Investigating Local Health Inequalities Using the Core20PLUS5 Approach

Engagement Report April 2024

Contents

Executive summary

Health inequalities are avoidable, unfair, and systematic differences in health found across the population and between specific groups of people. [1] When we investigate how health and care services contribute to health inequalities, we call these healthcare inequalities. This inequality is about poorer access, experience and outcomes for some communities. It is important to understand what healthcare inequalities look like so that the NHS and Local Authorities can change the way they plan and deliver services.

Individuals living in certain areas or who belong to marginalised communities, including those with lower socioeconomic status access healthcare less than others. This may be to do with a failure to provide suitable means of accessing care and lack of trust based on poor experiences that occur when people try to access care.

The aim of this project was to understand why people who are among the 20% most deprived in England and those who belong to marginalised communities are under-represented in receiving healthcare, and services that relate to the treatment of five common conditions. We explored the experiences of people living in the most deprived areas of Bristol and North Somerset in relation to accessing healthcare. The focus of our engagement activities increased our likelihood of meeting people with mental health issues, learning disabilities, recent immigrants, recent mothers, and those in homeless and traveller communities. We wanted to identify barriers they may be experiencing, so we were especially interested in how and when they access care and if they don't access care, why?

We recognise the extreme pressure that practices are facing, especially in areas of higher deprivation and that when healthcare is received it is usually perceived as good and caring. The greatest barrier to under-served or under-represented groups receiving care is the means of access.

We spoke to 102 people and logged 118 service related comments from people attending ten different local community groups in Knowle West, Hartcliffe and Weston-super-Mare about what prevented them getting help. We reached data saturation when no new themes were identified and at this point we ended the period of engagement.

We found evidence of a combination of systemic barriers and failure to adequately accommodate individual access requirements, and these mainly accounted for individuals' difficulties in accessing healthcare.

Access to appointments in GP practices appears to be key as;

- A significant number of people give up trying to make an appointment or reduce their health seeking behaviour. They say it is so difficult and too long a wait, reducing the opportunity for early diagnosis and timely intervention.

- The means of contact with GP practices i.e. triaging to manage demand creates feelings of being judged or stigmatised as the triage process asks people to justify wanting care.
- Communication challenges including not being listened to or feeling 'fobbed off', and uncomfortable with using the available means of access.

There is evidence of people having a difficulty getting to places where health and care services are provided because of;

- provision locally
- public transport cutbacks
- discomfort at being in an unfamiliar setting

In contrast, where there is specific provision for marginalised groups this is valued and well-used. Examples include; a health visitor working with travellers and van-dwellers, who visits their sites and has built a rapport., and the Compass centre for homeless people, where care is accessible and relatively quick. In the recent past there were drop-in & GP walk-in centres open to all where people wait for care when they have to.

Based on these findings our suggestions for improving early diagnosis and uptake of services for people impacted by healthcare inequalities and especially those who have the Core20PLUS5 priority conditions include:

- Choice of means of access – in person, online, telephone that allows more flexibility for patients to explain their concern in the way they can best manage.
- A timely response to all patient-initiated contact
- More flexible triage systems
- Flexibility of appointment times and length with a mix of book-ahead appointments and on-the-day or within two days appointments
- GP practices working with their Patient Participation Groups or local communities to co-produce an appointment system that works better for their patients and the practice.
- Improved listening skills and training for receptionists to counteract stigma and sub-conscious prejudice.
- Improved funding for GP practices working in areas of high need to increase provision of appointments.
- Continued funding for tailored provision to marginalised communities.
- More opportunities for patient-controlled access, such as drop-in, with opportunistic screening

Equalities Statement

Healthwatch BNSSG is committed to promoting equality and diversity and tackling social exclusion in all our activities. We aim to ensure equitable access to our initiatives and projects. We

include people's lived experiences in our work and identify and mitigate against barriers to enable people to become involved in our research. We address the participation needs of those who share one or more protected characteristics, or those that experience hidden discrimination, or are part of an 'invisible minority'. We provide access to communication support to adjust for people's needs and proactively assist people in attending events and meetings we hold. Healthwatch will connect with existing patient bodies, organisations that support people who draw on care and support, and voluntary sector organisations to reach into, and develop relationships with, diverse communities, and inclusion groups.

Healthwatch BNSSG's statutory duty as laid out in the health and social care act 2012 is to provide a voice for people about their local health and social care services. Its vision is that people's experiences help to improve health and care. Healthwatch is developing it's public engagement activity to support the Core20PLUS5 approach.

