British Dental Association's submission to the London Assembly Health Committee investigation into child dental health in London

The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. BDA members are engaged in all aspects of dentistry including general practice, salaried primary care dental services, the armed forces, hospitals, academia and research, and include dental students.

The BDA welcomes the Committee's commitment to look into child dental health in London, and the opportunity to respond to relevant questions in this consultation.

We agree with Mayor Sadiq Khan that "it is vital that the capital has the powers to plan and coordinate health services that meet the needs of local communities and ensure Londoners have proper access to them" and welcome his ambition to make London "the world's healthiest city". Given the extensive links between oral and general health and the key role dental professionals play in the prevention agenda, we want to stress that the aspiration to make London the "world's healthiest city" cannot be realized without addressing the poor outcomes and inequalities in Londoners' oral health and access to dental services.

As detailed below, we urge the Committee and the Mayor to act to improve the oral health of London's children, reduce the unacceptable inequalities in outcomes and access to NHS dentistry in the city, and educate children and parents on the importance of good diet and oral hygiene. Dentists in London are already engaged in a range of initiatives to improve child oral health, and are ready to do more. The BDA would be delighted to work with the Committee and the Mayor to support and facilitate this aim.

Summary of asks

1. We call for stronger action and better coordination to reduce inequalities and improve child oral health outcomes in London. We call on the Mayor, supported by expert advice, to have oversight of children's oral health initiatives across London and help disseminate good practice between boroughs.
2. We call on the Mayor to follow the Mayor of Greater Manchester in introducing supervised tooth-brushing into all early years settings across Greater London, and promote sustained Local Authority investment in other evidence-based and cost-effective oral health improvement measures.
3. We call on the Mayor to run a campaign to raise awareness of the importance of regular dental attendance from an early age and the fact that all NHS dentistry is free for all children under the age of 18.

4. We call on the Mayor to lead on making London a Sugar Smart city, promoting partnerships with health professionals, schools, children's centres and other Local Authority services to ensure consistent messaging about sugar intake and support for parents.
5. We call on the Mayor to consider oral health in messages about healthy diet, and to seek expert dental input to ensure that recommendations are appropriate and consistent.
6. We call on the Mayor to consider the food environment as a key element of healthy streets.
7. We call on the Mayor to incorporate oral health as an integral component of the food plan and to ensure that dentists are included in local schemes to promote healthy nutrition, via Local Dental Committees.
8. We call on the Mayor to consider the specific oral health needs of various immigrant groups in London, and co-ordinate relevant and accessible awareness raising campaigns on the risks of smokeless tobacco use and products such as shishas, betel nut and paan.

DENTISTS' VIEWS

In preparing this written evidence, the BDA has carried out a survey of member dentists practising in London, to gather information on their experience of child oral health, barriers to dental care and their ideas on what could be done to improve the situation. Responses were received from 139 dentists representing every single one of 32 London boroughs and the City of London.

- 98% of the respondents agreed that stronger action and better coordination was needed to reduce inequalities and improve child oral health outcomes in London.
- 98% of the respondents agreed the Mayor of London should run a campaign to raise awareness of the importance of regular dental attendance from an early age and the fact that all NHS dentistry is free for under 18s.
- 97% of the respondents supported the introduction of a supervised toothbrushing scheme in early years settings across the capital.

Throughout this submission, we have included quotes from our members' responses about their experiences in this area and suggestions for change.

CHILD ORAL HEALTH IN LONDON

Although dental decay can easily be prevented through reducing sugar consumption, regular brushing, and adequate exposure to fluoride, it has emerged as the number one reason why children aged 6 to 10 are admitted to hospital in London.

Over the past four years 35,262 children were admitted to hospitals in London for tooth extractions under a general anaesthetic due to extensive tooth decay. Last year, 85% of these hospital extractions – almost 7,000 in total – were performed on children aged 10 and under.

Considering tooth decay is almost entirely preventable and an average cost of such hospital extraction is £836, this means almost £7 million of NHS London money is wasted on these preventable hospital admissions for children every year – almost £30m over the past 4 years – on top of the significant cost of treating child tooth decay in primary care.

It is worth noting that due to data gaps and coding inconsistencies the figures above are highly likely to understate the true scale of the problem of child hospital tooth extractions in London.

