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Perceived inequalities in care and support for older women from Black and minority ethnic backgrounds in Wales: findings from a survey exploring dignity from service providers' perspectives

Abstract

Objective. As part of a large mixed-method study aimed at capturing understandings of dignity, and care expectations of community dwelling older women from Black and minority ethnic (BME) backgrounds living in Wales, the aim of this paper is to compare service providers' perceptions of their care and support provided to older people in general, and to older women from BME backgrounds in particular, with a focus on two dignity indicators: care and support needs, and effective communication.

Design. A survey design was used.

Results. A total of 124 responses from service providers in Wales were received. Perceived inequalities in care and support were found. Although most respondents reported that care and support provision was generally acceptable, more respondents believed that compared to older people in general, older women from BME backgrounds were seldom or never offered opportunities and support to express their needs, were involved in their own care, were provided appropriate information, had their key needs especially less visible needs (psychological and religious needs) been taken into account, or were communicated with effectively (all $p<0.05$). In some cases, respondents tended to report more positively in areas related to their own practice.

Conclusion. We suggest that learning from the views and perceptions of service providers, as well as older people and their families, remains key to developing services for the UK's increasingly diverse and ageing population. A better understanding of how inequalities may occur, their impact on older people and their families, and how they may be minimised can inform the development of high quality care for older people regardless of their ethnic and cultural backgrounds in Wales, other parts of the UK and beyond.

Key words: Community dwelling; dignity; ethnic minorities; older people; older women; service provision

Introduction

Call for dignified care for older people

Dignity is often considered as a multi-faceted, contested concept drawing on a person's sense of identity, autonomy, human rights, and recognition (Gallagher et al. 2008; Tadd et al. 2011). In a concept analysis of dignity in relation to older people, an inherent characteristic of dignity is regarded as being human, subjectively felt as an attribute of the self, and manifested through behaviour demonstrating respect for self and others (Jacelon, Connelly, and Proulx 2004). In addition, the social dimension of dignity has been emphasised in relation to wider social factors, social inequalities, and its impact on how people seek and respond to care and support services (Jacobson 2009).

Over the last decade, UK policy on health and social care for older people has increasingly emphasised person-centred, preventative approaches in community settings to facilitate quality of life, independence, individual choice, and autonomy (e.g. Welsh Government 2013). The need to foster and maintain the dignity of patients/clients have been highlighted in various codes of conduct for health and social care professionals in the UK (e.g. Nursing and Midwifery Council 2008; Care Council for Wales 2015). What has also emerged is a range of domains and indicators of dignity identified to monitor and assess hospital service delivery for older people, including autonomy, communication, eating and nutrition, end-of-life care, pain, personal care, personal hygiene, privacy, and social inclusion (Magee, Parsons, and Askham 2008). Choice, control, staff attitudes, and facilities were themes across many of these indicators, as are those linked to effective care, support, and communication.

Despite the policy and practice imperative to deliver care with dignity and a growing understanding of key components of dignified care, support and care for older people is often associated with abuse, neglect, and a lack of dignity, respect, and empathy, as shown in recent reports, such as the Francis (2013) report of the Mid Staffordshire NHS Foundation Trust in England, the Andrew and Butler (2014) report of two hospitals in Wales, and the reports on dignified care by the Older People's Commissioner for Wales (2011, 2013), an independent voice and champion for people aged 50 and over. Although there are significant differences between health and social care systems in England and Wales, especially in terms of the commissioning, regulation, and inspection, delivering on the dignity agenda in health and social care is a common challenge. In Wales, the Older People's Commissioner for Wales (2011) investigated the experiences of older people in hospitals and raised serious concerns about failures to treat people with dignity and respect, demanding fundamental changes in 12 specific areas. In the progress report, the Older People's Commissioner for Wales (2013) indicated that there were still too many cases of poor care received by older people and the NHS failed to get the basics right. Reviewing care for older people in care homes in Wales, the Older People's Commissioner for Wales (2014) revealed a reliance on a task-based approach and an unacceptable quality of life for too many older people, commending seven requirements for action.

UK demographic changes

As with other part of western European society, the UK population becomes ethnically diverse and ageing.

The ethnic composition of the population has changed dramatically due to large-scale migrations since the Second World War. In 2011, 12.9% of the UK population were from a Black and minority ethnic (BME) background, with African/Caribbean Black British (3.0%) forming the largest group, followed by Indian British (2.3%) (Office for National Statistics 2017a). In the UK, the terms 'minority ethnic' or 'ethnic minorities' are most often used to refer to all minority groups of the population not indigenous to the UK, which hold cultural

traditions and values derived, at least in part, from countries of their or their ancestors' origin. It is axiomatic that BME populations are heterogeneous, with differences both within and between groups.

The number of older people continue rising across all ethnic groups. In 2016, 18% of the UK population were aged 65 or over, while Wales had the highest proportion of 20.4% (Office for National Statistics 2017b; Welsh Government 2017). Of 563 million people aged 65 or over in Wales, 6.3 million (1.1%) are from BME backgrounds (Office for National Statistics 2017a). Although this percentage is lower than that in England (4.8%), the number of older ethnic minorities continue increasing in Wales. Moreover, older women outnumber older men across all UK population groups (Office for National Statistics 2017a).

