Towards equitable commissioning for our multiethnic society: a mixed-methods qualitative investigation of evidence utilisation by strategic commissioners and public health managers

S Salway,[1]* D Turner,[2] G Mir,[3] B Bostan,[4] L Carter,[5] J Skinner,[6] K Gerrish[7] and GTH Ellison[8]

[1]School of Health and Related Research, University of Sheffield, Sheffield, UK
[2]Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK
[3]Leeds Institute of Health Sciences, University of Leeds, Leeds, UK
[4]Public Health, NHS Leeds, Leeds, UK
[5]Communications and Engagement, NHS Airedale, Bradford and Leeds, Bradford, UK
[6]Public Health, NHS Sheffield, Sheffield, UK
[7]School of Nursing and Midwifery, University of Sheffield, Sheffield, UK
[8]Leeds Institute of Genetics, Health and Therapeutics, University of Leeds, Leeds, UK

*Corresponding author

Declared competing interests of authors: none

Published December 2013
DOI: 10.3310/hsdr01140

Scientific summary

Towards equitable commissioning for our multiethnic society
Health Services and Delivery Research 2013; Vol. 1: No. 14
DOI: 10.3310/hsdr01140

NIHR Journals Library www.journalslibrary.nihr.ac.uk

Scientific summary

Background

Although the volume of enquiry into the mobilisation and utilisation of research evidence within the health sector is growing rapidly, there remain important gaps in our understanding about which strategies work to encourage a greater and more appropriate use of research evidence and how and why specific approaches might work. In particular, our understanding of knowledge utilisation processes within the policy context is far weaker than our understanding of knowledge utilisation processes within the clinical practice environment. The Evidence and Ethnicity in Commissioning project responded to this gap in understanding by exploring the health-care commissioning cycle – an increasingly powerful determinant of the health services on offer and the care that patients receive – and by explicitly focusing on an area that has so far been overlooked, namely the mobilisation and utilisation of evidence relating to ethnic diversity and inequality.

Objective and aims

The study's broader goal was to support the commissioning of health services that better meet the needs of black and minority ethnic people and thereby help reduce ethnic inequalities in health-care access, experiences and health outcomes. The specific empirical aims were:

- to describe, across a range of commissioning contexts, how managers seek out, appraise and apply evidence relating to ethnic diversity and inequality alongside other forms of knowledge
- to identify factors (at evidence, individual and contextual levels and their interfaces) that support or inhibit the critical and effective use of evidence within the commissioning cycle and thereby identify promising routes of intervention.

Methods

The study adopted an integrated knowledge translation model. University researchers and NHS managers worked together across the life of the project to identify research questions, generate data, complete analysis, reflect on meaning and share findings with stakeholders in an iterative and interactive process. In-depth semistructured interviews were conducted with 19 national key informants. Detailed case studies of real-world commissioning work were undertaken focused on three primary care trusts and their partner organisations. Case studies involved > 70 interviews with key strategic and operational actors, extensive observational work and detailed analysis of related documentation. A series of good practice examples from around the country were also documented. Findings across all elements of the study were integrated and drawn on to develop a suite of draft tools and resources aimed at supporting evidence mobilisation and utilisation by commissioners and other stakeholders. Three national workshops were held to test the transferability of the findings to a wider set of commissioning contexts and utility of the draft tools. Testing, improving and disseminating the tools and related resources amongst the full range of commissioning stakeholders continue beyond the life of the current project.

Results

Knowledge mobilisation, ethnic diversity and inequality

Our findings suggest that knowledge mobilisation during the commissioning cycle, in general, is adversely influenced by a lack of clarity on how to appraise, weight or synthesise diverse sources of evidence. The absence of such skills suggests that evidence is likely to be used selectively to justify decisions that have been influenced by other factors. The transformational shaping of service provision, through collaborative partnerships that determine what outcomes are needed and how these are achieved, is significantly constrained by commissioners perceiving their role in transactional terms, that is, limited to a narrow remit of specifying and monitoring desired outcomes.