> *"I've seen children who have needed to have 16 or 18 teeth removed at the age of 5. This is entirely preventable. I've extracted primary teeth on children who have abscesses, pain, [have] lost sleep and [are] losing weight because of preventable decay. It should not be accepted and considered a fact-of-life that children are having general anaesthetics to remove teeth."*
>
> Response to BDA survey of London dentists

Over a quarter (26%) of 5-year-olds in London suffer from decay – this makes London the third worst area in England in terms of child tooth decay outcomes, after the North West and Yorkshire and Humber.

This figure also hides massive inequalities between different London boroughs, with outcomes varying from 14% in Bexley to 40% in Harrow. For comparison, in the best-performing local authorities in England only 5% of 5-year-olds suffer from decay.

Worryingly, while nationally we have seen slow but steady improvements in child oral health, 10 of the London boroughs have actually seen a deterioration in children's outcomes over the last two years, with children in areas like Camden and Sutton up to a quarter more likely to suffer from tooth decay now than they did two years ago (please see the annex for a full list of outcomes across Greater London).

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

Rates of decay at the age of 5 are a key measure in the Public Health Outcomes Framework. Oral health in young children is seen as an early and easily visible indicator of overall health and development, especially as oral disease shares many common risk factors with obesity/metabolic disorders and related conditions. These alarming oral health statistics should therefore be addressed by Local Authorities in London as a priority.

ACCESS TO NHS DENTISTRY IN LONDON

London has the lowest attendance rates of all English regions, with 18 out of 20 councils with the lowest proportions of children attending NHS dental services being London boroughs. In Hackney, a shocking two thirds of children (68%) are missing out on free dental care.

According to the figures released in February 2019, half of London children (50%) – one million children in total – have not been seen by a dentist in the past year, even though NHS dentistry is free for under-18s and NICE guidelines recommend children should be seen by a dentist at least once a year.

A recent YouGov poll for the British Dental Association revealed that more than two thirds (69%) of parents in London are not aware all dental treatment is free for children on the NHS. Over a quarter of London parents (27%) don't even realise check-ups for kids are free. One in ten of the parents surveyed in London admitted to delaying taking their child for an NHS dental check-up due to the cost involved – despite the fact these are free of charge.

We urgently need to raise awareness of the importance of children being regularly taken to the dentist for a check-up from the moment their first tooth erupts and the fact NHS dentistry is free for under-18s, and encourage parents in London to take advantage of this fact to help keep their children's teeth healthy.

> *"A father came to me with his 5-year-old daughter asking for a denture as she wasn't able to eat anymore: all her milky molars needed to be extracted! If the parents checked the daughter's teeth earlier and brought her to a dentist this could have been prevented or at least not ended up so tragically. We need a campaign to make parents aware of the importance to bring the kids to the dentist."*
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> Response to BDA survey of London dentists

RESPONSES TO THE COMMITTEE'S QUESTIONS

Why is dental health among London's children so poor?

Overall, levels of dental disease in children have declined over the past 30 years, in large part due to the widespread adoption of fluoride toothpaste. However, children in London continue to have poorer oral health than those across England as a whole, with 60% of London boroughs recording higher levels of tooth decay than the national average in the 2017 surveys carried out by Public Health England.

Reasons behind this include prevalence of diets high in sugar, low dental attendance rates, and the lack of awareness amongst parents about the importance of healthy eating and good oral hygiene.

Nationally, we have seen drastic cuts to Government spending on dentistry per head of population. The equivalent of nearly £42 per head was set aside by government to cover dental care for every adult and child in England at the outset of the Coalition Government in 2010. This fell by over £12 in real terms in 2017/18 – a decrease of 29%.

These cuts inevitably translate to reductions in spending at a local level. NHS London spent just under £407m on commissioning NHS dentistry in 2017/18. That's just 2% more than was spent on NHS dentistry in 2015/16, despite inflation amounting to approximately 3.5% in that period. This means there was a real-terms cut in spending on NHS dentistry in the last 2 years, despite significant population growth in the same period.

Westminster has also lagged behind the devolved Governments in terms of introducing a wide-ranging preventive oral health scheme for children. Scotland and Wales have been leading the way on improving child oral health with their early intervention preventive initiatives ChildSmile and Designed2Smile having led to unprecedented improvements in outcomes in these countries in recent years.

- ChildSmile in Scotland is said to be saving £5m a year in treatment costs.
- The scheme provides supervised tooth-brushing and oral health education in primary schools and nurseries, and provides twice yearly fluoride varnishes to children.
- It also sees public health nurses and health visitors able to refer a family to a dental practice.
- Over 900 dental practices in Scotland are now members of the scheme.

