CMA submission. Private Dental Services Market Study Response to Statement of Scope (Non-confidential)

Submitted by: Riverdale Healthcare
Contact: [✂] Dental Director [✂]
Geographic coverage: England
Date: 31 March 2026

Who we are?

Riverdale is a dental provider operating 60 practices across England covering the North East, Yorkshire and Humber, North West, East and West Midlands, Cambridge and South Essex. We provide a mix of mixed NHS and private, private-only and specialist services. We deliver preventive care, clinically necessary dentistry and cosmetic treatments, supported by clinical governance processes designed to ensure appropriate decision-making, clear consent, and high-quality patient experience.

We welcome the CMA's work to improve consumer outcomes in private dentistry. Our response focuses on practical, implementable changes that improve clarity and confidence for patients, while avoiding unintended consequences for access, affordability, and operational burden.

Scope note: We recognise the CMA's focus is the private dental market. In this response we refer to NHS provision and workforce rules only where they materially shape consumer outcomes in the private market-for example, where access constraints and mixed NHS/private delivery influence patient choice, information needs, and the availability of alternatives.

Riverdale's key points (summary)

- **Transparency must fit clinical reality.** Dentistry often requires diagnosis, staged planning, and treatment that evolves. "Transparency" should mean clear options, clear assumptions, and clear explanation of what may change and why—rather than forcing simplistic "single price at first contact" approaches that risk misleading comparisons.
- **The consumer journey is where the biggest gains are.** The best improvements are likely to come from standardising how treatment plans, estimates and options are explained (in plain English), improving the patient's ability to compare and decide, and ensuring patients know how to raise concerns and seek redress.
- **Trust in advice is central.** Patients' confidence is strengthened by consent quality, documentation, governance, and clear communication—not only by price publication.
- **Plans/finance can help affordability, but need clear guardrails.** Patients should be able to understand what is covered, what is excluded, what happens if they cancel, and how plan/finance discussions are kept separate from clinical recommendation.
- **Mixed NHS/private context matters.** While the CMA's primary focus is private dentistry, consumer confusion often arises in mixed settings. Clear signposting and consistent explanations are important for good outcomes.
- **System context shapes private outcomes.** Access constraints and workforce rules can influence who is able to provide NHS care, how mixed practices operate, and the extent to which patients are offered private options—all of which affects consumer experience in the private market.

Q1. Do you agree with the scope? What should be included/excluded/prioritised?

We support a UK-wide review of private dental services. We suggest the CMA prioritises:

- the quality and comparability of information patients receive before and at treatment planning (including what is included/excluded, and what may change);
- how patients understand NHS versus private options where both are offered; and
- the role of payment plans/finance in shaping choices.

We encourage the CMA to explicitly consider mixed NHS/private delivery contexts.

It is important that the CMA understands the vital importance of the "mixed economy" in NHS and private dental services, and how this mixed economy directly shapes consumer outcomes in the private market. In mixed NHS/private settings, private (and where relevant specialist) alternatives must be discussed as part of informed consent because the NHS does not provide fully comprehensive care. Not all treatment options that patients may reasonably wish to consider are available under NHS arrangements. Dental implants and purely cosmetic interventions are clear examples; and the availability of other options (including certain aesthetic materials, crowns, and higher-complexity endodontic or specialist pathways) can be limited or variable depending on local NHS pathways and commissioning. In practice, this means that patients are often presented with clinically valid options that span NHS and private routes; the consumer protection question is whether those options are explained transparently, comparably and consistently including treatment scope, likely sequence of care, costs, exclusions and follow-up.

This context is reinforced by current NHS access levels. Using the standard access measures for England (adults seen in the last 24 months; children seen in the last 12 months), only 40% of the adult population were seen by an NHS dentist in the 24 months to 31 March 2025 (around 18 million adults), and 57% of the child population were seen by an NHS dentist in the 12 months to 31 March 2025 (around 6.9 million children). In other words, a substantial proportion of the population is not accessing NHS dentistry within the standard reporting windows, and this inevitably influences behaviour and expectations in the private market.

It is also important for the CMA to appreciate that recent ministerial statements suggest the NHS dentistry budget is now being much more fully utilised. For example, the Minister for Care has told Parliament that the NHS dentistry underspend in England has fallen sharply from **£392m** to **£36m**. That matters because, even if the ring-fenced budget is now close to fully spent, the access measures above still show that a majority of adults and a substantial minority of children are not being seen within the standard reporting windows.

