Middlesex University

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A Mixed-Method Investigation of the Challenges and Opportunities for Commissioning Culturally Competent Mental Health (Dementia)S Services.

Submitted to Middlesex University in Partial Fulfilment of The Requirements for the Degree of Doctor of Professional Studies in Health: Leading and Developing the commissioning of Culturally Competent Mental Health (Dementia) Services

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Glossary of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BME	Black and Minority Ethnicity
CCC	Culturally Competent Commissioning
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CPD	Continuous Professional Development
CQC	Care Quality Commission
DoH	Department of Health
DProf	Doctorate in Professional Studies
EoL	End of Life
KPI	Key Performance Indicator
MH	Mental Health
NHS	The National Health Service
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework for Older People
PCT	Primary Care Trust

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Abstract

A mixed method approach was used to investigate the challenges and opportunities for commissioning culturally competent Mental Health (dementia) services whilst using thematically analysis to gain an understanding of the experiences, and practice levels of cultural competence amongst participants.

The NHS sited study found that cultural competence was an unfamiliar term though pockets of good practice exist in some parts of the system though based on a limited understanding, this status makes it essential to increase its knowledge, skills and practice. This is possible only if based on a consensus definition, relevant principles, training and research to develop an associated mental health commissioning framework. The aim is to transform the NHS into a culturally competent organisation capable of delivering mental healthcare that complements diversity and Human Rights standards.

This study concluded that dementia services grounded in culturally competent principles can improve healthcare experiences by improving inclusivity, diversity in leadership and service user engagement. It also argues that the empirical findings have ramifications in other public sector arenas and recommends sectors such as housing, employment, education etc embrace cultural competence also.

Other recommendations are that the NHS establishes mandatory training within a culturally competent framework and embeds it within CPD to ensure professionals can meet the needs of a diverse UK population.

Finally, the study contributes a first working definition of culturally competent commissioning based on the literature and participants contributions of

> ... *a vehicle for increasing accessibility to quality services designed for populations of varying values, ages and vulnerabilities, using culturally competent processes that include tailoring service delivery to meet social, cultural and linguistically assessed needs*...

DEDICATION

I dedicate this academic exercise to my late father who after my Master's degree programme more than 20 years ago, casually mentioned that a 'Master's degree is not enough'. It is also dedicated to all those who are affected by a mental health condition and the NHS and Social Care professionals who sometimes offer culturally competent services in recognition of the humanity in us (service users). Finally, this work is dedicated with awesome gratitude to God, the giver and supervisor of my life, and all the good work I will ever accomplish before I leave this world a more culturally competent arena.

Jehovah You Are Lord.

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I would like to acknowledge the support of the members of staff and students at Middlesex University. Gratitude toes to Professor Irena Papadopoulos et al for being trailblazers in the field of cultural competence as without you this may not have been my cause. I am deeply grateful Dr Gordon Weller, Professor Hemda Garelick and Dr Margaret Volante for their supervisory support and to Dr Joshua Aransiola my proof-reader/editor. Much gratitude also goes to all the NHS staff who gave their time, effort, and knowledge to get me started as an insider-researcher and for their labour of love during the Covid 19 epidemic.

I would also like to acknowledge all the people who are affected by any form of mental condition or long term illness, this work acknowledges your resilience and your struggle as factors that demand that NHS staff work together and stay committed to giving our best practice in ways that result in the delivery of culturally competent care and compassionate support to diverse individuals.

I would like to thank my sons, Adegboyega and Omogbolahan who believed in me and describe as an atmosphere that works to deliver the best possible outcome all the time. It is very important to have faith, therefore, I would like to thank the future Professor Noah Kolapo who is currently my only grandchild, I can see myself in you already. This work services to let my children know that I have great expectations of them because they can do greater things through Christ who strengthens them as He strengthened me to finish this work. Lastly, I thank my mum, a retired lecturer worth her weight in gold who despite a failing memory due to dementia never failed to keep asking if I was still doing the ‘doctor thing’, You Rock Mama T aka mummy...

Chapter 1

Introduction

1.0 Background

This study considers a vulnerable group of people (older people and others) and a major condition that affects them and their families profoundly, and secondly, being a multi-layered issue. The biggest issue this group faces is a fragmented system of care that when available following a diagnosis of dementia is not equitable and may favour some over others depending on their cultural background. Dementia has an equally profound impact on the national economy and individuals in caring roles however the focus of this study is the problem of the availability of culturally competent services/ and policies. Such services are needed to improve wellbeing following a diagnosis and the related policies are needed to ensure an optimal system of care delivered via an integrated system (holistic pathway of care). Achieving integrated care is an essential response to a need to overcome the problems of care fragmentation (Sheaff, 2018) that plague the current system (disjointed care pathways).

The term dementia is used to describe a group of related symptoms caused by damage to certain parts of the brain. It is commonly characterised by memory loss and changes in behaviour/mood. There are different types of dementia such as mixed dementia, Alzheimer's disease, Dementia with Lewy bodies, and vascular dementia.

The World Health Organisation and Alzheimer's disease International developed a report by raised the profile of Dementia (ADI, 2012) as a public health priority due to the devastating nature of the condition. It is the high numbers affected, the

underdiagnosed population, and the increasing numbers of those burdened as unpaid carers that are a threat to the global (health) economy.

Following the pronouncement made by the World Health Organisation (WHO), the UK Government response was to designate dementia as a new health priority area (challenge) for Public Health England. The challenge is to be overcome via the adoption of 50 specific commitments by relevant agencies, which include actions to boost research, improve care, and raise public awareness. The challenge also recognises that the cost of care is likely to rise faster than prevalence which could lead to a level of unpreparedness in addressing the associated social and economic burden. Alzheimer's Disease International (2018), a leading geriatric journal, estimated the number of people that will be living with Dementia globally by 2050 to be 152 million. Urgent action has therefore been advocated at both international and national levels based on the principles of evidence, equity, inclusion, and integration (Saxena and Wortmann, 2012). This study suggests that these principles (of evidence, equity, and inclusion), should also include culturally competent commissioning in relation to the services needed.

In recent times, two significant developments have emerged with a capacity to be platforms that transform the care of older people. First, the introduction of a framework for older people (National Service Framework for Older People) is a set of quality standards for health and social care. It is a policy framework that could be considered a forerunner to a second development that is the newly introduced Integrated Care System Approach (ICAS). This new approach will see local agencies taking a shared responsibility for improving health and social care within local populations. Sheaff, 2018 considered the implication of the idea that proposals for integrated care for older people should focus on the patient in the first instance. With this in mind, this study considers that the focus alluded to is that of the cultural perspectives/values of those who need services. This study will argue that the practice of considering the cultural nuances (needs assessment) of a served

population is the foundation for integrated care for those affected by the challenges of dementia or other long-term conditions but not exclusively.

At the forefront of the dementia challenge are the UK organisations charged with the care, medical treatment, policy development, and research responsibilities that underpin the role of the National Health Service. These are the agencies that are at the forefront and in partnership with Public Health England, and Social Care. This study advocates that the conceptualisation of culturally competent commissioning by health and social care professionals is a useful way to improve the quality needed to address the problems identified with dementia services or the lack thereof. This direction requires the acquisition of better knowledge via research and engagement with the affected population to gain an understanding of the cultural nuances of older people/vulnerable groups. The understanding must be relative to their cultural backgrounds and the consequent impact dementia has on their wellbeing, health needs, and ability to seek the healthcare that is right for them. This information has implications for designing and delivering services that meet the varying needs of those affected by dementia. In a broader context, this is a reference to the rights of the elderly to a health care system that respects personal beliefs and offers empathy when considering care needs (compassionate care).

Understanding the role that cultural competence plays in the well-being of those affected by dementia is considered a component of person-centred care (Engebreston et al, 2008). Additionally, it must be considered an important factor to those organisations that commission and provide health services in the UK. What this means is that it is crucial for these organisations to be staffed with professionals who are culturally aware, culturally intelligent, and have the cultural comfortability to translate these elements into meaningful service delivery. This is how to fulfil cultural competence in the delivery of care and treatment however this work is concerned with the step before delivery, the commissioning process.

The commissioning organisation responsible for most of the mental health services used in the UK is the National Health Service (NHS). Furthermore, the NHS is also

the leading provider organisation of mental health (dementia services) via acute hospitals and MH trusts; others would include the voluntary sector, community services, and primary care (GP's). The NHS also has some responsibility for research, training, prevention, and policy development. Given these crucial responsibilities, there is an expectation that the NHS might adhere to robust culturally competent principles. An additional expectation is that its professionals will also apply culture-based judgments to decisions that pertain to meeting the assessed needs of vulnerable populations in partnership with social care. The partnership approach includes the voluntary sector and primary care. The NHS is quite robust in taking steps to establish dementia prevalence, improve diagnosis rates, consider inclusion and develop understandings of what good treatment and prevention measures look like.

This work is an investigation of the status of cultural competence in the UK context of commissioning health services (looking to see how culturally competent is the NHS). The context of this study is on mental health (dementia) services for older people and other vulnerable groups. For these reasons, the context/setting of this study is the National Health Service (NHS) in partnership with other agencies in their role as commissioners and provider organisations.

As a joint commissioning partnership, the NHS and other agencies have responsibility for designing, procuring, and performance managing mental health services. These services are involved in delivering treatment, support, and the prevention of mental health conditions such as dementia, schizophrenia, personality disorder, and depression. These services are located within primary, secondary, and community care settings; they are also either generalist or specialist in nature.

This study engaged with a sample of staff (commissioners/providers) responsible for the commissioning and or providing mental health services. Participants were requested to respond to survey and interview questions to investigate how cultural competence is practiced, influenced, experienced (as service users) and understood.

To assist the reader to gain a grounded understanding of the study chapter 2 is a narrative summary of the context of the queries participants were asked to consider. The survey and interviews covered the following areas.

1. Cultural competence as a concept for commissioning services.
2. Cultural competence: Assessing levels of practice amongst professionals.
3. Dementia: definition, problems and status of commissioned services.
4. Commissioning: A definition.
5. Dementia: what is needed and why (prevention, preserving self, and Identity as the purpose of care).

1.1 Motivation for the Study

My background is in health service commissioning (mental health) across the children, adults, and older people service area (65+). My experience of the devastation caused by Dementia is both professional and personal. I registered for the professional doctorate programme at the end of an interim role as head of continuing healthcare (CHC). In the role, I was responsible for monitoring/managing the commissioning of care arrangements for older people diagnosed with long term conditions such as Dementia. To fulfil this role, my team of nurses has responsibility for assessing service users for their eligibility for continuing health care or funded nursing depending on the severity of health condition checked across 11 domains. We also consider how ill-health impacts the everyday life (domestic capabilities) of each person to ensure that whatever is deemed necessary can be fed into care packages and monitored by social workers. Suitable packages of health and social care are commissioned to meet assessed needs that are over and above those that would typically be met within primary or secondary care. This is a fulfilment of continuing health care legislation and is therefore a legal requirement/statutory duty for the department

The primary responsibility of the CHC department is to make all the arrangements for care to be delivered in the right setting, at the right time, and cost, and that the care is effective and of an acceptable quality to the recipient. This ensures the avoidance of delayed transfers of care, especially for those who are medically fit to be discharged from hospital. It is also vital that the CHC team works to ensure continuity of care from one setting to another while commissioning care close to home. All commissioning decisions are signed off in a panel system made up of clinicians, and social workers presided over by the head of the department. In this setting, the recognition of differing values is central to decision-making; it is an opportunity for the professional to consider their ethnocentrism, bias, and the perspective of the service user so that they can act culturally proficient. The process requires the commissioning system to be explicit about its values relative to those present in the community (Jensen and Mooney, 1990; and Woodbridge and Fulford, 2004). The panel outcome must always result in a care placement decision that is reviewed by the 3rd month and then yearly.

Within the remit of CHC service provision, decisions are also made for those service users who are terminally ill and in need of End of Life (EoL)/Palliative care. EoL services are usually provided within a hospice setting or by a care-at-home team within the patient's home; the CHC team works with the family and service user to put the right type of care in place. At the end of life phase it is critical to ensure that the cultural perspective of the recipient is considered in terms of pain relief, nutrition, religious belief, death, and other relevant aspects of culture (Fesser and Bon-Bernard, 2003; Jensen and Lenskjold, 2004; Kemp and Rasbridge, 2002 and Smith-Stoner, 2005). Such factors are crucial in advocating for cultural competence to be relevant in the commissioning and delivery of older (vulnerable) people's palliative care services.

At present, the recent introduction of the Personalisation Agenda also known as personal health budgets (PHB) makes for a progressive and assured step in the direction of cultural competence. This is because it is an agenda that will further

ensure that service users can exercise their ‘right to choice’ in all aspects of assessed care needs. This is a relatively new system that sees the budget for care handed over to the service user or family to procure care however they see fit. It is a welcomed change to policy as it removes the burden of commissioning numerous care packages from the commissioning team. This means that responsibility for monitoring the delivery of care package shifts from the commissioning team so that choice can be exercised by families though approved by commissioners. Aside from the positive stance of empowering families and service users, PHB gives family members the option of delivering care or employing carers of their choice from a pool of carers commissioners may not have access to if care is to be delivered at home. If care is to be delivered in a care home setting, a placement is sought from a list of preferred providers that have met the criteria set by a local commissioning forum. The practice of a notional budget that can be offered to a family is referred to as a personal healthcare budget (PHB) however the care received is specified by professionals in partnership with the family.

A significant disadvantage of the PHB system is related to possible safeguarding issues that may occur when professionals are not or no longer involved in the monitoring of the delivery of care. This can sometimes mean that the commissioning team is unable to have oversight which reduces opportunities to prevent safeguarding issues that may result from neglect, underfeeding, financial mismanagement, or physical or mental abuse.

The head of continuing healthcare role requires and furthers an understanding of how diversity in multicultural populations should be handled to ensure equity and equality. This is especially important in populations with increasing numbers of the elderly living longer but not healthy.

In summary, it means we need a new approach to commissioning care and that requires innovation and the recruitment of diverse workforces, CPD, and resources. A failure to appreciate what this means is evidence of little or no cultural sensitivity to the diverse needs present in communities. The non-consideration of diverse

issues and their impact (cultural perspectives of disease) in diverse communities could mean that the NHS is judged by older people and the BME population to be non-compliant as a culturally competent organisation. In terms of the agency responsible for ensuring that care is up to standard, that is the Care Quality Commission, they are a potential beneficiary of the findings of this study along with all other strategic health authorities and the NHS.

In general, the NHS is plagued with issues of accessibility, caring for a significant elderly population, engaging with BME communities, health inequalities, discrimination, and parity of esteem concerning spend on mental health services. The spend on mental health relates to as many long-term conditions such as dementia, eating disorders, schizophrenia, depression, substance misuse, and children and adolescent mental health issues. These are all issues that the principles of cultural competence can assist with addressing. Furthermore, related policies can promote the understanding of cultural diversity in the first instance and help to eradicate the use of the term 'difficult to engage with' groups. This is a term often used by commissioners when describing those in the population whose presence is often absent in the demographics of those using services. The notion causes commissioners and providers to act as if certain sections of the population do not require services, a discourse linked to a history of underutilisation. Service underutilisation should be understood in the context of cultural attitudes related to health-seeking behaviour and an acknowledgment that sections of the population underutilise services because they feel misunderstood or discriminated against. Furthermore, these are issues that might be attributed to a limited awareness of the advantages of cultural competence amongst providers and commissioners.

In recent times, the conclusion of the 2013 Mid Staffordshire (Sir Francis Report, 2013) public inquiry emphasized putting patients first with a headline recommendation for the NHS to develop a culture change. It is contended that the request for a culture change was about inviting the NHS to embark on a systemic journey of cultural competence to enhance person-centred care, promote

compassionate care, reduce inequalities, and increase accessibility. The report was the product of a public inquiry into poor hospital care at the Mid Staffordshire Trust which led to several deaths and evidenced a lack of respect between professionals and service users as a significant theme. Poor (dispersed) leadership prompted the report to recommend shared training and a shared code of ethics capable of enforcing standards and accountability. It can be argued that a culturally competent leadership model is the style of leadership needed to address the call for a culture change and compassionate care.

The Marmot Review (2010) into health inequalities proposed an evidenced-based strategy that addresses the social determinants that create health inequalities and by extension unfair settings. It is argued that culturally competent practices are significantly relevant to building fair societies and creating equitable healthcare systems. This study explores the possible contribution of cultural competence towards resolving health inequalities and the promotion of patient empowerment. Given the current climate, perhaps this is also a study that has the potential to ensure that in the wake of the Black Lives Matter movement equity as well as equality becomes a hallmark of the quality of experience had by ethnic minorities and other vulnerable populations. It is certainly a very important time to consider how and why the impact of Covid 19 has affected BME communities disproportionately.

Linking Cultural Competence to Commissioning

The literature highlights several reasons why it is essential to link cultural competence to commissioning, they range from healthcare disparities, poor service user experiences to issues of misdiagnosis, fragmented dementia care and embracing the cultural perspectives of disease. The latest reason might relate to how the impact of Covid 19 has adversely affected ethnic minority communities disproportionately. Poor access to services, higher C19 infections and deaths rates, further demand that professionals consider the need to link cultural competence to

commissioning services that respond to diversity issues. Furthermore, with the mounting evidence showcasing the poor service user experiences of minorities, culturally competent practice might be the required response. This demand and the possibilities for transformational changes might be what links cultural competence to race and racism. This is in keeping with the origins of cultural competence in the American context, where it is strongly associated with racism (Hanley, 1999). A review of research that considers the effectiveness of health service interventions to reduce variations in health may further support the rationale described above and might be a better argument for cultural competence in commissioning. The further suggestion is that it cannot be for the sake of ethnic minorities that professionals engage in culturally competent practices. it must be about all vulnerable groups which include the elderly, refugees, those with disabilities and those who belong to the LGBTQ community and others.

Culturally competent commissioning is in many ways a politically charged term that should sit comfortably within the remit of transforming the NHS in readiness for the future. This will be about the NHS becoming fit for purpose, improving its capacity to meet the needs of older people growing older less healthy, ethnic minorities and other vulnerable groups. It should be a framework that is necessary to address individual cultural needs at the point of delivery having been adequately defined at the point of commissioning.

1.2 Study Rationale

The rationale for linking cultural competence to mental health or dementia services for older people in a research study is based on experiential knowledge as a commissioner of health services and personal family experiences of dementia. As the study involves commissioner and provider participants, it looks to create awareness and set the scene to acquaint others with cultural competence in commissioning. The focus is on the relevance of the concept to the improvement of

issues that are particular to mental health/dementia service commissioning. The suggestion is that this study can transform the mental health landscape by enhancing the relevance of cultural competence in commissioning and address health care disparities.

In recent times, commissioners have made concerted efforts to redress discrimination against older people within health services, though evidence (for example around ageism) exists to the contrary (Keskinoglu et al 2007, and Cuddy, 2005). Ageism affects older people in many ways and can mean that they are unable to express their needs in appropriate forums or they develop depression as a comorbidity. These negative experiences often cause some elderly people to feel isolated and disempowered in their healthcare decisions (Kane and Kane, 2005; Ouchida and Lachs 2015). The issue of isolation and service underutilisation may then lead to a significant number of the elderly population being undertreated (Sherman, 2003; Phelan, 2008). The NHS and the Department of Health have gone to great lengths to develop policies that provide older people with better experiences from services. The policy specifies how services should function on being caring and sensitive to the nuances of old age (National Older Peoples Service Framework, 2001). This effort improves accessibility and treatment outcomes but does not address racism or bias or matters that relate to cultural incompetence in general. These are evident in healthcare in general (Bhopal, 1998; Henry et al 2004; Adegbembo et al, 2006 and Paradies et al, 2014. Papadopoulos et al, 2004 point out that although there is evidence of racism in the NHS (McKenzie, 1999, Sawley, 2001; Singh 2006) this is not out of spite. It is possible to attribute these issues to endemic failings in the system, especially when the failings are the result of a weakness in recognising cultural differences and their significance to health (Geiger, 2001). The consequence may have contributed to the continuous practice of commissioning for a mono-cultural society.

Issues that pertain to race, ageism, diversity, culture, and discrimination are rarely topics for discussions in commissioning meetings. This could mean that

professionals may not pay much attention to what it means to work within the context of diverse cultures. The question that is raised here is whether this is in some way due to neglect or a lack of awareness. For this reason, it is suggested that discussions that pertain to cultural competence should be considered during contract monitoring meetings/forums. These forums are used to monitor performance against agreed key performance indicators, and to ensure that providers and service users alike can contribute to the discussion of what works better in ensuring service user satisfaction. To this extent, there is a need to ensure that clinical commissioning groups and other commissioning bodies understand the relevance of age and cultural diversity to health promotion and prevention. Furthermore, there is a need to appreciate the clear link these factors must have to culturally competent commissioning when considering service accessibility, improvement, and a recognition that older people need services that respond to their individual needs.

Therapy compliance and positive service outcomes have long been a subject of concern in the healthcare arena such that much attention has been focused on the need for cultural competence to achieve these elements for diverse communities (Philleo and Brisbane, 1997; Ehrmin, 2005 and Geiger, 2010). A study by Philleo and Brisbane (1997) focused on the significance of cultural competency in an era of increasing globalisation, multiculturalism, and international communication. One of their conclusions reports that cultural competency is as vital as computer literacy. This would mean that to be considered culturally competent as professionals, there must be some considerations for the broader cultural context of the service user.

This thesis argues that cultural solutions demand cultural dialogues that relies on an awareness of cultural diversity by the professionals who commission and deliver services. It is essential to link this recognition to the need to achieve better treatment outcomes, therapy compliance, and value for money even in the current climate of efficiency savings. This thesis further suggests that cultural competence may address the limited research and service development issues that exist in disease areas that mostly affect ethnic minorities and older people.

1.3 Study Overview

Chapter 2 presents the terms of reference for the study along with the terms and objectives and a narrative of the detailed literature review and operational definition of important concepts. It also clarifies the definition of the questions that direct the study.

Chapter 3 is a narrative of the project design and considers the problem, politics, and definition of dementia, the dynamics of the healthcare arena, and the person.

Chapter 4 considers elements of the research project's activity alongside the design, some description of the setting, participant selection, and other essential elements.

Chapter 5 presents the presentation of findings in diagrammatic format along with a narrative of the contributions of participants following the outcome of the analysis phase.

Chapter 6 presents the discussion of findings narrative with diagrams, tables, and charts that showcase the statistical calculations that relate to the quantitative phase.

Chapter 7 is the final chapter and is a narrative of reflections from the study, recommendations and a conclusion. The reflections are thoughts or lessons learnt from the beginning of the doctorate journey, during and after data collation, and write up of the thesis.

Chapter 2

2.0 Terms of Reference/Objectives and Literature Review

This chapter defines the terms of reference for this work and considers the important terms used in the study. It also provides the research questions the study seeks to answer and the objectives and offers a summary review of the relevant literature acquainted to the study. This chapter will provide a literature review along with a detailed literature search strategy and description of databases, and key search terms used. Furthermore, the terms of reference for the project are also defined along with the research objectives stated including the main research question, and a list of research sub-questions. This chapter will also identify and critically reflect on how existing literature shapes and influences the study, especially as concerns the choice of methodology.

The literature review explores the complexity of cultural competence in the context of service delivery, how it could be used to improve the commissioning of health services in multicultural/vulnerable populations.

2.1 Terms of Reference

The terms of reference for this work are primarily linked to the experiential knowledge of the professionals responsible for designing, procuring, and performance managing mental health services. It is important to note that the all professionals involved as participants were commissioners or providers of mental health services or both, that is, those who are involved in commissioning decisions whilst also being consumers of NHS services. The role of the commissioning department is mostly concerned with designing and procuring services for the community; the focus is on meeting local community needs. The team works in collaboration with other agencies including secondary care and parents/carers to agree and design packages of care

for individuals with long term conditions. These long-term conditions are often life-limiting in nature and may include learning disabilities and mental health conditions. Commissioners have responsibility for approving packages of care and reviewing packages of care at regular intervals to ensure that care is fit for purpose (physical and mental health care). Planning for populations of diverse people with high numbers of those who are 65 and over and affected by long term conditions requires relevant professionals to respond sensitively to cultural needs or nuances. These cultural needs are not limited to the description of ethnicity but include disability, gender, religion, age, and any other nuances that constitute culture.

Cultural competence might be an emerging concept that can improve the outcomes of commissioning as well as service delivery. Its practice requires culturally competent skills and a support process that can be delivered in the form of a framework that guides commissioners. It also warrants the knowledge of which principles and guidelines should be applied when developing and designing mental health services. The reader is asked to note that it is not so much a question of what our culture or values are, but an acknowledgment that we are all cultural beings first and our biases must not compromise our ability to work within those of others. The significance of this is that tangible values that shape the way people live and express their perspectives of ill health should be factored into the commissioning of health or social care services so that the care received is meaningful to the recipient.

A study by Leininger, 1988, introduces a theory of nursing (caring) from clinical experiences. Culture as a holistic concept was reported as the missing link in nursing knowledge and practice. All professionals are asked to understand the variations in cultural values (Carter, 1991). Commissioning organisations serve communities; however, professionals are yet to understand the full impact of the values of society on the values of the organisation (Sagiv and Schwartz, 2007).

This study is timely to the government's current NHS, Social Care, Public Health and Well-being reform programme; it represents an opportunity to contribute to the task of highlighting the relevance of conceptualising cultural competence in the NHS. This

research is an important study not just relative to the quest to improve services for older people but also in light of the outcomes of the Staffordshire NHS Trust Public Inquiry. It is contended that cultural competence was implied by Sir Francis (2013) in his response to the Trust failings that led to the deaths of patients warranting recommendations that included a request for a culture change in the NHS. The report put the concept of culture, and specifically hospital culture, at the centre of the debate about improvements in the NHS.

The common thread that ran through the themes of the recommendations spoke to a “need for greater cohesion and unity of culture” throughout the healthcare system, Sir Francis (QC) maintained that another set of "top-down" pronouncements would not be a suitable response. He implied that what was needed was the engagement of all those who serve patients in contributing to a safer, committed and compassionate and caring service." (The Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2013, p18)

This maintains the vision set out in "High-Quality Care for All" which advocates for:

> “...*An NHS that gives patients and the public more information and choice and works in partnership and has the quality of care at its heart’* (Darzi, 2008, p7) ..."

The scope of this research study considers the challenges and opportunities for commissioning culturally competent dementia (mental health) services for older people and other vulnerable groups. It takes an opportunity to present much-needed evidence and new knowledge that can add value to the National Framework for Older People and Mental Health Framework for dementia service commissioning. These frameworks are the national guidelines for the procurement and design of different types of MH services delivered in local communities. It will be true to say that the task is an ambitious undertaking as there is an expectation of a level of successful negotiation and influence over long-standing NHS policies and practices. It is significant, in that the history of the NHS is that of an organisation that has

historical practices of commissioning services for a mono-cultural society (one size fits all).

It is intimidating to think of what it will take to successfully get the NHS and other health bodies (CQC, DoH, and NICE), to fully consider the relevance of cultural competence to commissioning and as a hallmark of quality. What we do know is that it will entail the recognition of the different values held by those engaged in making health and social care decisions in the first instance. The request to these agencies will be for them to act on the values that are culturally competent in the planning and implementation of services that are culturally relevant to service users.

This study plans to recommend criteria that can be included in a culturally competent commissioning framework that will offer guidelines to support the commissioning of all mental health services. This effort may amount to a valid contribution towards highlighting cultural competence as a quality outcome for all older people's services. This might address issues such as imbalances in the quality of services available, the negative reasons why carers and those affected by dementia do not access services, and the fragmented care problem (Nolan et al, 2002, Brodaty et al 2005, Markle-Reid 2001, Phillipson et al, 2013, Morgan et al, 2002, Lim et al, 2012 and Tanji et al, 2005). These adverse experiences are shared by many vulnerable groups and their carers.

A significant number of the studies considered in this research as far as desirable interventions are concerned are those focused on BME populations and disparities. In these studies, cultural competence is considered as a tool to reduce disparities in the delivery of services to BME populations. The consideration of cultural competence in commissioning and as a tool to improve service delivery makes this study important as it may be the first study of its kind to do so. It is even more significant given the study's focus on older and vulnerable people.

This study refers to the commissioning of mental health services particularly dementia services that are relevant to older people and a section of the younger population. It also considers dementia because the World Health Organisation

designated the condition a priority area and called for more research however most research has focused on treatment. This chapter presents a summary description of dementia without embracing or subscribing to any one of its theoretical perspectives of which there are many. The aim is to give the reader in-depth information (cogent facts about dementia) and an appreciation for the passion of the researcher for those affected by any type of enduring mental illness at any age.

Dementia must be understood in the context of what a service user needs on an individual basis (values/culture). The aim is to evidence how including an understanding of cultural diversity might improve how we care for those affected by dementia or other mental health conditions.

This work will also provide a critique of current policies affiliated to older people's services; these are the National Older Services Framework for service delivery and other related strategies.

2.2 Objectives of the Literature Review

- To determine previous work in the area of culturally competent commissioning;
- To explore factors that influence the practice of cultural competence in the NHS;
- To present a summary of the synthesised literature pertaining to cultural competence and commissioning;
- To further define the basis for which the study is needed.

2.3 Statement of Research Objectives

The main study objectives are to obtain an understanding of the current understanding of cultural competence in commissioning within the National Health Service. This entails exploring the understanding, practice, and influence currently within the NHS commissioning. This pertains to the skills, knowledge, confidence, and experience amongst commissioners.

On a personal level, this project will help to develop awareness of the complexities involved in identifying cultural competence practice, deficiencies, education and skills needs, and engagement with key stakeholders from the perspective of an outsider researcher.

- Gain an understanding of the personal views of participants concerning culturally competent commissioning
- Understand the level to which participants practice and influence levels of culturally competent commissioning in the NHS
- Obtain suggestions for components of culturally competent service provision
- Obtain a consensus profile of the criteria and principles needed to develop a culturally competent commissioning framework.

2.4 The Research Question

This section discusses what the research question is about, sets out the research question in line with how it will drive the inquiry, and very importantly how it is linked to the methodology. It pertains to how the problem relates to the research participants (relevant for professionals). The importance of the inquiry on some level is its capacity to demonstrate the appropriate skills, understanding and strategies that are required to promote quality, inclusivity, accessibility, equality and equity within the NHS commissioning arena. The suggestion here is that the ethos of Cultural Competence should be adopted for NHS employees.

The need to apply cultural competence to the commissioning of health services associated with dementia is about ensuring that those who need services have access to the best care possible. For this reason, this study explores how cultural competence may be used as a vehicle for improving MH (dementia) service commissioning. This makes it pertinent to consider the experiences of NHS mental health service commissioners and providers and their views of the challenges and opportunities for culturally competent commissioning. To do so the main research question has been framed as ‘what are the challenges and opportunities for commissioning culturally competent dementia (mental health) services for older people? The question warranted an exploration of the experiences and understandings of NHS mental health service commissioners and providers. Those aspects that needed to be explored were formulated into a list of research sub-questions set out in the design of a survey questionnaire:

- Which criteria are crucial to culturally competent commissioning?
- How can participants influence culturally competent commissioning within the NHS?
- To what extent can the NHS be considered a culturally competent organisation?

- Do participants understand and practice cultural competence?
- What role might a lack of training play in the description of the challenges or opportunities for commissioning culturally competent MH services for older people?
- What are the descriptions of services participants consider culturally competent?
- What are the challenges and opportunities for commissioning culturally competent services and the suggestions for addressing the challenges that may cause cultural incompetence?
- Is cultural competence vital (important/significant) to commissioning (older people services)?
- How do participants describe or define cultural competence?
- What are the components of cultural competence?

These sub-questions to the main research question were explored via the survey questionnaire as part of the of qualitative data while the quantitative questions focused on the demographics of the participants.

2.5 Research Aims

The main aim of the proposed research project is to explore how cultural competence may be used as a vehicle for improving MH service commissioning. The exploration task will employ a mixed methodology to capture the experience and views of MH service commissioners. Further aims are to:

1. investigate the challenges and opportunities for commissioning culturally competent mental health (dementia) services by interviewing participants to obtain their views of culturally competent commissioning.
2. investigate the drivers of cultural competence in the commissioning arena via survey questionnaires and interviews.
3. explore the culturally competent knowledge, perception, and phronesis (practical wisdom) of professionals via interviews.
4. propose a set of criteria for a future culturally competent commissioning framework for the NHS.
5. publish and disseminate the findings and recommendations of the project.

2.6 Operational Definition of Important Concepts

The important concepts dealt with in this study are cultural competence, culturally competent commissioning, commissioning, the complexity of commissioning, dementia, and the NHS as a commissioning organisation. The details of these concepts are narrated below.

2.6.1 Cultural Competence

The study of the role of cultural knowledge in shaping illness dates back many years as can be evidenced via a substantial tradition of cross-cultural research that describes the beliefs and practices associated with mental health disorders in different societies (Westermeyer, 1976). Furthermore, Day and Cohen, (2000) argue a role for culture in the design of environments for people with dementia. Laroche et al, 2004 also agree on culture playing a significant role in service quality perceptions and customer satisfaction. What is not apparent in the literature are studies that

measure the success of these efforts or those that factor in responses from service users as a measure of quality.

The literature offers up many definitions of cultural competence; it is also interpreted for many aspects of policy and practice from teaching to employment; however, its main application has been to health care delivery and never commissioning. In the UK, the closest phenomena could be Value-Based Commissioning; however, we are yet to explore in any detail the opportunities and challenges of its utilisation and there is paucity of research on what it is, and how popular it is beyond discussions or mentions in some forums.

Cross et al, 1989, defined cultural competence as a set of congruent behaviours, attitudes, and policies that come together as a system, agency or among professionals enabling that system, agency, or those professionals to work effectively in cross-cultural situations. The 1989 study coined the term cultural competence while working with children affected by severe MH disorders. Tse et al (2005) took a slightly different view and described it as the ability of individuals and systems to respond respectfully and effectively to members of all cultures, races, classes and ethnic backgrounds and religions in a manner that recognises, affirms, and values the cultural similarities and differences and their worth. There is no real mention of how this might be achieved. The goal is to use culturally competent tools to create person-centred care that is meaningful to the user. This makes cultural competence a component of patient-centeredness (Engebreston et al, 2008), originally defined by Balint in 1969 to explain the need for patients to be understood as unique human beings. This is laudable but falls short of ensuring that related tools capable of measuring outcomes are also put in place. Both definitions advocate respect and place the patient and their values at the centre of care and introduce an element of empowerment into the patient-physician dynamic. This is a dynamic that still only speaks to delivery of care and not the design of care or its procurement (commissioning).

There is evidence in the literature that patient-centeredness existed before cultural competence which didn't begin to appear consistently in the literature till after 1989 (possibly due to lack of research). So far, it has been included in curricula for training nurses and other medics, informed programmes to enhance service improvement, and considered a means of reducing health care disparities in America (Betancourt et al 2003, Anderson et al 2003, Brach and Fraserirector, 2000, Chin et al 2007, Lie et al 2011, Campbell et al, 2011, Qureshi et al, 2008 and Khanna et al, 2009).

Within the literature, there is a consensus of a need for health care practitioners to recognise the role culture plays in health-seeking behaviour, ethnic minorities' perspective of disease, the description of symptoms, and the ability of service users to comply with treatment. It is also known that with the advent of previously mono-cultural societies becoming multicultural, health practitioners are experiencing a different level of complexity in caring for people of different cultures, ages, and backgrounds. This has resulted in practitioners having to examine their understandings of culture, culture awareness, and ethnocentrism (Leninger 1995, Camphina-Bacote 1999, Papadopoulos 2006).

It is possible to describe cultural competence as a social movement that has evolved from efforts to reduce disparities in healthcare for ethnic minorities and vulnerable populations in America. In America, its focus has been on ensuring that BME communities and refugees have access to good quality care by reducing disparities. The source of these disparities is often complex and multifactorial and does not differ much from one setting to another, therefore the American experience may not be that different from the UK. Saha et al, 2008, contends that 'the principles of cultural competence are rooted in efforts that precede the high visibility of inequalities and disparity'. The definition of cultural competence along with its principles and skills can be said to still be emerging in the UK, this was first stated by Papadopoulos, 2006, and much progress has not been made. Several definitions have emerged over time however a consensus on an exact definition to be adopted across the board has not been made.

There are numerous definitions of cultural competence, each of which depends on the perspective of the author and the setting. Bhui et al (2007) defined the concept as a 'set of skills or processes that enable healthcare professionals to provide services that are culturally appropriate for the diverse populations they serve' (Bhui et al 2007, pg15).

A review of the literature found definitions or defining characteristics from different settings by a few researchers:

1. Lopez (1997) asserts that a defining characteristic of the culturally competent mental health service provider is cognitive flexibility or problem-solving skills.
2. Papadopoulos, 2006 defined it as 'a process one goes through in order to continuously develop and refine one's capacity to provide effective health care taking into consideration people's cultural beliefs, behaviours, and needs. (Papadopoulos 2006 pg.11)
3. Cross et al, 1989, described the concept as a set of congruent behaviours, attitudes and policies that come together in a system or amongst professionals enabling that system or those professionals to work effectively in cross-cultural situations. (Cross et al 1989, pg. 4)
4. Lavizzo-Mourey and Mackenzie, 1996 offered cultural competence as a demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Lavizzo-Mourey and Mackenzie, 1996 pg.919)
5. Roberts et al, 1990 defined the concept as a programme's ability to honour and respect those interpersonal styles, attitudes, and behaviours. Their definition includes families as deserving clients as well as the multicultural staff who provide services.
6. Cooper et al, 2002 see cultural competence as the ability of individuals to establish effective interpersonal and working relationships that supersede

cultural differences. Betancourt et al, 2003 agree that Cultural Competence is accomplished by recognition of the importance of social and cultural influences on patients, the considering of how such factors interact, and the devising of interventions (treatment and social care) that take such issues into account.

The common thread running through these definitions is that of a problem-solving and improving quality dimension. Sue and Torino (2005) offer a definition covering organisational and system-level activities. Overall, these definitions speak to this current study in that the level at which cultural competence is required in commissioning may be at organisational and systemic levels, the place where strategies evolve into practice.

The definitions stated above have an emphasis on performance at the delivery (provider) level and not much of an emphasis on the important elements of commissioning which are service design and specification, assessment of needs, budgets, and the procurement of services.

Each definition is applied accordingly but never has cultural competence been applied to the practice of commissioning using the same language. This might be the reason why there is no definition for culturally competent commissioning in the literature in the UK or globally nor is culturally competent commissioning mentioned in any of the literature. This study is in a unique position to offer up a unique opportunity for a first definition of the concept.

The new definition is a work in progress and must be linked to the purpose of cultural competence and how it might be achieved, expressed, and its product. It is made of as many constructs as scholars can theorize (cultural awareness, cultural intelligence, cultural comfortability, cultural translation, and cultural proficiency).

1. Cultural awareness is a quality that all health and social care organisations must have concerning the residents in the community that it serves; this pertains to the behaviour of an organisation and its self-awareness. This may have a great deal to

do with the ethos or philosophy of an organisation, very much of it depends on the quality of the leadership and the make-up of its workforce.

2. Cultural Intelligence is related to the information obtained during the process of a needs-assessment exercise; the information is used to boost the quality and quantity of cultural diversity knowledge of a commissioning organisation. It is acquired by consulting with services users and the community at large covering all aspects of the population (gender, religion, culture, health issues, local economy etc).

3. Cultural Comfortability is related to the level of preparedness a commissioning organisation or its professionals (commissioners) have in relation to understanding and embedding cultural intelligence into practice. A high level of comfortability should see cultural intelligence used to design service specifications and seek out those providers that can deliver accordingly. It refers to the capacity of an organisation to achieve at optimal levels by committing to cultural competence at a strategic level.

4. Cultural Translation is the ability of a commissioning organisation or group of commissioning professionals to translate culturally diverse strategies from policy to operational practice. When it pertains to a commissioning professional, it is the ability to use previous cultural encounters differently, by translating encounters in ways that meaningfully fit others. The purpose is to step away from professional bias or a one-size-fits-all approach. It is a quality that should be apparent when delivering services to patients or service users in health prevention or treatment scenarios. This is a new discourse proposed further on in the discussion and conclusion chapter.

5. Cultural Proficiency is the unifying quality or capability to perform in a culturally competent manner when given the opportunity. The concept relates to the acquisition of the previous four levels (awareness, intelligence, comfortability, and translation) to ensure improved commissioning performance by the commissioning organisation or the individual.

It is important to note that these reflections are a starting point for building the notion of culturally competent commissioning based on an initial understanding of the

literature. This stance will be reviewed further in chapter 6 considering the findings from this research.

There is a focus on cultural competence training in the literature, but the evidence is of a limited consensus on the validity of the various culturally competent interventions or training schemes. Concerning the impact of training, a study by Clarke, (2010) found participants of a multicultural training course still felt that they lacked adequate multicultural competencies following training. A study of health care provider educational interventions recommended that future research needs to focus on determining which teaching methods and content are most effective (Beach et al, 2005). In agreement with the Beach study, Chipps et al, 2008 carried out a systematic review of the literature concerning training for health professionals in community-based rehabilitation settings. The results reported positive outcomes for some programmes however the reviewed studies had used small samples and poor designs. The recommendation is that future studies that are methodologically rigorous are needed given the paucity of studies and lack of empirical precision in evaluating effectiveness. Despite the above findings and some dissenting views including studies that describe points of convergence and divergence, they all widely agree that cultural competence is a set of problem-solving skills learnt over time.

Cultural competence should also be considered a crucial tool for clinical professionals as diagnosis, treatment, and the reporting of symptoms are influenced by cultural beliefs (Jackson, 1993; Broome, 2006). The suggestion is for health staff to be adequately trained to meet the needs of older people with dementia needs especially those from culturally diverse backgrounds (Campinha-Bacote, 2003; Leininger and McFarland, 2006 and Mahoney, 2006). Aside from cultural competence aiding an understanding of service users, it also promotes empowerment as it enables the type of negotiation that enhances service user satisfaction, facilitation of dialogue, and compliance with therapy and retention in service (Langer, 2002; Caper, 1994) and improved outcomes.

Culturally competent policies have the capacity to ensure the availability of culturally appropriate services and corresponding culturally appropriate workforces (Cross, 1989; Lynch and Hanson, 1992; Weaver 1999, Van Den Bergh and Crisp, 2004). This being said, policy translation is only as good as those translating it for use in and the setting. Therefore, it is suggested and a recommendation for the development of a culturally competent commissioning framework may be required (ch6 and 7). Given the number of culturally competent studies available, it is disappointing to note that cultural competence has not yet acquired a hallmark status of quality, hence a further need for this study.

It appears that unlike in America, the concept of culturally competent frameworks is still very much an emerging field in the UK (Betancourt et al, 2002). In America, Betancourt et al, 2002, state that the emergence of cultural competence is recent and part of a strategy to reduce disparities related to access to quality healthcare. They further describe efforts to modify hospital culture to keep up with changing demographics. The description of efforts that define cultural competence beyond transcultural nursing and mental health care is also still evolving (Betancourt et al, 2002) and pacesetting in the UK. This work further argues that the term cultural translation is similar to transcultural nursing, which is it interacts with the concept of nursing. A further suggestion is that cultural translation in service commissioning relates to the capacity of commissioning professionals to translate the cultural needs in the population within services (generally or individually).

Cultural competence as a discourse is not apparent in commissioning language or UK literature; it is a term more entrenched in American literature, healthcare delivery, and health insurance/health management organisations due to the nature of the American healthcare system. This means that most of the research this work relies on is not concerned with previous commissioning research in the UK as there is little to none. In America, research and literature pertaining to cultural competence is mainly linked to health care delivery and though it is popular, it is not clear whether its primary driver is economics or the necessary improvements needed in health

issues that pertain to minorities. What is evident is that in America, cultural competence has been used by health businesses to take up larger shares of the health insurance market. It has also been used to help reduce healthcare disparities (Carter-Porkras and Dogra, 2005).

In the UK, it can be argued that though person centred-care is constantly a topic of discussion it is not adequately monitored by commissioners, that being said, the relevance of culturally competent care is entrenched in the Mental Health Act 2007 wherein the following issues are referred to as being crucial to informing decisions that are made into MH services. These include:

- Respect for patients' past and present wishes and feelings
- Respect for diversity generally, including diversity of religion, culture, and sexual orientation
- Minimising restrictions on liberty.
- Involvement of patients in planning, developing, and delivering care and treatment appropriate to them.
- Avoidance of unlawful discrimination.
- Effectiveness of treatment.
- Views of carers and other interested parties.
- Patient well-being and safety; and
- Public Safety

This study would then suggest that the language to be used be expressly that of cultural competence as an encompassing discourse to ensure it is embedded in practice.

The cultural values of commissioners are relevant in the procurement of health or social care services; this is an assertion that is also shared by those who belong to

the Value-Based Commissioning (VBC) school of thought (Heginbotham, 2012). This study is relevant in that it will explore what these values might be because the suggestion is that these values affect the ability of providers and commissioners to work within the cultural context of service users effectively. This expectation or requirement is a well-researched contention of experts, Campinha-Bacote, 1999; Atkinson, D.R., and Gim, RH, 1989 and Chevannes, M., 2002.

Many studies of the efficacy of cultural competence in healthcare have been carried out; furthermore, a few frameworks or conceptual models have also been developed. These studies have delivered and firmly establish the concept as an individual's core obligation for working effectively with individuals from 'other' cultures. There are many models of cultural competence from healthcare to business (Sue 2001, Suh 2004, Papadopoulos 2004, Doorenbos and Schim 2004, Balcaza 2009, Burchum 2002, Johnson et al, 2006 and Teal and Street 2009). It must be noted that despite all the available studies, none seem to have led to an agreed consensus regarding a definition or the finality of the exact components. Furthermore, there are few if any studies expressly linking cultural competence to commissioning though there is a dearth of empirical evidence indicating the benefits of cultural competence.

This study seeks to add a new dimension to the history of cultural competence by applying it to the practice of commissioning; it goes one step further by focussing specifically on services for older people and other vulnerable groups at a time when the UK older population is no longer strictly mono-cultural. The move in the UK from monoculturalism to multiculturalism should warrant a breakdown of what multiculturalism means. Are there types of multiculturalism or does it exist as one ideology? The answers to these questions are beyond the scope of this work, but what we do know is that multiculturalism means that the health arena must be ready to deal with complex issues related to gender, religion, and identity. At these times it must also be considered a high priority in the wake of the Black Lives Matter movement and the issue that is the disproportionate impact of C19 on the lives of BME's.

This work suggests that multiculturalism can be considered another word for diversity (diverse cultures) even though when mentioned it usually sparks debates about immigration, migrants/refugees, equality, and equity. On a positive note, the acceptance of multiculturalism has caused the drafting of suitable policies for different organisations to respond to the diverse needs represented in the community.

The shift in monoculturalism to multiculturalism has been influenced by several complex factors, with some studies arguing that multiculturalism in Britain is influenced by Australia and Canada (Macey, 2006). Macey further argues that multiculturalism was a response to cultural and religious diversity following the Second World War. For the most part, researchers cannot seem to agree on what multiculturalism is though there is some level of agreement on what it should be (Kukathas 1986, 1992, Modood 2001, 2005, Willett, 1998, Parekh, 2000). Kymlicka, 2011 argues that increasing multicultural societies have given rise to new issues (support of identity, citizen rights, and religious freedoms). Kymlicka (1998, 2001a, b), further states that there is no clear alternative to multiculturalism, which is the dominant and accepted approach to cultural and religious diversity. Macey, 2009 disagrees with Kymlicka, believing his version of 'western' multiculturalism to be fundamentally flawed given the extent to which different groups are adversely affected by it. A final note regarding multiculturalism is the shared understanding of it as a policy agenda designed to redress unequal treatment and culture racism (Phillips, 2007).

Perhaps this study is timely in joining the advocates of VcB and cultural competence in encouraging commissioning organisations to be aware of their customers' cultural needs that demand the provision of culturally congruent services (Strauss & Mang 1999, Sharma et al. 2009). Commissioning organisations are also asked to be aware of their own bias or prejudiced beliefs (ethnocentricity) and dedicate considerable resources towards acquiring better cultural diversity intelligence in their localities. The outcome of this is the availability of needs-led services and appropriate key

performance indicators that can be measured as part of contract monitoring schedules. Perhaps It should also be the remit of the commissioning organisation to ensure that the relevant culturally competent training is available to staff and available within the budgets of its service providers as part of their service development improvement plans (SDIP).

2.6.2 The Complexity of Cultural Competence

It was important to use the literature review to understand the complexity of cultural competence given there is a significant level of research reporting on its complexity, numerous definitions, applications, and dissenting views. Its complexity causes it to be described as multidimensional, contentious, and in high demand especially in the mental health care (delivery) arena. These issues are discussed further along and make the research an exciting undertaking as to what new knowledge exists in the arena (culturally competent commissioning) less researched.

The contentions have been the product of debates that have led to many dissenting views that centre on its relevance, use, training evaluation, measurement, outcomes, and definitions. Examples of studies confirming varying levels of contention include the following:

- Nadan, Y., 2017. Rethinking ‘cultural competence’ in international social work. International Social Work, 60(1), pp.74-83. The argument put forward by this study is that the common understanding of ‘cultural competence’ from the so-called essentialist perspective is inadequate.

- Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A. and Frank, B., 2007. Measures of cultural competence: examining hidden assumptions. Academic Medicine, 82(6), pp.548-557, the study concludes that existing measures embed highly problematic assumptions about what constitutes cultural competence. The argument does not take account of power relations of social inequality and assumes that individual knowledge and self-confidence are sufficient for change.

- Kleinman, A. and Benson, P, 2006. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS medicine, 3(10), pg 294, they contend that a major problem exists with the idea that cultural competency suggests culture can be reduced to a technical skill for which clinicians can be trained to develop expertise (Delvecchio, 1995). The study asserts there is a problem but lays the blame on the medical definition of culture which contrasts significantly from the original anthropological definition. It accepts culture relates to ethnicity, nationality, and language and that promotes medical professionalism that acts according to a series of cultural competency do's and don't's (stereotyping).

- Sue, D.W., 2001. Multidimensional facets of cultural competence. The counselling psychologist, 29(6), pp.790-821. Sue asserts that calls for incorporating cultural competence in psychology are hindered for several reasons: belief in the universality of psychological laws and theories, the invisibility of mono-cultural policies and practices, differences over defining cultural competence, and the lack of a conceptual framework for organizing its multifaceted dimensions.

- Wong, Y.L.R., Cheng, S., Choi, S.Y., Ky, K., LeBa, S., Tsang, K. and Yoo, L., 2003. Deconstructing culture in cultural competence: Dissenting voices from Asian-Canadian practitioners. Canadian Social Work Review/Revue Canadienne De Service Social, pp.149-167. This study as with others is not focused on commissioning but on delivery where they agree there is progress in culturally competent practice among social work and health professionals over the past decade. The researchers share concerns of a dissenting nature regarding the conceptualization of culture in most writings stating the failing of cultural competence to recognize the fluid boundaries and political character of culture.

These examples showcase the many levels of complexity attached to the implementation and development of the cultural competence discourse. Further examples of dissenting models include those of Purnell, (2000), Papadopoulos, Tilki and Taylor (2006); Camphina-Bacote, (2001), and Wong et al (2003). They expound on the complexities of deconstructing culture in cultural competence, asking for

recognition of the elusive, contextual and political character of culture. They also argue the need for a critical approach to cross-cultural practice that involves identifying power as central to how we all understand culture differently and negotiate the multiple narratives and meanings of culture.

Caminha-Bacote et al (1995) contend that cultural competence is a critical factor in nursing research, claiming that cultural competence must be linked to the need for an appreciation of the number of ethnic minorities that will be accessing services in the future. This study will contend that it is the commissioning arena that must take cognisance of future demands and the context of those demands in response to the needs of an increasing older diverse population.

Research could help deal with the corresponding expected challenges to health care professionals. O'Brien et al (2006) conducted a study on the self-assessment of cultural attitudes and the competence of clinical investigators to enhance the recruitment and participation of minority populations in research. They aimed to discover the strategies necessary to enhance the abilities of study investigators to relate and communicate effectively about health and clinical research within minority communities. They found that most participants were reasonably culturally competent, however, areas remained in which proficiency needed to be enhanced and recruitment of participants in clinical research required improvement. They also found an acceptable level of respect and reasonable knowledge of the cultures of most patients for whom participants provide care and conduct research. They however reported that there is still a need for continued cultural sensitivity and competency training to enhance the understanding of certain aspects of minority cultures, groups, international relationships, perceptions of disease, and wellness.

Engebreston et al, 2008 looked at cultural competence in the era of evidence-based practice, they maintain that it is concerned with contemporary health care delivery and ethical and legal implications aside from the challenges posed by the abstract nature of the concept (Engebreston et al, 2008). The study looked at highlighting the relevance of cultural competence to clinical practice by linking a cultural competency

continuum that showcases the performance of levels of cultural competency to identified values in healthcare. This, they reported ‘situates cultural competence and proficiency in alignment with patient-centred care. From a commissioner’s perspective, specifications for such a service would need to include key performance indicators such as patient satisfaction, improvements in medication compliance rates, accessibility, and seamless experiences of good care.

Overall, this literature review is an attempt at further justifying the need to apply cultural competence to the commissioning of mental health services (dementia) for older people and others. The positionality of the researcher on the issue is based on professional knowledge of mental health services for older people and others through the lens of a commissioner of health services which include memory services, psychiatric liaison, support services, and social care. The urgency of the matter pertains to the need for older people to have care that is not fragmented and for ethnic minorities to feel better valued in the wake of the Black Lives Movement.

In the American context, the struggle for the validity of cultural competence is a continuous exercise, it has for many years been accepted and used as a tool for addressing health disparities in a bid to reduce them and improve access to services by ethnic minorities. In the field of psychotherapy and counselling, cultural competency has been used to understand several desirable phenomena such as validating ethnic match between therapists and clients; it is also associated with treatment outcomes. There are still questions that pertain to the cognitive match between therapists and clients, in terms of whether there is a predictor link to outcomes and whether clients who use ethnic-specific services exhibit more favourable outcomes than those who use mainstream services (Stanley, 1998).

In terms of the evolutionary perspective for cultural competence, Burchum, 2002 described the problem of a need for conceptual clarity for effective communication related to the concept.

The first arguments for cultural competence were made in the face of increasing diversity in the population of America. Following on from there it was about

increasing access to high-quality care for the most vulnerable, this was possible because of the role of federal, state, and local governments in both managing and financing health care access for vulnerable populations. The focus was on all patient populations rather than just minority groups. Corresponding research by Betancourt et al (2005) showed participants viewed cultural competence as being driven by both quality and business imperatives such as health insurers marketing the initiative to employers to expand their market share. Other informants of the Betancourt study felt that by embedding culturally competent strategies into quality improvement initiatives, managed care could advance cultural competence. None of the responses or research studies considered the merits of cultural competence in commissioning; it seems that the focus had simply been central to just increasing market share as opposed to investing in cultural competence at large. Further emerging perspectives from the study showed that cultural competence was highly dependent on organisational, systemic, and clinical arenas for its advancement. Furthermore, links between cultural competence, improving quality, and eliminating racial and ethnic disparities in health care are described as being clear.

Additional arguments for culturally competent mental health services are those made on ethical grounds. Ridley (1985) contends that cultural competence is an ethical obligation, the current study agrees as all citizens have a right to services that are inclusive in design and delivery. He further asserts that this means cultural competence is imperative, putting therapeutic and cross-cultural skills on an equal footing with other specialized therapeutic skills. That being the case, he recommends that an appropriate level of training to reach adequate levels of competence is necessary to ensure professionals are qualified to deliver care and therapy. This study would assert the same however the added argument is that this must be a stance embraced from within the commissioning arena at this time.

Culturally competent healthcare is about the ability to deliver care to service users that are of a different culture to that of the professional caregiver. Furthermore, it is about tailoring services to the needs of those who have diverse backgrounds, values,

beliefs, and behaviours. A summary description of the literature on cultural competence places emphasis on delivery rather than commissioning. This description is another reason why this study needs to be about the commissioning professionals and process. Sue (1998) argues that a person is culturally competent when they possess the cultural knowledge and skills of a particular culture and can deliver effective interventions to members of that culture" (p. 441). Lopez (1997) considered the essence of cultural competence to be

> "*the ability of the therapist to move between two cultural perspectives in understanding the culturally-based meaning of clients from diverse cultural backgrounds*" (Lopez, 1997, p. 573).

Once again, we see that definitions relate to the capacity of the caregiver to utilise culturally competent skills yet there is no mention or reference to the role of the commissioner or the development of cultural competence in the service design. The wealth of cultural competence literature is evidence of how much it has been embraced in service delivery however it is still a challenging concept in commissioning for several reasons.

Betancourt et al (2002) offered 3 challenges to culturally competent care. The challenges reported were lack of diversity in the leadership of the workforce, poorly designed systems of care (commissioning responsibility), and poor communication between providers and patients of different backgrounds. Poorly designed services are scenarios that can be avoided if services are designed with adequate culturally competent intelligence. This can be accomplished within the needs of the assessment process; this is an important aspect of commissioning.

