

Teething problems

A review of NHS dental care in London

December 2007



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Health and Public Services Committee

The Health and Public Services Committee can identify and investigate any health and public services issues that are of concern to London as a whole. Recent investigations include community mental health services, post office closures and emergency life support training.

Further information about the Committee can be found at:
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Contents

Chair’s foreword	5
Executive Summary	6
Summary of Recommendations	8
1 Background and context	10
2 What is the current situation in London?	12
3 Why is uptake of NHS dental care so low?	14
4 What impacts have the 2006 reforms had on access to and uptake of NHS dental care?	23
Endnotes	31
Appendix 1: How we conducted this investigation	35
Appendix 2: Principles of London Assembly scrutiny	37
Appendix 3: Orders and translations	38

Chair's foreword

Only half of Londoners regularly visit an NHS dentist, meaning that oral disease and decay are common. However, London has more NHS dentists than most other areas of the country, so we decided to find out what's stopping Londoners going to the dentist.

Our investigation found that some Londoners face real problems accessing NHS dental care. This is for a range of reasons including the uneven spread of dentists across the capital and the limited opening hours of many surgeries. But perhaps the biggest barriers to NHS dental care are the costs of treatment, confusion about the costs of treatment and confusion about entitlements to free or reduced cost care.

The 2006 reforms to NHS dental care have the potential to improve access to dental care, by giving PCTs the power to commission services that better meet local needs. PCTs are also responsible for informing people about local dental services and the costs of care. Although PCTs have started to focus on these issues, much more work is needed to ensure Londoners are well-informed and able to access dental care that meets their needs.

The 2006 reforms have changed the way patients pay for NHS dental care. The previous, highly complex system of 400 charges has been replaced by a simple, clear system of just three charging bands. However, the new charging structure has made certain treatments more expensive and could discourage regular attendance. Changes to the charging structure may have also adversely affected dentists with many feeling they are not properly compensated for complex work.

The report makes a number of recommendations that we believe could tackle these issues, and make NHS dental care services easier to access for all Londoners.

I am very grateful to all the Londoners and professionals who contributed to this investigation. However, special thanks go to the 1,000 Londoners who gave their views in our survey, and to the staff in Tower Hamlets who organised an inspirational visit to their innovative dental outreach project.



Joanne McCartney AM

Chair, Health and Public Services Committee



'Some Londoners face real problems accessing NHS dental care'

Executive Summary

London has more NHS dentists than the national average, but fewer people using them. In fact, only half (51 percent) of Londoners went to an NHS dentist in the two years to March 2007. Worryingly, children in the capital are less likely to visit an NHS dentist than children anywhere else in the country.

‘Only half of Londoners went to an NHS dentist in the two years to March 2007’

Low uptake of dental care is an important public health issue for London, as people who do not attend a dentist regularly are more likely to have untreated dental problems and disease, which can impact on other aspects of their health. We therefore conducted this investigation to find out why uptake of NHS dental care is so low in the capital.

Major reforms to the way NHS dentistry is funded, managed and commissioned were made in April 2006. Media reports at the time suggested that these reforms would lead to thousands of dentists quitting the NHS, making access to NHS dental care more difficult. Consequently, we investigated what impact these reforms have actually had on access to NHS dental care in London.

We found a number of inter-related factors to explain the low uptake of NHS dentistry in London. A range of barriers that prevent certain groups accessing NHS dental care including: treatment costs, confusion about entitlements to NHS care and eligibility for free or reduced cost care, a lack of NHS dentists in some areas, and the inaccessibility of some surgeries. Furthermore, London’s population contains large numbers of young people, people who have recently moved, people from BAME communities and people on low incomes. Research shows that these groups tend to visit a dentist less regularly than others, partly because the barriers to NHS dental care mentioned above tend to affect them more. There is also some evidence that Londoners’ uptake of private dental care has increased in the past two years.

We found that the 2006 reforms have had some positive impacts. The reforms transferred responsibility for commissioning and managing dental contracts to PCTs, who now have the power to change services so that they better meet local needs. The reforms also introduced guaranteed, ringfenced funding for three years, which has ensured a stable level of provision of NHS dental care, and has allowed PCTs to forward plan effectively.

However, the 2006 dental reforms could actually reduce access to NHS dentistry. The new patient charging scheme may discourage patients from attending a dentist regularly, and has significantly increased the costs of some procedures. We heard evidence that the charging system also discourages dentists from taking on patients who have complex treatment needs because they do not think that they get properly compensated for undertaking these procedures. Plus, the dental budget has mainly been based on the level of provision in an area during 2004/05,

which has limited the extent to which PCTs can alter services to meet local needs, and also means dentists are unable to deal with any changes in demand for their service. Some dentists completed their target number of treatments before the end of 2006/07, and because no new money was available, they had to close their doors to NHS patients, until the following financial year.

Our report makes a number of recommendations to address these issues. We believe that to reduce patient confusion, PCTs need to improve publicity on local dental services, NHS charges and eligibility for free or reduced cost treatment. We think that the Department of Health should revise the patient charging structure to encourage regular attendance. We also believe that in the future, the Department of Health should base PCTs' funding allocations on local needs assessments, rather than historical provision.

Summary of Recommendations

Recommendation 1

NHS London should revise the Healthcare for London Framework to include proposals to improve access to dental care, through for example, the increased availability of home-based and outreach dental services, and by assessing whether proposals for new polyclinics, when developed, could include NHS dental surgeries in areas where access is limited.

Recommendation 2

A London PCT dental network should be set up to enable PCTs to share and discuss good practice in commissioning services that better meet local needs. Representatives of Tower Hamlets PCT should be invited to the first network meeting to outline how their mobile outreach dental surgery model has improved access to and uptake of NHS dental care.

Recommendation 3

PCTs need to publicise local NHS dental services, NHS patient charges and low-income scheme, and ensure relevant information is accessible to different local communities. PCTs should consider (jointly or individually) setting up local helplines to assist people in finding an NHS dentist.

Recommendation 4

PCTs need to ensure that all NHS dental practices display information about the costs of treatment and who is exempt from charges, and that all NHS practices keep copies of HC1 forms and promote the NHS low-income scheme to patients who may be eligible.

Recommendation 5

The Department of Health needs to revise the dental charge banding structure to ensure that it is equitable and encourages regular attendance. The Department should consider adding extra charging bands between bands one and two, and between bands two and three.

Recommendation 6

After April 2009, the Department of Health should base PCTs' dental funding allocations on local needs assessments, rather than historical provision.

Recommendation 7

The Department of Health should consider how it could revise the current NHS dental contract so that preventive care is explicitly built into the way PCTs manage and monitor dental contracts and should consider whether dentists should be separately financially rewarded for providing preventive advice.

Recommendation 8

The Department of Health should ensure that performance ratings from dentists' balanced scorecards are made available to the public to help them choose a good quality dentist.

