

Health and Social Care Committee

Oral evidence: NHS Dentistry: follow-up, HC 1179

Wednesday 9 July 2025

Ordered by the House of Commons to be published on 9 July 2025.

[Watch the meeting](#)

Members present: Danny Beales; Ben Coleman; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson; Gregory Stafford.

In the absence of the Chair, Paulette Hamilton took the Chair.

Questions 1-86

Witnesses

[I](#): Dr Shiv Pabary, Chair, General Dental Practice Committee, British Dental Association; Thea Stein, Chief Executive, Nuffield Trust; William Pett, Head of Policy, Public Affairs and Research, Healthwatch England.

[II](#): Stephen Kinnock, Minister for Care, Department of Health and Social Care; Dr Ed Scully, Director, Primary and Community Health Care, Department of Health and Social Care; Dr Jason Wong MBE, Chief Dental Officer, NHS England; Dr Amanda Doyle OBE, National Director, Primary Care and Community Services, NHS England.

Examination of witnesses

Witnesses: Dr Shiv Pabary, Thea Stein and William Pett.

Chair: Welcome to this one-off session on dentistry. It is a really important subject; I was a member of our predecessor Committee in the last Parliament, which also looked into dentistry. I want us to get the most out of our session today, to enable us to know where we are and where we think the issues align.

The Minister of State will be along later to speak to us, but before that we will take evidence from stakeholders. May I ask you to introduce yourselves?

Thea Stein: Hi, I am Thea Stein. I am the chief executive of the Nuffield Trust, a health and social care independent think-tank.

Dr Pabary: My name is Shiv Pabary. I am the current chair of the general dental practice committee of the BDA. My background is that I have been an NHS practitioner for the last 40 years, and I have worked in the north-east in deprived areas; I also took part in early pilots that were testing a new model of care. I work in an urgent access centre in one of the dental deserts in the north-east.

William Pett: Good morning. My name is William Pett, and I am head of policy, public affairs and research at Healthwatch England. We are the national statutory champion for people who use health and care services across England. It was announced in the 10-year plan that we will be closed down.

Q1 **Chair:** It is going to be a very hot day, so if you want to take your jackets off, please feel free to do so.

Dr Pabary, over the two years since the last report, what has changed? Have you seen any improvements or have things got worse, in your opinion?

Dr Pabary: Thank you for the invitation to give evidence. This is my first appearance before a Health Committee.

In 2008, the then Health Committee said that the current contract was not fit for purpose and needed reform. Your predecessor Committee, which you sat on, said the same thing and arrived at the same conclusion. I think you expressed frustration that for 15 years nothing had happened.

There has been very little progress since you last sat. We have been pushing for fundamental reform of the service, as you are probably aware, and we appreciate that we have a new Government in place. The Labour manifesto mentioned that contract reform would be a clear priority, but sadly we have made very little progress on that.

You will probably have seen the consultation that was launched yesterday. We have engaged constructively with NHS England on this consultation for the last two or three years. There are small, modest and positive changes



HOUSE OF COMMONS

within this, but to be very clear, this is not the fundamental contract reform that was promised. We agreed to work with NHS England to try to fix a broken system in the areas where it is not working, such as complex treatment, urgent care and prevention, but we said at the time that what we were expecting was fundamental reform of the contract.

A short answer is that we have made very little progress since 2023. I would ask this Committee to ask the Minister, when he appears, for a clear timeline of negotiations for a fundamental reform of the contract and for a very clear deadline for the roll-out.

Chair: Have things actually got worse, or do you think that at least the Government are trying to engage and get things moving?

Dr Pabary: When the Minister says that he is keen on the reform process, I think he has a genuine intention to do so, but we have not actually seen any progress towards that. I think things have got worse. Last year, we had a huge access problem, where more than—

Chair: I am going to stop you there, because we have only two hours for this session. In your opinion, the Minister has made the right noises, but you still believe things have got worse. Would you agree?

Dr Pabary: Yes. We still have an access problem. We are still working a contract that is target-driven.

Chair: I am going to have to move on, because I want to get the other two witnesses in. William, do you think things have got worse, or have there been any improvements?

William Pett: Good morning, Chair. Since Healthwatch was set up 12 years ago, we have given regular verbal evidence to your Committee. Today, I am likely to be the final Healthwatch representative to have that privilege, so I would like to start by saying thank you to your Committee for listening to the voices of patients.

Have things got worse since your last report? I think the answer is yes. You have to look at the latest national data, which shows that courses of treatment are down by 4.7 million in the last year, compared with pre-pandemic levels. We have seen 30,000 children and young people hospitalised for tooth extraction in just a single year. We have seen the last dental recovery plan, under the last Government, failing to deliver any new extra NHS appointments.

Those figures show a national crisis, and behind each of those stats are the real people living with their own individual crisis. They are people such as Ian, a former soldier from Andover, who told us that he would love to be able to smile without “a big hole in my mouth”. He served 26 years in the British armed forces, but he cannot find an NHS dentist. We heard from a headteacher in Leeds who told their local Healthwatch that you can smell the odour of tooth decay walking down school corridors.

We have countless other examples, and despite some modest progress yesterday, 2026 will mark two decades of a broken NHS dental contract—a contract that leaves patients de-registered without notice or explanation and leaves patients to fend for themselves. The 10-year plan promises a reformed dental contract by 2035. Unfortunately, for the public, that is a decade too late.

Chair: I will ask you the same question, Thea: have you seen any improvements or do you think things have got worse?

Thea Stein: I will not repeat what my colleagues have said. I support what they have put forward, but I will add one fact to it. In the 2023-24 DHSC public accounts, we see that it was spending £3 billion. That was £3.6 billion a decade earlier, so there has actually been a decrease in the amount of money going into the dentistry service.

We know, and I would imagine the Minister will say later, that there is significant underspend that takes place from the commissioners around dentistry, and that they are concerned with ensuring that underspend does not happen. I think that is great—it is really positive. Nevertheless, the quantum of money that is going forward to fund these reforms does not look to me, currently, as though it is growing.

Q2 **Chair:** With the commitments in the 10-year plan, will it achieve the Government's ambition to transform NHS dentistry by 2035? Do you think the 10-year plan goes far enough?

Thea Stein: No. I support my colleague Dr Pabary, who talked about the concerns expressed by all commentators and by the profession itself. They are calling for a fundamental root-and-branch reform of the contract, not for changes within the contract, which is what we are seeing. Are there things to be welcomed in the 10-year plan? Absolutely. Will it transform NHS dentistry and bring it back to being a service that is universal for everyone, all the time, in need? We do not see that.

Chair: Thank you. I will ask you the same question, William, as the voice of patients on the panel.

William Pett: I will not repeat some of what Thea has said. There are some measures to be welcomed in the plan, particularly the measures to introduce a tie-in for NHS dentists. That will be welcome, as well as a greater skill mix within the dental workforce.

There are two things missing from the 10-year plan. The first is any action on dental costs. Our research in Healthwatch England shows that one in four people are already avoiding NHS dentistry because of the cost. The Department froze NHS prescription charges this year. We need to see similar action on reducing the demands on people financially around dental charges.

The second thing missing from the 10-year plan is action on information for patients on where there is NHS availability in their local area. Currently, patients have to rely on the "Find a dentist" tool, which is



HOUSE OF COMMONS

woefully inadequate and only has to be updated by practices once every three months. That means that patients who are desperate for NHS appointments in their area have to phone around practices. Often that is done by their local Healthwatch, but that support is soon going to be removed from patients. We need much more real-time information for patients on where they can find an NHS appointment in their area.

- Q3 **Chair:** The last word goes to you, Dr Pabary. You have already said that you do not believe that the commitments have been met. Is there something that is missing that you would like to have seen? Just give me one thing, and I will leave it at that.

Dr Pabary: We welcome the commitment to reform the contract, which is stated within the plan. As the two other witnesses have said, we cannot wait 10 years to do this, so the one thing that we do need is to sit round the table now and discuss with the Government the art of the possible.

We have put a plan forward for the Government to look at. It would be very similar to what your predecessor Committee recommended, which is the patient-centred, prevention-focused capitation contract. We think it is possible to devise a contract, but we cannot wait for 10 years; it has to happen now. We need to start negotiations now, and they need to happen in parallel with the implementation of the current proposal.

Chair: That is a really good place to stop. Danny Beales is next.

- Q4 **Danny Beales:** Hello, everyone. I am Danny Beales, MP for Uxbridge and South Ruislip. My question is for the BDA. You said that the changes proposed are small and modest. You mentioned the need for more fundamental reform, and the fact that the pace is too slow. We have heard quite powerfully from Healthwatch about the implications of a failing dentistry system. Why do you think the pace has been too slow? Why has significant reform not happened more quickly across the previous Government and the first year of the new Government?

Dr Pabary: We have been asking for this. When we have sat down with the Department, they have said that they were waiting for the comprehensive spending review to see what was allocated to the NHS. We have had three very high-level meetings—very general meetings on principles—but we have had no progress on contract reform.

Now that we have the comprehensive spending review and we know what is allocated to the NHS, we would like to know what part of the budget is going to be allocated towards the reform of the service. We can ask for all the nice things we want, but without the necessary funding to have a sustained long-term contract, it is not going to happen. When I met the Minister in April, I said to him, “Wouldn’t it be nice if we sat here in 10 years’ time and looked back and said, ‘We made a difference’”? We are not talking about a lot of money in NHS terms. We have lost up to a third of our budget over the last 10 years.

- Q5 **Danny Beales:** So it is fundamentally a question of funding. You have talked about the CSR for this Government, but from what this Committee



HOUSE OF COMMONS

has seen, including from the Public Accounts Committee, and from what you have all submitted in evidence, significant contract reform has not happened for more than a decade, if not longer. Do you think that dentistry is an afterthought? Is it the poor relation of primary care?

Dr Pabary: The dental service has had the biggest reduction in money in the NHS. The spend in 2010 was 3.3% of the NHS budget; it is now down to 1.5%. As the Public Accounts Committee said, we cannot have tweaking at the margins; what we need is radical reform.

Q6 **Danny Beales:** Why do you think that that has not happened? We have seen contract reform in general practice and in pharmacy, albeit that it is not what they would like to see completely. Why do you think that for so long dentistry has not seen that fundamental contract reform?

