



Better
Health
Briefing **28**

**High Quality
Healthcare
Commissioning:
Obstacles and
opportunities for
progress on race
equality**

Sarah Salway, Daniel Turner,
Ghazala Mir, Lynne Carter,
John Skinner, Bushara
Bostan, Kate Gerrish and
George Ellison

A Race Equality Foundation
Briefing Paper



www.better-health.org.uk

Key messages

- 1 Healthcare commissioning has the potential to tackle inequalities in access, experiences and outcomes between ethnic groups. However, organisational cultures and structures frequently fail to support attention to ethnic diversity and inequality, while individual commissioners often do not recognise their responsibility, and lack the skills and confidence, to engage in this work.
- 2 Sustained and meaningful dialogue with both service providers and minority ethnic patients, carers and members of the public, can help to improve understanding of problems and find creative, viable solutions.
- 3 Effective mobilisation of wider evidence is essential. While accessing, interpreting and applying evidence on ethnic inequalities in health and healthcare is often challenging, there are robust strategies to address these issues, and commissioners can do more to access relevant sources and drive improvements in data collection and use.
- 4 Looking across the whole commissioning cycle, there are many missed opportunities to integrate attention to ethnic diversity and inequality. A range of stakeholders should be encouraged and equipped to both challenge and support commissioning organisations to take effective action on ethnic inequalities.

Introduction

This paper draws on findings from the Evidence and Ethnicity in Commissioning (EEiC) project¹, together with practice experience and other research, to highlight obstacles and opportunities for healthcare commissioning to enhance access, experiences and outcomes for minority ethnic people. The aim of the paper is to describe typical elements of commissioning work and to point out a range of actions that clinical commissioners, commissioning managers and other stakeholders can and should take to improve healthcare commissioning for multi-ethnic populations. An earlier Better Health Briefing Paper (Salway et al., 2013) presents the case for why healthcare commissioning must make race equality² a central concern.

Commissioning can be described as "the set of linked activities required to assess the healthcare needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes" (Woodin, 2006: pp203). As such, commissioning organisations have a key role to play in making progress on ethnic (and other) inequalities in healthcare access, experience and outcomes (Turner et al. 2013). NHS provider organisations have a legal duty to strive for equality in service access and provision and should be responsive to their own internal mechanisms that support this, such as clinical guidelines and professional standards linked to cultural competence, as well as patient satisfaction monitoring and clinical audit. However, commissioning organisations have a much broader

responsibility, and opportunity, to shape healthcare services so that they meet the needs of all groups within their local population. Commissioners must take a 'whole systems' approach, identifying gaps in service provision and opportunities for joined up working, as well as encouraging high quality, efficient and equitable care within existing service provision. There are also opportunities for commissioners to save the NHS money by addressing these issues: the 'Marmot Review' estimates that additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year (Marmot et al., 2010).

Commissioning organisations are also well placed to share learning and mobilise knowledge across the local health economy so that common obstacles to meeting diverse needs can be better understood and solutions effectively shared. However, Primary Care Trusts (PCTs), which from 2002 until very recently had responsibility for commissioning most local health services (Smith et al., 2006), made a disappointing contribution to tackling ethnic inequalities. Despite pockets of good practice, and some innovative local projects, PCTs did not generally embed attention to ethnic diversity and inequality within their commissioning action.

Race Equality Foundation Better Health Briefing 27 describes in general terms the current tendency for ethnic inequalities work to be side-lined within commissioning, and the need for commissioning organisations to establish strategic enabling environments that embed this agenda across all areas of work. The EEiC project and other research have also highlighted a number of obstacles at operational level that can hamper attention to ethnic diversity and inequality within commissioning activity. Given the current restructuring of the NHS,³ there is an opportunity for new commissioning organisations to learn from this experience and improve on poor past performance. There are three cross-cutting areas that require attention: organisational environment; stakeholder engagement; and evidence use. The paper then moves on to describe different aspects of commissioning work in order to highlight more specifically how ethnic diversity and inequality can and should be considered.

1

Commissioning organisational structures, processes and culture

The EEiC project revealed how marginalisation of the race equality agenda from commissioning priorities is reflected in the cultures, structures and operational processes of commissioning organisations. It found that PCT staff with an equality and diversity (E&D) remit were few in number (and declining) and often remote from 'core' commissioning activity. Meanwhile, the much greater resource devoted to quality and efficiency agendas, as well as routine performance monitoring, was not generally harnessed for equalities work. While overarching strategic documents were found to include general statements about the ethnic diversity of local populations and the need to address health inequalities, core documents that direct commissioning processes, such as those relating to quality assurance, are largely silent on ethnic diversity and inequality.

