UNIVERSITY OF LEICESTER

Centre for BME Health
reducing health inequalities

Research Report: Black, Asian and Minority Ethnic Communities: Ageing in Place, Exploring Social Infrastructure that Enables BAME Communities to Age in Place.

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Section 1: Local Context

Leicester city is located within the East Midlands and is the largest city in this region (Public Health England, 2018). The city is one of the most disadvantaged urban areas in England (Chattopadhyay, et al.,2019). It has a high level of deprivation, ranked 22nd out of 318 wards in the UK (ONS, Index of Multiple Deprivation, 2019). Income deprivation is relatively high, particularly for older people. Notably, more than two thirds of older people are affected by income deprivation in seven Lower-layer Super Output Areas (ibid). Health outcomes and life expectancy in this region are generally worse than the national average, (Public Health England, 2018). People are being diagnosed with chronic disease earlier and dying prematurely. Furthermore, mental health conditions are rising. This is particularly apparent for older people: "one in ten older people in Leicester city have a common mental health problem and is expected to increase by 10% over the next ten years" (Leicester City Clinical Commissioning Group, 2019).

Leicester is an ethnically diverse city with over 50% of its population identifying as ethnic minorities (ONS, 2018). The history of migration and settlement since the 1960s has played a central part in its diversity. Notably, there was an influx of migrants from Uganda, East-Africa and Europe in the 1960s. The presence of the hosiery and shoe industries attracted populations from India seeking employment. Leicester has also seen an increase in Black African-Caribbean populations from the West Indians since the 1950s (Herbert, 2016). More recently, Somalis, Eastern-European and Kurdish communities settled in the city. Areas around Spinney Hills, Belgrave and Highfields (now included in Wycliffe ward) are culturally diverse with large migrant cities. The sites, where our research is located is within these local authority wards, Spinney Hills, Wycliffe, and Belgrave.

The levels of multiple deprivation within these wards is high, with quintile scores ranging from 1-4 (ONS, Index of Multiple Deprivation, 2019). The level of accessibility to health hazardous environments includes fast food outlets, gambling venues, pubs, and commercial sites, is also relatively high (Index of Healthy Assets and Hazards AHAH, 2019). However, there is also limited accessibility to green spaces. Notably, Belgrave, Wycliffe, and Spinney Hills are in the 9th worst performing decile nationally for nearby green space (Index of Healthy Assets and Hazards AHAH, 2019). Despite this, the areas are well connected by public transport, due to the provision of buses near main streets. Transformation of these areas has occurred dramatically in last seventy years, due to an influx of predominantly Asian enterprises. Previously abandoned and dilapidated buildings within the Belgrave area have been renovated and there has been significant rise in commercial sites for these populations. The number of Black and Minority Ethnic people living in these areas is relatively high (ONS, 2011).

Belgrave

According to the (2011) Census the populations for Belgrave is 11,558 (ONS, 2011). The majority of the local population are Asian, and the common religious affiliation is Hindu. The area is known locally as possessing a high number of Asian retail outlets and restaurants in one street, commonly referred to as the Golden Mile. It is also renowned for its Diwali celebration, attracting over 30,000 people. This is largest annual Diwali celebration in the UK outside of India.

Belgrave is in the top 30% most deprived neighbourhoods in the country. The level of income deprivation for this area is relatively high, with elderly people being the most deprived. Notably, it is amongst 10% of the most deprived neighbourhoods for income deprivation affecting older people (ONS, Index of Multiple Deprivation, 2019). Over 50% of the local residents are ethnic minorities. Belgrave has a large population of Asian residents, the majority of which are of an Indian ethnic background (ONS, 2011). Bangladeshi and Pakistani residents also live within this area, but they are lower in numbers. The health of people in Belgrave is generally worse than the England average. Furthermore, lifestyle factors which influence health such as physical inactivity, are also worse than Leicester overall (Public Health England, 2018).

