

Accessing adult social care: ethnic minority communities



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Report published in March 2026.

Summary and recommendations

Summary

Purpose of the project

This project aimed to better understand the views and experiences of people from ethnic minority communities in North Yorkshire when accessing adult social care, either for themselves or as family members and unpaid carers.

The project had two main aims:

1. Understand the barriers people face when accessing adult social care, including cultural, practical and financial barriers, as well as awareness of what support is available.
2. Identify positive experiences and examples of good practice, including community support, as well as areas to develop.

What we did

We carried out interviews and focus groups with 38 people. This included people who had accessed adult social care, people who had not, and professionals working closely with ethnic minority communities in North Yorkshire.

What care people need and challenges faced by unpaid carers

Many people said they needed help with shopping, cleaning, personal care such as washing and dressing, and getting to medical appointments. Unpaid carers said they wanted to care for their loved ones, but this often left them feeling overwhelmed and exhausted, especially when balancing caring with work and other responsibilities.

Community support and barriers to using it

People said they often relied on family, faith groups and informal networks for support. While some people found these networks helpful, others described barriers. These included family members not understanding conditions such as dementia or neurodiversity. People also said there are limited community groups for some ethnic minority communities across North Yorkshire.

Key barriers related to capability

Capability refers to a person's ability to access and use adult social care services, including their knowledge and understanding of how adult social care works.

- **Language difficulties:** Limited English can make it harder for people to seek support or understand what's available.
- **Lack of awareness:** Many people did not know about their rights or how to access and use adult social care.

Key barriers related to opportunity

Opportunity refers to external factors that affect access to services, such as the availability of support, language services and cultural understanding.

- **Cultural and religious needs:** Some people were worried that services might not respect cultural practices or religious beliefs.
- **Translation issues:** Poor access to interpreters or translated materials can make communication difficult.
- **Wider barriers:** Problems such as poor housing, lack of transport and digital exclusion can make access more difficult.

Key barriers related to motivation

Motivation refers to factors that affect whether people feel comfortable asking for support, including beliefs, values and past experiences.

- **Cultural expectations of family care:** Some communities expect family members to provide care without formal help from services.
- **Stigma:** Negative attitudes towards dementia or mental health conditions can discourage people from asking for support.
- **Fear and mistrust:** Past experiences can lead to fear of dealing with authorities.

- **Modesty and privacy:** Some people were worried about personal dignity and mixed gender care.
- **Reluctance to ask for help:** Some felt that asking for help was a sign of failure or weakness.

What people would like to see

- **Personalised care:** Those providing care and support should recognise and respect individual cultural, religious and personal needs.
- **Positive stories shared:** Real life examples of good care experiences may encourage others to ask for help.
- **Training to help staff better understand different cultures and communities:** Helps staff understand cultural and religious needs.
- **A more diverse care workforce:** More staff from different ethnic and cultural backgrounds.
- **Better use of interpreters:** Staff should know how to access and use interpretation and translation services properly.
- **Easier to understand information:** Information should be available in different languages and formats. This is sometimes known as accessible information.
- **Conversations in community settings:** Information should be shared through groups and faith organisations.

Examples of good care

We also heard examples of culturally sensitive care shaped around the person. Some people shared experiences where care was tailored to their cultural and religious needs and beliefs, with these preferences reflected in care plans. There were also examples of organisations working well together to provide effective support.

Recommendations

These recommendations are based on what people told us and aim to improve access to adult social care for people from ethnic minority communities in North Yorkshire.

These recommendations are for North Yorkshire Council, which is responsible for adult social care locally.

1. Deliver personalised and culturally sensitive care

- Ensure care is tailored to individual needs, recognising and respecting cultural, religious and personal preferences.
- Care providers should work with local communities to better understand what culturally appropriate care looks like and reflect this in how services are delivered.

2. Improve communication and access to information

- Make information available in a range of languages and formats, both digital and non-digital, so it is accessible to everyone.
- Ensure staff receive regular training on how to access and use interpretation and translation services effectively.

3. Promote positive care experiences

- Social care providers and community organisations should share real life examples of good care experiences through trusted local routes such as community groups, faith settings, local networks, printed materials, websites and social media.
- Use these stories to build trust, challenge fear and stigma, and encourage people to ask for support when needed.

4. Invest in training for staff to help staff better understand different cultures and communities and to increase workforce diversity

- Social care staff should receive training to build awareness and understanding of different cultural backgrounds and religious beliefs.
- Develop and share a practical toolkit covering care planning, gender related needs, translation and inclusive practice.
- Develop approaches to increase workforce diversity, including recruiting care staff from a wider range of ethnic backgrounds and with relevant language skills to better support local communities.

5. Strengthen support in the community

- Work with community groups, faith organisations and trusted local leaders to share information about support in familiar and accessible settings.
- Train and help group leaders feel confident signposting or referring people to services when appropriate.

6. Expand community groups supporting people from ethnic minority communities

- Expand local voluntary groups offering transport, befriending, help with appointments and shopping, and support for carers.
- Promote and copy peer support models, such as carer to carer and buddy schemes, to support people from ethnic minority communities.
- Support the development of new groups in areas with smaller or more isolated ethnic minority populations.
- Work with voluntary, community and social enterprise organisations and community connectors to reach people who are not linked to existing networks.

7. Support voluntary, community and social enterprise organisations to better understand different cultures and communities

- Develop a practical toolkit for voluntary, community and social enterprise organisations, giving practical guidance on communicating with people who do not speak English as a first language, understanding religious practices including dietary needs, and promoting groups in ways that feel welcoming and accessible.

How the recommendations address the barriers

People told us about a range of barriers that make it harder to access adult social care.

Barriers faced include things like language difficulties, limited awareness of services, concerns about whether care would respect cultural needs, and mistrust of authorities.

To help organise these barriers and show how the recommendations respond to them, we used a simple framework often used in health and social care called COM B.

A framework is simply a way of organising information to help explain why problems occur and what might help address them.

This framework helps explain what affects whether someone can access support.

It looks at three areas:

- **Capability** which means knowledge, skills and understanding
- **Opportunity** which means external factors such as services, systems and environments
- **Motivation** which means beliefs, confidence and past experiences

The table below shows how each recommendation helps address different barriers to accessing and using adult social care.

Recommendations	Capability (Knowledge and skills)	Opportunity (External factors)	Motivation (Beliefs and emotions)
1. Deliver personalised and culturally sensitive care	Builds understanding of cultural needs through community input	Embeds cultural practices in service design	Encourages conversations through respectful, relevant care
2. Improve communication and access to information	Enhances awareness through accessible, translated information	Provides interpretation tools and services	Improves confidence in accessing and using services
3. Promote positive care experiences	Gives knowledge of what to expect from services	Uses community/social media channels to reach people	Reduces fear/stigma, builds trust in services
4. Invest in training to improve cultural understanding among staff and to increase workforce diversity	Improves staff knowledge and cultural awareness	Workforce reflects local population, improving access	Improves confidence in accessing and using services

<p>5. Strengthen support that is available in the community</p>	<p>Builds confidence of community leaders to talk with others</p>	<p>Brings information/support into trusted, local spaces</p>	<p>Reduces mistrust and fear of formal services</p>
<p>6. Expand community groups supporting ethnic minority communities</p>	<p>Supports informal learning through peer models</p>	<p>Improves access via local transport, befriending, carers groups</p>	<p>Normalises seeking help, especially through peers</p>
<p>7. Support voluntary, community and social enterprise organisations to better understand different cultures and communities</p>	<p>Provides practical guidance to design inclusive services</p>	<p>Helps voluntary, community and social enterprise organisations promote culturally appropriate support</p>	<p>Builds trust in voluntary sector-led care options</p>

Introduction

Introduction

What is adult social care?

Adult social care covers a wide range of support to help people who are older, living with a disability, or living with physical or mental illness to stay as independent, well and safe as possible. It can include support in people's own homes, community settings or residential settings, as well as support for family carers.

