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Contact:

Dr Juping Yu, Faculty of Life Sciences and Education, University of South Wales,
Glyntaf, Pontypridd, UK
juping.yu@southwales.ac.uk

A survey of service providers' views on care and support provision for older women from Black and minority ethnic backgrounds in Wales: implications for policy and practice

Abstract

Drawing quantitative data from a large study, we explored service providers' perceptions of the care and support provided to older women from Black and minority ethnic backgrounds living in the UK. Analyzing 102 responses to a questionnaire, we found that care needs of this group of older women were not adequately addressed, with ineffective communication being frequently reported. A number of information pathways and barriers to service provision were identified. More work is needed to explore how best not only to acknowledge diversity in care needs within older populations, but also to design and deliver responsive services accordingly.

Older people often depend on care and support from others in their daily living. There are some concerns about the quality of care for older people in the UK, a country with an ageing and ethnically diverse population (Office for National Statistics, 2011, 2016). Drawing on quantitative data collected from 102 service providers in a large study, in this paper we examine service providers' views on care and support provision for older women from Black and minority ethnic backgrounds living in community settings. This would allow us to gain an understanding of their experiences of service provision, and of issues around the design and delivery of appropriate services.

BACKGROUND

An ageing and ethnically diverse population

Similar to other western European societies, the UK population is increasingly ageing and ethnically diverse. It was estimated that in 2015, 17.8% of its population were aged 65 or over, with an estimated figure of 20.2% for Wales (Office for National Statistics, 2016; Welsh Government, 2016). Large-scale migrations since 1945 have led to major changes in the ethnic composition of the UK, and to the establishment of significant migrant and minority ethnic communities. According to the latest census, people from Black and minority ethnic (BME) groups made up 12.9% of the total population (Office for National Statistics 2011). Of these, African/Caribbean British (3.0%) formed the largest group, followed by Indian British (2.3%). In the UK, the terms 'BME', 'minority ethnic' or 'ethnic minorities' are most often used to refer to all minority groups of the population not indigenous to the UK that hold cultural traditions and values derived, at least in part, from countries of their or their ancestors' origin. The increasing longevity and ethnic diversity of the population remain key drivers in shaping changes in the design and delivery of social care services in the country.

Reshaping care for older people

UK health and social care policy has shifted away from services for people with a high level of need to services rooted in facilitating independence in older age; this has led to an increased focus on the maintenance of dignity, quality of life, and well-being (Department of Health, 2001; Welsh Government, 2013). What underpins this shift is the growing body of conceptual and empirical evidence on care, support, and dignity. Notions of care can be understood as characterized by relationships involving binding personal ties and levels of interdependence (Fine & Glendinning, 2005). Meanwhile, the concept of support in this context comprises five aspects, covering emotional, instrumental, informational, appraisal, and translational domains (Butt, Moriarty, Brockmann, Sin, & Fisher, 2003; Cattan & Giuntoli, 2010). The delivery of care and support is always operated within a specific social context, involving service providers and recipients, the relationship between them, and the settings where services are planned, provided, managed, and evaluated (Fine & Glendinning, 2005).

Dignity, closely linked to the concept of care, is understood as a multifaceted concept rooted in notions of autonomy, human rights, and recognition (Fenton & Mitchell, 2002; Gallagher, Li, Wainwright, Jones, & Lee, 2008). In their concept analysis of dignity related to older people, Jacelon, Connelly, and Proulx (2004) regard dignity as an inherent characteristic of being human, subjectively felt as an attribute of the self, and manifested through behavior demonstrating respect for self and others. In keeping with the notions of care and support,

Jacobson (2007, 2009) highlights the social dimension of dignity rooted in a concept that the recognition (or not) of a person's worth or social grouping is often linked to wider social factors and social inequalities.

