

Improving migrant health in Newcastle upon Tyne (1997-2017): a grey literature review of third sector involvement

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Abstract

The aim of this paper is to provide an account of third sector attempts over 20 years to improve the health of migrant populations in Newcastle upon Tyne, so as to inform, encourage and enable services to be better equipped to improve migrant health and wellbeing in an increasingly uncertain future. Employing a qualitative content analysis of 'grey literature' source material, the findings are presented in terms of the facilitators and barriers to service improvement, as well as reporting examples of good practice through the years. Though the foundations of collaboration between the voluntary and community sector and health organisations were established mainly through government initiatives, continued partnership between the statutory and third sectors is vital to sustaining collaboration. Intermediary and advocacy roles in networking organisations are important in continuing the trust relationships that have been built up over the years. While the widespread increased competition for funding has led to communities resorting to their own resources, this paper highlights those historically documented community-led and partnership initiatives that are rarely described in published academic literature.

Keywords: literature review, third sector, migrant health

Background

A migrant can be defined broadly as a person who has undertaken 'movement from a usual place of residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons' (International Organization for Migration (IOM), 2019). More specific to the UK, migrants have been defined as all those who are born outside the UK, whether recent, temporary, settling, or settled for many years (Jayaweera, 2014). Out of the ten regions of England and Wales, the North East has the lowest population share of non-UK born residents. However, a 2011 Census Profile (Krausova & Vargas-Silva, 2013) identified Newcastle upon Tyne as the North East local authority with the highest number (37,579) and proportionate share (13%) of residents born in countries other than the UK. Historically, Newcastle, like Sheffield (Robinson *et al.*, 2007), is a city to which relatively small numbers of people from different countries migrated. The majority of such residents tended to settle in the West End of Newcastle (Foggie, 2014). Following central and eastern European (CEE) countries' accession to the European Union in 2004 and 2007, and associated migration to the UK (Fitzgerald & Smoczyński, 2017), Benwell, Elswick and Scotswood in the West End were identified in the 2011 Census as having the highest numbers of CEE migrants among Newcastle wards.

Although a national guide¹ has been developed, to assist inclusion of the needs of migrant populations in the production of Joint Strategic Needs Assessments as part of the commissioning process (Rose *et al.*, 2011), the topic of migrant health continues to be challenging (O'Reilly-de Brun *et al.*, 2015; Such *et al.*, 2017). Community engagement interventions are undertaken across a wide range of contexts and community-centred

¹ This guide was produced in 2011 by the Health Inequalities and Local Improvement team at the Department of Health and was originally hosted on the Local Government Association website (<http://www.idea.gov.uk/idk/aio/26070159>). This page is no longer readily available and may have been archived.

approaches to health are being promoted by Public Health England and the NHS (South *et al.*, 2015). However, evidence of successful community engagement with migrant groups is scant (Bagnall *et al.*, 2015; Jayaweera, 2014). The policy-driven move to the private, independent or third sector for health and welfare service provision was heightened in the face of increased austerity, as a result of the economic challenges posed by the financial crisis of 2008. In Newcastle and Gateshead, the voluntary sector has a record of working with migrant groups over many years (Newcastle Council for Voluntary Service, 2018). But the challenges and risks for this sector to continue to deliver services are great (Curry *et al.*, 2011). The aim of the literature review described here is to provide an overview of third sector attempts (including partnership across sectors as appropriate), over a period of 20 years, to meet the health needs of migrant populations in Newcastle. This account of recent history could inform, encourage and enable services to be better equipped to improve migrant health and wellbeing in an increasingly uncertain future.

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Aim

To document third sector involvement in improving migrant health in Newcastle upon Tyne.

Objectives of the literature review

- 1) To conduct a qualitative content analysis of grey literature that records work by third sector organisations seeking to improve the health and wellbeing of migrant communities in Newcastle upon Tyne.
- 2) To identify the barriers and facilitators in improving the health and wellbeing of migrant communities and individuals.
- 3) To identify and describe exemplar case studies of third sector involvement or initiatives aimed at improving migrant health.

