DEVELOPMENT

Improving capacity in ethnicity and health research: report of a tailored programme for NHS Public Health practitioners

Sarah Salway[1], **Hilary Piercy**[2], **Punita Chowbey**[3], **Louise Brewins**[4] and **Permjeet Dhoot**[5]

[1]Professor of Public Health, Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK
[2]Senior Lecturer in Nursing, Faculty of Health & Wellbeing, Sheffield Hallam University, Sheffield, UK
[3]Research Fellow, Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK
[4]Public Health Specialist, Public Health Directorate, NHS Sheffield, Sheffield, UK
[5]Public Health Lead for Equality and Diversity, Public Health Directorate, NHS Sheffield, Sheffield, UK

Aim: To determine whether an intervention designed to enhance research capacity among commissioners in the area of ethnicity and health was feasible and impactful, and to identify programme elements that might usefully be replicated elsewhere. **Background:** How healthcare commissioners should be equipped to understand and address multiethnic needs has received little attention to-date. Being able to mobilise and apply evidence is a central element of the commissioning process that requires development. Researching ethnicity and health is widely recognised as challenging and several prior interventions have aimed to enhance competence in this area. These have, however, predominantly taken place in North America and have not been evaluated in detail. **Methods:** An innovative research capacity development programme was delivered to public health staff within a large healthcare commissioning organisation in England. Evaluation methodology drew on 'pluralistic' evaluation principles and included formative and summative elements. Participant evaluation forms gave immediate feedback during the programme. Participants also provided feedback at two weeks and 12 months after the programme ended. In addition, one participant and one facilitator provided reflective accounts of the programme's strengths and weaknesses, and programme impact was traced through ongoing partnership work. **Findings:** The programme was well received and had a tangible impact on knowledge, confidence and practice for most participants. Factors important to success included: embedding learning within the participants' work context; ensuring a balance between theory and practical tips to enhance confidence; and having sustained interaction between trainers and participants. Despite positive signs, the challenging nature of the topic was highlighted, as were wider structural and cultural factors that impede progress in this area. Although it is unrealistic to expect such programmes to have a major impact on commissioning practices, they may well make an important contribution to raising the confidence and competence of staff to undertake work in this area.

Key words: ethnicity; evidence mobilisation; health inequalities; public health practitioners; research capacity development

Correspondence to: Dr Sarah Salway, Centre for Health and Social Care Research, Sheffield Hallam University, 32 Collegiate Crescent, Sheffield, South Yorkshire S102BP, UK. Email: s.salway@shu.ac.uk

Introduction and background

Health policy and practice directives in England over several decades have repeatedly acknowledged the need to understand and tackle ethnic health inequalities (Kingsley and Parwar, 2002; DH, 2010a). However, progress to-date has been slow and persistent inequalities in service satisfaction and health outcomes remain, particularly for some minority ethnic groups (Nazroo, 1997; Gill *et al.*, 2007; DH, 2009a). Significant improvement for black and minority ethnic populations is in part hampered by the limited generation and application of high-quality research evidence to the commissioning, design and delivery of health services. Much health research in England continues to exclude participants from minority ethnic groups and/or fails to give considered attention to ethnicity within analyses (Hussain-Gambles, 2003; Oakley, 2006). There are also concerns regarding the *quality* of research that is carried out in this area (Ellison, 2005; Gunaratnam, 2007). Past research has been critiqued on a range of grounds including, among others: the use of outdated, inappropriate conceptual models that present ethnic 'groups' as stable, discrete entities; a failure to research issues that are of concern to minority ethnic people; a lack of cultural sensitivity in research practice; and inattention to broader social, historical and political dimensions (Salway and Ellison, 2010). It is increasingly recognised that those who commission, conduct or use research on ethnicity and health require support to gain the necessary 'cultural competence' to navigate the theoretical, methodological and practical complexities that arise (Papadopoulos and Lees, 2002; Bhopal, 2009).

Such concerns are not restricted to the United Kingdom and have received particular attention in North America (see for instance, Kaufman and Cooper, 2001; Krieger, 2005; Drevdahl *et al.*, 2006). A variety of responses have ensued including the development of research guidelines and principles (McKenzie and Crowcroft, 1996; Patel, 1999; Mir *et al.*, 2012) and interventions to enhance research skills of various health professionals, particularly nurses. For example, in the United States a number of initiatives, including mentoring programmes, have aimed to increase the ethnic diversity of the health research workforce, and thereby the volume of culturally competent research (Goeppinger *et al.*, 2009; Jeste *et al.*, 2009; Yanagihara *et al.*, 2009). Other initiatives have involved the design and delivery of specialist research training (Kirmayer *et al.*, 2008; Deatrick *et al.*, 2009).

