

A PRACTICAL GUIDE TO ETHNIC MONITORING IN THE NHS AND SOCIAL CARE

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FOREWORD

Health and social care services, provided by the NHS and local councils, should treat their patients, service users and staff with fairness, dignity and respect. They must aim to deliver appropriate, personalised services to the diverse communities they serve and to be employers of choice that recruit, develop and retain the best talent from all communities. This Practical Guide to ethnic monitoring will help the NHS and social care to monitor their performance with regard to race equality, and compile, review and actively use their Race Equality Schemes, to effect necessary improvements.

The Practical Guide offers straightforward guidance on a range of issues; but, most notably, it asks the NHS and social services to use the standard 16 codes for ethnic group as the mainstay of their approach to ethnic monitoring. It includes a number of good practice examples from up and down the country, which show what can be achieved with commitment, commonsense and public/staff involvement.

The Practical Guide emphasises that leaders in the NHS and social services must lead from the top, ensuring that patients, service users and staff fully appreciate the reasons for ethnic monitoring. I fully expect these leaders to rise to the challenge and to work with me in making sustained improvements to services and workforce practices for all communities based on sound and robust ethnic group data.

Rosie Winterton MP
Minister of State for Health Services

July 2005

EXECUTIVE SUMMARY

The importance of ethnic monitoring

- ❑ The collection and use of ethnic group data on patients, service users, and staff is the **foundation** on which NHS bodies and councils with social services responsibilities can assess and address health inequalities, difficulties in access and discrimination experienced by some black and minority ethnic individuals and communities. (See paragraphs 4,10, 69 & 71 from the main body of the Practice Guide)
- ❑ It is also the foundation by which they can assess and address workforce gaps and biases and in consequence attract, develop and retain a workforce made up of the best talent from all communities. (Paragraphs 4,11, 70 & 71)
- ❑ Senior management and Boards/Committees should demonstrate a **clear commitment** to ethnic monitoring and show staff and the public how they have used ethnic group and related data to influence their decision making. In doing so they should consult openly with local communities and their staff over their approaches to ethnic monitoring. (Paragraphs 72 to 78)

Critical drivers

- ❑ Ethnic monitoring applies to both patients and service users and to the workforce. (Paragraphs 10 & 11) The strongest driver for equality, informed by ethnicity and other monitoring, is the **business case**. If the needs of black and minority ethnic patients, service users and communities are ignored, or the NHS and social care do not employ the best people regardless of ethnic group, the NHS will face difficulties in contributing to national targets and meeting local standards and the performance of councils will not be as effective as it could be. (Paragraph 4)
- ❑ There are a number of other **critical drivers** that impel Trusts and councils to collect and use ethnic group and related data. For example, public bodies must monitor workforce and service activity under the Race Relations (Amendment) Act 2000 and present it in their Race Equality Schemes; they should compile Health Equity Audits in order to inform Local Delivery Plans; and some collections in the NHS are mandatory. (Paragraphs 14 to 22)

Ethnic monitoring applies to everyone

- ❑ Because **everyone belongs to an ethnic group**, everyone should be asked to select their ethnic group from an appropriate list of codes. (Paragraphs 31 & 32)
- ❑ **Ethnic monitoring applies to all areas**. It is not the sole preserve of Trusts and councils who have relatively large black and minority ethnic communities. (Paragraphs 69 to 71)

The standard for ethnic group codes

- ❑ Trusts and councils should use the **16 code national standard** as a minimum for collecting and reporting on the ethnic group of patients, service users and staff. These codes may be further sub-divided if necessary but only in ways that enable the sub-codes to be aggregated back up to the 16 codes. (Paragraphs 33 to 42, 79)

The process for collecting ethnic group data

- ❑ A fundamental principle is **self-classification**; that is, patients, service users and staff select their own ethnic group from the codes on offer. In doing so, they should be aware of the different codes they may choose from. Occasions where third parties identify the ethnic group of patients and service users will be exceptional and should be handled with care. (Paragraphs 84 to 90)
- ❑ **Consent and confidentiality** should be respected at all times. No-one should be forced into giving their ethnic group against their will. (Paragraphs 103 & 104)

- ❑ Trusts and councils should not offer patients, service users and staff the opportunity to respond “**Not stated**” to questions about their ethnic group. However, Trusts and councils should record and monitor all non-responses to ensure they are minimised and any problems are addressed. (Paragraphs 43 to 45)
- ❑ Collection of ethnic group and related data should be built into **registration, referral and office routines**. The more unremarkable they are, the better. Where patients and service users are in crisis, arrangements should be established for capturing ethnic group data once the crises have passed. (Paragraphs 94 to 97)

Religion and diet

- ❑ Trusts and councils should collect data on patients and service users’ **religion and diet**, where appropriate, in consistent ways. (Paragraphs 46 to 54)
- ❑ Some individuals may give their religion when asked about their ethnic group. Where this happens, Trusts and councils are advised to **record religion separately** but ask individuals to give their ethnic group as well, based on the codes that are used locally. (Paragraph 51)

Language

- ❑ Trusts and councils should establish whether patients and service users require the assistance of translators or interpreters. **Language** monitoring should be conducted in consistent ways that reflect local circumstances. For individual patients, Trusts should consider using the translation and interpretation service now provided through the framework contract procured through NHS Direct. (Paragraphs 55 to 68)
- ❑ **Written material** that is translated into different languages is not always the most effective means of communicating with different individuals and communities. Verbal means are often preferable. (Paragraph 58)

Training and public information

- ❑ Staff, senior managers and Board/Committee members should receive **training**, relevant to their needs, on the collection and use of ethnic group and related data. Initial and refresher training should be provided. Leaflets can be prepared to provide a ready reminder to them on the importance of ethnic monitoring. (Paragraphs 75, 80 to 83)
- ❑ Patients, service users and the public should receive **information, in leaflets or other formats**, on why ethnic group data are important. (Paragraph 102)

Using the information

- ❑ Ethnic monitoring is more than data collection. It is the process used to collect, store and analyse data about people’s ethnic background and then take action on the issues revealed. (Paragraphs 98 & 99)
- ❑ Trusts and councils that treat their **Race Equality Schemes** as working documents, and routinely use and update the ethnic group data contained within them, demonstrate excellent practice. (Paragraphs 14 to 16, 100)
- ❑ Finally, the **key to ethnic monitoring is using the data that are collected to make things more equitable and appropriate for patients, service users communities and staff**. Trusts and councils should base their analyses and reports on four types of information all of which use the same codes based on national standards: a national demographic baseline; the local demographic distribution, data about patients and service users; and data about the workforce. (Paragraphs 91 to 93, 105 to 107) The London Health Observatory plans to publish a report on the analysis and interpretation of ethnicity data later in 2005. It will be titled "Analysing ethnic differentials in health services and the workforce : a toolkit for local agencies". It will be available on <http://www.lho.org.uk>

INTRODUCTION

1. This document provides practical guidance to NHS and social care staff who are involved in the collection and use of ethnic group and related data. It updates, strengthens and widens similar guidance issued by the Department of Health (DH) to the NHS in October 2001 - "Collecting Ethnic Category Data – Guidance and Training Materials for implementation of the new ethnic categories from April 2001".
2. This new Practical Guide covers ethnic monitoring of patients and service users (including asylum seekers and refugees) and staff. It is relevant to the all Trust and council staff, but in particular the following :
 - ❑ **Front-line staff, including reception staff**, who will usually ask a range of questions about patients' and service users' personal details including their ethnic group on admission, first application or request for help.
 - ❑ **Managers of front-line staff** who may need to deal with exceptional and difficult cases.
 - ❑ **Personnel and Human Resources staff** who are responsible for collecting information from, and about, their workforce.
 - ❑ **Systems designers, analysts or information officers** who need to know how to set up and deliver useful information from ethnic group collection and storage systems.
 - ❑ **Service Managers** in NHS Trusts and staff in Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) or councils with social services responsibilities (hereafter referred to as "councils") who are responsible for service planning and development and need to know how to collect and use information about the local community.
 - ❑ **Board or committee members and senior managers** who need to know what the organisation and its staff are expected to deliver and look to sound data about patients, services users and local communities and their workforces in order to ensure equity, promote equality and meet their legal obligations to assemble and use their organisations' Race Equality Schemes.
3. By following this Practical Guide and its good practice examples, NHS Trusts, PCTs, SHAs and councils will be able to base their local approaches to ethnic monitoring on sound, proven and consistent principles.
4. Through the use of good and robust ethnic group data on patients and service users, the NHS and councils will be in a better position to address health inequalities, difficulties in access and discrimination experienced by some black and minority ethnic individuals and communities. As a result, the NHS will be better placed to contribute to national targets and meet local core standards. Similarly, through good and robust data on the workforce, the NHS and councils will be able to ensure that they are fair employers who attract, develop and retain the best talent from all communities. They will also be better able to

comply with the requirements of the Race Relations (Amendment) Act 2000.

5. This Practical Guide has been tailored to the NHS and social care. It draws on, supports and complements other guidance with a wider focus, most notably :
- “Ethnic Monitoring : a guide for public authorities”, Commission for Racial Equality, 2002, available at : http://www.cre.gov.uk/publs/cat_duty.html; and
 - “Ethnic group statistics – a guide for the collection and classification of ethnicity data”, National Statistics, HMSO, 2003, available at : http://www.statistics.gov.uk/about/ethnic_group_statistics/downloads/ethnic_group_statistics.pdf
 - “Ethnicity monitoring : involvement – guidance for partnerships on monitoring involvement”, ODPM, 2004, available from : <http://www.neighbourhood.gov.uk>

THE DEPARTMENT OF HEALTH'S COMMITMENT TO RACE EQUALITY

6. DH is responsible for the health and well-being of everyone in the country. DH aims over the next few years to change the whole system of health and social care. To move from a service that does things to and for its patients and service users to one which is led by patients and service users; where health and social care services work with them and support their health and social care needs. These changes will be profound. The need to focus on race equality in designing and delivering these changes is clear. Morbidity for some diseases is disproportionately high among people from black and minority ethnic communities. For example :

***Examples of health inequalities
(See Annex B for fuller details)***

- ❑ Young Asian women are more than twice as likely to commit suicide than young white women, according to data reported in 1996.
- ❑ Research on data from the early 1990s indicates that South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population.
- ❑ Amongst African-Caribbean and South Asian men in 2003, the prevalence of stroke was between about 40% and 70% higher than that of the general population respectively after adjusting for age.

7. Such people in this country are among the most disadvantaged groups in our society, and are also among those least satisfied with the services they receive. DH, the NHS and councils need to ensure that personalised and effective services are delivered to patients and service users from these communities. They also need to ensure that recruitment, selection, training and other staff policies promote race equality, and that the NHS and councils are able to draw on the talents of everyone in the country, regardless of ethnic group.
8. For further details please see Annex A. Reference can be made to DH's Race Equality Scheme for 2005 – 2008 (at http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4112158&chk=l6bqXd). Annex B gives information on how different black and minority ethnic communities are affected by different health conditions and the proportions of black and minority ethnic staff in the NHS and social care.

WHY ETHNIC MONITORING IS IMPORTANT

9. Collecting, analysing and using ethnic group information and, where appropriate, related information on language, religion and diet, is important for the following reasons.

10. **It is important for individual patients and service users :**
 - To contribute to assessments of individuals' needs and circumstances, thereby ensuring that access to services and service delivery can be as personalised and appropriate as possible. For example, insights into a person's ethnic background – or the ethnic background of their family – may assist with diagnosis. Information about a person's main spoken language and competency in English could indicate a need for translation and interpreting services.
 - To assist with the clinical management of patients as the prevalence and course of many conditions varies by ethnicity.
 - To compare uptake of services between different groups to ensure fairness in allocation of resources and delivery of services according to needs and, where appropriate, to address health inequalities experienced by particular ethnic groups. Annex B highlights some of the most notable health inequalities. By addressing such inequalities, Trusts will be able to better contribute to national targets and meet local core standards. Likewise, councils can perform better. In recent years a number of key publications have highlighted the inequalities and, at times, discrimination experienced by black and minority ethnic patients, service users and communities. Most notably, these include :
 - “They look after their own, don't they?”, SSI/Department of Health, 1998;
 - “The Health Survey for England : the Health of Minority Ethnic Groups 1999”, National Statistics, 2001;
 - various surveys published by the Healthcare Commission and its predecessors, a key report being “Unpacking the patients' perspective : variations in NHS patient experience in England”, Commission for Health Improvement, 2004; and
 - “Ethnic disparities in health and health care – a focused review of the evidence and selected examples of good practice”, London Health Observatory, 2004, available at :
http://www.lho.org.uk/Publications/Attachments/PDF_Files/Ethnic_Disparities_Report.pdf.
 - To fulfil the organisation's public duty to promote race equality in general and to contribute to the organisation's Race Equality Scheme (updated in May 2005) in particular.

11. **Ethnic monitoring is important for staff :**
 - To monitor fairness in recruitment and selection, learning and development opportunities, performance appraisal, and promotion.
 - To identify under-represented groups so that recruitment drives can be targeted to increase the organisation's attractiveness to them.

