House of Commons

Committee of Public Accounts

Fixing NHS Dentistry

Twenty-First Report of Session 2024–25 HC 648

Committee of Public Accounts

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Contents

Summary

The Department for Health and Social Care (DHSC) and NHS England's (NHSE) 2024 dental recovery plan has comprehensively failed to deliver improvements in access to NHS dentistry, and the most vulnerable patients continue to suffer the most from long-standing failures in the system. Meanwhile, the dental contract remains unfit for purpose and fails to incentivise practices to deliver sufficient NHS care. At best, current funding and contractual arrangements are only sufficient for around half of the English population to see an NHS dentist over a two-year period. In reality just 40% of adults saw an NHS dentist in the two years up to March 2024, compared to 49% in the two years prior to the Covid pandemic.

It is clear that the four main initiatives in the dental recovery plan have not delivered the more than 1.5 million additional courses of treatment that DHSC and NHSE estimated they would. Despite the incentives provided by the largest of the four initiatives, the new patient premium (NPP), NHSE data shows that initiative has actually resulted in 3% fewer new patients seeing an NHS dentist since the NPP was introduced in March 2024. The 'golden hello' recruitment scheme has seen less than 20% of the 240 expected dentists appointed, and no data is yet available showing any impact from the uplift to the minimum value of a unit of dental activity. The final initiative—mobile dental vans—has been dropped. The modelling that underpinned the dental recovery plan was flawed, and even if the plan had performed in line with expectations it was never actually ambitious enough to meet its stated aim of ensuring that everyone who needs to see an NHS dentist would be able to.

The new government has committed to delivering 700,000 extra urgent dental appointments, and to introduce more fundamental reform to the dental contract. It is clear that such reform is necessary to mend NHS dentistry, with dental practices having little incentive to take on NHS patients or, if they do treat NHS patients, to carry out more complex procedures. But NHSE and DHSC do not yet know what that reform might look like or to what timescales it can be delivered. Further tweaks to the existing contractual arrangements will not be enough. NHSE and DHSC need to be clear what the actual cost of delivering NHS dentistry is, and work with the entire dental profession and wider stakeholders to design and deliver short and long-term changes to prevent further decline of the service. The role of local commissioners will be central to this, as will having a workforce that is motivated to deliver NHS care.

Introduction

The Department of Health and Social Care (DHSC) is responsible for overall healthcare policy in England. The Government recently announced that over the next two years NHS England (NHSE), will be brought into DHSC, but in the meantime it is an arm's length body of DHSC, and is responsible for the implementation of health services in England, including NHS dentistry. Dentistry is delivered by independent dental practices, that enter into a contract with integrated care boards (ICBs), who are responsible for commissioning NHS dental care under delegation from NHSE.

Overall spending on NHS dentistry came to £3.11 billion in 2023–24, a fall from £3.66 billion in 2019–20. Access to NHS dentistry was affected by the COVID–19 pandemic, when the proportion of the adult population seen by an NHS dentist fell from 49% in the 24 months up to March 2020 to 34% in the following 24 months up to March 2022. While this recovered to 40% by March 2024, access remains below pre–pandemic levels.

In 2024 the then government announced its dental recovery plan. The plan had three components: four initiatives to deliver more than an additional 1.5 million courses of treatment in 2024–25 at a cost of £200 million; Smile for Life (a focus on prevention and oral health in children); and measures to support the dental workforce.

Conclusions and recommendations

1. **Minor changes to a contract that is not fit for purpose have failed to incentivise dental professionals to undertake sufficient levels of NHS work, and while more fundamental reform has been needed for decades there is still no sign of progress.** The current dental contract is based on arrangements agreed back in 2006 and pays dentists fixed amounts for delivering contractually agreed levels of dental activity. Officials broadly accepted that the contract was not fit for purpose and needs urgent and fundamental reform. When we asked NSHE if it would be better to rip up the NHS dental contract and start again, following a consultation with dentists to establish what their requirements are from a new system, they told us that was exactly what they were going to do. The contract no longer meets the needs of the population, provides disincentives for practices to take on NHS patients (especially patients with more complex needs), and leads to a situation where under–delivery on contracts leads to significant underspends in the NHS dental budget. There has only been one set of changes to this contract since 2006 and more fundamental reform, along with a clear focus on prevention and overall oral health, is desperately needed. The new government has committed to delivering this reform, but DHSC and NHSE cannot yet give an indication of when this process will begin. Patients and the dental profession alike deserve to know when they can expect further details on reform. They also need clarity on how prevention will be at the heart of changes, and how DHSC and NHSE will consult on what patients and professionals need from the service in future.

