REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC):

Dentistry Services in Oxfordshire

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Report to:
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- Dan Leveson (Director for Places and Communities, Thames Valley ICB).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on the current state of dentistry services in Oxfordshire in its public meeting on 11 June 2026.

2. The Committee would like to thank Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire, Thames Valley ICB) and Dan Leveson (Director for Places and Communities- Thames Valley ICB) for attending the meeting and answering questions from the Committee.

3. The topic of dentistry services is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the Thames Valley Integrated Care Board (ICB) to improve access to NHS dentistry services throughout the County.

4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:

   - Progress update against the Committee's previous recommendations on dentistry services.
   - The current position on access to NHS dentistry in Oxfordshire.
   - How access varies geographically within the county**,** including rural/urban differences where known.
   - Details of any local flexibilities available to the ICB in relation to dentistry commissioning and how these have been used in Oxfordshire since April 2024; including any reinvestment of underspends.
   - Whether decisions have been taken to target resources at areas or groups with the greatest need, and on what basis.
   - Any action being taken locally to improve children's oral health, especially among deprived communities;
   - How the ICB is working with local authorities and schools to support prevention, rather than relying solely on treatment-based solutions.
   - Details on workforce recruitment and retention in NHS dentistry services**.**

- How information about NHS dentistry access is communicated to Oxfordshire residents.

SUMMARY

5. During the 11 June 2026 meeting, the Strategic Lead for Primary Care advised that since the previous scrutiny session in 2024, four new dental practices had opened across Oxfordshire, including in rural areas, and that the system had replaced more activity than had been lost following contract handbacks after the pandemic period. Additional urgent care capacity had been commissioned, with practices delivering thousands of additional urgent appointments in line with national policy objectives.

6. The discussion highlighted the continuation of a flexible commissioning scheme, through which a significant number of vulnerable patients had accessed dental care. There was also an introduction of oral health promotion initiatives aimed at children, including early engagement in schools and nurseries.

7. The Committee queried what trajectory the Integrated Care Board expected for recovery and what interventions would be required to close that gap. The Strategic Lead for Primary Care acknowledged that returning to pre-pandemic levels would be challenging, citing changes in public behaviour, growth in private provision, and workforce constraints. The reformed dental contract, including the requirement for a proportion of appointments to be made available for urgent care, was intended to improve access and reduce the number of practices closed to new patients.

8. The Committee explored urgent dental care pathways and their integration with NHS 111. Members raised concerns about the reliance on urgent care provision and the sustainability of delivering such care predominantly through general practice. It was explained that urgent care was provided through a combination of high-street practices, commissioned urgent care slots, and the community dental service, including some out-of-hours provision. However, the new contract had only recently been introduced and it would take time to assess its impact on access patterns, including weekend demand.

9. Members also examined health inequalities and rural access, noting significant variation between districts, and highlighted data showing lower contract delivery rates and reduced access in areas such as Cherwell and the Vale of White Horse. In response, the Strategic Lead for Primary Care confirmed that variation existed and identified recruitment difficulties, geographic factors, and historic contract arrangements as key drivers. The Integrated Care Board was seeking to rebalance activity through commissioning decisions and to target additional provision to areas of highest unmet need.

10. The Committee examined workforce challenges, particularly in recruiting dentists to underserved areas. It was responded that although financial incentives had been introduced to support recruitment, only a small number of practices had successfully recruited staff to date, reflecting wider workforce

shortages. Reference was made to the lack of a dental school in the region as a structural challenge and how there were ongoing discussions at the regional level regarding training capacity.

11. Significant discussion took place regarding water fluoridation. The Director of Public Health confirmed that the evidence base remained clear that fluoridation was the most effective population-level intervention to reduce tooth decay, particularly among children. However, he explained that implementation was complex, involving legal, logistical and public acceptability challenges, including coordination with water companies and neighbouring regions.

12. The Committee discussed the limitations of data available to commissioners, noting that unlike general practice, dental data was relatively restricted. The Associate Director confirmed that the Integrated Care Board had limited visibility beyond activity data and urgent versus routine classification, which constrained strategic planning. Members emphasised the need for improved data in order to support effective scrutiny and commissioning decisions.

KEY POINTS OF OBSERVATION:

13. This section highlights six key observations and points that the Committee has in relation to dentistry services in Oxfordshire. These six key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

Supporting Public Engagement on Water Fluoridation as Part of a Long-Term Strategy to Improve Oral Health in Oxfordshire: In recommending that system partners continue to pursue previous requests to Government for a local public consultation and engagement exercise on the fluoridation of Oxfordshire's water supply, and that opportunities to work with any future Thames Valley Combined Authority should also be explored, the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) sought to emphasise the importance of prevention within the wider oral health agenda. The recommendation was not intended as an endorsement of fluoridation itself, nor as a proposal to bypass public debate. Rather, it reflected the Committee's view that Oxfordshire residents should be afforded the opportunity to engage with the substantial body of evidence surrounding one of the most significant population-level oral health interventions currently available and to participate in an informed discussion about its potential role within the county's future public health strategy[1].

The Committee reached this position following consideration of the report submitted as part of this item which highlighted both the progress and the continuing challenges associated with NHS dentistry across Oxfordshire and the wider Thames Valley area. Although access to NHS dental services has improved considerably since the pandemic, the

[1] [post.parliament.uk]

report demonstrated that access levels remain below those achieved prior to 2020. Across the Buckinghamshire, Oxfordshire and Berkshire West system, approximately 46% of the population had attended an NHS dental service within the previous two years by March 2026, compared to more than 51% before the pandemic. The report also outlined continuing challenges relating to workforce shortages, treatment backlogs, population growth, recruitment difficulties in rural areas and persistent inequalities in access to care. These challenges continue despite substantial local investment, the opening of new practices, targeted commissioning programmes, urgent care initiatives and major reforms to the national dental contract.

The Committee therefore recognised that while improvements to NHS dental services remain essential, improvements to treatment services alone are unlikely to be sufficient to address the underlying causes of poor oral health or to significantly reduce future demand for dental treatment. The report submitted to the Committee repeatedly highlighted the growing importance of prevention as a central principle underpinning future dental commissioning arrangements. This is reflected through the Children's Oral Health Improvement Programme, the expansion of supervised toothbrushing schemes, the introduction of new prevention-focused elements within the national dental contract and the wider ambition of the Thames Valley ICB to improve population health outcomes and reduce inequalities. Water fluoridation sits firmly within this preventative agenda.

