

DELIVERING EFFECTIVE NHS SERVICES TO OUR MULTIETHNIC POPULATION: COLLECTION AND APPLICATION OF ETHNIC MONITORING DATA WITHIN PRIMARY CARE

Report of a workshop convened by Yorkshire
and the Humber Strategic Health Authority

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Background

Government health policy has emphasised the importance of understanding and tackling ethnic disparities in health and healthcare for at least four decades. Yorkshire & the Humber includes areas with large, well-established minority ethnic populations. In addition, most cities in the region, including those that have in the past been dominated by the White British majority, are now experiencing rapid migration. Persistent patterns of health disadvantage among established minority ethnic communities are now compounded by the differing health needs of new migrant populations.

NHS organisations in Yorkshire & the Humber have begun to respond more systematically to the needs of minority ethnic groups. However, there is still progress to be made on establishing basic requirements for effective commissioning, including effective ethnic monitoring systems that provide high quality intelligence to commissioners, service managers and health professionals. While there are examples of innovation and good practice, there is significant variation across the region and a lack of sharing and learning between organisations.

Here we report on a workshop that was convened by the Strategic Health Authority in June 2009 as a first step towards addressing this recognised area of need. The Workshop Chair was John Chuter, Chair of NHS Bradford & Airedale. The aims of the workshop were to:

- Highlight the policy context and imperatives for ethnic monitoring.
- Raise awareness of the current position with regard to ethnic monitoring and use of data in Yorkshire & the Humber.
- Share emerging good practice.
- Identify ways to move forward to improved ethnic monitoring across the region.



Key messages from the day

High time for action

- The need for ethnic monitoring is not news! Many participants expressed frustration at slow progress and limited resources devoted to this important area of work in recent years.
- Ethnic monitoring is about identifying inequity and informing the delivery of high quality, accessible and effective care for all members of the population.
- Ethnic monitoring is just one element in a much broader programme of work that puts tackling health inequality centre stage. This means understanding the multiple causes of disadvantage and addressing the needs of deprived White British individuals and families as well as Black and Minority Ethnic (BME) groups.
- Ethnic monitoring in primary care is an essential element of understanding our populations. Inadequate ethnic monitoring in primary care undermines efforts in secondary care to understand patterns of service receipt.

Leadership and direction

- A lack of focus on ethnic monitoring by top leaders in organisations often means that it is not championed or prioritised. Promotion of values without follow up to ensure action has resulted in limited progress on the ground.
- There are examples of good practice in several areas across the region and these should now be shared and scaled up.
- An agreed view of minimum standards with regard to ethnic monitoring practice would help coherence in ambition and approaches across areas and services. The SHA could usefully play a role in setting standards and communicating good practice regionally.
- In some cases, individuals with responsibilities for equality and diversity are not always well informed of data collection issues and information departments are not always aware of the relevance of these data. There needs to be more effective dialogue between these individuals and sections within organisations.
- The lack of sharing of data across NHS systems creates inefficiency; this must be addressed at a senior level within organisations so that information on the needs and experiences of minority ethnic groups is made available across organisations.

Turning data into intelligence

- There are concerns that much routinely gathered data on patient ethnicity is of insufficient accuracy and completeness to sustain robust analysis. Urgent attention is warranted to raise the quality of these data.
- Ethnic monitoring data are not always regularly analysed and interpreted so that they can be transformed into intelligence that informs decisions. Regular analyses and feedback to practitioners and data gatherers would also improve the quality of the data as people begin to recognise their value.
- There is a need for consistent and effective training for all staff involved in ethnic monitoring to ensure that procedures are rigorous and staff are motivated to perform the task well.
- Organisations in the region should make use of the readily accessible tool kits and guidance documents that have been produced nationally (see resources below), as well as local lessons learnt.
- Analyses of ethnic monitoring data must be performed carefully to ensure that misleading findings are not produced. In particular, different age structures and patterns of migration or mobility can influence comparison across ethnic groups.
- Ethnic monitoring has limitations. Crude 'ethnic group' data is important for describing patterns of health and service receipt and thereby highlighting possible areas of inequity, but cannot provide insight into (i) the reasons underlying ethnic differentials, or (ii) policy or practice modifications that might address inequalities.
- Other types of data must complement ethnic monitoring to answer questions about why ethnic disparities exist and how they might be mitigated. At the practitioner level too, information other than crude 'ethnic group' will often be more relevant to the provision of care, such as religion or English language competency.
- As well as ethnicity, other diversity strands require attention. Where new initiatives are established to improve the collection and use of data on ethnicity, it will often be prudent to also address the monitoring of disability, sexual orientation, religion/belief, gender and age.

