



## Ethnic Monitoring Tool

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Produced by Health Scotland in collaboration with Information Services Division of NHS National Services Scotland.

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### Introduction

This Ethnic Monitoring Tool is targeted primarily at the following NHS Scotland staff groups who may be involved in the collection of information on ethnicity and the use of classifications in relation to their Race Equality and Fair For All Action Plans:

- Personnel and Human Resources managers who will be responsible for collecting information from and about their workforce.
- Key frontline staff (e.g. receptionists, admission clerks) and their managers who will be responsible for directly asking patients/clients for the information and may need to deal with exceptional or difficult cases.
- Clinical, nursing, paramedical and auxiliary staff who may need to know the questions that patients/clients have been asked.
- Analytical or information staff who need to know how to use ethnic category data.
- Information Systems & Technology designers and support staff.
- Senior management who may also require to be briefed on the data collection in relation to Race Equality Schemes and Fair For All Action Plans.

Data collection is poor because staff don't see the point.

*The information collected is too often seen as irrelevant to patient care and focused on the needs of the 'centre' rather than frontline service delivery. In particular, more effort is needed to involve clinical staff in validating and using information produced.*

Kmietowicz, Z. *BMJ*, 2004;328:786

Information and Data Quality in the NHS can be obtained from the Audit Commission's publications at [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

The Ethnic Monitoring Tool should be used in conjunction with the Communication Guidelines as a support in the planning and implementation of ethnic monitoring.



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### Background

The **Race Relations Amendment Act 2000** (RRAA) and **Fair For All** (FFA) policy initiatives place a duty upon NHS organisations to promote racial equality and to develop strategies to reduce ethnic inequalities in health. Under the RRAA, NHS organisations have a specific duty not only to monitor the effects of health policies on the different ethnic groups but also to monitor the equality of NHS employment by ethnic group.

The Scottish Executive, in **Our National Health: A plan for action, a plan for change** and its White Paper **Partnership for Care**, is committed to action that will redress the inequalities which exist between the health of the most and least affluent.

In addition, the over-arching equality and diversity agenda requires that all policy and service developments within the Scottish Executive Health Department and NHS Scotland can be shown not to disadvantage the people we serve and, in particular:

- minority ethnic communities (including gypsy/travellers, refugees and asylum seekers)
- women and men
- religious/faith groups
- disabled people
- older people, children and young people
- the lesbian, gay, bisexual and transgender community.

Therefore all **patient-focused public involvement** and health improvement policies will require monitoring, e.g. to demonstrate equality of access to health services.



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At present, there is a lack of detailed information on ethnicity in Scotland. It is not routinely collected. What is required at this moment is detailed person-based information to allow specification of the scope and scale of the problem facing NHS Scotland organisations, and the design of solutions to address these problems.

Initial analysis of local [Race Equality Schemes and Fair For All action plans](#) within NHS Scotland supports the statement that there is a lack of accurate, quality information on ethnicity. Few organisations have supplied plausible implementation plans to achieve that goal.

### [Race Relations Amendment Act 2000 \(RRAA\)](#)

The RRAA was introduced into Parliament in 1999 as a response to the MacPherson report into the death of Stephen Lawrence. The report concluded that all UK institutions were affected by institutional racism — that is *'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'*.

The RRAA places a new positive duty, the General Duty, on named public authorities to *'eliminate unlawful racial discrimination and to promote equality of opportunity and good relations between people of different racial groups'*. This legislation has recently been amended to require public authorities to also eliminate racial harassment.

Further specific duties, including ethnic monitoring of staff and production of a Race Equality Scheme (RES) with a realistic Action Plan, were placed on over 250 Scottish public authorities — including all NHS organisations. The RES, in essence, is the public statement of what each public authority is promising it will do in implementing the General Duty. Further [legal details](#) available here.



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General Duty includes the need to:

- eliminate unlawful racial discrimination (on grounds of race, colour, nationality, ethnic or national origins)
- promote equality of opportunity
- promote good race relations between persons of different racial groups.

Under this new duty, public bodies are **obliged** to consider the implications for racial equality in everything that they do, including monitoring.

**The Law, the Duty and You** provides a very useful overview for public employees in relation to the RRAA and the duty to promote race equality.

### **Fair For All HDL (2002) 51**

**Fair For All, the Scottish Executive, 2001 (FFA) stock-take report** was commissioned by the Scottish Executive to assess the extent to which black and minority ethnic communities could fairly access NHS services. The resulting report, whilst identifying areas of good practice, was largely concerned with the inability of the NHS to take effective action to ensure their services were open and accessible to all.

