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Towards equitable commissioning for our multiethnic society: understanding and enhancing the critical utilisation of evidence by strategic commissioners and public health managers

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Towards equitable commissioning for our multiethnic society: understanding and enhancing the critical utilisation of evidence by strategic commissioners and public health managers

Aims and objectives

Goal: To support the commissioning of health services that better meet the needs of black and minority ethnic patients and thereby help reduce ethnic inequalities in healthcare experiences and health outcomes.

Aim: To enhance the critical use of research evidence alongside other forms of knowledge by managers within the PCT commissioning cycle.

Objectives:

Theoretical:

- To develop a theoretical model of knowledge utilisation that explicates the emotional, ideological and political dimensions through the example of ethnic diversity and inequality.
- To contribute to the theoretical literature that addresses mechanisms for enhancing the critical use of research evidence by managers in complex decision-making environments.
- To contribute to the theoretical literature that addresses mechanisms for enhancing the cultural competence of healthcare services by integrating an understanding of the role of knowledge(s) mobilisation.

Empirical:

- To describe, across a range of commissioning contexts, how managers seek out, appraise and apply research 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 research evidence within the commissioning cycle and thereby identify promising routes of intervention.

Operational:

- To develop practical diagnostic, evaluative and change management tools for use by individual managers, teams and organisations to (i) assess and promote critical reflection on current competencies and practice with respect to utilisation of evidence on ethnic diversity and inequality, (ii) identify actions to strengthen competencies and good practice and (iii) support specific elements of the knowledge utilisation process.
- To educate researchers and research funders regarding the current limitations of the evidence base and how they might generate research products that are more appropriate and accessible for managers charged with the task of commissioning services for multiethnic populations .
- To strengthen links between university researchers and managers and contribute to the development of a shared commitment to enhancing research evidence utilisation for enhanced organisational performance.

Background

While 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 better 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 for the clinical practice environment (Pettigrew et al, 2004). The current project responds to this gap in our understanding by exploring the PCT commissioning cycle - an increasingly powerful determinant of the NHS 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 inequalities in health. While no prior studies have engaged with our specific area of focus, we identify three bodies of work that can be drawn upon and integrated to identify fruitful new avenues of investigation.

First, a growing body of studies explores knowledge mobilisation and utilisation within the health policy-making arena, and some take an explicit focus on health inequalities. Much of this work draws on broader theoretical perspectives that view policy making as a process of collective interaction between diverse stake-holders in which both the identification of, and responses to, problems, are viewed as socially situated and constructed (Yanow 1996; Colebatch, 2005; Hanney et al. 2003). These contributions highlight the distinctive nature of evidence utilisation in policy formation (at both strategic and service-design levels) when compared to the clinical practice context (Black 2001; Pettigrew et al., 2004). Kelly and Swann (2004) note the way in which evidence syntheses within public health can only offer 'scientifically plausible frameworks for action' (p270) and not prescriptions for specific intervention, since decision-making requires judgements based on knowledge of local context including prevailing practices, organisational structures, commitment and engagement of key actors. Similarly, Elliot and Popay's (2000) investigation of evidence use by NHS managers revealed that research was felt to offer clarity and to contribute to decision-making but rarely to provide simple, clear-cut answers. Other work confirms that healthcare policy-makers work with a 'mixed economy' of evidence, piecing together information from diverse sources in their decision-making (Pettigrew et al., 2004; Whitehead et al., 2004).

Blackman et al. (2006) look particularly at policy-making related to health inequalities and identify this area as a 'wicked problem' that cuts across traditional organisational boundaries and whose complexity limits the scope of evidence-based action. 'Wicked problems' tend to carry with them greater scope for debate around what should be done and how it should be achieved and more room for disagreement on what counts as robust and relevant evidence. They suggest that policy-making in relation to 'wicked problems' tends to be less a technical exercise and more a process of dialogue and argument with power relationships clearly in evidence. Exworthy et al., (2006) highlight similar factors that may complicate the knowledge-into-action process relating to the health inequalities agenda, including the multiplicity of agencies and the diffuse nature of responsibility. While this past research exploring the utilisation of evidence within the health inequalities context is an important backdrop to the present study, there is a need for enquiry that specifically focuses on ethnic diversity and inequality. Mir and Tovey's (2002) study begins to explore these issues and shows that whether managers act upon research and other knowledge is shaped by resources, organisational culture and particularly the absence of substantial disincentives. There is a need for further systematic study of the factors that hamper or facilitate the effective utilisation of research evidence relating to ethnic diversity and inequality, particularly because of the significant additional issues that arise in terms of the generation and application of a research evidence base in this area and also because of the embedded nature of racial discrimination within UK society.

Turning first to the consider the research evidence base, work that engages with the ethics and science of researching ethnicity and health is pertinent but has yet to be integrated with research that explores the role of the characteristics of research evidence within utilisation processes. As the volume of research on ethnicity and health expands, so too do concerns regarding quality, its potential role in stereotyping and stigmatising ethnic minorities, and its limited benefit to minority ethnic populations (Gunaratnam, 2007). Critically appraising and applying research evidence on ethnicity and health presents significant challenges and demands particular competencies (Salway and Ellison, 2009). Issues include the need to: interrogate conceptualisations of ethnicity that erroneously present ethnic 'groups' as stable, discrete entities and/or fail to address its multifaceted nature; question whether research adequately addresses the concerns of minority ethnic people; recognise the limited analytical potential offered by crude administrative ethnic categorisation; and carefully consider how evidence can best be synthesised across contexts when concepts and categorisations vary widely (Bradby, 2003; Gerrish, 2000; Morning, 2008). These issues are likely to impact importantly on how managers use research evidence relating to ethnic diversity and inequality, though to-date this has not been explored.

Related work in the broad area of health inequalities highlights a number of factors related to the characteristics of research evidence and research products that have relevance to the focus of the present study. Exworthy et al., (2006) suggest that the multifactorial nature of inequalities, the paucity of evidence of effective interventions and the need for upstream and long-term investments all complicate the knowledge-into-action cycle in health inequalities policy. Pettigrew et al. (2004) found that policy-makers charged with the health inequalities agenda commonly perceive the lack of locally relevant evidence and evidence on the distributional effects of interventions to be problematic. More generally, Greenahalgh et al.'s (2004) major review of innovation diffusion in healthcare organisations identifies a number of key attributes of successful innovation that are rarely applicable to the evidence base on ethnic diversity and inequality including: evidence of clear benefits and cost-effectiveness; low complexity; ease of adaptation and low risk or uncertainty. Indeed, utilisation of the research evidence relating to ethnic diversity and inequality is likely to be compromised by: the predominance of grey literature; the lack of evaluative studies; the lack of studies that consider the distributional effects of interventions by ethnicity; and the lack of consideration of ethnicity within influential evidence syntheses (e.g. Cochrane reviews, NICE guidelance) (Yamanda and Brekke, 2008). Notwithstanding weaknesses in the evidence base that need to be filled, there is nevertheless a substantial body of evidence that highlights the scale and nature of the health disadvantage suffered by black and minority ethnic groups, as well as evidence that identifies generic ways in which health services could be modified to better meet the needs of minority ethnic patients (such as the provision of adequate interpretation facilities and enhanced cultural competence among healthcare providers, (Kai et al., 2007; Betancourt et al., 2005)). Furthermore, in some service/disease areas the quality of the research evidence base could lend itself to more specific, instrumental use by commissioners in pursuit of improved outcomes for minority ethnic groups such as evidence-based diabetes interventions (Bellary et al 2008). However, while many studies have identified factors that shape whether such research evidence impacts upon policy or practice (Hanney et al., 2003; Susawad, 2007), none have specifically engaged with the issue of ethnic diversity and inequality. More needs to be understood regarding the factors that support or inhibit the use of evidence in this context including: how evidence is presented and conveyed to decision-makers; what is regarded as evidence or knowledge; how the quality and relevance of knowledge is assessed ; when evidence is regarded as necessary; how easily evidence can be accessed, appraised, synthesised and integrated with other knowledge so that it can be adapted to the local context; and how decision-making is achieved in the absence of adequate research evidence.

Finally, our study is informed by, and seeks to further develop, the body of work that explores factors involved in achieving cultural competence within healthcare organisations. Attempts to translate knowledge about ‘cultural competence’ into improved healthcare experiences and outcomes for black and minority ethnic patients have most often adopted either training/education or evidence-based practice approaches. To-date, there has been no investigation of how research evidence informs policy-making or the commissioning of services for multiethnic populations. Nevertheless, past studies of training/education or evidence-based practice approaches do offer some useful insights.

