

Health Needs Assessment of Gypsies and Travellers in Devon

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CONTENTS

1. Foreword
2. Executive Summary
3. Introduction
4. Background / context
 - Purpose of a HNA
 - Definitions
 - Regional Strategies
 - Local Strategies
5. Demography & population projections
6. Prevalence, epidemiology & impact on health
 - Follow up appointments
 - Evidence of Prejudice - Racism and Discrimination
7. Health inequalities
 - Women's Health
 - Children and Young People's Health
 - Mental Health
 - Self Harm and Suicide
 - Substance Misuse
 - Dental /Oral Health
 - Palliative Care
 - Secondary and Tertiary Care
 - Local Issues
 - Fast Access to Specialist Child Health Workers
 - Evictions
8. Evidence of effectiveness
 - Peer Educators
 - Community Development Workers
 - Information
 - Disease specific programmes
 - Other Evidence of Effectiveness
 - Summary of Evidence of Effectiveness
9. Current commissioning
 - Primary Care
 - Specialist Health Workers
 - Secondary Care
 - Local partnerships

10. Performance monitoring

- Public Service Agreement
- Local Area Agreements
- Public Health targets
- Primary and Secondary care

11. Recommendations

12. Conclusions

13. Acknowledgements

14. List of figures

15. Appendices

1. Foreword

- 1.1 For the purposes of this report Gypsies and Travellers have been grouped together as a particularly vulnerable community with specific health needs who experience health in-equalities. I recognise that there are distinct cultural differences within this community and small studies have found variations in their health needs and how these can be best met.
- 1.2 Evidence would suggest that Gypsies and Traveller communities experience worse health, die earlier than the rest of the population and are less likely to receive effective continuous health care that meets their needs. Overall there is a lack of quantitative data to describe their health needs leaving them largely invisible to health service commissioners
- 1.3 The lack of suitable accommodation, for these people in the form of 'sufficient authorised and transit sites' leads to a fear amongst some of eviction, families living in overcrowded conditions, living in some cases in less than suitable environments all of which lead to a negative impact on health and significant health inequalities. There is evidence of poor health, higher morbidity rates in certain chronic diseases including mental health, higher levels of infant mortality and perinatal death rates, low immunisation uptake, high accident rates (not to be confused with higher attendance at A&E departments overall) and lower life expectancy in men and women.
- 1.4 There is good evidence to suggest that this community experiences high levels of racism and discrimination and for some prejudicial health professional behaviours and this is unacceptable. Due to cultural beliefs and attitudes Gypsies and Travellers can have a low level of expectation of health services or trust that health professionals can make a difference. Ill health can be seen as standard and fatalistically accepted.
- 1.5 At a local level there are examples of good practice that need to be rolled out across the county and supported by sustained funding. Equally there are examples of poor or inadequate multi-agency working in Devon despite agreed protocols being in place. Improvements in communications and multi-agency responses in relation to un-authorized encampments and possible evictions need to be addressed.
- 1.6 The recommendations in this report are based on the evidence of what works and I believe that the Devon Strategic Partnership is the appropriate multi-agency body to monitor and performance manage the process given the complexity of the issues facing Gypsies and Travellers in Devon.
- 1.7 The existing multi-agency Gypsy and Traveller Task Group needs to review its membership and terms of reference so that it is fit for purpose to drive forward the recommendations within this report. The Devon Strategic Partnership can be advised of progress via the Stronger Communities and Health Improvement Group.

Dr Virginia Pearson
Joint Director of Public Health

2. Executive Summary

- 2.1 Whilst experts differ on the number of different Gypsy and Traveller groups in England most agree that the largest group, possibly comprising half of all Gypsies and Travellers, is Romany Gypsies. However, there is no national data on the number of Gypsies and Travellers living in the United Kingdom because the 2001 Census did not identify Gypsies and Travellers as an ethnic category. Other coding opportunities are largely incomplete but can reflect the desire of Gypsies and Travellers not to provide details of their cultural backgrounds for fear of prejudice and discrimination. See Sections 4 & 5.
- 2.2 Under race relations legislation, Romany Gypsies and Irish Travellers are both defined as minority ethnic groups. This means that NHS bodies as public organisations must consider the needs and circumstances of these communities when meeting their general and specific duties under the Race Relations (Amendment) Act 2000. Health commissioners must remember that they must ensure ...” healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably” (Standards for Better Health, Core standard C7e).
- 2.3 Many Gypsies and Travellers are settled, not all live a nomadic life although they may choose to travel for part of the year. There is evidence⁸ that Gypsies and Traveller communities, be they children, adults or older people, experience more poor health than any other disadvantaged group living in England. The health needs of settled Gypsies and Travellers are every bit as bad as that of mobile Gypsies and Travellers. A lifetime of exposure to prejudice, racism and discrimination is likely to contribute to poor health and mental wellbeing. Prejudicial professional behaviours must not be tolerated or be condoned.
- 2.4 Despite the lack of robust national or local statistics there is sufficient evidence from a number of studies of the in-equalities experienced by Gypsy and Traveller communities including in-equalities in health that must be addressed (see Sections 6 & 7). There is evidence of effective practice (see Section 8) pertinent to but not exclusively designed for Gypsies and Travellers that should be implemented across Devon in a uniform way and audited as part of an agreed audit programme by providers and reported to commissioners (See Section 10). There are many examples of good practice that should be rolled out.
- 2.5 The recommendations contained in section 11 have received support from those who have responded during the two week consultation phase. The recommendations cover training, intelligence, policy and protocol development and implementation, multi-agency working (strategic and operational), service reviews as well as supporting Gypsies and Travellers to be able to actively participate in design, deliver and monitoring where they see fit.
- 2.6 This report has been widely circulated to a range of organisations and individuals for comment and amendments; see Section 13.

- 2.7 There is a need to ensure a multi-agency task group drives forward the implementation of the agreed recommendations and that this task group should be held to account and supported by the Devon Strategic Partnership. See Sections 10 & 12.

3. Introduction

- 3.1 Gypsy and Traveller communities experience wide ranging in-equalities¹ and the lack of suitable accommodation underpins many of the in-equalities that these people experience and a lifespan of experiencing racism and discrimination in education, access to health care, employment and other social and public contexts.
- 3.2 Gypsy and Traveller communities experience worse health, die earlier than the rest of the population and are less likely to receive effective continuous health care that meets their needs. They are largely invisible to health service commissioners. There is little robust data available to assist in effective commissioning and monitoring of services to meet existing health needs and improve health outcomes.
- 3.3 The National Health Service is required to code ethnicity in order to monitor uptake of services by ethnic categories. In secondary care systems currently Gypsies and Travellers would be coded as a sub-set of the Black Minority Ethnic (BME) groupings, as either Gypsy Romany, Irish Traveller or Traveller, but often they are not coded partly because of their reluctance to inform services of their cultural backgrounds. In primary care there are four coding hierarchies within general practice computer systems and the level of coding can vary depending on the level the practice decides to code. In community services coding systems there is no ethnicity box on ethnic monitoring forms which relates to Gypsies and Travellers. Thus this vulnerable community remains for the most part invisible from any scientific analysis for planning or commissioning purposes.
- 3.4 This report, however, draws on the evidence available to describe the health needs that exist and makes recommendations for health service commissioners and their partners to improve health outcomes and reduce health in-equalities.

¹ In-equalities experienced by Gypsy and Traveller communities: A Review. Research report 12 Equality and Human Rights Commission, Winter 2009

4. Background/Context

Purpose of a HNA

- 4.1 The National Institute for and Health Clinical Excellence (NIHCE) describes a health needs assessment as a systematic method for reviewing the health needs of a particular population leading to agreed priorities and resource allocation which will lead to improved health, improved access to healthcare and reduced health in-equalities. This report will focus on the health needs of Gypsies and Travellers.
- 4.2 The objectives of this health needs assessment is to:
- raise the profile of the health needs of Gypsies and Travellers in order to inform and influence commissioners
 - describe what is currently understood about the health needs of this client group
 - determine what the gaps in information are and make recommendations to improve local understanding of health needs
 - to make recommendations to improve health and access to health care for Gypsies and Travellers

Definitions

- 4.3 Issues of definition are challenging² and Gypsies and Travellers are not counted in Census or other routinely collected data sources. The bi-annual Department of Environment, Transport and the Regions (DETR) / Department of Transport, Local Government and the Regions (DLTR), count of Gypsies and Travellers counts the number of caravans rather than the number of people. The count excludes those living in houses, which is estimated to be roughly half of the Traveller community. This community therefore remains a vulnerable minority group that are largely invisible from routine data sources and therefore invisible to health service commissioners.
- 4.4 Research commissioned on behalf of the local authorities in Devon³ adopted the following definition:
- “persons of nomadic habit of life whatever their race or origin, including such persons who on the grounds only of their own or their family’s or dependant’s educational or health needs or old age have ceased to travel temporarily or permanently, and all other person’s with a cultural tradition of nomadic or caravan dwelling” (Office of Deputy Prime minister 2-6:9). Devon Primary Care Trust for its equality scheme action plan has adopted a slightly different but complementary definition that is described in Appendix 5

² The Health of Travellers in the South West region South West Public Health Observatory 2002

³ Final Report Devon-wide Gypsy and Traveller Housing Needs Assessment Dr. R. Southern & Dr. Z. James, Social Research & Regeneration Unit University of Plymouth November 2006

- 4.5 This broad definition would include Romany Gypsies, Irish Travellers, Welsh Travellers, Scottish Gypsy and Travellers, new Travellers and Occupational Travellers including Show people⁴. The inclusive term Gypsy and Traveller will be used throughout the report to encompass all these groups whilst recognising they are culturally diverse.

National Policies

- 4.6 Reducing health in-equalities has been placed alongside health gain as a core objective of Government health policy since the Acheson Inquiry⁵ in 1998. In 2002 the government published a programme of action⁶ and made it clear that addressing health in-equalities included making mainstream services more responsive to the needs of disadvantaged populations. The policy framework includes the explicit drive to address the wider determinants of health: lifestyle, education, income, employment, housing, crime and environment, the domains that make up the Index of Multiple Deprivation, through joint assessments of need and partnership working across the public, private and voluntary sectors with progress performance managed through Local Area Agreements.
- 4.7 In 2007 a good practice guide for reducing health in-equalities in infant mortality⁷ was published to contribute to the aim of reducing in-equalities in life expectancy and an overall reduction in health in-equalities, see Appendix 4a,4b,4c for a summary of evidence based interventions that will help deliver the target outlined below.
- 4.8 In 2002 a national health in-equalities Public Service Agreement (PSA) target was set:
- 4.9 “To reduce in-equalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth. This target is underpinned by the following objective: starting with children less than one year by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole”.
- 4.10 Nationally there are unacceptable health in-equalities in infant mortality and although infant mortality affects all population groups, babies of families from certain groups are more likely to die before their first birthday. Studies of Gypsy and Traveller children² have suggested that they experience high infant mortality and peri-natal death rates as well as low birth weight and a high child accident rate.
- 4.11 The following two tables give a breakdown of infant mortality rates by district in Devon for 2005-2007. This shows there is variation in infant mortality across Devon but confidence intervals for the rates are wide and there are no significant differences between Devon districts, Devon overall and England. Rates are generally lower than the national rates of infant mortality. There is fluctuation in Devon rates from 1999 onward; however there are no significant differences.

