Wolverhampton Joint Strategic Needs Assessment

Children and Young People's Oral Health

Acknowledgements

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1. Scope

Improving children's oral health is a multi-agency partnership priority in Wolverhampton. This Joint Strategic Needs Assessment (JSNA) aims to provide a comprehensive picture of the oral health status and needs of children and young people (CYP) across the city. It also seeks to map existing services and community assets, helping to identify gaps in provision, areas of higher need, and opportunities to better target resources to improve outcomes. This JSNA will also explore the factors influencing CYP oral health outcomes, such as access to care, health behaviours, and the impact of socio-economic factors. The findings will inform local commissioning decisions and support the development of strategies and targeted initiatives to ensure that oral health services and interventions effectively meet the needs of children and young people, reduce health inequalities, and improve oral health outcomes across the city.

2. Executive Summary

2.1 Introduction

Oral health refers to the condition of the mouth, teeth, and gums. Poor oral health can significantly impact overall health, wellbeing, and quality of life. Children and young people from disadvantaged backgrounds are more likely to experience poor oral health, which can affect their physical development, school readiness, attendance, and self-esteem. If not addressed early, these issues can lead to long-term health inequalities, including ongoing pain, infections, and barriers to accessing dental care. Promoting good oral hygiene from an early age is important- not only to prevent immediate dental problems but also to reduce persistent inequalities and support better lifelong health outcomes.

2.1.1 Local Context

Demographics and Deprivation

- In the 2021 Census, Wolverhampton had a population of over 263,000, with 64,666 (25%) aged 0-18yrs and 10,299 (4%) aged 3-5yrs.
- Deprivation is strongly associated with poor oral health outcomes. Wolverhampton ranks the 24th most deprived local authority in England, with over half the population living in highly deprived areas, many of which have the highest concentrations of children and young people.

Population Characteristics and High-Need Groups

Early Years Provision

- According to the 2025 Spring School Census, early years provision in Wolverhampton was delivered across 172 settings: 70 state-funded schools (41%) and 102 private, voluntary, or independent providers (PVI) (59%).
- A total of 2,241 children aged 3-5 accessed free early years entitlement: 65% in PVI settings, 35% in schools.

Vulnerable and High-Need Groups

- In 2022/23, over a third (34.9%) of children lived in low-income families and in 2023/24 around nearly 4 in 10 (39.7%) received free school meals, both significantly above national averages.
- In April 2025, 495 children (<18 yrs) were in care, with nearly half placed outside the city, impacting continuity of dental care. Of those who had been in care for 12 months or longer, 354 (90%) had visited a dentist in the last 12 months and 39 (10%) hadn't.
- In the 2025 Spring School Census, there were 7,536 school-aged children who were receiving Special, Educational Needs (SEN) support in the city and 3,227 children and young people have an Education, Health and Care Plan (EHCP). Of those aged 3-5 years, there were a total of 132 children with Special Educational Needs and Disabilities (SEND). The large majority (94%) were in state-funded settings (not private, voluntary or independent settings).

- The 2021 Census revealed that language barriers exist for 9,082 households - where no English spoken, limiting health literacy and access to services.
- As of June 2025, there were 595 children and young people (<18 years) classified as 'homeless' living in temporary accommodation in Wolverhampton.

Dental Data

Prevalence of dental decay (Oral Health Surveys)

- In 2023/24, approximately 2 in 10 (22%) of 5-year-old children in the area had decayed, missing, or filled teeth - in line with the national average (22%) and among the lowest compared to similar areas.
- However, by Year-6, dental decay rose to 4 in 10 (43%) in 2023- significantly higher than the national average (16%) and the highest among comparator areas.
- There were differences by demographic groups.

Dental Access and Dental Activity

- In 2023/24, 53% of 0-18s visited a dentist in the previous 12 months, similar to the national average (55%) but lower than some comparator areas.
- Wolverhampton's treatment mix shows less focus on preventive care (Band 1) and more moderately complex treatment (Band 2 & Band 3) than comparator areas.
- Wolverhampton reports the lowest level of urgent dental care across all comparator areas.
- Between 2023 and 2024, the rate of tooth extractions for individuals aged 0-19 years with dental decay as the primary diagnosis was 139.5 per 100,000, the lowest amongst all comparator authorities. The highest rate was seen in the 5-9 year age band (354.8).
- Around 7 in 10 (69%) of hospital tooth extractions among those aged 0-19 years was due to dental decay. In the 0-4 and 5-9-year group, the proportion of hospital extractions that were due to dental decay was 100%, which is consistent with comparator areas.
- In 2023-24, there were 37,540 fluoride varnish applications given to child (<18 years) patients, representing 64% of all child courses of treatment. This is similar to comparator authorities (64%) and above the national average (56%).
- In 2023-24, there were 884 fissure sealants given to child (<18 years) patients, representing 1.5% of all child courses of treatment. This is similar to comparator authorities (1.6%) and the national average (1.6%).
- Recorded data on fluoride varnish and fissure sealant applications may underestimate actual activity, as anecdotal feedback from local dentists has indicated that not all applications are consistently recorded by dental practitioners.
- COVID-19 significantly reduced dental activity, although there has been recovery, with units of dental activity (UDAs) and courses of treatment (COTs) returning to pre-pandemic levels.

Oral Health Behaviours

- The local Health-Related Behaviour Survey (2024) showed differences in hygiene routines and dental access among different demographic groups.
- Children who were significantly more likely not to have brushed their teeth twice the day before included:

    - Children in Year 6 and Year 8 from White ethnic backgrounds
    - SEND children in Year 8 and Year 10
- Children who were significantly more likely to have brushed their teeth twice the day before included:
    - Children of non-White UK ethnicity in Year 8
    - Asian children in Year 6
    - Young carers in Year 4
    - Children receiving Free School Meals (FSM) in Year 8 and Year 10
- Wolverhampton also has a significantly higher proportion of overweight and obese children compared to the national average, a known risk factor for poor oral health, related to the consumption of low-quality diets and excess sugar.

Dental Services & Quality

Dental Services

- As of June 2025, 44 dental practices operate in Wolverhampton; 25 hold NHS contracts.
- Most residents of the city have a practice within 15 mins walking distance of their home, but pockets of the East, West, and Northwest of the city experience longer travel times.
- In February 2025, the Black Country ICB had 449 NHS 111 dental-related calls. NHS 111 calls have been increasing over the past five years, reflecting demand for urgent or out-of-hours care. The Black Country ICB has similar levels of NHS 111 calls to comparator areas.

Quality & System Experience

- The GP Patient survey found that 7 in 10 (75%) residents of the Black Country had a 'very good' (43.5%) or 'fairly good' (31.3%) experience using NHS dental practices.
- In February 2024, a local mystery shopper exercise in partnership with Healthwatch, found barriers to NHS dental care access.
    - Of the 28 dental practices contacted, 5 could offer NHS check-ups for both adults and children with a waiting time of 3-8 weeks.
    - A further 5 could offer an NHS appointment for a child only.
    - 2 practices could offer emergency NHS appointments to new patients.
    - 15 practices were at full NHS capacity and advised calling back in the new financial year.
    - Private appointments were more widely available but cost between £50–£110.
- Between January and February 2024, a local survey across Family Hubs and Library settings with 100 parents responding found that 26% had never taken their child to a dentist- with access, cost, and lack of information as key barriers. Findings highlight systemic issues tied to the national NHS dental contract and reflect national trends in reduced dental access and growing health inequalities.

2.1.2 Policy Landscape

Improving children's oral health is a multi-agency partnership priority in Wolverhampton and being actively championed by city councillors in the Local Authority. The Children and Young People Scrutiny Panel, the council's watchdog for children and young people's services, held a dedicated meeting to explore this issue on 23 July 2024[1], the aim of which was to:

- highlight the importance of children's oral health in Wolverhampton
- bring key partners together to explore the challenges and opportunities to improving children's oral health in the city
- agree a set of recommendations to share with the Black Country Integrated Care System, Health and Wellbeing Together Board and Health Scrutiny Panel.

Responsibility for progressing and building on these recommendations sits with the Oral Health Partnership and the newly established Wolverhampton Dental Commissioning Steering Group, with overall strategic oversight sitting with Wolverhampton's Health and Wellbeing Board, Health and Wellbeing Together.

At a national level, The NHS Ten Year Plan (published July 2025), includes a commitment to 'fixing the foundations in dentistry'[2] with the proposed introduction of a new dental contract as a central element. The Plan highlights the importance of improved access to dental care for children, and it builds on existing and new preventive initiatives- such as supervised toothbrushing programmes, expanded use of fluoride varnish, and more widespread application of fissure sealants- all of which are proven interventions with the potential to reduce tooth decay. These reforms are intended to ensure services better meet children's needs, reduce inequalities, and improve oral health outcomes across the country. As a way to progress with this, the Government launched a major consultation[3] on the NHS dentistry contract on 8 July 2025.

Supervised Toothbrushing Programme (STP)

In March 2025, the UK government announced enhanced funding for local authorities to support the national roll-out of the Supervised Toothbrushing Programme (STP), aimed at improving oral health among young children. Launching in April 2025, the initiative will focus on children aged 3 to 5 in early years settings- including nurseries and primary schools- with a particular emphasis on areas of high deprivation.

As part of the programme, children will receive toothbrushes and fluoride toothpaste and participate in supervised group brushing sessions. Trained staff or teachers will guide the children to ensure proper brushing techniques, including using the correct amount of toothpaste, brushing for two minutes, and covering all areas of the mouth effectively.

2.1.3 Local services and community assets

Wolverhampton has implemented a range of targeted community initiatives to improve children's oral health, particularly in areas of highest need:

- **Distribution of Oral Health Supplies:** Over 49,000 toothbrushes and tubes of toothpaste have been distributed citywide through health visitors (3,500), school nurses (3,500), early years settings (3,000), and to vulnerable families via food banks and community shops (40,000).
- **Workforce Training**: More than 100 local professionals, including school nurses, health visitors, and early years practitioners, have received oral health training. This enables them to provide brief interventions and guidance to families, with the programme expanding to those working with vulnerable groups.
- **Oral Health Education in Schools:** All local schools deliver oral health education at Key Stages 1-3 as part of statutory Personal, Social, Health and Economic Education (PSHE). Schools have access to high-quality teaching resources, and are encouraged to engage parents, and align lessons with National Smile Month to boost impact.
- **Supervised Toothbrushing ('Brilliant Brushers'):** This programme targets children aged 3-5 in the most deprived areas. As of March 2025, 11 early years settings and 350 children were participating. The scheme promotes long-term tooth brushing habits, provides training and supplies to staff, and is set to expand with increased national funding in 2025.
- **Community Engagement and Co-production**: As part of National Smile Month 2024, local children co-created an oral health storybook from over 80 creative submissions, promoting positive messages through characters designed by children themselves. The storybook introduces to children the importance of oral hygiene and visiting the dentist.
- **Oral Health Toolkit:** In 2025, a comprehensive local toolkit was published to support strategic planning and upskill partners. It provides an overview of key evidence-based strategies and resources to improve children's oral health.

2.1.4 Recommendations

Oral Health Partnership

- To continue to oversee and embed a core training offer for professionals working with children and families, such as school nurses and health visitors, equipping them with the knowledge, skills and confidence to provide high quality oral health advice.
- To continue to promote dental attendance for children from when their first milk teeth appear, or before they are 12 months old, followed by regular check-ups.
- To expand on oral health resources for families where English isn't their first language to ensure access to culturally appropriate information.
- To oversee the expansion of the Brilliant Brushers programme, including for more deprived areas of the city and special school settings.

Wolverhampton Dental Commissioning Group

- To explore with the Local Dental Committee how to strengthen prevention efforts within primary dental care, going beyond health education to include risk factor management and the promotion of preventative interventions such as fluoride varnish during dental check-ups.

- To continue to oversee and improve access to dental care for all children and young people, with a focus on actively reducing oral health inequalities related to both dental disease and access to services.

City of Wolverhampton Council: Public Health and Education Excellence

- To continue to encourage schools to provide opportunities for children and young people to learn about oral health education as part of the PHSE curriculum and where appropriate participate in the local Supervised Toothbrushing Programme (Brilliant Brushers).
- To continue to promote healthy eating in our Early Years and education settings in the city.
- To better understand the oral health needs of secondary school-aged children, in line with Children and Young People Scrutiny recommendations.
- To support the undertaking of the National Dental Epidemiology Programme (NDEP) oral health surveys to maximise participation and improve data quality.

OneWolverhampton

- To embed oral health promotion within in Make Every Contact Count (MECC) initiatives, ensuring consistent and routine messaging across all relevant services.
- To continue involving children, young people and parents in co-producing oral health campaigns and materials through involvement with our health champion and youth representatives.

Health and Wellbeing Together

- To maximise the opportunities in the NHS 10 Year Plan to embed a co-ordinated approach to oral health promotion and prevention and to consider how oral health can be incorporated into a future Neighbourhood Health Plan.
- For all partners to use the needs assessment to influence commissioning of local services, and inform a range of policy decisions for example, enabling a healthy food environment.
- To promote and facilitate local data sharing mechanisms between the ICB, health partners, and the council to improve local data capture, which can then inform commissioning, service design and delivery, and evaluation of service provision.

3. Background

Introduction

Definition of 'Oral Health'

Oral health is the condition of the mouth, teeth, and surrounding areas. It plays a key role in overall well-being, supporting self-esteem, confidence, and the ability to engage in daily activities without discomfort.[4]

Impact on Children and Young People

For children and young people, good oral health is particularly important as it affects their ability to eat, socialise, and play - all key aspects of their development. Poor oral health can lead to pain, difficulty eating, speaking, and sleeping, which impacts their health and quality of life. If left untreated, dental problems can cause long-term issues, making it important to promote good oral hygiene from an early age.[5] [6] The impact of poor oral health also extends beyond physical health to education. Children with poor oral health may struggle to concentrate at schools, or have more school absences, which can impact their academic performance.

National and Regional Oral Health Trends

Although largely preventable, tooth decay remains the most common oral disease affecting children and young people and it continues to be the leading cause of hospital admissions among children aged 5-9 years. In the financial year ending 2024, there were 19,381 admissions for tooth extractions due to dental caries among children aged 5-9 years across England, a figure significantly higher than those for other common childhood conditions. This represented 20% of all hospital admissions for this age-group. Across the broader age range of 0-19 years, there were 74,800 hospital admissions for tooth extractions nationwide, with 45,800 of these procedures linked to decay-related issues. The total cost to the NHS for these admissions was estimated at £74.8 million, with £45.8 million specifically related to decay-related extractions. [7]

In the academic year 2023 to 2024, the National Dental Epidemiology Programme (NDEP) reported that over 1 in 5 (23.7%) 5-year-old children in England have experience of dentinal decay. There was geographical variation in prevalence, with the North West experiencing the highest rate of dental decay at 28.7%.[8]

At Risk/Higher-Need Population Groups

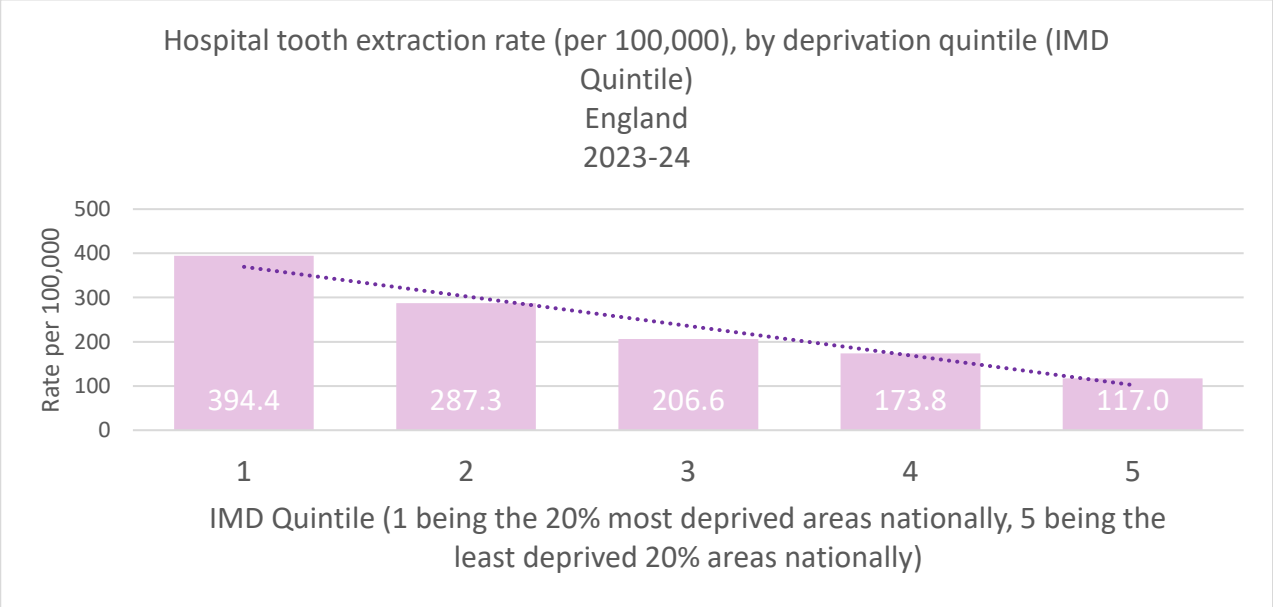
Certain population groups are at a higher risk of poor oral health due to a complex interplay of social, economic, and cultural factors. For children and young people, this includes those from socio-economically disadvantaged backgrounds, such as low-income families, as well as those with special educational needs or disabilities (SEND), dental anxiety, and those with diets high in sugar.

Additionally, children and young people from ethnically and culturally diverse communities, including migrants, refugees, and asylum seekers, may face increased oral health risks due to barriers such as language differences, limited health literacy, culturally inappropriate service provision, and reduced trust in healthcare systems. Cultural beliefs and practices around oral health, diet, and healthcare-seeking behaviour can also influence outcomes.

Other high-risk groups include children experiencing homelessness and those in care, who may encounter frequent disruptions in their living arrangements, making it harder to maintain continuity of dental care. Ensuring that services are culturally sensitive, accessible, and co-designed with diverse communities is essential to address these disparities and promote equitable oral health for all children and young people.

Figure 1 shows the impact of deprivation on tooth extraction rates among those aged 0-19 years, with those in the most deprived areas experiencing higher rates of tooth extractions, due to higher rates of decay. In the most deprived areas in England, children were more than twice as likely to have experienced dentinal decay (32.2%) compared to those in the least deprived areas (13.6%).[9]

Figure 1. Gradient to show the rate of tooth extractions by level of deprivation



Note: IMD – Index of Multiple Deprivation
Source: Office for Health Improvements and Disparities (OHID)

Cultural influences on Oral Health Behaviours and Access

Cultural beliefs and practices can significantly influence oral health behaviours, perceptions of care, and access to dental services among children and their families. In some communities, there is a belief that primary (baby) teeth are unimportant or that tooth decay is inevitable, leading to delays in preventive care. Language barriers, low health literacy, mistrust of healthcare systems, unfamiliarity with dental services and assumptions of cost can further reduce engagement, particularly among migrant, refugee and ethnically diverse families. Additionally, cultural norms around diet and hygiene may contribute to different health outcomes. [10][11]

These differences highlight the importance of culturally sensitive oral health promotion and service delivery, including the use of translated materials, interpreters, community engagement, and co-production with diverse groups to ensure equitable access and outcomes.

Evidence Of What Works

General Guidance For Parents And Carers

To promote optimal oral health in children and young people, families should follow these key evidence-based practices (in line with NICE and OHID guidance):

- Brushing teeth twice daily with fluoride toothpaste, applying a pea-sized amount of toothpaste from age 3 upwards (at least 1,000ppm fluoride), and a smear of toothpaste for children under 3 years old.
- Supervising toothbrushing until at least the age of 7 to ensure proper technique and fluoride use, making brushing part of the daily routine.
- Starting dental visits early, ideally as soon as the first teeth appear and attending regularly thereafter. Encouraging water and milk as main drinks**,** avoiding fruit juice or sweetened drinks.
- Transitioning from bottles to open cups between 12 and 18 months to reduce prolonged exposure to sugary drinks.
- Encouraging healthy eating habits that support both oral and general health, limiting the consumption of sugary foods, snacks, and drinks, especially between meals
- Leading by example - children are more likely to adopt healthy habits if parents model them consistently [12] [13] [14].

Figure 2. National recommendations for parents and carers of children and young people

Source: Office for Health Improvement and Disparities (OHID)

Evidence-based interventions for professionals and services

Professionals and public health teams can support improved oral health outcomes for children and young people through the following strategies:

- Incorporating oral health promotion into routine services such as health visitor checks, GP consultations, school nursing, and early years programmes.
- Targeting high-risk groups (e.g. children in deprived areas, with special needs, or in care) for additional support and tailored interventions.
- Applying fluoride varnish at least twice yearly for children at increased risk of tooth decay, as part of dental or outreach services.
- Delivering supervised toothbrushing programmes in nurseries and primary schools in areas of high need.
- Providing fluoride toothpaste schemes for families who may have limited access.
- Embedding oral health promotion within early years and school settings using a 'whole- setting' approach, including staff training and consistent messaging.
- Commissioning oral health training for all frontline staff working with children and young people.
- Using evidence-based behaviour change techniques, such as motivational interviewing, to support families in adopting and maintaining healthy routines.
- Monitoring and evaluating the impact of oral health programmes to ensure effectiveness and reduce inequalities.

Supervised Toothbrushing Programme (STP)

Supervised Toothbrushing Programmes (STPs) are important public health interventions designed to improve oral health outcomes in children. First recommended by the National Institute for Health and Care Excellence (NICE) in 2008, many local authorities had implemented STPs in nurseries and schools to promote better oral hygiene practices from an early age.

As part of a STP, children under 7 years of age are provided with toothbrushes and fluoride toothpaste, typically in a group setting. Teachers or trained staff supervise and assist the children, ensuring they use the correct amount of toothpaste, brush for the recommended two minutes, and clean all areas of their mouth properly. The primary aim is to help children develop strong oral hygiene habits and reduce the risk of tooth decay, especially in areas where access to regular dental care may be limited.

Evidence demonstrates that STPs are effective in reducing dental decay, particularly in regions that are more deprived, with higher need.

In March 2025, the UK government announced the launch of a national STP roll-out, aimed at improving children's oral health. Starting in April 2025, the initiative aims to targets children aged 3-5 years in early years settings, such as nurseries and primary schools, with a focus on areas of deprivation. The government is investing £11 million to support local authorities in rolling out the programme, which is expected to reach up to 600,000 children annually. Colgate-Palmolive has partnered with the initiative, donating 23 million toothbrushes and tubes of toothpaste over the next five years. The programme aims to reinforce positive brushing habits in young children and address oral health inequalities across the country. This national roll-out marks a major expansion and formalisation of previous efforts to improve children’s oral health in England. While there have been localised STPs particularly in disadvantaged areas, this new initiative takes a nationwide approach.

Water fluoridation

Water fluoridation in the UK involves adding fluoride to public drinking water supplies as a public health measure to reduce tooth decay as fluoride in drinking water helps to strengthen tooth enamel and reduce the risk of cavities.

Extensive evidence shows that water fluoridation is both safe and effective in reducing dental caries in children and young people. It benefits all populations regardless of individual behaviours, making it a particularly powerful tool for addressing oral health inequalities. Unlike other oral health interventions, fluoridation does not rely on individual compliance and can reach large populations passively.

Despite strong recommendations from organisations such as the World Health Organisation, the Royal College of Surgeons, and Office for Health Improvement and Disparities, formerly Public Health England water fluoridation coverage across the UK remains limited, with only around 10% of the population receiving fluoridated water. Local authorities, in partnership with NHS England and Integrated Care Boards, have the power to explore and consult on

expanding fluoridation schemes as part of a system-wide approach to improving children's oral health.

Most evidence for negative health impacts of water fluoridation are based on concentrations above safety limits determined by the World Health Organisation. Dental fluorosis (cosmetic changes to the teeth) can sometimes occur if children's teeth are over-exposed to fluoride when they are developing. Evidence does not suggest this is harmful.[15]

Several areas of England have longstanding water fluoridation schemes, many of which were introduced between the 1960s and 1980s. These include parts of the East and West Midlands, South Yorkshire, the North West, and the North East. More recently, some local authorities have brought forward proposals to introduce new fluoridation schemes as part of efforts to improve oral health and reduce inequalities.[16]

Breastfeeding vs. Bottle Feeding

Breastfeeding up to 12 months of age- especially when exclusive during the first 6 months- is generally considered beneficial to oral health and offers protection against tooth decay. Breast milk has natural substances that help protect your baby's teeth from decay.

In contrast, bottle feeding, especially with sugary liquids like formula, juice, or milk, and prolonged use of bottles or nighttime feeding, is associated with a higher risk of tooth decay. Sugars can pool around the teeth during sleep, feeding harmful bacteria and leading to early tooth decay.[17]

Where possible, breastfeeding is encouraged. But it's recognised that feeding choices are personal and can be influenced by many factors. Regardless of feeding method, good oral hygiene and regular dental care remain key to protecting a child's oral health.

How NHS Dentistry is organised

Primary Care

Primary dental services in England are part of the primary care system, provided through independent dental practices contracted by the NHS. There are around 11,000 dental practices, most offering a mix of NHS and private care, with some large corporate providers. All practices must be registered with the Care Quality Commission (CQC).

Unlike general practice, there is no national registration system for dentists. Patients are not required to be registered with a specific dentist to receive NHS care; they can visit any dental practice that holds an NHS contract. However, some practices may limit the number of new NHS patients they accept, depending on their capacity. Although patients may consistently see the same dentist and receive recall reminders for future appointments, they are not formally registered with that practice. The formal system of registration with a dental practice was abolished in 2006.

Secondary Care Dentistry

Most secondary care dentistry is delivered through NHS hospitals, including 10 specialist dental hospitals in England. It encompasses services like complex oral surgery, oral and maxillofacial pathology, and dental radiology. These providers also play a key role in dental training and may offer emergency primary care services.

Community Dental Services

Community Dental Services (CDS) deliver specialised care to those who face barriers accessing standard dental practices due to disabilities, medical conditions, or other challenges. This includes children and young people with physical or mental health conditions, social exclusion, SEND and complex care needs. These services are provided in a variety of settings, such as hospitals and specialised health centers. Access to CDS requires professional referral and eligibility is assessed on a case-by-case basis.

How NHS Dentistry is funded

Funding for NHS dentistry in England comes from a combination of government funding and patient charges.

Patient charges vary depending on the treatment band, with typical fees ranging from approximately £25 for Band 1 treatments to over £300 for Band 3 treatment. Certain groups are exempt from patient charges, including children under 18 years old (including those in care), young people under 19 years in full-time education, pregnant women and those who have had a baby within the last 12 months, individuals receiving specific income-related benefits or holding NHS Low Income Scheme certificates, and patients receiving NHS hospital dental treatment. Proof of eligibility is usually required to confirm exemption status.

Since 2006, NHS dentistry has been governed by the NHS dental contract, which uses Units of Dental Activity (UDAs) to measure and fund services (Table 1). This system was introduced to create a more efficient approach by moving away from the traditional fee-for-service model (itemising every treatment) and focusing on the overall activity within dental practices, reducing administrative burden.

Each dental practice is contracted to complete a certain number of UDAs per year, and if they meet that target, they are paid accordingly. However, if they exceed the target, they don't receive additional funding for the extra work. If the practice fails to meet their UDA target, a proportion of their contract funding will be reclaimed back.

Table 1. UDA framework as per the 2006 NHS dental contract[18]

Band	Number of UDAs	Includes
Band 1	1	Examination, diagnosis and advice
Band 2a	3	Everything in band 1, plus additional treatment such as fillings, root canals and extractions
***Band 2b**	5	Everything in bands 2 where there are three or more fillings/extractions in one course of treatment and/or non-molar root canal treatment to permanent teeth
***Band 2c**	7	Everything in band 2 plus molar endodontic care to permanent teeth
Band 3	12	Everything in band 2 plus more complex treatment such as crowns, dentures and bridges
Urgent	1.2	Examination, assessment, advice and urgent treatment

Source: NHS Dental Services in England

Criticisms of the UDA System and Its Impact on Care

The UDA system has faced widespread criticism for contributing to limited access, long waiting times, and declining service quality. A BBC inquiry into nation-wide dental access in 2022 revealed that 9 out of 10 dental practices were not accepting new adult patients, and 8 out of 10 were not accepting children.[19]

Dental practices are under time pressure to meet their UDA targets, and the system has been criticised for disincentivising preventive care and the acceptance of more complex cases, as payments do not adequately reflect the time or effort required. Once a practice reaches its UDA limit, it can no longer take on new patients, resulting in capacity issues, longer waiting times, and reduced access to care. This leaves the most vulnerable patients without the care and treatment they need, further widening health inequalities.

COVID-19 worsened the situation by creating a backlog of patients with more complex dental issues, limiting appointment availability, and increasing financial and capacity pressures on practices, all of which further reduced access to care.

Moreover, the payment per UDA often falls short of covering the actual cost of care. This financial strain has led to workforce shortages, as many dentists leave the NHS for private practice, where they can earn more and face less pressure.

The NHS Ten Year Plan, published in July 2025, recognises the built-in challenges of the existing dental contract and the Government launched a major consultation on the NHS dentistry contract on 8 July 2025. The proposed reforms aim to secure additional urgent dental care appointments, better support patients with complex treatment needs and encourage the delivery of more preventative care.

How NHS Dentistry Is Organised (Black Country)

In April 2022, the NHS Black Country ICB took on the responsibility for commissioning dental services in Wolverhampton, following the transfer of this responsibility from NHS England to ICBs. Accountability for these services lies with the Director for Primary Care. Commissioning officers are based within the Office of the West Midlands[20], a collaborative body that brings together the six ICBs in the region to carry out agreed commissioning functions across the West Midlands on behalf of their respective ICBs.

