NHS Education for Scotland
Equality Impact Assessment Report

Name of function, policy or programme:	Clinical Effectiveness Workstream
NES directorate or department:	Dental Directorate
Name of person(s) completing EQIA:	Michele West, Jill Farnham
Individuals or groups contributing to EQIA:	Doug Stirling, Linda Young, Irene Black
Date Report Completed:	11/3/2016

1. Define the function[1]

What is the purpose of the function?

To support healthcare professionals to deliver high quality, safe, effective, patient-centred care by:

a) The provision of user-friendly, evidence-based guidance on topics identified as priorities for oral healthcare.

b) Developing and evaluating evidence based interventions for the efficient implementation of guidance recommendations.

c) Conducting high quality primary care research on a wide range of topics broadly categorised as quality assurance, quality improvement, patient safety, academic support and knowledge generation.

d) Providing an effective and efficient administration process for the approval and certification of quality improvement research audit activity, undertaken by dentists as part of their terms and conditions of service.

e) Delivering in-practice clinical effectiveness education and training.

f) Developing e-learning and other educational courses.

g) Delivering education and training for the whole dental team including those in training and post graduates at a wide variety of training sessions and other events.

Who does the function benefit and what is the relevance of the function to those groups?

All members of the dental team, including trainees, benefit by being better informed and equipped to provide high quality care; **patients** benefit by receiving higher quality oral healthcare.

How are they affected or will they benefit from it?

All of the dental team will have access to up-to-date, evidence informed educational resources (e.g. clinical guidance, in-practice training, e-learning, CPD courses), quality improvement tools and patient safety tools. Patients benefit through the application of these resources in practice to improve their care. Where relevant, educational resources for patients are also available.

[1] In this document, 'function' is used broadly to cover all the areas of work for which impact assessment is required, as defined in the Regulations. This includes policy, programme, project, service and function, among others.

What results/outcomes are intended?

- Increased awareness and understanding of best practice and evidence-based guidance recommendations.
- To enable dental professionals to improve practice and where necessary augment their skills and knowledge and change behaviours.
- Enhanced patient safety through the delivery of high quality care.

What is NES's role in developing and delivering the function?

The Clinical Effectiveness Workstream comprises the Scottish Dental Clinical Effectiveness Programme (SDCEP), the Scottish Dental Practice Based Research network (SDPBRN), the Translation Research in a Dental Setting programme (TRiaDS) and Quality Improvement in Practice Training (QIiPT) and operates within the NES Dental Directorate. NES provides the operational infrastructure to support the delivery of this workstream.

Who are the partners in developing and delivering the function and what are their roles?

The Clinical Effectiveness Workstream works in partnership with dental and other healthcare professionals, dental educators and trainers, higher and further education institutions, Scottish Government Health and Social Care Directorates, NHS Boards and independent practices, each of which has a role in communicating and implementing current best practice recommendations in their own setting.

Individually, each programme may collaborate or liaise with other relevant bodies including:

- Cochrane Oral Health Group;
- Dental Health Services Research Unit (Dundee);
- Healthcare Associated Infection Team (NES)
- Health Services Research Unit (Aberdeen);
- Health Facilities Scotland;
- Healthcare Improvement Scotland;
- Health Protection Scotland
- Infection Prevention Society
- NHS 24;
- Professional Societies;
- Research Networks (UK & International);
- Royal Colleges;
- Scottish Government;
- Scottish Public Dental Service;
- Territorial Health Boards.

2. Evidence used to inform assessment

Briefly summarise or list the types of evidence you have used in this EQIA. (Evidence may include surveys, statistical data; consultation responses, in-depth interviews, academic or professional publications, scoping studies). You may also attach a bibliography or list of references.

i. Available diversity data on dental team members and trainees

Gender, disability and ethnicity data for all full time undergraduate and postgraduate enrolments into medicine and dentistry in 2013/14 is available from the Higher Education Statistics Agency for UK (https://www.hesa.ac.uk/free-statistics). 9.1% of undergraduates and 5.5% of postgraduates were known to have a disability. From data taken from all full time undergraduate and postgraduate students (of any discipline) the most prevalent disability reported is a specific learning difficulty (e.g. dyslexia, discalculia, dysgraphia, dyspraxia or auditory and visual processing disabilities). These account for 53% of disabilities reported.

An update of the Dental Workforce Report was published by NES in 2014 (http://www.nes.scot.nhs.uk/media/3056253/dental-workforce-report-final.pdf). This review reported that the proportion of dental students from Black and Minority Ethnic (BME) groups at Aberdeen, Dundee and Glasgow Dental Schools ranged from 14 to 25%.The percentage of students reporting a disability at these dental schools ranged from 4-13% with more than half of the disabilities categorised as dyslexia or a similar learning disability, consistent with the data above. The data from the Dental Workforce Report on disabilities for Oral Health Science students training to be dental hygienists and therapists are also similar to this.

