Why is Equality, Diversity and Inclusion critical for Leaders in GM?

Samina Arfan, Strategic Equality Diversity & Inclusion Lead, Heywood Middleton and Rochdale Clinical Commissioning Group

It's only by recognising the diversity of our populations and ensuring equal access to services and equal outcomes, that we will reduce long-standing inequalities in areas of employment, health and social care, education, early years, community justice, enterprise and skills.

As the public and voluntary sector organisations working towards place-based approaches to deliver public services to our diverse communities, there is a sizable risk that the link between equality, diversity and inclusion on one hand and inequalities on the other are missed, further widening disparities between groups.

Engaging our diverse communities and staff to be genuine partners in shaping what happens across the Greater Manchester localities needs to be viewed within the lens of acquiring a more textured understanding of local demographics.

While the focus and ambition across GM is, quite rightly, our ability to tackle together the underlying determinants of poor health outcomes across the life course and demonstrate what it is to be a 'Marmot City Region.' We need to develop approaches with an equal focus on services, based on responding to the diversity of the local populations. This requires developing our leaders and staff to improve equality, diversity and inclusive approaches by addressing bias, barriers, stereotypes and the impact of discrimination.

As leaders, we must reconcile the need to tackle deprivation to address inequalities for those in greatest need, whilst addressing the inequalities LGBT people or disabled people may face. These individuals may not happen to live in deprived communities, but still experience unequal access to services and therefore, poorer outcomes.

Taking the example of equality in the context of dementia, evidence shows that there are five population groups in which challenges arise:

- Age – younger onset dementia (under the age of 65 years).
- Race and ethnicity – black or minority ethnic/black Asian or minority ethnic (BME/BAME).
- Learning disabilities.
- Lesbian, gay, bisexual and transgender (LGBT).
- Disability – sensory impairment and socio-economic.

When we look at what research tells about BME/BAME communities, we know*:

- Dementia is increasing faster than for the white British community.
- Inequalities due to deprivation impact on BME/BAME people living with dementia and their families.

- BAME users face challenges within the dementia pathway at all stages, from prevention through diagnosis, care and end of life.
- Knowledge of dementia is still quite poor across communities/professionals.
- Carers are poorly supported.

Addressing such complex problems requires leaders to understand that our communities don't have the same starting point. Finding solutions and strength-based approaches may need to be addressed at multiple levels. Equally, it's important to reconcile population health information with equalities data and the lived experience to provide that more in-depth insight into our communities.

Within this context, inclusion within our public services require a more textured understanding of local populations. Our decisions must be based on knowing the diverse needs of our communities: whether they are an affluent, mainly white, living in a middle-class suburb, or a deprived ward with a more ethnically diverse population. If our approaches are not inclusive of the nuances of local needs what is the point of doing it locally?

* *Dementia and Black, Asian and Minority Ethnic Communities: Report of a Health and Wellbeing Alliance project 2018*