Ethnic monitoring: demographic, legal and policy imperatives

Diversity and disadvantage

In the 2001 Census, 13% of the population of England identified themselves as belonging to an ethnic 'group' other than White British and 9% self-identified as non-White. In parts of Yorkshire and the Humber, individuals reporting a minority ethnicity are in the numerical majority. Furthermore, the 'ethnic diversity' of the UK population, both in terms of the percentage of people identifying as a minority, and the range of ethnic identities reported, is set to increase in future years. Notwithstanding significant heterogeneity within ethnic groups and many similarities across groups, available evidence suggests important ethnic diversity in morbidity and mortality. Some groups, notably individuals identifying as 'Bangladeshi' and 'Pakistani' report much higher levels of 'bad' or 'very bad' general health than the population as a whole (Natarajan, 2004). Some diseases are particularly prevalent among some minority groups - for instance diabetes is more common among those men and women identifying as 'Black Caribbean', 'Indian', 'Pakistani', and 'Bangladeshi' than in the general population (Mindell and Zaninotto, 2006). The high levels of morbidity experienced by gypsy and traveller communities are also of growing concern, with evidence of particularly marked inequality compared to the general population in self-reported anxiety, respiratory problems and chest pain (Parry et al., 2004). However, disease patterns are complex and minority groups do not experience elevated risks across all conditions (Gill, Kai, Bhopal and Wild, 2007).

The NHS, through the provision of preventive and curative services, has the potential to mitigate these inequalities; unfortunately, it can also exacerbate them. A growing body of evidence documents the failure of Britain's health services to meet the needs of those from minority ethnic groups (Culley and Dyson, 2001). Healthcare Commission patient surveys have revealed significantly lower satisfaction with services amongst ethnic minority respondents (e.g. DH/HCC, 2008) and in-depth studies of various service contexts illustrate persistent problems relating to ineffective and insensitive patient-provider interactions, inappropriate constellation and design of services, inequitable allocation of resources and ethnocentric and oppressive cultures of care (Singh and Newburn 2000; Bhui et al., 2007).

Rashna Hackett reminded the workshop participants of the stark inequalities in mental health and mental healthcare receipt by ethnicity in the UK.

Legal requirements

Against this challenging demographic backdrop, the Race Relations (Amendment) Act (2000) places legal duties upon public bodies, in carrying out their functions, to consider the need to eliminate unlawful discrimination and to promote equality of opportunity and good relations between people of different ethnic groups. Further, most public authorities are bound by specific duties, such as publishing a race equality scheme or policy setting out how they will meet the general duty. Given that expectations of evidence-based health policy and practice are now the norm, these duties clearly imply the need for evidence/intelligence that reflects the ethnic diversity of the population. Indeed, following the Commission for Equality and Human Rights' (previously the CRE) formal investigation into the DH, and Nigel Crisp's 10-point action plan response, the need for ethnic monitoring has been reasserted. In the words of Surinder Sharma, the first ever Equality and Human Rights Director for the NHS, appointed in 2004:

'Data are essential to highlight inequalities, make the case for equality and to monitor progress' (Sharma, 2007)

Policy imperatives

Barry Mussenden's presentation to the workshop further illustrated the current policy imperatives for good quality ethnic monitoring. He argued that NHS organisations must not simply be concerned with avoiding discriminatory practices and policies, but rather must proactively address inequality. This requires a 'drilling down' in order to understand and address issues of disadvantage. Mr Mussenden explained how the newly created NHS constitution had made explicit the embedded principle that NHS services are provided equally to all at the point of delivery:

'The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.' NHS Constitution (January 2009)

Mr Mussenden highlighted the way in which the Darzi report, High Quality Care for All (DH, 2004) through its focus on fairness, quality and the personalisation of care, is directly relevant to meeting the needs of a diverse, multiethnic population. The outcomes and experiences of minority ethnic groups, he argued, can be seen as a barometer for assessing progress towards the review's aspirations more generally. The Darzi Review also places the generation of good quality data and evidence at the heart of delivering quality to patients, further underscoring the need for action to develop and utilise intelligence relating to ethnic diversity.

Mr Mussenden drew attention to the appointment of a new Secretary of State for Health, Andy Burnham. He argued that this would mean a continued commitment to tackling inequality and to evidence-based policy, but also a shift towards redesigning and tailoring services to patient needs as well as withdrawing from activities that do not add value - encapsulated in the acronym PRES - Prevent Re-engineer Evaluate and Stop. Again, this approach underscores the need for high quality intelligence.



Driving up the quality of ethnic monitoring in primary care: obstacles and solutions

Many of the workshop participants were aware that ethnic monitoring is not a newly introduced initiative, and they referred to experiences and commentary on this area of work from the 1990s onwards (see for instance, Pringle and Rothera, 1996). Indeed, among several participants there was a strong sense of frustration that more progress had not been made. In the words of one participant, 'There are no barriers; we're just not doing it!'

However, other participants felt that there were some important obstacles to driving up quality in this area and it was clear that the level of awareness regarding available resources and guidance, as well as current practice nationally and regionally, was very variable. A number of specific issues arose during the workshop discussions.