In the English context, staff involved in the commissioning of health services stand out as a group for whom such research capacity development initiatives are particularly relevant. Recent policy developments and NHS (National Health Service) reforms create new expectations of evidence-driven healthcare commissioning for all (DH, 2004; 2007; 2009b; 2010a). In addition, although commissioning structures are currently undergoing radical change, the new Coalition Government has reiterated a belief that 'research evidence is vital in providing the new knowledge needed to improve health outcomes and tackle inequalities' (DH, 2010b: 24). The role of public health practitioners in the commissioning cycle, via: profiling local health needs; undertaking special studies; and synthesising wider research evidence, has also gained importance (PHCN (Public Health Commissioning Network), 2009). The recent White Paper aspires to a public health that works closely with the new commissioning structures 'to support and encourage GP consortia to maximise their impact on population health and reducing health inequalities' (DH, 2010c: 62). Thus, public health practitioners will continue to work alongside clinical commissioners making a key contribution to healthcare commissioning decisions and therefore represent an important workforce requiring the skills and confidence to generate, mobilise and apply research evidence on ethnicity and health.

However, unlike the examples cited above from other health disciplines, we found no published evidence of interventions designed to enhance public health professionals' confidence and competence in this area of research either in the United Kingdom or overseas. Therefore, outstanding questions remain regarding how best to develop capacity in this area. The present paper begins to address these important questions by reporting on an innovative five month research capacity development programme that was delivered to a group of specialist public health staff working within a large citywide healthcare commissioning organisation (Primary Care Trust, PCT) in England in 2009. Evaluation was an

integral component of the programme; designed to support the consolidation of participant learning and its application to practice as well as to understand the process and outcomes of the intervention. The present paper aims to identify elements of learning – relating to the content, form, organisation and wider context of the programme – that might inform similar interventions in other settings.

Programme description

The programme idea was developed in partnership by university researchers and public health managers based in the PCT. PCT staff recognised the need for increased capacity among public health staff to generate, mobilise and apply evidence in the context of commissioning for an increasingly, ethnically diverse population. The university researchers were motivated by a desire to transfer their expertise in the area of researching ethnicity and health and more generally to seek ways of bridging the research-to-practice gap. As such, both partners saw value in undertaking a joint programme of capacity development for PCT public health staff and worked together to prepare a successful application to the Trent Research and Development Support Unit for around £14,000. The higher goal of the programme was to contribute to greater equity in healthcare experiences and outcomes within the city.

The programme included 10 participants voluntarily recruited from the public health directorate by open invitation. A baseline self-completion questionnaire revealed significant heterogeneity in terms of generic research training, skills and current roles, as well as in the levels of reported knowledge and experience in the area of ethnic diversity and inequality. Importantly though, all participants recognised the need to further enhance their confidence and competence in this area and none felt themselves to be experienced in researching ethnicity and health. In response to an open-ended question, participants reported their ethnicity as: Indian (1), British-born Indian (1), White British (6), White (1) and African-Caribbean (1). Facilitators self-identified as White English (1), British Indian (1), Black African (Somali) (1), Indian (1) and White British (2).

Overall programme design was influenced by existing evidence relating to three main sets of factors: (i) those that contribute to the inadequate attention to ethnicity in UK health research, monitoring and evaluation, (ii) those that undermine race equality work more generally in NHS organisations and (iii) those that support effective adult learning.

Prior work suggests that a range of factors act to discourage attention to ethnicity in health research including: a lack of awareness of the potential significance of ethnicity; a tendency to consider ethnicity as a specialist area of investigation; intentional exclusion of minority ethnic individuals on the grounds of added cost and complexity; and a lack of researcher confidence and skills to engage with individuals and communities that are labelled as 'hard-to-reach' (Salway and Ellison, 2010). At the same time, evidence indicates that NHS organisations have often been slow to embed attention to race equality within their work, and that where service design and development has engaged with ethnic diversity the tendency to employ poor conceptual models and partial understanding can result in inappropriate responses (Culley and Dyson, 2001). This context suggested the need for the programme to equip participants with the information and confidence to argue the case for greater attention to ethnicity within their organisation, as well as increase their awareness of the need for such work to be carefully framed. At the same time, there was a concern not to disempower or discourage participants by presenting the task as overly difficult and risky. Drawing on pedagogical approaches that seek to facilitate individual and organisational transformational learning (Mezirow, 1981; Baumgartner, 2001), suggested the programme should embed interactive sessions and action learning approaches to provide opportunities for engagement with the theoretical aspects of the topic and critical reflection on its applicability to the participants' organisational context (Revans, 1982; Marquardt and Waddill, 2006). In terms of programme content, this backdrop suggested the importance of engaging with conceptual debates regarding the nature of ethnicity and the wider socio-political context within which knowledge is generated, as well as methodological and practical issues involved in research design.