1 Background and context

The need for this investigation

- 1.1 Evidence shows that London is relatively well served for dentists, compared to other parts of the country. However, Londoners are less likely than others to visit an NHS dentist.
- 1.2 Major reforms were made in 2006 to NHS dental care, affecting the way services are funded, managed and commissioned. Dentists' dissatisfaction with these changes led to media speculation that large numbers of dentists would quit the NHS, which would make it more difficult for patients to access NHS dental care¹.
- 1.3 Therefore, we conducted this investigation to try and answer three key questions:
 - Why is uptake of NHS dental care so low in the capital?
 - What could be done to increase uptake?
 - What impact have the April 2006 reforms to dental services had on access to and uptake of NHS dental care?

How we conducted this investigation

- 1.4 We used a wide range of information to inform our investigation:
 - We invited written views and information from a range of professional stakeholders, as well as from ordinary Londoners. This call elicited around 35 responses including the Department of Health, NHS London, The British Dental Association, many London PCTs and 13 individual Londoners.
 - We held a public meeting to discuss the issues arising from the written submissions with a range of key stakeholders.
 - We conducted a telephone survey of 1,000 Londoners to gather their views on access to dental care in the capital, and the impact of the new dental contract.
 - Members of the Committee visited a mobile outreach dental service in Tower Hamlets to see how it has improved access to NHS dental care in the borough. The mobile outreach service goes out to areas of the borough where uptake of NHS dental care is low, and also targets services for groups of people such as drug users whose lifestyles mean they are less likely to access NHS services.

Further information on how we conducted this investigation can be found in appendix 1.

How NHS dental care operates in London

- 1.5 Major changes to NHS dental care were introduced in April 2006. NHS London has called these changes the most radical reforms to NHS dentistry since 1948², because they have altered the way services are managed, funded and commissioned. PCTs now commission and manage local NHS dental contracts, instead of this happening at a national level. The reforms also introduced a new simplified patient charging structure, with just three charge bands for different types of treatment, replacing a system of around 400 different charges. The impact of the 2006 reforms is explored in more depth in section four.
- 1.6 The reforms have also changed the way dentists are paid. Dentists now provide a target number of units of dental activity (UDAs) in return for a monthly payment. Therefore dentists get paid a fixed monthly payment for undertaking a fixed number of treatments. This replaces the previous fee-per-item system of payment for dentists.
- 1.7 Dentists choose whether to provide private care, NHS care or a mix of both. Most dental care is provided by General Dental Practitioners (GDPs). Specialist dental practitioners provide more complex, secondary care, often in hospital settings. In addition, every PCT commissions a Salaried Primary Dental Care Service (aka community dental services) to provide NHS dental care for people who find it difficult to use high street dentists, for reasons including mobility difficulties, phobias and learning difficulties.
- 1.8 The majority of NHS patients have to pay for their dental treatment. However, there is a national scheme for people on low incomes that helps with the costs of treatment. Furthermore, children and young people under the age of 18, people under the age of 19 who are in full time education, pregnant women and new mothers, and those in receipt of Job Seekers Allowance or Income Support are exempt from NHS dental charges. Retired people do not automatically get free or reduced cost treatment, although many will be eligible for help with treatment costs under the low-income scheme, and those who receive Pension Credit Guarantee Credit are exempt from dental charges.
- 1.9 The NHS budget for dental care in London is £356 million. The net spend on NHS dental care per head in London (£39.30) is slightly higher than the national average (£36.00), because of the particularly high proportion of NHS dental patients who do not have to pay for their treatment in the capital³.

‘The NHS budget for dental care in London is £356 million’

2 What is the current situation in London?

London is well served by NHS dentists

- 2.1 London has more NHS dentists than most other parts of the country. In March 2007, there were 3,841 dentists on open NHS contracts in London⁴. This equates to 51 NHS dentists per 100,000 Londoners, compared to a national average of 42 dentists to every 100,000 people⁵. Unlike other parts of the country, no London PCTs have waiting lists for NHS dentists⁶. Furthermore, analysis of information from the NHS website on London dentists shows that the majority of London dentists are taking on new patients⁷. Therefore, it appears that concerns about large numbers of dentists quitting the NHS in London have not been realised.
- 2.2 Despite relatively high levels of NHS dentistry in the capital, provision is not equally spread across the capital. This issue is explored in more depth in chapter three.

Low uptake of dental care

- 2.3 Despite the relatively high numbers of NHS dentists, Londoners are less likely than most to actually visit an NHS dentist. Only 51 percent of Londoners went to an NHS dentist in the two years to March 2007. This is one of the lowest uptake levels in the country, and is significantly lower than other big cities, as shown in the table below.

Proportion of residents who had been to an NHS dentist in the two years to March 07⁸

London	51%
England (national average)	56%
Newcastle	63 %
Manchester	60 %

- 2.4 Worryingly, London's children are less likely to visit an NHS dentist than children anywhere else in the country. Just 65 percent of children in London visited an NHS dentist in the two years to March 2007, compared to a national average of 71 percent⁹.
- 2.5 Furthermore, a significant proportion of Londoners do not regularly attend any dentist - NHS or private. Our survey of Londoners showed that 3.5% of adult Londoners had never visited a dentist - equivalent to around 205,000 people. A further 17% had not been to the dentist in the past two years - equivalent to almost a million people¹⁰.

‘Despite the relatively high numbers of NHS dentists, Londoners are less likely than most to actually visit an NHS dentist’

Why low uptake matters

- 2.6 Low uptake of NHS dentistry is a major public health issue in the capital, and contributes to stark oral health inequalities. People on low incomes and people from BAME communities tend to visit a dentist less regularly than others, and are therefore more likely to have untreated dental problems or disease¹¹. Children living in inner London boroughs, which tend to be more diverse and deprived than the national average, experience some of the worst levels of tooth decay in the country. For example, 5-year-old children in Newham have an average of 2.5 decayed missing or filled teeth, compared to a national average of 1.5¹².
- 2.7 Furthermore, dentists play an important role in checking for signs of oral cancer, and so symptoms are less likely to be noticed among people who attend a dentist less regularly. Certain individuals (such as people who use both tobacco and alcohol regularly) are at particularly high risk of oral cancer, and would benefit from regular surveillance.

3 Why is uptake of NHS dental care so low?

3.1 There are a number of inter-related factors to explain low uptake of NHS dental care in the capital. The costs of NHS care, the inaccessibility of some dental surgeries and confusion about NHS provision all contribute to low take-up rates. Furthermore, London's population contains large numbers of people who have recently moved, young people, BAME community members and people living in poverty who are all less likely than others to regularly access a dentist. Interestingly, our research shows that Londoners accessing private dental care may be an increasingly important reason for why uptake of NHS dentistry is so low.

People choosing private care

3.2 A minority of Londoners choose private dental care rather than NHS care. Healthcare Commission research in 2005 showed that around 24% of London residents go to a private dentist, which is similar to the national average of 23%¹³. These figures therefore suggest that Londoners choosing private care cannot be the main reason why uptake of NHS dentistry is lower in the capital than it is in other areas of the country.

