A needs assessment for General Dental Services in Kent, Surrey and Sussex

June 2018

Table of Contents

1. Executive summary....2
2. Introduction....11
3. Purpose of the needs assessment....11
4. Background: uptake of NHS dental services....11
5. Thinking beyond the NHS definition of dental access....13
6. Methodology....15
7. Findings....17
8. What is the relationship between uptake of NHS dentistry and deprivation? 17
9. Which age groups are less likely to attend an NHS dentist in KSS?....23
10. How much variation is there in the amount of dental activity (UDAs) commissioned from dental providers in KSS?....29
11. Where are GDS practices, with NHS contracts, located in KSS?....30
12. How do travelling distances to NHS dentists vary across KSS?....34
13. What is the public view?....43
14. What is the need for bariatric dental care in KSS?....52
15. What is the need for urgent dental care in KSS?....55
16. Conclusions 59
17. Recommendations....61
18. Next steps....63
19. Appendix....64
20. References....6

1. Executive summary

- **Which groups are of greatest concern in relation to dental access?**
  - People who are already vulnerable, e.g. older adults, young children, people with chronic health issues, are doubly burdened with more oral disease and less dental treatment.
  - Poor uptake of NHS General Dental Services in areas of deprivation is a greater concern than poor access in more affluent areas. People with deprivation are more likely to suffer from oral diseases and less likely to seek out dental care.
  - Areas where access and deprivation are low are likely to have higher use of private dental services, although there are no data to confirm this.

- **Why do people not attend an NHS dentist?**
  - There are many barriers that stop people from attending an NHS dentist. These include lack of perceived need to attend, anxiety, cost, and availability of suitable services.
  - Barriers are more likely to affect people from lower socio-economic backgrounds than people from more affluent backgrounds.
  - If barriers are not reduced, inequalities in oral health will increase.

- **The % of the population who have accessed NHS dental care in KSS varies by local authority:**
  - Children – varies from 61% in Thanet to 76% in Horsham.
  - Adults – varies from 31% in Elmbridge to 58% in Hastings.

- **Lower access in the following, relatively deprived areas**:
  - Thanet
  - Swale
  - Brighton and Hove
  - Gravesham

- Dover
- Eastbourne
- Rother

- **Variation in uptake, by age, in children:**
  - 13-17 year olds: 77% uptake
  - 6-12 year olds: 82% update
  - 3-5 year olds: 63% uptake
  - 0-2 year olds a particular concern - only 19% saw an NHS dentist in the past 2 years.

- **Variation in uptake, by age, in adults:**
  - For adults in KSS the majority have not attended an NHS dentist in the 24 months leading up to January 2018.
  - The uptake of care in adults ranges from 40-49% depending on age group, at the KSS level.
  - At the local authority level attendance in adults varies between 31% in Elmbridge to 58% in Hastings.
  - Greater variation is seen when data is broken down by adult age group: ranges from 23-63% depending on age group and local authority.
  - There is a general trend of decreasing uptake with age, with some exceptions, e.g. Dartford where 55-74 year olds show relatively high attendance rates.
  - In many local authorities however, some of the age bands fall below 40%, and in some cases below 30%. This is a concern where deprivation is relatively high, including Brighton and Hove and Dartford.

- **Variation in the amount of dental activity commissioned from dental providers in KSS (UDAs commissioned)**
  - Dental activity is commissioned through Units of Dental Activity (UDAs).
  - The number of Units of Dental Activity (UDAs) commissioned per individual for the population of a lower tier local authority varies from 0.8 UDAs per person in Tonbridge and Malling to 2.3 UDAs per person in Hastings, on average.
  - The number of UDAs per person that are most frequently found (mode) are 1.3, 1.4 and 1.6 UDAs per person. Each of these values is found in 5 local authority areas.
  - The value in the middle of the range (median) is 1.3 UDAs per person

High level comparison of lower tier local authorities in Kent, Surrey and Sussex, showing RAG rating, in relation to deprivation, child access, adult access, UDAs commissioned, travelling distances and contract performance.

	Total Contracted UDAs (2018/19)	Population size, all ages, mid 2016 (ONS estimates)	IMD rank in KSS [1]	% children using GDS in 24 months to January 2018	% adults using GDS in in 24 months to January 2018	UDAs per person (total contracted UDAs/population)	80% children in this LA travel up to a maximum of (km)	80% adults in this LA travel up to a maximum of (km)
Hastings	208,441	92,236	1	66.4	57.9	2.3	4	4
Thanet	202,800	140,652	2	61.8	53.3	1.4	11	18
Swale	156,684	145,042	3	64.9	46.1	1.1	15	16
Brighton and Hove	408,315	289,229	4	67.0	41.0	1.4	4	5
Shepway	183,110	111,190	5	70.6	50.9	1.6	11	17
Medway	415,079	278,542	6	70.6	45.1	1.5	5	6
Gravesham	160,524	106,808	7	65.3	47.3	1.5	8	11
Dover	147,257	114,227	8	63.6	49.8	1.3	16	17
Eastbourne	162,853	103,054	9	64.3	47.2	1.6	4	6
Rother	152,364	93,551	10	65.3	52.4	1.6	12	12
Adur	91,919	63,506	11	69.3	50.3	1.4	7	9
Dartford	93,609	105,543	12	63.8	42.1	0.9	10	11
Crawley	177,813	111,375	13	69.3	48.1	1.6	4	5
Arun	261,525	156,997	14	69.7	51.1	1.7	8	9

[1] * The Index of Multiple Deprivation is the official measurement of deprivation for small areas of England (called Lower-layer Super Output Areas). The IMD ranks each area with 1st being most deprived. The index covers 7 domains of deprivation: income, employment, education, health, crime, barriers to housing and services and living environment. More info here https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464431/English_Index_of_Multiple_Deprivation_2015_-_Infographic.pdf

Worthing	127,538	108,605	15	67.2	44.3	1.2	4	6
Ashford	188,127	126,151	16	70.8	51.1	1.5	13	17
Canterbury	194,395	162,416	17	66.7	37.9	1.2	9	13
Maidstone	222,309	166,360	18	66.6	42.3	1.3	10	13
Lewes	169,006	101,381	19	68.4	49.3	1.7	11	11
Spelthorne	133,584	98,902	20	68.5	43.9	1.4	6	7
Chichester	150,149	118,175	21	68.5	40.3	1.3	12	13
Sevenoaks	102,394	119,142	22	67.0	34.8	0.9	12	16
Tonbridge and Malling	95,609	127,293	23	61.6	36.0	0.8	12	15
Wealden	230,483	157,575	24	66.5	47.9	1.5	12	14
Tunbridge Wells	132,582	117,069	25	67.4	36.7	1.1	11	15
Runnymede	75,362	86,889	26	63.2	34.3	0.9	6	8
Tandridge	102,960	86,665	27	69.0	42.9	1.2	9	11
Reigate and Banstead	186,227	145,648	28	67.8	44.7	1.3	8	10
Woking	128,296	99,695	29	67.7	38.3	1.3	6	8
Horsham	198,783	138,018	30	75.7	51.2	1.4	12	15
Guildford	163,458	148,020	31	64.1	35.9	1.1	8	10
Mole Valley	91,611	86,223	32	68.4	43.7	1.1	10	12
Epsom and Ewell	136,544	79,588	33	70.3	50.2	1.7	4	5
Surrey Heath	92,037	88,387	34	71.3	39.3	1.0	9	10
Mid Sussex	233,328	147,089	35	73.8	48.8	1.6	8	11
Elmbridge	102,620	132,764	36	61.2	31.4	0.8	6	9
Waverley	151,248	123,768	37	63.4	43.1	1.2	11	13

- **Travelling distances:**
  - Adults – travelling for 80% of the population who visited a dentist varied from 4-18km, depending on the local authority. In general however, more adults travelled further than children to see an NHS dentist.
  - Children – travelling for 80% of the population who visited a dentist varied from 4-16km, depending on the local authority.
  - Local authorities where adults are travelling most, and where deprivation is relatively high: Swale, Shepway, Dover and Thanet.
  - Local authorities where children are travelling most, and where deprivation is relatively high: Rother, Swale, Shepway, Dover and Thanet.

- **The views of the public:**
  - Fewer people reported success when they tried to get an NHS dental appointment in:
    - West Kent
    - Horsham
    - Brighton and Hove
    - North West Surrey
    - South Kent coast
  - The vast majority of respondents said that NHS dental appointment they were trying to get was with a dental practice they had been to before for NHS dental care.
  - Over 90% said they were successful in getting an NHS dental appointment
  - Around half of respondents had either never tried to get an NHS appointment, or last tried more than two years ago.
  - 'When asked 'why haven't you tried to get an NHS dental appointment in the last 2 years?'
    - the vast majority of people reported that they preferred to attend a private dentist
    - a substantial number reported that they 'didn't think [they] could get an NHS dentist,' suggesting unmet demand in KSS.
    - Many also reported 'haven't needed to visit a dentist': some people just don't want to go or don't think they need to.
    - Time and cost do not appear to be major barriers to uptake of NHS dental service in KSS

- **Healthwatch concerned:**
  - Some patient groups are missing out:
    - Those who find it difficult to access high street dentists, e.g. care home residents
    - Those who don't go to the dentist at all, or who attend only when they are having problems
    - People living in areas where commissioning NHS treatment has not kept up with changes in demand
  - Problems exacerbated by NHS choices information being out of date and no reliable alternative source of information on dentists accepting patients.

- **How far are people prepared to travel?**
  - 43% would travel 10+ miles
  - People living in rural areas are prepared to travel further than urban dwellers
  - NHS dentist users would travel further than private dentist users
  - Varies by age - 65+ would travel 7 miles, 25-34 year olds would travel10.7 miles, 35-44 year olds would travel 9.9 miles.
  - Members of socio-economic group DE would be prepared to travel less distance than any other group (6.9 miles).
  - People with at least one car in the household would travel 10.1 miles, compared to 5.9 for those without.
  - Residents with children in the household would travel significantly further than those with no children (11.5 and 8.6 miles respectively).

- **Need for bariatric dental services**
  - Obesity is on the rise nationally and in KSS is higher than the national average (25% adults in KSS compared to 24% in England)
  - Obesity is experienced mainly by those from more deprived groups
  - Obesity levels in adults vary substantially across KSS

- **Urgent care:**
  - Urgent conditions are more likely to be experienced by people from lower socio-economic groups and they are more likely to experience more than one urgent condition

- Other vulnerable groups are also more likely to need urgent care, e.g. older people, people with a learning disability or mental illness, people who are housebound or in long term institutional care.

- **Oral cancers and urgent care**
  - Oral cancer incidence rates are rapidly rising and mortality is high. The key to improving health outcomes from oral cancer is to diagnose and treat early
  - People more likely get oral cancers are also more likely to be irregular attenders.
  - Early identification of possible cancerous lesions is crucial to save lives. Urgent care visits are a perfect opportunity to spot these lesions.

- **How to improve access to NHS dental services:**
  - Consider the '5 A's of access: availability, accessibility, affordability, acceptability and accommodation
  - Understanding what target groups want re: when, where and how dental care should be provided and using this to inform commissioning
  - Clear information for people on available local dental services and dental charges

- **Recommendations**

1) Lower tier local authority areas which are relatively deprived, and where there is more than one red RAG rating, should be targeted for action. The next level of priority should be given to lower tier local authority areas that are relatively deprived and have amber ratings.

2) Communications on availability of dental services should be reviewed and improved where necessary. Where possible, communications should be targeted to those population groups who have low uptake, such as older adults living in deprived areas and parents of young children.

3) Relatively deprived areas, where attendance in a number of age bands is below 40% and 30% and where travel distances are relatively high, should be considered a higher priority

4) Practices that are consistently under-performing on their contracts should be encouraged to promote their services to the local population especially in areas of higher deprivation.

5) In areas where practices have struggled to meet their contractual commitments due to lack of demand, there may be less justification to commission additional activity (unless the service offer is significantly redesigned to fit with public preferences).

6) Where the UDAs commissioned by population, for a local authority, are below the midpoint (rated red) they should be considered higher priority for commissioning, particularly when accompanied by deprivation.

7) Areas where UDAs commissioned per population are relatively high should be less of a priority for procurement.

8) Actions are needed to facilitate attendance at a dentist in the early years, e.g. communication plan, support to GDPs on how to manage this age group and training in oral health for health professionals who work with young families like health visitors.

9) Where availability of services is reasonable, but uptake is low and deprivation is relatively high, further work is needed to understand how to encourage non-attenders to visit the dentist, e.g. public engagement work. This is likely to involve considering the other elements of access, such as acceptability and accommodation. There is a need to design any public engagement or communication campaigns around the barriers reported locally. The issues that need to be address are those less frequently reported including perceived lack of need and lack of awareness that NHS dentists are available.

10) Consider the need to increase availability of urgent dental care in areas of higher deprivation

11) Plan for increased access to bariatric facilities in dental services to support access to dental services for people with obesity issues

12) Consider how the housebound can access dental care: possibly through the future special care procurement

- **Next steps**
  - Meeting to agree the areas where additional GDS capacity would be of benefit to the population.
  - Consult on priority areas with the public and the dental profession
  - Develop action plans for priority areas

- Implement action plans through a procurement process.

2. Introduction

Commissioning of NHS dental services in Kent, Surrey and Sussex (KSS) is the responsibility of the NHS England South East local office. As part of developing the commissioning across a wider area NHS England South East requested that a needs assessment, focusing on uptake of General Dental Services, be completed for the Kent, Surrey and Sussex area. This was completed in 2016. Since then a number of changes to local contracts has rendered the 2016 work out of date. This document is therefore an update of the 2016 needs assessment.

3. Purpose of the needs assessment

The NHS has a responsibility to spend public resources in a way that benefits those in greatest need and contributes to reducing inequalities. NHS resources are limited and so it is often necessary to prioritise funding.

The purpose of this needs assessment is to present data that can support the NHS England South East dental commissioning team to determine which areas within Kent, Surrey and Sussex should be a priority for additional NHS funding for General Dental Services. This paper gives an overview of need in lower tier local authority (LA) areas. Need is represented by a range of data showing uptake of NHS dental services, deprivation and commissioning data.

The information in this needs assessment is intended to inform further local discussion to agree final priority areas. This report will summarise data, raise issues, identify gaps and make recommendations. These recommendations will need to be further worked up into commissioning decisions through local discussion – this is because needs assessment is a process rather a document.

4. Background: uptake of NHS dental services

There are over 600 contracts for primary care dental services across KSS (209 in Kent, 171 in Surrey and 268 in Sussex). Simply having an adequate supply of services however, is not sufficient to ensure adequate levels of uptake: people will only be able to receive care if they are able to access these services.

There are many barriers to uptake of dental services. A number of surveys and studies have described barriers to access.[1,2,3] The barriers described include:

- Anxiety
- Cost
- Lack of perceived need
- Lack of appropriate services
- Physical barriers e.g. not served by public transport, lack of car parking, stairs/steps, practices unable to accommodate wheelchairs/pushchairs
- Uneven geographical distribution of services – long travel times
- Dental professionals who do not have the skills appropriate to the patient's needs
- Societal norms in relation to dental health i.e. dental health is not seen as a priority
- Language issues
- Mistrust of dentists

These barriers are more likely to impact on populations from lower socio-economic backgrounds than those from more affluent backgrounds. For example, the 2009 Adult Dental Health Survey found that more than a quarter (26%) of people surveyed reported cost concerns as a barrier to attending a dentist.[4]

Children and adults from lower socio-economic groups are particularly at risk of suffering from oral diseases. They tend to experience more dental decay, periodontal (gum) disease, tooth loss and edentulousness (no teeth). They also have more unmet need for treatment than more advantaged groups. In addition to the socially deprived, there are a variety of other groups who are at greater risk of developing oral diseases. These tend to be the more vulnerable, difficult to reach groups such as homeless people, people with mental health problems, people with learning difficulties and prisoners. This means that people who are already vulnerable are doubly burdened with more oral disease and less dental treatment.

If NHS dental services are to be used effectively, barriers to uptake need to be minimised. Improving access to care involves actions at individual, societal and system level. Actions include appropriate patient management by clinicians; consideration of when, where and how dental care is provided; and clear information for people on available local dental services and dental charges. If barriers are not minimised, inequalities in oral health will increase, as barriers have the greatest effect on those populations at highest risk of poor oral health.

5. Thinking beyond the NHS definition of dental access

It can be helpful to think beyond the NHS definition of dental access when trying to improve uptake of services. From the NHS perspective, dental access is the number of individual patients seen by a NHS dentist, at least once in the most recent 24-month period. Access to dental care however, is a complex issue of which the availability of services is only one aspect. It might be better described as 'the level of fit between the expectations of people who might use services, and what providers offer to meet those expectations'. A range of factors is known to influence access to care, including geographic, financial, socioeconomic, educational and cultural factors.