Research on care and support for UK older people from BME backgrounds

The 2011 census showed health inequalities across UK ethnic groups, with most ethnic minorities, especially those at older ages, reporting poorer health than white British people (Becares 2014). For example, of women aged 65 or over, Pakistani (77%), Bangladeshi (76%), White Gypsy or Irish Traveller (73%), Indian 68%), and Arab women (66%) reported a higher percentage of a limiting long-term illness, compared to all women at this age (56%). Similarly, a higher percentage of Bangladeshi, White Gypsy or Irish Traveller, and Pakistani men (69%, 69%, and 64% respectively) aged 65 or over reported a limiting long-term illness, compared with all men at this age (50%). A wide range of factors, such as biological, environment, social, and economic determinants, may have contributed to such inequalities (Becares 2014).

An ethnically diverse and ageing population calls for changes to health and social care policy and practice to diminish rather than exacerbate long-standing health inequalities. In the past, research exploring the care and support for UK older people from BME backgrounds has been lacking; however, there is an emerging evidence base that addresses this gap from the perspectives of older people, or service providers, or both.

Some studies have focused on older people's views. For example, Payne et al. (2008) explored older British Chinese people's views on the influence of food on cancer and its role in supportive cancer care. Participants highlighted the cultural and therapeutic significance of food, while expectations of the lack of culturally appropriate and acceptable food in hospitals became their major concerns. In another study of older people from BME backgrounds, examining their experience of proactive welfare rights advice, Moffatt and Mackintosh (2009) found that participants had very low levels of knowledge of state entitlements. Victor, Martin, and Zubair (2012) explored the understanding and experiences of care and support within the context of family and social networks among 20 older people from South Asian communities. Family care was regarded as the preferred option, while receiving care from statutory services was viewed as extremely negative.

Some research has focused on service providers' perspectives. For example, Ansari et al. (2009) examined the role of advocacy and interpretation services in the delivery of quality care to diverse ethnic minority communities in London, a multi-cultural city in the UK. A range of challenges were identified in relation to advocacy, services, and clients. In another study, Badger et al. (2012) explored issues around ethnicity and culture in nursing homes in England from managers' perspectives. One-third of the 101 homes surveyed had residents from BME backgrounds, but not all homes had established systems to respond to residents' diversity. Most participants acknowledged the specific needs of residents from BME backgrounds relating to diet, religion, end-of-life care, and cultural practice, and highlighted the need to address staff training to promote quality care for all residents.

In two studies, researchers have explored the perspectives of both older people and service providers. Bowes, Avan, and Macintosh (2012) conducted a qualitative study to

explore respect, dignity, and mistreatment of older ethnic minorities in residential care. Service providers identified various aspects of service provision crucial to ensuring good quality of care with dignity, highlighting the importance of effective communication and flexible, individualised care, which took account of individual cultural preference and personal choice. Perceived difficulties and gaps in care provision were thought to be mainly due to structural and contextual factors, while cultural factors had a small impact. Older people and their families perceived that care provision was less positive than did service providers, and had experienced some difficulties in using services, stressing the need for individualised care based on a good understanding of and engagement with the individual to avoid possible stereotyping of needs. Wilkinson et al. (2016) explored access to end-of-life kidney care for ethnic minorities in England, and found that some patients were unaware of their identified needs for end-of-life care, while care providers reported key issues around the difficulty of identifying patients with end-of-life care needs, language barriers, and the lack of time or confidence to discuss end-of-life care with patients.

The bulk of research on care and support for older people from BME backgrounds has been undertaken mainly in institutional settings, and in areas with higher densities of ethnic minority groups, such as London. In Wales, very little research is conducted with older people from BME backgrounds to understand their pathways through the care systems, perceptions of dignity, and expectations of care and support services. Also, very little research is undertaken with service providers to understand their experiences of service provision. This is despite the fact that, compared to men, women from ethnic minority groups face, to varying extents, barriers rooted in real and perceived social, cultural, gender, and ethnic differences, and a legacy of social exclusion, marginalization, and racism – factors that can lead to lower health and social outcomes and difficulties accessing services (e.g. Afshar et al. 2008). In Wales, there is a call for more research rooted in the experiences and perceptions of older people, especially older women, from BME backgrounds and of service providers who provide care and support. Such a call is framed not only by UK equality legislation, but also by national standards of care, professional codes, and standards for health and social care education.

Methods

Study aims

A mixed-method study was undertaken in Wales with two aims. The first aim was to capture understandings of dignity and care expectations of community dwelling women aged 50 or older from BME backgrounds. Working with community researchers, views were collected from 32 women from Indian, Caribbean, Bangladeshi, and Chinese heritage via in-depth interviews (Saltus and Pithara 2014, 2015). The second aim was to explore service providers' perceptions of the care and support received by all older people and by older women from BME backgrounds in particular (as reported in this paper), and their perceptions of barriers to and facilitators of providing high quality of care and support to older women from a BME background.

Design

A survey design was used to explore service providers' perceptions of their care and support provision.