Dr Pabary: To give you a very simple answer, I think it is lack of political will. We have said the right thing, which is that we want to reform the service, but we have not seen any kind of action from successive Governments. I think Professor Whitty said that since 1990 we have tried to reform the dental service, and not only have some of the reforms failed, but they have actually made things worse. I know that, having been an NHS dentist for 40 years. I work in an urgent care centre, and what I see on a daily basis is appalling. Children are turning up with pain and sepsis, because they have not been able to access a dentist for two or three months. We have to do whatever we can in an urgent situation.

Danny Beales: Those are experiences that I think all MPs here have heard.

Dr Pabary: Yes, I am sure.

Q7 **Danny Beales:** The majority of my constituents cannot find an NHS dentist. What do we need to learn from the previous attempts at reform? You mentioned some of the implications of previous attempts.

Dr Pabary: We need to do two things. First, we need to recognise that the UDA system is broken and is not working. We have not heard that from the Government. We need to move towards what your predecessor Committee said, which is a prevention-focused contract that is patient-centred and backed by capitation. I worked in one of the pilots with capitation, so I know the benefits of prevention and of continuing care within a capitation system.

Secondly, you need to find the necessary resource. We have had a huge cut in our dental budget and we need to put the necessary funding in place. We can develop a model of care—I will fight tooth and nail for this, because I am a big believer in the NHS and we want a system that is comprehensive for the patient—but we need to back it up with the necessary funding.

Q8 **Danny Beales:** What if we do not get there? From a dentist and patient perspective, what are the implications over the next 10 years if that does not happen?

Dr Pabary: I think we are already seeing them. We are seeing an exodus of dentists from the NHS, and once dentists leave the NHS they will not come back. We will get to a tipping point. Even if we manage to get a reformed contract that makes sense and works, it might be too late, because we will not have a workforce left.

Q9 **Danny Beales:** As I say, I think more than half of my constituents cannot get an NHS dentist. Does the BDA have any sense of where it will go unless we address NHS access and the number of dentists?

Dr Pabary: Yes. We have asked that question in a survey, and six out of 10 dentists would leave the service without fundamental reform. If we do not have the reform that we have been asking for, more than half the dentists on the NHS are thinking of leaving the service.

Q10 **Danny Beales:** Significant reform is difficult: it requires a lot of negotiation and it is complex. Practically, is there time in this Parliament to have a significantly reformed contract? How would you envisage getting there? What would the process be, from the BDA's perspective?

Dr Pabary: It has to happen in this Parliament. We cannot wait 10 years for a reformed contract. We need to have the discussions now about the art of the possible, as I said earlier. I believe that it is doable with the political will. I believe that the right words have been said by the Secretary of State, who has described dentistry as being at death's door. I believed the Minister when he said that we have had 14 years of broken promises. I believe the Minister when he says that the current situation cannot continue, and that it is a Dickensian state of affairs.

But we need some action. We need to get around the table. We sent proposals to the Government, when they took power, as to what our idea of a blended contract is. If there are things in there that they cannot work with, we are happy to sit down and negotiate on what can work, but we have not even started the discussions. We need to do that now, and it needs to happen in parallel with the consultation. This is important. I must stress to the Committee that the consultation, which was released yesterday, must not detract from or delay the discussions of wider reform.

Danny Beales: Both need to happen in parallel with the current tweaks, which it seems you broadly support.

Dr Pabary: Absolutely. That is one of the things that I would like the Committee to ask the Minister: to give us a commitment on a timeline and a deadline for when a new model of care could be rolled out. We also need to look at the funding model.

One thing the Department is doing that is really helpful, and which we have supported, is a survey of the cost of providing NHS care. We have done that locally in our area, because we had practices that were going to leave the NHS and we were really concerned. We actually increased their UDA values, because they are in deprived areas and we did not want the practices to fail. I know that the Government are doing that at the



HOUSE OF COMMONS

moment; a survey is going on, and we backed it, but I think that it will show that the service really is grossly underfunded.

- Q11 Danny Beales:** Do you have any evidence of what the financial costs are of not reforming the dentistry system? Have you any modelling about that? I think Healthwatch colleagues talked about 30,000 children being admitted to hospital. The financial cost of inaction seemed to be significant, too. Have you any data about that?

Dr Pabary: All I can say is that I know, from what Healthwatch has said as well, that the service is dying and the impact on patients is going to be huge—we won't have an NHS service left. As a clinician, I see this on a daily basis; people just cannot access care. They have to travel 30 or 40 miles to access care. They are bouncing around 111, trying to get an urgent appointment. I have not got any data for you, but the Prime Minister said of the NHS "it's reform or die" and I would say the same of the NHS dental contract. If we do not reform it, it will die as a service.

- Q12 Andrew George:** I am Andrew George, representing west Cornwall and the Isles of Scilly. We are a large dentistry desert for people because you cannot go north, south or west to find a dentist and you can go 120 miles up to Exeter and still struggle to find a dentist. That is what it is like for our area.

You will be pleased to know the Minister is listening to what you are saying. In relation to the contract itself, is it possible to hit the sweet spot where we can concentrate on prevention and achieve, or reassure the Government that you can get, value for money on that? I ask because I noticed that, in the Darzi report, there is an emphasis on the need for urgent action. That is obviously before 2035, please. The report says that "urgent action is needed to develop a contract that balances activity and prevention" and "is attractive to dentists". There is a lot of talk about establishing a contract based on prevention rather than, necessarily, too much emphasis on activity, and then reassuring Government about value for money—

Chair: Andrew, I am sorry, but that is not a succinct question. Who do you want to answer it?

Dr Pabary: Can I just very quickly answer?

Chair: It needs to be quick.

Dr Pabary: Yes, I will be very brief. I worked in a trial model, a new model of care, which was the pilot and the prototypes, and we had capitation, which is the ask that we have at the moment. We found that that is the best way to deliver prevention. It is also the best way to have continuing care with the patient. We realise there has to be a balance between activity and prevention, and we can put measures in to monitor the activity, but absolutely we need a prevention-focused contract and we can develop that—

Chair: Thank you. I am going to stop you there. William also wants to come in. This needs to be succinct.



William Pett: I will be very quick, Chair. There have been some questions about the contract, and I want just to say one thing from a patient perspective. We do not currently have a GP-style registration system for dentistry, but the public think that we do. We have done national polling work, and 68% of the public think that they have a GP-style relationship with their dentist when they don't. That is what is causing such dismay and frustration among patients when they are de-registered from their dentist. They are thinking, "Why am I being de-registered? This should be the same as with my GP." So we need to play catch-up with what the public expect, because we know that is also what the public want.

Q13 Ben Coleman: Yesterday the Minister, Stephen Kinnock, said that "we have to tackle the problems in the system at their root." I would have thought that "at their root" means the units of dental activity. Do you have any indication that that is what he means when he talks about tackling the problems at their root?

Dr Pabary: The short answer is no. We have asked for a move away from the UDA system—we have been saying that for years—because it is a very crude measure. It does not actually measure quality or reward quality; it is just a very crude measure of activity, and we need to move away from that and look at health outcomes. My patients are not interested in whether I have hit 97% of my contract. They want to know whether they can get an appointment tomorrow morning if they have pain.

Q14 Joe Robertson: Joe Robertson, Isle of Wight East. I am thinking about Healthwatch and its abolition soon. Certainly in my local experience on the Isle of Wight, Healthwatch has played a really valuable role in advocating for patients, particularly in dentistry, where we have a desert. It has certainly helped local councillors, through the policy and scrutiny committee, to hold to account the ICB, which in my view has not been doing enough, certainly historically. If Healthwatch is to be abolished and its local functions fused with the ICB, what is the implication for holding decision makers to account?

William Pett: Healthwatch has been going for 12 years. We are really proud of the impact we have had in those 12 years. We have helped literally millions of people nationally and locally, with information and advice and having their voice heard. We are proud of the impact we have had. The reaction to the news recently was fundamentally one of sadness. That is primarily for patients, because we know we have done a good job in representing them.

Where we have concerns—similar to the sentiment of your question—is around independence in future. What Healthwatch represents is an independent voice for patients to talk to freely and openly about the state of their local services. We worry that in future, if those functions are brought into Government, where is the independence? It strikes me that if the Government are not careful there could be a conflict of interest, whereby the new system does not in future bring to light some of the failings that Healthwatch brought to light over the past 12 years.

Q15 Joe Robertson: My experience of local Healthwatch has certainly been valuable to assist others in holding to account, and obviously providing information. More generally, does Healthwatch have any insights or opinions it would be helpful to share about tackling dental deserts, or meeting the needs of patients with the greatest dental need? I invite comment on workforce within that and further comment about potentially opening up easier pathways to recognise overseas qualifications quicker, with less bureaucracy.

William Pett: We would welcome an increased skill mix in the dental workforce. Amid all the doom and gloom here this morning, there is a positive news story. When patients see a dentist, we know from our research that levels of satisfaction are high on quality of experience. However, as you say, we have dental deserts and, at the moment, it seems that some previous attempts to get the dental workforce into the areas of most need have not been effective.

I would also say two things on the measures announced yesterday. First, I have already mentioned communication with the target group of patients. Quite simply, how will patients know in future when there is increased NHS availability? I have said already that the "Find a dentist" tool is not fit for purpose. We cannot simply rely on NHS 111 to let patients know locally that there is new NHS availability. That is a fundamental barrier. Secondly, I also mentioned dental charges. If we are to move to increased access, can the Government confirm that yesterday's proposals, which identified a £59 million shortfall in funding, do not mean that patients will literally pay the price?

Q16 Joe Robertson: Let us finish by going back to the beginning. You criticised the "Find a dentist" tool and said that it was not fit for purpose. That is the sort of opinion that is valuable, and we would see on a local level. When you are abolished, who will be able to provide that honest, independent viewpoint to help decision makers improve the system?

William Pett: I am afraid that is not a question for me but for the Minister. All I would say from the Healthwatch perspective is that we stand ready to support the Government on developing what is to become the directorate of patient experience within the Department of Health and Social Care. We will do whatever we can to advise on how to continue the legacy that Healthwatch leaves. But that is not a question for me to answer, I'm afraid.

