NHS England

To: Sir Geoffrey Clifton-Brown
Chair of Public Accounts Committee
House of Commons
London
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By email: pubaccom@parliament.uk

NHS England
Wellington House
133-155 Waterloo Road
London
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30 December 2025

Dear Sir Geoffrey,

Re: Public Accounts Committee: Twenty-First report of Session 2024-25, Fixing NHS Dentistry (Recommendations 2a)

As detailed in our letter of 25 November 2025, NHS England committed to write to the Committee with the outcomes of our analysis of the Dental Recovery Plan (DRP) as per Recommendation 2a.

Recommendation 2a

> ***2a. PAC 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;***

These analyses are detailed in the attached annexes:

- Annex 1: Analysis of data relating to the impact of the Dental Recovery Plan
- Annex 2: NHS England evaluation of the New Patient Premium Scheme in NHS Dentistry in England

The analysis points out that dentistry was not in steady state during the period when the DRP was implemented, due to the relatively recent implementation of the 2022 reforms (beginning in late 2022 and continuing into 2023), and the continuing recovery back towards pre-Covid levels of delivery. This meant that for some policies it has not been possible to isolate the impact of the DRP against the counterfactual (what would have happened had the DRP not been implemented), a limitation which needs to be taken into account when considering the report findings.

Taken together, these analyses indicate that whilst the New Patient Premium (NPP) was received positively by the majority of contractors and their teams as a 'signal' of a willingness to invest in NHS dentistry, concerns were expressed that the size of the incentive was

insufficient to address concerns about the increased failures to attend observed in new patients. Clinicians were also concerned that the incentive did not include urgent care. Focus group participants described some changes in practice to support new patients to secure appointments but these were not sufficiently widespread and, during the period of the Dental Recovery Plan, fewer new patients were seen than in previous years.

Analysis of available activity data in 25/26 suggests that more new patients have received care following the end of the New Patient Premium, suggesting that factors other than the incentive were influencing decisions to provide care to new patients.

During 24/25 there was a decrease in the number of new adult patients receiving care of 8% but new child patients increased by 1%. Overall, access for adults remained stable in 24/25 but has increased since. Access for children increased in 24/25. As reported in our previous response, a total of 4.3 million patients attracted a new patient premium but this was fewer than the total seen in the previous year. Access for adult patients has not improved since the NPP, suggesting that this policy was ineffective in encouraging dental practices to care for new patients.

We have integrated and reflected on these findings when developing the next round of dental contract reforms which Government consulted on in July and August 2025. These focus on more fundamental changes to the contract to address systemic under-payment for those with higher treatment needs and proposals to secure an urgent care safety net along with a renewed focus on quality and evidence-based care.

Yours sincerely,

Dr Amanda Doyle OBE, MRCGP
National Director for Primary Care and Community Services
NHS England

Analysis of data relating to impact of the Dental Recovery Plan

Evidence for Public Accounts Committee

1 Background

The Dental Recovery Plan was published in February 2024 with the aim of supporting the then Government's commitment to improve access to NHS dental care for people who need it. The main aim of the dental recovery plan was to accelerate the recovery from the Covid pandemic, and to address some of the inequalities in access between new and returning patients.

NHS dental services were significantly reduced during the pandemic period and were slow to recover following the lifting of infection control guidelines. The resulted in the situation that in 2023 delivery of dental care was lower than pre-pandemic with corresponding reductions in access. Additionally the GP Patient survey reported that success in making an appointment for patients new to a dental practice lower than for patients who had already visited a practice.

NHS England were responsible for the delivery of the following policies outlined in the Plan:

- Introduction of a new patient premium for dentists treating new patients.
- Deployment of mobile dental vans to areas with limited NHS provision, although it was decided not to proceed with this following the July 2024 election.
- Introduction of a 'golden hello' payment to dentist who move to work in areas that struggle to recruit.
- Raising the minimum indicative Unit of Dental Activity (UDA) value to £28.
- Supporting dental care professionals to work to their full scope of practice.

The aims of these policies were to influence dentists to take on new patients via the New Patient Premium, increase participation of dental therapists (a policy started in the 2022 reforms), and increase dental care in areas of particularly poor access via dental vans.

NHS England has undertaken analysis to explore the impact of these policies on overall dental delivery and access, number of new patients seen and changes in workforce we have

also considered low UDA value contracts separately top look for the impact of the increase in minimum UDA value. We have not analysed the impact of Golden Hello payments as 1) this requires data at the individual clinician level and this is not currently available and 2) these dentists have not been in post long enough to understand the impact they have on delivery of NHS care.

A difficulty in understanding the impact of the DRP is that dentistry was not in steady state. This is driven partly by the relatively recent implementation of the 2022 reforms (beginning in late 2022 and continuing into 2023), which may have had a broader positive impact on recovery, also because of the long duration of recovery back towards pre-Covid levels of delivery and it is difficult to be clear when this would have ended. Due to these factors and others, we do not have a clear counterfactual picture of what would have happened had the DRP not been implemented. This is a limitation of any retrospective study of a plan such as the DRP where a control is not established and this report should be read accordingly.

2 Main findings

The overall headline finding of this data analysis is that the dental recovery plan largely did not meet its stated aims.

Dental vans were not put into deployment following the change in Government in summer 2024. We have not been able to assess the impact of Golden Hello payments for the reasons described above.

Other findings against the other interventions are as follows

- **The DRP did not increase delivery of UDAs (excluding UDAs earned through NPP tariff) in 2024/25.**
- **Total new patients per working day declined over 2024/25 by 5%. Adult new patients declined by 8% whereas new child patients increased by 1%. Adult access overall remained stable over 2024/25 and has increased since. Child access increased in 2024/25.**
- **Increasing the minimum UDA value to £28 did not increase delivery in these contracts compared to other low value contracts.**
- **Increase in dental therapists participation in NHS dentistry is part of a longer term trend starting with the 2022 reforms.**

3 Changes in overall delivery

Finding: The DRP did not increase delivery of UDAs (excluding UDAs earned through NPP tariff) in 2024/25.

To assess the impact of the dental recovery plan we have considered change in delivery of UDAs both annually and per working day. These UDAs only include UDAs awarded for courses of treatment delivered and do not include UDAs awarded via the NPP. This allows a like for like comparison between years.

