Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Gypsy, Roma and Traveller Populations' JSNA Chapter Summary Update '2014/15'

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Introduction

The definition of individual Gypsy, Traveller and Roma communities and community members is complex because they are not one homogeneous group and the perceived identities of Gypsies, Travellers and Roma are affected by myths and stereotypes and historical interaction between communities. The term Gypsy, Roma and Traveller is a collective term which is being used to describe a wide variety of cultural and ethnic groups. Some of the groups are described by their legal ethnic status. Others define themselves as a group without the legal implications of ethnicity. Ethnically defined groups include:

- Gypsies (English or Welsh Gypsies, together described as Romany Gypsies
- Scottish Gypsy Travellers
- Irish Travellers
- Roma – the term 'Roma' accurately distinguishes between European Roma and UK Romany Gypsies.

Non-ethnically defined groups include:

- showmen
- circus people
- new age travellers
- bargees.

The Gypsy and Traveller communities have a long tradition of residing in Kent due to the traditional agricultural aspect of employment opportunities. This resulted in Gypsy and Traveller communities travelling around the county for work. Over time, members of the community have settled and integrated with the general population, although many retain a cultural identity that has distinct differences to the rest of the population.

Key Issues and Gaps

The Joint Parliamentary Human Rights Committee has described the Gypsy, Roma and Traveller community as the hardest to reach. The 2005 report states, 'evidence attests to the multiple discrimination faced by Gypsies and Travellers and their exceptional level of social exclusion. Poor levels of health even compared with other marginalised groups; high rates of infant mortality, and difficulties in accessing healthcare were cited in the evidence. Poor school attendance, low educational attainment and high levels of illiteracy were also particularly acute problems for Gypsy and Traveller children'.

A Department of Health funded study was undertaken by Parry et al. (2004). The results showed that Gypsies and Travellers are the most disadvantaged ethnic group in the UK experiencing significant inequalities in their health outcomes, particularly

around life expectancy, infant mortality and maternal mortality. This study was a well-conducted piece of research that involved 293 structured health interviews and 27 in-depth interviews with Gypsy and Traveller populations in London, Bristol, Sheffield, Leicester and Norfolk to take account of different attitudes in different parts of the country. The study involved matching the Gypsy and Traveller population participants for age and sex with a comparator of the non-Gypsy and Traveller population. Results showed that:

a. The Gypsy and Traveller population have significantly poorer health status and significantly more self-reported symptoms of ill-health than any other UK resident, English speaking ethnic minorities and economically disadvantaged white UK residents.
b. The Gypsy and Traveller population had higher levels of self-reported chest pain, respiratory problems including asthma and bronchitis and arthritis.
c. The proportion of the Gypsy and Traveller population that were smokers was considerably higher (57%) than the matched comparators (21.5%). The mean national smoking prevalence rate was 24% at the time of the study publication.
d. There was an excess prevalence of miscarriages, stillbirths, neonatal deaths and premature death of older offspring with 17.6% of the Gypsy and Traveller population of women that participated in the survey experienced the death of a child in comparison to just 0.9% of matched comparisons and 14% of Gypsy and Traveller women had experienced a miscarriage compared to 6% of matched comparisons.
e. Childhood immunisation uptake is considerably lower in the Gypsy and Traveller community in comparison to the general population.
f. They experienced higher levels of depression and anxiety in relation to matched comparators.
g. With regards to health beliefs and attitudes to health services, there was a cultural pride in self-reliance, a tolerance of chronic ill health, with a deep-rooted fear of cancer or other diagnosis perceived as terminal and hence avoidance of screening.
h. Illness was often seen as inevitable and medical treatment seen as unlikely to make a difference.
i. There was more trust in family carers rather than in professional care.

A review by Hajioff and McKee (2000) looked at the health needs of the Roma population, with the focus being on three countries (Spain, Slovakia and Czech Republic). They found that there was limited evidence that suggest there is increased morbidity from non-communicable disease, but little is published on this topic. Evidence on health care, although fragmentary, suggests poorer access to health services and uptake of preventative care.

In Ireland, a report by the Pavee Point Travellers Centre (2011) states that life expectancy for males is 15.1 years less than the non-traveller population and it is 11.5 years less for women. Whilst it is officially accepted in the UK, that Gypsies, Roma and Travellers have significantly lower life expectancy than the general population, there is a lack of data to accurately quantify this.

Due to the relatively recent arrival of Roma communities, there is a lack of longitudinal research on Roma life expectancy in this country. A World Bank report by Rhingold et al. (2005) showed that life expectancy and mortality data for Roma across Europe indicated significantly worse health conditions than for the rest of the population. That life expectancy for Roma in Central and Eastern Europe was on average 10 years lower than the rest of the population.

Dar et al. (2013) conducted a survey and mapping exercise of primary care trusts in England to ascertain what is known about Gypsy and Traveller populations, estimate immunisation rates and describe current services to increase immunisation and address health issues. They found that there are a considerable number of areas where knowledge of population numbers is poor, service provision is not based on need and the uptake of immunisation is low or not known.

Poor general health and poor access to health services are risk factors for problematic drug and alcohol misuse. Several drug and health agencies reported concern being expressed from within the Gypsy community, particularly from women. However, their knowledge and awareness about drugs was considered to be low (Drugscope 2004).

A family planning and sexual health survey was undertaken in Swale with 50 members of the Gypsy, Roma and Traveller population (Jones 2009). Outcomes from the survey demonstrated that there were gaps in knowledge and understanding about sexual health. The respondents were aware of their need to know more and were receptive to receiving information and advice but it had to be in a way that was appropriate for them.

