Health Committee

This document contains the written evidence received by the Committee in response to its Call for Evidence, which formed part of its investigation into Dentistry in London.

Calls for Evidence are open to anyone to respond to and in July 2024 the Committee published a number of questions it was particularly interested in responses to as part of its work, which can be found on page 2. The Call for Evidence was open from 23 July 2024 to 6 September 2024. Additional evidence, as requested by the committee at the formal meeting, was received in October from the National Association of Headteachers.

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What are the specific barriers that prevent adults and children in London from accessing NHS dental care?

London faces high demand for NHS dentistry and an inadequate supply, fuelled by a failed contractual model. BDA analysis of the GP Survey 2024 suggests that unmet need for dentistry in London stands at 2 million, or more than 28 per cent of the adult population. This includes an estimated 630,000 adults who tried and failed to secure an appointment in the last 2 years, 1 million adults who require care but are no longer seeking it as they believed they couldn't secure an appointment, 270,000 adults who could not afford the cost of care, and 80,000 adults who are on waiting lists.

The NHS dental statistics 2023/24 show over 4.2 million adults in London (60 per cent) had not seen an NHS dentist in the two years prior to June 2024. This is worse than the national average for England, and represents a significant worsening of the 55 per cent figure recorded in 2010.

The barriers to patients accessing NHS dental care in London arise directly from the failures of the contract for NHS dentistry and the Unit of Dental Activity (UDA) payment system which is focussed on managing short-term costs, rather than prevention and a longer-term approach. The UDA is a proxy measure that neither reflects the true cost to a dental practice of performing a given clinical intervention, nor enables dentists to deliver dentistry that is prevention focussed.

Under the current provider payment mechanism, dental practices that are unable to deliver the total volume of their contracted NHS activity must repay a proportion of their contract value, which is known as 'clawback'. Despite record demand for NHS dental services, 32 per cent of NHS dental practices in London experienced clawback in 2022/23. £11.9 million from the NHS dental budget was clawed back from these practices in 2022/23. This money, while budgeted toward the provision of NHS dentistry, has in the past been redirected to other parts of the NHS. It is critical that money budgeted for NHS dentistry is spent on dentistry, and given the ongoing crisis in the recruitment and retention of dentists facing dental practices, London's dental commissioners must ensure that any such funds go toward improving access to dentistry.

In addition to issues arising from the commissioning, contractual, and payment mechanisms for NHS dentistry, funding for dentistry in England has been frozen since 2010/11, representing a fall in real terms of over £1billion.[1] As a result of the long-term under remuneration of NHS activity delivered by General Dental Practitioners (GDPs), dental practices are forced to take on more private work to cover their unfunded costs, and therefore have less capacity available for NHS dentistry. Challenging economic conditions, unfunded increases in the costs of delivering NHS dentistry and understandable patient frustration at a lack of access to NHS dentistry had led to a beleaguered workforce with morale at a record low, with a predictable impact on the supply of NHS dentistry. The most recent BDA survey data indicated that 49 per cent of associate dentists rated their morale in their work as low or very low, with 60 per cent of practice owners saying the same.

How do these barriers differ across various demographics, including age, income, and ethnicity, and what are the underlying causes of these disparities?

Considering the total population in England, of those who access NHS dentistry, around 50 per cent[2] contribute via a patient charge. Roughly a quarter are children, and the remaining patients

[1] NHS Dentistry sees biggest fall in budget in decades (bda.org)
[2] Dental statistics – England 2023/24 | NHSBSA

are non-fee-paying adults. These cover a range of groups from those on Universal Credit to pregnant women, people with disabilities, and others.

Dental charges act as a tangible barrier to access for those on modest incomes, bringing down demand, and GP survey data suggests over a quarter of a million are put off by cost. These charges have been subject to multiple above inflation increases over recent years.

There are on average 4.9 dentists per dental practice in London. There are significantly more dentists in London per 100,000 people at 58.1 than the England average of 43. However, this represents a significant decrease compared to the period prior to the pandemic. In 2019, for example, there were 63 dentists per 100,000 people in London.[3] West London is the place with the most dentists per 100,000 of the population, with 64, while east London lags far behind the city average, at 47. It is important to recognise, however, that headcount data is at best a proxy measure for the supply of dentistry, as the currently available data is not weighted for the volume of activity a given dentist might perform. Better data regarding the composition of the dental workforce in London would support the effective commissioning of NHS dentistry.

London has among the lowest attendance rates of all English regions when comparing the percentage of children who have seen an NHS dentist in the last year. Access to dentistry varies from borough to borough in London, implying a widening inequalities gap. NHS dental statistics 2023/24 demonstrate that, while 53 per cent of adults in Lewisham saw an NHS dentist in the last 2 years, only 26 per cent of adults in Tower Hamlets did. In Haringey, 68 per cent of children were seen by an NHS dentist in the last 12 months, but only 38 per cent in Hackney. The South West is the only English region where a smaller proportion of children than in London are likely to see an NHS dentist. Even though NHS dentistry is free for under 18s and NICE guidelines recommend children should be seen by a dentist at least once a year, over one million children in London (53 per cent) have not been seen by a dentist in the past year.

NHS dentistry is provided and paid for in treatment bands, which are designed to reflect the clinical complexity of a given intervention, with band 1 being the lowest, and band 3 the highest. Treatment in London primarily falls under Band 1. However, fewer treatments fall under Band 1 in London than on average nationally, while Band 3 treatments take up a proportion of the total which is roughly double the average for all local authorities across England. Indeed, London boroughs occupy the top thirteen places in the ranking of local authorities by proportion of band 3 treatment, Westminster having the highest at over 12 per cent. The England average for urgent treatment is 10 per cent, while in London it is 13 per cent with Hammersmith having the highest proportion of urgent treatment at 19.66 per cent. While it is not possible to make definitive statements regarding the relative clinical complexity of caseloads in London as a result of poor quality or incomplete data, these figures do suggest that the clinical presentation of patients in London are among the most complex in the country.

What impact is the lack of availability of NHS dentistry in London having on the oral health of Londoners?

Tooth decay, which is largely preventable, can have a substantial impact on health and wellbeing. Poor oral health affects not only an individual's physical health, but also their overall wellbeing, confidence, mental health and development. Problems with teeth can impact on ability to sleep, eat, speak, and socialise. It can affect school readiness for children, both through loss of school days and because of pain and difficulty sleeping affecting the ability to learn. This can further impact on parents and carers, through missed workdays due to dental appointments. Other consequences include pain, infections, impaired nutrition and growth, with the impact of poor oral

[3] Dental statistics – England 2023/24 | NHSBSA

health, and treatments such as fillings, lasting a lifetime. Dental decay and gum disease are the most common oral conditions and the cost to the NHS of treating these is around £3.6 billion per year.

According to the National Dental Epidemiology Programme (NDEP), in London 13.5 per cent of school children aged 16-years and 25.8 per cent of school children aged 5-years had experience of tooth decay, for the academic years 2022/23 and 2021/22, respectively. Tooth decay remains the most common reason for hospital admissions in young children aged 5 – 9 years, and rates in London are amongst the highest in England, with 333 decayed hospital tooth extractions per 100,000 population. In the 2022/23 financial year 6,985 extractions due to tooth decay took place in London, equating to 27 hospital admissions every working day of that year, and an estimated cost of £9.1million to the NHS. The UK Government's Delivering better oral health toolkit advises that dental caries can be identified and reversible at an early age, and availability of NHS dentistry has an important role to play in this.

With 25.8 per cent of 5-year-olds in London suffering from tooth decay, London is the third worst area in England in terms of child tooth decay outcomes, after the North West and Yorkshire and Humber. This overall figure also hides massive inequalities between different London boroughs. Tooth decay incidences vary from 12 per cent in Lewisham to 46 per cent in Brent – the worst local authority in England for child tooth decay. For comparison, in the best-performing areas in England only 10 per cent of 5-year-olds suffer from decay.

Worryingly, while we have seen slow but steady improvements in child oral health nationally, 14 of the London boroughs have actually seen a deterioration in children's outcomes since 2015, with children in Brent now a third more likely to suffer from decay than they did in 2015 (please see the annex for a full list of outcomes across Greater London).

The incidence of tooth decay is more heavily concentrated in children from poorer socio-economic backgrounds; this inequality is stark within London. Those children in London who suffer from caries have some of the nation's highest level of decay per head in England, with an average of 3.7 teeth affected.

There is good quality research demonstrating that severe tooth decay requiring dental extractions amongst children disproportionately affects children from some ethnic groups. A recent study by Queen Mary University of London based on the GP and hospital records for 600,000 children between the ages of five and 16 living in North East London found that children from some ethnic groups are more likely to need a dental extraction, compared with children from White British ethnic groups. For example, Bangladeshi children were one and a half times more likely to need an extraction when compared to White British children, while White Irish children were twice as likely. The same study found that children living in areas with high levels of deprivation are three times more likely to have severe tooth decay that requires a dental extraction in hospital, compared with children living in more affluent areas.

Alongside tooth decay, incidences of oral cancer are also increasing and look likely to double by 2035 in the UK. Oral cancers are some of the most preventable types of cancer, and over 90% of all oral cancer cases could be avoided. The latest figures show that 8,846 people in the UK are diagnosed with mouth cancer each year, with rates higher in England and Wales compared with the rest of the UK (17 per 100,000). Dentists and their teams play a vital role in ensuring oral cancers are detected early and as they are often the first healthcare professionals to spot symptoms, can help to save people's lives by ensuring patients are aware of the risk factors. However, limited access to dental services means that fewer oral cancer cases will be detected early, which will lower the survival rate. Sufficient resources, funding and training is also necessary

to ensure effective treatment services are available and that dental patients can be appropriately referred.

Another key issue regarding the lack of access to NHS dentistry in London is the concern that the inequalities gap will widen further. Whilst there have been some improvements in oral health in recent decades, poor oral health still affects a huge proportion of the population and is strongly associated with deprivation. The most deprived communities are more likely to suffer higher rates of tooth decay and more likely to develop and die from oral cancer, than those in more affluent areas. In London, 5-year olds suffering from tooth decay have some of the nation's highest levels of decay per head in England, with an average of 3.7 teeth affected.

Patient access to NHS dentistry is also one of the barriers to tackling antimicrobial resistance (AMR), which according to the World Health Organization is one of the top 10 threats for global health. Dentists are responsible for 1 in 10 primary care antibiotic prescriptions in the UK and as such, have an important role to play in optimising their use of antimicrobials when patients present with infections and acute dental pain. The majority of dental infections are amenable to treatment through dental procedures, thereby reducing the need for antibiotics. Improved access to dentistry is key to optimising the use of antibiotics by dental teams and providing safe care for patients.

What preventative measures are currently being taken to support oral health in London, and how effective are these measures?

There is no silver bullet to preventing poor oral health. Any strategy to support and improve oral health should include sufficient access to preventative dental care and population level measures to address risk factors for tooth decay, including action on the marketing, labelling and sales taxes of foods high in sugar; increasing the availability of fluoride – through fluoridated water and supervised tooth-brushing schemes such as those in Scotland and Wales; and measures to minimise uptake and promote cessation of smoking and vaping especially among young people.

In London there is a range of preventive interventions being deployed to support oral health. Several boroughs across London are providing supervised toothbrushing schemes or fluoride varnish programmes, including The Camden & Islington Fluoride Varnish Programme, commissioned by Whittington Health NHS Trust, which aims to improve the dental health of children and involves a brief inspection of children's teeth at school, followed by application of fluoride varnish as a means of preventing tooth decay. The Kent Community Health NHS Foundation provides a supervised toothbrushing programme, while Tower Hamlets Council works with children centres to tackle the high rates of dental decay among children living in the borough. There is also the Healthy Teeth in School programme, which works with every primary school in the borough to provide fluoride varnish application to pupils twice a year.

PHE research indicates that in areas with poor oral health outcomes, for every £1 invested in supervised tooth-brushing, £3.06 is saved in treatment costs over 5 years. It has been demonstrated, through ChildSmile in Scotland and Designed2Smile in Wales, that supervised toothbrushing and fluoride varnish programmes have led to unprecedented improvements in outcomes in recent years. Decreased rates of dental caries have been reported among 5-year-olds in Scotland from 32% in 2014 to 26% in 2020, with ChildSmile particularly effective among socially disadvantaged groups. In addition, a review of Tower Hamlets' Healthy Teeth programme, carried out by Kings College London, found it was an 'effective and cost effective' intervention to improve children's oral health in the borough.

