

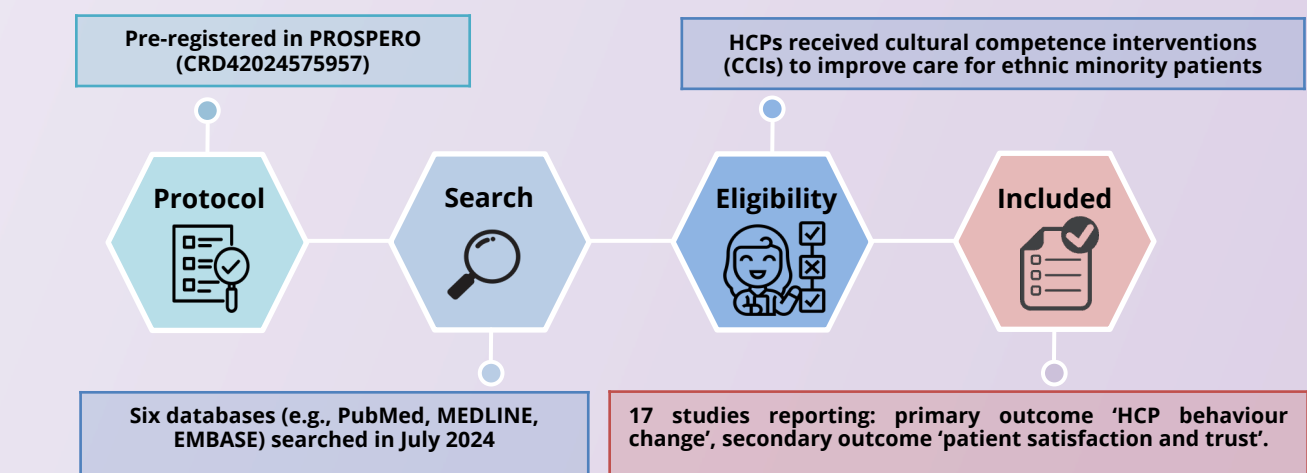
Introduction

- 15 million people in England and Wales identify as belonging to an ethnic group other than white British¹.
- Healthcare providers overlooking ethnicity and culture leads to health inequalities.
- Cultural Competency Interventions (CCIs) are employed for healthcare providers (HCPs) to ensure equitable services for ethnic minority patients.

Research Questions

- RQ1:** How effective are CCIs aimed at HCPs who serve ethnic minority patients in modifying provider behaviour in clinical settings?
- RQ2:** What impact do CCIs have on patient experience, trust, satisfaction and/or service uptake among minority ethnic patients?
- RQ3:** What behaviours are targeted by CCIs, and which behaviour change techniques (BCTs) are employed?

Methods



Results

RQ1: Intervention results

Overall, 13 out of 17 studies reported positive behavioural changes. Effect size (Cohen's *d*) was calculated with mean, standard deviation, and sample size, where possible (*n* = 9). The results were mixed, with two studies showing large effect sizes, four reporting small effect sizes, and three indicating negligible effect sizes.

RQ2: Patient outcomes (satisfaction, trust, and service uptake)

Only, 4 out of 17 studies assessed patient outcomes. Improvements were reported for satisfaction (2/4 studies), and trustworthiness (1/2 studies), while others found no significant changes. One study found no impact on service uptake.

RQ3: Behaviours targeted by CCIs

Overall, A range of behaviours was reported. Examples of target behaviours include:

- HCPs ask how a patient wants to be addressed and interacted with.
- HCPs restated the problem to validate an understanding of cultural influences.