The Birmingham Community Healthcare NHS Foundation Trust[21] is commissioned to provide community dental services (CDS) in all parts of the Black Country, with the exception of Wolverhampton, where the Royal Wolverhampton NHS Trust (RWT) is commissioned to deliver CDS. CDS is delivered via the Royal Wolverhampton NHS Trust (RTWT) via Wolverhampton Special Care Dental Service, and operates across community clinics across Wolverhampton including Pendeford, Phoenix, and Pennfield's Health Centres. It also offers domiciliary visits for housebound patients and runs a mobile dental unit that visits special needs schools.

The Health and Social Care Act (2012) places responsibilities on local authorities for health improvement, including oral health improvement, in relation to the people in their areas. Local authorities have a statutory requirement to provide or commission oral health promotion programmes to improve the health of the local population, to the extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys to facilitate the assessment and monitoring of oral health needs and the planning and evaluation of oral health promotion programmes dental services, and water fluoridation schemes.

There is also a small amount of provision for oral health improvement included within the CDS contract that equates to 3 days per week for a Dental Nurse. A 3-year workplan for this provision has been developed between the Local Authority, the Black Country Consultant in Dental Public Health and RWT.

Wolverhampton Dental Commissioning Group

Following a dedicated joint meeting of the Health and Children and Young People scrutiny panels, the Black Country ICB Managing Director for Wolverhampton established a local Dental Commissioning Steering Group. This is to explore the feasibility of flexible commissioning models in Wolverhampton, promote joined up working across the Black Country and collaborate and identify opportunities to improve capacity at high street dental practices and in the community dental service, located in the Royal Wolverhampton NHS Trust.

Oral Health Partnership

The Oral Health Partnership plays a central role in advocating for oral health and driving forward local priorities by coordinating efforts across the entire system. It is responsible for implementing key recommendations, supporting the development of services, and ensuring

that oral health remains a strategic focus. By working collaboratively with local partners across health, education, and community sectors, the partnership helps to improve outcomes and reduce inequalities in oral health across the population.

Changes to expect following the abolition of NHS England

Following the abolition of NHS England, the commissioning and oversight of NHS dental services in England will transition to Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs). These regional bodies will have the responsibility for planning, commissioning, and monitoring dental services to meet the needs of local populations. This decentralisation will allow for a more tailored approach to service delivery, with ICBs working closely with local authorities and healthcare providers to address specific regional challenges. Key changes include a shift in responsibility for both primary care and community dental services, the continuation of the UDA system for funding, and an emphasis on integrated local health strategies to improve oral health outcomes.

National Dental Epidemiology Programme (NDEP)

The National Dental Epidemiology Programme (NDEP) Oral Health Surveys are a series of standardised and co-ordinated national surveys which aim to measure oral health status across adult and child population groups in England, enabling comparisons by region and local authority. Under the Health and Social Care Act 2012, local authorities have a statutory responsibility to conduct these surveys to help plan oral health promotion based on local needs. Typically, local authorities commission dental providers to undertake the fieldwork following a national protocol. However, in some areas, NHS England (now devolved to ICBs) undertake the commissioning on behalf of the local authorities.

NDEP includes Oral Health Surveys for children in different age groups (3-year-olds, 5-year-olds, and 12-year-olds) to track the prevalence and severity of dental diseases across various stages of childhood. The surveys focus on representative, random samples of children from each age group, typically within state-funded mainstream schools or early years settings. For example, 3-year-olds are usually surveyed in early years settings, 5-year-olds in Reception year of primary schools, and 12-year-olds in early secondary schools. Each survey provides valuable insights into children's oral health, helping inform public health policy and local health services. The 5-year-old survey is conducted biennially (every other year), with surveys for the other age groups carried out in alternating (fallow) years. Please note that Wolverhampton schools did not participate in the latest Oral Health Survey for 3-year-olds (2020) due to COVID-19 disruptions.

4. Local Context

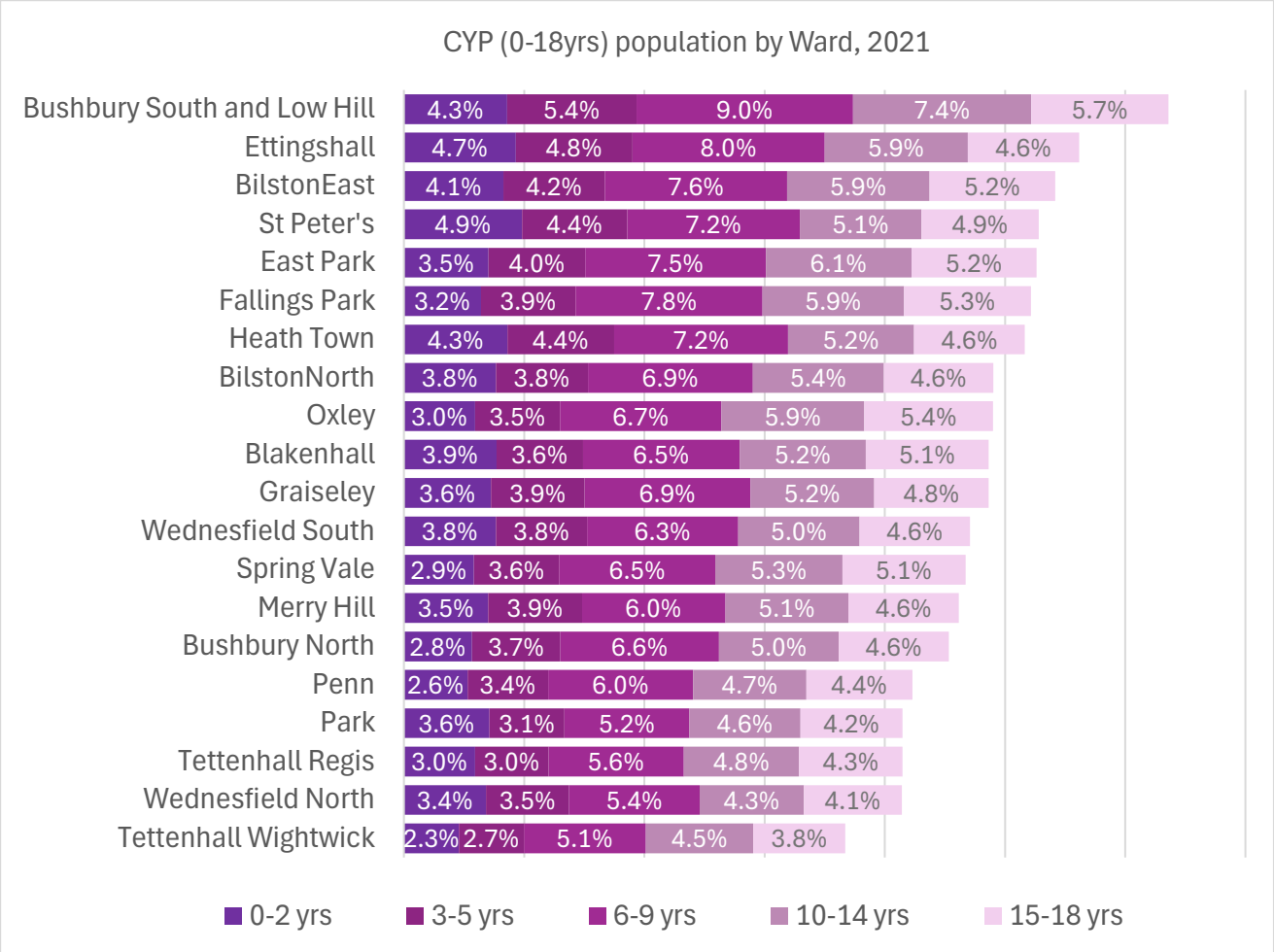
Local Population

In the 2021 Census, Wolverhampton's estimated population was 263,727, reflecting a 5.7% increase from the 2011 figure of 249,500. Of this total, approximately 64,666 (25%) were aged between 0 and 18 years.

0-18yrs Population

The proportion of children and young people (CYP) (0-18 years) vary across the city. By ward, Bushbury South and Low Hill has the highest proportion of CYP (31.8%), followed by Ettingshall (28.1%) and Bilston East (27.1%). By contrast, Tettenhall Wightwick (18.4%), Wednesfield North (20.7%), Tettenhall Regis (20.8%) and Park (20.7%) have lower proportions of CYP.

Figure 3. Population of CYP by ward (%), 2021



Note: *Historic ward names are presented as data is pre-2023, pre-dating boundary changes.*
Source: Census 2021

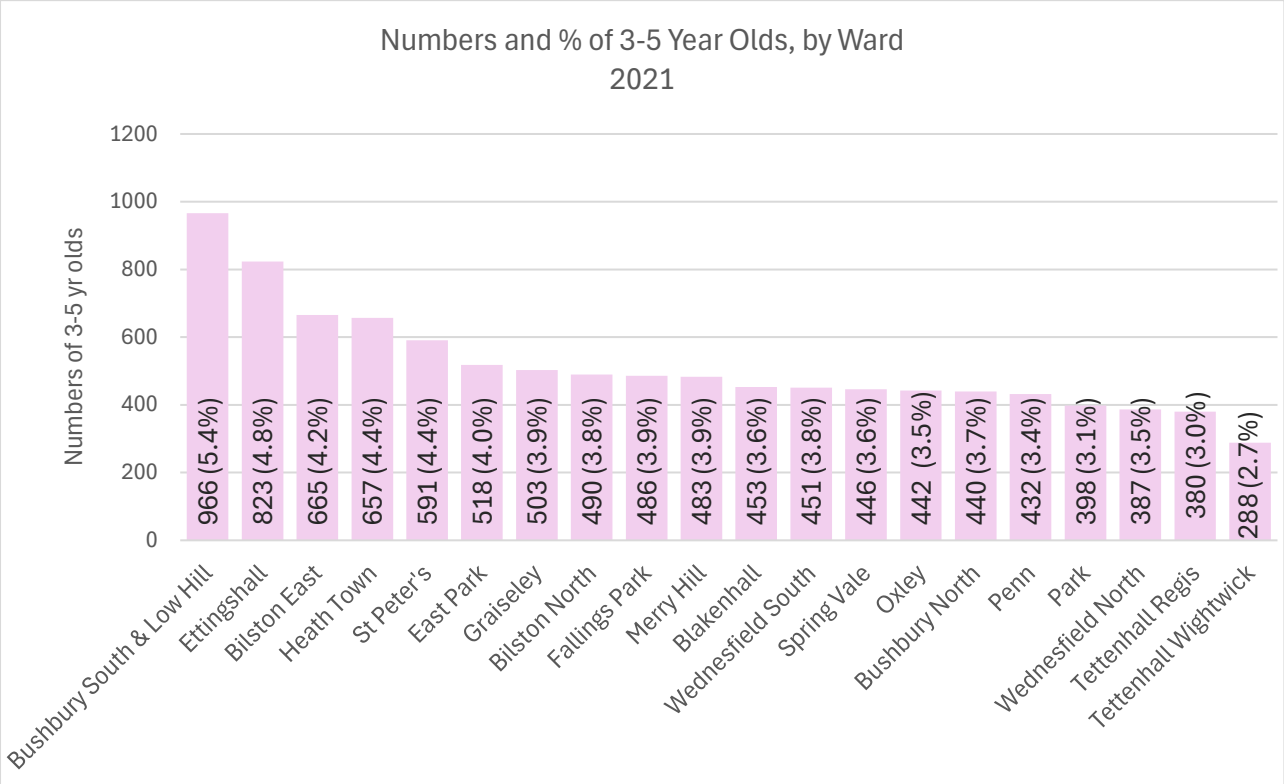
3-5yrs Population

In the 2021 Census, there were an estimated 10,299 (4%) children aged 3-5 years in Wolverhampton.

The number of children aged 3-5 years varies significantly by ward. The wards with the highest numbers of 3-5-year-olds are Bushbury South & Low Hill (966), Ettingshall (823), Bilston East (665), Heath Town (657) and St Peter's (591). The wards with the lowest numbers of 3-5 year olds are Tettenhall Wightwick (288) and Tettenhall Regis (380).

The wards with the highest proportion of 3-5-year-olds included Bushbury South and Low Hill (5.4%), followed by Ettingshall (4.8%) Heath Town (4.4%) and St Peter's (4.4%).

Figure 4. Numbers and % of 3–5-year-olds, by Ward, 2021



Note: *Old ward names are presented as data is pre-2023).*
Source: Census 2021

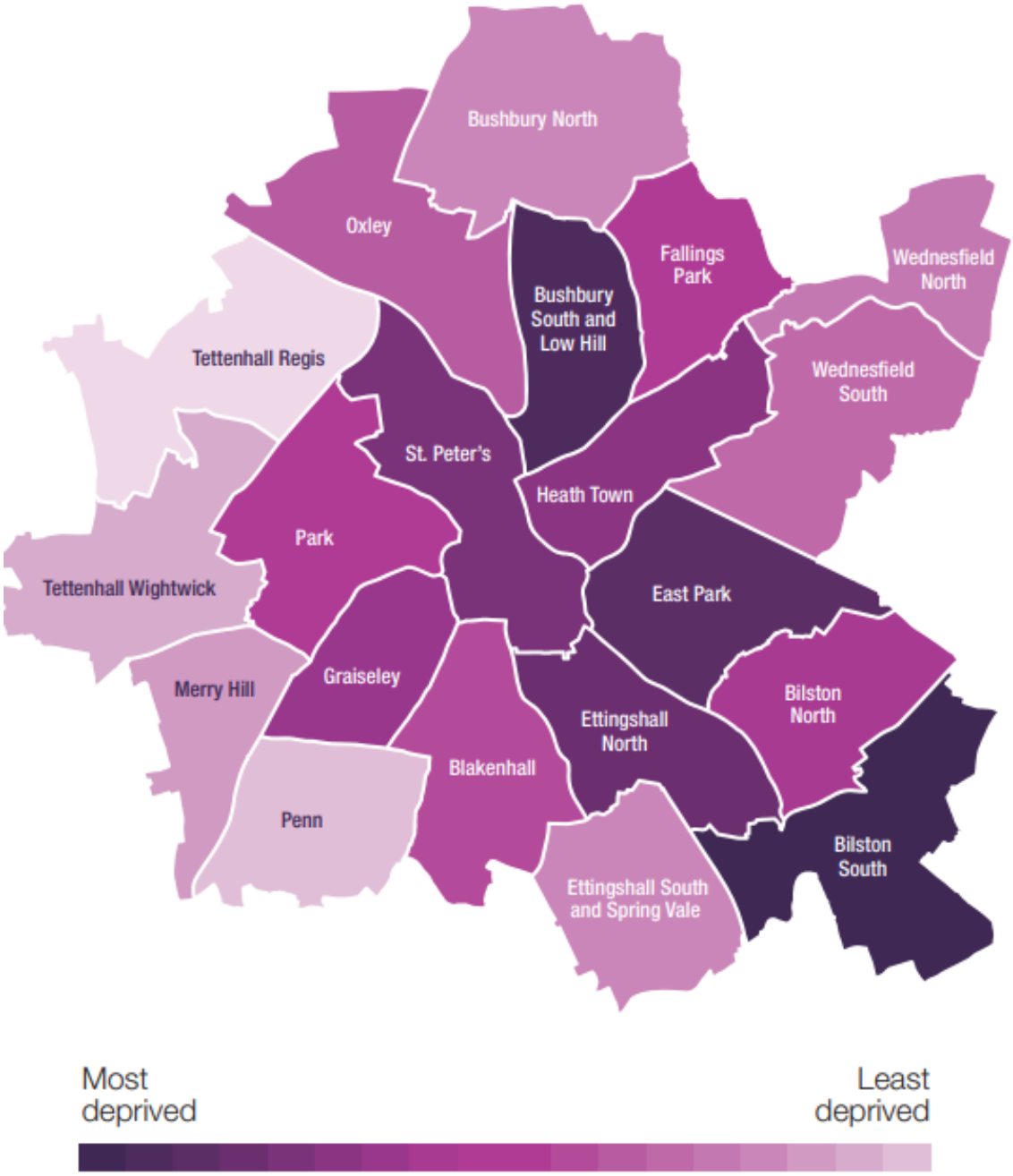
Deprivation

Wolverhampton is ranked as the 24th most deprived local authority in England according to the Indices of Multiple Deprivation (IMD). This ranking reflects the significant disparities in income, education, employment, health, and other factors affecting the well-being of its residents. Over 50% of Wolverhampton residents are living in areas amongst the most deprived in England. Wolverhampton is also the 2nd most deprived local authority in the Black Country.

The most deprived wards in the city include Bilston South, Bushbury South and Low Hill, Ettingshall North and St Peter's, which also have the highest proportions of CYP residents. In contrast, the least deprived wards are more concentrated in the West of the city, and includes Tettenhall Regis, Penn, Tettenhall Wightwick, Merry Hill, and Bushbury North, which have a lower proportion of CYP residents (Figure 5).

Deprivation has a significant impact on children's and young people's oral health, with deprivation often linked to broader socio-economic factors such as income, access to healthcare, education, and living conditions.

Figure 5. Map showing deprivation by ward, 2025



Source: Office of National Statistics (ONS)

Early Years Settings

In the 2025 Spring School Census, Early Years provision was delivered through 172 settings, including 70 schools (40.7%) and 102 private, voluntary, or independent providers (59.3%). A total of 2,241 children aged 3-5 years were recorded as using their free Early Years entitlement: 1,465 (65.4%) in PVI settings and 776 (34.6%) in schools. According to the Department for Education's Local Authority Interactive Tool, the take-up rate for free early education entitlement among 3- and 4-year-olds in Wolverhampton was 95.7% in 2024.

Table 2. Early Years Settings, by type

Early Years Setting	Type of Provider
61 Primary Schools With Nursery Classes	State-funded
7 LA Nursery Schools	
2 Infant Schools	
70 Total State Schools	
49 Private or Voluntary Providers	Private, Voluntary or Independent Providers (PVI)
2 Independent Schools	
51 Childminders	
102 Total PVI	

Source: School Census 2025 (Spring)

Higher Need Populations

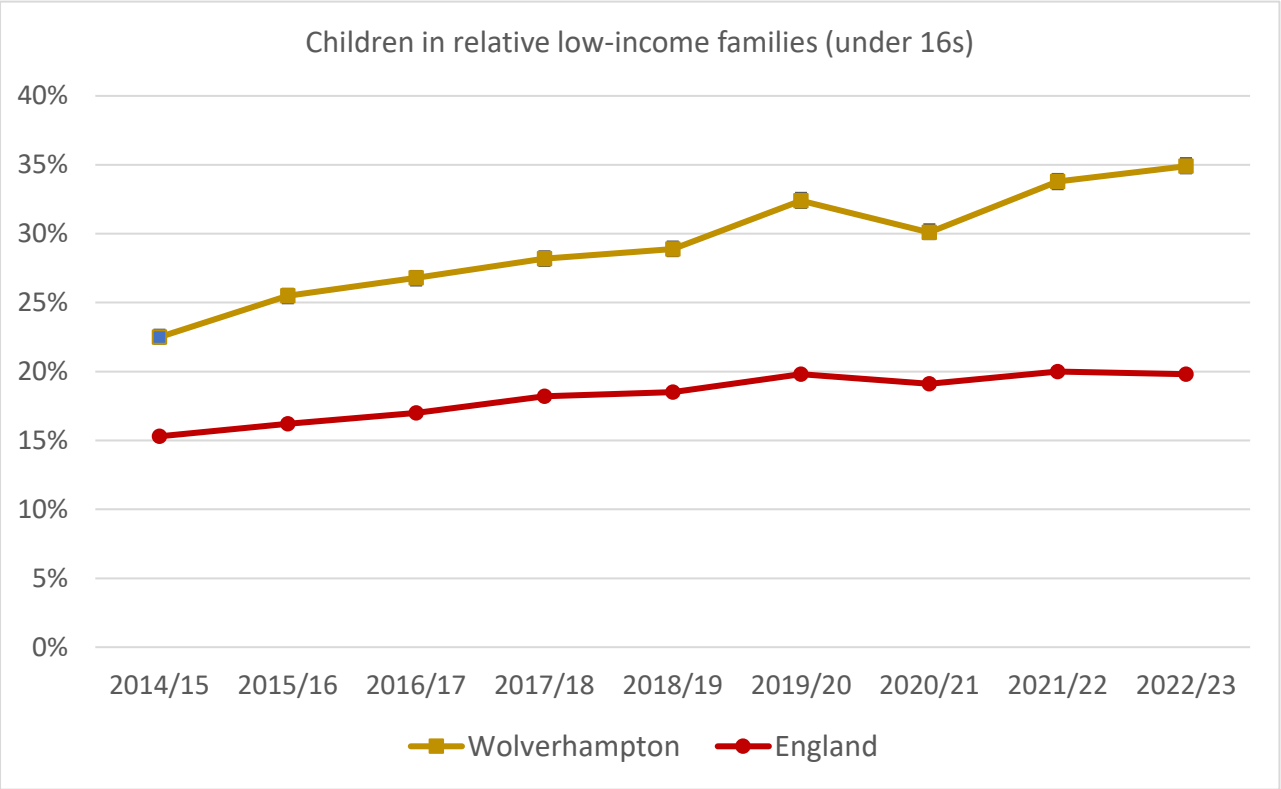
Certain groups of children and young people face significantly greater challenges in achieving and maintaining good oral health. These include CYP from low-income families, those with SEND, children in care and care leavers, those experiencing homelessness, CYP from migrant families, as well as transient populations such as asylum seekers and refugees.

Children In Low Income Families

Children living in low-income households experience higher rates of dental decay and are less likely to access regular preventive dental care. Socioeconomic deprivation is strongly associated with higher rates of untreated decay, lower rates of registration with dental practices and greater likelihood of requiring extractions under general anaesthetic.[22] Contributing factors include limited access to affordable healthy food, higher consumption of sugary products, parental oral health literacy, and challenges accessing dental services (e.g. transport, parental time off work).

In 2022/23, around a third (34.9%) of children (under 16 years) were living in relative low-income families in Wolverhampton, which is significantly higher than the national average (19.8%) (Figure 6).

Figure 6. Children in relative low-income families, before housing costs, 2022/23

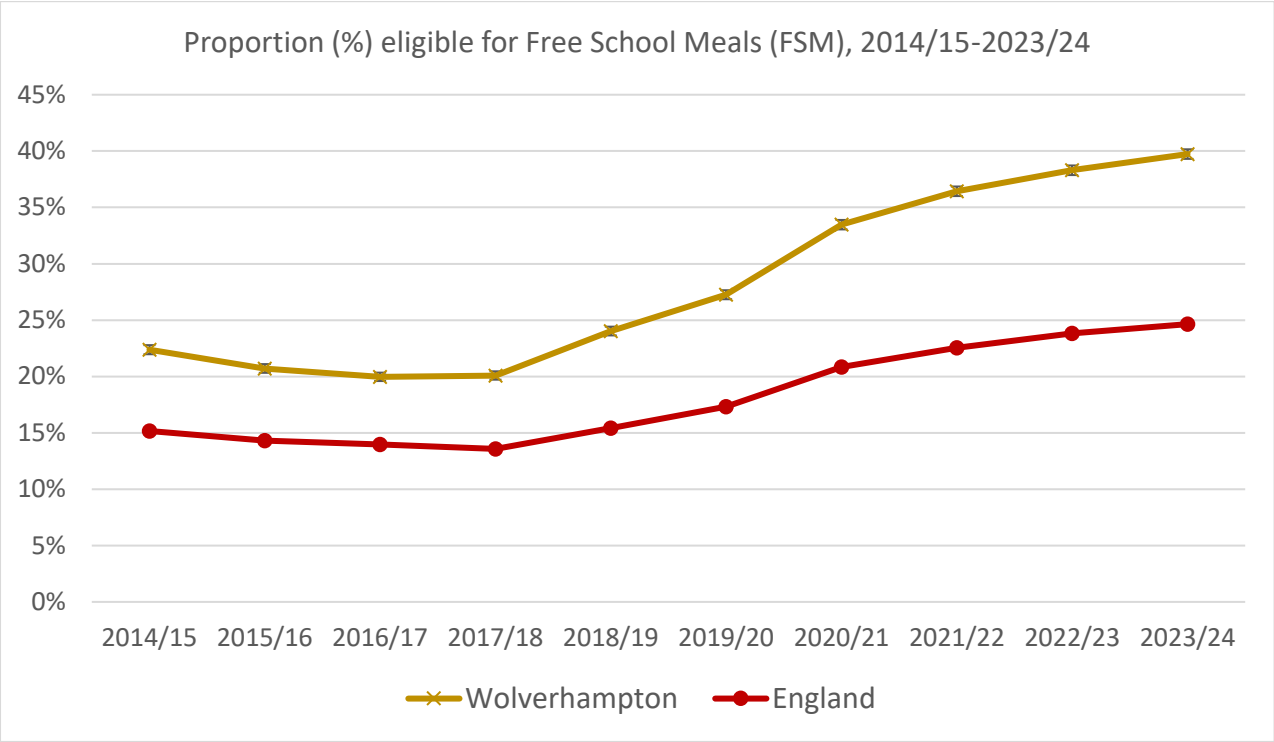


Note: *After housing costs have been deducted*
Source: Fingertips, Office for Health Improvement and Disparities (OHID)

The proportion of children eligible for free school meals is another indicator of the level of socio-economic disadvantage or income deprivation.

In 2023/24, around 4 in 10 (39.7%) children in state-funded education settings (nursery through to secondary, including special schools) were eligible for free school meals in Wolverhampton. This is significantly higher than the national average of 24.6% (Figure 7).

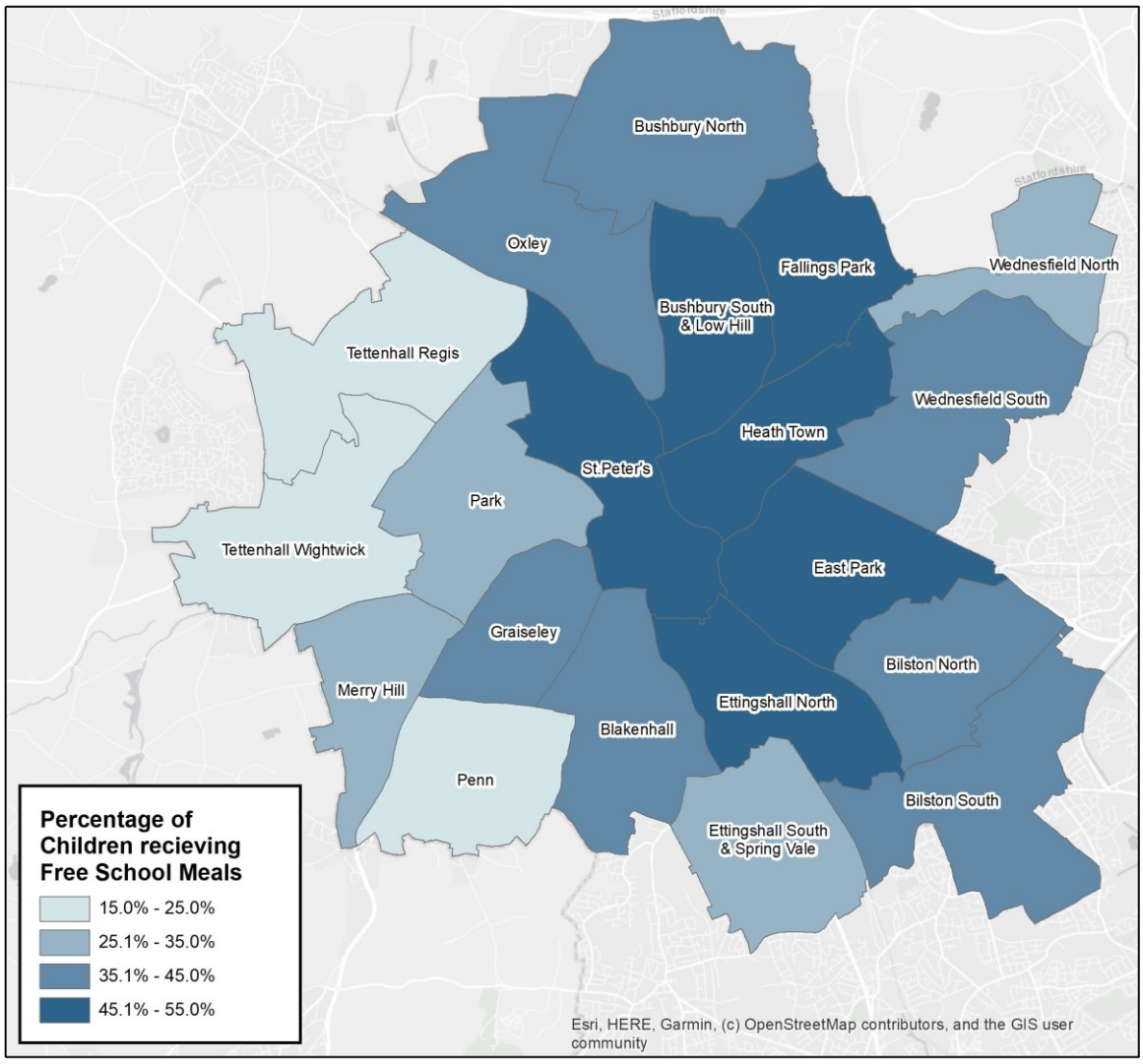
Figure 7. Proportion eligible for free school meals (FSMs), trend data



Source: Fingertips, Office for Health Improvement and Disparities (OHID)

Wards with the highest proportion of children receiving FSM was Heath Town (53.9%), Bushbury South & Low Hill (53.0%), St Peter's (51.9%) and East Park (49.3%) (Figure 8).