Q17 Joe Robertson: So my local Isle of Wight Healthwatch is going to be merged into the directorate?

William Pett: No, the functions of your local Healthwatch will be taken on by the local authority on social care and by the ICB on healthcare. At national level, Healthwatch England's statutory functions will be taken on by the Department of Health and Social Care.

Joe Robertson: My local Healthwatch, which is currently very valuable in scrutinising and holding the ICB to account, will have its functions merged into the ICB. Clearly, there is no longer that separation and independence



HOUSE OF COMMONS

of scrutiny.

William Pett: That would be one interpretation of it, yes.

Q18 **Dr Cooper:** I am Beccy Cooper, the MP for Worthing West. I want to move on to funding. I will come to Thea first, but others are welcome to join in. Could you remind the Committee of the current envelope for NHS dentistry, and then, if you are able to, say what the additional spending should be in order to get us to a comprehensive dentistry offer?

Thea Stein: It is approximately £3 billion at the moment. I think the question that needs to be discussed quite openly is whether any Government will bring back universal dental healthcare, when all Governments are faced with making very difficult choices.

Q19 **Dr Cooper:** If we brought back universal dental healthcare—I am not at all saying that we will—what would the additional spend need to be?

Thea Stein: I do not have a figure, but it would be billions. The choice, therefore, with an amount of money within which decisions have to be made, will be for a Government to decide whether those people who have already chosen or been forced to take private dental care will be enabled to come back in to the NHS. What we said in our report about the demise of NHS dentistry was that there needed to be a focus on comprehensively ensuring that those people who were vulnerable had excellent access to dentistry—children, the vulnerable, the poor and so on.

Q20 **Dr Cooper:** Perhaps we can focus on that, and take out those people who are currently accessing private dental care; we can put them to one side for the moment, and look at the people who are accessing dentistry alongside those who should be accessing dentistry, but are not. Do you know what the funding gap is there?

Thea Stein: I do not have a specific figure, but I would think it is at least £1 billion. My colleague might know.

Dr Pabary: As I said earlier, the funding for NHS dentistry has decreased by at least £1 billion over the last 10 years. The first thing we need to do is restore that funding. In NHS terms, I don't think we will need a lot of money to fix the system, if the political will is there.

Dr Cooper: Just to be clear, it is currently £3 billion. Your expertise in the room is that an additional £1 billion would go a great way towards meeting the unmet need gap right now—right?

Dr Pabary: It would certainly restore the funding that we had previously.

Q21 **Dr Cooper:** Thank you. I will move on to the current spend. Thea, you wisely talked about the commissioning underspend; for the benefit of the Committee, could you explain specifically why that occurs and what that gap currently is?

Thea Stein: As your colleague said, ICBs have the role of commissioning and planning NHS dental services. For a variety of reasons, over years, they have had an underspend against that budget.



HOUSE OF COMMONS

Dr Cooper: Could you give us a few of those reasons? That would be really helpful.

Thea Stein: It can be because they have not been able to find dentists in the area to spend it with. I and many others would question whether there is the creativity and the thought going into that. More broadly what happens—

Q22 **Dr Cooper:** Just to be really clear, you do think there is an issue in that there are not sufficient dentists to take up the contracts that are being tendered?

Thea Stein: For some places there are; more broadly, though, the NHS is always looking to balance its budget, and in my experience what will happen is that a dental underspend will be used to balance the budget of the ICB. That goes back to your colleague's question about why dentistry never gets to the top of the list or on to the table: urgent and emergency care, corridor care and primary care access will always top it.

Q23 **Dr Cooper:** I do not want to put words in your mouth, but do you think there is something deliberate about not commissioning to the full extent of the budget, in order to offset the urgent care requirements?

Thea Stein: I don't think it will be deliberate. I think it will be the muddling through that people do in order to try to make the money work.

Q24 **Dr Cooper:** So do you think there is a case to be made for ringfencing dental budgets?

Thea Stein: There are a lot of pros and cons when you get into ringfencing. There would be some pros to ringfencing it but, equally, you can be even more fluid if you do not ringfence it. The history of ringfencing budgets shows, on the whole, a neutrality of outcome

Dr Cooper: Dr Pabary, do you have any thoughts?

Dr Pabary: Absolutely. The Minister said that the contract is mad; you have an underspend, yet you have queues of patients trying to look for care. Without sounding like a broken record, it is the contract that is to blame. We cannot recruit. I work in an area where it is very difficult to recruit, and that is how we end up with clawback and an underspend. It is a vicious circle. It is meant to be ringfenced, and there are good ICBs such as ours that are using the ringfence to do some really innovative things, such as the urgent access scheme that we have in the north-east; that is from the underspend. We have supervised tooth-brushing schemes. We are trying to use the underspend but, fundamentally, we need to come back to reforming the current contract. Then, we should not have an underspend.

Q25 **Dr Cooper:** Perhaps I can stay on innovation and move us into the area of inequalities and prevention. In terms of spend from the dental budget, do you have any sense of how much is going into improving oral health and preventing dental issues?



Thea Stein: I do not have a figure, but the public health grant is also used for oral health promotion. If you look at where the money has gone, broadly, since 2014 the budget that has suffered the most is the public health grant, swiftly followed by community services. You have a situation with a dental underspend, and difficulties looking at what to do with it. You can use some of that for oral health promotion; you have examples across the country of directors of public health being really creative with the small amount of money that they have within councils who have taken some leadership on oral health promotion, but that budget has been seriously reduced over 10 years.

Q26 **Dr Cooper:** Just to clarify, in essence, promotion and prevention in dental health are left to individual innovation in regions—is that correct?

Thea Stein: Yes.

Dr Pabary: Can I just say one quick thing? On the underspend, the way that the NHS accounting system works is that by the time an ICB finds out whatever the underspend is, it tries its best to spend it as quickly as it can within that financial year. It spends some of it on ad hoc orthodontics and sedation, but a large percentage of the budget actually goes back. It is just the way the system works. I underdelivered this year; they won't find that out until June next year. By the time they find out what the underspend was—nearly half a billion over the past couple of years—you can't spend that.

Q27 **Dr Cooper:** That does sound nonsensical, you are right. Do you think that a certain percentage—I appreciate that there is a public health budget and a dental budget, so there may well be some conversations around how they work together—should be utilised for oral health prevention, and do you think that should be stipulated or made mandatory?

Thea Stein: We saw something in yesterday's announcements. We are seeing the roll-out of tooth-brushing in schools. It is a really well-evaluated intervention and it is really positive to see that happening. We have also seen the use of dental therapists for a range of interventions, which, again, is well-evaluated and hopefully would see positive results. Whether stipulating where an amount will go, it will still come back to this very boring answer that we all keep giving: you have to fundamentally reform the contract.

Dr Cooper: Heard loud and clear.

Dr Pabary: Could I echo that? On prevention, we have said to Government that the supervised tooth-brushing scheme is a good idea and we support it. It is a really good thing for prevention. The fluoridation in my neck of the woods in the north-east where the green light for fluoridation has been given, will help another 1.6 million people in my region. There are good things in terms of the public health measure that the Government have done, but I still think that we need to reform the contract.

Q28 **Dr Cooper:** Absolutely. For the benefit of the Committee, could you



HOUSE OF COMMONS

explain how the tooth-brushing will work? Will it be yet another thing that the teachers will be expected to do?

Thea Stein: Yes. I have had conversations with people doing this. There are schools that have embedded it very successfully, and are finding that it is helping and working well. Again, I am sure that you would find from your Education colleagues that there are many teachers who feel overwhelmed by something new to do. We have a range of views, but as an intervention, it is a very successful one.

Q29 **Dr Cooper:** I suppose the concern, again, would be looking at inequality—where the overwhelmed teachers are in terms of areas of deprivation.

Dr Pabary: I have had an argument about this with a teacher. I have spoken to a dentist who runs such a scheme in Yorkshire. It is very slick. The way they work in the morning works really well. It is about five or 10 minutes with the children. It makes a huge impact and it stops the kids having time off for dental treatment in the future, so it is really well-invested money. For every £1 that you invest, you save £3. It does make sense.

Q30 **Dr Cooper:** I am sure, but I am just thinking about our teaching colleagues and all the many things that they have had to take on over the years as wraparound services have been taken away, with the joys of austerity. One final question, Thea: my colleague just highlighted ringfencing. You said that overall it is a neutral intervention. Would there be the argument that if it was ringfenced, it would have to be spent, going back to the underspend argument?

Thea Stein: No. If you have a ringfence, you don't have to spend it. Broadly speaking, if you don't have something in the shop to buy, you can't buy it.

Dr Cooper: Okay, so contract reform. Thank you.

Q31 **Chair:** This is my last question. I have become synonymous with this, so I may as well carry on. Minister Kinnock is on the next panel, and he is in the room. If there is one message that you feel he has not heard that you would like to say, you have 20 seconds each: what would that one message be? I will start with William.

William Pett: We are all going to ask about the contracts, so let me try to say something slightly different. We had some proposals yesterday on improvement, and they are welcome in some respects, but will the Minister confirm that in the coming years, while we await a reformed contract, it will not be patients who pay the price through above-inflation increases in dental charges?

Dr Pabary: I want a clear timetable for negotiations on reform for the new contract—fundamental reform—and a firm deadline for when it is going to be rolled out in this Parliament. Also, what percentage of the comprehensive spending review budget allocation can the Minister allocate to dentistry? I know that is two things and I apologise.



HOUSE OF COMMONS

Chair: You have been naughty—you have given me three things.

Thea Stein: How much NHS money will be spent on dentistry over the spending review period, and will it be a significant increase above £3 billion in real terms?

Chair: Fantastic. I thank the panel for coming today.

Examination of witnesses

Witnesses: Stephen Kinnock, Dr Ed Scully, Dr Jason Wong and Dr Amanda Doyle.

Chair: Good morning. I thank the Minister and his team for coming. We are talking about what is happening with the dental contract two years on. Before we go into the questions, would you all formally introduce yourselves?

Stephen Kinnock: I am Stephen Kinnock, the Minister of State for Care in the Department of Health and Social Care and the MP for Aberafan Maesteg.

Dr Wong: I am Jason Wong, the chief dental officer for England. I work across NHS England and the Department of Health.