RECOMMENDATION

a. DHSC and NHSE should set out in their Treasury Minute response what they believe a realistic timetable would be if a decision to replace the existing dental contract with a new one is taken by ministers. This should include how they will consult on reforms with stakeholders and the public.

b. DHSC and NHSE should explain what steps can be taken to maintain patient access to dental services while a new contract is being negotiated.

c. NHSE and DHSC should also set out what their vision is for improving preventative care and promoting good oral health, providing an update on any wider preventative oral healthcare work that NHSE and DHSC are considering to support oral health outcomes.

2. **The dental recovery plan was never going to deliver its headline ambition that everyone who needs to see an NHS dentist would be able to, and has failed even to deliver the hoped for 1.5 million additional courses of treatment in 2024–25.** The plan's initial promise to expand access in 2024–25 so that everyone who needed to see a dentist would be able to was never aligned to its actual target of an additional 1.5 million courses of treatment. Even this target would have left overall delivery still around 2.6 million courses of treatment short of pre–pandemic levels. The dental recovery plan has failed to deliver the promised additional courses of treatment, the number of new patients seen is actually falling, and slow or no progress has been made on other initiatives. At least £88 million has already been spent on the new patient premium, but 3% fewer new patients have been seen since it was launched in March 2024. Given the public money spent on initiatives that have yielded little or negative results, it is important that NHSE and DHSC produce a transparent evaluation of what government spent on the plan and why it has not had the desired impact on access to NHS dentistry.

RECOMMENDATION
DHSC and NHSE must publish their evaluation of the dental recovery plan and what was spent on it. They should write to the Committee as soon as is practical to confirm their final analysis of the plan's performance in 2024–25, including details of:

- how many additional treatments the plan as a whole delivered;
- for each of the four main initiatives a breakdown of what they individually achieved;
- the final amount spent on each initiative; and
- how far the performance in the 2024–25 plan can be continued into 2025–26

3. **DHSC and NHSE's modelling of what might be achieved, and how much this would cost was wrong and it took too long to identify the error, raising wider concerns about the quality assurance processes in place for such plans.** DHSC and NHSE only identified an error in their assumptions about the cost of the new patient premium during preparation for our evidence session, a year since the publication of the plan in February 2024.

While they assured us that the error was not material to the delivery of the plan, we were concerned that something as fundamental as the cost of the plan, and the number of appointments it could deliver, was based on flawed analysis. The NAO report in November 2024, and the Health and Social Care Committee's inquiry into NHS dentistry in March 2024, had previously raised concerns over how robust this modelling was. We heard that DHSC and NHSE have now designated dentistry a "business-critical model", and that additional resource and quality assurance will be available in the future, but they have yet to make clear what this change will mean in practice.

RECOMMENDATION
In their Treasury Minute response to this report DHSC and NHSE should set out how they are strengthening their own analytical capabilities in dentistry, and explain what will change in practice as a result of dentistry being designated as 'business critical'.

4. **The dental recovery plan relied on centrally planned and imposed initiatives that ultimately failed to positively influence the amount of care delivered by dental practices.** The dental recovery plan set out national initiatives that relied on take-up and delivery at a local level, hoping to influence the behaviour of individual dental practices. This approach ultimately failed, with the example of mobile dental vans particularly illustrative of a nationally-planned idea failing to address issues on the ground. Going beyond this national plan, it is imperative that regional disparities in access to NHS dentistry are resolved–access to NHS dentistry ranged from 382 courses of treatment delivered per 1,000 people in Somerset ICB to 800 delivered per 1,000 people in South Yorkshire ICB in 2023–24. NHSE and DHSC must support ICBs to use what flexibilities they have in their commissioning powers to deliver improvements that will work for their particular areas, and where necessary there should be clear lines of accountability for how ICBs manage NHS dental services under their responsibility. Commitments like the new government's proposed 700,000 urgent appointments will rely on NHSE and DHSC's ability to work with the people who deliver the service to translate that national priority into a local reality.

RECOMMENDATION
NHSE and DHSC must in their future plans for NHS dentistry:

a. clearly articulate how they will improve on previous efforts to co-ordinate between central and local initiatives.
b. explain how they intend to support ICBs to innovate within their commissioning powers, while holding them to account for improving dentistry in their areas.

c. explain how they intend to support ICBs where, contrary to Government initiatives to expand access to dental treatment, practises may be experiencing a reduction in funding for 2025–26.