Spinney Hills

There are approximately 25,562 people living in Spinney Hills local authority ward. It is also in the top 30% most deprived neighbourhoods in the country. The level of income deprivation for this area is relatively high and this is particularly relevant for elderly people. Notably, it is also amongst the 10% most deprived neighbourhood for income deprivation affecting older people (ONS, Index of Multiple Deprivation, 2019). The local residents are predominantly ethnic minorities and the largest group, are of a South Asian ethnic minority background (ONS, 2011). The health of people in Spinney Hills is generally worse than the national average, lifestyle factors which impact on health including healthy eating and obesity are worse than the Leicester overall. Furthermore, the early death rates (in under 75 year olds) from CVD is higher than both the national and Leicester average (Leicester City Council, 2011).

Wycliffe

Wycliffe is one of the most diverse areas of the city with the highest percentage of ethnic minority groups. Over 50% of the local residents are ethnic minorities (ONS, 2012). This area has the highest number of African- Caribbean residents in Leicester; however, British Asian people from the Indian sub-continent are still the largest ethnic group (ibid). More recently, there has been an increase in arrivals from East-European countries (ONS, 2011).

The level of multiple deprivation is high, as it is in the top 30% most deprived neighbourhoods in the country. Income deprivation for this area is also relatively high, with elderly people being the most deprived. Notably, it is amongst 10% of the most deprived neighbourhoods for income deprivation affecting older people (ONS, Index of Multiple Deprivation, 2019). The health of people in Wycliffe is similar to those located in Spinney Hills and Belgrave, as it is generally worse than the national average. Lifestyle factors which impact on health including healthy eating and obesity are worse than the Leicester overall (Leicester City Council, 2011).

Section 2: Interviews with BAME-Led Organisations

a). About the organisations

Eleven BAME- led community organisations within Spinney Hills, Wycliffe, and Belgrave took part in the face-to-face interviews. The research found that all of the organisations provide culturally tailored services for members and visitors from BAME backgrounds. The services provided include education and skills training, health awareness services, social events and partnership working within wider organisational networks. They all aimed to support local people from BAME backgrounds by improving health, education, and social interaction. They also sought to empower elderly residents to participate in daily life by developing their educational, and employability skills, their health and self-confidence. The services provided aimed to reduce social exclusion, isolation, and poor health.

All of the organisations received support from volunteers. The majority (n=6) had between one and twenty volunteers, three organisations had between twenty and fifty-five and one organisation had one hundred volunteers. The number of staff employed ranged from two to twenty members. The majority of organisations (n= 6) had between ten and twenty, but this consisted primarily of part-time staff. The remaining organisations had under ten staff members. All of the organisations noted that their staff levels were highly dependent on the funding received.

The majority of the organisations (n=9) engaged primarily with people from Asian ethnic backgrounds within local wards and the wider city. One organisation differed and focused their services on people of African-Caribbean descent and another focused solely on women from different ethnic backgrounds. Two of the organisations who engaged primarily with Asian groups also provided services for African, Somalis and new arrivals from Eastern Europe, Italy and France. All of the organisations had medium to high levels of engagement, defined as engaging with elderly members more than once a week. None expressed any difficulty in engagement with elderly people from black and minority ethnic groups. Please **Table 1** below for further details.

The organisations offered various types of activities and campaigns for older members. These included education and training (such as IT, language skills, driving, and first aid). They also provided advice and guidance for healthcare access and citizenship, health promotion (physical activity sessions), health screening and emotional support via carers group and counselling. Various social, religious and cultural events that included coffee mornings and luncheons, religious ceremonies, celebrations and opportunities for prayer were offered. The central services provided amongst all the organisations focused on education, information, advice and guidance.

None of the organisations discussed any plans to change their services in the future. All of the organisations did express a willingness to offer more of the existing services, that included lunch clubs, and health awareness sessions to improve physical and emotional health and well-being for their users. However, all of the organisations stated that their dependency on external funding was problematic and difficult to sustain. Therefore, some organisations (n=6) were seeking alternative strategies to diversify income generation. Five organisations

discussed potential losses to their services if funding were to be cut. For example, one organisation commented on how they had resulted in self-funding an elders' luncheon club for social-isolated community members;

> *"We have found that South Asian elders are increasingly experiencing social isolation due to the loss of loved ones and changes in the support provided by families. In response to this, the staff here have started to make donations to support the set-up of a luncheon group. Some of them attending haven't seen anyone for weeks so it allows them to meet other people".*

It is evident that changes in the health and social care needs of elderly people from black and minority ethnic groups was impacting on services provided and needed. All organisations identified that elderly BAME people have more than one health condition, including dementia, arthritis, diabetes, depression and hypertension and this has risen dramatically in recent years. They all also identified that a rise in social isolation and loneliness had exacerbated older people's needs for support and services. When asked about the reasons for isolation and loneliness, participants felt that limited family networks and inadequate provision of culturally appropriate services by health and social care organisations had impacted significantly.

