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Increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham - an exploratory research study

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Increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham – an exploratory research study: *Interim report*

November 2015

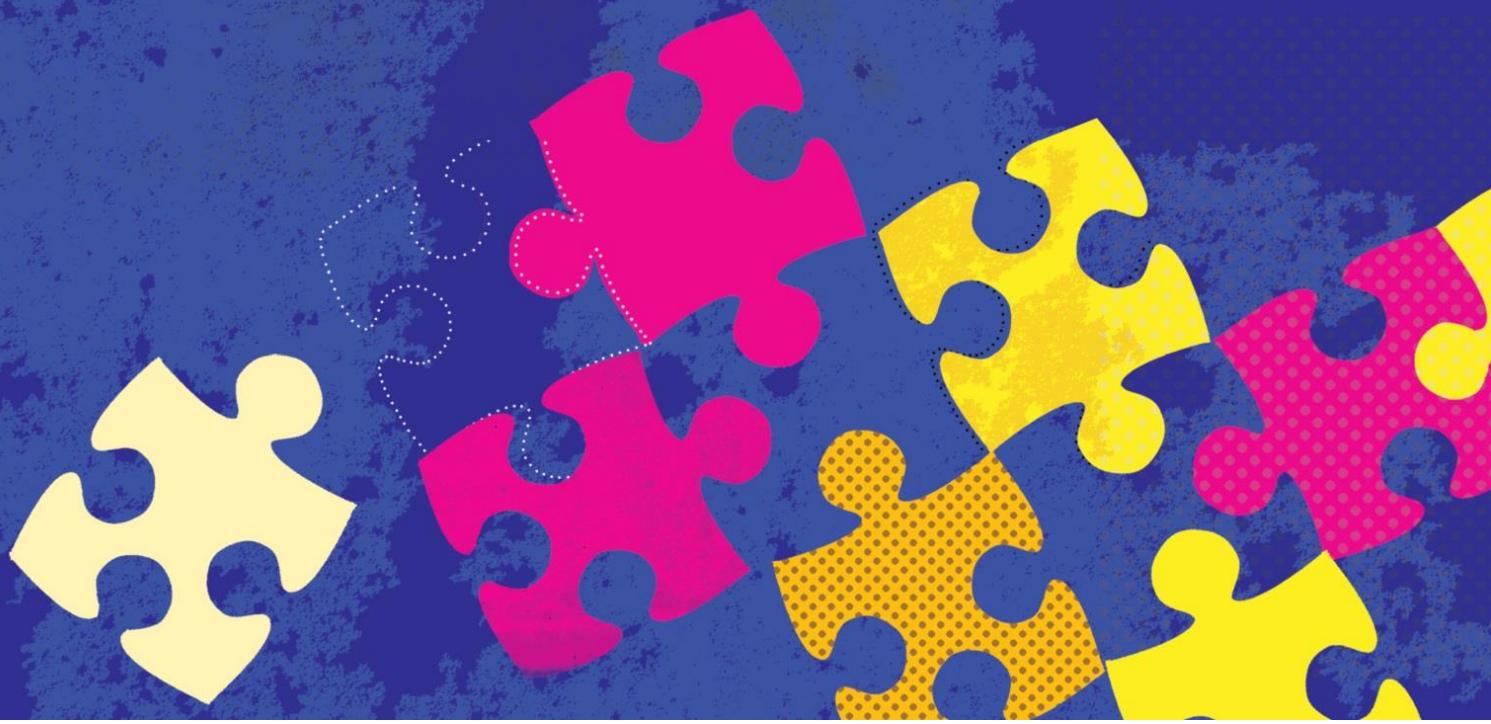Sheffield Hallam University | Centre for Health and Social Care Research

NHS Nottingham City
Clinical Commissioning Group

Increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham - an exploratory research study

Interim Report

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Executive Summary

This report provides the interim findings of an exploratory research study into the uptake of primary and community diabetes and respiratory long-term conditions services amongst Black and Minority Ethnic (BME) communities in Nottingham City. This interim report is based on a review of secondary data and literature. A number of important findings have emerged that will be of interest to local commissioners and their partners; these findings will also shape the direction of the study going forward.

1. Nottingham City has a **large BME population** which accounts for just over one third (35 per cent) of the total population, having increased from just under a fifth (19 per cent in 2001). Although, overall, BME residents are less likely than non-BME residents to report poor health, this is due to the younger age profile of BME residents, and masks an underlying trend amongst older BME residents (aged 50+) which indicates they are **more likely than non-BME residents of the same age to report poor health**. These demographic and health trends mean long-term condition support services for these communities are important and will grow in importance in the future.

2. There is a wealth of literature on the *barriers to* and *enablers for* BME communities accessing health-related services. This evidence comes from a mixture of condition-specific studies and studies into health conditions more generally, but the majority of lessons are likely to be transferable across conditions.

1. Use of evidence
2. Communication & trust
3. Culturally adapted interventions/training
4. Community links
5. Finances
6. Family support and social networks
7. Patient involvement

ENABLERS

1. Language & communication
2. Awareness of disease/ disease management
3. Social and cultural norms
4. Relationships with/ trust in health professionals
5. Community factors
6. Discrimination and socioeconomic status

BARRIERS

3. Asset-based approaches to health advocate **promoting and developing the individual and community-level factors that support good health and well-being** whilst ameliorating the symptoms and consequences of poor health. The evidence reviewed in this study highlights five key inter-linked assets that contribute to health and well-being.

Adapted from Hopkins and Rippon, 2015

Although policy makers and practitioners in health and social care have advocated in favour of asset-based approaches in growing numbers in recent years, this support has not been backed by significant levels of additional resource or strategic investment. Indeed, critics of the current interest in such approaches argue that it could be used as a smokescreen for ongoing reductions in statutory provision of public health, care and welfare services. Instead, these critics argue that involving members of the public in health service design and delivery should be embraced as a **mechanism for reducing barriers to the resources necessary for good health**, and should be framed as a key strategy for increasing equity in health.

4. There is potential to **reframe the research** around four stages suggested as necessary for the strategic development of an asset-based approach to health.

Adapted from Hopkins and Rippon, 2015

A series of underpinning research questions can be assigned to each stage and explored during the qualitative phase of this study.

5. The research has identified **a range of practice-based examples** to applying various principles of asset-based approaches to support people from BME and non-BME communities in accessing health-related services. There is much **transferable learning from these case studies** on which the CCG could draw as it seeks to embed an asset-based approach to working with and supporting BME people with long-term conditions to increase their uptake of services provided through primary and community care.

Introduction

1

This report is the first output from an exploratory research study into the uptake of primary and community diabetes and respiratory long-term conditions services in Black and Minority Ethnic (BME) communities in Nottingham City. The study has been commissioned by NHS Nottingham City Clinical Commissioning Group ('the CCG') and is being undertaken by a team from two research centres at Sheffield Hallam University: the Centre for Regional Economic and Social Research (CRESR) is leading the research with support from the Health and Social Care Research Centre (HSCRC).

The CCG has commissioned this study to inform how they can best work in partnership with local BME communities to increase the uptake of community and long-term conditions services in Nottingham. In particular, they want to better understand any barriers and enabling factors from the perspective of BME communities to support the development of effective commissioning strategies that meet their needs and promote and support increased service uptake. The study is therefore framed around four research questions:

- What are the blocks and barriers to patients from BME communities with long-term conditions accessing and taking up existing long-term condition services?

- How should the CCG, GP practices and service providers engage with BME communities most effectively, including through an asset-based approach?

- What changes need to be made to the way services are delivered?

- What are the next steps for commissioners to support a sustained increase in uptake of long-term conditions services by BME communities?

The study is being undertaken in two phases:

- Phase 1 is an evidence review, covering UK and international literature and including published academic papers and a wider body of 'grey' material from policy and practice. Secondary data have also been analysed and a number of stakeholder interviews undertaken to provide contextual information and to inform the next phase of the study.

- Phase 2 involves in-depth qualitative research to explore the local context further and identify what the CCG, GP practices and service providers need to do differently to ensure increased uptake.

This report is the outcome of Phase 1 of the research. It addresses the first two research questions above, and aims to provide the CCG and its partners with a better understanding of the barriers, challenges, and best practice associated with the delivery of long-term conditions services to people from BME communities, with a view to supporting the development of workable solutions that encourage greater uptake of these services in the future. The focus of the report is therefore about learning what has worked well elsewhere and why, with a view to stimulating debate with the CCG and its partners about how this learning can be applied in a Nottingham City context.

Context for the research

2

This chapter aims to provide some context for the research study. It outlines the CCG's rationale for commissioning the research before drawing on 2011 Census data, alongside other administrative data sources such as the JSNA, to provide an overview of the BME population in Nottingham City. Data presented include information about the composition of the BME population in the City as a whole and at Care Delivery Group (CDG) level; analysis of the health status of the BME population in different CDGs; and discussion of data on the extent to which the BME population is currently accessing key long-term condition services.

The rationale for the research

Enhancing the quality of life for people with long-term conditions - with a focus on diabetes and respiratory conditions - is one of six strategic priorities set out in the CCG's commissioning strategy for 2013-16. The strategy recognises that Nottingham City has high numbers of people with long-term conditions, and that this is expected to rise due to the ageing population and the impact of wider lifestyle factors, such as smoking or being overweight. In this context the CCG has identified diabetes and respiratory conditions as particularly problematic because, although there are a number of services already in place, local people with these conditions continue to have poor outcomes. As a result, the focus of the long-term conditions priority in the CCG's commissioning strategy is to deliver transformational improvements in health outcomes for patients with diabetes and respiratory conditions. This includes an emphasis on commissioning services which are targeted at a community level, in particular Black and Minority Ethnic (BME) groups where there are higher than average numbers of people with long-term conditions and poorer health outcomes.

Existing commissioned services focus on smoking, weight management and healthy living, and glucose control, but there is growing recognition within the CCG that these services could be more effective for people from BME communities if they utilised an 'asset-based' approach to overcome barriers and facilitate access for those individuals not currently engaging with the support available. The CCG has already taken important steps in this direction, through its commissioning of Self-Help Nottingham to facilitate peer-led groups for people from BME communities with long-term conditions, and through the process of re-commissioning diabetes services, which included a number of consultation events for service users from different BME communities across the City.

Through this research the CCG hopes to build a broader evidence base about the barriers and enabling factors for people from BME communities requiring diabetes and respiratory services through which a wider and more effective range of asset-based approaches can be developed. This report provides an important first step in this process by identifying the main barriers and enabling factors evident in the literature, and providing some practical examples of how asset-based approaches might be used to overcome these.

An overview of the BME population in Nottingham City

Demographic and geographic characteristics

According to the 2011 Census, 35 per cent of the population in the Nottingham City are from BME groups: this represents an increase from 19 per cent in 2001. The largest proportion of BME residents are Asian or Asian British (13 per cent), followed by Black African/Caribbean (7 per cent), people of mixed or multiple ethnicity (7 per cent) and people from non-British White backgrounds (6 per cent). Figures 1 and 2 provide an overview of the concentration of the BME population across Nottingham City by Ward and by Care Delivery Group (CDG). They shows that the BME population is concentrated in the centre of the City, in parts of CDGs 3, 4, 5 and 6, notably the Leen Valley, Arboretum, Berridge and St Ann's Wards, which each have more than 40 per cent of the population from BME populations. It also shows that a large area of the south of the City, in parts of CDGs 4, 6 and 7, particularly the Wollaton East and Lenton Abbey, Radford and Park, Dunkirk and Lenton, Bridge and Dales Wards, have between 30 and 40 per cent of their residents from BME populations. CDG 4 has the highest overall proportion of BME residents (39 per cent), followed by CDG 6 (35 per cent) and CDG 5 (33 per cent).

More detailed analysis of the 2011 Census by CDG is presented in Appendix 1. It reveals a number of community-level variations by specific ethnic group:

- CDG 3 has a concentration of residents from Pakistani communities

- CDG 4 has concentrations of residents from the Indian, Pakistani, Black African and Chinese communities

- CDG 6 has concentrations of residents from the Pakistani, Black African and Black Caribbean communities

Although not covered by the tables, the Nottingham City JSNA[1] notes that the 'other' White group listed in the Census, which includes people from the post-2004 EU Accession countries, notably Poland, are concentrated around specific Wards in CDGs 4, 5, 6 and 8. Similarly, evidence from a survey of migrants from the EU Accession countries[2] suggests that the main concentrations are in CDGs 4 and 6.

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[1]See http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA/Related-documents/Demography-chapter.aspx.
[2] 'A Study of A2 and A8 Migrants in Nottingham', University of Salford (for One Nottingham), April 2009.