Dr Doyle: I am Amanda Doyle, the national director for primary care and community services at NHS England.

Dr Scully: I am Ed Scully, the director for primary and community healthcare at the Department of Health and Social Care.

Q32 **Chair:** Minister Kinnock, thank you for coming this morning. We will go straight into the questions. I have been trying to wade through the 10-year plan. I will not say that I have got through the whole thing, but I have read the bit on dentistry. My point is a simple one, but something you said that really resonated in the report was the fact that from now on newly qualified dentists would be asked to work in the NHS for three years after being qualified. When I go to dentistry folk, they say to me that they do not have a problem with people working within NHS dentistry for the first few years, because they are trying to galvanise their skills and do what they need to following being qualified as dentists. When can patients see the impact of the actual interventions that you have talked about in the plan?

Stephen Kinnock: Thank you for the invitation to come before the Committee today. When you say the interventions, would you like me to say something more broadly, or specifically on the three-year tie-ins?

Chair: What I would like you to do—I thought you would do it anyway—is to start with a bit more of a broad statement, and then just end with the question I have asked. That would be really helpful.

Stephen Kinnock: On tie-ins?

Chair: Yes.

Stephen Kinnock: Got it—thank you very much, Chair. When we came into Government a year ago, we inherited a system of NHS dentistry that was on its knees. One of the most shocking statistics that I uncovered when I first started looking at the brief was that the biggest cause of children aged five to nine being admitted to hospital in our country is to have their decaying teeth removed. I described that as a Dickensian state

of affairs. There is a clear and strong moral imperative for us to fix NHS dentistry. We also have a crazy situation where demand for NHS dentistry is through the roof, yet there is consistently an underspend on NHS dentistry—sometimes to the tune of hundreds of millions of pounds. Those are two big pieces that we have to fix.

I listened with great interest to the previous witness panel, and I want to say that we are absolutely clear that we have to fix this before the end of this Parliament. What is set out in the 10-year plan relates to a whole range of ambitions that we have for 2035; we want to have transformed NHS dentistry by 2035, but it is clear that the fundamental contract reform to put us on the pathway to change has to happen within this Parliament. I just want to make that clear from the start.

The question then is what success looks like by the end of this Parliament. For us, success looks like the following: everyone who needs access to urgent and unscheduled care must be able to access it. Dentists must be incentivised and motivated to deliver NHS dentistry, so that every single penny that is allocated for NHS dentistry is spent on NHS dentistry.

Those will be the basic principles on which, once we have the financial envelope for dentistry—we are now doing the final reconciliations within the Department of Health and Social Care; we have the overall financial envelope from the spending review, but we are now putting it into portfolios, and by the end of the summer at the very latest we will have clarity on the financial envelope for dentistry—we go into contract negotiations, or fundamental reform in terms of the analysis of where we want to go on the contract. I am sure we will get in to that later. That contract needs to be in place and up and running by the end of this Parliament so that, in the latter half of the 10-year plan, we are seeing the transformation that flows from the reformed contract.

To your point on tie-ins, it costs the British taxpayer approximately £200,000 to put a dentist through the study and training process. We think it is only fair that we ensure that the British taxpayer sees a return on that investment. We currently have about 36,000 dentists registered in this country, but only about 10,500 full-time equivalent dentists doing NHS dentistry.

That cannot be right, and we need to redress that, but we are clear that this is not something that will apply to current students. It would not be fair to put a tie-in on to students who signed up on the basis of one set of assumptions—to fundamentally shift the goalposts. We have time to establish how exactly we want the tie-ins to work. We are also very clear that it will not be that you must spend 100% of your time doing NHS dentistry; we will tie in a percentage of time, and everybody who signs up to study to become a dentist will be signing up on the basis that that agreed percentage of their time will be spent on NHS dentistry from the moment they graduate.

The time lag is important; it will be about five years, because it takes five years to educate and train a dentist, so it will be the graduates of 2030

who are affected. That gives us time to agree what the percentage tie-in should be.

There are two important mitigating factors around tie-ins. I understand the concern, which is that you should not tie people into a contract that does not work and is dysfunctional, broken and not fit for purpose. We all agree with that. But, in parallel, we will be fixing the contract. Our intention is that by the time people graduate in five years, they will be tied in for a percentage of their time to a contract that actually works and incentivises them to do NHS work.

Q33 Chair: I know that the contract has only been out a week, but so far, how have the professionals within the service—the dentists and others—taken to what you have been saying?

Stephen Kinnock: On tie-ins?

Chair: Yes.

Stephen Kinnock: I think that, generally speaking, people can see that there is a very robust principle underpinning the tie-in proposal, namely that if the British taxpayer invests £200,000 in educating and training a dentist, that dentist should do some work on the NHS. I do not hear many people arguing with that principle. What they do say is, "But you shouldn't tie trainee dentists into a dysfunctional contract that does not incentivise or motivate them to do NHS work or remunerate them fairly for doing NHS work." That is the whole point of what I was saying earlier: one of the fundamental principles for the fundamental contract reform that we will do is that we will fix NHS dentistry so that dentists are incentivised and motivated to do NHS dentistry.

Q34 Chair: You have said clearly to me today that, even though the 10-year plan says that the service will be sorted out by 2035, you guarantee that you will have looked at the contracts and gone quite far to ensuring that the service is sorted out by the end of this Parliament in 2029 because you fundamentally believe that it is right to start with sorting out the contract and that all the other tie-ins in the 10-year plan will then be far more deliverable. Would you agree that that is what you have just said?

Stephen Kinnock: Yes, that is absolutely what I have just said. The sequencing is that we have to now get the final financial envelope for the remainder of this Parliament for dentistry. In parallel to that, we are working on the analysis of what the payment model for the NHS dentistry contract should be—I am sure the officials can share a little on that. There is no perfect payment model. The BDA likes weighted capitation. There are also sessional payments, item-based, service-based—there is a whole range of ways to restructure the contract to make it work for NHS dentistry. There is very clear feedback that the UDA model is not working and needs to be fixed.

We are ruling nothing out. We are very clear that we have to make our decisions based on evidence and the experience of previous failed attempts to reform the contract. For example, the new patient premium,



HOUSE OF COMMONS

which was at the heart of the previous Government's proposals, was a complete failure. It was supposed to increase the number of people doing NHS treatment by 1 million, but actually led to a 5% decrease. The lesson from that is: do not rush into things like a bull at a gate—get the evidence, do the analysis and look at the different contract models. Is it weighted capitation, sessional, service-based, item-based or perhaps a blended model of all those? Let's get that analysis and come to a view on the best way to do this. Then you start the negotiations with the BDA and other key stakeholders to make that happen.

As soon as we have the financial envelope, we will start that interaction and engagement. I do not want the Committee to think that we are not already doing the analysis of what basic model we need to look at for the NHS.

Chair: That is a good place to stop my questions. Joe, you had an additional question.

Q35 Joe Robertson: Minister, I know that for you and your Government, a key theme in your plans is devolution and having decisions made locally where possible. Speaking as a local MP and local councillor who used to sit on our health policy and scrutiny committee, one of our biggest and best tools for holding our ICB and other decision makers to account is our local Healthwatch, which provides information, data and support, and lifts the lid on some of the failings, where they exist. How will we be able to do that job locally with you dissolving our local Healthwatch?

Stephen Kinnock: You are right: one fundamental principle is around devolution and empowering people who are at the coalface, in terms of making decisions about their local community. The best people to make decisions about the local community are people who are rooted in that local community. The days of us sitting in an ivory tower in Whitehall or Westminster and making decisions in a highly centralised way, thinking that they are the right decisions for communities about which we know very little, are gone, in the opinion of this Government.

You are right that devolution is a key principle; the other is accountability, which flows, really, from the decision to abolish NHS England and merge that into the DHSC. The driving principle of that decision is that we believe that there should be a clear line of accountability, democratically speaking, from the Secretary of State through to Ministers, then through to ICBs and trusts, and those who are at the coalface. We need to make sure that happens with a culture change that ensures real accountability in the leadership, so that we set a set of targets and agreed outcomes, but it is then up to those at the coalface to deliver on those outcomes. We think that having lots of arm's length bodies and third parties involved in this accountability process just ends up diluting, fragmenting and undermining accountability.

The fundamental principle is that we need leadership that steps up and takes responsibility, and the functions that Healthwatch performed should be part of a cultural shift in how we lead within the Department of Health



HOUSE OF COMMONS

and Social Care, ICBs, trusts, practices and surgeries, right down to the grassroots level of how our health and care system works. That is the principle that underpins all of this.

- Q36 **Joe Robertson:** I suspect that quite a few ICBs will feel a bit relieved and will feel a release of accountability with Healthwatch abolished, because, speaking from experience, it has certainly been very valuable in holding ICBs' feet to the fire. It sounds like I am going to have to come to you directly to sort out Hampshire and Isle of Wight ICB.

Stephen Kinnock: I look forward to having that discussion.

- Q37 **Gregory Stafford:** Minister, in yesterday's press release about the consultation, talking about the NHS dentistry system, you said, "We have already started fixing this, rolling out 700,000 urgent and emergency appointments." That is not true, though, is it? There has actually been a delay in rolling out the 700,000 appointments. Why has there been this delay, and when do you think you will get to 700,000 extra appointments?

Stephen Kinnock: I would not agree that there has been a delay. We launched the 700,000 programme on 1 April, and it is happening. Every ICB was given specific targets for the contribution to the additional 700,000 that needed to be made, and we are now closely monitoring the performance of each ICB against those targets.

- Q38 **Gregory Stafford:** How many have been rolled out so far?

Stephen Kinnock: The data starts to come in from May, because it is a month-by-month process. We will have that data and be able to publish an update on it over the course of the summer, so there will be publication of the performance of each ICB against the targets that we have set by the end of the summer.

- Q39 **Gregory Stafford:** When do you think you will achieve the 700,000 extra appointments? By what date?

Stephen Kinnock: By 1 April 2026. We will do that every year, and one of the key points of the consultation that we launched yesterday is about how we embed the 700,000 in the NHS contract.