Several studies highlight the way in which education and training programmes designed to address gaps in professional knowledge require wider, systems-based approaches to achieve desired shifts in practice. Kripalani (2006) notes the importance of clear support from senior staff in terms of signifying priority and modelling desired behaviour, Yamada and Brekke (2008) identify the need for attention to organisational factors influencing practice, and Shapiro et al. (2006) suggest that practice-based learning and models of good practice are needed alongside training courses. These findings point to the embedded nature of practitioner assumptions and behaviours and the need to challenge ‘tacit knowledge’ through new learning that is context-specific, has a link to action and is informed by experience (Russell et al., 2004).

An evidence based practice (EBP) approach to developing culturally competent services has combined best available research evidence with clinical expertise in the context of individual client characteristics. This approach has drawn on research highlighting the significance of systems in the development of culturally relevant interventions and the importance of practitioner self-awareness (Yamada and Brekke, 2008). EBP efforts are hampered, however, by a lack of evidence about specific ways in which practice guidelines should be modified to improve health outcomes for minority ethnic populations (Chen et al., 2008; Yamada and Brekke 2008) and omission of these populations from studies of evidence-based treatments (Whaley and Davis, 2007). The lack of evidence on the efficacy and cost effectiveness of cultural competence interventions may result in these being seen as an extra burden, particularly in the context of staff shortages and financial restrictions (Engebretson et al., 2008).

In addition to the above work, there is a large body of research that explores 'cultural competence' within healthcare from an organisational development perspective without engaging specifically in an exploration of the mobilisation and utilisation of research evidence. Analyses that situate the formulation of healthcare policy and practice within the wider sociocultural context of contemporary Britain are helpful. Despite sustained attention, UK policy relating to ethnic diversity lacks coherence and suggests at best ambivalence towards minority ethnic groups and dissensus regarding the form that multicultural Britain should take (Ahmad 1993; Culley, 2006). Two significant wings of policy and legislation - relating to immigration control and citizenship on the one hand, and to racial equality on the other – conflict (Hepple, 1992). Atkin and Chattoo (2007) argue that strategies for addressing disadvantage in healthcare provision are undermined as providers and managers struggle to reconcile these conflicting messages regarding minority ethnic populations; their needs and entitlements. It is increasingly argued that progress towards more culturally competent health services requires practitioners and organisations to: examine value bases; expose stereotypes, prejudices and ethnocentrism; challenge power relationships and oppressive practices; and work in true partnership (Papadopolous et al., 2004). It is noteworthy, however, that while such models often emphasise the importance of community consultation and local intelligence data, they are commonly silent on the role of research evidence (Dreaschlin, 2007). Similarly, recent policy documents and initiatives aimed at supporting commissioners and managers to address ethnic diversity and inequality pay little attention to how research evidence might be mobilised and utilised in this endeavour (Race for Health, n.d.; Race for Health, 2009). This is particularly surprising given the significant recent investments and initiatives aimed at fostering an evidence based approach to tackling ethnic inequalities, including the Ethnicity & Health specialist library of NHS Evidence. The present study seeks to address these important gaps.

While research to-date has helped to describe the complexity of the processes involved in, and the very wide range of factors that can act as barriers to, the knowledge utilisation process (Greenhalgh et al., 2004; Mitton et al., 2007; Susawad, 2007), as yet little has been done to identify effective routes to shaping or enhancing the process in real-life policy-making contexts. There is a need to move towards identifying effective areas for intervention - so-called 'weak points' - where intervention can effectively shift embedded values, beliefs, structures and practices that serve to undermine the contribution of research evidence. The present study aims to contribute to this general need and to generate specific understanding in an important area that has not to-date been the focus of enquiry.

Need

The study's focus on enhancing critical use of evidence in the commissioning process aims to enhance the quality, acceptability and effectiveness of services for minority ethnic communities, which comprise 13% of the population of England (in terms of those identifying as other than 'White British' in the 2001 Census). Mortality and morbidity patterns are complex, however substantial evidence indicates that minority ethnic groups suffer significant disadvantage across a range of indicators (Nazroo, 1997; Natarajan, 2004; Gill et al., 2007) as well as lower satisfaction with services (e.g. DH/HCC, 2008). The study will support managers to utilise evidence to improve commissioning and delivery of healthcare that effectively serves the needs of minority ethnic people, an area in which progress has been limited to-date (Culley and Dyson, 2001). Better use of evidence will help to overcome persistent problems relating to ineffective and insensitive patient-provider interactions, inappropriate constellation and design of services, inequitable allocation of resources and ethnocentric and oppressive cultures of care, that have been documented across a variety of service settings (e.g. Singh and Newburn 2000; Bhui et al., 2007). The research products will have pertinence to the increasing 'ethnic diversity' of the UK population considering both persistent disadvantage among established minority communities alongside the differing health needs of new migrant populations. The study therefore responds to the Commission for Equality and Human Rights' (previously the CRE) formal investigation into the Department of Health, and Nigel Crisp's 10-point action plan response, which highlight the need for significant improvement in this area.

Past policy intentions to tackle ethnic health inequalities have been undermined by competing priorities and diffuse locations of responsibility. However, recent policy developments and NHS reforms signal the alignment of efficiency and equity principles (including the NHS Constitution, DH, 2009; High Quality Care for All, DH, 2004; and World Class Commissioning, DH, 2007) and create new opportunities for evidence-driven commissioning by primary care trusts (PCTs) (King's Fund, 2007). Key competencies for today's PCT commissioners place knowledge management centre stage and include: critically mobilising and utilising research and best practice evidence; effectively garnering local intelligence and promoting engagement to assess needs; turning information into knowledge and action for service reconfiguration that improves access, quality and outcomes (DH/Commissioning, 2007). Commissioners are to be transformatory, rather than transactional, encouraging innovation and ambition to serve those in greatest need. The role of public health teams in the commissioning cycle, via both profiling local populations and synthesising wider research evidence, is gaining importance (PHCN, 2009). At the same time, Practice Based Commissioning (PBC) is increasingly promoted as a way to ensure that practitioner experience and insight effectively inform the design and delivery of services. Practice Based Commissioning consortia are intended to articulate population needs and identify innovative solutions to delivering better care and increased patient choice more efficiently. While World Class Commissioning and PBC present important opportunities, it is clear that they also demand significant development in competencies and infrastructure, particularly in relation to the mobilisation and utilisation of evidence. For instance, early investigation by the King's Fund (2007a) suggests that a lack of timely and high quality information currently undermines effective PBC. The current project responds to the needs of this emergent commissioning environment by seeking to enhance PCT managers' critical use of evidence in their task of commissioning services for multiethnic populations.

Enhancing the utilisation of evidence is particularly pertinent to the task of tackling ethnic inequalities in health. As well as better ethnic monitoring at local level, there is a need for better understanding of ethnic inequalities in health - their nature, causes and potential solutions - among those responsible for commissioning services (Aspinall and Anionwu, 2002; King's Fund 2007b; Yorkshire & Humber SHA, 2009). Furthermore, while there has been significant investment by DH in initiatives aimed at improving the commissioning of health services that address the needs of minority ethnic populations (for instance Race for Health and Pacesetters), there has to-date been poor articulation of the role that research evidence should play or how commissioners should be supported to effectively bring research evidence to bear on such commissioning decisions. This project extends and links several strands of ongoing collaborative work focused on knowledge translation, intelligent commissioning and ethnic diversity and inequality between university researchers and PCTs. The research focus has been jointly identified and responds to expressed needs among NHS managers. Recent events indicate a high level of interest in this area nationwide (King's Fund, 2007b; Yorkshire & Humber SHA, 2009), so that the project will have relevance to current and future priorities of PCT managers both regionally and nationally. The project will generate new empirical and theoretical understanding of the factors that shape effective utilisation of evidence relating to ethnic diversity and inequality and identify promising routes of intervention to enhance such use. The project will then use this new knowledge to design specific tools to enhance performance in this area, for use by individual managers, teams and organisations. Managers in Public Health, Workforce and Corporate Development as well as Commissioning Directorates are particularly likely to benefit from these outputs. The study addresses the SDO's core aims through its focus on improving practice in the organisation and delivery of health care for minority ethnic communities in the UK and contributes an added dimension to theoretical knowledge to the knowledge utilisation literature. By generating new knowledge about the way that managers perceive and utilise evidence on ethic diversity and inequality within the PCT commissioning cycle, and developing tools which help to apply this knowledge, the project represents good value for money. Further, by linking to the NIHR CLAHRC programme, the project's tools will be taken forward into pilots to test their impact on commissioning practice and outcomes.