Figure 8. Ward map showing percentage of children receiving FSM, 2024



Source: City of Wolverhampton Council

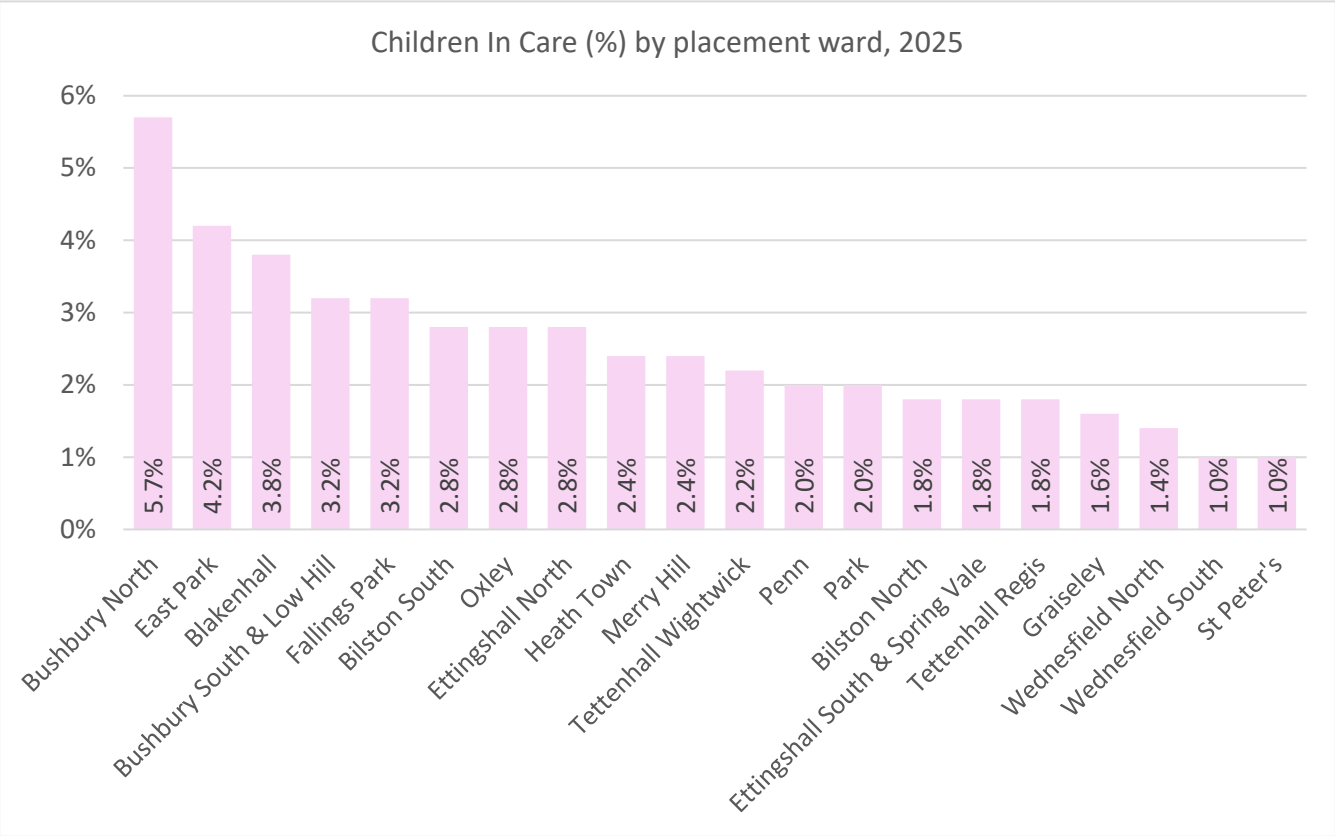
Children In Care and Care Leavers

Children looked after by the local authority (children in care), including care leavers, are understood to be disproportionately affected by oral health issues. Challenges include inconsistent routines and carer changes, which disrupt oral hygiene habits, limited access to dental care due to placement instability or delays in registration and competing health and wellbeing priorities, where oral health is not prioritised. While annual health assessments include oral health checks, uptake of dental treatment and follow-up care remains inconsistent.

As of April 2025, there were 495 children in care locally. This refers to children (≤18 years) who are living outside of their parents' or usual guardians' homes and are being cared for by a local authority). Nearly half (49.7%) were placed 'Out of Area.' This means they were placed outside of Wolverhampton, even though the local authority is responsible for them.

The wards with the highest proportion of children in care are Bushbury North (5.7%), East Park (4.2%), and Blackenhall (3.8%) (Figure 9).

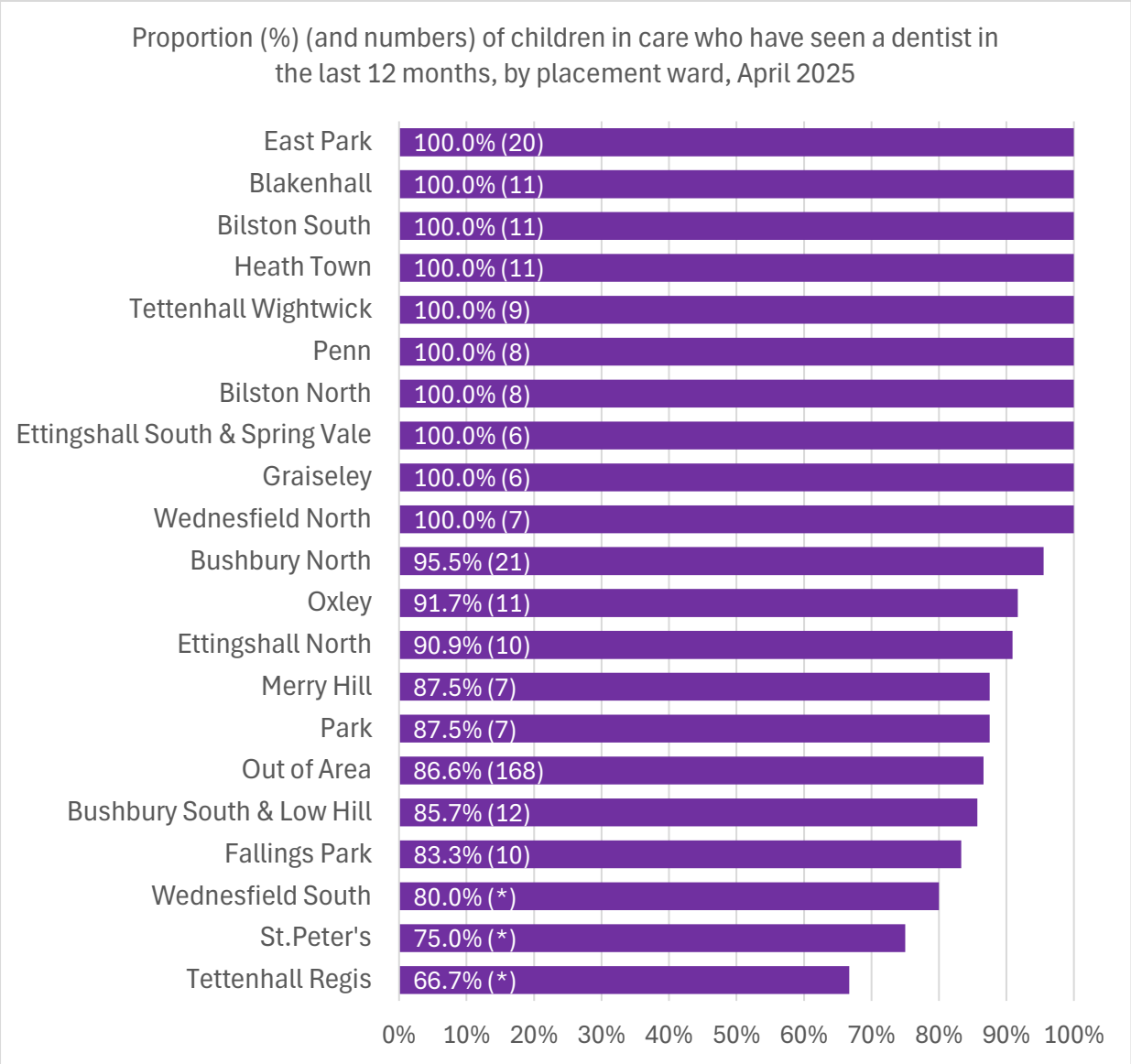
Figure 9. Proportion of children in care (%), by placement ward (where they have been relocated to under the care of the Local Authority)



Source: City of Wolverhampton Council

Annual dental visits are advised by the NHS. As of April 2025, of those who had been in care for 12 months or longer, 354 (90%) had visited a dentist in the last 12 months and 39 (10%) hadn't. The proportion varied by ward (Figure 10). All (100%) of children in care in East Park, Blakenhall, Bilston South, Heath Town, Tettenhall Wightwick, Penn, Bilston North and Ettingshall South & Spring Vale had visited a dentist in the last 12 months.

Figure 10. % and numbers of children in care who had seen in a dentist in the past year, as per recommendations

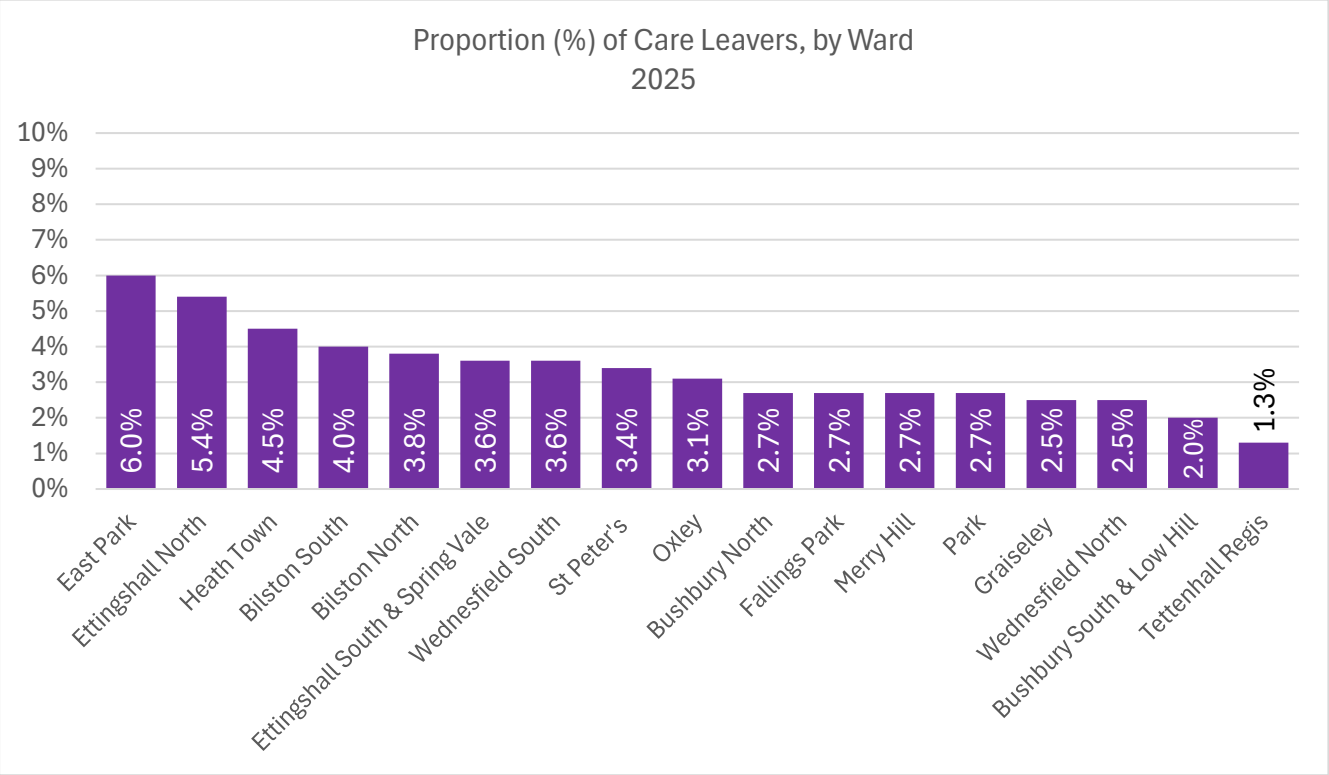


Notes:
i) indicates data suppressed due to small numbers.*
ii) Failed visit to dentist data is not shown due to small numbers, only completed dental visits is presented.
iii) Figures are based on those who had been in care for 12 months or longer.

Source: City of Wolverhampton Council

As of April 2025, there were 447 care leavers in Wolverhampton. These are young people aged between 16-25 years old who have been in care at some point since they were 14 years old and were in care on or after their sixteenth birthday. By ward, around 4 in 10 (41%) of care leavers' current location was not known, or outside of Wolverhampton. Wards with the highest proportion of care leavers were East Park (6%), Ettingshall North (5.4%) and Heath Town (4.5%) (Figure 11).

Figure 11. Care leavers (16-25 yrs), by ward, 2025



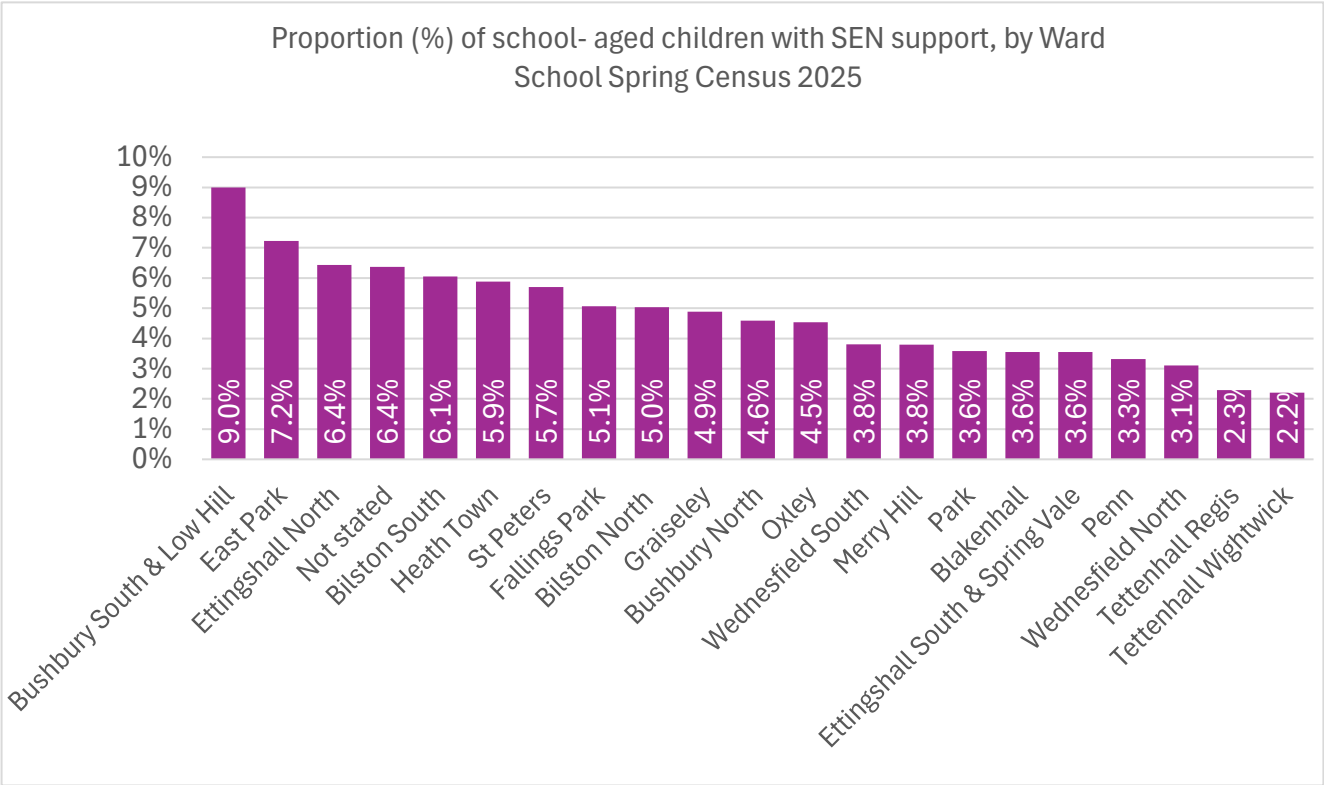
Note: Blackenhall, Penn and Tettenhall Wightwick have been suppressed due to low counts.
Source: City of Wolverhampton Council

Special Educational Needs and Disabilities (SEND)

Children with SEND often face complex barriers to good oral health. This is due to increased need for assistance with oral hygiene, sensory issues that make dental visits challenging, use of medications that may contribute to dry mouth or contain sugar and difficulty accessing specialist dental services with appropriate expertise. These children may require longer appointment times, specialist referral pathways, and multi-disciplinary care planning.

In the 2025 Spring School Census, there were 7,536 school-aged children who were receiving SEN support in the city. The wards with the highest proportion of students receiving SEN support included Bushbury South and Low Hill with 678 students (9.0%), East Park with 545 students (7.2%), Ettingshall North with 485 students (6.4%), and Bilston South with 456 students (6.1%). The ward name was not provided for 480 students (6.4%) (Figure 12).

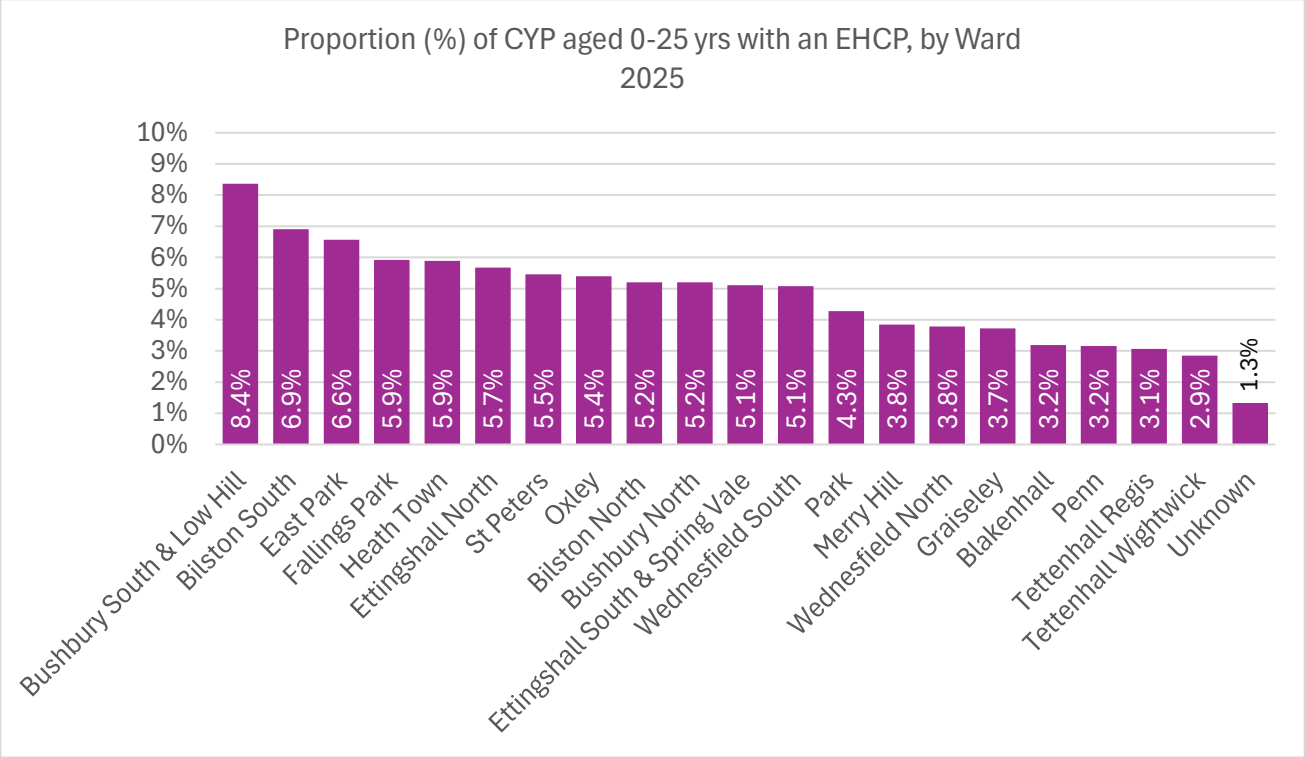
Figure 12. School-aged children with SEN support, by ward, 2025



Source: City of Wolverhampton Council

In the 2025 Spring School Census, there were 3,227 children and young people aged between 0-25 years who had an Educational Health Care Plan (EHCP) in the city. The wards with the highest proportion of CYP with an EHCP included Bushbury South and Low Hill with 270 CYP (8.4%), Bilston South with 223 CYP (6.9%) and East Park with 212 CYP (6.6%) (Figure 13).

Figure 13. School-aged children with EHCP, by ward, 2025



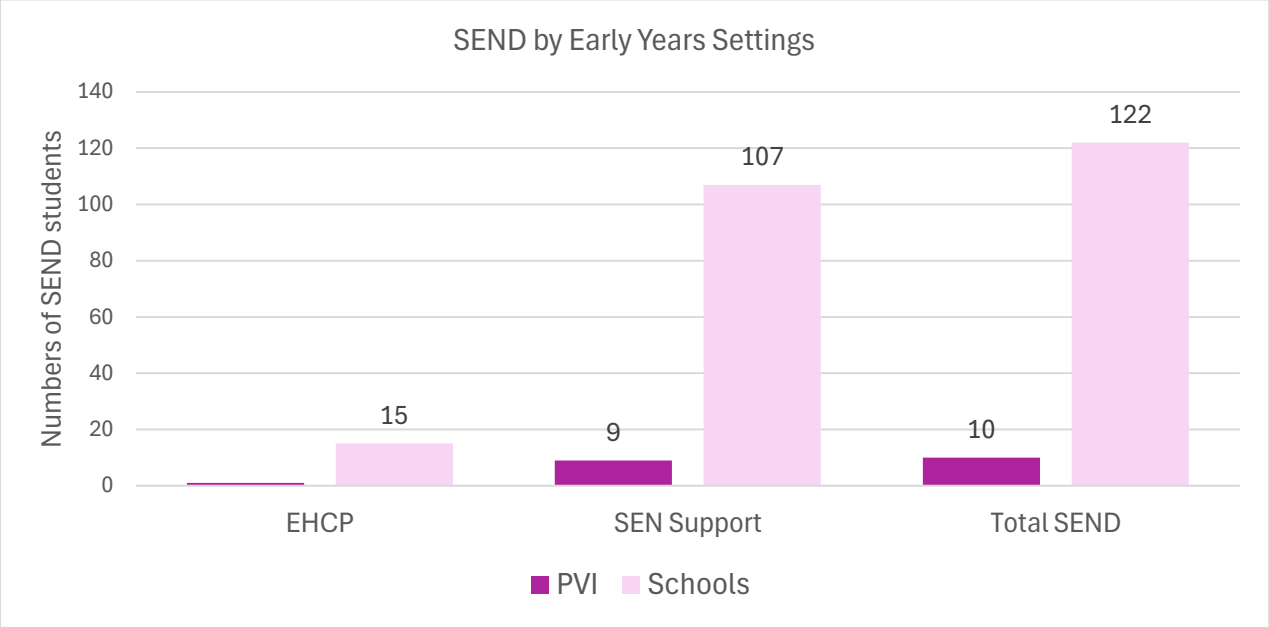
Source: City of Wolverhampton Council

SEND in Early Years Settings

As of the Spring 2025 census, a total of 132 children aged 3-5 years were recorded as having Special Educational Needs and Disabilities (SEND) across Early Years settings in Wolverhampton. This includes those in both private, voluntary, and independent (PVI) providers and school-based provision.

A total of 16 children were identified with an EHCP, with 15 (94%) children attending school-based settings and 1 child (6%) in a PVI setting. A total of 116 children were receiving SEN support, with 107 (92%) children in school-based settings and 9 (8%) children in PVI settings. Overall, schools account for the vast majority of children with SEND (92.4%), compared to PVIs (7.6%). This indicates that the majority of identified SEND provision occurs within school environments (Figure 14).

Figure 14. Numbers of children receiving SEND support by Early Years Setting, 2025



Note: EHCP by PVI data has been suppressed due to low counts
Source: School Census 2025 (Spring)

Migrant Families

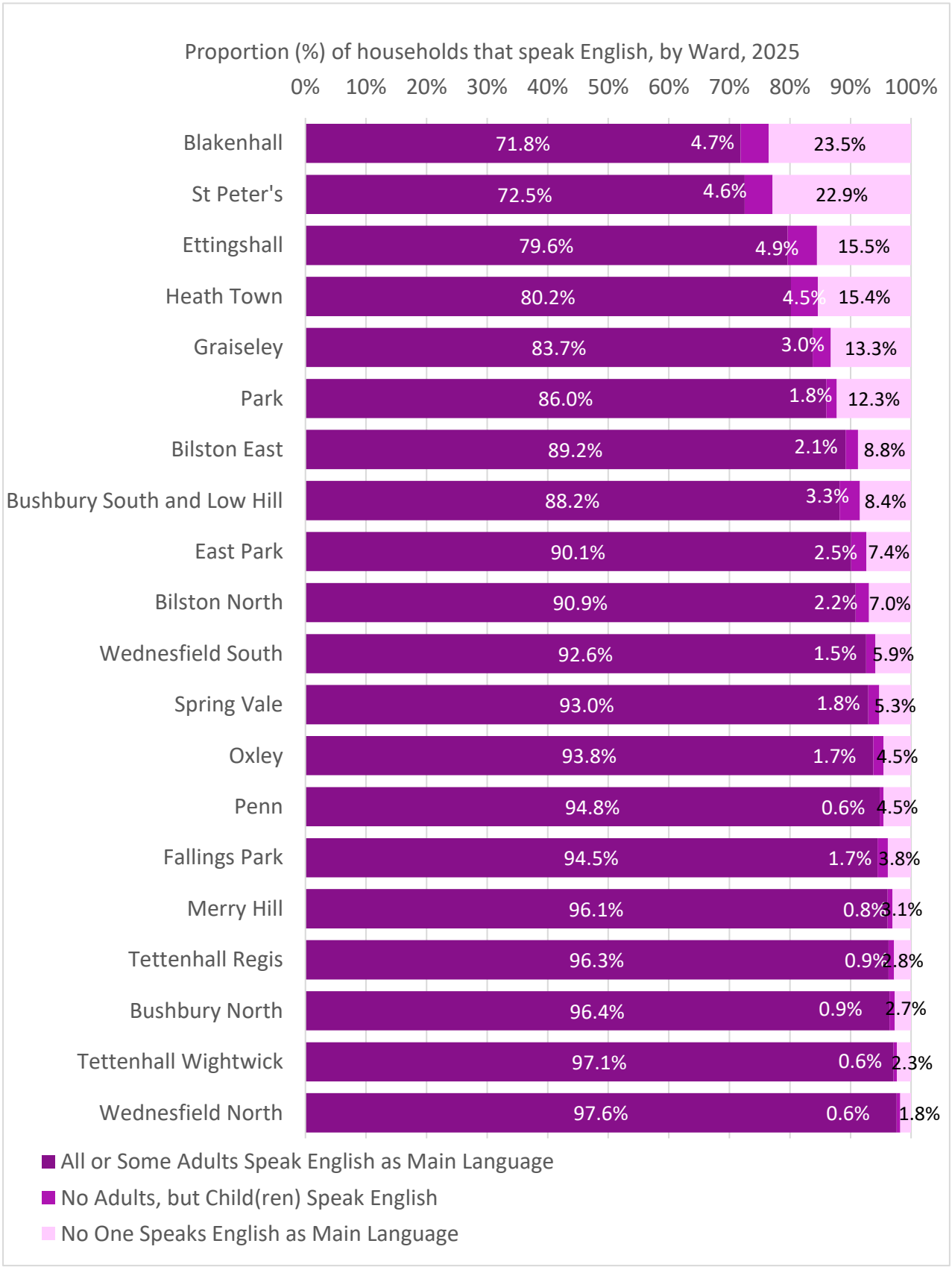
Children from traveller families, asylum seekers, refugees, and migrant communities often face significant barriers to accessing routine dental care. These challenges are largely linked to the transient nature of these populations, including not having a fixed address, frequent relocations, and uncertain immigration status. Additional barriers include language and cultural differences, such as varying perceptions of oral health, or perhaps lack of trust in healthcare services.

Outreach and mobile dental services, as well as culturally competent information and support, are essential to improving access for these groups.

Although local data on transient communities (traveller families, asylum seekers, and refugees) is limited, information is available for migrant families, often using household language as a proxy indicator.

In the 2021 Census, there were 9,082 households in the city that do not speak any English, and 2,400 households where only the child(ren) speak English. Figure 15 shows the proportion of households that speak English by ward. Wards with highest proportion of households that do not speak any English include Blakenhall (23.5%), St Peter's (22.9%), Ettingshall (15.5%), Heath Town (15.4%), Graiseley (13.3%) and Park (12.3%). Wards which have a higher proportion of only children speaking English in the household include Ettingshall (4.9%), Blakenhall (4.7%), St Peter's (4.6%) and Heath Town (4.5%) (Figure 15).

