



# Tackling Health Inequalities

**Findings from our second Health Champions  
community listening project**

**August to November 2022**

**healthwatch**  
Cambridgeshire

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## About Healthwatch Cambridgeshire

We are your local health and social care champion. We are independent and have the power to make sure NHS leaders and other decision makers listen to local feedback and improve standards of care.

We can also help you to find reliable and trustworthy information and advice.

The quotations in this report are all from people interviewed by volunteer Health Champions, unless otherwise stated. All feedback has been anonymised so that individuals cannot be identified.

Pictures included are of people photographed at local Healthwatch events and are not knowingly of anyone who was interviewed for this project.

# Introduction

## Reducing health inequalities is a top priority for Cambridgeshire and Peterborough Integrated Care System (ICS).

The ICS defines health inequalities as “avoidable, unfair differences in health and wellbeing between different groups of people whose circumstances or characteristics are different. They include issues like difference in average life expectancy and ease of access to healthcare services.”

Our Healthwatch was commissioned by the Cambridgeshire South Care Partnership (CSCP) to investigate the barriers that cause health inequalities and to highlight any suggestions to improve care, including what people would ask for if they could “change one thing”.

CSCP is a partnership of organisations responsible for planning health and care services for people in the southern part of Cambridgeshire, including Cambridge City, South and East Cambridgeshire.

This is the second project to be co-developed with a team of volunteer Health Champions for CSCP. The volunteers were recruited, trained, and supported by Healthwatch Cambridgeshire to undertake community research into local health and care issues.

The first project report, **‘The future of urgent and emergency care at Addenbrooke’s’**, looked at local people’s experiences of urgent and emergency care services. It also explored patients’ ideas on how services and buildings could be redesigned in future to deliver the best care.

## What we did

For this project, the Health Champions planned and delivered a series of focus groups across the CSCP area to identify what barriers to getting health and social care people may have. And to ask for people’s ideas and insight into how services could better support them. **See Appendix 1** for the list of questions.

The Health Champions recruited participants to take part in workshops in their local area using their own networks and community knowledge, together with Healthwatch links. This included sharing flyers, promoting the workshops through Facebook pages and community contacts.

We supported the Health Champions to develop a range of resources to plan and deliver the workshops to local people, considering the differing communication needs of those who may attend.

We trained and supported the Health Champions to chair and record each workshop.

Post pandemic, we found recruitment for face-to-face groups much more challenging than recruitment for online groups. This has been the case even though we sourced venues in the heart of the communities suggested by the CSCP.

As a result, we added an additional online event for people whose first language is not English, which also helped us better support people with differing translation needs.

## Who we spoke to

We spoke to groups of the public in Soham, Sawston and East Barnwell, Cambridge. We also spoke to people who are rough sleepers around Ely and Cambridge, Gypsy Traveller groups and people whose first language is not English.

We spoke to the following number of people at each event:

- Soham – 5 people
- Sawston – 6 people
- Cambridge – 7 people
- Ely Lighthouse Church Centre – 7 people including a rough sleeper, a parent of rough sleeper and support workers, and a lead volunteer for Caring for Cambridgeshire's Homeless.
- Gypsy, Traveller Roma community – 7 people including support workers and a vicar and 4 Gypsy Travellers at drop-in groups.
- People whose first language is not English – 4 people from the Taiwanese/Chinese community and 10 from the Ukrainian community.

Across the public workshops we had a diverse range of attendees. This included carers, people from different ethnic minority communities, as well as people with a range of long-term conditions including wheelchair users, people with learning disabilities, and people with mental health conditions.

Participants were offered a £20 Love2Shop voucher as a thank you for taking part in this project.

The qualitative information we gained is varied; however common themes were found within the different groups. These themes and what needs to change is set out below. **Please see Appendix 2** for the detail of the focus group discussions.

## Ethical Considerations

Before taking part, participants were informed of the full aims of this research project, gave verbal informed consent to take part, and were informed they would be able to withdraw from the project at any point.

# Background information

## What are health inequalities?

The King's Fund, a national independent charity working to improve health and care in England, has given the following definition of health inequalities.

"Health inequalities are ultimately about differences in the status of people's health. But the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- health status, for example, life expectancy
- access to care, for example, availability of service
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing.

Differences in health status and the things that determine it can be experienced by people grouped by a range of factors. In England, health inequalities are often analysed and addressed by policy across four types of factors:

- Socio-economic factors, for example, income
- Geography, for example, region or whether urban or rural
- Specific characteristics including those protected in law, such as sex, ethnicity, or disability
- Socially excluded groups, for example, people experiencing homelessness."