A range of additional factors appear to operate in relation to evidence on ethnic diversity and inequality. Such information is generally not part and parcel of broader evidence gathering for commissioning and is frequently overlooked. The interests and expertise of individual actors appears to be a key factor at both national and local levels in whether evidence on ethnicity is considered. Furthermore, commissioners' heavy reliance on evidence from sources such as the Department of Health or National Institute for Health and Care Excellence is problematic when this contains no details on ethnicity.

We found that service data and national guidance that does attend to ethnic diversity and inequality can provide a platform from which individual actors can seek to influence commissioning decisions. However, routine performance monitoring systems within services do not often include a focus on ethnic equality and commissioners rarely request that such data be collected. Creative approaches to evidence gaps exist, such as combining national quantitative data with local qualitative feedback to highlight unmet need, and audit procedures that incrementally build up an evidence base. However, such approaches need to be more widely shared within commissioning organisations.

Understanding of ethnicity and its relationship to health often remains unsophisticated and problematic. Conceptual models of commissioning can perceive a focus on particular ethnic groups as 'privileging' these populations rather than aiming to reduce health inequalities. Our findings highlight the absence of action within strategic and operational commissioning processes and structures that would dispel uncertainty or challenge unhelpful attitudes.

We found that the limited range and quality of evidence available on ethnic diversity and inequality is often a barrier to its use in the commissioning process, although evidence gaps could sometimes be imagined rather than real. Our findings confirm the need for intervention studies and high-quality evaluations exploring effectiveness and costs to inform transformational commissioning in the area of ethnic health inequalities.

Organisational context and evidence on ethnic diversity and inequality

In general, commissioning models, structures and processes do not currently support the routine generation and use of evidence as an indispensable aspect of decision-making and this is constrained by an absence of staff with specific evidence-mobilisation roles. Although public health staff are important actors in relation to needs assessment activity, we found that the fragmented nature of commissioning work may mean that their skills are not routinely utilised. Valued attributes for commissioning teams rarely ensure the presence of individuals with understanding of evidence relating to minority ethnic health needs. Furthermore, we found no reward or sanction for attention to or omission of such evidence.

The 'transformation agenda' appeared to focus on a narrow range of service areas within our three case study sites; in other areas the absence of this focus made transactional approaches to commissioning more likely. Low priority for the use of evidence was indicated by organisational constraints such as lack of time, resources and skills; silo working; and low expectations of commissioner knowledge in the service area for which he or she had responsibility. The use of evidence to support a transformation agenda appears to be

© Queen's Printer and Controller of HMSO 2013. This work was produced by Salway *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

secondary to other processes focusing on cost saving, particularly in the context of tight deadlines and a pressured environment.

Our findings highlight various missed opportunities to consider such evidence within the available resources and infrastructure such as the quality and transformation agenda. Neglect of the dimension of ethnicity within the national health inequalities agenda appears to have a major adverse impact on meeting unmet need within minority ethnic populations. There appears to be a clear interplay between the omission, ambivalence and marginalisation of ethnic health inequalities at the national level and how these agendas are conceptualised at the regional and organisational levels, resulting in low interest and demand for this type of evidence.

We found that expertise in, and insight into, ethnic health inequalities is often concentrated within equality and diversity roles but such staff are not embedded in the structures and processes that routinely contribute to commissioning decisions.

Positive examples of user input could demonstrate extended and meaningful engagement but this was neither consistent nor normal practice. Individuals or groups working within minority ethnic communities did not often have the capacity or resources to engage in ways that could significantly influence decision-making. Most significantly, membership of commissioning groups was not representative of minority ethnic populations, reflecting and maintaining their social exclusion.

Our findings suggest that organisational contexts can influence commissioners to be risk averse in this area of activity, requiring higher standards of evidence for small-scale service developments that meet the needs of minority ethnic communities than the standards of evidence for multimillion pound contracts to large providers. In such contexts, the rhetoric of an evidence-based culture can not only undermine progress towards reducing ethnic health inequalities but also mask the underlying dynamics that maintain the status quo.