Methods

Because of the regional specificity of the review, a narrative review rather than a full systematic review was conducted. The search plan involved consultation with content experts and snowball sampling of references in documents, followed by targeted hand searching of websites. Web searches accessed reports from Healthwatch Newcastle, the Angelou Centre (a Black-led women's centre), the Comfrey Project (improving refugees' and asylum seekers' health and wellbeing through allotment gardening, cooking and crafts) and online patient participation group reports from primary care providers. Search criteria are listed in **Table 1**.

The following local experts were given the aims and objectives of the literature review, and were requested to provide relevant documents, which were screened and selected according to the search terms above:

- 1) Vicki Harris (Network Coordinator) and Dr Ann McNulty (former CEO), Health and Race Equality Forum
- 2) Dan Duhin (Involvement Coordinator), INVOLVE North East Resource Bank
- 3) Lucy Hall (Equality and Diversity Lead), Newcastle upon Tyne Hospitals Trust
- 4) Christine Irklis (Project and Finance Lead), Riverside Community Health Project
- 5) Andy Lie (Project Leader, 1993-1998), Elswick Asian Project, Diocese of Newcastle.

Table 1. Search criteria.

Inclusion criteria	Exclusion criteria
Published or unpublished document reporting on health-related activities in Newcastle upon Tyne, UK	Document reporting on health-related activities beyond Newcastle upon Tyne
Dated between 1997 and 2017	Undated or not dated between 1997 and 2017
Available in English	Unavailable in English
Most current version of the document	Document in draft version
Contains references to ethnic minority or migrant health	Does not contain references to ethnic minority or migrant health
Health communication from Newcastle City Council or NHS organisations or third sector organisations	Memorandums; texts from social media

The type and number of source materials eventually used for the study were: annual reports (7); third sector initiatives (8); initiatives to improve community engagement (8); conference reports (18); research/project reports or evaluations (21); community feedback or consultations (16); and partnership events and initiatives (33).

Scope of the literature review

The third sector operates extensively across health and social care, working flexibly to address health inequalities and unmet needs in a wide range of communities. While recognising the social determinants of health, such as employment and economic deprivation, the study focused on health-related initiatives. These cover health promotion, signposting, and advocacy, including preventive and wellness support, on which much of the sector is focused (Curry *et al.*, 2011). In order to gain a more comprehensive understanding of voluntary sector involvement in health improvement for migrant communities, the review expanded to include a range of literature reporting on those voluntary groups that worked independently or in partnership, rather than relying solely on reports from the groups themselves.

In making decisions about inclusion and exclusion criteria, reports on voluntary groups that did not have a specific remit of addressing the health and social care needs of migrant populations (see **Table 1**) were excluded from the literature review. This is not to negate the excellent work that some organisations, such as the former Age Concern or HealthWORKS, have carried out, welcoming people from these communities to their activities, or which had some separate provision for selected groups within their overall programmes. However, large umbrella organisations, with specific aims and programmes of work to reach migrant communities in general, are included. Special mention should be made of the Riverside Community Health Project (McNulty, 2018) which over 35 years became well respected for their work with local people in an economically disadvantaged area, including working with relatively high numbers

of migrants, many of whom have settled in the West End of the city. Riverside supports local people across communities, working with an approach that avoids the risk of being gender and ethnicity blind (McNulty, 2017). Their focus on women, children and families has included the development of work to meet specific needs, for example Bangladeshi family support, Arab-speaking women's group, and more recently migrant families from central and eastern Europe, many of whom are of Roma background.

Also significant is the terminology used by services that seeks to meet the health and social care needs of 'Black, Asian and Minority Ethnic' (henceforth 'BAME'² even though the acronym BME has often been used in the sector) communities (see the **Discussion** section of this paper for further thoughts arising from the review findings).