From a public health perspective, fluoridation is distinct from many other oral health interventions because its benefits are delivered automatically across the whole population without requiring individuals to seek care, register with a dentist, pay for treatment or actively change their behaviour. This characteristic is particularly important in a context where access to NHS dentistry remains challenging for many residents. The Parliamentary Office of Science and Technology's comprehensive review of the evidence in 2024 concluded that there remains strong scientific evidence demonstrating that water fluoridation improves dental health outcomes and reduces levels of tooth decay. The review further noted that dental disease remains one of the most common preventable health conditions affecting children across England and remains a significant contributor to avoidable hospital admissions and wider health inequalities[2].

For the Committee, one of the most compelling aspects of the fluoridation debate relates to inequality. Throughout its work on health services, the JHOSC has consistently highlighted the need to address unequal outcomes experienced by different communities. Oral health is no exception. Nationally, children living in more deprived communities continue to experience significantly higher rates of tooth decay, are more likely to require hospital treatment and are less likely to enjoy good oral

[2] [post.parliament.uk], [researchbr...liament.uk]

health throughout adulthood. These inequalities often begin early in life and can persist for decades. The Government's 2026 Water Fluoridation Health Monitoring Report found that the benefits associated with fluoridated water supplies were particularly apparent amongst children living in more deprived communities, with evidence demonstrating reductions in tooth decay and related treatment requirements. Importantly, the report found no evidence of adverse impacts on children's cognitive development and no convincing evidence of wider health harms associated with fluoridation schemes operating within regulated parameters[3].

The Committee was also mindful that England already possesses decades of practical experience of fluoridation from which lessons can be drawn. Around six million people currently receive fluoridated water supplies, including large populations within the West Midlands, parts of the North East and other areas of England. These schemes provide a substantial evidence base regarding implementation, operation, governance arrangements, monitoring requirements and public health outcomes. Indeed, Government guidance continues to identify fluoridation as one of several evidence-based interventions capable of improving oral health alongside supervised toothbrushing, fluoride varnish programmes and wider preventative measures. The recommendation therefore reflected a belief that Oxfordshire residents should have the opportunity to understand the experiences and evidence emerging from these areas when considering whether fluoridation may have a role to play locally[4].

The economic dimension of the issue is also relevant. The dentistry report submitted to the Committee described substantial efforts by the Integrated Care Board to increase capacity, recover lost activity, improve urgent care provision, recruit additional dentists and commission new dental practices. These interventions represent significant investment and are likely to remain necessary for the foreseeable future. However, there is increasing evidence that prevention can contribute to reducing future treatment requirements and associated costs. The University of Manchester's LOTUS study, one of the largest studies of water fluoridation ever undertaken, examined the experience of approximately 17.8 million adults and adolescents over a ten-year period. The study found that people receiving optimally fluoridated water experienced fewer invasive dental treatments, lower NHS treatment costs and lower patient charges than those living in non-fluoridated areas. The researchers concluded that fluoridation remained cost-effective and generated savings over time through avoided treatment activity. While fluoridation is clearly not a substitute for accessible dental services, the findings suggest that it may contribute to a more sustainable oral healthcare system when combined with other preventative interventions[5].

[3] Water fluoridation: health monitoring report for England 2026 - GOV.UK
[4] [gov.uk], [acmedsci.ac.uk], [post.parliament.uk]
[5] [sites.manc...ster.ac.uk], [acmedsci.ac.uk]

Importantly, the Committee's recommendation recognises the constitutional and legislative context in which fluoridation decisions are now made. Under the Health and Care Act 2022, responsibility for introducing, varying or terminating water fluoridation schemes rests with the Secretary of State for Health and Social Care rather than local authorities. The dentistry report submitted to the Committee noted that the Integrated Care Board itself does not possess the statutory authority to initiate fluoridation consultations. However, the report also acknowledged that officers were aware of the potential oral health benefits associated with fluoridation and its capacity to contribute towards the reduction of oral health inequalities. The Committee therefore concluded that it remained entirely appropriate for local system partners, public health organisations and elected representatives to continue advocating for a public consultation process that would enable local views to be gathered and considered by Government.

The reference to future collaboration with any Thames Valley Combined Authority reflects the broader changes occurring across local government and NHS structures. The establishment of the Thames Valley ICB has already created a more strategic footprint for healthcare planning, whilst Local Government Reorganisation and devolution proposals may lead to the creation of new regional governance arrangements in the future. Given that water fluoridation schemes often operate across large geographical areas and require coordination between public health bodies, water companies, local authorities and central government, any future Combined Authority could provide an important mechanism through which evidence gathering, public engagement and health improvement initiatives may be coordinated at scale. This would be particularly relevant where population health challenges extend beyond individual county boundaries.

Ultimately, the Committee's recommendation reflects a wider principle that has consistently underpinned its scrutiny of healthcare services: that prevention should receive the same level of attention as treatment. Considerable progress is being made to restore and improve NHS dentistry across Oxfordshire, but the scale of current and future demand means that preventative measures will be increasingly important if improvements in oral health are to be sustained. Water fluoridation remains one of the most extensively researched oral health interventions available internationally. While reasonable debate continues regarding its application, the Committee considered that the evidence base is sufficiently significant to justify a formal programme of public consultation and engagement. Supporting that conversation would allow Oxfordshire residents to make informed judgements about a proposal that could have long-term implications for oral health, health inequalities and the sustainability of dental services across the county for generations to come.

Recommendation 1: *For system partners to pursue previously made requests to government by the JHOSC to support a local public consultation/engagement on fluoridating Oxfordshire's water supply. It is recommended that system partners work with any future combined authority at the Thames Valley level to further support this.*

Reviewing the local Impact of NHS Dental Contract Reforms: The Committee welcomes evidence of improvements in NHS dental activity, the opening of new practices, increased urgent care provision and investment in preventative initiatives, but remains mindful that significant challenges continue to affect residents seeking NHS dental care. It was against this backdrop that the Committee recommended that the Thames Valley ICB launch a formal review of the local impacts of the changes being introduced through the reformed NHS dental contract and that this review should involve key stakeholders, including the JHOSC itself.

