NHS England

Equality and Health Inequalities – Full Analysis Form

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Classification: OFFICIAL

PART A: General Information
1. Title of project, programme or work: Reprocurement of NHS Special Care Adult and Paediatric Dental Services for the South East of England.
2. What are the intended outcomes? The aim of this project is to reprocure Special Care Adult and Paediatric Dental Services (SCPDS) across the South East of England to start on 1st April 2022. These services will replace any existing services provided under contracts which will expire on 31st March 2022. Specific objectives are to: 1. Maintain continuity of service provision to eligible groups and existing patients of the current services. 2. Improve equity of access to services and reduce inequalities in outcomes, wherever possible. 3. Ensure both adults and children who require Special Care and Paediatric Dental Services, and who meet the criteria to receive NHS treatment, are able to receive such care and complete treatment within the transition. 4. Establish an appropriate assurance and monitoring system to facilitate and maintain compliance with national and local commissioning guidelines and quality standards. 5. Ensure clear communications and engagement with all stakeholders, including patients, regarding any changes to services in the South East as a result of the procurement. 6. Achieve effective, cost-effective, sustainable and financially-viable services including the ability to manage changes in demand over the longer-term. 7. Take account of the additional impact of COVID-19 on current and future services, particularly in relation to any access barriers. 8. Ensure compliance with the Public Contracts Regulations 2015 (PCR 2015) for NHS commissioners and any other relevant regulation and legislation.
3. Who will be affected by this project, programme or work? Please summarise in a few sentences which of the groups below are very likely to be affected by this work. • All current and potential patients of SCPDS across NHS England South East. These are patients who cannot be treated safely and / or effectively within a general dental practice as they need access to specialist skills and / or facilities and equipment. • All current and potential referrers into the services, including medical, dental, health and social care professionals and carers.

- Potentially, other commissioners who commission top-up services from the incumbent providers that would be unlikely to be sustainable as stand-alone services and the recipients of such services (e.g. supervised toothbrushing in schools commissioned by some local authorities).

Not included within this document:

- Staff currently working within existing services who may have a change with regards to the terms and conditions of their service. This will be managed, where indicated, through separate processes in line with The Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).

4. Which groups protected by the Equality Act 2010 and / or groups that face health inequalities are very likely to be affected by this work?

Some patients in the groups identified below will be affected by this work:

1. Children including those with additional complex medical / social issues which make it difficult for them to receive care safely and / or effectively within a general dental practice setting e.g. looked after children / children in care.
2. Older people, particularly those with additional medical problems or disabilities
3. Disabled people – people with physical, mental health and / or learning disabilities.
4. Refugees (in particular unaccompanied, asylum-seeking children) and Gypsy, Roma and Traveller communities.
5. Adults with additional complex medical / social issues which make it difficult for them to receive care safely and / or effectively within a general dental practice setting e.g. homeless people and those who have substance misuse issues.
6. Patients requiring bariatric dental care which is not available in general dental services.

For the purpose of the terms of reference of the SCPDS Steering Group, these groups have been listed as follows:

- Adults and children with learning disabilities
- Adults and children with physical or sensory disabilities
- Adults and children with complex medical problems
- Adults and children who require domiciliary dental care
- Bariatric adults
- Adults and children who require a general anaesthetic or sedation in order to receive their dental treatment
- Adults and children who require input from a specialist in special care or Paediatric Dentistry
- Children under the care of social services or with complex social problems

PART B: Equalities Groups and Health Inequalities Groups

5. Impact of this work for the equality groups listed below.

Focusing on each equality group listed below (sections 5.1. to 5.9), please answer the following questions:

If you cannot answer these questions what action will be taken and when?

For all groups:

a) Does the equality group face discrimination in this work area?

1. Age

1.1 Children

- Dental decay can lead to toothache, which is undesirable for anyone, but particularly in a young child. Toothache may mean sleepless nights (for children and parents), affect children's eating (and therefore overall diet and nutrition), and result in school absences (which may impact on learning)[1]. Oral pain and difficulties in eating, poor oral health in children is associated with being underweight and a failure to thrive[2].
- There is evidence that looked-after children are more likely to have dental treatment needs and less likely to access dental services even when accounting for sociodemographic factors[3].
- General anaesthetic (GA) in a hospital may be needed to either fill or extract teeth in young children as they are often unable to cooperate, particularly if they are in pain. Removal of teeth was the sixth most common procedure in hospital for children under 5 years of age, and it was the most common reason for hospital admission for children aged 5 to 9 years old [4]. Each course of GA treatment results in school absences[5]. There is a clear socio-economic gradient with children from more deprived groups more likely to experience dental extraction under GA (GAX), although children from all social backgrounds are affected[6].
- From the 20th March 2020, all elective GAX lists across the country were cancelled due to Covid-19; with limited access to emergency lists for the most urgent extractions. This has left thousands of children with untreated caries. resulting in pain and repeated antibiotic prescriptions. A separate health equity impact assessment (HEA) was carried out to highlight the child inequalities caused by the pandemic and identify potential approaches that may help manage this situation. The key findings are in Appendix 1.

