

Public Accounts Committee

Oral evidence: Fixing NHS Dentistry, HC 648

Thursday 13 February 2025

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[Watch the meeting](#)

Public Accounts Committee members present: Sir Geoffrey Clifton-Brown (Chair); Mr Clive Betts; Anna Dixon; Peter Fortune; Rachel Gilmour; Lloyd Hatton.

Health and Social Care Committee member present: Danny Beales.

Gareth Davies, Comptroller and Auditor General, National Audit Office, Lee Summerfield, Director, National Audit Office, and David Fairbrother, Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1 - 101

Witnesses

[I](#): Professor Sir Chris Whitty, Interim Permanent Secretary, Department of Health and Social Care, and Chief Medical Officer for England; Jonathan Marron CB, Director General for Primary Care and Prevention, Department of Health and Social Care; Amanda Pritchard, Chief Executive, NHS England; Dr Jason Wong MBE, Chief Dental Officer, NHS England; Ali Sparke, Director for Pharmacy, Optometry and Dentistry, NHS England.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Report by the Comptroller and Auditor General
Investigation into the NHS dental recovery plan (HC 308)

Examination of witnesses

Witnesses: Professor Sir Chris Whitty, Jonathan Marron, Amanda Pritchard, Dr Jason Wong and Ali Sparke.

Chair: Welcome to the Public Accounts Committee on 13 February 2025. There has been a widespread perception that NHS dentistry is in a state of crisis, with huge regional variations in access to dentistry. In 2024, the previous Government published their dental recovery plan, aiming to increase access to NHS dentistry by more than 1.5 million additional courses of treatment in '24-25. The NAO Report in November '24 found that the plan was not on course to deliver these extra courses of treatment. Even if the target were reached, there would still be 2.6 million fewer treatments per year than at pre-pandemic levels.

Today, we will be examining current levels of access to NHS dentistry; how the Department and NHS England set up and monitor the dental recovery plan; and the plans to improve access to NHS dentistry and reform the dental contract.

To help us with all that, we are very pleased to have with us Professor Sir Chris Whitty, who is the interim permanent secretary at the Department of Health and Social Care and the chief medical officer, as we know from our television screens; he was chief scientific adviser to the DHSC from January 2016 to August 2021. Jonathan Marron CB is director general for primary care and prevention at the Department of Health and Social Care; he was previously director general of the Office for Health Improvement and Disparities at the DHSC.

We are pleased to see back again Amanda Pritchard, who has been chief executive of NHS England since July 2021. To my extreme left is Ali Sparke, director for pharmacy, optometry and dentistry at NHS England; he has been in the role since August 2021. Between them is Jonathan Wong—sorry, Jason Wong. I am getting a new pair of specs; the lenses are ready for collection, and they will be bifocals so I can read things and see you all at a distance. Jason Wong is the chief dental officer for England at NHS England, in which role he is head of the dental profession in England.

We extend a particularly warm welcome to Ali Sparke and Jason Wong, as this is their first time in front of this Committee. Welcome, both of you, and a warm welcome to you all. Professor Whitty, how do you like to be referred to?

Professor Whitty: However you wish, Chair, but most people call me Chris, informally, or Professor Whitty, formally.

Q1 Chair: Right. Whichever Committee members want, then.

We have received, with fairly late notice, a letter of 11 February informing of us of an error in some calculations. Perhaps Professor Whitty or Amanda Pritchard could start by explaining the exact implications.

Amanda Pritchard: I am happy to take that one, Chair. We wanted to be completely transparent with the Committee, so as soon as we became aware that there was an issue with the modelling, we wanted to share that with you in advance of the hearing today.

My colleagues can give more detail, but basically what has become clear is that in taking account of what the £200 million funding for the plan would buy, we have overstated the number of new patients that that would cover, partly because there were some costs that were not included and there were others that were included. That was compounded, despite multiple Department of Health and NHS England reviews.

In practice, there are two things worth noting. First, the gap in funding to get to the number that was in the plan is about £33 million, well within the scope of the underspend and the total dental budget, so it did not impact on the operational ability to deliver the new patient premium. Nor did it flow through to systems when they were doing their allocations; they got the right numbers, not the wrong numbers. Secondly, it does not change the fact that this was not a successful plan.

Chair: Anna Dixon, do you want to examine that?

Q2 Anna Dixon: Yes. The NAO Report suggests, on the wider modelling underpinning the plan, that it was recognised back in March of last year that there were things that were not giving confidence. It is very disappointing that something as fundamental as the costs and number of appointments was based on flawed analysis. What confidence do you have that the modelling capabilities in support of any of your dental recovery work, now and in future, will meet the basic standards that an analytical service within Government should?

Amanda Pritchard: We have now designated the dental service as a business-critical model. That means that we have additional resource, but also quality assurance on anything that comes out of that model in future.

Q3 Anna Dixon: Why was there no quality assurance on it?

Amanda Pritchard: There was—I mean, it was a mistake, so I think we just have to hold our hands up. There were multiple people, both from NHS England and from the Department, who looked at these figures over a prolonged period, and they did not spot it. It is with apologies to the Committee that this has come out so late in the day.

Q4 Anna Dixon: Do you also have to notify formally the national statistician? Are there any other actions that you will be taking?

Amanda Pritchard: We have formally notified the NAO and will take advice on whether we need to formally notify anybody else. I would just say that the one reassurance is that it actually has no material impact



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either on what was said in the plan or on the ability or otherwise to deliver.

Q5 **Anna Dixon:** Is that because of the assumptions about the underspend?

Amanda Pritchard: Exactly.

Chair: Danny, do you want to come in?

Danny Beales: Yes, just briefly. I am guesting today on behalf of the Health and Social Care Committee.

Chair: I am sorry; I should have welcomed you. You are very welcome, Danny.

Q6 **Danny Beales:** Thank you, Chair. You did welcome me informally.

Back in March last year, as my colleague has mentioned, the Health and Social Care Committee looked at dentistry. It became clear to the Committee at that point that there were concerns about the modelling. In its evidence, the BDA raised concerns about the modelling. Based on the history of that concern, when was this designated as business-critical? When was extra quality assurance put in place—is it now, or was it following the concerns almost a year ago when the modelling was questioned?

Amanda Pritchard: Transparently, it is now. The NAO, I have to say, also did not pick up that there was an error, I think because it is so complicated.

Q7 **Danny Beales:** The Health and Social Care Committee, of which I was not a member at the time, is a respected Committee of this place. It heard the concerns about the modelling and raised them formally in its inquiry. It sounds as if those concerns were true. They were put to the Department and NHS England, but no action was taken. In response to the concerns, the then Minister said that in fact, while the modelling might not be fully correct, they were under-promising and were likely to over-deliver. That simply is not true, is it? As we have seen, you have under-delivered even on the poor modelling that you yourself had at the time.

Amanda Pritchard: Let me just say again that we have had multiple people look at this and nobody has spotted it, so it was not that people were not going back and checking again. In fact, we did an FOI response, I think in January, which again, I am afraid, repeated the same errors. Lots of people have looked at this and lots of people have not spotted it.

Q8 **Danny Beales:** From the evidence we have heard, the Health Committee and the BDA did spot it, but were not listened to.

Amanda Pritchard: Yes, and I am not at all defending the fact that we missed it. All I am saying is that after prompting from the BDA and others, multiple people looked at it again and did not spot it. It has now become clear, so we just wanted to be completely transparent.



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In terms of the impact on delivery, though, the size of the dental underspend last year meant that there was actually more funding available in practice. The fact that that was not included in the original model has not hampered people's ability to get on and deliver. That is no defence, in terms of the model, but I would not want the Committee to think that that was part of the reason that this was an unsuccessful initiative. That was not the reason that this did not work.

Danny Beales: I would just put it to you that perhaps it suggests something else to reflect on, if a parliamentary Committee and the BDA—the industry representative group—raises concerns about modelling, and yet quality assurance does not happen until an NAO Report a year later re-highlights the issue. That might be a learning point to take away. I will leave it there.

Chair: Thank you, Danny. Your point is very well made.

Q9 **Rachel Gilmour:** I am astounded. I have people in my constituency who live in acute pain for months, and sometimes years. When you are doing your work as a senior civil servant, do you bear those people in mind?

Amanda Pritchard: Is that to me? I am not a civil servant.

Rachel Gilmour: Yes—or to whoever is.

Professor Whitty: Well, I suppose I am a civil servant. To be clear, everybody on this side of the table is extremely concerned about dentistry, as indeed is everyone on the Committee. This has been a problem that has been slowly getting worse since the early 1990s. It is not a sudden, recent problem; it has been steadily getting worse.

We all see the harrowing stories in the press—there were more yesterday, and there have been all the way through. I am a frontline clinician; all of us see patients very much in the front of things. Anybody looking at dentistry in the round over decades, through multiple Governments, would say that the NHS dental system is very weak and has got weaker over time. The most recent things—the immediate things that the NAO has looked at—are important and demonstrate the fact that these are not easy fixes, but I think we would all say that this is a problem, particularly for those who find it difficult to get dental services when they need them in states of emergency.

Q10 **Rachel Gilmour:** All the more reason to have noted what the Health Committee and the BDA said a year ago.

Professor Whitty: Well, I would note that the chief medical officer, which was my job at that stage, has nothing to do with dentistry, because we are fortunate to have a chief dental officer, so I tended not to get involved in dentistry.

On the point that the chief executive made, I would say two things. First, the reasons that there were problems with this initiative over the last year are actually unrelated to the modelling. In fact, if the modelling had



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caused us a problem, that would have been a good thing, because we would have overperformed compared with where the modelling took us. Actually, what has happened is that the system has underperformed. While we absolutely must get the modelling right—I fully accept the points that have been made—I do not want people to draw a line of sight to saying that the modelling is the reason why there were problems, either with dentistry or with the initiative that was being considered by the NAO. Those would have occurred irrespective of the modelling. The modelling was to one side, in a sense, but we wanted to be entirely transparent in our response to the Committee once this had been identified.

Chair: Just to put it into context, Sir Chris, we have some constituency figures. With 382 courses of treatment per 1,000 people, Tiverton and Minehead, which Rachel Gilmour represents, has the worst figures in the country, so I think she has a right to be thoroughly outraged by this whole matter. My constituency of North Cotswolds, incidentally, is not far behind; we will be coming on to questions about inequalities across the regions. It is not acceptable, I would suggest, that Rachel's figures are at nearly half what the best figures are, which are for Clive's constituency. I just do not think it is fair that some constituencies are getting half the treatment that others are.

Q11 **Rachel Gilmour:** I am having to write two, three or four times to my local ICB, chasing NHS dental contracts that dentists who come to my surgery say that they have been offered but cannot get. It is a disgrace.

Professor Whitty: In a sense, I do not think that there is any disagreement from anyone in this room about the points that you have just made. My point was that this has been a long-standing problem that has been there for decades and has been getting worse. It has got worse since the pandemic—there is no doubt about that at all—but this is not a sudden and new problem. The disparities you have talked about have, unfortunately, been long-standing. Everyone should agree that NHS dentistry is in a much weaker state than most other areas of the NHS. I am sure we will come on to the reasons for that during this Committee hearing.

Q12 **Chair:** We will. I want to move on, but before I bring in Anna Dixon, let me quote from the evidence we have received from the Association of Dental Groups—a well-respected body, I think. I will want a yes or no answer from both Sir Chris and Amanda, please.

The association says that, based on the 2006 contract, "Currently the NHS dentistry contract is not fit for the purpose it was developed for...it can no longer cover even 50% (or less) of the UK population that it was designed for." Professor Whitty, is it fit for purpose—yes or no?

Professor Whitty: Asking someone like me for a yes or no, you are going to struggle. The short version is that I broadly agree with that—

Chair: Brilliant.

Professor Whitty: I do not agree with all the—



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Chair: No, no: that is all we need at the moment.

Professor Whitty: But broadly I agree with that.

Chair: Amanda Pritchard, yes or no?

Amanda Pritchard: Is the contract fit for purpose? No.

Chair: Brilliant. At least we are all starting from a common base. That is really helpful; thank you for the brief answers.

Q13 **Anna Dixon:** Sorry, I should have declared my conflict of interest: I previously worked as a civil servant in the Department of Health.

Today, we are looking at the so-called dental recovery plan. When it was published in February 2024 under the previous Government, it set out some ambitious aims for an additional 1.5 million treatments, equivalent to 2.5 million appointments. Are we on track to recover?

Professor Whitty: I will have a first go at that, and then others will want to join. The very short version is no. Within the dental recovery plan there were four components, of which I think one did not start at all. That was on dental vans; you might want to come back to that, but it was one of the smaller ones. The other three elements were aiming to address recognised problems. The problems were real—everyone, I think, would accept that, including dentists and people who look at this field—but the solutions were unsuccessful.

The first of the three problems to address was that dentists would say—the chief dental officer, I am sure, could give you better information on this—that the first appointment for a new patient takes longer, or at least should take longer, and is potentially more complex than an appointment for a repeat patient, and yet there was no incentive to take on new patients. There was a patient premium of £15 for a simple event or £50 for something which required greater measures. The aim was to address a problem that had been identified by dentists as one of the reasons why people were not taking on new patients in the NHS.

The second issue was about areas of the country where there is a particular lack of dentists. We have heard, absolutely rightly, that some areas are even worse than others, but there is no area of the country that is good on this. There was therefore a scheme—I will loosely call it the golden hello scheme, because I think that makes it clear what it was—which was a £20,000 premium given over three years to move to those areas. These were areas that had had long periods of dentists being advertised, but that were not able to fill posts. This was a way of trying to incentivise that.