The FFA report was subsequently complemented by a **Scottish Executive Health Department Letter HDL (2002) 51**. The HDL set out five key areas for delivery for all Boards and Trusts in the area of race equality and cultural competence. It also established the National Resource Centre for Ethnic Minority Health (NRCEMH) as the primary resource for NHS Boards and Divisions to assist them in the process of making health services more responsive to needs of black and minority ethnic communities and bringing them into compliance with the law.



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### *Relationship between RRAA and FFA*

At an early stage both the Commission for Racial Equality (CRE) and NRCEMH recognised that without explicit and complementary guidance, the requirements of the RRAA and FFA may confuse, rather than assist, Boards in their new duties. To assist, CRE and NRCEMH produced and disseminated a *Joint Monitoring and Reporting Framework* that explicitly states the required activities, evidential basis for monitoring progress and preliminary timescales and targets to be achieved.

### **Other legislation and policy documents**

- **The Sex Discrimination Act (1975) (Amendment) Regulations 2003**
- **Disability Discrimination Act (1995)**
- **Human Rights Act (1998)**
- **Data Protection Act (1998)**
- **The Scottish Executive's equality strategy 2004**
- **Spiritual Care HDL (2002) 76**
- **The NHS Reform (Scotland) Bill (based on Scotland's Health White Paper Partnership in Care) 2003**
- **Patient Focus/Public Involvement strategy 2001**
- **Protecting Patient Confidentiality 2002**
- **Partnership Information Network (PIN) Board 2003**
- **Macpherson Report 1999**



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### Why include ethnicity in routine health data collection? A short paper

This short paper could be used as a stand-alone section, e.g. to distribute to people before training on ethnic data collection; to provide background information, especially for clinicians, etc.

*To have an equality policy or scheme without ethnic monitoring is like aiming for good financial management without keeping financial records.*

Almost no information is available from routine data sources about the health of Scotland's ethnic minorities. Ethnic group is not routinely recorded in either hospital discharge or primary care databases and there is a general lack of consistency in the ethnic categories used. Ethnic minorities accounted for just over 2% of the Scottish population in 2001 and some might argue that the additional effort of collecting information on ethnicity is not worthwhile. However, there are strong arguments for doing so on legal and equity grounds, in order to address health needs and also in view of likely future demographic trends in Scotland.

#### *The legal and equity case*

The case for routinely collecting information about ethnicity has been greatly strengthened by recent legislation and policy initiatives. The RRAA goes further than previous legislation in defining a general statutory duty to '*eliminate unlawful racial discrimination and to promote equality of opportunity and good relations between persons of different racial groups*'. Public bodies are required to produce Racial Equality Schemes setting out the action they will take to address inequalities.

The Scottish Executive HDL (2002) 51 *Fair For All: Working towards culturally-competent services* defines a 'culturally-competent service' as one that recognises and meets the diverse needs of people of different cultural backgrounds. This applies to every individual with a healthcare need and not just minorities. It includes provision for religious and cultural beliefs such as worship, diet and hygiene requirements and takes account of communication and language diversity. A culturally-competent service aims to address discrimination on the basis of culture, belief, race, nationality or colour.



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HDL (2002) 51 requires Scottish NHS organisations to:

- make a clear commitment to address the challenge of ethnic minority health
- develop a local demographic profile
- ensure equitable access to services by all ethnic groups
- include ethnicity in human resource strategies
- involve ethnic minority communities in service development.

Without reliable information on ethnic group it will not be possible for NHS organisations to demonstrate that they have met legal and strategic obligations and may leave them vulnerable to legal challenge.

Underlying the legal case is the assumption that it is morally unacceptable to systematically disadvantage one racial or ethnic group and that in this regard the size of the community is not a determining factor. While it is clearly not possible or appropriate to develop separate health strategies for every ethnic group in Scotland, a truly culturally-competent service will benefit all groups alike.

### *Arguments from health inequalities*

Information on ethnicity is important to assess health inequalities, to target interventions and to monitor progress. Evidence from many sources outside Scotland indicates that there are likely to be wide inequalities in both risk factor levels and health outcomes by ethnic group.