The Healthier Advertising Policy Toolkit implemented by Transport for London in 2019 restricted the advertising of unhealthy (high fat, sugar, salt) food products across the TfL service. Research led by the London School of Hygiene and Tropical Medicine demonstrated that the intervention

significantly reduced unhealthy food purchases and had a particularly strong impact on sugary food purchases.

The provision of free school meals to primary school children in state-funded schools can mitigate the negative impact of diet-related inequalities and improve children's health, as children from deprived backgrounds are more likely to have higher rates of tooth decay.

The Soft Drinks Industry Levy (SDIL) was introduced to encourage manufacturers and retailers to reduce the sugar content in their drink products. An evaluation of SDIL demonstrated that in its first four years of implementation, total sugar sales from soft drinks decreased by 34.43% (~47,000 tonnes). Research published in BMJ Nutrition, Prevention & Health in 2023, suggested that 22 months after it was implemented, SDIL was associated with a 12% reduction in hospital admissions amongst children, aged 0 to 18 years.

What are the main challenges facing emergency dental care in London?

13 per cent of the courses of NHS dental treatment delivered in 2023/24 in London were recorded as 'urgent', although this likely understates current demand and makes no attempt to capture the large numbers who attempt to seek help in other parts of primary and secondary care.

The new UK Government has made a manifesto pledge for 700,000 emergency appointments England wide, supported by new investment. It is not clear what proportion of that pledge will be geared towards London. The Capital deserves its fair share of that funding, based on an assessment of unmet need. We have recommended that the UK Government proceed with a model for dealing with urgent care based on sessional payments, which remove many of the barriers presented by the current contract and have enjoyed some success in the North of England.

As it stands the challenges facing urgent care in London are an acute symptom of the chronic problem discussed earlier in this submission; namely, that of the underfunding of dentistry delivered in secondary care settings and in the community, and the long-term under remuneration by Government of NHS dentistry delivered on the high-street by GDPs. This underfunding and under remuneration has a predictable impact on the morale of the profession, further fuelling the ongoing crisis of recruitment and retention in dentistry.

It is not possible to reallocate existing funding to deal with the significant problem of urgent care without reducing access for routine care. After an extended period of constrained Government spending on the NHS and the under remuneration of NHS dentistry delivered by GDPs, only new funding will be able to significantly increase urgent care capacity.

There are significant challenges regarding the appropriate remuneration of the delivery of urgent care by GDPs through the current NHS contract for dentistry as a result of the failures of the UDA payment system. The UDA payment system creates significant disincentives for GDPs to deliver care to those presenting with urgent needs, who will often have complex clinical presentations requiring significant intervention. More widely, the UDA payment system focuses financial incentives on treatment activity, and does not provide support for prevention. An appropriately targeted, nationally funded 'sessional' approach to the commissioning of urgent care, in which dentists are paid for their time to provide a given number of urgent appointments, provides the best route to addressing unmet need for urgent care through a mechanism which is both tried and tested, and carries the support of the dental profession.

What specific actions need to be taken by the NHS and health partners in London to improve access to dental care and oral health outcomes?

A step change in in patient access and outcomes is impossible without a clean break from the discredited contract NHS dentistry works to. As outlined earlier in this submission, fundamental contract reform that includes a move away from the UDA toward a capitation based, preventative approach is an essential step in improving access to dental care in London.

The improvement of oral health outcomes in London requires the NHS and health partners to take a multi-faceted approach, with a shift to a patient-centred, prevention focused contract that supports a move from a 'drill and fill' model, supports education, and thereby improves access to dental services. On prevention, supervised toothbrushing schemes and fluoride varnish programmes can have a significant positive impact on oral health, and inequalities. The implementation of such programmes across London would help prevent tooth decay, encourage children to brush their teeth from a young age and encourage support for home brushing.

Given the high levels of sugar in the population's diet and its impact on oral health, the BDA recommends working with policymakers to create environments that support oral health. This would include taking action around the advertising of high sugar foods, with lessons learned from TfL's adverting ban. Alongside this, supporting national action, utilising the success of SDIL by expanding the levy to include other food products, such as milk-based drinks and taking the learning from international success with food labelling and advertising regulation in reducing sugar consumption.

Oral health is an important component of general health, and has been linked to conditions such as diabetes, obesity, and cardiovascular disease. Many of the key factors that can lead to poor oral health are also risk factors for other diseases, such as smoking, excessive alcohol intake and diet. A public-facing campaign, which could be promoted within a variety of settings, such as pharmacies and workplaces, would be effective at promoting oral health and the links to general health and wellbeing, and signpost the public to local services.

Data collection and surveillance is vital to good oral health outcomes. Oral health data, including tooth decay and hospital extraction rates, are critical for monitoring trends, to identify any areas for concern and to plan for interventions and preventive policies. It is important that the NHS continue to collect this data, working across the three other UK nations to ensure compatible methodology which allows for comparison, and affords the opportunity to learn from other nations with respect to success of oral health interventions.

Fundamentally, NHS and health partners should strive for adequate access to face-to-face dental care to ensure accurate diagnosis and guideline congruent treatment. This includes appropriate referral pathways, as early detection of oral cancer can lead to better survival rates and better quality of life for Londoners, in addition to saving the NHS money. To ensure timely referrals and avoid delay, it is important that referral pathways for oral cancer are up to date.

What action can the Mayor take to advocate and work with partners to improve the provision of dental care, including preventative measures, in London?

Lobby for dentistry in London. Call on the Government to invest in dentistry, securing a long-term funding settlement for NHS dentistry which keeps pace with demand, and remunerates dentists for their work fairly. Ensure ICBs ringfence the budgets allocated to NHS dentistry.

Fundamental reform of the contract for NHS dentistry. Urge the Government to commence immediate negotiations on a new NHS dental contract, and commit to a firm deadline for rolling out a capitation based approach which decisively breaks with the UDA, prioritises prevention, and ensures NHS dentistry is available to all those who need it.

Interim reforms to stabilise the sector, alongside contract reform. Play a convening role to

support ICBs in London to work creatively and collaboratively with dental providers through greater use of flexible commissioning approaches to ensure that money budgeted for dentistry is retained in the sector, and deploy a 'sessional' approach to the funding of urgent care to ensure those most in need of care are able to access it.

Support the workforce. Put pressure on NHS England and the Government to ensure the NHS is a place dentists would choose to build a career. Remunerate NHS activity fairly, draw a line under a 40% real-terms fall in incomes since 2010, and treat dentists as equal members of the NHS family.

Supervised brushing: To improve oral health, focus on prevention and tackle the impact of varied access across London, the Mayor of London could set children up for a lifetime of good oral health by introducing an ambitious prevention programme for London, including supervised toothbrushing in early years settings and schools, and targeted fluoride varnish applications.

Build on additional commitments to prevention and oral health. Invest in targeted fluoride varnish applications in early years' settings and introduce ambitious action to reduce smoking and vaping, with tougher measures to reduce sugar consumption. Data collection and surveillance are an essential aspect of good oral health and the NHS must play a leading role in collecting and sharing relevant data with health professionals and partners.

Ref No.002

healthwatch Islington

Experiences of accessing NHS dental services since the pandemic

Healthwatch Islington

Healthwatch Islington is an independent organisation led by volunteers from the local community. It is part of a national network of Healthwatch organisations that involve people of all ages and all sections of the community.

Healthwatch Islington gathers local people's views on the health and social care services that they use. We make sure those views are taken into account when decisions are taken on how services will look in the future, and how they can be improved.

www.healthwatchislington.co.uk

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Introduction

"I'm having a hard time finding a dentist taking NHS patients. Everyone is only taking private patients, which is unaffordable for me... Please help, I've looked everywhere."

Resident contacting our advice and information service, November 2021

Many people have reported difficulties accessing NHS dental services in Islington since the pandemic. Healthwatch Islington's advice and information service provides signposting and ongoing support to local residents who need help to access health, social care and wellbeing services. Before July 2020, no one had contacted us with a request for help finding an NHS dentist. Since then, the number of people contacting us with this problem has steadily increased. Currently four out of five residents who contact us about a problem to do with dentistry are doing so because they can't find an NHS dentist.

Our signposting service helped 64 residents resolve issues related to dentistry between July and December last year. 53 of these residents contacted us because they were unable to access NHS dentistry. We do our very best to support people until they get the outcome that they need. That can take a few hours or a few months, depending on the particulars of each case. This type of engagement is not superficial. The purpose of this report is to share what we have learned from this work.

We undertook these additional engagement activities, and include relevant findings in the pages that follow:

- An online survey running between September and December 2021 with 31 responses
- Healthwatch volunteers conducted phone interviews with staff at 19 dental practices
- Healthwatch volunteers conducted phone interviews with 6 care home managers

It's important to note that the feedback shared in this report is about the experience of accessing dental services and not about the quality of care. Generally speaking, feedback on the quality of care tends to be positive.

People are struggling to access NHS dental care

The table below shows the increase over time in residents contacting our information and advice service for help with issues related to dentistry, with particular reference to requests for help finding an NHS dentist

Time Period	Total number of signposting cases	Number of cases that are about dentistry	Dental cases as % of total cases	'Please find me an NHS dentist' requests
July - Sep 2019	31	3	10%	0
Oct - Dec 2019	37	3	8%	0
Jan - Mar 2020	39	1	3%	0
April - Jun 2020	32	1	3%	0
July - Sep 2020	71	6	8%	2
Oct - Dec 2020	61	6	10%	3
Jan - Mar 2021	81	9	11%	8
April - Jun 2021	77	14	18%	11
July - Sep 2021	108	38	35%	32
Oct - Dec 2021	81	26	32%	21

Pre-pandemic

Pandemic

More and more people have been asking Healthwatch for help to find a dental practice that will take them as an NHS patient

Healthwatch Islington's advice and information service provides signposting and support to residents who need help to access local health, social care and well-being services. The service is available to everyone who lives in Islington or uses services here.

When we see lots of requests for help to access a particular health or care service it can be a good indication that all is not well with that service. Understandably, many more people have contacted us for help to access health and care services during the pandemic. However, we have seen a particular increase in the number of requests we have received for help finding an NHS dentist.

- Before July 2020 no one had contacted us with a request of this type. The number of requests for help finding an NHS dentist has steadily increased since then until, in the last six months of 2021, this type of enquiry accounted for four out of five of all the dental enquiries we received (53 out of a total of 64 dental cases).
- Before the pandemic, issues relating to dentistry accounted for, at most, one in ten of the signposting cases we handled. In the last six months, the proportion of cases that relate to dentistry has risen to one in three.
- Dental enquiries that aren't requests for help finding an NHS dentist tend to be about access (for example emergency treatment, special needs access, or patient choice), entitlements (cost of care/dental charges) or complaints.

Mystery shopping dental practices

In November 2021, Healthwatch volunteers spoke to staff at 19 dental practices in Islington. On one or two occasions the practices were busy and staff were not able to talk for long, but most were able to make time to answer our questions. We wanted to understand whether existing NHS patients received priority over new NHS patients (NHS England has stated that patients are seen based on need, yet practices appear to work with a set list of patients who are already registered with the practice).

- 18 dental practices told our volunteers that they were able to book NHS appointments right now for their existing registered patients.
- 9 of these practices said that they were accepting new NHS patients for dental appointments and the other 9 said that they were not accepting new NHS patients.

Experiences of access

Case study one: This resident was not well supported by NHS dental services. Many agencies had to get involved, and many organisations needed to be approached, before she got the care she needed. The hospital carrying out the surgery failing to make a referral for dentures feels like a missed opportunity.

Over the last six months of 2021, we supported a client who was referred to us by her GP, in advance of surgery to have all her teeth removed. Her dentist was unable to offer any aftercare support. The resident had the surgery at the Homerton Hospital and was discharged with little information around mouth care after the surgery and no support or referral to a dentist for follow up care. She had called 16 different dental practices trying to find one willing to give her this care as an NHS patient before Healthwatch got involved.

The patient needed a few weeks' recovery time and we arranged an assessment with a dentist in Hackney. This was the only dentist we could find taking on new patients, there were none in Islington. The dentist was unable to help with the needs of the client, given some complications around bone loss in the gums. We contacted London Dental Confederation for advice on dentists with a denture specialism and were advised to apply to a Dental Teaching School but the client was anxious their denture fitting could take years.

We contacted the Community Dental Service who advised we contact the Eastman Dental Hospital and arranged for the GP to make a referral, which was rejected. A dentist was required to make the referral. The client went back to the dentist outside Islington who made a referral for the client to the Eastman. However, we learned there was a two year waiting list.

We have kept in regular contact with the client and updated the GP around events. This situation has been physically and mentally draining for the client, who is anxious and self-conscious, not able to go out or work, as it impacts their speech and eating.

