Black and Minority Ethnic Elders and Adult Social Care in the North East

Dean T. Huggins
March 2013
BECON

BECON is a region wide race equality organisation operating across the North East of England. BECON’s VISION is to create:

‘a society that creates equal life chances for Black and Minority Ethnic (BME) people and people living in deprived areas leading to a society that is racially and socially just.’

BECON provides services to BME (Black and Minority Ethnic) communities to address disadvantage, discrimination, exclusion, inequalities and racism. Services are geared to support individuals, groups and organisations to participate more fully and inclusively in the economic, social and cultural developments of their localities. BECON strives to bring about a more inclusive society promoting equality, diversity, human rights and social justice. In addition to providing services BECON is a network organisation with over a 100 members across the region providing a platform for influence, representation and voice.

For more information on the work undertaken by BECON visit www.becon.org.uk

Policy and Representation Partnership

The Policy and Representation Partnership is hosted by the Voluntary Organisations’ Network North East (VONNE) a three-year, Big Lottery-funded project which aims to increase the voluntary and community sector’s influence on public policy. The partnership does this in a number of ways: through quarterly policy forum events, training sessions, researching policy areas and sharing information. More on the work of the partnership can be found at www.vonne.org.uk/policy/partnership
Contents

1 Introduction 4
   1.1 BECON’s approach 4
   1.2 Fair Access to Care Services 5
   1.3 Fair Society, Healthy Lives 6
   1.4 Fairer Care Funding 6
   1.5 Terminology 7
2 Methodology 8
3 Demographic Changes 9
4 Findings 12
   4.1 Information and Advice / Awareness of Services 13
   4.2 Service Provision 14
   4.3 Social Contact / Supporting Independent Living 15
   4.4 Communication 15
   4.5 Personal Assistants 16
   4.6 Advocacy 16
   4.7 Commissioning 17
5 Conclusion 19
6 Recommendations 20
   References 22
   Appendix 1: Topic Guide 24
   Appendix 2: Ageing Matters Ethnic Concerns: North East Seminar for Elders from Minority Ethnic Communities”, Age Concern, 2001 25
1. Introduction

The challenges of an ageing population have been a prominent item on the news and political agenda, particularly in relation to adult social care (ASC) and the related costs of caring for people who are no longer as active or as fit as they used to be. It is, not only an issue related to an increase in numbers, but also linked to the challenges of economic and health inequality (Liveseley 2010:64) (The Marmot Review, 2010)

The Policy and Representation Partnership has supported BECON in conducting research into the issues of adult social care as they link to black and minority ethnic (BME) older people in the North East.

The scoping paper prepared for work on this policy topic noted the Law Commission’s definition of ASC

... the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers.

Law Commission 2011

In their view the key purpose of adult social care is to promote or contribute to the well-being of the individual. In its report on social care, the House of Commons Health Committee notes that this definition could also refer to the purpose of health care (House of Commons Health Committee 2012: 8). They are critical of the over eighty years of fragmentation of service which have resulted in health services being provided free whilst social care provision is means tested. They note that, in later life, many people require both health and social care. Fifty one per cent of people receiving state funded social care are aged over 65 whilst 91% of the people in nursing care are aged 65 and over, with 70% of acute hospital beds being occupied by older people (House of Commons Health Committee 2012: 6).

They identify a long standing problem with the way that adult social care and health needs are separated when in reality, particularly for older people, they are intimately linked. Black and minority ethnic older people feel marginalised.

“If we are to move forward successfully, all providers will have to listen attentively to ethnic minority elders who will say that they feel ignored and forgotten”

Age Concern England (undated)

The current direction for adult social care is for an increase in autonomy which has led to the introduction of personal budgets (PB’s) and direct payments (DP’s). The current system is designed to enable the person receiving care to have their needs assessed and, if they meet the eligibility criteria, have choices about the way in which their needs are met.

1.1 BECON’s approach

The key aim for the policy work was to assess adult social care policies of two local authorities in the North East to understand how these local authorities are integrating the needs of BME older people in their care policies, and identify the availability of options for voluntary sector influence on policy and practice.

The research was designed to achieve the following outcomes:
1. Local authority policy on social care for older people will be assessed leading to the identification of areas where the needs of BME communities have been integrated in the policy making, the available evidence and any gaps that exist.

2. Awareness will be built amongst BME older people, and the BME voluntary and community sector (VCS) organisations that support them, on the services that are available, and the processes for ensuring their informed participation in local authority policy making.

3. Information on the opportunities that exist for BME VCS organisations to participate in local authority policy making will be identified, disseminated and groups have been given the opportunity to influence policy makers.

4. BME social enterprises are better able to identify areas where they can develop service provision to BME communities.

Although these themes were identified at the outset, the nature of adult social care means that there needed to be further focus. This came after a discussion with a senior manager at Middlesbrough Council. It was decided that the primary focus areas for the study should be around Personal Assistants (PA’s), Advocacy and Commissioning.

Below we cover some of the background issues relating to any discussion of adult social care: Fair Access to Care, The Marmot Review and the Dilnot commission.

1.2 Fair Access to Care Services

The Fair Access to Care Services (FACS) guidelines were developed to introduce equity into the system of meeting social care needs in 2003. The fact that care needs are increasing and the resources available to meet those needs are reducing required a system that enables those needs to be fairly, proportionately and transparently managed. Local authorities in England have developed their own mechanisms for implementing the FACS guidelines. However, once a request for support is received local authorities are obliged to make an assessment of the care needs and develop a care plan to meet the assessed needs if the client meets the eligibility criteria. Local authorities are increasingly using automated computer based systems to make the assessment and identify the resources that the particular clients need. The Home Affairs Select Committee (2012) noted that Resource Allocation Systems (RAS) seem to introduce a process that is more ‘akin to social security than social care’. They felt that the Government needed to be ‘clear sighted’ about the impact of the personalisation approach on the total demand for social care and the related budgets.

There are four levels of need: critical, substantial, moderate and low. FACS guidelines require local authorities to support anyone whose needs are assessed as being ‘critical’, but the majority of local authorities support adults with both ‘critical’ and ‘substantial’ needs. In the region, Northumberland Council is the only authority to stick to the guidelines; it is one of only nine in England that only support those with ‘critical’ needs, at the time of writing. It is likely that, as the financial pressures increase on local authorities, they will feel the need to restrict the support they provide to those with ‘critical’ needs. However, given the experience of Birmingham City Council which tried to introduce this change to save some £15 million from its budget, these changes will need to be carefully introduced with a thorough assessment of the equality legislation (see the Guardian and Irwin Mitchell website links in references below).
The FACS guidelines also indicate that authorities should signpost people who do not meet the eligibility threshold to appropriate support for their needs. They also highlight the responsibility that local authorities have for developing the care market in their area.