Gill *et al* studied the mortality rates between 1989 and 1992 of adults aged 25–74 living in England and Wales. All cause mortality varied widely by country of birth. Standardised mortality ratios among women ranged from 70 (for those born in Bangladeshi) to 113 (Indian born) and among men from 79 (born in Hong Kong or China) to 114 (born in Bangladesh).<sup>1</sup>

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1 [http://www.mywebsearch.com/jsp/GGcres.jsp?id=uMs7\\_8VeVloJ&u=http://hcna.radcliffe-oxford.com/bemg.htm](http://www.mywebsearch.com/jsp/GGcres.jsp?id=uMs7_8VeVloJ&u=http://hcna.radcliffe-oxford.com/bemg.htm) See also Wild, S., McKeigue, P. Cross sectional analysis of mortality by country of birth in England and Wales, 1970–92. *BMJ*, 1997; 314:705–10

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Coronary heart disease (CHD) mortality varied even more widely: among Pakistanis (the largest ethnic minority group in Scotland after the Irish) mortality among men was almost 50% higher than the general population (see table). As well as being relatively more common, in absolute terms CHD was also by far the most common single cause of death among Pakistani men. CHD mortality was similarly raised among Indian- and Bangladeshi-born men but substantially lower for Chinese men.

### Standardised mortality rates (95% confidence intervals) for Ischaemic Heart Disease (ICD-9 410–414) by country of birth 1989–1992, England and Wales (from Gill *et al*).

	India	Pakistan	Bangladesh	China*	Caribbean	Africa**
<b>Men</b>	142 (137, 147)	148 (138, 158)	151 (136, 167)	44 (36, 54)	62 (58, 67)	58 (47, 70)
<b>Women</b>	158 (148, 168)	111 (93, 130)	91 (60, 133)	43 (30, 60)	86 (77, 96)	61 (37, 94)

\*Including Hong Kong and Taiwan

\*\*West and South

There are also wide variations by country of birth and ethnic group in the prevalence of CHD risk factors. For example, while smoking is less common compared to the general population among Indian, Pakistani and Bangladeshi women, the proportion of Bangladeshi men who smoke (42%) is the highest of any ethnic group.<sup>2</sup>

The prevalence of type 2 diabetes is 3–5 times higher among Indians, Pakistanis, Bangladeshis and Afro-Caribbeans, but among Chinese is similar to the general population. Impaired glucose tolerance, dyslipidaemia and C-reactive protein levels all show marked ethnic variations.

2 British Heart Foundation ([www.heartstats.org](http://www.heartstats.org)) cited in Eaton, L. Smoking habits of ethnic groups lead to higher risk of heart disease. *BMJ*, 2004; 328:1397



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It might be argued that programmes that target these CHD risk factors will be adequate to address CHD risk without any need to monitor rates in ethnic minorities. However, the evidence is that this may not be so. Quirke *et al* found that, as expected, Framingham risk predictions based on conventional CHD risk factors were high among Bangladeshi men, in keeping with their increased mortality. However, the same Framingham equation predicted lower CHD mortality among Pakistani men than among men from the general population, although recorded mortality is higher.<sup>3</sup> Some have argued that ethnic variations in health largely reflect the levels of deprivation faced by these communities. While material disadvantage makes an important contribution to ethnic variations in health, the evidence suggests that it does not fully explain them.<sup>4</sup>

### *Arguments from future demographic trends*

Although Scotland's ethnic minority population is smaller than that in England and Wales, it is growing rapidly. Non-‘white’ groups accounted for 1.25% (63,000) of the Scottish population in 1991 and 2.01% (89,000) in 2001 — an increase of 41%. Scotland's ethnic minority populations are considerably younger than the general population: 57% are aged under 30 compared with 36% of the white group. Diseases such as type 2 diabetes and CHD are strongly related to age so that the burden among ethnic minorities is likely to increase substantially.

Ethnic diversity in Scotland is likely to increase as more recent immigrants are from more diverse backgrounds than previously. All of this means that the challenge of meeting the healthcare needs of Scotland's ethnic minorities is unlikely to disappear, and that reliable data on ethnicity will be a crucial part of meeting that challenge.

### **Prepared by:**

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- 
- 3 Quirke, T.P., Gill, P.S., Mant, J.W., Allan, T.F. The applicability of the Framingham coronary heart disease prediction function to black and minority ethnic groups in the UK. *Heart*, 2003; 89:785–786
  - 4 Nazroo, J.Y. The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *Am J Public Health*, 2003; 93:277–84



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### What is monitoring?

**World Health Organization** (WHO<sup>5</sup>) defines the aims of monitoring as: identifying high risks groups; identifying the most serious and/or the most prevalent conditions; and monitoring the trends of these conditions and the implementation and impact of interventions which is very much seen as the role of public health departments.

**Commission for Racial Equality** (CRE<sup>6</sup>) defines ethnic monitoring as the process of collecting, storing and analysing data about people's ethnic backgrounds to:

- highlight possible inequalities
- investigate the underlying causes
- remove any unfairness or disadvantage.

### Why monitor?

In **employment**, monitoring lets you examine the ethnic make up of your workforce and allows you to compare this against your original benchmark data. It also lets you analyse how your personnel practices and procedures affect different ethnic groups.