The third problem was that the minimum unit of dental activity—UDA—amount has separated a long way from what a dentist would be able to make in the private sector. That is fundamental to why many of the problems exist. The minimum amount that would be paid was to be increased to try to remove that disparity. It applied only to a relatively



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small number of practices, but it brought them closer to the market median amount of money that people could make.

The concept behind them all was, theoretically, entirely reasonable. Of those, one of them clearly failed: the new patient premium. The reason that we can say it failed is that the expectation was that it would lead to an increase in people taking on new patients. There was evidence of an increase, for a short period, in practices saying that they would take on new patients, but the numbers show no evidence of any increase over what you would expect over the following years, so I think we would all accept that that one did not work.

The golden hello started relatively late, and I think it is too early to say how effective it will be in the long term, but some people have come into areas that have been difficult to enter. I would give it a provisional “let's see” rather than an absolute fail: it had not achieved its goals by the time the NAO looked at it, but that was relatively early on. These things take a period of time, so I would not want to say anything now.

On the UDA uplift, I think anybody who looks at the dental contract would agree that the gap between NHS UDAs and what someone would make in the private sector is part of the issue. The logic behind that was reasonable. But the most expensive of those was the new patient premium; it was also the one that was expected to have the biggest impact, but I think we would all accept that it did not. That is a statement of fact.

Q14 Anna Dixon: Thank you for explaining clearly and in lay terms the different elements of the plan. I know that colleagues will come back to those, but I was really thinking about the headline: are we or are we not on track to deliver the 1.5 million? If not, how many additional courses of treatment have been delivered under the plan? That may be a question for Amanda.

Amanda Pritchard: I am sure that Ali can provide a bit more detail. Overall, as Sir Chris said, or as Professor Whitty said—I have forgotten which we are calling him today—we are clear that the new patient premium, which was designed to drive more activity, has not only not delivered that but, as per the NAO findings, has produced fewer new patients this year. Overall, UDA activity is on track to be about 1% higher this year than last year. That is in line with the sort of increases that we have seen over previous years. That would not suggest that the impact of the measures has resulted in anything like the outcomes that were hoped for.

Anna Dixon: I am trying to get a number in relation to the 1.5 million, but I have not yet heard “We have delivered x”. Have we delivered any additional appointments?

Ali Sparke: I do not think we have evidence that we have delivered additional appointments yet, in-year. We have seen roughly 2.7 million new patients coming through already, but that is on track with what we



would have expected if this year's performance had been similar to last year's. In terms of the impact of the golden hellos and the £28, we need to look at the year-end data this year to see whether the contracts affected have seen an increase in performance. That is a small part of the 1.5 million, but I think it is too early to say at this point that we have delivered towards the 1.5 million.

Q15 Anna Dixon: In terms of recovery, relative to before the pandemic, some of the data suggests that there are 4.7 million fewer treatments than before the pandemic. We are still way off even recovery, recognising that even before the pandemic, dentistry was in a parlous state.

Ali Sparke: I think that that is correct. We have seen access across adults and children increase since the pandemic, but they are not yet at the levels that we saw prior to the pandemic. For example, as of 2024, we had seen about 40% of adults in the previous 24 months; before the pandemic, it was more like 48% or 49%. For children, that was 56% in the previous 12 months—we measure that on a different timescale—whereas before the pandemic it was 59%. Access for children has recovered slightly more quickly, because we tried to prioritise that, but it is absolutely true that access overall has not recovered to those levels.

Q16 Anna Dixon: I suppose the other measure is the extent to which people are accessing at all. As we have said, pre-pandemic only half of all people were accessing anyway—we may come on to some of the more fundamental issues with dentistry in general and how they are going to be resolved. We are also seeing dentists continuing to opt out, reducing the number of NHS hours, and some are giving up on NHS practice altogether. Is there any recovery there, or is it still going in the same trajectory that it was pre-recovery plan?

Ali Sparke: We actually have a similar number of dentists doing NHS activity than we had before the pandemic. It dropped slightly in '21-22 and it has climbed back up again, but the fundamental point that you are making is correct. On average, dentists who work in the NHS are spending slightly less of their time on NHS activity now and slightly more doing private work. Some of that is for some of the fundamental reasons that I am sure we will come to, which have to do with the attractiveness, or otherwise, and the performance of the underlying contract, but there are also broader workforce issues that are playing out in different parts of the country.

There are also other conditions, which have to do with the amount of money we have at the moment. You have already mentioned that we have enough to cover roughly 50% of the population, but we are not making the best use of that money in the most flexible way, for example to enable money to be moved from underperforming contractors to highly performing contractors. We have taken some steps on that, which I am happy to go into, but those are some of the fundamental reasons why we have seen some of the trends you are describing.

Anna Dixon: I will leave it to colleagues to follow up on that point, but



thank you, Ali.

- Q17 **Chair:** Can I just follow up on something? In preparation for this hearing, I got a brief from the Gloucestershire ICB. One of the things in that brief, which is absolutely shocking, is that 16.8% of five-year-old children in Gloucestershire have dental decay. This is storing up huge problems for the future. What more can be done to make sure that children, particularly young children, are receiving the correct education to do something about this—either via their parents or, if that does not work, in schools, or, if that does not work, in the health service system. I do not mind which of you covers that.

Professor Whitty: Others may want to add to this, but I will have a first go, because prevention of dental decay is something that I have been heavily involved in over time.

There are essentially three components to this. The first is trying to reduce the things that are likely to increase dental decay. One of the most effective measures, in broad terms, is the sugar levy. It was brought in for different reasons—it aimed to address obesity—but there is clear evidence that it has led to a reduction in dental decay. There was an inflection point and a reduction; I have the numbers in my notes and can give them to you. Reducing sugar in the diet, all the way through from the very first point at which children are weaned, is a critical part of reducing dental decay.

The second component, which affects older children but is important, is smoking. Smoking is a big risk factor for both dental disease and gum disease. Again, actions that are happening in this House at the moment will in due course have a positive effect on older children's health. That is less true further on.

The third thing, in terms of more general stuff, is extending water fluoridation, which we know leads to a significant reduction in dental decay, particularly in areas of relative deprivation. The evidence for that is around us from multiple environments. Only 10% of the UK population has water fluoridation at the moment. The figure is much higher in most other countries—up to 80% or 90% in some countries. There is currently a consultation for the north-east; I hope that the Government will respond to it very soon and then look elsewhere.

Those are things you can do across the board to reduce caries and dental damage in children in general. Then you come on to the specific actions. There are things that parents and schools can help with, and the Government can as well. Supervised toothbrushing is probably the most important. The current Government have put a lot of emphasis on that and are trying to work out ways to increase it. In a dental context, fluoride varnish is also highly effective at protecting teeth. The third line of defence, of course, is going to the dentist, and dentists dealing with things at an early stage of disease rather than waiting until teeth have got to the point at which things are damaged. It is a very sad reality that the commonest procedure for which children go into hospital is extraction of

teeth due to severe dental caries, which sets them up for lifelong poor dental health.

- Q18 **Rachel Gilmour:** And costs the NHS a lot of money. We all know—we see it time and again on this Committee, but it does not seem to be getting through—that prevention is cheaper than cure. The answer that you have just given is “These are all the things we can do: fluoridation and this and that.” The bottom line is that children need to have access to a dentist.

Professor Whitty: On both points, I completely agree. Prevention is absolutely critical. Much better than having a small tooth decay, which a dentist deals with, is not to have one at all, so I totally agree on prevention. I also completely agree—all of us would agree, and I am sure that the chief dentist would firmly agree—that dentists’ ability to get to children at the earliest point and deal with problems early is critical.

Dr Wong: With the statistics on five-year-old children, we have to look at the culture of prevention back in the home. We have not really normalised those messages as we have with the rest of healthcare. Simple things like “Twice a day; fluoride toothpaste; spit, don’t rinse”—are not part of our culture.

We looked at the return on investment for various measures, including water fluoridation, which came out on top; supervised toothbrushing, which is a focus; and focused toothbrush and toothpaste packs. That work is going on, and innovation is going on. A local authority will lead on that, where it is being focused on, and there is the new Government’s manifesto pledge on supervised toothbrushing.

There are also the cultural and demographic effects. The impact tends to map with deprivation, so the wider context needs to be taken into account. The impact in terms of the level of decay is also important. With the statistics that we all do not like seeing, on extraction, general anaesthetic and tooth decay, again it is about the impact and the inequalities. One of the struggles is how we target that, as well as access to dentists.

Rachel Gilmour: Can I give you a hint? Minehead, in my constituency, is 324th out of 324 on the social mobility scale. It is deprived. It also has the lowest amount of dentists in the country. Please will you take that statistic away and try to do something about it? If it means talking to the Somerset ICB, that would be great, so I do not have to write to it a fourth time.

- Q19 **Chair:** The NHS Confederation states in written evidence that “the ten-year health plan must commit to reforming the dentistry contract focusing on outcomes and incentivising prevention.” Professor Whitty, can we have your assurance that it will do that?

Professor Whitty: I am going to be a bit cautious here, simply because I am not a Minister; I am an official. What is in the 10-year plan is absolutely for Ministers, but they have made it clear that they want dentistry to be part of their plans. They fully recognise all the problems

that are there. All the current Ministers have made statements to that effect at various points.

If I may, I will read out something that came from Minister Kinnock, the Minister responsible. He wrote in the newspapers this week that we are bringing forward “fundamental change” that can get the sector “back on its feet”, but the problems in front of us are “increasingly evident”. I wanted to read that out, because those are his words—that this is about fundamental change.

Q20 Chair: That is really helpful. That fundamental change will hopefully involve more treatments by dentists. That will inevitably lead to more hospitalisation of dentistry. Shouldn't hospitalisation of dentistry be included in the whole dental programme?

Professor Whitty: I think the chief dentist would probably be a better person to answer that question.

Chair: I am very happy for him to answer.

Dr Wong: I think dentistry is focused about 90% or 95% in primary care. That is where the delivery—

Chair: That is the point of the question. I hope that we are going to improve primary care—that is the whole thrust of this hearing—but inevitably that will put more pressure on dentistry in hospitals, so should that not be included as well?

Dr Wong: Yes, I think it should. We have done quite a bit of work in moving quite a bit of hospital dentistry into tier 2 services across the country, although, again, not consistently. It is patchy across the country, but a lot of treatment can be carried out via enhanced services, and we are practising carrying out tier 2. We have set frameworks for the tier 2 accreditation, so that can be done. But yes, it definitely needs to be taken into consideration, because whenever you have more access to primary care, referrals will be generated.

Q21 Chair: I want to follow up on Anna Dixon's excellent questions; after all, she was a very senior civil servant and understands these issues. Amanda Pritchard, clearly the premium is the biggest part of the delivery of the whole system. What decision has been taken on its future?

Amanda Pritchard: The premium will end at the end of March.

Q22 Chair: What will replace it?

Amanda Pritchard: I should say that it was always intended to be a one-year interim position, and it will end as intended. It has not worked, so at the moment there is no obvious logic in continuing it.

The thing that we are focusing on next, which is a very clear priority for the Government, is the delivery of the 700,000 additional urgent dental appointments. We have been very clear, in planning guidance that has gone out recently, that we are expecting commissioners to begin to plan

for that now. Through Ali and Jason, we have begun engagement with commissioners to help them plan for that.

Crucially, we are learning the lessons of what has not worked. One of the things that we will be doing this time is being very clear, as per planning guidance, that we are expecting local commissioners to commission additional activity—not as part of the core contract, but additional activity. We have examples across the country of where some ICBs have done some interesting and effective work on that, including in Manchester and the London hubs. Norfolk and Waveney has done it through existing practices taking on more work. We have an interesting example in Suffolk, which has a partnership with a university. There are models out there that we know work, including in some of the rural areas that are more challenged around access. Part of what we will be doing is performance-managing that through ICBs over the coming year.

- Q23 **Chair:** That is all very well, but they need to be funded for it. In Rachel Gilmour's constituency or mine, I suspect that the only way the ICBs could do that would be by taking the money from somewhere else. How will all these extra initiatives be carried out in areas like Rachel's and mine, which are already struggling with the costs on this?

Amanda Pritchard: Unfortunately, your areas are examples of where too much money is being returned to the NHS because it is not being spent on dentistry. The funding is there to do this work, but rather than expect it to be done as part of the core contract, we will be treating it differently, because that is one of the big learnings from this.

- Q24 **Rachel Gilmour:** But in an article in *The Guardian* today, the headline is that dentists are "walking away" from the NHS because it loses them money to work as a dentist in the NHS. You can talk about modelling and this and that, but the basic facts are that dentists, with all the good will in the world, cannot afford to stay within the NHS. They are walking away, and their membership body has told you that.

Ali Sparke: That is a really important point. A lot of the experience we have seen over the last year is from ICBs that are starting to commission additional urgent care activity, but not through the core contract. It is through additional sessions—often additional appointments, commissioned by different routes. That is really important, because we accept your fundamental point, which is that the core contract is not working properly for urgent care at the moment. It is not differentially remunerating for the amount of care that patients need, and it does not set a core capacity that each practice needs to deliver.

What we are trying to do is build on a lot of the good work that has been in place in different parts of the country—certainly in the places where access is poorest, and I think your constituency is among them. We have put a ringfence in place again for this year, which means that dental funding is protected. That means that the money they know they will not be able to spend on some of the contracts for the underlying reasons you are describing will be available to commission these additional services,



which will not suffer from the same problems as the core contract has, which is one of the reasons why we are not seeing the delivery.

- Q25 Chair:** To follow that up, let us go to paragraph 1.19 in the NAO Report. There are 34,520 dentists registered with the GDC, of which only 24,193 are providing some NHS dental care, and that figure has dropped by 483 since 2019-20. Ms Gilmour is right: unless you incentivise dentists properly, they will not be there to treat people. What is the fundamental thinking within the NHS and the Department that will change that? How are you going to change the culture of dentists to want to provide NHS treatment?