Access can be broadly divided into five themes ('the 5 As'):

1. **Availability of services**

This refers to how well services are distributed, e.g. ratio of dentists to population.

2. **Accessibility of services**

This refers to location, e.g. travelling distance as well as physical accessibility within the practice itself, e.g. for disabled access.

3. **Affordability of services**

This includes both direct costs of dental treatment and indirect costs, e.g. travel costs, time off work, child-care. All of these costs tend to be more significant for those on a low income.

4. **Acceptability**

This relates to public expectations about how services should look. This can vary substantially for different population groups, e.g. a study of homeless people in London found that they prefer older, shabbier clinics as they perceive them to be more accepting of their appearance and circumstances.

5. **Accommodation**

This relates to how care is provided, e.g. opening hours, urgent care slots, waiting times, ease of booking an appointment. Again this may vary across different population groups. While some people appreciate seeing the same dentist at regular intervals,

those living in the most deprived areas tend to be irregular attenders. They may therefore fit poorly with the traditional high street dental practice model.

6. Methodology

This report attempts to answer 8 key questions on the uptake of NHS dental services in KSS. These questions, their rationale and the source of the data gathered for this report are summarised in figure 1.

41: Questions, rationale and data sources used in this report

	Question to answer	Rationale	Data source
1	**What is the relationship between uptake of NHS dentistry and deprivation in KSS?**	Low uptake of dental care is usually associated with deprivation. People living in deprivation have greatest burden of oral diseases and so greatest need for dental care.	BSA data (custom request) Indices of multiple deprivation https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
2	**What age groups are less likely to attend an NHS dentist in KSS?**	Poor access may be limited to specific age groups. Knowing which groups are not visiting a dentist gives clearer idea of who to target with interventions.	BSA data (custom request)
3	**Where are GDS practices with NHS contracts located in KSS?**	Helps visualise where services are located – particularly relevant where proportion of UDAs commissioned looks low. It may be that there are services in neighbouring LAs.	NHS England South East
4	**How do travelling distances to NHS dentists vary across KSS?**	Shows whether people are able to access care within a reasonable travel distance .	BSA data (custom request)
6	**What do the public report about how easy it is to access NHS dentistry in KSS?**	Gives an indication of whether people who want NHS care are able to access it. Important in areas where demand for private care is high.	GP Patient Survey Dental Statistics; January to March 2017, England https://www.england.nhs.uk/statistics/2017/07/06/gpps_dent_y111864861/
7	**What is the need for bariatric dental care and how does it vary across**	Shows where in KSS there are more people with obesity and therefore	Public Health England Local Health website

	KSS?	greater need for bariatric facilities in dental surgeries	http://www.localhealth.org.uk/#l=en;v=map4
8	**Who is more likely to need urgent dental care and how does this vary across KSS?**	Shows where in KSS people are more likely to use urgent dental care, rather than routine care.	Adult Dental Health Survey 2009 https://digital.nhs.uk/areas-of-interest/public-health/adult-dental-health-survey

The overall picture for KSS is summarised in figure 2, which RAG rates the local authorities across a number of different measures, such as deprivation and uptake of NHS dental services. The rest of the findings delve deeper into the local authorities that were rated as 'red', to better understand *who* is using/not using NHS dental services, and *how* they are using them, in these areas.

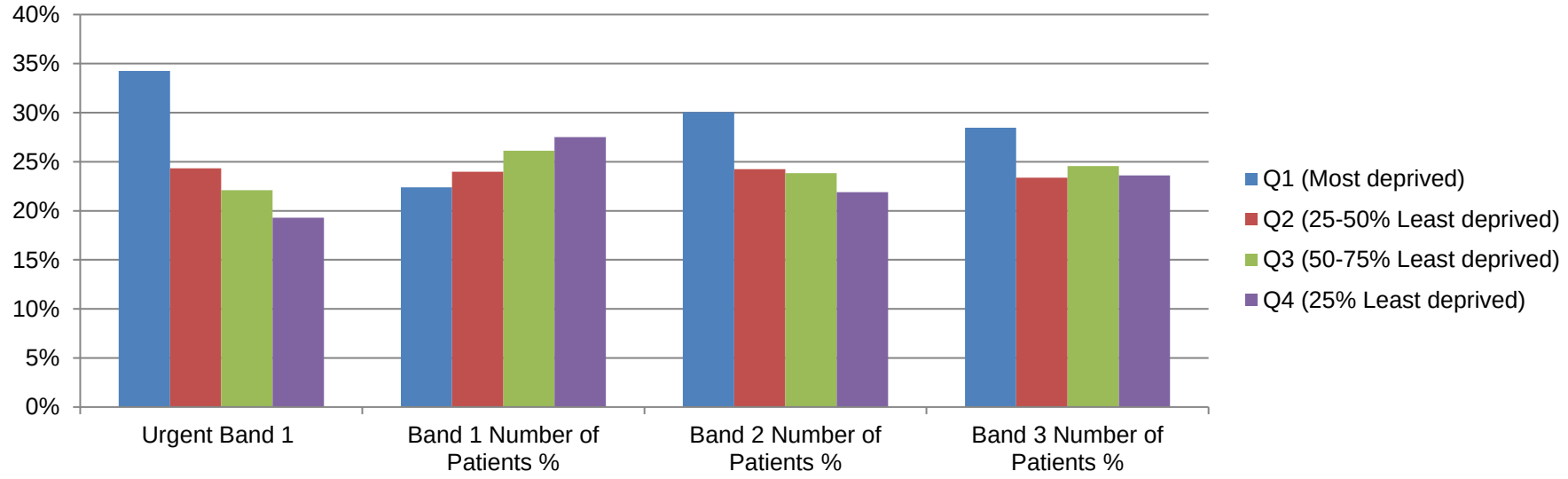
7. Findings

7.1. What is the relationship between uptake of NHS dentistry and deprivation?

Children and adults from lower socio-economic groups are particularly at risk of suffering from oral diseases. They tend to experience more dental decay, periodontal (gum) disease, tooth loss and edentulousness (no teeth). They also have more untreated disease than more advantaged groups, e.g. decayed teeth that have not been filled.

An analysis of uptake of NHS dental treatment over the 24 months to January 2018 by deprivation (figures 2 and 3) compares the uptake, by treatment band, between deprivation quartiles. This only compares deprivation within KSS because national comparisons do not give the local detail due to KSS being a generally affluent area.[2]

Figure 2 A comparison of the % of children from each deprivation quartile in KSS that received NHS treatment in 24 months up to January 2018, by treatment band

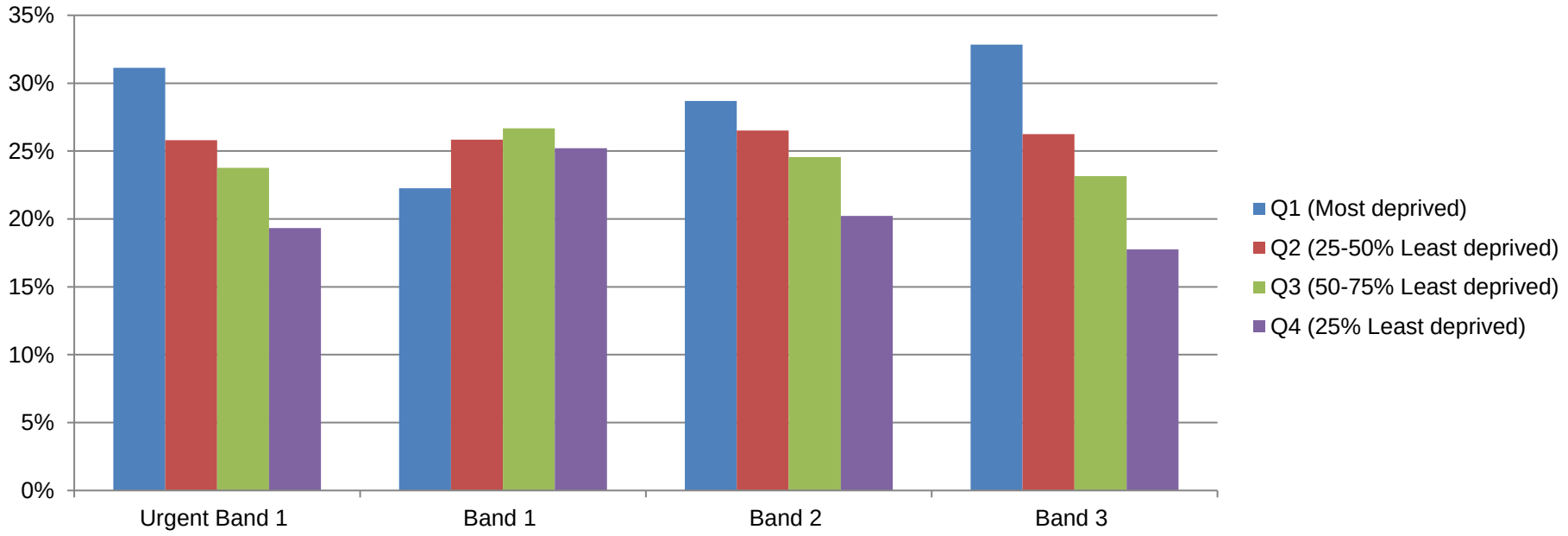


[2] Lower Super Output Areas in Kent, Surrey and Sussex were categorised by IMD score into those that are the 25% most deprived, 25-50% most deprived, 50-75% least deprived and 25% least deprived. Please note this is based on Kent, Surrey and Sussex Area Team areas.

The highest proportion of patients receiving treatment in bands urgent, band 2 and band 3 are from the most deprived quartile. This is true for both children and adults. This suggests that the highest need groups are receiving most care.

The highest proportion of patients receiving treatment in band 1, for both children and adults, is the least deprived group. This fits with population needs as the least deprived groups have less oral disease and therefore less need for treatment beyond a check-up (band 1).

Figure 3 A comparison of the % of adults from each deprivation quartile in KSS that received NHS treatment in 24 months up to January 2018, by treatment band



This picture does not however, indicate that everyone who has a treatment need is receiving care. Not everyone visits an NHS dentist regularly. Uptake of NHS dentistry varies by local authority and by age of patient in KSS. The data for each of the lower tier local authorities in Kent, Surrey and Sussex are shown in the table in section 5. The data in each column has been rated red, amber or green (RAG) according to where they fall in the ranking for each category. The worst third in each category are coloured red, the middle third orange and the best third green. Where the same value is repeated (such as 69% of children using GDS in last 24 months) they will be given the same rank.

The results are sorted by deprivation rank. This is because the evidence shows that populations from deprived areas have poorer oral health and are also less likely to access healthcare services than those from affluent populations. They are also less likely to access private dental care. Therefore poor uptake of NHS General Dental Services in areas of deprivation is a greater concern than poor access in more affluent areas.

The purpose of the RAG rating is to highlight those areas which are amongst the worst in each of the categories. A local authority with red in each of the four columns should be considered the highest priority for further data analysis. Please note however, that for the columns showing the proportion of adults and children using GDS services 'green' indicates the best in KSS but may not be good overall. For example in Arun, 51% of adults attended an NHS dentist in the 24 months to January 2018. This is in the top third of local authorities in KSS but is not something to aim for in itself. For comparison: in the 24 month period ending 31st January 2018, 44% of the adult population and 67% of the child population had visited an NHS dentist at least once in the last 24 months in KSS overall.[5]

Figure 4: High level comparison of lower tier local authorities in Kent, Surrey and Sussex, showing RAG rating, in relation to deprivation, child access, adult access, UDAs commissioned, travelling distances and contract performance.

	Total Contracted UDAs (2018/19)	Population size, all ages, mid 2016 (ONS estimates)	IMD rank in KSS [3]	% children using GDS in 24 months to January 2018	% adults using GDS in in 24 months to January 2018	UDAs per person (total contracted UDAs/population)	80% children in this LA travel up to a maximum of (km)	80% adults in this LA travel up to a maximum of (km)
Hastings	208,441	92,236	1	66.4	57.9	2.3	4	4
Thanet	202,800	140,652	2	61.8	53.3	1.4	11	18
Swale	156,684	145,042	3	64.9	46.1	1.1	15	16
Brighton and Hove	408,315	289,229	4	67.0	41.0	1.4	4	5
Shepway	183,110	111,190	5	70.6	50.9	1.6	11	17
Medway	415,079	278,542	6	70.6	45.1	1.5	5	6
Gravesham	160,524	106,808	7	65.3	47.3	1.5	8	11
Dover	147,257	114,227	8	63.6	49.8	1.3	16	17
Eastbourne	162,853	103,054	9	64.3	47.2	1.6	4	6
Rother	152,364	93,551	10	65.3	52.4	1.6	12	12
Adur	91,919	63,506	11	69.3	50.3	1.4	7	9
Dartford	93,609	105,543	12	63.8	42.1	0.9	10	11
Crawley	177,813	111,375	13	69.3	48.1	1.6	4	5
Arun	261,525	156,997	14	69.7	51.1	1.7	8	9
Worthing	127,538	108,605	15	67.2	44.3	1.2	4	6
Ashford	188,127	126,151	16	70.8	51.1	1.5	13	17

[3] * The Index of Multiple Deprivation is the official measurement of deprivation for small areas of England (called Lower-layer Super Output Areas). The IMD ranks each area with 1st being most deprived. The index covers 7 domains of deprivation: income, employment, education, health, crime, barriers to housing and services and living environment. More info here https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464431/English_Index_of_Multiple_Deprivation_2015_-_Infographic.pdf

Canterbury	194,395	162,416	17	66.7	37.9	1.2	9	13
Maidstone	222,309	166,360	18	66.6	42.3	1.3	10	13
Lewes	169,006	101,381	19	68.4	49.3	1.7	11	11
Spelthorne	133,584	98,902	20	68.5	43.9	1.4	6	7
Chichester	150,149	118,175	21	68.5	40.3	1.3	12	13
Sevenoaks	102,394	119,142	22	67.0	34.8	0.9	12	16
Tonbridge and Malling	95,609	127,293	23	61.6	36.0	0.8	12	15
Wealden	230,483	157,575	24	66.5	47.9	1.5	12	14
Tunbridge Wells	132,582	117,069	25	67.4	36.7	1.1	11	15
Runnymede	75,362	86,889	26	63.2	34.3	0.9	6	8
Tandridge	102,960	86,665	27	69.0	42.9	1.2	9	11
Reigate and Banstead	186,227	145,648	28	67.8	44.7	1.3	8	10
Woking	128,296	99,695	29	67.7	38.3	1.3	6	8
Horsham	198,783	138,018	30	75.7	51.2	1.4	12	15
Guildford	163,458	148,020	31	64.1	35.9	1.1	8	10
Mole Valley	91,611	86,223	32	68.4	43.7	1.1	10	12
Epsom and Ewell	136,544	79,588	33	70.3	50.2	1.7	4	5
Surrey Heath	92,037	88,387	34	71.3	39.3	1.0	9	10
Mid Sussex	233,328	147,089	35	73.8	48.8	1.6	8	11
Elmbridge	102,620	132,764	36	61.2	31.4	0.8	6	9
Waverley	151,248	123,768	37	63.4	43.1	1.2	11	13

The table above shows that the following lower tier local authority areas in the most deprived third of KSS are in the lower third for uptake of NHS dentistry for adults and children:

- Dartford

The following lower tier local authority areas in the most deprived third of KSS are in the lower third for uptake of NHS dentistry for adults or children:

- Thanet
- Swale
- Brighton and Hove
- Gravesham
- Dover
- Eastbourne
- Rother

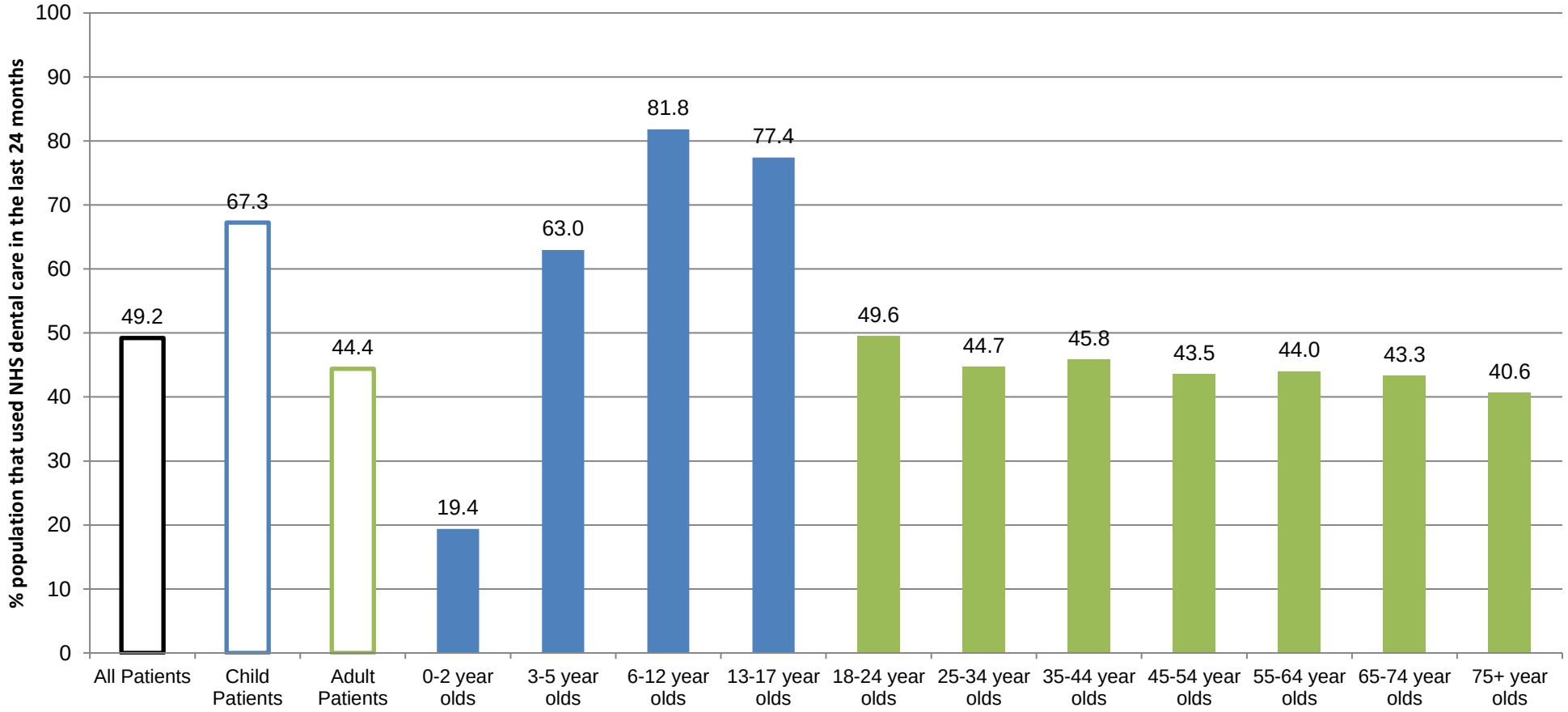
The following lower tier local authority areas in the least deprived third of KSS and are in the lower third for uptake of NHS dentistry for adults and/or children. It is likely that the private sector is playing a role in providing dental care to people living in these areas:

- Tunbridge Wells
- Runnymede
- Woking
- Guildford
- Surrey Heath
- Elmbridge
- Waverley

7.2. Which age groups are less likely to attend an NHS dentist in KSS?

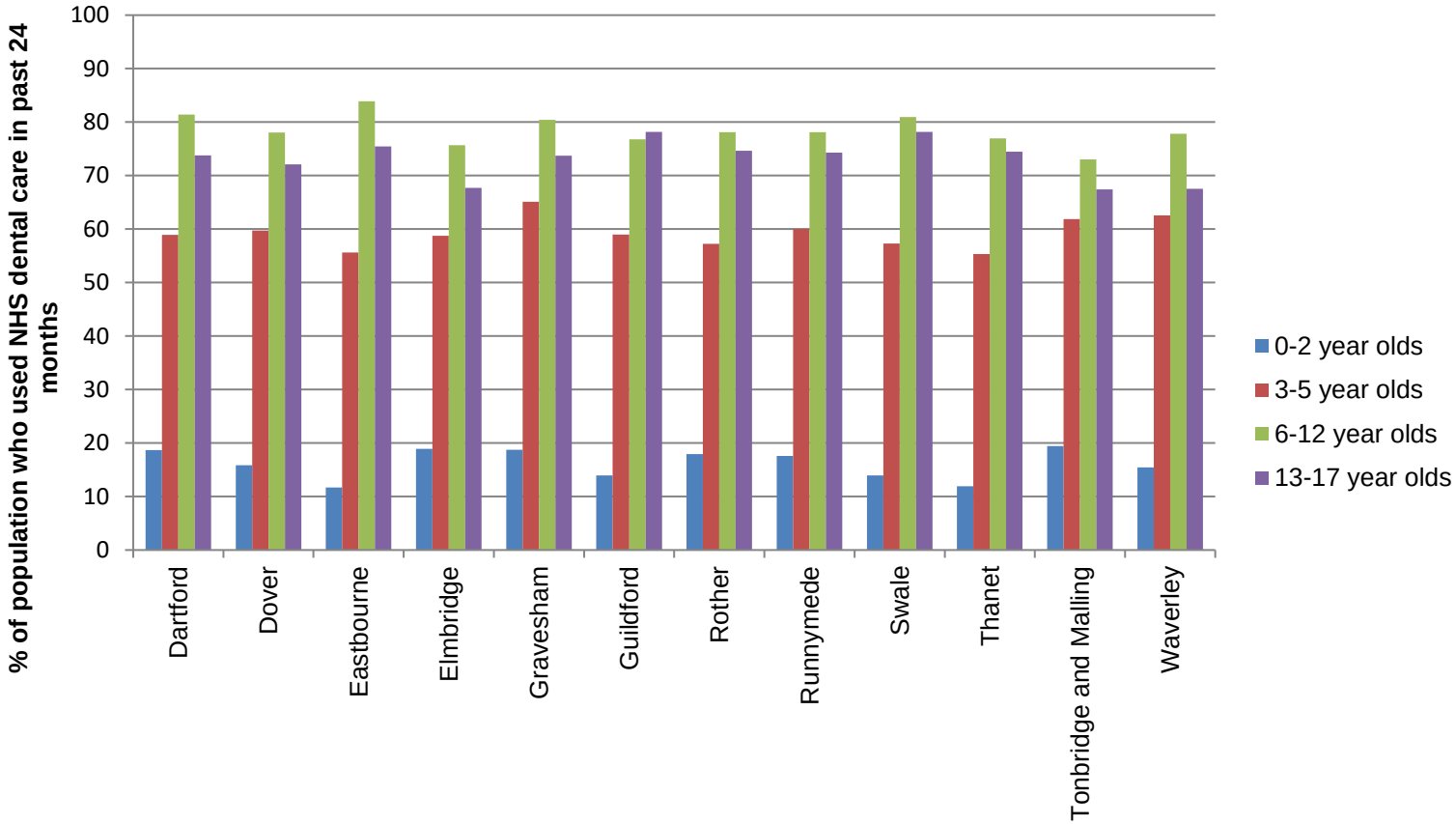
There is variation in attendance by age group, both for adults and children (figure 5). On average, 67% of children in KSS have attended an NHS dentist compared with 44% of adults in the 24 months up to January 2018.

Figure 5: Uptake of NHS dental services in Kent, Surrey and Sussex by age group, showing children and adults, in 24 months up to January 2018 Source: BSA Dental Services



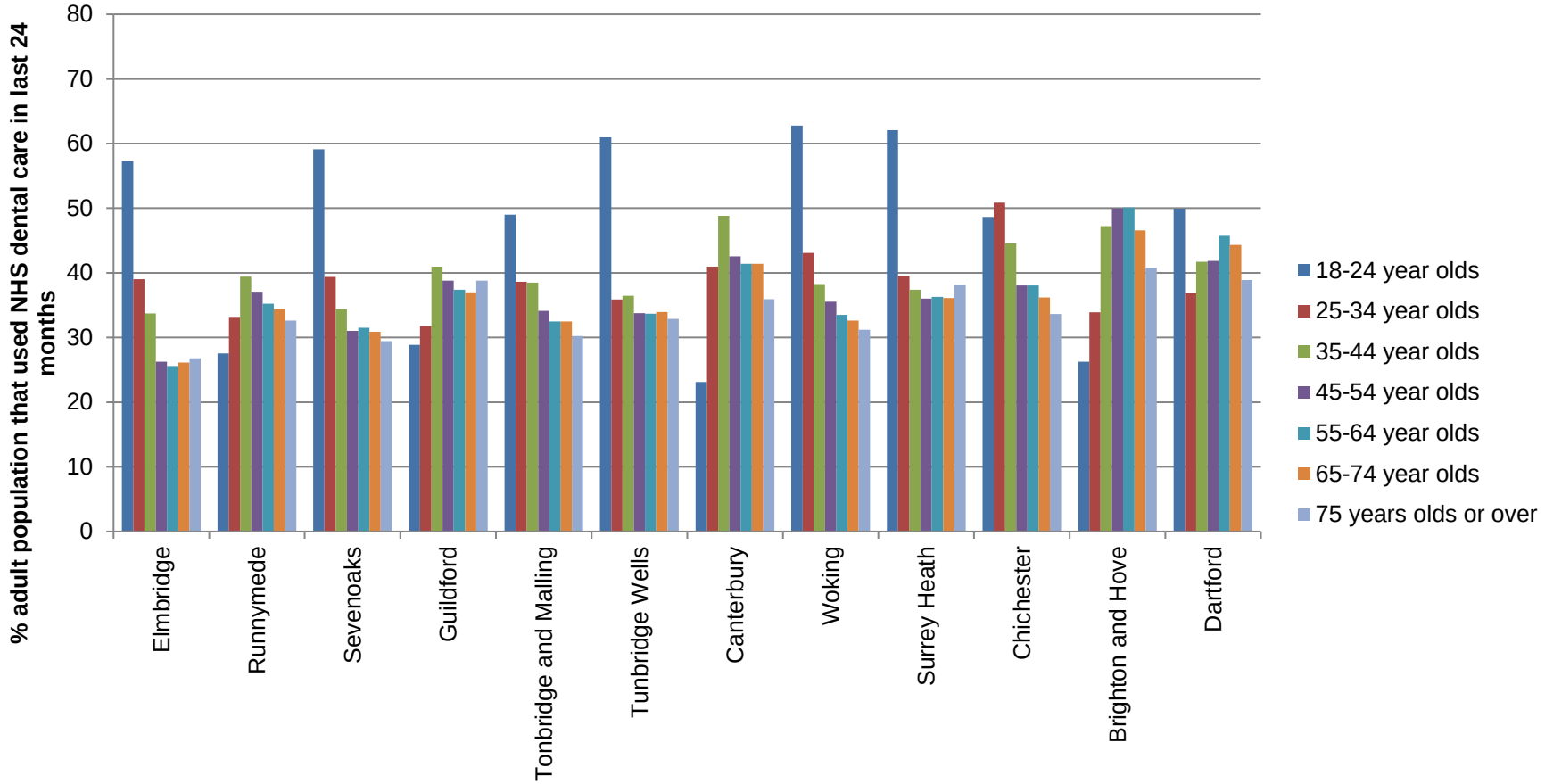
In children however, the variation is much more dramatic: the majority of those aged 6-12 (82%) have attended an NHS dentist in the 24 months leading up to January 2018 while in 0-2 year olds however, only 19% have seen an NHS dentist. This pattern is repeated across the 'red' rated local authorities, with some slight variation between local authority areas (figure 6).

Figure 6: Uptake of NHS dental services by children, arranged by age band, for the 12 local authorities where access was lowest in 24 months up to January 2018 Source: BSA Dental Services



For adults in KSS the majority have not attended an NHS dentist in the 24 months leading up to January 2018. The uptake of care in adults ranges from 40-49% depending on age group, at the KSS level. Looking more closely at the 'red' rated local authorities however, there is clearly more variation between age groups across local authorities (figure 7). For certain age groups, in some local authorities, uptake is as low 20-30%, e.g. Elmbridge has four age groups in this category. In the youngest age group (18-25 year olds) over 60% have attended an NHS dentist many of the 'red' rated local authority areas however, this is not always the case. In Runnymede, Guildford, Canterbury and Brighton and Hove the youngest age group shows lowest attendance of all adults (figure 7). There is a general trend of decreasing uptake with age, with some exceptions, e.g. Dartford where 55-74 year olds show relatively high attendance rates.

Figure 7: Uptake of NHS dental services by children, arranged by age band, for the 12 local authorities where access was lowest in 24 months up to January 2018 Source: BSA Dental Services



In many local authorities however, some of the age bands fall below 40%, and in some cases below 30% (figure 8). The local authorities that fall under these categories are summarised in figure 8.

Figure 8: Lower tier local authorities <40% and <30% adults, by age band, have attended an NHS dentist in 24 months up to March 2017 Source: BSA dental services

Attendance 30- 40%		Attendance 20-30%	
Local authority	**Age band**	**Local authority**	**Age band**
Elmbridge	25-34 35-44	Elmbridge	45-54 55-64 65-74 75+
Runnymede	25-34 45-54 55-64 65-74 75+	Runnymede	18-24
Sevenoaks	25-34 35-44 45-54 55-64 65-74	Sevenoaks	75+
Tonbridge and Malling	25-34 35-44 45-54 55-64 65-74 75+	Guildford	18-24
Guildford	25-34 45-54 55-64 65-74 75+	Canterbury	18-24
Tunbridge Wells	25-34 35-44 45-54	Brighton and Hove	18-24

	55-64 65-74 75+		
Canterbury	75+		
Surrey Heath	25-34 35-44 45-54 55-64 65-74 75+		
Woking	35-44 45-54 55-64 65-74 75+		
Chichester	45-54 55-64 65-74 75+		
Brighton and Hove	35-44		
Dartford	25-34 75+		

The areas of greatest concern here are those where deprivation is relatively high and access is low, such as Brighton and Hove and Dartford.

7.3. How much variation is there in the amount of dental activity (UDAs) commissioned from dental providers in KSS?

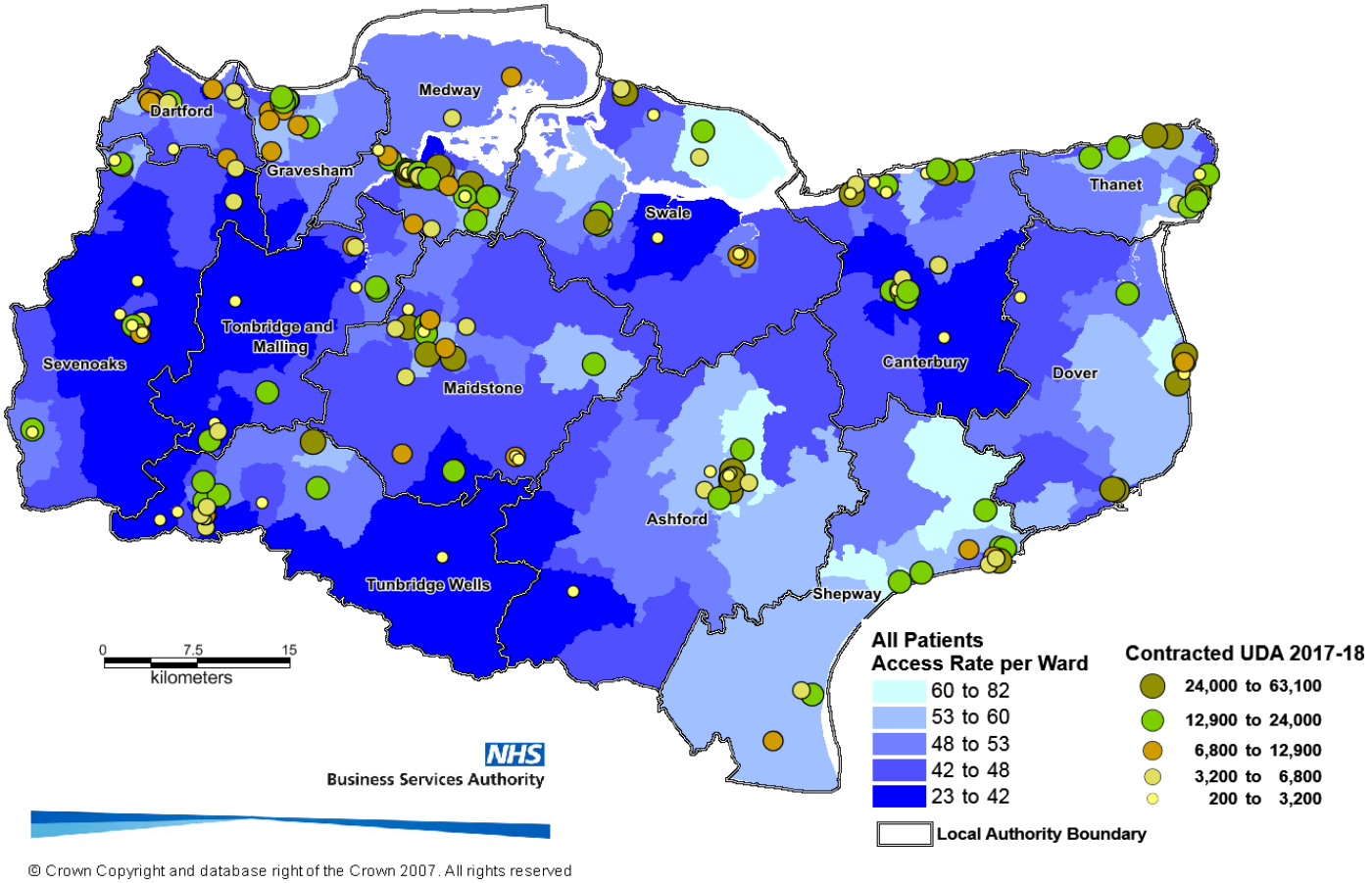
- Dental activity is commissioned through Units of Dental Activity (UDAs).
- The number of Units of Dental Activity (UDAs) commissioned per individual for the population of a lower tier local authority varies from 0.8 UDAs per person in Tonbridge and Malling to 2.3 UDAs per person in Hastings, on average.
- The number of UDAs per person that are most frequently found (mode) are 1.3, 1.4 and 1.6 UDAs per person. Each of these values is found in 5 local authority areas.
- The value in the middle of the range (median) is 1.3 UDAs per person