The significance of dignity in care settings has already been reflected in various professional codes of conduct (e.g. General Social Care Council, 2010; Nursing and Midwifery Council, 2008). Launched in 2006 by the UK Department of Health, the Dignity in Care Campaign showed the government's commitment to addressing the lack of dignity and respect in health and social care services through raising awareness of the importance of dignity and inspiring people to take action (<http://www.dignityincare.org.uk/>). However, recent reports have suggested that the care for older people is poor and often associated with a lack of dignity, abuse, and neglect, calling for the establishment of a culture of compassionate and dignified care (e.g. Francis, 2013; Andrew & Bulter, 2014).

Care for older women from BME backgrounds

People from BME communities often experience various barriers to accessing health and social services. For example, they may experience difficulties in obtaining relevant information or encounter language issues, which is compounded with old age (Maneze et al., 2016; Sin, 2005). Providing quality care for older people from these communities is challenging, although service providers often recognize the importance of dignity in care and have put essential values of appropriate care into practice (Badger, Clarke, Pumphrey, & Clifford, 2012; Bowes, Avan, & Macintosh, 2012; Manthorpe, Iliffe, & Moriarty, 2009).

There is some exploration of the provision of care for older people from BME backgrounds in institutional settings. In a qualitative study, both frontline and managerial staff members identified various aspects of service provision vital to ensuring care with dignity (Bowes et al., 2012). These included the importance of practicing respectful communication, providing flexible care, and adopting an individualized care approach with respect for individual cultural preference and personal choice. Various challenges of service delivery have been reported, such as maintaining service providers' values and standards; addressing interpersonal conflict, racism, discrimination, and stereotyping; tackling issues around access to available sources of support for older people and their families (Badger et al., 2009; Bowes et al., 2012; Gerrish, 2001; Gunaratnam, 2013; Patel, 2000).

However, very little research has been carried out to explore community-based care and support requirements for older people, not least those from BME communities. In addition, older women outnumber older men across all UK population groups; for a number of reasons, among ethnic minorities older women are more likely than older men to depend on other family members, and to be socially and economically disadvantaged (Afshar, Maynard, Franks, & Wray, 2008; Wray, 2007). Therefore, there is a need to explore service providers' views on domiciliary or home-based care for older women from BME communities.

This article is part of a large mixed-method study that explored the expectation for dignity and for care and support of older women from BME backgrounds. Data were collected from in-depth interviews with older women and from a survey of service providers. Findings from the interviews have been published elsewhere (Saltus & Pithara, 2014, 2015). Drawing findings from the quantitative data, in this paper we examine service providers' perceptions of the care and support provided to this group of women, barriers to service provision, and how services could be improved.

METHODS

Settings and sample

The research was conducted in Wales, UK, where social care services are delivered by 22 local authorities and around 1,800 private and independent organizations, supporting 150,000 people of all ages and ethnic groups (<http://wales.gov.uk/topics/health/socialcare/?lang=en>).

Participants were recruited from those who: (i) delivered care or support to people aged 50 or over living in their own homes, including older women from BME backgrounds; (ii) supervised others delivering such services; or (iii) managed such services. Various key organizations and networks in contact with older people or women, or with a specific remit to work with BME communities were approached. Information regarding recruitment to the study was also circulated via electronic mailing lists, newsletters, and social media sites.

Data collection

A questionnaire informed by relevant literature, policy documents, and advisory meetings with stakeholders was developed to collect data (Department of Health, 2001; Welsh Government, 2006). Considering the argument that it is more appropriate to explore one or two dignity indicators at a time, we focused on two domains relevant to caring for older people in community-dwelling settings: care and support needs, and effective communication (Magee, Parsons, & Askham, 2008). The questionnaire consisted of 24 questions, including items related to the delivery of care and support with dignity, and to barriers and facilitators of service provision. Demographic and organizational information was also collected. Most of the questions were closed, with two exceptions that asked participants to add free text regarding dignity and examples of good practice. The content and face validity of the questionnaire was piloted with 12 people who had expertise in working with older people or ethnic minorities, in questionnaire design, or in statistics. The questionnaire was refined using feedback received on aspects of its content, readability, flow, layout, and technique.

