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Equality & Health Inequalities Unit
NHS England

12 October 2020

Dear Leander,

Ethnicity coding in health records

I hope you are well. We spoke with you, others from NHSE and colleagues from Public Health England and NHS Digital on 10th September to discuss challenges with the current coverage and quality of ethnicity coding in health records. As noted in your e mail summarising our discussions, we've written a note summarising the issues and our concerns (see attached).

In summary, we welcomed NHSE's Phase 3 recovery letter urging the NHS and GPs to ensure completeness of ethnicity coding in patient records. However, the quality of coding also needs to improve (as indicated by several analyses to date), and this requires updated guidance to health care providers on the protocols for recording ethnicity. Such guidance was issued to the NHS in a Data Set Change Notice (DSCN) in 2001 and has not, to our knowledge, been updated since then. Without this, in our view, the coverage of ethnicity coding may improve but its data quality is unlikely to improve and could even, given the pressures to ensure completeness, deteriorate.

It would be for DHSC, NHSE and NHS Digital to specify the measures, if they consider any are required, that need to be taken to ensure health care providers are aware of the protocols for ethnicity recording, whether or not this would require a new DSCN, and how it ties in with the *Unified Information Standard for Protected Characteristics* that you mentioned. We are happy to engage in further discussions about this if it would be helpful.

On another note – given the widespread interest in ethnicity data in the current context, we'll share this letter with Lord Kakkar (Chair, The King's Fund and member of the Commission on Race and Ethnic Disparities) and Dr Habib Naqvi (Director, NHS Race and Health Observatory) in the

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Rt Hon Professor Lord Kakkar PC

Treasurer
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Chief Executive
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context of The King's Fund's discussions on supporting their work on ethnic inequalities in health.

We look forward to hearing further.

With best wishes

A handwritten signature in black ink, appearing to read 'Veena S. Raleigh'.

Dr Veena S Raleigh
Senior Fellow
The King's Fund

A handwritten signature in black ink, appearing to read 'Goldblatt'.

Professor Peter Goldblatt
UCL Institute of Health Equity

NOTE TO NHSEI ON ETHNICITY RECORDING IN HEALTH AND CARE RECORDS

Aim

Our aim in writing this letter is to highlight limitations in both the coverage and quality of ethnicity recording of people using NHS health and care services in England and to suggest how this can be improved.

Issue

Ethnicity data is essential for improving the health and wellbeing of people from ethnic minority communities. It plays a vital role in:

- supporting needs assessments and service planning
- enabling monitoring of equity of access and outcomes
- informing clinical practice
- improving the evidence on inequalities in population-based risks and outcomes
- supporting high quality research

The urgent need for accurate data on the ethnic group of people using health and care services has been graphically demonstrated by the Covid-19 pandemic, which has impacted disproportionately on people from ethnic minority communities. Several studies and reports have shown that the risk of Covid-19 infection, severe disease and mortality is significantly higher among people from ethnic minority communities than in the white population.

Good quality data is an essential cornerstone of an effective health care system. Without it, the ability to deliver equitable, high quality care to all is significantly compromised. This applies also to the data on ethnicity. However, the analyses to date demonstrate significant limitations in both the completeness (coverage) and the quality of ethnicity recording in health records (further details below).

The legal framework

Reducing inequalities in health is a moral imperative. It is also enshrined in legislation. The Health and Social Care Act 2012 introduced specific legal duties for a range of health bodies to have due regard to reducing health inequalities between the people of England. A dimension of inequality pertaining to race is specifically enshrined in legislation aimed at ensuring racial equality. The Race Relations Amendment Act 2000 built on previous legislation (Race Relations Act 1976) designed to ban discrimination on grounds of race and requires public authorities to promote race equality. The Equality Act 2010 extended anti-discrimination legislation to cover nine protected characteristics, including race.

Background

Ethnicity recording within primary care health records was introduced in 1991, followed by its mandated introduction into Hospital Episode Statistics (HES) in England in 1995. To enable public services to ensure and demonstrate compliance with equality legislation, the Department of Health and Social Care (DHSC) and NHS Digital (previously the Information Centre) have actively promoted ethnicity recording by NHS organisations and GPs. In response, the coverage of ethnicity recording in health records has improved significantly over the past two decades but it still not complete. Within primary care, the incentivisation of ethnicity recording under the Quality and Outcomes Framework (QOF) between 2006/07 and 2011/12 dramatically improved the completeness of ethnicity data for newly registered patients.¹ However, coverage is more complete in some sectors (eg hospital records) than others (eg GP records) and virtually non-existent in others (eg social care records). There is significant scope for improving ethnicity recording further in all sectors, including hospitals.

The move by NHS England and Improvement (NHSEI) in its [31 July 2020 letter to the NHS about the third phase of the NHS response to Covid-19](#), and the [subsequent guidance on implementation](#), requiring comprehensive recording of ethnicity by the NHS and GPs is therefore very welcome and should result in improvements in the completeness of ethnicity recording.

However, action is also needed to improve data quality by ensuring that, as far as possible, ethnicity is recorded accurately.

Data quality issues with ethnicity recording in health records

Although coverage of ethnicity recording has improved over time, several studies show that data quality can be variable, poor, and show evidence of systematic bias. We are aware that ONS is undertaking matched analyses of self-reported ethnicity in the 2011 population Census with ethnicity recorded in hospital records to assess the degree of concordance and identify systematic discrepancies. The results, when available, will provide valuable insights into the quality of ethnicity coding in health records and its concordance with self-reported ethnicity in the Census. This is important not only because it provides an indication of the quality of data recording, but also because it is essential to have accurate population-based treatment and disease rates for ethnic groups.

