practice managers and dental receptionists to achieve recognised qualifications and develop sustainable career pathways. Collectively, this provision contributes to the delivery of safe, effective and high quality dental care across Scotland.

Caroline Taylor, Associate Postgraduate Dental Dean (DCP Workstream) PSD Scotland said: "We are exceptionally proud that HM Inspectors have graded our Modern Apprenticeship in Dental Nursing programme as Excellent across leadership and management, delivery of training and progress and outcomes.

"These inspection outcomes strongly endorse our commitment to providing accessible, high quality, learner-centred education, and highlight the strength of the collaborative partnerships with apprentices and employers that sit at the heart of our work, reflecting our ethos of 'People first, Partnership always approach'.

This recognition acknowledges the dedication and professionalism of our colleagues and reaffirms our continued focus on developing a skilled and sustainable dental workforce across Scotland."

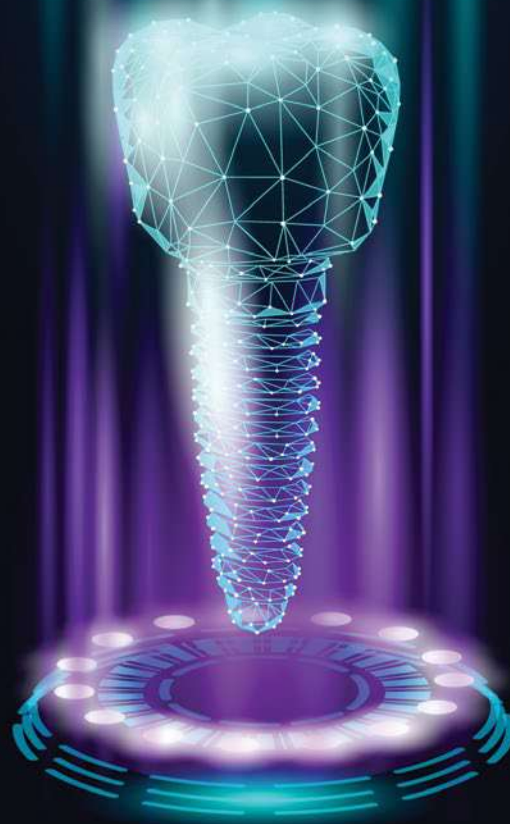
Lee Savarrio, Postgraduate Dean and Director of Dentistry, PSD Scotland, said: "This fantastic report is a clear signal that Public Services Delivery Scotland's dental nursing modern apprenticeship provision is setting a benchmark for excellence.

"It reflects a strong, consistent culture of improvement and a model of education that is responsive to service need, supports learners to thrive and strengthens workforce capacity where it matters most. I want to thank apprentices, employers and everyone involved in delivery and support for the professionalism, care and ambition they bring to this programme. We will continue to champion innovation, equity of access and robust quality assurance so that dental nurse students across Scotland can develop with confidence and their patients benefit from a resilient, future ready dental team workforce."

HMIE inspects all providers of apprenticeship training in Scotland to ensure that provision is of high quality, aligns with national strategies, and meets the needs of employers and apprentices. The inspection report has been published on the HMIE website: **https://tinyurl.com/t2pf5vxb**

The online application process for the 2026-2027 PSD Scotland Modern Apprenticeship in Dental Nursing programme starting in September will open on Monday 27 July 2026 at 9.00am and will close on Monday 3 August 2026 at 9.00am. Further information on the Modern Apprenticeship in Dental Nursing programme can be accessed at: https://tinyurl.com/uefph9xa

WHY CHANGE ANYTHING?



Adopting guided implant surgery may be one of the best clinical decisions you make

WORDS
DR VAIDAS VARINAUSKAS

Dental implants have been used to replace missing teeth for more than 60 years. The shape of implant threads, external design and fixation elements are still changing and evolving over time to improve integration with the jawbone and soft tissues. The classic dental implant placement protocol was introduced in the 1960s by Per-Ingvar Brånemark and involved delayed implant placement.

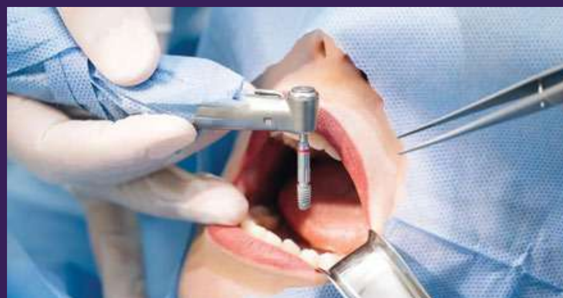
Per-Ingvar Brånemark in his study at the University of Gothenburg

Since then, we have progressed from delayed placement to immediate post-extraction placement with immediate loading. Naturally, freehand (or eye-guided) implant placement will be replaced by computer-assisted implant surgery, as this allows us to provide accurate, pre-planned implant placement using prefabricated prosthetics prepared in advance of the surgery.

Just like in everyday life there are people who are sceptical of electric cars and will always find a million reasons not to buy one, the same exists in the dental community. There are clinicians who believe guided implantology is not necessary for them; because they have been operating for five, 10, or 20 years, their complication rate is below 5%, and they ask: "Why should I change anything?"

The answer is simple. If you only have a few years of practice left, then do not waste your energy; continue working with your proven method. But if you have not yet reached the midpoint of your career, I want to encourage you to catch up with those already using this highly advanced, treatment-enhancing method.

I placed my first dental implant back in 2005. Over the past 20 years, I have built a strong foundation in surgical techniques, handling a wide range of clinical situations, from single implants to full-arch cases. I have consistently achieved very stable peri-implant bone



With traditional implant surgery, the dentist studies the patient's oral anatomy through X-rays or CT scans. They then place the implants into the jawbone at a depth and angle that they believe is the most appropriate. Only after the operation, the dentist can see if the positioning of the implant is good

levels; the kind of outcomes we used to call 'zero bone loss'. For many years, I approached implant placement entirely using the traditional freehand method.

Like many experienced clinicians, I was sceptical about guided surgery. I saw it as something useful for beginners or those with limited surgical confidence. But I was wrong. That perspective changed shortly after the

I CAN CONFIDENTLY SAY: ADOPTING GUIDED SURGERY WAS ONE OF THE BEST CLINICAL DECISIONS I HAVE MADE"

COVID disruption, when I introduced guided surgery into my daily workflow. I extend my sincere thanks to my colleague, whose support and guidance were invaluable throughout my transition into guided implantology.

Now, looking back, I can confidently say: adopting guided surgery was one of the best clinical decisions I have made. If I could turn back the clock, I would have embraced it much sooner. Guided surgery is not about replacing surgical skill; it is about enhancing precision, improving prosthetic outcomes and creating a more predictable workflow, especially when working on full-arch immediate loading cases.

Guided implant surgery utilises advanced dental technology such as 3D cone beam computed tomography to plan and perform the surgery with high precision

Why should I choose guided implant surgery over freehand?

Here are, in my opinion, some of the most important and indisputable indications:

• When high precision is required near critical anatomical structures; IAN, mental foramina, arterial branches, or atypical alveolar anatomy
• When inter-root distance requires extreme accuracy and parallelism to maintain safe distances and prevent root damage
• When aiming to avoid sinus lift procedures (due to pathology or patient preference) and maximise available alveolar height using non-standard/odd angulations
• For immediate placement cases where optimal implant positioning is crucial, whether in posterior or anterior regions
• When planning immediate loading with fixed partial or full-arch restoration
• When aiming for minimally invasive flapless procedures to reduce postoperative discomfort
• When working with porous bone and aiming to avoid "spinners" while achieving good primary stability
• In complex cases, e.g. full-arch rehabilitation involving extraction of non-restorable teeth (terminal dentition – this term itself deserves more open discussion within our dental community), alveolar ridge reduction and immediate full-arch restoration
• When placing orthodontic palatal implants
• When preparing a site for tooth auto-transplantation

Once you decide to step into (static) guided implantology, you will need a high-resolution CBCT, an intraoral scanner with high-quality scans, computer-aided design software, a 3D printer and a guided surgical kit of the implant system you are familiar with.

The most critical step in achieving the pre-planned outcome is transferring the virtually planned implant position from the software to the patient's mouth. I strongly recommend being actively involved in all stages of guide planning; from implant positioning and adoption of prosthetic components to selection of guide support teeth (and/or fixation pins) and designing the guide itself.

The accuracy of implant placement with static guided surgery depends on multiple factors. The three main groups of potential errors are:

• During image acquisition (CBCT, surface/dental registration, guide manufacturing)
• Related to the type of guide support (tooth-supported guides are most accurate; bone-supported are the least accurate)
• During the surgical procedure (surgeon-related).

The precision of guided surgery depends on the accumulation of all these factors, from scanning to final implant insertion. The main concern remains the deviation (coronal, apical and angular) between planned and actual implant positions. These deviations are well documented, and here are my tips to minimise them:

1. Find an experienced mentor (preferably a clinician rather than dental technician at the beginning) who can guide you from planning to analysis of the surgical results.

2. High-quality intraoral scans and properly processed CBCT data to reduce planning improvisation.

3. Careful selection of support teeth for guide fixation, minimising time between scan and surgery. Remember that mobile teeth may shift; always use the most recent scan in complex cases.

4. Design bilateral tooth-supported guides rather than unilateral; avoid starting with gum- or bone-supported guided; build confidence gradually.

5. After seating the guide, verify its fit; use perforation windows and consider printing guides in transparent resin.

6. Choose higher sleeves when possible, to reduce apical deviation and prefer metal sleeves over sleeveless guides.

7. Always maintain safe distances when planning near teeth or between implants as later components may not fit.

8. Choose an implant system that allow easier handling, especially in posterior regions where space is limited; we are not treating crocodiles.

9. Always have a Plan B in case the guide does not fit or fractures during surgery.

Dr Vaidas Varinauskas (PhD | DMD) is a Specialist Oral Surgeon and Clinical Director at Seapoint Clinic, Dublin.

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REVERSE EVIDENCE-BASED DENTISTRY

BRIDGING CLINICAL REALITY AND SCIENTIFIC EVIDENCE

Why starting from clinical observation may strengthen evidence-based practice rather than challenge it

WORDS
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rEBD encourages clinicians to start from recurring chairside observations, formulate structured questions and reconnect practice with scientific appraisal

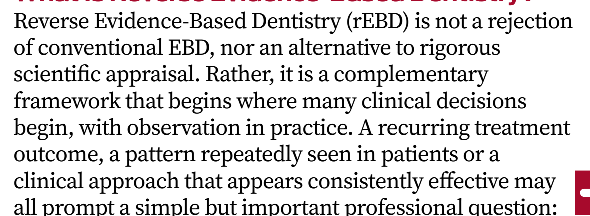
The reality of modern clinical decision-making

Every practising dentist recognises the complexity of modern clinical decision-making: balancing professional judgement, patient expectations, rapidly evolving technologies and an ever-expanding body of scientific evidence; all within the practical constraints of time, workload, service pressures and real-world care.

In Scotland, where dentistry continues to evolve through prevention-focused models, quality improvement, reflective professional development and increasing digital integration, clinicians are navigating new layers of complexity; from artificial intelligence and digital diagnostics to shifting patient behaviours, widening health inequalities and growing recognition of oral–systemic health connections.

Evidence-Based Dentistry (EBD) remains the gold standard for informed clinical care. Yet in everyday practice, decisions rarely begin with a systematic review or formal guideline consultation. More often, they begin with something immediate and familiar; a recurring chairside observation, a clinical pattern that raises questions, or a treatment approach that appears to deliver meaningful outcomes. It is precisely at that point that Reverse Evidence-Based Dentistry begins.