Local authorities are responsible for assessing people's needs and, if they are eligible, funding their care. They work in line with the Care Act 2014, which sets out the duties and responsibilities of local authority adult social care services in England.

You can find information about adult social care provided by North Yorkshire Council here:

[Learn more about adult social care.](#)

Understanding the local picture

North Yorkshire has a small but growing ethnic minority population. The 2021 Census showed that 6.7% of the population is from an ethnic minority background.

This includes people identifying as Other White, which covers people from a range of European backgrounds such as Polish, Romanian and other nationalities. This is the largest ethnic minority group in North Yorkshire at 2.8%.

The largest non-white ethnic group is Asian, Asian British or Asian Welsh at 1.4%.

As part of its work to make sure services are accessible and fair for all communities, North Yorkshire Council reviewed referral data for adult social care. This showed that 3.1% of referrals were from people from ethnic minority communities, compared with 6.2% of the adult population.

However, the ethnic minority population in North Yorkshire is, on average, younger than the White British population.

Referrals to adult social care are more common among older age groups.

When looking only at people aged 18 to 64, there was equal representation, with 6.3% of referrals coming from people from ethnic minority communities.

As these communities grow older, referrals for older people may increase. North Yorkshire Council wanted to better understand what sits behind the data and to build an evidence base to help ensure services are accessible and effective for everyone who needs them.

What existing research tells us

Before this project began, North Yorkshire Council reviewed published research¹.

This found there was limited research directly relevant to the questions the council wanted to explore, especially in rural communities in the UK.

The research highlighted several important issues:

- Difficulty navigating health and social care
- the importance of trusted relationships
- different cultural understandings of health and social care
- low awareness of support available in the community
- the importance of culturally appropriate support, including understanding family roles and gender issues
- language, literacy and communication barriers
- the cultural understanding of the social care workforce

The research review also identified useful guidance on increasing involvement from ethnic minority communities in health and social care research².

¹ Selected results (primary research) of a search on social care and ethnicity. Sources: Medline, Embase, CINAHL, Social Policy and Practice, PsycINFO, HMIC, ASSIA, AMED, Web of Science, Google Scholar, AgeInfo and forward citation searching of Greenwood 2015

² Farooqi, A., et al. (2022). **Developing a toolkit for increasing the participation of black, Asian and minority ethnic communities in health and social care research.** *BMC Medical Research Methodology* **22**(1): 17.

Aims of this project

Healthwatch was asked by North Yorkshire Council to carry out this project to better understand the views and experiences of different ethnic minority communities in North Yorkshire when accessing adult social care, whether as the person needing support or as a family member or unpaid carer.

In particular, the project aimed to:

- understand whether there are barriers to accessing adult social care, including cultural, practical and financial barriers, and awareness of what support is available
- identify positive experiences, examples of good practice and areas to develop

Why this work matters

This work helps build a clearer picture of how adult social care is working for people from ethnic minority communities in North Yorkshire, and where it needs to improve.

It also supports local efforts to make sure care is fair, accessible and works well for everyone.

How this work links to North Yorkshire Council's plans

North Yorkshire Council is responsible for making sure care is fair, accessible and works well for everyone. This includes meeting its legal duties under the Equality Act 2010, which requires councils to understand and address differences in people's experiences and outcomes.

The council has set out its approach through its [equality, diversity and inclusion policy](#), which explains how it works to provide services fairly for all communities.

It has also published its [equality duties](#), including equality objectives for 2021 to 2025, with a commitment to identify and address inequality in outcomes for people from ethnic minority communities.

Alongside this, the [North Yorkshire Council Plan 2025 to 2029](#) sets out its wider ambitions for the county. This includes working more closely with communities, acting earlier to support people, and helping people to stay safe, healthy and live well.

This work adds to that by sharing people's experiences and helping to highlight where change is needed.

What Healthwatch did

What Healthwatch did

We used interviews and focus groups to hear directly from people about their experiences and views.

We spoke with three groups:

- people from ethnic minority communities who had not previously accessed adult social care
- people from ethnic minority communities who had experience of using adult social care services
- professionals from NHS, voluntary, community and social enterprise organisations, and independent care organisations working with ethnic minority communities in health or social care settings

We used open questions to guide conversations, encouraging people to share their experiences, views and suggestions for improvement in their own words.

Supporting conversations and reaching people

The questions were developed with North Yorkshire Council.

This included colleagues with expertise in social care and in supporting people from ethnic minority communities, as well as members of the council's Value in Racial Diversity employee network. This helped make sure the questions were culturally sensitive and easy to understand.

To support understanding, participants were given translated information sheets explaining what adult social care is and the role of Healthwatch. These were developed with North Yorkshire Council and translated into relevant languages, including Pashto, Dari, Urdu, Bengali and Arabic.

To reach a wider range of people, we worked with trusted individuals, community leaders and volunteers to support conversations.

Training and support

Those helping with interviews and focus groups received support packs and optional training, which covered:

- how to handle people's information safely and get their consent, including recording and anonymising data
- an overview of adult social care
- how to use the conversation guide
- how to provide signposting where needed

We reached people by connecting with new and existing community groups, local voluntary, community and social enterprise organisations, and cultural associations. The project was promoted through email, social media and translated leaflets shared across networks.

Healthwatch staff, volunteers and North Yorkshire Council colleagues involved in the project also completed training to better understand different cultures and communities. This helped make sure the work was carried out sensitively and appropriately.

Challenges and limitations

Several challenges affected the reach and scope of the project:

- **Time constraints:** This limited how much time we could spend building relationships with some community groups. While we contacted a wide range of organisations, not all were able to respond or offer support because of capacity pressures or limited links with ethnic minority communities.
- **Geographical spread and isolation:** North Yorkshire's large rural area meant that people who were not connected to community networks, or who lived in more isolated places, were less likely to be reached.
- **How people identify:** We invited people who identified as being from an ethnic minority background. As not everyone identifies in this way, some experiences may not be reflected here.
- **Generational representation:** Most people who took part were from second or third generation backgrounds and were generally more confident speaking English, using digital services or navigating systems. Many were also supporting older family members, which means older voices may be underrepresented.

- **Language and translation challenges:** Interpreting support was essential in some focus groups, but it also brought challenges. Explaining what adult social care means, especially where there is no direct equivalent in someone's first language, sometimes made discussion more difficult. The quality and depth of interpretation also varied depending on the interpreter's understanding of social care.
- **Understanding of care:** Some people did not see their experiences as adult social care because of cultural views that care should be provided by family. This sometimes made discussion about formal services more difficult.

How we looked at the information

We reviewed what people told us and looked for common themes across their experiences. To help understand the different barriers people described, we used the COM B framework.

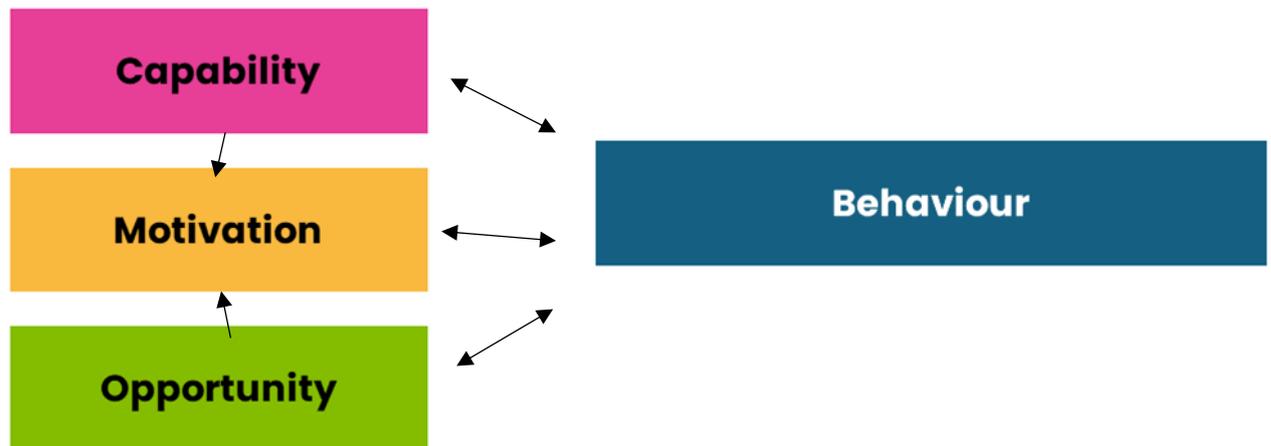
COM B is a simple way of understanding what needs to be in place for people to be able to use support or act. It is widely used in health and social care.