⁴ Travellers Wellbeing – Multi Agency Approaches. Devon Health Forum 2003

⁵ Independent Inquiry into in-equalities in Health Report : Chairman Sir Donald Acheson Nov. 1998 London Stationary Office

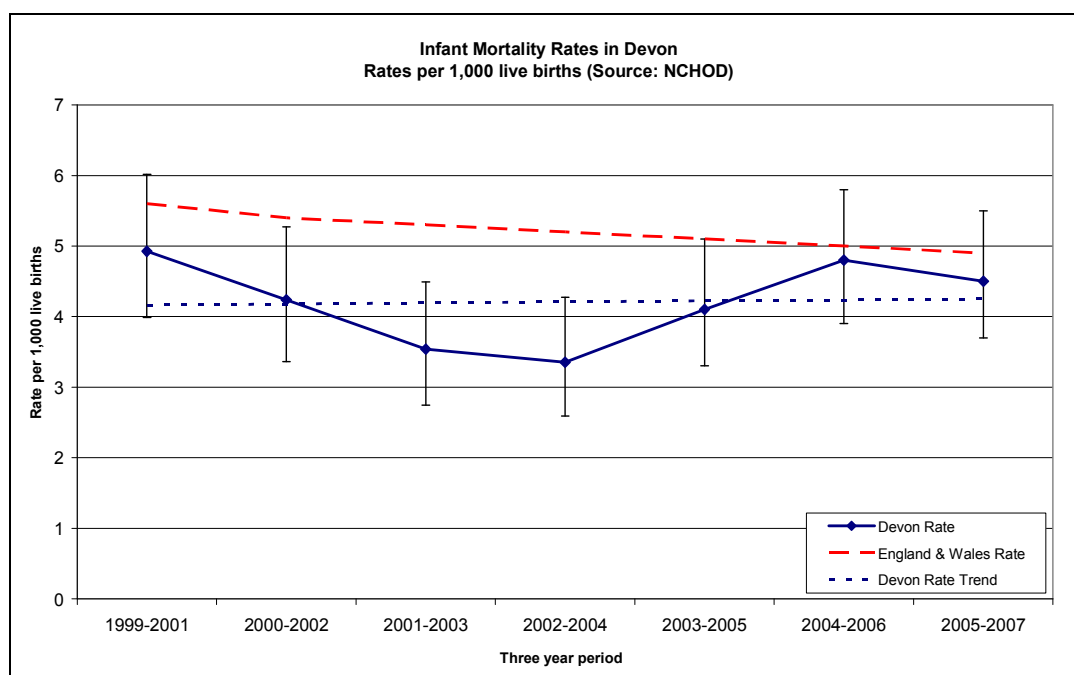
⁶ Tackling Health In-equalities a programme of action Nov. 2002 Department of Health

⁷ Implementation plan for reducing health in-equalities in infant mortality: a good practice guide. Department of Health Dec. 2007

Figure 1: Infant Mortality 2005-2007 (Source: NCHOD)

Local Authority	Rate per 1,000 live births	Confidence interval
East Devon	4.5	(2.7 - 7.6)
Exeter	5.3	(3.4 - 8.3)
Mid Devon	3.7	(1.9 - 7.2)
North Devon	5.4	(3.3 - 9.0)
South Hams	5.4	(3.0 - 9.7)
Teignbridge	2.3	(1.2 - 4.6)
Torrige	6.3	(3.5 - 11.3)
West Devon	3.8	(1.6 - 9.2)
Devon PCT	4.5	(3.7 - 5.5)
SOUTH WEST	4.2	(3.9 - 4.6)
ENGLAND	4.9	(4.8 - 5.0)

Figure 2: Infant Mortality Trends



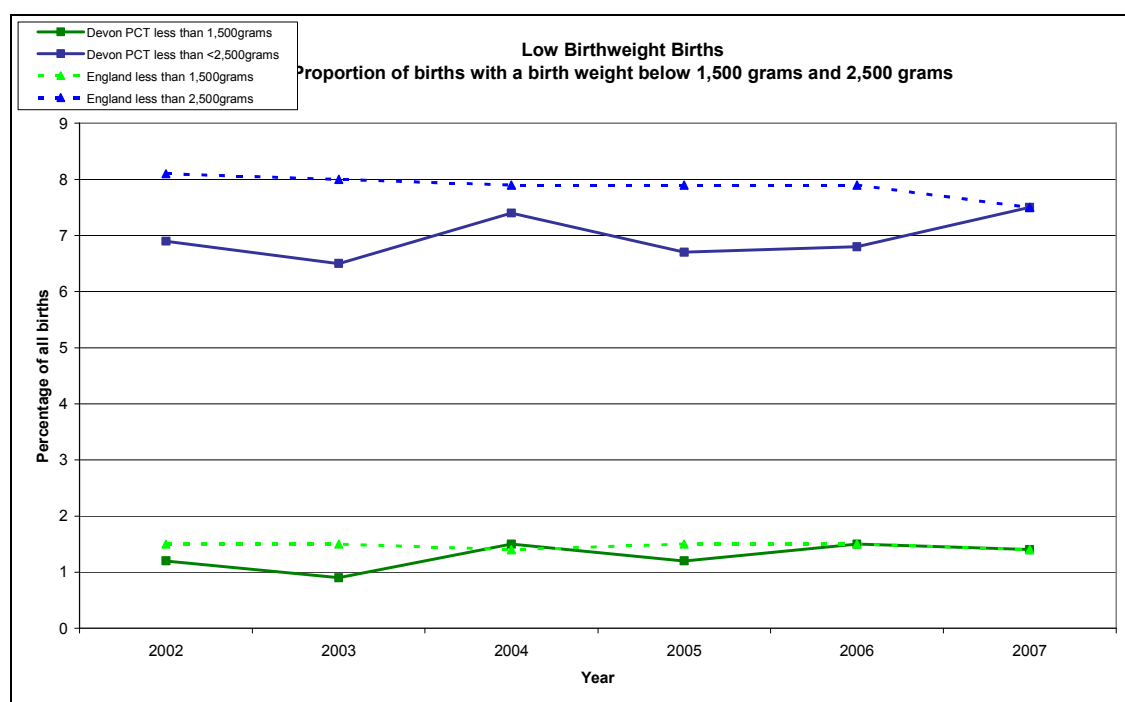
4.12 The following table shows the proportion of births with a birth weight of less than 2,500 grams.

Figure 3: Low Birth Weight

Local Authority	Number	% <2,500grams	Confidence interval
East Devon	63	6.0	(4.8 - 7.7)
Exeter	96	7.4	(6.1 - 8.9)
Mid Devon	44	5.4	(4.1 - 7.2)
North Devon	48	5.1	(3.9 - 6.7)
South Hams	37	5.6	(4.1 - 7.7)
Teignbridge	76	6.5	(5.3 - 8.1)
Torrige	42	7.1	(5.3 - 9.4)
West Devon	32	6.8	(4.9 - 9.5)
Devon PCT	438	6.3	(5.7 - 6.9)
SOUTH WEST	3716	6.6	(6.4 - 6.8)
ENGLAND	48993	7.5	(7.5 - 7.6)

4.13 Again Devon Primary Care Trust is lower than the South West and England although there is no statistical difference between the districts.

Figure 4 : Low Birth Weight Births Trend (Source: NCHOD)



4.14 Gypsy and Traveller communities in Britain experience wide ranging inequalities and discrimination⁸. A core theme is the corrosive and pervasive impact of experiencing racism and discrimination throughout an entire lifespan. There is a Devon Local Area Agreement (LAA 35 re prejudice and hate crime) in place and whilst racist offences have decreased yearly in number and proportion, racist offences (mostly harassment) are still the highest offences in hate crime. Furthermore such a trend is not necessarily concrete evidence of a decrease in the number of racist incidence but may be

⁸ The Health Status of Gypsies & Travellers in England – summary of a report to the Department of Health 2004 The University of Sheffield

indicative of low levels of trust and confidence often fuelled by previous negative contact with such statutory agencies and a subsequent reluctance to report incidents

- 4.15 The victims, mainly men (60% men) fall in the age 35-44 age group and the ethnicity of victims are mostly African-Caribbean followed by white European and then Asian with all offenders classified as white European⁹. Reports of racist incidents in Devon County Council primary and secondary schools¹⁰ are also prepared but neither current reporting mechanism captures incidents by Gypsy and Traveller categories.
- 4.16 The lack of secure accommodation for nomadic groups remains the lynchpin of a plethora of other in-equalities. Nationally the provision of authorised sites has diminished, which is also reflected in Devon County and there has been a direct rise in the subsequent health and welfare problems for Gypsies and Travellers. Whilst there may be a number of unauthorised but tolerated sites in Devon the threat of and the continuing cycle of evictions associated with homelessness among caravan dwelling across Devon and the United Kingdom is unacceptable. The cumulative impact of such evictions particularly on children's development whilst under researched is likely to be a severe for some children as well as for some adults.
- 4.17 At a local level the Safeguarding Children's Board should be engaged and actively involved in cases of evictions that involve children and the Adult Safeguarding Board in cases of vulnerable adults. An 18 month retrospective audit of male Traveller deaths in Devon, where drugs or alcohol misuse were known risks, was completed in January 2009 and the findings of this audit and recommendations made should be addressed by an appropriate multi-agency strategic body.

Legislative Framework

- 4.18 The policy and legislative context pertinent to this report is the framework of human rights and equality legislation. The Human Rights Act 1998 incorporated the 1950 European Convention on Human Rights in to domestic law. The 1989 United Nations Convention on the rights of the child is also relevant. Equality law covers racism, gender, disability, sexual orientation, religion and belief and age.
- 4.19 The Race Relations (Amendment) Act 2000 that amended the Race Relations Act 1976 introduced a positive duty on public bodies to promote racial equality and the Equality Act 2006 introduced a similar duty to promote gender equality as did the Disability Discrimination Act 2005 promote disability equality. Following consultation in 2008 a new Equality Bill with a single equality duty in relation to all six strands was included in the government's legislation plans for 2008/09. The Race Relations Acts and Race Equality duty cover the majority of these groups but the legislation does not protect New Travellers and Occupational Travellers as they are not a race and to designate them as a race would belittle the concept of a racial minority group. They are not a homogenous group with their own culture, language, traditions etc – in theory anyone could become a New Traveller or an

⁹ Devon County Council Hate Crime 2005/06 – 2008/09 Quarter 3.

¹⁰ Hate crime : Devon County Council Schools data reported racist incidents in schools summer 2005-Spring 2008 term.

Occupational Traveller and then stop being one a couple of months later. There is no doubt however that they also face discrimination.

Regional Strategies

- 4.20 The South West Public Health Observatory is currently reviewing a report published in 2002² and updating the evidence base, exploring examples of good practice in recognition of the need to assist primary care trusts and local authorities assess and address health needs.
- 4.21 Equality South West (ESW) is a registered charity and England's first regional equality and diversity body. It is supported by the South West Regional Development Agency, the Government Office for the South West, the South West Regional Assembly, South West Forum and the South West Trade Union Congress. The aim of the charity is to tackle discrimination on the grounds of age, disability, gender, race, religion or belief, sexual orientation and transgender. They support the dedicated regional networks for each of these seven strands and work with other groups including Gypsies and Travellers.
- 4.22 Equality South West organised the first regional Gypsy and Traveller meeting which took place in September 2008 at Bridgewater Fair. This was the first substantial piece of work led by Equality South West, the meeting was well attended and the feedback from the event was good. Another one will be arranged in the future with a date in November 2009 agreed to plan for it. The fact that the meeting was designed to take place at a traditional South West Gypsy and Traveller Fair was welcomed although concerns were raised about how to engage New Travellers, and this will be addressed by Equality South West.
- 4.23 Equality South West was asked to pull together a 'Useful Regional and Local Contacts' booklet. This booklet would be a list of key contacts who work locally and regionally with Gypsies and Travellers (either directly or strategically). Requests for information are open until Oct 2009. A joint funding application to develop a coordinated regional or sub-regional support service for Gypsies and Travellers in the South West region has been submitted.
- 4.24 Friends Families and Travellers is a nationally recognized voluntary organization which serves the whole spectrum of the Traveller community, both traditional and new, settled and roadside. They run a national helpline covering evictions, harassment, planning, employment, benefits, education, health and civil rights, discrimination and legal representation. They have just been awarded three year funding by the Department of Health to work across three strategic health authorities (one of which is the south west) to help join Gypsies and Travellers into the consultative and participative mechanisms being rolled out by the NHS. They will seek to identify, train, support and mentor individual volunteers from travelling communities to participate in the various NHS involvement mechanisms.

Local Strategies

- 4.25 Plymouth Universities Social Research & Regeneration Unit was commissioned by the Devon Local Authorities to undertake a 'housing' needs assessment. The final report³ contains a number of recommendations

including one for improving access to health provision along with non-discriminatory practices. The health issues identified in the report are summarised in Section Six of this health needs assessment. Key findings included:

- a high use of Accident and Emergency (A&E) departments was found implying the need to provide better support to access local services
- the need to improve support to disabled Gypsies and Travellers including those who may require more help in the future linked to Supporting People
- evidence of health practitioners acting in a prejudicial manner were found indicating the need for more generic and specialist diversity training
- a case for the development of specialist health workers working alongside trained and funded Traveller and Gypsy community advocates was muted.

4.26 Devon Racial Equality Council has produced a DVD 'The Pride and The Prejudice'. The DVD was produced and made by Gypsies and Travellers across the Southwest and was launched at Exeter University on 23rd September 2008. The DVD is being offered by Devon Race Equality Council (DREC) as part of a training package which will include 2 hours of one of the production team's time. For more details contact Penny Dane at Devon REC (penny@devonrec.org.uk).

