

**Managing Equality and Diversity in Health Care:  
The Case of Ethnic Monitoring at St George's NHS Trust**

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**ABSTRACT**

The collection and use of ethnic group data on patients, service users, and staff is the foundation on which NHS bodies and councils with social services responsibilities can assess and address health inequalities, difficulties in access and discrimination experienced by some black and minority ethnic individuals and communities'. It is also the foundation by which they can assess and address workforce gaps and biases ...' not only through temporary measures, but also ultimately through improved organisational design (DH, 2005).

There are few studies (e.g., Jones, 2008; Southwest London and St George's Mental Health NHS Trust, 2006) which show how ethnic monitoring can be used to improve organizational design in the healthcare sector, for example, by exploring certain patient and staff groups' journeys and capturing why they are privileged or disadvantaged in relation to other groups, although there are a few studies reporting on targeted interventions. It is known, though, that different ethnic groups take different paths through the healthcare system. For example, black and minority ethnic groups are less likely to enter mental health care via general practitioners with some being more likely to enter via the criminal justice system and others having difficulty accessing services at all (e.g., Burnett et al, 1999; Cole et al, 1995; Shashidaran, 2003).

The specific aim of this study, currently at the data collection stage, is to identify how a case study example, St. George's Hospital NHS Trust (STG), can effectively use ethnic monitoring to inform the care planning and provision of services within the organisation's overall design to reduce health inequalities. The more general aim of the study is to develop a generic framework for implementing vertically and horizontally integrated care pathways which address issues of equality and diversity in health care. Findings will be available in June 2010.

Ethnic monitoring should be a process which can go beyond simple correlations between ethnic minority status and specific health outcomes. It should be able to look into ethnic minority patients' pathways in, out and within healthcare services in order to disentangle the

multiple and complex causes of health disparities and ultimately reduce/eliminate these disparities. There is no doubt that targeted interventions are important, however they often provide temporary solutions, without addressing the causes of health disparities between different ethnic groups. There is a need to incorporate diversity management practices into the healthcare sector through macro-level management of organizational design.

## **Managing Equality and Diversity in Health Care: The Case of Ethnic Monitoring at St George's NHS Trust**

The NHS is the largest employer in the UK and the third largest in Europe and the organisation is the single largest employer of ethnic minority staff in England. As the UK is becoming increasingly diverse (the population of ethnic minorities in England has grown from 8% in 2001, to 15% in 2009), the issue of ethnic inequality is especially important for an organisation which is the main healthcare provider for the country, as well as the key employer of many people from ethnic minorities (Siva, 2009).

In healthcare settings interest in ethnic monitoring, i.e. *the systematic collection of data on ethnic minorities*, has grown in the past decade, particularly in response to growing healthcare and health disparities between different ethnic groups (Varcoe et al., 2009). Indeed, the importance of patients, service users and staff self-assigning their ethnic group is clearly acknowledged in public healthcare services in the UK. The Department of Health states that the collection and use of ethnic group data on patients, service users and staff is the foundation on which NHS bodies can assess and address health inequalities, difficulties in access and discrimination experienced by some ethnic minority individuals and communities. It is also the foundation by which they can assess and address workforce gaps and biases and in consequence attract, develop and retain a workforce made up of the best talent from all communities (DH et al., 2005: 5).

Before we briefly discuss the development and current state of ethnic monitoring in UK healthcare services, it is important to note that in Europe the collection of statistics about people described or defined in terms of their 'ethnic origin', 'ethnic group' and/or other racial, national, skin-colour or similar descriptors has always been controversial. This is because European history, through the experiences of 1939-45 and more recent 'ethnic cleansing' events bears terrible testimony to the dangers inherent in every form of ethnic registration (Johnson, 2008).

However, precisely because of these risks associated with any registration of ethnicity data, it is of the utmost importance that all EU Member States develop strategies that prevent the abuse of a system of ethnic monitoring, avoid stigmatisation of ethnic minorities and guarantee that the rights and safety of individuals can be safeguarded (Council of Europe, 2006). Several obstacles have been hampering the development of a standardised and

systematic data collection system on ethnic minorities' health and healthcare issues. The main problems lie primarily in the lack of clear concepts and definitions as well as adequate research strategies that can be used to describe and analyse health and healthcare disparities between ethnic groups, and to disentangle associated factors.

The Institute of Medicine in the US argues that while the literature provides significant evidence of such disparities, the evidence base from which to better understand and eliminate them remains less than clear. They add that several broad areas of research are needed to clarify how ethnicity is associated with disparities in the process, structure and outcomes of healthcare. They state that research must provide a better understanding of the contribution of patient, provider, and institutional characteristics on the quality of healthcare for minorities (Smedley, Stith & Nelson, 2003). The situation in European countries generally compares unfavourably with that in the US and other 'classical' immigration countries such as Australia and Canada. Only one EU Member State, the United Kingdom, has developed strategies that can be used to document the health status, the accessibility and the use of health care services by ethnic minorities (Council of Europe (2006): 19). In this paper we focus on the practice of ethnic monitoring in public healthcare services in the UK.

Ethnicity-related data has now been collected by the Department of Health for over a decade. More specifically, ethnicity data has been collected for the medical and dental workforce census since 1991 and for the NHS non-medical workforce census since 1998 (Aspinall & Jacobson, 2006). April 1995 is another important date because mandatory collection of ethnic group data for hospital inpatients was introduced (NHS Executive, 1994). Then in April 2009 the Department of Health mandated for the collection and central submission of ethnic category information for patients attending NHS accident and emergency (A&E) departments and outpatient departments (HES, 2004). Amongst community care statistics, Referrals, Assessments and Packages of Care for adults contained ethnic group from the first year of roll-out in England, i.e. 2000-01. There are now an increasing number of new ethnically-coded datasets, including the core datasets for coronary heart disease, diabetes and mental health. These have been added to by specific new collections such as those used for the surveillance of sexually transmitted infections and TB (Aspinall & Jacobson, 2006).

While these developments have been taking place there are specific critical policy drivers within the British healthcare system to encourage Trusts to undertake ethnic monitoring with the utmost seriousness. The most important policy initiative to be mentioned is the Race

Relations Amendment Act 2000, which gives public authorities a statutory duty to promote race equality in routine policy-making, service delivery and employment practice. Clearly then ethnic monitoring data is required across service delivery and policy areas to demonstrate that this duty has been met (Aspinall, 2006).