Background

People experiencing healthcare inequality are often divided into 4 main categories: socio-economic factors (such as low income or poor housing); geography (the area they live in); specific characteristics (such as ethnicity, sexuality or disability); and socially excluded groups (such as travellers, people who are experiencing homelessness or refugees). [1]

Core20PLUS5 [2,3] was developed to support NHS Integrated Care Systems (ICSs) to reduce healthcare inequalities and to enable prioritisation of energies and resources by acting both collectively and through specific organisations to positively impact on the "causes of the causes" of healthcare inequality. Some work will fall to the NHS, some to local authorities and some as joint working at 'place', or neighbourhood.

NSE England says it aims to reduce healthcare inequalities by 'providing exceptional quality healthcare for all ensuring equitable access, excellent experience and optimal outcomes'. It has asked all systems to take a Core 20PLUS5 approach to their work to help address healthcare inequalities.

'Core 20' refers to the 20 per cent of the population experiencing most deprivation, with 'plus' representing additional groups specific to each area who have poorer than average access and outcomes from healthcare. The 20% most deprived of the national population is defined by the Index of Multiple Deprivation (IMD). The 'PLUS' is ICS-determined groups experiencing poorer than average access, experience or outcomes from healthcare. The '5' clinical focus areas for adults are maternity, severe mental health illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding and management [2]. The aim is to narrow the current gap in life expectancy due to these inequalities.

The initial Core20PLUS5 adult framework we are using has developed a programme for Children and Young people (CYP) with specific consideration for the inclusion of young carers, looked-after children/care leavers and those in contact with the justice system. The CYP 5 clinical areas of focus for rapid improvement are asthma, diabetes, epilepsy, oral health, and mental health. [3]

Diagram 1 Target population identified adult only [3]
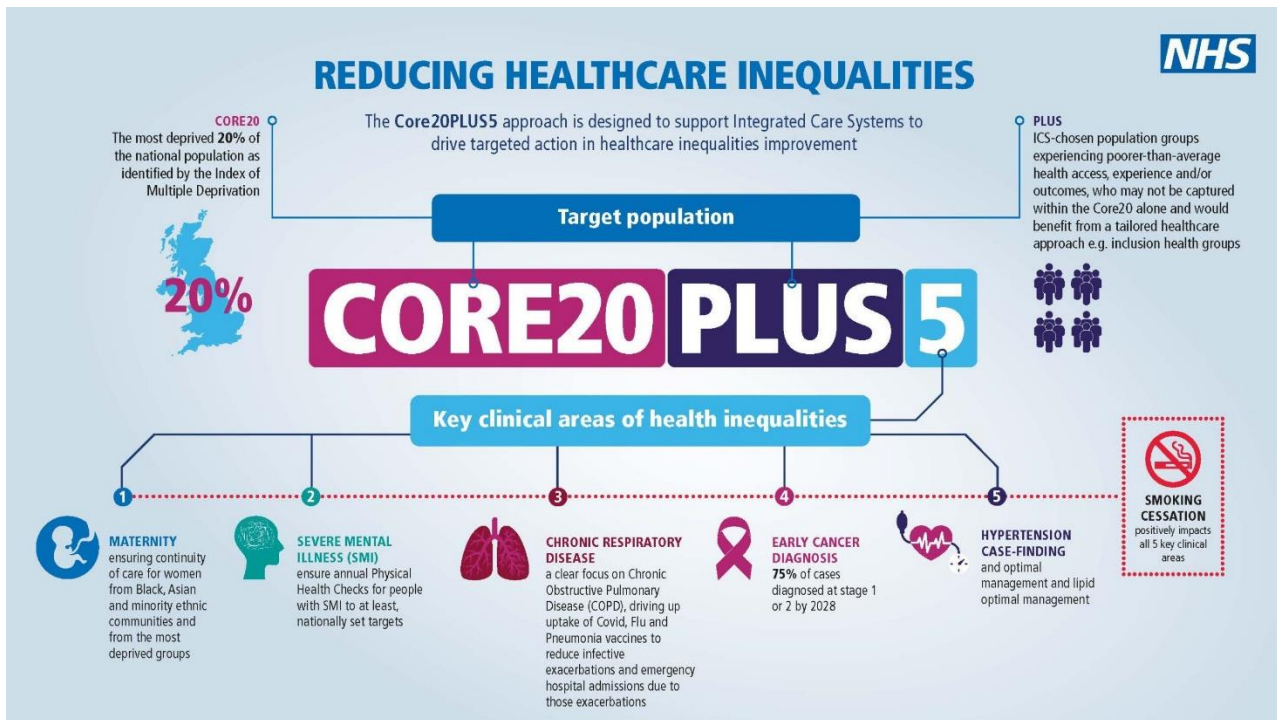
Bristol, North Somerset, and South Gloucestershire (BNSSG) needs assessment identifies the following areas of deprivation [4-6]:

Bristol

- Fifteen percent of Bristol's population live in the most deprived 10% of areas in England

- At ward level, the greatest levels of deprivation in Bristol are in the wards of Hartcliffe & Withywood, Lawrence Hill, and Hengrove & Whitchurch Park

- The ten most deprived neighbourhoods in Bristol are all in the South Bristol local areas of Hartcliffe, Whitchurch Park and Knowle West

North Somerset

- Within some geographical areas of North Somerset outcomes are worse than in others, the most deprived being within Weston-super-Mare and the least deprived outside of Weston-super-Mare.