The programme's specific objectives were:

1) To equip participants with theoretical, methodological and practical expertise to commission, undertake and/or apply health-related research that:
   - contributes to an evidence base reflecting the ethnic diversity of the population;
   - furthers understanding of the links between ethnicity and health experiences and outcomes;
   - is inclusive of minority ethnic individuals;
   - challenges exclusionary and oppressive practices and structures.
2) To increase participants' confidence and competence to develop research proposals and submit for external funding.

The programme consisted of two elements: (i) five one day workshops facilitated by a team of researchers and held at the university and (ii) a series of associated learning set activities, with participants expected to devote two days per month over the five-month period. Programme content was given coherence by mirroring the stages of work that take place in formulating a research project namely: conceptualisation and finding a focus; literature reviewing and identifying knowledge gaps; engaging with patients, the public and communities; identifying appropriate methodology and methods; and designing knowledge translation/dissemination activities. All workshops employed a mix of presentations, individual and group exercises, and open discussion.

Workshop one provided a theoretical basis for the programme, examining theories of race, ethnicity and racism(s) and the operationalisation of related concepts in research. We examined the current state of research evidence relating to ethnicity and health in England, raising for discussion factors shaping the research agenda and adequacy of research approaches.

Workshop two focused on the task of accessing and appraising quantitative and qualitative research evidence relating to ethnicity and health. It provided participants with practical tips – such as using NHS Evidence: *Ethnicity & Health* and the minority-ethnic-health jiscmail list – and engaged participants in reflection on the established hierarchy of evidence and its adequacy and ways of gaining meaningful involvement of patients and the public.

Workshops three and four explored quantitative and qualitative approaches to researching the links between ethnicity and health, respectively. Strengths and weaknesses of alternative approaches were highlighted as well as common challenges that pervade all research methodologies, including: the advantages and limitations of working with fixed ethnic categories and issues in cross-language and cross-cultural working.

Workshop five focused on knowledge translation (or knowledge-into-action) approaches and explored individual and organisational 'readiness' to apply these approaches in support of efforts to tackle ethnic health inequalities.

To complement the workshops, three action learning sets (each with 3–4 members) were established at the beginning of the programme and were expected to operate independently, meeting five times between the workshops. The sets were required to identify a collective work-based problem amenable to the development of a research question and to work towards developing a viable proposal for a research project. Structured activities were designed by the university researchers and PCT managers to optimise consolidation of workshop learning and to facilitate application to the organisational setting. A key component was the planning and undertaking of a community consultation exercise to inform research proposal development.

Experience and impact of the programme

Evaluation approach

The adequacy and appropriateness of randomised experimental approaches to evaluating complex interventions is increasingly questioned within the health arena (Milne *et al.*, 2004). A variety of alternative evaluation methodologies have been developing over the past 25 years, many of which focus on exploring the process and context of interventions in order to understand how and why particular effects ensue (see for instance, Nolan and Grant, 1993; Pawson and Tilley, 1997; Campbell *et al.*, 2000; Judge and Mackenzie, 2002). Our approach to the present evaluation drew particularly on 'pluralistic' evaluation principles (Smith and Cantley, 1985; 1988), in which there is attention to process and situational factors that may produce

unintended consequences, and recognition that stakeholders may hold contrasting understandings of desirable outcomes. Pluralistic evaluations tend to draw on varied data sources and to listen to the perspectives of those directly affected by the intervention; they have proved useful in evaluating health professional capacity development interventions (Gerrish, 2001). Our approach included both formative and summative elements. Completion of evaluation forms at the end of each workshop allowed participants' reflection on how the programme was experienced, its structure and content, and also required participants to identify personal learning and intended follow-up actions. This immediate feedback enabled facilitators to modify subsequent workshops as required. For instance, early feedback identified that some material was too technical/wordy and subsequent readings were therefore selected more carefully.

Two weeks after the final workshop, all 10 participants completed an evaluation questionnaire by email, which included both structured and open-ended items. Participants were asked to reflect on the programme's impact on their knowledge, understanding and working practice. In addition, one participant and one facilitator were asked to provide a frank, reflective account of the programme's strengths and weaknesses soon after the programme.

Ongoing partnership work in the months following the programme also allowed us to trace its impact over time in an informal way, particularly in terms of whether new pieces of research came to fruition. Finally, 12 months after the final workshop we re-contacted participants by email to ask whether they had: taken the programme learning into any aspects of their work and/or shared learning with colleagues; and whether any factors had supported or hindered the knowledge-into-practice process. Seven participants responded.