Although there has been a steady growth in collection of these data, levels of completion remain low and this makes healthcare disparities difficult to monitor in the UK. Therefore a consistent message from the literature is the need for better ethnic monitoring data in the NHS and for greater use to be made of these data in order to justify its collection (Szczepura, 2005). Low completion levels may be partly due to the perceived sensitivity of this area on the part of healthcare workers (Bhatti-Sinclair & Wheal, 1998a,b) and partly due to data quality issues. There is extensive literature on issues of data quality and what ethnicity data should be collected, as there can be enormous variations in the level of accuracy, standard classification and completeness of ethnic group data across hospitals and Trusts in the UK (Aspinall, 1999; Aspinall & Anionwu, 2002; Johnson, 2008), which make comparisons across regions but also across different datasets difficult. Yet, it is beyond our purpose to discuss these data quality problems. The issue we want to focus on - and which we aim to address through this case example - is the potential of these routine data to inform practice and address health inequalities. Indeed it is very important to shift the agenda of ethnic monitoring from issues of data quality to *actual use* of the data because ethnic monitoring is more than data collection; it is the process used to collect, store and analyse data about people's ethnic background and then take action on the issues that emerge (DH et al., 2005).

The purpose of this paper is to look at examples from the current patient 'equality and diversity' settings of St. George's NHS Trust in Southwest London, one of 152 such Trusts in England and 31 in London. In the following pages, we first discuss a literature review we carried out to explore how ethnicity data is used in public healthcare services in the UK (Swan/IPI, *in preparation*), examples from St. George's, which is in an ethnically diverse catchment area, and results from our initial audit. Finally we draw conclusions for wider uses of NHS routine ethnic monitoring data in identifying and addressing health inequalities.

## Literature Review on Ethnic Monitoring

### Methodology

The broader research question we initially set out to explore was "*How is ethnicity data used by public healthcare services in the UK to address health disparities between different ethnic groups?*" Here we review all the relevant material we came across while exploring our research question. For the purposes of this review a narrative approach was adopted. The term 'narrative review' has been used to describe the traditional literature reviews of the type still widely undertaken in the social sciences as well as some more methodologically explicit approaches such as 'thematic analysis', 'narrative synthesis', 'realist synthesis' and 'meta-narrative mapping' (Mays, Pope & Popay, 2005a). Narrative reviews have been typically concerned with questions such as 'what do we know about the causes of a particular social and/or health problem? What are the implications of evidence on causality for the type of programmes/interventions that should be developed?' Increasingly however, narrative reviews are also addressing questions of effectiveness and cost-effectiveness (Mays, Pope & Popay, 2005b). In this review we adopt the first traditional approach to a narrative review, i.e. we are less concerned with assessing the quality of evidence. This means that we do not just focus on examples of 'good practice' in ethnic monitoring, which seem to or have actually reduced healthcare and health disparities between ethnic groups. Instead, we are more interested in compiling relevant information that provides both context and substance to our overall argument, which is described in the following section.

The relevant reviewed evidence emerged through our search in the following databases: ASSIA (Applied Social Sciences Index and Abstracts), Social Care Online-SCIE's resources and publications, MEDLINE, CINAHL (Cumulative index of nursing and allied health literature), BMJ Group's publications, the NHS library's Specialist Library for Ethnicity and Health, London Health Observatory, Department of Health publications, Google Scholar, Sainsbury Centre for Mental Health, King's Fund publications. In addition, extensive search was carried out within the following journals: Ethnicity and Race in a Changing World: a review journal, Ethnicity and Inequalities in Health and Social Care, Journal of Public Health, Ethnicity and Health, Health Services Research, Health Affairs, Health and Social Care in the Community, Health Services Research and Policy, Critical Public Health, International Journal for Health Planning and Management. Because of the large number of papers identified, a publication date of 2000 is used as the date filter for this final review. Earlier

papers are included only if they are included as ‘seminal’, that is, well cited articles which contribute significantly to the review.

### How has Ethnic Monitoring been used?

Ethnicity data are typically collected as part of administrative data, or at the point of care, that is, when people seek care at physicians’ offices, hospitals or community health centres (Varcoe et al., 2009). The practice of ethnic monitoring in health services has been intended to enable the provision of services without racial or ethnic discrimination (Gill & Johnson, 1995) and as tackling growing social and health inequalities has become a key political objective worldwide and in the UK (Exworthy et al., 2003), the Department of Health is nowadays committed to mainstreaming ethnic monitoring in all its routine data.

A persistent problem in this area that should be noted is that in routine healthcare settings there has been the very limited use made of the data collected (Aspinall & Jacobson, 2006). Aspinall and Anionwu (2002) reported that although the ethnic identities of patients were obtained for an annual total in England of over 11 million admissions, the information has only been used to produce indices of quality, not to improve the quality of care provided. The possible reasons for such failure, which have been widely discussed, include that the contribution of racism and causes of inequities is complex, encompassing structural inequities and institutional racism (Bhopal, 2007a) and that additional resources required to address such inequities may not be prioritized in the context of global healthcare reforms that have emphasized cost cutting (Varcoe et al., 2009: 1660).

There is no doubt that the ethnic monitoring process provides healthcare services with an essential ‘template’ upon which they can build their efforts to address healthcare disparities at the local organizational level and ultimately reduce health inequalities between different ethnic groups (Aspinall & Anionwu, 2002; Bhopal, 2009; Department of Health et al., 2005). Indeed, we agree with policy makers’ and academics’ acknowledgment that in the ethnically diverse context of contemporary Britain, ethnic monitoring constitutes a fundamental platform which can help achieve the above goals.

Yet our main argument is as follows: we know that ethnic monitoring is only the first step for bringing the necessary changes to healthcare services in order to make them more equitable and to tackle ethnic disparities in healthcare and health. There are three further building

blocks of crucial importance: improving pathways to care for all ethnic groups; training in culturally competent; and lastly community engagement and participation in healthcare design and delivery (Bhopal, 2007b; Bhui et al., 2004a; Randhawa, 2007). We believe that these three building blocks of ensuring more equitable services for ethnic minority patients, service users and staff are not well integrated as they should be but are rather fragmented within public healthcare services. In order to build our arguments we map each area (i.e. improving pathways to care for all, cultural competency training and community engagement and participation) and we point to the current state of affairs.

### **Improving pathways to care for all ethnic groups**

There is considerable literature mapping ethnic variations in pathways into, through and out of healthcare, as well as the quality of care received (Szczepura, 2005). Understanding exactly *why* there are ethnic differences in pathways to care, with some ethnic minorities making less use of services than the White majority is quite complex as potential barriers to the use of health services among ethnic minorities seem to occur at the patient level, the provider level and the broader healthcare system level (Scheppers et al., 2006). Nevertheless, a large body of evidence nowadays supports the possibility that these disparities (and consequently health disparities) are largely due to socioeconomic differentials and experiences of racial harassment and discrimination (Bhopal, 2007b; McLean, Campbell & Cornish, 2003; Nazroo, 2003).