3.3 However, the picture is complicated by significant variation in the proportion of people accessing private care in different areas. The Healthcare Commission 2005 survey showed that 53 percent of residents in Richmond and Twickenham went to a private dentist in 2005, compared to just 12 percent in Barking and Dagenham¹⁴. Perhaps unsurprisingly, private dentists are far more popular in more affluent boroughs such as Richmond, Bromley and Kensington and Chelsea than in more deprived boroughs where people are less likely to be able to pay for private dentistry¹⁵.

3.4 Until 2006, both private and NHS dentists decided where to site their surgeries and what types of patients they wanted to treat. As a result, private dentists have tended to focus on more affluent boroughs where they will have a bigger patient base, and NHS dentists have tended to focus on less affluent boroughs. However, NHS dental surgeries are not evenly spread within boroughs with some areas having few or no local surgeries. The reforms to NHS dentistry introduced in 2006 gave PCTs commissioning powers which should enable them to ensure a more even spread of NHS provision within their areas. These reforms are explored in more depth in section 4.

3.5 There is also some evidence of a possible recent increase in the uptake of private care. Our survey of Londoners showed that 31 percent had private treatment at their last visit¹⁶. This suggests that private treatment may be becoming more popular in the capital, which could be linked to the limited availability of NHS care in some areas, as well as confusion about

entitlements to NHS care. These issues are explored in more depth in paragraphs 3.17- 3.20.

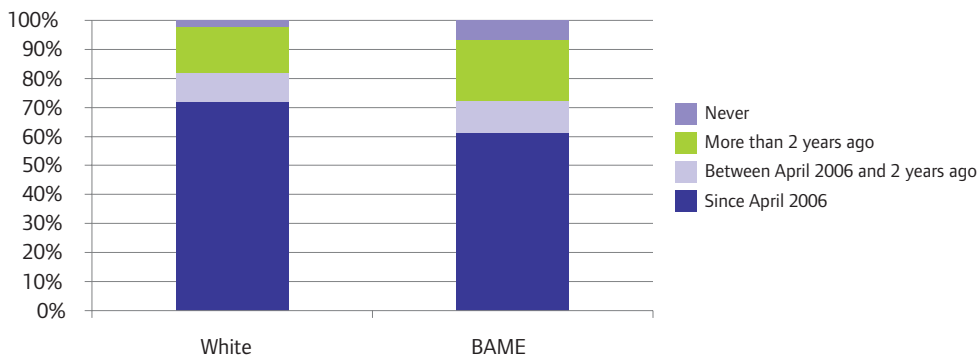
Demographic reasons

- 3.6 London’s population is extremely mobile. In 2004, around 370,000 people moved to the capital¹⁷, and there is also considerable population churn from people moving within London. New arrivals and recent movers may be less likely to access NHS dental care, for reasons including a lack of knowledge about local services or the fact that they may not stay in one place long enough to complete a course of dental treatment¹⁸.
- 3.7 Evidence shows that people from certain demographic groups are less likely than others to visit a dentist regularly. Older people, young people, people from BAME communities, and people on low incomes all tend to visit a dentist less often than other groups¹⁹, as shown in the graphs below. London’s population contains larger than average numbers of young people, people from BAME communities and people living in deprived communities²⁰, which could go some way to explaining why uptake of dental care in London is lower than average.

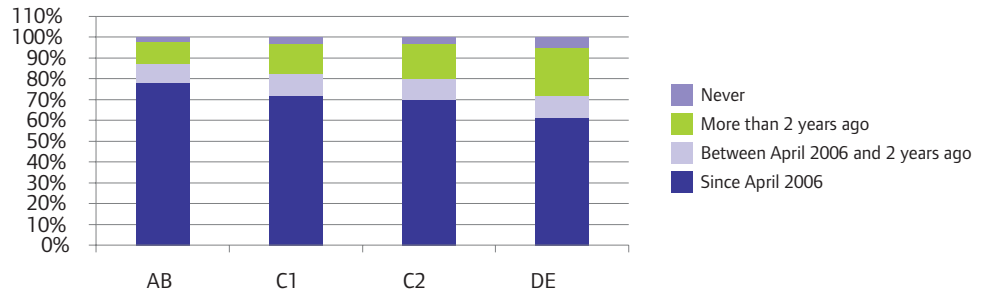
‘Older people, young people, people from BAME communities, and people on low incomes all tend to visit a dentist less often than other groups’

When survey participants last visited a dentist

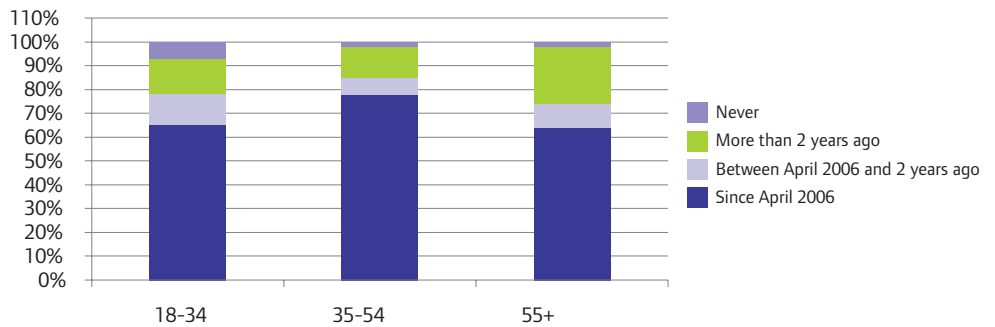
Ethnicity



Social class



Age



‘Over a third of Londoners in our survey had delayed or gone without dental treatment, and the most commonly cited reason for this was cost’

3.8 Low uptake of dental care among young people, older people, BAME communities and people on lower incomes is linked to a wide range of different factors. Some of these factors such as cost, a lack of awareness about eligibility for NHS treatment, and inaccessible dental services may affect a wide range of Londoners, but have a particularly big impact on these groups. These factors are explored in more depth in the rest of the chapter.