Data were collected between March and June 2012, and hosted by the Bristol Online Survey website. A link to the site was emailed to organizations and relevant individuals (<https://www.survey.glam.ac.uk/dignitybme>). Following the initial contact, two reminders were made at four-week intervals. An e-copy of the questionnaire was attached to all invitation emails; hard copies were available on request. Three-hundred hard copies were sent to various organizations for distribution, with freepost envelopes provided.

Data analysis

SPSS version 22 was used to assist data analysis. Descriptive statistics were used to describe frequencies and percentages of variables. Chi-square and Friedman tests were used to test different response rates across participants' ethnic groups or sectors. Statistical significance was set at $p \leq 0.05$ (two-tailed).

In total, 124 replies were received online (97) or by post (27). Twenty-two responses were excluded as participants had no experience of working with older women from BME backgrounds. The analysis was based on a sample of 102 responses.

Ethical considerations

The research was approved by a relevant research ethics committee of the researchers' university. General ethical principles in health and social care were followed. Participation was voluntary, with no incentives given. Submitting or returning a completed questionnaire was considered an indication of consent to participation. Any information provided remained unidentifiable.

FINDINGS

The participants

The largest proportion of participants for each characteristic were female; from a white ethnic group; educated at diploma level; aged 46–55 years (Table 1). Most participants were from the third sector (47.5%), followed by the public sector (36.6%), and the private sector (15.8%). Some participants had multiple roles and the largest proportion was involved in providing support (50.0%) (Figure 1). The length of time that participants had spent in their current roles ranged from less than a year to 43 years, with a mean of 11.3 years (SD 9.3).

Dignity: perceptions and indicators

Dignity was explored in terms of participants' understanding of dignity and two common indicators: (i) care or support needs and (ii) effective communication.

There were 100 responses to the question asking participants to list any words or phrases that came to their mind when they heard the word 'dignity'. 'Respect' was mentioned by almost all participants. Dignity was seen to be communicated or to manifest itself through the delivery of care in a 'humanistic', 'respectful', 'professional', or 'personalized' way. Participants also listed words linked to notions of human worth or value ('decency', 'grace', 'honor', and 'rights'); notions of self ('self-respect', 'self-esteem', 'self-worth', 'self-importance', 'self-confidence', 'self-determination', and 'self-awareness'); attitudes of others ('being seen', 'being understood', 'kindness', 'consideration', 'appreciation', 'empathy', 'compassion', 'politeness', and 'non-judgment'); behaviors in others that could diminish a person's sense of dignity ('insulting', 'condescending', and 'abusive'). Other words listed included 'control', 'freedom', 'choice', and 'privacy'.

Care and support were explored in terms of opportunities to express needs, involvement in care, and key needs being addressed (Table 2). An important minority of participants thought that older women from BME backgrounds were seldom offered opportunities to express their needs (20.4%) or support to do so (6.1%). Also, 27.8% reported that these older women were seldom or never involved in their own care. In terms of physical, social, psychological, religious, and cultural needs, the majority of participants reported that these needs were always or frequently addressed. However, Friedman tests indicated that there was a significant difference between the frequencies with which different needs were taken into account ($\chi^2 = 49.29$, $p < 0.001$). Physical needs were the most likely always to be taken into account (53.9%), while psychological needs were least likely (32.2%).

In terms of participants' agreement with six statements on effective communication (Table 3), statement 2 'BME older women can often discuss their care with people supporting them' produced the highest proportion of strongly agree or agree responses (80.0%), while

statement 6 ‘BME older women are often comfortable to raise concerns about their care’ had the lowest proportion of such responses (69.4%). More specific questions were asked regarding language choices and information provision. A considerable number of participants reported that older women from BME backgrounds were seldom or never offered a language choice for communication (45.0%) or provided with information relevant to their ethnic or cultural backgrounds (31.0%).

Barriers to care and support provision

Barriers to service provision were explored in terms of (i) general barriers and (ii) specific barriers. The focus was on those either providing hands-on care, or supervising/managing services.