4.27 The South Western Ambulance Trust (SWAST) has been successful in bidding for central funds over three years under the Pacesetter Programme¹¹. The Trust is undertaking a study in collaboration with Devon Primary Care Council and Devon Racial Equality Council to assess current health inequalities within Gypsies and Travellers communities and then piloting programmes to address them. A number of respondents from Romany Gypsy and New Traveller communities have been interviewed, with the aim of interviewing a total of 30. Initiatives planned to improve health and wellbeing will include sessions run on:

- Stroke awareness (FAST)
- Know your Blood Pressure
- Diabetes and Ischaemic Heart Disease
- Age specific information i.e. child health.

Sessions that have already been run include those covering first aid and Romany women's health with more planned in the future.

4.28 Further work on developing client held records and developing options for receiving follow up out patient appointments is planned. Once again staff prejudice has been identified as an issue which needs to be addressed as

¹¹ A Dialogue of Equals the Pacesetters programme Community Engagement Guide NHS Jan 2008

well as problems regarding access for those who are unable to read, e.g. primary care waiting room calling systems that use LED signs where clients are reluctant to indicate they have a literacy problem. (Recommendation)

4.29 Devon's Gypsy and Traveller Community Development Worker, employed three days a week by Devon Race equality Council and two days a week by Devon Primary Care Trust under the BME mental health team has led on or been involved in:

- assisting with the Pacesetters consultations (which the South Western Ambulance Trust researcher is leading) by identifying willing participants (and attending interviews as a trusted intermediary); i.e. n=30 across Devon. At the request of those interviewed as part of this process 3 First Aid classes on sites have been held as well as a Romany women's health day, and other sessions are pending
- a Traveller information pack is produced annually by Devon Racial Equality Council (DREC) with Travellers and is given out by Traveller Education staff, police, and Devon County County's Traveller liaison officers. The work is multi agency funded - there is a health booklet as part of the pack giving basic information on services including information on domestic violence and mental health and a leaflet with basic first aid advice
- working with 6 trainers (trained by Devon Racial Equality Council) from Gypsy and Traveller communities to deliver training to statutory and voluntary bodies throughout Devon – recent training given for local involvement networks LINK (East Devon) and child and adolescent mental health services CAMHS (North Devon) to raise awareness of who Gypsies and Travellers are and what obstacles there are in accessing services
- a health bus was taken out on June 3rd 2009 for Gypsies - for blood pressure tests, general advice etc. Due to good feedback from Travellers this may be expanded to take a health bus out periodically to sites and to other events
- training mentors within the different Traveller communities to increase knowledge within the community and enable more Gypsies and Travellers to be aware of what services exist and how to access them. Priorities for 09/10 are domestic violence and drugs/alcohol. National time limited funding has already been received and consideration will need to be taken regarding long term funding subject to the outcome of any evaluation.

4.30 Devon Primary Care Trusts equality scheme action plan was updated in April 2009 and is summarised in Appendix 5.

4.31 Devon County Council employs a Gypsy and Traveller liaison Officer whose role involves visiting unauthorised encampments on Devon County Council land plus other land where the ownership is unclear. The post holder has site responsibility for Sowton and Broadclyst and the job also includes an enforcement role and providing reports for the county solicitor prior to any

eviction. Information on health issues is gleaned although not routinely collected or collated and prejudicial behaviours have been observed.

- 4.32 Issues that have been raised by the post holder that need to be addressed include: training for key worker staff with help from members of the Gypsy and Traveller community, improvement in joint agency working and communication in particular around un-authorised sites, plus the need for accurate information on health contacts to ensure key worker staff coming on to un-authorised sites are aware of any planned action.
- 4.33 A multi-agency Gypsies and Travellers steering group exists chaired by a Senior Manager from Devon County Council. This group should ensure any existing multi-agency protocols are fully implemented across Devon and reviewed. The work of this group should ultimately be reported to the Devon Strategic Partnership via the Stronger Communities and Health Improvement Group
- 4.34 The recommendations described later in this report are aimed at addressing the issues that have been raised locally

5. Demography & Population Projections

- 5.1 The Department of Communities and Local Government estimated in 2006 that Gypsies and Travellers represented approximately 0.6% of the population In Devon this equates to 4,612 people. Whilst local authorities have a duty, bi-annually to undertake a 'caravan' count this does not capture the number of people. In addition there is said to be no uniformity in how each district council carries out their count and the figures gleaned may be inaccurate.
- 5.2 The number of caravans in Devon³ were said to be 299 in 2006 a slight increase from the 2004 figures, whereas the provision of pitches either by LA or private provision is said to have dropped in the same period. The table below provides an update of the number of caravans (not people) up to January 2009 showing an increase over time of caravans on unauthorised sites.
- 5.3 Gypsy and Traveller Caravan Count Source:
<http://www.communities.gov.uk/housing/housingmanagementcare/gypsiesandTravellers/GypsyandTravellersitedataandstat/>

Figure 5: Gypsy and Traveller Caravan Count

		Authorised sites (with planning permission)		Unauthorised sites (without planning permission)				Total All Caravans
		No. of Caravans		No. of Caravans on Sites on Gypsies own land		No. of Caravans on Sites on land not owned by Gypsies		
		Socially Rented ³	Private	"Tolerated"	"Not tolerated"	"Tolerated"	"Not tolerated"	
Devon	Jan 2009	23	116	11	15	248	29	442
	Jul 2008	25	124	18	4	180	3	354
	Jan 2008	22	156	13	6	169	3	369
	Jul 2007	20	138	18	41	99	3	319
	Jan 2007	20	132	55	19	87	5	318

- 5.4 The Devon Housing Needs Assessment report³ identified that there were 454 children aged 0-16 known to the Devon Traveller Education service during 2004/05. From the 2007/08 breakdown by funding local authority Devon has 438 children aged 0-19 contacted or known to be in the area¹². Some children were in two or more areas.

Figure 6: 2007-2008 breakdowns by Funding Local Authority

2007-2008 breakdown by Funding Local Authority						
	0-2	3-5	6-11	12-16	17-19	Totals
Devon	69	81	192	91	5	438
Plymouth	38	35	71	20	0	164
Torbay	15	19	26	5	0	65
unspecified	1	1	6	2	0	10

- 5.5 Within Devon 88 primary and 36 secondary schools had Traveller children on their roll. There were no known Traveller children in special schools. The Traveller Education Service is also able to provide a breakdown of the number of children by different Traveller groups. The greater proportion of children that are known to the Traveller education service come from the Gypsy and Traveller community followed by the new Traveller and Fairground Traveller communities with much smaller numbers from the other Traveller communities. However it is well known nationally and also felt to be true locally that there will be Traveller pupils in schools who are not identified as such as the parents choose not to declare their identity on enrolment forms for fear of bullying and prejudice.
- 5.6 The figure below provides information across Devon as a whole and is not broken down by District or Unitary Authority. Over half of the children had no educational provision beyond some contact with the Devon Community Traveller Service.

¹² Capita EMS Children Support Services Module – Traveller Education services 13th May 2009

Figure 7: Education Provision for Traveller Children

		2007/08	2006/07	2005/06
No. of children supported with distance learning some attended school periodically		85=18%	88=18%	61=15%
No. of children educated at home (primary and secondary)		20=6%	19=5%	21=5%
No. of children who had no provision beyond some contact with DCTS		295=53%	313=54%	268=57%
The reasons for the lack of provision were:	Medical	3=1%	34=6%	14=3%
	Parent refusal	64=11%	42=7%	19=4%
	No school place available	75=13%	65=11%	60=13%
	No time	142=25%		

5.7 Section six of the 2006 draft Regional Spatial Strategy¹³ provided an interim estimate of additional pitches required across the region of 1,100. Previous local needs assessment plans across Devon (district councils and unitary authorities) advised that there was no need for the allocation of new sites for Gypsies and Travellers in their geographical areas. Dartmoor National Park should also recognise the need for permanent and transit sites and this should be included in figures submitted. Figure 8 describes the estimated shortfall of extra pitches needed by 2011 in Devon.

5.8 The majority (92.2%) of those surveyed as part of the Devon Housing Needs Assessment 2006³ however felt that there were not enough long term pitches in Devon, leading to homelessness with an estimated shortfall in the region of 181 pitches. Those using unauthorised sites are considered to be homeless. The 2006 draft regional spatial strategy¹³ outlined the counties in the region with high numbers of unauthorised sites and this included parts of Devon.

Figure 8: Calculations used for District Authority Future Pitch Requirements in Devon³

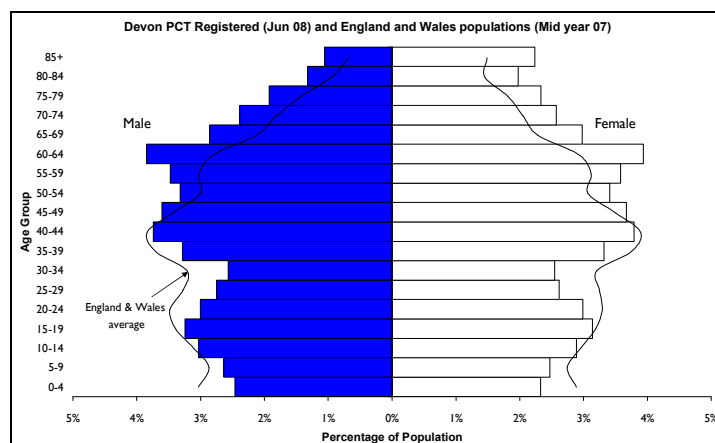
	East Devon	Mid Devon	North Devon	West Devon	Exeter	*South Hams	Torridge	Teignbridge
LA sites available	1	0	0	0	1	0	0	0
Authorised private sites	13	19	2	0	0	2	2	10
Unauthorised sites	5	5	3	1	2	17	10	7
Total extra pitch need 2006-2011	9	14	5	6	12	*51	24	65

* These figures exclude any sites on Dartmoor National Park land and following consultation it has been suggested that the total extra pitches needed in South Hams is nearer 94 not 51.

¹³ South West Regional Assembly, The Draft Regional Spatial Strategy for the South West 2006 – 2026, 2006

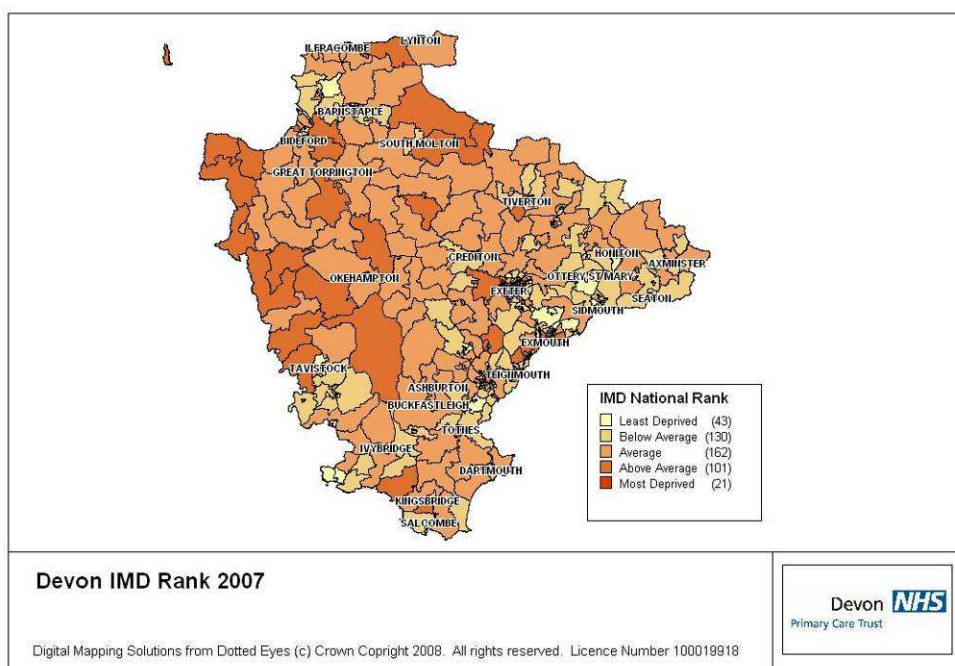
- 5.9 Of the people surveyed as part of the Devon housing needs assessment³ 70.3% lived on settled encampments and 29.7% were on the roadside. 68% had children with a slightly higher number of children per family of 2.6 than national average of settled population.
- 5.10 The total period fertility rate is the number of children a woman would have if she was subject to prevailing fertility rates at all ages from a single given year, and survives throughout all her childbearing years. It is a synthetic rate, not something that is actually counted. In Devon, the total period fertility rate varies between the districts from 1.34 in Exeter to 2.16 in west Devon. This is lower than the South West and England total period fertility rates of 1.86 and 1.91 respectively. Overall, however, there is an expectation that the Gypsies and Travellers population in Devon is expected to increase over time not diminish.
- 5.11 In Devon the average number of people per pitch are 2.79 higher than the average settled household's size of 2.29 with evidence of overcrowding whether on authorised or unauthorised sites. The link between overcrowding and poor health is well understood. Facilities provided such as water, electricity, refuse collection, drainage, problems with vermin and overall health and safety of the site if used for work, varied as did the benefits or not of the site being managed. Levels of fire protection (and hence greater risk of injury) were felt to be low as well as the availability of public transport whereas the postal service seemed to be the most comprehensive provision available.
- 5.12 Approximately a third of settled or roadside respondents experienced problems with neighbours or local people. Employment opportunities are said not to be linked with seasonal jobs but more to ad hoc paid work such as gardening, domestic road surfacing, landscaping and roofing. Feedback following consultation would however indicate a significant proportion taking seasonal employment opportunities.
- 5.13 The GP registered population of Devon Primary Care Trust totalled 755,601 as of 30 June 2008 of which 386,043 were female and 369,558 were male. A graphical representation (population pyramid) further breaking the population down by sex and age band is shown in Figure 9.