7.4. Where are GDS practices with NHS contract located in KSS?

The location of dental practices with an NHS GDS contract are mapped below (figure 6,7). Also included on these maps is:

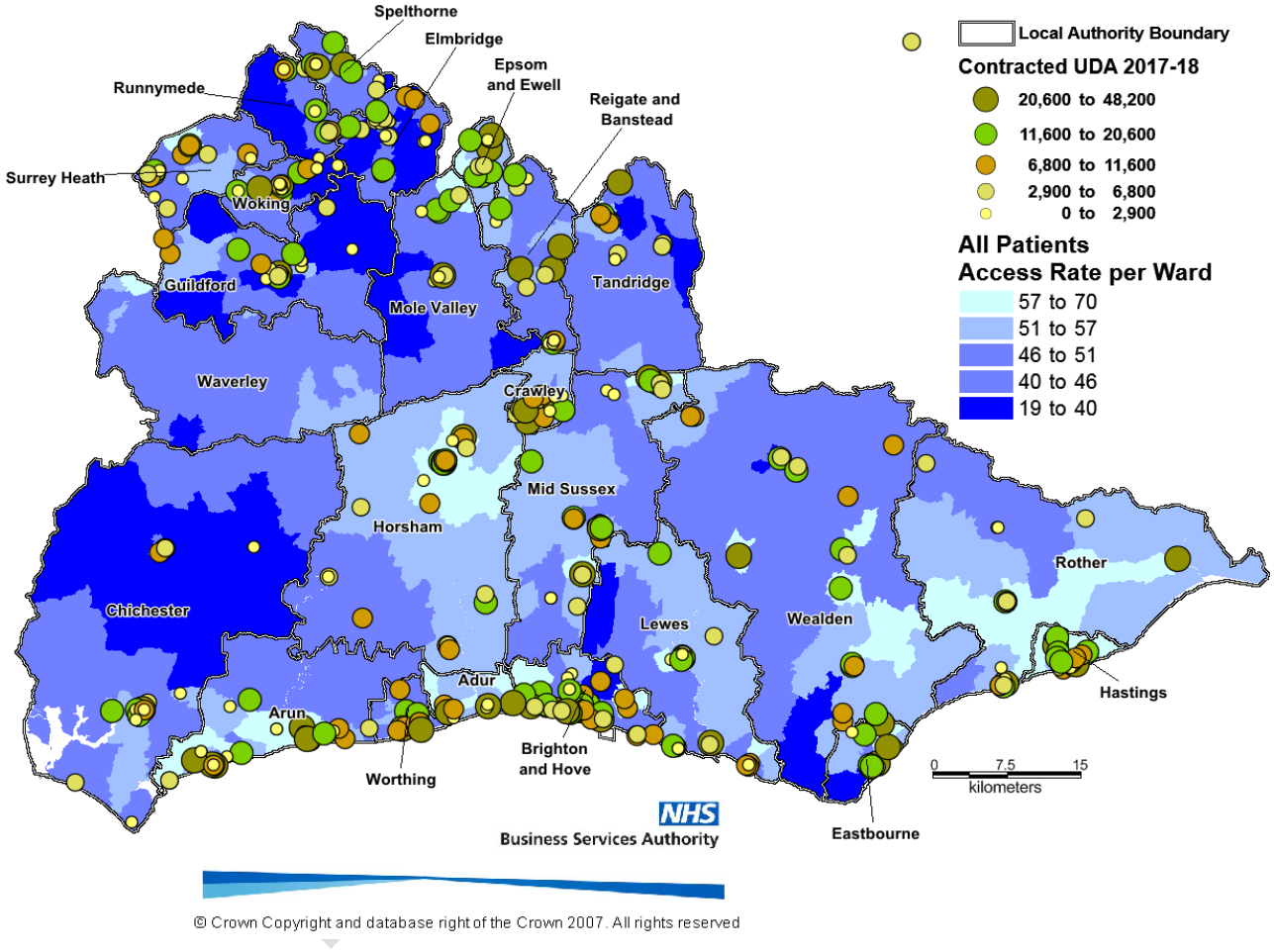
1. The % of the population who have attended an NHS dentist in the last 24 months (access rate)
2. A graphic indicating the relative size of the NHS dental contract

Figure 9: Location of dental practices with an NHS GDS contract in Kent and Medway (including relative size of contract and access rate[4]) 2017-18 Source: BSA Dental Services



[4] Access rate is the % of the population who have attended an NHS dentist in the last 24 months

Figure 10: Location of dental practices with an NHS GDS contract in Surrey and Sussex (including relative size of contract and access rate[5]) 2017-18 Source: BSA Dental Services



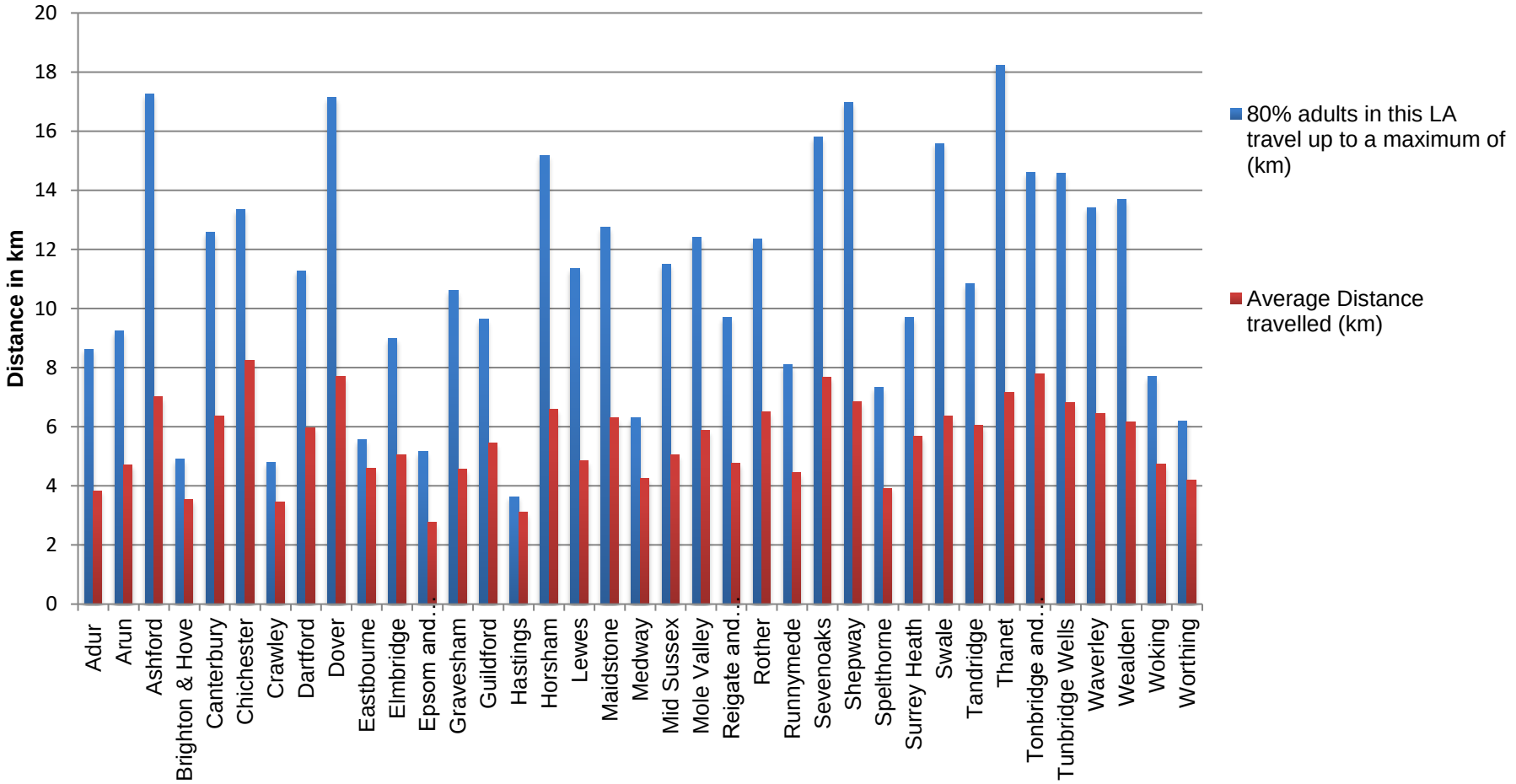
[5] Access rate is the % of the population who have attended an NHS dentist in the last 24 months

7.5. How do travelling distances to NHS dentists vary across KSS?

Distance travelled to visit an NHS dentist can indicate a barrier to uptake of dental care. In KSS the distance travelled by patients shows considerable variation across the region (figures 9,10,11,12). Commonly people living in larger towns have relatively short travelling distances while people in more rural or remote areas have to travel much further to access NHS dental care.

Figures 13 and 14 show the difference between the average distance travelled and the distance within which 80% of adults in that LA travel to an NHS dentist. Looking at the averages alone does not give an indication of how far some people are having to travel. For adults living in many areas of KSS, visiting an NHS dentist required relatively long journeys of up to 18km (figure 13).

Figure 13: Comparison of mean travelling distance and maximum distance travelled by 80% adults to see an NHS dentist, in each local authority from Jan 2017- Jan 2018



For child patients, there are fewer areas where residents had to travel more than 10km and no patients travelled beyond 17km (figure 14).

Figure 14: Comparison of mean travelling distance and maximum distance travelled by 80% children to see an NHS dentist, in each local authority from Jan 2017- Jan 2018

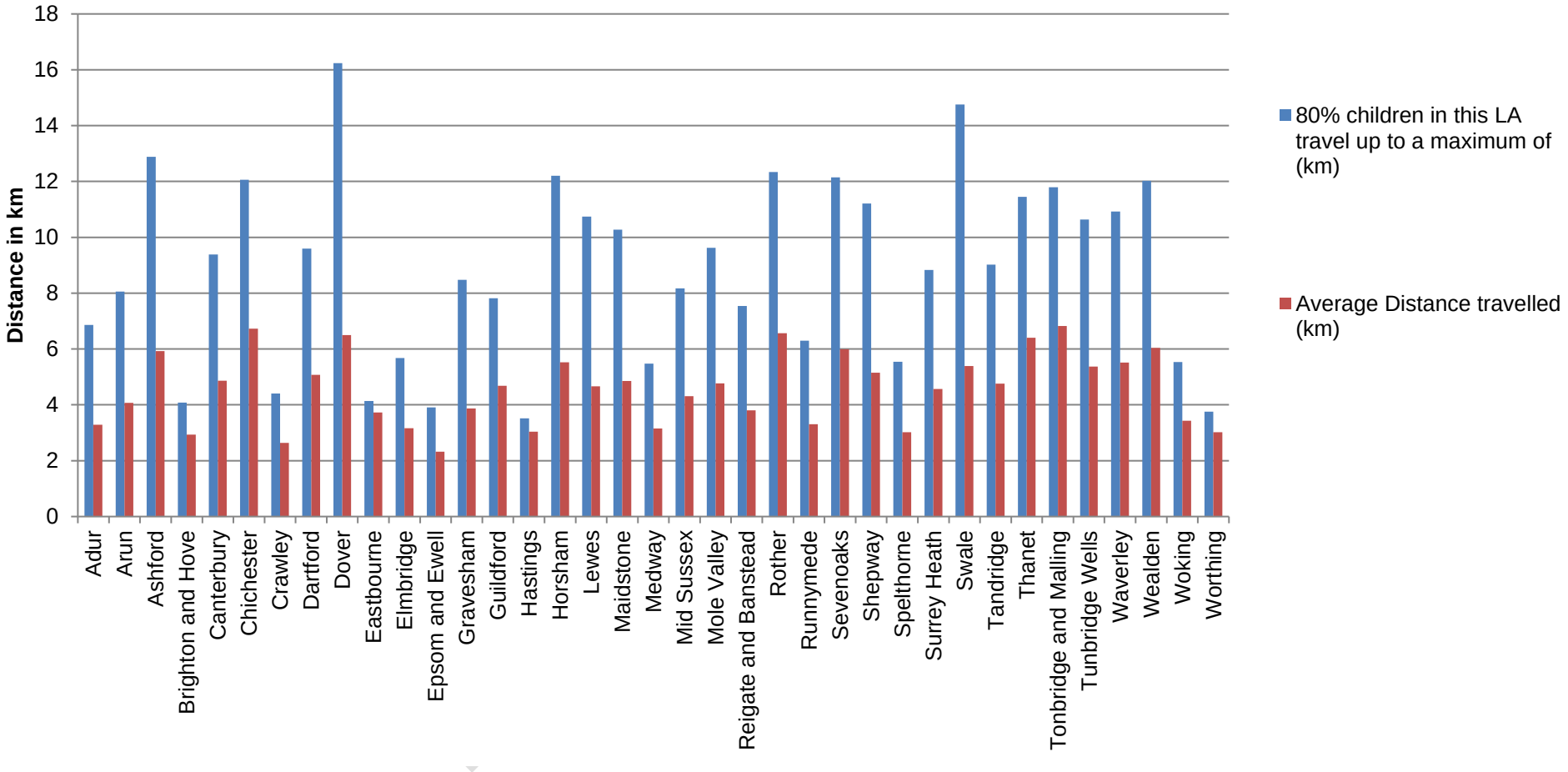
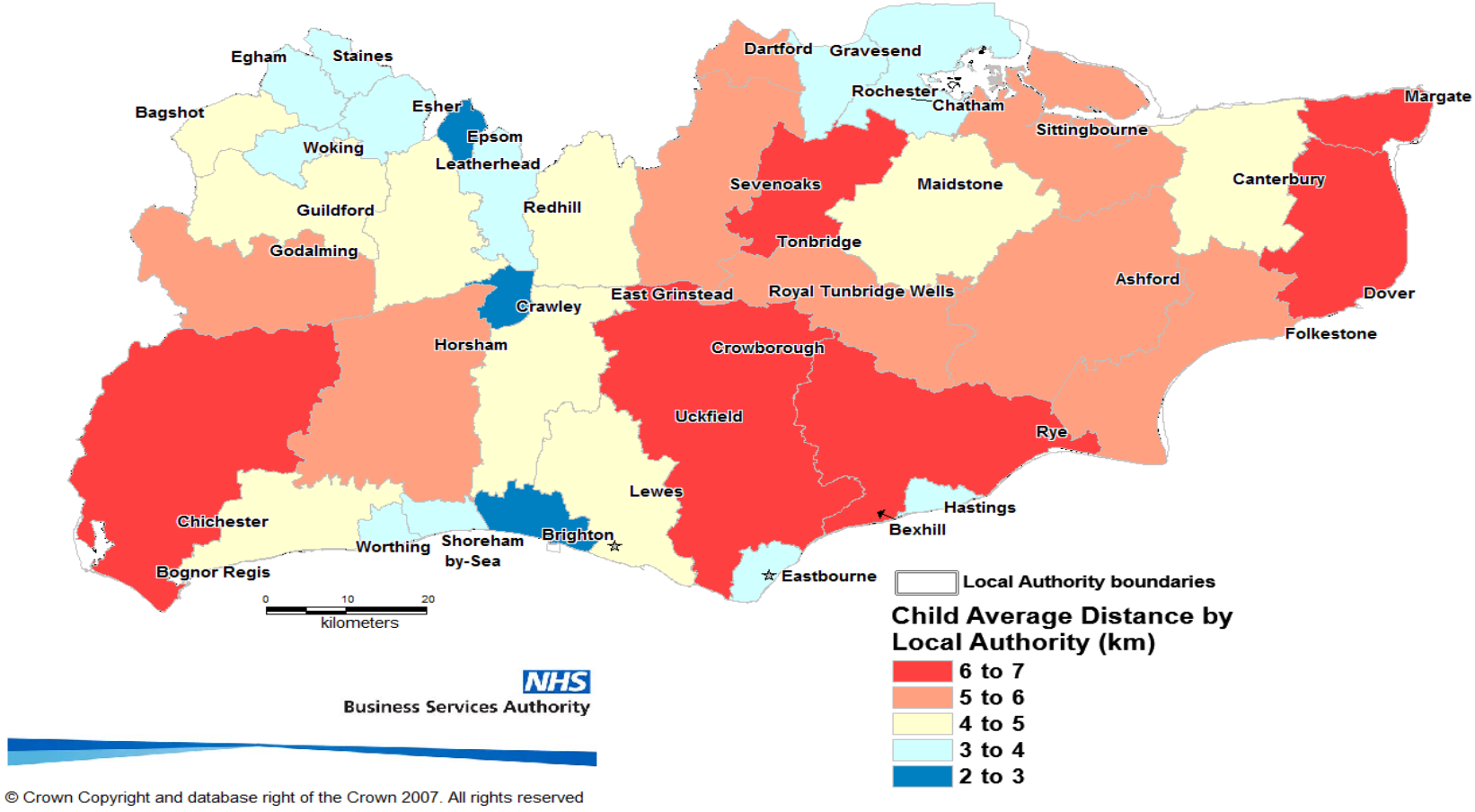


Figure 15: Average distances[6] travelled by child (<18 years) NHS dental patients in Kent, Surrey and Sussex between January 2017 and January 2018, showing local authority boundaries Source: BSA Dental Services



[6] 'Average Distance Travelled' is calculated by measuring a straight line between the home postcode and contract location.

