NHS Confederation

Briefing
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Exploring the future model of dentistry and oral health provision

This briefing examines the challenges facing NHS dentistry in England, Wales and Northern Ireland and summarises the consensus reached by system leaders on the essential components of a sustainable, prevention-led model.

The insights for an improved model of dentistry provision are drawn from a roundtable discussion hosted by the NHS Confederation in partnership with NEC Software Solutions, which developed Rego, an intelligent referral optimisation platform helping dentists to refer patients, so they are seen more quickly and releasing valuable time for clinicians across the health system. The roundtable brought together leaders from the three nations, including providers, commissioners, regulators, unions and patient representatives.

The briefing captures key discussions on workforce sustainability, improving access – particularly for people in deprived and underserved areas – digital innovation and integrated care models. It will be of interest to policymakers, commissioners, dental professionals and system leaders who are shaping the future of oral health provision across the UK. It is intended to inform strategic decisions that support a patient-centred, prevention-focused approach to dentistry, ensuring resilience and adaptability within the health system.

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In partnership with

NEC

Key points

- NHS dentistry faces a defining moment. Years of underfunding, a misaligned contract model and workforce attrition have left millions across the UK without access to care, with profound consequences for individuals, communities and the wider health system. The effects are felt most sharply in areas of deprivation, where unmet need continues to grow and preventable disease drives wider health inequality.

- This is why the NHS Confederation and NEC Software Solutions brought healthcare leaders together to uncover what model of provision will improve oral health – particularly for groups most at risk – and reduce the impact of failure demand on the rest of the system.

- The current NHS dental contract is unfit for purpose. Participants at our October 2025 roundtable agreed that the activity-based unit of dental activity (UDA) system distorts priorities, rewarding volume over value and throughput over outcomes. Yet despite these contractual constraints, examples of innovation across the UK demonstrate the potential for scalable, transformative change.

- More than 20 leaders from across England, Wales and Northern Ireland identified a shared blueprint to reduce failure demand and improve outcomes for those most at risk. Across diverse roles and geographies, clear points of agreement emerged on core principles and key actions.

Core principles

- **Be honest about what is feasible** within the current climate – honest with the public about what the NHS can provide, and with the profession about where resources must be focused to reduce inequalities.

- **Adopt a proactive, life-course prevention-first approach**, making education routine and using digital tools to enhance, not replace, care.

- **Embed oral health within wider health strategies**, ensuring it becomes a visible and measurable part of system planning.

- **Redefine access and bring care to people**, targeting those most in need and enabling local flexibility over a one-size-fits-all model.

- **Fully use the whole dental workforce**, enabling professionals to work at the top of their scope and integrating dentistry within neighbourhood health models that connect oral health to overall wellbeing.

Key actions

- **Start prevention early**: Make supervised tooth-brushing, sugar reduction and oral-health education routine in early-years settings and schools.

- **Maintain prevention across life stages**: Use workplaces, pharmacies and community venues to reach adults with limited access or low health literacy.

- **Improve care in care homes**: Implement mandatory oral health training, regular assessments and inclusion in care plans to reduce malnutrition and hospital admissions.

- **Reform incentives**: Shift dental contracts to reward improved oral health outcomes, not treatment volume.

- **Use technology to enhance care**: Deploy AI triage, tele-dentistry and shared health records to extend reach without replacing face-to-face care.

Background

Years of underfunding, static contract values and low remuneration have led to an exodus of NHS dental providers across the UK. Increasing numbers of dental professionals are moving away from NHS work, leaving an estimated 13 million people in England unable to access an NHS dentist. In Northern Ireland, NHS dentist registrations fell by 23 per cent in 2024/25, and similar pressures are reported in Wales and Scotland.

This shortage is not evenly distributed. Areas of high deprivation and rural isolation are disproportionately affected, and patients with complex oral health needs or disabilities are often turned away. The result is an entrenched pattern of inequality and 'failure demand' – the cost of preventable disease flowing back into hospitals, urgent care and primary services.

The one-size-fits-all commissioning model is widely viewed as unfit for purpose. It incentivises activity rather than prevention, fails to reflect local population need and offers limited flexibility to develop community-based models of care. Successive governments have recognised the problem, but reforms have been partial and reactive, focusing on short-term access initiatives rather than systemic redesign.

