

# Equality Diversity and Inclusion within Dentistry

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A profession wide  
commitment

**May  
2021**



# Contents

## Table of Contents

<b>Contents .....</b>	<b>2</b>
<b>Forewords.....</b>	<b>3</b>
<b>The DDAG Stakeholder Group .....</b>	<b>6</b>
<b>Strategic Oversight Group .....</b>	<b>8</b>
<b>1 Executive Summary .....</b>	<b>9</b>
1.1 Background .....	9
1.2 Commitment For Change .....	10
1.3 Recommendations .....	10
<b>2 Introduction .....</b>	<b>11</b>
2.1 Background .....	11
2.1.1 Leadership In Dentistry .....	11
2.1.2 Dental Careers And Education .....	11
2.1.3 Organisations And Workplaces .....	12
2.1.4 Patient Care .....	13
<b>3 Diversity In Dentistry Action Group (DDAG).....</b>	<b>15</b>
3.1 Purpose.....	15
3.2 Delivery.....	15
<b>4 DDAG Stakeholder Event .....</b>	<b>17</b>
4.1 Invitation For Collaborative Action .....	17
4.2 Key Presentations.....	17
4.2.1 A Case For Change-Funmi Oluwajana .....	17
4.2.2 The Ethnic Diversity Of Uk Dentistry- Patricia Neville .....	18
4.2.3 London Workforce Race Strategy - Samantha Rashid And Janine La Rosa .....	18
4.3 Stakeholder Breakout Sessions: Exploring Ambitions, Priorities, Barriers And Opportunities .....	19
4.4 Stakeholder Priority Setting .....	20
<b>5 Commitment For Change .....</b>	<b>21</b>
<b>6 Recommendations .....</b>	<b>22</b>
<b>7 Next Steps .....</b>	<b>23</b>
<b>Appendix A: November 2020 Stakeholder Event: Breakout Discussion Notes .....</b>	<b>24</b>
<b>Appendix B: Example Template To Support EDI Strategy Development.....</b>	<b>27</b>
<b>Appendix C: Suggested Actions For Organisations To Consider In Line With Key Principles For Change....</b>	<b>29</b>

## Forewords



*Sara Hurley, Chief Dental Officer for England*

Our profession set an early benchmark for diversity and our patients have always benefited from the care provided by a profession which has attracted individuals from different backgrounds and identities. In the various debates and welcome discussions prompted by Black Lives Matter, the very personal accounts of discrimination and bias, both conscious and unconscious, revealed that the fault lines that traverse society are equally evident in our profession.

Our conversations ranged from the lack of role models and peer support, to ways of acknowledging identity, recognition of the lived experience, the friction of ignorance and arrogance of privilege through to examples of opportunities denied. Many individuals spoke about the time and energy spent censoring themselves and an inability to truly be themselves. The uncomfortable home truth is that whilst we may have diversity in dentistry there is not true equality. As a profession we are not as inclusive as we may wish to believe. Our journey is incomplete; we must re-visit and test our benchmarks for trust, equality, fairness and inclusion.

Critical analysis, reflection and change is not merely an organisational responsibility but a personal one; our working practices, mindset and instincts need to be examined along with a critical appraisal of our systemic culture from top to bottom. In striving to be genuinely inclusive we must be open to challenge and prepared to challenge; to inspect and reflect on our people management, recruitment, mentoring and support at all stages of career development. In the words of Baroness McGregor-Smith in her 2017 independent review for Government, 'The time for talking is over. Now is the time to act'. Our role, as dental professionals, is to do precisely that.

Although we have seen some shift in thinking, we haven't seen it in practice to the extent or at the pace required. To add momentum to this important initiative I have asked Nishma Sharma to develop a "Diversity in Dentistry Action Group". I have asked the action group to garner the seldom heard, to identify and acknowledge the conscious and unconscious bias, to challenge the system to listen and act, to work collaboratively across the profession to co-ordinate sustained action.

This publication, and the commitments from each and every one of the organisations that have contributed to our call to action, sets the scene for sustainable change; from practice level to corporate boards, from dental policy to dental public health, from academic arenas to regulation. These organisations and their members, by virtue of their position and influence on the profession's culture, values and ethics, have publicly placed themselves in the vanguard of change, fostering greater equality, diversity and inclusion.

Through a pan-profession inclusive network we are more effective; one voice for equality, diversity and inclusivity. Synergy of action and a unifying purpose to reinforce faith in the dental profession as a healthcare career open and welcome to all, a career that will nurture talent and support individuals to fulfil their true potential and achieve the professional recognition they deserve.

The Diversity in Dentistry Action Group has focused, quite rightfully, on race. However we are all too aware that inequality and barriers to success exist for women, our LGBT+ community, those with a disability, people who are from different socio-economic backgrounds and many more. This isn't "job done" – there is more to do, more perspectives to understand, more stories to listen to – and action to take.

This report has reemphasised that there is an undeniable moral case for change. The diversity of ideas, perspective and ways of working afforded by people of different backgrounds and identities will benefit our patients, as much as our profession and the ripples will have an impact on society.

Sara Hurley



*Nishma Sharma, Chair of the Diversity in Dentistry Action Group  
(DDAG)*

Racism has no place in our society. End of. The dental profession must be part of the change we all need, to step up and stamp out prejudice, and to build diverse and supportive cultures of respect and fairness for all.

Accepting the role as Chair of the Diversity in Dentistry Action Group (DDAG) and progressing the debate has been an eye-opening experience. Whilst it has been good to listen, to empathise, to start to understand how it feels to walk in others' shoes, never did I think that the profession we belong to, invest in, have faith in would not welcome others the way I have always felt welcomed.

My eyes have been opened to the fact that my experiences of racism were not the same as my other colleagues, peers, friends. My stories, perspectives, feelings were different, but the clear thread of hate, prejudice and ignorance bound us together. How did I not see the hugely disproportionate void of Black representation in our dental schools, workforce, specialisms, academia, senior leadership roles? How could I have missed the blatant barriers to admission, acceptance, progression and attainment within the dental world?

The Diversity in Dentistry Action Group (DDAG), was formed with a view to:

Listen and allow others to be heard; to understand and acknowledge the presence of discriminatory problems; to educate others to become aware of the issues and why they require resolution; and to deliver action to help address, mitigate, prevent and reinforce positive messaging that dentistry is a healthcare career open and welcome to all.