COM B stands for:

- **Capability** which means a person's ability to access and use adult social care, including their knowledge and understanding of the system. For example, people may struggle if they do not know what help is available or if they face language difficulties.
- **Opportunity** which means external factors that affect access, such as the availability of care, language support or cultural understanding.
- **Motivation** which means the beliefs, values, emotions and past experiences that affect whether someone feels able to ask for help. This can include mistrust of those providing support, cultural views about care, or feelings of pride and stigma.

Each barrier identified in the report was grouped under one of these three areas.

We also used this framework to show how the recommendations address different barriers. This helps explain how the recommendations can support practical improvement.



Who we heard from

Who we heard from

We heard from 38 people in total. The experiences shared reflected the views of people from a range of ethnic backgrounds, including:

- Syrian
- Japanese
- Indian
- Asian
- Afghan
- Nepalese
- Pakistani
- Bengali
- South Sudanese
- Nigerian
- Egyptian
- Jordanian
- Iraqi
- Bulgarian
- Turkish
- Polish
- Afro-Caribbean
- Chinese
- Romanian
- South African

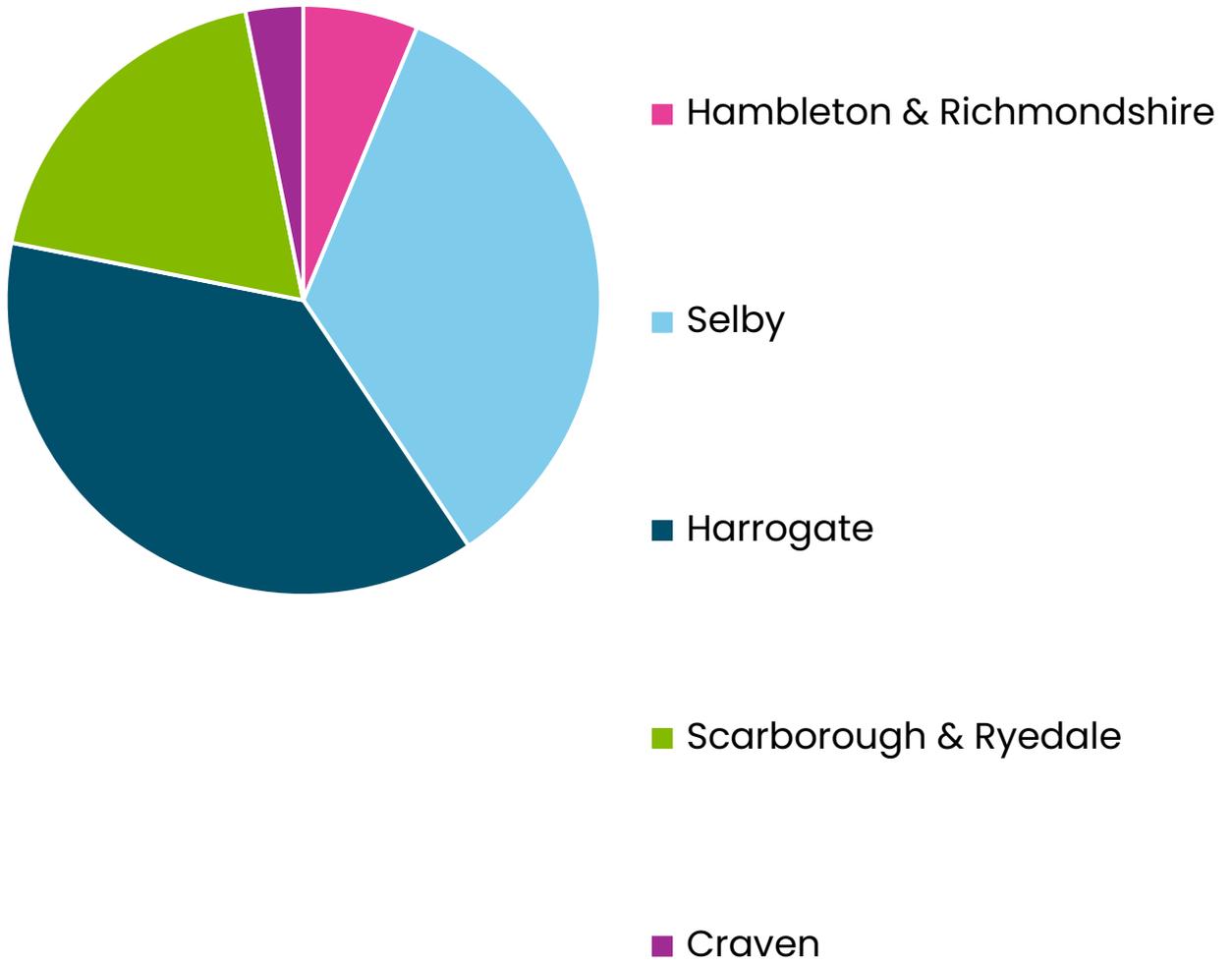
Those who identified as having a religion said they were either Muslim, Buddhist or Christian.

61% were male, 39% female, and ages ranged from 39 to 91.³ The graph on the next page illustrates the districts people were from.⁴

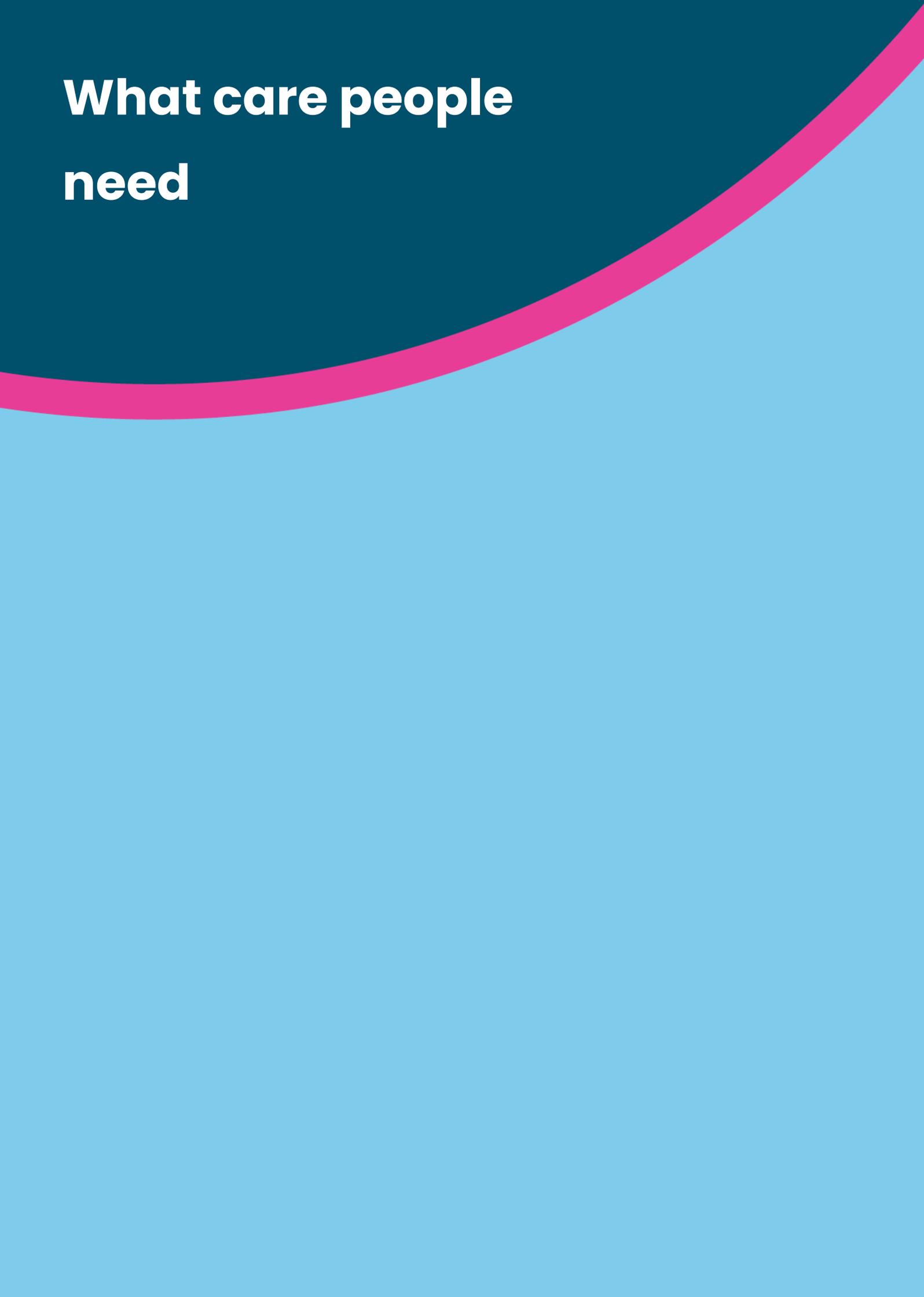
³ Please note these figures do not include the people from the focus groups or the professionals we spoke to as these details were not collected.