What Is Reverse Evidence-Based Dentistry?

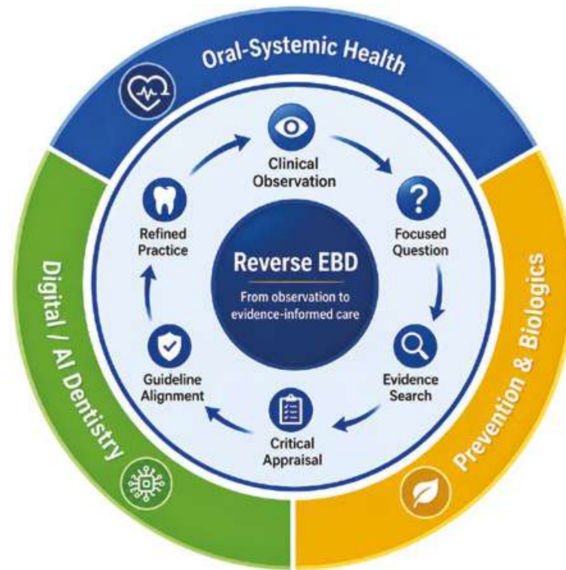


Reverse Evidence-Based Dentistry (rEBD) is not a rejection of conventional EBD, nor an alternative to rigorous scientific appraisal. Rather, it is a complementary framework that begins where many clinical decisions begin, with observation in practice. A recurring treatment outcome, a pattern repeatedly seen in patients or a clinical approach that appears consistently effective may all prompt a simple but important professional question:

"Why does this work, and what evidence truly supports it?"[1]

From that point, rEBD follows a structured pathway: clinical observation → focused question → targeted evidence search → critical appraisal → guideline alignment → refined clinical practice — moving backward from lived clinical experience toward scientific validation before returning forward into improved patient care.

Originally described as an educational and translational framework for strengthening reflective clinical reasoning, rEBD was conceived as a way to bridge the gap between everyday practice and scientific inquiry, creating a more dynamic dialogue between observation and evidence.[1,3] Properly understood, rEBD does not weaken EBD; it may, in fact, deepen it.



A conceptual framework of rEBD which transforms clinical observation into structured inquiry, scientific validation, and refined patient care through an iterative cycle of evidence-informed practice. Adapted from Mascolo et al.[1]

Why this matters in Scotland now

Scotland provides a particularly relevant environment in which to consider the practical value of rEBD. The country combines a strong tradition of evidence-informed clinical guidance with growing emphasis on prevention, reflective professional development, quality improvement and service redesign.

At the same time, Scottish dentistry continues to navigate challenges familiar across modern healthcare systems: oral health inequalities linked to deprivation, variation in access between urban and rural communities, changing attendance patterns and increasing expectations placed on the wider dental team.[5,6]

These pressures are unfolding alongside rapid digital transformation, expanding discussion around skill mix and direct access models, and renewed focus on professionally reflective care pathways. Within this evolving landscape, clinicians are increasingly required not only to apply evidence, but to interpret it critically within the realities of everyday practice.

That is precisely where rEBD offers practical value. By encouraging clinicians to start from recurring chairside observations, formulate structured questions and reconnect practice with scientific appraisal, rEBD aligns naturally with Scotland's culture of clinical audit, continuing professional development and evidence-informed service improvement. In this context, it is not simply a conceptual framework, it is a practical tool for modern Scottish dentistry.

Three chairside situations where rEBD makes a difference

rEBD becomes most valuable when applied to questions clinicians already encounter in everyday practice; not abstract theoretical problems but recurring chairside observations that deserve closer scientific attention.

Periodontal inflammation beyond the mouth

One example is the growing recognition that periodontal inflammation may extend beyond local oral tissues and interact with broader systemic pathways. Increasing evidence has linked periodontal inflammatory burden with markers of systemic inflammation, glycaemic control and cardiovascular risk profiles, encouraging a more integrated view of oral health within general healthcare.[2] For clinicians, this changes the conversation: periodontal assessment is no longer only about pocket depth or bleeding scores, but potentially about quantifying inflammatory burden in ways that improve interdisciplinary communication, patient motivation, and preventive care planning.

rEBD begins with a familiar clinical observation and asks the next scientific question: how can we measure and communicate this relationship more meaningfully?

Artificial intelligence and clinical reasoning

A second example concerns the rapid integration of artificial intelligence into dentistry. From radiographic

Clinical vignette: Reverse EBD in everyday practice

A familiar chairside challenge

A 52-year-old patient presents repeatedly with signs of peri-implant mucositis; bleeding on probing, localised inflammation and intermittent discomfort around a posterior implant restoration. Oral hygiene appears satisfactory, plaque accumulation is limited and the prosthetic design is accessible for cleaning. Conventional advice has been reinforced, professional maintenance provided and yet inflammation continues to recur.

At this point, rEBD asks a different kind of question.

Rather than assuming inadequate plaque control is the sole explanation, the clinician pauses to explore broader possibilities:

› Is biofilm quantity truly the main driver, or is biofilm composition more relevant?

› Could host inflammatory burden or systemic low-grade inflammation be amplifying the local response?

› Do implant surface characteristics, emergence profile, or prosthetic contours contribute to plaque retention or altered tissue interaction?

› What does current evidence suggest regarding adjunctive therapies, local antimicrobials, or biologically active agents?

› Are there patient-specific behavioural, metabolic, or immunological factors that standard maintenance protocols fail to address?

What began as a recurring clinical observation is transformed into a focused scientific inquiry.

The clinician moves from "Why is this happening again?" to "What evidence can better explain what I am observing?"

This is rEBD in practice:

observation → structured question→ targeted evidence search→ refined patient-centred management

In this way, chairside frustration becomes an opportunity for deeper understanding — and ultimately, better care.

rEBD WAS CONCEIVED AS A WAY TO BRIDGE THE GAP BETWEEN EVERYDAY PRACTICE AND SCIENTIFIC INQUIRY, CREATING A MORE DYNAMIC DIALOGUE BETWEEN OBSERVATION AND EVIDENCE"

interpretation and digital planning to workflow automation and decision-support tools, AI is increasingly shaping clinical environments. Yet adoption itself is not evidence of benefit. Emerging educational and translational experience suggests that AI-assisted interpretation may influence clinical judgement, enhance diagnostic confidence and support less experienced clinicians — while also highlighting the well-recognised risk of automation bias.[7]

rEBD offers a practical filter here: not simply should we use AI, but how does AI influence our judgement and under what conditions does it genuinely improve care?

Prevention, biologics and minimally invasive care

A third area lies in preventive and biologically supportive dentistry. Whether considering bioactive agents, remineralisation strategies, low-intervention protocols, naturally derived therapeutic compounds or evolving implant biomaterials and surface technologies, clinicians are increasingly confronted with approaches that appear promising in practice before their mechanisms are fully understood.

Emerging evidence on biologically active materials – including antimicrobial natural compounds such as honey-derived systems – together with ongoing investigation into implant macro-morphology and surface characteristics, illustrates how long-observed clinical effects can stimulate new scientific questions when approached critically.[8,9] In this way, rEBD reminds us that innovation is not always entirely new; sometimes it is familiar practice finally understood through stronger evidence.

From reflection to research: Scotland's opportunity

Scotland is particularly well positioned to translate the principles of rEBD into meaningful clinical and professional progress. Few healthcare systems combine such a strong culture of evidence-informed guidance, reflective professional development, structured clinical audit and practice-based research. Through the work of the Scottish Dental Clinical Effectiveness Programme, continuing professional development frameworks supported by the General Dental Council and collaborative research initiatives across primary care, Scottish dentistry already possesses many of the foundations that rEBD requires; clinicians who observe critically, question constructively and continuously refine care through evidence and reflection.[5,6]

A practical next step may be surprisingly simple; transforming recurring chairside observations into structured clinical questions capable of generating meaningful evidence. Whether investigating periodontal inflammatory burden, evaluating AI-assisted diagnostic workflows or refining prevention-focused care pathways, Scottish clinicians are exceptionally well placed to contribute directly to the next generation of evidence-informed dentistry. In this sense, rEBD is not merely a conceptual framework; it is a practical bridge between everyday clinical observation and purposeful research.

Dentistry 5.0: why rEBD fits the future

Dentistry is entering a new era, increasingly shaped by artificial intelligence, digital workflows, bioengineering, personalised prevention and translational science. Yet innovation alone does not automatically translate into better care. New technologies may be adopted prematurely, interpreted uncritically or integrated without sufficient understanding of their true clinical value in everyday practice.[3,7]

This is precisely where rEBD becomes especially valuable. It functions as an analytical filter; a disciplined way of asking not simply: 'What is new?', but rather: 'What is genuinely useful, for whom, and under what clinical circumstances?'

By linking innovation to clinical observation, scientific validation and reflective implementation, rEBD aligns naturally with the broader vision of Dentistry 5.0; a future in which technology supports professional judgement, strengthens patient-centred care and enhances clinical reasoning rather than replacing it.

One question every clinician can ask tomorrow

rEBD does not ask clinicians to move away from evidence, it invites them to engage with it more actively, beginning from the realities of everyday clinical care. Meaningful research questions do not always emerge from laboratories, policy papers or conference stages; often, they begin quietly at chairside, in the repeated observations that shape professional judgement over time.

A practical challenge for the months ahead is simple; choose one recurring clinical decision in your daily work – whether related to periodontal care, prevention, referral pathways or digital technologies – and ask: What evidence truly supports this approach in my patients, in my practice and in my clinical setting? That is not merely a reflective question; it is where Reverse Evidence-Based Dentistry begins.

Andrea Mascolo is Academic Director, European Institute for Medical Studies (EIMS), Malta and Full Professor of Digital Dentistry and Innovative Clinical Training, Grigol Robakidze University, Georgia.

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FRIDAY 12 JUNE

LECTURES

Infection Prevention and Control: an update on current guidance in practice
Laura Wilson, Dental Educator, NHS GG&Clyde.

The Use of Front-Line Drugs in a Medical Emergency
David Gilmour, Course Director, Safeaid Training.

Implants in Everyday Practice: what every GDP needs to know (and when to refer)
Dr Tariq Ali, Clinical Director & Principal Dentist, Centre for Implant Dentistry.

Safeguarding and Child Protection
Dr Christine Park, Professor of Clinical Paediatric Dentistry, Glasgow Dental Hospital and School.

Safeguarding Vulnerable Adults
Emma O'Donnell, Honorary Consultant in Special Care Dentistry, NHS GG&Clyde.

An Introduction to Cone Beam CT for the Dental Team
Kirstyn Donaldson, Honorary Consultant in Paediatric Dentistry, Glasgow Dental Hospital and School.

Oral cancer: early detection
Dr Lewis Olsson, Lead Trainer, Clinical Lecturer in Oral Medicine, University of Glasgow.

The science behind MINST for periodontal regeneration
Dr Varkha Rattu, Clinical Director, The Grove Practice.

Revolutionising Dental Extractions Clinically and Commercially
Colin Campbell, Clinical Director, The Campbell Clinic.

Beyond Injectables: a new clinical framework for treating volume loss and metabolic ageing
Dr Kaly Jaff, Founder, Dr Kaly Jaff Aesthetics.

Six Ways to Improve Your X-rays Constantly
James Elliott, Regional Sales Director, Clark Dental.

Intelligence Without Error? Navigating the Risks of AI
Simon Kidd, Head of The Dental Defence Union.

The Evolution of NHS Education for Scotland
Lee Savarrio, Dental Director and Postgraduate Dean, NHS Education for Scotland.

Vital Pulp Therapy: a paradigm shift in managing pulpitis
Mohammed Tiba, Clinical Lecturer in Endodontology at the University of Glasgow Dental School.