The Government have highlighted in ‘Healthy Lives, Healthy People: Our Strategy for Public Health England draws attention to the significantly poorer life expectancy in England when compared to other ethnic groups, even after adjustment for socioeconomic status.

The Level of Need in the Population

The 2011 Census recorded data on those who identified themselves as Gypsies and Travellers for the first time, however, it is recognised that Gypsies and Travellers are often reluctant to disclose their ethnicity for fear of discrimination. This will result in an under-reporting in the total number of the population. The total number estimates that there are 57,680 Gypsies and Travellers in England and Wales (this does not include Roma), although other studies and reports estimate the number to be between 200,000 and 300,000 (Commission for racial equality 2006, Clark and Greenfields 2006). Around half of the population are estimated to live in housed accommodation (Clark and Greenfields 2006). The data on these communities, particularly Roma, is still a problem. Estimates have increased since 2006 and recent mapping suggests 300,000 (including the Gypsy and Traveller population) to one million (Mapping Survey: Patterns of settlement and current situation of new Roma communities in England, European Dialogue August 2009). In 2010 the Department of Health, through their Pacesetters Programme, estimated that there were about 300,000 Gypsies, Roma and Travellers living in the UK.

The census data show that Maidstone and Swale are the two local authorities in England ranked with the highest proportion of the Gypsy and Traveller population, with Ashford having the fifth highest. Although the proportion is relatively low at around 0.5%, the reality is that there is a higher proportion than this in the overall population.
http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262

The school census data is one of the most accurate sources of data about the Gypsy, Roma and Traveller population. This data shows the population numbers and proportion of pupils from different ethnic backgrounds including Gypsy, Roma and white Traveller of Irish heritage. Many schools in Kent do not report to have any pupils from Gypsy, Roma or white Traveller of Irish heritage backgrounds, but there are some with considerable proportions. Table 1 shows the combined proportions of Gypsy, Roma and white Traveller of Irish heritage pupils across the Kent districts.

Table 1: % of school pupils across the 12 Kent districts – Spring 2014

District	Total Roll January 2014	Number of Gypsy/Roma and Traveller of Irish Heritage Pupils January 2014
Ashford	18775	209
Canterbury	20038	105
Dartford	17988	132
Dover	16155	177
Gravesham	16966	226
Maidstone	23698	221
Sevenoaks	11508	189
Shepway	14784	118
Swale	22083	173
Thanet	20223	219
Tonbridge and Malling	20060	136
Tunbridge Wells	17378	118
Kent Total	**219656**	**2023**

District	Total Roll January 2014	Percentage of Gypsy/Roma and Traveller of Irish Heritage Pupils January 2014
Ashford	18775	1.1
Canterbury	20038	0.5
Dartford	17988	0.7
Dover	16155	1.1
Gravesham	16966	1.3
Maidstone	23698	0.9
Sevenoaks	11508	1.6
Shepway	14784	0.8
Swale	22083	0.8
Thanet	20223	1.1
Tonbridge and Malling	20060	0.7
Tunbridge Wells	17378	0.7

Kent Total	**219656**	**0.9**

Data includes Free and Academy Schools

Table 2: Schools with 5% or more Gypsy/Roma and Traveller of Irish Heritage Pupils on Roll as at January 2014 * indicates number and percentage data suppressed to protect pupils identity

District	Schools with 5% or more Gypsy/Roma and Traveller of Irish Heritage Pupils on Roll as at January 2014	School Type January 2014	Total School Roll January 2014	Number of Gypsy/Roma and Traveller of Irish Heritage Pupils January 2014	Percentage of Gypsy/Roma and Traveller of Irish Heritage Pupils January 2014
Ashford	Bethersden Primary School	Primary	110	17	15.5
Ashford	Charing CEP School	Primary	118	20	16.9
Ashford	High Halden CEP School	Primary	109	26	23.9
Ashford	John Mayne CEP School	Primary	125	9	7.2
Ashford	St Mary's CEP School, Chilham	Primary	103	11	10.7
Canterbury	Parkside Community Primary School	Primary	141	11	7.8
Dartford	Bean Primary School	Primary	195	14	7.2
Dartford	Darenth Community Primary School	Primary	143	57	39.9
Dover	Priory Fields School	Primary	376	67	17.8
Dover	St Mary's CEP School, Dover	Primary	259	15	5.8
Dover	Vale View Community School	Primary	226	25	11.1
Gravesham	Istead Rise Primary School	Primary	259	13	5.0
Gravesham	Raynehurst Primary School	Primary	402	24	6.0
Gravesham	Vigo Village School	Primary	182	12	6.6
Gravesham	Westcourt School	Primary	248	19	7.7
Maidstone	Hunton CEP School	Primary	90	*	*
Maidstone	Kingswood Primary School	Primary	134	9	6.7
Maidstone	Laddingford St Mary's CEP School	Primary	75	8	10.7
Maidstone	Ulcombe CEP School	Primary	47	12	25.5
Sevenoaks	Downsview Primary	Primary	183	10	5.5
Sevenoaks	Edenbridge Primary School	Primary	381	19	5.0
Sevenoaks	Halstead Community Primary School	Primary	67	*	*
Sevenoaks	Hextable Primary School	Primary	392	30	7.7
Sevenoaks	New Ash Green Primary School	Primary	300	32	10.7
Sevenoaks	West Kingsdown C.E. (V.C.) Primary School	Primary	157	17	10.8
Shepway	Castle Hill Community Primary School	Primary	379	24	6.3
Swale	Holywell Primary School Upchurch	Primary	198	12	6.1
Swale	Lower Halstow School	Primary	135	14	10.4
Swale	Teynham Parochial CEP School	Primary	185	15	8.1
Thanet	Holy Trinity & St John's CEP School, Margate	Primary	454	31	6.8
Tonbridge and Malling	East Peckham Primary School	Primary	183	12	6.6
Tonbridge and Malling	Stansted CEP School	Primary	56	9	16.1
Tunbridge Wells	Cranbrook CEP School	Primary	158	9	5.7
Tunbridge Wells	Frittenden CEP School	Primary	97	*	*
Tunbridge Wells	Hawkhurst CEP School	Primary	189	15	7.9