Ahead of the 2024 UK general election, NHS dentistry featured prominently in all major parties' manifestos. The UK government has committed to contract reform in England, while Wales has begun implementing prevention-focused changes. Yet the scale of the challenge demands more than piecemeal adjustment; it requires honesty from governments, flexibility for local systems and collaboration across the whole NHS and wider system partners.

As the organisation representing the whole NHS, the NHS Confederation plays a unique role in connecting these efforts and exploring what is possible through genuine partnership. In collaboration with NEC Software Solutions, we convened a roundtable of more than 20 leaders from across England, Wales and Northern Ireland in October 2025. Participants included providers, commissioners, unions, regulators and patient representatives, and together they considered a central question: what is the model required to improve oral health, particularly for groups most at risk, and to reduce the impact of failure demand on the rest of the system?

From the discussion, five core principles for reform emerged – each essential to building a sustainable, prevention-led model of NHS dentistry and oral health.

Key components of a future model

The vision emerging from the roundtable is one grounded in honesty, prevention and local flexibility. Leaders agreed that meaningful reform begins with a realistic understanding of what the NHS can achieve within current resources. Only through transparent prioritisation can the system reduce inequity and ensure that care reaches those who need it most.

A future model must place oral health and prevention at the centre of strategic planning and delivery, make full use of the entire dental workforce, and give local systems the freedom to design services around community needs. Above all, it should embed dentistry within a neighbourhood health model that links oral health with overall wellbeing.

Principle 1: Honesty at the heart

> "The contract is broken – dentists are businesspeople and the current model pushes them toward private work."
>
> Roundtable participant

In a constrained economic climate, difficult choices are inevitable. Against this backdrop, honesty 'from the top' is essential. This will enable honesty with the public about what can reasonably be expected, and honesty with the profession about where effort must be focused to reduce inequalities and rebuild confidence.

Participants agreed that universal NHS dental access is not achievable within current funding levels or the existing contract

framework. Continuing to promise it risks eroding public trust and deepening professional disillusionment.

Reform begins with realism. System leaders must be open about what the NHS can sustainably deliver and focus resources on those at highest risk – children, older adults, people with disabilities and communities experiencing deprivation – while embedding prevention as the route to long-term stability.

Resources must be deployed intelligently, targeting urgent and preventive care for those most in need and underpinned by a performance framework that measures improvement in population health outcomes, not the number of procedures completed. This requires a shift in commissioning philosophy as much as contract reform.

The current unit of dental activity (UDA) model rewards volume over value, favours those already able to navigate the system, and offers little incentive for inclusion or innovation. It fails to attract new providers into NHS delivery and locks existing practices into short-term throughput rather than long-term health outcomes. Participants highlighted that a credible replacement would:

- balance access, prevention and outcomes rather than volume alone
- enable sessional and population-based funding that supports multidisciplinary, prevention-led delivery
- empower commissioners to contract for defined patient cohorts, aligned with Core20PLUS5 and local health inequality priorities.

By coupling transparency about limits with targeted reinvestment and clear outcome measures, system leaders can rebuild public confidence, re-engage the workforce and lay the foundations for a credible, prevention-led NHS dental service.

Case study: Equity-focused commissioning to address dental deserts

In several regions, including Greater Manchester and Cornwall, communities in rural, coastal and high-deprivation areas faced a stark reality: few or no NHS dental services, creating 'dental deserts.'

NHS commissioners and local integrated care boards carried out equity audits to map unmet need, then redesigned commissioning so funding followed people rather than activity. They introduced inequalities premiums, moved some contracts outside the standard UDA model, offered incentives for practices to accept new NHS patients, and prioritised funding for those least able to afford private care. The changes redirected resources to places of greatest need, drove higher uptake of NHS dental services in underserved communities, and encouraged inclusive, outcomes-focused delivery supported by stronger data and local responsiveness.

This targeted, flexible approach shows how financial levers and local autonomy can close access gaps and advance population health.

Principle 2: Prevention first, technology second

> "Technology isn't the solution to all problems – engagement and prevention are equally critical."
>
> Roundtable participant

Any future model needs to commit to a focus on prevention rather than increasing urgent access, which does not address the root cause.