Methods

Study focus

The focus of the study is the mobilisation and utilisation of research evidence within the health services commissioning cycle. Rather than taking as our starting point a discrete package of research evidence or a new innovation, we seek to understand how research is drawn upon and used within the everyday context of commissioning. In addition, we focus on research evidence that relates to ethnic diversity and inequality and examine whether, how and why this is brought to bear on the commissioning of healthcare services for multiethnic populations.

We adopt an explicit Integrated Knowledge Translation model for the conduct of the study (CIHR, 2007), bringing university researchers and PCT managers together in a collaborative team across the entire research process, to develop research questions, shape methodology, generate and interpret data and disseminate findings in accessible formats. Past work has indicated that sustained and intense interaction between users and researchers increases the likelihood that findings are utilised (Landry, Lamari and Amara, 2003). Given the complex and potentially challenging focus of the present study, such collaborative working is crucial to ensure the project's impact. PCT managers have contributed to the development of the proposal and preliminary work has confirmed the project's relevance to these and other stakeholders.

Theoretical framework

Recent reviews highlight the diverse streams of theoretical literature that may inform enquiry into knowledge utilisation processes (Crilly, Jashapara and Ferlie, 2009; Susawad,2007) and call for research within healthcare contexts to draw on these traditions and become more clearly theory-based (Greenhalgh et al. 2004; Eccles et al., 2009)

Recent work that seeks to integrate micro-, meso- and macro- level conceptual frameworks and to articulate the interplay between these layers is useful (such as Greenhalgh et al.'s (2004) review on the diffusion of innovations). So too are frameworks that emphasise the complex and contested nature of research knowledge and the messy, diverse and convoluted pathways that may link research evidence to policy or practice-making. Davies et al.'s (2008) notion of 'knowledge interaction' is attractive since it captures the way in which the application of research evidence involves multiple actors engaging with varied knowledge sources to craft policy-making within the context of competing drivers. Empirical work based on such holistic models seems more likely to identify fruitful avenues for intervention to enhance effective evidence use than those that focus on particular pieces of the jigsaw in a more piecemeal fashion. We therefore conceptualise knowledge mobilisation and utilisation within the commissioning cycle as resulting from dynamic interactions between individual agency, organisational rules, structures and processes, and the wider healthcare setting with its current restructuring agenda, all situated within the broader socio-political context of multicultural Britain.

Within this comprehensive framework, our focus on ethnic diversity and inequality demands that we foreground four particular aspects. First, we draw on Weiss's (1979) insights regarding the varied ways in which research might appear and be used within policy-making: as empirical findings (direct or instrumental); as ideas or challenges to current thinking (conceptual); or as briefs or arguments for action (persuasive/symbolic). We also recognise the often inherently contested and political nature of research evidence relating to ethnic diversity and inequality and that the characteristics of research evidence must be explicitly considered within our theoretical framework. Given that reviews of past work suggest that the direct use of evidence in policy making is in general the exception rather than the norm (Davies, Nutley and Smith, 2000), and the limited progress that has to-date been made in modifying services to meet the needs of black and minority ethnic populations, we give particular attention to elucidating the indirect influences of research evidence.

Second, at the level of individual actors and their interface with knowledge sources, we draw on socio-cognitive perspectives (Dunn, 1983; Ringberg and Reichlen, 2008) that emphasise the importance of the 'thinking subject' and the 'mental models' that guide people's sense-making. While the crucial role of policy-makers as receptors of knowledge is widely recognised (Landry, Amara and Lamari, 2001; Hanney et al.; 2003), socio-cognitive models look beyond technical skills and resources to values, assumptions and worldviews. We suggest that the ways in which individual commissioners understand the nature of ethnicity and associated inequalities will be central to how they seek out, appraise and apply different types of knowledge within their work. These perspectives fit closely with the work of Hunter (2005), Husband (1996) and Gunaratnam and Lewis (2001) who highlight the need to explore the 'felt dimension' of healthcare policy and practice-making within the multiethnic, post-Macpherson setting. As Hunter (2005, 150) argues, in exploring the role of those in policy-making positions, we must "consider these individuals as emotional as well as relational actors." For example, professional anxiety and uncertainty about cultural competence is disempowering to professionals and detrimental to care (Kai 2007).

Third, within the organisational context, we adopt a critical awareness of power and seek to expose the taken-for -granted 'ways of being and doing' that operate and how these interact with research evidence. We view the health system and healthcare organisations as not just mechanical structures that provide healthcare but rather as culturally embedded and politically contingent (Freedman, 2005), as “purveyors of a wider set of societal norms and values” (Gilson, 2003, 143). These ideas fit with Lam's (1997) notion of 'social embeddedness' - the recognition of the inter-connections between individual managers (micro), their organisational context (meso) and the wider societal context (macro) within which these operate. This means that although knowledge utilisation processes are characterised as anarchic and unpredictable, there are nevertheless 'deep structures' - in this case racialised hierarchies - that shape and constrain in persistent ways.

Fourth, within the wider context layer, we pay particular attention to the influence of stakeholders beyond the commissioning organisations, particularly patients and the public and their representatives. Given the strong focus on consultation and 'knowing communities' of World Class Commissioning in general, and ethnic equality guidance in particular, we seek to understand not only the ways in which these individuals and groups represent additional, perhaps conflicting, sources of knowledge (for instance patient preferences, or public opinion regarding entitlements), but also the ways in which they access, appraise, interpret and present research evidence to the commissioning tasks independently.

Notwithstanding our choice of a multilayered theoretical model that is sufficiently sophisticated to allow understanding of the complex processes of knowledge utilisation, our underlying assumption is that knowledge utilisation processes can be understood, that certain causes and effects can be identified, and that steps can be taken to modify these processes - building on strengths and mitigating weaknesses.

Overall approach

This theoretical framework directs our methodological approach in a number of ways.

- We combine detailed case study investigation of three commissioning organisations with broader data generation methods that allow us to engage with a wide range of commissioning contexts and managers in order to generalise theoretical understanding and develop research products that have wider relevance and transferablity.
- We employ a case study approach that excels at understanding complex, multivariate real-life situations allowing the integration of data on a number of levels and detailed contextual analysis of events and relationships (Keen, 2006; Flyvbjerg, 2006).
- Within the case studies we follow Innvær et al.'s (2002) recommendation to combine documentary review and interviewing, but go beyond this to incorporate naturalistic observation and reflective diaries. Drawing on the experience of researchers focusing on diversity and equality issues, we will 'follow documents around' (Ahmed, 2007) and tap into both official and private discourses in order to uncover taken-for-granted 'rules' and convoluted pathways of influence.
- We engage in the co-production of knowledge between university researchers and PCT managers.
- We focus on identifying factors that facilitate or hamper critical and effective use of research evidence, with a view to using these insights in the development of supportive tools that can help to enhance managerial practice in this regard.
- We seek to describe *how well* research evidence is being used, not just whether it is used at all:

Given our focus on improving the cultural competence of healthcare provision for black and minority ethnic groups, the ultimate test of how well research evidence is used is whether it leads to policy and practice modifications that improve levels of satisfaction and service outcomes for minority ethnic patients. Tracing the use of evidence to such outcomes or benefits is beyond the scope of the current study. Instead our focus is on assessing the intermediate steps in this process. Past research suggests that we should examine: accessing appropriate sources; critical appraisal and selection of appropriate evidence (rigour, relevance, bias, transferability); synthesis of evidence across sources and methods; adaptation and presentation of evidence in appropriate formats; effective integration of research evidence with other knowledge sources; explicit articulation of assumptions, priorities and values underlying the weighing up of different knowledge sources; and the translation of integrated knowledge synthesis into commissioning and benchmarking tools, products and processes (such as: service specifications, business cases, business models, service specifications, care pathway models, tenders, provider contracts, performance management tools, and quality and standards monitoring tools). Though the importance of each of these elements may vary depending on whether research evidence is being used instrumentally, conceptually or influentially, they are nevertheless likely to be of relevance across the board. Our Phase One Key Informant Interviews and preparatory work for the Case Studies (see below) will be used to refine our indicators of 'good use' across these steps so that they are meaningful to the stakeholders involved and relevant data can be accessed to illuminate how well these dimensions are being achieved in practice.