There is uncertainty among commissioning managers regarding whether it is appropriate to focus on the needs of minority ethnic groups, with some expressing concern that to do so would mean 'privileging' these groups, rather than viewing such attention as addressing unfair disadvantage. There is also a lack of awareness regarding what effective strategies might look like, and a tendency to place responsibility for identifying viable service responses with provider organisations. Individual commissioning managers may also lack the skills and confidence to engage in work around minority ethnic needs and the make-up of commissioning teams does not usually consider equalities expertise. Furthermore, processes that are designed to alert commissioners to ethnic (and other) equality considerations, such as Equality Impact Assessments, are widely considered to be 'tick box' exercises with no tangible influence on practice. While it is clear that there are areas of good practice, and passionate individuals who have instigated positive change, since organisational cultures do not generally give status to such work, it tends to remain project-based and isolated so that learning is not shared and approaches to 'core' commissioning work remain unchanged.

Importantly, findings from a number of earlier investigations have noted that attention to ethnic diversity and inequality within healthcare organisations is not linked to the level of ethnic diversity in the local population, but rather seems to depend on recognition of the links between ethnicity and health and the responsibilities of organisations to address inequality (LGID, 2010; Aspinall, 2000). Race Equality Foundation Better Health Briefing paper 27 sets out some broad factors that might help to shift commissioning organisational environments so that they are more enabling of efforts to mainstream attention to ethnic inequality as well as highlighting the need for action to:

- Align race equality with core commissioning agendas
- Clearly spell out: how ethnicity relates to health; what standards of service provision are expected; and what commissioning responses are appropriate
- Ensure that sufficient resource is allocated to this agenda
- Performance manage and reward progress
- Equip commissioners with the skills to undertake this work.

2

Partnership working and meaningful engagement

Many people can and should contribute to the commissioning arena, even though only some of these would consider themselves to be 'commissioners'. There is huge variety in terms of where and how commissioning action takes places, and particularly in terms of the extent to which service providers, patients and members of the public are engaged in the process. Providers, particularly front-line practitioners, often have creative solutions and important insights into need, and findings from the EEiC project and elsewhere suggest that service provider engagement is crucial to improving services for minority ethnic people (see for example, NMH DU, 2009; NHS East Midlands 2012). Additionally, where commissioners have little choice about who they procure services from, service improvement is impossible without provider buy-in to

proposed changes. Nevertheless, NHS providers can often be part of the problem, and commissioners must find ways to challenge them to improve their offer to minority ethnic people. Effective engagement of the Voluntary, Community and Faith (VCF) sector can be crucial to understanding minority unmet needs, but such inputs are not always valued by commissioners, and VCF organisations are often not 'at the table' when important commissioning work is undertaken.

Commissioners must also gain meaningful input from patients and the public, and should use structures and mechanisms that achieve this for minority ethnic communities. Respondents in the EEiC project were critical of commissioners who used consultants and intermediaries to undertake engagement and insight work on their behalf, arguing that this perpetuated commissioners' disconnection from marginalised groups and undermined community confidence that 'consultation' exercises would have any influence on the system. However, there is also evidence that the recently implemented Equality Delivery System has improved stakeholder engagement on equalities issues in some places (as discussed in Equal Opportunities Review, July 2012) and of some PCTs making sustained investment in structures to effectively channel minority perspectives into the commissioning process. Efforts to enhance stakeholder engagement across all elements of commissioning work seem crucial to improving services for minority ethnic people as we move into the new commissioning structures.

3

Mobilisation and use of evidence

Commissioners are increasingly expected to base their actions on sound evidence, bringing together strong local intelligence and nationally agreed evidence-based guidelines to shape high quality, efficient service provision. In practice, of course, evidence-informed commissioning is far messier, with often significant gaps in information and a range of other priorities shaping commissioners' responses to local issues and national drivers. Nevertheless, an evidence-based culture can impede progress on ethnic inequalities, with the potential that an absence of evidence will both undermine the confidence of commissioners to invest in new initiatives and provide justification for maintaining the status quo of inaction.

Significant obstacles to identifying, understanding and addressing ethnic inequalities may include:

- A lack of basic information on the size of local ethnic minority populations
- Incomplete ethnic monitoring data at service level
- A lack of published evidence on the effectiveness and cost effectiveness of potential interventions
- Limited accessibility or awareness of other relevant research evidence.

However, at the same time, the EEiC project found that many commissioners failed to request information broken down by ethnicity, overlooked relevant evidence sources (for instance, from local research studies or from VCF organisations) and assumed an absence where in reality data were available. A preference for quantitative over qualitative data could lead to some sources of evidence - for example, from community