Annex B demonstrates that while, overall, the NHS and social care can be proud of its record in employing black and minority ethnic staff, there are some marked differences within professional groups.

- To identify actual or potential groups of employees where positive action to, say, equip people from under-represented ethnic groups to apply for jobs or promotion, may be appropriate.
 - To fulfil the organisation's duties as an employer in general and to contribute to the organisation's updated Race Equality Scheme in particular.
12. Through using data in these ways, and openly sharing results with the public, patient and user groups, staff and other stakeholders, Trusts and councils can demonstrate that data collections are not tokenistic or expensive exercises but can make a positive difference to individuals' experiences of the NHS and social care. This is true for ethnic group data be it on patients, service users or staff.
13. The routine use of data, particularly at Board or committee level, also usually leads to improvements in the scope and quality of those data. Shortcomings in data that may be tolerated when data are used occasionally, often cease to be tolerated when Chairs, Chief Executives and Directors wish to make evidence-based decisions and want to see data as a matter of course.

CRITICAL DRIVERS TO ENCOURAGE ETHNIC MONITORING

Race Relations (Amendment) Act 2000

14. Within the health and social care system there are a number of critical drivers to encourage Trusts and councils to apply themselves to race equality and ethnic monitoring with the utmost seriousness. First, the Race Relations (Amendment) Act 2000 requires the NHS, local authority councils and other public bodies to demonstrate compliance with the statutory duty to promote race equality. Where evidence from monitoring shows unequal outcomes between different ethnic groups, public authorities are required to take action to promote greater equality and to prevent direct and indirect discrimination.

15. Under the specific duty of the Act, NHS, council or other public bodies are required to monitor, by reference to the racial groups to which they belong, the numbers of :
 - ❑ staff in post, and
 - ❑ applicants for employment, training and promotion from each such group.Where an NHS, council or other public body has 150 or more full-time staff, the body should also monitor, by reference to the racial groups to which they belong, the numbers of staff in each group who :
 - ❑ receive training
 - ❑ benefit or suffer detriment as a result of its performance assessment procedures
 - ❑ are involved in grievance procedures
 - ❑ are the subject of disciplinary procedures, or
 - ❑ cease employment with that person.Finally, NHS, council and other public bodies shall publish annually the results of such monitoring.

16. The Department of Health's own updated Race Equality Scheme, May 2005, provides an example of how the requirements of the Race Relations (Amendment) Act 2000 can be used to review both policy development and workforce matters. It can be accessed on : www.dh.gov.uk/.../PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4112158&chk=l6bqXd - 21k - 31 May 2005.

Health Equity Audits

17. Second, in drawing up Local Delivery Plans, PCTs and partners should conduct Health Equity Audits and equality impact assessments to identify how fairly and appropriately services and resources are distributed in relation to the health needs of different groups, including race equality and the inequalities experienced by black and minority ethnic communities. By using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery, Health Equity Audits should help the NHS to address inequalities in access to services and outcomes.

Leadership and Race Equality Action Plan

18. Third, in February 2004 DH launched the Leadership and Race Equality Action Plan (LREAP), which challenges NHS leaders to address race equality and the needs of black and minority ethnic individuals and communities in a systematic and professional way. With regard to information and monitoring, DH will continually consider how best to ensure that race equality is embedded into NHS practice with Strategic Health Authorities and the Healthcare Commission. In addition, the NHS is asked to build systematic processes for tracking the career progression of staff from ethnic minorities, including local and national versions of the NHS Leaders scheme.

Performance assessment

19. Fourth, since 1 April 1995, DH has directed the NHS to collect information on the ethnicity of individual hospital in-patients. Recent improvements in the quality of ethnic data for Hospital Episode Statistics (HES) probably started with the inclusion of a Data Quality Indicator (DQI) in Hospital Performance Ratings in 2001/02. One of the components of DQI was ethnic data quality, which therefore affected the overall data quality score (DQI score) of organisations. As a result, the ethnic data quality indicator score increased from 64% in 2002/03 to 72% in 2003/04. A further emphasis on ethnic data quality was introduced in 2003/2004 Performance Ratings by inclusion of an ethnic data quality indicator as a separate performance indicator, therefore increasing its weight in overall performance rating of organisations. The new indicator includes two elements on ethnic data quality, one of which is based on HES data the other one is on workforce data. This is likely to have a positive impact on ethnic data quality on HES in the future.
20. In assessing the performance of councils, the Commission for Social Care Inspection refers to several indicators with an ethnicity focus, including PAF AO/E47 – the ethnicity of older people receiving an assessment – and PAF AO/E48 – the ethnicity of older people receiving services following an assessment. In addition, the Commission has introduced a Key Threshold that limits its judgement on the performance of a council if the council has more than 10% with “ethnicity” not stated on assessments and reviews (from 2004/05) or receiving services (from 2005/06) recorded for the “Referral, Assessment and Packages of Care” (RAP) national return or for social services staff in post (from 2005/06).

Task force

21. It should also be noted that a National Health Information and Intelligence Task Force has been set up following publication of the White Paper on public health “Choosing Health” (DH, 2004). This Task

Force will lead action to develop and implement a comprehensive public health information and intelligence strategy. Among the issues included in its priorities is identifying an agreed set of core data to support agreed measures of progress to be used nationally and locally, and to tackle weaknesses within existing data, particularly information on ethnicity and the use of services.

Electronic Care Record

22. In addition, the development of the electronic care record, by NHS Connecting for Health as part of the National Programme for IT (see <http://www.connectingforhealth.nhs.uk>) will provide added impetus for the collection, appropriate sharing and use of a range of personal and treatment-related data including ethnic group.

ETHNIC GROUP COLLECTIONS IN THE NHS AND ADULT SOCIAL CARE

23. Trusts and councils already collect ethnic group and related data, and some do it very well. This platform of experience and practice can help them to improve their performance. Currently within the NHS and adult social care there are a number of ethnic data collections and associated uses. In addition, new developments are in the pipeline. Since April 2001, the following collections all ask for information on the ethnicity of patients or service users :
 - Admitted Patient Care Commissioning Datasets (Commissioning Minimum Datasets);
 - Hospital Episode Statistics; and
 - Referrals, Assessments and Packages of Care (RAP)
24. Data collection has been mandatory with regard to hospital in-patients, and the care they receive, including such care provided by mental health Trusts, since 1 April 1995. The NHS Executive's letter "Collection of ethnic group data for admitted patients", 30 September 1994, (EL(94)77), refers. Recent improvements in the quality of these data are described above.
25. As part of a broader strategy to ensure that mental health services are appropriate for, and fair to, all communities, a first annual census "Count me in" of the ethnicity of psychiatric in-patients, organised by the Mental Health Act Commission, with the National Institute for Mental Health in England and the Healthcare Commission, took place in March 2005. It will provide detailed figures on the ethnicity of patients detained under mental health legislation and also on the ethnicity of other (informal) psychiatric in-patients as at end March 2005. This exercise is expected to provide a firm statistical baseline for monitoring progress in reducing inequalities.
26. Collecting ethnic group data about patients in primary care is good practice and provides essential information necessary to monitor equity and meet the legal requirements of the Race Relations (Amendment) Act 2000. Ethnic group data should be collected as part of comprehensive patient profiles that include other demographic and needs-based information.
27. With regard to general practice, the Department of Health is currently undertaking a project to redesign the system for registration to access primary medical services via GP practices (or primary care providers). This includes (currently in draft) proposed new forms which enable people, including asylum seekers, to apply to join GP practices' (or primary care providers') lists of NHS patients. It is intended that these forms will include, for the first time, an ethnic monitoring section.
28. NHS Direct has included ethnicity monitoring as part of callers' demographic information since 2003.

29. Ethnic group data is also recorded on staff in NHS hospitals and community health services and council-based social care. The NHS Executive's letter "Ethnic minority staff in the NHS : a programme for action", 31 January 1994, (EL(94)12), and the actual Programme for Action, committed NHS managers to the central collection ethnic monitoring data on NHS staff from 1994.
30. While national data collections are important, local initiatives are also taken by many parts of the NHS and social care to fill local ethnic group data gaps with regard to both patients/service users and staff. For example, the Quality and Outcomes Framework, under the General Medical Services contract, is a useful means for PCTs to incentivise GP practices to collect ethnic group and other equality data. While such local initiatives are welcomed, it is important for good practice to be shared.

**Good practice example 1
Wandsworth PCT**

As part of Wandsworth PCT's work programme to improve the level of smoking cessation and the ethnic monitoring in primary care, the PCT introduced the following indicator as "platinum points" for the Quality and Outcome Framework (QOF) for 2004/05: *a practice will achieve 5/10/15 points if they reach a level of 55%/65%/75% ethnic coding.* For an average size practice (a practice with a list size of 5,891) each point is worth £77.50 for 2004/05. For an average practice this gave a financial incentive of £1,162.50 to achieve 75% ethnic monitoring. This incentive has helped to produce an increase in the percentage of patients with ethnicity data recorded in primary care. This information can be used by the PCT and the practices to review services and ensure that patients are able to access services. The PCT is looking to build on this base data and is putting together a proposal for "platinum points" for 2005/06. This proposal will incentivise practices to attend training and education sessions on ethnicity and diversity.

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NATIONAL STANDARDS FOR ETHNIC GROUP AND RELATED MATTERS

What is an ethnic group?

31. Ethnicity is complex to define as it is multi-faceted. Importantly, ethnicity is subjective : a person should self-assign his or her own ethnic group. While other people may view an individual as having a distinct ethnic identity, the individual's view of their own identity takes priority. Features that help to define ethnic group are as follows :
 - ❑ a shared history;
 - ❑ a common cultural tradition;
 - ❑ a common geographical origin;
 - ❑ descent from common ancestors;
 - ❑ a common language;
 - ❑ a common religion; and
 - ❑ forming a distinct group within a larger community.
32. While an ethnic group is sometimes perceived as a minority within a larger community, ethnic groups cover people from all communities not just those of African, Caribbean, Asian or Chinese backgrounds. For example, White British people are an ethnic group. Because they outnumber all other ethnic groups in England, comprising 87% of the population, they are the majority ethnic group at the national level. White Irish people are an ethnic group; because they only comprise 1.3% of the population, they are a minority ethnic group at the national level. Percentage figures for all ethnic groups in England are given in Annex C.

The national standard for ethnic group and its codes

33. From April 2001, DH, Trusts and councils have used, as a National Standard, a set of **16 codes** to record the ethnic group of patients, services users and staff (see the box below). The codes are identical to those used in the 2001 ONS census, in accordance with ONS guidance on national standards. They are grouped under **five headings** : White; Mixed; Asian or Asian British; Black or Black British; and Chinese or other ethnic group.
34. The headings should not be used as codes for direct data collection. They may be used to feedback broad findings; however, even then, feedback based on the 16 codes will almost always be preferable.
35. The 16 codes are used across Government. Use of the 16 codes helps to maintain consistency between DH central collections and ONS population information. Critically, their use enables ready comparison between NHS and social care information and national and local population counts based on the 2001 census. The codes are robust following much public consultation. It should be noted that the codes may be referred to as the "16+1" codes. The extra code is for "Not stated", where for various reasons individuals do not, or choose not, to

state their ethnic group. When used to record the ethnic group of patients, service users and staff, space should be left after each of the five “Any other ...” codes so that the individual can describe their own ethnic group.