Canterbury	Hersden Village Primary School	Primary Academy	88	6	6.8
Gravesham	Chantry Community Academy	Primary Academy	279	46	16.5
Sevenoaks	Horizon Primary Academy	Primary Academy	167	9	5.4
Shepway	Christ Church CEP School, Folkestone	Primary Academy	406	22	5.4
Canterbury	Canterbury & Swale Alternative Curriculum	Pupil Referral Unit	47	*	*
Shepway	Brook Education Centre	Pupil Referral Unit	7	*	*
Swale	Swale Inclusion Centre	Pupil Referral Unit	11	*	*
Tunbridge Wells	Tonbridge, Tunbridge Wells & Sevenoaks Alt Curriculum	Pupil Referral Unit	6	*	*
Thanet	Hartsdown Technology College	Secondary Academy	965	106	11.0

Source: MIU KCC

As shown in Table 2, there are considerably more primary schools with a proportion of pupils from the Gypsy, Roma and Traveller population compared to secondary schools. This may be due to the overall pupil numbers being considerably higher in secondary schools compared to primary schools with the school catchment population being drawn from a wider area.

Quantitative health data

There is limited data available on the health needs and service use of Gypsy, Roma and Traveller population in Kent. Primary qualitative research has been undertaken to collect data on the perceptions of the Gypsy, Roma and Traveller community. Some quantitative data has been utilised using postcodes from areas where there are a significantly high proportion of the Gypsy, Roma and Traveller population living in housed communities. These areas were identified from a community leader and professionals working with the communities. Once the areas were identified, postcodes were utilised and aggregated at Lower Layer Super Output Area (LSOA). The Gypsy, Roma and Traveller communities that live in housing, generally live in areas of relatively high deprivation. It is important to utilise this data with caution because it is displaying the data from the LSOA where intelligence has indicated that there is a relatively high proportion of Gypsy, Roma and Traveller communities. Not all residents within the LSOA will be from these communities so there are considerable limitations with the data. Also there are differences between the Gypsy, Roma and Traveller communities. For example, in Cliftonville West, there are relatively few (if any Gypsy and Travellers), but a relatively high proportion of Eastern European Roma from Slovakia, Czech Republic and Poland. In the other area examples utilised, the predominant group are English Gypsies. A further limitation is that this is only using data from housed members of the respective communities and not from those living on authorised sites or roadside.

Figure 1

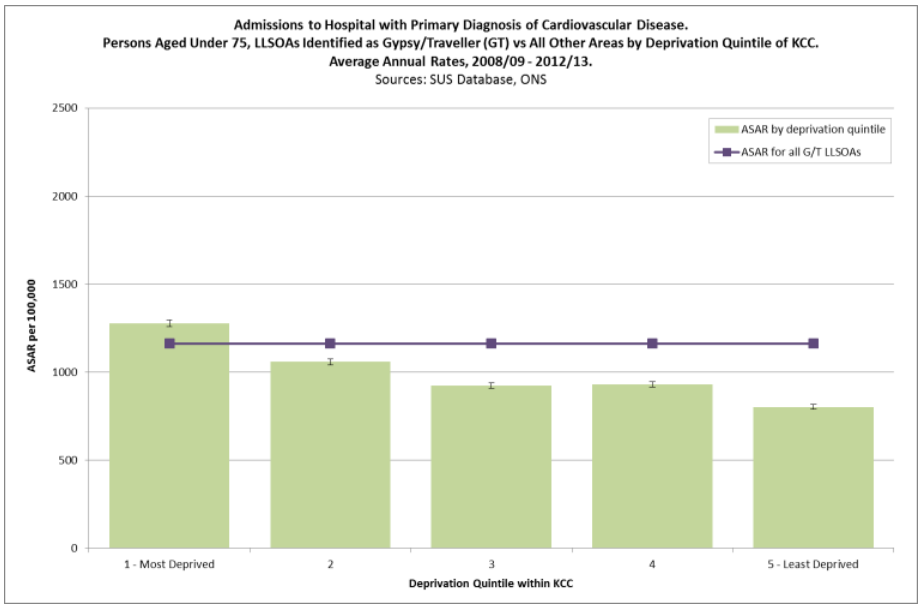


Figure 1 shows admissions to hospital with a primary diagnosis of cardiovascular disease by the Gypsy, Roma and Traveller population. It is comparable to the most deprived quintile of the Kent population across the county, but higher than the rest of the population.