2.6.3 Clinical Commissioning Groups (CCG) and Commissioning

CCG's were established as part of key reforms to the National Health Service under the Health and Social Care Act 2012 and formally replaced PCT's by April 2013. The purpose was to increase the accountability of those commissioning the care needs

of each locality whilst giving them greater autonomy. During this transformation in the NHS, no guidance was issued requiring the NHS or its commissioning agencies to expressly become culturally competent.

The practice of GP's as commissioners' dates to 1991, following a requirement to separate the purchaser-provider function. This directive called for GP's to take responsibility for both the provision and commissioning of service via clinical Commissioning Groups (CCG's). Up till then, local health authorities referred to as Primary Care Trusts were responsible for both the planning and the delivery of services for patients in their locality. NHS style commissioning is now a process that requires a group of GPs' to spend budgets on assessed health needs. They predominantly make decisions related to procurement, contracting, monitoring, and reviewing services used by the locality. Not all commissioning is carried out at a local level as specialised services that cater to complex care needs are commissioned at a regional or national level to achieve an economy of scale.

The government, from 2010 onwards required general practitioners via the Health White Paper, 'Equity and Excellence', to take responsibility for commissioning and contracting (Department of Health 2010). Years later, Clinical Commissioning Groups are still the agencies with the responsibilities that had previously been led by Primary Care Trusts (PCT). The new commissioning groups are referred to as CCGs; they have the authority to choose those with whom they wish to collaborate. It was felt that collaborative working with other health professionals would get GP's to consider the cost and resource implications of their referral, treatment, and prescribing decisions. They are required to engage with secondary care clinicians, local government, patients, and the public and to form a 'governing body' with at least one nurse, a secondary care consultant, and two lay members. In addition, it was specified that they should have an audit and a remuneration committee. Each CCG was given authorisation domains and guidance governance relating to the development of governance processes in CCGs (NHS Commissioning Board 2012e, Checkland et al, 2012).

The Authorisation Domains:

Domain 1: A strong clinical and multi-professional focus that brings real added value.

Domain 2: Meaningful engagement with patients, carers, and their communities.

Domain 3: Clear and credible plan which continues to deliver on the Quality, Innovation and Productivity Programme (QIPP) challenge within financial resources.

Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities.

Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities, and the NHS Commissioning Board as well as appropriate commissioning support.

Domain 6: Leaders capable of making a real difference. (NHS Commissioning Board 2012e).

Within each domain, CCGs must produce an annual report accessible by the public that contains evidence, plans and proposals, examples of work undertaken along with feedback from local stakeholders. In summary, the system requires GP's to procure the services needed in their locality; they do this with the assistance of other experts who are experienced commissioners.

There are arguments in the literature for embracing cultural competence in the delivery of all mental health services; these same arguments apply to the commissioning of mental health (or older people) services. On the other hand, a systematic review evaluating models of professional education and service (Bhui et al, 2007) and cultural competence included modification of clinical practice and organisational performance. Unfortunately, the studies included in the review found that as with other studies, there was no inclusion of the investigation of service user

and carer experiences and outcomes. This is a limitation that affects the promotion of the discourse.

In the new era of commissioning CCG's operate as independent and accountable bodies to the Secretary of State for Health through NHS England (NHSE). Responsibilities for primary care, community, and hospital services are firmly placed in the hands of GP's, a mention of their capability and capacity for commissioning is worthy of discussion after the fact. Their remit covers mental health, urgent and emergency care, elective hospital services, and community care.

In terms of the skills commissioners need, and how these should be developed, reference is made to the World Class Commissioning Strategy (DoH, 2007b). It is a statement of intent that represents a first attempt at specifying the required skills to deliver the competencies and performance needed. There is no real specific training targeted at commissioners though there are world-class commissioning standards of conduct and NHS management schemes to enrol in. This unfortunate position can be highlighted as a missed opportunity to develop cultural competence as part of training at the commissioning level. There are NHS Management schemes that develop personnel for human resources, finance, communications, and information departments but no courses for commissioners.

World Class Commissioning competencies are described by a series of 11 headlines. These require that commissioners:

1. Are recognised as the local leader of the NHS;

2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities;

3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health;

4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design, and resource utilisation;

5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements;

6. Prioritise investment according to local needs, service requirements, and the values of the NHS;

7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes;

8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration;

9. Secure procurement skills that ensure robust and viable contracts;

10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes;

11. Make sound financial investments to ensure sustainable development and value for money; (DoH, 2007b).

The competencies have other sub-components. So far, there is no requirement for commissioners to acquire culturally competent skills meaning that this probably represents a weakness.

2.6.4 Commissioning in the NHS

The NHS commissioning process is a complex and iterative cyclical process through which the health needs of the local population are identified, planned, and procured. Commissioners working with providers are responsible for designing service delivery (defining care pathways) and reviewing performance against key performance indicators. In the UK, commissioning is accomplished on a locality level via clinical commissioning groups and nationally via NHS England and other specialist

commissioning teams for services that are needed by lower numbers of people who need services that are of a specialist nature

Healthcare services that are specialist in nature are categorised as Tier 4 services and are required to treat complex conditions. Examples of specialised services are Autism, neuro rehab, or eating disorder tier 4 beds. Such services will typically be commissioned from the NHS specialist commissioning team. Services commissioned at a local level are paid for via a global sum of money given to all local commissioning groups. The amount each commissioning group is given is based on a population formula and poverty index, furthermore, certain levels of this funding are often ring-fenced for the specific provision of certain services especially those related to various aspects of mental health (workforce development, waiting times, increasing diagnosis rates etc).

The 'new system' has experienced criticism due to judgments over performance. The teething problems such as the question of value for money and matters relating to process are not unusual. Innovative ideas are not often fully embraced at the beginning, and teething problems are to be expected due to the complexity of a system that has limitations. The system was designed to have a positive impact, ensure improvement, and promote innovation and efficiency savings where needed (Ovretveit, 1995).

The relatively new system of clinical commissioning groups (CCG) plays a significant role in completing local needs-assessments for primary and secondary services. The CCG sets priorities, translates national strategy into operational pathways of care, and decommissions or reconfigures services when necessary. It may do so to recommission better services, merge services, save money, or change providers due to underperformance. The NHS is a continuously evolving system of healthcare that has in very recent times moved towards a system of collaborative commissioning (integrated care system). That being said, this study commenced before the new system of integrated care came into existence therefore it only considers the NHS system of commissioning, yet it is relevant to social care.

2.6.5 Culturally Competent Commissioning vs Value-Based Commissioning

The concept of cultural competence originated from Leininger's work on transcultural nursing in the 1950s though it was first called cultural congruence from which the term cultural competence was adopted once the term became popular. Cross et al, 2009 defined the term further while working with children with mental health conditions, however, one of the most popular definitions cited in the literature is by Campinha-Bacote (1999):

> …. *the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community)* ... Campinha-Bacote 1999

Culturally competent delivery has been around for a long time; however, this study takes a step back to before the delivery process to focus on commissioning. The term culturally competent commissioning (CCC) has never been defined; however, for this study, it is described as an emerging concept in the UK health arena, although it does not yet feature in the UK commissioning literature. What we may have are pockets of good practice not particularly guided by policy but credited to the individual judgment of professionals rather than prescribed standard operational practice. It may amount to any number of actions the professional deems appropriate to ensure that the needs of a locality or individual are met. Cultural competence could be associated with Value-Based Commissioning (VbC-MH), a novel concept that has at its core the patient and carer perspective along with clinical expertise and other systematic approaches. Value-Based commissioning evolved from the term value-based practice, a concept initially developed in the context of the practice of psychiatry. It is based on the recognition of human practices linked to values (Fulford et al, 2004, Fulford et al, 2012). Values in this context are described as qualities that guide our actions and subject our activities to be worthy of praise or blame (Sadler,

2004). Value basing like cultural competence is the description of a process applied to any activity, including commissioning. Heginbotham, 2013, defines VbC as the use of stated values to achieve an improved process for filtering available evidence to achieve improved outcomes. Heginbotham and Newbigging, 2013, defines Vb-C as

> ... *the practice of recognising and acting on the differing values held by all those engaged in making health and social care decisions, in order to plan and implement health and social care that is culturally relevant and appropriate, clinically and economically useful, and addresses need in a way that reflects the values of those using and providing care.' Heginbotham and Newbigging, 2012, pg 10.'*

Culturally competent commissioning (CCC) may be considered a synonym for Vb-C because both concepts focus or aim to ensure the values of those who use services are reflected in the care, treatment, and support delivered to them. Vb-C may be different from CCC which has an evidence-based construct that is based on specific skills. Both concepts work with an acknowledgment that success (therapy compliance and recovery etc) depends on the quality of the relationships that are fostered between providers, commissioners, and service users. This means more than respect for one another, but the respectful utilisation of the values shared by individual staff and an understanding of how those values impact their roles. This study focuses on culturally competent commissioning and the challenges and opportunities that may or may not exist when considering the commissioning of mental health services (dementia/older people's services).

Although VbC and CCC have a similar focus, and both are affected by a paucity of studies they are not necessarily interchangeable therefore the term culturally competent commissioning will be used for the entirety of this study.

The literature does not offer a working definition for culturally competent commissioning (CCC); therefore, a definition was offered to participants for consideration. It was presented as a continuum of knowledge at the beginning of

the study. The purpose was to enable participants to have a benchmark to consider when reporting back on their positionality, experience, and practice of the concept.

Without an exact definition within the literature, this study had to offer a working definition of culturally competent commissioning to anchor the study. Thus, in this study culturally competent commissioning is conceived as:

> ...a vehicle for increasing access to quality services that are fit for populations with different cultures and values using culturally competent processes to tailor services to individually assessed needs...

Culturally competent commissioning is a process that should produce a system of care that delivers services that meet the cultural, religious, gender, and linguistic needs of culturally diverse populations. Cross et al (1989) emphasises on how systems of care can be developed more effectively to deal with cultural differences and related treatment issues. They advocate a need to clarify policy, training, resources, practice, and research issues and view cultural competence as a developmental process. The elements they identify as being crucial to a systems' (commissioning) ability to become culturally competent are the value of diversity, cultural self-assessment, a consciousness of the dynamics of cultural interaction, the institutionalisation of cultural knowledge, and the development of adaptations to diversity. It is easy to agree with their assertion that cultural competence must be developed within the policy-making ranks, administrative, practitioner, and consumer levels. And that furthermore, the process of continuous professional development should play a significant role in developing culturally competent professionals.

The administrative level is the commissioning level; the significance being, that cultural competence must be embedded at the strategic level to influence operational levels or practice. Guarnaccia et al (1996) looked at the role different concepts of culture play in the development of culturally competent mental health services. They further described an enhanced definition of culture through a critical review of cultural ideas (multifaceted definitions of the influences of culture).

There are a few principles that should be adhered to in the production of culturally competent services. This study sets out to investigate what health and social care professionals' practice as culturally competent commissioning and how this may potentially impact service delivery. In so doing, this study will investigate what the challenges and opportunities are for commissioning culturally competent mental health (dementia) services to older people and others.

The most popular model complementary to defining a culturally competent system/service has been described by Cross, Bazron, Dennis, & Isaacs (1989), as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables professionals to work effectively in cross-cultural situations. This is an introductory statement to a fuller discussion in further chapters.

2.6.6 Cultural Competence, Racism and Race

Every person in need of NHS mental health services or otherwise has a race and a culture causing both factors to be a starting point for a discussion about cultural competence in the commissioning of services. Professionals involved in the study were representative of as many cultural backgrounds however it was apparent that white participants of the pilot group who described themselves as British did not think of themselves as being cultural. Indeed, the perception of cultural competence amongst them seemed vague and may be linked to paucity of studies investigating the perception of cultural competence amongst commissioners. This status may also be due to the use of alternative terms such as person-centred care or culturally responsive or inclusive care, as rarely were the words cultural and competence associated on the Department of Health website or in health literature. There was mention of a toolkit underpinning the creation of culturally competent healthcare in recognition of ethnic minorities (DH,1996) with no report of the success or performance of such to date. This lack of focus, clarity and familiarity of the term

plays a significant role in healthcare disparities, discrimination/racism, cultural incompetence amongst professionals, high attrition rates, poor service user experience and fragmented care. These are the reasons why it may be important to link cultural competence, race and racism and be very factual about the premise of racism/discrimination within the NHS. It is therefore reasonable to say these factors may be linked to bias, a lack of understanding by professionals, unprofessionalism and other issues yet defined. **What** can be argued is the idea that not all professionals recognise themselves as cultural beings and therefore they may not recognise that the needs and rights of others of a different ethnicity who embrace culture are equal to theirs. And that furthermore those rights must be upheld by all possible means according to Human Rights principles. The principles include both the right to the highest attainable standard of health that apply to patient care as well as civil and political rights. The rights further state that all patients be free from inhuman treatment which definitely means that regardless of age, religion, ethnicity, education, gender etc patients have the right to be treated with respect, make treatment choices and decisions about end-of-life care. In other words, good health care that suits the needs of the patient is a right and not a luxury.

In 1998 the Human Rights Act (1998) compels public organisations, including government, police and local councils to treat everyone equally, with fairness dignity and respect. This could be an argument for cultural competence as a legal requirement within healthcare and a deterrent of racism/discrimination/prejudice.

2.7 Literature Review

The literature review process yielded a significant amount of material for analysis however it was difficult to keep to predetermined boundaries to gather exact studies due to the paucity of Vb-C or CCC studies. The search was based on specific search criteria that allowed for the comprehensive collation of relevant studies capable of establishing a deeper understanding of cultural competence and how it can be applied to the commissioning of services.

2.7.1 Literature Search Criteria and Strategy

This section introduces aspects of the literature review and explains the difficulties with obtaining findings within the literature specific to culturally competent commissioning or service design. The search considered any studies related to culturally competent studies in the health arena which are mostly linked to BME service delivery, training, and the education of nurses and other professionals based in America. Within the UK context, cultural competence was not found as a term applied to commissioning however articles written about the UK phenomena of Value-Based Commissioning (Vb-C) where found. The focus of Vb-C is related to supporting balanced decision making within a framework of shared values practiced based on mutual respect and relies on good progress rather than pre-set right outcomes for practical effectiveness (Fulford et al 2012).

Heginbotham and Newbigging, 2013, define of VBC as

> *…the practice of recognising and acting on the differing values held by all those engaged in making health and social care decisions, in order to plan and implement health and social care that is culturally relevant and appropriate, clinically and economically effective, and addresses need in a way that reflects the values of those using and providing care...* (Heginbotham and Newbigging, 2012, pg.9)

There is a paucity of appropriate culturally competent studies related to commissioning and the determinants of cultural competence; this meant that inclusion and exclusion criteria were fluid to enable the identification of relevant articles. Some studies (BME related studies) were only marginally related but it was assumed that as many of the issues captured also affect the elderly in terms of health disparities, access, and quality therefore they were included. Also included in the literature review are studies of culturally competent models and those that focus the evaluation of their application within MH health services and training. Criteria chosen

were based on the issues to be discussed, the research questions, and the concept of cultural competence, dementia, and commissioning older people's services. They were applied as follows:

- Articles that provided evidence or related to any of the key research questions;
- Articles that provided data from related culturally competent studies in health services;
- Articles in a suitable time frame of publication dates in keeping with keyword searches;
- Articles pertained to addressing service disparities and inequality (BMEs);
- Articles covering commentaries from professional journals within a time frame of up to 30 years due to the paucity of relevant commissioning studies;
- Studies older than 30 years that shed light on the historical emergence/evolution of cultural competence;
- Articles defining cultural competence, value-based commissioning (MH), dementia services, commissioning and health services;
- Articles focusing on the determinants of cultural competence:
- Articles focusing on the role of culture in delivering services;
- Articles focusing on commissioning definitions.

The American literature reveals other important drivers of cultural competence such as insurance and diversity management (Dreachslin, 2007). The purpose here is for larger American insurance companies to oblige health services to stimulate cultural competence so that insurance companies can increase their market share in diverse communities. In America cultural competence has become a business tool for driving profit in health-related businesses; businesses have gone to the extent of including systemic cultural competence interventions as part of contracting language (Betancourt et al 2002).

The literature reveals that the health care (delivery) community was one of the first to place value on the usefulness of cultural competence in reducing disparities, this mainly relates to ethnic minorities (Campinha- Bacote, 2002; Purnell and Paulanka 2008; Paez et al 2009; Starr and Wallace 2009.

A working definition of culturally competent commissioning speaks to the use of culturally competent knowledge from the service user population to inform the commissioning of services that meet the specific needs of service users. The idea is that services should not be a generalised fit causing those who don't fit to struggle to obtain the care that they need. Based on the limited UK-based research this literature search is designed to enable an examination of the literature concerning the role and relevance of cultural competence in commissioning for quality mental health services. It is a suitable course of action given the aim of this study is to improve services for older people and others affected by dementia and other MH conditions. The suggestion is that they should all be able to receive culturally competent care commissioned in culturally competent ways. The process of commissioning relates to the design, procurement, and management of health and care services. It also involves the assessment and understanding of a population's health needs, planning, securing, and monitoring of the services commissioned. It is important to note that the quality of culturally competent services would very much be dependent on the skills of commissioning professionals. There is no formal training for commissioners or a requirement for culturally competent skills or training;

this might explain why there is a paucity of theoretical literature on the components of commissioning.

The literature contained numerous studies relating to the reduction of health care disparities/ethnic minority health care but very few had any bearings on design, service development, and the procurement of services. Literature of this nature would assist with a better investigation of the challenges of implementing cultural competence in commissioning practice. Other studies considered responses to the disparities affecting vulnerable groups such as older people, minorities and the LGBTQ community amongst others ((Mobula et, al 2015; Betancourt et al, 2016; Bonvicini, 2017; McCalman et al Purnell and Fenki, 2019).

The sources used included textbooks and grey literature, Medline, Proquest, PubMed/NCBI, Wiley online, SAGE, and the MDX library resource for journals and the google scholar search engine. A search of the references of various sourcebooks (articles) along with the advice of academic supervisors and access to British Library journals and textbooks.

A decision was made as to the time frame of published literature to be included, this kept the search to studies carried out or completed in the last thirty years. This was about ensuring coverage of the estimated period of the emergence of the literature from studies addressing health disparities and inequalities with cultural competence (the history/evolution of CC).

The literature search was carried out using single and combined keywords; culture, cultural competence, value-based commissioning, evaluation of cultural competence, cultural competence in healthcare or mental healthcare, cultural competent models, historical perspectives of cultural competence, the definition of cultural competence, determinants of cultural competence, commissioning dementia care, older people's dementia care, dementia strategies for care, reducing inequalities and disparities, etc.

The principal reasons for using the selected keywords were, first to consider the emergence of concepts. Secondly, to understand the ways definitions for cultural competence were developed and operationalized as solutions to problems investigated by previous works. Other reasons included identifying and describing any issues other researchers of this discourse considered important along with the limitations of their studies, and their recommendations. This style of literature review assisted in the consideration of how the judgments of these other findings could apply to this study. Furthermore, it also enabled an understanding of how these previous findings might defer from those that are the outcome of the current study. The extraction of data was considered according to how well it identified as having a relationship with the current overarching research questions and the capacity to justify or add value to the study.

Although there was a paucity of studies investigating the application of cultural competence to commissioning mental health or dementia services, some studies considered Relationship-Centred approaches (Nolan et al 2006). Searching for studies specific to cultural competence in commissioning older people's services was about attempting to continue where other researchers had left off, justifying the study, and applying any relevant aspects to answering the research questions. Assumptions were made that there would be a significant body of research relating to designing culturally competent commissioning models or cultural competence in service design. There were studies and definitions about the delivery of culturally competent health care, a significant number of these studies cited Camphina-Bacote, 1994, 1998a, 1999. There were also many pioneer studies focusing on the contemporary tools and practice of mental health care demands on the role of culture in the mediation of psychopathology and service delivery to BME populations. These studies include work by Strauss & Mang 1999, Sharma et al. 2009, Campinha-Bacote 2002, Papadopoulos, 2004, Harris et al 2010, Betancourt et al. 2003, Henderson et al. 2011, Johnson et al. 2006, Abbe et al. 2007 and Deardorff 2009.

This study intends to speak for older people and other vulnerable groups in general though findings may and should address other service and policy areas. This is because all services are accessed by marginalised groups of which older people are some of the most vulnerable. BME's and older people seem to have less than optimal experiences of quality healthcare; referenced studies are further listed further on. Although a significant portion of the literature search is extracted from studies linking BME health care improvements to cultural competence that is because not much exists for culturally competent commissioning. That being said, the focus is on the need to commission culturally competent services for all those affected by a mental health condition. As the experiences of this group can and should be addressed using culturally competent tools, perhaps findings from service delivery can be related to commissioning? Furthermore, it is suggested that this study's findings may also be linked to the value of cultural competence in providing person-centred health and social care services. This notion is related to a study investigating the role of cultural competence in the delivery of patient-centred care in times of cultural conflict (Campinha-Bacote, 2011). It is possible to argue that the significance relates to a consensus within humanities, medicine and professions allied to medicine (anthropology, psychology, social work etc.) regarding the role of sociocultural factors in the aetiology, and treatment of mental health disorders.

It is not possible to discuss cultural competence in the delivery of dementia/mental health care and not mention the role of those responsible for training the professionals and the professionals who deliver care. First, training providers have a responsibility to ensure that MH nurses are equipped to provide culturally appropriate care in any setting (global care). Studies have reported this not to be the case as nurses feel inadequate of the challenges within diverse communities, and some report nursing curricula not being compliant to teaching cultural competence (Reeves and Fogg, 2006; Leininger, 1994; Miller et al, 2008 and Koskien et al, 2009). Questions have been asked of the quality and role of undergraduate nursing education to equip a culturally competent workforce to deliver relevant care (Centre for Mental Health et al 2012; DoH, 2005 and NIMHE 2003). Koskien and others took

up the challenge and emphasised the need to respond with training that educates and produces culturally competent professionals (Koskinen et al, 2009; Chenowethm et al, 2006 and Mahoney 2006). Despite the importance of delivering culturally competent nursing, to an increasingly diverse world population, MH studies have revealed an inconsistency in training content (Hildenberg and Schlickau, 2002 and Dogra and Pokra 2005). Recommendations from a study by Hildenberg and Schlickau were for the improved preparation of students for transcultural nursing which is lacking. This would be in keeping with responding to the belief that people from different cultures have varying beliefs about disease aetiology, diagnosis, and treatment (Jackson, 1993 and Broome, 2006).

2.7.2 The Politics and Problem of Dementia

Dementia has political, economic, and social dimensions; in the UK, dementia has experienced a high level of politicization in its journey to become the nation's priority health issue (WHO, 2012). Dementia is often considered in terms of its economic cost or burden to the government, the cost to the NHS was estimated at £23 billion a year by Alzheimer's Society against dementia in 2012 and £34.7billion a year in paid and unpaid care as of 2018. At a social level dementia is considered within the context of the individual, family, and community, these are the factors that have shaped care principles and policies.

A major problem with dementia beyond the economic, emotional, and care burden is the level of stigma associated with it and its consideration as a mental health disorder for which the diagnosis rate is low and the pathway of care fragmented. Those affected are stigmatised (inclusive of self-stigmatisation, Corrigan et al 2006) on a scale that affects the care of those living with it (Benbow and Jolley, 2012, Angermeyer and Matschinger, 2003). Work to reduce stigma is needed to reduce the social handicaps and distress caused because of prejudice against people with mental health conditions (Crisp et al, 2000). Dementia is increasingly being understood through the eyes of those affected (research and policy) and is accepted as a condition that begins many years before it is diagnosed. Its prevalence is

increasing worldwide commensurate with a diverse aging population and there is increasing evidence that supports the terminal course of dementia and the requirements for higher levels of social care to cater for issues of challenging behaviour and issues of cognitive failings in the later stages of the condition. The argument here is related to the complexity of the condition as a multi-faceted syndrome with diverse underlying pathologies. Most of those affected will become, terminal and need some level of end of life care at the end. Health workers and family members find themselves confronted with knowledge deficiencies which make caring for their loved ones incredibly difficult (Alzheimer's Society 2012). These are further reasons why it is critical to establish what the essential aspects of dementia knowledge are that can support the need for culturally competent commissioned care. This notion is based on findings from related studies (Chodosh et al, 2006, Arai et al, 2008, Brodaty et al, 2005, Turner et al, 2004, Boise et al 1999, Kwok et al, 2011 and Zwakhalen et al, 2007.

Dementia no longer has a hidden 'face' as people affected by dementia are encountered in churches, supermarkets and other community settings, residential nursing homes, and hospitals. The remit of those affected exceeds those of the older age bracket as it affects younger people under 65 (early onset dementia), and those with learning difficulties may also be affected early on (Hoyer et al, 1987, Fadil et al, 2009, Jeffries and Agrawal, 2009, Rossness et al, 2011, McMurtray, 2006, Holland, 2000, Whitehouse, 2000, Kerr, 2007 and Cooper, 1997 and Emerson and Baines, 2011).

The growing prevalence of dementia, the numbers undiagnosed, and those diagnosed but not in touch with appropriate services is an issue. It does speak to that there is a need for better services, knowledge, and understanding that must be linked to cultural settings. A component of cultural competence is cultural awareness of the condition, it has the capacity to address the issue of stigmatisation which may affect timely attendance for early diagnosis (Ayalon and Arean, 2004, Henderson and Henderson, 2002, Link and Phelan, 2001 and Major and O'Brien, 2005). A

dementia label changes how people interact with a person diagnosed with dementia (Harding and Palfrey, 1997, Lee et al, 2005 and Leibing and Cohen 2006). There are still gaps in knowledge in this area as very little research on stigma and dementia exists. More research is needed on how to construct dementia care initiatives within the context of cultural diversity and cultural competence with greater respect for empowerment for those affected by the disease (including carers). Over one-third of the general population are reported to hold stereotypical or discriminatory views about dementia (Blay and Peluso, 2010), this is related to a lack of knowledge about the condition. Any efforts that help reduce the stigma attached to the condition and assist in the creation of dementia friendlier communities is a significant step in the right direction.

There is more than one type of dementia and though symptoms are similar the aetiologies are different, knowledge about each type differing from one group to the next based on culture, community, literacy, gender (Werner et al, 2004). The status of the individuals who provide paid and unpaid care (Robinson et al, 2014) is also implicated. It is thought that differences in knowledge may be moderated by the stigma attached to the condition. Knowledge about dementia can arguably enhance appropriate diagnosis, prognosis, therapeutic strategies; maintenance of independence, dignity, safety, care, and end of life decisions about care (Arai et al, 2008).

Excellent knowledge of the disease is significant in informing good commissioning practice as it helps the commissioner to use appropriate knowledge, cultural, or otherwise to inform social inclusion and psychosocial support. This is generally the remit of Adult Social Care in partnership with heath where relevant. This knowledge is also important to those providing care, including family members (Arai et al, 2008). Culturally competent commissioning should have a role to play in the development of a systematic healthcare approach to service design (dementia knowledge). The argument is that such a development could ensure an objective and up-to-date understanding of dementia.

Regardless of the ethnicity of an individual, all people have a culture of their own, for this reason; dementia must be viewed in the light of cultural diversity (Mahoney et al, 2005, Connell and Gibson, 1997, Chin et al 2011 and Milne, 2005). These studies imply that the construct of dementia differs from culture to culture, agreeing with this assertion are studies by Mahoney et al 2005, Henderson, 2002, Downs, 2000 and Dilworth-Anderson and Gibson, 2002. Different cultural perspectives of dementia can often mean that symptoms can be viewed as 'normal' signs of aging; this may be an important reason why people do not seek medical treatment timely. This is an issue that has implications for the NHS.

There has been significant progress within policy and practice informed by meaningful engagement with those affected or in a caring role. It enables progress to be documented in forums such as the Scottish Dementia Working Group, the Alzheimer's Society, Alzheimer's Disease International (Global Voice on Dementia), and other forums. Much of the credit for greater political awareness, improved understanding of the disease, and prioritising the views of those affected by all forms of dementia goes to these agencies. These agencies are experts at having dialogue with those affected and treating them as experts of their condition, furthermore, these agencies include the voice of the carer and families. This makes it less about how the condition progresses and more about how it affects the person (Kitwood 1997; Sabat 2001).

Some progress has been made in the UK in terms of responses to the dementia challenge; one response was the launch of the National Service Framework for Older People Services (NSFOP) (Department of Health 2001). It set national standards of care to deliver quality and radical reforms in recognition of future health challenges.

The main problem with dementia is its devastating impact, fragmented availability of care, and no known cure resulting in the debilitating effect it has on those affected and their families. Furthermore, the economic impact on nations, and the numbers affected made WHO designate it a priority for all nations. As a very significant health issue, it is defined in a way that describes why it has become the priority of nations.

The urgency of the priority is based on the way it impacts those affected and its significant economic impact on nations and the lives of those who are carers for those who are cared for outside hospital and care home settings. In current times, of particular concern is the significant number of people affected by dementia in the UK and their less than optimal experience of Dementia related services. Studies by Lawrence et al, 2011, aimed to define the standard for good palliative care for people with dementia following their findings of poorer quality end of life experiences for those with dementia in comparison to those who are cognitively intact. One of the problems is insensitivity to the cultural nuances of those caring for and those affected by dementia (cultural diversity).

Added to this is the minimal research linking culturally competent commissioning to the quality of services, and much less highlighting the impact that can be achieved on the quality of dementia services or the difference it can make to those affected by mental health illnesses. That being said, there are many studies that consider the significance of cultural competence to service delivery or the training of nurses or other professionals. Furthermore, there is a dearth of literature' concerning the importance of culturally competent commissioning and the significant change in the demographics of older people since the establishment of the NHS in 1948.

This study is partly about determining the level of understanding and utilisation of culturally competent practices amongst commissioners or other staff working within mental health commissioning and delivery of services to older people (and other mental health services). The study also seeks to understand the perceptions and attitudes and the considerations of how these factors affect any expression of levels of cultural competence (challenges and opportunities). The relevance of these factors is that they are significantly related to promoting person-centred care, the pillar of the constitution of the NHS. Cultural competence has proven to be an efficient tool in reducing health care disparities and improves healthcare quality (experiences, compliance with therapy, and reducing incidents of misdiagnosis), Saha et al, 2008. It has also long been considered a part of good practice within the

Mental Health arena and nursing care. The success of its use has been reported widely in the American provider and insurance arena, however, its relevance has not been documented in commissioning, an arena responsible for specifying, procuring, and monitoring health and social care services. To this extent, it would not be out of place to expect the first key principles of the NHS constitution to focus on culturally competent related principles; however, there is no use of these actual words within the constitution.

The first key principle of the NHS constitution states that the NHS

> *…has a wider social duty to promote equality through the services it provides and to pay attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population... (DH, 2009, p.3).*

The NHS constitution (DH, 2009) further states an additional key principle concerning the delivery of healthcare, that it 'must reflect the needs and preferences of patients, their families, and their carers.' This study contends that cultural competence is of significance to this principle, it is, therefore, reasonable to expect health commissioners and professionals to excel in culturally competent practice. It would also be essential for the concept to be embedded explicitly in the constitution and all commissioning policy. The question is why is cultural competence not yet part of the vocabulary of commissioning policy and the constitution of the NHS? This study asserts that we could start with the development of a research or evidence-based culturally competent framework for commissioning. Such a framework would be very useful to all the professionals responsible for engaging with patients effectively and those who enable patients to identify their roles and responsibilities within their own health. It would also mean that health commissioners can design services that enhance these responsibilities (patient empowerment).

2.7.3 Understanding Dementia and the Person

This chapter focuses on defining and understanding dementia-specific issues (symptoms, services, and staff), cultural competence, commissioning, and older people. Given the focus on these issues, understanding dementia as it affects individuals is a subplot of this study; by default, therefore, this chapter is dedicated to giving the reader a grounded understanding of the condition and problem that has become the priority of a nation (WHO, 2012). It is one of the most misunderstood conditions affecting societies worldwide, perhaps because its symptoms are often viewed as a condition of old age, ignored and underdiagnosed (Shores et al, 2004, Jitapunkul et al, 2009 and Sava et al, 2015). This chapter discusses the merits of focusing on dementia as a mental health issue that can benefit from the application of cultural competence. The literature is rich in findings from studies promoting cultural competence and person-centred mental health services (Edwardson et al, 2008, Baker, 2001, McCormack and McCance, 2006, Brooker, 2003, Kontos, 2005, Bhui et al, 2007, Campinha-Capote, 2002, Betancourt et al, 2003 and Whaley and Davis, 2007), the desired outcome is linked to the preservation of personhood (dignity), accessibility and improved experiences of care and treatment. The argument of this study is about achieving person-centred care via cultural competence or accepting that it is a component of person-centred care.

There is no reason to spend much time describing the multiple dementia fronts that are its epidemiology, pathology, diagnosis, and treatment because this study is concerned with commissioning dementia services in a culturally competent manner. Empirical evidence derived from a study of three people affected by Alzheimer's, revealed evidence of the presence of a first self (Self1) of personal identity which is said to persist far into the end stage of the disease. Further evidence of a second self, the multiple personae also exists; it requires the cooperation of others to come into being but can get lost, but only indirectly as a result of the disease (Small et al, 1998). The researchers of this study contend that the primary cause of the loss of the second-self (Self2) is associated with how others view and treat the person

affected. This is an issue that can be improved within the remit of cultural competence as a vehicle for setting up the types of services that enhance the way the service user is viewed, cared for, and assisted in the preservation of all of self. Recommendations from the research are those regarding interactions between the affected service user and their caregivers (Sabat and Hare, 1992).

Research by Kitwood, 1997, Sabat, 2002, Kitwood and Bredin, 1992 provide an understanding of dementia away from a biomedical construct. Their contribution is a good starting point for understanding dementia from a non-health professional perspective. The researchers unintentionally build a case for the urgent need to build cultural competence into commissioning relevant dementia (older people) services. This is because their work pays great attention to the preservation of self (personhood). The argument here, is that self is a reflection of a cultural entity hence there can be no cultural competence without appropriate considerations of culture, for this reason, and more cultural competence is of significant relevance to commissioning.

This study does not attempt to deny the importance of the biomedical, psychosocial, and gerontological or theoretical perspectives of dementia. These have advanced knowledge generation and played a role in developing dementia policy, research and practice. The central aim of the argument of this study remains generally about commissioning dementia and other mental health services in a culturally competent manner. This study also aims to influence from an insider-researcher advantage position that places the research and the researcher within the NHS with its staff as participants.

There is a personal approach to this study, based on personal experiential knowledge of how dementia affects people from diverse backgrounds and knowing that those affected maintain a cultural perspective about their condition. Cultural perspectives influence the way symptoms are reported and therapies are complied with (Mahoney et al, 2005, Downs, 2000, Henderson et al 2005 and Dilworth-Anderson and Gibson, 2002). It is possible to argue that the needs of individuals can

only be obtained and expressed fully during culturally competent needs assessments (of care). Expressed needs should be met by culturally competent services as opposed to those constructed by the traditional notions of medical or social care professionals. One of the issues explored by this study is the extent to which commissioners and providers embrace this notion.

Kitwood, 1997 describes a subjective world of dementia where the uniqueness of each individual's experience is related to their personality and defence process, he also refers to the psychological needs of people with dementia. The contention here is that psychological needs are explicitly linked to culture, and cultural needs can only be addressed optimally through services commissioned and delivered in culturally competent ways.

Research by Annear et al, 2015 used a Delphi study to identify 36 statements considered essential to the understanding of dementia. The results presented summary knowledge considered essential across dementia expert representatives belonging to key stakeholder groups in Australia, the UK, and America. The findings have implications for the commissioning and delivery of dementia care which should be translated from research to practice and the development of dementia education programmes. The study also found that of great importance to the majority were issues related to the care recipient and the caregiver. Other high consensus statements reached related to dementia characteristics, symptoms, disease progression, diagnosis, assessment, treatment, and prevention (Annear et al, 2015). This could be further evidence that commissioning must be achieved in a culturally competent manner in a bid to take full account of all that is important (values) to affected individuals. This may also be another reason to assert that dementia should be viewed with the same lens as those affected, this might be an assured way to be responsive to the social wellbeing of service users.

Often dementia is medicalised leaving both primary and secondary care to respond to those needs that are above social needs yet a lot of the time what is needed should relate to the culture of the service user. The UK care system considers the

level of help needed with regards to domestic assistance (provided by social care) via a legislative framework referred to as continuing healthcare (CHC). The appropriate assessment is part of the continuing healthcare framework as previously discussed in this work. It is not a perfect system as it relies on the availability of good care homes and carers that are trained to deliver culturally competent (person-centred) care. The assertion here is that the aim of care should always be to maintain personhood to the furthest extent possible. To this end, commissioners need an understanding of the 'self' of the individual with dementia and an acceptance that cultural identity is still intact though sometimes 'eroded' by a failing memory. Care should avoid being care only for the sake of care (one-size-fits-all) by incorporating the needs of the service user into care plans and ensuring that the voice of both carer and service user is a clear influence in care decisions made by both commissioner and provider.

For these reasons, it is important to present the evidence for alternative conceptualisations of dementia. To do this, a few works focusing on 'self and dementia' are included in the literature search using search terms related to self, person, loss of identity in dementia, preserved identity in dementia. The purpose was to gain an understanding of how to define cultural competent practices that might assist the mental health professional to understand the 'picture of self' (Small et al, 1998, Surr, 2006, Hughes et al, 2005, Kelly, 2009, Kalenzaga, 2013 and Caddell and Clare, 2010). Findings from these studies report that people affected by dementia still retain elements of culture/'self' (preserved identity). This may be further clarification that the cultural needs of those affected by dementia and those of their families are valid contributions to commissioning practice to achieve services that aim to provide person-centred care (culturally competent care).

2.7.4 The Prevalence of Dementia

Projections of future mortality and disability are studied and recorded via the Global Burden of Disease Study (GBD), which aids decisions made about health. A study by Murray and Lopez, 1997 found that health trends in the next few decades will be determined by the aging nature of the world's population, declines in age-specific mortality rates from communicable, maternal, perinatal, and nutritional orders, the spread of HIV and the increase in tobacco-related mortality and disability (Murray and Lopez, 1997).

Dementia has been established as the leading cause of dependence and disability in the elderly population worldwide (Sousa et al, 2009, Harwood et al, 2004). Figure 2.1 shows the estimated dementia prevalence by gender and local authority in the UK in 2011. A study carried out by Matthews et al, 2013 to enable future planning for dementia revealed findings that show that later-born populations have a lower risk of dementia than those born earlier in the past century (Matthew et al 2013).

In 2015 the World Health Organisation defined 8 international goals; these were replaced by 17 goals that were defined to be sustainable development goals in 2016. The goals are related to the overall goal of achieving a better and more sustainable future. The general areas that all 8+17 goals consider are the eradication of poverty, hunger, illiteracy, inequalities, climate change and injustice, and the promotion of good health, economic growth/clean energy, peace, gender equality, innovation, and education. These goals relate to the efforts required to achieve a significant impact on the future prevalence of Dementia which is high and varied across the UK according to a 2011 estimation study published in The Lancet (2013).

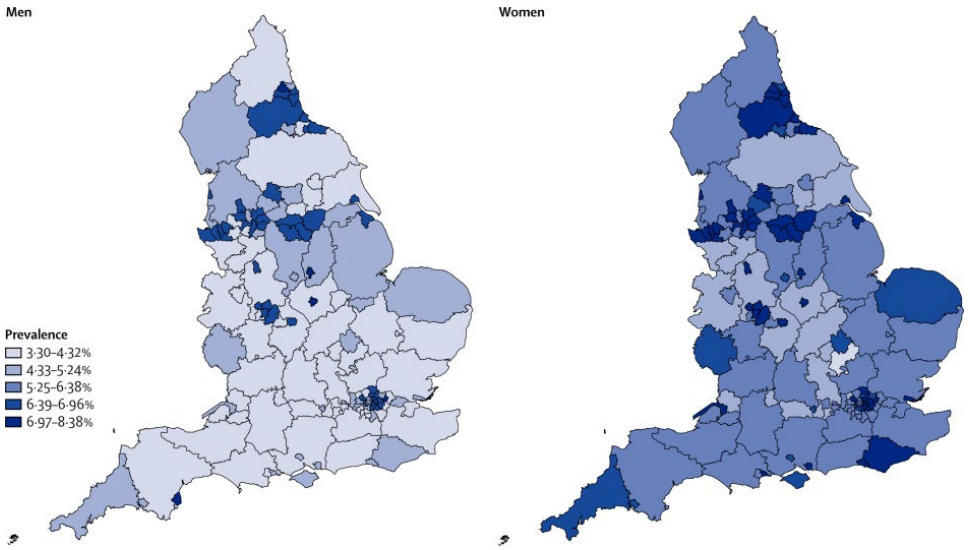


Figure 2.1: Estimated dementia prevalence in the UK in 2011, by sex and local authority (the Lancet, Vol 382 p. 1409, 2013)

Before 2007 there had been little or no mention of dementia in the policies of Scotland and England (Cook, 2007). The NSFOP was a response to an increase in the population of older people and the prevalence of dementia including a recognition that the quality of older peoples' care was not up to standard (HAS, 1998). The scale of the problem can be understood better from the results of studies showing temporal trends in dementia incidence since 2002 and projections for prevalence in England and Wales to 2040.

A model study by Ahmadi-Abhari et al, 2017 had an objective to forecast dementia prevalence with a dynamic modelling approach that integrates calendar trends in dementia incidence with those for mortality and cardiovascular disease (figure 2.). The results below are from their study which produced a model that was started in 2006 to predict the prevalence of dementia in 2011.

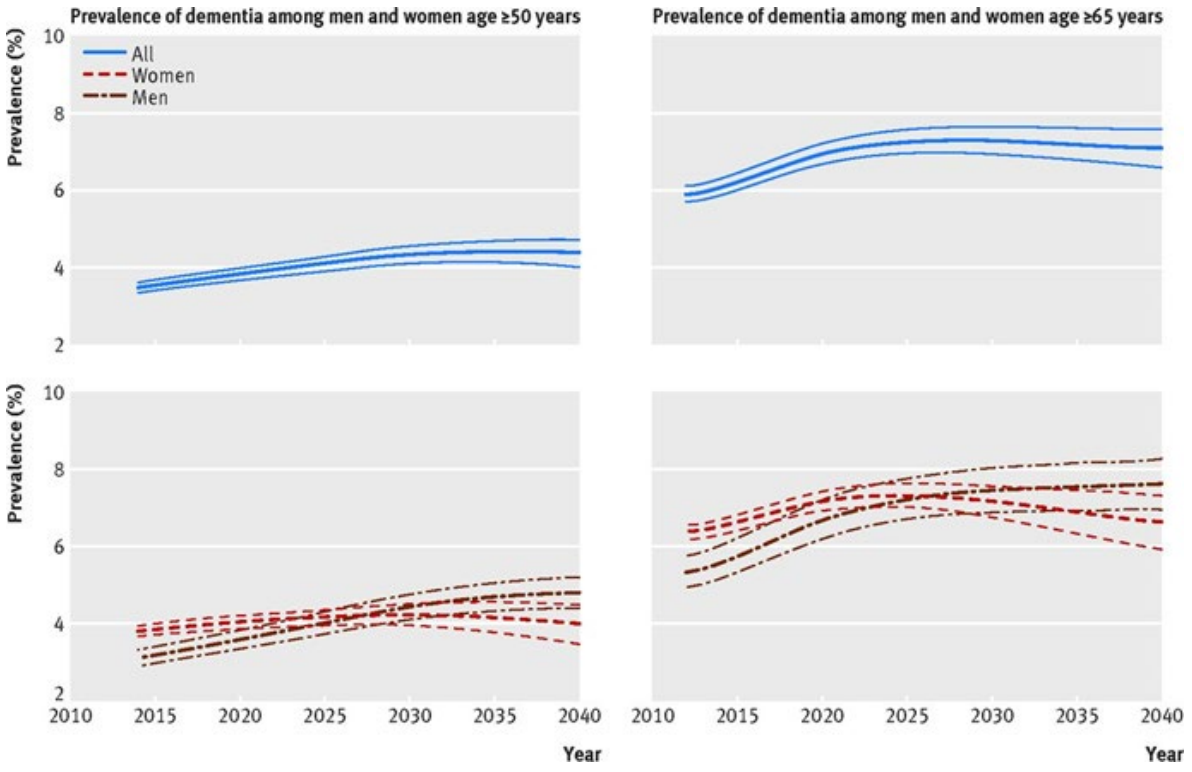


Figure 2.2: Projected prevalence of dementia in England and Wales, 2011-40 (Ahmadi-Abhari et al, BMJ 2017; 358).

There is some consensus amongst scholars (Milne et al, 2000; SantaCruz and Swagerty, 2001; Ahmad et al, 2010; Marshall et al, 2015) that now agree that one of the most important issues in the dementia arena is improving on accomplishing early diagnosis. This relates to a belief in the gains to be had in relation to early diagnosis promoting timely referrals for appropriate interventions (medical and social care decisions). The urgency of an early diagnosis is related to ruling out delirium and treatable aetiologies (SantaCruz and Swagerty, 2001). In 2010/11, in England, less than 42% of those estimated to have dementia received a diagnosis, fast forward to 2015, and improvements have seen a 61.6% rate in diagnosis and a revision of the Prime Ministers' 2020 Dementia Challenge (NHS, Digital, 2017).

To date, there have been steady improvements in recorded diagnosis by ethnic group across England as shown in Table 2.1. The information is extracted from the

Health and Social Care Information Centre a non-departmental body known as NHS digital.

Table 2.1: Recorded dementia diagnoses by ethnic group, England (2017 only, NHS, Digital, 2017).

Ethnic Group	**Patients** The total number of patients by ethnic group excludes some practices submitting data manually and may not be the total number of patients on the practice register	**Proportion (%)**
Asian & Asian British	9948	22
Black or African or Caribbean or Black British	12	0.0
Mixed or multiple ethnic groups	1898	0.4
White	97,725	21.9
Other ethnic group	1898	0.4
Not defined	334,747	75.0

The total number of patients by ethnic group excludes some practices submitting data manually and may not be the total number of patients on the practice register.

2.7.5 UK Dementia Guidelines and Policy: A Critical Review

This section explores the extent to which UK dementia guidelines and policies are culturally compliant in the commissioning or delivery of services. Furthermore, it also highlights gaps in support of a need for a re-evaluation of the current dementia strategy towards being more culturally competent and Human Right compliant.

Dementia represents a significant and urgent challenge to families (Carers), health and social care services, and the global society in terms of the number of people affected and the cost (burden) of care. As a designated UK national priority, dementia issues have caused the government to respond with many policies and guidelines which are regularly reviewed by sitting governments. The leading agencies are influenced by research, prevalence, evidence-based practice, and available resources. Of foremost importance amongst the policy documents is the UK National Dementia Strategy, first published in 2009, (2010 to 2015) with focused outcomes and an accompanying implementation plan which has four aims:

1. Early diagnosis and interventions;

2. Better care at home or care home;

3. Better care in hospital;

4a. Appropriate use of antipsychotic medication.

4b. Improved support for carers (National Dementia strategy 2009)

It is important to note that culturally competent skills will be of significant importance both within commissioning and the delivery of services. Beyond the skills that professionals will need, it would be important to ensure that the right culturally

competent policies that relate to recruitment, retention, practice, training, stakeholder engagement, and care all meet culturally competent standards.

2.7.6 The Dementia Strategy 2009 Onwards

Recently, the UK has recognised the significance of its diverse population and its consequential impact on health service provision. Despite this recognition, the need to enhance the status of cultural competence in the commissioning or delivery of services has not been embedded in the policy. The UK Dementia strategy (2009) mentions keywords such as equality, non-discriminatory practices, better access, and person-centred care; however, the accompanying actions do not amount to cultural competence.

The timely recognition of the dementia challenge owes its imposition to the 'triumph' of an aging population and the estimated cost of billions per year that relate to care (Alzheimer's Society, 2018). It is a credit to past governments who took up the challenge to refocus services for older people. In 2009 the Labour Government responded with the publication of a National Dementia Strategy: Living well with Dementia, 2009. It seeks radical change via 17 key objectives aimed at improving the way people with dementia are considered and treated. It has failed to ensure that primary care is equipped to assess and diagnose dementia early and it fails to mention the need for culturally competent dementia commissioning. There is also no emphasis on the need for a culturally competent workforce or for GP's to undergo any type of cultural competence training. It is also not accompanied by a plan to reconfigure services accordingly, especially primary care, where a diagnosis should be possible and perhaps mandatory. Furthermore, there is an inadequate focus on the need to ensure each clinical commissioning group (CCG) has a local dementia champion with responsibility for GP training, prevention strategies, and commissioning input. CCG's do not each have a GP with a special interest in

dementia. There is much focus on referral to secondary care as opposed to strengthening the activities of primary care (Greaves and Jolley, 2010).

The current dementia strategy, as with other policies and guidelines lacks a statutory focus on cultural competence resulting in services that lack a culturally competent compliant workforce. Furthermore, there is evidence to suggest that the numbers of those diagnosed in primary care in the UK are lower than anywhere else in Europe (Waldermar, 2006, Dubois et al, 2016). There are many reasons for this phenomenon including the reticence of ethnic minorities to attending services for diagnosis, treatment, or support. This bears similarity with other illnesses (substance misuse, diabetes) and is prevalent in men more than women as can be seen in the tables in previous chapters.

Commissioners are expected to use the Joint Commissioning Panel for Mental Health (JCPMH) guidelines drawn up by a group of dementia care experts in consultation with patients and carers. It is primarily evidence-based in clinical content. The guidelines are based on the premise of Vb-C which considers patient and carer perspectives in much the same way as cultural competence does. It is a relatively new approach that uses learnable skills to work with complex and conflicting values (Williams and Fulford, 2007). Organisations are encouraged to implement Vb-C by appointing commissioning leads to develop patient, service user, and carer leadership.

There is a current joint commissioning panel in support of the 2011 dementia commissioning guidelines; it has as its purpose a set of guidelines for procuring comprehensive dementia services. It has no focus on cultural competence but has five key areas:

- A strong public health component that focuses on prevention, early identification of people with dementia, and targets high-risk groups such as people who fall, those who have a strong family history of dementia, and those with vascular risk factors.

- Assessment and early diagnosis services for people with memory problems.
- Ongoing dementia support services based in the community.
- Specialist mental health care services for patients with dementia who present with behaviours that challenge, patients whose dementia is complicated by comorbid functional mental health problems, and those with complex diagnoses.
- Mental health liaison services based in acute general hospitals with specialist expertise in dementia and delirium. (Joint Commissioning Panel for mental health, 2011).

The support that dementia service users need is less of treatment and more of social care for which the Social Care Institute for Excellence and the National Institute for Health and Clinical Excellence (NICE – SCIE) commission the guidelines. This is often referred to as National Clinical Guideline Number 42 (CG42, 2006) and contains information that is based on the results of clinical studies. The guidelines only go as far as mentioning the prevention of discrimination and miss an opportunity to be explicit about cultural competence by including it as one of the pillars of person-centred care.

An equally important MH policy document is the 'No Health Without Mental Health': implementation framework (2012) which was authored by a few government agencies including the Department of Health (DoH) and the NHS Confederation Mental Health Network. It sets out the directives to be followed to implement the 'No Health Without Mental Health Cross-Government MH strategy for all ages'. The framework complements the aims of the dementia strategy and a range of other relevant services, once again there are no explicit directives concerning cultural competence. The framework is in four parts:

• Part 1 - sets out what changes are needed to turn the strategy's vision into reality.

• Part 2- sets out how progress in implementing the strategy will be measured and reported.

• Part 3- sets out what local organisations – both individually and collectively – can do to implement the strategy.

• Part 4 - sets out how local action will be aided by Government and other national organisations (DoH, 2012)

In 2013 Public Health England (PHE) was set up as a strategic health authority bringing together public health scientists and researchers ensuring a presence in every local authority. The aim is to break down barriers and ensure close ties to each clinical commissioning group (CCG). The overall responsibility of this body is to protect and improve the nation's health and wellbeing and reduce health inequalities. It is not quite certain how this will be achieved without consideration for cultural competence in commissioning or delivery. As one of the core priorities of PHE is disease prevention; in terms of dementia, it has the challenge of creating and supporting dementia-friendly communities. Given the new integrated commissioning agenda requiring relevant agencies to come together to make commissioning decisions, it can be argued that cultural competence has implications for all these agencies. Dementia-related policies have the following guidelines:

2.7.7 Dementia: Primary Care Guidelines

Primary health care has a dementia policy focus underpinned by the Dementia Toolkit: What Primary Care Needs to Know (2014), it was developed as a primary care educational guide for GP's in response to the need to increase diagnosis rates and ensure the provision of treatment and support to dementia patients and carers via primary care. The document was prepared by NHS England in partnership with Hardwick Clinical Commissioning group, it defines what primary care needs to know about diagnosis, clinical treatment, medical interventions (scans, ECG), benefits

advice/carers assessment and mentions aspects of daily living. Other aspects include the following:

- The assessment of cognition
- Symptoms
- Care homes and funding cares
- End of Life Care (EoL) (Dementia Toolkit, 2014)

It is reviewed as being user friendly and accessible as a useful skills development toolkit for GPs with a recommendation that it includes example conversations and case scenarios so that GPs can have a framework of reference for what might be difficult consultations. What is missing is a mention of the cultural perspectives of dementia and the significance of culturally competent skills concerning assessment and care for the individual who may or may not belong to a minority group.

The first opportunity to ensure a dementia service is culturally competent is at the primary care level for obvious reasons; however, there is no mention of the need for GP's to be culturally proficient. Reflecting on the training of GPs' at this level it is necessary to ensure that entry-level GPs are exposed to the appropriate level of cultural competence training.

2.7.8 Carers

National Dementia guidelines consider the UK's almost 700,000 carers (Alzheimer's Society, 2016), their psychological welfare, and the support services needed to enhance their capacity to cope with the demands of caring for a person with dementia. Caregiver related stress research has shown that 'caregiver's capacities' to cope with dementia patients is severely challenged as demands for care and impairment levels concomitantly increase. As there can be no cultural competence without culture, the support and training available to carers is another opportunity to

ensure that cultural competence is captured in the training curricula for carers. The aim would be to ensure cultural differences in caregiver expectations are addressed to reduce caregiver stress (Donaldson, 1998 and Lee et al, 2013). Services delivered by social workers are also a much-needed resource therefore it would be reasonable to consider how social care is commissioned to ensure care is sensitive to the diversity of values and expectations that can affect the experiences of older people. At this time, there is no specific cultural competence training offered to social workers, this impacts the quality of service delivered. Though there is a lack of cultural competence training delivery in the care arena it is not clear to what extent it is implicated in safeguarding issues.

2.7.9 Dementia: The Case for Joint Working

Dementia guidelines call for joint commissioning between social and healthcare agencies to encourage integrated services and eradicate fragmented experiences of care. An inclusion of culturally competent guidelines may ensure care and joint assessments take account of a person's cultural needs to produce joint care packages that are cost-effective in meeting culturally assessed needs. The absence of such a quality is a weakness in the policies that guide the commissioning of health services.

In recent times there has been a move towards the design of an integrated care system that will see social care and health achieve seamless approaches to all areas of care and treatment. Budgets are not yet joined up however some budgets are being pooled to ensure the joint commissioning of relevant service.

2.7.9.1 Dementia: Dealing with Challenging Behaviour

We know that people with dementia can develop non-cognitive symptoms resulting in challenging behaviour which further makes caring a complex task. The guidelines

do make a point of recommending assessments that take cognizance of an individual's biography, including religious beliefs and spiritual and cultural identity. The outcome is to produce a person-centred approach capable of reducing the use of physical and chemical restraints (Andrews, 2006). This is a welcome addition however the next level would be to ensure that this is achieved and that it is monitored and reported on. This may be further justification of the need for culturally competent guidelines that guide appropriate assessments to ensure a better understanding and actions for the improvement of dementia care. The guidelines also miss an opportunity to ensure the promotion of it as a statutory obligation for providers of care to undergo culturally competent care training. It would not be misplaced to assume that cultural competence can be implicated in some safeguarding cases. This means that there may be potential issues with the restrictive practices that are used to manage persons that display challenging behaviours due to their mental health or other conditions. Culturally competent practice would be very crucial to the choice or use of restraint, seclusion, or segregation regardless of background. What may be of greater importance would be the issue of safeguarding for which all professionals are trained to ensure wellbeing.

