

Equality and human rights duties impact analysis for the provider handbook on primary care dental services

1. Introduction

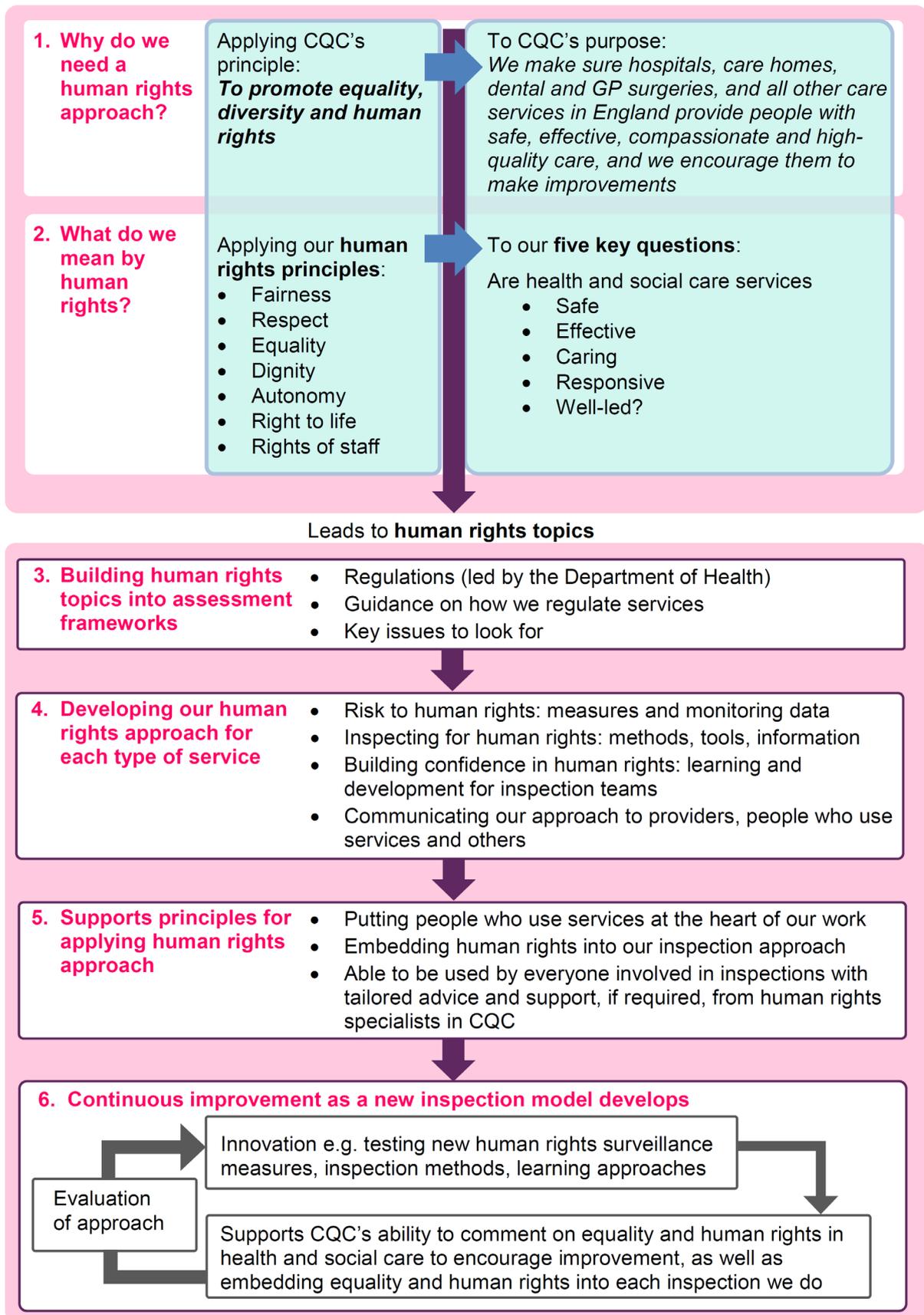
This equality and human rights impact analysis covers the provider handbook for primary care dental services. The purpose of this equality and human rights impact analysis is to ensure that, in developing our regulation of primary dental care, we meet our duties:

- Under the Human Rights Act 1998 to respect, protect and fulfil people’s human rights.
- Under the Equality Act 2010 to have due regard, when delivering our functions, to the need to:
 - eliminate discrimination
 - advance equality of opportunity, and
 - foster good relations between groups in relation to the ‘protected characteristics’ of age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

However, we view this as more than mere legal compliance; we have made one of CQC’s principles to promote equality and diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this principle into practice, we have developed a human rights approach to regulation. This approach looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask of services; safe, effective, caring, responsive and well-led. Our human rights approach is integrated into our new approach to inspection and regulation as this will be the best method to ensure equality and human rights is promoted in our work. We have integrated the human rights principles into our inspection prompts, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement. The diagram overleaf summarises our approach.

Our human rights approach to regulation



2. Engagement in developing our handbooks for the sector

The responses to the consultation on our strategy for 2013-16 and on our document 'A New Start' have helped us shape our approach to our inspections. In particular, this impact analysis picks up consultation responses from the [equality and human rights duties impact analysis for "A new start"](#). A summary of these responses can be found in our human rights approach consultation document.

We have engaged widely with stakeholders and dental providers when developing our new approach. We have:

- Published a signposting document about primary care dental regulation with an email address for responses/comments.
- Carried out social media activity to promote the signposting document.
- Compared our inspection prompts with the key lines of enquiry (KLOEs) that have been developed by other sectors i.e. GP/out-of-hours to ensure that our human rights principles are reflected in the inspection prompts.
- Asked members of our external reference group such as the British Dental Association, General Dental Council (GDC) and NHS England about the inspection prompts.
- Run an event/workshop for dental providers and those with an interest in dentistry including Experts by Experience to gain feedback about our approach and the inspection tools we have developed.
- Asked CQC's children and young people's panel about our inspection approach.

3. What we know about equality and human rights in primary dental care

What we know about equality and human rights for people using primary care dental services, in relation to:

Age	<p>There is regional variation in the prevalence of tooth decay in the five-year-olds surveyed as part of the national dental epidemiology survey. For those five-year-olds with decay, the extent of the decay correlates with deprivation. The more deprived the area the higher the rate of decay found in the five-year-olds surveyed.</p> <p><i>The Public Health Outcomes Framework now</i> includes an indicator about the level of dental decay in five-year-olds. The newly established Public Health England has also been providing dental public health expertise and advice as of April 2013.</p> <p>Demand for dental treatment from older people will increase both as they retain their teeth and have higher expectations of dental services. The most recent adult dental survey (2009) highlighted some significant changes in oral health over time; the proportion of</p>
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	<p>adults with no natural teeth, for example, has fallen from 28% in 1978 to just 6% in 2009. However the authors of the report note that many people in later life and older middle age have very complex dental needs with multiple restorations requiring continued maintenance.</p> <p>There are also significant issues for people living in residential care settings. A study conducted by the British Dental Association (BDA) identified that the provision of oral healthcare within residential homes was very patchy. The study concluded that generally, oral healthcare is generally just not seen to be as important as maintaining good general health and adequate nutrition.</p> <p>There is evidence that people/groups in residential care (such as older people, people with a learning disability or mental health problem, people who are physically or medically compromised and people in secure units) are more likely to have poor oral health and inadequate or restricted access to dental services.</p>
<p>Disability</p>	<p>Disabled people make up a significant percentage of the population (ONS Census 2011 data: 9.5 million people have a limiting long-term illness or impairment) and we know that disabled people are likely to use health services more frequently than non-disabled people, although monitoring data is not as well developed as it is for race, gender and age.</p> <p>The definition of disability in the Equality Act 2010 includes people with a physical or sensory impairment, people with a learning disability and people experiencing mental distress, as well as people with other long-term conditions that have a substantial and long-term effect on the ability to carry out daily activities.</p> <p>The provision of oral care for disabled people is often more complex and time consuming due to the primary condition itself or indirectly through medication (British Society of Disability and Oral Health).</p> <p>There can be barriers for disabled people in accessing a dental practice building. For example:</p> <ul style="list-style-type: none"> • Wheelchair users find it difficult to access some premises. • Anecdotal evidence that many dentist practices are in older buildings or upstairs, which makes it difficult for many disabled people to access the service. <p>Some groups of disabled people may face particular stigma when using primary care dental services. For example, people with HIV, who are included in the definition of disabled people under the Equality Act 2010.</p>