It should be noted that the concept of pathways to healthcare is quite complex and at times rather vague (Allen, 2009). Most of the times care pathways are defined as “*multidisciplinary care management tools which map out chronologically key activities in a healthcare process*” (Allen, 2009: 354). This definition is undoubtedly useful from a health services point of view, because it emphasises the importance of care pathways as a mechanism for creating the partnerships between healthcare professionals and managers necessary to bring improvements in service quality. But in this paper we adopt the broader conceptualization of care pathways which focuses on the dynamic processes underlying people’s use of healthcare services from the time they first enter the healthcare system, to the point where their treatment is complete and they leave the system (see following pages for the description of the Network Episode Model (Pescosolido 1991; Pescosolido et al., 1998) which examines these processes).



The main themes which emerged while searching this literature concern:

- The concept of care pathways as well as the theory underlying care pathway development when applied to ethnic minorities' journeys into, through and out of care (Bhui & Bhugra, 2002; Jack et al., 2001; Singh et al., 2007; Morgan et al., 2004; Sass et al., 2009; Wilson et al., 2009).
- Ethnic minority patients' care pathways-with an emphasis on pathways of mental healthcare (Borschmann et al., 2010; Commander et al., 1999; Hackett et al., 2009; Jacob et al., 2002; Leese et al., 2006; Morgan et al., 2002; Morgan et al., 2005a; 2005b)

### **Training in the provision of culturally competent healthcare**

In the US, since the early 2000s research on culturally appropriate/ sensitive/ competent healthcare has been burgeoning (Betancourt et al., 2005; Taylor & Lurie, 2004). Currently, as the cultural competency movement has reached 'the tipping point' various systemic, organizational, clinical and community-based cultural competency initiatives are underway (Like, 2007). In the UK progress in this area has been slow (see Bhui et al., 2007 for some possible explanations) but there has been significant investment in study days, short courses and more substantive cultural competence training programmes by NHS Trusts and public services providers (Papadopoulos et al., 2004), while the need to provide culturally sensitive services to ethnic minorities is increasingly recognized as a key to reducing ethnic disparities in healthcare and health (Bhopal, 2009).

The main themes which emerged while exploring the cultural-competence literature concern:

- Discussion of the inadequate (i.e. monocultural) training health professionals in the west receive, the limitations of western diagnostic models, methods of assessment and western concepts of therapy when applied to ethnic minorities and the need to provide culturally sensitive services (Anand & Cochrane, 2005; Fernando, 2005; Gerrish & Papadopoulos, 1999; Gunaratnam, 2007; Yazar & Littlewood, 2001).
- The development and implementation of culturally sensitive training programmes for healthcare professionals and the evaluation of their effectiveness through testing them on indigenous and ethnic minority populations (Bhui et al., 2004b; Brett et al., 2009;

Hackett et al., 2009; Hutnik & Gregory, 2008; Papadopoulos et al., 2004; Papadopoulos et al., 2008).

### **Community engagement and participation in healthcare design and delivery**

The approach of community engagement is commonly used to support the participation of communities in a range of activities which can improve healthcare and health and/or reduce healthcare and health disparities (Popay, 2006). Participation of members of socially excluded groups in healthcare design and delivery comprises an essential element of both academic and government recommendations in the overall effort to reduce health disparities in the UK (Campbell et al., 2004). Sometimes the term ‘coproduction’ is preferred precisely for emphasizing this active involvement of service users and communities in public healthcare services (Bovaird, 2007).

There are many barriers and challenges to community engagement and participation, such as the culture of statutory sector organizations (where professional cultures and ideologies usually prevail), the capacity and willingness of service users and the public to get involved, the skills and competencies of staff working in public services (Swainston & Summerbell, 2007). Barriers and challenges to ethnic community engagement and participation in public healthcare services have also been researched (Begum, 2006) and include poor communication as well as severe distrust between statutory and community sectors, disillusionment and disempowerment within certain ethnic communities as well as low levels of community capacity (Campbell et al., 2004; Stuart, 2008).

The key themes emerging from this body of literature concern:

- The barriers of effective ethnic community engagement and participation in healthcare design and delivery and suggestions for positive change (Cross et al., 2005; Hussain-Gambles, 2004; Vernon, 2002; Wallcraft et al., 2003).
- Evaluations of various public healthcare initiatives which have a commitment to engage with ethnic communities (Brett et al., 2009; Hackett et al., 2009; Kernohan, 1996; Patel et al., 2007; Shah et al., 2008).

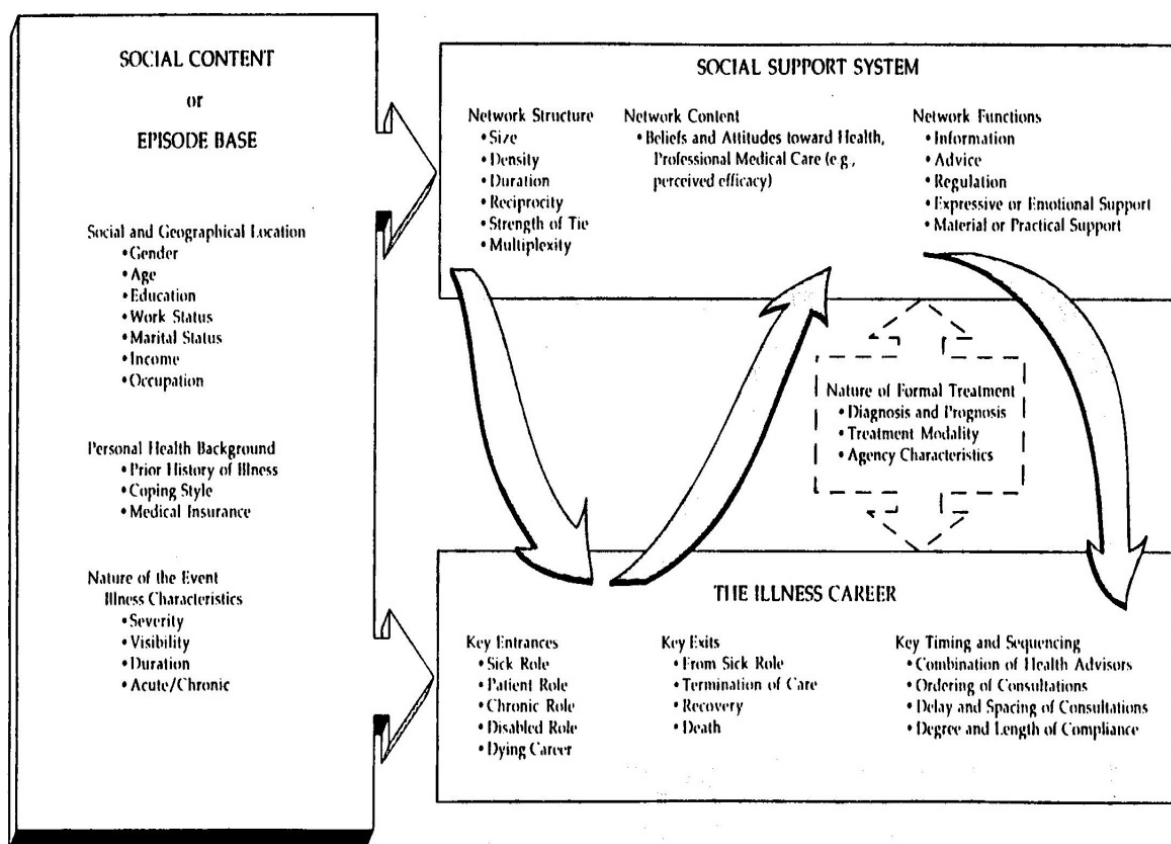
## **A critical look at the field of ethnicity, healthcare and health in the UK: the need for more integrated, theoretically sound and methodologically innovative interventions**