WORKSHOPS

Building a Better Treatment Plan
Dr Arshad Ali, Specialist in Restorative Dentistry and Prosthodontics, Scottish Centre for Excellence in Dentistry.

Team-Based Periodontal Management
Jenny Walker, Dental Therapist and Ikigai Educator.

Complaint Management: how to get it right!
Emma McGroarty, Dento-legal adviser, MDDUS.

NSK Handpiece Care and Maintenance
Asnain Sadiq, Territory Manager, NSK

Beyond the Notes: how AI can transform the dental workplace today
Agnieszka Nohawica, Principal Dentist, Practice Owner and Co-founder of Breez.

Crack Diagnosis and Management: from confusion to confidence through biomimetic principles
Amber Aplin, Principal and Owner, The Gentle Touch.

Dry Mouth and the Impact on Patients
Margaret Black, Oralieve Professional Educator and Clinical Dental Hygienist.

Inside Out: the mysterious dental resorption
Dr Navid Saberi, Specialist in Endodontics, Edinburgh Endodontist.

The role of Orthodontic Therapists in detecting mouth cancer
Joycee Rebelo, Orthodontic Therapist and Committee Member, ONG.

Recruiting and Retaining an International Dental Workforce
Amy Jones, Partner, Employment Team, and Jacqueline Moore, Partner, Global Mobility and Immigration Team, Thorntons LLP.

Pensions for Dentists
Derek Goodwin, Independent Financial Adviser, Chase De Vere.

The Good, the Bad and the Ugly of Social Media
Fiona Ellwood, Executive Director, Society of British Dental Nurses.

It Takes a Village: a multidisciplinary approach to full arch implant dentistry
Dr Jordan Bain, Dental Surgeon, EvoDental, and team.

Mental Health and Wellbeing for the Dental Professional
Jennifer Lindsay, Cognitive Behavioural Therapist.

Clinical Photography Training
Andrew McAllister, Photography Team Manager, and Kirstie Walker, Clinical Photographer, NHS GG&C.

Nutrition and Lifestyle Advice in the Dental Setting
Nina Farmer, Dental Therapist and Evidence-based Nutritional Therapist.

The Modern Dental Nurse: How the role is evolving
Carolyn Roberts, BADN President-elect.

EMFACE Device Demo
Dr Kaly Jaff, Founder, Dr Kaly Jaff Aesthetics.

NSK Ikigai workshops
Jenny Walker, Lauren Long and Siobhan Kellehe, will also be running hands-on workshops on Implant Instrumentation and Piezo tip selection, air-polishing and powders throughout both days.

SATURDAY 13 JUNE

LECTURES

An Introduction to Cone Beam CT
Kirstyn Donaldson, Honorary Consultant in Paediatric Dentistry, Glasgow Dental Hospital and School.

Sustainable Performance Under Pressure
Sam Wones, Stress Management Coach, The Adaptable Human Project

Menopause Is changing dentistry. Are you ready?
Adele Johnston, The Menopause Coach.

Infection Prevention and Control
Laura Wilson, Dental Educator, NHS Greater Glasgow & Clyde.

The Use of Front-Line Drugs in a Medical Emergency
David Gilmour, Course Director, Safeaid Training.

Oral cancer: early detection
Dr Lewis Olsson, Lead Trainer, Clinical Lecturer in Oral Medicine, University of Glasgow.

Safeguarding and Child protection
Dr Christine Park, Professor of Clinical Paediatric Dentistry, Glasgow Dental Hospital and School.

Air Polishing Essentials
Lauren Long, Dental Therapist and NSK Ikigai Educator.

Endodontics in 2026: key updates for everyday practice
Omayma Siddig, Clinical Teaching Fellow, Aberdeen Dental Institute and Hospital.

What About Us? Ergonomics and Wellbeing for Dental Professionals
Anita Hosty, Registered Dental Hygienist and founder of Loose Hands.

Vital Pulp Therapy
Mohammed Tiba, Clinical Lecturer in Endodontology at the University of Glasgow Dental School.

Implants in Everyday Practice
Dr Tariq Ali, Clinical Director & Principal Dentist, Centre for Implant Dentistry.

Safeguarding Vulnerable Adults
Emma O'Donnell, Consultant in Special Care Dentistry, NHS GG&CC.

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Beyond the Notes: how AI can transform the dental workplace today
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Ergonomics in Dentistry
Allan Wright, Territory Manager, A-dec.

Inside Out: the mysterious dental resorption
Dr Navid Saberi, Specialist in Endodontics, Edinburgh Endodontist.

Legal Support for Dentists: not just claims and complaints
Craig McKerracher, Partner, Harper Macleod.

From Detection to Restoration: an AI-driven workflow for modern caries management
Dr Amanda Bassey-Duke, Associate Dentist, Dental Care Perth.

A multidisciplinary approach to full arch implant dentistry
Dr Jordan Bain, Dental Surgeon, EvoDental, and team.

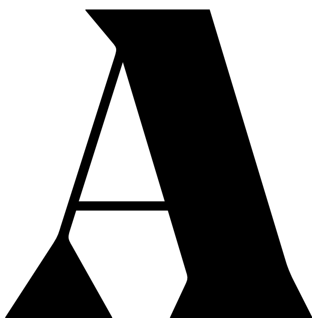
Introducing a Simple, Cost-Effective Bonded Retainer Technique
Andrew McGregor, Specialist in Orthodontics, Park Orthodontics.

The Modern Dental Nurse
Carolyn Roberts, BADN President-elect.

An Update on Dental Trauma
Clement Seeballuck, Clinical Lecturer in Paediatric Dentistry, University of Dundee.

Long-term outcome of guided crown lengthening and lip repositioning in the treatment of excessive gingival display

Hytham N. Fageeh, Department of Preventive Dental Sciences, College of Dentistry, Jazan University



A primary goal of periodontal plastic surgery is to achieve optimal aesthetic outcomes for the patient's smile. However, certain patients presenting with both gingival and skeletal deformities may necessitate more comprehensive aesthetic rehabilitation. For patients with complex needs, a multidisciplinary approach is advantageous in optimising the balance and integration of all three elements of the smile, teeth, lip framework and gingival scaffold.[1]

The ideal gingival display during smiling is generally considered to be ~1–3 mm.[2] Excessive gingival display (EGD), also referred to as a "gummy smile," is an important component of smile analysis and a common cause of aesthetic dissatisfaction. It is defined as excessive exposure of gingival tissue during smiling.[3] Reported aetiologies involve both hard- and soft-tissue factors, including altered passive eruption (APE), anterior dentoalveolar extrusion, vertical maxillary excess (VME), and a short or hyperactive upper lip (HUL).[2,4] Multiple coexisting aetiologies are common; therefore, accurate identification of the underlying factors is essential for treatment planning and prognosis[1].

APE is characterised by incomplete apical migration of the gingival margin following tooth eruption, resulting in short clinical crowns and excessive gingival coverage despite normal anatomic crown dimensions.[5] Coslet et al.[6] proposed a classification of APE based on the relationship of the gingival margin, keratinised tissue and alveolar crest to the CEJ, which guides treatment planning. The type of treatment proposed for any clinical situation of APE depends upon the given classification.[7] When APE occurs in combination with a HUL or mild VME, a staged surgical approach is often indicated, which includes minimally invasive periodontal and soft-tissue procedures that effectively enhance aesthetics.[8,9]

EXCESSIVE GINGIVAL DISPLAY (EGD), ALSO REFERRED TO AS A 'GUMMY SMILE', IS AN IMPORTANT COMPONENT OF SMILE ANALYSIS AND A COMMON CAUSE OF AESTHETIC DISSATISFACTION"

The first phase generally involves aesthetic crown lengthening (ACL), which aims to reestablish the proper biologic width (~2–3 mm apical to the CEJ) and create stable gingival margins that accurately define the clinical crown proportions.[9] Performing ACL before lip repositioning (LR) is essential, as it allows soft-tissue maturation, ensures periodontal health and prevents unpredictable margin rebound that could compromise the symmetry of the subsequent lip surgery.[3] The second phase, LR, is then planned relative to the newly established gingival line, targeting optimal harmony between dental and facial aesthetics.

Advances in digital smile design (DSD) and three-dimensional (3D) printing have significantly improved the precision of such interdisciplinary treatment planning.[10,11] Digital integration facilitates visualisation of both gingival and lip dynamics, enabling the fabrication of customised dual-purpose surgical guides that define the exact apical limit of crown lengthening while simultaneously predicting the anticipated dynamic lip line during a smile.[10,11] This workflow enhances surgical accuracy, predictability and communication between the clinician and patient.

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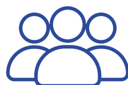

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This case report describes a digitally guided (scan → DSD → 3D-printed guide), staged management approach involving ECL followed by LR, with a five-year clinical follow-up, highlighting the use of a dual-purpose surgical guide that precisely defines the extent of gingival recontouring while simultaneously visualising the anticipated dynamic upper-lip line for enhanced aesthetic predictability.

Case report

A 28-year-old female presented to the College of Dentistry, Jazan University, with the chief complaint of EGD during smiling and laughter. Her medical history was non-contributory, with no relevant medications or allergies. The patient had completed orthodontic treatment two years prior to presentation.

Clinical examination

Extraoral assessment revealed an upper lip length of 19 mm from the base of the nose to the stomion superius at rest. On a posed/static smile, 1 mm of gingiva was visible (Figure 1A), whereas a spontaneous/dynamic smile revealed 7 mm of gingival display, indicating 6 mm of upper-lip mobility (Figure 1B). Intraorally, the patient exhibited a thick gingival biotype and a keratinised tissue width of 8–11 mm across the maxillary anterior sextant, with mild bilateral bony exostosis. Disproportionate crown height-to-width ratios were noted.

Bone sounding at tooth 13 under local anaesthesia revealed the alveolar crest 3 mm apical to the gingival margin, confirming APE (Coslet Type 1B). Periapical radiographs were taken to evaluate the CEJ-crest relationship and root morphology. The case was further classified as VME Class II with a HUL pattern. The diagnosis integrated both skeletal and soft-tissue aetiologies of a 'gummy smile'.

Treatment planning

After discussing treatment options, informed consent was obtained for a two-phase approach: (1) ECL followed by (2) LR after six weeks of soft-tissue healing. Digital preoperative photographs were imported into 3Shape DSD software to establish the ideal gingival zeniths and marginal levels (Figure 2).

Guide fabrication was carried out following intraoral scanning of both the maxillary and mandibular arches using a Trios 3 scanner (3Shape, Denmark) (Figure 3A). A dual-purpose 3D-printed surgical guide was subsequently designed based on a virtual wax-up generated from the DSD workflow. The guide incorporated (1) an apical reference to determine the precise extent of ECL and (2) a horizontal terminal border corresponding to the anticipated dynamic smile upper-lip line, allowing for a residual gingival display of ~2–3 mm posttreatment (Figure 3B).

The guide was printed and postprocessed per manufacturer instructions using a 3D printer (Form 3, Formlabs, USA) (Figure 4A) and verified in the patient for passive seating (Figure 4B).

Therapeutic intervention

Phase 1, ECL: After intraoral disinfection with 0.2% chlorhexidine, local anaesthesia was administered via infiltration of the maxillary arch using 2% mepivacaine with 1:100,000 epinephrine. With the surgical guide properly seated, gingivectomy was performed using an external bevel incision made with a No. 15C blade, following the DSD-defined soft-tissue

Figure 1: Baseline extra oral views. (A) Smile in posed/static position with 1 mm of gingival display. (B) Smile in dynamic position with 7 mm of gingival display.