### Why keep a record of a member of staff's ethnic group?

NHS workforce information on the ethnic origin of NHS staff is needed locally and nationally to ensure that sufficient staff are recruited in areas with high minority ethnic working populations. The NHS aims to recruit and retain, year on year, a more diverse workforce at every level of the service.

### The Scottish Executive Diversity Task Force

NHS is bound by the RRAA General Duty but also has a specific duty to promote race as employers. The duty says that NHS has to monitor, by their ethnic groups, all employees, and all applicants for jobs, promotion and training.

**NB: This 'toolkit' is primarily aimed at patient ethnic monitoring.**

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5 WHO. *Field Manual. Surveillance and Monitoring*, chapter 9

6 CRE. *Ethnic Monitoring: A guide for public authorities*. CRE, Dec 2001



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### Why keep a record of a patient's ethnic group?

In **service delivery**, monitoring can tell you which groups are using your services, and how satisfied they are with them. You can then consider ways of reaching under-represented groups and making sure that your services are relevant to their needs, and provided fairly.

Possible uses of ethnic monitoring:

- Ensure we are providing an appropriate and accessible service to all ethnic groups.
- Assess who uses the service now.
- Identify and assess the health needs and patterns of, e.g. chronic disease management among all ethnic groups.
- Highlight any gaps in service provision.
- Measure the outcome of the serviced responses to these highlighted gaps.
- Develop staff awareness of the diverse population and the need to respond to individual needs of different ethnic groups.

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### Who is involved in monitoring?

In part, this will be determined by who and what you are monitoring, but it should be based on your Race Equality and Fair For All Action Plans, e.g. planned actions and expected outcomes under human resource and/or access and service delivery.

Each NHS organisation will have a named **Lead for Race/Diversity**. This person/ persons should be a starting point for any work in relation to ethnic/diversity monitoring.

First Name	Last Name	Company Name	Work Phone	Email
Gavin	Brown	NHS Argyll and Clyde	01389 604509	gavin.brown@vol.scot.nhs.uk
Kirsten	Major	NHS Ayrshire and Arran	01292 885863	majork@aapct.scot.nhs.uk
Irene	Morris	NHS Borders	01896 828282	irene.morris@borders.scot.nhs.uk
Kenny	Richardson	NHS Borders	01896 825500 x 550	kenny.richardson@borders.scot.nhs.uk
Margaret	Morton	NHS Dumfries & Galloway	01387 244144	m.morton@dgri.scot.nhs.uk
John	Wilson	NHS Fife	01592 643355	john.wilson@faht.scot.nhs.uk
Alison	Richmond-Ferns	NHS Forth Valley	01786 457 286	alison.richmond-ferns@fvhb.scot.nhs.uk
Lindsey	Ferries	Golden Jubilee National Hospital	0141 951 5000	lindsey.ferries@gjnh.scot.nhs.uk
Tony	Duguid	NHS Grampian	01224 558098	tony.duguid@nhs.net
Nigel	Firth	NHS Grampian	01224 681818	nigel.firth@arh.grampian.scot.nhs.uk
Evelyn	Borland	NHS Greater Glasgow	0141 201 4617	evelyn.borland@gghb.scot.nhs.uk
John	Crawford	NHS Greater Glasgow	0141 201 4884	john.crawford@gghb.scot.nhs.uk
Emma	Witney	NHS Health Scotland	0131 536 5560	emma.witney@health.scot.nhs.uk
Lachie	Robertson	NHS Highland	01463 705400	lachie.robertson@haht.scot.nhs.uk

First Name	Last Name	Company Name	Work Phone	Email Name
Kenneth	Small	NHS Lanarkshire	01555 773747	kenneth.small@lanarkshire.scot.nhs.uk
Michele	McCoy	NHS Lothian	0131 536 9410	michele.mccoy@lhb.scot.nhs.uk
Peter	MacIntyre	NHS National Services Scotland	0131 275 6510	peter.macintyre@isd.csa.scot.nhs.uk
Marian	Wrigley	NHS Education for Scotland	0131 220 8629	marian.wrigley@nes.scot.nhs.uk
Kevin	Reith	NHS 24	0141 225 0099	kevin.reith@nhs24.scot.nhs.uk
Fiona	Smith	NHS Orkney	01856 888298	fiona.smith@orkney-hb.scot.nhs.uk
Ben	Carter	NHS Quality Improvement Scotland	0131 623 4332	ben.carter@nhshealthquality.org
Tom	Pickett	Scottish Ambulance Service	0131 446 7000	tpickett@scotamb.co.uk
Steve	Jack	NHS Shetland	01595 743069	steve.jack@shb.shetland.scot.nhs.uk
Stephen	Milloy	The State Hospital	01555 840293	stephen.milloy@tsh.scot.nhs.uk
Ann	Pearson	NHS Tayside	01382 424033	ann.pearson@thb.scot.nhs.uk
Dave	Tierney	NHS Western Isles	01851 702997	dave.tierney@wihb.scot.nhs.uk

Other people may include:

- communications/human resource persons
- various staff groups
- staff involved in data collection
- staff involved in data analysis and reporting
- medical, nursing and professionals allied to medicine
- patients
- carers
- advocacy.