Hard copy documents were scanned and together with those in electronic formats, were uploaded to NVIVO qualitative data management software (NVivo, 2012) for indexing and retrieval, coding and analysis. Sections of relevant textual references within documents were coded according to themes or topics that were developed to address the objectives of the review. There was also an analysis of whole documents to counter the potential fragmentation of data, and a recognition that texts are social constructs of their authors, of the audience (mainly community stakeholders) to which they are directed, and of the contexts within which they were written. This review is based on the key themes emerging from the data.

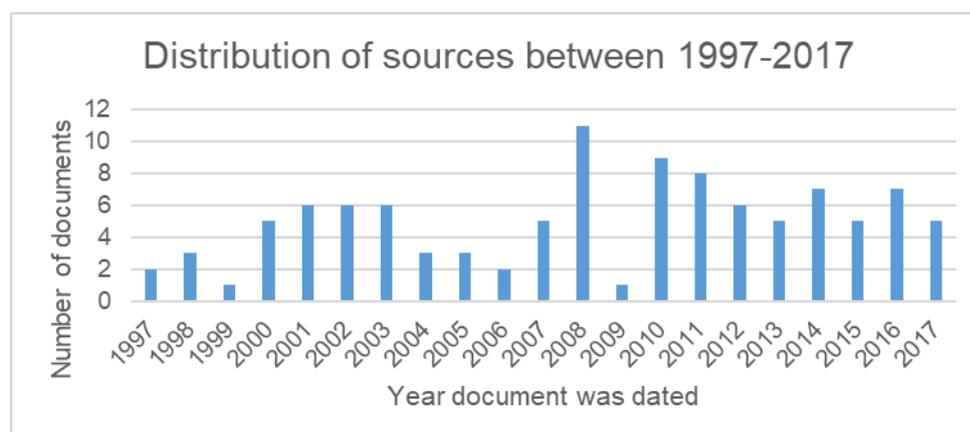
Findings

The figure below describes the distribution of the source material over the 21 years (1997-2017).

Thematic analysis

The themes in **Table 2** emerged from the coding of the textual sources and were used as the framework for the qualitative interpretation of the data to address the objectives of the project. The themes are listed according to the number of documentary sources where references to the theme are found, and the number of references indicates the frequency of references within the sources.

Figure 1. Distribution of sources (1997-2017).



² As an acronym, BAME is a contested term, but for want of a better practical alternative, has been used in the health and social care sector e.g. Advocacy Centre North's BAME Advocacy.

Table 2. Key themes emerging from the data.

Thematic codes	Sources	References
Cultural and community issues	65	256
Health promotion and information	60	152
Actions on behalf of BAME communities	58	208
Language issues and interpreting	57	202
Funding support and commissioning	55	137
Partnership working	50	102
Service providers – staff and training	45	131
Meetings and events	43	88
Community representation	40	62
BAME projects and services	35	80
Community engagement and support	35	66
Key leaders and workers	32	54
Community based research	31	62
Initiatives based on government agendas	31	58
Networking and shared learning	31	50
Racism, discrimination, crime and health	30	75
Fact finding about communities	25	43
Third sector organisations	19	26
Evaluations and reviews	17	32
Collective action	15	17
Primary Care and Hospital Trust initiatives	15	22
Health benefits from community participation	6	16

Findings from the review of the literature

Facilitators for improving the health and wellbeing of migrant communities and individuals

Voluntary and community sector (VCS) partnerships with health service providers and the local authority, in response to Government led public health initiatives, were often the main drivers and facilitators. Communication and consultation networks were established, particularly through the foundational work of Community Action on Health (CAH). Set up after a consultation with local people in 1997, this single-worker project was initially funded by the Health Authority and West Newcastle Primary Care Locality Group. It was not directly accountable to them, but to the community, supporting them to have a voice. The GP-trained community development worker's report 'Health and Race in Newcastle' (Crowley, 1997) explained how the CAH project put into practice the principles of community participation that appeared in the Government's Patient Partnership Strategy, and Green and White Papers at the time. CAH secured funding and adapted to the restructuring of the health service and demands of national policy initiatives, such as Health Action Zones (HAZs). These were established in 1998 (first wave) and 1999 (second wave), with a planned 7-year lifespan and clear priorities regarding the needs of BAME communities.