This recommendation reflects the Committee's view that the reforms currently being implemented are of such significance that they should be subject to structured local evaluation. The report presented to the Committee for this item explicitly noted that the changes being introduced from April and June 2026 represent the most substantial reforms to NHS dentistry since the introduction of the national dental contract in 2006. These changes include new urgent care payment arrangements, mandatory urgent care activity levels, complex care pathways for patients with higher levels of need, enhanced support for preventative interventions, funded quality improvement programmes and new approaches to workforce development. Given the scale of these reforms, the Committee considered it both reasonable and necessary that their impact should be assessed locally rather than relying solely upon national performance reporting.

The rationale for undertaking such a review begins with the long-standing challenges that have characterised NHS dentistry nationally. For many years, concerns have been raised regarding the sustainability of the NHS dental contract and the extent to which it has supported access to care. Successive parliamentary inquiries, professional bodies and health policy organisations have highlighted concerns regarding recruitment and retention, difficulties in securing NHS dental appointments, and questions about whether the Unit of Dental Activity (UDA) system appropriately rewards practices for treating patients with complex oral health needs. The House of Commons Health and Social Care Committee's report on NHS dentistry concluded that the existing arrangements had contributed to widespread access challenges and called for substantial reform of the contractual framework[6].

Similarly, the National Audit Office observed that, despite significant expenditure on NHS dentistry, many patients continued to experience difficulties accessing services and that fundamental reform would be necessary if long-term improvements were to be achieved. Its analysis

[6] https://committees.parliament.uk/publications/40571/documents/197217/default/

highlighted the gap between demand for NHS dental services and available capacity, emphasising the importance of ensuring that contractual arrangements incentivise the right outcomes[7].

The national reforms introduced during 2026 are intended to address many of these concerns. NHS England's new Quality and Payment Reform programme introduces the most extensive package of changes since the creation of the current contract model. These reforms seek to create stronger incentives for practices to provide urgent care, encourage preventative dentistry, improve the management of patients with significant oral health needs and support quality improvement activities[8].

However, whilst the ambitions behind the reforms are welcome, the Committee recognised that successful implementation cannot be assumed. National policies often produce different outcomes depending upon local circumstances, and Oxfordshire presents a distinctive environment in which to assess these changes. The county contains rapidly growing areas such as Didcot, Bicester and parts of the Science Vale, alongside more rural communities where access challenges can be particularly acute. Workforce pressures, demographic changes and patterns of deprivation vary considerably across the county. Consequently, a policy that appears successful nationally may not necessarily produce the same outcomes in every locality.

The Committee was particularly interested in understanding whether the reforms achieve one of their primary objectives: improving access to NHS dental care. The report submitted to the Committee demonstrated that progress has already been made. Across the former Buckinghamshire, Oxfordshire and Berkshire West footprint, the number of residents accessing NHS dental services increased substantially between 2022 and 2026. Nevertheless, access levels remain below those achieved before the pandemic. The report further acknowledged that many residents still struggle to obtain routine NHS dental appointments and that demand continues to exceed available capacity in some areas.

A local review would therefore provide an opportunity to determine whether the contractual reforms are translating into meaningful improvements for Thames Valley residents. This evaluation should not be limited to headline activity levels. It should examine whether more people are able to secure appointments, whether waiting times are reducing, whether residents are travelling shorter distances for care, and whether communities previously identified as underserved are experiencing tangible improvements in access.

[7] https://www.nao.org.uk/reports/progress-in-improving-nhs-dentistry/

[8] https://www.england.nhs.uk/long-read/nhs-dentistry-quality-and-payment-reforms-contractual-guidance/

The Committee also considered the importance of examining whether the reforms are delivering positive outcomes for vulnerable groups and helping to reduce oral health inequalities. The Thames Valley ICB has already established several initiatives aimed at improving access for populations who often experience significant barriers to dental care, including looked-after children, refugees and asylum seekers, people with learning disabilities, pregnant women, residents of care homes and other vulnerable groups. The JHOSC is keen to ensure that the new contractual arrangements strengthen rather than undermine this work.

This focus on inequalities is consistent with broader national policy. The Government's prevention strategy for oral health, *Delivering Better Oral Health*, emphasises that dental disease is largely preventable and highlights the importance of targeted interventions to address inequalities experienced by disadvantaged communities[9]. The Committee further recognised that workforce sustainability will be central to determining whether the reforms are ultimately successful. The Thames Valley ICB report highlighted the use of Golden Hello schemes, recruitment incentives and other workforce support measures designed to attract dentists to harder-to-recruit areas. Yet workforce shortages remain one of the most significant barriers to increasing NHS dental capacity. The reformed contract aims to improve the attractiveness of NHS practice by better recognising the complexity of patient care and improving remuneration arrangements. A structured review would allow the ICB to assess whether these intended workforce benefits are being realised and whether recruitment and retention challenges are beginning to ease.

The Committee was equally interested in the preventative aspirations underpinning the reforms. One of the principal criticisms of the previous contract was that it placed insufficient emphasis on prevention and incentivised activity rather than outcomes. The reforms seek to address this by supporting interventions such as fluoride varnish applications, quality improvement programmes and care pathways designed to improve oral health over time. This aligns with broader national evidence demonstrating that prevention represents one of the most cost-effective approaches to improving oral health outcomes.

The Committee therefore considered it essential that a review should assess not only activity levels but also evidence relating to prevention. The review should seek to understand whether preventative interventions are being delivered more consistently, whether practices are engaging with quality improvement programmes and whether there are early indications of improvements in oral health outcomes amongst children and adults.

[9] https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention

Importantly, the JHOSC recommendation emphasised the need for stakeholder involvement throughout the review process. The Committee recognises that quantitative performance measures alone would be insufficient to understand the full impact of the reforms. Patients, providers, local authorities, Healthwatch organisations, public health experts and community representatives all possess valuable insights that should inform any evaluation.

The involvement of the JHOSC itself is particularly important. As the statutory scrutiny body responsible for examining health services affecting Oxfordshire residents, the Committee has an established role in holding system partners to account and representing the interests of local communities. Participation within the review would help ensure transparency, provide democratic oversight and strengthen public confidence in the process and its conclusions.

Ultimately, this JHOSC recommendation reflects a straightforward but important principle: major reforms should be accompanied by robust evaluation. The Thames Valley ICB has inherited responsibility for implementing the most significant package of changes to NHS dentistry in two decades. It has also inherited responsibility for ensuring that these changes deliver meaningful benefits for residents. By undertaking a structured review involving a broad range of stakeholders, the ICB would place itself in a stronger position to identify successes, address emerging challenges and ensure that future commissioning decisions are informed by local evidence rather than national assumptions.

