

Guest editorial

Equality delivery in the NHS

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The NHS in England is facing its biggest ever challenge, with a £20 billion productivity requirement alongside huge pressures facing the social care system and the need to continue to drive up quality of care and health outcomes. In addition to those pressures are connected issues of reorganisation and the move towards a model of clinically led commissioning.

It is necessary both for reasons of legal obligation and because of the business case to engage with the challenges of equality and diversity. The NHS is an important part of our society. Its core principles are that it is free at the point of use and available to everyone on the basis of need, not ability to pay. The programme for the NHS has been developed in detail in the Department of Health's overarching White Paper, *Equity and Excellence: liberating the NHS* (Department of Health, 2010). The programme set out in the White Paper is rooted in the Government's intention to put patients first, to achieve among the best health outcomes in the world, and to empower clinicians to innovate and take decisions based on their clinical judgment. A patient-led NHS is one which involves all patients in the development of services that meet their needs and take account of their lifestyles, backgrounds and characteristics. Setting out that intent more explicitly that fairness should be a cornerstone of the new direction, the White Paper includes *equity* as part of its description.

Despite this, there is evidence of uneven access to and take-up of healthcare, wide variation in needs and inequitable outcomes. The first principle of the NHS Constitution reiterates the significance of rights, responsibilities and fairness in provision of services.

The Equality Act 2010, and obligations under the European Convention on Human Rights, mean that issues of social exclusion, whether caused by socio-economic inequality, as highlighted by the Marmot Inquiry (Global Health Equity Group, 2010), or due to inequalities linked to ethnicity, gender, disability, age and sexual orientation, are central to its mission to deliver improved health and healthcare to all of its users, and indeed all residents of the UK.

We highlight here two particular programmes, the Equality Delivery System (EDS) and the Personal, Fair and Diverse (PFD) campaign, both of which are designed to support NHS trusts in improving their equality performance for patients, communities and staff, whatever their background.

As Europe's largest employer, the National Health Service must act as a leadership beacon for others to emulate. The NHS needs to be the employer of choice for the populations that it serves, attracting and retaining the most talented staff and engaging a wider range of perspectives, voices, knowledge and expertise. And for those staff whom it recruits, personal and professional development and updating will be a priority need. It is estimated that between 2009 and 2014, women will fill five out of ten of the new jobs in the UK. In addition, between 2001 and 2005, ethnic minorities accounted for over 80% of the growth in the working-age population of England. Furthermore, there are 10.8 million disabled people in the UK, which corresponds to around 20% of the population (Family Resources Survey, 2008), and one in eight UK employees has a disability (Labour Force Survey, May 2009). The demographic of the UK's population is clearly evolving and, as such, it is important that the NHS is well equipped to ensure that its organisations and agencies are reflective of the communities that they serve and deliver appropriate services to all.

In addition to these ideals, there is a legal imperative placed by the Equality Act 2010 which came into effect from 1 October 2010. The act placed a general duty upon the NHS to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between different groups, and foster good relationships between different groups. Furthermore, the NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, the public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

So what is the reality? The main types of data and information relevant to diversity and equality available to the NHS centre on those that evidence discriminatory outcomes with regard to patient access to services, patient and staff experience, and the correlation between staff satisfaction and patient experience. For instance, examination of the data relating to patient access to services reveals that 25–50% of adult mental health disorders are potentially preventable by treatment during childhood or adolescence. People with mental health problems have much higher rates of physical illness, with a range of factors contributing to greater prevalence of, and premature mortality from, coronary heart disease, stroke, diabetes, infections and respiratory disease (Friedli, 2009). Similarly, 42% of gay men, 43% of lesbians and 49% of bisexual men and women have clinically recognised mental health problems, compared with rates of 12% and 20% for predominantly heterosexual men and non-lesbian women, respectively (Warner *et al*, 2004).

At the same time, the GP Patient Survey results for 2009/10 revealed variations in satisfaction levels according to ethnicity. Patients who were very satisfied with the care from their GP or health centre were predominantly those who reported their ethnicity as Irish (60%) or white British (56%), compared with those who described themselves as Chinese (27%), Bangladeshi (28%) and Pakistani (29%) (GP Patient Survey, 2009/2010). In addition, transgendered people are likely to have inadequate or inappropriate access to services (EHRC Tran's research review, 2009). Lesbian women are more likely to self-harm or suffer from eating disorders, and are less likely to take up health screening tests, than heterosexual women (Stonewall 'Prescription for Change', 2008). Furthermore, from an age perspective older people are less likely to receive screening and appropriate treatment for a range of conditions in both primary and secondary care than younger adults (Centre for Policy on Ageing, 2009).