General barriers to providing care and support were explored in terms of service structure, skills and competences, attitudes, and factors related to BME older women (Table 4). Barriers linked to the way in which a service was structured were most commonly reported, such as ‘lack of staff who can speak community languages’ (73.3%), followed by issues linked to skills and competences needed to work responsively in an intercultural context. Attitudinal barriers such as racism and negative attitudes toward people based on their age, gender, or ethnicity were least commonly reported. However, there were some significant differences between participants of different ethnicities and between the sectors in which they worked. Participants from BME backgrounds themselves were more likely than white participants to refer to several barriers, including ‘racism’, ‘negative attitudes to women’, and ‘negative attitudes to people from BME backgrounds’ ($p < 0.01$ in all cases). Only one barrier (‘negative attitudes to people from BME backgrounds’) was more likely to be referred to by participants in the third sector than those in the other two sectors ($p < 0.05$).

Responses to barriers facing specific stakeholder groups are presented in Table 5. Participants providing hands-on care most commonly reported ‘lack of staff who can speak community languages’ as being a barrier (71.4%). In terms of participants with management or supervising responsibilities, ‘not taking account of older people’s culturally specific needs when designing services’ was the most frequent barrier to organizing services (51.4%). Chi-square tests indicated that participants from BME backgrounds themselves were more likely than white participants to refer to ‘lack of staff training’ as a barrier to delivering hands-on care, and ‘racism’ as a barrier to organizing services ($p < 0.05$ in both cases). Participants in the private sector were more likely than those in either of the other sectors to report ‘racism’ as being a barrier to organizing services ($p < 0.01$); this was the only specific barrier to show a significant result in terms of differences between sectors.

Facilitators of care and support provision

Questions were asked about where participants sought information and support to help them provide better services.

Table 6 presents responses to information pathways, in terms of sources within an organization, external organizational sources, and other sources. The most frequently referred sources in each pathway were ‘best practice guidelines’, ‘organizations that mainly work with older people’, and ‘family members and friends of the person you provide care or support for’ (59.0%, 58.0%, and 78.0%, respectively). Chi-square tests showed that participants from BME backgrounds themselves were statistically more likely than white

participants to refer to their 'own experiences' (95.2% and 51.3% respectively); this was the only source to achieve a significant result ($p < 0.01$) in terms of ethnic differences. Care plans were more likely to be used by those in the private sector than those in the public or third sectors (81.3%, 50.0%, and 19.1% respectively; $p < 0.01$).

Presented in Table 7 are responses to key factors that might help participants provide better care or support. 'Information tailored to older people's needs' was most frequently referred to (62.4%), closely followed by 'staff training' and 'recognition of older people's needs' (61.4% in both cases). There were significant differences in the proportion of responses based on participants' ethnicity, with those from BME backgrounds themselves being more likely than white participants to refer to a number of key elements including 'positive attitudes to older people from BME backgrounds', 'recognition of older people's needs', and 'willingness to take action on older people's needs' ($p < 0.01$ in all cases).

DISCUSSION

Our findings shed light on the views of service providers on their provision of care and support with dignity to older women from BME backgrounds. Participants considered the concept of dignity mainly in the context of their professional practice, and regarded it as a multi-faceted concept, most frequently associated with respect that was communicated and manifested itself through actions and behaviors. Elements crucial to professional practice, such as empathy and compassion, were also seen to be closely linked to dignity. These findings are consistent with the literature on the concept of dignity (Anderberg, Lepp, Berglund, & Segesten, 2007; Jacelon et al., 2004), and are in keeping with UK professional discourses on dignity, practice guidelines and directives, and principles underpinning dignity campaigns and health and social care policy agendas (Department of Health, 2001; Social Care Institute for Excellence, 2009; Welsh Government, 2006, 2013).

Most participants in our study seemed to be aware of some key elements underpinning better services, such as recognition of older people's needs and information tailored to their needs. The majority of participants believed that older women from BME backgrounds were always offered opportunities and relevant support to express their care and support requirements. However, language difficulties in terms of a lack of language choices or interpreters were frequently referred to as barriers to service provision. Without sufficient language support, it would be unlikely that individual needs, especially those that are less visible (e.g. social, cultural, religious, and psychological needs), could be communicated, understood, and accordingly addressed. These findings may reflect the gaps and inconsistency between what participants thought to be good services and what they were actually able to deliver. Similar findings were reported in a study of health and social care workers (Calnan, Woolhead, Dieppe, & Tadd, 2005).