Research questions

We identify below the three broad research questions that guide the empirical components of the study. Each broad research question is followed a set of more detailed questions that illustrate the range of issues that are likely to be relevant and that indicate our intention to explore five inter-related 'levels' - evidence, individual managers, commissioning team, organisational setting and wider context - that make up the knowledge mobilisation and utilisation process.

RQ1: How does a focus on ethnic diversity and inequality shape the knowledge mobilisation and utilisation process within the health services commissioning context?

- What characteristics of research evidence relating to ethnic diversity and inequality influence how it is received by managers? (e.g. source; method, (un)certainty; relevance; concepts/theory);
- What mental models of 'how research evidence should be used' are managers working with?
- To what extent is the accessing and application of information relating to ethnic diversity and inequality part-and-parcel of broader evidence gathering exercises for commissioning, or rather a distinct exercise?
- What factors prompt managers to seek out research (and other types of evidence) relating to ethnic diversity and inequality? (policy directives, new priorities, external audit, stakeholder inputs, signs of service failure etc.)

RQ2: How does organisational context shape the mobilisation and utilisation of knowledge relating to ethnic diversity and inequality?

- How often, and at what stages, do managers apply research evidence relating to ethnic diversity and inequality in their commissioning tasks?
- How are commissioning teams constituted and organised? How does this impact upon evidence use?
- Who is seen as holding expertise and insight in relation to ethnic diversity and inequality? Why?
- To what extent do PCT commissioning organisations have explicit models, structures, processes and objectives that support the mobilisation and utilisation of evidence? Do these consider ethnic diversity?
- In what ways does managerial behaviour support and encourage, or deter, the explicit consideration of research evidence relating to ethnic diversity and inequality within commissioning teams?
- In what ways do the available infrastructure and resources support and encourage, or deter, the explicit consideration of evidence relating to ethnic diversity and inequality within commissioning teams?
- How do national, regional and organisational policy priorities inter-relate to shape the mobilisation and utilisation of evidence in this area?

RQ3: How can individual, team and organisational competencies be effectively enhanced to support critical use of research evidence for the commissioning of services that better meet the needs of a multiethnic population?

- How competent are managers to (i) identify and access, (ii) critically appraise and synthesise; (iii) adapt and apply, evidence relating to ethnic diversity and inequality?
- What expectations do managers have of, and what problems do they encounter with, the evidence base?
- What individual level factors facilitate or hinder the mobilisation and utilisation of research evidence in this area (knowledge/awareness; skills and experience; 'mental maps'; autonomy; authority; personal biography)?
- What areas of capacity development would likely improve the individual and team-level competencies required for the mobilisation and utilisation of research evidence relating to ethnic diversity and inequality?
- How does research (and other) evidence relating to ethnic diversity and inequality currently find its way into the commissioning process; via which actors and which routes? How can these be supported?
- Who are the key actors and what are the key organisational settings and processes that present barriers against enhanced mobilisation and utilisation of evidence?
- What factors in the wider societal and broader NHS context must be buffered against, or can be drawn upon, to support the routine, critical use of research evidence in commissioning for multiethnic populations?
- What characteristics of the form, content and delivery of interventions in support of enhanced mobilisation and utilisation of research evidence are likely to increase relevance and utility?

Research phases, methods and links to research questions

Preparatory work: Prior to the official start of the project the following tasks will be initiated if funding is confirmed from SDO: applications for ethics and governance clearance, recruitment of the full-time researcher and Advisory and User Guidance Group establishment.

Phase 1 (Oct-Dec 2010): Preparatory work; ethics and governance approvals; team building; literature up-dating; researcher induction. Literature reviewing and updating will focus particularly on new evidence relating to the form and content of interventions that have been shown to be effective at enhancing evidence utilisation in policy-making settings and will thereby contribute towards answering RQ3 above. Meeting of the Project Advisory Group and the User Guidance Group. Towards the end of this phase an internal briefing paper will be written to clearly articulate the conceptual framework and methodological approach guiding the project..

Phase 2 (Jan-Jun 2011): Expert Interviews (N=30-40) The purpose of Phase 2 is threefold (i) to gain, from a broad range of perspectives, insights into the key characteristics (relating particularly to the research evidence base, the PCT commissioning context, and the wider socio-political setting) that facilitate or hamper progress towards evidence utilisation in pursuit of reduced ethnic health inequalities, and thereby contribute to answering RQs 1 and 3 above; (ii) to document elements of good practice that have been developed during the PCT commissioning period that are valuable to preserve and promote as we move forward into new commissioning structures; and (iii) to inform the shape and focus of the Phase 3 case studies. Expert, in-depth interviews are well-suited to gaining insights into the structure and functioning of particular, complex environments (Berndtson et al., 2007) and recent studies have confirmed the usefulness of gaining expert opinion regarding the research-practice interface in relation to health inequalities (Lavis et al., 2008). An initial sample of 10-15 respondents will be identified through professional networks and contacts including those of our Project Advisory Group and the CLAHRC initiative. Subsequently, a modified snowball approach will be used in which respondents will be asked to recommend individuals who can offer particular perspectives. The main inclusion criteria will be that respondents are able to provide a detailed perspective on the evidence-practice interface within healthcare policy making. Different respondents will have differing expertise, but we will seek to recruit respondents who can provide rich description of: the PCT and newly evolving commissioning environment; the ethnic diversity and equality agenda; the research evidence base, its quality, accessibility and utility; and PPI. Respondents are likely to include: PCT managers involved in commissioning; managers within central DH directorates; Leads for specific relevant initiatives (such as DRE and Race for Health); clinicians actively involved in PBC; academics (particularly those involved with KT initiatives); SHA staff with a diversity and equality remit; and third sector stakeholder representatives (such as King's Fund, Race Equality Foundation and local BME networks). Respondents will also be mixed in terms of their seniority, gender and ethnicity. Respondents will be contacted by email and, if necessary, by follow-up phone call. Following full consent, respondents will be asked to complete a short online questionnaire to capture background information. Respondents will then be invited to participate in a loosely structured interview either face-to-face or by telephone at their convenience. The interview guide (which will need to be prepared prior to ethics approval) will be piloted and refined prior to the first interview and this will ensure that the main topics of interest are covered while not rigidly determining the direction of the interview. Interviewees will be asked to comment on the role of research evidence alongside other forms of knowledge within the commissioning cycle and specifically in relation to tackling ethnic inequalities in health; factors that support or inhibit research evidence utilisation in this area; ways of supporting better use and examples of good practice; and issues that are poorly understood and would warrant further attention.

In addition to the Key Informant interviews, a small number (4-6) of 'mini case studies' will also be completed in Phase 2 with the intention of capturing information about instances of 'good practice' in relation to commissioning specific services for multiethnic populations. The rationale for these is that at a time of major restructuring of commissioning infrastructure there is a danger that elements of innovation and effective working in this area may be lost. Potential case studies will be identified through professional networks, and we anticipate a mix of local case studies (Sheffield/Leeds/Bradford) and some further afield. For each mini case study we will interview 2-3 key actors, either individually or as a group, and also review relevant documentation. Case study respondents will be asked to contribute general information similar to that sought from the Key Informants, but will also provide information specific to their own field of practice, describing how they have addressed the issue of commissioning for a multiethnic population, how various types of information have been brought to bear on this task, and the barriers and facilitators to the use of evidence, as well as other factors that may have supported or hindered an explicit focus on ethnic diversity and inequality.

