Diversity and Cultural Awareness in Nursing Practice

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Edited by
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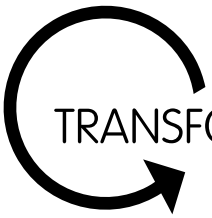

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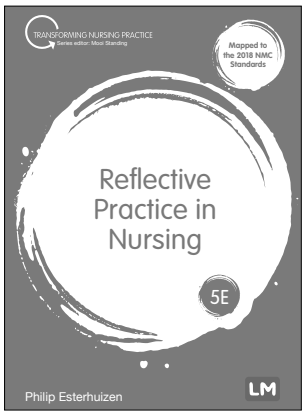

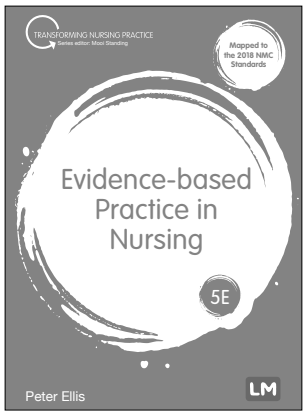

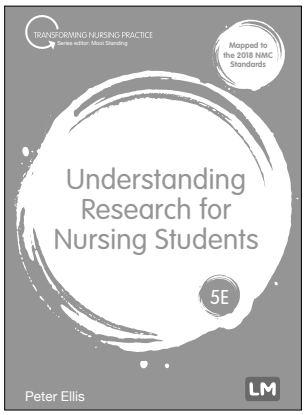

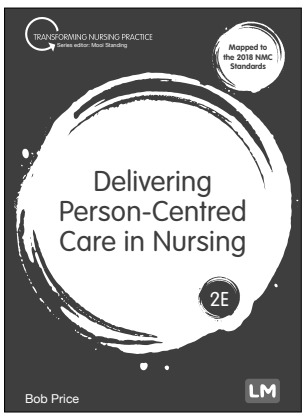

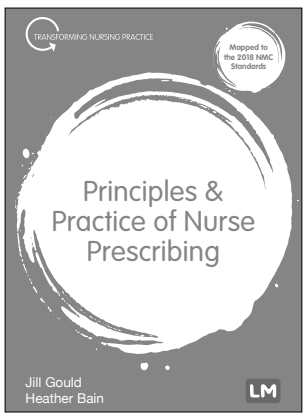

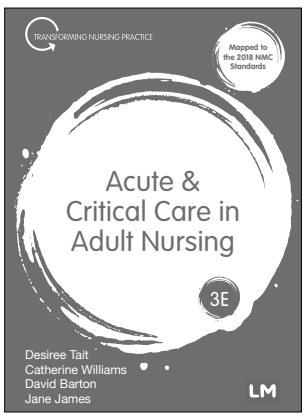

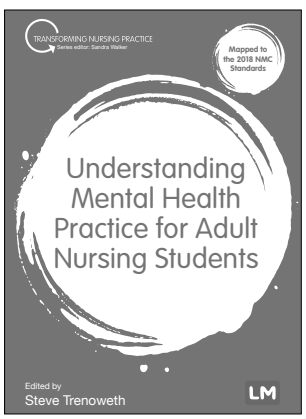

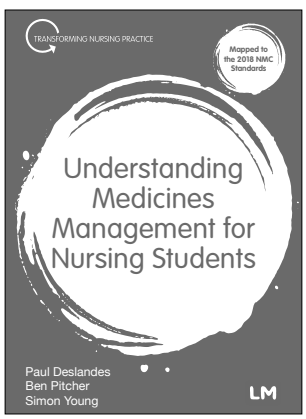

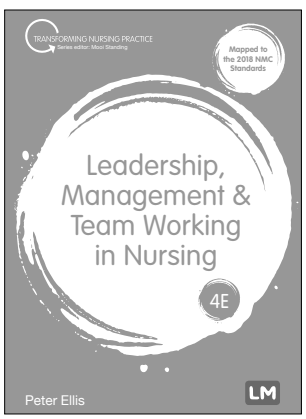

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Chapter 2 Diversity and cultural concepts of health

Beverley Brathwaite

NMC Future Nurse: Standards of Proficiency for Registered Nurses

This chapter will address the following platforms and proficiencies:

Platform 1: Being an accountable professional

1.4 demonstrate an understanding of, and the ability to challenge, discriminatory behaviour

1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence their decisions.

Platform 2: Promoting health and preventing ill health

2.2 demonstrate knowledge of epidemiology, demography, genomics and the wider determinants of health, illness and well-being and apply this to an understanding of global patterns of health and well-being outcomes.

Platform 7: Coordinating care

7.9 facilitate equitable access to healthcare for people who are vulnerable or have a disability, demonstrate the ability to advocate on their behalf when required, and make necessary reasonable adjustments to the assessment, planning and delivery of their care.

Chapter aims

After reading this chapter, you will be able to:

- explain what health is and how it relates to diverse members of the population;
- define the terms 'epidemiology', 'demography', and 'genomics';

- understand how power in relation to racism, prejudice, discrimination, and stereotyping affects healthcare outcomes for diverse groups; and
- understand determinants of health and inequality of health, and the impact of these within diverse groups.

Introduction

Case study: Cunningham Street continued

Let us go back to Cunningham Street, with its inhabitants of differing ethnicities, cultures, faiths, religions, sexualities, and intellectual abilities. Anish, of Asian descent, lives at number 35, and his wife is due for her first annual smear test. Karen at number 12, who is white, has been experiencing vaginal discharge for the past month and is worried, but she is reluctant to go to the GP as the practice nurse previously asked questions about her personal life with her wife. A middle-aged man who identifies as Roma is experiencing ongoing joint pain and is trying to get an appointment at the GP practice at the end of the road. At number 2, Olufunke's mother, who is of Nigerian descent, has high blood pressure. At number 5, Jennifer, who is a young woman of Caribbean descent and is on the autistic spectrum, is worried about her friend Jordan, who is of dual heritage and who is struggling to manage her new life following a below-knee amputation.

These residents on Cunningham Street all have health needs that require evidence-based clinical knowledge that is specific to their ethnicity, culture, sexuality, disability, and intellectual abilities.

In this chapter, we will be addressing health as a concept, and how it has changed over time, as well as looking at how the experiences of health and healthcare differ between members of the community. There have been some changes on Cunningham Street since the COVID-19 pandemic arrived in early 2020 and its residents have experienced multiple lockdowns, working from home, and delayed treatments (along with the emotional and psychological impact of this). The impact of the pandemic on 'normal' healthcare delivery, health outcomes, and negative experiences that can occur from within the NHS, as well as the drivers for these experiences, will be examined. We will also consider health both internationally and nationally from a diversity perspective. People from communities such as those that have been discussed already are more susceptible to certain health conditions, outcomes, experiences of healthcare, and differing life expectancy than the general population. Reasons for inequitable outcomes, such as COVID-19, determinants of health, institutional racism, and stereotyping based

on ethnicity, gender, LGBTQIA+ people, disability, and LD will also be examined. The legislation used to combat discrimination and the terminology used will be addressed.