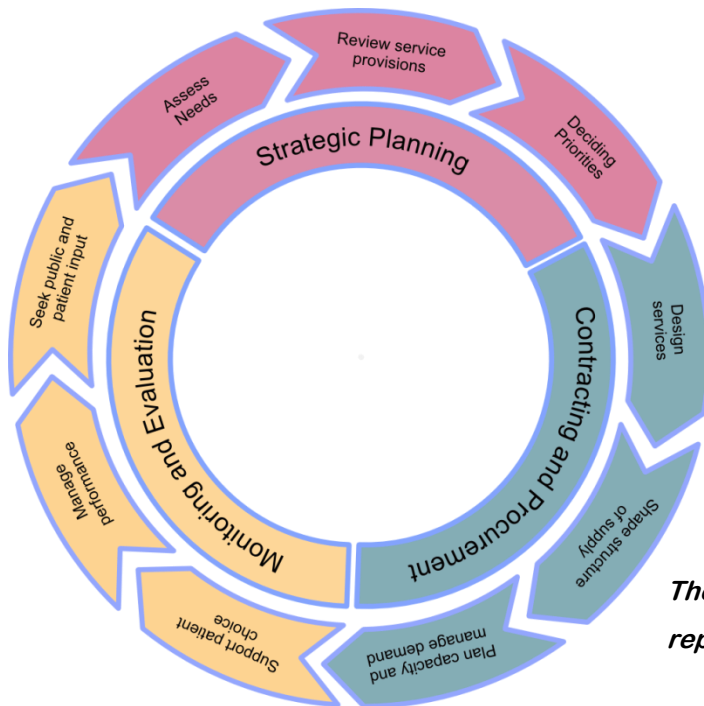
consultation or patient experience surveys – being discounted. Concerns about small sample sizes meant that data on some populations was excluded from consideration rather than being appraised in light of appropriate statistical advice. It was also common to find that data inadequacies, though recognised, were allowed to persist year-on-year, without commissioners putting in place actions to drive up data quality and completeness. The paucity of local information published by many PCTs in April 2012 as part of the requirements of the Equality Act 2010 is testament to that fact that insufficient work has been done to improve the local collection of health-related information by ethnicity (as well as other protected characteristics).

As well as shortcomings in the generation and mobilisation of relevant evidence, the EEiC project found that support was needed to enhance commissioning skills in making sense of and applying evidence. A very wide range of information/knowledge/evidence can be useful in commissioning work, but such disparate sources must be appraised and brought together to build a coherent picture. The project found that equality and diversity staff members, who might champion the race equality agenda, were not necessarily skilled and confident evidence users, and were also often distant from data analysts and people with stronger evidence skills who did not necessarily recognise the need for a focus on ethnic inequality. Questions about the credibility of evidence or a failure to comprehend the issues at hand could, at least in part, be due to ineffective presentation and packaging.

Finally, the EEiC project found that there was much room for improvement in terms of managing knowledge within, and sharing knowledge across, commissioning organisations. While no doubt a general issue, the implications of poor knowledge management for an area of practice that is marginal and poorly resourced are significant. Rather than PCTs playing an active role in compiling knowledge about local minority ethnic populations and sharing elements of effective practice across work-streams, service areas and organisations, the researchers found examples of: forgotten reports sitting on shelves; commissioning teams working in isolation to generate insight about particular communities; poor systems for organising and storing evidence; and commissioners failing to seek out existing experience and evidence on a topic area, opting instead to start from scratch.

4

Missed opportunities within the commissioning cycle



The NHS Information Centre's representation of the commissioning cycle

Commissioning is often portrayed as a structured and planned process, represented by a continuous cycle through which services are improved and developed against past experience and emerging population health need. The NHS Information Centre shows this cycle with three phases: strategic planning, procuring services, and monitoring & evaluation - though there are a number of similar representations, using slightly different terminology. In practice, however, commissioning resources are limited and commissioning organisations have to make choices about where they invest their time and skills. Therefore, for many areas of service provision, commissioning activity will focus entirely on contract monitoring and even here the large size of some contracts, and limited level of detail that can be specified, mean that some services are not subjected to any scrutiny by commissioners at all. Instead they are guided entirely by the provider organisations' own guidelines and procedures which in turn will be shaped to a greater or lesser extent by national guidance, professional standards and patient/carer feedback. More 'transformational' commissioning work, involving detailed needs assessments, review of existing provision, re-specification of pathways and so on, is therefore confined to a few particular areas of work seen as high priority. Such work programmes may be ongoing and extensive, drawing in diverse stakeholders and often being driven by national policy priorities, for example those set out in National Service Frameworks and NICE Quality Standards. However, they may also be more time-bound and focused, often responding to particular quality or efficiency (cost) concerns that have come to light via benchmarking processes or, in some cases, a set of local circumstances.

The amount, nature and organisation of transformational work varied considerably across PCTs (Smith et al., 2006, 2010). Nevertheless, the government's aspiration for commissioning organisations to play a stronger role in driving up the quality and efficiency of health services is clearly evident in the QIPP (Quality, Innovation, Productivity and Prevention) transformational programme, with its range of resources to assist commissioners in their role, including: comparative expenditure data; benchmarking of quality indicators; and a growing number of detailed disease-focused commissioning tool-kits. However, few of these national resources include consideration of ethnic diversity and inequality and at local level there were many missed opportunities for attention to ethnic inequality in the commissioning process.