1.3 Fair Society, Healthy Lives


Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair.


Every indicator reviewed demonstrated a correlation between poor outcomes and social status, employment status, or residence in areas of deprivation. Disability free life expectancy (DFLE) is a useful adult social care indicator, as it is derived from information on limiting long-term illness and mortality: ‘people in lower socioeconomic groups not only have shorter lives but they also spend more of their later years with a disability’ (ibid page 51). The review further notes that there is variation between areas with the same level of income deprivation which ‘is associated with regional variation in both mortality and disability’ (ibid page 51). The information presented shows that the North East and the North West have five years less DFLE than London, which has the highest DLFE in England.

There is a similar picture for Cardio Vascular Disease (CVD). Between 2001 and 2003, there were 2.7 more deaths from CVD among men in the most deprived twentieth compared with those in the least deprived twentieth (ibid page 52). CVD is a particular health challenge for some ethnic minority communities (ibid page 53).

These figures are extremely significant for the older lives of black and minority ethnic people when taken together with the information produced by Walker, and Nazroo and others in the Age Concern / ESRC Growing Older Programme publication (Walker and Northmore undated). They represent a greater challenge for older BME people living in the North East.

An important feature of the recommendations made by the Marmot Review is that there should not be, as in past and recent strategies, a focus only on those experiencing the worst outcomes. There should be ‘proportionate’ effort along the spectrum of socioeconomic status (a concept termed ‘proportionate universalism’) (ibid page 16). In this way the unfortunate disparities caused by some programmes could be avoided, Marmot argues.

1.4 Fairer Care Funding

The Commission, led by Andrew Dilnot, on the Funding of Care and Support was asked by the Government to make recommendations on how to achieve an affordable and sustainable funding system for care and support for all adults in England.
The report produced by the Commission outlined a new model of responsibility for care costs shared by the individual and state. The key recommendations were:

1. People are protected from extreme costs by a lifetime cap on payments ranging from £25,000 to £50,000. The Commission felt that £35,000 would be the best figure. Above that figure individuals would be eligible for full support from the state.
2. Means tested support for eligibility should continue below that level but the threshold for contributions should be increased from £23,250 to £100,000.
3. People who enter adulthood with previous care and support needs should immediately be eligible for free state support.
4. Universal disability benefits payment for people of all ages should continue as at present.
5. People should contribute a standard, fixed, amount to their general living costs in residential care of between £7,000 and £10,000 a year.
6. Eligibility criteria for social care service entitlement should be set on a standard national basis and this should be portable across England. The threshold should be ‘substantial’ needs.
7. The Government should invest in an awareness campaign to inform people of the new system and the need to plan ahead.
8. The Government should develop a new information and advice strategy to help when care needs arise. This should be produced in association with charities, local government and the financial services sector, with a statutory duty placed on local authorities to provide information, advice and assistance services in their areas – as suggested by the Law Commission.
9. There should be improved assessments for carers, which takes place at the same time as the assessment of the person in need of care, with the implementation of a Law Commission proposal to give carers new legal rights and improved assessments.
10. The Government should review the scope for improving the integration of adult social care with other services in the wider care and support system.

The proposals represented an attempt to pull together challenges facing the state and individuals in relation to the increasing costs of adult social care. Further information is available at [www.dilnotcommission.dh.gov.uk](http://www.dilnotcommission.dh.gov.uk).

1.5 Terminology

Katbamna and Matthews 2007 present a useful outline of the concept of ethnicity. It is a ‘self defined and fluid concept, which can embrace a number of features such as skin colour, national or regional identify, cultural, religion, country of birth, language, dress and political affiliation’. They add that the term ‘Black and minority ethnic refers predominantly to people from former British colonies in Africa, the Indian sub-continent (or South Asia). The term is also used to include other ethnic minorities of White ancestry who identify as Irish or White Other and includes people from Eastern Europe, Canada, Australia and South Africa. The phrase ‘ethnic majority’ will be used, from time to time, to represent White British people.
2. Methodology

A range of qualitative techniques were used to gather information. Semi structured interviews were conducted with local authority staff in Middlesbrough. Unfortunately, whilst supportive, managers at Gateshead Council decided not to take part in interviews for the project. A number of black and minority ethnic staff in voluntary and public sector in Middlesbrough and Gateshead were interviewed along with BME and non-BME staff from other agencies in other parts of the region involved in work on adult social care. A senior manager in Stockton also gave support to the project, particularly in relation to the ways that BME VCS could understand the commissioning process and gain access to larger, mainstream providers.

In addition to this the website information on adult social care for Gateshead, Middlesbrough, Newcastle, Northumberland, Stockton and Sunderland authorities was reviewed.

The interviewees were gathered by snowball technique.

The following interventions were conducted:

- Two focus groups were held with ethnic minority groups (including the Tees Valley Chinese Community Centre with 33 participants: 26 women and 7 men). The other group consisted of 12 women of South Asian origin and 1 female South Asian interpreter.
- Interviews with three ethnic minority local authority staff in Middlesbrough.
- Interviews with two managers of a voluntary sector organisation in Middlesbrough.
- Interview with a BME support worker in Authority 3.
- Interviews with three advocacy service providers in two local authorities (Gateshead and Authority 4).
- Interviews with four BME voluntary sector workers in two local authorities.
- Interview with a commissioning manager in Authority 5.
- Notes of issues identified during attendance at the Gateshead Visible Ethnic Minority Support Group Drop-in.
- Notes of discussion with GVOC Manager in Gateshead.
- Notes of a meeting with Middlesbrough LINk workers.
- Notes of meetings with senior managers in Gateshead and Middlesbrough Councils.
- Attendance at the Health and Social Care Voluntary Sector Forum coordinated by MVDA.
- Attendance at Middlesbrough BME Network meetings.
- Attendance at a Stockton LINk meeting.

Given the sensitive nature of some of the comments made, the information will be presented in the context of the themes identified in analysing the interviews. Any identification of individuals will be kept to a minimum.