Participation

All participants attended at least three workshops and five of the ten participants attended all five. Participation in the learning set activities was more problematic. The first three included eight participants, but participation dropped off substantially for the last two – largely due to other work pressures – and only two participants from

one set completed all five activities. As these activities had been structured to build incrementally from one activity to the next, low participation impacted negatively on their outcome.

Impact on knowledge and confidence

Post-workshop evaluation forms indicated that all participants could identify clear learning points from the day's activities. In just one case did one participant indicate that a workshop – Workshop Three on quantitative methods – covered material with which s/he was already thoroughly familiar. Many of the learning points identified related to ways in which participants' prior assumptions had been challenged or their conceptual understanding increased.

> *The flexible, contingent and contested nature of ethnic labels is far greater than I realised* (comment after workshop 1).

> *It helped me to explore my own assumptions about race and ethnicity* (comment after workshop 4).

Table 1 summarises the responses to a series of statements included in the two-week evaluation questionnaire about the understanding gained through the course. All respondents reported new understanding across several areas of research practice, with nine out of ten reporting better understanding of theoretical concepts. One participant reported that s/he was already familiar with much of the programme content, though this participant attended only three of the workshops.

Open-ended responses indicated some variability in terms of the aspects of new knowledge that were most salient or challenging to participants, a reflection of the different backgrounds of participants. In particular, the quantitative element of the programme was unproblematic for some but challenging for those less confident in handling numeric data. The critical reflection provided by one of the facilitators also highlighted the mixed experience and ability of the group and the associated challenges of ensuring all participants were gaining new knowledge at an appropriate pace.

Notwithstanding this variation, the two-week evaluation open-ended responses again revealed that improved conceptual understanding was salient for several participants. Respondents found the theoretical debates about the nature of

Table 1 Participants' reports of enhanced understanding and confidence (self-completion email evaluation questionnaire at two weeks)

Statement (as worded on the questionnaire)	'Agree' or 'Strongly agree' (*n* = 10)
I have a better understanding of:	
The theoretical concepts underpinning ethnicity and health research	9
The existing ethnicity and health research evidence base	8
The links between race/ethnicity and health experiences and outcomes	8
Methodology approaches appropriate to ethnicity and health research and their relative merits and limitations	8
Operational issues associated with conducting ethnicity and health research	9
Ethical issues associated with conducting ethnicity and health research	8
The current situation and status of ethnicity and health research in my organisation	5
Opportunities for implementation of work around ethnic inequalities in health and healthcare in my organisation	5
Barriers to implementation of work around ethnic inequalities in health and healthcare in my organisation	5
I feel more confident:	
About embedding ethnicity and health research into my role	7
To commission research, monitoring and evaluation activities that address issues of ethnicity and health	7
To undertake research, monitoring and evaluation activities that address issues of ethnicity and health	6
Question (as worded on the questionnaire)	'Yes'
Has the programme had any impact on the way that you understand or think about ethnic inequalities in health?	10
As a result of the programme, have you, or are you intending to, implement any changes to your practice in relation to ethnic inequalities in health?	8

ethnicity, how it can be operationalised and how the links between ethnicity and health outcomes can be understood, to be relevant and important.

> *It has raised my awareness of how health inequities can be exacerbated even by attempts to address them. It has therefore highlighted the need for an informed and circumspect approach to addressing the health inequities of all marginalised groups, including those from diverse ethnic backgrounds.*

> *My view of health and ethnicity has broadened, not looking at ethnicity alone but also deprivation and socioeconomic status and how services are designed and commissioned appropriately or effectively to meet the needs of users.*

Participants also identified some of the more practical aspects of the programme as providing them with important new knowledge, such as greater awareness of the available literature, its location and the means by which to access it. Reflective accounts from both the facilitator

and the participant suggested that the balance between theoretical content and practical 'tips and tools' was important; highlighting complexity and the need for reflexivity, while also generating a constructive atmosphere and concrete ideas for improved practice.

> *The programme was both revealing and meaningful in so far that it uncovered many misconceptions and gaps in the evidence base whilst offering practical solutions that I would not necessarily have considered previously.*

Participants were also asked to rank statements relating to their improved understanding of their own organisational context. In comparison with learning related to the research process, fewer participants reported increased understanding of the current situation, opportunities or barriers that exist within their own organisation (Table 1). This limited impact relates, at least in part, to the poor participation in the learning set activities that were intended to provide the vehicle for relating the relatively abstract workshop material to the real-life context of the participants' organisational

culture and structures. Clearly this raises important questions regarding the likely impact of the programme on participants' working practices since effective generation and application of research evidence to inform commissioning action requires an understanding of organisational culture and context, as well as research expertise.