It is important to note that the practices we briefly described which build on the ethnic monitoring process, i.e. the improvement of pathways to care for all ethnic groups, cultural competence training and community engagement and participation in healthcare design and delivery, are not well integrated. For example, some of them (Hutnik & Gregory, 2008) focus on providing cultural competence training to healthcare professionals without however involving the local ethnic communities in order to understand how *they* want their healthcare needs to be met and whether these needs were addressed after the completion of the training (for a similar critique see Bennett et al., 2007). But when it comes to actual healthcare interventions, it is crucial that these practices *are* integrated. One noteworthy exception is the EPIC project (Brett et al., 2009; Hackett et al., 2009; Wilson et al., 2009) which has indeed synthesized the above practices while working on improving pathways into care for ethnic minorities from diverse cultural backgrounds in England.

To achieve an integrated approach, there is need for practices to be based on solid theoretical foundations. There is a wide range of generic theoretical frameworks which are valuable when examining people's healthcare behaviours and healthcare utilization and very useful for understanding socio-cultural differences in healthcare access, quality of healthcare received and health outcomes. Some of the most well-known frameworks are: the Socio-behavioural Model of Health Services Utilization (Andersen & Newman, 1973; Andersen, 1995); the Health Care Systems Model (Kleinman, 1980); the Pathways into Psychiatric Care Model (Goldberg & Huxley, 1980; Goldberg, 1995); the Network Episode Model (Pavalko et al., 2007; Pescosolido, 1991; 1992; Pescosolido et al., 1998); the Help Seeking Model (Cramer, 1999); and the Process Model of Seeking Mental health Services (Goldsmith et al., 1988).

During our review of the relevant frameworks (Swan/IPI, *in preparation*), a particular one was of interest, the Network Episode Model (NEM), which will be described in further detail. This model stems from Pescosolido's (1991, 1992) attempt to capture the dynamic nature of mental health system entry, repeat use, adherence and outcome. Indeed, the NEM is a process-oriented framework which does not make assumptions about how people come into the treatment system. Rather it focuses on the dynamic processes underlying the use of healthcare services, while acknowledging at the same time that family, social network and community contacts, as well as individual factors (i.e. age, race, gender) all play a very

important role on shaping when, how and if people receive healthcare. What renders the NEM different from other approaches to healthcare behaviours and utilization is that it does not conceptualise healthcare service use as an exclusively individual rational choice. Instead it supports that in order to understand people's routes in, though and out of healthcare we must consider simultaneously the various ways they come to obtain healthcare, their roots in community-based influences and the impact of contingencies (such as age, race and gender) that may shape both modes of entry and social network ties (see Figure 1) (Pescosolido et al., 1998: 277).



**Figure 1: Pescosolido's Network Episode Model**

**Sources:**

1)Pescosolido, B.A. 1992. "Beyond Rational Choice: The Social Dynamics of How People Seek Help." *American Journal of Sociology* 97: 1096-1138.

2)Pescosolido, B.A. 1991. "Illness Careers and Network Ties: A Conceptual Model of Utilization and Compliance." Pp. 161-184 in Gary Albrecht and Judith Levy (eds.), *Advances in Medical Sociology, Volume 2*. Greenwich, Connecticut: JAI Press.

Stemming from the healthcare utilization literature, the NEM not only fits well within the wider worldwide debate about the organisational redesign of the healthcare sector discussed in the management literature, but also complements it. The explosion of medical advances over the last three decades has radically changed the nature of healthcare and at very much faster rate than healthcare organizations have been able to respond to them. The current organisational design of most hospitals around the world stems from a time when our understanding of illness was more opaque and so relied on the individual physician evaluating and treating individual patients with the support of a small team of nurses and others. Hospitals were designed as physicians' workshops offering customized services in much the same way as manufacturing industries first developed (e.g., the automobile was first crafted in workshops by a master craftsman and his support team) (Bohmer, 2010). Many other sectors of the economy have been through the standardization that followed and, at least for some players in these other sectors, have entered the era of mass customization (Pine II, Victor & Boynton, 1993). More recently many healthcare processes can be standardized, programmed into computers and delivered by non-physicians enabling many more patients to be treated and so hospitals have followed the route to standardization taken by manufacturers and more recently also by the service sector. The challenge of healthcare however is that patient care remains complex with predictability and ambiguity co-existing (Bohmer, 2010). The key seems to be to move to mass customization in healthcare as in other industries. Without being prescriptive as to specific organizational design, Bohmer (2010) suggests that the key critical elements of healthcare redesign are: 1) manage the care (i.e., standardize); 2) corral variability (i.e., customize); 3) reorganize resources (e.g., across silos); and 4) learn from everyday care (e.g., encourage ideas from below). The NEM provides some elements (such as the dynamic interplay of individual and social factors) towards our improved understanding of how to corral variability to mass customize. In this paper, we are of course concerned with one aspect of variability – that of ethnic diversity - in terms of healthcare provision and utilization and health outcomes.

Finally, we conclude this section with a methodological note: in the effort of making healthcare services more equitable, an actual synthesis of all or some of the above practices will produce great amounts of data, which will be inevitably quite diverse (e.g. ethnicity related and other demographic data from standardised forms, patients' qualitative accounts of care pathways followed, standardised measures of the units of healthcare (such as consultations, procedures etc) that people have consumed etc). Then constructively

synthesising such large and diverse sets of data in order to inform future interventions can be fraught with methodological difficulties. Moreover, in most occasions there is the risk that these combined datasets may not even shed light on the main issue they set out to explore, i.e. *why* there are healthcare and health disparities between certain ethnic groups and what can be done about it (Forbes & Wainwright, 2001; Morgan et al., 2004).