Sample and sampling

Eligible respondents were service providers in Wales who (i) delivered hands-on care or support to older people aged 50 or over living in their own homes, including older women from BME backgrounds (ii) supervised others delivering such services, or (iii) managed such

services. These included people delivering community-based services, good-neighbour-scheme coordinators/volunteers, reablement/settlement workers, welfare-rights support workers, supported-shopping workers, and those providing domiciliary care.

A convenience sample was used. An invitation was circulated via a number of electronic mailing lists, bulletins, and newsletters of various key local, regional, and national organisations in contact with older people or with a specific remit to work with ethnic minorities. Other strategies included the use of social media sites and snowballing techniques, where respondents invited their contacts to take part. In addition, 300 hard copies were sent to various organisations for distribution. Although not all service providers in Wales were reached, the sampling method did not introduce significant biases in terms of the sample that was recruited, and as such it can be considered to be generally representative of eligible service providers.

Research setting

The survey was conducted in Wales, where social services and social care are delivered by 22 local authorities and approximately 1,800 private and independent organisations, supporting around 150,000 people of all ages and ethnic groups (http://wales.gov.uk/topics/health/socialcare/?lang=en). Ethnic minority representation in Wales had increased to 4.1% in 2009, with Asian and Asian British being the largest group, accounting for 1.8% of the population (Welsh Government 2011).

Data collection

A questionnaire was developed to collect data, informed by literature on good quality of care for older people (e.g. Gallagher et al. 2008; Magee, Parsons, and Askham 2008); literature on dignity in care for older people (e.g. Tadd et al. 2011); policy documents (Welsh Government 2013); advisory meetings with stakeholders. Magee, Parsons, and Askham (2008) recommended that only one or two dignity domains should be explore in-depth at a single time. Therefore, we focused on two dignity indicators relevant to caring for older people in community-dwelling settings: care and support needs; effective communication.

We asked respondents a set of similar questions on their perceptions in relation to all older people, and older women from BME backgrounds in particular (Table 1). This allowed some comparative analysis to be undertaken to explore whether there were any differences in their perceptions, whilst helping to secure a greater response rate.

Demographic information was also collected. Most questions were closed, with a few open questions allowing respondents to add free text. The content and face validity of the questionnaire were piloted with a group of 12 people, who had expertise in older people's issues, questionnaire design, or statistics. The questionnaire was refined using feedback received on aspects of its content, readability, flow, layout, and technique issues.

The questionnaire was available to be completed online at the Bristol Online Survey website. A link to the site was emailed to organisations and relevant individuals. Following the initial contact, two reminders were made at four-week intervals. An e-copy of the questionnaire was attached to all invitation emails and a hard copy with a free freepost envelope was available on request.

Data analysis

IBM SPSS version 22 was used to conduct the data analysis. Data collected online were imported directly and those collected via hard copies were entered manually. Descriptive statistics were used to describe frequencies and percentages of variables. Wilcoxon tests were used to compare responses to the sets of questions on respondents'

perceptions in relation to old people in general, and older women from BME backgrounds in particular. Chi-square, Mann-Whitney, and Friedman tests were used to compare responses from respondents with different professional roles or from different ethnic backgrounds. Statistical significance was set at $p \leq 0.05$ (two-tailed).

Where respondents did not answer all questions, the remainder of their data was retained to maximise the sample size, with 12.3% of the required responses missing.

Ethical considerations

The research was approved by a relevant research ethics committee of the researchers' organisation. General ethical principles in health and social care were followed. Participation was voluntary, with no incentive given. Submitting or returning a completed questionnaire was considered an indication of consent. Respondents were assured that any information they provided remained unidentifiable, with confidentiality preserved in data analysis and reports.

An information sheet was provided, fully explaining the purpose of the study and the nature of participation. The research team could be contacted to answer any queries. Respondents were informed of their right to withdraw and, with all questions optional, they were not forced to answer those they preferred to skip.

Findings

The respondents

A total of 124 replies were received (97 online and 27 by post). Table 2 shows their self-reported demographic profiles. The largest proportion of respondents for each demographic characteristic was female (89.3%); aged 46-55 (39.7%); educated at diploma level (28.8%); from a white Welsh background (49.2%); worked in the third sector (43.9%). Some respondents had multiple professional roles and the largest proportion was involved in providing support (48.4%). The length of time in their current roles ranged from less than a year to over 40 years, with a mean of 11.31 years (SD 9.20).

Understandings of dignity

There were 113 responses to the question asking respondents to list any words or phrases coming to mind when hearing the word 'dignity'. Dignity was viewed as multifaceted. A word-frequency query showed that 'respect' was most frequently mentioned. Respondents reported that dignity was often communicated or manifest itself through the delivery of care and support in a 'respectful' and 'person-centred' manner, where older people should be treated 'equally' and 'fairly', irrespective of their age or ethnicity. Respondents also listed words associated with the concept of human worth (e.g. 'grace', 'honour', and 'rights'); the notion of self (e.g. 'self-esteem', 'self-importance', 'self-confidence', and 'self-determination'); attitudes and professional conduct promoting (e.g. 'empathy', 'compassion', 'politeness', and 'non-judgmental') or diminishing a person's sense of dignity (e.g. 'insulting', 'condescending', and 'abusive').