1.2 Older people

[1] Sheiham and James. A new understanding of the relationship between sugars, dental caries and fluoride use: Implications for limits on sugar consumption. *Public Health Nutr* 2014 Jun 3:1-9

[2] Sheiham A. Dental caries affects body weight, growth and quality of life in preschool children. BDJ 201: 625-626

[3] McMahon, A. D. et al. 2018. Inequalities in the dental health needs and access to dental services among looked after children in Scotland: a population data linkage study. Archives of disease in childhood 103(1) 39-43.

[4] Public Health England. Health Matters: child dental health. June 2017.

[5] Goodwin M et al. Issues arising following a referral and subsequent wait for extraction under general anaesthetic: impact on children BMC Oral Health. 2015; 15: 3. Published online 2015 Jan 17.

[6] Mortimore A. et al. Exploring the potential value of using data on dental extractions under general anaesthesia (DGA) to monitor the impact of dental decay in children. Br Dent J 2017; 222: 778-781

- As people get older, the need to maintain a good state of dental health becomes important in order to maintain a healthy diet which in turn contributes to good health and wellbeing and good quality of life.
- Research indicates that, compared with peers living in the community, both dentate and edentate care home residents are more likely to experience poorer dental health and live with one or more impacts on their oral health (as measured by the Oral Health Impact Profile)[7, 8].
- A publication assessing data from the National Diet and Nutrition Survey found that older people in Britain with less than 21 natural teeth were, on average, more than 3 times more likely to be obese than those with more standing teeth[9].
- Published research suggests that oral health and oral health-related quality of life is poor at end-of-life[10].
- Results of a systematic review suggest that poor oral hygiene is associated with dementia, and more so amongst people in advanced stages of the disease. Poorer oral health (gingivitis, dental caries, tooth loss, edentulousness) appears to be associated with increased risk of developing cognitive impairment and dementia[11].
- There are additional challenges with those who have medical conditions which compromise their ability to care for their dental health and receive dental care, such as patients with mobility issues such as stroke[12] or cognitive disorders such as dementia[13].
- Some patients who had to "shield" during the COVID-19 pandemic may not have been able to access routine healthcare, including dental care, and their dental condition may have deteriorated as a result.
- The COVID-19 pandemic has also meant that domiciliary care to care homes has had to be delivered under strict infection control processes, which has meant a reduced service, largely focused on responding to urgent dental problems.

2. Ethnicity

- Published evidence highlights a link between ethnicity and oral health, after taking account of the compounding effect of deprivation. UK studies have

[7] Moore, D. & Davies, G. M. 2016. A summary of knowledge about the oral health of older people in England and Wales. Community dental health 33(4) 262-266.
[8] Monaghan, N. et al. 2017. Measuring oral health impact among care home residents in Wales. Community dental health 34(1) 14-18.
[9]Sheiham A et al. The relationship between dental health status and Body Mass Index among older people: a national survey of older people in Great Britain. 2002. Brit Dent J 2002;192:703-706.
[10] Fitzgerald, R. & Gallagher, J. 2018. Oral health in end-of-life patients: A rapid review. Special care in dentistry: official publication of the American Association of Hospital Dentists, the Academy of Dentistry for the Handicapped, and the American Society for Geriatric Dentistry 38(5) 291-298.
[11] Daly, B et al. Evidence summary: the relationship between oral health and dementia. Br Dent J. 2018 Jan;223(11):846-853.
[12]Dai R et al. A systematic review and meta-analysis of clinical, microbiological, and behavioral aspects of dental health among patients with stroke. J Dent. 2014 Jun 21. Epub
[13]Naorungroj. S et al. Cognitive decline and dental health in middle-aged adults in the ARIC study. *J Dent Res* 2013 92(9):795-801.

highlighted oral health inequalities between children of different ethnic backgrounds[14,15,16,17].

- Those from minority ethnic backgrounds living in more deprived circumstances are most likely to have poorest oral health. They may also face additional language barriers in trying to access dental care.
- It is known that Gypsy, Roma and Traveller communities have poorer oral health and greater difficulty accessing health services, including dental services[18]. (Please see section 6.6).
- Individuals relocating to the UK as part of the UK's Resettlement Programmes may also have poorer oral health and greater difficulty accessing services due to cultural, language and other barriers (please see 6.2). They may also move / be moved several times from reception centres to settled accommodation. This generates challenges around continued access to healthcare, including dental care.
- Evidence indicates that those from Black and Minority Ethnic (BAME) backgrounds may be more likely to get infected and die from COVID-19[19]. BAME patients with added co-morbidities who access these services may feel unable to access dental care because they are afraid of the risk of attending.

3. Physical disabilities

- An American study found that individuals with physical disabilities were more likely to have unmet medical, dental, and prescription medication needs with those deprived at higher risk[20]. Financial issues (cost of dental care and travel) and physical accessibility (toilet and waiting room facilities) were reported as barriers to accessing care[21].
- Other impairments can also be a barrier to accessing healthcare, including dental care. For example, hearing impairment can create a communication barrier. Visual and communication technologies are needed to facilitate good communication[22].