What is health?

Many people in contemporary times regard health as one of the most precious values in life (Nordenfelt, 2007). However, for some diverse groups, health is experienced in different ways. It is important to understand how stigma, determinants of health, and social determinants can influence the health outcomes and personal experiences of culturally diverse patients. It is influenced by national/international evidence and guidance, and individual interactions. It may seem that you have little control over all of this, but you have more influence than you think. As student nurses, you represent the NHS every day and your interaction with patients makes a significant difference. This should never be underestimated. The more positive the interactions are between you and your patients and their families, significant others, or carers, the bigger the effect on their health in the short and long term. Therefore, this chapter will endeavour to bring together international ideas and key terms that heavily influence national legislation, policy, and care delivery that affect all patients and service users. It will take into consideration the distinctive needs of certain diverse groups. First, let us look at the idea of what 'health' means and how this has changed over time by considering definitions from a variety of organisations:

> *A state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity.*
>
> (WHO, 1948)

> *A healthy person is someone with the opportunity for meaningful work, secure housing, stable relationships, high self-esteem and healthy behaviours. A healthy society, in turn, is not one that waits for people to become ill, but one that sees how health is shaped by social, cultural, political, economic, commercial, and environmental factors, and acts on these for current and future generations.*
>
> (Health Foundation, 2018, p7)

> *A structural, functional, and emotional state that is compatible with effective life as an individual and as a member of society.*
>
> (McCartney et al., 2019, p9)

There has been a shift away from the term 'complete' used by the World Health Organization (WHO, 1948), which would indicate that if you have a manageable long-term condition, you can be considered healthy. Health is not static and will need to incorporate cultural factors and the ability for people to re-establish a sense of well-being that may have shifted due to physical, mental, and social changes (Naidoo and

Willis, 2022). The transformation of what health can mean has coincided with the change in the diversity of the population both internationally and here in the UK. In parts of the country, differing ethnic, cultural, and religious groups interact with each other as never before. The Health Foundation (2018) gives a broader idea of health within the context of the patient being a member of society, focusing on how that person interacts in society, and considers what can be done to reduce ill health before it happens, with a clear acknowledgement of how society can shape how this happens. McCartney et al. (2019) consider society but appreciate that an individual is a member of society and that the two are inexplicably linked. COVID-19 highlighted the issue of the individual and society in relation to following lockdown restrictions or taking the COVID-19 vaccine – both are based on an individual's health choice, but affect the health of not only the individual but the population as a whole.

Demography and health can give us a better understanding of the distribution of health within a given region and group. With this information, decisions about how, where, and on whom resources are spent can be made. We will take some time to look at health issues related to some of these groups.

Gypsy, Roma, and Travellers

GRTs are now part of the census data; they were finally added as an ethnic group in the 2011 census. The current estimated size of the population is between 100,000 and 500,000 (Parliament UK, 2019). There has been continued research taking place into their healthcare needs, including older members of the community (Burchardt et al., 2018; Lane et al., 2019).

There are multiple issues related to health and social exclusion that are experienced by GRTs. They are more prone to long-term conditions, and have a higher perinatal infant mortality rate of all ethnic minority populations, as well as higher levels of stress, anxiety, depression, and smoking, and increased alcohol consumption (Cromarty, 2018; Gill et al., 2013). They suffer poorer physical health and poorer access to health and primary care services (EHRC, 2016a). For the GRT community, accessing healthcare is difficult. One reason is their nomadic lifestyle, which means that registering with a GP, and even access to a dentist, can be a challenge. The health issues for this community run throughout the life span from birth, with this group having the highest maternal death rate of any ethnic group, and young children are more at risk due to lower immunisation rates. GRTs live in caravans and houses and still experience *accommodation insecurity* which leads to serious poor health outcomes (Sovacool and Del Rio, 2022).

Greenfields (2017, p25) identified practical and administrative challenges for GRTs, as well as a lack of appropriate documentation, including adequate citizenship documentation, which affects entitlement to services following recent migration and entitlement

to welfare. Limited access to or awareness of NHS entitlement is exacerbated by low literacy levels. It is also worth adding that evidence has identified fear of racist attacks and abuse, and racial discrimination and prejudice which worsen their interactions with society and healthcare (Taylor and Hinks, 2021; Lane et al., 2019). More on the experiences of GRT can be found in Chapter 7.

LGBTQIA+

The term LGBTQIA+ covers a wide range of communities that have similar and differing needs and differing levels of understanding of those needs. For example, is the life of a trans woman the same as a gay man's? It's important to remember that although many communities regrettably face disadvantages and discrimination, this does not mean that their needs are the same. As with any patient, asking questions is important, but more important is what and how you ask. What a patient would like to be called is an obvious first encounter question, but we also need to think about what pronouns our patients want to be identified as and when told follow this through consistently.

Globally, the LGBTQIA+ community must combat discrimination, violence, and criminalisation as same-sex relationships are illegal in 69 UN member states (ILGA, 2020b). Although transgender people have existed across history and cultures throughout the world, transgenderism and transsexualism are considered abnormal in many societies as they diverge from the predominant normative male–female binary that exists across the world (Wylie et al., 2016). The United Nations High Commissioner for Human Rights states that human rights law is obligated to protect all people from discrimination on the grounds of gender identity. This is not always the case, and to determine the experiences of the LGBTQIA+ community in the UK, the Government Equalities Office carried out a national survey in 2018 (see link in useful websites for results of the survey). Possibly based on this information and the British Mental Health Association clearly being against all types of conversion therapy, the British Government are looking into the legalities of conversion therapy.

In relation to Platform 7.13 of the NMC Code, it is necessary for you, as a student, to appreciate the political context and wider determinants of health from which your patients come and in which they find themselves with you and the NHS. For example, the fear of physical violence is an unacceptable reality for many in the LGBTQIA+ community in Europe and the UK (Clark, 2014). The damaging effects of hate crimes against members of the LGBTQIA+ community not only affect their physical but also their emotional and psychological well-being (Jurcic, 2016). Your first encounter with an LGBTQIA+ patient could be in the emergency department, where physical needs would need to be addressed, but where it could also be an opportunity to help with emotional and psychological needs. When a trans person is going for reassignment surgery a non-judgemental and open approach will only benefit their journey. Overall, heterosexuals fare better in healthcare, while bisexuals have the worst experiences,

and gay and lesbian people have poorer mental health (Booker et al., 2017). In the longer term, it may be that mental health services are best suited to support the emotional and psychological trauma that can result from experiences of being part of the LGBTQIA+ community. For example, there is a higher risk of suicide and attempted suicide (Peate, 2016). This must not be underestimated as a significant and possible outcome if appropriate support and interventions are not put in place. Bachmann and Gooch (2019), the RCN (2016), and Robinson (2019) have acknowledged the discrimination that LGBTQIA+ patients experience from healthcare professionals. The RCN (2016) has provided a clear policy to reduce this discrimination. It is your responsibility and accountability once registered with the NMC to deliver care equitably. Bristowe et al. (2018) found that the impact of discrimination on the LGBTQIA+ community's health covers their life span. They have a higher risk of some cancers and greater all-cause mortality than heterosexual people. They often present later in the treatment and disease pathway, have unmet bereavement needs, and have a higher rate of mental illness and risky behaviours (e.g. drinking, smoking, drug use) that are linked to discrimination. This discrimination could lead to a reluctance to seek and adhere to effective follow-up or community care and to experiencing poor levels of care while in treatment (Glasper, 2016; RCN, 2016). During COVID-19, self-harming increased due to the social isolation caused by lockdown measures (Phillips, 2021). The effects caused by lockdown and continued discrimination will require you as a nurse to create welcoming and non-judgemental encounters and environments for these service users.