Effective communication, including being listened to, understood, and able to discuss one's own care and raise concerns, is a key indicator underpinning many dimensions of dignity (Bowes et al., 2012; Magee et al., 2008; Webster & Bryan, 2009; Woolhead et al., 2006). There is also a growing recognition that being treated as an individual, whose needs are assessed and responded to appropriately, is crucial for the provision of care with dignity (Arino-Blasco, Tadd, & Boix-Ferrer, 2005; Bowes et al., 2012; Magee et al., 2008; Tadd et al., 2011). As highlighted in the literature and the media, language is a well-recognized barrier to ethnic minorities' accessing health and social care services (Al-Amoudi, Cañas, Hohl, Distelhorst, & Thompson, 2015; Liu & McDaniel, 2015; Wright 2010). However,

narrowly focusing on language barriers and ignoring the contexts in which services are organized and delivered can lead to biased or misleading conclusions (Bhattacharyya & Benbow, 2013). Taking into account levels of health literacy, together with assessing language needs, has been recommended as a minimum quality indicator of culturally appropriate care for a diverse older population (American Geriatrics Society Ethnogeriatrics Committee, 2016).

In the current study, a large majority of participants recognized that key elements underpinning individualized care in relation to cultural or religious requirements were not fully embedded in how services were structured. Moreover, although there was little reference to racism and negative attitudes toward ethnic minorities, older people, or women, a small but important number of participants (especially those from BME backgrounds) did mention these issues. These findings may indicate that BME participants have experienced racial discrimination themselves or that they were more likely to recognize and report such issues. There might also be a denial of racism, as reported by Vydellingum (2006) in a qualitative study of nurses who cared for hospitalized South Asian patients in England. The author argued that to ignore or choose to deny the existence of racism where it did occur was a major shortfall in service provision.

Based on our findings, we highlight the necessity of finding an effective way to bridge the gap between acknowledging the need for care with dignity and delivering responsive, person-centered services. Some key building blocks were seen already in place, including participants' links with external and third-sector organizations with expertise in age and ageing, ethnic diversity, or older people. This also included in-house expertise of people with some experience of working in a multicultural context. Considering that dignity was viewed by participants in the current study mainly in the context of professional practice and care standards, more work is needed to explore the social and interpersonal aspects of dignity (Jacobson, 2007, 2009; Saltus & Folkes, 2013). Such work would help us understand how intercultural competences can be captured appropriately and enhanced effectively.

Study limitations

Our study focused on service providers' perceptions of their own practice. It has been found in previous research that professionals often perceive their own practice more positively than do older people and their families (Bowes et al., 2012). The sample size was small, limiting the generalizability of our findings; some significant associations observed might reflect an unrepresentative set of participants. Male participants were under-represented, which may reflect the demography of occupational groups involved in care settings. Participants' experiences of working with older ethnic minorities varied; this may have affected their perceptions. Also, as with research in general, there is potential selection bias. Those who participated might have a particular interest in or concerns about caring for older people from BME communities. Finally, the questionnaire used for data collection was presented in English. Organizations providing services to a specific ethnic community often employ staff from their own community, who may or may not be proficient in English. As such, we might have limited their ability to participate in this study. Despite these limitations, some recommendations can be made.

Implications

The shift in emphasis in how care is perceived, experienced, commissioned, and delivered has led to a focus on previously disregarded and intangible aspects of care, including autonomy, respect, decision-making, and dignity. However, without attention to the wider societal context in which care and support are delivered and experienced, including the social dimension of dignity, a narrow focus on the person could limit the development of competences needed to engage and work in an intercultural context.