Subject to consent, interviews will be tape-recorded. Interviews will be transcribed in full and soon after the interviews researchers will prepare detailed, holistic memos to record observations on the interview process as well as capture overarching themes. Ongoing reflection and aggregation of the interview memos will allow the research team to identify when data saturation is achieved. We anticipate 30-40 interviews, conducted by the Researcher, SS, GM and PCT co-researchers. Following completion and transcription of around 20 interviews, the Researcher (with support from SS) will establish a project database using the qualitative analysis package *Nvivo* which is ideal for managing large quantities of qualitative material and coordinating analysis across teams of researchers. Data analysis will follow an inductive, interpretive approach combining holistic, contextual analysis and indexing (Mason, 2005). In practice this means that interview transcripts will be subjected to both line-by-line coding and holistic 'narrative' analysis. The coding scheme will be developed for use through an iterative process involving line-by-line blind coding of a sub-sample of transcripts by several members of the research team, comparison, refinement and annotation. Once finalised, the coding structure will then be applied to all the interview transcripts and, through multiple 'search-and-retrieve' actions, information from across the range of respondents will be brought together for further theme building. This 'code and compile' approach will be complemented by the detailed memo writing for each interview which will use a consistent guideline in which themes running through each narrative, contextual information, and more interpretive comments (for instance regarding inconsistency or obvious omissions) will be noted. The Researcher and SS will lead the development of the analysis approach, but will work closely with GM and the PCT co-researchers to co-produce the final presentation of themes and claims. The findings from this phase of the study will be written up as a journal paper and a shorter briefing note. An internal project workshop involving all co-applicants will also be held to discuss the findings and identify key issues for shaping the case studies.

Phase 3 (Jul 2011- Mar 2012): In-depth Case Studies of 3 commissioning organisations serving Leeds, Sheffield and Bradford. Involving a minimum of: 36 in-depth individual interviews; 15 focus group discussions; 60 naturalistic observation periods; 45 documentary analyses and 6 diaries across the three sites combined.

In contrast to some case study designs, we have not selected our case study sites to be exemplars of good practice in terms of research utilisation. Given the emergent nature of commissioning practices, particularly in relation to ethnic diversity and equality issues, such an approach would not be feasible or appropriate. Instead, we have selected our sites with the intention of providing sufficient variation to be able to compare and contrast commonalities and differences and thereby gain analytical purchase, but also to engender cross-fertilisation of ideas and mutual learning across the sites.

We have therefore opted for a regional focus and within this to include three PCTs and related commissioning organisations that - by virtue of serving populations with diverse ethnic profiles and having distinct organisational approaches - offer sufficient variety to support the generation of findings that will have transferability to a wide range of commissioning settings. Bradford, with its history of immigration from the Indian sub-continent, has long recognised itself as a multiethnic city and 24% of its population identified as belonging to an ethnic group other than the majority White British in the 2001 census. In contrast, Sheffield and Leeds had much smaller minority ethnic populations at the 2001 census - around 10% - and their public services have only more recently engaged seriously with the needs of these communities. Despite this, Sheffield is home to some long-established minority ethnic groups, including the Yemeni and Somali communities, and the Leeds population includes significant concentrations of Pakistani and Indian groups as well as smaller minorities such as Turkish and gypsies and travellers with particular unmet health needs. All three cities have experienced high levels of in-migration in recent years and now have both well-established and newer minority communities, with the pace of ethnic diversification being particularly marked in Sheffield. The choice of case study sites also offers the potential for exploring issues related to commissioning services for individuals and groups with varied migration statuses, socioeconomic resources and health profiles.

Importantly, all three PCTs have engaged in significant recent work related to achieving World Class Commissioning and to meeting the needs of black and minority ethnic groups, so that the current study has pertinence. NHS Sheffield has recently undergone a knowledge management review and is currently examining the ways in which qualitative evidence, and particularly patient experience data, can be effectively integrated with other forms of evidence. In addition, a recent Audit Commission review of health inequalities progress has prompted new work on BME populations. Both Leeds and Bradford & Airedale are members of Race for Health. Relevant initiatives in Leeds include the commissioning of community development workers through third sector organisations with a specific remit to consult with BME communities to feed knowledge into the commissioning cycle. In Bradford a number of commissioning areas are currently under review from an equality and diversity perspective and there are several examples of innovative service design and delivery to meet minority ethnic needs. Not surprisingly, there are important differences in emphasis and approach between the three PCTs and related commissioning organisations in relation to issues of ethnic diversity and equality and these will ensure that a range of minority ethnic communities and related concerns will be explored during the case study work. For instance, it is likely that in Leeds some attention will be given to gypsies and travellers since this is a current focus, in Sheffield economic migrants and the Somali community are potential 'groups' of focus, while in Bradford we would aim to explore issues relating both to the well-established and very large Pakistani community as well as to a smaller, newer community.

Over a nine month period, the research team will work intensively across the three sites employing a range of methods. During the course of the case studies, the PCT co-researchers will act as Key Informants for their organisational contexts, playing the combined role of guide, assistant, interpreter and historian (Burgess, 1985). It is important to note that, in line with our Integrated KT approach, the details of data generation will be developed in consultation with stakeholders in each city and that the draft description below is based on preliminary discussions regarding what would be feasible and effective at generating the required data.

Given the current uncertainty regarding the shape of commissioning organisations of the future, we can not specify precisely what the case study units will consist of at this time. However, our intention is to focus on organisational units that are likely to have longevity so that study findings are perceived to be meaningful for commissioners as they move forward with work within the emerging structures. In each commissioning organisation, data generation will focus at two levels, using Black's (2001) typology these are:[I] 'Governance policy-making', that is, the strategic, agenda-setting level, and [II] 'Administrative policy-making', that is the operational level, at which two focused areas will be identified for each organisation. The operational commissioning areas of focus (which may be defined by disease or service /care pathway) will be selected in consultation with stakeholders since it will be important to produce findings that are pertinent and timely. These are likely to be areas identified within existing commissioning plans as in need of service improvement, extension or redesign. However, priority will be given to areas for which the research evidence base is relatively rich in relation to minority ethnic needs and effective service interventions (e.g. diabetes, mental health). We will also seek diversity in terms of how the commissioning teams are constituted, and in particular the role that different directorates, including public health, play within these teams.

In each commissioning organisation, for both level [I] - agenda-setting and [II] - operational commissioning, data generation will begin with a comprehensive mapping of people, processes and partners (including identification of the timeline and cycle of activities and stakeholder analysis); essential given the diverse and evolving structures. Exploration at both levels will also include in each organisation: participatory workshops, documentary analysis, focus group discussions, in-depth follow-up work with 2-3 key managers (sequential interviews and naturalistic observation) and consultation exercises with BME forum/user groups.

We anticipate using participatory workshops early on during the case studies to gain a broad understanding of prevailing practices and competencies within teams and the organisations. These will employ prompting techniques that integrate and extend diagnostic tools developed for assessing research capacity (e.g. ARC for CLAHRC, Sarre & Cooke, 2009) and race equality or cultural competence (e.g. Mir 2008; Department of Health 2004; Dreaschlin, 1999; CRE's SHA Race Equality Performance Framework, 2004). These will generate data that will begin to address RQ1 and 2 above, particularly relating to *commissioning teams* and *organisational setting.*

Interpretive documentary analysis (Abbott, Shaw and Elston, 2004) will be employed to identify and synthesise key themes from relevant documents. This analytical approach will enable us to identify different layers of explicit and implicit meaning. The identification and selection of relevant documents will be guided by the PCT co-researchers and other managers/commissioners. At the 'governance/agenda setting' level these are likely to include: JSNAs, Commissioning Strategies; Health Inequality Action Plans, Race Equality Strategies, Research & Development Strategies; broad level Equality Impact Assessments, external evaluations, relevant meeting minutes and background briefing documents that trace the origins and evolution of key strategy documents. We will explore: how key issues are framed and what knowledge sources have informed the articulation of these issues; what assumptions exist regarding the desirability or necessity of change and the possible routes of intervention and what knowledge(s) have informed these; who are the key stakeholders and what knowledge(s) they bring. At the operational level, we anticipate looking for signs that ethnic diversity and equality issues have been considered at a general level (e.g. do service specifications include interpretation/language support requirements, is monitoring data to be collected by ethnic group, are expected outcomes clearly specified with respect to ethnicity?) as well as in more specific ways (e.g. do service specifications stipulate particular models of care that have been shown to be more effective than standard approaches for minority ethnic populations?) Where these are evident, investigation will seek to explore the prompts to such inclusion and the possible role of different types of knowledge. Where these are not evident, investigation will focus on the reasons for absence. Templates will be designed to guide document review, though these will not be rigidly prescriptive. Documentary analysis will be carried out side-by-side with the interviews and group discussions (see below) so that we can develop a detailed understanding of the factors that fed into the production of these documents and subsequently how these documents circulate and impact practice. The documentary analyses will particularly generate data that will address RQ1 and also RQ2 in relation to *commissioning teams, organisational setting* and *wider context.*

In-depth follow-up work will take place with 2-3 key managers for the strategy level and each of the operational levels within each commissioning organisation involving sequential interviews and naturalistic observation (shadowing) in order to understand more about the individual factors that shape evidence use in this area. We follow Hunter's (2005) advice to use reflexive, narrative approaches emphasising dialogue within the research context (since 'prior and ongoing relationships with professional participants make it difficult and indeed undesirable for researchers to maintain silence' (p149) in order to access more implicit understandings and discuss sensitive topics that might not easily be articulated within the interview setting. This element of data generation will particularly address RQs 2 and 3providing rich information relating to *individual managers,* and *commissioning teams* as well as enabling refinement of emerging claims relating to the influences of *organisational setting* and *wider context.*

Focus group discussions will be held with senior managers and commissioning teams, two each if possible, part-way through each case study period. In addition to open-ended question prompts, a variety of prompting tools may be used including: problem tree exercises, vignettes, and ranking exercises. The design and focus of the group discussions will be informed by ongoing analysis so that they are used purposively to generate data to test emerging claims. These discussions will particularly aim to generate data that address RQ2 in relation to *commissioning teams, organisational setting* and *wider context* as well as RQ3.