The action plan is a distillation of the key themes. It heralds the necessary challenge for change and the joint collaboration that will continue to conversation and conversion of a profession respected for inclusivity and for developing talent wherever it's found, with the goal of delivering excellence in healthcare.

Nishma Sharma



## The DDAG Stakeholder group



*promote, educate & advance*



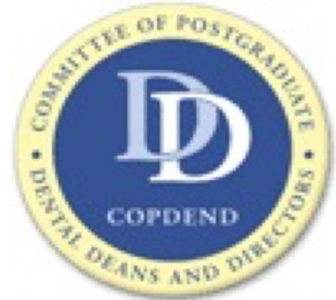


Dental  
Protection



General  
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Council

dental  
Professionals  
Alliance

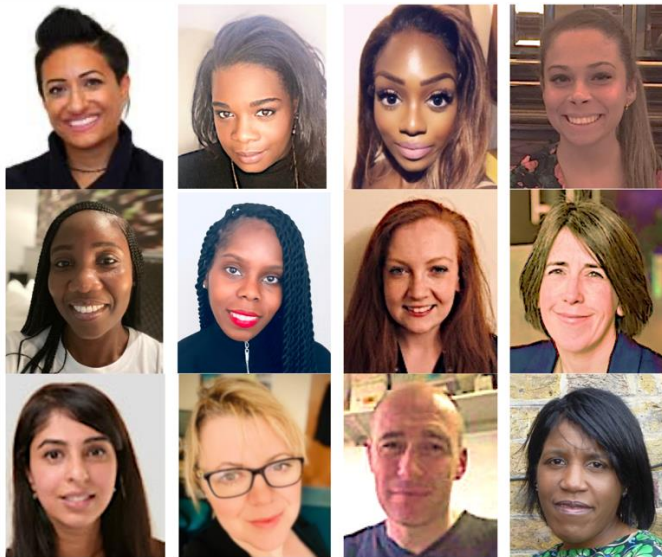


NIHR | National Institute  
for Health Research



NHS  
Health Education England

## Strategic Oversight Group



## Message from Nishma Sharma

The issue of racism, prejudice, bias is an outdated, stagnant corroded bolus, stuck and wedged into the throat of society; choking progression, suffocating innovation, stifling the potential of a fresh representative workforce where there are no glass ceilings. This can no longer be ignored. Its deep roots are steeped in history, entrenched in the many conflicts and injustices endured over the years. It is **now** time to break down the barriers using the armoury of education, understanding, empathy, proactive reaction, energy, insight and allyship. Together we are a profession, yes, but we are also individuals with a responsibility for change within our own spheres of influence and extending to wider society.

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### Nishma Sharma (Chair)

Clinical Leadership Manager, Office of the Chief Dental Officer (OCDO)

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### Sophia Morris

HAIL Senior Clinical Fellow MSE Health & Care Partnership. Senior Clinical Fellow MESFT OMFS

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### Funmi Oluwajana

Speciality Registrar Restorative Dentistry, Manchester. Clinical Fellow

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### Alina Grossman

Senior Clinical Policy Manager, OCDO

---

### Tayo Mateola

Programme Manager, OCDO

---

### Tynita Patterson

Programme Business Manager, OCDO

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### Hannah Pugh

Speciality Registrar Orthodontics, Bristol

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### Claire Stevens

NHS Consultant in Paediatric Dentistry, University Dental Hospital of Manchester

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### Mariyah Nazir

NHS Consultant in Orthodontics, University Dental Hospital of Manchester

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### Ilona Johnson

Reader in Dental Public Health, Cardiff University, BASCD representative

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### Barry Gibson

Professor in Sociology, Director of Equality, Inclusion, Diversity and Wellbeing, University of Sheffield School of Clinical Dentistry

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### Vanessa Muirhead

Clinical Senior Lecturer in Dental Public Health, Queen Mary University of London

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# 1 Executive Summary

## 1.1 Background

The principles of equality, diversity and inclusion are central to dental care and are part of core standards<sup>1</sup> for all dental professionals.

The core ambition of Diversity in Dentistry Action Group (DDAG) is to co-create a systematic approach for practical action by working across all of our stakeholders and professional representative bodies.

We aspire to ensure operational processes, ways of working and people management policies are dissected and improved, so as to allow our profession to reflect a culture of equality and inclusion

On 25<sup>th</sup> November 2020 the DDAG held its inaugural event, where stakeholders from across the dental profession were invited to drive the conversation on cultural and organisational approaches to racial equality and inclusion.

This event identified many issues relating to racial equity within the profession and put forward opportunities to deliver positive change through collaboration.

The profession is being invited to sign up for a commitment to change.

Top three priorities for the DDAG are currently:

- Creating a diverse, inclusive and representative **workforce**; with equal opportunities in the workplace
- Creating diverse, inclusive and representative **educational environments**
- Ensuring **equitable access to dental care** for patients and the public

As per voting at the November 2020 stakeholder event

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<sup>1</sup> General Dental Council Standards for the Dental Team. <https://standards.gdc-uk.org/Assets/pdf/Standards%20for%20the%20Dental%20Team.pdf>

## 1.2 Commitment for change

The DDAG has invited stakeholders to become contributing partners in their quest for equality by pledging to the key principles for change.

### Key Principles For Change

Creating a positive open, learning culture across the profession and organisations which develops understanding and supports people to embrace diversity and inclusion

Ongoing improvement through constant enquiry, investigation and learning

Working together, to address inequalities and increase diversity in dentistry

Exploring and developing opportunities for representation and inclusion

Actively committing to addressing racism and discrimination

Organisational commitment to change at all levels

Embracing workforce diversity

## 1.3 Recommendations

The following recommendations, based on discussions and findings from the November 2020 Stakeholder Event, are made to support the key principles for change:

Develop **strategies for positive, sustainable change** with short-term, medium-term, and long-term approaches to be implemented across the profession. An example template to support EDI strategy development is found at Appendix B.

**Work collaboratively** to influence policy, shape culture and transform the profession's approach to race equality, **learning from other sectors** to identify opportunities for change.

Promote open and ongoing profession-wide conversations to support continuous improvement.