5. **DHSC and NHSE have not undertaken the analysis needed to understand the actual cost of delivering NHS dental care, without which any efforts at reform will fail to address fundamental issues around the affordability of NHS work.** The discrepancy between what a dentist can earn delivering NHS work and private work is a fundamental issue for improving access. The current NHS dental contract, and its reliance on Units of Dental Activity (UDA) rates that were set nearly two decades ago, is unfit for purpose. Recent attempts to address disparities in what practices can earn for delivering NHS work by increasing the minimum UDA value first to £23 and then to £28, and to better reflect the different costs of treatments of greater complexity, have failed to deliver any identifiable improvements. We agree with DHSC when it says that fiddling around with the contract fails to address the real problem. In April 2023, there were 34,520 dentists registered to provide dentistry in England, but only 24,193 of these provided some NHS dental care in 2023–24. Without proper remuneration it is likely that even more will move exclusively to the private sector. However, it does not appear that NHSE and DHSC yet have a sense of what level of funding would provide a realistic incentive for dentists to prioritise NHS work. Until there is a clear and evidence–based proposal for remuneration that reflects the true costs of dentistry, that issue is unlikely to be resolved.

RECOMMENDATION
DHSC and NHSE should commit in their Treasury Minute response to conducting and publishing analysis of the actual costs of providing NHS dental care as part of any future work on reforms to NHS dentistry, reflecting the full range of complexities of treatments that patients might need. This should include an explanation of how the current structure of payments to dentists, in terms of the range and complexity of treatment, has different impacts depending on the deprivation of the community served.

6. **Without a workforce sufficiently supported to deliver NHS dental care, there will be no future for NHS dentistry and DHSC and NHSE have not yet done enough to address workforce issues.** The total number of dentists delivering some NHS dental care is in decline and NHSE data showed that in March 2024 there were over 5,500 vacancies across the NHS dental profession with many of these going unfilled for over 180 days. Whether the issue is a lack of dental professionals altogether, or a lack of dental professionals willing to take on NHS work, it is clear that there

is a need to go further on efforts to support the dental workforce. This is particularly true for deprived, rural and coastal parts of the country where challenges in attracting dentists to work are particularly acute. The dental recovery plan included some measures to address this challenge, such as a consultation for a dental graduate "tie-in" to the NHS, expanding training places and helping patients access care from a variety of dental professionals. The results of the consultation on the dental graduate tie-in is still outstanding, and work by DHSC on the other measures is ongoing. The success of these measures will depend on buy-in from all members of the dental team, and a clear sense from DHSC and NHSE of what the barriers are to attracting professionals to NHS work.

RECOMMENDATION

DHSC must:

a. publish its response to the consultation on a dental graduate "tie-in"; and

b. set out what more the department and NHSE intend to do to address obstacles to attracting dental professionals to carry out NHS work and close the gap between it and private work. This response must include detail on what further work is planned on skills mix and ensuring that dental practices make best use of all members of the wider dental team. This should include an explanation of how all dental professional groups will be consulted on future reforms.

1 Contractual reform and the 2024 dental recovery plan

Introduction

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department for Health and Social Care (DHSC) and NHS England (NHSE) on NHS dentistry and the dental recovery plan.[1]

2. We also considered written evidence from submissions from dentistry stakeholders, including membership bodies and thinktanks.[2] This evidence raised with us a variety of concerns, including:

   - issues with the NHS dental contract;
   - workforce challenges; and
   - the impact of inequalities in access to care throughout England.

3. DHSC is responsible for overall healthcare policy in England. The Government recently announced that over the next two years NHSE will be brought into DHSC, but in the meantime it is an arm's length body of DHSC, and is responsible for the implementation of health services in England, including NHS dentistry. Dentistry is delivered by independent dental practices, that enter into a contract with integrated care boards (ICBs), who are responsible for commissioning NHS dental care under delegation from NHSE.[3]

4. Overall spending on NHS dentistry came to £3.11 billion in 2023–24, a real-terms fall of just over £500 million since 2019–20. Access to NHS dentistry was affected by the COVID-19 pandemic, when the proportion of the adult

1 C&AG's Report, Investigation into the NHS dental recovery plan, Session 2024–25, HC 308, 27 November 2024
2 Fixing NHS dentistry - Written evidence - Committees - UK Parliament
3 C&AG's Report, paras 1.2 to 1.5; Oral statement to Parliament, NHS England: Health and Social Care Secretary's statement, 13 March 2025

population seen by an NHS dentist fell from 49% in the 24 months up to March 2020 to 34% in the 24 months up to March 2022. While this recovered to 40% by March 2024, levels of access remain below pre-pandemic levels.[4]

5. In 2024 the then government announced a dental recovery plan. The plan had three components: initiatives to deliver more than an additional 1.5 million courses of treatment in 2024–25 at a cost of £200 million; Smile for Life (a focus on prevention and oral health in children); and measures to support the dental workforce.[5] At our evidence session in February 2025, NHSE and DHSC acknowledged that the plan had failed to deliver additional dental activity, that the dental contract is unfit for purpose and that more fundamental reform will be required to address the decline in NHS dental services.[6]