Organisations:

- **Information Services Division (ISD)** NHS National Services Scotland
- **National Resource Centre for Ethnic Minority Health (NRCEMH)**  
NHS Health Scotland
- partnership organisations, e.g.
  - \* local authorities
  - \* police
  - \* education
  - \* housing
  - \* ambulance
  - \* voluntary and community groups.
- technical expertise
  - \* hospital/primary care information technology and system experts.
- external advisors.



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**NB:** Please refer to the Communication Guidelines to support this process.

## How is monitoring done? Getting started

**A business case** should be developed for the ethnic monitoring project that contains the following:

- Reasons for ethnic monitoring.
- Options — what options were considered for **how** and **what** ethnic monitoring will deliver?
- Benefits — e.g. for patients, staff, organisation.
- Risks — ethnic group sensitive data. What, for example, has been done regarding communication of the project, securing data?
- Costs — human and other costs.
- Timescales.
- Investment appraisal — the balance between the development, operational, maintenance and support costs and the financial value of the benefits over a period of time

**Project management** — what skills, knowledge/ experience is required?

- Project Board, e.g. Race Equality/Diversity Group.
- Project team to deliver ethnic monitoring project, e.g.
  - \* Do you have information management and technology (IM & T) expertise?
  - \* Human resource/organisation development trainers?
  - \* Communication agents/Patient Focus and Public Involvement (PFPI)?
- Project manager to manage the day-to-day management.



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**Project plan** — essential for managing the information of the ethnic monitoring project

- Describe how, when and by whom a specific objective or set of objectives is to be achieved, e.g.
  - \* Who, how and when is assessing information systems?
  - \* Who, how and when requires training?
  - \* Who, how and when are staff and patients being involved in the process?
  - \* Who, how and when is responsible for producing any data feeder sheets?

**Management of risk** — what governance arrangements are in place to support ethnic monitoring?

- How can staff and patients safely be assured that their information is secure?
- What training, professional accountability and supervision has been agreed?
- How have resources and sustainability issues been addressed?

**Evaluation** — what mechanisms are in place to evaluate the ethnic monitoring project?

- How will evaluation and planning for continuous monitoring be achieved?
- Who has responsibility to analyse the data and produce reports?
- To whom will the reports be given?
- How will the information be used? Some examples are given below for your consideration:
  - \* Eliminate unlawful racial discrimination (on grounds of race, colour, nationality, ethnic or national origins)?
  - \* Promote equality of opportunity?
  - \* Promote good race relations between persons of different racial groups?
  - \* Ensure we are providing an appropriate and accessible service to all ethnic groups?



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- \* Assess who uses the service now?
- \* Identify and assess the health needs and patterns of, e.g. chronic disease management among all ethnic groups?
- \* Highlight any gaps in service provision?
- \* Measure the outcome of the serviced responses to these highlighted gaps?
- \* Develop staff awareness of the diverse population and the need to respond to the individual needs of different ethnic groups?

## What needs to be in place?

It is probably to your advantage to start at the beginning of this 'toolkit' unless you have acquired knowledge, skills and competencies of both the RRAA 2000 and FFFA.

## Back to 'How is monitoring done? Getting started'

This is the start of the process and all steps need to be in place before moving forward.

## Ethnicity classifications

The word 'ethnicity' derives from the Greek word *ethnos*, meaning a nation. Ethnicity is a multi-faceted quality that refers to the group to which people belong, and/or are perceived to belong, as a result of certain shared characteristics, including geographical and ancestral origins, but particularly cultural traditions and languages.

Classifications allow us, in an accurate and systematic way, to arrange data according to common features, such as Census categories, so that e.g. the resulting statistics can be easily reproduced and compared over time and between different sources. For more information go to the [ISD Data Dictionary](#) which comprises definitions and codes for data collection within the NHS Scotland.

It is recommended that the classification system for monitoring of ethnicity, the **Scottish Census 2001 classification** is used as listed below. (Cross-reference – ISD Letter: Monitoring of Ethnicity in Health, 30 April 2004).