3.9 However, there are also certain reasons for low uptake that are specific to BAME communities. Cultural barriers can be an issue for some communities. For example, women from certain BAME communities in Tower Hamlets may be uncomfortable receiving dental care from male dentists, and the majority of dentists in the borough are male²¹. Furthermore, the idea of regular dental attendance does not fit with some BAME communities’ cultural beliefs around health:

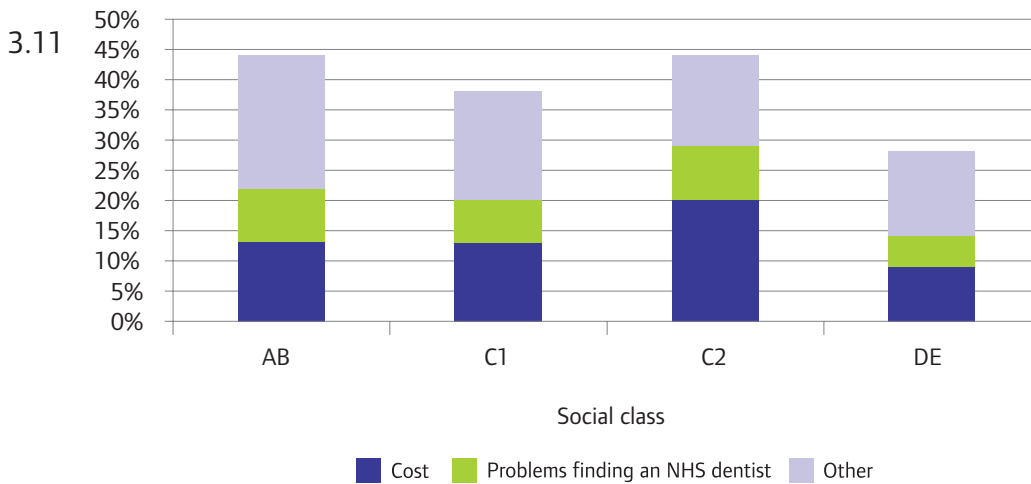
“[In] Lambeth...we have a Vietnamese project, and the idea of going for six monthly checkups just would not occur to them at all. They only visit the dentist when they have a problem”. (Sophie Chapman, Citizens Advice)²²

The costs of treatment

3.10 The costs of treatment can be a major barrier to dental care. In fact, over a third (35 percent) of Londoners in our survey had delayed or gone without dental treatment, and the most commonly cited reason for this was cost²³.

Survey participants from the C2 social class (skilled manual labourers) were the most likely to have delayed or gone without treatment because of cost, as shown in the graph below. People from this social class are likely to have incomes that put them just above the threshold for receiving free or reduced cost NHS care, and may therefore have the biggest problems affording dental care²⁴.

Reasons why respondents went without or delayed treatment by social class



‘Dental surgeries are not evenly spread across the capital, leaving some areas with little or no provision’

Citizens Advice has found that many people do not know they are entitled to free or reduced cost NHS dental treatment. One of the main reasons for this is that many dental surgeries do not advertise the scheme that reduces the costs of NHS dental care for people on low incomes. In addition, many surgeries do not have the HC1 forms that people need to fill in to claim free or reduced cost treatment²⁵. People from BAME communities who do not speak English or who have recently arrived in the UK are particularly likely to lack knowledge about their entitlements to free or reduced cost dental care.

3.12 The costs of dental treatment can cause people to seek dental care abroad. Research by Citizens Advice found that many Londoners from BAME communities only visit a dentist when they go back to their home country, and that the two main reasons for this are the high costs of NHS care, and fears around the quality of treatment in the UK²⁶.

3.13 The new pricing structure, introduced as part of the 2006 reforms to NHS dentistry has also impacted on the costs of treatment. These issues are explored further in chapter four.

Accessibility of local services

- 3.14 Although the number of NHS dentists in London is relatively high, local NHS dental services are not accessible to all Londoners, for a number of reasons²⁷.
- 3.15 Many surgeries are not accessible to people with mobility or communication difficulties. Every PCT funds a Salaried Primary Dental Care Service to provide treatment for people who find high street dentists difficult to access. However, lack of awareness of this service may be an issue for some groups, such as non-English speakers.
- 3.16 Many practices only open during office hours, making them difficult for working people and people with other daytime commitments to access.

“I think we have probably got... a model of service provision, that compared to modern needs, is relatively old fashioned. It is predicated on a basis that if you are open relatively restricted hours on the high street people will find the time and the inclination to turn up.” (Andrew Ridley, Tower Hamlets PCT)²⁸

- 3.17 Dental surgeries are not evenly spread across the capital, leaving some areas with little or no provision. Before the 2006 reforms, dental care was a supply-led service, with NHS dentists deciding where they would like to site their practices. This means that people in some areas may have to travel long distances to access NHS care. According to the Department of Health, provision of NHS dental care is particularly low in parts of South West London, and in line with this, our survey showed that residents in South West London are more likely than those elsewhere to report problems accessing NHS dental care²⁹.
- 3.18 The availability of NHS dental care is extremely limited for particular groups in certain areas. As the table overleaf shows, there is wide variation across London in terms of the numbers of NHS dentists accepting new patients, and what kinds of new patients they will accept. For example, in Barnet, Redbridge, Ealing, and Haringey there were more than 40 NHS dentists accepting new fee paying adult patients. In contrast, no NHS dentists were accepting new fee paying adult patients in Sutton, Merton and Brent³⁰, meaning that residents in these areas would have to travel to another borough to access NHS dental care. This variation in provision for different groups in different areas stems from the fact that until April 2006, dentists could decide how many of each type of NHS patient they wanted to treat.

Number of dentists in each PCT area - April 2007³¹

PCT area	NHS dentists taking on all types of new patients including paying adults	NHS dentists only taking on charge exempt patients	NHS dentists not taking on any new patients	Non-NHS (private) dentists
Barking & Dagenham	16	2	1	0
Barnet	42	20	7	31
Bexley	12	4	20	2
Brent	0	52	7	17
Bromley	11	18	20	19
Camden	29	0	10	43
City & Hackney	28	3	1	44
Croydon	24	22	3	22
Ealing	49	0	2	13
Enfield	23	8	9	16
Greenwich	26	9	2	5
Hammersmith & Fulham	30	0	0	20
Haringey	47	4	0	5
Harrow	27	16	4	16
Havering	22	7	2	11
Hillingdon	19	13	7	5
Hounslow	31	1	3	20
Islington	20	1	1	13
Kensington & Chelsea	21	0	0	56
Kingston **	2	12	9	16
Lambeth	37	1	1	12
Lewisham	31	2	0	10
Newham	28	2	2	5
Redbridge	41	3	7	12
Richmond	9	13	7	20
Southwark	35	3	0	0
Sutton & Merton **	0	67	1	25
Tower Hamlets	18	7	2	11
Waltham Forest	29	0	2	0
Wandsworth	5	29	8	25
Westminster	33	9	12	46

** Information for these PCTs was not available for April 2007, so figures for these PCTs are based on analysis from September 2006.

- 3.19 NHS London has recently launched ‘Healthcare for London: a framework for action’, which is a draft strategy for improving the quality of NHS services, and access to those services. However, despite the problems Londoners have in accessing NHS dental care, improving access to dental services is not one of the framework’s priorities. The Committee therefore believes that the framework should include more proposals for improving access to dental care, through for example, increasing the availability of home-based and outreach dental care and by ensuring new polyclinics include NHS dental surgeries in areas where access is limited.

Recommendation 1: NHS London should revise the Healthcare for London Framework to include proposals to improve access to dental care, through for example, the increased availability of home based and outreach dental services, and by assessing whether proposals for new polyclinics, when developed, could include NHS dental surgeries in areas where access is limited.

