Final report October 2013

Meeting the Challenges of Diversity:

a report for Health Education South London

iCoCo Foundation

Ted Cantle

John Tatam

Nadeem Baksh

Alan Carling

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The iCoCo foundation is dedicated to the promotion of interculturalism and community cohesion.
It challenges old style multiculturalism and promotes new and progressive policy and practice in an era of multi-diverse and globalised societies. (see www.icocofoundation.com)

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Foreword

I am delighted to present the first iCoCo report on “Meeting the challenges of diversity in South London.” During our first year, we have been determined to advance and embed equality and diversity principles across Health Education South London’s (HESL) core functions.

The National Health Service has a proud and strong history of promoting equality and diversity. Indeed, it is enshrined within the NHS constitution that service users are entitled to expect services which are of high quality, person centred and accessible. There have been significant changes in equality legislation over the past few years, which will impact on all service delivery in the future. Both the Equality Act 2010 and the Health and Social Care Act 2012 aim to tackle inequality and drive improvements in service delivery.

We want our services to be an example of good practice. We can only achieve this if we involve service users in the design and delivery of services, and develop a workforce which reflects the communities we serve. As we continue to operate and deliver services in an increasingly multicultural and diverse environment, we need to ensure that our processes, procedures and practices promote an environment which values diversity.

Tackling inequality can only be done by truly understanding the communities we serve, and providing appropriate care to all communities. This also means valuing one of the key tools at our disposal – a caring, skilled and diverse workforce.

The progress and achievements made to date are thanks to the efforts and commitments of our staff. My gratitude and recognition goes to all staff and stakeholders for embracing and promoting this agenda, and for continuing to make it a key to all that we do.

HESL will continue to engage with service users to deepen its understanding the local communities we serve. We look forward to meeting the challenge that all individuals who use our services have a positive experience.

Richard Sumray

Chair

Health Education

South London

Introduction

London is probably the most diverse city in the world. As long ago as 2005 a survey of London's ethnic and religious diversity claimed that there were more than 300 languages spoken and 50 non-indigenous communities with a population of more than 10,000 in London[1]. Since then diversity has continued to increase: the 2011 Census showed that 55% of London's residents were non-White British. London is truly a 'super diverse' city.

Serving a diverse and rapidly changing population presents challenges for health services and health service staff.

- The incidence of some health conditions and the expectations of health services vary with ethnic and religious identities. Changes in the ethnic profile of the client population therefore not only affects clinical need, but poses challenges to engaging different communities to improve their health outcomes.

- The effectiveness – or even the appropriateness – of clinical care and treatment can be affected by cultural differences, through processes of communication (including language differences) and/or cultural norms or understandings concerning treatment, sickness or health. Optimum service provision will be sensitive to cultural difference, and ready to respond constructively to it.

- Health care providers may wish to broadly reflect the ethnic composition of their client populations in their employment, recruitment, training and education policies, not only as part of a commitment to equal opportunities and inclusive practice but also to enrich their pool of resources and experience.

In line with its commitment to develop a health workforce with the skills, knowledge and confidence to deliver high quality service to South London's diverse population HESL commissioned the iCoCo Foundation to:

a) To map the extent, range and rate of change in the diversity of South London at a finer grain than is possible from the Census alone
b) Explore how far health providers understood the changing diversity of their patient population and were responding to it
c) Establish the ethnic composition of the South London health providers and the health trainees in the various health education providers.

[1] Benedictus, Leo (2005-01-25). "Every race, colour, nation and religion on earth". *The Guardian*. Retrieved 2009-08-22

Methodology

Our approach was a combination of quantitative and qualitative analysis:

a) Analysis of the Census data for 2001 and 2011 and the School Census data for 2007 and 2013
b) Analysis of the NHS data on employees in South London Trusts and CCGs (excluding GPs)
c) Analysis of the data on health trainees in the six universities working with HESL
d) Analysis and commentary on the complex variations within the broader ethnic and religious categories
e) Interviews with twelve representatives of South London acute and community trusts and CCGs.

Diversity in South London: The picture from the Census 2001 -2011*

Population Change

The main features of population change between 2001 and 2011 are:

- An increase in South London's overall population by 11%, to just over 3m. (At a greater rate than the increase for England (8%), but less than for London as a whole (14%)

- An increase in diversity, with greater representation of a large variety of minority BME groups, both in absolute numbers and in proportional terms. The Black or Black British population share increased from 12% to 15%; the Asian or Asian British share from 7% to 11%, and the population of Mixed heritage from 3% to 5%

- A decrease in the White British share of the population from 69% in 2001 to 55% in 2011 (compared with a decrease from 87% to 80% for England, and from 60% to 45% for London as a whole). There was also a decline in the absolute numbers of White British (WB) residents of South London, by very nearly 200,000 individuals, or 10% of the 2001 WB population.

* The following analysis has been compiled by comparison of the Census data for 2001 and 2011 for the twelve boroughs of South London, and from a variety of other sources. The boroughs are: Bexley, Bromley, Croydon, Greenwich, Kingston, Lambeth, Lewisham, Merton, Richmond, Southwark, Sutton and Wandsworth.

These main features of change were evident in each of the twelve Boroughs, but there were at the same time very large variations in the ethnic composition of the different Boroughs, and in the incidence of demographic change. South London may be an area of contiguous settlement within a single conurbation, but the patterns of ethnic composition and change are by no means uniform, which leads to considerable differences *within* the district covered by HESL.

The overall rate of population growth varied, for example, from 5% in Bromley to 19% in Greenwich. The Black or Black British population share was 2% in Richmond in 2011, and 27% in both Lewisham and Southwark. The Asian or Asian British population share was 5% in Bromley and 18% in Merton, whilst the White British population share was 77% in both Bexley and Bromley, and 39% in Lambeth. Rates of change also varied widely. As noted above, every Borough experienced a net loss of WB residents, but Richmond lost just 2% of its WB population, whereas Merton lost 20% over the course of a single decade. It is convenient to look at this experience of ethnic change in terms of the figures in Table 1, which list the Boroughs in order of their WB population share in 2001.

Table 1: White British and Minority Population Change: South London Boroughs 2001-11

	White British Population Share %		**Increase in minority pop. share %**
Borough	**2001**	**2011**	**2001-11**
Bexley	88	77	88
Bromley	86	77	67
Sutton	84	71	78
Richmond	79	71	34
Kingston	76	63	54
Greenwich	71	52	62
Wandsworth	65	53	32
Merton	64	48	44
Croydon	64	47	45
Lewisham	57	41	36
Southwark	52	40	26
Lambeth	50	39	21
S London	**69**	**55**	**42**

Bexley, Bromley and Sutton began the decade with a WB share of between 88% and 84% which had declined to 77% to 71% a decade later. The non-white share doubled in each case, from around 10% to 20% or so, and the increase was similar in relation to each of the main minority groupings – Asian or Asian British, Black or Black British, and Mixed heritage.

The recorded minority religious population of each Borough – including Buddhist, Hindu, Jewish, Muslim, Sikh and Other (non-Christian) religious identities – increased from about 10,000 to about 17,000, representing about 5% of the population in each case.[2] The representations of all these constituent denominations also increased, except for the Jewish population, which experienced a slight fall (in common with South London as a whole).

Overall, these three Boroughs show similar patterns of increasing diversity from a starting point of populations that were predominantly White British in 2001, with moderate rates of growth in total population (of around 5%, compared with the South London figure of 11%). General social conditions were also similar for the three Boroughs, with rankings on the Index of Deprivation for 2010 somewhat above the median value for English Local Authorities.[3]

Richmond is, by contrast, the least deprived of the South London Boroughs – nearly nine out of ten Local Authorities in England have populations that are more deprived on average than the population of Richmond. Richmond is also the least affected by ethnic demographic change in the 2000s, even though its population grew by 9%. Indeed, it ended up in 2011 as the only Borough in South London which was (fractionally) less diverse than England as a whole – the common experience in South London is by comparison to be more multi-ethnic than the national average. The White British population of Richmond fell by just 2%, which is the lowest proportional fall in South London, and the non-white population share grew from 9% to 14%. The minority religious population increased by the smallest number of all the Boroughs – just over 3,500 in the course of the decade. The 'Other White' population (which includes all those self-classified as 'White' but not 'White British') was high in 2001 – 9% of the total – but this also changed relatively little over the decade compared to every other Borough, adding just over a third in numbers, to reach a 12% share by 2011. Wherever the Census statistics are inspected, Richmond stands out in South London as the area that is least subject to population movements that changed its ethnic profile in the 2000s.