Efforts to contact the advocacy service provided in Middlesbrough, Jewish community organisations in Gateshead and BME personalisation support service in Newcastle proved unsuccessful.
3. Demographic Changes

The tables recently released by the Office for National Statistics (ONS) show that there have been changes in the numbers of ethnic minorities in the region. The figures are not exactly comparable; for example, the ‘Chinese / Other Ethnic Group: Chinese’ is now within the ‘Asian / Asian British: Chinese’ and there are now, also, a category that represents people who identify themselves as 'Gypsy Traveller' or 'Arab'.

The table below makes comparisons where it seems possible to make them, but the information for age analysed by ethnicity are not yet released.

Craig 2010 reviewed ONS’ 2009 estimates of the population within the North East and noted that population had increased by 1.7 per cent (44,000). However the figures from the Census table show that all ethnic minorities (that is including ‘White Irish’ and ‘White Other’ categories) was actually 75,617. There has been a decrease in the number of people who describe themselves as ‘Irish’ within the region. In the 2001 Census figures this grouping had the greatest number of older people at 24.7%.

In 2001, the Caribbean community had the next largest age profile at 10.4%. The lowest numbers of people 65 and older was amongst the Chinese community at 1.8%.

Between 2001 and 2006 the greatest increase in ethnic minority communities was in Redcar and Cleveland (136%) and the lowest increase in Middlesbrough (29%). The average increase for the North East was 68%. (DRE 2009: 11.)

Kurowska and Whaley (?2011) note that the North East is “ageing more quickly than other English regions due to the geographical distribution of the region’s population and steady outward migration of younger workers seeking employment” in the south of England. The ONS predicts that by 2029 the 65 - 79 age group will increase from 321,000 to 432,000 in the North East. At the same time the ONS predicts a fall by 1,538 in the numbers of 15 - 64 age group with a concomitant fall in the numbers of under 15’s of 50,000.

Katbamna and Matthews 2007 noted that in the 2001 Census showed that the North East had some of the lowest numbers of ethnic minorities aged 65 and older across England. The largest group was Asian or Asian British with the numbers of Chinese and Black or Black British being significantly lower. The mixed group fell somewhere in between the Asian or Asian British and the other two groups. All of these communities were represented less than 0.5 % of the population.
Table 1. The numbers and percentages of black and minority ethnic older people resident in the North East. (From the Census 2001 and 2011 Census Tables KSW102EW and KS201EW)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total number</th>
<th>2001 Census – 65 and over</th>
<th>% of total population</th>
<th>% of the category</th>
<th>2011 Census Numbers</th>
<th>Change since 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>All People</td>
<td>2,515,438</td>
<td>416,306</td>
<td>16.6</td>
<td>16.6</td>
<td>2,596,886</td>
<td>81,448</td>
</tr>
<tr>
<td>White British</td>
<td>2,424,592</td>
<td>409,160</td>
<td>16.3</td>
<td>16.9</td>
<td>2,431,423</td>
<td>6,831</td>
</tr>
<tr>
<td>White Irish</td>
<td>8,682</td>
<td>2,148</td>
<td>0.1</td>
<td>24.7</td>
<td>8,035</td>
<td>-647</td>
</tr>
<tr>
<td>White Other</td>
<td>21,142</td>
<td>2,309</td>
<td>0.1</td>
<td>10.9</td>
<td>34,425</td>
<td>13,283</td>
</tr>
<tr>
<td>Mixed - White B Caribbean</td>
<td>2,783</td>
<td>154</td>
<td>0.0</td>
<td>5.5</td>
<td>5,938</td>
<td>3,155</td>
</tr>
<tr>
<td>Mixed - White B African</td>
<td>1,744</td>
<td>56</td>
<td>0.0</td>
<td>3.2</td>
<td>3,549</td>
<td>1,805</td>
</tr>
<tr>
<td>Mixed - White Asian</td>
<td>4,731</td>
<td>119</td>
<td>0.0</td>
<td>2.5</td>
<td>8,022</td>
<td>3,291</td>
</tr>
<tr>
<td>Mixed Other</td>
<td>2,970</td>
<td>136</td>
<td>0.0</td>
<td>4.6</td>
<td>4,940</td>
<td>1,970</td>
</tr>
<tr>
<td>Asian / AB - Indian</td>
<td>10,156</td>
<td>593</td>
<td>0.0</td>
<td>5.8</td>
<td>15,817</td>
<td>5,661</td>
</tr>
<tr>
<td>Asian / AB - Pakistani</td>
<td>14,074</td>
<td>645</td>
<td>0.0</td>
<td>4.6</td>
<td>19,831</td>
<td>5,757</td>
</tr>
<tr>
<td>Asian / AB - Bangladeshi</td>
<td>6,164</td>
<td>151</td>
<td>0.0</td>
<td>2.4</td>
<td>10,972</td>
<td>4,808</td>
</tr>
<tr>
<td>Asian / AB - Other</td>
<td>3,181</td>
<td>126</td>
<td>0.0</td>
<td>4.0</td>
<td>13,695</td>
<td>10,514</td>
</tr>
<tr>
<td>Black / BB - B Caribbean</td>
<td>930</td>
<td>97</td>
<td>0.0</td>
<td>10.4</td>
<td>1,193</td>
<td>263</td>
</tr>
<tr>
<td>Black / BB - B African</td>
<td>2,597</td>
<td>159</td>
<td>0.0</td>
<td>6.1</td>
<td>10,982</td>
<td>8,385</td>
</tr>
<tr>
<td>Black / BB - Other</td>
<td>427</td>
<td>42</td>
<td>0.0</td>
<td>9.8</td>
<td>1,045</td>
<td>618</td>
</tr>
<tr>
<td>Chinese / O E Group – Chinese</td>
<td>6,048</td>
<td>334</td>
<td>0.0</td>
<td>5.5</td>
<td>14,284</td>
<td>8,236</td>
</tr>
<tr>
<td>Chinese / O E Group - other ethnic group</td>
<td>4,217</td>
<td>76</td>
<td>0.0</td>
<td>1.8</td>
<td></td>
<td>-4,217</td>
</tr>
<tr>
<td>Total of all categories of ethnic minority</td>
<td>89,846</td>
<td>7,145</td>
<td>0.3</td>
<td>8.0</td>
<td>165,463</td>
<td>75,617</td>
</tr>
</tbody>
</table>
Livesley 2010 presented information from the 2007 Annual Labour Force Survey for the top five most common countries of birth for people born outside the UK and living in the North East (page 11):

- Germany 10,000
- India 10,000
- Poland 7,000
- Pakistan 6,000
- Republic of Ireland 6,000

The North East has one of the highest proportions of people over 60 in England with the rural north displaying a generally older population than the more urbanised south of the regions (O’Donnell et al 2008). Gross pensioner income is well below the UK average which will have an impact on the lives of all older people in the region.