**Develop the workforce**, across the dental pipeline from dental school entry, apprentice/training programmes to senior leadership, through education, role modelling and leadership development.

**Support research and the collection of high-quality data and lived experiences data to improve understanding of inequalities** and address the barriers to a diverse and inclusive environment.

Ensure a profession wide commitment to **zero tolerance of racism and discrimination**.

Suggested actions for organisations to consider, in line with the key principles for change (Section 1.2), are found in Appendix C.

## 2 Introduction

### 2.1 Background

**The global Black Lives Matter movement has shone a stark spotlight on the need for society and organisations to stop, reflect and acknowledge where they need to start making changes. While laws and changing social norms have helped to make overt and blatant racism unacceptable, a shake-up in working practice and systemic culture is required. And that will only happen if we all take ownership of the issue.**

***Nigel Cassidy, Chartered Institute of Personnel and Development, 2020***

Equality and inclusion are fundamental to dental care. The recent social justice activity to uphold racial equality has prompted the dental profession to reflect on whether the guiding principles of inclusion, equality fairness, justice, dignity and respect are wholly embedded to address inequalities and to ensure the best possible outcomes for patients, the profession and wider society.

#### 2.1.1 Leadership in Dentistry

Diversity in leadership is associated with more effective patient-centred care, greater innovation, higher staff morale and access to a wider talent pool. However, there is significant under-representation of individuals from an ethnic background and women<sup>2</sup> in leadership positions within dentistry. For example, in 2020, only 10 out of 26 dental boards surveyed had a gender balance. Importantly, 8 boards had less than 40% women members.

“If we look at the LDN there is an element of diversity but if you look at the core LDN there isn’t any. What barriers contribute to this? Are we culturally unaware of things? If we look at LDCs too then everyone does look the same. How do we improve things?”

November 2020 Stakeholder Event

#### 2.1.2 Dental Careers and Education

Medical and dental data from the 2016/17 Higher Education Statistics Agency (HESA 2017) data indicated that two thirds (63.5%), of students were recorded as White ethnicity, a quarter (24.1%) as Asian ethnicity and a small proportion (3.7%) were recorded as Black ethnicity.<sup>3</sup> A freedom of information request to the GDC in July 2020 listed the stated ethnicity of registrants. This indicated that 1.7% of dentists and 2.2% of Dental Care Professionals (DCPs) identified as Black,<sup>4</sup> whilst 51% of dentists and 75% of DCPs in total (67% of registrants overall) identified as White.

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<sup>2</sup> <https://kevinobrienorthoblog.com/balance-boards/>

<sup>3</sup> Neville P. <https://www.mededpublish.org/manuscripts/1496>

<sup>4</sup> <https://www.gdc-uk.org/about-us/freedom-of-information/information-released-under-the-foi-act>

Students are future healthcare professionals, training to deliver care to diverse populations and will need to be supported into operating within a diverse environment. Research in medical education<sup>5</sup> has shown that students that studied within a diverse medical school had a more positive attitude to diversity-related issues and this may also have a positive effect on their preparedness to care for ethnic minority patient groups.

There are significant disparities in the ethnic profile of dental clinical academic positions.<sup>6</sup> In 2017 72.6% of dental clinical academics in the UK identified as White, 15% as Asian, 5.7% as Other, 1.2% as Chinese and 0.9% as Black. A 2018 survey of dental clinical academic staffing found that the proportion of

people identifying as White were greatest for the most senior positions. At professorial level 91% of staff identified as White with a male gender majority (78%) at this level also. Ethnic representation differences were seen across dental specialities, with those identifying as white being 100% in Oral Microbiology, and 85% in Oral and Maxillofacial surgery. Representation from those identifying as BME was greatest for Endodontics, Prosthodontics and Periodontics all (38%, 34% and 31% respectively). These findings demonstrate that representation of ethnic minority groups declines with seniority, and the degree to which there is a lack of representation varies for different ethnic groups with people identifying as Black and Chinese least represented at senior levels. The additional disadvantage of intersectionality (e.g. ethnicity and gender) is less well reported.

“Some people don’t see people who look like them in dental careers or in senior/specialty positions in dentistry”

November 2020 Stakeholder Event

A 2019 report from the Higher Education Policy Institute highlighted four areas for change.<sup>7</sup> Firstly, a need for strong leadership; secondly, the need to create a culture in which it is possible to have open and honest conversations about race and racism; thirdly, developing a racially diverse and inclusive environment; and finally obtaining the evidence, understanding what it means and understanding what works.

### 2.1.3 Organisations and workplaces

There is evidence to show that workplace culture has an impact on patient care.<sup>8</sup> Furthermore, research has shown a direct link between discriminatory treatment of minoritized racial ethnic staff and lower levels of patient satisfaction. There is very limited data relating to racial discrimination, bullying, harassment and abuse within the dental profession. Specialist groups such as the BDA/FGDP(UK), Dental Schools Council and Society of British Dental Nurses have recently started to look at this issue in more detail.

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5 Steven, K., Dowell, J., Jackson, C., & Guthrie, B. (2016). Fair access to medicine? Retrospective analysis of UK medical schools application data 2009-2012 using three measures of socioeconomic status. BMC medical education, 16, 11. <https://doi.org/10.1186/s12909-016-0536-1>

6 Survey of Clinical Academic Staffing Levels. A report by the Dental Schools Council. <https://www.dentalschoolscouncil.ac.uk/wp-content/uploads/2017/07/Survey-Dental-Clinical-Academic-Staffing-Levels-2017.pdf>

7 The white elephant in the room: ideas for reducing racial inequalities in higher education. Higher Education Policy Institute . HEPI report 120. <https://www.hepi.ac.uk/2019/09/19/the-white-elephant-in-the-room-ideas-of-reducing-racial-inequalities-in-higher-education/>

8 West et al 2011 NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215455/dh\\_129656.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf)



#### 2.1.4 Patient Care

There is a significant correlation between race and ethnicity, and quality of care and health outcomes. Since the 1965 White Paper “Immigration from the Commonwealth” which drew attention to migrant health - UK legalisation and policies such as The Equality Act of 2010, the NHS Ethnic Health Unit, 1996 and special initiatives such as Equality Delivery System (EDS) 2011<sup>9</sup> have sought to improve health equality. Despite this we continue to find evidence of ethnic healthcare inequity – Asian and Asian British newborn babies are 60% more likely to die than White babies, whilst Black women have a fivefold risk of dying in pregnancy<sup>10</sup>, and minority ethnic communities are disproportionately impacted by social factors associated with mental illness<sup>11</sup>.