- The most deprived areas where outcomes are poorer are within the Central, Hillside and South areas of Weston-super-Mare.

South Gloucestershire

- South Gloucestershire is ranked 267th of 317 with one being most deprived.

- South Gloucestershire are in the 10% least nationally deprived and it has no concentrated geographical pockets of deprivation.

Purpose

Healthwatch BNSSG facilitated this project to influence the improvement work of the Integrated Care System (ICS) and accelerate impacts. This partnership of service providers plan services and improve health in Bristol, North Somerset and South Gloucestershire (BNSSG). All ICS's aim to tackle healthcare inequalities in outcome, access and quality of experience.

The project worked with our 'Core20PLUS5' population to;

- Develop insights from data to inform work programmes on inequalities.
- Collect lived experiences of people who represent a 'deprived' or socially excluded group.
- Amplify the voice of public, patients and carers to encourage systems to truly listen and co-design service changes.
- Understand why some communities access healthcare disproportionately less than others.
- Identify barriers in certain communities in accessing the relevant healthcare

Healthwatch findings are shared with leaders across our system nationally and locally, including the BNSSG Integrated Care Board, ICS Primary Care Development Team, Public Health and Adult Social Care Commissioners, The Care Quality Commission, Healthwatch England, NHS England and individuals and organisations who helped us collect the information contained in this report.

Engagement methodology

The project was managed by two lead volunteers for Healthwatch BNSSG, supported by six other volunteers who were recruited and trained to support engagement activities. In October 2023 a steering group was set up and a project plan and timetable developed. A review was completed of the local demographic data taken from the Joint Strategic Needs Assessments from BNSSG Local Authorities, and data specific to Locality Partnerships. [4-6]

Using this information and the Core20PLUS5 programme structure we focused on public engagement in Bristol's Hartcliffe, Whitchurch Park & Knowle West, and North Somerset's Central Ward, Hillside and South Ward of Weston-super-Mare.

The project also aimed to prioritise socially excluded groups within BNSSG. These included people with learning disabilities, those experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities. We were unable to contact other socially excluded groups including sex workers, people in contact with the justice system and victims of modern slavery.

We emailed contacts within each area and some of these provided further routes of contact. From these responses we engaged with and visited ten local community groups, working with a varied demographic of people. Our sample was therefore identified using a combination of convenience sampling, snowballing methods, and purposive sampling to reach people where there are information-rich qualitative cases.

Table 1 Identifies groups by area and role in the community.

Where	Description of Group	Forms
Community Garden Knowle	All ages, free community lunch club for residents of Knowle runs weekly.	12
St Cuthberts Church Brislington/Knowle	Afternoon tea club for all ages run weekly by volunteers.	9
Quakers square	Feed the Homeless all ages, runs twice a week, run by volunteers.	10
Symes Resource Centre Hartcliffe	Christmas fair organised by Hartcliffe and Withywood Partnership.	7
Citizen advice Shop Weston-super-Mare	Independent charity that provides free, impartial, and confidential advice.	9
Community bus Hartcliffe and Withywood	Community bus. Provides door to door transport and social interaction for people with mobility needs.	8
For-All Healthy Living Centre Weston-super-Mare	Rattlers peer support group. People with multiple long-term conditions meet monthly.	9
Mowcroft Methodist Church Hartcliffe	Family & Friends: BS13 and beyond. Young immigrants anniversary event.	17
Hartcliffe Nursery school and children's centre, Hartcliffe	Baby Hub for Mothers in Hartcliffe. Run by community health to provide advice and health checks.	6
Foodbank in Weston-super-Mare	The foodbank was founded by local churches and community groups.	15

A lead volunteer was allocated to each local community group that responded to our initial email to follow up the response and arrange a visit. If they agreed to a visit, an information pack about

Healthwatch was forwarded to the community group contact before the visit with an explanation. We visited areas where the local community may be experiencing barriers to accessing any health or social care services. A set of questions were devised to ascertain how people did access care and if they did not, what prevented them reaching out.

