



## Mini Case Study Book

Real world examples of using evidence to improve  
health services for minority ethnic people

**EEiC** Evidence and Ethnicity  
in Commissioning



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# Introduction

Recent years have seen growing interest within the health sector in finding ways to close the gap between what we know and what we do; ways to ensure that research evidence and other types of knowledge actually lead to benefits for patients and populations. This casebook is about how we can make progress on putting evidence into practice to bring about improvements in health service access, experiences and outcomes for black and minority ethnic (BME) people.

England has long been recognised as a multiethnic society, and the diversity of our population continues to increase. Latest estimates show that around 20% of people self-identify as belonging to an ethnic group other than White British. Though patterns of ill-health are complex, BME groups have poorer health than the majority White British across a range of indicators. Ethnic identity influences the health of individuals and groups in a variety of ways, through:

- Direct and indirect discrimination
- Differential access to health-promoting resources
- Cultural practices
- Migration
- Genetic factors

Our strong legal and policy framework dictates that NHS health services should remove discrimination and promote equality of access, experience and outcome for all patients regardless of ethnicity. However, despite areas of good practice, progress has been slow and services commonly fail to tackle BME disadvantage. Unmet need, delayed diagnosis, poor patient-provider communication and negative service experiences are common and are not confined to new migrants or people who lack English language skills.

The commissioning process has the potential to shape better services for BME people. Commissioners are now expected to bring about improvements and transformation, rather than simply pay for existing services. Commissioners must understand population needs and find new ways to deliver care both more efficiently and more equitably. They are also expected to find and use the best available evidence to support their decisions.

The expectation that commissioning decisions will be evidence-based can, however, unintentionally block progress towards better services for BME people. The collection and analysis of ethnic monitoring data remains poor in many service settings, making it hard to demonstrate inequalities. National guidance documents are usually vague about how the needs of BME people should be met. Engagement with BME communities is often tokenistic, so that

the experiences of users and carers do not inform service improvement in a meaningful and sustained way. At the same time, there is limited published research on what works to enhance equity across ethnic groups. Limited data, insight and evidence can make it difficult for commissioners to understand need, identify solutions and develop persuasive business cases to leverage resource. The current climate of austerity makes decision-makers risk averse and reluctant to pilot service changes. There is, therefore, a need for perseverance and creativity in generating and using evidence that can lead to service improvements for BME people.

The present casebook recognises these significant challenges but also seeks to raise awareness and motivate action through the sharing of real world experiences. The case stories presented below are not 'polished' examples that suggest all is plain sailing. Instead, we highlight successful strategies alongside persistent obstacles and descriptions of the hard work needed to bring about change.

Understanding and addressing ethnic inequalities can bring significant benefits for all, including:

- More efficient use of resources;
- Lower morbidity and premature mortality;
- Compliance with legal duties;
- Better progress towards key performance targets;
- More responsive and flexible services.

Effective work in this area does, however, demand particular organisational and individual skills, including the effective use of evidence. The brief examples in this case book aim to inform and inspire the reader to take action on this agenda, with examples linked to different stages of the commissioning cycle. Further detail is available online, so please do follow up those case studies that are of particular relevance to you. This guide is part of an on-going, collaborative process of learning and sharing, and we welcome suggestions and further contributions through our website.

We would like to thank our funders, colleagues who have offered invaluable advice and support, and our participants, for working on great projects, and taking the time to share their experiences and expertise.

# Contents

Introduction		p1
Contents		p3
Key Themes		p4
Listening to clinical experience	Primary Care	p6
<i>Awareness of vitamin D deficiency in Liverpool's Somali community</i>		
When you can't do it alone	Mental Health	p7
<i>Improving access to mental health and related services through shared leadership</i>		
Where there is no data	Dementia	p8
<i>Making the most of what is available</i>		
Making EqlAs work	Provider trusts	p9
<i>Assessing services and setting priorities</i>		
Getting the board on board	Cardiac network	p10
<i>Packaging information for decision makers</i>		
Translating aspiration into action	Social enterprises	p11
<i>How commissioners can provide space for innovation</i>		
Building brick by brick	New migrants	p12
<i>Innovating and growing new services</i>		
Evidence begets evidence	Chronic conditions	p13
<i>Drilling down to gain deep understanding</i>		
Commissioners and providers as partners	Third sector organisations	p14
<i>Evaluation and piloting with third sector providers</i>		
Champions for change	Cardiac rehabilitation	p15
<i>Raising awareness to reduce ethnic health inequalities</i>		
The Evidence and Ethnicity in Commissioning Project		p16
Glossary		p17