Figure 9: Devon Primary Care Trust Registered (Jun 08) and England and Wales Populations (Mid year 07)



- 5.14 Projections for the population change across Devon between 2006 and 2031 suggest that the overall population will increase from 741,000 to 967,900. The 0-14 and 15-64 age groups are forecast to increase by around 20% with larger increases, of 75% and 85%, being anticipated in the over 65 and 75 population. By 2031 forecasts suggest that there will 270,500 people over the age of 65 and 146,600 over the age of 75.
- 5.15 Variations in the levels of multiple deprivation, by lower super-output area in Devon are shown below. The most deprived areas can be found in parts of Exeter and North Devon.

Figure 10: Map Showing Indicators of Multiple Deprivation in Devon



6. Prevalence, Epidemiology & Impact on Health

- 6.1 The health status amongst Gypsies and Travellers in terms of mortality and morbidity are significantly worse than other UK resident English speaking ethnic minority and economically disadvantaged white UK residents⁸.
- 6.2 Extracts from the health questions covered by the Devon wide housing needs assessment³ study show that in terms of their health, the majority of respondents recruited to the study perceived and stated that their health was 'very good' (42.2%), with only 8.6% of respondents having said that their health was 'very poor' (see Appendix 7). When asked about the health status of family members though 21.1% of the sample said that they had family members with either 'poor' or 'very poor' health.
- 6.3 Just over half of respondents responded to a question on disability. Of those people who responded, 10% said that they did have a 'disability' (although that might not necessarily be a diagnosed disability) and the majority of these

were among the people who had rated their health as 'poor' or 'very poor'. Of the people who answered questions about disability in the family, 11% said that they had a family member with a disability. Despite these findings on disability, only 2.3% of all respondents said that they had help at home, and only 2.7% of all respondents said that they would like help. 18.8% of respondents said that they would be likely to need help provided in the home within the next five years, and it was recommended that the Supporting People task group should explore this in more depth for future planning. (Recommendation)

6.4 When feeling unwell Gypsies and Travellers in Devon utilised a range of services including:

- 83.6% called on a doctor
- 64.1% the Accident and Emergency (A&E) department of a hospital
- 14.8% had used their local health visitor
- New Travellers were most likely to have used an alternative therapist (8.6%)
- Gypsies and Travellers living on the roadside were relatively likely to talk to Traveller Education Services about health matters
- Only 41.4% of respondents used a dentist - this finding may simply reflect the national difficulty of attaining National Health dental care.

Follow up appointments

6.5 Respondents living on roadside sites were asked about their ability to attain 'follow on' appointments for health care. The majority said that they would arrange their movements around such appointments to ensure they could attend and therefore this was not viewed as particularly problematic. Feedback from consultation however would indicate there are considerable problems where continuity of care including tertiary care is affected by repeat evictions. Consideration needs to be given as to the use of text messaging over appointments sent by mail, where clients specify this preference. Gypsies and traveller have also expressed a desire to have client held records to capture key medical information and assist with continuity of care when travelling either by desire or because of eviction. (Recommendation).

Evidence of Prejudice - Racism and Discrimination

6.6 There is overwhelming evidence of persistent racism experienced by Gypsies and Travellers from the public, services and local officials which can have a negative impact on their health and wellbeing¹. Children and young people are particularly vulnerable from their peers, their teachers and from adults and children in general. The Devon study³ found nearly a quarter of the respondents experienced victimisation with only 53% willing to report this to the police. Gypsy and Traveller communities feel that they are often victimised by the police which in turn leads to under-reporting and low levels

of confidence in such services. In relation to racism half had experienced this with only 17.2 % willing to report this to the police. See Section 4 information on hate crime.

- 6.7 Respondents to the Devon survey³ were asked about their positive and negative experiences with health and social care professionals. The results show that 10.9% of respondents said that they had had poor experiences, most commonly with the doctor or the dentist. The most common reason given for poor experience by respondents was the evidence of prejudice by the health professional. Alongside the occasional complaint of poor health practice is a more positive response from respondents with 42.2% of respondents stating that they had had a good experience of people in the health services.
- 6.8 There is a need to ensure specialist diversity training for all staff working with Gypsy and Traveller communities, with members from the community helping to design and deliver the training. The training currently delivered by Devon Race Equality Council provides an example of local good practice. Organisations need to consider this model as they develop their own training strategies and consideration needs to be given to the development and delivery of a multi-agency training programme. Recommendation

7. Health In-Equalities

- 7.1 Statistical data currently collected within the NHS does not cover or describe the health needs of Gypsies and Travellers or the services they use, so national data about their health and healthcare status is not currently available. Small studies have found that the health status of Gypsies and Travellers is much poorer than the general population and they die earlier than the rest of the population. Life Expectancy for Irish Traveller men and women is lower than the general population by 10 and 12 years respectively. Limited evidence would suggest that the health status and life expectancy of Show People is generally better than Gypsies and other Travellers. Data collection nationally, regionally and locally needs to be improved to aide a better understanding of health needs to inform strategic commissioning. (Recommendation).
- 7.2 The lack of suitable secure accommodation underpins many of the inequalities that Gypsy and Traveller communities experience. Health hazards include: poor sanitation, poor access to clean water, poor quality utility facilities', failings in fire safety, contamination by vermin partly due to poor rubbish collection leading to higher infection rates.
- 7.3 Poor quality or inappropriate accommodation and overcrowding all exacerbate existing health problems and lead to new problems. When Gypsies and Travellers access healthcare they more commonly present with more than one complaint. Despite greater health need Gypsies and Travellers use mainstream health services less than other members of the population¹ & ⁸. The most common problem for Gypsies and Travellers is difficulty in accessing primary care when GPs insist in having a permanent address, for call-out purposes, before agreeing to register them. Gypsies and Travellers can be turned away from surgeries or told that they can only access primary

care through the Clock Tower surgery. Devon Primary Care Trust must review its policy with regard to the eligibility of patients without fixed addresses to ensure the Trust conforms to its duty of care (Recommendation).

- 7.4 It has been said that Gypsies and Travellers have low expectations of good health particularly with increasing age and some believe that health professionals are unable to significantly improve people's health status. The concept of self reliance, staying in control together with a degree of fatalism characterised people's health belief, particularly held by Traveller men, to be stoical about their health add to the complexity of the issues to be addressed. There are cultural concerns amongst some and intense fears of certain health problems such as cancer and a reluctance to attend screening or seek preventative care.
- 7.5 Research on health promotion within the wider population often refers to the need to provide community outreach services, particularly where there is low take-up of provision, as can be the case with ethnic minority or disadvantaged groups. Reports highlight the efficacy of employing specialist health outreach staff to work with Gypsies and Travellers, in order to ensure their health needs are identified and addressed. A review of the current capacity in Devon of specialist outreach workers for this client group should be undertaken. Recommendation
- 7.6 Specialist health workers can ease access to services and outreach services (such as health visitors), can partly plug the gaps in advice or preventative services such as immunisation. Gypsies and Travellers place a high premium on health staff being good listeners and communicators and staff change from being seen as 'nurses' and take on a wider role as advocates, bridging the gap between health and social care providers. Training Gypsies and Travellers in basic healthcare and recognition of common symptoms would help to promote trust in the National Health Service and then they can signpost the person with ill health to local services.

Women's Health

- 7.7 There is evidence to suggest a poor up take of preventative health care including immunisation programmes and screening, i.e. cervical screening (often because of the need to ensure female staff are available). There is evidence of higher smoking prevalence and poor nutrition.
- 7.8 High rates of maternal death during pregnancy or shortly after childbirth with the majority of deaths considered preventable with better information, better access and support. Infant mortality nationally has been reported as 3 times higher than the rest of the population with high rates of miscarriages and still births. Concerns about healthcare providers perception of Gypsies and Travellers resistance to services or that they are 'wilfully' non compliant highlights the need for better communication and mutual understanding. The role of trained peer educators or community members trained in basic first aid, basic midwifery needs to be considered. A review of current maternity services needs to be under taken to ensure targeted support is available for high risk women. (Recommendation).

- 7.9 Although domestic violence occurs in families of all ethnicities, socio-economic backgrounds, levels of education, age and in same sex relationships international evidence indicates it is most commonly experienced within relationships or communities where there is support for strong male dominated relationships and where male authority over women and children is culturally expected or condoned¹. Gypsies and Travellers who are victims of domestic violence are predominantly female and domestic violence can be triggered by insecure or in-appropriate accommodation and arguments can start as they experience isolation, discrimination and financial hardship.
- 7.10 Violence against women has serious consequences on both mental and physical health with abused women more likely to suffer from depression, anxiety and other psychosomatic disorders such as eating disorders and sexual dysfunction. Such issues are often compounded by a lack of culturally appropriate domestic violence services and stigma of such issues within Gypsy communities. Victims of domestic violence are often forced to take up a 'settled' lifestyle and sever links with travelling communities.

Children and Young People's Health

- 7.11 It is clear that conditions early in life have long term effects on adult health and because of this, in-equalities in children's socio-economic circumstances make an important contribution to inequalities in health in adulthood¹⁴. Comprehensive data in respect of children from Gypsy and Traveller communities are lacking¹, but studies have found higher rates of illness among these children as compared with others and an excessively high rate of premature deaths among children.
- 7.12 Low levels of immunisation partly due to greater mobility, a lack of continuity of care, a lack of specialist health staff for the Gypsy and Traveller community and concerns as to side effects can also be an issue. Studies have shown higher rates of accidents related to parental difficulties in accessing appropriate information on accident prevention and the impact on poor quality sites on greater injury rates. Commissioners should ensure that specialist community public health nurses are targeting their services to the needs of the most vulnerable children and their families. Commissioners working jointly across the local authority and health should review Gypsy and Traveller access to children services such as children's centres to address any inequalities in access and support. Recommendations.
- 7.13 The impact on children's wellbeing and future emotional and psychological development is well documented¹⁵ and at a local level it is imperative that the local Safeguarding Children's Board should take a proactive approach when evictions are considered to safe guarding vulnerable children within the Gypsy and Travellers communities. (Recommendation).
- 7.14 Children are likely to suffer psychologically from repeated brutal evictions, family tensions associated with insecure lifestyles, domestic violence, enduring poverty and the unending stream of overt hostility including racism

¹⁴ Childhood disadvantage and adult health: a life course framework H. Gram C. Power Health Development Agency 2004

¹⁵ Every Child Matters Department of Children school and Families 2004

from the wider population¹⁶. There is an increasing problem of substance abuse among unemployed and disaffected young people.