Figure 1: Overview of Nottingham City BME population by Ward and Care Delivery Group (CDG)
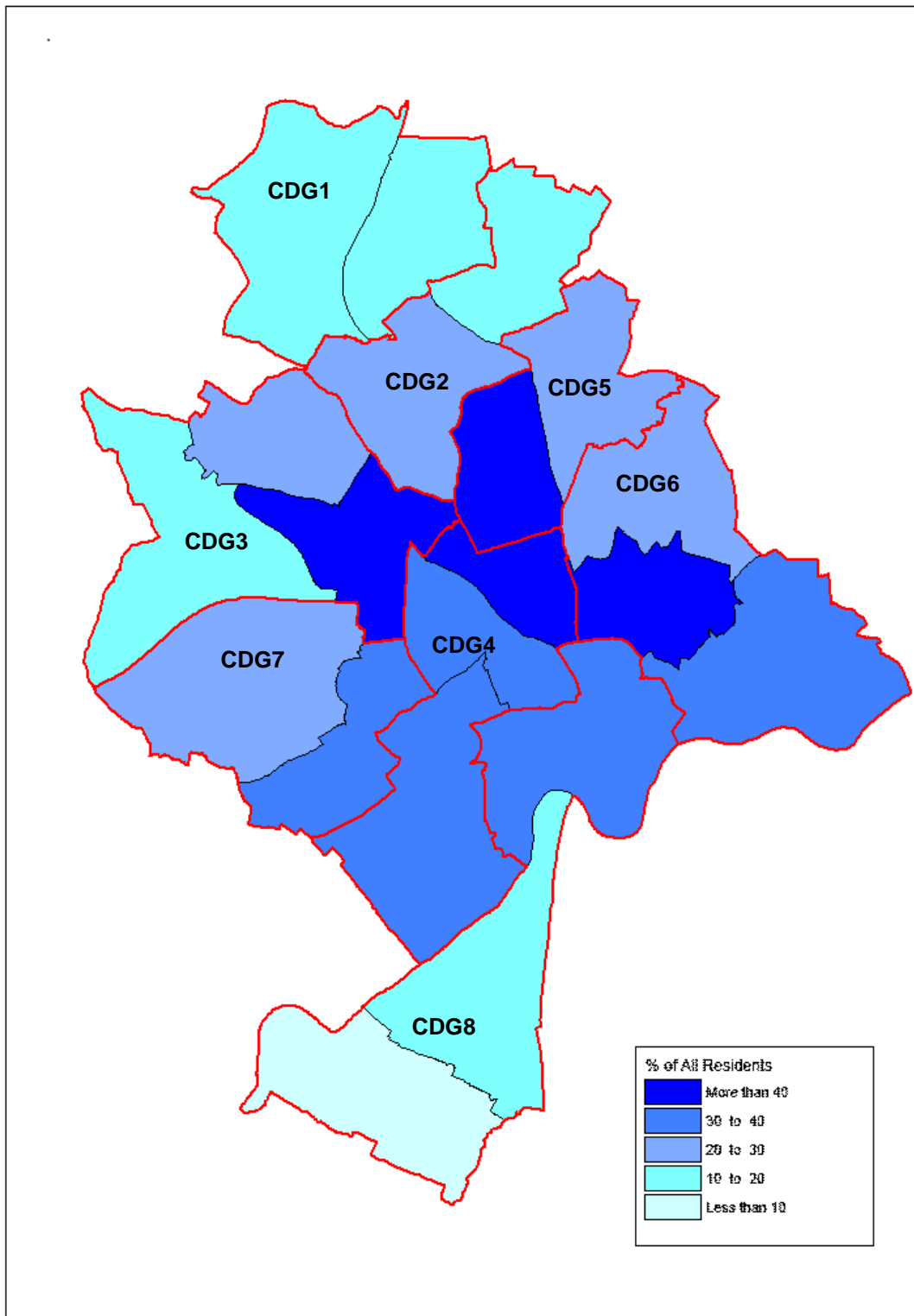
Source: 2011 Census, Office for National Statistics

Figure 2: Overview of Nottingham City BME and non-BME residents by CDG
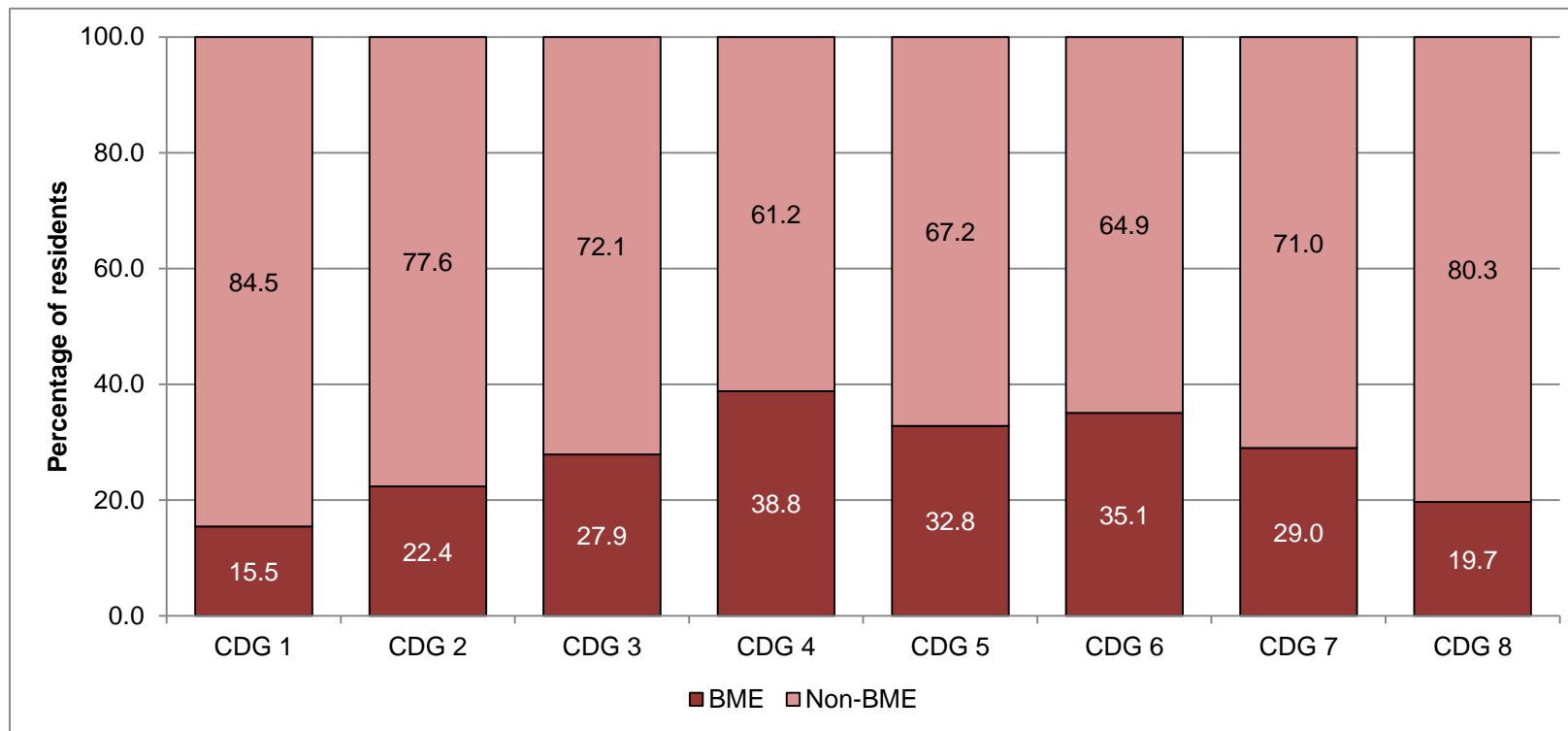
Source: 2011 Census, Office for National Statistics

Health status

The 2011 Census also provides insights into the health status of residents from BME communities: this includes residents who report having 'limiting long-term health problems' and those who say they have 'bad' or 'very bad' health. Figure 3 provides an overview of the number of BME and non-BME residents per thousand residents with 'limiting long-term health problems', including by CDG area. Figure 4 provides an overview of the proportion of BME and non-BME residents with 'bad' or 'very bad' health, including by CDG area. Perhaps surprisingly, these figures suggest that, overall, members of BME populations in Nottingham City were less likely to report limiting long-term conditions and poor health than non-BME groups. This pattern is repeated across the CDGs, with the exception of CDG 4, which is the CDG with the highest total BME population, where BME residents are more likely to report poor health than non-BME residents.

More detailed analysis by age group reveals a very different picture. Amongst the older age groups in each CDG, particularly those aged 65 and over, BME residents were more likely to report poor health. This is illustrated by figures 5 and 6 which show the number of BME and non-BME residents per thousand residents aged 65 or over with 'limiting long-term health problems' and the proportion of BME and non-BME residents aged over 65 with 'bad' or 'very bad' health, including by CDG area.

Figure 3: Percentage of Nottingham City BME and non-BME residents per thousand residents with 'limiting long-term health problems' by CDG area
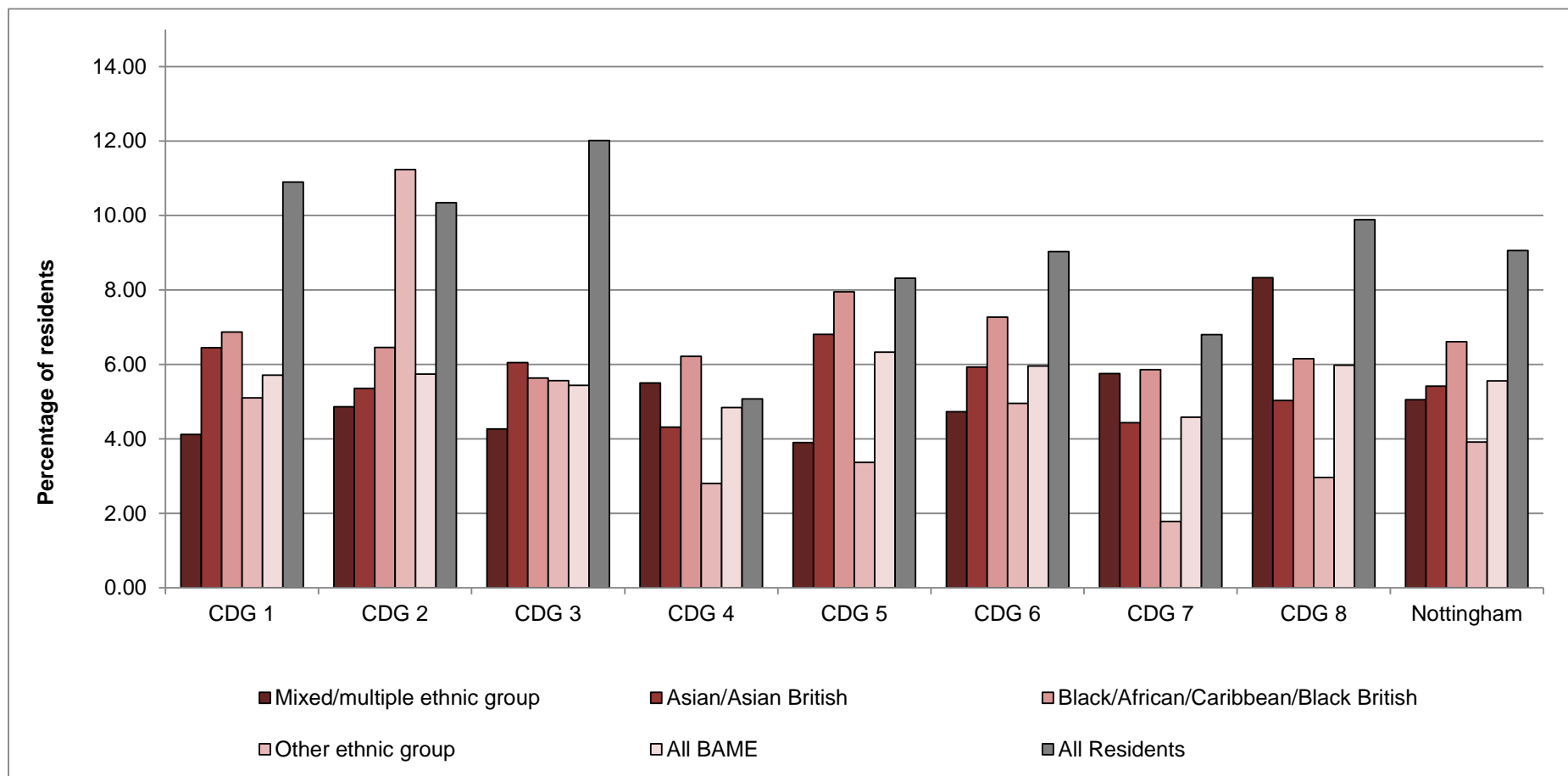
Source: 2011 Census, Office for National Statistics