## Why act on health disparities and inequalities?

Prior to Covid-19, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and between £20 and £32 billion a year in lost tax revenue and benefit payments.

Taking action on health inequalities:

- improves the quality of lives of individuals and their families
- reduces cost to the NHS and social care system of treating and caring for people with preventable conditions
- benefits the wider economy.

People cannot be put into a single category, often they experience a combination of barriers which means they are at risk of a bigger health inequality. This in turn leads to a shorter life span, in poorer health.

We know that tackling inequalities is multi-faceted and that health outcomes are influenced by where you live, your income, your social connections, your education and more. Working together to remove some of the barriers, the NHS, social care services, local councils voluntary and community groups, will mean a better, longer lifestyle for people and less demand on the local services.

## Cambridgeshire and Peterborough Health Inequality Strategy

Cambridgeshire and Peterborough ICS **Health Inequality Strategy** was developed in 2020 to help tackle health inequalities. This strategy highlights significant gaps across the area in life expectancy driven by inequalities, such as early deaths in cardiovascular disease, cancer and respiratory conditions. Furthermore, there is a clear correlation between that strategy and the findings of this report.

The strategy describes how the Covid-19 pandemic has increased health inequalities; with higher death rates in poorer communities and some minority ethnic communities than the general population.

It sets out seven principles to help tackle this including:

- Exploring the impact of decisions on health inequalities early in the decision-making process
- Partnering with other organisations to take a place-based approach to addressing health inequalities
- Allocating health resources according to need.

Cambridgeshire and Peterborough Health Inequalities Board was set up to implement the strategy and monitor and drive action on health inequalities.



# Key Findings

Clear common themes emerged from amongst the barriers that people identified. These included:

- **Poor communication** from health and care providers, with people often unaware of the help available within their community or being unable to find it in a format they can use.
- **The rising cost of living** which is impacting on people's ability to afford suitable housing, eat a healthy diet and to access health and care services. People on the lowest incomes are affected the most and money worries increase the risk of people experiencing poor mental health.
- **Digital exclusion** makes it harder for people to access online information or services. This is when people do not have the basic skills or equipment or connectivity to access online services.
- **The lack of public transport in rural locations** makes it more challenging and expensive to attend appointments. The reduction of rural bus services and community car schemes has exacerbated this issue.
- **Lack of suitable housing causing additional problems for some**, for example rough sleepers need suitable accommodation with access to support for addictions.
- People with limb loss and those from the Gypsy and Traveller communities report living in accommodation that is unsuitable for their needs.

The above factors all have a layering effect increasing the difficulties people face in accessing services.

The focus groups had a range of ideas to help overcome barriers to getting health and social care which could be actioned at a local level. These included:

**Communication** – Local support services, charities and voluntary groups should meet to discuss local issues. Initially ensuring no duplication of services and wasted resources. Any gaps in services can be identified and supported by the relevant service and funding.

Provide people clear information about local services in an accessible and translated format. This could be a printed leaflet, online, or via videos, shared round community centres, support hubs, GPs, and hospital websites.

Any translation services should use the appropriate language and have the skills and knowledge to discuss medical issues.

People wanted to know where to find information they can trust.

**Rising cost of living** – Have people with lived experiences working alongside benefit assessors to ensure all information is considered.

Provide accessible information about services and grants available to assist those who are struggling.





**Transport** - Due to the cost-of-living crisis, there has been a reduction in public transport services. This affects especially rural and vulnerable communities. Local and Parish councils could plan alternative options which have been used successfully in some areas.

**Lack of suitable housing** - Our participants recognise the housing shortage around Cambridgeshire. However, if Housing Associations, charities and councils really understand individual health requirements, a person could live safely and independently without having to keep asking for additional resources.



# What needs to change

The findings of this report are extensive and provide rich intelligence to inform change. We look forward to a range of programme boards and delivery groups using these findings to improve understanding of the barriers faced by people and develop and enhance plans to tackle these. The learnings from this report might be applicable across the ICS. There is therefore, potential for greater impact if the findings are shared across the whole of Cambridgeshire and Peterborough health and care system.

The six focus groups identified gaps in services, which, if filled, would support better health outcomes for all. We believe these ideas could have significant impact at a neighbourhood level. As Primary Care Networks are increasingly working with local partners as Integrated Neighbourhoods this is an ideal opportunity to have ideas taken up and build on existing work.