4.1 Strategic planning (assessing needs, reviewing provision and deciding priorities)

Findings from the EEiC project and elsewhere suggest that commissioning organisations rarely focus comprehensive assessments of unmet health need on minority ethnic groups. A recent review of 20 Joint Strategic Needs Assessments across England identified significant shortcomings in relation to ethnicity (LGID, 2010). In addition to gaps in descriptive information, this report highlighted the limited recognition of the complex links between ethnicity and health and inadequate exploration of causes of observed inequalities. Earlier work has highlighted the persistent gaps in ethnic monitoring at service level (Fulton, 2010) but there is also frequently a failure to exploit existing monitoring data or to draw on other sources of information, for instance patient satisfaction surveys or the experiences of front-line professionals. The LGID report also found that while some JSNAs had used service data to highlight low uptake by minority ethnic groups, particularly in relation to social care, these were rare exceptions. Finally, it remains uncommon for commissioning organisations to systematically identify priority actions for addressing unmet needs and ethnic inequalities, whether in focused areas of commissioning work or more broadly. The LGID (2010) report found that none of their reviewed JSNAs were 'excelling' in this regard, and only 30% were making some progress. The EEiC project found that though some attempts had been made in this direction by committed individuals, they had not been embraced by the wider commissioning organisations. For instance, though there is evidence of some good pieces of focused needs assessment and insight work being undertaken with minority ethnic communities, this work tended to be isolated and the knowledge generated to be short-lived, rather than contributing to growing, collective organisational understanding. Institution-wide strategies to address ethnic health inequalities at a whole-system level, and commitment from senior management were lacking, underlying this piecemeal approach.

It seems clear that many commissioners are missing opportunities to better describe, understand and prioritise action on the unmet health needs of minority ethnic populations, and that the structures and cultures of commissioning organisations do not currently highlight or penalise these omissions. However, some commissioners are taking more concerted and creative action in this regard, and other stakeholders are also making an important contribution.

Promising practice 1

This table gives examples of positive practice that may be used to inform the commissioning process:

- *Creative and careful combination of national and local data to fill gaps*

For example, a commissioning manager at NHS Sheffield used national data on levels of coronary heart disease by ethnicity from the Health Survey for England 2004, plus local information on population profiles and in-patient activity, to identify potential inequalities in access to revascularisation among Asian/British Asian people. In the absence of published research, this led to a small local qualitative study focused on Pakistani women that identified factors along the care pathway undermining access to this life-saving procedure (Piercy et al. 2012)
- *Initiatives to improve the collection and use of ethnic monitoring data* (Fulton, 2010; Hull et al., 2011) *and other types of evidence* (as highlighted in the LGID report, 2010)

For example, the Princes Park Model in Liverpool was documented over 10 years ago (www.nwpho.org.uk/reports/Ethnic%20HEALTH%20RE-lay.pdf). A heart failure commissioning group in Leeds used audit procedures to incrementally build up currently unavailable data and review it annually to inform service planning; a similar approach could be used for ethnicity data.
- *Focused needs assessments involving research or insight work with particular communities or on particular service areas.*

For example in Liverpool, focused investigation with the Somali community provided important insights into local issues and behaviours that shaped effective responses to widespread vitamin D deficiency (www.eeic.org.uk/mcs/vitd).
- *Mechanisms that facilitate the ongoing flow of insight and evidence from minority ethnic communities into the commissioning process*

For example, Kensington & Chelsea and Westminster BME Health Forum aims both to empower communities to engage effectively in debate with health services and to enable statutory services and health professionals to understand and respond to the needs of minority ethnic communities (www.bmehf.org.uk/).
- *Review and synthesis of evidence on need and experiences across settings and careful consideration of its relevance to commissioning*

For example, Maternity Action has produced a useful document on commissioning maternity services for vulnerable migrants (www.whec.org.uk/wordpress/?page_id=306).

4.2 Contracting and procuring services (service design, shaping the structure of supply, managing demand)

Once ethnic inequalities in service access, experiences or outcomes have been recognised, commissioners should play a key role in both challenging and supporting providers of existing services to make improvements. Commissioners should also lead on shaping service developments that aim to tackle priority gaps or inadequacies in existing provision, whether in the form of specialist services or enhancements to current services. In addition, commissioners should ensure that transformational work prompted by national drivers and/or efficiency or quality concerns does not overlook ethnic equalities issues. Clearly, undertaking such service improvement work requires a wide range of knowledge and expertise and while commissioning

commissioners cannot be expected to have all the answers but they should ask the right questions and mobilise expertise and evidence from varied sources to answer them. However, the EEiC project suggests that commissioners are rarely playing this active role and that a range of obstacles needs to be addressed.

First, commissioning managers may question the legitimacy of focusing on ethnic inequalities, feeling that this could detract from service and pathway redesign work that should benefit 'the whole population'. Some commissioners, having identified an area of ethnic inequality, then struggled to make progress on addressing it. There was wide variation in the extent to which commissioners worked cooperatively with provider organisations to support their improved delivery of services to minority ethnic people. Though some commissioners were clearly instrumental in shaping service responses, it was common for others to view finding solutions as beyond their remit. While external input was sometimes sought within the context of a structured, deliberative process, in other cases commissioners appeared to abandon responsibility, expecting provider organisations to develop effective responses within the boundaries of an existing contract. The latter approach is clearly problematic since provider organisations may well not have the motivation, skills or resource to make the necessary improvements.

