House of Commons

Health and Social Care Committee

Oral evidence: NHS Dentistry: Follow-up, HC 602

Tuesday 19 March 2024

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Chris Green; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell.

Questions 142 - 208

Witnesses

I: Rebecca Curtayne, External Affairs Manager, Healthwatch England; Shawn Charlwood, Chair, British Dental Association, General Dental Practice Committee; and Thea Stein, Chief Executive, Nuffield Trust.

II: Dr Amanda Doyle OBE, National Director for Primary Care and Community Services, NHS England; Jason Wong MBE, Interim Chief Dental Officer, NHS England; and the right hon. Andrea Leadsom MP, Parliamentary Under-Secretary of State (Minister for Public Health, Start for Life and Primary Care), Department of Health and Social Care.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

HOUSE OF COMMONS

Examination of witnesses

Witnesses: Rebecca Curtayne, Shawn Charlwood and Thea Stein.

Q142 **Chair:** Good morning. This is the Health and Social Care Select Committee. We are in Portcullis House in the Palace of Westminster in London. To those watching and to our guests, who I will introduce imminently, thank you for joining us. We are talking about NHS dentistry today. This Committee published a reasonably well noticed report last year on the state of NHS dentistry, which the organisation of one of our guests described as a road map to save NHS dentistry. Today is a follow-up session to that and to the subsequently published dental recovery plan for England, which the Government published last month.

We will be discussing all of that with Shawn Charlwood, chair of the British Dental Association's General Dental Practice Committee; Rebecca Curtayne, external affairs manager at Healthwatch England; and Thea Stein, the chief executive at the Nuffield Trust, which published a very high profile report on NHS dentistry just before Christmas. Thank you very much for joining us. We have a cross-party Committee of Members who are all ready to ask questions. We will finish this panel and move on to the Minister, NHS England and the chief dental officer at 11 am.

Mr Charlwood, when we did the evidence session in our NHS dentistry inquiry, the then Dental Minister said of the Government's ambition for NHS dentistry, "We do want everyone who needs one to be able to access an NHS dentist—absolutely." I was not expecting such an unequivocal answer to my question, if I am honest. In many ways, it was echoing Tony Blair's promise in 1999, just a couple of years into his Government, that that would be the case. Are we in a place where former Minister O'Brien's ambition is on course to be met?

Shawn Charlwood: Thank you, Chair. I was surprised at the level of ambition at the last Committee as well when that was stated. Much as I would like to say that we are on track to deliver that, you will not be at all surprised to know that we do not think that is the case. I am, as always, very grateful to this Committee for the opportunity to present the profession's perspective on that question and on what is happening in NHS dentistry. As you say, your report remains an instruction manual to save NHS dentistry. I am afraid that the Government have given the impression that they are willing to skip over your first, and most fundamental, recommendation. That, of course, is contract reform. My colleagues are grateful that you continue to keep up the pressure on the Department behind the scenes, in the Chamber and in the form of today's session.

I will be honest. Having sat in negotiations for many months, my expectations of the recovery plan were pretty low. We waited nearly a year for the document. My worry then was that, with every day that passed, more colleagues would pare down their NHS commitment or walk away entirely. Now that it has landed, I am afraid there is really nothing

there to bring the service back from the brink and deliver the promise that was made.

I did not want to come here and just offer opinions. What we have done is to survey the membership so that we can give you some facts. Having spoken to countless colleagues, the sense of disappointment and, frankly, resentment in the profession is profound. As I say, we wanted members' feedback on the recovery plan today. We were taken aback, frankly, by how brutal that feedback was.

The Government told this Committee, as you say, Chair, that their objective is to provide NHS care to all who need it. We asked dentists if they thought the plan was capable of keeping that promise, and 1% agreed. One in 100 respondents thought that this plan could deliver that promise, to answer your question directly. Just 3% said the measures in the plan would keep them providing NHS care in the long term. Most damningly, dentists do not believe that it will improve access for patients. Only 3% believe that this plan will result in their practice seeing more NHS patients. Almost half believe it will do the exact opposite and lead to their practice seeing fewer NHS patients. That is not fewer existing patients to make space for those who have not been seen, but fewer patients overall.

To conclude, we asked our members to sum up the plan in their own words. This gives you a sense of the emotion. We didn't offer any prompts; it was free text. What we got was unambiguous cold fury from colleagues who have given up hope, frankly, of change. I read the words "Too little, too late" over 100 times in responses. We counted the phrases used most often. They were, "Not fit for purpose", "Dishonest", "Inadequate", "Rubbish", and, I'm sorry to say, "A joke".

It is a pretty good summary of what the profession makes of the plan. It feels to me that this plan was not designed to rescue NHS dentistry. It was designed with the upcoming election in mind, to try to limit the political damage the access crisis is doing to political prospects in constituencies. The measures in the plan make for a good press release, a nice photo opportunity or something for candidates to talk about on the doorstep. To be honest, this recovery plan is not worthy of the title. The fundamental perversity of the system remains unchallenged.

To conclude, one colleague commented that you cannot rebuild a collapsed wall with a box of Polyfilla. That is precisely what is, sadly, being attempted here once again. There is more papering over of the cracks, rather than the decisive and fundamental reform that you and your Committee recommended to deliver care to the millions of your constituents who cannot access NHS dental care.

Q143 **Chair:** That is the global view. You have covered your survey responses. I know that you do not appreciate the sum of its parts, but are there any parts within the dental recovery plan where you thought, "Thank goodness," such as the registration of overseas dentists, golden

handshakes, or mobile vans? Were there any parts of it where you thought, "Yes, that is a positive step forward"?

Shawn Charlwood: Yes. I think the components of the Smile4Life programme are all things that we have called for for many years. I am glad that we are finally seeing some movement on prevention in the early years. It is better than nothing but, of course, it could have been far more ambitious, like the schemes in Wales and Scotland where far more wide-ranging programmes have led to unprecedented improvements in children's oral health. Let's be clear: the 165,000 children this plan pledges to deliver fluoride varnish to are approximately 2% of all primary-age children in England. In scale of ambition, it just is not enough.

We have to ask ourselves why, after almost a decade and a half of discussions, this is happening now. I would love to know much more about this proposal. I would love to know how much money will be spent on it. Where is the money coming from? Will it be universal? Which children will benefit? I would really like to know the detail of that.

Q144 **Chair:** Rebecca from Healthwatch, you talked about policymakers better informing the public about NHS dentistry and, most notably, people being aware that you do not have to register like you do with a GP in a locality to go to a specific practice. You talk about something which I think is quite interesting, which is the Government saying in the dental recovery plan that they will roll out a national "marketing campaign" to encourage people who have struggled to find an NHS dentist to contact dental practices. You welcome that move. You say that it is important for dentists to actively "promote availability of appointments to new patients and prioritise slots to people most in need"—people who haven't seen a dentist for over a certain length of time. Is that happening?

Rebecca Curtayne: Thank you, Chair, for inviting Healthwatch to return to the Committee on this important topic. I would like to offer some initial reflections—

Q145 **Chair:** We don't really have time for pre-prepared reflections. We need to cut to it. Can you answer my question? Is it happening? Are dental practices in a position where they are actively promoting availability of appointments to new patients?

Rebecca Curtayne: Not that we have heard of. We are still waiting for that national marketing campaign. About two weeks ago, we met about a dozen local Healthwatch who work in dental deserts. Many said that their ICBs had been caught by surprise with the publication of the plan. They did not have details to hand on how a lot of the plan would be implemented.

The most common question that Healthwatch continues to be asked is, "How do I find out if my dentist is offering new NHS appointments?" We believe that the plan should have required dentists to put a digital flag on their NHS website listings, to indicate to the public, "I am open to seeing

new NHS patients who have not been seen in the last two years." We continue to hear desperate stories from patients about lack of access. In the last week I have heard about one person who overdosed on prescription painkillers that they had borrowed from a friend in desperation to treat pain for untreated problems.