# Main Themes

Our case studies tell real stories of how using different kinds of evidence on ethnic diversity and inequality can help to commission better services for multi-ethnic populations. However, a key finding of the project was not just the importance of evidence, but also the people and processes that make service improvements happen. Below are some of the common themes across the stories.

## Use experience to identify service gaps

Often people who started service change did so because they could see current services were not meeting the needs of particular minority ethnic people. The **experience of those directly engaged with service delivery**, with an eye for spotting inequalities, was the essential first step in many of the stories.

Yet getting data to prove these inequalities quantitatively was often difficult. Sometimes people were able to get seed money to do a short study, if they could persuade fund-holders that there were potential unmet needs. Stories of patient experiences from service providers, examples from elsewhere in the country and service evaluation could also help build this picture. However, the first step was often **taking the initiative to analyse routine service utilisation data** to show underutilisation or poor patient experience in particular groups.

In some cases this evidence would be enough to get a project or service improvement to a pilot stage, or encourage a simple change to existing services. In other cases, **partnering with academics or data analysts** from the PCT was needed to make a stronger case for demonstrating inequalities and improving services.

## Bring together national and local evidence

Incomplete local data was a common problem, but some people did not let this obstruct action. Informed **combination of national prevalence data and local ethnicity profiles** could be used to flag up likely areas of poor service/treatment uptake, or under-diagnosis of particular conditions in certain communities.

National initiatives that highlighted the importance of addressing ethnic inequalities were often the impetus for a strong local project, even when local information was limited. When local commissioners had the flexibility to tailor national initiatives, for example on stroke awareness or mental health issues, they were able to tailor services for local communities. As every area had a different ethnic mix, there was no one-size-fits-all approach, and the best way to make sure the whole population was engaged was to **look at innovations from other**

areas and to engage local communities in different ways to design services that effectively respond to local needs.

## Partnership working is key to change

All the examples in this book got off the ground because committed individuals took the initiative to address an important issue. However, project success was down to 'getting the right people round the table'; involving **a group of people with the necessary skills, experience and responsibilities** to improve services.

Developing partnerships and building new working relationships was often essential. Some projects needed particular skills, such as data analysis or community experience, to make the case for a project, or make a service a success. Involving **senior staff early on was often important to make sure there was buy-in from decision-makers**. It also ensured that there was someone who 'spoke the right language' and would be able to suggest the right way to present to a funding board.

Partnerships with BME community groups and service users gave legitimacy to proposals and allowed services to be designed directly with the input of potential users. **Long-term relationships with commissioners and providers, with mutual trust and understanding**, produce the best input into service improvements. The more that local community members are engaged in service design, the more likely they are to be able to contribute constructively, and understand what can be achieved (and how long it might take). Cross-sector partnerships can also prevent endless re-consultation by different organisations on the same issues, and show participants that their contributions are an integral part of the commissioning process, not just a tick-box exercise. **Services designed with good community engagement are more likely to be accepted by target groups**, and have a bigger impact.

## Perseverance

None of the stories here happened overnight. In most cases it took several years of evidence gathering, planning and lobbying to build a picture and get the message across before a new or improved service was delivered. **But committed individuals can infect others with their enthusiasm and convince key players** that with their help they can make a difference to disadvantaged communities. Most people work in health services because at some level they want to make a positive difference to people's lives, and remembering this common aim can help to turn plans into action.