2.7.9.2 Dementia: End of Life Care

NHS dementia guidelines state that people with an incurable illness such as dementia should have access to good end of life care (palliative care). Care is to include support for family members; it can be provided at home or in a hospice and paid for either from a self-funding source or via personal health budgets. This would mean that a dementia care plan is drawn up by health and social care professionals to ensure that End of life care is a key part of the plan from the onset. To this extent, there is research pertaining to the negotiation of palliative care in the context of culturally and linguistically diverse patients (CALD). In Australia, meeting the healthcare needs of CALD communities has garnered support for effective communication and sensitivity to cultural and linguistic specificities. Findings report a particular challenge to clinicians is the process of transitioning CALD patients to

specialist palliative care. The researchers suggest a focus on further research that can systematically document and model existing CALD-specific clinical processes and pathways to support the development of targeted educational interventions (Renzaho, 2008). This includes developing a multi-stakeholder understanding of the CALD experience that moves beyond cultural stereotyping and prediction of need (Renzaho, 2008). This has implications for UK policy given similar experiences in the UK setting in terms of the underutilisation of palliative care (Richardson et al, 2006, Gatrad et al, 2003, Karim et al, 2000, Diver et al, 2003, Randhawa et al, 2003 and Crawley et al 2000).

Studies about the relevance of culture to end of life care reveal that discussions about end of life care with patients are fraught by many challenges. For starters, some issues might pertain to a patient's cultural norms being different from the health care providers resulting in a possible impact on the provision of quality end-of-life care (Payne et al, 2005, Owens and Randhawa 2004, Gunaratnam 2007, Randhawa et al 2003). The studies considered care received by ethnic minorities and highlighted that services are not adequate; however, levels of dissatisfaction are also experienced by Caucasian service users. The significance of cultural competence concerning end of life care is the avoidance of conflicts or indeed professional bias leading to inadequate or inappropriate symptom management. Furthermore, it could result in health disparities or fragmented care, miscommunication with the patient and family and inevitably poor quality of life and a painful death for the patient. Further information expanding on the above factors are presented in studies all of which booster the argument for culturally competent dementia services (Campinha-Bacote, 2011; Doorenbos et al, 2010; Eues, 2007; Giger, Davidhizar, & Fordham, 2006; Kline &Huff, 2007b; Searight & Gafford 2005a).

A level of optimised cultural competency is essential with regards to providing end-of-life care and is identified as a need for hospice nurses, social workers, family practice physicians, psychiatrists, and other health care providers (Braun, Ford, Beyth, & McCullough, 2010; Rushton, Scanlon, & Ferrell 1999; Schim & Doorenbos,

2010, Schim, Doorenbos, & Borse, 2006). These researchers focus on the study of cross-cultural issues at the end of life for ethnically and culturally diverse groups in the United States. They make the case for the importance of culture as it relates to end of life and its significance to commissioning end of life services in a culturally competent manner for diverse communities. Cultural competence is about human dignity and upholding human rights hence palliative care is an opportunity for the NHS to commission in a culturally competent manner.

A review of the literature revealed key factors significant to the importance of commissioning culturally competent end of life dementia care services are:

- A critical component in making hospice and palliative care services accessible and acceptable to diverse communities is the preparation of all providers to enhance cultural competence (Schim, Doorenbos, & Borse, 2006).

- The challenge for family physicians in an increasingly diverse society is to learn how cultural factors influence patients' responses to medical issues such as healing and suffering, as well as the physician-patient relationship (Searight & Gafford, 2005a).

- Physicians involved in a multi-racial/ethnic sample emphasized their commitment to their professional role in End of Life care decision-making. Implicitly invoking the professional virtue of self-effacement, they were able to identify racially/ethnically common and diverse ethical challenges of EOL (decision-making. Previous studies showed racial/ethnic differences in preferences for end-of-life (EOL) care (Braun, Ford, Beyth, & McCullough, 2010).

- Culture provides the context for all health and social care services throughout the human life span. Improving end-of-life and palliative care and enhancing patient and family outcomes requires a nuanced understanding of cultural contexts for those who provide care and those who receive it. The authors of this article propose an emerging model of culturally congruent care that can guide intervention for social workers, mental health professionals, nurses, and other health care workers caring

for a diverse population of patients, families, and communities (Schim & Doorenbos, 2010).

- There is a need for significant attention to culturally specific rituals germane to end-of-life rituals are important for the nurse who is delivering culturally competent care (Giger, Davidhizar, & Fordham, 2006).

The studies also recommend that health care providers take cognisance of the specific influences cultures have on behaviour, nutrition, domestic needs, mobility and preferences for end-of-life when the prognosis is terminal. What this means is that the professionals must be conversant with identifying needs (forward planning where possible). This is only possible when it is noted that patients with one culture, religion or ethnic group does not necessarily mean that they adhere to those values. This also means that assessments should establish how acculturated a person and their family are (cultural comfortability), their communication skills and possible involvement of interpreters (cultural translation). A critic of the guidance on palliative care and indeed all care to those who are mentally incapacitated is that commissioners and health care practitioners are asked to take cognisance of the general cultural values of the specific communities in which they practice. There should be an expectation that all practitioners have an awareness of relevant themes as they may relate to the provision of the individual's care. This is the essence of culturally competent commissioning within dementia and other older people's services.

2.8 The Dementia Challenge

The successor to the 2012 WHO and ADI Report mentioned in chapter 1 which described the challenge to be overcome by 2020 was published in 2015 to highlight progress made in the areas of investment, research, training, and awareness. From 2016/17 deliverables within the mandate include the need to maintain a minimum of a two-thirds diagnosis rate for people with dementia, locate a dementia institute, and improve the quality of post-diagnosis treatment and diagnosis. The first task falls to

GP's whilst commissioners and the local authority are to ensure adequate treatment and social care services.

Table 2.3 below shows the 2013 status of dementia rates across the UK, it shows that fewer than 4 in 10 people affected by dementia have their condition recognised by the NHS. The study estimates that the number of those affected but not yet diagnosed is 351,000 with numbers rising each year

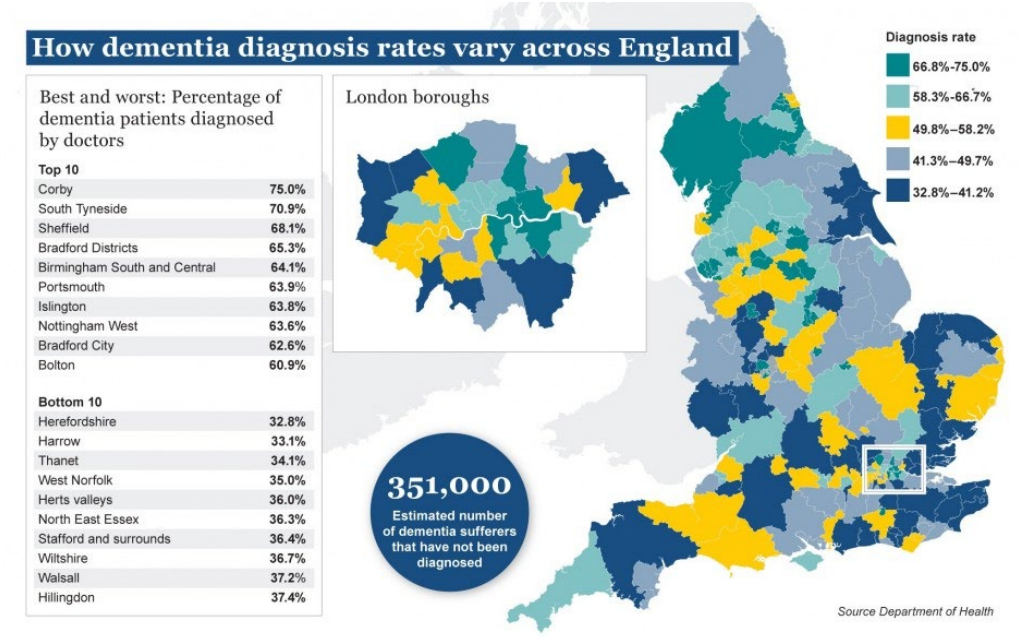


Figure 2.3: Status of dementia rates across the UK in 2016 (DoH)

A new dementia atlas showing patchy availability of NHS services was published in 2016. The status of services at that time was evidence of the compromised experiences of those using services, considering that the required standards are about offering regular reviews and support. The atlas above was produced to show the areas where improvements are needed towards eradicating the semblance of a post lottery system of dementia care. The darker blue areas show greater activity perhaps because greater spend and targeted activity had occurred within primary and secondary care. The atlas was produced by the Department of Health (2016))

who has responsibility for a significant number of tasks focused on adequate preparations for an increasingly diverse elderly population. What is further needed is good knowledge of the cultural diversity that exists amongst patients in terms of plans to provide support, social care, and treatment to those of a BME background

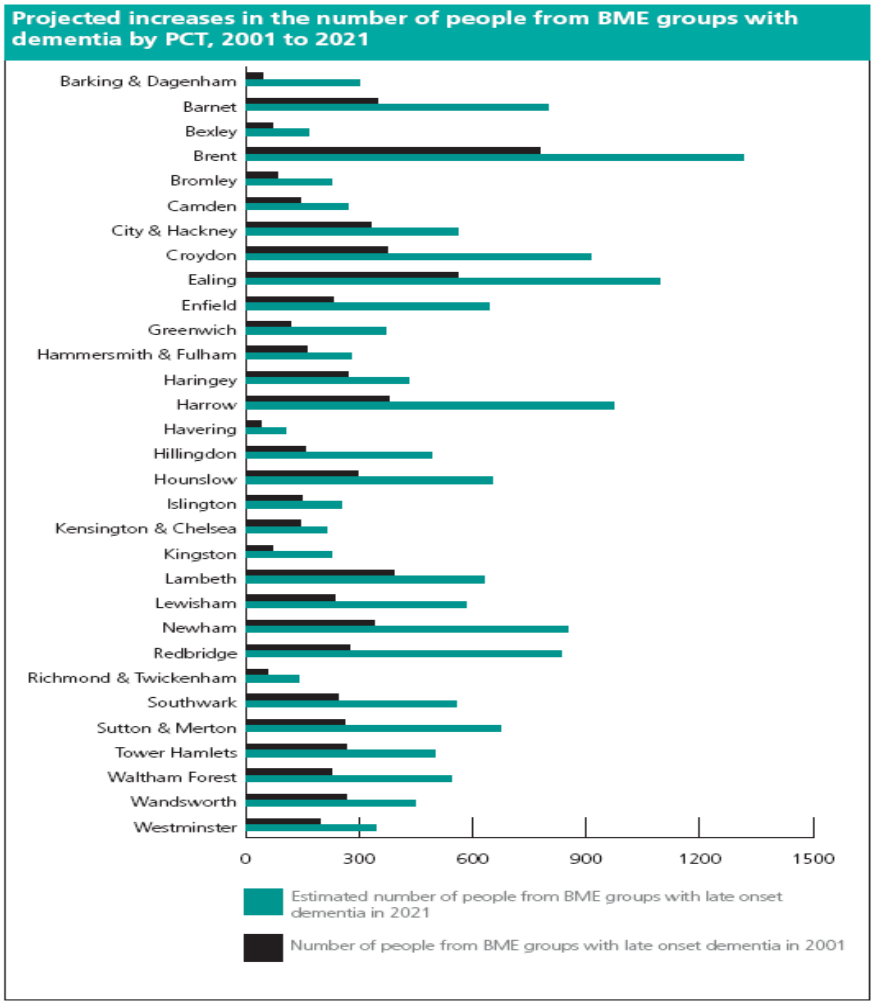


Figure 2.4: Projected increase - BME Groups with Dementia by former PCTs (CCG) from 2001 to 2021 (DoH, 2015)

Fig 2.4 offers a snapshot of the progress that has been made across UK regions; the darker areas are the areas of the most success. The purpose of the dementia atlas is to show progress against standards set across England, region by region.

The standards (Department of Health Quality Outcomes Framework, 2015) are in keeping with interventions that promote the following:

- Preventing well: Healthy behaviour
- Diagnosing well: Early diagnosis
- Supporting well: Care and support
- Living well: Care reviews
- Dying well: Mortality rate

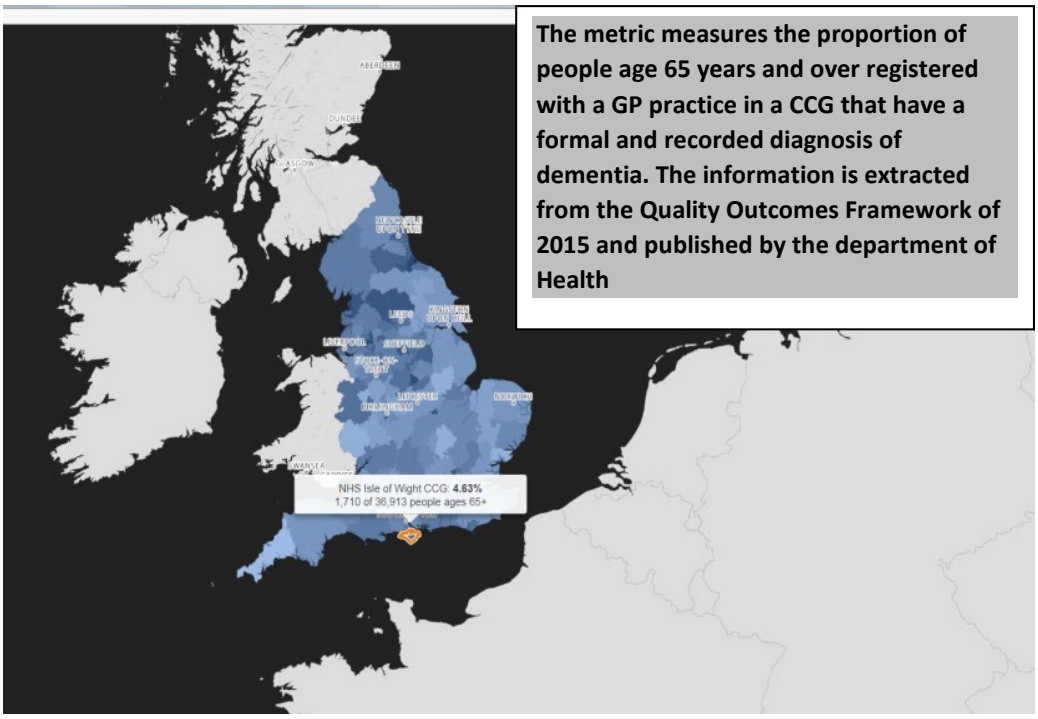


Figure 2.5: Atlas of Dementia Check- up Progress (DoH 2015)

The metric measured is the number of people aged 65+ affected by dementia and the proportion registered with a GP practice, and having a recorded diagnosis of dementia.

Mental health conditions of which dementia is one affects a high proportion of the population, and while it is true that there are gaps in service the more pressing concern is the inequalities or healthcare disparities therein. It is well documented that various groups experience disparities in mental health services (Iezzoni, 2011; Dovidio and Fiske, 2012). Ageism is also classed as a disparity and affects those aged 65 and over in long term need of care (Eymard and Douglas, 2012; Ozdemir and Bilgili, 2014).

2.8.1 Dementia and Culture

Given this study is about cultural competence it is not possible to leave the issue of culture out of the narrative though there is paucity in the literature regarding dementia and culturally competent commissioning. That being said, some studies look at the influence of culture on dementia as well as other long-term conditions and the matter of palliative care. Sun et al (2012), argue that there is an influence of ethnicity and culture on dementia caregiving. The evidence is a reason to ensure that both commissioners and providers understand what these influences are and how they can be used to improve both care and prevention of dementia. For this reason, commissioners can be asked to consider the cultural demographics of their localities when preparing to commission dementia services. We know that culture shapes perceptions and behaviours and therefore shapes responses to cognitive impairment and dementia. Cox (2007) backs this claim up by asserting that the cultural beliefs of a patient are implicated in the ways that the symptoms of dementia or aging are perceived or displayed (wandering, confusion and forgetfulness). This is further evidence as to why we might need to commission services using culturally competent tools and practices. Success in this area might enable us to describe culturally competent care as compassionate in its delivery as it considers the values of the care receiver. Discharging the care duty must be in a manner that delivers assistance, respite, dignity, and personhood.

Factoring elements of culture into the design and development of services demands a significant amount of cultural intelligence if services are required to ensure that in the delivery of care personhood is preserved (Kitwood, 1997). The researcher explored the concept of personhood and its relevance for a new culture of dementia care, explaining that the concept of care is linked to personhood both of which have ethics as a fundamental matrix.

The literature sheds some light on why the numbers of those accessing services or receiving a diagnosis does not match the numbers affected by dementia. Mahoney et al (2005) did a study of cross-cultural similarities and differences studying African American, Latino, and Chinese people. Their assessment was concerned with impressions of onset and memory test diagnosis of dementia. They found that the major deterrent to having a relative assessed was a lack of knowledge about Alzheimer's disease rather than culturally influenced beliefs. Furthermore, a failure on the part of the GP to recognise the disease was much blamed for low referrals for assessment and diagnosis rather than language or ethnic barriers. Motivating clinicians to adopt culturally sensitive communication patterns was a recommendation. To this end, commissioners should play a significant role in ensuring this happens by including appropriate key performance indicators (KPI's) where appropriate. KPI's could include the level of cultural competence training and the development and implementation of culturally competent workforce standards.

The literature asserts that cultural competence can reduce discrimination, improve compliance to therapy and increase service accessibility (Betancourt et al 2002, Beach et al 2005, Kagawa-Singer and Kassim-Lakha, 2003, Saha et al, 2008, Bhui et al, 2012. With this in mind, culturally competent care can be described as Evidence-Based Care (research to practice). Evidence-based care has long been hailed by the NHS as the way forward and is the premise that value-based commissioning relies on (Heginbotham, 2012). Nolan et al, 1998, questions this notion and contends that the alternative is a relationship-centred approach to care.

Their study explored the development of research with family carers and people with dementia.

As younger people are also affected by dementia the search looked at a study by Beattie et al (2010) and found that concerning younger people in dementia care (less than 65 years) there was a need for person-centred care that is tailor-made to the needs of the individual. Such care is expected to fulfil culturally competent criteria, and this must be defined ahead of time and be capable of being measured. The study used a systematic review methodology to investigate studies which originated in the UK to highlight evidence that person-centred care, the advocated model of practice is not currently reflected in most services provided in the UK. Findings argued for inter-agency collaboration, early assessment, and an awareness of individual needs. All these elements are those which should be considered within the design of services in line with findings from the culturally competent needs assessment process. Here we see that cultural competence and person-centred care are linked, hence it is discussed in some depth later in this study.

A study by Mackenzie et al (2005) is one of the first to lead in the movement towards culturally competent dementia care however their focus was only on black and ethnic minorities affected by dementia. This is perhaps one of the most important studies considered in this study. The researchers were concerned with the question of evidence-based culturally appropriate care for BME populations affected by dementia. They highlighted the crucial issue of a lack of evidence base to guide professionals working with people affected by dementia. An equally important finding was the limited focus on beliefs about dementia and the type of treatment and support needed. These two issues are implicated in the problems faced by providers who have responsibility for supporting BME service users and families affected by dementia. As a researcher looking to justify the need for culturally competent dementia services, these are findings that support the relevance of my research.

So much has been said about the capacity of cultural competence to yield good results and its importance as a core requirement for successfully working with

diverse patient groups, however, the literature also presents dissenting views with regards to this notion. An important study led by Wong et al, 2003 expounds on the dissenting voices from Asian-Canadian practitioners who have embraced the concept of cultural competence. They assert that the conceptualisation of culture in most writings about the concept fails to recognise the fluid boundaries and the political character of culture (Wong et al, 2003). Participants of the study who work with ethnic minorities on a multi-ethnic project promoting mental health found that their knowledge and experience did not guarantee cultural competence. What these practitioners could evidence was the elusive, contextual and political character of culture amongst other things (Wong et al, 2003). In a recent study looking to define a conceptual model of organisational cultural competence for use in MH services (Hernandez et al, 2015) found that although the proposition that increased cultural competence in providing psychiatric services can reduce existing disparities, cultural competence lacks a clear means of operationalisation that can direct research and practice. This research study begs to defer from that school of thought in stating that the place to begin is in the culturally competent commissioning of all areas of earmarked for transformation.

There is much to be said of the practice of cultural competence in terms of its efficacy, for this reason, the training programmes used to skill practitioners should come under scrutiny. Beach et al, 2003 carried out a systemic review of health care provider educational interventions by identifying studies that evaluated interventions to improve cultural competence from 1980 to 2003. They searched for evidence of effectiveness and costs and found evidence that there is an impact on patient satisfaction but poor evidence of an impact on adherence to therapy and poor evidence of the determination of costs. What is not clear is whether patients were included in every area of consultation for the transformation needed. Stakeholder engagement is crucial to the skilling up of professionals.

In summary, the literature review has covered studies/findings of dementia/MH and cultural competence/value-based commissioning, policy, models/frameworks,

definitions, and the evaluation of some training programmes. The purpose was to give an understanding of its relevance to the commissioning of dementia and other MH services by highlighting how cultural competence has been used to impact health care delivery. It was clear that there is a significant big gap in the literature of studies that look at cultural competence commissioning.

The literature review comprehensively establishes the relevance of cultural competence to care delivery and understanding service users of all cultures. Furthermore, the wealth of studies without a consensus over its definitions leaves no doubt of the need to improve on its application to MH care delivery and the designs of training/teaching curricula. As there are few if any studies that relate to commissioning, it is clear that this study is necessary and pertains to the development of key performance indicators (KPI's). Commissioners and agencies responsible for auditing the quality of care need a set of KPI's to enable the measurement of quality and performance. Auditing the quality of cultural competence must be accomplished alongside the effectiveness of services and patient satisfaction.

Although there is no doubt that much progress has been made (research, nursing, mental health care delivery, psychology, health care counselling etc) there are significant gaps in research and practice. To this end, a concerted effort is needed to ensure cultural competence is operationalised within health commissioning and the leadership hierarchy of NHS. It may be a better way of accomplishing the delivery of optimum person-centred care that service users find meaningful. Furthermore, it may ensure the concept and all that it embodies is embedded at a strategic level, this is because it is culturally competent policies and that confers the status of cultural competence on organisations.

This literature review is clear evidence that the concept of cultural competence is complex and multifaceted, it is also showcased a lack of effective guidelines such as those that have been developed for family therapists by Bean, Perry and Bedell, 2001, 2002; Kim, Bean, & Harper, 2004.

At a systemic level, the NHS when embracing cultural competence will need to make the type of progress the American Psychological Association (APA, 1993, APA 2003) and the Association of Multicultural Counselling and Development (AMCD) have made. Their framework will need to focus on being outcome-driven which is what is needed to ensure that performance can be measured optimally. This should be the case for all services but most especially dementia services for older people and mental health services for others. To this end, there is a need for more studies that evidence the integration of mental health care (professionals) in primary care. This should be done despite evidence of the challenges that relate to cost.

Further research is needed given the dearth of literature around culturally competent commissioning for dementia care. Guidance on dementia care speaks of high-quality compassionate care (NHS Improvement, 2017) and patient-centred care as a standard. There are 8 standards in total yet no mention of cultural competence; this is significant in that there can be no patient-centred care without cultural competence. Furthermore, care plans considered outside the cultural perspective of service users must be deemed inadequate even as the limitations of the guidance are very much linked to finance. A positive development in the dementia care arena has been the personalisation agenda that promotes empowerment, choice, improved access and continuity of care, etc. The main criticism this research study has of the guidance currently available is in the absence of culturally competent guidelines that maintain the personhood of those affected by a mental health condition. There is limited literature on the cost and sustainability of culturally competent services in the UK. The same applies to America where its adoption sits mainly within culturally competent delivery to attract customers to health insurance. Here we see cultural competence as a tool to boost profit and not the commissioning of culturally appropriate services.

Studies that consider healthcare systems similar to the UK report worse healthcare outcomes for some migrants and BME groups (Sorensen et al, 2019). When checking the preparedness of medical doctors to cope with the needs of migrant

communities a study of 12 European medical programmes showed no inclusion of cultural competence (Sorensen et al, 2019). This all adds to the deficiencies in the healthcare system which can be improved with the adoption of culturally competent commissioning practices.

2.9 Summary

Every aspect of dementia-related care, support, and treatment is influenced by government policy and commissioning guidelines shaped by specialist agencies (NICE, SCIE, CQC & PHE). At the current time, now more than ever, both dementia and commissioning related research is needed to assist the NHS in its responsibility to deliver better services to an increasingly older and diverse population. There particularly needs to be a better emphasis on cultural competence and a set of guidelines that enables commissioners to specify and monitor the right key performance indicators. The challenges discussed in this review so far are:

- The problems of dementia prevalence, diagnosis, and assessment rates
- Availability of culturally competent dementia services care and treatment
- The status of UK Dementia policy, cultural competence, and multiculturalism
- The CCG as a commissioning body

In summary, it seems there is a current need for scholars of cultural competence to interact with the concept beyond the delivery of health care. Furthermore, there is a need to encouraged scholars to define the concept of cultural competence and generate conceptual models that describe the attributes of culturally competent commissioning. This review identified a paucity of studies that relate to culturally competent commissioning and any associated frameworks that might elaborate on how health organisations might operationalise the concept to procure the same in services. The review also revealed a paucity of evidence regarding the impact of

cultural competence on service user compliance to therapy, efficiency, safety, equity, performance, or quality of service.

This chapter concludes by asking the reader to note that for the purpose of this study, value-based commissioning cannot be interchanged with culturally competent commissioning. The study is an opportunity for research to improve commissioning practice from the inside.

To achieve the relevant cultural skills or behaviour described as the communication and behavioural capacity to interact effectively with culturally different people should be desired and promoted within all health organisations. Training is essential (mandatory) to ensure that these skills flow through the hierarchy of a health and social care organisation are paramount to the success of culturally competent practices. For this reason, the choice of a survey questionnaire was to assess the extent to which these skills need to be included or offered as part of training practiced and valued by participants. Open-ended questions were used to elicit the data needed. In a provider organisation, it can be defined as the ability to utilise culturally competent tools to make accurate physical or psychological assessments and collect health data from ethnically diverse patients. Based on the findings from the literature review, this study argues that assessments should be completed using culturally competent assessment tools and that all assessed needs should be considered in the planning of care.

Chapter (3) describes and justifies the methodological and theoretical context and underpinnings of the current study. The justification of a mixed methodology approach is explored further and backed up by a brief literature review of the approach. The chapter also explains how each of the chosen approaches is to be used and offers a description of the setting, participant selection, ethical considerations, and challenges.

Chapter 3

Design and Methodology

3.0 Introduction

This chapter has a focus on the research design and methodology along with a narrative of the study settings, target population, sample size, sampling techniques, methods of data analysis as well as the ethical issues involved in the study.

The study setting considers the organisational commissioning setup of the National Health Service and the reasons it is relevant to this study. A crucial reason the NHS is important to this study is that it is the main organisation that delivers and commissions mental health services. For this reason, it could be expected to showcase cultural competence in all aspects of commissioning as it also holds the main budget for healthcare. Furthermore, it has responsibility for training and research, and is the main stakeholder for the recommendations of this work. It is for these reasons that the participants of the research are the commissioners and providers affiliated with the NHS.

3.1 Commissioning, Cultural Competence and Pragmatism

Excluding nursing, culturally competent related research reveals a scarcity of documented evidence of methodological challenges. Methodological approaches are rooted in anthropology (Leininger and McFarland, 2002; Giger and Davidhizar, 2002; Campinha-Bacote, 2003 and Purnell and Paulanka, 2008) however, there is evidence that they can also be situated within pragmatic domains (Mahoney and Engebretson, 2000). For this reason, a mixed methodology that allowed the flexibility of combining quantitative and qualitative methods was chosen. The qualitative approach was used to predominantly yield findings from an interpretative analysis

while the quantitative method was used to collect sociodemographic data. The argument and perhaps justification for the exploration of cultural competence in commissioning is related to the importance of meeting individual needs when commissioning services for general use. This means that personal qualities, experiences, and values should be considered in the development of health and social care services/commissioners.

Pragmatism – A Philosophical Framework

Guba, 2017 defines a paradigm as an interpretive framework guided by a set of beliefs and feelings related to how the world should be understood and explored. The choice of pragmatism is because it is a useful paradigm that supports the idea of many truths and realities that are socially constructed (Martens, 2005). Simply put, paradigms are road maps or sets of guiding principles that give order or structure to a chosen inquiry providing a lens, frame, and process for the investigation (Weaver &Olson, 2000).

The philosophical underpinnings of pragmatism allow and provide a road map for mixed-method research approaches, in simple terms pragmatism is about embracing what works to arrive at a workable solution when a single method is not suited to a problem. To this end, the availability of multiple paradigms has meant that varied stances on incorporating paradigms have enabled mixed methods as a suitable choice. Creswell and Plano, 2007, 2011 suggest that multiple paradigms relate to different phases of research design, thereby linking paradigms to research design.

Pinning down a research paradigm to pragmatism emphasises the importance of the research question, the value of experiences, practical consequences, action, and an understanding of real-world phenomena. This study adopts a pragmatic approach for its pluralist advantage but also for the clear road map it offers as an easy way to set out the thesis report. The advantage of pragmatism is that it rejects the

dichotomies suggested by Howe and Eisenhart (1990) and equips researchers with ways to combine methods that best suit investigating and answering specific research questions (Burke, Johnson and Onwuegbuzie 2004).

Considering the position of an insider-researcher attempting a work-based research project to obtain a new way of working, a mixed-methods approach (pragmatism) is the most appropriate choice, according to Costely et al, 2010. Pragmatism is an old philosophy (classical pragmatism) or doctrine of meaning that focuses on the truth of an ideology only if it works, suits a purpose, and creates an action. It is embraced due to the insights it offers research and the provision of epistemological justifications for mixing approaches and methods (Onwuegbuzie, et al, 2009).

A constructivist or interpretative approach proposes social relationships (social constructivism), that is, constructs made should be interpreted as meaning and language are socially constructed. It does not predefine the variables under investigation but seeks to investigate the complexities of emerging situations of which this study will have a few. Its philosophy speaks to the practical nature of reality while allowing the use of different methods and even different modes of data analysis. Pragmatism means an interest in actions as primary units of analysis in an empirical world; hence it gives a focus to 'what works' and the development of understanding the process of knowing. The focus on actions (what people do) is about letting the social world become meaningful (Goldkuhl, 2004). The choice of pragmatism is about an interest in change as opposed to interpretivism which is linked to a social constructivist model of thinking (Orlikowski and Baroudi, 1991; Walsham, 1995). The aim of interpretivism is linked to understanding how people partake in social processes, experience their realities, give meaning and show how these meanings, beliefs, and intentions constitute their social action (Orlikowski and Baroudi, 1991).

3.2a Epistemology and Ontology

This study notes the controversy surrounding mixed methods research that pertains to paradigms, particularly which paradigms might be compatible with a mixed-methods approach. It also avoids the confusion of logic justification (Onwuegbuzie and Teddlie, 2003); therefore, the justification of the methodology chosen does not seek to tighten the relationships with the data analysis. In other words, it has no close bearing on the choice of the data collection approach or data analysis methods, according to Bryman, 1984, and Howe, 1992, who also agree that epistemology and method are two different things. Johnson and Onwuegbuzie, 2004 suggest that more work is needed to offer clarity on philosophical position, design, data analysis validity strategies, mixing, and integrating procedures.

Johnson and Onwuegbuzie, 2009, advise that mixed-method studies can use a method and philosophy capable of utilising the advantages of quantitative and qualitative research and, indeed, any other approach.

As the study is about understanding participants' knowledge of cultural competence, the outcomes may reveal gaps in knowledge and highlight the need for further development and/or training. This being the case, this study could be understood as being transformative in its outlook and therefore in need of a transformative paradigm. Such a paradigm is characterised as placing a central importance on impacting the lives and experiences of marginalised groups (Mertens 2003).

The ontological stance is one that argues that reality exists as actable and also takes a constructivist view of a world created through social interaction (an accountable and socially meaningful world).

Ontologically, pragmatism asserts that singular and multiple realities exist alongside multiple perspectives to examine them; therefore, it fits in with the choice of multiple or mixed methods of collecting and analysing data. For this reason, the collection of data in this study had a stance that allows the choice of what works based on the research context and questions. The research question asks what the challenges

and opportunities are for commissioning culturally competent dementia services for older people. The nature of the question demands an ontology aligned with pragmatism as it supports the view of multiple truths and multiple realities; it also provides an opportunity for the voice, concerns, and practices of research participants to be embraced in a meaningful way.

3.2b Theoretical Rationale: Pragmatism as an Epistemology

Cultural competence is a complex notion to investigate, the evidence is related to the challenges documented from the number of epistemological and philosophical vantage points previously contemplated. These methodological challenges in researching cultural competence have been sparsely documented. Mahoney and Engerbreston (2000) working within interpersonal nursing care research place cultural competence within contextual, experimental and pragmatic domains. Duffy (2001) differs by considering critical reflection with a postmodernist stance. Sue's (2001) multidimensional model of cultural competence incorporates racial and culturally specific attributes of competence, aspects of cultural competence and foci of cultural competence (constructivism). Whitley (2007) offers a different stance by claiming that cultural competence is embedded in postmodernism and multiculturalism.

Pragmatism is a design with philosophical assumptions that can be analysed at all levels in the research process (Teddlie and Tashakkori, 2009; Greene, 2008) and suits the design of this study based on plans to collect data qualitatively and quantitatively. Culturally competent commissioning is a public administration process therefore an argument for the choice of pragmatism is its relevancy as a philosophy of science to public administration theory and practice (Shields 1998).

This research presents an argument in agreement with Feilzer (2009), in the assertion that pragmatism has a practical relevance as a research paradigm and supports the using quantitative and qualitative methods. It is also about the ability to

exploit the inherent duality of the data analyzed and the further advantage it gives the researcher to undertake a continuous cycle of abductive reasoning while being guided primarily by the researcher's desire to produce socially useful knowledge (Feilzer, 2009). It is also argued that pragmatism can serve as a rationale for formal research design as well as a more grounded approach to research especially as it concerns the evaluation process. Hall argues that mixed methods evaluation has a long standing history of enhancing the credibility of evaluation findings that does not discount the danger of being accused of adopting the method purely in a utilitarian way for the sake of convenience as opposed to for its philosophical underpinnings (Denscombe, 2008). Researchers who have been criticized based on the above stance have also been referred to as assuming an a-paradigmatic stance (Greene, 2007) as it is assumed that they have simply taken that threatens the validity an unreflective what-works approach (Denzin, 2012). Such an approach is thought to be a threat to the validity of findings (Lipscomb, 2008) and a contrast to Deweyan Pragmatism which empathizes intelligent action to explore central questions in mixed methods evaluation and evidence-based practice (Hall, 2013).

Finally, Pragmatism as a philosophical stance helps to shed light on how the mixed method approach will and can be mixed to respond to the research questions (Hoshmand, 2003). This supports the argument that research approaches should be mixed in ways that offer the best opportunities to respond to important queries.

3.3 Mixed Methods – Justification of Approach

In keeping with Johnson and Onwuegbuzie (2013), mixed methods research allows the development of techniques that bridge the schism between quantitative and qualitative research (Onwuegbuzie & Leech, 2004). This then calls for a movement away from the logic of justification as noted by Onwuegbuzie and Teddlie (2003). They contend that in doing so, there is a tendency to treat epistemology and method as being synonymous (Bryman,1984; Howe, 1992). This does not hold as

the logic of justification (an important aspect of epistemology) does not dictate the specific data collection or data analytical methods to be used, Johnson and Onwuegbuzie, 2013).

The first choice for this study was an action research inquiry that was abandoned because the immediate research problem could not be solved by one person working alone and the research site was not amenable to the implementation of change during a research study. The initial choice had been based on the capacity of participatory action research to understand the world. The mixed-method approach was chosen because of the need to employ a multisource perspective of cultural competence, by employing an approach capable of delivering an increased confidence in the findings (using 2 independent measures). The thinking was that a more comprehensive picture of the results would entail the use of two or more rigorous approaches along with a more in-depth understanding. The definition of superior results in this study relates to being able to approach the exploration of the phenomena by first exploring it with one group of survey participants and confirming validity with another set of in-depth interview participants.

A mixed-method approach is justified in this study because the questions posed will play a part in driving the method, and they are of a qualitative and quantitative nature.

Creswell and Plano Clarke (2011) describe mixed methods research as:

> “...a research design with philosophical assumptions as well as methods of inquiry. As a methodology, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone..." (Creswell & Plano Clark, 2007, p. 5).

This better understanding is arguably what is possible when using multiple ways of seeing. Their view provides an allowance for (mixed method) pragmatic inclinations and for dealing with research questions that require more than one method to address the question fully.

This study uses qualitative and quantitative tools to look at four distinct areas of culturally competent commissioning, these are the challenges, opportunities, attitudes, and the guidelines or criteria. In exploring these four areas there is an expectation that meanings will be constructed, and arguments further developed according to the definition of theory offered by Allan (2011). Allan, 2011 contends that the nature of emerging theories can be as wide-ranging as the behaviours and understandings from which it is generated. This is because theory is constructed from assumptions, perspectives, concepts, definitions, and relationships, and the function of theory is to explain how things work or come into existence (Allan, 2011).

3.4 Research Design

This study employed a sequential mixed method research design. Quantitative data was collected followed by qualitative data to provide further clarity on the emerging themes from the survey questionnaire. The questionnaire was used to obtain quantitative data while an in-depth interview guide was used to gather qualitative data.

The choice of the questionnaire survey was to assist in describing and comparing attitudes/behaviours or explain knowledge amongst participants. It served as an efficient way of collecting data within a specified timeframe and was favoured for its capacity to reduce researcher bias and collect expressed meaning.

The survey questionnaire was used to collect quantitative and qualitative data to explore emerging themes further, to do this an interview guide framed questions to gain a better understanding of responses. This means that the interviews served to ascertain the level of cultural awareness, sensitivity, and cultural knowledge and

desire amongst participants. Knowing this was necessary the selection of appropriate participants with an adequate understanding of the subject was important and very much considered in the selection of participants. Another important use of the survey questionnaire was that it made it possible to recruit participants outside the main research site/host organisation (Creswell, 2009; Fox, Murray & Warm, 2003; Hanley, 2011; Schmidt, 1997).

The questions responded to were those that could elicit data related to cultural competence, such as the levels of awareness, skill set, and willingness to embrace it (desire), encounters, perceived challenges, and opportunities for commissioning culturally competent services. The outcome of the survey questionnaire was used to inform the schedule of the in-depth interviews and gain clarity of a meaningful way to interpret or gain more insight into the responses from the survey. This was deemed a meaningful process because the findings from the questionnaire were used to guide/design the questions for the semi-structured interviews. Though the data from the questionnaire provided limited insight into the subjective experiences of participants (Strier & Kurman, 2009), the employment of the semi-structured interviews had the purpose of exploring emerging themes further and kept the focus on the research questions.

3.5 The In-depth Interview Phase

Qualitative methods are suitable where there is a lack of research (Sizq &Taget, 2009) as was the case in this study; hence interviews were used as a verbal qualitative approach to elicit in-depth information. The predetermined questions permitted progress in a conversational manner. Open-ended questions were developed concerning what needed to be known further from the emerging themes from the survey questionnaire phase. One of the purposes of this was to gain a better understanding of ambiguous responses. The subject area was familiar to the participants as they were allowed to see the responses from the survey questionnaire phase. The interviews were an opportunity to study how people feel about the need to be culturally competent professionals (social opinion). Van Manen,

2016 asserts that everyday lived experience is an approach to research methodology. The participants were at liberty to explore the phenomena and render their opinion on the subject area of cultural competence and how this relates to designing, procuring, and delivering services in response to health needs. The open-ended questions were designed in a manner that considered how participants could respond based on their knowledge and experience instead of the researchers' experience; this was important due to the familiarity with the participants

As the subject was quite emotive as are discussions about culture, ethnicity, and diversity, the Interviews were multipurpose as conversation (Lincoln and Guba, 1985). Responses were recorded on a recording device directly and manually (notes) by the researcher. All interviews were transcribed and crosschecked for accuracy and enabled familiarity in readiness for the analysis phase.

3.6 Target Population

Mental health service commissioners and those who work in provider organisations affiliated to the NHS were the target population for the study. This group also includes those responsible for the development of mental health and social care policies. These professionals work with the Public Health team and others within strategic health authorities. NHS professionals and affiliated professionals were the research respondents and deemed suitable to represent the target population as they along with the target population usually participate in commissioning discussions and work at the exact locations with the insider-researcher. Being available for both phases of the study helped with consistency (reduce attrition) and was convenient.

3.7 Sample Size and Sampling Procedure

100 people were approached to participate in the study however a significant number declined or found it inconvenient, perhaps believing that the research topic was

irrelevant to their role less. There had been an intention to perform a comparison of the characteristics of those who participated with those who had declined however profiles were not completed for those who declined meaning that issues with bias could not be confirmed (Bryman, 2012).

The sample size of a research project is directly related to the type of study being conducted, hence small sample sizes relate to qualitative studies, while large sample sizes relate to quantitative studies. Onwuegbuzie & Collins, 2007 assert that three criteria should dictate sample size; these are the objectives, questions, and design of the research study. Based on this, 70 participants were shortlisted for the survey questionnaire; some contacts were obtained from the NHS global address list while others were colleagues at various places of previous employment.

Of the 70 questionnaires handed out only 43 were useable however some of those who submitted unusable questionnaires continued to participate in the in-depth interview phase to keep numbers on track. The reasons why some questionnaires were not useable included illegibility of handwriting, incomplete questionnaire, late returns, and non-returns. All participants were drawn at the senior and operational levels to ensure a wide range of views from decision-makers. 31 commissioners and 12 providers were involved in the survey while 15 commissioners took part in the in-depth interviews. A summary participant profile is in chapter 5.

All participants were advised of their right to have anonymised details, withdrawal at any time, and an opportunity to validate their contribution should they wish to do so. A few participants were qualified health professionals working as commissioners (Urgent care nurse, GP, head of quality–a nurse by background, safeguarding lead-nurse Placement manager-nurse), see demographics for further information.

The choice of participants was also about extrapolating description and meaning of experience as lived and understood by participants (Van Manen, 2007, Smith and Osborn, 2007, Silverman, 2010). The significance of this relates to both concepts being outcome-focused in that commissioning ensures services are available for the

general population while cultural competence is about ensuring that services/care are of value to individuals (person-centred).

A purposive sample was chosen to explore the experiences, understanding, and perceptions of the participant provider and commissioner staff affiliated with the NHS. A total of 85 people participated throughout the project which also had a pilot (test) phase or group in addition to the survey questionnaire, and in-depth interview phase. The reader should note that the pilot group (15 colleagues) are technically not considered part of the study due to their involvement in designing the study (questionnaire survey). For this reason, none of the data collected from during the pilot phase was included as the group did not sign up as participants and were also not required to provide feedback under research conditions. Their role was to design research documents for usability, assist in testing the research documents, (provide feedback and advice).

3.8 Data Analysis (Atlas.ti.8)

Qualitative research analysis involves the conversion of raw text data into a set of coherent findings (Patton, 2002). The process involves working through significant amounts of meaningful and non-meaningful untreated data to set aside the meaningless from the meaningful. The purpose is to construct emerging themes and patterns (Creswell, 2007). Although all qualitative analysis appears similar, there is an involvement of different but related approaches that produce varied analytical procedures that can be chosen based on what suits the research project (Kwan & Ding, 2008).

The analytical process of this study began from the data collection phase and continued throughout the study (Bradley, Curry, & Devers, 2007). This was accomplished by vast amounts of reading, understand, and converting semi meaningful statements into meaningful ones. This was followed by extracting

meaningful statements and making memos in preparation for use with the chosen software.

Qualitative methodology involves searching for patterns, similarities, and differences across units of analysis with similar variables and outcome measures (Ausburn, Martens, Washington, Steele, & Washburn, 2009). These identified patterns, similarities, and differences are described by Boyatzis (1998) as themes or recurrent underlying statements or concepts. The themes served the purpose of providing meaningful descriptions of the phenomenon under scrutiny (Ryan & Bernard, 2003) and entailed vast amounts of reading. The task of analysis is, therefore, about identifying emergent themes that are salient to the qualitative research questions. Thematic analysis was achieved via Atlas.ti.8 and its use is explained further on in this chapter.

Figure 3.1 shows the workings of Atlas.ti.8. and though there are numerous snapshots of the process only a few have been chosen to showcase the specific output from this study. The process began with the creation of the project; this involved the creation of a hermeneutic unit for the project within the software. In this project, the two levels to the process of working in Atlas.ti were the data level, and the conceptual level. Atlas.ti.8 software was used to thematically analyse both sets of data separately and then the refining of the theme development phase was achieved by reading the product of the computer-assisted analysis in bits and making sense of the whole.

3.9.3 Data Preparation and Analysis

The documents were first formatted with clear identifiers and were added to the hermeneutic unit. This process was followed by document grouping then coding where necessary. In terms of the survey questionnaire responses from each questionnaire were collated per question so that each document was a collation of responses to the same question (Similar responses were coded and categorized

together). The resulting product was queried using the various analysis tools available within the software. In other words, the overall data was divided, grouped, and reorganized and then linked to sections of the research questions and the aims and objectives of the study, this enabled readiness for the definition of the themes. It also served the purpose of consolidating meaning and the development of explanation (Grbich, 2013). Developing meaning was possible following the search for and finding of patterns, this is because the task of analysis is about searching for patterns in data (Bernard, 2011). At this stage, accomplishing the grouping of patterns that look alike (Lincoln and Guba, 1985) assisted in the development of meaning. The final themes/subthemes were visualized as a diagrammatic presentation offered further on in chapter 5.

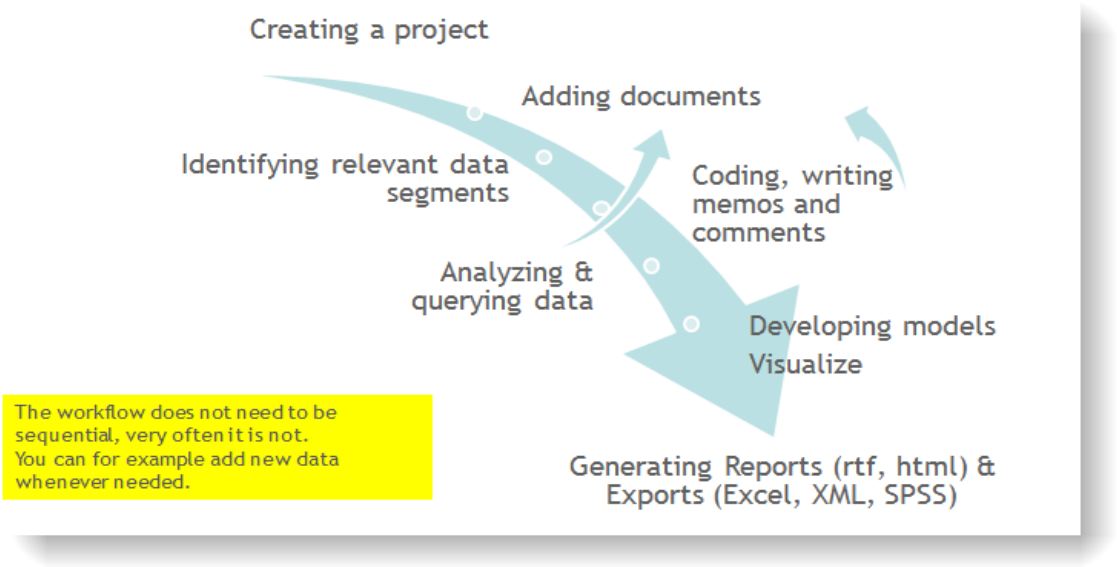


Figure 3.1: Workflow in Atlas.ti version 8 (Atlas.ti Manual Image)

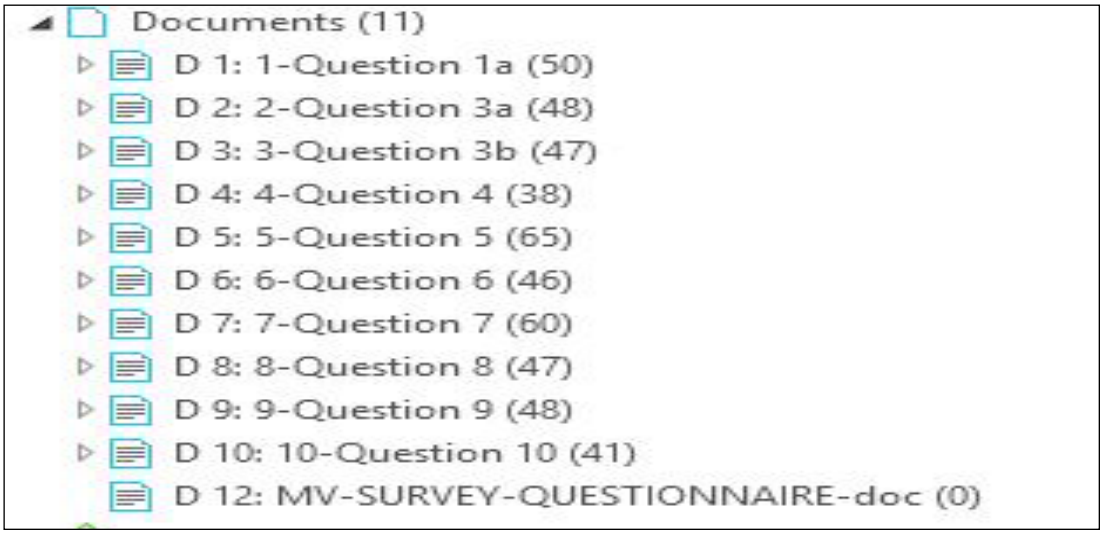


Figure 3.2: Documents loaded and coded (excluding D12-the questionnaire)

For the sake of clarity and understanding it was deemed useful to have a report that codes per question, this was best done using a prefix so that the codes per question could be grouped as suggested by Friese et al (2012, p. 115). For example, each code produced had the prefix: "Question number _ inductive code" which means a question number followed by an underscore and then an *inductive reading of the meaning* of the text/quotation: **Q3**_*NHS* entity as *CC* (meaning Question 3 how the NHS as an entity is seen as culturally competent). Additional prefixes were used, when required, such as: *CC*-Cultural Competence; COMMS-Commissioners; *NHS*-National Health Service; POLICY-for policy issues.

The second level of coding covered the following:

- Checking the wording and accuracy of the codes manually
- Checking the coding in terms of their prefixes (See Figure 9)
- Merging some codes to lump the data (Saldaña, 2016) and rationalise the number of codes via a manual researcher process
- Reviewing the Code Summary and the Code frequency counts to get a sense of how "grounded" the codes are in the data researcher process

- Saving the codes to achieve a compiled final code list.

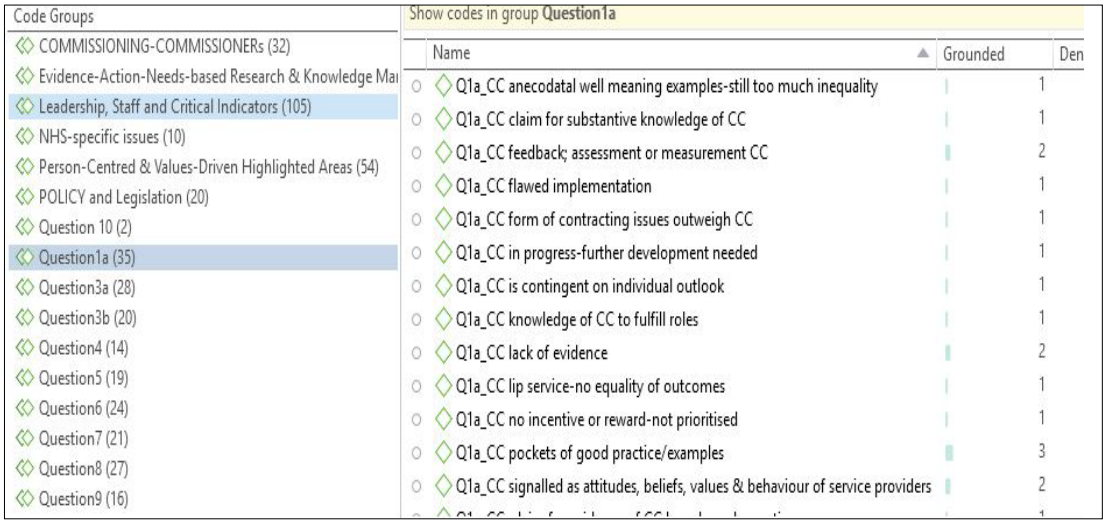


Figure 3.3: Sample of Codes with prefixes and code families

Regarding figure 3.3, the highlighted row is (Question 1a) alongside the number of codes in parenthesis (35). It links to the column showing all 35 code frequencies (groundedness) which is the number of quotations linked to a code. The quotations are segments from the document of interest that are important to consider when responding to the research questions. The grounded column indicates the number of quotations a memo is linked to and memos are long passages of text that relate to captured thoughts from the documents (quotations or drafted notes by the researcher). The column next to the grounded column is the density column, it dictates the number of memos and codes a memo is linked to. The density column shows the number of links to other quotations/codes.

As a reminder to the reader, question 1 was asked in 2 parts, the first part asked participants if in their view the NHS commissioning process was culturally competent. The responses varied, therefore the second part of the question asked for explanations. The explanations formed the codes.

3.9.4 Category level

At the category level, the coding moved into the categorisation stage, this is the clustering of codes into groups, both conceptually and in ATLAS.ti.8 The following steps or considerations were made:

- Allocation of all codes per question to code families which represent the patterning of the data and the data categories;
- To assist the understanding of the cluster of codes per question, memos were written on each question, where codes were grouped into headings within the question/category: this served to assist with early theme-ing of the categories dependent on the literature to be consulted;
- A realisation of patterns within the data seemed to suggest certain central categories that could be captured, over and above the question level (See Figure 4 -red parenthesis);
- Groups were created from the strongly patterned codes;
- While noting the ethics of moving into themes, the patterns were highly grounded and therefore the grouping was well provided for making final decisions against the literature.

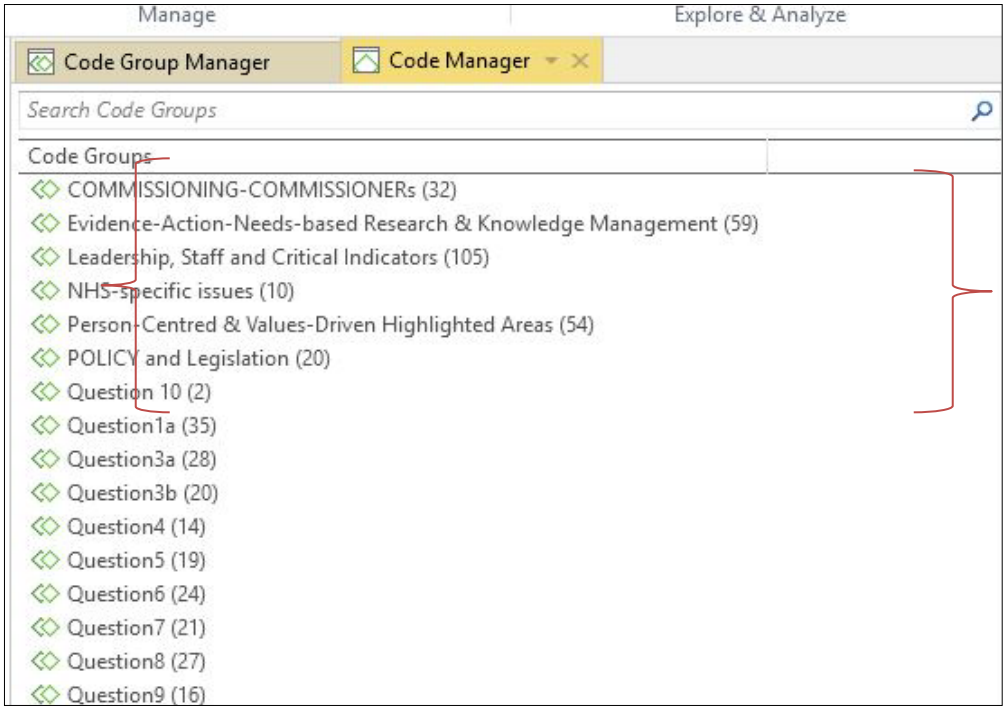


Figure 3.4: Groups of Clustered Codes: Per Question and Strong Patterns

The focus here is on question 10 of the survey questionnaire which asked participants how and why training might be a challenge to culturally competent commissioning. The codes that were of significance to the question were categorised to define the theme. A diagrammatic representation of these codes to themes linked to the question is presented in the presentation of findings in chapter 5 of this thesis.

3.9.5 Level 3

Reports of all the codes and quotations were achieved using the Atlas.ti computer software application. Following this the following steps were also adhered to:

1. A review of codes several times to make sense of them against the data;
2. A review of each of the specific codes in relation to each question to make sense of them and relate them to the main research question constantly;
3. A review of the suggested prominent categories-separated out from the question-by-question categorisations as these are signalling potential themes that need to be checked against the literature;

4. An analysis of the data codes to category/grouping sets – Atlas.ti was used to organise the codes into groups or families;
5. A conceptualisation to the level of themes and sub-themes

For the qualitative interviews, Step 1 of the process of analysis started with uploading the 15 transcribed interviews. Figure 3.5 shows a screenshot of the transcribed documents in Atlas.ti.