Figure 16: Average distances[6] travelled by adult (>18 years) NHS dental patients in Kent, Surrey and Sussex between January 2017 and January 2018, showing local authority boundaries Source: BSA Dental Services

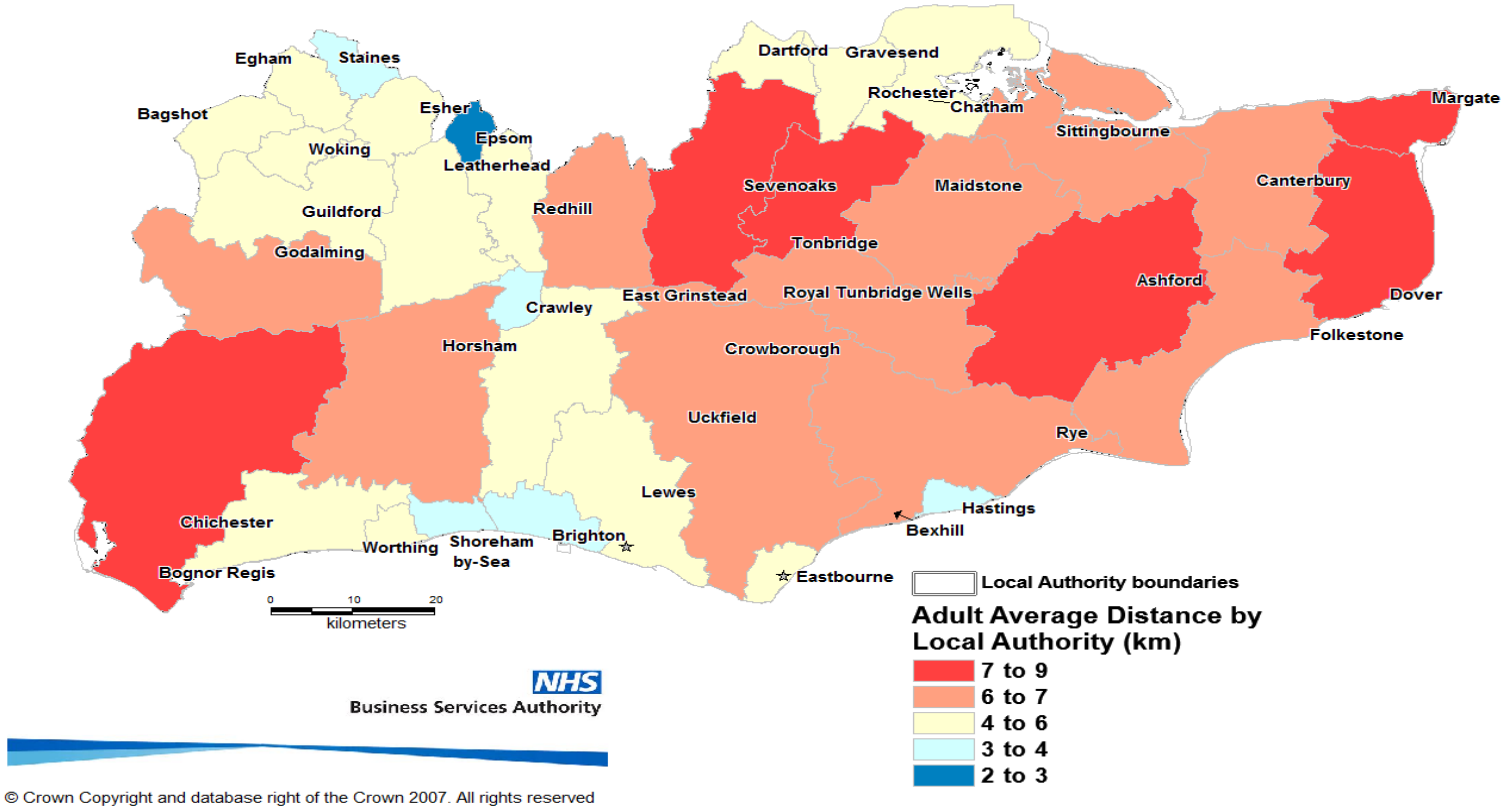
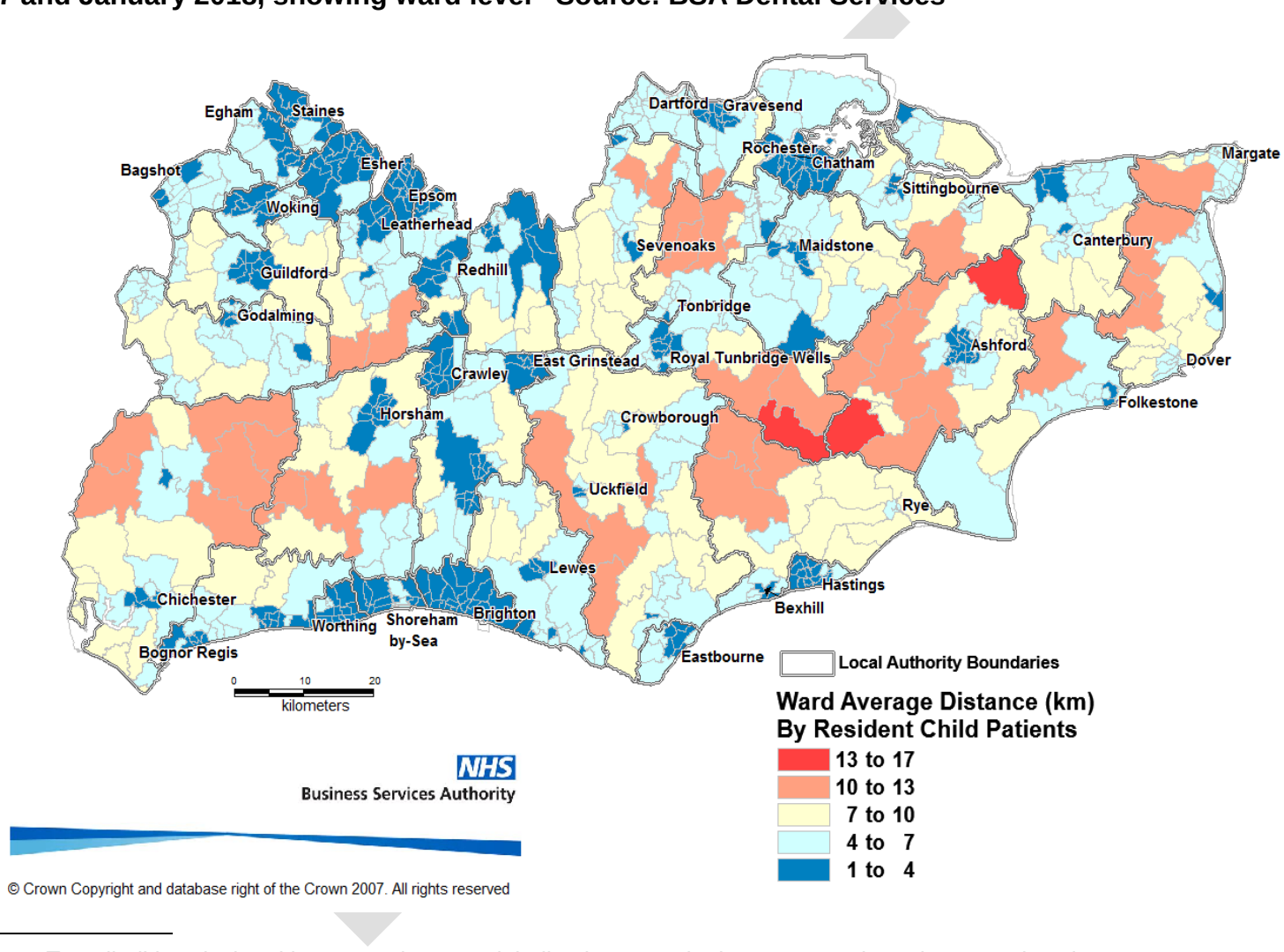
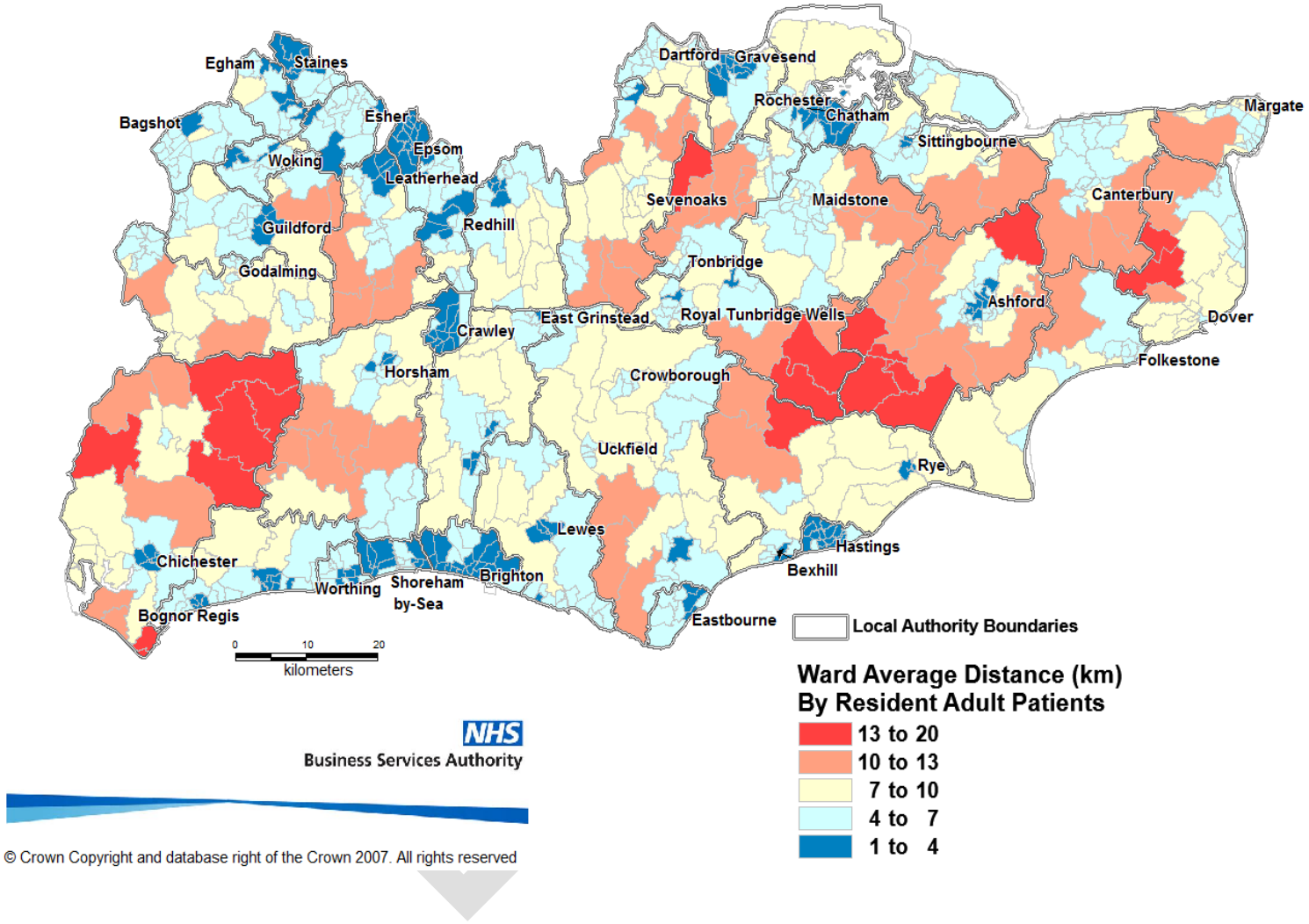


Figure 17: Average distances[7] travelled by child (<18 years) NHS dental patients in Kent, Surrey and Sussex between January 2017 and January 2018, showing ward level Source: BSA Dental Services



[7] 'Average Distance Travelled' is calculated by measuring a straight line between the home postcode and contract location.

Figure 18: Average distances[8] travelled by adult (>18 years) NHS dental patients in Kent, Surrey and Sussex between January 2017 and January 2018, showing ward level Source: BSA Dental Services



[8] 'Average Distance Travelled' is calculated by measuring a straight line between the home postcode and contract location.

The areas where adults and children are travelling longer distances are summarised in figure 19. Of greatest concern are the areas where both deprivation and travel distances are red and/or amber.

Figure 19: Comparison of RAG rating for travel distances[9] to NHS dental care, for adults and children, by lower tier local authority, ranked by deprivation.

Lower tier local authority	IMD rank in KSS	Travel distances for children (80% max)	Travel distances for adults (80% max)
Hastings	1	4	4
Thanet	2	11	18
Swale	3	15	16
Brighton & Hove	4	4	5
Shepway	5	11	17
Medway	6	5	6
Gravesham	7	8	11
Dover	8	16	17
Eastbourne	9	4	6
Rother	10	12	12
Adur	11	7	9
Dartford	12	10	11
Crawley	13	4	5
Arun	14	8	9
Worthing	15	4	6
Ashford	16	13	17

[9] 80% of the population travel a maximum of this distance to see an NHS dentist

Canterbury	17	9	13
Maidstone	18	10	13
Lewes	19	11	11
Spelthorne	20	6	7
Chichester	21	12	13
Sevenoaks	22	12	16
Tonbridge and Malling	23	12	15
Wealden	24	12	14
Tunbridge Wells	25	11	15
Runnymede	26	6	8
Tandridge	27	9	11
Reigate and Banstead	28	8	10
Woking	29	6	8
Horsham	30	12	15
Guildford	31	8	10
Mole Valley	32	10	12
Epsom and Ewell	33	4	5
Surrey Heath	34	9	10
Mid Sussex	35	8	11
Elmbridge	36	6	9
Waverley	37	11	13

For adults, local authorities that are ‘red’ for both deprivation and travelling distances are Thanet, Swale, Shepway and Dover. Local authorities that are ‘amber’ for deprivation but red for travelling distances are Ashford, Canterbury, Maidstone, Chichester, Sevenoaks, Tonbridge and Malling and Wealden.

For children, the local authorities that are ‘red’ for both deprivation and travelling distances are Thanet, Swale, Shepway, Dover and Rother. Local authorities that are ‘amber’ for deprivation but red for travelling distances are Ashford, Chichester, Sevenoaks, Tonbridge and Malling and Wealden.

7.6. What is the public view?

In January to March 2017, almost 143,000 adults across KSS were asked about their views on NHS dentistry.[6] Of the 143,000 adults questioned in KSS, just under 65,000 responded: a response rate of 45%.

Participants were asked if they had tried to obtain an appointment with an NHS dentist and, if so, whether it was with a practice they had been to before and if they had been successful. They were also asked what their overall experience was of NHS dentistry. Patients who hadn't tried to obtain an NHS dentist in the previous two years were asked to select the main reason why they hadn't tried. The results of this survey, from KSS residents, are summarised below.

When KSS residents were asked 'when did you last try to access an NHS dentist?', around half of respondents, for each local authority, reported that they had either never tried to get an NHS appointment, or last tried more than two years ago. Other respondents were more likely to have tried to access an NHS dentist recently: either in the last 3-6 months or between 3 and 6 months ago (figure 1`).

When KSS residents were asked 'was the NHS dental appointment you were trying to get with a dental practice you had been to before for NHS dental care?' the vast majority of respondents said yes, which suggests that people may be less inclined to look for a new NHS dental practice (figure 12). Similarly, when KSS residents were asked 'were you successful in getting an NHS dental appointment?' over 90% said yes (figure 13). This suggests that when people try to get a dental appointment, they are successful in doing so.