Table 1 shows that annual delivery of UDAs increased by 1% in 2024/25 compared to 2023/24. UDA delivery per working day was 1% lower in 2024/25 than in 2023/24, but due to the 4 more working days in 2024/25 this resulted in a higher total UDAs delivered. This is in contrast to 2022/23 compared to 2023/34 and 2024/25 compared to year to date 2025/26 where UDA delivery per working day increased in the second year.

It should be noted that these changes are small, and as shown in Figure 1 delivery of UDAs per working day is stable with a slow increasing trend over the time period March 2023 to July 2025. However, it is clear that 2024/25 did not see a step change increase in delivery of UDAs.

	2022/23	2023/24	2024/25	2025/26 (to end July)
UDAs delivered excluding NPP	67,284,246	69,377,539	69,815,943	24,168,693
working days	251	250	254	84
delivery per working day	268,065	277,510	274,866	287,723
annual change in UDAs delivered		3%	1%	
annual change in delivery per working day		3.5%	-1.0%	4.7%

Table 1: Summary of UDA delivery

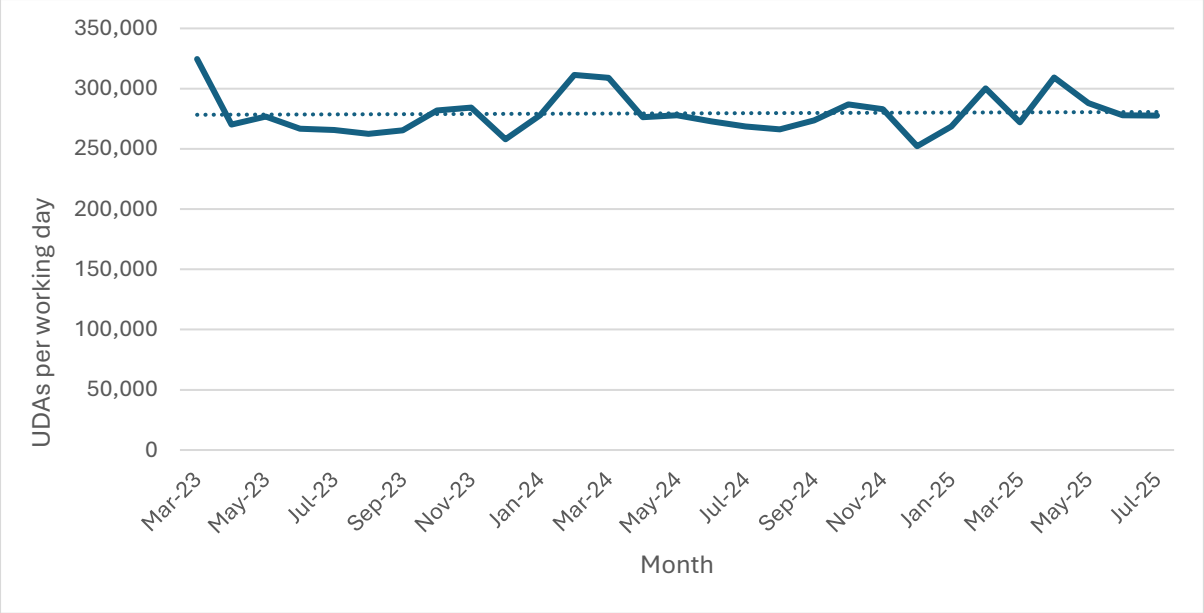

Figure 1: UDA delivery per working day

4 Changes in overall access and new patients seen

Finding: Total new patients per working day declined over 2024/25 by 5%. Adult new patients declined by 8% whereas new child patients increased by 1%. Adult access remained stable over 2024/25 but has increased since. Child access increased in 2024/25.

The New Patient Premium paid an additional £15 for patients receiving a Band 1 and £50 for patients receiving a Band 2 or 3 course of treatment. Eligible patients were those who had not been seen by the same dentist or contract in the previous 24 months for band 1, 2 or 3 care. For simplicity we refer to eligible patients as NPP patients in this report. Dentists were only paid the additional premium for patients whose courses of treatment started on or after 1st March 2024. In some instances courses of treatment are spread over more than one appointment and so there are patients whose treatment started before 1st March 2024 and ended after. These patients are not included in the published activity data but are included here as to exclude them would artificially decrease NPP patients seen from March 2024 onwards.

Because an increase in new patients seen would be expected to lead to an increase in overall access we have analysed these two aspects of dentistry together. We first compare NPP patients in the period the policy was in place compared to the previous year and then

consider the impact this had on overall access, and recovery of access to pre-pandemic levels. The intention behind the NPP policy was that overall access to an NHS dentist would increase and it would narrow the gap between new and returning patients successfully making an NHS dental appointment, which is measured by the GP patient survey. The final piece of analysis was to consider whether there was a relationship between overall contact performance and change in NPP patients seen.

4.1 NPP patients seen

The fact that fewer patients matching the new patient premium definition were seen in the first half of 2024/25 compared to the same months in 2023/24 was reported in the NAO report[1], and this finding did not change by the end of the year. The full year comparison in change in NPP patients split by adults and children is shown in 2. Compared to a baseline period of April 2023 to February 2025, child NPP patients increased over 2024/25 whereas adult NPP patients decreased, and overall, there was a decrease in NPP patients seen. Figure 2 shows the relative stability in NPP claims per working day from March 2023 to March 2025. There was an increase in the number of NPP patients seen in March 2023. This is likely to be due to increased contract delivery in that month due to contractors being allowed to deliver up to 110% of their contract and receive payment for this additional activity. This led to more NPP patients being seen.

	All patients	Children	Adults
Baseline period April 2023 to February 2024	17,328	6,579	10,749
NPP period March 2024 to March 2025	16,503	6,667	9,836
Change	-4.8%	1.3%	-8.5%

Table 2: New Patient Premium Summary

[1] https://www.nao.org.uk/reports/investigation-into-the-nhs-dental-recovery-plan/