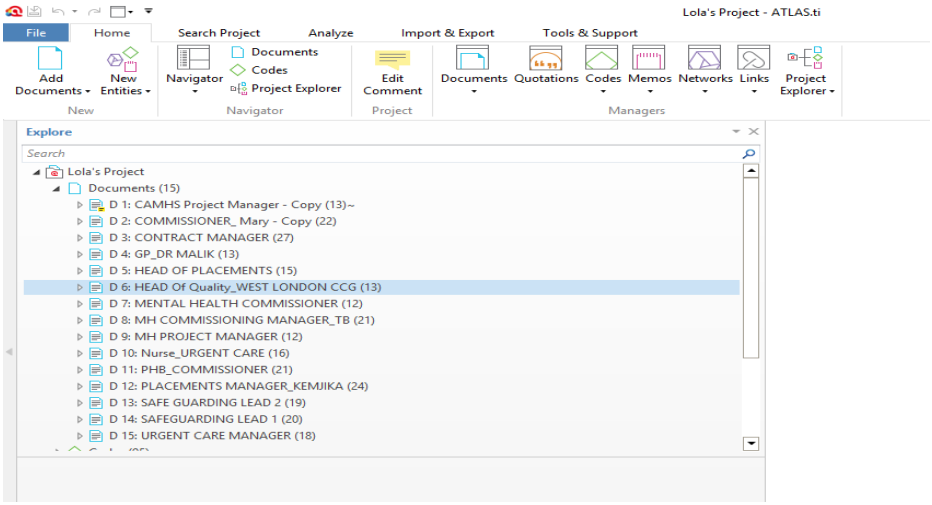


Figure 3.5: List of transcribed documents in Atlas.ti Version 8

Step 2 was the coding of the documents which required a significant amount of iterative reading of the transcribed data to enable further understanding, synthesising, theorizing, and constant comparison of the emerging codes. The result was the emergence of themes and sub-themes from the generated data; this is common practice in qualitative research (Thomas and Harden, 2008).

Open coding was used to generate codes by labelling segments (text) of the document with a phrase. This initial coding process was the first coding cycle used to summarise segments of the data. Figures 3.6 and 3.7 below are example screenshots of the generated codes and quotations respectively.

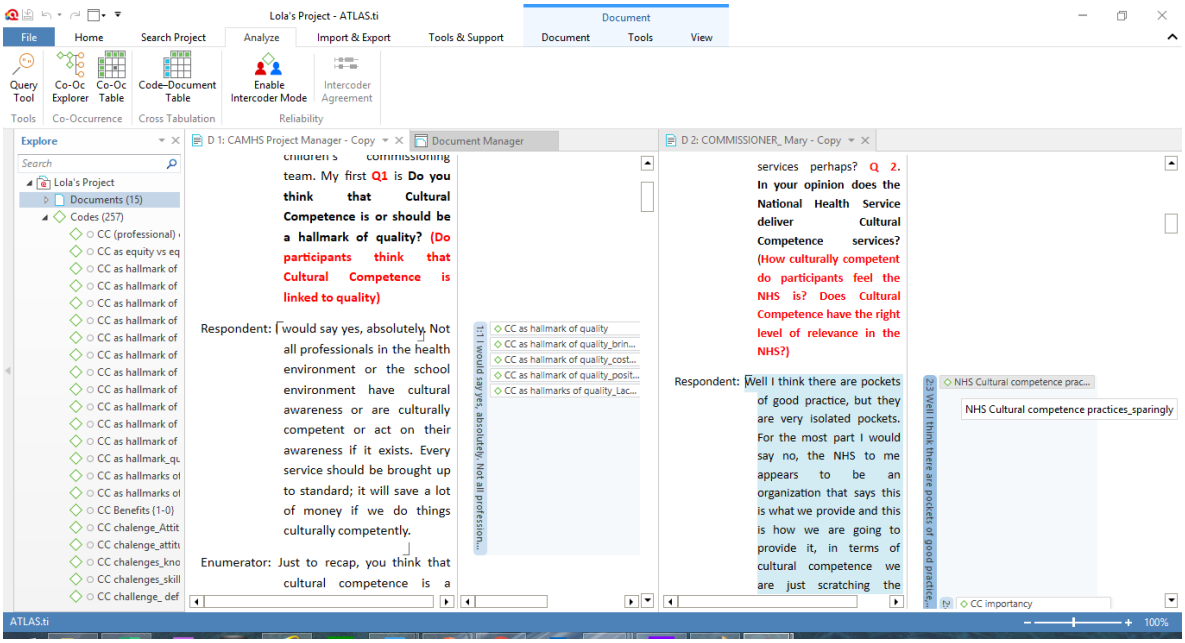


Figure 3.6: (Authors own 2020) Screenshot of codes (first cycle codes)

For clarity, figure 3.7, starting from the left moving to the right shows the 257 generated codes in the first cycle coding. It is impossible to show all the generated emerging codes in the figure above however questions 1 and 2 are represented by documents, D1, and D2 as shown in the figure. Several codes were generated from Q1 which relates to the perceptions of the participants on cultural competence as it pertains to quality. This then yielded codes generated that are shown as CC as a hallmark of quality_brings service to standard; CC as a hallmark of quality_cost saving; Hallmark of quality_positive outcomes, etc. Some of the generated codes from D2 on question 2 are also shown in the figure. Question 2 seeks the views of the participants as to the practice levels of cultural competence in NHS and yielded such codes as culturally competent practices_sparingly and CC importance were developed. Detailed presentations of these emerging codes are developed and presented in chap 5.

The first cycle of coding generated 266 quotations. A screenshot of a portion of the generated quotations is shown in figure 3.7 below. Starting from the right pane

shows the generated codes, the emerged quotations are shown in the next (second) pane. For example, given the first quotation on the pane, 1.1 “I would say yes, absolutely”. Not all professionals in the health environment… The highlighted row 1.1shows the first generated quotations from the first uploaded transcript (D1). The third pane shows the various transcripts. The fourth pane shows the quotation density. Density shows the number of links between entities. For example, a density of 4 means the quotation is linked to 4 quotations other as shown below;

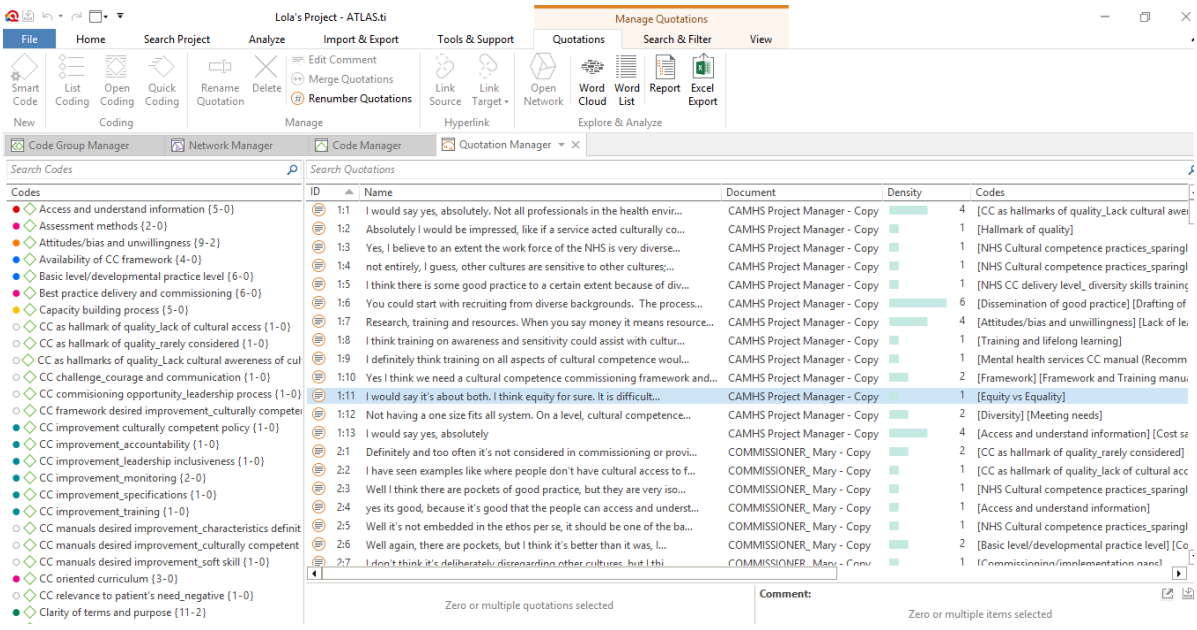


Figure 3.7 (Authors own) Screenshot of quotations (first cycle codes)

3.9.6 Second Coding Phase

The second coding phase was accomplished using axial coding techniques to identify patterns from within the codes. This was done by observing links between

the codes and data to generate sub-themes. The main themes were deductively generated from the research objectives. Nine (9) main themes were derived from the research objectives however 55 sub-themes were deducted from the data. Some of the sub-themes are associated with fewer codes, that being the case, the codes were grouped and retained in their respective sub-themes to avoid the possible tendency of the software stripping the interview of its meaningful content. The goal of axial coding is to “determine from the codes in the research which ones are dominant and which ones are not. Following this, the data set was reorganised to select the best representative codes” (Boeije, 2010: 109). The following section describes in detail the analytical process of coding used in the study. Figure 3.8 below shows a screenshot of the themes and sub-themes.

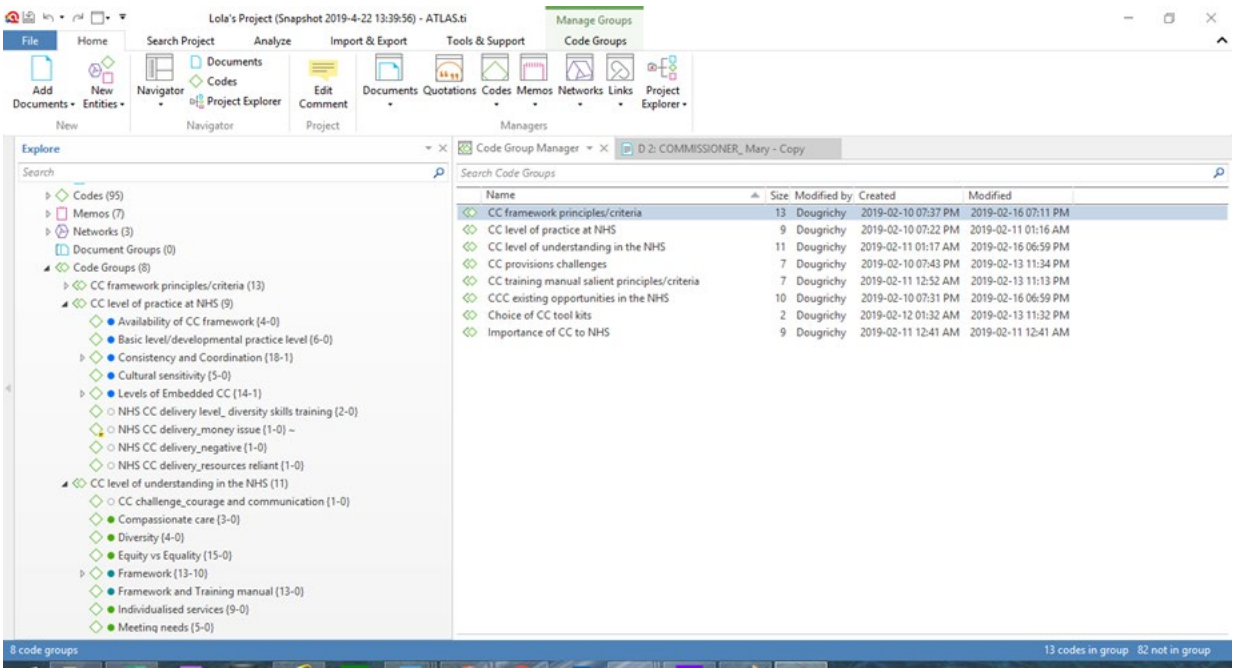


Figure 3.8: Screenshot of Themes and Sub-themes (Authors own 2020)

The snapshot of the second coding process shows 257 initial codes were streamlined to 95 codes and further grouped to yield 8 main themes and 55 sub-themes as shown in figure 3.9 (see vertical left pane). These main themes were; CC framework principles/criteria; CC level of practice at NHS; CC level of understanding

in the NHS; CC provisions/criteria; CCC existing opportunities in the NHS; choice of CC tool kit; and importance of CC to NHS. The emerged sub-themes for the various main themes are highlighted in colour as shown in figure 15 (see vertical left pane). As shown on the pane, for the main theme: CC level of practice at NHS, 5 sub-themes emerged as thus: Availability of CC framework; Basic level/developmental practice; consistency and coordination; cultural sensitivity and levels of embeddedness. These were manually refined to respond to the research question and are presented in chapter 5 in diagrammatic fashion.

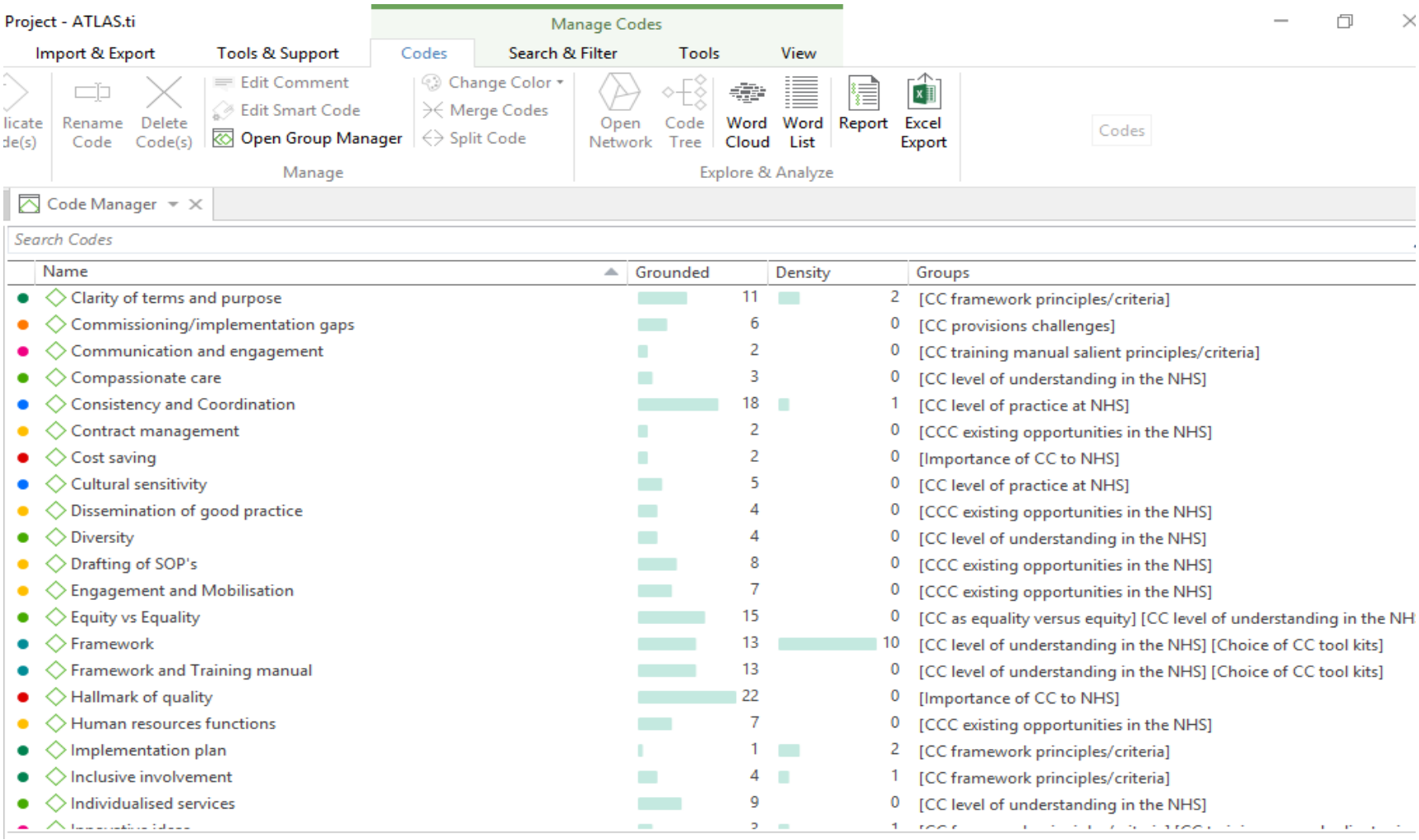


Figure 3.9 Screenshot of themes, sub-themes, and codes (Authors own 2020)

Data from the survey questionnaire was split into 2, quantitative (demographic data) and qualitative data. Relevant qualitative data was transformed into quantitative data and merged (mixed) to the original quantitative data to enable comparison and triangulation.

Following the thematic analysis of the 43 survey questionnaires and 15 transcripts from the interviews, 15 main themes and sub-themes were developed to represent the experiences and perceptions of participants.

The network diagram below (figure 3.10) shows how all the themes and subthemes are linked together summarily. The individual themes supported by their codes (quotes) are presented in chapter 5.

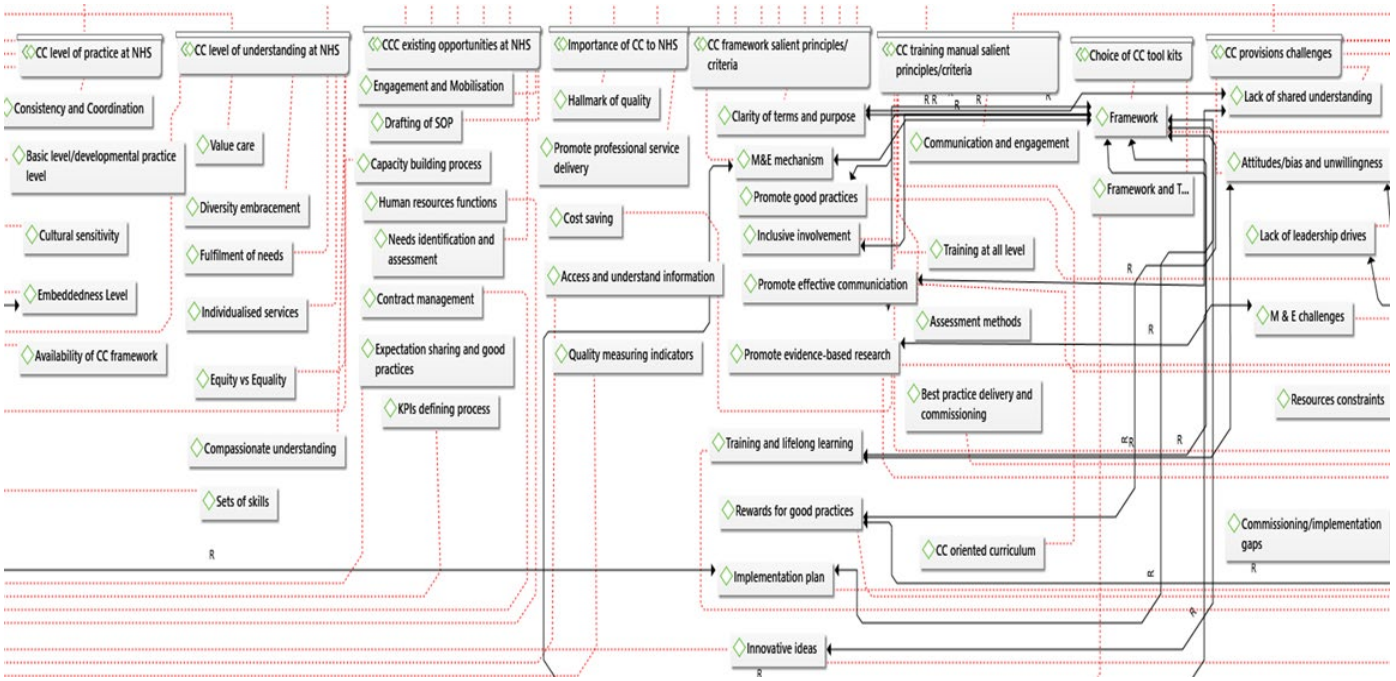


Figure 3.10 Screenshot of the Network of Themes and Subthemes

3.9.7 Ethical Considerations

Permission was obtained from the university and relevant NHS Research and development departments. Obtaining the necessary permission was time-consuming even for an insider-researcher familiar with the hierarchy of the NHS and the individual participants. Each NHS department required formal letters and discussions with various departments/colleagues before authorisation could be given. Authorisation letters had to cover intentions/process and a schedule of interviews, relevant research documents, and a narrative of the position of an insider-researcher. Researching official duties as an employee was also a challenge due to resource constraints. The NHS approved of the study via an online process and a letter of support was signed off by the Head of Research and Development of the host organisation. Research access to the NHS was agreed by the relevant external research authority as the study was considered a service evaluation not requiring full NHSREC approval as it also did not include vulnerable participants. The research project was also considered by the Health and Social Care Ethics Sub-committee of Middlesex University and approval was given based on the fulfilment of university ethics and prior approval by the relevant NHS research and development bodies.

The insider-research position was maintained in 5 locations as an interim commissioner (North and South of England) with minor challenges related to maintaining research momentum and contact. The advantage was access to a wide range of views across the UK where some areas are diverse in population and others are not.

Chapter 4 considers elements of the research project's activity alongside the design, description of the setting, participant selection, and other essential elements of the study.

Chapter 4

Project Activity

4.0 Introduction

This chapter is a narrative of the activities of the project including the insider-researchers' status, limitations of the study, pilot test, and constraints among other issues.

4.1 Insider Researcher Status

Working for a commissioning organisation (NHS) with responsibility for commissioning services is also about influencing service design, deciding on which services to procure, and the translation of policy. This makes the role political because of the conflicting agendas and levels of negotiation needed to operationalise government strategy. As an insider researcher/commissioner, dissemination of duty is in partnership with professionals in the employment, criminal justice system, social care, and housing arena because the role entails translating government white paper to policy and strategy at a local level. Considering this positionality, there must be an awareness of the power dynamic of the role of the insider researcher, how it impacts the commissioning role and the status of the research study. This being said, there was little if any infringement on the collaborative effort with other commissioners and provider professionals. This is a good reason why the mixed method choice was suitable as it matches the philosophy of work-based learning. It is also why Costly et al, 2010 assert that work-based learning offers an opportunity for collaborative research.

It will be remiss not to include a mention of the power dynamic of a commissioner (principal investigator) investigating the practice or professionalism of co-commissioners. Having the status of an interim commissioner (temporarily employed) was an advantage during the research in the organisation of employment; this is because as a temporary member of staff 'interims' are seen as an 'extra pair of helping hands' in the first instance, therefore, the research element could be viewed as an additional benefit as opposed to an intrusion. This means exploring cultural competence to enhance its status was seen by some as an added advantage and not an avenue for criticism of the professional practice. There was mutual respect and a sense of joint ownership of the investigation on some level; this was related to the ability to involve co-professionals in an investigation of common interest. The expectation was that the outcomes and benefits are for all involved.

It was important to have a personal awareness of the space occupied temporarily and also maintain one's objectivity/neutrality. This was about being reflexive and non-judgemental of those being researched, especially since cultural competence is one of the ethical skills that should be possessed by all researchers. This means having respect for those being researched, their space, and views and representing those views clearly and truthfully. This is the definition of ethical research which should be empowering and culturally competent.

The insider-researcher positionality can fit in with being a member of a team as opposed to feeling like an outsider looking in (Adler & Adler, 1994); this gives the advantages identified by Bonner and Tolhurst (2002). These advantages include being seen as a member of the group, more economical, easy acceptance, and trust. There are disadvantages to being an insider researcher; these include familiarity that can lead to loss of objectivity (DeLyser, 2001; Hewitt-Taylor, 2002) and the matter of balancing the duality of being a researcher and employee (DeLyser, 2001; Gerish, 1997). These disadvantages were not part of the experience of this study; furthermore, the research process did not involve access to privileged (patient data)

information or encounter bias on data collection or other ethical issues related to anonymity. The disadvantages also include role conflict, bias towards findings, and being seen as an intruder. In this study, the comfort of the researcher positionality was linked to having a greater understanding of the problem being studied, not altering the flow of social interaction, and having an established intimacy. These three advantages helped to save time in meeting and choosing the relevant participants, booking the use of space and time in diaries, and knowing what works (Smyth & Holian, 2008).

The experience was somewhat difficult but meaningful in that the process of investigating cultural competence also served as an opportunity to discuss and highlight the relevance of cultural competence. It was also a chance to correct the notion that cultural competence is about race rather than individuals and their values. It would be interesting to consider the limitations of cultural competence as in those things that would not be acceptable in terms of recognising and accommodating culturally competent practices).

The choice of a mixed-method approach fitted in with the philosophy of insider research/work-based learning using what will work to approach complex issues that do not fit neatly with other paradigms.

4.2 Data Collection – Instrumentation

This was a sequential explanatory mixed-method design characterised by the collection of quantitative and qualitative data via a survey questionnaire. This was followed by the collection of qualitative data collected via in-depth interviews (Creswell, 2003).

Participants received research documentation via email with a 2-week deadline to return survey questionnaires along with signed consent forms via post or email. Following the completion of the survey questionnaire phase participants were

shortlisted for the in-depth interview stage based on how well questionnaires were completed, availability, backgrounds, and roles to reflect diverse views

4.3 The Pilot Study

The purpose of the pilot study has been mentioned briefly above. It was carried out using 15 commissioning colleagues within a collaborative commissioning team of South West London commissioning groups. The pilot study was carried out as part of lunchtime learning sessions across 2 weeks. The group was made up of 5 males and 10 females who had various roles related to commissioning health services, including maternity, cancer mental health. The group was asked to consider several iterations of the questionnaire survey for clarity and ease of use, which means the pilot study, tested the validity of the questions and the ability of others to understand and complete (Creswell, 2005). This is referred to as instrument fidelity (Collins et al, 2006). Comments were taken and used to adjust the questions appropriately over a few iterations. None of the 15 participants from the pilot group participated in the main study. This process was only used for the survey questionnaire phase to ensure that the emerging themes from the phase would be a good basis to explore cultural competence further.

The practice of pilot testing is described by Creswell as a procedure in which the researcher makes changes to an instrument based on feedback from individuals who complete and evaluate the instrument before it is used (p.367). The purpose in this study was to assess the usability of the questionnaire, this helped determine whether potential participants who are similar in profile to the pilot group could understand the questions and complete the questionnaire (Creswell, 2005). Furthermore, it was a way to consider the extent to which the questions represent the subject being measured, the total content area, interest, and value to the participants (face, sampling, and item validity). The ability to maximise the appropriateness of the questionnaire with the 15-member pilot group before the

commencement of data collection provided an opportunity to make adjustments and maximise the time taken to deliver the task.

4.4 The Survey Questionnaire Phase

The definition of a survey is a detailed and quantified description of a population – a precise map or precise measurement of potential, Sapsford (2006). The choice of the questionnaire survey was to assist in describing and comparing attitudes/behaviours or explaining knowledge amongst participants. It served as an efficient way of collecting data within a short timeframe and was favoured for its capacity to reduce researcher bias.

The survey questionnaire was used to collect quantitative and qualitative (mixed) data that would provide emerging themes to guide the questions for the in-depth interview. It was the precise outcome needed to explore shared understandings, experiences, and motivations for practicing cultural competence amongst participants. The outcome provided the feedback (emerging themes) to design the questions for the semi-structured interview phase. Finally, an important use of the survey questionnaire was that it made it possible to recruit participants outside the main research site/host organisation (Creswell, 2009; Fox, Murray & Warm, 2003; Hanley, 2011 and Schmidt, 1997).

The questions responded to were the research sub-questions related to cultural competence (awareness, skill set, encounters, perceived challenges, and opportunities). Though the data from the questionnaire provided limited insight into the subjective experiences of participants (Strier & Kurman, 2009), the employment of the semi-structured interviews had the purpose of exploring emerging themes to provide deeper insight.

The final sample size remained considerably reasonable even though, of the number that were involved in the survey questionnaire only 43 returned questionnaires. The

criterion for usability was first, that the documents had to be returned on time, word-processed for legibility, and fully completed

A limited amount of quantitative data pertaining to age, number of years in employment, gender, and ethnicity was collected using the survey questionnaire. In total, the participants were asked to respond to 19 mixed (quantitative/qualitative) questions. Some of the qualitative data collected during the survey questionnaire phase was later quantified (quantitisation) to supplement the limited quantitative data collected. This meant that data was mixed at the point of collection and was also mixed at the point of analysis and interpretation.

The purpose of quantitisation was to enable a level of comparison (to determine possible relationships where relevant) and possible generalization (Voils and Knafl, 2009). The quantitative information was extracted from the survey and is presented in a diagrammatic format in the presentation of findings (chapter 5).

4.5 The In-depth Interview Phase

Qualitative methods are suitable where there is a lack of research (Sizq &Taget, 2009) as was the case in this study; hence the individual interviews were used as a verbal qualitative approach to elicit further information. The predetermined questions ensured that the interviews flowed conversationally. Semi-structured/Open-ended questions were developed from what was needed to be known further concerning the emerging themes from the survey questionnaire phase. One of the purposes was to gain a better understanding of ambiguous responses and explore emerging themes further.

The interviews were an opportunity to study how people feel about the need to be culturally competent professionals (social opinion). Van Manen, 2016 asserts that everyday lived experience is an approach to research methodology. The participants were at liberty to explore the phenomena and render their opinions about cultural

competence and how it relates to designing, procuring, and delivering services in response to health needs. As the subject was quite emotive as are discussions about culture, ethnicity, and diversity, the Interviews were multipurpose as a conversation (Lincoln and Guba, 1985). Only 15 of the 20 interview transcripts were considered for use. The numbers were affected by the inaudible quality of taped interviews, attrition rate, quality of recording, timely returns, and location. It is difficult to discount possible bias in the sampling protocol for the interview phase which was based on choosing individuals based on background, knowledge, availability, and commissioning ranking.

At the in-depth interview phase, the interview schedule along with relevant research documentation (participation information sheet/invitation letter and consent forms) were sent to participants along with a choice of dates for interviews. These were scheduled to take place within 8 to 10 weeks of the collation and initial manual analysis of the questionnaire survey.

The interview schedule was based on extracted themes from the survey questionnaire data, these were reframed as clarification questions in addition to the reframing of some of the survey questions or short phrases offered as responses. This was done to obtain deeper responses for better clarity of the areas of interest. The in-depth interview questions were related to the purpose, definition, quality, quantity, measurement, and expectations of cultural competence in commissioning. This is how the emerging themes were explored further to gain a better understanding.

Interviews were scheduled to last between up to 50 minutes each and were conducted once per participant, in person (face to face), or via Skype. Interviews were recorded using a security coded digital recorder with consent from participants. Each participant was sent a copy of their transcript for comments, clarification, or corrections before transcripts were transcribed and prepared for thematic analysis using Atlas.ti.8.

4.6 Quality Assurance and Data Management

Research must engage in an intentional quality assurance process to minimise researcher subjectivity. Guba and Lincoln (1985) suggest quality assurance measures for both qualitative and quantitative research. In the case of quantitative versus qualitative research quality assurance measures would be validity versus credibility, generalisability versus transferability, reliability versus dependability, and objectivity versus confirmability respectively.

This mixed-method research study was achieved with rigour and trustworthiness by incorporating criteria mapped out by Cresswell and Plano, 2010.

4.7 Quantitative Quality Assurance

Content validity is defined by Polit & Beck (2004) as the extent to which an instrument has an appropriate sample of items for the construct being measured. Kumar (2010) further suggests that face validity is established when each of the research questions are designed to have a logical link to the objective. To ensure that this was the case in this study, content validity was improved by using the pilot study group to review the usability of the quantitative and qualitative data collection tools. They did this by informing the structure/content of the questions used in the survey questionnaire and cross-checking the content of the emerging themes. The pilot group consisted of mental health commissioning colleagues with various professional backgrounds.

4.7.2 Reliability

T**he** extent to which an instrument is consistent or stable over time is described by Bowling, 2009 as the reliability quality of an instrument. The survey questionnaire was tested by a pilot group who were exempted from the study as including them would have influenced how they would have responded by way of presenting their training needs or understanding of the phenomena Bryman (2012)

Polit and Beck (2006) argue that though an instrument may have good stability when measuring variables that change over time the reliability quality.

4.7.4 Trustworthiness

The trustworthiness of the qualitative phase of the study was based on Lincoln and Guba's (1985) criteria of credibility, dependability, confirmability, and transferability.

4.7.5 Credibility

The credibility quality is used to determine whether the interpretation of the participant views by the researcher's analysis 'fits' (Schwandt 2001), in other words, can the findings be said to be true. For this reason, the study used direct quotes from participants to develop the themes to enhance the credibility factor or quality. This being said, Lincoln and Guba (1985) argue that the state that the strongest measure of credibility is better achieved by 'member checks'. This means transcripts or final analysis is considered by participants to check that they agree with the findings. Interview transcripts were returned to participants as were the results from the final analysis. This might be best placed in chapter 3

4.7.6 Validity

Validity is the degree to which an instrument measures what it is supposed to measure (Cutter and Jordan 2012). The purpose of having the survey questionnaire tested by the pilot group was to further enhance the content and face validity quality (Terry and Cutter 2013). As mentioned earlier, the pilot study group reviewed the questionnaire and interview schedule. They checked useability, structure, language, and content. Minor revisions were made to include questions that relate to both commissioner and provider colleagues who participate in commissioning decisions.

The interview schedule was not piloted because some of the group were likely to be involved as participants in the interviews. This may weaken the construct validity of

the questionnaire however it does not apply to an interview schedule (Parahoo 2006).

4.7.7 Dependability

There is a strong link between dependability and reliability. Ensuring the 2 qualities are adhered to in a research project demands that research activity is documented. Documenting and crosschecking research activity can be done via an audit trail of the documentation of the data, methods, and the decisions about the research. As long as these can be laid open to external scrutiny (Finlay, 2002) the matter of dependability and reliability can be fulfilled. Several journals were kept along with notebooks of shorthand notes that were a record of project activity, ideas, and peculiarities of the project, impressions, and significant observations.

4.7.8 Confirmability

Qualitative data is usually vulnerable to the issue of subjective interpretation according to Cutter and Jordan (2012). This is because the mind of the researcher is involved; therefore, the extent to which the findings of this study are shaped by the respondents is significant. A confirmability audit can be used to influence the degree of neutrality of the research process, Lincoln and Guba 1985). The confirmability quality of this project was enhanced by having a person neutral to the study check transcripts, significant statements, and crosscheck theme development, and final analysis to check for consistency. The process ascertained that the qualitative study themes were derived from the interpretation of participants experiences recorded in the transcripts and that the themes could be meaningfully interpreted in the findings and translate to recommendations.

4.7.9Transferability

Concerning this study which pertains to dementia, which is a mental health condition, the question would be whether the findings can be transferred to the considerations of other mental health conditions? As far as qualitative research is concerned, the quality of transferability can be enhanced with the availability of a detailed account of how the research was conducted, to enable others to consider the transferability and credibility of the findings. The outcome confirms whether the same process can be repeated in similar research.

4.8 Delimitations

Research participants were limited to the spread of the CCG's where access was easier due to the advantage of work-based insider positionality. It is important to note that though the study was carried out while working across a few CCGs, therefore; colleagues are to be considered NHS research participants. The reader is asked to note that commissioners in other parts of England could have differing views from those obtained in this study.

A significant delimitation of this study is the research question itself as it sets boundaries and dictates the type of data to be collected. It takes a central, interactive, emergent, and evolving position, Onwuegbuzie, and Leach, 2006). This means that further on in the research process (analysis stage) the research question may undergo re-evaluation.

4.9 Limitations of the Study

This being a doctorate research project with data coded by one person and themes identified by the same person naturally confers limitations on the study. This is because no other perspectives or viewpoints other those of the researchers are offered following the interpretation of the data/findings. A further limitation relates to the use of a design perceived to be incompatible as argued by Tashakori and Teddlie

(2003), they say that the use of two opposed worldviews, ontologies and epistemologies confers a weakness on mixed methods research. A second limitation of the research is that the voice of vulnerable service users (older service users) are absent. This does mean that an understanding, definition and experience of cultural competence within services may appear to be one sided. To compensate for this fact the interpretation of findings, discussions and recommendations consider the contributions within this study to be those of participants who both work for the NHS and use the services of the NHS.

Other limitations in quantitative and qualitative studies regardless of the design of a study are usually related to threats to the status of validity. The use of quantitative and qualitative data collection methods was time-consuming in that the collection of data was achieved in 2 phases in one phase after the other set up. The qualitative phase was accomplished mostly by telephone interviews, which are impersonal, meaning that the non-observance of behaviour and body language could have limited the value of the participants' input. It is possible that the clarity of the discussion was or could be compromised, causing the interview recording not to be reflective of what was meant by the interviewee (validity). This issue was considered in addition to considering whether the limitations of the research data may have risked causing further bias in the findings. There was recognition of this from the beginning. For these reasons validity in this study was greatly enhanced by returning transcripts to participants to cross-check that contributions had been captured succinctly. Participants were also allowed to check/validate the analysis before the themes were refined. Once conclusions were drawn participants were invited to review the results to see if they fit with expectations and when they may not have fit consideration was given to measuring how far apart the discrepancies were and why (checking alternative explanations). Finally, given the study used a pilot group to test the useability of tools (survey questionnaire, interview agenda) at the beginning they were once again asked to review the findings for hidden bias.

4.9.1 Time Constraints

Considerable time was spent hosting work-lunch time sessions to prepare colleagues to be a part of the pilot group involved in designing the questionnaire for use with prospective participants. This was all part of preparative fieldwork in advance and essential to the purpose of gaining trust and rapport, which was important to the insider-researcher position. Though the described process was time-consuming, it was the only opportunity to build trust and gain possible buy-in with several new colleagues as few required more time to understand and decide their level of participation (Lobiondo-Wood and Haber, 1998). Further time constraints delayed the preparation of documents because of several amendments were made and along with difficulties in concluding the participant list and the time it took responding to various circumstances during the fieldwork (Moore and Savage, 2002). Time and geographical constraints caused the timeframe of the interview phase to be drawn out; especially when slots were missed however, time was made up by offering Skype calls.

In summary**,** the mixed-method study collected mixed data using a survey questionnaire that was designed by a pilot test group not involved in the actual survey phase. The data was collated on to excel spreadsheet for review purposes after which the emerging themes were extracted to inform an in-depth interview schedule. Only 43 of the 65 questionnaires were usable therefore a further 15participants were selected to be involved in the interviews.

The semi-structured interviews used open-ended questions to explore the views held of cultural competence related to commissioning in the NHS (definition and practice of cultural competence). The open-ended questions were designed in a manner that considered how participants could respond based on their knowledge and experience instead of the researchers' experience; this was important due to familiarity with the participants.

Chapter 5 is a narrative presentation of the findings along with diagrammatic presentations, tables, and figures.

Chapter 5

Presentation of Findings

5.0 Introduction

This chapter is the narrative of the validation of data activity, it is set out as a mixed presentation of the findings in line with the shift in the definition of mixed-method research in recent times. The definition of mixed methods as an approach has gone from being one that just utilises at least one quantitative method and one qualitative method to merit the definition. It is now an approach that is about mixing in all phases (Tashakkori and Teddlie, 1998). Mixing can occur from the philosophical stance to final inferences to the interpretation of results (Creswell, 2010). Cresswell and Plano describe a focus on mixing both quantitative and qualitative data in a single study for a better understanding of research problems. This focus suits this project due to the liberty that the new definition of mixed methods offers and the very complex design of the study which collected mixed data (quantitative and qualitative) using a mixed survey questionnaire, in-depth interviews, and the quantitisation of (qualitative) data to explain hidden patterns.

An initial review of the survey questionnaire data was first completed to extract the quantitative data of interest to be considered and analysed, this was followed by the extraction of initial emerging themes that were further explored via the in-depth interview phase. Emerging themes were reframed as questions in the in-depth to further examine the understanding, experience, perceptions, and definitions of the practice of cultural competence in commissioning.

The significant inquiry focus of the survey and interviews was the notion of the NHS as a culturally competent organisation, professional practice, and establishing the perceptions of commissioning as culturally competent or otherwise. To do this,

the definitions participants ascribe to cultural competence as a concept, its drivers, challenges, and suggestions to address them were explored. Furthermore, an understanding as to why and how participants might describe the NHS as culturally competent or otherwise was also explored. This is because it was important to ascertain why any perception might be prevalent over another. It was also quite important to review the related responses to consider the possibility of an outright conclusion that the NHS is a culturally competent organisation. In addition to this, there was an exploration of the capacity participants might have to influence cultural competence. Participants were also asked to choose between a culturally competent commissioning framework and a stand-alone training manual as a means of ensuring that all professionals practice cultural competence consistently across the NHS. Possible criteria for the development of a culturally competent commissioning framework was popularly suggested as having more merit than a training manual. This tied in with the views shared by participants of the perception of training, or the lack thereof as a challenge to cultural competence in the NHS. Participants were asked to consider whether they might need to access training to meet gaps in knowledge and understanding (culturally competent skills). Almost all participants suggested that training was one of the solutions to addressing cultural incompetence.

Another area of importance was the consideration/exploration of the ability/capacity of participants to influence cultural competence. The purpose of this line of questioning was to obtain an understanding of the nature of the underlying factors that influence cultural competence and shape the beliefs of participants one way or another. A further consideration was an understanding of whether age, gender, role, ethnicity, or the number of years working in a commissioner or provider role had a bearing on practice /understandings of culturally competent commissioning.

5.1 Socio-Demographic Characteristics of the Respondents

Participants were aged between 20 and 65 and represented a wide range of ethnicities and health/clinical backgrounds. At the local level (CCG), the NHS is represented by teams of doctors and other specialists such as commissioners. Within the narrative, participants are referred by a pseudonym, role, and age, to assist the reader to appreciate the perspectives shared differently to that of the researcher.

All participants were commissioners or providers, the decision to include provider participants was influenced by the pilot group who rightly noted that as providers they play a crucial role in the commissioning process. This was particularly relevant because it is not uncommon for organisations/individuals to execute the commissioner and provider role. This is the case with GPs/GP practices that deliver general medical services and commission other services with their practices. This is the case when a GP as a provider contracts with other specialists to deliver services within their practice, such as pharmacy or counselling services within a GP practice. The NHS itself is both a commissioner and provider organisation.

5.2 The Research Participants

Participants participated in the study based on their role, location, availability, and background to ensure a good representation. Table 5.1 is the profile table describing the total number of participants (43 survey questionnaire participants + 15 interviewees =58).

It is important to note that the commissioner and provider role is sometimes interchangeable depending on the organisation (NHS). Health and social care organisations often have professionals employed to operate in the dual role of both the commissioner and provider.

The role of a commissioner is the same regardless of the type of service to be commissioned, it is the expert knowledge needed in the service area to be commissioned that sets each commissioner apart. Commissioners design service specifications and may not always have the related clinical knowledge but will work alongside clinicians who do. They are also involved in completing the needs assessment, procurement, performance management, and finance-related decisions including service developments when needed.

The quantitative questions were used to obtain socio-demographic data to ascertain how and why responses might differ when exploring the levels of understanding, practice, and ability to influence cultural competence amongst participants. An interesting consideration was the idea that those from BME backgrounds might be more inclined to understand, practice, influence, and believe in the importance of cultural competence. A further consideration was the assumption that those from a non-BME background might be more inclined to judge the NHS as a culturally competent organisation based on how it meets their needs alone.

The reader is advised to note that the contributions shared by participants would have been rendered on more than the basis of their roles and may also include their perceptions as consumers of NHS services.

Table 5.1: Quantitative Data - Socio-Demographic Characteristics of Respondents

Age	N=43	%
<25	01	2.3
25 – 35	19	44.2
36 - 45	09	20.9
46 – 65	10	23.3
No Response	04	9.3
Gender		
Male	11	25.6
Female	32	74.4
Ethnicity		
White British	16	37.2
Black	02	4.7
Black African	03	7.0
European	04	9.3
Afro-Caribbean	02	4.7
Northern Irish	02	4.7
British	06	14.0
Black British	03	7.0
Asian-Indian	01	2.3
Asian	01	2.3
Canadian	01	2.3
British/Asian Indian	01	2.3
No Response	01	2.3
Primary Role		
Commissioning	31	72.1
Service Provider	12	27.9
Years of Experience		
Less than 1 year	05	11.6
1 – 5 years	26	60.5
6 – 10 years	07	16.3
11 years and above	01	2.3
No Response	04	9.3

5.1b

Designation		
Team Manager	02	4.7
Consultant+	02	4.7
Manager Consultant	01	2.3
Chief Executive	01	2.3
Provider	05	11.6
Commissioner	11	25.6
Strategy Manager	01	2.3
Engagement Manager	01	2.3
Project Support Officer	01	2.3
Project manager	01	2.3
Administrator*	01	2.3
Director of Commissioning and Enforcement	01	2.3
Personal Assistant*	01	2.3
DSW and Social Worker	01	2.3
Dementia Support Manager	02	4.7
Manager Operations	01	2.3
Commissioning Manager	01	2.3
Group Coordinator	01	2.3
Dementia Advisor	02	4.7
Information Worker	01	2.3
Dementia Manager	02	4.7
Governance lead	01	2.3
Head of Quality	01	2.3
CAMHS PM	01	2.3
Head of Placements#	01	2.3
Placements Manager#	01	2.3
Contracts Manager	01	2.3
Safeguarding Nurse	01	2.3
Safeguarding Manager	01	2.3
GP	01	2.3
Nurse	01	2.3
Urgent Care Commissioner	01	2.3
MH Project Manager	01	2.3
MH Commissioner	01	2.3

Table 5.2: Qualitative Data –
Socio-Demographics of in-depth-interview Respondents

Commissioning Role	Ethnicity	Years of Experience	Gender
MH COMMISSIONER	White British	**6**	**M**
SAFEGUARDING LEAD	White British	5	**F**
MH PROJECT MANAGER	Chinese	**3**	**M**
URGENT CARE MANAGER	Chinese	**7**	**F**
NURSE	Caribbean		**F**
COMMISSIONER	African	**10**	
COMMISSIONER	White British		**F**
PERSONAL HEALTH BUDGET MANAGER	African	**8**	**F**
CONTINUING HEALTHCARE MANAGER	White British	**5**	**F**
CONTRACT MANAGER	Afro Caribbean	**3**	**M**
GENERAL PRACTITIONER	Asian	**10**	**M**
PROJECT MANAGER	Chinese	**6**	**M**
COMMISSIONER	African	**5**	**F**
URGENT CARE NURSE	Irish White	**10**	**F**
COMMISSIONER	White British	**4**	**F**

5.3 Themes

The construction of themes by thematic analysis speaks to the understanding, importance, experience, and challenges of cultural competence. Braun and Clark (2006) contend that thematic analysis exists to provide a flexible and useful tool that

can provide detailed accounts of complex data. Theme construction was via Atlas.ti.8 software for both sets of data.

Data from the survey questionnaire was split into 2, quantitative (demographic data) and qualitative data. Relevant qualitative data was transformed into quantitative data and merged (mixed) with the original quantitative. Analysis of both sets of data was achieved separately followed by a comparison of the outcome which revealed similar themes and sub-themes across both sets. This was not unusual as the questions were similar in inquiry, therefore both sets of data were collated (mixed) together to form a new data set. The final data set was reviewed, refined, and is presented diagrammatically to show any relevant relationships. The data is further interpreted and narrated in the discussion of findings chapter further on. So far, the data from this study will have been mixed at the level collection, analysis, interpretation, and discussion.

Following the thematic analysis of the 43 survey questionnaires and 15 interview transcripts, 15 main themes were developed to represent the experiences and perceptions of participants. The narrative of this chapter is informed by the direct quotes of participants and also some of the main quotes (codes) from participants. In the diagrammatic representation of the themes/sub-themes. Doing so enables the reader to appreciate the extent of the wealth of contributions from participants and how the themes and subthemes are linked together.

List of Themes

- Description of culturally competent services
- The NHS is a culturally competent organisation
- The NHS is not a culturally competent organisation
- The uncertainty of the NHS as a culturally competent organisation
- Importance of cultural competence
- The significance of cultural competence to commissioning
- The components of cultural competence
- Definitions of cultural competence
- Challenges of culturally competent commissioning
- Addressing the challenges of culturally competent commissioning
- Influencing cultural competence in commissioning
- Opportunities for cultural competence in commissioning
- Developing a culturally competent commissioning framework
- Training as a challenge and tool for developing cultural competence
- Leadership

Theme 1: Descriptions of Culturally Competent Services

Study participants were asked to give descriptions of services that they considered to be culturally competent. Table 5.3 shows the similar themes that ran through the descriptions shared. Most descriptions show that to a large extent, most participants suggested that a culturally competent service is one that embraces the beliefs and backgrounds of service users (23.91%). The table was produced by first quantitising relevant aspects of the qualitative data to produce meaningful quantitative data.

Table 5.3: **Descriptions of Culturally Competent Services**

Sub-themes	**Number of Respondents across the survey and interview**	**% of Respondents**
CC HR services & Recruitment	3	6.52%
Capacity building	4	8.70%
Inclusivity	4	8.70%
Needs and preferences are met	4	8.70%
Person-centred approach	4	8.70%
Resources to meet needs	4	8.70%
Service usage of CC tools	4	8.70%
Engagement and mobilisation	8	17.39%
Beliefs and backgrounds respected	11	23.91%
Total	**46**	100.00%

From the information in table 5.3, it is possible to suggest that the beliefs of participants are one of the determining factors of cultural competence. Given participants mostly mentioned that services that embrace beliefs and backgrounds are qualities that contribute to the cultural competence of a service. It might also be a significant quality that contributes to service user satisfaction. Furthermore, it may enable services to engage and mobilize service users (17.39%) on a level that might enhance service user experience. The qualitative data provided gives further credence to the views of participants concerning culturally competent services. The descriptions offered in the in-depth interviews show there to be differing levels of expectations/understandings of the concept within the professional knowledge base. This would also mean that the descriptions/suggestions/opinions of culturally competent services commissioned by participants or others are based on their personal or professional aspirations for culturally competent services. A point of interest would be to consider whether the professional and personal views of participants align.

Research participants were uniquely placed to respond to the question of which services they would consider to be culturally competent especially since they are responsible for the performance management of these services (and may use these services). Participants were asked to share their views on how their roles impact their ability to be culturally competent, this would relate to their ability to influence or address and of the issues identified/suggested as challenges.

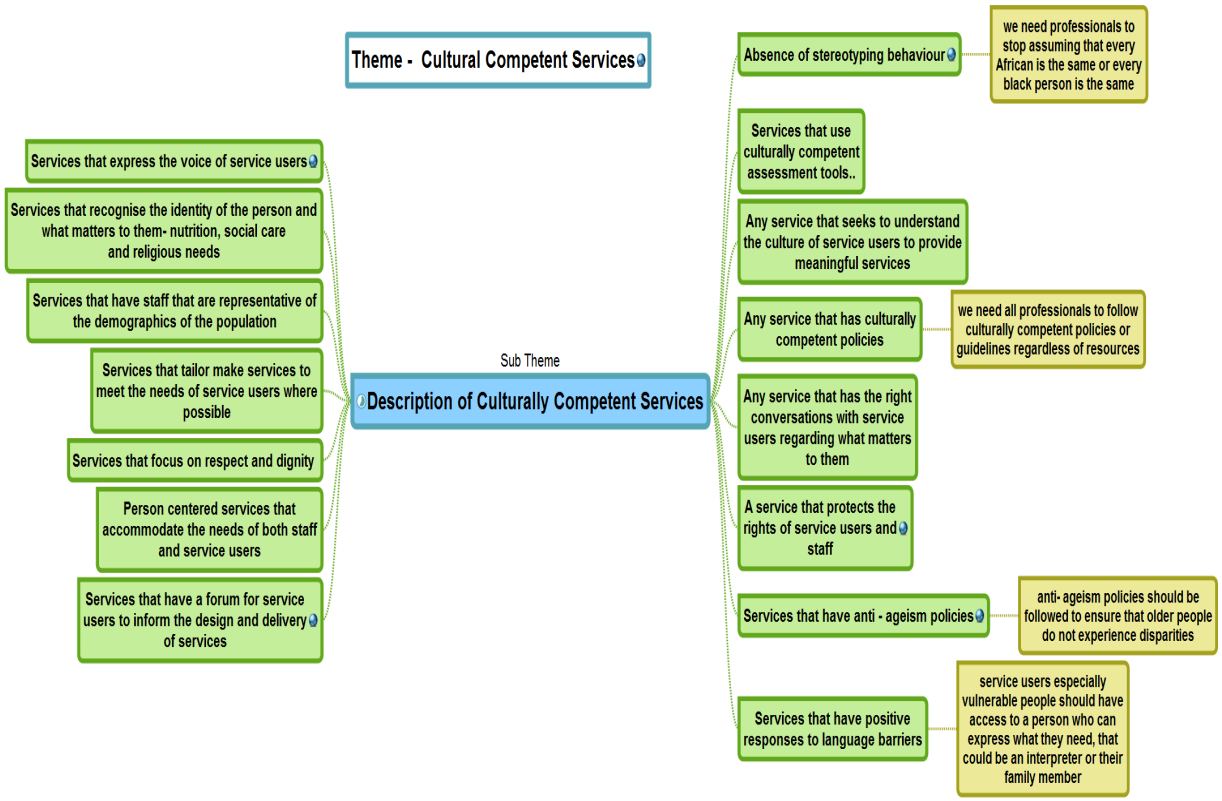
When participants shared their descriptions of culturally competent services, the contributions showed that BME's tended to favour the need for culturally competent commissioning (survey questionnaire phase) and by extension culturally competent service provision. That being said, when considering the importance of culturally competent services there did not appear to be much of a difference in the perceptions of non-BME participants in comparison to BME participants. This is an interesting observation discussed further on (chapter 6). This is a significant observation if it is important for all professionals to value cultural competence equally.

The description of culturally competent services should not be confused with the definition of cultural competence though they seem interchangeable. Participants were required to describe a service that is culturally competent so that their views on the components of cultural competence could be considered. Further asking participants to share their definitions of cultural competence was to test the validity of assertions in the literature concerning the lack of a consensus definition for cultural competence. A review of the definitions of cultural competence offered by participants who are NHS professionals and consumers of NHS services, suggests evidence of differing perspectives. It is suggested that the definitions were unique reflections of beliefs, religion, race, age, gender, sexuality, professional role, education, and possibly the length of employment.

Figure 5.1 represents offers a diagrammatic representation of theme 1, which is made up of the different descriptions shared by participants. The quotations in

green represent responses from the questionnaire while the ones in amber are the responses from the in-depth interview phase.

Theme 1



Quotes from interviews

Quotes from survey questionnaire

Figure 5.1 Descriptions of Culturally Competent Services by Participants

Theme 2: Defining Cultural Competence in Commissioning

The purpose of the data collected was to test relevant assertions from the literature. One assertion was that overall, the complexity of cultural competence relates to a lack of consensus as to what it is, what it is not, and how it can be measured. In commissioning, an additional complexity may relate to the absence of a working definition within commissioning, therefore, this study asserts that it is more than a process with a set of identifiable skills. Perhaps it is a belief system, an attitude, and a willingness to create something that means everything to those who need the endpoint or product of what it has been applied to. This study also shows that what must be reflected in its definition and practice, is a desired outcome on the part of the persons who need it. This study seeks to influence how future literature might include cultural competence as it pertains to commissioning health services over and above how it pertains to the delivery of services. For these reasons and perhaps more, it was important to ask participants to define their understanding of cultural competence as it relates to the services they use and commission.

Obtaining a consensus definition is the next level up from ascertaining the specific components and descriptions of culturally competent services. This is particularly important when a service is to be newly designed or reconfigured if it already exists and has and running for a while. As expected, some of the definitions offered by provider staff were about the provision of services, perhaps because providers offer services based on the specifications drawn up by commissioners. Such services are delivered in line with prescribed key performance indicators and are performance managed likewise. For this reason, it is possible to suggest that the weakest link is the absence of a requirement by the commissioner to measure cultural competence as a key performance indicator. It needs to be an explicit quality defined by agreed parameters reported to and monitored by commissioners. To determine if participants agreed with this notion, during the in-depth interview phase participants were asked whether cultural competence should be considered a hallmark of quality.

This line of inquiry was explored to understand whether participants consider cultural competence to be a quality indicator and how they may measure and monitor it.

The fifteen definitions offered in the in-depth interview phase were similar, this may suggest that culturally competent services reflect the values of service users and that these values align regardless of background. The definitions were also evidence that participants have a good grasp of cultural competence as it relates to person-centred care. Definitions implied that services should reflect more than the values of service users but should also be reflective of the significance of equity and equality. The definitions offered are based on experiential knowledge and personal consumption of health services, meaning that the definitions show subtle nuances of cultural and professional backgrounds and, therefore, contain a quality that influences practice. Furthermore, it could be inferred that any evidence of limited understandings by participants may relate to identified challenges to culturally competent commissioning.