We were particularly interested to hear from people with the following characteristics that may influence access to care:

Severely impacted by the cost of living, Relying on a food bank, Long term unemployed, Limited access to transport, Limited social or family networks, Being a refugee or asylum seeker, Within the justice system, Misusing drugs and/or alcohol, Treated unfairly because of how they live, People who are not registered with a GP.

With the help of a volunteer with learning disability, we adapted Healthwatch BNSSG's engagement feedback form to highlight the characteristics that might link demographics to themes around access to care:

- Postcode and demographics, which identified those within 20% most deprived areas.
- An expanded list of special characteristics as above that might contribute to experiencing barriers to healthcare access.
- Whether they were able to access services online.
- Additional questions to identify anything that might discourage people from seeking healthcare and to identify their usual means of accessing healthcare.
- The PLUS 5 comorbidities were also added as a drop-down menu to identify long-term conditions.

See Appendix 1: Core20PLUS5 feedback form

What we were looking for:
We were particularly interested in the opportunity to undertake further engagement with key stakeholder groups within the communities. We did this by visiting a local group, being part of any existing activities, or collaborating with a local community group on developing a joint engagement visit.

Co-production

The two lead volunteers co-designed the means of delivering the project, including the training for volunteers, with suggestions from Healthwatch staff. The engagement form was co-designed with the help of input from a volunteer with a learning disability who advised on the words to use to describe the special characteristics. Further questions came from the involved volunteers following the training event. The changes we could make were limited by the need to input into

Healthwatchs existing database of feedback from engagement events. Healthwatch added several data entry areas as a result of this project.

We tailored the format of each engagement activity following discussion with the individual community group organisers to accommodate special requirements for interacting with their group.

Findings

People who were interviewed (participants)

We interviewed 102 individuals who between them gave 118 pieces of feedback about a range of services.

Graph 1 Identifies age range of people interviewed by postcode;
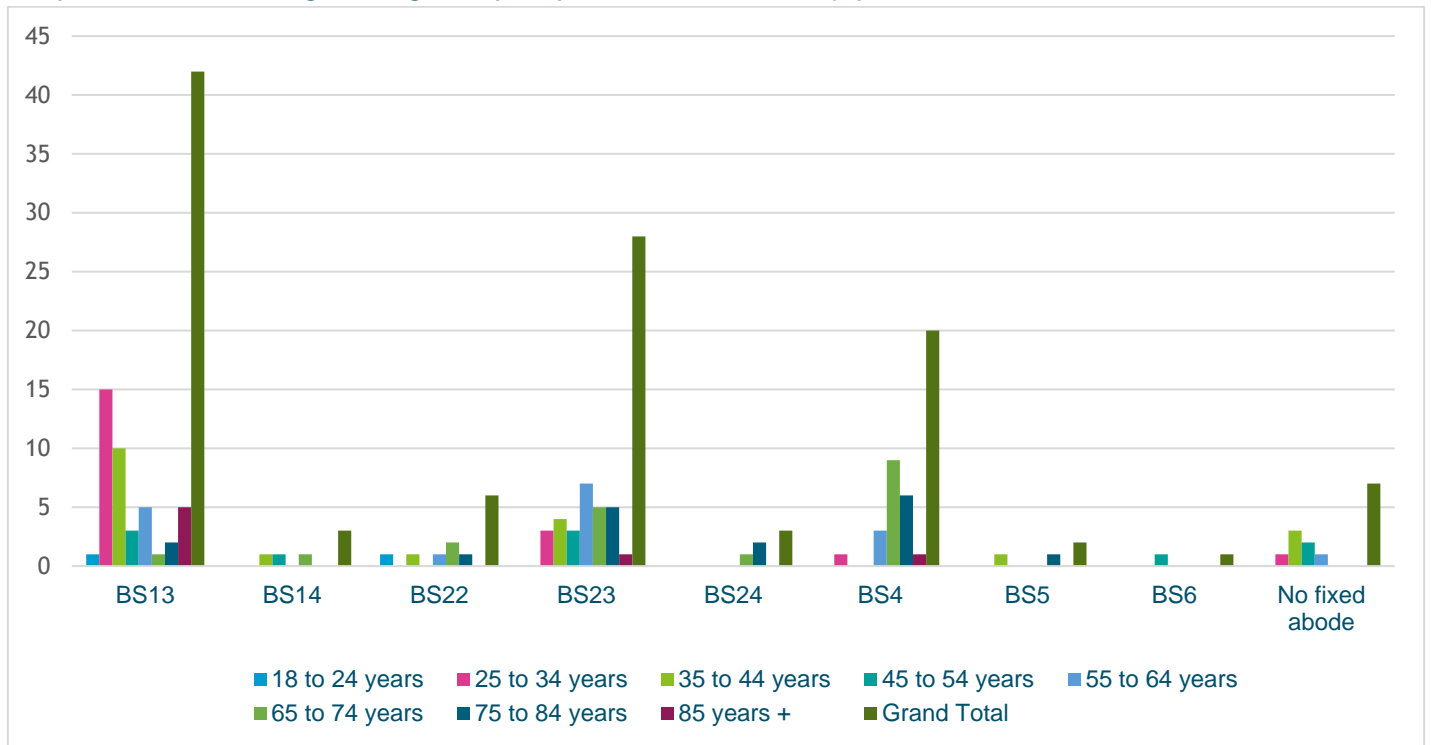
Bristol postcodes are in Hartcliffe, Whitchurch Park & Knowle West. The Compass Centre was visited in BS6. North Somerset postcodes are in Central, Hillside and South areas of Weston-super-Mare.