In the interim, we provide selected examples of issues with ethnicity coding below, although they don't reflect a comprehensive review of the literature:

- A study comparing ethnicity recorded in HES to the 'gold standard' of self-reported ethnicity as captured in the 2010 Cancer Patient Experience Survey in England reported high concordance of HES coding for patients of White British ethnicity, but far weaker agreement for all other ethnic groups.² For major ethnic groups (Indian, Pakistani, Bangladeshi, Chinese, Black-Caribbean and Black African), routine hospital data miscoded between 20% and 35% of all patients who self-report that they belong to these ethnic groups. Further, up to 20% of patients recorded as belonging to some major ethnic groups self-reported that they belonged to other ethnic groups.
- A study comparing ethnic coding in the Clinical Practice Research Database (CPRD) and HES similarly found high concordance but only for the White group; for patients of South Asian ethnicity, the agreement was only 50%, and weaker still for other ethnic groups.³
- A qualitative study in general practices and hospitals found substantial variations in data classification, and practical challenges in data collection and usage, that undermine the integrity of data collected.⁴
- These studies also provide evidence of multiple ethnicities being recorded for the same patient in different episodes of care.
- Evidence of discrepancies in mortality rates of some ethnic groups between PHE's figures based on ethnicity recording in Hospital Episode Statistics (HES) and ONS Census-based figures go beyond other differences in their methodologies.
- A recent review by ONS identified several potential issues with the comparability and coherence of data sources on ethnicity for equality monitoring purposes.⁵

A particular problem that is evident is the disproportionate number of records coded as "Other", either overall or for example as "Black Other". These numbers result in disproportionately high rates for the "Other" groups. Examples of the effects of such miscoding are given in the Annex:

- Figures 1, 2, PHE's report comments: *The rates in the Other ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases data and the population data used to calculate the rates.*
- Figure 3, PHE's report comments: *The rates in the Other ethnic group are likely to be an overestimate due to the difference in the*

source of allocating ethnicity codes to the mortality data and the population data used to calculate the rates. This may explain the high mortality rates in the Other group, which cannot be interpreted and requires further investigation.

(NB: The ethnic-specific mortality rates in this graph were derived by linking mortality records to HES records in order to derive ethnicity from the latter since it is not available in the former. The data therefore reflect the quality of ethnicity coding in HES).

- Figure 4: The GOV.UK website [Ethnicity Facts and Figures](#) on Detentions under the Mental Health Act notes that: *Out of the 16 specific ethnic groups, Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other').....the highest rate of detention was for people in the Black Other ethnic group, followed by those in the Mixed Other ethnic group – however, these rates are considered to be overestimates because 'Other' categories may have been used for people whose specific ethnicity wasn't known.*
- GOV.UK's [Race Disparity Audit 2017 report](#) para 9.15 notes that: *Around 4,800 in every 100,000 Black British or Black Caribbean adults were in contact with NHS funded adult secondary mental health and learning disability services in 2014/15 compared with around 3,600 in every 100,000 adults overall. The highest rates were among adults in the Other Black and Other ethnic groups, but this is thought to reflect recording practices whereby patients' ethnicities were often not collected in sufficient detail. As a result, rates of contact for specific ethnic groups, and particularly among Black ethnic groups, are likely to be under-estimated.*
- GOV.UK's [Race Disparity Audit 2017 report](#) para 1.11 of the Introduction notes that: *The quality of data on the ethnicity of individuals varies and is generally better when reported by people themselves, as it is in surveys and the Census. Administrative data – such as is collected from service users – can suffer high levels of non-recording of ethnicity and overuse of 'other' categories, undermining the ability to identify differences in how people in each ethnic group are treated.*

The above examples refer to different data sets, suggesting that miscoding of ethnicity in health records is occurring across a range of data sets. Overuse of the "Other" categories inevitably means that ethnicity is not being recorded correctly for every ethnic group, including the White group. Ethnicity is intended to be self-reported and consequently will be more accurate when this is adhered to, as in the national Censuses and in surveys. See Figures 5 and 6.

We reiterate we have not done a comprehensive review or assessment of data quality relating to ethnicity recording, but we believe that the examples provided make a strong case for action. Moreover, we are aware that ongoing analyses by ONS and PHE of ethnic differences in co-morbidities in hospital records and in mortality rates are complicated by inconsistencies in ethnicity recording in HES and Census records.

Causes and consequences of miscoding of ethnicity

As noted above, there is evidence of discordance between ethnicity in health records on the one hand, and self-reported ethnicity in surveys and the Census on the other hand, and of multiple ethnicities being recorded for the same patient during different health care episodes. There is also evidence of disproportionate number of records coded as “Other”.

The extent and causes of such miscoding are unknown, but there are some pointers. Although we cannot definitively say what causes the disproportionate use of “Other” codes, resulting in biases in the data, it is possible that this results from ethnicity being ascribed by staff rather than being self-reported. Requesting patients to complete a form asking for their ethnicity can undoubtedly present challenges in a clinical setting when staff may be under pressure and patients are unwell or lack capacity. Hence, it is possible this requirement is not always followed. It may also occur if staff are simply unaware that self-reporting is the required procedure (see next section) or, for example, if there is uncertainty about whether staff are required to ask for ethnicity again if it is already recorded for an earlier episode of care.

Inaccurate recording of ethnicity in health records can have several consequences. It can introduce bias in the results, such as over-coding of “Other” groups, with the knock-on consequence that rates for other ethnic groups, minority groups in particular, are likely to be underestimated, as noted in the Race Disparity Audit Report. This significantly impairs the epidemiological utility of the data, as Figure 3 on all-cause and Covid-19 mortality rates by ethnic group illustrates. Overall, misclassification of ethnicity could result in an underestimation of ethnic variation or an inability to detect such variation when it exists – thereby defeating the reasons for collecting it. In order to reduce such distortions in the data, assumptions based on knowledge of the data may need to be applied in order to reassign some of the “Other” records to other ethnic groups.

In England ethnicity is not recorded at death registration, hence mortality analyses currently inevitably depend on retrospective linkage of mortality records to other data sets, such as hospital records or the population

Census. In order to derive mortality rates by ethnic group for its [report on Covid-19](#), PHE had to link mortality records to HES to derive the ethnic group of people who died from Covid-19, which resulted in the disproportionately high rate for the “Other” group (see comment above for Figure 3).

To obtain Covid-19 death rates by ethnicity both National Records of Scotland (NRS) and the Office for National Statistics (ONS) linked death records back to the 2011 Census.^{6 7} While ONS and NRS linkage of mortality records to the 2011 Census provides the “gold standard” for those records that can be linked back to 2011, it necessarily means that those born after 2011 or migrating to this country after 2011 are excluded from the analysis. If their health outcomes are to be measured, ONS and NRS will also need to rely on linkage to HES ethnicity data.