Minority ethnic groups continue to face discrimination, bullying, harassment and abuse from staff and patients at a greater level than white staff

NHS Staff Survey in England 2019

Equality and inclusion are fundamental to dental care, yet whether overt or through unconscious bias, we know that racism within healthcare and society still occurs. Bias held by dental professionals can affect quality of care. Consider the survey study conducted by Patel et al (2019)<sup>12</sup> which measured explicit bias in the treatment offered by dentists and their perception of patient dental cooperativeness. The findings showed White patients were more likely to be

recommended root canal treatment for presentation of a decayed tooth with symptoms of irreversible pulpitis, whilst Black patients were more likely to be offered dental extractions. Such bias is problematic. When we consider the ideal position of maintaining natural teeth and the known long-term effects of missing teeth e.g. reduced function, poor aesthetics and psychological distress, it can be appreciated how quality of care and oral health outcomes can become inequitable.

UK Research in racial disparities in oral health outcomes and access to care is lacking. However, we do have some data highlighting lack of access to NHS dental services between 2011 – 2018 that show after the ‘Any Other’ group and ‘White Gypsy Traveller’, ‘Black African’ then ‘Black Other’ were consistently least likely to report success in securing an NHS dental appointment<sup>13</sup>. The 2018 Oral Health Survey showed people of an ethnic background were more likely to have tooth decay, have one or more PUFA (pulpal involvement, ulceration, fistula and abscess) signs and increased reporting of experiencing a negative impact due to their oral health than in the previous year<sup>14</sup>.

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<sup>9</sup> Salway, Sarah et al. “Obstacles to “race equality” in the English National Health Service: Insights from the healthcare commissioning arena.” Social science & medicine (1982) vol. 152 (2016): 102-10. doi:10.1016/j.socscimed.2016.01.031

<sup>10</sup> Draper ES, Gallimore ID, Smith LK, Fenton AC, Kurinczuk JJ, Smith PW, Bobby T, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2018. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2020.

<sup>11</sup> Bignall T, Jeraj S, Helsby E, Butt J

Racial disparities in mental health: Literature and evidence review. 2019 Race Equality Foundation

<sup>12</sup> Patel N, Patel S, Cotti E, Bardini G, Mannocci F. Unconscious Racial Bias May Affect Dentists' Clinical Decisions on Tooth Restorability: A Randomized Clinical Trial. JDR Clin Trans Res. 2019 Jan;4(1):19-28

<sup>13</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/access-to-nhs-dental-services/latest>

<sup>14</sup> Oral health survey of adults attending general dental practices 2018. Public Health England 2020

Racism and discrimination are not a recent discovery. Racism is a complex social structure rooted in a foundation of unequal power relations and beliefs, which unfortunately manifests in negative outcomes such as marginalisation of ethnic minority groups. The dismantling of the systems that uphold systemic racism will not be eradicated overnight or by a single action; but we can put into place purposeful actions which can start to turn the tide.

## 3 Diversity in Dentistry Action Group (DDAG)

Established by the Office of the Chief Dental Officer (OCDO) England in June 2020, the Diversity in Dentistry Action Group (DDAG) is co-ordinated by a Strategic Oversight Group (SOG).

### 3.1 Purpose

The purpose of the group is to co-create a shared strategic approach to action change by working across all stakeholders, with integrity, intelligence, and openness in order to:

#### **DDAG Mission Statement**

The DDAG exists to promote a collaborative approach to shape a dental profession which respects, values and lives by the principles of equality, diversity and inclusion.

**-Identify and describe the current challenges** and issues within our profession, with respect to equality, diversity and inclusion

**-Scrutinise and improve operational processes, ways of working and people management policies** in order to combat issues of institutional and structural prejudice and discrimination.

**-Propose solutions** to improve diversity across the dental profession.

**-Share learning and good practice** across the UK.

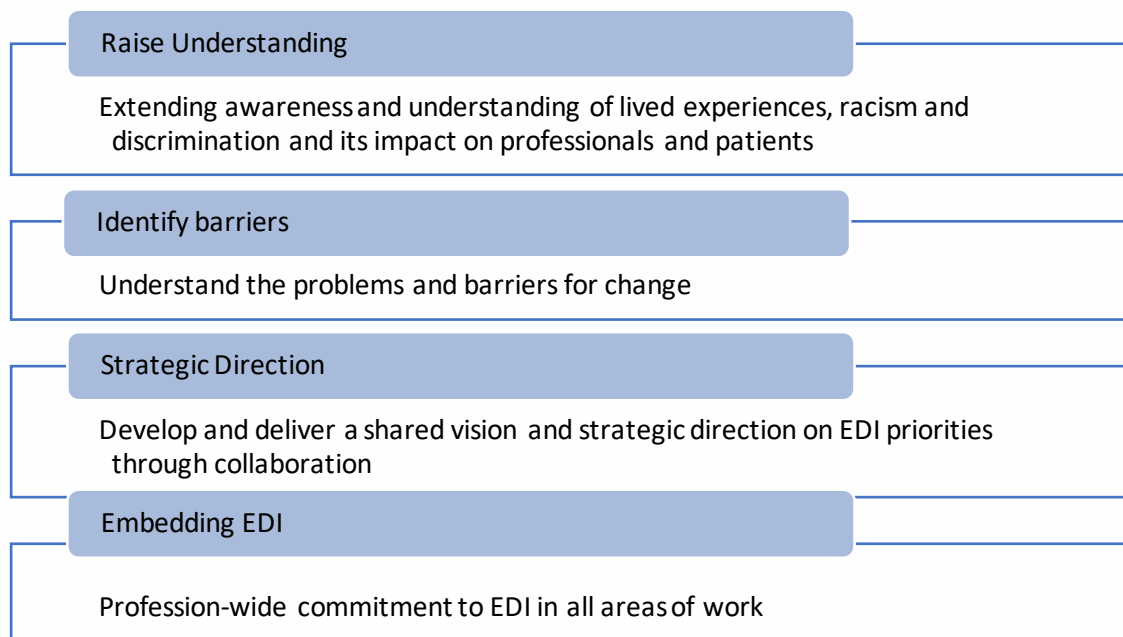
### 3.2 Delivery

The DDAG SOG will bring together a wide range of dental stakeholders through regular meetings (the inaugural meeting is described in section 4), which will create a forum to co-create a strategic vision, share good practice, promote collaboration, provide support and report on progress – in order to deliver change across the profession.