Three Boroughs that stand out by contrast for the rapidity of demographic change are Merton, Croydon and Lewisham. The White British population share fell from majority figures of 64%, 64% and 57% respectively in 2001 to minority figures of 48%, 47% and 41% ten years later. The similarity of these changes meant that the aggregate contribution of non-WB ethnic populations was also similar in each of the three Boroughs, but this aggregate increase was composed rather differently in the three cases: the greatest net contribution in Merton was from Asian and Other White groups; in Croydon from Black and Asian groups and in Lewisham more equally from all three groups. Croydon had the greatest increase in South London of its minority religious population, of just under 18,000.

[2] The question on religion is a voluntary one in the Census, and was not answered by 8% of respondents in South London.

[3] The Index of Deprivation is calculated for local authorities by averaging the figures that apply for each resident of the authority. It thus represents the level of deprivation experienced on average by residents in a given local authority.

This similarity in the main changes to the ethnic compositions of the three Boroughs came about despite the fact that their general social conditions are quite different: Merton is ranked close to the most affluent third of English local authorities; Croydon is at the boundary of the lowest third, and Lewisham is in the lowest ten per cent. These findings underline the fact that demographic change is differentiated in quite complex ways even within the confines of South London.

To drive this point further home, Southwark and Lambeth are amongst the poorest of the Boroughs, and had the lowest White British population share in both 2001 (52% and 50% respectively) and 2011 (40% and 39%), but they did not experience the same rate of demographic change as the three Boroughs considered in the previous paragraph. The WB population loss was 10% in each case – the same as for South London as a whole. Southwark and Lambeth experienced the lowest proportional increases in the Black or Black British population during the decade, which took the Black population share to 27% and 26% respectively in 2011. There were greater proportional increases in the Other White populations, to 12% and 16% respectively. Diversity thus increased in Southwark and Lambeth mainly through the diversification of the non-Black populations.

This leaves three Boroughs to consider: Kingston, Greenwich and Wandsworth. These are characterised by their intermediate ethnic mix, in terms of the WB shares of the population in 2001, which stood at 76%, 71% and 65% respectively. These proportions are close to the 2001 figure for South London as a whole (69%). By 2011, this share had fallen in each case – to 63%, 52% and 51% – which is roughly in line with the overall change in South London, which was reduced to 55%.

Closer inspection shows however that this common pattern came about for different reasons in the three Boroughs, and with different net effects. The total populations of Greenwich and Wandsworth grew faster than any other South London Borough, at 19% and 18% respectively (apart from Southwark, which also increased by 18%). But Greenwich lost 12% of its WB population at the same time, whereas Wandsworth lost just 3%. Kingston, by contrast, grew much less rapidly overall (by 9%) but lost a similar proportion of its WB population to Greenwich (10% as against 12%). The net effect of these distinct sources of change is that Kingston and Wandsworth experienced a similar drop in the WB population share, but for different reasons: in Kingston the reduction arose mainly because the WB population itself fell; in Wandsworth because the new populations coming into the Borough were from backgrounds other than WB, which reduced the WB proportion in comparison.

Greenwich experienced both tendencies simultaneously, which is why its ethnic composition changed more rapidly from this point of view than any other Borough in South London (the WB share dropped by 19 points, from more than two-thirds to just over one half in a ten-year period). And once again, this broadly similar ethnic change occurred despite the fact that the three Boroughs are very different in socio-economic character: Kingston is the second most affluent Borough in South London (after Richmond), whereas Greenwich is the most deprived, and Wandsworth is close to the middle of the South London distribution. Between them, these three Boroughs span almost the whole range of social conditions that can be found among local authority areas in England.[4]

[4] Kingston, Wandsworth and Greenwich are at the 78th, 37th and 9th percentiles respectively of the English national distribution.

It can be seen in summary that despite some important constants in the process of change, the experiences of different Boroughs in South London in the period between the Census dates were often very different. Although the ethnic composition of every Borough became more diverse, there was a surprisingly large range of different types of population movement that had very different consequences for the rates and directions of ethnic change. One Borough changed relatively little (Richmond); others changed a great deal (Greenwich, Merton, Croydon and Lewisham). Some changed because of the loss of existing (White British) majority populations (Merton, Kingston); others because of population growth favouring minority ethnic groups (Wandsworth), and some from both factors (Greenwich). And the changes in different Boroughs tend to be differentiated by the identities of the 'new' minority populations. Sometimes the largest contribution comes from just one of the three main minority identities (Other Whites in Southwark and Lambeth, for example), sometimes from two of the three identities in roughly equal combination (Other White and Asian groups in Merton, or Asian and Black groups in Croydon, Bexley and Bromley), and sometimes from all three main identities together (Lewisham).

It is also surprising that there appears to be very little general or systematic relationship between the socio-economic standing of Boroughs – at least as measured by the Index of Deprivation – and the changes in their ethnic demography. Among the most affluent Boroughs, Richmond changed rather little, and Merton a great deal in the 2000s; among the most deprived, Greenwich also changed a good deal (as much as Merton), but Southwark and Lambeth, rather less. Wandsworth and Croydon are similar in their socio-economic standings, yet in Croydon the non WB population changed from 30% to 45% between 2001 and 2011 while in Wandsworth the change was from 22% to 29%. It would be possible to multiply examples of this lack of easy fit between ethnic change and wider social and economic factors.

It does not seem that geography offers an explanation for variations either, since the variations do not correspond at all closely to the relative locations of the twelve Boroughs within South London (see Figure 1 overleaf). It is true that Lambeth and Southwark are inner city neighbours on the south bank of the Thames, and share similar profiles of ethnic composition and change. And the same point can be made about the more affluent Boroughs of Bexley, Bromley and Sutton, which belong to an outer suburban ring. But there is little geographical similarity beyond these cases. Merton experienced greater change than any of its closest neighbours in the west of the district, for example, whilst Lewisham changed more than its neighbours in the east, and Croydon more than its neighbours in the south. Wandsworth changed in different ways to Lambeth next door. Again, examples might be multiplied.

Figure 1: South London Boroughs

If there is a lesson to be learnt from these patterns of variation, it is that ethnic change can occur even in large populations – numbered in the hundreds of thousands – in quite dramatic ways over a relatively short period of time, but that it is very difficult to predict where – or indeed if – the changes are likely to occur, and – if and when they do occur – which directions they are liable to take. It follows that health providers, and other suppliers of services to local populations, would do well to remain on continuous alert to the ethnic changes that are taking place among their principal client groups.

In order to respond appropriately, service providers will need to know more about these changes than is given by the broad ethnic categories considered in this section, because the bare knowledge that a potential client falls within an aggregate classification such as ‘Asian’, ‘Black’ or ‘Other White’, say, may not carry the agency very far in its attempts to address ethnic diversity in its service delivery. In the next section, Census data for 2011 will be used to illustrate the range of language communities resident in South London. This will bring the analysis closer to the practical situation faced by agencies in their day-to-day operations.

Language and National Identity in South London

The 2011 Census distinguishes 91 different languages or language groups at a detailed level, in addition to English. The 'superdiversity' of languages spoken in South London can be highlighted from the Census data in several different ways:

- Every single one of these language groups is represented somewhere among the residents of South London, down to the two residents whose main language is Manx Gaelic, and the three whose first language is Yiddish

- About 15% of South London residents have a main language other than English, which is almost twice the proportion for England as a whole (8%)

- There are only a handful of languages for which South London has less than the national proportion*

- There are on the other hand, a number of languages whose main speakers are represented very strongly among residents: South London contains almost half of the Krio speakers in England, over a third of the Yoruba and Korean speakers, around a quarter of the Vietnamese, Tamil and Spanish speakers, with many more examples of proportions above the national average.

In terms of absolute numbers, the Polish speakers form the largest non-English language group in South London (with over 40,000 residents), followed by the French, Spanish, Portuguese, and Tamil-speaking groups (with over 20,000 residents each). The linguistic range is illustrated further by the list of languages with more than 10,000 residents each: Urdu, Italian, Chinese, Gujurati, Arabic, Turkish, German and Somali. These figures make the point that multilingualism and multiculturalism in South London is often a matter of European diversity, as much as – or as well as – the more familiar forms of Caribbean, African or Asian diversity. At the same time, there is a substantial representation from African language groups, and from the languages of all the major regions within Asia, especially South Asia and East Asia.