Figure 15. Households that speak English, by ward, 2025



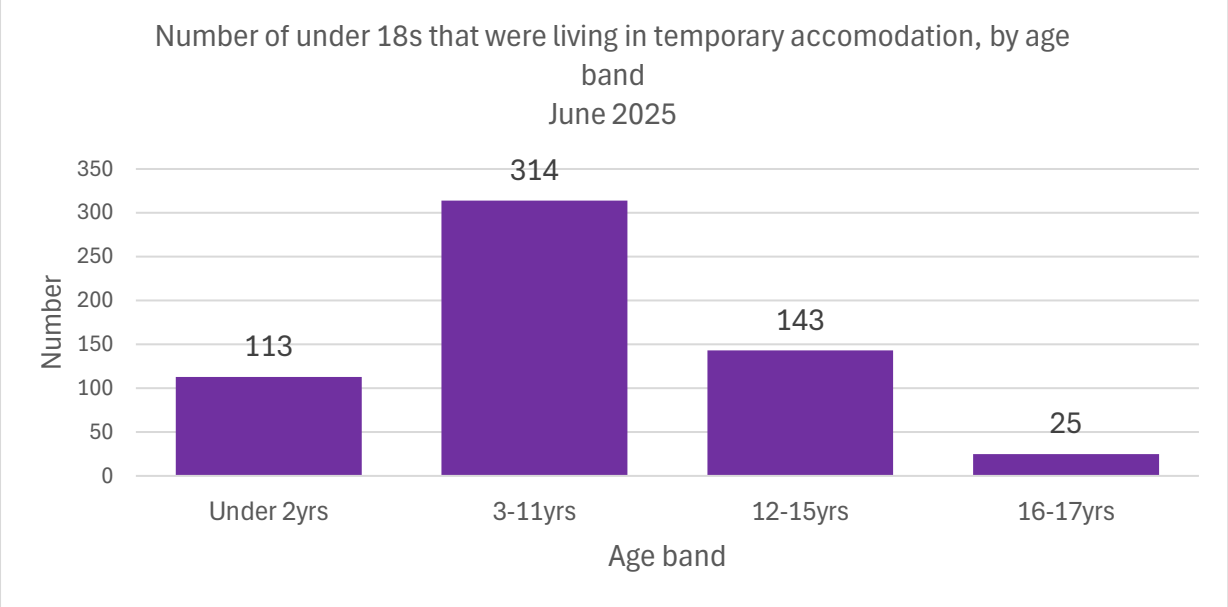
Homelessness

Children and families experiencing homelessness are among the most vulnerable. Living in temporary accommodation can lead to irregular meals and poor nutrition, limited access to hygiene facilities for tooth brushing and minimal engagement with preventive health services, including dentistry.

Oral health is often overshadowed by urgent housing and financial concerns. Integration with housing, social services, and community health can help support early intervention.

As of June 2025, there were 595 individuals aged between 0-18 years in Wolverhampton that were living in temporary accommodation due to homelessness. Over half (53%) were aged between 3-11 years old, and around 2 in 10 were aged under 2 years (19%), or between 12-15 years (24%). A small proportion were aged between 16-17 years (4%) (Figure 16).

Figure 16. Number of under 18s that are in temporary accommodation for homelessness, 2025



Please note that the true number of homeless CYP may be higher than this as not all homeless individuals are known to authorities.

Source: City of Wolverhampton Council

Children With Poor Dietary Habits

National Child Measurement Programme (NCMP)

The NCMP records weight status of children in mainstream state schools and reveals a lot about dietary patterns of children. Higher rates of overweight and obese children are strongly correlated with socio-economic disadvantage and deprivation, related to lower access to nutritious food, lower parental health literacy, more densely urbanised environments and reduced access to outdoor, green space.[23] Childhood excess weight and poor oral health are closely linked because they share the same social, economic and environmental risk factors.

In 2023/24, around 2 in 10 (26%) of children in Reception year, and 4 in 10 (44%) in Year-6 in Wolverhampton were recorded as being either overweight or obese. This is significantly higher than the national and regional averages (Table 3).

Table 3. Prevalence of overweight and obese children

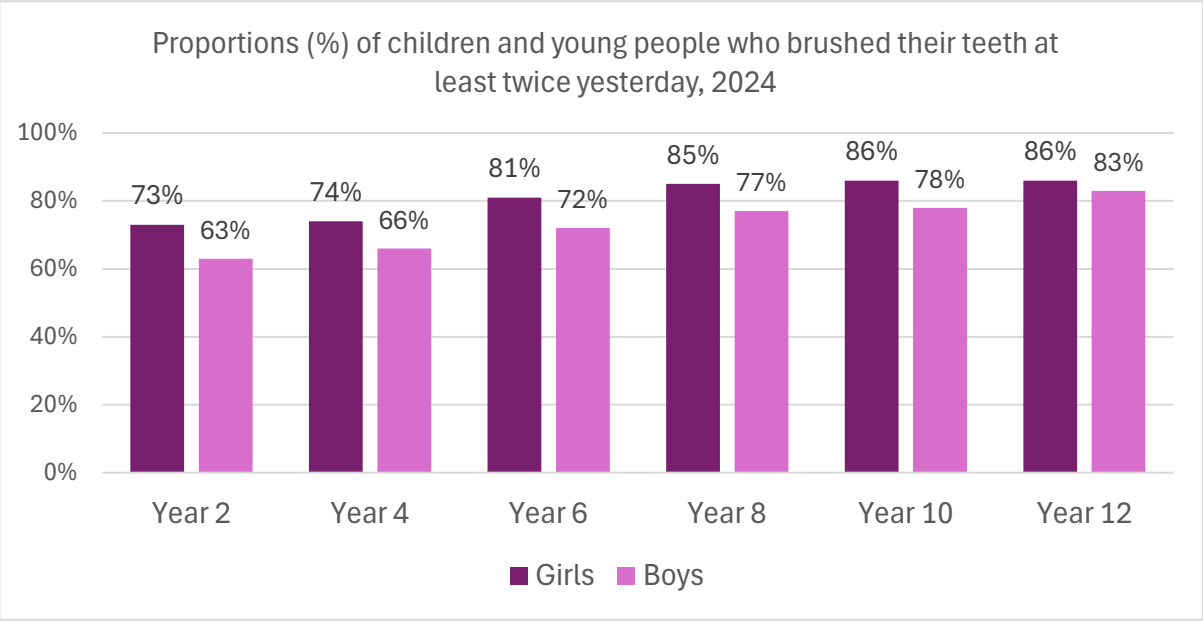
Prevalence of overweight (including obesity)	Year	Wolverhampton	West Midlands	England
Reception Yr	2023/24	26.2%	23.4%	22.1%
Year-6	2023/24	44.3%	38.4%	35.8%

Note: Red indicates significantly worse than national average

Health Related Behaviour Survey

In the 2024 local Health Related Behaviour Survey, the proportion of children who brushed their teeth at least twice the day before completing the survey varied by year group and by gender. Girls were more likely than boys to report brushing their teeth, and the likelihood of brushing twice daily increased with age (Figure 17).

Figure 17. Routineness of toothbrushing by year group, 2024



Source: Health Related Behaviour Survey (HRBS 2024)

Table 4 shows the differences in tooth brushing by demographics. Children in Year 6 and Year 8 of White ethnicity were significantly more likely to have not brushed their teeth twice the day prior, as well as SEND children in Year 8 and Year 10. Children that were significantly more likely to have brushed their teeth twice the day before included those of non-white UK ethnicity in Year 8, Asian children in Year 6, young carers in Year 4, and children receiving free school meals in Year 8 and Year 10.

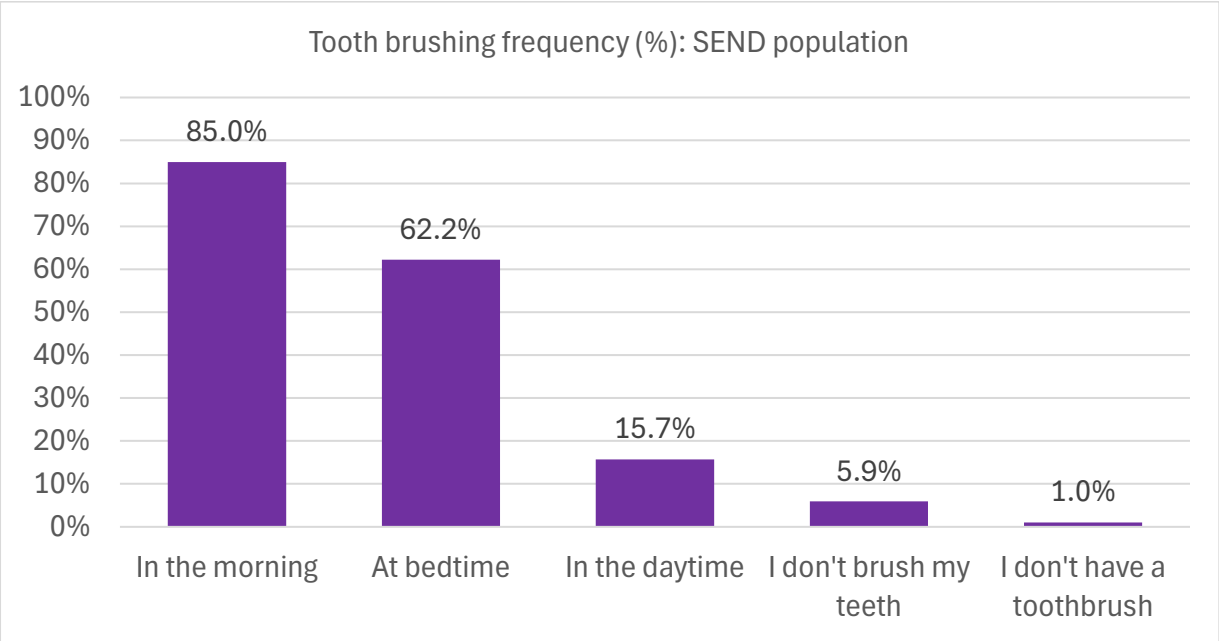
Table 4. Proportion who had brushed their teeth twice the day prior, by demographics (%)

Year group	Year 4	Year 6	Year 8	Year 10
All	70%	76%	81%	82%
Male	66%	72%	77%	78%
Female	74%	81%	85%	86%
White UK	70%	73%	77%	83%
Mixed	74%	78%	83%	84%
Black	72%	76%	80%	76%
Asian	69%	81%	81%	84%
Middle East/West Asian	63%	76%	88%	92%
English not 1st language	70%	77%	85%	80%
Single Parent Family	70%	76%	81%	81%
Young carer	76%	74%	81%	81%
Currently receives FSM	69%	75%	84%	81%
SEND	Not available	67%	71%	76%

***Notes**:*
i) Data not available for Year 2.
Ii) Green indicates significantly higher (better), and red indicates significantly lower (worse) than average.

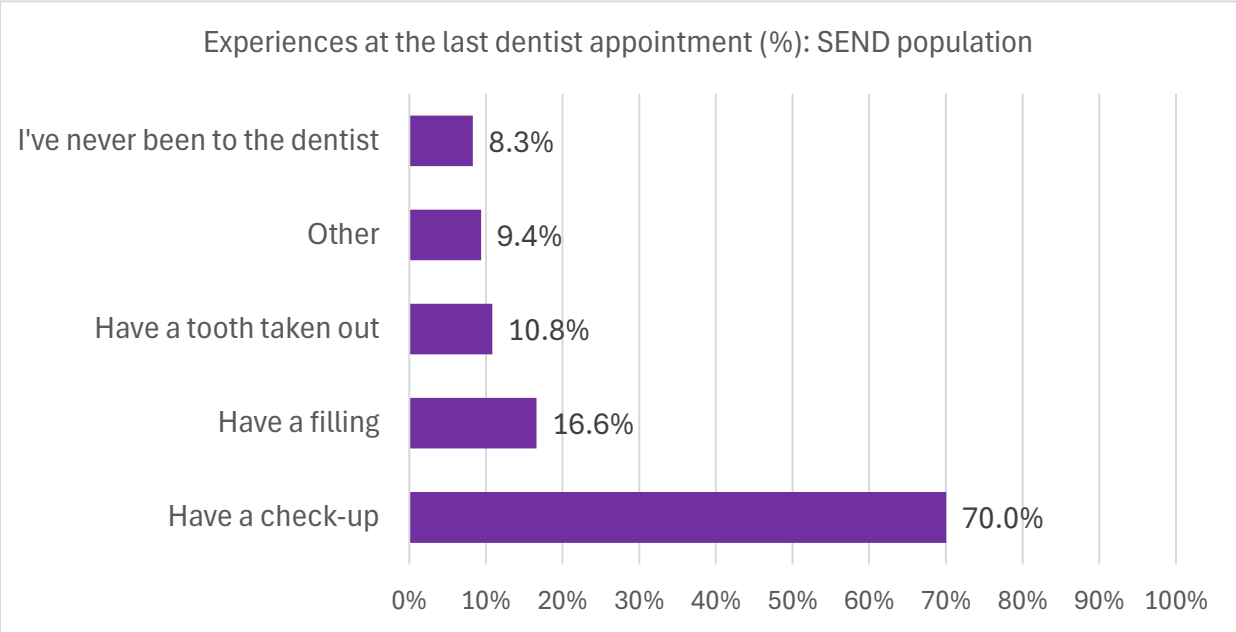
SEND children across KS2-KS4 and Year 12+ were asked when they brushed their teeth, nearly 9 in 10 (85%) reported brushing their teeth in the morning and 6 in 10 (62%) at bedtime. A smaller proportion reported they don't brush their teeth (6%) and don't own a toothbrush (1%). Nearly 1 in 10 (8%) of SEND students reported they had never been to a dentist (Figures 18 & 19).

Figure 18. Tooth brushing frequency by SEND population (%)



Source: Health Related Behaviour Survey (HRBS 2024)

Figure 19. Experiences at the most recent dental visit (%)



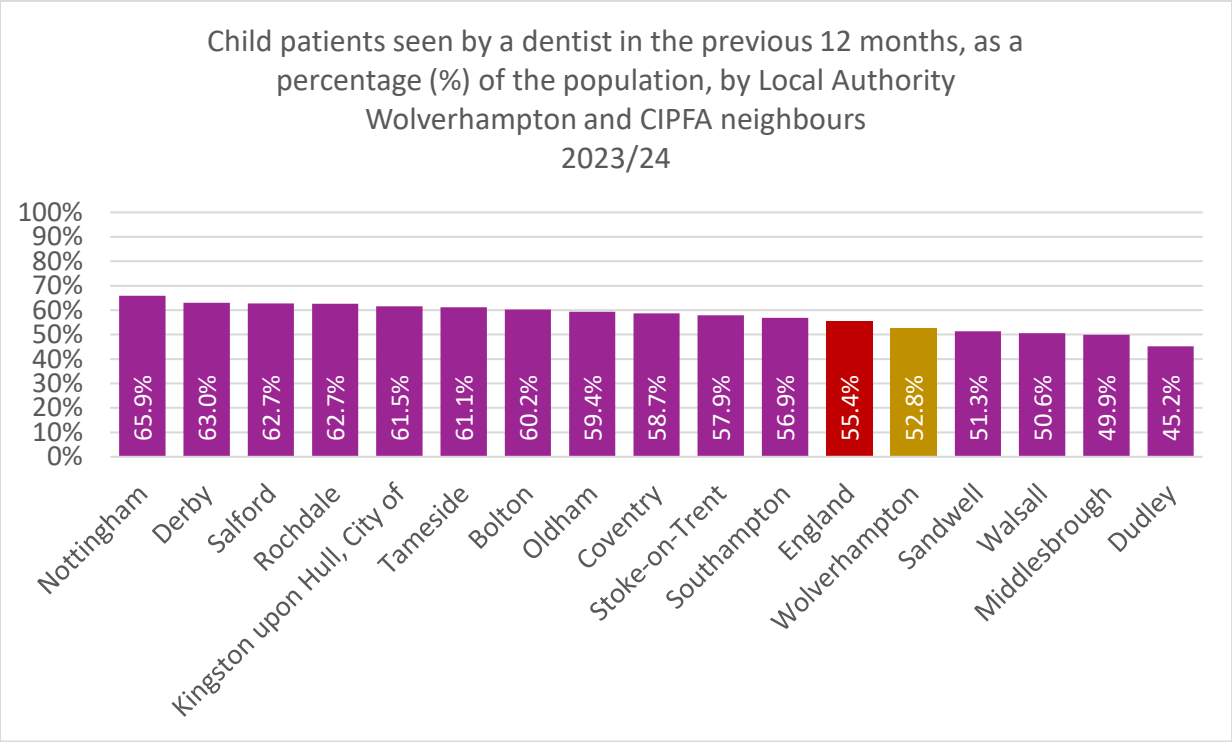
Source: Health Related Behaviour Survey (HRBS 2024)

Dental Activity

Child Dental Visits

In 2023/24, approximately 34,496 (52.8%) children under 18 were seen by a dentist in the previous 12 months, placing Wolverhampton fifth lowest among its CIPFA neighbouring authorities for child dental visits, but similar to the national average (55.4%). This may indicate that a significant portion of the child population in Wolverhampton may be facing challenges in accessing dental care (Figure 20).

Figure 20. Children being seen by a dentist in the previous 12 months, 2023/24

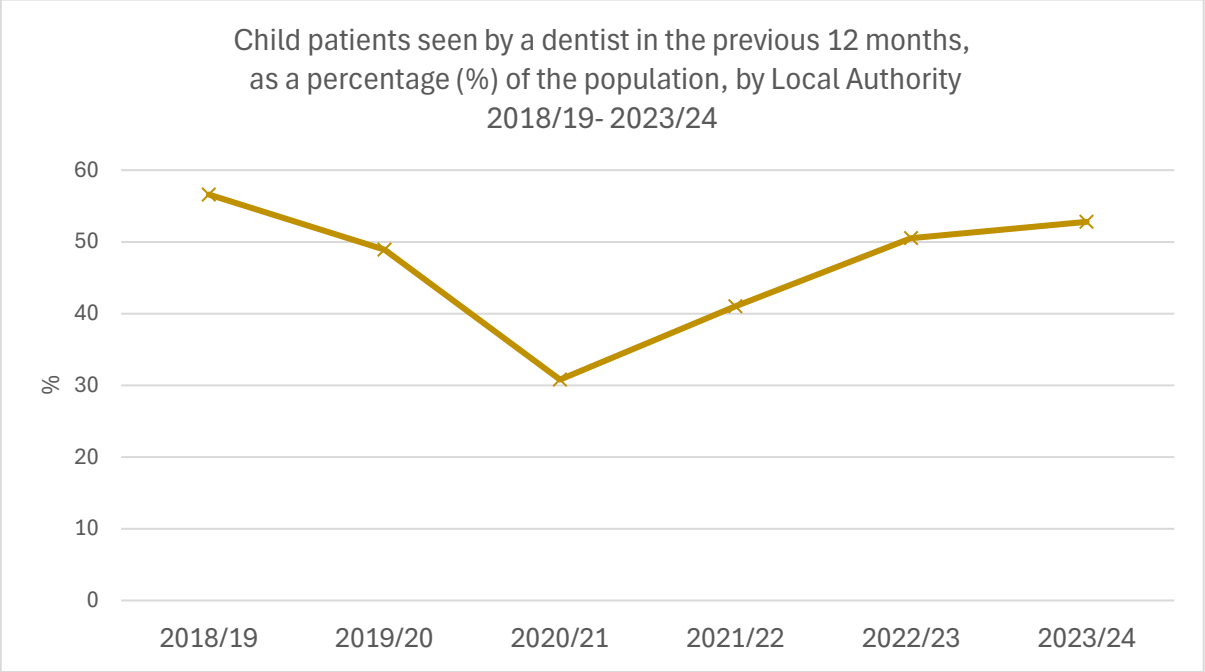


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes.

Source: NHS Business Services Authority (NHS BSA)

Trend data shows that child dental access was significantly impacted by the pandemic, but there has been a steady recovery since 2021. While current access levels remain slightly below the pre-pandemic high, the upward trend is encouraging, highlighting ongoing efforts to restore and improve dental services for children (Figure 21).

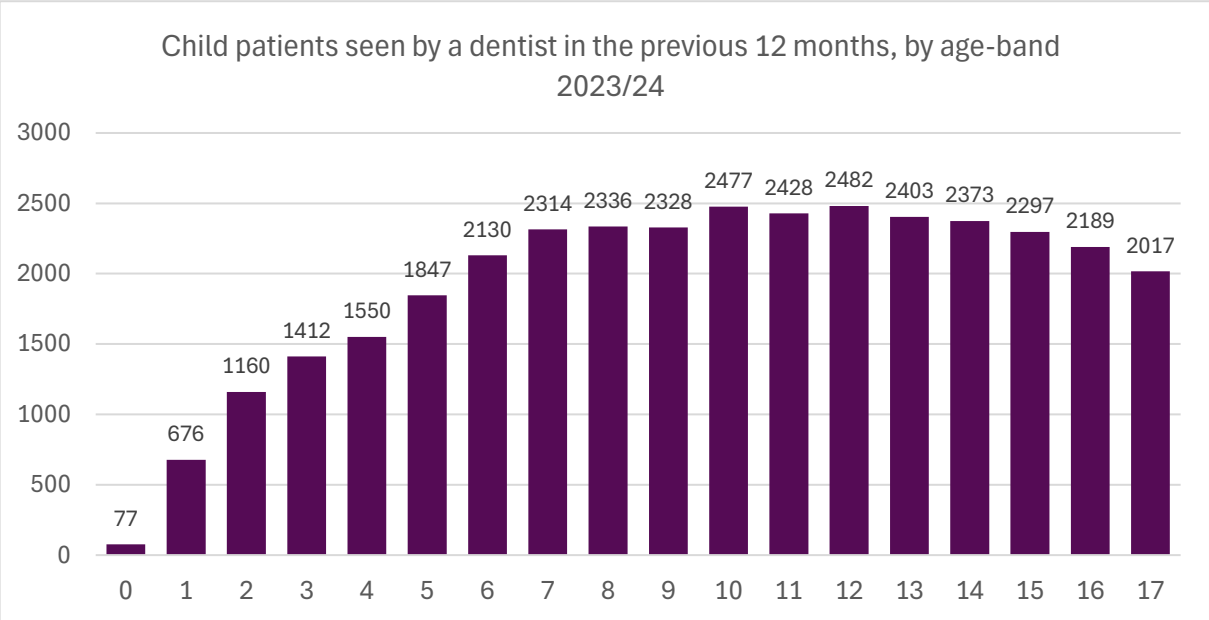
Figure 21. Children being seen by a dentist in the previous 12 months, 2018/19-2023/24



Source: NHS Business Services Authority (NHS BSA)

Of all those seen by a dentist in the last 12 months, the highest number of patients seen was among 12-year-olds (7.2%), closely followed by ages 10 (7.18%) and 11 (7%). The lowest was among infants aged 0 (0.2%) (Figure 22).

Figure 22. Child patients seen by a dentist in the previous 12 months,, by single year of age, 2023/24



Source: NHS Business Services Authority (NHS BSA)

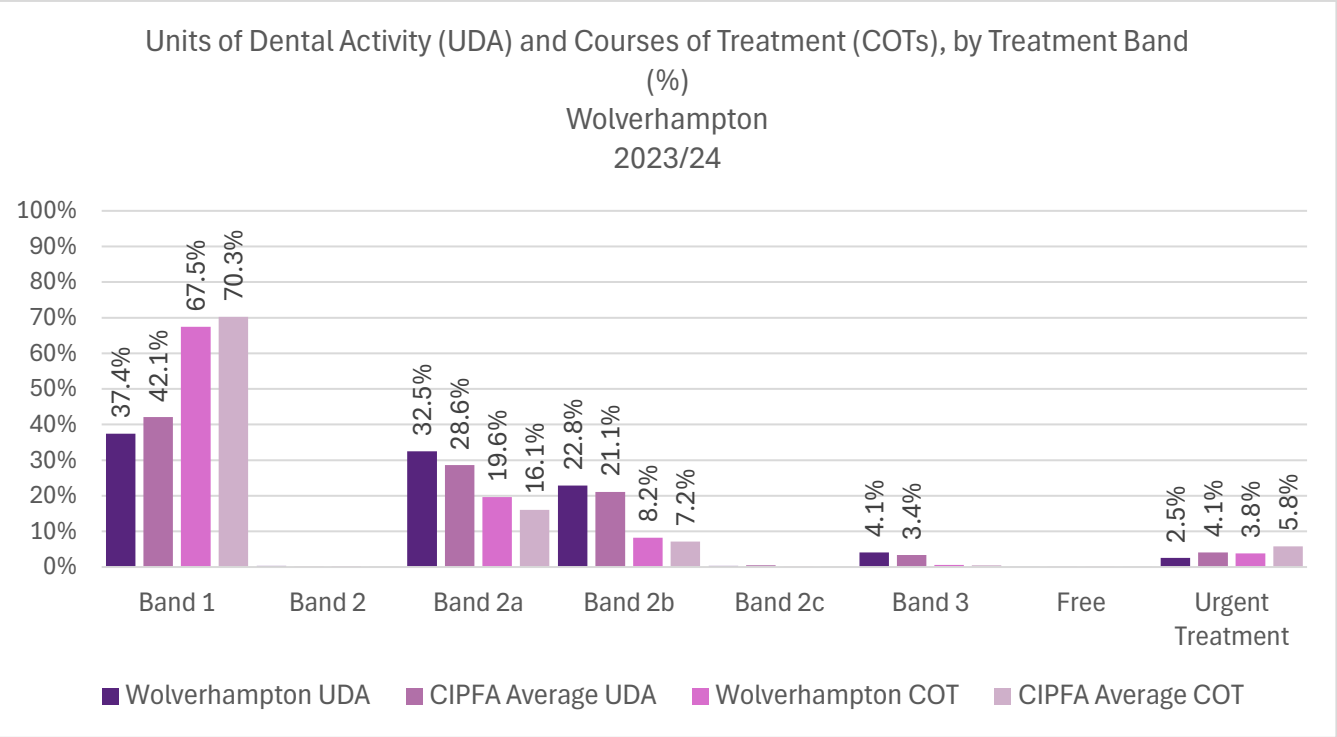
In 2023/24, 37.4% of Units of Dental Activity (UDAs) and 67.5% of Courses of Treatment (COTs) for child (<18s) patients in Wolverhampton were focused on preventive care (Band 1), which is a slightly lower proportion compared to neighbouring CIPFA authorities, where 42% of UDAs and 70.3% of COTs were Band 1.

Wolverhampton shows a higher proportion of Band 2 activity, with 56% of UDAs and 28% of COTs, compared to the CIPFA average of 50.3% for UDAs and 23.4% for COTs.

The city also reports a higher level of Band 3 activity, with 4% of UDAs and 0.6% of COTs, compared to the CIPFA averages of 3.4% UDAs and 0.5% COTs. Furthermore, urgent treatments in Wolverhampton are the lowest across all CIPFA neighbours, accounting for 2.5% of UDAs and 3.8% of COTs. This suggests that the majority of dental activity in those under 18 years of age in Wolverhampton focuses on routine and moderately complex treatments, with a slightly lower emphasis on preventative care than CIPFA neighbours. However, there is less focus on emergency care for urgent dental treatment across the city than compared to CIPFA neighbours, suggesting fewer urgent dental issues (Figure 23 & Figures 24).

However, it is acknowledged that access constraints may influence treatment patterns, and this should be considered when interpreting Band activity.

Figure 23. UDA and COT activity for child patients (<18 yrs), by treatment band

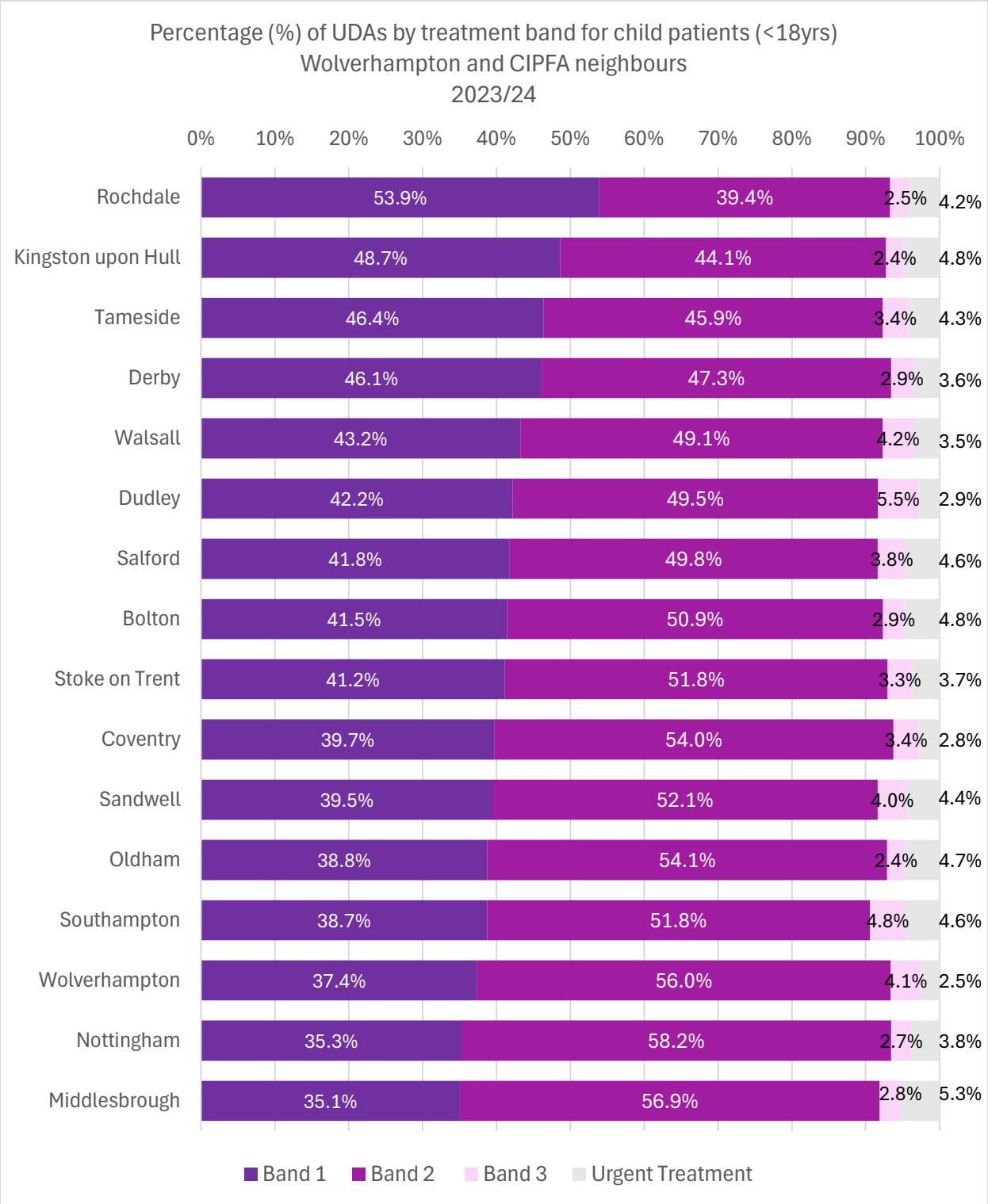


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. These figures reflect activity recorded in

General Dental Services (GDS) and do not capture dental care delivered through Community Dental Services (CDS) or hospital settings. As such, they don't provide the full picture of dental activity.

