



Leeds City Council

Health Needs Assessment of Gypsies, Travellers and Roma Groups in Leeds 2019

**Liz Bailey Head of Public Health (Health in all
Policies)**

Adults and Health Directorate

June 2019 – final

Contributors to the HNA

Thanks are extended to all the individuals from the Gypsy, Traveller and Roma communities who have engaged with the HNA, given their views, told us of their experiences and provided an indication of where efforts need to be placed to help them improve their health in the future. Without their assistance this HNA would not have been possible.

Thanks are also extended to the following people who gave of their time to contribute to this HNA and without whom our insight would have been more limited.

Patricia Amerty-Herbert
Pria Bhabra
Georgina Bright
Jill Hayward
Liz Keats
Kerrie Murray
Vickie Rafferty
Ellie Rogers
John Walsh
Louise Warwick Booth
Sue Wilkinson
Jenny Woodward

Contents page

Contents	Page no
1. Glossary of Terms	6
2. Executive Summary	8
2.1 Main findings	8
2.2 Key issues for work going forward	8
3. Gypsy, Traveller and Roma Groups – Leeds City Council Targeted Population	10
4. Gypsy, Traveller and Roma Groups – Population	11
4.1 Gypsies and Travellers population size	11
4.2 Roma Groups	13
Recent migration of Roma Groups to UK	13
Roma Groups Population Size	13
5. Background Information	13
5.1 Models of Health and Wellness	14
Medical Model	15
Social Model	15
Complementarity of Models	15
5.2 The Vulnerability Framework	15
6. Purpose and Rationale of HNA	17
7. HNA Methodology	17
Literature Review	17
One to one questionnaires and conversations	17
Insight from professionals who form the wider public health workforce	18
Stakeholder consultation	18
7.1 Literature Review of Gypsy and Travellers Health	18
Health status of Gypsies and Travellers	18
Prejudice, discrimination and marginalisation	18
7.2 Life expectancy	19
Gypsies and Travellers	19
Key health issues for Gypsies and Travellers	19
Health beliefs and lifestyle	19
Nomadic lifestyle	20
7.3 National research on Gypsies and Travellers health	20
Access to health services	22
Lifestyle factors	22
Wider determinants	22
Fuel poverty and cold related illness	22
Educational attainment	23

7.4 Health needs of Gypsies and Travellers in Warwickshire	23
7.5 Health needs of Gypsies and Travellers in Leeds	24
Access to health services through the Gypsy and Traveller Health Improvement Project 2018	26
Findings of the Leeds 2018 Health Needs Assessment Service User Views	26
7.6 Literature Review of Roma Health	27
Health Status of Roma Groups	27
Health Status	27
Life Expectancy	27
Access to Services	28
Wider Determinants	29
Educational Attainment	29
Employment and Housing	29
7.7 Health needs of Roma groups in Leeds	29
Language barriers	29
Access to services (2016)	30
Findings of the Leeds 2018 Health Needs Assessment of Roma	31
Service User views	
Access to services (2018)	31
Healthy Living	32
Wider determinants	32
7.8 Questionnaires and Conversations	32
Questionnaire delivery	33
Group 1	33
Group 2	34
Group 3	35
Group 4	35
Individual one to one discussion	36
Key message from community questionnaires	36
7.9 Wider insight into the Public Health Needs of Gypsy Traveller Communities in Leeds	37
Spatial planning, and living accommodation measures and effects on Gypsy and Traveller health	37
Insight from professionals working directly with Gypsy Traveller Communities in Leeds	39
Cottingley Springs Gypsy and Travellers site	39
Roadside Gypsies and Travellers	40
Work around health and health services	41
Key messages from professional insight into Gypsy and Traveller health needs	44
7.10 Insight into the Public Health Needs of Roma Communities in Leeds	45
Housing	45

Disruption to Education	46
Poor mental health	46
7.11 Services working to meet the needs of Roma Communities	46
Migrant Access Project	46
Better Together Community Health Development	47
City Wide Service	47
East and North East Leeds	47
West Leeds	48
Key messages from professional insight into Roma health needs	48
7.12 Contract Review of previous Gypsy, Traveller and Roma Health Needs	49
Contract Monitoring Returns	51
Health Advocacy	53
Key messages from previous Gypsy, Traveller and Roma public health work	53
8. Discussion	54
8.1 Similarities and Differences	55
8.2 Asset Based Approaches	55
8.3 Roads, Bridges and Tunnels	56
8.4 Assets within the Gypsy, Traveller and Roma Communities	57
8.5 Key Issues to enable a holistic service	59
9. Conclusions and Recommendations	59
10. References	62
Appendix 1 – questionnaire responses	65

List of tables:

Table 1. Gypsy and Traveller Roadside encampments in Leeds by area and average Nos of caravans per camp Jan 1 st - 31 st Dec 2018
Table 2. Gypsy and Traveller groups identified as registered with Leeds GPs between Jan and July 2018
Table 3. Outreach Nurse appointments (2017)
Table 4. Outreach Nurse appointments 2018
Table 5 Health Advice offered by Outreach Nurse

1. Glossary of terms

Romany Gypsies

Gypsies, or more correctly, **Romany Gypsies** – Whilst the origins of Gypsy people are still open to some debate it is generally agreed that there is a group or groups of people who left India over a thousand years ago and dispersed across the globe. Along the way they were defined (usually by others) as being ‘Egyptian’ and this has become shortened to Gypsy. Gypsy people began occurring in UK records in the 16th Century and have settled here ever since. Romany is the word that Gypsy people in England and Wales apply to themselves hence the term ‘Romany Gypsy’. This term is not used to describe more recent incomers to the UK from Central and Eastern Europe, generally described as Roma (see below).

Romany Gypsies are recognised as an ethnic minority group in UK Law (Race Relations Act (amended) 2000 and Equalities Act 2010).

Source: Leeds GATE 2014

Irish Travellers

Irish Travellers, whilst having much in common in terms of lifestyle and to some extent shared history with Romany Gypsy and Scottish Gypsy Traveller people, have a different ethnic route and do not come originally from India. The best evidence available suggests that Irish Travellers (or Pavee as they refer to themselves) have been a distinct ethnic group within Irish Society, possibly for millennium.

Source: Leeds GATE 2014

Scottish Gypsy Travellers

Travelling people in Scotland, whilst sharing much in common with other Travelling groups have recently been recognised as a separate ethnic group in Scotland. The origins of Scottish Gypsy Travellers may be linked to Romany Gypsies *and* Irish Travellers as well as having some distinct routes of their own.

Source: Leeds GATE 2014

Roma

The term “Roma”, as used internationally, denotes all groups sharing a common Indian origin (Roma, Sinti, Kale), and the communities who refer to themselves as Roma, found mainly in the Balkans and central and eastern Europe, but also throughout the world.

The Roma branch strictly speaking constitutes up to 87 to 88% of the total Roma population (in the generic sense) in Europe.

In terms of language they speak variants of Romani (“*romani chib*”).

Domestic Roma

Autochthonous Roma who are a national ethnic minority – also known as ‘domestic Roma’, they are historic communities, settled for centuries, with the same rights as the majority population.

http://nws.eurocities.eu/MediaShell/media/Roma_mapping_in_cities2017_final.pdf

EU Roma

The European Roma can be sub-divided into three main branches: Roma, Sinti (also referred to as Manush) and Kale (or Spanish Gypsies).

Sinti (Manush)

The Sinti are to be found primarily in the German-speaking regions (Germany, Switzerland, and Austria) where they settled in the 15th century, and in Benelux and Sweden. The Sinti/Manush speak a Germanised version of Romani (called *Romnepen*) which is significantly more different from Romani than other variants of the language.

In France, they are also called Manush (Manouches) from the Romani word *Manus*, meaning “to be human/a man”.

There is a southern sub-branch of the Sinti in northern Italy (Piedmont, Lombardy) and in south eastern France (Provence), whose language comprises a partly Italian-based vocabulary.

Sinti/Manush represent 2 to 3% of the total Roma population (generic sense) in Europe.

The Kale (more commonly called “Gitanos” or “Spanish Gypsies”) form the third main branch of European Roma (in the generic sense), who crossed the Pyrenees in the 15th century. The Kale/Spanish Gypsies live in the Iberian Peninsula and in southern France (in particular families who crossed the Pyrenees in the opposite direction to flee the Franco and Salazar regimes). They have almost totally lost the use of Romani, a consequence of the severe repression suffered under the Catholic Kings. They speak Kaló which derives from Spanish (vocabulary and grammar) with some Romani borrowings.

Romani

The **Romani**, colloquially known as **Gypsies** or **Roma**, are an Indo-Aryan, traditionally itinerant ethnic group living mostly in Europe and the Americas and originating from the northern Indian subcontinent from the Rajasthan, Haryana, Punjab regions of modern-day India.

Source: (Wikipedia)

Romanichals

In the United Kingdom, mainly in England and south Wales, there is a group, the Romanichals (derived from the Romani “*romani cel*” which means Roma people), who identify themselves as “Gypsies” (sometimes “Roma/Gypsies” in official texts). They speak Anglo-Romani, which has a mixed English/Romani vocabulary and English grammar.

Romani Language

Romani is a single language – it is incorrect to speak of Romani languages in the plural. It is understood by a very large proportion of European Roma, although there are numerous variants (it is better to speak of “variants” of Romani than “dialects”).

Source: Council of Europe Descriptive Glossary of terms relating to Roma issues (18 May 2012)

2. Executive Summary

The overarching aim of this Health Needs Assessment (HNA) is to inform the commissioning of a service that can help deliver the vision of the Leeds Joint Health and Wellbeing Strategy (2016-21) so that: **Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest**, with a particular focus on outcome one (People will live longer and healthier lives) and outcome five (people will live in healthier and sustainable communities).

The HNA has provided an opportunity to assess what is currently provided to meet the health needs of Gypsy, Traveller and Roma groups, identify gaps and use this to plan a holistic service, that is in step with current user needs and the wider health activity that is taking place around the Gypsy, Traveller and Roma communities. Taken in the whole, this will help ensure that a new service can be future proofed, be flexible and provide on-going value for money.

In a climate of shrinking public sector funding which is impacting on public health budgets and activity, it is imperative that services across the health system are well aligned, to minimise gaps in service, maximise user satisfaction and ultimately improve health outcomes and reduce inequalities in health.

2.1 Main findings

The HNA found that in order to improve the health and wellbeing of both the Gypsy, Traveller and the Roma communities, there is a need to focus on two main areas:

1. **Tackle the wider determinants of health.** This includes poor, or insecure housing, improving health knowledge and literacy, alongside capacity to act. Improving wider literacy, reducing financial exclusion, addressing prejudice and discrimination, poor mental health, accommodating cultural differences and in the case of Roma groups, language needs.
2. **Increase opportunities for healthy living** as the evidence connecting physical inactivity, poor diet, obesity, alcohol use and smoking tobacco and other substances to a host of serious health conditions, poor quality of life and poor outcomes is strong. A systematic review by O'Mara-Eves et al (2013) provides some evidence that community development approaches that improve social inequalities, also improve health behaviours and by extension inequalities in health.

2.2 Key issues for work going forward:

- A community health development approach to public health issues is required- enabling each community to collectively identify issues and co-design culturally acceptable solutions.
- Health improvement in these groups requires a holistic approach which pro-actively engages with and utilises all available assets and resources, both financial and human that is within and surrounds the Gypsy, Traveller and Roma communities in Leeds.

- There is an ongoing need to build trust and extend the reach of self-reliance, to improve the Gypsy, Traveller and Roma communities' health and make health improvement activity more sustainable. Previous work suggests this is better achieved by one enduring person (external to the community) working over the long term with the community, rather than bursts of activity with different staff.
- In the short term, face to face health promotion activity and information that is accurate, translated, easy read, or doesn't require literacy skills is most likely to work, but in the longer term improving literacy levels within each community is an imperative to ensure connectivity and appropriate use of health and other services.
- Work to address the wider determinants of health should be prioritised. However, the HNA indicates that unhealthy lifestyles are cutting short and if left unchallenged, will continue to cut short the lives of Gypsy, Traveller and Roma individuals who live in Leeds. This should include improving access to healthy food and converting current knowledge and skills into practical everyday solutions.
- Issues around alcohol use, drug use, tobacco use, poor mental health, literacy levels and improving maternity and child outcomes are key issues to address, in a non-stigmatising way across all three Gypsy, Traveller and Roma communities.
- Building on successful strategies identified and adopted by some Gypsies, Travellers and Roma for healthy living activity it may be possible to collectively adapt, promote and embed culturally acceptable measures to help extend the lives of Gypsy Travellers and Roma individuals who live in Leeds, as well as identifying work that can promote good mental health, reduce self-harm and improve maternity and child outcomes.
- Cultural preferences, transient living and the nature of closely knit, marginalised and socially isolated communities demands tailored activity that is meaningful in the context of the Gypsy, Traveller and the Roma communities' everyday lives.
- Encouraging more interaction between Gypsy, Traveller and Roma groups and other community health improvement and development services, service users and the wider community, as long as sensitively considered (i.e. doesn't reinforce discrimination), could serve as useful bridges between these communities and the general population in Leeds. Each and every positive connection would help improve health and wellbeing.
- Opportunities to improve the cultural awareness and address any prejudice that service providers have towards the Gypsy, Traveller and Roma communities should be taken as and when required.
- Whilst public health work appears to have previously focused predominantly on and been more successful in engaging women, ways to engage men in prevention and early treatment must be prioritised, possibly drawing on learning from other marginalised men's work e.g. 'men in sheds'. Insight work by Leeds GATE (2019) shows some support from men for this approach and also a keen interest amongst Gypsy and Traveller males around physical fitness.
- Identifying, training and supporting individuals (particularly women) from each community to build health capacity as volunteers, peer educators and health

champions may help develop inbuilt support and skills to secure paid work e.g. health support workers/link workers/advocates etc.

- Work needs to be done to address the many barriers that women experience to accessing health and wellbeing services e.g. relying on men for transport, men monitoring their use of services, poor literacy and a general lack of independence. All of these affect their health and wellbeing and may hinder women's opportunities to report and receive support around, for example domestic violence, or other taboo issues. Ways need to be found to empower women in their communities in a way that respects their culture and their personal relationships, but ensures they can thrive.
- Increasing the awareness and knowledge of the Gypsy, Traveller and Roma communities of how to access health and other services appropriately is still required and a good way to build trust with the community, but should become the secondary focus of public health work. Working closely with the Outreach Nurse will enable both public health and health service outcomes to be achieved.
- There should be close working arrangements between this contract and the CCG commissioned Outreach Nurse, but with clarity around funding parameters, KPIs and delivery. This will allow assessment of performance on the public health aspects of Gypsy, Traveller and Roma health and ensure that scarce resource is targeted appropriately to meet the terms of the contract.
- Performance measures should be designed, monitored and evaluated around the findings of this HNA, using learning from other similar contracts such as the Better Together contract.
- Work to enhance monitoring and evaluation mechanisms across the breadth of Leeds City Council's contracts should be prioritised to ensure vulnerable groups including Gypsy, Traveller and Roma group's access to services and projects can be tracked.

3. Gypsy, Traveller and Roma Groups-Leeds City Council Targeted Population

Gypsy and Traveller communities in the UK, including Romany Gypsies, UK and Irish born Gypsies and Travellers are a diverse group, and although there is not one commonly shared culture amongst these groups, many people share the tradition of a nomadic lifestyle.

For the purposes of Leeds City Council Public Health targeted work the main groups we seek to reach are Romany Gypsies, Irish Travellers and Roma groups. When referred to collectively in this report this will be as Gypsy, Traveller and Roma groups. Whilst the differences between these groups are recognised and acknowledged, there are aspects of similar shared experience and when this is identified they will be referred to in this way.

Because the groups are not always studied collectively in this way, may study Gypsies and Travellers together, or separately or may use different terms e.g. Romani, where research findings are drawn on, the terms used in that research will be reported as such.

4. Gypsy, Traveller and Roma Groups – Population

4.1 Gypsies and Travellers Population Size

A nomadic lifestyle and the lack of consistent monitoring of Gypsies and Travellers by services and statutory bodies limits our understanding of the size of this community, so the number of Gypsies and Travellers can only be estimated. We also know that Gypsies and Travellers may choose not to disclose their ethnicity, due to a history of public hostility, based on their identity.

Groups may be wholly or predominantly nomadic, e.g. in terms of some roadside groups, partially in terms of the 'travelling season' or those such as Roma and house Gypsies, who may only live (often insecurely) in more mainstream accommodation.

The 2011 Census found that the majority (76%) of Gypsies and Irish Travellers in England and Wales lived in conventional bricks-and-mortar accommodation (house, bungalow, flat etc). This compared to 99% of the population as a whole. 24% of Gypsies and Travellers in England and Wales lived in a caravan or other mobile or temporary structure (Office for National Statistics 2014).

The category 'Gypsy/Traveller' was included in the census for the first time in 2011 and showed that there were 54,895 Gypsy and Traveller people living in England equating to 0.1% of the total population.

However it is widely believed that the 2011 census figure is a significant undercount, most likely due to many Gypsies and Travellers not self-ascribing.

In 2013, a briefing written by the Irish Traveller Movement in Britain (ITMB), which is a leading national policy and voice charity, working to raise the capacity and social inclusion of the Traveller communities in Britain suggested that the Council of Europe statistics estimated the UK's Gypsy, Traveller and Roma population to be in the region of 150,000 to 300,000.

In January 2018, the national caravan count in England recorded 22,946 caravans, which was 1026 more than in January 2017. Most, (87%) of Travellers caravans were on authorised land and 13% on unauthorised land. However, people who lived in the caravans were not counted, so this data is of limited use for health related purposes.

Locally, a census undertaken in Leeds in May-July 2004 found 1,071 Gypsies and Travellers living in Leeds, out of a total population of 715,402 (Baker 2004).

The 2011, national Census identified 652 residents across 257 households in Leeds who stated they had Gypsy or Irish Traveller ethnicity. 43 (16.3%) of these households lived in a caravan, or other mobile temporary structure with the remainder (83.3%) in bricks and mortar (house, bungalow, flat, or maisonette).

Since then, Gypsy and Traveller Exchange (GATE) which is a member's organisation for Gypsies and Travellers in Leeds, has estimated that in 2018 there are about 3,000 Gypsy and Traveller people in Leeds and the surrounding area (<https://southleedslife.com/leeds-gypsy-and-traveller-charity-wins-national-award> 2018) and probably about 7,000 in West Yorkshire.

The following table shows the number of roadside encampments from 1st Jan 2018 to 31st December 2018 that were recorded by the Leeds Housing Options Outreach Team.

Table 1. Gypsy and Traveller Roadside encampments in Leeds by area and average Nos of caravans per camp Jan 1st-31st Dec 2018

	Q1	Q2	Q3	Q4
Total No.	23	33	31	21
North	0	5	0	0
South	7	4	7	6
East	8	14	13	7
West	8	10	11	8
Avg no. caravans per camp	7.4	9	9	6

Unsurprisingly there are more Travellers moving around Leeds in the Spring and Summer months when weather conditions are more favourable, but outside these quarters, there are considerable numbers of families who technically may be considered homeless.

Against this, the Leeds City Council Housing Options waiting list currently has 25 applicants for rehousing at Cottingley Springs / Kidacre Park with approximately 1-2 plots becoming available each year for allocation.

The way that Travellers are dealt with when setting up unauthorised encampments is set to change. On 6th February 2019 the Home Secretary Sajid Javid set out draft measures aimed at making it easier for officers to intervene and remove Travellers from land they should not be on and will also consider making it a criminal offence to set up such camps. It is currently defined in law as trespassing and dealt with as a civil matter.

At the same time, the Home Office announced that it will also consult on proposals to amend the Criminal Justice and Public Order Act 1994 to:

- lower the number of vehicles needed to be involved in an illegal camp before police can act from 6 to 2.
- give the police powers to direct Travellers to sites in neighbouring local authorities. Currently they can only direct trespassers to sites in the same area.
- allow officers to remove trespassers from camping on or beside a road.
- increase the time - from 3 months to a year - during which Travellers are not allowed to return to a site they have already been removed from.