For these reasons, the Committee concluded that a formal review of the local impact of dental contract reform is both necessary and proportionate. Such a review would support accountability, strengthen partnership working, ensure that the experiences of patients and providers are properly understood and, ultimately, help maximise the likelihood that the reforms deliver lasting improvements in access, quality, prevention and oral health outcomes across Oxfordshire and the wider Thames Valley system.

Recommendation 2: *For the Thames Valley ICB to launch a review of the local impacts of changes being made to the dental contract. It is recommended that there is stakeholder involvement in this review, including the JHOSC.*

***Addressing Rural and Wider Oral Health Inequalities in Oxfordshire*:** Whilst the Committee welcomes evidence of improvements in NHS dental activity, increased urgent care provision, the opening of new dental practices and targeted initiatives for vulnerable groups, it remains concerned that significant inequalities continue to affect both oral health outcomes and access to NHS dentistry across the county. It was for this reason that the Committee recommended that system partners take collective action to reduce the effects of rural inequalities on poor dental outcomes and access to NHS dentistry, develop robust data indicators at District and Neighbourhood level to improve visibility of local

population need, and strengthen action to address broader inequalities affecting vulnerable groups and disadvantaged communities.

The recommendation reflects a long-standing concern of the Committee that access to healthcare services cannot be viewed solely through the lens of overall service performance. Whilst improvements are clearly being made across Thames Valley, the Committee recognised that some communities continue to face significantly greater barriers to accessing NHS dentistry than others. Rural communities, in particular, often experience a combination of challenges including workforce shortages, limited public transport, longer travel times, dispersed populations and reduced availability of NHS providers. These issues are not unique to Oxfordshire, but they are highly relevant to a county containing extensive rural areas across West Oxfordshire, the Vale of White Horse, South Oxfordshire and parts of Cherwell.

The report received by the Committee for this item highlighted examples of progress in addressing access challenges. Four new dental practices had opened within Oxfordshire since the previous scrutiny item, including in Chipping Norton, Witney, Milton and Faringdon, all locations serving significant rural populations. Commissioners had also succeeded in replacing more activity than had been lost following contract handbacks after the pandemic and had introduced a range of initiatives aimed at expanding urgent care and improving access for vulnerable groups. The Committee welcomes these developments and recognises the considerable work undertaken by the Integrated Care Board. However, the Committee also noted that approximately 46 per cent of the population had attended an NHS dentist within the previous two years, compared with over 51 per cent before the pandemic. This demonstrates that, despite progress, significant unmet need remains.

The Committee was particularly mindful that access challenges are often more severe in rural communities. National research increasingly demonstrates that geographical inequalities play a significant role in determining whether people are able to secure NHS dental care. A neighbourhood-level study published in the *European Journal of Public Health* found substantial spatial disparities in NHS dental accessibility across England and concluded that both deprivation and rurality are important determinants of access. The research identified significant differences in the availability of NHS dental provision between urban and rural communities and highlighted how the closure of even a single practice can have major consequences for local accessibility in rural areas[10]. Similarly, analysis undertaken by the Local Government Association identified persistent "dental deserts" across England and found that rural communities are significantly more likely to have lower levels of NHS dental provision. The research highlighted the uneven distribution of NHS practices and warned that poor access risks worsening broader health inequalities[11].

[10] Spatial disparities in access to NHS dentistry: a neighbourhood-level analysis in England.
[11] Persistent dental deserts risk deprived and rural communities being left behind.

There is also evidence that oral health inequalities extend far beyond geography alone. Poor oral health is strongly associated with deprivation, social exclusion and vulnerability. The Office for Health Improvement and Disparities' review *Inequalities in Oral Health in England* concluded that oral health inequalities remain a significant public health challenge throughout England and affect communities across the life course. The report highlights substantial inequalities by socioeconomic status, deprivation, geographic location and vulnerable group status. It further notes that groups including homeless people, looked-after children, travellers, prisoners and people experiencing social exclusion often experience considerably poorer oral health whilst simultaneously facing the greatest difficulties in accessing dental services[12].

These findings closely align with evidence presented within the Thames Valley ICB report to the JHOSC, which highlighted that local flexible commissioning programmes had specifically targeted groups known to experience barriers to care, including looked-after children, refugees, asylum seekers, pregnant women, residents of care homes and people with learning disabilities. The continuation of these programmes demonstrates that inequalities within oral health are already apparent locally and require targeted intervention. The Committee welcomed these initiatives but felt there was a need to go further by developing a more comprehensive understanding of where unmet need exists and how it varies between communities.

A key element of the recommendation therefore relates to data. The absence of consistently available oral health and dentistry access indicators at District, locality and Neighbourhood level limits the ability of the system to identify where intervention is most required. This concern is not new. During previous scrutiny of dentistry provision in 2023, the Committee recommended the creation of a baseline dentistry dataset that could be used to understand patterns of oral health, deprivation, service utilisation and access across Oxfordshire. It was argued that improved data would allow commissioners and partners to better identify disparities, target resources more effectively and monitor whether interventions were achieving their intended impact.

This recommendation is arguably even more relevant in the context of the NHS's growing emphasis on neighbourhood health planning. National policy increasingly seeks to understand population health needs at a much more granular level than traditional county-wide metrics allow. The NHS 10-Year Health Plan and the development of neighbourhood models of care place considerable emphasis on understanding local variation and targeting resources where they will have the greatest impact. Without comprehensive local indicators relating to dental attendance, oral health outcomes, workforce availability, deprivation and vulnerable populations, there is a risk that communities with the greatest need remain hidden within aggregate county-wide statistics.

[12] Inequalities in Oral Health in England.

The Committee also considered the importance of public and stakeholder engagement in tackling oral health inequalities. Good oral health is shaped by a wide range of factors extending well beyond dental treatment alone. Educational attainment, income, housing conditions, health literacy, dietary habits, community infrastructure and access to preventative services all influence oral health outcomes. For this reason, reducing inequalities requires collective action involving local authorities, NHS organisations, schools, parish councils, voluntary organisations, community groups and residents themselves.