**We hope learning from the experience and success of others who have overcome all the hurdles and improved health outcomes is a useful step along this journey.**

## Listening to clinical experience

### Awareness of vitamin D deficiency in Liverpool's Somali community

*Mysterious pain was confusing the doctors of Somali patients in Liverpool. One GP recognised that vitamin D deficiency was the likely culprit, and set about getting the evidence and support she needed to change practice in Liverpool, and eventually across the UK.*

#### Use expertise to recognise local problems

GPs in Liverpool were seeing lots of patients from a Somali background present with muscle and bone pain and general malaise – vague symptoms that were difficult to diagnose. Suspecting vitamin D deficiency (linked to the UK's depressing lack of sunshine), a local GP had success in treating her patients with dietary supplements, but suspected the problem was more widespread.

#### Lever connections and funding to reveal the scale of the problem

Working with colleagues in Public Health and researchers at Liverpool School of Tropical Medicine, the team was able to undertake **a small local study showing that 80% of people from a Somali background were deficient in vitamin D**. A more detailed qualitative investigation suggested that dietary preferences in the community were compounding the problem.

#### Use peers to spread the message

Armed with this knowledge, the team produced a brief booklet, and told colleagues in Liverpool about the importance of testing for vitamin D deficiency in Somali and other Black African populations. **Since this message came from another doctor, and offered a practical solution to a known problem, the idea spread.**

#### Commissioners need to listen to the experience of local clinicians

Although instigated by health care providers, commissioners at Liverpool PCT took notice of this work, using it to inform their approach to vitamin D deficiency as a central part of their Healthy Start programme for pregnant women. Although this is a national programme, **the local evidence has been critical to enable commissioners to effectively target the local population and educate health workers.**

#### Time and money are always problems

It's difficult for clinicians to have the time to put together research proposals for funding, and **without the 'pump prime' investment of time and energy from a few committed individuals, the project would not have got off the ground.** Even now, it is difficult to find resources to further scale up the research.



For more information on this case study, including more details on the research, visit [www.eeic.org.uk/mcs/vitd](http://www.eeic.org.uk/mcs/vitd) or scan the QR code with your smartphone or tablet



## When you can't do it alone

### Improving access to mental health and related services through shared leadership

*When the Mental Health Transcultural Group at Wakefield realised that their effort alone was not enough to reduce mental health inequalities in BME populations, they got support through the Shared Leadership for Change Award Team. Getting signed approval from the CEOs involved in this team helped gain support to tackling ethnic inequalities in mental health.*

#### Recognise the opportunities in policy and legal frameworks

Following the Race Relations Amendment Act in 2001, Wakefield PCT established the Mental Health Transcultural Group as a Social Services and Health initiative for addressing inequalities in adult mental health. Winning a Health Foundation award for improving the health of BME communities, was an opportunity to bring both providers and commissioners together from adult mental health and substance misuse services to tackle mental health inequalities together.

#### Work together to identify clear objectives and targets

Key strategic managers from primary and secondary care, public health, the local authority, substance misuse services, and the acute mental health trust **identified clear objectives and targets for** improving access to mental health and related services through the Health Foundation Shared Leadership for Change Award.

#### Generate and use evidence to raise awareness

Following the 'Count Me In' census which showed major inequalities in the number of BME patients being detained in mental health services, **research was commissioned to document the experiences of local BME users of mental health services** confirming inequalities in local services. Based on these findings, the Mental Health Transcultural Group was also responsible for commissioning a "Beautiful Minds" DVD using real life case studies to raise awareness of mental health within the community.

#### Link with BME communities and other disadvantaged groups

**The skills and expertise of frontline staff** who attended the Mental Health Transcultural Group were used to identify areas for action. From this work, a local Mosque was commissioned to deliver mental health promotion and provided training to raise awareness and appropriately signpost to mental health services. Although the initial focus was on South Asian communities, the work has now expanded to include vulnerable groups such as asylum seekers, refugees and other minority ethnic communities including BME children.

#### Documentation and evaluation

Currently there is little documentation of the work being done in Wakefield. A mechanism for monitoring and evaluating the project would help to make the case for further funding and share the lessons learned by the project.