ChildSmile policies have been adopted in nations from Chile to Israel, but they are still not benefitting children in the vast majority of local authorities in England.

> *"England is dropping way behind Wales and Scotland in tackling children's oral health issues. I see on a daily basis the misery decay can cause and prevention would be a more cost-effective cure than treating or not treating the problem."*
>
> Response to BDA survey of London dentists

In England, the Government recently launched oral health prevention schemes called 'Starting Well' and 'Starting Well Core'. While this is a welcome step in the right direction, the schemes have a narrow scope, they lack ambition and any new funding.

'Starting Well' is limited to just a few wards in 13 local authorities, with Ealing being the only London borough to be chosen to take part. The scheme sees participating dentists getting extra funding up front to see more young children, with practices appointing 'oral health champions' who reach out to the local community.

'Starting Well Core' is a new commissioning approach, which allows a dental practice to 'over-deliver' on their contracted activity targets by up to 2% in order to see more children aged 0-2. We welcome NHS London making this scheme available to all London dental practices – the first region in the country to do so.

However, the BDA is concerned that the scheme contains no outreach element which would ensure it brings in those hard-to-reach children who most need to see a dentist. This means that while it might increase the total attendance numbers in children, it is unlikely to do anything to improve the deep oral health inequalities that we see between children from more and less deprived backgrounds in London. The scheme also relies on a dental practices' ability to deliver more than 100% of their contracted activity – something only a third of dental practices are currently managing to achieve.

Neither programme has received any new funding – any extra activity commissioned is recycled dental 'claw-back', i.e. money taken off other dental practices for failing to meet their activity targets, for example because they struggled to fill a vacancy in their practice.

The BDA has heard reports that NHS London is due to launch a local variant of Starting Well called 'Starting Well Plus', but we are yet to learn any details, including whether the scheme will receive any dedicated funding and include an outreach element.

The BDA continues to urge both central and local government to learn from the success of the solutions tried and tested in Scotland and Wales and roll out a properly funded universal oral health prevention programme to children in England. We hope the Mayor of London will follow the leadership of the Mayor of Greater Manchester in introducing supervised tooth brushing in all early years settings across the capital, and take a lead in coordinating other existing local oral health initiatives and rolling them out further.

Why do some London boroughs appear to be going backwards on dental health outcomes for children?

The London population is exceptionally diverse and highly mobile, which might explain the variations in outcome trends between different boroughs.

Another factor that might play a role in the deterioration seen in some parts of London are the swingeing cuts to local authority public health budgets we have seen in recent years. The Government has recently announced that 2019/20 will see a further £85 million cut from local government public health grants, with these cuts disproportionately hitting oral health services. This means that many councils lack the resources to make an effective stand against tooth decay.

High incidence of caries in children in the poorly performing areas translates to a high volume of general anaesthetics for dental extractions and the associated cost to the NHS, absence from school and days off work for parents/carers, as well as pain, discomfort and anxiety. However, the good standard of children's oral health in some areas of London demonstrates that this burden is far from inevitable.

What impact does poor dental/oral health have on children's development?

There is increasing acknowledgement across the public health sector that oral health is an essential component of overall health, and that establishing good oral health is central to providing children with the best possible start in life. Oral health has a substantial impact on wellbeing and quality of life and plays a crucially important role in children's development. Although they are almost entirely preventable, oral diseases carry a huge societal and financial cost. Their burden is overwhelmingly borne by the most socio-economically disadvantaged and vulnerable members of the population; indeed, poor oral health is a strong marker of deprivation.

Bad oral health affects not only children's physical health, but also their overall wellbeing, confidence, mental health and life chances. It can impact upon a child's ability to sleep, eat, speak, play and socialise with other children, as well as their school readiness (both through loss of school days and because of pain and difficulty sleeping affecting the ability to learn). Other consequences include pain, infections, poor diet, and impaired nutrition and growth.

According to the latest Children's Dental Health Survey:

- 58% of 12-year-olds reported that their daily life had been affected by problems with their teeth and mouth in the past three months.
- More than a third (35%) of 12-year-olds reported being embarrassed to smile or laugh due to the condition of their teeth.

- A fifth of 12 and 15-year-olds (22% and 19% respectively) reported experiencing difficulty eating as a result of bad dental health in the past three months.
- More than a third (35%) of the parents of 15-year-olds reported that their child's oral health had impacted on family life in the last six months; and 23% said they took time off work because of their child's oral health in that period.