**General Register Office for Scotland (2001 Census) Ethnic Group  
2001 Census for Scotland**

**A White**

Scottish

Other British

Irish

Any other White background (specify)

**B Mixed**

Any mixed background (specify)

**C Asian, Asian Scottish or Asian British**

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background (specify)

**D Black, Black Scottish or Black British**

Caribbean

African

Any other Black background (specify)

**E Other ethnic background**

Any other background (specify)



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### Useful guides

Scottish Social Care Data Standards Project

[www.show.scot.nhs.uk/scds/Publications/Main.htm#2](http://www.show.scot.nhs.uk/scds/Publications/Main.htm#2)

#### *Ethnic Monitoring: A guide for public authorities*

Commission for Racial Equality, Published July 2002

ISBN 1 85442 434 3

#### *Ethnic Group Statistics: A guide for the collection and classification of ethnicity*

**data** This guide has been written primarily for England & Wales but contains useful information that is transferable but **NOT** census classifications.

**Department of Health** have produced a guidance document and training materials to deal with issues directly related to the introduction of revised ethnic codes from April 2001 as well as tackling some of the wider issues that prevent the collection of good quality ethnic information. Please note that this is primarily aimed at England & Wales but contains useful information that is transferable but **NOT** census classifications.

*Fair For All: The wider challenge* leaflet gives a useful overview with definitions of the equality and diversity agenda and includes a list of useful contacts for further information.

### Useful contacts

#### For ethnicity issues

Joan Jamieson, Programme Manager: Diversity

c/o National Resource Centre for Ethnic Minority Health

NHS Health Scotland

Clifton House

Glasgow G3 7LS

Tel: 0141 300 1041

email: [joan.jamieson@isd.csa.scot.nhs.uk](mailto:joan.jamieson@isd.csa.scot.nhs.uk)



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### For general code use enquiries

Catrina Cameron  
Data Definitions & Standards Manager  
Information Services Division  
NHS National Services Scotland  
Gyle Square, 1 South Gyle Crescent  
Edinburgh EH12 9EB  
Tel: 0131 275 6122  
email: [catrina.cameron@isd.csa.scot.nhs.uk](mailto:catrina.cameron@isd.csa.scot.nhs.uk)

### For communication guidelines

Christopher Homfray  
Communications and Marketing  
National Resource Centre for Ethnic Minority Health  
Clifton House  
Glasgow G3 7LS  
Tel: 0141 300 1038  
email: [christopher.homfray@health.scot.nhs.uk](mailto:christopher.homfray@health.scot.nhs.uk)



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### Training materials

The attached PowerPoint slides and notes aim to support and offer guidance to those training staff in the collection of ethnic group data.

This tool will need to be modified depending on the targeted group for data collection. These materials are for generic use but are possibly more suited to administrative and clerical staff.

We are grateful to the earlier work of the Department of Health in England that has informed the development of this tool for Scotland.

A prerequisite for using the training pack:

- It should be administered by a person/persons who has undergone appropriate training, e.g. the Equality & Diversity Training two-day workshop [www.hebs.scot.nhs.uk/learningcentre/trainers/index.cfm](http://www.hebs.scot.nhs.uk/learningcentre/trainers/index.cfm)
- Local information where possible should be used.
- Training notes are a guide only.
- All staff receiving the training must have undergone your local NHS Race/Diversity Introduction Course.

### PowerPoint presentation

#### Training in Ethnicity trainer's notes

**Slide 1**      **Title: Training in Ethnicity Data Collection** (include local details of date, group, etc. as required)

**Slide 2**      **Aim:** To enable you to sensitively and accurately collect data on the ethnic group of patients.

**Objectives:** By the end of the session the participants will:

- \* be able to demonstrate an appreciation of the need to collect ethnic group data

- \* know how to collect the information from patients, clients and the workforce (as applicable)
- \* be able to deal with questions and concerns about the information.

### **What do participants already know about ethnic monitoring?**

- \* A quick brainstorm to gauge current levels of knowledge.

### **Anything participants particularly want to know / learn during this session?**

- \* To make sure that training will cover what is needed; if not, trainer should make this clear.

#### **Slide 3 A Good Working Definition of an Ethnic Group**

#### **Slide 4 How Ethnicity Differs from Culture and Race**

(from Fernando, S. (1988). *Race and Culture in Psychiatry*. London: Tavistock/Routledge.)

#### **Slide 5 A Definition of Culture**

#### **Slide 6 Patient Journey Promoting Equality**

Stressing the point that people, processes and systems all contribute.