4. Learning Disabilities

[14] Marcenes W et al. Ethnic disparities in the oral health of three to four-year-old children in East London. *Br Dent J* 2013 Jul; 215(2):E4.
[15] Dugmore CR and Rock WP. The effect of socio-economic status and ethnicity on the comparative oral health of Aisan and White Caucasian 12-year-old children. Community Dent Health 2005 Sep;22(3): 162-9.
[16] Gray M et al. The oral health of South Asian five-year-old children in deprived areas of Dudley compared with White children of equal deprivation and fluoridation status. Community Dent Health 2000 Dec; 17(4):243-5.
[17] Delgado-Angulo et al. Ethnicity, migration status and dental caries experience among adults in East London. Community dentistry and oral epidemiology 46(4) 392-399 2018.
[18] Alison McFadden et al. Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. European Journal of Public Health, Volume 28, Issue 1, 1 February 2018, Pages 74–8
[19] Public Health England. COVID-19: review of disparities in risks and outcomes. https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
[20] Mahmoudi E. Disparities in access to health care among adults with physical disabilities: analysis of a representative national sample for a ten-year period. Disabil Health J. 2015 Apr;8(2):182-90.
[21] Rouleau T et al. Receipt of dental care and barriers encountered by persons with disabilities.
[22] Kuenberg A. Health Care Access Among Deaf People. The Journal of Deaf Studies and Deaf Education, Volume 21, Issue 1, 1 January 2016, Pages 1–10

- Evidence indicates that those with intellectual disabilities had poorer oral health[23]. These individuals may also experience a number of other issues, including higher rates of obesity and systemic problems. A holistic approach to care is, therefore, recommended [24].

5. Gender

- A national report highlights that a third more women than men travelled by bus and a third more men than women travelled by rail[25].
- Women are also more likely than men to have caring responsibilities that may require them to make multiple short journeys during a day, (for example to drop children off at school, visit an elderly parent and shop for food).
- Any changes in locations should take account of the current "catchment population" of existing services and minimise impact on patients, and their carers, as far as possible.

b) Could the work tackle this discrimination and / or advance equality or good relations?

Yes. The current services are positioned to address the specific needs of these patient groups. Some of the local services shared the patient feedback (Hampshire and Oxfordshire) that they had from local processes which highlighted positive feedback from patients about access to care and the quality of care received. Engagement with the Health and Wellbeing Alliance (represents those with learning disabilities)[26] has been carried out through Public Health England. This provided information about making these services accessible and acceptable to service-users, which is being used to inform service development. Extensive engagement via hard copy and online surveys, including an easy read version, has taken place during July – August 2019. This has targeted existing patients as well as user led disability organisations and charities in the South East.

Ongoing care will need to be available to those who cannot be treated safely in general dental practices due to complex health, social and / or behavioural issues. These patients will have conditions which mean that they need access to specialist skills and / or facilities to enable them to receive care safely. Other patients may be able to receive most of their care in a general dental practice but may require care from specialist services for a particular procedure, e.g. dental extraction of multiple teeth. This includes young children who need a general anaesthetic initially to get them "dentally-fit" so they can then be "socialised" into receiving care under a local anaesthetic. Some patients may only need to have their care transferred from general dental services to specialist services if / when their ability to co-operate or the complexity of their condition changes.

[23] Anders PL et al. Oral health of patients with intellectual disabilities: a systematic review. Spec Care Dentist. 2010 May-Jun;30(3):110-7. Spec Care Dentist 31(2): 63-67, 2011
[24] Jane Ziegler. Nutritional and dental issues in patients with intellectual and developmental disabilities JADA 2018:149(4):317-321.
[25] UK Women's Budget Group. Public Transport and Gender. Oct 2018
[26] Health and Wellbeing Alliance. http://www.bild.org.uk/about-bild/hwba/

Domiciliary care and care under sedation and general anaesthesia will be included within the services commissioned to facilitate access to dental care for those patients who need them, thus ensuring that there is equivalent access and quality of care available to all eligible patients.

c) Could the work assist or undermine compliance with the Public Sector Equality Duty (PSED)?

The work could assist compliance with PSED by providing services which improve equity of access and care to special care adults and all children from vulnerable backgrounds who cannot be treated safely or effectively within other settings. Providing opportunities to improve oral health would help reduce potential oral pain and contribute to self-esteem, therefore, contributing to improved quality of life for those with identified protected characteristics. If challenged, a clear rationale for why these services are needed for existing groups can be set out using the information included in this document.

d) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?

Patients with less complex needs, who may be currently treated by the service, are less likely to be accepted into the SCPDS under the new contracts. There is a risk that these patients will not be able to access care from general dental practices because these teams do not have the appropriate skills or capacity to manage their care. These patients may not seek alternative dental care and could feel excluded from provision. There are plans to incorporate “system leadership” within the new SCPDS to support shared-care arrangements with general dental services. This will include developing, and supporting, the general dental service workforce to manage the care of these individuals within their competence. This will also help families with one / some members who require specialist care, to receive care together at a general dental practice, where this is possible.