Participants were also asked to rank statements about their increased confidence and to comment on whether the programme had influenced '*the way that you view health and ethnicity research (for instance; its importance or relevance to your work*)'. Most, but not all, participants reported enhanced confidence and motivation to embed attention to ethnicity and health research into their role, to commission and to undertake research in this area.

> This was already important to me. But it supports my approaches and gave me more confidence, back-up, with the wealth of information out there.

> The programme has influenced how I view health and ethnicity and made me realise how important it is in public health and health promotion work.

It is important to note, however, that some participants were less confident. The facilitator's reflection highlighted how participant confidence could be undermined by the perceived external barriers to progress in this area and suggests strategies that help create a more optimistic ambience including drawing on the diversity and personal narratives within the group as well as existing strengths and elements of good practice within the organisation. Nevertheless, some respondents were uncertain about taking learning into their work.

> My understanding has improved but I would still be facing barriers in respect of colleagues and other staff members understanding and taking on board ethnic inequalities in health.

Impact on practice

Responses to the post-workshop questionnaires illustrated that participants were able to identify concrete follow-up actions linked to each workshop such as: finding out more about current practices within the organisation (eg, exploring whether or not ethnicity data were being collected in a particular service); revisiting recent work to examine whether and how ethnicity was considered; and trying out new tools that had been introduced.

In the questionnaire administered two weeks after the end of the programme, just one respondent answered 'no' to the direct question on whether they had, or intended to, implement any changes to their practice as a result of the programme, while another was 'unsure'. Unfortunately, neither respondent offered more detail on their form as to why they had not taken action. Both did, however, report that the programme had met their expectations and had resulted in new understanding, and that they would recommend it to others if it were to run again. Nevertheless, most respondents identified changes that they had implemented or were planning to implement. In some instances, these were broad and relatively non-specific, such as an increased commitment to take action on the reduction of ethnic health inequalities. Others were more specific. Participants reported that the programme had influenced the development of strategic documents such as the joint strategic needs assessment (JSNA). Another participant reported routinely using some of the tips and tools presented in the workshops as well as sharing these with colleagues. Some also identified ways in which they would seek to apply their learning in the future, for instance one participant expressed the intention to instigate work on the development of a cultural competency framework. Notwithstanding these important initiatives, several participants expressed awareness of the wider challenges, or what one respondent referred to as the '*practicalities of embedding the concepts into organisational culture.*'

In terms of the learning set work, by two weeks after the programme one of the three learning sets had made substantial progress towards developing a concrete research proposal, with clearly identified research questions and a plan of action for taking the work forward. It proved difficult for the other learning sets to make similar progress. In part this was because other work commitments (including the swine flu epidemic) impacted upon participation levels. In addition, these two learning sets were slower to identify a clear and manageable focus for a research project. Nevertheless, these learning set activities were popular and generated ideas that may be taken forward beyond the programme as highlighted by the participant's reflection.

A year on from the programme, the research proposal identified by one of the learning sets had resulted in completion of a successful piece of pilot research work exploring the experiences of, and barriers to, revascularisation among Pakistani women with coronary heart disease. Furthermore, the seven email evaluation responses received indicated that all had been or were engaged in new work with a focus on minority ethnic populations.

> *I have attempted to consider the complexities of meeting the needs of BME communities in the work programmes being developed for weight management services – specifically asking for BME segmentation in two pieces of social marketing work that I'm commissioning.*

Participants also mentioned other, less tangible, lasting effects including greater awareness and interest in the topic area, as well as increased confidence to take the lead on work addressing ethnic diversity and inequality.

> *I have taken a lot more notice of the ethnicity and health research literature since the programme because I am interested in knowing more.*

> *As a result of this work, I feel I have been able to engage colleagues in conversations that have been productive and have led to work in the PCT aimed at reducing ethnic health inequalities.*

Despite a common sense that the programme had had a significant impact on practice, several respondents felt that work in the area was hampered by competing priorities and lack of resources. Some also expressed frustration at the lack of strong leadership within the organisation to give serious attention to ethnic inequalities.