#### **Slide 7 Equality in Service Delivery**

#### **Slide 8 Ethnic Minority Population 1991**

Different classification and note the 1.3% minority ethnic groups in Scotland.

#### **Slide 9 Ethnic Minority Population 2001**

Note the five output Census classifications that are available. This describes the 15 Health Boards in Scotland. Participants could be encourage to discuss this slide

- \* Do the five output groups reflect the Scottish population?
- \* Who is missing?

**Slide 10 Ethnic Minorities in Scotland Include ...**

Do not forget the missing groups — can you think of others in your local area?

**Slide 11 Local Ethnic Minority Population**

Please include your local information that describes your population and other salient factors.

**Slide 12 Group Exercise 1 (optional)**

Much will depend on the time and target audience.

**Slide 13 Why Keep Records of a Patient's Ethnic Group?**

Ensure we are providing an appropriate and accessible service to all ethnic groups:

- \* Assess who uses the service now.
- \* Identify and assess the health needs and patterns of, e.g. chronic disease management among all ethnic groups.
- \* Highlight any gaps in service provision.
- \* Measure the outcome of the serviced responses to these highlighted gaps.
- \* Develop staff awareness of the diverse population and the need to respond to the individual needs of different ethnic groups.

**Slides 14–16****Definitions of racial discrimination from the Race Relations Act 1976**

**Direct racial discrimination** — treating a person less favourably on the grounds of race.

**Indirect racial discrimination** — applying a requirement or condition which, although it applies to all, can only be met by a considerably smaller proportion of a minority group.

**Refusing or deliberately omitting to provide a service** or as regards quality, or the manner in which, or the terms of which, they are provided, is unlawful under section 20 of the RRA 1976.

**Institutional racism** — the collective failure of an organisation to provide a proper service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours, which amounts to discrimination. This is through unwitting pressure, ignorance, thoughtlessness and stereotyping which disadvantage minority ethnic people.

### Slide 17 **Questions Arising from the Macpherson Report**

- \* Are we acting fairly?
- \* Does the service we provide reach all the communities it's meant for and does it meet their needs?
- \* Are we providing the same professional standard in every situation?

### Slide 18 **Race Relations (Amendment) Act 2000**

- \* Extends the scope of the Race Relations Act 1976 to cover NHS providers.
- \* Extends the provision of the Act to cover indirect discrimination (the failure to provide equitable services to black and minority ethnic groups).
- \* Places a statutory duty upon public services to eliminate unlawful racial discrimination and to consider the race equality implications in all of the policies that shape their operations.

### Slide 19 **Policy Context: Fair For All HDL (2002) 51**

#### **Element 1: Energising the Organisation**

Statement of Organisational Intent; Executive Leadership; Action Plan

#### **Element 2: Demographic Profile**

Surveying the Local Population; Needs Assessment;  
Commitment to Research

#### **Element 3: Access and Service Delivery**

Access Audit; Personal Care; Food; Spiritual Care; Translation and Interpretation; Advocacy; Gender Issues; Bereavement

**Element 4: Human Resources**

Equal Opportunities; Improvement Policies; Bullying and Harassment

**Element 5: Community Development**

Collaborative Mechanisms; Developing the Community

**Slide 20 NHS Relationship with Commission for Racial Equality****Slide 21 Group Exercise 2 (optional)**

Ways in which information about ethnic groups could be used to improve services within participants, discipline/area.

Brainstorm to get participants to think of the positive aspects of having such data available. This information could be written up and sent back to the team of participants for future service development ideas.

**Slide 22 Ethnic Monitoring Categories**

Explaining the 2001 Census categories; introducing the categories.

Who defined the categories? Office of National Statistics/General Register of Scotland, Commission for Racial Equality.

How to categorise the patients — where do some minor ethnic groups fit in?

Local variations.

**Slide 23 Points to Note about Ethnic Group Data Collection**

- \* Use of prompt sheet and coding minor ethnic groups.
- \* Patient self-classifies.
- \* Cannot be changed by a staff member unless patient asks for the change.
- \* Coding the information onto a computer database.

**Please ensure you have your local handouts and contacts for your participants**

**Slide 24 Other Important Data Required** (this will depend on target audience)



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### Scenarios (taken from DoH Trainer's Notes)

#### Role-play — collecting the information from a patient

These scenarios are only suggestions; you may have local examples that could be used which will give the participants a more meaningful and effective feeling of what it is like in your area.

Use role-play to work out how to deal with 'not-so-straightforward' patients.