COVID-19 has had a major adverse impact on all healthcare services, including dental services. Patients have been unable to access routine dental care from March to June 2020. From July 2020, some services have resumed, initially, to provide urgent dental care. NHS England and NHS Improvement South East (NHSE / I SE) has been engaging continuously with current providers which have highlighted the issues experienced by patients who would normally access their services. This includes patients with complex medical histories and co-morbidities who have had access to urgent care, provided by CDS Urgent Dental Care hubs, as they have been “shielding” in line with national guidance. Strict infection control regimes between appointments are now required which mean fewer patients can be seen in the course of a day. There is now a backlog of patients for all services, including dental services. Engagement and collaborative working with future providers is needed to develop measures which may help mitigate these issues, wherever possible, whilst remaining compliant with national regulations and guidelines.

Since the pandemic reduced face to face access to health and social care services, video consultations are being used widely across all services, including dental services, to enable more patients to access the advice they need. This may provide an alternative for patients who are apprehensive about attending and, therefore, delaying accessing care. It may also provide access as a first point of contact for those who are “shielding” in the event of any resurgence in COVID – 19, or anyone without to suitable transport. Appropriate adjustments are needed for those patients who may find it difficult to use video consultations, for example, patients with dementia, those who are digitally excluded, patients with communication difficulties or disabilities.

e) If you cannot answer these questions, what action will be taken?

NA.

6. Implications of our work for the health inclusion groups listed below.

Focusing on the work described in sections 1 and 2, in relation to each health inclusion group listed below (Sections 6.1. To 6.12), and any others relevant to your work, please answer the following questions:

a) Does the health inclusion group experience inequalities in access to healthcare?
b) Does the health inclusion group experience inequalities in health outcomes?
c) Could the work be used to tackle any identified inequalities in access to healthcare or health outcomes?
d) Could the work assist or undermine compliance with the duties to reduce health inequalities?
e) Does any action need to be taken to address any important adverse impact? If yes, what action should be taken?
f) As some of the health inclusion groups overlap with equalities groups you may prefer to also respond to these questions about a health inclusion group when responding to 5.1 to 5.9. That is fine; please just say below if that is what you have done.
g) If you cannot answer these questions what action will be taken and when?

6.1. Alcohol and / or drug misusers

Individuals with substance misuse disorders have greater and more severe dental caries and periodontal disease than the general population but are less likely to have received dental care[27]. Some of these individuals also have complex mental health and other conditions and may need to be managed within a specialist dental service. Those who meet the criteria for disability and / or complex medical / social issues will be included within the service.

6.2. Asylum seekers and / or refugees

Research indicates that these communities find primary care services difficult to navigate with issues around language barriers and inadequate interpretation services;

[27] Baghaie, H. et al. 2017. A systematic review and meta-analysis of the association between poor oral health and substance abuse. Addiction (Abingdon, England) 112(5) 765-779.

lack of awareness of the structure and function of the NHS; difficulty meeting the costs of dental care, prescription fees, and transport to appointments; and the perception of discrimination relating to race, religion, and immigration status[28].

Those who meet the criteria for disability and / or complex medical / social issues will be included within the SCPDS. All service providers, including general dental practitioners, will be expected to meet the Accessible Information Standards and meet their duties under the Equality Act[29]. to provide fair access to services, which may include translation and interpreting services, and other adjustments needed. Pathways will need to be clarified to ensure that all health & social care providers are aware of how to refer those who meet the SCPDS criteria.

6.3. Carers

Those who meet the criteria for disability and / or complex medical / social issues will be included within the service. The adjustments needed are in line with other groups for the service and will be accommodated. In addition, providers will need to give reasonable notice of appointments and any changes, to enable carers to make alternative arrangements for those under their care. This will extend to providing flexible and out-of-hours appointments.

6.4. Ex-service personnel / veterans

Not applicable other than to those who meet the criteria for disability and / or complex medical / social issues included within the service. The adjustments needed are in line with other groups for the service and will be accommodated.

6.5 Those who have experienced Female Genital Mutilation (FGM)

Not applicable other than to those who meet the criteria for disability and / or complex medical / social issues included within the SCPDS. The adjustments needed are in line with other groups for the service and will be accommodated.

6.6 Gypsies, Roma and travellers

A health needs assessment in Brighton and Hove[30] indicated that local Traveller communities experience poor dental health with many children having large numbers of teeth extracted. The interviews attributed the poor dental health to high consumption of fizzy drinks and to poor oral hygiene practices. Those who meet the criteria for disability and / or complex medical / social issues will be included within the specialist service. Patients can be referred based on either residence or their GP practice location.

6.7 Homeless people and rough sleepers

[28] Kang C et al. Access to primary health care for asylum seekers and refugees: a qualitative study of service user experiences in the UK. Br J Gen Pract. 2019 Feb 11

[29] UK Government. Equality Act. https://www.gov.uk/guidance/equality-act-2010-guidance

[30] Brighton & Hove. Gypsy and Traveller Rapid Health Needs Assessment. 2012. http://www.bhconnected.org.uk/sites/bhconnected/files/Gypsy%20%26%20Traveller%20Rapid%20HNA%20Brighton%20and%20Hove.pdf

Homelessness is known to contribute to increased need for dental care and barriers to access that care[31]. Those who meet the criteria for disability and / or complex medical / social issues will be included within the specialist service. Patients can be referred based on either residence or their GP practice location.