> *[There is] a continued lack of support at a senior management level to 'push the boundaries' and challenge current practice in order to support the work around health inequalities and BME issues.*

Overall experience

The findings across the evaluation indicated that this was a successful and enjoyable programme, assessed by the participants as valuable and highly applicable to practice. For some, the most interesting elements were the theoretical aspects of the programme, the opportunity to examine concepts, the existing evidence base and the translation of that evidence into practice. For others, it was the opportunity to learn alongside colleagues, to engage in a range of tasks and activities in the workshops and the learning sets and through this to generate ideas and identify creative approaches to addressing ethnic health inequality issues. Participants did identify some challenges related to the programme, the most salient of which was the large time commitment (10 days over five months) and the difficulty of putting other work to one side. Similarly, suggestions for improvement to the programme largely related to time and capacity issues. Nine participants said that they would recommend the programme to colleagues if it were offered again (with one respondent not answering this section of the questionnaire).

Discussion

Before drawing conclusions it is important to acknowledge the limitations of the work. Our evaluation was based primarily on participants' own reports, rather than on any objective assessment of the extent to which their attitudes or knowledge had changed over the period of the intervention. However, the ongoing working relationships between the researchers and the PCT staff have allowed us to identify together the programme impact. Nevertheless, in assessing impact we have largely looked for evidence of increased ethnicity research and related activity, rather than exploring the quality of that activity or the extent to which it is adequately informed by the conceptual and methodological understanding that the programme aimed to impart.

Notwithstanding these limitations, the experience of initiating, designing and conducting this development programme indicates that public health professionals are receptive to the idea of enhancing capacity in the area of ethnicity and health research. This reflected the growing importance of evidence-based public health contributions to commissioning on the one hand, and the increasing ethnic diversity of the city's population on the other. It is increasingly recognised that the ability to generate, appraise and apply research evidence, alongside

other forms of knowledge, is a core skill for public health professionals and other staff who contribute to the commissioning of health services for multi-ethnic populations.

The evaluation of the programme suggests that the content was by-and-large appropriate and well received. It was particularly encouraging to find that participants were interested in, and saw the value of, engaging with conceptual issues as well as more practical aspects of research design. A majority of participants felt that their understandings of ethnicity and ethnic health inequalities had developed importantly and that this conceptual knowledge had increased their confidence to engage with these issues, confirming the importance of the programme's focus on theory as well as methods. Exercises that were based on local data and participants' own working context were effective, as were individual and group exercises that drew on the strengths and experiences within the group. The topic area was recognised by all as theoretically and politically challenging, making it important to create a positive environment for learning and development. There were parallels in the findings with the work by Joe Kai *et al.* that has highlighted the way in which healthcare professionals can become apprehensive leading to inertia and poor care when dealing with minority ethnic patients (Kai *et al.*, 2007). The extended and supportive nature of the programme, and the identification of concrete actions to move forward with the agenda, seemed to be important in counteracting feelings of uncertainty and disempowerment.

Regarding organisation, some simple measures were helpful including: holding workshops away from the participants' usual work location; providing reading materials well in advance of workshops; involving participants in the ongoing appraisal and shaping of workshop content; and conducting the programme over a period of several months, allowing time for reflection. However, some aspects could be improved. In particular, participants struggled to devote time to the learning set activities that were reliant upon the group organising and maintaining a schedule independent of the researchers. This finding might suggest that an alternative approach to delivering experiential aspects of the training is warranted such as individual problem-based learning activities or shadowing opportunities.

However, the learning set activities were highly valued by participants and presented an important opportunity for collective reflection on organisational supports and obstacles to greater attention to ethnicity. To enhance participation it seems likely that such activities should also be scheduled in advance to take place outside the workplace like the facilitated workshops. Delivering the programme to a group of staff from the same directorate within one PCT had both advantages and disadvantages. Participants clearly appreciated the opportunity to spend extended periods of protected time working through important issues with colleagues and found benefit in collective learning as opposed to one or two individuals gaining new knowledge, which would then be difficult to convey to other colleagues. On the other hand, delivering the training to a group of colleagues was made difficult by some participants' tendency to get side-tracked into important but unrelated discussions at times (perhaps reflecting the limited time they had during the normal working day to debate organisational issues).

The evaluation data presented above suggest that all participants felt they had gained significant new knowledge and that most had planned or already initiated changes to practice as a result of the programme, including inputs to key strategic documents and initiation of new research work. Most participants reported greater confidence to address issues of ethnic diversity and inequality in their work, and to commission and undertake research in this area. As noted above, a concrete outcome of the programme was a small-scale funded study, the findings from which had been shared with commissioners at regional level and resulted in a paper submitted for publication. These findings are encouraging and there is clearly the potential for such programmes to contribute to better commissioning of health services for minority ethnic communities.