Awareness of available services

- 3.20 Access to NHS dental care is affected by a lack of awareness about what is available. Londoners are often confused about the difference between private and NHS treatment, their eligibility for NHS care, and how to find an NHS dentist³². Again, this is likely to be a particular issue for non-English speakers, and people who have recently arrived in the country.

“When we were interviewing (Citizens Advice Bureau) clients we still picked up a huge amount of confusion, not just about charges but whether something was NHS or private.”³³ (Sophie Chapman, Citizens Advice)

‘Londoners are often confused about the difference between private and NHS treatment, their eligibility for NHS care, and how to find an NHS dentist.’

- 3.21 A number of organisations have suggested that media reports about large numbers of dentists leaving the NHS are likely to have affected Londoners’ perceptions about accessing dental care. They believe that media reports might mean that Londoners do not even try to access NHS dental care, believing that no NHS dentists will take them on³⁴. However, our survey casts doubt on the negative impact of the media on Londoners’ perceptions, with just 4 percent of survey respondents saying the media influenced their thinking about how easy it was to find a dentist³⁵.

PCTs lead role in tackling barriers to dental care

- 3.22 PCTs have the lead role in tackling the barriers to NHS dental care. Following the 2006 reforms, PCTs now commission NHS dental services in their area. This means that they can deal with uneven provision and other barriers to accessing dental care, and ensure that local dental services meet local needs.

Good practice - Tower Hamlets PCT

Tower Hamlets PCT has implemented a groundbreaking project of mobile dental surgeries to improve uptake of local NHS dental services. These mobile surgeries are highly visible and visit parts of the borough where access to NHS care is difficult, and/ or where uptake of NHS care is low. They also provide outreach services for people such as drug users, whose lifestyles mean they are unlikely to regularly attend a dentist.

People using the outreach service are offered advice and/ or treatment in the mobile unit, and are then referred to local high street dentists where possible. The mobile surgeries are staffed by NHS dentists and link workers whose role is to encourage people to attend the mobile surgeries, and to answer queries such as how much NHS dental care costs. Link workers have been intentionally recruited from local communities, so that they have useful local knowledge, and many are also able to speak local community languages. Local community members have been involved in developing, designing and helping to run the mobile surgeries, which has helped ensure the service meets local needs.

The mobile surgery model has been extremely successful, both in terms of patient satisfaction, and in terms of increasing uptake of dental care.



- 3.23 The mobile surgery project started in 2003, before the 2006 reforms were introduced. However, following the 2006 reforms, PCTs now have a ringfenced budget for dental services, which would make it easier for other areas to replicate the Tower Hamlets model, if evidence shows a need for this kind of service.
- 3.24 The set up of a London PCT Dental Network is currently under discussion. The Committee believes that this network could provide an excellent opportunity for PCTs to share good practice in terms of improving access to and uptake of NHS services, including the Tower Hamlets model of mobile outreach dental surgeries.

Recommendation 2: A London PCT dental network should be set up to enable PCTs to share and discuss good practice in commissioning services that better meet local needs. Representatives of Tower Hamlets PCT should be invited to the first network meeting to outline how their mobile outreach dental surgery model has improved access to and uptake of NHS dental care.



3.25 PCTs also have a role in informing people about available local NHS dental services and costs. Providing good quality, easy to access information could help reduce people's confusion about local services and how to access them, as well as ensuring people are clear about the costs of treatment, and whether they are eligible for free or reduced cost care. Information about local dental services is available on www.nhs.uk and through PCTs, but many Londoners are not aware about these information sources, which may also be difficult for some people to access. Since many surgeries do not keep or publicise the HC1 forms that people need to fill in to claim free or reduced cost treatment, there is a real need for PCTs to ensure that all NHS surgeries hold these forms, and promote them to patients.

3.26 Some PCTs outside London such as Leeds PCT and Dorset and Somerset PCTs have set up and publicised local dental helplines to assist people in finding an NHS dentist in their area. These helplines have proved to be very successful, with the Leeds helpline managing to put 30,000 callers in touch with practices that are accepting new patients since April 2006.

Recommendation 3: PCTs need to publicise local NHS dental services, NHS patient charges and the low-income scheme, and ensure relevant information is accessible to different local communities. PCTs should consider (jointly or individually) setting up local helplines to assist people in finding an NHS dentist.

Recommendation 4: PCTs need to ensure that all NHS dental practices display information about the costs of treatment who is exempt from charges and who may be entitled to reduced cost care. In addition, PCTs should ensure all NHS practices keep copies of HC1 forms to distribute to patients.

4 What impacts have the 2006 reforms had on access to and uptake of NHS dental care?

- 4.1 Major reforms to NHS dentistry were introduced in April 2006, to tackle a number of problems. Firstly, before 2006, the patient charging system for NHS dental care was extremely complex, with around 400 different charges. This led to many NHS patients being confused about what they were paying for, and sometimes feeling that they were being charged for treatments they did not need. Secondly, prior to 2006, NHS dental care was a supply-led service, with dentists free to choose where they practiced, and whom they treated, leading to a situation where services often failed to meet local needs. Thirdly, the old system involved dentists being paid on a fee for item basis, which kept dentists on a 'drill and fill treadmill' and created incentives for dentists to carry out more lucrative invasive and complex treatments.
- 4.2 The 2006 reforms of NHS dentistry have brought major changes for dentists, PCTs and patients. The reforms had three main aims³⁶:
- i To improve access to dental services, by putting PCTs in charge of local dental budgets so that they can use their local knowledge and commissioning powers to make services better fit with local needs. Previously, PCTs had no control over local dental services.
 - ii to give dentists more time for oral health advice and preventive care, and to remove incentives for dentists to carry out more complex and invasive treatments by replacing the fee per item charging scheme with a scheme whereby dentists are paid a fixed monthly amount for undertaking a specified number of treatments.
 - iii To make the patient charging system simpler and more transparent by replacing the previous system of around 400 different charges with just three charging bands. Patients now pay £15.90 for a check up (band one), £43.60 for a check up plus simple work such as fillings and extractions (band two) and £194 for everything covered by bands one and two plus crowns, dentures and bridges (band three).
- 4.3 The reforms have had a number of positive impacts, including the ability for PCTs to make dental services more accessible to local people. However, the reforms have also brought in measures that could actually reduce access to NHS dental care, such as using historical levels of provision to determine funding levels. Furthermore, dentists do not get paid any extra for providing preventive care under the new contract, so the new funding system is unlikely to meet its aim of increasing preventive care. The positive and negative impacts of the reforms are discussed below.

'The new reforms have enabled PCTs to redesign services to better meet local needs'

A Positive impacts of the 2006 reforms

Stability of funding and provision

- 4.4 The reforms introduced guaranteed, ringfenced funding for NHS dental services for 2006 to 2009. The three-year guaranteed funding means that there should be no drop in dental provision during this time. The ringfencing of the funding means that if a dentist decides not to sign an NHS contract, the local PCT can recommission their work to another local dentist.
- 4.5 Uptake of NHS care has also remained more or less stable following the introduction of the reforms. In March 2006, before the new reforms were introduced, 51.7 percent of Londoners had been to an NHS dentist in the previous two years. In March 2007, a year after the reforms were introduced, 51.2 percent of Londoners had been to an NHS dentist in the previous two years.³⁷ The table overleaf shows how uptake of NHS dentistry has changed across London before and after the new contract was introduced.