These figures raise a dual issue for service providers, and a corresponding dilemma for service management. On the one hand, patients may present to surgeries or clinics with a wide variety of individual language needs – and it is after all the individual patient who is ultimately important. Should health authorities therefore make provision for interpreters in ninety and more different languages in South London? On the other hand, it is clear that these services are liable to be called upon much more frequently in the case of some minorities than of others. Should provision concentrate therefore on the main minority language groups, at the implicit expense of the rest?

And the demands for provision are likely to vary across the Boroughs. Following on from the analysis of the previous section, some of the language communities are to be found in some parts of South London more than others, and this is surely responsible in part for the patterns of ethnic diversity noted above. Nearly three quarters of South London's Nepalese

* These include three specific S Asian languages - Panjabi, Bengali and Pahari - and Latvian alone amongst the continental European languages.

speakers, for example, live in Greenwich, and a half of the Koreans in Kingston. Lambeth has Portuguese and Spanish; Lewisham has French and Turkish, and Richmond has speakers of German and Persian. Wandsworth has Urdu and Polish speakers, whilst Croydon has Gujurati and Tamil speakers.

The social and practical implications of such super-diversity need to be addressed with some care nevertheless. The Census figures report the numbers of residents whose *main* language is as stated. This does not necessarily mean that the residents whose main language is not English are not also fluent in English, so that the diversity of language communities does not in itself indicate the incidence of communication barriers, or the existence of issues that need to be addressed in service provision conducted in the English language. Indeed, a large majority – over 80% – of the residents in the London region whose main language is not English can speak English either 'well' or 'very well' according to Census data.[5] There is however a considerable variation in English proficiency among language communities.

Of the groups represented most frequently in South London, the Turkish, (Other) Chinese, Polish and Somali groups are the least proficient, with 35%, 25%, 24% and 24% respectively not able to speak English or not able to speak it well. On the other hand, the speakers of German, French and Italian are the most proficient among the major non-English language communities, with just 2%, 6% and 8% experiencing difficulty in English communication.

In case the impression is left from these findings that proficiency in English is a matter of (some) European language groups versus the rest, it is worth noting that very high proficiency in English (with 3% or less experiencing difficulty), is also recorded for the smaller Shona, Igbo and Yoruba communities with African origins, the Tagalog/Filipino community from East Asia and the Telugu speakers from South Asia. There is evidently no substitute for detailed knowledge of particular groups when it comes to predicting service needs from ethnic, or even linguistic, backgrounds. And in many cases, diversity presents no distinctive problems for communication on matters of health.

The concern with language differences in the national debate about diversity relates to questions of social integration and community cohesion. A similar concern has motivated investigations of national identity, which received especial emphasis in the 2011 Census. The issue here is the extent to which groups with different ethnic backgrounds – including relatively new immigrant groups – identify with the country, and with corresponding notions of 'Britishness'. The inquiry was designed to enable respondents to make multiple responses, to reflect mixed or 'hyphenated' identities, such as 'Asian British'. The findings for South London are set out in Table 2 overleaf, whose first line reflects a response which includes any UK identity (English, Scottish, Welsh, Northern Irish, or British) possibly in conjunction with another national or ethnic identity.

It will be seen that large majorities of the Mixed, Asian and Black groups identify with the UK as a part at least of their self-perception, and there are also substantial proportions – of a quarter to a third – who feel similarly among the Irish and Other White groups. Although this evidence does not have any immediate implications for service delivery, it helps to reinforce the point made in relation to language, that diversity does not in itself imply difference. There

[5] Note that data on language proficiency is only available at the Regional level, for London as a whole, and not specifically for South London.

is always a delicate balance to be struck – in terms of both policy and practice – between an awareness of inter-group variation and sensitivity to the complexities of individual situations. The aim throughout is to generalise constructively without falling into stereotypical thinking.

Table 2: National Identity by Ethnic Group: South London 2011

(Percentage of Group)

Ethnic Group	All	White: UK	White: Irish	Other White	Mixed	Asian/AB	Black/BB	Other
UK identities	82%	99%	34%	24%	84%	66%	76%	61%
Irish identity only	1%	0%	63%	0%	0%	0%	0%	0%
Other identity only	17%	1%	3%	75%	15%	34%	23%	39%
	100%	100%	100%	100%	100%	100%	100%	100%
All categories	3,070,462	1,700,676	58,387	306,241	1586,29	325,770	460,740	600,19

Diversity in South London's Schools

The extent of diversity in South London and the rapid rate of change is illustrated even more clearly by the School Census. Each local authority completes an annual census of school pupils including ethnicity and first language. As this is a count of local pupils and there is movement of pupils across borough boundaries, there is not a complete correspondence between the School Census and the borough population. Nevertheless this provides both a rich and a regular source of data on diversity.

Table 3: Percentage White British from 2011 Census and 2013 School Census

	White British Population Share %		
		2013 School Census	
Borough	2011 Census	Primary	Secondary
Bexley	77	65	65
Sutton	71	60	58
Richmond	71	62	64
Kingston	63	49	51
Greenwich	52	34	40
Merton	48	35	36
Croydon	47	31	32
Lewisham	41	24	23
Southwark	40	21	21

Notes: Wandsworth: All 'White' – 2011Census 71% ; 2013 School Census 39%

Lewisham figures do not include Academies in 2013

Southwark classification differed from others

Table 3 compares the percentage of the population defined as White British in the 2011 Census with the percentage of White British pupils in the nine boroughs from which School Census data was obtained. In every case the percentage of White British pupils is considerably lower than that for the population as a whole from the Census: no borough has more than two thirds White British pupils; Kingston has one half; Merton and Croydon around one third; and Lewisham and Southwark less than one quarter. As these children

grow up and move into the adult population then the overall population is likely to reflect that increased diversity.

Table 4 shows the speed of change in diversity in South London's schools over the last six years. The table compares the percentage of White British pupils, the percentage for whom English is their first language and the number of different first languages spoken by pupils in both 2007 and 2013. In virtually every case there is a substantial decrease in White British pupils and those for whom English is a first language and an increase in the numbers of first languages spoken. Some of these changes might fairly be described as dramatic. In Greenwich the percentage of White British Primary pupils has gone down from 47% to 34% and the number of first languages spoken from 86 to 163; in Richmond, one of the boroughs with a proportionately large White British population, the number of different first languages spoken by its pupils has gone up from 78 to 125 in Primary schools and 42 to 101 in Secondary schools. Only Sutton, with 93, has less than 100 different first languages represented in its Primary schools and four have 150 or more.

This extraordinary range of languages underlines the truly super diverse nature of South London's population and the rate of change shown by these School Census figures generally confirms that growing diversity will indeed be a challenge for the foreseeable future.

Table 4: Percentage White British and First Language in 2007 and 2013

	2007		2013	
	Primary	**Secondary**	**Primary**	**Secondary**
Bexley				
White British %	76	78	65	65
English First Language %	91	87	84	86
First languages (No.)	104	94	123	122
Sutton				
White British %	73	71	60	58
English First Language %	86	78	77	82
First languages (No.)	87	64	93	92
Richmond				
White British %	67	68	62	64
English First Language %	84	84	79	81
First languages (No.)	78	42	125	101
Kingston				
White British %	57	58	49	51
English First Language %	72	76	65	71
First languages (No.)	88	70	113	107
Greenwich				
White British %	47	49	34	40
English First Language %	67	72	58	63
First languages (No.)	86	102	163	140
Merton				
White British %	46	47	35	36
English First Language %	69	74	56	67
First languages (No.)	91	62	111	91
Croydon				
White British %	42	46	31	32
English First Language %	75	80	67	75
First languages (No.)	118	94	150	109
Lewisham				
White British %	29	31	24	23
English First Language %	66	72	66	71
First languages (No.)	156	77	157	113
Southwark				
White British %	24	23	21	21
English First Language %	57	56	54	61
First languages (No.)	163	84	197	119

Mapping Community Diversity

The 2011 census included a variety of useful new categories, including first languages spoken but even these do not cover the range of diverse economic, faith, belief, cultural and life-stance differences influencing people's access to and perceptions of health care services. This section explores some of these other dimensions drawing an outline framework for Understanding and Appreciating Diversity (UAD).

Understanding and Appreciating Diversity (UAD)

UAD Analysis is an innovative research framework – proven to be effective in capturing details and information across a range of dimensions evident within super-diverse populations. UAD combines statistical and qualitative 'Understanding' of multiple-diversities with 'Appreciative Inquiry' – a business growth concept which affects rapid improvements through focusing on the most favourable features of an organisation's culture and also facilitates sharing of best-practice and knowledge-based experiences across the organisation.