Perceptions of care and support needs

Respondents were asked a set of similar questions on their perceptions of a key dignity indicator - care and support needs, in relation to all older people and older women from BME backgrounds in particular, in terms of expressing their needs, care involvement, and key care requirements being addressed.

Perceptions of opportunities and support to express needs

As presented in Table 3, most respondents believed that older people and older women from BME backgrounds were always or frequently offered opportunities or support to express their needs. However, a minority of respondents perceived that such opportunities or support were seldom offered to all older people or older women from BME backgrounds (12.1%, 22.0% respectively in terms of opportunities; 6.3%, 7.7% respectively in terms of support).

Wilcoxon tests were conducted to compare responses to these two sets of questions with regard to perceptions in relation to all older people compared with those in relation to older women from BME backgrounds. The majority of respondents had the same perception across the two groups; however, of those who did not, fewer respondents perceived that older women from BME backgrounds were always or frequently offered such opportunities (p=0.002) or support (p=0.008). Chi-square tests were conducted to explore differences in responses from respondents with different professional roles. Respondents with a supporting role were significantly more likely than those with other roles to perceive that older women from BME backgrounds were always supported to express their needs (59.0% vs 34.6%), the only role to achieve a significant result relating to this question (p=0.04). Mann-Whitney tests indicated that there were no significant differences based on respondents' ethnic backgrounds.

Perceptions of care involvement

Respondents were asked about their perceptions of the extent of care involvement of those they supported (Table 3). Although most respondents perceived that older people were always or frequently involved in their own care, 18.2% thought this to be the case only seldom or never (compared with 27.8% in relation to older women from BME backgrounds).

Wilcoxon tests were performed to examine differences in responses to this set of questions with regard to perceptions relating to all older people compared with those relating to older women from BME backgrounds. The majority of respondents had the same perception across the two groups for all of these questions. However where respondents did have different perceptions of the two groups, fewer perceived that older women from BME backgrounds were involved in their own care (p=0.005). Analysis using chi-square tests indicated that perceptions of care involvement were not different regardless of respondents' professional roles (all p>0.05). Mann-Whitney tests were conducted to compare responses based on respondents' ethnic backgrounds. It was found that the perception that older people were involved in their own care was less frequently reported among respondents who were from a BME background themselves (p=0.02). No such difference was found when respondents were asked about older women from BME backgrounds.

Perceptions of key needs being addressed

Respondents were asked about their perceptions of the extent of key needs of those they supported being addressed, in terms of physical, social, psychological, religious, and cultural needs (Table 4). The majority of respondents perceived that all of these needs of older people and older women from BME backgrounds were always or frequently taken into account.

However, Friedman tests indicated that there was a significant difference in how often each need was perceived to be addressed among older people (χ^2=74.72, df=4, p<0.001) and also among older women from BME backgrounds (χ^2=77.55, df=4, p<0.001). Respondents were more likely to perceive that physical needs of both older people and older women from BME backgrounds were always taken into account (54.6% and 59.0%, respectively), while they were least likely to perceive that religious needs were always taken

into account for older people (32.4%) and that psychological needs were always taken into account for older women from BME backgrounds (33.0%).

Table 4 also shows the results of Wilcoxon tests comparing perceptions relating to older people and older women from BME backgrounds in terms of responses to the set of questions on different needs being taken into account. The majority of respondents had the same perception across both groups. Where this was not the case, fewer respondents perceived that older women from BME backgrounds had their needs taken into account, in the case of physical (p=0.002), social (p=0.02), psychological (p=0.02), and cultural needs (p<0.001). A non-significant effect was observed for religious needs (p=0.09).

Some significant differences were found based on respondents' professional roles. There were associations between whether respondents performed hands-on care and their perceptions of whether older women from BME backgrounds had their physical (p=0.04) and religious needs (p=0.05) taken into account. Respondents who did perform this role were more likely than those who did not perform the role to think these needs were always taken into account (84.2% vs 47.4% for physical needs; 63.2% vs 28.8% for religious needs). There was also an association between whether respondents had a managerial role and their perception of whether older women from BME backgrounds had their psychological needs taken into account (p=0.004). Respondents with this role were more likely to think that such needs were always or frequently taken into account (60.0% vs 30.5%).

Mann-Whitney tests showed that respondents from a BME background themselves were less likely than those from a white background to perceive that psychological needs of either older people or older women from BME backgrounds were taken into account (p=0.009, p=0.008, respectively). The same finding was observed in terms of physical needs of older people (p=0.04).

Perceptions of dignity indicators relating to effective communication

Respondents were asked about their perceptions of effective communication with those they supported, in relation to appropriate information provision and language choices, being listened to, and being understood.

In total, 31.9% of respondents perceived that older people they cared for were seldom or never provided with information relevant to their ethnic or cultural backgrounds, whereas, 44.1% of respondents indicated that older women from BME backgrounds were seldom or never given language choices for communication. Chi-square tests indicated that there were no significant differences between respondents with different professional roles in terms of perceptions of either information provision or language choices (all p>0.05). However, Mann-Whitney tests showed that respondents from a BME background themselves were more likely than respondents from a white background to perceive that older women from BME backgrounds were given language choices for communication (p=0.04).