Figure 4: Number of Nottingham City BME and non-BME residents with 'bad' or 'very bad' health per thousand residents by CDG area

Legend:
- Mixed/multi-ethnic
- Asian/Asian British
- Black African/Black Caribbean/Black British
- Other ethnic group
- All BAME
- All Residents

Source: 2011 Census, Office for National Statistics

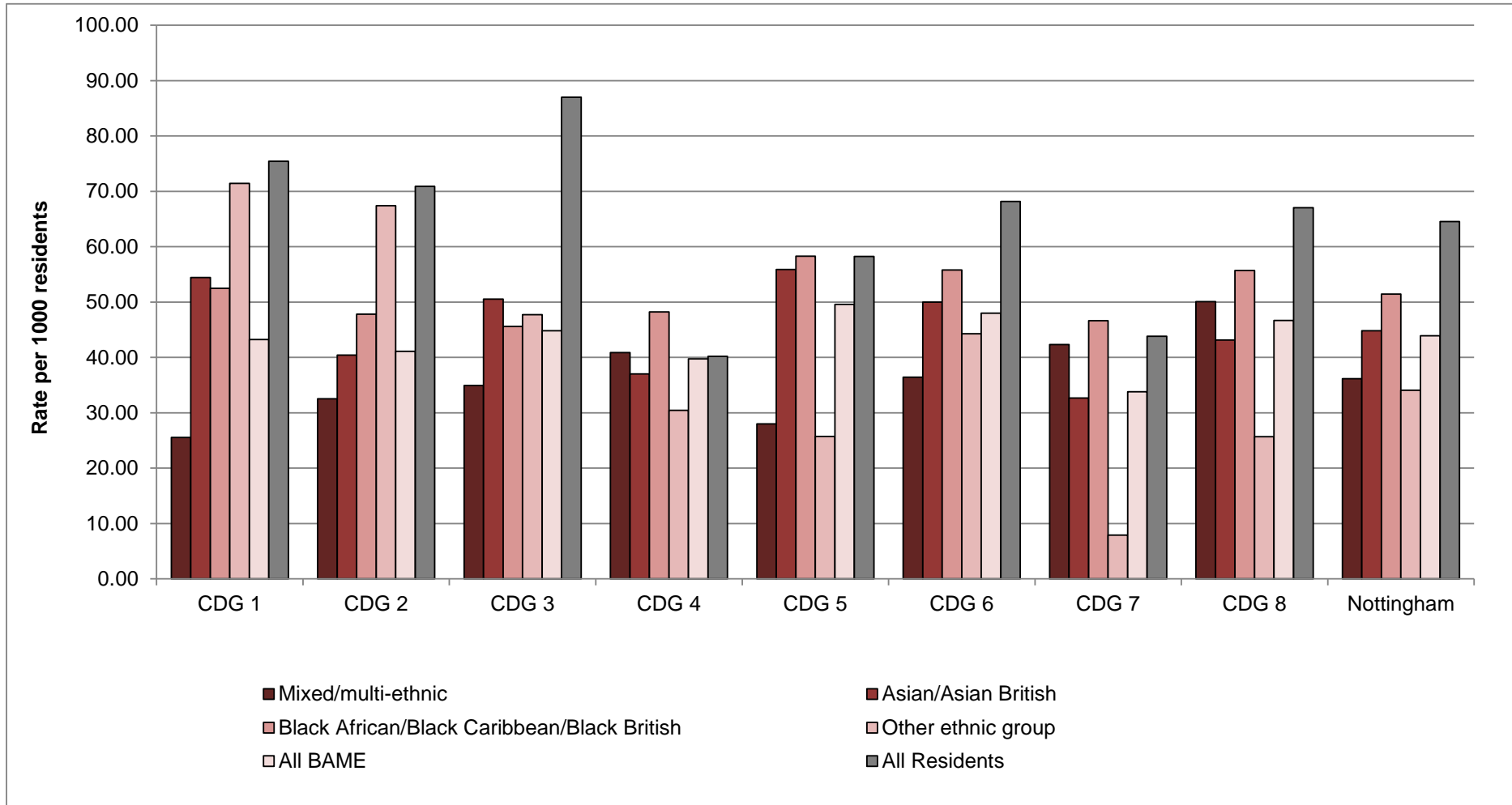**Figure 5: Proportion of Nottingham City BME and non-BME residents per thousand residents age 65 and over with 'limiting long-term health problems' by CDG area**

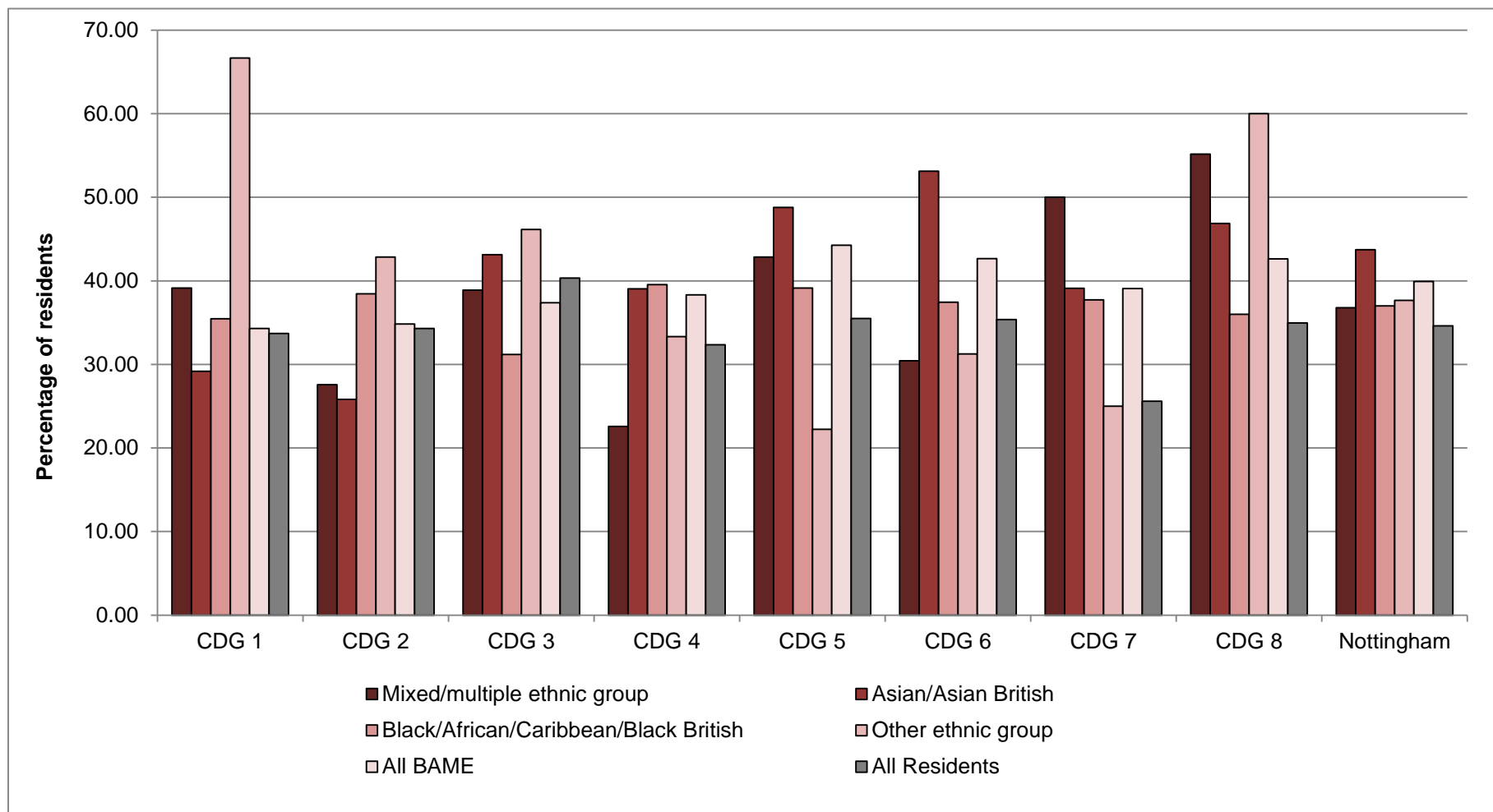Source: 2011 Census, Office for National Statistics

Figure 6: Number of Nottingham City BME and non-BME residents aged 65 and over with 'bad' or 'very bad' health per thousand residents by CDG area
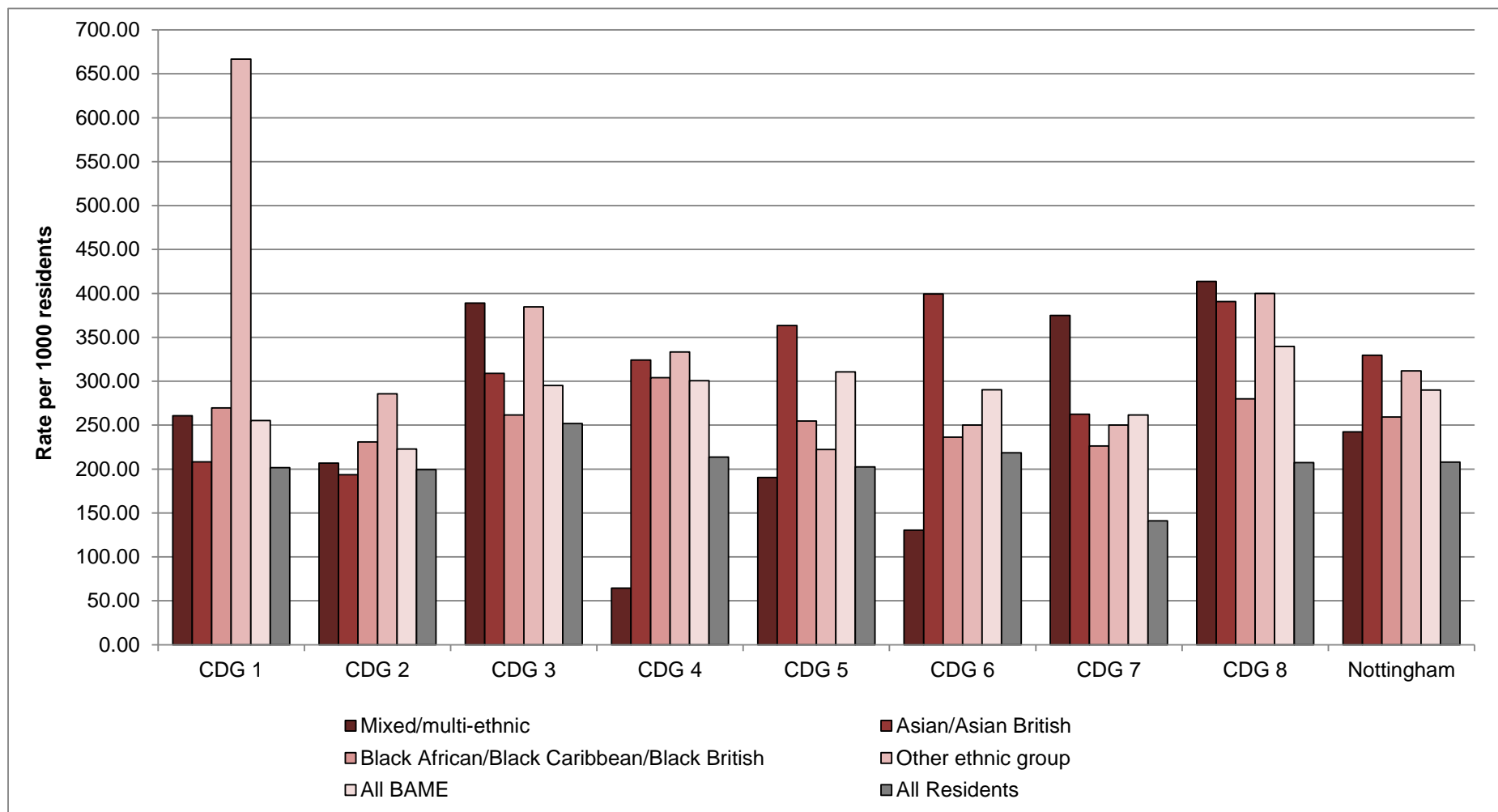

Source: 2011 Census, Office for National Statistics

Access to services

Nottingham CityCare Partnership, who deliver a range of community-level nursing and healthcare services across Nottingham City, provided data on the ethnic composition of the caseload for three of the main long-term condition services commissioned by the CCG: Diabetes Specialist Nursing; the Integrated Diabetes Service; and the Integrated Respiratory Service. An overview of these data is provided in table 1. However, these data are provided with a major caveat as the ethnicity is unknown for more than half (59%) of service users. CityCare have recently introduced some functionality into their clinical system which prompts the clinician if the ethnicity field is blank or recorded as unknown. This ought to improve the reliability of these data over the course of the study which is important, as in order to understand whether uptake of these services by BME residents increases as a result of a move towards asset-based approaches, the CCG will need an accurate baseline against which measure progress.