There are however some recent methodological initiatives which seem to offer a solution to the above impasse: Dixon-Woods et al. (2006) and Dowrick et al. (2009) have developed methodological approaches to managing multiple and diverse sources of evidence on access to healthcare services by vulnerable groups in the UK. Dixon-Woods et al. (2006) offered a critical literature review technique which tackles the limitations of conventional systematic literature review approaches and Dowrick et al. (2009) developed an approach to evidence synthesis which comprises of a systematic review of published evidence, meta-synthesis of published qualitative literature and secondary analysis of qualitative datasets as well as interviews with service users and carers. In both cases the research teams acknowledge the need for testing the validity of these methods in further contexts, however we believe that their approaches to evidence gathering and synthesis are innovative and can help inform the evaluation of integrated interventions as well as the design of new ones.

In this paper we combine a narrative review and the initial steps of secondary analysis of quantitative data. We believe this is a small but important step towards informing future healthcare redesign. In the following pages we describe the patient settings of St. George's NHS Trust, our partnership with the Trust and our initial audit of the Trust's routine ethnic monitoring databases.

### **The Case Example: St George's Healthcare NHS Trust**

St George's Hospital is one of the oldest hospitals in London. It is also one of the UK's largest teaching hospitals and shares its main site in Tooting, southwest London with St George's, University of London which trains NHS staff as well as undertaking advanced medical research. In terms of size, STG Healthcare NHS Trust employs over 6,000 staff, offers around 1,000 hospital beds and serves a population of 1.3 million across southwest London. The Trust provides all the usual care expected from a local NHS hospital - such as accident and emergency, maternity services and care for older people and children - but, as a

major acute hospital, St George's also offers very specialist care for the most complex of injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation, cancer care and stroke.

A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling about 3.5 million people. St George's also provides care for patients from a larger catchment area in the South East England, for specialties such as complex pelvic trauma, and other services treat patients from all over the country, such as family HIV care and bone marrow transplantation for non-cancer diseases.

In 2011 the Trust is planning to become a Foundation Trust. The key difference between a Foundation Trust and existing NHS Trusts is that local people and service users will have a real say in running their hospital by becoming members of the Trust and representing local views by becoming and/or electing governors. In this new context it is anticipated that service users' feedback will significantly improve the practice of ethnic monitoring and will prompt the actual use of the data that is being collected and analysed in order for healthcare and health disparities to be reduced. But in the meantime we think this is the right time for exploring how St George's Hospital has been using ethnic monitoring to inform the planning and provision of healthcare services within the organisation's overall commitment to Equality and Diversity with a view to informing future initiatives inside and outside this specific Trust.

#### Population in STG catchment areas

South West London, where STG is located, has a resident population of 1.34 million people living in six boroughs – Croydon, Wandsworth, Merton, Sutton, Kingston and Richmond (NHS, 2009). Whilst residents tend to be wealthier, younger and live longer than many other places in England, there are considerable differences between and within these boroughs in terms of life expectancy and deprivation. South West London's population is growing and becoming older. This means there will be a significantly greater need for healthcare in future. It is projected that the population of South West London will grow over the period 2009 to 2019 – on average by 5.8% (varying between 2.2% in Sutton and Merton and 12.7% in Croydon). This compares with a growth rate of 8.8% over the same period for North East London. The mortality rate is expected to decrease across the sector, with Richmond and

Wandsworth seeing the greatest decline. Croydon has over 335,000 residents – the largest population of any borough in London – and a GP registered population of 371,448. The borough also has a highly transient population, including high numbers of refugees and asylum seekers with specific health and social care needs.

There are more people aged 25-34 years in SW London than the England average, and fewer children and young adults aged 5-24 years. However, again this picture is not uniform across boroughs – for example, Richmond and Kingston has a higher proportion of people aged over 75 than the London average, whilst Croydon and Sutton both have an above average population of children under the age of 16.

Residents in this London area live one year longer than the average London resident – the average life expectancy for women in South West London is 83 years, and 79 years for men. However, there are significant differences between boroughs – life expectancy for men is 76.9 years in Wandsworth and 80 years in Richmond; and between different wards in a borough. There is a seven-year difference in life expectancy between the least deprived and most deprived wards in Wandsworth alone. A key factor in life expectancy is deprivation.

### Deprivation

Residents have an average gross annual income that is higher than that of London or England although the picture is mixed. The boroughs' Index of Multiple Deprivation (IMD) ranking by degree of deprivation indicates that some areas are faced with higher deprivation than others as indicated in the table below which lists IMD positions of the 6 SW London boroughs:



**Box 1: IMD ranking of SW London Boroughs**

Borough	Overall IMD 2007*
Croydon	125
Wandsworth	144
Merton	222
Sutton	234
Kingston	245
Richmond	309

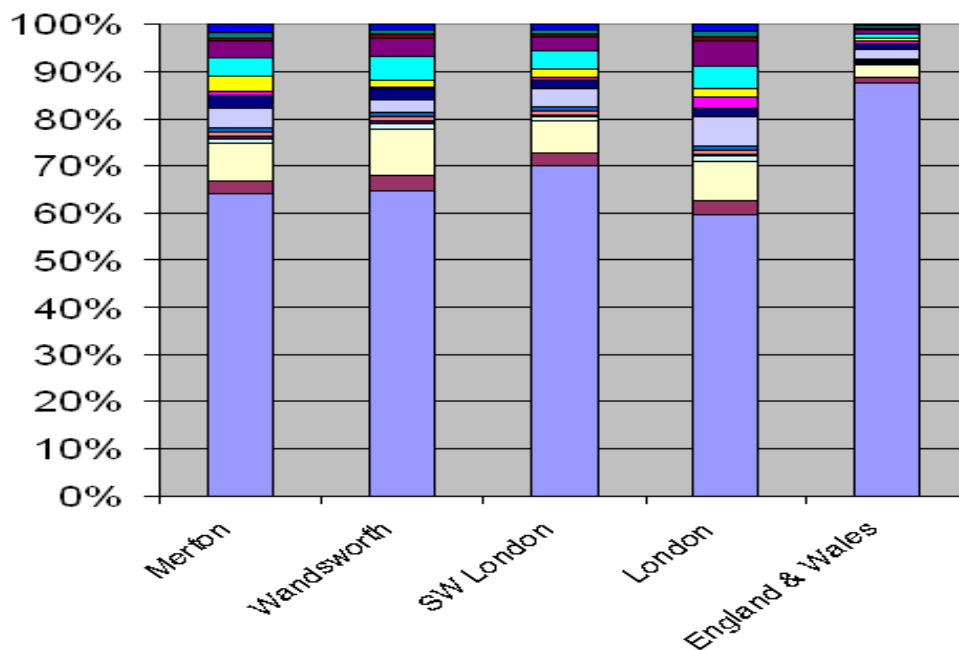
\* 1 is most deprived borough in England and 354 is the least deprived

(Source: *The South West London Sector Case for Change*, Healthcare for South West London, NHS, 2009)

Indeed, there are pockets of very high socio-economic status in all six boroughs alongside areas of severe deprivation, with Wandsworth and Croydon having the highest proportion of deprived areas. In these wards over a quarter of children are living in poverty/deprived areas.