Issues around interpretation have been frequently documented, in terms of availability of interpreters, difficulties encountered in translating medical terms, and ethical aspects surrounding the use of interpreters in care settings (Mastrocola & Nwabine 2009; Rozario 2005). Some good practice with regard to the use of interpreters has been recommended including: seeking the most-qualified person available; not asking family members to interpret; briefing the interpreter before and after an encounter; not leaving the interpreter alone with the service user; paying attention to body language and nonverbal behavior (American Geriatrics Society Ethnogeriatrics Committee, 2016). Employing people who speak the required language may overcome some barriers (Bowes et al., 2012). However, this may raise other issues, since as reported in the current study, participants from a BME background themselves tended to experience additional barriers; thus, ongoing training, supervision, and support must be in place. Also, service providers need to be aware of good communication strategies, and to understand how these strategies can be applied effectively to their own practice.

The merits of a person-centered approach to meet the needs of diverse older people have been highlighted (Badger et al., 2012; Manthorpe et al., 2009). There is a need for future research to explore how to provide mainstream care tailored to the individual, rather than offering separate specialist services for older people from BME backgrounds. Services focusing on individuals, while considering a cultural explanation of needs and level of health literacy, would be appropriate to serve all people (American Geriatrics Society Ethnogeriatrics Committee, 2016; Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

CONCLUSION

Our findings provide some evidence of the perceived quality of care and support services for older women from BME backgrounds, and suggest a need to improve the overall quality of such services. In an increasingly ageing and diverse society - such as that in the UK - service providers are challenged to deliver high-quality care (i.e. care that is culturally appropriate and takes into account levels of health literacy) to older people of all ethnic groups. Exploration of service providers' perceptions on how care and support are provided to and received by individuals and population groups, and of barriers associated with professional practice, can inform the improvement of care for older women from BME communities in Wales, other parts of the UK, and beyond.

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Table 1 Self-reported demographic information

	n*	%*
Gender		
Male	12	11.9
Female	89	88.1
Age (years)		
Under 25	1	1.0
25-35	15	14.9
35-45	23	22.8
46-55	39	38.5
56-65	22	21.8
Over 65	1	1.0
Educational level		
Certificate	11	11.2
Diploma	26	26.5
Bachelor's degree	25	25.5
Graduate diploma	12	12.2
Master's degree and above	20	20.4
None of the above	4	4.1
Ethnic background		
White-Welsh	47	47.0
White-British	29	29.0
White-Irish	1	1.0
Any other White background	1	1.0
Black or Black British-Caribbean	1	1.0
Black or Black British-African	4	4.0
Asian or Asian British-Indian	2	2.0
Asian or Asian British-Pakistani	2	2.0
Asian or Asian British-Bangladeshi	1	1.0
Any other Asian background	2	2.0
Chinese	9	9.0
Any other mixed background	1	1.0

* Some information was not provided by all participants.

Table 2 Care and support needs

Needs		Always	Frequently	Seldom	Never
		n (%)			
Being offered opportunities to express their needs		41 (41.8)	37 (37.8)	20 (20.4)	-
Being supported to express their needs		38 (46.3)	39 (47.6)	5 (6.1)	-
Being involved in their own care		30 (30.9)	40 (41.2)	24 (24.7)	3 (3.1)
Addressing care and support needs	Physical needs	48 (53.9)	32 (36.0)	8 (9.0)	1 (1.1)
	Social needs	37 (42.0)	30 (34.1)	17 (19.3)	4 (3.9)
	Religious needs	30 (35.3)	26 (30.6)	23 (27.1)	6 (7.1)
	Cultural needs	28 (32.9)	25 (29.4)	25 (29.4)	7 (8.2)
	Psychological needs	28 (32.2)	36 (41.4)	19 (21.8)	4 (3.9)

Table 3 Statements on effective communication

Statements	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	n (%)				
1. People often ask how BME older women would like to be addressed.	38 (38.4)	36 (36.4)	15 (15.2)	8 (8.1)	2 (2.08)
2. BME older women can often discuss their care with people supporting them.	40 (40.0)	40 (40.0)	15 (15.0)	4 (4.0)	1 (1.0)
3. People often listen carefully to what BME older women have to say.	39 (39.4)	33 (33.3)	20 (20.2)	4 (4.0)	3 (3.0)
4. People often take time to listen to what BME older women have to say.	35 (35.0)	41 (41.0)	18 (18.0)	3 (3.0)	3 (3.0)
5. People often make sure BME older women understand them.	33 (33.7)	35 (35.7)	20 (20.4)	8 (8.2)	2 (2.0)
6. BME older women are often comfortable to raise concerns about their care.	33 (33.7)	36 (36.7)	19 (19.4)	6 (6.1)	4 (4.1)