Learning disabilities

A learning disability (LD) is a reduced intellectual ability and an increased difficulty with everyday activities – for example, household tasks, socialising, or managing money – which affects someone for their whole life.

People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complicated information, and interact with other people (Mencap, 2022). The term intellectual disability is also used (Cluley, 2018).

Current research has found that health and social care professionals do not feel comfortable working with people with learning disabilities due to a lack of knowledge about their needs (Ee et al., 2021). Feeling uncomfortable and having diminished knowledge will absolutely impact on the problem-solving and decision-making of clinical teams and their care delivery to patients with LDs. Evidence also indicates that the reasons for the poorer health of people with intellectual disabilities primarily fall within two broad spheres. First, a range of secondary health conditions is associated with the specific causes of intellectual disabilities. Second, people with intellectual disabilities are much more likely than their non-disabled peers to be exposed to a range of well-established social determinants of poorer health (e.g. poverty, social exclusion, discrimination, and reduced access to timely and effective healthcare) and a lower life expectancy (LE)

than those without a LD (University of Bristol, 2021). These are the stark and unacceptable realities of children and adults with LDs. British adults with a LD have a distinctly poorer quality of health than their non-disabled peers (Scottish Learning Disabilities Observatory, 2021). There is also a higher relationship between physical and mental health problems among those with LDs than among the general population (Hatton et al., 2017). As a student nurse of any field, adult, child, mental health, and of course LD, it is extremely likely that you will be providing care for a patient with a LD, and in a variety of different sites of care delivery poor patient safety outcomes continue to be an issue and it is for us as nurses to do better (Louch et al., 2021). A therapeutic relationship between patients who have a LD and their caregiver/support system is an important aspect of care that is crucial for creating and maintaining a safe environment. The community setting is also an area for care delivery for many patients with a LD in their homes and specialised care facilities. The multidisciplinary team (MDT) is, not surprisingly, frequently utilised in care delivery with patients who have mild to severe LDs.

As a member of the MDT, it is important that you know the other members and their role in delivering care holistically to the patient, carers, and family. You will need to know when to refer and the reason for the referral. Activity 2.1 will allow you to think about which members of the MDT are involved.

Activity 2.1 Teamworking

Make a list of the MDT members who can be involved in the care of patients with learning disabilities and what role they would take in their care.

An outline of what you might find is given at the end of the chapter.

Activity 2.1 demonstrates that you must have identified multiple members of the MDT with whom you have worked already or know of the vital role they play. The need to work as a member of the healthcare team in providing the best possible care for this group of patients is an ongoing skill, as new roles are developed particularly to enhance care for patients with learning disabilities.

Due to medical and societal advancement, there has been an increase in the life expectancy of people with LDs (Welsh Government, 2018; Dolan et al., 2021). However, members of the population with LDs continue to have a lower life expectancy than the general population (Dolan, 2021). The mortality rate of people with LDs is complex and incorporates issues of age, gender, ethnicity, deprivation, and type of LD. Table 2.1 highlights some of the common causes of mortality and the relationship between health problems associated with having a LD.

Health Problem	Cause of Death
Neurological disorders – Epilepsy	Seizures / convulsion
Dementia	
Gastrointestinal problems	Aspiration
	Constipation
	Colorectal cancer
Respiratory problems	Bacterial and aspiration pneumonia
	COVID-19
	Lung Cancer
Cardiac circulatory problems	Congenital cardiac dysfunction

Table 2.1 Health problems and cause of death associated with learning disability (Tyrer et al., 2022; University of Bristol, 2021)

Due to these complex issues, many people with LDs can have more obstacles to identifying health problems and getting treatment for them. For example, autism can be identified as a LD (although some argue it is not) but understanding an individual's detailed, long-term diagnosis, where they are on the autistic spectrum and how this impacts them both physically and mentally is essential for giving individual patient care (O'Brien and Pearson, 2004).

Annual LD health checks have been a key part of NHS plans to improve care and health for people with LDs and reduce premature mortality since 2008, but unfortunately some evidence suggests it has not helped to reduce the mortality rate (Tryer et al., 2022). Communication, as well as patients not understanding what is happening to them and why, can make it difficult for you to make an accurate clinical decision. There are many identifiable types of LD, for example, Down's Syndrome, but there is not always a physical attribute that may indicate that a LD affects your patient. Even if there is such an attribute, it can be challenging to ascertain the individual's level of understanding of what they are being told or asked. This could easily be misunderstood as incomprehension or uncooperativeness. Hatton et al. (2017) state that *there may be uncertainty over patients' capacity to consent to interventions and a lack of understanding of the legal requirements for proxy decision-making if they cannot* (p24). This is another area where the family, caregivers, and support workers are vital to aid this process. Areas of best practice in which to aid care delivery to patients with LDs have been identified as:

- *Taking a person-centred approach to care and support.*
- *'Joined-up' working with good communication between those involved.*
- *The involvement of families.*
- *Responsiveness to a change in a person's health.*

(University of Bristol, 2020).

Activity 2.2 Evidence-based practice and research

What is a learning disability? We have discussed a lot about people with LDs but what exactly are LDs and is there any other terminology that can be used instead of or with LDs?

Find the answers to the following questions on the NHS and Gov.uk websites:

1. What is a learning disability?
2. What causes LDs?
3. What does PMLD stand for?

Having gone through this process you will see how multifaceted both the LD community and the terminology used to describe it is.

An outline of the answers is given at the end of the chapter.

There is an unfortunate similarity in the health outcomes and experiences of patients with LDs and other forms of disability, as we will look at now.