Q146 **Chair:** Can we talk about dental deserts? You just mentioned that expression. Is there anywhere that isn't sandy? There are areas where there are not dental deserts, right? I have been talking to colleagues in parts of London, for instance. My colleague from Sheffield is nodding, and in a minute we will bring him in. Are there areas where your members do not ask those questions?

Rebecca Curtayne: We have heard from local Healthwatch in all 153 areas about dental problems. Yes, the crisis hasn't hit England equally. You may have seen some figures that came out in the *Health Service Journal* yesterday, which show that spending on contracted dental activity ranges from 70% in the quite populated west midlands to only 40% in Somerset, I believe.

Chair: It is very disparate, in many ways like the waiting lists, which are certainly not uniform in every single part of the country, proving that the national health service is an aim. Let's bring in Paulette Hamilton, and then we will bring in my colleague from Sheffield.

Q147 **Mrs Hamilton:** I feel as if I might be repeating myself, but I am going to ask the question. I am not sure whether Thea or Rebecca should answer it. Basically, I want any insights that you have had on the ground from people who have heard about the plan, or that you have sat down and spoken to about the plan, a bit like Shawn said about what the dentists have been thinking. What have people on the ground been saying?

Rebecca Curtayne: As I said before, people are still waiting for the marketing. We acknowledge that the plan is only six weeks old tomorrow. It will take time for the plans to filter through, but we don't feel that there is much proactive communication happening. What we do know is that people continue to face barriers to care. We recently carried out some cost of living polling, which shows that 20% of people were put off going to the dentist because of cost. That is up from 15% from the same poll that we carried out 12 months ago. It is even higher for people in the worst financial situation; 40% of that group are put off going to the dentist because of cost.

Q148 **Mrs Hamilton:** My second point is this. What do you feel your role is nationally and in local areas to assist the health service to get to a stage where you feel the information is being distributed so that people have the information they need?

Rebecca Curtayne: Local Healthwatch stands ready in every area to work with, and inform, their ICBs and to work with councils to share public opinion and to be able to tell them which communities and areas need the most help-intensive access. With initiatives like the dental vans,

how are the decisions going to be made about where they park in a community? How often will they be in an area? Who should they be targeted at? We have been told that the dental vans will be providing general dental services whereas, in the past, they have been mostly targeted at bespoke communities, such as asylum seekers or people who are homeless.

Q149 **Mrs Hamilton:** For my last point, can I just challenge that? I really respect Healthwatch—I'll start there—but do you not think that this is where you have a role to really get started in some of these areas, and then ask for forgiveness if that is not where the Government truly wanted you to go?

Rebecca Curtayne: If you mean that local Healthwatch should be spreading the word about the plan, yes, absolutely. Every Healthwatch in the country published details about the plan when it was first published, but there is an issue about raising public expectation. We need to understand which dentists are offering these new NHS appointments. If local Healthwatch cannot get that information, how can they share it with the public?

Mrs Hamilton: I'll stop there. That is a really great point.

Q150 **Chair:** Can we briefly give Thea a quick feel of the ball? I know that Paul is going to go back to the BDA on some survey stuff. I asked the Prime Minister about this just before Christmas at the Liaison Committee. You said in your report that NHS dentistry was at its most perilous point in its 75-year history. Obviously, that was pre the recovery plan coming out. You echo what Shawn says about the survey. You said that it is not going to be anywhere like big enough to restore universal access. Give me your scorecard out of 10 for what you saw in the recovery plan against what you had written in that big piece of work last year.

Thea Stein: I am a very generous person, so I will give it a three or a four.

Q151 **Chair:** Oh excellent. That is you being generous?

Thea Stein: It is. Compared to my colleague here, I think I am probably doubling or tripling where my colleague would be. As you pulled out in the conversation with Shawn, there are some things that could work at scale. They could be good green shoots, but in a root and branch overhaul of dentistry, and indeed the gripping of whether it is a universal service for all or whether it is actually going to be a good, gold-plated service for the most vulnerable and those with the most need and a service that is means- tested for others, it goes nowhere near recognising or grappling with those fundamental issues.

There are potentially a few green shoots if they are advertised properly, if they are talked about appropriately and if the vans are used in the right way. Sure, I would give it a three or a four.

Chair: Fine; thank you. Let's bring in Paul. We have to try to keep our questions and answers as concise as possible so that we can cover a lot of ground.

Q152 **Paul Blomfield:** Shawn, I was going to ask you about the survey, but you have comprehensively dealt with that.

Shawn Charlwood: Sorry.

Q153 **Paul Blomfield:** No. That's absolutely fine. It is important to get that in front of the Committee. Let me ask you a bit more about the issue at the nub of this, which is the UDAs in the contract. From your conversations with NHS England and the Department prior to the publication of the recovery plan, was fundamental reform ever a possibility in your view? Is that where the Department was at any stage of the process?

Shawn Charlwood: I think we had a very narrow window where the Department's interest in an alternative system certainly increased, but that window was very short, and it closed very abruptly. One of the greatest damages of the recovery plan is that it has, in effect, pushed back meaningful contract reform, which was the chief recommendation of your Committee. I know that others will say, "Well no, we will talk about it later in the year." We know what is happening politically later in the year. Realistically, do any of us think that a recovery plan and a new contract are going to be top of the list for discussion?

As I say, I think one of the greatest damages and disservices of this recovery plan is, perversely, to have pushed legitimate contract reform, which is the only thing that will save the service, much further down the line. Clearly, that is what is required. To answer your question, essentially the interest in contract reform was very much diluted and distracted by the recovery plan.

Q154 **Paul Blomfield:** Let me push you a little bit further on that. You are right to talk about the electoral timelines that frame this, but the Government said, as you have just highlighted, that they are developing further recommendations for dental contract reform. Has the BDA been approached regarding the scope of that further work?

Shawn Charlwood: No.

Q155 **Paul Blomfield:** Have you been approached regarding the timelines for it?

Shawn Charlwood: No.

Q156 **Paul Blomfield:** So it is a pretty meaningless statement in your view.

Shawn Charlwood: Yes. I will leave you to judge how meaningful it is. In essence, we have had no clear discussions about meaningful contract reform since last autumn, when all discussions, essentially, stopped. Clearly, work was then being done on the recovery plan, which had been announced last April. Once that work took hold, all meaningful discussions about contract reform stopped. We have had no discussion

about the timings, extent or ambition of that. All we have heard is within the recovery plan, that further discussions will happen later in the year, but it is such a loose arrangement that, frankly, we have little faith that it will deliver what is required.

Q157 **Paul Blomfield:** That is interesting. The Government are not saying that they are planning to develop; they said in the recovery plan that they are currently developing further recommendations, but they have not engaged with you at all if that is happening, and you doubt that it is happening.

Shawn Charlwood: No, I wouldn't go that far. Developing a contract could have been one conversation. I do not know the extent of their conversations and their discussions, but we have certainly not had any of that information shared with us in terms of timelines, how meetings will be set out or what they are thinking of developing.

Q158 **Paul Blomfield:** Thank you. Thea, what do you think the impact of delaying contract reform until 2025 will be? What would be your proposals for how the issue should be resolved? What is the way forward for Government and NHS England, in your view?

Thea Stein: The impact of delaying contract reform will be the continued march of dentists away from NHS dentistry. That has a catastrophic effect on the country, which has been laid out to this Committee many times, so I am not going to repeat it. Reform is clearly what colleagues in the dental community are asking for. Delaying it is clearly the issue that is going to drive more and more dentists into private dentistry.

Paul Blomfield: Thank you.

Q159 **Rachael Maskell:** Shawn, I want to start with you on money. I noticed in your opening remarks that you said that you think the plan could even be detrimental to the number of patients being seen. Could you set out why that is? Also, where is the money going to come from for the increased UDA rate, for example, and the other fiscal measures mentioned in the plan?

Shawn Charlwood: The fundamental problem with the plan is that there is no new money. Even the increase of the minimum UDA value is accommodated financially—afforded, if you like—by reducing the number of UDAs, so it is within the current contract value. Practices reasonably felt that this would mean more money. It does not mean that. It means that there are actually fewer UDAs to deliver, so their ability to deliver care to patients is actually reduced. The new patient premium of £15 and £50 for band 1 and bands 2 or 3 is accommodated within the current contract value.