36. The 16 codes, presented under the five headings, plus instructions for completion taken from the 2001 ONS Census, are as follows :

Ethnic group – 16+1 codes
<p>What is your ethnic group? <i>Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group.</i></p> <p>A : White</p> <ul style="list-style-type: none"><input type="checkbox"/> British<input type="checkbox"/> Irish<input type="checkbox"/> Any other White background (please write in) <p>B : Mixed</p> <ul style="list-style-type: none"><input type="checkbox"/> White and Black Caribbean<input type="checkbox"/> White and Black African<input type="checkbox"/> White and Asian<input type="checkbox"/> Any other mixed background (please write in) <p>C : Asian or Asian British</p> <ul style="list-style-type: none"><input type="checkbox"/> Indian<input type="checkbox"/> Pakistani<input type="checkbox"/> Bangladeshi<input type="checkbox"/> Any other Asian background (please write in) <p>D : Black or Black British</p> <ul style="list-style-type: none"><input type="checkbox"/> Caribbean<input type="checkbox"/> African<input type="checkbox"/> Any other Black background (please write in) <p>E : Chinese or other ethnic group</p> <ul style="list-style-type: none"><input type="checkbox"/> Chinese<input type="checkbox"/> Any other (please write in) <p>Not stated</p> <ul style="list-style-type: none"><input type="checkbox"/> Not stated

Detailed breakdown of the 16 codes

37. Both questions about, and analyses of, ethnic group may refer to a more detailed breakdown of the 16 codes. A recommended detailed breakdown, based on how ONS classified 2001 census responses, is given in Annex D. When and how local NHS bodies and councils decide to use categories from the detailed breakdown in Annex D depends on local circumstances and issues. Although the 16 codes would suit most NHS and social care situations most of the time, resort to some of the breakdowns shown in Annex D is acceptable.
38. This is how it works. If a Trust or council used the 16 codes only, people who say that they belong to the "Greek Cypriot" ethnic group would be coded to the "Any other White background" group. If there is a large Greek Cypriot community in a Trust's or council's area or there is particular interest in that community, when data are being collected the Trust or council should (with reference to Annex D) include a Greek Cypriot code under the "White" heading. In this way, the Trust and council can explore issues for that community while at the same time being able to re-aggregate the Greek Cypriot code back into the "Any other White background" code for comparison with local or national population data or with data from other places.
39. Similarly, a PCT may have a relatively large Arab community. If it did nothing, the PCT would expect people of Arabic origin to code themselves under the "Any other" code of the "Chinese or other ethnic group" heading. However, the PCT (with reference to Annex D) could include an "Arab" ethnic group code under the "Chinese or other ethnic group" heading. The PCT could then explicitly identify Arab patients and staff, while retaining the ability to re-aggregate the Arab code back into the "Any other" code. Westminster PCT takes this approach in its Patient Profiling.
40. Trusts and councils should avoid using too many of the sub-codes from Annex D, the reason being that forms and questionnaires seeking ethnic group would be too long and cumbersome, and analyses too complex with the danger that important trends are lost in the detail. However, it is a matter of balance. Too few sub-codes, which mask important aspects of the local population mix, can serve just as poorly as too many sub-codes.
41. The sub-codes of Annex D may be included on forms seeking ethnic group information. Doing it this way would make coding relatively easy. Alternatively, sub-codes may be shown to patients, service users and staff if they opt for one of the five "Any other ..." codes from the 16 codes. Their answers from the fuller code list can then be recorded on forms or data storage systems. Either way, a consistent and clear approach to Annex D sub-codes allows fuller analyses of ethnic group to be carried out consistently and in a way that can build back into the 16 codes.

42. Where records for individual current patients, service users and staff still rely on the 1991 ONS Census codes for ethnic group, Trusts and councils should consider how best they might readily update these records so that individuals' ethnic group can be described using the 2001 codes. (This is important as the 1991 codes do not directly translate into the 2001 codes.)

Not stated

43. When providing information about themselves, it is not advisable to give patients, service users and staff the opportunity to record "Not stated" on the forms and questionnaires they might be asked to self-complete. Hence the "Not stated code" should not be an option. However, where patients, service users and staff leave the form or questionnaire blank or write on it that they are not willing to give their ethnic group, data processors should ensure that they can enter "Not stated" on their collection and storage systems.
44. It is important for Trusts and councils to monitor the number of "Not stated" entries on their systems. Reasons for relatively high numbers should be explored. Trusts and councils should also make provision for instances where staff administering questions about ethnic group fail to, or cannot, ask the question. Such instances are of a different order from those occasions where individuals whose ethnic group is to be coded choose not to supply the information.
45. It is generally true that "Not stated" codes and other non-entries can be minimised when senior managers are committed to ethnic monitoring, staff are trained and patients and users are given clear explanations on why they are being asked about their ethnic group. NHS bodies will be aware that the proportion of invalid and "Not stated" codes form a component of the Data Quality Indicator (DQI) and high proportions have an adverse affect on the overall DQI and hence on the organisation's overall performance.

Religion

46. DH encourages the appropriate collection of additional information that is often related to a person's ethnicity or culture. Typically, this information concerns religion, diet and language. It should be collected only if it is relevant for a particular facility or local area, and analysed locally. Its collection at an individual level should ensure that when individual patients and service users are receiving support, matters of their religion, diet and language may be taken into account. The benefits to both individuals and those providing the support are obvious. For example, if an individual is to spend any length of time as a hospital in-patient, a care home resident or day facility user, s/he may wish to express their spirituality in prayer or other means. They

may wish to receive their care in particular ways. Indeed some forms of care and treatment may be prohibited by their religion.

47. Questions about religion can be asked by using the question and codes from the ONS Census of 2001 :

Religion
<p>What is your religion? <i>Tick one box only.</i></p> <ul style="list-style-type: none"><input type="checkbox"/> None<input type="checkbox"/> Christian (Including Church of England, Catholic, Protestant and all other Christian denominations)<input type="checkbox"/> Buddhist<input type="checkbox"/> Hindu<input type="checkbox"/> Jewish<input type="checkbox"/> Muslim<input type="checkbox"/> Sikh<input type="checkbox"/> Any other religion (please write in)<input type="checkbox"/> Not stated

48. As with the ethnic group codes, the above six codes (Christian to Sikh) may be broken down to reflect local population or specific needs. For example, it may be important to distinguish Protestants from Roman Catholics and within Protestant to identify, for example, Jehovah's Witnesses. Useful breakdowns of religion are given in "The Health Survey for England, 1999" (National Statistics) and in "Count me in", the census of conducted by the Mental Health Act Commission, the National Institute for Mental Health in England and the Healthcare Commission. These breakdowns are given in Annex E. Whatever options that are offered to individuals should not be "Christian-oriented".
49. ONS makes the useful distinction between religions practice and religious identity. Religious practice comprises active faith or belief and participation in worship and religious identity. Religious identity is about identifying with a particular religious community even though the religion may not be practiced. Data on these two aspects of religion are generally used for different purposes. Data on religious practice would be used to inform and assist actual patient care and the provision of immediate facilities to enable the religion to be practiced, if needs be, in a care setting. Data on religious identity would help to monitor race equality obligations towards religions that are also considered to be ethnic groups in law. (See below.)
50. The "Not stated" category should not be included on forms asking for religions for the same reasons given above with regard to ethnic group.

51. It is noted that among the detailed breakdown of the “Any other ethnic group” code in Annex D, there are religious groups – Buddhist, Hindu, Jewish, Muslim and Sikh. If possible, (and despite the fact that for the purposes of the Race Relations Act 1976, both “Jewish” and “Sikh” constitute ethnic groups) these five groups should be avoided in recording ethnic group because they mask ethnic group. (For example, a Jew can be from any ethnic group.) If a patient, service user or staff member volunteers one of these or other religions as an ethnic group, they should be encouraged to choose another ethnic group from the 16 codes or other sub-codes from Annex D. However, some people see their religion as central to their identity and hence may feel reluctant to choose an alternative ethnic group. If that is how they feel and perceive themselves, their wish should be respected. Where Trusts and councils are recording religion as well as ethnic group, then individuals can be satisfied that their religion will be recorded, and this might persuade them to choose another ethnic group.

Diet

52. Trusts and councils that provide meals for patients and service users in hospitals or other care settings, might wish to consider using checklists when identifying individuals’ dietary requirements. If the various diets on the checklist can be coded, then Trusts and councils can use the information to monitor the types of diets that are requested, which may influence how and what food stuffs are procured.
53. Broadly speaking, diets can be grouped into five broad types :
- No special requirements
 - Vegetarian diets
 - Vegan diets
 - Diets related to religious practice such as Kosher or Halal.
 - Diets related to allergies and medical conditions such as low sugar/fat, high fibre diets for people with diabetes.

Trusts and councils may wish to use these broad types as a basis for their checklists. Staff should guard against assuming that because people are from particular ethnic groups or faiths, they will automatically need or ask for particular foods prepared in particular ways. Using the checklist, staff should discuss dietary preferences with each individual patient or service user.

54. Two recent publications can help Trusts and councils to think through their approach to diets for people from various faiths and minority ethnic communities. They are “Culturally Competent Care – a good practice guide for care management”, Kent County Council, 2002 (at www.kent.gov.uk/care.html) and “Community Handbook – a guide to understanding the diverse faith and ethnic communities in the UK”, Ambulance Service Association, 2005 (at www.asa.uk.net).

Language

55. For many people from black and minority ethnic communities it will be crucial for Trust and council staff to establish their ability and preferences in speaking and communicating in languages other than English. Trusts and councils should be prepared to ask for this information, and record it, at the earliest opportunity.
56. The NHS is founded on the principles of equal access and equal treatment for all. Providing communications support to service users is not an optional extra; this is driven by the requirement to comply with legislation and supporting guidance. The Disability Discrimination Act 1995, the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998 make it imperative for public organisations, including PCTs, other NHS bodies and local councils, to provide language and other communications support to individuals seeking help. For people who have difficulty in communicating in English or can only readily communicate using sign language, the provision of information about services in different languages and formats is essential. Likewise, when talking through their needs and circumstances with health and social care professionals, patients and service users need to be able to communicate in the most effective way possible. This may call for professional translation and interpretation services or support.
57. Reliance on family members and friends of the individual seeking help for translation and interpretation is not a good idea, as, on the one hand, the individual may feel constrained in talking about personal matters and, on the other, family members and friends may lack the expertise and knowledge to put over the individual's views accurately.
58. Trusts and councils should note that, generally speaking, written translations of hospital or care processes, procedures, treatments and services may not be the cost-effective. Some people, resident in the UK, who cannot read English also cannot read their own preferred language. Different strategies, such as putting verbally translated information on video- or audio cassettes, should be explored. Local community and staff consultations should confirm the most appropriate approaches.
59. The 2001 ONS Census did not ask a question on language or ability in English, although some questions were asked about abilities in Welsh, Scottish Gaelic and Irish languages. However, the 2005 "*Count me in*", census, organised by the Mental Health Act Commission and partners, included a categorization of language that Trusts and councils may wish to use locally. The codes are as follows :
 - Arabic
 - Bengali
 - Cantonese
 - English

- ❑ Farsi
- ❑ French
- ❑ Gaelic
- ❑ Gujarati
- ❑ Hakka
- ❑ Hindi
- ❑ Korean
- ❑ Mandarin
- ❑ Patois / Creole
- ❑ Polish
- ❑ Portuguese
- ❑ Punjabi
- ❑ Somali
- ❑ Spanish
- ❑ Tamil
- ❑ Turkish
- ❑ Urdu
- ❑ Vietnamese
- ❑ Welsh
- ❑ British Sign Language
- ❑ Any other language (specify)

60. However, local variations will need to be taken into account. For example, in London, according to recent evidence (see P Baker and J Aversely (eds), "Multilingual Capital, London", Battlebridge, 2000) with respect to black and minority ethnic groups, the 10 most spoken languages other than English are :

- ❑ Bengali and Sylheti (40,400 speakers);
- ❑ Punjabi (29,800);
- ❑ Gujarati (28,600);
- ❑ Hindi/Urdu (26,000);
- ❑ Turkish (15,600);
- ❑ Arabic (11,000);
- ❑ English-based Creoles (10,700);
- ❑ Yoruba (10,400);
- ❑ Somali (8,300); and
- ❑ Cantonese (6,900).

61. Data from NHS Direct indicates that among callers requiring interpretation in the course of 2003 and 2004, the most frequently requested languages included Punjabi, Urdu, Bengali, Gujarati, Hindi, French, Spanish, Polish, Arabic, Turkish, Portuguese, Farsi, Tamil and Somali.

62. Trusts and councils should make the distinction between languages that are spoken (as some people are fluent in more than one language) and where people genuinely need to communicate in languages other than English. The "Health Survey for England, 1999" (National Statistics) includes questions that can be used to establish competency in written and spoken languages including English.

Help with translation and interpretation

63. NHS Direct (on 0845 45 47 or at www.nhsdirect.nhs.uk), which operates from call centres across England and is available on line, provides advice to callers on symptoms they or others are experiencing and local help that is available. Nurse Advisors or Health Information Advisors answer calls as appropriate.
64. From October 2004, NHS Direct started utilising one national supplier (Bowne Global Solutions) to provide services to callers for interpretation, translation and British Sign Language interpretation. All callers who have difficulty in speaking English, and prefer to speak in other languages, can have a telephone interpreter on the line during a consultation. The interpretation service provides interpreters in whatever language is required, and the service is available 24 hours a day seven days a week. Callers can request that details of relevant local health resources be read out over the phone or posted to them, and information will be made available in languages other than English. The NHS Direct Access to Information Centre holds stocks of all materials in languages other than English. Information can also be made available in formats other than print, including Braille and audio-tape.
65. The national contract which NHS Direct has procured also provides a framework contract for all NHS bodies for BSL, translation and telephone interpreting. Trusts can purchase services through the contract and benefit from the economies of scale, delivery standards and quality assurances that have been incorporated within the contract. The contract also makes provision for a shared web-based database of translated materials, including patients information leaflets, standard letters, and so on.
66. The Government-funded "Health for Asylum Seekers and Refugees Portal" (HARP) website, www.harpweb.org.uk, is aimed at health professionals working with asylum seekers and refugees. The site is maintained by a non-profit making organisation based at the University of East London. It includes a multi-lingual appointment card that translates appointment information into 31 languages and is freely available to NHS staff and other agencies. It also provides an on-line resource so that local organisations can share locally developed translated material.
67. Sign, the National Charity for deaf people with mental health problems, on www.signcharity.org.uk, has developed software for use in healthcare settings. This software provides video clips of British Sign Language phrases to support communication. It can be easily adapted to provide translations into minority community languages, and can also be used to produce written information about health conditions, medications and treatments for patients to take away.