⁴ Please note the district information includes which district the professionals work in.

Where responses came from across North Yorkshire



What care people need



What care people need

We asked what type of care people need

People described many support needs. This included help with everyday tasks such as cooking meals, shopping, getting to medical appointments, household admin and attending family or community events.

Support with washing, dressing, using the toilet and taking medication was also mentioned. In some cases, people needed support to attend places of worship.

“Family carers help by cooking, cleaning and spending time with them. They take them out for walks, help with medical appointments and support them with letters and bills.” (Syrian participant, Muslim)⁵

“Because of limited mobility, they sometimes need help with dressing, shopping and travelling to places such as their place of worship.”

“Helping with washing, dressing and preparing food. Supporting them to move around the house, helping with shopping and taking them to family events. Also helping them manage medication.”

⁵ Where possible we have included the ethnicity and religion of the person who needed the care. In some cases, we do not have this information (for example, professionals spoke about a range of ethnicities and religions) hence why this information is not included after every quote.

The challenges of being an unpaid carer

The challenges of being an unpaid carer

People described both the positives and challenges of caring for a family member

It was often mentioned that help comes from a family member or someone in the local community. If the carer was a family member, we asked how easy it was to provide this care alongside other parts of their life.

People said caring for a family member can be positive and is something they want to do. However, it can become very demanding when there is no formal support in place.

Unpaid carers said they often manage alone and must adjust their own lives to meet the needs of the person they care for. This included changing work patterns and using annual leave to provide care.

Others spoke about the difficulties of balancing caring responsibilities with childcare, studies or their own health needs.

Living far from loved ones means some people have to make round trips around work and school runs. Others said that although they want to provide care, it can become overwhelming and leave them struggling to keep up with household tasks, feeling isolated and having little or no time for themselves to rest.

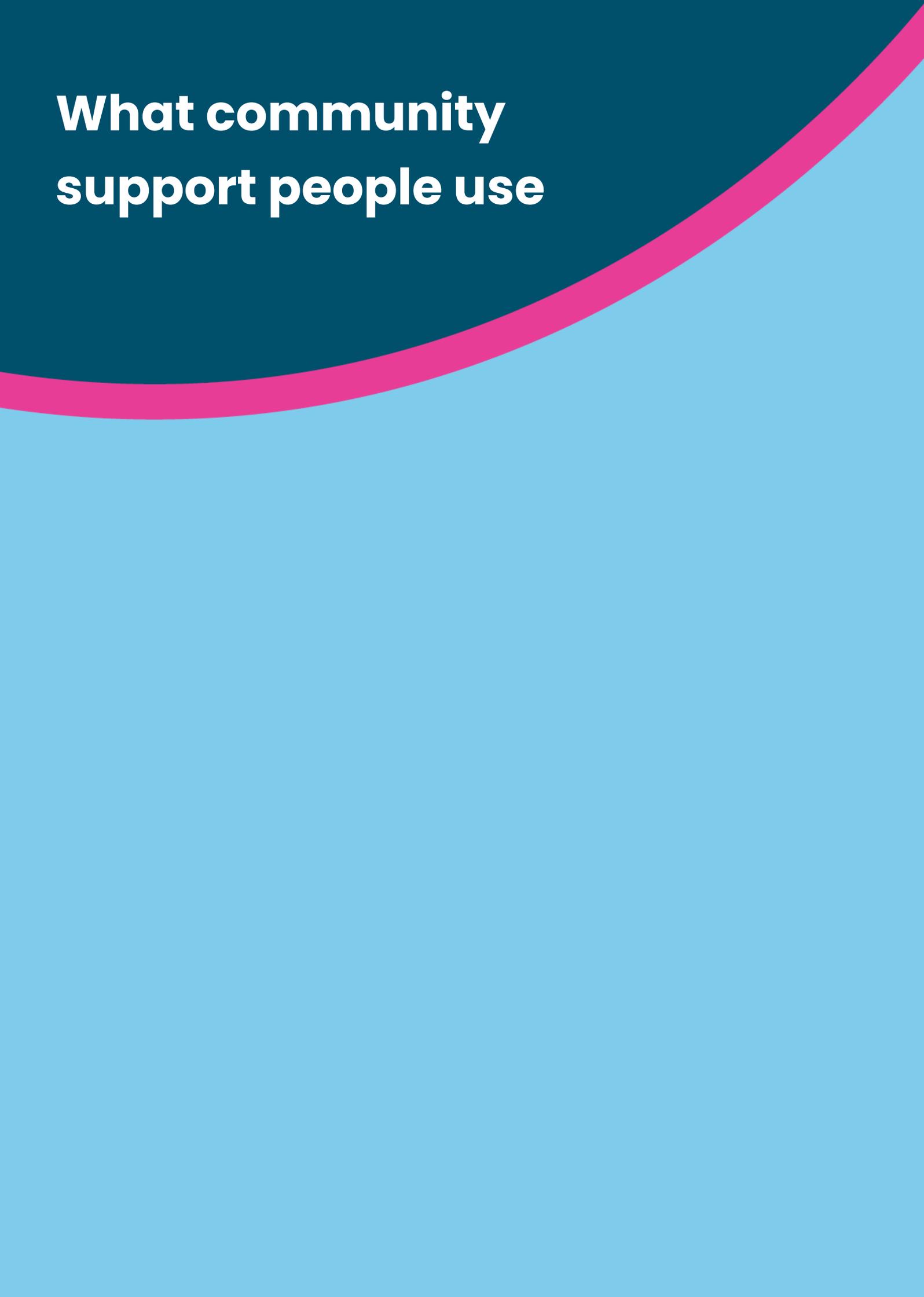
These experiences show the importance of understanding the barriers that may stop people from seeking or receiving help from adult social care and community organisations.

They also show the important role of trusted community groups and networks, which often provide vital informal support.

“Being a family carer can be positive if you manage your time well, but it can also affect your ability to work or study. I used to work part time and could help more, but now I work full time my time is limited. I often spend my annual leave helping and rarely get time off for myself.” (Syrian participant, Muslim)

“It is difficult because both son and daughter work and they have four children with busy routines, including school and other activities.” (Bangladeshi participant)

What community support people use



What community support people use

Many people rely on family, friends and community groups for support

Some people said that instead of using regular health and social care, they receive practical and emotional support from family, friends, neighbours and community groups.

Faith communities and places such as mosques and synagogues were also important sources of support.

One professional in Harrogate shared how members of a Jewish synagogue supported an older woman by spending time with her and sharing meals.

Others described faith communities as extended families.