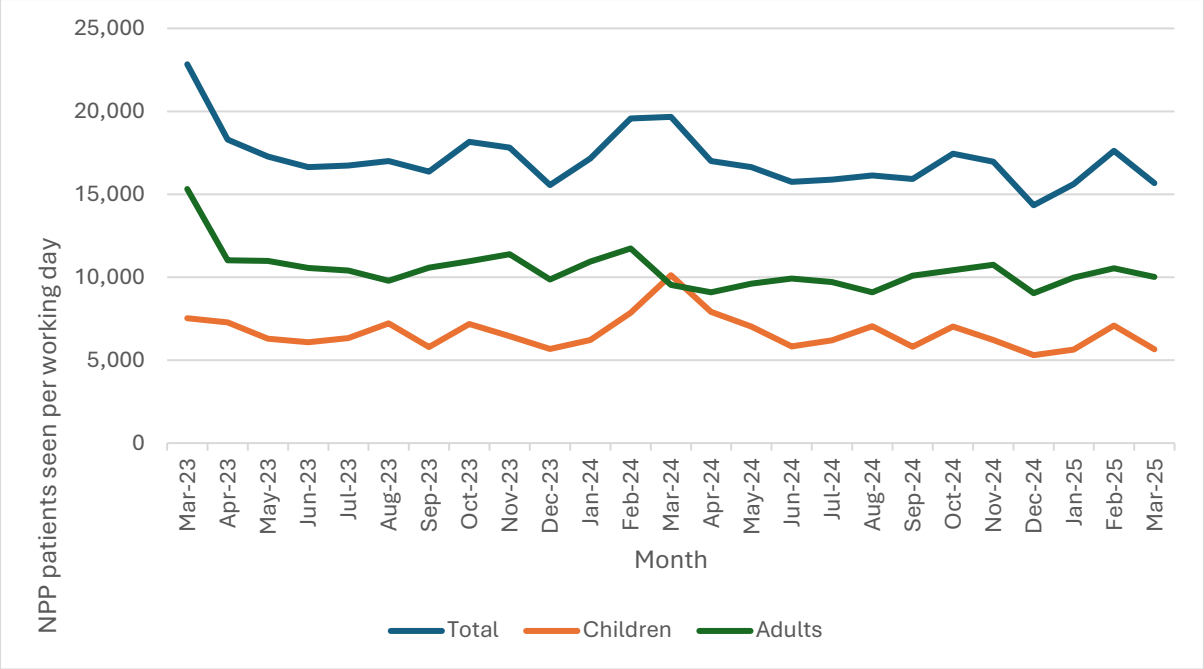

Figure 2: NPP claims per working day

4.2 Overall access

Table 3 shows changes to the overall access to NHS dentistry over the years since the pandemic compared to pre-pandemic levels. Child access improved noticeably over 2024/25 whereas adult access did not. Since the end of the NPP, adult access has improved, suggesting factors other than the NPP have influenced this. It should be noted that urgent care delivery is included in the access data and is not included in the NPP patients seen. It is possible that the additional adult patients seen since the end of the NPP may be adults accessing urgent care. As expected from the reduction in adult NPP patients seen, the results of the GP Patient survey in 2025[2] showed that there was no significant difference in success rate of patients not known to a practice in making an appointment compared to the previous year.

[NOTE: these adult/child access figure will not match official statistics. These data exclude orthodontic only contracts and are extracted by NHS BSA using a slightly different specification to the official statistics. However, they are self-consistent.]

[2] https://www.england.nhs.uk/statistics/gp-patient-survey-dental-statistics-january-to-march-2025-england/

Time period ending in	Apr-19	Mar-22	Mar-23	Mar-24	Mar-25	Jul-25
Unique patients seen in the previous 12 months	24,100,825	17,945,935	20,379,434	20,843,827	21,325,602	21,436,668
Unique adult patients seen in the previous 24 months	21,730,701	15,050,172	17,838,812	18,111,864	18,117,891	18,175,998
Unique child patients seen in the previous 12 months	7,184,519	5,567,545	6,452,590	6,817,463	7,118,704	7,202,843
Change in all patients from previous time point (Change from April 2019)		(-25.5%)	13.6% (-15.4%)	2.3% (-13.5%)	2.3% (-11.5%)	0.5% (-11.1%)
Change in adults seen from previous time point (Change from April 2019)		(-30.7%)	18.5% (-19.7%)	1.5% (-16.7%)	0.0% (-16.6%)	0.3% (-16.4%)
Change in children seen from previous time point (Change from April 2019)		(-22.5%)	15.9% (-10.2%)	5.7% (-5.1%)	4.4% (-0.9%)	1.2% (0.3%)

Table 3: Change in overall access for adults and children

4.3 Relationship between ICB performance and NPP

Stakeholders have suggested that a potential reason for the lack of increase in NPP patients was that contracts close to delivering 100% of their contracted UDAs were more reluctant to see new patients because the addition premium would put them into over delivery and so they would not receive the additional payment. The data we hold on contracted UDAs is not accurate enough to allow us to measure this at a contract level. However, when aggregated to ICB level we can look for a relationship between change in NPP patients and percentage contract delivery. Figure 3 shows that ICBs with contract delivery between 70-80% were more likely to see an increase in new patients compared to the lowest and highest performing ICBs in terms of contract delivery. To a limited extent this supports the stakeholder view but shows that it is not a straightforward relationship.