From a staff perspective, the evidence indicates that some staff are experiencing discrimination, bullying and harassment from fellow colleagues, patients and their families. Indeed the NHS experiences very high rates of staff absence and a high turnover rate, which are estimated to be costing the NHS approximately £1 682 048 391 and £766 077 482.6, respectively, a year (NHS Health and Wellbeing, 2008). Also, looking at research that puts together both patient and staff experience indicates that high levels of bullying, harassment and abuse of staff by outsiders relates to many negative patient experiences (Dawson, 2009). Similarly, in a report published in August 2011, based on the NHS staff survey results, researchers analysed how, over time, the experience of NHS staff at work is linked with performance measures that illustrate the quality of care that NHS trusts deliver. The research demonstrated that the higher the proportion of staff from

a black or minority ethnic (BME) background who reported experiencing discrimination at work in the previous 12 months, the lower were the levels of patient satisfaction (West and Dawson, 2011).

To address the above issues, the NHS has invested resources in two important programmes.

First, the Equality Delivery System (EDS) (www.nhsemployers.org/EmploymentPolicyAndPractice/EqualityAndDiversity/Pages/TheNHSEqualityDeliverySystem.aspx) was designed as a means of helping the NHS to improve its equality performance for patients, communities and staff, whatever their background. The EDS is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. In addition, it will help NHS trusts to deliver on the Government's commitment to localism and local decision making (Department of Health, 2010), and to deliver on the Government's commitment to fairness and personalisation, including the equality-focused rights and pledges of the NHS Constitution (Department of Health, 2010). Adopting the EDS will also support the adaptation of the principles, objectives and requirements of the Human Resources Transition Framework (Department of Health, 2011), and help providers of services to comply with the public-sector equality duty and respond better to CQC Essential Standards of quality and patient safety.

The EDS, and previous coverage relating to legalisation and surveys, represent measurement and compliance from a strong regulatory perspective. This is important, but it is also crucial to try to engage staff from the 'bottom up' and from a 'hearts and minds' perspective.

This approach is why NHS Employers recently launched the Personal, Fair and Diverse (PFD) campaign (www.nhsemployers.org/pfdchamps). This reflects growing literature around the 'social movement theory' (www.institute.nhs.uk/images//documents/BuildingCapability/NewModels/social%20movement/nhs_social_movement.pdf), which highlights the importance of working right from the start with the groups of people who might adopt the changes to design services and delivery approaches in their language context and meeting their exact need. The PFD campaign aims to create a vibrant network of champions, who are committed to taking some action to help to turn the vision of a Personal, Fair and Diverse (PFD) NHS into a reality. The campaign is about doing whatever people can in their day-to-day jobs to improve patient experiences and to create fairer, more inclusive working environments.

Champions from across the NHS have signed up to the campaign and are sharing with others how they have taken responsibility and promoted equality and diversity in their day-to-day roles. The following gives

a flavour of the various activities in which champions have been engaged.

‘I arranged an awards ceremony to highlight organ donation within Asian communities.’

(Jagtar Singh, Non-Executive, Luton and Dunstable Hospital)

‘I helped to organise a hugely popular HIV and LGBT fundraising and awareness-raising event every year in Lancashire which involves hundreds of people from all diverse backgrounds.’

(Clive Taylor, Lancashire Care NHS Foundation Trust)

‘To forward BME issues I held a social event in the trust.’

(Anand Pilai, East of England Ambulance Service)

All of these provide opportunities for work-based learning, and highlight the importance of individual, personal responsibility and action for improvements.

It is because of these examples and experiences that we believe that every opportunity should be taken to ensure that all research and ‘best practice’ publication should incorporate opportunities for the reader, especially if they are staff responsible for planning, commissioning or delivering health and care services, to reflect on the implications for their own actions and practice, and to gain accreditation for this against their regular appraisal and professional development targets. We are pleased to learn that the journal *Diversity and Equality in Health and Care* will be seeking to highlight the learning points and providing self-test or reflection prompts to a carefully chosen set of the research and development papers that it carries in future.

To support further CPD, we would encourage you to consider the following questions:

- Can you describe the three public-sector equality duties in line with the Equality Act 2010?
- What is the relationship between patient satisfaction and staff satisfaction?
- What is the purpose of the NHS Equality Delivery System (EDS) and how can it help to deliver a more personal, fair and diverse NHS?
- What is the underlying philosophy underpinning NHS Employers Personal, Fair and Diverse programme?

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