

## Access to Health Care for Travelling Communities in the East of England

*Burrows, S.<sup>1\*</sup> Green, G.<sup>1</sup> Speed, E.<sup>1</sup> and Thompson, C.<sup>2</sup> September 2021*

<sup>1</sup> School of Health and Social Care, University of Essex

<sup>2</sup> School of Health and Social Work, University of Hertfordshire

\*Corresponding author: [sally.burrows@essex.ac.uk](mailto:sally.burrows@essex.ac.uk)

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## Summary

We consulted with Travelling communities in the East of England from March to May 2021 to find out if they would like to do some research around issues of access to health and care, to ascertain what issues were current and of importance to these communities, and to develop research priorities collaboratively. This project was an extensive user-led engagement exercise which worked directly with different sectors of Travelling communities in diverse parts of the East of England (Essex, Hertfordshire, Cambridge and Peterborough). The communities represented here predominantly identify as either English Romany Gypsy, Roma (from Romania, Slovakia and Czech Republic), or Irish traveller. Feedback from these groups about health needs and priorities has illustrated that although there are pockets of good practice, the relationship between Travelling communities and health providers continues to be characterised by poor communication and misunderstanding, including limited staff cultural competency and limited skill in ensuring patients understand. The COVID-19 led move towards more digital forms of health care is adding to already numerous intersecting barriers to access.

In 2021, Gypsies, Roma and Travellers in the East of England continue to experience significant health needs and barriers to accessing health care. Access to health care is problematised by a range of intersecting and compounding factors. There is a sense of fear and distrust in the system, and until more inclusive modes of communication are routinely offered, members of these (and other) communities are likely to miss invitations to health checks, immunisations and outpatient appointments.

In response to comments from East of England Travelling Communities and those who work closely with these families, the authors of the report recommend that researchers and policy makers make efforts to inclusively involve Gypsies, Roma, Travellers and health workers in finding out what works to improve access to healthcare together. We conclude that the continuing barriers to accessing health care would be best addressed through co-design, co-implementation and co-evaluation of interventions. Finally, we believe an urgent review of patient/staff risk assessments around attending Travellers Sites is required.

## Background to the Research Development work

The inequalities in health, and the difficulties that Gypsies, Roma and Traveller families (from this point referred to collectively as Travelling communities) can experience in accessing health care, are well-documented in the research literature (Alison McFadden, February 2018). Whilst individuals within Travelling communities can be healthy, overall health is significantly below that of the general population. There is high child mortality and life expectancy is 10-12 years below the average (Safa Abdalla, 2013) (Feder GS, 1993). There are also high levels of chronic illness and late presentation of these. Some of this is associated with poverty, high density living and poor access to facilities, such as adequate drinking water. Levels of engagement with the health service in terms of GP registrations, vaccinations, health checks/screening/ dental check-up rates have also been reported as low (Gordon M, 1991) (Pahl JM, 1984) (Walshaw, 2017).

We set out to learn more about East of England travelling communities' research priorities. This project was initiated by the School of Health and Care at University of Essex who are part of the National Institute of Health Research (NIHR) East of England (EoE) Applied Research Collaboration (ARC) Inclusive Involvement in Research for Practice Led Health and Social Care (IIRP). We partnered with Travelling Communities support organisations and other researchers at the Essex Human Rights Centre and at the University of Hertfordshire, and were awarded research development funding by the Foundation for Sociology of Health & Illness (SHI) . This enabled participants who were not in paid positions to be financially reimbursed for their time and expenses. This payment was aligned with the general principles of inclusive involvement which underpin this research theme from the [ARC](#).

Three organisations working to support Gypsies, Roma and Traveller communities agreed to be partners in this endeavour: Gypsies and Travellers Essex; Compass; and Oblique Arts Traveller Advocacy project. The Project Development Officer and Lead Nurse working within the Cambridgeshire County Council Public Health Traveller Health Team, and a researcher from the EoE ARC Prevention and Early Detection in Health theme also brought their questions, knowledge and experience to the project team.