Enhancing evidence use in commissioning for multiethnic populations

The study findings painted a disappointing picture of evidence-based health-care commissioning in general and suggested that there were particular obstacles to evidence mobilisation and utilisation in pursuit of reduced ethnic inequalities. However, several opportunities for improvement were also suggested. Study findings suggested the need for action at three levels: creating an enabling environment, equipping health-care commissioners and empowering wider stakeholders. These opportunities are presented in three interlinked elements of evidence mobilisation.

Increasing demand for evidence on ethnic diversity and inequality

- The importance of policy drivers in incentivising and rewarding action indicates that greater attention to national policies focusing on the needs of ethnically diverse populations will increase the demand for evidence.
- The adoption of clear and unequivocal statements within policies on quality and efficiency that emphasise the relevance of ethnic diversity and inequality to these other central agendas will increase the legitimacy of this focus and again help to increase the demand for evidence.
- Clearer articulation of expectations around the role of commissioning in shaping services and reducing health inequalities. Our findings suggest that the Equality Delivery System may have the potential to provide a necessary strategic framework within which the use of evidence on ethnicity by commissioners could be expected and legitimised.

Increasing access to varied sources of relevant evidence

- The development of a diverse workforce and collaborative partnerships between commissioners, providers and third-sector organisations representing minority ethnic service users will improve the flow

of information to and from target populations, service users, health and social care professionals and service providers to support the emergence of transformational commissioning.
- The allocation of sufficient resources to support the ongoing production, evaluation, interpretation and application of evidence is likely to help identify where existing and new services might better address unmet health and social care needs within ethnically diverse populations. Senior-level appointments dedicated to evidence mobilisation along with rewards and incentives to facilitate the inclusion of hitherto 'hard-to-reach' and less influential community and professional stakeholders are likely to make these and the evidence that they can offer less 'easy to ignore'.

Enhancing confidence and competence to use evidence critically and systematically

- Easy access to a diverse range of evidence on ethnic health inequalities and support to understand what kinds of data on ethnicity would be meaningful in particular contexts.
- A suite of brief, succinct, practical and stand-alone or modular tools that could provide support to identify, collate, analyse and present evidence on ethnic diversity and inequality.
- The creation of local, regional and national structures to overcome piecemeal and fragmented approaches in this area of activity could facilitate the pooling of resources, sharing of intelligence, development of 'allies' and adaptation of innovation. Such improvements in evidence production, evaluation, interpretation and application can be brought to bear on the development of standards and models for service specifications that effectively target the needs of ethnically diverse populations.

Strengths and limitations

The study generated a wide range of data and included in-depth analysis of evidence from national key informants as well as detailed case studies of three NHS commissioning organisations with a regional focus. Findings were validated at three national workshops, allowing claims to be tested with a wider range of people with experience of commissioning in diverse contexts. Nevertheless, some important dimensions of our research questions may have been overlooked. In particular, it was harder to identify enablers of effective use of evidence in this area than barriers. Including a case study of an organisation that had achieved greater mainstreaming of the ethnic diversity agenda might have added to our understanding of enabling factors. That said, findings from national respondents and workshops suggest that the organisations that we studied share much in common with other places. The study was conducted during a period of fundamental restructuring of NHS commissioning structures. This caused some difficulties in gathering data and it is possible that widespread change and uncertainty may have produced more negative narratives from participants than would otherwise have been the case. However, this potential influence on the results should have been balanced by the 2-year period of data collection and the varied data-generation methods, including observational and documentary evidence as well as interviews.

A strength of the project was the use of study findings to develop a draft set of tools and resources intended to support commissioners and other stakeholders in increasing demand for evidence on ethnic diversity and inequality; improving accessibility of a range of evidence sources; and enhancing the critical use of such evidence within commissioning work.

