Appendix D: Revenue growth strategies and incentives

D.1 This appendix sets out some of the evidence from internal documents and responses from the large dental groups relating to the commercial and strategic levers that are used to grow revenue, including evidence on targets, KPIs, and financial incentives.[1]

Targets and KPIs

D.2 We have seen several examples of KPIs linked to volumes or revenues of certain treatments or products sold; the cross-selling of private treatments to NHS patients; the sale of dental payment plans (**DPP**s), and recall success rates, being tracked by large dental groups. From such KPIs, we infer that dental firms have strategies relating to:

(a) **Promotion of high-value treatments:**

(i) Evidence relating to the four largest dental groups: Some of the four largest dental groups directly track whitening revenue and/or whitening treatment volumes.[2] Some documents contain targets for increasing the share of revenues from whitening (either alone or in combination with other high-value treatments, such as implants and clear aligners),[3] including one that sets a target for practices to increase home whitening treatments by 10 per month, with the aim of generating approximately £4.8m revenue (of which £1.1m is additional profit).[4] Documents from some of the four largest dental groups also note that whitening is a gateway to further treatments, with patients often taking up other cosmetic/high-value treatments such as aligners and composite bonding.[5] Some of the four largest dental groups directly track implant revenue and/or volumes,[6] and some also set targets/budgets for implant revenue.[7] One of the four largest dental groups tracks the number of implants placed by individual practices and clinicians, noting that there is an opportunity to support practices and clinicians in different ways dependent on volumes delivered and growth potential,[8] and another places clinicians into implant performance tiers based on revenue and volume metrics.[9]

[1] References to KPIs or targets refer to business targets, not personal targets, unless otherwise indicated.
[2] Responses to the CMA's information requests: [✂].
[3] Responses to the CMA's information requests: [✂].
[4] [✂] response dated [✂].
[5] Responses to the CMA's information requests: [✂].
[6] Responses to the CMA's information requests: [✂].
[7] Responses to the CMA's information requests: [✂].
[8] [✂] response dated [✂].
[9] [✂] response dated [✂].

(ii) Evidence relating to other large dental groups: One large PE-backed dental group submitted that it does not track KPIs at the treatment/procedure level as treatment mix is largely a clinical decision and that monitoring or incentivising specific procedure volumes could create the wrong behavioural drivers.[10] In contrast, another large dental group tracks conversion rates with a focus on implants, whitening, and aligners, and expects business managers to account for performance in these areas.[11] Another large dental group tracks Invisalign cases and whitening treatments as KPIs,[12] and a small to mid-size group has KPIs related to consultations for implants and aligners, whitening and composite bonding treatment volumes, and revenue from high-value treatments.[13]

(b) **Cross-selling of private treatments to NHS patients:** Documents from all of the four largest dental groups discuss the conversion of patients from NHS to private treatment, and/or the sale of additional private treatments to NHS patients.[14] Some of the four largest dental groups track conversions of patients from NHS to private treatment and/or metrics relating to the sale of additional private treatments to NHS patients.[15] Board documents from one of the four largest dental groups contain tracking of composite fillings completed on the NHS that could have been done privately,[16] a target to decrease the percentage of composite fillings completed on the NHS from [✂]% to [✂]%,[17] and details on how clinical advisors target worst performing clinicians to change behaviours.[18] The group submitted that composite white filings for cosmetic reasons are not covered under its NHS contracts. Documents from some of the four largest dental groups note that conversions and upselling additional private treatments (eg hygiene plans) are an opportunity to increase revenue and profits,[19] including some that identify underperforming practices or clinicians and suggest increasing NHS upsell.[20] Some documents make reference specifically to upselling private orthodontics,[21] and one document tracks weekly NHS to private conversion