Data quality concerns

There was broad consensus among the workshop participants that current ethnic monitoring is not carried out to a high standard in the region and that ethnic monitoring in primary care is particularly poor. An important observation was that the inclusion of 'not stated' cases in reports of completeness suggests that information on ethnicity is more complete than is really the case. A participant reported that the proportion of records for which ethnic group is 'not stated' is as high as 20% in the in-patient data for Rotherham and other participants felt that levels were likely to be similar in their areas too. However, it is also clear that there is variation across services and sectors, with some services managing to achieve higher levels of completeness. A recent review by the King's Fund came to similar conclusions - in general PCTs did not have adequate data on the ethnic make-up of their populations, though a few PCTs were found to be very active in trying to meet the local needs of their multiethnic populations (King's Fund, 2007).

Strategic leadership

A common theme among the workshop discussion groups was the need for clear strategic leadership in relation to monitoring and analysis. In particular:

- Participants felt that broad policy commitments and value statements had not been backed up on the ground with clear action plans and follow up to ensure progress.
- The lack of reference to this area of intelligence gathering in some Joint Strategic Needs Assessments was felt by some participants to be indicative of the low priority given.
- It was felt that there was the lack of liaison in some organisations between those individuals with the equality and diversity remit and those who lead on information and intelligence.
- Better communication is needed to ensure that ethnic monitoring is prioritised and that the data generated is translated into meaningful intelligence that answers important questions.

While workshop participants felt that it is important for all employees to regard equality and diversity as 'their business', there nevertheless is a need for some staff to take a strategic leadership role in this area. Barry Mussenden's presentation reminded the group that while the NHS as a whole is ethnically diverse, it remains a 'snow-capped' institution with few minority ethnic individuals in senior positions and that this lack of leadership undermines progress towards understanding and responding to the needs of minority groups.

Logistics and time: putting effective systems in place

Workshop participants raised a number of concerns regarding the practicalities of putting in place effective systems for ethnic monitoring. Though some of these concerns may be well-founded, others are not supported by documented experiences elsewhere in the country and this underscores the need for more active learning across regions. For instance, some participants expressed concern that both practitioners and patients may be reluctant to cooperate in the collection of ethnicity data. This assumption is not well supported by the available published literature (Pringle and Rothera, 1996) or experiences at national level in surveys and the Census 2001 in which there were high response rates to the ethnic group question, as well as the questions on religion and country of birth. Another concern was that some patients might be asked for their ethnic group many times over at different service points and therefore become frustrated.

Other participants worried that for frontline provider staff the collection of ethnicity data could be an added burden that interferes with their delivery of care. However, others felt that if the data collection included items that had relevance to the care of the patient, such as religion or English language competency, then providers would see the information not just as something to be submitted for analysis at an aggregate level but also something of direct relevance to their work. This discussion highlights the importance of clarity regarding the reasons for collecting ethnicity data.

More generally, several workshop participants expressed the need for more guidance on how to operationalise effective systems for collecting and using ethnic group data. Others drew attention to the useful guidance that has already been produced by both the DH and other bodies, such as Aspinall and Jacobson's 2006 toolkit on 'How to analyse ethnic differences in health, healthcare and the workforce' published by the London Health Observatory.

Clearly, there is a need for more active sharing of lessons learned and good practice, but also for those responsible for ethnic monitoring to more actively seek out the experiences and materials available so that time and effort is not wasted on reinventing solutions. Some participants felt that in their areas other public bodies are already collecting ethnicity data more efficiently and with higher quality than many NHS organisations and that there could therefore be opportunities to learn from these other organisations and share in their intelligence.

Increasing clarity regarding the rationale and importance of ethnic monitoring

A lack of clarity regarding the rationale and importance of ethnic monitoring appears to undermine progress. Again, the various guidance and toolkits are useful here, but so too are local case studies that can illustrate the ways in which these data have informed decision-making and ultimately outcomes for patients (see Local Good Practice Example 1). Some workshop participants illustrated the potential confusion that can arise when the people involved in data collection are unclear as to how the information will be used. The type of information (and analyses) that are useful at the level of broad policy development/strategic planning differs from that required for service (re)design, and this in turn differs from the information that might inform better care for individual patients of minority ethnic background. It is important that these levels of information need are not conflated and better training of staff is needed to ensure adequate understanding.

Local good practice example 1: Sheffield Case Register

The Sheffield Case Register has been in existence as a monitoring and planning tool for many years. It is a 'cradle to grave' monitoring tool that includes data on ethnicity. Ethnicity is collected for people registered during home visits and the level of completeness is believed to be very good. In the past, data from this monitoring system has been used to analyse the prevalence of learning disabilities among people identified as 'British Asian' compared to those identified as 'non-Asian' using population figures from the census. The information has also been used to inform a multitude of developments such as:

- Development of the Joint Learning Disabilities Service BME Strategy.
- New ways of working in developing BME Link Worker posts .
- All service strategies

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Directives, targets and incentives

Many participants felt that the slow progress towards high quality ethnic monitoring reflects the lack of priority given to this area and the absence of explicit targets or rewards. The inclusion of ethnic monitoring in the Quality Outcomes Framework for GP practices from 2006 was welcomed but felt to be ineffectual because this recording relates only to newly registered patients and attracts very little financial incentive. Workshop participants also highlighted the Clinical directed enhanced service (DES) for GMS contract 2008/09 focused on the recording of ethnicity and first language but again felt that the payments involved were too low to encourage improved standards of ethnic monitoring. Concerns were also expressed that the World Class Commissioning framework, as currently structured, does not provide sufficient challenge to local commissioners to use intelligence to improve services for minority ethnic communities.