Table 1: Overview of long-term condition service users by ethnicity (Nottingham CityCare Partnership caseload)

	Diabetes Specialist Nursing		Integrated Diabetes Service		Integrated Respiratory Service		All Services Combined*	
	n	Per cent	n	Per cent	n	Per cent	n	Per cent
White British	298	71%	179	84%	297	91%	774	81%
Other White	22	5%	7	3%	14	4%	43	4%
Pakistani/British Pakistani	42	10%	8	4%	9	3%	59	6%
Indian/British Indian	10	2%	7	3%	3	1%	20	2%
Other Asian	11	3%	3	1%	1	0%	15	2%
Black African	3	1%	4	2%	1	0%	8	1%
Black Caribbean	30	7%	4	2%	1	0%	35	4%
Other Black	3	1%	0	0%	1	0%	4	0%
Total (Ethnicity known)	419		212		327		958	
Ethnicity unknown	1,053	72%	107	34%	209	39%	1369	59%
Total (All service users)	1,472		319		536		2,327	

Source: Nottingham CityCare Partnership, July 2015
*This combined figure is likely to include multiple instances of the same individual if they have accessed more than one service.

Table 1 shows that across all three services, of the service users whose ethnicity was known, only about a fifth (19 per cent) were from BME groups. This is considerably less than the 35 per cent figure for the Nottingham City population as a whole, and if it is an accurate representation of the caseload as a whole, it suggests that people from BME communities with long-term conditions are not accessing services at the same rate as non-BME residents.

Evidence review

<div style="text-align: right">3</div>

This chapter provides the findings of the evidence review undertaken by the Research Teams. It begins by briefly outlining the review methodology before presenting thematic analysis of the barriers and enabling factors associated with people from BME communities' access to long-term conditions services. It then moves on to discuss asset-based approaches and how, based on this evidence, they might be used to improve the uptake of services by BME residents.

Methodology

The evidence review utilised a 'rapid evidence assessment' (REA) framework to examine the over-arching research question of *'what works in increasing the uptake of primary and community long-term conditions services in Black and Minority Ethnic (BME) communities'*. This involved a review of academic, grey and practitioner literature, including, where relevant, evidence from overseas and from allied fields. Although the CCG's commissioning focus is on diabetes and respiratory conditions, the scope of the review encompassed other conditions, and long-term conditions as a broader concept, to ensure the widest range of evidence and learning was captured. Overall, the review identified a wealth of relevant literature associated with the *barriers to* and *enablers for* BME people accessing health services for general long-term conditions as well as specific conditions such as mental health problems and diabetes. However, there was less evidence identified in the area of respiratory conditions, although the lessons from other conditions are transferable in many cases. In a separate exercise, key literature around the role of asset-based approaches in health and social care was identified and reviewed.

In total, more than 100 published papers, reports and documents were reviewed. An overview of the number of documents reviewed by theme is provided in table 2.

Table 2: Overview of evidence reviewed by theme

	Barriers	Enablers	Asset-based approaches	Total
No. of documents reviewed	91		17	109
No. of documents graded high for relevance and quality	18	21	n/a	39
No. of other documents reviewed	54		17	72

Note: some documents covered both barriers and enablers and are counted in both columns.

Barriers to accessing services

This section draws the key themes to have emerged from the literature regarding the barriers for BME people accessing health-related services. Although each theme is presented as distinct, it is important to note that they are multiple and complex in nature and are often interrelated, meaning they cannot be understood or addressed in isolation.

Language and communication barriers

One of the principal barriers to the uptake of primary and community long-term conditions services among BME groups is language. A lack of sensitivity to language differences on the part of the care providers acts as a barrier to the uptake of services, especially for those whose first language is not English. Issues around language also affect care providers' ability to recognise disease.

Research by Mainous *et al.* (2006) documents the relationship between English language skills, and diabetes and hypertension. Their research focuses on language skills among foreign-born South Asians in England and the prevalence of diagnosed diabetes, hypertension, undetected elevated blood glucose and high blood pressure in a nationally representative sample. A greater prevalence of detected and undetected disease was found among young foreign-born South Asian adults compared to those born in the UK. Poor English language skill was 'significantly associated with undetected elevated blood glucose among Bangladeshis' (pp. 335). The article attests to the importance of being culturally sensitive to language differences within ethnic minorities in order to better detect and respond to any potential barriers.

Language barriers partly accounted for differences in emergency ward use observed between Asian/Pacific Islanders and Hispanics compared with Whites and Blacks in a US-based study by Vargas *et al.* (2004). The research found that groups with language barriers were more likely to use outpatient services where translation services were more readily available.

The use of interpreters does, however, have its own complexities. As Knifton (2012) found across the three communities in his study – Scottish citizens with Pakistani, Chinese and Indian heritage – interpreters also constituted a barrier to uptake of services as they were viewed as a compromise to confidentiality and with a sense that it would be difficult to convey emotions accurately. Instead, participants would frequently seek advice from religious leaders from within their community with whom they could easily communicate. As Knifton (2012: 293) states, 'for a high proportion of respondents, religious leaders were seen as the first and foremost point of contact and support, particularly for those with Muslim, Hindu and Sikh heritage'.

Allmark *et al.* (2010) identify the barriers influencing the uptake of provision among BME people and categorise them as: personal factors, local factors and systemic factors. These are seen as interrelated. They reviewed evidence from a range of sources, including official government websites, academic databases and non-academic sources to determine reasons behind low satisfaction with the Pension, Disability and Carers Service (PDCS) and the low uptake of benefits among BME people who are eligible for them. Although evidence related to the PDCS was scarce, they found less direct, but relevant factors, which can be generalised to provide explanations about the low uptake of other services among BME people. Language difficulty is indeed highlighted as a significant factor, but they emphasise that where certain factors interrelate, the issue might further intensify. For instance, an individual with a language problem (a personal factor) might struggle to access provision when simultaneously faced with a systemic factor, such as inadequate provision to address

that language problem. The authors assert that poor English language skills become a greater challenge and deter those negotiating access to provision, for a number of reasons: when translation and interpretation services are poor; when overly complex terminology is used which is difficult to interpret or translate; or, if during the process, terminology with a negative cultural meaning is used – such as 'disability'.

The lack of uptake of long-term conditions services can be due to the inappropriateness of health information and materials for ethnic minorities – if, for instance, they are not available in minority languages then many patients will know very little about their disease and its management (Raleigh, 1997). As one study by Hawthorne (in Raleigh, 1997) shows, if diabetic patients from BME groups know less about their disease, they are less likely to engage with services aimed at its management.

Unsuitability of advertising and educational materials was a prevalent theme in the literature. The language used in the materials for Scotland's anti-stigma campaign was explored in a focus group with BME communities in a study by Knifton (2012). A number of problems with the campaign materials were discussed, and identified as: materials were printed in the English language and were unavailable in translated formats; they used cryptic, subtle and indirect wording; they failed to include multi-racial images; few materials reached the BME communities and little attention was paid to advertising through press, radio and television stations accessed by many BME groups.

A review of evidence by Wilson *et al.* (2012) further explores language and communication issues between care providers and patients as barriers to accessing healthcare services for BME groups. They found that the adequacy of information in terms of improving access to services was problematic in terms of cultural relevance and format, particularly for speakers of other languages. Further studies (Ledda *et al.*, in Wilson *et al.*, 2012) emphasised the need for caution when adapting materials; in their study, Black African patients over the age of 60 preferred multi-ethnic materials whilst younger patients preferred materials adapted to specifically Black African culture.

Failure to consider cultural, community and religious needs and circumstances in communication of health materials, campaigns and information excludes a significant number of people within BME communities who may have less confidence with the English language. This is likely to exclude those who need that information the most.

Awareness of disease and disease management

It is important to note that variability in patients' problem-solving skills is determined by clinical factors and self-management behaviour, not by race or ethnicity (Glasgow *et al.,* in Wilson *et al.*, 2012). Where differences have been noted across ethnicities it is in knowledge and understanding, with several studies highlighting poorer baseline knowledge, particularly by Bangladeshi (Rankin and Bhopal, in Wilson *et al.*, 2012), and African/Caribbean patients (Brown *et al.*, in Wilson *et al.*, 2012). Other studies have found that this lack of baseline knowledge is by no means due to a lack of willingness on the part of patients to understand their illness; patients in fact wanted to learn more if adequate channels of learning were in place (Greenhalgh, in Wilson *et al.*, 2012).

Gerrish, Ismail and Naisby (2010), in a community participatory study of the socio-cultural factors influencing the understanding of TB within the Somali community in Sheffield, found that lack of knowledge about the disease acted as a barrier to seeking treatment to begin with. Many patients did not recognise the significance of their symptoms and so did not seek proper medical advice. As Chowbey *et al.* (2008) state, any preventative measure, response to an eating disorder (or indeed, any illness), and the uptake of a service related to it, will be

ineffective if it is not recognised as such by a community. Indeed, recognition of a disease as a problem is an essential first step in seeking and engaging with treatment.

A lack of awareness of disease is compounded, in some cases, by certain perceptions of services. Participants in Chowbey *et al.* (2008) knew that services must exist in their locality but were sceptical of how accessible they would be for BME communities. Older generations were unaware that certain services existed due to a lack of mobility and an inability to travel beyond places within walking distance.

Råberg Kjøllesdal *et al.* (2011) explored perceptions of diabetes risk factors among Pakistani immigrant women as part of their explanatory model of the disease, and the changes in these perceptions after a culturally adapted intervention. Most women enrolled in the intervention programme perceived that consumption of sugar could increase the risk of diabetes, and that vegetables were the food items most commonly regarded as important to include in the diet in order to prevent diabetes. However, they also found that 12 per cent of the women could not identify any diabetes risk factors at all. Awareness of the importance of weight in the development of diabetes was also low. As the authors state, 'the proportion not knowing any remedy that could reduce or increase the risk of diabetes is disquieting' (pp. 292). This research is important in suggesting an extensive need for education about the causes of diabetes. Knowledge and awareness increased among the women during or after the intervention, suggesting that a culturally adapted intervention may succeed in equipping Pakistani women with knowledge to prevent or manage diabetes in their own life.

In relation to the awareness of eating disorders, it was older members of the BME groups involved in the study (Pakistani, Bangladeshi, African, Caribbean, Somali and Yemeni), who had migrated to the UK, who were more likely to lack general knowledge and awareness of the issue - in other words, a clear divide existed between younger and older generations (Chowbey *et al.*, 2008). Younger generations were largely more informed about eating disorders, receiving the majority of information from school and the media. A number of study participants felt that this lack of awareness has led to an under-reporting of eating disorders in BME communities. Eating disorders may therefore remain 'hidden' among BME groups.

Social and cultural norms

As Kohli and Dalal (1998) argue, people look beyond medical explanations when trying to understand their disease; they also try to understand the disease through their social and cultural context. As well as medical practitioners, family members, friends and social networks all play a role in jointly constructing an understanding of the disease. The study by Kohli and Dalal (1998) – based in India with 132 Hindu women – focused on examining the content of causal explanations of illness given by cervical cancer patients. Patients primarily attributed their cancer to God's will, fate, and karma, instilling in them an attitude of acceptance of their own and other's suffering. It is thus important that health practitioners understand the assumptions and theories that patients tie to their disease.

Research by Salway *et al.* (2007) identifies a number of complex factors which discouraged individuals from four different ethnic groups (Bangladeshis; Pakistanis; White British; and Black Africans) from claiming Disability Living Allowance (DLA). Although focusing on the take-up of a benefit, the research contains knowledge and insight around barriers faced by BME groups which are transferable to the uptake of LTC services. Evidence of 'concealment' of ill-health was found across all ethnic groups – though closer inspection revealed differences in the motivations and meanings attached to this concealment. While White British respondents attributed concealment to family or personal character, BME respondents were more likely to relate it to expected norms for their ethnic community. For instance, among the Pakistani and Bangladeshi respondents, concealment was associated

with the 'feminine ideal of bearing distress in silence and gaining strength, maturity and high moral status through suffering' (2007: 921). Concealment was reinforced by the notion of a 'moral community', and concern that information would spread quickly through the community leading to gossip and stigmatisation.