## Participants and Methods

Gypsies and Travellers Essex, Compas and Oblique Arts Traveller Advocacy project, Public Health at Cambridgeshire Council, and the members of the IIRP theme at University of Essex all undertook interviews with local community members.

In total, we consulted 81 members of Travelling communities within the East of England about their health experiences and their priorities for research around access to health care. We spoke with more than 23 English Gypsies, 23 Irish Travellers and 19 Roma<sup>1</sup>, at least 21 were male, and at least 5 had lived in the UK for less than five years<sup>2</sup>. Compas charity were able to speak with Roma participants in Slovak and Czech, enabling people to take part in their native languages.

The conversations took place during the COVID-19 pandemic, between March 2021 and May 2021, by phone, Zoom, Whatsapp, and Facebook Messenger; some were one-to-one whilst others were held in small groups. These conversations identified five key themes; the socio-political context; travelling lives and home visits; direct and indirect racism; questions of cultural competency; and (in)appropriate communications. The report summarises the key findings in relation to each of these five themes.

### 1. Socio-political context

The social and political context clearly impacts upon the ability of families to access adequate healthcare. Challenges, such as COVID-19 and consequent lockdowns, Brexit and issues of freedom of movement across the EU, and new legislation targeted at Travelling communities are exacerbating long-standing challenges for Travelling communities. The experiences of Travelling communities in the East of England, and across the UK, indicate that the UK response to the COVID-19 pandemic and associated social isolation have increased already

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<sup>1</sup> Community groups of the remaining 15 were not recorded, but likely to include a high number of Irish Travellers.

<sup>2</sup> Gender and length of time in the UK were not recorded in every case

salient problems of poverty and unemployment, as well as negatively impacting upon physical and emotional health (Lucy Hetherington, 2020). Travelling community members involved in this project have reported that anxiety, depression, loneliness, concern for loved ones, sense of failure, bereavement and grief, alcohol and substance misuse have all been heightened through the COVID-19 lockdowns. Relatedly, people reported that they have found it particularly difficult to get the financial help they need during lockdowns. For some, health appointments are a pre-requisite to benefit payments and one person explained that they had lost their benefits due to being unable to get to the hospital. Others have not been able to access benefits because those who would usually help them with reading letters or filling in benefit forms were not available.

Of enormous concern to Travelling communities, and particularly to Gypsies and Travellers who live on the road, is the forthcoming Police, Crime, Sentencing and Courts Bill which seeks to create a criminal offence of residing in a vehicle on land without permission.

In this context, it is perhaps unsurprising that people spoke of the need for mental and emotional health information and support.

*“You hide it and the more you hide away from it the worse it is for yourself. You go into more depression and more serious it gets”*

*“I’ve had to get tablets off the doctor, only over phone, but the stress and worry of it all was making me bad”*

*“I phoned the doctors, I was 14th in line, I got through, said I feel suicidal. They said call the crisis team. I couldn’t get through all day. “*

A number of people said they would like to talk with someone about concerns about their own mental health and four shared that they had sought access to mental health services themselves. Respondents reported being particularly concerned for men as there was a feeling that they tend not to talk about their mental and emotional health.

## 2. Travelling Lives and Home Visits

In March 2020 Friends Families and Travellers estimated, for the UK, there to be around 10,000 Gypsy and Traveller people living roadside on unauthorised encampments<sup>i</sup>, around 70,000 people living on Gypsy or Traveller sites<sup>ii</sup> and around 15,000 people living on canals and waterways<sup>iii</sup>. There is a national shortage of Traveller site pitches (House of Commons Library, 2019) and families are no longer permitted to 'double-up' (share). Participants explained their difficulties in obtaining regular access to primary and secondary health care when travelling.