6.8 Those who have experienced human trafficking or modern slavery

Those who meet the criteria for disability and / or complex medical / social issues will included within the SCPDS. The adjustments needed are in line with other groups for the service and will be accommodated.

6.9 Those living with severe and enduring mental health issues

- It is known that people who have experienced a mental health disorder are often vulnerable because of lifestyle and health habits including poor diet, cigarette smoking and substance abuse. They often experience fatigue, a lack of motivation and a lack of interest in self-care which results in poor hygiene, particularly for those experiencing anxiety and depression.[32]
- There is also evidence of difficulty accessing health services and inability to cooperate with dental treatments[33]. This may lead to poor oral health outcomes and, potentially, higher costs of dental care act as another barrier. Dental care for these individuals is also more likely to involve extractions of teeth rather than preventive or complex restorative care[34].
- Oral health is known to contribute to self-esteem and improving oral health may support their recovery[35].
- A more collaborative approach is needed which avoids 'siloing' dentistry and encourages partnerships between dental professionals, other health professionals, community groups and advocacy groups to be developed. Implementing standards may also support improvements in the quality of care[36].

Those who meet the criteria for disability and / or complex medical / social issues will be included within the SCPDS. Patients can be referred based on either residence or their GP practice location.

6.10 Sex workers

[31] Paisi, M. et al. Barriers and enablers to accessing dental services for people experiencing homelessness: A systematic review. Community dentistry and oral epidemiology 2019
[32] Slack-Smith L et al. Barriers and enablers for oral health care for people affected by mental health disorders. Aust Dent J. 2017 Mar;62(1):6-13.
[33] Torales J et al. Oral and dental health issues in people with mental disorders. Medwave 2017 Sep 21;17(8)
[34] Slack-Smith L et al. Barriers and enablers for oral health care for people affected by mental health disorders. Aust Dent J. 2017 Mar;62(1):6-13.
[35] Clark DB. Mental Health Issues and Special Care Patients. Dent Clin North Am. 2016 Jul;60(3):551-66.
[36] Slack-Smith L et al. Barriers and enablers for oral health care for people affected by mental health disorders. Aust Dent J. 2017 Mar;62(1):6-13.

Those who meet the criteria for disability and / or complex medical / social issues will be included within the SCPDS. The adjustments needed are in line with other groups for the service and will be accommodated.

6.11 Trans people or other members of the non-binary community

From the PHE Health and Wellbeing Alliance survey, the LGBT Foundation wanted a service which was inclusive and non-judgemental with consideration of the wider issues faced by these communities.

Those who meet the criteria for disability and / or complex medical / social issues will be included within the service. The adjustments needed are in line with other groups for the SCPDS and will be accommodated.

6.12 The overlapping impact on different groups who face health inequalities

Those who meet the criteria for disability and / or complex medical / social issues will be included within the SCPDS. The adjustments needed are in line with other groups for the service and will be accommodated.

7. Other groups that face health inequalities that we have identified.

Have you identified other groups that face inequalities in access to healthcare?
Yes:

- *Those from more deprived backgrounds*
- *Those who weigh more than 23 stone*

Does the group experience inequalities in access to healthcare and / or inequalities in health outcomes?
Yes.

1. There is evidence that although, dental disease affects people from all social class backgrounds, those from the more deprived backgrounds experience higher levels of dental disease[37] [38] [39]. Those from more deprived backgrounds were also less likely to attend for dental care[40]. A range of barriers, including health literacy and cost of treatment, would need to be addressed in these groups. Even travel to access treatment may be challenging as this may entail a cost and there may be challenges relating to getting time off work and securing childcare.

2. Analysis of dental epidemiology data from Wessex and Kent, Surrey & Sussex children's dental data indicates that children from some minority ethnic groups

[37]Broomhead et al. What are the most accurate predictors of caries in children aged 5 years in the UK? *Community Dent Health* 2014 Jun;31(2):111-6.
[38]Joury, E., Bernabe, E., Gallagher, J. E., et al. 2018. Burden of orofacial pain in a socially deprived and culturally diverse area of the United Kingdom. Pain 159(7) 1235-1243.
[39]Cheema, J. & Sabbah, W. 2016. Inequalities in preventive and restorative dental services in England, Wales and Northern Ireland. British dental journal 221(5) 235-239.
[40] Holmes, R. D., Porter, J., Devapal, L., et al. 2016. Patterns of care and service use amongst children in England, Wales and Northern Ireland 2013. British dental journal 221(8) 509-514.

living in deprivation are most likely to experience dental decay[41]. Language and cultural differences may be some of the barriers for these children.

3. Patients who weigh more than 23 stone cannot be treated within a standard dental chair. Some general dental practice sites will have a bariatric dental chair and facilities which will enable to them to provide care for these patients. Those patients who cannot access this care due to the lack of availability of suitable facilities, and have additional complex needs, will be cared for within the SCPDS.

4. Those who need wheelchair recliners will be included within the SCPDS as such facilities are generally not available in general dental practices.