68. The importance of providing support to people who have difficulty in communicating in English, and the importance of monitoring changing patterns of language use and the take-up for translation and interpretation services, is shown in the good practice example below.

Good practice example 2
Leicester City Council

The Social Care & Health Department (SCHD) of Leicester City Council arranges for extensive translation and interpreting services so that language support is available for interaction between SCHD and those users whose first language is not English. SCHD regularly uses the interpretation skills of up to 100 sessional interpreters who, between them, speak over 65 African, Asian and European languages. The service also has access to communication in British Sign Language and translation in Braille. During 2003/2004, over 7,144 hours of service were used. Gujarati and Punjabi are the two main languages with over 43.5% usage in that year. A noticeable increase has taken place in certain languages; these are Afrikaans, Cantonese, French, German, Italian, Japanese, Kurdish, Mandarin, Mongolian, Farsi, Pushto, Romanian, Russian, Serbo-Croat, Swahili, Thai and Urdu. SCHD continues to provide ongoing supervision, support and consultation for interpreters and efforts are made to undertake quality monitoring visits with interpreters to identify any issues and future training needs. Work will continue around identifying the need for increases in languages covered and recruiting interpreters to meet the demand. Currently SCHD is undertaking a survey of all people who have used its interpreters, in order to evaluate and assess the quality and accessibility of the service, and identify whether any equal opportunities issues are reported by service users accessing this provision. Further work will be undertaken upon the results of the survey to ensure the service has attended to race equality and other equality issues.

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HOW TO IDENTIFY, COLLECT AND REPORT ETHNICITY DATA

Ethnic monitoring applies to all populations and parts of the country

69. All Trusts and councils need to collect and analyse data about the ethnic groups to which their patients, service users and staff belong. This is not just an issue for organisations serving areas with large black and minority ethnic populations. If the NHS and councils are to provide fair and fast access to care services, they need to assure themselves that all communities, including majority and minority ethnic communities, no matter how large or small, can access services equally according to their needs.
70. Similarly, if the NHS and councils are to be fair employers, they need to assure themselves that individuals from all communities, no matter how large or small, have equal chances of being successful at interviews or other selection processes for health or social care jobs and, once employed, are treated fairly in terms of career development and can be free of discrimination at work.
71. The best way to ensure fairness for patients, service users and staff is to undertake ethnic monitoring, with routine reports coming to senior managers, staff groups and community groups. The requirements of the Race Relations (Amendment) Act 2000 and the “National standards, local action” framework from DH further emphasise the need for consistent and intelligent ethnic monitoring.

Senior management commitment

72. Race equality in general, and ethnic monitoring in particular, needs drive, ownership and commitment from the top of the organisation, including clinical leaders or senior service managers and senior administrators and planners. This is true of all NHS bodies and councils and is also true of DH. The role of clinical leaders and senior service managers cannot be emphasised enough as it is their staff in front line practice positions, together with reception staff, who are often best placed to collect and use ethnic group and other personal data on reception or at referral.
73. This important principle of committed leadership is recognised by DH, as shown by the 10-point Leadership and Race Equality Action issued in February 2004 by Sir Nigel Crisp. It is recognised by PCTs. The Race for Health programme (www.raceforhealth.org), which involves 13 PCTs in effecting local and wider improvements for patients and staff from black and minority ethnic communities, is based on the commitment of the Chair, Chief Executive and Chair of the Professional Executive Committee in each participating PCT.
74. NHS and council senior managers and Board/Committee members should ensure that they understand how best to use ethnic group data

in their decision making. They should consider reinforcing messages about how ethnic group data fit in with the business objectives of the Trust or council. They should make it clear to staff and local communities that ethnic group data are used in strategic decision making, and they should demonstrate this use of ethnic group data through feed back.

***Good practice example 3
Croydon PCT***

The Chief Executive of Croydon PCT has supported the introduction and implementation of ethnic monitoring in all community services. As a result over 300 staff attended the training and all community services now collect good data. So far the PCT is able to collect the ethnicity of 75% of patients and have started using it to monitor the take-up of services. The PCT acknowledges that there is a long way to go and that ethnic monitoring needs to be rolled out across all primary care services.

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***Good practice example 4
North West London SHA***

North West London SHA has led the development of sector-wide ethnic monitoring. It has done so by issuing guidance on an agreed data set supported by the DH/ONS national standard for ethnic group. The SHA has incorporated an ethnic monitoring indicator in GP quality contract monitoring. It has provided support and advice to ensure that PCTs and NHS Trusts take a consistent approach to ethnic monitoring. It has facilitated collective negotiation with software suppliers. It has advised on systems for analysis and reporting back, and on how data may be used.

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75. Trusts and councils should develop easy-to-read leaflets, or information in other formats where appropriate, for Board or elected members and senior managers that explain the reasons for ethnic monitoring and how decision-making may be informed from data that derive from this monitoring. A “model” leaflet is provided in Annex F. Trusts and councils are encouraged to use or adapt this leaflet.

Local consultation and involvement

76. There is a slogan in the learning disability field “Nothing about us, without us”. This means that people with learning disabilities and their families, or carers, should be consulted and treated as partners, at all

times, when service issues affecting their care are discussed and decided.

77. This selfsame principle should also apply to black and minority ethnic patients, service users and staff. If important initiatives or changes are being proposed, Trusts and councils should consult with relevant black and minority staff groups and communities.
78. Ethnic monitoring still arouses suspicion for some people. Rather than see it as a force for good, they see it as a means of further discriminating against them. The reasons for ethnic monitoring should, therefore, be carefully explained, and analyses and decisions, based on the results of ethnic monitoring, should be openly shared. In addition to consultation, Trusts and councils can further gain the confidence of black and minority ethnic communities and staff by involving them in understanding the data and decision-making. ODPM's 2004 publication "Ethnicity monitoring : involvement – guidance for partnerships on monitoring involvement" may be referred to in this regard.

***Good practice example 5
Westminster City Council and Westminster PCT***

As part of a Civic Renewal Programme, Westminster City Council and Westminster PCT wished to audit the service and community development needs of seven local black and minority ethnic communities. The needs covered not only health and social care but also benefits, education, housing, leisure, employment, literacy, and community safety. The audit was carried out by Imperial College London in partnership with local black and minority ethnic organisations. It identified barriers to access and how these could be overcome, how services could be better targeted, and how black and minority ethnic communities could be involved, informed and consulted more effectively. Information for the audit involved field and desk research. The field research was carried out by members of the seven communities that were the focus of the audit. Almost 50 black and minority ethnic community members were recruited and trained as fieldworkers. The outcome of the audit has been used to inform the Race Equality Schemes of the City Council and the PCT and the Local Delivery Plans for the PCT. It has led to the setting up of a Strategic Partnership Group involving representation from black and minority ethnic communities in Westminster. On the ground, as a result of this community-based partnership activity, language support to service providers has been improved, and two Healthy Living Centres and Sure Start programmes have been supported.

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Good practice example 6
Leeds Race Equality Council supported by Leeds City Council

In common with the rest of the UK, the history of Gypsies and Travellers in Leeds was one of exclusion and discrimination. From 2000, the Leeds City Council-facilitated Race Equality Advisory Forum (REAF) began to focus attention on the lack of local services for Gypsies and Travellers. As a result, REAF established the Gypsies and Travellers Working Group. Shortly afterwards, the City Council developed a Senior Officers Group to consider matters pertaining to Gypsies and Travellers across the council's major services. While some headway was made, a common problem was the absence of a data-base against which to identify needs and assess progress. In March 2004, the Leeds Race Equality Council, with financial support from the City Council, undertook a census of the Gypsy and Traveller community in Leeds. Working with Gypsy and Traveller community members through the established community representative groups, a questionnaire was developed by the Chair of the REAF working group. Gypsy and Traveller community members came forward to act as enumerators. In view of low literacy, a numbered questionnaire using a graphic format requiring only a tick or number as a response was approved. In this way, the census elicited basic information about household composition, age profile and accommodation type. Enumerators divided the task according to type of accommodation and area and then interviewed heads of family. Enumerators were advised to use a "snowball" system to extend the number of respondents from those known to them to the unknowns. The data were analysed as far as possible by comparison with local data on other groups from the 2001 ONS census.

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Decide which codes for ethnic group, religion, language and diet to use

79. Trusts and councils should make decisions about which codes and sub-codes to use based on local circumstances and issues. As a minimum, for data collection purposes, the 16+1 ethnic group codes should always be used. If needs be, sub-codes of the 16 codes may be used as long as they aggregate back up to the 16 codes. (Annex D provides a breakdown of the Census codes for ethnic group into further sub-codes.) Trusts and councils should not, for data collection purposes, group the three White codes into one. The reason for this is that there is compelling evidence that White Irish and Other White individuals and communities in England experience significant health inequalities compared with White British counterparts. If White British, White Irish and Other White codes are merged at the data collection stage, Trusts and councils will have no way of monitoring and keeping tracking of such health inequalities. Likewise, grouping any of the

Mixed, Asian/Asian British, Black/Black British codes at the data collection stage will not allow Trusts and councils to monitor the different health inequalities experienced by different individuals and communities.

***Good practice example 7
Central Liverpool PCT***

In Central Liverpool, one of the first initiatives introducing ethnic monitoring into primary care was based in Princes Park Health Centre. The initiative had two goals : first, to develop a mechanism for determining morbidity and service usage profiles for patients registered at the centre; and, second, to use the profiles to develop action plans to improve access to health care services in general and in particular for black and minority ethnic communities. The project steering group examined the possibility of using existing data collection systems as the basis for expanding the information. However because of the piecemeal and opportunistic nature of the information held at that time, and the fact that different baselines had been used for the gathering of past information, useful comparability between different data sets could not be established. As a result, a new Patients Information Form (PIF) was constructed. The questions and codes of the PIF were designed to be compatible with those used in other national survey work such as the 2001 ONS Census. The PIF was mailed out to all registered patients aged 16 and over with a stamped addressed envelope. The initiative is now fundamental to Central Liverpool PCT's Diversity Equality Scheme and is being rolled out to the remaining practices across the PCT. To date over 120,000 patients registered with GP practices have been asked to complete the PIF. The information is being used to review and improve services at practice level. The response rate varies from 46% to 69%, with the great majority of practices achieving over 60%. Solutions to low response rate are at present under investigation.

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Staff training and getting main messages to busy frontline staff

80. Training of NHS and social care staff is critical to the success of collecting ethnic group data. The training should be an integral part of new staff and refresher training programmes. The content of training materials should be tailored to local circumstances and experiences of ethnic monitoring. However, all training should emphasise why ethnic monitoring is important and that self-classification is imperative. It should include the uses to which good ethnic monitoring data may be put. Local community groups should be asked to comment on the content of the training and asked to contribute to, or lead, particular parts of the event.

81. Attendance on training courses will be essential for all staff who may need to collect ethnic group and related data from patients, users and fellow staff members. It is also essential for staff and Board members who analyse, report and make decisions based on the data. However, the design of training programmes should recognise that different staff groups are likely to have different training needs.
82. This Practice Guide should be made available to those on training courses about ethnic monitoring. Other good source material includes the National Statistics 2003 publication “Ethnic group statistics – a guide for the collection and classification of ethnicity data” and the CRE’s 2002 guidance “Ethnic Monitoring : a guide for public authorities”.

***Good practice example 8
Hammersmith & Fulham PCT***

Hammersmith & Fulham PCT has developed an in-house “Ethnic Monitoring Training” (EMT) programme. It is a three-hour awareness session on collecting ethnicity data and is run four times a year. The course is essential training for all employees that collect ethnicity data. Particular staff groups may be targeted for the training if they have problems in collecting and recording the data. A trainers pack has been developed to provide trainers with consistent messages, including how ethnic group data may be used.

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83. Trusts and councils should develop easy-to-read leaflets for front-line staff, and the same information in other formats where required, that explain the reasons for ethnic monitoring, how patients and service users should be asked for their ethnic group, and uses made of the information. A “model” leaflet is provided in Annex G. Trusts and councils are encouraged to use or adapt this leaflet.

Self-classification

84. As said above, a person should self-assign their own ethnic group, once they have agreed for the Trust or council to have this information. Self-classification is not a courtesy but a recognition of the fact that a person’s ethnic group is an integral part of their identity. How an individual sees her or himself may be different from how that person’s parents, other family members or third parties see them. Individuals should not be assigned by a member of staff and certainly not without explanation or discussion.
85. There are some unavoidable exceptions to this rule. For example, parents or carers should speak on behalf of babies and young

children. However, a baby or young child should not be automatically accorded the ethnic group of the mother. Computer systems should not have a default to the mother's ethnic group. As far as children are concerned, their views should be sought if they are capable of understanding and responding to what they are being asked. Parents or carers may support children in giving their answers.