We contacted the Dental Commissioner who was also contacted by Jeremy Corbyn's office, as the issue was also taken up with the local MP by the client's friend. The original dentist now arranged to see the client in early November and arranged a series of appointments to successfully fit the dentures. The client was pleased to get dentures that suit her and has been given good care by the dentist. Issues around bone loss meant it was a complicated and painful fitting over a number of appointments, as the jaw bone is uneven so the client could only have them in for a hour at a time.

This case has shown the difficulties with the dental treatment pathway following the pandemic. Services are stretched and there have been issues finding dentists taking NHS patients. There is also little provision available for specialist treatment. The options have been opaque and inconsistent.

Case study two: A lack of clarity and consistency in the information we were given on access to urgent dental support for asylum seekers.

The British Red Cross contacted our advice and information service on behalf of an asylum seeker who needed urgent dental treatment. This individual had been asked to pay for their treatment. We provided details of NHS entitlements for asylum seekers and some options around finding a local dentist. We also contacted the Whittington Health Community Dental Service to find out about the support they could offer.

We were told that the Community Dental Service were unable to provide non-urgent treatment for asylum seekers, except in some cases for children where a lack of care might lead to a significant deterioration in oral condition. However, we were assured that they could treat urgent cases.

We conveyed this information and a referral form to the British Red Cross. However, when the referral was made, it was not accepted. We went back to the Community Dental Service who said they were in the process of reviewing their referrals criteria. We checked again by phone and email but did not receive any further clarification about this. This was disappointing as we had sought to give the best advice we could to the British Red Cross supporting an asylum seeker.

Case study three: Helping a resident with complex health needs to find a wheelchair accessible dental practice.

We received a query from a Social Prescribing Link Worker on behalf of a resident with complex health needs who had missed some appointments with his dentist, owing to ill health and mobility issues. The dentist would not keep him on as a patient. The patient had an urgent need for denture care as he was having issues eating and was worried about the choking hazard.

We provided details of NHS guidance which stressed that practices should continue to follow clinical prioritisation, especially for urgent care and priority groups such as children. Our volunteer team had recently conducted a series of calls to all Islington dentists around their availability to take on new NHS patients. From this list, we rang to check on dentists who were taking on patients and were wheelchair accessible.

We found a practice with availability and access and were able to pass on this information, as well as other key details around finding a dentist. The patient was very pleased to be given this option and was able to make an appointment the same week.

Patients who don't already have an NHS dentist have less access to treatment

The tables below shows responses to questions we asked in our online survey on dental access, which ran between September and December 2021. There were 31 respondents.

How did you find a dentist when you needed one?	
I called my usual dental practice	12
I looked it up on the internet	4
I was recommended by a friend or another person	2
There was no available appointment or NHS dentist	12
I called Healthwatch Islington	1

If you were not already registered at a dental practice, did you find a dentist taking NHS patients?	
No	18
Not applicable to me	12
Yes	1

"The current system doesn't protect the patients and it makes them feel worthless. As far as I knew I was registered as an NHS patient at a dentist only to find out I wasn't when I needed it the most (emergency). It is absolutely appalling that the dentists can do whatever they like without being held responsible to anything."

Survey respondent, October 2021

From our conversations with dental practioners we have heard that not enough NHS dental provision has been commissioned nationally. This means that there is insufficient supply to meet demand. This was already the case before the pandemic, but the pandemic has made that situation much worse.

Patients who are already registered with a dentist have had fewer issues with access. We have seen this in our signposting work. They have often had to wait a long time for an appointment, but they have been prioritised.

As a group, survey respondents who were registered with an NHS dentist gave a much more positive response to the question, 'In the past 18 months, how easy or difficult have you found getting a dental appointment?' than did respondents who weren't registered.

People are less likely to be registered with a dentist if a) they have recently moved to Islington (within the last two years), or b) they have fallen off the system/lost connection with their previous dentist.

In December 2021 the NHS England Director for Dentistry and the Chief Dental Officer for England stated, "Practices should continue to follow clinical prioritisation, especially for urgent care and priority groups such as children. As there is no patient registration within dentistry patients must be prioritised against clinical need and priority groups regardless of whether the member of public is on a practice's business list or not – this is a condition of ongoing financial support."

Our mystery shopping exercise in November 2021 showed that dental practices were following clinical prioritisation for urgent care and priority groups such as children. However, the idea that there is no patient registration within dentistry does not reflect the reality of the patient experience. Many residents have shared their experiences of calling around numerous practices trying to find one that was able to accept them as an NHS patient. These interactions do not appear to have been informed by clinical assessments of need. Rather, the practices have an existing patient cohort and don't have capacity to take on more patients for ongoing NHS care.

> Pickering Dental told me I fell off their systems because I didn't go for a few years. So annoying as my kids are there. I had to get private dental treatment.

Respondent who was unable to access urgent NHS treatment, November 2021

> There was quite a wait for my father's dentist to re-open after the lockdown and begin to see urgent cases initially, but once he was booked in for routine treatment, things went fairly smoothly.

Survey respondent, December 2021

> My [existing] NHS dentist was not undertaking root canal patients and I struggled immensely for the last year and a half to be accepted as a new NHS patient.

Survey respondent, October 2021

Emergency care

Of the 13 survey respondents who needed to access emergency or urgent dental care, 8 said they were able to access it, 2 said they accessed it but not when they needed it, and 3 were unable to access emergency care. Between July and December 2021, our advice and information service offered support to 53 residents who were unable to access NHS dentistry. Many of these residents reported an urgent or emergency need. Cloudesley, an Islington based charitable trust, has made funding available to local residents on low incomes who have not been able to access emergency dental treatment on the NHS and have been forced to pay for private dental care.

Final thoughts

Some residents will value the convenience that the current model of access seems to promise. Unlike your GP practice, you do not need to live within a certain catchment area to go to a particular dental practice. You register at the dentist for a course of treatment and once that is complete it is easy to go to a different dental practice to access other care. This flexibility is good. However, it is important that the relationship doesn't become too transactional. Residents always tell us that they value services that are holistic. Ongoing relationships with trusted professionals who know your medical history are important. This is absolutely the case with dental services, as this survey respondent's comment demonstrates:

"I have been with the same dental surgery as an NHS patient for 40 years. It's in Southwark! I get there on the Overground and then a short(ish) walk, so I will stay with them while I can manage the journey. During COVID precautions, patients had to wait outside till called in for their appointment and thus I met a woman who now lives in Ramsgate but is still registered with the same dental surgery and combines a dental appointment with a day out in London!"

When people enjoy good physical health they do not visit the doctor. When they become ill they can visit their GP and receive appropriate care. Many of us have an expectation that dental services should work in the same way. However, this is not necessarily the case. If a patient does not engage with preventative dentistry (check-ups) they can find that when they do develop a problem and need urgent treatment, their dental practice no longer recognises them as a patient.

During the pandemic in particular, this has meant that patients with high levels of need have found it difficult to access treatment. Giving patients clearer information about the value of dental check-ups (and the possible consequences of not having them, in terms of their ongoing relationship with the dental practice) would be one way of addressing this problem. Dental practices should also make every effort to let patients know when they have been removed from their lists, to give them ample time to make alternative arrangements before their needs become more pressing.

"I wonder if some groups (for example I am pregnant and entitled to free dental care) could be offered NHS appointments on a best effort basis - even if the dentists are very busy."

Survey respondent, October 2021

In the past 18 months, how easy or difficult have you found getting a dental appointment?	
Easy	3
Neither easy nor difficult	4
Difficult	8
Very difficult	13
No answer	3

If you needed emergency or urgent dental treatment were you able to get it?	
Yes	8
Yes, but not when I needed it	2
No, I wasn't	3
No answer/ Not applicable me	18

Our recommendations

1. Dental practices should provide patients with better information about the possibility of no longer being registered for treatment if they do not go for regular check-ups.

   If dental practices intend to remove patients from their lists they should make every effort to warn those patients, and to inform patients who have been removed. This would give patients more opportunity to take appropriate action to avoid finding themselves in the unenviable position of needing urgent dental care whilst lacking access to a dentist.

2. There is a need for greater clarity from providers on the eligibility criteria for adult asylum seekers who wish to access Community Dental Services.

3. In Islington, not many dental practices are wheelchair accessible. This needs to be addressed over time.

4. Hospital based dental services need better integration with general dental services, particularly when hospital treatment will necessitate after care from a regular dental practice. It should not be left to the patient to organise the referral for follow up care, particularly in cases where the resident is vulnerable and/or may struggle to be accepted as an NHS patient.

5. Some care home managers we spoke to felt that dental support had become harder to access for their residents. Dentists no longer come into the homes. This makes it harder for residents to access appointments, particularly for those with mobility issues. There are also longstanding difficulties with patient transport services. It was suggested that an "on call dentist who could come in and assess or give appointments to residents who can't easily get out to one" would help with this.

Equality Monitoring

Dental signposting cases - July to December 2021

Gender	
Female	42
Male	18
Prefer not to say	2
No answer	2

Age	
18 to 24	6
25 to 49	14
50 to 64	9
65 to 79	7
Prefer not to say	25
No answer	3

Do you consider yourself to have a disability	
Yes	3
No	19
Prefer not to say	1
No answer	41

Ethnicity	
Asian or Asian British	8
Black or Black British	2
Chinese	1
Mixed	4
White British	13
White other	9
Prefer not to say	24
No answer	3

Online survey respondents

Gender	
Female	22
Male	6
No answer	3

Online survey respondents (continued)

Age	
18 to 24	2
25 to 49	12
50 to 64	6
65 to 79	7
80 +	1
No answer	3

Ethnicity	
Asian or Asian British	2
Black or Black British	1
Chinese	1
Mixed/Other	1
White British	13
White other	10
No answer	3

Do you consider yourself to have a disability	
Yes	11
No	16
Prefer not to say/No answer	4

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healthwatch Islington

Ref No.003

Feedback on dentistry for the London Assembly Health Committee

In response to the **London Assembly Health Committee's** call for evidence, we went out into our community and were able to obtain **three pieces of feedback from local service users about their experiences of accessing dental care in London.**

This feedback was collected throughout the month of August 2024 through a qualitative survey, distributed online and at in-person outreach events. Their feedback is as follows:

Service user #1:

1. **What has your experience been of using dental services in London?**

I was very impressed with the care I got at King's College Dental School, Lambeth, over several years. I was able to access as a carer who lived close to the hospital. I needed dentures by this time circa 2017/18 and was the project of a final year student. I can't remember who referred me but there was info at the time. I went to hygiene clinic for starters, and it was thorough and I felt their enthusiasm and care. I had to be available every 2 weeks, which got more difficult near the end as my mum got unwell and I was having to travel and then she passed away. This was additional to support to another relative living in London.

Before that I had a dentist in north London I had had since I moved here in the 1980s. He had been recommended by a friend.

I contacted King's again just after Covid as I had had to pay a lot for dental care when I spent several years away from London looking after my dad.

2. **Have you ever delayed going to the dentist when you needed to?**

Currently yes, as I am travelling between 2 places. My dentist is now out of London, and I have to pay privately, caught out in another place during Covid.

3. **What action would you like the government the NHS or other public authorities to take to improve dentistry and oral health in London?**

Get into schools early – remember the person who came to check your hair for nits in the 1960s? It seems impossible to get an NHS dentist where I am now, and suspect this true of London, although I did see one possibly attached to a surgery. Encourage young dentists to not go private, have oral hygiene clinics, triage level of seriousness. Make this part of physical health checks for those held long periods in hospital under the Mental Health Act. Go into pubs and shopping centres, summer fairs and festivals to raise awareness. Be part of Thriving Communities' ventures through Primary Care Networks, think out of the box.

4. **If you have a child or children what has your experience been of accessing dental care in London for your children?**

I don't have children, but I'm aware of issues associated with poverty and children's dental health.

5. **Demographic profile:**

- **Age:** 65-79 years
- **Gender:** Woman
- **Ethnicity:** White: British/English/Northern Irish/Scottish/Welsh
- **Financial situation:** I have more than enough money for basic necessities, and a LITTLE spare to save or spend on extras
- **Carer**: Yes
- **Disability:** Yes

Service user #2:

1. **What has your experience been of using dental services in London?**

Dental appointments were sometimes very available, e.g. same day, but also very unavailable – I needed an emergency appointment and had to wait a week.

Quality of care is questionable. I have a cavity and have had three temporary fillings for it, which have all come out. The last one came out because it was put in a crevice of my tooth, so it cracked, as I could not fully close my mouth with it in the way.

Unclear information about referral waiting time until I inquired multiple times. Disappointing overall, as my cavity issue is yet to be fully resolved.