*“The Travellers... can't get the address and when they do the police keep moving them on, from post to pillar. Then they get an appointment and they've missed it because they haven't got an address for the letter to come to.”*

*“For the GP, no matter where you go, your GP will be able to pull up your files, but then they need an address to send the letters - or maybe they will phone you.”*

*“Hospitals have to accept Travellers but when you go to a doctors they want you to fill in all these forms and give an address and its difficult. Firstly you have Traveller/Gypsy, then no fixed abode, no address, then if you get the tests there is nowhere to send letters.”*

Participants reported that it is harder these days for both boaters and road travellers when someone needs care as families are not permitted to stop for long. Participants highlighted the implications of this policy on children's education as well as pregnant women and new mothers, and those receiving a series of treatment such as chemotherapy.

Whilst Roma communities in the UK usually reside in bricks and mortar accommodation, they are also likely to often migrate across Europe, sometimes to find work and sometimes to reconnect with family. Whilst Slovakian and Czech Roma (who tend to have been in the UK for longer) are usually GP-registered, many newly-arrived Romanian Roma are not yet registered with a GP. A number of Romanian families arrived into the UK before the end of Brexit deadline and due to the COVID-19 pandemic have not been able to register with a GP.

A couple of people commented that in the old days they had benefited from hand-held health records which supported continuity of care whilst they were on the road.

Serious cases around access to Traveller sites and roadside homes for emergency care were reported. Travelling communities recounted two particular instances where people had died whilst waiting for paramedics to be accompanied by police officers before attending to critically ill patients living on site. It was reported that a man died in Hertfordshire whilst the ambulance was waiting outside the site with a defibrillator. The community were not permitted to take the potentially life-saving defibrillator onto the site. In another case, participants reported that a baby died in Thurrock whilst the ambulance was waiting outside for police accompaniment. In this instance, the family took their baby to the ambulance but it was too late. In terms of police procedure, it is standard practice in some parts of the East of England for Traveller sites to be flagged in the same way as Drug houses so police must accompany paramedics when attending an emergency.

There are also issues reported in regard to midwifery visits. Families living roadside can have difficulty accessing midwifery care and support as illustrated in the quote below:

*“If the woman has a settled place. I’ve seen time and again - only if the police will leave them alone for a bit - the midwife will come out. But I’ve seen them moved on 5 times and then they are moved to a different county and the midwife can’t do her work. It’s like the olden days you know”*

One commented that health workers do not always feel safe on site (despite an apparent lack of reported incidents that would explain this feeling). Some participants had experienced midwives visiting them on site but visiting policies appear to vary across the East of England. Participants explained that in Hertfordshire for example, midwives need to go on site in pairs and appointments need to be in the Communal Managers Office or a “dilapidated” day room. Women are usually quite uncomfortable having private appointments outside of their homes.

### 3. Direct Racism

People reported racial discrimination as a barrier within all areas of life and equally so within the national health service. Two people describe the prevalence of discrimination in the East of England today:

*"... it was terrible how we were treated. It doesn't matter if it's a doctors or hospital or a pub or restaurant. We are human beings, and we should all expect to be treated regardless of who you are or where you come from."*

*"It's now 2021 and the discrimination has been going on for hundreds of years. No blacks and no Irish still apply. No Irish Travellers allowed to book in Pontin's recently. Tyson Fury could not get served a pint of beer in his own hometown and he is a millionaire champion of the world."*

Another person described how she believed that her ethnic background was likely the cause of being *"treat disgustingly"* by hospital staff during the birth of her first child.

The denial of "basic human rights" was strongly felt by some:

*"What gets abused is basic human rights: the right to a home, the right to education. The Housing Act, Site Act, Caravan Act and Highways and Byways Act gave us rights and then took them away. We are entitled to a GP, sanitation and to live in a home."*

However, whilst some pursue justice through legal action, others seem to have lost hope and to be beyond seeking change.