[10] [✂] response dated [✂].
[11] [✂] response dated [✂].
[12] [✂] response dated [✂].
[13] [✂] response dated [✂].
[14] Responses to the CMA's information requests: [✂]. One of the four largest dental groups submitted that 'NHS-to-private conversion' is used in two settings. In orthodontics, it counts patients who begin private treatment after being assessed as ineligible for NHS treatment under the Index of Orthodontic Treatment Need (IOTN), choosing not to wait on the NHS waiting list after being told about waiting times and private alternatives, or requesting an appliance the NHS does not offer. In general dentistry, it refers to NHS patients choosing private treatment where (i) the practice cannot offer NHS treatment in a timely way, (ii) the treatment is not available on the NHS (for example veneers for aesthetic purposes), (iii) the patient asks for private treatment, or (iv) the patient wants an appointment time not offered under the NHS contract.
[15] Responses to the CMA's information requests: [✂].
[16] [✂] response dated [✂].
[17] [✂] response dated [✂].
[18] Responses to the CMA's information requests: [✂].
[19] Responses to the CMA's information requests: [✂].
[20] Responses to the CMA's information requests: [✂].
[21] Responses to the CMA's information requests: [✂].

for orthodontic treatment at the practice level.[22] More generally, documents from some of the four largest dental groups identify that staff such as clinical leads or treatment co-ordinators' responsibilities include focuses on NHS upsell.[23] One document notes that proposed NHS England contract changes to reduce clinically unnecessary check-ups is a very positive opportunity for private upsell.[24]

(c) **Promotion of DPPs:** Some of the four largest dental groups, one other large dental group, and six small to mid-size dental groups track KPIs directly related to DPP sign-ups/membership.[25] Documents from some of the four largest dental groups explicitly track sign-ups at the practice level,[26] one of which also sets targets for DPP sign-ups.[27] Documents from some of the four largest dental groups explain that every NHS patient should be asked about and/or offered a DPP.[28]

(d) **Use of scanning technology to drive treatment volumes**: All of the four largest dental groups track intraoral scan volumes as a KPI or against a set target.[29] Some documents note that scanners increase the conversion or volumes of private treatments (including high-value treatments such as implants and orthodontics),[30] and one of the four largest dental groups notes that scanners drive treatment volumes and upselling.[31] One document notes an ambition to scan every new patient,[32] and a due diligence report produced for one of the four largest dental groups explains that intraoral scans help patients visualise treatment outcomes, increasing adoption and driving high-value treatment such as cosmetic dentistry.[33]

(e) **Recall success rates:** Some of the of four largest dental groups, two other large dental groups, and two small to mid-size dental groups have KPIs related to recalls, lapsed patients, or future appointments booked.[34] Some of the four large dental groups also have financial incentives linked to recall success.[35] A document submitted by one of the four large dental groups states that the majority of patients are recalled every 6 months.[36] Another document from one of the four large dental groups includes an initiative to implement a 'check-up reminder' for lapsed patients who haven't visited in

---

[22] Response to the CMA's information requests: [✂].
[23] Responses to the CMA's information requests: [✂].
[24] [✂] response dated [✂].
[25] Responses to the CMA's information requests: [✂].
[26] Responses to the CMA's information requests: [✂].
[27] [✂] response dated [✂].
[28] Responses to the CMA's information requests: [✂].
[29] Responses to the CMA's information requests: [✂].
[30] Responses to the CMA's information requests: [✂].
[31] Responses to the CMA's information requests: [✂].
[32] [✂] response dated [✂].
[33] [✂] response dated [✂].
[34] Responses to the CMA's information requests: [✂].
[35] Responses to the CMA's information requests: [✂].
[36] [✂] response dated [✂].

the last 6 months to drive ‘lead generation’ (ie increasing their patient base).[37]

Evidence from acquisition documents on some of the non-price commercial and strategic levers used to grow revenue

D.3 We are undertaking a review of acquisition documents and have so far focussed our review on documents from the largest groups. We have requested further documents from all large groups and will update our analysis in the final report as this evidence is reviewed.

D.4 A recurring focus in the due diligence acquisition documents we have reviewed to date, many of which include strategies and business plans to be implemented at a site level after the acquisition has been completed, is the opportunity to grow private revenue.