Employment & Economic Status

South London's residents include owners of large, medium and small businesses, professionals in high paid jobs, as well as people working in low paid and insecure occupations, people with three or four jobs, self-employed and unemployed people. There are, however, some areas of employment which are more attractive to people from particular ethnic backgrounds and heritages (as we have seen in terms of health). To understand some of the reasons for this it is important to recognise that definitions of social class and status may not apply to all communities in the same way.

Some cultures – in varying degrees – adhere to clan, tribal and ancestral heritage identities. These can influence career choices as well as in some cases exert high levels of social control.

Health and Social Care Provision and Ethnicity

We know that certain ailments affect certain communities disproportionately. South Asians have a high incidence of diabetes and heart disease, for example. Some mental health issues are more common amongst new arrival, refugee and asylum seeker communities as a result of the lengthy refugee asylum decision process and/or PTSD due to pre-migration experiences. This may well have affected new arrivals of Tamil heritage settled in Mitcham and Merton. A recent report from Prostate Cancer UK suggests that prostate cancer is twice as common in black men.

There are also sensitivities and controversy over the impact of certain traditions: first cousin marriages resulting in higher rates of birth defects; female circumcision, sometimes referred to as female genital cutting (FGC) but better known as Female Genital Mutilation (FGM) – which is illegal in the UK. These practices are considered to mainly affect Somali heritage communities however less is known about other communities where the practice may be prevalent.

Care provision for the elderly needs to recognise diverse traditions where care at home by the extended family may be preferred. However, it is equally important to appreciate that some of these traditions are also being eroded.

It is fairly common knowledge that Jehovah's witnesses will not accept blood transfusions and that the Catholic Church considers abortion a sin. However, there are some less known facts e.g. many Muslims and Jews will accept organ transplants but most will not agree to organ donation.

Furthermore, in such a diverse population dietary restrictions can add to complexities – it is generally known Muslims will only eat Halal (permissible) meat however most will also accept Kosher meat although Jews who adhere to religious dietary restrictions will not accept Halal meat. In addition, there are some interesting theological developments specific to certain minority Muslim groups i.e. followers of the Nation of Islam (NOI) will not consume any processed foods – this it is suggested is a modern extension of the rules defining what is and isn't Halal. In contrast, some Muslim scholars argue for relaxing the rules related to what is and is not Halal.

Locality

In terms of community engagement it is important to recognise that the relative level of reach and influence of cultural and religious based representative structures are usually dependent on the size and residential concentration of the respective community group. For some communities, residential concentration can have positive effects but in other cases, such as the stigma around mental health, it can be detrimental to accessing health care. There are notable variations in the nature of communities living in specific areas of the 12 boroughs with some clear indications of population concentrations e.g. a variety of African and African Caribbean heritages residing in Lambeth and Southwark as well as Tamil heritages living in Mitcham, Merton and antipodeans traditionally drawn to living in Wimbledon.

Age Groups

Irrespective of ethno national or cultural background, older and younger people have different networks. Within certain communities older people more often tend to use community organisations and religious centres for networking. Younger people are more likely to access networks through their peers in schools, colleges, work, social activities and online media.

Migration history and nature of immigration

Some BME communities have been settled in South London for over six decades, but there are also many recently settled. The length of time settled here impacts on confidence and familiarity with systems and accessing services. As typical across London, there are also significant numbers of transient residents, both from overseas and other parts of the UK.

Community and Faith organisations

Community, faith and voluntary organisations reflect – to some extent – the diversity of resident populations. These vary in terms of services, structure and sophistication. For BME communities these centres may also reflect migration histories and settlement patterns.

The types of organisations, support networks and facilities available in each area also vary and can provide an indication of the range of communities resident in particular areas as well as helping to provide information about their needs.

South London has a wide range of community and voluntary based organisations. Detailed information is accessible from the individual borough councils' websites which list a vast number of groups and organisations (see Appendix 2). However, the effectiveness of engagement across communities whether it be for raising awareness, health improvement campaigns, or research, is dependent on detailed understanding and appreciation of diversity. Some organisations have varied and limited capacity to engage as well as questionable levels of influence and reach into the communities.

It is important that information about community organisations is up to date and to recognise the limitations of engaging people through such channels. For example, although organisations are open to all, the user profile often depends on the group who established and manage the centre.

In addition structural arrangements are varied with different roles for religious and community leaders. For example, within certain places of worship the religious leader may hold less influence than the management committee.

Faith and Belief Diversity

As in other places, South London's main faith and belief communities are – in varying degrees – represented along patterns of corresponding diverse cultural, ethno national, and religious dimensions. This diversity is illustrated by the variety of faith places of worship located in the Boroughs which represent a wide range of theological, cultural and other diversities. It is important to note, for example that rules and traditions can be quite varied. For some Muslims of Sunni Deobhandi, Salafi and devout Shia Ithna Ashari backgrounds as well as some orthodox Jews shaking hands with the opposite gender is strictly forbidden, for instance.

Christian Communities

Christians are the largest faith group with over 420 churches/congregations based across South London and representing a diverse range of religious, cultural and other variations. The majority denomination is Catholic and second is Church of England. The table in Appendix 3 provides a full breakdown of churches by denomination across all 12 South London Boroughs.

Christian congregations generally reflect the diversity of local populations however there are patterns of affiliations corresponding with denomination and ethno national backgrounds. For example, Gypsy Roma Traveller (GRT) communities are considered to be devout Catholics and African and African Caribbean heritages are prominent within evangelist and Seventh Day Adventist congregations.

In addition the Ruach City Church is a very vibrant and fast growing church popular amongst South London residents of various African heritages. South London also has several unique specialist Christian congregations catering for language and cultural differences such as the Pakistan Christian Forum (established in 1976) based in Bexley and two Korean

churches/congregations in New Malden, which is said to be home to the largest concentration of Koreans resident in the UK[6]. There are Jehovah's Witness meetings in each of the 12 boroughs and a number of Seventh Day Adventist Churches.

As with all faiths there are complex divisions with culture, traditions and constantly changing dimensions.

No religion and Non Stated

According to the 2011 census data, South London's second largest 'faith' category recorded is 'no religion', constituting 25% of the total population and those choosing not to state are the third largest i.e. 8%. These groups presumably include Humanists, Atheists, Agnostics and those not wishing to be defined by any of the categories listed. These people range across a variety of ethno national heritages and backgrounds. However, those affiliating to Humanists and Atheist beliefs are generally considered to be from more educated backgrounds than those affiliated to traditional faith groups. It follows such collectives are well organised, and there are an array of organisations and meeting groups in and around London. In addition there is a number of cult movements and new age beliefs such as scientologists which have a growing presence and influence.

Buddhists in South London (Appendix 4)

Although the Buddhist population in South London is fairly small, it is diverse and unique. There are five temples located across South London including the Wat Buddhapadipa in Wimbledon, which is the oldest Buddhist Temple in the UK established by the Royal Thai Government and essentially catering for Thai heritage Buddhists. The London Peace Pagoda is a popular site in Wandsworth and based on the Japanese Nipponzan Myohoji tradition, whereas the Dorjechang Buddhist Centre is the main Kadampa Buddhist Centre in South London. Kadampa[7] Buddhism attracts a relatively diverse range of followers including a large proportion of white British.

There is a number of regular Buddhist meetings across South London catering for the diverse and varied traditions.

Hindu Communities in South London (Appendix 5)

Most Hindus are of Indian heritage, however, South London is also home to significant numbers of Tamil heritage Hindus who constitute the majority in certain parts e.g. in the borough of Merton and parts of Wandsworth.

Religious diversity within the Hindu faith is exceptionally complex with many denominations and varied beliefs. Some Hindus prefer not to claim to belong to any denomination. However, caste identity is for many integral to the faith, beliefs and traditional social structures. Essentially based on ancestry, caste identity is linked to several aspects including economic, spiritual and social dimensions. In addition Hindu religious practices can reflect

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[6] *'The Merton Story Refreshing of the Community Cohesion Strategy and Developing an Action Plan for* Engagement' Institute of Community Cohesion 2011

[7] http://kadampa.org/en/buddhism/kadampa-buddhism/

culturally diffused variations for example Tamil Hindu rituals are said to be influenced by aspects of language and Buddhism.

South London's established Hindu faith populations include diverse ethno national, regional, political and religious differences. There are 5 Hindu places of worship (Temples or Mandir) located in South London, 2 catering mainly for Hindus of Tamil heritage and 3 for those of Indian Guajarati and Punjabi heritages.