> *"Due to tooth decay children are in pain and have time off school, parents have time off work to bring them to appointments. Tooth decay affects everyone around the child as well as the child in pain."*
>
> Response to BDA survey of London dentists

Poor oral health in childhood is a strong indicator of oral health problems later in life, whereas early establishment of good oral hygiene habits sets a solid foundation for these to continue into adulthood. Studies show that having poor dental health can impact on a person's ability to find a decent job or can hold back their career progress. Someone with discoloured, broken or missing teeth might often get passed over for a job or promotion in favour of someone who may not necessarily be more qualified, but gives off a more professional appearance. This is especially the case for jobs which require interaction with the public. Being embarrassed by their bad teeth may also make people less likely to look for a job or affect their confidence during interviews.

A recent survey by YouGov for the British Dental Association shows that 71% of people in London feel decayed teeth or bad breath would hinder a candidate's chances of securing employment in public or client-facing roles – while just under half that number (38%) felt the same about being overweight. 6 in 10 of respondents feel applicants with poor oral health would be at a disadvantage securing any job, and believed it could hinder promotion prospects.

What is access to free NHS dental services like for different groups of London's children?

There are great disparities between rates of access to NHS dentistry in different parts of London, ranging from just 34% of children having had an NHS check-up in Hackney in the last 12 months, to 61% in Hounslow. While it is worth pointing out that these statistics don't include children attending private dentists, it is still an unacceptable variation in the number of children missing out on their free NHS check-up.

It's also likely that there are variations in access to NHS dentistry between more and less deprived communities within the boroughs. More than two thirds of parents in London (69%) are not aware that all dental treatment is free for children on the NHS, with one in ten admitting to delaying taking their child for an NHS dental check-up due to the cost they thought was involved. Parents from poorer backgrounds are more likely to be discouraged from taking their child to the dentist due to the perceived cost involved, and they might also be less able to take time off work to attend appointments.

NHS DENTAL CONTRACT

It is also widely acknowledged that the current NHS dental contract, introduced in 2006, limits dental access in areas of greater deprivation and higher oral health need. The contract is based on Units of Dental Activity (UDAs), with dentists being paid to provide treatment instead of taking a preventive approach to oral health. Dentists are commissioned to deliver a set number of UDAs, and are not paid for the activity they deliver beyond that, which effectively sets quotas on the numbers of patients a dentist is able to see on the NHS.

The contract rewards the dentist a set number of UDAs for a particular type of treatment, regardless of the number of teeth that need treating. This means e.g. that a dentist would receive 3 UDAs (worth on average £75) for an entire course of treatment including 6 fillings, 3 extractions and a root canal, which wouldn't be enough to cover their overheads. They would receive the same amount for performing a single extraction. This system means dentists in areas with poorer oral health outcomes are more likely to struggle to hit their contracted activity targets and they are able to see fewer patients overall in a given period of time.

Reform of the contract has been underway since 2011 and different prototypes of a new system are currently being tested around the country. The BDA has been pressing hard for prevention to be at the heart of the final model, so that dentists are not penalised for seeing high-needs patients.

LOW MORALE AND PROBLEMS WITH RECRUITMENT AND RETENTION

Another factor which might impact on the patients' ability to access NHS dentistry is the growing problem with recruitment and retention of dentists in NHS practices, fuelled by chronic underfunding and the failing dental contract. The BDA's 2018 survey of dental practice owners has shown that morale among dentists in London is low; with 61% of London dental practice owners responding to a recent BDA membership survey saying they were considering leaving the profession within five years.

At the same time, it is possible we might see a decrease in the number of EU dentists coming to the UK, which might place further strain on an already over-burdened system. Currently around 17% of dentists in the UK are registered here on the basis of an EU/EEA degree – while this includes UK citizens who have studied in Europe and returned, the vast majority of this group are EU/EEA citizens. In the last 3 years we have seen a drop of 28% in the number of new registrants trained in EU/EEA countries applying to practise in the UK – from 571 in 2015 to 409 in 2017. As EU-trained dentists on average perform more NHS dentistry than their UK-trained colleagues, a sustained decrease in the number of EU dentists coming to the UK is likely to disproportionately affect access to NHS dental services.

What action is already being taken to address this problem at local levels in London?

70% of London-based respondents to our recent member survey indicated that they are already involved in some type of unfunded oral health promotion in their practice. e.g. visits to local schools and nurseries or taking part in national campaigns such as National Smile Month, Mouth Cancer Action Month, Sugar Awareness Week or Sugar Swaps, in addition to talking to their patients about their oral health.