Source: NHS Business Services Authority (NHS BSA)

Figure 24. UDAs by treatment band, child patients (<18 yrs), Wolverhampton and comparators



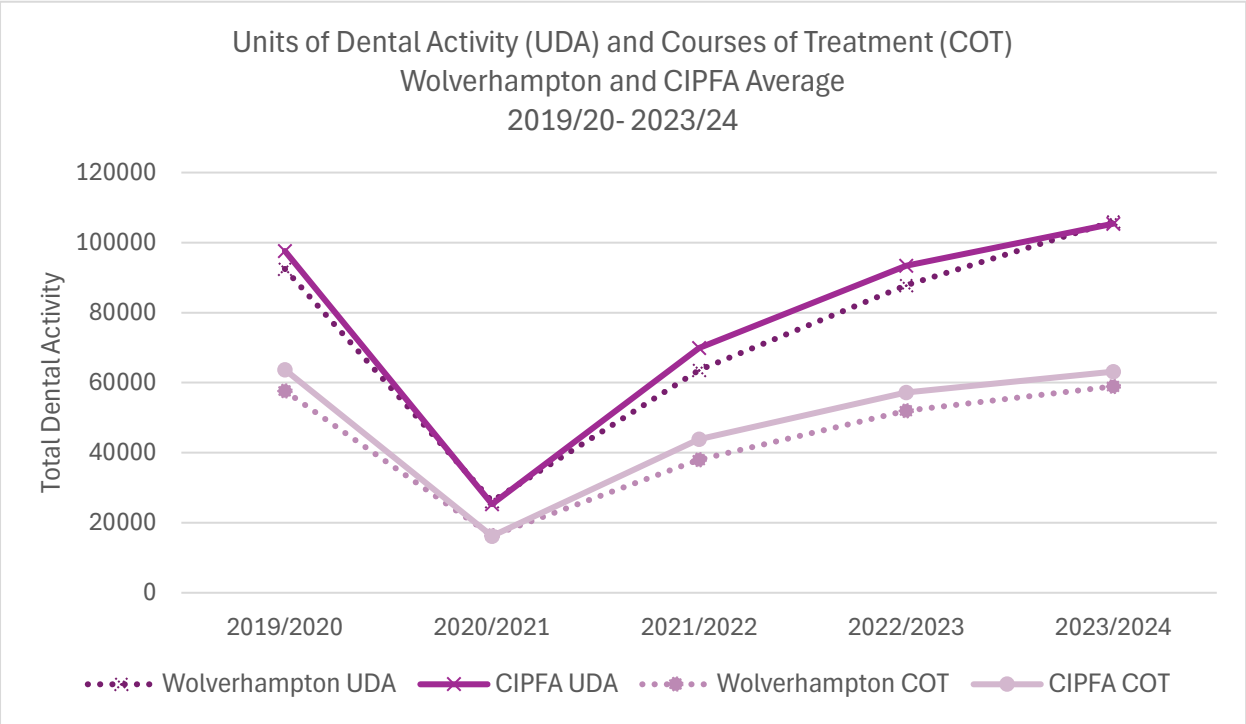
Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. These figures reflect activity recorded in General Dental Services (GDS) and do not capture dental care delivered through Community Dental Services (CDS) or hospital settings. As such, they don't provide the full picture of dental activity.

Source: NHS Business Services Authority (NHS BSA)

Over the past five years, Wolverhampton's dental activity has fluctuated, primarily due to the impact of the COVID-19 pandemic and subsequent recovery efforts. In 2020/21, the pandemic caused a significant decline in dental activity, reflecting the widespread disruption of services due to COVID-19 restrictions. Since then, dental activity has gradually returned to pre-pandemic levels.

In the most recent full financial year (2023/24), Wolverhampton surpassed the CIPFA average, completing 106,030 UDAs compared to 105,400 UDAs across CIPFA authorities. However, the number of Courses of Treatment (COTs) delivered remains below the CIPFA average, with 58,938 COTs completed in Wolverhampton compared to 63,153 across CIPFA authorities. This suggests that, in absolute numbers, Wolverhampton is delivering fewer COTs overall, even though the proportion of those treatments that are Band 2 and 3 is higher (Figures 25 & Figure 26).

Figure 25. Trend of dental activity (UDAs and COT) over 5-year-period



Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. These figures reflect activity recorded in

General Dental Services (GDS) and do not capture dental care delivered through Community Dental Services (CDS) or hospital settings. As such, they don't provide the full picture of dental activity.

Source: NHS Business Services Authority (NHS BSA)

NHS 111

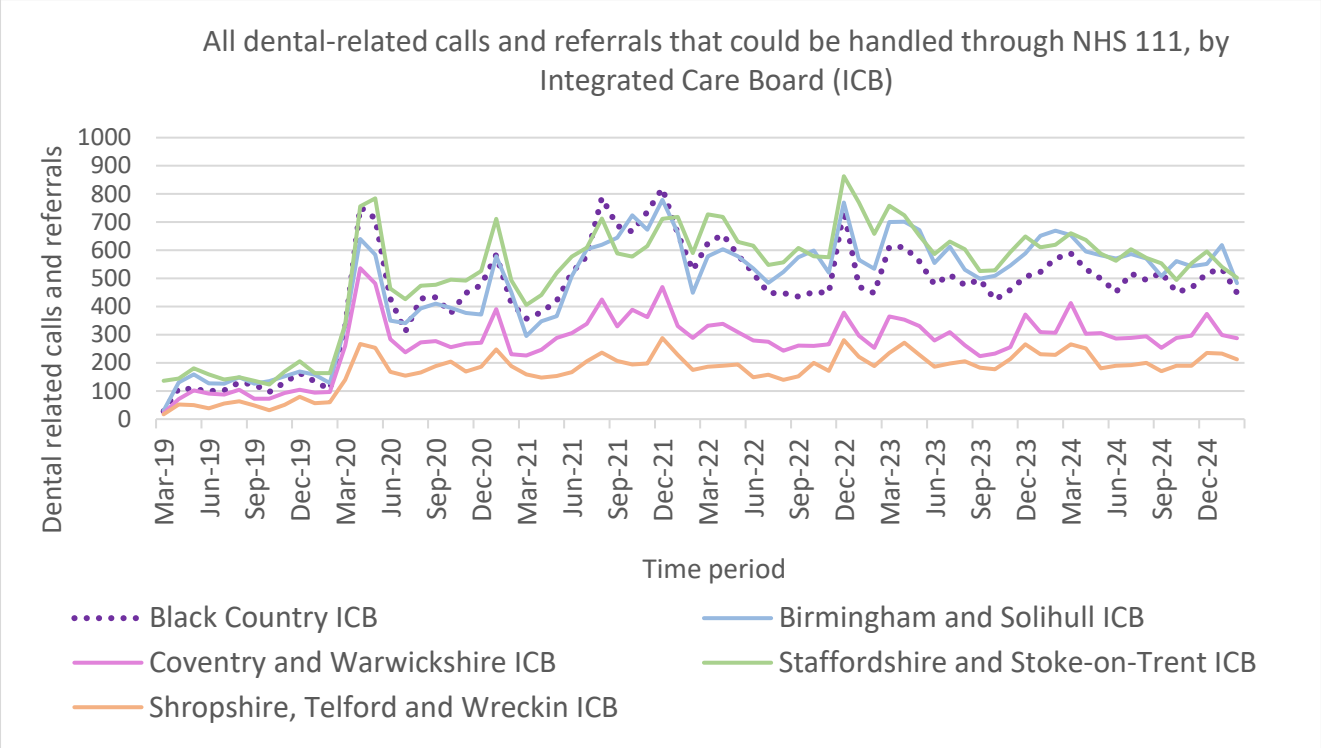
Figure 26 shows the number of NHS 111 calls and referrals related to dental health from March 2019 to February 2025. These calls are made by individuals within the ICB locality seeking advice or referrals for dental issues, indicating the demand for dental care services triaged through the NHS 111 helpline.

Over the past five years, the volume of NHS 111 calls related to dental issues in the Black Country ICB has shown an overall increase, with call numbers gradually rising year-on-year. In February 2025, the Black Country ICB had 449 NHS 111 dental-related calls. This upward trend reflects a growing demand for dental care services, which may be attributed to a combination of factors, including increased awareness of NHS 111 as a resource, growing population, and perhaps changes in dental care accessibility or service availability.

In comparison to neighbouring ICBs, the Black Country ICB generally falls in the mid-range in terms of call volume. Larger, more urbanised ICBs such as Birmingham and Solihull ICB and Staffordshire and Stoke-on-Trent ICB consistently record higher numbers of calls. However, the Black Country ICB shows a steady level of demand, with a higher volume of calls than Coventry and Warwickshire ICB and Shropshire, Telford and Wrekin ICB.

The general trend over the years shows significant fluctuations, particularly during the pandemic period (2020-2021), with a sharp rise in calls during the initial months of the pandemic, likely due to limited access to in-person dental care. As restrictions eased, the number of calls stabilised but remained elevated compared to pre-pandemic levels.

Figure 26. All NHS 111 calls classified as 'dental' related (includes referrals)



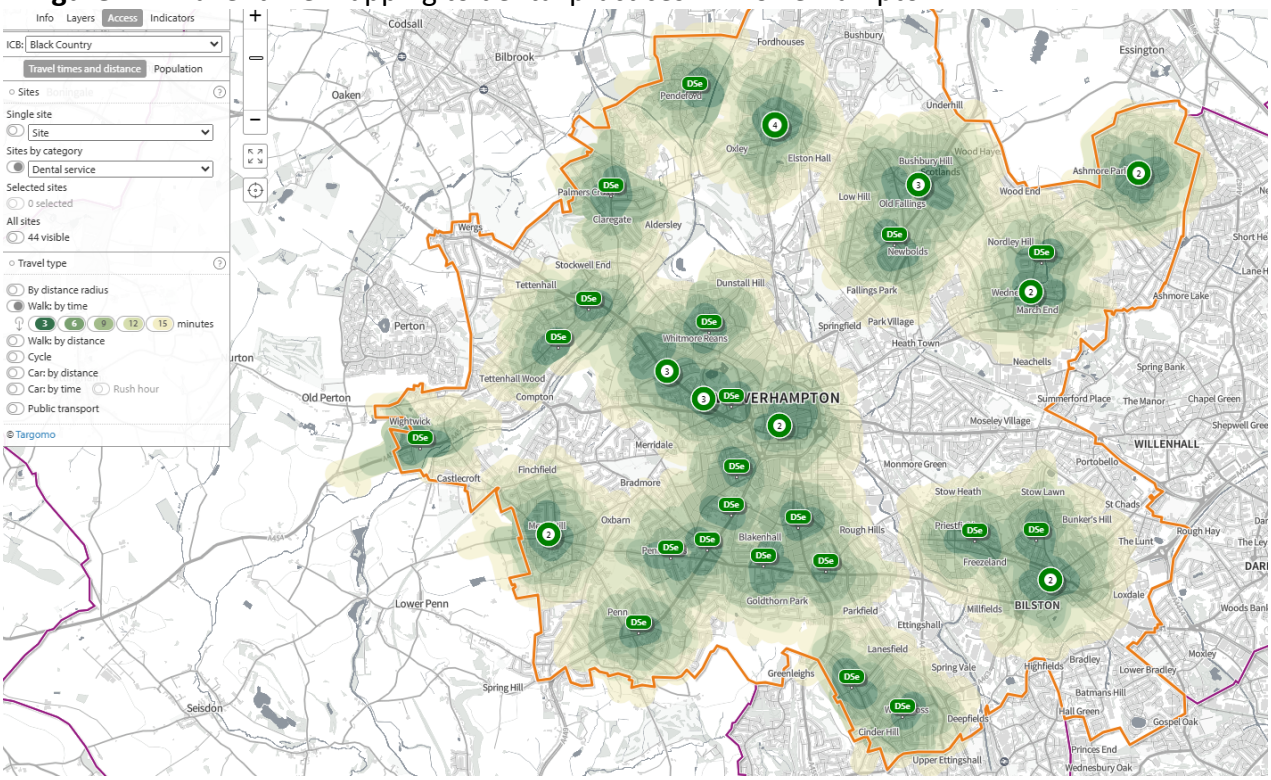
Source: NHS Business Services Authority (NHS BSA)

Geographical Spread of Local Dental Practices

As of June 2025, there were 44 dental practices in Wolverhampton.

The majority of dental practices are accessible by walking, with the large majority within a 15-minute walk from their home. However, there are pockets of the city in the East, West and North West of the city that would not be able to walk to their local dental practice within 15 minutes (Figure 27). All dental practices are accessible within a 30-minute journey from home by vehicle.

Figure 27. Travel-time mapping to dental practices in Wolverhampton



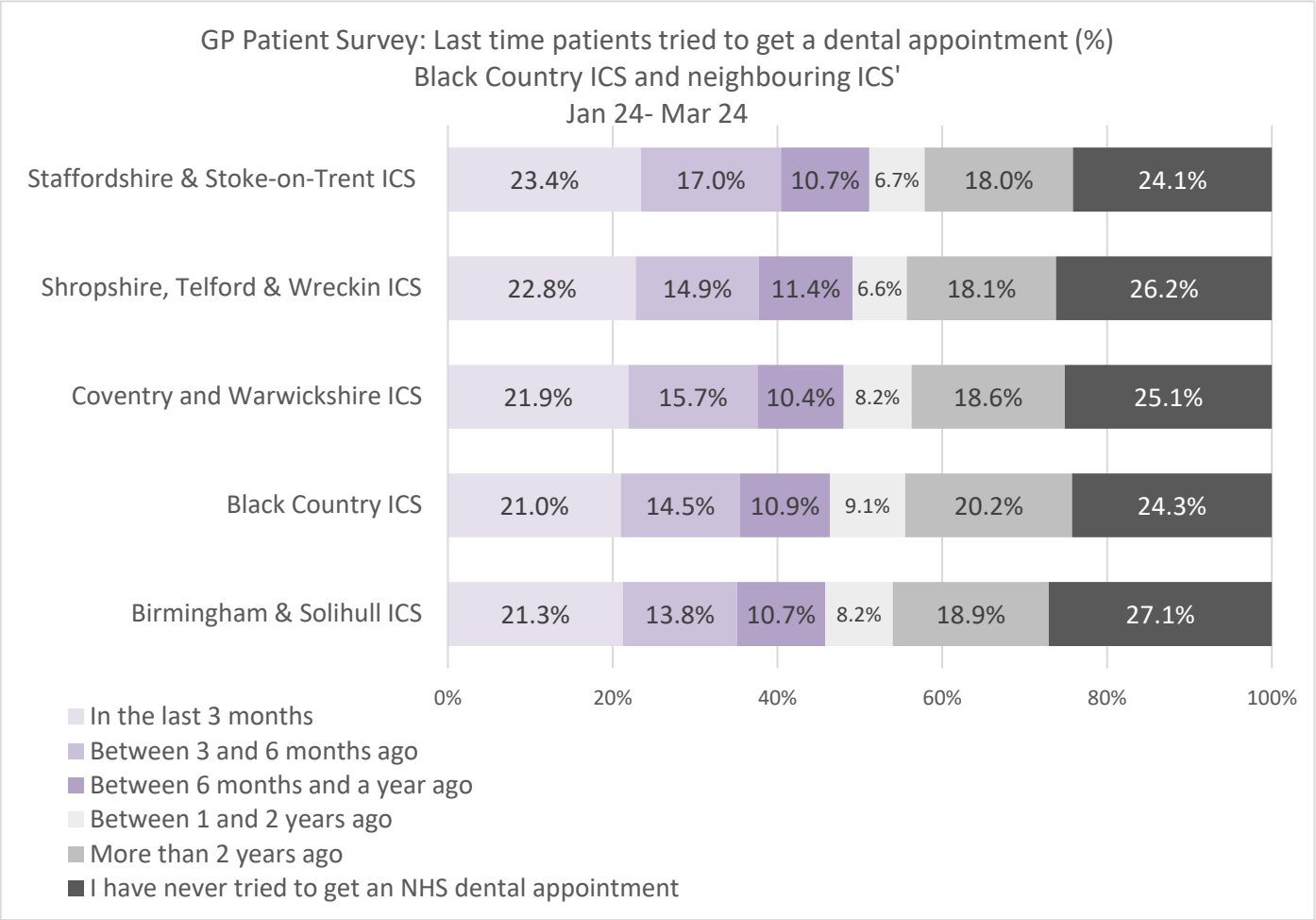
Source: SHAPE Atlas

GP Patient Survey (Jan 2024-March 2024): Patient Experiences Using NHS Dentistry

Between January and March 2024, a total of 19,214 patients from the Black Country locality participated in the GP Patient Survey, resulting in a 22% response rate. Figure 11 shows that nearly half (46%) of respondents reported attempting to access NHS dentistry within the last 3 to 12 months. Around 1 in 10 (9%) tried to access NHS dentistry between 1 and 2 years ago, and around 2 in 10 (20%) attempted to access services more than 2 years ago, and just under a third (24%) of respondents indicated that they have never tried to book an NHS dental appointment (Figure 28).

The large majority (86%) of respondents reported to try and access an NHS dental practice they had used before previously.

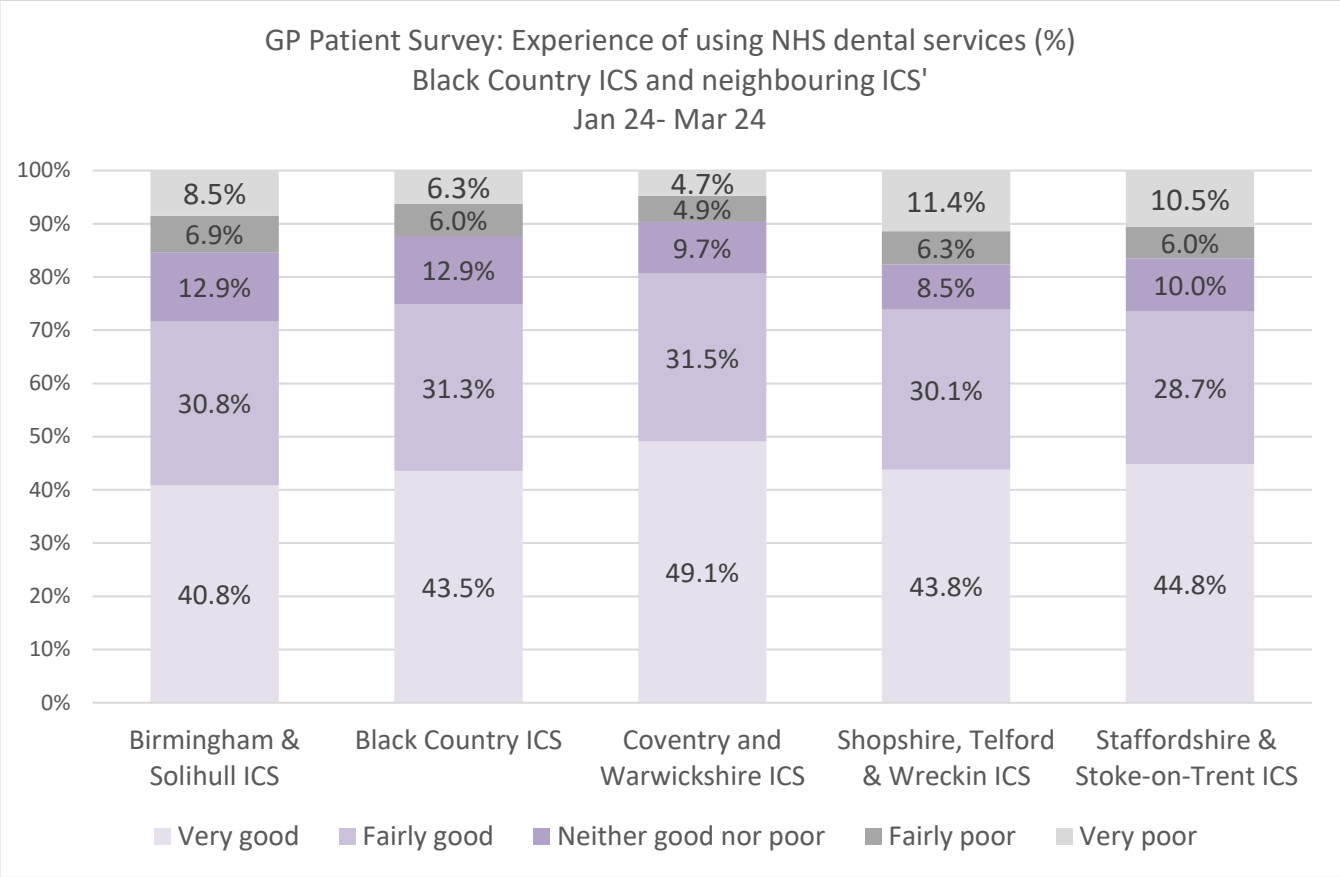
Figure 28. Last time respondents tried to access NHS Dental Practice: GP Patient Survey



Source: GP Patient Survey

Around 7 in 10 (75%) reported that their experience of using NHS dental practices was ‘very good’ (43.5%) or ‘fairly good’ (31.3%), which is similar to residents from neighbouring ICB localities. Around 1 in 10 (12%) reported that their experience was ‘fairly poor’ (6.0%) or ‘very poor’ (6.3%). A further 13% reported it was ‘neither good nor poor’ (Figure 29).

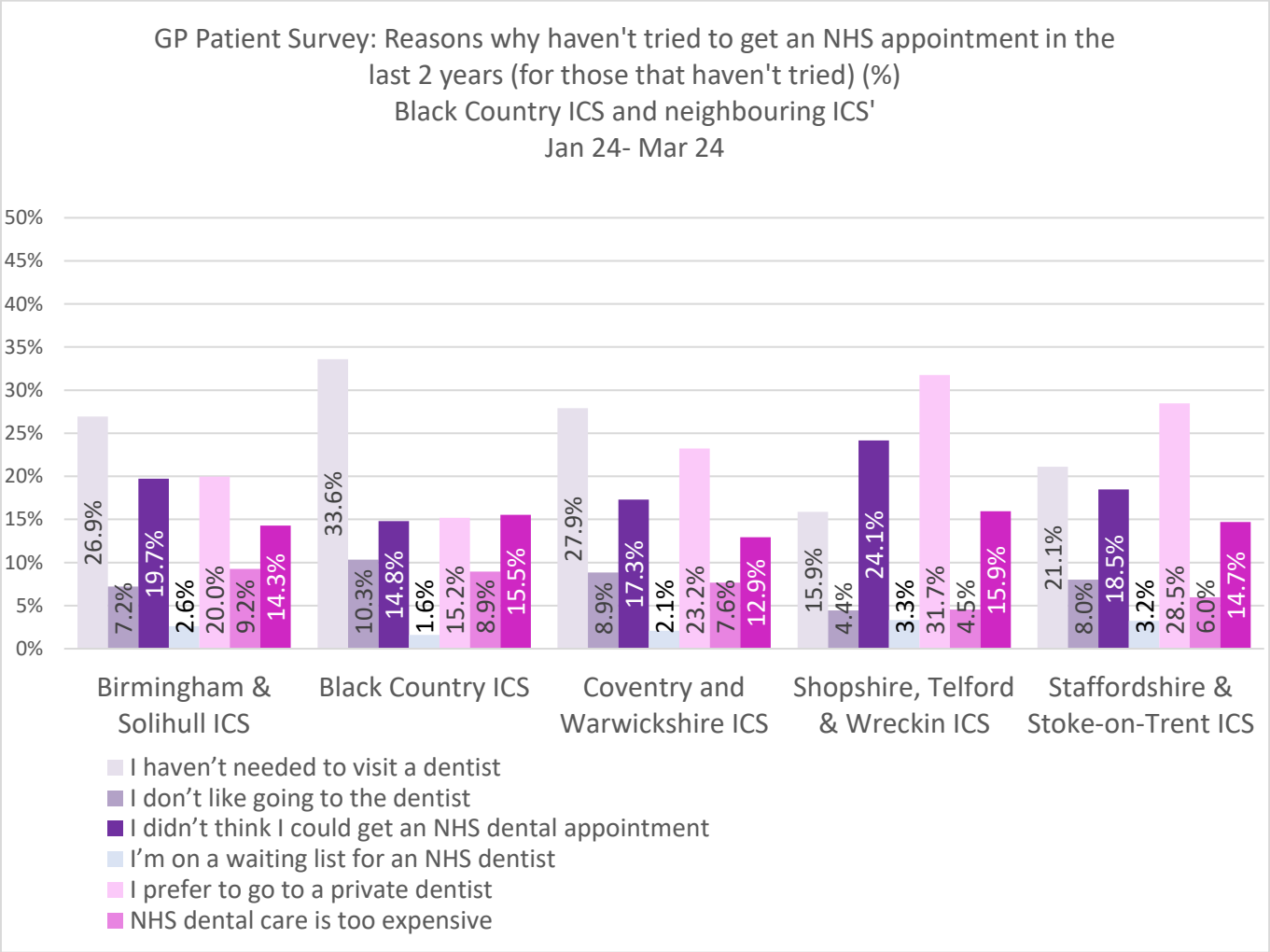
Figure 29. Experience of respondents using NHS dental services: GP Patient Survey



Source: GP Patient Survey

Of those that reported they had not tried to book an NHS dental appointment in the last 2 years, a third (34%) reported they hadn't needed to access a dentist. A smaller proportion reported they don't like going to the dentist (10%), they didn't think they would be able to get an appointment (15%), they prefer going to a private dentist (15%), NHS dental services were too expensive (9%), or because they were on an NHS waiting list (2%). A further 16% reported not accessing an NHS dentist for 'another' reason (Figure 30).

Figure 30. Reasons for not accessing an NHS appointment in the last 2 years: GP Patient Survey



Source: GP Patient Survey

Please note: Vulnerable populations are often underrepresented in surveys like the GP Patient Survey. These individuals may be less likely to be registered with a GP practice, which could result in their underrepresentation in the survey sample.

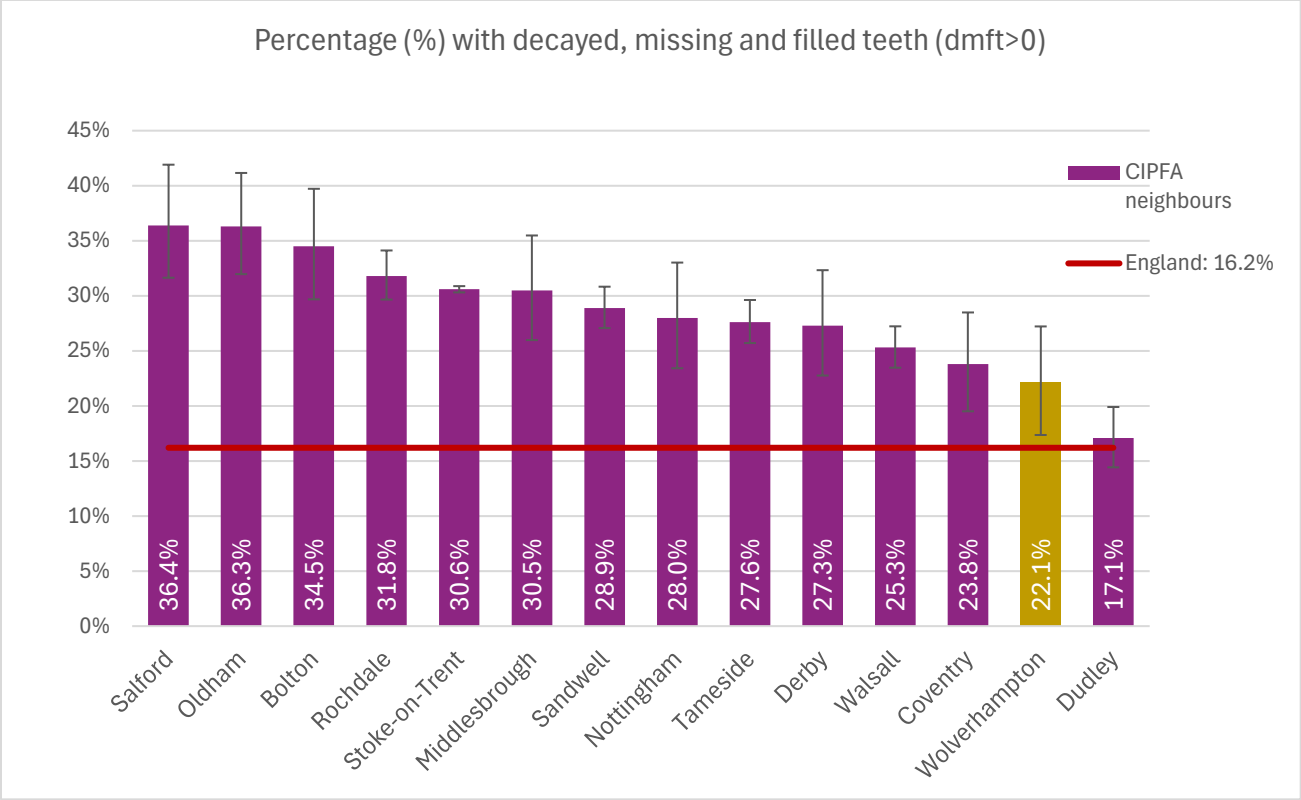
National Dental Epidemiology Programme: Oral Health Surveys

Oral Health Survey of 5-Year-Olds (2024)

During the 2023/24 school year, Wolverhampton participated in the seventh National Dental Epidemiology Programme Oral Health Survey of 5-Year-Olds, achieving a participation rate of 55%, which is similar to the national average of 60%.