There are positive examples of such approaches elsewhere in the country. The supervised toothbrushing programmes introduced in parts of the North West, the Greater Manchester oral health improvement initiatives, and targeted community engagement programmes undertaken in areas of the North East have demonstrated the benefits of combining preventative interventions with local community engagement. Similarly, national guidance contained within *Delivering Better Oral Health* emphasises the value of community-based prevention programmes and targeted interventions aimed at populations experiencing the greatest levels of disadvantage[13].

The Committee recognises that Thames Valley ICB has already made progress in this area through its Children's Oral Health Improvement Programme, support for supervised toothbrushing initiatives and targeted commissioning arrangements. However, the scale of oral health inequalities across Oxfordshire warrants a more coordinated system-wide response which places reducing inequalities at the centre of future planning and commissioning decisions.

Ultimately, this recommendation reflects the belief that improving overall access to NHS dentistry, whilst important, is not sufficient on its own. A service can improve at aggregate level whilst continuing to leave behind particular communities, rural areas and vulnerable groups. The Committee therefore concluded that system partners should adopt a more sophisticated and targeted approach to understanding and addressing oral health inequalities. This requires better local intelligence, stronger data, greater visibility of need at neighbourhood level and meaningful engagement with the communities most affected by poor oral health outcomes.

The recommendation is therefore both preventative and strategic in nature. It seeks to ensure that future improvements in NHS dentistry are distributed fairly across Oxfordshire and that the benefits of investment are experienced not only by the average resident, but also by those communities that have historically experienced the greatest challenges in accessing dental care. By combining improved data, place-based planning, targeted interventions and meaningful stakeholder engagement, system partners can place themselves in a significantly

[13] Delivering Better Oral Health: An Evidence-Based Toolkit for Prevention.

stronger position to reduce oral health inequalities and improve outcomes for all residents across Oxfordshire's urban, rural and vulnerable populations.

Recommendation 3: *For system partners to take collective action to reduce the effects of rural inequalities on poor dental outcomes and on access to NHS dentistry; and to develop data indicators at all District and Neighbourhood levels to provide visibility to population need and other/rural health inequalities affecting oral health and dentistry access. It is also recommended that strong measures are taken, including through public/stakeholder engagements, to tackle broader inequalities around oral health, including amongst vulnerable population groups.*

Reinvesting NHS Dentistry Underspends into Areas of Greatest Need in Oxfordshire: The Committee has examined evidence regarding improvements in urgent dental provision, ongoing workforce challenges, inequalities in access to care, children's oral health initiatives and future developments in NHS dental commissioning. Whilst the JHOSC welcomes evidence that some improvements had been achieved since its previous review of dentistry services in 2024, it remains concerned that significant inequalities in access to NHS dentistry persist across Oxfordshire. In response to the evidence presented, the Committee recommended that NHS dentistry underspends should be reinvested into those areas experiencing the worst dentistry access in order to improve oral health outcomes across the County. This recommendation reflects broader national policy objectives, established public health principles, academic evidence regarding health inequalities, and growing concerns about the sustainability of NHS dental services nationally. It is a recommendation rooted in the principle that resources intended for dentistry should remain focused on improving dentistry services and should be directed towards those communities where unmet need is greatest.

This recommendation emerges against the backdrop of one of the most significant access crises in the history of NHS dentistry. Despite dentistry being a core component of the NHS since its foundation in 1948, access to NHS dental services has deteriorated significantly over the past decade. The House of Commons Health and Social Care Committee concluded in its *report on NHS Dentistry* that access to NHS dentistry had become one of the most frequently raised concerns by members of the public and described the system as being in need of fundamental reform. The Committee noted widespread concerns about geographical inequalities, workforce shortages and the inability of existing arrangements to meet patient demand[14].

National evidence demonstrates that difficulties accessing NHS dentistry are not simply an inconvenience but constitute a significant public health challenge. The World Health Organization's Global Oral Health Status Report 2022, estimates that oral diseases affect approximately 3.5 billion

[14] https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html.

people worldwide and identifies oral health as an essential component of overall health and wellbeing. The report highlights clear associations between poor oral health and wider health inequalities, emphasising that disadvantaged populations consistently experience poorer oral health outcomes than more affluent groups[15].

These findings are highly relevant to Oxfordshire. Whilst the county is often regarded as relatively affluent, significant inequalities exist both between and within communities. The evidence presented to the JHOSC highlighted continuing concerns regarding workforce recruitment, geographical access, rural provision and the distribution of services throughout the county. Although improvements had been reported in some areas of urgent access and patient activity, the Committee heard that ensuring equitable access to NHS dentistry remains a substantial challenge.

One of the strongest justifications for the Committee's recommendation lies in the contradiction that exists between significant unmet patient demand and continuing underspends within NHS dentistry budgets. Across England, NHS dental budgets have repeatedly been underspent despite widespread reports of patients being unable to secure routine NHS appointments. The National Audit Office's investigation into the government's dental recovery programme found that hundreds of millions of pounds allocated for NHS dentistry have remained unspent in recent years. Importantly, these underspends were not caused by a lack of public demand. Rather, they reflected workforce shortages, recruitment challenges, contractual limitations and difficulties delivering commissioned activity[16].

Similarly, the British Dental Association has consistently argued that dental funding should be protected and reinvested into dental services wherever possible. The Association has reported significant levels of underspend across England whilst simultaneously highlighting record levels of unmet patient need[17].

The existence of underspends under such circumstances raises important questions about equity and public accountability. If dental funding was originally allocated to improve access to care, and if substantial populations remain unable to access NHS dentistry, there is a compelling argument that any unspent funding should remain within dental services rather than being diverted elsewhere. Therefore, reinvestment offers a practical mechanism to ensure that public resources continue serving their intended purpose.

This recommendation is also firmly grounded in the principles of health inequality reduction. The landmark Marmot Review, *Fair Society, Healthy*

[15] https://www.who.int/publications/i/item/9789240061484
[16] https://www.nao.org.uk/reports/investigation-into-the-nhs-dental-recovery-plan/,
[17] https://bda.org/news-centre/latest-news-articles/pages/Millions-meant-for-patients-going-unspent-as-government-fails-to-save-NHS-dentistry.aspx.

Lives, introduced the concept of "proportionate universalism". This principle argues that whilst services should be available universally, additional resources should be directed towards those communities experiencing the greatest levels of need. The review concluded that reducing health inequalities requires deliberate action to address unequal distributions of health, wealth and access to services.