2. **What action would you like the government the NHS or other public authorities to take to improve dentistry and oral health in London?**

Encourage communication, find a way to reduce waiting lists.

3. **Demographic profile:**

- **Borough**: Lambeth
- **Age:** 18-24 years
- **Gender:** Woman
- **Ethnicity:** Mixed/multiple ethnic groups: Black African and White
- **Financial situation:** I have more than enough money for basic necessities, and aLITTLE spare to save or spend on extras
- **Disability:** Yes

Service user #3:

1. **What has your experience been of using dental services in London?**

There seems to be a backlog in dentistry as everyone is waiting for an appointment. It was particularly difficult during Covid and it seems like we are still seeing the effects of it now.

Finding a dentist is really tough. I can't afford private dental care, but even NHS has costs. For example, I know several people that did not have braces as children and now have to pay to get adult braces.

I had some issues on my teeth and had to pay £300 for treatment. Then, it wasn't done correctly and I had to be seen again to fix the mistakes of the care I'd received. So, I'm paying for care and then receiving poor care.

2. **What action would you like the government th NHS or other public authorities to take to improve dentistry and oral health in London?**

They need to fix multiple issues, such as the waiting times and the costs.

3. **Demographic profile:**

- **Borough**: Lambeth
- **Age:** 25-49 years
- **Gender:** Man
- **Ethnicity:** Black/Black British

We hope that this feedback is useful in informing the London Assembly Health Committee's investigation.

Healthwatch Lambeth is your local health and social care champion. We amplify local voices to drive change and improvement in health and social care services. We do this by listening to Lambeth residents' experiences of using services and feeding this up to commissioners and service providers. We also run an Information & Signposting service, where we can direct residents to local health and social care services and help them navigate and raise issues within the NHS.

Ref No.004

Call for evidence: Dentistry in London

Introduce myself

1. The barriers for both adults and children in accessing NHS dental care in London and the reasons behind the decrease in the number of Londoners accessing NHS dentistry

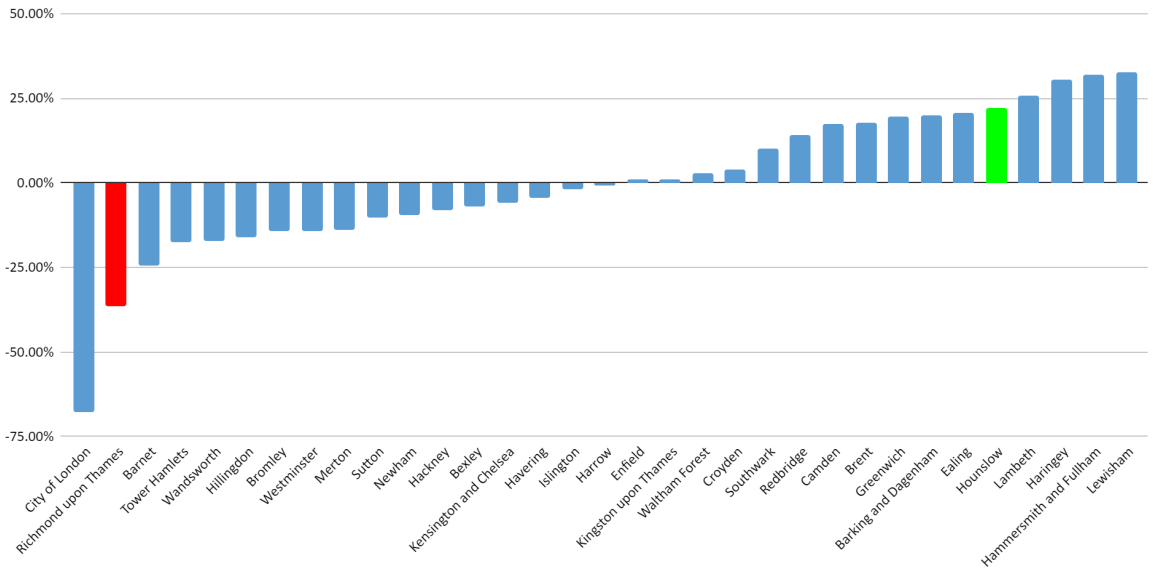
Summary

- Access to NHS Dentistry is geographically unequal
- Commissioners (NEL ICB) have failed to identify this and have not taken action to address it.

Evidence

In Richmond upon Thames, residents are unable to find an NHS Dentist who has capacity to treat them. Most have not been able to since 2020.

Richmond has the lowest level of NHS Dentistry delivered per capita in London (excluding City). We are the lowest by a large margin: 35% less dentistry appointments are delivered in Richmond per person than the average for London.



Hounslow and Richmond are highlighted as neighbouring boroughs. Despite their geographic proximity:

- most residents of Hounslow have seen a dentist recently (2 years for adults, 1 year for children)
- most residents of Richmond (72% of adults and 53% of children) cannot regularly see a dentist.

Adult patients seen in the previous 24 months and child patients seen in the previous 12 months, as a percentage of the population by Local Authority in 2023/24

Local Authority name	Adult population	Child population	Total population	Adult percent	Child percent
Hounslow	227,918	67,788	295,706	43.50	61.40
National	45,689,812	11,998,282	57,688,094	39.54	54.98
London	6,969,318	1,896,862	8,866,180	39.34	52.92
Richmond upon Thames	151,566	43,947	195,513	28.17	46.47

Whilst these numbers are stark, they hide the experience and the human cost of facing challenges and delays to accessing dentistry. Behind these figures, even for those that can see a dentist, are difficulties with finding a dentist and extensive delays before receiving an appointment. Few will have waited less than 6 months. Most often dentists tell us that they are not taking new patients, but those that are have waiting lists of 12, 18 or 24 months.

The dentistry crisis began in 2020 and since then we helped someone to find an NHS Dentist almost every day. These dentists were almost always a considerable distance from Richmond, but often also outside of London

Whilst this has improved slightly in recent times as provision opens up in neighbouring boroughs, we still help people most weeks because they are unable to find dentists themselves.

How we help - nationally

We have raised these concerns consistently in person locally, nationally (parliamentary inquiry) and regionally, in reports, through interventions by our MPs and our national body.

The commissioner NEL ICB, and NHSE before them, resolutely refused to engage with these issues or take any action that we can see to address them.

How we help - individuals

To help these people find a dentist often takes us around 2 hours of research to:

- Call the dentists we had previously been referring people to, to check they are still taking on NHS patients
- if not -
    - check the information available on the NHS.uk website (which is often not accurate)
    - call dentists (usually in excess of 20) to check whether they are taking on NHS patients until we can identify one that can see the patients within a reasonable period of time.

We estimate that we have spent the equivalent of £17,150 of staff time on this since the start of the pandemic and saved Richmond residents in the region of £400,000 in private dentistry costs alone.

Case study

On 27th August we heard from "Anna". Anna had received an appointment letter for urgent medical treatment to take place the following month.

It stated that she needed to be free of dental infection prior to commencing the NHS treatment. Anna had been living with some dental pain and discomfort as she not been able to see a dentist for some years and was keen to rule out or treat a potential infection so that her treatment was not delayed. She called us after having been unable to find a Dentist who could see her within 6 months as an NHS patient, albeit most had offered her a private appointment. We called all 20 Richmond Dentists and 5 in Hounslow (the next nearest borough for Anna).

- 1 in 20 dentists in Richmond could offer an appointment in 3 months.
- 2 of the 5 dentists we checked in Hounslow could see an NHS patient in 1 month (i.e. the capacity in Hounslow is roughly 8 times higher than in Richmond).

We were able to find Anna 1 dentist that could see her. Fortunately she was able to go ahead with her medical treatment without further delay as a result.

2. A comparative view of access to services in London compared with the rest of the country

To understand why Richmond was experiencing so much less capacity than neighbouring areas, we used our statutory power to request the following information from NEL ICB in September 2023:

- The amount of NHS Dentistry commissioned by borough
- The amount of commissioned NHS Dentistry that has been delivered by borough
- what, if any, action has been/will be taken to resolve the lack of NHS dentistry capacity.

NEL ICB failed to provide the requested information despite multiple requests from ourselves and SWL ICB, breaching their statutory duty.

Recently published national data (August 2024) however sheds some light this and shows:

- Richmond: 36.5% **below** London average UDAs per capita
- Hounslow: 21.9% **above** London average UDAs per capita.

We do not have commissioning data, it is clear that either:

- insufficient dentistry is commissioned for Richmond
- insufficient commissioned dentistry is delivered in Richmond

3. The experiences of Richmond residents who have used or tried to access dental care in London

Around 700 people have shared their experience of trying to access dentistry with us since the start of the crisis in 2020. This is about 10 times more feedback than we received about dentistry over the same period pre-pandemic.

For almost all of these people, their key need is help finding an NHS dentist that can offer them an appointment. There have been some stories of incredible personal impact arising from a lack of access to dentistry.

Worry

Whilst we have heard dramatic stories of people in extreme pain, needing hospital treatment or suffering complications, these are relatively uncommon.

Much more common are the themes of worry and deteriorating health.

Many of the people we speak to have been looking unsuccessfully for NHS dental care for some time as low level problems deteriorate and face indefinite waits.

The impact of this worry on peoples wider wellbeing should not be underestimated. For some it can include feeling that they are failing as parents or carers, for others it can include reduced confidence in social or work settings and withdrawing from or not actively pursuing opportunities in these areas.

Often people are concerned that they will eventually need to pay privately when problems become urgent. Concerns about the cost of private dentistry are incredibly common, requiring people to go to considerable lengths to fund their care needs whether by incurring debt, selling assets or borrowing large sums from friends or family members.

Other concerns that are more common than might be expected are about the impact of not being able to access dentistry on other treatments including cancer, surgical and medical treatments or of people being unable to access dentistry during and after pregnancy.

4. The health inequalities that exist in accessing dental care in London

In areas such as Richmond that fall so far behind the national and regional averages in terms of access, inequalities of access are hidden. Inability to access dentistry is the norm and "living in Richmond" appears to be the key barrier to access.

The bar to finding an NHS dentist is fairly high in terms of:

1. access to and skill in using technology
2. ability to speak and read English (whether by education or language)
3. time to research and call the number of dentists required to find one with availability
4. knowledge of the system (e.g. NHS vs private, where information can be found etc.)

It is undoubtedly more difficult for those less proficient in these skills to access care.

The impact of the access issues falls unequally on those who:

- Require cancer and some other medical treatments
- Eligible due to pregnancy/postnatal
- Have not seen a dentist for 2+ years
- cannot afford to access private care

It might be reasonable to assume that higher financial status and access to private transport may improve access to NHS Dentistry care as people will be better able to travel further to an NHS Dentist. However, confoundingly, appears to be the main driver deprived areas may reduce the availability of NHS Dentistry.

Financial deprivation may be linked to reduced access generally and may compound the impact of a lack of access. That areas of relative deprivation have better availability of NHS Dentistry in our locale confounds what may otherwise be an inequality more broadly.

Describing inequalities in access is therefore relatively difficult as geography and availability are overriding factors. There are some characteristics that appear to be linked to better or worse access.

Those who are new to an area (whether domestic or international migrants) and young children will face higher barriers to access as there is a tendency for Dentists to prioritise seeing “existing patients” (despite that objectively being against the contract).

In addition those requiring more complex care or who have accessibility or social needs may find accessing care more difficult as not all dentists can provide for these.

Our experience however, is that below a minimum level of provision, geography is the overriding factor.

5. **Why Londoners who are entitled to free NHS dental care across London are not taking up appointments**

Predominantly because they are unable to find provision.

There is also confusion and ambiguity about who qualifies for free NHS dentistry. Claiming free NHS Dentistry is reliant on the patient certifying their eligibility within uncertain and complex criteria. Patients are often aware that they risk being fined for making inappropriate claims – even if those claims were made in good faith.

6. **What preventative measures are being taken to support the oral health of adults and children, including the promotion of oral health in schools**

Despite the low levels of access to NHS Dentistry in Richmond, we have amongst the lowest levels of tooth decay by year 6 both nationally and in London. This means that preventative measures could have only a limited impact here.

Conversely, we are all too aware of young people whose oral health deteriorates because they have to wait extended periods of time to access care. In our view, enhanced access to NHS Dentistry, not other prevention, is indicated where access is below the national average.

7. **What action needs to be taken by the NHS and health partners in London to ensure all Londoners can access an NHS dentist and support good oral health**

As we have previously mentioned, the Commissioners of Dentistry for London, NEL ICB have failed to provide us with their commissioning data.