Figure 3: (A) Baseline intraoral scan of the maxillary arch. (B) Dual-purpose surgical guide on virtual wax-up of teeth based on digital smile design.

Figure 2: Digital smile design to determine adequate crown height/width ratio.

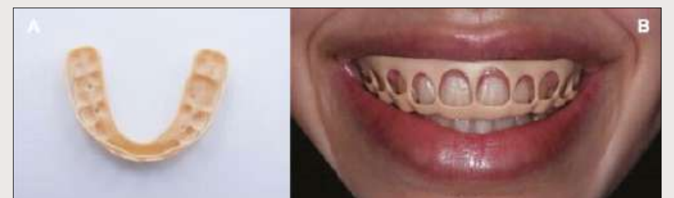

Figure 4: (A) 3D-printed guide for aesthetic crown lengthening. (B) Intraoral seating of the surgical guide

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margins and using the guide as a visual reference (Figure 5A). A full thickness mucoperiosteal flap was then reflected from the upper right to upper left maxillary molar to facilitate osseous resection and osteoplasty, reestablishing the biologic width ~3 mm apical to the CEJ, as verified with a periodontal probe. Osteoplasty was performed on the buccal aspect using a multi-fluted bur, whereas osteotomy was accomplished with an end-cutting bur to minimise the risk of tooth or root surface damage.

Root planing was performed to reduce tissue rebound and facilitate soft-tissue adaptation. The interdental papillae were deepithelialised using curved micro scissors (Figure 5B). Thereafter, the flap was repositioned and sutured with 4–0 silk using single interrupted sutures engaging the palatal aspect of each papilla (Figure 5C). No periodontal dressing was applied.

Postoperative instructions included applying ice packs bilaterally for two days (10-min sessions twice daily) and cleansing the sutures with gauze soaked in 0.2% chlorhexidine after toothbrushing for one week. The patient was advised to maintain a soft and cold diet for two days and was counselled on modified oral hygiene measures. Ibuprofen (600 mg every eight hours as needed) was prescribed for analgesia.

AFTER 10 DAYS, ALL SUTURES WERE REMOVED. THE PATIENT REPORTED MINIMAL DISCOMFORT"

After 10 days, all sutures were removed. The patient reported minimal discomfort, with no evidence of swelling or edema. Satisfactory gingival healing and an observable gain in clinical crown height were noted. A healing period of six weeks was allowed to permit soft-tissue maturation and margin stabilisation before proceeding with LR surgery. At the follow-up visit, the gingival tissues appeared stable, and probing depths remained within normal limits (Figure 6).

Phase 2, LR: The LR procedure was performed according to the technique described by Al Jasser et al.12 (Figure 7). The preoperative anaesthetic protocol included buccal vestibular infiltration and infraorbital nerve block using 2% mepivacaine with 1:100,000 epinephrine. The excision outline was marked with a No. 15C scalpel blade, extending between the maxillary molars while preserving an adequate band of attached gingiva along the mucogingival line (Figure 7B). The superior margin of the excision was delineated parallel to the inferior margin at a distance corresponding to twice the measured upper-lip mobility between the static and dynamic smile positions (Figure 8A). Specifically, the vertical distance between the upper and lower borders of the rectangular outline measured 12mm.

A partial-thickness mucosal strip was excised along this outline to expose the underlying connective tissue. A selective myectomy of the elevator fibres of the levator labii superioris was performed to reduce excessive superior lip retraction. Muscle separation was completed with the help of blunt dissection, and the muscle fibres were pushed upward, leaving underlying periosteum intact. The displaced muscle fibres were trimmed to eliminate any remaining pull. Haemostasis was achieved primarily through direct pressure with sterile gauze. Minor bleeding points were controlled using low-power electrocautery in a spot-coagulation mode, ensuring minimal thermal damage to surrounding tissues. The surgical field was thoroughly irrigated with sterile saline before flap repositioning and suturing.

Deep horizontal mattress sutures with 5–0 chromic gut were placed at predetermined intervals to stabilise the lip in a slightly inferior position and minimise relapse. These were supplemented by 4.0 silk simple interrupted sutures placed along the incision line (Figure 8B). The labial frenum was preserved throughout the procedure to maintain midline alignment and was repositioned only during suture placement.

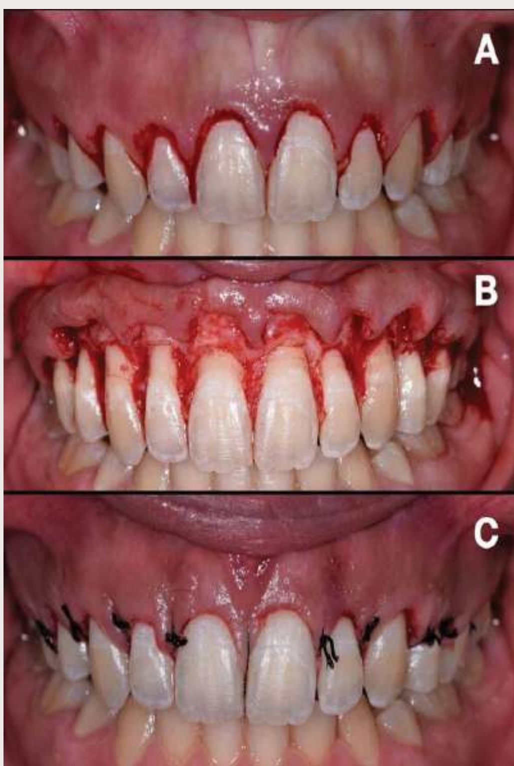

Figure 5: (A) Gingivectomy by external bevel incision following crown outline on the surgical guide. (B) Osseous resection of alveolar crest to reestablish the biologic width, interdental papillae deepithelialised using curved micro scissors. (C) Flap repositioned and sutured with 4.0 (silk) sutures.

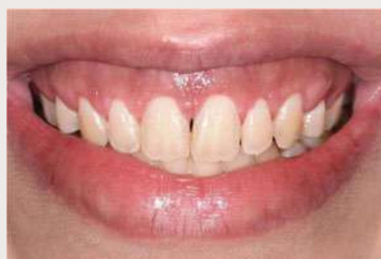

Figure 6: Frontal view of healing at six weeks following aesthetic crown lengthening.

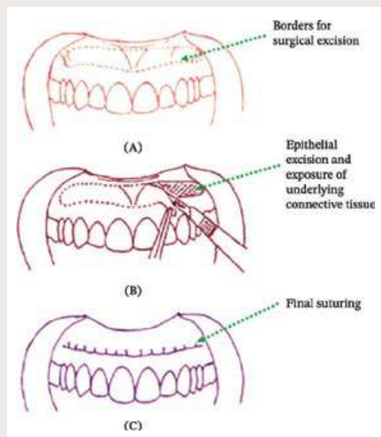

Figure 7: Schematic representation of lip repositioning surgery. (A) Marking borders for surgical excision. (B) Epithelial excision and exposure of underlying connective tissue. (C) Final suturing.

Postoperative instructions

Postoperative medications included a corticosteroid regimen of prednisone (5 mg, two tablets three times daily for the first three days, followed by one tablet three times daily for days four

Figure 8: (A) Intraoral view following excision of the mucosal strip and partial-thickness flap. (B) Simple interrupted sutures with 4.0 silk approximating the upper and lower border for primary intention healing.

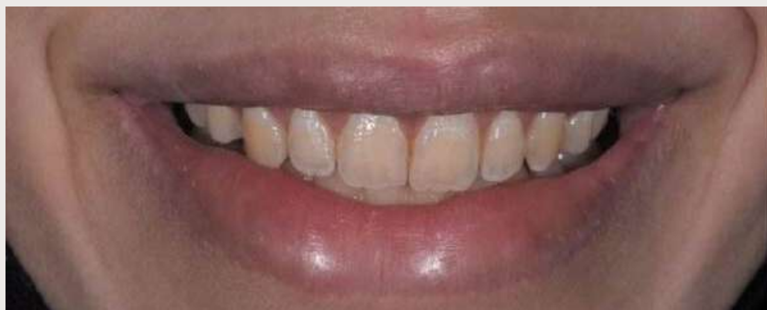

Figure 9: 90 days' postoperative period following lip repositioning procedure.

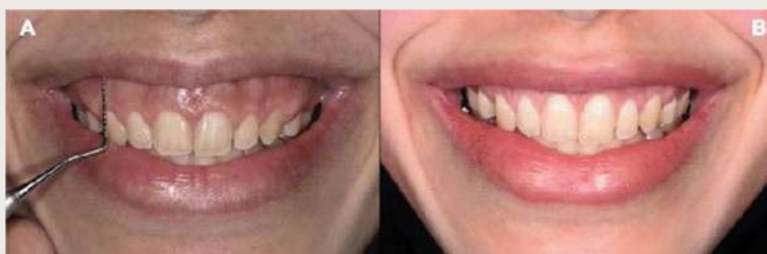

Figure 10: Frontal view. (A) Initial appearance in dynamic smile. (B) Appearance in dynamic smile after five years of follow-up.

and five) and diclofenac potassium (50 mg every eight hours, as needed). Postsurgical instructions emphasised the application of ice packs, avoidance of exaggerated facial expressions or lip elevation for 14 days, adherence to a soft diet and cleansing with gauze soaked in 0.2% chlorhexidine for one week following toothbrushing.

At the one-week follow-up, mild discomfort and tightness were noted, with limited upper-lip motion. Sutures were removed after 14 days. Gingival display was completely reduced in the early postoperative period, and at one- and three-month follow-ups, no relapse was evident with 0 mm gingival display at three months (Figure 9).

Outcome and follow-up

At the five-year follow-up, the crown height-to-width ratio achieved by ECL remained stable. However, partial relapses of upper-lip position were observed during dynamic smiling (Figure 10B). At the five-year follow-up, gingival display measured 2–3 mm, indicating a 2–3 mm partial relapse compared to the three-month outcome. Despite this minor recurrence, the patient expressed high satisfaction with the aesthetic and functional outcomes. Written informed consent was obtained from the patient for publication of the clinical details and accompanying images.

Discussion

EGD, commonly referred to as a 'gummy smile', is a multifactorial aesthetic concern that may arise from a combination of skeletal, dental and soft-tissue factors. Among these, VME, APE and HUL movement are frequently reported etiologies[13]. A comprehensive diagnostic assessment is thus essential for accurate classification and individualised treatment planning.

LR was originally described by Kostianovsky and Rubinstein[14] in 1976 as a surgical approach for reducing EGD. In the present case, the patient exhibited features of APE (Coslet Type 1 B), VME (Class II) and HUL mobility, necessitating a multidisciplinary approach involving periodontal and mucogingival corrective procedures.