Mental Health

- 7.15 There are higher rates of mental ill health such as anxiety (three times greater than others); depression (twice the rates) and sometimes self destructive behaviour (suicide and substance misuse) exist. Women are twice as likely as men to experience mental health problems. A range of factors may contribute to this, including the stresses caused by accommodation problems, unemployment, racism and discrimination by services and the wider public, and bereavement (some linked to higher infant mortality rates)
- 7.16 Attitudes towards mental health problems in Gypsy and Traveller communities, and the language used to describe them, are culturally specific, terms such as 'nerves' have been found to be discussed openly whereas the word 'mental' has been found to be viewed with suspicion, being linked to madness. Cultural beliefs, such as keeping problems within the family or extended family unit, can be reasons why people do not access mental health services. Keeping the problem hidden can increase the burden, while using alcohol as a coping strategy introduces new problems.
- 7.17 Mental health issues can be overlooked. Studies have shown that women who had experienced the death of a child (excluding miscarriages), which could be a reason for depression were more likely to be offered antidepressants and not counselling. Other studies have noted that Gypsies and Travellers were not looking for a specialist mental health service: they just wanted the same as everyone else. However, it is important that Gypsies and Travellers are supported to access culturally sensitive services by community groups, GPs, health workers or advocates with whom they have built up a relationship of trust.
- 7.18 Long-term mental health difficulties for women can be as a result from feeling trapped on a site where no-one would want to live, moving into housing is associated with depression and anxiety, and may be reflective of loss of community as well as experiences of racism and discrimination.
- 7.19 A more 'joined-up' approach to meeting Gypsies' and Travellers' mental health needs, with services working across boundaries may be needed with increased education, information and training on mental health needs for both health staff and community members, to reduce discrimination and increase support. (Recommendation)

Self Harm and Suicide

- 7.20 The suicide rate amongst Gypsies and Travellers is higher than the general population. Studies have shown greatly raised levels of depression and anxiety, the two factors most highly associated with suicide, with relative risks 20 and 8.5 times higher than the general population¹ Male members of social class V (comprising occupation groups such as labourers, and including many Gypsies and Travellers) have greatly increased suicide rates when compared with other socio-economic classes. Communities who find themselves subject

¹⁶ Research Report DCSF – RR077, Improving the Outcomes for Gypsy, Roma and Traveller Pupils – Literature Review, The Department for Children, schools & Families (DCSF), 2009

to oppression, racism and rejection of their community norms and way of life are likely to experience heightened levels of substance misuse, suicide and self harm all of which inflict a negative impact on the health and wellbeing of the rest of the family.

- 7.21 Depression caused by bereavement frequently appears to be a trigger for suicide or self harm through alcohol or drug misuse which can itself lead to a vicious cycle of contact with the criminal justice system. Gypsy and Traveller should be included as a category in all health records to assist in mapping of self harm, depression and associated risk factors. (Recommendation).

Substance Misuse

- 7.22 Like mental ill- health, substance misuse is more common in circumstances of poverty, discrimination and socio-economic disadvantage¹. Whilst alcohol misuse has always been known to exist amongst a minority of Gypsy and Traveller populations, recent studies would indicate an increasing dependency (alcohol and drug – poly substance use) amongst young men in poor housing situations. An eighteen month Devon wide retrospective audit of Traveller deaths amongst men with an alcohol or drug problems concurs with these national findings. A multi-agency steering group needs to consider and implement the recommendations made as a result of the audit. Recommendation
- 7.23 The sharing of prescriptive drugs such as anti-depressants is felt to be common amongst women.
- 7.24 Where specialist trusted outreach staff are attached to mainstream services there is general consensus from both professionals and the community that these models are effective and efficient interventions as in line with other forms of healthcare delivery (Recommendation).

Dental / Oral Health

- 7.25 Gypsies and Travellers are significantly disadvantaged in access to dental care and oral health through the inability to obtain regular check-ups and on-going treatment. Studies imply that access to preventative dental services has worsened in recent years and the general decline in access to NHS dentists over the past few years is likely to have an even greater impact on highly mobile families. A review of access to these services locally should be undertaken. (Recommendation).

Palliative Care

- 7.26 The needs of terminally ill Gypsies and Travellers of whatever age are felt to be overlooked by hospitals and GPs, and although Gypsies and Travellers prefer to die at home, there is often little support from healthcare professionals. The reasons included pride in caring for a person at home, clashes with medical staff over large numbers of visitors, and limited knowledge of the services available. Enforced mobility reduces access to GPs and can make it difficult to organise programmes of palliative care to support Gypsies and Travellers who wished to die at home. Devon Primary Care Trust should monitor the access to palliative care services for this vulnerable group. (Recommendation).

Secondary and Tertiary Care

- 7.27 Studies have noted a lack of understanding of Gypsy and Traveller culture in hospitals, including those that provide tertiary care. Elderly patients admitted to hospital or hospice can feel threatened and scared by the lack of cultural familiarity. Many who are unable to read and write can be reluctant to admit this. An inability to fill out menus or order food, or breaches of cultural hygiene rules all added to feelings of being a 'fish out of water'. Poor provision for visiting family members, cultural clashes with staff and other patients, distress experienced by people with limited literacy skills, and unfamiliarity with being inside bricks and mortar, all contribute to Gypsies and Travellers frequently choosing to discharge themselves early from hospital.
- 7.28 Hospital in patient data now records the patient's ethnicity. There are defined codes for Gypsy Romany, Traveller and Irish Traveller. There are, however, no records in the Devon data coded with these ethnicity groups. This may be due to poor recording or the persons desire not to disclose their actual ethnicity.
- 7.29 Equality and diversity leads in NHS Trusts must ensure they have robust strategies in place and these should be reported to and monitored by their Boards with the reports shared with the commissioners. (Recommendation).

Local Issues

- 7.30 The information included within this section has been provided by the Gypsies and Travellers community development worker currently employed by Devon Racial Equality Council and Devon Primary Care Trust. It has been précised by the author, of this report but this qualitative information has been included because it provides a powerful snapshot picture of some of the day to day issues Gypsies and Travellers encounter.

Fast Access to Specialist Child Health Workers

- 7.31 There is a need for staff working with Travellers (e.g. Devon County Council's Traveller Liaison/Traveller education personnel) to be able to easily and urgently, given the mobility of this client group, access a health visitor to visit unauthorised sites where there are health concerns about children. For example:
- where a family wanted the children inoculated
 - where children had suspected scabies.
- 7.32 Whilst there are pockets of good practice within Devon, it can be very difficult to get a health visitor out to site. The families in question were Romany or Irish, and are often not in the area for long as they get evicted very quickly. They are often reluctant to go to a GP on their own because of historic/anecdotal problems registering temporarily with GPs. There is a need for a protocol to be agreed to ensure urgent referrals are responded to in a timely manner. A review should be undertaken to ensure that there is sufficient capacity in the specialist child health worker provider workforce to work with families on the wider public health issues for children and young

people including obesity, sexual health and substance misuse (Recommendations).

- 7.33 The involvement of intermediary groups such as the Independent Travellers Advisory and Support Service needs to be addressed (Recommendations).
- 7.34 For example, Gypsies and Travellers have requested their own client held records or summaries of their medical records to assist primary care of the key medical issues they faces in order to support improved continuity of care and achieve the best health outcomes (Recommendations).

Evictions

- 7.35 The question of evictions is important but very difficult to quantify. They can happen in different ways – Devon County Council (DCC) evicts and serves notice, so do District councils, the police (section 61), and private landowners. Often Travellers will move off before the case goes to court.
- 7.36 There have been instances where the police have told Travellers that they will report them to social services and the Travellers move off in case this happens as there is still a worry within the Traveller community that their children will be taken away from them. The Police have had Gypsy and Traveller training this year from Devon Race Equality Council, and have adopted a new draft policy on unauthorised encampments so it is hoped behaviours will change.
- 7.37 Families are threatened with eviction from unauthorised sites - they could be council or private or they could be on their own land but without formal planning permission. Whilst the impact on children cannot be underestimated, it is not easily quantified and does not appear to come up on any agency's radar. Local examples include:
- a family with one child in school. In the 4 years they have been known to the community development worker they have been evicted, served notice or asked to move on from road side encampments over 10 times. There is no authorised site in Devon where they can live. The child has continued with education despite the pressures of moving on and living by the roadside without facilities. The child is now having difficulties in school and has had some racist abuse in and out of school. The whole situation is having an impact on the child's wellbeing and ability to stay on and complete secondary school, and it is also causing great stress to the parent which the child is witness to
 - a family on local authority (roadside) land, the child in school doing Standard Assessment Tests and just before the exams the family is served notice. The eviction is due to happen in the middle of Standard Assessment Tests week. Also, unusually for a Traveller child in school on a temporary basis, the child has been selected to star in a school performance at the end of term - the eviction means that this may not happen. The stress on the mother (single parent) is evident to the child, who also has the worry of Standard Assessment Tests and the possibility of not being in the school play. These are not considered to be good enough reasons to delay the eviction despite the fact that the

family has stated clearly that they would move on at the end of the school term

- four families with 10 children between them, in Devon for seasonal work, on an unauthorised site on private land on an industrial estate. (The site is out of the way, on a dead end road; some of the children are put into a local school on a temporary basis) The families would have moved on but one of the children had an accident in the caravan and has severe burns. The child is admitted to burns unit out of county. The mother stays with the child in hospital and the father remains with the 3 other children on the site. The families are not familiar with sites nearer to where the child is being treated some 80 plus miles away and decide to remain in Devon where they have easy access to the M5 until the child is discharged. The landowner serves notice and on the day of the eviction 4 bailiffs arrive and police in a riot van. The father of the sick child explains to the police officer that his child is ill in hospital and is accused of lying. The families are given an hour to pack up and leave or have their caravans removed if they do not. This is all legal. All the children witness the situation including a father being accused of lying, in despair for a sick child, their homes being threatened and the complete powerlessness of the Traveller adults. Had there been a transit site in Devon, these families would have had a safe and secure place to stay as it is they have no choice but to stay at unauthorised locations whilst visiting Devon.

- 7.38 There is a need for an agreed multi-agency proactive response in cases of eviction and the involvement of the Safe Guarding Children's board where children are involved or the Safe Guarding Adults Board in the case of vulnerable adults. (Recommendation)

8. Evidence of Effectiveness

- 8.1 Whilst community development and community engagement are two complementary but different terms, there is good evidence to support these approaches to improve health and reduced health inequalities. Crucial to these approaches for a long term sustained improvement in health and wellbeing is the principle that the identification of the issues/problems and the solution to those issues/problems must come from the community itself, involve the community long term and not be imposed by others, however well intended.

Peer Educators

- 8.2 A number of initiatives or programmes that have aimed to improve the health of Gypsy and Traveller women have been based on the concept of peer educators. In relation to depression and bereavement, Gypsy and Traveller women have said that they would welcome support from trained members of their community who would both understand the issues and their cultural concerns.
- 8.3 Other programmes have utilised a method of peer education that was first piloted in Dublin. This involved working with a Gypsy and Traveller outreach

worker to visit sited and housed Travellers and set up support groups in different localities. Work was then undertaken with Traveller women to identify their health needs and priorities and put in support and training around those needs. The groups were for women only, as many women said they would not feel comfortable talking about their health issues in front of men. Participants reported that most members of their families could benefit from the skills that the women acquired and that information and knowledge would accordingly be shared with other members of the community. These initiatives have enabled the workers to make contact with Gypsies and Travellers hitherto 'hidden' from mainstream health services. The work thus evolved from the provision of a direct service to becoming a link between statutory health agencies and the Travelling community, helping to reduce the real or perceived mistrust that is commonly held by both. A similar model is being developed Devon wide under the Pacesetting Programme but the funding is time limited.

- 8.4 A group for Gypsy and Traveller women in Cornwall was set up in partnership with the Traveller health visitor for the local site. Her aim was to address health inequalities and access to services, and she sought to build skills, confidence and self-esteem through a range of activities for both adults and children. The group subsequently obtained the free use of premises at the local Children's Centre and received visits from family learning staff, a drugs and alcohol information group, midwives, a breast awareness group and other health support groups.
- 8.5 Other national projects in partnership with Gypsies and Travellers have included developing a patient-held record, designing audio-visual educational materials, appointing a family worker from within the Gypsy and Traveller community, supporting Gypsy and Traveller communities to link with people through appropriate mental health services, mobile health units and providing training for health service staff.

Community Development Workers

- 8.6 In Devon, the Primary Care Trust arranged for a part-time community development worker with a public health remit to identify and support mental health needs and wellbeing in the Traveller community. A copy of the job description for this post is included in Appendix 6. The Devon Primary Care Trust Community Development Worker post was introduced 1.5 years ago as part of the 'Delivering Race Equality' in mental health services programme which is a five year government plan to increase access to, experience of and outcomes for Black and Minority Ethnic Communities using mental health services.
- 8.7 Devon Race Equality Council has had a part time Community Development Worker working with Gypsy and Traveller families funded mainly by Devon Children's Fund for nearly 5 years. Funding ends for this post in September 2009. These two part time posts are currently held by the same person but the long term funding arrangements are not clear.

Information

- 8.8 Locally specific booklets for health staff on Gypsies' and Travellers' cultural values with the aim of supporting Gypsies and Travellers to access healthcare. Information booklets stressing practitioners' responsibility for

engaging with their patients and ensuring they were, for instance, familiar with instructions relating to medication. The publication of such materials reflects a trend which is increasingly, if slowly, being utilised across the country to enhance communication and awareness of health engagement processes.