Without this we cannot say whether more dentistry needs to be commissioned, or whether the needs could be met with more intelligent use of the existing funds.

The first step to recovering NHS Dentistry is to ensure that the Commissioners get a grip on what they are commissioning, what is being delivered, and that they maximise the benefits from this.

The second step is to inject some intelligence into the levels of service that are commissioned to ensure that all residents of London have a reasonably equal level of access to NHS Dentistry.

The dentistry access crisis in London

healthwatch

Healthwatch are trusted, local, independent organisations.

- **152 local Healthwatch** organisations across England.
- Each local Healthwatch is **independent**.
- Our focus is on the health and social care needs of our **local communities.**
- **Mike Derry, Chief Officer, presented to the London Assembly on 18th September.**
- We have a statutory responsibility to give **people a voice.**
- We have **powers to:**
  - **request information**
  - **make recommendations**

Healthwatch is the champion for people using health and care services

What we do:

- **Engage and gather insights** from local people about their experience with health and care
- **Scrutinise** whether public leaders are adequately engaging the public in decisions that affect their health and care
- **Signpost** people to the right services that can support their health and care
- **Communicate** with people in accessible ways about issues that affect their health and care.

What have Healthwatch Richmond heard about Dentistry?

We have heard from many hundreds of patients since the start of the dentistry crisis in 2020. Every week since, Healthwatch Richmond has helped people who are unable to find NHS dentists to access care.

On Monday 7th October, we called the 19 NHS dentists in Richmond.

- **9** practices haven't updated their status on the NHS website in more **than 90 days**.
- **0** practices can offer adults an NHS appointment within 6 months
- **7** are accepting children under the age of 17.

There are no available NHS dental appointments for adults in Richmond.

"The care was fine; the wait was disgraceful. It greatly impacted me. Being in pain for prolonged periods is very draining. I found it utterly barbaric that I was unable to get much needed dental treatment for months on end. It was very stressful."

- patient in Richmond

Healthwatch Richmond - Case Study

On 18th September 2024, whilst the CEO of Healthwatch Richmond was presenting to the Committee, Dave called Healthwatch Richmond looking for a dentist.

We told him we would be happy to help but that he would probably have to go to Hounslow. Dave said that this would be hard for him as he has **mobility issues**: he is recovering from a hip operation and is awaiting a knee replacement.

Dave had previously had **private dentistry** which cost him £1000. As a pensioner, this was much more than he could afford.

We could not find an NHS dentist in Richmond. We gave him the contact details of:

- a dentist accepting new NHS patients in **Hounslow**
- his local Neighbourhood Care Group which provides transport for medical appointments.

What have SWL Healthwatch done on dentistry?

In December 2023, along with colleagues from Healthwatch in SWL, we formally requested the following information on dentistry from **NEL ICB**:

- Details of dental services provided in SWL over the last financial year including:
  - Contracted activity, delivered activity and the gap between the two.
  - Monitoring of dentistry in SWL since responsibility transferred from NHSE to ICSs.

NEL ICB did not discharge their statutory duty to provide the requested information. Instead, January 2023, they provided:

- An explanation of dental delivery during the pandemic.
- Tooth decay statistics among 5 year olds across London.
- Information about pilots to improve dental health for Looked After Children.

What have SWL Healthwatch done on dentistry?

Unsatisfied with this we worked with partners to seek this information:

In February 2024, SWL ICB requested this data from NEL ICB.

This was not provided.

In March 2024, SWL ICB requested this data from NEL ICB.

This was not provided.

In August 2024, SWL ICB requested this information from NEL ICB.

1 line of 2022/23 data was provided per borough.

In September 2024 –

- NEL ICB provided the following slide which does not answer the questions asked and provides out of date information.
- Local Healthwatch obtained publicly available data from NHS BSA for year to date delivery (2024/25) and performance for 2023/24.

Some of the findings from this data are presented in the following slides.

Information received from NEL ICB in September 2024

This information provided by NEL ICB in September 2024 is out of data and not what was requested.

Richmond Primary Care Dental

- NEL Commissioners in process of reconciling performance for 23/24. 22/23 data is shown below:

Richmond	42% of practices delivered >96%
Kingston	44% of practices delivered >96%
Merton	26% of practices delivered >96%
Sutton	44% of practices delivered >96%
Croydon	49% of practices delivered > 96%
Wandsworth	48% of practices delivered >96%

Dentists offering NHS services based on this website: Find a dentist - NHS (www.nhs.uk)

- 3 not accepting NHS patients
- 1 only taking new NHS patients for specialist dental care by referral
- 9 have not updated their details to advertise whether they are taking nhs patients
- 4 accepting new NHS patients if they are children aged 17 or under when availability allows
- 2 accepting new NHS patients if they are children under 17, adults 18 and over, adults entitled to free dental care when availability allows

NHS
South West London

SWL Dental Engagement Plan

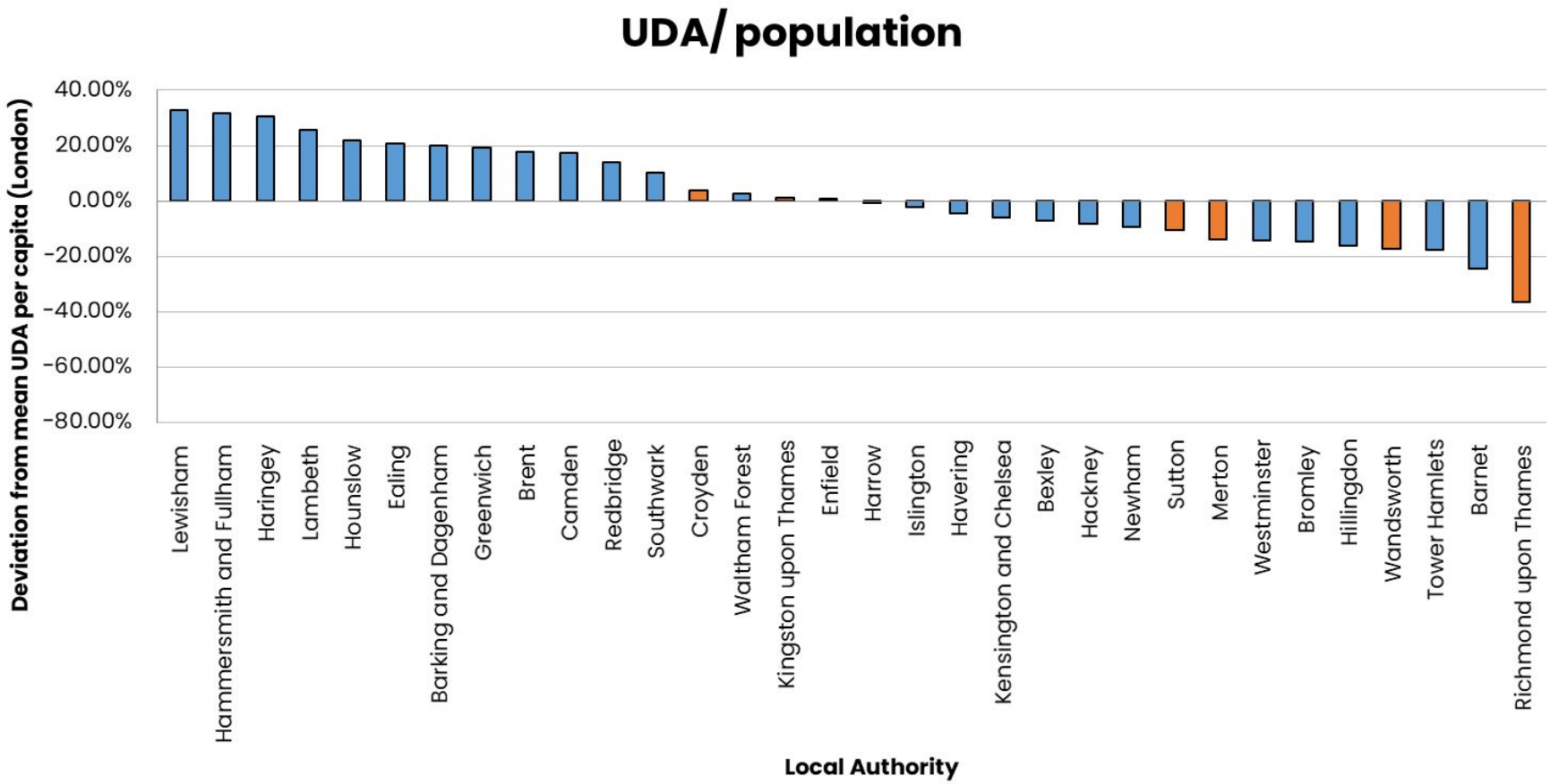
Following the delegation of primary care commissioning functions to all ICBs on 1 April 2023, Integrated Care Boards (ICBs) have been exploring opportunities to prevent poor oral health, as well as protect and expand access to high quality care.

The SWL dental engagement plan aims to support access and equity of access to NHS primary dental care, oral health improvement and reduction of health inequalities across SWL ICB geography & drive the integration of oral health and dental care services into wider primary health and care services.

The objectives are to develop an integrated primary care dental model, through a collaborative engagement approach [dental providers, dental commissioners, local authority public health teams and NHSE workforce, education and training (WTE) and dental public health] to develop a model of care, funding and data reporting.

Healthwatch analysis of publicly available data

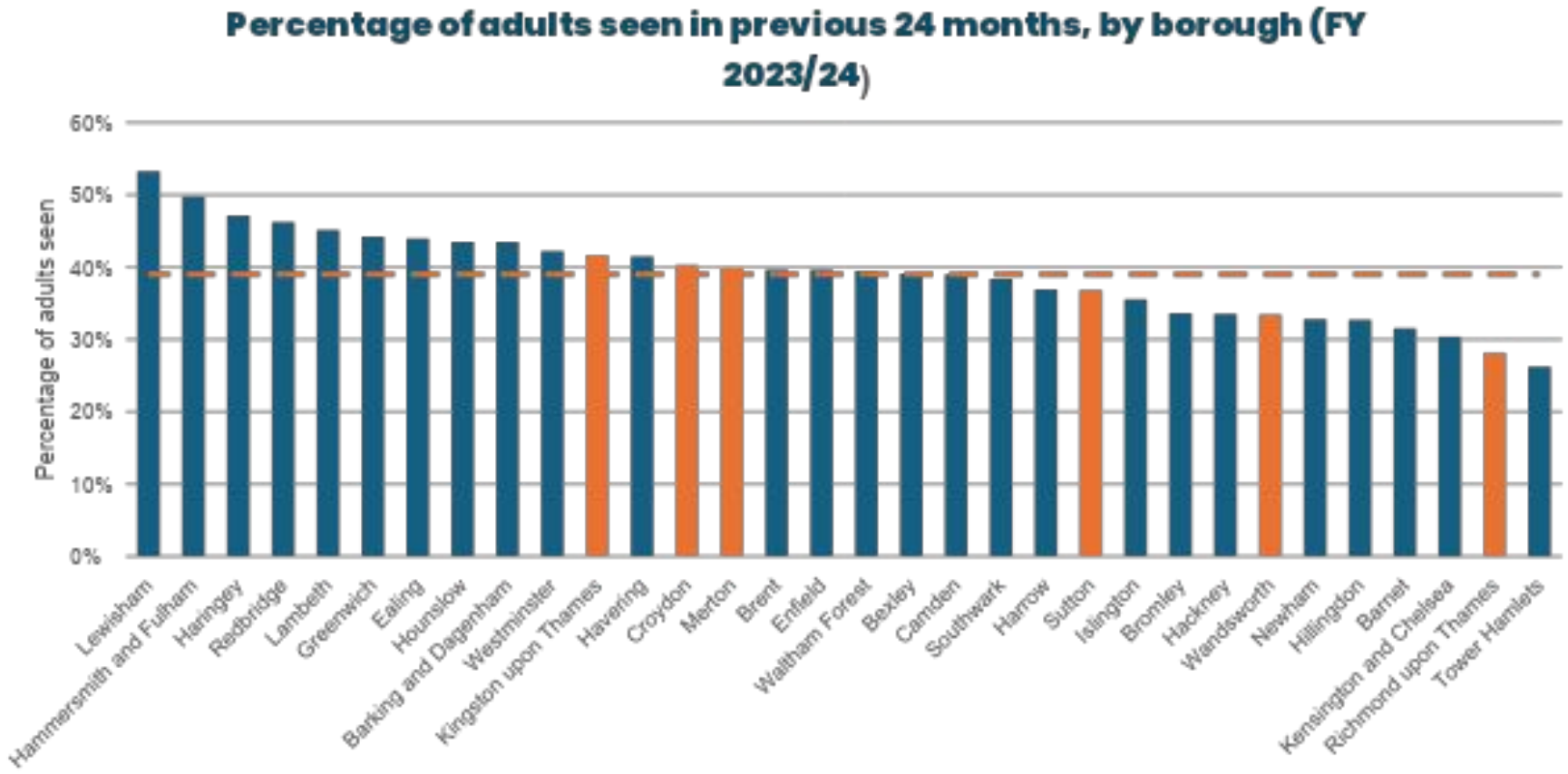
Commissioning in London FY 2023/24



From the information Healthwatch richmond obtained from tNHS BSA, we calculated the mean per capita UDAs for each London local authority (1.35 UDAs/capita). This is approximately the same as the national average but there is huge variation across London.