DSD can enhance aesthetic treatment planning by integrating facial and dental parameters into a reproducible workflow[15]. The use of 3Shape's DSD software in this case enabled precise identification of gingival zeniths and target margin levels, providing both the clinician and patient a visual simulation of the expected outcome. Furthermore, the fabrication of a dual-purpose 3D-printed surgical guide served as an innovation in controlling the vertical extent of gingivectomy and correlating the lip line with the anticipated smile arc. Such digital integration has been shown to increase accuracy in gingival margin repositioning and improve postoperative aesthetic predictability.[15,17]

The first therapeutic phase, ECL, aimed to correct the APE and establish ideal crown proportions. According to the biologic width/ supracrestal tissue dimension concept, ~2–3 mm between the alveolar crest and gingival margin is required for periodontal health.[2] In this case, osteoplasty and osteotomy were performed to reestablish this dimension, preventing tissue rebound. A six-week healing interval was selected to allow initial soft-tissue healing and clinical reassessment before LR; however, gingival margin remodelling after crown lengthening may continue beyond this period, and long-term margin stability should not be inferred from early healing alone.[18-20]

The second phase of LR targeted the hypermobile muscular component of the upper lip. Originally described by Kostianovsky and Rubinstein,[14] the procedure has since undergone several modifications aimed at reducing relapse, optimising symmetry and minimising postoperative discomfort.[21, 22] In this case, the modification described by Al Jasser et al.,[12] was used, which limits the superior extent of mucosal excision to twice the measured lip mobility and preserves the frenum for midline stability. The addition of a selective myectomy of the levator labii superioris was performed to reduce the elevator muscle pull, a step that has been associated with improved long-term stability in some reports.[3, 21, 22]

Postoperative outcomes demonstrated a marked reduction in gingival display from 7 mm at baseline to 0 mm at three months post-LR, with 2–3 mm gingival display at the five-year follow-up, achieving a harmonious smile line. Early follow-ups revealed minimal discomfort, confirming the minimally invasive nature of the approach. The patient expressed high satisfaction both aesthetically and functionally. These outcomes align with prior literature showing positive patient-reported satisfaction and improved smile aesthetics following LR.[15, 16, 19, 20]

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Long-term stability remains a challenge in the management of EGD. Several studies have documented partial relapses in gingival display postoperatively, attributed primarily to muscle reattachment or incomplete fibrosis at the resection site.[3, 19-22] In this report, a mild degree of relapse was noted at the five-year follow-up, although the crown lengthening results remained stable. This finding reinforces that LR, while effective, may not be permanent and requires careful patient selection and realistic expectations. Adjunctive approaches, including modified surgical techniques and myotomy, have been explored to enhance longevity but require further evidence.[1, 2] In a systematic review by Ardakani et al.,[1] it was concluded that minimal relapse occurs in the selective myotomy surgeries. In randomised data, outcomes have been compared with and without myotomy, with relapse reported more frequently in non-myotomy groups.[23]

Reported postoperative complications ranging from discomfort and lip tightness to swelling, bruising, paraesthesia and rarely mucocele formation are generally mild and self-limiting. Overall, LR remains a safe, conservative, and effective adjunct or alternative to orthognathic surgery in carefully selected patients; nevertheless, larger prospective studies with extended follow-up are required to better define long-term stability and predictors of relapse.

This case underscores the importance of addressing both hard- and soft-tissue aetiologies in a staged, evidence-based manner. The use of digital planning, guided surgery and modern mucogingival techniques allowed for optimal control over both aesthetic and functional parameters. From a biomechanical perspective, preserving the attached gingiva and minimising tension on closure likely contributed to the favourable healing and minimal scarring observed.

Limitations

Although the five-year follow-up strengthens the longitudinal value of this current case report, conclusions regarding long-term stability of LR with selective myectomy should be interpreted cautiously. Gingival display measurements were based on standardised photographic analysis, which may be subject to minor variability in head position and smile reproducibility. Skeletal assessment relied on clinical and conventional radiographic evaluation without 3D imaging. Additionally, muscle healing and reattachment were not objectively quantified. Future controlled studies with larger samples and standardised outcome measures are necessary to validate these findings.

Conclusion

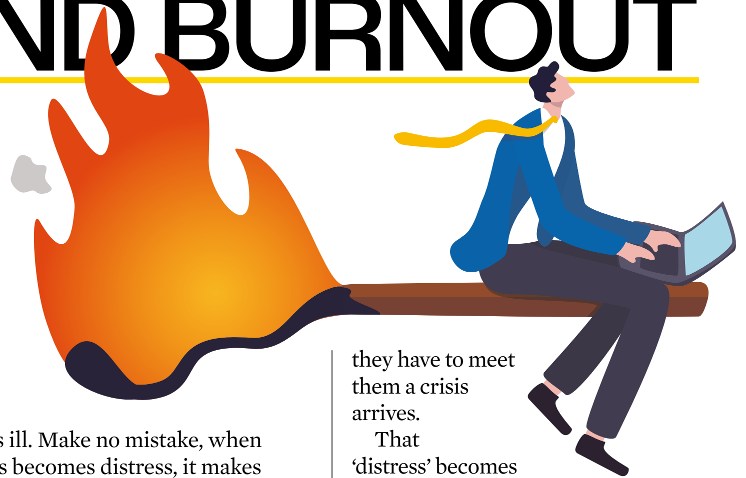
A comprehensive diagnostic approach is crucial in managing EGD involving skeletal, dental and muscular factors. In this case, digitally guided ECL and LR achieved substantial aesthetic improvement over five years, with minor recurrence (2–3 mm) but sustained patient satisfaction. The digital workflow and 3D-printed guide enhanced surgical precision, while staged management ensured biological stability. Despite minor relapse, long-term results remained satisfactory, highlighting the efficacy of this minimally invasive, technology-integrated approach. Incorporating digital planning into periodontal and mucogingival surgeries offers a predictable, patient-centred pathway for aesthetic rehabilitation, though further studies are needed to standardise protocols and optimise long-term outcomes.

Fageeh, Hytham N., Long-Term Outcome of Guided Crown Lengthening and Lip Repositioning in the Treatment of Excessive Gingival Display, Case Reports in Dentistry, 2026, 7330406, 8 pages, 2026. www.doi.org/10.1155/crid/7330406

References: www.sdmag.co.uk/2026/05/04/references

WHEN STRESS LEADS TO DISTRESS AND BURNOUT

When the demands that people face outstrip the resources they have to meet them, a crisis arrives



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.

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IN the 'old days', which I refer to as BC (Before COVID-19) I used to take my one-man show around British Dental Association (BDA) sections, specialist groups and anyone else who would give me supper and listen to the story of my burnout and how I came out the other side. Judging from the post-presentation conversations on the night or, in the days, weeks and months that followed, the title and content of the evening, *Is Dentistry Making You Sick?*, appeared to resonate with many listeners.

Sadly, the challenges that individuals in dentistry face have not gone away. The phrase "Dentistry is tough" that I once used in an article and was flattered to be quoted by the incoming BDA President, Dr Roz McMullan OBE, in her inaugural address, applies even more today.

The causes are not limited to the clinical elements of our roles, which are, like most professions, constantly evolving and changing, usually for the better for our patients. Rather, I do believe that we suffer from the increasing external pressures that are indirectly related to the jobs. These include, but are certainly not limited to, societal expectations, social media, political instability, the threats and/or promises of Artificial Intelligence – and that is just today's headlines.

A recent conversation with a client who, on the face of things, has a successful practice is typical of what I routinely hear. Although they are busy, popular and successful (on many measures) they told me that the anxiety they felt every day has got to a point where they have difficulty getting out of the door to go to work in the morning.

Certainly, that chimed with my personal experience where I endured a significant panic attack, which I believed when it was happening was possibly a heart attack or a stroke, left me stopped at the side of the road literally unable to continue my drive to work. The team that worked with me at my small and, if not exactly perfect, then well formed, practice were not in the least surprised that I was ill. Make no mistake, when stress becomes distress, it makes you ill with a sickness that you must acknowledge and face. It is more than a 'fed up – have a duvet day' situation.

Firstly, I had to admit I was not superman, then I needed to examine what was going on and why I had become ill. Stress is normal and can be defined as 'the non-specific response of the body to any demand'. It is part of life; we are supposed to feel stress and react accordingly. What is not normal is 'burnout'; defined as "a state of vital exhaustion".

Hans Selye, the physiologist and physician, published his findings on research into hormones in nature as long ago as 1938. He described GAS (the General Adaptation Syndrome) where our first reaction is fight, flight or freeze. The next stage is adaption or resistance, and then a return to the baseline. However, if stress is repeated beyond our capability of adaptation it leads to exhaustion and, in animals, to their death.

Selye acknowledged that some stress, which he called eustress (from the Greek prefix eu, meaning good) was good. It motivates and brings short-term focus, we can cope, it may feel exciting and it often improves performance. On the other hand, distress is negative, causes anxiety, is both unpleasant and outside our coping mechanism. It decreases performance and can eventually lead to mental and physical problems.

Workplace stress can lead to distress for many of us when our workload, and time pressure are governed by someone, or something, else, when there is a conflict in our roles, a lack of autonomy or we are not in control of our decisions. Ultimately when the demands that people face outstrip the resources they have to meet them a crisis arrives.

That 'distress' becomes our old friend (not) 'burnout', which has three dimensions; emotional exhaustion, depersonalisation and reduced personal accomplishment. The first time I became aware of this third factor was as an Associate when my principal was, with hindsight, unable to complete any paperwork; vital in those days to claim for treatments completed. He would sit at his desk in the evening and stare at the mound of notes and forms and achieve nothing, poor soul. But it is the emotional exhaustion manifesting itself as feeling used up, unable to concentrate, easily upset, frequent sickness and problems sleeping which causes much harm. The individual often cannot move forward, nor can they see a way out, and often they refuse to admit that there is anything wrong or that there could possibly be a way out. Make no mistake, without change the individual is driving down a blind alley where they will run out fuel or they will hit the end wall; either way there will need to be a reckoning after the crisis.

I was fortunate, my GP was on leave, and his locum told me how he had given up his career path as a neurosurgeon. His epiphany came one morning when, instead of continuing his drive to work at Addenbrooke's Hospital, he wanted to drive his car into a Fenland dyke. He laid it on the line that a day or two off was not enough and, for the first and last time in my career I took sick leave and claimed on my illness cover. A fortnight later I returned on my own terms, to my own practice. The changes I made meant that I enjoyed my last five years in practice far more, but they also led to my changing course in career to assisting others prevent the crisis that I endured.

ANGELA GLASGOW & NICOLA MUIRHEAD • NSK

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A practice valuation should be based on the current income, current staff costs, current associate and hygienist/therapist costs and standard expenditure from the latest set of accounts. It should not rely on historical data e.g., staff costs from previous accounts or proposed future income. A valuation is the perfect time to obtain all current information.

2 IDENTIFY STRENGTHS AND WEAKNESSES

Within a valuation, a valuer will highlight any areas that may need your attention as a new owner. Perhaps the practice is currently understaffed, and an additional nurse is needed to provide sufficient holiday and sickness cover. Or maybe the practice is overstaffed, and you will need to make redundancies to ensure continued profitability.

3 NEGOTIATION POWER

Should your valuation come back lower than the seller expects for the practice, you will have a full report from an experienced practice valuer that clearly explains how the value has been calculated. With this, you can discuss each point with the seller to hopefully come to an agreement on price.

4 FINANCIAL PLANNING AND BANK FUNDING

A valuation will give you an open market assessment of the practice and the projected profit under both an Associate Led and Principal Led model. However, you will still need to factor in your personal costs e.g. tax and loan repayments, to determine what you will have left to live on. Having a valuation ahead of personal projections will save you time and money in calculating this.

5 SAVE ON FEES

As soon as your offer is accepted on a practice you will start to incur costs; a deposit, legal fees, and bank instructed valuation are usually the first of these. A bank valuation now costs in the region of £2,000 – £3,000 and marks a crucial point in your purchase. The bank will only lend based on the value provided by their panel valuer. Therefore, should the valuation come back significantly lower than your offer, you would either need to reduce your offer for the practice, or make up any difference in cash.

Article by Samantha Hodgson, Practice Valuer and Finance Broker (samantha.hodgson@pfmdental.co.uk. Contact PFM Dental Sales & Valuations to instruct your purchase valuation on 01904 670820 or email sales@pfmdental.co.uk. Full article: www.sdmag.co.uk/five-reasons-to-get-a-valuation-before-buying-a-dental-practice

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WHY CYBER SECURITY MUST BE A PRIORITY FOR DENTISTS AND DENTAL PRACTICES

By Rebecca Wilson, Cyber Security Solutions Manager, Armstrong Watson

Dentistry is increasingly digital and online bookings, cloud-based practice management systems, digital imaging, e-prescribing, remote access and card payments are now routine. But this reliance on technology brings real risk. Cyber criminals are faster, more targeted and increasingly using AI to scale phishing and impersonation attacks.