Figure 2

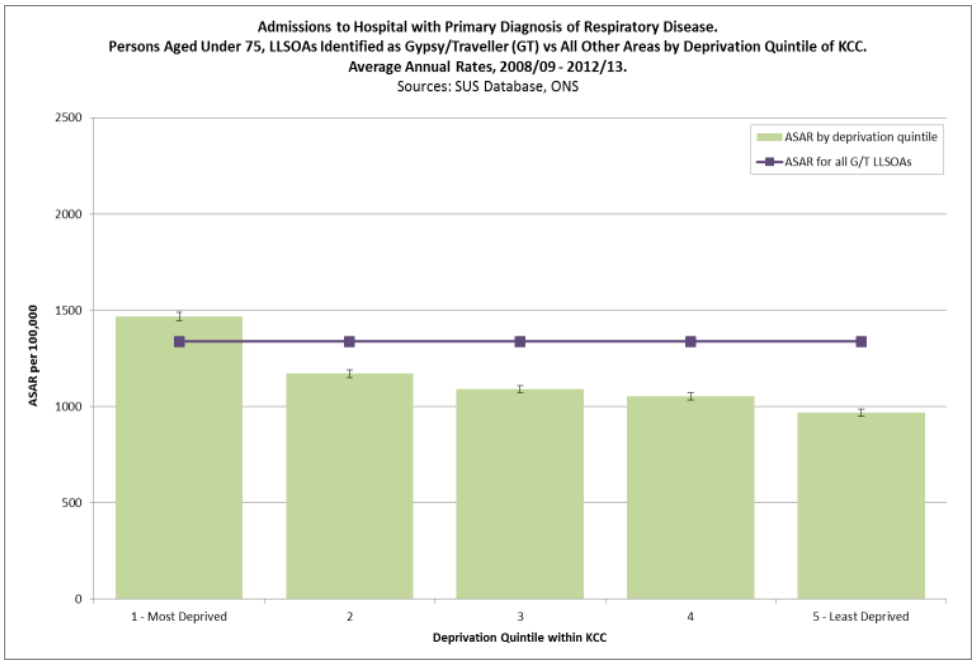


Figure 2 shows admissions to hospital with a primary diagnosis of respiratory disease by the Gypsy, Roma and Traveller population. It is also comparable to the most deprived quintile of the Kent population across the county, but higher than the rest of the population.

Figure 3

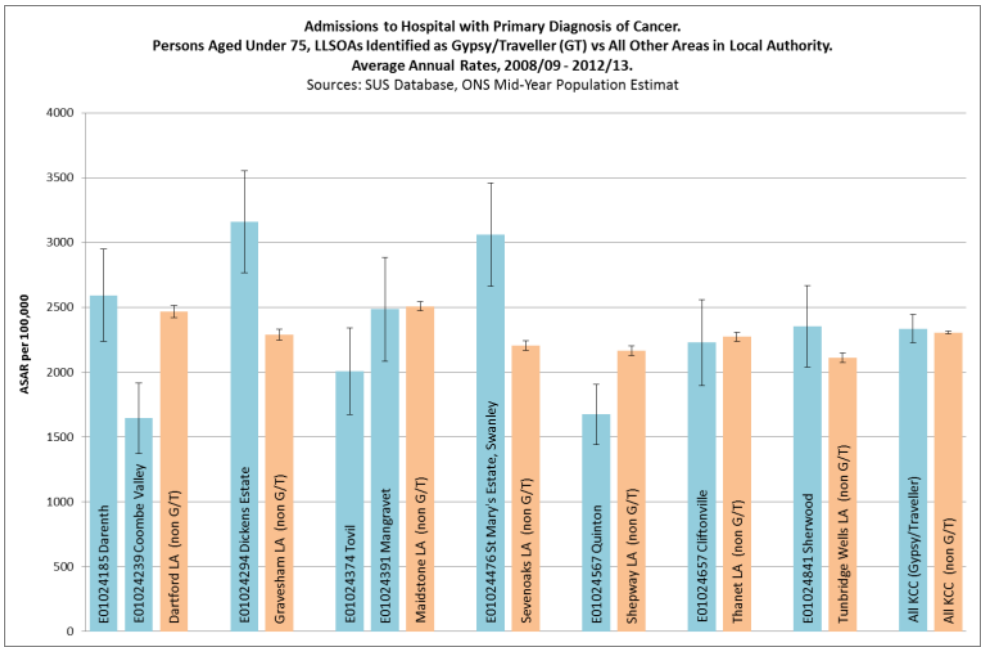


Figure 3 shows admissions to hospital with a primary diagnosis of cancer by the Gypsy, Roma and Traveller population in specified LSOA areas that have a relatively high proportion of the communities living in housing. It is then compared to the mean admission rate for the district where the area is. The results show variable differences, for example, the Dickens Estate in Gravesham and St Mary's Estate have statistically higher rates than their respective district average, yet Coombe Valley and Tovil are statistically lower. Caution must be used when interpreting this data due to the relatively small population numbers involved in the LSOA areas, reducing the statistical robustness of the data. Notably, there is no statistical difference when all areas are combined when compared to the county average.