The effect of that will be that if you see new patients, who as we all know very often take considerably longer to treat, it will consume more clinical time. It will therefore reduce the number of existing patients who can be seen. New patients, inevitably, take longer to be seen. The net result is

that many of our members, who clearly know this stuff inside out and have looked at their particular practice, say that they are fearful that the effect of this, because it is not new and extra money but within contract value, will be to reduce the number of patients that can be seen. That is where that statement comes from.

The fact that there is no new money in an environment where over £450 million was taken out of NHS dentistry last year is bizarre. Even in a system where it is effectively costing less and less each year—we talk about a figure of over £1.5 billion being taken out of NHS dentistry per year because of the effect of inflation and clawback—dentistry is getting cheaper and cheaper for Government to deliver. It is getting more and more expensive for practices to deliver and it is getting harder and harder for practices to access NHS dentistry.

The final point is this. The reason NHS dentists are leaving the service is not that they want to. They cannot recruit and retain NHS dentists. If you run an NHS practice with a contract, and you do not deliver the contract, the Government will take the money back off you. You still need to pay your nurses. You still need to pay the mortgage and all the other things that we know go into healthcare. Fundamentally, NHS dentists are struggling to afford to run NHS practices because it is not attractive enough. I go back to the contract.

Q160 **Rachael Maskell:** Thea, I have a similar question for you. We now know that the contract negotiations, or any implementation, are delayed until 2025. What impact do you think that will have, particularly on retention of the workforce? Where is that going to lead us?

Thea Stein: Retention of the workforce is something that really needs to be focused on in dentistry, as it does across all of the NHS. If we are to retain dentists and raise the morale of the dentists that we currently have, unfortunately it is a bit circular. We come back to the contract, the way in which dentists are allowed to work and the way in which dentists want to work around oral health promotion, working with the whole patient and with the most vulnerable. If you do not have the capacity to do that, it will be very difficult to retain and raise the morale of the dental workforce that we have.

There are about 24,000 full-time equivalent dentists doing NHS work. There are about 44,000 dentists in England. You have a workforce that you could create incentives for and support to be more rapidly deployed to areas and with vulnerable groups, but to maintain and raise morale takes you in a circular way back to the way the contract is done.

Q161 **Rachael Maskell:** Are you seeing any indication that contracts will be handed back?

Thea Stein: I am sure they will.

Q162 **Dr Johnson:** I want to ask you a bit about the contract and money. It seems that, essentially, there is a supply and demand problem, where

you have a lot of dentists, but increasingly they are moving to work in the private sector rather than the NHS. Indeed, looking through the number of dentists per capita, apparently we have more dentists per capita than we had 10 years ago, so theoretically the problem should be easing and not getting worse.

Shawn, do you think that NHS payments can ever compete with the fees that private dentists are able to charge, sufficient that dentists would wish to work for the NHS rather than for the private sector? When you are looking at supply and demand, how much would you need to increase payments to attract people over, if you think you could? What level of massive increase in dentists would you need to bring the overall price down, such that they could become more comparable? Who else could do dental work, such as nurses, that would enable you to deliver some of the more straightforward work more cheaply?

Shawn Charlwood: I will take those in order. Do I think that NHS treatment can ever compete with the private market? Yes, I do. The reason I say that is based on experience. When I first qualified, all those years ago in the mid-1980s, broadly everybody worked in an NHS dental system. Broadly, people were content. They moaned about this and that, but that is the nature of life. Broadly, the dental profession worked in NHS dentistry. They did some private work. Some practitioners were private, but there were very few.

We had a system that was funded and supported. People saw value in it, and they wanted to work in it. It is all very well to talk about money in isolation, but there is a lot more to running a dental practice in the local community than the cost of it. There is a tremendous moral, ethical tie that health professionals have to their local populations. I know that because I know how traumatic it is when practitioners feel forced out of the NHS. It is not something that people do lightly.

Yes, if the NHS dental service was adequately funded in a sustainable way, you would see significant numbers of dentists wanting to work in it. That is the first hopeful element. That is the frustration for us as a profession. We need support for that in order for the profession to deliver NHS care. That is the first thing.

In terms of what level of UDA value I think would make a very good start, when we formally gave evidence, we suggested a minimum figure of £35 per UDA. The reason we chose that figure is that we thought it would impact significant numbers of practices. There is a direct connection between the minimum UDA, or the UDA value that practices have, and their ability to deliver UDAs. You cannot escape from that. You cannot recruit dentists at low UDA values.

We pitched at a level of £35 minimum UDA value that would impact significant numbers of practices. The other area that was important for that figure is that it was completely affordable within the figure that is being clawed back out of NHS dentistry, so it did not require any

additional funding. We were not being greedy; we were being realistic. If you cannot spend the clawback money, why don't you spend it supporting the lowest supported practices? The figure that we set was £35.

Your third question, about the numbers of dentists in the profession and the numbers working within NHS dentistry, is interesting. The GDC have started to collect data in the annual returns that dentists have to submit. The workforce plan talks about increasing 8,000 whole-time equivalent NHS dentists to over 20,000 to make NHS dentistry more attractive. Do you really think that is feasible, when we see NHS dentists leaving the NHS? The idea that we are going to more than double the number of dentists working in the NHS without significant strides around contract reform is clearly fiction. I think I have answered your three specific questions directly.

Q163 **Dr Johnson:** The other part of the question was about other people being able to do some of the more straightforward dental work. To go back to you on the issue of numbers of dental students, particularly as part of the supply part of the market, during covid there was an issue with exam results that you will be aware of, so a higher number of students went into the system in 2020-21. Do you know how successful the training of that large number has been? There were concerns that it would be too many to train at once. If it was successful, would you recommend that it was continued rather than going back to normal numbers?

Shawn Charlwood: There is concern as to whether the experience that undergraduates are receiving clinically is preparing them as we would want for practice. Foundation training—vocational training as it was—certainly has a role in that, where undergraduates go into particular practices with support. We clearly need to have a system where dental schools are producing undergraduates of a standard that is both safe and appropriate. Having spoken to the dental schools, deans and the people who are teaching undergraduates, I think they are concerned, first, about the capacity of dental schools to increase the number of undergraduates, because clearly that is going to need funding and support and, secondly, about the numbers of academic tutors who will be available to teach those undergraduates.

The final point to think about is this. Once those undergraduates come out of dental school, they are going to work in a practice environment, potentially foundation training. We are going to need a lot more foundation trainers to look after those dental students. All of this is possible, but it clearly needs a joined-up approach. Clearly, when they then move from foundation training to, hopefully, working in the NHS system, we will need as a country to commission many more whatever it is then—hopefully, not units of dental activity—for those dentists to be remunerated and for care to be delivered. At the moment, if we are to

move from 8,000 to 20,000, we need significantly to increase the amount of dentistry that is commissioned.

Q164 **Dr Johnson:** A final part of the question was about other professionals within the dental service being able to do some of the simpler and more straightforward tasks that dentists currently do.

Chair: Children's check-ups, for instance. There is a big debate in healthcare at the moment about physician associates. It is controversial, but there is a role for a wider disciplinary team.

Shawn Charlwood: There is certainly a role for skill mix within a team environment, where certain clinical procedures are carried out by different members of the team. What is difficult within the current UDA system is making that work, for various remuneration reasons as much as anything. I would guard against the sense that skill mix is going to be the silver bullet for everything. Fundamentally, we need to have the whole team engaged with an appropriate NHS dental service, but I would not underestimate the value of skill mix.

Q165 **Chair:** Let's come back to Nuffield. We have the Minister, NHS England and the chief dental officer in next, sitting where you are sitting. What would you ask? When you were doing your report, what would you like to have asked them?

Thea Stein: I would start with reflecting on whether or not the dental action plan, in their view, really tackles the underlying issues that we all understand and have described. Where do they think it needs to go further faster? I would ask whether they believe universal dental healthcare is really going to be back, that there is a commitment to that and what that means. I would ask whether they see the urgency for those who are most vulnerable and those who are being failed the most, and whether they genuinely think that what is in the dental action plan is going to meet those people's needs, with the speed that is necessary, and why they have not grasped the need for a more long-term and full review of the contract with the speed that has been asked for over a very significant period of time.