Short explanatory notes - other groups that face health exclusion.
As we research and gather more data, we learn more about which groups are facing health inequalities. If your work has identified more groups that face important health inequalities please answer questions 7 and 8. Please circle as appropriate.

If you have not identified additional groups, that face health inequalities, just say not applicable or N/A in the box below.

Yes Complete section 8	No Go to section 9	N/A

8. Other groups that face health inequalities that we have identified.
None at this stage (March 2019)

If answer is Yes, complete section 8
If answer is No, go to section 9
The third option is not available

[41] John JH et al. Predicting the presence or absence of tooth decay in the South East: briefing note for local authorities. 2017 (unpublished)

PART C: Promoting integrated services and working with partners

Short explanatory notes: Integrated services and reducing health inequalities.

Our detailed guidance explains the duties in relation to integrated services and reducing health inequalities. Please answer the questions listed below.

9. Opportunities to reduce health inequalities through integrated services.

Does the work offer opportunities to encourage integrated services that could reduce health inequalities? If yes please also answer 10.

Yes

Yes Go to section 10	No Go to section 11	Do not know

10. How can this work increase integrated services and reduce health inequalities?

Please explain below, in a few short sentences, how the work will encourage more integrated services that reduce health inequalities and which partners we will be working with.

There are opportunities to develop more holistic care for these patients through creating more integrated care pathways. This will involve working with public health teams within local authorities, managed clinical networks, primary care networks, and commissioners of other health and social care services. For example, incorporating messages about oral health into dietary messages around reduction of sugar and healthy eating would help to improve oral health improvement as well as reduce overweight and obesity. Local authorities can also use local regulations to restrict sales of unhealthy foods near schools e.g. fast food takeaways; restrict unhealthy foods in school canteens and tuck shops; and make available fresh potable water in schools.

The COVID-19 pandemic has impacted on all health and social care services. All will need to find ways to restart services to those in their care. Identifying and working with other service providers in local areas may help enable the most vulnerable to continue to access dental care. This is particularly important as periodic increases in COVID-19 infections in local areas are anticipated for some time. Some limitations to service access may be needed to control these outbreaks and enable everyone, particularly the most vulnerable, to be safe. Integrating dental services with other health and social care services would facilitate access to dental care to be considered within this context.

PART D: Engagement and involvement
11. Engagement and involvement activities already undertaken. How were stakeholders, who could comment on equalities and health inequalities engaged, or involved with this work? For example, in gathering evidence, commenting on evidence, commenting on proposals or in other ways? And what were the key outputs? To support the commissioning process for an equitable service which is readily accessible to all groups listed above, the following work has been undertaken: • Discussions with Public Health England (PHE) Health & Wellbeing Alliance which identified 3 questions for further exploration: 1. What makes it easier for people to access dental care? 2. What matters most when receiving dental care? 3. What prevents people for accessing dental care? The 3 questions were then used for a questionnaire survey of members of the PHE Health & Wellbeing Alliance. • The 3 questions were used for a literature review carried out by PHE's Knowledge and Library Services (Jan 2019). • A focus group was organised and eight individuals with mild learning disability participated, all of whom accessed care from general dental services. All were happy with the care they were receiving. • A "stocktake" was carried out where a template was co-developed with current providers and then used to collect and collate current contracted activity, what was working well and any issues which would need addressing. • A Health Equity Assessment carried out Child Oral Health in Wessex and Kent, Surrey, Sussex areas has been included. • A full list of actions is being updated as part of the Communication and Engagement Strategy devised for this work. • Interviews with local CDS providers were carried out as part of a separate Health Equity Assessment focussing on the impact of delays and cancellations to child GAX due to the Covid-19 pandemic.
12. Which stakeholders and equalities and health inclusion groups were involved?
Please see reports of above.
13. Key information from the engagement and involvement activities undertaken. Were key issues, concerns or questions expressed by stakeholders and if so what were these and how were they addressed? Were stakeholders broadly supportive of this work?

Engagement with local authorities across Wessex and KSS indicated that stakeholders were broadly supportive of the efforts to ensure that local services to be "future-proofed" so that they would continue to meet patient needs as populations changed.

14. Stakeholders were not broadly supportive but we need to go ahead.

If stakeholders were not broadly supportive of the work but you are recommending progressing with the work anyway, why are you making this recommendation?

N/A

Will need to be reviewed later, once engagement data has been received and analysed.

15. Further engagement and involvement activities planned.

Are further engagement and involvement activities planned? If so what is planned, when and why?

- Further engagement work was carried out to address gaps in the results from the above processes with expertise from Wessex Voices, a local patient engagement group. Wessex Voices compiled a database which included contacts for health charities, user-led health and support organisations, user and carer groups. This database was utilised in sending out a survey as part of stakeholder / public engagement.
- NHS England and NHS Improvement South East commissioners have been engaging with SCPDS Managed Clinical Networks across the region from the start of the process to understand the complexities of the service. This has included sharing the draft service specification for comments and suggestions.
- Local engagement has been organised with local authorities in Wessex and Kent, Surrey and Sussex. All local authorities in the South East were invited to a market engagement event held with providers. Information was sent to local authorities for sharing with relevant departments and scrutiny panels.
- NHS England and NHS Improvement – South East has engaged with other commissioners (STPs / ICSs and CCGs).
- NHS England and NHS Improvement – South East will ensure that all relevant stakeholders are kept informed of progress.
- Engagement of vulnerable groups to assess how the Covid-19 pandemic has impacted on them accessing care is important to ensure any barriers are identified and addressed.