There are other Hindu organisations based in London focused on specific sections of the communities e.g. the Audichya Gadhia Brahma Samaj Society (AGBSS)[8] and Britannia (Shiva) Hindu Temple Trust[9]

The AGBSS is an affiliate of the Hindu Council UK and aims to promote the social, cultural and religious needs of the Audichya Gadhia community across London. The Audichya Gadhia community is a Brahmin[10] caste Indian Gujarati heritage based group. The Britannia (Shiva) Hindu Temple Trust is based in Highgate, North London though offers support through advice on Tamil religious and cultural matters including insights into the effects of events in Sri Lanka and the impact on diaspora communities in the UK.

Jewish communities in South London (Appendix6)

According to Census data, although South London's Jewish communities' populations are declining they have long been established across the boroughs. There are nine synagogues located across South London representing a wide range of religious and cultural differences. The majority of Synagogues in South London are described as Ashkenazi Orthodox. There is also one described as Masorti-Conservative, a Reform Synagogue and one representing Liberal Judaism. Below is a list of representative organisations for Synagogues located across South London.

1. **Sephardi or Eastern Ritual (Spanish and Portuguese speaking and eastern Jews).** Head Office: 2 Ashworth Road, London W9 1JY

2. **United Synagogue** (Head Office: Adler House, 735 High Road, North Finchley, London N12 0US. Website: www.unitedsynagogue.org.uk)

3. **Federation of Synagogues** Head Office: 65 Watford Way Hendon, London NW4 3AQ. Website: www.federationofsynagogues.com

4. **Union of Orthodox Hebrew Congregations**, Head Office: 140 Stamford Hill, London N16 6QT

5. **Assembly of Masorti Synagogues**, Head Office: 1097 Finchley Road, London NW11 0PU. Website: www.masorti.org.uk

[8] Audichya Gadhia Brahma Samaj Society (AGBSS), 10 Copse Hill, SW20 0NL.
[9] Tel: 02083489835, www.highgatehillmurugaran.org

[10] Brahmin is considered the highest Hindu Caste

6. **Independent Congregations** are generally congregations that subsequently became, and remained, affiliated. Includes French speaking

7. **Movement for Reform Judaism** (formerly Reform Synagogues of Great Britain)**.** Head Office: Sternberg Centre for Judaism, 80 East End Road, London N3 2SY. Website: www.reformjudaism.org.uk

8. **Liberal Judaism** (formerly Union of Liberal and Progressive Synagogues)**.** Head Office: The Montague Centre, 21 Maple Street, London W1T 4BE. Website: www.liberaljudaism.org

Muslim Communities in South London (Appendix 7)

Muslims are the fourth largest group – though second largest when taking out categories 'No Faith' and 'Non Stated'– resident in South London. As with all other faith communities, there is much diversity within and between Muslims, including, to some extent, corresponding theological and ethno national/cultural dimensions as well as certain variations appealing to different generations. There are two Muslim Sects of Shia and Sunni, both of which have many diverse branches.

Shia Muslims are the minority with the Ithna Ashari being the main theological branch represented in South London, though varied practices are evident between the major groups of Pakistani, Iranian, Iraqi and Turkish heritages.

Sunni Muslim organised religious affiliations are generally identifiable with Madhahib (School of Thought – emerging circa 7th and 8th centuries) often corresponding to geographical regional origin, and/or Sufi Order or Salafi variation. There are also modernist and ideological political groups.

There are over seventy masajid (mosques) located across South London (Appendix 7). The majority are affiliated to the mainly South Asian heritage Sunni Hanafi madhab (School of Thought) Deobhandi maslaq (sub-school) which is also attributed with instituting the largest Muslim evangelical group in the world 'Tablighi Jamat'. Notably, the South London boroughs of Lambeth and Southwark have possibly the most diverse Sunni Muslim African and Salafi Muslim practices represented anywhere in the world, including possibly the largest concentration of African Caribbean Muslims resident in the UK. Wandsworth uniquely has a Guyanese heritage managed and purpose-built masjid with a vibrant and mixed congregation. A number of ideological and political movements also exist, but these are beyond the scope and range of this review.

In addition, South London is resident to minority Muslim collectives such as the African American origin supremacist group Nation of Islam (NOI) and also significant populations of Pakistani heritage Ahmadiyya Muslims. Both of these are religiously distinct, and are not considered to be part of the Islamic faith by the vast majority of other Muslims (Shia and Sunni). Equally it is important to note* that Ahmadiyya and NOI Muslims do not consider Sunni or Shia Muslims to be followers of the "*true*" Islamic faith. Whilst Amaddiyya tend to be a persecuted minority overseas, in South London they have prominent positions and status. Two of the UK's most important Ahmadiyya centres are located in Merton and Wandsworth. Similarly, NOI Muslims whilst a minority – due to intellectual positioning and beliefs of supremacy – do, both individually and collectively – exude high levels of confidence. Both

groups also tend to be strict religious adherents with some quite specific beliefs. For example NOI Muslim interpretations of Halal (permissible) food are particularly strict and different from other Muslims as NOI Muslims definition of the Haram (forbidden) foodstuffs to extend to all processed types.

In general, respect for elders' forms an integral part of the fabric of Muslim religious and traditional cultures. Care for Muslim elderly therefore requires kindness and respect.

Sikh Communities in South London (Appendix 8)

Whilst Sikhs are largely ethnically mono-racial mainly of Indian-Punjabi heritage there are differences in terms of class and settlement patterns. The majority of British Sikhs are affiliated to the Kalsa Movement which along with confirmation to the traditions of Guru Gobhind Singh form the basis for the only Gurdwara established in South London, located in Wandsworth. The community consists of long established second and third generations and newer arrival settlement of Sikhs from India as well as a small number of recent refugees from Afghanistan with distinct language and cultural traditions.

Diversity of the South London Health Workforce

We have seen how extraordinarily diverse the South London population is becoming. How far does the health workforce also reflect this diversity? Having a diverse workforce does not, of course, remove the need for all individual staff to understand difference and be sensitive to cultures other than their own, but it does provide a much richer base of experience and information for staff to draw on. It should also make patients feel more comfortable that this is a service which better understands them and their needs.

Table 5: The South London Health Workforce by Ethnicity

	Trusts		CCGs		South London
	Number	% of total	Num	%	%
White	**18,468**	**48.6%**	**324**	**59.8%**	**67.3%**
White British	13,205	34.8%	281	51.8%	55.4%
White Irish	1,434	3.8%	13	2.4%	2.0%
White other/unspecified	3,829	10.1%	30	5.5%	10.0%
Mixed/multiple ethnic	**1,833**	**4.8%**	**11**	**2.0%**	**5.2%**
White and black Caribbean	479	1.3%			1.8%
White and Black African	317	0.8%			0.8%
White and Asian	360	0.9%			1.2%
Other mixed /unspecified	677	1.8%			1.4%
Asian/Asian British	**5,660**	**14.9%**	**57**	**10.5%**	**9.1%**
Indian	2,662	7.0%	41	7.6%	3.1%
Pakistani	669	1.8%	5	0.9%	1.5%
Bangladeshi	397	1.0%	2	0.4%	0.7%
Other Asian/unspecified	1,932	5.1%	9	1.7%	3.8%
Black/African/Carib/Bl Brit	**6,369**	**16.8%**	**55**	**10.1%**	**15.0%**
African	3,175	8.4%	30	5.5%	7.8%
Caribbean	2,349	6.2%	20	3.7%	4.9%
Other Black/unspecified	845	2.2%	5	0.9%	2.3%
Other Ethnic groups	**2,562**	**6.7%**	**19**	**3.5%**	**3.5%**
Chinese	788	2.1%	11	2.0%	1.5%
Filipino	296	0.8%			
Malaysian	29	0.1%			
All others	1,449	3.8%	8	1.5%	2.0%
Ethnicity not stated	**3,066**	**8.1%**	**76**	**14%**	
TOTAL	**37,958**	100.0%	**542**	100%	100.0%