In addition to the varied data generation activities with NHS managers, group discussions will be held with relevant representatives of BME populations and other stakeholders (e.g. PBC consortia) that have a significant role in the commissioning cycle. These discussions will provide information in support of answering RQ3 particularly in relation to the *wider context* and how this can help or hinder individual and organisational change.

Producing an integrated analysis of rich data generated through these diverse methods is clearly challenging both practically and theoretically. SS and GM, who will be closely involved in data generation across all three case studies, are both experienced in handling large quantities of qualitative data, as are KG and SN who will contribute to this stage of the study. The research team will use *Nvivo* to systematically organise and index materials from each of the data generation methods described above. As with Phase 2, analysis will combine 'code and retrieve' approaches across the data sources with holistic memo writing for each data source. Reflective journals will also be kept using a standard format by SS, GM, the Researcher and PCT Co-researchers. Regular analysis sessions will engage researchers and PCT managers in the inductive and interpretive identification and testing of emerging themes and ensure the ongoing iterative co-production of knowledge that is both credible and relevant to the end-users. Visual and diagrammatic methods of organising data will be used alongside text-based methods (e.g. using software *Inspiration*) and the generation and refinement of theory will be carefully documented to ensure transparent links between data and claims. In line with the theoretical model described above, the overarching approach to the analyses is informed by critical ethnographic perspectives in that we attempt to synthesise the traditional ethnographic focus on subjective meanings and beliefs of respondents with the insights gained from a broader structural analysis (Wainwright, 1997). While we give a central place to the ways in which managers describe their commissioning roles and their experiences of working within their organisations, we consider that such accounts require situating within an understanding of the broader socio-political structures that constrain and direct the behaviours of individual actors. In this way our approach can be seen to be 'grounded' in the emic perspectives of our respondents, but also guided by the theoretical perspectives outlined above.

Analysis of case study material from each site will first be conducted at a 'within-case' level. The focus will be on integrating, and triangulating, data across the domains of analysis (evidence, individual, team, organisation and wider context) in order to holistically describe the factors that shape evidence utilisation and to identify promising routes of intervention in support of more effective evidence use. Analysis approaches will include 'process-tracing' whereby data are integrated across sources to elucidate intervening processes and the exploration of implicit and explicit 'predictions' that should be observed if emerging claims are defensible. As Mahoney (2007) argues, detailed case studies of this type can provide substantial leverage for causal inference and, by virtue of developing rich contextualized knowledge, decrease the likelihood of overlooking key variables or mis-specifying the interrelations among factors of interest. Each case study will result in an internal project paper that will inform the development of the draft managerial/organisational tools, as well as feed into the cross-case analysis (see below). Tools development will begin towards the end of case study 1 and be ongoing throughout the case study period and into Phase 4.

When descriptions and explanations are complete for the within-case analyses we will move on to cross-case analysis, that is, the systematic comparison across the three sites to identify relational and substantive patterns. Such cross-case analysis is appropriate since the project aims to generate theory, and also practical tools, that can have applicability to a wider universe of commissioning contexts. While recognising the need for caution regarding the potential limits to extrapolation beyond the case study sites, we concur with Mahoney (2007) that good quality case study work can provide a strong position from which to make suggestions about the kind of modifications that might be necessary to extend causal theories to other settings. Initial cross-case analysis work will be conducted by the Researcher, SS and GM, followed by a participatory workshop including all the co-applicants and other interested managers in order to integrate findings across the settings and shape the form and content of research products including the supportive tools.

Phase 4 (June 2011 - July 2012): Tools development, refinement and Testing and Development Workshops

This Phase overlaps with Phase 3 in that as case study work proceeds the team will start to develop potential tools and to seek feedback from respondents. Part way through this phase, SS, GM, the Researcher and the PCT Co-researchers will work together to further develop these supportive tools for use by managers and commissioning organisations, as well as to develop the format and materials for the Testing & Development Workshops. These draft tools and workshop materials will be circulated to all team members for input and will be discussed in Advisory and User Guidance Group meetings.

Three national-level Testing & Development Workshops will be facilitated. These events constitute a further round of data generation, analysis and synthesis, and not merely an opportunity to disseminate findings from the prior phases. The intention of these workshops is to test and further develop the explanatory models emerging from Phases 2 and 3 and to refine the practical, supportive tools in order to take account of stakeholders' concerns and priorities and to maximise their transferability to a wide range of commissioning contexts. This Phase of the study thereby contributes data towards answering both RQ2 and RQ3 and directly feeds into the refinement of the practical tools that flow from the empirical and theoretical insights generated. Potential participants will be identified via professional networks including: the CLAHRCs, the NHS Institute for Innovation and Improvement and the Public Health Commissioning Network. Participants will be PCT managers involved in commissioning. Each workshop will include around 20 participants and we will seek to recruit diverse sample of participants in terms of the size and geographical location of their organisations, age, seniority, ethnicity and area of expertise. Additional participants will be included from key stakeholder groups that input into commissioning decisions relating to black and minority ethnic health including service user representatives from local LINks. Participants will be expected to have detailed knowledge and experience of the commissioning cycle within their organisation. All participants will be expected to complete preparatory work prior to the workshops which will include the completion of a short online questionnaire and a reflexive exercise based on the findings from Phases 2 and 3. This background information will then be drawn on in the workshop exercises. The workshops will be carefully facilitated and comprehensively documented so that the insights from these events can be effectively integrated with the data gathered through the earlier phases. Other recent work has successfully used similar 'Think Tank' approaches to generate understanding in the field of KT (Pettigrew et al., 2004).

Phase 5 (overlapping with Phase 4: Mar-Sept 2012): Wider dissemination and follow-on work
Team members will engage in writing for academic publications and delivery of dissemination seminars at stages throughout the project period. In addition, we allocate three months at the end of the project for completion of additional academic outputs and conference attendance (subject to conference timing, of course). Phase 5 will also put in place vehicles for increasing the sustainable impact of the project via the preparation of protocols for the piloting of the supportive tools within CLAHRC (SY) lead by KG and SS and promotion via ETN and other networks.

Collective research effort

Contribution to knowledge

This study begins to build a body of research knowledge about how commissioners and managers respond to the significant unmet health need among minority ethnic communities, and specifically how commissioners can be supported to better use evidence in decision-making. Such research is currently missing from the UK evidence base and from the NIHR SDO programme. The project will make both an empirical and a theoretical contribution, innovatively integrating ideas across usually disparate strands of work.

Specifically, the project will generate new knowledge regarding: how managers source, appraise and integrate different forms of knowledge regarding the needs and entitlements of minority ethnic populations, as well as managers' potential responses to these demands; how strategic commissioners operate in the face of limited evidence including whether and how they seek to generate evidence or otherwise inform decisions; whether the commissioning of services for minority ethnic needs are disproportionately affected by poor evidence; and how personal attributes, identities and competencies of managers inter-relate with organisational contexts, and the wider socio-political context, in the appraisal and application of different types of knowledge. The project will integrate empirical findings and theoretical insights to identify promising routes of intervention in support of more effective evidence use.

Reaching multiple audiences; maximising reach:

The project will contribute significant outputs in a range of formats aimed at reaching the diverse set of stakeholders with interests in this area. The project will develop a comprehensive website to provide easy access to all project outputs. Team members will be active across the project life in delivering seminars, workshops and sharing work-in-progress to maximise project impact. Wide-ranging networks and complementary disciplinary and professional associations will increase the project's reach.