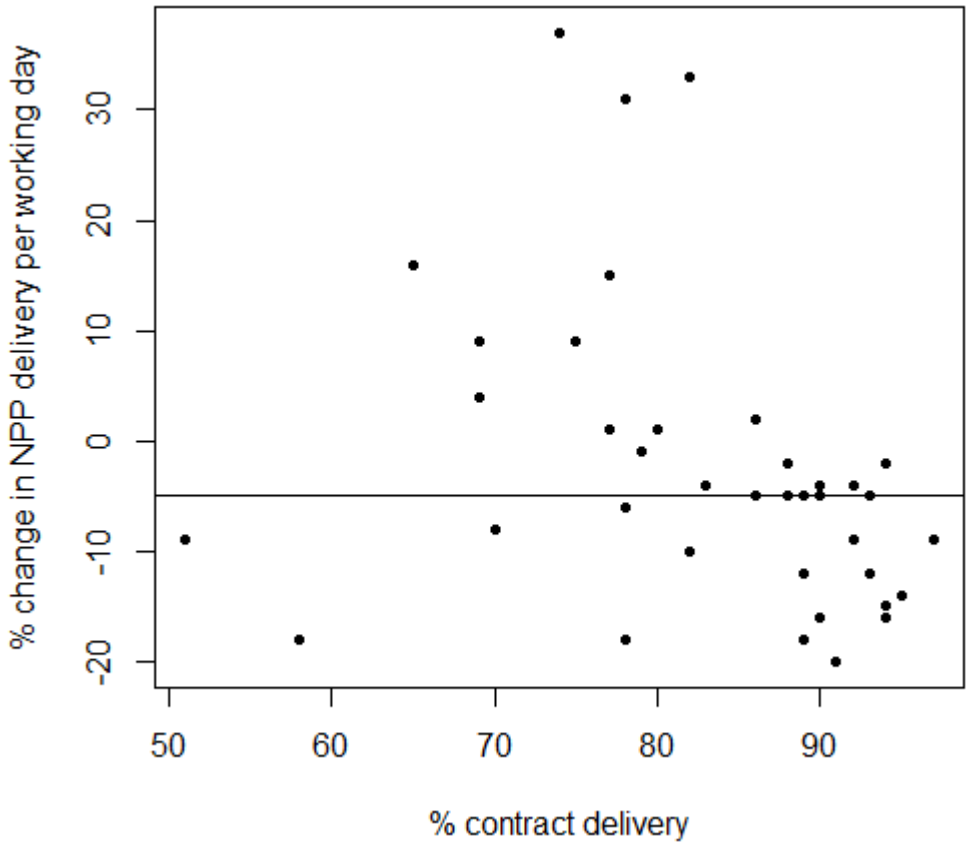

Figure 3: Scatterplot of relationship between ICB contract delivery and change in NPP patients, horizontal line indicates median change in NPP delivery

5 Minimum UDA value

Finding: Increasing the minimum UDA value to £28 did not increase delivery in these contracts compared to other low value contracts. It suggests supply of NHS dentistry is inelastic to price for low UDA value contracts.

The Dental Recovery Plan set a new minimum UDA value for NHS dentistry of £28. The reason for implementing the minimum UDA value was to increase delivery of care by recognising that there are likely to be minimum costs to the provision of care.

To understand whether or not increasing the minimum UDA value to £28 changed the delivery of contracted UDAs in this cohort of 870 contracts we have compared their contract delivery to contract delivery in a comparator group of contracts with UDA values between £28 and £30 in March 2024 with more than 100 commissioned UDAs. This comparator group was 1087 contracts in March 2024. Across both cohorts there were 5 contracts with zero delivery in 2023/24: two in the comparator group and three in the minimum UDA group.

The reason for this is unclear as all these contracts had UDA targets and financial values. We have therefore excluded these from further analysis.

The distribution of change in delivery from 2023/24 to 2024/25 is not normally distributed, the median change in delivery in each contract for the minimum UDA group was -0.011% and the median change in delivery in the comparator group was -0.006%. The mean change in the minimum UDA group was 22 UDAs and the mean change in the comparator group was 0.1 UDA, highlighting the skewed distribution of difference in UDA delivery. The non-normality of the data did not change when outliers were removed. We therefore used the Wilcoxon signed-rank test to investigate whether or not there was a significant difference in stochastic distribution of change in UDAs delivered between the two groups. The resulting test demonstrated that there was 98% chance of no difference in performance between the two groups. Figure 4 illustrates that the probability distribution of change in performance is almost identical for each group.

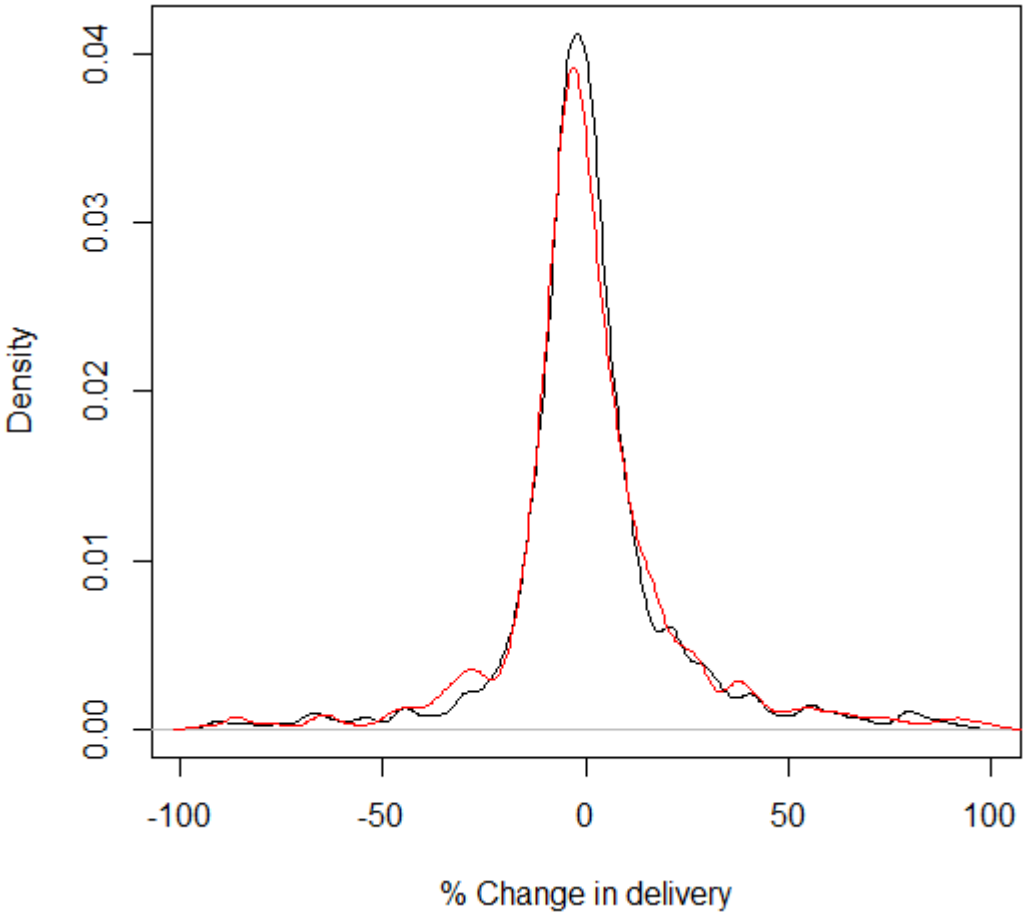

Figure 4: Kernel density estimate of percentage change in deliver for minimum UDA value group (red) and comparator group (black) (outliers above 100% change excluded)

6 Skill mix of dental care professionals delivering NHS dentistry

Finding: Increase in dental therapists participation in NHS dentistry is part of a longer term trend starting with the 2022 reforms.

