Written evidence submitted by The Local Government Association (DTY0047)

1. About the Local Government Association

1.1. The Local Government Association (LGA) is the national voice of local government. We are a politically led, cross-party membership organisation, representing councils from England and Wales.

1.2. Our role is to support, promote and improve local government, and raise national awareness of the work of councils. Our ultimate ambition is to support councils to deliver local solutions to national problems.

2. Summary

2.1. The LGA and councils are concerned that many people are unable to register with an NHS dentist and as a consequence they are not provided with regular, restorative and preventative dental care.

2.2. In October, the LGA published stark analysis that showed a shortage in affordable dental treatments for communities all over the country. There is significant regional variation in access to NHS dental care. In particular, it is concerning that it is rural areas as well as those living with the highest levels of deprivation that are more likely to miss out on NHS dental provision.

2.3. Many councils already have a strong base within local General Dental Practices and the majority of dentists are already providing an excellent service, including a number of prevention and enhanced services. Through their health and wellbeing boards and health overview and scrutiny committees, councils have been trying to work with local dentists, and trying to improve access, particularly to emergency dental care.

2.4. The scope of health services needs to expand to include a responsibility to improve health outcomes in addition to providing treatment. Improving health by focusing on prevention also improves the cost-effectiveness of services. Intervening early through universal and targeted interventions reduces the need for more specialist services in later years.

2.5. NHS England must engage local authorities within the planning and evaluation of local dental services, influencing the preventive focus of dental services. In particular, local authorities have unique powers around health scrutiny, which enable them to review the planning, provision and operation of health services in their area. This specifically allows local authorities to seek assurance that there is equitable access to dental services for children and young people focused on their needs.

2.6. As highlighted by the Office for Health Improvement and Disparities, tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Councils will want to work with their ICSs to ensure that children services, schools, community and voluntary groups and primary care work together to maximise children and young people's dental health. Potentially, ICSs have a coordinating role in this work.

3. What steps should the Government and NHS England take to improve access to NHS dental services?

3.1. Access to NHS dental services has been a key issue both nationally and locally. The LGA and councils are concerned that many people are unable to register with an NHS dentist and as a consequence they are not provided with regular, restorative and preventative dental care. The LGA has warned that the current crisis in NHS dentistry is having a disproportionate impact on high needs patients, in already underserved communities.

3.2. Millions of patients are struggling to access NHS dentistry, there is a growing gulf in terms of access and provision across the country, and funding pressures and an acute shortage of NHS dentists mean hundreds of dental practices may have to close in the years ahead.

3.3. An estimated ten million people in the UK are currently waiting for routine dental treatment and 19 million appointments have been missed during the pandemic, according to the British Dental Association.

3.4. In October, the LGA published stark analysis that showed a shortage in affordable dental treatments for communities all over the country. There is significant regional variation in access to NHS dental care. In particular, it is concerning that it is rural areas as well as those living with the highest levels of deprivation that are more likely to miss out on NHS dental provision.

3.5. A lack of NHS dentists has led to people choosing to forgo routine dental treatments or even resort to DIY dentistry, risking more costly emergency dental treatments being needed further down the line.

3.6. Many councils already have a strong base within local General Dental Practices and the majority of dentists are already providing an excellent service, including a number of prevention and enhanced services. Through their health and wellbeing boards and health overview and scrutiny committees, councils have been trying to work with local dentists, and trying to improve access, particularly to emergency dental care.

3.7. There are a number of actions needed to improve access:
   - 3.7.1. Whilst there is considerable local work being undertaken to improve dental health, now is the time to refine and refocus our work post pandemic and ramp up our preventative approaches to ensure support is being delivered for the right people, in the right places.
   - 3.7.2. We will not solve problems of decayed, missing and filled teeth only by only improving access to dental services. Improving access to dental care does not necessarily equate with improvements in oral health. Improving oral health and reducing oral health inequalities requires community-based oral health promotion programmes and a more prevention-focused dental service.
   - 3.7.3. NHSE who are the responsible commissioner are doing best they can to maximise access for our residents within a difficult contractual environment and probably not able to fix the privatisation of dentistry without fundamental national shift.
   - 3.7.4. Councils need real terms increase in their public health grant so they can provide vital oral health improvement programmes to prevent longer term health problems.
   - 3.7.5. The Government should reform the contract it has with dental surgeries as well as develop a workforce strategy to ensure we can have affordable dental treatments for communities across the country.
   - 3.7.6. Despite the continuing problems with NHS dentistry and inequalities in children's oral health in particular, there has been no mention of a coherent strategy for dental services nor any commitment for additional NHS dentistry funding.
   - 3.7.7. Greater clarity in the information about NHS dentistry– improving information, including online, so that people have a clear picture of where and how they can access services, as well as the cost.
   - 3.7.8. Look at using dental practices to support people's general health – harnessing opportunities, working in partnership with local authority public health teams, to link oral health to other key issues, such as weight management and smoking cessation. For example, the Healthy Living Dentistry (HLD) Programme is unique to Wigan and builds on the success of the Healthy Living Pharmacy (HLP) Programme

nationally. The primary aim of the HLD Programme is to demonstrate the quality and effectiveness of community dentistry services, and to show how they contribute to better health and wellbeing services overall.