Conclusions

Our findings highlight and confirm the complex and contested nature of knowledge and the messy, diverse and convoluted pathways that may link evidence to policy- or practice-making, through an in-depth look at commissioning practice. The study demonstrates that knowledge mobilisation and utilisation within the commissioning cycle occurs in the context of dynamic interactions between individual

© Queen's Printer and Controller of HMSO 2013. This work was produced by Salway *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

agency, organisational rules, structures and processes, and the wider health-care setting with its current restructuring agenda, all situated within the broader sociopolitical context of multicultural Britain. Our findings support previous critiques highlighting slow progress on ethnic inequalities, with isolated pockets of good practice amidst a general picture of limited organisational engagement and low priority. Study findings indicate the need for specific guidance, standards and models relating to commissioning for a multiethnic population alongside incentives and resources to generate and disseminate creative approaches to problems with current evidence. More comprehensive infrastructure is also required to facilitate and support access to evidence. Perhaps most importantly, there is a need for greater political will and commitment to promote practice that focuses on reducing ethnic health inequalities at all stages of the commissioning cycle.

Recommendations for further research

The project's findings suggest the importance of further research in relation to:

1. patterns and determinants of evidence use within commissioning organisations:

    i. evaluative research that assesses the acceptability and impact of interventions aimed at increasing evidence use within commissioning
    ii. exploration of patterns and determinants of evidence mobilisation and utilisation (both generally and relating to ethnic diversity and inequality) within new commissioning organisations
    iii. case studies of organisations that have made good progress towards embedding equalities work within commissioning (exploring both evidence use and other factors)

2. the evidence base that can inform commissioning action in relation to minority ethnic health needs:

    i. evaluative studies that identify the effectiveness, cost-effectiveness and routes to impact of interventions aimed at reducing ethnic inequalities
    ii. evidence syntheses focused on effectiveness and cost-effectiveness of interventional approaches to tackling ethnic inequalities in health-care access, experiences and outcomes
    iii. methodological work to develop approaches to evidence synthesis and transferability that take account of conceptual and practical challenges of ethnicity.

Funding

The National Institute for Health Research Health Services and Delivery Research programme.

Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: nihredit@southampton.ac.uk

The full HS&DR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr. Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: www.journalslibrary.nihr.ac.uk

Criteria for inclusion in the *Health Services and Delivery Research* journal
Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: www.netscc.ac.uk/hsdr/

This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its proceeding programmes as project number 09/1002/14. The contractual start date was in October 2010. The final report began editorial review in December 2012 and was accepted for publication in May 2013. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

© Queen's Printer and Controller of HMSO 2013. This work was produced by Salway *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Published by the NIHR Journals Library (www.journalslibrary.nihr.ac.uk), produced by Prepress Projects Ltd, Perth, Scotland (www.prepress-projects.co.uk).

Health Services and Delivery Research Editor-in-Chief

Professor Ray Fitzpatrick Professor of Public Health and Primary Care, University of Oxford, UK

NIHR Journals Library Editor-in-Chief

Professor Tom Walley Director, NIHR Evaluation, Trials and Studies and Director of the HTA Programme, UK

NIHR Journals Library Editors

Professor Ken Stein Chair of HTA Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

Professor Andree Le May Chair of NIHR Journals Library Editorial Group (EME, HS&DR, PGfAR, PHR journals)

Dr Martin Ashton-Key Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

Professor Matthias Beck Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

Professor Aileen Clarke Professor of Health Sciences, Warwick Medical School, University of Warwick, UK

Dr Tessa Crilly Director, Crystal Blue Consulting Ltd, UK

Dr Peter Davidson Director of NETSCC, HTA, UK

Ms Tara Lamont Scientific Advisor, NETSCC, UK

Professor Elaine McColl Director, Newcastle Clinical Trials Unit, Institute of Health and Society, Newcastle University, UK

Professor William McGuire Professor of Child Health, Hull York Medical School, University of York, UK

Professor Geoffrey Meads Honorary Professor, Business School, Winchester University and Medical School, University of Warwick, UK

Professor Jane Norman Professor of Maternal and Fetal Health, University of Edinburgh, UK

Professor John Powell Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

Professor James Raftery Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

Dr Rob Riemsma Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

Professor Helen Roberts Professorial Research Associate, University College London, UK

Professor Helen Snooks Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

Please visit the website for a list of members of the NIHR Journals Library Board:
www.journalslibrary.nihr.ac.uk/about/editors

Editorial contact: nihredit@southampton.ac.uk