PART E: Monitoring and Evaluation

16. In relation to equalities and reducing health inequalities, please summarise the most important monitoring and evaluation activities undertaken in relation to this work.

A variety of methods was used to identify the different patient groups for these services including a literature review, surveys and discussions. The work was collated and "gap-analysis" undertaken to identify areas where more work could be done.

Current activity from services across the South East was collated and highlighted variations between services. These are primarily due to local services evolving over time to meet local needs. Further work has been undertaken to develop a standard service specification with “core” services. A gap-analysis has been undertaken to identify any services outside the scope of this procurement. Potential key performance indicators have been identified to facilitate benchmarking of services across the South East and ensure that patient needs are prioritised and managed appropriately.

17. Please identify the main data sets and sources that you have drawn on in relation to this work. Which key reports or data sets have you drawn on?

- Published evidence was used for the literature review.
- A Health Equity Assessment and regression analysis on child oral health carried out across Wessex and KSS.
- Details of the existing services across the South was collected from the existing providers as part of the stocktake.
- Discussions and questionnaire survey with the Public Health England Health and Wellbeing Alliance.
- A focus group of eight patients with mild learning disability who accessed care successfully from general dental services.
- A Health Equity Assessment carried out in August 2020 to assess the inequalities caused by delays / cancellations to child GAX sessions due to the COVID-19 pandemic.

18. Important equalities or health inequalities data gaps or gaps in relation to evaluation.

In relation to this work have you identified any:

- important equalities or health inequalities data gaps or
- gaps in relation to monitoring and evaluation?

Yes	No

None identified to date.

19. Planned action to address important equalities or health inequalities data gaps or gaps in relation to evaluation.

PART F: Summary analysis and recommended action
20. Contributing to the first PSED equality aim. Can this work contribute to eliminating discrimination, harassment or victimisation?

Yes	No	Do not know

If yes please explain how, in a few short sentences

Yes. This work will inform the recommissioning of Special Care Adult and Paediatric Dental Services across the South East of England and Dorset. The services provide care for vulnerable patients who are unable to access care safely and / or effectively from general dental practices. These services will provide equitable access to these patients and contribute to the reduction of inequalities in dental access.

21. Contributing to the second PSED equality aim.

Can this policy or piece of work contribute to advancing equality of opportunity? Please circle as appropriate.

Yes	No	Do not know

If yes please explain how, in a few short sentences

No

22. Contributing to the third PSED equality aim.

Can this policy or piece of work contribute to fostering good relations between groups? Please circle as appropriate.

Yes	No	Do not know

If yes please explain how, in a few short sentences

No

23. Contributing to reducing inequalities in access to health services.

Can this policy or piece of work contribute to reducing inequalities in access to health services?

Yes	No	Do not know

If yes which groups should benefit and how and / or might any group lose out?

Yes, the service specification includes the following areas to support equity of access to vulnerable patients who meet the criteria for the services.

- Clinics need to be readily accessible to all patients, which includes step-free access or elevators, wheelchair access etc.. This extends to parking, treatment areas, waiting rooms and toilet facilities. Arrangements will also need to be in place for those with other disabilities, such as hearing impairments. In particular, the environment will need to be accessible and welcoming for patients with conditions such as autism and dementia.
- Domiciliary care will be needed for those with severe mobility restrictions.
- Arrangements need to be in place to ensure that relevant consent is secured to enable any care needed to proceed without delay.
- Flexible appointments and providing reasonable notice of appointments, including any changes, particularly for those who need to be accompanied by a carer. Extended hours are proposed to offer a choice of appointments to patients and family carers.
- Arrangements to provide care for those who do not have personal documentation, such as homeless patients, to ensure that they are still able to access care.
- Access to sedation (Inhalation and intravenous) and general anaesthesia should be available for those who are unable to access care under local anaesthesia.
- Pathways will need to be in place for collaborative working and / or referral to other services. For example, referral to safeguarding services where there is evidence of dental neglect, working with carers and care home staff to improve mouth care and with other health & social care services to integrate oral health into dementia and other care pathways.
- Multidisciplinary working within the service as well as with other health and social care professionals will be needed to adopt a more holistic approach to care. This includes arrangements for “Best Interest” meetings to discuss individual treatment plans.
- “Shared-care” arrangements with general dental services will facilitate effective, cost-effective and flexible care for all patients. Pathways and thresholds will need to be clearly set out and agreed with all parties.
- Video consultations will provide a first point of contact for those who are unable / find it difficult to travel to access dental care, or for whom a dental appointment is not immediately available. Adjustments will be needed for those who find it difficult to interact in this way, including interpretation services for those who communicate in a language other than English.