Figure 4

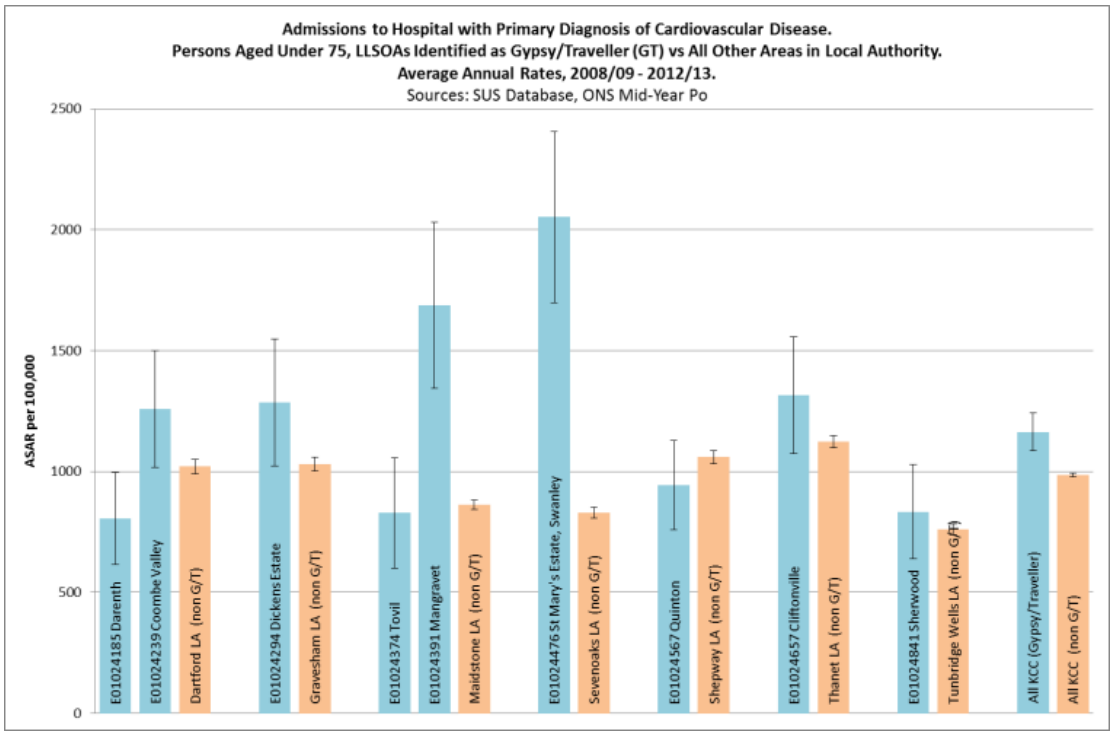
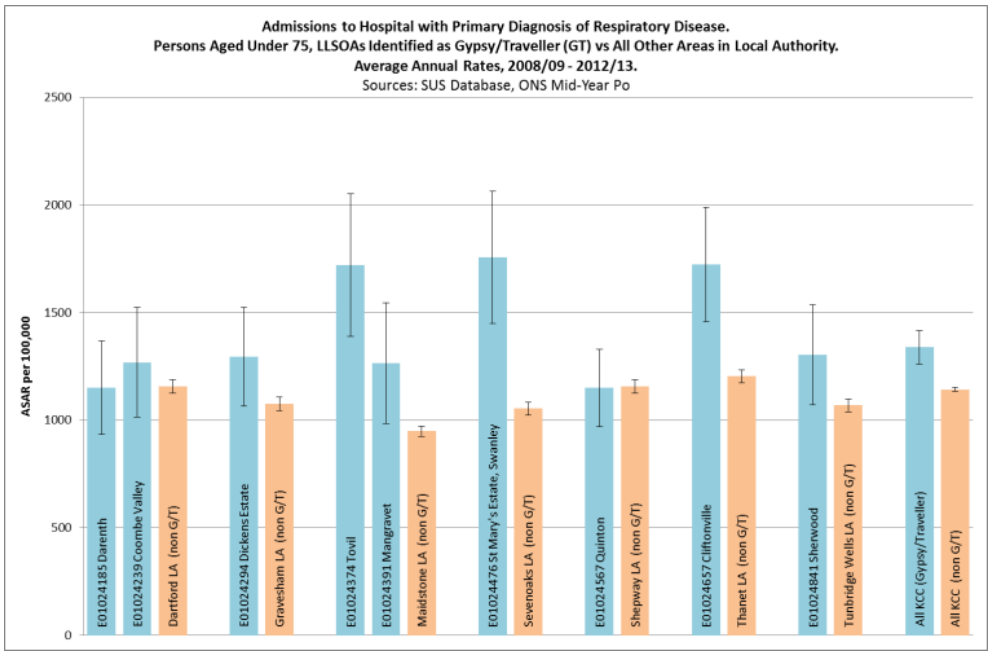


Figure 4 shows admissions to hospital with a primary diagnosis of cardiovascular disease by the Gypsy, Roma and Traveller population in specified LSOA areas that have a relatively high proportion of the communities living in housing. It is then compared to the mean admission rate for the district where the area is. The results show Mangravet in Maidstone, and St Mary's Estate have statistically higher rates than their respective district average, Darenth is statistically lower than the Dartford average, although there is no statistical difference for most areas when compared to the district mean.

Figure 5 shows admissions to hospital with a primary diagnosis of respiratory disease by the Gypsy, Roma and Traveller population in specified LSOA areas that have a relatively high proportion of the communities living in housing. It is then compared to the mean admission rate for the district where the area is. The results show Tovil and Mangravet in Maidstone, St Mary's Estate in Sevenoaks, Cliftonville West in Thanet have statistically higher rates than their respective district average.

Figure 5



Qualitative health data

Due to the lack of quantitative health data available about Gypsy, Roma and Traveller populations, a range of qualitative interviews have been undertaken by members of the Gypsy population trained as community researchers in order to find out more about the population health needs. In total, 29 interviews were conducted with members of the community across Kent, 18 were with females and 11 with males. The ethnicity from within the sample was 13 English or Romany Gypsies, five Irish Travellers, one Romany Traveller, three Roma, one show-woman and six interviewees who did not have a record of their ethnic group. The interviewees were from mixed ages starting at 16 years old.