In summary, poor quality ethnicity data in health records impairs the practical utility of the data and its use for the aims for which it is being collected. It also risks misinforming NHS staff and commissioners, patients, the public, policymakers, researchers and the many other potential users of this data. Measures to rectify biases in the data become unavoidable if the data is to be used, but the need for such measures should be reduced to a minimum by improved data recording at source. Although the data quality problems described here may not be totally avoidable in all circumstances, the risks of data “contamination” can be reduced if staff are provided with updated, comprehensive guidance on how to record ethnicity and are encouraged to comply with it.

Guidance on ethnicity recording

Ethnicity is a complex, multidimensional concept, often defined by features such as a shared history, common cultural traditions, a common geographical origin, language and literature. It is therefore a highly subjective classification that an individual is required to articulate within a simple data item structure, and as such, it has been argued that the only true meaningful categorisation is self-definition. This was specifically made clear in the Data Set Coding Notice (DSC Notice: 02/2001) issued to NHS organisations in February 2001 after passing of the Race Relations Amendment Act 2000 (see Annex 2). Specifically, in Annex 1 the DSCN says in relation to the ethnic codes to be used:

1. *All clients/patients/staff are to be classified under one or other of the 17 categories above. This is to be the national standard.*
2. *These new codes facilitate differentiation between the old ethnic codes based on the 1991 Census (which will need to be retained for a transitional period) and the new ones.*
3. *It is accepted that the categories are not exclusive in all cases. This is a feature of the Census categories as they stand. **This reinforces***

the importance of presenting respondents (i.e. the patients/clients/staff) with the category list from Annex 1 in full and in exactly the same order, to allow them to select the category that applies to them (see also Annex 2 – Introduction: paragraph 2). In this way, the categories will be comparable with the Census data.

In addition to issuing the DSCN, the Department of Health and Information Centre held a series of events with NHS organisations to introduce the ethnic category code changes and discuss the implications with key staff, and training materials for use nationally were developed and provided to the NHS.

In 2016, the [ONS published guidance for the collection and classification of ethnic group, national identity and religion data in the UK](#). Although the guidance relates to how questions should be asked in social surveys, the general principles apply also to recording ethnicity in health records. The guidance notes that *collecting data on ethnic group is complex because of the subjective, multifaceted and changing nature of ethnic identification..... There is no consensus on what constitutes an ethnic group and membership is something that is self-defined and subjectively meaningful to the person concerned.....* The guidance provides advice on how to ask questions on ethnic group, noting that *the ethnic group that each person chooses as his or her own is intrinsically the ethnic group of self-identity, rather than being ascribed by anyone else..... It is recommended that the ethnic group question will be asked in a way that allows the respondent to see all possible response options before making their decision.*

We are not aware of refreshed ethnicity coding guidance being issued to the NHS since the DSCN of 2001 and consider that revised guidance is overdue. To ensure that ethnicity recording in health records is fit-for-purpose to support the many key functions it is designed to do, we strongly recommend that DHSC, NHSEI and NHS Digital take steps to ensure that NHS organisations and staff, and GPs, are aware of how this information should be collected from patients and recorded. This should make clear that ethnicity should be self-reported, using the official classifications of ethnicity, and that “not stated” is a legitimate response ie patients should have the option of declining to state their ethnicity (which is different to the “unknown” category, where it wasn’t possible to ask the patient their ethnicity). There should also be an agreed set of rules to account for situations in which the patient has a temporary or permanent lack of capacity.

It is timely for the existing guidance (if there is any) to be reviewed, and refreshed guidance issued to the NHS, ideally in another DSCN, or other means if this is not practicable, so that there is a rules-based order for

ethnicity recording that reflects good practice and is applied consistently across organisations. Such a move would ensure that the instruction for comprehensive ethnicity recording by the NHS and GPs contained in the phase 3 guidance is implemented properly and results in high quality data rather than more data of mediocre or poor quality. Indeed, without such guidance, there is a real risk that the pressure for more complete recording impairs data quality further.

Conclusion

The critical importance of having high quality data on the ethnicity of patients using health and care services has been highlighted all too tragically by the Covid-19 pandemic. It illustrates graphically that as a society we must be able to monitor reliably the access to, use and outcomes of health care by ethnic minority populations in order to reduce health inequalities and improve health and wellbeing – not just in relation to Covid-19 but also for all other conditions. Currently such epidemiological surveillance is constrained by the quality of ethnicity recording in health records.

Many epidemiological analyses also require linkage across different data sets, critically as for mortality, and data quality is all-important if discrepancies and biases in the data are to be avoided. While ONS and PHE are taking all measures to ensure their analyses are as robust as possible, inevitably the findings will be caveated by the underlying data quality issues such as those we have highlighted here (and there may be others).

We welcome the moves by NHSEI for more comprehensive ethnicity recording in health records and advise that this is accompanied by refreshed guidance to ensure that the process of ethnicity recording is compliant with official protocols. Otherwise the risk is that the well-intentioned and much-needed call for more comprehensive ethnicity recording in NHSEI's guidance on implementing phase 3 of the response to Covid-19 could result in data that is more complete but the quality of which remains poor.

Ethnicity recording in death certificates

Currently, in England ethnicity is not recorded at death registration, hence, comprehensive analyses of ethnic differences in mortality require linkage with health records to obtain ethnicity. It is therefore critically important that good quality information on self-reported ethnicity is recorded during the life of the deceased, as we have argued above. Since the Covid-19 pandemic, there have been calls for the introduction of ethnicity recording in death certification, including in PHE's report *Beyond the Data: Understanding the impact of Covid-19 on BAME*

groups.^{8 9 10} Recording of ethnicity at death registration, on a voluntary basis, was introduced in Scotland in 2012. However, the quality of data on ethnicity of the deceased is not deemed suitable by NRS for calculating reliable mortality rates¹¹, including most recently in its analysis of Covid-19 deaths which had instead to use linkage to the 2011 Census to derive the ethnicity of the deceased.^{12 13} If the introduction of ethnicity recording at death registration comes under consideration for England and Wales, we suggest a detailed feasibility review is undertaken in order to avoid the data quality problems seen in Scotland being replicated here.