When asked about the barriers BAME older people may face when accessing services, all felt transport (for those with limited mobility) was a central barrier (n=10). However, multiple systems of stratification and its simultaneous impact were also noted here, as they also identified financial barriers (n= 3) and a lack of culturally competent staff and provision (n=3). Some organisations (n=3) felt that the latter had led to a distrust of service providers amongst older people from BAME groups. Recognition of intersectionality and its relevance for service provision is important here, as these older people possess multiple disadvantages and several axes of oppression, all of which impact on their access to services simultaneously (Crenshaw, 1989; Manthorpe et al., 2009).

b). Ways of working

Ways of working with other external voluntary and service organisations were relatively similar. They all worked informally in partnership with other organisations and did so to achieve more as a collectivel. They all felt that wanted to influence local decision makers in the public sector to achieve more in their local area. However, they felt that doing "things in their own way" was important because they knew it works for their BAME beneficiaries. As discussed above, the provision of culturally tailored and relevant services was a vital part of their provision. They all recognised that elderly people from BAME groups have different health and social care needs, and often experience health, and healthcare access in

very different ways from white British people due to multiple disadvantages. This is reflected in comment below by one of the organisations;

> *"We know that they are likely to use groups or services run by us because they are familiar with our other services and we are more likely to meet their cultural and language needs. We often get calls from organisations asking, if we can take members because they don't offer English translation or suitable activities".*

c). Methods of Engagement

Many of the community organisations described the way they usually engage and reach BAME older people as being through word of mouth (n=9). Face to face interaction by staff team members (n=3), with friends and family (n=3) and referrals by other organisations and social workers (n=3) were discussed. Traditional forms of communication that included paper leaflet distribution was also utilised. The community and support workers often visited communities and distributed leaflets at festivals, community events and faith centres. They also contacted them by phone, text message and WhatsApp. They also presented on local Asian or Caribbean radio stations. These approaches were chosen due to lack of IT skills, loss of capacity and social isolation of older people from BAME groups.

The types of places in which the organisations carried out their work were primarily BAME community venues that are perceived as culturally acceptable spaces. These environments allowed visitors to adhere to cultural, traditional and religious beliefs and practices. They also contained a high number of other individuals, from their own ethnic group that allowed members to experience shared understandings of faith, culture and practice.

None of organisations identified any significant barriers when trying to engage with elderly populations, due to their provision of culturally tailored services. However, as discussed above, the central barrier all of the organisations faced was the lack of funding for sustained provision (n=10). This included costs for transport, activities, staff, and talks by external health professionals. This also impacted on their aspirations to expand their organisations and offer more services. Two organisations also felt that a lack of formalised referral process via GPs (e.g social prescription) or engagement with external agencies created barriers in their service provision and support for older people BAME groups.

Table 1: Organisation Interviews (Communities, Aims, Volunteers and Level of Engagement).