The Ministry for Housing, Communities and Local Government (MHCLG) announced it will provide local authorities with practical and financial support to handle unauthorised encampments and has committed to give councils up to £1.5 million of

extra funding to help them enforce planning rules and tackle unauthorised sites, with funding also available under the £9 billion Affordable Homes Programme to help pay for legal pitches.

Alongside this, the department stated it has given £200,000 to support projects working with Gypsy, Traveller and Roma communities to tackle discrimination, improve integration, healthcare and education.

Source: <https://www.gov.uk/government/news/government-announces-plans-to-tackle-illegal-traveller-sites>

Insight by Leeds GATE 2019 has revealed that some of the Leeds Gypsy and Traveller community felt that there was little trust in the police to support or assist them. Any increased availability of authorised pitches, that can help meet their accommodation needs will be likely to be appreciated but poor relationships between the Travelling community and police is likely to be a pressing and on-going issue.

4.2 Roma Groups

4.2.1 Recent migration of Roma groups to the UK

Most modern-day Roma migrants are from central and Eastern Europe, in Leeds particularly Romania, Slovakia, and the Czech Republic. Roma come from an almost unique position of disadvantage within the EU, with open discrimination, racism and intolerance towards them. Therefore it is important in the UK that Roma integrate into their local communities and that communities and services are prepared and accept them (Migration Yorkshire 2014).

4.2.2 Roma Groups Population size

We know that Roma communities have increased in Leeds over the past few years but once again, it is difficult for local authorities and service provider organisations to know the precise numbers, locations, or needs of these communities residing in their areas.

Figures extracted from Data on nationality of newly arrived, registrations to doctor practices, National Insurance registrations and data on Roma pupils from school census show that in 2017 there were estimated to be 5000 Roma in Leeds, a mixture of EU Roma and domestic Roma (Eurocities, 2017). We know that over the years, a significant number of these have settled in the Harehills area of Leeds (Travellers Health Partnership Social Audit 2006) with other smaller, but concentrated numbers of Roma families living in Armley and Beeston.

5. Background Information

Evidence suggests that local government and the NHS have important roles in building confident and connected communities and the assets within communities, such as the skills and knowledge, social networks and community organisations are building blocks for good health (South 2015).

Community centred approaches to health are not just community based, they are about mobilising assets within communities, promoting equity and increasing people's

control over their health and lives. Building community capacity to take action on health and the social determinants of health, developing volunteer and peer roles and connecting people to community resources is important (South 2015).

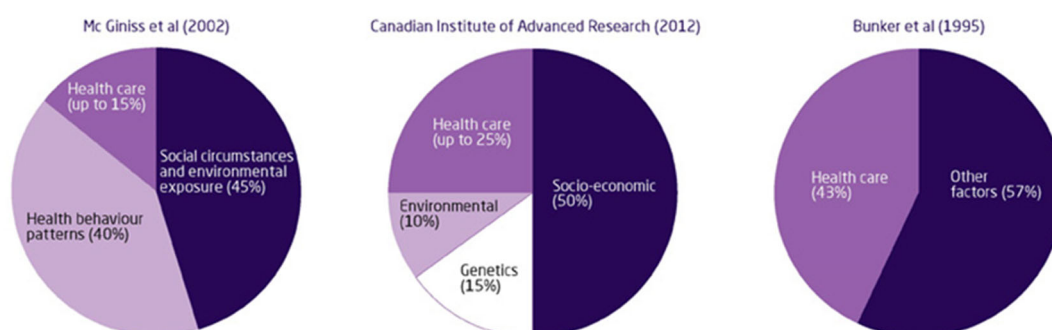
It is widely recognised that our health is influenced by a number of factors including where we live, who we are, our healthy behaviours and our access to health care. A number of studies have considered the relative importance of these factors. Evidence from the Kings Fund (2015) concludes that the 'The biggest contributor (to health inequalities) is the wide bundle of factors wrapped up in the phrase 'the wider determinants of health', those factors that are not health care, behaviours or genetics.

It highlights the overall importance of 'Place' above all over indicators. It also gives an estimation for percentage of contribution for wider determinants of every 10% difference between areas for every month of life expectancy (employment - 11.8%; housing deprivation - 2.2%; and income deprivation among older people - 6.1%) and some lifestyle factors (binge drinking - 4%; fruit and vegetable consumption + 6.9%).

Source: The Kings Fund Report on Inequalities in Life Expectancy (2015).

Several studies have attempted to estimate how the broader determinants of health impact on health. The three pie charts below depict the main findings of three research papers spanning twenty years.

Figure 1. Estimation of contribution of broader determinants on health status-three studies 1995-2012



Source: www.kingsfund.org.uk/time-to-think-differently/trends/broader-determinants-health-messages.

Despite showing that health is affected more by economic, social and environmental factors than by anything else, in England, only 3.6p of every pound spent on healthcare goes towards prevention (NICE).

5.1 Models of Health and Wellness

It is recognised that there are two broadly opposing models of health.

5.1.1 Medical Model

A medical model of health addresses illness or poor health as the result of physical conditions and risks. Health intervention has an intrinsically individual focus. Health improvement activity informed by this model typically involves identifying and controlling illness and focuses on treatment and behaviour change.

5.1.2 Social Model

A social model of health focuses on the context of individual health. It is therefore concerned with the relationship between health outcomes and socio-economic conditions. It recognises that the unequal distribution of health outcomes is related to psychosocial and physical environmental impacts. The links between poverty, social and material environment, and health outcomes require a holistic, or ecological view of health, instead of just a diagnostic or pathological one.

5.1.3 Complementarity of models

However, it is important to understand the two models as complementary. For example, behaviour change interventions alone are unlikely to be effective for disadvantaged communities, but similarly improving the health of disadvantaged communities requires access to appropriate and effective services, which focus on treatment and supporting individual behaviour change where this is appropriate and agreed (Dailly & Barr 2008).

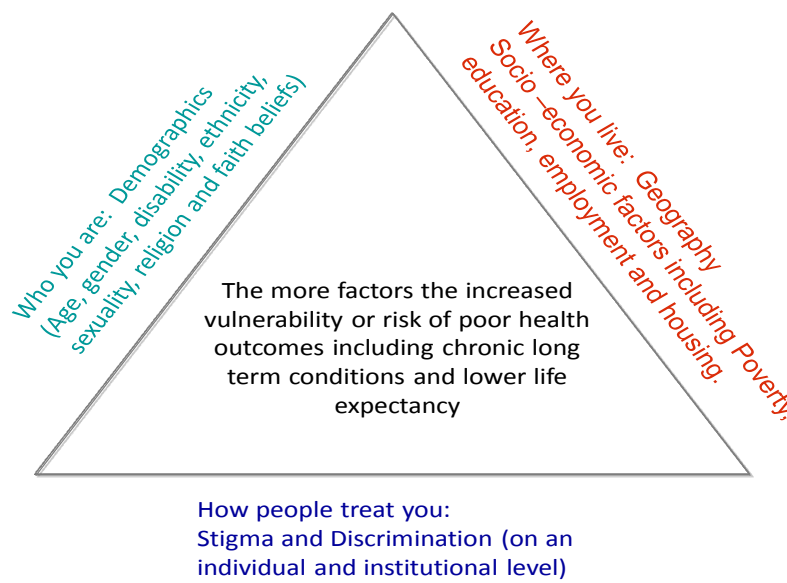
A social model of health suggests that an “upstream” approach to health improvement is essential (i.e. a focus on the conditions that support wellbeing is required, as well as intervention to address individual health behaviour).

5.2 The Vulnerability Framework

In terms of health and health inequality, Gypsy, Traveller and Roma groups are considered ‘vulnerable groups’ as they belong to sub populations, where health is known to be much poorer. The NHS Leeds Public Health Vulnerable Groups team devised a health inequalities model of vulnerability to clarify the concept of ‘Vulnerable Group’, seldom heard groups and terminology used when describing vulnerability. The model (shown below) recognises that Vulnerable Groups are not static, but change and reflect demographic shifts and societal attitudes.

Figure 2.

Health Inequalities Model of Vulnerability



It helps to explain the complexities of how health inequalities are linked to vulnerability, that vulnerability is complex and also affects mental wellbeing. There is a plethora of factors around vulnerability that can increase, or contribute to the risk of being vulnerable to poor health, barriers to accessing services and poor patient experience, thus resulting in poorer health outcomes. The model highlights how these different elements interact, to reflect the experiences of population groups and individuals.

It identifies three key factors that contribute towards poor health outcomes and enables consideration to be given to how these different factors synergise to create risk. This can then be used for health and social care professional planning and designing mainstream services and services for vulnerable groups. The three factors are:

- **Who you are:** the link between demographics/population groups (closely aligned to the protected characteristic groups identified in the Equality Act 2010 i.e. age, gender, disability, religion and belief, race, sexual orientation, gender re-assignment, pregnancy and maternity and marriage and civil partnership) including the increased risk of higher prevalence or incidence rates for certain conditions in specific population groups and illnesses.
- **Where you live:** the importance of geography and the impact of socio-economic factors such as poverty, housing, worklessness and education on health outcomes. It also includes how geography can impact on opportunities to access and adopt healthy lifestyle choices. As poverty is a key factor in health inequalities, geography is an important factor to consider.
- **How people treat you:** the impact on self-efficacy and self-esteem of stigma and discrimination both at an individual and institutional level. This can have a particular impact on real and perceived access to services, patient experience and mental health and wellbeing.

6. Purpose and Rationale of the Health Needs Assessment

The purpose of this health needs assessment is to ascertain the health experiences, beliefs, needs and preferences of Gypsy, Traveller and Roma communities in Leeds, to inform commissioning and programme development for the Public Health department of Leeds City Council.

This has been with a view to:

- Identifying current health need, gaps and opportunities for the future in the Gypsy, Traveller and Roma populations to help inform the new contract.
- Continuing the focus on reducing the health inequality gap and ensuring that those who are the poorest, improve their health the fastest.
- Learning from what works, both in Leeds and elsewhere.
- Enabling Gypsy, Traveller and Roma communities to make informed decisions to improve their health and wellbeing whilst building on their own and other community assets.
- Improving consistency of standards and robust outcome measurement, monitoring and management process.
- Ensuring the new service links well with, and adds value to other commissioned services and programmes.
- Achieving value for money.

7. Health Needs Assessment Methodology

It was considered important to seek views from as varied a sample of Gypsies, Travellers and Roma as possible in terms of gender, age, length of stay in Leeds, current state of health and current connection to services etc. However, the work was not designed as a controlled piece of research study and yielded more qualitative information. Taking into account language and literacy limitations, time restrictions on participants and the challenge of identifying and engaging enough people from the different sub communities of Gypsy, Traveller and Roma groups, in the time available, this health needs assessment has drawn on a combination of methods (described below) to provide a snapshot of current health needs of the Gypsy, Traveller and Roma communities in Leeds.

• Literature Review

A literature review of previous studies and health needs assessments (national and local).

• One to one questionnaires and conversations

Gypsies, Travellers and Roma individuals who were living in Leeds were asked to provide information by questionnaire. These were mainly taken opportunistically, in places where they naturally meet, or congregate. These were administered either by public health staff (e.g. at Lee Gap Fair) or by the Leeds City Council Youth Offer Improvement - GRT Outreach & Inclusion Team, which works with all three communities i.e. Gypsy, Traveller and Roma individuals on a weekly basis.

- **Insight from professionals who form the wider public health workforce**

A number of other professionals who work, or have recently worked with these groups have also provided insight into the day to day culture of the Gypsy, Traveller and Roma communities, some of the gaps and what might work with regards to health promotion and health improvement with these groups in the future. This insight was collected by means of short conversations, using listening analysis e.g. listening to and recording issues raised by staff working at community drop-ins (used by all three groups), by telephone conversations with individuals who had been identified as having good working knowledge of Gypsy Traveller and Roma needs, and a number of dedicated meetings with LCC and other staff, who continue to work with these communities.

- **Stakeholder consultation**

The draft Health Needs Assessment was circulated to stakeholders to enable them to comment, add further perspective, identify omissions and provide clarifications. These additions were incorporated into the final version.

7.1 Literature Review of Gypsy and Traveller Health

Health Status of Gypsies and Travellers

As with population figures, there is also a general lack of up to date and accurate data on the health status of Gypsy, Traveller and Roma groups. Drawing on robust and reliable data is a significant challenge for many reasons, notably poor data recording and the nature of the transient population. However, the studies that we have, repeatedly show that these communities (individually and collectively) experience some of the poorest health outcomes in our society, even when compared to those living in the lowest socio-economically deprived areas of the country. They also experience the lowest life expectancy of any group in the UK (Ministry of Housing, Communities and Local Government, 2012).

Prejudice, discrimination and marginalisation

In 2005 The Commission for Racial Equality – highlighted that discrimination against Gypsies and Travellers was often regarded as the last ‘respectable’ form of racism, while a more recent report by the Equality and Human Rights Commission highlighted that collectively Gypsy, Roma and Traveller people continue to face bias and hostility in society.

The Council of Europe’s (2016) monitoring activities on Roma and Traveller groups (Gypsies not specified) show they still suffer from widespread anti-Gypsyist prejudice and stereotyping and are victims of massive discrimination in many member States. It also highlights that Roma and Travellers are extremely vulnerable to violence, crime and economic and cultural discrimination. Within these communities, women, children and youth are particularly exposed to multiple discrimination and specific forms of violence, including early or forced marriage, domestic violence, trafficking and forced begging.

All have an adverse effect on the health status of the individuals and groups affected, particularly for increasing social isolation and poor mental health, as building supportive networks outside of the tightly knit community is extremely difficult.

Young women and men are considered to receive insufficient support in their transition to autonomy and working life and risk permanent exclusion. At the same time, women, children and young people are fundamental for bringing about social and economic change in Roma and Traveller communities; their full enjoyment of rights requires special support, including from within the Roma and Traveller communities themselves.

The Council of Europe states it will keep a focus on the access of Roma and Traveller children, in particular girls, to inclusive education and address the negative consequences of early/child marriage. Priority topics will be school attendance, early school-leaving and absenteeism, particularly of girls, early and forced marriage, human trafficking within Roma and Traveller communities, the situation of street children, prostitution, forced begging and domestic violence, and access to personal identity documents, where they do not yet have them. Therefore the work we develop in Leeds can make a significant contribution to tackling these issues.

7.2 Life Expectancy

Gypsies and Travellers

Gypsy and Traveller women live 12 years less than women in the general population and men 10 years less, although some research has suggested that the life expectancy gap could be much higher (Dept of Communities and Local Government 2012). Locally, in Leeds, average life expectancy is approximately 50 years of age, compared to the Leeds population of around 78 years (NHS Leeds Clinical Commissioning Group 2018).

Key Health Issues for Gypsies and Travellers

Health beliefs and lifestyles

Among Gypsy and Traveller communities, strong cultural beliefs and attitudes underpin their health-related behaviour, and we are urged to understand that health experiences must be considered within this context (van Cleemput, et al. 2007). There appears to be a fatalistic acceptance of ill health and disease and a view that illness is inevitable and a natural process of reaching middle age (Greenfields, 2009) therefore medical interventions are not always considered necessary (Parry et al, 2004).

There may also be 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. There is often more trust in family carers, rather than in professional care (NHS Kingston 2016).

Nomadic Lifestyle

Both Gypsies and Travellers who are highly mobile and those who are settled experience difficulties, but these vary with accommodation status. Those who are highly mobile, due to frequent evictions from sites experience high levels of uncertainty and anxiety caused by displacement and sometimes, separation from their extended family groups. Gypsies and Travellers on unauthorised sites are technically homeless and often trapped in cycles of eviction. They have the poorest access to health services and unauthorised sites are likely to be situated in an unhealthy environment on the road-side, or on contaminated land.

A nomadic lifestyle is also most likely to lead to difficulties in accessing other public services, securing mainstream work opportunities, attending regular screening and health promoting activity. Also securing good quality/affordable accommodation when required.

Figures suggest that due to a shortage of sites, some 20,000-25,000 Gypsies and Travellers in the UK, some of whom will pass through Leeds from time to time, do not have a legal place to stop.

However settled Travellers can also experience high levels of depression, linked to loss of their traditional lifestyle (Van Cleemput *et al.*, 2007).

7.3 National Research on Gypsies and Travellers Health

Gypsies and Travellers are recognised to have poorer health status than non-Travellers, but reliable evidence on the health of adults is sparse.

A large-scale epidemiological study of Gypsies and Travellers (variously described as Gypsies, Travellers, Romanies or the Roma people) by the University of Sheffield in 2004 used standard health measures, supplemented by in-depth interviews to explore health experiences, beliefs and attitudes. A survey of Primary Care Trusts and Strategic Health Authorities in England also addressed health planning and provision for this ethnic minority.

It engaged 293 Gypsies and Travellers across five locations, with 260 of the participants matched for age and sex with a comparator living in one of five locations, from diverse ethnic groups, from urban and rural environments and from socio-economically deprived areas. The Sheffield study still remains the most robust research currently available.

In terms of general health outcomes, the Sheffield report found that:

- 38% of the sample had a long-term illness, compared with 26% of comparators.
- Significantly more Gypsies and Travellers reported having arthritis, asthma, or chest pain/discomfort than in the comparison group.
- They were over three times more likely to have a chronic cough or bronchitis, even after smoking status had been taken into account.
- Mobility problems were reported by 25% of Gypsies and Travellers and 15% of the comparison group.

- For Gypsies and Travellers, living in a house was also associated with long term illness, poorer health state and anxiety. Those who rarely travelled had the poorest health. This was considered to relate to Gypsy and Traveller people moving into settled accommodation as a result of developing health problems, but was also evident in younger Gypsy and Traveller people.

In summary the work showed it was clear that the scale of health inequality between Gypsy and Traveller people and the UK general population was large, with reported health problems between twice and five times more prevalent.

Later, in 2014, work by Aspinall from the University of Kent found health status was still being compromised in a number of other areas:

- Poor birth outcomes and maternal health. There is an excess prevalence of miscarriages (29% compared with 16% in a matched comparison group), stillbirths, neonatal deaths, and infant mortality.
- Low child immunisation rates and commensurate elevated rates of measles, whooping cough, and other infections in comparison to the general population.
- Mental health: Gypsies and Travellers are nearly three times more likely to be anxious than average and just over twice as likely to be depressed.
- Generic health status: poorer general health and higher rates of limiting long-term illness (even after controlling for socioeconomic status) and higher rates of respiratory and chest symptoms (even after smoking status had been taken into account).
- Low level use of services particularly by men e.g. of use of GP, national screening programmes, sexual health, and dental services.
- Diabetes: A higher prevalence of diabetes has been reported in the Gypsy/ Irish Traveller population.

There is a much higher prevalence of poor mental health in Gypsy and Traveller communities. Male Irish Travellers in Ireland have been found to have a suicide rate 6.6 times higher than the general population (Traveller Health Study 2010) and the report of the Confidential Enquiry into Maternal Deaths in the UK, 1997-99, found that Travellers have 'possibly the highest maternal death rate among all ethnic groups'. Although it could be expected that with passage of time, the situation may have improved, anecdotal evidence suggests otherwise and that stark inequalities continue to affect this community.

These population health findings were based on robust data and were considered to require urgent public health focus, including targeted suicide prevention services, a robust system of reporting of infectious diseases in the Gypsy and Traveller populations and of levels of immunisation.

The close-knit nature of Gypsy and Traveller culture, high birth rate and pattern of extended family residence means that the death of an individual is not only more frequent than in the rest of the population, but is keenly felt as a loss by a large number of kin, including significant number of children (Greenfields, undated). This is against the backdrop of 18% of Gypsy and Traveller women having experienced the death of a child (Parry et. al., 2004) and only 2.3% of Gypsies and Travellers being aged 60+ Leeds Baseline Census (2005).

7.3.1 Access to Health Services

In relation to Gypsies and Traveller's experiences in accessing health care and the cultural appropriateness of services provided, widespread communication difficulties between health workers and Gypsies and Travellers, with defensive expectation of racism and prejudice have been found. However, barriers to health care access have been experienced, with several contributory causes, including reluctance of GPs to register Travellers, or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal barriers. Poor staff attitudes have also been identified elsewhere, including research by McFadden et al (2018) of Gypsy, Roma and Traveller people's experiences, or perceptions of discrimination when accessing and using health services.