The BDA has recently developed an oral health campaign in partnership with the National Day Nurseries Association (NDNA), which will run in NDNA member nurseries in London and throughout the country during the week of 25th March. This provides oral health advice for nursery staff and parents/carers of children under school age, in addition to activities for the children to engage them with toothbrushing, healthy eating and getting used to visiting the dentist.

The BDA also partners with Colgate to deliver the Oral Health Month/*Bright Smiles, Bright Futures*™ campaign each September, providing educational materials and promoting oral health messages to the public and particularly to school children. We encourage dentists to engage with local communities via this programme, as well as through various other national campaigns that we actively support.

Nationally, the BDA has been at the forefront of efforts across the UK to improve children's oral health and reduce inequalities. We have a long-standing campaign on sugar awareness and reduction, and have worked successfully with partners across the health sector to secure the Soft Drinks Industry Levy. We continue to apply pressure on Government to tighten the regulation of advertising and promotion of unhealthy food and drink products, and are monitoring PHE's reformulation programme. Collaboration via coalitions including the Obesity Health Alliance, Children's Food Campaign and Sugar Smart is central to our work and ensures alignment of messages across broader health campaigns.

We also continue to promote other oral health-specific initiatives for children, including through our work with the Children's Oral Health Improvement Programme Board. The Board aims to join up relevant organisations across health, education and local government to deliver integrated programmes, for example to promote the delivery of evidence-based oral health advice to parents by health visitors. We are currently working with the Office of the Chief Dental Officer for England to ensure that oral health advice and reminders are included in the digital version of the child health record (Red Book).

NHS England has made the Starting Well scheme available in parts of Ealing, and is offering Starting Well Core to practices across London as detailed above. While this is a welcome development, the BDA remains concerned that the scheme has received no new funding, and is unlikely to get the hardest-to-reach children who need it most through the dentists' doors.

The BDA also welcomes the principle of the 'Dental Check by One' campaign initiated by the British Society for Paediatric Dentistry with backing from the Chief Dental Officer. All children should start visiting the dentist regularly as soon as their first tooth erupts, to receive oral health advice, become accustomed to the surgery environment and establish a lifelong positive habit. However, the current dental contract does not support the additional volume of child patients that dentists would need to see to make this a reality, and this problem needs to be addressed before we can truly improve child dental access rates in London and beyond.

There are many other child oral health initiatives in London organised by local authorities, schools, voluntary groups and Local Dental Committees, but their effectiveness has been undermined by lack of central coordination and funding.

What can be done to raise parental awareness of the need for good child dental health?

The BDA feels the Mayor of London is ideally placed to lead an awareness-raising campaign on the importance of good child oral hygiene and the fact that all NHS dentistry is free for all children under the age of 18. This should involve cooperation between local authorities, Health and Wellbeing Boards, schools, dentists and other health professionals including midwives, health visitors and pharmacists, to promote the benefits of regular dental attendance and daily tooth brushing. To be most effective, evidence shows that a public information campaign should be underpinned by practical action, such as a supervised toothbrushing scheme.

> *"We need promotions to actually get the children into the dental surgery; too often it is the patients who need us most who fail to make it through the door. Dentistry is not seen as a priority until the patient is in pain and by this stage it is often too late. Getting the message to children and parents about the importance of limiting sugar and regular check-ups is paramount."*
>
> Response to BDA survey of London dentists

How can the Mayor help, through his existing programmes and other activity?

As mentioned before, unlike Scotland and Wales, England has no national children's oral health improvement programme. The devolution of public health to Local Authorities is often cited as a barrier to establishing effective oral health schemes that are co-ordinated between areas and allow sharing of resources and dissemination of good practice. In London, there is now an opportunity for the Mayor to oversee and facilitate the expansion across the city of children's oral health interventions with a demonstrable record of success. Our survey of London BDA members found that 97% believed the capital would benefit from a city-wide programme of supervised tooth brushing in early years settings.

The Mayor should work in partnership with Health and Wellbeing Boards and Local Dental Committees to ensure that oral health needs are identified in each area and plans and funding put in place to meet them. We support the call from the LDC Confederation to integrate oral health plans into schools and early years settings, with support from an expert adviser. As expressed in a response to our survey, co-ordination is key.