86. Close relatives or advocates may speak on behalf of individuals who because of physical illness or disability, learning disability, cognitive impairment or mental ill-health, are unable to speak for themselves or are not able to understand what is being asked of them or give an accurate reply. However, past care assessments or other records, reflecting a time when the individual could respond for themselves, which include a previous self-assessment of ethnic group, may be as good a source as any in these circumstances.
87. As with all other aspects of the care process, some individuals who have difficulty in communicating in spoken or written English, may need the support of translators or interpreters to help them understand and respond to questions about their ethnic group. With regards to visually impaired patients, users or staff, braille or other accessible versions of the necessary paperwork may need to be provided. For people with learning disabilities, easy-to-read paper-based versions should be available. Where staff members read out the questions on ethnicity they should take care to read all the instructions and codes.
88. When responding to ethnic group codes or sub-codes, individuals should not select more than one code or sub-code. In some cases, one of the five other codes might be suitable. Use of the actual question from the 2001 ONS Census will help individuals choose the right code for them. The question (in bold) and related guidance (in italics) are as follows :

What is your ethnic group? *Choose one section from A to E, then tick the appropriate box to indicate your ethnic group .*

The sections A to E are the headings given in paragraphs 33 and 36 above. After each of the five "other" codes from the 16 code list, space should be left for individuals to write in their ethnic group.

89. Staff should keep a note of genuine coding difficulties as Trusts and councils should keep their coding lists under review to ensure that they remain comprehensive and representative of local demographics and issues.
90. Trusts and councils are reminded that forms and questionnaires that patients and service users are asked to self-complete, should not include a "Not stated" code, as this might encourage people not to volunteer their ethnic group. Data collectors and analysts, however, should have a means of entering "Not stated" onto data collection

systems where patients and users decide not to give their ethnic group.

Four types of information

91. Broadly speaking the collection and analysis of ethnic group data requires four sets of information :
 - a) A national demographic baseline
 - b) The local demographic distribution
 - c) Data about patients and service users – using the same codes as those of (a) and (b) above
 - d) Data about the workforce – using the same codes as those of (a) and (b) above

92. For example. a council may wish to compare the number of referrals it has from different black and minority ethnic communities in its patch. Under the RAP return, the council is already recording the ethnic group of people referred to it for social care help, using the 16 code national standard. While absolute numbers are useful in their own right, the council wants to know if some ethnic groups are disproportionately represented among referrals compared with other groups. To make this comparison, for each ethnic group, the council calculates the referral rate per 1,000 people living in the community. In this way, it discovers that while most of the 16 ethnic groups have a 40 to 50 referral rate per 1,000 population, the referral rate for one of the groups is under 10, while the referral rate for another is 100. The council then explores the significance and meaning of these disproportionate rates.

93. Similar analyses can be undertaken with respect to the workforce and how representative it is of local communities and the proportions of staff from different black and minority ethnic populations at different grades and in different professions.

<i>Good practice example 9</i> <i>Kings College Hospital NHS Trust</i>

<p>Kings College Hospital NHS Trust is committed to providing high quality health services. In order to do this the Trust recognises that it must have a workforce that, at all levels, reflects the community it serves. Kings employs about 5,300 staff of whom 45% are from black and minority ethnic backgrounds. This compares with the black and minority ethnic population in Lambeth and Southwark of around 35%. There is ongoing workforce monitoring, based on the ONS 16+1 codes, to track progress and inform decision-making. In most occupational areas in which black and minority ethnic employees are under-represented, the proportion of such staff is growing. Although black and minority ethnic employees are still under-represented in senior positions and some professions, significant progress has been demonstrated in recent years and steps are in place to make the organisation more representative.</p>
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Kings also monitors staff attitudes through an annual attitude survey. The most recent survey revealed that black and minority ethnic members of staff have, on average, similar views and experiences as their white colleagues about their working lives. The Trust recognises that collecting good quality data on ethnicity is essential to ensure that it is a fair employer who provides equality of opportunity for people from all backgrounds. 95% of members of staff have known ethnicity and the introduction of new software at the end of 2004 will ensure that Kings can begin to monitor the ethnicity of applicants for employment and promotion and staff undertaking training.

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Collect the information routinely and effectively

94. Data on ethnic group, related matters and other personal information should be collected, as far as possible, as a matter of routine at reception or referral or when patients and users register for a service. Reception staff and frontline staff will play the most prominent part in these processes. The more the process is routine and unremarkable the better. While organisations differ with respect to function, structure and procedures, there are some general principles that will stand all organisations in good stead :
- It should always be made clear to patients and service users that the provision of ethnic group data is voluntary.
 - As with all personal information, procedures should be in place to ensure privacy when ethnic group data is sought.
 - Patients and service users usually should be shown the full range of ethnic group codes that are in local use so that they can select the code that best describes them.
 - Collecting ethnic group information at the same time as the bulk of registration, admission or referral information is collected is natural and efficient. Staff should explain why such information is required.
 - Issuing ethnic monitoring forms with outpatient literature or with appointment letters saves time at registration (but only if forms are accompanied by clear guidance notes).
 - Staff should be trained and supported in identifying and working with patients and users with communication needs, such as individuals with learning disabilities.
95. Of course in some situations, the admission will be an emergency or the individual being admitted may be in no fit state at the time to talk lucidly about themselves let alone give their ethnic group. Trusts and councils, should therefore have arrangements in place for recovering ethnic group and other data following such admissions. Psychiatric hospitals or hospitals with busy Accident and Emergency departments should take particular note of this particular piece of guidance.

96. In some situations, perhaps when details are being taken over the phone, it may not be practicable or possible to read or show patients and service users the full set of ethnic groups when asking them to describe their ethnic group. Trusts and councils should give thought on how to minimise these situations and attempt to capture the information at a more appropriate time.
97. As said earlier, braille, easy-to-read or other accessible versions of the necessary paperwork may need to be provided. Where staff members read out the questions on ethnic group to visually impaired individuals they should take care to read all the instructions and codes.

Good practice example 10
Kent County Council

Kent Social Services Department's record of ethnic monitoring used to be patchy but it is now much improved through becoming part of normal information gathering on all care assessments. The first stage was the redesign of the ethnic monitoring codes on the initial assessment form following adoption of the 16 codes from the 2001 ONS Census. These forms are completed electronically and give social workers and care managers drop-down tick-box options. Training and the general dissemination in 2002 of "Culturally Competent Care" (the Social Services Department's own guide that has achieved national recognition) supported the proper completion of the forms. The second stage was the establishment of a County Duty Service (CDS) in May 2002, which now handles the great majority of new contacts with the Department. This centralised service has developed a consistent but flexible approach to ethnic monitoring. It is standard practice to try and establish the ethnicity of prospective or new service users. This message is reinforced through duty manuals and training. Even though asking about ethnicity is routine, CDS officers use a flexible approach depending on the service user and their individual situation. The CDS have found that a directly asked question about ethnic group may not work. Some people simply misunderstand it, and others (especially White British people) volunteer their religion, as they do not perceive themselves as belonging to an ethnic group. Where there is confusion, CDS officers explain the question further and, as a result, most people grasp what is being asked of them. CDS officers recognise that further assessments and actual services may be influenced by responses to the ethnicity question. Hence they approach it with due care and regard.

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Good practice example 11
Leicestershire County Council

Leicestershire Social Services Department has been routinely collecting information on the ethnicity of service users since the introduction of SSIS, its main client database in the early 1990s. With the introduction of the “Referrals, Assessments and Packages of Care” (RAP) national returns in 1999, monitoring of ethnicity became a key element of internal management information. This provides an ethnic breakdown of client numbers using the 16+1 Census categories for those referred, assessed, and receiving services (shown by services for adults and children). Among front line staff there is a wide ownership and understanding of the need to record ethnicity information. The numbers of ‘Not stated’ ethnicity for those assessed and receiving services is less than 1%. The high level of recording of ethnicity by front line staff has enabled the monitoring to be embedded in the wider quarterly performance and activity reports. The regular presentation of data in this way informs service planning, generates specific analyses, and keeps all staff in touch with the ethnic diversity of people supported by the department.

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Information in context – the process

98. Ethnic monitoring is more than data collection. It is the process used to collect store and analyse data about people’s ethnic background, and then to take action on the issues that are revealed. Ethnic group data should be regularly analysed and questioned, then followed up, and any issues that they have highlighted should be tackled. For further discussion reference can be made to “Ethnic Monitoring : a guide for public authorities”, Commission for Racial Equality, 2002.
99. There are a number of frameworks that Trusts and councils can use to help them make the most of ethnic group data in an ordered and outcome-focused way. The completion of Health Equity Audits and related equality impact assessments requires good local data on a range of issues including health inequalities experienced by different black and minority ethnic individuals and communities, where these inequalities are genuine and significant. Information and analyses from the Health Equity Audits then feed into Local Delivery Plans.
100. Trusts and councils that update their Race Equality Schemes on a routine basis and actively use Scheme data to understand and tackle race inequalities in service provision and in the workforce, will have a ready framework for collecting ethnic group and related data and taking action where appropriate. Those Trusts and councils that take a

“tick box approach” to their Race Equality Schemes every three years, and make no use of its contents in the interim, will not be able to demonstrate they are meeting their legal obligations or doing their core business effectively.

Good practice example 12
Bradford City Teaching PCT(tPCT)

Because Bradford City tPCT serves a community where black and minority ethnic residents account for more than 60% of the total population, the Board takes its employment duties under the Race Relations (Amendment) Act 2000 extremely seriously and is determined that the tPCT is an employer of choice. In consequence, the tPCT's Race Equality Scheme is comprehensive and serves as a working document. Through it, the Human Resources Team routinely collects data on the ethnicity, gender and age of all employees. This team is charged with presenting data on the workforce, broken down by ethnic group, every six months to the Board who monitor progress. The data cover numbers of staff in post and grades; shortlisted, interviewed and successful applicants; and promotions; and training opportunities. The tPCT has used the data to develop a number of key initiatives that have led to a more diverse and representative workforce. These initiatives include : a positive action trainee scheme in speech and language therapy; a “succession planning scheme” to provide coaching and mentoring for students aged 16 and over interested in pursuing a career in the NHS; and career progression for black and minority ethnic staff in areas of under-representation through programmes such as the Beacon Leadership Programme and Breaking Through. The tPCT has recently appointed a Positive Action Implementation Manager to enable the tPCT to sharpen its focus on jobs and skills gaps and effect change. Bradford tPCT, supported by its ethnic group data, also works in partnership with other local stakeholders to promote the NHS as a career in schools and further institutes of education and within local community groups. The tPCT has also created a NHS Job Shop, as part of local regeneration agendas linked to national initiatives such as “Fair Cities”.

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Good practice example 13
Bedfordshire County Council

Bedfordshire County Council routinely collects and analyses data on all employment practices across the authority. Over the last two years, the Council has been able to undertake increasingly sophisticated employment monitoring. The following data are now being analysed on a regular basis in accordance with the council's Race Equality Scheme :

- ❑ Applications for employment, promotion and training;
- ❑ Grievances;
- ❑ Disciplinary action;
- ❑ Sickness; and
- ❑ Leaving employment.

In addition, the Council is now producing a range of reports covering the recruitment and retention of employees and workforce profile data with analyses by gender, ethnicity and disability. This information is provided by a Human Resource system which was implemented during 2003/04 and further development work is taking place to ensure the system is fully compliant with the Council's statutory reporting requirements (including Best Value Performance Indicators) as well as its Race Equality Scheme.

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101. Similarly, the "Race equality guide 2004 : a performance framework", published by North Central London SHA, in collaboration with the Commission for Racial Equality, on behalf of all English SHAs, rehearses the arguments for ethnic group recording, the uses to which resulting information may be put, and how NHS bodies may improve their performance in this regard. The framework can be accessed at www.cre.gov.uk.

Information to patients, service users and the public

102. Trusts and councils should prepare leaflets for the public, and put the information in easy-to-read and other formats where necessary, which explain why information such as ethnic group is important to them and how it may be used. The content of the leaflet, and dissemination, should be discussed with local community groups. The leaflet should allay any fears that information on ethnic group may be used to discriminate against individuals and groups. The leaflet should emphasise that while Trusts and councils would value the information, individuals are not obliged to disclose their ethnic identity if they so choose. A "model" leaflet is provided in Annex H. Trusts and councils are encouraged to use or adapt this leaflet.

***Good practice example 14
Kings College Hospital NHS Trust***

Kings College Hospital NHS Trust has developed a poster to inform patients why the Trust needs to know about their ethnic origin. The poster is displayed in prominent places in the hospital's buildings including the Accident and Emergency Department and the main Reception area. It explains that information on ethnic origin helps the Trust to plan and develop its services to best meet the needs of everyone in the diverse community it serves. The poster

emphasises that ethnic origin information is particularly helpful so that the Trust can develop its sickle cell, bone marrow transplant and diabetes services. It adds that ethnic origin and related information can help to plan patient menus and translation and interpretation services and to raise awareness about African Caribbean organ donation. The poster includes supporting evidence about the prevalence of sickle cell in certain communities and information on the availability of translation and interpretation support.