Building on the foundation of honesty, the next imperative is to shift focus from repair to prevention. For decades, NHS dentistry has been organised around treating disease once it occurs rather than preventing it in the first place. Despite overwhelming evidence, proven tools and simple logic, the system still rewards intervention after failure instead of action to stop it. A credible and sustainable future model must invert that logic, making prevention, education and early intervention the organising principles of dental and oral healthcare.

Over 90 per cent of dental disease is preventable, yet the NHS continues to devote most of its dental spend to treatment rather than prevention. Reversing that balance is essential. A prevention-led model must make education and early intervention the default across the life course, reducing disease burden and future cost.

Case study: Pop-up dental clinics for vulnerable children

In the east of England and East Midlands, many children in deprived communities had never seen a dentist, leaving them at risk of untreated oral health issues and emergency admissions.

To tackle this, Community Dental Services CIC introduced mobile pop-up clinics in schools using a 'screen and intervene' approach. Children received on-the-spot screening and basic care, while QR codes linked families directly to dental practices for follow-up.

In one session, 98 children were screened – 80 per cent for the first time – creating immediate digital referral pathways and reducing barriers to access. This model shows how mobile outreach and digital tools can bring essential services to those most in need, aligning with prevention-first strategies and neighbourhood health integration.

A prevention-first approach moves the system from episodic, intervention-led care to proactive, population-health improvement. It focuses on sustained education, behaviour change and timely intervention to stop disease before it starts. Prevention should be built into every stage of service design and incentivised through contracts that reward measurable improvements in oral health outcomes, not just procedures delivered.

Case study: Prevention-focused public health campaigns

In Blackburn with Darwen, rising childhood tooth decay in deprived neighbourhoods prompted the public health team to deliver a sustained, prevention-focused programme over four to five years. The local authority combined oral health education across community venues, schools and nurseries with supervised toothbrushing in early years settings and targeted outreach to families in the most deprived wards, embedding daily brushing routines and engaging parents and carers with practical advice and support.

- The programme delivered measurable change:
- childhood tooth decay rates fell significantly
- public awareness and parental engagement increased
- early-years oral health behaviours improved.

Stronger collaboration between public health and education sectors helped institutionalise the activities, illustrating how sustained local leadership and a mix of universal and targeted prevention measures can shift population outcomes and reduce oral health inequalities.

Key actions and enablers

- **Start early**. Make supervised tooth-brushing, sugar-reduction and oral-health education routine in early-years settings and schools. In England and Northern Ireland, this would be supported by local authority public health teams, while in Wales this would be the responsibility of NHS health teams.

- **Sustain prevention through adulthood**. Use workplaces, pharmacies and community venues to reach adults with low health literacy or limited access to routine care.

- **Embed oral health in care homes**. Deliver the Care Quality Commission's Smiling Matters recommendations – mandatory oral-health training for staff, regular assessments, and inclusion in every resident's care plan – reducing malnutrition, infection and hospital admissions.

- **Align incentives with outcomes**. Reform dental contracts so instead of volume of treatments, they reward reductions in decay, improved recall compliance and greater patient self-care.

- **Use technology as an enhancer, not a substitute**. Digital tools, such as AI triage, tele-dentistry, shared health records and population dashboards, can extend reach and target prevention, but must never replace face-to-face care. The goal is to enhance equity, not create new divides.

Principle 3: Oral health as a strategic priority

> "Dentistry can no longer be looked at in isolation. The future relies on a system approach and parity with other primary care models."
>
> Roundtable participant

Embedding prevention across the life course will only succeed if oral health is treated as a core part of overall health, not a separate service.

For too long, dentistry has been managed in isolation; a system that fixes problems rather than helping to prevent them. This separation has created failure demand across the wider NHS: preventable oral disease driving unnecessary A&E visits, increased prescribing, delayed elective care and worsening long-term conditions.

To achieve lasting improvement, oral health must be recognised and resourced as a **strategic priority** across national, regional and local health planning.

Why it matters

- **Good oral health underpins everyday life**: eating, speaking, socialising and working.