Overall, approximately 22.1% of children had decayed, missing, or filled teeth, which is in line with the national average of 22.4%. This figure is also among the lowest across CIPFA neighbouring authorities (Figure 31). Among those with dental decay experience, each child had an average of 3.7 teeth affected by decay, which is slightly higher than the national average of 3.5 but still lower than many statistical comparator authorities (Figure 32).

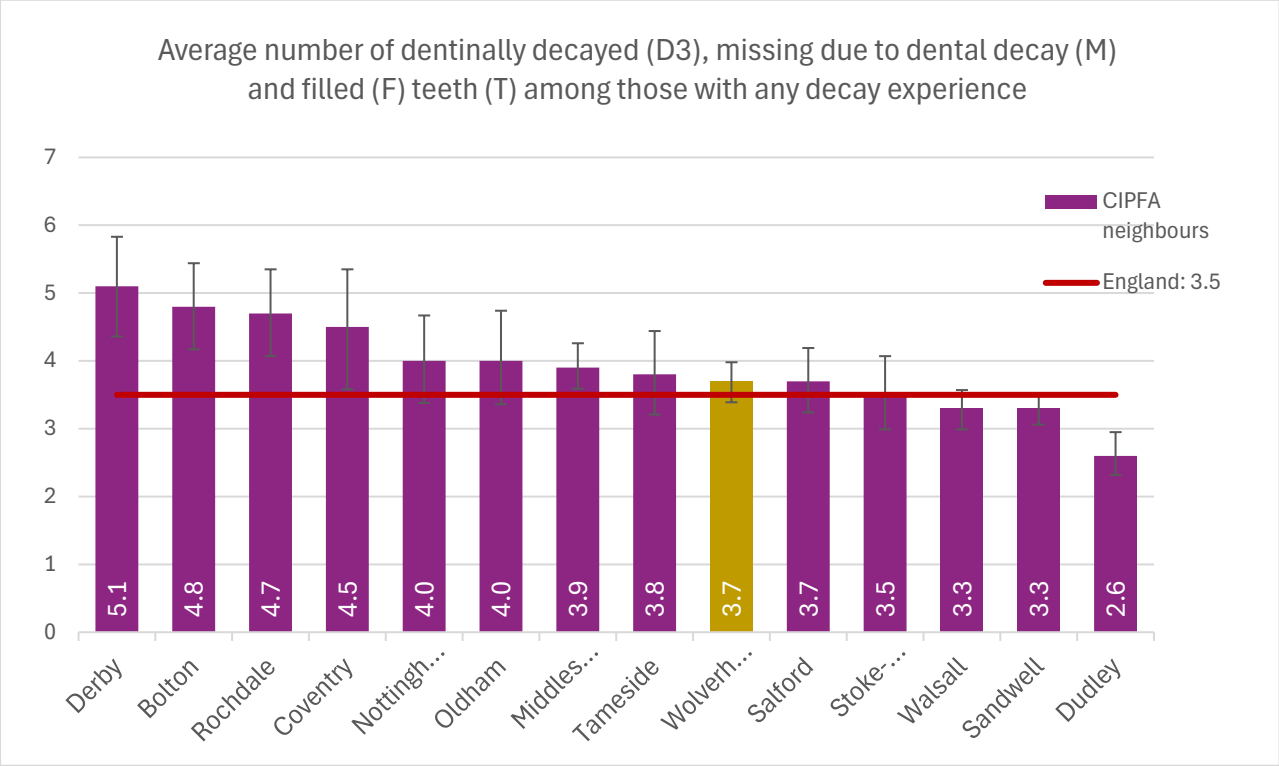
Figure 31. Percentage of 5-year-olds sample with decayed, missing and filled teeth, (5-Year-Olds)



Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2024

Figure 32. Average number of dmft among those with decay experience (5-Year-Olds)



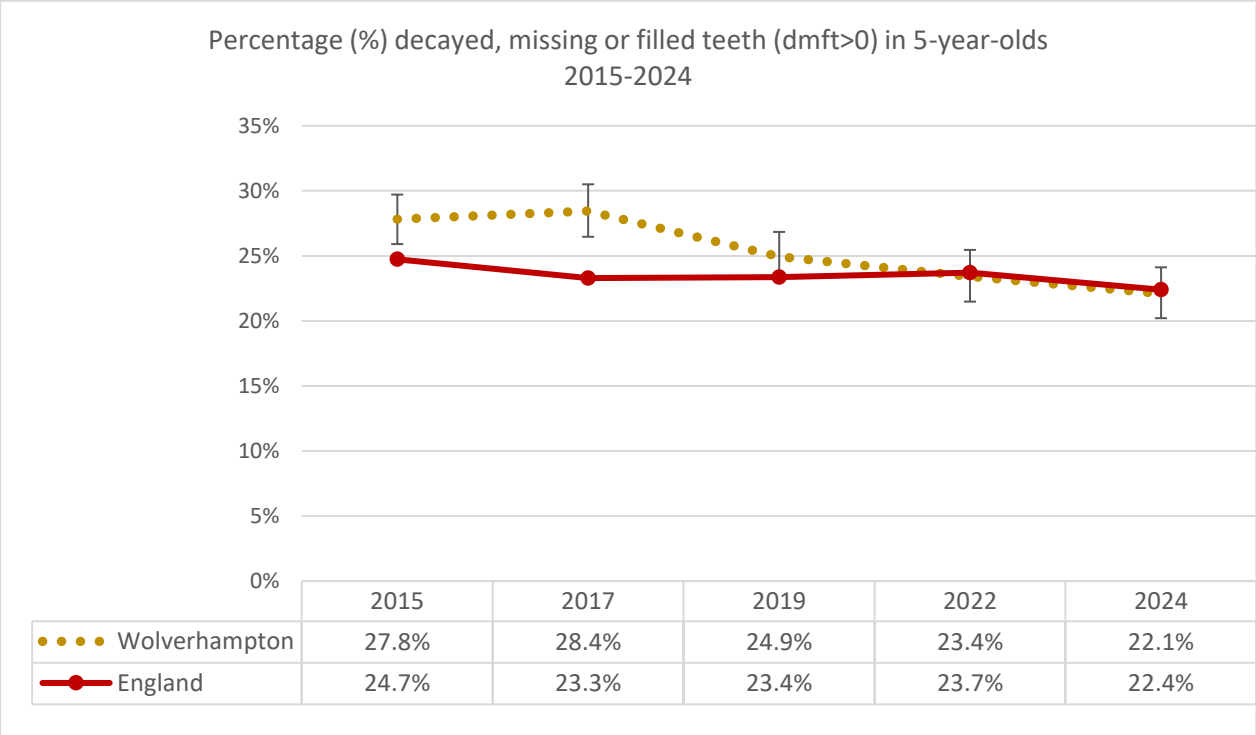
Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2024

Figure 33 shows the improvements in child oral health over time. Since 2015, the proportion of 5-year-olds with decayed, missing, or filled teeth has declined both locally and nationally. The local prevalence has fallen more sharply, with a 5.7 percentage point decrease between 2015 and 2024.

In both 2015 and 2017, the local prevalence was higher than the national average, and this difference was statistically significant. However, in recent years, the gap has narrowed, and the local prevalence of decayed, missing, or filled teeth is no longer statistically significantly different from the national average.

Figure 33. Trend data for % dmft>0 (5-Year-Olds)

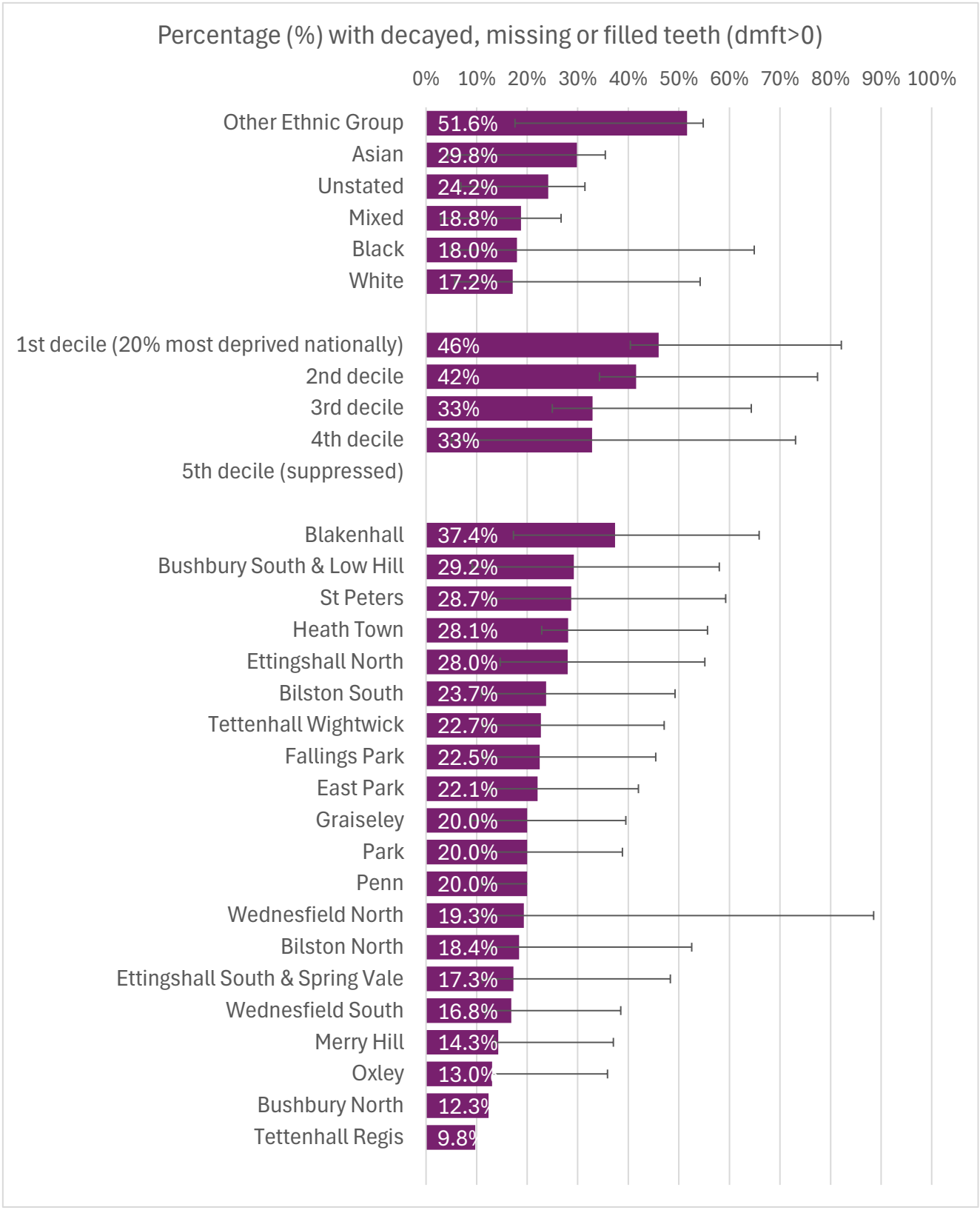


	2015	2017	2019	2022	2024
Wolverhampton	27.8%	28.4%	24.9%	23.4%	22.1%
England	24.7%	23.3%	23.4%	23.7%	22.4%

Source: National Dental Epidemiology Programme (NDEP), 2024

There were differences in the prevalence of tooth decay by ethnic group. A higher proportion of children of 'Other' (52%) and Asian (30%) ethnicity had decayed, missing or filled teeth, and this was statistically significant. Children living in the 2 most deprived deciles had around 10% greater prevalence of tooth decay compared to those living in the less deprived 3rd and 4th IMD deciles. There were also differences by ward geography, with children from more affluent wards experiencing less decay. Children residing in Tettenhall Regis (10%), Bushbury North (12%) and Oxley (13%) had the lowest rates of dental decay, which was found to be statistically significant (Figure 34).

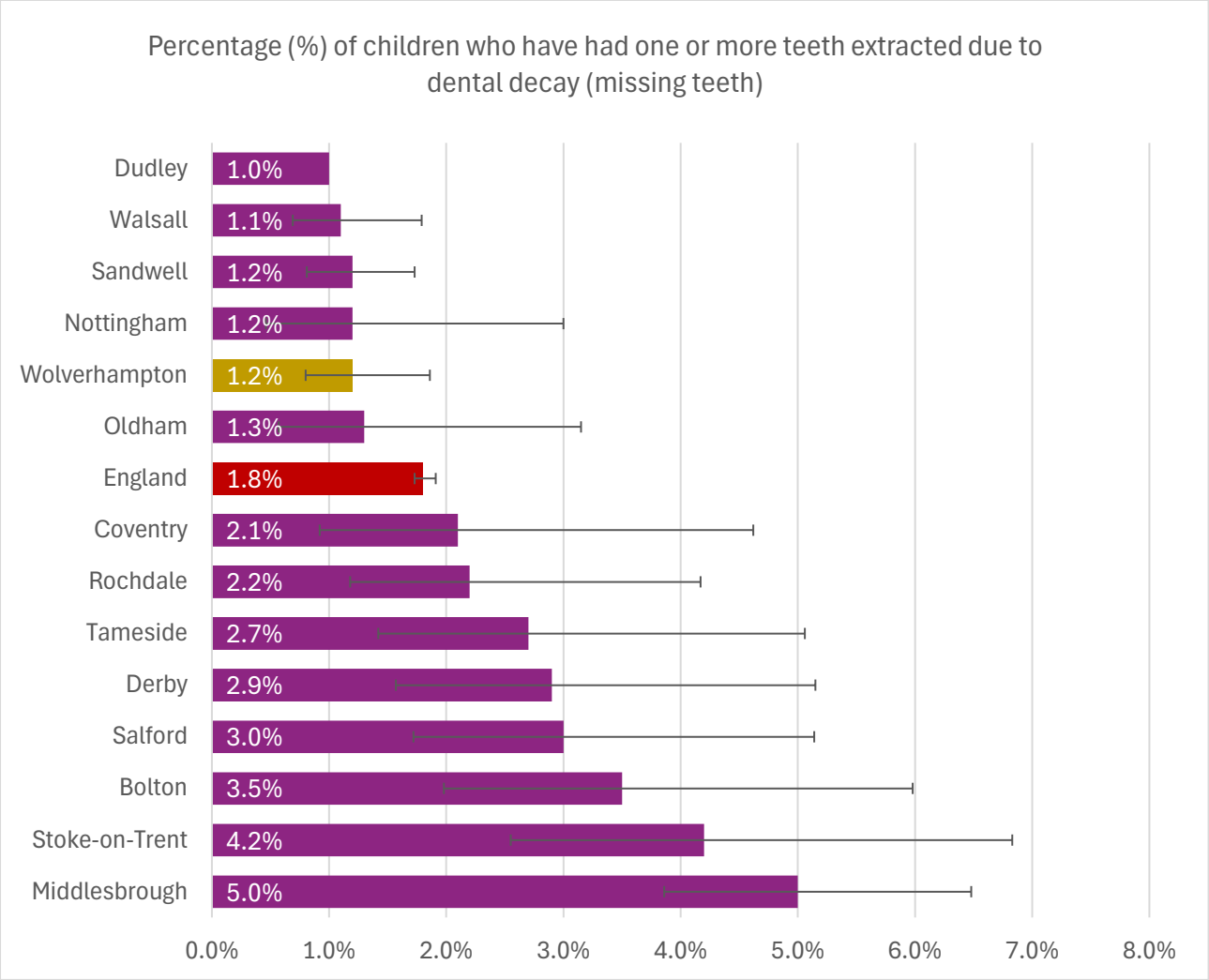
Figure 34. Demographics of those with decayed, missing and filled teeth (5-Yr-Olds)



Note: Further breakdowns by ethnicity were not available due to low sample sizes and data suppression protocols to protect individual confidentiality.
Low counts have been suppressed to protect individual confidentiality.
Source: National Dental Epidemiology Programme (NDEP), 2024

The proportion of the sample that have had one or more teeth extracted due to dental decay was low at 1.2%, which is lower than the national average of 1.8%, and CIPFA average of 2.3% (Figure 35).

Figure 35. Percentage of 5-year-old children who have missing teeth due to dental decay (5-Year-Olds)

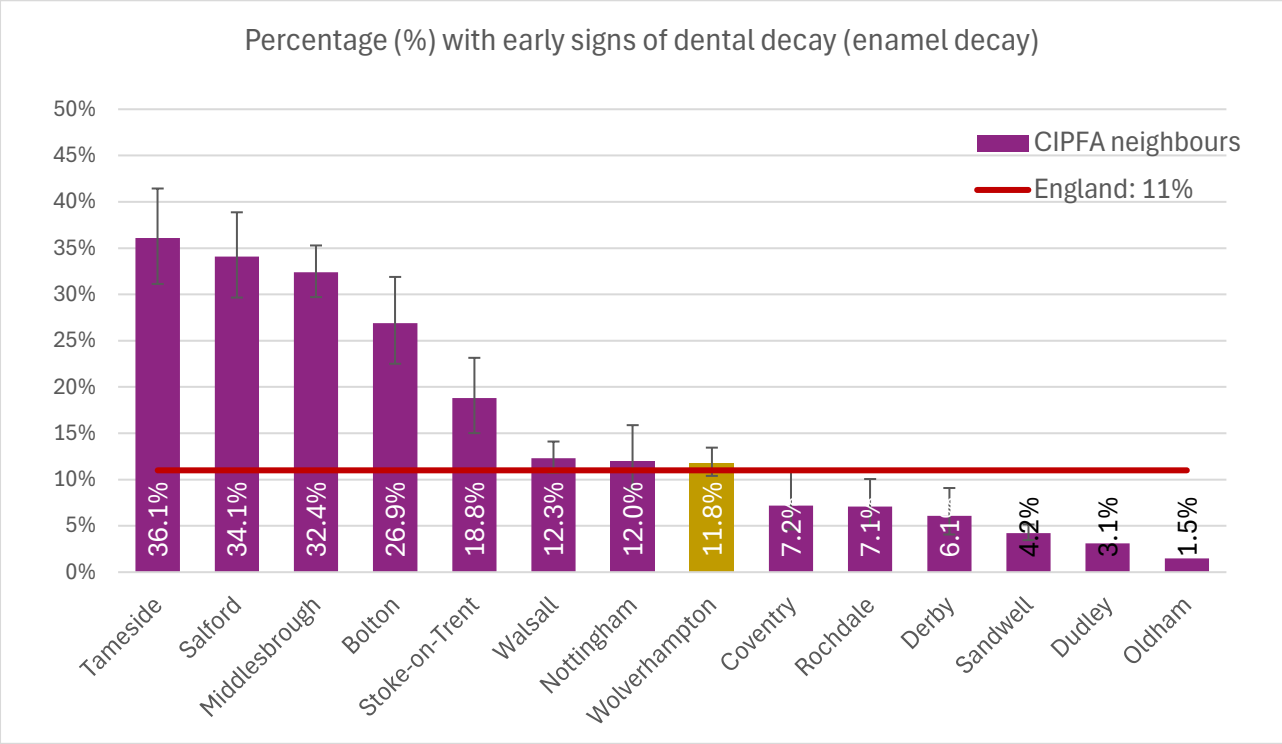


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2024

The proportion of children with early signs of dental decay (enamel decay), where the hard protective layer of the tooth starts to break down was 11.8% in Wolverhampton, which is not significantly different to the national average (11%) and is significantly lower than the average of CIPFA neighbouring authorities (15.3%) (Figure 36).

Figure 36. Percentage of 5-year-old children who have early signs of dental decay (5-Year-Olds)



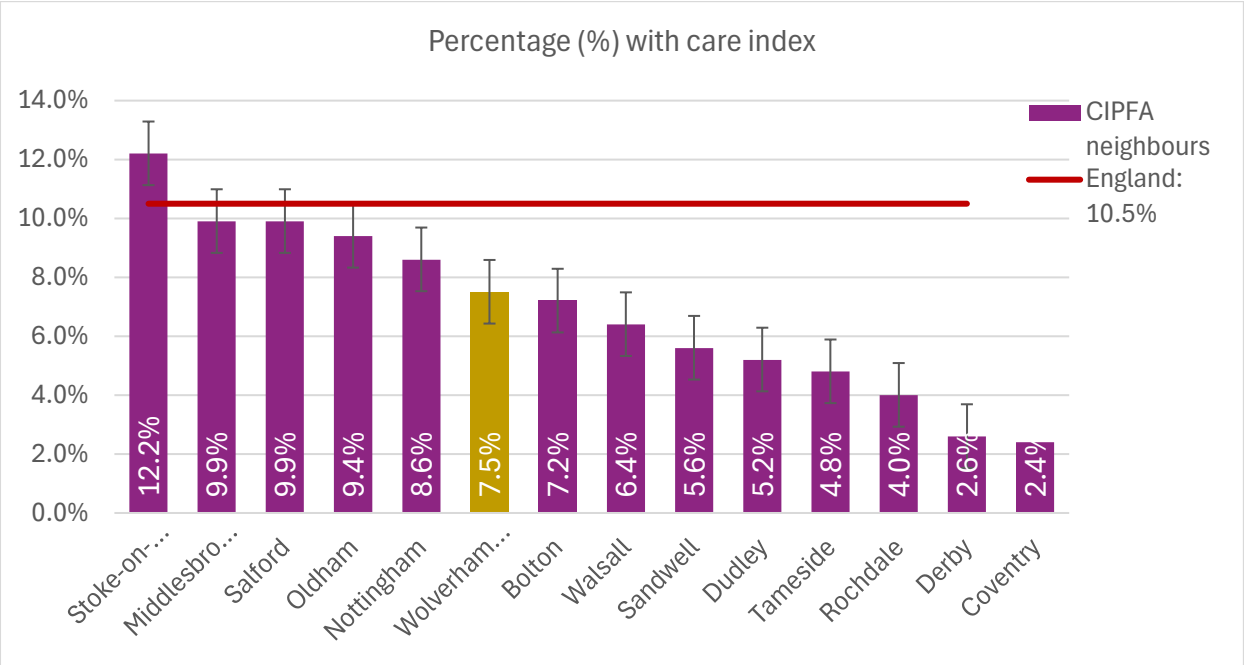
Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2024

The care index indicates the proportion of teeth that show dentinal decay and have also been treated with a filling. Essentially, it measures how well decay in children's teeth is being addressed with restorative treatment (fillings). A higher care index suggests that more of the decayed teeth are being treated, while a lower index might imply that many decayed teeth are not receiving the necessary restorative care.

In Wolverhampton, this was 7.5% of the sample, which is significantly less than the national average at 10.5%, and slightly above the average across CIPFA neighbours at 6.8%. This could indicate that a higher proportion of decayed teeth in Wolverhampton are either left untreated or are not receiving the required fillings compared to other areas, which may point to gaps in dental care access or treatment for children (Figure 37).

Figure 37. Percentage with care index (5-Year-Olds)



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Source: National Dental Epidemiology Programme (NDEP), 2024

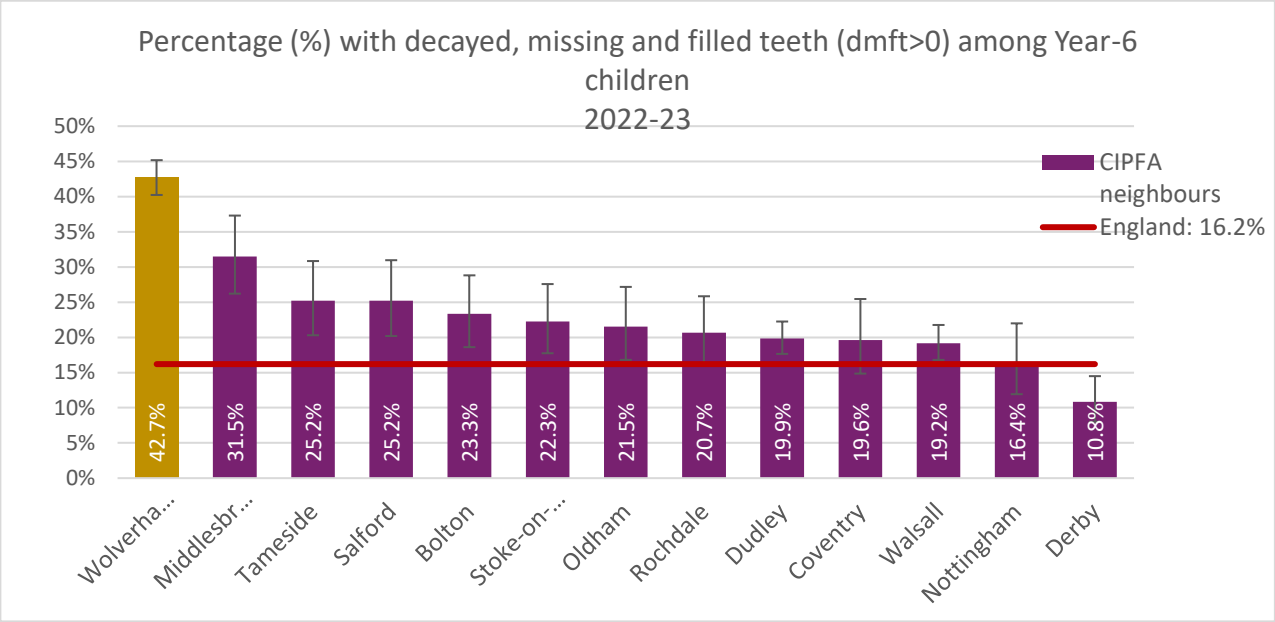
Oral Health Survey of Year-6- Children (2023)

During the 2023 school year, Wolverhampton participated in the seventh National Dental Epidemiology Programme Oral Health Survey of Year-6 children, achieving a participation rate of 46%, which is similar to the national average of 50%.

Overall, approximately 42.7% of children had decayed, missing, or filled teeth, which is significantly higher than the national average of 16% and the average of CIPFA neighbour authorities at 21.3% (Figure 38). Among those with dental decay experience, each child had an average of 2.4 teeth affected by decay, which is also higher than the national average of 1.8 and the CIPFA average of 1.7 (Figure 39).

There were differences in the prevalence of tooth decay by ethnic group. A higher proportion of children of 'Mixed' (46%) and White (45.6%) ethnicity had decayed, missing or filled teeth, although differences were not significant. Children living in the 2 most deprived deciles had a 10% greater prevalence of tooth decay compared to those living in the less deprived 3rd and 4th IMD deciles. There were also differences by ward geography, with children from more affluent wards experiencing less decay. Children residing in Tettenhall Regis had the lowest rates of dental decay, which was found to be statistically significant (19.6%) (Figure 40).