We have categorised our suggested improvements into themes:

## System improvements

### Accessible health and care services

- Organisations should ensure that records adhere to the requirement of the Accessible Information Standard, so that people are communicated with in a way that meets their needs.
- Provide paper resources as well as online resources.
- Focus on using accessible language that all can understand and move away from clinical language.
- Continue to develop coherent IT systems so that people's information is shared and they don't have to repeat their stories time and time again.

### Translation services

- Offer translation services in the language of the person's choice. Ensure extended appointment times to allow for the extra time this will take.
- Provide interpreted information about how and where to find health services.
- Provide an easy-to-use translation service for NHS 111 service.
- The contracts for translating services should specify that the provider offers a service with sufficient language skills to interpret medical words and terminology.

## Specific service improvements

**Training for staff** – Develop and provide training for the health and social care workforce about different communities and cultures and underline the importance that being inclusive can make to people's health and wellbeing.

**Home visiting** – Primary Care Networks could expand their health home visits to housebound people, for example, diabetes checks and blood tests. This will ensure long term health conditions are monitored and prevent escalation of poor health.

**Community health bus** – Rural locations with little or no transport could be served basic health care via an integrated mobile clinic. Dressings, and routine checks could be carried out without the need for GP/hospital appointments or trips.

**Right to register** – Remind health providers across all Primary Care Networks and Integrated Neighbourhoods that people with no fixed abode have the right to see a healthcare professional. Distribute Healthwatch yellow "right to register" cards to local services, community hubs, libraries etc. These are available from our local Healthwatch.

**Multi-agency drop-ins** – Build in regular multi-agency drop-in groups into Integrated Neighbourhoods. Specifically in areas where we know communities are less likely to use and trust services; such as homeless people and Gypsy and Traveller communities. Drop-ins could offer longer appointments and assist people with complex living challenges, such as rough sleepers, holistically.

**Health Screening** – Coproduce and target publicity about screening and routine health checks in areas of high deprivation, especially to people who are highly vulnerable such as people with learning disabilities, rough sleepers and Gypsy, Roma, and Traveller communities. Raise awareness of screening programmes for prostate and breast cancer through libraries, community centres, and warm hubs. Ensure health screening appointments are accessible and inclusive.



**Communications** – Due to poor Wi-Fi and signal, NHS services need to have greater flexibility for people to respond to emails and phone calls within a set time. People told us it would be helpful if calls from the NHS system identified as “NHS” rather than “ caller unknown”. Unidentified calls are not responded to. We were told people with little money do not have the phone credit to allow lengthy waiting times for health providers to answer calls. A text service was suggested for vulnerable communities to use as a way to make contact.

## Awareness of entrenched difficulties

- The difficulties that a fragmented health and care system causes the majority of the population is experienced more intensely by marginalised people.
- Cultural attitudes to family financial arrangements means that not every family keeps their own money separate. This was particularly noted with Gypsy and Traveller families. And is then problematic for financial assessments.

## Areas for further investigation

- Provide health education to GRT communities using video, TikTok or cartoons.
- An integrated local transport system that incorporates community transport and non-emergency patient transport.
- Explore introducing a volunteer or paid person, with similar lived experience, to help with assessments for people experiencing challenges.
- Investigate better mileage rates for community-based volunteer drivers.
- Look at possible models for health, social care and the voluntary sector to support migrant farm workers and their families, including translated information and on-site services.





# Common experiences of inequality



## Barriers to accessing health and social care

When local residents told us about their experiences, a range of clear commonalities emerged across all the groups. The exact nature of the barriers and difficulties were specific to individuals or cohorts, but the overall experience, and resulting inequality, are the same.

### Inadequate income

Lack of finances can cause poor health due to not being able to access health services, transport, heating, and healthy food.

**“I have had to take Equity Release on my house to get it warmer. The fear of increasing energy bills terrifies me, and it can’t be covered by the State Pension alone.”** –

Participant at Soham workshop.

**“The question of rising energy, petrol, fuel bills will have a major consequence on what I eat and what I do”** – Participant at Soham workshop

**“I am diabetic, and it is too expensive to eat healthily”** – Participant at Sawston workshop

**Who said this?** Carers, men, and women of all ages. People on low incomes. Disabled people, including people with limb loss and people with long-term health conditions.

### Information

It can be difficult to get the right information and advice in an accessible format from healthcare professionals, voluntary groups, housing associations and local councils.

People told us there is confusion around finding reliable and current health service information, information about local voluntary groups, and which benefits and grants are available.