Degrees of concealment also varied across ethnic groups. Among the Pakistani and Bangladeshi communities, with the rise of a discourse around 'Asian diets' and 'Asian diseases', diabetes and heart disease were less problematic and less concealed. Among Ghanaians, however, as a community discourse on long-term health conditions has only just begun to emerge, the tendency to conceal all types of health condition was very strong. The authors also acknowledge the importance of structural factors, including migration histories and settlement patterns. For Ghanaians, the pressure to work and to generate an income to send home to family members often overrode the importance of revealing a health condition and engaging with support and care (if it meant income generation might be compromised). The extent to which the long-term health condition was perceived to be incompatible with valued social roles was also of note. Bangladeshi and Pakistani men in their 40s and 50s accepted more readily the identity of someone with a long-term health condition, whereas White British men felt greater discomfort with this identity (Salway *et al.,* 2007).

In a similar vein to the study cited above, several participants from the Somali community hid their TB from others. This concealment stemmed from the belief that TB was regarded as stigmatising within the Somali community, and the fear that healthcare practitioners would share information with family members, employers or the rest of the community (Gerrish, Naisby and Ismail, 2012).

As those from BME backgrounds are likely to inhabit two cultural discourses about disease, tension could also occur where the perceptions of disease are conflicting (Hjelm *et al.*, in Boman *et al.*, 2015). This issue was raised by the Boman *et al.* (2015) study which found that adolescents with immigrant backgrounds inhabited cultural discourses where perceptions of disease sometimes differed from the dominant one. The adolescents were exposed to the knowledge and norms of the medical profession with which they had contact, and to their parents' and wider families' cultural perceptions of disease and treatment. Inevitably, this pull in different directions has implications for individuals' management of their condition and which healthcare services they decide to take up, if any.

Several community beliefs emerged as barriers to seeking treatment in a study by Knifton (2012). This research explored perceptions of mental health treatment and services among the three largest BME communities in Scotland – citizens with Pakistani, Chinese and Indian heritage. Amongst older and 'first generation' populations, in all three communities, 'recovery-pessimism', or the sense that 'there is no cure' was common. Respondents of Muslim, Hindu and Sikh heritage perceived mental health problems as 'the will of God', inheritance, or spirits, so that medication was not considered as a cure.

Similarly, in Chowbey *et al.* (2008), seeking medical help for eating disorders was delayed by religious beliefs. Key informants interviewed in this study noted that many people in the Pakistani community preferred to seek help from a 'Pir' (a figure believed to have spiritual healing powers) rather than a health professional. This preference stemmed from their belief that their illness came from the will of Allah or possession by evil spirits.

Studies reviewed in Wilson *et al.* (2012) found some use of herbal medication in South Asian cohorts (Hawthorne, in Wilson *et al.*, 2012), and a preference for natural remedies in a focus group discussion with African and Caribbean participants (Brown *et al.*, in Wilson *et al.*, 2012). Wilson *et al.* (2012) were keen to point out, however, that there is little to suggest that these were widespread views amongst patients or substantially affected self-management behaviour.

As Kohli and Dalal (1998: 125) explain, 'many patients feel confident about the beliefs they hold and employ these beliefs accordingly while complying to the treatment regimen'. Acknowledging the role of culture and beliefs in their communications with patients, health practitioners may encourage better treatment regimens and adherence to medical advice: 'a little effort on the part of health practitioners to take cognisance of the patient's perspective will go a long way in augmenting recovery' (Kohli and Dalal, 1988: 126). Some beliefs are deep-seated, and are thus – as Gerrish, Naisby and Ismail (2012) acknowledge – difficult to challenge, especially if reinforced by community norms. Challenging misconceptions and deconstructing perceived stigmas attached to certain diseases remains a difficult yet vital element in practitioners' interaction with patients.

Relationships with and trust in healthcare professionals

As Raleigh (1997) highlights, compliance with recommended dietary, lifestyle, and medical advice depends on good rapport between patients and healthcare professionals. A range of studies concur that doctor-patient communication and patient satisfaction influence adherence to recommendations. While self-managed care is known to be a facilitator it may simultaneously act as a barrier if support is not implemented correctly. Raleigh (1997) notes that the quality of care for BME patients is variable, and that poor doctor-patient communication often results in poor metabolic and blood pressure control. Since day-to-day management is mostly in the hands of the patients themselves health professionals need to be familiar with the culture, customs, and sensitivities of their BME patients (Raleigh, 1997). Part of this sensitivity means ensuring that advice and treatment are integrated into traditional diets and lifestyles.

Evidence demonstrates that communication patterns between patients and doctors influence patients' health outcomes (Basáñez *et al.*, 2013). By examining patients' perceptions of their physician's attentiveness, Basáñez *et al.* (2013) found that perceptions did indeed make a difference to the patient's general health status. Notably, differences of perceptions were found across ethnic groups: Hispanics and African Americans perceived their physicians as significantly less attentive to them as did Caucasians. Whilst an in-depth explanation for this finding was beyond the remit of this article, the research highlights the importance of physicians' communication skills and cultural sensitivity in encouraging patient adherence. Evidence of intergroup bias and prejudice was also found – in that physicians provided 'equally at risk' patients with different recommendations, and this advice varied by ethnic group.

In Chowbey *et al.* (2008), English-speaking BME persons expressed frustration at struggling to communicate effectively with health professionals; the information that they provided was misinterpreted and their needs were not understood. This was attributed to the lack of cultural awareness and sensitivity of health professionals and highlighted as an institutional barrier to the uptake of services. Related to this, they found that some service providers were keen to meet the needs of patients from different ethnic backgrounds, but expressed uncertainty and lacked confidence in themselves due to a lack of training. The authors suggest that the level of cultural competence training of staff is likely to determine the cultural appropriateness of services and consequently how well those from BME communities engage with them.

Chowbey *et al.* (2008) emphasise that if an organisation's workforce is not representative of the people it serves it may act as a barrier to service access. In other words, BME professionals should be part of a workforce which aims to meet the needs of BME people, so that they are better understood, as well as sending out a clear message about embracing diversity and ensuring equal access to services among the population it serves. However, the authors stress that 'choice' in service provider is more important as some people from BME communities would choose not to receive support from a professional of the same

ethnic background due to concerns about confidentiality, 'being judged' or being 'too close' (pp. 42) whereby assumptions are made about an individual based on their 'insider knowledge' of an ethnic group/community.

Wilson *et al.* (2012) cite several studies which have explored barriers around communication more specifically at different levels of healthcare provision. Cortis (2004) argues that in terms of nursing, it is often due to a poor understanding of Pakistani culture and the underuse of interpreting services. In medical consultations, perceptions of physicians as authority figures make some patients feel misunderstood (Bissell *et al.*, 2004). Some evidence suggests that advice is perceived as contradictory or inadequately adapted to certain BME groups (Wilson *et al.*, 2012).

A lack of trust in healthcare professionals emerged as a barrier for some sections of the communities studied by Knifton (2012). Participants explained how they were fearful of 'being asked too many questions'; and expressed a lack of trust in personal information remaining confidential. Likewise, in Gerrish, Ismail and Naisby (2010), a lack of trust in their general practitioner was cited as an obstacle to seeking treatment for TB by many in the Sheffield Somali community: 'some participants thought that some GPs did not have sufficient understanding of TB and its implications for Somali people' (pp. 26). A lack of trust is also identified by Chowbey *et al.* (2008) as a community-level barrier, and one which can lead to the low uptake of services by people from BME communities. This can be a lack of trust in a particular organisation or service due to hearing about previous negative experiences or individuals' concern about their confidentiality being compromised. Apprehension about confidentiality acts as a barrier to accessing support, particularly where certain health conditions are stigmatised within specific BME communities – for instance, mental health problems and eating disorders. Concealment and stigma are interrelated, and both lead to a reluctance to engage with services.

One alternative explanation for the low uptake of specific long-term conditions services is provided by Boman *et al.* (2015), which reveals adolescents' perceptions about the different professionals involved in their care. All of them viewed the doctor as *'most important'* for their care, compared to other professionals, due to his/her knowledge of diabetes and how best to manage it. In their view, the doctor epitomises the 'all-knowing' authority on the body and the treatment of diabetes. The adolescents reported that the majority of their discussions were with their doctor who asked many questions, imparted information, and provided solutions. The nurses, on the other hand, were perceived as serving a welcoming and socialising function, to alleviate any unease and performed assistive roles, such as taking blood tests. The function of dieticians was correctly described, but the adolescents could not remember their last contact with them. Essentially, the doctor was viewed as integral to their care, and all trust was placed in him/her.

Community-level barriers

Chowbey *et al.* (2008) highlight that the bigger and more visible a BME community is in an area, the more resources there are directed to that particular community – for example, in the provision of appropriate interpreting and translation services. The larger community is also likely to have more 'spokespersons' (pp. 32) than the smaller BME communities living there, hence, raising a greater awareness of their needs, and leading to a greater demand for services from that particular community. However, when people from less visible BME communities are in contact with services they encounter the additional barrier of service providers lacking an awareness of their specific culture, needs, and expectations. Further, community organisations often channel most of their resources into the majority BME group, which in turn, leads to a high uptake of their services by that group, excluding (often unintentionally) others from accessing them.

People from BME communities who are keen to pursue a healthier lifestyle may be restricted by the services that are available to them. A difficulty in finding community facilities and services, which are inexpensive/free and culturally appropriate within their local communities, such as women-only gyms, can present a barrier to improving health outcomes. In their research, Chowbey *et al.* (2008) learned that some BME groups are reluctant to access facilities outside of their local communities, particularly those that are costly, and they stressed that heath education on healthy lifestyles and well-being should acknowledge the 'limited resources and facilities available to people at community level' (pp. 34). This point can be expanded to assert that health education should be realistic and informed by the resources available to the communities they aim to educate, for those communities to effectively engage with the content, and to continue to be engaged with the programme of education they are undertaking. The *type* of services being offered in a given community can also make a difference to uptake. A systematic evidence review of lay-led self-management interventions for BME populations (Sidhu *et al.*, 2014) found five studies which addressed barriers to service uptake. One of these (Choudhury *et al.*, in Sidhu *et al.*, 2014) associated high levels of drop-out with the length of the intervention. A six-session intervention was subsequently reduced into a one-day workshop in a (successful) attempt to improve completion rates.

Discrimination and socioeconomic status

Health is not always a priority, particularly for those people from BME groups experiencing severe social and economic disadvantage, which, coupled with other issues – such as commitments to family nearby and abroad, immigration issues and so on – add layers of complexity (Chowbey *et al.*, 2008). Individuals struggling to make ends meet on a small – sometimes insecure – income, may, for example, have difficulty paying for travel to health appointments, where public transport may be inconvenient, and taxis too expensive. Multiple pressures and obligations can also make it difficult for people to keep appointments.

Some research has sought to understand patient perceptions of racial discrimination in healthcare as a barrier to care, as well as a cause of health disparities. Peek *et al.* (2011) investigated associations between self-reported healthcare discrimination and the following diabetes outcomes: (1) quality of care, (2) self-management and (3) complications. While Peek *et al.* (2011) found that self-reported racial/ethnic discrimination in healthcare was associated with worse diabetes care and more diabetes complications, healthcare discrimination was unrelated to self-management (self-glucose monitoring, self-foot examinations, and participation in diabetes education). This suggests that factors beyond patients' own behaviours may be the main source of differential healthcare outcomes.

For more disadvantaged groups, the burden of self-managing a long-term health condition will likely be greater when added to existing life demands (Pesantes *et al.*, 2015); these groups have fewer opportunities to put the treatment suggested to them into practice. Wilson *et al.* (2012) came across evidence highlighting the influence of socioeconomic status and perceived discrimination on health status. This included a study by Bhopal *et al.* (in Wilson *et al.,* 2012) which showed the heterogeneity within South Asian groups, with relative disadvantage of Pakistani and Bangladeshi groups, and significant correlation between disadvantage, ethnicity and health status.

Negative healthcare experiences among African Americans posed an ongoing barrier to achieving a common understanding with their clinicians about the role of medication use in their overall diabetes management (Piette *et al.,* 2010). Negative medication beliefs were consistently more common among African American than White patients, and were tied up in perceptions and experiences of racial discrimination in their healthcare.

Enabling factors

This section builds on the barriers section by highlighting the main themes within the literature about the types of enabling factors that have improved or have the potential to improve the way that BME people access health-related services. It should be noted that enabling factors are inevitably linked to the barriers they seek to overcome, but for the purposes of this report that have been separated for the sake of clarity and understanding.