*"it's hospitals and places like chemists and pharmacists who are really awkward with you. It's the way life is... it's been going on for more than a couple of decades and nothing has changed. It could do with getting better and changing but people won't change - that's the sad thing."*

Whilst some participants had themselves had bad experiences of public authorities and health care providers within the East of England or in Eastern Europe, others shared in the collective memory of multi-generational racism: from ethnic cleansing during the Holocaust to stories about being moved on from a site or barred from a pub. There were also a number of people who had had good experiences of health care within the East of England, and those that had been pleasantly surprised by the care that they had received. One Romanian woman recently arrived in the UK, decided she would give birth to her child in her home country as she didn't trust UK health provision and could not speak English. When her second child was born in the UK, she was positively surprised about the kindness and professionalism of the service and admitted her own prejudices were challenged.

One consequence of racism is that people sometimes choose not to disclose their background for fear of negative response. However, it not always possible to stay hidden: Romanian Roma requiring interpretation services during health appointments have been subjected to racism during their health care appointments, from non-Roma interpreters who can speak their language but who translate in a derogatory way.

Traumatic memories such as having children taken away into care or being beaten by police (collective or otherwise) are difficult to forget. People have come to expect racism and can be suspicious of newcomers and outsiders.

#### 4. Cultural Competency

A lack of cultural competency can cause serious issues for people from Travelling communities. Health practice which does not respect important community values deters people from going to the doctors, making the cultural acceptability of service a requirement for accessibility to that service.

Two priority issues raised around cultural competency were questions around the involvement of the whole family in illness, and also, difficulties for Travellers in seeking help from outside their communities.

Participants explained the importance of whole family involvement in illness and how professional understanding of this is variable:

*“You get a lot of stick ringing about your loved ones. My parents were very very poorly and the hospital didn’t want us ringing at all you know. It’s difficult to have a large number of the family there which is traditional.”*

*“they accepted all the family being there when he died, they didn’t moan”*

Poor cultural competency around bereavement can cause unnecessary amplification of the families’ suffering through (inadvertently) stifling cultural practice and effectively preventing mechanisms for coping.

*“They had no clue with my boy, they took him before we could see him, wouldn’t let me kiss him, no one explained why, made it so much harder on the night”*

Participants reported that their communities are used to being insular and self-sufficient, tending to look after themselves. Lots of people have a *“fear of discussing private things”*, and women certainly don't want to discuss female matters with a man. People can be frightened of taking an issue to the doctor if they think they might need a medical examination. In one example, an older woman was concerned about a male doctor seeing her leg, although her sister and a nurse were there to support her. She explained that when they were growing up, boys weren’t allowed to see their sisters in their pyjamas. Another said they *“would rather not go [to the GP] - it goes against my culture and upbringing”*. Compounding these issues, Travellers can also be proud, seeing hospital as a last resort.

*“They put their pride in their pocket, especially the men, and they won’t go and get the help they need.”*

Some Roma participants expressed doubts about the veracity of the pandemic and uptake of the COVID-19 vaccine has been low amongst this group (more on this later). Some were against vaccination on religious grounds, and some were not convinced the vaccine was

effective. Relatedly, in one focus group there was a heated discussion among the participants about their children being tested for COVID-19 at schools, with some participants saying they would rather keep their children at home than allow them to be tested.

These factors - individually and combined - make people reluctant to seek help from health professionals, resulting in late presentations with serious symptoms. When they do present, people are still sometimes turned away from the GP if they do not have addresses or if they are from another country. Initial registration with the GP can be the hardest part, with a *“battle to get past the receptionist”*. A health professional suggested that this was a sad legacy of confused messages around the UK as a *“hostile environment”*. GP surgery receptionists can be abrupt and *“don't give time to explain your story”*. Meanwhile, some Roma participants – particularly those with unconfirmed status - expressed their fear as to what services they will be allowed to access after the 30th June when everyone must have EU settlement status.