Q166 **Chair:** Why do you think that is? You have looked at this in more detail than most. Why do you think that has not been gripped?

Thea Stein: I think it's neglect. I don't think it is a plot. Nuffield's view was that this was policy neglect and looking the other way. As the Committee will be more than aware, the NHS has quite a lot of things to look at. Over a period of time, this is an area of policy that simply has been neglected. Those who could chose to go private, quietly. A group in the middle fought for what was left in the provision, and some people started to do DIY dentistry. It was only at points of urgency, when the water was boiling, that it became really clear what those decades of policy neglect had caused. Clearly colleagues, like those on my right, have been spending a lot of time saying, "Hey, look over here, look over here." Our view, looking at it over a period of years, was that this has

just been neglected. I say "just", but it has been neglected because there have been so many other things to look at. It never got to the top of the agenda.

Q167 **Chair:** Rebecca, finally to you. On the mobile vans, I saw a comment from Hampshire Healthwatch—obviously, I am a Hampshire MP. The ICB has funded some vans, and the message that I saw reported was again that it was not enough, nowhere near enough. What is your understanding of these mobile units? I shall ask NHS England this. Are they delivering treatment or are they delivering toothpaste and toothbrushes?

Rebecca Curtayne: We understand, and I think have been told by the Department, that they will be fully equipped with dental chairs.

Q168 **Chair:** Do you understand who is going to staff them?

Rebecca Curtayne: We are told salaried dentists, but we don't know where they are coming from.

Q169 **Chair:** Shawn, do you know about these vans? Where is the workforce coming from to do it?

Shawn Charlwood: We understand that we are looking at between 12 and 15 vans throughout the whole country. We have done a little bit of analysis of that. We optimistically think that they might deliver between 50,000 and 70,000 appointments per year. That is quite optimistic.

Vans clearly have a role in targeting specific vulnerable groups. That may be homeless people or other groups. It is not the way to deliver mainstream dentistry to 12 million people who have unmet dental need. Again, I don't want to disparage it, but it is not the method to deliver the scale of care that is required.

Q170 **Chair:** But given where we are, is it not a dentist blue light that is going to go into communities that are under-served or not served, where inequalities are high and where people have not seen a dentist in any form for a couple of years? Is that not what is necessary right now, given where we are?

Shawn Charlwood: I don't think it is the answer. There is a bit of me who thinks that if I was working in one of those vans, I would be a little bit fearful. We all saw the queues for the Bristol practice. Can you imagine working in a dental van that pitches up in any town anywhere on Monday morning? That will soon go around the town, and wider areas.

Q171 **Chair:** It will be a busy van.

Shawn Charlwood: It could be a rather unsafe environment, actually. "What do you mean, you won't see me? I've been queueing here for hours." The police will arrive, as they did in Bristol. I reiterate that I do not think it is appropriate. I am not disparaging it in the sense that it has

a role in some places, but it is not going to deliver the scale of dental and oral healthcare that your constituents require.

In terms of a question for the Minister, I hope you will ask her for some clarity on the figures underpinning the plan. The Prime Minister, the Secretary of State and the Minister herself have repeatedly mentioned the figure of £200 million invested into this plan. From the conversations that we have had, we understand that none of it is new money. I really would like you to push her on that. It is funded entirely, as I spoke about earlier, by recycling the current underspend and the current budget within dentistry. So far, the Minister has refused to answer questions on where exactly this money is coming from or how much each part of the plan costs.

There are lots of figures flying around about access. We have heard about 2.5 million additional appointments; 1.5 million courses of treatment; and 1 million more patients seen. Frankly, I am puzzled as to how those figures were arrived at. I would like to see the modelling published in order that we can be satisfied and reassured that the correct modelling has taken place. Those numbers make for a nice press release, but we have seen so many of those press releases. We do not know where they have come from.

Q172 **Chair:** There are just a couple of other quick things before we switch to the Minister. Do you have any liaison through the BDA with dentists who work in the military?

Shawn Charlwood: Yes. We have representation of military dentists.

Q173 **Chair:** You will be aware that there is a health check that people who join the services have to go through. There will be a dental check that sits alongside that; for instance, if you had braces or tracks fitted you would not be able to join the Navy for a certain period. That bar is changing, but because we have this lag from the challenge of NHS dentistry and young people not being able to see a dentist who are now at the age at least where they may join the forces, is that impacting on recruitment into the forces, and has that fed back to you?

Shawn Charlwood: Yes. This crisis is now working its way through all streams of society. We are seeing it in the military where, as you say, it is imperative that our soldiers, airmen and sailors are dentally and oral health fit. It is impacting on the ability to recruit. It is also impacting on the number of days that personnel are taken out of service as a result of emergencies.

Q174 **Chair:** That is the concern I have. Finally, before I bring in the other team, the BDA warned about the EU phasing out amalgam, which is basically the silver filling that you give, and the impact that may have in Northern Ireland in particular, because obviously, under the protocol, it is treated as part of the EU. Does the imminent phasing out of amalgam in the EU have an impact wider than Northern Ireland?

Shawn Charlwood: I think it will because the supply of amalgam will be reduced. The demand for amalgam within the EU will stop.

Q175 **Chair:** The market will disappear.

Shawn Charlwood: The incentive to create a business to produce amalgam will decline and the cost of amalgam will increase. In Northern Ireland particularly, they are going to have to use materials that are mercury-free. Those materials take significantly longer to place clinically, which is creating all sorts of angst among dentists in Northern Ireland in a national health service system.

Q176 **Chair:** We have all been to the dentist when they have said, "You can have a silver filling or a white tooth-coloured filling," and the former is clearly cheaper. If there is a shortage of that product, it could then push up the costs of dentistry across the board.

Shawn Charlwood: Yes, absolutely. Particularly where amalgam is banned, which it is likely to be in the future, the costs will increase.

Q177 **Mrs Hamilton:** This is a really silly question, but it is bugging me. Shawn, recently my GP closed, and I waited nearly a year to find another one. Thanks be to God, I have a brilliant one now. When I started with the new dentist, I had been with the old dentist for 26 years. She had all my records and knew everything about me, but everything was lost. Where does it go?

Shawn Charlwood: It won't have been lost, but what we don't have is a method where clinical records are automatically transferred from one dental practice to another, because of the lack of IT development within the NHS dental service. They will not have been lost.

Q178 **Mrs Hamilton:** As part of the plan, has anything been considered around the development of IT?

Shawn Charlwood: It is not a specific part of the recovery plan, but it is certainly something that we have mentioned on several occasions. The digital investment within NHS dentistry needs to be made.

Mrs Hamilton: Chair, can I come back to you and say that I think that is a big issue at the moment? Nothing pertaining to people's records is being transferred anywhere when dentists close. I just want to make that point.

Chair: Thanks, Paulette. Let's leave it there for now. We will switch panels. Shawn Charlwood from the BDA, Rebecca Curtayne from Healthwatch and Thea Stein from the Nuffield Trust, thank you very much for your time.

Examination of witnesses

Witnesses: Dr Doyle, Jason Wong and Andrea Leadsom.

Q179 **Chair:** Welcome. We had Healthwatch and the British Dental Association,

alongside the Nuffield Trust, sitting in those seats just now. You passed them on the way in. For our second panel we have the right hon. Andrea Leadsom MP, who is a parliamentary Under-Secretary of State and the Minister for Public Health, Start for Life and Primary Care, in the Department of Health and Social Care. Dr Amanda Doyle OBE is the national director for primary care and community services at NHS England. It is nice to see you again, Amanda. Jason Wong MBE is the interim chief dental officer at NHS England. Nice to see you, Jason.

We have a number of questions. I am going to kick off and then I will bring in Rachael Maskell and Paul Blomfield, who has to go very shortly. We will get to you as quickly as we can, Paul.