Disability

As with other communities, the term 'disability' covers a wide range of characteristics. Historically disability was thought of as a direct consequence of sin or fault or arising due to some inadequacy of the individual (Bunbury, 2019). As they should, contemporary ideas around disabilities have changed but these old ideas still linger and influence how people with disabilities are treated today. The Equality Act defines disability as a physical or mental impairment, where the impairment has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities (Equality Act, 2010). Consider what we as healthcare professionals think about this definition, or what the patient/service user thinks. Our ideas could be very different, and you must remember that patients may see themselves differently from you as they have every right to. It is the healthcare professional's duty both professionally, legally, and as a member of society to see beyond the disability and see the whole person. There are also hidden disabilities that are not physically apparent. One example would be someone going through cancer treatment. Smith (2021, p74) gives a useful discussion on her personal journey with cancer and how she was treated by friends and colleagues. One of the main areas for her and others is 'that many disabilities are misunderstood and the lack of understanding and awareness results in discrimination'.

The following scenario gives an example of an adolescent with a new disability and how you would try and address not only the physical but the emotional needs.

Scenario: Jordan, a teenager newly disabled

Jordan Owusu, who is 16, had a below-knee amputation at the beginning of the first COVID-19 lockdown due to osteosarcoma in the lower tibia bone. They are finding rehab and managing their new life difficult both emotionally and physically. Unfortunately, the amputation wound has broken down due to infection. You are a children and young people's student nurse in your second year and have gone with your practice assessor (PA) to review the wound on the ward. Jordan had to be admitted for intravenous antibiotics and monitoring as there was a concern that sepsis could be an issue. When you go to tell Jordan that you would like to renew the dressing, it is obvious that they have recently been crying. You draw the curtains around Jordan, quietly state that it looks like they have been crying and do they want to share why to see if you can help. Jordan says that they are experiencing sadness, anger, and frustration about the amputation, and are worried about how non-disabled people view them, particularly family and friends.

The following activity will help you think about what you can do in more detail.

Activity 2.3 Decision-making

What do you and your PA do to help, and who else could be involved?

1. Immediately
2. Longer term

An outline of what could be done is given at the end of the chapter.

The scenario also shows that disability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life. Over 1 billion people currently experience disability, with this number increasing due in part to population ageing and an increase in the frequency of non-communicable diseases (WHO, 2022c).

Diversity: epidemiology, demography, and genomics

There are key terms within Platform 2.2 that deserve to be addressed as they can be aligned with the understanding of issues relating to the changing British population. Demography is the way in which a population is studied to determine the causes of

health and disease. Key components of studying the demography of a population are morbidity, mortality, migration, ethnicity, class, and gender. Epidemiology has a close relationship to demography as it is the study of a population and how often disease occurs in different groups within that population (Gurdasani et al., 2019). An example would be to consider a single group – say transgender, women or men, people with LDs or another disability – and then look even closer by separating women by ethnic group or age and determining what disease or illness rates occur in these particular groups, and what targeted prevention or care delivery needs to be arranged. Women over 50 years old should go for breast screening every three years as the risk of breast cancer increases (NHS, 2019). Some Black and Brown (B&B) women are less likely to take up this screening compared to their white counterparts, indicating a need to target campaigns at specific ethnic groups (Baird et al., 2021). Transgender individuals are more at risk of psychological distress and risk of suicide due to stigma-related stress (Bränström and Pachankis, 2020). This is an example of the importance of demographic and epidemiological knowledge in targeting healthcare delivery for diverse groups.

Genomics incorporates and identifies that multiple genes work together with environmental influences, resulting in a situation of health or illness. For example, there is a connection between genetics and pain associated with sickle-cell crisis (Lakkakula et al., 2018). In the case of sickle-cell crisis pain management, nurses will need to appreciate this when assessing a patient for pain.

However, even here there is inequality, as only 2 per cent of the Human Genome Project has been collected from Africa, meaning fewer opportunities to use genomics to aid specific and effective treatments for Africans and patients of African descent (Mabuka-Maroa, 2019).

The pandemic required significant utilisation of epidemiology, demography, and genomics, internationally, for example, by the WHO and nationally by the ONS. Both are used consistently to inform practice and resources such as COVID-19 vaccine testing and access.

In 2020, Genomics England announced that they would begin a study of 20,000 hospitalised patients who had experienced the worst symptoms of COVID-19 and compare them to 15,000 patients who had only mild symptoms. This is an effort to explore potential genomic differences in susceptibility to the disease. The study will take some time to complete, and it is not known how the research will either collect or address other risk factors alongside genetic variability. Similarly, the Biobank longitudinal study in the UK has requested that its current participants enrol in a subsidiary study to examine those factors (genetic or otherwise) that could influence susceptibility to COVID-19, although the proportion of B&B individuals participating in the Biobank study is lower than white people (Bently, 2020).

There are some genetic conditions that in the UK are more likely to be found in B&B people. The activity below encourages you to discover what they are and how they can be treated.

Activity 2.4 Evidence-based practice and research

Go to the Genomics Education Programme web page on the Health Education England website: www.genomicseducation.hee.nhs.uk/resources/genetic-conditions-factsheets/

Look for the following genetic conditions: sickle-cell anaemia and alpha thalassemia.

Find out:

1. What ethnic groups are more likely to have the condition?
2. What is given as the reason for the genetic condition?
3. What is the clinical management of the condition?

An outline of what you might find is given at the end of the chapter.

Some genetic-based conditions have a strong connection to ethnic and cultural groups. Activity 2.4 will get you to look at sickle-cell anaemia and find out more about this genetic condition and the ethnic groups in which it is more likely to be found.

As you can see from Activity 2.4, Health Education England is a resource not only for healthcare professionals, but patients and family members, and it can be used as an additional source of information. Accessing varied forms of health information in differing formats improves health literacy, particularly for diverse groups. This is looked at in more detail in Chapter 7.

The ethnic demography of an area will increase the possibility of certain genetic conditions being prevalent, and in turn the need for the use of local primary and secondary services. As a nurse working in certain parts of the country, it is in your and your patient's best interests that you are familiar with these genetic conditions to ensure that competent care can be given. These are conditions that will require lifelong support and medical and nursing interventions not only for the physical symptoms, but the psychological symptoms that can coexist with them, such as depression (Jonassaint et al., 2016). There is also a cultural context. For example, patients with sickle-cell anaemia can have negative experiences in hospital services and care delivery (Haywood et al., 2014). These patients and their family members can feel shame, blame themselves, or see sickle-cell anaemia as a curse (Buser et al., 2021). As a nurse, it is your responsibility to respond to these ideas in a respectful manner and to support patients in moving away from these negative feelings. Giving clear information on the genetic reasons for sickle-cell anaemia, as well as referring to the appropriate specialist nurse in the hospital and within the community to ensure continued support, is of paramount importance to the ongoing well-being of patients with sickle-cell anaemia.

It is necessary to recognise that a genetic link is specifically based on a mutated missing or additional gene causing a diagnosable health problem. 'Race' and ethnicity

are not completely linked to genetics – 'race' is socially constructed and largely signifies a complex mixture of behavioural, environmental, and social exposures (Seewoodhary, 2021). Although diabetes, hypertension, and prostate cancer are more prevalent in B&B ethnic communities, we must be careful not to engage in biological racism (the idea that there is an innate biological basis for these medical conditions in B&B people that does not clearly exist). Biological racism omits serious consideration of complex social factors such as poverty, austerity, and varied forms of prejudice that impact on why B&B people are more at risk of certain conditions, including a greater risk of death from COVID-19 (Saini, 2020). It puts the focus on health completely on the individual and does not address the associated social, socio-economic, and political causes of poor health.