How the percentage of residents accessing NHS care has been affected by the April 2006 reforms

	% accessing NHS care in the two years to March 06	% accessing NHS care in the two years to March 07
England	55.8	55.7
London SHA	51.7	51.2
Barking and Dagenham PCT	48.1	49.9
Barnet PCT	44.9	45.6
Bexley Care Trust	51.4	49.6
Brent PCT	62.3	61.6
Bromley PCT	46.4	44.5
Camden PCT	49.1	47.3
City and Hackney PCT	39.3	39.7
Croydon PCT	53.1	52.1
Ealing PCT	59.9	60.1
Enfield PCT	56.3	55.3
Greenwich PCT	57.2	58.7
Hammersmith and Fulham PCT	56.9	58.0
Haringey PCT	67.8	67.2
Harrow PCT	51.3	52.2
Havering PCT	57.3	56.1
Hillingdon PCT	51.6	53.2
Hounslow PCT	68.9	68.7
Islington PCT	50.9	51.1

	% accessing NHS care in the two years to March 06	% accessing NHS care in the two years to March 07
Kensington and Chelsea PCT	22.2	21.3
Kingston PCT	45.9	44.1
Lambeth PCT	54.4	51.0
Lewisham PCT	60.9	61.4
Newham PCT	50.5	52.7
Redbridge PCT	64.5	63.3
Richmond and Twickenham PCT	33.1	30.8
Southwark PCT	49.8	50.6
Sutton and Merton PCT	52.1	49.7
Tower Hamlets PCT	44.1	44.2
Waltham Forest PCT	52.6	53.2
Wandsworth PCT	45.5	45.4
Westminster PCT	44.5	39.8

4.6 The supply of NHS dentistry has remained more or less stable during the transition from the old to the new dental contracts. The vast majority (93 percent) of London's NHS dentists signed up to the new contract³⁸. Furthermore, PCTs have reported that the NHS work of dentists who decided to stop providing NHS care has been easily reallocated to other dentists³⁹. Some PCT areas have seen a small increase in the number of NHS dentists during the first year of the new contract, and other areas have seen a small decrease. However, a few of PCTs have seen big changes in numbers, notably Camden, which had 38 fewer dentists in March 2007 compared to March 2006, and Tower Hamlets PCT, which had 66 more NHS dentists in March 2007 compared to March 2006⁴⁰. However, since PCTs have generally not had a problem reallocating NHS dental work when a dentist leaves, a drop in dentists' numbers does not necessarily lead to a drop in available provision in an area.

Services redesigned to fit local needs

4.7 The new reforms have enabled PCTs to redesign services to better meet local needs. For example, Tower Hamlets PCT and Croydon PCT have both decided to commission primary care dentists, rather than dentists in hospitals to provide specialist dental care, such as minor oral surgery. This approach enables patients to access specialist services closer to home, reduces waiting times, and cuts the PCT's costs by reducing referrals to expensive hospital specialists⁴¹.

Simple, clear charging system

- 4.8 The new simplified charging system should bring some benefits for NHS patients. The three-band system should mean that patients are clear about exactly what they will have to pay for a course of treatment, and can be confident that they will not be overcharged. Furthermore, the new system means no-one will ever pay more than £194 for a course of treatment, so the costs for having a lot of complex work have been reduced⁴².

B Negative impacts

Problems with the patient charging system

- 4.9 The new patient charging system could make NHS dental care less accessible for some Londoners, partly because of the big cost differences between the three charging bands.

‘It is now more expensive over time to visit the dentist for regular check ups and treatments than it is to visit the dentist occasionally to have multiple treatments’

- 4.10 Under the new charging band system, it is more expensive over time to visit the dentist for regular check ups and treatments than it is to visit the dentist occasionally to have multiple treatments⁴³. For example, a patient pays the same for a check up and one filling as they would for a check up and five fillings. This could encourage patients to wait until they need multiple treatments before going to the dentist⁴⁴. The fact that the 2006 reforms could discourage regular dental attendance is contrary to their aim of increasing preventive dentistry, which requires regular visits to a dentist. Adding an extra charging band between the current band one and band two, (which could perhaps cover the cost of a check up and one filling), could help to resolve this issue. Reducing the costs of check-ups could also encourage more regular attendance.
- 4.11 The banding structure could actually increase existing dental health inequalities, by making it more difficult for people on low incomes and from BAME communities to access complex dental treatments. The Committee has received some evidence that because of the high costs of complex work such as crowns, fee-paying patients are deciding to have lower cost treatment such as extraction instead⁴⁵. Furthermore, dentists in some parts of the country have decided not to treat people who are likely to require multiple or complex treatments, because they don't believe they get properly compensated for these types of treatment⁴⁶. This is likely to have a particularly big impact on deprived and BAME communities, as these groups tend to visit the dentist less frequently, and therefore are more likely to need complex or multiple treatments. Adding extra charging bands could help to resolve these issues for patients, by reducing the huge jump in costs between bands two and three. For example, an extra charging band could be inserted between the current bands two and three to cover the cost of a single major treatment such as a crown.

4.12 There is some evidence that the costs of some NHS treatments have actually increased under the reforms. According to an NHS dentist, for example, a patient now has to pay twice as much for a crown as they did under the old charging system⁴⁷. Furthermore, Londoners believe that the new contract has increased the cost of NHS care. Ten times as many Londoners in our survey thought the costs of dental care have increased in the past two years compared to those who thought the costs have gone down⁴⁸. As section three shows, costs can be a major barrier to dental care, so the new charging system could actually lead to a reduction in dental attendance.

Recommendation 5: The Department of Health needs to revise the dental charge banding structure to ensure that it is equitable and encourages regular attendance. The Department should consider adding extra charging bands between bands one and two, and between bands two and three.

Problems with the dental budget

4.13 The ringfenced dental budgets given to PCTs by the Department of Health for 2006-09 are set using historical levels. It is unclear whether these levels have been adjusted to meet increasing demand linked to London's growing population. PCTs can use their local budgets to supplement central funding. However, because of the huge number of competing demands on their local budgets, PCTs are unlikely to be able to significantly supplement their ringfenced Department of Health allocations.

4.14 The new funding system means that PCTs can only have a limited impact on altering services to ensure they meet demands. PCTs must reinvest any money saved from dentists quitting the NHS back into local dental services. However, the funding for dental care a PCT receives from central government has been based mainly on the level of NHS provision in that area during 2004/05, rather than a population needs analysis. This means that it will be difficult for PCTs to address any historical under-provision in their area, as they have little or no new money to do this. Therefore, the new contract will do little to tackle the uneven spread of provision outlined in the table under paragraph 3.13, meaning that patients in areas of lower provision such as South-West London may continue to struggle to find a dentist.