The initial phase of the SOG will prioritise racial equality, focussing attention on the issues faced by Black people within dentistry – whether that be at undergraduate or training level, within the profession, or as a patient accessing services.

## The future

The aspiration is to shine a light on all discrimination of protected characteristics with the aim of inclusivity for all within the profession. Through the use of evidence and collaboration with stakeholders, we will explore opportunities to influence policy, practice and perceptions. We will endeavour to learn from models and exemplars of success from within dentistry and from other sectors.





## 4 DDAG Stakeholder Event

#### 4.1 Invitation for collaborative action

## Preparatory phase of the DDAG engagement

1. Stakeholder involvement, discussion and feedback
2. Co-creation of a joint statement on diversity and inclusion
3. Stakeholder commitment to organisational changes.

On the 25<sup>th</sup> November 2020 DDAG hosted its inaugural stakeholder event attended by seventy-one representatives from a wide range of dental organisations. The event shared the purpose and ambitions of DDAG with the wider dental profession and served to open the dialogue around the racial equality within dentistry agenda. This inaugural event was the first in a series of action events supporting the preparatory phase of DDAG engagement. Highlights of the event are described below.

## 4.2 Key presentations

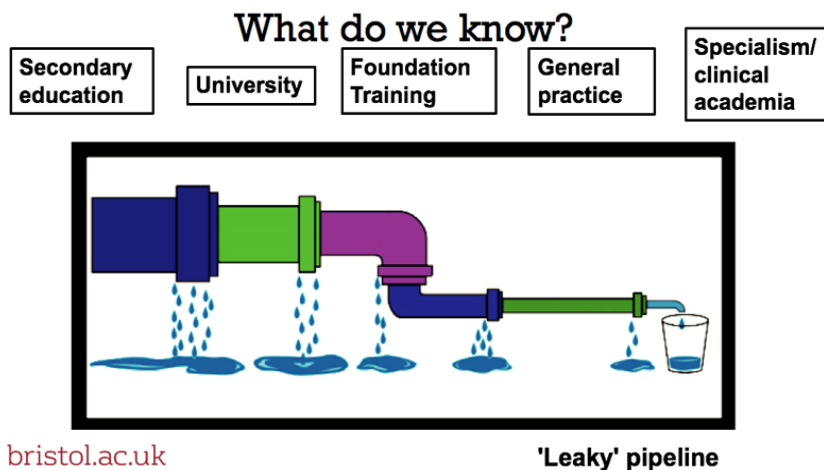
#### 4.2.1 A case for change-Funmi Oluwajana

Dr Oluwajana led an audience participation activity before briefly sharing her lived experience of being a Black female Specialty Registrar in Restorative Dentistry. This exercise demonstrated not only the pervasive nature of racial discrimination but also the invisibility of underrepresented groups. A range of emotive responses elicited were captured in the word cloud shown on the right, generated using Mentimeter interactive software. “Uncomfortable”, “sad”, “frustrated” and “concerned” were the most common responses depicted by the word displayed in the largest font size.

How did this make you feel?



#### 4.2.2 The ethnic diversity of UK dentistry- Patricia Neville



Dr Neville, Lecturer in Sociology at Bristol University, presented data showing the ethnic diversity of the dental workforce across the dental pipeline and the key transition points from secondary school to university entry, general practice, specialism and clinical academia. BAME dentists are also persistently underrepresented at other key stages in the dental pipeline in clinical academia, in dental specialties and at the professorial

level. She then described key information gaps that included limited research exploring the barriers that prevent or enablers which encourage Black British students to study Dentistry and progress into specialty and clinical academic careers. She also highlighted the paucity of research about creating inclusivity in dental school environments and the lack of data or missing data that would provide a clearer understanding of the problems.

Patricia concluded her presentation with a call for action:

- More focused research;
- Engagement with grass roots organisations in actions;
- A call to action for key dental organisations to lead the charge and hold the profession to account with regards to barriers and everyday racism experienced by minoritized ethnic registrants.

#### 4.2.3 London Workforce Race Strategy - Samantha Rashid and Janine La Rosa

Whilst London has the most ethnically diverse NHS workforce nationally, it has been shown the experience of many of the BAME London workforce is not equitable. Launched in November 2020 the London Workforce Race Strategy aims to make *a significant and tangible difference to the experiences of London BAME NHS staff*. Samantha Rashid, Senior Programme Lead, London Workforce Inclusion (NHSE/I) and Janine La Rosa, London Regional Head of Equality, and Inclusion (NHSE/I), introduced the strategy's long-term approach to produce sustainable change. The positive impacts of diversity on patient care, teamwork and staff experience were highlighted as drivers for the implementation of the evidence-based strategy. Equity data, alongside staff narratives capturing lived experiences of racial discrimination formed the basis for the London Workforce Race Strategy and its 15 key recommendations.

**Translational learning:** A diversity strategy should start with evidence and a clear understanding of current status of racism and racial discrimination in Dentistry. Dentistry currently has an information gap conflated by the term "BAME/BME" masking underrepresentation and the tendency to publish/report combined

data on Medicine and Dentistry. A strategy for Dentistry needs to adopt a short-term, medium-term, and long-term approach; we will not see changes overnight, hence the need for a long-term plan.

### The importance of allyship in tackling racial discrimination and underrepresentation, presenting the seven As of Authentic Allyship



### 4.3 Stakeholder breakout sessions: Exploring ambitions, priorities, barriers and opportunities

Stakeholders were allocated to one of four breakout rooms for discussion of specific questions. Each room fed back a summary of their discussions to the whole group.

#### Stakeholder Questions

What ambitions and priorities does your organisation have in relation to diversity and underrepresentation?

What are the challenges or barriers that your organisations face in achieving your ambitions?

What support is required to make a change?

How can we collaborate together for the benefit of all?