	<p>In 2012 there were approximately 100,000 people living with HIV in the UK (Public Health England). Work by The National Aids Trust suggests that a significant minority of the public still hold stigmatising and discriminatory views about people with the virus. This can be particularly relevant for people using primary care dental services, if work is not done to address staff attitudes.</p>
<p>Gender, including pregnancy and maternity</p>	<p>Clinical studies have shown that oral tissues can be affected by pregnancy. Pregnant women and nursing mothers (until a child is one year) are exempt from paying NHS dental charges. Pregnancy may affect the provision of dental care. For example, the dentist may put off taking x-rays until after the birth of the baby. However, if dental x-rays are unavoidable, the dentist can take precautions to ensure the safety of the baby from radiological exposure.</p>
<p>Race</p>	<p>The Race Equality Foundation (2013) has identified a range of evidence from surveys to suggest differences in the way certain Black and minority ethnic groups utilise dental services compared to the general population. While the links between oral health and ethnicity are complicated and often confounded by socio-economic status, the prevalence of certain oral diseases is higher in some ethnic groups.</p> <p>A number of minority ethnic groups also have specific cultural habits (e.g. betel quid (pann) chewing), which can place them at an increased risk from oral cancer. Furthermore, diabetes and oral health are also linked with ethnicity and people with diabetes have a greater risk of periodontal breakdown.</p> <p>The <i>Health Survey for England</i> (2004) has stated that children from all minority ethnic groups (especially Pakistani and Bangladeshi children) are less likely to have ever visited a dentist. For those who had visited a dentist, the reason cited was because of a dental problem rather than for a routine dental check-up. There is also evidence that dental care needs for families from eastern European communities may be higher than white British communities – their experience and expectations of dental services may also be quite different.</p> <p>For young children, weaning practices are particularly important in terms of the risk of dental caries. Guidance from the Department of Health recommends that babies should start drinking plain water from a cup from six months, and stop using bottles by the age of one year to avoid dental caries. A study (by Watt, 2000) comparing the weaning habits of Bangladeshi, Indian, Pakistani and White mothers in England found that Asian women were more likely to bottle feed for longer, and to add sugar, rusks, baby rice or cereals to bottled drinks.</p>

	<p>The NHS constitution, which applies to dental services, states that a comprehensive service is available to all irrespective of race and that people have a right not to be discriminated against in the provision of NHS services on the grounds of race (NHS Constitution 2013). Attempts have been made to improve the availability of NHS dental services in many parts of the country, although there is some evidence to suggest that utilisation of dental services varies between different ethnic groups.</p> <p>The UK has become highly multi-cultural at quite a rapid pace. Dental Protection state that few dentists have undertaken any specific training to help them understand and prepare themselves for the possible implications, particularly around consent.</p>
<p>Religion and belief</p>	<p>There are several ways in which religious practices and beliefs have the potential to impact on the delivery of primary dental services and contribute to inequalities in health. For example,</p> <ul style="list-style-type: none"> • Dietary requirements. This includes whether certain medicines or products are unsuitable (for example those containing alcohol such as fluoride varnish). • Observation of religious days for some groups may make it difficult to attend appointments on certain days and times, or, receive treatment such as during Ramadan.
<p>Sexual orientation</p>	<p>The Government uses figures of between 5-7% to estimate the number of Lesbian, Gay and Bisexual (LGB) people in England. There are no census figures to support this estimate.</p> <p>The General Dental Council (GDC) states that dental care professionals must not discriminate against patients on the grounds of:</p> <ul style="list-style-type: none"> • age • disability • gender reassignment • marriage and civil partnership • pregnancy and maternity • race • religion or belief • sex • sexual orientation.