- Q40 **Gregory Stafford:** Obviously, you have stated that you will be monitoring that. What happens if individual ICBs—Joe has talked about Hampshire and Isle of Wight, which also covers part of my patch—are not meeting the requirement? What is the sanction? What support will the Department be giving to ensure they can meet that?

Stephen Kinnock: I will hand over to colleagues, because they are going to be very closely involved with that, but I am getting a monthly update from officials, and they are updating me on the performance of each of the ICBs. There will be a check and challenge process so that where we see that there may be challenges around hitting those targets the DHSC will intervene. I could perhaps hand over to Amanda to say a little bit more about that.



HOUSE OF COMMONS

Dr Doyle: When we set a target for each ICB, that was not strictly per capita; it was dependent on the degree to which they were meeting urgent care need already. So we set them all targets of extra activity to commission. We checked, prior to the start of the financial year, that each ICB was in position and had commissioned necessary extra activity. That was to be commissioned from 1 April. Dental practices have 62 days after they complete a course of treatment to put the claim in for that course of treatment. Often it is more than one visit.

So we have not yet, from 1 April to now, reached the period where we have got full reconciled claims even from 1 April, although we are not far off for April. What we are doing then is monitoring by ICB as those verified activity figures come in, to monitor them against the trajectory they need to be on. We have got a process set up through the regions to speak to each ICB on a regular basis if it looks like they are not delivering; because we know they have commissioned the activity, they also need to make sure that patients actually get it.

- Q41 **Gregory Stafford:** Will you publish either to the general public or to this Committee, from ICB to ICB, how far they have got down that route? Because I think it will be very helpful for us as a Committee to be able to understand whether this is succeeding or not.

Dr Doyle: I think it will be helpful to publish it; I think you are right. We have got to have the verified data for more than one month before we start to do that, but later on in the year we will start to do that.

- Q42 **Gregory Stafford:** Let us move on to the second part of your statement, Minister. In your press release, you state, "We have already started fixing this", and the quote goes, "bringing in supervising tooth-brushing for 3 to 5 year olds in the most deprived areas of the country." Now, putting aside whether you think it should be schools or actually parents who teach their children how to brush their teeth, could you give an update on the progress in meeting this commitment?

Stephen Kinnock: Yes. That is going to launch across the country at the beginning of the school year. We have got now the 23 million toothpastes and toothbrushes that we have secured through that innovative partnership with Colgate-Palmolive. They are being delivered across the country over the course of the summer, and the programme will start in September of this year.

- Q43 **Gregory Stafford:** Have you identified the areas or the schools where that intervention will go in?

Stephen Kinnock: Yes. We have used the index of multiple deprivation, the 20% top percentile in terms of the super-outputs of that. We then have agreed the numbers for each ICB and each public health authority, and they have identified the schools where it will start. So yes, we have not micromanaged that from the centre. We have said, "This is the index that you need to use."

The schools that are identified—not only schools, but nurseries and other settings for young children—are the places that will be benefiting from the



scheme. The budget for it is £11 million. Of course, with the additional partnership with Colgate, that is a significantly bigger package. But it is very much a programme that is focused on areas of greatest deprivation in the country.

- Q44 Gregory Stafford:** I think you have said that that would cover about 600,000 pupils. Presumably that will not all happen on 1 or 2 September or whenever people go back to school. What is the period in which you think you will reach 600,000 young people? And again, what is the monitoring process to ensure that that target is reached?

Stephen Kinnock: Our target is to get the 600,000 reached over the course of the school year starting in September. The monitoring process is that the public health authority in each ICB area will be reporting into the ICB, and the ICB will then be reporting in to us. It is similar to what Amanda just set out on the 700,000—there will then be, if necessary, a check and challenge process if we think that for some reason those targets are not being met. I do not know whether officials wanted to add anything on the detail of that at all.

Dr Scully: No, that is correct. It will be monitored. There will then be a full evaluation by the National Institute for Health and Care Research on the programme.

- Q45 Gregory Stafford:** Presumably, if this is seen to be a success, it is something the Government would want to continue year on year. Has any assessment been made of the cost of that, as opposed to, for example, educational assistance for parents to teach their children how to brush their teeth?

Stephen Kinnock: We will absolutely be evaluating the programme based on a whole range of indicators, including feedback from teachers and educators, in settings, from parents, and from the evidence of also, for example, things like a reduction in the number of days lost due to tooth decay. Children losing time in school because of tooth decay is obviously a massive challenge that we need to address. If the evaluation shows that it is positive and things are working, I would be very keen to continue it.

Of course, this does also relate to getting the financial envelope for dentistry agreed, and then making sure that we carve out a budget for preventative measures in the financial envelope. But with all of those things being considered we are very clear, as I think colleagues in the previous session said, that the evidence base for this is very, very strong. We are not prepared to stand by whilst the greatest cause of five to nine-year-old children being taken into hospital is tooth decay.

On the visit that I did to a school in Bristol when we launched the scheme, it was really interesting talking to the parents because they said that because of them doing the supervised tooth-brushing in school, it has become much easier for them to get their kids to brush their teeth with great levels of co-operation at home. So it is having a win/win positive impact, not just on what is happening in school, but on what is happening at home. So we are absolutely convinced that this is the right thing to do.

It is the kind of partnership between schools and parents that can have a very positive impact.

- Q46 Jen Craft:** Thank you for joining us today, Minister. I would like to return briefly to the tie-in policy. I wondered whether you would assess the potential risk of delays to reforming the dental contract on this policy and wider policies in the 10-year plan as well.

Stephen Kinnock: I think it is really important to say that we are going to do fundamental contract reform in parallel to a number of the other things that we are doing—such as supervised tooth-brushing. Also the consultation that we launched yesterday, which will be around those really important, and I think high-impact, interim reforms that we need to see, such as making sure that the 700,000 target is hit by mandating dental practices to do a percentage of their time on urgent and unscheduled care. Also, the complex care pathways—it is really important that people who have complex needs in terms of their dental care will now have pathways that will be funded as a lump sum, which will really de-risk complex care and help dentists to do that kind of work. Fluoride varnish is also really important for young children.

I heard in the previous session people saying, “Oh, these measures”—the ones that we launched a consultation on yesterday—would be “minor tweaks”. I do not agree with that at all. I think the changes that we proposed yesterday are really important and positive steps in the right direction. To your point on tie-ins, absolutely, this is something that we will work on in terms of assessing how to ensure that it works, so that the percentage agreed in terms of how much time you should be tied into NHS work after you graduate is fair, both to the British taxpayer and to dentists; and that will slot into the broader contract reform that we are doing. I would say that the tie-ins will be a subset of the broader contract reform.

- Q47 Chair:** Before the next question, can I make a point, Minister? Unfortunately, the Committee did not get the consultation document that you talked about till 6.30 last night, so none of the Committee members have had an opportunity to read it or even really look at it. Could we ask that in future, if we are going to do something like this, we get the documents so that we can properly scrutinise them? Then it does mean that you are not saying something that we cannot respond to.

Stephen Kinnock: Thank you, Chair. It is a very fair point. The timing was not mainly in my control. I had been hoping that it would go out on Monday, but then for various reasons it went out yesterday instead. I am also very happy to set out a little bit of what is in there.

Chair: I would prefer it if you did not, because the Committee likes to have a look first and then do that.

Stephen Kinnock: I am also very happy to respond in writing once the Committee has had a chance to digest it. Please do send in your questions.

Chair: Thanks for that offer; we will take you up on that.

Q48 Jen Craft: I appreciate your previous response. I would perhaps press on the fact that we heard in the previous panel from members of the dental profession, including the chair of the BDA, and their feeling that came across fairly clearly was that while they were very appreciative of some of the parts of the ten-year plan and the things that you may have said were minor tweaks—although you dispute that—what has been coming forward sounds like very good noises, but what they need to see is very clear progress. Is there a clear timetable for setting out negotiations towards the fundamental reform of the contract, and how do you see that going forward?

Stephen Kinnock: I can certainly answer your question in terms of the first steps, because they are more within our control, in the sense that we have got to finalise the financial envelope for dentistry, and that will happen by the end of the summer at the latest. As soon as we have that, we are in a position to draw on some of the analysis that we are already doing around what is the right kind of payment model, recognising that there is a lot of concern about the UDA model, looking at the other models—capitation, sessional payments, item-based and service-based payments—of course, engaging with the BDA and other key stakeholders throughout that process.

We have also got to look at the prioritisation because, as I think the previous panellists said, the resources are finite. There will be a budget for dentistry. We have to cut our cloth according to that budget, and we have to prioritise. One fairly clear signal I think you will have got from some of my opening remarks was that we are looking to prioritise those who have urgent need—people with broken teeth, an abscess, infections. We have prioritised them in the 700,000. Assuming that our strategy continues to be that we will prioritise them in terms of fundamental contract reform, that will be a strong influence on the way in which we seek to reform the contract.

Q49 Jen Craft: I hear what you are saying on this, but there has only been one phrase in there that could be taken to be an indication of a timeline, which is to have the spending review envelope finalised by summer. I think what the previous panel is looking for is an indication of when they will see that timeline. I am sure you can appreciate their cynicism, and perhaps some of the cynicism of the Committee, given that the previous Committee has highlighted that the success of several things, such as three-year tie-ins, and any other interventions, relies on having fundamental contract reform. Is there a timeline for when that will take place? What can the dental profession look forward to? When can they expect to be brought in potentially to negotiations, and when will they have an indication that this process is truly under way?

Stephen Kinnock: I am sure that officials will want to come in on this, but we are in a constant dialogue with the BDA. I don't think it is a question of there being a lot of work that we are going to do internally before we start to engage with them. We want to do that as an iterative process, working with the BDA. But we do have to learn from the experience of the previous dental recovery plan, particularly around the failures of the new patient premium, and ensure that we do not do that



again.

We also have to be very clear around what our strategic priorities are, given the finite resources that we have. I think today there is a clear signal that the strategic priority will be people with urgent need. There is also a big strategic priority around preventative care, and that is where we see the commitment in the consultation that we launched yesterday to fluoride varnish, which is so important for children.

We have to put all those things into the mix and, until we are clear on what kind of payment model will work best in delivering those strategic priorities, it is difficult to know what the timeline for finalising the contract might be. For example, some of the changes that we decide we need may require legislation. As soon as we get into a discussion about needing legislation, particularly if potentially primary legislation might be required, we already then have some doubt about how much control we have over the timeline.