The Dental recovery plan aimed to increase participation by dental therapists and hygienist in NHS dentistry and legislation was introduced to enable dental therapists and hygienists to supply and administer agreed medicines without a prescription. This was part of a longer-term policy to allows these dental care professionals to work to their full scope of practice. To understand whether change occurred we looked at workforce data and delivery for different dental care professionals. The changes to skill mix guidance were announced in July 2022 and published in January 2023. Changes to the FP17 form to allow DCPs to report that they had led a course of treatment were implemented in April 2024.

We have used the NHS England workforce data collection from March and December 2024 to assess changes in the time spent on NHS work. March 2024 was the first collection of this data set and as such are likely to be of relatively poor quality. Therefore, we cannot be certain if relatively small changes in reported data between March and December 2024 are real or due to data quality. However, larger changes are likely to be a change in workforce rather than data quality. For this reason, we have not attempted to measure statistical significance and suggest the actual reported change is taken as an indicative rather than a definitive answer.

As shown in Table 4 between March and December 2024 there is very little difference in the number of dentists or the proportion of NHS work dentists are doing. However, there is a difference for dental therapists, there were 28% more NHS FTE therapists and a 5% increase in percentage of time therapists spend delivering NHS work in December compared to March. The corresponding switch in dental hygienists spending 4% less of their time delivering NHS work suggests it’s possible that they may be delivering the private work that therapists were delivering. The increase in delivery of NHS care by dental therapists can be seen in Figure 5. Before the change was made to the FP17 allowing reporting of DCP led courses of treatment the proportion of courses of treatment assisted by therapists had been rising steadily. This increase stopped once the change was made, but stayed at an increased level, whereas the proportion of courses of treatment led by a therapist has continued to rise.

The timing of the increase in participation of dental therapists in NHS care means that this change is almost certainly driven by the 2022 reforms rather than the dental recovery plan.

	December 2024 data				Percentage change from March 2024			
	Role count	**FTE**	**NHS FTE**	**% of FTE that is NHS**	**Role count**	**FTE**	**NHS FTE**	**% of FTE that is NHS**
Dental Hygienist	5,722	2,168	323	15%	-1%	4%	1%	-4%
Dental Nurse	25,752	19,731	13,716	70%	2%	2%	2%	0%
Dental Therapist	3,419	1,710	1,310	77%	17%	22%	28%	5%
Foundation Dentist	1,110	808	761	94%	13%	2%	0%	-1%
General Dentist	25,911	15,293	10,727	70%	1%	2%	2%	0%
Orthodontic Therapist	1,056	598	496	83%	-2%	2%	2%	0%
Orthodontist	1,207	469	366	78%	-3%	-10%	-12%	-2%
Other Staff	7,858	5,397	3,684	68%	-8%	7%	3%	-4%
Receptionist	13,331	10,107	7,409	73%	0%	-3%	-4%	0%
Trainee Dental Nurse	11,082	9,840	7,289	74%	-4%	-2%	1%	3%

Table 4: Workforce changes between March and December 2024

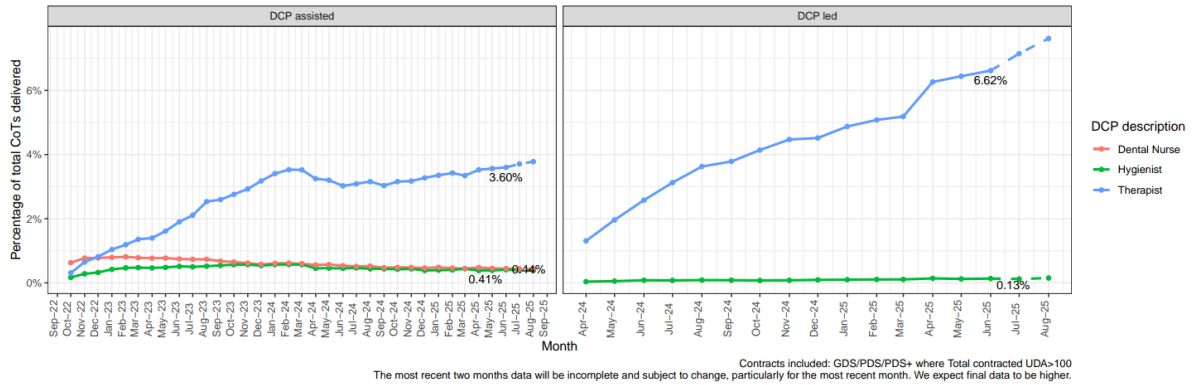

Figure 5: Percentage courses of treatment delivered by DCPs

NHS England qualitative evaluation of the New Patient Premium Scheme in NHS Dentistry in England

Introduction

1. The aim of this report is to understand stakeholder perceptions of the New Patient Premium scheme (NPP) by reporting on a series of focus groups held in November 2024.

Methodology

2. NHS England held 6 clinical focus group events on evenings between 4 November 2024 and 18 November 2024, in which stakeholders were invited to express their opinions about the NPP scheme. Stakeholders invited to participate were contractors, associates, therapists, hygienists, and practice managers. In response to a request from the BDA, a BDA representative was also invited to, and attended, each of these focus groups.

3. Two separate focus groups, one for NHS finance colleagues (including dental finance leads from NHS England regions and ICBs) and one for NHS commissioner colleagues from across England, were also held during November 2024.

4. To ensure the clinical focus groups were representative of the NHS Dentistry community, potential participants were asked to provide details of their age, sex, ethnicity, role in the practice, location of practice/work and whether they work as part of a corporate or independent practice. When the invitations to the focus groups were prepared, individuals were purposefully selected on the basis of the characteristics listed so as to ensure a diverse representation of participants. (For more detail on the methodology on setting up the focus groups please see annex A, including the topic guides which cover suggested questions used in the focus groups).

5. Throughout the focus groups, NHS England assured participants that their views would be reported anonymously, and their comments would not be associated with the organisations they represented. In this report, some of the words used in the focus groups are repeated verbatim. NHS England is confident that it would not be possible for any reader to identify any particular individual from the comment(s) they made.

6. Recognising these points, the transcripts of all the meetings were read, considered, and analysed thematically. Where points were unclear or there appeared to be a case of mistranscription, the recordings of the meetings were watched, selectively, to bring clarity.

7. During the focus groups some participants were keen to quantify some of the statements they made (e.g. talking in terms of the numbers of new patients seen, or the percentage in reduction of complaints, etc). However, such statements were not ‘fact checked’ at the time or subsequently. Rather, the participants’ views and thoughts about the NPP scheme were distilled and are discussed in this report.