D.5 Some of the strategies may not be in the best interests of consumers and (depending on the wider context and the extent to which consumers are supported to make informed choices) could give rise to potential consumer harm. Examples of these non-price strategies include:

(a) **Introduction or increased sales of high-value private treatments such as aligners, whitening and implants**: For example, a document from one of the four largest dental groups noted a plan to introduce high-value private treatments such as aligners and whitening, combined with a strengthened focus on the implant service (as well as noting plans to increase the private treatment share from [5-10]% to [10-20]% in the merging practices by year 2, maturing at [30-40]% by year 4 - although we note that this does not necessarily imply they would reduce their NHS business).[38] A document from another large dental group noted an opportunity to focus more on specialised treatments at the target practice where most of the revenue was previously generated through practice plan and general treatments.[39]

(b) **Cross-selling services to NHS patients:** For example, a document from one of the four largest dental groups notes that NHS dental services “can translate into private elective treatments”[40]. A document from a large dental group noted significant private growth potential at the target practice through private upsell.[41] The same document notes ‘huge scope for growth’ due to a

[37] [✂] response dated [✂].
[38] [✂] response dated [✂].
[39] [✂] response dated [✂].
[40] [✂] response dated [✂].
[41] [✂] response dated [✂].

historic lack of converting patients on the NHS waiting list to private at the target practice.

(c) **Selling DPPs**: We have reviewed acquisition documents which refer to DPPs as an opportunity to increase private revenue. These documents refer to 'conversion of patients to plan', 'increase plan', and 'plan optimisation' as a revenue opportunity in the context of an acquisition screening tool, or 'implementation of plan', which we understand refers to DPPs. [42]

D.6 Other documents identify revenue-growth initiatives that may benefit patients, including increasing fulfilment of existing NHS contracts,[43] expanding surgery utilisation,[44] increasing opening hours,[45] investing in equipment/ premises/ software,[46] expanding services/ practice capabilities,[47] and recruiting additional clinical labour.[48]

D.7 We are in the process of a detailed review of the group strategies and business plans of large dental groups. We have found some of the strategies applied in relation to add-on acquisitions also to be components of a number of the strategic plans of large dental groups in relation to their existing estates.[49]

Financial incentives

D.8 Some dental groups offer nominal financial incentives for each additional sale of cosmetic treatments, such as teeth whitening, or DPPs. Some of these incentives are payable only to employed staff,[50] and exclude associates (who account for a high proportion of all dentists), while others are based on team- or practice-level activity and include all staff and associates. The CMA found evidence of:

(a) **Incentives linked to whitening kit sales**: Financial incentives for each additional sale of whitening kits in some of the four largest dental groups' internal documents. One of the four largest dental groups offered a financial incentive of £10 to all colleagues and clinicians from every additional sale of a home whitening kit (relating to a single supplier) which would be added to a social fund.[51] 'Operations Managers [were] also […] financially incentivised to increase sales, [with a bonus of] £500 per month for the area with the highest increase in home whitening volumes'.[52] The internal operations manager

[42] Responses to the CMA's information requests: [✂].
[43] [✂] response dated [✂].
[44] Responses to the CMA's information requests: [✂].
[45] Responses to CMA information requests: [✂].
[46] Responses to the CMA's request for information: [✂].
[47] Responses to the CMA's request for information: [✂].
[48] Responses to the CMA's request for information: [✂].
[49] Responses to CMA's request for information: [✂].
[50] Employed staff include patient/treatment coordinators, hygienists, reception staff.
[51] [✂] response dated [✂].
[52] [✂] response dated [✂].

briefing presentation containing details of the scheme stated that the group's objective was to grow its whitening revenue and market share, while noting the additional 'opportunity to promote patient finance'.[53] This particular scheme related to one supplier's whitening kits, with the document noting that this would 'allow [the group] to 'test the water on supplier promotion' since 'whitening is less contentious with clinicians'.[54] Another of the four largest dental groups offered a financial incentive in the form of a flat payment of £5 for each sale of a whitening kit (of any brand, and regardless of kit price) by any employed practice member.[55] The amount went into a practice 'pot' to be used on practice days out.