Rachel Gilmour: When it does not lose them money.

Ali Sparke: It is an absolutely fundamental point. I have a couple of things to say. The first thing is that we are talking today predominantly about the dental recovery plan. It is important to be clear that that plan and the new patient premium as an example within it were not intended to address the underlying issues you are both describing that are facing constituents in your areas.

We started a programme of reform in 2022, which made some initial changes to start to help move the dial on some of the things that dentists were telling us. We have known and recognised even since that point—in fact, it was a commitment in the plan last year and under the previous Administration—that further reform is absolutely fundamental to changing the incentives and making sure that dentistry remains attractive to NHS dentists.

We have worked quite hard over the last year and a half to look at a number of different themes, and we have an understanding—I am really happy to go into more detail, if it is useful to the panel—of some of the core issues that we would need to tackle and the ideas we have started to develop to address some of the issues that we are seeing, a couple of which we have touched on.

Chair: We may well want to come back to it, because this is so fundamental, but we have a lot to cover. Let us see where we get to. Thank you for that important question, Ms Gilmour.

- Q26 Anna Dixon:** I would like to move on to another element of the recovery plan, which is the uplift in the UDA, or units of dental activity. It was set at £28, I presume with the hope that it would better compensate dentists. What analysis have you done of the impact of the uplift in the UDA?

Ali Sparke: It comes back to the conversation we had earlier, which is that we are still in the first year of seeing the impact of that uplift. It affected roughly 850 contractors, obviously to different degrees. We did have a minimum UDA value in place before it was established for the first time in 2022. We had some evidence from the previous analysis that raising the UDA value was associated with slight improvements in activity, and, for the reasons Professor Chris gave earlier, it was the right thing to



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do given the huge range of prices that we were paying dentists for the same activity.

We will see. It is too early to say definitively what impact that has made. The qualitative, anecdotal feedback so far is that it has been important in supporting the sustainability of those practices, but we will see more quantitative data once we look at the activity over the full year. We will know that at some point in early 2025.

Q27 Chair: I would like to get your reaction to this, while we are on UDAs, which Ms Dixon rightly raised. The NHS Confederation told us in evidence that the UDA system “fails to consider the complexity and cost of the treatments provided. For instance, a simple filling that ‘costs’ three UDAs is reimbursed the same amount as a more complex treatment involving five fillings, a root canal, and an extraction—also classed as ‘costing’ three UDAs.” It is not only the amount; it is what they are supposed to cover that is a problem. I do not know which of you wants to cover that.

Professor Whitty: Shall I have a first go at it? The danger is that we get into the weeds, and then we can then get into more of the detail, which is really important. Firstly, one of the fundamental points is about not necessarily automatically accepting what the British Dental Association—which is a union, just like the British Medical Association—is saying. I am not going to accept all their numbers as the correct numbers; I am not commenting on them one way or the other.

The general principle is that, if you go back to the early 1990s, 90% of dentists were getting two thirds or more of their income from NHS work. What has happened since then—Dr Wong can probably give more details on this—is that the gap between NHS work and private work has started to widen. Additionally, a number of things available in the private sector, particularly cosmetic, are not available in NHS care.

So a dentist, perfectly reasonably—this is not a criticism of dentists; it is a perfectly reasonable position—is now essentially faced with a much higher financial incentive to go down private routes in many situations than to go down the public route. That is the fundamental problem, as far as I can see it.

Within that—this goes directly to your question—the structure of the dental contract has been a disincentive to do some of the more complex work. There was a reform in 2022, which I think was the first reform since 2006, that actually made a useful difference. It split what was called band 2—I am now getting into the weeds—which really was everything from a relatively simple procedure to a complex procedure, into three subcomponents, recognising that more complex things, of course, took more time, and therefore should be remunerated on a scale commensurate with the additional time they took.

It was clear that that was a step in the right direction, but what it did not do, and has not done, is fundamentally deal with that first issue—the gap. In a very mixed economy, compared with other bits in the NHS, the gap

between private provision and NHS provision is there, and most dentists do both. So in a sense, they have a choice. That is the real issue.

- Q28 Chair:** I am really sorry, but I just want to come back on this. That was a rather long-winded answer, but there is a fundamental question in here, which I raised earlier. It is no good addressing the world of dentistry as we might like it to be; we have to address it as it is, and the fact is that that finite number of 34,000-odd dentists have to be properly remunerated, otherwise they will increasingly go to the private sector. Are we at least agreed on that as a basis?

Professor Whitty: You have put rather more concisely what I said—I was trying to put a bit of technical detail underneath it—so I agree with that point.

Chair: Good. Anna Dixon?

- Q29 Anna Dixon:** I would like to carry on probing on the way that we are currently paying for dental care. I will also quote the NHS Confederation, which says: “The current NHS dental payment system, based on...UDAs...has led to inefficiencies in both care delivery and budget allocation, with many dental practices avoiding NHS work due to uncompetitive rates. This has resulted in underspending on dental budgets locally and poor access to care for patients, particularly in the most deprived areas.” The Nuffield Trust, which is independent and respected, is also saying that this model “inherently fails to recognise variable patient complexity, disincentivising treatment of those with the greatest needs.”

It is not only about the differential in price between the private and the NHS sector; dentists are actually losing money on some of these procedures. There is a suggestion that, for dentures, they might be losing as much as £42.60.

I guess that is why one of my constituents, Graham, who needed to go to a dentist to get new dentures fitted, was faced with a very long waiting list to get access to NHS dentistry, which obviously had a significant detrimental impact on his health; he lost weight because he was finding it so difficult to eat. He actually got the problem solved through a referral to a community dental team—which I assume is completely outwith this sort of usual general dental practice contract model—so thankfully he has managed to get an expedited health appointment, but that is sort of getting around what is otherwise a broken system.

Coming back to this point, okay, we agree that the UDA is not properly recompensing, so why did you think that uplifting it to just £28 was actually going to have any impact? We have received local examples where they have tried £30. Why not £35? Was this a question of cost? I am trying to get at what you thought the £28 was going to achieve.

Ali Sparke: You are drawing a really important distinction between the absolute value associated with the UDA for any one particular practice and the amount of UDAs we then pay for the care that is delivered—

Anna Dixon: Procedures.



Ali Sparke: Yes. Both are real issues, and they both need separate remedies. The first issue is about ensuring that there is at least a minimum amount of income available for a practice, and that it is not disadvantaged for doing a check-up for which another practice would be paid significantly more. That is why we raised the minimum UDA value, but that is not the whole answer.

The next step—this is exactly what we started to do in 2022, but we have to go a lot further—is to differentiate, exactly as Sir Chris said, in a much clearer way so that the types of patients it is not attractive to treat on the NHS are better funded and better incentivised. That means creating further distinctions and making more funding available for the people who need it most. That requires us to make more significant changes to the remuneration mechanisms than we have already done.

Q30 **Anna Dixon:** Yes. Obviously, lots of suggestions have been made about dental contract reform, and I am sure we will come on to that—or should we just ditch that and recognise that we need to directly commission community-based health? Would not that be better value for money ultimately and a quicker remedy than doing some of these things that obviously have not resulted in getting better access for the patients who most need it?

Ali Sparke: Dr Wong may want to come in on the community issue. It is important to point out that community dental services provide a very distinct function within the system that we have at the moment. They complement the access that we have to primary care, but they are focused on particularly vulnerable groups. There is a different mechanism, and a different set of provisions exist for those patients. We absolutely need to get both right, but I don't think one is a replacement for the other.

Q31 **Anna Dixon:** But when poor people in deprived areas cannot get registered and cannot be seen on the NHS, do they not effectively become vulnerable patients? They cannot get routine dental care or cannot afford it privately. Maybe you would like to answer this, Dr Wong. It seems that community dental services and urgent dental care are picking up due to the failure in primary care.

Rachel Gilmour: Let me quote your own words back to you, Mr Sparke. I can't believe I have to repeat this. You said: "patients it is not attractive to treat on the NHS". What a shocking statement!

Dr Wong: Community services tend to be targeted at special care services such as pain and anxiety management. I think you are asking whether, as a model, we should directly commission and hold the contract for the whole team, and do it in a different way. I don't think the evidence suggests, in terms of a direct costing, that that would make giving wholesale care affordable.

In terms of priorities—that is effectively what we have been looking at—those specific commissions, such as what has been considered and done in many areas for urgent care, have relied more on that kind of set-up for



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providing care. In fact, during the pandemic, that was a model that we used.

The fiscal part is not for me, but my understanding is that if you were to hold that contract wholesale, pay all the staff and have all that, that model would be in some ways better than what you manage to get, although I understand access is the issue here. Certainly, in certain localities and some of your constituencies, where the workforce is particularly challenged, that needs to be considered. But as a wholesale system change, I am not sure the evidence backs that.

Anna Dixon: I guess there is a question about value for money. We are probably spending far too little, given that most people are not getting any access. The question is: what, from a very broken system, is the most cost-effective route to getting access for the people who really need it? I suppose we will come back to this, Chair.

Q32 **Chair:** No, I think that is the most important point of all in this entire session. Wouldn't it be better to rip the whole thing up and start again? Let us have a consultation and talk to the dentists first to see what they need, and then try to redesign a new system that actually works. We are still spending a terrific amount of money on dentistry—£3.3 billion—and yet we are not succeeding, so wouldn't it be better to start again?

Amanda Pritchard: The short answer to your question is that that is exactly what we are going to do. I will say three things. Talking about today's hearing, the plan that we were discussing, which I think we would all accept has not delivered the outcomes, was a sincere attempt to address some of the known problems within the existing contractual framework. There is a set of things that we have begun to discuss that could be amendments to the existing contract. Indeed, there are live discussions with Ministers at the moment about all of the things that we have discussed that would go some way to addressing the really obvious problems. We are keen, as I know Ministers are, to explore that properly.

But the right answer is to consider a much more radical reshaping of dentistry in this country. It feels to us, going back to the 2022 reforms, that tweaking around the edges, which is ultimately what we are talking about, made some difference, but not enough.

Q33 **Chair:** I have a plea for you. That was a very candid, honest answer, but if you are going to move to a brand-new system, we know from Public Accounts Committee hearings that it takes time. On behalf of our constituents, who are the people who are really suffering in all this, what we need is a proper transition plan so that they do not suffer further.

Rachel Gilmour: Talk to the dentists and the people on the ground. You cannot do this without—

Chair: I have made that point, thank you.

Amanda Pritchard: I completely agree. That is why we are keen to do two things in the short term. One of them is to ensure that we have really



learned the lessons of the attempt to make tweaks that has not worked, so that as we think about the urgent access challenge for next year, which we are focused on now, we are doing it in a different way that is more likely to be successful.

Part of that is commissioning specific enhanced services for urgent access, rather than baking it into the contract. The second thing is, shorter term, making those tweaks to the contract to address some of the issues that we have been talking about today. Again, with Minister's support we are keen to do that. Otherwise, you are absolutely right: we could end up spending too long before we get to a place where we are in a much better shape.

The other thing that we do not want to wait on is workforce. We had a commitment in the long-term workforce plan to increase training by 40% over the course of the next few years. Starting in 2028-29, the Government have made a commitment to review the long-term workforce plan in line with the 10-year plan. But given what Professor Whitty said earlier, it is our expectation that dentistry will still be an important part of that.

We need to seriously think about how we improve the supply of dentists. This goes to some of the points that we were talking about earlier: for those colleagues who are doing some NHS dental work, but not as much as they used to, we are keen to ensure they feel part of the NHS family. I was at a dental practice last week talking to colleagues, and one of the things they said was that they do not feel part of the NHS in the same way as many other colleagues do. One of the things we are going to do, for example, is ensure that every ICB has a chief dental officer or a lead clinician for dentistry, whose job will partly be to pull together not just dentists but the wider oral health team, so that they are supported properly in their roles.

Q34 Chair: May I just bring that together? On the dental workforce gap, the Association of Dental Groups tells us that there are currently 2,749 NHS vacancies for general dentists, 1,161 NHS dental nurse vacancies and 497 NHS trainee dental nurse vacancies. Many of those roles remain unfilled after being advertised for 180 days. Does that answer encompass the entire dental workforce?

Amanda Pritchard: I will let Jason come in in a second, but my headline point would be that we have to train more dentists.

Chair: It is not just dentists. As I have just illustrated, it is the entire professional family.

Amanda Pritchard: Exactly right—and members of the oral dental team. That is the only really long-term solution here. But in the meantime, I think there are—and I do not want to overclaim for them—incremental things that will help. Making people feel more valued as part of the NHS is one. We need to let the golden hellos keep going to see if they can give us greater benefit over time. We need to ensure that members of the oral



health team are able to work at the top of their licence—we have begun to see some movement on that, but it is still early days. There are some initiatives around international trained dentists that are making a contribution. But I would not want to overclaim for the numbers on any of those.

Professor Whitty: I will add one point to Amanda's, which is that the number of dentists has actually gone up, but the number of dentists doing NHS work has gone down. So the question is not purely about the number of dentists, but about how many are going into the NHS.

Chair: I agree.

- Q35 **Danny Beales:** We are dancing about the issue; you bring it back to the attractiveness of private work, but is it not the unattractiveness of NHS work that is the fundamental issue? Cross-subsidy in primary care is not a new thing. Pharmacy and optometry colleagues would say the same—that, relatively, the value of their NHS work has not kept pace with the real costs. So they cross-subsidise that work, usually with private work, which has expanded. In dentistry, it seems to have reached a very critical point, where even that is not sustainable.