For more information on this case study, the structures and the DVD, visit [www.eeic.org.uk/mcs/mhtg](http://www.eeic.org.uk/mcs/mhtg) or scan the QR code with your smartphone or tablet

## Where there is no data

### Making the most of what is available

*As often is the case, local quantitative prevalence data by ethnicity was not available for a dementia team in Nottingham. The group used national and regional data, combined with local intelligence on dementia in BME communities to inform the development and commissioning of services. They tried a range of strategies, from extrapolating WHO statistics, to head counting in hospital wards!*

#### Recognise the problem

NHS East Midlands held regional workshops on the National Dementia Strategy, but didn't have any representation from BME communities. Nottingham Health Care Team believed that **BME people within Nottinghamshire were not accessing dementia services** in proportion to the expected incidence of the condition.

#### Gather the best available evidence

There was little local evidence to support a strong business case to promote use of dementia services by BME people. So, the community development worker and the General Manager of the Mental Health Strategy for Older People **worked together to gather evidence** with support of other committed individuals. The team wanted to generate quantitative data to support their hypothesis that use of dementia services was low. Head counting in hospital wards showed occupancy by ethnicity, creating basic evidence to support their observations. They strengthened their findings by extrapolating national level statistics to estimate dementia prevalence locally by ethnicity.

#### Work in close collaboration with the BME community and other partners

NHS East Midlands Development Centre was able to offer matched-funding to support efforts to increase the proportion of BME community elders accessing dementia services in Nottingham. Two linked strategies were adopted: raising awareness of dementia services in collaboration with twenty community organisations, and **training local Community Development Champions**. The aim was to raise awareness of dementia among minority ethnic communities in Nottingham.

#### Bring together national agendas and local commitment

The joint working in this project was facilitated by a shared commitment to ethnic health inequalities, the dovetailing of two national level agendas namely Delivering Race Equality and the National Dementia Strategy, and **robust relationships between different organisations and partners**, especially at the community level.

#### Sustainability and meeting community expectations

There is a risk that the community organisations will lose interest because **much of the project is being discontinued and many people involved are changing jobs**. The community members could also lose trust in the services if their needs are not being adequately met in the future, so it is vital that these initiatives are mainstreamed across the service.



For more information on this case study, the structures and the DVD, visit [www.eeic.org.uk/mcs/dementia](http://www.eeic.org.uk/mcs/dementia) or scan the QR code with your smartphone or tablet

# Making EqIAs work

## Assessing services and setting priorities

*Equality Impact Assessments don't always make an impact. An innovative framework developed by Bradford Teaching Hospital NHS Foundation Trust's head of E&D shows how EqIAs can be used for service evaluation and real improvement.*

### Prioritise what services need an EqIA

The E&D lead developed an **Excel framework for rapid assessment** of the 250+ services offered by Bradford Teaching Hospital. By using staff knowledge of previous equality concerns and some common sense, every service was briefly assessed. A few services identified as most likely to have equality issues were prioritised to receive a full Equality Impact Assessment. One of the services selected for full assessment was the mobile breast screening service.

### Get the right people round the table to compile the evidence

By having a round table meeting with the department and trust E&D leads and a radiologist from the screening service, **the group were able to quickly collate evidence** from patient feedback, service use data and staff experiences to identify problem issues. All evidence was collected in a large 20 page EqIA, including relevant patient feedback.

### Identify specific service problems

The EqIA showed that the breast cancer mobile screening unit was **not making the most of the interpreter service**, and this was leading to some people who came for appointments being turned away. Since this was a mobile service with short time slots, it was important to request interpretation services in advance.

### Deliver flexible solutions

The E&D lead was able to use a small pot of money to **have a diversity trainer work with staff at the screening unit** on equality, showing staff the importance of making sure screening was available to everyone, and how to achieve this by booking the local interpretation services.

### Have a process for evaluation

The EqIA and the action points agreed from it were **made priorities by the service and by senior management** which can challenge providers if these improvements are not made. However, there are no performance indicators being used to evaluate improvement, and a process for regularly assessing these should be set up in the future.