<p>Gender identity</p>	<p>There is no official estimate of the transgender population in England. However, the Gender Identity Research and Education Society (GIRES) estimate the number of transgender people in the UK to be between 300,000 to 500,000. Existing evidence suggests that transgender people experience, and are badly affected by, discrimination.</p> <p>Like all other people, transgender people will experience the need for primary dental care, they are as likely as everyone else to need to visit the dentist.</p>
<p>Carers</p>	<p>At the time of the 2011 census, figures showed that the total number of people providing unpaid care in England was 5.5 million (10.3% of the population). Of these people, 1.2 million (2.4%) provided more than 50 hours of unpaid care each.</p> <p>Regarding young carers:</p> <ul style="list-style-type: none"> • Only small numbers of young carers are currently being identified or assessed for support. • Young carers are 1.5 times more likely than their peers to be from Black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language. • They can experience substantial physical, emotional or social problems, and encounter difficulties in school and elsewhere. • Research also suggests that more girls than boys act as carers (Health and wellbeing of young carers- SCIE). <p>Carers can experience stress, not have time to eat properly, need respite breaks, and can become ill themselves. This can have a negative effect on their oral health, often putting their own needs on hold to support others.</p>
<p>Human rights principle of fairness</p>	<p>People should be treated fairly by primary care dental providers regardless of their background.</p> <p>In 2006, NHS dental services were no longer free at the point of delivery and fees were introduced as part of the NHS regulations. However, some groups in society, such as homeless people, experience barriers in accessing free NHS dental treatment because they may not have the required evidence to prove exception from NHS fees.</p> <p>NHS dental services are commissioned for anyone who seeks them, regardless of where they live. Therefore, patients may access NHS dental care in any locality of their choice. However, we recognise that in some areas of England access to NHS dental care is limited and some places have longer waiting lists than others.</p>

	<p>Fairness also requires that people who use the service have ways of giving their views about their care, including making complaints about the service.</p>
<p>Human rights principle of respect</p>	<p>All people have the right to respect, regardless of their background. There is the potential for people to disengage from health services if they have not been treated with respect. The GDC summarises this as 'putting patient's interests first' and state that registrants must:</p> <ul style="list-style-type: none"> • treat patients fairly, as individuals and without discrimination • be honest and act with integrity • treat patients with kindness and compassion • treat every patient with dignity and respect at all times • protect the confidentiality of patients' information and only use it for the purpose for which it was given.
<p>Human rights principle of dignity</p>	<p>People have the right to be treated in a way that upholds their dignity. There is the potential for people to disengage from health services if they have not been treated with dignity.</p> <p>Situations in primary care dental practice that may involve breaches of dignity include:</p> <ul style="list-style-type: none"> • Lack of privacy and safety in treatment rooms. • No chaperones/ same sex staff present when being examined. • Patients not being given as much time and privacy as is required to take on-board any 'bad news' given by a dentist – staff should anticipate this need and leave sufficient time between appointments, as necessary. • Reception staff talking in loud voices about the patient and their Oral health/personal circumstances within earshot of other people/ nowhere for private conversations to take place with reception staff. <p>The treatment does not need to be deliberate – it is the impact it has on the person that matters.</p>
<p>Human rights principle of autonomy</p>	<p>People have the right to choose where they want to receive care and treatment. This includes the right to live as independently as possible, to make routine decisions and to be consulted about professional decisions about their care and treatment.</p> <p>The GDC standards reflects this, for example:</p>