The age pattern and gender distribution for BME communities reflects the migration patterns which saw young people from the former colonies coming to the UK to contribute to the post war reconstruction. It was a pattern that saw, in the main, men migrating from their home countries with intentions of returning after, in many cases, five years which were never fulfilled. In general the majority of people from the Indian subcontinent and the Caribbean came to the UK in the 50s and 60s, with the different Asian people (including Chinese) and Africans coming at different times in the 60s, 70s and 80s.

BME groups are not all ageing at the same rate (Katbamna and Matthews 2007: 37). Mixed and Chinese groups are more youthful than Indian and Black Caribbean. In addition the people who were in the 50 – 64 group in 2001 will now be entering older age. They have spent most of their lives in the UK and Katbamna and Matthews 2007 note that they are likely to have different aspirations and expectations from the ‘current generation of older people’.

Within Bangladeshi and Pakistani communities men over 65 outnumber women. In the White group women over 65 outnumber men. There are financial implications for women who are likely to be widowed before they reach pensionable age.

Another way of looking at the information available is presented by Gunaratnam et al 2008. Referring to Office for National Statistics data, they noted that 9% of the Black Caribbean and 6% of the Asian Indian groups were 65 and over. This compares with a figure of 16% for White British people. By 2051 the figures are expected to increase to 30% for Black Caribbean, 21% for Asian Indian, 20% for Chinese and 29% for White Irish groups, whilst the White British population is estimated to get to a proportion of 27% being 65 and over.

The same analysis identifies the fact that over 65s from BME groups had poor perception of their general health. The ‘rates of limiting long term illness were worryingly high’ (ibid, page 38). There are likely to be higher levels of disability in old age within BME communities. This could lead to a high level of need for health and social care within those communities in comparison with ethnic majority people. Moffatt and Mackintosh 2006: 7) referenced several studies which demonstrated the links between self-reported health status and long term mortality and use of health services. Quoting Fitzpatrick, J, Jacobson, B, and Aspinall, P 2006 they note that Pakistanis and Bangladeshis recorded the highest level of ‘not good’ health in every region.
In addition, they note that research had identified a health penalty for those who had experienced racially motivated verbal abuse in comparison with those who had not experienced racial harassment (ibid, page 7).

Katbamna and Matthews 2007 refer to Evandrou 2000 who created an index of multiple disadvantage that confirmed that ‘just under half of Pakistani and Bangladeshi older people experienced medium or high levels of deprivation, compared with one fifth of the majority white population’ (page 5). Additionally, Warren and Britton 2003 (Katbamna and Matthews 2007: 6), showed that ‘Black African, Black Other, Pakistani and Bangladeshi families were disproportionately income-and asset-poor and were much less likely to have a safety net in times of economic adversity ....’ Further ‘[T]he cost of caring and providing for older families members is likely to be substantial and is generally considered a non-negotiable responsibility – particularly, but not exclusively among South Asians (Warren and Britton in Katbamna and Matthews 2007: 6).

These points, taken together with the fact that many BME people live in inner city areas where there are problems of deprivation and where ‘resources and services are particularly stretched’ (Katbamna and Matthews 2007: 38), will result in a major expansion in the needs of black and minority ethnic communities in the UK and consequently in the North East. The relatively small numbers of BME people who live in rural areas are likely to experience problems of social isolation along with any health and social care challenges. For both groups there are challenges that policy makers will need to take into account when planning social care service delivery. In relation to local authorities’ general duties to promote equality, this information indicates that they will need to give a clear and specific appraisal of the way that they ensure equality of outcome for BME communities.

4. Findings
Themes identified

‘Ethnic Elders: Access, Equality, The impact of government policy for black and minority ethnic elders’, Age Concern England (undated) identifies several key issues for BME older people:

- To increase access to information and advice and encourage service take up
- Service provision and support in order to ensure equitable services and deal with identified need or low service uptake
- Social contact a need for all older people and a particular need for BME older people as they do not feel comfortable accessing mainstream service provision of day centres and lunch clubs
- Supporting independent living and ensuring BME older people get the support that they need to live independently
- Healthy ageing projects to ensure that older BME people’s care and health needs are addressed coherently
- Consultation and hearing the voices of older BME people, as with other older people it is important to offer appropriate ways for views and experiences to be fed back to service providers and policy makers
- Recognising that older people are a valuable resource for the whole community and developing ways of encouraging dialogue across age, gender, ethnicity and nationality and cultures
A number of these themes were present in one form or another in the interviews and will be used to help present the information gathered from the two focus groups, interviews and attendance at meetings.

The study aimed to look at the issues of Personal Assistants, Advocacy and Commissioning within the social care process. The information gathered on these topics will also be presented below.

4.1 Information and Advice / Awareness of Services

It was particularly noticeable that participants in the Tees Valley Chinese Community Centre (TVCCC) in Middlesbrough said that this was the first time that they were aware that they had received comprehensive information about the social care system, the availability of Chinese translations and the assessment capital cut off levels before a person has to contribute to the cost of social care.

In all of the interviews and focus groups held with BME community members, it was clear that the efforts being made to inform them about the adult care services available to them were not working. The members of the Tees Valley Chinese Community were extremely grateful for the information that was provided during the study process and were, it seems, completely unaware that the guides and briefings were available in Chinese.

This group were also concerned about the need to make contributions to the cost of their social care and were not aware of the savings threshold of £23,250. The group did seem to find the proposals of the Dilnot Commission, of a maximum £35,000 contribution acceptable, but wanted further information.

In Gateshead, there was a similar picture with local BME people saying that they were not aware of the services available.

As a separate exercise a telephone call was made to the number given for obtaining translations of the publicity information on social care produced by Middlesbrough Council. The response received was helpful but indicated that there were not many, if any, requests for translated information, particularly in Chinese. It is clear that the lack of awareness of the availability of the information results in a low uptake.