Conversely, there were also positive experiences of those GPs and health visitors who were perceived to be culturally well-informed and sympathetic, and such professionals were highly valued (Parry et al 2004).

7.3.2 Lifestyle factors

We know that historically Gypsies and Travellers have had active lifestyles due to their traditional ways of working in the outdoors. However "the transition from high levels of physical activity and healthy eating, to a more sedentary lifestyle and frequent use of convenience foods appears to have had a disproportionate impact on their health" (Greenfields, 2009).

Whilst research around Gypsy and Traveller communities and their lifestyles is scant, existing studies have repeatedly shown unhealthy and sedentary lifestyles, high rates of obesity and limited awareness of healthy eating patterns (Saunders, 2007; Roberts et al, 2007). Other studies provide evidence around high rates of cardio vascular disease, overrepresentation in Type II diabetes, arthritis, asthma, obesity and increasing reports of problematic substance misuse and high rates of anxiety and depression (Parry et al, 2004; Cemelyn et al, 2009; cited within Institute for Diversity Research, Inclusivity, Communities and Society, 2016).

There is even less research around the effectiveness of such lifestyle interventions with the Gypsy, Traveller and Roma communities. The majority of interventions have focused on earlier access to healthcare, rather than keeping people well through health promotion throughout the life course and at population level.

However, a review of JSNAs and the inclusion of health needs of Gypsy and Traveller communities has concluded that asset based approaches are useful and should seek to identify the health promoting behaviours in Gypsy and Traveller culture, for example, close-knit family ties, connection with the land and nature, as well as resilience (Greenfields, 2009).

7.3.3 Wider Determinants

Fuel poverty and cold related illness

Cold related illness is also a recurrent theme. For Gypsies and Travellers on site accommodation, or travelling, thermally inefficient trailers with little insulation combined with the expense of Calor gas can cause fuel poverty. Housed Gypsies and

Travellers frequently reside in areas of deprivation in poor quality housing with poor insulation that can also lead to fuel poverty.

There is little research into fuel poverty in Gypsy and Traveller communities but data collected as part of a fuel poverty project conducted by London Gypsy Traveller Unit in 2005 found that “every household spent more than 10% of their income on heating and was therefore in some degree of fuel poverty. The survey also showed a high incidence of health problems, especially respiratory problems on the site and that most households had difficulty keeping warm. Since trailers and the ‘houses’ continue to be the predominant accommodation of Gypsies and Travellers and are inherently difficult to treat with conventional insulation measures, it is likely that this situation still persists.

Recently local Gypsies and Travellers in Leeds have confirmed that they find gas and electricity unaffordable. There were also perceptions that energy costs were higher on Traveller sites than for housed individuals and that there is an inequality in upkeep of Traveller sites, compared to council homes. One individual had switched their method of payment to a (more expensive) meter to avoid running up quarterly bill arrears but was still cold, despite spending £60 per week on gas. The community is further disadvantaged by their lack of literacy when required to resolve difficulties online (GATE 2019).

Educational attainment

Gypsy, Roma and Traveller pupils are reported to be amongst the lowest achieving ethnic groups within schools in England, are more likely to be identified as having special educational needs (SEN), and are four times more likely than any other group to be excluded from school as a result of their behaviour (DfES, 2005; DCSF, 2009a).

Where Gypsy and Traveller pupils do transfer successfully to secondary school, their attendance is unlikely to continue beyond the age of 14 (DfES 2006a; Derrington and Kendall, 2004).

Parental literacy skills and the cultural expectations within the Travelling communities can also be a barrier to young people engaging in education. For example, the domestic and caring expectations for girls, and for boys, starting work and cultural attributes unconnected with traditional educational achievement may be more important (Friends, Families and Travellers 2017).

7.4 Health needs of Gypsies and Travellers in Warwickshire

A JSNA Health Needs Assessment of 40 Gypsies and Travellers (95% women) in Warwickshire in 2015 identified a number of key health needs in its Gypsy Traveller population.

Approximately 40% of residents on the Griff Caravan site, Nuneaton were found to be suffering with an illness and five residents were advised to visit a GP, or hospital immediately. Contrary to the national evidence and perception of some professionals that Gypsies and Travellers prefer to go to A&E when unwell, this study showed that 87% of Gypsies and Travellers were registered with a GP practice and 70% would prefer to see a GP when unwell. However, only 60% were satisfied with the services

and only 54% said that they were comfortable talking to a doctor. These percentages were lower than the general population in Warwickshire.

The needs assessment showed that mental health issues were the most prevalent health issues in the Warwickshire Gypsy and Traveller communities and the rate of smoking in the Gypsies and Travellers interviewed was higher than the general population in Warwickshire.

The Gypsy and Traveller Service of Warwickshire County Council have also undertaken a snap shot of the health and wellbeing issues of the community. The initial findings showed that the majority of residents spoken to had, or were taking medication for either depression or anxiety, the community did not understand the importance of immunisation and screening and a large proportion of the ageing population stated that they suffered from high blood pressure or angina, but had not seen a doctor recently. At least 50% of those spoken to had some kind of respiratory condition, and a number of both men and women relied on alcohol to 'calm their nerves'.

7.5 Health needs of Gypsies and Travellers in Leeds

The last Health Needs Assessment of the Leeds Gypsy and Traveller communities (not including Roma) was published by Gypsy and Traveller Exchange (GATE) in April 2013.

At this time, a good proportion (92%) of respondents were registered with a GP, and 80% said all the people living with them were also registered. Four people who were not registered were all men.

Although there were relatively good levels of registration, this was still identified in discussions as often problematic with specific practices. Generally respondents were positive about their last experience of using a GP, but it was noted that even those who were not registered answered this question, so their 'rating' may have referred to treatment several years ago and possibly not in Leeds. 25% of those who were currently registered with a GP (n 48) had to travel more than 3 miles to the practice.

40% of those registered said they had been invited for an NHS Health Check and 68% of those who had been invited had attended.

Moving forward, Table 2 shows that in January 2018, the following numbers of individuals, from the Gypsy and Traveller communities were recorded as having registered with a GP. Although these may have been recorded at any time in the past and may have left Leeds at any time since registering, it does show that 754 (around 25%) of the 3,000 Gypsy Traveller people estimated to be in Leeds by GATE are, or have been registered with a GP.

It will also be noted that 'ethnic category 2001 census' is used, although this ethnic monitoring through the census was not introduced until 2011. Further investigation revealed that the GP systems append this text to almost all ethnicity descriptions, so for the purposes of this exercise can be safely ignored.

Table 2.

Gypsy and Traveller groups identified as registered with Leeds GPs between Jan and July 2018

Ethnicity	Number of GP registrations (data lifted from Jan 2018)
Gypsy/Romany - ethnic category 2001 census	657
Traveller - ethnic category 2001 census	41
Irish Traveller - ethnic category 2001 census	42
Gypsies	14

Usually, a person moving house would register at a new practice and details of the transfer to the new practice would be captured in official data sets, but it is not possible to assess how this system works for Gypsies and Travellers, where the NHS may not be as able to match patients.

In terms of other health services, the 2013 HNA showed that 31% of respondents were not registered with a dentist, but use of pharmacists was high, with only 12% (n 6) saying they did not use the chemist in the previous month. At last visit 86% rated their visit as 'good to excellent'.

89% (n 41) of those who got medicine from the chemist said its use was explained to them in a way they could understand and remember and also that they had had helpful advice. 53% visited the chemist monthly or more often and found it easy to find a chemist (93%), and open when needed (87%).

Easy access for this vulnerable group was also noted in the LCC 2018 Pharmacy Needs Assessment, with a view to building on this reported good practice, not only by continuing to provide accessible and high quality services for Gypsy Travellers but also to replicate for other minority ethnic groups, e.g. Roma, who may have more limited language and literacy skills.

42% (n22) had phoned NHS Direct for advice in an emergency, but the internet was less popular with only two people reporting using the Internet service for NHS Direct. A & E had been accessed for a number of serious health problems, including a broken leg, pneumonia, blackouts, breathing difficulties and vomiting blood; as well as some which might be more appropriately managed within primary care, such as flu, infection and sickness. Those living on site and housed had more varied use pattern, whilst 86% (n6) of those living roadside had used only A and E.

At this time, many relayed the experience of being treated less well than others by many professionals because they were Gypsy and Traveller people and felt that it was harder for them to access equivalent services, for a variety of reasons.

Nationally, in 2015, there were indications that whether living in housing, on authorised sites or nomadic, lack of access to services still persisted. Reasons included difficulties in primary care registration that requires proof of identity and address; poor literacy skills; fear of discrimination and an over reliance on A & E services. Health professionals were viewed as lacking the skills and cultural understanding/awareness

of these communities that would enhance engagement and help deliver better quality care to these groups (The Traveller Movement, 2015).

However, the majority of respondents in the 2013 Leeds HNA, who identified as having a diagnosed health problem and had support from health professionals, felt they had been fairly well supported. This was echoed in the discussion groups, where participants were very positive about individual health professionals, who treated them with respect.

7.5.1 Access to health services through the Gypsy and Traveller Health Improvement Project 2018

In the recent (2018) interim evaluation of a Gypsy and Traveller Health Improvement Project (Outreach Nurse), commissioned by Leeds West CCG (now NHS Leeds Clinical Commissioning Group), views were mixed- some Gypsies and Travellers have built up good and long relationships with their GP, whilst others may have disconnected from a particular GP, or failed to engage with primary care because of historical bad experience.

Getting appointments when needed was still viewed as a problem by most, also a common theme in this HNA sample. There were also cases where the Gypsies and Travellers felt that health service staff did not have sufficient cultural awareness.

The Outreach Nurse appears highly valued within the community and very helpful in terms of connecting individuals with relevant health services. Having friendly service providers on site can also help link people into relevant support networks, something particularly valuable if an individual is for any reason left unsupported by their community.

The final evaluation of this project found that barriers for Gypsy, Traveller or Roma women may also come from within their own communities, as they are often heavily reliant on access to resources that are essentially controlled by males. Low levels of literacy were also found: of all the people seen by the Outreach nurse 78% had no or some literacy – only 3% had good literacy.

The younger generation were found to have no better literacy than the middle / older generation which means that health services, which are already extremely difficult to navigate will become more inaccessible as more moves to the internet. It also significantly affects life chances in terms of integrating with other communities and opportunities to access employment etc (Warwick Booth et al 2018).

7.5.2 Findings of the Leeds 2018 Health Needs Assessment Service User views

- Issues around appointments, relationships and cultural awareness of NHS staff were found in the Gypsy and Traveller service user responses in this HNA (full responses at Appendix 1).
- Most Gypsy and Traveller people use GPs, walk in centres, community pharmacies or phone NHS Direct (not internet).
- Close relatives, strong social ties and family life are seen as supportive to health (but stigma around certain conditions may threaten that support).

- Most reported good health even though they had been diagnosed with a chronic health condition. A number had been concerned about a health problem but not sought help.
- Poor mental health is considered prevalent in the Gypsy and Traveller communities.
- Men are most likely to conceal illness and not take a pro-active approach to health.
- There still appears to be a general resistance to health screening.
- Regular physical activity and eating a good healthy diet was recognised as health promoting.
- A number of respondents had incorporated individual, no cost adjustments around healthy living that could be further developed collectively.
- Alcohol and drug use is considered increasingly prevalent within the Gypsy and Traveller communities.
- Face to face health promotion activity that builds trust and doesn't require literacy skills is most likely to work with the Gypsy and Traveller communities.

7.6 Literature Review of Roma Health

7.6.1 Health Status of Roma Groups

Health Status

Roma groups share a lot of problems in common with Gypsy and Traveller groups (Roma Support Group 2012) and we do know that like Gypsy and Traveller groups generally, the Roma community is still one of the most disadvantaged ethnic groups in the UK today.

However, existing evidence shows that many Roma communities have received little attention in relation to their health requirements, despite a large evidence base that illustrates how the Roma community suffer from poorer health and unhealthier living conditions when compared to majority populations (Masseria, et al. 2010) and as with Gypsy and Traveller groups, that their poor health can be closely linked to the wider social determinants of health (Foldes and Covaci 2012).

7.6.2 Life Expectancy

Migration Yorkshire, in its Roma MATRIX work in 2014 identified that:

- Roma have a life expectancy 10 years lower than other European citizens.
- Roma child mortality rates are between two and six times higher than the general population of Europe.

The Equality and Human Rights Commission (2016) found emerging evidence that health inequalities of Roma people are similar to those identified among Gypsies and Travellers, including a high prevalence of diabetes, cardiovascular disease, premature myocardial infarction, obesity, asthma and mental health issues such as stress, anxiety and depression (EC, 2014). Poor familiarity with healthcare provisions and

language barriers may also make it difficult for them to access health services (EC, 2014; Lane et al., 2014).

As has been found with Gypsy and Traveller men, Roma men may not easily acknowledge a mental health problem, or accept help, and support would more likely come from family and friends.

This is particularly challenging, since self-harming and poor mental health, especially in some of the men was raised as an issue during this HNA. However, language, poor understanding of services and how to access them appropriately is likely to affect women also. Head lice in children and interrupted schooling/difficulty getting a school place in the same school as family and friends were also stated as issues.

The Roma Mental Health Advocacy Project-Evaluation Report by the Roma Support Group in 2012 found that over 90% of the (mostly female) respondents (66%) who came to the UK from Poland (88%) before 2004 and were asylum seekers (77.5%) stated that they suffered not only from mental health problems but also from physical health problems. 90% stated that they also struggle with non-health related problems such as housing, low income and debts and other family members suffering from long term illnesses.

The recommendations coming out of this work suggested a model of work which would focus on:

- Improving communication strategies with Roma mental health service users.
- Person-centred care.
- A holistic approach that combines individual and social empowerment.
- A holistic approach that supports individuals to improve other aspects of their lives that improve mental health such as housing, welfare etc.

7.6.3 Access to Services

Cultural norms may also prevent some Roma people from accessing services for support with mental health, sexual health, and drug and alcohol misuse (EC, 2014). Infrequent contact with health providers may also be exacerbating the health problems of some Roma patients (Social Marketing Gateway, 2013).

The Roma Mental Health Advocacy Project - Evaluation Report by the Roma Support Group (2012) identified several main reoccurring themes including lack of trust towards mental health professionals and the lack of knowledge about mental health and services available, communication difficulties and isolation, which were closely interrelated and impacted negatively on the service users' state of mind, contributing hugely towards their feeling of disempowerment. Poor familiarity with healthcare provision is often exacerbated by lack of English language skills [language barriers may make it difficult to access health services \(PDF 3.45MB\)](#).

Stigma around certain conditions (as in the Gypsy and Traveller communities) is also a barrier to this community accessing healthcare, as described by Robinson et al (2016). Similarly, adapting to the UK appointments system is a challenge; and many

men are not able to describe symptoms, or understand questions and diagnoses, without interpreting support. Despite this it was suggested that the language line interpreting service continues to be under-used.

7.6.4 Wider Determinants

Educational Attainment

Less than half of Roma children complete primary school and a very low number attend secondary school. Therefore nearly one fifth of Roma children fail to achieve a “good level of development” in the early years, and it continues as they get older.

Just 14% of Roma children succeed in reaching minimum GCSE expectations compared with 60% of their white peers. This is less surprising when school attendance is considered – Roma children are four to five times more likely to be excluded from school than their peers. Therefore, low attainment, literacy and numeracy at a young age trap Roma (and Travellers) in low paid, uncertain work as adults (LeBas DJ & Barsony K 2016).

Employment and Housing

Employment rates are lower for Roma than the general population and housing is often poor, with inadequate access to services. The UK Roma support organisation Equality has described the low wage and temporary contracts culture, commonly organised and enforced by gang-masters, which is faced by many Roma in the UK. This vulnerable position is often exploited, with many forced to live in sub-standard accommodation, which is shared with other families.

The consequences of this lifestyle include poor physical and mental health, contributing to their life expectancy being 10 years below the UK average. Although this HNA did not directly explore these aspects of Roma life in detail, some informal insight was collected and suggests that this may also be the case in Leeds.

7.7 Health needs of Roma groups in Leeds

The Roma community in Leeds is based predominantly in Harehills, with smaller pockets in Armley and Beeston. As with national findings, healthcare access issues for the Roma community have also been found in Leeds.

Language barriers

Leeds City Council public health team has previously identified that the Eastern European migrant population (which includes Roma) has a number of challenging health issues, including language barriers, although locally this has led to high use of language line in primary care. Leeds North CCG audited the use of language line for translation across all of its practices between April–Dec 2015 and found:

- During this time, language line was used 1784 (utilised most frequently for Romanian, followed by Czech and Slovak service users).

- One practice in Harehills used the service 1052 times.
- At the same Harehills practice there were a total of 214 DNAs during April 2016, which resulted in a total cost to the practice of £5,136.00.
(Source: Cresswell & McGready 2016).

Although primarily manifesting as an inability to understand the English language, this may also be in the context of and compounded by poor literacy in own language, the language being spoken and the complexities of contextual understanding.

Cresswell and McGready suggested that holistic care should simultaneously address the patient's clinical needs and the social and environmental factors, which increase the risk of disease and poor treatment outcomes. These factors include, but are not limited to, mental health issues, homelessness, addiction, detention, destitution and exclusion from care services.

Access to services 2016

Jeffreys et al (2016) in a report of health within the Leeds Roma Community, again found language to be a key barrier in relation to accessing health care and understanding health messages.

Participant's understanding of the health system were hindered by their different experiences within their countries of origin, hence frustration was expressed when no examinations were undertaken during consultations, as well as in instances where prescriptions were not discharged. This led to a lack of confidence within UK health service provision. Roma service users have expressed similar perceptions during this HNA.

In terms of health services, the majority of respondents (91.4%) were registered with a doctor and the most popular source of help for medical advice was the GP (80% of respondents), followed by friends and family (37.1%) and then A&E (12.9%). However, only just over a half (55.7%) were registered with a dentist.

Almost half of the respondents described the service that they received from their GP as good (31.4%) or excellent (10%) and more than half of the respondents (57.1%) who had used hospital services within the last year reported the services as good, 12.2% rated them as poor and 17.1% felt OK/indifferent in relation to hospital services.

There were good levels of awareness of childhood immunisation programme (88.6%) and also high levels of awareness of pregnancy/childhood screening programmes (77.3% for new born screening and 59.1% for anti-natal screening). However, there was less awareness of NHS health checks (18.2%).

In terms of lifestyle:

- 67.1% of questionnaire respondents were current smokers.
- Almost half (51.4%) of the respondents reported that they consumed alcohol 'monthly or less', and a further 40% stated that they never drank alcohol.

- Over half of respondents (54.3%) reported it 'very easy' to access fruit and vegetables but only 1.4% consumed the recommended daily allowance of 5 or more portions per day.
- Over a third (34.3%) of respondents were physically active for 30 minutes 5 or more times per week.

Key areas for attention from this report were suggested as:

- Language support (in a variety of forms, including interpreters).
- Understanding rights and entitlements (related to housing and welfare benefit provision).
- Work and money advice.
- Understanding how health services work, as well as appropriate points of access.

Roma tend not to travel once at their final destination so avoiding some of the hazards of a transient lifestyle, but as with the Gypsy and Traveller communities, several wider determinants of health were identified as key causes of stress.

It is possible that this situation has since changed-at the time of the research national welfare reform was taking place, which may have reflected participant concerns related to on-going financial support.

7.7.1 Findings of the Leeds 2018 Health Needs Assessment of Roma Service User views

Access to services (2018)

- Most of the combined sample (Gypsies, Travellers and Roma) knew to go and did go to their GP or Walk in Centre, rather than straight to A & E when they had a health concern. There were instances where A & E would be the first choice e.g. when children were ill, or long wait for GP appointment times. Those individuals who had lived in Leeds for longer (more than 5 years), were most likely to access a GP or Walk in Centre, rather than A & E.
- 14 out of the 16 Roma who completed the shortened questionnaire had lived in Leeds less than five years, and despite having generally good health 15 reported that they had used health services whilst they have been here GP services (13) and a substantial proportion (9) had used A & E.
- Roma individuals in Leeds are also frustrated with the time it takes to get GP appointments and there is a perception that if an examination isn't done, or treatment (beyond paracetamol) prescribed, then a poor service has been received.
- Some frustration was identified around GPs being able to consider only 1 issue at one appointment.
- There is very limited knowledge of the NHS Health check initiative in the Roma community, possibly reflecting the age range of the respondents.
- As with the Gypsy and Traveller communities, poor mental health appeared prevalent in the Roma community.