The Health and Race Equality Forum (HAREF) is a network of organisations and community groups working to reduce health inequalities related to ethnicity. Linking practitioners and BAME organisations and individuals since 2000, it grew out of and continued the work of the Newcastle HAZ Race Equality Area of Special Action (or ASA, part of the Tyne and Wear HAZ). The forum was initially one of the areas of work of the charity 'Newcastle Healthy City Project' (which started in 1994 as part of the World Health Organization's Healthy City Network). The project hosted the Race ASA, employed its coordinator, and supported the continuation of the HAREF network after HAZ funding ended³.

The Newcastle Health Improvement Programme (HImP, programmes as first mentioned in *The New NHS*, 1997 (Department of Health, 1997)) aimed to reduce inequalities in health through local NHS services working with community groups, voluntary sector organisations, and the local authority. CAH played an important role in this by developing meetings in order to address the needs of populations in different parts of the city. Responding to the (national) Acheson report of 1998 (Acheson, 1998), Newcastle Primary Care Group's strategy was for the development of equitable and sustainable partnerships, with CAH funded by it and by the Health Authority to facilitate the process, together with a reference group of local BAME organisations and individuals.

The work of CAH, Newcastle HAZ Race Equality Area of Special Action, and HAREF resulted in links, for example, to the South Asian community, the Chinese community, Islamic Scholars Health Forum, African Community Advice North East, and the Regional Refugee Forum. They also served to facilitate the collection and dissemination of health information, based on relationships of trust built up over the years, including community-based research and consultation, especially more recently for commissioning purposes.

In an evaluation of the work of CAH (Green, 1999), the two major achievements reported to date were its appraisal for the Community Health Council of the unmet needs of black users of mental health services, and its involvement in the development of the Newcastle Interpreting Service, based on results from their community consultation activities. By 2005, successes reported had also identified agencies with common agendas working together, sharing time and resources to achieve targets together, with the 'interweaving' of services that captured joint working.

Results from these networks and interactions over the years were:

- 1) Considerable awareness-raising among service-providers and reminders about unmet health needs of migrant communities.
- 2) Greater liaison between health providers and VCS providing information about health policy developments and public health alerts, for example swine flu (2010).
- 3) Employment of community development workers and health professionals from migrant or minority ethnic communities.
- 4) Race equality training for all health and social care professionals, and
- 5) Training of people in BAME communities, for example bilingual Health Trainers in Mental Health First Aid training (2008).
- 6) Established community relationships of trust and credibility, for example awareness-raising about sex and relationship education among BAME parents and faith leaders (2007) and providing information about access to a male infant circumcision service (2008).
- 7) Established partnership working between primary care providers and voluntary agencies, in particular HAREF, raising the profile of BAME health needs for mainstream health agendas.

³ Information from personal communication with Dr Ann McNulty.

- 8) Research, development, and planning including consultation work in particular by HAREF, for example in plans for the transformation and integration of health and social care services through the Better Care Fund (2014).
- 9) The greater use of information technology for research, intelligence and communication services, including access to resources such as online training. For example, a checklist was produced to support staff in ensuring their services are culturally appropriate (2013).

Thus, a tradition of partnership working with migrant groups was built up through local authority funded community workers. Often instigated by government health policy agendas, as well as by committed health professionals with particular expertise (e.g. in relation to diabetes), this partnership was established, and evolved, adapting to societal demands and the digital information and communication age.