Table 4 General barriers to providing care and support

Barriers	n (%)	Participant's ethnic group (%) [†]	Participant's sector of work (%)#
Service structure			
Lack of staff who can speak community languages	74 (73.3)	75.3/71.4	73.0/93.8/66.0
Lack of interpretation services	47 (46.5)	42.9/61.9	37.8/43.8/53.2
Lack of staff training	41 (40.6)	33.8/71.4**	35.1/50.0/42.6
Limited time	41 (40.6)	33.8/71.4**	44.7/33.3/35.3
Skills and competences			
Not recognizing culturally specific needs of older people	42 (41.6)	37.7/61.9	45.9/31.3/42.6
Lack of knowledge of older people's religious beliefs	37 (36.6)	35.1/47.6	35.1/37.5/36.2
Attitudes			
Negative attitudes to people from BME backgrounds	16 (15.8)	10.4/38.1**	5.4/12.5/25.5*
Racism	13 (12.9)	6.5 38.1**	2.7/18.8/19.1
Negative attitudes to older people	10 (9.9)	9.1/14.3	8.1/0/14.9
Negative attitudes to women	3 (3.0)	0 /14.3**	0/0/6.4
Factors related to BME older women			
Perceptions of local services	32 (31.7)	27.3/52.4*	24.3/31.3/38.3
Lack of access to information	31 (30.7)	26.0/52.4*	27.0/25.0/36.2
Perceptions of local councils	22 (21.8)	18.2/38.1	21.6/12.5/25.5
Limited use of services	8 (7.8)	9.0/4.8	10.8/6.3/6.3
Other	8 (7.9)	6.5/14.3	5.4/0/12.8

Chi-square tests

* $p \leq 0.05$; ** $p \leq 0.01$

[†] Participants from white/BME backgrounds

Participants from the public/private/third sectors

Table 5 Specific barriers to delivering hands-on services or organizing services

Barriers	n (%)	Participant's ethnic group (%)†	Participant's sector of work (%)#
Barriers to delivering hands-on services			
Lack of staff who can speak community languages	35(71.4)	72.2/66.7	68.8/81.8/66.7
Lack of interpretation services	30 (63.8)	59.4/71.4	56.3/66.7/66.7
Limited time	27(61.4)	58.6/71.4	71.4/50.0/57.1
Not knowing the culturally specific needs of older people	20(46.5)	40.0/66.7	46.7/55.6/44.4
Lack of staff training	19(46.3)	34.6/71.4*	50.0/50.0/45.0
Lack of supervision and support	11(30.6)	33.0/30.0	41.7/25.0/26.7
Barriers to organizing services			
Not taking account of older people's culturally specific needs when designing services	38 (51.4)	46.7/76.9	44.4/58.3/55.9
Not taking account of older people's culturally specific needs when evaluating services	36(49.3)	45.8/69.2	44.4/50.0/54.5
Not taking account of older people's culturally specific needs when commissioning services	34(46.6)	42.4/69.2	38.5/50.0/52.9
The way local services are perceived	31 (43.7)	40.4/61.5	34.6/41.7/53.1
The way local services are accessed	30(50.8)	47.9/70.0	40.0/60.0/55.2
Negative attitudes to older people	12(17.6)	17.5/20.0	16.7/9.1/21.9
Negative attitudes to BME older women	11(16.2)	14.0/30.0	4.2/18.2/25.0
Racism	9(13.4)	7.3/45.5**	0/25.0/20.0*
Negative attitudes to women	9(13.4)	12.5/20.0	4.2/10.0/21.9