It's all about access

We found evidence of a combination of systemic barriers and failure to adequately accommodate individual access requirements that mainly account for the individuals' difficulties in accessing healthcare.

Access to appointments in GP practices appears to be key;

- A significant number of people said they give up trying to make an appointment as it is so difficult and too long a wait (reducing your health seeking behaviour means a reduced opportunity for early diagnosis and timely intervention).
- The means of contact with GP practices i.e. triaging to manage demand may create feelings of being judged or stigmatised, asking people to justify why they are wanting care.
- Communication challenges including not being listened to or feeling 'fobbed off', and uncomfortable with using the available means of access.

There is evidence that people with characteristics which make them extra vulnerable to marginalisation also experience difficulty getting to health and care service settings, because of;

- provision locally
- public transport cutbacks
- feelings of discomfort at being in an unfamiliar setting

These experiences often led to the people we spoke to not wanting even to attempt to access healthcare because it was so difficult i.e. they had 'given up'.

Where specific provision is made for marginalised groups it is valued and well-used: The health visitor known to travellers and van-dwellers who visits their sites and has built a rapport., the Compass centre for homeless people where care is accessible and relatively quick. Drop-in centres or GP walk-in centres (and A&E) which are open to all and where people go to wait when needed.

Graph 2 number interviewed with characteristics that might act as barriers;
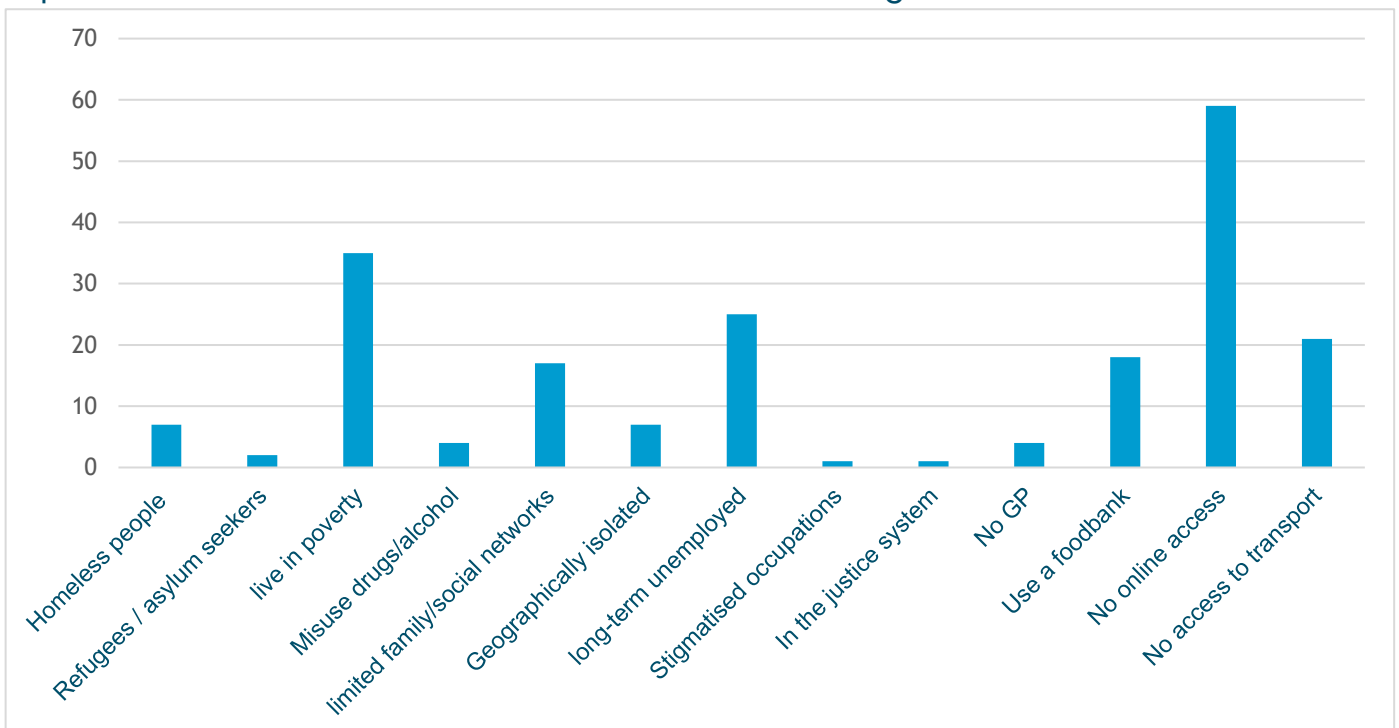
What's stopping people from receiving the care they need?