To go back to the UDA, fundamentally, do we not just need to look at what the actual real-terms costs of dentistry are, and then what the UDA rates and relative extra payments are—the more complex rates? If we do, what modelling has informed your current UDA rate? What modelling will you be doing on the actual costs of providing dentistry to inform the future contract?

Ali Sparke: We should be up front and say that the current UDA rates were set a very long time ago; it was back in 2006 that the new contract, as it was at that point, was put in place. I do not think that any of us around this table would argue that those rates are fit for purpose now. There have been flexibilities that we have made really clear and we have been supporting ICBs over the last three years. There are flexibilities to change UDA rates within contracts that already exist, and ICBs are absolutely making use of those flexibilities.

- Q36 **Danny Beales:** They are, because they realise that their local system is not sustainable, so they are using their money to try and sustain it.

Ali Sparke: That is right. They are trying to support practices that are really struggling. I think this comes down to the fundamental question of how much it costs to treat different groups of patients, and back to my comment earlier which you picked up on, which is that those patients with the highest needs obviously cost the most; that differential is bigger in dentistry than it is in general practice or pharmacy.

- Q37 **Danny Beales:** Time is tight, so my question is: what modelling informs the £28 rate, and what modelling are you doing to understand the actual costs of the dentistry? For both complex and general patients, what modelling have you done and will you do to inform what rates people actually need to earn to sustain NHS care?



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Ali Sparke: Very briefly, on the £28—I think the NAO Report drew attention to this—we looked at the relationship between UDA rates and delivery, and we made the decision on how far we could lift the rate, with the expectation that we would be able to see better and more sustainable practices.

Q38 **Danny Beales:** That is not modelling related to the costs; that is modelling relating to what might drive more activity.

Ali Sparke: That is correct. It was not modelling relating to the costs. It was based on that relationship that we looked at. In terms of the next steps and the things we have described already, we have absolutely got a model we are working on. That is where Amanda's comment comes in, about this becoming part of a much more assured process between us and the Department. Those are the conversations we are having at the moment with the Government, about how we make the case for different types of remuneration that we think is required under the contract. So that modelling—

Q39 **Danny Beales:** Are you committed—because, as you highlighted, you have not done that previously—to actually modelling what the costs of dentistry are in 2025 and going forward, looking at the actual costs of dentistry and not just incentives that might lead to more activity?

Ali Sparke: Yes. We are absolutely looking at what we think is required for a patient, as part of a course of treatment, and how much that costs in order to inform the rates. We think that—

Q40 **Danny Beales:** Will you be engaging the BDA and industry players in that modelling?

Ali Sparke: Yes. We have already had conversations with the BDA and the ADG about some of these early ideas, and those are drawn from conversations that we have had across the profession, not just dentists but also therapists, hygienists and nurses over the past few—

Q41 **Danny Beales:** It is obviously important to get the modelling right, based on previous modelling failures.

Lloyd Hatton: We are sort of dissecting the different parts of the recovery plan; I wanted to touch on the golden hello scheme. To start, could you let us know how many dentists as of today have been appointed with the golden hello scheme, and can you give us an idea of where they are working? Obviously, at the time the NAO Report was published, that number was just one, so it would be helpful for the Committee to get a more accurate figure today.

Amanda Pritchard: As of today, it is 39. There are, I think, 246 posts out to advert with a golden hello attached. It is fair to say it has had a slightly slower start than we had hoped, because the actual agreement over the locations of the posts that were eligible for the golden hello took longer than we had hoped, but it has now kicked off. As Ali said, we will probably need a few more months to see whether the posts that are out to advert actually convert into recruited dentists, or whether we end up, as the



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Chair said earlier, just with long-term vacancies, and finding out that the scheme has not delivered what we had hoped.

- Q42 **Lloyd Hatton:** What is the long-term sustainability of the golden hello scheme? Taking into account that we have gone from one to 39, how much longer do we want this scheme to run, and what do we see as a success story? How many appointments would we like to see?

Amanda Pritchard: I will let Ali come in on the detail, but at the moment our view is that we need to let this one run for longer. It is not like the new patient premium, which we are all very clear needs to end at the end of March. There is not an end date for golden hellos. We would want it to run longer to see whether it is going to generate benefit.

- Q43 **Lloyd Hatton:** What will success look like, in terms of the number of appointments?

Amanda Pritchard: The original aim was 240 posts—that was what was in the original plan. The number that has actually been approved to go out to advert is more than that, but we would clearly be looking to get to at least the 240 in order to be confident that it has delivered what we had hoped.

- Q44 **Lloyd Hatton:** Okay. As it stands, not a single dentist practice in my constituency is taking on new adult NHS patients. One of my constituents, a sergeant stationed in a camp, has said he is unable to get himself, his wife or his three children registered, despite serving in the armed forces. How can you assure my constituents that these golden hello dentists will be appointed where they are most needed? In my constituency, it feels like they are absolutely nowhere to be found.

Ali Sparke: There are a couple of things to say. The first is that we have obviously relied in part on ICBs to work with practices where there is a long-term vacancy in place, which is one of the criteria for eligibility for a golden hello under this national scheme. There are local variations of this. It may be—and we can look at this—that your ICB is doing other work in this area as well. However, the golden hellos are designed for particular practices in particular areas where there are real issues with recruitment.

If the issues your constituents are facing in those practices are because there just is not enough dentistry commissioned in your constituency full stop, that comes back to the original point: we know there is only enough funding for 50% of the population. Obviously, the wider funding available for dentistry is not my role; our job is to make sure that that funding is absolutely prioritised for the people who need it most. That is why some of the changes that we have described and the urgent care work that we are doing are about making sure that there is at least a safety net and access for the people who really need it. There are, I guess, a couple of different answers to that question.

- Q45 **Lloyd Hatton:** My constituent is a sergeant stationed at Bovington army camp in Dorset. My concern is that that is an area with the kinds of problems that this scheme is meant to address; there are vacancies for



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NHS dentists that go unfilled for a very, very long time, and it is a rural area, so when that becomes a problem you really feel it, because the next nearest dentist might be a very long way away. Again, it would be good to drill into a bit more detail about how we can ensure that these golden hello dentist appointments, on which there is an aspiration to go further, actually reach constituents like mine at Bovington camp.

Ali Sparke: I do not know whether the particular practices in your area have already been given permission to advertise a post with the additional incentive attached. As you say, though, those are exactly the kinds of practices that the scheme is intended to address.

Amanda Pritchard: Chair, should we write to you with detail on which practices have attracted the golden hello posts?

Chair: Yes. That would act as an incentive.

Amanda Pritchard: We will explain the allocation process as well.

Chair: That would be really helpful. Thank you.

Q46 **Lloyd Hatton:** It would also be helpful to have some clarity that those posts are going to where the need is most acute. You have offered us reassurance today, but further clarity there would be appreciated.

Finally, on the golden hello scheme, as has been touched on by Members here today, dentistry has been in crisis for many years. The policy was announced last February, when over 60% of my constituents had to wait more than two years to see a dentist. Why did it take until October to appoint the first dentist via the golden hello scheme? Why have only 39 dentists been appointed? The roll-out has been quite slow. What lessons are we going to learn from that slow roll-out as we seek to reach the much higher figure you have given us today?

Ali Sparke: We accept that the roll-out was slow. We were ready to start rolling the allocations out to regions at the time of the plan, but unfortunately it took a little bit longer for us to finalise conversations with the Government at the time around the exact distribution of posts, and therefore targets in different parts of the country. We published the scheme in May. It was always our expectation that it would take around six months for the different stages to complete before people would come into post. We are around that point now, following the publication in the early summer. It is our expectation that we will be translating and converting the offers and approved posts into roles as quickly as possible over the next couple of months. We are not where we wanted to be. We wanted to be at this point a couple of months ago.

Jonathan Marron: We have spent more time trying to make sure that the golden hellos are going to the places of most need than we perhaps first thought we would need to. That is why it has taken longer—it is about trying to get it targeted properly.

Q47 **Chair:** Will this resolve the regional disparity? I don't in any way begrudge



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Clive Betts, but he has the highest number of courses of treatment.

Mr Betts: Well, Sheffield South East does. There are differences within Sheffield—

Q48 **Chair:** Okay: your constituency of Sheffield South East has 800. I don't begrudge you that, but poor Rachel Gilmour over here has only 382. That is a shocking regional disparity. Amanda, what can be done to start to address that?

Rachel Gilmour: It is a shocking regional disparity, but it is also shocking that my constituency, the most deprived in the country, has the lowest number of dentists. It is not just the regional disparity; it is the social-economic disparity. I am trying not to explode.

Chair: You have made the point powerfully. Amanda, would you like to answer that question?

Amanda Pritchard: I will start by saying that I agree that it is a shocking regional disparity. Two primary things are driving that. The first, which we have begun to talk about, is workforce. We don't have enough dental practices doing enough NHS work in the least well served places. The south-west is a particular problem area. The second, which Ms Dixon touched on earlier, is local commissioning practice. Even in areas that have fewer dentists, we are increasingly seeing some ICBs coming up with much more creative solutions. We have referenced some already. It might be worth calling out Suffolk, which has a partnership with the local university. They are doing something that is about training into practice as a social enterprise model. There are universities and dental schools in the south. It is early days in terms of the ICBs' maturity and setting up some of those new arrangements, but it may well be that some of those things would be applicable and would work well in areas where there is currently under-provision.

We have to do two things. In addition to the points we have made about the contract in itself, we have to keep going on what it will take to make it more attractive for dentists to work in the places where we currently have less provision. We also—this is one of the things we take very seriously—have to work with local commissioners, because it is now a delegated service, to share best practice, and, more than that, to hold people to account for following through on implementing that locally.

Chair: Thank you very much, Ms Pritchard. We like innovation in this Committee, so I am hopeful that Lloyd Hatton will ask about innovation.

Q49 **Lloyd Hatton:** Yes. I would like to move on to another segment of the recovery plan: the idea of dental vans, which were specifically to deal with rural, coastal areas that may not have the infrastructure in place to appoint dentists soon. These vans would help to plug that gap and drive up health outcomes in those areas. As far as I am aware, this Report makes it clear that no dental vans have been procured, and the issue of procuring dental vans has essentially now been handed down to individual ICBs across the country. My ICB, NHS Dorset, is on a list of those



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expressing an interest, but as far as I am aware, there has not been any procurement going on. What would be helpful is if you could identify which, if any, ICBs have actually gone ahead and procured these dental vans.

Professor Whitty: First, there are already dental vans in the system. There are probably around 20. Some of them are not in the NHS; some of them are in charities. They tend to be either in areas of considerable remoteness and rurality, or for very specific groups, such as homeless people in London.

It is quite an expensive way to provide the same level of service, and it is quite labour-intensive. The number of people who can go through a dental van per day is lower than would be true for a normal dental practice. So there are some difficulties. Notably, some of the dental vans currently in place are now termed “static”—that is, they are stationary, although they are providing dental services, so their van-ness has not actually provided enormous help.

The view of Ministers in the last Government was that they wanted to have a national scheme to increase the number of dental vans. Ministers in the new Government really wanted to delegate that decision down to ICBs, so that is what happened, and to date no ICB has said that it wishes to invest in a dental van.

Q50 **Lloyd Hatton:** My understanding is that it looks like there was a bit of a disagreement between Ministers in the previous Government and NHS England as to whether dental vans provided good value for money. Amanda, is it your understanding that Ministers wanted this, but there was little in terms of a value for money argument to defend procuring the vans?

Amanda Pritchard: I might let Ali talk to the detail of this, but overall I think we were quite clear that, as Professor Whitty said, there can be a useful role for dental vans, and they are in use for some very targeted purposes, but they are not a replacement for a well-established dental practice that provides comprehensive care. That was the discussion we had with the previous Government. Perhaps Ali would like to add some detail.

Ali Sparke: As an overall point, we were concerned that, as a catch-all solution to impose on a range of ICBs, it did not feel like it guaranteed being good value for money, not least because many ICBs would have to purchase a new van or lease a new van, and that could have very high start-up costs. Clearly, ICBs have important priorities around thinking through other options for their most vulnerable populations, and some of those initiatives did not involve the use of vans. Where that was the case, we obviously supported them to do those instead.

As Professor Whitty said, the vans just do not offer a comprehensive service. They are very expensive, and there are lots of things you cannot do from a van. They often require a patient to be followed up in another place anyway.



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Q51 Lloyd Hatton: I completely appreciate that the point of the vans was not to fix all our problems; it was to address a very specific problem for a very specific demographic. It seems that there is a consensus here that the van policy pursued by Ministers in the previous Government did not provide particularly good value for money, so why was this taken forward? Or was it a case that they wanted to be seen to be doing something, but it was not going to deliver the additional appointments and treatment that we needed to see for patients?

Professor Whitty: Leaving aside the fact that we would be very cautious to criticise past Ministers, as we would to criticise current Ministers, I think that the point about dental vans is that they have an important niche. For example, dental vans in Devon look at the dental needs of people working in the fishing industry, because they find it very difficult to access services.

None of us thinks that there is no role for dental vans. The real question is: what is the specific niche in a particular area? That is why the decision under the new Government was not to say, "Don't do dental vans"; it was to say that ICBs, which know their own patches, will know whether there is a niche for which this is an effective way to provide dental services, rather than trying to direct that from Whitehall. That is really the difference.

Chair: Professor Whitty, that is a really helpful answer.

Q52 Lloyd Hatton: It is a really helpful answer.

I have one final point. You are basically saying that the shift towards the ICBs leading on this is welcome and that it is better done at ICB level than centrally. With that in mind, what work is going on to ensure that ICBs that want to pursue this, where they have a very rural or large coastal community who might benefit from it, are enabled to get on and procure and implement an NHS dental van in their area? As you said, there are communities where it would make a big difference. How do we enable and empower ICBs to get on with that?