The NHS dental contract

6. The NAO's report found that the current dental contract is widely regarded as in need of reform with many in the sector viewing the contract as a disincentive to perform NHS care when practices have the choice of offering private care too. The current contractual arrangements were introduced in 2006. Individual practices and commissioners (integrated care boards, or ICBs, have acted as commissioners since 2023) have a contract where practices agree to deliver a certain number of Units of Dental Activity (UDA).[7] This system was developed rapidly and intended to be temporary,[8] and an independent review in 2009 by Professor Jimmy Steele noted that the dental profession's reaction to the 2006 contract was "particularly hostile". Steele's review found that concerns centred around the adverse effect on patients, increased business risk for dentists, a lack of piloting, and growing bureaucracy.[9]

7. In our evidence session we asked NHSE if it would be better to rip up the NHS dental contract and start again, following a consultation with dentists to establish what their requirements are from a new system. NHSE's response was "that is exactly what we are going to do",[10] and it also accepted that the current contract is no longer fit for purpose.[11] In later correspondence

4 C&AG's Report, paras 1.7, 1.9, 1.27
5 C&AG's Report, para 1
6 Qq 12, 13 and 81
7 C&AG's Report, para 11
8 House of Commons Library, NHS dentistry in England (Research briefing), published 29 May 2024. See page 22
9 NHS, NHS dental services in England: An independent review by Professor Jimmy Steele, published June 2009. See page 27
10 Q 32
11 Q 12

NHSE reiterated its commitment to fundamentally reforming the dental contract, said it was progressing discussions with ministers on the options, and added that it recognised the "urgency of the situation".[12]

8. In the written evidence submitted to our inquiry, concerns included that:

- UDA rates are linked to the figures used in 2006 which no longer reflect current need.[13] Rates vary from practice to practice so dentists in the same location may be paid different amounts for the same work; [14]
- the contract is rooted in ineffective incentives that make it easier to complete targets by seeing patients with lower levels of need, while making high-needs patients the least "welcome"; [15] and
- the overall level of funding means that NHS rates are not competitive with the private sector. The resulting contraction in NHS coverage leads to a "feedback loop", in which the design of the contract leads to underspends and less spent on dentistry than was intended.[16]

9. The NAO report reflects this last point, finding that in 2022–23 £479 million was recovered from dental contracts where practices had not delivered the full amount of care that they had been contracted for.[17]

10. DHSC told us that issues with NHS dentistry pre-date the 2006 contract, and that with any change since the 1990s, "things have got worse".[18] DHSC began attempts at contract reform in 2010, testing changes through a prototype programme which combined payment by activity with a fixed amount paid per registered patient. Further prototype contracts ran between 2016 and 2019, but these arrangements ended in 2022 with DHSC concluding that the prototype had led to reductions in access and activity.[19] In 2022, the first changes to the 2006 contract were introduced, including:

- dividing band 2 treatments into three categories to reflect different complexities of treatment;
- introducing a minimum indicative UDA value of £23; and

12 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to a follow up on the oral evidence session held on 13 February 2025 on Fixing NHS Dentistry, 18 March 2025
13 FND0002, see page 4
14 FND0007, see page 3
15 FND0007, see page 2
16 FND0011, see page 2
17 C&AG's Report, Figure 9
18 Q 82
19 C&AG's Report, para 1.24

- enabling commissioners to address worsening access due to persistently under–delivering dental contractors.[20]

11. DHSC told us that it believed that those reforms "made a useful difference" and were a "step in the right direction".[21] We note, however, that the NAO report found that it saw no evidence of a full evaluation of these reforms.[22] NHSE said that it recognised since the 2022 reforms that further reform is "absolutely fundamental".[23] The new government has also committed to contract reform.[24] Given the length of time in which the dental contract has been identified as a barrier to improving NHS dental access, we pressed DHSC and NHSE on when they could deliver this. DHSC said that it is not possible to give a timeframe, but that some reform is "fairly imminent", and that it could look to provide a timeframe on what can be done within the current framework, while beyond that much rests with political decisions.[25] In written evidence following our session, NHSE and DHSC told us that they are working with representatives of the dental sector and patient groups to "fully consider the options at pace", and that while these fundamental reforms are being developed work is ongoing on medium–term changes to improve the current NHS dental contract.[26]

12. The new government's commitment to contract reform includes reference to a focus on prevention,[27] and also to a programme of supervised toothbrushing for three, four, and five–year olds "most in need".[28] Tooth decay is a leading cause of hospital admissions for children in this country,[29] and as DHSC told us in the session, prevention is preferable to needing treatment from a dentist.[30] Strengthening preventative oral healthcare measures is an important accompaniment to ensuring access to dentists, particularly for children. The government has now published further information on its proposed supervised toothbrushing scheme,[31] and has confirmed its intention to expand community water fluoridation in the