Getting through to the surgery;

Within our sample of participants in this study, appointment availability in GP practices and difficulty in getting through to the practice was described as a huge problem. A significant number of people said they had given up trying to make an appointment because they felt it is difficult and takes too long. Different systems are used to manage demand for appointments and some people felt disadvantaged by this. This may be a triage system via reception or via an online form such as 'eConsult' or 'Accurex'. One person described having to access the online system at 8.00 am or they would be too late to get an appointment as it would be closed after that.

> "AskmyGP is only open at 8.00 for a short time so unless you are very quick, you can't get an appointment."
>
> - Man, 55-64, White, BS23

Another told us that *'you have to be first in the queue to get an appointment' Woman 25-34 White BS13*. A man reported that he tried to phone for an appointment at 8.00 am - *'there were 16 in the queue and all appointments were gone by the time I got to the top of the queue' Man 45-54 White BS13*

People repeatedly told us that telephoning is frustrating, often unsuccessful or involves an extremely long wait. Some people reported their practice *'never answers the telephone'* so they could not get through via telephone at all.

> "The GP practice never answers the telephone."
>
> - Woman, 35-44, Black, BS14

One person made a call while observing from outside the surgery. He reported ' *I can't get an appointment on the phone. I rang from just outside the building and watched to see what happened. No-one answered.' Man 65-74 Mixed White/Asian ethnicity BS4.*

One woman stated that staff at her GP practice were *'nice and you do not feel like a nuisance'*, but *'phoning is a nightmare'* as there is a *'long queue'* and it's *'impossible to get an appointment'*. *Woman 65-74 White BS14*

One person reported he cannot get through, so he gives up trying.

> "I could not get an appointment or get anywhere near"
>
> – Man, 25-34, White, BS4

Securing the right support quickly enough;

Several people who felt they had an urgent need reported that they were unable to get an appointment because no appointments were left or, if available, they were offered an appointment for days or weeks later. This included people who felt they had a potentially serious condition or an infection such as a chest or bladder infection.

'You have to be triaged; I was waiting a month for a urine infection' Woman 55-64 White BS4

One person reported a 2 week wait *'even to be triaged'* or it being several weeks until they were offered an appointment.

Another said: *'The online system gets back quickly but 1st appointment is not for 2 weeks. If you have an infection that is too long, and you have to ring between 8am or 1pm and I'm not always able.' Woman 35-44 White BS13*

Others reported that the GP surgery had been quick to respond, and we noted that this depended on demographics. Older people with known conditions and parents trying to make an appointment for their child reported easier access.

In addition, people reported long waits to access secondary care, which, for one person was made worse by the referral not being sent due to an administrative error at the GP practice and for another by not receiving any information about its progress. (see section below on healthcare services internal communication)

'I've been waiting over a year for a skin cancer appointment' Woman 75-84 White BS4

Securing the right support first time;

Another barrier to getting a timely response mentioned by at least four people is that patients who succeed in making contact with the GP practice are told to try their pharmacy first, who then refer back to the GP as the problem is outside their ability to help. People told us they find this frustrating as it can feel like a delaying tactic. They said they only try to access the GP practice when it is necessary, due to the difficulties of doing so.

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"They tell you to go to the chemist instead of getting an appointment. Your situation has to get worse before they will give you an appointment"

- Woman, 25-34, Minority ethnic, BS13

Communication barriers

For many individuals when they do make contact with reception, they feel the outcome is dependent on the receptionist/care navigators judgement of their need. Receptionists were sometimes experienced as 'unhelpful', 'judgemental', 'not listening', or 'fobbing them off' and could block access to the GP.

We heard examples from several people who knew they needed care but had difficulty persuading the receptionist and described feeling not listened to. This included a man with a heart condition, a woman with severe asthma, a woman with a chest infection and a man with worsening chronic fatigue syndrome following COVID, among others.