- Some coping strategies were offered, including physical activity, family/home activities, quiet places and hobbies and activities, all were considered helpful in managing poor mental health.
- Conditions of the liver, lung, cancer and gynaecological/URTI issues were thought to be common in the Roma community.

These findings are similar to those reported by Cresswell and McGready (2016) in that in some Eastern European countries, the concept of a GP as a healthcare gatekeeper to other services is unfamiliar, perhaps being experienced as a denial of care, or a cost-saving manoeuvre.

This suggests that increasing understanding of appropriate use of health services, in a way that can be easily understood, would continue to be useful to this group.

Healthy Living

- Healthy eating, exercise, drinking water and caring about what is eaten and hygiene were put forward as to what makes you healthy.
- As in the Gypsy and Traveller communities, alcohol use was perceived to be having an effect on members of their community.

Wider determinants

- One person, in keeping with national findings said that being on a Council housing estate made them unhappy.
- Working conditions, benefits/benefits advice and clean air was put forward as affecting their, or their family's health, or was something that would improve their family's health.
- Accessing health information via social media appeared more acceptable to the Roma community than it was to the Gypsy and Traveller communities.

7.8 Questionnaires and conversations

The Sheffield study remains the most robust wider research in terms of identifying Gypsy and Traveller needs and several years have elapsed since the last Leeds Health Needs Assessment in 2013. Therefore a local survey amongst an opportunistically sampled group of Gypsies, Travellers and Roma individuals who are living locally in Leeds, either roadside, in houses, or on Cottingley Springs Gypsy and Traveller site was undertaken to provide an indication of current needs within each community.

Whilst focus groups were considered, as they can generate rich data and are less resource intensive than one to one enquiry, strong relationships and trust are needed between participants and the researcher in order for this approach to be successful. As a time restricted exercise, deploying people who were already known to and working with each community was considered a more time efficient and effective approach to data collection on this occasion. With this in mind, assistance from a number of colleagues from Public Health and the LCC Youth Improvement Team-GRT Outreach & Inclusion was secured.

Assistance was sought from an LCC employee who self identifies as being a Romani Gypsy to develop the questionnaire. Heeding existing research (Papadopoulos, 2007) and then piloting with another person from that community enabled an approach that was felt to be culturally appropriate and ensure people felt respected.

The piloting was conducted in the person's own home environment, tape recorded with permission and the information gained was also fed into this review.

Post piloting, face to face questionnaires, using an interpreter where necessary were administered by staff who had an established rapport with each community and so were more likely to be 'trusted'. Gypsies and Travellers have been found more likely to disclose personal information to them and follow their advice, which is more likely to impact positively on them in the longer term (Carr et al 2014).

All individuals who engaged, were assured that information gathered would be presented on a non-identifiable basis.

As most research and delivered activity seems to have focused primarily around improving access to health services, rather than (at Leeds level) on population health, healthy living, or determinants of health, we were keen to gather information around wider impacts on the health and wellbeing of each community. With this in mind, information obtained from individual community members was supplemented by additional information from other colleagues who currently work, or have recently worked intensively with the Gypsy, Traveller and Roma communities.

A balance was struck between gathering as much information from each group as possible whilst accommodating respondent's needs. For instance some Roma groups could not engage with a detailed or lengthy questionnaire, as they often needed an interpreter, and were to be approached opportunistically, whilst they were waiting to be seen by a support service. Hence a tailored, but perhaps less personal, shortened questionnaire was used for this purpose.

A longer questionnaire was completed by other individuals (including some Roma), when time allowed. For these questionnaires a £15 food voucher was provided as a thank you. Although the voucher was only provided at the end of a completed questionnaire, in a close knit community, there is a chance that for some individuals the voucher was the main motivation for engagement. It was agreed that should young people wish to participate, they would not be offered the voucher individually, but it would be used to help provide food at any youth activities that the young person attended.

7.8.1 Questionnaire delivery

Five different sections of the Leeds Gypsy, Traveller and Roma communities were sampled using face to face questionnaires as follows:

Group 1

Public Health colleagues attended Lee Gap Fair, a venue where Gypsy and Traveller people meet to socialise and trade horses. 6 individuals who live in Leeds (5 female and 1 male), provided information, via the longer questionnaire.

This group in the main were using a range of health services, including GPs, Walk in Centres, pharmacies and NHS Health checks when called. They were aware of the benefits of healthy eating and regular physical activity for health, with the majority being physically active on most days. 50% of this sample smoked tobacco, rather than e cigarettes and two thirds of the sample drinks alcohol- for one third this is a few times a week.

Most felt that there are things you can do to reduce the chance of you getting ill although most were already living with ongoing conditions. There was evidence that poor mental health e.g. depression was considered something that **'you get on with'**. Living in a safe area was thought important to health, with the majority feeling very satisfied and very safe in the area in which they live.

In summary, further work to understand and address any alcohol, poor mental health and tobacco consumption issues should be prioritised in this group.

Group 2

Workers within the LCC Youth Improvement Team- GRT Outreach & Inclusion Team have weekly contact with Gypsy and Traveller families on the Cottingley Springs Site in Leeds, as well as Gypsies, Travellers and Roma who live in houses and roadside. They were given basic training on how to deliver the face to face interviews and consistency around the use of prompts was also explained. 8 people (all female) provided information via the longer questionnaire. 4 respondents lived on the site, 3 were housed Gypsies who had previously lived on site and one was a roadside Traveller.

This group were most likely to visit their GP first if they became unwell, but the practice nurse, or outreach nurse on site and Walk in Centres were also used. Pharmacists were not so well used, being seen as too expensive to buy medication, or illnesses being seen as too serious. Bad chests, water infections, diabetes, depression (in younger women) anxiety and infectious conditions were raised as common in this community.

Men were seen to be reluctant to seek help through fear (of cancer) of weakness, or through a 'fight it off' mentality. However, younger men were perceived to be more receptive to change out of concern for their children, should they die. In this sample also there was an attitude towards illness of **"you just have to get on with it"**.

Preventive screening was seen to create worry by **"looking for illness you haven't got"**, or unpleasant (e.g. smear test). Awareness of the NHS Health check was low, although one person said they would like one.

There was an awareness of the benefits of healthy eating and physical activity and a number of respondents were making personal changes. Family was seen as key to protecting health and the wider determinants (pollution, living conditions, less money) as harming health. Alcohol and drug use were raised as issues affecting this community's health.

Activities such as going to the gym, or holidays to help unwind, were considered out of reach, but use of parks was seen as a good substitute.

In summary, further work to understand and address signposting, overweight, mental health concerns, alcohol and drug use and activity to reduce the general fear around cancer in the community appear to be areas of public health worthy of consideration at the Cottingley Springs site.

Group 3

The LCC Youth Improvement Team- GRT Outreach & Inclusion Team also delivered questionnaires to Roma individuals as part of their ongoing work. 11 self-identified Roma individuals (8 women, 1 young woman and 2 males) responded and provided information via the longer questionnaire when possible.

Most of this group had lived in Leeds between 5 and more than 10 years and had used a range of health services. The GP would be first port of call but speed of being seen is important and a Walk in centre or A & E would be used if no immediate GP appointments were available. Pharmacists once again were well used, trusted and thought perhaps a more accessible source of assistance for men.

The cost of some services e.g. dental treatment was raised as an issue, leading to some only attending with a problem, rather than regular check-ups and awareness of the NHS health check, was once again low. Health issues, thought to be prevalent in the community were remarkably similar to other groups and included cancer, liver issues, lung issues and ladies problems/urine infections.

Poor mental health was raised by some and a number of coping mechanisms such as exercise, socialising and focusing on family offered up as helpful. In common with the Gypsy and Traveller community, alcohol and drugs were similarly seen to be adversely affecting this community. However, when asked about what would improve community health, the responses were almost universally couched in terms of NHS health services, translated information and Roma working for the NHS were raised.

In summary, awareness raising of and appropriate use of health services, especially preventive services and addressing poor mental health and drug and alcohol use should be prioritised in this group.

Group 4

This group of Roma individuals were opportunistically approached and completed a short questionnaire. 16 individuals (7 males and 9 females) responded.

Most of this group had lived in Leeds for less than 5 years and although reporting good health, GP and A & E use was high. Access to services was found to be easy and responses when accessing these services had been helpful. The wider determinants were mentioned more in this group, working conditions, benefits and benefits advice were issues of concern. Similarly in terms of things that would improve their and their family's health, stress free living and fresh air was seen to be beneficial. Stopping smoking and relief of painful legs, were also highlighted.

In summary, awareness raising of and appropriate use of health services and improving the economic and wider determinants of health, which would also improve mental health, should be prioritised in this group.

Individual one to one discussion (as part of piloting work with self-identified Romani Gypsy female)

This respondent was aware of and used her GP as first port of call for health advice and lamented what she saw as wasteful use of resource by anyone attending A & E rather than using GPs. She also highlighted the costs of clean ups if Gypsies and Travellers are inconsiderate when roadside, or on unauthorised sites. She was aware of the benefits of good eating habits, exercise and fresh air on health, but she felt that many modern Traveller families don't cook as they did and rely more on takeaway.

She had had a NHS health check and felt that common conditions in her community included infections, such as sickness and diarrhoea and urinary problems. She also offered insight into how some traditional remedies might be used to treat e.g. drinking lemon and barley water for urinary problems. She also raised the issue of male reluctance to engage with preventive health and the fear of cancer, being described as 'the bad thing'.

Whilst intended as a brief distillation of the findings of the community survey work, the key messages from the responses for the work going forward is shown below. The collation of the full responses to the questionnaires are shown at Appendix 1.

In terms of limitations of this method of sampling, it is acknowledged that the findings from each sample cannot be fully and exactly compared across the Gypsy, Traveller and Roma communities as a whole because the sample size was relatively small (15 Gypsies and Travellers and 27 Roma individuals) some questionnaires were more detailed, as time allowed, whilst others were designed to secure engagement and basic information from those who had less time, inclination or needed language support to participate. It is also recognised that there was little input from roadside Travellers and Gypsy or Traveller men. However, taken together the responses provide a useful insight into the current health related issues for Gypsy, Traveller and Roma groups which can be further explored in the future work programme.

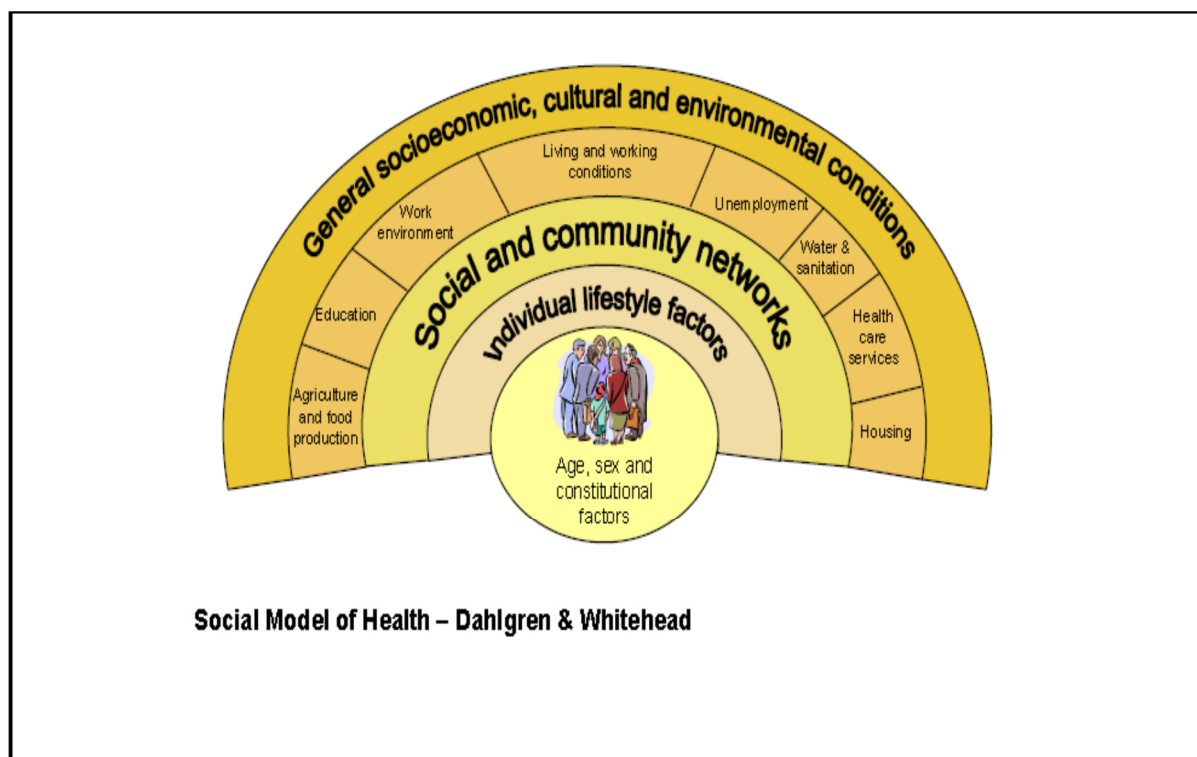
7.8.2 Key messages from community questionnaires

- Once an appointment is secured, most groups appeared able to access health services relatively easily, but more work to make primary care more welcoming to Gypsy, Traveller and Roma Groups is required.
- More work to raise awareness of how to access health services appropriately, and what can be expected at each level is needed with all groups, but especially Roma.
- Further work to increase acceptability and uptake of preventive screening and NHS Health checks in all groups is required.
- Although the community tended to focus mainly on NHS services, further work to better understand and address poor mental health alcohol, substance use and tobacco consumption issues should be prioritised.
- Some community members had devised coping strategies to help manage stress, poor mental health, weight management etc. This could be built on and developed collectively via health champions, peer educators etc.
- Targeted work to engage Gypsy, Traveller and Roma men in health promotion measures is required.

7.9 Wider insight into the Public Health Needs of Gypsy and Traveller Communities in Leeds

Because the Gypsy, Traveller and Roma communities are dispersed throughout Leeds, making direct connections with individuals who are not linked to existing health or other projects was more difficult. Therefore professional knowledge and insight from those who work regularly with or on behalf of these communities was sought. Most of these professionals do not have a dedicated health remit, but as the Dahlgren and Whitehead model below (Fig 3) depicts, they are part of the wider public health workforce and interact with these groups at many stages of their lives, particularly in terms of the wider determinants of health. As well as understanding current cultural norms, attitudes towards health and the impact of these on family life, they also see the community outside of any dedicated 'health activity' and so are valued partners who can help build a supportive environment in the future, so helping to tackle the wider determinants of health, and around which healthier behaviour change can develop and be sustained.

Figure 3.



7.9.1 Spatial planning, and living accommodation measures and effects on Gypsy and Traveller health

One of the main public health needs for transient populations, such as Gypsies and Travellers is safe, stable and secure living accommodation and the Public Sector Equality Duty Housing Act 2004 requires local authorities to assess the accommodation needs of Gypsies, Travellers and Show people as part of their housing needs assessments.

Leeds City Council has developed a number of accommodation initiatives over recent years, to help improve the health of Gypsies and Travellers. The 41 pitch permanent Gypsy and Traveller site at Cottingley Springs West Leeds, accommodates both English Gypsies and Irish Travellers. The community consists of 83 adults and 63 children (classed as 16 and under). B site was substantially refurbished in 2002 and since then the Disabled Facilities Grant has enabled adaptations and more space to allow vulnerable older, or disabled people to accommodate carers if required.

There are additional challenges for groups such as Gypsy, Traveller and Roma families, who may live in conventional housing (Gypsies Travellers and Roma), or caravans (Gypsies and Travellers). For housed families, as well as possible insecurity around length of tenure, or affordability of accommodation, home improvements, overcrowding and potential safety issues are also more difficult to address in short term rented accommodation, particularly in the private rented sector.

With regards to Gypsy and Traveller families, mobile accommodation is both very difficult to insulate and often expensive to heat using on peak electricity, or calor gas heaters for example. In the past, particular challenges have been encountered with trying to improve the kitchen buildings at the Cottingley Springs Gypsy and Traveller site. Technicalities around the required format of living accommodation can mean that where funding is available to the wider population for accommodation upgrades, funding criteria often cannot be met on site, or in mobile accommodation and so families are unable to benefit from such opportunities, for example, installation of insulation measures. In the past, Groundwork Leeds has attempted to plug some of these anomalies by undertaking some remedial insulation work, which was funded as part of their 'Green Doctor' work.

Looking forward, Leeds City Council is positively planning for the provision of new permanent Gypsy and Traveller sites across the district in order to meet Leeds' need for 62 new pitches for Gypsy and Travellers and 15 plots for Travelling Show people between 2012-2028. These are planned to have good access to health care, schools and local services and will not be on land deemed unsuitable for general housing such as contaminated land, or land adjacent to refuse sites or heavy industry. Gypsy and Traveller input has helped to ensure the appropriate provision of sufficient and good quality sites in Leeds and helped to reduce any tensions with the settled community.

A site of 8 new pitches, which includes a clean water supply and electricity connection has now been developed at Kidacre Street. Its edge of City Centre location allows access to a wide range of services and facilities. Insight gathered by GATE in January 2019 showed that Gypsy and Traveller community members showed a preference for smaller sites (approx. 6 caravans) as although the community is generally thought to be close knit, there are instances where 'Travellers don't really get on very well together'.

Leeds is also positively planning for Gypsies and Travellers who are temporarily stopping in Leeds through a 'Negotiated Stopping' management approach, which makes sites available at short notice for a period of up to 28 days. The Council provides basic services on the site, such as refuse collection and toilets, so these sites are significantly better than road side conditions. Additionally this breaks the eviction cycle, as there is no immediate threat of eviction.

This is important as Leeds GATE's insight in January 2019 showed that insecurity of accommodation was the most important factor that was impacting on Gypsy and Traveller health. This included not enough sites to accommodate all those who needed them (potentially likely to be exacerbated by the Home Secretaries announcement on increased police powers to deal with unauthorised sites in February 2019), stress caused by being moved around, difficulty in obtaining planning permission for purchased land and long waiting lists/difficulty getting council accommodation.

The difficulties of working, the pressure to earn an income and managing frequent moves was also considered to lead to lack of sleep, irregular eating patterns and adverse impacts on children's nutrition, mental health and education.

Lack of basic sanitary facilities such as toilets, water and showers was also cited and despite a generally understood agreement that Travellers can use nearby Local Authority Leisure Centre facilities, they reported that in practice they were often refused entry, or required to pay, once their identity was known.

Serviced negotiated stopping for Gypsies and Travellers which has been held up as good practice (van Cleemput 2017) has now been implemented in Leeds. However, this approach is a very recent intervention and will be carefully monitored over the short term period.

7.9.2 Insight from professionals working directly with Gypsy and Traveller communities in Leeds

Up until 30th June 2018 the GATE public health contract has been the main public health focused activity for improving Gypsies and Travellers health. This provided a dedicated service, intended to raise the health status of the Gypsy and Traveller communities, but has not until now considered or included Roma. Until very recently Children's Services also had a contract with GATE.

Alongside this work, a number of other LCC teams have worked and continue to work with Gypsies and Travellers and other marginalised communities, including Roma. This has enabled them to build up in depth knowledge of day to day Gypsy, Traveller and Roma needs and individuals from these teams have been consulted and fed into the HNA. These include Better Together (Community Health Improvement and Development Service), Visiting Housing Related Support (Housing), Gypsy and Travellers Services Team (management of the permanent Traveller site at Cottingley Springs and the recently developed Kidacre Street) and the Youth Offer Improvement Team- GRT Outreach & Inclusion (Young People).

7.9.3 Cottingley Springs Gypsy and Travellers site

The Cottingley Springs site is located in West Leeds. It has a number of non-health wider public health workers engaging with the residents.