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Consent and confidentiality

103. When it comes to seeking, collecting, storing and using personal information about patients, service users and staff, Trusts and councils should pay due attention to the Data Protection Act 1998 and the Human Rights Act 1998. Patients, service users and staff should expect personal information held about them to be held securely and access to it only given to people on a need-to-know basis. Individuals should be asked to give their consent for their personal data, including, ethnic group to be recorded on computer and other systems. They should also be told who might have access to this information and be given the chance to say whether or not they are content for the named agencies and individuals to have access to their personal information. These matters should be communicated to individuals appropriately. Consent should be regularly reviewed, and individuals should have the opportunity to withdraw it at any time. While the NHS and councils aim to give everyone a good care experience, individuals who withhold or withdraw their consent should be informed of any implications for the quality of the assessments or care they will receive. Individuals should not be coerced or forced into giving information about their ethnicity.
104. For further details Trusts should refer to “The NHS Confidentiality Code of Practice”, published in 2003. This Code is an authoritative guide to required practice for those who work within or under contract to NHS organisations concerning confidentiality and patients' consent to use their health records. It replaces previous guidance. HSG(96) 18/LASSL (96)5 - “The Protection and Use of Patient Information” - and is a key component of emerging information governance arrangements for the NHS. The key messages of the Code apply equally to councils as they do to the NHS.

Reporting and using ethnic group in the NHS and social care

105. Through using data, and openly sharing results with the public, patient and user groups, staff and other stakeholders, Trusts and councils can demonstrate that data collections can make a positive difference to individuals' experiences of the NHS and social care. The routine use of

data, particularly at Board or committee level, also usually leads to improvements in the scope and quality of those data.

106. The London Health Observatory's (LHO) forthcoming report "Analysing ethnic differentials in health services and the workforce : a toolkit for local agencies" should help Trusts and councils, with the support of public health colleagues, to turn their data collections into useful analyses and reports for sound decision-making. The LHO report will also offer quick tips on approaching various analyses and insights into issues addressed in this Practical Guide.
107. What follows are a number of examples where the use of ethnic group data is making, or has made a difference.

**Good practice example 15 (in support of No. 7)
Central Liverpool PCT**

Good practice example 7 highlighted Central Liverpool PCT's introduction of ethnic monitoring into primary care. In this example, uses made of the results of the ethnic data obtained via the Patient Information Form are given. With the introduction of the new GMS contract Quality & Outcome Framework, the PCT was able to link patients' ethnicity and their conditions. The PCT included four conditions to start with : coronary heart disease, diabetes, smoking and obesity. By doing so, the PCT gained a clearer picture than before about who, living where, has what condition in order to plan an appropriate service for patients. Because of this work, dialogue was commenced between GP practices and public health colleagues on health inequalities. The direct profiling of patients listed on disease registers, such as coronary heart disease and diabetes, gives the PCT a good picture about individual practices and possible support needed to enable access to services. One surgery used the information to recruit staff from minority ethnic groups to meet the needs of minority ethnic patients. Another practice had a high proportion of smokers from ethnic minority background. Here smoking cessation and initiatives were targeted at people from these backgrounds and practice staff were offered smoking cessation training to empower them to work alongside and independently of other smoking cessation services. The ability to target certain communities with health promotion information led to successful initiatives such as the yearly Arabic/Yemeni Health Day. Training surrounding equality and diversity is undertaken in each profiled practice. Because of the work in Central Liverpool, ethnicity monitoring is now seen as an essential step in assessing the health needs of the ethnically diverse local population.

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Good practice example 16
Sheffield North PCT

In 2002 a GP practice in north Sheffield, with a high and diverse number of black and minority ethnic patients, was experiencing difficulties in providing care for patients with coronary heart disease. In addition, many patients were failing to turn up for appointments and those that did sometimes had difficulty in communicating their needs. In response, through support from Sheffield North PCT, a black and minority ethnic support worker post was created to improve the recording of ethnic data and language and communication needs. A clinical system template and data collection system was developed with support of the local PRIMIS (Primary Care Information Services) worker. Links were also established with national groups which had interest and expertise in ethnic monitoring and patient profiling. The GP practice used the information from the new systems to identify its interpretation and translation needs, resulting in the employment of two bilingual receptionists (who were Urdu/Punjabi and Somali speakers) and additional support from Arabic-speaking link workers. The support worker post is now funded on a permanent basis by the PCT, and its role has expanded to provide support to other practice keen to update their ethnic monitoring systems.

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Good practice example 17
Hammersmith Hospitals Trust

When developing and expanding its renal services, Hammersmith Hospitals Trust noticed in its ethnic monitoring data, which uses the ONS national standard, that these services are disproportionately used by Asian and African Caribbean people. Accordingly, a GP training seminar focusing specifically on this issue was set up. The event was well attended, especially by GPs from Ealing, which has a large Asian population. It was led by a hospital consultant and highlighted that presenting symptoms and issues often differ between different ethnic groups. The public health challenge is now to educate the different individuals and communities about prevention and treatment. The Trusts and the local PCT are working together on this challenge.

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ANNEX A

HEALTH, SOCIAL CARE AND RACE EQUALITY : AN OVERVIEW

Abstract : this annex summarises recent, current and planned Department of Health initiatives to promote race equality in the NHS and social care.

The National Health Service

Commitment to fairer and faster services

Ministers are committed to transforming the health and social care system so that it produces faster, fairer services - designed around and responsive to service users - that deliver better health and social care and tackle inequalities. (See the NHS Plan.)

Leadership and Race Equality Action Plan

Sir Nigel Crisp, Chief Executive of the NHS and DH, launched the 10-point Leadership and Race Equality Action Plan in February 2004. It challenges NHS leaders to address race equality in a systematic and professional way. This plan addresses service delivery and workforce issues. The aim is to ensure that equality and diversity are fundamental to NHS strategies and that the needs of minority ethnic communities are effectively addressed. DH has set up an Independent Panel of experts to keep the Action Plan under review, provide advice and challenge progress.

Race for Health

At the same time, the Race for Health programme was commenced to demonstrate how effective leadership by Primary Care Trusts (PCTs) can effect real, lasting improvements for minority ethnic patients. This programme aims to effect transformational and enduring change in the way in which services are commissioned and delivered, and includes innovative and better ways of identifying and tackling diabetes, coronary heart disease, sickle cell and other conditions that can significantly impact on the lives of individuals from minority ethnic communities.

The "Race for Health" programme not only focuses on commissioning and service delivery but also on workforce development including demonstrating ways of attracting people from local minority ethnic communities to work in the NHS, helping them prepare for applying for jobs and, once appointed, ensuring that they have a fair and equal chance of career development.

"National standards, local action"

In July 2004, "National standards, local action : health and social care standards and planning framework – 2005/05 – 2007/08" was published. This framework requires PCTs, as part of local target setting and local delivery plans, to take full account of different needs and inequalities in their local populations, including issues of race equality, through Health Equity Audits. The Healthcare Commission is developing inspection criteria for the standards of the framework that, among other things, will help to ensure that health care is provided equitably to all groups in local communities.

National Director for Equality and Human Rights

In October 2004, the first ever National Director for Equality and Human Rights for the NHS took up his post. Surinder Sharma will promote the Leadership and Race Equality

Action Plan, tackle inequalities in health and social care delivery, and ensure that the NHS can draw on the talents, skills and experiences of all parts of the community.

Tackling health inequalities

“Choosing Health”

The publication of the White Paper “Choosing Health” in November 2004 underlines the Government’s commitment to improving the health of the public. Ministers and senior officials at the at DH are committed to mainstreaming race equality (as recommended by the Acheson Inquiry), tackling health inequalities and improving the experiences of, and outcomes for, minority ethnic patients and services users and staff working in the NHS and social care.

Spearhead Group

By 2010, the Department aims to reduce, by at least 10%, the gap between the fifth of areas with the “worst health and deprivation indicators” and the population as a whole. These target areas are collectively called the “Spearhead Group”, and inclusion in the group is based on male life expectancy at birth, female life expectancy at birth, cancer mortality rates, circulatory disease mortality rates and the ODPM Index of Multiple Deprivation. Targeting the Spearhead Group of the fifth of areas with the worst health and deprivation indicators encompasses 44% of the black and minority ethnic population of England, compared to 28% of the population of England. Although targeting areas with poor health and deprivation indicators alone will not necessarily lead to higher life expectancy amongst minority ethnic communities, the large proportion of minority ethnic communities within the lower life expectancy areas does imply a greater potential for impact and improvement amongst these communities.

Mental health

“Count me in”

There is evidence that some minority ethnic groups are over-represented among patients who are detained under the Mental Health Act 1983. A first annual census “Count me in”, organised by the Mental Health Act Commission, with the National Institute for Mental Health in England and the Healthcare Commission, took place in March 2005. It will provide detailed figures on the ethnicity of patients detained under mental health legislation and also on the ethnicity of other (informal) psychiatric in-patients as at end March 2005. This exercise is expected to provide a firm statistical baseline for monitoring progress in reducing inequalities.

Delivering Race Equality in Mental Health Care

This work is part of a broader strategy to ensure that mental health services are appropriate for, and fair to, all communities. Concerns have been expressed over a number of years that minority ethnic communities do not have access to appropriate mental health services. DH is addressing these concerns through *Delivering Race Equality in Mental Health Care*. This important publication was published in January 2005 together with the formal response into the independent inquiry into the death of David Bennett. *Delivering Race Equality in Mental Health Care*, and its plan for action, provides the a long-term national programme on minority ethnic mental health, and sets out what those planning, delivering and monitoring local primary care and mental

health services need to do to improve services for users, relatives and carers from minority ethnic communities.

NHS Workforce

Proportions from black and minority backgrounds

In terms of NHS executive directors in England, there has been an increase in the proportions from minority ethnic backgrounds over the last four years. The proportion of NHS directors was 3 per cent in March 2000, but this has now increased to 7.5 per cent in March 2004, bringing figures closer to the proportion of minority ethnic staff in the NHS that stands at about 14 per cent, which is itself significantly higher than the proportion of minority ethnic people in the population.

“Improving Working Lives” and Positively Diverse

Central to dealing with race equality in the NHS workforce is “Improving Working Lives”, published in October 2000. This document and its associated standard make it clear that every member of staff in the NHS is entitled to work in an organisation that can prove it is investing in diversity and tackling discrimination and harassment. Over 600 NHS organisations have now achieved the Improving Working Lives standard at Practice level and are now working towards Practice Plus. Within “Improving Working Lives”, there is a national “Positively Diverse” programme of action to support employers in achieving these aims. Specifically, “Positively Diverse” aims to develop the knowledge and capacity of NHS organisations to build and manage a diverse workforce. It also supports work on recruitment and retention of minority ethnic staff in the NHS, including a partnership with Universities UK to increase the number of successful applications from minority ethnic students on professional healthcare courses. “Positively Diverse” has already produced some concrete results. For example, it has launched a healthcare apprenticeship scheme that is attracting under-represented groups to health service professions including nursing. It has also prompted job-shops, job-stalls and other innovative ways of recruiting people from local communities.

Staff networks

As a result of “Improving Working Lives”, many NHS organisations have helped to set up staff networks so that minority ethnic staff can celebrate success, support each other, and influence the way in which their employers address their concerns.

Mentoring

Workforce matters are addressed in the Leadership and Race Equality Action Plan. Immediate challenges set out in the plan for NHS and DH leaders include mentoring people from minority ethnic groups and targeting recruitment and development opportunities at people from minority ethnic groups whose skills are most often under-used. In terms of mentoring, over 600 mentoring arrangements have been put in place since February 2004, in addition to the 200 to 300 mentoring arrangements that pre-dated the Action Plan. This will be an on-going programme.

Breaking Through

In addition, launched by the NHS Leadership Centre in 2003, the “Breaking Through” programme provides leadership and personal development opportunities for minority ethnic staff wishing to move into senior positions. The programme offers a range of

development opportunities for all staff, at different stages in their career. It was developed in collaboration with minority ethnic staff across the NHS.

Social services provision and workforce

In response to difficulties people from minority ethnic communities may face in accessing effective social care services, DH has, in recent years, held events and issued guidance to councils with social services responsibilities on how they might make improvements. DH keeps the situation under review. To help it do this, there are two personal social services Performance Indicators relating to minority ethnic groups. One measures ethnicity of older people receiving assessment and the other measures ethnicity of older people receiving services after assessment.

DH is aware of the relative lack of people from minority ethnic groups within senior directing staff of social services. As a result, as part of its Top Managers' Programme, there is a sub-programme for minority ethnic managers, at all levels, to enable them to develop the skills and confidence to move up. The programme is run by the Improvement and Development Agency and the overall programme is now managed by the Social Care Institute for Excellence.