The implication is that the constraint is not simply whether funding is "allocated", but whether the current model can translate that funding into routine access at scale (given workforce, capacity and contract design). In that gap, private dentistry becomes the route by which many patients obtain care—and in mixed settings the point-of-choice interaction becomes central to consumer outcomes in the private market. Against that backdrop, the CMA enquiry is timely because of the NHS dental contract quality and payment reforms planned from April 2026 in England. These reforms are designed to rebalance activity and incentives within the contract, with a clear emphasis on urgent/unscheduled care and higher-needs/complex care, alongside prevention and quality improvement. Key elements include:

- **Mandatory urgent/unscheduled care requirement:** a minimum requirement equivalent to 11 urgent/unscheduled courses of treatment per £10,000 of contract value (i.e., £825 per £10,000, 8.25% of contract value), within a fixed contract envelope.
- **Revised payment mechanism for urgent/unscheduled care: £75 per urgent/unscheduled course of treatment**.
- **Quality improvement focus on recall intervals:** a quality improvement approach that reinforces clinically appropriate recall intervals, which may be perceived by some patients as reduced routine access if they are accustomed to more frequent attendance.
- **Prevention and skill-mix changes from April 2026:** changes intended to support greater use of prevention and skill-mix (for example, enabling appropriately trained members of the team to deliver specified preventive interventions under prescription and defined rules).
- **Further reforms expected later in 2026:** including additional pathways for higher-needs/complex care.

In the absence of clear additional recurrent funding for NHS dentistry, these reforms appear primarily designed to reallocate activity and incentives within existing resources. While this may improve delivery of urgent/unscheduled and higher-needs care, it is difficult to see how it will materially increase the overall proportion of the population accessing routine NHS dentistry. Indeed, there is a credible risk that routine availability tightens in many areas if contract value is redirected into mandated urgent/unscheduled activity and more complex pathways.

The practical consumer consequence is that, in mixed NHS/private settings, practices are likely to face more frequent points in the contract year where routine NHS capacity is exhausted. Where that happens, more patients will be offered a private alternative to NHS care, whether as private fee-per-item or via private plans -not necessarily due to practitioner choice, but because contracted NHS activity (funded through UDAs and related mechanisms) has been used up.

This may be particularly acute for routine care demand, including circumstances where patients are unhappy to be advised that recall intervals may be extended (even where that is clinically appropriate and aligned with evidence-based guidance). If routine NHS access tightens, the mixed economy and the point-of-choice information patients receive become even more central to consumer outcomes in the private market.

For these reasons, we recommend that the CMA explicitly prioritises mixed NHS/private delivery within scope and tests, in real-world settings:

1. how NHS versus private options are explained and distinguished (including when NHS capacity is not available within a practice's contracted activity);
2. how estimates, inclusions/exclusions and scope-change triggers are communicated in phased care and documented as part of consent; and
3. how plan/finance options are presented, ensuring patients can understand, compare and decide without confusion or undue pressure.

Q2. Do you agree with the CMA's description of a "well-functioning market"?

Broadly yes. A well-functioning private dentistry market should enable patients to:

- make informed choices;
- receive clear, trustworthy information about options and costs;
- trust professional advice; and
- access complaints and redress routes that are easy to understand.

We would add one practical refinement: dentistry often involves phased care and scope of treatment changes as diagnosis and treatment progress. A well-functioning market therefore needs transparency standards that support clear estimates and assumptions (including ranges where appropriate), and clear explanation of triggers for scope change so patients are not misled by oversimplified headline pricing. Treatment plans can change as complexity evolves and the full extent of dental disease is revealed; options that appear viable at initial examination can become less appropriate once diagnostic and clinical findings develop, sometimes requiring a different intervention or referral.

Q3. Does the market currently show these characteristics? What drives issues, and how could they be addressed?

Our experience is that patient understanding and confidence varies significantly. When problems arise, they often relate to:

- misunderstanding of what is included/excluded;
- scope changes during phased care not being clearly explained and documented; and
- confusion about NHS versus private options in mixed settings.

We think the most effective fixes are practical and standardised, rather than punitive:

- a minimum “treatment plan summary” standard in plain English (options, benefits/risks, what is included/excluded, assumptions, follow-up expectations);
- clearer estimate formats (including what could change and why);
- stronger signposting of complaints and redress routes, encouraging local resolution in the first instance; and
- encouragement of governance measures that support consistency (audit of consent documentation, peer review/second-opinion routes for higher-value plans, and clinician communication support).

Q4. Are there key differences across the four nations the CMA should reflect?

Devolved policy, regulatory approaches, and different patient pathways can affect incentives and consumer outcomes. We support explicit analysis across the four nations, and suggest the CMA tests whether differences in policy or system context change patient understanding, access patterns, and the prevalence of confusion around NHS versus private pathways. Our practical experience is in England; however, through sector engagement we are aware that different contractual models and reform approaches across nations may create different incentives and consumer experiences in mixed settings. The CMA may wish to consider whether planned reforms (including those expected from April 2026) change consumer journeys and choices and learn from the initial reaction to and uptake of reform in Wales.

Q5. What should the CMA focus on in the consumer journey and choice?

We support a focus on:

- **Information at the point of decision:** clear description of options and likely pathway, including "monitor/do nothing" where appropriate;
- **What the patient will pay:** inclusions/exclusions, estimate assumptions, and likely follow-ups;
- **Confidence in advice:** supported by documentation and governance; and
- **Access and switching:** practical frictions (including continuity during ongoing treatment, record transfer, and appointment availability), and how these affect choice and consumer experience.