- **The Gypsy and Travellers Services Team** - their work on the site has led them to believe that the main public health issues in the Gypsy and Traveller community are increased drug and alcohol use, particularly smoking of 'weed,' (also identified in the 2013 GATE HNA) and reliance on fast foods, including men breakfasting at fast food outlets during their working day. They have also

observed that a high proportion of the community appear to have depression and that undefined 'liver' problems also appear very common. They work closely with and have sought assistance from the Outreach Nurse e.g. when illness or disability prevents a person from living in their accommodation.

7.9.4 Roadside Gypsy Travellers

As well as managing the Cottingley Springs site, **The Gypsy and Travellers Services Team** also deal with roadside encampments when they arrive in Leeds. They detail their work as roadside welfare checks, such as checking whether pregnant women have a midwife. They are able to call for one, but in practice they said that many women express an intention to (and do go back) to their place of origin, nearer the birth.

However, whilst it is imperative for all agencies to work collaboratively around the welfare of the Gypsy and Traveller communities there are a number of barriers to be broken down, not least the differences in desired service outcomes. For instance, the current role of the Leeds Gypsy and Travellers Service is primarily an enforcement role and this can often restrict productive communication with support agencies, who are simultaneously trying to build confidence with roadside Travellers.

In terms of roadside encampments the Gypsy and Travellers Service deal with three main groups of Travellers:

- Large extended family groups who are primarily operating as a business in the area or surrounding areas/towns. They tend to stay for a few weeks/months and generally engage on a limited basis so rarely would the team be able to get welfare needs completed.
- Smaller groups of Travellers who tend to pass through mainly in the spring/summer months. They tend to camp on known sites from previous years and are known to the Gypsy and Travellers service. As short stay groups, they do not complete a housing registration form and this type of group is considered more suited for negotiated stopping.
- Groups that have an element of local connection to Leeds or have housed family members in the vicinity. Over time these groups do form a relationship with Gypsy and Travellers service staff and are more likely to register for housing, although this is not always the case. Typically they can be in the area for years and will continue on the roadside during winter.
- **Visiting Housing Related Support** staff from ENGAGE provide a city wide service for housing related support, including for Gypsies and Travellers. The team of Housing Support Workers and Advice Workers work across a range of tenures including caravans, local authority accommodation & private rented sector. Support is very varied, including benefits advice, employment / engagement, mental health, safeguarding, overcrowding, violence / offending risks, DV, literacy, health, tribunal, recourse to funds, wheelchair accessibility, children / school attendance, anxiety, poor property standards, bidding, arrears / shortfalls. The team also support volunteers and peer mentors. In February 2019, 12 Gypsy and Traveller cases were being supported.

- **The Youth Offer Improvement Team** has a Gypsy, Roma and Traveller Outreach Team, which works with families on the Cottingley Springs site and house based Gypsies, Travellers and Roma families throughout Leeds. This team, which is well known to and appreciated by the Gypsy, Traveller and Roma communities assisted the HNA by engaging members of these communities and administering the questionnaires aided where required by a translator. Based on experience, this team considers there are a number of similar needs within each community. Whilst it would not be appropriate to treat the three separate communities as a whole, a targeted approach with each, using similar methods of engagement is most likely to work.

7.9.5 Work around health and health services

In terms of dedicated health related work, historically Leeds West CCG and West Leeds public health team has had the strongest connections to the Gypsy and Traveller communities via GATE, which has been variously commissioned to serve the Gypsy and Traveller population in Leeds.

Most recently, an Outreach Nurse post, funded by NHS Leeds CCG, and running from January 2017-March 2019, was implemented, as a result of needs identified in the 2013 Gypsy and Traveller Health Needs Assessment. This has provided better access for the community into mainstream healthcare, along with improved NHS health services engagement with Gypsy and Traveller groups. Most (just over 60%) of the Cottingley Springs site residents are registered with Middleton Health Centre in the South and East of the city.

There is evidence (including from this HNA) that this post has been well received by the community, as the nurse has been able to build up trust and is seen to overcome barriers to NHS health service access when needed. She has been able to proactively manage health conditions, thus preventing more serious developments. The overview of this activity extracted from SystemOne practices only is described below:

Between 4th Jan 2017 and 26th June 2018 the outreach nurse saw 68 unique people in 283 appointments. 28 people saw the nurse only once, but some (8) have seen the nurse more than 10 times.

The quarterly totals were as follows:

Table 3. Outreach Nurse Appointments (2017)

Quarter	No of appointments
1	33
2	40
3	58
4	24

Table 4. Outreach Nurse Appointments (2018)

Quarter	No of appointments
1	65
2	63
3	
4	

Source (Adults and Health Public Health Information Team 2018)

This was a total of 283 appointments.

Within the group of 68 people seen by the nurse between 4th January 2017 and 26th June 2018:

- 5 people had a total of 25 Primary Care Mental Health team appointments.
- 1 person had 14.

Amongst this group of 68 people there were also:

- 113 visits to A &E by 28 patients during this time.
- 9 visited once.
- 8 more than 5 times with (2) visiting 14 times.

These figures suggest that a number of individuals are using this and other health services, such as A & E on a frequent basis.

The table below, taken from the final evaluation report of the Warwick Booth et al (2018) Leeds CCG Gypsy and Traveller Health Improvement Project breaks down reasons for consultations. There were relatively few community members given lifestyle advice, the most common being stop smoking advice. The highest numbers of consultations appears to confirm community feedback that mental health issues are of most concern. However a significant proportion (34%) of consultations were in the undefined 'other' category, something that may need to be explored further.

Table 5 – Health Advice Offered by Outreach Nurse Source Warwick Booth et al (2018)

	Main Advice Given		Secondary Advice Given		Total (% of advice given)
	Number	% of interactions	Number	% of interactions	
Other	115	34%	54	16%	34%
Depression	73	22%	19	6%	18%
Stress / anxiety	23	7%	37	11%	12%
Medication	25	7%	21	6%	9%
Smoking	22	7%	6	2%	6%
Diet	18	5%	13	4%	6%

Other mental health	16	5%	10	3%	5%
Physical Activity	12	4%	10	3%	4%
Alcohol	6	2%	4	1%	2%
Sleeping	2	1%	8	2%	2%
Losing weight	1	0%	5	1%	1%

Conditions such as ‘nerves’ and poor mental health connected to bereavement, especially through suicide appear to be the main issues. Poor uptake of screening services is still problematic, although positively, evidence is emerging that men are beginning to engage with health checks.

A 3 year Cancer Awareness Community Service is currently running to the end of March 2020 which is intended to increase awareness of the signs and symptoms of breast, bowel and lung cancer and to encourage uptake of screening, targeting deprived geographies and 6 priority groups including– BME and Gypsies, Travellers and Roma. Positively, the Outreach Nurse is part of the steering group and facilitating access to the Gypsy and Traveller community.

Data from the final evaluation of the NHS Leeds CCG Gypsy and Traveller Health Improvement Project showed that over the course of the project, cancer screening was recommended as follows:

- Breast cancer – 9 interactions.
- Cervical – 7 interactions.
- Bowel – 3 interactions.

Prostate, AAA (abdominal aortic aneurysm) and chest were recommended once each.

In terms of public health the nurse has contributed to a number of health related awareness sessions e.g. diabetes awareness but her interactions are generally healthcare focused and on a one to one medical model basis.

From the final evaluation it was suggested that “the impact has been to individuals, rather than a massive impact to the whole community”. However **“being able to engage with and be trusted by a community that many people felt that wouldn’t be possible, or that there would be risks involved, I think has been an achievement really.”** (*Specialist Nurse*). Therefore any resource allocated to encourage community development should help expand and strengthen the health team, enable individuals to access the support they need in a more timely way, co-ordinate health activity and in the longer term build healthier and more sustainable Gypsy and Traveller communities.

There still appears to be work to be done to ensure more vulnerable women can access the services they need. For instance, trying to embed health visiting to roadside families was reported to have been so far fraught with difficulty.

The evaluation of this work also shows that the health needs of those in this community are not always being met within the scope of current primary care provision and a wider range of health issues that affect community members, often being related to the broader social determinants of health have been identified.

7.9.6 Key messages from professional insight into Gypsy and Traveller health Needs

- The success of negotiated stopping sites in terms of Gypsy and Traveller health and wellbeing needs is a positive development but needs to be carefully monitored over the short term period.
- It is important to continually build trust, and work sensitively on messages and activities that have relevance to each community as a whole, to help break down barriers and reduce the perceived vulnerability to adverse comments/judgements/rumours felt by some individuals.
- Both the community questionnaires and professional insight demonstrate the influence of family and friends within these communities. A colleague observed **“they are a closed community and the advice they get from each other.”** It is essential that information is received from a credible source, relayed in an appropriate way for each audience and is workable in the setting in which Gypsies and Travellers are living their lives.
- Total reliance on the support of members living in such a closed community can have its downside, if support is unavailable, or withdrawn. Certain conditions e.g. cancer are seen as taboo subjects and not spoken about in this very tight knit, extended family community.
This can lead to a crushing isolation for the individual (possibly a young person) when diagnosed, leaving them to carry a huge burden alone. One staff member relayed how she had been able to help someone in this position, having gone through the very same condition herself.
- Building on previous asset based work is desirable, but some caution is needed as there may be a reluctance to engage. It is important to get the backing of opinion leaders/influential individuals as **“if one will do it, all will do it”** but equally **“if one doesn’t, then no-one will engage.”**
- Good communication is key. A colleague, who is familiar with Gypsy and Traveller’s needs suggested it is vital to explain things in a way that Travellers can easily understand because **“when things are said to them that they don’t understand, they switch off.”**
- Colleagues considered that whilst older people suffer ill health at a relatively young age, it cuts across the whole life course and as shown in national research, young people are disproportionately affected. Health promotion/improvement initiatives are therefore required from pregnancy/early childhood to older age groups and embedded into everyday life.
- Some family focused work may assist learning across generations and help mitigate some of the adverse effects of cultural norms around formal learning environments.
- Geographical isolation compounds social isolation. Whilst vehicle ownership on Cottingley site is high and reliance on personal transport similarly high, men traditionally work off site during the day, taking vehicles with them. Social isolation for some groups, including women of all ages and teenagers, together with lack of everyday physical activity, may add to the poor health burden.

- In Gypsy and Traveller communities males are less likely to engage in public health related activity, but more likely to use alcohol and drugs and hold power over others, particularly women in their community (Morrison 2007). Ways need to be found to engage males in order to improve their lives, the lives of Gypsy Traveller women and their children.
- Longstanding cultural practices continue to influence everyday life including nutrition and food preferences. Despite living on a settled site for years, people may still express a yearning to travel and often still live as if they are roadside. The frequent (and immediate) requirement to move on when travelling, the desire to keep caravans clean and increasingly easy access to fast foods, has led to a preference for fast food, as it has with other sections of the population.
- Cooking courses remain popular and should be built on to include workable strategies for men, women and children, to incorporate into everyday living.
- Work around the broader social determinants of health is required to support the work of the Outreach Nurse and promote healthy living in the Gypsy and Traveller communities.

7.10 Insight into the Public Health Needs of Roma Communities in Leeds

This HNA has identified a gap in provision around dedicated public health work with Roma, although they have considerable public health and healthcare needs. Positively several wider public health teams, facilities and projects in Leeds cater for some of the needs of this group. In addition to service user questionnaires, valuable information was obtained from these teams about the public health needs of Roma groups in Leeds.

The Youth Offer Improvement Team has highlighted substantial public health need in the Roma population. Some of these needs and characteristics are similar to the needs of the indigenous Gypsy and Traveller population:

Housing

Families are not likely to camp roadside, because of historical persecution of groups in Europe, but issues with insecure housing and moving around within the housing system are common. High rents, damp and poor facilities have been frequently mentioned in previous research around these three (Gypsy, Traveller and Roma) communities (Warwick Booth & Woodward 2019).

Many Roma work and so may not qualify for, or have difficulty managing if eligibility for e.g. housing benefit changes. Although complex, if a customer, who is claiming a legacy benefit, such as JSA, is out of work for a while and then returns to employment, any housing benefit they have been claiming may be paid for a further two weeks by the local authority.

However, if claiming Universal Credit, then DWP would pay the housing element. Any earnings received would be taken into account in the month the payment was due, so if a person started work mid-month and got paid straight away, earnings may be included against benefit entitlement, including the housing element in that month. This may then exceed the benefit, with subsequent loss of housing benefit.

An example of this complexity became evident during one such conversation with a support worker at a Roma drop in where a Roma male main provider had reported he had moved into work, with subsequent loss of housing benefit. Although he was now working, an £850 housing commitment each month for a house in Harehills was leaving him and his family impoverished.

This commitment can be taken in the context of the median rent for property let in Leeds in 2016 being £624pcm, with Rent for apartments the highest in the City Centre at £750pcm and lowest in East Leeds (which includes Harehills) at £524pcm (Leeds City Council, 2017).

This clearly demonstrates the discrimination and hardship this community faces, in just one case of evidence that is surfacing around people's housing experience. Further disadvantage often co-exists, including exploitation by private landlords and overcrowded dwellings. This may be in part due to the culture of extended family living in this group, but may also be as a result of activity such as trafficking, slavery and general exploitation.

Disruption to Education

Families are likely to be uprooted if a parent becomes seriously ill, such as a mother with breast cancer is likely to go back to Romania for treatment. This usually means that the whole family moves back with her, creating further disadvantage for the rest of the family, including the children, who then lose their school places.

Poor mental health

Self-harm in some of the men folk and mental health issues are considered prevalent.

7.11 Services working to meet the needs of Roma Communities

There are a number of support services that include Roma, Gypsies and Travellers in their work.

Migrant Access Project

The Migrant Access Project (MAP) works with Migrant Community Networkers (MCNs) people who are often migrants themselves, and who are passionate about enabling newer migrants to successfully settle. MCNs are connected to communities of diverse backgrounds through groups and activities; ability to speak English and community languages and committed to supporting Leeds by 'bridging the gap' between new communities and service providers. The project recognises services can experience challenges engaging effectively with new communities, whereby language barriers and lack of understanding of UK systems are contributing factors.

MCNs work in partnership with service providers to 'bridge the gap' by:

- Supporting new communities by **sharing key messages and signposting information** to enable better access to services and support.

- Providing **voice and influence to services providers and decision makers** to enable service and citywide development to meet the needs of our changing population.

MAP has a weekly drop-in which brings MCNs together to discuss issues and solutions through shared knowledge, guidance, resources and peer support. Services have the opportunity to attend and raise awareness of their service with MCNs or consult with them to facilitate community engagement. These initial connections may lead to follow up outreach work directly with community groups outside of the drop-in if requested.

The Better Together Community Health Development and Improvement Service is contracted to work with all members of the community, including the full range of vulnerable groups within their contract boundary and positively the monitoring returns show that some Gypsies, Travellers and Roma are already accessing mainstream activities from these providers. This allows a wider range of health promoting options, than have been provided by the Gypsy and Traveller contract and also suggests that all groups may be starting to build stronger and cohesive bonds with other communities, which is positive. BARCA, which operates in West Leeds has previously delivered work to the Gypsy and Traveller community and staff are therefore likely to be particularly conversant with this community's needs.

A number of other services have drop in sessions for these groups throughout Leeds but none of these currently have any associated and dedicated public health based activity.

These are detailed below:

City Wide Service

Touchstone provide a Leeds wide support service for BME communities across Leeds.

East & North East Leeds

Reginald Centre, Chapeltown

The Reginald Centre in Chapeltown runs a drop in, specifically for Roma every Tuesday. Interpreters are present and users can be directed to the most relevant person/service to deal with their queries. On both occasions that the Public Health staff member visited, the drop in was very full and busy, well before the service opened. Users appeared to know that they could find assistance and it is close to the multi-cultural neighbourhood where most live (Harehills). Those leaving the drop in appeared comfortable and satisfied with the assistance they had received.

Compton Centre, Harehills

A Fresh Start group is held every Wednesday in the Compton Centre Harehills. This is a children's group, which is designed to enable children (including Roma) to continue learning, whilst they are waiting for a school place. Children from this community are considered at a disadvantage in competing for school places, where

the emphasis is often to seek academic excellence. Language barriers and poor continuity of education often combine to hinder progress.

Nowell Mount, Harehills

An information session and Roma ESOL with Stay and Play for Roma takes place every Friday at Nowell Mount Community Centre, Harehills. This is very easy for Roma individuals to access.

Technorth Learning Centre Harrogate Road

The Migrant Community Networkers (MCN) Drop-in takes place every Tuesday at Technorth Learning Centre, 9 Harrogate Road, Leeds, LS7 3NB. This includes MCNs from the Roma community.

Roundhay Road

A number of Advocacy Support and signposting services for Roma are held across Leeds, including Advocacy Support at Roundhay Road (2 sessions weekly) and Roma Work Club (1 session weekly).

The Hub, Hovingham Primary School, Harehills

A Roma Friendly Young People's Group takes place each Friday and Saturday at The Hub, Hovingham Primary School, Harehills.

West Leeds

An Advocacy and signposting service for all Eastern European communities takes place on a Tuesday at Armley One Stop Centre, 2 Stocks Hill, Armley.

7.11.1 Key messages from professional insight into Roma health needs

- Housing and housing insecurity issues are likely to remain of importance to Roma communities over the coming years.
- Communication has to be at the right level and in the right format to have meaning in the context of Roma communities' everyday lives.
- Issues around alcohol use, drug use, tobacco and poor mental health have also been identified as issues in the Roma community.
- A multi-agency partnership approach between each community and the full range of services, including NHS health services, LCC public health services and other LCC and third sector organisations within and outside the Roma community should be adopted to ensure that a comprehensive and holistic service can be delivered and positive outcomes achieved.
- As with the Gypsy and Traveller communities, ways need to be found to engage males in order to improve their lives, the lives of Roma women and their children. Whilst the HNA was not sensitive enough to detect power imbalance in the Roma individuals surveyed, this should not be discounted and future work should explore any such imbalances that could affect outcomes.

- Spaces where Roma currently congregate and feel safe to meet should be further developed to include health advocacy and run activities to help them develop their assets and confidence as previous work has found this community to be at a far earlier stage of developing community assets than other vulnerable communities (Warwick-Booth 2019).
- Identifying and training community members to become peer educators and champions to pass on credible health messages, expand their health knowledge and build health capacity for themselves and of others from within, is desirable.
- Partnership working should also be further strengthened to listen to unheard voices; to develop organisational roles for Roma and help build Roma led organisations. Mental health education and support can be included in this way as suggested by Robinson et al (2016).

7.12 Contract Review of previous Gypsy, Traveller and Roma Health Needs

The intention of this HNA is to ascertain how the health of local Gypsy, Traveller and Roma groups can be improved and indeed how it has, or has not improved since the last commissioning period for the Leeds Gypsy and Traveller Public Health Improvement contract.

The previous contract, which was to a value of £37,450k was delivered for a number of years by Leeds Gypsy and Traveller Exchange (GATE). This was the case both pre, and post-transfer from the NHS to Leeds City Council.

The original contract stated that: **‘the focus of the work will be on the Gypsy and Traveller communities that live within the city of Leeds’** and included the Roma community **‘as part of an inclusive approach, where the needs and interests of Roma people are similar’**.

Since then, further discussions between provider and commissioner led to the Roma part of the contract being removed, as it was believed that there were few similarities between the two groups.

The focus of the contract has most recently been: **to improve the health of those most vulnerable to poor health, increase access to health care services and improve significantly the evidence base on demographics, health needs and inequalities of Gypsies and Travellers.**

However, since the number of Roma have expanded rapidly in Leeds and evidence collected in this HNA suggests their needs are also significant, a gap in public health focused provision has been identified. Ascertaining any similarities and differences in needs between Gypsy, Traveller and Roma groups at this point, will help consideration of how the needs of all three vulnerable groups can be adequately met in the future.

The GATE contract expired at the end of June 2018.

Since this is the first time the Gypsy and Traveller public health contract has been formally reviewed, since the transfer of Public Health into Leeds City Council, it

provides an opportunity to consider its strengths and successes, as well as its consistency and interface with other professionals, projects and contracts that have been commissioned to deliver work with these and other vulnerable groups.