Ethnic monitoring – the business case

Service access and delivery

The Department fully recognises the importance of information on the ethnicity of patients of NHS and social care and staff working in those sectors in helping to plan and deliver services and ensuring that employment practices are fair. Over and above the legal and moral case for equality, such information can contribute to business case arguments for equality. In summary, local NHS bodies will be unlikely to fully and effectively contribute to national targets and local standards, as set out in Local Delivery Plans, if the needs and circumstances of patients from different ethnic groups are ignored or misunderstood. Information for the purposes of Health Equity Audits and equality impact assessments can help NHS bodies to identify groups and communities who are experiencing health inequalities in terms of access, service receipt and health outcomes. Information can subsequently be used to monitor the impact of remedial action. The specific duties on public bodies of the Race Relations (Amendment) Act 2000, also call for NHS bodies and councils to, among other things, conduct impact assessments of proposed policies and to monitor, review, and evaluate the impact of policies. Information on the ethnic group of local communities and patients, will be essential if the NHS is to carry out these duties.

Employer of choice

Similarly, the NHS will not be able to function as an employer of choice, one that attracts, develops and retains the best talent from all communities if it overlooks or discriminates against potential or actual employees from particular communities. Without good and comprehensive ethnic group information on local communities, job applicants and staff, the NHS will not be in a position to assess, and redress, its performance in this regard.

These business case arguments are set out in more detail in the joint DH, Appointments Commission and NHS Confederation publication "Promoting Equality and Human Rights in the NHS : a Guide for Non-Executive Directors of NHS Boards", published on 21 July 2005. The Guide can be accessed at : www.dh.gov.uk/PolicyAndGuidance/EqualityAndHumanRights/fs/en.

Exactly the same arguments can apply to councils and social care.

Race Equality Schemes

General duty

The Race Relations (Amendment) Act 2000 places a general statutory duty on a wide range of public authorities (including DH and NHS bodies) to promote race equality.

This means that DH and NHS bodies must have due regard to the need to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups

Specific duty

Specific duties have also been placed on listed authorities (including DH, NHS trusts, primary care trusts, special health authorities and strategic health authorities) to assist them in meeting the general duty, including the need to publish a Race Equality Scheme. (Social Services Departments' plans are part of those of the local authority.)

The specific duties include, on the employment side, a requirement to collect and publish a specific set of information; on the policy/service delivery side the requirement is to set out information on a number of actions that will help meet the general duty to promote race equality.

Centrality of Race Equality Schemes

The Race Equality Scheme is central to the delivery of the Government's commitments on NHS reform, as well as those on race equality and social cohesion as a whole. The DH's strategy for meeting the needs of minority ethnic communities is to set action on race equality squarely within the overall framework being used to manage and deliver the agreed priorities and delivery plans across a whole range of activity across health and social care. Delivery on DH's Race Equality Scheme is a core part of the Department of Health's vision of equality and fair treatment for patients and staff.

DH's scheme applies to all those who work within it. DH has updated its scheme, as required, in time for 31 May 2005. Through SHAs, DH ran a series of regional events in March and April 2005 so that the local NHS bodies were supported in reviewing and updating their own Race Equality Schemes.

ANNEX B

INFORMATION ON THE HEALTH AND CARE STATUS OF BLACK AND MINORITY ETHNIC COMMUNITIES AND THE PROPORTIONS OF BLACK AND MINORITY ETHNIC STAFF IN THE NHS AND SOCIAL CARE WORKFORCES

Communities, patients and service users

- **Population:**
 - 92% of the UK population is white. According to the ONS 2001 census data, the UK's population grew by 4% in the 1990s. 73% of this growth was due to black and minority ethnic groups, which grew by about 1.6 million people compared with 600,000 in the white group. (1)
 - Black and minority ethnic groups are considerably more likely to live in England than in the other countries of the UK. In 2001, they made up 9% of the total population in England compared with only 2% in both Scotland and Wales, and less than 1% in Northern Ireland. (2)
- **Long-term illness:**
 - Asian women aged 65 and over have the highest rate of limiting, long-term illness in 2001 (64.5% compared to 53.1% for all women aged 65 and over). (2)
- **Infant mortality rates:**
 - The infant mortality rate for England and Wales in 2003 was 5.2 per 1000 live births. Babies of mothers born in Pakistan had an infant mortality rate of 10.5, more than double the overall infant mortality rate. The second highest infant mortality rate of 8.5 per 1000 live births was among mothers born the Caribbean. (3)
- **Gypsies and Travellers:**
 - This community has significantly poorer health status and significantly, more self-reported symptoms of ill-health than other UK residents. At the same time, Gypsies and Travellers are less likely to visit the GP, practice nurse, health, a counsellor, chiropodist, dentist, optician or alternative medical workers, or to contact NHS Direct, than their counterparts. (4)
- **Mental health:**
 - Young black men are 6 times more likely than their white contemporaries to be sectioned under the Mental Health Act for compulsory treatment. (5)
 - There is a higher propensity to visit a GP for a nervous or mental health condition among older women of Indian, Pakistani and Bangladeshi origin. (6)
- **Suicide:**
 - Young Asian women are more than twice as likely to commit suicide than young white women, according to data reported in 1996. (7)
- **Heart disease:**
 - Research on data from the early 1990s indicates that South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population. (8)

- **Stroke:**
 - Amongst African-Caribbean and South Asian men in 2003, the prevalence of stroke was between about 40% and 70% higher than that of the general population respectively after adjusting for age. (9)
- **Diabetes:**
 - In 1999, men and women of Pakistani and Bangladeshi origin were more than 6 times as likely as the general population to have diabetes, and Indian men and women were almost 3 times as likely. Rates of diabetes among Black Caribbeans were also significantly higher than in the general population. (10)
- **Dental health:**
 - In 1999, around 90% of children in the general population had visited a dentist. This can be contrasted with approximately 40% of Bangladeshi and 60% of Pakistani children. (10)
- **Smoking:**
 - In 1999, smoking rates were higher among black and minority ethnic men including black Caribbean men (35%) and white Irish minority ethnic men (39%), and especially Bangladeshi men (44%) compared to 27% of the general population. (10)
- **Obesity:**
 - In 2003, 22.2% of men and 23% of women were obese. (9)
 - Women of Caribbean origin are the most likely to be obese – with 50% of those aged 55 or more falling into this category. (6)
- **Access to social care:**
 - In 2003/04, 5.0% of adults with completed assessments or reviews were from black and minority ethnic backgrounds. (11)
 - In 2003/04, 4.9% of adults receiving social services were from black and minority ethnic backgrounds. (11)

NHS Workforce (12 & 13)

- As at March 2004, of Chairs and Non-Executive Directors of local NHS organisations, the following proportions were from black and minority ethnic backgrounds :
 - Total : 10.4%
 - Chairs : 5.8%
 - Non-Executive Directors : 11.2%
- As at March 2004, of NHS Executive Directors, the following proportions were from black and minority ethnic backgrounds :
 - England : 7.5% (compared with 3.0% in March 2000)
 - PCTs : 9.2%
 - NHS Trusts : 3.9%
 - SHAs : 1.8%
 - Special SHAs and other statutory bodies : 1.2%
- As at 30 September 2004, of NHS staff working in hospitals and community health services, the following proportions were from black and minority ethnic backgrounds :
 - England : 14.1% (compared with 10.4% in September 2000)

- Total medical and dental staff : 38.1% (32.3% in September 2000)
- Total non-medical staff : 12.0% (8.4% in September 2000)
- As at September 2004, of qualified nurses working in NHS hospitals and community health services, the following proportions were from black and minority ethnic backgrounds :
 - England : 17.8% (compared with 10.9% in September 2000)
 - Nurse consultants : 5.4%
 - Nurse managers : 7.5% (7.2% in September 2000)
- As at 30 September 2004, people from black and minority ethnic groups comprised 39.1% of hospital medical staff yet they comprised only 22.1% of all hospital medical consultants. The comparative figures from September 2000 are 33.1% and 19.4% respectively.

Social care workforce (14)

- As at September 2004, of council social services staff, the following proportions were from black and minority ethnic backgrounds :
 - Total : 9.6%
 - Senior directing staff : 3.4%
 - Central & strategic senior professional support staff : 12.4%
 - Assistant directors and area managers : 6.3%

Sources :

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- (10) "The Health of Minority Ethnic Groups", *Health Survey for England*, 1999, National Statistics

- http://www.dh.gov.uk/PublicationsAndStatistics/PublishedSurvey/HealthSurveyForEngland/HealthSurveyResults/HealthSurveyResultsArticle/fs/en?CONTENT_ID=4015530&chk=cKvNuP
- (11) Information on access to social care is from the Department of Health's Referrals, Assessments and Packages of Care return.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4104361&chk=JzAYv/
- (12) Information for NHS Staff is from the Department of Health's Medical and Dental Workforce Census and Non-Medical Workforce Census
http://www.publications.doh.gov.uk/public/work_workforce.htm
- (13) Information for Non-Executive Directors is from *Annual Report 2003-2004*, NHS Appointments Commission
http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingProfessionalRegulation/NHSAppointmentsCommission/fs/en?CONTENT_ID=4052361&chk=wiAWEy
- (14) Department of Health - SSDS001 data page
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ANNEX C

ETHNIC GROUPS IN ENGLAND

Broad ethnic groups by region

Regional population breakdown by ethnic group (% , numbers)						
<i>Region</i>	<i>White</i>	<i>Mixed</i>	<i>Asian or Asian British</i>	<i>Black or Black British</i>	<i>Other ethnic categories (including Chinese)</i>	<i>All groups</i>
<i>North East</i>	97.6% 2,455,416	0.5% 12,228	1.3% 33,582	0.2% 3,953	0.4% 10,263	100.0% 2,515,442
<i>North West</i>	94.4% 6,355,495	0.9% 62,539	3.4% 229,875	0.6% 41,637	0.6% 40,218	100.0% 6,729,764
<i>Yorks & Humber</i>	93.5% 4,641,263	0.9% 44,995	4.5% 222,486	0.7% 34,262	0.4% 21,827	100.0% 4,964,833
<i>East Midlands</i>	93.5% 3,900,380	1.0% 43,141	4.0% 168,913	0.9% 39,477	0.5% 20,263	100.0% 4,172,174
<i>West Midlands</i>	88.7% 4,674,296	1.4% 73,225	7.3% 385,573	2.0% 104,032	0.6% 30,182	100.0% 5,267,308
<i>East of England</i>	95.1% 5,125,003	1.1% 57,984	2.3% 121,752	0.9% 48,464	0.6% 34,937	100.0% 5,388,140
<i>London</i>	71.2% 5,103,203	3.2% 226,111	12.1% 866,693	10.9% 782,849	2.7% 193,235	100.0% 7,172,091
<i>South East</i>	95.1% 7,608,989	1.1% 85,779	2.3% 186,615	0.7% 56,914	0.8% 62,348	100.0% 8,000,645
<i>South West</i>	97.7% 4,815,316	0.8% 37,371	0.7% 32,800	0.4% 20,920	0.4% 22,027	100.0% 4,928,434
<i>England</i>	90.9% 44,679,361	1.3% 643,373	4.6% 2,248,289	2.3% 1,132,508	0.9% 435,300	100.0% 49,138,831

Source : Census 2001 (Office for National Statistics)

Regions and districts with highest proportions of different ethnic groups

<i>Ethnic group</i>	<i>Percentage</i>	<i>Region with highest proportion</i>	<i>District with highest proportion</i>
White			
British	87.0	North East (96.4)	Easington (98.8)
Irish	1.3	London (3.1)	Brent (6.9)
Other White	2.7	London (8.3)	Kensington & Chelsea (25.3)
Mixed			
White & Black Caribbean	0.5	London (1.0)	Lambeth (2.0)
White & Black African	0.2	London (0.5)	Lambeth (0.8)
White & Asian	0.4	London (0.8)	Westminster (1.3)
Other Mixed	0.3	London (0.8)	Kensington & Chelsea (1.4)
Asian or Asian British			
Indian	2.1	London (6.1)	Leicester (25.7)
Pakistani	1.4	Yorkshire and the Humber (2.9)	Bradford (14.5)
Bangladeshi	0.6	London (2.2)	Tower Hamlets (33.4)
Other Asian	0.5	London (1.9)	Harrow (5.2)
Black or Black British			
Caribbean	1.1	London (4.8)	Lewisham (12.3)
African	1.0	London (5.3)	Southwark (16.1)
Other Black	0.2	London (0.8)	Hackney (2.4)
Other ethnic categories			
Chinese	0.4	London (1.1)	Westminster (2.2)
Other Ethnic Groups	0.4	London (1.6)	Westminster (4.1)
All ethnic groups	100		

Source : Census 2001 (Office for National Statistics)

The above table is presented for information and interest. The fact that London features a great deal in the table, should not be interpreted as a “green light” for Trusts and councils with fewer or relatively few people from black and minority ethnic communities in their populations and workforces to conclude that ethnic monitoring is a task only for London and other big city Trusts and councils. It is an important task for all Trusts and councils.

ANNEX D

DETAILED BREAKDOWN OF THE ONS 2001 CENSUS CODES FOR ETHNIC GROUP

Notes :

- The 16 codes from the ONS 2001 Census are shown in red bold italics.
- Below each “other code” (eg “Other White Background”) are various sub-codes which breakdown, but aggregate back up, to the particular “other code”.
- The NHS Workforce Censuses referred to below comprise the annual NHS Medical and Dental and Non-Medical Workforce censuses.