For more information on this case study, including examples of the rapid equality impact assessment template and a link to the equality impact assessment, visit [www.eeic.org.uk/mcs/eqia](http://www.eeic.org.uk/mcs/eqia) or scan the QR code with your smartphone or tablet

# Getting the board on board

## Packaging information for decision makers

*NHS Sheffield wanted to take an innovative approach to getting the message across to BME communities about the importance of acting FAST in the event of strokes. However, one of the key challenges proved to be getting the message to the board who makes funding decisions...*

### Make the case for innovative approaches

Making sure that people call 999 quickly when they suspect a stroke can make a big difference to outcomes, and is a national priority. When considering how to deliver the message across the North Trent Network of Cardiac Care, **the team realised there would be an extra challenge in reaching people from BME backgrounds**. They decided to try a social marketing approach to target tailored stroke messages to these communities: this had never been tried before in Sheffield.

### Collect evidence with the community as partners

The Campaign Company was brought in to **develop and test awareness messages with community members from several ethnic groups**. They collected a series of stories about what people did when someone they knew had a stroke, and identified potential ways to encourage people to make calling 999 their first priority. Armed with this qualitative evidence they went to the cardiac network board for further funding.

### Package your evidence for your audience

The board found the **information was too long, and not in a digestible format**. The group realised the clinically focused board needed a brief summary matrix of the key messages from the data, and produced numerical summaries of the qualitative data. At the next meeting they got board approval for the next stage.

### Train community activists

With funding for the next stage, the team has started training community members as 'champions', **spreading the message with customised materials to the wider community**. This model is being considered in other locations, and for other public health issues.

### Timing is everything

With the board only meeting every two months, there were delays in getting later phases going. The team also feels that it would be more difficult to get a new approach off the ground in the current funding squeeze, where **commissioners are increasingly playing it safe**.



For more information on this case study, including more details on the research, visit [www.eeic.org.uk/mcs/fast](http://www.eeic.org.uk/mcs/fast) or scan the QR code with your smartphone or tablet

## Translating aspiration into action

### How commissioners can provide space for innovation

*The 'right to request' scheme allowed the manager of the Bradford and Airedale PCT interpretation and translation service to turn it into an independent social enterprise called Enable2. But the road to independence was long and complicated, and there are still challenges in the new competitive market.*

#### Meet the needs of staff and plan for growth

A bank of translators, many from minority ethnic backgrounds, were keen to expand and increase the quality of their service. Becoming an independent organisation would allow them to bid for contracts from other public sector organisations and create innovative schemes to give apprenticeships to young people from Bradford struggling to find work.

#### Recognise and take advantage of opportunities

The manager submitted an initial 'right to request' to the PCT board to become a social enterprise. The board knew about the strengths of the service and were supportive of the idea of it being allowed to grow and innovate. With money won from the Social Enterprise Investment Fund, **the team hired an expert to help prepare a detailed and costed business plan and risk assessment** to submit for the next phase. This evidence of how the service could work was essential to proving to the PCT board that the project was viable.

#### Build strategic alliances

The organisation needed a board, and having the right people volunteer was essential. **By having one of the PCT deputy directors around the table, there was corporate buy-in, and input from the major customer.** The manager of a local haulage firm also sits on the board and brought years of experience in running a successful business to the table. While networking with other newly formed social enterprises in different fields, each realised there was an opportunity to work together, to share ideas and combine purchasing power.

#### Create a space for innovation

By recognising the potential for the translation service to grow and innovate, **commissioners have been able to nurture a service that can grow** and deliver better services more efficiently in the long run. An on-going, constructive relationship between the purchaser and provider ensures services continue to improve.

#### Playing the competitive game

Enable2's main challenge now is winning tenders against for-profit services who offer seemingly cheap, but lower quality services. Enable2 will have to **use evidence to show their proven track record, and that good translation is more cost effective in the long run.** But this will be a challenge when public sector customers are trying to save every penny.



For more information on this case study, including details of networks of social enterprises and links to the Enable2 website, visit [www.eeic.org.uk/mcs/enable2](http://www.eeic.org.uk/mcs/enable2) or scan the QR code with your smartphone or tablet

## Building brick by brick

### Innovating and growing new services

*The Health Integration Team at Barnsley PCT has worked since 2003 to promote access to health and social care services to new migrants and asylum seekers. The service has grown to provide health services including advice for new migrants and asylum seekers in initial accommodation, health screenings and school road shows. The team has now expanded to work with gypsy, Roma and traveller communities.*

#### Taking the initiative

A lack of appropriate services and limited information for asylum seekers was concerning practitioners working with the Initial Accommodation Centre, a service for asylum seekers commissioned by the Department of Health. The practitioners **worked with a local commissioner to build a case for providing an initial health check and screening** for infectious diseases in new arrivals, and information on local health and social care services.