Prior to the end of contract, three meetings were held with GATE staff, firstly to monitor progress and secondly to enable current provider input into the HNA process, look back on achievements, take heed of any lessons learnt and use this to formulate ideas for taking the work forward in the future. The public health staff attending these meetings were independent of previous monitoring or performance discussions with the provider, or the running of the contract up to this point. GATE have also provided very useful additional information from the Gypsy and Traveller communities as part of the stakeholder consultation on the draft HNA and this has been used to compare, contrast and complement the information initially gathered from other Gypsy, Traveller and Roma community members.

GATE works across the city (on camps, roadside and residential) – advertising their group activities on Facebook, but also pro-actively ringing round to encourage participation and promoting referrals to and from their advocacy work. Whilst this was successful in getting more Gypsy and Traveller participation, they also reported that travel restrictions and poor mental health were the main barriers to attendance. Also whilst roadside groups are usually informed of local activities, it is recognisably more difficult for them to be able to participate.

As was usual at the time of issue of this contract, no KPIs were listed, so the monitoring report provided a breakdown of the groups and services which had been delivered, the majority of which were at Leeds GATE head office in Cross Green.

The work was reported under the three themes below:

Community Facing Work – including delivery of health development activities, fundraising for and management of staff doing health delivery at Leeds GATE, supporting the engagement of other health professionals with Gypsy and Traveller communities, particularly the primary care health improvement project with West Leeds CCG nursing outreach post, to whom they provide ongoing support and a hot-desking facility.

Voice and Influence Work – supporting community members to contribute to city discussions and engage in consultation and service development.

Strengthening Partnerships and Strategic Development – running and chairing a Practitioner Forum for professionals working with Gypsy and Traveller communities across the city, service liaison on behalf of its members, including the management of roadside encampments, strategic advocacy about the provision of homes for Gypsy and Traveller communities, strategic advocacy to improve health outcomes and accessibility of services for Gypsy and Traveller communities.

GATE's website details the main health issues of its members as long term illnesses, low levels of immunisation and the consequences of smoking and poor outcomes for new babies and mums. These are felt to be worse amongst the Gypsy and Traveller communities, because of poor access to health care services.

7.12.1 Contract Monitoring Returns

Contract monitoring returns during 2017/18 show Leeds GATE running a number of offsite healthy living activities for the Gypsy and Traveller communities, generally on one afternoon per week. These included 4 sessions of healthy eating/cooking (15 adult participants, 11 young people), and/or Box-ercise, with an awareness raising section, (mainly run by volunteers/members). Volunteers were paid expenses with a view to encouraging volunteering activity. In quarter 4, 2 Keep Fit sessions were also run, which attracted 14 participants.

An 8 week sewing group was also provided, which usually attracted 5-6 members and a number of individuals were provided with domestic violence support.

From time to time, other health service type activities such as health checks and blood pressure checks were reported and individuals were supported to access services such as GP and dental registrations. Although reported under public health reporting mechanisms, a number of other 'health' related contracts were also being delivered by the same provider, so it is sometimes unclear as to what public health spend was committed to those pieces of work, the outcomes achieved and whether it was wholly part of the public health contract, the Leeds CCG Outreach Nurse, the NHS Health Check programme, which is commissioned by another public health team, or another NHS Leeds CCG funded initiative.

GATE received 42K grant funding from South and East CCG Third Sector Health Grants to pilot Health Advocacy, which ran from April 2016 for 12 months. It has since (April 2018) received a further 42K grant over 12 months from NHS Leeds CCG to provide care of post addresses and health advocacy. This is confirmed as separate from the strategic advocacy about the provision of homes for Gypsy and Traveller communities detailed above.

A number of other health promotion activities were also reported, including on site gardening sessions and a diabetes awareness session, which was positively received. It is unclear whether the gardening sessions have been continued/embedded as a means to provide ongoing access to a healthier and more socially inclusive lifestyle, but as a successful model elsewhere, it provides an opportunity to engage all parts of the community, particularly those who are most sedentary in regular gentle and sociable physical activity.

It may also be possible in the future for the public health contract to provide backup education sessions with practical everyday advice, activities and support aimed at long term conditions prevention and management.

Over the final year of the public health contract, Leeds GATE undertook strategic health work including working with Touchstone around Mentally Healthy Leeds and presenting aspects of Gypsy and Travellers health needs at the Leeds Health and Wellbeing Board. In terms of wider determinants, GATE supported the Gypsy and Traveller community to lobby services and institutions to change practice e.g. around 'Negotiated Stopping' for roadside Gypsy Travellers, which very positively has led to a scheme being implemented in Leeds. Also facilitating Gypsy and Traveller input to

the new Kidacre site, which has enabled 9 families to move from statutory homeless into accommodation.

In terms of influence it reported working with (NHS) Health Services to raise awareness of best practice for improving the experience of Gypsy and Traveller groups e.g. training professionals (including hospital staff) and raising awareness of Gypsies and Travellers needs at conferences.

Positively, some members of the community have become active in public speaking at these events, which will have helped to build their confidence and self-esteem and is clear evidence of follow up of the need identified in the previous HNA published by GATE. A number of community action groups were also reported, which suggests capacity within the Gypsy and Traveller community is building.

In quarter 4 it was reported that community volunteers had formed a steering group to address suicide within their community, with a view to supporting a new GATE project called 'Don't Be Beat' (addressing mental distress and suicide). As this was to focus on men, this HNA suggests that this will be welcomed by the community and future public health work should aim to complement this developing grassroots activity. A Mental Health Advocate will also work to ensure increased accessibility to mental health support services, reflecting on and implementing best practice.

The previous public health funded activities appear to have been predominantly targeted at women, although GATE have successfully engaged men- they reported a gender split of women (65.3%) and men (34.7%), which they believe reflects gender roles within the community.

The returns often did not break down public health activities by gender, so it is not entirely clear whether the 34.7% of men were engaging in some public health activities (lower male engagement in health related activity in the wider community is common), or predominantly using other (non-public health funded) services that GATE offer. Although not evidenced directly through the public health contract, it is entirely possible that some of this activity would have provided additional public health benefits to the Gypsy and Traveller communities.

Although women often access the services on behalf of the whole family, the monitoring returns show that children and young people also attended activities in their own right.

In terms of numbers reached, a total of 220 contacts were made in Q3 2017/18, which is approximately 7% of the 3,000 Gypsies and Travellers estimated to be in Leeds. A substantial number (60) of these were attendance at a Christmas party and 75 for a diabetes film, screened via social media. In addition, 4 domestic violence appointments were also made and 1 DV support activity undertaken, 2 GP registrations, 2 dentist registrations and 3 midwifery appointments made. 13 of the contacts this quarter were new members and 9 Care of Post sign ups (a CCG funded initiative) were reported.

In quarter 4, 118 contacts were made (approximately 4% of the Leeds Gypsy and Traveller population). Of these, 15 families (3 people per family) were outreached and

assisted around advocacy, participation in community development activities and requests for 'Negotiated Stopping'. 13 new contacts were reported and 5 new Care of Post sign ups. Whilst it is positive that a holistic approach was taken and individuals could receive interventions from a number of initiatives, to avoid double counting issues, greater clarity on contacts made under each initiative would be helpful for contract monitoring going forward.

7.12.2 Health Advocacy

GATE has also been funded by the Leeds South and East CCG and currently NHS Leeds CCG to deliver a Health Advocacy project. In its report Health Advocacy, cost-benefit analysis, (2017) GATE reported that for many years it has provided advocacy to members in support of its four key objectives:

1. Improving accommodation provision
2. Improving health and well-being
3. Improving education, employment and financial inclusion
4. Increasing citizenship and social inclusion

Practically this is detailed as:

- One to one support for individual members and their families (this is the main aspect of the role (accounting for at least 50% of the health advocate's time).
- Liaison with NHS and other health service providers (e.g. IAPT, other Third Sector support organisations) to facilitate improved access for Gypsies and Travellers.
- Preparing health information and publicity (e.g. leaflets) aimed at Gypsies and Travellers in Leeds, including those living 'roadside' or passing through
- Health promotion and outreach at events attended by Gypsies and Travellers, such as the Lee Gap Horse Fair.

Evaluation of the Health Advocate work suggested that Gypsy and Traveller people may turn to their GP and medication as a first measure towards addressing mental health issues and they are often not given accessible information about other options, or wellbeing strategies. This is an opportunity for work going forward as it was suggested that communication is not in a format that Gypsy and Travellers can easily understand and is not understanding of Gypsy Traveller culture, or of the existing resilience and strengths of the individuals and community.

They also continue to provide roadside outreach and eviction support.

7.12.3 Key messages from previous Gypsy, Traveller and Roma public health work

- Going forward, strong partnership working on shared agendas is essential to improve public health, but in order to make best use of scarce resource and avoid duplication/double counting/funding, it would be helpful to have greater clarity around activities being delivered and outcomes achieved under the public health specification.

- The future direction of this work should reflect past successes and formulate realistic, but challenging future aspirations, which can involve recipients of services as active participants in their own health improvement.
- There is evidence of developing community capacity with some members beginning to collectively tackle difficult and controversial issues in their community. This should be built on to encourage others and ensure everyone is supported to contribute should they wish.
- The public health contract will be one of several health related contracts designed to reduce health inequalities in the Gypsy and Traveller communities so it is essential to work closely with the Gypsy and Traveller community, NHS Leeds CCG, Third sector organisations and other partners to ensure a good fit with community needs and complementarity with other ongoing work.
- As shown throughout the rest of the HNA, work around drug use, alcohol, tobacco and men's health appear to be potential gaps.

8 Discussion

The Marmot Review (2010) made a case for improving the conditions, in which people are born, grow, live, work and age. A social determinants approach is needed to tackle the root causes of inequalities and address social exclusion. Marmot recommends proportionate universalism and targeted approaches to reach socially excluded communities in order to 'improve the health of the poorest fastest.'

Whilst we know that tackling the wider determinants of health and healthy living issues are important factors for the long term health of Gypsies, Travellers and Roma people, this HNA suggests that most of the health related work with the Gypsy Traveller community in Leeds to date, as it has elsewhere, focused primarily on improving access to NHS services and changing NHS practice, rather than taking a longer term view of promoting health across the life course for Gypsies, Travellers and Roma people as a whole.

This does not diminish the importance of this work and there is still much to be done, as the HNA suggests that access to and appropriate use of health services remains an issue for many marginalised groups, including Gypsies, Travellers and Roma groups.

Because of time restrictions, the fragmented nature of transient communities and the natural reticence of marginalised groups to involve themselves in official surveys, it is recognised that this HNA has managed to reach only a small fraction of the Leeds Gypsy, Traveller and Roma communities. The sample size was also too small to make robust generalisations for each group, or indeed the group as a whole. Despite this, it has revealed useful insight into similarities and differences and the future work programme will need to be sufficiently flexible to accommodate and expand on these initial findings, particularly in assessing and developing innovative ways to build health promotion activities that have relevance in the everyday lives of Gypsy Traveller and Roma people.

8.1 Similarities and differences

This HNA has shown that similarities appear to be greater than differences with these communities, although tailored solutions relevant to each community will be required.

- As a wider group, all experience **prejudice** in their daily lives – whether perceived, or actual this negatively impacts on their wellbeing, their health and their ability to address the wider determinants of health.
- The key wider determinants of health to be tackled in both groups are poor education and literacy, insecure employment /low income and housing issues.
- Poor mental health such as anxiety nerves and depression is prevalent in all three communities.
- All need information that is culturally appropriate, preferably face to face and easy read, or translated.
- The negative perceptions and stigma surrounding poor mental health (and other conditions such as cancer) in these communities, means access to appropriate information will not be sufficient in itself.
- The main healthy living issues identified in the Gypsy Traveller community are increased drug and alcohol use, liver problems, smoking 'weed,' low levels of physical activity and increased reliance on fast foods.
- Increased alcohol and drug use, "liver issues", "lung issues" cancer and "water in the body/in the lungs" are also issues for Roma, as is poor housing, low income and low educational status, so a targeted and creative approach will be required to help tackle these issues.
- In females, gynaecological issues and urinary tract infections could be an important area for preventive and educational activity.
- Both groups value the medical model of health but need support to translate knowledge of health promotion, into culturally appropriate adoption of healthy lifestyles, taking into account poverty, geographical isolation and wider trends linked to sedentary lifestyles.

8.2 Asset based approaches

In the 2013 HNA, GATE were keen to understand how the peer support approaches, such as Nesta's 'People Powered Health' could help address some of the issues facing Gypsies and Travellers, specifically innovations that involve patients, their families and communities more directly in the management of long term health conditions.

It considered asset based approaches to health improvement empowering for the individual, and a powerful tool for communities that historically have been marginalised. Although focused around access to services, it identified that Gypsy and Traveller communities in Leeds have many internal assets - but that communities can encounter problems when they can't reach some of the external assets they need access to (described in this case as the NHS, schools and accommodation) which the community felt can lead to poor quality of life.

8.3 Roads, Bridges and Tunnels

In describing responses to these access issues, it came up with the concepts of Roads, Bridges and Tunnels.

It described Roads as getting you from a to b - a direct route, free from obstruction. However there may be a road block (an example might be not being able to access schools places whilst travelling), meaning you need to navigate a way around this road block. It identified two responses to road blocks, one was to build a bridge and the other was to dig a tunnel.

Bridges overcome an obstacle and are strongest when they are built from both sides, bridges are good because they acknowledge and highlight a problem, whilst working to overcome it.

Tunnels were identified as the solutions people find for themselves - a do it yourself approach, often involving personal negotiation and connections between community members and somebody or something (knowledge/ resources) who could help solve the problem.

In terms of health services, this HNA suggests that the outreach nurse, funded by NHS Leeds CCG appears to have made and continues to make a very positive impact on improving access to health services for the Gypsy Traveller community and wider influence work by GATE has impacted on the way NHS services interact with and serve the Gypsy and Traveller communities. In effect, a bridge has been built.

Whilst there is more to be done, it is anticipated that the Outreach Nurse post will be continued and expanded to include other vulnerable groups. This work, together with the Health Advocacy post will continue to build bridges between the Gypsy and Traveller community (potentially Roma) and NHS services.

Whilst primarily bridge building, this work is simultaneously, through capacity building, influence and lobbying, also helping the community to dig their 'own tunnels'.

The model suggests that the presence of self-navigated solutions doesn't remove the obligation on statutory services to provide equitable access, for these communities and for the purposes of this HNA, the Roma community, but there is now a case for, and an opportunity to support work that incorporates wider community capacity building and collaborative approaches to improve population health from within each community.

This includes peer led approaches, to develop and support health strengthening opportunities in the community, as well as continuing to 'widen the road' to services for the future.

Widening the Road -describes a service whose access options are inclusive of all those who wish to access, meaning a service is designed and commissioned to accommodate all people. It is a partnership approach, including capacity building for health, inside and outside each community, which can improve the experience of those

often marginalised by mainstream services and society – GATE named this concept commissioning from the margins.

Gypsy, Traveller and Roma groups can also draw benefit from wider public health and primary care work, such as that developing out of the Leeds City Council Migrant Health Board. This has recently promoted the training of primary care colleagues around the concept of Safe Surgeries. The Safe Surgeries Toolkit is a key guidance document which lays out seven steps for practices to help ensure that everyone in their community, including Gypsies, Travellers and Roma groups can access the primary healthcare they're entitled to.

8.4 Assets within the Gypsy, Traveller and Roma Communities

Family ties are strong in all three Gypsy, Traveller and Roma communities and this is positive in many ways when individuals need to draw on support in times of need. This needs to be further strengthened in work going forward.

Gypsies and Travellers have also been identified as a very self-reliant community in terms of caring for vulnerable individuals and adapting to a precarious employment environment. The 2011 census indicated:

- Gypsy or Irish Traveller ethnic group was among the highest providers of unpaid care in England and Wales at 11 per cent (10 per cent for England and Wales as a whole) and provided the highest proportion of people providing 50 hours or more of unpaid care at 4 per cent (compared to 2 per cent for England and Wales as a whole).
- Gypsy or Irish Traveller had the highest proportion of self-employed out of the ethnic groups at 26 per cent compared to 14 per cent for England and Wales.

Community Development approaches need to both recognise the assets the community possesses but also the burden that ill-health, familial caring, suicide and other mental health problems place on the community and individual's time and capacity.

Similarly, in such a tightly knit community, it needs to be mindful of potential for community disapproval and subsequent isolation, community norms around school attendance, and gendered patterns of employment and unequal access to resources which may be a barrier to independent living.

Insight supplied by GATE (2019) suggested that some Traveller women are engaged in training and employment and that many would be keen to enter employment where opportunities were provided.

Similarly although men have traditionally followed trades done by their fathers and brothers, this appears to be changing, with the younger generation more likely to wish to train and work in non-traditional work. Building external support mechanisms, more effective joint working and collaboration between agencies can help provide a stronger coping mechanism for such individuals for the future. It can also extend the reach of this individual/family, but possibly reactive resilience to a more collective and proactive community resilience to help build sustainable changes for the future.

In all three communities, a collaborative model of health that feeds into and is supported by a multi-agency working group would be beneficial. Although such groups have been convened previously, including one at Cottingley Springs site (now disbanded), public health staff involvement has not been consistent and this could be strengthened. As this was the original conduit for introducing housing related support to Cottingley Springs site, building a multi-disciplinary collaborative model of health should help facilitate a 'joined up' and holistic approach to each community's needs.

Previous work suggests that in order to engage Roma with new services, where no previous relationship exists, targeted work with already established support services is most effective. This includes non-health services, such as schools, children's centres and benefits advice services, as well as voluntary and faith groups.

There are a number of such supportive mechanisms for all three communities that can help deliver the public health component of this work. This includes LCC HUBs and associated staff at drop-ins and the Migrant Access Project (Roma). Working with these established mainstream mechanisms will allow the Roma community, to build confidence, assets and skills in an integrated and sustainable way.

Connecting with libraries and other public health commissioned services e.g. Better Together, as well as professional staff working daily with these communities, on site and throughout Leeds will likely benefit all groups.

The restrictions in terms of meeting places on site at Cottingley Springs, the wish for dedicated health services to be delivered on site (or to the community directly) and the previous focus within the Gypsy, Traveller and Roma communities on the medical model of health means that innovative methods will need to be employed in order to build on-going trust and empathy with each community, before it can begin to articulate and help deliver on its public health needs, as defined by this HNA.

Notwithstanding the historical reticence of Gypsy, Traveller and Roma groups to engage with this way of working, if sufficient trust can be built with a number of key individuals, then they may be willing to cascade messages, encouragement and later stimulate engagement amongst others. The Roma community appear to already willingly embrace this model as demonstrated by the Migrant Access and Migrant Access + projects. However, it is essential that the public health aspects of the work not only educate, but build on this knowledge to help individuals and groups embed health promoting principles, in the context of their own lives.

There are indications that some individuals from the Gypsy and Traveller community have been engaged in capacity building work in the past, including the 2013 GATE health needs assessment. The MAP and MAP + project, which has capacity building components has also been very well received by Roma groups. In the Gypsy and Traveller community this successful approach could be re-visited with a view to re-engaging those, or other interested individuals to help provide ideas for developing appropriate health promotion activity. In the Roma community there are examples where volunteering has led to paid work opportunities (e.g. in a GP surgery) and this could perhaps be further explored in relation to both groups and potential public health opportunities in the future.

Further substantial effort will need to be made in order to increase accessibility and engagement in health promoting activities to all sections of the community as it appears that some Gypsies and Travellers have been unable, whether through disability, age, lack of transport, social isolation, or poor mental health, to engage in the activities on offer. This will require more targeted work both on site and with housed and roadside groups to extend reach to those who have not previously engaged and build stronger links between other commissioned services such as Better Together to increase access to other mainstream health promotion and capacity building services.

The 2019 Leeds GATE Gypsy and Traveller insight group found that there is a desire for more interaction with the settled community and some individuals have already established supportive relationships outside the Gypsy Traveller circle and were well connected. However, others felt that they were not included and that relationships were often threatened when problems caused by temporary Travelling groups were automatically generalised to the Gypsy Traveller community as a whole. A male house dweller described how it was initially difficult to relate to a different kind of conversation, but on the whole, most felt that having more opportunities to interact with people outside of the Traveller community would be helpful to demonstrate that **“we are all the same and we are not different”**.