### Diversity

The community at the vicinity of St George's Hospital is more ethnically diverse than the national population with local residents belonging to a wide variety of ethnic groups. Compared with the national average, the proportion of people from ethnic minorities in this area is 30% higher than the rest of England and Wales, which is just 13%. Overall, across South West London 80% of people class themselves as White, 8% Asian, over 7% Black, 3% of mixed origin and 2% of other ethnic origins, such as Chinese as reflected in Chart 1. This trend is set to continue, as the population in South West London keeps on growing at a higher rate than the national average, bringing with it even further increase in ethnic diversity (St George's Healthcare Trust, 2010).



**Chart 1:** Ethnic origin in Wandsworth, Merton, South West London, England and Wales (2001 Census)

The Trust's diverse patient population is also evident from Table 1 presenting demographic characteristics such as age, gender, ethnicity and religion of outpatients and hospital admissions in 2008:

**Table 1: Demographic profile of STG outpatients and admissions in 2008**

	<b>Outpatients</b>		<b>Admissions</b>	
	<i>N</i>	<i>Percentage</i>	<i>N</i>	<i>Percentage</i>
<b>Age</b>				
0-16 years	41358	9.0%	14178	12.1%
17-30 years	71847	15.6%	15566	13.3%
31-50 years	135466	29.3%	26735	22.9%
51-70 years	123999	26.9%	32426	27.8%
70+ years	89138	19.3%	27903	23.9%
<b>Total</b>	<b>461808</b>	<b>100.0%</b>	<b>116808</b>	<b>100.0%</b>
<b>Gender</b>				
Female	273290	59.2%	61114	52.3%
Male	187250	40.5%	55678	47.7%
Unknown/Not recorded	1268	0.3%	16	0.0%
<b>Total</b>	<b>461808</b>	<b>100.0%</b>	<b>116808</b>	<b>100.0%</b>
<b>Ethnicity</b>				
White British	191778	41.5%	47811	40.9%
White other	63056	13.7%	13415	11.5%
Bangladeshi, Indian & Pakistani	29240	6.3%	7214	6.2%
Black African	21036	4.6%	5264	4.5%
Black Caribbean	24889	5.4%	9511	8.1%
Black Other	10651	2.3%	3104	2.7%
Chinese	2723	0.6%	816	0.7%
Mixed	8420	1.8%	2104	1.8%
Other Asian	24799	5.4%	7541	6.5%
Any other	11535	2.5%	3459	3.0%
Unknown/Not recorded	67682	14.7%	15235	13.0%
Patient did not disclose	5999	1.3%	1334	1.1%
<b>Total</b>	<b>461808</b>	<b>100.0%</b>	<b>116808</b>	<b>100.0%</b>
<b>Religion</b>				
C of E - Anglican	110524	23.9%	26316	22.5%
Roman Catholic	65157	14.1%	14706	12.6%
None	51428	11.1%	11284	9.7%
Other Christian	48917	10.6%	12795	11.0%
Muslim	34202	7.4%	9320	8.0%
Hindu	16333	3.5%	3745	3.2%
Other	6789	1.5%	1593	1.4%
Jewish	1810	0.4%	415	0.4%
Jehovah Witness	1565	0.3%	752	0.6%
Buddhist	1562	0.3%	287	0.2%
Sikh	1445	0.3%	360	0.3%
Unknown/Not recorded	122076	26.4%	35235	30.2%
<b>Total</b>	<b>461808</b>	<b>100.0%</b>	<b>116808</b>	<b>100.0%</b>

Notes: Total numbers as at 11/01/2009:  
 Outpatients attendances = 461808  
 Admissions = 116808 (includes inpatients, day cases, regular day attenders and regular night attenders)

## Equality and Human Rights mechanisms within the Trust

The work of the Trust has recently focused on improving the governance and reporting framework for mainstreaming equality and diversity into clinical and operational services. To support this objective, they have established the Equality and Human Rights Committee in 2009 against the new Corporate Scorecard and Strategic Aims of the Trust. This is strategically fitting with the Trust's current move to apply for Foundation Trust status in 2011; during this process they aim to evidence current status and plan for greater involvement of diverse patient, public and staff members to improve services and experience at the Trust.

To this end, the Trust has introduced a new Single Equalities Scheme for 2010-13 (due to be finalised in September 2010), which will take account of all equality dimensions and will remain as a 'live' document responsive to needs and priorities. Their diversity work is largely underpinned by Human Rights legislation and a focus on achieving dignity and respect for all, irrespective of race, disability, gender, sexuality, age, religion or belief, deprivation, class or background.

An important mechanism in these latest developments, the STG Equality and Human Rights Committee is a sub-committee of the Trust's Board, chaired by a Non-Executive Director. The Committee has a fundamental role in assisting the Trust Board to set the strategic direction for Diversity, Equality & Human Rights, promoting dignity and respect for patients and staff. It aims to offer strategic guidance and leadership, ensuring that equality and diversity becomes integral and central to all decision making. Also, one of its main tasks is to challenge where appropriate, scrutinise, monitor, sustain and report on progress to the Board. Finally the committee aims to ensure that due regard is given to all aspects of diversity across the Trust, including race, disability, age, gender, religion and belief, sexual orientation and socio-economic indicators.

For St George's Hospital NHS Trust as for all other Trusts in the UK ethnicity monitoring of patients, service users and staff is statutory requirement. In addition, as already mentioned above, St George's Healthcare Trust is seeking to become a Foundation Trust. The key difference between a Foundation Trust and existing NHS Trusts is that local people and service users will have a real say in running their hospital by becoming members of the Trust and representing local views by becoming and/or electing governors. In this new context, it is

anticipated that service users' feedback will significantly improve the practice of ethnic monitoring and will prompt the actual use of the data that is being collected and analysed in order for healthcare and health disparities to be reduced. Therefore, it is of particular importance to explore how STG could be using ethnic monitoring to inform the planning and provision of healthcare services within the organisation's overall commitment to Equality and Diversity with a view to informing future initiatives inside and outside this specific Trust.

### **The Audit Process**

At the beginning of 2010, a dialogue was initiated between the Trust senior managers, the South West Academic Network (SWan) and researchers from Kingston University and St George's University of London, to explore potential partnerships which would create opportunities for academic research to inform the Trust's care management and practice. During these meetings, the issue of using routine ethnic monitoring data in clinical practice and quality of care was identified as an area of mutual interest. As a result, the authors of this paper applied for and secured a Kingston University Business Fellowship grant to conduct an audit of existing ethnic monitoring data and explore their potential use.