	<ul style="list-style-type: none"> • You should find out what your patients want to know as well as what you think they need to know. • Patients can withdraw their consent at any time, refuse treatment or ask for it to be stopped after it has started. You must acknowledge their right to do this and follow their wishes. • If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits and likely outcomes to help them to make a decision. <p>Research from the UK and other countries suggests that strategies to enhance shared decision making can improve people’s knowledge about their condition and treatment options, people’s involvement in their care and people’s satisfaction with care. (Health Foundation report).</p>
<p>Human rights principle of rights to life</p>	<p>There are no identified implications for right to life in dentistry. However, the GDC expects dentist to follow the guidelines set out by the Resuscitation Council, which include having the necessary equipment and medication to preserve life in an emergency.</p>
<p>Human rights principle for staff working in the sector</p>	<p>Staff working to provide healthcare (including dental practices) have the right to be safe and to be treated with dignity and respect (NHS constitution section 49). For example, staff should:</p> <ul style="list-style-type: none"> • Expect reasonable steps to have been taken by the employer to ensure protection from discrimination by fellow employees, people using the service and others. • Expect employers to deal with bullying and harassment. • Expect employers to enable staff to speak freely about concerns, not only by upholding the legal rights of whistleblowers, but by creating a culture that values staff views. • Deal appropriately with safety risks that staff might face. <p>Also, under the Equality Act 2010 employees can:</p> <ul style="list-style-type: none"> • Expect reasonable steps to have been taken by the employer to ensure protection from discrimination by fellow employees, people using the service and others. • Expect employers to deal with bullying and harassment.

4. Development work on equality and human rights to date

We have consulted with our external reference group, which includes representation from the General Dental Council, British Dental Association, NHS England, Healthwatch England, Faculty of General Dental Practice and dental indemnity organisations. Our stakeholders have shared their expertise and knowledge of the dental sector, which has helped develop our approach. Our long-term approach to the regulation and inspection of primary care dental services will be influenced by the work of the dental programme board, referred to as the tripartite programme board in our signposting statement.

In our signposting statement, *A fresh start to the regulation and inspection of primary care dental services*, we stated that we would look at the experiences of certain population groups through a thematic approach to inspection. During 2015, we need to further review the evidence for certain population groups and work across sectors to develop our thematic activity programme.

In August 2014, we held a workshop with over 20 representatives from the dental sector, including an Expert by Experience, where we shared our inspection approach and the tools we had developed. The feedback at the workshop has enabled us to develop an inclusive inspection model, which includes relevant inspection prompts and incorporates human rights principles. We have planned another workshop for January 2015.

Our inspectors have started to plan for the inspections starting in December 2014 (wave) where we will test our inspection approach and methodology. The learning from our wave activity (December 2014 and January 2015) will inform the development of our new regulation and inspection model, which will be implemented from April 2015.

We will continue to consult with our stakeholders and review our tools and methods against relevant human rights topics, drawing on our experience from the other sectors we regulate. We know from these inspections that, while it was possible to pick up all the human rights topics with our range of methods, whether this happens in practice will depend on two key factors: the awareness and skills of inspection teams around human rights, and the evidence that comes into inspection teams, from patients, members of the public, staff and others.

We will review our methods of engaging with people who use primary care dental services during our inspections. We have commissioned research starting in December 2014, which will explore people's perception of primary dental care services. We will use this to develop our understanding of what high quality care looks like. In particular, we will focus on engaging with people from a diverse range of backgrounds.

We have designed and delivered training for our inspectors in the new approach, which includes equality and human rights. However, we will continue to support the equality and human rights learning and development of operations and policy staff teams (policy, intelligence, registration and inspection) to ensure they have the knowledge, skills and aptitude to deliver a human rights approach to their work in the regulation of primary care dental services.