Four interviews were also conducted with health professionals. The results were analysed by Khor and Trevelyan (2013). The key findings were as follows:

a Self–reported health – interviews confirmed a picture of chronic and multiple health problems among many of the interview respondents, with 17 of the 29 interviewees reporting one or more chronic ailments. These ailments ranged from diabetes, circulatory and respiratory problems, to cancer and many other health issues. Only seven out of the 29 people interviewed indicated that they felt their health to be ok.

b Expectations and experiences of services – amongst the community members interviewed, awareness of local health services appeared to be fairly high. This may have been a function of the profile of the community members interviewed, tending to be those in touch with services provided by the Swale health trainer service. Many interviewees named their GP and a dentist and talked about particular local hospitals where they had received care in the past; whether good or poor. A few also talked about using a local pharmacy for items such as pain killers, cough medicine and hay fever tablets. The data collected indicates the role played by word of mouth, and the experience of

family and other community members, is a powerful one. Interviews show that if word got round about a bad experience with a particular health professional, or institution, that this tended to have a negative impact of people's likelihood of feeling confident about accessing them, themselves, again much as with non-Gypsies and Travellers.

c Enablers to accessing health and social care services – cultural sensitivity, when encountered are especially valued. Several participants spoke highly of institutions where the staff are said to 'know what travellers are like' and where there has been a willingness to 'make an exception' especially with regards to visiting regulations. For those interviewees who had experience of the Swale health trainer service, there was significant positive feedback. One woman talked about her experience where a health trainer had encouraged her to book a check-up which had resulted in early diagnosis and successful treatment of cervical cancer.

d Barriers to accessing health and social care services – lack of trust in the quality of health services can function as a barrier to access. A number of participants spoke disparagingly about the quality of care they had received in the past; casting doubt on the capability of the health professionals they had come across. The interviews revealed a tendency to rule out accessing a particular health care professional or institution after a negative experience, which was particularly pronounced when the treatment patients received was considered by them to be undignified and disrespectful. The lack of confidence and trust in health services described above was sometimes connected with a preference for treating ailments at home. Health workers explained, 'they think they can do it better themselves' and this sentiment was echoed by a number of community members themselves.

e Knowledge about preventative health and practical obstacles to accessing information – a high proportion of the community members who contributed to this project, both Roma and across the Gypsy and Traveller identities did show a keen awareness of the importance of immunisation. In fact, one Roma participant explained that she had gone out of her way to make sure her child received his immunisations in spite of problems registering the new-born at the local GP surgery after a move.

f Screening – With regards to NHS national cancer screening services, health workers felt that many members of the travelling community would object to an uncomfortable, intimate procedure, believing such things to be 'very private': This view was echoed by some community members. However, not all of the participants agreed. Seven of the community members who took part in this research had used screening services of some sort. Of those who had not, most claimed they had never heard about or been offered such a service. In some cases, there was concern that written invitations or reminders are not reaching their intended audiences because of illiteracy. One community member, who reported that she had been screened for both breast cancer and cervical cancer, explained that part of the problem is that the current system relies on individuals to be proactive.

g Knowledge and confidence and appropriate use of services – late presentation or over-accessing services – Several community members explained, 'that they don't tend to go to the doctors unless they absolutely have to'. Although this perspective was juxtaposed by one GP's observation that members of the Roma community are 'quite high attenders for fairly trivial things'. This was often justified in terms of a dislike of 'wasting people's time'. One interviewee explained that the 'hassle' involved with the process of securing an appointment acts as a deterrent.

h Negative attitudes of health and social care workers encountered – Many interviewees object to the fact that they 'never see the same person twice' at their local GP. In fact, the answers provided by the community members who took part in this research reveal the importance of strong relationships that are built on trust and familiarity. Others talked about experiences and expectation of long waiting times and difficulties booking appointments when they need them, as another factor affecting their likelihood of accessing their GP.

i Access to information and literacy – One participant spoke of receptionists' assumptions that everyone they meet can read and write, alluding to the embarrassment that this can cause. Another complained, 'We can't all read and write for a start, so don't be bombarding us with forms.' Illiteracy functions as a barrier to access on a number of other levels. For example, one participant referred to information leaflets and written reminders about services such as screening as being 'no use'. In several cases participants explained that no one on their site was able to read or write. This means that vital information about health entitlements fails to reach people and can exacerbate feelings of isolation. As one health worker explained, 'this means that communication strategies around entitlements to preventative health are often redundant'.

Current Services in Relation to Need

The qualitative interviews undertaken by the community researchers also addressed questions as to how services cater for needs. Highlights from the interviews were as follows:

a **GPs** - All 29 of the interviewees appeared to be registered with a GP, or to have access to a local surgery if needed. However, there was variation in the level of engagement with GP services. While some community members reported that they might see their GP fairly regularly, others explained that they 'don't really go' at all. Interviewees reported a mixture of positive and negative experiences in relation to GP practices. Some participants were impressed with the swiftness of registration processes and the ease which they were able to book appointments at their local practice.

b **Dental care** – Twelve of the 29 participants consulted for this research told us that they were registered with a dentist. Health professionals interviewed highlighted the dental health of some Gypsy, Traveller and Roma community members as an area of concern for them. One health visitor who works primarily with the Roma community speculated that that the reasons for this

could be linked to a lack of understanding about the importance of seeing a dentist.

c **Pharmacists** – A number of participants reported positive experiences of using the pharmacy. The ease and accessibility of receiving ad hoc medical advice in this manner was seen as a real plus. Some interviewees spoke of a strong 'rapport' with a local pharmacist. In one case a community member reported that the strength of this relationship had proven lifesaving; the pharmacist's knowledge of this interviewee's normal medication regime meant that he refused to provide a form of anti-depressant that had been prescribed by a GP. The interviewee reported that it was their pharmacist who correctly identified that the anti-depressant could have interacted with the heart medication they were taking and potentially induced a coma. Unsurprisingly, therefore, this participant spoke very highly of their pharmacist's level of professionalism.