- **Poor oral health does far more than cause pain**: it fuels systemic inflammation, worsening chronic diseases such as diabetes, cardiovascular and respiratory illness.

When left untreated, oral disease adds pressure to already stretched services – general practice, community nursing, urgent care and hospitals – creating costly failure demand that diverts resources from prevention and planned care.

The social and economic impact is equally profound. Oral disease leads to school absences, reduced employability, malnutrition and social isolation; problems that fall hardest on low-income and vulnerable groups.

The case for integration

> “It’s time to put the mouth back into the body.”
>
> Roundtable participant

For decades, oral health has sat on the margins of health policy design. Integration means embedding it across every level of planning and accountability.

Case study: Strategic oral health partnership for system-wide planning

In Cheshire and Merseyside, fragmented oral health planning across local authorities and health services led to inconsistent prevention strategies. A new partnership brought together nine local authorities, Healthwatch, education providers and social care to embed oral health into wider population health plans.

This collaboration integrated oral health into ICS-level strategies, improved coordination across sectors, and ensured prevention was central to local health agendas.

Towards a unified strategy

Placing oral health at the heart of prevention and population-health agendas delivers measurable system benefits:

- lower hospital costs
- improved chronic-disease management
- better patient experience.

Achieving integration will require cross-departmental collaboration between NHS England, the Office for Health Improvement and Disparities (OHID), local authorities and education partners to align data, planning and accountability. This coordination will ensure oral health is no longer an afterthought but a shared public health responsibility.

Case study: Integrated dental care for people with complex needs in Plymouth

Plymouth's dental pathway for people experiencing homelessness has evolved from a standalone initiative into a fully integrated component of a city-wide coalition. This alliance brings together healthcare, housing, social care, local government and voluntary sectors to address complex needs holistically.

While collaboration existed before, the new model formalises integration and reciprocity between services, making this the first example in the UK of integrated commissioning for dental care within a broader system of support.

The pathway began in 2018 as a community-based model co-designed by the University of Plymouth and Peninsula Dental Social Enterprise, combining research, peer-led education and a dedicated dental clinic.

Over 300 individuals have received care, improving pain relief, nutrition, confidence, and self-esteem, often acting as a catalyst for broader life changes. Cost-effectiveness analysis showed every £1 invested returned £3.02 in health benefits. The approach has influenced national policy and inspired similar pathways elsewhere, demonstrating how integrated, collaborative models can reduce stigma and improve outcomes for marginalised populations.

Principle 4: Reimagine access

> "Move away from the UDA model; it's a tick-box exercise that doesn't capture patient needs."
>
> Roundtable participant

Embedding oral health as a strategic priority must be matched by delivery models that make care genuinely accessible. Policy ambition means little unless people can experience it in practice. The next step is to redefine what 'access' means, moving away from a uniform, volume-driven system towards one that is locally designed, prevention-focused and equitable.

Across the three nations, commissioners and providers are already working creatively within the constraints of existing contracts, introducing sessional payment models, raising UDA values to maintain viability, and partnering with universities to expand clinical training and community capacity. Yet with the proportion of NHS-contracted providers continuing to fall, it is clear that incremental adjustments are no longer enough.

Now is the time to rethink capacity and redefine access. Improving access to NHS dentistry is not simply a matter of adding appointments. It requires designing services around people and place, reaching those with the greatest need, making full use of the local workforce, and removing the barriers that make care feel distant or unattainable.

From uniformity to local flexibility

The current one-size-fits-all commissioning model does not reflect the diversity of communities or the complexity of their

oral health needs. Rural, coastal and urban deprived populations face very different barriers; from travel distance and cost, to language, disability and trust in public services.

A reimagined model must give systems the freedom to tailor provision to local needs. Commissioners should be empowered to shape markets rather than simply respond to them, using the full range of contracting options – sessional or salaried models, blended payments and outcome-based incentives – to stimulate capacity, attract innovative providers, and better align funding with population priorities.

In England, predictable underspends within ICB budgets could be strategically reinvested to develop prevention-led pilots, strengthen outreach and reduce waiting times in high-deprivation areas.

Such flexibility must be matched by delivery models that bring these principles to life. Care should be given closer to where people live, learn and receive support; be delivered to quality standards; and be anchored to permanent, high-quality clinical facilities.