#### Working in partnership

The team developed supportive pathways with voluntary agencies for people with HIV and survivors of rape. It **developed strong links with other health teams regionally and nationally** as well as local statutory and voluntary service providers. Crucially, the local commissioner and provider see delivering services that meet the needs of disadvantaged patients and users as their joint responsibility.

#### Enhance use of documentation and evaluation

The team has commissioned local research to inform the project. It also uses audit tools to **demonstrate the value of the service, as well as identifying areas for improvement**. However, there is a need to properly monitor all the activities and have regular evaluations to improve project delivery and demonstrate impact.

#### Transferring the evidence

TB was one of the main health problems among the new arrivals. The team struggled to persuade funders to try a new technology for TB detection called T spot blood test, which would show more recent infections that would be missed by the existing system. This new test had a proven track record in Africa, but could not be used until it had been shown to work in a UK context. It took the team years to secure a small amount of funding from the Department of Health to run a pilot, and the new test was only adopted after another organisation successfully used this test in the UK. Barnsley PCT has now commissioned this service, but this example illustrates the difficulty in transferring evidence from different contexts.



For more information on this case study, including details of the research and evaluations the team use, visit [www.eeic.org.uk/mcs/hit](http://www.eeic.org.uk/mcs/hit) or scan the QR code with your smartphone or tablet

## Evidence begets evidence

### Drilling down to gain deep understanding

Coventry PCT was running a pilot intervention called the Expert Patient Programme (EPP), where patients with chronic health conditions are trained by peers to build confidence and expertise in managing their condition. However evaluation showed no attendance by BME people in the programme. Further investigation was undertaken to unpack the causes for non-attendance of BME people.

#### Recognise the gap in service use

Coventry University had undertaken a pilot study of the EPP, in close association with the commissioner at Coventry PCT. Looking at the data with an eye to possible inequalities, it was clear that there was **non-attendance from minority ethnic communities in the EPP, despite operating in areas of high ethnic diversity**. The team drew on other academic evidence, including a study by Warwick and Coventry Primary Care Research, which confirmed the generic acceptability of chronic condition self-management in South Asian Indian Hindi and Sikh Groups; the biggest ethnic minority populations in the EPP area.

#### Generate evidence for appropriate action

The commissioner wanted to understand the reasons for non-attendance of BME people on the course, with a view to expanding the reach of EPP in Coventry for these groups. She collaborated with the researchers to win funding from Arthritis UK to further explore the facilitators and barriers to uptake of self-management support among Punjabi Sikh women.

#### Deliver targeted solutions

Coventry PCT appointed a member of staff with expertise of Punjabi Sikh culture and language, ensuring good participation from Punjabi Sikh women and that the findings could effectively inform development of the EPP courses for this group. The BME EPP specialist led to the **delivery of the programme in many different languages** by tri-lingual volunteer tutors, resulting in increased participation by BME patients. Coventry PCT is now bucking the national trend of struggling to attract BME attendees on this course.

#### Evaluate the impact of service improvement

A local evaluation by PCT commissioners supported the on-going necessity of this specialist role, and will help establish whether the intervention was effective across other health issues. The role has now been expanded beyond EPP to consider broader health inclusion issues for BME groups.

#### Strengthen the partnership at the organisational level

The partnership between the PCT and University has grown to include the local Council and carers centre. However, many members of the original team have moved on, and regular networking events between Coventry PCT and Coventry University could lead to more productive work in future.