When people were asked 'why haven't you tried to get an NHS dental appointment in the last 2 years?', the vast majority of people responded that they preferred to visit a private dentist (figure 14). A substantial number however, reported a lack of perceived need to visit a dentist or that they 'didn't think [they] could get an NHS dentist,' which suggests there is some unmet demand in KSS.

On the other hand the second most commonly reported reason was 'haven't needed to visit a dentist' which confirms what is already know about non-attenders: some people just don't want to go or don't think they need to. The findings of the GP survey also suggest that time and cost are not major barriers to uptake of NHS dental service.

Figure 11: Response to GP survey, January to March 2017, from residents of KSS when asked 'When did you last try to access an NHS dentist?', by CCG. Source: GP Patient Survey Dental Statistics[6]

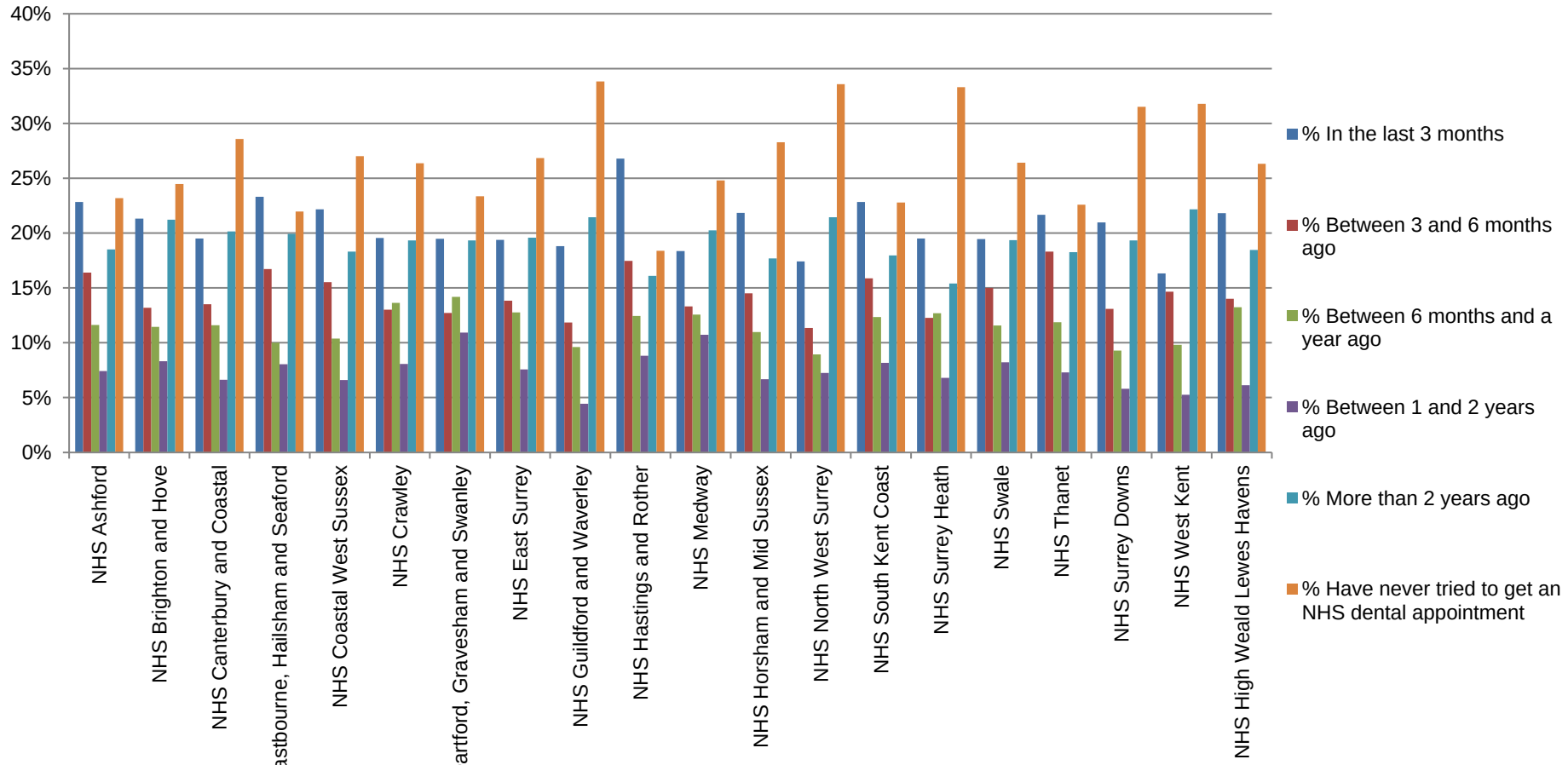


Figure 12: Response to GP survey, January to March 2017, from residents of KSS when asked 'was the NHS dental appointment you were trying to get with a dental practice you had been to before for NHS dental care?' (Weighted), by CCG[6]

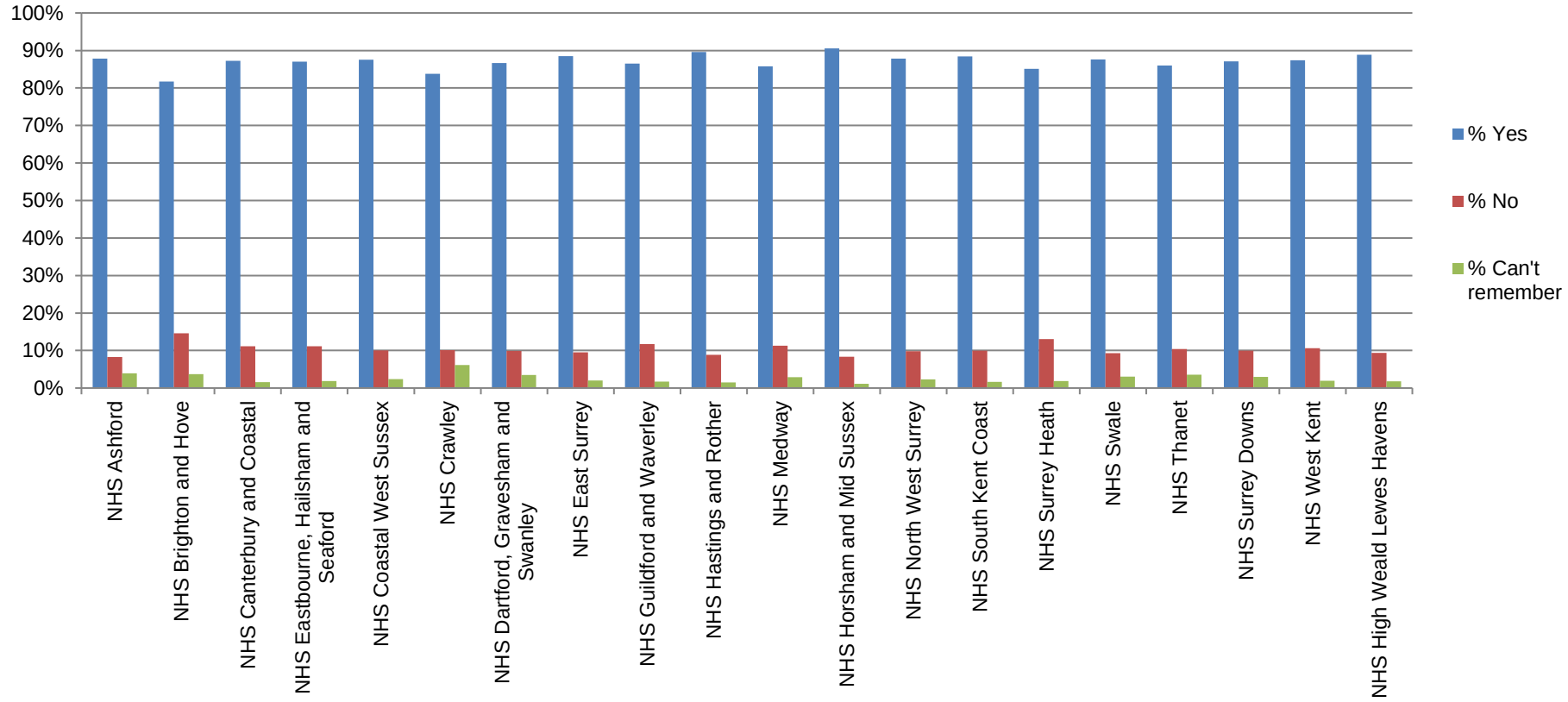


Figure 13: Response to GP survey, January to March 2017, from residents of KSS when asked 'were you successful in getting an NHS dental appointment?' (weighted), by CCG[6]

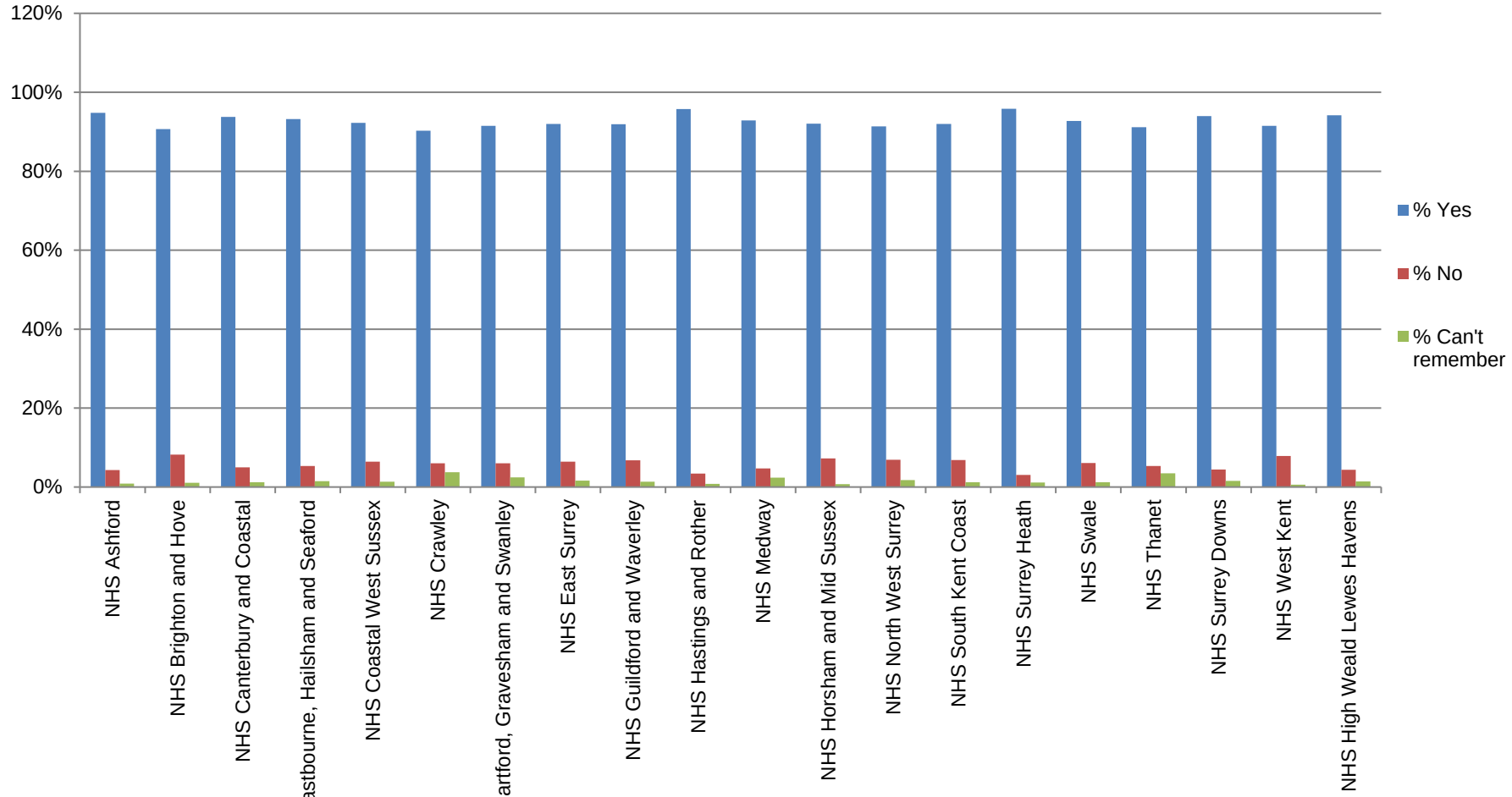
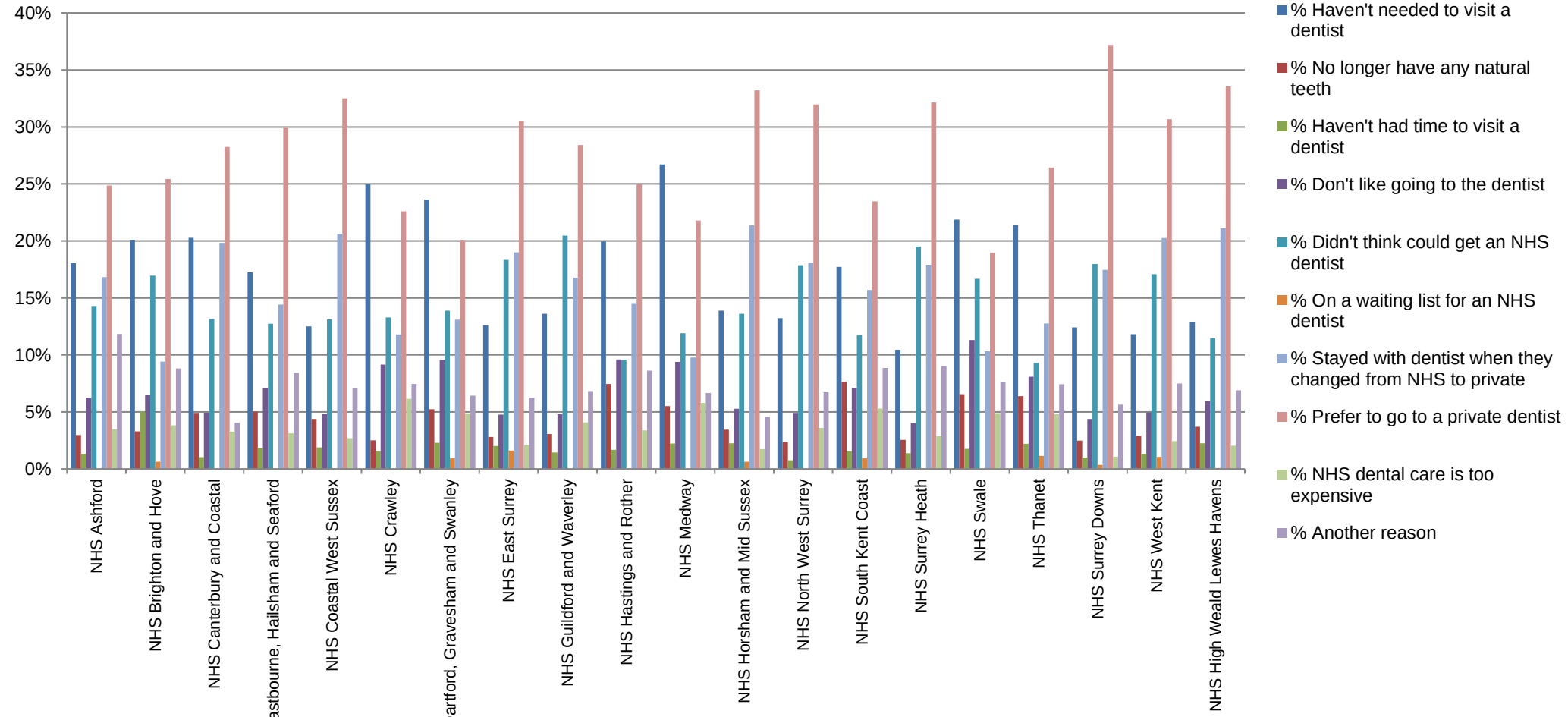


Figure 14: Response to GP survey, January to March 2017, from residents of KSS when asked 'why haven't you tried to get an NHS dental appointment in the last 2 years?' (Weighted), by CCG[6]

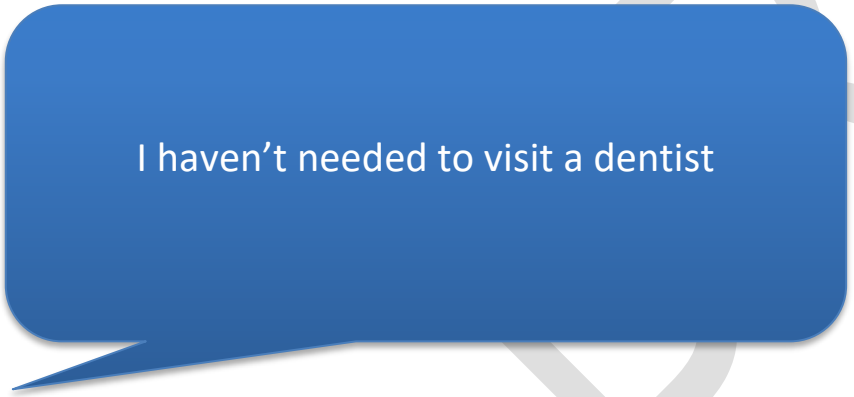


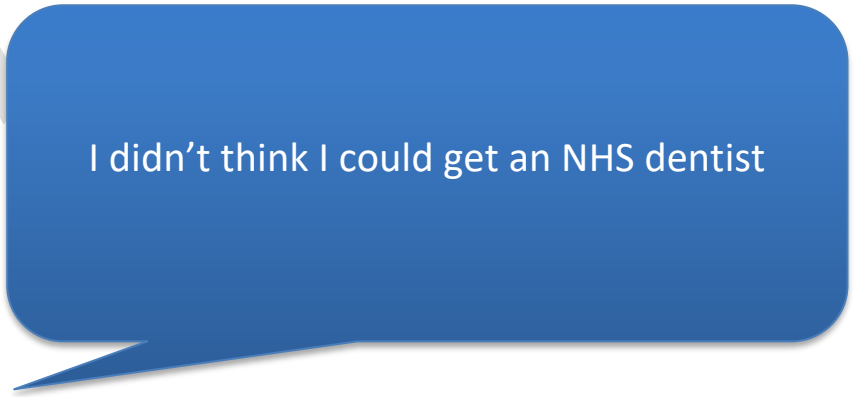
Fewer people reported success when they tried to get an NHS dental appointment in:

- West Kent
- Horsham
- Brighton and Hove
- North West Surrey
- South Kent coast

There is a need to design any public engagement or communication campaigns around the barriers reported locally. In many areas the preference to attend a private dentist is the most commonly given reason for not trying to get an NHS appointment. This is down to individual patient choice and is unlikely to have an impact on health inequalities. The issues that need to be address are those less frequently reported including perceived lack of need and lack of awareness that NHS dentists are available.