20 C&AG's Report, para 1.25
21 Q 27
22 C&AG's Report, para 1.26
23 Q 25
24 NHS Dental Contracting Framework, 15 October 2024
25 Qq 77 and 97
26 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to a follow up on the oral evidence session held on 13 February 2025 on Fixing NHS Dentistry, 18 March 2025
27 NHS Dental Contracting Framework, 15 October 2024
28 Schools: Dental Health, answered 4 February 2025
29 C&AG's Report, para 1.10
30 Q 18
31 DHSC, Supervised toothbrushing for children to prevent tooth decay, published 7 March 2025

north–east.[32] However, as DHSC noted, a relatively low percentage of the UK population has water fluoridation in comparison with some other countries, and there are other measures (including fluoride varnish) that can also be highly effective at protecting teeth.[33]

The 2024 dental recovery plan

13. The 2024 dental recovery plan included four headline initiatives, which aimed to provide an additional 1.5 million courses of treatment at a cost of £200 million in 2024–25.[34] Funding for these initiatives would be drawn from anticipated underspends in the 2024–25 dental budget.[35] These initiatives were:

- the new patient premium (NPP): in 2024–25, participating practices could receive a credit of UDAs equivalent to £15 or £50 for each eligible new patient they saw (depending on the complexity of the treatment);
- 'golden hello' payments to dentists: incentive payments of £20,000 (paid over three years from 2024–25) for 240 dentists;
- uplift to the minimum value of a UDA: the new minimum UDA value would be £28 rather than £23; and
- mobile dental vans: mobile units to deliver treatments in targeted communities.[36]

14. The NAO's report found that the plan was not on track to deliver the expected number of additional courses of treatment.[37] When the report was published in November 2024:

- fewer new patients had been treated under the NPP than in the equivalent period in the previous year;
- no data was available on the UDA uplift; [38]
- only one 'golden hello' dentist had been appointed; and
- mobile dental vans had been abandoned as a national initiative and left for local commissioners to procure if they wished to.[39]

32 DHSC, Consultation outcome: consultation on community water fluoridation expansion in the north east of England: government response, published 7 March 2025
33 Q 17
34 C&AG's Report, Figure 10
35 C&AG's Report, para 13
36 C&AG's Report, para 2
37 C&AG's Report, para 16
38 C&AG's Report, para 16
39 C&AG's Report, Figure 11

15. At our session in February 2025 DHSC acknowledged that whilst the concept behind the initiatives were "entirely reasonable" the initiatives in the plan had ultimately not been successful, and that one—the new patient premium—"clearly failed".[40] NHSE also agreed that the plan had been unsuccessful but noted that overall UDA delivery for 2024–25 is on track to be about 1% higher than 2023–24, which NHSE felt was "in line" with increases in previous years.[41] The NAO report, however, found that DHSC had assumed an increase in activity in 2024–25 of around 3.7% without the added hoped–for activity from the dental recovery plan.[42] We asked for a number of how many additional courses of treatment had been delivered against the overall 1.5 million target, but NHSE could not give a specific answer, saying that it is "too early to say at this point that we have delivered towards the 1.5 million".[43]

16. NHSE did tell us that "roughly 2.7 million new patients" had come through during the year so far, which they claimed was "on track with what we would have expected" based on last year.[44] However, DHSC and NHSE published information in February 2025, shortly after our evidence session in the same month, that stated there was a 3% decrease in the number of new patients accessing NHS dentists since the introduction of the NPP, and that the NPP has cost £88 million.[45]

17. In terms of the other initiatives, NHSE confirmed that it is too early to say whether the uplift to £28 minimum UDA value has had any impact.[46] It said that it will only be after the year end that data will be available on the UDA uplift.[47] For 'golden hellos', as of February 2025 only 39 (less than 20% of the hoped for 240) 'golden hello' dentists had been appointed. NHSE acknowledged that this was a "slightly slower start than we had hoped" but felt that a longer time scale will be needed to evaluate whether that initiative has generated benefits.[48] No ICB has decided to commission a mobile dental van.[49] NHSE has begun publishing data on the NPP, and a programme of evaluation has commenced, but beyond that will need more time to definitively say what impact, if any, the plan has had.[50]

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40 Q 13
41 Q 14
42 C&AG's Report, para 3.5
43 Q 14
44 Q 14
45 DHSC, Dental patients to benefit from 700,000 extra urgent appointments, published 21 February 2025
46 Q 26
47 Q 14
48 Qq 41–42
49 Q 49
50 Q 73

18. The initial announcement of the dental recovery plan claimed that its aim was to "significantly expand access so that everyone who needs to see a dentist will be able to".[51] However, that ambition was never aligned to the actual targets of the plan, as an additional 1.5 million courses of treatment would have left overall delivery in 2024–25 around 2.6 million courses of treatment short of pre–pandemic levels.[52] DHSC confirmed this to us, saying that "even had all the aspirations of this plan been achieved, we would not have got to a point where everyone could see a dentist".[53]