d **Hospitals** – Twenty one of the community members consulted as part of this research shared thoughts on their experiences of hospitals. Some had very positive experiences. For example, one participant spoke highly about the staff and general atmosphere at one particular Kent hospital. Some participants, on the other hand, had been exposed to negative experiences which had tainted their impression of local hospitals. For example, one male participant used terms such as 'dirty' and 'unhealthy' to describe a particular hospital, concluding, 'I wouldn't send my dog up there'.

e **Drug and alcohol services** – Health workers and community leaders reported that the level of substance misuse amongst the Gypsy and Traveller community was relatively high, but estimated that it was probably on a par with that experienced by other disadvantaged communities. They stressed that there was not any data available to support this anecdotal observation. Poverty and the absence of available work were seen as the key factors contributing to substance misuse, and mental health issues. A health worker identified male prostitution linked to heroin use as a growing problem for Roma community members. Locally, the Kent Drug and Alcohol Action Team (KDAAT) has had limited contact with Gypsy, Roma and Traveller communities. However, this certainly does not mean that there are no substance misuse issues within these communities.

f **Mental health services** – Health professionals interviewed raised some concerns over high levels of stress and depression within the Gypsy and Traveller community. Several of the professionals interviewed talked about unemployment and on-going financial anxiety contributing to low self-esteem and impacting on people's wellbeing. Some interviewees expressed similar views. Three of the community members interviewed for this research had lost male family members to suicide. Many community members spoke frankly about times when mental illness has affected them or members of their families. Their experience ranged from mild depression and mood swings to mental break down. One of these participants explained that her husband had been affected by depression and that his death had severe implications on her own mental health.

Evidence of What Works

A primary care framework was developed in the Market Harborough area (Leicestershire) in 2009. The aim of the framework was to ensure that Gypsy and Traveller communities can access the same high quality, mainstream primary care services as the rest of the population. The framework was designed to take account of a relatively high proportion of patients from the community living on sites; authorised or mobile.

The framework states that to improve the health and quality of life of Gypsy and Traveller communities, three key factors need to be addressed:

a The need to improve Gypsy and Traveller communities access to GP and primary care services, because without the same sort of access enjoyed by the general population, the health status of Gypsy and Traveller communities is likely to remain poor.
b Cultural issues relating Gypsy and Traveller communities that impact on their access and use of health services, for example, the strong traditional gender roles.
c Lack of cultural awareness on the part of health service providers can form a barrier to accessing services for Gypsy and Traveller communities.

The framework states that primary care organisations should consider including cultural awareness training as part of their regular mandatory training for all new and existing staff. This should be geared towards conveying what it is actually like to be a member of the Gypsy and Traveller communities, including their enduring legacy of discrimination and disadvantage, their culture, family life, and health needs. It also states that practices should adopt a policy of not turning away any Gypsy or Traveller member who attends without an agreed appointment, even if all appointments for that day are full. Practices should allow up to 20 minutes for consultations. Any requests to see other family members in the consulting room should be agreed (within reason), as this provides an opportunity to improve the screening status of potentially vulnerable patients.

The value of outreach work is emphasised. This could take the form of a practice-based outreach worker/advocate, (or a nurse) with responsibility for visiting sites regularly to provide health information and promote proactive health care and facilitate access to mainstream services, encouraging screening and full GP registration, liaison with other community staff serving the Gypsy and Traveller communities, promoting cultural awareness within the GP practice, monitoring Gypsy and Traveller communities views of services being provided.

With regards to screening, child health surveillance and immunisations, the framework recognises the fact that mobile Gypsy and Traveller communities may be forced to move on from unauthorised sites, as well as travel of their choice, it is likely that Gypsy and Traveller communities will not be as reliable as the settled population in keeping or making appointments. Using SMS text messaging software to send reminders may be useful in such circumstances.

Health trainers promote behaviour change among the socially disadvantaged and hard to reach in Kent and across England and Wales. They are non–judgmental and they are from the communities they work in therefore deeming them more accessible, seen as less of a threat than other services and 'a way in'. Health trainers support all their clients and empower them to help themselves around behaviour change, working in areas of health inequalities. Health trainers are the most logical link between hard to reach services as they can build trust between their community and healthcare services, reduce costs to the NHS by fewer hospital admissions, help their community to access the right services earlier and register them with a GP and dentist, while building professional relationships with other services to reduce health inequalities.

There are currently two part-time health trainers from the English Gypsy population who work as health trainers in Swale. In the last two years the health trainers have helped 52 clients gain access to a GP and 35 people have been signed up with a dentist. As NHS employees on Band 3 salary, working 16 hours each, they are a relatively cheap workforce and vital to reaching out to this community plus a link with healthcare professionals.

User Views

User views have been taken into account via the qualitative interviews undertaken that have been described in the section above. Survey interviews have also been undertaken by Smyth (2013) with that focused on the Gypsy and Traveller communities in Swale. In total, 41 interviews were undertaken. The findings showed:

- only 19% (seven out of 35) of families with children chose to have them immunised
- 50% of those that answered breast fed their children
- 75% of the people surveyed suffered from a diagnosed health problem that included asthma, heart conditions, cancer, arthritis and child health problems
- half of the 21 people out of 41 questioned, drank alcohol. From the 41 a quarter drank more alcohol units than is recommended. There are no specific Gypsy and Traveller statistics but referring to my questionnaire results it is likely to be an issue amongst this community
- half of those surveyed were smokers. The majority started smoking before they were 14 years old
- 18 of the 41 questioned did not use a dentist and 20 out of 30 people who answered, said their children do not go to the dentist.

Unmet Needs and Service Gaps

The identification of barriers to accessing services discussed above also identify areas of unmet health needs for Gypsy, Traveller and Roma communities in Kent. Those in touch with the health trainer service clearly benefit from this, both in raising awareness and building confidence to access the right services at the right time.