Ethnic Category	NHS Workforce Census and HES Codes	Medical Read Codes	SNOMED CT Code	Social Services Staffing Return
White Group				
<i>British or mixed</i>				
<i>British</i>	[A*]	9i0..	92391000000108	1
<i>Irish</i>	[B*]	9i1..	92401000000106	2
<i>Other White background</i>		9i2..	92411000000108	
English	[CA]	9i20.	110761000000106	3
Scottish	[CB]	9i21.	92541000000108	4
Welsh	[CC]	9i22.	92551000000106	5
Cornish	[CD]	9i23.	92571000000102	6
Northern Irish	[C2]	9i24.	92561000000109	38
Ulster Scots		9i25.	93921000000101	
Cypriot (part not stated)	[CE]	9i26.	92791000000109	7
Greek	[CF]	9i27.	93931000000104	8
Greek Cypriot	[CG]	9i28.	93941000000108	9
Turkish	[CH]	9i29.	110401000000103	10
Turkish Cypriot	[CJ]	9i2A.	93951000000106	11
Italian	[CK]	9i2B.	93961000000109	12
Irish Traveller	[CL]	9i2C.	88911000000101	13
Traveller	[CM]	9i2D.	88921000000107	14
Gypsy/Romany	[CN]	9i2E.	88931000000109	15
Polish	[CP]	9i2F.	88941000000100	16
Baltic States (Estonian or Latvian or Lithuanian)		9i2G.	88951000000102	
Commonwealth of (Russian) Independent States		9i2H.	88961000000104	
All republics which made up the former USSR	[CQ]			17
Kosovan	[CR]	9i2J.	93981000000100	18

Ethnic Category	NHS Workforce Census and HES Codes	Medical Read Codes	SNOMED CT Code	Social Services Staffing Return
Albanian	[CS]	9i2K.	88971000000106	19
Bosnian	[CT]	9i2L.	93991000000103	31
Croatian	[CU]	9i2M.	94001000000108	32
Serbian	[CV]	9i2N.	88981000000108	33
Other republics which made up the former Yugoslavia	[CW]	9i2P.	94011000000105	34
Mixed White	[CX]			36
Mixed Irish and other White		9i2Q.	94021000000104	
Other White European or European unspecified or Mixed European	[CY]	9i2R.	94041000000106	37
Other mixed White		9i2S.	94031000000102	
Other White or White unspecified	[C3]	9i2T.	94051000000109	39
Mixed Group				
<i>White and Black Caribbean</i>	[D*]	9i3..	92421000000102	21
<i>White and Black African</i>	[E*]	9i4..	92431000000100	22
<i>White and Asian</i>	[F*]	9i5..	92441000000109	23
<i>Other Mixed background</i>		9i6..	92451000000107	
Black and Asian	[GA]	9i60.	92581000000100	24
Black and Chinese	[GB]	9i61.	92591000000103	25
Black and White	[GC]	9i62.	110771000000104	26
Chinese and White	[GD]	9i63.	92601000000109	27
Asian and Chinese	[GE]	9i64.	92611000000106	28
Other Mixed or Mixed unspecified	[GF]	9i65.	92621000000100	29
Asian or Asian British Group				
<i>Indian or British Indian</i>	[H*]	9i7..	110751000000108	41
<i>Pakistani or British Pakistani</i>	[J*]	9i8..	92461000000105	42
<i>Bangladeshi or British Bangladeshi</i>	[K*]	9i9..	92471000000103	43
Other Asian background		9iA..	92481000000101	
Punjabi	[LB]	9iA1.	92641000000107	45
Kashmiri	[LC]	9iA2.	92651000000105	46
East African Asian	[LD]	9iA3.	92661000000108	47

Ethnic Category	NHS Workforce Census and HES Codes	Medical Read Codes	SNOMED CT Code	Social Services Staffing Return
Sri Lankan	[LE]	9iA4.	86461000000107	48
Tamil	[LF]	9iA5.	92671000000101	49
Sinhalese	[LG]	9iA6.	110781000000102	50
Caribbean Asian	[LJ]	9iA7.	92691000000102	57
British Asian	[LH]	9iA8.	92681000000104	51
Mixed Asian	[LA]	9iA9.	92631000000103	44
Other Asian or Asian unspecified	[LK]	9iAA.	92701000000102	59
Black or Black British Group				
<i>Caribbean</i>	[M*]	9iB..	107691000000105	61
<i>African</i>	[N*]	9iC..	92491000000104	62
<i>Other Black background</i>		9iD..	92501000000105	
Somali	[PA]	9iD0.	92711000000100	63
Nigerian	[PC]	9iD1.	92731000000108	64
Black British	[PD]	9iD2.	110791000000100	65
Mixed Black	[PB]	9iD3.	92721000000106	66
Other Black or Black unspecified	[PE]	9iD4.	92741000000104	69
Other Ethnic Groups				
<i>Chinese</i>	[R*]	9iE..	92511000000107	81
<i>Other</i>		9iF..	92521000000101	
Vietnamese	[SA]	9iF0.	92751000000101	84
Japanese	[SB]	9iF1.	92761000000103	85
Filipino	[SC]	9iF2.	92771000000105	86
Malaysian	[SD]	9iF3.	92781000000107	87
Buddhist		9iF4.	94131000000103	
Hindu		9iF5.	110831000000107	
Jewish		9iF6.	88991000000105	
Muslim		9iF7.	89031000000104	
Sikh		9iF8.	94141000000107	
Arab		9iF9.	89001000000105	
North African		9iFA.	94061000000107	
Middle Eastern (excluding Israeli, Iranian and Arab)		9iFB.	94071000000100	
Israeli		9iFC.	94081000000103	
Iranian		9iFD.	89011000000107	
Kurdish		9iFE.	94091000000101	
Moroccan		9iFF.	94101000000109	
Latin American		9iFG.	94111000000106	

Ethnic Category	NHS Workforce Census and HES Codes	Medical Read Codes	SNOMED CT Code	Social Services Staffing Return
South and Central American		9iFH.	89021000000101	
Multi-ethnic islands: Mauritian or Seychellois or Maldivian or St Helena		9iFJ.	94121000000100	
Any other group	[SE]	9iFK.	94151000000105	89
Not Stated				
Ethnic category not stated	[Z*]	9iG..	92531000000104	99

ANNEX E

DETAILED BREAKDOWNS OF RELIGION

Health Survey for England, 1999

- None
- Baptist
- Buddhist
- Church of England / Wales / Scotland / Ireland
- Islam / Muslim
- Hindu
- Jain
- Jehovah's Witness
- Jewish
- Methodist
- Parsi / Zoroastrian
- Pentecostal / Church of God / Church of Christ
- Rastafarian
- Roman Catholic
- Seventh Day Adventist
- Sikh
- United Reformed / Presbyterian / Congregational
- Other Christian
- Other (specify)

"Count me in", 2005

- No religious group
- Atheist / Agnostic
- Church of England
- Other protestant
- Orthodox Christian
- Roman Catholic
- Other Christian
- Muslim
- Shi'ite Muslim
- Sunni Muslim
- Sikh
- Jewish
- Orthodox Jewish
- Buddhist
- Hindu
- Jain
- Parsi / Zoroastrian
- Rastafarian
- Any other religion

ANNEX F

MODEL LEAFLET FOR NHS BOARDS, COUNCIL COMMITTEES AND SENIOR MANAGERS

Collecting and using information about ethnic group

Through the use of good and robust ethnic group data on patients and service users, the NHS and councils will be in a better position to address health inequalities, difficulties in access and discrimination experienced by some black and minority ethnic communities. As a result, the NHS will be better placed to contribute to national targets and meet local core standards. Similarly, through good and robust data on the workforce, the NHS and councils will be able to ensure that they are fair employers who attract, develop and retain the best talent from all communities regardless of ethnic group.

Executive Directors, Non-Executive Directors, elected members and senior managers working within the NHS and councils have a leading role to play in championing the collection and use of ethnic group and related data, based on the standard 16 codes developed by the Office for National Statistics.

NHS Boards, council committees and senior managers should lead from the top by :

- ❑ **making ethnic group data collections on patients, service users and staff an integral part of their Race Equality Schemes**, which they maintain as a working document.
- ❑ **consulting with local communities and staff groups** on the importance, principles and details of ethnic monitoring.
- ❑ **encouraging staff to collect ethnic group data** and related data on all patients and service users as part of routine registration, referral and office routines.
- ❑ **requiring that complete data on patients, service users and staff are presented to them in aggregate on a regular basis** so that differences and trends among different ethnic groups may be explored.
- ❑ **reviewing policies and practices in light of routine reports and effecting change** whenever appropriate in order to address health/care inequalities among patients and service users or biases in workforce recruitment, development and promotion.
- ❑ **feeding back to local communities and staff groups** how ethnic group data have been used and what changes have resulted.

The “Practical Guide to ethnic monitoring in the NHS and social care”, published by the Department of Health in July 2005 on the Internet, will help NHS Boards, council committees and senior managers to understand the reasons for ethnic monitoring and how it should work in practice, and to sustain/improve local practice. The good practice examples included in the Practical Guide demonstrate what some Trusts and councils have been able to achieve through effective consultation, use of the standard codes and a determination to champion race equality. It is anticipated that NHS Boards, council committees and senior managers would wish to emulate these Trusts and councils.

ANNEX G

MODEL LEAFLET FOR STAFF

Collecting information about ethnic group

Everyone belongs to an ethnic group, so all our patients and service users are being asked to describe their ethnic group.

We are collecting this information to help the NHS and social care :

- **Understand the needs** of patients and service users from different groups and so provide better and more appropriate services.
- **Identify risk factors** – some groups are more at risk of specific diseases or care needs so ethnic group data can help treat patients and support service users by alerting staff to high-risk groups.
- **Improve public health** by making sure that our services are reaching all of our local communities and that we are delivering our services fairly to everyone who needs them.
- **Comply with the law as the Race Relations (Amendment) Act 2000** gives public authorities a duty to promote race equality and good race relations and ethnic monitoring is important in making sure that race discrimination is not taking place.

It is important that patients and service users are asked to **describe their own ethnic group**. Ideally this should take place at registration/reception/referral and be part of the routine information collection procedures. Occasionally you may have to ask someone to describe the group of another person – a baby, or a person who is unable to communicate – however on no occasion should staff ever have to make their own judgement about a patient's or service user's ethnic group.

The 16 ethnic groups used are standard categories for collecting ethnic information. Using these codes will help us to compare information about the groups using our services with information from the census which tells us about our local population. The list of groups is designed to allow most people to identify themselves. The list is not intended to leave out any groups of people, but to keep the collection of ethnic information simple.

Patients and service users are not required to complete the question but you should stress that providing this information is very important. Experience shows that when people are asked their ethnic group, the proportion of people who choose not to answer is small.

You should also make sure that the patient or service users knows that the information they provide will be treated as part of their confidential NHS or care notes and will not be shared with any other person or organisation. The NHS and social care have strict standards regarding data protection and the information will be carefully safeguarded.

You will have been asked to complete your own ethnic group. As a good employer, your employer will also be collecting ethnic group data about the workforce to ensure that recruitment, development and promotion practices are working fairly. Self-classification and confidentiality apply to staff, patients and service users in the same way.

ANNEX H

MODEL LEAFLET FOR PATIENTS, SERVICES USERS AND THE PUBLIC

Collecting information about your ethnic group

Everyone belongs to an ethnic group, so all our patients and service users are being asked to describe their ethnic group.

We are collecting this information to help the NHS and social services :

- **Understand the needs** of patients and service users from different groups and so provide better and more appropriate services for you
- **Identify risk factors** – some groups are more at risk of specific diseases and care needs so ethnic group data can help treat patients and support service users by alerting staff to high-risk groups.
- **Improve public health** by making sure that our services are reaching all of our local communities and that we are delivering our services fairly to everyone who needs them.
- **Comply with the law as the Race Relations (Amendment) Act 2000** gives public authorities a duty to promote race equality and good race relations and ethnic monitoring is important in making sure that race discrimination is not taking place.

The 16 ethnic groups used are standard categories for collecting ethnic group information. Using these codes will help us to compare information about the groups using our services with information from the census which tells us about our local population. The list of groups is designed to allow most people to identify themselves. The list is not intended to leave out any groups of people, but to keep the collection of ethnic information simple.

It is important to us that you are able to **describe your own ethnic group**. If you need to complete any of the boxes labelled 'any other group' then please give some details so that we can better understand your needs.

You do not have to complete the question but providing this information is very important. It will help us with diagnosis and assessment of your needs, and it will also help us to plan and improve our service. Experience shows that when people are asked their ethnic group, the proportion of people who choose not to answer is small.

The information you provide will be treated as part of your confidential NHS or care notes and will not be shared with any other person or organisation. The NHS and social services have strict standards regarding data protection and your information will be carefully safeguarded.

If you have any concerns or questions regarding this request or you want to make any comments or complaint about the collection of this information or the way in which you have been treated by staff requesting this information please contact your local Patient Advice and Liaison Service or a NHS or social services manager.