Responses to stakeholder breakout sessions (Appendix A) included considerations for increasing diversity and representation through recruitment, visibility of role models and increasing diversity in senior roles. Awareness raising, addressing unconscious bias, advocacy and allyship were also discussed alongside learning and opportunities for change.

## 4.4 Stakeholder priority setting

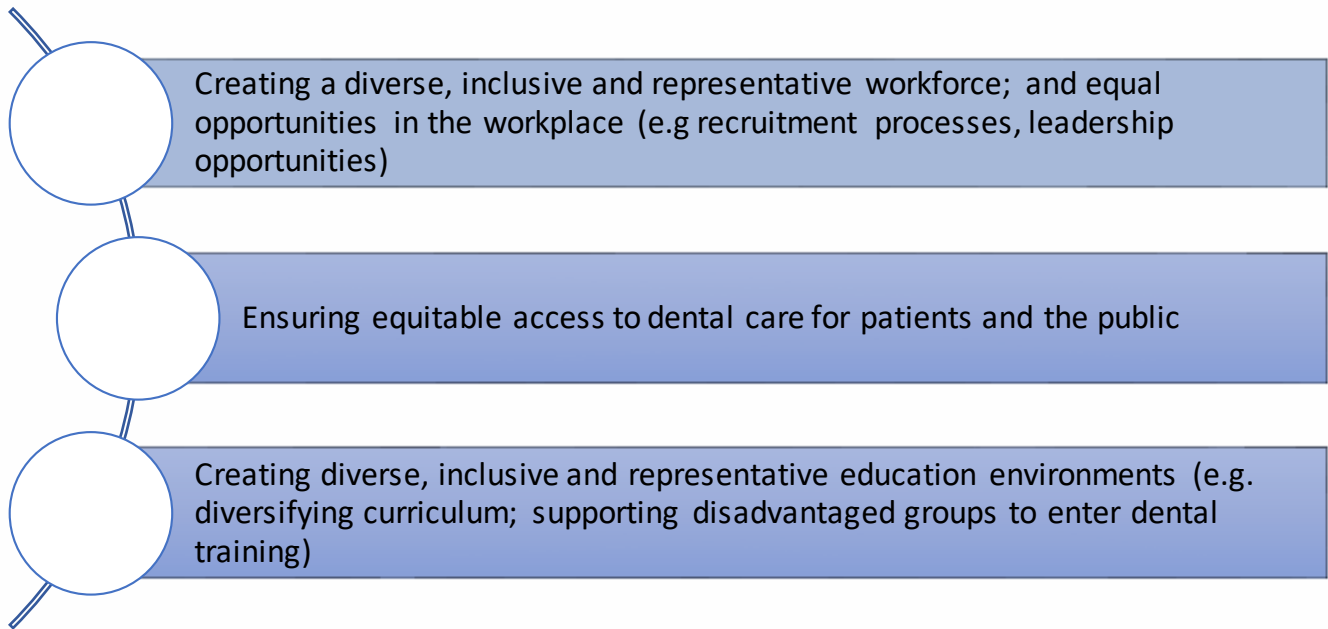
Following the breakout group discussions and feedback, Voxvote audience participation software was used to capture responses to 11 questions and suggested priorities for the DDAG to focus on. The images show a summary of the key findings from this activity.

### Stakeholder participation feedback and priority setting using VoxVote

<b>Institutional Racism</b> Most participants (90%) felt that institutional racism was a primary factor preventing individuals progressing their dental careers in their organisation	<b>Inclusive workplace strategies</b> Almost all participants (92%) worked in organisations that had already considered strategies to make the workplace more welcoming and inclusive	<b>Equality and Diversity Leadership</b> More than a half of the participants (51%) had a dedicated Equality Diversity Inclusion (EDI) Lead sitting at board level in their organisation	<b>Equality and Diversity Leadership training</b> Nearly half had completed effective EDI training in the last two years that had impacted their thoughts and actions on inclusivity
<b>Raising concerns about Equality, Diversity, and Inclusion (EDI)</b> Most (90%) participants felt comfortable speaking about EDI concerns or issues within their organisation	<b>Equality and Diversity Leadership challenges</b> <ul style="list-style-type: none"><li>• Lack of understanding around EDI issues</li><li>• Lack of effective training</li><li>• Difficult or uncomfortable to talk about EDI issues with colleagues</li></ul>	<b>Taking actions to address racism</b> 59% felt that if they witnessed racism in the workplace, they would know what steps to take and would feel confident to take actions	<b>Taking action to address underrepresentation</b> 68% had not considered challenging the organisers of a conference about whether the panel/other speakers were from diverse backgrounds but would do now



## Top priority areas for DDAG



## 5 Commitment for change

The DDAG has invited stakeholders to become contributing partners in their quest for equality by pledging to the key principles for change. Stakeholder organisations who have pledged their support are listed in Appendix D shown on the final pages of this document.

### Key Principles For Change

Working together to address inequalities and increase diversity in dentistry

Ongoing improvement through constant enquiry, investigation and learning

Creating a positive open, learning culture across the profession and organisations which develops understanding and supports people to embrace diversity and inclusion

Exploring and developing opportunities for representation and inclusion

Actively committing to addressing racism and discrimination

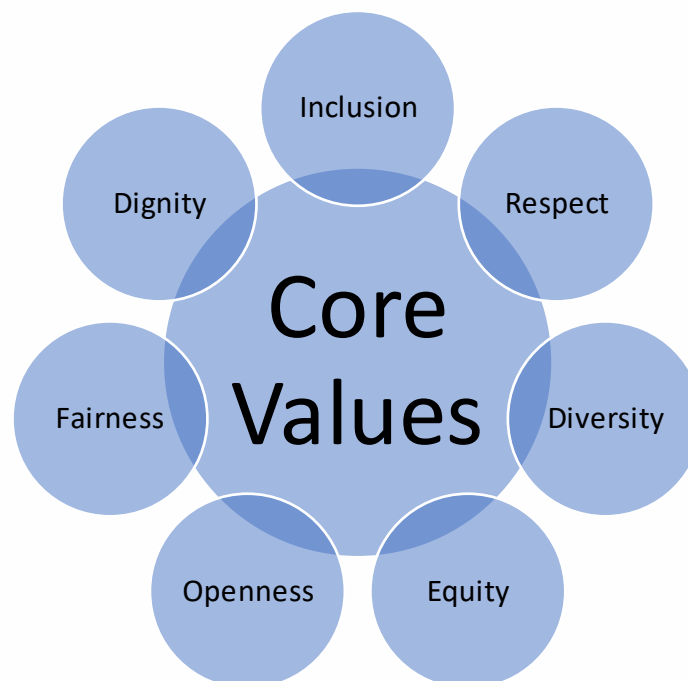
Organisational commitment to change at all levels