Barriers to improving the health and wellbeing of migrant communities and individuals

These include the lack of political will and action to address unmet need, lack of relevant concrete actions and outcomes based on available evidence, exacerbated by social conditions of economic deprivation, racism, and isolation faced by migrants, and their increasing numbers and diversity. Health professionals might well perceive work with migrant groups as time consuming and 'a distraction' from their main focus. For example, feedback in a CAH feasibility report included 'very time consuming to deal with the needs of non-English speakers'. There were reported tensions between providing targeted services and mainstreaming services, and services not being sufficiently equipped to meet need. With the increasing diversity of BAME communities, rarely were there specifically targeted projects, but greater attempts were made at directing attention to the needs of these communities within the generalised service provision for all. However, by 2002 the needs of asylum seekers and refugees were being represented in the Asylum Seekers and Refugees Working Group, which was a subgroup of the Newcastle Health Partnership⁴. A specific service for these migrants was supported by CAH West, in the form of a surgery attending to their immediate health needs when they first arrive in the city, before registration at other surgeries.

In mainstream services, the Newcastle Carers' Project identified in 2002:

- a need for a change in the culture of health and social services towards adapting existing ways of working and engagement to encompass cultural and religious differences,
- more understanding of community workers' roles, and their need for more support in their roles, made more complex and demanding by the financial climate and new funding regimes,
- greater understanding of, and trust in, what the VCS could offer.

The economic downturn, immigration from CEE (2004-2007), and the arrival of refugees and asylum seekers, challenged the sustainability of services and existing knowledge about migrant communities. Also, the restructuring of the health service i.e. the merger of the two Strategic Health Authorities and clustering of primary care trusts (2006-8), led to challenges and changes in relationships and established ways of working. 'Community engagement' was the catchphrase, but a 2008 report on *Delivering Race Equality in Mental Health* identified that this was not sufficiently balanced by 'clinical engagement' i.e. from health professionals. In public health, initiatives tended to be a result of a professional working with the community to identify need, for example Supari (betel nut) addiction identified by a HealthWORKS health trainer, and a support group being established for the Bangladeshi community.

⁴ A group of different organisations whose aim is to improve the health of the population of Newcastle upon Tyne through partnership work across the city

While there were many benefits from the networks of relationships between health providers and migrant communities, these were far from reaching the aspirations of the 2004 White Paper on health and social care, to involve the VCS in commissioning and providing health services. Advocating for community organisations, a CAH report of GPs' views of working with the VCS (Community Action on Health, 2012) highlighted that in the previous few years, VCS organisations had increasingly to provide evidence, costings, and benefit analyses to meet funding requirements if the services they offered were to be paid for. Comments in a report on the VCS in Newcastle (Young *et al.*, 2014) noted that '*NHS and social care staff worry about risks, safeguarding, sharing information, quality of services, and have a low understanding of the breadth and depth of the voluntary sector offer*' (p.17). But from another viewpoint, '*what is really needed is greater community development within neighbourhoods, to ensure that communities look after each other*' (pp.17-18).

Austerity and further restructuring took its toll. The Health Improvement Service for Ethnic Minorities (HISEM, part of the Newcastle HImP in the late 90s), was decommissioned in 2017, leaving a gap in services for migrant communities. Following the closure of Newcastle's Healthy City Project in 2012, HAREF became an independent organisation with charitable status, before moving in 2017 because of lack of funding, to become part of Newcastle Council for Voluntary Services, with a remit that covered Gateshead as well as Newcastle⁵. Several charitable groups were closed, or their projects catering to migrants' needs ended, because of lack of funding. With the withdrawal of public funding and support, the need for communities to draw on their own resources increased.

Conferences and networking events

The organisation of city-wide conferences, to include the voices of disadvantaged communities, was a key strategy employed by CAH, which worked hard to encourage participation from marginalised groups. Notably, the 1998-99 CAH conference report made the point that every health issue was an issue for BAME communities, and the danger was that if these communities were treated separately, they could be marginalised. West Newcastle PCG in 2000 adopted a Race Equality Strategy based on this feedback, and as a response to the Government's agenda emphasising fair access to health services. CAH conferences were the vehicle for producing information and receiving feedback on topics (see **Table 2**) such as language issues and interpreting, cultural and community issues, the negative health impacts of racism and the city-wide 'Going for Growth' economic regeneration strategy.