Ali Sparke: There is no barrier to ICBs doing this now; they have the full powers to commission these services should they want to. Indeed, as we have talked about, some already—

Q53 Lloyd Hatton: But it is a bit worrying that none of them has, if we accept that it would help in some areas.

Ali Sparke: Some have. We have talked about Devon and Cornwall, and there are different services. I know we are short of time, and Jason may want to talk about some of the other examples, but there is absolutely nothing stopping this. We are supportive of ICBs that want to take it forward. All we are saying is that we do not wish to impose it on an ICB where it does not want to make that choice.

Chair: That is really helpful—both from Professor Whitty and from you, Mr Sparke.

Q54 Mr Betts: Stakeholders were engaged in the formulation of the dental recovery plan, except the feedback is that they were not engaged very well. They did not feel that it was very satisfactory, and there was not enough information there at the beginning—indeed, it was completely obscure whether any funding would be available. That made a pretty big difference to what you were consulting on, didn't it?

Ali Sparke: I think the core concern that you have heard and that you have read in the Report is that the ICBs and bits of the sector were not fully aware of exactly what was going to be included in the plan until the very late stages—indeed, the plan was almost ready for publication. I think that is true. We were in discussions all the way up to the publication of the plan about exactly what it could afford and what it would be able to deliver.

That said, there was a huge amount of work with ICBs and with other representatives of the sector about the kinds of idea that could be included in the plan. As you have heard already, the new patient premium, dental vans and golden hellos all draw on and take inspiration from really good initiatives that ICBs have already put in place. We absolutely talked to ICBs in the course of those discussions about which elements of those could work and how we could take them forward. We talked about the ideas that we thought would make it into the plan. What we could not do until the plan had actually been published was tell them exactly what would be included and under what funding.

Mr Betts: Not a great place to start, then.

Jonathan Marron: We were discussing with the stakeholders the concepts that were in the plan. While it is true that the detailed plan was not shared in advance, we had talked about all the elements. The new patient premium was based on conversations with the dental stakeholders, who said that they simply were not properly paid for new patients—that there was a distinct under-reward. That is why we tried to do that.

NHS England had lots of these conversations, and we worked also at the Department of Health. The Minister had a roundtable in December to talk about these ideas. So there was consultation on what we were trying to do, if not specifically on the plan itself. We may do more of that in future.

Mr Betts: Sorry, but if you are going to have a plan, you have to consult properly and in detail with those who will have to implement it; otherwise, it is not likely to work. That is probably one of the problems.

Jonathan Marron: We had talked about the ideas in the plan. It is not that we did something with no consultation, but—

Q55 Mr Betts: That says a lot. Those who will have to implement it on the ground, whether they be ICBs or dental practices, really need to know the details to comment properly on whether they think it will work, don't they?

Ali Sparke: We absolutely had conversations with ICBs saying, "This is our idea: the new patient premium. What do you think?" It was the same



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with the profession. So there was an open conversation about them. What we could not do was say, "They're definitely going to be in the plan," until we had finalised it. That is the only distinction we are making. In fact, we have seen from the feedback since that the initiatives themselves have been welcomed, but they clearly have not gone far enough and have not always worked.

- Q56 **Mr Betts:** Let's try to ask what you were actually consulting about, because that seems fairly fundamental. You were consulting about the extra 1.5 million treatments, but you were also consulting about anyone who wanted to see a dentist being able to do so. Which was it?

Jonathan Marron: The plan is clear that it sets out three stages. First, there was a set of initiatives for 2024-25 aimed to try to deliver the 1.5 million extra appointments, which we have already talked about and we have not delivered. There is then a section on trying to improve the oral health of children, which would have a long-term benefit.

There is also a set of longer-term commitments, which are really around further reform of the dental contract—the things that we have talked about today and we all accept need doing. There is a set of things designed to get more out of the existing contract, including having ICBs use their new powers to reduce the contract levels of dentists who are not doing NHS work to allow them to give it to others. That was part of this process. There is then a set of things around the workforce—both increasing the numbers of the workforce, as the chief executive of the NHS has talked about today, and trying to help with skill mix. For example, we have changed some of the regulations around practice to allow dental therapists and hygienists to do more things, really freeing up—so there was a broader set of things that were meant to get there.

- Q57 **Mr Betts:** Going back to the key objective, that was 1.5 million additional dentistry treatments, and it has not been hit. That was a clear target. You then had another target—or an aspiration or hope—that everyone who needs to see a dentist will be able to do so.

Jonathan Marron: That aspiration requires us to deliver all three of those elements that I have just talked about, including the longer-term reform of the contract and—

Professor Whitty: Sorry, can I just correct that last statement? Just to be clear, even had all the aspirations of this plan been achieved, we would not have got to a point where everyone could see a dentist. I just want to be really clear about that.

- Q58 **Mr Betts:** That was part of the plan, wasn't it?

Rachel Gilmour: It was not an aspiration; it was part of the plan.

Professor Whitty: I am giving a mathematical statement.

- Q59 **Mr Betts:** I know. Essentially, what we had was a grandiose aspiration, which was part of the plan, and a mathematical statement, and the two did not link up, did they? They were not the same.



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Professor Whitty: I was not involved in this at that stage, so I am going to stick to the maths. The maths of this is that if you put the two together—

Q60 **Mr Betts:** Nevertheless, Sir Chris, you are the interim permanent secretary. In your current role, you can see that you have a plan—

Professor Whitty: I am agreeing with your point, Mr Betts. All I am saying is that I am not trying to explain the difference.

Mr Betts: Fair enough.

Chair: As is established practice for this Committee, I will now suspend the sitting for a short break.

Sitting suspended.

On resuming—

Chair: Welcome back to the Committee's hearing on fixing NHS dentistry. That is a very apt title—fixing NHS dentistry. If we fixed it, we would all be in a much better position. To help us again with that, I come to my excellent deputy, Clive Betts.

Q61 **Mr Betts:** Thanks, Chair. We were exploring before what probably went wrong, or what aspirations could not have ever been hit with the dental recovery plan. Let us try to think what lessons we can learn, going forward. What do you think are the most significant barriers that are preventing people from securing access to NHS dentistry in this country, and was anything achieved through the dental recovery plan to address those barriers, or have you simply shown that the barriers exist and still need addressing?

Professor Whitty: Pretty clearly, what they demonstrate is that tinkering around the edges of the barriers, it is worth trying things, but the problems are quite fundamental here. For example, I think there was a genuine belief, not just in Government but outside it, that the new patient premium would be likely to lead to an increase in dentists taking on new patients. It was done in consultation with the BDA, which was mentioned, and others, so the fact that it had no effect at all, accepting that we don't have the counterfactuals—we don't know what would have happened had that not been in place; nevertheless, let's just take the numbers straight as they are—I think shows that this is a more fundamental problem even than originally you would have assumed.

To go back to, in a sense, the whole tenor of what people were saying earlier, the gap between what people can earn through the private sector doing the same work and through the NHS is quite a fundamental one. It is not a tiny little gap that you can just manage with a very small amount of bridging. This is the whole point, in a sense, about the minimum UDA amount: while a perfectly sensible move in itself, as for the idea that it was going to bridge the gap and therefore solve any major problem, I think this makes it pretty clear that that is not going to be the case.



Q62 Mr Betts: Is the fundamental problem, then, the nature of the contract? We will come on to questions about the details of what might be done to change it, but is that the fundamental barrier?

Professor Whitty: My view—I am going to give a personal view, rather than a departmental view—is that you could fiddle around with the contract as a contract; the real problem is the gap between what is available for a good dentist in the private sector and what is available for a good dentist in the NHS. I think that is really fundamental; the rest flows from that. There is a lot you can do in terms of the details of the contracting, but that is the biggest barrier, in my view.

Dr Wong: I agree that that is one significant issue. The other issue to remember is where the workforce want to work and how they want to work. Maldistribution of the dental workforce is a worldwide issue. Some of the cases raised happen more in certain areas. In some areas, such as London, activity has gone back to pre-pandemic levels; in others—Members have already highlighted the disparity. It comes back to the fundamental question: is it the fact that we have got enough dentists and they just don't want to work in the service, or is it the fact that we haven't got enough dentists overall, or indeed dental team members? For that, while a certain number of dentists are working, you have to look at the whole-time equivalent and what they are committing towards clinical work. The General Dental Council survey suggested that 42% of dentists were working less than 30 hours clinically. That is a cultural change that has happened, and we need to keep that in mind.

Rurality is an absolutely key issue, not just because there is a general trend towards an urban life and where the young professional wants to work, but there are some fundamentals in terms of where our specialist services are. If you are a young dentist, do you want to go into an area? It is all right to have Charles Clifford dental hospital and a dental school there to refer to, for example, where you can think about developing your career, but if you move into a more rural locality, you run into an area where you are thinking, "How do I as a professional develop?" I think we need to look at that.

Chris wants to come in, but let me add that where we recruit from is also quite key—the high-grades entry into dental schools. The available evidence is that it is not necessarily where they train, but the fact that they quite often want to be near friends and family. We are predominantly recruiting, because we are not looking into widening out participation, from certain areas; they tend to cluster around where they have trained but also where they have come from. Therefore, if you want services out in those areas, we need to look towards the long-term growth of that.

In terms of the pipeline that Amanda has just talked about and the NHS long-term workforce plan, increasing our own production is key. Some of the plan did look at international recruitment. I think Chris wants to come in on that.

Q63 Chair: I will bring you in, Chris. That was a really helpful and



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comprehensive reply from Jason Wong. This issue applies across medicine, really, because you cannot deliver medicine without people. If the taxpayer is paying to train expensive professionals, shouldn't the taxpayer expect that those young people, when they have trained, should spend a bit of time with the health service before they move into the more lucrative private sector?

Professor Whitty: I will add a comment and then directly answer your question. On the first point about the funding model, I think that is quite specific to dentistry. On attracting people to NHS posts in coastal, rural and remote areas, that is across the whole of the board. One of the previous questioners was asking about Minehead. There were the same issues when I was last in Minehead, and the thing I was discussing was how we attract GPs to come to Minehead.

Rachel Gilmour: We still have the same problem.

Professor Whitty: Exactly. Dentistry is probably the most extreme, but it is not the only issue. All around the coastal strip—I did a whole report on this, for people who are interested—there has been a serious problem with attracting people: doctors, nurses, dentists and other health and social care workers.

Q64 **Rachel Gilmour:** Could I have a meeting with you about Minehead, please?

Professor Whitty: I am extraordinarily keen to talk about how we improve areas of low productivity, so the answer is yes.

Rachel Gilmour: Brilliant.

Professor Whitty: But I will not be able to solve your dental problems immediately, just to be clear. I do not want to build up expectations.

That is the general point. On your specific question about whether we should require people to do this, there is a consultation on this, and Jason and others may wish to comment on it. That was part of the way people were addressing this for dentistry specifically.

Dr Wong: There was a commitment in the plan to consult. The consultation has since closed, and we are feeding up to Ministers currently and working through that, in terms of the consultation on the tie-in and what might be done for the dental graduate.

Jonathan Marron: Actually, the consultation was launched the day after the election was called. We completed that consultation, asking in principle, "Should we introduce a requirement for new dental graduates to spend some time working in the NHS?" We have had the consultation response back. It is now with our Ministers, who are considering how to take it forward.

Q65 **Chair:** That is really helpful. In that consultation, did you discuss how long they might spend working for the NHS?



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Jonathan Marron: I think our time period was three years, but I would need to check for you. It was in a broad sense, about the principle; the practicalities of exactly how it would work would come if the Government wanted to do this.

Chair: That is very helpful.

Q66 **Mr Betts:** Let me come back to the feedback from the development and what you have learned from it. We talked earlier about Sheffield having this wonderful utopia where everyone can see a dentist when they want, but that is not quite the case, and there are differences within Sheffield. We often say that it is one city in two countries, and that is shown in the disparities in dental care in the more deprived parts of the eastern side of the city that I represent.

Let me give you one example of something that is not working under the plan and is a barrier, and ask how you might look to address it. I have Darnall dental practice in my constituency. Mr Orliaklis, the owner and head of the practice, has 12,000 patients. He has general funding for about half of those and additional funding given for the other half, but that expires in March. He has taken dentists on and put new surgeries in. He has actually offered to take more on. He has another surgery that is empty that he cannot use. Everyone knows there will be underspends at the end of the year, but they cannot be anticipated—and what do you do next year, when the underspends are actually being spent this year and dentists are being paid on that basis? When I went to see the practice, there were 30 people in the queue down the road, waiting to join. You have a really successful practice and more people being taken on, but the financial basis is completely unsound.

Ali Sparke: This is a critical point, and you make a really important contribution. We have a couple of different things going on here. The first thing to say is that even in your constituency where there is relatively good access, even if all the dental funds were spent there would not be 100% access for your population.

We know that even in a place like Sheffield—indeed, it is true everywhere—there will be some funding that is returned to the NHS every year, because practices are not able to deliver that care. That is a really important feature; it is partly the result of the fact that we have a contract that is not attractive enough, and it is also to do with some of the workforce issues that Jason and others have described.

We have taken a number of steps to help ICBs to better prioritise the money they have available. There is a couple of things that I think are relevant to your point. The first is that we have given ICBs new powers to reappportion funding that is not used by a contractor that is consistently under-delivering, so that it can be reinvested in new contracts. That is really important. This is the first year that ICBs are able to take those steps, and we are seeing some really positive progress towards that from a number of different ICBs across the country.



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Secondly, we know there are contractors who reach 100% of their contracts and want to go further. We have been encouraging—we have published some guidance on this a couple of years ago after the first set of reforms—and in the last two years, we have seen really positive progress from ICBs in making use of those additional flexibilities. We know that in the year so far, over 1,500 dental contractors across the country have been offered additional activity by their ICBs because they are close to reaching 100% of their contractual value. These actions are really important to make sure that we spend as much of the budget as we possibly can.