Our primary audience is managers at various levels of seniority who contribute to the process of commissioning health services for multi-ethnic populations. Our Integrated KT model is well-suited to the development of research products that are accessible, appropriate and impactful. Preliminary team work has highlighted the need to identify and target not just the end-users of the research products, but the senior managers who shape organisational processes and structures and therefore determine whether or not such innovations are adopted and sustained. Working in partnership, NHS managers and university researchers will identify the key people and processes that need to be targeted in order to effect change; the appropriate language, style and content of research products; and the routes to introduction that are likely to be successful.

The project will also link closely to the NIHR CLAHRCs regionally and nationally, thereby capitalising on opportunities for mutual learning and dissemination. Several team members are associated with CLAHRC work and the present project is borne out of synergistic links with this programme. The project will also make use of relevant networks and organisations including: the Ethnicity Training Network; Minority Ethnic Health jiscmail (large virtual network); and Race for Health. We also intend to link with the NHS Institute for Innovation and Improvement at Warwick University that produces tools and resources to support commissioners and the Public Health Commissioning Network. The Project Advisory Group (see below) will ensure opportunities to enhance the usefulness and relevance of the research, to contribute to the collective research effort and to disseminate effectively to all stakeholders are maximised.

Our secondary audience is the research community, including researchers and the funders of research. The project will highlight the current inadequacies in the evidence base in terms of informing effective commissioning for black and minority ethnic populations. We aim to prompt more researchers to make their research inclusive of, and appropriate to, the health needs of minoritised groups. For researchers already working in the field of ethnic inequalities, the project will increase awareness of the barriers and facilitators to utilisation of research findings in this area. The project will provide a greater appreciation of the focus, content and format of research studies and products that are likely to make an impact; as well as give insights into the factors that might help to build relationships with commissioners that can enhance the contribution of research evidence to tackling ethnic inequalities in health.

Specific research products and outputs:

- A suite of practical diagnostic, evaluative and change management tools that can be used by individual managers, teams and organisations to (i) assess and promote critical reflection on current competencies and practice with respect to mobilisation and utilisation of evidence on ethnic diversity and inequality, (ii) identify actions to strengthen competencies and good practice and (iii) support specific elements of the knowledge utilisation process. We intend to build on existing tools (across knowledge utilisation, organisational development and cultural competence) to develop new products that respond specifically to (i) the emergent commissioning context, and (ii) the complexity and challenges associated with evidence utilisation relating to ethnic diversity and inequality. Without wishing to pre-empt the findings of the study, which we expect to shape both the content and the format of the tools, as well as provide insights as to the key actors and processes that need to be targeted, we provide some indication here of the likely form that these tools may take. The final tool design will also be informed by the wider evidence base on effective intervention to enhance evidence use.

The **diagnostic tools** are likely to focus on assessing the readiness and capability of individual commissioners and teams to mobilise and critically utilise appropriate evidence relating to ethnic diversity and inequality within the commissioning cycle. These may take the form of text-based checklists or questionnaires linked to a hierarchy of descriptive statements that characterise different 'levels' of competence and good practice to which the individual or team might aspire. These tools might use a similar format to that adopted for the ARC for CLAHRC tool (Sarre & Cooke, 2009) or the CRE's SHA Race Equality Performance Framework (CRE, 2004). We envisage that such tools would be made available for self-directed use by individuals and teams via download from our project website. In addition, however, it may be that a package of materials is developed for use as a facilitated workshop and that this would form part of the Phase 5 piloting activities.

The **evaluative and supportive tools** are likely to be designed to follow on from the diagnostic tools to allow individuals and teams to identify more clearly those aspects of their competence and current practice that are strengths and should be supported and areas in need of further improvement, while being flexible enough to be applicable to diverse commissioning contexts. We envisage text-based tools that comprise prompting questions and issues for reflection as well as illustrative case stories (derived from our empirical data) that bring to life potential strengths, weaknesses, opportunities and threats that commissioners may face in this area. As in the case of the diagnostic tools, it is likely that the evaluative tools would be prepared in a self-directed format for use by individuals and teams via download from the project website, as well as in the format of a package of materials for use as a facilitated workshop, again likely to be piloted in Phase 5 (which extends beyond the life of this funded project).

These evaluative tools would help individuals and teams identify which of a linked set of supportive learning and development tools they might benefit from (as well as guide engagement with the change management tools mentioned below). Here we envisage the production of a number of tools designed to support commissioners in specific aspects of the knowledge mobilisation and utilisation process as it applies to ethnic diversity and inequality. Possible topics include: sourcing evidence on ethnicity and health; assessing the relevance of research evidence from national sources or other regions to local circumstances; developing an economic argument for investments in equitable services; and working with researchers to generate useful knowledge. The format of the supportive tools is likely to be web-based and interactive, allowing flexible engagement with the material as-and-when needed. The tools are likely to be made up of 'nuggets' of learning points tailored towards the realities of the commissioning cycle (perhaps similar in form to the 'evidence nuggets' found effective by Brocklehurst and Liabo 2004), self-assessment tests that allow users to assess their own understanding and competence, and guidance checklists to remind commissioners of key points during their working day. In this way, these tools may be similar to the ‘intervention packages’ described by Nieva et al. (2005). Topics will be prioritised to address those issues identified through the study as presenting the greatest impediments to evidence mobilisation and utilisation.

The **change management tools** will seek to support managers in bringing about the necessary shifts in thinking and behaviour to embed new practices that enhance the critical mobilisation and utilisation of research evidence relating to ethnic diversity and inequality within the commissioning cycle. We expect our empirical work to generate substantial insight into the factors at organisational setting and wider context level that can support or hinder the routine best use of research evidence in this area and anticipate using this material to generate hypothetical scenarios that illustrate the issues that can arise and effective ways to negotiate them, similar to those presented by Iles and Cranfield (2004). It is likely that such scenarios would be combined with prompting questions, templates and checklists that would enable managers to develop and deliver an action plan aimed at enhancing the critical use of evidence within the commissioning of services for multiethnic populations. Again, we envisage that such tools will be produced in the form of a web-based self-directed analysis and planning resource, but that in addition we would produce materials for facilitated workshops and possibly learning set activities, since the process of change is likely to extend over a period of several months. Careful consideration will be given to the form of these tools, how these tools are administered, and who they seek to engage with. These issues will be explored during Phase 4 (as well as with our Project Advisory Group) and may result in the development of networks of individuals across the country who are working, and mutually supporting, shifts in commissioning practice in this area.

Depending on the findings from Phase 4, it may be that we aim to consolidate all the materials into a comprehensive tool-kit that would guide managers through the diagnostic, evaluative and change management stages in an integrated way. Alternatively, a more flexible set of tools may be warranted that is more responsive to the differing starting points of individuals and teams who may wish to engage with the materials.

- **Briefing Papers for NHS managers**. University researchers will work in close collaboration with the NHS co-researchers to produce a series of Briefing Papers to disseminate the newly generated knowledge to peers regionally and nationally. These will be carefully designed and may be modelled on 'evidence nuggets' (Brocklehurst and Liabo, 2004).

- **High quality, peer-reviewed journal article**s. We expect to publish at least 5 papers in high quality journals, including open access journals, across public health; management science; implementation science; sociology; and health services research. All co-applicants will contribute to these outputs.
- **Seminars and conference presentations.** SS, GM, the Researcher and PCT Co-researchers will all engage in dissemination of work-in-progress during the life of the project, seeking opportunities regionally and nationally to engage with researchers and PCT research users. In addition, we have budgeted for attendance at two national conferences towards the end of the project. We anticipate presenting at the UKPHA conference, but, given the likelihood of new, NHS commissioning-focused conferences, we will decide on the most appropriate forums for our work in light of the available opportunities at the time. KG is a member of the International Knowledge Utilisation Colloquium and will take the opportunity to present findings from the study at annual meetings of this influential group.