Chi-square tests

* $p \leq 0.05$

† Participants from white/BME backgrounds

Participants from the public/private/third sectors

Table 6 Information pathways

Internal sources n (%)		External organizational sources n (%)		Other sources n (%)	
Best practice guidelines	59 (59.0)	Organizations mainly working with older people	58 (58.0)	Family members and friends of the person you provide care or support for	78 (78.0)
Internal policy	54 (54.0)	Organizations providing health and social care	52 (52.0)	The person you provide care and support for	74 (74.0)
Managers	52 (52.0)	Organizations mainly working with older people from a BME background	50 (50.0)	Own experience**	59 (59.0)
Co-workers	44 (44.0)	Equality organizations	38 (38.0)	Multi-cultural sources	46 (46.0)
Care plan\$\$	40 (40.0)	Cultural associations	32 (32.0)	Independent advocacy	37 (37.0)
Supervisors	34 (34.0)	Organizations mainly working with women from a BME background	28 (28.0)	Books, journals, or magazines	31 (31.0)
Other	3 (3.0)	Religious organizations	24 (24.0)	Religious sources	22 (22.0)
		Other	19 (19.0)	Other sources	12 (12.0)
				Online training	12 (12.0)
				Online discussion forum	7 (7.0)

** $p < 0.01$ for ethnic group

\$\$ $p < 0.01$ for sector

Table 7 Key elements of providing better care and support

Key elements	n (%)	Participant's ethnic group (%)†	Participant's sector of work (%)#
Information tailored to older people's needs	63 (62.4)	57.1/85.7*	58.3/56.3/66.7
Staff training	62 (61.4)	61.0/71.4	63.9/56.3/62.5
Availability of interpreters	62 (61.4)	58.4/76.2	63.9/56.3/62.5
Recognition of older people's needs	60 (59.4)	51.9/90.5**	58.3/50.0/62.5
Positive attitudes to older people from BME backgrounds	58 (57.4)	51.9/85.7**	47.2/50.0/68.8
Willingness to take action on older people's needs	49 (48.5)	41.6/76.2**	41.7/43.8/54.2
Organizational culture	38 (37.6)	31.2/66.7**	36.1/31.3/41.7
Other	10 (9.9)	7.8/19.0	5.6/6.3/14.6

Chi-square tests

* $p \leq 0.05$; ** $p \leq 0.01$

† Participants from white/BME backgrounds

Participants from the public/private/third sectors

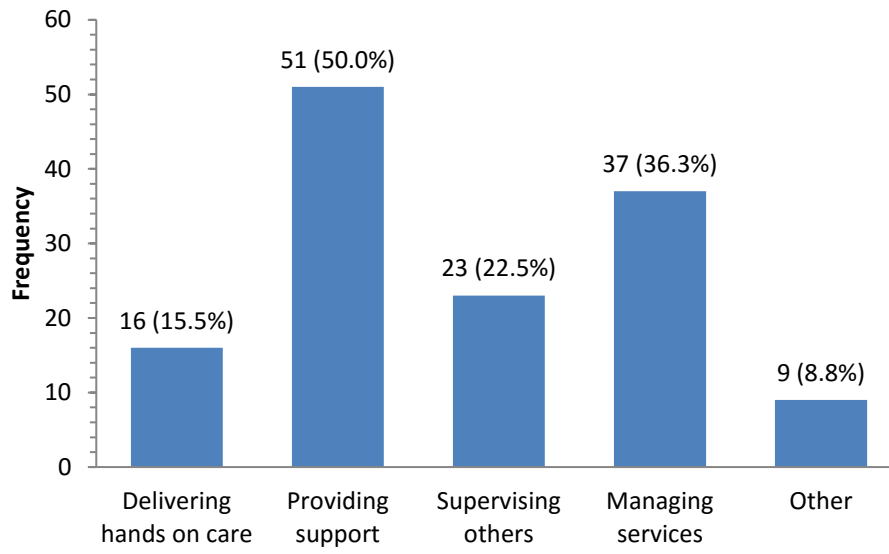


Figure 1 Participant's professional roles (multiple responses permitted)