This is a good place to look closely at the social reasons for poor health, particularly forms of prejudice and stigmatisation.

Stigma

Let us take a moment to discuss stigmatisation. Stigma refers to the negative regard, inferior status, and relative powerlessness that society collectively accords to people who possess a particular characteristic or who belong to a particular group or category (Frost, 2011). If we reflect back on the social groups we have looked at already, stigma can definitely be a contributing factor to how they sadly continue to be treated and their lived experiences of disadvantage and discrimination in society and healthcare.

In this chapter, we have looked at the LGBTQIA+, GRT, LD, disability, and B&B communities. In one way or another, all of the groups we have looked at experience stigma, discrimination, stereotyping, or other significant social constructs, such as racism. The LGBTQIA+ community faces so much stigmatisation that they fear informing health professionals of their sexuality because they have experienced homophobia (Rostosky et al., 2021). In turn, this fear means people are more likely to approach a health professional later in the progress of symptoms and illness (Richman and Hatzenbuehler, 2014). In the LD community, stigma not only harms care for the patient, but the family can also be stigmatised. Werner and Shulman (2015) call this *stigma by association* (p272). As a result, the voiced concerns of the family and main carers of people with a LD may be ignored, with disastrous consequences, which has led to the unnecessary deaths of patients with LDs (University of Bristol, 2021). The GRT community experiences racism, discrimination, and being stigmatised at an unprecedented level. They experience social deprivation, low literacy, and educational attainment (Sovacool and Del Rio, 2022). The NHS and healthcare professionals encounter significant challenges to meet the complex GRT healthcare needs caused by these experiences. Healthcare professionals can be judgemental, and their lack of cultural awareness is likely to be influenced by the media reinforcing stereotypes of poor behaviour and bad attributes of the GRT community (EHRC, 2016a). As with other minority groups, this can lead

to them accessing health services later in the progression of their health problem, and consequently poorer outcomes from treatment.

You must take into consideration prejudice when defining racism. *Prejudice is the property of all people, but racism can be attributed only to those who have the power to translate their prejudices into action* (Baxter, 1988, p3). The health service as an organisation has the power to implement practices that offer equality but are not equitable. In the following section, we will look at how forms of racism impact healthcare.

Racisms and bias in healthcare

Before addressing racisms, some understanding of what constitutes 'race' is required. 'Race' is a social construct and there is no biological basis to it. This must be acknowledged and understood as a concept if there is to be any attempt to seriously address the real issue of racisms in healthcare (Hamed et al., 2020). Stating 'racisms' and not racism here is to acknowledge that there are different forms of racisms and biases. The addition of BLM to academic discussions on racism in health is an indication of how global racism is, which it has always been, and frames it in a way that positions the B&B experience as central. This is not to the detriment or exclusion of any other group, but an examination of the evidence in healthcare consistently indicates that B&B groups face health inequalities due to racism (Essex et al., 2020).

Baxter (1988) states the following on institutional racism within the NHS:

> *Institutional racism means racism is embedded in organisational structures. There are various ways in which racism is maintained and reinforced within British institutions. Firstly, there is racism which operates through default. Here the institution adheres to the traditional way of doing things, ignoring the multiracial and multicultural nature of the society it is now called upon to serve. Secondly, within the institution there are people in positions of power who are not consciously racist, but who are nevertheless influenced by racist stereotypes. Thirdly, racism occurs in institutions through the rules and regulations which, although they appear neutral, have the effect to exclude Black people while maintaining the privileged position of whites.*
>
> (Baxter, 1988, p4–5)

> *Racism acts as a barrier to the creation of better healthcare systems.*
>
> (Russell, 2022, p11)

These two quotes are over 30 years apart but unfortunately the underlying problem of racism and its impact on the NHS and health continues. This more recent idea about how racism impacts health continues to appreciate that systems within institutions are a factor, not only individual action. However, we are all part of institutions and either formulate or follow systems. Whether racism is systemic or individual in healthcare, one does not function without the other.

The existence of racism in healthcare is about individual practitioners making racially based decisions, unconsciously or consciously, through bias. If the outcome means poor treatment, healthcare cannot be fully effective for all who use it. This leads to social and health disadvantages causing the social determinant of health to have a racial component (Marmot et al., 2020a).

As a student, you may already have witnessed this in the clinical setting in the varied interactions that take place between the nurse, patient, and significant others such as family carers and support workers. Without a clear understanding of how stigma, unconscious or conscious bias, or racial stereotypes work, a patient's treatment, or any attempt at altering the way diverse individuals and groups are treated in the NHS, will never change, and unacceptable clinical decisions will continue to be made. You must look at your own conscious and unconscious biases and racist stereotyping of your patients. This is an unacceptable practice that must be worked on constantly as you have a duty of care to your patients that is non-discriminatory. Biases, particularly racial infused, should have no place in your clinical decision-making process and care delivery.

An example of a situation that can arise in the clinical environment can help to give you an idea of how stereotyping and racism, both conscious and unconscious, can influence communication and clinical decisions.

Scenario: communication

You are a third-year adult nursing student on your final placement before finishing your degree. Olufemi is a 25-year-old Black British man of African descent; he is over six feet tall and well-built, and it looks like he works out regularly. He is admitted overnight to your acute medical ward placement in a sickle-cell crisis. He has not had a severe crisis that required admission to hospital since his teens, and this is his first time being admitted to an adult ward. On the morning shift with your practice supervisor (PS) at handover at 7.30 a.m., he is said to be in a little pain and is 'a bit needy like a lot of "sicklers" are'. He has intravenous morphine prescribed every two hours, which is just about managing his pain, and he has intravenous fluids running over eight hours. When you both go on to the ward after the handover, Olufemi is in terrible pain, particularly in his legs, which have suddenly worsened. He is ringing the bell and calling out in pain when you enter the bay. Your PS goes straight to the call bell and turns it off and tells him to try to be a little quieter as the noise he is making is disturbing the other patients. Before you and your PS have a chance to do anything else, Olufemi angrily states that you are more concerned about the noise he is making than the excruciating pain he is experiencing; he wants some painkillers now, and after this he wants to go home as he would be better off there than in here, where his illness is not understood and 'the care is rubbish'. Your PS replies to the patient that she is going to get the doctor to speak to him and does not engage in any other form of communication with Olufemi. She asks you to take his vital signs and

walks away, saying to you, 'I don't have to take being spoken to like that by that type of patient'. You introduce yourself to him and ask if you can take his vital signs; he continues to be angry and says, 'Go the hell away and just get me my painkillers, I can't take this pain anymore'.