“They support each other through the Nepalese Community Gurung.” (Nepalese participant)

“The Jewish family supported their mother-in-law. The local synagogue helped. People would spend time with her, share meals and look through old photo albums. It was amazing.”

Organisations also play an important role in supporting people from ethnic minority communities.

Support from City of Sanctuary was praised for being inclusive and shaped around the people they support. Professionals described how these types of organisations can help people navigate the system and form social connections when they move somewhere new.

“City of Sanctuary supports people with kindness. Local volunteers help families settle, for example helping with paperwork so relatives can join family members in the UK.”

Barriers to accessing community support



Barriers to accessing community support

Community support is valued but not always easy to use

Community support such as family, faith groups and local organisations was described as valuable. However, people also talked about barriers to using it.

One key issue was that family and friends do not always understand conditions such as mental health issues and neurodiversity.

While faith settings can be valuable places of support, some people also raised concerns linked to religious rules. In one example, a Muslim woman with dementia became distressed when she was separated from her son in the mosque because of gender rules.

“The mosque didn’t really make it more accessible for her to go, even though that’s her faith space. She had some behaviours of unmet need and had become very dependent on her son. She was always looking for him when separated. Because of gender segregation in the mosque, his presence wasn’t permitted where the women congregated and the female family weren’t here.” (Iraqi participant, Muslim)

The lack of community groups for some ethnic groups across North Yorkshire was another issue raised.

People said access to this kind of support is uneven across the county, with some areas having more established support than others.

While places like Leeds offer more culturally specific groups, smaller towns in North Yorkshire often have fewer options. However, professionals did note a growing Muslim population in places such as Selby, which may lead to better community provision in the future.

“Harrogate is not very diverse. When people move here it can be a big culture shock, and it can be difficult for them to build a community.”

“There is now a larger Muslim community in Selby, so there are more options than before.”

There are also voluntary support groups across North Yorkshire that can offer informal support. However, some people were concerned that if they attended these groups, they might feel excluded if they could not understand what was being said. Others worried that they might not feel welcome, for example if they wore a hijab.

“Sometimes it can feel difficult attending groups face to face. As a Muslim woman wearing what I choose to wear, I might wonder whether I would feel welcome.”

Barriers to accessing adult social care: Capability

Barriers to accessing adult social care: Capability

Knowledge and understanding

These barriers relate to people's knowledge and understanding of adult social care, including how to access and use it.

Key barriers include:

- language difficulties
- lack of awareness of rights and how to seek help

Language difficulties

One key barrier raised was language.

Not being able to express yourself in English, or understand English well, can make contacting those who provide care and support confusing and overwhelming.

One person said it was difficult to explain where their pain was when their English was limited.

Professionals supporting refugees and people who had experienced trauma said that accessing social care or talking about trauma is especially difficult when people do not have the words to explain what they have been through.

Older carers and older people needing care were more likely to struggle with English than younger generations, often relying on their children to translate.

“He was very scared because he didn’t understand what was happening. The language barrier made things much harder.”

(Syrian participant)

“Now my English is better I can explain what is wrong and where I feel pain. Language is very important when you move to a new country.”

“Accessing trauma and mental health support in another language is incredibly difficult.” (Syrian participant, Muslim)

“Language barriers can be a challenge, especially for older carers. It is important to help break down that barrier.”

(Bangladeshi participant)

Language difficulties can also affect confidence and willingness to ask for help. One support worker told us about someone calling them for help when they should have called an ambulance because they did not feel confident speaking English.

“One person called me for help when they should have called an ambulance. When I asked why, they said they didn’t feel confident speaking English. There can be a real fear around the language barrier.” (Professional supporting Polish residents)

People also raised the issue of those who speak English as a second language losing fluency as they age or develop conditions such as dementia. Some professionals said this can make communication even more difficult.

“Even people who speak English may use it as a second language. If someone develops dementia or declining memory, their ability to use that second language can become much harder.”

Lack of awareness of rights and how to seek help

Another issue raised was a lack of awareness about how to access adult social care.

This included not knowing who to contact, how to begin the process or what support and care existed.

“I wouldn’t know where to go or who to speak to. There is very little awareness of this service.” (Indian participant, Christian)

“I don’t know how to start the process of getting help with care.” (Bangladeshi participant)

People also raised wider difficulties in understanding how systems work in the UK. One professional described supporting a man who did not know how to navigate adult social care because he was unfamiliar with the process and was missing important documents.

“I worked with a Romanian man in the homeless shelter who had his ID stolen. We had to link up with the Romanian Embassy to try and get that sorted. I think the biggest challenges are not having the ID and paperwork, not understanding how services work in the UK.” (Romanian professional)

There were also concerns about a lack of information on how adult social care is funded. One professional told us that knowledge about self funding was limited in some Asian communities and said unpaid carers often did not know they could claim money or were worried about doing so.

“There is a lack of awareness about funding. Many people don’t realise that if you have savings above a certain amount you may need to self-fund care until that reduces.”
(Professional from a Bengali and Pakistani background)

“Some people don’t know they can claim support as unpaid carers. Even when they find out, they may feel worried about claiming it.” (Professional from a Bengali and Pakistani background)



Barriers to accessing adult social care: Opportunity

Barriers to accessing adult social care: Opportunity

Availability of care and support

These barriers relate to external factors that affect access to adult social care, such as the availability of services, language support and cultural understanding.

Key barriers include:

- concerns that care may not meet cultural or religious needs
- difficulties accessing interpreters or translated information
- wider barriers such as housing, transport and digital access

Concerns that cultural and religious needs will not be met

People were concerned about whether their cultural and religious needs would be respected if they needed adult social care.

Some worried that care services would not understand or take account of religious practices or dietary needs.

When people are nearing the end of life, they may want familiar food, routines and opportunities to pray in the way that matters to them.

People from Muslim backgrounds raised concerns that care provision might not meet their religious dietary needs, especially around halal food and fasting.

“I am planning now for my care as I worry that when I become ill or frail I want to be in the right place. I would not want to go into any care home as I want my religious beliefs to be understood. I want to be able to eat rice for breakfast and have all those comfort things I had when I was a child in my final years. When you feel unwell you want that for yourself.”

(Participant from a Japanese background, Buddhist)

“We wouldn’t want to be in a care home because of the food, culture, language and religious practices may not be respected. With meals being delivered there is a concern that it wouldn’t be Halal food.”

(Participant from a Syrian background, Muslim)

“People might not find care homes the most appropriate place to send their parents because there’s ‘cultural norms’. Dietary requirements like halal food options may not be available. Cultural preferences, such as celebrating special religious festivals like Ramadan or Eid may not be considered. There are also religious obligations where they must pray five times a day or they must fast.”

(Participant from a Bengali and Pakistani background)

In some communities, these concerns were so strong that people said they would prefer to avoid care altogether if they became frail or needed support.

For example, Nepalese veterans were said to prefer to return to Nepal rather than go into residential care in the UK because of concerns about food, language and cultural understanding. Similar views were shared by some people from Polish communities.

“If they needed social care, they would prefer to return to Poland.” (Polish participant)

“Some Nepalese veterans in Catterick tend to go back home to Nepal when they are finding it difficult to look after themselves and they have no family here. Some people prefer to go home than to go into residential care. They are concerned it wouldn’t have food they like to eat, the language spoken and a lack of understanding of the culture. Older Nepalese people have their own ‘Little Nepal’ within their homes.” (Nepalese participant)

Translation issues

Translation difficulties were identified as another key barrier when accessing or using adult social care services.

Tools such as Google Translate were described as not always reliable or accurate, with meaning sometimes getting lost.

One person described how the word for continence pad was translated as cushion, which caused confusion until carers found another way to explain what they meant.

“The carers used Google Translate to communicate. At one point they tried to explain a continence pad, but the translation came out as ‘cushion’, which caused confusion. He couldn’t understand what they meant by changing his cushion so they tried different ways to explain.” (Syrian participant, Muslim)

Staff also said that when interpreters are only available over the phone, body language and expression can be lost. This can make it harder to understand someone’s needs and feelings.