Q67 Mr Betts: What happens next year, when the money is not repeated automatically into the contract?

Ali Sparke: We might have to come back on the specific arrangements the ICB put in place locally, but absolutely they all want to be prioritising sustaining that capacity into next year.

Q68 Mr Betts: And there are empty surgeries when we know that there are going to be underspends?

Ali Sparke: Yes.

Jonathan Marron: The point that Ali is making about being able to take that contract back is really important. Those powers were only taken a couple of years ago. Previously, a dentist who was under-delivering—say, delivering only 60% of their contract—gets awarded 100% of the value the next year, the next year and the next year. We have now taken powers to allow us to draw that back. That will allow ICBs to think much more long term about how they spend their money, because essentially they will be able to reallocate on a more permanent basis.

Q69 Mr Betts: I am not being critical of the ICB in South Yorkshire at all. Gavin Boyle has replied to all my questions. He is going to come with me to visit the practice that I referred to, because I think we can see the future there. It is not the fault of the local ICB; it is the fault of the financial framework.

Jonathan Marron: And until two years ago, there were no powers for the ICB at all. We have changed that and actually given them the powers that might allow them to take decisions they need to take.

Amanda Pritchard: Can I add something? First, let's come back on the specifics, but on the general point, the important thing that we can do only from this year is permanently rebase contracts. ICBs have been able to use underfunding on a non-recurrent basis, but now, because there had to be a number of years of underperformance before you could permanently rebase the contract, we have hit that point. I do not know whether that is true in this particular circumstance, but it may be that that rebasing is part of the solution.

Q70 Mr Betts: Is there anything else from the feedback about the problems with the recovery plan or the things that did not work that you now need to address and that you actually can address?



Ali Sparke: It comes back to the broader points we touched on at the start. We have talked about the overall availability of money and the ability for us to repurpose that; that is the first key issue. The second is workforce, but the third—in many ways, all roads lead back here—is that the contract is not helping us to prioritise properly the money we have for the patients who most need it. That is why the changes to the contract, which we have discussed already, are really important.

Mr Betts: We can come on to the details at the end.

Ali Sparke: Sure.

Q71 **Lloyd Hatton:** We have discussed in quite a lot of detail the initial contract changes that were made in 2022, dissected in quite a lot of detail the recovery plan, and talked about what success they have had. I think we all agree that, in many ways, they have fallen short of what we want. How are we learning from the shortcomings as we look towards what comes next, particularly after the end of March; and how will those lessons learned influence future reforms?

Ali Sparke: In response to Mr Betts, we talked in general about the broader messages we have taken from this experience, but I will give you one concrete example: the new patient premium. Clearly, the way that worked was that additional money was paid to practices on top of the value they would earn for a new patient anyway, irrespective of if it was a band 1, band 2, or band 3 course of treatment. We hoped that that would make a difference to practices' willingness to take on some of the patients who they know will often present with a more complex set of conditions.

The drawback of that as an ongoing fundamental reform to the system is that we know that some patients do not present with anything like that complexity. We were able to demonstrate that the extra time taken, and therefore the amount that we have currently set for the new patient premium, was justifiable based on the evidence we had about the amount of time—it goes back to the question about modelling the cost from earlier—but if we did make that a wholesale change to the contract, we know that we would be fundamentally overpaying for certain patients who were coming through.

That is why changing the underlying payment mechanisms—this is the learning—is really important, because it means that we can better tailor the resources we are giving to practices to meet the actual needs of patients. Professor Whitty referred earlier to the initial changes in 2022 to create different sub bands within band 2. That is the sort of change it is important to make and we want to go a lot further than that.

Q72 **Lloyd Hatton:** Do you think that, having learned the lessons of what went wrong and what worked, we can address the issue that Professor Whitty highlighted when he said that while the number of dentists overall has gone up, the number of those providing NHS care has gone down? Will what you are talking about now ensure that we can address the fundamental structural problem of having fewer dentists actually working

with NHS patients?

Ali Sparke: Yes, I think it will go some way towards addressing that issue. What it will not address is the problem that even if all our money was spent in the most appropriate way, we would still have close to 50% of the population who would not be able to access dentistry. It will really help us in prioritising, which is, I think, our fundamental job—making make sure the patients who absolutely need this care receive it. What it will not do is create universal access for NHS dentistry.

Q73 Lloyd Hatton: As we learn from what has happened in the last few years and look to what comes next, particularly around the golden hello scheme, I am keen to know what has been done at the grassroots level to talk to those providing dental care, to make sure that the scheme does deliver what we aspire to be delivered, which I think is the right aim. We understand it has been a bit slower than we would have hoped. What bottom-up work has been going on to make sure that it is more of a success in future?

Ali Sparke: We have started a programme of evaluation. We always intended that to continue into the new year once we thought a number of posts would be in place. I think we will be able to come back and give a more detailed answer on that in the future.

What we can say is that we know that the scheme itself was designed with a number of very specific purposes—to target places which had an ongoing long-term recruitment problem where we knew there was already under-delivery and access issues for a particularly vulnerable or difficult to reach population. Those broad lessons were drawn from experiences of other golden hello schemes run by ICBs in different parts of the country. What we are referring to here is a national version of something that exists in different places, in different ICBs, and that we know they have found successful. We have reason to believe it is right.

We do not know whether for some of the most difficult places, where there is really challenging workforce availability, this will be enough to encourage dentists to relocate for a longer period—for the three years that we hoped. That is one of the things we will learn as part of this evaluation over the next couple of months.

Q74 Chair: You say you do not know whether it will be enough. Surely you can go out and ask them.

Ali Sparke: The £20,000 available to dentists under this national scheme is split over three years—£10,000 the first year, then a further £5,000 the subsequent two years. That is based on the experiences in different parts of the country where golden hellos have worked. It is also based on the similar GP scheme that has been in place for a number of years. What I am not saying is that we can guarantee that in every part of the country that is struggling to get a dentist, this will be sufficient to attract dentists. We need at the same time to fix the contract and some of the other underlying causes of the NHS not being a sufficiently attractive system.

Q75 Lloyd Hatton: It would be really useful for the Committee to get a better understanding of what the main challenges are that dentists and the wider workforce come back to you with when you do this bottom-up engagement with them. Even with these schemes, things are obviously deteriorating. As we have seen, most of the figures are going in the wrong direction and the number of dentists providing NHS care has been going down, so what is the feedback? It sounds as if there has been some genuine engagement, which is welcome, but what are you hearing, and are we going to make sure that whatever comes after the end of next month, as we look beyond the current recovery plan, actually takes that into account?

Ali Sparke: Everything that we have described so far comes out of a range of conversations that we have had with not just dentists but therapists, hygienists and nurses. We have run a series of focus groups over the last 18 months to try to understand and get underneath these issues in a much more detailed way. I can come back to some of the detail if that is useful, but I know that Dr Wong wants to come in.

Dr Wong: Some of the feedback that we have received is about whether the incentives were strong enough for people to change behaviour and accept new patients. One of the worries that I think practices, providers and performers have is opening the book to what they see as the risk of someone with higher needs, in terms of the level and complexity of their treatment. I suppose the lesson to be learned from this for the next one is that if you are going to have an access scheme of any sort, whether it originates from urgent care or routine care, you must do something to address the incentives that the practice has. Where there are higher needs and higher-level treatment needs, and such treatment needs to be carried out, that needs to be worked in as part of the plan. If you pull the lever here, it will not affect the other. The remuneration system must change in that part, so that if they do have higher needs patients coming in, that has been looked at and is rewarded appropriately.

Q76 Lloyd Hatton: That is a significant structural change. As I said earlier, there isn't a single dentist practice in my constituency that is taking on new adult NHS patients. Do you believe that the engagement and consultation at grassroots level has been sufficient that we can begin to turn around the structural problem so that for the first time more of those dentists are actually going to reopen their books and say, "We will take on more NHS patients"? Even if we implement a number of the reforms that you have outlined today, which I welcome and support, we have to fundamentally change the structure where you can have whole swathes of the country where not a single dentist is willing to take on a new NHS patient.

Dr Wong: What we can say is that the idea of remunerating that part appropriately is not only a part of longer-term reform; it is actually part of the thinking in the next set. The short answer to your question is, yes, that feedback is going to feed into what we bring in to make that change.

Q77 Lloyd Hatton: I suppose the million-dollar question is how quickly do you



think we can expect to see those sorts of changes, so that communities like mine and those of many others on the Committee will see a dentist practice begin to take on new NHS patients? That is what is really important for patients in my part of the world. They look online, they go on the Dental Choices website, and absolutely nobody is taking on a new patient. They want to know the timeframe for when that might begin to change.

Dr Wong: I am not sure that I can give an exact answer, but the hope is that some reform is fairly imminent. Obviously, we will await announcements. There will be variability—that is probably something that we need to address. For some of the initiatives, it depends whether you sit on the incentive part. I actually think that both are going on. I do not think you can ignore the workforce part, and what drives that, as well as the system, but in terms of addressing certain parts of the population where you may be able to commission flexibly, that might be much quicker than other, more structural parts.

Ali Sparke: May I add some comments on the two sets of onward work that we have already described? On the urgent care work, we are already in discussions with Government, as Amanda said, and we might see progress on that very soon. That will not address all of the issues that your constituents are facing, but clearly where there is an urgent need, such as the need for a safety net or for their immediate requirements to be met, particularly for people in pain, we expect to make very quick progress on that over the course of this year. It was in the planning guidance. For some of the more fundamental changes in the reform, the discussions we are having with the new ministerial team are important, but it is obviously a decision for them to make.

Q78 Lloyd Hatton: May I put one final point to you? A constituent came to one of my coffee mornings and raised a particularly frustrating issue. When they went on to the NHS “Find a dentist” website, it listed some dentists as taking on new NHS patients, but when they picked up the phone or sent an email, they found that was not the case. That is deeply confusing and deeply frustrating. As I have pointed out, there is not a single dentist in my area taking on new patients, yet the NHS’s own website gives a list of those that are. As we look to implement future reforms and go beyond the current recovery plan, and as we do the extra engagement and consultation that we are already doing, how do we address those big gaps where you have patients who are being told one thing by the NHS website and a completely different thing when they pick up the phone to speak to the dentist?

Ali Sparke: You raise a really important point; it is clearly incredibly frustrating for patients. We hear that as well. We should stress that the website itself is updated by dental practices, so they are the ones that are posting that information. What I think happens is that sometimes that information becomes out of date, or they do see some new patients and then suddenly it is no longer relevant. We introduced in 2022 a requirement to update those profiles much more regularly, but clearly, as you just highlighted, there is a long way to go. Some of this will come



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down to fixing the fundamental issues that are preventing new patients from being seen in the first place. The website itself will never be the whole answer.

Q79 Lloyd Hatton: You can see where my constituent is coming from when they are faced with this bizarre situation. You are saying that in the future we will get to a point where we are starting to see some dentists take on new NHS patients, but those patients will need to know who those dentists are and to have a reliable place where they can find that information. Right now, if they go on the "Find a dentist" website, that is not the case.

Ali Sparke: According to the latest report we have, some 45% of practices are advertising to us and to patients that they are taking on new patients in their practices at the moment. Clearly, as you have just highlighted, that is not always the case in practice. I agree that we need to understand what the reasons are for that misalignment of information.

Q80 Chair: Can I come in on the back of Lloyd Hatton's excellent questions? NHS Gloucestershire is innovative, but it says that it currently achieves only 68% of the contracted targets it has been set. No doubt it will, at the end of the year, have money unspent, and the NHS, Sir Chris, has been playing on this business that there is £200 million unspent, but if places like Gloucestershire do not have the levers to address the problem, that it is not really the answer, is it? I have two questions: first, will this new contract give them the levers they need to start seriously addressing the problem; and, secondly, is the NHS going to put some real, new and extra resources into trying to solve this whole problem so that we can maybe begin to solve this gap between the private sector and the NHS?

Professor Whitty: I will give a departmental view, but I suspect that Amanda will want to give one from the NHS. I think there are several issues, but I will highlight three in particular. Some of them can be solved, but some will require a more fundamental rethink, and ultimately it is for Ministers to decide where they want to put this.

The first is the bizarre situation that was previously talked about by some of my colleagues in which a dental practice can have reached 100% of its contract, wish to go further and have dentists who want to be paid, but not be allowed to, whilst there is another dental practice down the road that has not done its full allocation. The obvious thing to do is switch the money from one to the other, but that is currently difficult. That is a solvable problem, and it should be solved with some of the changes that are being made at the moment. That is mechanistic, but it is a daft situation. I think everybody would accept that it is daft, and that daftness needs to change.

The second one, which is more fundamental and will need to be quite a big political decision—I mean that in the broadest sense—is the total amount of funding that goes to dentistry, and specifically how much money per unit of activity. The second reason why people underspend their dental contract is because they are offered money at an NHS rate and they choose not to take it because they are using their time to do private



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practice, perfectly legitimately—this is not a criticism of the dentists; it is simply a statement of fact. That is because they do not see, at this point in time, the NHS rate to be appropriate compared with what they would be able to achieve in other areas. That is quite a big issue that needs to be dealt with.

The third one is to have a ringfence around the dental budget so that there is not, in a sense, an incentive—although I am sure it would not be seen that way—for ICBs and others, at the end of the year, knowing that the money is available, to shift it into other areas of the NHS that are under pressure. There are always pressures, as everybody knows for their own areas.