Use of evidence

The limited research on ethnicity and health fails to adequately represent the needs of BME groups (Health Survey for England, 1999; 2004; Salway 2014). Research shows creative use of evidence by some local authorities in putting together an evidence base that can inform decisions on health of diverse populations at a local level. Turner *et al.* (2012) document the efforts of Nottingham dementia team. Given the lack of data on dementia, the team in Nottingham used local intelligence to conclude that BME individuals were under-represented within Nottinghamshire in dementia services. To create an evidence base, they conducted head counting in wards to show occupancy and extrapolated national-level statistics to estimate dementia locally by ethnicity. Although, it was not a scientifically rigorous study, but raised awareness of dementia and made a case for targeted interventions to meet the needs of diverse populations of Nottinghamshire (for more information, please see Turner *et al.*, 2012).

Communication and trust between patients and healthcare providers

Doctors' and patients' communication, including the communication skills of healthcare providers and the availability and accessibility of the appropriate interpretation services, have a big influence on patient and health outcomes. Mainous *et al.* (2006) argue that being able to convey appropriate information to patients and enabling them to become more health literate is a crucial role for the physician, particularly with patients of low educational attainment, immigrants, and racial and ethnic minorities.

The availability of interpreters and bilingual providers, along with cultural diversity training for healthcare staff and culturally appropriate health education, could go a long way towards providing culturally specific healthcare and consequently towards improving health in BME groups. The assistance of professional interpreters (Povlsen *et al.*, 2005) or bilingual educators (Jones *et al.*, 2001) is an important strategy for communicating health information to ethnic groups (Campos, 2006). Further, culturally-appropriate terminologies and culturally-validated materials are critical for early and correct diagnosis. Understanding of cultural phrases and idioms can help individuals to better engage with health providers.

Culturally adapted interventions and training

Culturally adapted interventions have been shown to be effective in improving patient outcome; though there is limited evidence of different types of cultural competency techniques and their effectiveness, and evidence on implementation (Brach and Fraserirector, 2000). There are a small number of case studies published that add knowledge to the specific elements of intervention needed to effectively and sensitively educate other cultures. More research is required into identifying which strategies or components of cultural interventions are most effective in achieving positive health outcomes for children, adolescents and/or their families from ethnic groups. This study identified that the perspectives adopted in the delivery of cultural interventions for ethnic groups fell into four categories: (1) translation into native language of ethnic groups; (2) accommodation of beliefs, myths and practices of ethnic groups; (3) acculturation of interventionists; and (4) adopting a collaborative approach to intervention development with ethnic groups.

Delivering an intervention in the native language of ethnic groups is an important cultural strategy because language is considered to be an obvious barrier in the provision of healthcare to ethnic groups (Caballero, 2006). According to Whittemore (2007), the availability of health services in the language of those receiving care marks the beginning of 'culturally competent healthcare'. Although language is important as a cultural strategy for communicating health information to ethnic groups, it needs to be complemented with strategies for promoting health literacy. Health literacy concerns an individual's capacity to understand and process health information necessary to function in the healthcare environment (Caballero, 2006) and is dependent on an individual's reading and numerical skills including the capacity to accurately interpret the meaning of terminology used in healthcare (Campos, 2006). However, in order to engage with ethnic groups during the course of an intervention, there is a need to accommodate their beliefs, values and behaviours in order to provide cultural context and meaning to the healthcare information delivered (Kreuter *et al.*, 2003).

A Danish study into the barriers to diabetes education, by Povlsen *et al.* (2004) recommends that for the educational support provided by healthcare professionals to be effective it should 'match' and be tailored to the educational qualifications and needs of the BME groups targeted for such interventions. Concepts such as anatomy might be communicated intelligibly, but might not necessarily be understood. Therefore, healthcare professionals should adjust the educational level of their diabetes education to meet individual needs. This may require healthcare professionals to undertake additional training themselves to be adequately skilled, for example, in different methods of delivery, and knowledgeable of the religious, cultural, and social norms and attitudes within different ethnic communities on health and illness. For patients to understand and develop the ability to manage diabetes, the educational programmes have to be fit for purpose and move away from the notion of 'one size fits all'.

Chowbey *et al.*'s (2008) study on the needs of BME people with eating disorders revealed that professionals involved in the care of BME groups lacked knowledge about their specific needs and preferences, impacting on uptake of services. This barrier has implications for service delivery and practice for a wide range of professions dealing with BME communities, and can be addressed through the provision of cultural competence training, which is ongoing and reflects changing local BME populations, circumstances, and health needs. In line with the authors' discussion on training needs, the staff that they spoke to who had previous cultural competence training agreed that there was a need for further training, recognising that 'addressing issues of diversity and equality should be ongoing, not once-and-for-all concerns' (pp. 44).

In the same vein, they point out the importance of understanding the diversity that exists within BME groups, which, although collectively categorised as 'BME', consist of people from various ethnic backgrounds with different customs, beliefs, and social and cultural norms. To engage effectively with these groups, they stress that staff should avoid generalisations and stereotypes of different ethnic groups. This does not translate into the impractical undertaking that staff gain an in-depth knowledge of all the diverse communities which constitute the BME groups that they work with, but instead, 'being open, listening carefully, asking questions and being non-judgemental' (Chowbey *et al.*, 2008: 44).

To overcome issues around trust and to instil confidence in BME people before they access a particular service, Chowbey *et al.* (2008) emphasise the importance of adequately preparing individuals prior to their arrival, so they are aware of what will be involved, and be given the opportunity to ask questions to alleviate any uncertainty or anxiety about a service. During the process of preparation, rapport and trust can be built, to ensure individuals feel comfortable and less apprehensive about accessing the service. The researchers also propose that information about what to expect from services is imparted through various

mediums – for instance, a phone call, recorded information, audio/video testimonials and so on – and not simply be provided as written material.

The diversity within BME groups is also reflected in the multiplicity of family structures and the different dynamics within them. Obligations and inter-dependency may vary within these structures according to, for example, age, gender, and cultural and religious beliefs. Chowbey *et al.* (2008) recommend that service providers gain an understanding of how these obligations and dynamics may hinder or support the uptake of services, but warn against making assumptions and generalisations about individuals and their family set-ups, and instead advise providers to make an effort to find the required information.

Increasingly, the potential drawbacks of using translated publicity materials has been recognised (Chowbey *et al.*, 2008). Materials translated into local community languages can be costly, poorly translated, or ineffective if the people at whom they are targeted are largely illiterate in their mother tongue. In some BME communities, there is a high rate of illiteracy in the mother tongue, in addition to poor language skills in English. However, specific strategies can be employed to share health and service information with some of these hard-to-reach groups – for instance, using other mediums, such as local community radio, audio/video recordings and so on. Chowbey *et al.* (2008) suggest that only limited translated material in local community languages be used – for welcome statements or for signposting purposes – which let BME groups know that the services are inclusive of groups who do not speak English as their first language. Further, they stress that where images are used for publicising health services, these should reflect the ethnically diverse population the services aim to serve, sending out a clear message that the services are also intended for those from BME communities. And, when publicising health services, 'testimonies' from BME service users should be drawn on to create a level of identification and to convey the inclusivity of health services.

Community links

The development of community-level links and an outreach strategy is seen as an effective way of reaching BME people who are not accessing services. Chowbey *et al.* (2008) recommend that outreach work is ongoing and contacts be made with key community-based organisations. Usually, due to their long track records and expertise in working with minority ethnic groups, such organisations have a thorough understanding of the issues affecting specific BME communities, and their socio-cultural and religious needs. A sizeable client base is usually built up on trust. Health providers can capitalise on the captive audiences that local community-based organisations attract, to raise awareness of their services and explore wider possibilities such as taking their services there. By establishing links, opportunities can be created for staff to learn generic lessons from such organisations, which can be applied to specific issues – the low uptake by BME communities of particular health services, for instance. Moreover, the links may open up opportunities for health providers to gain in-house diversity training, and allow them access to networks where people with substantial experience of working with BME communities come together.

The knowledge that is shared in relation to outreach work by Chowbey *et al.* (2008) is transferable, and a range of providers can learn from it. For example, outreach work with BME communities can achieve a number of outcomes for service providers: raise awareness of services; raise the profile of long-term conditions services so that more BME people get involved, and subsequently help shape the services according to need; as well as changing socio-cultural norms and attitudes towards long-term conditions.

Chowbey *et al.* (2008) recognise the influence of key figures (sometimes referred to as community leaders) within BME communities, who are often consulted on a wide range of issues affecting the communities for which they are often 'spokespersons', and it is these

key figures that service providers are advised to engage with. By establishing strong relationships with key figures from BME community organisations service providers increase their opportunities for accessing the traditionally hard-to-reach members of communities who usually place their trust in community leaders and follow their advice and guidance.

Finances

Finances are closely linked to health outcomes (Marmot, 2010; Karlsen and Nazroo, 2002). Poor health outcomes have material consequences which make individuals and families even more vulnerable (Harriss, 2008). Economic position not only influences structural positioning such as education and employment options but also influences more immediate and health relevant gains such as fitness membership and healthy eating (Weaver *et al.*, 2014). Accessibility to health services are deterred by costs of transportation. The Consumer Council in its research with 366 people who completed the questionnaire found transportation costs as one of the central challenges for people in accessing healthcare services (The Consumer Council, 2013). It recommends meeting the transportation needs of the service users to enhance access to health and social care.

Family support and social networks

Family, including members of extended family, play a crucial role during illness. Harriss (2008) demonstrates financial dependence of sick individuals on family and extended family for expenses such as payment for specific domestic expenditures like bills, items in the weekly shopping, or regular gifts. Influence of family on self-care behaviour has been demonstrated. In the USA, middle-aged and older African Americans with hypertension perceived family support – including reminders, seeing others take medication, and family member approval – as facilitating medication adherence (Ogedegbe *et al.*, 2004). Other evidence indicates family members' engagement in promoting healthy behaviours, such as exercise (Becker *et al.*, 1998; Lin *et al.*, 2007). However, the support extended to all family members was constrained by the resources available to the household (Harriss, 2008). It is important to recognise the role of family members, and extend adequate support. At the same time, constraints on households and the changing nature of family obligations and expectations require a flexible approach based on an individual's unique circumstances.

The health benefits of strong social networks have been evidenced (Department of Health, 1999). The White Paper, Healthy Lives, Healthy People: Our strategy for Public Health for England (Department of Health, 2010) acknowledges the powerful influence of social networks on individual behaviour 'as part of building capable and confident communities, areas may wish to consider grant funding for local communities to take ownership of some highly focused preventive activities, such as volunteering, peer support, befriending and social networks' (Department of Health, 2010: 56). For example, friends play an important role in cases of ill-health; older Chinese adults rely on neighbours and friends, in addition to family, for health-related help; and utilise this broad social network for help with transportation, language assistance, and decision making (Pang *et al.*, 2003). Social networks play an important role in signposting people to find out information about accessing benefits (Salway *et al.*, 2007).

Self-help groups and community-based organisations (Raleigh, 1997) are identified as serving an important function for sharing experiences and information to raise awareness of diabetes and cultural issues and explanations related to the condition, which may allow patients to better understand and manage their diabetes. Usually formed on the basis of commonalities, and to address specific issues, such groups hold specific knowledge, for example, on BME groups: their needs; cultural norms and values, and are able to deliver information and services, in a culturally appropriate way.

Patient involvement

Patient involvement is a widely-used term in the literature on health and social care and is often used interchangeably with other similar terms such as 'service user involvement', 'patient engagement', 'patient partnership', and 'patient collaboration' (Barnes *et al.*, 1998; Beenstock *et al.*, 2001; Johnstone *et al.*, 2009).

Patient involvement recognises that the personal experience of patients and service users helps to develop interventions and services that are responsive to their needs and are applicable to real life situations (Ridley and Jones, 2002; Gallivan, 2012; Ismail *et al.*, 2014) and the ethical argument that service users and the public have a right to have a say about services that are provided for them (Department of Health, 2005).

There is a considerable literature and body of evidence about the successes and challenges of different kinds of national and local initiatives designed to secure the engagement of patients and service users, including some of the more seldom-heard groups (Farrell, 2004; Lapsley, 2004; Ismail *et al.*, 2014). The present commitment to patient involvement in the designing of health services reflects the current policy commitment to personalisation and patient-centred care (Department of Health, 2006; 2008).

Stewart and Taylor (1995) argued that determining which issues the service users are allowed to be involved in is central to an understanding of participations and empowerment. Moreover, Ridley and Jones (2002) argued in their literature review that there are greater benefits to directly involving patients in their own care which included; (a) empowering patients and giving people a greater sense of dignity and worth; (b) better informing patients by demanding more information about their health conditions, treatment and care which could result in reduction of inappropriate use of services and; (c) a greater likelihood that patients will act in accordance with the treatment plan if it has been explained and they understand it.