Figure 15: Commonly reported reasons for not trying to make an NHS dental appointment





Another issue is finding a dentist – Healthwatch in Buckinghamshire reported the following:

"It became very obvious, very quickly, that the data on the NHS Choices list of dentists was not always up-to-date with practices having merged, been moved entirely into private practice, or having other out-of-date details e.g. phone numbers and names. This creates more frustration than is necessary and possibly encourages people to give up finding dental help. This in turn might fuel rumours that access to NHS dental treatment is very difficult and, longer term, may affect the dental health of certain parts of the population." Feedback from Healthwatch Bucks (2015)

There are no local data on patient preferences around travelling distances however a public survey was carried out in South central, in 2009, which asked about travel to dental practices. While this is somewhat out of date it provides a sense of what is acceptable to the public.

Key findings from the South Central Dental Survey Report, in relation to reported travel preferences (also see figure 15):[7]

- Four in ten people overall (43%) *would* be prepared to travel 10 miles or over to see their NHS dentist, only 13 per cent of NHS dentist users *currently* cover this distance.
- There is some evidence of an urban-rural divide when it comes to accessing dental services. Those who live in rural areas are prepared to travel further to visit an NHS dentist (a quarter would travel more than 15 miles compared to around one in six urban dwellers).
- Residents in urban areas are significantly more likely to be very satisfied with the distance they *currently* travel to visit an NHS dentist (59% compared to 47%).
- NHS dentist users, on average, would travel further than private dentist users (11.0 *mean* miles compared to 8.9 miles).
- Older residents aged 65+ say they are prepared to travel a smaller distance than other age groups: a mean of 7 miles, significantly lower than the distance recorded for 25-34 year olds (10.7 miles) and 35-44 year olds (9.9 miles).

- Members of socio-economic group DE would be prepared to travel less distance than any other group (6.9 miles) presumably reflecting the fact that this group is least likely to own a car. This is corroborated by the finding showing that the mean response for those with at least one car in the household is 10.1 miles, compared to 5.9 for those without.
- Residents with children in the household would travel significantly further than those with no children (11.5 and 8.6 miles respectively).

Figure 16 Distance prepared to travel to see a dentist, reported by population subgroup. Source: South Central Dental Survey Report 2009

Q7. Approximately how far, in miles, is the maximum you would be prepared to travel to visit an NHS dentist?

Base: All NHS South Central residents aged 16+ (2,700), interviewed by telephone between 8th and 24th June 2009

Total	9.62
Age	
16-24	8.92
25-34	10.65
35-44	9.85
45-54	12.52
55-64	8.79
65+	7.01
Socio-economic group	
AB	11.56
C1	9.85
C2	8.08
DE	6.84
Children in household	
Yes	11.52
No	8.62
Car in household	
Yes	10.14
No	5.89

7.7. What is the need for bariatric dental care in KSS?

The need for bariatric facilities in dental surgeries is indicated by areas of KSS where there are more people with obesity (figure 17). Obesity is on the increase nationally: nearly two thirds of adults (63%) in England were classed as being overweight (a body mass index BMI of over 25) or obese (a BMI of over 30) in 2015.[8] Nearly a third of children aged 2 to 15 are overweight or obese and younger generations are becoming obese at earlier ages and staying obese into adulthood.

Figure 17: A summary of obesity levels in England

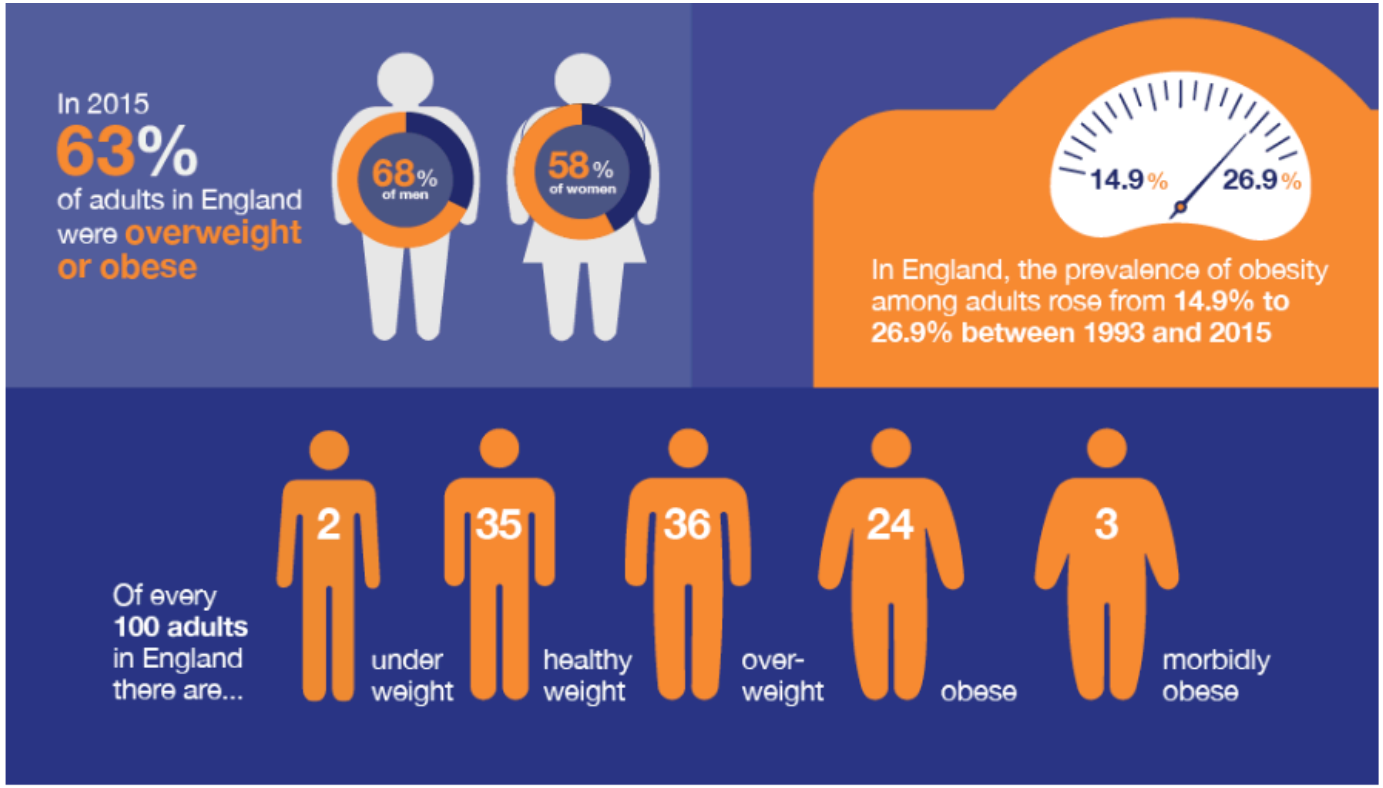
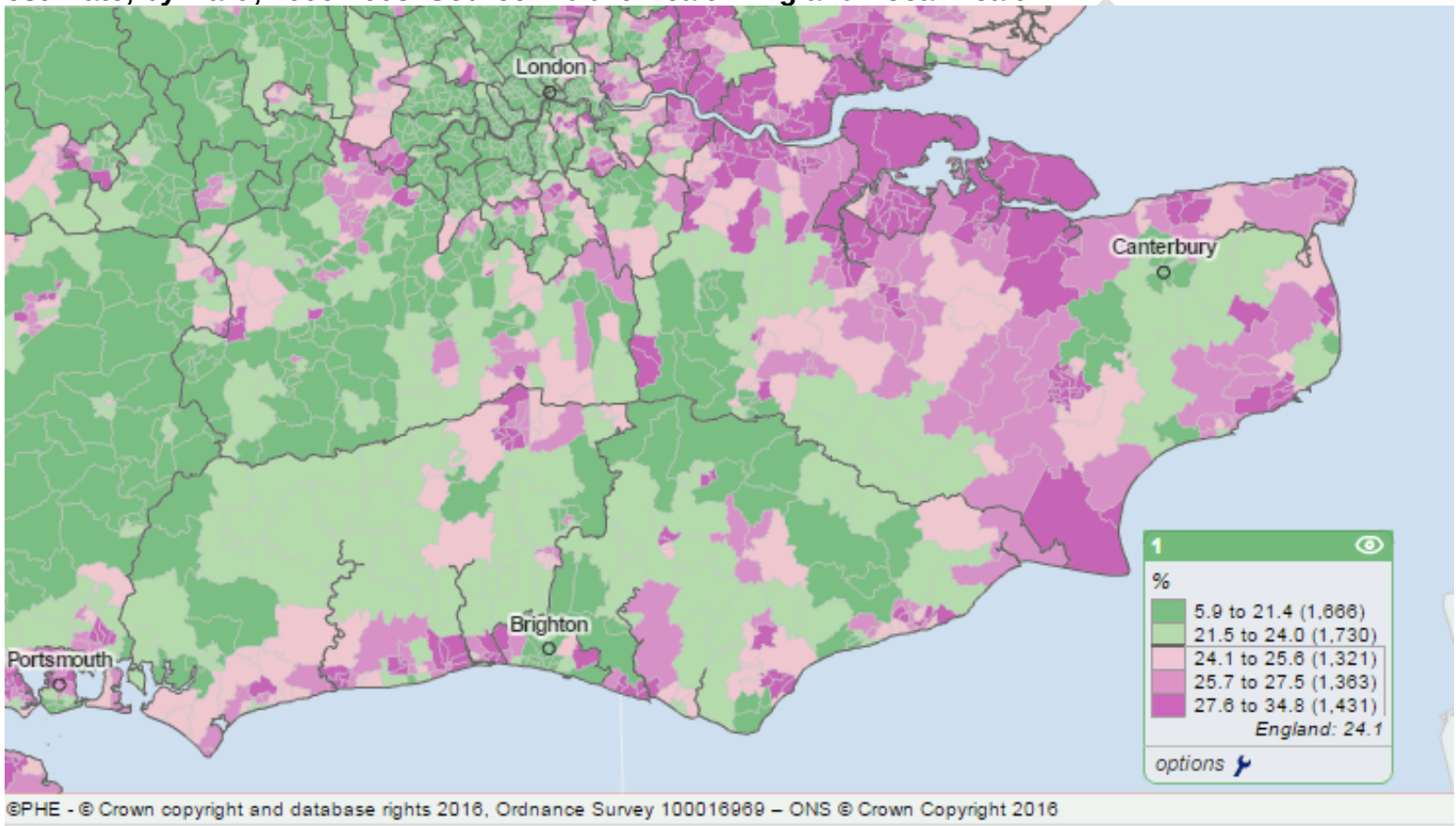


Figure 18 Map showing percentage of the population in Kent, Surrey and Sussex, aged 16+ with a BMI of 30+, modelled estimate, by ward, 2006-2008 Source: Public Health England Local Health[10]



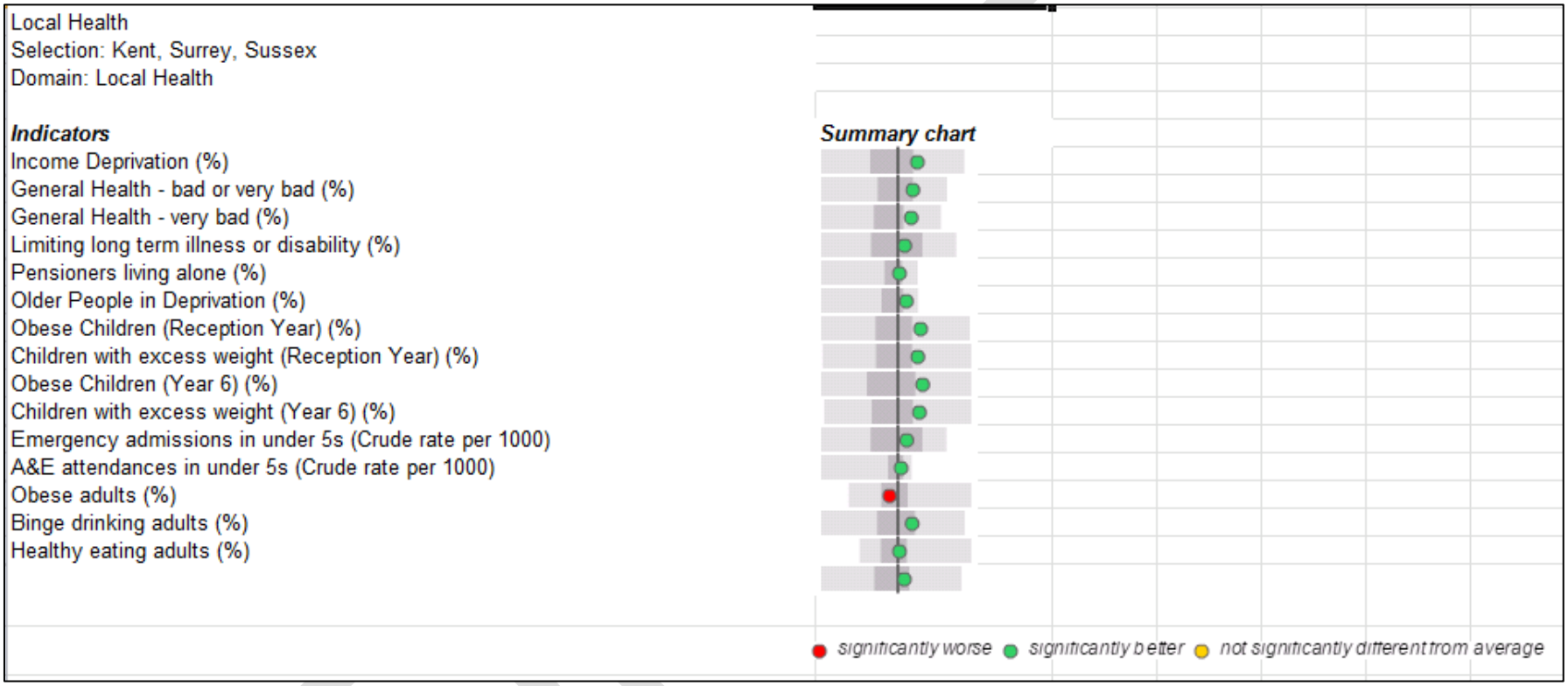
As with other common health problems, obesity is experienced mainly by those from more deprived groups. No one is 'immune' to obesity, but some people are more likely to become overweight or obese than others. There is a strong relationship between deprivation and childhood obesity.

[10] The need for bariatric dental care begins at 22 stone or 139 kg so this measure would somewhat overestimate the need for dental services with bariatric facilities.

Figure 19: A summary of which population groups suffer from obesity

In Kent, Surrey and Sussex obesity in children is significantly lower than that of the national average. In adults however, obesity is significantly higher than the national average (25% adults in KSS compared to 24% in England) (figure 17).