Minister, I will start with you on contract reform. This Committee brought out its big NHS dentistry report. You subsequently brought out the NHS dental recovery plan six weeks ago. There has been lots of talk about contract reform. The plan says that the Government are developing further recommendations for dental contract reform, with any changes phased in from 2025 onwards.

Can I try to unpack the conversations had since you have been in office and that you know you have inherited from briefings you will have had as the plan was put together? How did we get to this place where contract reform is still pending? It says in the report "from 2025 onwards". Where are we on contract reform? How do you view the situation as it stands? Clearly, the BDA is very concerned about it being now, or yesterday actually. Where are you on contract reform at the moment?

Andrea Leadsom: First, thank you very much for having me today. I really appreciate the amazing work of this Select Committee. For me, when I was first in this role, your report on dentistry was incredibly helpful. It steered a lot of my thinking.

Tackling your question directly, contract reform is absolutely the priority. However, when I first came into this role, it seemed to me that dental recovery was even more urgent than contract reform. Having got the dental recovery plan out the door, which is going to free up significant numbers of appointments and has the golden hellos—for me personally the whole prevention and Smile4Life agenda is absolutely crucial—we are now turning seriously to contract reform.

I have had a number of roundtable meetings with dentists and stakeholders about the urgent need for contract reform. I completely accept that. In fact, I have my first serious meeting with stakeholders and practising dentists on 27 March. I hope that you will be able to attend that meeting to talk about some of the issues, such as recruitment and retention, and obviously the way that patient treatment is funded, particularly the need to stabilise high care needs for more complex patients. That work is very much under way. It is my expectation that we will consult later this year, with a view to rolling out contract reform in 2025.

Q180 **Chair:** Does that move us fundamentally away from units of dental activity to what we talked about in our report, which is a much more preventive holistic oral health approach for dentistry? If you talk to dentists, as I know you do and we all do as constituency MPs, the issue that they have, and one of the main reasons they cite for leaving the profession, is the fact that they are UDA'd.

Andrea Leadsom: Specifically on prevention, I think the dental recovery plan very much shows the direction of travel. The whole Smile4Life agenda is all about prevention. If you start your life with good oral health because your parents understood about feeding, weaning and first foods, and then you have good oral health because in your early years setting your teeth are brushed for you by your nursery worker, and your parents understand the importance of regular brushing and are shown how to do it—we are working to get some sponsorship for toothbrushes and paste for small children—and you are given the information to spit, don't rinse, our ambition is that by the time you reach primary school it is routine for every child to brush their teeth twice a day. We know that if you start with good oral health, you are much more likely, from a prevention point of view, to need fewer interventions later on. Prevention is absolutely integral to our plan. That is already out there, and that is what we are doing.

To your broader point about whether we will move away from UDAs, I don't want to second-guess that. I would say almost certainly for complex cases. UDAs can work quite well for check-ups, for example. My ambition would be to see much easier access to check-ups. As you will be aware, one of the things we are doing in parallel to improve capacity is to bring forward a statutory instrument to enable dental therapists to do much more work so as to free up the capacity of dentists—for example, to enable dental therapists to go into schools and brush milk teeth with fluoride varnish, and they could do basic check-ups and provide oral health advice. I think there could be a role for UDAs, but certainly where more complex cases are concerned it will be the case that we will want to look at other systems.

To come back to capitation—I know lots of people say that we should have capitation—I have tried to dig exactly into the experience. There have been pilot schemes. Amanda might want to say a bit more about that. I gather that capitation pilots that the Department held between 2011 and 2022 actually demonstrated lower access for people in greater need. It does not seem to back up the fact that it would provide more access to people with those greater needs. I need to understand that further. I am starting from a clean sheet of paper, talking to stakeholders and practising dentists about what they would like from a future contract.

Q181 **Chair:** Dr Johnson was talking in the previous session about the wider dental workforce doing some of the children's check-ups, for instance. We see that in other public services, where teaching assistants work in schools. They are not fully qualified teachers. They have a role to play, in

your mind, and you say you are bringing something regulatory through to allow that to happen.

Andrea Leadsom: Yes.

Q182 **Chair:** That is interesting. Going back to Smile4Life, all the stuff that you have talked about differs from the Smile4Life programme on the NHS England website, which currently has a Smile4Life section. How does it differ from that? Will it be the stuff that you have just outlined?

Andrea Leadsom: Essentially, it is building on what has gone before. I am told by Jason's predecessor as chief dental officer that there used to be a programme pre-covid, which I am certainly keen to reinstate. For example, every one-year-old would have a first dental check-up just to make sure that the gums are healthy, the little milk teeth are being cared for and that the parents have the information and advice they need.

Of course, Smile4Life has a big opportunity because of the roll-out of the family hubs, which are a one-stop shop. If you have a baby, go to the family hub. That is where you get support and services. Right across my portfolio as Public Health and Primary Care Minister, I am looking at what else we can deliver in family hubs, which I know have cross-party support, so that we can make sure that all of the education that parents need, as well as the support for good oral health, starts in the very earliest days. All of the ingredients are there. As I say, the key has to be that by the time your child goes to primary school they are already in the habit of brushing twice a day.

Q183 **Chair:** We are going to talk a bit about money, how the plan is funded and whether that is new money or existing money. Amanda, from NHS England, I am going to ask you about money. There has been a lot of talk about underspends in this space. As you know, we, as a Select Committee, talked in our report about that underspend and that it should be being invested in dentistry. Did NHS England write to ICBs giving them the green light to use some of the underspend outside dentistry?

Dr Doyle: During 2023-24, at the beginning of the financial year, we ring-fenced the dental allocation and encouraged ICBs to spend it entirely on dental services. During the course of the year it became apparent again, for a further year, that despite the fact that ICBs had committed every penny of that allocation in contracts—at the start of the year there are contracts in place that commit all of the spend—that money being used is dependent completely on dental providers delivering the activity that they are commissioned to deliver. It becomes apparent during the course of the year whether that is happening or not. For the past years, particularly since the pandemic, it has become increasingly apparent that not all of that money is being spent.

Normally, if we apply a ring-fence to funding, we would say at the end of the year, "If you've not spent it on what it is supposed to be spent on, we will claw that money back centrally into the central pot." By November last year, it became apparent that dentists in aggregate were under-

delivering on the commissioned activity, so we would be in a position at the end of the year to claw back money from their contracts. They would not have used all the funding that they were allocated.

It also became apparent that there were huge financial pressures developing across ICBs for a range of reasons, including industrial action and other things that had impacted costs across the NHS. What NHS England said was, "At the end of the year we still want you to spend all that money on dentistry." In fact, I wrote to ICBs to remind them of the opportunities they had to commission flexibly and use more of the dental funding on dentistry but that if, for any reason, they were unable to do that, we would not claw the money back centrally. Instead, it would remain with ICBs and would effectively offset pressures elsewhere in the system. There was no point at which we said, "Please go ahead and use that money for something that's not dentistry," but we recognised that ICBs have a duty to balance financially, and that underspends in one area sometimes offset overspends in another, as they will in any big organisation.

Q184 **Chair:** And that had ministerial oversight, did it?

Dr Doyle: It was an NHS England financial decision, but we did not write to ICBs and say, "Please go ahead and spend this money on something else."

Q185 **Chair:** With decisions comes accountability, which is why you are here. I think our constituents will be slightly perplexed as to how we can be in a situation where so many MPs are hearing from constituents who cannot get treatment from NHS dentistry, and yet dentists are unable to spend the money that is allocated for NHS dentistry on fixing their teeth. What would you say to our constituents? You don't have to face them on a daily basis, but we do. We are accountable to them, and you are accountable to us.

Dr Doyle: Absolutely. I can understand the concerns of both you and your constituents in that case. The challenge we have is that, for various reasons, and particularly since 2021 during the pandemic, dentists have delivered a lower proportion in aggregate of their commissioned activity. What we are seeing is a move away from a willingness or ability to deliver NHS care in favour of other activities.

We recognise that. There is complexity, in that not only are there more people facing a backlog in trying to get care because of the dip that was necessary during the pandemic, but dentists feel that they are not adequately remunerated for some of the packages of care and some courses of treatment that may be required by those people. That is why we have brought in the recovery plan incentives, so that dentists will be more adequately remunerated, particularly for patients who have not had routine dental care over the past two to three years, and to incentivise dentists to deliver more NHS activity. How much of the allocation we spend relies entirely on how much NHS dental activity dentists deliver.