Respondents were asked to perceive whether older people and older women from BME backgrounds they cared for would agree with each of the six statements on effective communication, as linked to being listened to and being understood (Table 5). Statement 2 *'I can discuss my care with people who support me'* produced the highest proportion of 'strongly agree' or 'agree' responses in relation to older people (85.1%), and older women from BME backgrounds (80.0%), while statement 6 *'I am comfortable to raise concerns about my care'* had the lowest proportion of such responses (69.1% and 69.2%, respectively).

Wilcoxon tests were carried out to compare responses to the set of statements relating to all older people and older women from BME backgrounds. The majority of respondents had the same perception for both groups of people, but among respondents who had different

perceptions for the two groups, fewer thought that older women from BME backgrounds would 'strongly agree' or 'agree' with the following four statements:

- Statement 2: *'I can discuss my care with people who support me'* (p=0.02)
- Statement 3: *'People who provide care or support to me listen carefully to what I have to say'* (p=0.03)
- Statement 4: *'People who provide care or support to me take time to listen to what I have to say'* (p=0.04)
- Statement 5: *'People who provide care or support to me make sure I understand them'* (p=0.03).

Chi-square tests were performed to compare responses from respondents in different professional roles. It was found that 53.6% of respondents with a supervisory role perceived that older women from BME backgrounds would strongly agree with statement 1 *'I have been asked how I would like to be addressed'*, compared with 32.1% of respondents without this role (p=0.04), the only role to achieve a significant result. No significant differences were observed based on respondents' ethnic backgrounds (all p>0.05).

Discussion

The aim of this paper was to explore service-providers' perceptions of community-based care and support provided to all older people and older women from BME backgrounds in particular. Based on the findings reported here, we found some issues around perceived inequalities in service provision and respondents' perceptions of their own practice.

The importance of dignity in care

It was found that dignity in the context of care was understood as a multi-faceted concept, most frequently associated with respect, and communicated and manifested itself through actions and behaviours. Elements crucial to professional code of practice, such as empathy and compassion, were seen to be of importance. These findings are consistent with literature on the concept of dignity (Jacelon, Connelly, and Proulx 2004) and on the importance of empathy and compassion in care settings (Yu and Kirk 2008), as well as in keeping with the principles underpinning dignity campaigns and UK health and social care policy agendas in terms of dignified care (Welsh Government 2013; Social Care Institute for Excellence 2009). However, the social dimension of dignity was not evident in respondents' responses.

Perceived inequalities in service provision

Perceptions of service provision were explored via two dignity indicators: care and support needs; effective communication. Some perceived inequalities were found. Most respondents reported that care and support provision was generally acceptable and had the same perception of services provided to all older people, and to older women from BME backgrounds in particular. However, of a small number of respondents who did not have the same perception, more respondents believed that compared to older people, older women from BME backgrounds were seldom or never offered opportunities and support to express their needs, were involved in their own care, were provided appropriate information, had their key needs especially less visible needs (psychological and religious needs) been taken into account, or were communicated with effectively.

These findings may be partially explained by the lack of effective communication. Language is a well-recognised barrier for ethnic minorities to accessing health and social care services (Fryer et al. 2013; Maneze et al. 2016). For example, in residential settings, Bowes, Avan, and Macintosh (2012) reported that inadequate translation provision was seen

by many service providers in their study as an important factor impacting their ability to ascertain cultural and spiritual needs of older people from BME communities. Similarly, nurse respondents in Gerrish (2001) identified various risks associated with inadequate language support for UK South Asian patients and their families, including the potential for misunderstanding of diagnosis and treatment, a lack of psychological and emotional support, and ongoing needs not being adequately assessed.

Effective communication is a key indicator underpinning many dimensions of dignity (Woolhead et al. 2006; Magee, Parsons, and Askham 2008). The use of appropriate forms of address, listening, giving choice, involving people, making them feel valued, and respecting their needs are all seen as important ways to endow a sense of dignity (Woolhead et al. 2006; Bowes, Avan, and Macintosh 2012). As reported by some respondents in the current study, without giving older people, especially BME older women, relevant opportunities and appropriate language support to express their needs, it would be unlikely that individual needs can be recognised and addressed accordingly. However, narrowly focusing on language issues can overlook the wider societal context including the social dimension of dignity, in which services are provided and received, thus leading to an inappropriate conclusion (e.g. Bowes, Avan, and Macintosh 2012; Yu, Saltus, and Jarvis 2017).

Another possible explanation for these findings may be that in practice service-providers tend to apply a task-orientated approach due to time restraints, leaving less time for effective communication. Similar findings were reported by others (Woolhead et al. 2006; Tadd et al. 2011). Many older people do require some physical care due to frailty, chronic illness, disability or impairments, and it is therefore essential to ensure appropriate physical support is always provided (National Public Health Service for Wales 2005). However, needs related to social, mental, and psychological well-being, should also be recognised and addressed appropriately (Welsh Government 2013), while lack of time should not be used to justify task orientation in care. It is recommended by UK National Institute for Health and Care Excellence (2015) that each visit to older people living in their own homes should last for at least 30 minutes, emphasising the need to shift to a person-centred approach to promote independence, rather than 'one size fits all' services.