The 2005, 2007, 2008 and 2010 HAREF conferences followed the pattern set by CAH earlier. This involved bringing together more than 200 people to include senior representatives from health care commissioning and provision, the local authority, local universities and VCS organisations. One example in a conference workshop was the use of 'stories' to exchange ways of understanding mental health between the African community and mental health professionals in primary and secondary care. Each workshop was informed by community feedback from previous CAH and HAREF conferences, as well as by local reports.

In response to the Health and Social Care Bill 2010, a consortium of GP practices serving West Newcastle (Newcastle Bridges Commissioning Consortium) held a conference 'Redesigning services to meet the needs of a multicultural community', with workshops attended by a range of organisations including from the VCS. Following the conference there were meetings organised between Bridges practice managers and local community development projects, networks and communities of identity and interest.

⁵ <https://www.informationnow.org.uk/organisation/connected-voice/>
<https://www.connectedvoice.org.uk/gateshead/>
 (Accessed: 16.12.2019)

Also, from the beginning of 2012, HAREF facilitated a regular quarterly Community Forum, for people in marginalised communities and protected characteristics groups⁶ to be able to inform local commissioning. With no further funding to organise conferences, HAREF instead contributed to conferences organised by Clinical Commissioning Groups. From 2016, HAREF bi-annual Network Meetings took the place of conferences, and they included 'action logs' detailing lists of actions to be carried out by the members, where they could sign up to fulfil some of the goals decided by the Network.

In 2015, a regional conference on 'Dementia and Caring in the Chinese Community' was attended by over 200 people. It was organised by the Chinese Health Group 'Wah Hong', in partnership with statutory and other CVS organisations, with presentations in Cantonese and aiming to support people in the Chinese community across north east England to live well with dementia.

Initiatives involving the third sector (not including consultation or networking events and conferences)

A range of initiatives by local voluntary groups to improve migrant communities' health and wellbeing through the years has been identified. The review could establish their existence but not exactly how long each lasted.

In 1997 the Elswick Asian Project Drug Education Initiative was an arts-based initiative in a primary school in the West End of Newcastle, part of a wider Church of England funded project working to build bridges with the South Asian community. In 1998-99 the Black Counselling Project, and Black Mental Health Forum and User Group campaigned for the mental health needs of Black communities. In 1999, Dekh Baal Asian Carers Project was formed to support Asian carers in the community. In the same year, the Black Family Health Project, a city-wide voluntary organisation was formed, working with and for Black and Minority communities, mainly Asian elders, to promote healthy living.

In 2003, Bondhon (bonding) group for Asian mothers, developed out of a piece of research by Dr Sayed Noor on the maternal mental health of South Asian women in the Westgate area of Newcastle: a project initiated by SureStart Westgate and New Deal for Communities. In 2008 'Sahelian' Women's Wellbeing Project was established, and based at the Pakistan Cultural Society premises, while in 2011 'Angelou Carers' – a forum and support group for BAME carers – was established.

The Chinese community were notably active in seeking help to provide for their community needs. In 2002, Chinese Complementary Therapy was a 3-year pilot scheme of free complementary therapy available to residents in West Newcastle, initiated by Chinese community representatives. In early 2006, members of the Chinese community approached HealthWORKS to help them plan and host the 2007 National Chinese Mental Health Conference in Newcastle. A *Dementia Carers' Guidebook* in Chinese and English produced with the help of healthcare professionals was launched at the conference. In 2007, they drew up a governing constitution for a Newcastle Chinese 'Healthy Living Centre'. By 2014 the Wah Hong Project began, organising the regional dementia and caring conference in the same year. Registered as a charity in 2016, the project aimed to address health and wellbeing issues for the Chinese community, together with the Chinese Healthy Living Centre and the South Mountain Luncheon Club, which have continued in their activities.