A review of the dental workforce in Scotland published in 2010 by the Scottish Government (http://www.gov.scot/Publications/2011/03/07154848/0) provides additional information about dental team members including DCPs (dental care professionals). DNs (dental nurses) make up the largest proportion of this group (75%). DNs, DHs (dental hygienists) DH/Ts (dental hygienist/therapists) and DTs (dental technicians) are predominantly female (93%), while 83% of DTs are male. The majority of DCPs (~40%) are under 30 years old. DCPs must have an appropriate qualification or be in appropriate employment and undertaking a recognised qualification.

Data specific for practicing dentists and other members of the dental team for equality groups other than gender and age was not found.

ii. Data on remote and rural populations

According to data from the Scottish Government on rural populations from 2014 (http://www.gov.scot/Publications/2014/11/2763/downloads), 6.1% of the Scottish population live in areas classified as Remote and Rural (i.e. areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 or more).

iii. Reports on digital learning and inclusive education

Key factors in digital inclusion are likely to be digital accessibility and digital literacy according to a review of inclusive digital education (Helen Allbutt, *Inclusive Digital Education in Health and Social Care Working Environments. 2015*; NES internal

paper). Access to digital technology does not necessarily equate to confidence in its use in all contexts or to effective digital literacy and learning. Digital literacy appears to be closely linked to reading, writing and numerical literacy skills and this may be linked to socio-economic status.

In the context of dental practice, barriers to digital inclusion might include a lack of access to computers or the internet and incompatible software, browsers and operating systems. Varying levels of digital accessibility and digital literacy may exist within a dental practice.

iv. **Ongoing evaluation of data collected by the CE workstream** from:

- Scoping interviews with dental healthcare professionals.
- Patient questionnaires.
- Consultation feedback, discussions with guidance development stakeholders including topic experts and lay members.
- Diagnostic surveys, pilot and feasibility studies.
- Details of course bookings including numbers and categories of course participants.
- Action plans for all in-practice training delivered.
- Feedback from training sessions.

3. Results from analysis of evidence and engagement

What does the evidence and any engagement activities tell you about:

The relevance of this function for different equality groups and the specific issues you identified for particular groups – evidence of barriers, under-representation, particular needs

Disability:
A reasonable assumption based on the evidence about dental and oral health science students is that a small proportion of dental professionals in practice may have a disability, particularly a specific learning difficulty. This should be taken into consideration in the work carried out across the Clinical Effectiveness workstream (see end of this section).

Other protected characteristics:
Direct discrimination based on the other protected characteristics resulting from the work of the Clinical Effectiveness workstream is judged to be very unlikely, although the potential for indirect discrimination should be considered in the ongoing reviews of projects within each programme. The evidence indicates that the gender balance and age distribution for different professional groups in the dental team varies. For example, dental nurses in Scotland are predominantly female and in the younger age ranges. A proportion of this group could have childcare responsibilities and so the place and time for workstream activities should be chosen to promote inclusion of this group.

Data on equality groups in the Scottish population as a whole are available via reports published by the Scottish Government on the 2011 Census (http://www.gov.scot/Publications/2014/10/8378 and http://www.gov.scot/Publications/2015/03/8716). This information should be used when

considering the impact on delivery of dental care to patients, resulting from specific activities carried out by the programmes within the workstream.

Educational background:
Members of dental teams will have varied educational backgrounds with training requirements for their professional roles ranging from in-job training to undergraduate and postgraduate qualifications. This diversity needs to be taken into account when providing educational resources such as clinical guidance and in-practice training and when engaging dental staff in research, surveys etc.

Rurality:
A proportion of dental practitioners and patients who would be within the target audience for activities carried out within the Clinical Effectiveness workstream will be based in remote and rural locations. Means of ensuring the accessibility of the educational and research resources and opportunities delivered by the workstream to those in rural locations should be adopted where possible.

Recommendations for clinical practice made in SDCEP's guidance should be assessed for the potential to discriminate against patients in remote and rural locations who may have greater difficulties accessing dental care.

A key issue that has been identified from this analysis is ensuring the accessibility of guidance, training, education opportunities and research results. This includes considering:

- the accessibility of paper documents and online digital versions (including the format of online documents and likelihood of computer access for the target audience)
- educational background and digital literacy
- raising awareness of training and educational opportunities through inclusive marketing strategies

Other potential issues will be highlighted through analysis of feedback and study data. For each specific piece of work or activity, any recommendations, implementation, audit or educational resources will be considered for potential discrimination against any particular groups.