I am therefore reluctant to name a specific date for saying, "By this date, a fundamentally reformed contract will be in place", apart from what I said at the start, which is that a fundamentally reformed contract will be in place, up and running, and beginning to give people in England particularly a very different experience of NHS dentistry by the end of this Parliament.

Q50 Jen Craft: Is there an assessment of the risk of delays on the fundamental reform of the dental contract to the various parts of the 10-year plan relating to dentistry? Again, tie-ins come into it. What is your thinking? If the reform does not come forward in a timely manner, what is your thinking about the impact that that will have on recruitment and retention? In the previous panel, we heard that six out of 10 NHS dentists would leave if they did not see fundamental reform. What is your personal assessment from a wider perspective as to the impact of potential delays?

Stephen Kinnock: My assessment is that we are on a burning platform. We have a moral imperative to fix NHS dentistry in our country. How can it be that we live in a country where the biggest cause of five to nine-year-old children being taken to hospital is to have their decaying teeth removed, when tooth decay is an almost entirely preventable problem?

There is no doubt in my mind that we need to move with great speed. However, we also have to ensure that when we move, it is based on strong analysis, evidence testing and learning from previous errors that have been made. We have to get that balance right between speed and accuracy, but I absolutely agree that if we do not move quickly and fix this, we are going to have a really serious problem with the dental health of this country.

I will say that, although I am not going to go into detail about the consultation that was launched yesterday, the moves that we are making on urgent care, particularly on the 700,000 and on embedding that, I think will have a positive impact on patients and on the motivation and incentivisation of dentists. One of the important things is that we are proposing in that consultation, a very substantial increase in the UDA tariff



HOUSE OF COMMONS

for urgent care, from an average of £40 to an average of £70 to £75. That is how we incentivise dentists to do the urgent care that is required.

- Q51 **Jen Craft:** Thank you, Minister. I will give you a brief break. Dr Doyle, are you able to provide a little more detail on how you plan to recruit and fund dental therapists and dental nurses to work in the neighbourhood teams? That seems fundamental to the transformation.

Dr Doyle: That's right. We are very clear that a neighbourhood health service includes dentistry. Some of the reforms that we are proposing through the 10-year plan—but effected sooner than that—are about increasing the skills mix. We have already made changes that enable better use of the skills mix, and a lot of activity, particularly in care for children—fissure sealants, fluoride varnish, simple check-ups—can be carried out by dental therapists or enhanced dental nurses. Jason is probably the expert, but we have various programmes around increasing the numbers of professionals we train. We have given flexibility to the way dental contractors can claim for delivery, to make it more straightforward to claim equally for courses of treatment delivered by people other than just the dentists. We hope that that will encourage dental contractors to recruit a wider skills mix and therefore give us more capacity for the funding that we have available. I do not know if Jason wants to add anything.

Dr Wong: It is a positive thing that I sense the profession actually wants—spreading the workload out further, rather than having only dentists doing almost the entirety, and moving towards a shared care model. Changes have been made to allow direct access to dental therapists and dental hygienists in particular. As Amanda said, the scope of practice in the children's spaces matches quite nicely, but overall in terms of dental teams I think it would be quite a positive move for us to look at a whole team approach to care.

- Q52 **Jen Craft:** So it is a case of incentivising and encouraging dental contractors at the local level to recruit more of these roles. Am I right?

Dr Wong: There are two parts. One is in the work that we have been doing up to now. The commitment of the 10-year health plan is slightly different and looks at the potential of neighbourhood models, as Amanda said.

- Q53 **Jen Craft:** What is the idea behind these potential models in the 10-year plan? How will they drive recruitment into these roles?

Dr Wong: That is work that we still have to do, but that is the commitment made to the work that we will do moving forward.

Dr Doyle: We expect the core provision of dental services as part of neighbourhood health services to be from current dental providers, but with an opportunity to increase their skills mix and change how they work to deliver easier access to the urgent care that we have just talked about, along with preventive dental interventions with children.

Chair: I will have to wrap this up now, otherwise we will never finish. I

will go swiftly over to Danny.

- Q54 Danny Beales:** Lord Darzi said in his review of the NHS that “urgent action is needed to develop a contract that balances activity and prevention” and “is attractive to dentists”. Do you think that the action you are taking does that?

Stephen Kinnock: I think we are moving in the right direction. We are clear that we have to have a contract that ensures that everybody who has an urgent need for dental care gets it, that dentists are incentivised and motivated to do NHS work, and that every single penny allocated for NHS dentistry is spent on NHS dentistry. We are quite a long way from that now. We know that we have a big gap to fill—that is not meant to be a pun, by the way. We have to move into that space. The sequencing of it is as I have set out previously, but we have to move forward. I agree with Lord Darzi’s assessment that this is urgent. We have to deal with it urgently, but we have to get it right, based on strong analysis and evidence.

- Q55 Danny Beales:** I appreciate that you agree on the problem, but I come back to the urgency. Do you feel that urgency is being shown? I take the point that the timetable is challenging, but can you accept that in the absence of a timetable for more fundamental reform, it does feel urgent? Again, I take my colleague’s point about complexities and that legislation could be needed. We as a Committee understand that legislation is coming forward to enable the NHS England changes. There might be legislative opportunities as a part of that, but without a timetable it is hard for this Committee, which for many years has recommended fundamental reform, to be assured that that is happening urgently. Rather than labour the point, would you be happy to write to the Committee to outline what steps and timescales could be provided around the sequence towards a fundamental reform?

Stephen Kinnock: Yes, I would be happy to do that. I would just say that since we came in 12 months ago we have launched the 700,000, urgent appointments programme and the supervised tooth-brushing programme, and yesterday we launched this consultation which is going to have a significant impact on complex care pathways, fluoride varnish and embedding the 700,000 appointments.

We have a mixture of crisis management and strategic change, and we have had to prioritise the former because of the dreadful mess that we inherited. We must now move at pace on the latter—the strategic change. That has also been tied up with the overall financial envelope, which we have already discussed. So yes, I am happy to write to the Committee. I just emphasise that we are doing two things: crisis management and strategic reform.

- Q56 Danny Beales:** This Committee and the PAC, in its report a few months ago, recognise the complete failure of previous efforts under the last Government to make progress, so I understand the scale of the challenge. On the fundamental question of the budget envelope you mentioned, once



that is settled in the summer, would you be happy to provide the Committee with a breakdown of how that compares in terms of percentage increase with other areas of primary care and secondary care?

Is it fair to say that, for a long time, dentistry has been a poor relation of primary care and health care more generally in terms of its budget? We heard previously about a real-terms decrease and a significant underspend despite the problems that you have outlined—you talked about the perverse situation of rising demand but increasing spend and underspend. Do you agree with the assessment that dentistry has been under-prioritised in terms of funding for too long? Are you prepared to share that information with the Committee once it is set in the summer?

Stephen Kinnock: I agree that there has been a real-terms cut in the NHS dentistry budget over recent years. I also agree that, in a sense, we had the perfect storm, because we had that overall cut but also a contract that did not work, so we have ended up with a cut and underspend, which is a truly absurd situation to be in. So I agree with that.

The one thing I would say is that the overall budget for NHS dentistry is actually £4.1 billion; I think previous panellists talked about £3 billion. That £3 billion is for primary care; then there is about £1 billion being spent on secondary NHS dentistry. So it is £3.7 billion for primary care, £0.3 billion for community care and £0.9 billion for secondary care. Then you have an £800 million netting off to do because of the dental charges paid by patients, which leads you to £4.1 billion. But I would be happy to look at your question about how that relates to other parts of the health and care system, with the focus on primary care that you are after.

Q57 **Danny Beales:** Primary care and secondary care more generally. It would be good to understand how the increases—hopefully—in the budget relate and compare with other areas of care, to understand relative prioritisation.

Stephen Kinnock: Yes.

Danny Beales: Thank you for confirming.

You highlighted the need for good evidence and to learn the lessons of previous abortive and failed attempts at reform; I think the Committee would agree. We have previously suggested changing the method of payment to capitation-based models, which was partially but not fully accepted. I am sure we would welcome exploration of that as a Committee.

In terms of having a full picture of the information as well as the types of payment models, do you have access to information about the costs of inaction and failure in the current system? We have talked somewhat about in-patient episodes for children, but do you have analysis around lost work time for people due to dentistry issues? There is emerging evidence about the role of gum disease and its potential relation to dementia and Alzheimer's in later life, and there is a lot of evidence around the links to cardiovascular disease and dentistry issues. Are you looking at both the costs of doing something with payment models and the current costs from a failed dentistry system?



HOUSE OF COMMONS

Stephen Kinnock: On your point on capitation, I know that the BDA's view is that we should move to a system based on weighted capitation. We are absolutely open to having that discussion, but there are pros and cons of capitation.

The prototypes for capitation were run from, I think, 2011 to 2022, which was before my time, but I am sure that colleagues can talk a little bit about that. It did have some issues. It didn't deliver in terms of access, and it didn't necessarily deliver in terms of improved patient outcomes—so we need to look at the lessons learned from those prototypes. I don't have specific statistics to show the cost of inaction, both the clinical cost and the cost to the economy. I am not sure what the methodology would be for gathering those statistics.

Dr Wong: Public Health England did a bit of work a few years back about the loss of school time and the cost resulting from children going for extraction and general anaesthetic. It is something that has been talked about, but I am not aware that we have a full analysis of what you are suggesting.

Q58 **Danny Beales:** The lack of that data, compared with other areas of care, may explain the lack of prioritisation of dentistry.

Dr Scully: What we do have is data on what happened with weighted capitation when it was piloted: a 10% reduction in the number of people seen, the number of urgent appointments dropped to 46% of the previous level, and the number of band 2 treatments dropped to 64% of what they were previously. The pilots did loads of great stuff, and weighted capitation should obviously be considered, but it is not black and white. There are loads of different ways to do weighted capitation, but those access figures and activity numbers were quite stark and strong, and that is probably what formed part of the basis for the response.