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12 October 2020

ANNEX 1

Figure 1

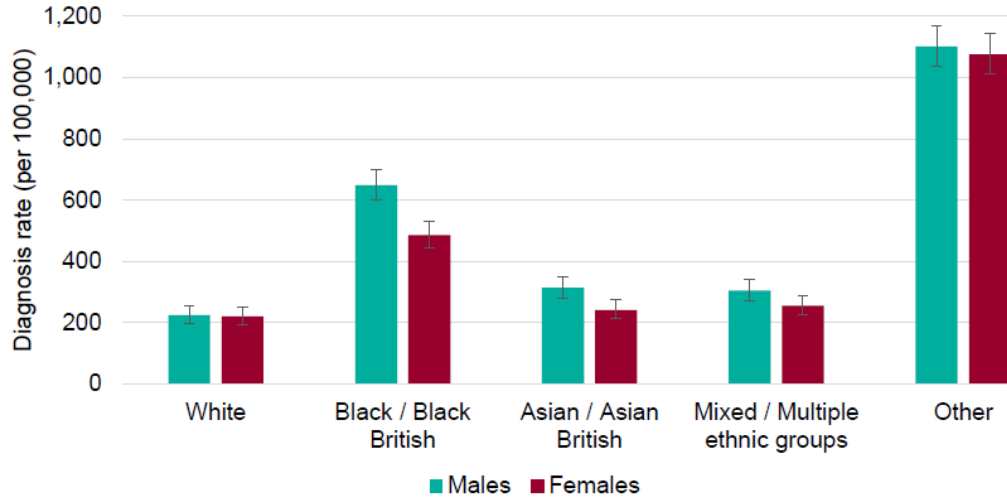


Figure 4.2. Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.
Source: PHE [Disparities in the risks and outcomes of Covid-19](#), 2020.

Figure 2

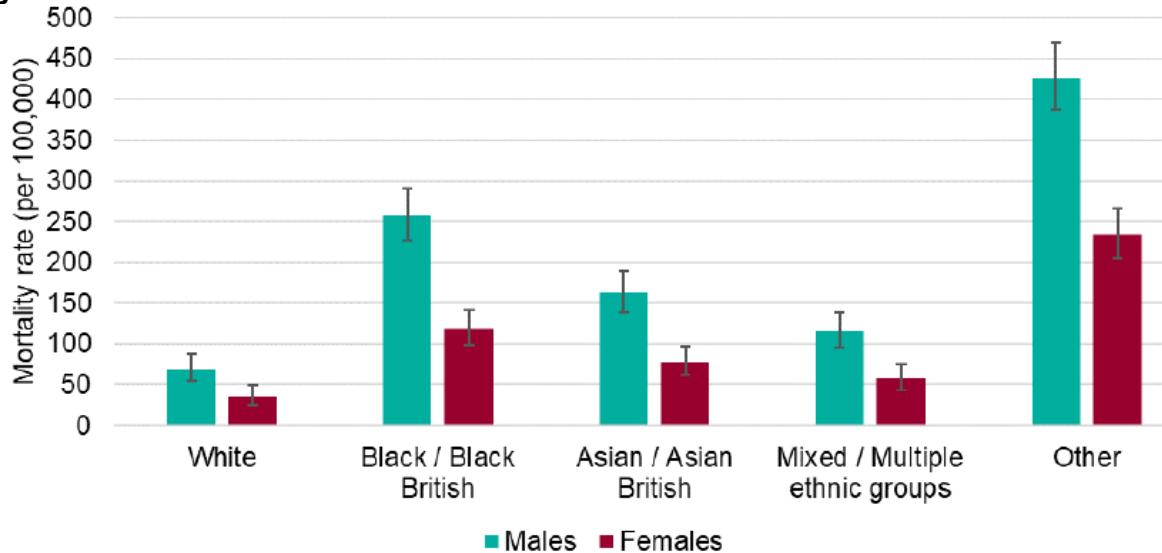


Figure 4.5. Age standardised mortality rates in laboratory confirmed COVID-19 cases by ethnicity and sex, as of 13 May, England. Source: Public Health England: COVID-19 Specific Mortality Surveillance System.

Source: PHE [Disparities in the risks and outcomes of Covid-19](#), 2020.