'It will be difficult for PCTs to address any historical under-provision in their area, as they have little or no new money to do this.'

4.15 The lack of flexibility in the funding system has led to some patients experiencing problems accessing care. Dentists are now paid a fixed amount of money for undertaking a fixed number of treatments, based on the number of treatments they carried out in 2004/05. This lack of flexibility in the funding system meant that some dentists completed their target number of NHS treatments before the end of the 2006/07 financial year, and so had to stop providing NHS treatment until the new contract year started⁴⁹.

- 4.16 There has been a shortfall in predicted patient charge revenue during the first year of the new contract. The amount of money the Department of Health allocates to PCTs for commissioning NHS dental care assumes the PCTs will receive a certain amount of income from fee-paying patients. A number of PCTs have had a shortfall in terms of expected patient charge revenue for 2006/07. As an example, Hammersmith and Fulham PCT had a shortfall of £350,000, which equates to around five percent of their total dental budget⁵⁰. The shortfall in patient charge revenue could lead to financial problems for PCTs, especially those that are still dealing with deficits. According to a representative of the Federation of London Local Dental Committees, some London PCTs have decided to hold back some of their dental budget to make up the shortfall from patient fees, rather than spending this money on commissioning dentists to provide treatments⁵¹. This could lead to patients experiencing further difficulties in accessing NHS dental care.
- 4.17 The ringfenced dental budget for PCTs is due to end in 2009, creating a situation of uncertainty for the future of NHS dental funding. After April 2009, funding for dental services will simply be included in PCTs main (unified) health budgets⁵². This means that dental services will have to compete for funding against all other services that a PCT funds, many of which have Department of Health targets attached to them. This could lead to a reduction in funding for NHS dental services.
- 4.18 All PCTs should have undertaken an oral health needs assessment and be developing a strategy to tackle these needs. Because ringfencing of funding will end in 2009, the Committee calls on each PCT to develop a detailed financial plan for how much it will cost to deliver high quality, easy to access NHS dental services in their local area, at the same time as tackling any particular oral health needs they have identified through their needs assessments. NHS London could then gather together these costs to give the Department of Health a clear sense of the costs of providing NHS dental care across London post 2009, to help ensure London PCTs receive realistic and fair funding allocations for dental services.

Recommendation 6: After April 2009, the Department of Health should base PCTs' dental funding allocations on local needs assessments, rather than historical provision.

Limitations of the new dental contract

- 4.19 The new contract does not specifically reward dentists for providing advice on preventing oral health problems.⁵³ Preventive advice should form an integral part of any course of treatment, but dentists do not get paid

anything extra for providing this advice. There is therefore no real incentive for NHS dentists to provide preventive advice to their patients. They get paid the same whether they do or do not give advice. As a result, our survey found that 86 percent of people going to private dentists received oral health advice at their last visit, compared to just 69 percent of those who had NHS only treatment⁵⁴. The fact that people using NHS services are less likely to receive preventive advice could compound the oral health inequalities faced by people in deprived communities. Furthermore, the fact that the new contract does not explicitly incentivise dentists to provide preventive care means that the reform's aim of increasing the time dentists spend on prevention⁵⁵ is very unlikely to be met. Therefore, the Committee believes that the Department of Health should consider how provision of preventive care can be more explicitly built into the way NHS contracts are managed and monitored in the future, and should consider whether dentists should receive separate financial rewards for providing preventive advice.

- 4.20 The 2006 reforms have not made it easier for patients to choose a good quality NHS dentist, as there is no publicly available ratings information on dentists. NHS Primary Care Contracting has started working with PCTs and dentists to develop a balanced scorecard to assess how practices are performing in terms of the quality of the patient experience, clinical practice and the practice environment⁵⁶. The Committee welcomes this quality assessment work, and feels that it is essential that the scorecard results are made publicly available, and that PCTs should use balanced scorecards to manage and monitor contracts, and withhold funding to dentists that do not meet minimum requirements.

Recommendation 7: The Department of Health should consider how it could revise the current NHS dental contract so that preventive care is more explicitly built into the way PCTs manage and monitor dental contracts and should consider whether dentists should be separately rewarded financially for providing preventive advice.

Recommendation 8: The Department of Health should ensure that performance ratings from dentists' balanced scorecards are made available to the public to help them choose a good quality dentist.

Conclusion

- 4.21 The Committee welcomes many aspects of the new contract, and notably that commissioning is now in the hands of PCTs who are starting to alter services to better meet local needs. However the setting of funding using historical 2004/05 levels, the lack of flexibility in the funding system and the design of the new patient charging scheme have meant that some

Londoners have experienced problems accessing the NHS care they need. Therefore, the Committee calls on the Department of Health to ensure future funding allocations for dentistry are based on a needs assessment, rather than historical funding, and to revise the patient charging system and dental contract so that patients have equitable access to dental services, and so that dentists are rewarded for undertaking preventive work.

Endnotes

- 1 “Up to one million Londoners to lose their NHS dentist” Evening Standard, 10 April 2006; “One in three dentists ditch NHS patients “ Evening Standard, 2 May 2006; “Thousands left without access to NHS dentists” Daily Telegraph, 29 March 2007
- 2 Written submission - NHS London
- 3 Written submission - NHS London
- 4 NHS Dental Statistics for England 2006/07, August 2007, Information Centre for Health and Social Care
- 5 NHS Dental Statistics for England: Quarter 4: 2007, June 2007, Information Centre for Health and Social Care
- 6 Transcript of Health and Public Services Committee Meeting 11 July 2007
- 7 See graph under para 3.13
- 8 NHS Dental Statistics for England: 2006/07; Information Centre for Health and Social Care - Birmingham figures are for the Heart of Birmingham PCT
- 9 NHS Dental Statistics for England: 2006/07; Information Centre for Health and Social Care
- 10 Based on a London population of 5,842,000 people aged 18+. 3.5% of this figure is 204,470 and 17% is 993,140. Adult population figure from Greater London Demographic Review 2005, 2006, Greater London Authority. 4% of respondents stated that they had never visited a dentist, but 0.5% had actually visited a dentist abroad.
- 11 London Health Observatory website, Adult Dental Health Survey 1998; 2000, Kelly M et al; A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 12 The dental caries experience of 5-year-old children in England and Wales 2003-04; 2005, BACD
- 13 Primary Care Trust Survey of Patients, 2005, Healthcare Commission
- 14 Primary Care Trust Survey of Patients, 2005, Healthcare Commission
- 15 Primary Care Trust Survey of Patients, 2005, Healthcare Commission