(b) **Incentives linked to DPP sales**: Financial incentives for each additional sale of a DPP at some of the four largest dental groups.[56] These tended to be small per-sign up cash payments or vouchers and some were periodic or trial schemes. The CMA notes that these payments were for employed practice staff only and were not payable to self-employed clinicians. Another large dental group offers a flat £5 fee per DPP sign-up for all team members.[57]

D.9 Practice managers, who are responsible for developing and managing the business at a practice level (but may span more than one practice),[58] hold a salaried position.[59] In addition to the financial incentives set out above, practice managers' terms of employment usually include bonuses linked to practice performance metrics including EBITDA and growth in private revenue. For example, the CMA found:

(a) **Bonuses linked to EBITDA and other practice financials**: For example, employed colleagues at one of the four largest dental groups are eligible for a bonus of up to 25% of base salary, tied to EBITDA outperformance and other KPIs.[60] Another of the four largest dental groups offered a discretionary bonus scheme to practice managers worth up to £[2,000-3,000] per year calculated based on a practice's ([✂]) performance against three metrics (total revenue, profit and customer experience), with additional 'prizes' to be won for best performance against pre-agreed KPIs.[61] Five other large dental groups and one small to mid-size dental group also offer bonuses to managers that depend partially or fully on the profitability of practice(s).[62]

[53] [✂] response dated [✂].
[54] [✂] response dated [✂].
[55] [✂] response dated [✂].
[56] Responses to the CMA's information request: [✂].
[57] [✂] response dated [✂].
[58] [✂] response dated [✂].
[59] [✂] response dated [✂].
[60] [✂] response dated [✂].
[61] [✂] response dated [✂].
[62] Responses to the CMA's information request: [✂].

(b) **Bonuses linked to overall revenue** (paid on additional income over a baseline income earned): for example, [✂]% of fee per item private income, on every pound above a given target.[63]

(c) **Bonuses linked to sales volumes of specific treatments and products**: An internal document from one of the four largest dental groups contained a worked example of communications sent to practice managers titled 'your chance to earn more'.[64] It contained a customised table illustrating how many additional sales of certain cosmetic treatments, hygiene appointments and DPPs would be required per week/month in order for them to achieve a bonus payment of over £[1,000-2,000].[65]

(d) **Awards based on DPP retention and cancellation prevention**: a graduated award increasing with every [10-15]% improvement from a baseline (starting at £[50-60]).[66]

D.10 One of the four largest dental groups offered its associates an annual performance payment directly linked to the revenue generated by the individual.[67] Specifically, self-employed dentists were offered an annual performance payment based on 'over achievement' on their 'core deliverables of NHS and private income earned above the minimum income stipulated within [their] agreement [with the Group].' For example, [✂].[68] [✂]. Another large dental group pays an amount into a team pot for every new private patient which is distributed based on hours worked as a bonus to support staff.[69]

Evidence of these KPIs/targets being passed on to clinicians

D.11 The CMA found evidence from internal documents and RFI responses that KPIs/targets are communicated to clinicians, directly or indirectly, across all of the four largest dental groups through a variety of methods.[70]

D.12 Some of the four largest dental groups encourage practice managers to hold discussions with individual clinicians and/or teams, briefing them on things like current performance and key metrics such as conversion rates:

---

[63] [✂] response dated [✂]. Additionally, one large dental group has salary bands for practice managers that are linked to the size of practice revenues – with practice managers able to climb the salary bands by growing the practice revenues. [✂] response dated [✂].
[64] [✂] response dated [✂]. The commercial incentives included in the example include a range of cosmetic treatments and DPPs.
[65] [✂] response dated [✂]. The commercial incentives included in the example include a range of cosmetic treatments and DPPs.
[66] [✂] response dated [✂].
[67] [✂] response dated [✂].
[68] [✂] response dated [✂].
[69] [✂] response dated [✂].
[70] Responses to the CMA's information requests: [✂].

