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EQUALITY, DIVERSITY AND INCLUSION:

Promoting difference and reducing inequality across healthcare

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PROMOTING DIFFERENCE AND REDUCING INEQUALITY ACROSS HEALTHCARE

Covid-19 has impacted communities in different ways and exacerbated health inequalities, but at the same time a new social contract between healthcare services and local communities has emerged. **Udara Ranasinghe** looks at how equality, diversity and inclusion (EDI) will play a crucial role in the transformation of healthcare.

After a period of immense strain and enforced change due to Covid, the UK healthcare system faces a perhaps once in a generation opportunity to reset and transform the system to tackle health inequalities. The pandemic did not create these inequalities but it exacerbated them and shone a spotlight on the need to tackle them as part of rebuilding the system after Covid. None of that is likely to be controversial but what are the levers to affecting change which for so long has eluded the system?

LEADING FROM THE FRONT

Leadership is of course crucial when it comes to delivering on EDI. Leadership figures from public and private practice carry the decision-making authority to drive and enact change, while also serving as sources of inspiration and examples to follow.

The NHS Leadership Academy duly acknowledges that "diversity and inclusion leads to improved health and greater staff and patient experiences of the NHS; and [they] welcome the challenge of enabling staff from all backgrounds to develop and excel in their roles".

Greater leadership diversity creates better decision-making and attracts a more diverse range of people to healthcare professions across all levels, while making a more diverse range of people comfortable in seeking or accessing care. It means that EDI issues infiltrate recruitment and hiring decisions and brings positive challenge and accountability to the wider system. Diverse leaders are more likely to develop new ways to inspire broader groups, and so the snowball effect takes hold.

Whether through having diverse figures in leadership positions, or via leaders of any background serving as EDI champions, the visibility of transformation around EDI is pivotal. Visibility is both powerful and inspirational. Showing that inclusion is being prioritised in visible ways empowers and inspires others to take action and to believe that change is possible.

> *"It's really important that we think about a workforce and leadership that reflects the community it serves,"* says Phil Wood, Chief Medical Officer and Deputy Chief Executive at Leeds Teaching Hospitals. *"Leadership that is more recognisable to communities enhances the sense of connectivity and encourages engagement."*

In Leeds, Wood is working with providers to better understand the barriers people face in terms of getting into leadership positions.

> *"It's a bit of a chicken and egg challenge,"* says Wood. *"You want to avoid tokenism, because that isn't effective. What we need is a pipeline of talent development, linked to a conscious effort to recognise and address some of the EDI issues we need to work on. Senior leaders being very visibly committed to addressing those challenges is an important and powerful message."*

RELATABILITY AND REFLECTING THE EVOLUTION OF COMMUNITIES

Another critical element of the health inequality challenge has ironically been the (lack of) participation of the communities most affected. This focus on not just promoting EDI, but on promoting – and celebrating – it in a visible way, is likely to boost community engagement and allow patients to relate to and trust the healthcare system better.

Nnenna Osuji, Chief Executive of North Middlesex University Hospital and formerly Medical Director and Deputy Chief Executive at Croydon Health Services, as well as Joint Clinical Lead for South West London, notes that North Middlesex is a hospital where roughly 60-70% of staff come from a minority ethnic group. Those staff members are also members of the local community.

> *"It's the very definition of an anchor organisation,"* says Osuji. *"So when we serve our staff, we also serve our local community."*

Osuji says the richness of a workforce helps to attract staff committed to making a difference.

> *"The opportunity to level-up care is there for us to take. That said, the historical and current experiences of our staff from diverse backgrounds has been challenging,"* says Osuji. *"Look at the fact that certain ethnic characteristics and gender characteristics pre-dispose a poorer outcome from Covid. But equally there is a hesitancy among people from within these communities to take up the vaccine. That poses a risk for the future in how we manage and dialogue with staff."*

Through open conversation with staff members and community members alike, breakthroughs can be made. Osuji's emphasis on "dialogue" is important here – the conversation is two-way. Being visible and speaking to the community is not enough. Listening is as important – if not more so. Only through listening and learning can true understanding (and improvement) take place.