Table 6: The South London Health Workforce: Ethnicity by Occupation

	Nurses		Midwives		Physios		Radiographers		Consult/s. reg	
	Num	% of total	Num	%	Num	%	Num	%	Num	%
White	**3,858**	**43.3%**	**260**	**45.1%**	**472**	**69.5%**	**267**	**49.2%**	**2,622**	**48.1%**
White British	2,603	29.2%	150	26.0%	361	53.2%	164	30.2%	1,661	30.5%
White Irish	524	5.9%	43	7.5%	30	4.4%	40	7.4%	145	2.7%
White other/unspec.	731	8.2%	67	11.6%	81	11.9%	63	11.6%	816	15.0%
Mixed	**507**	**5.7%**	**46**	**8.0%**	**27**	**4.0%**	**24**	**4.4%**	**211**	**3.9%**
Asian/Asian British	**1,037**	**11.6%**	**44**	**7.6%**	**66**	**9.7%**	**119**	**21.9%**	**1,368**	**25.1%**
Indian	347	3.9%	16	2.8%	48	7.1%	59	10.9%	765	14.0%
Pakistani	63	0.7%	4	0.7%	6	0.9%	13	2.4%	196	3.6%
Bangladeshi	61	0.7%	2	0.3%	3	0.4%	9	1.7%	68	1.2%
Other Asian/unspec.	566	6.3%	22	3.8%	9	1.3%	38	7.0%	339	6.2%
	('Asian British' 454)									
Black/African /Carib./Bl. British	**2,165**	**24.3%**	**146**	**25.3%**	**42**	**6.2%**	**64**	**11.8%**	**312**	**5.7%**
African	1,133	12.7%	68	11.8%	22	3.2%	40	7.4%	238	4.4%
Caribbean	710	8.0%	53	9.2%	18	2.7%	18	3.3%	37	0.7%
Other Black/unspec.	322	3.6%	25	4.3%	2	0.3%	6	1.1%	37	0.7%
Other Ethnic groups	**849**	**9.5%**	**44**	**7.6%**	**23**	**3.4%**	**32**	**5.9%**	**470**	**8.6%**
Chinese	199	2.2%	24	4.2%	7	1.0%	10	1.8%	200	3.7%
All others	650	7.3%	20	3.5%	16	2.4%	22	4.1%	270	5.0%
Ethnicity not stated	**498**	**5.6%**	**37**	**6.4%**	**49**	**7.2%**	**37**	**6.8%**	**465**	**8.5%**
TOTAL WORKFORCE	**8,914**	**100%**	**577**	**100%**	**679**	**100%**	**543**	**100%**	**5,448**	**100%**

The NHS collects extensive data on its workforce. There are over 38,000 individual records for employees of the fourteen community, acute and mental health trusts and twelve CCGs covered by HESL showing employer, job title, grade, ethnicity and more for each individual.

The records are rather complex and not immediately easy to interrogate. There are over 250 different job grades and 75 different ethnic classifications. These include, for example, White Cornish; White ex USSR; Asian Punjabi; Asian East African. It would appear that staff have been allowed considerable freedom to choose their ethnic group. The records also include what look like summary groups – White; Indian; Black Caribbean etc. but these have only a

handful of entries. This does perhaps raise questions about how far this information is actually used rather than just collected.

The data has been analysed to give, as far as possible, an ethnic breakdown which corresponds to the categories used in the Census in order to allow a comparison with the South London population. Table 5 gives this breakdown for the 37,958 staff employed by the trusts and the 542 employed by the CCGs. In both cases there is a high level of diversity, in general greater than that for South London as a whole. Only 34.8% of trust and 51.8% of CCG employees are White British as compared with 55.4% for South London, for example, (although there are fairly high levels of 'ethnicity not stated'); 14.9% of trust and 10.5% of CCG staff are Asian compared with 9.1% for South London; and 16.8% of trust and 10.1% of CCG staff are Black as compared with 15% for South London.

When we examine the breakdown by occupation and grade, however, some notable patterns emerge. Table 6 shows the ethnic breakdown for five professional groups: nurses, midwives, physiotherapists, radiographers and consultants/specialist registrars. There are relatively large numbers of Black nurses and midwives – 24.3% and 25.3% respectively – but low numbers of Asians, particularly in midwifery – 11.6% and 7.6% respectively. Physiotherapists are 69.5% White. Radiography and medicine have high proportions of Asian staff - 21.9% and 25.1% respectively – but only 5.7% of consultants/specialist registrars are Black.

It was not possible to obtain any data about the ethnic breakdown of staff in GPs' surgeries. This is a significant gap as GPs are at the front line of the health service and need to be closely involved in health promotion where engaging with different communities is particulary important.

Table 7 shows ethnicity by selected grades (covering 61% of the workforce). This shows an increase in the proportion of White staff from Review Body Grades 1-4 to Grades 8-9 – 39.8% for grades 1-4 to 46.5% for grades 5-7 and 75.8% for grades 8-9 - and corresponding decreases in Asian staff – 14.4% to 13.5% and 6.6% - and Black staff – 26.2% to 20.1% and 6.8%. The position for consultants/ specialist registrars is different, as we have seen, with 25.1% Asian but only 5.7% Black.

Table 7: The South London Health Workforce: Ethnicity by Grade

	Review body 1-4		Review body 5-7		Review body 8-9		Consult/ sp reg	
	Number	% of total	Num	%	Num	%	Num	%
White	**1,726**	**39.8%**	**5,440**	**46.5%**	**1,812**	**75.8%**	**2,622**	**48.1%**
White British	1,200	27.7%	3,606	30.8%	1,457	61.0%	1,661	30.5%
White Irish	130	3.0%	662	5.7%	119	5.0%	145	2.7%
White other/unspecified	396	9.1%	1,172	10.0%	236	9.9%	816	15.0%
Mixed/multiple ethnic	**262**	**6.0%**	**604**	**5.2%**	**55**	**2.3%**	**211**	**3.9%**
Asian/Asian British	**625**	**14.4%**	**1,583**	**13.5%**	**158**	**6.6%**	**1,368**	**25.1%**
Indian	227	5.2%	664	5.7%	94	3.9%	765	14.0%
Pakistani	68	1.6%	128	1.1%	13	0.5%	196	3.6%
Bangladeshi	76	1.8%	96	0.8%	4	0.2%	68	1.2%
Other Asian/unspecified	254	5.9%	695	5.9%	47	2.0%	339	6.2%
Black/African/Carib/Bl Brit	**1,135**	**26.2%**	**2,355**	**20.1%**	**162**	**6.8%**	**312**	**5.7%**
African	502	11.6%	1,189	10.2%	77	3.2%	238	4.4%
Caribbean	421	9.7%	768	6.6%	69	2.9%	37	0.7%
Other Black/unspecified	212	4.9%	398	3.4%	16	0.7%	37	0.7%
Other Ethnic groups	**294**	**6.8%**	**998**	**8.5%**	**108**	**4.5%**	**470**	**8.6%**
Chinese	60	1.4%	276	2.4%	41	1.7%	200	3.7%
All others	234	5.4%	722	6.2%	67	2.8%	270	5.0%
Ethnicity not stated	**295**	**6.8%**	**720**	**6.2%**	**95**	**4.0%**	**465**	**8.5%**
TOTAL WORKFORCE	**4,337**	**100%**	**11700**	**100.0%**	**2,390**	**100.0%**	**5,448**	**100.0%**

Does the distribution of ethnic groups across professions matter?

The experience of maternity services

Does the differing distribution of ethnic groups across professions matter? Does the fact that there are only six midwives of Pakistani or Bangladeshi heritage in South London trusts have any implications for the quality of service delivery, for example. Some research evidence on the experience of maternity care suggests that it may.

A national survey of women's experience of maternity care carried out by the National Perinatal Epidemiology Unit in 2010 found that BME women experienced poorer staff communication and felt that they were not treated with respect. They were also less likely to have seen a health professional by 12 weeks about their

pregnancy care or to be aware of all the options for where they could give birth[11]. However, this study did not distinguish between different BME groups and as we have seen there are in fact a large number of Black midwives. Perhaps more informative is the study of Muslim parents' experience of maternity services carried out by the Maternity Alliance in 2004[12]. This study found that that whilst some Muslim women receive good quality maternity care, many do not. Basic facilities and services in the NHS are often insensitive to their and their partners' needs".

Problems included:

- low awareness and use of antenatal classes
- acute discomfort and embarrassment amongst Muslim parents due to the lack of privacy in hospitals and too few female staff
- a lack of appropriate, easily understandable information during pregnancy, childbirth and the postnatal period, particularly for Muslim women whose first language is not English and for those with low literacy skills
- poor communication between health professionals and Muslim parents
- a severe shortage of interpreters who are available when Muslim women and NHS staff most need their support
- on over-reliance on English speaking family members and friends to act as translators, which can affect the quality of maternity care being provided to Muslim women
- insufficient involvement of Muslim parents in maternity services, and little choice for Muslim women about the treatment and care they receive

They concluded that

"These difficulties are partly due to a lack of understanding amongst NHS staff about how Islamic beliefs and practices can affect Muslim women's experiences. However, the poor quality and insensitive care received by many Muslim parents also appears to be a result of discriminatory attitudes held by some NHS staff. Many women we interviewed had experienced stereotypical and racist comments during the course of their maternity care.