Despite the efforts being regularly made by local authorities to provide information to groups that are often described as ‘hard to reach’, in all of the interviews with BME individuals and focus group, there was a sense that the communities didn’t know what services were available to them.

There is the challenge that some people from South Asian communities may not be literate in their community language.

Finally, the TVCCC focus group were extremely clear that they did not complain. Firstly, they were grateful for the services that they received and, secondly, they didn’t like making a fuss. They, also, were not aware of the complaints processes and would raise any issues they had via the Centre Manager.
4.2 Service provision

A key part of the service provision received by the different BME groups in Middlesbrough, particularly for South Asian communities was the fact that there were five workers within the system who were themselves from ethnic minority communities. This enabled them to play a number of roles such as information and advice provider, translator, advocate and general encourager of uptake of mainstream services. They also played a role in supporting the development of specific services targeted at older BME people. However, it seems that with the pressures on budgets within the council four of them are no longer employed within the council or have changed roles in a way that has taken them away from providing the support to specific communities.

During the interviews with BME workers, the lack of awareness of service provision was identified as an issue with black and minority ethnic communities.

It is clear that, in all parts of the region, BME workers play a vital part in mediating service delivery to black and minority ethnic communities. They are a valuable resource and sometimes experience challenges from white colleagues who are concerned at possible differential and inequitable service provision to black and ethnic minority communities as compared with ethnic majority people.

The South Asian women’s focus group were clear that the difficulties that they had in understanding forms, challenging decisions or gaining access to services were resolved by contact with BME workers.

Moffatt and Mackintosh 2006 evaluated welfare rights service provision for older black and minority ethnic people in Newcastle upon Tyne and concluded that dedicated services along with community events (page 55) were useful ways of counteracting the low take up of benefits and raising awareness. This underlines the value of having dedicated staff from black and minority ethnic communities who speak a range of community languages providing services for those communities. They help to overcome the barriers that lead such communities to be called ‘hard to reach’. They also identified a value in producing materials audio materials and making use of media used by BME communities to get information disseminated. The dedicated services increased take up of benefits and led to an inflow of £422,056 in new and backdated benefits claims.

Participants in the TVCCC focus group expressed concern about the social care assistants provided for them. For one client with dementia, there was anger and frustration that the same person wasn’t providing care on a daily basis. They had to repeat themselves over and over again. This ‘induction’ process is wearing, and could create a negative response to the carer for a person with dementia.

The interview with the BME support worker identified an issue around going to public buildings. This relates to the specific South Asian toileting practice of using water rather than paper. If a public building’s toilets also had a jug of clean water next to the toilet pan, it would give an indication of a wider awareness of different cultural needs.

Local authority staff have a concern about the way that personalised budgets were managed by families. They believe that the money goes in to the family financial pot and that there is not a full recognition that it is there to meet the specific needs of the particular client. An example of this was when a client asked why they could not access a particular service. It became clear that the barrier lay with the family thinking that it was not appropriate.
4.3 Social contact / Supporting independent living

In the interview with a black and minority ethnic support worker in a third authority it raised specific issues around the assessment process and the resources allocated as a result. The worker noted that half hour time bands were used for the social care allocations. She felt that there was not necessarily enough time given for washing and toileting support for some Muslims that their project supported.

There had been arguments about using the shower, as older person preferred to have baths and had had a bath all of their lives. They were being advised to move to having showers. As the person was unfamiliar with this, they weren’t happy. The workers suggested that the social worker look at a way of introducing the idea to the client sensitively and looking at the idea of having only one bath a week.

The worker identified an occasion where their project supported a Muslim man who wanted care support to be able to attend prayers in a local Mosque five times a day. Initially, the need for this support was not acknowledged and the white social worker made a comment about the need that would then exist to let Christians get support to go to church. Apart from being irrelevant, the comment indicates that the social worker didn’t recognise that, apart from being a religious observance, the process of going to the Mosque also provided social contact and helped to break down social isolation. It might also be useful to provide similar support to older Christians.

One Chinese person using social care support found that the lack of communication between health and social care services meant that he was getting a nurse visiting him to give him his insulin injection at a time much earlier than his care worker was coming. As he needed to eat in order to get the injection, it wasn’t possible for him to get his insulin. This has a limiting impact on his independence.

Discussions in Gateshead highlighted the fact that there are no BME organisations set up specifically to support BME older people. However, this seems to be the case across the region. There was a concern that there were no BME staff available to explain the use of personalised budgets.

4.4 Communication

All of the authorities in the region have information available in English on their websites.

In Gateshead a key forum for communication with leading members of black and minority ethnic communities is the regular Wednesday afternoon drop-in sessions run by the Gateshead Visible Ethnic Minority Forum. It is widely used by voluntary and statutory agencies to communicate with a number of ethnic minority groups. There was, however, a sense that some participants felt that they were not being fully involved in communication on the issues impacting on their lives.

There is also a bi-monthly Diversity Forum chaired by the Leader of the Council held in the Civic Centre in the early evening. This does provide a forum for issues to be raised and it is clear that the representatives of ethnic minority groups attending feel able to present their concerns. It is not overly formal, but does not seem to be a space within which issues can be discussed in depth because of the size of the attendance and the constraints of time. This issue is also relevant to the topic of commissioning and discussed below.
An example of the difficulties that exist in relation to communication was observed during the research process when the voluntary organisation being visited was contacting an energy service provider on behalf of a client. The client was not able to communicate in English and the energy provider was not able to make use of an interpreter and, understandably, needed to go through an authorisation process to make sure that the worker had the authority to speak for the client. For such a short interaction getting hold of an interpreter would have been difficult. It is likely that, without the assistance of experienced workers, the issues for that client would not have been resolved and the arrears situation being dealt with could have escalated.

There is a strong preference in black and minority ethnic communities for face to face communication. This helps in building trust and can avoid the problems caused during telephone conversations.

4.5 Personal Assistants

A number of the interviewees acknowledged difficulty in recruiting Personal Assistants (PA) from black and minority ethnic communities. There is a concern about being seen as a helper for someone who is not well. In some South Asian communities there is a concern about confidentiality in using someone from the community who would be able to communicate in their first language. In Middlesbrough, Apna Services recruits local people and provides training and access to qualifications for them. One challenge of using family members lies in ensuring that the family member is fully aware of the protection, lifting and health and safety requirements of care work.

A number of interviewees noted that some relatives were coming to England to help care for relatives. However, this could result in difficulties with the immigration services and protracted legal cases to try to extend their stay.