Having a ringfence at least means that people will be very serious that the money must be for dentistry. There can then be a very legitimate political discussion about what is the correct ratio between dentistry and other areas of the NHS—I consider that to be a political question—but at least the money that has been allocated by Ministers to dentistry should be spent on dentistry, in a way that deals with some of the appalling problems that people around the Committee have been rightly highlighting.

Q81 Chair: It is great to hear that it will be ringfenced, because that gives people an incentive to really think about how they can spend their money most effectively. Do you think the changes we have been talking about will be sufficient levers to enable them to spend that money? The problem is that they cannot spend it at the moment.

Professor Whitty: Leaving aside the issues I have just talked about—as I say, Amanda might want to come in—I think the changes will be sufficient to make some useful movement. But fundamental reform—that was the word that the Minister used earlier this week, so I feel comfortable in using it—is what we will need to significantly shift the dial. These are important changes, but they are relatively modest. I don't believe any of us think that they are sufficient to deal with the gap between where the public rightly wish the system to be and where the system is at this point in time.

Q82 Chair: I am going to press you again, because we did cover this earlier on. What I would like to get out of this session is some sort of confidence from you that we will not be sitting here in five years' time in the same sort of situation, and that we will have delivered a much better dental service to our constituents than is the case now.

Professor Whitty: I think that the right time to ask that question—I am not being weaselly about this; I am being realistic—is when the actual plan has been laid out. Ministers are looking across the whole board of the NHS, including dental practice, in a bottom-up way. They have been very clear about the 10-year plan. At the point that happens, it is legitimate to ask people whether they think it will do the job, but this is not the moment, since we don't know that.



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Part of the reason why I am being cautious, if I am very honest, is that since the beginning of the 1990s a whole series of changes has happened. With each one, people have said, "This is going to fix it," and each time things have got worse. I am very nervous about sitting here and saying confidently that the next plan, which I don't yet know because Ministers have not yet agreed it, will fix this, because previous plans have failed to do so. I think we need to bear that fundamental reality in mind when we are discussing this.

Amanda Pritchard: I could not agree more with what Professor Whitty says about reform. Just to reassure the Committee, one of your key questions was whether we are going to spend the money that has been allocated to dentistry, and whether the short-term things that we have talked about, which are not attempting to fix the bigger picture problems that we have discussed, will get us further from where we are now, so we are not returning money back unspent when there is such an obvious level of need that is not being met in dentistry.

I think I can give some confidence that certainly the three things that we are doing right now will make a difference. Those are contracting for urgent care, additional activity, in a different way, as extra activity; working with commissioners so that they are developing enhanced access schemes locally; and having the ability now to rebase contracts where there has been historical and persistent under-delivery. Those three levers are important.

Certainly, this coming year, '25-26, we would expect people to have a much greater ability to spend the money they have been allocated on dentistry. My caveat on that—we have talked about it a lot today—is workforce, because it is not as if we have a lot of dentists who are sitting around not working. They are working—they are working very hard. If they are not doing NHS dentistry, they are doing private dentistry. So, in order to fix the workforce long-term challenge, the incredibly important point about training enough of our own dentists and then keeping them within the NHS just cannot be ignored.

Q83 Chair: To crystallise that—to put the money where your aspiration is—are you reasonably confident that if we have you back to examine the '25-26 situation, all the money allocated to dentistry will have been spent?

Amanda Pritchard: That is absolutely our aspiration. As I say, where I would be concerned is just where we know we have not got enough dentists. That is my one caveat. I should add a technical but important point. We are, in agreement with Ministers, going to make sure that dental delivery is part of our formal oversight framework for the NHS for next year, so we will be actively monitoring and holding to account ICBs. Some of them are doing an amazing job, but we will be holding them to account for spending this budget.

Chair: That is really helpful.

Q84 Rachel Gilmour: You mentioned the workforce, which is what I would like



to question you about. I am presuming that you have new data on the dental workforce that informs the decisions or initiatives that you make. How is that informing any future initiatives on workforce support and development? What sort of support and development have you got in mind, or data that supports it?

Dr Wong: We are very much supporting the use of skill mix—using the wider dental team to provide care. In both '22 and '23, and since then, resources have been sent out to help the profession and to help providers in utilising that team. The other part, as I said, is that we need to start to think about a career structure for the dentists coming in, in certain localities that don't have the support in terms of their development, so that they have that opportunity. But, as Amanda said, we do have dentists in full employment. I am still convinced that there is a number issue here and we need to grow that workforce in terms of numbers as well.

In terms of how we are trying to support it, part of the reform plans and the commitment is on how to make the workforce feel more part of the NHS, because I don't think that is where the workforce feels it is currently. So it is a case of making sure that it is feeling safe in providing that treatment. Aside from the NHS and contractual issues, there is a feeling at the moment, I think, within the workforce that the current clinical negligence or regulation system is slightly stacked against it. There is a real culture within the dental workforce in terms of how it feels in providing care. I think we need to address some of that. Some of that is about seeing where the legislation can be updated so that those processes can be much better. There are discussions that we have had, in terms of both clinical negligence and the regulation system, with the General Dental Council.

But I think it is really important not to lose sight of the fact—apart from the incentives, which are really important—that this is about making sure that people can provide safe care and feel safe in doing so. In some respects, everything that we talk about seems really complex, but at the basic level, that is the place we need to get to, to make sure that the workforce then provides the care that we want it to provide.

Rachel Gilmour: When I use the term “workforce”, I am not talking just about dentists. I am talking about having the ability to start as a dental nurse, maybe, and having the confidence and ability to grow in your professional role.

Dr Wong: Indeed.

Q85 **Rachel Gilmour:** I had a situation in my constituency, in Dulverton, where the only person who provided NHS care was a trainee. I do not think that that is fair. I do not think it is fair on my constituents and I do not think it is fair on that trainee.

Dr Wong: The dental nursing group is the biggest registered group within dentistry. We are doing some work in conjunction with the chief nursing officer to make the whole professional group develop so that you do not have to leave the profession to do it. At the moment, they have to go into



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dental hygiene or dental therapy, or into management. A lot of the reforms were aimed at dental therapists and dental hygienists. I think that is quite important.

Another group we are trying to help are clinical dental technicians—the smallest registered group, who provide removable prostheses. We made plans to give them a preceptorship, or a foundation year, so that they would form part of the workforce as well. They can have direct access. The NHS took steps to ensure direct access can be provided by a clinical dental technician, dental therapist and dental hygienist. That is really important. Yes, it took a while from when the legislation allowed it, but now they can work via direct access. We have seen some encouraging data on the amount of direct access coming out of those groups.

Q86 Rachel Gilmour: So you are talking about retention.

Dr Wong: Yes, we are talking about retention, and how they feel that they can be part of the NHS and how they can develop.

Q87 Peter Fortune: A couple of people have touched on this. We are essentially talking about the liberalisation of dentistry, to a certain extent. The option could be that if you are having a check-up, a filling or polishing, somebody like a dental therapist could do that. That is not a drop in quality, right?

Dr Wong: No, definitely not.

Peter Fortune: Because they have still three years of training, but it is at probably half the cost. There was a paper on this by, I think, Tim Leunig. Is this being looked at, in terms of where that delivery could be? That would increase capacity as well.

Dr Wong: You are exactly right: we are not talking about any drop in quality whatsoever. Really, the cost is a side issue. Obviously, they take less time to train, but within a surgery setting, we also think that it allows the dentist to develop and work to the top of their scope as well. We want all the registrant groups, including dentists, to be able to work to the top of their scope. It is about the team working as a multi-disciplinary team. We have not been particularly good on this as a sector. If you walk into other places, other professions have that split. We still seem to believe that the only work that gets carried out is with a dentist sitting right next to the patient. That is something our profession will need to make progress on.

Q88 Peter Fortune: It is interesting, because the cultural element of this will be really challenging. I can see that Ali wants to come in as well. A couple of people have hinted at and touched on this, because people want to go and see a dentist, which is what we need to look at.

Ali Sparke: That is a really important point. I will add two brief things to what Jason said. First, in 2022, when we last announced the package of changes, one of the things we made quite a big deal about was the wide misapprehension that other members of dental teams cannot deliver a course of treatment—particularly a band 1—or carry out some of these

activities on the NHS. We published some guidance on exactly that, and we have seen, over the last three years, the number of courses of treatment being carried out by therapists increasing. It is still at a relatively low level, but it has increased from almost nothing to around 4% or 5% of courses of treatment now.

That links back to the reform question. The way we pay for and structure the contract incentivises the course of treatment to be delivered by dentists, because it is quite hard to separate out some of the other activities and do them separately. One of the things we would like to address—we are talking to the Government about this at the moment—is that we are seeing too-low rates of evidence-based prevention activities in children such as fluoride varnish or fissure sealants. We know those do not need a dentist to be delivered, but the current payment strategy does not really support them to operate independently on the NHS. One of the things we would like to better support is, for example, extending duties to dental nurses so that they can do some of that work themselves. That is within the structure of the NHS contract, but it is really trying to develop the whole team. It is really important to go further on this.

Q89 Peter Fortune: I know we are short on time, but I sense some hesitancy there. There is that cultural shift with the public, but what about the profession? How would the profession feel about that sort of change of delivery?

Dr Wong: While there is definitely a core of the public who want to see a specific person, actually, as long as you delivering good care, they probably do not have as much of a—

Peter Fortune: There has been a change recently, hasn't there, in terms of seeing pharmacists rather than your GP?

Dr Wong: Yes, but in dentistry—this is not to do with the remuneration system—the cultural shift for the public is in their relationship with the practice and the essence of that, rather than the set individual. That has been changing a little bit already.

In terms of the profession, the introduction of skill mix and moving on it has been welcomed in all quarters. There are certain parts where we need to make sure that there is parity within the system for all people who work in it. The NHS's relationship is with performers and people with performer numbers. Part of the aim is that we need to make sure that the NHS's relationship is with more than that, and to make sure that the whole team feels part of the NHS. I think we have to shift that so the profession feel part of it.

Q90 Peter Fortune: Are the unions broadly supportive of that direction of thought?

Dr Wong: Yes. I have not had anyone approach me and say that the whole idea of skill mix is not something we should pursue, even from the union.



Q91 Chair: Given that the workforce is such a vital part of this whole recovery plan, I want to put some evidence that we have received on record. It is slightly long, but I want to get your reaction to it, because I think this is really important. The Dental Schools Council has given us evidence in which it has suggested a few things: "Establish outreach centres associated with existing dental schools in underserved areas to expand access to care and increase opportunities for student placements...Explore innovative approaches, where students complete foundational training in local institutions and later finish degrees in more specialised settings...A government-led recruitment drive for staff for dental schools corresponding to bigger numbers including local clinical supervisors and dental nurses".

On the dental recovery plan, the evidence reads: "The previous government's NHS Long-Term Workforce Plan proposed a 40% increase in training places for dentists and dental therapists by 2031...Retain the proposed 40% uplift in the...cap on dentistry places...Prioritise funding for new outreach centres", including "flexible graduate programmes...Widening participation...Recruiting students from disadvantaged areas is key to addressing workforce distribution issues"—this point was made by you earlier, Jason—"as graduates are more likely to work near where they grew up." These ideas represent thinking out of the box and really considering how we can recruit and train more dentists.

Dr Wong: Yes. I am just trying to make sure that I have got them all, but I do not think I disagree with the push of any of the issues raised there by the Dental Schools Council. On widening participation, there is a real question when we are considering where we actually want the workforce to be in the long term. In 2040, do we still want—this is not just about the NHS—95% of dentistry provided by dentists, or do we want to change? If you do not want to change, there is a real question of whether training the straight-A students in the places where we are carrying out the training right now is actually the right process, or if you should widen participation.

It is fundamental to the future. I recognise that this is in the longer-term future, and we have some issues we need to address before that, but having the treatment carried out in areas that are under-provided in terms of outreach is very much part of the plan. We supported the increase in numbers.

Chair: That is very helpful.

Q92 Anna Dixon: I think that earlier in the hearing there was a general view, which I was pleased to hear from Amanda, that the dental contract as it currently stands needs radical reform. I think that was the broad view. I would like to come down to some of the potential options.

We have received evidence from a number of different organisations. Healthwatch England suggests introducing a weighted capitation system. It would like, I guess, to reverse the 2006 contract and ensure that everybody has the ability to permanently register with a dental practice, much like we do with the GP, and certainly like the lifelong relationship that I enjoyed with my dentist when I was growing up.



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In contrast, the Nuffield Trust says, "Let's accept reality. We have a partial service. We cannot go back to a universal service. We need to focus public sector dental capacity"—I am guessing it means public sector expenditure—"on those who cannot afford private care, people with elevated risk such as those with dementia, and children and others who would benefit from prevention."

From the NHS Confederation, there are various suggestions about much more flexibility, as we have been discussing for ICBs, to look at local need and commission in line with that. The thinking there is perhaps much more about assessing and paying for oral health outcomes—more of a population approach, rather than rewarding dentists for treatment and activity.

So there are three contrasting options. What options are on the table as you consider this, in terms of future reform?

Professor Whitty: Dividing this into the kinds of things that are largely for technical people like Amanda, Jason and Ali to deal with and things that are going to require quite a political choice, I will leave them to deal with the more specific ones. On the bigger questions, all the suggestions you have put are perfectly reasonable things for people to consider, and there is quite a long list beyond that.

I think what Ministers have to do—this is clearly a job for Ministers; it is a political choice—is to choose which of the political philosophies they wish to follow between those different approaches, and then build the service around that fundamental choice. They will be looking—I know they are looking—at a range of different ideas, including all the kinds of things that you have talked about. Where they will finally come down, I do not know, because they have not yet come to a final conclusion on that. I cannot prejudge where Ministers will choose to land, but all these things are perfectly reasonable to be debated. This is a good time for people who have strong ideas about how the whole system can be fundamentally rethought to put them on the table and say why it is that they think this is a better model.