"Maternity services must be informed and shaped by the diverse needs of the communities they serve. Increasing the accessibility and quality of maternity care will play an important role in improving the health outcomes of the UK's black and minority ethnic population, including Muslim communities."

Their recommendations included:

- "Ensuring effective pre- and post-qualification education and training for all health professionals on religious, cultural and ethnic issues that can influence users' needs for and experiences of health services, including maternity core.
- Employing more female and Muslim health professionals to improve the

[11] *Delivered with care: a national survey of women's experience of maternity care*, National Perinatal Epidemiology Unit 2010

[12] *Experiences of Maternity Services*: *Muslim Women's Perspectives* The Maternity Alliance, November 2004

sensitivity of maternity services and to ensure NHS staff reflect the communities they serve.

The Diversity of Trainees

How far does the diversity of trainees coming through the six training providers serving HESL mirror the existing distribution across the different professions?

The records provided by the training providers are even more extensive and confusing than those for NHS employees. There are 133,000 individual records across six training providers: Canterbury, Kings, Kingston, Surrey, Greenwich and St Georges. These include thousands of courses, many of which appear not at all relevant, plus post graduate and CPD training. It is not clear how this is compiled and what it is used for. We have chosen to select by first degree for Nursing, Midwifery, Physiotherapy, Radiography, and undergraduate Medicine, which covers 21,000 trainees in all. Again we have tried to follow Census categories though there were no sub categories for White and Mixed/Other.

Table 8 shows the ethnic breakdown by profession. Nursing and Midwifery have much higher proportions of White trainees (65.9% and 75.5%) than the current South London nursing and midwifery workforce (43.3% and 45.1%) and notably small proportions of Asians (5.2% and 1.8%) as compared with current 11.6% of nurses and 7.6% of midwives in the South London NHS. This suggests that the current batch of trainees will do nothing to address the shortfall of Asian nurses and, particularly, midwives.

Radiography has even numbers of Asian and Black trainees – around 14%. Physiotherapy has 13% Asian and 7.4% Black trainees. For medicine the picture is very different – 28.3% of trainees are Asian and 6.5% Black of whom only 0.8% are Caribbean. So again this would appear to be perpetuating the distribution across the current workforce.

Of course not all trainees will go on to work in South London. Physiotherapists and doctors tend to move around. Nurses are more likely to stay locally. We have therefore looked at the variation between the five providers of nurse training (Table 9). The variation here is almost entirely around the proportion of Black trainees which ranges from 7.1% in Surrey to 32.6% in Greenwich. None have more than 6.8% of trainees who are Asian.

Table 8: Trainees by Profession and Ethnicity

	Nursing		Underg. Medicine		Midwifery		Physiotherapy		Radiography	
	Number	% of total	Num	%	Num	%	Num	%	Num	%
White	**3,405**	**65.9%**	**4,599**	**40.6%**	**1,668**	**75.5%**	**725**	**59.0%**	**590**	**52.0%**
Asian/Asian British	**269**	**5.2%**	**3,211**	**28.3%**	**40**	**1.8%**	**160**	**13.0%**	**151**	**13.3%**
Indian	90	1.7%	1,479	13.0%	13	0.6%	91	7.4%	68	6.0%
Pakistani	16	0.3%	586	5.2%	10	0.5%	22	1.8%	15	1.3%
Bangladeshi	21	0.4%	262	2.3%	5	0.2%	14	1.1%	14	1.2%
Other Asian unspecified	142	2.7%	884	7.8%	12	0.5%	33	2.7%	54	4.8%
Black/African/Carib/Bl British	**799**	**15.5%**	**734**	**6.5%**	**298**	**13.5%**	**91**	**7.4%**	**167**	**14.7%**
African	605	11.7%	627	5.5%	185	8.4%	51	4.2%	152	13.4%
Caribbean	149	2.9%	89	0.8%	99	4.4%	33	2.7%	11	1.0%
Other Black unspecified	45	0.9%	18	0.2%	14	0.6%	7	0.6%	4	0.4%
Chinese	**26**	**0.5%**	**352**	**3.1%**	**7**	**0.3%**	**13**	**1.1%**	**12**	**1.1%**
Other (including mixed)	**202**	**3.9%**	**885**	**7.8%**	**116**	**5.3%**	**93**	**7.6%**	**71**	**6.3%**
Ethnicity not stated	**267**	**5.2%**	**365**	**3.2%**	**66**	**3.0%**	**86**	**7.0%**	**100**	**8.8%**
Non-UK	**197**	**3.8%**	**1,189**	**10.5%**	**13**	**0.6%**	**60**	**4.9%**	**43**	**3.8%**
TOTAL TRAINEES	**5,165**	**100.0%**	**11,335**	**100.0%**	**2,208**	**100.0%**	**1,228**	**100.0%**	**1,134**	**100.0%**

Table 9: Trainees in Nursing by Ethnicity and Training Provider

	Canterbury		Kings College		Kingston		Greenwich		Surrey	
	Number	% of total	Num	%	Num	%	Num	%	Num	%
White	**980**	**75.4%**	**1,227**	**66.5**	**465**	**49.9%**	**214**	**52.1%**	**519**	**76.4%**
Asian/Asian British	**50**	**3.8%**	**103**	**5.6**	**48**	**5.2%**	**28**	**6.8%**	**40**	**5.9%**
Indian	20	1.5%	34	1.8	19	2.0%	5	1.2%	12	1.8%
Pakistani	2	0.2%	11	0.6	1	0.1%	0		2	0.3%
Bangladeshi	1	0.1%	10	0.5	3	0.3%	1	0.2%	6	0.9%
Other Asian unspecified	27	2.1%	48	2.6	25	2.7%	22	5.4%	20	2.9%
Black/African/Carib/Bl Brit	**107**	**8.2%**	**293**	**15.9**	**217**	**23.3%**	**134**	**32.6%**	**48**	**7.1%**
African	92	7.1%	212	11.5	153	16.4%	110	26.8%	38	5.6%
Caribbean	11	0.8%	63	3.4	46	4.9%	20	4.9%	9	1.3%
Other Black unspecified	4	0.3%	18	1	18	1.9%	4	1.0%	1	0.1%
Chinese	**2**	**0.2%**	**9**	**0.5**	**6**	**0.6%**	**4**	**1.0%**	**5**	**0.7%**
Other (including mixed)	**32**	**2.5%**	**92**	**5**	**39**	**4.1%**	**21**	**5.1%**	**18**	**2.7%**
Ethnicity not stated	**37**	**2.8%**	**87**	**4.7**	**127**	**13.6%**	**0**		**16**	**2.4%**
Non-UK	**91**	**7.0%**	**34**	**1.8**	**29**	**3.1%**	**10**	**2.4%**	**33**	**4.9%**
TOTAL TRAINEES	**1,299**	**100.0%**	**1,845**	**100**	**931**	**100.0%**	**411**	**100.0%**	**679**	**100.0%**

How far do health providers recognise and respond to South London's diversity?

To begin to answer this question telephone interviews were held with twelve representatives of acute and community trusts, CCGs and a Community Education Network chosen by HESL. Such a small sample cannot be conclusive but it can provide useful pointers to areas of strength and weakness. Responses were very varied ranging from, in one instance, seeing this as a non-issue (at least initially) to sophisticated examples of actions to engage different communities or develop the confidence of BME staff. In broad terms CCGs were less engaged with this agenda than trusts. However, in every case, by the end of each interview, there was recognition that this was an important area of focus for HESL and needed to be given greater attention by providers.

The following issues were raised:

1. **Is this a non-issue?**
   It was suggested that in parts of South London diversity was not really an issue for health. This view appeared to be based on a significant underestimation of the extent of diversity: as we have seen even in the borough with the largest White British population 23% of the overall population and 35% of school pupils are non- White British.

2. **Complying with equalities legislation**
   Many of the organisations referred to their processes for meeting equalities requirements, particularly in terms of staffing, including the production of annual reports. But often it was admitted that not much was done with this data.

3. **Language**
   Another common theme was to see the challenge posed by diversity as one principally around the need for translation and interpretation. Some referred to the informal use of staff with language skills to assist with this.