Name of organisation	Highfields Centre, 96 Melbourne Rd, Leicester LE2 0DS	Antigua and Barbuda Ass. 12 East Park Rd	Shama Women's Centre, 39-45 Sparkenhoe St, Leicester LE2 0TD	Sikh Community Centre, 219 Clarendon Park Rd, Leicester LE2 3AN	Ansaar, 112 Melbourne Rd, Leicester LE2 0DS	Santosh Community Centre, 2 Wingfield St, Leicester LE4 5DS	Wesley Active Hall; 76 Hartington Rd, Leicester LE2 0GN	Diabetes Self-Help Group, Belgrave Neighbourhood Com. Centre Rothley St, Leicester LE4 6LF; Belgrave Library, Cossington Street, LE4 6JD	Pakistan Youth & Community Association (PYCA), 58 Earl Howe St, Leicester LE2 0DF	Bangladesh Youth & Cultural Shomiti; 34 Biddulph St, Leicester LE2 1BF	Shree Prajapati Association,21 Ulverscroft Rd, Leicester LE4 6BY
Location-ward	Wycliffe	Spinney Hills	Wycliffe (bordering Stoneygate).	Wycliffe (bordering with Castle).	Wycliffe	Belgrave	Wycliffe	Belgrave	Wycliffe	Wycliffe	Belgrave
Communities they work with	Indian sub-continent (Asian) African, African-Caribbean	West-Indian – African - Caribbean	Women, Indian, Pakistani; Bangladeshi, Arabs, African E. European	Indian sub-continent, Sikh	Indian sub-continent	Asian.	Asian.	South Asian	Pakistani; Bengali, Somali; other BAMEs	Bangladeshi, Sri Lankan, Eastern Europeans, Italians & French	Guajarati
Aims	Reflects in 3 Es motto: Enhancing lives, Empowering communities, Enterprise for all; Act as a community anchor organisation, providing community leadership and as a driving force in community renewal	Support Health, Education, Sports and Recreation for ABB nationals and diaspora	Empower women to became more active, economically, educationally and socially through a range of activities to develop their confidence, language and employability skills	Supporting community with skills, social and wellbeing needs; and brining community together; day trips	Providing support and empowering LD adults; challenging negative stereotypical views, myths and cultural barriers of learning disabilities and carers (particularly carers from BAME communities)	Providing culturally adopted day care services for adult and tackle social exclusion	Support the needs of the local community by facilitating the education, cultural and social development of individuals and community groups	Self-help and support group based in Belgrave for people with type 1 or 2 diabetes, their carers, and those who would like to know more about diabetes. Social support	Assist members of the Pakistani and other BAME individuals to develop themselves in order to better participate in mainstream society; provide support and training	Improving opportunities for services users in life, work and education	Membership organisation; members are from Guajarati descent; promote Shree Prajapati culture and heritage to members; raise awareness of issues important to the community - domestic violence, health matters
No of volunteers	8	3	24	50	12	2	54	1	100	3	100
Level of engagement low to high	Medium	High	Medium	High	High	Medium	High	High	High	Medium	High

Section 3: Important Social Infrastructure for Older Members of South- Asian Communities

Demographic information

The interviews were completed with fifteen South Asian participants. 14 members described their ethnicity as Indian and one as Asian from any other background. 60% were males and 40% were females and all were aged 50 years and over. 53% had existing health conditions including Type 2 Diabetes and the majority were carers for family members. The majority identified their religious affiliation as Hindu (80%). Please see the infographic and **Table 2** for further details.

Analysis of the interviews and social contact diaries revealed that participants attended religious buildings (temples, churches, and mosques), community centres and organisations, commercial sites and outdoors spaces regularly. Religious venues were visited most frequently by all of the participants and were identified as being important for social contact with others and information. All of the participants attended them daily for religious practice and prayer. However, these sites commonly served as locations for health support, care delivery, and socialisation. Support groups (n= 4), community organisations, centres (n=3) and parks (n=3) were also identified by the many of the participants as being important to them. The outdoor spaces identified in the interviews and diaries by participants are located in areas in which there is a high density of Asian residents. Participants enjoyed visiting them because they provided opportunities for walking and meeting others from their Asian communities.

Commercial venues such as shops and cafés were also visited daily. These shopping areas predominately serve Asian products, including food, household items, clothing and services. They are also located in areas that have a high number of Asian residents. Public services, such as GPs, pharmacies and health events were attended by most of the participants, but less frequently than temples and commercial spaces. They attended these sites mainly for healthcare products, and healthcare support.

The dominant forms of communication used by all of the participants were telephone (direct calls) and WhatsApp. All participants utilised these at least twice a day. Other forms of communications (Facebook, Twitter, Skype) were used less frequently, if at all. Similar platforms of communication were also identified by the organisations to engage and reach older members. The majority of the organisations did not use social media platforms such as Twitter and Facebook.