Chair: Hold that thought. To be continued, as they say. I am going to bring in Paul Blomfield.

Q186 **Paul Blomfield:** Thank you, Chair. I must apologise because I have to rush off to Treasury questions after asking these questions. I want to ask a couple of questions, Minister, about the recovery plan. You claimed that it is going to deliver 2.5 million more appointments. That is an incredible number of appointments. Can you explain how you arrived at that figure?

Andrea Leadsom: That was NHSE modelling that took into account the views of dentists, the usage of contracts and various other factors that came up with an assessment of what could be 2.5 million appointments or 1.5 million courses of treatment. Obviously, many appointments are sometimes needed for particular individuals. It also, of course, reflects the fact that those payments would be made where somebody had not seen an NHS dentist for two years. By definition, they had not been seen within the recommended period of time. It might be the case that they would need more than one appointment. It is a complicated set of factors but, at the same time, it has quite a high likelihood of not being reliable, as is the case with all modelling. As a previous finance person myself, I can absolutely assure you that it is not rocket science, but forecasting is a very tricky issue.

What we are going to be doing is monitoring the spend over 2024-25 on a monthly basis through the ICBs reporting, to make sure that we can see blow by blow how much their contracts to their dentists for NHS care are being used. We can then see exactly how much is being spent. On the one hand, we will be able to report to members of the public, who want to have the confidence that there are dentists in their area who will take NHS patients. We will also be able to see the financial spend on a month-by-month basis. We will then be able to adjust the recovery plan, potentially increasing NHS contracts by up to 10%, if we see that dentists are in fact delivering more than they are commissioned to provide as a result of the incentive. It is not an exact science, as you will realise. Let me be very clear about that.

Q187 **Paul Blomfield:** Could I ask that you share that modelling with the Committee?

Dr Doyle: It is essentially based on the size of the under-delivery currently. What activity have we commissioned that is not being delivered? If we delivered all of that—if all the measures we are taking to incentivise dentists to deliver all of their commissioned activity were successful and all of it was delivered—that is roughly what it would translate into, as the Minister said.

Q188 **Paul Blomfield:** Thank you very much. It would be very helpful if you could share that with the Committee so that we could have a look at it.

Dr Doyle: Yes, we will share that.

Q189 **Paul Blomfield:** That was quite an admission, Minister. The 2.5 million

was the headline that accompanied the recovery plan. What you are now saying is that it is not really very reliable.

Andrea Leadsom: The 2.5 million is the out-turn of the modelling. I am merely making the point that, as we all know as politicians, forecasting is not an exact science. That does not undermine the fact that the modelling comes out with a number of 2.5 million. I am merely being cautious in saying that it could be more or it could be less, as is the case with all forecasting. It is not an exact science, whether you are forecasting the deficit, interest rates or wages. They are never an exact science when you are forecasting.

Q190 **Paul Blomfield:** It is very helpful to be cautious with us. Do you not think it would have been helpful to be cautious with the public when you announced the recovery plan?

Andrea Leadsom: It is very important for people to understand the quantum. When I say that it could be under or over-exaggerating, it can be either of those things. As you know, with economic forecasting, there is sometimes a span of potential outcomes to provide more detail. Actually, with a £200 million recovery plan, like that one, which clearly would result in financial incentives that increased dentistry activity, I think it is perfectly legitimate—as we do in all areas of public policy—to put out the forecast and the number that gives people an idea of the extent of the increase. As you say, it is quite significant and reassuring for members of the public. At the end of the day, all of us as constituency MPs have people writing to us all day, every day, saying, "I can't get an NHS dentist." People want to know that there is a material number.

Conversely, if we said, "We don't really know because we can't be accurate, blah, blah, blah," that is not helpful to members of the public. I think having a headline number is entirely legitimate. I am merely saying to the Committee that it could be more than 2.5 million or it could be less than 2.5 million, but that is a best guess using robust modelling. I think it is entirely legitimate.

Q191 **Paul Blomfield:** Thank you very much. Which part of the plan do you think is going to enhance capacity in practices or bring dentists back to the NHS?

Andrea Leadsom: That is a really interesting question. I think there are different aspects. The golden hellos have the potential to really improve things; 240 dentists will receive £20,000 over a three-year period to go to an area where they are really struggling to get capacity. That will be because there is an NHS contract and there are not enough dentists willing to deliver under that contract. That is hugely beneficial in just providing capacity. That is one bit.

We anticipate that there will be around 15 to 18 mobile dental vans in perhaps more remote areas or where there is less access due to transport issues and so on. Again, that will really improve capacity to very under-served areas. Equally, the additional payment of £15 or £50 simply

incentivises all dentists to do more under their contract. As Amanda said, the reason why, for years, we have had under-delivery on contracted UDAs is that dentists have found private patient work more lucrative than NHS work. It is straightforward: we are effectively allowing them to take more remuneration for delivering more. It will be interesting to see. As I say, we will be monitoring it monthly to see exactly what is improving capacity overall.

As I mentioned, there is a separate initiative with secondary legislation that will enable dental therapists to take on much more work. That will also significantly increase capacity. The numbers are roughly 68,000 dental therapists and about 35,000 dentists on the dental register, so enabling dental therapists to take on more work expands the capacity in its entirety. Of course, the point is that you want to expand capacity in the places that need it. In places where they are already doing all their UDAs, and people are not struggling to get an NHS dentist—there are some places like that—there is obviously not an issue with capacity. It is more in places where they are struggling to recruit dentists, or in more rural places, or in places where there are not enough practices with an NHS contract. That is where you really want to expand the capacity, and that is why this is quite a comprehensive plan.

Paul Blomfield: Thank you.

Q192 **Rachael Maskell:** Jason Wong, as the interim chief dental officer you have been reported as saying that the plan is "nowhere near enough" and as having expressed a sentiment around abolition of the UDAs. Your position, clearly, is for advancing oral health in our country, so in the light of that why isn't the Department taking on board your expertise to shape the dental plan and ensure that we get the contract right?

Jason Wong: It is important to get the context of that particular conversation, which was based around contract reform as opposed to the whole dental plan and the whole of dentistry. I am entirely supportive of the recovery plan and I made that clear in the comments I made. There was, at that time, a lot of commenting that unless you get a complete, wholesale change, there is no reason to co-operate with anything that comes out from the centre, which was the answer I was giving to a colleague in that particular place.

In terms of the recovery plan, when I said "nowhere near", it is about whether we are looking for a recovery plan, or something that will sort out dentistry. That, in effect, is what the conversation was about. I think that the recovery plan has some important components as the next step towards reform. It can bring in reform, which is being worked on in parallel; it has already been announced that it will be consulted on this year and will come in next year. It is not so much that advice has been given and not been taken.

We have talked about the UDAs. Sometimes, regardless of what metric you use, and the fact that opinions are split as to whether capitation is

the way to go, people have approached me and, anecdotally, there seems to be a liking for fee-per-item among some colleagues. The UDA has probably got to a stage now where the brand is so difficult that I think we need to find some way of getting out of it, notwithstanding the reasons already given.

As to the basis of the discussions we have just had about the new patient premium, we have some really good information from Greater Manchester, which has led on this. They have had something like 80,000 on general dental services and about 76,000 new patients in Greater Manchester alone on the urgent care part of that. That is about 160,000 new patients in about 10 months in Greater Manchester alone. There is some track record based around having a new patient premium and being able to change behaviour.

Anyone who knows my record knows I would be very supportive of the early years intervention that the Minister has just talked about. We quite often gloss over the workforce component, about how dental therapists, dental hygienists and clinical dental technicians can come in to be part of the NHS. Numbers have just been given by the NHS. Hopefully, in future, enhanced dental nurses can come into that as well. As the Minister was saying about the statutory instrument, a significant part of this is the fact that at the moment, operationally, that exemption is the one thing that is holding back hygienists and therapists from making a bigger contribution. We are hoping that that will come through, and will change that particular aspect. Growing the workforce with the NHS long-term workforce plan, plus the provisional registration for international dentists, are significant parts of the plan. It is one thing for a newspaper to catch on to one particular comment and one particular response to a great big thread, but, make no mistake, I back the recovery plan.