It is clearly stated in the UK Equality Act 2010 that all public bodies and private or voluntary organisations carrying out work on behalf of a public sector have a legal duty to eliminate discrimination and promote equality (https://www.legislation.gov.uk/ukpga/2010/15/contents). Individuals working in regulated professions such as the respondents in our study would have a duty to inform their regulator, in this case the Care Council for Wales, if there is evidence of systematic discrimination. However, what we found are perceived, not necessarily actual, inequalities, and thus this needs to be explored in future research.

Respondents' perceptions of their own practice

Exploring service providers' perceptions of service provision, we found some differences in responses based on respondents' ethnicity and professional roles. Respondents responded more positively in some areas related to their own practice.

For example, it was found that respondents from a BME background themselves were more likely than white respondents to perceive that language choices were often offered to older women from BME backgrounds. These respondents might think that they themselves had always done an excellent job in terms of providing language support where needed, as in practice, staff members from a BME background would be preferably asked to provide care for clients speaking the same language. However, this finding may also indicate that these respondents were more likely to experience or recognise issues other than those around the language. For example, Yu, Saltus, and Jarvis (2017) found that compared to

respondents from a white background, those from a BME background tended to experience additional barriers such as lack of staff training and racism.

Also, it was found that respondents in a supporting role were more likely than those without this role to think that older women from BME backgrounds were supported to express their needs, while those providing hands-on care were more likely to perceive that physical needs of older women from BME backgrounds were addressed appropriately. Due to the subjective nature of self-reporting, it is difficult to know whether these perceptions were actually the case. These findings, on the one hand, may reflect the fact that respondents in those roles had in fact fulfilled their roles and duties satisfactorily as they perceived. On the other hand, these respondents may perceive that these roles and duties are performed satisfactorily to a greater extent than is actually the case, leading to an inflated perception of this outcome. Similarly, in a previous study, it was found that care professionals tended to perceive their own practice more positively than did older ethnic minorities and their families (Bowes, Avan, and Macintosh 2012).

Limitations

The main limitations of this study are the sample and its size. The sample (n=124) represents a very small proportion of all care providers in Wales. Although we approached a wide range of organisations and networks across Wales, the sample was drawn from a relatively homogenous group in terms of ethnicity, gender, and location. In particular, most respondents were from a white ethnic group (21.2%) and male respondents were under-represented (10.7%), which might reflect the demography of occupational groups involved in care settings. The variation in respondents' experiences of working with older people from various ethnic backgrounds might have impacted on their responses. Also, as with research in general, there was potential selection bias. Those who participated might have a particular interest in or concerns about caring for older people or ethnic minorities in particular. Finally, the data collection tool was written in English only. We might have limited the ability of service providers not proficient in English to take part.

Despite these limitations, the study does add to empirical research evidence and some recommendations can be drawn.

Recommendations

Dignity remains a key priority in health and social care policy and practice. There is a need to continue to explore this concept, including its social dimension, in the context of care across different population groups and key professional groups.

The perceived inequalities in care and support as found in this study indicate the need for future research to explore whether and how such inequalities occur, their impact on the lives and well-being of older people, and how they can be addressed effectively. Such inequalities should be explored and understood in the wider context, where social, economic, environmental, and cultural explanations of health and care needs are considered.

The views of service providers remains a crucial element in the reformulating of service provision. Considering our findings of some respondents perceiving more positively in areas related to their own practice, it is important for future research exploring care and support provision not only to compare service providers' perceptions with those of older people and their families, but also to compare perceptions of service providers with different professional roles. Older people, regardless of their ethnic and cultural backgrounds, often have common expectations about the quality of health and social care services, as well as individual expectations, aspirations, and desires based on their life experiences and backgrounds in relation to culture, religion, and ethnicity (e.g. Bowes, Avan, and Macintosh

2012). A better understanding of their views and experience, in addition to those of service providers would be crucial.

As reported in the current study and in the literature, issues around language barriers to service provision still exist (e.g. Fryer et al. 2013; Maneze et al. 2016). There are some excellent practice guidelines on using an interpreter (American Geriatrics Society Ethnogeriatrics Committee 2016), and the use of a diverse multilingual staff team in residential care has also been recommended (Badger et al. 2012; Bowes, Avan, and Macintosh 2012). A multilingual workforce may meet a client's specific linguistic needs; however, culturally competent care is not necessarily guaranteed, while service providers from BME backgrounds may experience some additional barriers and issues, such as experience of racism and lack of staff training (Yu, Saltus and Jarvis 2017). It is important to pay attention to the wider societal context, while narrowly focusing on language or the person could limit the development of necessary cultural competences needed to engage and work in an intercultural context.

Conclusion

The findings reported in this article provide some evidence of perceived inequalities in care and support provision for older people and a tendency of reporting one's own practice more positively, suggesting a need for improving the overall quality of services for older people. Learning from the views and perceptions of service providers, as well as older people and their families, remains the key to develop services for the UK's increasingly diverse and ageing population. A better understanding of whether inequalities actually occur, how they may occur, how they may impact older people and their families, and how they may be minimised can inform the development of high quality care for older people regardless of their ethnic and cultural backgrounds in Wales, other parts of the UK, and beyond.