Results

8. More than 160 people completed the expression of interest to participate in the clinical focus groups. Of those, 83 were invited to take part and 54 individuals participated in the clinical focus groups (for more detailed breakdown of the participants see annex B).

9. Five participants attended the finance focus group and 10 participants attended the commissioner focus group.

10. Whilst the feedback received from participants in the groups was diverse and nuanced, the feedback has been separated into 3 broad themes and split according to whether it was positive or negative in nature:

    1) reception to the scheme;
    2) views on implementation of the scheme; and
    3) views on the impact of the scheme.

11. Participants mentioned a number of wider issues that they felt needed to be addressed in NHS Dentistry. Whilst there was an acknowledgement that the NPP scheme was not intended to address these issues, participants noted that if these issues were addressed, it may directly or indirectly allow more 'new' patients to be seen. A summary of the areas that were reported can be found in annex C and are not discussed further in this section.

12. Unless otherwise stated, findings presented below relate to the clinical focus group participants.

1) Feedback relating to reception to the NPP scheme

Positive responses

13. When asked to summarise their views at the end of the session, the majority of people that spoke about the NPP did so in positive terms. The positivity was borne out of a number of factors. Participants said that, in their opinion, the NPP scheme:

    - is a positive 'signal' about relevant bodies willingness to invest in NHS Dentistry. This in turn had led to a perceived increase in staff morale, "*loyalty*" and raised awareness of NHS Dentistry.
    - provides acknowledgement that it can be more expensive to treat 'new patients' than existing ones;
    - provides increased job satisfaction for professionals, in delivering care to patients who had not been to a dentist for a long time.

Negative responses

14. A small cohort of participants stated that they viewed the introduction of NPP with '*scepticism*' and '*pessimism'* when it was first introduced, stating that the scheme was more of a "political thing", in view of the up-coming general election.

15. Some participants told NHS England that the quantum on offer, the actual value of the NPP itself, in their opinion is insufficient to cover the costs of the necessary treatment for a given patient. As such, whilst the NPP may inspire loyalty amongst NHS dentists, this is not universally the case. Additionally, some participants felt that, even with the NPP incentive in place, the remuneration on offer is not sufficiently attractive compared to private provision.

16. There were also some participants of the view that the NPP does not compensate for the fact that 'new patients' may be more likely to fail to attend an appointment; and that the NPP does not apply to urgent care treatments.

17. The commissioner group in general felt that the NPP "*seemed like a good idea in principle*". However, the group felt that the level of remuneration for the scheme meant that it may be insufficient to motivate practices, and thereby it may not lead to patients not known to the practice being seen. There were specific concerns that the NPP may lead to existing patients who had not been seen in 2 years being "recycled" rather than specifically targeting patients not known to the practice.

18. Finance leads were generally less positive about the NPP than the other groups had been. Furthermore, some participants expressed a view that the NPP had not been well-received by the Local Dental Networks (LDNs) that they engaged with.

2) Views on the implementation of the NPP scheme

Positive responses

19. Some contractors' positive opinion about the NPP had been enhanced because stakeholders had found the NPP had been easy to implement technically. In terms of integration into the Compass system (the current dental contract management, payments, and superannuation system), for example, the implementation was "*seamless*".

20. One participant mentioned that they had previously been part of a local scheme which was linked to mandatory targets and they felt there was a risk they would not be able to deliver mandatory targets in addition to their UDA contract. Therefore they preferred the NPP scheme because it had no targets.

Negative responses

21. Participants indicated that they felt that the timing of the introduction of the NPP was unhelpful ("*at the 11th hour and to some confusion*"), meaning that organisations had to change financial arrangements and other plans late in the financial year. They felt that this issue was exacerbated because they were not initially clear whether the introduction of the NPP scheme represented a new investment in NHS Dentistry, or merely a different way of accessing the same funding. This, in turn, meant that these participants felt there was limited time at the beginning to make an informed decision about whether to opt-out of an existing local scheme and engage in the NPP scheme, or even whether to change behaviours in order to actively deliver the NPP scheme or not.

22. Participants in the groups reported that it was not made clear for how long the NPP would continue to be in place beyond March 2025 and supported by NHS England. Finance participants also reflected on the need to understand how and indeed *whether* any such incentive would operate next year. Taken together, there was clearly a concern for the long-term plans for the scheme, and this was the reason that participants felt it was difficult for them to make plans that took the NPP into account, whether those plans were purely financial, or (for example) around the means and frequency with which they recall existing patients.

23. Associates and therapists communicated that it was not clear how the NPP credits would "*filter down*" to them from the outset and they felt that they needed more information on how the premium could be distributed within a practice.

24. Some administrators referred to "*operational challenges*" including initial issues with NPP credits not being shown correctly on dental practice management software systems and updating NHS.uk practices' website pages.

25. Commissioners and finance leads both described situations in which different parts of the country had experienced differences in the response to the NPP. Participants assigned much of this to the difference in concentration of corporate practices over independent practices and the rurality of different regions. Commissioners and finance leads also highlighted the interaction between local schemes and the national NPP, emphasising the need for better alignment and understanding of local needs.

26. The clinical and commissioner groups reflected on how details of the scheme had been communicated. The commissioner group spoke more than other groups about patients' understanding of the scheme. Commissioner participants commented that patients often misunderstood the initiative, leading to frustration and difficult conversations with practice staff – and clinical participants shared that those difficult conversations (see example below) sometimes resulted in practices reconsidering their participation in the scheme.

    "[we have been] bombarded with … patients saying it says you're accepting new patients. Well, it does, but unfortunately, we do have a waiting list"

3) Views on the impact of the NPP scheme

Positive responses

27. One of the strongest, repeated messages from the clinical focus groups was participants' preference for the scheme to continue. When expanding on the reasons why they thought the NPP should continue, participants indicated:

    - The NPP gave people in the NHS Dental community a sense of "*loyalty*" towards NHS Dentistry – and believed that those who were actively considering moving exclusively to the private sector may have been persuaded to continue to provide NHS services.

      "Not because the new patient premium is so fantastic in its own right, but because it shows the momentum swinging towards making an improvement overall … and that's something that's hard to measure"

    - Some practices had altered their ways of working in response to the NPP. For example, associates stated that it encouraged colleagues to start working late evenings and on Saturdays; to open up "kids' clubs" on Saturdays; and in some of their practices where there were part time associates and mentors, they engaged with the scheme by taking on more overseas mentees to deliver care. They felt it would be disruptive to change back were the NPP to be withdrawn.
    - Some participants perceived that withdrawal of the NPP would be likely to lead to fewer 'new' patients being seen, as if the NPP incentive was taken away, the incentive to hold extra evening and Saturday clinics would also cease.
    - There was a perception that the NPP had directly led to NHS Dentists seeing more new patients and had also directly led to NHS Dentists receiving fewer complaints.