Many of the Chinese community members in Middlesbrough didn't receive personal budgets and were cared for by family members, who, they felt, had their own pressures to deal with.

There was, at least, one instance of a client not clearly understanding their role as an employer. The payment and payroll functions of employing a PA are often provided by private sector organisations which are approved by the local authority, there is a need for training for people employing PA's.

4.6 Advocacy

Advocacy is an essential part of the mix of services for social care service users. As seen above, there are ways in which workers from BME communities with the language skills to communicate with those communities provide, to a small extent, advocacy for the people they serve.

Durham County Council's website has this definition of advocacy: 'Advocacy is helping and supporting someone else to speak up for what they want. Advocacy can be used to achieve better results for people receiving or seeking services'.

One advocacy interviewee noted the tension between maintaining independence and the sources of finance being often a local authority. The same interviewee also noted that since the legal decisions relating to Birmingham City Council's decision to cut its
social care, solicitors have become involved in providing support for work on advocacy.

Unpublished research on advocacy in London conducted by the Older People’s Advocacy Alliance indicates that there are problems in payment and support for the costs of advocacy. Some organisations had lost their contracts and had received assurance that payments would be covered from personalised budgets. However, the care plans being developed for clients didn’t include the elements required to replace the grant payments. So 90% of the cost was still being unmet in a number of cases.

There is a growing concern about the role being played by private providers. These concerns relate to the charges being made and the capacity of individuals to make informed choices about service providers. The costs of advocacy can vary from £25 to £55 per hour. This is more an issue where people are paying for their own services. One interviewee felt that there was a particular problem in Northumberland where many residents were asset rich, but cash poor. They don’t meet the eligibility threshold. So it is difficult for them to afford to pay for services. They need advocacy to help them make choices about the services that are on offer. This is a problem across all communities.

There is also a tension caused by the attitudes of medical and social work staff. They can have strong and close relationships with service users and, in some cases, believe that they are adequate advocates for their clients. However, the nature of their role in service provision and making decisions on care needs could result in conflicts of interest. This reinforces the need for independent advocacy.

In another authority, there are problems in relation to mental health assessments. The interviewee felt that the authority uses the phrase ‘intractable social problems’ to get around a mental ill health assessment which could then lead to needs that would have to be met from service budgets. There is a similar difficulty in the use of the phrase ‘reactive depression’. It is meant to indicate that the depression is not a primary illness, but an understandable reaction to the client’s circumstances. It was clear that the worker felt that these were ways of limiting spending from core budgets.

It should be noted that some advocacy organisations provide brokerage support. There is a danger in this, as indicated above.

4.7 Commissioning

Authority 5 has a significant number of people from black and minority ethnic communities living within its boundary. A senior manager, the Lead Commissioner (Older People) in Authority 5 met with BECON’s Chief Executive and the Policy and Representation Partnership researcher. The discussion led to identification of routes into provision for black and minority ethnic voluntary organisations to meet with existing providers of adult care services. This would provide a possible avenue for BME voluntary sector to establish sub-contracts with existing providers. However, the Transfer of Undertakings Protection of Employment (TUPE) regulations would have to be considered, as any organisation taking over delivery of an existing service is likely to be liable to take on responsibility for employing the staff currently providing that service. Black and minority ethnic voluntary organisations would need to take legal advice and proceed with extreme caution in cases where TUPE is factor.
The manager recognised that there was a need for capacity building for the BME sector.

The current level of ethnic minority take up of home care services in Authority 5 is:

- For 18 – 64 year olds: - 1.4% service users are Pakistani; 0.4% service users are Indian
- For 65+: - 0.5% service users are Pakistani; 0.2% service users are Indian.

These proportions are extremely low, and the information has to be taken with care as a number of people ‘decline to confirm their ethnic origin’.

In the course of the research, two ‘meals on wheels’ providers were contacted to explore the food options that were available for black and minority ethnic service users. Wiltshire Farm Foods which provides food for residents in Stockton provide a specific menu for BME clients. The offer includes 200 meals with 70 items for Caribbean, Kosher, Asian Halal and Asian vegetarian diets. The meals come in frozen form in single portions that need to be micro waved. The meals need to be booked 8 – 10 days in advance. However there was ‘not much call for them’. There was a clear indication that no one had ever asked for them. The reason for this was not clear, but may be due to lack of awareness of their availability as well as a low number of clients from the relevant groups.

Another provider Oaklands Foods didn’t respond to the message that was left on their system.

The Fair Access to Care Services guidelines make it clear that local authorities have a role in developing the market for care provision. This enables them to create routes to the market for smaller voluntary and community sector organisation. With the passage of the Public Services (Social Value) Act 2012 which requires public authorities to have regard to economic, social and environmental well-being in connection with public services contracts, there is hope for space for the voluntary sector to play a greater role in service provision. It is too early to say how the legislation will work. However, FACS guidelines indicate that there is a key role for the voluntary sector as part of a ‘whole systems’ approach to service and market development.

One organisation which had been providing meals for community members in a number of localities was concerned that their funding for this work was coming to an end. They had tried to engage the authority in the area concerned in a discussion about this. However, they had not had a response.

There seemed to be a low level of awareness of the Joint Strategic Analysis process among the groups that were met. In Gateshead there was an acknowledgement that staff were consulted but there was a feeling that communities weren’t effectively consulted. Further, there was a feeling that a recent opportunity for using ethnic minority community members or groups to increase consultation response rates was lost. This was contrasted with awareness of a situation in Middlesbrough which resulted in a high response rate as a result of using BME volunteers to conduct the research.

The research process did not uncover any organisations that have their costs met from the pooling of personal budgets. However, one organisation in Middlesbrough did have some of the costs of its drop in sessions paid for from the personal budgets.
of those attending. There was some uncertainty about the ability of the service to continue.

Finally, there was experience of a commissioning process for BME day centre in Middlesbrough. However, the tender was not awarded and the interviewees were not clear about the reasons for that outcome. It is thought that changes in the council’s finances was a factor in the decision not to proceed, as the council has closed all but one of the day centres that it previously supported.

Conclusion

It must be said that the issues faced by black and minority ethnic communities are the same, or similar, to those faced by ethnic majority communities. However, there is an additional penalty which arises as a result of social inequality linked to racism, which means lower income levels, and, in the long term, lower occupational pensions, or none, for black and minority ethnic communities.