Participants felt that unless ethnic monitoring is part-and-parcel of performance management it will not be prioritised and some felt that it had to be made mandatory.

A workshop participant representing Sheffield Teaching Hospitals Trust reported that with strong performance management the Trust has been able to achieve quite good standards of ethnicity data collection with levels of completeness being approximately 89% and 84% for in and out patients respectively. These data indicate that approximately 91% of patients accessing inpatient and outpatient care self-identify as 'White'. Participants also highlighted the fact that where recording is mandatory, such as in Stop Smoking Services, the quality is much higher than in other services.

Working carefully with the data we have

Notwithstanding the concerns highlighted regarding the potential for misleading findings from poor data, there was broad consensus at the workshop that in order to drive up quality, the data currently being gathered must be analysed, interpreted and fed back to varied stakeholders. Despite some exceptions (see Local Good Practice Example, 2), participants felt that data were often not well used and rarely translated into intelligence that could inform policy or practice in any meaningful way. This opinion echoes that of Aspinall and Jacobson (2007) who have identified a number of approaches to analysing ethnic monitoring data when they are of less-than-desirable quality, including imputation, record linkage, naming algorithms, proportional mortality (morbidity) ratios and meta-analysis. John Chuter also reminded the group that sensitivity analysis can be used to illustrate the assumptions that have been built into a set of analyses and the range of possible findings that would result from making different assumptions. The workshop discussion suggested that there is wide variation across the region in the types of analyses that are being performed and the skills available to carry out sophisticated quantitative work. It would be useful to have some regional standards on the types of basic analyses that would be expected at PCT level as well as more active sharing of approaches to handling data problems.

Feedback to data collectors

Several participants felt that staff are not motivated to collect information on ethnicity if there is little evidence that it is being analysed and used to identify actions for commissioners and service providers. Most participants felt that there is currently little feedback to staff on either (i) whether the data they are collecting are sufficiently complete and accurate or (ii) how the data have been put to use in improving service quality and efficiency. It was also clear that there is highly variable practice in relation to training staff in the collection of these data and their importance. However, we again found evidence in the region of good practice that could be emulated (Local good practice example 2).



Local good practice example 2: Ethnic monitoring in Bradford District Care Trust

At Bradford District Care Trust, ethnic monitoring data and related intelligence are used on a routine twice yearly basis to underpin a dialogue with staff about the needs of people from minority ethnic communities. These forums also provide an opportunity for frontline staff to challenge and engage with equality and diversity policy. Bradford District Care Trust also runs courses to help staff understand why the collection of ethnic monitoring data is important and how it can enhance the quality of services and patient outcomes. The Trust has established 'equality panels' made up of service users, carers, staff, managers and clinicians to facilitate meaningful engagement and dialogue in this area. Furthermore, from 2005 to 2008, Bradford District was one of seventeen national Focused Implementation Sites (FIS) spearheading the Delivering Race Equality action plan within Mental Health Care. As such Bradford District Care Trust has made significant progress in establishing effective structures and processes to mainstream attention to ethnic inequalities and to use intelligence to inform practice in a more systematic way.

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Towards better NHS services for Black and minority ethnic populations: contributions and limitations of ethnic monitoring in primary care

The workshop highlighted both the potential role, and the limitations of, ethnic monitoring in primary care in informing the development of better NHS services for black and minority ethnic patients.

Clarity of motivation: identifying inequality

As noted above, DH policy clearly highlights the identification of inequality and the monitoring of progress towards equality as the factors behind the drive for better ethnic monitoring. It is worth remembering, however, that ethnic monitoring can and has been used for less benign purposes. The recording of individual ethnic group and the aggregation of such information can have negative consequences both for individuals and for minority ethnic communities. The workshop reminded participants that ethnic group information is not currently recorded on birth or death registration and cannot be held within the personal demographic spine of the NHS Number - decisions that have been informed by the recognised potential for misuse of data at individual and group level.

The potential importance of ethnic monitoring in highlighting areas of inequality, and possible inequity and in challenging assumptions was highlighted by a representative from NHS Rotherham. There, recent analyses had revealed that contrary to perceptions black and minority ethnic individuals did not use A&E services more than majority 'White British' people. They also found that there were some services, such as diabetes clinics, that appeared not to be accessed as often by minority ethnic groups as the majority 'White British' population. An important message from these recent analyses was that patterns of use vary from service to service and that there is great diversity within and between minority ethnic groups so that generalisations can be dangerous.