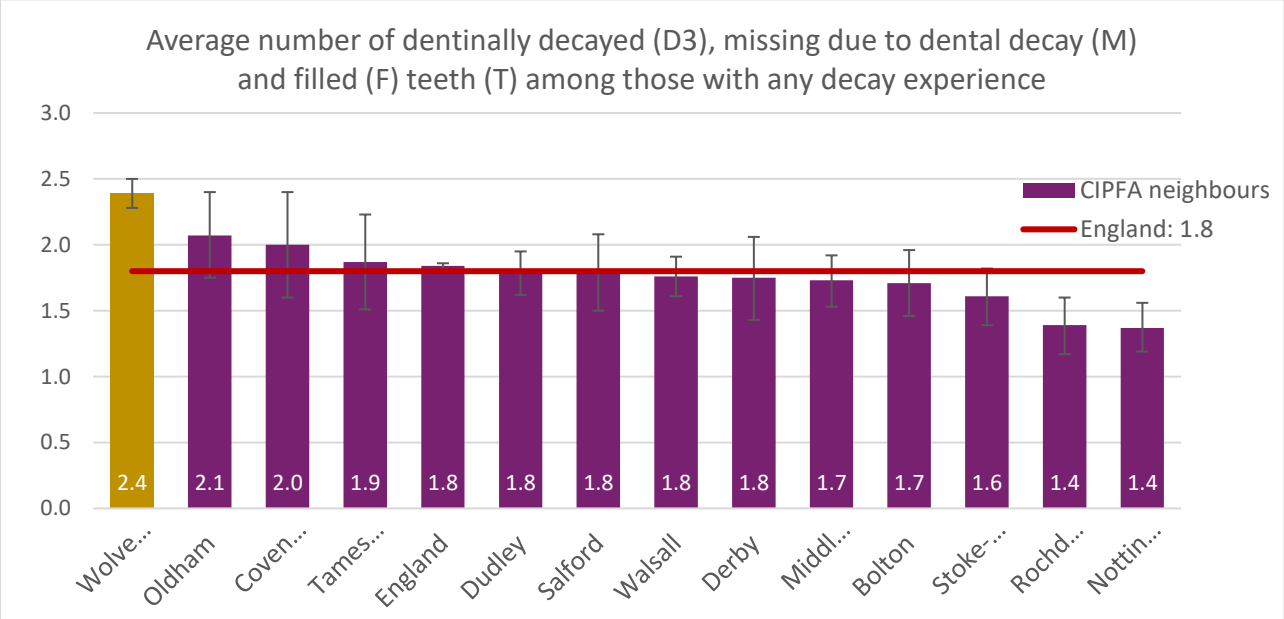
Figure 38. Percentage with decayed, missing and filled teeth (Year-6)



Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2023

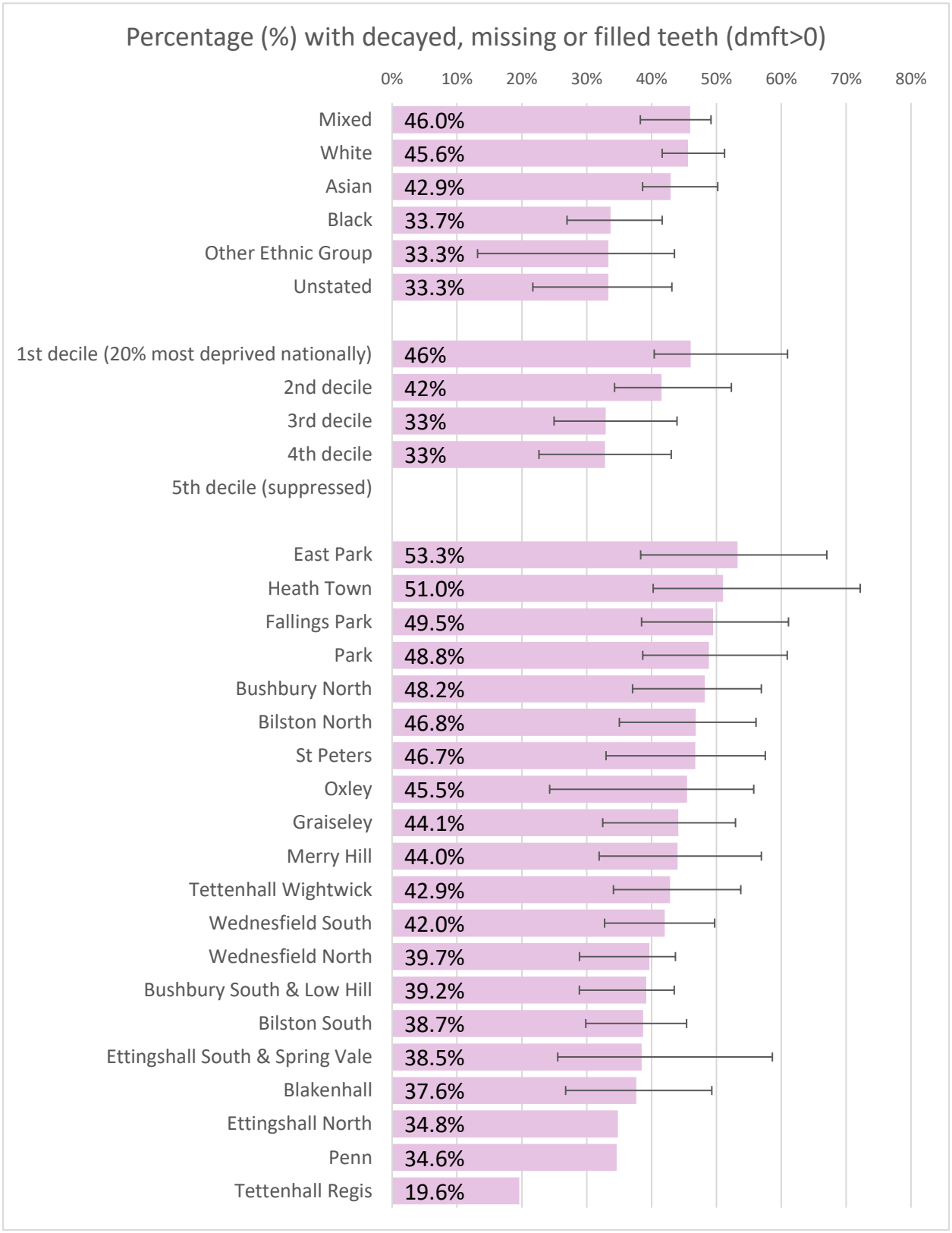
Figure 39. Average number of DMFT among those with decay experience (Year-6)



Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2023

Figure 40. Demographics of those with decayed, missing and filled teeth (Year-6)

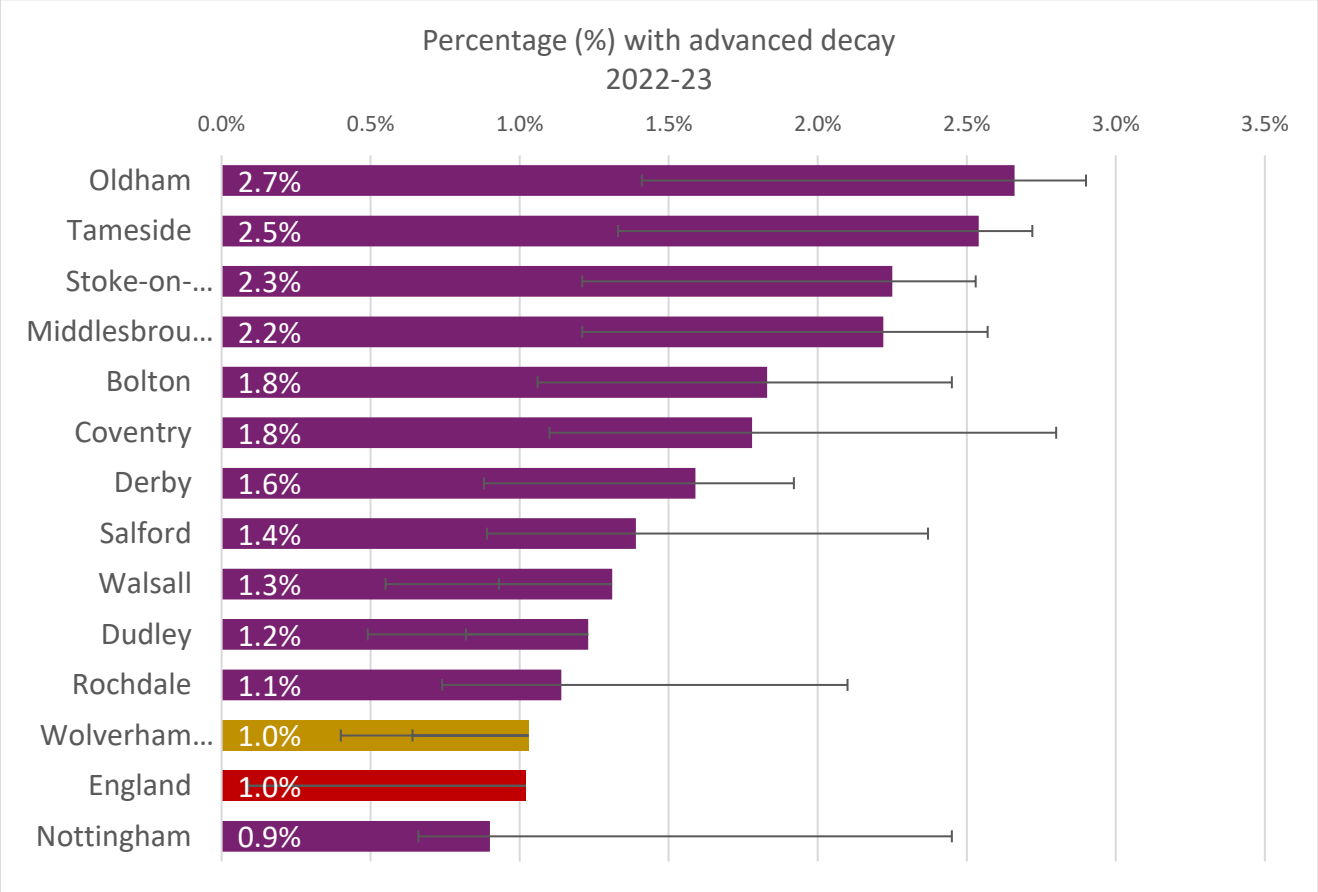


Source: National Dental Epidemiology Programme (NDEP), 2023

Note: Further breakdowns by ethnicity were not available due to low sample sizes and data suppression protocols to protect individual confidentiality.

The proportion of Year-6 children with advanced decay was low at 1% of the sample, which is in line with the national average, and falls below the CIPFA average of 1.7% (Figure 41).

Figure 41. Percentage with advanced decay (Year-6), Wolverhampton and comparators

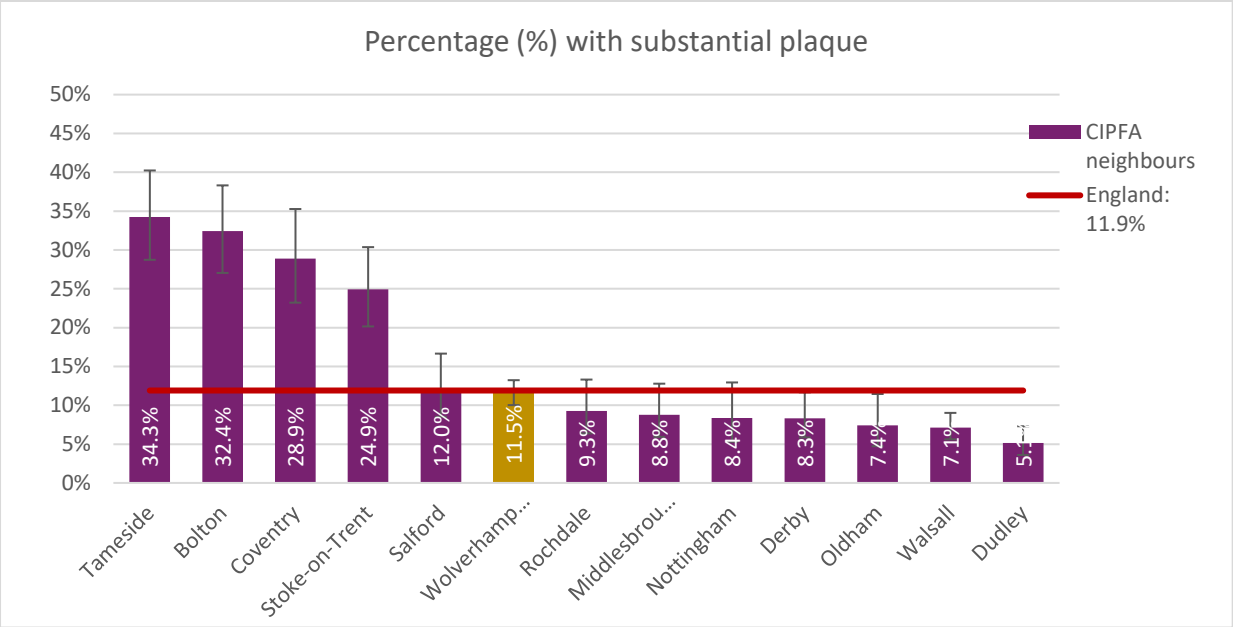


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2023

The proportion of children with substantial plaque provides a proxy measure of children who do not brush their teeth or brush them infrequently. In the 2022-23 survey, 11.5% of Year-6 children had substantial plaque, which is not significantly different to the national average of 11.9% and the average across CIPFA neighbours (15.6%) (Figure 42).

Figure 42. Percentage with substantial plaque (Year-6), Wolverhampton and comparators

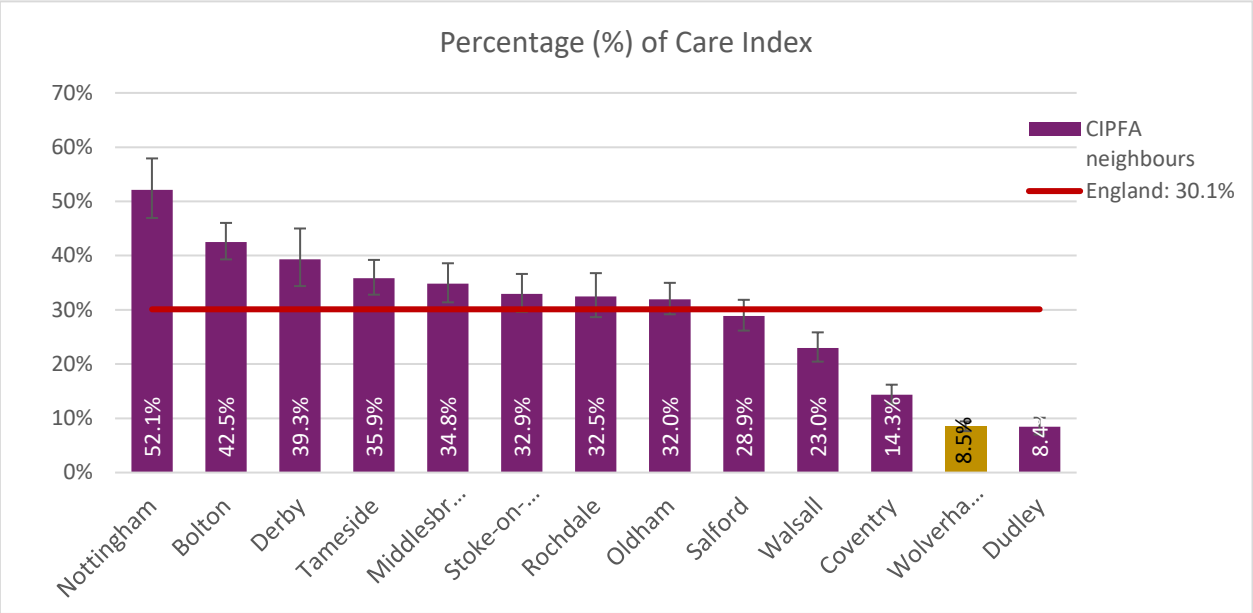


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2023

Similar to the 5-year-olds survey, the proportion of Year-6 children with untreated dental decay (Care Index) was significantly lower than the national average of 30% and the average across CIPFA neighbours at 31.4%. This may indicate that a higher proportion of decayed teeth in Wolverhampton are either left untreated or are not receiving the required fillings compared to other areas, which may point to gaps in dental care access or treatment for children (Figure 43).

Figure 43. Percentage of Care Index (Year-6)

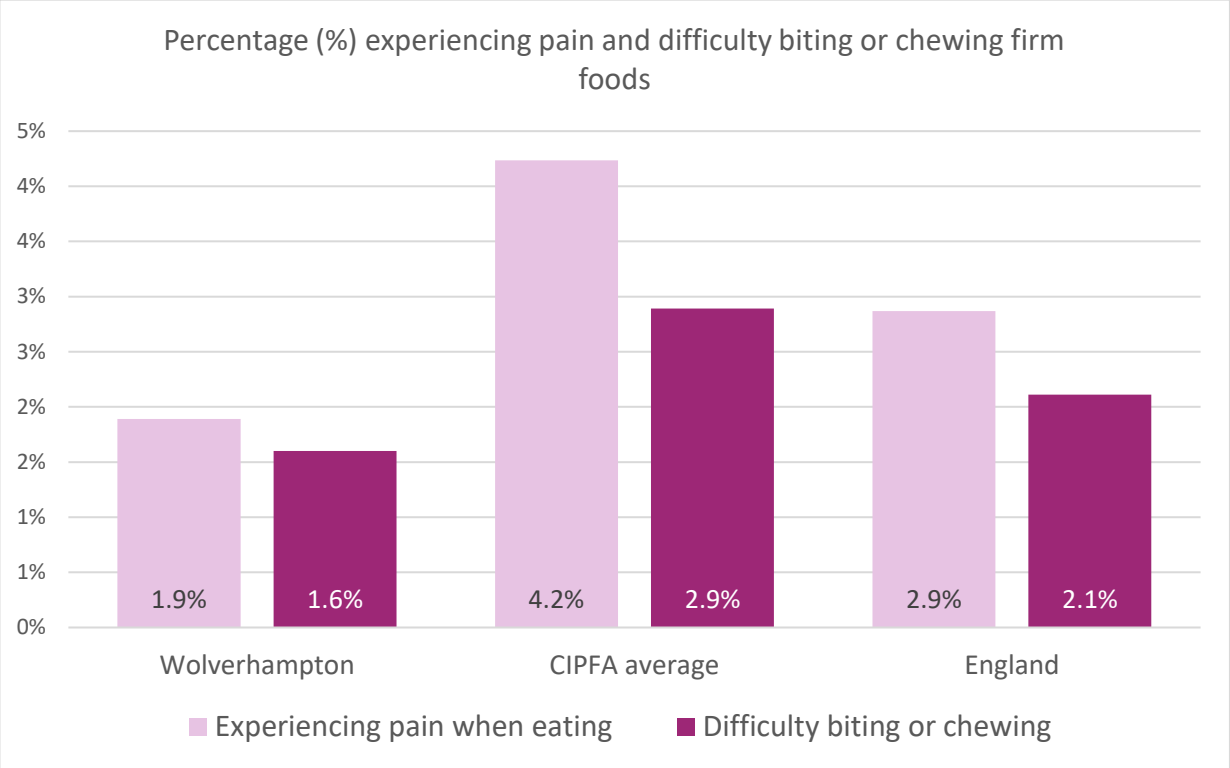


Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Data was not available for all CIPFA neighbours, so some neighbours may be excluded from this analysis.

Source: National Dental Epidemiology Programme (NDEP), 2023

Approximately, 2% of Year-6 children reported to have had pain in their teeth or mouths 'often' or 'very often' and 1.6% reported to have had difficulty biting or chewing firm foods often or very often in the past 3 months, which is less than both the national average and the average of CIPFA neighbours (Figure 44).

Figure 44. Percentage experiencing pain or difficulty with eating (Year-6)



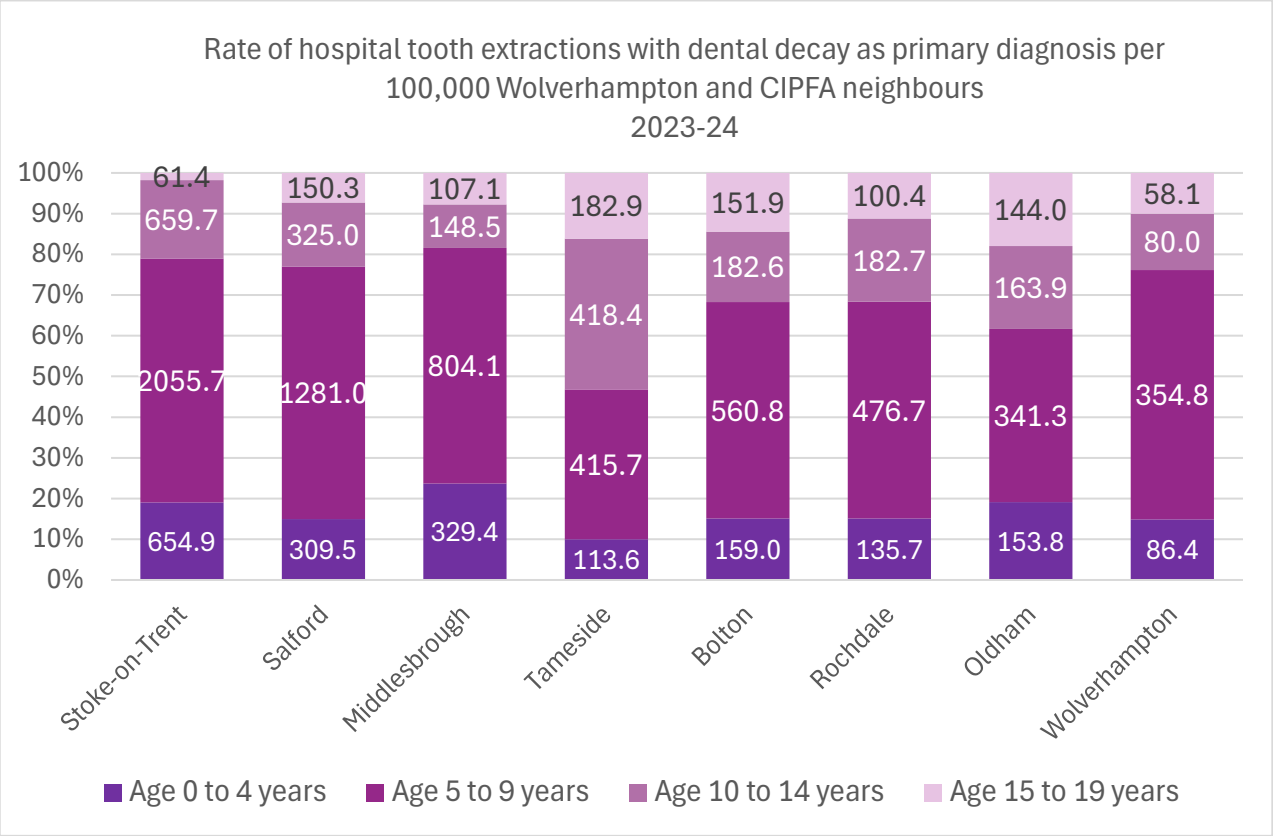
Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes.

Source: National Dental Epidemiology Programme (NDEP), 2023

Hospital Teeth Extractions (0-19 Yrs)

Between 2023 and 2024, the rate of tooth extractions for individuals aged 0-19 years, with dental decay as the primary diagnosis, was 139.5 per 100,000 - the lowest rate among all CIPFA neighbouring authorities. The highest rate was observed in the 5-9-year age group, at 354.8 per 100,000 (Figure 45).

Figure 45. Rate of tooth extractions with dental decay as primary diagnosis, per 100,000

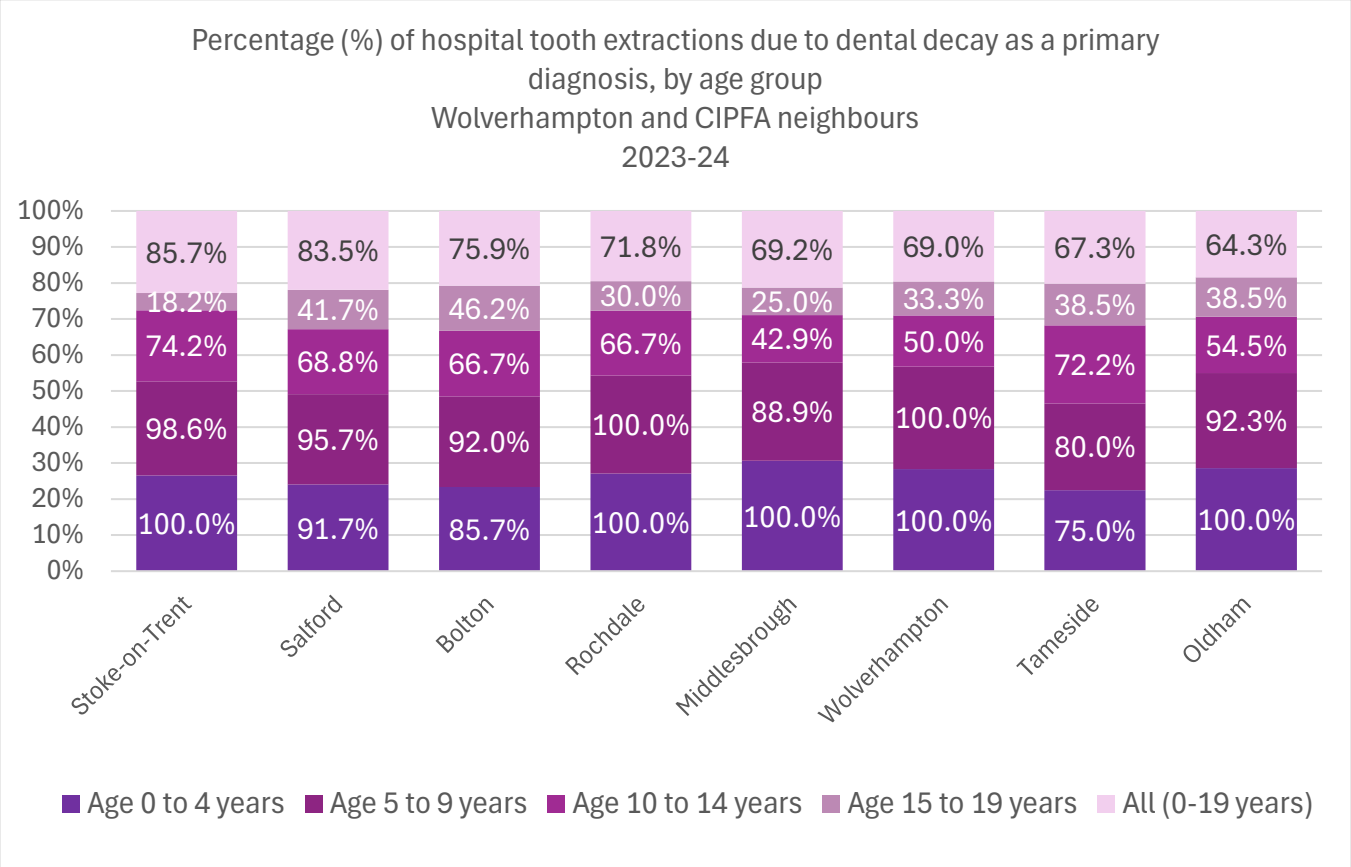


Notes:
The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes.
Data for all CIPFA neighbours was not available due to data suppression.

Source: Office for Health Improvement and Disparities (OHID)

In Wolverhampton, 69% of hospital tooth extractions among those aged 0-19 years were due to dental decay. The percentage varies by age group. In 2023-24, 100% of tooth extractions in the 0-4 years and 5-9 years age groups were attributed to dental decay, highlighting the significant impact of tooth decay on early childhood oral health. As age increases, the percentage of extractions due to dental decay decreases, although it remains the primary cause, accounting for the majority of extractions. This pattern is consistent across all CIPFA neighbouring authorities* (Figure 46).

Figure 46. Percentage (%) of tooth extractions due to dental decay as a primary diagnosis, by age-group

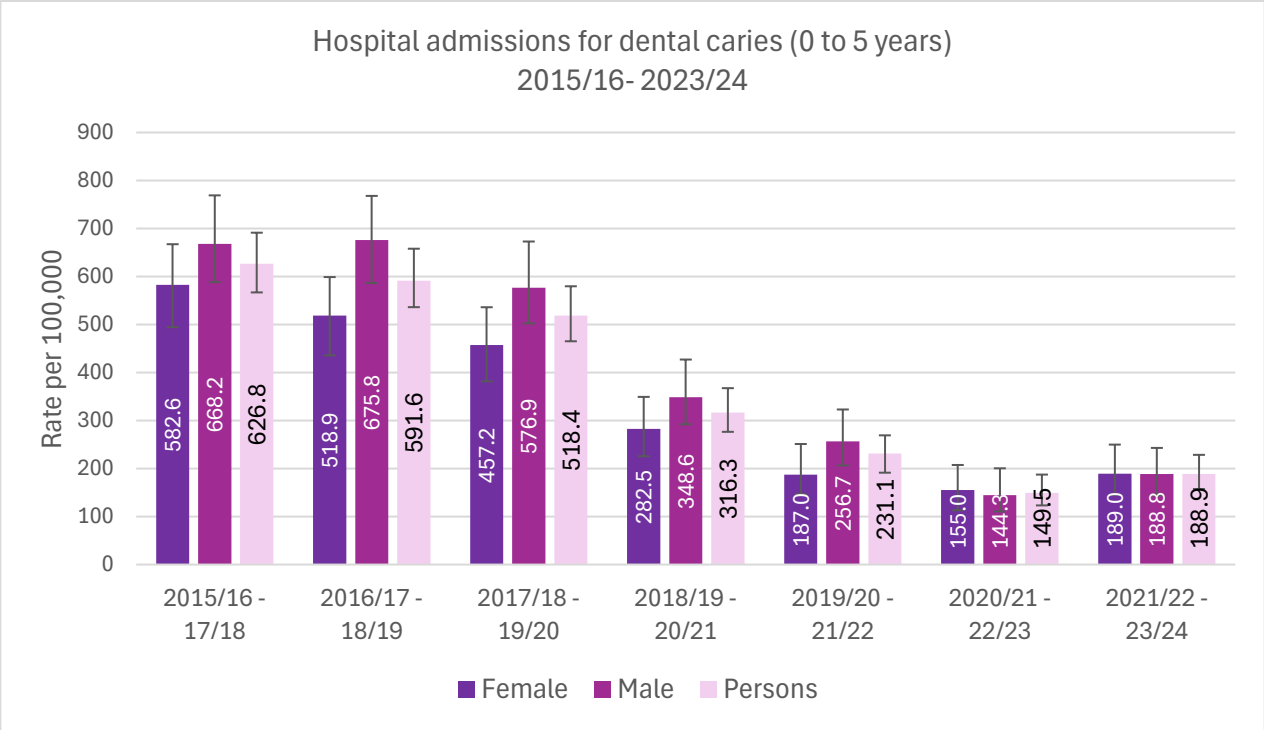


***Notes**:*
i)The Chartered Institute of Public Finance and Accountancy (CIPFA) identifies "statistical neighbours"-local authorities with similar population, economic, and geographic profiles-used to compare and benchmark services.
ii) Data for all CIPFA neighbours is not available due to data suppression rules, which prevent reporting of small numbers to protect confidentiality.
iii) The data reported on may be an underestimation of child tooth extractions conducted in a hospital setting. It is recognised that there are tooth extractions conducted by community dental services in hospital settings, and that this activity is not always included in the HES data.
iv) Differences in how hospitals record procedures and diagnoses, and limited information about anaesthesia used, may affect how the data is interpreted across regions.
v) No assumptions can be made about the method of anaesthesia provided for these procedures, but it is likely that the majority of episodes involved general anaesthetic.

Source: Office for Health Improvement and Disparities (OHID)

Figure 47 illustrates the trend in hospital admissions for dental decay among children aged 0-5 years. The data shows a consistent decline in admission rates for both sexes, from an overall rate of 626.8 per 100,000 in 2015/16-17/18 to 149.5 per 100,000 in 2020/21-22/23. In the most recent period (2020/21-22/23), females experienced higher hospital admission rates than males for the first time, although these differences were not statistically significant.