For more information on this case study, including more details on EPP and self-management, visit <http://www.eeic.org.uk/mcs/epp> or scan the QR code with your smartphone or tablet

# Commissioners and providers as partners

## Evaluation and piloting with third sector providers

*Sharing Voices is a community organisation that provides services to improve the mental health and wellbeing of inner-city Bradford residents, where over 50% of people are from a BME background. For the last 10 years, the organisation has developed constructive links with the PCT and provider trust to deliver comprehensive services as a team.*

### Work out the strengths of all your providers

Sharing Voices recognise that generic psychiatric services were not always the best way to help people from minority ethnic backgrounds, and are able to **tailor support to the needs of their clients** using long-term, in-depth assessments. By targeting these services to individuals that would benefit the most from them alongside the standard treatment models, there are services suitable for everyone in the locality.

### Share evidence of service use

Sharing Voices makes sure they can **document and provide evaluation data for their services**, so that commissioners can have evidence that the work is being done effectively. In mental health, this also raises confidentiality issues, especially where there are small numbers of clients with very specific issues. Client feedback and stories prove the worth of the services without needing huge quantities of data, but must be anonymised.

### Build strong relationships between providers and commissioners

Key to the success of Sharing Voices has been the good relationship it has with its commissioners in the care trust and PCT. This takes time and commitment from all partners, but has ensured Sharing Voices staff have had input into PCT consultations and that **commissioners can rely on the organisation to deliver good services** without micro-management.

### Lightweight responsiveness

Small service delivery organisations can adapt quickly to the needs of their clients and providers. For example, a successful idea Sharing Voices had to train Imams (Islamic leaders) to deliver culturally appropriate mental health advice was able to get off the ground quickly. When the PCT wanted to trial a mental health screening tool called SUNSHINE, Sharing Voices was able to direct feedback from a pilot they ran.

### Dual identities

Sharing Voices often has a dual role; as a service provider, but also as advocate and source of insight to make services better for the BME community. Juggling these roles can sometimes be tricky, but commissioners may sometimes need to work closely with providers and develop the market before they can deliver the best services for minority communities.



For more information, including links to the SUNSHINE and Listening Imam projects, visit [www.eeic.org.uk/mcs/sharing](http://www.eeic.org.uk/mcs/sharing) or scan the QR code with your smartphone or tablet



# Champions for change

## Raising awareness to reduce ethnic health inequalities

*NHS Leeds wanted to ensure its cardiac rehabilitation services considered the needs of BME service users at higher risk of poor health outcomes, but lacked ethnicity data on local patterns of service delivery and outcomes for diverse ethnic groups. Improving local data linked to key performance indicators helped refocus resources to identify and address service user needs.*

### Build the team

Staff at NHS Leeds wanted to utilise national guidance on ethnicity and underuse of cardiac rehabilitation services. The multidisciplinary redesign team included the Commissioning Manager for Long Term Conditions, the Cardiac Rehabilitation Service Manager, a Consultant in Public Health and a GP with special interest in coronary heart disease (CHD).

### Build on evidence from national and local data

A local Health Needs Assessment showed higher mortality and morbidity from CHD in deprived areas and lower access to services such as vascular checks. Deprivation disproportionately affected service users from minority ethnic backgrounds, but as local ethnicity data about patients with CHD was very limited, national data was used to fill the gaps. New specifications for cardiac rehabilitation services included a target for routinely collecting ethnicity data, and a separate group is promoting ethnic monitoring by GP practices.

**Increasing awareness about national policy and the links between ethnicity and specific clinical outcomes helped to influence the approach** of the heart failure group.

### Work with what is available

The team unsuccessfully tried to obtain additional resources to support the service redesign. Despite this, two cardiac nurses were appointed using existing resources with a specific remit to engage with higher risk BME service users and relevant voluntary organisations.

### Train and develop operational staff

Following the new appointments, training for the whole staff team provided an opportunity for cardiac rehabilitation nurses to **discuss issues of concern, strategies for better engagement and effective ways of working** with the BME groups in question.

### Individuals can make a difference

The redesign team acted as champions for reducing ethnic health inequalities in a context focusing on overall clinical outcomes and generic service pathways. Their progress was slowed by a change in the project management at a late stage of the redesign process leading to a steep learning curve for the new Commissioning Manager. However, the new Manager's enthusiasm for the work helped the team to regain momentum.