**“There are so many doors a person could use to access services. Don’t know which one to open.”** – Sawston group participant

**“You cannot access services you don’t know are there.”**

**“I was reasonably prepared with bringing up my child – I took all the courses and help I could to help him and me. Now he’s turned into an adult- there is no help at all.”** – Soham group participant

“Clinicians need to be taught how to speak to their patients and families in a way they understand, without medical jargon.” – Sawston group participant

Who said this? All people of all backgrounds, ages, sensory and learning disability, people whose first language is not English.

## Experiences of feeling judged

Having health and wellbeing needs dismissed as mental health issues or stemming from autism. Front line staff may not understand chaotic lifestyles, or cultural differences.

Some people feel ashamed using foodbanks.

**“I don’t count.”**



Who said this? Rough sleepers. Gypsy and Traveller people. Autistic people. People with existing mental health issues. Disabled people including people with limb loss. People from all areas.

## Challenges receiving the right assessments and support

People told us about challenges in receiving access to social care. Some people with long term conditions told us assessors do not understand their requirements.

People with limb loss said they were particularly affected by a lack of access to physiotherapy which impacts recovery.

Some people told us the health system is more complicated than it needs to be. One person said they required frequent re-referrals for an ongoing condition which they should be able to self-refer.

**“Gaining access to social care from the LA in a timely manner is an ‘absolute nightmare’. It took 26–28 weeks before we even got to the assessment stage.”**

**“Someone with my relative’s needs requires more than a 45 min visit to get washed, dressed etc but this is the only time the assessor allocated. Because s/he didn’t have a full understanding or experience of the needs. We abandoned the idea of having a carer’s assessment after this process.”** – Soham workshop participant – woman aged 50–60

**“The whole PIP process took more than 2 years. ‘It was gruelling, and we were reduced to tears on several occasions.’ ‘I can see why so many people give up, it was rude and intrusive... it was horrible.’ They said that this had been the worst experience of their life. Assessors had no experience of the conditions that the person had.**

**The whole process had a huge impact on the family as a whole. ‘It is easy to see why people give up on the process.’** – Soham workshop participant – woman aged 50–60

**Who said this?** People with long term conditions, limb loss, carers.



## Isolation

Loneliness has a serious negative implication for the health and well-being of individuals. We were told that loneliness can result in increasing addictions to drugs and alcohol.

Housebound people find it difficult to get home visits to help support medical requirements such as diabetic checks.

**“Homelessness is a stressful, lonely and often traumatic experience which has a major impact on mental health.”** – Support worker for homeless. Ely.

**Who said this?** People who are housebound, rough sleepers, people with poor mental health

## People don’t necessarily know about Direct Payments

Everyone is entitled to a social care assessment which identifies their needs and as a result people can be awarded a Direct Payment to pay for the help they need. It was noted that the Councils are exploring Individual Service Funds which are the same as a Direct Payment, but the fund is managed by an organisation on their behalf. (The NHS have a similar scheme called Personal Health Budgets).

**Who said this?** People with special educational needs (SEN). Autistic people. People with limb loss, carers, and people with experience of mental ill-health.

## Digital exclusion

People told us about not being able to afford to pay for equipment, data or broadband to access digital services.

We were told older people often switch off their mobile phone, therefore miss text reminders of appointments. It was thought this was due to lack of understanding of the technology. In parts of Cambridgeshire phone signals are extremely poor.

**Who said this?** People on a low income, people living in isolated areas, older people, and rough sleepers.

**[digital appointments are] “never enough! What do they learn about the patient on the phone? It might be efficient but is it effective?”** – Man aged 60–70 years



## Charities often work in isolation

We were told that different charities are working in silos to provide food and warm clothing for homeless people. This scatter approach means some nights food is available, while other evenings there is nothing. Missing access to food has an impact on physical and mental health.

## Lack of dentists

There are major issues with access to NHS dentist in all areas of Cambridgeshire. A recent poll from Healthwatch England identified that people on low incomes were less likely to have dental treatment than those on high incomes .

**“I at last went to re-register with my old dentist, who wouldn’t see me, unless I agreed to go private. I was in terrible pain and I had to go private. The equity release is also having to cover my dentistry bill which is £2,000!”** – Soham workshop participant

**Who said this?** All groups.



## Transport

Rural areas have seen major reductions in bus routes. Taxis are expensive for some people and fewer voluntary car schemes run in the more deprived areas. Generally, car schemes have reduced due to the costs involved for the driver. There is little access to transport for out of hours care.