With participants expressing their expectations of what cultural competence is, it becomes possible to gain an understanding of how individuals influence or practice cultural competence. This was the purpose of asking participants to describe the components and definitions of cultural competence separately. It is important to note that some of the definitions are aspirational, and not necessarily what participants perceive to be the norm. On a positive note, definitions included considerations for culture and diversity, the assertion here, is that commissioning policies, training, strategies, and specifications should consider cultural diversity.

The focus on providers was about their role in assessing the needs of service users and then formulating suitable interventions or models of care. This would mean that in terms of the therapy or care assessed as needed, the assessment should always move from the general to the specific to ensure service users receive a care plan that is of value to them. The many references to culturally competent services by participants include:

"…*any service that seeks to understand the culture of its service users in order to provide meaningful services…"* **Jenny- White British -Consultant Provider - 8 years' experience.**

Another provider respondent expressed;

"…Services that ensure access to interpreters or multilingual staff members and include cultural needs in care plans e.g. religion or nutritional preferences. **Abi- White European- Commissioner- 6 years' experience**

Yet another participant stated:

"Services that meet individual needs socially as well as therapeutically. It includes aspects like food, music, and literature. Allowing individuals especially those living in health or social care residential settings to wear their own cultural clothing and eat what they like rather than what is available". **Sandy – White British- Provider - 1-year experience**

These statements amount to evidence that the research participants though professionals may also be viewed as consumers of NHS services who seek to or prefer to be treated as culturally identifying individuals with similar values, thoughts, and desires that match those of the general public. These are the same factors that shape the perspectives of disease and treatment preferences. Participants alluded to wanting their individual needs, such as nutrition, clothing, religion, disability considered just as the general public would. Some participants highlighted a wish to eliminate discrimination (health disparities) from NHS services using cultural competence as a tool.

Figure 5.2 presents the theme defining cultural competence in commissioning. It is made up of the 15 definitions offered by participants. These definitions may be aspirational or precise in terms of the perceptions of the participants.

Theme 2: The Definitions of Cultural Competence

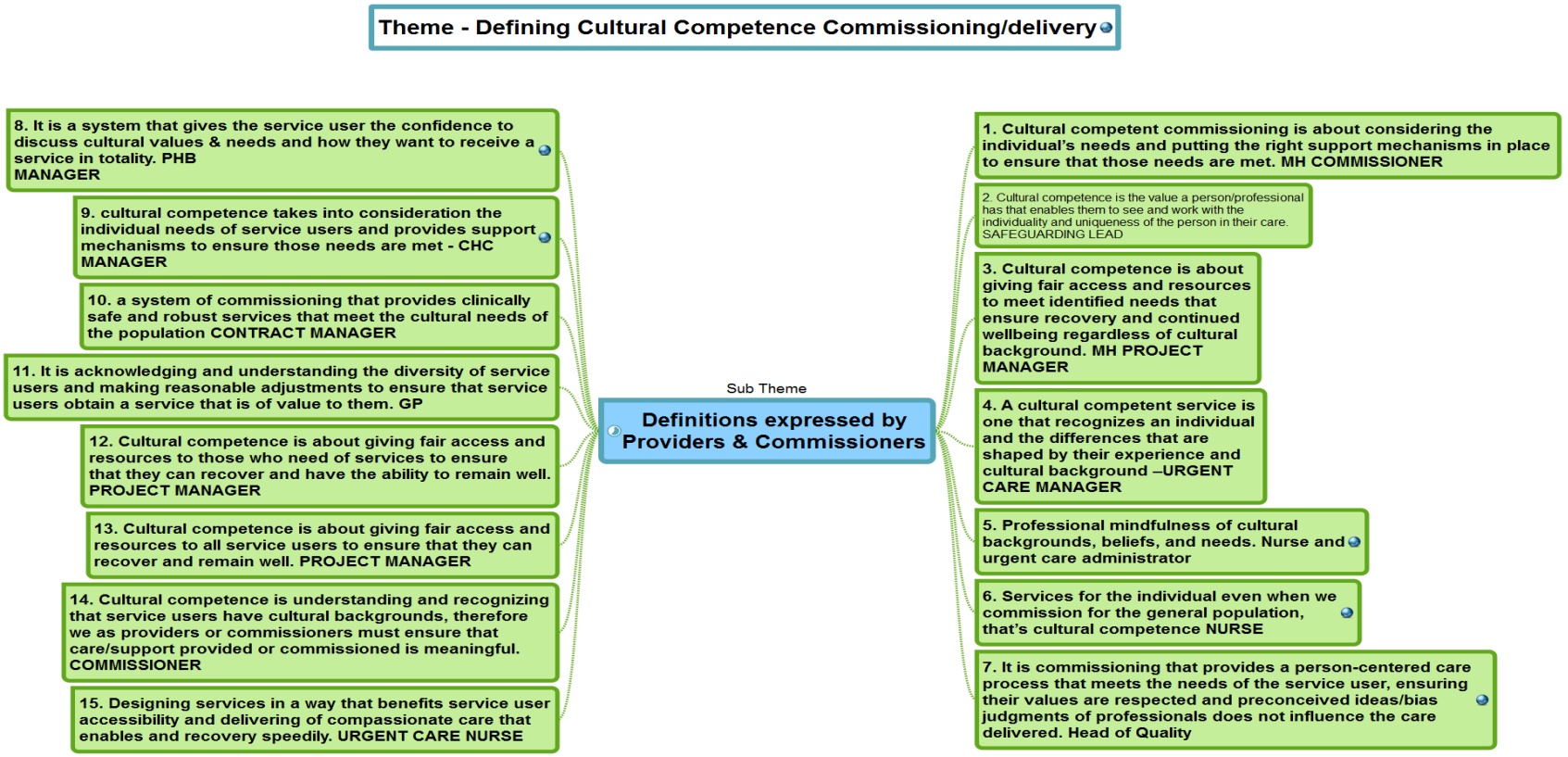


Figure 5.2: **Defining Cultural Competence in Commissioning and Service Delivery**

Theme 3: Components of Cultural Competence

Exploring the components of cultural competence was about unpacking the understanding that participants have in comparison to the generally agreed constructs within research (awareness, sensitivity, knowledge, and competence). Furthermore, it was about exploring what participants understood the essential skills of cultural competence to be and which terms (humility, respect, incompetence, and encounters) should be used to express them. This speaks to knowing what understandings exist and how such understandings contribute to the challenges and opportunities of culturally competent commissioning. Furthermore, it also speaks to how the understanding of cultural competence drives the delivery of responsibilities, especially concerning the acquisition of skills (CPD, learning, and workforce development) required to reflect cultural competence

There was an assumption that the study's' explorations at this level would lead participants to share an understanding of their role in the challenges identified. The same can be said of the solutions or suggestions shared especially concerning the ability of participants to influence cultural competence. These factors may be linked to enhancing the practice of cultural competence within the NHS.

Responses seemed to suggest a significant consensus of NHS as an organisation that does not have a status of cultural competence. Participants were mindful of pockets of good practice as many instances were mentioned. Figure 5.3 shows the components described in addition to the significant comment that cultural competence should be woven into the fabric of the NHS services, stating;

> *"...The awareness of cultural issues within commissioning is crucial so that all groups receive person-centred services. This could mean that services are inclusive as opposed to the provision of services to a population where a significant number of service users are targeted or offered a non-specific service for their specific grouping, cultural needs should be included in more general services or service users*

should be referred to culturally specific services..." **Fay – White British -Provider - 4years experience**

The representations included in the diagram show that participants are clear on the role of service users in the description of culturally competent services; by extension, they also infer that cultural competence is not possible without the voice of the service user. It is crucial to mention that there can be no cultural competence without culture (cultural considerations). The mention of respect for the professional may also imply that cultural competence is a partnership between the service user and professional.

Three (sensitivity, awareness, and knowledge) of the four most commonly accepted components of cultural competence were mentioned in the definitions. This may denote that participants have an appreciation for what the ideal of cultural competence is. The 4th component is competence however an alternative term would be proficiency (cultural proficiency).

Cultural competence covers the considerations of cultural origins (cultural knowledge) and the translation of this knowledge to practice. This can be taken to mean that there is an expectation that professionals must consider the cultural diversity of populations when designing policies, services, strategies, and staff training. This is important given the role the prevalence of disease plays in the commissioning of services; prevalence is related to population demographics. Participants stated;

"…any service that seeks to understand the culture of its service users to provide meaningful services…" **Sandy – White British- Provider - 1-year experience**

There were further declarations;

"…services that ensure access to interpreters or multilingual staff members. Possibly to include their culture in care plans e.g. religion or nutritional

preference. Respected as an individual. Not reduced to a cultural stereotype…" **Agnes- White European- Provider- 3 years' experience**

The availability of multilingual staff within the NHS speaks to its status as an organisation that is fit-for-purpose on some level. It is argued that the employees of the NHS are its most valuable asset. This means that the culture of the NHS (work ethic) must be changed if aspects of its output (service user experience) are to be improved. Sheaff et al, 2002 argue that it is commonly claimed that a fundamental prerequisite for improving the NHS relies on changing its culture. Their study concluded that the culture of primary care practice is an important component of health system reform and quality improvement (Sheaff et al, 2002). This is a claim that does not oppose the significance of culturally competent commissioning and its significance to healthcare improvement.

"...any care or service where an old person lives should allow and cater to cultural aspects of nutrition, food, music, literature because it enhances wellbeing…" **Kerry-White-New Zealand-Head of Placements-Commissioner- 5 years' experience**

The above statement might be evidence that participants seek to or prefer to be treated as cultural individuals who have a history, likes, dislikes, values, and desires. These notions may shape the cultural perspectives of disease and preference for treatment. Some participants highlighted a wish to eliminate discrimination from NHS services and suggested how this may be achieved;

"...*even if staff do not understand a particular culture, they should be of a disposition to find out or ask, the goal should be to make service users feel valued by including them in decisions about their care, staff need to understand this…"* ***Julie- White British-Information Worker- 2 month's experience***

The arguments were for patients to be treated as individuals which could suggest that participants understand and believe in the importance of being patient-focused as suggested;

> "…tailoring care (person-centeredness) to cultural needs. Services that are dynamic and reactive to assessed needs..." **Neeta- Asian Indian- Operations Manager –Provider -3 years' experience**

Also offered;

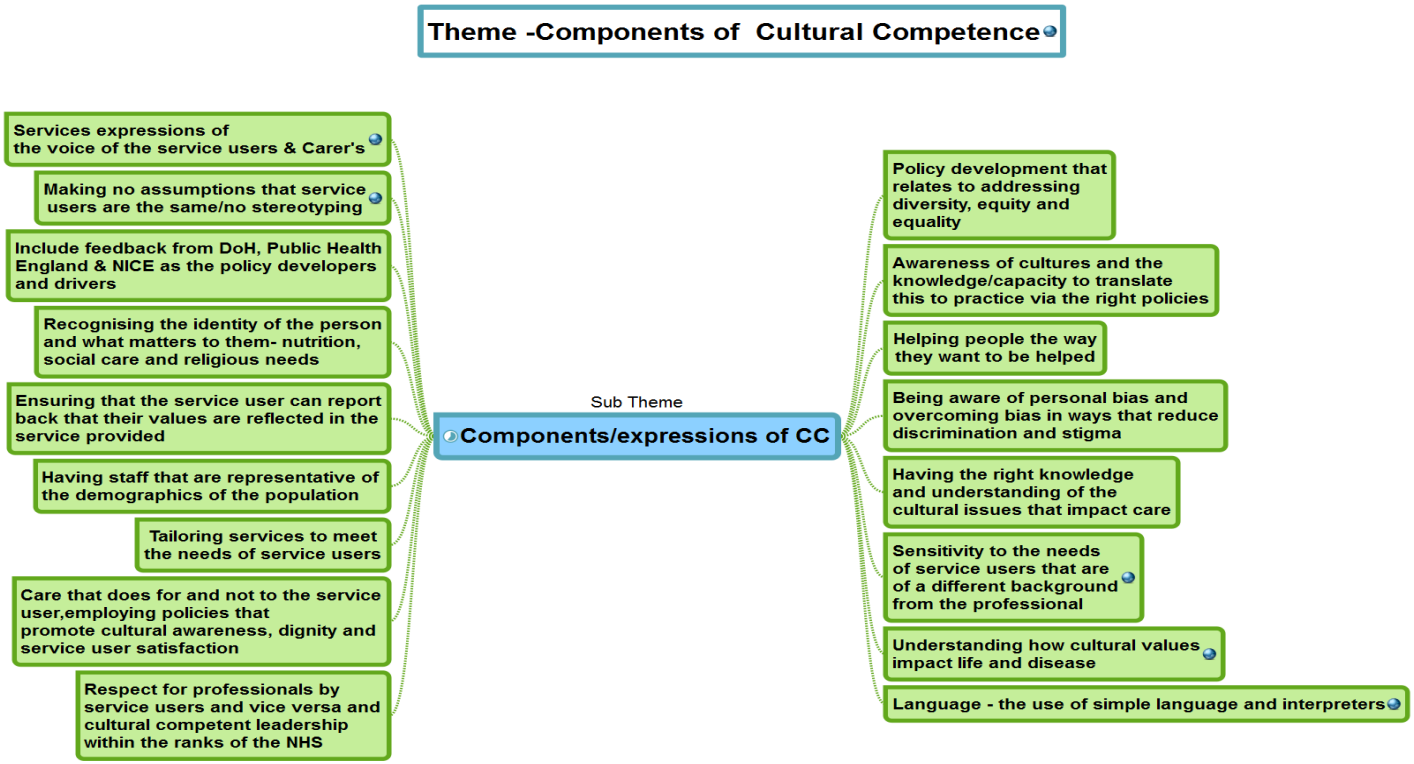
> "...P*erson-centred care services, services where people are treated as individuals, cannot use a one- size fits all approach…"* **Zainab –British Asian –Commissioner - Governance Lead - <1years' experience**

However, another participant added two important factors, respect, and dignity;

> *"...Treat individuals using a person-centred approach. Works better overall. Knowing people's beliefs and backgrounds can only help to provide a more suitable service for them..."*-**Bob-White British-** Social Worker –**Provider -4 years' experience**).

The diagram below (figure 5.3) reflects contributions by participants. In general, the suggested components of cultural competence demand that those who commission or deliver services set aside all bias when delivering services. This is a task that calls for appropriate knowledge, awareness, and sensitivities to the backgrounds of service users. This further assists to promote engagement, compliance with therapy, and better outcomes. A common thread runs through participant contributions, it is that of respect or dignity all round when communicating with service users.

Theme 3: Components of Cultural Competence



Quotes from interviews

Figure 5.3: Components of Cultural Competence

Theme 4: Cultural Competence in the NHS

Table 5.4 and 5.5 showcase the descriptive analysis of the responses given to survey question 1. The question informed the theme named ‘cultural competence in the NHS’, it is represented by 3 subthemes that are presented as (1) ‘uncertainty of the NHS as a culturally competent organization’ (2) ‘the NHS is a culturally competent organisation’ and (3) ‘the NHS is not a culturally competent organization’**.** The sub-themes are also considered as stand-alone themes to be discussed further in the discussion chapter. Participants were also asked to explain any reasons for their responses to give context to their perceptions (SQ2).

46% of the participation sample said the NHS was not a culturally competent organization against 23% of participants who believe the National Health Service to be a culturally competent commissioning organization.

Table 5.4 Cultural Competence in the NHS

Responses	N=43	%
Mostly	1	2.3
Not always	2	4.7
Not sure	2	4.7
To a degree	3	7.0
Don’t know	5	11.6
Yes	10	23.3
No	20	46.5

It was important to understand the underlying reasons for participant responses. Reasons were disparate, 21.28% considered the NHS to be a one-size-fits-all organisation. Perhaps the reason for this perception is linked to its historical foundation which is steeped in the discourse of the mono-cultural population of 1948. The reasons given for the various opinions of the status of the NHS are defined in table 5.5

Table 5.5: Reasons for Cultural Competence Perceptions of NHS

Individual Perceptions	Number of Respondents	Percentage
Limited resources	2	4.26
Diversity is not embraced	2	4.26
Hard to measure	2	4.26
Discrimination exists	3	6.38
Understanding levels are low	3	6.38
All needs not accommodated	4	8.50
Dev understanding levels	5	10.64
CC not reckoned with	8	17.02
Evidence of random practices	8	17.02
One size fits all health system	10	21.28
TOTAL	**47**	**100.00**

Evidence from the qualitative data revealed three divergent opinions that align well with the opinions of the quantitative respondents. These opinions include (i) that the NHS is culturally competent, (ii) NHS is not culturally competent, and (iii) uncertainty of the culturally competent status of NHS.

The questions participants responded to were related to their perceptions of the NHS as a culturally competent organisation and their reasons. The responses offered constitute the 3 sub-themes developed. The themes offer insight into the levels of practice, gaps in knowledge, and the underlying influence participants have on cultural competence in commissioning. It was important to consider possible bias that might shape professional practice or affect the status of the largest employer in Europe as a culturally competent organisation.

The themes also reflect the participants' assessment of the perceptions and practices of staff other than themselves. This reflects the reputation of the NHS as a culturally competent organisation and is in turn related to the offered opinions based on experience, observations, and interactions (provider, commissioner, and NHS service user). Participants expressed affirmations such as;

> "*There is awareness in the NHS. e.g. Understanding cultural trends amongst service users from different cultures and the culture of accessing healthcare...*" **Chris-White British- Consultant – Commissioner- 8 years' experience**

This study does not indicate whether those who state that the NHS is culturally competent are apt to say so based on their ethnicity. Another comment offered was;

> *"I think the NHS is culturally competent…"* **Jenny- White British – Consultant – Commissioner -8 years' experience**

And;

> *"…staff practice with substantial knowledge of various cultures and customs which they use when they deliver their duties…"* **Mary-White British –Team Manager –Provider -3 years' experience**

On a positive note another participant noted;

> *"...cultural competence is very much individualised, and experiences will very much depend on the outlook and training of the NHS professionals you come in contact with…"* **Andy- White Irish – Dementia Adviser- Provider 3.5 years' experience**

Describing the NHS as culturally competent could be based on the activities that commissioners are involved in during, before, and after the commissioning process. Commissioners may also base opinions on their observations as service users. Once a service has been procured/set up, commissioners are responsible for its performance management and contract monitoring as part of the commissioning cycle. In terms of its process, it begins with a set of commissioning intentions based on what is needed, guidelines/policies, and a budget. Other activities include a needs assessment and stakeholder engagement from the start of the process. These processes were referred to by participants and might have contributed to their perceptions of the NHS as a culturally competent organisation. Participants also

mentioned the recruitment of a diverse workforce as having an influence on their expectations of the NHS as a culturally competent organisation. This opinion could have been offered due to the presence of BME employees within the NHS. It is also an opinion that may be based on the role the NHS plays in serving a diverse population, the use of interpreters, and health information in various languages. Some participants may have based their opinion of the NHS as culturally competent on a simple expectation that it should be based on its role. Participants might also assume this stance based on how well the NHS works for them and not witnessing any cultural incompetence. This led to the development of a 4th theme defined as cultural competence in the NHS, it is made up of 3 subthemes.

1 The NHS is culturally competence

2 The NHS is not culturally competent

3 Uncertainty of the NHS as a culturally competent organisation

The theme and subthemes are represented diagrammatically below starting with figure 5.4.

Theme 4: Cultural Competence in the NHS

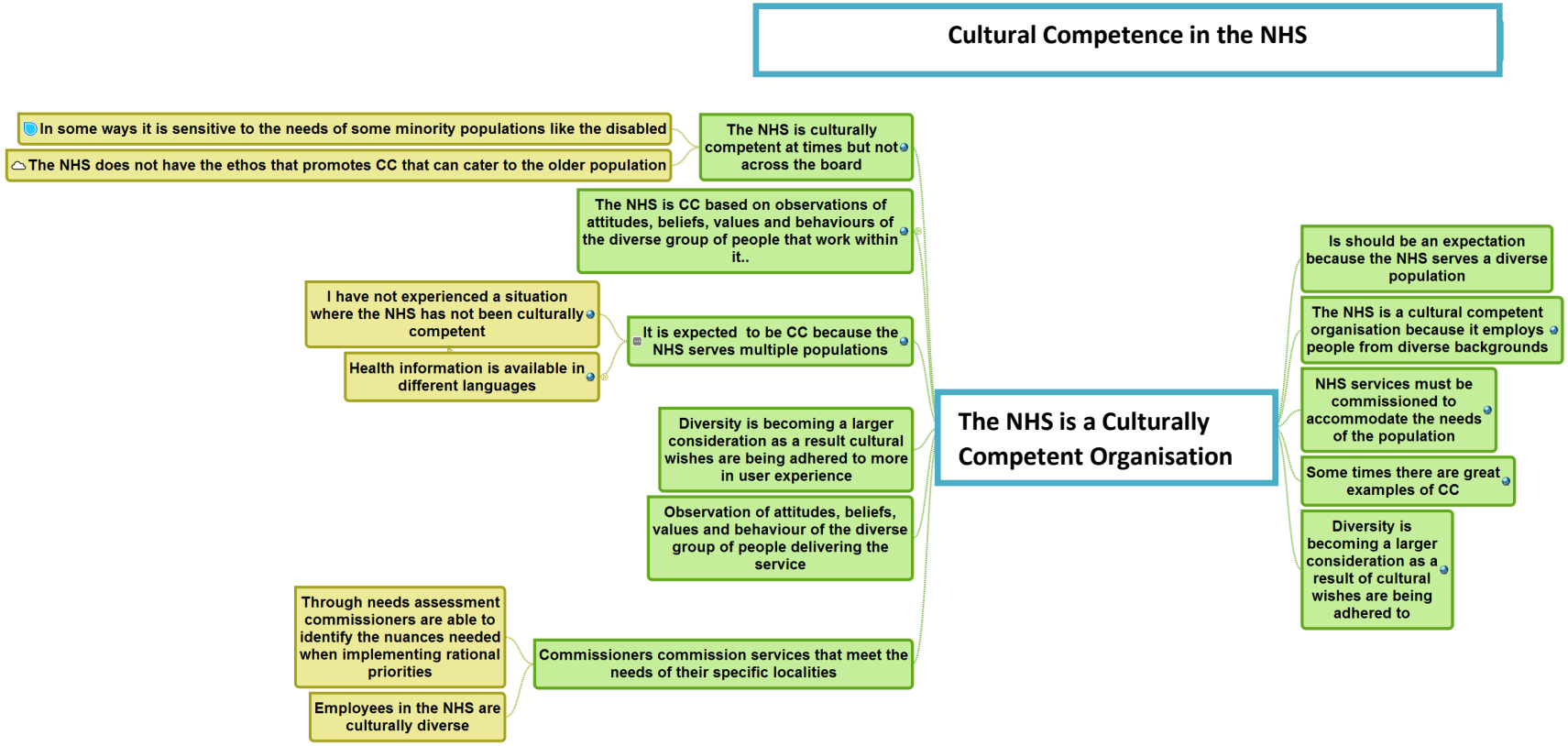


Fig 5.4 The NHS is a Culturally Competent Organisation

Stating that the NHS is culturally competent when evidence may be to the contrary may simply indicate an aspiration or an expectation that it should be or is working towards being so. Marshall et al, 2002, in their study of the cultural changes needed to implement clinical governance in primary care note that senior managers regard culture and cultural change as fundamental.

Theme 5: The NHS Is Not A Culturally Competent Organisation

The NHS is not a Culturally Competent organisation was a second sub-theme (of cultural competence in the NHS). Some comments from participants highlight negative perceptions about the culturally competent skills of commissioners or providers and by extension the NHS.

> *"Lack of awareness means the NHS is not culturally competent…"*
> **Pat-White British –Dementia Support Worker- Provider -4years' experience**

Significant words of another participant were;

> *"There are great examples (of cultural competence) but it is definitely not yet the custom or practice in the NHS neither is there any significant attempt at making policies culturally competent…"* **Gwen-Afro Caribbean** – **Commissioner – 4years' experience**

Other reasons advanced to justify disagreeing that the NHS is culturally competent were related to generalized care politics that appear not to consider the individual characteristics (cultural values) of patients:

> *"Commissioners focus more on the general population rather than individuals…"* **Rob - White British- Strategy Manager- Commissioner – 1-year experience**

Another participant contended that;

> *"Commissioning is about block contracts that don't consider culture-specific issues such as disability, nutrition or religion …"* **Anne - White British- Dementia Advisor –Provider-6months' experience**

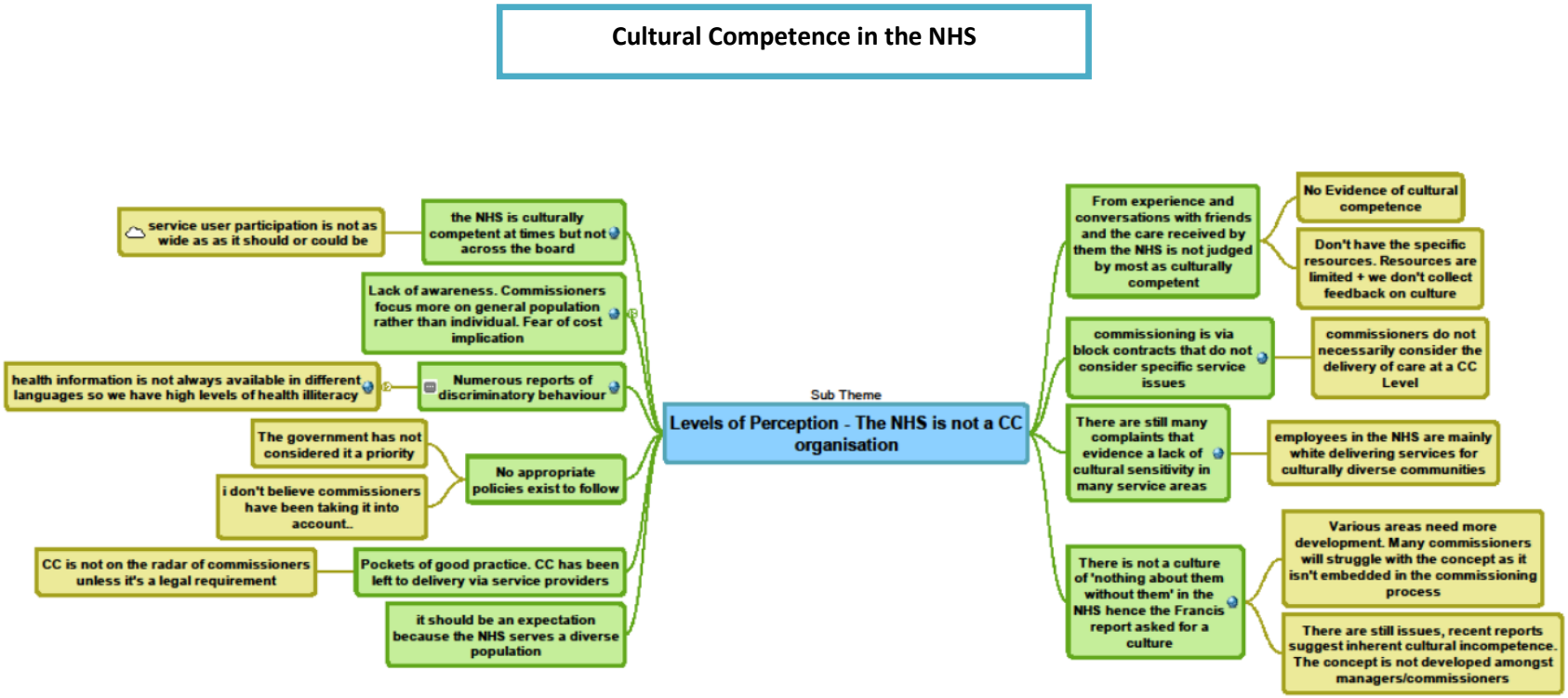
Likewise, participants highlight discriminatory behaviour, this varies from assumptions that what suits one group would suit another (the one-size-fits-all approach). At the extreme of the spectrum of issues, some comments spoke to how badly some groups are treated based on their age and or socioeconomic status. Mentions of the Francis report were made a few times;

> *"...Numerous reports of discriminatory behaviour mean the NHS is not culturally competent…even the Francis report had to specifically mention a requirement for support and compassionate caring and committed care"* **Tracey –White European- Commissioner- 3 years' experience**.

These negative perceptions were evident in other shared views and serve to possibly maintain the dichotomy or division in participants' perceptions. Further on in this work, the narrative presents possible underlying reasons (beliefs, experiences, and skill set) for the views. The narrative unpicks the perceptions of participants who are both professionals and service users. Below is the third sub-theme (figure 5.5) along with some of the main associated quotes from research participants. Cultural competence in healthcare demands a high level of stakeholder engagement, culturally competent policies, health promotion literature in relevant languages, and cultural competence in leadership. If these qualities are not visible across the board it is argued that pockets of good practice amongst a

few professionals can not amount to the status of the NHS as a culturally competent organisation. This is the suggested perception of a significant number of participants based on the views in the diagram below.

Theme 5: The NHS is not a Culturally Competent Organisation



Quotes from interviews

Quotes from survey questionnaire

Figure 5.5: The NHS is not a Culturally Competent Organisation

Theme 6: The Uncertainty of the NHS as a Culturally Competent Organisation

The uncertainty of the NHS as a culturally competent organisation sub-theme relates to the inability of some of the participants to share such a perception conclusively. Participants will have needed to reflect on leadership, recruitment, training, services, policies/processes, and ethos. It is suggested that the difficulty participants had in being resolute on the issue of the NHS as a culturally competent entity could be related to unmet expectations or experiences as NHS professionals or service users. Furthermore, as NHS employees, participants had been asked to consider the opportunities they have to influence cultural competence. Though some participants assert that opportunities exist for cultural competence, they also suggest that there are challenges that negate these opportunities (resources, CPD, workforce issues, bias, and training opportunities).

The theme described as the uncertainty of the NHS as a culturally competent organisation was derived as a sub-theme of the theme 'the NHS as a culturally competent organisation'**.** The uncertainty factor could be related to various reasons including the lack of a consensus definition for culturally competent commissioning, attitudes, resources, training, leadership, and communication. It is an important theme in this study as there still exists some difficulty in presenting an outright opinion on the status of the NHS as culturally competent or otherwise though participants agreed that there were pockets of good practice.

The subtheme was defined using the codes/responses that leaned towards an uncertainty perception. It was important to include these contributions as they would be significant to gaining an understanding of how they might be implicated in the challenges and opportunities for commissioning culturally competent services. Furthermore, the significance of this sub-theme could be evidence of the underlying lack of a consensus opinion of the culturally competent status of the NHS by participants. And more significantly, a lack of understanding of what

cultural competence is. These factors are in keeping with the literature that states that a major problem with cultural competence is the lack of a consensus over what it is and how it can be measured.

A shared view was;

"I have not experienced a situation where the NHS has not been culturally competent, but others have…" **Ray-Black British-Counsellor –Provider -2years' experience.**

Another participant declared;

> *"...There is no evidence that it is culturally competent…"* **Betty-White Canadian – Group Coordinator –Provider -1.5 years' experience**

And;

> *"...It is hard to rate cultural competence..."* **Ryan-Black British – Head of Quality-Commissioner -5 years' experience**

Another asked;

> *"...Can it be quantitatively assessed"* and *what factors can or do you measure..."* **Stan –White British- Service Manager –Provider- 6years' experience**

Participants responded to the question of whether they felt that they would need training/CPD to gain or improve culturally competent skills or whether they would favour the development of a culturally competent framework. In addition, they were asked what they could do to influence cultural competence. It was also important to ascertain whether participants who were uncertain of the notion of the NHS as culturally competent would suggest the possible challenges that maintain this perception. Furthermore, would these challenges be related to the biases of participants? Further on, there is mention of ethnocentrism and racism which may be related to the underlying reasons why participants could not agree or express a

degree of certainty of the NHS as culturally competent. A participant mentioned that there was no evidence of the NHS statutorily meeting the needs of all adequately;

> *"...It is important to meet the needs of the diverse populations in all boroughs. It should be statutory so that no one is disadvantaged by not being able to access the services they need. But is it achievable..."* **Lena-White British- Dementia Adviser- Provider -5years' experience**

Another participant did not think cultural competence was a matter of importance to and therefore stated;

> *"...the most important thing is decent care delivered by well-trained, competent staff at the right time and cultural competence does not necessarily achieve that…"* **Pat –White British-Dementia Support Worker –Provider -4 years' experience**

Another participant said;

> *"Duty of care - engaging with the community to understand the diversity in all age groups and to ensure appropriate care provision is in place…" (P20-*Zoe-Black British- Carer- **Provider- 14 years' experience**

It is important to note that in expressing an uncertainty as to the culturally competent status of the NHS, participants may not necessarily be alluding to this quality as being an unnecessary quality. Evidence of this is clear from their definitions, expectations, and considerations for the possible development of cultural competence within NHS services. The contributions (quotes) defining the uncertainty theme are included in the diagram below.

Theme 6: Uncertainty of the NHS as a Culturally Competent Organisation

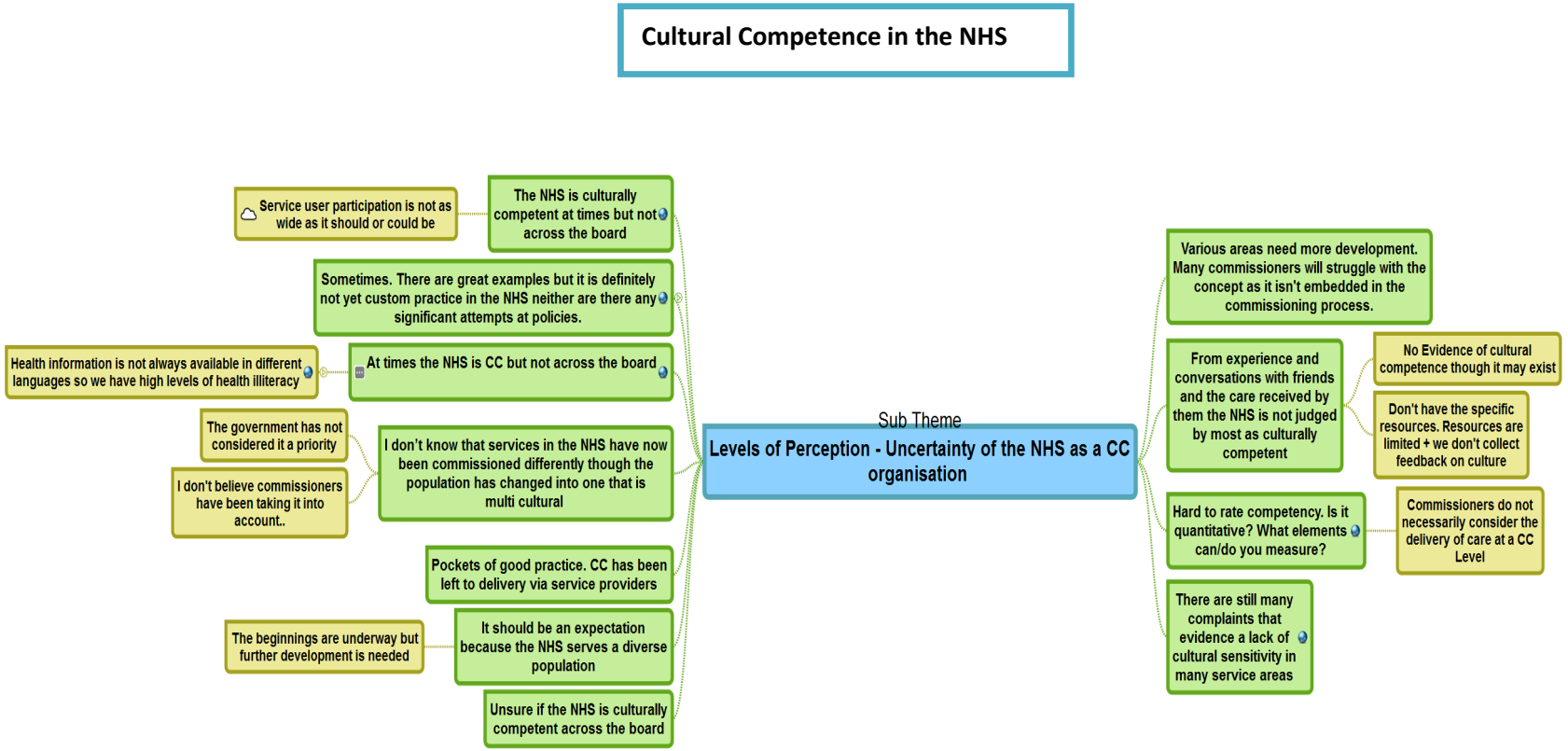


Figure 5.6: Uncertainty of the NHS as a Culturally Competent Organisation

Theme 7: Importance of Cultural Competence

Culturally competent commissioning was a main theme with 95.35% of survey participants (figure 5.7) considering cultural competence to be important to the commissioning of services for older people. However, of interest to further research is the understanding of why any number of professionals may disagree with the importance of cultural competence in commissioning. A conclusion that this research cannot reach is that this negative opinion is an underlying reason for any level of cultural incompetence in the NHS.

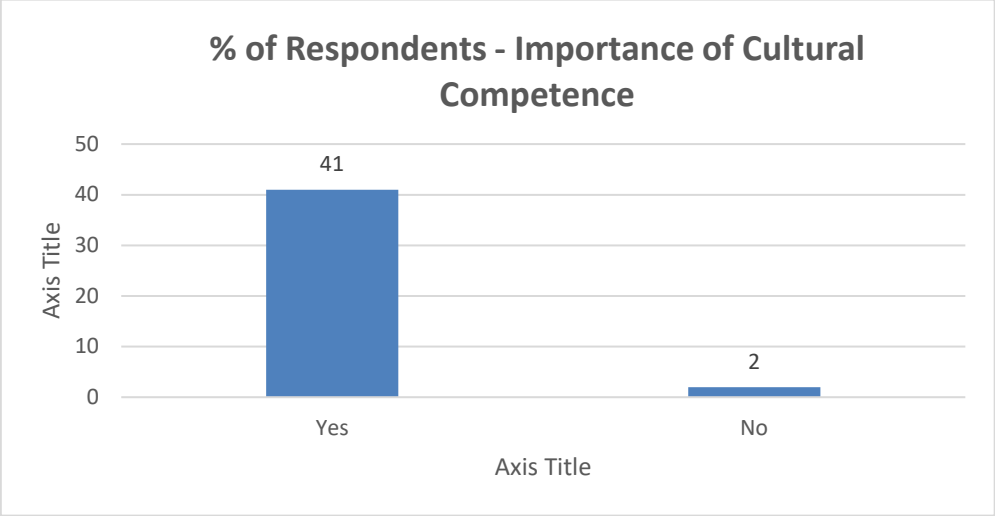


Figure 5.7 33: % of Respondents – Importance of Cultural Competence to Commissioning

To respond adequately to the question of the importance of cultural competence to the commissioning of older people's services, participants were expected to understand what cultural competence is in theory and practice (professional experience). Participants offered opinions that may be related to their professional stance, gender, cultural beliefs, ethnicity, bias, experience, and training.

To this extent, participants expressed concern for;

"...Duty of care, engaging with the community to understand the diversity in all age groups and ensure appropriate care provision is in place to meet identified needs…" **Uzo- African – Commissioner -3 Years' experience**

Another participant goes as far as mentioning;

"...It is important as it supports better outcomes for the service user and good carer experience, and it enables motivation and fulfilment for staff…" **Paddy- Northern Irish -Consultant – Provider – 18 Years' experience**

An additional response was;

"...It means that for patients and services culturally competent commissioning can achieve better outcomes. It is also important to improve service user satisfaction within budget..." **Chris -White British -Manager Consultant - Commissioner - 8 years' experience**

It is possible to accept that cultural competence is about continuously achieving improved quality in services amongst other things. Participants highlight the necessity to focus care on patients without generalizing patients as one homogeneous community. This suggests that it is necessary to employ an individualized approach to commissioning and delivering care.

A further illustration by a participant was;

"...*It means better person-centred care which means cultural competence equates to better care as a description of quality resulting in patients being discharged from hospital quicker…"* **Trevor –Afro Caribbean counsellor-Provider**

Another participant suggested;

"...Important to acknowledge our differences because 'a one-size-fits-all' approach will leave some people without appropriate care, information, and support (health care literacy).

And also asserted;

"...needs must be considered from the onset of the commissioning process otherwise it may be difficult to prioritise later…" **Ray- Black British-Counsellor- Provider- 2 years' experience**

If cultural competence is important, negative feedback about the skills of professionals, experiences of service users, or the reputation of the NHS as culturally incompetent suggests that this study may cause professionals to focus on enhancing the relevance of cultural competence. Two hard-hitting comments from participants concerning the skills of commissioners included;

"...Lack of awareness means the NHS is not culturally competent…" **Julie-White British-Information worker –Provider- 2 months' experience**

And;

"…*there are great examples (of cultural competence) but it is not yet the custom or practice in the NHS neither is there any significant attempt at making policies culturally competent…"* **Preya –Asian Indian - Commissioner - 5 years' experience**

As perceptions varied, it became significantly important to consider the reasons for the variations.

As far as this work is concerned, it suggests that the importance of culture (diversity) and cultural competence is related to its significance in the commissioning and delivery of healthcare services. The survey required participants to share their opinions on the importance of cultural competence to commissioning and also consider if and how or why the NHS could be considered culturally competent. The in-depth interview questions were about exploring the

significance of cultural competence to commissioning. Figure 5.8 shows the contributions made by participants in the survey (amber text box) and interviews (green text box).

Theme 7: The Importance of Cultural Competence to Commissioning

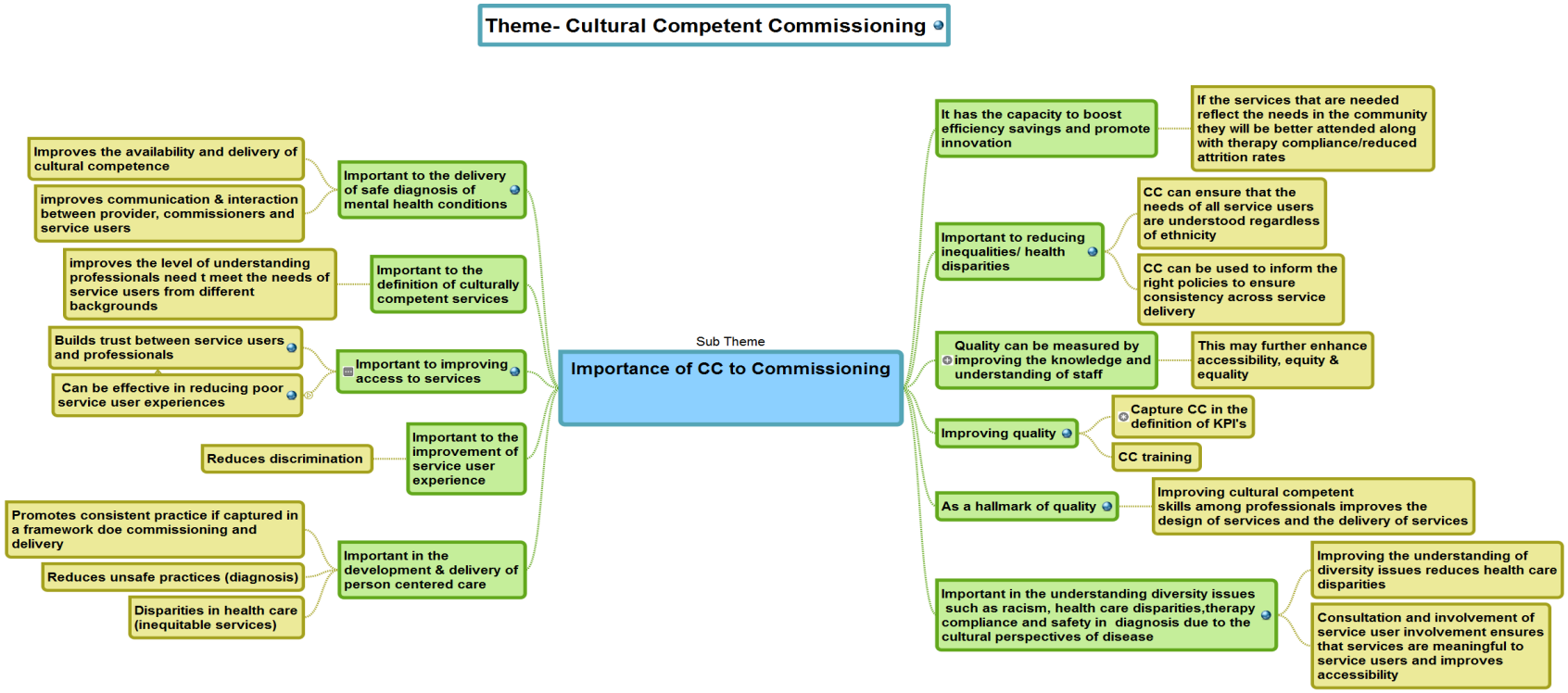


Figure 5.8: Importance of Cultural Competence to Commissioning Older Peoples Services

Theme 8: Significance of Cultural Competence to Service delivery for Older People and Others

Participant perceptions suggest that the utilization of cultural competence is very significant to the delivery of services to older people and others. According to participants, cultural competence goes hand in hand with a recognition and appreciation of the different cultures of those working in and using the services provided by the NHS. To this end a participant highlighted that;

> *"...Culture is important to each individual. Everyone has their own needs that are defined by their culture; therefore, it is important for older people to have their cultural wishes included in their care…"* **Stella- White British Provider manager –Provider -7 years' experience**

Cultural competence is more than just knowing the characteristics of each culture, this is not possible or necessary to begin with, yet this is what the proponents of cultural competence seem to imply (Ben-Ari and Stirer, 2010). Their study reports that it can be as simple as engaging in respectful conversations during assessments and respectfully incorporating cultural sensitivities within commissioned services or packages of care. This was pointed out by one participant;

> "...*older people have values that they have lived by for very long periods therefore these should be respected even in the delivery of care or treatment…"* **Preya- Asian Indian –Commissioner – 5 years' experience**

Another participant added;

> "...*It's important because the values of the older person are critical to the care they might value as they have their own wisdom and should be involved in the planning of the care they receive where possible…"* **Kath- Black British-Commissioner - 4years' experience**

By recognizing values, beliefs, and customs, the commissioner/provider gets to consider service users in the context of their cultural setting (values/cultural perspective of disease). When care is fit for purpose by the judgment of service users, they comply, recover quicker, and have a better experience of care which may result in prolonging their wellbeing or preventing illness. These elements of culture must then be factored into designing efficient services within budget to ensure sustainability on the part of the commissioner. On the part of the provider, cultural competence becomes a significant factor when attempting to make an accurate diagnosis of dementia or otherwise (medical professionals), formulate care plans, or deliver treatment. Research participants offered an expectation that service users be treated as individuals as opposed to being treated as a part of 'a cluster' of patients receiving the same treatment without due regard to cultural differences in language, nutrition, gender, habits, or religion. At least two offerings from participants shows evidence such a view;

> *"...It is important that service users' wishes, and beliefs should be respected so long as they are reasonable…"* **Fola- Black African –Commissioner- 4 years' experience**

And;

> *"...to recognize culture means taking it into account, that is, to value those beliefs and customs that are important to patients because these have been part of their life, their identity, expression of self and a perspective of illness and symptom reporting. And it should be noted that culture also influences how treatment or care is complied with...* **Max-Black African-Provider - Support Officer -7 Months experience**

By considering patients or service users as cultural individuals the commissioner/provider perspective is respecting and accepting of the service user as an individual and moving away from a one-size-fits notion. This was highlighted in a comment;

> "...*I would describe a service as culturally competent if the service commissioned or provided is respectful, open-minded and considerate of the values of service users…"* **Bob – British-Social worker- Provider-4 years' experience**

Another participant mentioned;

> "...*People are individuals and receive services as individuals, their cultural needs are important as are their other needs…"* **Matt-White British-Director of commissioning and enforcement –Commissioner -5 years' experience**

Some participants expressed the need for the development of a person-centred approach to care that starts with how services are designed and performance managed, this is related to the consideration that beliefs and values are significant in improving patient experiences and these must be known and considered by commissioners of care;

> *"…It is important to create a more person-centred approach and make people feel valued including family members and friends, not just the patient. It should be statutory just like safeguarding and health and safety is. It allows professionals to understand service users and enhance the provision of better services…"* **Fatima -Black African -Commissioner**

The figure below depicts some of the quotes/codes that were categorised to construct theme 9. The 2 coloured text boxes show the quotes from the interview and the survey. Most of the quotes were similar in context as is the nature of interviews once saturation is reached.

Theme 8: Significance of Cultural Competence to Older People's Commissioning

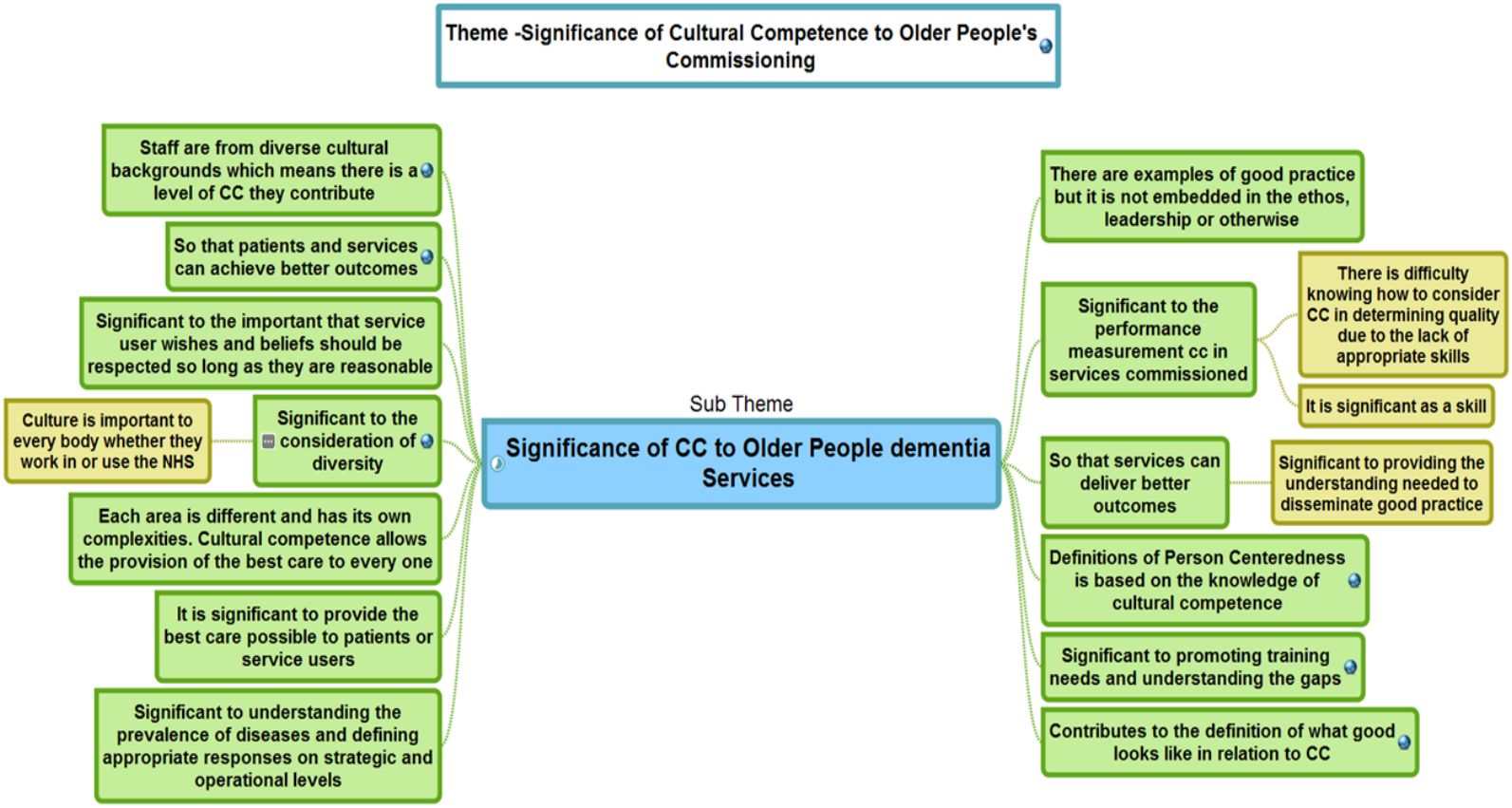


Figure 5.9: The Significance of Cultural Competence

Quantitative Data Findings:

Theme 9: Influencing Cultural Competence in Commissioning

The quantitative data used to inform this theme and a few others further on were obtained by quantitising segments of text (Emerson, Fretz and Shaw, 1995; Poland, 2006). Accomplishing it was by constant comparison and the assignment of numerical values as is shown in tables further on. Quantitisation allowed the discernment of hidden patterns or irregularities that may not have otherwise been easy to convey. Survey question 9 asked participants how they might influence cultural competence in commissioning. Table 5.6 and figure 5.10 are comprised of the quantitative data showing the most popular suggestions to be the engagement and mobilization of service users in the relevant phases of the commissioning cycle (needs assessment, planning and design, procurement recruitment). A pertinent task often neglected by commissioners but not overly suggested by participants of this study was the matter of directly involving service users in the quarterly performance monitoring meetings. Engaging with service users who have direct experience of services is an adequate means of measuring/assessing cultural competence based on the definitions, knowledge, understanding, and experience of service users.

Table 5.6: Influencing Cultural Competence

Sub-themes	Number of Respondents	% of Respondents
Accommodate diversity	1	1.41%
Knowledge of stakeholders	3	4.23%
Availability of resources	5	7.04%
Building capacity	5	7.04%
Monitoring and Evaluation	6	8.45%
Prejudice and discrimination	7	9.86%
Disseminate good practice	8	11.27%
Promote willingness	9	12.68%
Engagement and mobilisation of stakeholders	27	38.03%
Total	**71**	**100.00%**

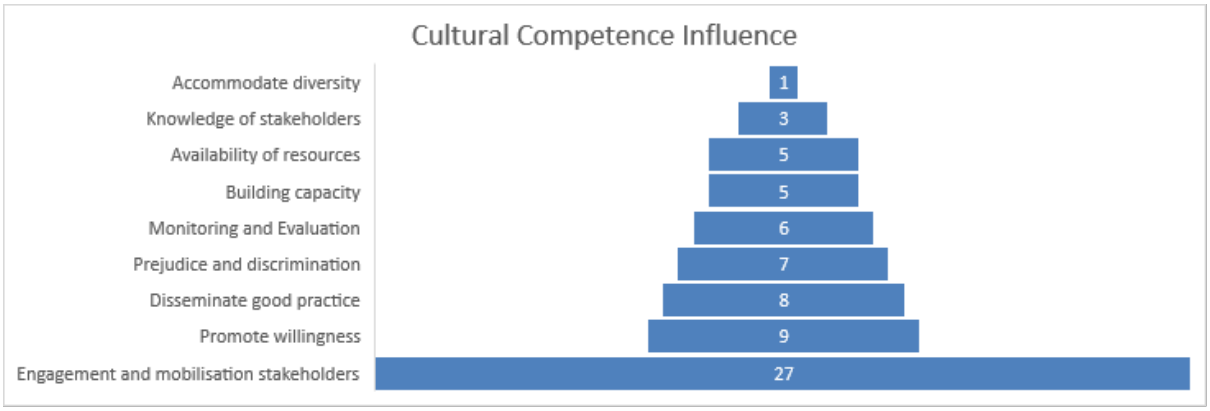


Figure 5.10: Influencing Cultural Competence

In the survey questionnaire phase, participants suggested that acts of prejudice and discrimination speak to the recognition of personal bias and a need to put effective policies and professional development in place. Data from the interviews supported

the various suggestions offered in the survey as to how cultural competence can be influenced in commissioning by commissioners and others.

Influencing cultural competence in health commissioning or service delivery is integral to ensuring that the served population can access services that are of value to them in times of vulnerability and to prevent ill health. In recent times the responsibility of delivering cultural competence has sat with service providers via person-centred care. This study suggests that there needs to be a shift towards a shared responsibility meaning that commissioners should be in the driving seat at the level of service design. Furthermore, commissioners should also influence its delivery by designing culturally competent key performance indicators (KPI) to be monitored as a hallmark of quality. The significance is to create a next-level hallmark of quality measurable in partnership with service users whose experience should be the evidence considered to quantify cultural competence. The creation of such KPI's would benefit and give service users a better experience. It would also challenge commissioners further in their ability to design beyond the ethics of a one-size-fits-all NHS. Making this a reality is dependent on having skilled commissioners from diverse backgrounds in positions to influence it whilst using the appropriate opportunities identified or created. This is because culturally competent in commissioning requires those with skills and understandings of what is needed especially so in the Black Lives Matter movement. A mention of the Black Lives Matter movement is key given a significant number of those affected by severe mental health conditions are BME's who tend to be 'health-seeking shy and are often referred to as 'difficult to engage with'. To understand what some of the drivers for culturally competent commissioning might be participants were asked what influences they could bring to bear on the commissioning process to accomplish what is needed over and above the mere expectation of providers delivering person-centred care (culturally competent services).