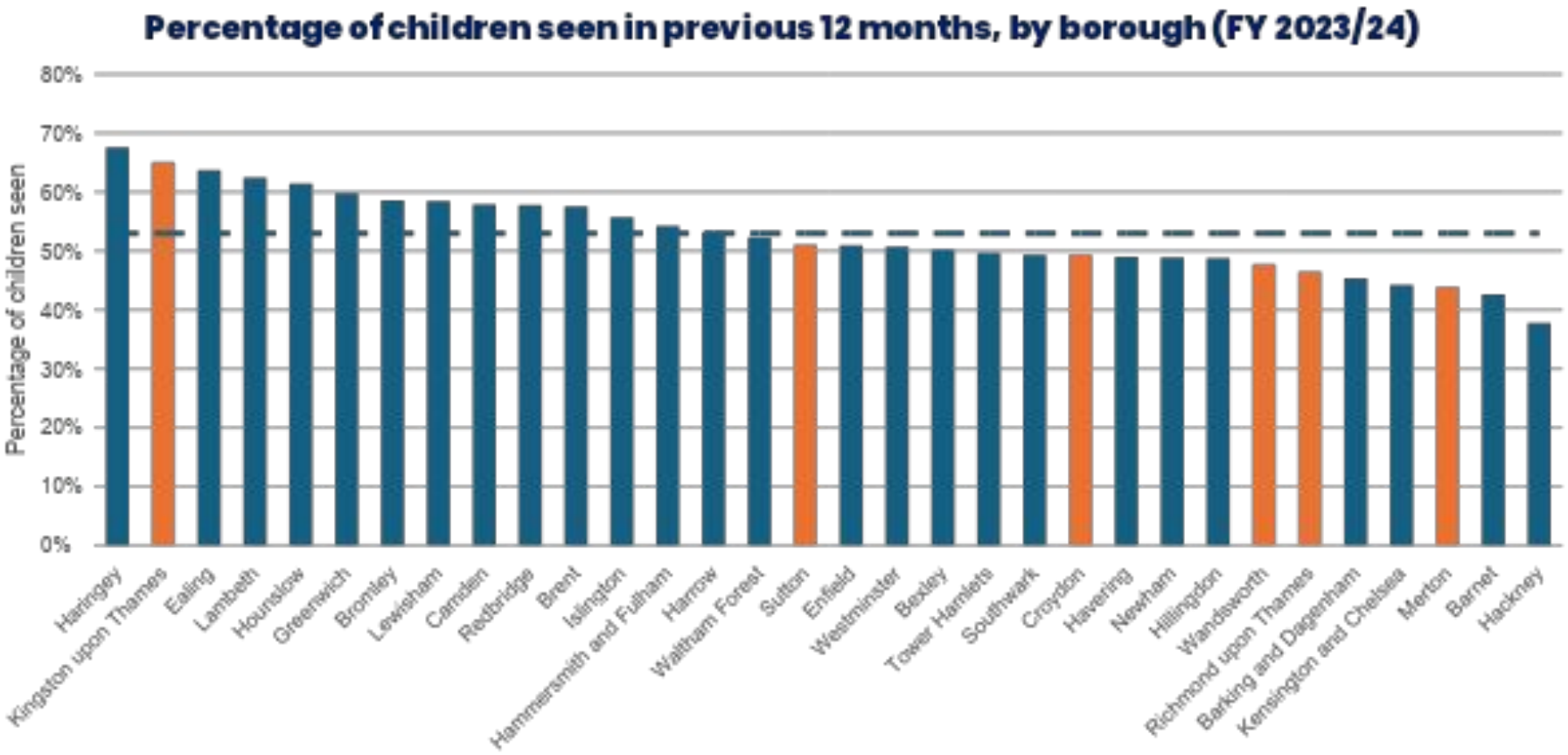
Richmond has insufficient UDAs per capita at around 0.8 UDAs/capita. As a result, residents are unable to find an NHS Dentist who has capacity to treat them.

Healthwatch analysis of publicly available data



Across London, the maximum percentage of adults by borough who have seen an NHS dentist in the past 24 months is just 53%, with an average of 39%, in line with the national average. The South West London average (data not shown) is 37% with only 28% in Richmond seeing a dentist in 2 years.

Healthwatch analysis of publicly available data



Across London, the maximum percentage of children by borough who have seen an NHS dentist in the past 12 months was 68%, with an average of 53%, slightly higher than the national average. In South West London, the average is 52%.

Healthwatch analysis of publicly available data

There is little correlation between UDAs commissioned by borough and the percentage of population living in deprivation ($R^2 = 0.144$).

As a result, the percentage of adult and children seen, also shows almost no correlation with deprivation ($R^2 < 0.1$).

This suggests that the borough-specific accessibility differences observed are not explainable by differences in their relative deprivation.

Indeed, we were unable to identify any underlying rationale for the variation in funding or performance.

It is notable, despite formal requests for information, that this data was not supplied by NEL ICB who are responsible for commissioning.

Summary: Commissioning in London FY 2023/24

- **More dentistry needs to be commissioned.**
  - 97% of commissioned activity is delivered in South West London (FY 2023/24).
  - In Richmond 99.6% of commissioned dentistry is delivered
  - There isn't enough commissioning to meet local need.

- Richmond has the lowest levels of dental commissioning per capita, far below the London average.

- We did not find evidence that a borough's relative affluence or deprivation was correlated to the amount of dentistry commissioned per capita.

Recommendations to The Assembly

Act as a convenor to support ICBs in London to:

- address the **variation** and **under provision** of NHS dentists in London.
    - Increase the number of commissioned UDAs
    - Advocate for increases to dentistry finding in areas that are underserved, not just redistribution of insufficient funds – *Healthwatch can be partners in this.*
- **Obtain up-to-date commissioning data quarterly from NEL ICB** who hold the contract for commissioning dentistry across London.
- Ensure that local needs assessment are undertaken to inform increased commissioning overall, and especially to our CORE20 communities.
- Examine potential evidence based solutions to address these inconsistencies.
- Use evidence to ensure the provision of primary care dentistry to residents.

Ref No.005

Dentistry in London
GLA Health Committee Investigation 2024
September 2024

Introduction

The LDC Confederation is a membership body for Local Dental Committees (LDCs). We represent four LDCs in London covering 22 boroughs and around 3,500 NHS primary care dentists.

We welcome the Committee's investigation into NHS dentistry and the fact that it is the first investigation of the new term. This reflects the importance of NHS dental services to Londoners and its ability to reduce health inequalities and improve health outcomes.

The LDC Confederation called for an investigation into dental services, more specifically the issues affecting older adults. The Committee's decision to focus on general access is welcomed, but we recommend that more targeted investigations which align more closely with the powers of local authorities with whom the GLA can work most effectively would have a greater impact should the Committee revisit dental services in the future.

The LDC Confederation presented oral evidence to the Committee on 17 July and this response builds on many of the points presented there.

We would welcome any follow up meetings to discuss our response in more detail if required.

1. What are the specific barriers that prevent adults and children in London from accessing NHS dental care?

While there will be many explanations given, there is really only one relevant explanation: there is insufficient commissioned activity to meet the needs of the population of London.

The LDC has already provided ward level access data by age group to the Health Committee and this clearly demonstrates the paucity of access in certain areas of London. An example of access figures pre-pandemic and post-pandemic for London show:

Adult patients seen in the last 24 months to 31 March 2017
London - 45.2%
National - 51.5%
Child patients seen in the last 12 months to 31 March 2017
London - 48.9%
National - 58.2%
Adult patients seen in the last 24 months to 31 March 2022
London - 30.1%
National - 34.1%
Child patients seen in the last 12 months to 31 March 2022
London - 39.2%
National - 44.8%

While a drop off in access post-pandemic was to be expected and access rates are now closer to where they were pre-pandemic it is clear that pre-pandemic access was not high or in-line with a prevention based primary care service. Nor is it clear how such a limited service can support Integrated Care Boards in their legal responsibility to reduce health inequalities and improve health outcomes. The proportion of Units of Dental Activity (UDAs) used pre-pandemic was routinely close to 100 per cent. While UDAs are not a proxy for access what this means is that if all the activity commissioned was used and yet within a two year appointment recall (the maximum permitted) less than half the adult population and in a one year recall for children (the maximum permitted) less than half the child population could access an NHS that clearly there were insufficient UDAs commissioned. We have provided a brief explanation of how the UDA contract works here: https://ldc.org.uk/what-is-a-uda/

2. How do these barriers differ across various demographics, including age, income, and ethnicity, and what are the underlying causes of these disparities?

As far as we are aware only limited research on this specific question has been undertaken. This is why it was one of our recommendations to the Mayor of London in our London Manifesto[1] to undertake this research.

In our response to the Parliamentary Health and Social Care Committee we recommended that a proper needs assessment be undertaken to assess how dental services meet the needs of the local population as to our knowledge no needs assessment has actually taken place. Instead current contracts are historic from 2006, which in turn was simply based on activity from 2004. This will have exacerbated access issues in certain areas.

Further the lack of registration or catchment areas, and insistence that anyone can access care anywhere, means that those who are most active, mobile and confident will access NHS dental services to the detriment of those who are less mobile and less sure about how systems work.

3. What impact is the lack of availability of NHS dentistry in London having on the oral health of Londoners?

The lack of access to NHS dentistry in London is having a profound and multifaceted negative impact on the oral, general, and mental health of Londoners. As routine dental care becomes increasingly inaccessible, various oral health issues are emerging, such as untreated dental decay and periodontal disease. These conditions often lead to severe and chronic pain, crumbling teeth, tooth loss, swelling, bleeding, and infections that could have been prevented with timely dental interventions. The long-term consequences of such poor oral health are not limited to the mouth; they can also contribute to serious systemic health issues, including life-threatening conditions like sepsis.

Emerging research suggests a bidirectional relationship between periodontal disease and endodontic disease with several systemic conditions, including Alzheimer's disease,

[1] https://ldc.org.uk/london-election-manifesto/

dementia, diabetes, adverse pregnancy outcomes and heart disease[2]. This means that addressing dental issues could also help mitigate these serious health conditions, underscoring the broader implications of the current NHS dental care crisis[3].

Beyond the physical ramifications, the inability to access dental care is taking a toll on mental well-being. Many individuals become self-conscious about the state of their teeth and gums, leading to social withdrawal and a diminished quality of life. The impact on basic functions such as speaking, eating, and enjoying food further exacerbates mental health issues, creating a vicious cycle of distress[4]. Additionally, the pain and swelling associated with untreated dental conditions often results in missed days at work or school, further disrupting lives and livelihoods[5].

In some extreme cases, the lack of timely dental care has led to emergency hospitalisations, placing additional financial strain on the NHS due to complications that could have been avoided with regular dental check-ups.

A particularly alarming consequence of a lack of access is the increased risk of missed oral cancer diagnoses. Health experts have raised concerns that many cases are being detected at later, less treatable stages due to the shortage of available dental appointments. Recent data shows that in 2020/21, there were nearly 9,860 cases of mouth cancer in the UK, a 12 per cent increase from the previous year. The disease killed more than 3,000 people in 2021 - up 46 per cent, from 2,075 a decade ago. Early detection results in a roughly 90 per cent survival rate, compared to a 50 per cent survival rate for delayed diagnosis. This rise coincides with the ongoing crisis in dental access, suggesting that the lack of timely appointments may be contributing to the increase in missed diagnoses and, ultimately, preventable deaths[6].

In summary, the severe shortage of NHS dental care in London is not only jeopardising oral health but is also contributing to a range of systemic health problems and exacerbating mental health issues. This crisis highlights the urgent need for improved NHS access to dental care to prevent these adverse outcomes and reduce the burden on the NHS.

4. What preventative measures are currently being taken to support oral health in London, and how effective are these measures?

The Community Dental Services are commissioned in a variable fashion by individual local authorities to provide oral health promotion. We will, therefore, largely leave this question to be answered by NHS England, the Community Dental Services and local authorities.