⁶ The UK 2010 Equality Act protects people with the following characteristics from discrimination, i.e. age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

There were several initiatives that came from service providers working with communities. Reported in 2005, one of the successes of HAREF's partnership working was a case advocacy subgroup, dealing with health and social care issues. Between 2000-2005 it was based at the Newcastle Advocacy Centre, which included South Asian and Chinese communities, health and community professionals, interpreters, and community organisations. In 2005-6, a multi-agency initiative helped increase the uptake of the flu vaccine across communities. In order to do this, a working group looked specifically at BAME needs, and involved community groups in suggesting ways to achieve improvement on uptake. It was led by the Clinical Nurse Lead from the Asylum Seekers Health Team, Newcastle Primary Care Trust. From 2006-8, as part of the national Delivering Race Equality (DRE) initiative aimed at mainstreaming race equality in mental health, through screening, signposting, networking, training and awareness raising, a 'Message on a Mug' campaign was organised. BAME mental health issues were highlighted through mugs distributed among service providers, using messages developed with input from the community.

In 2008 HAREF worked with Islamic scholars and the Diabetes Centre consultant diabetologist to address the health needs during Ramadan fasting of Muslim people living with diabetes. This was the first of several years of producing the annual Ramadan calendar with appropriate and trusted messages about how to manage diabetes during periods of fasting. In 2012-13 there were records of further partnership work, 'Demystifying Diabetes', resulting in 'important messages about diabetes for South Asian taxi-drivers'. In 2014, there was a similar leaflet, developed by a partnership involving HAREF, Newcastle British Bangladeshi Taxi Association and Newcastle Diabetes Centre, and distributed to taxi-drivers.

There were also examples of work among refugees, asylum seekers and newer migrants. In 2002, the Comfrey Project started as a pilot and was established as a charity looking to provide facilities for refugees and asylum seekers, to improve their wellbeing mainly through horticultural activities. In 2008, the Refugee and Asylum Seekers Health Action Group was established. From 2015-18, the Riverside Migrant Support Team focused on support for people who had moved from central and eastern European countries, as part of the Riverside Community Mental Health Project's overall approach to reducing health inequalities.

Discussion

This literature review is limited in many ways, most of all in its ability to record the full picture of community initiatives on the ground, and mainly because of the paucity of written records of action taken through community groups to improve migrant health and wellbeing. In addition, there were often no clear lines of demarcation between health and wider social issues, such as poverty alleviation, social deprivation, alienation, homelessness and crime that many communities experienced and that they therefore developed support groups (such as the Iranian Centre, Jewish Community Services and African Community Advice North East) to counter.

It is quite characteristic of the third sector in general that on account of funding constraints, time-limited projects come and go, and often there is not a paper trail or much documentation that is associated with initiatives, including those to improve the health and wellbeing of migrant groups. It is highly likely that religious organisations and universities have undertaken projects, or initiatives, or have participated collaboratively with other organisations. Apparently, there were only three instances of this occurring, as cited from the literature that was examined. (One was a drug education initiative by a Church of England diocesan project in the West End, and two were research reviews of projects by Northumbria University.) This small number is possibly because of the specificity in the terms of reference of this study of BAME 'health and wellbeing'. The community of interest being identified as 'BAME' extends to include refugees and asylum seekers, and indeed in recent years the term 'BAMER' has been adopted in some community development practice. However, this latter term has been avoided here because of the lack of usage in the literature studied.

With respect to health, people came together for mutual support, health information, health promotion and advice. In some groups, keep-fit sessions and cookery classes were organised. These activities could be classed as 'strengthening communities' and 'volunteer and peer roles' in the family of 'community-centred approaches to health and wellbeing' (South *et al.*, 2015). But many groups lacked the necessary personnel or infrastructure to record their activities and store these records, or if they did, they were not easily available for study. Despite requests made for the purpose of this review, reports to funders were also not made available, so secondary sources, which made reference to their work, were used wherever possible. A decision was made not to include projects working to address domestic and sexual violence because of the sensitive and confidential nature of their work, and their focus also related more to the consequences of crime than to health.