Another consequence of typically insufficient staff cultural competency is that health care workers who care well for people from travelling communities are widely recommended, well known and preferred. Some GP surgeries are identified as *“safe”*. Overall, there is a sense of fear and distrust in the system and, personal or at least cultural familiarity is reassuring.

*“They have been really good for me... but they have dealt with me before so know what to expect”*

## 5. (In)Appropriate Communications

**Literacy** was frequently cited as an issue. People reported that many in their communities cannot read well, fill in forms or write emails/letters, because they have not had much schooling. This means that official medical letters often go unread. Even when it is in practical terms easier to get help with reading, it was pointed out that *“it's not nice to need help with reading when it's personal confidential issues”*. One person said she could not even *“read when it is time for my appointment on the screen”*, expanding that *“they used to announce it.”*

Another individual explained what can happen when a health screening invitation is posted to a Traveller living on site. There can be multiple people with same name on the site and one post-box. *“None of them are much good at reading, and they wouldn’t know what to do with a test kit if they’d got it.”* Hence, many conditions that could be picked up through screening are not.

Participants reported that lots of people cannot read the medicine labels and are at risk of using inhalers incorrectly or even accidentally overdose, rendering medicines ineffective or even harmful. It was also reported that swapping prescriptions is common, sharing medicines that have helped them without seeking professional medical advice.

Literacy issues were exacerbated during lockdown when family and friends were not so available to help. Support usually offered by local libraries and community organisations was also inaccessible during lockdowns. Without being able to read well it can be very difficult *“to have paperwork in order (especially during COVID) so you know it’s not right and that you could get into trouble with it if found out”*. Initial uncertainty of a health issue and reluctance to seek help can be followed by a period of wondering where to get help from (there is still more confusion about the post-COVID health system), culminating perhaps in an appointment letter that won’t ever be read.

*“I had a lot of trouble getting help with him and any benefit to help with the children. They were saying that I was not sick enough to get benefits. They said that I was not high risk but I had letters all the time telling me to stay in because I was high risk. I have a lot of health conditions and the communication from the hospital was really difficult.”*

**Health literacy** is also an issue. Respondents reported that people have limited information around all sorts of health matters, from mental health to strokes and heart disease, Covid, substance misuse and addiction. There is low knowledge of what services are available and how to access them. People shared their struggles to access help, and to understand what health professionals were saying.

When people do get to an appointment, it can be difficult to understand what the health professional means. Travelling communities can be more reluctant than most to ask questions (particularly to professionals) so when people “*use long words and medical jargon*” and “*don’t explain properly or listen properly*”, it is easy to go away with limited understanding of the medical condition or the advice they have been given.

Whilst many avoided asking any questions, one woman was trying to find more information around the suitability of particular medicine during her pregnancy, but somehow her communication appeared to be ineffective: the consultant only responded on occasions when an advocacy caseworker communicated by email.

Health issues can be caused and exacerbated when a community’s primary sources of information are unreliable. It was explained that many Roma people have only a basic level of English and the community is still very enclosed and marginalised. This tends to mean that they predominantly rely on information from social media or from prominent members within the community (priests / pastors, elders, singers). People from all backgrounds can be vaccine hesitant. Within Roma communities, vaccine hesitancy and fears around the MMR and other vaccinations are typical, and the doubts about the effectiveness and efficacy of the COVID-19 vaccinations on social media have caused much additional anxiety. Respondents reported that at the beginning of the pandemic Roma typically believed that COVID-19 was ‘just a flu’. Even though they mostly recognise the seriousness of the pandemic now, Roma are still typically reluctant to get vaccinated. Many of these fears were related to conspiracy theories about the vaccine. Some shared a strong belief that the vaccination could harm them and change their DNA. Others had heard a theory that the vaccination contains an electronic chip. Two strongly believed a theory they’d learned on social media: that the tests and face masks contain microscopic worms and by doing the tests or wearing a face mask you get the worms inside your body. In contrast it was reported that after some initial hesitancy, there was some generally good uptake of vaccine amongst the Gypsies & Travellers spoken with, as well as those Roma who have lived in the UK longer and have more established networks and are susceptible less prone to conspiracy theories.