Q59 **Danny Beales:** I guess the core of my question is that, far too often, we view dentistry as a cosmetic issue rather than a fundamental healthcare issue that has costs in people's lives, mental health, physical health and long-term health outcomes, and if you can't indicate that you have access to relevant data, I suggest that it might be helpful were the Department to do some work to understand what those costs could be.

Dr Scully: We have lots of data with the work and health unit. There is a joint work and health unit between the Department and DWP, and it has lots of figures across all sorts of different areas, so we will pull those out.

Q60 **Danny Beales:** Will you send it to the Committee?

Stephen Kinnock: We would be happy to do that.

Danny Beales: Thank you. I will leave my questions there.

Q61 **Josh Fenton-Glynn:** Thank you for coming today, Minister Kinnock. You said to my colleague Jen that we are on a burning platform. We have heard a lot about the problems involved. Do you think that the level of our solution meets the crisis that you outlined of being on a burning platform?



Stephen Kinnock: I think we have to define what we want to do with the NHS contract, based on the reality of the finite resource that we will have. We are of course going through the negotiations about the financial envelope. We have to work on the assumption that we will have a financial envelope that is in the region of the current financial envelope. That is the reality of the world that we live in.

The question then is: how do we make the NHS contract work to its maximum impact for the people who need it the most? We have to cut our cloth based on the resources that we have. We must ensure that there is never again a penny of underspend, and that there is a focus on people with urgent need—people with broken teeth, severe gum disease or abscesses—as defined under the 700,000. Once we have those key principles in place, we have to engineer a contract that delivers to them, and then we have to be realistic that that is what the contract is about.

If we go into the discussion about fundamental contract reform with unrealistic expectations about what can be achieved, that would be the wrong way to do it. We need to be very clear and robust about what we can achieve with the finite resources that we have, and then it is up to us to ensure we can achieve that to an excellent and outstanding level.

- Q62 **Josh Fenton-Glynn:** Just to paraphrase, I don't feel like you are saying that we are treating this like a burning platform. You are saying, "We are treating this as a burning platform within the resources that we have, and we only have buckets and water." I guess, to paraphrase what you are saying, we are going to scotch the urgent problem now, and then we will look to a more sustainable system. Is that correct?

Stephen Kinnock: I think your question was: do the means of resolving the problem match the scale of the problem? My response is that we first have to define what we can do within the resources that we have and what the priorities are. It is going to be about choices and prioritisation—that is the nature of Government in general. We have to make some choices.

The lesson from previous attempts to reform the contract is that was no clarity about what the priority problem we were seeking to solve was, so that is what we are going to do. We are going to be robust, clear and honest about what the problem is that we are seeking to resolve, and how our reforms will deliver on that basis.

- Q63 **Josh Fenton-Glynn:** I feel like that goes back to the previous panellists who said that one of the issues we have is that people feel like dentistry should operate like their GP and they just do not feel it does, so we need to say what the relationship is with dentistry and NHS dentistry.

Stephen Kinnock: Yes, I think that is correct.

Josh Fenton-Glynn: Sorry—I have gone way off my questions. I will go back to where I am supposed to go.

Stephen Kinnock: It is a very important point.



Q64 Josh Fenton-Glynn: Something that I think is quite close to your heart is the Welsh Government. They have proposed a reform of the dental contract to move away from routine appointments, and the introduction of the central dental access portal. What do you think of that proposal?

Stephen Kinnock: I think it is a really interesting proposal and we should definitely look at it.

NICE guidance on routine check-ups is that an adult with good oral health doesn't need a check-up more than between every 12 and 24 months, and a child with good oral health doesn't need a check-up more than between six and 12 months. We do think that there is quite a lot of unnecessary recall in the system and that is one of the issues that I think the Welsh approach is seeking to address.

That is something that we are looking at. It is in the consultation we launched yesterday. How can we get the routine check-ups to be appropriate and necessary, but not overkill? We think that will free up resources in dental practices. The approach that the Welsh Government are taking is an important step in that direction.

Dr Wong: From the perspective of applying NICE guidance, my hope is that the profession will continue to embrace that without the centre telling them to do so. We are trying to build communities of practice in the profession; in terms of whether someone should be recalled, it is based on risk assessment and there is a clinical judgment in that. I cannot comment on what Wales is doing on that front, but from my perspective, there is work to be done with the profession on that and we aim to do it.

Josh Fenton-Glynn: Obviously, my only fear is that the habit of the six-monthly check-up is quite useful to get into. I say that as someone who once went eight years without a check-up and would probably be a poster child for prevention, because my teeth aren't great.

Moving away from that revelation that I did not intend to make—

Stephen Kinnock: It is on the record now, Josh.

Q65 Josh Fenton-Glynn: On telly, and everything.

The aim of the dental cost survey is to provide an accurate understanding of the costs and pressures facing the dental sector. Can you give us a bit of a timeline for when it will be published and how we will use the initial findings to inform contract reform?

Stephen Kinnock: The consultation on the survey closed on 16 June, and we are now going through those statistics. I am very keen to get a conclusion as rapidly as possible, because if we can put that information together with the financial envelope, we can go into contract reform with all the basic information we need—both your costs and how much money you have. Those are two really important elements.

Can colleagues clarify when we will be publishing or sharing the results of the survey?



HOUSE OF COMMONS

Dr Scully: We can come back with that. I think it is not too far away. We are talking about—

Q66 **Josh Fenton-Glynn:** Are we talking weeks or months?

Dr Scully: We are talking two months, I would have thought. Let me come back to you.

Chair: You will come back to us, but it will be a few months.

Dr Scully: It will be a couple of months. We want to feed it into the consultation that was published yesterday.

Chair: Fantastic. Thank you very much.

Q67 **Alex McIntyre:** I am Alex McIntyre, the MP for Gloucester. I will start on something that Josh questioned. Has any analysis been done on what additional costs a reduction in routine appointments—check-ups, for example—would lead to due to people being caught later down the line? Obviously, one of the big shifts in the 10-year plan is a shift to prevention, and a lot of the focus is rightly on the urgent part of the treatment and the crisis in NHS dentistry. But what is the opportunity cost? If we do not see people for their routine check-ups, how many more people will be caught further down the line with tooth decay, and what additional costs might that have for the system?

Dr Wong: I don't think we have done that analysis. There was anecdotal evidence, as we emerged from the pandemic, that people were coming in with higher needs, so more intervention was required. Overall, system-wise, it was really difficult to pinpoint an exact figure for the cost. On that directly, there is no analysis. The question that has been looked at is whether there is an opportunity cost in decreasing the number of routine check-ups, which will give an opportunity to free up capacity within the system to do other treatments and maybe concentrate on those in greatest need.

Q68 **Alex McIntyre:** The impact assessment published with the consultation that came out yesterday shows that if you eradicated those unnecessary check-ups and used the underspend properly, you could—the aim is to get to 500,000 more patients next year. At the moment, the problem is that there are too many unnecessary check-ups.

Dr Wong: That is not the question you asked.

Alex McIntyre: We have recognised in the 10-year plan that shifting to prevention will relieve pressures on the system as a whole. For example, if you tackle obesity, you will have fewer people developing bowel cancer, which will cut costs overall. If the longer-term reform of the contract is focused on urgent treatment, are we not at risk of ending up with exponential growth of urgent treatment? I hear what you say about 500,000 extra appointments, but how do you know that it would not have been a necessary check-up? Presumably these things are relatively broad. You cannot say for certain that somebody who is coming for their routine check-up does not need it, because you cannot profile that. I guess my



concern is that it seems to be counterintuitive to what we are trying to do in the 10-year plan.

Dr Doyle: The recommendations we are making are based on NICE guidance, and NICE guidance is drafted after looking at all the evidence. We know who are the higher-risk patients who may need to continue coming in every six months, and we know that is not the case for generally orally healthy adults. We know there is not a detrimental effect from those adults having check-ups every 18 months.

Stephen Kinnock: I think the difference, Alex, is that there is good prevention that is effective and there is prevention that is not really adding any value. What we are trying to get to is based on the NICE guidance of 12 to 24 months, or six to 12 months for children. Let's do that, because that is clinically demonstrated to be effective prevention, which then frees up capacity and adds value.

The other important point is on the fluoride varnish, which we think is really important, and that will be a big part of the prevention agenda. The complex care pathways will be an opportunity to take a patient through treatment over a longer period of time. That will also get more chair time between the dentist and the patient, which is a good opportunity to hammer home the messages about how you look after your teeth. In some ways, treatment and prevention are two sides of the same coin.

Dr Wong: Although most of what we treat is entirely preventable, there is a difference between primary and secondary prevention. The evidence base is clear on how primary prevention can have an impact overall. By the way, most of that probably occurs outside dental surgeries, so although it is an important role of dentists and dental teams, we have to think of it as globally inclusive. But on your substantive point, that particular analysis has not been done.

Alex McIntyre: I will move swiftly on to the questions I am meant to be asking.

Chair: Alex, I am afraid you can ask only one more question. It is quarter past 11.

Q69 **Alex McIntyre:** Okay. Can you provide an update on how the roll-out of the golden hello scheme is going, and the data you have to support the impact it is having on access in areas of high demand?

Stephen Kinnock: There is a budget for 240 golden hellos. We are currently at 93, which is not as high as I would like it to be, so we need to drill down to understand why we have not had more take-up. A large number are out for advertisement as we speak, and we hope there will be improved take-up as information and awareness of this opportunity get into the system. We are committed to reviewing it, and we are very happy to report back to the Committee as and when we do that review.

Chair: Thank you. Sorry, Alex—I will make up for it next week. We will now go swiftly to Andrew.



Q70 Andrew George: I am Andrew George, representing west Cornwall and the Isles of Scilly. Stephen, you mentioned that you would see the contract as a success if you both achieved no underspend—I think “not a penny of underspend” was your expression—and were on top of all the needs for emergency treatment. Those are the two factors that you were going to take into account. Whatever happened to the shift from treatment to prevention? The contract should surely be about that shift, shouldn’t it?

Stephen Kinnock: We absolutely recognise that routine check-ups are important, but our view, based on NICE guidance, is that unnecessary routine check-ups are taking place, so one thing is to shift into effective prevention rather than ineffective prevention. We are also doing a lot of prevention work through supervised tooth-brushing and by enabling dental nurses to do fluoride varnishing, rather than constantly thinking that it has to be done by dentists. We passionately believe that NHS dentistry is a team sport. We really want to see hygienists, therapists and nurses operating at the top of their licence, and fluoride varnishing will be an important part of that.