From this scenario, we now proceed to Activity 2.5, where you will consider the possible reasons for what happened and why.

Activity 2.5 Decision-making

From what was said in the handover and by your PS considering issues of gender, ethnicity, and Olufemi's sickle-cell disorder, what is being stigmatised?

- Olufemi is obviously angry. Why do you think this is?
- What could you and your practice supervisor do to improve this situation?

An outline of what you might answer is given at the end of the chapter.

In the above scenario and in Activity 2.5, we have looked at the possible experience of a Black man of African descent in the NHS. There sadly has been a real case in which Evan Smith, a young Black man with sickle cell, died due to delayed treatment. The coroner for the case stated: *The delay in treating Mr Smith with a timely exchange transfusion was the cause of his death.* He also went on to say, *although staff provided basic medical care, it was the 'wrong' care* (BBC, 2021).

There may never be a clear reason for what impacted the decision-making of the healthcare professionals looking after Evan Smith, but the sad loss of this young man's life illustrates the importance of not letting stigma or stereotyping influence your willingness to listen to a patient. Being prepared to develop an understanding of the individual experience of a condition is vital and reflection may help you to understand the impact of not doing so.

Social determinants of health in the UK

Many different factors contribute to a person's current state of health. Marmot et al.'s (2020a) report lists some of the areas considered as social determinants of health, and some of the main points are highlighted below in Figure 2.1.

Children in their early years and young people – poverty, childcare workforce, schooling, free school meals, youth crime, school exclusion, funding for schools
Work and employment – pay, quality of work and in-work poverty
Food and fuel insecurity and poverty
Austerity – funding cuts
Housing
Transport
Climate change

Figure 2.1 Some social determinants of health

Our patients come from parts of our local areas that experience these social determinants of health to varying degrees. Physical social environments and deprivation differ greatly, therefore having an idea about the population that your clinical environment serves will give you a sense of why they are unwell and what can be done to support them in the short and long term, particularly if they have a long-term condition. Life expectancy (LE) varies greatly across the UK, even within a city, and is an indication of how effective healthcare is and the impact of social determinants of health (Marmot et al., 2021). The LE of the population has not significantly improved in recent years but there is a mixed picture based on gender and ethnicity in the general population (ONS, 2021a).

The World Health Organization (WHO, 2008b) has made it its core business to address social determinants of health internationally. As can be observed, the social determinants of health are only one area covered by the determinants of health. The importance of these social determinants on diverse groups cannot be underestimated.

To give your local area of work some global context, it would be worthwhile looking at the Commission on Social Determinants of Health's final report: *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (WHO, 2008b).

In Activity 2.6 we will look at what the WHO has to say about the determinants of health in more detail.

Activity 2.6 Evidence-based practice and research

Using the link below,
www.who.int/news-room/questions-and-answers/item/determinants-of-health
find the following:

Three determinants of health that the WHO identify as important.
The other seven factors that they consider make people healthy or not.

An outline of what you should find is given at the end of the chapter.

Following on from Activity 2.6, social and health determinants are external societal forces that have a huge influence on how well a person succeeds throughout their life span, including ill health. There is only so much the NHS (which is free healthcare at the point of access) can do if inequality in society continues. This does not mean that we, as nurses, should not do our utmost to ensure that care is delivered to a high and equitable standard. We also need to understand how social determinants affect health and that we can signpost patients for support in social care and from the multidisciplinary team.

Going back to the Marmot Reports (Marmot et al., 2020a; Marmot et al., 2020b), they argue that the most effective way to reduce health inequalities is to make changes to the background causes of ill health. There are a lot of complexities in addressing social and health inequalities and Marmot argues that over the last ten years things have actually worsened, with COVID-19 only exacerbating health inequalities (Marmot et al., 2020b; Marmot et al., 2021). We have highlighted that members of society from diverse and marginalised groups add an additional layer to these complexities. Governments, and to a certain extent healthcare, focus on lifestyle interventions or *lifestyle drift* (Marmot et al., 2010, p86). Diverse populations can belong to lower socio-economic groups, which perpetuates the inequalities they face. How much you earn determines where you live, and the education you attain will improve your earnings and your ability to navigate the health and social care systems to benefit your health.

As a healthcare professional, it can appear that our role will have insufficient impact on the health outcomes for diverse groups, but this is not the case. A large, knowledgeable, multidisciplinary workforce is paramount for acting on the social determinants of health. The Marmot Review clearly understands that a shortage of trained healthcare staff to deliver basic functions of service delivery, and to deliver interventions to reduce inequality and improve health outcomes, will cause a *major impediment to success* (Marmot et al., 2010, p88). Therefore, your role as a student nurse is important.

Social determinants of health and the COVID-19 pandemic

The diagram below illustrates how some groups within the population have been disproportionately affected by COVID-19. As you can see, many of the groups and areas that we've discussed so far are in Figure 2.2. For example, older adults, B&B men, pregnant B&B women, B&B healthcare workers, and people with LDs.

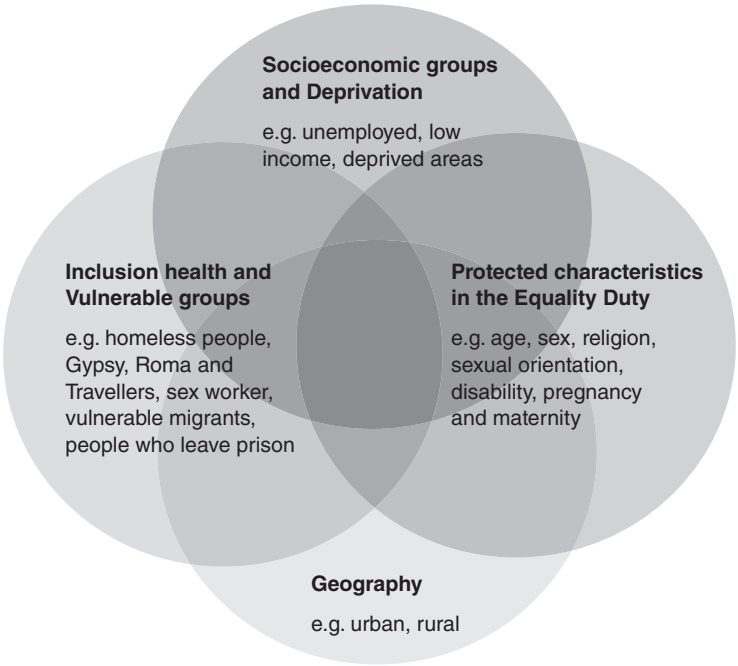

Figure 2.2 From Public Health England (2021), *Health Equity Assessment Tool (HEAT): Executive Summary*

There is so much data and evidence on the inequality that exists with social determinants of health and the reasons for certain groups of people having a higher infection and mortality rate due to the COVID-19 pandemic (much of which has been cited in this book). Bentley (2020) takes a detailed look at the structural racism in British society that increased the risk of exposure to COVID-19 for B&B people, such as being a healthcare professional or other essential worker unable to work from home, poor fitting personal protection equipment, and being in urban areas with limited space for social distancing. Phillips (2021) suggests that the available data on LGBTQIA+ risk is due to 'physical health inequity' (p1), such as a potential increase in long-term conditions of the respiratory system and cardiovascular disease due to a higher usage of alcohol and smoking than the general population, and lesbian and bisexual women being more likely to be obese, all which increase the risk of severity of symptoms with COVID-19. Kavanagh et al. (2021, 2022) consider children and adults with LDs and the health and social care systems that were unable to respond effectively to the rapidly evolving needs created by the pandemic. On an individual level, many in the LD community require assistance with personal hygiene and constant supervision, meaning that social distancing was impossible and increased the risk of COVID-19 due to exposure.