For more information on this case study, including more details on the research, visit <http://www.eeic.org.uk/mcs/cardiac> or scan the QR code with your smartphone or tablet

# The Evidence and Ethnicity in Commissioning project

This mini-case study guide is part of a larger two year project looking at health commissioners' use of evidence on ethnic diversity and inequality when commissioning for multi-ethnic populations. The funding comes from a NIHR work-stream looking at ways to improve the use of evidence, especially research evidence, in the NHS.

The project is a collaboration between Sheffield Hallam University, the University of Leeds and the PCTs serving Sheffield, Leeds and Bradford. The aim is to identify barriers and obstacles to systematic and critical use of evidence on ethnic diversity and inequality in commissioning, and to develop tools and interventions that can support commissioners. This project has used more than 40 key informant interviews with health professionals, including commissioners, 3<sup>rd</sup> sector organisations, DH, PCT and SHA senior staff. In addition, detailed case studies in Leeds, Bradford and Sheffield have used interviews, participant observation and document analysis to examine first-hand how commissioners are using evidence.

A key part of the project design is the involvement of three PCT based co-researchers, one from each study area; who are examining their own work, interviewing colleagues and shaping the investigation to understand the best ways to increase the use of evidence. Ultimately, the project's goal is to contribute to better access, experiences and outcomes for BME people using health services.

During the planning for the main project, many participants from existing commissioning organisations expressed concern that expertise developed in understanding and meeting the needs of BME people could be lost as posts were lost or relocated during the NHS restructuring.

A public call for submissions was made on the Ethnic Minority Health JISCMail e-mail group and other professional networks. In addition, interviewees in the main EEiC project were asked to identify examples of good practice, to invite to take part. Participants sent back a brief form outlining their project, and how commissioners and evidence had been part of the process. From these, a sample was chosen of projects that had used evidence on ethnicity to inform commissioning, and provided a wide picture across many different areas of health.

A semi-structured interview was conducted with at least one person for each case study, often this was the commissioner, project lead, or other staff who were involved in the instigation or design of the project. These interviews were recorded, transcribed, and analysed alongside key documents from the project, such as proposals, briefs, contracts, board presentations, and evaluations. From this information, the researchers summarised the story and 'evidence journey' of each project, sharing drafts with the interviewees to get comments and corrections. For this booklet, a micro-summary was prepared for each case study, drawing out key messages illustrated by each particular project. More extensive descriptions for each case study are available online and linked on the bottom of each page.

For more information and reports from the project, visit [www.eeic.org.uk](http://www.eeic.org.uk)

## Glossary

BME	Black and Minority Ethnic
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
DH	Department of Health
E&D	Equality and Diversity
EEiC	Evidence and Ethnicity in Commissioning
EPP	Expert Patient Programme
EqIA	Equality Impact Assessment
GP	General Practitioner
HIV	Human Immunodeficiency Virus
JISCmail	An academic e-mail network
NHA	Health Needs Assessment
NHS	National Health Service
NIHR	National Institute of Health Research
HS&DR	Health Services and Delivery Research
PCT	Primary Care Trust
QR code	Quick Response Code - a visual barcode that can be read by a smartphone or tablet camera
SHA	Strategic Health Authority
TB	Tuberculosis

# Mini-case study book on evidence and ethnicity in commissioning

Designed for all commissioners and practitioners in health and social care, this collection of 10 case studies shows how evidence can be used in commissioning for multi-ethnic populations to:

- Raise the profile of BME issues
- Understand particular needs and causes of inequalities
- Design solutions
- Monitor and create on-going improvement

Short, direct, and easy to read, these taster stories link to more detailed descriptions at [www.eeic.org.uk](http://www.eeic.org.uk) to help overcome common barriers in service design and delivery, and give practical, real-world examples of using evidence in innovative ways.

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Hallam  
University** | Centre for Health  
and Social Care  
Research

**EEiC** Evidence and Ethnicity  
in Commissioning

# Sheffield Hallam University

*Mini Case Study Book Real world examples of using evidence to improve health services for minority ethnic people*

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Available from the Sheffield Hallam University Research Archive (SHURA) at:

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