Key messages

(1) There is some evidence of perceived inequalities in care and support service provision for older people, although the provision may be generally acceptable.
(2) In some cases, respondents may perceive their own practice more satisfactorily.
(3) There is a need for future research to explore whether inequalities actually occur, how they may occur, how they may impact older people, and how they may be minimised.
(4) A better understanding of the views of service providers, as well as older people and their families, remains the key to future development of high quality services.

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Table 1. Questions in relation to two dignity domains

Domain 1: care and support needs	Domain 2: effective communication
Are older people / older women from BME backgrounds offered opportunities to express their needs?	Are older people / older women from BME backgrounds provided information relevant to their ethnic and cultural background?
Are older people / older women from BME backgrounds offered support to express their needs?	Are older women from BME backgrounds given a choice of language they wish to use?
Are older people / older women from BME backgrounds involved in decision-making of their own care?	Would older people / older women from BME backgrounds agree with the following statement? 1. I have been asked how I would like to be addressed. 2. I can discuss my care with people who support me. 3. People who provide care or support to me listen carefully what I have to say. 4. People who provide care or support to me take time to listen to what I have to say. 5. People who provide care or support to me make sure I understand them. 6. I am comfortable to raise concerns about.
Are physical, cultural, religious, psychological, or social needs of older people / older women from BME backgrounds met?	

Table 2. Self-reported demographic information

	n	%*
Gender		
Male	13	10.7
Female	108	89.3
Age (years)		
Under 25	1	0.8
25 - 35	17	14.0
35 - 45	26	21.5
46 - 55	48	39.7
56 - 65	27	22.3
Over 65	2	1.7
Educational level		
Certificate	13	11.0
Diploma	34	28.8
Bachelor's degree	27	22.9
Graduate diploma	14	11.9
Master's degree and above	25	21.2
None of the above	5	4.2
Ethnic background		
White Welsh	58	49.2
White British	35	29.7
Chinese	9	7.6
Black or Black British - African	4	3.4
Other white background	2	1.7
Asian or Asian British - Indian	2	1.7
Asian or Asian British - Pakistani	2	1.7
Any other Asian background	2	1.7
White Irish	1	0.8
Black or Black British - Caribbean	1	0.8
Asian or Asian British - Bangladeshi	1	0.8
Any other mixed background	1	0.8
Organisations		
Third sector	54	43.9
Public sector	48	39.0
Private sector	21	17.1
Professional role		
Providing support	60	48.4
Managing services	44	35.5
Supervising others	29	23.4
Delivering hands on care	22	17.7
Other	12	9.7

* Some information was not provided by all respondents.

Table 3. Perceptions of expressing needs and care involvement

Item	Group	Always	Frequently	Seldom	Never	Professional role (Chi-square test)	Respondents' ethnic backgrounds (Mann-Whitney test)	Perceptions in relation to older people and older women from BME backgrounds (Wilcoxon test)
		n (%)						
Being offered opportunities to express their needs	Older people	58 (46.8)	51 (41.1)	15 (12.1)	-	df=2 All $p>0.05$	U=848.0 1 vs 2 $p=0.11$	z=-3.15 $p=0.002$*
	Older women from BME backgrounds	44 (41.4)	41 (37.6)	24 (22.0)	-	df=2 All $p>0.05$	U=778.5 1.5 vs 2 $p=0.42$	
Being supported to express their needs	Older people	56 (50.0)	49 (43.8)	7 (6.3)	-	df=2 All $p>0.05$	U=698.5 1 vs 1.5 $p=0.83$	z=-2.67 $p=0.008$*
	Older women from BME backgrounds	41 (45.1)	43 (47.3)	7 (7.7)	-	df=2 Respondents with a supporting role: $\chi^2=6.39$, $p=0.04$* All other groups: $p>0.05$	U=523.5 2 vs 2 $p=0.84$	
Being involved in their own care	Older people	43 (35.5)	56 (46.3)	20 (16.5)	2 (1.7)	$\chi^2=4$ All $p>0.05$	U=744.5 2 vs 2 $p=0.02$*	z=-2.84 $p=0.005$*
	Older women from BME backgrounds	34 (31.5)	44 (40.7)	27 (25.0)	3 (2.8)	$\chi^2=4$ All $p>0.05$	U=703.5 2 vs 2 $p=0.15$	