The possibilities of an asset-based approach

This section provides a brief overview of the literature on asset-based approaches. It begins by discussing what is meant by the term 'asset-based approach' before situating the rise to prominence of asset-based approaches in the wider national policy and political context, and discussing how this research could be reframed around an understanding of some of the underpinning principles of how asset-based approaches can be implemented.

What do we mean when we talk about asset-based approaches?

The aim of asset-based approaches is to promote and develop the individual and community level factors that support good health and well-being whilst ameliorating the symptoms and consequences of poor health. They are encapsulated by the following quote from Morgan and Ziglio (2007), who describe a health asset as:

> *"…any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses."*

Similarly, Foot and Hopkins (for the IDA, 2010) in a report into how asset-based approaches could improve community health and well-being, described them as:

"Asset approaches make visible, value and utilise the skills, knowledge, connections and potential in a community. They promote capacity, connectedness, reciprocity and social capital.

The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities. Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods.

The professional's role is to support people to recognise and mobilise the assets and resources they have."

In their detailed review of *evidence about* and *practice of* asset-based approaches in health, care and well-being Hopkins and Rippon (2015) identified five key inter-linked assets that contribute to health and well-being and highlighted the evidence base underpinning these relationships:

1. **Communities:** engaging with people with a shared sense of cultural or geographic identity provides valuable sources of resilience, support, opportunities for participation and a greater sense of control over their lives; all things which have the potential to contribute positively to psychosocial well-being and wider socially determined health outcomes (Marmot, 2010).

2. **Social networks (social capital):** well-developed social networks - facilitated through civic/community organisations and more informal linkages such as self-help, peer support or mutual aid - can create high levels of 'social capital', which is associated with higher levels of health and well-being at both individual and community levels (Putnam, 2000). This includes through the generation of tangible resources such as money; reinforcement of positive behaviour and socio-cultural norms; mobilisation, cooperation and collective action for mutual and individual benefit; and increasing social equity by improving access to resources and power.

3. **Connectedness:** the quality and quantity of social relationships with family, friends, neighbours and social networks have been shown to affect morbidity and mortality (Holt-Lundstad *et al.*, 2010). There is evidence of a clear link between stronger social relationships and lower mortality that is at least comparable to more commonly-associated lifestyle risk factors such as smoking, excessive alcohol consumption, obesity and lack of physical activity. Linked to this, social isolation and loneliness have been associated with a variety of health problems, from raised blood pressure and weakened immune system to increased risk of depression and heart attack (Victor and Bowling, 2012)

4. **Resilience:** it has been argued that individual resilience - the capacity and capabilities required to overcome adversity - is promoted by long-term relationships in the family, neighbourhood and wider civic society, alongside secure parenting, educational progress, satisfying work and support for self-esteem (Harrison, 2013). Similarly, a resilient community or neighbourhood is characterised by a 'collective held belief' in its 'ability to adapt and thrive in spite of adversity' (Seaman, 2014). However, the concept of resilience has been criticised in some quarters (Hickman *et al.*, forthcoming) for its propensity to detract from the real issues, such as poverty or discrimination, to which people and communities are expected to be resilient.

5. **Psychosocial health:** positive mental well-being and access to key psychosocial resources - attributes such as self-esteem, self-efficacy, and optimism that help people manage stressful events - are important to a person's overall enjoyment of life. There are marked social class differences in mental illness and mental well-being, with the less

materially wealthy in society more likely to experience mental health problems and low mental well-being. Poor mental well-being therefore needs to be understood as both a cause and a consequence of inequality and health inequity.

Understanding the wider context

The rise to prominence of asset-based approaches needs to be understood in the context of marked changes in public services both nationally and locally, with local authorities and their statutory health partners increasingly constrained in budgetary resources available to them. This challenge, in combination with widening health inequalities and a rapidly ageing population, is a major driving force behind the change in emphasis in some quarters towards asset-based working in health and social care. However, as Hopkins and Rippon (2015) highlight, at the moment developments in asset-based working are in their infancy, and evidenced in small projects or pilots, rather than large programmes or system wide approaches to their implementation. This is despite several national policy and strategy documents advocating a much wider role for asset-based working in mainstream health and care. For example, NHS England's 2014 publication, *Improving General Practice - a call to action (Phase 1 report)* makes the case for preventative care, advice and interventions that will support communities and individuals to better manage their own health to avoid becoming ill, and prevent unnecessary interventions. Similarly, the Department of Health's *Wellbeing: Why it matters in health policy?* (2014) makes the case for a stronger focus on action for well-being to improve health outcomes as it is estimated that high levels of subjective well-being can increase life by four to 10 years. In addition to these national developments, numerous local *Better Care Fund* plans and *Health and Well-being Strategies* make reference to an increased role for voluntary and community organisations and co-production of solutions with service users.

However, none of the national policy documents referenced provides significant additional resources for asset-based working. Although there are some area-level examples of funding for asset-based working, for critics of these approaches, or more accurately, critics of the current policy interest in such approaches, the failure to question the balance of power between public services, communities and corporate interests is a real concern. Hopkins and Rippon (2015) argue that asset-based approaches provide a smokescreen for reductions in statutory provision of public health, care and welfare services, alongside further marketisation of public services, and the withdrawal of the social rights of citizens (Friedli, 2012). South *et al.* (2013) reinforce this point, arguing that involving members of the public in health service design and delivery (i.e. co-production) should not be a pretext for reducing public services. Rather, it should be embraced as a mechanism for reducing barriers to the resources necessary for good health, and should be framed as a key strategy for increasing equity in health.

Towards an asset-based approach to BME long-term conditions support in Nottingham City

Although there is a wealth of literature on what asset-based approaches are and the benefits of applying them, methods by which they can be implemented by commissioners have been less well-documented. However, Morgan (2014) does suggest a set of principles that can support the practical implementation of asset-based approaches which can be applied in a health and care context:

- Prioritising approaches that emphasise building positive well-being and associated psychosocial resources.

- Involving individuals and local communities effectively and appropriately, for example by embedding the principles of co-production.

- Connecting the individual with community and broader society, including through solutions and activities that utilise and develop voluntary organisations and community groups.

- Working in a decision-focused, multi-professional and multidisciplinary way, including through integration of teams working in health, social care and community development.

- Securing investment from a variety of sources (statutory and non-statutory) through a multi-method, evidence-based approach.

Hopkins and Rippon (2015) draw on Morgan's ideas, alongside their own research findings to propose a logical model, or theory of change, through which to explore and analyse the mechanisms for change in the asset-based-projects. This model can in turn be used conceptualise how the CCG and its statutory, voluntary and community sector partners might implement an asset-based approach to increasing the uptake of long-term conditions support in Nottingham City. As such it provides a helpful framework through which to conceptualise the qualitative phase of this study, by repositioning each strand as a series of underpinning research questions that can be explored with commissioners, practitioners, community representatives and residents with long-term conditions. An overview of Hopkins and Rippon's (2015) model, and how this can reframed as a series of research questions, is provided in figure 7.

Figure 7: A framework for researching an asset-based approach to increasing the uptake of long-term conditions support in Nottingham City

	Elements of the Model	Linked Research Questions
1. Reframing	• Changing the way that practitioners and commissioners think about how they work • Requires significant culture change that moves organisational thinking and processes away from disease, illness or deficit defined targets to longer-term outcomes linked to individual and community level well-being	• To what extent does the CCG and its partners recognise and take account of assets in the planning and delivery of LTC services? • What challenges need to be overcome before asset-based thinking and practice can be implemented?
2. Recognising	• 'Mapping' the assets that are already in place, but also stimulating a wider approach to engaging in dialogue with and between local people, helping them to identify the range of resources already available to them • Means understanding and agreeing what assets can be connected and how they can be used.	• What assets currently exist and to what extent do practitioners and communities recognise and relate to those assets? • Are there any barriers that need to be overcome before these assets can be utilised? • What gaps in assets currently exist and how can they be filled or more assets developed?
3. Mobilising	• Asset mapping and recognition must be linked to an ambition for utilising these assets for positive effect • Being clear about why and asset-based approach is needed, how it will be developed and implemented, and the outcomes it is aiming to achieving	• How can assets be mobilised in a way that improves local BME residents' uptake of long-term conditions services? • What is the long-term ambition or vision for asset-based approaches in Nottingham City?
4.Co-producing	• Asset-based approaches should be co-produced and the intended outcomes agreed by all stakeholders in the process • Means moving away from often passive community consultations about service improvement toward a form of engagement that genuinely recognises all stakeholders as equals, with their own assets and strengths, through which a common purpose and set of outcomes are agreed	• What are the shared long-term possibilities for an asset-based approach? • How can these be co-produced to ensure positive outcomes for all local stakeholders?

Source: Adapted from Hopkins and Rippon (2015)

Practice-based examples

4

This chapter provides a series of practice-based boxed examples of services and solutions of relevance to the research aims. The examples provided are not necessarily specific to diabetes or respiratory conditions, nor are they all BME-specific, but they have been selected to illustrate the types of approaches that commissioners and their partners seeking to increase the uptake of services might develop.

BME-specific examples

Diabetes support and education in a minority ethnic group, delivered through bilingual health advocates

An intervention was developed for diabetes education using a 'sharing stories' approach, led by bilingual health advocates. It was delivered through a Community Centre on a deprived estate in East London, attended mainly by elderly Bangladeshis.

A regular women's lunch club was established, and the attendees, despite having lived in the United Kingdom for 20-30 years, spoke little English. Many of the women were strict Purdah observers and wore a burqa covering all but the eyes. Half of the women had diabetes and most had a relative with the condition. A weekly diabetes storytelling group was established by word of mouth and proved popular from the outset. It grew from eight to 42 regular attenders in 18 months.

Health advocate training included taster sessions for advocates to identify and reflect on their knowledge gaps and learning needs in relation to diabetes and group support through which a number of structured sessions were organised. During the sessions participants shared stories about clients in small groups. Success factors for the project included:

- Buy-in from top/middle management and HR. For example, adjusting job descriptions and allowing flexibility at a practitioner level
- Having a regular venue and time for group session and establishing multiple referral routes (such as self-referral, referral by advocate, or referral by a doctor or nurse)
- Involving clinicians to refer patients and support advocate led initiatives.

Source: Greenhalgh, T, Collard, A, and Begum, N. (2005) *Sharing stories: complex intervention for diabetes education in minority ethnic groups who do not speak English*. BMJ 330: 628–31

Partnership working between mainstream and BME voluntary sector organisations: the Alzheimer's Society's Information Programme for South Asian Families

BME communities are significantly under-represented in the take-up of dementia services. In response this project provided a culturally tailored adaptation of the Alzheimer's Society's (AS) Carer Information and Support Programme. AS recognised the limits of their cultural expertise and worked in partnership with a local BME community and faith organisations to deliver the service to key BME populations. An independent evaluation of the programme identified a number of key outcomes:

- Community outcomes: participants in the programme, and their families, experienced improved knowledge and understanding of dementia and reported changes in care practices, improved up-take of services, and accessing peer support. In addition, there was some evidence of a greater willingness to discuss dementia across BME communities.
- Organisational outcomes: AS, as the lead organisation, saw an increase on the cultural knowledge, understanding and awareness of BME communities amongst staff. Similarly, BME community and faith organisations welcomed the opportunity to work with a larger and more established organisation like AS, which they felt had improved their capacity and capability to meet specific the needs of the populations they served.

Source: Blakey, H, Parveen, S and Oyebode, J (2015) *'David and Goliath': the benefits and challenges of voluntary sector partnerships in dementia service provision for South Asian communities*. Paper to the Voluntary Sector and Volunteering Conference, September 2015.

Evaluation and piloting with third sector providers

Sharing Voices, a community organisation in Bradford, West Yorkshire, provides services to help improve the mental health and well-being of inner-city residents. The starting point of the service was the recognition that generic psychiatric services were not necessarily the most adequate way of treating people from BME backgrounds in Bradford (a city where over 50% of people are from a BME background).The organisation has developed constructive links with the Primary Care Trust to deliver comprehensive services as a team. *Sharing Voices* demonstrates good practice in terms of delivering the best services for BME communities by:

- tailoring support to the needs of the clients by using long-term, in-depth assessments
- documenting and providing evaluation data (including client feedback) for their services to evidence their work
- establishing a good relationship with commissioners in the care trust and PCT
- working closely with clients and providers to develop grassroots health initiatives, e.g. training Imams to deliver culturally appropriate mental health advice to the community.