Interestingly, in some cases both commissioning and providing managers expressed frustration at the unwillingness of the other party to devote time to finding solutions to ethnic inequalities. Wide variation also exists in the evidence sources drawn on in seeking solutions, with missed opportunities to:

- Learn from innovations taking place elsewhere
- Synthesise published evidence on 'what works'
- Engage with affected communities and VCF organisations.

In practice service specifications, whether locally initiated or based on national templates, often contain very limited detail on the needs of minority ethnic people, the types of inequalities they may face, or how the service is expected to respond to these issues, including instead very generic statements about ensuring equitable provision for all that fail to prompt effective action.

This element of the commissioning cycle will often require leveraging resources to fund proposed service improvements. This may involve commissioning managers (or indeed stakeholders from provider organisations or community groups): negotiating for reallocation of resources within a fixed spend; 'bidding' internally for investment (for instance by making an invest-to-save proposal to a QIPP programme); or perhaps putting an application to an external source of funding designed to encourage innovation. Regardless of who is making this case, it can often be challenging to prepare a strong business case in the face of incomplete local data and very limited evidence on the cost effectiveness of proposed interventions. Nevertheless, evidence gaps need not necessarily hamper progress and the effective synthesis, packaging and communication of evidence can be key to securing decision-makers' support for proposals (van Kammen et al., 2006; Walter et al., 2003). This influential use of evidence can be particularly important when the focus is on an issue that is currently marginalised from the core focus of commissioning organisations.

Promising practice 2

- Using needs assessments to inform the development of service specifications that include specific detail on why and how the needs of minority ethnic patients must be addressed by the service*

For example, in Coventry, engagement with South Asian people led to the re-specification of the self-management service to include a link worker and course provision in different community languages (www.eeic.org.uk/mcs/epp).
- Systematically drawing on learning from other parts of the country to inform service development*

NHS Sheffield gained funding from CLAHRC (SY) to undertake a formative review of existing services addressing the issue of consanguinity and rare recessive genetic disorders to inform the development of a service response in Sheffield. This review has also been made available for others to learn from (Salway, Ratcliffe et al. 2012).
- Establishing and maintaining mechanisms for sharing learning and materials to support better service specification for minority ethnic people*

For example, the Health Equality Library Portal run by NHS North West (www.help.northwest.nhs.uk).
- Establishing and promoting standards for care and service delivery that address particular issues faced by minority ethnic service users*

There have been some useful attempts at guidance and standards for commissioning advocacy services for black and minority ethnic people (see: www.scie.org.uk/publications/guides/guide21/files/guide21.pdf and www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/standards-framework-delivering-effective-health-social-care-advocacy-black-minority-ethnic-Londoners-rukshana-kapasi-mike-silvera-kings-fund-1-march-2002.pdf).

4.3 Performance monitoring and evaluation

Commissioning frameworks recognise that the commissioning task does not end once services have been procured. Instead, commissioning has a central role in performance monitoring services against outcome indicators and evaluating them more broadly to: understand how services are functioning; establish the impact of any changes made; and swiftly identify emerging issues that may require service modification.

The EEiC found that routine monitoring of service performance, whether undertaken at a local level (for instance via contract meetings and review of Key Performance Indicators) or drawing on national resources (for instance via the benchmarking of NHS Outcome Framework indicators or expenditure patterns) rarely had a focus on ethnic diversity and inequalities (or indeed equality at all). Outcome indicators were rarely specified in terms of ethnicity and available levers within contracts, such as general statements around ensuring equitable access, were rarely used to support service improvements for minority ethnic people. This in turn meant that prompts for active, ‘transformational’ commissioning work were primarily efficiency (i.e. excess spend) or quality driven.

There was evidence that some commissioners did not believe their role was to look in detail at whether services met the needs of minority ethnic people, considering this level of scrutiny to be too detailed or complex. However, this approach is clearly inconsistent with other areas of performance monitoring, particularly various detailed quality indicators that commissioning organisations report against regularly. Some commissioners appeared to shy away from performance monitoring against this agenda, assuming that such a focus would mean unnecessary complexity and/or resistance by providers. Interestingly, however, there were examples of providers suggesting the need for outcome indicators defined by ethnicity and expressing disappointment that commissioners did not scrutinise performance in this way. Further obstacles to performance monitoring by ethnicity were inadequate routine data collection and lack of disaggregated service user feedback. In addition, a focus on achieving short-term savings discourages the monitoring of areas where deeply ingrained inequalities mean progress is slow, difficult to quantify, and incremental gains must be recognised. Despite the overall rather gloomy picture, some promising areas of work were identified.

Promising practice 3

- *Developing Key Performance Indicators that demand ethnic breakdowns and include explicit targets for minority ethnic groups.*

A smoking cessation service commissioned by NHS Sheffield included explicit targets for black and minority ethnic service users as well as other under-served groups.

- *Using the Commissioning for Quality and Innovation payment framework (CQUIN) to link a proportion of contract payment to outcomes for minority ethnic groups.*

For example, in Yorkshire & Humber PCTs developed a CQUIN related to the care of minority ethnic patients in its contract with NHS mental health service providers.