**“Social connection is so crucial for some people.”** – Sawston workshop participant

We were told there is a lack of transport services willing to attend Traveller sites. This results in missed health and other important appointments.

People who are rough sleepers do not have spare funds to pay for transport to attend appointments.

**“My daughter can’t get to her appointment with the baby at Addenbrookes because no one will take her.”** – GRT communities

**Who said this?** People on low income, people living in rural areas, GRT communities people with disabilities, rough sleepers.

## What do you think would help you get the health care you or your family need?

We asked people what suggestions they had to help them and their family.

### Getting information

People wanted clear, accessible information.



**“Give leaflets directing you to the support available in your area, specific to your need (e.g. help with applications/ advocates etc). Make sure health services information is also online up to date and maybe along the lines of some of community FB pages. Make sure it is accessible for those with sensory disabilities.”**

### They also suggested that:

- All organisations, including foodbanks have the information for signposting to health and social care services
- Provide a translated information pack of resources about health and social care, including voluntary sector information. (For people whose language is not English)
- Train clinicians to always use simple language.

### Being judged

People often felt they were being judged by health and care professionals. Many groups of staff and volunteers would benefit from training about cultural differences and lifestyle choices to why some people appear to be different.

### Personal Independence Payments (PIP) and other benefit applications

The group called for clearer information and a more empathetic approach to dealing with PIP and other benefit assessments.

People with long term conditions and sensory impairments require an intermediate person with lived experiences to aid with communication.

**“Why doesn’t somebody with the same lived experience attend with the assessor? They can empathise with the needs and have a better understanding of them.”**

**“Making PIP applications or any other grant/funding easier to understand- there are health and mental health implications of a crisis situation to other family members”**

## Transport

People attending our groups suggested that the 'Dial a Ride' scheme is extended to cover wider areas and that "discount set price taxi fares" be introduced for those who lack public transport.

People suggested that the Ting bus scheme currently being trialed by Cambridgeshire & Peterborough Combined around West Huntingdonshire, could be extended to cover a wider area.

Although requiring digital access, a Ting app on a phone can book trips and the bus will pick you up at your chosen time. Travel is anywhere within the service zone for just £2 for a single fair, £4 return. OAP and disabled concessionary passes accepted for free travel. Make this free for rough sleepers.

We were informed about an unusual type of community transport. A Tuk Tuk called "Nellie" is used around Soham. Providing transport to community events, it helps to reduce isolation. Around £4,000 was raised by members of the community to buy "Nellie".

There was a suggestion to increase the mileage paid to voluntary car scheme drivers to incentivise drivers, as currently volunteer drivers are subsidising taking people to health and care appointments.

Bus services have issued a small supply of bus passes to some communities. This could be extended to people who are homeless. This would help enable attendance to appointments.

## Dental services

People suggested the following options to help tackle issues relating to access to NHS dental services.

**"Fast track Ukrainian dentists (and other nationalities) so they can practice in the UK"**

## Digital exclusion

Ensure that services are accessible to those who are not able to or who do not wish to use a digital option.

# Bigger barriers for some



## Less likely to seek help early

Being homeless and for others, not living in secure accommodation is very difficult, both physically and mentally and has significant impacts on health and wellbeing. People who are homeless and those from Gypsy, Roma, Traveller communities (GRT) experience premature mortality and increased mortality rates.

For many people the challenges of day-to-day living are exhausting. Looking for necessities such as food and shelter is time consuming and often unachievable. Seeking help for health problems comes low down on their list of priorities and so they do not have the energy or capacity to seek help early on. This is particularly true for dental and GP help:

**“I now need dentures, where do I go to get these?”** – Homeless person

Support workers told us how often homeless people don't seek help until they are in crisis.

**Who said this?** Rough sleepers, GRT communities, migrant farm workers.

## Less likely to know where to go for help

Many people find health and care services confusing. People experiencing greater challenges in life will find this even harder.

We heard expectations of, awareness and understanding of health and care, treatment and diagnosis was influenced by experiences of systems in people's country of origin.

**“It is a very different system from my country.”** – Ukraine participant

We heard of people being turned away from GPs as health services are often not aware of the right to register if there is no home address or identity. This prevents access to services and adds to the feeling of stigma and helplessness for people who are already struggling. This also means that people are not being invited for routine screenings or immunisations.

People with the most barriers were not aware of social prescribers and the work they do to help health inequalities. Other people told us they needed to be referred to the service, which is difficult due to the barrier of getting a GP appointment.