Disease specific programmes

- 8.9 In recognition of the problems faced by mobile Gypsies and Travellers in accessing health care, and the particularly high risks of cardio-vascular disease within these communities, the Welsh Assembly Government's Inequalities in Health Fund supported a research project in Wrexham, North Wales. The 'Coronary Heart Disease and Travellers: Redressing the Balance' project began in 2002, with initial funding for three years. Its aims were to engage with residents of local sites and families passing through the area, improve access to health services, and reduce and prevent the incidence of heart disease amongst Gypsies and Travellers. The project was staffed by a project health worker, a mental health worker and a researcher, and provided mobile outreach health services from a camper van.
- 8.10 By 2004 the project was reported as demonstrating: Dramatically improved access to health services, so that more than 95% of Travellers involved with the project are now registered with a GP. The Mobile Health Unit on the Traveller site also provides a private and safe environment for people to discuss their health concerns. Eighty-seven adults and 70 children have been reached by the project. The project was the first in Wales, and possibly the UK, to undertake an in-depth study of the coronary health of Gypsy Travellers. (Welsh Assembly website, 2004) A subsequent evaluation has noted that Gypsies and Travellers felt they 'owned' the project: this indicates the importance of joint service planning by health providers in partnership with community members.

Other Evidence of Effectiveness

- 8.11 National Institute for Health and Clinical Excellence (NICE) Public Health Guidance No.917, published in 2008, entitled Community Engagement to improve health is summarised in Appendix 1.
- 8.12 National Institute for Health and Clinical Excellence (NIHCE) Clinical Guidelines for managing Depression (no. 23) and Anxiety (no.22) in primary secondary and community care (amended in 2007) is summarised in Appendices 2 and 3.
- 8.13 The National Health Service Implementation plan for reducing health inequalities in Infant Mortality - a good practice guide – is summarised in Appendix 4a, 4b, 4c. This practical guidance for implementation covers both commissioners and providers in the development of local services which should include:
- raising awareness of health in-equalities in infant mortality and infant health (Director of Public Health Annual report)

¹⁷ Public Health Guidance No9, Community Engagement to improve health, National Institute for Health and Clinical Excellence, February 2008

- giving priority to evidence based interventions that will help ensure delivery of the target
- improving access to maternal care (as measured by Public Service Agreement (PSA) maternity indicator - a set of full health and social care needs, risks and choices by 12 completed weeks of pregnancy), improving services for Black and Minority Ethnic (BME) groups
- gathering and reporting on improved data on maternity and paediatric activity (including breast feeding rates at 6 to 8 weeks (Public Service Agreement 12), infant screening, and immunisations). To note that the Department of Health is working with the NHS Connecting for Health and the Information Centre to develop a maternity data set towards the end of 2009
- provision of high quality primary care, midwifery, obstetric, neonatal and health visitor care including proactive identification of 'at risk' women, provision of maternity care in community settings, promotion of early access to maternal care, antenatal screening help with nutrition for women on low incomes and neonatal screening
- encouraging ownership of the target through effective performance management
- undertaking a joint strategic needs assessment around health inequalities in maternal health and infant mortality.

Summary of Evidence of Effectiveness

- 8.14 There is, overall, a consensus of opinion about the value of community outreach health projects undertaken in partnership with the voluntary sector and local Gypsy and Traveller agencies. A major obstacle concerns the short-term nature of many projects. While evaluations are overwhelmingly positive and indicate significant health gains, the majority of projects run for between one and three years, with a risk that the health improvement will be lost once they finish. It is clear that a national strategy on Gypsy and Traveller health is needed, supported by dedicated funding, to continue the improvements commenced by local projects.
- 8.15 The summary of evidence based recommendations underpinned by dedicated long term funding includes:
- Peer educators programmes
 - Site based health visitor/health worker, community development worker posts
 - Information :
 - The publication of locally specific health booklets for health staff re Gypsies and Travellers cultural values and supporting them to access healthcare including understanding medication

- The development of patient held records for Gypsy and Traveller families (about to be rolled out in Devon)
- Disease specific programmes (Coronary heart disease and Travellers) designed in partnership by health providers and members of the community

9. Current Commissioning

- 9.1 Despite greater health needs Gypsies and Travellers use mainstream health services less than other members of the population and flexible innovative systems need to be developed to improve access to services.

Primary Care

- 9.2 Gypsies and Travellers state that they experience difficulties when registering if they are required to give a permanent address, but if a temporary address is accepted exclusion from some services such as screening programmes still occurs. Enforced movement can result in discontinuity of care and interruption or delays in medical treatment. There is an increased reliance in walk in centres or Accident and Emergency (A&E) departments with no follow up or continuity of care.

- 9.3 The majority of GP practices in Devon have agreed a directly enhanced service (DES) to code ethnicity but there is no agreement as to what level of hierarchy or sub set they will code so there is no guarantee that local intelligence to inform commissioners on the health needs of a defined population will be enhanced

- 9.4 A primary care service framework, see Appendix 8, for Gypsy and Traveller communities has been published with an overall aim to improve access to primary care services on the basis that better access will lead to improve health outcomes. Any development though must avoid creating isolated Gypsy and Traveller only practices or ghetto approaches. The scope of the framework is for mainstream primary care services aimed at Gypsies and Travellers, whether mobile or settled, and outreach and advocacy services may also be included. Devon Primary Care Trust should consider this framework in order to assure them that Gypsy and Traveller communities can access the same high quality mainstream primary care services as everyone else. Recommendation

Specialist Health Workers

- 9.5 Specialist health workers can ease access to services and outreach services (such as health visitors), can partly plug the gaps in advice or preventative services such as immunisation and wider public health issues.
- 9.6 Gypsies and Travellers place a high premium on health staff being good listeners and communicators and staff change from being seen as 'nurses' and take on a wider role as advocates, bridging the gap between health and social care providers

Secondary Care

- 9.7 Trusts Equality and Diversity leads are responsible for developing and implementing effective strategies and NHS Boards should receive regular reports on progress. Their strategies should include diversity training, information and support to ethnic groups and greater compliance with ethnic coding and support

Local partnerships

- 9.8 The South Western Ambulance Trust has been successful in bidding for central funds over three years under the Pacesetting Programme¹⁸ and is undertaking a study across Devon to assess current health in-equalities within Gypsy and Traveller communities and pilot programmes to address them (see Section 4 for details).
- 9.9 An outline of the work currently undertaken by the Gypsy and Traveller Community Devolvement Worker has been described in Section 4 and a copy of the Devon Primary Care Trust element of the job description is included Appendix 6.
- 9.10 Devon Primary Care Trusts equality scheme action plan was updated in April 2009 and is summarised in Appendix 5.
- 9.11 The role of the Devon County Council Gypsy and Traveller Liaison officer has been described.
- 9.12 A multi-agency Gypsy and Traveller steering group exists chaired by a Senior Manager from Devon County Council. The work of this group should ultimately be reported to the Devon Strategic Partnership via the Stronger Communities and Health Improvement Group. Representatives from intermediary groups such as the Independent Travellers Advisory and Support Service needs to be considered.

10. Performance Monitoring

- 10.1 There are a range of targets nationally prescribed and/or locally agreed that provide evidence over time of improvements in health and reductions in health in-equalities. Performance against these targets is monitored by a range of organisational boards and strategic partnerships.
- 10.2 The Devon Stronger Communities and Health Improvement Group needs to agree the mechanism, frequency and process of performance monitoring the large range of indicators that it should be used to ensure progress on addressing the health in-equalities identified in this report and the recommendations outlined. Summary reports should be regularly presented to the Devon Strategic Partnership.
- 10.3 The indicators outlined below offer a summary of, but not an exhaustive list of the relevant and potential targets that currently exist:

¹⁸ A Dialogue of Equals the Pacesetting programme Community Engagement Guide NHS Jan 2008

- **Public Service Agreements (PSA 15)** is set to address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief
- **Public Service Agreements PSA 18 / National Indicator (NI) 120 (Life Expectancy)** – all age all cause mortality rate per 100,000 population i.e. by 2010 increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women
- **Infant mortality.**

To reduce in-equalities in health outcomes by 10% by 2010 as measured by infant mortality and life expectancy at birth. This target is underpinned by the following objective: starting with children less than one year by 2010 to reduce by at least 10% the gap in mortality between the routine and manual group and the population as a whole”.

Devon Local Area Agreements

10.4 Local Area Agreements (LAAs) are three year agreements between a local area and central government. Local area agreements describe how local priorities will be met by delivering local solutions and bring together partners from the public, private and voluntary sectors with the aim of providing services in a more joined up way.

- **Strong and Inclusive Communities**
 - LAA15a. Work towards the economic inclusion and social integration of vulnerable population
 - LAA35 Prejudice and hate crime – increase levels of reporting and maintain victim satisfaction
 - LAA 36/NI32 Domestic abuse – Repeat incidents of domestic violence at Multi Agency Risk Assessment Conferences (MARACs)
- **A Growing Economy**
 - LAA15b - Work towards the economic inclusion and social integration of vulnerable populations
- **Homes and Housing**
 - LAA27 - Improve housing options for the homeless and vulnerable clients
- **Inspiring young People**

- Narrow the gap in the lowest attaining 20% of children 0-19 and the achievements of all young people in Devon (LAA29)

- **Health and Wellbeing**

- LAA30 – Promote health and reduce health in-equalities

Public Health Targets

- 10.5 The 'Vital signs' are the targets expressed within the National Health Service operating framework, i.e. those that are national priorities for local delivery for improving health and reducing health in-equalities. These include: reductions in circulatory disease and cancer mortality rates, reductions in the prevalence of smoking, obesity, teenage conceptions and sexually transmitted infections. Improvements in breast feeding rates, the proportion of pregnant women who are assessed for health and social care needs by 12 completed weeks of pregnancy, improvements in childhood immunisation rates, the uptake of screening programmes and the number of drug users in effective treatment as well as a reduction in the suicide and undetermined injury rates.

Standards for Better Health – Seventh Domain Public Health

- 10.6 **C22** - Health care organisations promote, protect and demonstrably improve the health of the community serviced and narrow health in-equalities by:
- a) co-operating with each other and with local authorities and other organisations
 - b) ensuring that the local Director of public Health's Annual report informs their policies and practices and
 - c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships
- 10.7 **C23** - Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuses and sexually transmitted infections.
- 10.8 **C7E** - Healthcare organisations should enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

11. Recommendations

- 11.1 The overall recommendation is that Gypsies and Travellers must be treated decently by all health service providers in Devon and that their different cultures and ways of life need to be understood and respected. This recommendation is based on the fact that when this happens, Traveller health will improve because access to services and trust in the system will improve. The health inequalities that this special group suffer should be publicised to raise public awareness and help to reduce the prejudices Gypsies and Travellers suffer. A summary of recommendations is below:

Intelligence

- 11.2 Improve local coding in primary, community and secondary care to improve understanding of local needs and to assist commissioning and performance monitoring.

Training

- 11.3 Improve diversity training programmes for all staff and engage Gypsies and Travellers in the design and delivery. This could be based on a local training programme that has been developed by the Devon Race Equality Council and from which feedback from both statutory and voluntary agencies has been good.
- 11.4 Build on, support and mainstream fund existing training currently delivered in partnership by Devon Primary Care Trust and the South Western Ambulance Trust with other local agencies of Gypsy and Traveller peer educators or community members in basic first aid and basic midwifery, domestic violence, drug and alcohol awareness.

Service Reviews

Community Services

- 11.5 A review of the current capacity in Devon of specialist outreach workers and community developments workers for Gypsies and Travellers should be undertaken and mainstream funding found where necessary to include the consideration of trained and paid Gypsy and Traveller Community Advocates.
- 11.6 Review and ensure that specialist community public health nurses are targeting and addressing the needs of the most vulnerable children and their families, to include their work with high risk families on the wider public health issues for children and young people including obesity, sexual health and substance misuse, in order to ensure that there is sufficient capacity to meet identified needs.
- 11.7 Commissioners working jointly across the local authority and health should review Gypsy and Traveller access to children services such as children's centres to address any in-equalities in access and support.
- 11.8 The Supporting People task group should review the services currently supporting Gypsies and Travellers in the community and make changes to reduce any in-equalities that exist.

- 11.9 Review access to dental services.
- 11.10 Monitor access to palliative care services for people of all ages.