Equality legislation

The Equality Act 2010 collated legislation that already existed covering a variety of areas and older legislation focusing on anti-discriminatory practices in work and society. Ultimately, it identified nine protected characteristics that are unlawful to discriminate against. They are age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity. There is a legal framework that acknowledges discrimination exists even within a country that is so diverse.

It is important that, as healthcare professionals, we are aware that there can be legal consequences for organisations, as well as poor health outcomes for patients, if discrimination exists. The Equality Act 2010 is a good place to start looking at the different types of discrimination:

- *Direct discrimination:* This occurs when a person treats another less favourably than they treat, or would treat, others because of a protected characteristic.
- *Indirect discrimination:* This occurs when an apparently neutral policy (provision, criterion or practice) is applied *that puts, or would put, people sharing a protected characteristic at a particular disadvantage, and puts the individual at that disadvantage* (HM Government, 2013).

Reasonable adjustment is part of the Equality Act 2010, and it is Platform 7.9 (NMC, 2018a) which identifies that, as nurses, we must consider what is important and can be changed in order to ensure that when dealing with vulnerable and disabled patients, an appropriate level of care is given. An example of this in practice is that some patients require a nurse to deliver care on a one-to-one basis for the duration of their stay in hospital, or a relative can stay for long periods to be with their family member and provide essential aspects of care independently or with the assistance of a healthcare professional.

Research summary: gender and age

It is necessary to take a moment to think about issues of gender and age. In health, the biological difference of sex means that women are more likely to have breast cancer than men, but men also get breast cancer (Cancer Research UK, 2020). Trans women and men, depending on whether they have had any bottom or top surgery, are still at risk of sex-specific cancers of the prostate or cervix/womb. These matters would need to be addressed in a respectful and dignified way. In the Equality Act 2010, sex, gender reassignment, sexual orientation and pregnancy are considered protected characteristics (PC). Evidence repeatedly shows that B&B women are more likely to die from complications of pregnancy and childbirth than their white counterparts (MBRRACE-UK, 2021; Birthrights, 2022).

Chapter summary

This chapter started by discussing the changing emphasis on what is considered health. It then explored crucial healthcare issues related to LD, disability, GRT, and LGBTQIA+ communities, as well as life expectancy differences between diverse communities. The chapter introduced concepts and ideas that you may not have considered in this way before around how they impact patients' experiences of healthcare and having their needs met. The importance of epidemiology and demographic genomics, as well as their effect on diverse groups, was discussed, and we built on Chapter 1's discussion on the relationship between the social determinants of health and health inequalities caused by racisms, conscious and unconscious bias, stigmatisation, prejudice, and discrimination. We looked at the impact of the COVID-19 pandemic on the health of diverse groups and ages. Finally, the legal framework against discrimination that exists in society and healthcare was addressed by looking at the Equality Act 2010.

Activities: brief outline answers

Activity 2.1 Teamworking (p28)

It is important to acknowledge the value of a positive and constructive relationship between patients, families, carers, and healthcare professionals. Below is a list (not complete) of the MDT members that could be involved.

- *Consultant (doctor):* LDs cover a broad spectrum of conditions; therefore, the right senior doctor is very important. Specialist knowledge, correct diagnosis, and ongoing care are their role.
- *General practitioner:* Also important to the ongoing care of the patient with an LD in the community.
- *Teacher:* Education and assuring the right type of educational support for a person with an LD needs to be carefully considered due to the varied abilities that a person with an LD may have.
- *Learning disability liaison nurse:* can help with facilitating admissions to hospital for a person with an LD, especially when it is a planned admission (RCN, 2017, p10).
- *Community learning disability teams (CLDTs):* an invaluable resource. They typically comprise of learning disability nurses, psychologists, psychiatrists, speech and language therapists, physiotherapists, occupational therapists, and arts therapists. They normally have an open referral system and are experts in helping people with learning disabilities access various community facilities, especially healthcare (RCN, 2017).

Activity 2.2 Evidence-based practice and research (p30)

1. *What is a learning disability?*

A LD, not to be confused with a learning difficulty such as dyslexia or dyspraxia, is a label given to a group of conditions that are present before the age of 18. This impacts on the way individuals develop in all core areas, and ultimately how they live their lives and access healthcare.

A LD needs to be viewed as a *complex way of being* (Gates, 2001).

For simplicity, this document has grouped causes and conditions. The causes of a learning disability mainly fall into three distinct areas:

prenatal period

perinatal period

postnatal period

2. *What causes learning disabilities?*

We do not always know why a person has a LD. Sometimes it is because a person's brain development is affected, either before they are born, during their birth, or in early childhood. This can be caused by things such as: the mother becoming ill in pregnancy; problems during the birth that stop enough oxygen from getting to the brain; or the unborn baby having some genes passed on from its parents that make having a LD more likely. Other causes include illness, such as meningitis, or injury in early childhood.

There are some health conditions where you may be more likely to have a LD. For example, everyone with Down's Syndrome has some level of LD, and so do many people with cerebral palsy. Some people with epilepsy also have a LD and so do many autistic people.

3. *What does PMLD stand for?*

A profound and multiple learning disability (PMLD) is when a person has a severe learning disability and other disabilities that significantly affect their ability to communicate and be independent.

Someone with a profound and multiple learning disability might have difficulties seeing, hearing, speaking, and moving. They may have complicated health and social care needs due to these or other conditions.

Activity 2.3 Decision-making (p31)

What do you and your PA do to help, and who else could be involved?

1. *Immediately:* Acknowledge their feelings; ask if anything specifically happened today or recently to make them feel this way today; have they been able to express their feelings to family and friends; reassure them feelings are normal; ask if you can tell their parents about how they are feeling; speak to their doctors; refer onto counselling, support groups, websites that might be helpful.
2. *Longer term involves support groups:* Assure GP is aware of Jordan's feelings on discharge; consider the use of medication in consultation with the psychiatric team; keep reinforcing to the family how important they are as part of their recovery by listening and that Jordan expressing their feelings are helpful and contributes to their recovery both physically and mentally. See if support groups or online groups have been used, and if so, were they helpful?