- 16 A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 17 Focus on London 2007; 2007 Greater London Authority and Office for National Statistics
- 18 Written submission - Tower Hamlets PCT
- 19 Adult Dental Health Survey 1998, 2000, Kelly et al; Written submissions from Lewisham PCT, Hillingdon PCT, Redbridge PCT, Department of Health and the British Association for the Study of Community Dentistry; Transcript of Health and Public Services Committee 11 July 2007; a Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 20 Focus on London 2007, GLA and Office for National Statistics
- 21 Written submission - Tower Hamlets PCT
- 22 Transcript of Health and Public Services Committee 11 July 2007
- 23 A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 24 Transcript of Health and Public Services Committee 11 July 2007, Written submission - The Federation of London Local Dental Committees
- 25 Written submission - Citizens Advice
- 26 Transcript of Health and Public Services Committee, 11 July 2007
- 27 Written submissions from Federation of London Local Dental Committees, Lambeth PCT, Tower Hamlets PCT, Islington PCT
- 28 Transcript of Health and Public Services Committee 11 July 2007
- 29 Written submission - Department of Health, A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 30 Analysis of data on London NHS dentists from www.nhs.uk in April 2007
Data for Sutton and Merton PCT relates to September 2006, due to a lack of more up to date information

- 31 Information in this table was taken from data on www.nhs.uk in April 2007 regarding available NHS dentists by PCT area
- 32 Transcript of Health and Public Services Committee, 11 July 2007; Written submission - Tower Hamlets PCT
- 33 Transcript of Health and Public Services Committee, 11 July 2007
- 34 Written submissions - Department of Health, Tower Hamlets PCT, Lewisham PCT
- 35 A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly:
- 36 NHS Dental Reforms - one year on, 2007, Department of Health
- 37 NHS Dental Statistics 2006/07, August 2007, The Information Centre for Health and Social Care
- 38 NHS Dental Statistics 2005/06 and 2006/07, The Information Centre for Health and Social Care. There were 3,841 NHS dentists in London in March 2007, compared to 4,120 in March 2006.
- 39 Written submissions from Redbridge, Havering and Hillingdon PCTs
- 40 NHS Dental Statistics 2005/06 and 2006/07, The Information Centre for Health and Social Care.
- 41 Written submission - Tower Hamlets PCT; NHS Dental Reforms: one year on, 2007, Department of Health, Transcript of Health and Public Services Committee Meeting 11 July 2007
- 42 NHS Dental Reforms: One year on, 2007, Department of Health
- 43 Transcript of Health and Public Services Committee Meeting 11 July 2007
- 44 Written submission - Lewisham PCT
- 45 Written submission - Lewisham PCT; The written submission from Tower Hamlets PCT also states that fewer paying patients are having band two and three treatments compared to charge exempt patients.

- 46 Written submission- Tower Hamlets PCT, Transcript of Health and Public Services Committee 11 July 2007, Richmond and Twickenham PCT.
- 47 Transcript of Health and Public Services Committee Meeting 11 July 2007
- 48 A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 49 Transcript of Health and Public Services Committee 11 July 2007
- 50 Transcript of Health and Public Services Committee 11 July 2007
- 51 Transcript of Health and Public Services Committee 11 July 2007
- 52 NHS Dental Reforms: one year on, August 2007, Department of Health; Transcript of Health and Public Services Committee 11 July 2007
- 53 Preventive work is included within Band 1 of the courses of treatment along with doing an examination, providing dietary advice and providing topical fluoride solutions to prevent caries.
- 54 A Survey on NHS Dental Services in London, August 2007, GFK for the London Assembly
- 55 NHS Dental Reforms: one year on, August 2007, Department of Health
- 56 NHS Dental Reforms: One year on, August 2007, Department of Health

Appendix 1:

How we conducted this investigation

Call for written evidence

The following organisations responded to our call for written evidence in April 2007

- British Association for the Study of Community Dentistry
- British Dental Association
- Citizen's Advice Bureau
- Croydon LDC
- Department of Health
- Federation of Local London Dental Committees
- Havering PCT
- Hillingdon PCT
- King's College London Dental Institute
- Kingston PCT
- Lambeth PCT
- Lewisham PCT
- London Borough of Islington
- London Borough of Merton
- Mount Vernon Dental Specialists
- Redbridge PCT
- Richmond and Twickenham PCT
- Royal Borough of Kingston Upon Thames
- Royal London Hospital
- Southwark PCT
- The Strategic Health Authority: NHS London
- Tower Hamlets PCT

In addition, a letter was sent to local newspapers across London. Fourteen Londoners and two retired dentists responded to this call for views and information.

Site Visit

In June 2007, Members of the Committee visited Tower Hamlets PCT's Community Dental Access Project. This project involves mobile outreach dental surgeries that provide dental advice and NHS treatment for people who live in areas where access to NHS dental care and/ or uptake of NHS dental care is poor. The mobile surgeries also visit services for people such as drug users whose chaotic lifestyles make them unlikely to access mainstream health services. This Community Dental Access Project was set up to address the fact that uptake of NHS dental care was low in Tower Hamlets, despite need for NHS dental services being high. The Committee Members who attended had an opportunity to meet the managers of the service, NHS dentists and link workers who work on the mobile surgeries, and patients who use the mobile surgeries.

Survey of Londoners' views and experiences

The Committee commissioned GFK NOP to undertake a survey of 1,000 Londoners views and experiences of NHS dental care in the capital. The survey was conducted in June- July 2007, and a report of the findings is available at www.london.gov.uk/assembly

Public Meeting

A public meeting was held in July 2007 to discuss the issues arising from the call for written evidence, the site visit and the survey. The following people attended the meeting to answer Committee Members questions:

- Nick Kendall, Acting Dental Public Health Advisor to NHS London and Consultant in Dental and Public Health, South West London PCTs
- Sara Osborne, Director of Policy and Knowledge, British Dental Association
- Henrik Overgaard-Nielsen, NHS Dentist and Chair of the Federation of London Local Dental Committees
- Jenny Gallagher, Senior Lecturer and Hon. Consultant in Dental Public Health, Kings College London Dental Institute, and London Dental Health and Education Strategic Partnership
- Sophie Chapman, Social Policy, Campaigns and Development Officer, Citizens Advice
- Andrew Ridley, Director of Primary Care Commissioning, Tower Hamlets PCT.

A transcript of the meeting is available at www.london.gov.uk/assembly

For further information on this investigation or how it was conducted, please contact Sarah Hurcombe, Assistant Scrutiny Manager, on 020 7983 6542 or email Sarah.Hurcombe@london.gov.uk

Appendix 2:

Principles of London Assembly scrutiny

An aim for action

An Assembly scrutiny is not an end in itself. It aims for action to achieve improvement.

Independence

An Assembly scrutiny is conducted with objectivity; nothing should be done that could impair the independence of the process.

Holding the Mayor to account

The Assembly rigorously examines all aspects of the Mayor's strategies.

Inclusiveness

An Assembly scrutiny consults widely, having regard to issues of timeliness and cost.

Constructiveness

The Assembly conducts its scrutinies and investigations in a positive manner, recognising the need to work with stakeholders and the Mayor to achieve improvement.

Value for money

When conducting a scrutiny the Assembly is conscious of the need to spend public money effectively.

Appendix 3:

Orders and translations

How to order

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