Ethnic group categories: advantages and limitations

Workshop discussions highlighted the pros and cons of using the Census 2001 categories in ethnic monitoring. The advantages of adopting standardised codes that have been tested for acceptability and resonance at community level and that can be aggregated and compared across settings was recognised. Indeed the use of these standard codes is promoted and expected by DH. However, some participants also drew attention to the crude nature of the categories and their inability to differentiate between important ethnic sub-groupings (such as those with different religious, socioeconomic or ancestral characteristics). The broad 'White Other' category was felt to be unhelpful given the growing numbers of European migrants. Other participants also questioned whether ethnic categories were very meaningful in terms of identifying factors that influence health and that might inform service delivery. The limited analytical potential offered by crude administrative ethnic categorisation has been the subject of much discussion (Hilton, 1996; Bradby, 2003) and local organisations should consider the advantages of adding to the standard set of codes in order to more accurately capture the ethnic make-up of their local populations (for instance by using a sub-code for 'Somali' within the broad 'Black African' category). However, regardless of any refinements that may be useful, any such bounded categories will only ever be crude measures of complex processes of social identification.

Population denominators

Rapid changes in population make-up due to migration mean that Census data (including inter-census projected estimates) are unreliable; none of the PCTs represented at the workshop felt that they had sufficiently accurate, up-to-date figures on the ethnic composition of their catchment populations. Ethnic monitoring in primary care is clearly crucial in this regard and the current poor performance is undermining progress in the acute sector. For instance, a workshop participant representing Sheffield Teaching Hospitals Trust reported that despite reasonably complete ethnic monitoring data of in- and out-patients, lack of information on the ethnic make-up of the Trust's catchment population makes analysis of receipt in relation to potential need very difficult.

Appropriate analyses and interpretation

While recognising the crucial role of ethnic monitoring in primary care in (i) providing population figures and (ii) highlighting areas of inequality, the workshop also alerted participants to the need for caution in conducting analyses. The presentation by Helen Brown (Local good practice example 3) highlighted a number of ways in which misleading findings can result if analyses are not conducted rigorously. In particular, different age structures and different patterns of mobility can compromise comparisons between ethnic groups. More generally it is important to remember that:

- There are many similarities across ethnic groups and an exclusive focus on ethnic inequalities can divert attention away from areas of important health need that affect minority ethnic groups similarly to the majority White British.
- It is not always the case that minority ethnic groups fare worse, or that the majority White British are the appropriate comparator - multiple comparisons are often warranted.
- There is great diversity of health experience within ethnic groups, particularly along the lines of socioeconomic status.
- Descriptive analyses of ethnic differences (and similarities) should not be taken as evidence of causal factors that can not be directly examined; there are dangers in overreaching the data particularly when unfounded assumptions about cultural explanations are offered.

Local good practice example 3: Mortality analyses by ethnicity, NHS Bradford & Airedale

Helen Brown presented analyses conducted by Bradford & Airedale Teaching PCT's Intelligence and Analysis team. Helen explained that the Yorkshire and Humber BME Panel had requested information on average age at death by ethnicity. These figures, showing a 20 year difference between 'South Asians' and 'non-South Asians', were presented in the BME Panel's report, 'Unequal Health'. However, average age at death is an inappropriate measure of mortality and the Bradford team therefore undertook a systematic and staged analysis to investigate mortality differences more rigorously. Standardised rates suggested a reverse inequality with higher mortality among 'non-South Asians'. Closer examination suggested that 'South Asians' had higher mortality in the early years, but much lower mortality over age 30. However, outmigration at older ages and possible GP list inflation may in part explain these lower death rates. Further analyses of causes of death for the two broad ethnic 'groups' have highlighted the different causes contributing to 'Potential Years of Life Lost'. The findings are being used in commissioning plans across B&A and, in conjunction with social marketing, will enable interventions to be tailored to diverse needs. B&A's analysis used the Nam Pehchan name algorithm software and checks suggested a good level of accuracy. However, this approach can result in high misclassification in some contexts (Cummins et al. 1999) and can only identify 'South Asians', leaving all other minorities indistinguishable from the 'White British'. B&A's experience illustrates that careful analyses can yield meaningful information even where data are less than perfect. It also, however, underscores the need to continue to improve ethnic monitoring so that findings are more robust and the increasing diversity of the population is adequately captured.

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The need for complementary forms of intelligence

Workshop participants highlighted the limitations of ethnic monitoring in terms of (i) explaining the reasons why ethnic inequalities exist and (ii) suggesting effective avenues for intervention to address disparities. Workshop participants called for the use of varied types of intelligence including community level consultation, focused needs assessment exercises and dedicated research on particular issues of concern. Both Barry Mussenden and Rashna Hackett highlighted the importance of meaningful engagement with minority ethnic communities in shaping NHS services that are sensitive and appropriate to their needs. Rashna Hackett cited the example of the National BME Mental Health Network that is a strong voice within Delivering Race Equality (the five-year DH-funded national action plan for achieving equality and tackling discrimination in mental health services in England). Other effective models exist around the country that could be emulated, such as the BME Health Forum of Kensington & Chelsea and the City of Westminster. Workshop speakers emphasised the need for the NHS to learn from the people it seeks to serve. Workshop participants also offered examples of local studies that had focused on particular issues and generated important understanding of the circumstances of migrant or minority ethnic groups (see Local Good Practice Example 4 for an illustration from Wakefield).