Activity 2.4 Evidence-based practice and research (p33)

Sickle-cell anaemia

- *What ethnic groups are more likely to have the condition?* Sickle-cell disease is common in people of African, Mediterranean, Middle Eastern, and Indian ancestry, and in people from the Caribbean and parts of Central and South America.

- *What is given as the reason for the genetic condition?* Being a carrier for sickle-cell disease is thought to convey some protection against malaria, and as such there is an increased prevalence of people with sickle-cell traits where malaria is common.
- *What is the clinical management of the condition?* Management guidelines recommend that all patients should receive an optimal level of care delivered close to home, as well as access to clinical experts in specialist centres. In addition, services should support 'expert' patients, parents, and carers in managing the condition at home when appropriate. Multidisciplinary management should aim to prevent and treat infections, pain, and complications, and include social and psycho-educational support. The mainstay of primary prevention is to avoid dehydration, extremes of temperature, physical exhaustion, and extremely high altitude.

Alpha thalassemia

- *What ethnic groups are more likely to have the condition?* Alpha thalassaemia is most prevalent in sub-Saharan Africa, South and Southeast Asia, the Middle East, and regions of the Mediterranean, such as Cyprus.
- *What is given as the reason for the genetic condition?* The genetic basis of alpha thalassaemia is complex, as each person inherits two alpha-globin genes from each parent. Because of the complexity, referral to specialist clinical genetics services is recommended.
- *What is the clinical management of the condition?* Most patients with HbH disease (alpha thalassaemia) are well but will have a haematological evaluation every 6 to 12 months. Occasional red blood cell transfusions may be required, particularly during febrile illnesses when haemolytic crises are more likely.

Activity 2.5 Decision-making (p37)

From what was said in the handover and by your practice supervisor considering issues of gender, ethnicity, and Olufemi's sickle-cell disorder, what about Olufemi is being stigmatised and why do you think he's being stigmatised?

The racial stereotype of the angry violent young Black man is unfortunately a strong one, and this may dominate the interaction with you and your practice supervisor. He can be stereotyped due to having sickle-cell disease and the racially stereotyped 'drug-seeking behaviour', based on the opiate medication required to manage the pain. In this case, the medication is being assumed to have been requested for reasons of addiction, not pain management. Olufemi is being racialised due to his ethnicity and potentially discriminated against because of this by the individual nurse and the systemic culture of the organisation that perpetuates this. There is evidence that pain management, which is an important part of his nursing care, is not being conducted successfully due to racially based unconscious bias, and poor clinical decision-making due to this by healthcare professionals.

Olufemi is obviously angry. Why do you think this is?

His pain is not being managed and he is not being listened to. In previous encounters with healthcare professionals, they may have managed his pain inadequately, with nursing staff not knowing about how to manage his condition appropriately. This could easily have led to his angry behaviour. Think about how you would feel if you were in severe pain, and it was not being managed in a clinical environment that should be able to manage your pain effectively.

What could you and your practice supervisor do to improve this situation?

Listen to your patient, particularly when they have a long-term condition and communicate clearly. They may well know more about their condition and how to manage it than you, so work with them. Explain what you are doing as well as why you are doing it. Manage what is obviously his main concern – pain management. Think about why he is behaving in the way he is and look beyond your unconscious bias.

Activity 2.6 Evidence-based practice and research (p38)

Find the three determinants of health that the WHO identify as important.

1. The social and economic environment.
2. The physical environment.
3. The person's individual characteristics and behaviours.

Find the other seven factors that they consider to determine whether people are healthy or not.

1. *Income and social status*
2. *Education*
3. *Physical environment*
4. *Social support networks*
5. *Genetics*
6. *Health services*
7. *Gender*

Further reading

Centre for Aging Better (2022) The state of aging. Summary. Available at: **https://ageing-better.org.uk/sites/default/files/2022-04/The-State-of-Ageing-2022-online.pdf** (accessed 23 July 2022).

This document gives a summary of a comprehensive review of national data on ageing that took place and offers explanations for the changes happening to the older population pre- and during the pandemic.

Jarrett, S and Tilley, E (2022) The history of the history of learning disability. *British Journal of Learning Disabilities.*

This article looks at the history of learning disability in society.

NHS Digital (2021) Health and Care of people with learning disabilities experimental statistics 2019 to 2020 in *Health and Care of People with Learning Disabilities*. Available at: **https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2019-to-2020#** (accessed 30 May 2022).

This report looks in detail at data and evidence on all aspects of care for people with LDs.

Phillips, C (2021) How COVID-19 has exacerbated LGBTQ+ health inequalities. *BMJ*, 372.

This article addresses the inadequate monitoring of health in the LGBTQIA+ community; the data suggest a disproportionate effect of the COVID-19 pandemic and its control measures.

Royal College of Physicians (2021) *COVID-19 and Mitigating Impact on Health Inequalities.* Available at: **www.rcplondon.ac.uk/news/covid-19-and-mitigating-impact-health-inequalities** (accessed 6 June 2022).

Examples of how NHS providers have mitigated the impact of COVID-19 on health inequalities.

Useful websites

Friends, Families and Travellers. Getting a fair deal for Gypsies, Roma, and Travellers:

www.gypsy-traveller.org/

This organisation works to end racism and discrimination against Gypsy, Roma, and Traveller people and to protect their right to pursue a nomadic way of life.

ILGA World – The international lesbian, gay, bisexual, trans, and intersex association:

https://ilga.org/

Since 1978, ILGA has been committed to equal human rights for rainbow communities and their liberation from all forms of discrimination. They support LGBTQIA+ civil society worldwide through advocacy and research projects and give grassroots movements a voice within international organisations.

National LGBT Research Report:

www.gov.uk/government/publications/national-lgbt-survey-summary-report

An analysis of responses to a survey of the experiences of LGBTQIA+ people in British society.

World Health Organization (2008b) *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health – Final Report of the Commission on Social Determinants of Health.* Geneva: WHO.

www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Learning Disability:

www.learningdisability.co.uk/

A useful website that has valuable videos from people with learning disabilities and key points of importance when working with people with learning disabilities.

Scottish Learning Disabilities Observatory:

www.sldo.ac.uk/

The Observatory has been set up to provide better information about the health and healthcare of people with learning disabilities and people with autism in Scotland in order to inform actions, practice and policy.

The Health Foundation:

www.health.org.uk

An independent charity committed to bringing about better health and healthcare for people in the UK. Its organisers believe that good health supports positive social and economic outcomes – both for the individual and society as a whole – understanding the quality of healthcare through in-depth analysis of policy and data.

Runnymede Trust:

www.runnymedetrust.org

Runnymede is a charity and the UK's leading independent race equality think tank. They generate intelligence for a multi-ethnic Britain through research, network-building, leading debate, and policy engagement.

UK Health Security Agency:

www.gov.uk/government/organisations/uk-health-security-agency

Responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological, and nuclear incidents, and other health threats.