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[2] Kim J, Amar S. Periodontal disease and systemic conditions: a bidirectional relationship. Odontology. 2006 Sep;94(1):10-21. doi: 10.1007/s10266-006-0060-6. PMID: 16998613; PMCID: PMC2443711.

[3] Al-Abdulla, N., Bakhsh, A., Mannocci, F., Proctor, G., Moyes, D. & Niazi, S.A. (2023) Successful endodontic treatment reduces serum levels of cardiovascular disease risk biomarkers—high-sensitivity C-reactive protein, asymmetric dimethylarginine, and matrix metalloprotease-2. International Endodontic Journal, 56, 1499–1516. Available from: https://doi.org/10.1111/iej.13979

[4] https://ldc.org.uk/policy/oral-health-and-mental-health/

[5] https://www.dental-nursing.co.uk/news/children-missed-15m-school-days-in-the-past-year-due-to-dental-problems-1

[6] https://www.bda.org/media-centre/oral-cancer-access-problems-will-cost-lives/

General Dental Practitioners are occasionally invited to be involved in prevention focussed programmes, but these are often episodic and untargeted, simply focused on using up funding rather than providing a sustained model of prevention.

5. What are the main challenges facing emergency dental care in London?

London has a dedicated emergency dental care service. We anticipate that the NHS England London Dental Commissioning Hub will provide more detail on these. While emergency dental services are effective they do not represent a sustainable model of care representing the best long term interests of patients. Upon discharge patients are advised to attend their regular dentist, which they often do not have which is why they required emergency care. Without a model of care which encourages a sustainable and regular relationship, emergency dental care cannot represent the most efficient long term use of funds. There may well be patients who do not want a regular relationship with a dental practice, and wish only to access emergency care. More research is required to understand exactly why this is and whether it represents a reasonable expectation of how to access NHS dentistry. Furthermore, the growth of emergency dental care centres reverses previous decisions to close walk-in centres. This lack of coherence and long term planning is something that must be addressed.

6. What specific actions need to be taken by the NHS and health partners in London to improve access to dental care and oral health outcomes?

The first thing that needs to be considered is what is meant by an improvement to access. It is clear that there is insufficient financial commitment to allow for a significant increase in access. The current contractual arrangement, based on UDAs, would support an increase in access only for the most healthy. As we explain in our briefing on UDAs (link in answer to Q1):

"Four thousand UDAs does not mean access for 4000 people as not all require only a check up. If every patient needed a Band 3 treatment then 4000 UDAs would provide access to just over 333 people.[7]"

Nor does the much repeated advice that patients should be on a two year recall (the maximum permitted for an adult) make much sense. Adults on a two year recall would have to have such fantastic oral health, behavioural and lifestyle factors that the question would have to be asked if that is where NHS dental services should be focussed. The NICE guidelines actually state:

"Recall intervals for patients **who have repeatedly demonstrated that they can maintain oral health and who are not considered to be at risk of or from oral disease** may be extended over time up to an interval of 24 months.[8]" (emphasis in the original)

Needless to say this will be a very small minority of the population as who can really be considered in a two year cycle to be from risk? Further the guidance states that this cohort "may" have a recall of up to 24 months, not that they should.

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[7] https://ldc.org.uk/what-is-a-uda/

[8] https://www.nice.org.uk/guidance/cg19/chapter/Recommendations

Integrated Care Boards have a statutory responsibility to reduce health inequalities and improve health outcomes[9]. If sufficient funding is not allocated to provide universal access to an NHS dentist then the ICB should operate on a system of proportionate universalism, whereby those in the greatest need are given the greatest aid.

The LDCs and LDC Confederation have long argued for the more effective use of flexible commissioning to achieve this. Guidance, however, remains unclear and unsupportive. NHS England and the Department of Health and Social Care need to provide clearer guidance which gives more freedom to ICBs to apply a percentage of their contracted activity to support initiatives reducing health inequalities. These strategies should be determined at the "place" level with local partners, including the LDC.

At present there is no clear plan, objective or vision for NHS dentistry at the local or national level. No-one has articulated what it is that they expect NHS dentistry to be. This is a shocking neglect of responsibility and one that must be addressed. The LDC Confederation recently adopted a new policy position that all ICBs should work with local partners to develop a clear vision and mission for NHS dentistry in their area[10]. This would ensure that all partners within the Integrated Care System are moving in the same direction, enabling greater scrutiny and focus. The creation of local visions and missions will also inform a Londonwide and national one, which must be led from the ground up.

7. What action can the Mayor take to advocate and work with partners to improve the provision of dental care, including preventative measures, in London?

The LDC Confederation set out six actions that the Mayor and the London Assembly could take to improve NHS dentistry in London. One of our recommendations, as noted in the introduction, was the holding of an investigation into access for older adults[11], we take this investigation as at least partially meeting that recommendation. The full manifesto, along with the supporting statements from the Labour, Conservative and Liberal Democrat parties can be found here: https://ldc.org.uk/london-election-manifesto/

The Mayor also supported our manifesto and we expect this support to translate into action following the Committee's investigation: https://ldc.org.uk/mayor-supports-ldc-confederation-manifesto/

We reiterate and expand on our other recommendations here:

- Mayor and the London Assembly to champion the establishment of Centres for Dental Development as set out in the NHS Long Term Workforce Plan. To work with the NHS and Integrated Care Boards to make suitable premises available and ensure long term funding. - we are pleased that some progress on this has been made. Sana Movahedi from NHS Workforce, Training and Education will be able to provide more detail on progress. The value of the Centres is explained here: https://ldc.org.uk/centers-for-dental-development/

[9] https://www.legislation.gov.uk/ukpga/2022/31/part/1/crossheading/integrated-care-boards-functions
[10] https://ldc.org.uk/policy/vision-and-mission-for-icbs/ We are pleased to note that this will be on the agenda for the South West London Integrated Care Board's Dentistry Day in October.
[11] The LDC Confederation's position statement on older adults is available here: https://ldc.org.uk/policy/older-adult-oral-health/

- Dentistry and oral health to be recognised in relevant reports from the Mayor's office and Greater London Authority, such as strategies to tackle obesity, health inequalities, healthy eating, etc. - At present most reports fail to recognise the oral health element of their focus. The mouth, throat, gums, tongue, and overall oral health is vital to the ability to eat, speak and socialise with confidence which is in turn vital to a fulfilled life. We want to see dental services properly integrated as part of holistic care[12]. This requires leadership from outside the dental sector, such as the Mayor of London and London Assembly to ensure that oral health is not forgotten about. Ensuring that the LDCs are recognised as key stakeholders and oral health considered in every relevant report would help to change attitudes to dental services. An attitude shift will be the first step in encouraging integration and improved care for the public.
- London Assembly Members and the Mayor to receive annual reports from the Integrated Care Boards and Local Dental Committees on how they are engaging and working together, to ensure integration. - At present there is insufficient oversight of plans. Integrated Care Systems cannot hold themselves to account and as the main democratic institution for London the London Assembly should have oversight of plans to ensure that services are meeting the need of Londoners. Without informed scrutiny ICBs will not be encouraged to make the changes necessary to ensure that NHS dentistry is integrated and as effective as it can be. We would welcome further dialogue with the Health Committee, Mayor and Mayor's health adviser on how this recommendation could be taken forward.
- The Mayor to investigate how oral health inequalities are being addressed in each borough taking into account demographic variation, language and technological barriers. - There are fantastic and dedicated public health teams in each local authority and experienced and dedicated consultants in dental public health who can make this a robust and valuable piece of work which will inform future commissioning. Rather than asking for views on the issues facing specific groups we would like the London Assembly to take the lead on investigating this thoroughly. Not just for dentistry but for all aspects of care to ensure that services are meeting needs.
- All Health Committee enquiries to include a public review of the implementation of recommendations within the Mayoral period to ensure action has been taken. We are very pleased that dentistry is the first topic to be addressed by this Health Committee. This means that there is ample time before the next election for recommendations from this investigation to be implemented and reviewed. Without reviewing what has happened to the reports and recommendations, the investigation will not have the power it could. We recommend that the final session of this Committee's term is dedicated to reviewing which of its recommendations have been implemented and which have not, along with an account being given by the bodies which were informed of the recommendation for why and how recommendations were or were not implemented. This would help inform a new Committee and administration of what is feasible and where more assistance and guidance is required.

In addition to our London Manifesto recommendations the Mayor could provide helpful national leadership by calling on the NHS and Department of Health and Social Care to:

- Provide improved guidance/regulations giving ICBs much more power to flexibly commission to allow for local initiatives. Current guidance is quite restrictive and is also

[12] https://ldc.org.uk/policy/integrating-the-nhs-dental-service-within-the-wider-nhs/

contradicted by other initiatives such as the New Patient Premium which uses part of the existing contracted budget to enhance payments to practices. This initiative is not targeted, and has not been used to reduce health inequalities and actually risks reducing overall access as the funding comes from within the existing contracted activity. This is why we call on the NHS and Government to develop, with the profession and informed by the local level, a clear vision for NHS dentistry which is consistent. Improved guidance on flexible commissioning, which frees ICBs to work with LDCs to help practices use their funding in a more targeted way would support integration of services, improving efficiency and the patient journey and outcomes. This could be achieved by working on local initiatives such as increasing access for children through links with family hubs, diabetic pathways, maternity units etc.

- A clear national vision for NHS dentistry, some real leadership and clarity on expectation. As mentioned earlier, for too long NHS dentistry has been on the periphery of the NHS, with a contract which supports chaotic and untargeted access doing nothing to reduce health inequalities or improve health outcomes. A clear statement on what NHS dental services are for is required. This must be developed in partnership with the profession and informed by local experiences to ensure that it supports integration and the ability of dentists to play their part in reducing health inequalities and improving health outcomes.
- Leadership from the Mayor to make it easier to recruit dentists to work on NHS contracts would be welcomed. This could be made much more simple by the removal of the national Performers' List which performs no real function and simply duplicates the work of the statutory regulator for dentistry, the General Dental Council.
- In addition practices in London do not receive any London weighting on their contracts making them less competitive than practices outside of London. This has been exacerbated by the recent increase in the minimum UDA value which benefited practices outside of London but hardly any in London.
- The Mayor could work with partners in the NHS and Government to ensure that it is a statutory requirement of ICBs to engage with LDCs on any discussion or decision involving NHS dental services. This would simply build on the existing legislation which creates LDCs as the voice of primary care NHS dentists anyway but would greatly enhance service design.
- Mayoral support for a reformed dental contract developed in association with the BDA but informed by local and frontline experience would be welcomed.
- Environmental sustainability is a major concern but existing guidance for dental practices makes adhering to environmental concerns difficult. A review of HTM0105 to make it compatible with dental environmental sustainability would ease the financial pressure on practices and reduce the environmental impact of dentistry by bringing it in line with modern developments.
- While the LDC represents dentists we are concerned that other members of the dental team involved in the provision of NHS dental care do not have access to NHS benefits. This is true of reception staff, dental nurses as well as hygienists and therapists who have now been given the "opportunity" to provide care to patients on the NHS but do not receive any NHS pension, or other benefits. This is an unacceptable variation[13].

[13] https://ldc.org.uk/equal-treatment-for-the-dental-team/

Ref No.006

NAHT written submission to:

London Assembly Health Committee investigation into dentistry and oral health in London.

1. NAHT welcome the invitation to provide written evidence to the London Assembly Health Committee on the issue of supervised toothbrushing in schools.

2. NAHT understand the Committee is currently carrying out an investigation into dentistry and oral health in London and is collecting evidence through public meetings, a call for evidence and a survey.

About NAHT

3. NAHT is the UK's largest professional trade union for school leaders. We represent more than 38,000 head teachers, executive heads, CEOs, deputy and assistant heads, vice principals and school business leaders.

4. Our members work across: the early years, primary, special and secondary schools; independent schools; sixth form and FE colleges; outdoor education centres; pupil referral units, social services establishments and other educational settings.

5. In addition to the representation, advice and training that we provide for existing school leaders, we also support, develop and represent the school leaders of the future, through the middle leadership section of our association. We use our voice at the highest levels of government to influence policy for the benefit of leaders and learners everywhere.

Introduction

6. As the Committee will be aware, a report following the National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5-year-old children in 2022, which was updated 11 October 2023[1], noted the following key findings
   a) the national prevalence of children with enamel and/or dentinal decay was 29.3%.
   b) Overall, 23.7% of 5-year-old children in England in this survey had experience of dentinal decay. This was similar to the finding of the previous survey of 5-year-olds in 2019.
   c) There was wide variation in both prevalence and severity of experience of dentinal decay by geographical area.
   d) At a regional level, 5-year-old children living in the North West of England were most likely to have experienced dentinal decay (30.6%). At upper-tier local authority level Brent, in the London region, had the highest prevalence of experience of dentinal decay (46.0%).