People who are unable to leave their home due to disability, or lack of transport means they are unable to access regular health care checks, attend social events or support groups.

**“A rough sleeper had been in hospital for treatment to a stab wound (after being discharged). It may now be infected, and he is in pain. He doesn’t know where to go to get it treated.”** – Outreach volunteer working with homeless people.

**Who said this?** People who are housebound, people who first language is not English, GRT communities, rough sleepers.

## Language and literacy

People with the lowest levels of language, literacy and numeracy are the people who suffer the poorest health outcomes in society. This includes people with low educational attainment, low income, older people, people with a long-term condition or disability and people with a sensory impairment.

Having low literacy skills means not having the confidence and motivation to seek out information and make decisions or understand the links between health outcomes and broader social, cultural, and economic choices.

We heard people with low literacy are unable to read and understand information such as appointment letters, prescriptions, or health promotion materials. This may result in missed appointments, not taking medication, and not taking self-care advice. Some GRT families share bank accounts. This means that they are often unable to obtain a financial assessment for an individual for social care or claim benefits.

Language barriers presented significant challenges, and interpreter support was mixed and not always offered. People spoke of being reliant on family and friends for booking appointments, registering, and navigating health care. Access to other government services will also be restricted due to this barrier.

We were told there is an unwillingness to discuss sensitive topics through an interpreter.

Some translation services did not have the expertise to translate medical terminology, and some male interpreters have not been willing to use female terminology.

We heard local migrant farm workers live in crowded accommodation and do not have access to translated information about how to use health, care, or broader local and national government services.

People told us it would be helpful to have information written in an accessible format. Staff providing health, care and local authority services could work in a holistic way to provide information to vulnerable communities.

**Who said this?** GRT communities, People who English is not first language, Migrant farm workers.

## Lack of trust in services

Many people told us about poorer health outcomes due to barriers from the lack of trust in services from historic discrimination, poor experiences, stereotyping, and cultural barriers associated with accessing health services – contributed to by low income and poverty.

A lack of cultural awareness, or not considering cultural differences can lead to people unnecessarily worrying about their health or feeling unnerved in a service setting.

**“a small number of health professionals’ attitude towards people whose first language is not English or who are from ethnic minorities could become a barrier contributing to the distrust and health inequalities”** – Chinese participant

We were told that people have trust issues due to lack of understanding of cultures, or different lifestyles.

Within the GRT community there is little education around health. These factors contribute toward a deep lack of trust in services. This means preventative measures such as screening programmes and vaccines do not feature highly for these communities.

We heard that people from more restrictive countries are unlikely to question or complain about a service due to a fear of causing problems or repercussions.

**“I wouldn’t want to complain, it might make them treat me differently”**

It is difficult for people from other countries to understand the laws around data sharing and this will give a feeling of being insecure.

**“The system should fit the person, not the person fit the system”** – GRT community

People told us that feeling understood, listened to, respected, and heard was important to their sense of safety, trust, and satisfaction.

**Who said this?** People who English is not first language- established and short stay communities. GRT communities.







## Unable to access online resources

Most organisations require some form of communication by technology. Making and receiving health appointments, applying for benefits or jobs often require a computer and this is virtually impossible for people living in difficult, insecure, or unsafe accommodation.

Often poor signal, no Wi-Fi, low literacy, and lack of knowledge means this is an added barrier to people not receiving the services they need.

Some people have to wait for a weekly visit to a support hub to access a computer and Wi-Fi. Appointments and opportunities to organise benefits are therefore often missed.

People who are homeless face difficulties in maintaining appointments and medication regimes due to a lack of IT devices, for example smart phones.

**“Filling in the housing form online with help took about 2 hours at a drop-in session.”**  
- GRT community

**Who said this?** Rough sleepers, Gypsy Roma, Travellers communities.

## Next steps

This report will be presented for discussion to the Cambridgeshire South Care Partnership, the Health Inequalities Board and other decision-making boards and groups who are able to act and effect change.

Healthwatch Cambridgeshire and Peterborough will be tracking progress and undertaking further work on many of the areas highlighted.

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## Contact us:

The Maple Centre  
6 Oak Drive  
Huntingdon  
PE29 7HN  
0330 355 1285  
[enquiries@healthwatchcambspboro.co.uk](mailto:enquiries@healthwatchcambspboro.co.uk)  
[www.healthwatchcambridgeshire.co.uk](http://www.healthwatchcambridgeshire.co.uk)