Participants identified the promotion of positive outcomes as an influence and impact of cultural competence. The suggestion was;

> "…i*mplement policies demonstrating the positive outcomes that can be gained from cultural competence…"* **Chris–White-British-Manager Consultant-Commissioner- 8years' experience**

And;

> *"…emphasise the benefits of cultural competence and the positive impact that it can have on both professionals and patients…"* **Rufus - White British-Team Manager-Provider- 1 years' experience**

Funding was cited as one of the challenges of culturally competent commissioning and also a way to influence cultural competence when available for the purpose,

> "…*the provision of more resources…*" **Mary-White British- Team manager- Provider- 3 years' experience**

And;

> "…*make funding available…*" **Tracey – European-Commissioner - 3 years' experience**

Also;

> "…*resources need to be dedicated*…" Matt **-White British Male Director of commissioning and enforcement -5 years' experience**

Participants alluded to a necessity to assign resources to train staff in culturally competent skills acquisition via CPD activities, and that furthermore, any training or professional development should be built into a culturally competent commissioning framework for the sake of consistency. It was asserted that resources should be focused on training that involves service users who can share their experiences and

give insight into what is needed to reflect cultural competence. It is contended that such practices could get professionals to see themselves first as service users designing/commissioning care for service users. There were also observations related to "*collecting cultural competent data;*

> "...*undertaking relevant research and increasing the awareness of person-centred care and its importance even to the professional that needs a service user to be compliant with treatment or therapy…"* **Fay-British –Provider Manager – 4 years' experience**

Policy and Legislation were referenced concerning the development of culturally competent policies that are expected to be developed by government departments (National Institute of Clinical Excellence, Department of Health, NHS England, and the Care Quality Commission). Relevant policies that can influence the status and practice of cultural competence can be those that govern how we design, deliver, and monitor the performance of both health and social care services. These are crucial areas offered as areas of opportunities for influencing cultural competence at both local and national levels. These national bodies are responsible for disseminating policy and good practice. Other relevant mentions include;

> "…*design of policies that specify the exact needs of older people*..." **Agnes-European –Provider manager-3 years' experience**

And;

> *"…precise protocols on how to meet the needs of individuals & populations…"* **John-White-British –Chief Executive–Provider-2years' experience**

One participant went as far as saying;

> "…*design culturally competent key performance indicators which can be built into both commissioning and monitoring processes and quality reports so that more providers can design culturally competent policies, assessments and*

care plans that are culturally meaningful. Commissioners can include KPI's within service specifications for dementia services…" ***Abi - European- Commissioner -6 years' experience***

Although staff training (CPD) was a very common suggestion as an opportunity to influence cultural competence so was consultation and engagement with service users;

" … *consulting the patient as early as possible*…" **Tan-Chinese British - CAMHS Project Manager- Commissioner -3 years' experience**

And;

"…*consultation with older people and providers of relevant services…"* **Tara - White British – Commissioner- 5years' experience**

A very significant contribution by one participant was;

"…*use the needs assessment process to find out from the population what cultural competence means to them and include it in service designs*…" **Kerry - New Zealand- Head of Placements-Commissioner - 5years' experience**

Some of the other contributions that make up the ninth theme are presented in figure 5.11 below.

Theme 9: Influencing Cultural Competence in Commissioning

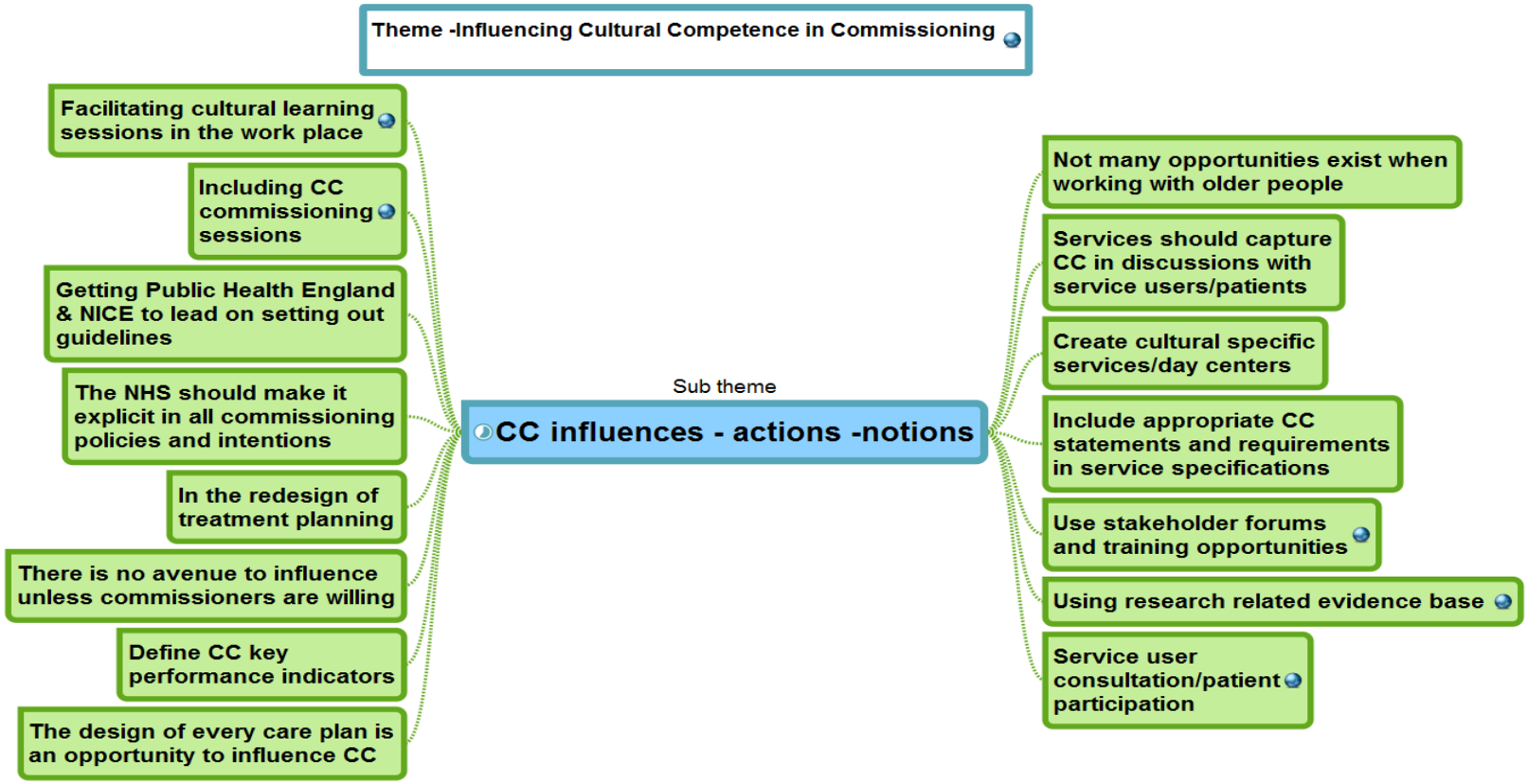


Figure 5.11: Influencing Cultural Competence in Commissioning

Theme10: Opportunities for Commissioning Culturally Competent Services for Older Peoples (others)

In keeping with the main research question in both the survey and in-depth interview phase, participants were asked what opportunities exist for culturally competent commissioning. Table 15 and figure 40 show the variety of suggestions offered for different reasons. The most suggested or main opportunity for commissioning culturally competent services for older people and others was the consideration of the beliefs and backgrounds of others (21.57%) including those of professionals. These factors may influence how needs are met and the resources portioned (7.84%) or needed to inform, sustain and transform planning (5.88%)

Table 5.6: Opportunities for Culturally Competent Commissioning

Sub-themes	Number of Respondents	% of Respondents
Sustainability and transformation plan	3	5.88%
Capacity building	4	7.84%
Diversity.	4	7.84%
Examples of good practice	4	7.84%
Quality and innovation exercise	4	7.84%
Resources to meet needs	4	7.84%
Service usage of CC tools	4	7.84%
Engagement and mobilisation	6	11.76%
Evaluation and feedback	6	11.76%
Needs and preferences	8	15.69%
Beliefs and cultural backgrounds	11	21.57%
Total	**51**	100.00%

Participants were asked what opportunities if any they had to practice ensuring cultural competence in commissioning or otherwise. A few mentions were related to leadership

> "…*the government should take the lead along with researchers who should shift the focus from delivery to commissioning...*" **Yemi – African-Placements Manager - Commissioner -5years' experience**

While another participant spoke of a need for;

> "…*skilled workforce that has sensitive or compassionate leadership…the NHS hierarchy needs a culture shift...* Other contributions *offered related to …any chances that exist to increase the skill mix meaning recruitment and training should be culturally competent, development of appropriate competencies, clear leadership of cultural competency, designing outcomes that are measurable when assessed…"* **Ola-Black African-Commissioner-5 years' experience**

According to participants, institutions, and national organisations, such as Public Health England and other stakeholders should design opportunities and lead the way in developing required changes. A participant declared;

> "…*Public Health England and the National Institute Clinical Excellence should take a lead in setting out guidelines to ensure that cultural competence is fully embedded in all services*…" **Chris -White British - Manager Consultant –Commissioner -8 years' experience**

While another mentioned;

> *"… all available resources in England and Wales but need commissioners to understand the specifics of their locality*…" and "…*use national forums to improve CC inclusion…*" **Tracey-European –Commissioner -3 years' experience**

And;

> "… *if leadership is responsible for setting the scene then it would be right that the opportunity lies at the national level where policies are defined…"* **Tracey-European –Commissioner -3 years' experience**

Participants also felt that commissioners should proactively consult research bodies stating;

> "…consultation with appropriate scholars in the field and the leading health agencies but is anyone researching how we commission after all these years…" **Gwen – Afro Caribbean-Commissioner -4years' experience**

And another participant concluded that;

> "…*all agencies responsible for inspecting care services should lead the way and include cultural competence as a hallmark of quality…*" **Rob- White British-Strategy manager -Commissioner -1years' experience**

Various other meaningful contributions not included or commented on in this narrative are included in the diagrammatic presentation in figure 5.12 below. The summary codes or quotes are in green (survey questionnaire) and amber (in-depth interviews) respectively.

Theme 10: Opportunities for Culturally Competent Commissioning

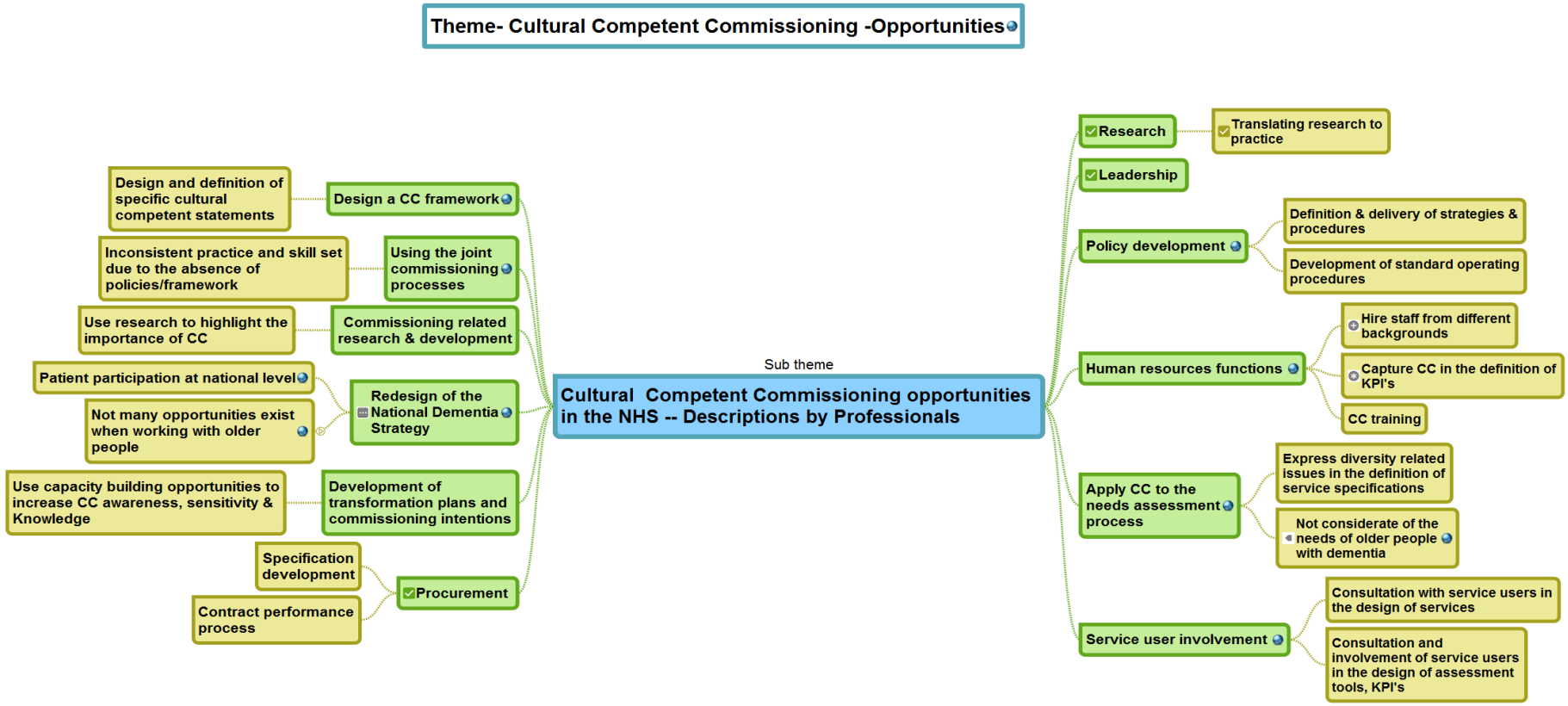


Figure 5.12: Opportunities for Culturally Competence in Commissioning

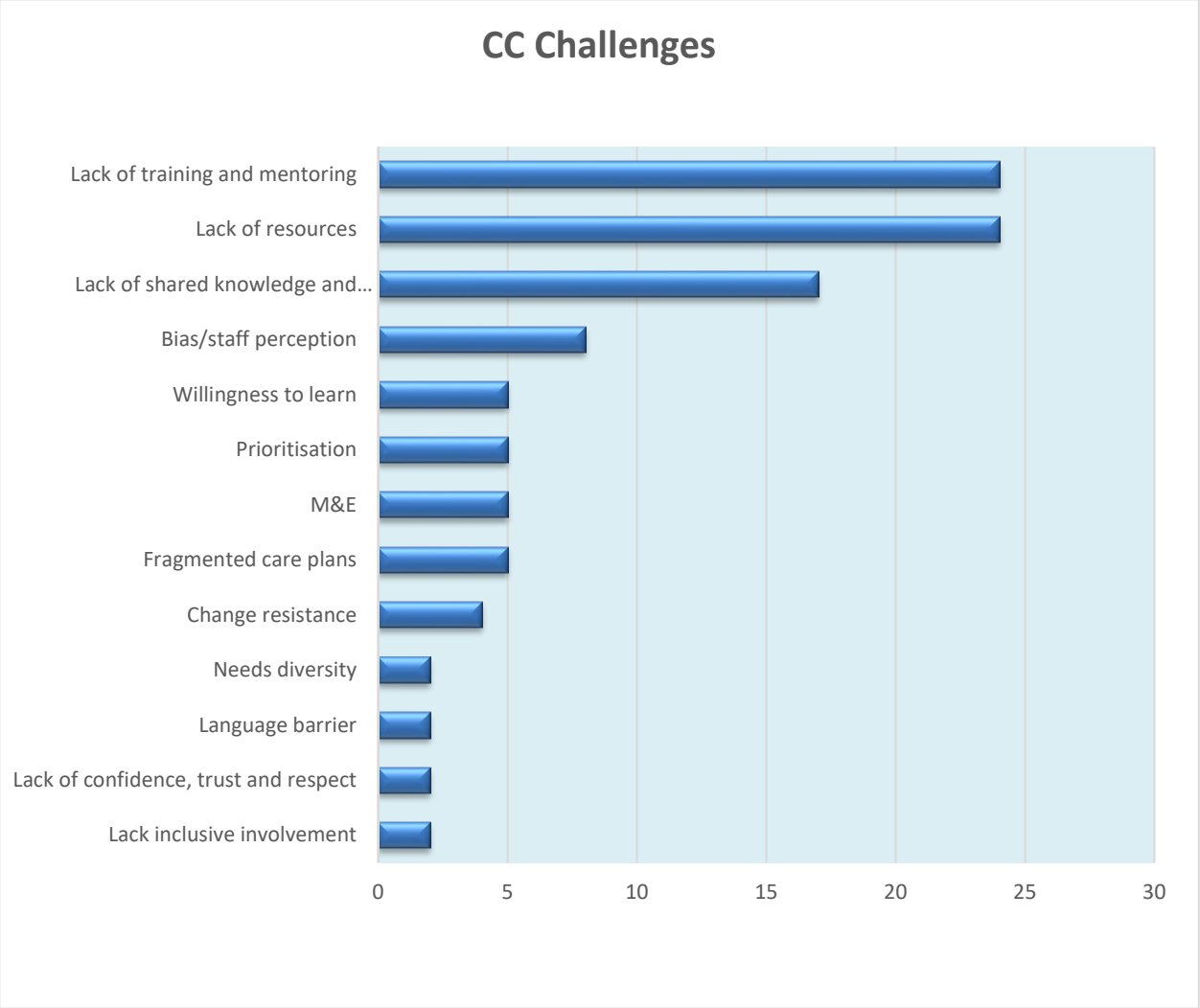
Theme11: Challenges to Culturally Competent Commissioning for Older People's Services

Responses to the research question of what the challenges are to culturally competent commissioning are defined in the table below. The perceptions of participants suggest that the main challenge offered is that of the lack of training (CPD) and mentoring which relates to continuous professional development in the workforce (22.86%).

Table 5.7: Challenges to Culturally Competent Commissioning

Sub-themes	Number of times the Response was mentioned	% of Respondents
Lack inclusive involvement	2	1.90%
Lack of confidence, trust, and respect	2	1.90%
Language barrier	2	1.90%
Needs diversity	2	1.90%
Change resistance	4	3.81%
Fragmented care plans	5	4.76%
M&E	5	4.76%
Prioritisation	5	4.76%
Willingness to learn	5	4.76%
Bias/staff perception	8	7.62%
Lack of shared knowledge and understanding	17	16.19%
Lack of resources	24	22.86%
Lack of training and mentoring	24	22.86%
Total	**105**	**100.00%**

Figure 5.13: Challenges of Culturally Competent Commissioning



A lack of resources was also suggested as a factor that could be linked to the lack of training, this being the case, it is suggested as a challenge to culturally competent commissioning. The implication of increasing resources and training could be linked to improving the status of cultural competence in the NHS. In responding to the research inquiry, it is significant that almost 8% of participants perceived bias to be a challenge to culturally competent commissioning. Participants did not suggest or name any particular type of bias as a challenge.

Challenges as a theme describes some of the perceived challenges participants considered to exist within the health commissioning arena. A few participants reported there to be a lack of an understanding of the cultural differences of others. Could this be explained by the lack of diversity in the workforce or the limited priority placed on cultural competence? Others mentioned the several differences in what cultural competence means to others especially since these differences reflect the cultural and professional backgrounds of the participants. The significance of this speaks to evidence that the practice of cultural competence might be based on how professionals do or don't define the concept and cultural backgrounds. A further significance might speak to the importance of a consensus definition of the concept as it is lacking at this time. Some participants felt that it was about race and therefore about ethnic minorities and their needs only, this of course is a wrong assertion. Others made suggestions that alluded to a lack of understanding. One participant further explained that limited understanding was because;

> "...there is a need for a *cultural competence executive" to define it firstly*…" **Stan - White British-Provider manager –Provider -6 years' experience**

Another participant mentioned;

> "…*inadequate understanding of what cultural competence is in commissioning and how it can be achieved..."* **Gwen –Afro Caribbean – Commissioner -4 years' experience**

Also offered;

> "*…a lack of understanding of the importance of culture and dementia..."* **John- White British-Chief Executive-Provider -2 years' experience**

Participants also alluded to the need for a better understanding, training, and resources to improve how professionals deal with service users from various cultures;

"…people have to be willing to learn more about other cultures and want to engage with them, also service users have to feel comfortable telling people their cultural preferences or issues..." **Sue- British-DSW and social worker- Provider -1.5 years' experience**

Another participant highlighted:

"…*a lack of understanding in the local community, recognizing diversity issues, not educating the professionals, cultural competence should be part of the rotation programme for medical students, and involve all relevant health providers* …" ***Zoe*- Black British-Personal Assistant/Carer-Provider- 14 years' experience**

A further contribution offered was;

"…The NHS has not ensured that there is an acceptable working definition of cultural competence or defined key performance indicators that are understandable and easily measured. The evaluation of the satisfaction of service users is also missing as a measurement of service user experience concerning cultural competence…" **Abi-White European-Commissioner-6 years' experience**

While participants expressed thoughts or perceptions as to the significant numbers of professionals lacking an understanding of cultural differences, they also offered possible underlying reasons for the limited understanding suggested in the study. For example, they pointed out that a lack of adequate budgets and time are relevant challenges to the culturally competent improvements needed within the NHS;

"…*difficulties in balancing clinical care vs cultural requirements in a cost pressured environment…"* **Jenny-White British-Consultant commissioner-8years' experience**

An interesting statement is offered by

"...l*ack of awareness, lack of training, time implications, and no statutory status for cultural competence, too costly and training…"* **Fola -Black African-Commissioner-4years' experience**

Regarding the lack of time factor, participants noted;

"…*staff time*. There is not *enough time to include culturally competent feedback* …" **Chris- White British-Manager Consultant -8years' experience**

Another participant stated:

"*...time and money are the biggest barriers. More time with service users will be needed to create culturally competent services especially when you are a GP or nurse...* "**Ray-Black British-Counsellor-Provider - 2 years' experience**

Concerning the numerous mentions of limited budgets, the questions are how much does it affect the time factor that participants say is a challenge, and secondly, what is the cost of cultural competence? Furthermore, is it true that cultural competence is or has a cost implication given that sometimes it may be as simple as showing kindness or consideration to those of a different culture, age, or background? These acts are the definition of compassionate care.

Training was a factor that several participants mentioned as being essential, for this reason, it was suggested as a challenge though some participants also asserted that they did not need training. This is sometimes the case when a vulnerable or minority group assumes that they know what groups similar to their own might need and are oblivious to what a majority group might need. This is a definition of professional bias. Further on in the discussion chapter, this work discusses the possible underlying reasons for these assertions;

"…*Robust training in culturally competent skills...*" **John- White British -Chief Executive- Provider-2 years**

Training in culturally competent skills was a consideration and defined as necessary to ensure that staff possess relevant culturally competent skills. The suggestion was that these skills are necessary because of issues such as;

> "...*not enough traction in raising concerns that are related to cultural competence...*" **Rob-White British-Strategy Manager-Commissioner-1years' experience**

And;

> "…*lack of training and staff understanding* is a challenge as is *awareness via training and mentoring, statutory community engagement..."* **Paddy-*Northern Irish-Consultant –Provider -18 years' experience***

The issue of improved information sharing protocols that are the bedrock of integrated services and better partnership approaches in dementia services was mentioned. These are the causes of fragmented services and are defined as cultural incompetence. Aside from the perceived absence of cultural competence by some participants, some cited the process of 'assessing needs' as being important to them;

> "…*quality of the needs assessment process does not lend itself to the good practice of cultural competence and there is not much understanding of how cultural competence links to the commissioning cycle*…" **Paddy - Northern Irish white–Consultant- Provider -18 years' experience**

Another participant pointed out that;

> *"…older people are coming over from other countries and all have different needs, but confidence is lacking to ask or talk about specific needs…"* ***Gwen-White British -Administrator-Provider -8 years' experience***

Comments from another participant were;

> "...*making assumptions about names and religion… cultural background of staff will impact their empathy. Services are currently set up to align with typically Western views and values, departing from this stance will take a lot of time and energy…"* **Sara -White British-Dementia Advisor- Provider -<1years experience**

Another participant provided an interesting summary of the challenges to cultural competence cited as;

> *"...resistance to change. Lack of readily available information. Not enough feedback from patients/carers to address individual needs. Patient-choice and respecting the views of patients. Discrimination bias/prejudice. Stereotyping. Cultural imposition from professionals. Cultural ignorance. The inability to share care plans between health providing organisations..."* **Zainab-British/Asian-Governance Lead – commissioner -<1years experience**

Some participants went further to describe those aspects they considered to be challenges of culturally competent commissioning in the NHS. The rendering of this contribution speaks to the very core of the importance of culturally competent commissioning and delivery in all health and social care services.

> *"…All services need to consider deprivation levels and the backgrounds of those in a locality… Commissioners should know which diseases are prevalent in the areas they commission… especially since some patients are from backgrounds and cultures that are more prone to certain diseases…"* **Max-Black African-Provision Support Officer –Provider-7 months experience**

The absence of appropriate culturally competent policies/KPI's enables discriminatory behaviour from NHS staff towards patients, and from patients to professionals. A statement to that effect was rendered as;

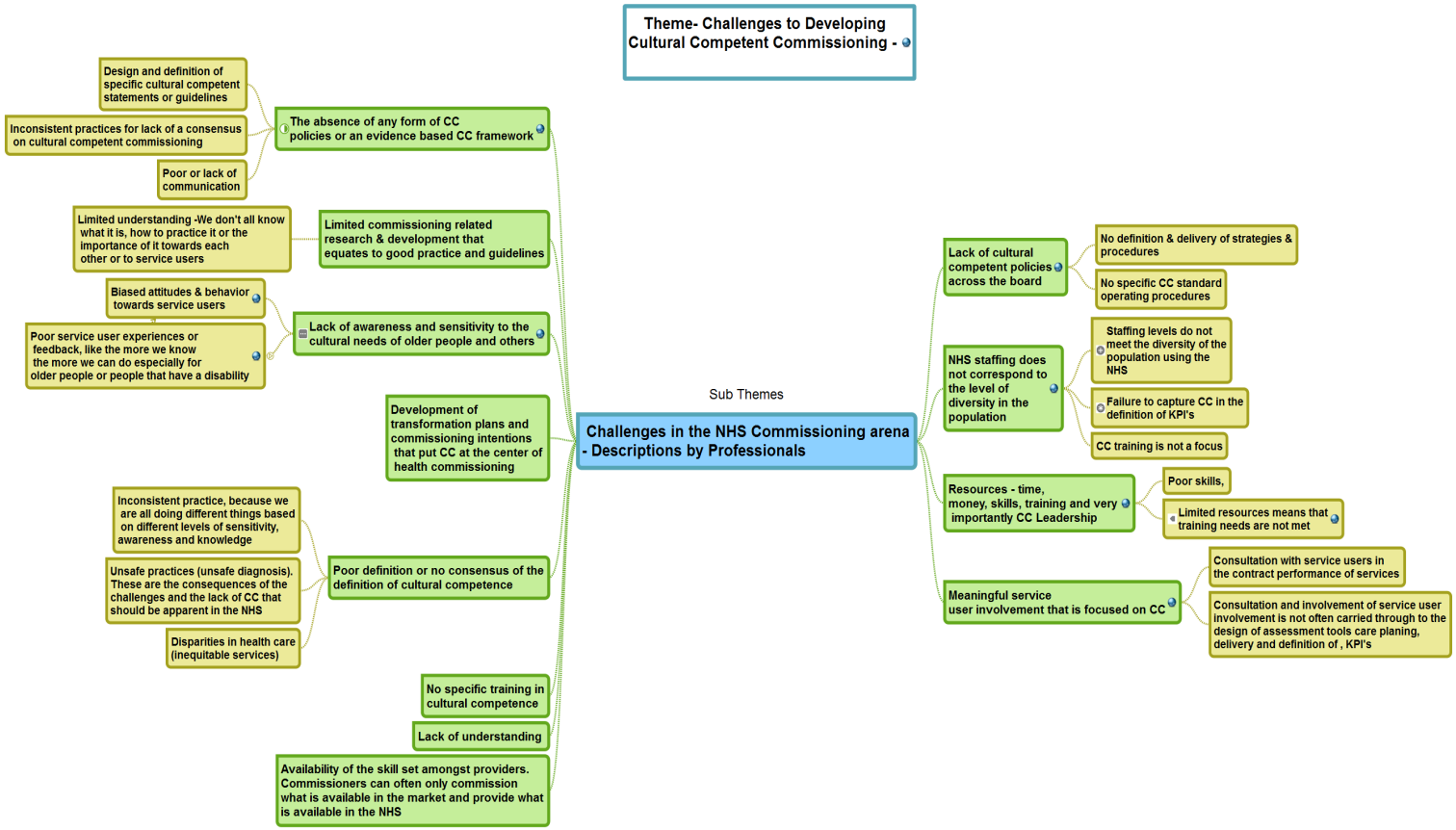
> *"...Cultural competence reduces stigma: more research and training provision and making sure services are well staffed with trained personnel goes a long way to eradicate the problem of cultural incompetence. Both have possible financial implications in the short term however they prove cost-effective in the long run…"* **Andy - Northern Irish –Dementia adviser –provider – 3.5 years' experience**

The lack of research into cultural competence in commissioning was also a factor mentioned by participants and a recommendation included further on.

There was also a contribution concerning finance, data, workforce, and a lack of evidence-base (culturally competent commissioning evidence) and limited the consensus amongst professionals as to what cultural competence is. Considering mentions in the literature cited earlier of a clear need for a consensus definition and what needs to be addressed, this study might contribute to the paucity of literature related to cultural competence generally and cultural competence in commissioning.

A diagrammatic representation of the challenges suggested by participants based on their perceptions is offered in figure 5.14. it shows that a lack of training was a popular challenge; this was linked to limited resources, time, relevant policies but more importantly an unwillingness to embrace change or a genuine unawareness of what is needed (lesser priority). Such offerings are considered as evidence of honesty amongst participants who were speaking about their profession. This level of honesty was appreciated and evident when issues about attitudes, bias, negative behaviours, and other related issues were offered as true reasons why services and commissioning may not be culturally competent. The need for organisational cultural change in the leadership hierarchy of the NHS and that of its strategic partners was mentioned and very brave or bold contributions.

Theme 11: Challenges of Culturally Competent Commissioning



Quotes from interviews

Quotes from survey questionnaire

Figure 5.14: Challenges to Culturally Competent Commissioning

Theme12: Training (CPD) as a Challenge to Culturally Competent Commissioning

Participants were asked if training as an opportunity to learn via CPD is a requirement to boost the practice of cultural competence (or lack of it is a challenge to cultural competence). There was consensus that training/continuous professional development has an impact on the practice of cultural competence. For this reason, participants were further asked if they needed access to training to gain culturally competent skills. As participants had suggested that training was a significant challenge to culturally competent commissioning it became a theme as shown in table 5.8 and figure 5.15. The diagrams show the distribution of responses to the question about the need for training to improve or gain culturally competent skills. 32 (74 %) participants said they would need training while 9 (21%) declined the need for training.

Table 5.8: Distribution of Responses to Culturally Competent Training

Responses	No of Respondents	% of Respondents
Yes	32	74.42%
No	9	20.93%
No response	2	4.65%
Total	43	100.00%

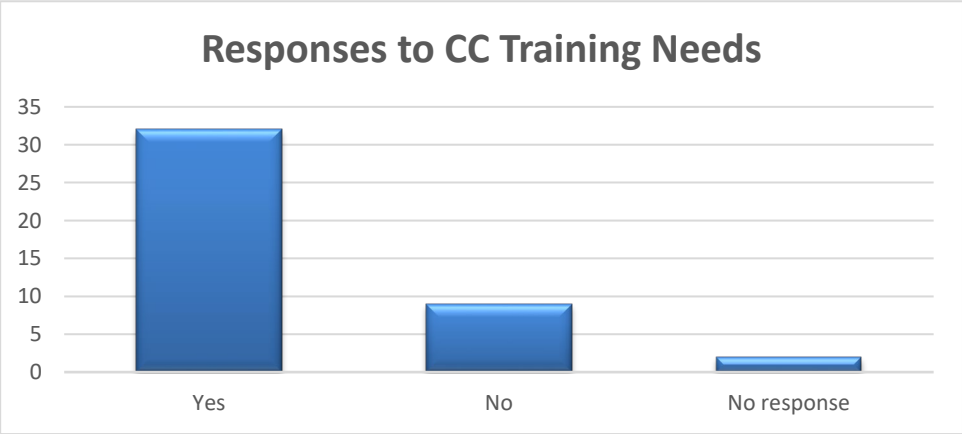


Figure 5.15: Distribution of Responses to Culturally Competent Training

Participants were asked to explain why limited or the lack of training in cultural competence otherwise referred to as continuous professional development linked to cultural competence might be a challenge to culturally competent commissioning? Table 17 and Figure 42 shows that 100% of participants suggest lack of training/CPD as a main challenge to culturally competent commissioning. In other words, CPD linked to cultural competence would be an enabler of culturally competent commissioning (CCC)

Figure 5.16: Training as a Challenge

The qualitative data provided further clarifications on training/CPD as both an enabler and challenge to the culturally competent commissioning of dementia services and by extension mental health services. The perception/suggestion here is that with adequate CPD/training that is informed by culturally competent research and stakeholders such as service users the NHS could become increasingly

culturally competent as organisation. This also implies that the perceived weakness of the NHS as a cultural organisation could be due to a lack of training/continuous professional development. The theme considers lack of training/CPD as a challenge with comments such as;

> "*... the absolute need for developing a culturally competent training program that should be badged as mandatory...*" **Sara - White British-Dementia Advisor – Provider -<1years experience**

Another participant declared;

> "*...lack of training in the NHS is a challenge…"* **Ryan -Black British-Head of Quality-Commissioner - 5 years' experience**

Participants shared a common consensus regarding culturally competent training not being a priority for the NHS and that there is no time to devote to training stating that;

> "…*the cost of training might be a reason for its non-availability*…" **Ryan- Black British-Head of Quality-Commissioner-5 years' experience**

And;

> "…it is n*ot considered a priority*…" **Stan-White-British-Provider/operations manager-provider- 6 years' experience**

A further comment was;

> "…t*here is no understanding or awareness of its importance to begin with…"* **Nesta- White British - Dementia Manager - Provider -3 years' experience**

It was also said that the culturally competent skill set is not well established because the NHS has not considered it an issue to be prioritised. How far this a valid statement would need further research.

Participants were more amenable to the development of a culturally competent training program of continuous professional development embedded in a commissioning framework as opposed to a separate programme of training. It was suggested that training should not stand alone, that it should be mandatory, and commence at the start of induction to ensure consistency and continuity of practice.

Additionally, participants mentioned that it would be meaningful or of additional value for mandatory training developed as an online resource to ensure the adequate development of culturally competent skills. Mandatory training would ensure the development of cultural competence across the board and improve the dissemination of good practice if also monitored as part of quality assurance.

> "…Cultural competence awareness should be a part of all induction programmes…" **Stan- White British -Provision manager – Provider -6 years' experience**

And;

> "…training that includes a definition of cultural and population diversity…" **Fran – White British –Commissioner -5 years' experience**

Another participant insisted on the need for a culturally competent manual in addition to online training. Other issues mentioned related to poor awareness observed as part of staff behaviour (bias, discrimination, misdiagnosis, safety, inequalities, and less spending on interventions for vulnerable groups). Participants also pointed out the requirement to address patients' needs in more adequate ways;

> "…n*o training means that staff cannot assess the cultural needs of patients…"* **May- White European- Provider Manager-Provider - 3 years' experience**

Likewise, the difficulty translating theories and research into practice was mentioned by a participating stating;

> "…without training there can be no translation of knowledge to practice…" **Sandy-White British- Engagement Manager –Provider – 1 years' experience**

And;

> *"...without training, staff cannot improve on their knowledge of how to use what they have learnt…"* **Fola –Black African-Commissioner- 4 years' experience**

Participants agreed that the difficulty ascribed to improving culturally competent commissioning and practice in general is related to a lack of training/culturally competent related CPD. It was suggested that without a training program, staff are unable to satisfy client needs. Furthermore, there was an assertion that the lack of specific culturally competent commissioning training/CPD available in the NHS makes it difficult for professionals to improve any culturally competent skills they may have or need to gain. There was a strong consensus that training/CPD fosters improvement and innovative discussion, as without it, innovation is impossible and the opportunity for new thinking and skills is lost

Likewise, the comment;

> *"…training helps teams have a common goal when new concepts are being introduced…"* **Zoe-Black British - Personal Assistant/Carer –Provider – 14 years' experience**

The final few comments were related to a wish for the development of a culturally competent training program that enhances learning;

> "*…new concepts require training and "…lack of training means people do not understand how to define cultural competence or include it in practice…"* **Fran- White- British -Commissioner -5 – years' experience**

Finally;

> "…n*o training means staff are ill-equipped therefore it is a big challenge…"*
> **Gwen-Afro Caribbean –Commissioner -4 years' experience**

The focus on training seemed to be about the lack of training as a challenge to the delivery of cultural competence. There was an acceptance that training should also be seen as a tool that assists better communication and should, therefore, be situated as mandatory in CPD. An interesting comment was of cultural competence being too important to only be part of one-off training sessions which might miss some employees but may also not be mandatory or comprehensive enough to be embedded practice. The concern was that it would not be sufficient for an organisation that has a high turnover because if staff missed sessions, they would remain untrained. Furthermore, most participants agreed that training should be integrated into a culturally competent commissioning framework to ensure all staff embrace it as a consistent approach.

The expectation is perhaps that participants and others could be trained to understand and practice cultural competence as a process and not an event to achieve once and for all. What makes this an interesting contribution is that if cultural competence is a process (continuous professional development) perhaps it is traditional NHS ideas and the delivery of so-called training that is the challenge to culturally competent commissioning and the delivery of MH services?

The data seems concerned with enabling people to learn to develop cultural competence. If the consensus is that cultural competence is an ongoing process, then there is a need to explicate learning processes that are enabling of the ongoing development required. A good example would be reflective practice for professional effectiveness, possibly using group supervision that would enable commissioners and providers to translate their experiences into new understandings of how to deliver culturally competent practice in commissioning and provision. Furthermore, the consideration of such a discourse gives a more robust argument and greater support to the claim this study seeks to make

concerning our understanding of cultural translation as a learning process for the development of culturally competent commissioning practice.

The further argument is that training professionals has to be an evolving process that demands the translation of relevant culturally competent knowledge as it best suits. This is a new way to qualify the definition of cultural translation.

The training theme is one that can be looked at as supporting or enabling cultural competence in commission or a challenge to cultural competence, see and figure 5.17 below. It is comprised of some of the main contributions from participants that are not included in the narrative above.

Theme 12: Training as an Enabler and Challenge to Culturally Competent Commissioning

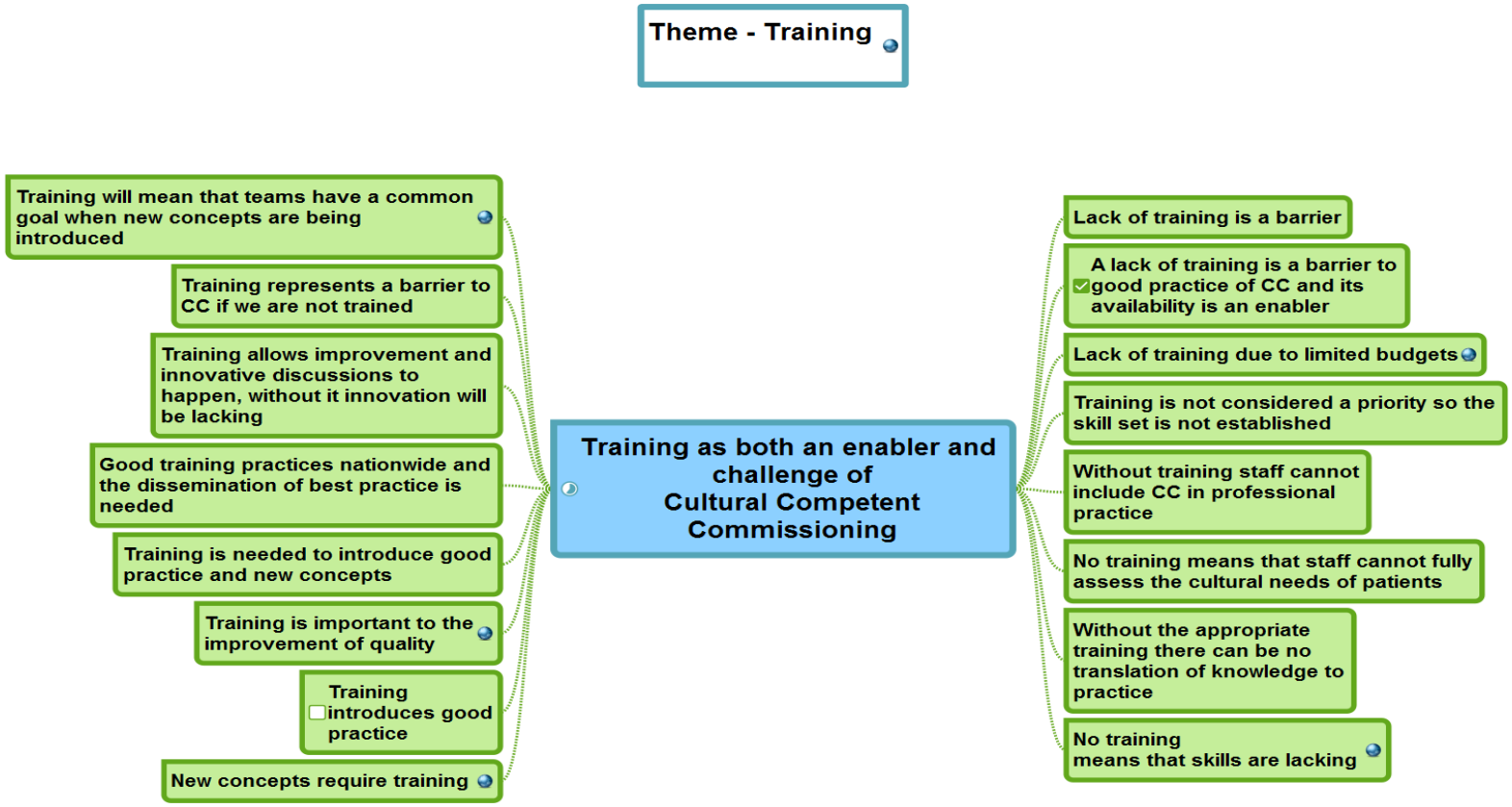


Figure 5.17: Training as an Enabler and Challenge to Culturally Competent Commissioning

Theme 13: Addressing the Challenges of Culturally Competent Commissioning

Participants were asked how the perceived challenges of culturally competent commissioning could be addressed. The data shows that the most important challenge to overcome might be that of the bias of staff (negative attitudes). Other challenges were related to the phases of commissioning, such as the needs assessment, planning, and procurement, monitoring, and performance phases (table 5.9). If any of these processes are not robust enough then they present a challenge to culturally competent commissioning. In commissioning there is always room for improvement as and when challenges are identified

Table 5.9: Addressing the Challenges of Culturally Competent Commissioning

Sub-themes	Number of Respondents	% of Respondents
Monitoring & Evaluation	1	2.78%
Make cultural competence a part of best practice	1	2.78%
Improved cooperation amongst agencies via joint commissioning protocols	2	5.56%
Increase resources	2	5.56%
Prioritise Cultural Competence	3	8.33%
Create CC commissioning guidelines	5	13.89%
Improve stakeholder mobilisation and engagement	5	13.89%
Address bias/staff perception	17	47.22%
Total	**36**	**100.00%**

The qualitative data elaborates further on how the challenges of culturally competent commissioning can be addressed. The development of culturally competent policies was mentioned as a means of addressing cultural incompetence, a new terminology to the study. There was a specific mention of the need to develop policies that support culturally competent related training for NHS and social care staff. Feedback included the matter of staff training and;

> *"… education should be compulsory. Community/service user inclusion should be central to commissioning not a token...."* **Matt-White British-Director of Commissioning and Enforcement-Commissioner-5 years' experience**

And;

> *"...Develop best practice guidance/information to share with commissioners..."* **Agnes-British-Manager–Commissioner -2 years' experience**

A significant theme was one that spoke to the need to raise awareness amongst NHS staff about the different cultures present in the population it serves such that being African is not confused with being Afro Caribbean and vice versa. The citation was;

> *"…recognise the diversity within potential service users…"* **Lena -White British-Dementia support officer -Provider- 5 years' experience**

And;

> *"...for health care providers to be more aware of the issues and needs of their patients and deal with these accordingly though it won't always be possible given with time and money restraints…"* **Ray-Black British- Counsellor-Provider-2 years' experience**

Given cultural awareness is one of the constructs of cultural competence it was not unexpected that the matter of awareness appeared as a common thread. It was evident from contributions that commissioners and providers who are also themselves service users recognise themselves as cultural individuals and therefore note that cultural competence should be a prerequisite for working in the NHS;

> "…*include as a prerequisite for employment and as a criterion for quality in services…"* **Stella-White British- Manager Provider -7 years' experience**

This statement might imply that staff should be skilled in cultural competence as part of their qualifications and would only be possible if training (education curriculum) is culturally competent specific. It would need to be included in relevant educational curriculum and all related research would need to be translated to practice and become a part of the mainstream to improve service user experiences, safety in diagnosis, quality in commissioning, and perhaps reduce discrimination and bias.

It is reasonable that participants would profess an expectation that positive outcomes from developing cultural competence should be promoted. A participant said this should be about;

> *"...demonstrating the value and benefits of cultural competence…"* **Tara-White British -Commissioner – 5years' experience**

Another participant offered;

> *"…implement policies demonstrating the positive outcomes that can be gained from cultural competence…"* **Tan-Chinese British - CAMHS Project Manager – Commissioner -3years experience**

Yet another participant highlighted;

> *"…emphasise the benefits of cultural competence and the positive impact that it can have…"* **Rufus- White British-Team Manager-Provider-1years experience**

Participants were particular about the need to increase allocated time and other resources towards CPD for the acquisition of cultural competence skills. Training was a common code that became categorised into a separate theme as it was considered both a challenge and an enabler of cultural competence concerning suggestions for addressing challenges identified. Participants considered training as an option for addressing cultural incompetence in commissioning. It was mentioned as a means of addressing people's attitudes and lack of sensitivity (bias). Could this be a reflection of how participants view the attitudes of colleagues, themselves, and experiences from those they receive services from, or does this perception relate to their difficulties in dealing with service users?

The training theme fits the literature review narrative concerning a lack of or the need for training, the literature relates to gaps in the training needed to address the lack of cultural competence within health systems. A further suggestion was;

> "…*staff training and culturally competent education (for clinicians) being compulsory, it needs to be a requirement for commissioners..."* **Matt- White British-Director of Commissioning and Enforcement –Commissioner -5 years' experience**

Additionally, another participant stated;

> *"…develop courses within regions, consider prevalence and demographic factors..."* **Max- Black African -Provider Support Officer -7 Months experience**

This theme implies that participants' comments relate to a significant need for training focused on the impact of cultural diversity.

Another important contribution by some participants put the focus on the need for appropriate policies for addressing the limited practice of culturally competent

commissioning. Participants felt that this should be a steer from the major stakeholders responsible for policy development in saying;

> *"…the government via the Department of Health has not considered it a priority nor has Public Health or NHS England…"* **Trevor- Afro Caribbean -Provider**

Another participant expressed;

> "…*the gaps in cultural competence are due to a lack of any culturally competent prioritisation in commissioning…"* **Uzo- Black African – Commissioner -3years' experience**

It was also pointed out that there are still issues and recent reports suggesting inherent cultural incompetence as the concept is not developed amongst managers/commissioners. This may be a suggestion of racism in the NHS and an assertion that many commissioners may struggle with the concept of cultural competence as it is not embedded in the commissioning process or vocabulary or literature. Other contributions are represented in the diagrammatic representation of the codes/quotes that contributed to the overall main theme addressing the challenges of culturally competent commissioning.

The diagram (Figure 5.18) shows the challenges in green and the offshoots (amber) represent some of the ideas (codes) that were offered as actions to address them

Theme 13

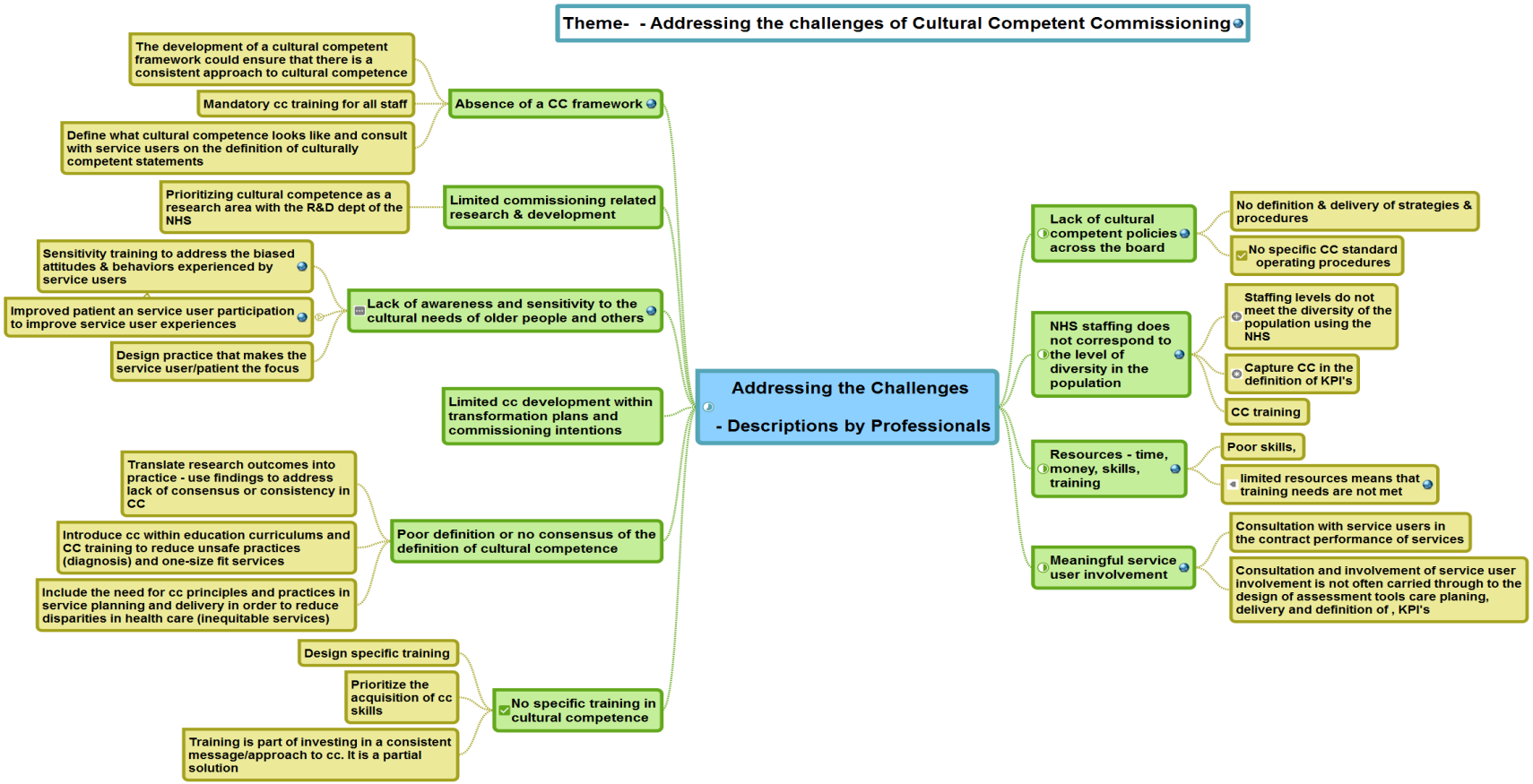


Figure 5.18: Addressing the Challenges of Culturally Competent Commissioning

Theme 14: Culturally Competent Leadership

Participants were asked what opportunities if any they had to practice skills that pertain to cultural competence in commissioning or otherwise. Several responses suggested that it is a task for the leadership of the NHS and further suggested the need for culturally competent communication in the hierarchy of the NHS. The main subtheme to this theme was leadership and communication, both being linked to all the other themes making it an overarching theme. Good leadership is based on good knowledge and the communication skills to express what needs to be done operationally. It is suggested further that this is a reference to leadership within the commissioning and delivery ranks.

Participants also focused on the leadership external to the NHS, this refers to the local authority and other partners. This category is defined by the participant's suggestions that governmental organizations should take the lead in ensuring the required changes within the NHS. This is about the need to set culturally competent governance from the Department of Health, perhaps even from the Minister of Health. Regarding the first code leadership characteristics, participants declared that beyond government leadership, compassion and sensitivity need to be evident;

> "...*The government should take the lead and also researchers..."* **Matt- White British-Director of Commissioning and Enforcement -Commissioner-5years experience**

There was some consensus on the need for a skilled workforce that is led by sensitive compassionate leadership; this is only possible if learning is encouraged via CPD. It seems that participants perceive the cultural competence of the NHS to be the responsibility of the top hierarchy of the NHS. This responsibility may be related to recruitment and retention and the skilling up of the workforce in cultural competence as participants assert that there is a need to increase the skill mix with training in appropriate competencies. A commissioner participant indicated that;

> *"...a sense of clear cultural competent leadership that could warrant the need for a culturally competent agency of some sorts..."* **Kath-Black British –Commissioner- 4 years' experience**

Another commissioner argued that;

> *"...the NHS Leadership should design culturally competent outcomes that are measurable and fit the needs of the population*…" **Ola-Black African –Commissioner -5 years' experience**

It was further suggested that institutions and national organizations, such as Public Health England and other stakeholders should lead the way in developing the required changes that the Staffordshire inquiry recommended, a culture of change in the NHS. There was a suggestion that there should be a pooling of all available resources in England and Wales, but we need commissioning leads to understand the specifics of their locality and use national forums to improve culturally competent inclusion. This could be a suggestion that the main opportunities exist at the national level where policies are defined, it is a reference to national leadership. Research was also mentioned as an arena where leadership is capable of influencing cultural competence;

> "...consultation with appropriate scholars in the field and the leading health research agencies..." **Gwen -Afro Caribbean – Commissioner -4 years' experience**

The implication is for research to be translated into practice in the leadership hierarchy of the NHS given the NHS has a research and development department. A provider participant concluded that;

> *"...all agencies responsible for inspecting care services and secondary care should lead the way in including cultural competence as a hallmark of quality…"* **Agnes –White European -Provider- 3 years' experience**

Participant perception of where the steer of cultural competence lies is at the national level and within the institutions that have responsibility for setting the policies and targets for health (treatment and prevention). This would also include the agencies that develop guidelines and lead research and development, including those responsible for inspecting the quality of health and care delivery. Theme 14 is represented diagrammatically in figure 5.19 below and links communication to leadership in the ranks of the NHS and other health agencies.