Social Capital

The central type of social capital identified and valued by the participants was **bonding** (Bourdieu, 1986). This included strong supportive ties which occur within their religious and/or ethnic group. This occurred frequently in religious venues that were perceived to be calming and relaxing spaces. All of the participants had been attending these spaces for a “number of

years". Socialisation opportunities that created bonding occurred at religious venues but also support (carers) groups, parks and community centres or organisations that they attended most frequently. People, who they knew very well, were those they met at religious settings, community centres or organisations, support (carers) groups, festivals and functions. Where longer forms of interaction occurred with family and friends, these individuals were also members from the same background and/or ethnic group. Thus, **bonding** ties continued. Opportunities for interaction and **bridging** with other ethnic or religious groups with whom them have weaker ties from different communities was infrequent for all of the participants (Bourdieu, 1986). They also rarely visited places that afforded opportunities to develop weak bridging ties. However, the organisations felt that their older members and visitors from black and minority ethnic groups had negative experiences of marginalisation in other non-culturally tailored or specific provision.

Linking connections between those with different levels of power or status occurred for some participants in faith venues (Bourdieu, 1986). These venues connect people that may have similar views regarding faith and culture, but some move in different social classes and circles. Analysis of the interviews with organisations revealed that many wanted to improve their linking connections by working with other ethnic groups, notably white British groups and local decision makers in the public sector. They believed that this will allow for more services to be provided, and further partnerships to be developed. They also felt that this would allow for greater cultural awareness between ethnic minority groups. As discussed above, organisations wanted to host community talks and invite external speakers that would assist in improving bridging ties. Linking ties were thus perceived by the organisations, as being important for improving strategic outcomes, and for increasing the ability of culturally tailored and relevant services for older BAME people. Some organisations (n=3) recognised the impact self-appointed community gatekeepers can have on accessing and defining needs for older BAME people and their influence on public sector decision-making.

Concluding points

The research has indicated that changes to the health of older BAME people has impacted on their increased need for service provision. All organisations found that these older people have multiple health conditions and a rise in social isolation and loneliness had exacerbated their needs for support and services. Furthermore, decreases in social and health care support from families and public sector organisations has impacted on the increased level of social isolation and loneliness experienced by BAME older people.

A reduction in sustained funding for the community organisations has impacted significantly on the level of services they can provide for these groups. The implementation of social prescribing in the NHS Long-Term plan (2019), needs to recognise the growing demand for services amongst these organisations and their capacity to deliver them. If "900,000 people are to be referred to social prescribing by 2023/24" from primary care, much further financial support should be provided to BAME led community groups and organisations that provide health and emotional support (NHS England, 2019).

It has been recognised that older BAME people face multiple disadvantages in accessing services due to decreased mobility, financial barriers, and limited provision of culturally competent services. Additionally, an increase in two or more health conditions amongst this group has augmented their demand for additional health and social care services.

The daily social contact data and individual interviews show that these participants have strong bonding ties with members of their own ethnic and/or religious group. This is evidenced in their communication methods, as they regularly utilised WhatsApp and the telephone to contact members of their own communities. Bridging ties with others beyond this are weaker. However, these forms of social bonding and relations amongst ethnic and/or religious groups shouldn't necessarily be perceived as having negative effects that lead to separation of 'cultures' and further marginalisation from services (Anthias, 2007). This report shows that public sector organisations and commissioners should enhance further *their* bridging practices with these older groups to improve the provision of inclusive services for older people from black and minority ethnic backgrounds.

Recommendations

- In accordance with the Public Services (Social Value) Act (2012), commissioners should be further encouraged to recognise the social value and its long-term community benefits BAME-led community organisations provide. Development of a social value policy as part of the local Joint-Needs Assessment and commissioning strategies is advised. BAME-led community organisations should also demonstrate further their capabilities in delivering additional social value for older BAME people in funding applications and tender bidding processes.

- Health and social care commissioners and policy makers should work in partnership with BAME-led community organisations to improve access to culturally competent and culturally- tailored mainstream services for older BAME people. Provision of more inclusive settings in which all older BAME groups feel included are recommended.

- Further public funding should be provided to support the sustained provision of services provided by BAME-led community organisations for older BAME people. Support should also be given to these organisations to consider alternative or additional income generation models to assist in the sustained provision of the services for BAME elderly people.