DHSC and NHSE's modelling

19. Shortly before our evidence session in February we received a letter from DHSC and NHSE explaining that an error had been identified in their initial modelling of the dental recovery plan.[54] The error related to the cost of the NPP, which NHSE and DHSC had estimated would be £164 million for an additional 1.13 million courses of treatment in 2024–25.[55] Their modelling did not, however, account for the cost of the premium for new patients who would have seen an NHS dentist in 2024–25 without the additional incentive. Factoring this in meant that the £164 million attributed to the NPP would only be able to deliver 690,000 additional treatments. Delivering all 1.13 million additional treatments would cost an additional £33 million.[56]

20. The £200 million assumed cost of the dental recovery plan was to be drawn from expected underspends in the dental budget for 2024–25.[57] As there was an under–spend of £392 million in 2023–24, NHSE and DHSC said that this additional cost would be affordable within the overall dental budget, and was not material to the delivery of the plan.[58]

21. Given this error, NHSE assured us that additional analytical resources would be put in place for the dental service, which would in future be designated a "business–critical model".[59] We were told that there had been

51 DHSC, Faster, simpler and fairer: our plan to recover and reform NHS dentistry, published 7 February 2024
52 C&AG's Report, para 12
53 Q 57
54 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to the modelling error in the plan to reform NHS Dentistry, 11 February 2025
55 C&AG's Report, Figure 10
56 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to the modelling error in the plan to reform NHS Dentistry, 11 February 2025
57 C&AG's Report, para 13
58 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to the modelling error in the plan to reform NHS Dentistry, 11 February 2025
59 Q 2

quality assurance in place on the figures in the plan, although we note that the NAO found a lack of analysis on why the costs between initiatives were allocated as they were and that it was unclear how NHSE's models had arrived at the final numbers included and published in the plan.[60] Concerns about the quality of the modelling involved were raised by the Health and Social Care Committee in March 2024, when the then responsible minister acknowledged that there was a "high likelihood" of the modelling not being reliable.[61]

Delivering changes at a local or central level

22. Responsibility for commissioning dental services was delegated to integrated care boards (ICBs) in April 2023.[62] Within the national dental contractual framework, ICBs have some flexibilities that NHSE says should help them to tailor services to meet specific population needs.[63] This includes the ability to commission additional services, and to support practices that receive lower payments for each UDA they deliver. The NAO's report outlines how some ICBs have used these flexibilities, for example through raising the minimum UDA value in their area to £30 (rather than the national minimum of £28), or through initiatives such as Greater Manchester's dental access quality scheme.[64]

23. The dental recovery plan's four main initiatives were centrally planned by NHSE and DHSC with instructions given to commissioners as to how to carry them out.[65] The plan's delivery, therefore, was heavily reliant on ICBs implementing these initiatives at a local level and delivery by dental practices. The NAO's report notes that ICB's had "mixed experiences" of engaging with NHSE and DHSC, and that while some met with the national team to discuss local initiatives and any overlap with the proposed national schemes, these were not always fully taken into account.[66] Given the failure of the plan to deliver any increase in activity, it seems clear that these nationally-planned initiatives failed to influence behaviour at a local level, although NHSE told us that they have seen feedback that the initiatives were

60 Q 3; C&AG's Report, para 2.9 and 2.12
61 Health and Social Care Committee evidence session on 19 March 2024, NHS dentistry, see Q186
62 C&AG's Report, para 1.5
63 NHSE, Opportunities for flexible commissioning in primary care dentistry: A framework for commissioners, published October 2023
64 C&AG's Report, para 2.11
65 DHSC, Faster, simpler and fairer: our plan to recover and reform NHS dentistry, published 7 February 2024
66 C&AG's Report, paras 2.11, 2.15

welcomed.[67] The NAO's report notes that there was some flexibility at a local level, for example where the new patient premium potentially overlapped with existing local schemes, and that regions were taking different approaches to implementing the 'golden hello' incentive payments.[68]

24. The idea of identifying ICBs to commission mobile dental vans seems a particular example of an ineffective interaction between a national policy and an appropriate measure on the ground. NHSE and DHSC identified twelve ICBs to deliver the initiative,[69] but none of these ICBs have since chosen to invest in a dental van.[70] DHSC acknowledged that ICBs know their own "patches" the best, and that allowing them to use that knowledge to decide on the best way to provide dental service would be preferable to trying to direct that from Whitehall.[71] NHSE also acknowledged the importance of working with local commissioners, especially given that dentistry is a delegated service, to share best practice and to have accountability for implementing reforms locally.[72] We note that this will be tested in the proposed method for actioning the new government's commitment to delivering an additional 700,000 urgent appointments.[73] In written evidence after the evidence session, NHSE and DHSC told us that dental commissioning teams within ICBs will be working to make these appointments available as soon as possible from April 2025.[74]