Case study: Flexible commissioning using clawback funds

In Cambridge and Peterborough, rigid national contracts and underused budgets limited local innovation. Commissioners reinvested clawback funds to pilot flexible commissioning models, including sessional payments and bespoke service design focused on prevention and outreach. These initiatives enabled tailored delivery, supported vulnerable populations, and demonstrated proof-of-concept for scalable reform.

Bringing care closer to people

Access should no longer depend solely on the traditional dental chair setting. Integrated delivery models can bring oral health into community spaces while maintaining clinical governance, safety and continuity of care:

- **Community hubs and schools** supporting early identification and upstream prevention through case-finding, referral pathways, fluoride varnish programmes and practical oral-health education.
- **Mobile and outreach units** serving rural or coastal areas, bridging distance and deprivation while anchoring patients into a permanent provider as their long-term dental home.
- **Care home and domiciliary teams** delivering preventive and restorative care for older adults and people with disabilities.
- **Partnerships with universities and community interest companies (CICs)** expanding sustainable clinical capacity and creating local training and employment pipelines.

Case study: Working with universities to build dental capacity and grow the workforce

Collaborating with universities has been one approach to creating sustainable dental capacity and addressing workforce shortages. By integrating education with service delivery, these partnerships provide clinical placements for dental students while expanding access to care in underserved communities.

Models such as Peninsula Dental Social Enterprise and University of Suffolk Dental CIC demonstrate how co-located training facilities and community clinics can deliver thousands of patient

appointments annually. At the same time, they equip future professionals with real-world experience in prevention-focused, inclusion-driven care. This approach not only strengthens the pipeline of skilled dental therapists, hygienists and dentists but also embeds social accountability into training, ensuring graduates are prepared to meet the needs of vulnerable populations and support integrated neighbourhood health models.

Digital and tele-dentistry tools can complement these models through remote triage, advice and follow-up. However, remote access must not mean remote care. Technology should enhance, not replace, face-to-face prevention, treatment and the patient relationships that underpin quality NHS dentistry.

Together, these approaches align with the NHS Long Term Workforce Plan, building sustainable placements, developing local talent and embedding oral health within community-based care.

A new definition of access

True access cannot measured by how many patients are seen, but by the difference made in improved oral health outcomes, reduced inequalities and fewer urgent care episodes.

Services should therefore be commissioned against population-level outcomes, such as reductions in decay rates, improved recall compliance or fewer dental-related A&E attendances, rather than by counting individual treatments.

By shifting from uniform provision to locally designed, prevention-focused models, the NHS can move beyond the access crisis. This would create a dental service that is fair, flexible and rooted in community need, with outreach as an enabler and every patient supported by a secure, prevention-led dental home.

Principle 5: Embedding the dental workforce into a neighbourhood health model

> "Think boldly about community-based hubs with multi-chair dental centres, integrated with health and social care."
>
> Roundtable participant

Reimagining access is only part of the solution. To create lasting change, dental care must become a core element of the neighbourhood health model, delivered through integrated, multidisciplinary teams that address oral health alongside the wider determinants of wellbeing.

There was strong consensus from roundtable participants that dentistry should no longer operate in isolation but be embedded within neighbourhood systems which connect prevention, primary care and population health. A sustainable future for NHS dentistry depends on full integration into the fabric of community health.

Why neighbourhood integration matters

Poor oral health is shaped by the same social determinants that drive wider health inequalities – poverty, poor housing, diet, education and access to care. A neighbourhood model, built around shared community infrastructure, offers a practical way to tackle these upstream causes.

Embedding dental services within neighbourhood hubs links oral health directly to primary, community and social care, creating seamless referral pathways. For example:

- a patient with diabetes referred directly to a dental therapist for periodontal management
- a care home resident receiving integrated oral health and nutrition assessments
- a family accessing preventive advice and health visitor support through a single community clinic.

Such joined-up approaches deliver measurable patient benefits and system efficiencies, preventing complications, improving medication control and reducing avoidable hospital use.

Collaborating across systems

Neighbourhood integration requires collaboration that extends well beyond dentistry. Alignment across local, regional and national levels (in policy, planning and data) is essential to embed oral health as a core part of integrated care.