7. It was clear from the survey that children living in the most deprived areas of the country were almost 3 times as likely to have experience of dentinal decay (35.1%) as those living in the least deprived areas (13.5%), so the link between poverty / deprivation and health outcomes appears to remain strong.

8. There had been a decrease in the prevalence of experience of dentinal decay in 5-year-olds from 30.9% in 2008 to 23.3% in 2017. However, improvement stalled in 2019, and findings remain similar in this latest survey.

9. Both Wales and Scotland have also implemented national toothbrushing programmes. The structure of the programmes include co-ordinated activities across the home environment, in dental practices and in nurseries / schools.

10. Findings in Wales' latest report on the Designed to Smile programme, published in February 2024, showed the prevalence – the percentage of children examined in the study who have decayed, missing or filled teeth - had reduced from 47.6 per cent in 2007/08 to 32.4 per cent in 2022/23.[2]

11. However, as in other parts of the UK, the prevalence of decayed, missing or filled teeth remains substantially higher in the areas of highest deprivation in Wales.

12. Paul Brocklehurst, Consultant in Dental Health at Public Health Wales, responded to the report:

    > "While it is really encouraging to see the decrease in both the prevalence and severity of dental caries in young children in Wales, it is concerning that children in less well-off areas in Wales are more likely to experience higher levels of disease.'

13. Much of the available research continues to highlight the key link between the quality of children's diets and their oral health. We know that high sugar / less healthy diets are more prevalent in disadvantaged areas, often due to issues faced by families, such as food insecurity and availability.

[1] National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old children 2022 - Updated 11 October 2023
[2] Tooth decay rates in children in Wales fall, but issues remain - 1st February 2024

Nurseries' / Schools' role

14. Nurseries and schools undoubtedly have a crucial role to play in educating children about oral health, healthy eating and making improved choices for better health outcomes.

15. However, it is equally important that government policy – both national and local – focuses far greater resource and efforts on addressing the underlying drivers of poor health outcomes. These include families facing poverty (including those in low-paid employment), food insecurity and the poorer development of healthy routines and availability of heathy food choices in the wider community.

16. Schools understand their role in meeting the wider needs of children and young people in their care. Schools also have an important role to play in children's mental health, in their safeguarding and in their oral health.

17. However, it is equally clear that schools cannot be the panacea for all the issues faced by children and young people in the wider world. School staff are not fully qualified mental health therapists, neither are they experienced professional social workers, or dental healthcare specialists.

18. In addition, where schools are being asked to take on additional roles, such as in proposals for a toothbrushing programme, they cannot be expected to deliver it effectively without sufficient funding, resources (including building space), capacity (including staff numbers) and proper training.

19. In a recent funding survey by NAHT, the vast majority of school leaders reported that they were having to divert funding from their core school budget to address insufficient funding required for health (85 per cent) and social care provision (88 per cent) for their pupils. This is an unsustainable situation, and any additional expectations placed upon schools must be carefully considered, and can only be effectively delivered with additional, sufficient resourcing.

20. It is also important to understand the current constraints schools face in terms of curriculum time. School leaders and teachers do not have sufficient spare capacity in the current school timetable for substantial additional activities, unless they become part of existing curriculum delivery.

21. Whilst acknowledging that the current government curriculum and assessment review[3] does not include the Early Years – focusing only on Key Stages 1 to 5 – the committee may wish to consider providing feedback to the government illustrating where pressures in the current curriculum could be eased for nurseries and schools in order to focus more on oral health.

22. Whilst school leaders may have reservations about an additional pressure on nurseries and schools to deliver a toothbrushing programme, if one were to be implemented, lessons from parts of the UK where it has already taken place will prove invaluable.

[3] Curriculum and assessment review

23. A national survey of supervised toothbrushing programmes (STPs) in England[4] found that there were significant barriers for schools taking on such a programme, including:
    a) acquiring funding
    b) poor communication and engagement between Local Authorities, oral health providers and settings
    c) oral health not being a priority
    d) logistical challenges in implementation
    e) a lack of capacity

24. Features that appeared to be key in any successful implementation included:
    a) an integrated public health approach
    b) collaboration and ongoing support between Local Authorities, oral health providers and settings
    c) clarity of guidance
    d) enabling a flexible approach to delivery
    e) sufficient available resources
    f) ownership and empowerment of setting staff

25. It is also interesting to reflect on Scotland's – Child-smile Toothbrushing initiative. The barriers identified there included:
    a) communication about the programme to parents and staff
    b) frequent staff turnover
    c) lack of parental support
    d) staff feeling overburdened and acting as pseudo parents

26. The final concern of school staff in Scotland above, that they may be inadvertently acting as pseudo parents, is particularly important to note. It is also not a new concern with such additional initiatives.

27. **An Evaluation of Toothbrushing in schools (2014)**[5] included the debate as to whether school staff should be delivering the toothbrushing programme or whether it was a role for parents in the home.

28. It was a concern frequently raised and worthy of note. There were some tensions from both the school staff interviewed and parents on this debate.

29. The toothbrushing scheme was placed by some school staff within the wider context of teachers having increasing responsibility for supporting children in rudimentary activities. It was inferred that teachers felt that their role as educators was increasingly being replaced as pseudo-parents:
    a) *"I have been teaching for long time and more and more things the parents used to do I think it's put on to our heads….learning to use knife and forks, learning to get dressed, learning to go to the toilet all those things children used to come and be able to do."* (School staff)

30. Conversely, some parents questioned the reason why schools were replacing their duty as parents and several parents had initial scepticism of the scheme, especially concerning the storage of brushes and hygiene practices.

[4] A national survey of supervised toothbrushing programmes (STPs) in England
[5] An Evaluation of Toothbrushing in schools (2014)

However, it seemed that these initial worries had been allayed by the systematic process of storing brushes:

a) *"I was concerned about whose brush they were going to use, but later my daughter told me that they are divided into groups and they probably recognised what brush is theirs so that made me less concerned and I am fully ok with it right now."* (Parent)

Conclusion

31. National and local government policy must focus greater resource and efforts on addressing the underlying causes of poor health outcomes e.g. the impact of poverty and deprivation on tooth decay. Schools alone cannot continue to focus on the symptoms of deprivation unless underlying causes are tackled head-on at the same time.

32. Schools fully understand their role in meeting the needs of children and young people in their care, and recognise the role they play in children's overall development and health outcomes.

33. However, it is equally clear that schools cannot be the panacea for all the issues faced by children and young people beyond the school gates. School staff's primary role is as educators, and it is potentially damaging to children's progress and development to over-burden schools with less academic activities.

34. NAHT understand that whilst the primacy of the school role as educator must be maintained – for example, if reading skills were falling in a local area, health providers would not expect to have to provide reading programmes in support – it does remain clear that schools have some role to play in improving oral health in partnership with well-co-ordinated cross-sector services.

35. It is, therefore, critical that a number of foundations are in place if the decision is taken to progress such programmes:
    a) schools must have the capacity, the funding and resources to deliver any additional programme,
    b) improving children's health and social skills must operate as an integral part of the activities schools do alongside, not as an addition to, educational progress,
    c) dental programme providers must work directly with schools on an ongoing monitoring basis to understand and mitigate against the logistical challenges they may face – e.g. hygienic storage of brushes, staffing capacity, curriculum pressures, parental engagement etc
    d) the ultimate longer-term aim of such programmes (and wider government policy) must be to improve the drivers of domestic oral hygiene practices so that the school-based programmes become redundant over time.

Rob Williams
Senior Policy Advisor

Ref No.007

Dear Sir/Madam,

Please see below my responses to the 7 mentioned questions:

1. What are the specific barriers that prevent adults and children in London from accessing NHS dental care?
Access to NHS dental care in London is hindered by several significant barriers. One major issue is the shortage of available NHS dentists, with many reducing their NHS commitments due to insufficient funding and overwhelming administrative tasks. This has left many patients facing long waiting times for routine check-ups, discouraging them from seeking care altogether. As a private clinic, Serio Dental operates in an environment where patients often turn to private providers like us after struggling to access NHS services.

2. How do these barriers differ across various demographics, including age, income, and ethnicity, and what are the underlying causes of these disparities?
The barriers to accessing NHS dental care vary considerably across different demographic groups. Older adults and individuals with lower incomes often face the most substantial challenges, as many cannot afford private treatment and must rely solely on the overstretched NHS system. As a private clinic, Serio Dental sees a wide range of patients, and we notice that ethnic minorities, in particular, face additional obstacles such as language barriers or a lack of trust in healthcare services, which prevent them from seeking care. For children in disadvantaged families, limited awareness about free dental services and poor oral health education contribute to lower rates of dental attendance.

3. What impact is the lack of availability of NHS dentistry in London having on the oral health of Londoners?
The scarcity of NHS dentistry in London is having severe consequences for the oral health of its residents. At Serio Dental, we frequently see patients who have delayed seeking care due to their inability to find an NHS dentist, often resulting in more serious oral health issues that require complex and expensive treatment. This is especially true for those from lower-income backgrounds, who are less likely to access preventative care and, as a result, more likely to suffer from advanced dental problems such as tooth decay and gum disease. The lack of access to NHS dentistry is also exacerbating health inequalities, as individuals unable to afford private treatment are left with fewer options, leading to worse overall health outcomes. Poor oral health is linked to other medical conditions, such as cardiovascular disease, meaning that the impact extends beyond dental issues alone. We have recently opened the practice in the evening for emergency appointments. Although we are a private clinic, we have been added to the NHS 111, list of clinics that can see emergency patients.

4. What preventative measures are currently being taken to support oral health in London, and how effective are these measures?
Several preventative measures are currently in place to support oral health in London, although their effectiveness is limited. Schools in some boroughs provide oral health education, but these programmes are not consistent across the city and often fail to reach the communities most in need. We are trying hard to voluntarily offer our dentists to give talks at schools but have not found this easy even though they have up to date DBS checks.

Public campaigns promoting dental hygiene are also beneficial, but they tend to lack the reach and engagement necessary to make a substantial difference. At Serio Dental, we emphasise preventative care for our patients, but we recognise that the broader population needs more support in this area. Measures such as water fluoridation, which could reduce tooth decay

rates, have not yet been implemented in London. A more coordinated effort is needed to expand the reach of preventative initiatives and ensure that they effectively address the oral health needs of all Londoners.

5. What are the main challenges facing emergency dental care in London?
Emergency dental care in London faces a number of significant challenges, primarily related to capacity and access. As a private clinic, Serio Dental often treats patients who have been unable to access NHS emergency dental services due to long waiting times or a lack of available appointments. The limited number of NHS dentists providing emergency care means that many patients eventually seek treatment from private providers like us after experiencing delays. This situation creates a two-tier system where those who can afford private care receive prompt treatment, while others are left waiting, often experiencing preventable complications as a result. Additionally, there is a general lack of awareness about how and where to access emergency dental care, particularly among individuals who are not regularly engaged with dental services.

6. What specific actions need to be taken by the NHS and health partners in London to improve access to dental care and oral health outcomes?
To improve access to dental care and oral health outcomes in London, a number of key actions must be taken by the NHS and its health partners. First, NHS dental services must receive increased funding to expand capacity and reduce waiting times. Public health campaigns must also focus on educating vulnerable communities about the importance of oral health and how to access services. Finally, preventative care should be prioritised, with schools, healthcare providers, and local authorities working together to ensure that routine dental check-ups and education are widely available.

7. What action can the Mayor take to advocate and work with partners to improve the provision of dental care, including preventative measures, in London?
The Mayor of London has a vital role to play in advocating for improved dental care provision across the city. One of the key actions the Mayor can take is to lobby central government for increased funding for NHS dental services, ensuring that all Londoners have access to affordable care. At Serio Dental, we frequently encounter regulatory barriers that complicate the provision of both niche and basic NHS services that we may be able to potentially offer. The Mayor could support efforts to streamline these regulations and reduce the red tape that makes it difficult for private clinics to offer a full range of services. Additionally, the Mayor could advocate for the introduction of water fluoridation in London, a proven measure to reduce rates of tooth decay, particularly in children. The Mayor should also work to foster partnerships between private clinics like ours, the NHS, and community organisations to expand access to preventative care and oral health education. By addressing these issues, the Mayor could help to reduce oral health inequalities and ensure that all Londoners receive the care they need.

Kind Regards

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