- *Use of service quality improvement plans or KPIs around ethnic monitoring to encourage improvement in data collection prior to introducing more specific outcome indicators.*

- *Use of Equity Audits to provide an in-depth picture of access and outcomes across ethnic groups*

The Tower Hamlets Health Equity Project in East London used GP practice data to produce Equity Audits that identified ethnic inequalities in access to self-management intervention for chronic diseases and thereby informed action to address these inequalities

(www.icms.qmul.ac.uk/chs/ceg/health_equality_programme/index.html)

- *Engagement of service user groups and members of black and minority ethnic communities in service evaluations*

For example Kent and Medway engaged with Race for Health to facilitate a peer review of their mental health services (www.raceforhealth.org/resources/peer_review_reports).

- *Commissioning independent service evaluations that take an explicit focus on the needs and experiences of minority ethnic patients*

For instance, NHS Sheffield and South Yorkshire Eating Disorders Association commissioned an internal scrutiny and external consultation exercise to identify ways in which the eating disorders service could be more appropriate to minority ethnic needs (Chowbey et al., 2008).



Conclusion

To-date, commissioning has not been a significant lever towards reducing ethnic inequalities in healthcare access, experiences and outcomes. Indeed, in common with other areas of health service development where some progress has been made, this has more often been the result of efforts driven by health and social care providers (see for instance Ham et al., 2011 on integrated care). Nevertheless, there are many potential opportunities that commissioners can take and examples of good practice that can be emulated (see below for some key actions). In the absence of strong national directives and infrastructure, it is up to individual commissioning organisations to ensure that the principles and processes guiding their work give adequate and consistent attention to understanding and responding to the ethnic diversity and inequality within their catchment populations. To achieve this aim, commissioning organisations will need to ensure that they establish and sustain meaningful dialogue with key stakeholders, including local communities. At the same time, there is a clear role for these wider stakeholders, particularly NHS and third sector provider organisations, healthcare practitioners, user and carer groups, the emerging Health & Wellbeing Boards and researchers, to challenge and support commissioners in their work. Many of the promising examples identified above involved strong partnership work between commissioners and other stakeholders. The generation, mobilisation and use of evidence is clearly central to the task of improving commissioning for minority ethnic people, but it is important that narrow understandings of what counts as adequate evidence do not become a block to action. Instead, where data and research evidence are lacking incremental and creative strategies are needed to pilot service improvements while at the same time improving data sources, evidence bases and organisational knowledge. Greater efforts to share approaches to describing, understanding and tackling ethnic inequalities are needed. Better documentation, evaluation and dissemination of such commissioning work should help to: increase its legitimacy; challenge perceptions that such work is too complex; share effective practice; and prompt the possibility of benchmarking to drive up standards more generally. It remains to be seen whether the new commissioning organisations, including Clinical Commissioning Groups, will improve on the performance of Primary Care Trusts by addressing the obstacles and grasping the opportunities highlighted here.

Key Actions for Commissioning Organisations

Cross-cutting action

- Create the enabling environment for embedded attention to ethnic diversity and inequality across all commissioning activity (see REF Briefing Paper no. 27)
- Take advantage of transformational work as it arises, regardless of area and impetus, to embed ethnic health issues in strategic priorities and local targets
- Seek out diverse sources of evidence and intelligence; adopt systematic approaches to access, appraise, synthesise and apply relevant information on ethnic diversity and inequality
- Take steps to increase understanding among all stakeholders of the nature, causes and potential solutions to ethnic inequalities in service access, experiences and outcomes
- Refuse to tolerate information gaps on ethnicity; support and incentivise improvements in the quality and completeness of routine data and evidence generation
- Build positive relationships with provider organisations and work together to improve the generation and application of evidence on ethnicity
- Build strong partnerships with all local communities to ensure meaningful engagement and increased understanding of minority ethnic health issues
- Package and present evidence to link with current policy and to explain concisely the quality, patient outcome and efficiency case for reducing ethnic inequalities in health

Strategic planning

- Ensure key strategic documents (JSNAs, Commissioning Intentions, Quality Frameworks, Health & Wellbeing Strategies and so on) provide detailed information on local health needs broken down by ethnicity; go beyond description to understand causes and prioritise action to address ethnic inequalities
- Use creative approaches to combine data and evidence to build a coherent picture of unmet need
- Undertake detailed needs assessments for communities or service areas where particular inequalities are recognised but poorly understood

Contracting and procuring services

- Use service specifications to spell out clearly how and why services must be delivered so that they meet the needs of minority ethnic people; avoid vague statements that do not prompt clear action
- Document and share service designs, delivery standards and innovative practice in relation to minority ethnic populations
- Work with providers to mobilise evidence on 'what works' to improve access, experiences and outcomes for minority ethnic service users and carers
- Engage users and members of the public in finding creative solutions
- 'Read across' between service areas to promote promising practice in addressing ethnic inequalities