Some workshop participants also questioned whether attention to ethnic diversity is sufficiently mainstreamed across all data gathering exercises. For instance, a participant from North Yorkshire and York described a new initiative in which real-time feedback is being gathered from patients to assess the patient experience. To his knowledge there was no explicit attention to whether and how minority ethnic patients would be appropriately included in this exercise.

Further suggestions for ways in which intelligence gathering could be strengthened included: efforts to consider the other diversity strands alongside ethnicity and more effective synthesis of evidence from other parts of the country.

Local good practice example 4: Health Needs Assessment of the Dispersed Asylum Seeker Population in Wakefield, NHS Wakefield District

In 2008 NHS Wakefield District undertook a focused health needs assessment to raise understanding of the health status and needs of its 350-400 asylum seekers. The HNA used a mix of methods including: quantitative analyses of asylum seeker statistics and the induction centre health data set; focus group discussions with key staff who work with asylum seekers, a survey of 50 asylum seekers contacted through advocacy agency contacts; an age-sex matched comparison group of non-asylum seekers contacted in public places, and a literature review. Engaging partner organisations was a key part of the exercise. The study confirmed that the asylum seeker population in Wakefield cannot be considered to be a homogenous group. However, they do have common experiences in leaving their home country, seeking asylum and difficulties accessing health care which result in common health care needs. The findings identified a number of areas where services require configuration in order to respond better to the needs of this vulnerable section of the population including, a need to:

- Reconsider the use of 0844 numbers for primary care access as these are expensive on pay-as-you-go mobile phone contracts often used by asylum seekers.
- Provide different models of primary care - drop-in facilities and longer appointment slots could facilitate more equitable access.
- Respond to high levels of mental ill-health.
- Improve providers' awareness of good communication methods and effective use of interpreting services.
- Improve access to information about health services.

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Recommendations and next steps

The following suggestions for moving forward were made:

- Lobby for more effective strategic leadership in this area. Passionate people are currently leading this agenda but without positional power, change is slow.
- Make sure that all the necessary people are involved in new initiatives to improve practice. In particular, where necessary strengthen links and common understanding between 'equality and diversity' people and 'intelligence and analysis' people.
- Review the capacity and skills of 'intelligence and analysis' sections to ensure that the necessary rigour and sophistication is possible in analyses.
- Consider investing in one-off initiatives to fill gaps in information as well as incremental improvements to ongoing systems.
- Compile good practice case studies across the region and showcase these so that others can emulate - perhaps via the SHA.
- Form strategic partnerships with community organisations and user groups who can effectively represent the needs of minority ethnic communities, champion this agenda and hold commissioners to account.
- Seek new ways of engaging with GPs and encouraging their commitment to ethnic monitoring.
- Make use of existing guidance and toolkits to strengthen ethnic monitoring practice.
- Establish regional networks to enable the sharing of skills and experience. For instance, NHS Bradford & Airedale are willing to share their approach to analysis of 'Potential Years of Life Lost'.
- Develop minimum standards and common aspirations across the region for what should be achieved in primary care ethnic monitoring. The SHA and the Y&H Public Health Observatory could play a lead role in this.
- Review the processes through which Equality Impact Assessments might better (i) draw on ethnic monitoring data and (ii) inform commissioning intentions. Find ways to make these links more explicit and effective.
- Engage with existing national and regional networks that focus on black and minority ethnic health issues (e.g. Race for Health and see links below).
- Review current practice with regard to cultural competence/race equality training delivered to NHS staff and ensure that ethnic monitoring is adequately covered.
- Prioritise the use of ethnic monitoring data to identify opportunities for early intervention. This will mean reduced costs and will strengthen the case for the importance of these data collection systems.
- Where new initiatives are established to improve the collection and use of data on ethnicity also explore the opportunities for improving the monitoring of disability, sexual orientation, religion/belief, gender and age.



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Further resources and weblinks

BME Health Forum of Kensington & Chelsea and the City of Westminster

This is a forum active in generating intelligence relating to the needs of minority ethnic populations and informing the commissioning of services for the area:

<http://www.westminsterpct.nhs.uk/diversity/bmehealthforum.htm#reports>

Delivering Race Equality

The Delivering Race Equality in Mental Healthcare Programme was formed in 2005. This innovative programme is a five year plan established to improve access, outcomes and experiences for people with mental health needs.

<http://www.mentalhealthequalities.org.uk/dre/>

Equality and Human Rights at Department of Health

www.dh.gov.uk/en/managingyourorganisation/equalityandhumanrights

King's Fund

Report of a seminar held by the King's Fund with the London Health Observatory: Equitable Commissioning for a Diverse Society: are we using the right intelligence?

The seminar was held in June 2007 to discuss the challenge of equitable commissioning for ethnically diverse populations and explore what data and intelligence are needed by commissioners in order to commission well. The focus of the day was on ethnicity data in the NHS in England, although it was recognised that similar, if not greater, challenges lie ahead in relation to data collection and use relating to disability and sexual orientation.