* $p \leq 0.05$

Table 4. Perceptions of key needs being addressed

Item	Group	Always	Frequently	Seldom	Never	Professional role (Chi-square test)	Respondents' ethnic backgrounds (Mann-Whitney test)	Perceptions in relation to older people and older women from BME backgrounds (Wilcoxon test)
		n (%)						
Physical needs	Older people	69 (59.0)	39 (33.3)	8 (6.8)	1 (0.9)	df=3 All $p>0.05$	U=756.5 1 vs 1 $p=0.04$*	z=-3.05 $p=0.002$*
	Older women from BME backgrounds	53 (54.6)	35 (36.1)	8 (8.2)	1 (1.0)	df=3 Respondents with a role of providing hands-on care: $\chi^2=8.56$, $p=0.04$* All other groups: $p>0.05$	U=576.5 1 vs 1 $p=0.08$	
Social needs	Older people	52 (45.2)	46 (40.0)	14 (12.2)	3 (2.6)	df=3 All $p>0.05$	U=895.0 1.5 vs 1 $p=0.50$	z=-2.36 $p=0.02$*
	Older women from BME backgrounds	41 (42.7)	33 (34.4)	18 (18.8)	4 (4.2)	df=3 All $p>0.05$	U=676.0 2 vs 1 $p=0.53$	
Psychological needs	Older people	43 (37.7)	47 (41.2)	20 (17.5)	4 (3.5)	df=3 all $p>0.05$	U=642.5 2 vs 2 $p=0.009$*	z=-2.32 $p=0.02$*
	Older women from BME backgrounds	31 (33.0)	39 (41.5)	20 (21.3)	4 (4.3)	df=3 Respondents with a managerial role: $\chi^2=11.25$, $p=0.01$*	U=458.0 2 vs 2 $p=0.008$*	
Religious needs	Older people	36 (32.4)	45 (40.5)	26 (23.4)	4 (3.6)	df=3 All $p>0.05$	U=680.5 2 vs 2 $p=0.06$	z=-1.72 $p=0.09$*

	Older women from BME backgrounds	33 (35.9)	28 (30.4)	24 (26.1)	7 (7.6)	df=3 Respondents with a role of providing hands-on care: χ^2=7.81, *p*=0.05* Other groups: *p*>0.05	U=556.5 2 vs 2 *p*=0.22	
Cultural needs	Older people	39 (34.2)	46 (40.4)	25 (21.9)	4 (3.5)	df=3 All *p*>0.05	U=870.5 2 vs 2 *p*=0.61	z=-3.71 *p*<0.001*
	Older women from BME backgrounds	31 (33.7)	27 (29.3)	26 (28.3)	8 (8.7)	df=3 All *p*>0.05	U=571.5 2 vs 2 *p*=0.29	

* $p \leq 0.05$

Table 5. Perceived agreement on effective communication statements

Statement	Group	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Professional role (Chi-square test)	Respondents' ethnic backgrounds (Mann-Whitney test)	Perceptions in relation to older people and older women from BME backgrounds (Wilcoxon test)
		n (%)							
1. I have been asked how I would like to be addressed.	Older people	49 (40.8)	42 (35.0)	21 (17.5)	6 (5.0)	2 (1.7)	df=4 All $p>0.05$	U=906.5 1 vs 2 $p=0.34$	z=-1.30 $p=0.19$
	Older women from BME backgrounds	41 (37.6)	41 (37.6)	17 (15.6)	8 (7.3)	2 (1.8)	df=4 Respondents with a supervisory role: $\chi^2=9.78$, $p=0.04$* All other groups: $p>0.05$	U=797.5 1 vs 2 $p=0.30$	
2. I can discuss my care with people who support me.	Older people	56 (46.3)	47 (38.8)	14 (11.6)	4 (3.3)	-	df=4 All $p>0.05$	U=880.5 1 vs 1 $p=0.21$	z=-2.31 $p=0.02$*
	Older women from BME backgrounds	43 (39.1)	45 (40.9)	17 (15.5)	4 (3.6)	1 (0.9)	df=4 All $p>0.05$	U=780.0 2 vs 2 $p=0.20$	
3. People who provide care or support to me listen carefully to what I have to say.	Older people	49 (40.5)	47 (38.8)	21 (17.4)	3 (2.5)	1 (0.8)	df=4 All $p>0.05$	U=962.5 2 vs 1.5 $p=0.54$	z=-2.18 $p=0.03$*
	Older women from BME backgrounds	42 (38.5)	36 (33.0)	24 (22.0)	4 (3.7)	3 (2.8)	df=4 All $p>0.05$	U=920.5 2 vs 1.5 $p=0.10$	
4. People who	Older people	48 (40.0)	48	20 (16.7)	2 (1.7)	2 (1.7)	df=4	U=870.5	z=-2.05

provide care or support to me take time to listen to what I have to say.			(40.0)				All $p>0.05$	2 vs 2 $p=0.22$	$p=0.04$*
	Older women from BME backgrounds	37 (33.9)	44 (40.4)	22 (20.2)	3 (2.8)	3 (2.8)	df=4 All $p>0.05$	U=845.5 2 vs 2 $p=0.52$	
5. People who provide care or support to me make sure I understand them.	Older people	47 (39.5)	45 (37.8)	18 (15.1)	8 (6.7)	1 (0.8)	df=4 All $p>0.05$	U=934.5 2 vs 1 $p=0.55$	z=-2.19 $p=0.03$*
	Older women from BME backgrounds	36 (33.6)	39 (36.4)	22 (20.6)	8 (7.5)	2 (1.9)	df=4 All $p>0.05$	U=870.0 2 vs 2 $p=0.79$	
6. I am comfortable to raise concerns about my care.	Older people	43 (35.8)	40 (33.3)	26 (21.7)	7 (5.8)	4 (3.3)	df=4 All $p>0.05$	U=985.0 2 vs 1.5 $p=0.72$	z=0.000 $p=1.00$
	Older women from BME backgrounds	34 (31.8)	40 (37.4)	23 (21.5)	6 (5.6)	4 (3.7)	df=4 All $p>0.05$	U=870.5 2 vs 2 $p=0.73$	

* $p \leq 0.05$