I think the thrust of your question is whether this is an either/or. Is it either treatment or prevention? I don’t think it is, but it is a clear signal that we have to prioritise people who need urgent care because they have a broken tooth, an abscess, severe gum disease or whatever it might be—the categories we set out when we launched the 700,000 appointments.

To the point made by a previous panellist, a lot of people use private dentistry. Dentistry is a mixed economy, and that is established. When we have the NHS dentistry contract, we also have to look at which groups of people in the country who have urgent care needs are prioritised, because when we say that everybody who needs urgent care gets it, it is about defining what we mean by need.

Chair: Can you move on to workforce, Andrew?

Q71 Andrew George: Yes, absolutely. We will come back to the contract on another occasion, because it doesn’t tie up in my mind. On the questions or the theme of urgency that Danny raised earlier, we understood that the workforce plan was literally days away. We were talking about the summer, and now we are talking about later this year. If we are to address the requirement for recruitment into dentistry, surely the workforce plan should be brought forward as quickly as possible.

Stephen Kinnock: Colleagues in the Department are working hard on the workforce plan. It is useful to have the 10-year plan, because it is generally a very good idea to define your strategic purpose as an organisation before you define the workforce to deliver it. It is very good that we have sequenced it on that basis.

On workforce, I would add that we have thousands of international dentists waiting to do the overseas registration exam—we have a backlog of something like 5,000. I met the GDC two weeks ago to make it clear that we need to see the backlog being cleared. There is a big opportunity to do that. The GDC is currently procuring a new supplier for the



HOUSE OF COMMONS

infrastructure and supervisory capability to do the exams. We need to crack on with that. I said to the GDC that I need to see a plan by October setting out very clearly how we will clear that backlog, because there are 5,000 internationally qualified dentists who need to do the ORE, which is an opportunity to boost the workforce. We have the lowest number of dentists per capita in the G7.

Q72 Andrew George: On the incentives to encourage new dentists or graduates to come into the NHS, you were talking about tie-ins earlier. If you are to meet or fill the gaps in the dentistry desert, to what extent will you use incentives or requirements that tie them to geographic areas where the need is greatest?

Stephen Kinnock: Assuming that we continue with the golden hello scheme, or something like that, it is very targeted on dental deserts. There is a commitment to having a scheme that targets underserved areas. Whether the current golden hello scheme, as it is set up, is workable and delivering what we want is another question. We need to ensure that we target that. We recognise that there are very clearly underserved geographic areas of the country, particularly the south-west and east of England, but there are also other parts with severely underserved areas, and we have to address that.

On the dental schools question, there is a clear correlation between people going to study in a particular area of the country and starting to lay down roots. How do we ensure that our dental schools strategy reflects the need to get more dentists into certain parts of the country? If you have studied in an area, gone to university and spent five years there, you start to put down roots and it is more likely that you will stay there.

Andrew George: Do I have time for one more question?

Chair: Not really, no. There are lots of questions that Members still want to ask, so if you do not mind, we will put them in writing. For the final couple of questions, over to Ben.

Q73 Ben Coleman: We have covered a lot. Thank you all very much for coming today. I am the Member of Parliament for Chelsea and Fulham. I read the long-term plan and attempted to read the consultation, which came out at 6 pm yesterday. That was bad, as it should have come out earlier—I want to make that very clear. I do not know which one of you was responsible, or whether it is outside your control, but it was not good and not polite to the Committee. Looking at those things, you said that you will require dentists to practise in the NHS for three years. Is that not already happening? What will be different about this?

Stephen Kinnock: Sadly, they are not. We have 36,000 registered dentists in the country, but only about 10,500 full-time equivalents are working in NHS dentistry. There is clearly a gap. The British taxpayer invested £200,000 in every single one of those 36,000, or at least the ones who were educated and trained in the UK. We believe it is fair to have a tie-in, but it will, of course, not be 100% of their time.



HOUSE OF COMMONS

Q74 Ben Coleman: What percentage of new graduates are staying in NHS dentistry for three years at the moment?

Dr Scully: One year after dental foundation training, 15% to 18% of dentists who have graduated do not work in the NHS at all. You have to do a year of dental foundation training after your undergrad course, and you have to do dental foundation training to be able to do NHS work. Some 95% of graduates do dental foundation training, and after that year, 15% to 18% do not do any NHS work at all.

Q75 Ben Coleman: Will you require them to do up to three years of exclusively NHS work, or only some?

Stephen Kinnock: A percentage.

Ben Coleman: Do you know what percentage it will be?

Stephen Kinnock: It will need to be negotiated and agreed with the BDA.

Q76 Ben Coleman: Before we talk about underspends, are you prepared to consider salaried dentists?

Stephen Kinnock: Do you mean within the tie-in or within the contract reform?

Ben Coleman: Generally, as part of resolving the problem. Ed, you made a face. Do you want to respond?

Dr Scully: That's just my face. I always look like that.

Stephen Kinnock: That is his resting face.

Ben Coleman: A very interesting resting face.

Dr Scully: We obviously already have some salaried dentists in the NHS, in community and secondary care. We have consulted on the principle of the decision, but we will now have to consult on its design. That is the next stage, and we will be consulting fully.

Q77 Ben Coleman: Will you be consulting on having more salaried dentists?

Dr Scully: No, we will be consulting on the design of tie-ins, and what that looks like. Having more salaried dentists is not being factored in. That will be a political decision, but it has not been part of the discussion so far.

Ben Coleman: Is it worth considering?

Stephen Kinnock: As things stand, virtually all dentists are self-employed, so it would be a big shift to go to salaried dentists. I want to make it clear that, when it comes to fundamental contract reform, we are not ruling anything out at this stage. We will look at all sorts of different ways of improving the current situation, but we would have to be clear on how moving to salaried dentists would improve patient outcomes, access and all the priorities we set out. That is the question that would have to be answered.



HOUSE OF COMMONS

Q78 **Ben Coleman:** That is very helpful. We have talked a lot about underspends, so forgive me for asking a final question on that. Is there not an argument for just rolling over the underspends into the following year? I am coming back to the question of ringfencing, because I think it was not sufficiently answered in the previous session. Could we not ringfence dental funding so that you get a combination of ringfencing and rolling over? Would that not help?

Stephen Kinnock: Dental funding is ringfenced.

Dr Doyle: Dental funding is ringfenced.

Q79 **Ben Coleman:** In the ICB? At the moment, you have a situation where ICBs are required to ringfence the funding, but they do not actually observe the ringfence, so it does not seem to be enforced. When you say it is ringfenced, it is not in practice.

Dr Doyle: It is. We have a ringfence of the dental budget. The opening position—

Ben Coleman: We heard in the previous session that money was being taken from the underspend and spent on other things.

Dr Doyle: They were mistaken.

Ben Coleman: They were mistaken?

Dr Doyle: They were mistaken.

Q80 **Ben Coleman:** If we look at all the 100-and-whatever ICBs in the country, would we find that it had not happened in any of them?

Dr Doyle: There are 42 ICBs in the country.

Ben Coleman: There are 42, sorry.

Dr Doyle: We are finalising the audited accounts for last year, but we are in the process of getting that money back from those ICBs that underspent on their dental ringfence last year. Part of the reason is that it is a huge incentive for ICBs to find new and innovative ways to commission more dental activity to ensure it is spent. This is the third year.

Q81 **Ben Coleman:** I remember from sitting on an ICB that there was quite a hefty discussion about what it was doing with the underspend, and the implication was that it was being spent on other things.

Dr Doyle: That is why we made it a ringfence.

Dr Scully: The rules changed last year, in 2024-25, so it could not be spent on anything else by the ICB; it would be pulled back to NHS England.

Q82 **Ben Coleman:** You are pulling it back?

Dr Doyle: We are pulling it back.



HOUSE OF COMMONS

Ben Coleman: Why don't you leave it with them and let them spend it in the following year? Why are you pulling it back?

Dr Doyle: With the way in which the money works, we cannot roll it forward.

Q83 **Ben Coleman:** In the brave new world that we are meant to be in, and in trying to be a different sort of Government doing things in different ways, why not leave the money with them and insist that they spend it on dentistry in the following year?

Dr Scully: You are talking to the wrong Department, as these are Treasury rules.

Q84 **Ben Coleman:** Is that a discussion you are prepared to have with the Treasury?

Dr Doyle: There are two things. First, we have increased ICBs' commissioning abilities and flexibilities to make it easier for them to spend all the allocation on dentistry. We also brought in changes in 2022 to enable ICBs to go to dental contractors who are consistently underdelivering on their contract and shrink the size of their contract to free up the funding to commission activity from those who are able to deliver it. That will shrink the underspend, because much of it was due to contractors consistently underdelivering on their contract but still having the right to retain the size of that contract. We have put a stop to that. We have ringfenced and are continuing to do so. There are now very few ringfences in the NHS budget, but dentistry is one of them. We do not have finalised numbers for last year, 2024-25, but I am very confident that the size of the underspend will have very significantly reduced.

Ben Coleman: Did you have—

Chair: No, Ben. We are nearly at 11.30 am, so it has to be a one-word answer from whoever you ask.

Q85 **Ben Coleman:** Why not measure underspend quarterly? Why wait until the end of the year?

Dr Doyle: We monitor the position of the underspend on an ongoing basis.

Q86 **Ben Coleman:** If you monitor it already, what figure are you expecting to come up with this year?

Dr Doyle: I do not have the final, audited end-of-year figure for 2024-25.

Ben Coleman: What is it roughly?

Dr Doyle: It has very significantly reduced from the previous year.

Ben Coleman: Roughly what sum are we talking about?

Chair: A third? Half?

Dr Doyle: Less than 10% of what it was the year before.



HOUSE OF COMMONS

Ben Coleman: What was it the year before?

Stephen Kinnock: It was £400 million the year before.

Ben Coleman: So it is £40 million this year? We have made significant progress since July.

Dr Doyle: I cannot say that, because we do not have the final details, but I can confidently say it is very much lower than it has been.

Chair: We will leave it at that. Thank you all so much; it has been an interesting session.