67 Q 55
68 C&AG's Report, para 2.11
69 NHSE, Dental recovery plan update, Annex B, published 10 May 2024
70 Q 49
71 Q 51
72 Q 48
73 Q 101
74 Letter from the Interim Permanent Secretary of the Department of Health and Social Care and the Chief Executive Officer at NHS England relating to a follow up on the oral evidence session held on 13 February 2025 on Fixing NHS Dentistry, 18 March 2025

2 Future reform of NHS dentistry

Establishing the true cost of NHS dentistry

25. Under the current NHS dental contract, dentists are contracted to deliver a certain number of Units of Dental Activity (UDAs). Based on current treatment bands, there are six different levels of UDAs that a treatment can attract depending on the complexity of the treatment. Simple treatment such as a regular check–up counts as one UDA whereas the most complicated treatments, such as crowns and dentures, count for 12 UDAs.[75]

26. UDA payment rates are not however, uniform across the country with evidence submitted by the British Dental Association suggesting, for example, that the average UDA rate in North East London ICB is more than £7 greater than the average rate in Lincolnshire ICB.[76] Government took the decision in 2022 to introduce a minimum UDA value of £23, with NHSE telling us that this decision did lead to some "slight improvements in activity".[77] As part of the dental recovery plan, NHSE and DHSC agreed to push this minimum value up to £28, leading to 876 individual contracts being uplifted to this new minimum rate. This was a ministerial decision rather than an evidenced–based one, with DHSC's own analysis unconvinced as to whether the uplift would lead to any real increases in contract delivery.[78] The impact of the uplift is not yet known in quantitative terms, but NHSE told us that the qualitative feedback has been positive in terms of supporting the sustainability of the affected practices.[79]

27. DHSC told us that even with these uplifts to UDA rates, there is still a large gap between what dentists are earning through NHS work compared with the larger amounts they can make in the private sector.[80] It described this as the "fundamental problem" facing NHS dentistry and commented that it was perfectly reasonable for dentists to choose to go down private routes

75 C&AG's Report, Figure 1
76 FND0007, see page 3
77 Q 26
78 C&AG's Report, Figure 11 and para 2.10
79 Q 26
80 Q 13

given the greater financial incentives that exist.[81] It said that whilst there is plenty that can be done in terms of the detail of the dental contract, the biggest barrier remains the gap in pay that is available for a NHS dentist versus one operating privately.[82] This tallies with much of the written evidence that we received, with stakeholders from across the dental profession noting the disparity between pay in the NHS compared with the private sector, and arguing that such disparities are leading to the under provision of NHS dental care.[83]

28. There is also a clear sense that UDA rates do not sufficiently distinguish between the different levels of complexity and cost attached to various treatments. This is despite the government decision in 2022 to split up band 2 treatments into three separate bands each attracting a different number of UDAs. This was in acknowledgement of the fact that there are different costs associated with, for example, treating someone for one filling compared with performing molar endodontics on permanent teeth.[84] Many stakeholders feel that this does not go far enough, however, with submissions to us pointing out that one filling can still be reimbursed to the same level as a treatment requiring five fillings.[85] NHSE confirmed that the later decision to set the minimum UDA value at £28 was not based on modelling relating to costs, but was based on how much they could lift the rate and drive greater activity rather than an actual understanding of the costs of the treatments. NHS England told us that it is committed to modelling this costing going forward and engaging with the sector to understand it properly.[86]

NHS dental workforce

29. The NAO reported that in 2023–24 there were 24,193 dentists providing some NHS dental care in England, a 2% decline on the total since 2019–20.[87] NHSE data outlines that there is a large workforce gap that exists in NHS dentistry, with over 5,500 vacancies across the entire dental workforce in March 2024. Many of those vacancies go unfilled for more than half a year.[88]

30. NHSE, acknowledging these numbers, said that there has to be an acceptance that we need to train more dentists.[89] DHSC, whilst not disagreeing with that assessment, told us that this is not the whole story

81 Q 27
82 Q 62
83 FND0005, page 1; FN0007, page 2
84 C&AG's Report, Figure 1
85 FND0005, page 2
86 Qq 37–40
87 C&AG's Report, para 1.19
88 NHS England, Dental workforce statistics, March 2024
89 Q 34

because the overall number of dentists has actually gone up; it is the number who are delivering NHS work that has gone down.[90] Survey data from the General Dental Council shows that of the 34,520 dentists registered with them in April 2023, 22% reported in December 2023 that they were not providing any NHS dental care, and were only providing private dental care.[91]