Figure 47. Trend data for hospital admissions attributed to dental decay in 0-5s

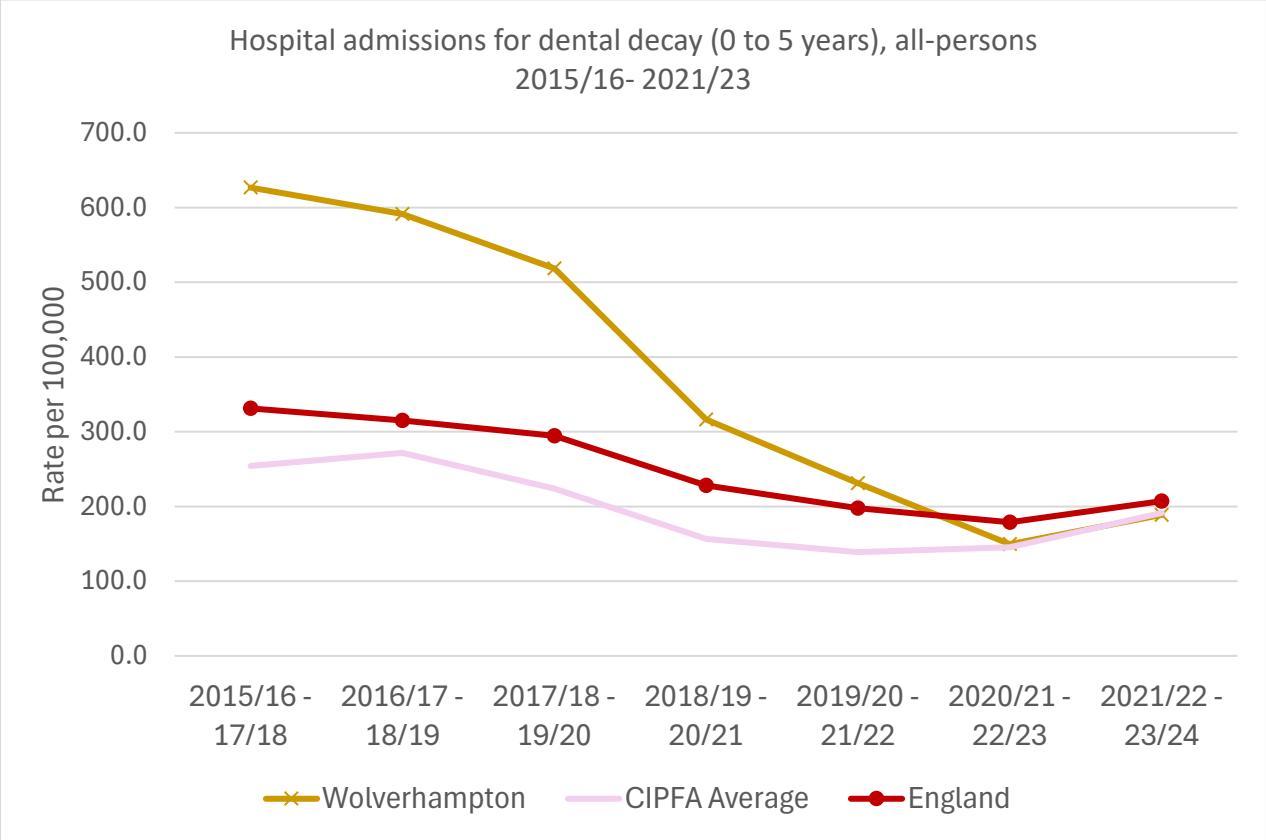


Notes: No assumptions can be made about the method of anaesthesia provided for these procedures, but it is likely that the majority of episodes involved general anaesthetic. Differences in coding practices across sites may explain some variation in the data. The data reported on may be an underestimation of child tooth extractions conducted in a hospital setting. It is recognised that there are tooth extractions conducted by community dental services in hospital settings, and that this activity is not always included in the HES data.

Source: Office for Health Improvement and Disparities (OHID) – Fingertips

Between 2015/16 and 2023/24, Wolverhampton saw a significant overall decline in hospital admissions for dental decay among children aged 0-5 years, dropping from 626.8 per 100,000 to 188.9 per 100,000. This reduction is sharper compared to both the national average and the average of CIPFA neighbour authorities, which have also decreased but at a slower pace. By the latest period (2021/22-2023/24), Wolverhampton's admission rate was lower than both the national and CIPFA average (Figure 48).

Figure 48. Trend data to show hospital admissions for dental decay (0-5 years), all-sexes
Source: Office for Health Improvement and Disparities (OHID) – Fingertips



Notes:
i)The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes.
ii) The type of anaesthesia used isn't clear, but most cases probably involved general anaesthetic. Differences in coding practices across sites may explain some variation in the data. Additionally, some tooth extractions done by Community Dental Services in hospitals might not be captured in hospital records, meaning the total number of cases could be underestimated.

Source: Office for Health Improvement and Disparities (OHID) - Fingertips

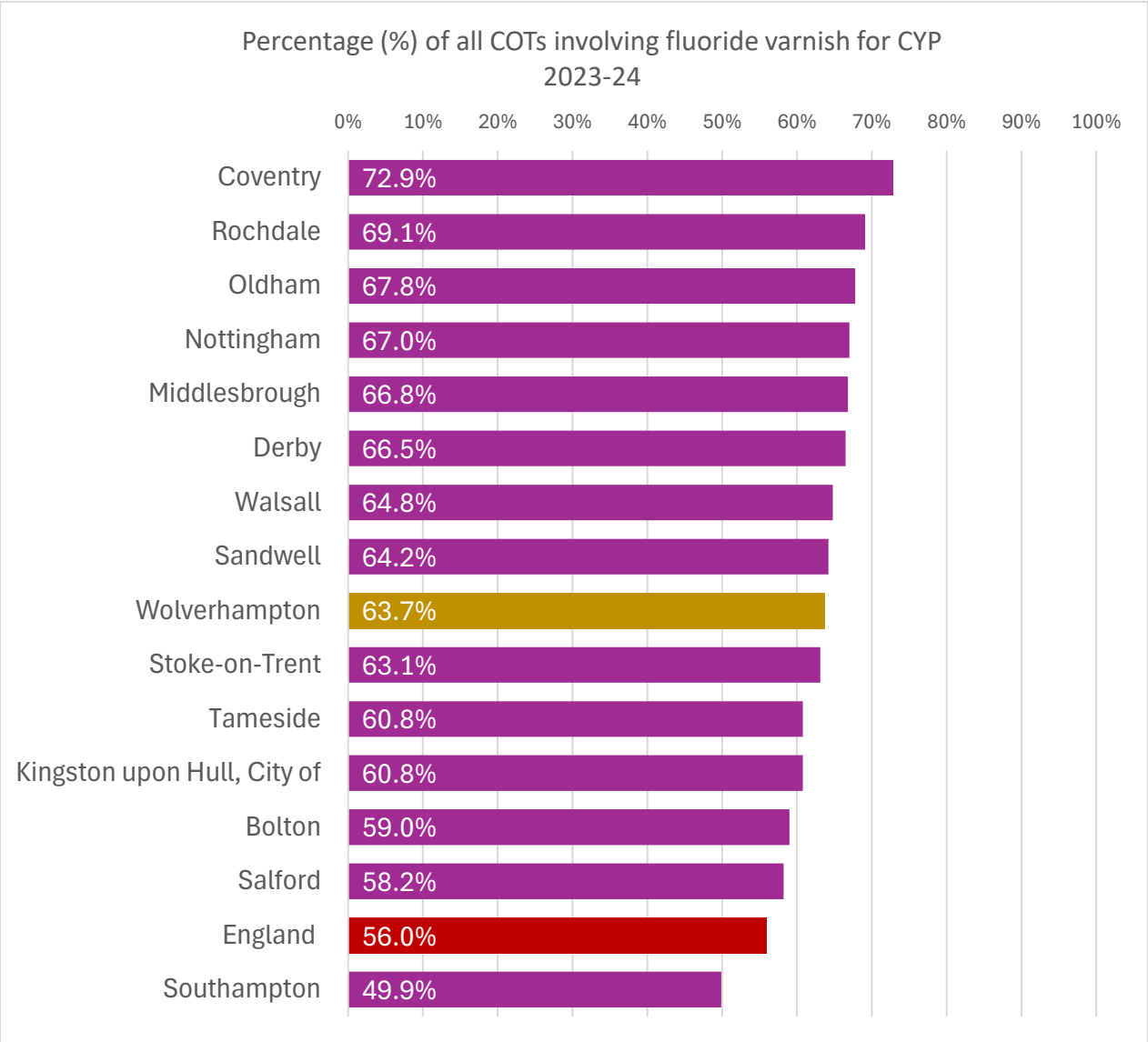
Clinical Treatments

Fluoride Varnish Applications

Fluoride varnish is a preventive measure that is aimed at reducing the risk of dental decay in children. At dental practices, it is considered a Band 1 treatment. Fluoride varnish is considered an effective and low-cost preventive treatment for reducing the risk of dental caries (tooth decay). It helps to strengthen the enamel and re-mineralise early stages of tooth decay, providing extra protection for children's teeth. If fluoride varnish is frequently applied, it may reflect a focused effort to address childhood dental health issues.

In Wolverhampton, there were 37,540 fluoride varnish applications given to child patients in 2023-24, representing 64% of all child courses of treatment (COTs). This is similar to the average of CIPFA neighbouring authorities (64%), and above the national average (56%) (Figure 49).

Figure 49. Percentage of all COTs involving Fluoride Varnish applications in child (<18) patients



The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes.
Note: The recorded data on fluoride varnish and fissure sealant applications may underestimate actual activity, as anecdotal feedback from local dentists has indicated that not all applications are consistently recorded by dental practitioners.

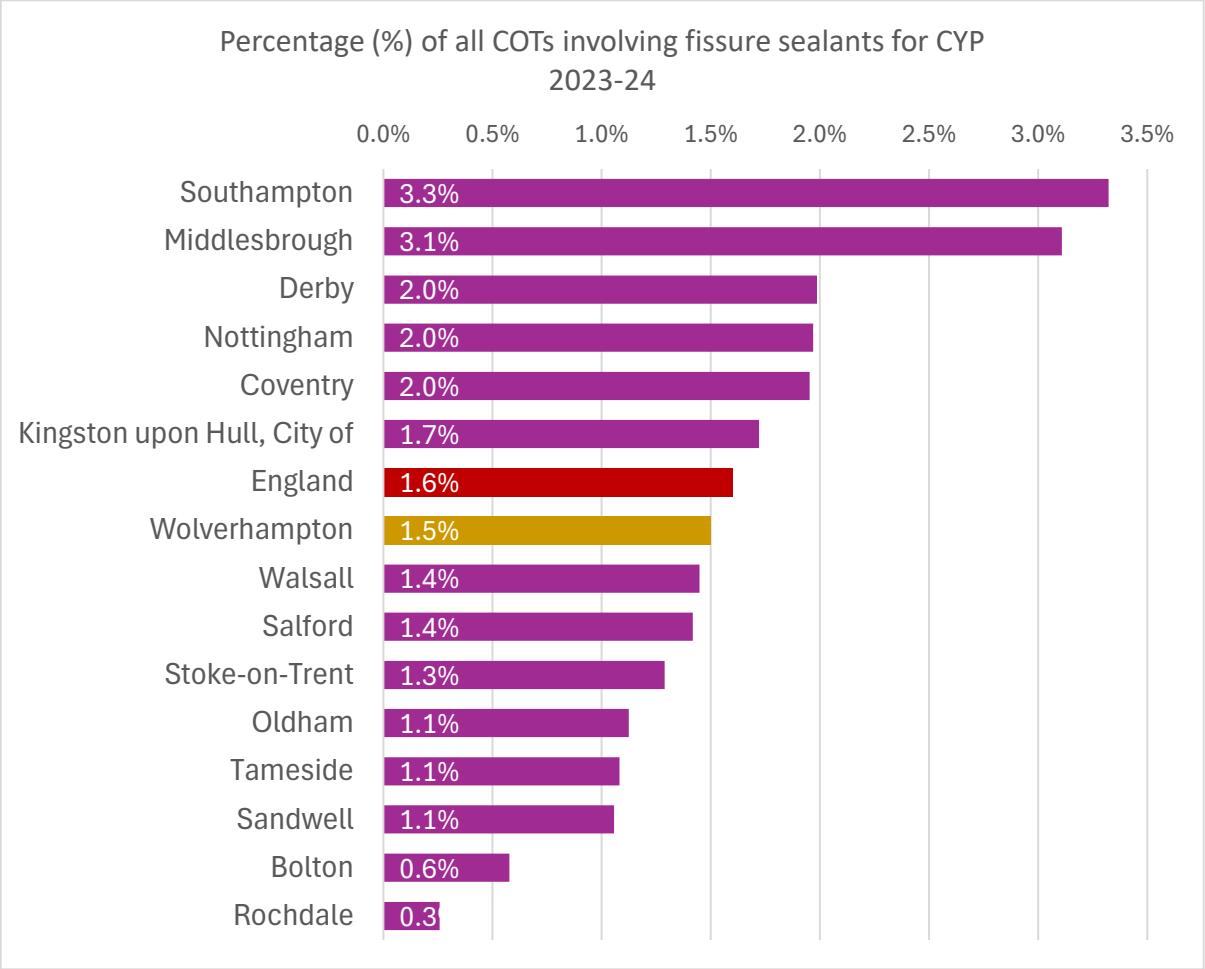
Source: NHS Business Services Authority (NHSBSA)

Fissure Sealants

A fissure sealant is a protective dental treatment designed to prevent tooth decay, especially in the back teeth (molars and premolars), which have deep grooves and pits on their chewing surfaces. These grooves, called fissures, can trap food and plaque, making them hard to clean and more prone to cavities. Sealants act as a barrier, preventing food and bacteria from settling in the grooves, which significantly reduces the risk of decay. Fissure sealants can be applied once a child's permanent back teeth have started to come through (usually about the ages 6-7 years).

In Wolverhampton, there were 884 fissure sealants applications given to child patients in 2023-24, representing 1.5% of all child courses of treatment (COTs). This is similar to the average of CIPFA neighbouring authorities (1.6%), and the national average (1.6%) (Figure 50).

Figure 50. Percentage of all COTs involving fissure sealants in child (<18) patients



Note: The Chartered Institute of Public Finance and Accountancy (CIPFA) are a number of local authority statistical neighbours i.e. local authorities similar in terms of demographic, economic and geographic characteristics, used for benchmarking purposes. Note: The recorded data on fluoride varnish and fissure sealant applications may underestimate actual activity, as anecdotal feedback from local dentists has indicated that not all applications are consistently recorded by dental practitioners.

Source: NHS Business Services Authority (NHSBSA)

Gaps In Data/Intelligence

There are several notable data gaps that limit the ability to fully understand and address oral health inequalities among children and young people. In particular, there is a lack of routinely available, disaggregated (broken down) data by key demographic characteristics such as ethnicity, disability status, language, and socioeconomic background. While some demographic breakdowns were obtained through a request for local oral health survey super-user data, the small sample sizes and data protection regulations (including statistical disclosure controls) restrict the extent to which this data can be publicly shared or analysed in detail.

Additionally, data relating to the provision and usage of Community Dental Services (CDS) was not available for inclusion in this assessment. Despite efforts to obtain this information, it appears that such data is either not routinely recorded in a standardised, shareable format or is not centrally collated for public health or strategic planning purposes. This represents a limitation-particularly in assessing the oral health needs and service access of vulnerable groups, such as children and young people with complex needs, disabilities, or those requiring specialist care. These data gaps should be acknowledged when interpreting the findings of this needs assessment and prioritised for future data collection and system improvement. In August 2025, NHS England introduced plans to improve national data collection for Community Dental Services (CDS), focused on improving data collection around waiting times for assessment and treatment.[24]

There is also a local request for clearer information on CDS referral thresholds and criteria, which needs to be communicated to general dental practitioners.

In addition, recorded data on fluoride varnish and fissure sealant applications may underestimate actual activity, as anecdotal feedback from local dentists has indicated that not all applications are consistently recorded by dental practitioners.

5.0 Stakeholder Engagement

Healthwatch – 'Mystery Shopper' Exercise

A list of NHS dentists in Wolverhampton is publicly available on the NHS 'find a dentist' webpage. Over a three-week period in February 2024, Healthwatch volunteers called 28 local dental practices twice in the guise of a new patient. The first call was to ask for availability for a routine check-up. The second call was to ask for an emergency appointment. Prior to making the calls volunteers attended a training session led by the West Midlands Consultant in Dental Public Health.

As NHS patients can no longer 'register' with a dental practice, ability to attend an appointment is not based on any geographical considerations. As previously highlighted, the way the national contract is organised with dental providers reimbursed for their NHS work through the UDA system. This means providers are paid a set fee for each UDA completed rather than for numbers of patients seen and payment is based on completion of a course of treatment. One of the unintended consequences of this is that towards the end of the financial year dentists may have utilised all their UDAs for that period and this can impact of dental appointments available - this was explicitly mentioned to callers, who were invited to call back in the new financial year, even though they called in February.

Findings from the Mystery Shopper Exercise

- Most calls answered in a few minutes. Receptionists often acknowledged wider system problems often referring to a lack of dentists and "dentist crisis".

Routine checkups

- 5 practices could offer a check-up for an adult and child with an approximate waiting time between 3-8 weeks. Of the 5, 1 could offer a private appointment with a significantly reduced wait time.
- A further 5 could offer an NHS appointment for a child only, with 4 of the 5 offering an appointment to an adult if they paid privately – average cost £50, before any additional treatment.
- 15 stated that they were full to capacity for both adults and children and advised calling back in the new financial year, calling 111 or ringing other dental practices, including out of area.
- Of the 15 that were full, 7 could offer private appointments, with a varying waiting time from less than a week to up to 6 weeks.
- 2 did not take NHS patients and 1 was a specialist dentist.

Emergency appointments

- Only 2 practices were able to offer an appointment to a patient that was not already known to them and not for a month, despite the caller saying that they were experiencing pain and swelling around the tooth.
- 16 practices could offer an appointment if the caller offered to pay privately, where a price was given, this ranged between £61-£110 for an initial assessment. Waiting time for this varied from a few days to up to 3 months and receptionists noted squeezed capacity even for private appointments.
- Where an appointment wasn't available the caller was advised to ring 111, ring round other dentists or in one case go to A&E.
- These access issues mirror national findings, as the King's Fund reports: "While people can theoretically be treated by any dentist with an NHS contract, data from 2022 found that people who had been to a particular practice before were much more successful in getting an NHS dental appointment than those who were not previously known to the practice (82% compared with 32%). Younger adults and people from minority ethnic groups were had the lowest levels of success in accessing appointments." Local and national evidence also suggests that lack of access leads to increased attendance at A&E.

Family Hubs and Library survey

Over a 3-week period during January-February 2024 Public Health staff attended Family Hub stay and play sessions and library story time sessions at the following locations: St Peters, Merry Hill, Bilston North, Penn, Ettingshall South and Spring Vale, Tettenhall Wightwick, Heath Town, Oxley, Graiseley, Bushbury South and Low Hill and East Park. Parents were asked to complete a short online survey with questions related to their oral health and experiences related to dentistry.

A total of 100 responses were received.

- Overall, 20% parents reported they were very concerned about their child's oral health, and 26% had never been to the dentist.
- Not being able to find a dentist/ knowing how to and cost were top to reasons for not visiting a dentist.

Youth voice

Youth representatives at both the Children and Families Together Board and evidence review workshops shared personal experiences and insight. This included reflections on pressures associated with body image and the role of social media in promoting a particular aesthetic; knowledge and awareness of key oral health messages and experiences associated with visiting the dentist including from the perspective of being a care leaver and the difficulty of navigating the current system for some young people.

6.0 Services and Community Assets

Targeted provision of toothbrushes and toothpaste by health and local authority staff and the third sector

Over 49,000 tubes of toothpaste and toothbrushes have been distributed across the city by Health Visitors at the 12-month developmental review (3,500), School Nurses when undertaking child measurements in reception age children (3,500), Early Years Settings to 3-4-year-olds (3,000) and to other vulnerable groups through places such as food banks and community shops (40,000).

Oral Health training for the wider professional workforce

Over 100 School Nurses, Health Visitors and Early Years Practitioners locally have been educated on the key messages related to oral health, signs and symptoms of poor oral health and access to oral health educational resources. The offer expanded to professionals working with vulnerable groups more recently. This enables all practitioners who come into contact with families to offer quality brief advice.

Personal, Social, Health and Economic (PSHE) Education Provision

All schools in Wolverhampton deliver lessons on Oral Health in Key Stages 1, 2 and 3 as per the PSHE statutory guidance. The City of Wolverhampton Council has provided schools with links to appropriate oral health lesson resources by commissioning Kapow for primary schools and providing a framework of additional quality assured links to oral health resources. Schools are encouraged to deliver this element of the curriculum during National Smile month to have more impact and to promote the delivery on their websites to encourage parental involvement. Schools are regularly reminded to include the benefits of good oral hygiene as part of a whole school approach to good health through PSHE network meetings and PSHE newsletters.

Supervised toothbrushing ('Brilliant Brushers')

Evidence suggests that children living in more deprived communities are less likely to brush their teeth twice a day contributing to increased rates of poor oral health when compared to children from more affluent areas.

In 2016, a toolkit to support the commissioning of supervised brushing programmes in early years settings was published by the Public Health England (PHE), now known as Office of Health and Disparities (OHID). The toolkit provides an evidence-based practice for establishing the programme across England.

The toolkit provided a foundation for the regional adoption of Brilliant Brushers, a daily supervised toothbrushing scheme for children aged 3-5 years. The scheme in Wolverhampton has targeted settings within in those more deprived communities, whilst also considering

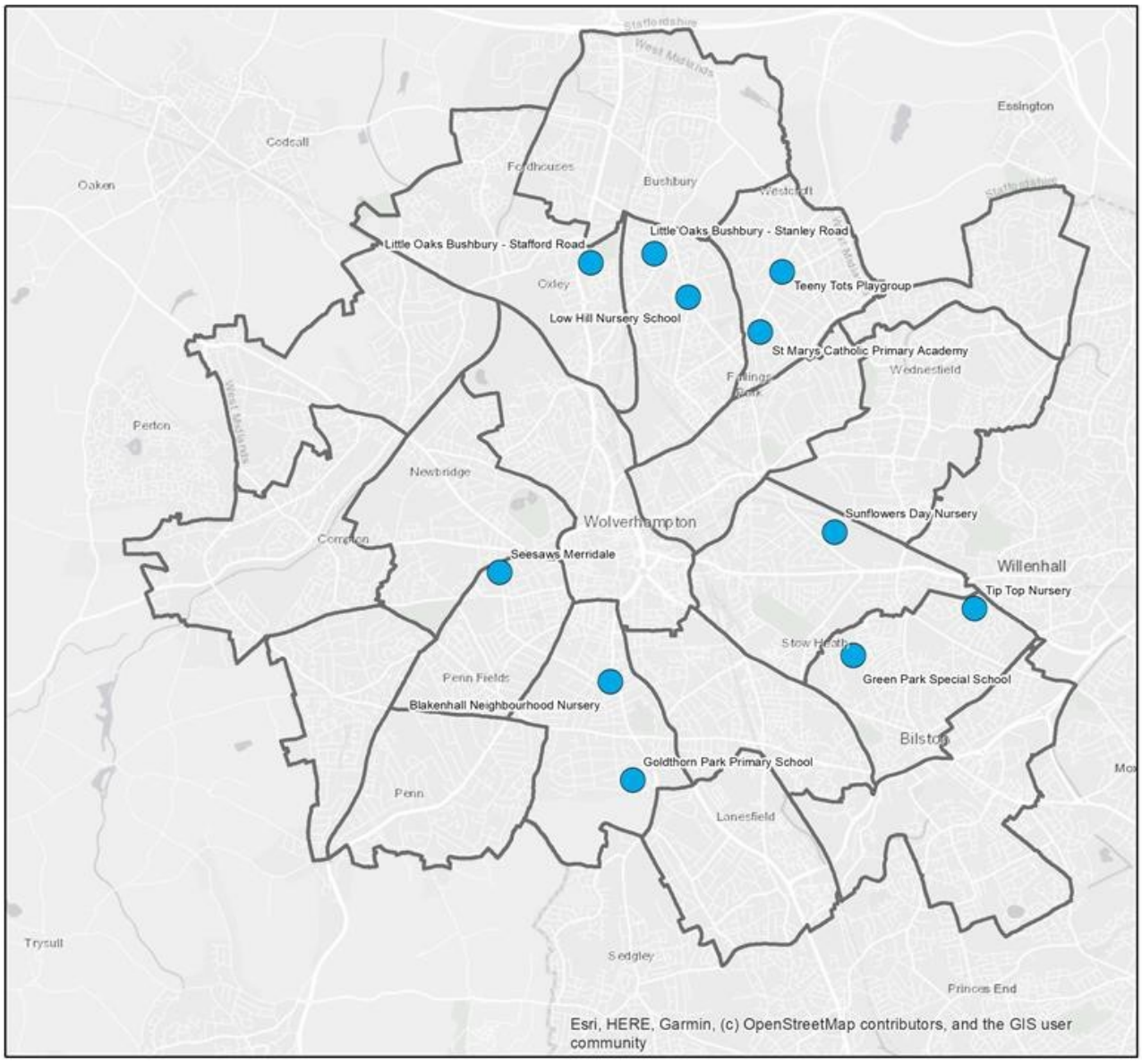
additional areas of health inequalities such as, rates of dental decay rates in 5 years, childhood obesity (NCMP) and child poverty rates to determine the communities and settings that would benefit from the adoption of Brilliant Brushers.

Brilliant Brushers isn't intended to replace toothbrushing at home but more so to encourage adopted behaviour that parents continue to brush children's teeth at home, as it's more likely that this becomes a habit for children that establish brushing their teeth at an early age. Resources (e.g. brushes, toothpaste and the 'toothbrush racks' – a storage facility for brushes are provided to schools and replenished every 3 months. Training is also given to school staff to ensure that hygiene standards are maintained, and cross-contamination of brushes are avoided. Appropriate informed parental consent arrangements are also put in place for participating children.

In June 2025, there were a total of 11 settings engaged with the Brilliant Brushers Scheme in Wolverhampton, with approximately 350 children having benefited, adopting daily toothbrushing within their settings. For more on information on the local Brilliant Brushers programme, please watch the following video: https://www.youtube.com/watch?v=iyvFvnHfdtM.

Figure 51 shows the 11 settings which currently deliver Brilliant Brushers, as of June 2025. These settings are in the more deprived wards of the city.

Figure 51. Map of settings that deliver Brilliant Brushers as of June 2025



Source: City of Wolverhampton Council

Following the recent government announcement to invest £11 million pound across local authorities in England for supervised brushing schemes, particularly targeting the most deprived areas of the country will see further investment in the scheme. The aim is to increase the number of settings and children involved in the programme, helping hundreds of thousands of children aged between 3 and 5 years old to develop positive brushing habits. Supervised toothbrushing for children to prevent tooth decay - GOV.UK.

Oral Health Local Toolkit

In 2025, Public Health produced and published a comprehensive local toolkit was produced to support strategic planning and upskill partners. It provides an overview of key evidence-based strategies and resources to improve children's oral health. Available here: Oral Health Toolkit

Oral Health Story Book and Competition

During the National Smile Month (May 13- June 13, 2024) themed 'Love Your Smile', children aged 5-11 years were encouraged to submit drawings of characters related to Oral Health that could be included within a story book targeted at early years children. Over 80+ submissions were received from local schools. Six characters designed by young people were used to co-produce (with young health champions, health colleagues, library staff and Parent Champions) a story book advocating positive oral health and key health messages.

See e-version of the story book here:

The Tooth Family - Oral Health Storybool

Figure 52. The co-produced oral health storybook

7. Recommendations

Oral health is a vital component of overall wellbeing, and is particularly important for children and young people, as poor oral health can have long-term consequences on health, development, and quality of life.

In Wolverhampton, significant inequalities persist in oral health outcomes, especially among children from deprived communities. The following set of recommendations aim to address these inequalities through a comprehensive, preventative, inclusive and evidence-based approach that is integrated across whole systems. By scaling up proven interventions, enhancing access to care, and embedding oral health into broader public health and education strategies, we can ensure every child can grow with a healthy smile.

Oral Health Partnership

- To continue to oversee and embed a core training offer for professionals working with children and families, such as school nurses and health visitors, equipping them with the knowledge, skills and confidence to provide high quality oral health advice.
- To continue to promote dental attendance for children from when their first milk teeth appear, or before they are 12 months old, followed by regular check-ups.
- To expand on oral health resources for families where English isn't their first language to ensure access to culturally appropriate information.
- To oversee the expansion of the Brilliant Brushers programme, including for more deprived areas of the city and special school settings.

Wolverhampton Dental Commissioning Group

- To explore with the Local Dental Committee how to strengthen prevention efforts within primary dental care, going beyond health education to include risk factor management and the promotion of preventative interventions such as fluoride varnish during dental check-ups.
- To continue to oversee and improve access to dental care for all children and young people, with a focus on actively reducing oral health inequalities related to both dental disease and access to services.

City of Wolverhampton Council: Public Health and Education Excellence

- To continue to encourage schools to provide opportunities for children and young people to learn about oral health education as part of the PHSE curriculum and where appropriate participate in the local Supervised Toothbrushing Programme (Brilliant Brushers).
- To continue to promote healthy eating in our Early Years and education settings in the city.
- To better understand the oral health needs of secondary school-aged children, in line with Children and Young People Scrutiny recommendations.

- To support the undertaking of the National Dental Epidemiology Programme (NDEP) oral health surveys to maximise participation and improve data quality.

OneWolverhampton

- To embed oral health promotion within in Make Every Contact Count (MECC) initiatives, ensuring consistent and routine messaging across all relevant services.
- To continue involving children, young people and parents in co-producing oral health campaigns and materials through involvement with our health champion and youth representatives.

Health and Wellbeing Together

- To maximise the opportunities in the NHS 10 Year Plan to embed a co-ordinated approach to oral health promotion and prevention and to consider how oral health can be incorporated into a future Neighbourhood Health Plan.
- For all partners to use the needs assessment to influence commissioning of local services, and inform a range of policy decisions for example, enabling a healthy food environment.
- To promote and facilitate local data sharing mechanisms between the ICB, health partners, and the council to improve local data capture, which can then inform commissioning, service design and delivery, and evaluation of service provision.

Improving oral health outcomes for children and young people requires co-ordinated action across health, education, and social care systems. These recommendations provide a roadmap for targeted, evidence-based interventions that prioritise prevention, equity, and accessibility. By investing in early years programmes, strengthening community dental services, and empowering families and professionals with the tools and knowledge they need, we can reduce oral health inequalities and support lifelong health. Continued engagement with children, families, and frontline workers will be essential to ensure these initiatives are effective, culturally appropriate, and sustainable.

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