Several individuals reported that legitimate concerns were dismissed. One person reported that he told a receptionist he needed to be seen when he experienced severe bloating after a bowel examination. The receptionist was '*not understanding*'. Four days later he was admitted to hospital because of a perforated bowel. *(Man 55-64 White BS23)*. Another described how her partner '*phoned the surgery several times. He was triaged but not listened to so called 999. He was subsequently diagnosed with a heart condition.*' *(Woman 75-84 White BS24)*

For some, the obstacle is the discomfort of having to present and explain themselves to someone who may not be experienced as helpful. Added to that is the feeling that there is no confidentiality in this situation.

"At reception you have to explain what is wrong with you. Confidentiality is gone."

- Woman, 65-74, White, BS4

Some individuals stated that it wasn't easy to get the type of care they needed. A woman told us she had to *'jump through hoops just to get an appointment to see the doctor in person rather than a phone or video call'* Woman *55-64 White BS23*

Some also felt uninformed or uninvolved in decision-making. A significant number of people told us that the difficulties and experiences put them off from trying to get care.

'Doesn't bother with healthcare as uncomfortable' with using online access *'receptionists prevent access to services'* and *'difficult to get there because of bus service'* (Woman 65-74 White BS4)

'Avoids trying to use health service because of experience by his family' (Man 45-54 White BS13)

'Cannot get through to request healthcare so gives up trying' (Man 25-34 White BS4)
'Doesn't go because she feels she is just seen as a 'pain in the neck'' (Woman 75-84 White BS22)

'Put off trying to get healthcare by feeling judged or being fobbed off' (Woman 25-34 White BS13)

'I haven't even tried lately. I can't be bothered and it's put me off for life.' (Woman Age not known White BS4)

It may be no surprise that A&E or walk-in centres which are open to all if you're willing to wait, attract people who feel they can't get care they need via a GP.

Difficulties with online access to services

Access to services via online portals can create significant barriers. The service may be turned off whenever the GP practice is closed, even over lunch, and in the evening and at weekends. *'The online service is helpful but unfortunately if GP practice closed it does not work.'* Woman 35-44 White BS13.

The potential benefits of online access that would allow people who are working full-time and not available during the day to access services when they can, are lost if services are turned off outside office hours.

> "Most of the time you can't use online services as it is turned off regularly"
> - Woman, 45-54, White, BS23

Most people we interviewed felt that the way Information Technology was used was not helpful and that there was over reliance on it. Some people were uncomfortable having to manage services online. One person *'manages to do so but feels very uncomfortable as not able to tell whole story using it'* (Woman 65-74 White BS4). Others do not have access to a home computer. One man described feeling stigmatised by this and that he has to go to the local library to use a computer. This is causing him concern because hours are being reduced there.

> "There is a stigma to people without computers at home."
> - Man, 55-64, White, BS4

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In one case a woman said that *'her husband went for his appointment, and they had no record even though he had his (appointment) card.'* She concluded they were *'too reliant on IT'* (*Woman 65-74 White BS4*).

Communication between and within healthcare services

People told us that sometimes they experienced delays to receiving healthcare because of problems with internal communication between providers. People often felt uninformed and 'kept at arm's length'.

One woman was very unhappy with the progress of her referral for a dementia diagnosis.

"I have had to jump through hoops with tests involved that required a panel of people. They then decide if you have dementia. It's a remote decision and they do not know you as an individual. They have not explained what they are doing."

- Woman, 55-64, White, BS13

Sometimes there was a delay in sending the referral from the GP practice.

"My husband had to wait 18 months for a referral to be completed to Weston (WSM). Now he is having specialist care there but a bit too late. GP did the X-ray, but the referral was not passed on."

- Woman, 65-74, White, BS22

In another example, it was uncertain about which department should deal with a referral. One woman described her husband's experience: *'He has been wasting time as he was on the cataract list, was seen then said no, and had to start again on neurological list'* (woman 55-64, Mixed ethnicity BS4)

In some cases, people were passed around from department to department which contributed to delays in receiving care.

"I was sent from department to department then the appointment was cancelled."

– Woman, 65-74, White, BS4

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A person with diabetes described being an in-patient and repeated transfers between wards which meant his diabetic meals were sent to the wrong ward.

Having to travel to access care

Going in-person to the surgery is difficult for some due to distance or travel difficulties. Lack of an adequate local bus service particularly affects people living in South Bristol who do not have independent means of transport. 'Bus services have changed' and been decreased, making it more difficult. *(Man 75-84 White BS4).*

> "You can't get a bus to south Bristol anymore. It's hard to get an appointment unless in central Bristol."
> - Woman, 65-74, White, BS4

People living in Weston-super-Mare (WSM) say they are affected by the lack of adequate local provision of some services, such as physiotherapy, a pain service and rehabilitation services. They quite often had to travel to Southmead for these. One woman said there needed to be more availability of tests locally as she had to travel to Southmead often for tests which were not available in WSM *(Woman 45-54 White BS23).*

Another found it difficult to get pain management support.