28. In expressing keenness for the NPP to continue, some clinical participants (though not all) used particularly emotive language which indicates a strength of feeling. They stated the consequences of removing the premium would be negative: "*absolutely tragic*"; "*it*

would be felt as a kick to those dentists who are using this scheme" "*[it has helped with a workforce that is] demoralised*".

29. Rather than focussing on how practices would respond to the withdrawal of the scheme, some articulated the impact on patient numbers were the scheme to be withdrawn, with one participant noting:

    "*The following year, data [would be] …very grim in terms of the number of new patients that practices have been taken on"*

30. The commissioner group's view remained positive about the impact of the scheme; some commissioners believed that the scheme had had a significant impact on the numbers of new patients being seen.

Negative responses

31. Participants described their concerns about the impact on the NPP scheme on practices that usually deliver their annual contracted UDA value. They shared that the payment mechanism can lead to practices fulfilling all their contracted UDAs more quickly than desirable, a phenomenon repeatedly described as "burning through" UDAs. As a knock-on effect of this, participants stated that they felt that the NPP created difficulties, and mentioned receiving negative responses when seeking extra funding from ICBs.

    Others, however, told a different story indicating that in their view there is variation in how ICBs invest in Dentistry at a local level:

    "*Different ICBs have different priorities. Some ICBs are so proactive. They're willing to uplift UDAs. They're willing to work with you and other ICBs are saying. 'Sorry – we've got other stuff that's more important' [and dentistry is] just way down the list [of priorities]…for them*."

32. Some participants felt that mechanisms such as NPP are unlikely to maintain the oral health for some of the patients being seen, (for example high need patients). They stated while the NPP will help towards the cost of treating these patients, they recommended other funded oral health programmes (running parallel to this scheme) are required, which may also help to keep these patients motivated, ensuring that these patients do not return in the immediate future with a significant clinical need again.

33. Participants mentioned that because practices are not required to take on a specific number of new patients, some practices and clinicians were less engaged with the scheme. Participants expressed concern that this may not lead to improvement in access to NHS dentistry in the geographical areas where it is needed most (some referred to 'inequalities'; others to 'dental deserts').

Discussion

34. The NPP was introduced as a part of the 2024 Dental Recovery Plan[1] as a time-limited scheme to increase the number of patients able to get an NHS dental appointment and, to address the statistics above, to improve the oral health of those who do not have an existing relationship with a dental practice. The scheme was also intended to recognise the additional time that may be needed for practices to assess, stabilise and manage the oral health needs of patients who have not received NHS dental care for more than 2

[1] Our plan to recover and reform NHS dentistry - GOV.UK

years. The launch of the scheme was coupled with the intention to measure the impact of the new payments by assessing the number of new patients accessing NHS dentistry.

35. The results above demonstrate that the principles of the scheme were welcomed, mainly due to it signalling a willingness to invest in NHS Dentistry (it being part of the first additional investment package in the sector since 2006) and because it acknowledged and attempted to address the issue that new patients can be more expensive to treat than existing patients.

36. Although the qualitative data suggests that there was a perception among participants that more new patients have been seen as a result of the scheme and there was support for continuation of the scheme, the quantitative data suggests that at ICB and national levels the scheme has not achieved the desired impact of changing practice and clinician behaviour to take on more new patients. This does not exclude the outcome that some contracts may have seen more new patients as a result of the scheme. However, if this is the case, then the data suggests this is offset by lower new patient numbers across other practices.

37. Whilst the scheme was welcomed as a positive message of intent from NHS England to the sector, a great deal of feedback was shared relating to difficulties with the scheme's implementation and delivery. These represent valuable learnings for planning initiatives in general, and should local commissioners wish to implement similar schemes in the future. A summary of this feedback is shared below.

    - Financial incentives should be refined to ensure appropriate remuneration for the time taken for the service and to encourage dentists to deliver NHS services, but also taking into account the responsible spending of tax-payers money.
    - Consideration should be given to the complexities of patients who present to a service, for example new patients who specifically require urgent care, and how these can be accommodated in the service.
    - Improved communication (clear and consistent) with providers and the public should be planned ahead of implementation (it should be recognised that the NPP was implemented at speed to support the governments dental recovery plan and communications did not allow for an optimal time for assimilation), including clarity on whether financial commitments are additional and the term of commitment.
    - Consideration should also be given to the appropriate level and messaging of communications for patients. A balanced approach is needed to ensure that practices are not overwhelmed with an influx of new patients but equally that patient expectations are managed to avoid potential conflict with providers.
    - There is a need to understand and address the reasons for local variations in the level of support that commissioners delivered to the scheme.

38. NHS England addressed some of the issues heard in the focus groups around implementation at the time. For example, NHS England worked with dental practice software suppliers to correct issues and provided alternative solutions in the meantime; and in response to early feedback from contractors and changed the options given to practices to report their availability to accept new NHS patients on the NHS.uk website.

Strengths and Limitations

39. It is recognised that different representatives of bodies corporate may present their organisation's view in focus groups. There is a risk that the feedback heard from the

focus groups was impacted by this, as it was noted that some participants from the same organisations tended to share very similar points.

40. Focus groups tend to draw participants who have very strong views of a topic, which is likely to be the case here, therefore the feedback should be interpreted with this in mind. Similarly qualitative research can only reflect the views of the people included and relies on this being a representative sample. An open expression of interest process was undertaken and purposive selection of participants used to try to counter this risk and also ensure a range of protected characteristics was represented. A facilitator from outside of the NHS Dental Policy team was also used to ensure views could be shared openly and reported in a balanced manner. Nevertheless, some residual risk of bias may remain.

Conclusion

41. Participants from the focus groups received the intention of the NPP positively, mainly due to the investment in the sector, the recognition of the costs of treating new patients and the associated improvement to job satisfaction and moral. Some also perceived that behaviour change at a practice level had resulted in access to new patients.

42. Quantitative data suggests that this behaviour change has not been widespread and the NPP has not resulted in more new patients being treated than was seen in the period before its implementation.