“Translation over the phone can miss body language and tone, which are important when discussing care decisions.” (Syrian participant, Muslim)

“I was working with a vulnerable family and we had a translator. I would explain what was going on and the translator would say five words and I know they hadn’t captured the nuance of what I was trying to say, such as the kindness and that we don’t want to put any pressure on you, but we’re here for you.”

Wider barriers (housing, digital access and transport)

Some barriers raised were not directly about adult social care itself, but about wider issues such as housing problems, poor phone signal, lack of internet access and transport difficulties.

These are challenges faced by many people, but they can be especially discouraging for people who are already hesitant to ask for help or face other barriers.

A person described how their temporary living situation was affecting their health and making it hard to think about adult social care.

“The main issue is that we currently live in a very small flat, with two bedrooms and there are five of us. I sleep downstairs in the living room, and it is not accessible for me. If the housing issue was sorted, then I would be in a much better position. I need a permanent home.” (Asian participant)

Issues linked to poor phone signal and digital connectivity in rural parts of North Yorkshire were also raised. Poor signal can make it hard to make calls, and some people said they could not afford a phone or internet connection. Others said they could not find out what help was available because they did not have access to the internet.

“The internet stops me getting help and understanding social care.” (Afro-Caribbean participant)

One professional told us how a small carers grant helped someone get online and stay in touch with family in Africa, which supported their wellbeing.

“A worker from Living Well completed a carer's assessment for this lady who cared for her husband and had no money. Through the carers assessment she managed to allocate her a carer's grant for £650 to cover the cost of her internet. Her connection was her way of maintaining her well-being and staying connected with her family in Africa.”

The importance of good transport links was also raised. One worker described how someone they supported from Malton started using the bus once they found out it only cost £2. This helped them access services in Scarborough and York.

“When they got information that bus only £2 so cheaper than by car they used it, they had never left Malton. Now she is going to Scarborough and York to access services and support.” (Polish participant)

**Barriers to accessing
adult social care:
Motivation**

Barriers to accessing adult social care: Motivation

Confidence, beliefs and trust

These barriers relate to people's beliefs, experiences and confidence in asking for support.

Key barriers include:

- expectations that families should provide care
- stigma around dementia and mental health
- fear or mistrust of services
- concerns about privacy and dignity
- reluctance to ask for help

Cultural expectations around family care

In some cultures, caring for older family members is seen as a personal and family duty.

Support is expected to come from within the family, and using formal care services can be seen as shameful or a sign of failure.

Placing a loved one in a care home can be heavily judged and may lead to guilt.

“It is difficult to balance work, raising a family and caring responsibilities. My brother and I used to look after my father between us, but it became very difficult. In our culture, asking for outside help is frowned upon because caring for family is seen as our duty, but we knew we needed support.” (Syrian participant, Muslim)

“There is a big stigma around putting a family member into a home and not looking after them yourself. That is a very strong feeling in the South Asian community because family is so important. There can be a real sense of shame about putting a loved one into a care home.” (South Asian participant, Muslim)

In some cases, the caring role was clearly expected of certain family members, such as daughters or daughters in law.

People told us about women giving up jobs and careers to care for relatives because this was seen as their role. Others reflected that although family caring may once have felt more manageable, rising living costs now mean both adults in a household often need to work, making it much harder to keep up this caring role.

“Culturally, children would stay and look after their parents or, if the son was at work, the daughter in law would stay home, give up her career and care for the elderly parents. It should not be the case that highly educated people, who have gone to university and built careers, must give those up to become unpaid carers at home.” (Bengali and Pakistani participant)

“The daughter was the main carer and provided all of the care for her mum. There was a strong sense that this was her role as a daughter.” (Egyptian participant)

“Over the last 10 years or so, with the cost of living rising, both adults in the household often have to work just to keep things going. That makes it much harder for that cultural norm to continue.” (Bengali and Pakistani participant)

Stigma surrounding dementia and mental health conditions

Another theme was stigma and taboo around dementia and mental health conditions in some cultures and religions.

These conditions are sometimes not openly talked about and may be associated with shame or fear, which can stop people asking for support.

In some languages there is not an accepted word for dementia. One person said that in Urdu it may be described using words linked to madness. Another person spoke about working with a Nigerian family who believed dementia was linked to demons and wanted the person to be cleansed of evil spirits.

“In some languages, like Urdu, there is not an acceptable word for dementia. It can be replaced with words like ‘madness’, which are terrible and stigmatising.”

“One family I worked with believed dementia was linked to demons. There was an urge to have the person cleansed or rid of evil spirits. These beliefs can be deeply rooted, so we approach them with care, but it is crucial to build understanding.” (Nigerian participant)

In another example, a Chinese woman avoided support from adult social care because of the shame she felt about her husband’s condition.

“The family wanted his condition to be kept completely secret.” (Chinese participant)

“They tried to hide the mental health side of it and, because of the shame around it, she was kept at home.” (Iraqi participant)

Fear and mistrust of authority

Fear and mistrust of authority was another barrier raised.

This was especially mentioned in relation to first and second generation migrants who may have experienced corrupt or unsafe governments in their home countries.

One professional said some families had stepped back from services because the financial assessment felt too intrusive and sharing personal and financial information with authorities felt risky.

“Fear of authority is a barrier. I am third generation, but there is still a lot of fear, especially among first and second generation families, when dealing with authorities.

There is also fear around social services funding. People can be afraid to talk about money or being assessed for disability benefits.” (Bengali and Pakistani participant)

“I supported a family who were accepting of me, but they stepped back when they were referred to social services. They resented the financial assessment and were not willing to share the details. They did not have that trust to hand over all their financial information. The family was very wealthy and chose to fund it themselves and move into a care home, but they still felt the process was intrusive. When you come from a culture where governments are not trusted, that can really affect how willing you are to talk.”

Some professionals also described the need to build trust slowly, especially where people had experienced persecution or trauma.

“He had experienced terrible persecution and torture, so there was a real fear of authorities.” (Iraqi participant)

“Some families are deeply wary of authorities, including local councils, and will not even claim benefits they are entitled to. When it comes to social services, there can be real reluctance to come forward.”

Worries about modesty and privacy

Some people, especially those from Muslim backgrounds, said that men and women should not mix when care is being delivered. While third generation families appeared more open to mixed gender care, first and second generation families often felt less comfortable with this.

“Mixed gender care can also be a problem in that generation. It is less of an issue for third generation families, but for first and second generation families it can be quite significant.”

(Bengali and Pakistani participant)

“They were quite strict Muslims, so there were challenges around male workers supporting the wife and female workers supporting the husband and brother.” (Syrian participant)

“Another barrier can be religious belief, where men are not considered appropriate carers for women.” (Syrian participant, Muslim)

Some people also felt that inviting carers into the home would be a loss of privacy. Accepting help from someone outside the family could feel intrusive, and some people said they would not want strangers in their home.