Applied to dentistry, this principle suggests that additional investment should not necessarily be distributed equally across all communities. Rather, it should be directed towards areas where residents experience the greatest barriers to care and the worst oral health outcomes. Such an approach would allow Oxfordshire to maximise the impact of any available resources by targeting interventions towards those populations most likely to benefit.

Furthermore, academic literature strongly supports this position. Research published in the *British Dental Journal* has repeatedly demonstrated clear associations between deprivation, rurality and poor dental access[18]. Studies have consistently found that populations living in disadvantaged or geographically isolated communities experience higher rates of untreated tooth decay, lower utilisation of preventative services and greater difficulties securing NHS appointments. Similar findings have been reported by research published in the *Community Dentistry and Oral Epidemiology journal*[19].

The Committee's recommendation is further reinforced by evidence demonstrating the significant economic value of preventative oral healthcare. Poor oral health creates substantial costs for individuals, healthcare systems and wider society. Research published in the *Journal of Dental Research* has repeatedly shown that preventive dental interventions generate long-term savings by reducing the need for more costly restorative and emergency treatment[20]. Similarly, evidence reviewed by the Office for Health Improvement and Disparities has demonstrated that investments in oral health promotion programmes frequently deliver substantial returns through reductions in disease burden and hospital admissions[21].

Perhaps nowhere is the importance of prevention more evident than in children's oral health. Dental decay remains one of the leading causes of hospital admissions among young children for procedures performed under general anaesthetic. NHS England has repeatedly highlighted the need to improve preventative oral health services and reduce inequalities in childhood dental disease[22]. Improving access to NHS dentistry in underserved communities would support earlier intervention, greater

[18] https://www.nature.com/bdj/,
[19] https://onlinelibrary.wiley.com/journal/16000528
[20] https://journals.sagepub.com/home/jdr
[21] https://www.gov.uk/government/collections/oral-health
[22] https://www.england.nhs.uk/long-read/nhs-dentistry-and-oral-health-update/.

uptake of preventative care and ultimately improved oral health outcomes for future generations.

Examples from elsewhere in England also demonstrate the value of targeted investment. The Government's Dentistry Recovery Plan introduced targeted "golden hello" recruitment incentives, mobile dental initiatives and enhanced commissioning arrangements specifically aimed at areas experiencing the worst access problems. The policy explicitly recognised that some communities face disproportionately severe challenges and therefore require disproportionately greater support[23]. This philosophy mirrors approaches taken elsewhere across healthcare and public health policy. Whether addressing health inequalities, primary care workforce shortages, or access to preventative services, policymakers increasingly accept that targeted investment often delivers greater improvements than uniform investment. Reinvesting dentistry underspends into those parts of Oxfordshire experiencing the poorest access would therefore be entirely consistent with established national policy approaches.

Ultimately, the recommendation made by the JHOSC reflects a straightforward but important principle: where dentistry funding cannot initially be utilised as intended, it should remain within dentistry and be redirected towards those communities experiencing the greatest unmet need. The evidence considered by the Committee demonstrated that significant challenges remain regarding access to NHS dentistry, workforce sustainability, rural provision and health inequalities across Oxfordshire.

In this context, reinvesting dentistry underspends into underserved communities represents not merely a sensible financial decision but an important commitment to equity, prevention and population health improvement. It is a recommendation that aligns with national policy objectives, reflects the findings of leading academic research, is supported by public health evidence, and offers a practical mechanism through which oral health outcomes can be improved for those Oxfordshire residents who currently face the greatest barriers to accessing NHS dental care.

Recommendation 4: *For NHS dentistry underspends to be reinvested in the areas of worst dentistry access in Oxfordshire to improve oral health outcomes within the County.*

Supporting Oral Health Promotion Through Neighbourhood Health Planning and Community Partnerships: The Committee welcomes evidence of improvements in urgent dental access, expanded commissioning initiatives, children's oral health programmes and efforts to increase workforce recruitment. However, improving NHS dental services alone would not be sufficient to address the underlying causes

[23] Faster, Simpler and Fairer: Our Plan to Recover and Reform NHS Dentistry.

of poor oral health across the county. Consequently, the Committee recommended that system partners should continue to support oral health promotion, using neighbourhood health planning at community level as an opportunity to pursue this work, and that parish and town councils, schools and grassroots community organisations should be utilised to support these efforts. This recommendation reflects a growing consensus across public health, healthcare policy and academic research that lasting improvements in oral health require prevention, community engagement and action on the wider determinants of health, rather than reliance upon clinical treatment alone. The recommendation is particularly relevant at a time when the NHS is increasingly seeking to shift from a model focused primarily on treatment towards one centred on prevention, population health management and neighbourhood-based care.

The recommendation is fundamentally rooted in the understanding that oral health is not merely a dental issue but a significant public health issue that affects wider health, wellbeing and life chances. The World Health Organization's Global Oral Health Status Report 2022 notes that oral diseases affect approximately 3.5 billion people worldwide and remain among the most common non-communicable diseases globally. The report highlights that oral diseases share many of the same risk factors as cardiovascular disease, diabetes, obesity, respiratory disease and certain cancers, including unhealthy diets, tobacco use, harmful alcohol consumption and socioeconomic disadvantage[24].

The importance of prevention has also been emphasised repeatedly within national policy. The Government's *Faster, Simpler and Fairer: Our Plan to Recover and Reform NHS Dentistry* explicitly identifies prevention and oral health improvement as central components of long-term dentistry reform. The policy recognises that improving access to treatment alone will not be sufficient to narrow oral health inequalities and that greater emphasis must be placed on preventative approaches, community engagement and early intervention[25].

The evidence presented to the Committee for this item demonstrated that system partners are already supporting children's oral health programmes and undertaking targeted commissioning initiatives designed to improve access amongst groups facing the greatest barriers to care. However, the Committee recognised that oral health outcomes are profoundly shaped by factors that sit outside the formal healthcare system. These include educational attainment, health literacy, dietary habits, deprivation, housing conditions, social isolation and broader community circumstances. Consequently, improving oral health requires action across entire communities rather than solely within dental surgeries.

A particularly important aspect of the recommendation concerns the use of neighbourhood health planning as a vehicle for oral health

[24] https://www.who.int/publications/i/item/9789240061484.

[25] Our Plan to Recover and Reform NHS Dentistry.

improvement. This reflects broader national policy developments within the NHS. The NHS Long Term Plan established a clear ambition to strengthen place-based and neighbourhood-level approaches to improving population health[26]. More recently, NHS England's emerging neighbourhood health service model has placed increasing emphasis on partnership working between healthcare providers, local authorities, schools, voluntary organisations and local communities[27].