Embracing workforce diversity

## 6 Recommendations

The following recommendations, based on discussions and findings from the November 2020 Stakeholder Event, are made to support the key principles for change:

- Develop **strategies for positive, sustainable change** with short-term, medium-term, and long-term approaches to be implemented across the profession. An example template to support EDI strategy development is found at Appendix B.
- **Work collaboratively** to influence policy, shape culture and transform the profession's approach to race equality, **learning from other sectors** to identify opportunities for change.
- Promote open and ongoing profession-wide conversations to support continuous improvement.
- **Develop the workforce**, across the dental pipeline from dental school entry, apprentice/training programmes to senior leadership, through education, role modelling and leadership development
- Support research and the collection of high-quality data and lived experiences data to improve understanding of inequalities and address the barriers to a diverse and inclusive environment
- Ensure a profession wide commitment to **zero tolerance of racism and discrimination**
- **Suggested actions for organisations to consider, in line with the key principles for change (Section 1.2), are found in Appendix C.**



## 7 Next Steps

The DDAG has co-created this report with a range of dental organisations and groups, who have pledged their commitment to the key principles for change (see Section 5). It marks their collaborative commitment to change, in order to promote equality, diversity and inclusion in dentistry.

Each dental organisation or group will be responsible for planning, delivering and evaluating their actions for change, mindful of the strategic priorities and recommendations of the DDAG; and through singular or collaborative approaches as appropriate. They will be accountable under their existing organisational governance structures.

The DDAG core group will continue to host regular stakeholder meetings and workshops to develop a forum for co-creating strategic vision, reporting progress, sharing good practice, promoting collaboration, and providing support. The structure of these meetings/workshops will be informed by the findings of stakeholder events and continued learning, feedback and experience as organisations deliver change.

## Appendix A: November 2020 Stakeholder Event: Breakout discussion notes

What ambitions and priorities does your organisation have in relation to diversity and underrepresentation? (Group A)	What are the challenges or barriers that your organisations face in achieving your ambitions? (Group B)
<p>This group shared several examples from their organisations on prioritising and taking actions on EDI that provide opportunities for shared learning and collaborative working. These ambitions focused on:</p> <ul style="list-style-type: none"> <li>(i) Increasing diversity through recruitment processes (targets and fair selection and training)</li> <li>(ii) Eliminating discrimination</li> <li>(iii) Increasing inclusivity and representation on panels</li> </ul> <p><i>“NIHR has an Equality Diversity and Inclusion programme (<a href="https://www.nihr.ac.uk/about-us/our-contribution-to-research/equality-diversity-and-inclusion.htm">https://www.nihr.ac.uk/about-us/our-contribution-to-research/equality-diversity-and-inclusion.htm</a>).</i></p>	<p>This group mentioned several barriers including:</p> <ul style="list-style-type: none"> <li>▪ A lack of visible role models – “People don’t see people who look like them in dental careers or in senior/specialty positions in dentistry”</li> <li>▪ Unconscious bias and lack of education and awareness</li> <li>▪ Lack of acknowledgement that EDI is an issue – “The key is acknowledging there is actually an EDI problem. Need to start and continue a healthy dialogue around this”</li> <li>▪ A lack of appetite to change, possibly influenced by regional differences (i.e. London is more diverse compared to less diverse regions therefore there is no impetus to act)</li> <li>▪ A level of anxiety about engagement around race inequality and the need to support allyship</li> <li>▪ Time lag between acting and seeing real change</li> <li>▪ A lack of knowledge about what do to once the problem has been acknowledged. – where do you go next? What do you do? We know where we are now, but how do we practically take steps to get where we want to go?</li> <li>▪ Power dynamics with DCPs / dental nurses – There may be barriers within dental team related to the role people play in the team linked to intersectionality (race/ethnicity and gender).</li> </ul>

	<ul style="list-style-type: none"> <li>▪ A lack of opportunities for irregular attendees to engage with dental teams and dental services, possibly limiting their opportunity to explore Dentistry as a career that may related to race/ethnicity</li> </ul> <p>This group also mentioned the need for a “whole profession” approach and a focus on allyship and unconscious bias training to support people in power/decision-making positions who may not be diverse currently.</p>
What support is required to make a change? (Group C)	How can we collaborate together for the benefit of all? (Group D)
<p>This group suggested several actions that would drive change:</p> <p>(i) Having leaders and key people who can act as spokespersons who have experience and influence to speak out in support of change.</p> <ul style="list-style-type: none"> <li>– This will address the lack of role modelling barrier. A cohesive team of leaders is more likely to have an effect than a few voices.</li> </ul> <p>(ii) Better support for allies and advocates</p> <ul style="list-style-type: none"> <li>– Providing practical support for White colleagues who know how to act as advocates and allies and to White people who are supportive of this agenda but require further training</li> <li>– Further discussion is needed about whether White allies can be leaders</li> </ul>	<p>(i) Cultural change</p> <ul style="list-style-type: none"> <li>– This needs to be inclusive and have bottom up involvement</li> <li>– Needs to be meaningful</li> <li>– Senior structures need to support and fully sign up to this</li> </ul> <p>(ii) Structure</p> <p>Active organisational change to support diversity to include:</p> <ul style="list-style-type: none"> <li>– Ensuring diversity at senior levels/ boards of organisations</li> <li>– Visibility of diversity</li> <li>– Respect of culture</li> <li>– Increase awareness and insight for ongoing development</li> <li>– Having plans that are signed up to with clear involvement</li> </ul>