“Allowing people from outside the family into the home can feel very vulnerable. It can feel like an invasion of privacy, and trust is a big issue when you are letting a stranger into your home.” (Indian participant, Christian)

“For cultural reasons, they did not want anyone outside the family to support him with that.” (Jordanian participant)

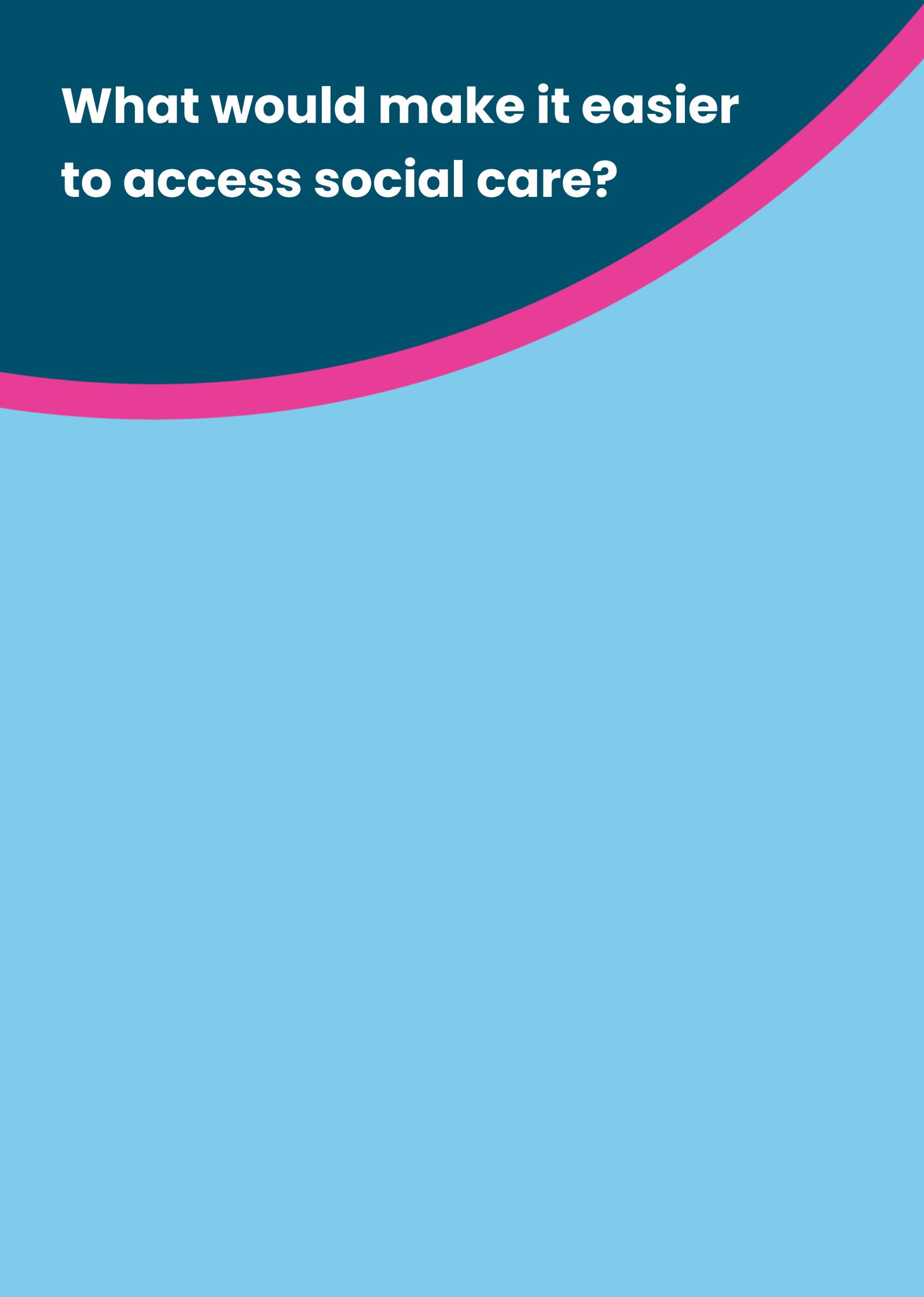
Reluctance to admit help is needed

Another barrier was reluctance to admit when help is needed. This was often linked to cultural beliefs about relying on themselves and staying strong. Some people also spoke about pride, and the sense that asking for help could be seen as a sign of weakness.

“A lot of people are very stoic, and there is a real sense of pride as well.”

“In some Asian communities, asking for help can be seen as a weakness.” (Indian participant, Christian)

**What would make it easier
to access social care?**



What would make it easier to access social care?

People were clear about what would help them feel more able to access and use adult social care.

These are the views and suggestions shared with us. They do not necessarily reflect what services already provide.

What people would like from social care

- care that is personalised
- positive stories shared to encourage people to ask for help
- training to help staff better understand different cultures and communities
- more care staff from a wider range of ethnic backgrounds
- better training for staff on how to access interpreters and translators
- information about support in different languages
- more awareness raised through community groups and faith settings

Ensure care is personalised

One suggestion was that services should ask people directly what matters to them, rather than assume or take a one size fits all approach.

People who had not used services wanted reassurance that care would be shaped around their cultural background, religious beliefs, communication needs and personal preferences.

This includes things such as food preferences, religious practices and gender-based preferences.

One professional said they supported an Indian family who sat on the floor to eat and that equipment designed to support sitting in a chair would not necessarily be right for them. Services need to make sure conversations about individual preferences are built into assessment and care planning.

“Ask the person what they want and what would help them. Treat each person as an individual and explore what matters to them. That may include cultural background as well as personal choices.”

“You do not want to see people in care homes being given food they would never have chosen in life. For example, someone Jewish being served something that does not fit with their faith, just because they have lost capacity. We should not say, ‘they have lost capacity, so it does not matter.’”

If someone has lived their whole life observing something, we need to uphold and respect that. It is about respecting the person and understanding the full picture of who they are.”

It was also highlighted that people need confidence to speak up about the care they want, but not everyone is able to do that. Lack of family support or cognitive impairment can make it hard for people to explain what matters to them. In these cases, services and professionals should take responsibility for asking about cultural needs rather than waiting for people to raise them.

“To be able to say, ‘actually, my culture matters here, I need it to be this person,’ takes confidence and awareness. But what about the people who do not have that, those who are isolated, without family, or facing cognitive challenges? Some people cannot explain what matters to them and they do not have anyone to speak up for them either. We need to be mindful of that in how services are delivered. If those issues are not being raised with us, we should raise them. Many people’s needs will go unspoken unless someone actively speaks up on their behalf.”

Share positive stories to encourage people to seek help

People suggested that sharing real life examples of support working well may help break down barriers to using adult social care.

Hearing about others' experiences, especially from similar backgrounds, may help build trust, reduce fear and challenge negative assumptions. It could also help show that care can be personalised.

Podcasts and videos were suggested as possible ways of sharing these stories.

“Give people stories of when support has worked well, for example through home care.” (Syrian participant, Muslim)

“As a care provider, we are looking at doing five-minute podcasts for staff. They will cover a theme of ‘one piece of advice’ for working in care. And have a person with multiple sclerosis talking about what is important to them, as well as a trans lady talking about their experience. So personal stories are a good way to demonstrate good practice.”

Training to help staff better understand different cultures and communities

Another suggestion was to ensure all adult social care staff receive training on different cultures to improve understanding and awareness. This could help staff feel more confident and better able to support people from a wide range of backgrounds.

It was also suggested that learning about each other's cultures can be a two-way process, where care staff learn about the culture of the person they are supporting and vice versa.

While some said this happens informally, people felt more formal training would help make this more consistent across North Yorkshire.

“Training to help staff better understand different cultures is another good idea.” (Bengali and Pakistani participant)

“The carers manage to communicate well, they are kind to him, and they are learning about each other's cultures.”
(Syrian participant, Muslim)

Recruit care staff from a wider range of ethnic backgrounds

People also suggested that having care staff who speak the same language, or understand the same cultural background, would help. This was seen to build trust and make communication easier. One person said that some communities, such as those from South Asia, seem underrepresented in the care workforce and that more targeted recruitment could help meet local needs.

“Recently, with care visas, people have come from a wide range of backgrounds, but I see fewer people coming from the Indian subcontinent compared with, for example, parts of Africa. That could be something to look at, having more carers who speak the same languages and can help people feel more comfortable receiving care.” (Bengali and Pakistani participant)

Staff need better training on how to access interpreters and translators

The need for clearer processes and better staff training on accessing translation and interpretation services was also raised. Uncertainty about how to book interpreters and who covers the cost can lead to delays and inconsistency. People said training would help make sure interpretation and translation support is used properly and consistently.

Professionals suggested that interpreters should be used for complex or formal conversations, while family members may sometimes help with short and informal conversations.

“There is some uncertainty around the process for getting an interpreter or translator. Things can go back and forth for a couple of days while people work out which budget should cover the cost. I do not think we are as confident as we should be in understanding the process before we offer support.”

Provide information about support in different languages

People said it would be helpful if information about adult social care was available in their own language. They wanted information on what support is available, how to access it and how funding works.