8.5 Key issues to enable a holistic service:

- **Strategic connections** - The service should ensure that work is in line with the strategic, co-ordinated and inclusive approach of Leeds City Council to migrants and recognise the cross cutting challenges identified by the Leeds Strategic Migration Board and the Leeds Migrant Health Board.
- **Strong linkages to other work** - The service should dovetail with and add value to other work and funding streams that are being developed by other professionals and commissioners to enable future proofing.
- **Local knowledge and connections** - There is a continuing need to extend the reach from within, to improve Gypsy, Traveller and Roma communities' health, to connect them to the opportunities in the wider community and make health improvement activity more sustainable.
- **A need for more consistency** - there is a case for increasing consistency of practice in this contract with others delivering similar community based work, particularly around monitoring and tracking service user outcomes.

9. Conclusions and recommendations

- A community health development approach to public health issues is required-enabling each community to collectively identify issues and co-design culturally acceptable solutions to complement the previous and current work being done to improve access to NHS services.
- Health improvement in these groups requires a holistic approach which pro-actively engages with and utilises all available assets and resources, both financial and human that is within and surrounds the Gypsy, Traveller and Roma communities in Leeds.
- There is an ongoing need to build trust and extend the reach of self-reliance, to improve the Gypsy, Traveller and Roma communities' health and make health

improvement activity more sustainable. Previous work suggests this is better achieved by one enduring person (external to the community) working over the long term with the community, rather than bursts of activity with different staff.

- Work to prioritise the wider determinants of health should be prioritised. However, the HNA indicates that unhealthy lifestyles are cutting short and if left unchallenged will continue to cut short the lives of Gypsy, Traveller and Roma individuals who live in Leeds. This should include improving access to healthy food and converting current knowledge and skills into everyday practical solutions.
- Issues around alcohol use, drug use, tobacco use, poor mental health, literacy levels and improving maternity and child outcomes are key issues to address, in a non-stigmatising way across all three Gypsy, Traveller and Roma communities.
- In the short term, face to face health promotion activity and information that is accurate, translated, easy read, or doesn't require literacy skills is most likely to work, but in the longer term improving literacy levels within each community is imperative to ensure connectivity and appropriate use of health and other services.
- Building on successful strategies for healthy living which have been identified and adopted by some Gypsies, Travellers and Roma for healthy living, it may be possible to collectively adapt, promote and embed culturally acceptable measures to help extend the lives of Gypsy Traveller and Roma individuals.
- Cultural preferences, transient living and the nature of closely knit, marginalised and socially isolated communities demands tailored activity that is meaningful in the context of the Gypsy, Traveller and the Roma communities' everyday lives.
- Encouraging more interaction between Gypsy, Traveller and Roma groups and other community health development services, service users and the wider community, as long as sensitively considered (i.e. doesn't reinforce discrimination), could serve as useful bridges between these communities and the general population in Leeds. Each and every positive connection would improve health and wellbeing.
- Opportunities to improve the cultural awareness and address any prejudice that service providers (including health services) have towards the Gypsy, Traveller and Roma communities should be taken as and when required.
- Whilst public health work appears to have previously focused predominantly on and been more successful in engaging women, ways to engage men in prevention and early treatment must be prioritised, possibly drawing on learning from other marginalised men's work e.g. 'men in sheds'. The insight work by Leeds GATE (2019) shows some support from men for this approach and also a keen interest amongst Gypsy and Traveller males around physical fitness.
- Issues around alcohol use, drug use, tobacco use, poor mental health, literacy and improving maternity and child outcomes are key issues to address across all three Gypsy, Traveller and Roma communities.
- Low attainment, literacy and numeracy at all ages in all three communities hinder young people's development and subsequently trap them in low paid, uncertain work as adults (LeBas DJ & Barsony K 2016) as well as creating barriers to accessing health information and healthcare services. Therefore the

needs of these communities should be included and addressed within the Learning English in Leeds strategy and health and well-being activities should be designed to pro-actively encourage development of literacy and numeracy skills.

- Identifying, training and supporting individuals (particularly women) from each community to build health capacity as volunteers, peer educators and health champions may help develop inbuilt support and skills to secure paid work e.g. health support workers/link workers/advocates etc.
- Joint activities for mothers and children or a 'whole household' approach has been found to be beneficial but Roma women have also been found to be most open to new information in a non-family environment. The preferences of Gypsy and Traveller women will similarly need to be explored.
- Gypsy, Traveller and Roma women often have very little experience of traditional learning environments, so a bespoke and culturally appropriate training package could provide a blueprint for the future.
- Women face many barriers to accessing health and wellbeing services e.g. relying on men for transport, men monitoring their use of services, poor literacy and a general lack of independence. As well as affecting their day to day health and wellbeing, opportunities to report and receive support around domestic violence, or other taboo issues are reduced. Ways need to be found to empower women in their communities in a way that respects their culture and their personal relationships, but ensures they can thrive.
- Increasing the awareness and knowledge of the Gypsy, Traveller and Roma communities of how to access health and other services appropriately is still required and a good way to build trust with the community, but should become the secondary focus of public health work. Working closely with the Outreach Nurse will enable both public health and health service outcomes to be achieved.
- There should be close working arrangements between this contract and the CCG commissioned Outreach Nurse, but with clarity around funding parameters, KPIs and delivery. This will ensure that scarce resource is targeted appropriately to meet the terms of the contract.
- Performance measures should be designed, monitored and evaluated around the findings of this HNA, using learning from other similar contracts such as the Better Together contract.
- Work to enhance monitoring and evaluation mechanisms across the breadth of Leeds City Council's contracts should be prioritised to ensure vulnerable groups including Gypsy, Traveller and Roma groups' access to services and projects can be tracked.

10. REFERENCES

All Ireland Traveller Health Study-Our Geels, Summary of Findings (2010). School of Public Health, Physiotherapy and Population Studies, University College, Dublin

Aspinall P. Hidden Need Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers (2014) Inclusion Health & Centre for Health Services Studies, University of Kent

Baker M MBE Leeds baseline Census 2004-2005, published by Leeds Racial Equality Council 2005

Barsony K & Le Bas DJ (2016) <https://www.independent.co.uk/voices/before-you-make-another-offhand-remark-about-roma-and-travellers-in-the-uk-wed-like-you-to-consider-a7168506.html>

Carr SM, Lhussier M, Forster N, Goodall D, Geddes L, Pennington M, et al. Outreach programmes for health improvement of Traveller communities: a synthesis of evidence. Public Health Research 2014; 2 (3): DOI: 10.3310/phr02030

Cemelyn S, Greenfields M, Burnett S, Matthews Z, Whitwell C. Research report 12: Inequalities experienced by Gypsy and Traveller communities. Equality and Human Rights Commission, 2009

Cresswell L & McGready K Public Health and Migrants PH internal report to PHSLT July 2016.

Council of Europe Information Documents SG/Inf (2015) 38 Final.
Thematic Action Plan on the Inclusion of Roma and Travellers¹ (2016-2019)
Published Strasbourg 2nd March 2015

Department of Communities and Local Government (2012) Progress report by the ministerial working group on tackling inequalities experienced by Gypsy Travellers
Ministry of Housing, Communities and Local Government-Count of Traveller Caravans
Jan 2018 (June 2018)

Eurocities report, Roma inclusion in cities-mapping of the situation of Roma in cities in Europe. Eurocities, 2017

Forster N Consultation on the health needs of Gypsies and Travellers in Leeds commissioned by Leeds GATE (January 2019)

Equality and Human Rights Commission -England's most disadvantaged groups: Gypsies, Travellers and Roma, *Is England Fairer?* Review. Spotlight report (1 of 4), (2016)

Greenfields M Listening to bereaved Gypsy and Traveller children, young people and families. Society and Health Presentation (undated).

Greenfields M (2009) *Falling by the wayside*. Diabetes Update, Winter 2009: pp. 28–31

<http://www.ucd.ie/news/2011/10OCT11/031011-Traveller-infant-mortality-still-higher-than-the-general-population.html>

Irish Traveller Movement in Britain (ITMB), Gypsy and Traveller population in England and the 2011 Census-an Irish Traveller Movement in Britain Report August 2013

Leeds City Council (2017) Private Rented Market in Leeds [Internet] available from: <https://www.leeds.gov.uk/docs/arc4MainReportPRS%20reviewLeedsJuly2017v2.pdf>

Leeds City Council Strategic Housing Market Assessment 2017

London Borough of Hillingdon- HOPE Energy Link, Health through Warmth Community Project, Final Report (undated)

McFadden A, Siebelt L, Gavine A, Atkin K, Bell K, Innes N, Jones H, Jackson C, Haggi H, MacGillivray S. Gypsy Roma and Traveller access to and engagement with health services: a systematic review.

European Journal of Public Health, Volume 28, Issue 1, 1 February 2018, Pages 74–81, <https://doi.org/10.1093/eurpub/ckx226> Published: 16 January 2018

Migration Yorkshire (2014) Migration in Yorkshire and Humber, an Overview

Ministerial Working Group on tackling inequalities experienced by Gypsies and Travellers, 2012

<https://www.gov.uk/government/publications/reducing-inequalities-for-gypsies-and-travellers-progress-report>

Morrison K. 'One Punch Kills' Leeds Gypsy and Traveller Exchange Domestic violence Project Report (2007)

NHS Leeds Clinical Commissioning Group Partnership. Improving the health of the Gypsy and Traveller Community. Paper for the Women and Equalities Health Select Committee – February 2018

Office for National Statistics, *2011 Census analysis: What does the 2011 Census tell us about the characteristics of Gypsy or Irish Travellers in England and Wales?*

Statistical Release, 21 January 2014

Papadopoulos, I. (2007) The health promotion needs and preferences of Gypsy Travellers in Wales. Diversity in Health and Social Care, 4, pp. 167–76

Parry, G., Van Cleemput, P., Peters, J., Moore, J., Walters, S., Thomas, K. and Cooper, C. (2004) The Health Status of Gypsies & Travellers in England. Report of Department of Health Inequalities in Health Research Initiative Project 121/7500 SCHARR

Roberts A, Adkins J, Lewis H, Wilkinson C (2007) Coronary Heart Disease and Mental Health in Gypsies and Travellers in Wrexham: redressing the balance. Presented at: *Community Practitioners' and Health Visitors' Association Annual Conference*.

Robinson M, Woodward J, White J & Kinsella K, The mental health support experiences of Roma Men, born outside of the UK in Leeds.
Leeds Beckett University (February 2016)

Roma Inclusion through Culture and Education (RICE Project) Harehills Primary School harehills.leeds.sch.uk/r.i.c.e-project

Roma Mental Health Advocacy Project - Evaluation Report The Roma Support Group (2012)

Saunders R (2007) The Forgotten Minority. *Diabetes Update*. Spring (2007), pp. 26–9

<https://moderngov.rotherham.gov.uk/documents/s103693/APPROVED%20FINAL%20RMBC%20CSE%20Needs%20Analysis%20report%20-%20Salford.pdf>

Van Cleemput P, Parry G, Thomas K, Peters J, and Cooper C, Health-related beliefs and experiences of Gypsies and Travellers: a qualitative study [J Epidemiol Community Health](#). 2007 Mar; 61(3): 205–210.

Walters J, Royal Borough of Kingston upon Thames, Gypsy and Roma Travellers. JSNA Needs Assessment Oct 2016

Warwick-Booth, L Trigwell, J., Kinsella, K., Jeffreys, K., Sankar, D. and Dolezalova, M. (2017) Health within the Leeds Migrant Roma Community; An Exploration of Health Status and Needs within One UK Area. *Health*, 9, 669-684.
<https://doi.org/10.4236/health.2017.94048>

Warwick- Booth, L, Woodward, J, O'Dwyer, L, Di Martino, S. An Evaluation of Leeds CCG Gypsy and Traveller Health Improvement Project Final Report (October 2018)

Warwick- Booth, L, Woodward, J, O'Dwyer, L, Di Martino, S. Leeds West CCG Gypsy and Traveller Health Improvement Project Evaluation Interim Analysis (September 2017)

APPENDIX 1.

Current Health Needs of Leeds Gypsy, Traveller and Roma Groups

Group 1 Lee Gap Fair sample

In this sample, 6 people (5 females and 1 male), 4 of whom self-identified as Romani Gypsy and 1 as Traveller, aged 16-25 (2), 26-35 (1), 36-45 (1).55-64(1) and 65+ (1) provided information, via a long questionnaire.

Table 1

Home tenure

Local Authority site	Private site with planning permission	Private rented accommodation	Own house
1	1	2	2

As shown above, only 1 person in this sample lived on a Local Authority site, with the rest being in housed, or private site accommodation.

Health services

There appeared good engagement with health services. All 6 were registered with a GP as were all the people that they lived with. Most (4) had had a very good or good experience last time they had contact with a GP, but 2 had had a poor experience. However, since living in, or travelling through Leeds, 1 had had problems with getting an appointment at a GP, 1 with the attitude of reception staff, and one with tests and treatment. These problems were around **'not engaging'**, **'not getting back'** and **'getting names mixed up'**.

Positively, 2 people knew of the NHS Health check, had been invited to go for one and both had attended.

When asked if someone they knew, including themselves, had a health problem and needed care, who would they seek help from. Close relatives were the most likely source of help and advice, with 4 out of the 6 saying they would go to their mother. 1 person out of the 6 was caring for someone at the moment.

Other people who had been asked/offered to help in the past were family and health worker, with one person being helped at home and another at a health centre. Both of had been satisfied with the care received. None had been visited by a GP, health visitor or midwife at home.

The walk in centres appeared to be popular. When they last needed medical advice, 2 had phoned NHS Direct, 3 had used a GP or Walk in centre and 1 had used another form of advice (pharmacist). All consultations were for minor ailments such as coughs colds, grazes and one for toothache.

All 6 had heard of NHS Direct and 4 had used this service, although none had used it via the Internet.

Use of community pharmacists was also high, with all 6 saying they use the chemist, for prescription (5), buy off the shelf medication (3), advice on a health problem (3) and 1 for other shopping items. 4 said that the chemist had explained how to take medicines in a way they could understand and was useful. It was easy to find a chemist (6) and was open when needed (6). 3 people said their last experience of using a chemist was very good, or good.

Most (5) were registered with a dentist and all of these go regularly for check-ups. 1 went only when they had a problem. 3 had had a very good experience at the dentist and 2 a good experience.

50% (3) people said they wear glasses with all 3 getting them from opticians, but only 1 had regular 2 yearly eye examinations. 2 people reported that when they last had contact with the optician, the experience was very good.

Only 1 had used other health services, this being Community/District nursing.

When asked "What does being healthy mean to you" all 6 recognised 'eating a good healthy diet' and 5 said 'regular activity that keeps you active and fit'.

5 respondents said they ate fruit and vegetables daily and 1 a few times a week. 1 person said they eat takeaway food daily and 1 a few times a week. However, 4 said they rarely eat takeaway.

On the physical activity side, 5 said they were physically active daily but 1 was rarely physically active and 2 considered themselves to be overweight.

The sample was evenly split between smokers (3) and non-smokers (3) with all of the smokers smoking tobacco (rather than vaped e cigarettes) daily.

4 out of the 6 people drink alcohol and of those, 2 drink a few times a week, although 1 rarely drinks. None of the respondents said they took (illegal) drugs.

The next most popular responses, selected by 3 people in each category were 'living in a safe area', 'being happy' and 'good access to health and care services'.

2 said 'having a good education', 2, 'good loving relationships' and 2 'not smoking'.

In terms of safety and where they live, 4 were very satisfied and 2 satisfied with their local area as a place to live. 4 felt very safe and 2 fairly safe in their area during the day and 2 felt very safe or fairly safe in their local area after dark.

Interestingly no one selected 'not taking illegal drugs' as a sign of being healthy, nor prayers and religion, or employment. Most (4) people out of the 6 felt that you can reduce your risk of getting poor/ill health.

In terms of health at the moment, 1 reported excellent, 1 very good and 4 good.

However, most had been diagnosed with a health problem, including breathing difficulties (1), diabetes (1), high blood pressure (2) and 1 arthritis, or other mobility problems. 3 respondents said they had had a health problem that they had been/are concerned about, but hadn't sought help with.

There was a certain stoicism about this and when asked how they manage the problem, only one person responded, saying "**depression-get on with it, deal with it, kids get me through!**"

When asked if they had ever asked for help from others, including health and social care services and not got it, 1 stated 'yes', and 2 'no'. However this person stated that it was friends that had refused them help, but didn't state the reasons for this.

2 people had cared for someone who was near to the end of their life and both stated they had been able to care for them how they wanted to and their family had supported them with this.

However, it was evident that some formal health service had been involved as when asked 'what did you think of the nurses who helped' only 1 person answered with a neutral response, but others, when asked what was unhelpful, said 'general attitude' and 'did not understand Gypsy Traveller ways'.

No one said that there was 'anybody they would have liked support from at this time, but didn't get it'.

A question was then asked as to where best deliver future public health based work, since facilities for such a transient and dispersed group of people are very limited, including at Cottingley Springs, where the Gypsy and Traveller community is most concentrated.

Most communities have welcoming spaces for activities adjoining places of worship but only 2 out of the 6 said they would be more likely to attend such activities if they were held in their local place of worship and 3 said they wouldn't. This is a little surprising since faith seemed to be important with 5 declaring themselves as Catholic, 3 of whom were practising their faith. However, if they were to attend activities, education about health and learning about their own health were put forward as interest areas.

Surprisingly, considering the responses received when asked about where best to hold future activities, when asked which places they and their children use in their local area they answered 'churches' (2) and 'pubs' (2). However, community centre, children's centre, gym, library and working men's club were also used, so these venues may be worth considering in the future.

Group 2 Cottingley Springs Gypsies and Travellers sample

Cottingley Springs site is a Leeds City Council maintained Gypsy and Traveller site accommodating both English Gypsies and Irish Travellers. There are 146 people (83 adults and 63 children) (aged 16 and under) living on site.

In this sample, 8 people (all female) 4 of whom live on site, 3 housed individuals who have previously lived on this site and 1 roadside Traveller provided information. 6 had lived in Leeds for (more than 10 years), 1 (5-10 years) and 1 (less than 5 years).

In contrast to the Lee Gap group, if they were to become unwell all said their first port of call would be the GP, although 1 stated she might first speak to the outreach nurse who visits the site.

A small number would bypass the GP- by going to A & E to seek a paediatrician's advice if her children appeared very ill (1) or if she couldn't get an appointment at her

GP (1), or alternatively ring out of hours service. Having access to a female medic was important for 1.

Most people in the sample seemed to view the GP as an expert and would take their advice for follow on action. However, side effects of medication seemed to be important factors. 1 said she wouldn't take medication as she felt it would make her worse, and another was more likely to take advice for an operation, but not tablets, if they had side effects. Being referred to the practice nurse, or seeing the outreach nurse on site was also mentioned as extra support accessed via the GP or independently. However, chemists were not seen to be as useful to this group, being too expensive to buy medication, or their condition being deemed too serious for the chemist to deal with.

The walk in centres again appeared well used, especially when GP appointments are unavailable or out of hours. Bad chests, water infections, high blood pressure, high fevers and children's rashes were examples of ailments taken to these centres.

All of the sample were registered with a dentist with (5) attending regular check-ups. However, 3, whilst prioritising children's regular attendance, only attend themselves when they have a problem.

3 of the sample go regularly to the optician, one because of a child's needs.

When asked if they had any traditional remedies which they might use, onion juice, honey and lemon drinks for colds was raised, together with salt water to soak tired feet, hot water bottles for 'belly ache', hot lemonade and paracetamol for flu and flat coke/lemonade to treat 'sickness bugs'.

When asked 'Are there any illnesses that you think are common in your community' several were offered up including **dyslexic** and **diabetes**. Also infectious conditions such as chicken pox and sickness/diarrhoea, **depression** and **anxiety**, **water infections** and **depression** in '**women my age, not my mum's generation.**'

However, cancer was seen to be **amongst everybody**, and not more prevalent in their community (1) and the community's illnesses were the "same as everyone" (1). A further 2 said "No."

In terms of men seeking help and advice, the respondents agreed that they have particular issues. Men were seen to be afraid of cancer and therefore do not discuss it. In some, a '**fight it off**' mentality or a perceived weakness if seen to be ill, encourages them to conceal their illnesses. There was also a sense that men don't get as sick as women. However, positively, things were felt to be changing with younger men more likely to seek health advice and care because they are "**caring about what happens to their children if they die.**" There was also a sense that it was important to encourage men to talk about it more, to encourage them to see their GP more regularly and have more health checks on site.