- Clinical Commissioning Groups should expand the use of social prescribing to BAME-led community organisations, for older people from black and minority ethnic backgrounds, through the adequate allocation of funding. Support should also be provided for GPs and other local agencies to identify these organisations, and to highlight the importance of culturally tailored services.

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Table 2: Individual Interviews, Demographic Information

Interview	Total	Gender		Age			Disability		Carer		Religion		
	N (%)	Male N (%)	Female N (%)	50-59 N (%)	60-69 N (%)	70 + N (%)	Yes N (%)	No N (%)	Yes N (%)	No N (%)	Hindu	Sikh	Jehovah. Witness
Overall	5 (100)	9 (60)	6 (40)	5 (33.3)	5 (33.3)	5 (33)	8 (53)	7(47)	5 (33)	10 (67)	13 (86)	1 (7)	1 (7)
Indian	14 (93)	8 (53)	6 (40)	5 (33.3)	5 (33.3)	5 (33)	8 (53)	6 (40)	11(73)	3 (20)	12 (80)	1 (7)	1 (7)
Asian Any other background	1 (7)	1 (7)	0 (0)	0 (0)	1 (7)	0 (0)	0 (0)	1 (7)	0 (0)	1 (7)	1 (7)	0 (0)	0 (0)

References

- Anthias, F., (2007). Ethnic ties: Social capital and the question of mobilisability. The Sociological Review, 55(4), pp.788-805.
- Bourdieu, Pierre (1986), 'The Forms of Capital', in Richardson, John G., ed., Handbook of Theory and Research for the Sociology of Education, New York: Greenwood.
- Chattopadhyay, K., Biswas, M. and Moore, R., (2019) NHS Health Check and healthy lifestyle in Leicester, England: analysis of a survey dataset. Perspectives in Public Health, p.1757913919834584.
- Crenshaw, W. K. (1989) 'Demarginalizing the Intersection of Race and Sex: a Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics.' University of Chicago Legal Forum, 139: 139–67.
- Herbert, J., 2016. Negotiating boundaries in the city: Migration, Ethnicity, and Gender in Britain, London: Routledge.
- Index of Healthy Assets and Hazards AHAH Version 2 (2019), Available at: https://data.cdrc.ac.uk/dataset/ahah2, accessed 23/10/2019.
- Leicester City Commissioning Group (2019) The Health of the Population, Available at: https://www.leicestercityccg.nhs.uk/about-us/gppracticevacancies/the-health-of-the-population/, accessed 23/10/2019.
- Leicester City Council (2011) Leicester Ward Health Profile-Belgrave, Available at: http://www.cabinet.leicester.gov.uk/documents/s26420/2011_Ward_Profile_Belgrave.pdf, Accessed 24/10/2019.
- Leicester City Council (2011) Leicester Ward Health Profile- Spinney Hills, Available at: http://www.cabinet.leicester.gov.uk/mgConvert2PDF.aspx?ID=26434, Accessed 24/10/2019.
- Manthorpe, J., Iliffe, S., Moriarty, J., Cornes, M., Clough, R., Bright, L. and Rapaport, J., (2009). 'We are not blaming anyone, but if we don't know about amenities, we cannot seek them out': black and minority older people's views on the quality of local health and personal social services in England. Ageing & Society, 29(1), pp.93-113.
- NHS (2019) Social Prescribing, Available at: https://www.england.nhs.uk/personalisedcare/social-prescribing/, accessed 28/10/2019.
- NHS Long Term Plan (2019) Available at: https://www.longtermplan.nhs.uk, accessed 20/10/2019.
- Public Health England (PHE) (2018) Health Profiles: Leicester. London: Public Health England.
- The Public Services (Social Value) Act (2012) Department for Digital, Culture, Media and Sport, London: HMS0, Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/690780/Commissioner_Guidance_V3.8.pdf, accessed 20/10/2019.
- Office of National Statistics. (2011) Census. Key statistics for local authorities in England and Wales. Dec 2012. Available at: www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/index.html, accessed 30/10/2019.
- Office of National Statistics. (2018) Regional ethnic diversity, Available at: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest, accessed 25th Oct 2019
- Office of National Statistics. (2019) English Indices of Deprivation, Index of Multiple Deprivation, 2019, Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019, Accessed 24/10/2019.