Suggestions for where to share this information included leaflets or posters in community spaces such as religious settings, libraries, community centres and a Citizens Advice bus. GP practices were repeatedly mentioned as an important place because most people are already registered there. Pharmacies were also suggested.

People also said any leaflets or materials should use plain language and avoid confusing jargon.

“Information should be available at GP practices or pharmacies in people’s own language.”

(Bangladeshi participant)

“A welcome pack could explain where to go and how to access services, with a QR code for more information that people can translate. GP practices are probably the best place for this because almost everyone is registered with one.” (Polish participant)

Raise awareness of services in community groups and faith settings

As well as sharing printed information, people suggested that staff should go to places people already use and feel comfortable in, such as community groups and faith settings, to raise awareness of services.

Religious settings such as mosques were mentioned as important places to speak to communities, especially at busy times such as Friday prayers when different age groups are present.

“Friday prayers are a good time to speak to people because the mosque is usually full, a bit like church on a Sunday. I do not think I have ever heard anyone come in and explain these services. At my local mosque there is a mix of younger and older people and just knowing that support is available would help.”

Others mentioned local community centres and suggested talks on health conditions that matter to the community.

One person suggested that a similar approach could work for dementia, where explaining the physical causes might help reduce stigma and encourage people to ask for support.

Another person talked about the value of working with local schools that already have strong links with families and, in some cases, staff who speak different languages.

“These conversations should happen in local community centres because they are already there in the community. It would also help to run information sessions there. Diabetes is a big issue in our community because our diet is often high in carbohydrates and oil. For example, in Pakistani communities that may be bread and chapatis, and in Bengali communities it may be rice. Some first and second generation family members do not always understand how carbohydrates turn into sugar in the body, so there may need to be more clear information about that too.” (Bengali and Pakistani participant)

**Where care is
working well**

Where care is working well

We heard positive examples of care working well for people from different backgrounds.

This included:

- care that reflects people's culture, beliefs and what matters to them
- care homes and carers supporting specific ethnic groups
- joined up support and continuity of care

Supporting people in ways that respect their culture and preferences

A range of positive experiences were shared where care was tailored to cultural and religious needs.

In some cases, care staff took time to understand daily routines and practices such as prayer.

Some professionals explained that they ask detailed questions about dietary preferences, end of life wishes, communication needs and religious practices.

Certain services use equality, diversity and inclusion checklists that include questions about cultural preferences, such as whether halal food is needed or whether there are prayer needs.

One positive example involved a Chinese woman with early dementia whose care plan was developed with her family. This meant they could explain that physical comfort such as hugging can feel inappropriate to her, so this was included in the plan.

“The care worker did ask about his routine, and that included prayer times.” (Syrian participant, Muslim)

“The family of a Chinese woman in the early stages of dementia helped develop her extra care plan. It included guidance on what to do if she became tearful or distressed. For example, staff were asked not to comfort her with a hug, as that could be seen as disrespectful.”

“Our care plans and assessments are tailored, even though only a small proportion of our clients come from ethnic minority backgrounds. We include sections on cultural awareness and dietary requirements. If someone is receiving end of life care, we ask about their wishes. For example, a Muslim person may want certain words said in Arabic before they die, or their body handled in a particular way. We build that into the care plan from the start and make sure the wider care team understands it. We have supported Catholic, Jewish and Hindu clients, and each situation is different. Even people who are not religious may still have specific wishes that matter to them.” (Bengali and Pakistani participant)

Another positive example involved flexible decision making around care. A woman had been in hospital for several months but could only be discharged once a culturally appropriate care package could be arranged.

Her dementia meant she switched between Bulgarian and Turkish mid-sentence, so her carers needed to speak both languages.

Rather than placing her in residential care, which was cheaper but could not meet her language and cultural needs, funding and council services worked flexibly to support a higher cost package of care at home. This helped protect her dignity and comfort.

Care homes and carers supporting specific ethnic minority groups in North Yorkshire

Professionals shared examples of care settings designed specifically for different ethnic communities. In areas with larger ethnic populations, such as Bradford and London, people described care homes that support South Asian or Caribbean communities. These models can be especially helpful for people living with dementia, as shared language, food, traditions and memories can create familiarity and comfort.

“In Bradford, where I worked on a South Asian dementia care project, there are care homes that cater specifically for South Asian communities. There are some with separate units for different groups. That is more possible in places with larger and more established communities. Colleagues in London have also seen care homes tailored to specific cultures, such as Caribbean communities. Shared culture, food, language and memories can provide familiarity, which can be very comforting for people living with dementia.”

Other professionals shared examples of international care models. For example, in Australia, some dementia care settings are organised into small homes with live in staff and tailored environments. Homes may be grouped by culture, religion or interests. The Netherlands uses a similar village model. A new facility in York called Wellen Court was mentioned as an example of a UK service drawing on learning from these models.

“Australia is ahead in this area. They have reformed their social care system and moved away from the traditional British model. They now have dementia care villages made up of small houses for eight or nine people, with live in staff and tailored environments. Homes can be based not only on culture, but also on shared interests such as the arts or farming, like the dementia village model in the Netherlands. They do not even use the term ‘care home’.”

One professional described how a home care organisation in West Yorkshire recruits carers from within the local community to support people from the same ethnic group. This allows carers to share a cultural understanding of values and religious practices.

Another professional who works for a home care service in Selby and Malton said, if possible, they aim to have a coordinator or staff member from a similar cultural background to help with initial introductions into the service.

“When we took on an Egyptian client, our coordinator, who is also Egyptian, made the first contact to help put the family at ease. I have done the same with an Indian woman because, although our countries are different, there are cultural similarities that can help build trust.” (Indian participant)

Examples of joined up support and continuity of care

Specific examples were shared where organisations worked well together to provide effective support. In one example, a Syrian family was already receiving help from the Refugee Council. With the family’s permission, a professional involved in their care arranged for someone from the Refugee Council to join the support team.

This person helped with translation and made sure the family felt understood and supported. In another example involving a Jordanian family, professionals stayed in regular contact over time, which helped build trust.

“I became aware that the Refugee Council was already supporting the family. With their permission, I asked someone from the Refugee Council to help with translation and wider support, and they became an important part of helping the family.” (Syrian participant)

“We stayed involved with the family throughout, and that helped build a stronger relationship.”

Conclusion

Conclusion

This project highlighted the complex challenges that ethnic minority communities in North Yorkshire can face when accessing and using adult social care.

Many people relied on family members for help, with relatives taking on unpaid caring roles. While family support can be valued and important, it can also affect carers' own health, wellbeing and financial security.

Participants described barriers including language difficulties, limited awareness of services, stigma around asking for help and concerns about whether support would be culturally appropriate. While some community support does exist and is valued, cultural barriers and lack of awareness can still stop people from using it.

Despite these challenges, we also heard positive examples of care that respected people's culture and what mattered to them. In these cases, support was tailored to people's cultural and religious needs and reflected in care plans. In some instances, organisations also worked well together to provide more effective and inclusive support.

The project also found that community groups play an important role in offering practical and emotional support in trusted and accessible settings.

These spaces can act as a bridge to formal care services by helping people understand what support is available, building trust and helping people find their way through the system.

North Yorkshire Council has welcomed the findings of this report and the experiences people shared. It has said it will use these insights to help shape its ongoing work, including developing action plans and working with communities to improve how care is provided.

This includes building on existing work and working alongside other organisations to make sure support is joined up.

Programmes such as **Swift**, which supports people who have moved to North Yorkshire by providing information, advice and connections to local services and community groups, are part of this wider approach. This helps people better understand how services work, access support earlier and feel more confident finding the help they need.

“Some people cannot explain what matters to them, and they do not have anyone to speak up for them. Many needs will go unspoken unless someone actively speaks up on their behalf.”

Both North Yorkshire Council and Healthwatch North Yorkshire would like to thank everyone who contributed to this project, including those who shared their experiences and the individuals, organisations and volunteers who supported this work. Your input has been invaluable in shaping this report and its recommendations.



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