The evidence of the Marmot Review is that there is a strong link between social status and disability free life expectancy, which is essential to a good quality of older life. The proportionate universalism approach recommended by the Marmot Review is sensible but might be difficult to introduce as resources become more restricted.

A fundamental value in all areas of work in the public arena is to ensure that there is equality and equity in service delivery. From some of the comments of white workers reported by interviewees, it seems that white works are concerned that the specific actions taken to meet the needs of BME older people result in discrimination against White British people and is unfair. However, the evidence is clear, there is an age disadvantage disproportionately linked to being an older person from a black and minority ethnic community.

In some cases this disadvantage is substantial: nine out of ten Bangladeshi and three out of four Pakistani households with at least one person aged 50 or more are in the bottom tenth of the income distribution compared with just over one-third of equivalent white English households ...Over half of Pakistanis experience social exclusion in two or more domains. These findings call for action from policy makers and, for those living in deprived urban neighbourhoods, this need is an urgent one. (Walker and Northmore, undated: 7 - 8)

At the same time, this does not mean that race and membership of an ethnic minority are synonymous with disadvantage and exclusion. The evidence shows a need for specific, not ‘special’, actions to be developed to tackle them. The notion of ‘special’ interventions can lead to a sense of inequity in relation to dealing with the problems experienced by White British people. Every older person deserves care which meets their specific circumstances. It is a driving feature of the choice agenda promoted by recent governments.

Effective communication is essential to making any change and the evidence of this work and others is that employing staff from within the communities being served is a key part of strengthening service provision. There is an expectation of staff from the same ethnic group and staff of the same gender, particularly among South Asian communities (Naina 2004).
Since the work done by Age Concern in assessing the issues in the North East (see Appendix 2), there has been little change. This work provided a blueprint for what needs to be done to make life more equitable for black and minority ethnic older people in the region. The reality is that, particularly as funding decreases, black and minority ethnic communities face a continued future of marginalisation resulting from well meaning, but inadequate, service provision and both direct and indirect racism.

Finally, this report has only scratched the surface of a major issue of concern. For example, more work is required across all of the regions authorities to identify the ways in which rural black and minority ethnic communities can be best supported as they age. There may be opportunities for social enterprises from within BME communities to be developed that seek to provide services to communities across the board and not just to BME communities. Some work on the feasibility of this would open up avenues for the black and minority ethnic voluntary and community sector.

Recommendations

1. Local authorities, along with central government, must invest in a high profile awareness campaign to make people aware of the changes to social care and the need to plan ahead (in line with the Dilnot Commission’s key recommendation 7, above).

2. In view of the low levels of awareness of services within BME communities, local authorities should seek to recruit suitably qualified and experienced staff from black and minority communities. However, in view of the financial constraints they are facing, it may be more cost effective to look at establishing service level agreements or some other form of contract with BME voluntary and community sector organisations.

3. With resources being reduced, local authorities should seek to establish shared services with other agencies (particularly those responsible for health and social care) that have similar black and minority ethnic communities within their boundaries. This would also lead to a more holistic service and reduce waste caused by poorly coordinated service provision.

4. In moving from grant to commissioned services, local authorities should ensure that the BME voluntary and community sector take part in programmes to develop contracting skills.

5. There should be an increased investment in advice and guidance service provision with a particular emphasis on voluntary sector involvement in its design and delivery (in line with the Dilnot Commission key recommendation 8, above).

6. Local authorities should work with existing providers to help build the capacity of BME VCS organisations to take part in the care sector supply chain.

7. Local authorities should work with training providers and black and minority ethnic groups to ensure that personal assistants from BME communities are available to service users from all communities.

8. BME voluntary and community sector organisations should ensure that they play an active part within the Joint Strategic Needs Assessment (JSNA) and review processes. The JSNA process provides one way for the needs and
views of BME communities to feed into the planning and commissioning of services within localities.

9. BME VCS organisations should make use of any opportunities to develop their capacity and become registered as providers within commissioning processes.

10. There is a need to ensure that the isolation experienced by BME people living in rural areas is mitigated by an increased awareness of their needs amongst service providers. Specific efforts should be made by local authorities to increase their awareness of BME people in rural areas and to make them aware of sources of appropriate support for their needs.

11. BME voluntary and community sector organisations should work together to establish viable bidding consortia which enable to reduce costs whilst maximising the quality of service provision to a wide range of ethnic minority communities.

12. There is an overall need for local authorities to ensure that all staff receive training that makes them aware of the specific variations within black and minority ethnic communities. Such training should be more than just training about cultural variety and should encourage staff to be creative and innovative in thinking about how different needs are met.

13. Local authorities need to find ways of making small inexpensive changes in the way that service provision and buildings are organised that make them more welcoming to different ethnic minorities and provide simple demonstrations that a variety of cultural needs have been considered.
References

Achieving genuine voice, choice and control for all: A manifesto for independent advocacy services in England & Wales
Age Concern 2001, Ageing Matters Ethnic Concerns: North East Seminar for Elders from Minority Ethnic Communities, Report of a seminar held on February 15th 2001 at The Old Assembly Rooms Newcastle upon Tyne

Age Concern England Research and Development Unit (undated), Ethnic Elders: Access, Equality, The impact of government policy for black and minority ethnic elders, Age Concern England

Begum, Nasa 2006, Doing it for themselves: participation and black and minority ethnic service users, Social Care Institute for Excellence and the Race Equality Unit

Community Action on Health January 2012, “Time and People that we don’t have” Working With the Voluntary and Community Sector: the views of GPs in Newcastle upon Tyne

Community Action on Health March 2012, “My body, my life” Choice and Control: views of patients, carers and the public in Newcastle upon Tyne

Dilnot, Andrew 2011, Fairer Care Funding, The Report of the Commission on Funding of Care and Support in England, Department of Health


Katbamna, Savita, Matthews, Ruth 2007, Ageing & Ethnicity in England: A Demographic Profile of BME Older People in England, Age Concern England


Law Commission 2011, Adult Social Care: Final Report, Law Commission No 326, HC 941

Leach, Jeremy and Hanton, Angus 2012, Intergenerational Fairness Index: Measuring Changes in Intergenerational Fairness in the United Kingdom, Intergenerational Foundation
Livesley, Nat 2010, Older BME People and Financial Inclusion Report: The future ageing of the ethnic minority population of England and Wales. Runneymede and the Centre for Policy on Ageing