A practical and proportionate improvement would be a simple, standardised "treatment plan summary" as discussed in Question 3 that improves consumer understanding and comparability without forcing dentistry into a simplistic retail price model.

Q6. Are any areas likely to disproportionately affect vulnerable consumers?

Yes. Vulnerability in dentistry often presents through pain/urgency, anxiety, communication barriers, disability or safeguarding issues, cognitive impairment, and financial fragility.

Practical mitigations that could be encouraged sector-wide include:

- written summaries and clearer "pause points" for high-cost elective care;
- accessible formats and communication support; and
- simpler, more visible complaints/redress signposting.

Q7. Do dental payment plans or financing impact the consumer journey and choice?

Yes. Plans and finance can support affordability and preventive attendance, but can also create confusion if not communicated clearly.

We suggest the CMA focuses on guardrails that support patient understanding:

- a simple one-page summary for any plan (what's included, excluded, cancellation rules, what happens mid-treatment, and how patients can switch);
- clear separation between clinical recommendation and payment route discussion; and
- clear explanation of any finance terms and responsibilities.

Q8. Are there particular competition dynamics the CMA should focus on?

Competition in dentistry often operates through access, continuity, service quality, and patient experience, not only price. Remedies focused solely on headline pricing risk oversimplifying a clinical service and may reduce meaningful comparability if they encourage providers to compress complex treatment into simplistic categories.

We suggest the CMA focuses on competition outcomes that matter most to patients: clarity of information, access, confidence, and fair redress.

Q9. Are there specific practices or conduct the CMA should focus on?

We support action against genuinely misleading advertising and high-pressure selling. Any response should be evidence-based and careful to distinguish isolated poor practice from systemic issues. We also suggest that strengthening basic standards for documentation, consent, and plan/finance clarity may reduce the drivers of disputes without requiring overly broad restrictions that could reduce access or increase defensive practice.

Q10a. Do regulatory frameworks and enforcement support good outcomes for consumers (including complaints/redress)?

We support the CMA examining whether patients can easily understand:

- where to complain first;
- what response timeframe and outcome they should expect;
- how to escalate; and
- what redress options exist.

The goal should be clarity and consistency for patients, not duplication or additional layers that make navigation harder. Signposting should encourage local resolution as the first step, with escalation only where local resolution is not possible or appropriate.

Q10b / Q11. Are there unnecessary or disproportionate barriers to entry/expansion, including for smaller providers?

Some requirements are essential for safety and quality. However, administrative duplication, avoidable delays, and workforce constraints can restrict supply and reduce access.

The CMA should be aware that workforce constraints and regulatory gateways materially limit the supply of dentistry and can shape the mixed economy in which private dentistry fills unmet demand. These constraints affect expansion and day-to-day capacity and can lead to situations where practices have clinicians available to deliver private care but limited ability to deliver NHS care.

Workforce gateways that constrain supply include:

- **Overseas registration pipeline (ORE capacity and timing):** there remains a significant bottleneck in the ORE route to GDC registration for overseas-qualified dentists. Our understanding is that over 2,000 overseas-qualified dentists are already resident in the UK while awaiting progression through the ORE/registration pathway. Some are working in other dental roles while they wait; others are excluded from the dentist workforce entirely until they can register.
- **Scale of expansion relative to need:** while there has been recent action to increase assessment/registration capacity, the scale may not be sufficient to address the underlying pipeline quickly.
- **NHS performer list gateway (post-registration):** even once GDC-registered, non-UK graduates may be unable to provide NHS care until they obtain an NHS performer number via the relevant training routes (including supervised practice/vocational training requirements).
- **Mentoring/supervised practice capacity and administrative friction:** access to supervised practice and mentoring placements can be difficult; where mentoring

capacity is constrained, the ability to convert registered dentists into NHS-delivering dentists is constrained.

- **Recruitment constraints for key DCP roles (including visa/sponsorship):** practices report constraints recruiting and retaining dental care professionals (including dental therapists) where immigration/sponsorship routes are more difficult to use.

Why this matters for the CMA's assessment of private dentistry

- These gateways can result in dentists being able to deliver private care but not NHS care, not because of practitioner preference, but because NHS delivery is constrained by performer list status and supervised practice capacity.
- They can create a "capacity split" within mixed practices: one dentist may be on track to deliver their full NHS UDA allocation (meaning NHS capacity is exhausted), while other dentists in the same practice may not hold performer status and therefore can only provide private care.
- If these constraints are not understood, the CMA risks misinterpreting why private care is offered or why private alternatives are presented in mixed settings when in many cases the driver is a supply constraint created by workforce gateways and contractual capacity limits.

In effect, this can produce a system where the NHS dentistry budget may be described as "spent", yet population access remains constrained and private dentistry fills the residual demand created by that gap.

Closing

Riverdale supports the CMA's focus on improving consumer outcomes in private dentistry. The CMA should understand that pressures on NHS funding and difficulty with performer list processes (even if ORE exams are released) can be significant contributing factors as to why practices offer predominantly private care especially when also consider the more limited scope of what can be delivered under mandatory NHS care.