The rationale for this approach is well-established within academic literature. Research consistently demonstrates that health interventions are more effective when delivered within communities and shaped by local relationships. A substantial body of evidence published in journals such as *Social Science & Medicine* and *BMC Public Health* has shown that community-based health promotion programmes can improve health literacy, increase uptake of preventative services and reduce health inequalities. In oral health specifically, research published within the *Community Dentistry and Oral Epidemiology journal* has repeatedly demonstrated that community-level interventions are most successful when local stakeholders play an active role in programme design and delivery[28].

The Committee's specific reference to parish and town councils reflects the important role that local democratic institutions can play in supporting health improvement. Parish and town councils are often amongst the most trusted and accessible local institutions within communities. Their detailed understanding of local circumstances enables them to identify community needs, promote health initiatives, facilitate engagement opportunities and support local campaigns. Whilst parish councils have not traditionally been viewed as healthcare partners, increasing emphasis has been placed nationally upon utilising community assets to improve health outcomes. The Local Government Association has highlighted the growing importance of local councils in supporting preventative health interventions through its publication *Prevention in Action*[29].

Moreover, schools represent another crucial component of the Committee's recommendation. The importance of school-based oral health interventions is strongly supported by academic evidence. Research published in the *British Dental Journal* and the *Journal of Public Health Dentistry* has shown that school-based oral health education programmes can significantly improve oral hygiene behaviours, increase knowledge regarding healthy diets, and reduce levels of dental decay amongst children. Schools provide an unparalleled opportunity to reach children and families at an early stage, thereby supporting lifelong oral health habits. The significance of this work is underscored by continuing concerns regarding childhood oral health

[26] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[27] https://www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-2026/.
[28] https://onlinelibrary.wiley.com/journal/16000528
[29] https://www.local.gov.uk/topics/social-care-health-and-integration/public-health/prevention

nationally. Data published by the Office for Health Improvement and Disparities demonstrates that tooth decay remains one of the leading causes of hospital admissions amongst young children[30]. The Committee therefore recognised that schools provide a natural platform through which oral health promotion activities can be embedded into wider programmes concerned with healthy lifestyles, nutrition and wellbeing.

There are also numerous examples from elsewhere in England demonstrating the effectiveness of community-based oral health promotion. Greater Manchester's Starting Well programme has successfully worked with schools, communities and dental practices to improve access and oral health outcomes among children living in deprived communities[31]. Similarly, supervised toothbrushing schemes operating across several local authority areas, including programmes supported in Yorkshire and the North East, have demonstrated measurable reductions in dental decay amongst participating children. These initiatives have frequently relied upon partnerships between schools, community organisations and healthcare providers.

The recommendation's emphasis on grassroots community organisations is equally important. Community groups often have relationships with residents who may be less likely to engage with traditional public services. This includes disadvantaged populations, minority ethnic communities, vulnerable adults and individuals experiencing social exclusion. Evidence from public health research has repeatedly shown that trusted local organisations can be highly effective in promoting healthy behaviours and supporting healthcare engagement. The King's Fund has highlighted the importance of harnessing the strengths of community assets within preventative health programmes, as outlined in its work on population health and community-centred approaches[32].

This recommendation being made by the JHOSC is also consistent with wider policy developments concerning integrated care systems. A core objective of integrated care is to address the social, economic and environmental factors that influence health outcomes. The Health and Care Act 2022 strengthened requirements for integrated care systems to improve population health, tackle inequalities and work collaboratively with local partners. Promoting oral health through neighbourhood planning and community partnerships directly supports these objectives by bringing together healthcare organisations, local authorities, education providers and community groups around a shared public health goal.

Ultimately, the recommendation made by the JHOSC reflects a recognition that improving oral health outcomes requires a whole-system and whole-community response. While access to NHS dental services

[30] https://www.gov.uk/government/collections/oral-health
[31] https://www.england.nhs.uk/long-read/starting-well-core/
[32] //www.kingsfund.org.uk/publications/population-health-systems

remains critically important, long-term improvements in oral health will only be achieved through sustained investment in prevention, health promotion and community engagement. The evidence considered by the Committee demonstrated that positive work is already taking place across Oxfordshire, including children's oral health initiatives and outreach programmes. However, the Committee concluded that these efforts should be strengthened further through neighbourhood health planning and deeper collaboration with parish and town councils, schools and grassroots organisations.

Such an approach aligns with national NHS policy, public health best practice, academic evidence and the broader ambitions of integrated care. Most importantly, it offers an opportunity to improve oral health outcomes before problems develop, reduce inequalities between communities, strengthen local resilience and ensure that oral health becomes a shared responsibility across the whole system rather than solely the responsibility of dental services. By embedding oral health promotion within neighbourhood-level planning and community partnerships, Oxfordshire would be well positioned to develop a preventative, community-centred model of oral health improvement capable of delivering lasting benefits for residents across the county.

Recommendation 5: *For system partners to continue to support oral health promotion, using neighbourhood health planning at community level as an opportunity to pursue this. It is recommended that system partners utilise parish and town councils and schools, as well as grassroots community organisations, to support this work.*

Supporting the Establishment of a Local Dental School: The Committee remains concerned about the long-term sustainability of the dental workforce and the continuing difficulties many residents experience in accessing NHS dental services. In response to these concerns, the Committee recommended that the Thames Valley Integrated Care Board (ICB) should continue to engage with the Dentistry Deanery to support the case for a local dentistry school to be established as a matter of urgency. This recommendation reflects a growing recognition that the workforce challenges facing NHS dentistry are structural rather than temporary and that sustainable solutions will require long-term investment in professional education, training infrastructure and workforce development. The recommendation is not simply about increasing the number of dentists; rather, it is about creating a resilient local workforce pipeline capable of supporting the future oral health needs of Oxfordshire and the wider Thames Valley region.

The starting point for understanding this recommendation is the national workforce crisis currently affecting NHS dentistry. Over the past decade, concerns regarding workforce shortages have become increasingly prominent within national health policy discussions. The House of Commons Health and Social Care Committee concluded in its report *NHS Dentistry* that workforce shortages represented one of the most significant barriers to improving access to NHS dental services and

highlighted growing concerns regarding recruitment and retention across many parts of England[33].