3.8. The Health and Social Care Act 2012 conferred the responsibility for health improvement, including oral health improvement, to local authorities. Local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys.

3.9. Many risk factors for oral health are also risk factors for poor general health and thus in supporting and promoting oral health, we are also effectively helping patients to care for their general health.

3.10. As highlighted by the Office for Health Improvement and Disparities, tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable.

3.11. The scope of health services needs to expand to include a responsibility to improve health outcomes in addition to providing treatment. Improving health by focusing on prevention also improves the cost-effectiveness of services. Intervening early through universal and targeted interventions reduces the need for more specialist services in later years.

3.12. NHS England must engage local authorities within the planning and evaluation of local dental services, influencing the preventive focus of dental services. In particular, local authorities have unique powers around health scrutiny, which enable them to review the planning, provision and operation of health services in their area. This specifically allows local authorities to seek assurance that there is equitable access to dental services for children and young people focused on their needs

3.13. Although oral health is improving in England, the oral health survey of five year olds in 2019 showed that just under a quarter have tooth decay. Each child with tooth decay will have on average three to four teeth affected. For those children at risk, it can happen early in life. The oral health survey of three year olds in 2020 found that 11 per cent had visible tooth decay, with on average three teeth affected.

3.14. It is important to consider that untreated dental problems can eventually lead to more serious health problems (for instance, infections), which then have to be treated in hospitals, adding strain to NHS services (including through A&E attendances).

3.15. When tooth decay progresses irreversibly in children the only solution is tooth extraction, which in most cases has to happen under general anaesthetic in hospital. The literature shows that one child is admitted to hospital for tooth extractions in the UK every 10 minutes.

3.16. Out of these children who had missed school, 52 per cent had to miss one day, 19 per cent missed two days and 8 per cent missed three days, as tooth decay can cause problems with eating and sleeping as well as causing pain. Public Health England estimate that at least 60,000 days are missed from school during the year for hospital extractions alone (Public Health England, Child Oral Health: Applying All Our Health, 2019).

4. What role should ICSs play in improving dental services in their local area?

4.1. NHS England currently commission dental services but the intention is that all primary care commissioning will be delegated to ICBs at some point in the future. We believe in

subsidiarity in decision-making so would support devolving commissioning of dental services to the most appropriate local level – this could be ICSs to take advantage of their system-wide overview and ability to deploy resources, or could be place or primary care network level.

4.2. Access to NHS dentistry is an ongoing and significant concern for many areas – especially in poorer areas. Many Health and Wellbeing Boards have raised this as one of their key priorities for improving health. Therefore, we would support delegation of more resources to the most local level.

4.3. Children and young people's dental health is a big concern for many councils. They will want to work with their ICSs to ensure that children services, schools, community and voluntary groups and primary care work together to maximise children and young people's dental health. Potentially, ICSs have a coordinating role in this work.

5. Does the NHS dental contract need further reform?

5.1. The Dental profession is facing significant challenges with regard to NHS contractual arrangements and patient charges. There's a significant call from across the political spectrum for a rapid and radical reform of NHS dentistry, the way it's commissioned and provided.

5.2. Despite tweaks to the NHS Dental contract over the years, the original arrangements were aimed to provide greater access to NHS dentistry for all, improving oral health and enabling NHS dentists to spend more time with each patient and avoiding a "treadmill" of treatments.

5.3. Units of Dental Activity (UDAs) were introduced as a measure of dental activity and as the basis of renumerating dentists employed by the NHS in 2006, and they proved problematic.

5.4. A report issued by the National Audit Office in November 2004 entitled "Reforming NHS Dentistry: Ensuring Effective Management of Risks" and the resulting report from the Public Accounts Committee (PAC) in April 2005. These reports correctly highlighted the risk that as a consequence of the contractual reforms that took place at the time, some dentists may reduce their NHS commitments.

5.5. Although the 2006 contract was meant to sort many of the challenges out, clearly it did not. While somewhat reassuring to see that recent proposals have a more detailed focus on prevention, there have been over 15 years of patient access challenges and a significant loss of morale in the NHS dental workforce.

5.6. Our message to the Government is that they need to look at the contracts they're offering the profession and take seriously the concerns that are being raised by the LGA, councillors and others. There needs to be meaningful engagement with all key stakeholders, patients, dentists and local system leaders and testing of any refreshed system before it is rolled out.

6. What incentives should be offered by the NHS to recruit and retain dental professionals, and what is the role of training in this context?

6.1. In 2021, approximately 37.2 thousand dental practitioners were in employment in the UK. In recent years, the number of dental practitioners has generally decreased in the UK, as in 2015 there were roughly 46 thousand dentists in employment.

6.2. To improve access to NHS dentistry around the UK, especially for the most deprived

communities, there is strong public support nationwide for the recruitment of highly skilled dentists from overseas, with nearly four-out-of-five people (78 per cent) supporting overseas recruitment of skilled clinicians.

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