Figure 3

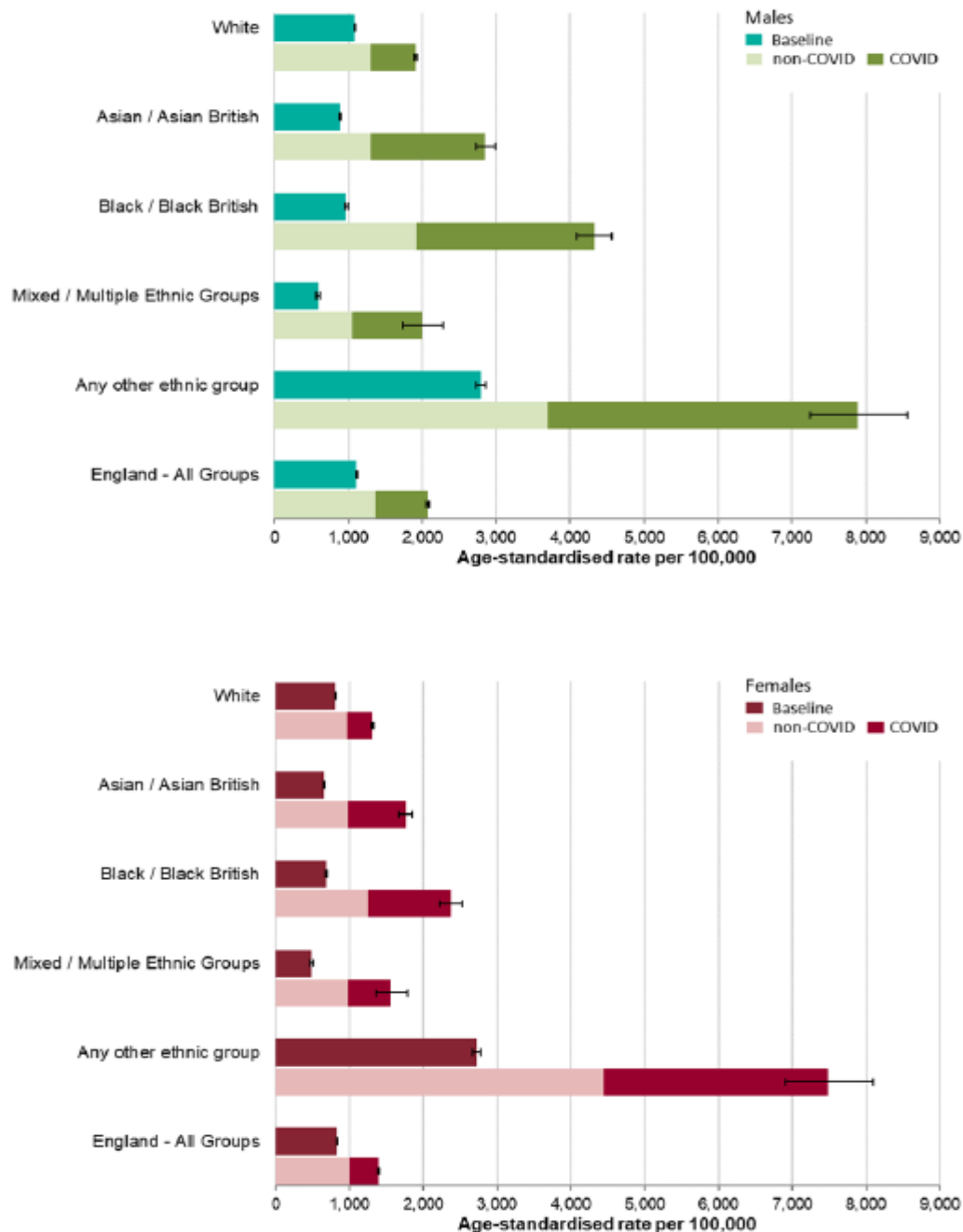
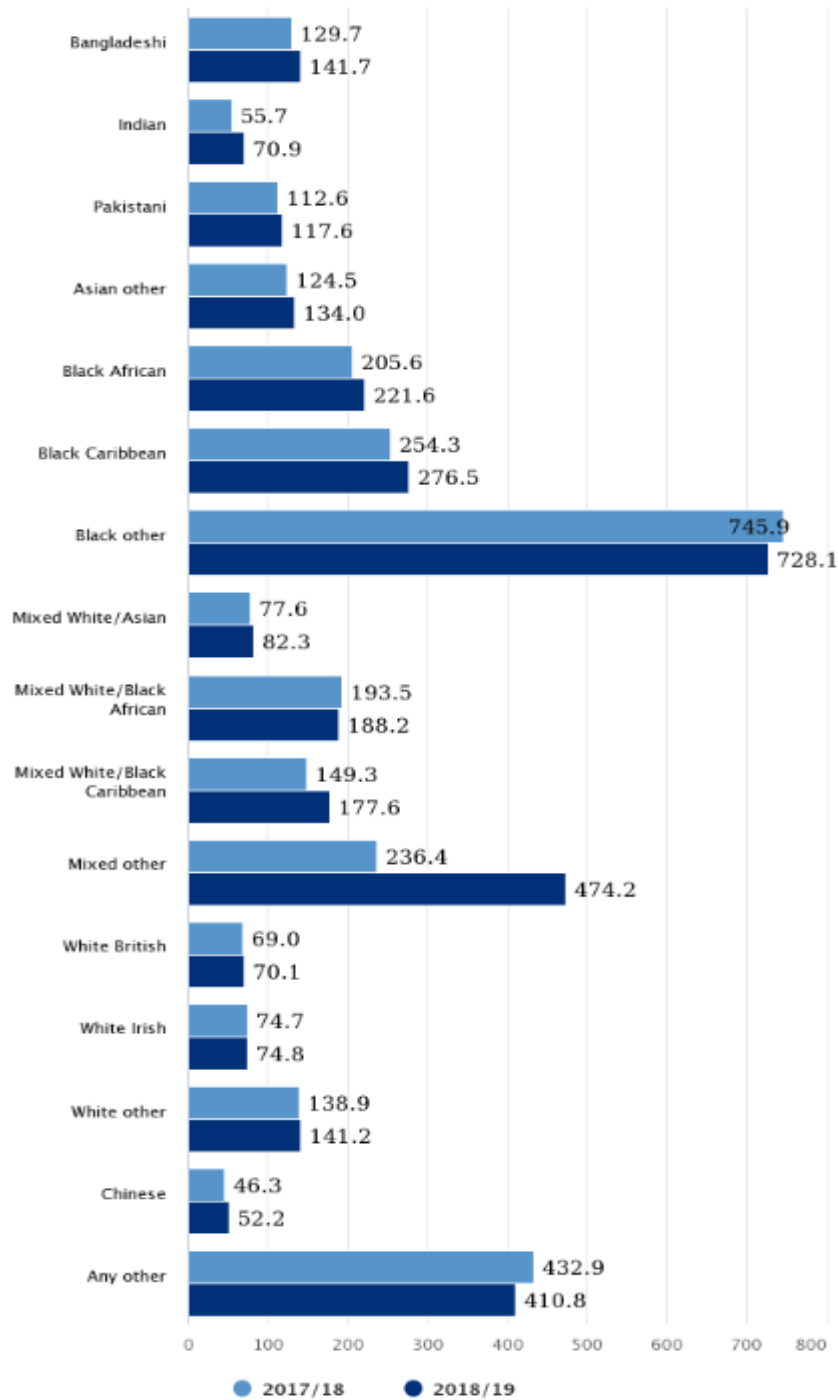


Figure 4.6A and 4.6B. Age-standardised mortality rates for all cause deaths and deaths mentioning COVID-19, 21 March to 1 May 2020, compared with baseline mortality rates (2014 to 2018), by ethnicity and sex, England. Source: Public Health England analysis of ONS death registration data.

Source: PHE [Disparities in the risks and outcomes of Covid-19](#), 2020.