Primary Care Services

- 11.11 Devon Primary Care Trust should consider the National health Service Primary Care Contracting Framework covering Gypsies and Travellers in order to assure themselves that Gypsy and Traveller communities can access the same high quality mainstream primary care services as everyone else

Secondary Care Services

- 11.12 undertake a review of maternity services to ensure a proactive outreach approach is available and monitor access by ethnicity and booking dates

Policy and Protocols Development and Implementation

- 11.13 Develop protocols in consultation with the Traveller community for engaging Child and Adult Safeguarding Boards proactively in eviction situations.
- 11.14 Develop a protocol in consultation with the Traveller community to improve the multi-agency approach to meeting mental health needs with services working across boundaries, with increased education, information and training on mental health needs for both health staff and community members to reduce discrimination and increase support.
- 11.15 Develop a protocol in consultation with general practice to ensure all urgent referrals for specialist community public health nurses are responded to in a timely manner and ensure all general practices sign up to the protocol.
- 11.16 Develop a clear protocol for primary care services with regard to eligibility of patients with no fixed address to register at and use services.
- 11.17 Develop protocol for involving intermediary groups such as the Independent Traveller Advisory and Support Service to facilitate better links between the Gypsy and Traveller community and health organisations.

Audit and Performance Monitoring

- 11.18 A multi-agency steering group needs to consider and implement the recommendations of the retrospective audit on male Traveller deaths.
- 11.19 To code Gypsies and Travellers in all health records to assist in the mapping of self harm and associated risk factors.
- 11.20 Commissioners should to monitor NHS Trusts' equality and diversity strategies.

Others

- 11.21 Develop a directory or information base of key points of contact i.e. people within services that have specialist knowledge and can give information to the community as well as to their own professional groups and health providers.

Whilst this already exists to some extent, (Devon County Council Traveller Liaison, Devon County Council Traveller Education Officer, Devon Race Equality Council and an Emergency Care Practitioner in the South Western Ambulance Service Trust) it is not as comprehensive as it needs to be, lacks a midwife and a health visitor. A small working group including representatives from the Gypsy and Traveller community could agree the content.

- 11.22 Health care appointments to be sent by text where requested and not by post for those without permanent addresses.
- 11.23 Develop a robust system for disseminating key public health messages and information (for example Swine flu leaflets) to unauthorised sites).
- 11.24 The development of client held records should be considered in order to support improved continuity of health care and thus health outcomes for those mobile because they wish to be or because of eviction.

12. Conclusions

- 12.1 Gypsies and Travellers experience a wide range of in-equalities including health in-equalities. They experience high levels of racism and discrimination throughout their lives. Prejudicial behaviours amongst some health professional staff are unacceptable and must not be tolerated.
- 12.2 The impact of poverty on health is well recognised and Gypsies and Travellers should receive support and advice to help them to understand what benefits they are entitled to in order to maximise their income and thus positively affect their health and well-being.
- 12.3 Gypsies and Travellers are largely an invisible group in terms of health service commissioning due to the lack of robust national intelligence available which is in part due to Gypsies and Travellers reluctance to be categorized. The NHS has a clear role in reducing health inequalities and whilst there is only limited quantitative intelligence there is sufficient data to be clear that this is a vulnerable group in need of urgent and sustained action if existing health inequalities are to be reversed.
- 12.4 There are over 4,500 Gypsies and Travellers in Devon at significant disadvantage. There is some evidence based action that should be taken to improve health outcomes and narrow the existing health inequalities gap.
- 12.5 The multi-agency Gypsy and Traveller steering group should take forward the recommendations of this report and may need to review its membership and terms of reference to ensure it has the correct skill mix to drive forward the recommendations outlined in Section 11 above.
- 12.6 The steering group should report to the Devon Strategic Partnership via the Stronger Communities and Health Improvement Group. The Steering Group may wish to consider if a joint agency (i.e. Devon County Council and Devon

Primary Care Trust) strategic lead should be identified to support the committee in driving forward the agenda.

13. Acknowledgements

- 13.1 The Public Health Directorate of Devon Primary Care Trust has led in the production of this health needs assessment of Gypsies and Travellers.
- 13.2 The author of the report however, is indebted to people from a number of organisations across the south west region. All have freely given up time and offered support, advice and expertise. The list below details those who contributed to the initial draft and / or who commented on it. Their comments have informed the final version of this report.
- 13.3 The author of the report takes full responsibility for any inaccuracies.

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14. List of Figures

1	Infant Mortality 2005-2007 (Source: NCHOD)
2	Infant Mortality Trends
3	Low Birth Weight
4	Low Birth Weight Births Trend (Source: NCHOD)
5	Gypsy and Traveller Caravan Count
6	2007-2008 breakdown by Funding Local Authority
7	Education Provision for Traveller Children
8	Calculations used for District Authority future pitch requirements in Devon ³
9	Devon Primary Care Trust Registered (Jun 08) and England and Wales Populations (Mid year 07)
10	Map Showing Indicators of Multiple Deprivation in Devon

15. Appendices

1	National Institute for Health and Clinical Excellence (NIHCE), Community Engagement to Improve Health, Public Health Guidance No.9 ¹⁷
2	National Institute for Health and Clinical Excellence (NIHCE) Clinical Guidelines for managing Depression 23
3	National Institute for Health and Clinical Excellence (NIHCE) Clinical Guidelines for managing Anxiety 22
4A	Implementation plan for reducing health in-equalities in infant mortality – a summary of evidenced based interventions that will help deliver the target ⁷
4B	Delivery of Interventions to Reduce Health Inequalities in Infant Mortality ⁷
4C	Identifiable Actions to Reduce the 2002-04 Gap in Infant Mortality
5	A Section of The Devon Primary Care Trust Equality Scheme Action Plan (Reviewed April 2009)
6	Job description of community development worker
7	Housing Needs Assessment Health Questions
8	A new primary care service framework from NHS PCC covering Gypsies, Travellers and other communities whose health needs require Primary Care Trusts to develop more flexible approaches.

APPENDIX 1

National Institute for Health and Clinical Excellence (NIHCE), Community Engagement to Improve Health, Public Health Guidance No.9 ¹⁷

A summary of the recommendations includes:

Prerequisites for success:

- coordinated implementation of the relevant policy initiatives
- a commitment to long-term investment
- openness to organisational and cultural change
- a willingness to share power, as appropriate, between statutory and community organisations and the development of trust and respect among all those involved

Infrastructure to support practice on the ground includes:

- support for appropriate training and development for those working with the community – including members of that community
- formal mechanisms which endorse partnership working
- support for effective implementation of area-based initiatives

Approaches to support and increase levels of community engagement

- provision of appropriate training and development to help improve communications between the local community and service providers and may attract more people to community groups. (For example, by offering the opportunity to gain new skills and potential employment in the health and 18 social care sector)
- partnerships (both between sectors and with the local community) and local input into area-based initiatives and regeneration activities are essential to ensure community engagement activities are coordinated and reflect the community's views
- 'agents of change' and a range of other approaches can be used to encourage local communities to become involved in health promotion activities and area-based initiatives to address the wider social determinants of health

Evaluation

- improving the quality of evidence is a continuing process. Better evaluation processes are needed to increase understanding of how community engagement and the different approaches used impact on health and social outcomes.

APPENDIX 2

National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 23 (amended) 2007, Depression: Management of Depression in Primary and Secondary care

Key priorities for implementation

Screening in primary care and general hospital settings

- Screening should be undertaken in primary care and general hospital settings for depression in high-risk groups – for example, those with a past history of depression, significant physical illnesses causing disability, or other mental health problems, such as dementia.

Watchful waiting

- For patients with mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting').

Antidepressants in mild depression

- Antidepressants are not recommended for the initial treatment of mild depression, because the risk–benefit ratio is poor.

Guided self-help

- For patients with mild depression, healthcare professionals should consider recommending a guided self-help programme based on cognitive behavioural therapy (CBT).

Short-term psychological treatment

- In both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered.

Prescription of a Selective Serotonin Reuptake Inhibitor (SSRI)

- When an antidepressant is to be prescribed in routine care, it should be a selective serotonin reuptake inhibitor, because selective serotonin reuptake inhibitors are as effective as tricyclic antidepressants and are less likely to be discontinued because of side effects.

Tolerance and craving, discontinuation/withdrawal symptoms

- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping, missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but can occasionally be severe, particularly if the drug is stopped abruptly.

Initial presentation of severe depression

- When patients present initially with severe depression, a combination of antidepressants and individual CBT should be considered as the combination is more cost-effective than either treatment on its own.

Maintenance treatment with antidepressants

- Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years.

Combined treatment for treatment-resistant depression

- For patients whose depression is treatment resistant, the combination of antidepressant medication with CBT should be considered.

CBT for recurrent depression

- CBT should be considered for patients with recurrent depression who have relapsed despite antidepressant treatment, or who express a preference for psychological interventions.

NICE Guideline – depression (amended April 2007)

APPENDIX 3

National Institute for Health and Clinical Excellence (NIHCE) Clinical Guideline 22 (Amended) Issue April 2007, Anxiety (Amended) Management of Anxiety (Panic Disorder, with or Without Agoraphobia and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care

Key Priorities for Implementation

General management

Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care.

Patients and, when appropriate, families and carers, should be provided with information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including information on the use and likely side-effect profile of medication.

Patients, families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate.

All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.

Step 1: Recognition and diagnosis of panic disorder and generalised anxiety disorder

The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. (See also 'Which NICE guideline?' page 4.)

Step 2: Offer treatment in primary care

There are positive advantages of services based in primary care practice (for example, lower drop-out rates) and these services are often preferred by patients. The treatment of choice should be available promptly.

Panic Disorder

Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder.

Any of the following types of intervention should be offered and the preference of the person should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are:

- psychological therapy (cognitive behavioural therapy) (CBT)
- pharmacological therapy (a selective serotonin reuptake inhibitor [SSRI] licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement, imipramine or clomipramine¹⁹ may be considered)
- self-help (bibliotherapy – the use of written material to help people understand their psychological problems and learn ways to overcome them by changing their behaviour – based on cognitive behavioural therapy principles).

Generalised anxiety disorder

Benzodiazepines should not usually be used beyond 2–4 weeks.

In the longer-term care of individuals with generalised anxiety disorder, any of the following types of intervention should be offered and the preference of the person with generalised anxiety disorder should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are

- psychological therapy (cognitive behavioural therapy) (CBT)
- pharmacological therapy (a selective serotonin reuptake inhibitor) [SSRI]
- self-help (bibliotherapy based on cognitive behavioural therapy principles).

Step 3: Review and offer alternative treatment

If one type of intervention does not work, the patient should be reassessed and consideration given to trying one of the other types of intervention.

Step 4: Review and offer referral from primary care

In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered.

Step 5: Care in specialist mental health services

Specialist mental health services should conduct a thorough, holistic, re-assessment of the individual, their environment and social circumstances.

Monitoring

Short, self-complete questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

¹⁹ Imipramine and clomipramine are not licensed for panic disorder but have been shown to be effective in its management.