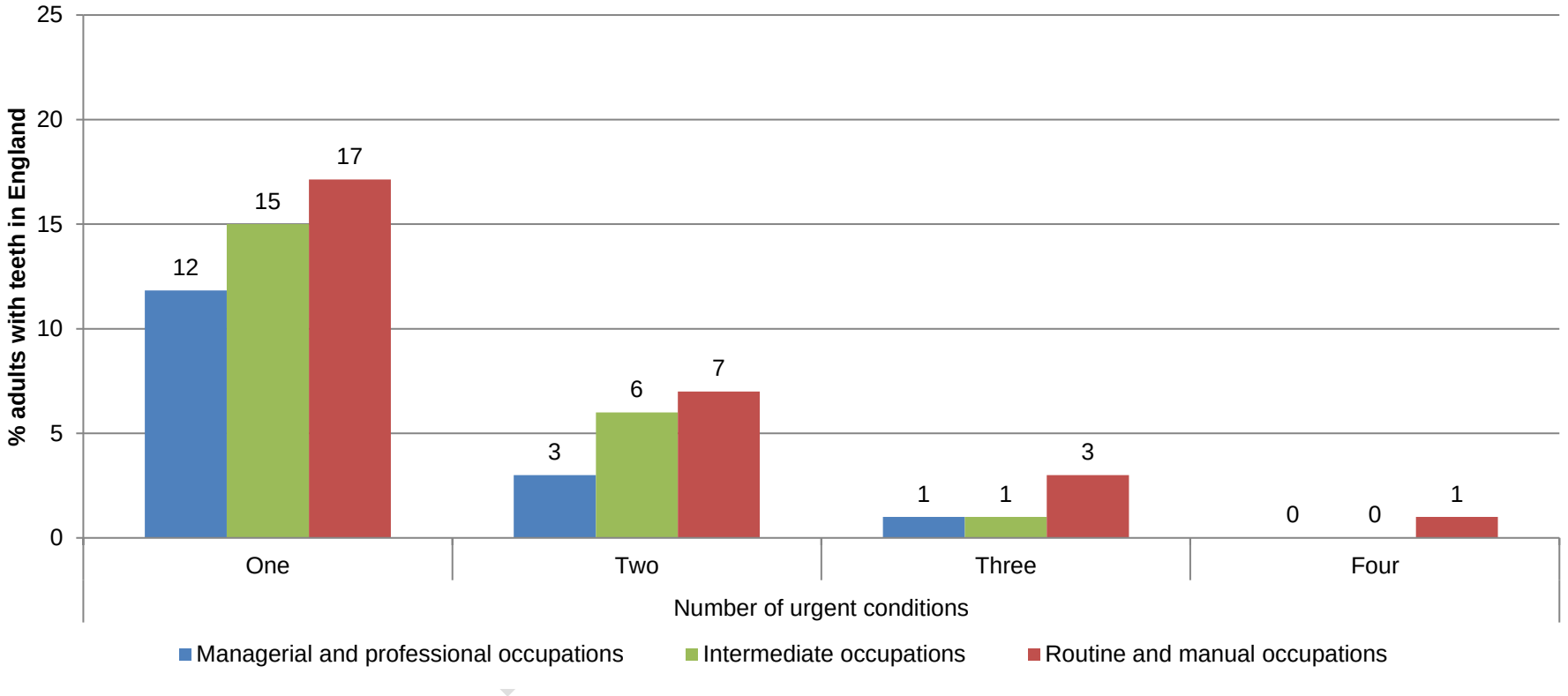
Figure 20 Comparison of common health indicators in KSS with England levels 2017. Source: Public Health England Local Health website.



7.8. What is the need for urgent dental care in KSS?

Urgent conditions are more likely to be experienced by people from lower socio-economic groups and they are more likely to experience more than one urgent condition (Figure 21). **Error! Bookmark not defined.** This is important for Kent, Surrey and Sussex where there are pockets of deprivation in a broadly affluent area (see appendix).

Figure 21 Proportion of adults with teeth (%) who have one or more urgent condition, by socio-economic classification, 2009. Source: Adult Dental Health Survey, 2009



Urgent conditions are increasingly likely to be experienced by:

- Older people
- People who attend a dentist only with trouble
- Smokers
- People who suffer from dental anxiety
- People from lower socio-economic groups**Error! Bookmark not defined.**

A number of other groups are at risk from oral diseases and experience barriers to access. These include:

- Children, particularly preschool children
- Older people
- People who have a learning disability
- People with mental illness
- People in long term institutional care (including prisons)
- Looked after children
- Homeless people
- Some refugee and asylum seeker groups
- Some migrant groups
- People requiring palliative care
- People with serious medical conditions, e.g. undergoing chemotherapy.
- Housebound people

These population groups tend to have a higher need for easier access to health care. There is limited knowledge on barriers experienced by many of these groups and more work is required to gain a fuller understanding of their needs.

People from lower socio-economic groups are also more likely to suffer multiple urgent problems simultaneously. People from deprived areas are more likely to suffer from decayed teeth, no teeth, gum disease, urgent dental problems, impacts on their daily life and oral cancer. **Error! Bookmark not defined.**

BSA data have also shown that the reasons for attendance show variation between different socio-economic groups; with children from the most deprived populations being twice as likely to receive care for an urgent dental problem than those from the least deprived populations.

Children from the most deprived backgrounds are more likely to experience dental problems and need urgent treatment at dental practices than those living in affluent areas. They are also most likely to need dental treatment e.g. fillings and extractions and less likely to attend regularly for routine examinations.

Oral cancer is strongly related to socio-economic deprivation and those living in deprived areas, with the highest rates occurring in the most disadvantaged groups.**Error! Bookmark not defined.**,9 Lower socio-economic status (measured in various ways: occupation, income or education) is a significant risk factor for oral cancer independent of lifestyle behaviours.**Error! Bookmark not defined.**

People who are more likely to suffer from oral cancer are also more likely to be irregular attenders. Oral cancer incidence rates are rapidly rising and mortality is high. The key to improving health outcomes from oral cancer is to diagnose and treat early. As people more likely to get oral cancer are also more likely to be irregular dental attenders, it is crucial that urgent services routinely screen patients for oral cancer.

8. Conclusions

There are inequalities in uptake of NHS dental services across Kent, Surrey and Sussex. Uptake of NHS dental services by lower tier local authority is greater for children than adults. In children, uptake by local authority ranges from 61%-76%, while for adults the range is 32%-59%. Access for adults shows particularly large inequalities.

Inequalities in uptake of NHS dental services are of particular concern where the local authority area is relatively deprived. This is because people from more deprived areas tend to be doubly burdened with low uptake of care and high levels of disease.

Breaking down uptake of NHS dental services by age reveals further inequalities within adult and child groups. Children aged 0-2 are particularly unlikely to attend across the board, despite their teeth being vulnerable at this age and this being a crucial time for establishing good habits, such as becoming comfortable with the dental surgery.

The majority of adults in KSS do not attend an NHS dentist, other than (in most lower tier local authorities) the 18-25 age group. The inequalities in uptake of NHS dental services are almost certainly influenced by demand for, and access to, private dental care. This is particularly likely to be true in local authority areas that are relatively affluent, such as Waverley, which is the least deprived area in Kent, Surrey and Sussex and has only 43% of adults using NHS dental services in the last 24 months. It is likely that many adults in KSS choose to access dental care on a private basis. While there are no local data on this, most practices which provide NHS dental care also provide some element of private dental care. The 2009 Adult Dental Health Survey (ADHS) reported that the proportion of people paying privately for dental treatment is increasing; from 6% in 1968 to 26% in 2009.[4] This is likely to be an underestimate for KSS which is a generally affluent area of the UK with numerous dental practices offering private dental care. Private care however, is unlikely to account for adults from more deprived areas who do not attend an NHS dentist. These groups may be going without care and would be a high priority for any action to increase uptake of dental services.

The GP patient survey asks respondents who have not sought NHS dental care for the reasons why they have not tried to access care. This reveals that many people who tried to get an NHS dental appointment were able to so. Commonly however, these are people who already have a relationship with a dentist. Those who have not tried tended to be on a waiting list for NHS dentistry (suggesting demand outstrips supply in some areas) or didn't feel they needed to visit a dentist. The fact

that some people report they did not know NHS dentistry was available suggests that clearer communication about NHS dentistry might be worthwhile.

Longer travelling distances may be due to lack of services close to where the person lives or it could be due to personal choice, such as a person choosing to stay with a particular dentist even when they move out of the area, or visiting a dentist close to where they work. Where higher travelling distances are seen in locations where other indicators raise a concern then they may be indicative of a barrier to uptake of NHS dental care.

9. Recommendations

1) Lower tier local authority areas which are relatively deprived, and where there is more than one red RAG rating, should be targeted for action. The next level of priority should be given to lower tier local authority areas that are relatively deprived and have amber ratings.

2) Communications on availability of dental services should be reviewed and improved where necessary. Where possible, communications should be targeted to those population groups who have low uptake, such as older adults living in deprived areas and parents of young children.

3) Relatively deprived areas, where attendance in a number of age bands is below 40% and 30% and where travel distances are relatively high, should be considered a higher priority

4) Practices that are consistently under-performing on their contracts should be encouraged to promote their services to the local population especially in areas of higher deprivation.

5) In areas where practices have struggled to meet their contractual commitments due to lack of demand, there may be less justification to commission additional activity (unless the service offer is significantly redesigned to fit with public preferences).

6) Where the UDAs commissioned by population, for a local authority, are below the midpoint (rated red) they should be considered higher priority for commissioning, particularly when accompanied by deprivation.

7) Areas where UDAs commissioned per population are relatively high should be less of a priority for procurement.

8) Actions are needed to facilitate attendance at a dentist in the early years, e.g. communication plan, support to GDPs on how to manage this age group.

9) Where availability of services is reasonable, but uptake is low and deprivation is relatively high, further work is needed to understand how to encourage non-attenders to visit the dentist, e.g. public engagement work. This is likely to involve considering the other elements of access, such as acceptability and accommodation. There is a need to design any public engagement or communication campaigns around the barriers reported locally. The issues that need to be address are those less frequently reported including perceived lack of need and lack of awareness that NHS dentists are available.

10) Consider the need to increase availability of urgent dental care in areas of higher deprivation

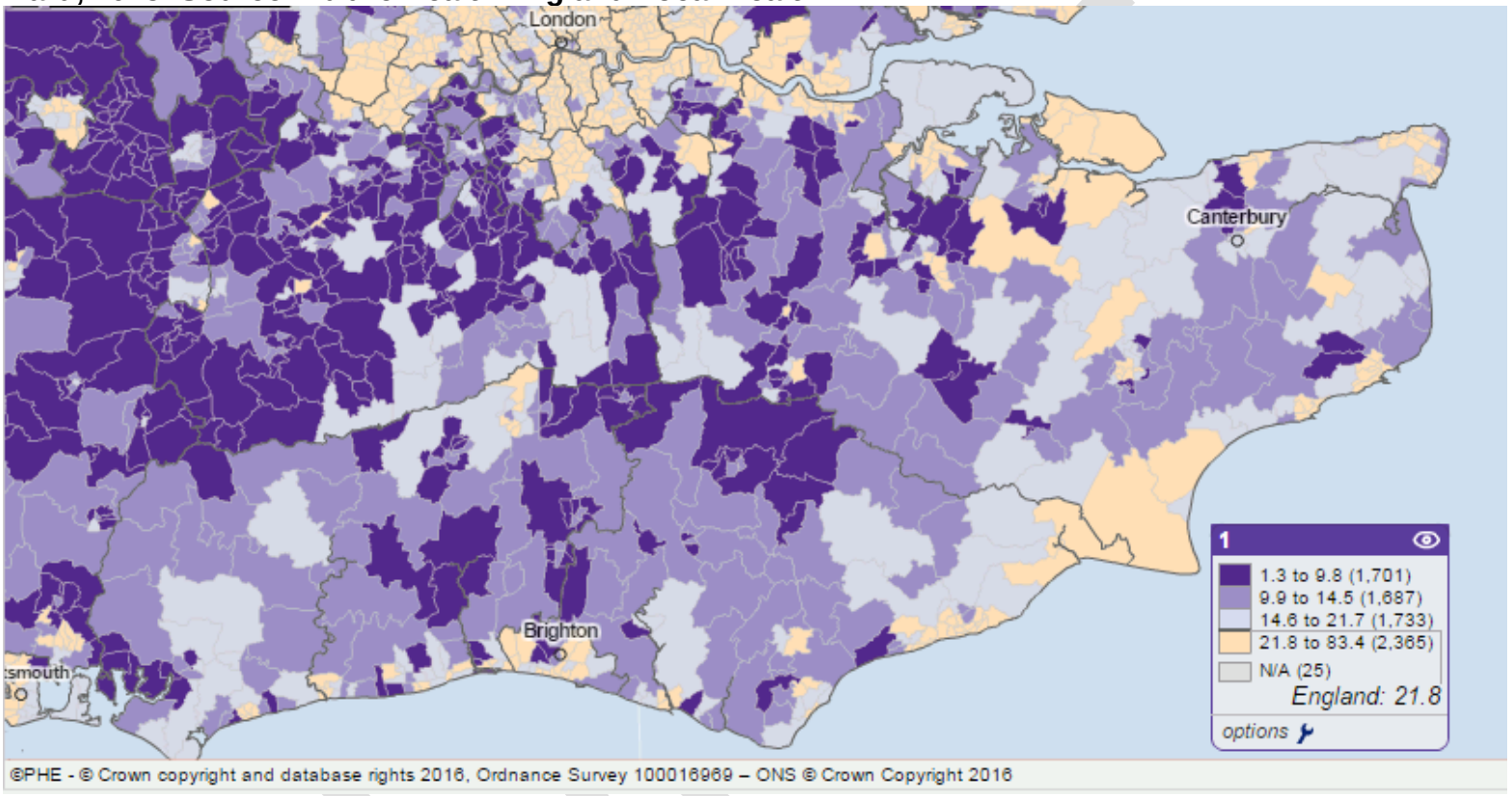
11) Plan for increased access to bariatric facilities in dental services to support access to dental services for people with obesity issues

12) Consider how the housebound can access dental care: possibly through the special care procurement

10. Next steps

- Meeting to agree the areas where additional GDS capacity would be of benefit to the population.
- Consult on priority areas with the public and the dental profession
- Develop action plans for priority areas
- Implement action plans through a procurement process.

11. Appendix: Map showing Deprivation quartiles (IMD - Index of Multiple Deprivation[11]) in Kent, Surrey and Sussex, by ward, 2015 Source: Public Health England Local Health



[11] The Index of Multiple Deprivation 2015 is the official measure of relative deprivation for small areas (or neighbourhoods) in England. The Index of Multiple Deprivation ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). To help with this, deprivation 'deciles' are published alongside ranks. Deciles are calculated by ranking the 32,844 neighbourhoods in England from most deprived to least deprived and dividing them into 10 equal groups. These range from the most deprived 10% of neighbourhoods nationally to the least deprived 10% of neighbourhoods nationally. Here we have summarised these data into quartiles to simplify the findings.

12. References

[1] NHS England. Improving dental care and oral health – a call to action. 2014. [Accessed 30 Nov 2014]. Available from http://www.england.nhs.uk/wp-content/uploads/2014/02/imp-dent-care.pdf.

[2] Freeman R. Barriers to accessing and accepting dental care. BDJ.1999; 187(2):81-84. [Accessed 30 Nov 2014]. Available from: http://www.dentistry.bham.ac.uk/ecourse/files/36/BDS%201/Freeman_paper_6_-_access.pdf.

[3] Marshman, Z. Oral health and access to dental services for people from black and ethnic minority groups. Race Equality Foundation. 2013. [Accessed 30 Nov 2014]. Available from http://www.better-health.org.uk/briefings/oral-health-and-access-dental-services-people-black-and-minority-ethnic-groups

[4] Office for National Statistics Adult Dental Health Survey 1998. 1998. [Accessed August 2017]. Available from: http://content.digital.nhs.uk/pubs/dentalsurveyfullreport09

[5] NHS Digital NHS Dental Statistics for England - 2016-17, Third Quarterly Report http://content.digital.nhs.uk/searchcatalogue?productid=25121&topics=1%2fPrimary+care+services%2fDental+services&sort=Relevance&size=10&page=1#top

[6] GP Patient Survey Dental Statistics; January to March 2017, England website [accessed 14th August 2017] https://www.england.nhs.uk/statistics/2017/07/06/gpps_dent_y111864861/

[7] NHS South Central NHS South Central Baseline Dental Survey 2209 [unpublished]

[8] Public Health England Health Matters Obesity and the food environment 2017 https://publichealthmatters.blog.gov.uk/2017/03/31/health-matters-obesity-and-the-food-environment/

[9] Cancer Research UK UK oral cancer incidence statistics. 2014. [Accessed 30 Nov 2014]. Available from: http://info.cancerresearchuk.org/cancerstats/types/oral/incidence/?a=5441