Source: Turner, D., Salway, S., Chowbey, P. & Mir, G. (2012). *Mini Case Study Book.* Sheffield, Centre for Health and Social Care Research

Packaging information for decision makers

NHS Sheffield used an innovative approach to raise awareness among BME groups about the importance of reacting quickly in the event of suspected stroke symptoms. They delivered a social marketing approach which would target tailored stroke messages to BME communities. This approach involved:

- piloting and developing awareness messages with a sample of community members from several ethnic groups
- designing materials based on qualitative evidence - condensing materials into a more digestible format
- training community members as 'champions'
- spreading the message with customised materials to the rest of the community.

Source: Turner, D., Salway, S., Chowbey, P. & Mir, G. (2012). *Mini Case Study Book.* Sheffield, Centre for Health and Social Care Research.

Raising awareness of vitamin D deficiency among Liverpool's Somali community

GPs in Liverpool identified a widespread vitamin D deficiency among the Somali community after seeing a large number of patients presenting with muscle and bone pain and general malaise. Working collaboratively with colleagues in Public Health and researchers at Liverpool School of Tropical Medicine, the team undertook a small study confirming that 80% of people from a Somali background were deficient in vitamin D. A more in-depth follow-up study revealed that dietary preferences in the community were compounding the problem. Responding to this issue, the team:

- produced a short booklet for local health practitioners about the importance of early testing for vitamin D deficiency
- inspired commissioners at Liverpool PCT to use this knowledge to inform a central part of their Health Start programme aimed at pregnant women
- used the knowledge to enable commissioners to effectively target the local population and educate health workers.

Source: Turner, D., Salway, S., Chowbey, P. & Mir, G. (2012). *Mini Case Study Book.* Sheffield, Centre for Health and Social Care Research.

Linking people with long-term health conditions to healthy community activities: development of Patient-Led Assessment for Network Support (PLANS)

This project was funded by the NIHR Collaboration for Leadership in Applied Health Research and Care for Greater Manchester. The objective was to combine insights from service users with long-term conditions to assist the development of a community referral intervention designed to promote engagement and improve access to health-relevant resources.

A series of focus groups and interviews were held with members of community groups in Greater Manchester, designed as an iterative and collaborative approach, to elicit the role of personal and community networks that support long-term condition management (LTCM) to develop a community referral tool.

- Stage 1: involved exploring the meaning and role of the community and voluntary sector for people with long-term conditions. At this stage a group of people were recruited from health support groups and community centres offering activities to local people. These groups were selected on the basis that they had local memberships and provided activities or services which were relevant to health or well-being and were in areas of high deprivation.

- Stage 2: involved developing, refining and piloting the PLANS assessment tool. Six participatory workshops with members of a patient and public involvement (PPI) group recruited from Stage 1. Then eight interviews were conducted with people with long-term conditions recruited from existing contacts, who had agreed to participate in the PPI work to refine the intervention and provide feedback about practical implementation. This stage included a related resource called CONECTS (Community and Networks for Condition Support), a series of short films about the experiences of two people with vascular disease and their difficulties managing their health, who have tried taking part in community activities (specifically walking and slimming groups). These films were shown to participants in the focus groups to encourage reflections on their experiences of engaging in social and community activities.

These stages informed the development of a tool designed to improve awareness of existing local resources and make clear links to local support based on the criteria of expressed 'need' and 'acceptability': PLANS. The idea of PLANS was to reflect the everyday needs and concerns of people who live with a long-term condition and consolidate up-to-date information about health-relevant local resources into one website. The website contains a self-assessment questionnaire, which is completed by users who are provided with a tailored set of options based on personal preference.

The project concluded that a tool to increase social contact and promote community support and engagement within deprived populations has potential to address some of these factors and hopefully reduce the impact of social deprivation. The close engagement with people with long-term conditions during the development of PLANS helped inform a grassroots understanding of the range of health-relevant support which is valued and locally available. Working sensitively with the concerns and priorities of people living with long-term conditions has significant potential to improve the effectiveness of health-care campaigns in general.

Source: Blickem, C., Kennedy, A., Vassilev, I., Morris, R., Brooks, H., Jariwala, P., Rogers, A. (2013). *Linking people with long-term health conditions to healthy community activities: development of Patient-Led Assessment for Network Support (PLANS)*. Health Expectations, 16(3), e48–e59.

Community outreach

Coventry PCT ran a pilot study of the Expert Patient Programme (EPP), in which patients with chronic health conditions were trained by peers to build confidence and expertise in managing their condition. However, a study by Coventry University and Coventry PCT showed zero attendance of BME groups in the project. In response to the problem, Coventry PCT appointed a member of staff with expertise in Punjabi Sikh culture and language to help gain access to respondents to improve use of EPP courses for different groups across Coventry. As a result of this study, Coventry PCT has implemented some of the findings, including recruitment of a BME EPP specialist to work with the community in local languages, and is now bucking the national trend of struggling to attract BME attendees on this course.

Source: Turner, D., Salway, S., Chowbey P, & Mir, G., (2012) *Mini Case Study Book: Real world examples of using evidence to improve health services for minority ethnic people*, NIHR CLAHRC for South Yorkshire

Wider Examples

Building the capacity of community organisations to engage with GPs/Primary Care providers: NHS Rotherham CCG and its social prescribing and GP referral projects

NHS Rotherham CCG and Voluntary Action Rotherham have developed the Social Prescribing Service to provide GPs operating through Integrated Case Management Teams (ICMTs) with a referral pathway for patients with long-term conditions to access sources of non-medical support provided by voluntary and community sector organisations. A team of five advisors is employed to receive referrals from ICMTs, identify patient needs, and make appropriate onward referrals to voluntary and community services.

A series of 'pump-priming' grants have been made to local and voluntary and community organisations to develop new services and increase capacity within existing services in support of the Social Prescribing Services. This includes a grant to a number of local BME community organisations to provide BME-specific support, including advocacy isolated individuals and exercise classes for men from south Asian communities.

Following a successful pilot the service has been 'mainstreamed' through the Better Care Fund and the learning used to develop further pilots specific to mental health and dementia support.

Source: Bashir, N and Dayson, C (2015) *The social and economic impact of the Rotherham Social Prescribing Pilot.* Sheffield: Centre for Regional Economic and Social Research

Asset-based approaches to healthcare and support

Community Well-being Officers support Doncaster Council's Well-being service, by reaching out to elderly people, a vulnerable and hard-to-reach group, and help them to engage with relevant services to meet their needs. Approximately, 17% of Doncaster's population are aged 65+ and the proportion of elderly people in this borough is expected to increase by 30% in 2030. Elderly people face various issues, of which many have underlying loneliness problems. To address some of these issues, Community Well-being Officers provide elderly people with one-to-one support to access advice and information, preventative services and activities to maintain health and independence. Clients are signposted to a range of services: NHS services; community groups and organisations; and departments within the Council etc.

The requirements of the community well-being officer (CWO) are:

- they are members of the community they work in
- their roles involve carrying out a variety of tasks that are related to health promotion and healthcare.

Source: Begum, S. (2015). *A qualitative investigation of the role of community well-being officers in meeting the needs of the elderly population.* Sheffield: School of Applied Health and Related Research

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Appendix 1: Detailed 2011 Population Statistics

Table A1: Detailed Breakdown of Nottingham City BME Population by CDG (% of resident BME population)

Area	CDG 1	CDG 2	CDG 3	CDG 4	CDG 5	CDG 6	CDG 7	CDG 8	Nottingham	East Midlands	England
White and Black Caribbean	26.3	24.0	16.7	8.5	11.1	14.8	5.7	15.4	14.0	5.4	8.3
White and Black African	3.0	3.3	3.2	2.3	2.1	2.0	0.9	1.9	2.3	2.1	1.8
White and Asian	3.3	3.2	3.8	4.0	3.4	4.1	4.0	3.9	3.8	4.3	4.5
Other Mixed Ethnic Group	4.9	4.2	3.0	2.7	2.9	3.4	2.3	3.6	3.2	3.7	3.1
Indian or British Indian	9.4	10.0	7.8	13.2	10.8	7.6	23.2	14.3	11.4	18.1	34.7
Pakistani or British Pakistani	4.6	7.6	23.0	17.9	33.3	19.9	20.7	13.6	19.3	14.4	10.1
Bangladeshi, British Bangladeshi	0.7	0.7	1.4	1.6	1.5	1.1	0.7	1.0	1.2	5.6	2.7
Chinese	3.3	2.6	2.4	11.3	1.9	7.3	14.7	9.0	6.9	4.9	5.0
Afghan	0.0	0.6	0.6	0.8	0.5	0.6	0.1	0.7	0.6	0.9	0.5
Filipino	0.4	2.2	1.9	0.5	0.5	0.3	0.1	1.6	0.9	1.7	1.1
Iranian	0.5	0.3	0.5	0.9	0.4	0.8	1.7	0.9	0.7	0.8	0.5
Kashmiri	0.3	0.2	0.9	0.6	1.5	1.0	1.0	1.0	0.8	0.3	0.3
Kurdish	0.3	0.4	0.4	0.9	0.5	1.1	0.8	0.8	0.7	0.5	0.6
Malaysian	0.1	0.1	0.1	2.2	1.2	0.2	0.7	0.5	0.8	0.2	0.4
Nepalese (includes Gurkha)	0.1	0.1	0.0	0.2	0.5	0.4	0.1	0.4	0.3	0.8	0.2
Sri Lankan	0.7	0.2	0.5	0.8	0.5	0.3	0.8	0.5	0.5	1.9	1.0
Thai	0.2	0.1	0.1	0.7	0.1	0.3	1.1	0.6	0.4	0.4	0.4
Turkish	0.3	0.1	0.1	0.3	0.2	0.5	0.1	0.2	0.3	0.5	0.2
Vietnamese	0.2	0.2	0.2	0.5	0.2	1.1	0.2	0.4	0.5	0.4	0.3
Black African	12.6	13.4	12.9	11.7	8.2	12.7	5.5	12.1	11.4	12.6	8.6
Black Caribbean	20.0	18.9	11.9	7.9	10.1	11.2	4.7	8.3	10.8	7.6	5.9
Black British	4.0	3.2	2.5	1.5	1.2	2.0	0.9	1.8	2.0	1.7	1.0
Somali	0.0	0.0	0.0	0.2	0.2	0.3	0.0	0.1	0.1	0.5	0.4

Area										
Arab	0.5	0.6	2.4	4.1	2.0	2.4	4.4	3.5	2.7	2.9	2.0
Other Ethnic Group	4.4	4.1	3.8	4.8	5.1	4.7	5.6	4.2	4.6	7.8	6.5

Source: 2011 Census, Office for National Statistics

Table A2: Detailed Breakdown of Nottingham City BME Population by CDG (no of BME residents)

Area	CDG 1	CDG 2	CDG 3	CDG 4	CDG 5	CDG 6	CDG 7	CDG 8	Total	
									n	Per cent
White and Black Caribbean	1,210	1,766	2,096	1,506	1,240	2,687	407	1,254	12,166	4%
White and Black African	136	241	399	408	230	368	67	155	2,004	1%
White and Asian	151	236	472	714	384	747	285	315	3,304	1%
Other Mixed Ethnic Group	226	307	383	479	324	617	162	293	2,791	1%
Indian or British Indian	431	734	981	2,344	1,211	1,375	1,660	1,165	9,901	3%
Pakistani or British Pakistani	212	557	2,898	3,175	322	3,616	1,482	1,109	16,771	5%
Bangladeshi, British Bangladeshi	30	52	175	291	167	206	47	81	1,049	0%
Chinese	153	195	300	2,011	213	1,330	1,053	733	5,988	2%
Afghan	1	43	70	140	53	111	10	58	486	0%
Filipino	19	159	244	81	60	48	9	131	751	0%
Iranian	24	20	68	152	43	140	125	76	648	0%
Kashmiri	12	18	108	100	170	176	74	79	737	0%
Kurdish	16	26	51	152	60	205	54	67	631	0%
Malaysian	4	6	17	385	133	39	52	39	675	0%
Nepalese (includes Gurkha)	5	6	5	28	60	77	8	33	222	0%
Sri Lankan	33	14	58	148	52	56	55	38	454	0%
Thai	8	8	7	124	7	55	81	45	335	0%
Turkish	16	6	15	51	19	87	7	19	220	0%
Vietnamese	7	15	29	87	21	197	11	35	402	0%

Black African	579	991	1,620	2,078	914	2,319	391	985	9,877	3%
Black Caribbean	921	1,391	1,495	1,395	1,133	2,033	337	677	9,382	3%
Black British	185	236	310	262	133	371	62	144	1,703	1%
Somali	0	0	0	37	26	50	3	5	121	0%
Arab	22	46	304	727	229	444	317	283	2,372	1%

Source: 2011 Census, Office for National Statistics