The COVID-19 pandemic has also accelerated a national move toward **digital health care**, and patients are increasingly asked to do things online: from getting repeat prescriptions, to accessing Midwifery care, to taking part in online appointments. Important information can be predominantly distributed online. In order to access care, a person needs to know the local system, have an email address, access the internet and be able to complete the online form.

This shift to digital healthcare can have negative implications in terms of processes of digital exclusion. The increased reliance on online systems has negative impacts for those with limited literacy and computer literacy skills, or with limited access to computer technology. All of these issues can function to limit access to health care whilst increasing levels of exclusion from mainstream society (this is digital inequality) and adding the stress of finding an alternative route to health care. People shared their various experiences and frustrations:

*“they forget about my community... it’s all online and half of us cannot do it”*

Online-only services are *“really daunting and hard to navigate”*.

*“I tried calling, they said go online, I have only got a phone, it took loads pages to get anywhere, I lost connection, I was fuming in the end and I gave up and drove to the surgery in lockdown”*

*“Everything’s online, I’m not very good online, I have to get the children do it. “*

*“I missed 3 appointments online because I didn’t know how to do it, they phoned but I didn’t know the number or code, thought it was fraud call on funny number.”*

Even when people are gifted computer tablets, they do not always know what to do with them.

It was reported that telephone calls can be a better communication option for Travelling Communities: a fixed address and ability to read is not required, and there is possibility for an exchange of information between provider and service user. However, long calls and wait

times can be costly, putting people off calling for example cancer helplines. People can also be suspicious of calls from private numbers and unfamiliar dialling codes. There is a preference for face to face contact where possible, although lockdown rules and fear of contagion have made such opportunities rare.

## Conclusions

In 2021, Gypsies, Roma and Travellers in the East of England continue to experience significant needs and significant barriers to accessing health care. Struggles with emotional and mental health are perhaps unsurprising given that long-standing challenges linked to social exclusion and marginalisation (Yin-Har Lau, 2011). Covid-19 seems to have worsened these issues and brought new ones. As with the UK population more broadly, the pandemic and subsequent lockdowns have caused financial difficulties which have, in turn, impacted upon health. The burden-of-proof for health and incapacity related welfare benefits claims has meant that not being able to get to health appointments can lead directly to a loss of benefits.

Access to health care is problematised by a range of intersecting and compounding factors. Overall, there is a sense of fear and distrust in the system. Direct personal experience/collective memories and current/historical politics, mean that imagined interactions with public bodies can be strongly associated with racism and trauma. This can deter people from approaching health services to ask for help and some will only seek help when disease is advanced. Physically accessing care is another significant barrier. Being moved on makes it difficult to complete courses of care and keep appointments. Health workers having to visit Traveller sites in pairs or with a police escort limits provision and can result in fatalities. When care is accessed, people can be confused by the information and advice provided by health professionals; and Gypsies, Roma and Travellers can be more uncomfortable than most in discussing their symptoms and with asking questions to check their comprehension. Furthermore, racism and poor cultural competency can lead to trauma, poor health outcomes and a lack of culturally acceptable treatment.

The dominant communication channels pose further significant challenges for people who are not well-used to reading, writing or digital technologies, and still more for those with no fixed abode. Until more inclusive modes of communication are routinely offered, members of these (and other) communities are likely to miss invitations to health checks, immunisations and outpatient appointments.

In the UK population more generally, the COVID-19 pandemic is thought to be amplifying health and economic disparities. This trend seems to be very much apparent in the Traveller community. The pandemic has accelerated a national move towards digital health care which has the potential to increasingly limit access to health care for those who are in one way or another digitally excluded.