Unfortunately, dental practices can be easy targets for those looking to exploit vulnerable systems. Like many SMEs, practices often run lean teams and outsource IT.

Attackers know smaller organisations may not have the same layered controls as larger ones, making them attractive targets. The threat is widespread: the UK Government's Cyber Security Breaches Survey 2025/2026 found that 43% of businesses reported a cyber breach or attack in the past 12 months, with phishing the most prevalent and disruptive threat affecting 38% of businesses.

PERSONAL DATA AT RISK

For dentistry, the stakes are particularly high because of the data you hold. Patient records are not just names and contact details – they can include medical histories, treatment plans, NHS/private payment information, insurance details, correspondence and sometimes ID documents. If accessed, stolen or encrypted by ransomware, the consequences can be severe and lead to cancelled clinics, delayed care, regulatory exposure under GDPR, financial loss and reputational damage.

Cyber security needs to be approached as a profession-wide issue, not just an IT problem. Associates may access systems across multiple sites, team members use email daily, suppliers send invoices and payment requests, and practice owners often approve payments while on the move. Many incidents start with human error, such as clicking an email link or approving a fraudulent change of bank details.

Rebecca Wilson

WHAT SHOULD PRACTICES PRIORITISE NOW?

Start with the basics (multi-factor authentication on email and core systems, regular patching of devices and systems, secure, tested backups), then take a structured approach.

You will need to understand vulnerabilities, test your response, and build a culture of awareness. Armstrong Watson's Cyber Security Solutions (**www.armstrongwatson.co.uk/services/cyber-security-solutions**) can help dental practices assess risk, implement employee training, test incident response plans and strengthen compliance; helping protect patient data and maintain continuity of care.

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SIMPLIFYING ENDODONTICS

With the HyFlex EDM OGSF Sequence

Endodontic success depends on a combination of various elements, with precision and control vital, within an efficient workflow. With the curves and complexities involved in root canal treatment, achieving safe and accurate results requires tools that are reliable in their performance and designed for excellence.

Rotary NiTi systems have transformed endodontic preparation, with their intricate design made for function. However, the extreme complexity of some multi-file systems available can actually inhibit workflows by slowing them down and introducing unnecessary decision-making during treatment.

COLTENE, constantly ahead of the game, has addressed these challenges by creating the HyFlex EDM OGSF Sequence – a streamlined file system designed to ensure remarkable endodontic performance, without overcomplicating instrumentation and decision-making. The system affords clinicians the ability to deliver consistency in endodontic cases with unwavering confidence and efficiency.

SIMPLE AND STRUCTURED

The HyFlex EDM OGSF Sequence is designed with incredible logic in mind: a four-step workflow that offers clinicians guidance through each of the key canal preparation stages. The acronym 'OGSF' represents the sequence of files used during treatment, in order: Orifice Opener, Glidepath file, Shaping file and Finishing file.

The different instruments should be used for their particular role within the root canal treatment, and are designed as such. The Orifice Opener prepares the canal entrance, creating coronal and improved access to the root canal system. The Glidepath file then establishes a glide path to the working length followed by the Shaping file and Finishing file for preparing the full length and final shaping.

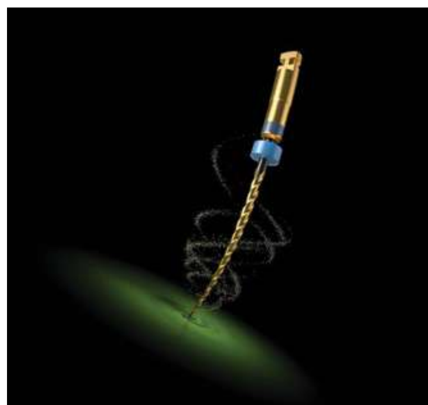
The natural progression throughout the treatment when using the OGSF files facilitates decision-making greatly, compared to the excessive complexity often associated with multi-file endodontic systems. COLTENE now allows dental professionals to progress smoothly through canal preparation with fewer pauses during treatment, supporting increased patient and clinician satisfaction.

EFFICIENT EVERYDAY ENDODONTICS

The HyFlex EDM OGSF Sequence has been developed to provide a tailored solution for fast and reliable root canal preparation.

Carefully matched tip sizes and tapers across the sequence allow for a smooth transition between instruments, helping clinicians maintain control throughout instrumentation. This optimisation reduces unnecessary file changes while enabling efficient progression through the canal.

In many cases, clinicians can reach working length with a few tapping motions. As described by Dr Thomas Rieger, Endo Specialist, Memmingen, Germany: "With just a few peckings, I reach the measured working length without any stops in between. Previously, a file had to be inserted into the root canal several times. That is no longer necessary here! The OGSF sequence can be applied effortlessly, even in difficult cases."



The result is a workflow that supports an amalgamation between pure efficiency and predictable accuracy. For practices, this level of efficiency is incredibly valuable as endodontic procedures can fit into everyday schedules with greater ease. Furthermore, for patients, shorter chair time and procedure length augment satisfaction greatly, particularly for anxious patients.

As explained by Professor Dr Eugenio of Pedullà University Catania, Italy: "Whether simple or complex root canal anatomy, almost all clinical cases can be treated with one sequence. The file dimensions (tip size and taper) are perfectly coordinated. I have everything under control, and the success is predictable."

EFFICIENT AND PRECISE ENDODONTIC WORKFLOWS

The HyFlex EDM OGSF Sequence is available in multiple lengths – including 21 mm, 25 mm and 31 mm – allowing clinicians to select instruments appropriate for working approach and patient-specific requirements.

Modern dentistry requires efficiency without compromising success in precision. Regardless of the level of the clinician's skill, the best way to guarantee consistent results is by working with the very best instruments for the job. The HyFlex EDM OGSF Sequence from COLTENE provides the perfect solution, by offering a protocol that can be easily integrated into everyday practice.

For more information, visit www.coltene.group/hyflex-edm-ogsf email info.uk@coltene.com or call 0800 254 5115.

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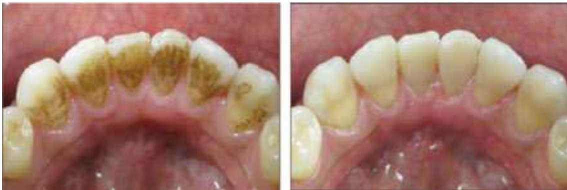
TREATMENT OF PERIODONTITIS AND MINIMALLY INVASIVE TREATMENT WITH MODERN TECHNOLOGY

MINIMALLY INVASIVE DENTISTRY IN FOCUS

Minimally invasive treatment has received increased attention, especially in periodontitis treatment and prophylaxis. The goal of minimally invasive treatment is to preserve healthy tissue and reduce pain and recovery time. Ideally, patients will experience the benefits of this approach, making it easier for them to engage in the preventive care we offer in dentistry.

MODERN TECHNOLOGY: AIRPOLISHING, POWDER THERAPY AND PIEZO

Prophylaxis is gaining increased attention and the demand for modern, minimally invasive equipment has increased.



AIR POLISHING

Air polishing technology was first developed in 1945 by Dr Robert Black, originally using aluminium oxide for tooth preparation.
In the 1970s, it became popular to remove discolouration using a gentler powder, mainly for use supragingivally. Air polishing was previously seen as a cosmetic treatment, but today it has an important role in pathological treatments, in the form of powder therapy and biofilm removal.

POWDER THERAPY: A BREAKTHROUGH IN BIOFILM REMOVAL

In the 1990s, the development of biocompatible powders began, and research looked at the potential of air polishing technology to remove biofilm. The development of new powder types and lower-pressure technology enabled both sub and supragingival treatment, throughout the mouth, making treatment more preventive and pathologically directed. In the late 2000s, subgingival air polishing was introduced as a new treatment modality. The method was initially a revolution in implant maintenance and peri-implantitis prevention but has since proven to be highly effective for full mouth debridement – including biofilm removal on gingiva, tongue, mucous membranes, furcations, crowns, bridges and root surfaces. The powder, which consists of amino acids, the body's own protein, is biocompatible and gentle while effectively removing biofilm and light discolouration. The fact that the powder does not contain antiseptics is also an advantage in terms of sustainability and resistance development.

IPIEZO TECHNOLOGY

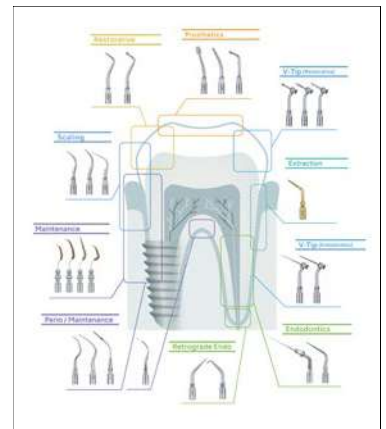
Technological developments have also improved ultrasonic scaling and mechanical depuration techniques. NSK has Intelligent Piezo, an ultrasonic scaler that can distinguish between calculus and the root surface.
This ensures that only calculus and biofilm are removed, while the root surface is preserved. The treatment is fast, efficient and more comfortable for the patient.

Hand instruments are still important but are increasingly used as a supplement to control the work of the ultrasonic scaler. Ultrasonic scaling creates a cavitation effect that breaks down the biofilm and eliminates bacteria, as well as acoustic streaming that removes dissolved particles from the pockets. NSK offers a wide range of more than 80 different tips suitable for use with the Varios Combi Pro2 for minimally invasive treatment.
Find out more here: www.uk.nsk-dental.com/products/oral-hygiene/oral-varios_ultrascaler_tips

EFFICIENCY AND EFFICIENCY AND PATIENT COMFORT

Modern, minimally invasive equipment is not only gentle, but also efficient and timesaving. Clinicians are exposed to less strain, while the patient experiences a faster and more comfortable treatment.

To view more NSK content for Dental Therapists and Dental Hygienists, visit www.mynsk.co.uk/ikigai/



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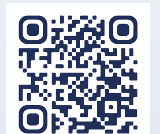

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The Dental Clinic Ayr

One of three surgeries at the clinic

WHAT A TRANSFORMATION

The Dental Clinic Ayr is a showcase for IWT Dental Supplies' expertise and exceptional service

Miller Road in Ayr is named after John Watson Miller, a master gunsmith who made his fortune in India catering to the demand for high-quality firearms among the British military and colonial elite. In 1852, on his return to Scotland, Miller purchased the barony of Montgomerieston, the site of an old Cromwellian Fort, and set about developing the area, including the building of a classic Victorian residential street that would take his name.

Number 13 Miller Road was one of several blonde sandstone fronted townhouses that were home to Ayr's merchant and professional classes. Throughout the mid-to-late 20th century, like many of its neighbours, Number 13 transitioned from a private residence into an office and commercial space – and today it is home to The Dental Clinic Ayr, founded by Dr Ailey McAllister.

Somewhat rundown when Ailey took it over in October last year, today the building has been transformed – thanks to her building contractor partner, who undertook the physical renovation, and to IWT Dental Dental Suplies Ltd., who provided surgery layout drawings and management support to the building contractor team. In addition, IWT Dental supplied three Siger U-500 ambidextrous dental chair packages, three Durr VSA single surgery suction motors, a Durr Vista Pano – 2D – Digital OPT machine, a Durr Vista Scan, intraoral x-ray scanner with smart scan technology, NSK iCare Hand piece cleaner, Bien-Air dental hand pieces, two Mocom B Classic – 22 Sterilisers, a MOCOM – D60 Tethys Range Washer, three Myray RXDC Intra oral x-ray machines with wireless firing switches and DenComp DC 4 dental compressor.

