Instilling and improving equitable access to Dental Services in The Black Country

Sarah Kaddour; Consultant in Dental Public Health, NHS West Midlands
s.kaddour@nhs.net

Background: Inequalities exist in oral health outcomes and access to dental services. A health equity audit seeks to examine whether resources are distributed fairly, relative to the health needs of different groups. To address oral health inequalities and inequities in service provision requires disproportionate re-distribution of resource to those most at need i.e. a 'levelling up approach'.
Access to NHS general dental services (GDS) has become challenging, particularly for those most burdened by and vulnerable to poor oral health. The current fiscal climate and challenges in NHS workforce retention has created scarcity of available resource in some areas. To prioritise targeted action of funding allocation to those most at need residing in the West Midlands, an internal, bespoke Dental Service Equity Audit (DSEA) was developed for each Integrated Care System (ICS). This poster presents the DSEA for The Black Country (BC)

Aims and Objectives: The audit tool aimed to inform targeted action, fair distribution and re-allocation of resources towards local populations identified most at need. This aimed to improve equity to GDS services and reduce inequalities in oral health outcomes.

Methods: Led by Dental Public health and shaped by Local Authority public health, analytic teams and dental commissioners, the DSEA acted as an internal decision informing tool to aid commissioning intentions. The audit was developed in 3 parts (Fig. 1).

PART 1: Understanding the context.
Triangulation demographic, health, oral health and dental services access data

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PART 2: Priorities for investment and re-direction of resource.
Analysis and justification to level-up equity in access to dental services

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PART 3: Recommendations and future work.
How this tool can be put to practice and future developments

(Fig. 1)

A variety of data sources was triangulated for populations of each electoral ward in The BC. This included:
- Deprivation data (e.g. Index Multiple Deprivation 2019)
- Geographical data: number of lower super output areas (LSOAs) IMD 1 or 2 within ward i.e. the 20% most deprived in England
- Oral health outcomes: child dental caries prevalence by electoral ward (National Dental epidemiology surveys of 5–year old children 2019 and 2022)
- Access to services: 12month child and 24month adult access rates for primary dental care (up to March 2024)
- Wider health outcomes to help build a wider context of prioritisation, utilising common risk factor approach: child overweight and obesity prevalence

A weighting system (Fig.2) was created that disproportionately empathised the most deprived areas, high prevalence of experience of child dental decay and dental access rates below the BC average. The weighting criteria was applied to each ward, which resulted in a list of priority 1, 2 and 3 areas. The methodology and priority areas were validated with public health and analytic teams in Local Authorities of the BC.

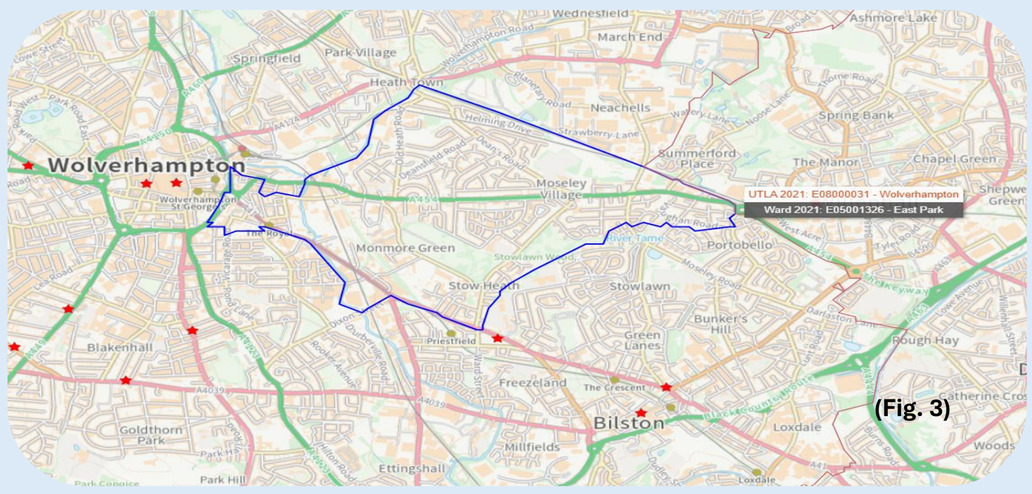
PRIORITY 1: Child access rates AND adult access rates below ICB average PLUS Child experience of decay above BC average AND WM average from National oral health survey of 5-year-olds 2022 PLUS Deprivation of ward: >7 LSOAs with IMD 1-2

PRIORITY 2: Child access rates OR adult access rates below ICB average PLUS Child experience of decay above BC average OR WM average from National oral health survey of 5-year-olds 2022 PLUS Deprivation of ward: >7 LSOAs with IMD 1-2 OR 4-6 LSOAs with IMD 1-2

PRIORITY 3: Child access rates OR adult access rates below ICB average PLUS: Child experience of decay above BC/WM average from National oral health survey of 5-year-olds 2022 OR Deprivation of ward: 4-6 LSOAS with IMD 1-2 OR >7 LSOAs with IMD 1-2

(Fig. 2)

Results: The 88 BC electoral wards were prioritised using the weighting system in the DSEA. This resulted in; 17 (19%) priority 1 wards, 20 (22%) priority 2 wards and 13 (14%) priority 3 wards across BC. Each priority ward was geographically mapped to include current NHS dental contracts in the locality (example in Fig3). This helped identify gaps in provision, and areas with reduced dental activity. Additional or repurposed dental contractual activity and resources are now being targeted to these priority wards, using a justified, public health approach to health equity.



(Fig. 3)

Conclusions: Additional or repurposed dental contractual activity and resources are now being targeted to these priority wards, with the aim to reducing oral health inequalities and improving equity to access and utilise dental services.