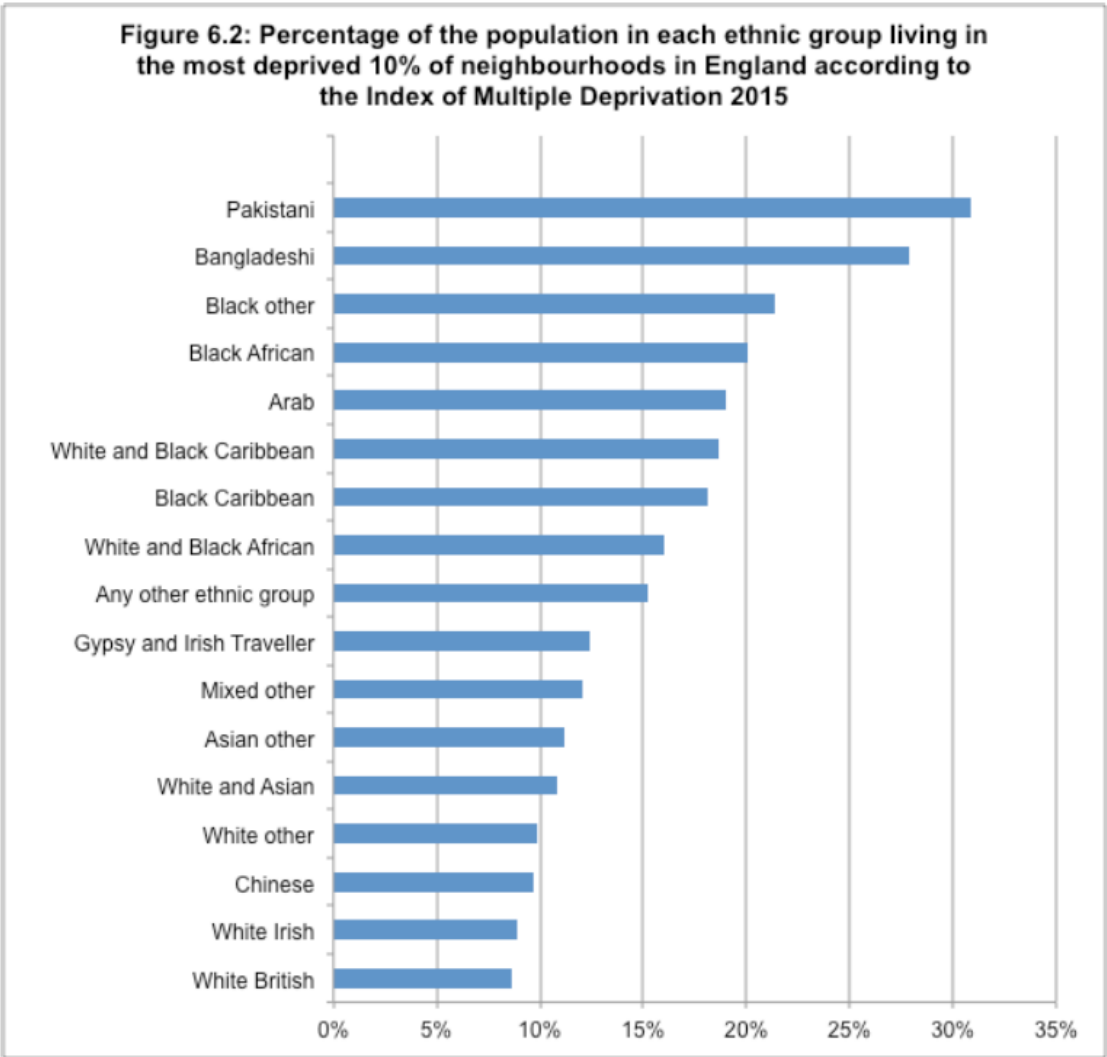
Figure 4

Title: Number of detentions under the Mental Health Act per 100,000 people, by specific ethnic group (standardised rates). Location: England. Time period: April 2017 to March 2019. Source: Mental Health Services Data Set| Ethnicity Facts and Figures GOV.UK



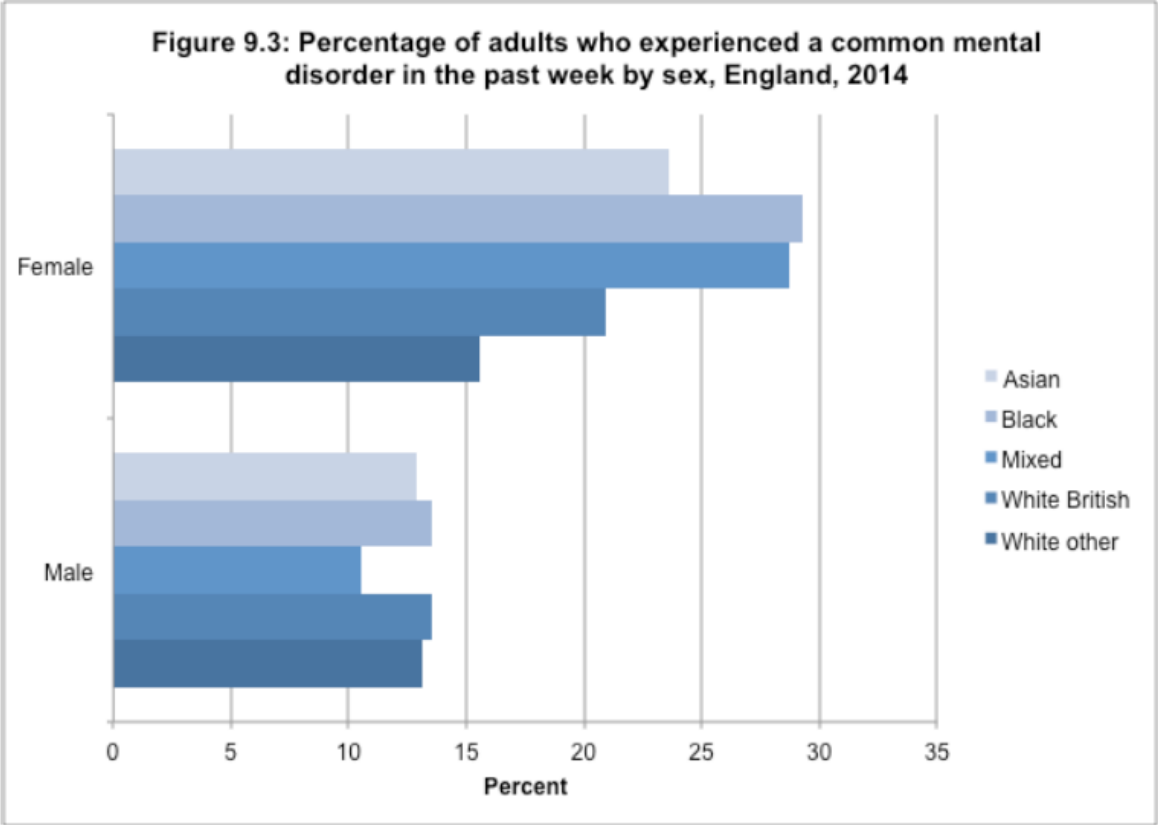
Source: GOV.UK [Ethnicity Facts and Figures](#)

Figure 5



Source: English Index of Multiple Deprivation and 2011 Census, Department for Communities and Local Government
Source: GOV.UK [Race Disparity Audit 2017 report](#)

Figure 6



Source: Adult Psychiatric Morbidity Study, NHS Digital
Source: GOV.UK [Race Disparity Audit 2017 report](#)

ANNEX 2



Information Authority

DSC Notice 02/2001*

Date of Issue: February 2001

**NHS Information Standards
Board**

Subject:

**CDS, HES & Workforce:
Ethnic data
Finalised Coding Frame**

Implementation date: **1 April**

DATA SET CHANGE CONTROL PROCEDURE

This paper gives notification of changes to be included in the NHS Data Dictionary, the NHS Data Manual and the NHS CDS Manual in due course.