Similarly, NHS England's Long Term Workforce Plan identified dentistry as one of several healthcare professions where training capacity would need to increase significantly if workforce demand was to be met over the coming decades. The plan acknowledged that demographic growth, increasing healthcare demand and changing patient expectations require substantial expansion of professional training pathways[34]. The recommendation made by the JHOSC aligns closely with these national objectives by recognising that workforce shortages cannot be solved solely through short-term recruitment initiatives and instead require investment in local education infrastructure.

The evidence presented to the Committee for this item highlighted that workforce recruitment remains a challenge in parts of Oxfordshire despite initiatives including incentive schemes and targeted commissioning approaches. The JHOSC explored issues relating to recruitment difficulties, workforce sustainability and persistent challenges in ensuring adequate provision across all parts of the county. These concerns were particularly notable in relation to certain rural and underserved communities where recruiting NHS dentists has historically proved more difficult.

A substantial body of academic evidence suggests that the location of professional training has a significant influence upon where clinicians ultimately choose to practise. Research published in the *journal Medical Education* has consistently demonstrated that healthcare professionals frequently establish careers in regions where they undertake their education and postgraduate training[35]. Similar findings have been identified in dentistry. Research published in the *British Dental Journal* has shown that dental graduates often remain within the geographic areas in which they have trained, particularly when high-quality clinical placements and postgraduate opportunities are available locally[36].

This relationship between education and workforce retention has become a major consideration in healthcare workforce planning across the United Kingdom. Health Education England, prior to its integration into NHS England, repeatedly emphasised the importance of developing regional educational infrastructure to support local workforce needs. The rationale is straightforward: if a region lacks a dental school, students frequently leave the area to pursue education elsewhere and may subsequently establish careers in those regions after graduation. Conversely, regions with strong educational and training institutions are often better positioned to recruit and retain healthcare professionals over the long term.

[33] https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/964/report.html
[34] https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan/,
[35] https://onlinelibrary.wiley.com/journal/13652923,
[36] https://www.nature.com/bdj

For Oxfordshire and the wider Thames Valley area, this issue is particularly significant. The region contains one of the fastest-growing populations in England and has experienced substantial housing growth across communities including Didcot, Bicester, Witney and other parts of the county. Population growth inevitably increases demand for healthcare services, including dentistry. The Office for National Statistics has consistently projected continuing population growth across much of southern England, creating additional demand pressures upon healthcare systems[37].

At the same time, the Thames Valley region remains one of the few larger population centres in England without its own established dental school. This contrasts with other parts of the country where dental schools play a crucial role in supporting local healthcare economies. For example, the University of Plymouth Peninsula Dental School was explicitly established with the objective of addressing regional workforce challenges and improving access to dental services across Devon and Cornwall[38].

The Plymouth example is particularly relevant because it demonstrates how a dental school can contribute not only to workforce supply but also to patient care. The Peninsula Dental School operates teaching clinics that provide care to local communities whilst students undertake supervised clinical training. Academic evaluations of the model have suggested that it has contributed to increasing local workforce capacity and improving access to services in areas historically affected by workforce shortages. Research examining the impact of the school has been published through the *British Dental Journal*[39]. Similarly, the establishment of the University of Central Lancashire School of Dentistry in Preston was motivated in part by concerns regarding workforce supply in the North West of England[40]. These examples demonstrate that educational institutions are increasingly being viewed as strategic tools for addressing regional healthcare workforce challenges.

The Committee's recommendation is also supported by evidence concerning the economic and social benefits generated by health education institutions. Universities and professional schools frequently act as anchors for innovation, research, economic development and community engagement. Dental schools support clinical research, facilitate partnerships between healthcare providers and academic institutions, and create opportunities for workforce development across multiple professional groups, including dental therapists, hygienists, nurses and technicians. The General Dental Council's publication *Shaping the Dental Team* highlights the increasingly multidisciplinary

[37]https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections

[38] https://www.plymouth.ac.uk/schools/peninsula-dental-school

[39] https://www.nature.com/bdj

[40] https://www.uclan.ac.uk/schools/medicine-and-dentistry

nature of modern dentistry and the need for integrated educational pathways that support the entire dental workforce[41].

Furthermore, this recommendation being issued by the Committee also aligns with the government's broader ambitions regarding preventative healthcare and neighbourhood-based services. Modern dental schools increasingly emphasise community dentistry, public health and outreach work as part of their educational programmes. The World Health Organization's *Global Oral Health Status Report* advocates stronger links between oral health services, public health interventions and academic institutions. By establishing a dental school within the Thames Valley region, opportunities could be created for students to support community-based oral health initiatives, undertake placements in underserved areas and contribute to neighbourhood-level prevention programmes.

In addition, a local dental school could strengthen research capacity relating to oral health inequalities. Oxfordshire contains world-leading academic institutions and health research infrastructure. A dental school could complement existing healthcare research activity and contribute to evidence-based approaches for addressing inequalities in access, improving prevention and supporting innovation within NHS dentistry. The National Institute for Health and Care Research has increasingly emphasised the importance of applied research partnerships between academia and healthcare providers[42].

Hence, the recommendation made by the JHOSC recognises that many of the challenges facing NHS dentistry cannot be resolved through short-term interventions alone. Whilst recruitment incentives, contract reform and targeted commissioning initiatives all have an important role to play, sustainable access to NHS dental services will ultimately depend upon the development of a strong and resilient workforce pipeline. The evidence considered by the Committee highlighted continuing concerns regarding recruitment, workforce sustainability and equitable access to care across Oxfordshire.

In this context, continuing to engage with the Dentistry Deanery and other relevant partners to support the establishment of a local dental school represents a strategic and forward-looking response. Such an institution would have the potential to strengthen workforce recruitment and retention, increase regional training capacity, support community dentistry, improve access to care, enhance research and innovation, and contribute to the long-term sustainability of NHS dentistry across Oxfordshire and the wider Thames Valley. The recommendation is therefore firmly grounded in workforce evidence, national health policy, academic research and the Committee's broader objective of securing equitable and sustainable dental services for future generations.

[41] https://www.gdc-uk.org/docs/default-source/quality-assurance/shaping-the-dental-team.pdf
[42] https://www.nihr.ac.uk

Recommendation 6: *For the ICB to continue to engage with the Dentistry Deanery to support the case for a local dentistry school to be established urgently.*

Legal Implications

14. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  Power to scrutinise health bodies and authorities in the local area
  Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

15. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

16. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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