However, positive change is not assured and challenges of embedding new concepts into the organisational culture and practices, and particularly the difficulties of working with colleagues, who have not acquired the same degree of understanding or commitment, were highlighted by participants. It is worth noting that no consultant level staff participated on the programme, meaning that most participants would continue to work to a senior manager who had not undergone

the same programme of learning. With hindsight, it would likely have been useful to include a half-day synopsis session with these senior managers to enhance their 'buy in' and optimise translation of learning into practice. Furthermore, while participants reported sharing their new knowledge with colleagues informally, it might have been useful to build into the programme a more formal process through which participants could pass on their learning to the wider group of staff across the organisation.

Opportunities for refresher training were also felt to be important by most participants but were beyond the scope of the programme. Refreshers might help to maintain both momentum and also conceptual clarity and critical reflexivity when operating within an organisational context that does not routinely promote this area of work. In the absence of formal refresher sessions, a number of factors do seem to have supported the sustained impact of the current programme, including: the commitment of many of the participants to the core programme aims and the continued partnership working between the PCT staff and the university researchers supported by other initiatives, notably the Collaboration for Leadership in Applied Research and Care for South Yorkshire (CLAHRC-SY), which has enabled frequent interaction and funded a number of small related projects.

In summary, while it is unrealistic to expect research capacity development programmes such as the one described here to have a major impact on commissioning practices in a short space of time, there are positive signs that they can make an important contribution to raising the confidence, competence and commitment of staff to undertake work in this area. The current Government appears to be committed to both evidence-based public health and a continued attack on health inequalities. It remains to be seen whether the newly emerging structures will support investment in the necessary research capacity development initiatives that are needed to achieve these goals in the context of our multiethnic society.

Acknowledgements

References

Baumgartner, L. 2001: New directions for adult and continuing education. *Special Issue: The New Update on Adult Learning Theory* 200, 15–24.

Bhopal, R. 2009: *Ethnicity, race and health in multicultural societies.* Oxford: Oxford University Press.

Campbell, M., Fitzpatrick, R., Haines, A., Kinmonth, A.L., Sandercock, P., Spiegelhalter, D. and **Tyrer, P.** 2000: Framework for design and evaluation of complex interventions to improve health. *British Medical Journal* 321, 694–96.

Culley, L. and **Dyson, S.** 2001: *Ethnicity and nursing practice.* Basingstoke: Palgrave.

Deatrick, J.A., Lipman, T.H., Gennaro, S., Sommers, M., de Leon Siantz, M.L., Mooney-Doyle, K., Hollis, G. and **Jemmott, L.S.** 2009: Fostering health equity: clinical and research training strategies from nursing education. *Kaohsing Journal of Medical Science* 25, 479–85.

Department of Health (DH). 2004: High quality care for all. Retrieved 07 July 2009 from http://www.ournhs.nhs.uk/?page_id=915

DH. 2007: *World class commissioning: vision.* London: DH.

DH. 2009a: *Report on the experience of patients in black and minority ethnic groups, based on data up to and including 2008 patient surveys.* London: DH.

DH. 2009b: The NHS Constitution for England. Retrieved 9 July 2012 from www.dh.gov.uk/en/Publicationsandstatistics/ Publications/PublicationsPolicyAndGuidance/DH_093419

DH. 2010a: *Liberating the NHS: commissioning for patients – a consultation on proposals*. London: DH.

DH. 2010b: *Equity and excellence: liberating the NHS*. London: DH.

DH. 2010c: *Healthy lives, healthy people: our strategy for public health in England*. London: TSO.

Drevdahl, D.J., Philips, D.A. and **Taylor, J.Y.** 2006: Uncontested categories: the use of race and ethnicity variables in nursing research. *Nursing Inquiry* 13, 52–63.

Ellison, G.T.H. 2005: 'Population profiling' and public health risk: when and how should we use race/ethnicity? *Critical Public Health* 15, 65–74.

Gerrish, K. 2001: A pluralistic evaluation of nursing/practice development units. *Journal of Clinical Nursing* 10, 109–18.

Gill, P.S., Kai, J., Bhopal, R.S. and **Wild, S.** 2007: Black and minority ethnic groups. In Stevens, A., Raftery, J., Mant, J. and Simpson, S. editors, *Health care needs assessment: the epidemiologically based needs assessment reviews*. Abingdon: Radcliffe Medical Press Ltd, 227–39.

Goeppinger, J., Miles, M.S., Weaver, W., Campbell, L. and **Roland, E.J.** 2009: Building nursing research capacity to address health disparities: engaging minority baccalaureate and master's students. *Nursing Outlook* 57, 158–65.

Gunaratnam, Y. 2007: Complexity and complicity in researching ethnicity and health. In Douglas, J., Earle, S., Handsley, S. Lloyd, C., Spurr, S., editor, *A reader in promoting public health: challenge and controversy, Ch 19*. Basingstoke: Palgrave, 147–56.