(a) An internal document from one of the largest four groups stated that practice managers should have monthly income review meetings with each self-employed dentist using the Monthly Income Statement as a key tool and they are advised to highlight to dentists how they might be able to increase their income.[71]

(b) One of the four largest dental group's written guidance for practice managers prompts them to keep all teams briefed on current performance and provide them with a clear set of actions to deliver more and better care. It prompts them to monitor their conversion rates and discuss these with clinicians, as well as holding 1-2-1s with clinicians to review worked hours reports.[72]

D.13 The internal documents from another of the four largest dental groups showed this information on targets and current performance being passed on through wider practice team meetings. The meeting minutes outlined information sharing for team awareness which covered performance and delivery against targets and budgets. The team were updated on things such as monthly referrals for aligners compared with the practice monthly average, and weekly uptakes of patients signing up to a DPP.[73]

D.14 Internal documents from some of the four largest dental groups show that relevant information was communicated directly to staff:

(a) An internal document from one of the four largest dental groups stated that it provides information for staff to track KPIs in real time and to drive practice-level decision making.[74]

(b) Another of the four largest dental groups told the CMA that it held working groups with clinicians, practice managers and operations managers in 2025 to agree which KPIs should be prioritised. KPIs included NHS-to-private conversions, each clinician's revenue as a proportion of total practice private revenue and a breakdown of revenue by treatment type.[75]

[71] [✂] response dated [✂].
[72] [✂] response dated [✂].
[73] [✂] response dated [✂].
[74] [✂] response dated [✂].
[75] [✂] response dated [✂]. The group submitted 'NHS-to-private conversion' is used in two settings. In orthodontics, it counts patients who begin private treatment after being assessed as ineligible for NHS treatment under the Index of Orthodontic Treatment Need (IOTN), choosing not to wait on the NHS waiting list after being told about waiting times and private alternatives, or requesting an appliance the NHS does not offer. In general dentistry, it refers to NHS patients choosing private treatment where (i) the practice cannot offer NHS treatment in a timely way, (ii) the treatment is not available on the NHS (for example veneers for aesthetic purposes), (iii) the patient asks for private treatment, or (iv) the patient wants an appointment time not offered under the NHS contract.

Evidence of four largest dental groups evaluating the effectiveness of KPIs, incentives and targets

D.15 The CMA has identified several internal documents from the four largest dental groups which show that they evaluate the effectiveness of KPIs, targets, and incentives, and in some instances propose actions to improve performance and/or changes to the design of these systems with the aim of aligning clinician incentives with commercial objectives,[76] focused on maximising overall revenue.

D.16 The CMA has seen internal documents from all of the four largest dental groups which review and report on whether performance is on track, ahead or behind target, across several KPI's/metrics.[77] For example:

(a) Several documents from one of the four largest dental groups contain practice scorecards which map metrics such as DPP sign-ups and £/hour rates by month and use a traffic light system to show where these metrics are at, below or above target. Two documents show or reference updates made to these scorecards, upon which some staff bonuses are based. The scorecards appeared in board packs as well as in documents prepared for practice managers.[78]

(b) A board update for one of the four largest dental groups reported on various metrics against the same time last year and target performance for this year. The document reported that the main drivers of private growth had been revenue from DPPs, whitening, implants and aligners, with the latter driven partly by treatment planning services which aid clinician confidence.[79]

D.17 The CMA has seen evidence that some of the four largest dental groups suggested specific actions relating directly to sub-optimal performance against certain targets:

(a) One of the four largest dental groups' internal document noted that while scan volumes are in a better place in Q3, they still remain significantly below target and the focus for the year is to drive utilisation using a number of means including encouragement of clinicians to adopt digital workflows and BAU training days for clinicians throughout the year.[80]

(b) One of the four largest dental groups' internal document reported on strong growth for whitening treatments, partly driven by incentives, but suggested