The vulnerable groups listed in sections 5 and 6 above who continue to meet the referral criteria would benefit. Some current patients of existing services may no longer be eligible to receive care from the new services if referral criteria change. In these

cases, patients will be signposted to general dental practices so they continue to be able to access dental care. There are plans for the new SCPDS to provide “system leadership” so that general dental practices are supported to provide appropriate care to individuals who may not meet the criteria for specialist care within the SCPDS.

24. Contributing to reducing inequalities in health outcomes.

Can this work contribute to reducing inequalities in health outcomes?

Yes	No	Do not know

If yes which groups should benefit and how and / or might any group lose out?

The vulnerable groups listed in sections 5 and 6 above who continue to meet the referral criteria would benefit. Some current patients of existing services may no longer be eligible to receive care from the new services if referral criteria change. In these cases, patients will be signposted to alternative services, so they can continue to receive appropriate treatment.

25. Contributing to the PSED and reducing health inequalities.

How will the policy or piece of work contribute to the achieving the PSED and reducing health inequalities in access and outcomes? Please describe below in a few short sentences.

This work will inform the recommissioning of Special Care Adult and Paediatric Dental Services across the South East of England. The services provide care for vulnerable patients who are unable to access care safely and / or effectively through general dental practices. These services will provide equitable access to these patients and contribute to the reduction of inequalities in dental access.

26. Agreed or recommended actions.

What actions are proposed to address any key concerns identified in this Equality and Health Inequalities Analysis (EHIA) and / or to ensure that the work contributes to the reducing unlawful discrimination / acts, advancing equality of opportunity, fostering good relations and / or reducing health inequalities? Is there a need to review the EHI analysis at a later stage?

Please see below for list of actions.
Equity of access will be reviewed as part of contract monitoring arrangements.

Action	Public Sector Equality Duty	Health Inequality	By when	By whom
Identify and address gaps within engagement work with regard to any of the groups listed	✓	✓	Before service specification agreed	Procurement Group
Ensure that all population groups across ethnicities and social classes are included within engagement process.	✓	✓	Before service specification agreed	Procurement Group
Include key performance indicators to reduce inequalities with regard to access to these services	✓	✓	Before service specification agreed	Procurement Group

PART G: Record keeping	
27.1. Date draft circulated to E&HIU:	
27.1. Date draft EHIA completed:	1 August 2019
27.2: Date final EHIA produced:	
27.3. Date signed off by Director:	
27.4: Date EHIA published:	
27.5. Review date:	NA

28. Details of the person completing this EHIA		
Name	Post held	E-mail address
NHSE / I South Special Care Adult and Paediatric Dentistry Steering Group	NHS England	NA

29: Name of the responsible Director	
Name	Directorate
Richard Woolterton	Direct Commissioning, NHS England / Improvement

Appendix 1

Key findings from Health Equity Assessment carried out in August 2020 to highlight inequalities caused by cancellation of child GA dental extraction lists due to Covid-19.

Inequalities identified during HEA:

- Children from more deprived backgrounds and / or from BAME groups are more likely to experience dental caries and need access to GAX care. They are therefore more likely to have been disproportionately impacted by cancellations. These children have experienced prolonged periods of pain and repeated antibiotic prescriptions. This can subsequently impact on their educational achievements due to missed school sessions with pain and also impact on family life due to stress and financial burden on parents.
- Data gathered from CDS providers in the South East (Thames Valley, Hampshire and Isle of Wight, West Kent and East Surrey) indicates that over 1500 patients have had their GA extraction slots cancelled. This data doesn't include those on waiting lists to be seen and treated.
- There is limited access to GA care but the processes needed have been difficult, particularly for vulnerable families. Families are required to self-isolate for 7-14 days (depending on trust policy). This is not feasible for families with parents who cannot work from home or who do not have childcare support. This has resulted in children unable to access the service.
- Children are also required to have a Covid swab 2 days prior to the procedure which is difficult for young children. In some cases, caregivers have had to be swabbed if a sample cannot be obtained from the child.

Interviews with current providers of Special Care and Paediatric Dental services have highlighted the following options for future services.

- Increasing the use of other interventions, such as the Silver Diamine Fluoride (which inhibits the spread of decay) and provision of dental care under sedation.
- Provide information in local languages, in addition to English, to ensure that the new procedures for dental care in primary and secondary care, including GA, are understood by all communities.
- Consider using "Red" areas for patients whose COVID-19 infection status is considered "unknown", so there is no requirement for self-isolation and swab-testing.
- Re-evaluate provision of NHS paediatric services and consider developing primary care dental teams to provide more complex care. This would involve specialist services partnering with local primary care dental teams. There would need to be appropriate renumeration for intensive preventive care and advice, particularly where children are at increased risk of dental decay.
- Health inequalities identified need to be taken into consideration when commissioning and evaluating services during the restoration and recovery period. This could include working with local data analysts to risk stratify the population using deprivation and ethnicity as highlighted by the literature and local analyses.
- Consult local populations to understand the "lived" experience to identify facilitators and barriers to accessing care. This can be used to improve access for all patients and reduce any inequalities in access to care.
- Integrate dental services into the health and social care system through the emerging Primary Care Networks and Integrated Care Systems so that dental services can be considered with other health and social care services within each local context. This supports the ethos of "place-based" commissioning.