Theme 14: Leadership in the NHS

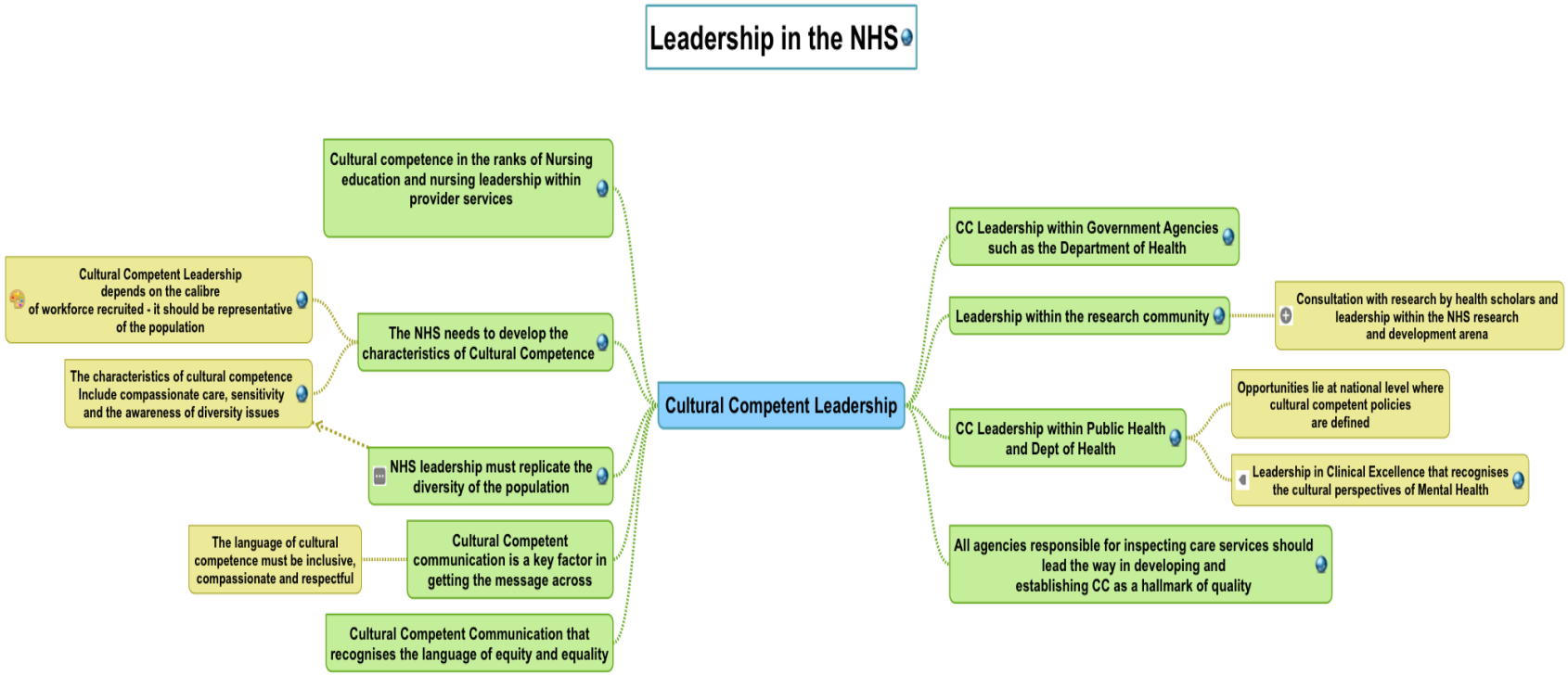


Figure 5.19: Culturally Competent Leadership

Theme 15: Culturally Competent Commissioning Framework Criteria

Participants had a consensus opinion on a need for a code of conduct framework that could ensure consistency in the practice of culturally competent commissioning. The significance being that occasional training may not mean that the whole workforce is trained due to staff schedules and the nature of health delivery roles and shift patterns. It was suggested that training would have to be mandatory, far from being a tick box exercise because of the high turnover of staff in some departments. It was also a significant mention given the need to take cognizance of the very different population that the NHS has to care for and the statues that still align with the 1948 era. Table 5.10 and figure 41 show the criteria or guidelines suggested for inclusion in a culturally competent commissioning framework for mental health services. The need to create an awareness of cultural competence amongst professionals and service users (23.8%) and the development of culturally competent policies (23.8%) were the most popular suggestions.

Some of the contributions (excerpts) are offered in this section while others are included in the diagrammatic representation below. The contributions are also considered further in the discussion chapter.

Some of the suggestions included;

> *"…defining meaningful cultural competent statements…"* **Fay –White British Provider manager-4years' experience**

Another participant remarked that;

> *"…the use of definitions that are meaningful and simple…"* **Julie -White British- Information worker- Provider -2 months experience**

That this could be achievable by achieving a consensus on what cultural competence is and what it should look like in a service and that most importantly;

"...Simplicity and meaningfulness should prevail in defining the notion of cultural competence..." **Abi-White European-Commissioner -6 years' experience**

A GP explained further;

> *"…different cultures should inform NHS services along with a visualization of what it should look like and another commissioner commented "…use discussions at commissioning meetings to gain a consensus as to what culturally competent dementia services should look like at local and national level or adhere to the findings of a local needs assessment*…"**Usman – British Asian -GP Commissioner-10 years' experience**

A few participants put the focus on translation services as part of good communication as a facilitator for understanding culture and diversity issues. These participants made suggestions that a communication and engagement strategy could be included in a culturally competent framework for commissioning along with the use of good definitions that providers/commissioners can understand and can implement and measure.

> *"...include the definitions or criteria of what culturally competent (dementia and mental health) services should look like so that professionals have a better understanding of what needs to be designed and monitored…"*
> **Jenny- White British-Consultant-Commissioner -8years' experience**

Although no specific research-related questions were asked, research was mentioned by a few participants concerning increasing a deeper understanding of cultural competence. Participants felt that more research could help to support the implementation of a culturally competent framework. Participants stated that;

> *"...researchers can give suggestions as to how cultural competent principles can be used to enhance service commissioning and delivery…"*
> **Betty- Canadian -Group coordinator –Provider- 1.5months experience**

A related statement corroborating the idea of more research was related to transferring research findings from theory to practice;

> *"…include the need for consultation with academia and clinical researchers which could mean research can inform commissioning practice…"* **Rufus-White British -Team Manager- Provider-1years' experience**

And;

> *"...more research on how cultural competence can make services efficient and save money in current periods of austerity measures/cuts…"* **Abi – White European –Female -Commissioner -6 years' experience**

A final statement in the research domain;

"...Use evidence from research". Not enough research in the area, include the evidence base and actions that are translated from research and service user consultation should be included …" **Uzo-Black African-Commissioner -3 years' experience**

Shared knowledge was also an observation noted by participants as they pointed out the need to share cultural information between commissioners, service users, and service providers;

> *"…offering educational/learning sessions that are culturally competent (lunchtime learning sessions at work) …"* **Mary - White British-Team manager - Provider- 3 years' experience**

Another participant commented that;

> *"…sharing examples or case studies of where culturally competent services have been implemented and worked successfully so we can show commissioners the importance of cultural competence and ensure funding is set aside to implement changes…"* **Sue – White British –Dementia Social Worker – Provider - 1.5 years' experience**

Once again funding is seen as crucial to promoting cultural competence and supports the belief that a lack of funding could be a challenge to culturally competent commissioning. This initiative is related to the desire to collaborate and improve the quality of the services provided, this was expressed as;

> *"…specify the need for promoting cultural and linguistic competency e.g. display posters of different ethnic backgrounds, ensure provider information is available in different formats and languages…"* **Zainab -British/Asian-Governance Lead - Commissioner <1years' experience.**

Other contributions are represented in the below along with other codes/quotations. The significant contribution of participants was the need to ensure the addressing of language barriers which means that regardless of the ethnicity, health literacy, and socioeconomic status of stakeholders, participation would be valuable. Overall, it is suggested that the success of the design would also depend on it being a road map of good practice that relies heavily on evidence-based practice from other agencies and research. The purpose of a culturally competent commissioning framework is more than about ensuring consistency in the practice of cultural competence. Ultimately, it is about improving the quality of clinical judgments as they relate to the care of frail adults and other vulnerable groups affected by dementia or other mental health conditions. On another level, the development and adoption of the framework could overcome the difficulties in implementing organizational initiatives to improve the quality of mental health care. Gask et al, 2008 argue that these difficulties result from constant changes within the NHS among other things.

Table 5.10: Guidelines for a Culturally Competent Commissioning Framework

Sub-themes	Number of Respondents	% of Respondents
Simple principles	1	3.85%
Evidence from and health agencies	3	11.54%
Definitions of good practice	3	11.54%
Evidenced based research	3	11.54%
Service Quality indicators	4	15,38%
Address language barrier	6	23.08%
Stakeholder engagement	6	23.08%
Total	**26**	100.00%

Participants were asked to suggest criteria that could be used to develop a culturally competent commissioning framework; the suggested criteria are shown in Table 5.11 and figure 5.20 Study participants were first given the option of a culturally competent MH commissioning framework with an embedded training manual or a stand-alone culturally competent training manual to choose from. They were asked which would be the best choice to enhance culturally competent commissioning. All participants chose the culturally competent framework with an embedded training element; therefore, they were further asked to suggest criteria to be included. Top of the list was the need for a clear definition of cultural competence to establish the purpose of cultural competence in commissioning (20.45%). This matches up with the literature that calls for a consensus definition to deal with the complexity of its practice, measurement, and communication.

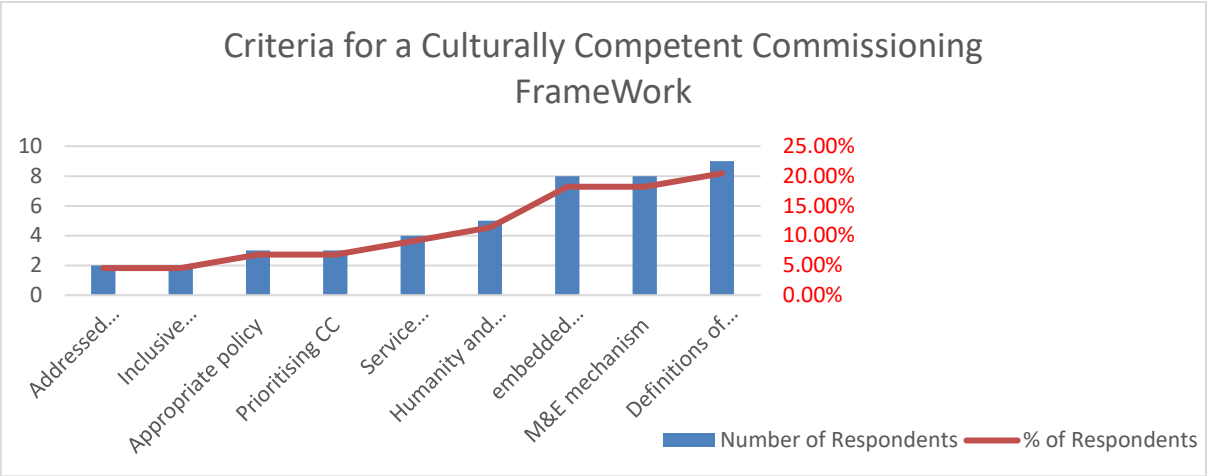


Figure 5.20: Criteria for a Culturally Competent Mental Health Commissioning Framework

Theme 15

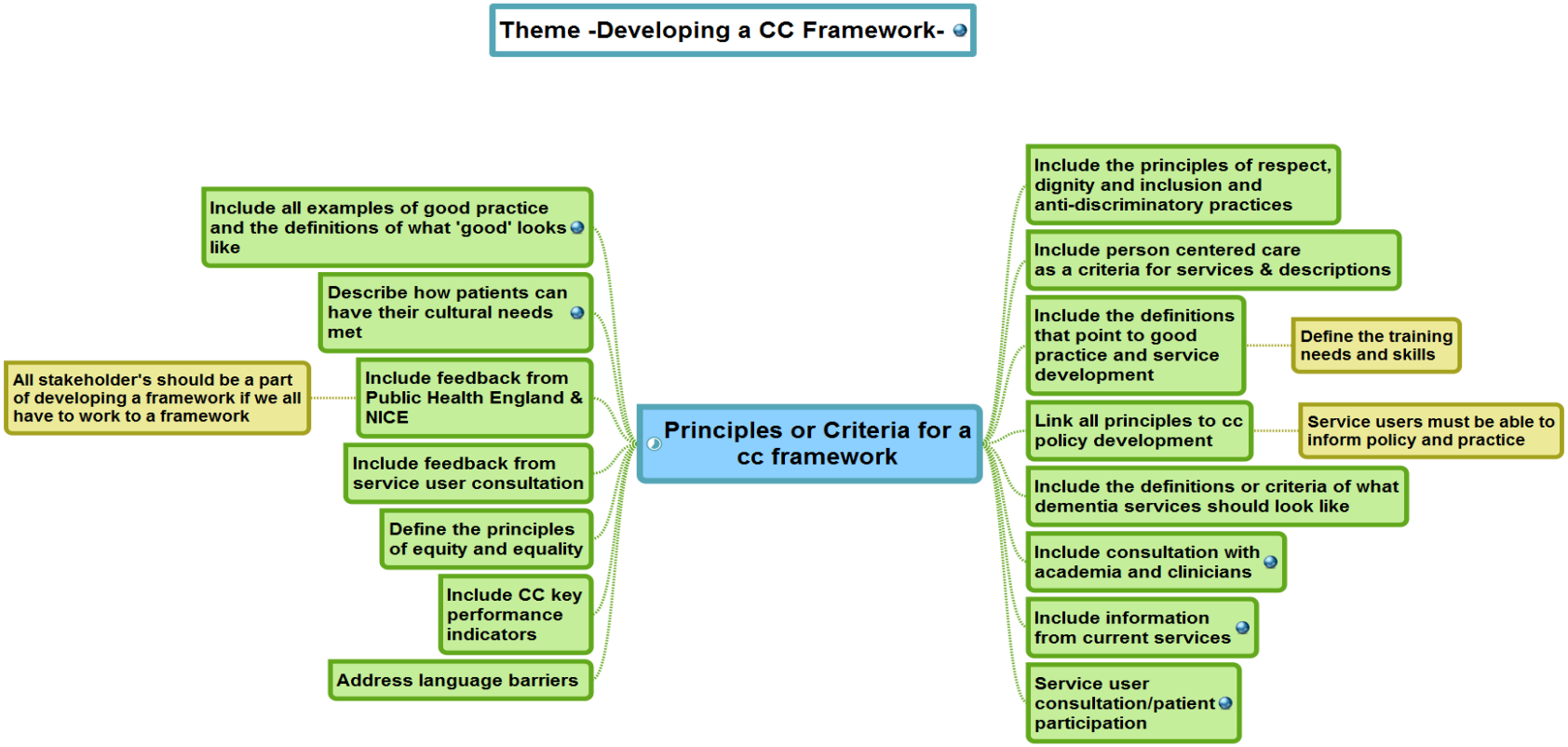


Figure 28: Developing a Culturally Competent Commissioning Framework

In summary, it is interesting to note that when considering the responses of participants across age groups there does not appear to be any significant relationship between the level of understanding of cultural competence and age difference. The suggestion is that age is not a determinant of cultural competence in professional practice and neither is ethnicity. This may suggest that ethnicity is not a determinant of culturally competent practice. The number of years in a role or the type of role did not appear to cause respondents to describe or define cultural competence in ways that showed dissenting views. The survey question required participants to reveal the number of years they had been working in their roles, when considering responses based on the number of years, there were no differing opinions expressed across the board.

Chapter 6 focuses on discussing the findings of the study. The findings are a mix of the significant contributions of the study participants, the reflections from previous studies, and those of the researcher. Though Johnson and Onwuegbuzie (2004) argue that the mixed method approach is not yet able to provide perfect solutions, it does retain a capacity useful to researchers. That is to use both quantitative and qualitative research alongside a philosophy that can attain the best feasible solutions. This suggests that the study can offer guidance and new knowledge that may accomplish goals which include improving the relevance of cultural competence in commissioning, leadership, stakeholder engagement, and criteria for a commissioning framework.

Chapter 6

Discussion of Findings

6.0 Introduction

A pragmatic philosophical approach was used to conduct this study to enable a comprehensive understanding of the phenomena via a main research question and sub-questions to guide the reporting of findings (Biesta, 2010; Onwuegbuzie et al 2009). The focus of the study was an iterative investigation of the challenges and opportunities for commissioning culturally competent mental health (dementia) services for older people and others.

The context for the research is a consideration of the nature of increasing healthcare disparities that affect those who are affected by mental health conditions within the changing demographics of the UK population. Secondly, a consideration of those living with the challenges of dementia, with limited access to culturally competent services. The study considers dementia as an example of a mental health condition/service along with the issues that affect the population using dementia-related services. Older people, those with disabilities, and from BME or LGBTQ communities are referred to as vulnerable populations in this work.

Although dementia is mainly a geriatric condition, it affects a younger population also (early-onset dementia) thereby increasing the prevalence of dementia considerably. When considering the current UK population affected by dementia, we find that it affects people of diverse backgrounds who are further impacted by the nature of differing access to services along with the cultural perspectives of health-seeking behavior. Furthermore, there is anecdotal evidence of the difficulties that older people, those with disabilities, and BME cohorts have when accessing services. This study of cultural competence, therefore, considers issues relating to the capacity to cater to the cultural needs of vulnerable groups.

This discussion section is covered in 6 sections via an interpretative methodology and research design that has yielded several themes and closely related subthemes. For this reason, the discussion is organized logically and in keeping with the summary of the themes/subthemes as they pertain to the sub research questions. This layout was chosen for 3 reasons; first, it favors the use of mind maps that link the themes together

and jointly with a narrative that relays the richness of the mixed quantitative and qualitative data collected. Secondly, it showcases the mixing of the data, which occurred first at the level of collection (mixed-method questionnaire). The second level of mixing was at the analysis stage and then the interpretation stage.

Section 1 is a discussion of the understanding, perceptions, Practice (skills) and influence participants have concerning cultural competence in NHS commissioning. This narrative relates to the perception of the NHS as a culturally competent organization in terms of its practices, vision, and workforce. The themes expressed were drawn from the analysis of relevant responses to questions from the survey questionnaire and in-depth interview phase. The questions assume what can be known of the NHS as a culturally competent organization and is based on the perceptions and experiential knowledge participants have of their own practice/experience and that of others. This includes their experiences as service users also and their perceived capacity to practice and influence culturally competent practices.

Section 2 discusses the challenges and opportunities of culturally competent commissioning and secondly, the narrative of how the identified challenges can be met. The challenges identified were related to the commissioning of culturally competent services, training/CPD, the lack of a consensus definition and resources, bias, and the makeup of the workforce. Service commissioning and the subsequent delivery of services are closely related aspects of healthcare as they are driven by guidance/policies, resources, research and development, bias, service user engagement, equity/equality, and principles of inclusion. This means that services and commissioning practice are only as good as the quality of these tools which are crucial at a time when the NHS and Social Care are working towards a more integrated care system approach to establish an improved seamless care provision and procurement. The implication is that the commissioner-provider divide is becoming narrower making the discussion of challenges and opportunities significant in the discussion of equity and equality in service delivery. The consideration of both areas enables a more robust discussion in terms of how linked they are and how they can be improved.

Section 3 focuses on the culturally competent perspectives of BME and non-BME participants as this data was collected; this relates to achieving an understanding of the underlying drivers of cultural competence as they may relate to individual cultural perspectives. The significance of this quality speaks to knowing whether cultural backgrounds are implicated in the understanding and practice (drivers) of cultural competence. Furthermore, it is also about ascertaining whether participants have an acceptance that cultural competence is not about race, but the values held by individuals. What further research might consider is how the diversity makeup of the leadership of the NHS may or may not influence the understanding and/or practice of cultural competence.

Section 4 discusses the importance/significance of cultural competence in the commissioning of services (for older people and others) and the importance of the adoption of a culturally competent commissioning framework might have on commissioning. Participants were asked if cultural competence is important to commissioning services to older people in the survey questionnaire, second phase participants of the in-depth interview were asked what significance it had to commissioning in general. For further value, participants were asked to suggest criteria/guidelines for the future development of a culturally competent commissioning framework for dementia/mental health. The purpose of this question was 2-fold, first to gain insight into what study participants consider relevant to improving/influencing culturally competent practice. Secondly, to ascertain what recommendations should be considered for future research.

Section 5 discusses the factors that influence or drive the understanding and levels of practice of cultural competence. The discussion is based on themes from the interviews and survey phase. The 2 phases were about exploring the experiences of participants and their perceptions of the challenges of culturally competent commissioning along with their suggestions for meeting the challenges. The suggestions on offer give some insight into those factors that can influence cultural competence. It is suggested that the limit of the suggestions offered correlate to the limits of the understandings of participants.

Section 6 offers a summary discussion of the other relevant themes as they relate to the overarching research question and provide better insight into the phenomena under investigation.

Section 1

Perceptions of Cultural Competence and Commissioning amongst Participants

To capture levels of understanding, participants were asked about the status of cultural competence in the commissioning organization they work for (NHS) and the provider organisations they work with.

Research participants showcased their understanding of cultural competence in MHS commissioning by describing services that are and offering definitions for the concept. They defined the components that express cultural competence, the practice and weaknesses, and suggestions for improving it. They suggested or described the roles professionals play and the inclusivity of service users in designing services (engagement and mobilization). The features of definitions/descriptions of services included equality, equity, diversity, non-biased attitudes, language, and other elements that relate to gender, religion, age, and disability. These are important factors as they may contribute to the definitions of the drivers, beliefs, and influence participants have in practicing and promoting cultural competence.

In consideration of the above, this study may argue that the definitions and perceptions of cultural competence offered by participants are relevant on several levels. The first is the notion of the NHS as a culturally competent organization, secondly, the level of practice amongst professionals and thirdly, participants' expectations for themselves or others when considering, seeking, or receiving health services. These expectations vary according to cultural setting, education, age, gender, and other beliefs such as they may be. It is these dynamics that professionals are asked to be sensitive and aware of when responding to the expectations of other cultures (Dogra, 2001) and when commissioning health or social care services. This fits in with cultural competence as a dynamic continuum (Ferguson, 2003). Fourthly, the elements of the shared definitions (15) are those that drive professional/participants practice or relationships with service users. This is a dynamic that fits an earlier definition of cultural competence as a process of working with patients from different cultural backgrounds other than one's own (Hadwiger, 1999). A sixth level for consideration asserts that the definitions (cultural competence as a vehicle that ensures quality, safe diagnoses, and non-discriminatory practices) are a consideration of how service users' expectations should be met. This fits the definition

offered by Kondrat et al (1999), that the best practice approach is pragmatic, practice-driven, and results-oriented. Furthermore, it is an argument for the reasons why the aspirations of service users should be reflected in key performance indicators.

Understanding service user aspirations (needs) and being able to specify these when procuring services is a crucial part of the needs assessment process and pertinent to the commissioning cycle. This relates to an assertion by Cross et al (1999), that the agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations should be culturally competent. This should be the focus of commissioning for diverse populations with a high prevalence of mental health conditions.

Cultural competence definitions offered by participants had common themes; they related to dignity, respect, compassion, support, and fairness and are linked to modes of communication and the expectation of good outcomes of care, treatment, therapy, recovery, and wellbeing. As the participant group was made up of nurses, a GP, social workers and career commissioners from similar professions related to health a code of practice or framework promoting cultural competence would be useful.

Commissioners and providers are required to focus on what is referred to as the 'patient journey'; the pathway service users follow (access –assessment –treatment- recovery) as they move through the health system. The process of accessing the interventions and moving through the system is called the care pathway. The patient-journey is defined or mapped out by commissioners in partnership with other clinical or non-clinical professionals (providers) and service users where appropriate during the planning cycle. It can also be influenced by carers, evidenced practice, joint commissioning decisions related to gaps in services, recruitment, government policy, and resources. These were the areas shared by participants as opportunities to be culturally competent or influence cultural competence. This is because these are the areas that providers and commissioners participate in aside from policy development, training, research, and contract reviews, quality, and performance management.

Commissioners have a vested interest in how the patient-journey can be improved as it affects the outcomes of quality, efficiency, and cost. All 3 are areas performance managed by commissioners whilst monitoring key performance indicators (KPI's) which are set by both commissioners and agreed to by providers. These KPIs are related to

access, waiting times, service user experience, models of care and treatment outcomes etc. This would explain the underlying notions that influenced the definitions offered by participants as they included the importance of fair access, resources, equity, and equality in their definitions. Furthermore, it must be noted that while participants offered their opinions on what is needed, they equally referenced those that need to be eliminated (disparities, bias, discrimination, misdiagnoses language barriers, and other forms of unfair conduct).

Much can be deciphered from the definitions offered; making it useful evidence as to what might drive practice and give insight as to why it is timely for the commissioning arena to have a working definition of culturally competent commissioning. A working definition influenced by the contributions of study participants is offered in the recommendation section. Furthermore, to state that its causal factors are its drivers as asserted by Jongen et al (2018) suggests a good reason to argue that the drivers of cultural competence justify the importance of cultural competence.

The role of the National Health Service in meeting the needs of a diverse population that is now far different from the population that existed when it was founded in 1948 must change. This can be attributed to the views, norms, backgrounds, and beliefs present in the population of that time which are now different. This would mean that the setup principles at inception were suitable for the mainly mono-cultural population (Sue, 1999, 2003; Bernal and Scharron-Del-Rio, 2001 but no longer for the current population. This should suggest recognition that safety in diagnosis, therapy compliance, equity, equality, fairness, and service user satisfaction cannot be achieved within a historical system. For these reasons health and social care professionals need to consider the benefits of cultural competence to commissioning and service delivery equally, and the hierarchy of the NHS should change the culture of the NHS substantially away from the guidelines and culture of that time to fit in with the current population. This is about treating all individuals differently yet equally in terms of accessibility and experience throughout the care pathway. Furthermore, given the higher number of older people living longer but not healthier (affected by dementia and other long-term conditions); cultural competence becomes an even more desirable concept capable of enhancing or promoting compassionate care.

Cultural competence can cater for significant variations in age, language, ethnicity, gender, and sexual orientation, history of trauma from wars and famine, disability, and

the religions present in the population. For this reason, the National Health Service along with partner agencies must develop policies that promote equality, equity, and respect for diversity and the needs of older people (National Older People's Framework, 2014). This is in keeping with the assertion that the NHS needs to develop the capacity to function effectively (Cross et al, 1989:13) and the Mid Staffordshire report (2015) that called for a culture change within the NHS.

Significant efforts have reduced health care disparities across the board for ethnic minorities, vulnerable and older people because health professionals are becoming aware of themselves (bias) and not letting their self-awareness affect service users (Purnell and Paulanka, 2003). There is still a long way to go, Smith et al 2009, Papadopoulos et al 2006 and Bhui et al 2007 contend that in terms of Mental Health, cancer, and stroke, minorities receive similar services that are inferior to those of Caucasians. This is because there are still many of the challenges (disparities in healthcare) that have been identified by participants in play today.

The challenge of our time is how to ensure that all service users regardless of culture have a valuable and equitable experience of health and social care. The appropriate response to this challenge is what this study attempts to offer. The problem being how to equip professionals with the skills, awareness, and knowledge competencies capable of ensuring optimum provision and engagement of service users from diverse backgrounds? For this reason, cultural competence must be considered as a tool capable of addressing the major inequalities in health care. Its constructs provide the desirable skills which are a major feature of cultural competence, a journey or process of being or becoming culturally competent as there is no endpoint to be achieved (Camanha Bacote, 1999, Bentley et al, 2008, Capell et al, 2007and Dudas, 2012).

Section 2

The NHS as a Culturally Competent Organization

To give participants a chance to discuss cultural competence in their practice and that of others along with their experiences of the services they use a question was asked of about their perceptions of the NHS as a culturally competent organization. A range of responses were offered while some claimed to be unsure of whether they could judge the NHS to be culturally competent. The themes that contributed to the perception of the NHS as culturally competent were developed from the responses relating to influence, practice, belief, and how important they perceived cultural competence is to commissioning services for older people and the possible opportunities for cultural competence in commissioning.

Some participants suggested that though there were pockets of good practice this was not enough to agree with the perception of the NHS as a culturally competent organisation. This is perhaps because cultural competence in commissioning practice is not yet consistent across the board, explicit in policy or measured for quality purposes as that is what is needed. Responses varied from being uncertain, not sure, and sometimes, to strongly disagree, such perceptions may be based on experiences as employees who understand the workings or responsibilities of the NHS or as service users with varying experiences of services.

A culturally competent health organization is one that has a good grasp of the services needed by the population in terms of quantity, quality, technology, professional development, workforce, and resources. This grasp of what is needed and or responsibility also stretches to understanding the opportunities and challenges of culturally competent commissioning and the cultural needs of a diverse UK population.

Participants were asked to put their responses into context; these are captured in the contributions that offer further insight into the understanding participants have of the status of NHS as a culturally competent organization. These themes and subthemes were captured or developed as ‘the ‘NHS is not a culturally competent organization’, ‘the uncertainty of the NHS as a culturally competent organization, and the ‘NHS is a culturally competent organisation’. The suggested perceptions are captured as a summary of the main codes that define the suggested reasons why the NHS may or may not be considered culturally competent.

The Culturally Competent Organization

The determination of organizational cultural competence is closely related to its infrastructure and diverse workforce. It would be difficult to argue otherwise and extends to the design of buildings and services that enable optimum access for those who may be challenged with any form of disability, the workforce, policies, and values/beliefs. These are factors that should influence or drive recruitment concerning the level of diversity in the population. In addition to these administrative factors; direct service personnel, improvement of workforce personnel, cultural competence, and the documented way organizations act on factors that have a link to cultural competence cannot be ignored (Hernandez et al 2015; McCalman et al, 2017; Jongen et al, 2018). These factors have been described as markers that articulate the importance of cultural competence and reflect the commitment of organizations to cultural competence (Hernandez et al. 2015).

Relevant governance that is culturally competent needs to be in place as a vehicle to enact the right policies, procedures, and goals especially those that relate to communication. Communication is essential for cultural and communicative competence in the caring relationship with patients from other cultures (Hemberg, 2017). This is because the exchange of information between health organizations and the communities (service users) they serve must achieve maximum engagement. Engagement with service users and other stakeholders was suggested as an opportunity to influence cultural competence as it is critical to the quality of health care (Markova and Broome, 2007). Cultural competent communication is also crucial to responding to the impact of increasing demographic changes (Teal and Street, 2008); promoting the reduction of disparities (Taylor and Lurie, 2004) and the development of end of life care (Randhawa et al 2003; Kataoka et al, 2017 and Brown et al, 2016).

The main examples of the opportunities suggested by participants as related to influencing cultural competence were related to research, leadership, recruitment, training, and the commissioning process. These were aside from engaging with service users in the design of services, care pathways, location, and availability of services. In terms of a few participants' views as to the perception of the NHS as a culturally competent organization the theme is described as 'the NHS as a culturally competent organization'. It is made up of the collective of the sub-themes or codes of which the

mention of recruitment of people from diverse backgrounds is very interesting. Its significance relates to the emergence of another issue around inequality in human resourcing (diversity in the hierarchy of the NHS), as well as perceived discrimination in the NHS. These issues are those that may also be addressed by cultural competence.

Training (via Continuous Professional Development)

The main suggested challenge to culturally competent commissioning was training or the process of learning cultural competence (CPD), this fits with the consensus amongst health research scholars studying ethnic disparities. They assert that cultural competence training is linked to improved health outcomes (Betancourt and Green, 2010). This is about learning and is linked to the concept of cultural translation which is defined as the ability of a professional to move away from a one-size-fits discourse in service delivery (or commissioning). It is accomplished by learning from each cultural encounter and relating it to different groups in ways that suit and ensure meaningful service experiences.

The learning process starts during the professional training of practitioners and follows through to work-based learning via CPD and may offer a conceptual bridge between the findings of this study and the argument for cultural translation. Cultural translation in the context of this study refers to a reworking or recontextualisation of culturally competent knowledge (Allan et al, 2015).

Healthcare disparities (fragmented care) are noted in older people's care where limited healthcare literacy is implicated as an independent factor alongside the demographics of populations and access to healthcare (Sudore, et al 2006). Pecukonis et al, 2008, argue that training is a means to promoting inter-professional cultural competence learning to ensure cross-disciplinary practice. This is essential to joint commissioning as the health and social care sector is slowly moving towards a more integrated approach of commissioning. The purpose is for an integrated care system (ICS). This is a notion supported by the outcome of a study by Delgado et al, 2013, demonstrating an increased level of cultural awareness after culturally competent education. That being said, a review by Chusman & Schiltz, 1997, asserts that several training programmes developed for healthcare professionals on cultural competence are based on incomplete conceptualizations. Perhaps what this means is that training programmes have been

focusing on improving the skills of professionals based on ideas that have not been fully tested or rationalized.

In the clinical arena, current training models focus on developing non-technical skills such as empathy, openness, or kindness (Seeleman et al, 2009) and the attitudes (cognitive and evaluation components) needed by healthcare professionals (Seeleman et al, 2009). Training often targets specific health professions such as nurses (Purnell, 2002; Jirwe, Gerrish, Keeney & Emami, 2009) or physicians (Mostow et al, 2010; Perloff, Bonder, Ray, Ray, & Siminoff, 2006). Others concentrate on specific specialties (Qureshi, Collazos, Ramos, & Casas, 2008) or health promotion (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003). This study asserts that for all the availability of cultural competence there is rarely much of cultural competence training that applies or attends to career commissioners.

In Canada, it has been deemed necessary to develop culturally competent indigenous mental health programmes to enhance the skills of professionals across the board (Kirmayer et al, 2012). Once such programmes are developed the appropriate training must be designed with service user input to embed the right skills for trainers and professionals alike. This results in necessary training materials being developed to tackle any demonstrations of cultural incompetence (Betancourt, 2006; Ring, Nyquist & Mitchell, 2008; Tseng & Streltzer, 2004; Warren, 2000).

Training is crucial to the enhancement of culturally competent communication, service user engagement, and provider-leadership. This being said, some scholars still assert that the methodological rigor of training programs is limited and a challenge to the measurement of the desired impact (Crosson, et al, 2004; Beach et al, 2005; Green et al, 2007 and Price et al, 2008). Measuring cultural competence was cited as a challenge by participants, this is because it is rarely measured or considered as part of performance indicators (KPIs)and therefore rarely addressed or prioritized. This being the case, this study suggests that cultural competence must be measured as a hallmark of quality, an indicator of high or improved performance, and include the experiences of service users.

Bentley et al (2008) argue that as far as the UK is concerned, efforts in training health care professionals in cultural diversity are inadequate. Using the NHS as an example it can be argued that as far as the need for person-centered care and the development of healthy work environments is concerned, cultural competence is an essential factor. This

was supported by the proposal commissioned by the Cochrane Review (2007), that culturally competent skills are essential to systematic change. That being said, the UK has not considered the urgency this represents as much as the United States where the term and the concept are present in literature, insurance, and business-related to health. This means that the United States leads the way in culturally competent training models for healthcare professionals.

In both phases of this study participants overwhelmingly offered training as both a challenge and enabler of cultural competence. The very nature of healthcare professions and those associated with designing and delivering services makes the need for training/CPD an essential requirement. A study by Pecukonis et al 2008 concluded that professionals were not prepared for interdisciplinary practice as they were not trained across disciplines or care models and that this was related to diverse professions and training in health education environments (undergraduate level) also. It is argued that the way forward is for a professions' specific "cultural frame", this agrees with Pecukonis et al, 2008.

Training/CPD - Culturally Competent Leadership

Training was suggested as a reason for the limited perception of culturally competent leadership and therefore a challenge to cultural competence. Most strategic leaders in the hierarchy of the NHS usually have clinical backgrounds and should understand the cultural perspectives of disease and its role in cultural safety and diagnosis. Culturally competent leadership should be an essential skill amongst this group as they define policy and practice, furthermore, this power dynamic also determines budget management, commissioning intentions; spend on training, recruitment, and professional development. They further determine how training programmes are set within clinical settings and the level and nature of inter-professional communication, conflict resolution, and the management of partnerships/relationships. Cultural competence is important in all these areas especially at a time when the social care and health agenda are merging into an integrated care system.

Training: Teaching of Cultural Wisdom

Cultural competence, aside from being a translational process, could also be known as a type of collective professional wisdom that is the cultural skills learned over time towards becoming culturally competent. This type of wisdom is referred to as *phronesis* meaning 'practical wisdom' that is derived from learning practical things. It is an Aristotelian concept linked to the development of virtue and character (Cook and Carr, 2014).

The teaching of wisdom is about the development of professional knowledge via CPD, it is crucial to commissioning which is a profession that does not have a set of qualifications. This means that learning and skills acquisition in the health care commissioning arena is crystallised through an integration of theory with practice in the workplace (Richardson, 1999).

Phronesis should be considered in terms of 'practical ethics', which might provide a powerful platform for training and development due to its bearings on professional knowledge (Kinsella & Pitman 2012)

In recent times the organisational culture of the NHS has been implicated in the mistreatment of service users resulting in mismanaged care and loss of life. The headlines of more than one public inquiry were summed up with a statement that revealed 'a profound crisis of culture' following evidence from 200 people (Mid Staffordshire Francis Report, 2015). Sir Francis suggested that the only solution to the 'cultural crisis' was a cultural revolution, his report further asserted that the NHS Constitution should be revised. This concern was related to ensuring transparency and candour systemically; strong leadership in nursing and other professional values; more support and training for those in leadership roles.

This study argues that the Sir Francis inquiry findings support the need for cultural competence training to enhance the status of cultural competence that focuses on exploring cross-cutting issues such as age (ageism), race, ethnicity, leadership, bias, and culture. This would go a long way towards increasing awareness of the biases held by both professionals and service users. It could have a positive impact or warrant a review of the Mental Health Act (Dec 2018) including recommendations for recognising cultural needs and culturally appropriate advocacy.

During the study, it was noted that participants (non-BMEs) often considered cultural competence and their practice of it to mostly be about race. By race they meant BME's, this could be misinterpreted as meaning that non-BME participants considered the concept to be about commissioning or delivery of services specific to ethnic minorities. They further offered the cost or cultural competence as a challenge to its practice not considering that it is attitudes, conversations, and thinking (bias) that can be reflective of cultural incompetence, and therefore related changes may incur very little cost. This study is in a position to play a role in defining cultural competence as a tool that defines how the needs of the individual can be met within general service specifications. The definition further asserts that when commissioning for the individual extra attention must be paid to the capacity of the individual to partake of the service on offer. For this reason, training programmes must focus on issues of equality and equity, noting that they are 2 different concepts to be addressed in different ways.

Health and social care services are heavily relied on by vulnerable groups (people with a disability, long term conditions, older people, and others). For this reason, professionals must deal with their bias or misunderstanding of other cultures, or beliefs to avoid behaving in ways that service users consider to be discriminatory or oppressive. This may enhance the ability of health professionals to deliver outside the boundaries of a one-size-fits-all ethos.

The NHS needs to ensure that any plans for culturally competent training are based on a comprehensive training needs assessment. Furthermore, as opposed to a stand-alone policy or training manual the implementation plan and training should be developed as part of an overall culturally competent commissioning framework. This will ensure that the approach to training is a seamless and consistent exercise, mandatory and evaluated as part of the performance of the organization. This is important because the National Health Service is concerned with the employment, education, training, mentoring and supervision of professionals over and above the delivery and commissioning of services and the training model should address these main areas.

Continuous professional development (CPD) is one of the areas that will need NHS investment (money, time, workforce, and infrastructure), it was implicated as lacking and therefore a challenge to culturally competent commissioning.

Targeted resources or the reconfiguration of organizational investment will be needed to develop and accommodate culturally competent changes in the following areas:

1. Recruitment and Retention (workforce)
2. Education, Research and Training (development)
3. Policies and Procedures (infrastructure)
4. Supervision and Mentoring (leadership)
5. Communication

Cultural Competence Leadership in the NHS

Cultural competence in the workplace can eradicate discrimination through the use of appropriate policies that promote, protect, include and create safe and productive environments (Van Den Bergh, 2008). Safe and productive work environments are crucial to the production of culturally competent services for the wellbeing of staff.

In the age of dynamic workforces such as we have in the NHS that employs people from diverse backgrounds (gay, lesbian, bisexual, and transgendered) demands competent leadership that is inclusive and compassionate. For this reason, it is important to be more than a qualified or a seasoned professional in a specific field, this is because the needs of the workforce a multilayered and constantly changing. In addition to qualifications, the right attitudes, knowledge, language, and skills that are culturally competent are required to address the needs of colleagues and service users alike. The requirements for a culturally competent work environment must be promoted and dictated by the leadership hierarchy; also, cultural competence must be recognized as a criterion for transformational leadership to achieve it in reality, the purpose is to ensure that everyone feels valid. This is all hat the Black Lives Movement is demanding.

Transformational leadership is critical to the implementation of good culturally competent policies as far as it relates to the recognition and responsiveness of organizations. It also relates to the service needs of culturally and linguistically diverse populations. The purpose is to improve health care quality, engage racial and ethnic minority client's care and reduce outcome disparities for them and older or vulnerable populations. Several research participants suggested the need for culturally competent NHS leadership within the hierarchy, further suggesting that its absence is a challenge to effective the

commissioning and provision of services. This makes leadership a key recommendation to be focused on.

The theoretical framework of leadership is the anchor of transformational leadership (Judge and Piccolo, 2004, Yukl 2012), it is defined as the ability to inspire others to follow a particular course of action and perform beyond previous achievement levels (Bass & Avolio 1994, Piccolo et al 2012). Leadership must create an organizational vision or ethics in employees (Aarons, 2006, Aarons & Sommerfield 2012, Battilana et al 2010, Michaelis et al 2010). Leaders in the context of this study refer to heads and directors of commissioning in both health and social care now that we have moved to integrated care systems.

Dauvrin and Lorant, 2015 rightly assert that cultural competence among healthcare professionals is only acquired in part through leadership and necessitated by international migration. This is only partially true as it is time to accept that cultural competence is not about race but includes the culture of vulnerable groups such as the older population, the disabled, and those with long term conditions. Concerning migrants or BME groups across Europe, their vulnerability pertains to accessibility, poor health outcomes, and literacy levels (Stansbury, Jia, Williams, Vogel, & Duncan, 2005; Norredam & Krasnik, 2010; Sandhu et al., 2013).

Finally, this study asserts that culturally competent leadership is important to understand the concept of culture and how each encounter should be a learning opportunity that translates to professional practice (cultural translation). Cultural translation would be the modification of each cultural component in relevant settings, ensuring that services or encounters are not of a one-size-fits quantity.

Culturally Competent Policies and Practices – NHS England

When considering the theory of innovation implementation as it relates to the commitment of organizational members using an innovation, Klein and Sorra (1996), this relates to culturally responsive practices (Guerrero et al 2017). It is evident that concerning the concept of culturally competent commissioning, coordinated action is needed by the National Health Service (workforce) to implement this new concept. The concept is declared fairly new as part of commissioning vocabulary, and a concept

whose descriptions participants were not familiar with though they had some knowledge of what it can address or achieve. Participants did feel that there would be high-cost implications to the NHS at every level of service provision, the suitable response to such an assertion or suggestion in the first instance is for the NHS to begin the conversation with professionals and service users alike. There was some mention of pockets of good practice that do amount to the description of the NHS as a culturally competent organization. This is because practice lacks consistency across the board and is suggested as a reason why the NHS may not be considered culturally competent by some participants. A few participants argued that the need for training was linked to the need to promote culturally competent commissioning as an innovation to ensure equipped consistency and quality. Klein and Sorra, 1996 affirm that consistency and quality of targeted organizational members' use of an innovation is a function of the strength of the organization's climate for the implementation of that innovation and secondly, the fit of that innovation to targeted users' values (Klein and Sorra, 1996).

Participants who assert that the challenges to culturally competent commissioning lie with the willingness of the leadership hierarchy fit the absence of the concept from commissioning vocabulary. This can be attributed to culturally incompetent leadership that would be weak in developing new strategies/policies making related practices/processes a non-starter or inconsistent. A positive step in the right direction would be for the leadership of the NHS to take responsibility for shaping culturally competent policies in the first instance and embedding these policies into practice to affect transformation.

Battilana et al, 2010, assert that good leadership is necessary for the transformation of organizations, such as the rules and the subsequent influencing of behaviors of employees (Dinh et al 2014). Battilana et al, 2010 emphasise that for organizational change to be affective there needs to be an effective communication strategy communicating the need for change, mobilization of the support for change, and an evaluation of the change implemented. This would be crucial to cultural competence as an innovative and misinformation discourse capable of enhancing or influencing transformational change. For these reasons, transformational leadership is required to promote and translate a culturally competent vision within the National Health Service.

Cultural competence has multiple theoretical underpinnings, yet a significant challenge is its limited consensus on how to generate the outcomes necessary to provide and

commission services. Culturally competent commissioning is a concept being introduced to ensure services are those that are of cultural value to diverse populations made up of BME's, older and disabled people, refugees, migrants, and others. These groups make up the vulnerable population commonly affected by healthcare disparities that represent the care gap between majority and minority populations (Collins et al 2002, Kepple et al 2002).

The Importance of Cultural Competence in the Commissioning of Services

Cultural competence (commissioning) is not necessarily a new way to define how services are made available to culturally diverse populations. The concept is defined by this study as a tool that informs the design and procurement of culturally competent services that meet the needs of diverse populations. This is because research has shown that quality health care requires attention to the variations in the cultural presentations in populations (Kleinman et al. 2004; Moffic & Kinzie, 1996 and Lavizzo-Mourey & Mackenzie, 1996). Furthermore, the constructs, awareness, sensitivity, and knowledge must be skills embraced by commissioning and provider organizations if the expectation is the delivery of quality healthcare.

The relevance of this study was the exploration of the significance of cultural competence in the improvement of mental health services for older service users and others. Furthermore, it was about examining how professionals consider the needs of diverse cultures and perspectives. It was also about how far cultural competence is embedded in both commissioning and the delivery of services that should be responsive to the needs of older people and others with dementia or other MH conditions.

Section 3

Cultural Competence: BME Perspectives versus Non-BME Perspectives

Preconceived perceptions before the start of this research were that participants from a minority background might have a better understanding and level of practice than non-BME participants. And that the expectations, definitions, and importance of cultural

competence would be profoundly different from those of non-BME participants. To test this hypothesis the 15 in-depth interview participants were asked to give their definition of cultural competence separately from services they would define as culturally competent.

Whilst this study is about cultural competence in commissioning, it is also about the commissioning of services used by others (BME'S and vulnerable groups). Because service users, regardless of background are seen by professionals of other ethnic backgrounds when seeking healthcare, it was important to understand whether ethnicity played a role in influencing how participants define, commission, and practice cultural competence.

Although cultural competence is a concept developed to reduce healthcare disparities as they pertain to minorities, in today's' healthcare arena there are concerns about the healthcare received by older people and other vulnerable groups. The former led to the development of the National Services Framework for Older People (2001) setting out quality standards for health and social care. This was a positive response; however, culturally competent commissioning is not specifically mentioned within the framework. There are concerns for other vulnerable groups along with anticipated changes to the prevalence in MH conditions over the next few decades with cultural competent interventions suggested as a framework capable of eliminating disparities and improving healthcare (Mobula et al 2015; Betancourt et al, 2016; Bonvicini, 2017; McCalman et al Purnell and Fenki, 2019).

A review of the definitions by participants of a BME or non-BME background did not seem to offer dissenting views. Individual definitions show that participants' may have responded from the point of view of a service user. What is clear from definitions is that they prefer culturally competent services. When all the definitions were reviewed, aspirational elements were apparent along with evidence of cultural competence awareness that could mean participants do have the ability to reflect their aspirations in the services they commission.

Participants suggested that there was a lack of adequate strategic planning or processes that specify the constructs of cultural competence however they also suggested there was evidence of good practice that was producing better service user engagement.

On both sides of the ethnic divide, there was participant awareness of bias among professionals and acceptance that training was needed. The collective discourse of

participants focused on organizational responsibility (resources and training needs) and their expectations as service users. What is needed is for professionals to take full responsibility for culturally competent practices not owned by professionals.

Section 4:

The Challenges of Culturally Competent Commissioning

Perhaps one of the biggest challenges of cultural competence during this study relates to the assumption that cultural competence is specific only to addressing the issue of healthcare disparities concerning minorities. In other words, that cultural competence is just about race. This may not be evident on the pages of this thesis; however, it may be a valid assumption given the number of professionals who declined to participate on the basis that they did not think commissioning practice had anything to with cultural competence. This was the specific view of GP's, a crucial group responsible for the health of thousands; this is of course a cause for concern.

One of the aims of this study is to promote the relevance of cultural competence for the benefit of all service users for reasons related to person-centered care, equity of access, equality, and cultural safety. Professionals will need to appreciate that cultural competence is about individuals as their perspectives and needs change depending on experiences and settings (Yin, 2016). Secondly, it is reasonable to note that while culture is a universal concept, there are marked variations or different perspectives (Groce, 1999) ad they apply to all people.

Other challenges suggested poor skillsets, limited-service user engagement, and the absence of a working definition for culturally competent commissioning, no culturally competent policies or leadership, and limited resources. The leadership issue is linked to organizational cultural competence (cultural competence in the hierarchy of the leadership of the NHS). It is an area that suffers from a paucity of research however studies by Sieglel et al, 2000, 2003; Stork 2001 present evidence of a link between the cultural competence of an organisation and those of its professionals making it a clear requirement for the NHS to adopt its language and activities explicitly. Furthermore, Paez et al, 2008 assert that organizations that embed cultural competence into planning and operational policies are likely to develop culturally competent staff. The role these staff

should play is in understanding what and how the organisation needs to improve and what and how to serve its population. This is the important role that NHS commissioning should play in partnership with service users and providers.

Language has already been described as a well-known challenge to cultural competence in this study therefore good health care systems are those that provide culturally and linguistically appropriate services. These are services that are sensitive to cultural differences and choose to address language barriers by using interpreters (Anderson et al 2003). A certain challenge to cultural competence lies within the history and infrastructure of the NHS which was developed in 1948 while the UK was predominantly a mono-cultural population.

There is evidence that most policies and practices are still linked to those times when the ethos had a one-size-fits-all focus. This status was described in the National Health Service Framework as having a one-size-fits-all world view of the post-war years. Taylor, 2005 reports on the role of staff development in addressing the challenges to cultural competence within the NHS. He asserts that these challenges are due to gaps in knowledge, lack of training, and limited diversity within the hierarchy of the NHS.

This study aims to convince stakeholders that commissioning must continue to increase awareness and promote attitudinal and behavioral changes that will result in the delivery of culturally competent mental health services.

Beyond the challenges of commissioning services in a culturally competent manner, other factors identified in this study include:

(1) Lack of diversity in the hierarchy of the national healthcare system underrepresentation of minorities in the workforce of social care and the National Health Service. As the main users of health/social services and the main population affected by dementia, it is crucial to ensure that all services offer efficient access, optimum quality, and a seamless pathway of care.

Getting it right is beneficial to older people and others affected by mental health and other long-term conditions as it enables independence, quality of life, and emotional wellbeing.

(2) Professional bias

(3) Gaps in knowledge

(4) Resources

(5) Training

(6) Appropriate policies and strategies.

Addressing the Challenges of Commissioning Culturally Competent Services

Participants suggested how identified challenges could be addressed and possible opportunities to influence cultural competence. A common suggestion points to the need to overcome the recruitment deficit of BME's in the NHS hierarchy. Participants further suggested that BME's are in the NHS but invisible in leadership roles. A study by Kline, 2014, spoke of the snowy peaks of the NHS when investigating discrimination in governance and leadership. Furthermore, Salway et al, 2013 report a level of ambivalence concerning the importance of addressing ethnic inequality. In addition, Sobieraj, 2012 looked at unrepresentative Trust Boards, noting that there is under-representation from the communities served by the NHS. Better representation is known to influence service experiences and the quality of performance. For these reasons, this study suggests that NHS recruitment and its leadership should reflect the demographics of the population it serves. Furthermore, that cultural knowledge and awareness should be available within the workforce via training, CPD, and research and the learning must be evidenced as translated. This could be achieved by a code of conduct that is embedded in the suggested culturally competent commissioning framework.

Culturally responsive services are important to vulnerable groups as they often mistrust services and stay away causing them to need urgent care much later and at a higher cost to the NHS. This also relates to the older population who sometimes feel alienated for reasons that include ageism, social isolation, health literacy, etc. furthermore if a need is mental health-related it is not unusual for particular cohorts of the younger population to delay accessing health causing entry into the healthcare system to happen via the criminal justice system. These are factors that have been verified by international studies, (Bhui et al. 2003; Mohan et al. 2006; Leese et al. 2006; Fearon et al. 2006; Warfa et al 2006a; Warfa et al 2006b).

Responding to Opportunities for Culturally Competent Commissioning

The suggested opportunities available to commissioners relate to all aspects of the commissioning cycle (needs assessment, planning, procurement, performance management, etc.). Other areas include information-sharing protocols and the design of Key Performance Indicators and policies. Furthermore, every relevant service user encounter should be considered an opportunity to be culturally competent (joint commissioning/service user engagement forums and recruitment). This may be referred to as cultural translation as it involves learning and transitioning the knowledge in different settings to benefit others (work-based learning) Evans, 2011 and Guille, 2010. Service users are often included in the needs assessment and service specification tasks as these areas need to be informed by the voice of the patient/service user but the practice is inconsistent.

Training was an important mention as an opportunity to be culturally competent; the suggestion was for training to be part of an overall culturally competent commissioning framework within which every member of staff can be trained for the sake of consistency (workforce development). Furthermore, suggest use another term?, the literature reports limited evidence of how effective culturally competent training is to the improvement of quality and service outcomes (Anderson et al, 2003; Beach et al, 2005; Kleinmann and Benson, 2006 and Bhui, 2007).

The discussion concerning black and ethnic minorities brings us to the issue of race and ethnicity and links to culturally competent commissioning, however it is a limited discussion within the scope of this work. This is because this work is not directly about black and ethnic minorities and how the disparities in mental healthcare that relate race or culture affect them. It is about all individuals affected by dementia and other mental health illnesses, and what they need in terms of health and social health care service.

The question of culture and commissioning was asked by most non ethnic participants though there is an expectation that those who deliver services should do so within the context of person-centered care. The response is that because all people have a culture/value system that has a bearing on how they are affected by disease or report symptoms (cultural perspectives of disease) commissioning must cater for individual needs. Furthermore, commissioning is driven or informed by needs assessments, and needs assessments are conducted with the assistance of service users therefore the

commissioning process can be described as a culturally driven process that should be designed cater for the needs of all and not a few. This must be the case as culture is not all about race, it is about the value system of individuals regardless of their race though shaped by race to an extent but also by nurture and the environment. Nurture and the environment speak to what individuals like and dislike, believe, eat, know, feel, and understand (religion, gender, ability, socioeconomic status, age, ethnicity etc.), therefore these factors must be taken into consideration when commissioning and delivering MH health services.

Culturally Competent Communication

Communicating what is needed is a crucial part of getting things right in commissioning, it is equally important for the mode of communication to be adequate at the service delivery level, this will depend on how well professionals translate what has been learnt during the needs assessment to service design. The significance of these issues may be linked to evidence that shows that culture-based misunderstandings influence relationships, service design, diagnosis, and healthcare compliance (Karout et al 2013). Communication is an important aspect of disseminating information across organizations and with the public (service users); therefore, it was included as an opportunity to be culturally competent by participants. Communication must be culturally competent, especially when dealing with patients/service users facilitates service user satisfaction and adherence to treatment (Gilbert and Hayes, 2009).

Often the issue of clarity over what is to be commissioned (or delivered) causes friction between professionals and service users due to differences in opinions and limited funding. When such misunderstandings occur between professionals it can lead to unsafe practices or misdiagnoses where delivery is under tight deadlines or in emergencies. This can lead to medical errors (Helmsley, Balandin and Worrall (2012). Issues that can be implicated in communication are language, culture, resources, poor training, and poor staffing levels amongst other reasons.

Culturally Competent Research

Participants mentioned research as an opportunity to influence, understand, deliver and enhance cultural competence for this reason translation of the outcomes of relevant research to practice (Cultural Translation) is crucial. Further on from this, participants called for a working definition of cultural competence in commissioning, this is a relevant

outcome of this research. This would be important to the purpose of finally achieving a consensus definition for culturally competent commissioning and could assist with suggestions for clarity on a defined mode of measurement for cultural competence in practice.

Measuring Culturally Competent Practice

Defining key performance indicators for culturally competent commissioning was mentioned as a difficulty by participants asking how and what should be measured. This fits in with literature that reports a sparse definition and a competent means of measurement (Loftin, 2013). Scholars ascribe the difficulty of measurement to the self-administration of instruments based on individual perceptions. Lin et al 2017 report on the paucity of articles in the literature identifying or describing instruments regularly used to measure cultural competence in healthcare provision. Shen, 2014 reviewed culturally competent models and assessment instruments concerning their components, theoretical background, empirical validation, and psychometric evaluation with results yielding varying levels of psychometric properties. Chusman & Schiltz, 1997 assert that a review of several programmes developed for training healthcare professionals is based on incomplete conceptualizations. The matter of measuring the practice of cultural competence and its outcomes were factors suggested as opportunities to ensure cultural competence in commissioning. Also mentioned were the design of key performance indicators and the task of performance management of services. These are all aspects of the commissioning role.

The task of measuring cultural competence has presented scholars with the issue of a lack of uniformity in terms of the measures or tools used in addition to limited guidance on how to measure (Kumas-Tan et al, 2007). The problem with not having a definitive means of measuring cultural competence is that it limits the progress that can be made on many fronts and allows the perpetuation of wrong assumptions. The most prominent assumption is that cultural competence is about race and ethnicity and that the groups defined as BME and racialized others are the only ones it concerns. In other words, that culture is that which others possess, this would be a wrong assumption given the dominant cultures in the UK are those of the Scottish, English, Welsh, and Irish. The correct notion must be that everyone is a person of culture with preferences or nuances that can offer insights as to how and why they should be treated one way or another as

suits them. Two surprising assumptions by some non-BME participants were that the study was about getting white professionals to work better with BME's rather than all professionals working better for the whole population and secondly, that non-BME participants did not often see themselves as people of culture.

Developing Measurable Elements of Cultural Competence

Cultural competence is underpinned by what has been described as cultural intelligence (cultural quotient). It is the development of individuals in a cross-cultural context and the capability that individuals need to have to be effective in intercultural interactions (Thomas, 2015). If it is essential for commissioners to design culturally competent services and for providers to deliver the same, then cultural competence becomes a quality that must be measured. The practice of measuring cultural competence as a KPI may ensure that the relevance, practice, and measurement of cultural competence become embedded in commissioning processes. This was an area the participants judged to be weak and challenging for the practice and delivery of culturally competent mental health services. Participants further suggested that a consensus on what service users assess cultural competence to be, along with their involvement in assessing services is essential to getting it right and should define how it is measured. What this suggests is the possibility that service users play a part in assessing the impact of culturally competent learning via CPD on services/service user experience.