As part of our risk-based model to inspection, we are developing our approach to how we share information between other regulators and oversight bodies involved in primary care dentistry. We need to ensure that this information has coverage of key human rights topics.

5. Conclusion and actions required

Our approach to regulating and inspecting primary care dental services draws on our overall human rights approach, which aims to have a positive impact on equality and human rights by:

- Mainstreaming human rights by applying human rights principles to the inspection prompts that cover human rights topics and ensuring that our commentary on the five key questions CQC asks of services addresses human rights.
- Integrating human rights into our inspection approach through new methodologies that address key human rights principles and topics.
- Enabling inspection team members (who are not human rights specialists) to know, understand and apply the human rights approach, with specialist advice/support if needed.

We need to continue to work with the dental sector to gain a deeper understanding of the risk to quality and safety, and in particular, identify if there are specific issues related to equality and human rights.

We need to evaluate our inspection approach, which we are testing in December 2014 and January 2015, and in particular, further develop our methods for ensuring people have the opportunity to tell us about their experience. For many equality and human rights topics, the main source of evidence is the views and experiences of people using the service or people close to them. However, we know there are several barriers that these people face in accessing primary care dental services. We need to work with different equality groups to establish how we ensure we capture their experiences when they use primary dental care services.

We will continue to develop our assessment framework and methodology for primary dental services; we need to ensure that these developments will enable inspectors to assess performance against key human rights topics which are embedded in the regulations.

We need to ensure appropriate weight is given to the evidence and views of all members of inspection teams – inspectors, Experts by Experience and specialists (where applicable).

Proposed actions

Issue to address	Proposed action	Lead	Timescale (start and end)
Methodologies and Inspection prompts will develop over time – need to ensure continued attention to human rights topics in frameworks	Continue to use the human rights topics list to check methodologies adequately reflect the human rights topics for primary dental care services	Policy teams to provide assessment frameworks and make amendments EDHR team to provide specialist check at appropriate development stages	November 2014 – April 2015
Developing tools and methods will continue over time – need to ensure continued attention to assessing human rights topics in methods and tools	Embed human rights topics in generic tools	Policy teams to provide tools for checking and make amendments EDHR team to provide specialist check at appropriate development stages	November 2014 – April 2015
Intelligent Monitoring for primary dental services has yet to be developed, need to ensure any monitoring includes human rights topics	Work to develop intelligent monitoring which includes human rights topics	Intelligence (with advice from EDHR team) and in partnership with members of the dental programme board i.e. NHS business services authority	April 2015 – March 2016
Many human rights topics depend on obtaining the experiences of people using services or those supporting them beyond those actually gathered on inspection visits	Ensure local teams have links, methods and skills to gather information about human rights topics e.g. local engagement work and, use research findings to identify ways of engaging with different groups	Engagement / Primary Medical Services and Integrated Care directorate (with advice from EDHR team)	January 2015 – March 2015

Issue to address	Proposed action	Lead	Timescale (start and end)
Inspectors need knowledge, understanding and confidence to apply the human rights approach in primary care dental services	Develop role specific learning on applying the human rights approach and human rights topics for Primary Care inspectorate staff	Learning and development, with specialist input from the EDHR team	December 2014 – March 2015
We need to develop our thematic programme to enable us to look at the experiences of primary care dental services for certain population groups	Review the evidence for specific population groups to inform the primary care dental input into future thematic activity	Policy with cross sector engagement	April 2015 – March 2016
Our regulation and inspection model focuses on inspecting 10% of providers. We need to ensure this approach does not have an unintended consequence that providers become complacent about human rights topics	Further develop our understanding of risk within the sector and our approach to how we 'monitor' the 90% providers whom we don't inspect	Policy with input from the dental programme board, Primary Medical Services and Integrated Care directorate (with advice from EDHR team)	January 2015 – July 2015