Q93 **Anna Dixon:** Thank you for that answer, Sir Chris. I guess Ministers also want advice on value for money. In setting out any options and the analysis that you already have, we have spent the last two hours discussing what has and has not worked in relation to value for money. We know that there are people, perhaps at the wealthier end, who have managed to retain an NHS dentist that they can access, and yet many of us have many constituents who literally cannot access dental care because they cannot afford to make the choice to go private. I understand there are political choices that Ministers will, I am sure, consider. But in even appraising the options, how confident are you that you are able to assess the value for money of different choices and how to target the current modest spend, as we have been discussing, better?

Professor Whitty: I was talking about the more fundamental changes. On the second, I will turn to Amanda, but on the fundamental changes,



the Committee have rightly highlighted a number of things that are major priorities. There is a geographical disparity; there is a disparity by age; there is a disparity by severity; we have not talked about this, but there is a disparity by ethnicity. You have to look at all of those. To some extent, you have to start off with which is the one that drives it, except that you are having to do all of these, and the most cost-effective way to approach each of them will vary. These are analysable problems, as you know, given your previous roles. You have to start off with the choices in front of you and then analyse those choices. There is not an abstract “What is the best value?”, because it really starts with what you are fundamentally trying to achieve in the changes that need to be made.

What we should be doing is supporting Ministers who say, “I want to achieve these aims,” and then say, “Okay, here are the best, most cost-effective ways of doing this, and here are the trade-offs.” To repeat a point that was previously made, the current model cannot actually cover more than 50% of the population. You could change the model completely, but that is the reality, so the question is: within that, how do you prioritise the different, very important, points that people have made? That is a fundamentally political decision. There is an analytical underpinning for that, but it has to be for elected politicians to make that judgment. Then there are the more day-to-day analytical things; Amanda might want to talk about those.

Q94 Anna Dixon: I am interested in what is on the longlist. Are there things that you have done in the past that you know do not work, so they are on the “don’t even put them to Ministers” list because we have tried them and they have failed? I appreciate that you cannot prejudge a Minister’s decision, but we are keen, in this Committee, to understand that there are lessons, and that value-for-money appraisals and evaluations have been conducted and are informing future choices. We have consultants with contracts that allow them to opt for certain sessions but that tie them to doing a certain amount of their working hours for the NHS—that would potentially address the erosion of hours. I am trying to get a bit more of a flavour without pre-empting what Ministers might be—

Professor Whitty: Dentistry was new to me when I started looking at it for this Committee. It has been a voyage of discovery, and not a very encouraging one. It is clear that quite a lot of things have been tried and failed, so we can give Ministers a longlist of failures going back to the early 1990s, unfortunately. There are a few things that have been tried and were successful. I consider that the 2022 changes—I know the Chair said this was too detailed, but I am still going to say it—which split the band 2 activities were genuinely useful.

As we discussed throughout the first half of this sitting, all the things that were tried in the dental recovery plan were perfectly logical. At the time they were put forward, large numbers of very sensible people, including some of the people you talked about, said that they were sensible ideas. The fact is that, in particular, the new patient premium did not work. So there are quite a few things that we should take off the table and say, “That was perfectly sensible, it has been tried and it has not worked.”



We should be clear, however, that this is not a situation where we can say, “Actually, five years ago there was a brilliant system—if only we could revert to that.” I think that the last time most people in the country would consider that NHS dentistry was operating as they would anticipate it should was probably in the early 1990s. The changes since then have all tended to either do nothing or make things worse.

Q95 Anna Dixon: That was the period when I was doing my master’s and learning about dental public health. I remember reading papers then that said there was something called supplier-induced demand, which meant that if you pay dentists by activity, you will get them to do things that they do not need to do—it is basically stuffing their mouths with gold. We have changed things in the GP contract, such as the quality and outcomes framework, and we have plenty of other evidence-based approaches to how we pay professionals to get better outcomes and do the things that we want them to do. I really hope that, in looking fundamentally at dental reform, you will be looking at all of these things.

Amanda, would you and your team like to add anything more on dental reform?

Amanda Pritchard: I will be brief, because I think that Professor Whitty has absolutely nailed the bigger-picture issues. Clearly, policymaking sits more with the Department than it does with us, but the important thing will be—we talked about this earlier on and you mentioned it again, Mr Beales—making sure that we have really good underpinning modelling, that we are really learning from the past and what we have tried in this country, and that we are looking at what we can learn from international examples. There are then political decisions that it is important to overlay on that.

Good policymaking will require us not to do this in a rush, but clearly there is an urgency here and nobody wants to see the current state of affairs continue any longer than it needs to. That is why we are trying, within the existing contract, to do the things that we can crack on and do now, while making sure that we are doing the next set of probably more minor contractual reforms. Those are things that we can see are going to be in the range of things that we talked about earlier—I will not go back over them—which we can do while this much more fundamental piece of work goes on to look at what a completely, radically rethought approach to dentistry might be, in line with what Minister Kinnock has already said.

Jonathan Marron: We have talked a lot in this Committee about the development of the current contract. We did spend about 10 years, from 2009, looking at whether we could do a capitation contract—so, you would have a registered list and be paid for those. There were pilots for about five years and then a prototype contract between 2016 and 2020. The evaluation of that found that access reduced, activity went down, there was no significant increase in preventive work and we collected fewer patient charges. So we stopped that in 2020. It did not seem successful. That is not to say that there is not another way of doing capitation, but we



have had some quite significant goes at trying to do a different contract, which, as Chris said, have not proved to be hugely successful.

Q96 Danny Beales: You have talked about the need not to rush. I think that is true—we need to get this right—but what timescales are you working to regarding a new dental contract? Has the process started, and what do you envisage as the end date for an updated dental contract?

Jonathan Marron: We are talking to our Ministers about significant and fundamental reform to the dental contract. I think there are three things that we should think about in terms of timescales. Ministers are very clear that the urgent thing they want to address is access for people who have urgent need. It is in the planning guidance, and we expect to see significant progress on 700,000 more appointments. That will make an immediate difference. As we said at the beginning of this process, we are doing that outside of the contract, so that we can make it happen and learn some lessons. That is part one.

I think we will be looking with NHS England at what other changes to the current contract can make a difference, and whether those are worth doing. We have those conversations going on. Ali has been talking to the BDA and others. Then we are having a conversation with Ministers about their appetite for more fundamental reform.

Danny Beales: Thank you for that explanation. Reading between the lines, I think it is fair to say that the process for a new dental contract has not started yet.

Jonathan Marron: We are working with Ministers on proposals for both short-term changes and what they might want to do for a more fundamental reform. I think we need to do that carefully, and clearly Ministers will come and talk about their decisions when they have taken them.

Danny Beales: I am reading into that—maybe I am over-reading—that a significant process for a new contract has not started at pace yet. What would a timescale for a new contract be? I appreciate that we need to get it right and not rush it, but what would you envisage? I think we have all accepted that we need a new contract. That is what I have picked up from this inquiry and what you have said. If we accept that—I understand that it would be complex—I am keen to understand what the timescales would be for a new contract.

Jonathan Marron: We will have work to do to think about the level of change before we want to do a contract. A very significantly reformed contract will take longer. We are working through those options for what Ministers might want.

Danny Beales: How long do you envisage that taking for a significantly new contract?



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Jonathan Marron: As I have said, we have immediate work, to which we have already committed, to get increased access to urgent dental care. We will look at the short-term changes to the contract—

Danny Beales: That is not really my question. That is the previous point you made. Perhaps you can write to the Committee with what the options might be. My question was about a new contract. I appreciate that you are tinkering with the contract and doing other things.

Jonathan Marron: It depends on the decisions taken about what sort of contract we want. Those decisions have not been taken.

Danny Beales: So we have not started the process significantly yet.

Jonathan Marron: We have started that work.

Q97 **Chair:** Professor Whitty, I think Danny Beales is asking a reasonable question, and I would like to back up his request that you write to the Committee with a timetable as to the short term and the long term. If I were sitting in the middle of the Cotswolds unable to get a dentist appointment, I would want to know when I was going to get that dentist appointment or whether I would be dead before I got the toothache seen to. I think we do need a timetable. We do not want to be sitting here at the end of this Parliament with no improvements at all. Could we have a fairly detailed note from you, setting out a timetable?

Professor Whitty: I think I am going to promise half of what you have asked for, Chair. I think we can relatively quickly and with some precision provide, largely through NHSE, a detailed timetable on all the things we can do within the current framework. The rest of it depends on political decisions, over which, with the best will in the world, no one on this side of the table has any control. The level of fundamental change will determine how long it takes to get these things to happen.

Ministers have been very clear that they are going through their 10-year forward look and 10-year plan, and I anticipate this being either part of that or very closely associated with it. It will follow, in broad terms, the timetable of that plan. I think it would be very dangerous for us to start making promises in detail about milestones, because those start with, "What do Ministers intend to do?" That is really the starting point, and we haven't got to that final starting point.

Q98 **Chair:** You have a consultation on fluoridation and a consultation on the wider dental recovery plan. However, I think that if I was sitting and watching these proceedings, I would be getting more and frustrated. I would be saying, as one of my constituents in the Cotswolds would say, "I use the system. I know what needs to be done to fix it."

I have a question for you, to get your reaction. Amanda has been very clear that she does not want to do this in haste, and I agree with that, but why don't you have a wider consultation to allow our constituents to give their views? They are the people who will be using the system. Why don't you allow them to express their views and formulate part of the long-term improvement plan?



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Professor Whitty: I am going to use “consultation” in two different ways, because they have different purposes. The fluoridation consultation is very specific. As with all Government decisions, you often have specific consultations about a particular thing—yes/no, and then the details of it. That is not what you are asking about; that is not a fundamental thing.

The 10-year plan system is the other kind of consultation, which is what you are asking about. It is a mechanism by which the general public can feed their ideas into Government. They are not given a yes/no choice or a very restricted set of choices; they are asked to put their own ideas in. That mechanism is currently in play and people should absolutely use it to put ideas, however radical and however fundamental, to the Government about how they should rethink this. That was the whole point of the mechanism that Ministers currently have for the 10-year forward plan.

Chair: That is really helpful. Thank you.

Q99 **Lloyd Hatton:** I should start by saying that I welcome the fact that the new Government have made this pledge to try to have 700,000 additional urgent dental appointments available on the national health service. However, a constituent got in touch with me to say, “It’s shocking. The only way I can get any treatment on the NHS as it stands is to wait to be an emergency and then get seen as a one-off. If I was able to get my regular check-up, I could get preventative care early on and I would be able to save the NHS a lot of money and myself from enduring a lot of pain.”

I suppose my main concern is that although it is great that we have this pledge to have 700,000 additional appointments, how do we ensure that they are genuinely used by those with a dental emergency, and that those who should not be using up those appointments get their care elsewhere?

Ali Sparke: We will be very clear in the way we define what urgent care means. In fact, we already have a working definition; it has been developed. There is already a published urgent care standard, which we are looking at again in the context of the new manifesto commitment and the work that is happening at the moment. We will not be counting business-as-usual activity—ongoing check-ups—as part of those appointments. It is really important, and it is exactly what the Government have asked for, that these are reserved for people who absolutely have an urgent need.

We want to take this opportunity, having learned from some of the places that are doing this already. There is a lot of experience out there. I think we have already mentioned London and Manchester as examples, but there are a number of other places where they have looked at different ways of identifying precisely who that urgent cohort is. We would like to make sure that we are as clear as possible that that is consistent across the country in the way that it rolls out. We absolutely cannot be counting appointments that are part of a patient’s ongoing care plan as urgent appointments.

Q100 **Lloyd Hatton:** Thank you. I imagine that this will speak as much to



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Rachel's constituents as to mine, but how do we make sure that those areas where there is little capacity are the places that get their fair share—which will inevitably be more, and therefore a priority—of the 700,000 additional urgent dental appointments?

Ali Sparke: We have already had conversations with Government about how we would make this work—obviously, it has not been finalised yet, and there is still an announcement to come. We have recommended taking into account a number of different measures of need. Under delivery, we are looking at existing contractors as well. That means that where we already have poor access in different parts of the country, we will make sure that those areas are prioritised for the additional urgent care appointments. That will be taken into account in the way we roll this out.

Q101 Lloyd Hatton: This is the right aspiration. The Government did this very early on, and they have spoken a great deal about dentistry since the election—indeed, the Front Bench did so before the election as well. Will you go into a bit more detail about the timeframe for delivery of the additional 700,000 urgent appointments?

Ali Sparke: Clearly, there has not yet been an announcement. We have been doing some early work with our commissioners, learning from what is out there already to prepare for making rapid progress. We have already put it in the planning guidance this year. It is one of the key priorities that we are holding ICBs to account on. We will be talking to them in a lot of detail about this shortly, to make sure that we are clear on what targets there are and how quickly to achieve them.

Chair: This is only the beginning of the Committee's journey on this subject. We will be going on the journey along with all of you, because we desperately want to see an improvement in dentistry services for our constituents.

Our next opportunity to examine this will be our hearing into the DHSC annual report and accounts, when hopefully Professor Whitty and Amanda Pritchard will be joining us. To give you fair warning, one of the subjects that will be interesting to the Committee on that occasion is the increasing costs of NHS clinical negligence, in particular in view of the dreadful story today about the Nottingham trust's natal care. That will be an interesting session, when we will no doubt be able to cover a lot of subjects, and no doubt dentistry may feature in that hearing.

We have gone over a lot of ground today and have had a lot of answers—some good, candid answers. I thank all our witnesses today for attending. An uncorrected transcript of the hearing will be published on the Committee website in the coming days. The Committee will consider the evidence provided and will produce a Report with recommendations in due course.