Annex A: Methodology

Invitation for Expressions of Interest

Excluding the commissioners and finance leads focus groups, participants for the clinical focus groups were purposefully selected to provide a diverse sample in terms of age, sex, ethnicity, whether the individual works on a corporate or independent practice, and the region within which the practice operates. Where there was sufficient interest, 15 participants were invited to each group. For the group involving dental therapists, all those who expressed an interest in attending were invited. For the commissioner and finance leads focus groups, regional leads were asked to put forward 2 volunteers for commissioners and finance leads who would be willing to represent each respective region.

Pre-testing of questions

Whilst the questions that were asked in the groups were not complex, the questions were discussed in advance with a small number of colleagues, to test whether the questions would be likely to generate conversation around the NPP. The discussions indicated strong support for the simplicity of the questions. Accordingly, the questions that were asked remained unaltered from the original intention. During the course of these discussions, the views colleagues expressed about the NPP were recorded and the feedback they provided has been analysed appropriately and is included within the main part of this report.

Analysis by characteristics to ensure representativeness

We monitored the responses to the Expressions of Interest and drew up invitations lists that represented the characteristics of respondents proportionately

Topic guide for clinical focus groups

1. What did you think about the New Patient Premium when it was first introduced / when you first heard about it? – this is in part icebreaker but may provide interesting feedback
2. What's been your experience of the scheme?
   Specifically, what kind of impact has it had upon you and your practice?
   - (Prompt: thinking in terms of business, and impact upon colleagues, have there been any changes in relation to providing care to new patients, what about the level of incentive) (follow on prompt: what kind of mechanism do you think might encourage more practices to see new patients?)
   - (Prompt: how have you and/or your practice responded to the scheme and approached implementation)
   - (Prompt: direct and indirect – what kinds of patients have you been seeing through this scheme? are you seeing new kinds of cases? Are a greater proportion of patients requiring treatment?)
   - (Prompt: some of our stakeholders have mentioned that they thought that the dental needs of new patients would be greater than that of the existing population that currently use NHS Dentistry – has this turned out to be the case?
   - Prompt: have there been any other benefits that you didn't expect that you think we might need to know about

There is also the opportunity to ask questions with additional context that focuses the conversation – these usually start:
"Some of our other stakeholders have told us" or "Some of our desktop research appears to show…"

Extra question for Associates:
What has been your experience of how the NPP has been shared with associates and other clinicians?

Extra question for Contractors:

How did you manage the remuneration attached to this scheme with your associates?

Topic guide for finance and commissioner focus groups

1. What did you think about the New Patient Premium when it was first introduced / when you first heard about it? – this is in part icebreaker but may provide interesting feedback
2. What are you doing locally to communicate the NPP scheme to practices and patients and to support practice participation?
    - (Prompt: how have practices in your region / ICBs responded to the scheme and how was implementation of the scheme approached?) – (Follow on prompt: have there been particular practical challenges, or things that have made it easier to implement)
    - (Prompt: how have new patients been signposted/matched to practices?) (Follow on prompt, if local schemes are running, how are patients being signposted into practices operating the NPP versus any local scheme?)
    - (Prompt: Has anything been put in place locally to assure that contractors are implementing the scheme appropriately?)
3. What's been your experience of the scheme?
   Specifically, what kind of impact has it had upon the patients and contractors in your region / ICBs?
    - (Prompt: thinking in terms of any impact upon patients, contractors and interactions with any local initiatives, have there been any changes in relation to providing care to new patients)
    - (Prompt: what kind of mechanism do you think might encourage more practices to see new patients?)
    - (Prompt: Has there been any impact on local relationships following the introduction of the NPP or any local new patient scheme?)
    - (Prompt: have there been any other benefits that you didn't expect that you think we might need to know about?)
4. You will have a view on how incentives operate, do you have any views on how the NPP could have been improved?

    - (Prompt: Do you have any views on the level of renumeration? If you have a local scheme how have any financial differences between the schemes played out?)

There's also the opportunity to ask questions with a bit of context that focuses the conversation – these usually start:
"Some of our other stakeholders have told us" or "Some of our desktop research appears to show…" or perhaps "In our other Focus Groups, participants told us…"

Annex B: Analysis of participation

Breakdown of attendance

Progressing through: Responses to Expressions of Interest, Invitations, Attendance

Sex	Responses to calls for Expressions of Interest		Invitation to take part		Attendance at Focus Group	
Female	91	55%	47	55%	29	54%
Male	75	45%	39	45%	25	46%

Age	Responses to calls for Expressions of Interest		Invitation to take part		Attendance at Focus Group	
25-34	17	10%	6	7%	3	6%
35-44	51	31%	31	36%	18	33%
45-54	71	43%	34	40%	22	41%
55 and over	24	14%	13	15%	10	19%
Prefer not to say	3	2%	2	2%	1	2%

Ethnicity	Responses to calls for Expressions of Interest		Invitation to take part		Attendance at Focus Group	
Asian or Asian British - Any other Asian background	8	5%	4	5%	1	2%
Asian or Asian British - Bangladeshi	1	1%	1	1%	0	0%
Asian or Asian British - Pakistani	9	5%	6	7%	6	11%
Mixed - White and Black African	1	1%	0	0%	0	0%
Mixed - White and Black Caribbean	1	1%	0	0%	0	0%
White - British	60	36%	33	38%	21	39%
Arab	1	1%	1	1%	0	0%
Asian or Asian British - Indian	47	28%	23	27%	15	28%
Black or Black British - African	2	1%	2	2%	2	4%
Mixed - Any other mixed background	6	4%	1	1%	0	0%
Mixed - White and Asian	1	1%	0	0%	0	0%
Other Ethnic Groups - Any other ethnic group	6	4%	3	3%	2	4%
Other Ethnic Groups - Chinese	1	1%	0	0%	0	0%
Prefer not to say	7	4%	4	5%	1	2%
White - Any other White background	6	4%	5	6%	4	7%
White - Irish	3	2%	2	2%	2	4%
(blank)	8	5%	1	1%	0	0%

Type of Practice	Responses to calls for Expressions of Interest		Invitation to take part		Attendance at Focus Group	
Corporate	56	34%	27	31%	16	30%
Independent	109	66%	59	69%	38	70%
(blank)	1	1%				

Geographic Representation

Expressions of Interest were received from individuals who work primarily in 41 of 42 ICBs.
The individuals invited to take part work primarily in 32 different ICBs.
The individuals who attended the focus groups work primarily in 27 different ICBs.