Dr Ailey McAllister and her team

The clinic, born of Ailey's commitment to addressing the critical shortage of NHS dental services in South Ayrshire and aiming to provide high-quality care to a community facing long waiting lists, has three dentists, a dental therapist, a dental hygienist and support staff. It opened its doors in early February, with a visit from the local MP Elaine Stewart later that month to celebrate the launch. As well as being the home of first-class dental care, to patients the clinic's comforting interior feels like home; relaxing and stylish – but with a structural design that also pays tribute to its historic past.

ABOUT IWT

IWT Dental Supplies Ltd., delivers industry-leading solutions for dental practices of all sizes and at every stage of development

We partner with you to optimise your practice, equipment, and clinical workflows, so you can focus entirely on delivering exceptional patient care. From single-surgery installations to fully managed, end-to-end projects — including building works, plumbing, electrical services, flooring, dental chairs, and bespoke cabinetry — we collaborate closely with you and your team to understand your unique requirements and bring your vision to life.

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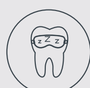
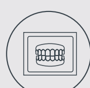
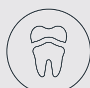


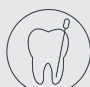
Sedation



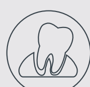
CBCT scanning



Restorative dentistry



Endodontics



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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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WHERE TO START WITH SYSTEMS

Practice Plan Regional Support Manager Richard O'Brien outlines the practical, stress-free way for dental practice owners to introduce systems, KPIs and workflows without overwhelming their team

If it has dawned on you that systems are what you need to cure the daily chaos of dental practice life, then the obvious next question is: Where to begin?

The idea of creating systems might feel a little daunting for some. They fear adding more work to an already packed schedule or that the practice may become somewhere rigid and bureaucratic. However, building systems doesn't mean you need to stop the day job, rewrite your practice manual or create a screed of documents. You simply begin with where you are now and what you have and build things gradually. The aim is progress, not perfection.

Here is a step by step suggestion as to how to begin.

START WITH THE STRESS POINTS

Before mapping workflows or designing KPIs, identify the three areas in the practice that cause the most frustration or confusion. These are your system hotspots.

Common examples of these include DNAs/FTAs (did not attends/failed to attends) and late cancellations, treatment plan follow up, new patient enquiries, stock management and surgery turnaround times. Please note: this list is not exhaustive!

Ask yourself (and your team): "Where are we currently losing time, money or our sanity?" Identifying these areas will give you the biggest and/or quickest wins.

MAP THE WORKFLOW AS IT EXISTS TODAY

Capture what really happens in your practice rather than trying to design the ideal process. Doing this will help reveal where there are gaps, inconsistencies and duplicated work.

To do this, try using this simple structure:

- What triggers the task?
- Who is responsible?
- What steps do they take?
- What tools or software do they use?
- How does it get completed or passed on?

All this can be done without any special software. Using a whiteboard, a shared document or even sticky notes will help you achieve your goal, which is visibility.

IDENTIFY WHERE THE PROCESS BREAKS DOWN

Once the current workflow is mapped, ask:

- Where do delays happen?
- Where do we rely on one person's memory?
- Where do things get missed?
- Are any steps unclear or duplicated?
- Does everyone do it the same way?

The answers to these questions will tease out the root causes of your stress points. Most breakdowns happen because the systems are not clear (or non-existent) rather than because staff members are not trying,

SIMPLIFY FIRST, THEN STANDARDISE

A system should make life easier, not complicate things. For each workflow you should remove any unnecessary steps, reduce handovers where possible, standardise scripts, templates or checklists and ensure the right person owns the task.

Once things have been simplified, write the workflow in a format that matches your practice culture. Some teams like to use a checklist while others prefer a simple step by step guide. Whichever way you choose, what you are trying to achieve is clarity.

CHOOSE 3–5 KPIS THAT MATCH YOUR SYSTEMS

Once you have built your systems, you need KPIs that tell you whether those systems are working.

Examples of this would be if you have a system to map new patient enquiries then your KPI will be your new patient conversion rate. If you build a system for DNAs/FTAs then your KPI is the percentage of appointments attended. And so on.

Don't choose too many. You want a small dashboard that tells you what matters quickly.

GIVE EACH SYSTEM AN OWNER

A system without ownership is simply a suggestion. For each workflow you should name the primary owner and who the backup support would be. You also need to clarify what "done well" looks like and decide how progress will be reported. Assigning ownership increases accountability without micromanagement.

TRAIN THE TEAM IN SMALL, MANAGEABLE CHUNKS

It takes more than just a single meeting to roll out systems. Take things gradually and focus on one system per week. Arrange short, focused huddles and make use of visual aids such as printed guides, laminated checklists and dashboards.

For communications systems such as treatment follow up or triaging calls, try shadowing or role play.

When team members know why a system exists and understand how it helps them, they are far more likely to buy into things.

REVIEW MONTHLY, IMPROVE QUARTERLY

Systems are things that constantly develop as the practice evolves. To ensure they are still relevant set up a short monthly review (10–15 minutes) to check your KPIs and a quarterly system update where you refine workflows based on any feedback you have received. This prevents bottlenecks from creeping back in and keeps the practice adaptable.

START SMALL, START TODAY

There is no 'right time' to start setting up systems. It is best to just bite the bullet and start with one stress area, build one workflow and choose one KPI then take things step by step. You should notice the difference within a short space of time. You will experience less firefighting, fewer surprises, a calmer team, clearer leadership and a practice that feels lighter, more structured and more predictable. As well as supporting your business, systems protect your wellbeing. By starting small and building gradually, you will create a practice that is easier to run, easier to grow and far less stressful for everyone working there.

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Richard O'Brien has around 20 years' experience in the dental industry. His diverse career has seen him managing territories focusing on dental solutions, conducting training sessions and ensuring safety compliance in CDS and NHS clinics. He also has considerable experience as a hands-on trainer and presenter.

Some good news from the NHS to private conversion experts

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*"Leaving the NHS has literally changed my life for the better. The advice and support I received from the team at **Practice Plan** was brilliant. Their depth of knowledge and experience is incredible.*

Ant Davies : Dentist and Practice Owner

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NEW REPORT EXPLORES THE GROWING SHIFT AWAY FROM NHS DENTISTRY – AND WHAT IT MEANS FOR PRACTICES

A major new report from Patient Plan Direct (PPD) is shedding light on one of the biggest pressures currently facing UK dentistry, as practices across the profession reassess sustainability, workload, recruitment and patient access in the wake of April's contract revisions and ongoing debate around the long-term viability of NHS dentistry.

Drawing on first-hand experiences, clinician perspectives and data from practices across the nation, The *State of NHS Conversion 2026* report examines the financial, operational and personal factors shaping NHS to private conversion, helping to build a clearer picture of what the transition can look like in practice and why increasing numbers of practices are exploring alternative models of care.

WHAT THE DATA SHOWS

Among the report's headline conclusions, PPD's long-term conversion data suggests practices often require a much smaller proportion of their NHS patient base than many expect to support a viable private model, with around 40% patient retention frequently sufficient depending on practice structure and patient demographics.

PPD's findings also show that 70% of conversions currently take place as full-practice transitions, while 30% follow a phased or clinician-led approach, with almost a third of phased conversions later progressing to full conversion within two years. Conversion timelines are continuing to shorten, with practices PPD has supported through conversion now reaching target plan patient numbers in an average of seven weeks, compared with 11 weeks three years ago. Taken together, the findings suggest a profession under growing pressure to rethink what good dentistry, sustainable practice ownership and professional fulfilment could realistically look like in 2026 and beyond.

Simon Reynolds, Managing Director of PPD, said: "There has been a huge amount of discussion around NHS dentistry over recent years, but far less visibility around what conversion from NHS to private looks like in practice and how those decisions are being made.

"What this report shows is that there is no single model or route forward. Every practice is different, but there are clear trends emerging around sustainability, patient behaviour and the factors shaping long-term decision making. Our aim was to create something grounded in real experience and real outcomes that helps practices better understand the realities of conversion, rather than relying on speculation or assumptions alone."

Read the full article here:
www.sdmag.co.uk/ppd-state-of-nhs-conversion-2026

Download the report here
www.patientplandirect.com/report

ABOUT *SCOTTISH DENTAL* MAGAZINE

Our aim is to report and reflect the issues affecting the whole dental profession.

So, let us know if you have an opinion on any of our news, features or clinical articles featured in the pages of the magazine or online at: **www.sdmag.co.uk**

EDITORIAL

If you have articles – news, features, opinion or clinical case studies – you would like to be considered for publication then please do get in touch.

Direct all editorial enquiries to Will Peakin, by email **will@sdmag.co.uk** or by phone 0141 560 3019.

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MANAGING WORKPLACE CHALLENGES DURING HOT WEATHER

WORKPLACE TEMPERATURES SHOULD BE REASONABLE

There is no legal maximum working temperature. The Health & Safety Executive (HSE) advice is that the temperature in all workplaces inside buildings must be reasonable. The HSE offers advice on how to carry out a thermal comfort risk assessment if staff are unhappy with the temperature: **www.hse.gov.uk/temperature/index.htm**

KEEPING COOL AT WORK

Switch on any fans or air conditioners to keep workplaces comfortable and use blinds or curtains to block out sunlight. Staff working outside should wear appropriate clothes and use sunscreen to protect from sunburn.

STAY HYDRATED

Employers must provide staff with suitable drinking water in the workplace. Workers should drink plenty of water throughout the day to prevent dehydration and not wait until they are thirsty. Employers could allow extra breaks for staff to get cold drinks.

DRESS CODE

Employers are not under any obligation to relax their uniform or dress code requirements during hot weather but where possible it may be advisable to for employers to relax the rules for wearing ties or suits.

GETTING INTO WORK

If public transport gets adversely affected by the hot weather, this could affect staff attendance and their ability to get into work on time. Staff should check timetables in advance, and employers should be flexible. See: **www.acas.org.uk/disruption-getting-to-work**

VULNERABLE WORKERS

Workers with health conditions or disabilities may be affected more by hot weather. Employers should assess for any risks and discuss what they need to reduce or remove that risk. This might include providing fans, portable air-cooling units or more frequent or longer breaks. Employers must make reasonable adjustments for workers with disabilities. See: **www.acas.org.uk/reasonable-adjustments**

For further advice, please see: www.acas.org.uk/extreme-temperatures-in-the-workplace

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THE SCOTTISH BUDGET'S IMPACT ON DENTISTRY

No big announcements but that does not mean the year ahead will be an easy one

At first glance, there is not much in the 2026/27 Scottish Budget that directly targets dentistry. No big announcements, no immediate changes to how practices operate. But that does not mean the year ahead will be an easy one.

What is actually happening is more subtle. With tax thresholds frozen, more dentists will drift into higher rates without necessarily feeling better off. We have already seen conversations happening with multiple clients who have increased their profits over the past couple of years yet feel like they have less room to breathe personally. That disconnect is becoming more common.

For practice owners, this sits alongside cost pressure that has not really gone away. Wages are still rising, lab bills have not eased and suppliers rarely move in your favour unless you push them. The practices that are coping best are the ones keeping a close eye on numbers throughout the year, not just at year-end. Simple things like regularly reviewing supplier terms or updating forecasts quarterly are making a noticeable difference.

The bigger question, though, continues to be NHS versus private. The Budget does not move the dial here and, realistically, any real change will come from contract reform rather than tax policy. In the meantime, most practices are having to work it out for themselves.