[76] In relation to one of the four largest dental groups, we note the aim also includes delivering good customer/patient outcomes and experiences.
[77] Responses to the CMA's information request: [✂].
[78] Responses to the CMA's information request: [✂].
[79] [✂] response dated [✂].
[80] [✂] response dated [✂].

that these incentives needed a refresh as performance had dropped off after six months.[81]

(c) One of the four largest dental groups' internal document noted positive movement in composite fillings since a practice manager conference but suggested continuing conversations with clinical teams, particularly the worst performing ones.[82]

D.18 One of the four largest dental groups considered structural changes to the design of clinicians' employment and remuneration model to more closely align individuals' incentives with the group's incentives:

(a) One internal document outlined that it is unclear whether 'on-the-ground teams are looking at the right KPIs.' The document stated that clinicians currently 'have little skin in the game', 'think as self-employed consultants [rather than] involved owners' and there is 'potential to develop new partnership models that benefit the clinicians and the Group'.[83]

(b) A separate document from the same group discusses 'key initiatives' to prioritise. These include projects to increase available hours such as using sliding scales and variable fee structures; by aligning incentivisation with profitability; the creation of KPIs with results tables; engaging partners in practice performance conversations; reviewing and managing low performing clinicians; and stronger enforcement of clinician contracts.[84]

Supplier agreements

D.19 We have seen several examples of agreements between suppliers and dental groups that contain pricing linked to sales volumes and/or revenues of either individual or multiple products, including rebates and discounts. These examples provide further evidence of commercial strategies that may have the potential to influence clinicians' incentives. These include:

(a) **Volume-linked pricing for DPPs**: Some of the four largest dental groups,[85] and four other large dental groups[86] have agreements with DPP providers that involve pricing dependent on volumes. An agreement between one of the four largest dental groups and a DPP provider includes [✂] in addition to patient volume thresholds for achieving discounts and rebates and a higher [✂] growth target for patient volumes which, if not met, triggers a review of

[81] [✂] response dated [✂].
[82] [✂] response dated [✂].
[83] [✂] response dated [✂].
[84] [✂] response dated [✂].
[85] Responses to the CMA's information requests: [✂].
[86] Eg responses to the CMA's information requests: [✂].

the terms of the contract.[87] A comprehensive partnership document (as well as several board packs)[88] include initiatives to reach the [✂] target such as NHS conversions (ie reducing UDAs), upselling hygiene plans to NHS patients, and incentives for practices and staff to upsell plans.[89]

(b) **Volume- and revenue-linked pricing for materials**: Some of the four largest dental groups have agreements with implants and/or biomaterials suppliers with terms linking pricing to sales volumes and/or revenues.[90] Some agreements contain agreed growth based rebates,[91] while another details multiyear targets for implant volumes, multiyear targets for customer spend on biomaterials, and a clause for [✂] to discuss the delivery of these targets and other KPIs related to implant and biomaterial sales values.[92]

(c) **Volume-linked pricing for aligners**: All of the four largest dental groups have agreements with clear aligner suppliers that include volume-based rebates.[93] Some of these agreements include specific volume targets,[94] and some also contain clauses enabling the supplier to terminate the agreement should the group fail to meet these targets.[95] One large dental group explained [✂].[96] [✂].

D.20 We also found one agreement that contains joint ambitions of the dental group and the supplier such as to 'triple implant numbers by [✂]',[97] and an agreement including a commitment to provide targeted training on the use of their product to a certain number of clinics, or at a discounted rate.[98]

[87] [✂] response dated [✂].
[88] Response to the CMA's information requests: [✂].
[89] [✂] response dated [✂].
[90] Responses to the CMA's information requests: [✂].
[91] Responses to the CMA's information requests: [✂].
[92] [✂] response dated [✂].
[93] Responses to the CMA's information requests: [✂].
[94] Responses to the CMA's information requests: [✂].
[95] Responses to the CMA's information requests: [✂].
[96] [✂] response dated [✂]. One large dental group explained [✂]. See [✂] response dated [✂].
[97] [✂] response dated [✂].
[98] [✂] response dated [✂].