<p>(iii) Garnering early support at the primary and secondary school level through to university entry</p> <ul style="list-style-type: none"> <li>– The African Caribbean Dental Association’s involvement in schools was highlighted. The group suggested that similar school initiatives could be developed.</li> <li>– Creating mentoring opportunities</li> <li>– More work needs to be done to understand why young Black students do not feel they can pursue Dentistry, and to explore barriers in school and the social determinants that impede students applying to study Dentistry – need to address financial barriers (upstream)</li> </ul> <p>(iv) Addressing racial and gender diversity across all stages of the dental pipeline and leadership roles.</p> <p>This could be supported by:</p> <ul style="list-style-type: none"> <li>– Shared learning from each other</li> <li>– Collaboration and cross-cutting actions</li> <li>– Providing and sharing feedback about effective practices</li> <li>– Adopting a coordinated approach across agencies</li> </ul>	<p>(ii) Involvement</p> <ul style="list-style-type: none"> <li>– Encouraging diverse involvement with the inclusion agenda</li> <li>– Supporting and mentoring talent to work with organisations to overcome barriers to becoming appointed/elected to senior roles</li> <li>– Creating safe spaces for people to be heard and for this to be used as insights for further improvement</li> <li>– Education to support awareness raising and training to support an inclusive environment</li> </ul> <p>(iv) Strategic approaches to working collaboratively</p> <ul style="list-style-type: none"> <li>– Cohesive plans linking work of organisations together so as to be truly collaborative</li> <li>– Clear roles and joined-up working so as to avoid duplication of effort</li> <li>– Issues of self-interest can get in the way</li> <li>– Using involved stakeholder approaches similar to those for patient facing programmes “e.g. Child Oral Health Improvement Programme Board, Prevention in Practice and Starting Well (if this can be done for patients, why can it not be applied to our workforce?)</li> </ul> <p>(v) Learning from others</p> <ul style="list-style-type: none"> <li>– Learning from good practice and success in other areas</li> <li>– Examples include: <ul style="list-style-type: none"> <li>• Pharmacy – developed a set of core principles</li> <li>• British Council- developed archives and repository of experience</li> </ul> </li> </ul>
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## **Appendix B: Example template to support EDI strategy development**

### **Workstrand 1: Profession Wide Focus On EDI With The Current Priority Of Racial Inequality**

- Create awareness across the dental profession of racial inequality issues
- Establish a pan profession commitment (pledge) to driving positive change towards race inclusion & anti-racism
- Drive a collaborative action plan to address equality within the dental profession

### **Workstrand 2: Develop Professional Capacity – Embed EDI Principles Into The Culture Of The Dental Profession**

- Leadership and community driven approaches
- Implement sustainable organisational commitment to equality and diversity policies
- Identify the structural and cultural barriers which are maintaining inequalities
- Develop racial literacy to increase racial inclusion understanding through education and training development

### **Workstrand 3: Equal Opportunities - Promoting diversity within the workforce**

- Build cultures of trust and support, providing safe channels encouraging freedom to speak for all individuals for colleagues/members to express their voice and share their experiences
- Identify the structural and cultural barriers to inclusion of underrepresented groups
- Promote diversity within the workforce where Black professionals are underrepresented
- Implement drivers to increase representation within underrepresented areas of the profession

#### **Workstrand 4: Drive Diverse and Inclusive Educational Environments**

- Identify and address barriers to recruitment of Black pupils into dental profession programs
- Encourage research into barriers of entry into dental careers
- Encourage reporting and monitoring systems relating ethnicity and attainment gaps
- Implement processes to identify and address racial discrimination within dental schools.
- Diversify curricula by ensuring that representation of diverse patient and student groups and challenging stereotypes are covered

#### **Workstrand 5: Access to Dental Care**

- Encourage research into racial inequalities related to delivery of dental care and oral health outcomes
- Promote fair and equitable access to dental care

## **Appendix C: Suggested actions for organisations to consider in line with key principles for change**

### **Working together to address inequalities and increase diversity in dentistry**

#### **Organisational commitment to change at all levels**

- Develop action plans to promote equality and address racism and discrimination.
- Include diversity and inclusion as a permanent item on their organisation's meeting agenda integrally linked to organisational strategies.
- Appoint a race champion within the leadership team to take responsibility for progress and to focus attention on delivering change.
- Race inclusion expertise as part of organisational leadership to inform action and challenge thinking.
- Participate in the evaluation of the effectiveness of activity.
- Agreed metrics for profession wide outcomes and with progress shared across organisations to drive tangible change in recruitment, management, development and promotion of colleagues across all ethnicities.

#### **Ongoing improvement through constant enquiry, investigation and learning**

- Identify the structural and cultural barriers which are maintaining inequalities
- Critically examine success in selection of different groups into leadership roles where there may be glass ceilings. Share that insight across the profession.

#### **Embracing workforce diversity**

- Ensure a visible commitment to equality throughout organisational channels for recruiting
  - Consider the feedback for, and success of, channels used for outreach.
  - Use of inclusive images and language in communications
- Data analysis with appropriate metrics for fair and inclusive recruitment
- Mechanisms for issues of inequality to be addressed
- Develop wider access opportunities to inspire and encourage the future workforce.

#### **Creating a positive open, learning culture across the profession and organisations which develops understanding and supports people to embrace diversity and inclusion**

- Education to ensure recognition of race equality, racism and discrimination
- Develop the skills to talk openly about race, alongside active support of discussions internally and externally to support change.
- Workforce development of all staff to become champions for race inclusion and to take a stand against racism and discrimination as allies.

- Introduce diversity-related reverse or mutual mentoring programmes so that the organisation's leaders have a better understanding of lived experiences in relation to race.
- Develop knowledge and confidence to talk about diversity and inclusion at internal and external engagements; for example, in conference addresses, briefings and interviews.
- Ensure conferences, organisational and member events have diverse representation in their presenters/speakers, questioning events and where necessary withdrawing support in situations where there is inadequate representation.
- Ensure that ethnic minority staff have access to mentoring/shadowing to support them with their career progression.
- Reach outside of normal channels and connect with community groups to show support and develop an understanding of needs

### **Actively commit to addressing racism and discrimination**

- Provide safe channels for colleagues/members to express their voice and share their experiences, to feel confident and safe in highlighting issues about inequality and sharing their views on matters affecting them at work or within the organisation.
- Ensure that disadvantaged and disconnected groups have ongoing access to mechanisms through which they can safely express their voice to enable change.
- Actively commit to zero tolerance of racism and discrimination.