APPENDIX 4A

Implementation Plan for Reducing Health Inequalities in Infant Mortality⁷ - A Summary of Evidenced Based Interventions that will Help Deliver the Target Include;

- Reducing the prevalence of obesity in the routine and manual (R&M) group by 23% to the current levels in the population as a whole
- Meeting the national target to reduce smoking in pregnancy from 23% to 15% and meeting this target in the R&M group
- Reducing sudden unexpected death in infancy (SUDI) by persuading 1 in 10 women in the R&M group to avoid sharing a bed with their baby or putting their baby to sleep on its front
- Achieving the teenage pregnancy strategy to reduce the under-18 conception rate in the R&M group by 50% compared with the 1998 levels
- Meeting the child poverty target to halve the number of children in relative low income households between 1998-99 and 2010-11 by increasing the income in the R&M group by an average of 18%
- Reducing housing overcrowding in the R&M group through the effect on reducing SUDI
- Promoting early antenatal booking among disadvantaged groups

APPENDIX 4B

Delivery of Interventions to Reduce Health Inequalities in Infant Mortality⁷

ACTIONS ON WIDER SOCIAL DETERMINANTS						
DWP/DH	Meeting the 2010 and 2020 child poverty target					
CLG	Reducing overcrowding Supporting local partnerships, particularly devolution of power to local partnerships through the new local government performance framework					
DCSF	Reducing the under-18 conception rate and supporting teenage mothers and young fathers Prevention focus on teenagers most at risk through targeted youth support and Sure Start Children's Centres					
DH/NHS	Promotion of healthy diet and exercise General advice to all women regarding diet, alcohol, general health, stopping smoking					
DH/NHS	Advice regarding SUDI prevention and breastfeeding					
Birth	One year	Childhood	Adolescence	Preconception	Pregnancy	Birth
Provision of high-quality primary care, midwifery, obstetric, and health visitor care						
Support to breastfeed Infant screening Immunisations	Immunisations	Proactive identification of at-risk women		Identifying high-risk women and targeting resources to deliver evidence-based interventions	Neonatal screening	
		Support for women with pre-existing conditions		Provision of maternity care in community centres		
		Provision of genetic counselling services		Promotion of early access to maternity care		
				Antenatal screening Help with nutrition for women on low incomes (Healthy Start)		
NHS ACTIONS						

APPENDIX 4C

Identifiable Actions to Reduce the 2002-04 Gap in Infant Mortality⁷

Impact on 2002-04 gap (percentage points)

What would Work

Reducing conceptions in under-18s in the R&M group by 44% to meet the 2010 target

1.0

Reducing overcrowding in the R&M group, through its effect on SUDI

1.4

Targeted interventions to prevent SUDI by 10% in the R&M group

1.4

Reducing rate of smoking in pregnancy by 2 percentage points by 2010

2.0

Reducing the prevalence of obesity in the R&M group to 23%

2.8

Meeting the child poverty strategy

3.0

Immediate actions

Optimising preconception care
Early booking
Access to culturally sensitive healthcare
Reducing infant and maternal infections

Long-term actions

Improving infant nutrition
Improving maternal educational attainment

Actions / Interventions

Targeted prevention work at-risk teenagers and targeted support for pregnant teenagers and teenage parents

Increase the supply of new social housing; pilot innovative approaches to making temporary social stock permanent; encourage better use of housing stock

Maintain current information given to mothers and target the Back to Sleep campaign and key message to the target group

Smoking cessation as an integral part of service delivery for the whole family during and after pregnancy

Support the contribution LAAs can make to tackling obesity
Develop plans to implement NICE obesity guidance with a focus on disadvantaged groups
Develop plans to help women with a BMI of over 30 to lose weight by providing a structured programme of support

Help lone parents into work
Ensure that people stay in work and progress in their jobs
Develop a family focus in DWP's work with all parents
Tax credit measures

Provide comprehensive preconception services
Provide advice / support for at-risk groups within the target group e.g. BME groups
Increase direct access to community midwives
Provide 24/7 maternity direct line for advice and access
Implement NICE antenatal and postnatal guidelines
Health equality audit of women booked by 12 weeks and more than 22 weeks gestation
Commissioners and maternity service providers agree improvement plans in contract
Improve uptake of immunisation in deprived population
Implement Baby Friendly standard

APPENDIX 5

A Section of The Devon Primary Care Trust Equality Scheme Action Plan (Reviewed April 2009)

Ref	Expected Outcome	Executive Lead	Lead Manager	Action Due / Taken / Evidence	Due by / Progress
33	The Trust has a consistent approach to Gypsies and Travellers access to Trust services	Director of Public Health	Community Development Worker	<p>1. Provide a working definition to the Primary Care Trust of Gypsies/ Travellers.</p> <p>People of nomadic or semi nomadic lifestyle or of a nomadic heritage. This would include: 2 Ethnic minority groups – Romany Gypsies (also Roma) and Irish Travellers. Also: New Travellers, Showmen, Circus, Occupational Travellers, Bargees.</p>	Transfer to SES Under review
		Director of Public Health	Community Development Worker	<p>2. Training and awareness sessions for Gypsy & Travellers on how to access, use health services (could include briefings on Lifestyle) – also tailored workshops on Healthy Lifestyle and other practical health self interventions.</p> <p>Up to April 2009: 1 x Romany women’s health session; 3 First Aid Courses for different sites. Other workshops/sessions planned for 09/10. PD Working with SWAST and Primary Care Trust staff and DCC Traveller Liaison to deliver.</p>	Transfer to SES Under review
		Director of Public Health	Community Development Worker/Health Improvement specialist/L&D lead	<p>3. Training and awareness sessions for Trust staff on the culturally diverse needs of this group – ideally involving G&T people as providers.</p> <p>With DREC – training programme led by DREC (PD) and Gypsy / Traveller trainers. Already being provided for variety of agencies around Devon, hoping to incorporate it within Learning and Development for Primary Care Trust staff.</p>	Transfer to SES Under review
		Director of strategic commissioning	Equality and Human Rights Manager	<p>4. Ensure commissioning managers are aware of their responsibilities to monitor existing commissioned services appropriate services such as GP surgeries and Dentistry</p>	Transfer to SES Under review
		Director of Public Health	Community Development Worker/	<p>5. Map health services provision in relation to the known sites used by the G&T people – establish if local services have capacity to meet needs.</p>	Transfer to SES Under review

Ref	Expected Outcome	Executive Lead	Lead Manager	Action Due / Taken / Evidence	Due by / Progress
			Primary Care Manager (GMS/PMS)	PD working with Ambulance Service on pace setters consultation Devon wide.	
		Director of Provider Development	Primary Care Manager (GMS/PMS)	6. Provide a mechanism to all Gypsies and Travellers giving them information on where they can access a GP surgery PD working on case by case basis – often with Patient Advice And Liaison Services	Transfer to SES Under review
		Director of Provider Development	Primary Care Manager (GMS/PMS)	7. Ensure all Gypsies and Travellers are registered with a GP surgery	Transfer to SES Under review
		Director of Provider Development	Primary Care Manager (GMS/PMS)/E&HR working group	8. Monitor registration of Gypsies / Travellers	Transfer to SES Under review
		Director of Public Health	Consultant in Public Health	9. Health needs assessment for Gypsies / Travellers	Transfer to SES Under review
		Director of Public Health	Community Development Workers	10. Update and improve health information in G&T health information pack In progress – with SWAST and Travellers	Transfer to SES Under review
		Director of Public Health	TBC	11. Increase the amount of outreach work with Gypsies and Travellers from Primary Care Trust provider to meet the effective delivery of health needs	Transfer to SES Under review
		Director of Public Health	TBC	12. Identify resources to replicate the model of CDW role as per Penny Dane	Transfer to SES Under review

APPENDIX 6

A Copy of the Gypsies and Travellers Community Development Worker Job Description

This is part time (2 days per week) and only reflects the PCT role and not the DREC role (3 days per week)

DEVON PRIMARY CARE TRUST

JOB DESCRIPTION

JOB TITLE: COMMUNITY DEVELOPMENT WORKER FOR BLACK AND MINORITY ETHNIC COMMUNITIES (Especially Gypsy and Travellers)

BAND: Band 5

LOCATION: Devon –Wide

HOURS OF WORK: 15 hrs per week

REPORTS TO: Senior Community Development Worker

ACCOUNTABLE TO: Devon Primary Care Trust

JOB PURPOSE:

- To improve the healthcare experience and outcomes of the Gypsy and Traveller population in Devon and reduce and eliminate inequalities (with a specific but not exclusive focus on mental health and wellbeing).
- To facilitate community development and active engagement across the various stakeholder groups in order to develop the capacity and capability of the Gypsy and Traveller community, and improve the interface between the NHS and the Gypsy and Traveller population.
- To support the delivery of race equality in mental healthcare across the statutory and voluntary sectors.

MAIN DUTIES AND RESPONSIBILITIES:

1) General

- To promote understanding and awareness of the Gypsy and Traveller Community Development Worker role.
- To work collaboratively with the Senior CDW, the diversity leads in statutory organisations and other stakeholders to help develop a shared project implementation plan.
- To work collaboratively and share experiences and learning with other community development workers locally and across the South West utilising the support and training facilitated by the CSIP(Now SWDA) network.

- To establish effective working relationships with other key NHS staff including Patient Advice and Liaison Services, PPI leads, Diversity leads, Gateway Workers etc.
- To maintain awareness and be responsive to local and national incidents and events that may impact on the local mental health and well-being of Gypsy and Traveller groups and individuals.
- To support the development and provision of an integrated, whole-systems approach bringing together opportunities for improved health, social care, housing, income, employment, leisure and social inclusion in order to promote positive mental health and well-being in Gypsy and Traveller Communities.

2) Community Engagement

- To engage actively and sensitively with BME groups, faith and community leaders/members across Devon and establish meaningful and ongoing working relationships.
- To assist in identifying the cultural strengths, issues and concerns of Gypsy and Traveller groups and individuals.
- To promote increased community confidence in services and help to tackle issues of stigma and fears related to mental health, both directly and by working through existing networks, individuals and groups.
- To identify opportunities for and support capacity building with Gypsy and Traveller individuals and groups where it is needed and wished for.

3) Service Development

- To keep employing organisations updated with information which will support them in delivering race equality.
- To promote anti-discriminatory practice across primary, secondary and tertiary care in Devon through contributing to training and awareness raising.
- To raise awareness amongst mental health service providers of the needs of Gypsy and Traveller individuals and communities and assist them to utilise the cultural strengths and resources available to improve the delivery of services.
- To advise and support providers in ensuring that information about current provision of mental health services is made available and kept up to date in accessible formats, languages and places.
- To improve the exchange of information, knowledge and skills between mental health services and the communities they serve.
- To help provide a framework and an environment in which people from BME communities can have meaningful involvement in the planning and delivery of services.

TERMS & CONDITIONS OF SERVICE: In accordance with national NHS Terms and Conditions of Service and Trust policies and procedures.

APPRAISAL/PDR: The post holder will have an appraisal or Personal Development Review annually with their Line Manager and this process will include the development of a Personal Development Plan.

CONFIDENTIALITY: In the discharge of their duties the post holder may often be in possession of or have access to confidential/personal information and must not disclose or discuss such information outside their place of work, or within their place of work except in the proper discharge of their duties. Failure to observe confidentiality may result in disciplinary action.

CRB DISCLOSURE: Employment in this post is subject to a satisfactory Enhanced Disclosure. This procedure is undertaken by the Criminal Records Bureau.

TIME COMMITMENT: this is a part-time post. The hours worked will normally be between 9am and 5pm Monday to Friday but will require some flexibility in order to meet the requirements of the role.(Days to be arranged with Senior CDW)

NO SMOKING POLICY: Staff are not permitted to smoke on Trust premises and will be required to adhere to Trust policies

HEALTH AND SAFETY/RISK MANAGEMENT: The post holder must know and comply with responsibilities under the Health and Safety at Work Act, 1974. The post holder will be expected to adhere to the Trust's Risk Management procedures including the Incident Reporting and Complaints Procedures.

EQUALITY & DIVERSITY To carry out your duties at all times in accordance with the Trust's Equality & Diversity Policy (available from your Line Manager or the Intranet) and in accordance with Equal Opportunities legislation.

MANDATORY TRAINING: To undertake all mandatory training appropriate to your Post.

NOTE: This job description represents the range of duties required of the post holder at the time of issue. It is not an inflexible specification and may be reviewed according to service needs.

Health Visitor		
District Nurse		
Nurse		
TES		
Dentist		
Midwife		
Alternative Therapist		
Hospital A&E		
Hospital other		
Support Worker other		

Have you had any poor experiences with any of these people?

Yes / No

Who?

Why?

Have you had any good experiences with any of these people?

Yes / No

Who?

Why?

37. Does your lifestyle affect your health in anyway (positively or negatively)? Please explain:

APPENDIX 8

National Health Service Primary Care Contracting Framework, A New Primary Care Service Framework from NHS PCC Covering Gypsies, Travellers and other Communities whose Health Needs Require Primary Care Trusts to develop more Flexible Approaches.

Purpose of this Primary Care Service Framework

This Primary Care Service Framework (PCSF) is not about providing different or separate services for Gypsies and Travellers; rather, it is about ensuring that these communities can access the same high quality, mainstream primary care services as everyone else. It may be used to assist Primary Care Trusts to design new services where none exist or to adapt or front-end existing ones to make them accessible to these groups. There is evidence⁸ that Gypsies and Traveller communities experience more poor health than any other disadvantaged group living in England. Many Gypsies and Travellers are settled. The health needs of settled Gypsies and Travellers are every bit as bad as that of mobile Gypsies and Travellers.

The purpose of this framework is therefore:

- to equip Primary Care Trust commissioners, with the necessary background knowledge, service and implementation details to work with providers and practitioners to deliver accessible primary care services, over and above mainstream services, for Gypsy and Traveller communities
- to improve Gypsy and Traveller health and quality of life by providing effective, appropriate, ongoing support, recognising three key factors:
 1. The need to improve Gypsies and Travellers' access to GP and primary care services, because without the same sort of access enjoyed by the general population, the health status of Gypsies and Travellers is likely to remain poor.
 2. Cultural issues relating to Gypsy and Traveller communities that impact on their access and use of health services, for example, the strong traditional gender roles.
 3. Lack of cultural awareness on the part of health service providers can form a barrier to accessing services for Gypsies and Travellers