Performance monitoring and evaluation

- Make (in)equalities issues a consistent prompt for transformational work alongside quality and efficiency concerns; ensure effective mechanisms for identifying such poor performance
- Use contract levers, such as KPIs, CQUINs and service improvement plans, to challenge providers through ethnicity-specific targets; monitor delivery on a regular basis
- Undertake Equity Audits to scrutinise services in relation to ethnic diversity and inequality
- Expect more from providers; share positive examples to motivate improvement on this agenda
- Evaluate service re-designs carefully using both process and outcome tools; use appropriate cost effectiveness and cost-benefit analysis to assess efficiency implications

Additional Resources

General guidance on issues arising during needs assessments for black and minority ethnic populations is available here: www.birmingham.ac.uk/Documents/college-mds/haps/projects/HCNA/04HCNA3D4.pdf

Peter Aspinall and colleagues have produced a number of useful papers and reports that discuss approaches to making use of ethnic monitoring data. See for example:

Aspinall PJ, Jacobson B. Why poor quality of ethnicity data should not preclude its use for identifying disparities in health and healthcare. *Quality and Safety in Health Care*. 2007 Jun;16(3):176-80.

The London Health Observatory produced a useful review and synthesis of evidence on ethnic disparities in health and healthcare which can provide information to complement local data www.lho.org.uk/viewResource.aspx?id=8831

The London Health Observatory has undertaken a series of analyses focused on issues of equity in commissioning. www.lho.org.uk/PUBLICATIONS/LHOPublications.aspx

A general resource for supporting the use of evidence on equity issues is: Promoting action on equity issues: A knowledge-to-action handbook. CIHR. University of Alberta. Winnipeg Regional Health Authority. www.publichealth.ualberta.ca/research/~media/publichealth/Research/Research%20Publications/action_equity.pdf

'Commissioning services for people with dementia' is an example of a comprehensive, Department of Health-promoted resource for commissioners, that includes some limited reference to diversity and inequality issues, and illustrates the types of support that can be useful to guide commissioning work. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_127381

Maternity Action - Guidance for Commissioning Health Services for Vulnerable Migrant Women www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/guidancecommissioninghealthservvulmigrantwomen2012.pdf

Race for Health supported NHS trusts to conduct peer service reviews, many examples can be found at (http://www.raceforhealth.org/resources/peer_review_reports).

The EEiC project has produce a range of tools and resources to support this agenda in commissioning. www.eeic.org.uk

C-TIE is a tool that has been developed to provide a systematic framework for integrating evidence from user and population engagement and provider experience alongside JSNA and other population needs assessment into the commissioning decision making process and into the performance monitoring. It is currently being used by Luton CCG. See <http://ctiesolutions.wordpress.com/c-tie/>.

References

Aspinall, P (2000) 'The mandatory collection of data on ethnic group of inpatients: experience of NHS trusts in England in the first reporting years', *Public Health*, 114, pp. 254–9.

Chowbey, P Salway, S and Ismail, M (2012) "Influences on diagnosis and treatment of eating disorders among minority ethnic people in the UK", *Journal of Public Mental Health*, 11, 2, pp.54 – 64.

Equal Opportunities Review (2012) Case Studies: Implementing the new public sector equality duty. *Equal Opportunities Review*, 226, pp:12-23 <http://www.rubensteinpublishing.com/default.aspx?id=1170222> [last accessed 21st May 2013]

Ham, C, Smith, J and Eastmure, E (2011) Commissioning integrated care in a liberated NHS. The Nuffield Trust: London. <http://www.nuffieldtrust.org.uk/sites/files/nuffield/commissioning-integrated-care-in-a-liberated-nhs-report-sep11.pdf> [last accessed 21st May 2013]

Hull S A, Mathur R, Badrick E, Robson J, Boomla K (2011) Recording ethnicity in primary care: assessing the methods and impact. *British Journal of General Practice* 61:290-29 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080234/> [last accessed 21st May 2013]

LGID (2010) *Culturally responsive JSNAs: a review of race equality and Joint Strategic Needs Assessment (JSNA) practice*. www.idea.gov.uk/idk/aio/24252469 [last accessed 21st May 2013]

Marmot, M et al. (2010) *Fair Society, Healthy Lives: The Marmot Review*, Institute of Health Equity: London <http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review> [last accessed 21st May 2013]

NHS East Midlands (2012) *Good engagement practice for the NHS*, <http://www.eastmidlands.nhs.uk/about-us/inclusion/eds/good-engagement-practice-for-the-nhs/> [last accessed 21st May 2013]

NMHDU (2009) *Delivering Race Equality in Mental Health Care: a review* <http://www.nmhd.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf> [last accessed 21st May 2013]

Piercy, H, Chowbey, P, Soady, J, Dhoot, P, Willis, L, Salway, S (2012) A care pathway approach to identifying factors that impact on diagnosis of heart disease in British Pakistani women Ethnicity and inequalities in health and social care, 5(3), 78 – 88.