<http://www.kingsfund.org.uk/go.rm?id=20582>

National BME Mental Health Network

The Network is a member of the Mental Health Alliance which consists of representatives from MIND, The Mental Health Foundation, Together, The Sainsbury Centre for Mental Health, The Royal College of Psychiatry among many others. The Network has held and participated in consultations on the Draft Mental Health Bill, Draft Mental Incapacity Bill, in addition to submitting written and oral responses to the Parliamentary Scrutiny Committees

<http://www.bmentalhealth.org.uk/>

NHS Constitution

http://www.dh.gov.uk/en/Healthcare/NHSConstitution/DH_093184

NHS Evidence-Ethnicity and health

Includes many relevant policy documents, toolkits and reports: www.library.nhs.uk/ethnicity

NHS Evidence-Race Equality

Includes many relevant policy documents, toolkits and reports:

<http://www.library.nhs.uk/healthmanagement/ViewResource.aspx?resID=276957>

MIGHEALTHNET

Part of an EU Project that aims to give professionals, policy makers including health authorities, researchers, educators and representatives of migrant and minority groups easy access to a dynamically evolving body of knowledge and a virtual network of expertise.

http://mighealth.net/uk/index.php/Main_Page

Minority Ethnic Health jiscmail

A lively and informative email discussion group devoted to minority ethnic health issues:

<https://www.jiscmail.ac.uk/cgi-bin/webadmin?A0=MINORITY-ETHNIC-HEALTH>

Mosaic: equality procurement for the NHS

The Mosaic project team work with key stakeholders in the NHS supply-chain to promote equality in and through procurement. Funded by the Department of Health, it works with staff, suppliers and interested parties to align efficiency and equality goals. It also looks at facilitating greater links between the procurement and commissioning processes and the need to look at the wider equalities agenda in relation to effective healthcare.

<http://www.mosaic.nhs.uk/>

Pacesetters Programme

Pacesetters is a partnership between local communities who experience health inequalities, the NHS and the Department of Health (DH). The Equality and Human Rights Group (EHRG) of DH is working with six strategic health authorities (SHAs) on the programme including Yorkshire and the Humber.

<http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Pacesettersprogramme/index.htm>

Making the difference: The Pacesetters beginner's guide to service improvement for equality and diversity in the NHS (2008) is available here:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086039

Race Equality Foundation: Improving health services for black and minority ethnic communities

This programme of work aims to develop a national resource to help improve the quality of health provision to black and minority ethnic communities. This is being achieved through a series of conferences, seminars and workshops to help embed the evidence and promote good race equality practice in order to encourage and facilitate change in practice and service provision. Central to this work is a collection of Better Health briefing papers containing research evidence, good practice tips, resources, and key messages for practice on a range of topics for housing and health practitioners.

<http://www.raceequalityfoundation.org.uk/health/index.asp>

Race for Health

Race for Health is a Department of Health-funded, NHS based programme that works with PCTs and Trusts to drive forward improvements in health for people from Black and minority ethnic backgrounds.

<http://www.raceforhealth.org/>

Race Relations (Amendment) Act (2000)

http://www.opsi.gov.uk/acts/acts2000/ukpga_20000034_en_1 and DH commentary on the Act:

http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Raceequality/DH_4135737

Strategic Review of Health Inequalities in England Post 2010 (Marmot Review)

The Review follows the publication of the global Commission on Social Determinants of Health, also chaired by Sir Michael Marmot and published by the WHO. The CSDH advocated that national governments develop and implement strategies and policies suited to their particular national context aimed at improving health equity. The English review is a response to that recommendation and to the Government's commitment to reducing health inequalities in England. The aim of the Review is to propose an evidence based strategy for reducing health inequalities from 2010.

<http://www.ucl.ac.uk/gheg/marmotreview>

Yorkshire & the Humber BME Information Service

The Regional Forum has been operating the Black and Minority Ethnic (BME) Information Service since 2004 to support effective development of services for BME communities in the region.

www.bme.org.uk

Programme of the day

Programme

The workshop was convened by the Yorkshire and Humber Strategic Health Authority on June 8th 2009. It was held at the Lateral Building in Leeds. The programme was as follows:

Welcome; *John Chuter, Chair NHS Bradford & Airedale*

Department of Health Policy and Priorities; *Barry Mussenden, Equality and Human Rights Group, Department of Health*

Bradford experience - BME data collection and analysis; *Helen Brown, Assistant Director Intelligence and Analysis, NHS Bradford & Airedale.*

Mental Health - Delivering racial equality; *Rashna Hackett, Race Equality Lead for Yorkshire and Humber*

Sharing local experience in Yorkshire & the Humber; *Workshop participants, small group discussions and feedback*

Participants were asked to reflect on:

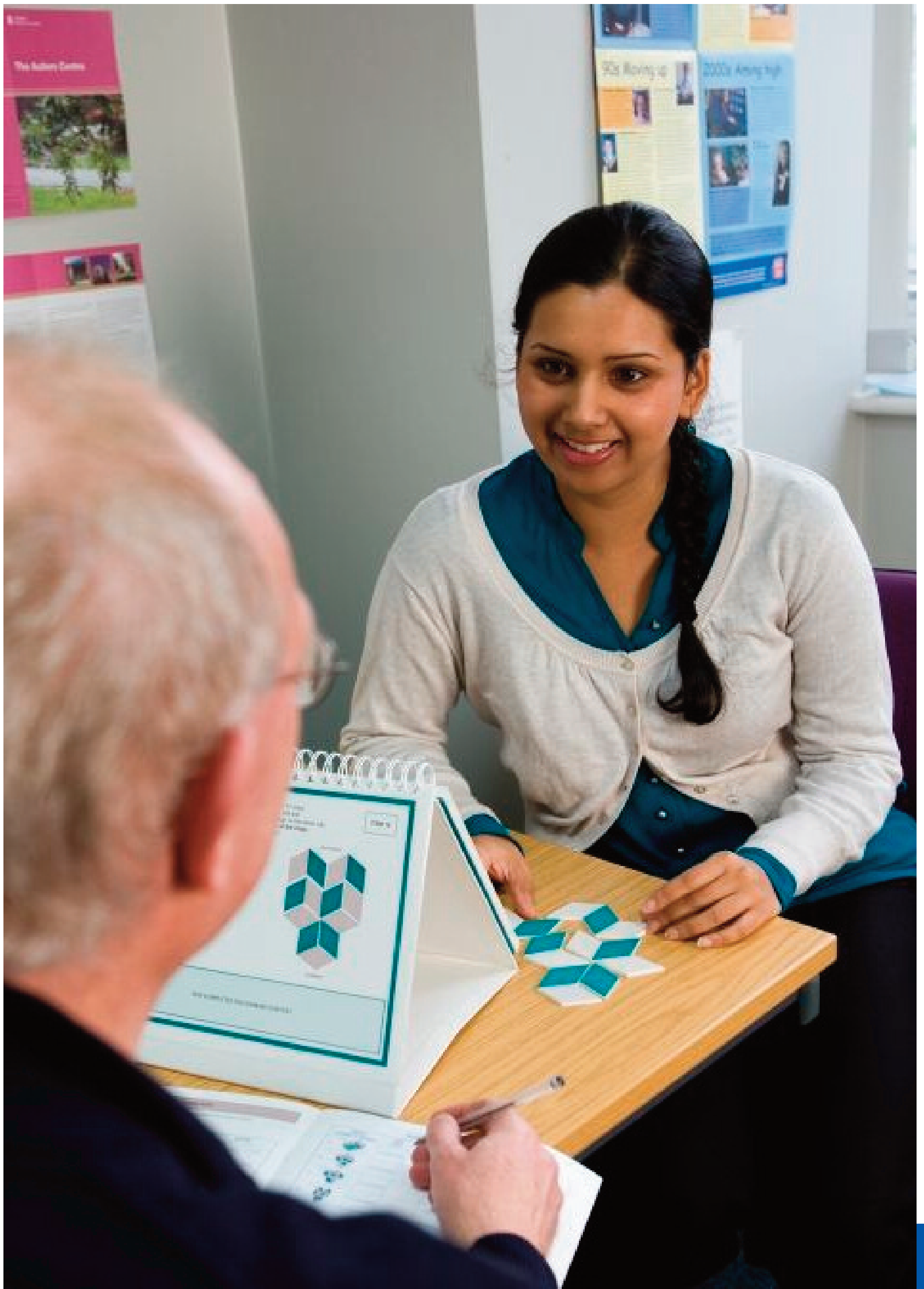
- Current performance regarding ethnic monitoring in primary care and the acute sector.
- The types of ethnic monitoring and analyses performed routinely and ad hoc.
- Categorisation and alignment with population data.
- Links between ethnic monitoring data and the commissioning and provision of services and how the process could be strengthened.

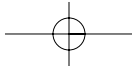
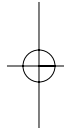
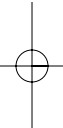
Organisations represented

Barnsley Primary Care Trust
 Bradford District Care Trust
 Bradford Teaching Hospitals NHS Foundation Trust
 Bradford Royal Infirmary
 Department of Health
 Leeds Teaching Hospitals Trust
 NHS Bradford & Airedale
 NHS Calderdale
 NHS East Riding of Yorkshire
 NHS Kirklees
 NHS Leeds
 NHS North Yorkshire & York
 NHS Rotherham
 NHS Sheffield
 NHS Wakefield
 NHS Yorkshire & the Humber Strategic Health Authority
 NHS Yorkshire & the Humber/RPHG
 Sheffield Health & Social Care NHS Foundation Trust
 Sheffield Teaching Hospitals NHS Foundation Trust
 South West Yorkshire Mental Health Trust
 Yorkshire Ambulance Service NHS Trust

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Delivering effective NHS services to our multiethnic population: collection and application of ethnic monitoring within primary care

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<http://shura.shu.ac.uk/2682/>

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