Q193 **Rachael Maskell:** Thank you. Obviously, contract reform is the most important part, moving forward. There is recognition of that right across the profession. Minister, can you explain to the Committee, at this stage in the plan and the proposals you have put forward, where the money is coming from to fund the reforms? Certainly, the lifting of the UDA rate and the premium for new patients seem to come out of the current contract. I wonder if you would clarify that for us and explain where the money—the £200 million that was announced—is going to be spent.

Andrea Leadsom: Yes, absolutely. There is about £3.8 billion spent on dentistry, including community dentistry services—so £3 billion on high street dentists, if you like. The issue is that for years there has been under-delivery on contracted UDAs. As Amanda explained, the ICBs will contract with dentists to deliver a certain number of UDAs. The contract is signed and agreed. The dentists will do that. And then they don't. The problem is that until the end of the financial year, when they have to give back the money that effectively they have not earned because they did not deliver the NHS care that they contracted to do, we have ended up each year, for several years, with an underspend. In a ring-fenced budget

that underspend would be brought back. As Amanda said, NHS England decided to allow them to keep the underspend for elsewhere.

In bringing forward the recovery plan I was determined to ensure that that underspend would in fact not exist any more. What patients want is to see an NHS dentist. They are not interested in the money, the budget and so on. They just want an NHS dentist. If NHS dentists delivered on the NHS care that they had contracted to do, many more patients would be seen. The idea of the recovery plan is to provide other incentives, other ways to spend the money that is ring-fenced for dentistry, to enable much more access to NHS dentists. That is the idea of it.

As I said, we will be monitoring on a monthly basis how that is working. We expect that dentists will deliver much more against their NHS contract, with a view to its being possible later in the year, should they be right up against the top of their contracted UDAs, for ICBs to increase that and allow them to do up to 110% of their contracted delivery, which will be good news for patients.

Q194 **Rachael Maskell:** Thank you very much for that answer. In my area there is an acute shortage of NHS dentists and it takes seven or eight years for somebody on a waiting list to see a dentist in a new area. There is already a £28 minimum UDA that the new patient premium will certainly not cover, because people will not be seeing a new dentist within the time limit; it takes seven or eight years. For patients in my area and other dental deserts, how will the plan benefit people who are waiting, undertaking DIY dentistry or, indeed, just not seeing a dentist? How will it bring benefit to my community?

Andrea Leadsom: That is a really good question and there will be lots of constituencies in the same boat, mine included. The fact is that in the first instance people go on the NHS website to find a dentist, but they can't because all the dentists say, "We're not taking new NHS patients." The first thing is that with the new patient premium, which is £15 for a check-up and £50 if it goes on to further treatment, there is a direct incentive for the dentist who has the contract to fulfil the contract to the maximum, potentially going to 110% of contract.

Dentists who are currently thinking, "Do you know what, I'm not going to deliver my NHS work, because I've got plenty of private work," will be incentivised to think, "Actually I am now more attracted to NHS dentistry." The statutory instrument that enables dental therapists to provide more care will also increase the capacity. We have golden hellos, so if there is an NHS contract but not enough dentists to do the work, it will be possible to attract a dentist on a golden hello—a newly graduated dentist.

Q195 **Rachael Maskell:** And that is new money.

Andrea Leadsom: It is all coming out of the £3 billion that is currently so underspent. Each year it has been underspent. It is new in the sense

that it was otherwise not going to be spent on dentistry, but it is part of the budget that for years now has simply not been spent on dentistry because there hasn't been the incentive or the capacity in the system to deliver the contracted UDAs. I am really trying to make this clear, and please ask me again if it is not fully clear, but it is essentially two things: the incentive and the capacity. The recovery plan is trying to deal with both.

The third thing it is dealing with is, of course, prevention, which at the end of the day is the biggest money saver for families; if people start out with good oral health they do not need so many interventions later. I felt that the recovery plan was an essential first step in making sure that we use the £3 billion on dentistry, which has not been the case in the past.

Rachael Maskell: Okay, thank you, Chair.

Chair: That is very useful. Thank you.

Q196 **Dr Johnson:** Good morning. I have three questions and the first is for Andrea. You have talked about the importance of early years. As a children's doctor I see children coming into hospital to have sometimes many teeth removed under general anaesthetic. It is pretty awful to think that children are coming in for that. You talked about children having their teeth brushed in nursery. The Labour Opposition have talked about getting children's teeth brushed at school, but children are not at school or nursery every day of the week and they need to develop this habit every day—every morning and every night. To what extent do the Government believe that it is parents' responsibility to ensure that small children's teeth are brushed? What are they doing to reinforce to parents the importance of maintaining children's teeth?

Andrea Leadsom: I completely agree with you that it is parents' responsibility to ensure that their children's teeth are brushed. However, in our family hubs programme, which is rolling out across England and which, as I mentioned at the start, has cross-party support, the family hubs are a one-stop shop for people with a new baby. Of course, oral health starts during pregnancy. Mum's own oral health is an important factor, because if a mum has terrible teeth that will potentially harm the unborn baby in her womb. It is very important for pregnant women to get their teeth checked. That will be part of the advice that is given to families in family hubs. As colleagues know, dental care for pregnant women is free.

There is advice antenatally on feeding and weaning. We absolutely know that breastmilk is the best nutrition for babies, but some mums cannot breastfeed, or choose not to, hence advice on infant feeding and bottle feeding, and not giving your baby Ribena or orange juice or other things that you might have thought would be fine because it's fruit and it's good for you. Parents need to understand that ideally babies will have breastmilk and, if not, infant formula, until they are six months old; and for weaning, don't give them things with added sugar, and don't give

them certain processed foods that have far too much sugar. Alongside all the advice that families need, there is advice on caring for babies' gums and milk teeth. That includes brushing.

We are working in the Department with some providers of toothpaste and toothbrushes to try to get packs in family hubs, for families who might struggle to provide their own. There will be toothcare clinics in family hubs and advice through dental therapists going to family hubs and early years settings. Obviously, if your baby or toddler is in nursery, it makes sense, with the general physical and social care—feeding, changing nappies and so on—for toothbrushing to happen as well. I recognise that, as you say, not all babies and toddlers go to nursery, so ultimately it is for us to give parents the information they need to ensure that their babies have good oral health right from the start.

Q197 **Dr Johnson:** Thank you, Minister. My next question is for Mr Wong—hello. It is about fluoride and the fluoridation of water. We have talked about prevention and the Committee is looking at a separate strand on that at the moment. What do you think the evidence is about fluoridation of water? Some areas, including mine, have fluoride in the water, and others do not. Do you think this should or should not be more widespread?

Jason Wong: I think it should be more widespread, and the plan makes a commitment for the start of that in the north-east. Some of the evidence has been around for quite a while. It is quite established that it is a safe and effective public health measure. I very much support the team. In fact it is part of Smile4Life that the Minister's team is working on right now, and I was feeding into it last night and this morning. I am very supportive of that. The evidence is clear to me and always has been.

In Lincolnshire, we have a split through the county and you can clearly see the result in children's oral health according to that split. Taking in all the other factors, it is living proof, as well as Birmingham having had it for a good while, that it is something where we should support a more widespread roll-out.

Q198 **Dr Johnson:** Thank you very much. This is my final question. You talked about incentives, Minister, specifically for more vulnerable groups and groups that are more challenging to reach. I want to ask you about a specific group, for which there is a particular impact in my constituency—the armed forces. The armed forces—service personnel—are looked after by the armed forces themselves, with their own dentists, but the families of such personnel often have to move around the country, frequently at short notice, at the request of, essentially, the Government.

The Government put the armed forces covenant into law because we have such a strong commitment to our armed forces, but I hear from constituents who have moved from other parts of the country that they have to make round trips of many hours to attend their former dentist to maintain an NHS contract, because once they have moved they cannot

get a dentist within the timeframe before moving again. I am interested to know what you are doing to support the families of our service personnel to meet the terms of the armed forces covenant.