4. **Differing patterns of morbidity**
   There was fairly widespread recognition that morbidity varied across ethnic groups: sickle cell disease was an obvious example but also diabetes, heart disease and mental health. For some, but not all, this had led to differentiated approaches, some examples of which are given below.

5. **Access and engagement**
   Some trusts had developed specific initiatives to engage different ethnic groups to help them access services and understand better the services available. Often this was in direct response to evidence of high prevalence of some diseases or low take-up of screening. Examples include:

   - **Engaging with communities.** The Royal Marsden Community Trust has recently engaged two Urdu and Arabic speaking community advocates to engage with some of their harder to access communities. They have also run a series of road shows to try to access harder to reach groups – ethnic, religious and gay

and lesbian - with information about the early detection of cancer. Wandsworth Children's Services established a Somali parents group in their Children's Centres and produced an awareness rising campaign aimed at the Asian communities on breast and cervical screening. Sutton CCG has used volunteers to talk to different ethnic groups, including the Tamil community, about the use of the NHS.

- **Black pastors project**. Members of the black community in Wandsworth have disproportionately high levels of mental health problems but are often slow to come forward to the health services. It was felt that many were more likely to speak to their pastors. St George's Mental Health Trust therefore set up this project to train black pastors in family therapy, to help them recognise when distress might be mental illness, work with those with mental illness and recognise when they needed to refer people to appropriate mental health services. The project is now being extended to local Imams.

6. **Service quality**

A number of the interviewees specifically argued that recognising and responding sensitively to individual difference be it arising from ethnicity, religion, disability sexuality or whatever, was key to providing a quality patient service. For St George's Mental Health Trust, the essence of their approach is to start from the individual, understanding their particular circumstances and supporting them in managing their own condition. This means understanding their culture and community and the strengths and restrictions it may pose. At the Royal Marsden staff need to be aware that some communities will not talk about death at all – so discussions about palliative care are inappropriate for some patients.

While there was very widespread mention of the growing challenge of an ageing population there were no examples of work to address the particular challenges of an increasingly diverse elderly patient population When raised this was said to be in a number of cases 'not on the radar'.

7. **Workforce skills**

In answer to questions about how the workforce was equipped with the skills and confidence to respond to a super diverse patient population most interviewees either said that there was no particular training or support or referred to a equalities training courses which seemed to be focused mostly on the legal position. It was common to mention that the workforce was itself diverse but there was much less said about how this diversity was harnessed and used to improve service delivery.

- At the Royal Marsden staff are both given advice and helped to reflect on tricky situations which may arise from a whole variety of situations which may vary from giving advice on having sex after cancer treatment – particularly difficult when, for example, the professional may be heterosexual and the patient gay – to different cultural attitudes to death. They are shortly to do work with the Point of Care foundation at the Kings Fund to help staff to share and reflect on difficult decision making situations. At St George's Mental Health Trust there is support for reflective practice within the teams.

- St George's Hospital Trust (SGHT) has recognised that having a very diverse workforce does not ensure sensitive services if BME staff are not able to perform to the best of their abilities. It is well established that BME nursing and midwifery staff underperform at university, are less successful than white candidates in obtaining a first job and progressing their careers, and are overwhelmingly over-represented in disciplinary cases. SGHT sought to address this post qualification shortfall and improve the quality of midwifery services with an intensive programme, Midwifery Futures. Using an external facilitator this used dialogue, round tables and action learning sets to identify where BME staff felt that their voices were not being heard.

  The opportunity to lead was identified as an area that was felt to be lacking. So staff were invited to identify an area of service where patient experiences needed to be improved, and offered support to lead an improvement plan through the system. Three areas of improvement were identified and led by BME staff: an FGM patient service; 'fathers and families', to promote the greater involvement of fathers in the maternity journey; and post-natal service improvement relating to compassionate care which was midwife-led but focused principally on care assistants. In this way the confidence and effectiveness of BME midwives was improved and services were improved.

Recommendations

It is clear that not only is South London extraordinarily diverse – super-diverse - but that it is continuing to change rapidly both overall and in very localised ways. If the health service is to effectively provide for this degree of diversity it is clear that staff will need to be better informed and more confident. All those we interviewed agreed that this was an area which deserved greater attention but there was a very wide variation in knowledge, awareness and practice.

Awareness

Recommendation 1 HESL will need to consider how it can best contribute to raising awareness of the new and changing diversity of the patient population. This could be done through many different mediums – intranet and other internal communications regular stories and snippets; displays, social media, lunchtime 'brown bag' presentations; etc.

Diversity training

Recommendation 2 Staff training, pre and post registration, should give greater attention to diversity and its challenges:

- All trainees need to be comfortable in seeing this as a key area to explore and discuss
- Key staff will need specific training in how to recognise and respond to diverse needs
- Ethnic, religious and cultural profiles could be developed but with care to avoid homogenising groups and failing to recognise the diversity within groups – there is a danger of a little knowledge being unhelpful

Engaging diverse communities

We know that different communities have different incidences of disease, attitudes to health and the health service - not least around mental health - and levels of visibility and engagement. We have seen some imaginative ways of engaging with different communities in this short study. Such good practice needs to be gathered and promoted[13].

Recommendation 3 Staff need to be encouraged to explore ways of effectively engaging with different communities to better understand health needs, encourage greater access to the health system and promote targeted health improvement campaigns.

[13] There is an interesting example of taking health checks out into community settings, including mosques, by Greenwich in Health Service Journal /Local Government Chronicle Health Check Supplement, 4 October 2013

Reaching GP practices

Because of the structure of the health service there is a particular challenge of influencing GP practices. Awareness of the challenges of diversity was generally lower in CCGs than trusts. CCGs are of course still at a formative stage.

> **Recommendation 4** HESL should to seek to influence the CCG agendas as they emerge to ensure a clearer focus on diversity

A diverse workforce

The South London Health workforce is diverse but

- There is an uneven spread across occupations with, for example, few Asian midwives or black doctors
- There is an uneven spread across grades with less BME staff at senior levels in general, except Asian doctors
- It is not clear how far the diversity of the workforce is harnessed to enrich knowledge and understanding
- Perhaps most seriously, there is strong evidence that BME staff underperform and are very disproportionately represented in disciplinary procedures

> **Recommendation 5** Workforce data needs to be used more actively to understand where there are gaps or shortfalls in the extent to which it reflects the communities served. This will then allow the development of targeted action in terms of staff development and recruitment and also action to better equip staff for dealing with diversity in areas where imbalances in staff are likely to persist for some time (such as Asian midwives)

> **Recommendation 6** Ways need to be explored to address the underperformance and underuse of some groups of BME staff (e.g. as seen in St George's Trust with midwives).

Trainees and training providers

Working with training providers is central to HESL's mission. We have seen that the ethnic distribution of trainees is, if anything more skewed by occupation than it is in the workforce. So the next batch of trainees will not address that shortfall. We also know that all BME groups underperform at university, including those who outperform white students in schools, and that, at least in the case of nurses; they are less successful in obtaining a good first job.[14] There is therefore much to be addressed here in addition to awareness and confidence raising for all trainees in dealing with the health needs of a diverse population.

[14] Tatam, J., and Ross, F 2013. *How can we ensure equal access to job opportunities for nurses?* in International Journal of Nursing Studies 50 (3) 301-302.

Harris, R., Ooms, A., Grant, R., Marshall-Lucette, S., Sek Fun Chu, C., Sayer,J., Burke, L., 2013. *Equality of employment opportunities for nurses at the point of qualification: An exploratory study.* International Journal of Nursing Studies 50 (3), 303–313.

Recommendation 7 Training providers need to ensure that the health challenges presented by a superdiverse population are properly addressed

Recommendation 8 Training providers need to understand and address the reasons why BME trainees underperform on their courses and when leaving

Recommendation 9 That a second phase of this project be initiated working with education providers to review:

- their polices and approaches to promoting diverse workforces and equipping them with the skills and confidence to deal with the needs of very diverse communities, including support for BME staff
- the policies and approaches to recruitment, selection and course marketing

This phase could also include an initial exploration of more general attitudes of potential recruits towards the health service as employers including their motivation and the influence of friends and family, to understand better why certain occupations attract certain ethnic groups.

Wider dissemination

The focus on diversity feels very timely and was recognised as such by all those interviewed. In general the understanding of this agenda seems to be lagging behind local government. HESL now has the opportunity to take a lead.

Recommendation 10 That HESL considers how best to share and promote this agenda with other health education commissioners, and more widely in the health service