31. It is also clearly the case that NHS dental workforce issues are much more pronounced in some parts of England than others and that this is leading to some shocking regional inequalities in access to dental care.[92] At the lowest end of the scale, Somerset ICB delivered 382 courses of treatment per 1,000 people in the region, whereas South Yorkshire ICB was delivering more than double this, at 800 courses of treatment per 1,000 people.[93] Neither NHSE or DHSC denied that there are regional inequalities in the provision of NHS dentistry though, for context, NHSE noted that "maldistribution of the dental workforce is a worldwide issue". DHSC also added that the issue around attracting dentists to work in coastal, rural and remote areas is very applicable to GPs and other types of medical professionals too.[94]

32. DHSC and NHSE have begun some strands of work that might usefully improve the workforce situation if they are fully implemented. For example, there is a commitment in the NHS long-term workforce plan to increase training places for dentists by 40% by 2031–32.[95] There was also a consultation put out last year proposing a tie-in period for dental graduates, ensuring that where graduates have benefited from taxpayer subsidies through their training, they then give back to the NHS for at a minimum period after completing their training.[96]

33. Alongside ensuring that there are sufficient numbers of dentists and that they are equitably spread across the country, NHSE also told us that there is a cultural shift for the public in terms of their relationship with a dental practice, rather than with a set individual providing care. NHSE said that part of its package of changes in 2022 was aimed at tackling the "misapprehension that other members of dental teams cannot deliver a course of treatment". It claimed that these changes have led to more treatments being delivered by dental therapists though acknowledged that it is still at a relatively low level.[97] NHSE also felt that increasing the skills

90 Q 34
91 C&AG's Report, para 1.19
92 Q 48
93 C&AG's Report, para 1.15
94 Qq 62–63
95 NHS England, NHS Long Term Workforce Plan, published June 2023
96 DHSC, Proposal for a 'tie-in' to NHS dentistry for graduate dentists, published May 2024
97 Qq 88, 89

mix across the dental profession had been welcomed in all quarters of the profession though acknowledged that there was more to do to ensure that all parts of the profession feel a part of the NHS.[98]

98 Qq 89–90

Formal minutes

Monday 31 March 2025

Members present

Sir Geoffrey Clifton-Brown, in the Chair

Mr Clive Betts

Mr Luke Charters

Peter Fortune

Lloyd Hatton

Chris Kane

Fixing NHS Dentistry

Draft Report (*Fixing NHS dentistry*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 33 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Twenty-First Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Thursday 3 April at 9.30 a.m.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Thursday 13 February 2025

Professor Sir Chris Whitty, Acting Permanent Secretary, Department of Health and Social Care; **Jonathan Marron CB**, Director General–Primary Care and Prevention, Department of Health and Social Care; **Amanda Pritchard**, Chief Executive, NHS England; **Jason Wong MBE**, Chief Dental Officer England, NHS England & DHSC; **Ali Sparke**, Director for Pharmacy, Optometry, Dentistry, NHS England Q1-101

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

FND numbers are generated by the evidence processing system and so may not be complete.

1	Anonymised	FND0006
2	Association of Dental Hospitals	FND0001
3	British Dental Association	FND0007
4	Denplan	FND0008
5	Dental Schools Council	FND0003
6	Healthwatch England	FND0013
7	LDC Confederation	FND0014
8	Local Government Association	FND0009
9	NHS Confederation	FND0005
10	Organise Community	FND0010
11	The Association of Dental Groups	FND0002
12	The Dental Defence Union (DDU)	FND0004
13	The Nuffield Trust	FND0011
14	Toothless in England	FND0012

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2024–25

Number	Title	Reference
20th	DCMS management of COVID-19 loans	HC 364
19th	Energy Bills Support	HC 511
18th	Use of AI in Government	HC 356
17th	The Remediation of Dangerous Cladding	HC 362
16th	Whole of Government Accounts 2022-23	HC 367
15th	Prison estate capacity	HC 366
14th	Public charge points for electric vehicles	HC 512
13th	Improving educational outcomes for disadvantaged children	HC 365
12th	Crown Court backlogs	HC 348
11th	Excess votes 2023-24	HC 719
10th	HS2: Update following the Northern leg cancellation	HC 357
9th	Tax evasion in the retail sector	HC 355
8th	Carbon Capture, Usage and Storage	HC 351
7th	Asylum accommodation: Home Office acquisition of former HMP Northeye	HC 361
6th	DWP Customer Service and Accounts 2023-24	HC 354
5th	NHS financial sustainability	HC 350
4th	Tackling homelessness	HC 352
3rd	HMRC Customer Service and Accounts	HC 347
2nd	Condition and maintenance of Local Roads in England	HC 349
1st	Support for children and young people with special educational needs	HC 353