Interviews identified a number of specific unmet health needs for the communities. These are identified and described in Table 3 below. It should be noted that the identification of unmet needs draws solely on evidence from the 29 interviews with

community members and four interviews with health professionals and a community leader and that as such care should be taken in making any generalisation to the wider populations.

Table 3: Unmet health needs of Gypsy, Roma and Traveller community members who were interviewed

Health need	Evidence of gap
Sexual Health and family planning advice	Talking about sexual health cultural taboo, evidenced by lack of focus in community researchers' interviews with community members, and health professional's experience of the issues.
Childhood immunisation	Mixed uptake of childhood immunisation evidenced through community member interviews and health professionals experiences. Barriers to uptake include not being able to provide an address for paperwork. Health workers describing this as a 'time bomb' – 'All of us Health Visitors here to be quite honest are just waiting for it, I know that sounds very dramatic but I think it is only a matter of time.'
NHS Screening programmes	Mixed awareness and uptake of national screening programmes for cervical, bowel and breast cancer amongst those community members interviewed. Otherwise awareness and uptake appeared to be patchy, for cervical, breast and bowel cancer screening, among those who would be eligible. This appeared to be a combination of not receiving invitations, 'not been offered this' and opting out. One female, Romany Gypsy respondent said: "I don't even know what a smear test is".
Public health information, particularly smoking cessation	Health professionals anecdotal view of high levels of smoking among male Roma community in particular.
Male accessing of health services	Some male community member interviewees referring to self-treatment ahead of accessing health services. Health professionals identification of old-fashioned gender identities amongst some community members.
Mental health	Three of the 29 interviewees had been affected by family suicide.

	Community members' distrust of medication for mental health, and anecdotal evidence of cultural attitude of 'getting on with it', rather than seeking help for mental health issues.
Health visitors and maternity services	Amongst community members interviewed there were mixed reports of health visitors' coverage of the patch. One respondent said that health visitors did not come up to their site very frequently; those interviewees who did have contact with health visitors had very positive experiences. Health professionals' expectations of low acknowledgement of post-natal depression, contrasted with community members identifying this themselves. Health professionals indicated that some community members opt out of using maternity services at all.
Dental health	Interviews indicated that whilst community members were registered with a dentist that there was a preference amongst some for not accessing this, or self-treatment. Health professionals interviewed identified dental health access as key issue for the community.

Recommendations for Commissioning

a Additional health trainers or community workers who have an understanding of the language and cultural issues should be considered for areas where there is a relatively high proportion of Gypsy, Roma and Traveller populations. It would ensure representation for wider community groups, including Roma community members and male representatives from the community.

b Maximise the opportunity of health trainers/community workers within the Gypsy and Traveller community trained up to help deliver Health Checks to encourage the community to attend.

c Immunisation education through health visitors or community nurses alongside health trainers/community workers would encourage more parents to immunise their children and reduce risk of outbreaks of certain communicable diseases.

d Work with and involve the community more around changing health beliefs and how they access health services. There may be scope to do this by utilising health trainers to perform targeted work.

e Services that aim to change lifestyle behaviour such as the Stop Smoking Service and drugs and alcohol services should actively ensure that there is appropriate outreach offered to Gypsy, Roma and Traveller communities.

f Improving the coverage of Gypsies, Roma and Travellers in ethnic monitoring relating to health and social care would address their 'invisibility' in public health terms.

g Provision of training that improves the knowledge of staff around the cultural needs of Gypsy, Roma and Traveller communities, particularly those that are delivering primary health care services. Training could be formal, but could also be offered online or via the production of a DVD to ensure wider coverage.

h Knowledge and awareness of how to access health services like GP, family planning, national screening programmes and dentists appear to be particularly low amongst the Roma community in Kent. Educating health care professionals, community members, and community leaders to raise awareness is vital if the health needs of this community are to be met. The production of DVDs explaining how and when to access different health services in Slovak or other languages could help. Provision of DVDs to increase knowledge and awareness of health services in the Gypsy and Traveller communities would also have a positive impact because there are higher levels of illiteracy in comparison to the rest of the population.

i Greater access to dental services is an issue for the Gypsy, Roma and Traveller populations. Innovative solutions such as a mobile dental unit with both a male and female dentist on board should be considered to improve access to treatment from the Gypsy, Roma and Traveller populations. Work could be done in partnership with voluntary sector organisations involved in Gypsy, Roma and Traveller health, and with Gypsies, Roma and Traveller communities themselves, to identify specific dental practices with a particular interest in developing and promoting their services to the Gypsy, Roma and Traveller population.

j Ensure there is provision of guidance to all GP practices across the county, making clear that that they do not need to insist on three forms of identification in order to see Gypsy, Roma and Travellers. Guidance should also highlight the particular difficulties that Gypsy, Roma and Traveller communities face in accessing primary care, and recommend that that GP practices should apply discretion and flexibility when approached by Gypsy, Roma and Traveller community members.

Recommendations for Needs Assessments

A major weakness of this JSNA chapter is that it is focusing on a very broad topic in a large geographic area. In order to assess the detail as to what the specific needs are, further needs assessments should be completed that have a focus on specific communities or specific topics (ie Health and Social Care needs of Slovak speaking Roma community in Cliftonville, substance misuse Health Needs for Gypsy and Traveller population).

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Evidence of What Works

Improving access to health care for gypsies and travellers, homeless people and sex workers: an evidence-based commissioning guide for Clinical Commissioning Groups and Health and Wellbeing Boards Published 01/01/2013

Hidden Needs: Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers
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