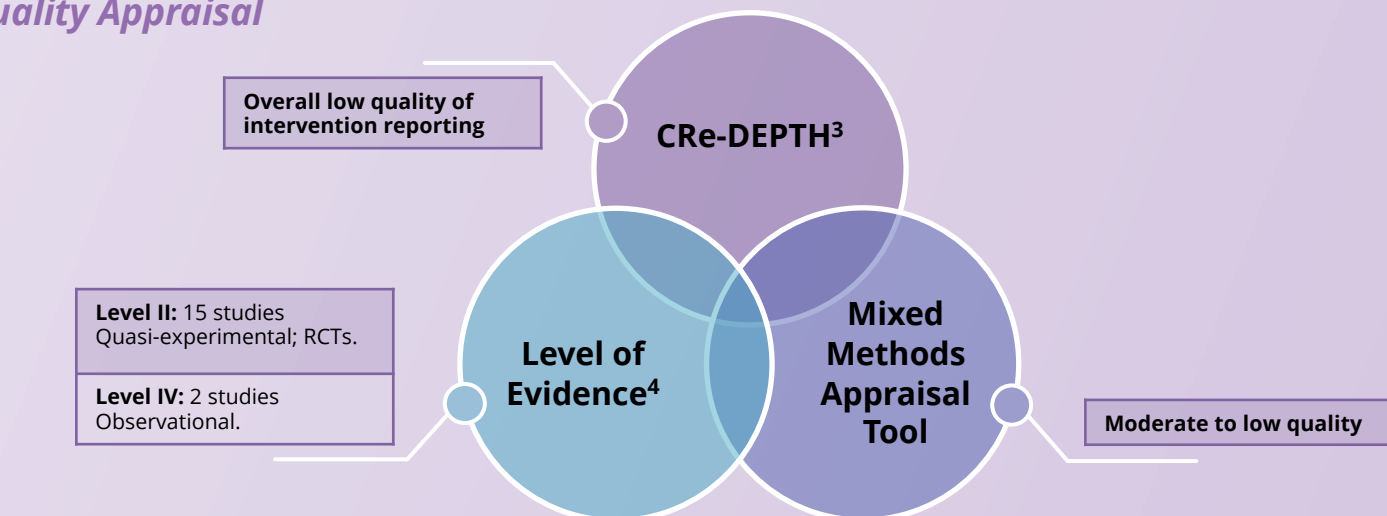
Behaviour Change Techniques (BCTs)

Five common BCTs were coded² and recorded from the studies. These BCTs were:

1. Problem-solving, 2. Instruction on how to perform a behaviour, 3. Information about health consequences, 4. Demonstration of behaviour, 5. Behavioural practice/rehearsal.

No significant associations were seen between the number of BCTs used and the outcome of the intervention. Studies might have used a range of BCTs which were not reported.

Quality Appraisal



Discussion & next steps

- Most studies reported positive behaviour change following CCIs. However, behaviours were not always measured in the context of interest.
- Self-reported measures from HCPs (questionnaires and self-reflection activities) were commonly used, with only four studies capturing patient perspectives on behaviour implementation. This reliance on HCP self-reporting is a key limitation.
- As interventions are generally effective in improving cultural responsiveness of HCPs, our next steps are to understand the barriers and facilitators to culturally responsive hearing services in hearing care professionals.

Interview study - Barriers and facilitators to culturally responsive hearing care services in England (work in progress)

Study aims

- What are the barriers and facilitators for hearing care professionals in providing culturally responsive care to ethnic minority children and their families?
- What are the barriers and facilitators to access and engagement with hearing care services among ethnic minority families of children with hearing loss, from the perspective of hearing care professionals?

Methods

Remote semi-structured interviews with hearing care professionals (*n*=12).

Sex	Female (<i>n</i> =9); Male (<i>n</i> =3)
Ethnicity	White British (<i>n</i> =7); Asian/Asian British (<i>n</i> =4); White Other (<i>n</i> =1)
Mean years in profession (SD)	17.1 (11)
Job role	Paediatric audiologist (<i>n</i> =6), NHS clinical leads in paediatric audiology (<i>n</i> =2), and Teachers of the deaf (<i>n</i> =4).

Interview questions were informed by the **Capability, Opportunity, Motivation-Behaviour (COM-B)⁵ model and Theoretical Domains Framework (TDF)⁶.** Examples of open-ended and close-ended questions included:

- Do you have the *social opportunity* to provide culturally responsive care to ethnic minority children and their families?
- What is your understanding of culturally responsive care?
- How often do you inform them of resources in their local community where they can find help with?

Coding and analysis:

Coding will be done in two levels. Transcripts will be inductively coded to identify barriers and facilitators, which will then be mapped to TDF and COM-B domains.

Emergent findings

Preliminary inductive coding of transcripts yielded the following themes:

- Lack of environmental, accessible, and culturally responsive resources** - "we don't have leaflets in other languages" "if two parents come in, if you then added a translator into that mix, I'd have to rebook the room".
- Affordability: Lack of funds** - "for funding purposes, we can't afford to have a in-person translating".
- Peer support** - "In very rare cases we might have a family... and I have a colleague who speaks the language".
- Lack of knowledge** - "I wouldn't know about their local community".
- Community based assumptions** - "we have a repeat sort of no-shows for appointments and sometimes it's just sort of written off as, 'well they are travellers'..."

References

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Acknowledgements - This work is supported by NIHR Manchester Biomedical Research Centre, with award reference number NIHR-INF-3321, Manchester Centre for Health Psychology and NIHR Greater Manchester Patient Safety Research Collaboration. **Contact details:** sathveeka@manchester.ac.uk