In particular, the aim of the audit process was to identify how the data collected by St. George's Hospital NHS Trust (STG) could be effectively used to inform further care planning and provision of services by STG to reduce ethnic health inequalities. The ultimate goal would be to develop a framework for implementing vertically and horizontally integrated care pathways which address issues of equality and diversity in health care. The process would be owned jointly by STG and the academic partners and would be shaped by ongoing dialogue and collaboration during the analysis of data.

There were 3 proposed stages of analysis:

1. To explore 3 existing (and most recent) datasets: A&E, inpatients, outpatients, in relation to demographics, referral source, complaint/diagnosis, discharge/further referral. From this analysis, we would be able to examine how Black and other minority ethnic (BME) groups enter the system (there is evidence for example that some BME groups will enter at a point of crisis/emergency and not through GP referrals).

2. To identify 1 or 2 services (in consultation with the Trust), e.g. breast screening and/or mental health, to examine closer in the same way, i.e. to assess ways of entry and care pathways as much as possible.

3. From this analysis, to develop a framework to examine inconsistencies in BME care pathways in specific services and how routine data could be improved to help us with assessing users' needs.

Currently, we are at the first stage of our analysis and we will present some examples of issues that come up in our preliminary work.

Before discussing examples from our analysis, it is useful to provide some background context on how ethnic groups are defined according to NHS ethnic monitoring guidance (A practical guide to Ethnic Monitoring in the NHS and Social Care, 2005).

#### The National Standard for Ethnic Group and its Codes

From April 2001, the Department of Health (DH), Trusts and councils have used, as a National Standard, a set of 16 codes to record the ethnic group of patients, services users and staff (see Box 2 below). The codes are identical to those used in the 2001 Office for National Statistics (ONS) census, in accordance with ONS guidance on national standards. They are grouped under five headings: White; Mixed; Asian or Asian British; Black or Black British; and Chinese or other ethnic group. The headings are not to be used as codes for direct data collection but may be used to feedback broad findings in various agency reports.

The 16 codes are used across Government which helps to maintain consistency between Department of Health central collections and ONS population information. According to the DH guidance (2005), their use enables ready comparison between NHS and social care information and national and local population counts based on the 2001 census. DH claims that these codes are robust following much public consultation. They are referred to as the “16+1” codes; the extra code is for “Not stated”, where for various reasons individuals do not, or choose not, to state their ethnic group. When used to record the ethnic group of patients, service users and staff, space should be left after each of the five “Any other ...” codes so that the individual can describe their own ethnic group.

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

**Table 2: NHS Ethnic Groups as Recorded for Ethnic Monitoring Purposes**

<p><b>Ethnic group – 16+1 codes</b></p> <p><b>What is your ethnic group?</b> <i>Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group.</i></p> <p><b>A : White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background (please write in)</p> <p><b>B : Mixed</b> <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed background (please write in)</p> <p><b>C : Asian or Asian British</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background (please write in)</p> <p><b>D : Black or Black British</b> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background (please write in)</p> <p><b>E : Chinese or other ethnic group</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other (please write in)</p> <p><b>Not stated</b> <input type="checkbox"/> Not stated</p>
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### Examples from Initial Analysis

To highlight some of the potential uses of routine ethnic monitoring data, we will use examples from the A&E dataset from the 6 first months of 2009. Table 3 presents a breakdown of ethnic groups as recorded per NHS categories. While 39% declared that they belong to a White ethnic group, 27% have identified themselves as belonging to a non-White ethnic group, which indicates a high level of ethnic diversity in this patient population (10% Black; 9.1% Asian; 6.1% Chinese/Other; 1.8% Mixed), compared to the ethnic composition for the region.

**Table 3: A&E attendance at St George’s Hospital by Ethnic Group (1/1/2009-30/6/2009)**

	N	Percentage
White British	17748	27.1%
White Irish	640	1.0%
Any other White	7229	11.1%
<b>White (total)</b>	<b>25617</b>	<b>39.1%</b>
Black African	56	.1%
Black Caribbean	2078	3.25%
Black African	2072	3.2%
Any other Black background	2364	3.6%
<b>Black (total)</b>	<b>6570</b>	<b>10.0%</b>
Pakistani	1026	1.6%
Indian	845	1.3%
Bangladeshi	179	.3%
Any other Asian background	3936	6.0%
<b>Asian (total)</b>	<b>5986</b>	<b>9.1%</b>
Chinese	215	.3%
Other	3521	5.4%
Any other ethnic group	231	.4%
<b>Chinese/Other (total)</b>	<b>3967</b>	<b>6.1%</b>
Mixed - White & Asian	129	.2%
Mixed - White & Black African	112	.2%
Mixed - White & Black Caribbean	276	.4%
Mixed ethnic group	495	.8%
Any other mixed background	151	.2%
<b>Mixed (total)</b>	<b>1163</b>	<b>1.8%</b>
Missing	22232	33.9%
<b>Total</b>	<b>65535</b>	<b>100%</b>

Table 4 presents the arrival mode of patients to SG Accident and Emergency’s unit by ethnic group. While most patients come to A&E by private transport (36.5%), through dialling 999 (20.8%) or other means (21.5%), there are some differences between ethnic groups which may be indicative of socio-economic factors. For example, public transport is used more by Chinese/other (11.8%) and Black (9.1%) ethnic groups than by White ones (5.7%). On the other hand, dialling 999 is used more by White (22.8%) than any other ethnic groups (Black – 19.5%; Asian – 16.8%; Chinese/other – 17.3%; Mixed - 15.7%), which could be indicative of language barriers in explaining the emergency faced by some non-English speaking people included in non-White groups.



**Table 4: A&E arrival mode by ethnic group**

Arrival Mode		Ethnic Groups					Total
		White	Black	Asian	Chinese/ Other	Mixed	
<b>Private Transport</b>	N	8927	2289	2328	1788	468	15800
	% within Ethnic Group	34.8%	34.8%	38.9%	45.1%	40.2%	36.5%
<b>Other</b>	N	5418	1469	1464	661	286	9298
	% within Ethnic Group	21.2%	22.4%	24.5%	16.7%	24.6%	21.5%
<b>999</b>	N	5842	1284	1006	687	183	9002
	% within Ethnic Group	22.8%	19.5%	16.8%	17.3%	15.7%	20.8%
<b>Ambulance</b>	N	1746	422	302	172	53	2695
	% within Ethnic Group	6.8%	6.4%	5.0%	4.3%	4.6%	6.2%
<b>Foot</b>	N	1465	498	419	182	91	2655
	% within Ethnic Group	5.7%	7.6%	7.0%	4.6%	7.8%	6.1%
<b>Public Transport</b>	N	2187	599	460	469	80	3795
	% within Ethnic Group	8.5%	9.1%	7.7%	11.8%	6.9%	8.8%
<b>Police</b>	N	26	9	7	5	2	49
	% within Ethnic Group	.1%	.1%	.1%	.1%	.2%	.1%
<b>GP Surgery via LAS</b>	N	5	0	0	3	0	8
	% within Ethnic Group	.0%	.0%	.0%	.1%	.0%	.0%
<b>Total</b>	N	25617	6570	5986	3967	1163	43303
	% within Ethnic Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Similarly, Table 5 the A&E presents referral sources which are mainly self-referral (54.9%) and other (27.3%) in the overall population of patients. Nonetheless, again we can observe some differences among ethnic groups. Chinese/other have the lowest percentage (43.3%) of self-referrals and the highest percentage (41.4%) in other referral source than any other ethnic group and the overall percentage in these referral categories (54.9% and 27.3% respectively), which could indicate ethnic specific issues of A&E referrals. Unfortunately, there is no information of what the ‘other’ referral sources may be to be able to explore further this difference.