The BDA recognises that public health budgets are under ever-increasing pressure, but urges the Mayor to support a long-term view, whereby investment now in evidence-based preventive measures will prove cost-effective by reducing future expenditure on treatment. PHE has developed a Return on Investment tool, which enables Local Authorities to enter local population data and calculate the potential return on investment in a range of oral health improvement measures for children – from supervised toothbrushing schemes to fluoride varnish application or community water fluoridation. This shows that in areas with high rates of decay, for every £1 invested in supervised tooth-brushing £3.06 are saved in treatment costs over 5 years.

We welcome the commitment some London boroughs have already made to become Sugar Smart areas, whereby partnerships are created between Local Authorities, schools, businesses

and other stakeholders to promote reduction of sugar purchase and consumption among the community. The BDA would like to see the Mayor take the lead on making all London boroughs join this scheme.

We support the Mayor's aim to reduce inequalities through good planning. We would urge him also to consider the food environment as a key element of "healthy streets". This should include, for example, reductions in the number of outlets selling unhealthy food and drinks in the vicinity of schools, restriction of the sale of sugar- and calorie-rich options in vending machines within public facilities such as leisure centres, and stricter controls on billboards or other advertising that might be viewed by children.

We welcome the Mayor's ambition to address obesity in London via an "integrated food plan". However, any such plan must explicitly include oral health considerations to be successful. Sugar consumption is a key common risk factor for oral and metabolic diseases, with a strong link to socio-economic deprivation in both cases. Dentists are well placed to discuss diet with their patients, since dental caries is a more rapidly-developing disease and can be a less sensitive issue to discuss than obesity and related systemic conditions.

We also urge the Mayor to consider the specific oral health needs of various immigrant groups in London. This would include a culturally-sensitive approach to addressing practices that are detrimental to oral and general health, which could involve peer oral health champions. Required action includes measures to reduce sugar consumption and co-ordination of relevant and accessible awareness raising campaigns on the risks of smokeless tobacco use and products such as shishas, betel nut and paan.

The use of smokeless tobacco in various forms, which is a particular concern among South Asian communities, is a significant risk factor for oral cancer, but awareness of its harms is low and use is high among populations that are already at greater risk of poor health and may be less likely to engage with health services. For example, research shows that a large proportion of teenagers of Bangladeshi origin chew betel nut, with the median age of first chewing being 9 years. A number of responses to our survey stressed lack of awareness in those communities of the carcinogenic nature of this habit, with one member quoting an example of a young patient who as a result developed pre-cancerous cells in his mouth by the age of 14.

> *"In addition to the tooth decay campaign, I believe general oral health and specifically in Tower Hamlets campaigns regarding paan/betel nut chewing must be supported. I recently had a 14-year-old patient whom had never seen a dentist that presented as an emergency appointment as they couldn't open their mouth properly. They had been chewing paan since they were 5 years old and as such had a precancerous condition known as submucosal fibrosis, at the age of 14! This is a condition usually associated with the elderly."*
>
> Response to BDA survey of London dentists

Dentists in London are already engaged in a range of initiatives to raise awareness of the importance of good oral health and address oral health inequalities in their own areas, and are ready to do more. The BDA would be delighted to work with the Mayor, the dental profession and other partners to support and facilitate this aim.

Annex:

Percentage of 5-year-olds in London with experience of tooth decay

(boroughs which have seen a deterioration since 2015 marked in red):

	2015	2017
Harrow	34.2%	39.6%
Brent	30.8%	34.6%
Waltham Forest	29.8%	32.9%
Hillingdon	37.8%	32.5%
Tower Hamlets	35.5%	31.1%
Ealing	39.0%	30.7%
Enfield	33.9%	30.5%
Westminster	35.1%	30.3%
Camden	23.5%	30.0%
Newham	28.3%	29.0%
Haringey	30.3%	29.0%
Barking and Dagenham	31.4%	28.6%
Croydon	26.3%	28.5%
Kensington and Chelsea	33.4%	26.6%
Wandsworth	23.2%	25.8%
Hounslow	30.5%	25.7%
Sutton	19.0%	25.6%
Hammersmith and Fulham	26.3%	24.2%
Barnet	31.6%	24.1%
Hackney	27.0%	22.9%
Merton	26.1%	22.5%
Islington	24.4%	22.5%
Greenwich	23.9%	22.2%
Lambeth	22.1%	21.7%
Kingston upon Thames	22.9%	21.5%
Redbridge	23.7%	20.9%
Havering	20.0%	20.5%
Lewisham	23.3%	19.4%
Bromley	16.0%	17.4%
Richmond upon Thames	19.0%	16.4%
Southwark	18.8%	15.9%
Bexley	17.0%	14.4%