Feedback about health needs and priorities has illustrated that although there are pockets of good practice, the relationship between Travelling communities and health providers is characterised by poor communication and misunderstanding, including limited staff cultural competency and limited skill in ensuring that patients understand. Conversations with Gypsies, Roma and Travellers experiencing difficulties in accessing healthcare, revealed that culturally competent intermediaries can ameliorate these barriers. This forms the basis of the recommendations below.

## Recommendations

### **1. Inclusively involve local Gypsies, Roma, Travellers and health workers in finding out what works to improve access to healthcare together**

Travelling Communities and health workers in the East of England share an aspiration for greater inclusion in health research and practice, but there is agreement that healthcare in the East of England could be more inclusive. Changes in service could enable more people to access healthcare, resulting in more equitable provision and reducing inequalities in health outcomes. It is recommended that the collective will to learn together how to improve access to health care for Travelling Communities which has been identified during this project is acted upon.

Inclusive health practice is best led by inclusive research and next steps to learn what works should be planned together with local communities and health workers for the best chance of sustained positive impact.

## **2. How to reach out and involve the Travelling community**

The Travelling community are often felt to be 'hard to reach' due to the longstanding stigmatisation of the community and a lack trust between the community and mainstream services. In addition, this project was conducted entirely during the COVID-19 pandemic when the researchers were not permitted to hold face to face meetings with the community. We therefore worked exclusively with Traveller community organisations to access the community and all contact was virtual. These organisations were all either set up and/or staffed by members of the Travelling community and they provided a vital bridge to the communities and were instrumental in collecting feedback. Working with the community organisations in this way was highly effective and efficient and we would recommend this approach for researchers going forward. All the organisations were helpful, responsive, attended regular meetings with the researchers and delivered feedback as requested and on time.

## **3. Co-design, Co-implement and Co-evaluate interventions**

Whilst various interventions to reduce barriers to access have been trialled in the UK, few have been formally evaluated and fewer still have been sustained in the longer term (McFadden et al, 2018). It is recommended that an East of England community of practice should be constituted to draw upon their combined experience and strengths to consider together what might work locally, and co-design, implement and evaluate interventions that could improve access to health for Travelling communities.

Our engagement has identified many possible interventions which could ameliorate some of the barriers to access cited above. It is recommended that choices as to what intervention(s) to trial and how, should be made collectively. Here are some suggestions which have emerged through our conversations:

- Employing culturally competent community-link workers who can support communities to access appropriate care
- Providing Mental health first aid training for community health workers (which could be cascaded to additional community members) to help more people to gain support for their emotional health.
- Training health workers (eg doctors and pharmacists) in communication techniques to make it easier for patients to understand their advice.
- Training frontline staff (including receptionists) in cultural competency could make the environment more welcoming and encourage engagement
- Offering digital champions to guide people through accessing appointments online on the phone to facilitate engagement for those people who have devices and data but need assistance in accessing software and developing relevant digital skills
- Offering a culturally appropriate, free phone, anonymous mental health helpline
- Providing safe surgeries and clinics that offer drop-in appointments with culturally competent professionals

#### 4. **Urgent review of patient/staff risk assessments around attending Traveller Sites**

Finally, there appears to be a mix of practices around the East of England regarding whether police are required to accompany paramedics to Traveller sites and the prioritisation of response on these occasions. The potentially grave consequences of how locations of risk are identified and attended raise serious questions as to how best to manage potential risk to both patients and staff, and we would recommend an urgent review of policy around risk assessments. The people involved in this research believed that the idea that Traveller site locations posed a risk to paramedics was largely unfounded.

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<sup>i</sup> Estimate based on 3.3-3.5 people per household, 20,000 households living on sites

<sup>ii</sup> <https://www.rboa.org.uk/q-a/>

<sup>iii</sup> [https://www.sheffield.ac.uk/polopoly\\_fs/1.43714!/file/GT-final-report-for-web.pdf](https://www.sheffield.ac.uk/polopoly_fs/1.43714!/file/GT-final-report-for-web.pdf)