The Case for Cultural Competence and Dementia

This study was about the need to provide culturally competent dementia (mental health) services to older people and others by investigating the opportunities and challenges for culturally competent commissioning. Questions posed and responded to related to the practice and importance of cultural competence amongst participants, its definition and the opportunities, challenges in practice including the means of addressing the suggested deficiencies (cultural incompetence). That being said, participant responses, suggestions and the discussion quickly moved away from dementia to race and equality and mental health services in general.

Bringing the discussion back to dementia and older people, participants considered the relevance of cultural competence to older people's mental health services and suggested

the need for training in cultural competence at all levels of health and social care. The significance of this is to ensure the following:

- Better dementia communication amongst nurses and other carers
- Culturally competent end-of-life care
- Culturally competent assessments
- Dementia friendly wards/settings
- Dementia friendly communities
- Positive MH outcomes
- Understanding the cultural aspects of mental health

The responses/findings that relate to the above suggest that there are pockets of good practice, a need for culturally competent stakeholder engagement, training and leadership. Furthermore, there was an acceptance that cultural competence is important and can be influenced by professionals. It was suggested that opportunities for influencing cultural competence to ensure that dementia services are in turn delivered in a culturally competent manner include the following:

- Joint commissioning discussions
- The needs assessment process
- Recruitment process
- Training opportunities
- Research
- Design of key performance indicators
- Promote willingness
- Design of treatment
- Development of a culturally competent commissioning framework/guidelines
- Design of policies and practices
- Review of the NHS Constitution

These suggestions generally apply to the development of standards/framework for cultural competence and by extension to the commissioning of all mental health (services). This would specifically apply to dementia as a mental health service for older people (vulnerable groups) and speaks to how and why participants suggested that the NHS is not culturally competent in its leadership/hierarchy.

Practice and Policy Implications

A particular strength of this study is that it explores the understanding and practice of cultural competence from the perspective of commissioners and their colleagues. This is significant in that participants all suggested that there needs to be a consensus definition for cultural competence in commissioning and clearly defined principles.

The findings reflect clear implications for practice and policy given the benefits suggested by participants, the acceptance that there is room to improve the status quo and the further suggestion that leaving things as they are has an impact on the healthcare of those in need of services. Furthermore, the suggestions speak to the notion of cultural incompetence in the delivery and commissioning of dementia services to older people. Specifically, these are as follows:

- Fragmented care
- Accessibility issues
- Bias
- Healthcare disparities
- Lack of diversity
- Lack of resources
- Misdiagnosis
- Equality and equity issues
- Poor service user experience
- Poor commissioning practice
- Poor person-centred care

The problem with cultural competence in the NHS is cultural incompetence in the NHS therefore the findings have implications for practice. The findings from this work demand first and foremost a debate that includes the argument for a review for the constitution of the NHS. This is because the constitution does not make any mention of cultural competence, it is therefore suggested that the findings from this work be used to inform advanced research that can further contribute to a redesign of the NHS constitution to fit the current UK population.

Required changes to policy are important considering the relationship between policy and practice. Furthermore, improved polices shaped by innovative research demand

training in elements that are unfamiliar to professionals, this was evidenced by the numbers suggesting that the NHS needs a culturally competent commissioning framework. Participants had further suggested that there needs to be a consensus definition of the term which should be informed by service users and that training should be mandatory for all staff. This is in keeping with convergent recognition of cultural competence beyond cultural awareness (London Deanery, 2012).

A key turning point for this research was the suggestion by participants that the perception of cultural competence was closely related to their understanding and ability to design services for others who belong to minority groups. This might be due to the absence of the concept flowing through key policy and practice areas including links to the definition of quality, therefore it was eye opening to have participants suggest cultural competence becomes a hallmark of quality.

Considering the implications for policy is a complex area to navigate given the level of transformation it will entail along with the willingness needed to make progress or execute desired change. This is because Including the notion of cultural competence in policy/practice is or will be tantamount to transforming policy, service programs, recruitment and practice. Furthermore, the complexity of the argument is situated within the Human Rights framework and the Black Lives Matter discourse among others.

Getting it right means that all stakeholders (NICE, CQC, DoH, DH, 5YFV etc) will need to collaborate towards the task of reviewing the core competencies regarded as essential for the mental health workforce and the healthcare arena in general. This fits in with the No Health Without Mental Health Agenda, and the demand for culturally appropriate services documented in a raft of policy guidelines and frameworks. The aim is to formalise and embed the following in practice:

- Cultural awareness
- Cultural safety
- Cultural sensitivity
- Cultural knowledge
- Cultural skills

Policy and practice will need to continually evolve along with research findings and recommendations as it is a continuous (dynamic) process and demands a constant state of learning, reflection and vigilance. These factors will all need to take place in relation to

the evolving nature of populations, the prevalence of disease, an increasing older population, migration and possible pandemics in the post Covid era.

Genaralisation of Empirical Findings

External validity relates to generalization of research findings either from a sample or larger population or to settings and populations other than those studied. In this research, the subject matter, research sample and, the larger population all belong to the same organisation (NHS setting). Generalisation was the overall long-term goal of the study therefore the research design planned for anticipated generalizations within the context of supporting evidence. The plan for generalisation began with the inclusion of quantitative questions and the quantitisation of qualitative data. The quantitative element was about testing causal relationships, finding patterns and being able to generalise results to wider populations. The aim of this was first to ensure that it would be possible to generalise on the matter of the characterisation of the NHS as a culturally competent organisation. It would have been inadequate just to ask the specific question and not take cognisance of the number of participants responding one way or another along with their profiles. Given the high percentage of those who suggested that the NHS is not culturally competent it is reasonable to generalise that most commissioners who work for the NHS would agree. Secondly, on the importance of cultural competence in commissioning it was important to ascertain the extent to which it would be considered an important aspect of commissioning along with suggested ways to embed it in commissioning, how quantify it and define it. To this extent what was accomplished was analytical generalisations from which the recommendations were based. The mixed method approach chosen was to enhance the capacity for generaisation (Polit and Beck, 2010).

Chapter 7 is the concluding chapter of the study. It presents a summary of the outcomes of the research study along with significant reflections and recommendations. A detailed conclusion is offered by way of presenting the final evidence that justifies the inclusion of cultural competence in the commissioning of mental health (dementia) services. It also responds to the overall research question of what the challenges and opportunities are for commissioning culturally competent dementia services for older people and others. Whatever these are, it is suggested that they have a significant impact on the quality of care available to older people affected with dementia (other mental health conditions).

Chapter 7

Reflections, Conclusions, and Recommendations

Introduction

This chapter is the concluding narrative of the study. It offers a summary of reflections, recommendations, and a conclusion to the main outcomes of the research project and sheds some light on incidentals to the research query. The reflections are based on perceptions and activities from during the study whilst the recommendations are based on evidence emerging from the study and the literature.

The summary conclusion of this study considers a diverse range of perceptions that include those of the participants and the researcher pertaining to where, how, when, and why enhancing the relevance of cultural competence is vital.

What we all want to know is and how cultural competence can be achieved as there is no doubt as to why we must achieve it if its importance in the commissioning of older people services is accepted. In the course of this study, a new climate (Black Lives Movement) emerged to make it even more pertinent based on the need for inclusivity and fairness in all areas of life including health. The results of this research are a consideration of the challenging issues that relate to culture, diversity, competence, training, leadership, communication, and mental health-related services. These issues have a significant impact on the quality of care available to older people affected with dementia (other mental health conditions). Furthermore, the assertion is that all aspects of dementia care for older people (and others) should be culturally content in design and delivery.

Reflections

Being reflexive and writing reflexively are not natural traits but skills that have to be acquired over time and not while a written work is prepared for the scrutiny of others however there is an endeavour to present a reflexive narrative on how we plan care for vulnerable people. The importance of ensuring that this research study offers reflections

is concerned with the fact that there can be no real learning, improvement, or new knowledge without reflections on what was to produce what should be. An even more significant reason relates to the ethics of cultural competence itself (ethics of compassionate care and research). These elements are crucial because studies that involve the health and social participation of people are culturally competent to get the best results, which are those that reflect the 'truth' or 'reality' (values) of participants. To achieve and reflect new knowledge (phronesis) that represents truth and reality requires that researchers treat participants with respect and maintain their dignity. The same applies when health professionals are dealing with service users in those times when mental health is compromised.

One way that this study ensured that it was culturally competent was in the use of an adapted methodology that relied on a pilot group that tested how best to select sample participants and design a user-friendly approach. The pilot group had assisted in the design and testing of the research documents for usability; this does mean that being culturally competent also means being flexible. Furthermore, cultural competence in this study means that the research was conducted in collaboration with NHS staff.

An important reflection from the study notes that an awareness of cultural competence and sensitivities to cultural issues by participants might not amount to the practice of cultural competence by participants. What cultural competence takes is the translation of what is known generally to what is needed individually for people or communities. Furthermore, this study shows that though research participants have some level of culturally competent knowledge and sensitivities, these factors did not lead them to judge the NHS to be a culturally competent organisation. This study was not concerned with why this was the case.

This reflection leads to the first recommendation being one that calls for cultural competence to have a prominent place in the annual reporting system of the NHS. Making this possible means further research may be needed to define what the performance indicators and mode of measurement of cultural competence should be. What is clear is that when measuring cultural competence, feedback from service users is vital and must be considered as part of the measurement of quality and performance.

Reflections on New Learning

The epistemological journey was a new one as it was personally non-existent until the research study was considered and commenced as a learning experience complicated by the epistemological debates that relate to mixed methods. It was a confusing experience entwined with the battle to 'pick a side' in the epistemological debate, and research approach. The need to overcome the struggle to choose between action research, case study, or mixed methods. The final choice of a mixed-method design and pragmatism suited the research and personality, and though leaving the epistemological debates behind was difficult and unresolved a personal level, it was not to the extent of denying on any level the pleasantries of a mixed methodology research.

New Knowledge

Though this study was grounded in commissioning practices related to the commissioning of dementia, it does contribute to existing knowledge in mental health commissioning and the cultural competence arena. A thorough review of the literature revealed this study to be the first attempt at researching culturally competent commissioning offering of a first-time definition which states that it is;

> …a vehicle for increasing access to quality services (care and treatment) for populations with diverse values, beliefs, and behaviours, using culturally competent processes, including tailoring service commissioning to meet social, cultural, and linguistic needs...

A further important contribution that could revolutionise the quality of commissioning and, in turn, the quality of service delivery is the offering of a set of suggested criteria for the development of a culturally competent NHS commissioning framework. The framework will be based on a theory referred to as the cultural translation theory, defined as the capacity of a system or professional to translate cultural encounters that relate to the general aspects of cultural diversity to individual aspects of cultural values.

Fourthly, this study introduces a new construct into the cultural competence arena. Previous to now, there have been four significant constructs (awareness, sensitivity, knowledge, and cultural competence) proposed by scholars. These constructs are considered pertinent to the delivery of culturally competent services and can define culturally competent commissioning. Culturally competent practice where individuals or

diverse communities are concerned must entail the translation of what is already known about the cultures in the general population to fit that which is about to be known about the individual. The general theory of cultural translation proposes that whatever is considered culturally competent by the professional must not be directly imposed on individuals or communities unless it is evident that it is fit for purpose. Therefore, the culturally competent professional is required to appropriate their cultural awareness, sensitivity, and knowledge in different ways until cultural proficiency or competence is delivered to the satisfaction of an individual service user. The reason for this assertion is that cultural competence cannot be fully achieved by any one individual based on a few encounters with those from a similar culture.

This is the definition of a fifth construct of cultural competence referred to as cultural translation (Kolapo, 2018). It is achieved by translating previous encounters of cultural sensitivity, awareness, and knowledge into the commissioning or delivery of services (Kolapo, 2017)

Cultural Translation: A New Perspective

This study proposes a new construct relating to cultural competence as a skill that requires more than sensitivity, awareness, and knowledge. This is because cultural competence cannot be achieved as an event especially since it is a process that will require the translation of cultural encounters into meaningful approaches for individuals or communities. This is contrary to the one-size-fits-all discourse that participants have suggested is part of the culture of the NHS. Cultural translation is concerned with ensuring that no two individuals are treated the same way based on assumptions that individuals from similar ethnic backgrounds or cultures (religion, gender, age, etc.) are the same.

Cultural translation is a term that has been around for a long time and defined in various other contexts (anthropology, nursing, and cultural studies, etc.) but it is put forward as an important emerging construct (theory) of this research based on the definitions and descriptions of cultural competence (services) by the participants. These definitions speak to commissioners (or indeed providers, practitioners) needing to be supported in the process of being and becoming culturally competent via a learning process (rather than a training process). For this reason, cultural translation as a learning process for

being and becoming culturally component is a very important contribution of this study and is taken a step further in terms of the need for a framework for culturally competent commissioning practice. The expectation as suggested by the participants is for a governance framework (code of conduct) for commissioning of services that will include workforce development and capacity building for culturally competent capability. It is significant in that it means that on an individual level, commissioned care packages must suit the values of the community, whether they are related to treatment during an illness or End of Life care when there is no longer a viable cure. These same values should be captured in individual assessments as informed by the service user.

This study presents a crucial argument that the NHS or other commissioning organisations can address the need for efficiency savings with culturally competent commissioning. This is because it can play a role in ensuring that what is commissioned is what is needed. To achieve this, culturally competent commissioning will need to have also achieved six further outcomes:

1. Increased equitable access to services
2. Provision of services that are needed (fill gaps in service)
3. Enhanced compliance with therapy or care
4. Improved service user experience
5. Safety in diagnosis
6. Reduction in attrition rates

These six factors will seem obvious however this is not the case as there are several instances of fragmented health care in certain health services. Examples relate to reduced access to services (ASD/ADHD), misdiagnoses (mental health), high attrition rates, wide gaps in provision (sickle cell anaemia, IVF), lottery system of care (oncology). If these issues exist at the low end of the scale, the issue of discrimination, bias, and other health disparities exist at the end of the scale (ageism, stigma, and racism).

At the beginning of this study, the understanding underpinning this research was the discourse of cultural competence as one that is important to equality and equity, especially where minority/vulnerable populations are concerned. Minority or vulnerable

populations are described as populations that include older people, those affected by a learning disability or a mental health condition, LGBTQ groups, and other minority communities. That being said, cultural competence is a tool to ensure that service users that belong to vulnerable groups are offered services that are of value to them and ensure swift recoveries and wellness for longer periods. This understanding has the potential to define the discourse of cultural competence as one that is important to the values and needs of the individual not just at the point of service delivery but from the start of the commissioning process. This level of person-centred thinking can ensure that commissioning focuses on the individual, ensuring the abolition of the one-size-fits-all discourse. This fits in with the personalised commissioning agenda and Place-Based Commissioning, a new concept in improving healthcare and value for money.

Exploring cultural competence amongst professionals is a challenging task; this was evident in this study where a significant number of professionals may have declined to participate to avoid ‘being judged’ for a lack of understanding of the role of an insider-research project. In this study, GP's were the most difficult to engage with, those approached to participate in the research perceived it to be a challenge to their professionalism and declined participation.

From the narrative above, what is quite clear is that there can no longer be an assumption that being qualified in any profession within the NHS or social care arena implies that culturally competent skills are in use or the norm. The right skills may be in use some of the time by the minority but perhaps not to the level that speaks to the status of the NHS as a culturally competent commissioning organisation. This much was evident from the study. If the NHS is to attain the status of a culturally competent organisation, cultural competence will have to become a mandatory part of training, relevant undergraduate education, and continuous professional development. It will also have to be explicitly expressed in the constitution and health commissioning policy. Most participants agreed that training was one of the essential requirements in the promotion, acquisition, and use of culturally competent skills.

Designing a culturally competent framework falls outside the scope of this study; however, participants suggested criteria that could inform a culturally competent commissioning framework for future use. The purpose of a culturally competent commissioning framework would be to ensure training:

- Improves dementia care for older people and others
- Improves mental health care and wellbeing for all
- Addresses cultural and ethnic diversity issues
- Improves the quality of health and social care
- Promotes safety in diagnoses
- Reduces bias/discrimination
- Increases the understanding of culturally competent commissioning

A framework that can address these issues must illustrate:

- A consensus definition of cultural competence and its related skills
- Knowledge of epidemiology and the differential effects of treatment in various ethnic groups in various settings
- Awareness of how culture shapes individual behaviour, perceptions, and health-seeking habits.
- Awareness of the social context in which specific ethnic groups live
- Awareness of the bias, prejudices, and tendencies to stereotype by professionals and ways to address the negative impact of these behaviours
- Training that improves and enhances skills and is informed by service users
- Recruitment of professionals from diverse backgrounds to the leadership hierarchy of the NHS
- Culturally Competent Research
- Communication strategy and stakeholder engagement
- The views of service users
- Culturally competent related Key Performance Indicators

Study findings discovered that overall, there were varying levels of culturally competent skills amongst professionals; however, there was willingness towards improved culturally competent practice. There is also an acceptance that training is needed to promote better practice. The necessary drivers are in place though somewhat latent; however, what is lacking overall is two-fold. First, the prioritisation of cultural competence in commissioning within the hierarchy of the NHS is not explicit in policies. Secondly, the training needed to ensure a consistent approach across the NHS and Social Care arena has not been considered.

Recommendations

This study is the first to investigate the understanding of cultural competence amongst commissioning professionals or within the NHS as a commissioning organisation. For this reason and more, it seems inevitable that a pragmatic approach was suggested to seek answers to questions that pertain to the exploration of culturally competent skills, perceptions, opportunities, challenges, and solutions.

The recommendations were about how to move forward with the development of a much-needed road map towards organisational cultural competence (internally and externally). Internally, because competence that relates to diversity in the workforce focuses on all employees through the ranks (employee relations) to address cultural diversity and gender issues (Capek & Mead, 2006; Briody & Trotter, 2008). Externally, because health systems do not work in isolation but with social care, education, the criminal justice system, and housing in the least. Furthermore, internal harmony promotes good relationships with external organisations and is therefore important between the NHS and its commissioned service providers and service users.

Achieving cultural fit within organisations that serve diverse populations is important and can be achieved by modifying policies, training, research, and recruiting in culturally representative ways (Strober, 2005; Capek & Mead, 2006; Briody & Trotter, 2008 and Sobo 2009).

Study results provided insight into the perceptions of commissioners concerning the importance, knowledge, experience, and practice of cultural competence. Some of the information or outcomes fit closely with a range of outcomes from other studies that

pertain to the relevance, measurement, significance, and practice of cultural competence in the literature. What could not be found in the current dearth of cultural competence literature were interpretations of the challenges of embracing cultural competence in commissioning or the procurement of services. None of the considered studies focused on the employment of cultural competence in improving the process or the quality of commissioning and, by extension, the quality of mental health or dementia services for older people. This study highlights the need for further research on how best to influence cultural competence in commissioning across the health and social care system. Further research is also needed to understand how best to overcome the challenges of culturally competent commissioning and promote any opportunities for culturally competent commissioning. Training or CPD could go some way in addressing the issue though Bentley et al, 2008 argue that as far as the UK is concerned; the training of health care professionals in cultural diversity is inadequate.

It must be accepted that given person-centred care remains a high priority along with the development of healthy work environments, cultural competence is an essential factor. This is because it is essential for service users and for those professionals that work in the health system and supported by the Cochrane Review (2007); it proposed that culturally competent skills would be essential to the systematic change defined as urgently needed.

This study took note of how the role of the National Health Service has changed significantly in how it met the health needs of the UK as a homogenous population in 1948, and the current diverse needs in 2020. In keeping with the times, cultural competence should influence the road map to a better NHS and must start from the needs assessment phase and extend beyond service design. To accomplish this, professionals will need to be well versed in the attributes of cultural competence. This is because the current population needs health and social care professionals that can understand and meet the diverse needs of service users regardless of their age, language, ethnicity, gender, sexual orientation, disability, and religion. For this reason and much more, the National Health Service, along with its stakeholders and other strategic health authorities must recognize the need to develop policies that promote equality, equity, and respect for diversity and the needs of older people and vulnerable populations.

This study has focused on mental health service commissioning as an arena in need of a change; however, the literature is clear that despite efforts to reduce broader health care disparities for minorities and older people, not much has changed. Bench and Keating, 2009; Smith et al 2009; Papadopoulos et al,2006 and Bhui et al 2007 contend that in terms of Mental Health, cancer, and stroke, minorities receive services that are inferior to that of Caucasians.

An appropriate response to the challenge of disparities has been to answer the question of how to equip professionals with the skills, awareness, and knowledge competencies capable of ensuring efficient engagement with service users from diverse backgrounds. Cultural competence is widely accepted as a tool capable of addressing significant inequalities in health care. Its constructs provide the desirable skills which are the dominant feature of cultural competence (Campinha Bacote, 2003, Bentley et al, 2008 and Capel et al, 2008).

The following suggested recommendations have been defined based on the outcomes of the study. The expectation is that it will assist stakeholder organisations such as the Department of Health, Public Health, and the National Institute for Health and Care Excellence of Clinical to improve services. The recommendations are related to developing culturally competent commissioning by focusing on how cultural competence should relate to addressing conflicting definitions, understandings, and limited practice. It is hoped that this study is one small step in the right direction of identifying an appropriate body of knowledge towards the adoption of cultural competence in commissioning. The recommendations are as follows:

Recommendation 1

A Culturally Competent Commissioning Framework for Health Commissioning Organisations

The purpose of a culturally competent commissioning framework transcends the immediate purpose of culturally competent health and social care. Its first premise is to address diversity issues. It is also about improving the quality of care via a code of conduct that is desperately needed to meet the needs of patients/service users/staff

(Darzi, 2008 and Smith et al, 2006. Further research could assist in the development of a framework that addresses or promotes:

- A standardised meaning of the term culturally competent commissioning enabling specified outcome measures to be identified;
- Knowledge of epidemiology and the differential effects of treatment, therapy and diagnosis in various ethnic groups;
- Awareness of how culture shapes individual behaviours and thinking (symptom reporting and health-seeking behaviour);
- Awareness of the social context in which specific ethnic groups live;
- Awareness of professional prejudices or preconceptions;
- A partnership approach between commissioners, providers, and service users ensuring that cultural competence is appraised from the point of view of the service user;
- Guidelines for commissioning and delivering services in ethnically diverse populations
- Opportunities that are supported by evidence-based practice
- Culturally competent definitions and skills that translate to practice
- Training manual

Recommendation 2

Leadership and Culturally Competent Practice in Provider and Commissioning Organisations

This is a recommendation to the leadership hierarchy within NHS England, the leading health authority with oversight of clinical commissioning groups.

Culturally competent commissioning is an innovative concept that this study recommends should be embraced and implemented in its entirety along with robust KPIs that are jointly defined in partnership with service users. By this Klein and Sorra, 1996 meant that

this is about gaining targeted organisational members' appropriate and committed use of cultural competence as an innovative concept. And that furthermore, the consistency and quality of targeted organisational members' use of such an innovation is a function of (a) the strength of an organisational climate for the implementation of the innovation and (b) the fit of the innovation to targeted users' values. The outcomes of the process of implementation include resistance, avoidance, compliance, and commitment to best practice (Klein and Sorra, 1996). For these reasons, there must be committed efforts and consequences for weaknesses.

In terms of culturally competent-based practice, it is linked to culturally competent-based leadership as it demands an appreciation of the forces at play in the promotion of culturally competent practice; this is an assertion similar to that of Prilleltensky, 2010. His study introduced a model of value-based leadership that is based on tensions among values, interests, and power. The success of value-based practice is dependent on the alleviation of these tensions. Furthermore, the ability to enact certain values is conditioned by the power and personal interests of communities, NHS professionals, and leaders of provider organisations. Prilleltensky (2010) further contends that leaders have four main roles in promoting value-based practice of which cultural competence is an example:

- Clarify values
- Promote personal harmony among value, interests, and power
- Enhance congruence of value, interest, and power and the public, employees, and leaders
- Confront those subverting values or abusing power to promote personal interests

Recommendation 3

Stakeholder Engagement for Service Users and Health Professionals

A major weakness of the cultural competence discourse is its lack of a consensus definition and limited feedback from service users in terms of what it is and how to measure it (how well service users perceive services and professionals to be culturally competent in commissioning care). There have been some improvements in including

service users in the overall strategic planning of services but not enough in their performance management. This influence can be linked to the diversity framework as with cultural competence, and work being done to improve service user experience especially those of ethnic minorities (Walt and Ingley, 2003, fay et al, 2006, Avery and McKay, 2010, King et al, 2011, Hewlett et al 2013).

The need to have the voice of the service user reflected in services has enabled person-centred care to feature more prominently in service delivery yet the extra that is needed is culturally competent policies. That means organisations such as the NHS should incorporate cultural competence into strategic planning, leadership, and operational policies to develop culturally competent professionals (Paez et al, 2007, Metcalf, 2012, Francis, 2013, Berwick, 2013). It is suggested that stakeholder engagement should move from the micro to macro/major level which is about including service users in more than the commissioning process. The next level of inclusion should be in the performance management of services so that the voice of the service user can act as a barometer in the measurement of cultural competence.

Recommendation 4

Continuous Professional Development (CPD) For Professionals

The recommendation of continuous professional development (CPD) to boost workforce development should be concerned with the cultural translation process wherein professionals learn to practice cultural competence rightly (Curtis et al 2007, Madera et al 2011, Perry et al, 2015 and Phillips et al 2016). The benefits must be visible in the work of commissioners, health practitioners, and providers (nurse, GP, or counsellor). This study speaks to the suggestion that healthcare professionals need to develop transferrable skills that are linked to cultural competence. This means skills that are related to the delivery of health and the commissioning of health services to ensure equality of care, better service user satisfaction, and improved health outcomes among other things. It also means commissioning should be multifactorial; this is because the cultural challenges facing the UK population are multileveled and most likely affect the older population disproportionately and those who are BME's far worse. They range from the interpersonal to those that are personal to the ethos and leadership of the NHS. For these reasons, training needs must be met in systemic and holistic ways that are capable

of transforming policies, practices, communication, recruitment, and healthcare delivery and professionals (Chiarenza et al 2012, Horvat et al 2014,

Participants emphasised a preference that a training manual should be embedded within a culturally competent commissioning framework that is evidence-based and influenced by service users. Furthermore, that training should be mandatory and possibly joined up across social care and health to ensure a seamless approach and future consistent practice. And that such a framework should sit within the wider political and economic context of the socio-cultural system of the NHS. This would make sense given the latest agenda for an Integrated Care System that should hopefully see a blurring of lines between the commissioning and provision of care and treatment.

Training will need to encompass communication and stakeholder engagement that includes all professionals, and service users along with carers to ensure that they consider themselves first-line customers of cultural competence. This means that professionals and service users get to achieve an understanding of the need to be respectful and collaborative in cross-cultural ways that promote excellence and shared practice. This study has already emphasised the importance of a 1:1 individualistic approach rather than the general to achieve person-centred care that is of value. For this reason, the outcome of the training model will need to achieve effective relationships, cultural diversity competence, and reflexive practice. This being said, the first focus should be a training needs assessment across the board, including exploring the role that language plays in communication.

Language covers tone of voice and is an area professionals might need to understand in terms of how specific cultures may come across as aggressive, timid, or non-compliant. Issues related to these issues can lead to conflict if professionals lack the right culturally competent skills. This does mean that training must be conducted as a 2-way approach to improve how professionals communicate and understand other service users from cultures other than their own. Training must also ensure that professionals understand that speaking the same language (English or other languages) does not equate to similar cultural beliefs or meanings. Furthermore, training should convey the crucial need to understand that those who share an ethnicity or age do not automatically share the same language, religion, value system, and perspectives of mental health conditions. Understanding this nation may assist in safety in diagnosis and improve therapy compliance.

The expectation cannot be that training is seen as a complete event but as a process that aims to assist the learner to overcome personal bias and work within the perspectives of others. It does this by equipping the learner with the skills needed to translate various cultural encounters appropriately (cultural translation). Furthermore, culturally competent training is about setting the scene for a lifelong professional quest to understand the nuances of diversity and ensure that every cultural encounter is meaningfully translated to culturally competent services.

Culturally competent training must teach culture as encompassing diversity and diverse concepts and assist the professional in becoming aware of their own bias and attitudes. Secondly, there must be an acceptance that culture is about identity and values that are generated in many ways and held on to by individuals.

Recommendation 5

Integrated Health Care Research

The NHS has a department responsible for research and development; therefore, this study recommends that resources should be dedicated to culturally competent research in commissioning.

There is a paucity of studies relating to culturally competent commissioning; hence this study recommends that the NHS and other stakeholder agencies at the forefront of research and development set aside funding that looks at how best to incorporate cultural competence within performance management and commissioning. Ahead of that, it would be crucial to fund research that contributes to the design of appropriate key performance indicators and a dashboard of targets that will promote the consistent practice and performance management of cultural competence.

It has been suggested that cultural translation is linked to the definitions and descriptions of culturally competent services offered by participants. They further speak or are linked to commissioners (providers) needing to be supported in the process of being and becoming culturally competent via a learning process (rather than a training process). For this reason, a recommendation is made concerning the need for further research into how professionals learn and develop cultural competence for professional effectiveness and desired patient outcomes (recontextualisation of knowledge).

Recommendation 6

Culturally Competent Health Promotion – Public Health England

There is a significant body of literature that speaks to the importance of the social determinants of health. Kirmayer, 2010 asserts that cultural competence points to ways to improve cultural responsiveness, appropriateness, and the effectiveness of clinical services. In doing so, the outcome is the reduction of health inappropriateness. When considering this desirable outcome, it is reasonable to expect commissioners as well as clinicians to be as culturally competent as each other for the sake of cultural safety in diagnosis. A further expectation is for public health consultants to partner with commissioners to embrace culturally competent health promotion strategies. Other reasons why this recommendation is vital relates to the cultural influences or perspectives of disease, health-seeking behaviour, the outcome of mental health problems, compliance to therapy, responses to health promotion, and service user experience. Commissioning is also part of the fabric of Public Health hence it is necessary to understand the social factors that influence mental health and health-seeking behaviour to design appropriate health promotion and disease prevention. To understand these factors culture must be taken into account (Corin, 1994; Gone & Kimayer, 2010) in diverse populations, this amounts to the definition of being culturally competent or culturally proficient and by extension, clinical efficiency can be achieved (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003) by clinicians.

Recommendation 7

Health Care Policy Development – NHS England

The Department of Health, Public Health England, and other strategic health authorities play a significant role in health policy development; therefore, the recommendation is for these agencies to focus on culturally competent policy development and research.

As stakeholder organisations that provide guidelines for improving health and social care, they should be more informed by culturally competent research as their guidelines inform health commissioning policies. Relevant policies must be linked to commissioning strategies and evidence-based practice to ensure that health commissioning and delivery incorporate the value of culture and diversity. Policies need to promote self-awareness amongst professionals to help them recognize their personal biases against different cultures, the focus being to eliminate disparities. Policies should promote the development of cultural awareness to further the acceptance of differences and the responsibility of embracing and adapting the knowledge of different cultures to further the dynamics of equality and equity.

On another level, culturally competent policy development is pertinent to the promotion of safety in diagnosis concerning psychiatry, and psychology services by ensuring that the nuances of different cultures are known and understood by the professional. It is well documented in the literature that ethnic minorities mistrust mental health and social care services as they feel that professionals do not understand the cultural perspective of mental illness enough to ensure they are understood or that care is culturally compliant. Ethnic minorities appear to be much more at risk of being placed under Section 12 or committed to prison via the criminal justice system due to misunderstandings of culture and racial discrimination. Mohan et al, 2006 describe a feeling of generally being misunderstood and alienated.

Culturally competent policies are essential to understanding the dynamics of healthcare organisations or systems and the needs of multicultural populations. It is recommended that research into organisational cultural competence is boosted as there are very few studies that have investigated it. We need better evidence that further establishes the link between the cultural competence of professionals and the cultural competence of organisations.

Conclusion

It was not surprising that training/CPD or the lack of it was a prevailing theme in response to the challenges of culturally competent commissioning. Participants viewed it as a significant challenge even though person-centred care is the focus of service delivery. The 15 definitions offered to describe cultural competence by participants in this study are a testament to the understanding or perceptions held by participants. This

would mean that professionals understand the needs of service users and what their own personal preferences are when or if they need to use services themselves. Furthermore, although descriptions/definitions were different, they were not that far apart, this may speak to the lack of consensus on a definition of cultural competence and its complex an ambiguous nature. The literature speaks of this deficiency; therefore, this study contributes to the call for a common consensus definition and offers a definition that can be adopted within commissioning for the first time. Furthermore, it reiterates the need for healthcare professionals to develop transferrable (translational) culturally competent skills that translate to culturally competent communication, inter-professional collaboration, and continuous professional development. These are essential to an evolving NHS, serving a continuously evolving diverse population that is an older population living longer, unhealthy, and demanding to be treated fairly and equally (Black Lives Matter).

We need transformational leadership in all public sector arenas (employment, education, the criminal justice system, housing, and health) in the UK; therefore, this study proposes the adoption of cultural competence in leadership is the way forward. Its impact on the leadership climate in all health and social care organizations will be critical to the implementation of good culturally competent policies and better services. Cultural competence in this context refers to the recognition and responsiveness of organizations to the service needs of a culturally and linguistically diverse population that is getter older, living longer, and not healthy.

To improve health care by reducing ageism, engaging with ethnic or vulnerable minorities, and reducing disparities, cultural competence must become part of everyday quality improvement discussions that relate to healthcare commissioning. This becomes even more crucial in light of the Black Lives Movement wherein the older population are finding their voice to speak out about negative experiences across the board and how need should be provided

This cultural competence study is about overcoming challenges and promoting opportunities, its inclusion in policies, practices, and procedures, and very importantly how cultural competence should flow throw the fabric of the leadership of the NHS via a culturally competent commissioning framework. It was also about the values of its professionals and the needs of the older population of service users. The study started by defining culturally competent commissioning so that professionals had a better

understanding of what was expected of them as participants in the first instance. Secondly, so that they could consider the opportunities, challenges, and drivers of culturally competent commissioning and which skills were necessary to commission culturally competent services. Finally, this study was about obtaining and using the relevant contributions from participants to design a consensus definition for cultural competence in commissioning. The new definition of a culturally competent service is offered as:

> *...any service that is commissioned to deliver care in accordance with an individual's preferred physical, mental, spiritual, social, and personal cultural needs, affording them the capacity and ability to maintain self-worth and recover expediently...*

And Culturally Competent Commissioning, for the first time is defined as;

> *... a vehicle for increasing accessibility to quality services designed for populations of varying values, ages, and vulnerabilities, using culturally competent processes that include tailoring service delivery to meet social, cultural and linguistically assessed needs...*

The literature suggests that cultural competence has an integral role to play in reducing disparities in health care provision or closing the health care gap between majority and minority populations (ethnic minorities, older people, migrants, and refugees)(Collins et al 2002, Kepple et al 2002, Bawuet & Commissiskey 1999). This study agrees with the literature and raises the bar by setting the focus a step behind service delivery and placing it in the commissioning arena. To this end, it is about the needs assessment process, the design of services, defining key performance indicators, stakeholder engagement, and research. Beyond the commissioning phase and delivery, the focus of cultural competence should be on quality, performance, and service user experience. That is to say, cultural competence should be monitored as a hallmark of quality by the relevant organisations (NICE, CQC, and DoH) responsible for health inspection and guidance.

The suggested or perceived challenges can be overcome by increasing resources such as funding, the workforce (increase diversity), time, research, training and changing attitudes, and historical mono-cultural practices.

Assertions by study participants are that a significant challenge to implementing culturally competent policies and practices lies within the willingness of organisational leadership. The role that leadership plays in developing new strategies, policies, practices, and exemplary leadership is crucial to the successful change in organisational culture. Battilana et al, 2010 assert that leadership is necessary for the transformation of an organization, such as the rules and the subsequent influencing of the behaviours of employees Dinh et al, 2014.

The NHS is evolving; it has embraced a personalisation agenda, seeks to work closely with social care by creating an integrated care system, and embraces the needs of vulnerable populations, but there is a lot more to do. What is needed is transformational leadership that can push the envelope of culture change within the NHS further. To achieve the required change, the NHS requires a theoretical framework of leadership to anchor its leadership definition (Judge and Piccolo, 2004; Yukl 2012). It should be defined as the ability to inspire others to follow a particular course of action and perform beyond previous levels (Bass & Avolio 1994, Picollo et al, 2012). Leadership must create the vision of an organisation, which must be very translatable to the understanding and work ethic of all employees (Dragon, 2005, Aarons, 2006, Daumo 2006, Aarons & Sommerfield 2012 and Battilana et al,2010; Michaelis et al,2010). The leaders in the context of this study refer to the heads and directors of commissioning and their teams.

The study findings, to some extent, contribute to leadership theory, where few studies in the literature investigated the leadership process of implementing cultural competence. Its contribution is a challenge to the hierarchy of the NHS to consider ensuring that it embraces diversity to ensure that the theory, reality, practice, and policies are very representative of the population.

Cultural competence has been described as innovative, and a misinformation discourse capable of enhancing or influencing transformational change; therefore, this study calls for transformational leadership. Its purpose is to promote and translate culturally competent commissioning visions into culturally competent mental health services for all.

This study makes a strong assertion for a very clear consensus on the definition and mode of measurement for cultural competence in practice because the literature is sparse on its exact definition and measurement (Loftin, 2013). The difficulty in measurement is ascribed to the self-administration of instruments based on individual

perceptions; therefore, this is a challenge. Furthermore, Lin et al, 2017 report on the paucity of literature identifying and describing instruments regularly used to measure the cultural competence of healthcare providers. It is time to add commissioners to the mix rather than what has seemed like a singular focus on providers/delivery of services.

Language is also a well-known challenge to cultural competence, if professionals don't understand what is needed by the individual or the community it results in gaps in services. On an individual level professional healthcare delivery staff dealing with service users must be culturally sensitive enough to understand that a lot gets lost in translation. Good health care systems are those that provide culturally and linguistically appropriate services; these are services that are sensitive to cultural differences using interpreters (Anderson et al 2003). This much is correct; however, the next level up would be for service users to have representation in the commissioning hierarchy, therefore culturally competent recruitment is vital and is included as a recommendation.

The commissioning process is an exercise that must achieve increased culturally competent awareness and promote attitudinal and behavioural changes that result in the delivery of culturally competent mental health services.

The lack of diversity in the hierarchy of the National Healthcare System, underrepresentation of minorities in the leadership hierarchy of social care, and National Health Service must be addressed to ensure services offer efficient access, optimum quality, and seamless pathways of care. This is the good practice that needs to be achieved, however, what we need to eliminate is bias, racism, ageism, and all other forms of discrimination. Above all what must be eradicated from the health and social care system is any form of care that is not compassionate and any commissioning practices that are not culturally competent.

Cultural competence in commissioning is all about getting care and treatment right; it is equally about changing the attitudes of those who are responsible for providing culturally responsive care to the population using the NHS. This means that regardless of age, sex, ethnicity, gender, religion, or culture the experience of each person using the NHS is optimal.

This study contends that what is needed is for all relevant health and social care partnership organisations to embrace the right strategies and tools for assessing organisational responsiveness to cultural competence. This study recommends the

design and use of appropriate tools and strategies for measuring cultural competence. These tools and strategies are needed to address professional bias, gaps in knowledge, training, and appropriate policies and strategies. To accomplish the above, it will also be important to set aside the resources to ensure compliance at all levels.

Finally, this study asserts that cultural competence is crucial to service commissioning and the improvement of service delivery to vulnerable groups as a starting point. A claim is made that though the project is grounded in dementia commissioning practice, the outcome of the study has applicability to the wider field of mental health services.

A further claim also is made concerning a redefinition of cultural translation making a clear contribution to new understandings about the learning and development of culturally competent commissioning practice in the context of dementia services.

It is argued that this study of cultural competence as it exists in the NHS has potential applicability to the wider field of mental health, this is underpinned by the definition offered by Cross et al, 1989;

> …a set of congruent behaviours, attitudes, and policies that come together as a system, agency, or among professionals enabling that system, agency, or those professionals to work effectively in cross-cultural situations...

To support this argument, this study asserts that the attitudes, behaviours, and policies (the system) referred to are gained from the new definition (discourse) of cultural translation offered by this study as;

> *...the reengineering of previous cultural encounters and knowledge gained from any cultural group to suit other or similar groups in ways that ensure a reflection of what is assessed as needed according to the values or perspectives indicated as suitable enough to achieve expedient recovery and or improved wellbeing...*

Given that fragmented care is one of the biggest issues for older patients with multiple chronic conditions such as dementia it is vital that culturally competent commissioning becomes embedded within the new system of collaborative commissioning approach. Achieving singular culturally competent collaborative partnerships (clinical commissioning groups and providers) will address the challenges and opportunities for commissioning culturally competent services for older people and others.

Finally, it is important to mention what could be considered the possible high cost or expense of initiating cultural competence across the board (NHS). A suitable response would be that, first, it must be noted that cultural competence does not require funds in the first instance, the starting point is the right attitudes, and an understanding of what is needed. Following this, it is concerned with the right conversations between professionals and with service users. This means that the initial associated costs of embedding cultural competence pertain to cultural changes (attitudes and policies) and human resources. In other words, the tangible things that amount to cultural competence and compassionate care that are the attitudes and language used to give service users the assurances they need in times of failing health.

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Appendix A

School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

26th August 2016

HEESC APPLICATION NUMBER: NO93 Tiwalola Kolapo

Dear Tiwalola

Re your application titled: "A Mixed Methods investigation of the challenges and opportunities for commissioning culturally competent dementia services"

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. This approval is valid until 31st December 2017.
If you require an extension to this end date please complete Form E which can be found at http://ethics.middlesex.wikispaces.net/Health+Studies

Please ensure that you contact the ethics committee if there are any changes to the study to consider possible implications for ethics approval. The committee would be please to receive a copy of the summary of your research study when completed.

Please quote the application number in any correspondence.

Good luck with your research.

Yours sincerely

Kay Caldwell

Professor Kay Caldwell
Health & Social Care Ethics Sub-Committee

Appendix B

PARTICIPANT INFORMATION SHEET
Questionnaire Survey
MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION

Health and Social Care Ethics Sub-committee
Version Number…9

Participant Identification Number: (1-60)
Number of participants:1-60 (to capture 50)

1. Study title:

A Mixed Method investigation of the challenges and opportunities for commissioning culturally competent mental health (dementia) services.

2. Invitation paragraph

You are invited to take part in the above titled research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the information, discuss it with others if you wish and decide on participation. Ask further questions to gain clarity or if you would like more information.

3a. What is the purpose of the study?

Background

This study has a focus on cultural competence in the NHS Commissioning process and aims to consider how cultural competence can be used to transform the current dementia and other mental health services guidelines for commissioning, culturally competent. The study will consider the challenges and opportunities for commissioning culturally competent mental health services. The significance of transforming is to ensure services are fit to serve a diverse multicultural population. Furthermore it is about catering to the needs of the UK's population which is increasingly affected by a higher prevalence of Dementia and severe mental health illness. Study findings will determine if the outcomes can be used to enhance the status of cultural competence to that of 'statutory' when considering the quality and sustainability of care. The research study will start in August 2016 and run for two years.

3b Questionnaire Survey

As a participant, you are required to answer ten questions related to your awareness and knowledge of cultural competence as it relates to commissioning mental health and

dementia services. You will receive a link to the survey electronically or a questionnaire via email following your completion and return of the consent form. This phase of the study will be collated and analysed for emerging themes to be used to prepare an interview schedule for the second phase. You will receive an invite to participate in-depth interview phase to gain further insight into the views and ideas shared by you during the questionnaire survey phase. This will be completed in a location convenient for you or via an online forum (Facetime or Skype) or phone and booked in advance.

*Please tick the box to participate in the in-depth interview phase

4. Why have I been chosen?

You have been chosen to participate in this phase of the study because you are considered to have professional experience/knowledge that informs the mental health commissioning process. There will be up to 60 provider or commissioning participants involved in the project.

5. Do I have to take part?

Please note that taking part in this research is entirely voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You will always be free to withdraw at any time without giving a reason.

6. What will happen to me if I take part?

If you choose to be involved in this study please note that all appointments for meetings will be set at your convenience and at a location that suits you. You may choose a number of IT options (Phone, Skype, Facetime, and email).

7. Participant Requirements: What do I have to do?

Click on a link to complete the survey or complete it manually via email
The study and data collection phase requires:
Complete the questionnaire survey
All information relates to cultural competence and its significance to mental health services commissioning guidelines (NICE):

8. What are the possible disadvantages and risks of taking part?

There are no known risks associated with this project to participants and self, however there is the minor inconvenience of time given up by participants. This is anticipated to be 2hrs or less and up to (on-line survey/in-depth interview).

11. What are the possible benefits of taking part?

There is no directly intended benefit to you as a participant taking part in this study nor is there financial benefits to your participation, however, the advantages can be quantified as educational or informative. There are no costs involved on your part however you may be required to give up as much as 2hours of your time to participate in an online survey or an in-depth interview. All participation will be timed and scheduled at your convenience. The information we get from this study may help us to commission provider better services in the future.

12. Will my taking part in this study be kept confidential?

All information that is collected will be about your professional experience or knowledge. If any personal information about you is given during the course of the research it will be kept strictly confidential. All information will be stored on a computer that is password protected. All data will be stored, analysed and reported in compliance with the Data Protection Legislation of the UK.

13. What will happen to the results of the research study?

The results of this research will be available within the next 18 to 24 months. You may contact me should you wish to receive a copy of the summary report.

14. Who has reviewed the study?

The Middlesex University, School of Health and Education, Health and Social Care Ethics Sub-committee have reviewed this study.

15. Contact for further information: Tiwalola Kolapo

A contact point for further information: Email: TK452@LIVE.MDX.AC.UK

Academic Advisors:
Prof Papadopoulos on 02084116626r.papadopoulos@mdx.ac.uk or
Dr Gordon Weller on 02084114509 (g.weller@mdx.ac.uk)
Middlesex University, Hendon Campus, The Burroughs, London NW4 4BT.
Thank you very much for participating and assisting in the progress of my doctorate programme

*(please note that you are entitled to and will be given a copy of this document (The Participant Information Sheet)

Appendix C

PARTICIPANT INFORMATION SHEET (PIS)

(In-depth Interview)

MIDDLESEX UNIVERSITY

SCHOOL OF HEALTH AND EDUCATION

Health and Social Care Ethics Sub-committee

Version No 9

Participant Identification Number: (1-15)

1. Study title:

A Mixed Methods investigation of the challenges and opportunities for commissioning culturally competent Mental Health Related services for older people (Dementia Services).

2. Invitation paragraph

You are being invited to take part in the above titled research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss with others and ask questions if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

3a. What is the purpose of the study?

Background

This study has a focus on cultural competence in the NHS Commissioning process and aims to consider how cultural competence can be used to transform the current dementia and other mental health services guidelines for commissioning, culturally competent. The study will consider the challenges and opportunities for commissioning culturally competent mental health services. The significance of transforming is to ensure services are fit to serve a diverse multicultural population. Furthermore it is about catering to the needs of the UK's population which is increasingly affected by a higher prevalence of Dementia and severe mental health illness. Study findings will determine if the outcomes can be used to enhance the status of cultural competence to that of 'statutory' when considering the quality and sustainability of care. The research study will start in August 2016 and run for two years

3b In-depth Interviews

The in-depth interview phase is a qualitative method that will be used to gain further insight into the views and ideas shared by participants and others during the questionnaire survey phase. The interview will be conducted in a confidential and secure conversation at a venue and time convenient to you (or via Phone, Facetime or Skype). The topic of discussion is related to cultural competence awareness and knowledge as it relates to commissioning MH/dementia services.

4. Why have you been chosen?

You have been chosen to participate in this phase of the study because you are a commissioner or a provider or you have participated in the survey questionnaire phase. There will be no more than 20 participants all of whom work for provider or commissioning organisations affiliated to the NHS.

5. Do I have to take part?

Please note that taking part in the research is entirely voluntary. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason and can do so by sending an email to TK452@LIVE.MDX.AC.UK

6. What will happen to me if I take part?

If you choose to be involved in this study please note that all appointments for meetings will be set at your convenience and at a location that suits you. Alternatively, you may choose from a number of IT options (Phone, Skype, Facetime, and email) to take part at a distance.

7. Participant Requirements: What do I have to do?

Participate in a 30min to 1 hour interview

The study and data collection phase requires:

Participant to arrange to be interviewed at a convenient time and place or via phone, skype or Facetime. All information relates to cultural competence and its significance to MH/dementia services commissioning guidelines (NICE):

8. What are the possible disadvantages and risks of taking part?

There are no known risks associated with this project to participants and self, however there is the minor inconvenience of time given up by participants.

11. What are the possible benefits of taking part?

There is no directly intended benefit to you as a participant taking part in this study nor is there financial benefits to your participation, however, the advantages can be quantified as educational or informative. There are no costs involved on your part however you may be required to give up your time to participate in an in-depth interview. All participation will be timed and scheduled at your convenience. The information obtained from this study may help us to commission provider better services in the future.

12. Will my taking part in this study be kept confidential?

All information that is collected will be about your professional experience or knowledge. If any personal information is given by you during the course of the research it will be kept strictly confidential. All information will be stored on a computer that is password protected. As the researcher, I will be responsible for ensuring that when collecting or using data collected, I am not contravening the legal or regulatory requirements in any part of the UK.

All data will be stored, analysed and reported in compliance with the Data Protection Legislation of the UK.

13. **What will happen to the results of the research study?**

The results of this research will be available within the next 18 to 24 months. You may contact me should you wish to receive a copy of the summary report.

14. Who has reviewed the study?

The Middlesex University, School of Health and Education, Health and Social Care Ethics Sub-committee have reviewed this study.

15. Contact for further information: Tiwalola Kolapo

A contact point for further information and to request a summary report: Email: TK452@LIVE.MDX.UK.AC

Academic Advisors:

Prof Papadopoulos on 02084116626 r.papadopoulos@mdx.ac.uk or

Dr Gordon Weller on 02084114509 (g.weller@mdx.ac.uk)

Middlesex University, Hendon Campus, The Burroughs, London NW4 4BT.

Thank you very much for participating and assisting in the progress of my doctorate programme

*(please note that you are entitled to and will be given a copy of this document (The Participant Information Sheet) and a signed consent form to keep).

Appendix D

Version No3

Participant Identification Number:

CONSENT FORM

Title of Project: Mixed Methods investigation of the challenges and opportunities for commissioning culturally competent dementia services.

Name of Researcher: T F Kolapo
Please place your initials in the box
Please return the consent form by email before you commence participation

1. I confirm that I have read and understand the information sheet dated .....……..…for the above study and have had the opportunity to ask questions. 1

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. 2

3. I agree that this form that bears my name and signature may be seen by a designated auditor. 3

4. I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers. 4

5. I understand that my interview may be taped and subsequently transcribed. 5

6. I agree to take part in the above study. 6

Name of participant		Signature
T F Kolapo	Sept 2017	
Name of person taking consent (if different from researcher)	Date	Signature
T F Kolapo	Sept 2017	
Researcher	Date	Signature

Appendix E

Letter of Invitation
Version 7

Date

Dear (Participant's Name):

This letter is an invitation to consider participating in a study I am conducting as part of my Doctoral degree in the School of Health and Education at Middlesex University. This letter also provides you with background information about this project and what your involvement would entail if you decide to take part.

The UK is now one of the most diversely populated countries in the world today, and of its total population there are over 850,000 people directly affected by Dementia and many more affected by an enduring MH illness. Two thirds of those affected live in the community and one third are cared for at home. My research project is investigating the challenges and opportunities for commissioning Culturally Competent MH/Dementia services to a diverse multicultural population. For the purpose of this exercise I describe Culturally Competent services as those commissioned to deliver care in accordance with an individual's preferred physical, mental, spiritual, social and personal cultural needs affording them the capacity and ability to maintain self-worth and recover expediently.

The purpose of this study is also to inform a culturally competent commissioning framework for MH/dementia services.

This study consists of two phases hence you have been invited to participate in a questionnaire survey and an in-depth interview to explore the ideas and themes you have shared in the survey.

Both phases can be conducted 1:1 or (electronically) virtually/online.

Your invitation to participate is based on your professional standing and knowledge of dementia/MH services/provision and or commissioning in general. I believe that because you are actively involved in these areas you are best suited to speak to the various issues, such as:

- Commissioning
- Dementia
- Older people
- Mental Health services
- Providers
- Cultural Competence
- Person-centred care

Participation in this study is entirely voluntary. It will involve an online survey and/or an in-depth interview each taking approximately 1hr each. The interview will be used to explore emerging themes further and will take place in a mutually agreed upon location or via Skype or telephone to cause you the least inconvenience. You may decline to answer any of the interview questions if you so wish. Furthermore, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher in writing or via email. With your permission, the interview may be recorded to facilitate collection of information, and later transcription for easy analysis. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, without your permission though anonymous quotations may be used. Data collected during this study will be retained for (3 years) on a university computer or laptop. There are no known or anticipated risks to you as a participant in this study.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me at tkolapo452live@mdx.ac.uk or Fiona.nolanandi.nhs.uk. You can also contact my supervisors, Prof Papadopoulos on 02084116626 or Dr Gordon Weller on 02084114509 (r.papadopoulos@mdx.ac.uk or g.weller@mdx.ac.uk), Middlesex University, Hendon Campus The Burroughs London NW4 4BT.

I would like to assure you that this study has been reviewed and received ethics clearance through the Health and Social Care Ethics Sub-committee at Middlesex University. However, the final decision about participation is yours.

I hope that the results of my study will be of benefit to the NHS, those affected by MH and other stakeholders such as the Care Quality Commission, Alzheimer's society and other voluntary organizations not directly involved in the study, as well as to the broader research community.

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Sincerely,

(Tiwalola Kolapo BSC MA)
(Health and Education MDX)

Appendix F

Survey Questionnaire

1. In your view is the NHS commissioning process culturally competent?
2. Please explain the reason(s) for your response to Q1
3. Do you think culturally competent commissioning is important? - The significance of cultural competence
4. Explain why it might be important for the commissioning of services for older people (or other services) to be culturally competent? – The significance of cultural competence"
5. Please describe the type of service that you might consider to be culturally competent - Components of cultural competence
6. List the possible challenges which prevent the commissioning of Culturally Competent dementia services for older people (or other services) -
7. In your view, how should these challenges be addressed? Please list your suggestions
8. Describe criteria you would consider important to include in a culturally competent commissioning framework - Draft Framework
9. How might you or others influence the commissioning of culturally competent MH services? Please list your suggestions
10. What opportunities exist for commissioning culturally competent older peoples services now or in the future?
11. Please offer suggestions for developing guidelines or principles to be used to enable commissioners to achieve culturally competent commissioning for MH/dementia services.
12. Explain why training in Culturally Competent Commissioning may or may not be a challenge to cultural competent commissioning.
13. Age?
14. Gender?
15. Ethnicity?
16. Is your role primarily in commissioning or service delivery?
17. Do you need cultural competence training?
18. What is your role?
19. How many years have worked in your role?

Appendix G

In-Depth Interview Questions (Purpose of questions)

1. Do you think that Cultural Competence (CC) is or should be a hallmark of quality? (do participants think that CC is linked to quality)
2. In your opinion does the National Health Service deliver CC services? (How culturally competent do participants feel the NHS is? Does CC have the right level of relevance in the NHS?)
3. Do you think that CC is captured within the ethos of the NHS as both a provider and commissioning organisation? (How Involved are participants in the role of the NHS as a CC organisation? Is the construct part of the vernacular of the NHS?).
4. The 4 constructs of CC are Awareness, Sensitivity, Knowledge and Competence, what is your opinion about the levels delivered in relation to the diverse population using NHS services. (To obtain a deeper understanding of what the draft CC framework should focus on or obtain an understanding of how participants judge the levels of CC in NHS services.
5. What opportunities would you say the NHS or you in the delivery of your role have for being CC? (Research question: What are the opportunities for commissioning CC dementia services for older people).
6. What are the challenges to being CC as an individual and or an organisation? (The challenges to commissioning CC MH services for older people)
7. What aspects of CC should be addressed in a framework for CC commissioning FOR Mental Health services across the board? (Recommendations to be included in the relevant section of the thesis).
8. What aspects of CC should be addressed in a training Manual for commissioners/providers of CC MH services across the board? (To be included in recommendations for a CC training or framework)
9. Do we need a CC Training Manual or CC Framework? (Merit of one over the other)
10. Would you say cultural competence is about equity or equality? Explain (To obtain an understanding of what participants judge CC to address)
11. What is your definition of CC (What does CC mean to the participant and How much importance does the participant attach to the discourse of CC)