When talking about the health services they had used, 6 people were satisfied with their treatment but, despite this, a number of people did relay less than satisfactory feedback. This ranged from waiting times for an appointment, to not being supported at a service she accessed when feeling low. Another had been reassured by her GP about her condition, but collapsed later that day and had to be taken to hospital. One felt the GP had an attitude problem and the practice was generally not to welcoming

to Gypsies and Travellers. Another, who had been advised not to do so much at home in order to improve a knee condition felt **“you just have to get on with it.”**

When asked “if you wanted to find out something about a health issue, where would you look for information?” they identified that lack of literacy skills presented a distinct disadvantage and so they required face to face consultations. These ranged from seeing a GP, ringing 111 or looking on the Internet and then going to hospital.

One was concerned that confidentiality may be breached if she was to share information with others and said that issues that they wish to be kept private would not be shared with anyone to avoid ‘rumours’ spreading. However, 2 of the sample did say they would seek advice from GATE (1) and friends and family (1).

There was also a sense that pro-active screening could create needless worry **“I wouldn’t go to the doctor for a check-up if I was feeling well, looking for illnesses I haven’t got, you become paranoid, why go looking for treatment, for things you haven’t got?”**

There were some subjects such as women’s gynaecological issues which were seen as inevitable- **“Smear tests, didn’t like smear test. Went for one but not gone back. If you get problems down below, you get them.”**

5 people said they knew what a NHS health-check is, but from the responses received, it is unclear whether they are actually referring to the dedicated NHS Health-check programme, or a routine check of e.g. blood pressure as part of a consultation.

One person said they **“A check you have every so often. I haven’t had one, but would like one”**, whilst another said **“don’t know anything about it”**

Respondents were then asked “What does being healthy mean to you”?

There were several people who appreciated the benefits of healthy eating and physical activity including **“I have stopped eating chips and crisps to lose weight”**, **“I try to move-tidying up, cleaning the house, we go out for a walk”** **“eating healthy, exercising”** and **“I am not healthy – my weight has made me unhealthy”**.

There was then another set of replies which were more holistic ideas including the social, mental and emotional side of health and the importance of family and kinship. For example **“What makes you bad - smoking. What makes you healthy - fruit. Worry will make you unhealthy, bad husbands affect health, exercise and fresh air makes you feel better”**

“Not going to worry myself to death about what I haven’t got, money is a bonus-makes you happy.

Family was seen as protective of health **“Having a family stops you feeling isolated, makes you feel better when family – grandchildren etc are around- family is better than friends”**

“Family, happiness, children, lifestyle, family life”

“If I haven’t seen a doctor for a while, not drinking or smoking or eating the wrong food, exercise makes people healthy. If people are by themselves they

get lonely and start thinking about things. Family spot when you feel lonely-living conditions affecting health”.

“Exercising, healthy diet, been happy around family and friends having their support and “if I see my daughter enjoying herself I am happy.”

1 person stated that eating healthy and exercise makes you healthy, but extended this by **“sometimes are meant to be, I never drink or smoked and have cancer”**. She continued **“less money can cause stress and you do without things. Living near pollution could affect health. If we stop on camp near pollution I can’t breathe.** She continued **“Can tell if smokers have been in home”**.

In terms of general wellbeing 5 out of this sample felt happy in their day to day life, 1 OK and 2 not OK. However, this might be” **I feel not sad, but angry toward other people. It’s not good to feel like that.”** It was also felt that you could feel happy that day, but then sometime slip into a depressed state (1).

When asked “if you/ or anyone in your family ever experienced nerves, feeling stressed or depressed”, 5 people replied that they had and 3 had not. 2 had found help that was useful at this time. 3 considered that hobbies can improve mood and mental health, although 2 felt otherwise.

Doing household tasks such as cooking and cleaning was seen as beneficial to some, whilst spending time with family, children, sewing and painting was beneficial to others. Although 1 enjoyed Zumba, the gym was seen as too expensive and going to the park was viewed as a good alternative. Holidays were similarly expensive and out of reach (1). Another was clear that **“I just want to live as I live and nothing stops me doing my activities- not really anything I can think of that I would like to go to.”**

When asked “What health topics do you think your community would like more information on?” there was a mixed response, including signposting and losing weight. However whilst mental health concerns were raised there were indications of the stigma surrounding it and despite earlier responses, there was mention of the increase in cancer in the community, the fear of cancer and general fear of conditions that you could die from.

In terms of ways to get this information across to the Gypsy Traveller community it was clear that a trusted person, who could relay information verbally face to face was appreciated. They also suggested via practice nurse, bringing information to the site and getting information via the TV was good. Most (7) of the respondents said they did not watch health information on You Tube, neither did they think Facebook or Whats App were good ways to get health information (6) although 1 thought it was. 4 of them had concerns about the internet in terms of sharing information about themselves, or other members of their community. This was about not knowing who was looking at it/using it and concerns about copying anti-social behaviour such as **“violence, crime, dirt and filth”**.

When looking at the general switch in the wider community from tobacco to e cigarettes, the picture was mixed with 4 of the sample thinking this was occurring in

the Gypsy Traveller community, but half hadn't noticed. When considering alcohol and drug use however, 6 out of the 8 felt it was affecting their community's health.

Few ideas for service improvement were suggested, but bringing services to people was a common theme **"except to have a GP who will come out, especially for the elderly and those with children"** and, if we wished to get engagement from men **"A health bus on site with a GP. I feel that men might go to just talk. Men would be better if health services went to them"** **Dentist as well."**

Group 3 Roma sample (detailed questionnaire)

The Roma sample was an opportunistic sample administered by LCC colleagues, with individuals who were either waiting to be seen by support services, or had attended activities. (11 Roma (8 women +1 young female) and 2 males completed a longer questionnaire.

From this, most of the group had lived in Leeds for some time. For those who answered this question, 4 people had lived in Leeds for less than 5 years, 5 for 5-10 years and 1 more than 10 years.

Health Services

Again, most (8) of the group would use the GP as a first port of call, if they felt unwell, but 2 would use A & E. Others would consult with family such as mum (1) with GP afterwards and 1 her sister then GP.

In terms of how they decide who to go to, 5 would go to the GP as a matter of course, but the difficulty of getting an appointment with a GP was identified by several and 2 people would go elsewhere, such as A & E or Shakespeare House.

Speed of being seen was important. Going to a Walk in centre as it is quicker than hospital (1) and going straight to A & E (1). 3 people said it would depend on the situation/nature of the illness.

When asked "if after seeing a doctor he/she suggested that you need some form of treatment to improve a medical condition how would you feel about this?", 5 respondents said they would do as the GP says, 3 would ask for further information, 1 said they would ask **'why and how is it going to work'** before deciding and 1 said **"if it seemed reasonable"** they would take the advice of the doctor. Another would take the information and if serious **"go for it"**

Fear seems to affect some, with 1 person taking her daughter to the GP for an injection, after she refused to have it at school. Another would be worried, as they are afraid of doctors and injections so **"I've gone to the local chemist with a toothache, I've been advised to apply bonjela on the affected area of the gum"**.

As in the previous GATE HNA and Gypsy and Traveller groups in this HNA, community pharmacists appear to be valued and trusted health professionals for this community with 6 people stating that they would seek the advice of a chemist.

7 people reported they had used a Walk in Centre, which was considered useful for an emergency appointment, if the GP was busy. The reasons were varied-2 had used them for check-ups (1 from school and 1 from social worker), 1 for tonsillitis, water infections and foot problems (because they couldn't get a GP appointment), 1 for stitches and 1 for antibiotics for their children's illness.

In terms of seeking help from a dentist, 9 were registered and 5 would go for regular check-ups (both adults and children). 1 person didn't see a dentist regularly, but her son did, whilst 3 only went if they had a problem. Cost was identified as a barrier for 1 respondent- **"My sibling just registered and they have an appointment next week, I will go once I am on job seekers and have free, when I work so can pay it."**

The situation was similar in terms of seeing an eye doctor (optician) where 6 people see an optician, but 3 would only see them if a problem developed, 1 if they felt they were getting worse and another who said they had just been, after some years. 1 person had both children who wore glasses, as did another's sibling.

Several traditional remedies to help them or their community self-care were then mentioned, most of which appeared to help them relieve cold related symptoms. These included a steaming bowl of water and cover over the head, a wet towel for headaches and onions in various forms, onion tea, onion juice, herbs, cloves and honey. Salt and water gargle was also used, although 1 said **"Know some of the remedies, don't use them"**

When asked if they knew of any illnesses that were common in their community, 3 said **"No"**, 2 said **"not really"** or **"haven't heard of any"** and 2 **"didn't know"**. However others suggested **"Cancer is becoming quite common"** (1), **"Liver issues, lung issues and ladies problems- urine infection"** (1), **"water in lungs"** (1) and **heart complications, cancer and "water in body"** (1).

A question was then posed about whether Gypsy Traveller men seek help from health services early enough if unwell and if so how this might be improved. 6 people thought this was the case, but 2 women and 1 young female thought it was not so. 1 person thought **"men might go to chemist more."**

4 people were not sure how to change this situation, with 1 saying **"No idea how to change the men"**. A further comment received was **"Not sure, the older men in the community are scared of doctors."** However **"encouraging men to attend the GP more regularly"** (1) and **"telling men why it is good to make an appointment as soon as possible"** (1) was thought to be helpful.

When asked about their experience of the health services they have used, 9 respondents said they were satisfied with the response to their requests with just 1 being dissatisfied. However, when asked **"Was there anything that didn't go well"**, 4 people out of the 11 said **"yes"**.

These included **“It is a problem when you get an appointment, they will only deal with one matter at a time. I felt the two problems would have been linked, but they wouldn’t let me talk about both issues.”**

Also **“I am not being assessed properly, not checked and asked questions, only given paracetamol”** and **“Always recommend paracetamol”**

If wanting to look for health information, most respondents (5) would ask their GP. A similar number (4) would look on the internet, combined with consulting family, friends and/or GP.

One said they **“don’t want to know”** although it is unclear as to whether this means they are not interested in knowing about their health and so not pro-actively seeking information, or that having developed a problem, they would rather not know the diagnosis.

Knowledge of the NHS Health Check was low. Whilst 7 had no awareness, 2 people confused it with childhood checks in their Czech, or Romanian country of origin, 1 said a **“full body check”** and 1 said **“yes. I have one soon”**.

Although 4 said they had had an NHS Healthcheck, the answers above, coupled with the fact that one was a young person well below the age of eligibility, suggests that they may have had some sort of check/examination, but not the formalised NHS Healthcheck.

In order to get an idea of whether health is perceived in medical model terms, social model or wider determinants, an open question was asked. This was **“What do you think makes you healthy”?**

5 people explicitly stated healthy eating, exercising, veg and fruit, drinking water, eating soups-vegetable and meat soups and **“caring about what I eat, exercise and hygiene”**.

It was also recognised that **“things can make you go up and down-living on a council estate makes me unhappy”**. 2 people mentioned **“my faith/being blessed by god”** made you healthy.

The above comments, although not explicitly termed ‘feeling at ease’ do seem to suggest this concept. Another comment, whilst not concurring with our ideal model of health promotion, also suggests that relaxation through **“a coffee and a cigarette, eat regularly”** is what ‘makes you healthy’.

Other comments suggested health was something from which you were automatically excluded, if adopting certain behaviours, for example **“I don’t know I smoke”** or was expressed in terms of not being healthy **“I don’t feel healthy right now.”**

Respondents were then asked to decide which one of three symbols most reflected their feelings on most days when they wake up. 6 (including the young person) chose a happy face and 5 chose an 'OK' situation, midway between happy and not OK.

When asked if either they, or other members of their family had ever suffered from stress, depression, anxiety or low mood, 4 said yes, but 7 (including the young person) said 'no'. 3 out of the 4 who had suffered, had found help that was useful at this time. Respondents were then asked about the importance of hobbies and activities that they enjoy to improve mental health and mood. Several appreciated exercise (football, boxing, going out for a walk) the value of friends/not being alone when down (3) or keeping busy by cooking, cleaning/cleaning the house, sewing or focusing on "kids" as coping mechanisms. Others would watch TV or pass time by **"reading, sleeping"** (young female).

If they were looking for an activity to help them relax, cost, transport, childcare and time were considerations for 3, and existing activities such as watching TV or cooking would have to be considered (3). 1 would value **"some sort of calm place to sit and relax, have a conversation. Somewhere nearby in the afternoon"**, 1 would seek **"some work, to let the problems go, contact with my girlfriend, talk to her."**

When asked what health topics they thought their community would like more information on, most of the respondents answered they **didn't know** or **not sure**. 1 said general information, 1 said how to look for health support (1) and 1 said different kinds of illnesses people can be suffering from. The young female said information about services and how to access would be useful.

In terms of getting information to the community, in person, door to door, telephone, some nurse to explain in person and word of mouth were all cited, possibly reflecting a need to accommodate language and literacy levels in this community. Web information and letters (possibly translated) were also suggested by fewer people.

Interestingly, 6 people said they had used social media (You Tube) to find health information, whilst 5 (including the young female) had not. The majority (7) thought Facebook and What's App good places to share health information, although 4 (including the young female) thought it was not. 6 people had concerns about sharing information about themselves, or other members of their community on the internet, although again 3 (including the young person) did not.

We then looked at whether the Roma community was moving from traditional tobacco products to e cigarettes, which is now seen as an acceptable way to reduce health risk. 6 said they thought the switch was happening in their community as well. **"It is happening a lot in older women"** (1) and also in the workplace where **"all who work, use it because you can use it at work anytime"** (1). It was not clear from these comments whether those who use at work, extend this into out of work vaping, or if they switch to conventional products, when restrictions don't apply.

1 person felt it was **“Just another way to smoke, more people doing it, new craze”**
4 people said either **“don’t think so”**, **“no”**, **“not noticed”** or **“not around me”**
In terms of whether alcohol, or drugs were affecting their community, there was an overwhelming **Yes** response, with 10 respondents answering this way. This was **“alcohol mainly”** (1) and **“a lot”** (1).

When asked if there is anything they would like to see in a new service that would improve their community’s health, the majority responded in terms of NHS health services such as **“Waiting for appointments, waiting in hospital to be seen, treatment to be done properly, not just paracetamol for any issue”** and **“New pills to treat illnesses, shorter waiting lists to be seen, communication about appointments between GP and specialist and me”**

3 said **“no”**, **“nothing”** or **“not really”** but more interpreters and translated information e.g. **“More of the services to be delivered in Czech or Slovak – leaflets and information translated”** responses were recorded. Also that we **“should have Roma people working for NHS”**.

Something which could be of concern, in terms of potential future NHS costs, and poor awareness of the links between alcohol and liver disease/poor understanding of a major operation is the following quote **“It is good, you don’t have to pay here, better than in Slovakia, you’d have to pay to have a liver changed”**.

Group 4 Roma sample (Shortened Questionnaire)

16 other, self-identified Roma (7 males and 9 females) who attended the drop in at Chapeltown Reginald Centre or Nowell Mount, Harehills, completed a shortened questionnaire. This was designed with a view to obtaining information from individuals who wouldn’t usually participate in surveys and this does seem to have encouraged some men to provide their views.

The majority of people (14) in this sample, in contrast to those completing the longer questionnaire had lived in Leeds for less than 5 years and only 2 between 5 and 10 years.

13 people reported good health since they have been in Leeds, 2 said reasonably good and only 1 had had bad health since being in Leeds. However, the vast majority of people (15) had either themselves, or other members of their family used health services whilst they have been here. The number of people who had used health services by type of service used is shown below and demonstrates that use of GPs is high amongst this small sample, but so is A & E.

As the questionnaire didn’t ask for reasons for attendance, it is not clear whether this is considered a convenient route to more immediate attention, even for non-emergencies, or that this sample has had a high number of emergency incidents, which legitimately necessitated an A & E visit.

Table 2.

Visits to health services by service type

Type	A & E	GP	Chemist	Dentist	Health Visitor
Numbers visiting	9	13	9	1	1

Once again, community pharmacists appear to be well used by this community. 9 people found the service they used easy to access and 6 others said access was OK. The majority (15) found the people they had asked to be helpful with none saying people they had asked for help being unhelpful.

When asked more widely about whether there is anything in particular that you feel is, or has been affecting your or your family's health, the effects of the wider determinants of health became more apparent, with working conditions, benefits and benefits advice being raised by 4 people. However, 5 people said there was nothing they felt was affecting their own or their family's health. 1 person mentioned that their child's health was affecting them.

Despite this, 12 people indicated that they usually feel happy when they wake up in the morning, 3 chose an 'OK' situation, midway between happy and not OK and only 1 chose the symbol that suggested they were not OK on most days of the week.

Finally respondents were asked "What do you think is the single most important thing that would improve your or your family's health? The picture was mixed. 2 "didn't know" and one said nothing as **"all's well at the moment"** but stress free living, clean air, wanting to stop smoking and 'pain in my legs' were also cited.

In depth one to one conversation

One in depth conversation was held with a female self-identified Romani Gypsy. This was initially to check out the suitability of questions with the Gypsy Traveller community, but in the process valuable insight was given around some of the health issues this community face.

This lady vented her frustration at what she observed in terms of inappropriate use of health services, such as using hospital services rather than GPs. This she felt was for convenience and not consideration of limited health resource. She also highlighted that historically, Gypsies and Travellers had travelled considerably, of the environment and how people and places are left afterwards. She made reference to the cost of inappropriate use of the health service and also of costs to Local Authorities when unauthorised sites are left with huge clean up exercises. To a certain extent she saw this as unwelcome differences in the values of the older generation and those of the new.

In terms of accessing healthcare, personally when the GP was open she would speak to them, and if not ring 111. She now gets repeat prescriptions from pharmacies and she also talks to staff during reviews. Whilst this works most of the time, there are times when **"Chemist and doctors altogether still can't do it right."** For minor ailments such as colds she would self-care with paracetamol.

If needing some form of treatment to improve a medical condition she felt it important to weigh up the advice and options before deciding, describing her experience of dealing with her own heart condition. However she felt this was only possible, when not presenting as an emergency.

In terms of traditional remedies, although she considered they had been watered down over the years, lemon and barley water (for urinary problems) and less conventionally **'bread soaked in milk and covered in sugar'** was suggested as helping recovery from tooth extraction.

This, she felt wasn't commonplace now as in her community, anything (including breakfast) that makes a trailer smell is unwelcome **"never use the cooker you know and things like that because of the smell, they want everything that clean that's cleaner than new you know."**

In terms of illnesses that she thought might be common in her community she replied **"yeah there's always something going about, like diarrhoea and sickness"**

More serious issues such as cancer were referred to as the bad thing- **I think it's just the same as it's always been, I've heard over the last few years that a few young ones having it and even dying with but no I don't really think it's any worse and they don't talk about it anyway you know, they call it 'bad thing'.**

In terms of use of health services and satisfaction with the way requests were dealt with, this lady was satisfied **"apart from A&E this winter it was murder, absolute murder but couldn't help it there were that many people that were ill you know it's a sign of the times, in it?"**

It was clear that whilst the older generation may not always be technologically savvy, they are, via younger members of the family using e.g. the internet, to increase their health knowledge **"well I have asked, big A's wife to look up on the computer you know"** and **"there's a lot that look at that to find out things now because they all got a phone and they're all computer literate nowadays, whereas at one time they couldn't read and write"**

This lady did know what the NHS Health Check was **"yeah I do I've had one, I don't have now, because I'm never away from the doctors, but my son's to go for one in a fortnight. Is usually about fortyish"**

When asked about men and them not seeking help early enough she said **"I don't know they just [don't go], I have a son like that. He is half dead and you know he will not go anywhere you know, it's true he literally won't go."** She felt it difficult to change this as- **"I don't really know to be honest you know. It's just that way and it's been that with the generations."**

When asked "what do you think makes you healthy?" she felt that **"it's eating right isn't it, getting plenty of exercise and fresh air."** However she felt that this was not now the way of new generations **"you know a lot of Travellers don't eat properly."**

They just eat twice a day - takeaway you know, they don't cook or anything like that all the healthy stuff."