Summary of change:

Office for National Statistics (ONS) has confirmed (January 2001) the detailed ethnic classifications they will use in the 2001 Census.

There are some additions and changes to Annex 2 of DSCN Notice: 21/2000, for example see ONS codes 44-59. Introductory text and notes have been amended for clarification and implementation.

There are minor clarifications to Annex 1: Ethnic Categories. Information about training materials and revised contact points is also provided.

Summary of impact and guidance: See DSCN 21/2000

***Change Proposal
Reference No: N/A***

The NHS Information Standards Board (ISB), established by the NHS Information Authority, is responsible for approving

information standards. The NHS ISB is supported by the Management Information Standards Board, Clinical Data Standards and Technical Standards sub-boards.

*The DSCN Number Format has been changed to denote the new arrangements as follows: sequence number/year of issue (ccyy). The service identifier and service sequence number are redundant owing to changes in practice and have been removed.

The packaging of standards documentation is under review. Any changes will be notified in due course.

Please address enquiries about this DSCN to the Data Standards Team, NHS Information Authority, Aqueous II, Aston Cross, Rocky Lane, Birmingham, B6 5RQ. Tel: 0121 333 0237.

Data Set Change Notices are located on the Internet in the Electronic Library at

<http://www.standards.nhsia.nhs.uk/library/index.htm>

and on the NHSnet at

<http://nww.standards.nhsia.nhs.uk/library/index.htm>

Annex 1: Ethnic Categories*

These are the standard categories to be used for the collection of ethnicity information from 1 April 2001.

Notes on this framework are given overleaf – changes to the original Annex 1 are shown in bold italics

Ethnic Categories*	Codes	Ethnic Classifications (Annex 2) included within category
a. White	-	
<input type="checkbox"/> British	A	01
<input type="checkbox"/> Irish	B	02
<input type="checkbox"/> Any other White background	C	03-19, <i>31-39</i>
b. Mixed	-	
<input type="checkbox"/> White and Black Caribbean	D	21
<input type="checkbox"/> White and Black African	E	22
<input type="checkbox"/> White and Asian	F	23
<input type="checkbox"/> Any other mixed background	G	24-29
c. Asian or Asian British	-	
<input type="checkbox"/> Indian	H	41
<input type="checkbox"/> Pakistani	J	42
<input type="checkbox"/> Bangladeshi	K	43
<input type="checkbox"/> Any other Asian background	L	44-51, <i>57,59</i>
d. Black or Black British	-	
<input type="checkbox"/> Caribbean	M	61
<input type="checkbox"/> African	N	62
<input type="checkbox"/> Any other Black background	P	63-65, <i>66,69</i>
e. Other ethnic Groups	-	
<input type="checkbox"/> Chinese	R	81
<input type="checkbox"/> Any other ethnic group	S	82-86, <i>87,89</i>
f. Not Stated	-	
<input type="checkbox"/> Not stated	Z	
* Based on 2001 Census		

Notes on Annex 1

- 1 All clients/patients/staff are to be classified under one or other of the 17 categories above. This is to be the national standard.
- 2 These new codes facilitate differentiation between the old ethnic codes based on the 1991 Census (which will need to be retained for a transitional period) and the new ones.
- 3 It is accepted that the categories are not exclusive in all cases. This is a feature of the census categories as they stand. This reinforces the importance of presenting respondents (i.e. the patients/clients/staff) with the category list from Annex 1 in full and in exactly the same order, to allow them to select the category that applies to them (see also Annex 2 – Introduction: paragraph 2). In this way, the categories will be comparable with the Census data.

Annex 2: Ethnic Classifications*

The detailed framework of ethnic coding given on the following pages is derived from the way in which the Office for National Statistics will classify Census responses. In what follows, some of the groups exist nationally only as one category in the Annex 1 list (eg "British"). These are referenced as [A*] etc, the star being a "wild card" character which is not required for national collection.

These more detailed categories are purely optional and for local use in any way or not at all, provided that any such use does not cut across the national standard as set out in Annex 1. See also note 3 to Annex 1, which implies that the classification should be done in a "top down" fashion starting with the 17 ethnic categories in Annex 1.

This classification is now final - changes to the original annex 2 in DSCN 21/2000 are in bold italics

* Based on 2001 Census

DESCRIPTION	proposed code
WHITE GROUP	
01 British, <i>Mixed British</i>	[A*]
02 Irish	[B*]
03 English	[CA]
04 Scottish	[CB]
05 Welsh	[CC]
38 Northern Irish	[C2]
06 Cornish	[CD]
07 Cypriot (part not stated)	[CE]
08 Greek	[CF]
09 Greek Cypriot	[CG]
10 Turkish	[CH]
11 Turkish Cypriot	[CJ]
12 Italian	[CK]
13 Irish Traveller	[CL]
14 Traveller	[CM]
15 Gypsy/Romany	[CN]
16 Polish	[CP]
17 All republics which made up the former USSR	[CQ]
18 Kosovan	[CR]
19 Albanian	[CS]
31 Bosnian	[CT]

<i>32 Croatian</i>	<i>[CU]</i>
<i>33 Serbian</i>	<i>[CV]</i>
<i>34 Other republics which made up the former Yugoslavia</i>	<i>[CW]</i>
<i>36 Mixed white</i>	<i>[CX]</i>
<i>37 Other white European, European unspecified, European mixed</i>	<i>[CY]</i>
<i>39 Other white, white unspecified</i>	<i>[C3]</i>