> *"One element which has been particularly enjoyable has been having direct outreach conversations with our populations. Not through the interface of a hospital appointment, but through an interface that is uniquely theirs,"* says Osuji. *"To be able to hear first-hand some of the real, lived experiences of what diversity means and what the history of that diversity means in terms of confidence in the system."*

The healthcare ecosystem must hear, understand and reflect the real world around it.

> *"It all comes back to the question of need and mutuality in serving the needs of the populations we're responsible for. That cultural shift is enshrined in some of the legislation particularly picking up on health inequalities, so in terms of how we distribute resources and assets to deliver, that is an important incentive, indicator and driver of change,"* says Osuji. *"Those cultural aspects are going to be big drivers as we move forward."*

As Osuji alludes to, healthcare policy and legislation contained in the white paper, the Long Term Plan and regionally through things like the London Vision, is geared towards facilitating this cultural shift. On the workforce side, one of NHS England's core equality objectives is to improve the recruitment, retention, progression, development and experience of its employees to enable it "to become an inclusive employer of choice".

The Institute for Public Policy Research (IPPR), a policy thinktank, argues that improvement will come from the NHS developing its service, finance and workforce plans by focusing on questions such as "what skills mix is needed for ICSs to improve population health and reduce inequalities?".

IPPR identifies the growth of new roles as key to tackling workforce challenges in the long term, alongside reforming education and training so that all staff have a broader range of skills enabling them to work across different care settings. It also suggests measures including widening entry routes to clinical professions, adopting shorter and more skills-focused training requirements, and increasing access to learning throughout careers.

> *"These reforms will increase the quantity and the diversity of the workforce in the long term,"* says the IPPR's 2021 State of Health and Care report.

Potential reform of legal frameworks around employment policies might also improve recruitment and workforce issues, says Ben Morrin, Deputy CEO of Barking, Havering and Redbridge University Hospitals NHS Trust.

> *"Positive action allows us to think about improving how we bring talent on. Unless we are more radical in how we think about that, we are more likely to take incremental steps in improving diversity and leadership across our systems, as opposed to the more radical options which the best organisations, within and beyond the UK, are taking,"* says Morrin.

However while the 2010 Equality Act allowed a slightly broader approach to positive action, it is still very much curtailed under current UK law and so employers need to approach positive action with care (or be on the wrong side of discrimination claims from those disadvantaged by positive action policies).

NO ONE-SIZE-FITS-ALL

On the care provision side, delivery must be responsive to the needs of the local population. As my colleague **Charlotte Burnett explores**, successful healthcare delivery requires an appreciation for nuance. Sometimes, even local isn't local enough.

> *"The city's overall ambition around health is to improve the health of the poorest, the fastest, so actually just to talk about Leeds as an amorphous city is itself not local enough if we want to address health inequalities and improve outcomes,"* says Wood.

For figures like Wood operating across a large city, the needs of the most deprived communities are very different to those in the least deprived communities, so engagement and service provision must cater to that.

> *"The pandemic and its repercussions have widened those inequality challenges. The ability to work-from-home, to self-isolate, to look after children who aren't in school,"* says Wood. *"The pandemic has highlighted the vast gap within a city like Leeds, let alone between cities around the country."*

The link from diversity and inequality challenges to health inequalities is easy to see. Communities that are excluded on the grounds of ethnicity, income or other equality metrics are in turn more likely to suffer widened health inequalities because of a failure to reach and engage them.

The vaccination programme highlights some of these issues, as well as showing the shortcomings of broad-brush labels. Terms like Black, Asian and minority ethnic (BAME), risk obscuring the appreciation of nuance discussed earlier. While, for example, Pakistani, West African and Caribbean communities would be captured by the term 'BAME', those communities do not function and operate in the same way.

> *"Setting up a model which was never going to be one-size-fits-all inevitably produced disparities between different groups,"* says Wood. *"Talking about the BAME community was in itself unhelpful because, when you break the data down, vaccine uptake levels were vastly different within different communities."*

Vaccination engagement has been boosted by linking with the power of local community leaders, harnessing voices and locations that those communities trust and are comfortable with. Wood says this can be extrapolated to apply in other health and care settings.