#### Scenario 1

Before you start, inform your partner in this exercise that you are a 40-year-old male from a visibly non-white background. You will be asked to self classify your ethnicity. As someone who has suffered from discrimination against you in the past, you are suspicious of the process. You fear that by giving the information, it may jeopardise the care that you receive. Ask why this information is being asked for. Ask who will have access to the information. Ask the staff member if they believe the Board line as to what this information is to be used for. If you are satisfied with the answers you get, give your classification. If not, refuse until you receive an adequate explanation.

#### Scenario 2

Before you start, inform your partner in this exercise that you are a patient from a visibly non-white background. You will be asked to classify your ethnicity. Refuse. Say you feel this is an invasion of your privacy and not relevant to your accessing healthcare. Consider the response you get. Ask if this will have any effect on the standard of treatment you receive. Continue to refuse to co-operate until you receive an adequate explanation of what the information is to be used for.

#### Scenario 3

Before you start, inform your partner in this exercise that you are a 73-year-old woman of Asian appearance. You will be asked to classify your ethnicity. You don't understand the request. You do not understand what ethnicity means.

You do not think it applies to you — perhaps because although from a minority ethnic group, you have lived in Scotland for 70 of your 73 years. Then say it is not important and ask the staff member to decide the classification for you. Consider the reaction you get. If the explanations around ethnicity and the choice of category seem adequate, then go ahead and classify yourself.

### Scenario 4

You will be asked to classify your ethnicity. Explain that your parents both emigrated to the UK from different parts of the world (mother from Thailand, father from Mauritius). You were born in the UK and don't feel any particular allegiance to either background, you're just 'you' and you don't know how to classify yourself, it's not something you've ever been asked to do before. Ask for help in determining your ethnic classification.

### Scenario 5

Before you start, inform your partner in this exercise that you are a visibly white patient. You will be asked to classify your ethnicity. Although of white ethnic background yourself, you have strong feelings against categorising of people given what this has led to with apartheid in South Africa and ethnic cleansing in the former Yugoslavia. Listen to the reasons why, consider the prompt sheet and then ask the staff member why the information is needed (if this has already been explained, say that you are still not clear as to why you are being asked for this information).

Consider the explanation you receive. Now ask why these particular categories have been selected and who by. Ask who will have access to this information. If you are satisfied with the explanations, give your classification. If you are not, ask the staff member to explain again.

### Scenario 6

You will be asked to classify your ethnicity. Give your reply as 'Kurdish'. Consider the reaction, as this is not listed on the prompt card. Stand adamantly by your choice until you receive an adequate explanation of the categories, who defined them and how Kurdish would fit into the categories.

### Any questions / worries not covered by the session?

### Evaluation



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### Frequently Asked Questions

**Q** What codes should I be entering into the computer within Primary Care?

**A** READ codes to match the 2001 Census.

9S13 White Scottish

9S14 Other white British ethnic group

9S11 White Irish

9S12 Other white ethnic group

9SB.. Other ethnic, mixed origin

9S6.. Indian

9S7.. Pakistani

9S8.. Bangladeshi

9S9.. Chinese

9SH.. Other Asian ethnic group

9S2.. Black Caribbean

9S3.. Black African

9SG.. Other black ethnic group

9SJ.. Other ethnic group

9SE.. Ethnic group not recorded

For other ethnic groups, please refer to the [Ethnic Record Keeping for Ethnic Monitoring for Social Care Definitions, Codelists and Guidance 2004](#)

**Q Where can I find out about what information is available from the Census?**

**A** The General Registrar of Scotland provides free data through the **SCROL** (Scotland's Census Results OnLine) website to expand access to Census data to all users and improve the use of the data. Using the Scrol analyser allows the user to select by, e.g. health board or local authority area.

**Q What current work is taking place across Scotland in relation to improving the health of minority ethnic groups?**

**A** Each NHS organisation has published as a minimum a Race Equality Scheme which describes what actions they are undertaking.

Some examples of what is currently known:

A Diabetes Report among minority ethnic groups in Scotland is available via <http://www.diabetesinscotland.org/diabetes/Publications.asp>

For more information contact: [maureen.dunn@health.scot.nhs.uk](mailto:maureen.dunn@health.scot.nhs.uk)

Dr Colin Fischbacher (Information Services Division) in conjunction with the National Resource Centre for Ethnic Minority Health (NRCEMH) is involved in a project to assess the availability of information about ethnicity in routine health service data in Scotland. The aim is to obtain information on ethnicity using country of birth, country of birth of parents and names as proxies. Permission has been granted to analyse Scottish hospital discharge databases and chronic disease registers using name search software.

For more information contact: [colin.fischbacher@isd.csa.scot.nhs.uk](mailto:colin.fischbacher@isd.csa.scot.nhs.uk)