Evidence of existing good practice and opportunities to promote equality or good relations

The programmes within the Clinical Effectiveness workstream already promote inclusivity in the way in which they carry out many of their activities:

- All members of the dental team are invited to participate in the consultation process during guidance development via the dental portal and by other methods depending on resources.
- The published guidance is disseminated in various formats, including printed copies in some cases, which are sent to all dental practitioners and for relevant topics to all hygienists and therapists in Scotland. All guidance is openly available and free of charge online and is advertised and promoted widely. Accessible versions of the guidance and supporting documents are also available on the website.
- To try to ensure digital inclusivity, documents which are published on-line are provided in alternative formats (PDFs, accessible word documents) to enhance accessibility. We aim to provide supporting tools in formats compatible with multiple devices and with

ease of navigation considered (e.g. Dental Prescribing App for android and Apple devices). The language and content of guidance and e-learning packages aims to be appropriate for the end user group.

- In relation to in-practice training, practices are advised of the benefits of participation by all members of the dental team and the category of course participants is recorded e.g. dentist, DCP, technician, trainee, etc. to encourage inclusive participation. Training sessions are scheduled to suit individual practices. All participants are asked to complete a post course evaluation. Feedback received is reviewed and any aspect of the training which appears to have been a barrier to any participant is highlighted. E-learning alternatives to the in-practice training are available. There is a fee for in-practice training but this is charged at practice level and not to individuals.
- For the majority of research studies practitioners are randomly selected from the whole population. The randomisation process ensures that each practitioner has an equal chance of selection.
- We aim to continue to make publications and events inclusive to all members of the dental team from all practices.

4. Actions taken or planned in response to issues identified in the analysis

Issue identified	Action to be taken in response to issue	Responsibility	Timescale (indicate whether actions have already been completed, or provide timescale for carrying out the action)	Resources required	What is the expected outcome?
Addressing learning needs for trainers, guidance producers, researchers etc on the adjustments required to promote inclusion of individuals with learning difficulties such as dyslexia.	Identify suitable courses or resources (e.g. resources provided at http://intranet.nes.scot.nhs.uk/help-me-with/equality-and-diversity/accessibility/ or http://www.saifscotland.org.uk/#sthash.JI0WwxIB.dpbs).	Project/programme leads		Time	
Ensuring accessibility of online documents.	Create accessible word versions of published documents e.g. according to advice provided on NES intranet (http://intranet.nes.scot.nhs.uk/help-me-with/equality-and-diversity/accessibility/).	Project/activity lead to delegate	By time of publication of project/activity	Time and staff	
Ensuring target audience is accessed e.g. availability of contact details for dental nurses.	Practical solution to be identified				

5. Risk Management

In this assessment, have you identified any equality and diversity related risks which require ongoing management? If so, please attach a risk register identifying the risks and arrangements for managing the risks.

Any risks identified in this process should be added to the appropriate project or organisational risk register. See the NES risk management guidance for advice on identifying and scoring risks, or take advice from your directorate's risk champion.

None identified

6. Consideration of Alternatives and Implementation

Note that if the impact assessment indicates that a function will negatively discriminate, either indirectly or through discrimination arising from disability, the function must be objectively justified[2]. This may require taking legal advice. If the function is to be objectively justified, outline the justification here, including analysis of any alternatives. See the guidance notes for instructions.

Not applicable

[2] Direct discrimination cannot be justified other than on very narrow grounds in relation to age. If the EQIA indicates that a function discriminates directly, it should not be implemented.

7. Monitoring and Review

Monitoring and review of equality impact should ideally be part of a wider monitoring or review process.

Please explain how the function will be monitored and reviewed, including:

- What data will be collected, at what time?
- What analysis of the data will be undertaken?
- Are there specific targets or indicators to be monitored?
- How will results of monitoring be reported, when, and to whom?
- When will you review the function, taking into account any monitoring information?
- Who will be responsible for leading this review?

Each of the programmes within the Clinical Effectiveness workstream will produce a checklist to be completed for each new project. These will prompt analysis of the data collected during each project and consideration of equality impact at appropriate points in the programmes' respective processes.

The lead for a given project will have responsibility for completing the checklist and for leading the review for that project. The results will be reported to the programme lead.

A review of the equality impact assessment across all programmes in the Clinical Effectiveness workstream will take place after 1 year in the first instance and every 2 years thereafter.

Sign off (by accountable director)

David H Felix

Date 27 April 2016