Hussain-Gambles, M. 2003: Ethnic minority under-representation in clinical trials: whose responsibility is it any way? *Journal of Health Organisation and Management* 17, 138–43.

Jeste, D.V., Twamley, E.W., Cardenas, V., Lebowitz, B. and **Reynolds, C.F.** 2009: A call for training the trainers: focus on mentoring to enhance diversity in mental health research. *American Journal of Public Health* 99 (S1), S31–37.

Judge, K. and **Mackenzie, M.** 2002: Theory-based evaluation: new approaches to evaluating complex community-based initiatives. In Mackenback, J., Bakker, M., editor, *Reducing inequalities in health: a European perspective*. London: Routledge.

Kai, J., Beavan, J., Faull, C., Dodson, L., Gill,, P. and **Beighton, A.** 2007: Professional uncertainty and disempowerment responding to ethnic diversity in health care: a qualitative study. *PLoS Medicine* 4, e323.

Kaufman, J.S. and **Cooper, R.S.** 2001: Considerations for use of racial/ethnic classification in etiologic research. *American Journal of Epidemiology* 154, 291–98.

Kirmayer, L.J., Rousseau, C., Corin, E., Groleau, D. *et al.* 2008: Training researchers in cultural psychiatry: the McGill-CIHR strategic training program. *Acad Psychiatry* 32, 320–26.

Krieger, N. 2005: Stormy weather: *Race*, gene expression and the science of health disparities. *American Journal of Public Health* 95, 2155–60.

Kingsley, S. and **Pawar, A.** 2002: *Putting race equality to work in the NHS – a resource for action*. London: Department of Health/HMSO.

Marquardt, M. and **Waddill, D.** 2006: Optimising the power of learning within action learning. In Rigg, C., Richards, S., editor, *Action learning, leadership and organisational development in public services, Ch 3*. London: Routledge, 26–40.

McKenzie, K. and **Crowcroft, N.S.** 1996: Describing race, ethnicity and culture in medical research. *British Medical Journal* 312, 1054.

Mezirow, J. 1981: A critical theory of adult learning and education. *Adult Education* 32, 3–24.

Milne, L., Scotland, G., Tagiyeva-Milne, N. and **Hussein, J.** 2004: Safe motherhood program evaluation: theory and practice. *Journal of Midwifery & Women's Health* 49, 338–44.

Mir, G., Salway, S., Kai, J., Karlsen, S., Bhopal, R., Ellison, G.T.H. and **Sheikh, A.** 2012: Principles for research on ethnicity and health: the Leeds Consensus Statement. *The European Journal of Public Health*. doi: 10.1093/ eurpub/cks028.

Nazroo, J. 1997: *The health of Britain's ethnic minorities*. London: Policy Studies Institute.

Nolan, M. and **Grant, G.** 1993: Service evaluation: time to open both eyes. *Journal of Advanced Nursing* 18, 1434–42.

Oakley, A.M. 2006: Ethnicity and research evaluating health interventions: issues of ethics and science. In Nazroo, J., editor, *Health and social research in multiethnic populations, Ch 9*. London: Routledge142–64.

Papadopoulos, I. and **Lees, S.** 2002: Developing culturally competent researchers. *Journal of Advanced Nursing* 37, 258–64.

Patel, N. 1999: *Getting the evidence: guidelines for ethical mental health research involving issues of 'race', ethnicity and culture*. London: TCPS and MIND.

Pawson, R. and **Tilley, N.** 1997: *Realistic evaluation*. London: Sage Publications.

PHCN. 2009: Developing a public health commissioning network (PHCN) for England. Retrieved 17 August 2009 from http://www.nks.nhs.uk/commissioningnet/A4%20flyer% 20Jan%2009.pdf

Revans, R. 1982: What is action learning? *Journal of Management Development* 1, 64–75.

Salway, S. and **Ellison, G.** 2010: Nursing research for a multiethnic society. In Gerrish, K., Lacey, A., editor, *Nursing research, Ch 5*. Oxford: Wiley-Blackwell, 50–61.

Smith, G. and **Cantley, C.** 1985: *Assessing health care: a study in organisational evaluation*. Milton Keynes: Open University Press.

Smith, G. and **Cantley, C.** 1988: Pluralistic evaluation. In Lishman, J., editor, *Evaluation: research highlights in social work*. London: Jessica Kingsley, 118–36.

Yanagihara, R., Chang, L. and **Ernst, T.** 2009: Building infrastructure for HIV/AIDS and mental health research at institutions serving minorities. *American Journal of Public Health* 99 (S1), S82–86.