What we are seeing in practice is a gradual shift rather than a sudden change. Owners are not walking away from NHS work entirely, but they are becoming more selective. At the same time, they are putting more structure around private income: membership plans, hygiene-led growth and better uptake of elective treatments.

For Associates not much changes on the surface, but the underlying drivers of income are becoming more important. Earnings still come down to the fundamentals: the practice model, the fee structure and how costs are shared. Two associates doing similar work can end up in very different positions depending on where they are based.

Anna Coff
Senior Manager
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There is also a noticeable shift in expectations. Associates are more focused on long-term earning potential and flexibility than they were a few years ago. For owners, that makes retention less straightforward. It is no longer just about offering a competitive split but creating an environment where people can see a future.

From a personal planning perspective, the frozen thresholds make forward planning more valuable than ever. Pensions, timing of income and overall structure all play a part, particularly as private income grows. Small adjustments here can make a bigger difference than people expect.

For now, success in 2026/27 will come down to the basics: keeping costs under control, being clear on your income mix and making decisions early rather than reacting late. The external environment may be steady, but what happens inside the practice will matter more than ever.

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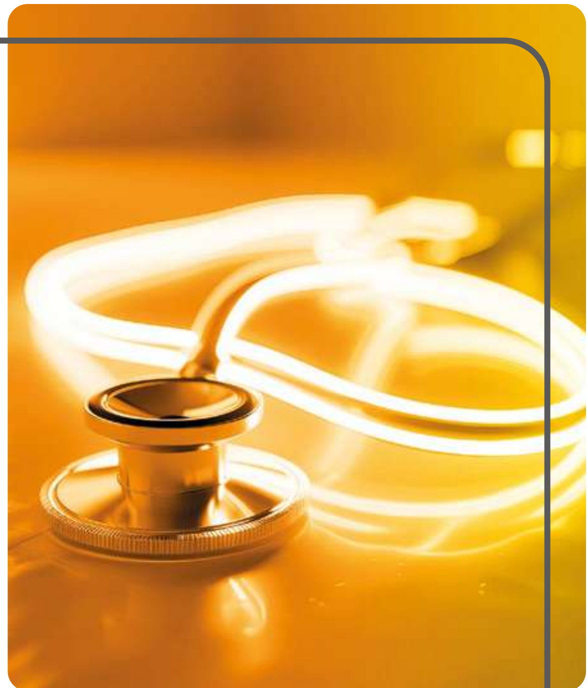

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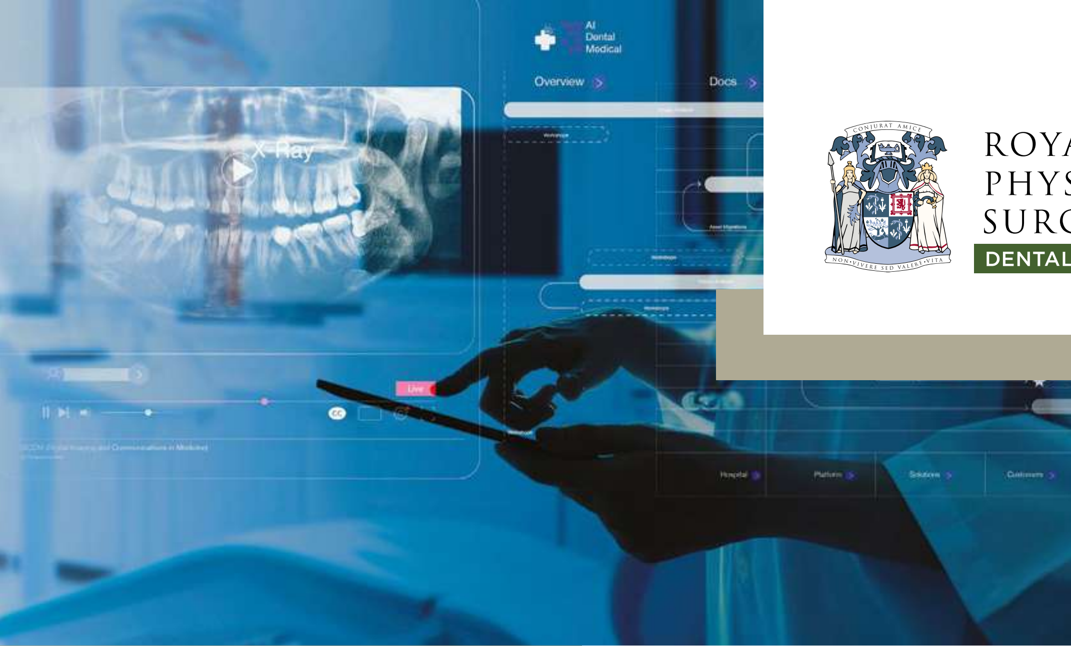

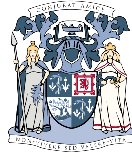

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BUYING A DENTAL PRACTICE

Do not let the property be a hidden toothache, writes Carys Magee

Buying a dental practice is a significant investment, with much of its value tied up in goodwill, reputation and an established patient base. However, one of the most important – and often underestimated – aspects of the transaction is the property itself. While some practice premises are purchased outright, many are occupied under a lease from a third party landlord. Leased premises can work perfectly well, but without proper scrutiny, they can quickly become a real toothache. A little early attention can prevent small issues from turning into painful (and expensive) problems later on.

DILAPIDATIONS

Commercial leases in Scotland are typically granted on a full repairing basis. This means that when the lease ends, the tenant must return the property to the landlord in good repair, regardless of its condition at the start of the lease or when the buyer took occupation.

DILAPIDATIONS EXPOSURE, LENDER REQUIREMENTS AND LANDLORD PROTECTIONS CAN ALL LEAVE BUYERS PAINFULLY EXPOSED IF NOT HANDLED CORRECTLY"

Carys Magee
Associate,
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Dilapidations claims at the end of a lease are frequently overlooked and can carry a hefty price tag. Buyers would be well advised to instruct a building survey before accepting an assignation of the lease. A survey can identify existing disrepair and help avoid liability for issues caused by the seller.

Armed with this information, buyers may be able to negotiate a purchase price adjustment, require the seller to complete remedial works before completion, or agree a schedule of condition with the landlord to limit future liability. Skipping this check up risks inheriting someone else's problems and footing the bill for them.

LEASE LENGTH AND LENDER REQUIREMENTS

Most banks and specialist dental lenders require an unexpired lease term of at least 15 years from completion. This is often to align with the loan repayment profile, ensuring the practice has secure premises to trade from throughout the duration of the lending arrangement.

Short leases, or those nearing expiry, can seriously undermine funding options. Buyers may find themselves needing to negotiate a lease extension with the landlord, often at additional cost through increased rent or additional obligations.

Understanding lender requirements from the outset is key. Early discussions with both the seller and the landlord can help avoid delays and reduce the risk of rushed negotiations weakening the buyer's position.

RENT DEPOSITS AND PERSONAL GUARANTEES

Where a practice is being acquired through a newly incorporated company – as is common in dental transactions – landlords will often seek additional security. This typically takes the form of a rent deposit, a personal guarantee, or sometimes both.

Rent deposits can strain cashflow at a crucial time, while personal guarantees can expose directors to significant and personal long term risk. Like an unnecessary extraction, these obligations should only be agreed where unavoidable – and ideally limited in scope and duration. Knowing this may be required allows buyers to budget properly and negotiate more effectively.

Buying a dental practice with leased premises is a significant long term commitment. Dilapidations exposure, lender requirements and landlord protections can all leave buyers painfully exposed if not handled correctly. As with oral health, early advice and preventative care are key. A well informed approach at the point of purchase can save significant discomfort further down the line.

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WHAT DOES EBITDA MEAN FOR THE SALE OF YOUR DENTAL BUSINESS?

By Joel Mannix, Director – Dental, Christie & Co

If you are selling your dental business, you are likely to come across a plethora of financial jargon, which can sometimes feel like learning a new language. One such term is EBITDA, which stands for Earnings Before Interest, Taxes, Depreciation and Amortisation.

Put simply, EBITDA is a measure of how much profit a business generates from its day-to-day operations, before the impact of financing decisions, tax structures and certain non-cash accounting items. It helps buyers, lenders and valuers understand a practice's trading performance without distortion from factors that can vary significantly between owners.

EBITDA removes the effect of:

- Interest, which depends on how a business is financed
- Taxes, which vary based on ownership structure and personal circumstances
- Depreciation, which reflects the age and accounting treatment of equipment
- Amortisation, which relates to the accounting value of goodwill and other intangible assets

By stripping out these items, EBITDA provides a clearer view of a dental practice's underlying operational profitability.

HOW IS EBITDA CALCULATED?

The basic formulas are:

EBITDA = Net Profit + Interest + Taxes + Depreciation + Amortisation

To calculate EBITDA, the starting point is the profit and loss account within the practice's year end accounts. From there, your agent will typically help review and normalise the figure by adjusting for one off, exceptional or owner specific items to reflect the true, sustainable earnings of the business.

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HOW IS EBITDA USED IN THE DENTAL SECTOR?

Dental practices are commonly valued for secured lending, transactional and sale purposes using the profits method, expressed as a Years Purchase (YP) multiplier, alongside analysis of comparable sales. This involves applying a YP multiple to the practice's EBITDA.

The multiple applied will vary depending on factors such as the nature of the business, quality of provision, location, operational strength and prevailing market conditions.

Understanding EBITDA is therefore fundamental when preparing a dental practice for sale, acquisition or formal valuation, as it underpins how businesses are assessed and compared across the sector.

If you'd like help calculating your EBITDA or understanding what your practice may be worth, get in touch.

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THE CAPACITY CRUNCH – ARE YOU MAXIMISING YOUR CHAIR TIME?

By Victoria Forbes, Director, Dental Accountants Scotland

Most Scottish dental practices remain extremely busy, but busy does not always mean profitable. With rising wage costs, increasing Employer National Insurance Contributions, higher material prices and continued recruitment pressures, many practices are now facing what we refer to as the 'capacity crunch'.

The challenge for practice owners is no longer simply about filling the diary; it is about ensuring that valuable chair time is being utilised in the most effective and commercially sustainable way possible. A poorly structured diary can quietly erode profitability, increase stress levels and restrict growth opportunities.

As we move further into the revised NHS SDR landscape, many practices are now operating on longer examination intervals than historically seen. This creates both opportunity and responsibility. Have you reviewed how this additional capacity is being used? Are you strategically zoning your diary to maximise efficiency, restorative opportunities and patient flow?

Victoria Forbes
Director, Dental Accountants Scotland
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We are encouraging practices to analyse key areas such as failed appointments, surgery utilisation, hygiene and therapist integration, and underperforming chair sessions. Even small operational improvements can have a significant impact on both profitability and team morale over time.

The most successful practices are often not those working the longest hours, but those who continually refine and improve how they operate. In the current financial climate, working smarter rather than simply harder is becoming increasingly important.

If you would like support reviewing your practice efficiency, benchmarking your performance or identifying opportunities within your current operations, we would be delighted to help. Sometimes an external perspective can unlock significant potential.

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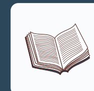
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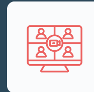
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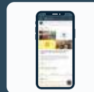
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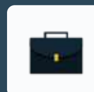
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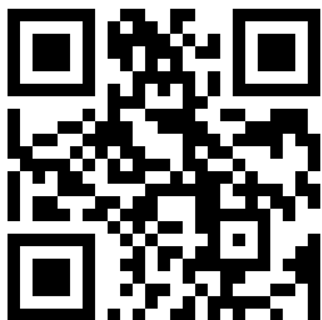

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Alastair Fraser, Principal Dentist, Greygables Dental

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