**Table 5: A&E Referral Source by Ethnic Group**

Referral Source		Ethnic Groups					Total
		White	Black	Asian	Chinese/ Other	Mixed	
<b>Self</b>	N	14241	3810	3424	1718	566	23759
	% within Ethnic Group	55.6%	58.0%	57.2%	43.3%	48.7%	54.9%
<b>Other</b>	N	6450	1653	1641	1641	426	11811
	% within Ethnic Group	25.2%	25.2%	27.4%	41.4%	36.6%	27.3%
<b>Own GP</b>	N	1839	459	409	241	77	3025
	% within Ethnic Group	7.2%	7.0%	6.8%	6.1%	6.6%	7.0%
<b>Other Professional</b>	N	1524	215	197	160	33	2129
	% within Ethnic Group	5.9%	3.3%	3.3%	4.0%	2.8%	4.9%
<b>Walk in centre</b>	N	599	155	138	79	23	994
	% within Ethnic Group	2.3%	2.4%	2.3%	2.0%	2.0%	2.3%
<b>Other GP</b>	N	390	83	75	45	11	604
	% within Ethnic Group	1.5%	1.3%	1.3%	1.1%	.9%	1.4%
<b>Police/ Prison</b>	N	333	99	47	58	16	553
	% within Ethnic Group	1.3%	1.5%	.8%	1.5%	1.4%	1.3%
<b>School</b>	N	102	58	32	15	9	216
	% within Ethnic Group	.4%	.9%	.5%	.4%	.8%	.5%
<b>Care Navigator</b>	N	11	2	1	0	0	14
	% within Ethnic Group	.0%	.0%	.0%	.0%	.0%	.0%
<b>Second Opinion Required</b>	N	1	0	0	0	0	1
	% within Ethnic Group	.0%	.0%	.0%	.0%	.0%	.0%
<b>Work</b>	N	126	36	22	10	2	196
	% within Ethnic Group	.5%	.5%	.4%	.3%	.2%	.5%
<b>Total</b>	N	25617	6570	5986	3967	1163	43303
	% within Ethnic Group	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

## Discussion of Examples

Our initial investigations of the Trust's A & E patient databases show that a significant number of A& E patients are non-White therefore there is need for services to be culturally sensitive and appropriately designed, as previously noted in relevant literature. Also, there are some significant differences among ethnic groups in terms of access to the Trust's A&E services as indicated by the routine data. BME groups are about twice as likely to arrive at the hospital by public rather than private transport than are Whites (see Table 4 above). Whilst it is likely that this difference in mode of arrival is due to socioeconomic class, it is also possible to result in delayed care or avoidance of care altogether for those in the BME groups even at a time when serious rather than routine medical help is being contemplated. Further, our analysis indicated that the Chinese/other ethnic group has a significantly lower self-referral rate than do other groups (see Table 5 above). Although we have no further information as to why this is the case, it could be assumed that it is unlikely that these ethnic groups experience significantly lower rates of acute illness than other groups but there is a likelihood that the Chinese/other group is at a higher risk than other BME groups to avoid seeking help from health services which may be due to cultural reasons or lack of information or even a tendency to mistrust health services. Such a difference should be further explored to appreciate its significance for health care provision of these communities. Such examinations of routine ethnic monitoring data, although fairly straightforward in nature, appear to be informative of potential health inequalities among BME groups if applied systematically and coherently in various available singular and combined datasets. This is of great importance if we consider the fact that it is only recently that the NHS has started collecting this information as a mandatory requirement of service performance.

Although we have only 'begun to scratch the surface' of the St. George's databases, we have already identified a potential access issue especially for the Chinese/other group. Further as this ethnic group makes up only 2% of the patient population base, it is possible that data indicating issues around healthcare use might be obscured (see earlier discussion of methodological issues). A solely tool-based institutional understanding of pathways to care might preclude consideration of access issues. In order to provide the customization needed for this particular group (Bohmer, 2010), it will be necessary to investigate family, social network and community contacts, as well as individual factors (i.e. age, race, gender) to

determine when, how and if the Chinese /other ethnic group is receiving the necessary care. This is where a model such as NEM can provide us with a good framework for analysis.

### **Concluding Remarks**

As other authors have already pointed out, there is great potential in exploring patients' care pathways through analytically flexible and multi-method approaches (Rees-Jones et al., 2009). In this paper we have highlighted the value of investigating ethnic minority patients' care pathways through such an approach which is methodologically sophisticated but also theoretically informed.

Nerenz et al (2006), while discussing the effects of a variety of types of interventions designed to address healthcare and health disparities in the US context, point out the following: "Understanding a problem is one thing; being able to actually do something about it is another. The large number of potential underlying reasons for disparities suggests that there will be no single or dominant solution to the disparities problem. It seems more likely that there will be a variety of legitimate approaches, whose specific features will have to be tailored to local circumstances. We are just beginning to learn about the actual or potential positive effects of a variety of types of interventions designed to address disparities..." (p. 1448). The same applies to the UK which has been among the international leaders in terms of setting targets and driving cross-government and public health policies to reduce the identified problem of health inequalities (Department of Health, 2009). Indeed, the policy context for addressing (ethnicity related and other) healthcare and health disparities seems to be appropriate for fostering change, but much more practical work needs to be undertaken for actually bringing the desired change as part of the future overall redesign of healthcare.

Working towards gearing the NHS to meeting the needs of a multi-ethnic society is very difficult, especially because 'funds have been scarce, competing priorities many, expertise sparse and champions of the issue at a senior level too few' (Bhopal, 2006: 60). Moreover in the current socioeconomic context where pressure is put on the NHS to improve the quality of care for all service users and patients at the same time as improving productivity and efficiency (Raleigh & Foot, 2010) it is certain that much more work is needed for identifying exactly 'what works best and for whom' and implementing it accordingly.

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