Salway S, Ratcliffe G, Ali, P and Bibi S (2012) *Responding to increased genetic risk associated with consanguineous marriage: a formative review of current service approaches in England*. CLAHRC for South Yorkshire clahrscopy.nihr.ac.uk/images/health%20inequalities/resources/Responding%20to%20increased%20genetic%20risk.pdf [last accessed 21st May 2013]

Salway, S, Turner, D, Mir, G et al. (2013) *High Quality Healthcare Commissioning: Why race equality must be at its heart*, Race Equality Foundation, Better Health briefing paper 27 <http://www.better-health.org.uk/briefings/high-quality-healthcare-commissioning-why-race-equality-must-be-its-heart-0> [last accessed 21st May 2013]

Smith, J, Curry, N (2011) *Commissioning in Understanding New Labour's Market Reforms of the English NHS* edited by Dixon A, Jones L. King's Fund: London.

Smith, J, Curry, N, Mays, N and Dion, J (2010) *Where next for commissioning in the English NHS?* The Nuffield Trust, London [http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/Where next commissioning KF NT March %202010.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/Where%20next%20commissioning%20KF%20NT%20March%202010.pdf) [last accessed 21st May 2013]

Smith, J, Lewis, R and Harrison, T (2006) *Making commissioning effective in the reformed NHS in England*. Health Policy Forum: London.

http://www.npa.co.uk/Documents/Docstore/PCO_LPCs/HPF_Effective_Commissioning_Report_Dec_2006.pdf [last accessed 21st May 2013]

Turner, D, et al. (2012) *Evidence and Ethnicity in Commissioning mini-case study book* www.eeic.org.uk/mcs [last accessed 21st May 2013]

Turner, D., Salway, S., Mir, G., Ellison, G.T.H., Skinner, J., Carter, L., Bostan, B. (2013) Prospects for progress on health inequalities in England in the post-primary care trust era: professional views on challenges, risks and opportunities. *BMC Public Health*, 2013, 13:274
<http://www.biomedcentral.com/1471-2458/13/274> [last accessed 21st May 2013]

Van Kammen J., de Savigny, D., Sewankambo, N. (2006) Using knowledge brokering to promote evidence-based policy-making: the need for support structures, *Bulletin of the World Health Organization* 84:608-612 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2627440/pdf/16917647.pdf> [last accessed 21st May 2013]

Walter, I., Nutley, S., Davies, H. (2003) Research impact: A cross sector review, ESRC Network for Evidence Based Policy and Practice, <http://www.st-andrews.ac.uk/~ruruweb/pdf/LSDA%20literature%20review%20final.pdf> [last accessed 21st May 2013]

Woodin, J. (2006) 'Commissioning', in Walshe, K. and Smith, J. (eds) *Healthcare Management*, Open University Press: Maidenhead.

Sarah Salway

Professor of Public Health, Sheffield Hallam University

Daniel Turner

Research Fellow, Sheffield Hallam University

Ghazala Mir

Principal Research Fellow, University of Leeds

Lynne Carter

Senior Associate – Equality and Diversity, NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit

John Skinner

Research and Evaluation Manager, Sheffield City Council

Bushara Bostan

Health Improvement Specialist, NHS Leeds

Kate Gerrish

Professor of Nursing, University of Sheffield

George Ellison

Senior Lecturer Biostatistics, Centre for Epidemiology and Biostatistics, University of Leeds

Readers

Mina Jesa

Brian Colman

We welcome feedback on this paper and on all aspects of our work. Please email briefings@racefound.org.uk

Race Equality Foundation

Unit 17, Deane House Studios

27 Greenwood Place

London NW5 1LB

T: 020 7428 1880 F: 020 7428 0912

www.raceequalityfoundation.org.uk

Copyright © Race Equality Foundation

June 2013

ISBN: 978 1 873912 98 6

Notes

¹ The EEiC project was funded by the National Institute for Health Research HS&DR programme (project number 09/1002/14) with additional funding from NIHR CLAHRC for South Yorkshire. The views and opinions expressed here are those of the authors and do not necessarily reflect those of the HS&DR programme, NIHR, NHS or the Department of Health. CLAHRC SY would also like to acknowledge the participation and resources of its partner organisations.

² In keeping with the terminology of the Equality Act (2010) and the Race Equality Foundation, we use the term 'Race Equality' to refer to the broader agenda of promoting equality between racial/ethnic groups and removing racist discrimination. However, elsewhere in the paper we use the terms 'ethnicity', 'ethnic group' and 'minority ethnic group', as these are in more common usage in the UK and are preferred by those who are wary of the association of the term 'race' with discredited 19th century work labelled as 'scientific racism'.

³ Responsibility for commissioning most local health services moved from PCTs to Clinical Commissioning Groups (CCGs) in April 2013, with other PCT support functions moving to Commissioning Support Units (CSUs) and much of the public health function relocating to Local Authorities. Health and Wellbeing Boards (HWBB) were established as strategic partnership bodies to co-ordinate health and social care commissioning across the new structures. HWBBs are expected to have a significant role in tackling health inequalities. Specialist health services and primary care are commissioned through local outposts of the national commissioning board (NHS England).