Follow-on work - extending project impact:
CLAHRC (SY): The managerial and organisational tools developed by the project will subsequently be piloted in the NIHR CLAHRC South Yorkshire as follow on activity supported by existing funding from the CLAHRC. A total of 4 PCTs, including NHS Sheffield, are partners in the CLAHRC SY. Drawing upon the joint expertise of CLAHRC SY implementation themes on knowledge translation (lead KG) and evidence-based commissioning (lead MW) research products will be trialled and evaluated with strategic commissioners and managers from these PCTs. After piloting, the research products will be shared more widely across the other 8 NIHR CLAHRCs. KG as implementation lead for the SY CLAHRC has excellent links with the implementation leads of the remaining CLAHRCs to support this activity. Workshops will be hosted linked to CLAHRCs located in areas with an ethnically diverse population, for example Manchester, Leeds, Leicester, Birmingham, North London. This

activity will be supported by CLAHRC (SY) funds and will occur following completion of the proposed project.

Ethnicity Training Network: ETN will also be an important conduit for the research products. The theoretical and empirical knowledge generated will be used refine the strategies and model of knowledge transfer currently used within ETN's programme of work. In addition, the ETN will be an important route through which to promote and disseminate study findings and tools through its network of around 2,000 members, many of whom are leads for diversity within NHS settings.

Canadian links: Several team members have ongoing collaborative links with researchers and policy-makers in Canada, including: Gina Higginbottom, Canada Research Chair in Ethnicity & Health, University of Alberta; Zubia Mumtaz, Assistant Professor, School of Public Health, University of Alberta; Carole Estabrooks, Professor and Canada Research Chair in Knowledge Translation, University of Alberta; Jacqueline Tetroe, Senior Advisor Knowledge Translation, Canadian Institutes of Health Research. We would welcome the opportunity to extend the project focus to include comparative work in Canada should this be possible via the SDO programme.

Outcomes:
Tools developed from the study will enhance PCT managers' and commissioners' ability to draw on research evidence relating to ethnicity in health decision-making at both strategic and operational levels. Findings will support academics to draw on new knowledge about how to increase the impact of research on ethnic diversity and where to focus their efforts. The study will also equip Local LINks and service users with the knowledge to draw on the existing evidence base in lobbying for improved service provision and for research that fills current gaps in knowledge via the commissioning process.

Approval by ethics committees

Governance approval will be sought from all participating PCTs. The project will need ethics approval from the NHS Research Ethics system for phases 2-4.

Project management

Involving quite a large team engaged in a wide array of activities across several organisations, the project will require strong management structures and a high level of effective communication to be successful. SS will be the project manager and will design and employ formal project planning and management proformas. A wikispace will be established as a repository for all project documents and as a medium for within-team consultation and consultation with the PAG. Brief monthly progress reports will be prepared by SS and the Researcher to indicate progress against clearly identified activities and outcomes and distributed to all team members. More detailed 6-monthly progress reports will be prepared in accordance with SDO reporting requirements. SS, the Researcher, KG, SN and MW will be co-located at Sheffield Hallam University. Weekly contact will be maintained with GM and the PCT Co-researchers across the life of the project. Regular team meetings will bring all co-applicants together at critical junctures and teleconferences will also be used to ensure close communication. All meetings will have clear agendas, objectives and minutes/action points. The project builds on past successful working relationships and we do not anticipate communication or management problems.

Project Advisory Group

A Project Advisory Group including academics, statutory and third sector managers, practitioners and policy-makers will be convened to provide guidance to the study and to ensure that connections are made to other relevant work. Membership will include people with expertise across: knowledge translation; equality and diversity; organisational transformation; PPI and commissioning. The group will meet face-to-face three times at critical junctures in the research cycle. Additional email communication and wikispace posting of material will maintain engagement and input across the project life. The following individuals have expressed interest in being part of this group: **Professor Helen Hally**, National Director - Race for Health; **Dr Mark Exworthy,** Reader in Public Management and Policy and Director, Centre for Public Services Organisations (CPSO) and Deputy Director, Institute of Leadership & Management in Health (ILMH), Royal Holloway, London; **Dr Peter Aspinall**, Reader in Population Health, University of Kent, Research Advisor, NHS National Institute for Health Research: Research Design Service SE and Honorary Special Advisor, London Health Observatory; **Dr Ruth Thorlby,** Fellow in Health Policy, King's Fund; **Lynda Brooks**, National

Programme Director, NHS Equality Delivery Team, Workforce Directorate, 'Everyone Counts'; **Judy Carrivick**, Health Inequalities Manager (Vulnerable Groups), NHS Leeds; **Ronny Flynn**, Director of Health and Housing, Race Equality Foundation; **Mark Gamsu**, Programme Director, Health Inequalities and Local Improvement, Department of Health
Dr. Elizabeth Goyder Reader in Public Health ScHARR University of Sheffield and Theme Lead for Inequalities Implementation Theme, CLAHRC (SY); **Dr Ade Adebajo** Consultant Rheumatologist, Patient and Public Involvement Lead, NIHR CLAHRC South Yorkshire; **Professor Christine Godfrey**, Head of Department, Department of Health Sciences, University of York and Addictions lead for LYBRA CLAHRC and **Professor Uduak Archibong,** Professor of Diversity & Director Centre for Inclusion and Diversity, University of Bradford.

Service users/public involvement

The project's approach is underpinned by the belief that the active involvement of service users and the public is central to the endeavour of conducting high quality research that has the potential to contribute to positive change. The project team members have extensive experience of user involvement in research and strong links with user-groups. Sheffield Hallam University is a leading institution in the field of user involvement in research and service design (http://research.shu.ac.uk/chscr/user-involvement/) with strong links to INVOLVE. Preparatory work for this proposal has included consultation with individuals and groups representing the needs of black and minority ethnic communities and confirmed the appropriateness of a two-pronged approach:

First, we will convene a User Guidance Group that will meet three times during the course of the project to provide advice on the direction of the study and to offer user perspectives on the emerging findings. Provision is made within the budget to ensure meaningful contribution from all participants including: interpreting facilities for non-English speakers; honoraria; travel and carer expenses; and appropriate venues and formats for events. The group will include individual service users and members of the public as well as representatives of the LINk organisations and BME-focused patient/user groups in Sheffield, Leeds and Bradford. The following organisations and individuals have expressed interest in being part of this group: Melvyn Newton, Project manager, Bradford LINk; Jim Kerr, Leeds LINk Equality & Diversity Group; Jon Beech, Co-ordinator Community Development & East Leeds Health For All, Touchstone, Leeds; Hardeep Pabla, Service Manager, Breakthrough - f.k.a. Sheffield Black Drugs Service and Sheffield BME Network; Mike Smith, Chair, Sheffield LINk; Blake Williamson Governing Board member, Sheffield LINk ; Mubarak Ismail Governing Board member, Sheffield LINk.

Second, the case studies will each include three open-ended group discussions with service users and representatives from minority ethnic communities. Again, there will be provision for non-English speakers and events will be organised with guidance from local people to ensure effective and meaningful participation.

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Pre-project preparatory work																								
Project Advisory Grp & User Grp establishment																								
Ethics and governance applications																								
Recruitment researcher																								
Phase 1: Preparatory work																								
Induction of researcher	▨	▨	▨																					
Updating literature review	▨	▨	▨ 🗋 ← Conceptual paper																				▨	▨
Website initiation and maintenance			▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Team building work (site visits, team workshop)	▨	▨	▨																					
Project Advisory Grp & User Grp involvement		▨ ✋					✋						@						✋				@	
Phase 2: Expert interviews																								
Interviews and analysis first wave				▨																				
Interviews and analysis second wave					▨	▨																		
Analysis and planning workshop all team members						▨ 🗋 ← Summary of findings																		
Phase 3: Case studies																								
Preparatory work, materials, logistics							▨																	
Case study 1							▨	▨	▨	▨														
Case study 2											▨	▨	▨	▨										
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Analysis and devt. workshop all team members																		▨ 🗋 ← Summary of findings						
Phase 4: Tools devt & testing																								
Tools development									▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨					
Workshop materials development																				▨				
National-level testing workshops (x3)																				▨	▨			
Tools refinement																						▨		
Phase 5: Dissemination & follow-on																								
Briefing papers aimed at managers/commissioners										▨ ☑								▨ ☑					▨ ☑	▨ ☑
Academic journal paper writing										▨ ❐								▨ ❐				▨ ❐	▨ ❐	▨ ❐
Seminars and conferences																								▨
Protocol development for CLAHRC pilots																								▨

✋ = PAG and User Group face-to-face meetings; @ = PAG e-consultation; 🗋 = Internal project paper; ☑=Briefing paper; ❐= Academic journal article