By combining population-level data with local intelligence, commissioners and providers can target resources where they will have the greatest impact, focusing on communities where deprivation and disease intersect, and measuring outcomes consistently across neighbourhoods.

Integration also provides a shared platform for:

- **Joint workforce training and professional development** across dental, medical and allied health professions, building shared understanding of prevention and early intervention.

- **Collaborative estates planning**, co-locating oral health within neighbourhood health hubs to improve visibility, accessibility and value for money.

- **Interoperable digital infrastructure** that enables seamless referral, shared records and unified population health monitoring.

A GP-style registered patient list could further strengthen this approach, enabling dental teams to manage defined populations, stratify risk and deliver proactive, prevention-led care.

Together, these measures reduce duplication, improve patient experience and maximise public investment, allowing oral health to operate as a fully integrated part of the NHS system rather than a parallel service.

Case study: A digital transformation in dental referrals

Dentists across Shropshire and Staffordshire relied on paper referrals, leading to delays, lost documents and limited visibility for both clinicians and patients. The Local Dental Network, working with NHS England commissioners, identified referral modernisation as a priority and selected NEC Rego, an intelligent referral optimisation platform, to support the move to digital referrals.

The approach supports accurate and timely referrals by guiding clinicians to the appropriate pathway and enabling radiographs and images to be uploaded securely. When a patient's needs change, specialists can redirect cases to another provider without returning them to primary care, preventing further delay. More than 220 practices now use the digital pathways for extractions, orthodontics, paediatrics and intermediate minor oral surgery.

The shift has reduced administrative workload, improved triage accuracy and shortened waiting times. Referral quality has also improved, with 95 per cent of dental referrals now accepted on first submission. Continuous refinement of pathways, supported by shared learning across neighbouring areas, is helping commissioners understand local demand and align provision more effectively. This model shows how digitising referral processes can strengthen local oral health systems, improve coordination and support timely access to specialist care.

Realising the potential of the whole dental team

Achieving effective neighbourhood integration depends on using the whole dental team to its full potential. Across the UK, many qualified dental therapists, hygienists and dental nurses remain underused. Empowering these professionals to work at the top of their scope of practice, supported by robust supervision, governance and clear career pathways, can expand clinical capacity, strengthen prevention and improve continuity of care.

This shift requires a change in both culture and structure. Embedding oral health within neighbourhood health models transforms the role of dentistry in the NHS from:

- **episodic treatment** to **continuous prevention**
- **isolated contracts** to **shared outcomes**
- **standalone surgeries** to **community anchors** of health and wellbeing.

By bringing dentistry into the mainstream of neighbourhood and population health, the NHS can deliver better outcomes, greater equity and stronger communities.

'Putting the mouth back into the body of healthcare' is not only a public health imperative, it is essential to building a sustainable, prevention-led NHS that serves everyone.

Conclusion

Participants in the roundtable were united in recognising that universal NHS dental access cannot be delivered under current conditions. However, there was strong agreement that a targeted, prevention-focused model can deliver equity, sustainability and measurable improvement in population health.

The collective challenge now is to move from diagnosis to delivery; to design a service that is honest about what is achievable, clear in its priorities and bold in its reform.

The way forward

1. **Define a clear national offer for NHS dentistry**: a realistic, life-course approach, prioritised and prevention-first, focused on those with the greatest need.

2. **Reform contracting and funding models**: reward outcomes and enable multidisciplinary, team-based care rather than activity.

3. **Embed oral health in system planning**: through population-health dashboards, integrated care system (or equivalent in Wales and Northern Ireland) governance structures and prevention strategies.

4. **Empower local flexibility**: enable commissioners to innovate, adapt models to community needs and bring services closer to people, tackling inequitable outcomes.

5. **Integrate and maximise the workforce**: ensure every dental professional contributes fully to prevention, education and care.

Participants agreed that while the crisis in NHS dentistry is undeniable, the opportunity for reform is equally clear. Through honesty, collaboration and innovation, the NHS can restore public trust, reduce health inequalities and create a prevention-led, locally responsive dental service that truly supports the nation's wellbeing.

The NHS Confederation is the only membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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