"At the moment we have a one-size-fits-all model – you go to a GP, to a hospital or community service centre. But we have to think about the different community issues that make people more or less likely to engage with those locations. The vaccine programme has shown us how important that is if we are to make a difference."

Richard Graham, Clinical Director at digital mental wellbeing organisation Good Thinking, agrees that the pandemic has shone a light on this potential pivotal moment.

"There is an opportunity to look at the dark side of health – the bit we don't see because it doesn't come to the door or make the appointment," says Graham. *"That's the opportunity, if we are to have a substantial and positive public health response to Covid."*

'Bridge-building' – both generally and in relation to digitisation – is a key phrase that must be a core tenet and not a mere buzzword. If access and engagement are to improve, the sector cannot be preaching to the converted – that is, directing resource and effort towards those people who already want to access services. Awareness, access, trust and comfort are key to engaging harder to reach communities. This means diversifying tactics and services, rather than trying to provide more of the same to areas which are perceived to suffer from health inequalities. Graham notes the impact of this in relation to mental health service provision.

"Good Thinking, with support from Public Health England, took a stance of asking why we weren't more curious about the 75% who weren't already engaging. It isn't simply a matter of capacity," he says.

Greater tailoring of service provision to 'new' users is required, and it has to strike a chord.

"People have a preference for different types of support. People want something that is specific to their life – their time or stage of life, the issues they face," says Graham.

TRACKING SUCCESS

There is more bridge-building to be done to create environments where people don't fear judgement, and can co-create solutions. But what do successful solutions look like and how can progress be measured? There is a role for data, and bodies like the Race and Health Observatory and Equality and Diversity Council not only keep eyes fixed on the issue through advocacy, but also through the provision of survey and experience data.

Cold, hard facts provide a powerful mandate for change.

"It's one thing to have awareness of an issue and say 'something must be done' but another thing to be faced with the clear reality of people's experience of discrimination, particularly within your own organisation," says Wood. *"It's powerful for senior leaders to see the reality of people working within the organisation and to challenge ourselves to improve that experience."*

Such non-adversarial challenges to authority are helpful, and metrics (whether that is data or anecdotal information) bring the accountability that is needed to break down echo chambers and draw in external viewpoints. Osuji notes the impact of greater information sharing during the height of the pandemic.

"Working in a knowledge void, there was a shared problem but also, as a result, a shared hunger and want for knowledge, as well as sharing of knowledge. The facilitation of information being shared with the right purpose was a great enabler of how everyone worked together at place and system level," says Osuji. *"Those open, honest, challenging conversations allowed us to compare and better understand if inequalities were developing in terms of what we were delivering, so we could redress and take action."*

This type of behaviour that is organisation-agnostic and includes the entire healthcare system is critical to avoid unwarranted

variation. Morrin echoes this sentiment around the formation of strong alliances being formed with openness and information-sharing at their heart.

> *"When you have united working, focus and the mood to inspire, you can best utilise the resources you have for populations,"* says Morrin.

CELEBRATING AND RAISING THE BAR

Promoting difference and reducing inequality is clearly a work-in-progress and celebrating diversity and approaching it with a positive mindset is an important part of the cultural transformation process.

> *"I'm excited but cautious,"* says Osuji. *"I hope this isn't a flash in the pan, and actually something that is embedded in how we move forward and captured in the way we think and measure what we do. EDI must be right at the centre of recovery when it comes to the contribution to economic and social development of place, borough, community and of the whole system."*

Osuji adds that, too often, people speak about diversity as if it's a problem.

> *"It's an opportunity, and one that brings with it amazing celebration, richness and difference,"* adds Osuji. *"Difference always raises the bar in the way we think, approach and solve problems."*

The UK Healthcare system is at a pivotal point. The pandemic combined with structural changes to focus on population-based health solutions, provide a once in a generation opportunity to tackle long-standing health inequalities. While the problems may appear daunting, it's clear that many of the answers are out there already.

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