Moffatt, Suzanne and Mackintosh, Joan 2006, “It makes a huge difference” Evaluating welfare rights advice for ethnic minority older people in Newcastle upon Tyne, Newcastle University


Office for National Statistics 2012 a, 2011 Census: KS102EW Age structure, local authorities in England and Wales


Patel, Naina 2004, Summary Findings of the Minority Elderly Care (MEC) Project, PRIAE

Shared Intelligence 2008, Evaluation of the National Programme for Third Sector Commissioning: Consultation with BME Third Sector Organisations

DRE 2009, Mental Health Needs Assessment of Black and Minority Ethnic Communities, South of Tyne and Wear PCT

Walker, Alan and Northmore, Simon (eds) (undated), Growing older in a black and minority ethnic group, Age Concern

Ward, Sue (Editor) 2009, Mental Health Needs Assessment of Black and Minority Ethnic Communities, South of Tyne and Wear PCT


We Were There 2006, Ministry of Defence

**Websites**


http://www.ons.gov.uk/ons/dcp171776_290558.pdf
APPENDIX 1

Question / Topic Guide

General
What examples do you have of things that work well?
What do you like about the services that you receive?
What do you like to see changed?
What contact have you had with the local authority?
What information do you get around personal budgets?

Individuals
What services are you receiving?
What role does your family play in supporting you?

Organisations / Groups
What services do you provide?
Do you know about the Joint Strategic Needs Analysis process?
APPENDIX 2
Ageing Matters Ethnic Concerns: North East Seminar for Elders from Minority Ethnic Communities”, Age Concern, 2001

On 15th February 2001 in The Old Assembly Rooms, Newcastle upon Tyne, Age Concern organised one of its four seminars around the issues facing older black and minority ethnic (BME) people.

A total of 113 people took part in the event: 89 older people and 24 workers from a range of agencies providing services in Tyne and Wear.

The summary report produced following that event identified the following issues arising in a series of round table discussions:

- **Lack of culturally sensitive and appropriate services**
  - Lack of understanding / empathy from social / health service staff

- **Access issues**
  - Lack of information and awareness about existing services
  - Inadequate methods of communication – leaflets not adequate
  - Language barriers preventing elders getting existing services
  - Transport difficulties
  - Chinese older people lack the confidence to approach services

- **Attitudes**
  - A stereotype exists that assumes that Asian families do not need services for older people but most families need to go out and work
  - Racism and attitudes to elders
  - Life in Britain is different from that in India, Pakistan and Bangladesh and China. Many elders are isolated and it is difficult for some to understand the systems that exist in Britain.

The following quotes were also presented

- “Families need to go out and work, they cannot stay at home to care for their elders”
- “There needs to be a change to make things better”
- “Status and treatment of refugees is especially atrocious”

Recommendations

We need culturally appropriate services and support

**Minority Ethnic Drop-in Centre**
- Chat
- Read newspapers
- Get advice – Bus pass, Benefits, etc
- For a better quality of life
- In the City Centre with good transport – buses to pick up elders

**Day Care Centre for Asian Elders**
- Run and managed by Asian staff
- Culturally sensitive to their needs
• Removing isolation for men and women
• Sensitivity to dietary needs

Minority Ethnic Counselling
• Bartenders’
• Advice & information
• Funeral plans
• Advocates
• Escort service
• Wardens and alarms systems. Keep fit – special sessions in current facilities (own language). The list is endless

Home services must be culturally sensitive with staff aware of food and language needs
• Home helps
• Meals on wheels providing Chinese food and Indian food
• Chinese Home Care
• Cultural needs now and in future
• Need free services for retired people, the same free care services available to those who are over 80 in Scotland

“Food, for example in hospitals, is symbolic of alienation – there are many ‘symbols’ like this in society, through lack of culturally appropriate support; ‘systems’”

We need culturally sensitive housing, residential and nursing care
• Asian Sheltered Accommodation in a safe location – near Asian communities
• Design, size and location to be discussed and decided by elder people
• Wardens – to speak Asian languages
• Asian Nursing Home
• Asian staff. Language is a key barrier
• Food to be catered for the Asian palette (sic)
• Residential care for Chinese people

“It will help us to develop a community for the Asian elderly”
“It will help stop feelings of embarrassment”
“Sometimes it is difficult for families to bear the burden of caring for [the] very sick”
“When will we get meals on wheels services / Hope not in ten years”
“Then we can be a real group and organise ourselves so we can get better services with paid workers”

Increase access to services
• Improve access to health / social services’ existing services by ensuring greater awareness of staff at senior or management level
The ideal situation is to employ staff who can communicate
• Place of prayer and places for education / training opportunities. All community festivals should be celebrated emotionally
• Attitudes could be improved through better media coverage
• Involvement of ethnic minority elders in the development and planning or services
• Interpreters are needed especially at doctors’ surgeries

Information and advice
• One-stop Advice Centre for Ethnic Minority elders with information translated into appropriate languages. This should include information about services available such as benefits, health services, doctors, travel, solicitors, other professionals and details about interpreting services

Transport
• Free transport services for older people
• Free service for those who do not live locally, to travel to religious Centres and by Asian grocery
• Escort services for hospitals and health appointments
• The booking of care transport and services can be written in Chinese or guided by an interpreter

“changing buses in wet, cold weather is difficult because of multiple health problems, lack of mobility and fear of being attacked”

Lack of funding and resources
Asian elders have been consulted before and still do not see any changes; they need resources and finance to provide services
Community safety and security are big issues
Better police liaison so older people feel safe at night
Better coordination and cooperation between agencies and organisations
Greater co-operation and co-ordination could save money and provide better services, especially in health and social services

Innovation and research
There is a culturally diverse community in the North East, with specific needs. These could be further identified through local research
The recent report ‘Future Trends’ highlighted the demographic changes in the North East and the need for more information about expanding minority ethnic communities.
Delivering diversity and working for equality

Newcastle Office
34 Grainger Park Road
Newcastle upon Tyne, NE4 8RY
Telephone: 0191 2722339

Stockton Office
Parkfield Community Centre
Parkfield Way
Stockton-on-Tees, TS18 3SU

E-mail: information@becon.org.uk  website: www.becon.org.uk

A company limited by guarantee registered in England no: 4329582
Registered Charity no: 1094993

Supported by
The National Lottery
through the Big Lottery Fund

Policy & Representation Partnership