Since the late 1990s there have been projects initiated from communities themselves, often supported by local authority community workers, to support health and wellbeing. There has also been voluntary action, led by ordinary British residents, to address need in migrant groups. Some of these projects were church based, but a case in point is the Comfrey Project, organised to meet the needs of asylum seekers and refugees. There are also examples of action arising from community research, for instance with Bangladeshi women.

But an issue arising from the reports is the sustainability of these voluntary activities, particularly where they have not been developed with statutory funding and support. CAH, the Race Equality ASA and HAREF, with support from the Healthy City Project, laid the foundations for collaboration and partnership working with health authorities and service providers; and other newer networking organisations, such as HealthWORKS, built on these. Government health agendas provided the stimulus over periods of time, which primary care providers and health authorities responded to as part of their statutory duty. But successive structural and financial changes took their toll on this arrangement.

The lesson from all of this is that partnership between the statutory and third sector is key to sustainability. The importance of partnership is not new, as the Labour Government in 1997 devised compacts to set out the terms of partnership between the state and the third sector, even though the 'independence' of third sector organisations became contested (Martin, 2011). Partnerships may be built, but ultimately power imbalances remain, with control in the hands of commissioners and service providers, who hold the means of implementing change. Nevertheless, this review has identified intermediary and advocacy roles for networking models such as CAH and HAREF, with evidence that networks of communication and trust (Windrum, 2014) built up over the years provided the oxygen for good working partnerships. Outcomes of this relationship include race equality and diversity training, which has to be updated and ongoing, BAME staff were employed and capacity maintained to continually build up knowledge of newer communities, and the employment and support of community workers on the ground. Partnership working improved the task of health promotion and literacy, and enhanced preventive services in the communities they supported, while mainstream services were regularly informed of health and wellbeing needs, so that targeted interventions could be co-produced with community representatives, though not necessarily co-governed or co-managed (Martin, 2011).

The examples cited point to a degree of positive co-production between patients and providers, recognised as helping to meet the demands of preventive health and the management of chronic disease. Co-production and partnership working also benefitted from 'competence differentiation' (Windrum, 2014), in this case in relation to migrant health, drawing on the specialist knowledge of communities and cultures that was available. The 'third sector', as defined by New Labour (Baggott & Jones, 2014) includes not only community and voluntary organisations, but not-for-profit social enterprises, mutuals and cooperatives. However, actions from these latter groups were not very evident from the literature in relation to initiatives to improve migrant health. In an increasingly business-oriented and risk-accountable environment, perhaps there could be greater partnership with these actors in the future. But there are barriers

to be overcome, such as the need for trust to be generated as a result of previous interactions between stakeholders (Windrum, 2014). In addition, there are tensions between mainstreaming or targeting services, providing for the majority rather than minority patient populations, with the rationale of 'good health for all' needing a greater profile in the face of institutional racism.

The impact of the digital age has led to more IT intelligence (data gathering, analysis and presentation) such as baseline measures of unmet need, and web communications used in practice, for example the Health Signpost directory⁷ and the HAREF e-bulletin⁸. Digitalisation will be the shape of things to come (Pedersen & Wilkinson, 2018), with the possibilities of greater democracy as individuals from all communities become au fait with smart technology and social media, supported by organisations that are skilled and funded for the full benefits of digitalisation. Research in this area is lacking, and particularly as the widespread increased competition for funding has led to greater need for communities resorting to their own resources, this paper makes a contribution where 'community-led initiatives rarely make it into the literature' (South & Phillips, 2014).

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⁷ This directory was run by Involve Northeast but funding ended in 2016 and the information was taken over by Information NOW (<https://www.informationnow.org.uk/>) – accessed 16/12/2019 – information provided by personal communication with Dan Duhrin.

⁸ <https://www.connectedvoice.org.uk/content/40-services/haref/453-haref-bulletin>

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