Andrea Leadsom: That is a very interesting question. Just recently in my constituency, we had a Mission Motorsport event at Silverstone Circuit for veterans of the armed forces, where we were talking about the challenges that veterans have in accessing services when they leave the armed forces, sometimes with all sorts of specific challenges related to their service.

I have looked into what, specifically, we do for the armed forces. As you say, it is not considered necessary to make specific provision for the armed forces. There could be a case for doing so, but, again, the way dentistry works is not by running lists in the same way that a GP does. You do not have to be registered with a dentist in the same way you do with a GP.

However, as we know, whether it is a hairdresser or a dentist, they will keep a list. They will contact you with thoughts, and you will get preferential access by being a loyal customer. That they do not maintain lists as a GP would does not change the fact that, very often, once you have a relationship with an NHS dentist, it is easier to stay with them, and they will prefer you.

That is backed up by the evidence that it is harder, if you do not have an NHS dentist, to get one, than it is to see an NHS dentist if you already have one. One can understand that. A dentist looking at whether to take on a new patient might almost want to see what their teeth are like before deciding to take them on. Therein lies an intrinsic problem.

Again, the answer is to improve capacity. That is why the dental recovery plan was so important. I completely take your point that people are forced to move around with work, including the families of armed forces. They therefore have to change areas at short notice for short periods of time. Because of the lack of capacity, they are not able to access an NHS dentist. If we can improve capacity for everyone, so that it is not so hard to get an NHS dentist, that would solve the issue. I take what you say seriously and I will look again at whether we should do something very specific for armed forces families.

Q199 **Dr Johnson:** Thank you. I have not seen a survey of it—Mr Wong may have—but I imagine that service personnel families' teeth are in better nick than the public average, because the military life is very disciplined and so forth, so the idea that they are responsible people who brush their own teeth and their children's teeth would seem to me intuitive; but we have a commitment to the people who are prepared to put their life on the line, that we will look after their families. That means making sure, if we are asking families to uproot themselves and their children every few years for our benefit as a collective, that we put them first. I would be really grateful if you could look at what could be done to target some of

that incentive money to families that are asked to move.

Andrea Leadsom: I certainly will.

Dr Johnson: Thank you.

Q200 **Mrs Hamilton:** Minister Leadsom, I have two really specific points, which are quickies. The first relates to the east of England, which currently has some of the worst outcomes. Going back to staff and their development, there are no dental hospitals built in that area for training and development. Is anything being planned to plug that gap, so that we can offer the correct resources in that area as a start point?

Andrea Leadsom: Yes. That is all part of the contract reform consultation that will be starting, I think, on 27 March with the first meeting with dental stakeholders and practising dentists. It will not surprise you that I have had lots of approaches from different colleagues talking about the potential for a dental school in their area. I am aware that a lot of graduate dentists will stay where they trained so, obviously, if there is a dental school in an area, it is more likely to have the pick of the crop.

Equally—we have not covered this yet—there is the important point that at the moment graduate dentists, who cost the taxpayer more to train than, for example, GPs, do not have a tie-in to do NHS work. Commensurate with the issue of where we have dental schools, we are going to consult on whether there should be a graduate tie-in to require new graduate dentists to do some work in the NHS as part of their payback for the cost of the training that they received. The work on looking at new dental schools will be tied up with where we need dentists to be located.**Mrs Hamilton:** My final question—it all ties in—is related to the last panel. Thea Stein made a really poignant comment that stuck with me: dentistry has been neglected for decades. As I told the last panel, I found a new dentist recently and I was delighted. I could have kissed her. Anyway, the point is that none of my records graduated over to her. As part of what you plan for the future—I know that the Prime Minister and others have talked about IT, which was highlighted in the Budget—what is being done to ensure that NHS dentistry starts to really develop in the area around IT and IT development, so that notes can be moved around with the patient, especially when patients have many other conditions?

Andrea Leadsom: Actually, connectivity, as the Chairman will appreciate, having had my role before, is key in primary care, whether opticians, dentists or GPs, and in the link to secondary care. I am sure that you will be delighted that, at the Budget just gone, the Chancellor allocated £2.5 billion to improving technology and data, and linking up different record-keeping and so on, within the NHS.

Q202 **Mrs Hamilton:** Will that include dentistry? Will there be new money for that in dentistry?

Andrea Leadsom: There is new money to upgrade IT and connectivity in the NHS. The discussions about exactly where that goes are under way. Amanda, do you want to comment on that?

Q203 **Chair:** It will include wider primary care, which is obviously where we are.

Dr Doyle: Investment in IT includes the whole of the NHS system. Detailed plans have not been made yet about how that is applied, but it is really important, as the Minister says. General practice is a very highly digitised part of the NHS, but wider primary care—pharmacy, dentistry and optometry—is much less so. We have made huge strides forward in digital connectivity for pharmacies, as part of the access recovery plan and Pharmacy First, but you are absolutely right—

Q204 **Mrs Hamilton:** I know about all of those. My point is whether dentistry will start to see some of this, taking you back to what Thea Stein said: dentistry has been neglected for decades. We do not want it to be continually neglected because something as simple as IT has not been planned for in that area.

Dr Doyle: I absolutely recognise that we have not, since the 2006 contract was put in place, fundamentally made reforms of dentistry, until we started to implement the current changes in summer '22, and then with the recovery plan and the contract reform that we are looking to consult on. Absolutely, part of considering that reform will be looking at the enabling infrastructure, for want of a better term, which includes IT as well as the structure of the contract.

Andrea Leadsom: Paulette, I will take that point forward.

Q205 **Mrs Hamilton:** Please. Because I will ask again.

Andrea Leadsom: Of course. I would expect you to.

Q206 **Mrs Hamilton:** The rest of it is really important, but these guys want to feel like equals.

Andrea Leadsom: Absolutely. Understood.

Q207 **Chair:** Minister, I thought I might just give you a chance to give some hope to the sector. A lot of work has gone into the plan over a long time. Nuffield said it is "not going to be anywhere like big enough to restore universal access to NHS dentistry." The British Dental Association said, "This 'recovery plan' is not worthy of the title. It won't halt the exodus from the workforce." Healthwatch England said it was "a good start", in the Government's own press release. It is a recovery plan. The clue is in the name. We had a pandemic that massively impacted close contact clinical services, of which dentistry is as close as you get. I want to give you a couple of minutes to give some hope to the sector, who will be listening to this session, that yes, this is a recovery plan. It might be a good start but it is a start, with a lot more to come.

Andrea Leadsom: Yes, you said it yourself, Chairman. This is better than where we were before. This will significantly improve the capacity and incentive to dentists to deliver on their NHS contracts. It will also, as I have outlined, provide the golden hellos, the dental vans, and the increased capacity through dental therapists. We have not talked about the overseas registration, but the provisional registration will make a big difference. Graduate tie-ins and looking at new dental schools are all part of the review that I will start on what I keep saying is 27 March. I hope I am right. It is certainly in March.

Q208 **Chair:** Sounds good.

Andrea Leadsom: It sounds good, and I hope you will be there and able to report back to your Committee. What I would say to the sector is, please just work with me. Give us the chance to reform the contract. I totally understand, and have heard time and again, that the UDA is not working. I am absolutely committed to fixing this. I would really love to see that being a very quick turnaround. It is clear to me which things could change to make a significant difference, and we have already made a very good start on that in just the last couple of months, so I ask the sector to stick with it.

I want to end by saying that I think the Smile4Life is a game changer. I know I am always banging on about babies, but I really think that that is where it all begins. It is incredibly important that we focus on good oral health right from the start.

Chair: That is a good place to start, and it is a good place for our session to end. You can find us @CommonsHealth on X, where you can keep up to date with all the work we are doing. Thank you for tuning in and thank you very much, Jason Wong, the interim chief dental officer, Dr Amanda Doyle from NHS England—nice to see you—and the Minister, Dame Andrea Leadsom MP. That concludes the session.