MIXED GROUPS	
21 White and Black Caribbean	[D*]
22 White and Black African	[E*]
23 White and Asian	[F*]
24 Black and Asian	[GA]
25 Black and Chinese	[GB]
26 Black and White	[GC]
27 Chinese and White	[GD]
28 Asian and Chinese	[GE]
29 Other Mixed, Mixed Unspecified	[GF]
ASIAN or ASIAN BRITISH GROUP	
41 Indian or British Indian	[H*]
42 Pakistani or British Pakistani	[J*]
43 Bangladeshi or British Bangladeshi	[K*]
44 <i>Mixed Asian</i>	[LA]
45 <i>Punjabi</i>	[LB]
46 <i>Kashmiri</i>	[LC]
47 <i>East African Asian</i>	[LD]
48 <i>Sri Lanka</i>	[LE]
49 <i>Tamil</i>	[LF]
50 <i>Sinhalese</i>	[LG]
51 <i>British Asian</i>	[LH]
57 <i>Caribbean Asian</i>	[LJ]
59 <i>Other Asian, Asian unspecified</i>	[LK]
BLACK or BLACK BRITISH GROUP	
61 Caribbean	[M*]
62 African	[N*]
63 <i>Somali</i>	[PA]
64 <i>Mixed Black</i>	[PB]
65 <i>Nigerian</i>	[PC]
66 <i>Black British</i>	[PD]
69 <i>Other Black, Black unspecified</i>	[PE]
OTHER ETHNIC GROUPS	
81 Chinese	[R*]
84 <i>Vietnamese</i>	[SA]
85 <i>Japanese</i>	[SB]
86 <i>Filipino</i>	[SC]
87 <i>Malaysian</i>	[SD]
89 <i>Any Other Group</i>	[SE]

(99) Not stated	[Z*]
Note: Classification “99” is not included on the census code list and is included here for completeness.	

Notes on Annex 2

There are 25 categories within group C – “any other white background” – but only 23 codes are available for the local field - since I, O and Z cannot be used. Therefore a number has been used for the last two categories in the ONS listing - lines 38 and 39 are coded as C2 and C3 above.

This list excludes the codes used in the Census when respondents enter a religion having recorded “other”. It is suggested that these should not be included in NHS ethnic category recording, but this is not obligatory in as much as use of more detailed local codes is for local decision.

Training materials for the new ethnic categories

The Department of Health is planning to initiate a series of events to introduce the ethnic category code changes and discuss the implications with key staff (information and IT people as well as those responsible for collecting data). Training materials for use nationally are also being developed and will be provided to the NHS within the next few months. The guidance and training materials are in addition to normal contacts on HES and Workforce Censuses.

Contacts

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Specific NHS workforce census enquiries - John Bates, tel 0113 254 5876, email john.bates@doh.gsi.gov.uk

Personal Social Services enquiries - Mike Barker, tel 020 7972 5593, email mike.barker@doh.gsi.gov.uk

REFERENCES

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- ¹ Mathur R, Bhaskaran K, Chaturvedi N, et al. Completeness and usability of ethnicity data in UK-based primary care and hospital databases. *J Public Health (Oxf)*. 2014;36(4):684–692. doi:10.1093/pubmed/fdt116
- ² Saunders CL, Abel GA, El Turabi A et al. Accuracy of routinely recorded ethnic group information compared with self-reported ethnicity: evidence from the English Cancer Patient Experience survey. *BMJ Open* 2013;3(6). <https://bmjopen.bmj.com/content/3/6/e002882>
- ³ Mathur R, Bhaskaran K, Chaturvedi N, et al. Completeness and usability of ethnicity data in UK-based primary care and hospital databases. *J Public Health (Oxf)*. 2014;36(4):684–692. doi:10.1093/pubmed/fdt116
- ⁴ Morrison Z, Fernando B, Kalra D, Cresswell K, Robertson A, Sheikh A. The collection and utilisation of patient ethnicity data in general practices and hospitals in the United Kingdom: a qualitative case study. *Inform Prim Care*. 2014;21(3):118–131. <file:///C:/Users/vraleigh/Downloads/63-465-1-PB.pdf>
- ⁵ Office for National Statistics. *Inequalities data audit: focus on ethnicity*. Office for National Statistics, 2018. <https://www.ons.gov.uk/methodology/methodologicalpublications/generalmethodology/onsworkingpaperseries/inequalitiesdataauditfocusonethnicity>
- ⁶ National Records of Scotland. *Analysis of deaths involving coronavirus (COVID-19) in Scotland, by ethnic group*. National Records of Scotland, 2020. <https://www.nrscotland.gov.uk/files//statistics/covid19/ethnicity-deceased-covid-19-june20.pdf>
- ⁷ Office for National Statistics. *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020*. Office for National Statistics, 2020. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbyethnicgroupenglandandwales/2march2020to15may2020>
- ⁸ Public Health England. *Beyond the data: understanding the impact of COVID-19 on BAME groups*. Public Health England, 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
- ⁹ Khunti K, Platt L, Abbasi K. Covid-19 and ethnic minorities: an urgent agenda for overdue action. *BMJ* 2020;369:m2503.
- ¹⁰ The Independent Scientific Advisory Group for Emergencies (SAGE). *Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action*. The Independent SAGE Report 6, 2020.

https://www.independentsage.org/wp-content/uploads/2020/07/Independent-SAGE-BME-Report_02July_FINAL.pdf

¹¹ National Records of Scotland. *Ethnicity of the deceased person: The quality of the data for 2012 to 2014*. National Records of Scotland, 2017.
<https://www.nrscotland.gov.uk/files/statistics/vital-events/ethnicity-of-deceased/ethnicity-deceased-report.pdf>
<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/deaths-background-information/ethnicity-of-the-deceased-person/the-quality-of-the-data/the-quality-of-the-data-for-2012-to-2014>

¹² National Records of Scotland. *Analysis of deaths involving coronavirus (COVID-19) in Scotland, by ethnic group*. National Records of Scotland, 2020.
<https://www.nrscotland.gov.uk/files/statistics/covid19/ethnicity-deceased-covid-19-june20.pdf>

¹³ National Records of Scotland. *Deaths involving coronavirus (COVID-19) in Scotland by ethnicity recorded at death registration*. National Records of Scotland, 2020.
<https://www.nrscotland.gov.uk/files/statistics/covid19/ethnicity-deceased-covid-19-may20.pdf>