> "Pain clinic at Southmead is very difficult for me to get to and I can't do the pain management course online. No pain clinic in Weston"
> - Woman, 75-84, White, BS22

The need for tailored services

Feeling judged, stigmatised, or uncomfortable with the available means of access, or being unable to use their usual means of access discourages or prevents people accessing healthcare. People with anxiety or communication and literacy difficulties such as dyslexia find it harder than others to access healthcare. They are often reluctant to use online means to communicate their need for care and may find it hard to use a phone or to go out to GP practice.

> "She wants a female GP. She has to write a letter for the reason but is dyslexic."
> - Woman, 65-74, White, BS22

Another woman was 'concerned about her son who has anxiety and panic attacks. 'He has a lump in his abdomen but won't go to the doctor. He needs a home visit' *(Woman 75-84 ethnicity not known BS23)*

Learning disability can also create communication problems at reception.

> "Receptionists don't take into account his learning disability and use language that is hard to understand."
> - Man, 55-64, White, BS13

A lack of understanding by professionals of individuals' conditions can create problems for people receiving or trying to access healthcare. For example, the mother of an apparently small-for-age baby receiving care at the Childrens Hospital found a lack of understanding from community health professionals who were applying standard guidelines. A man with chronic fatigue syndrome/ME found that GP practice staff were unresponsive to his report that his condition had worsened following COVID, and a woman with neck pain felt that the GP practice had given up trying to help her.

Carers are another group of people who find it especially hard to access healthcare for themselves.

> She has diabetes but does not have time to access health care as she is a carer. Feels a lack of support as a carer.
>
> "No support 24/7"
>
> Woman, 65-74, White, BS24

Others with restricted availability to attend appointments include those working, and the self-employed.

The inability to get online or phone at 8.00 a.m. to be at the front of the queue disadvantages some people . One man with insomnia finds it hard to get up in time to get online to book one of the few available appointments because he doesn't get to sleep until 4.00am. If he goes to the GP practice later, he finds them unhelpful. *(Man 55-64 White BS23)*

> "Work commitments mean he can't take an appointment in the middle of the day as he would be letting down people who depend on him. Needs an operation but won't bother because too many hoops."
> - Man, 45-54, White, BS13

Closed communities, such as travellers, or those with no permanent address, and people who are homeless or living 'off grid', face additional barriers of trust and stigma. They are usually not registered with a GP practice so can miss out on early and preventive care.

> "He has no GP and goes to the Compass Centre. He is on drugs so was given a script by Compass Centre."
> -Man, 45-54, White, No fixed abode

One homeless man who was GP registered said he *'had no problems with his GP but also went to The Compass centre which he said was excellent' Man 35-44 White No fixed abode.*

A health visitor providing a healthcare service to Gypsy, Roma and traveller communities and van dwellers, gave an interview. She explained that trust and fear of outsiders are the major factors superseding all other barriers and there can be discrimination from health and social professionals. She identified the following issues; *'Discrimination by health and social professionals, with healthcare not tailor-made to suit their culture and lifestyle. The limitations of the 9am-5pm static services, digital and literacy difficulties, letters being sent when most can't read or write and some don't get post delivered on site, finances/travel to appointments, challenges parking vans or large vehicles/caravans in health service car parks.'*

She says Healthcare currently expects these communities to navigate a system they do not always understand. *'Trust and transparency, relationship building and genuine compassion are a must. Make accessing health services more patient focused rather than process driven'.* IT access to services *'depends on phone/WIFI signal, data, understanding of the IT processes such as making GP appointments, and the use of language. Even when these communities have literacy, they have said to me they don't understand the words and what they mean. Rather than finding out, they avoid the issue, which can result in potential did-not-attend appointments (DNA)'*

Appendix 2 shows the feedback sentiment by service provider.

**Priority conditions the NHS want to support in these communities**

The Core20PLUS5 initiative focuses on 5 conditions. Participants in this research told us about having some of these as well as a wide range of other conditions which made it more complex to identify why people within the Core20PLUS demographic might not seek help for the 5 conditions as much as would be expected. If access to GP care is very difficult, we would expect that some people would not be aware of having the condition in the first place and others would find it hard to access the necessary information or have the regular check-ups or monitoring.

Graph 3 The number of people with Core20PLUS5 conditions that were identified;
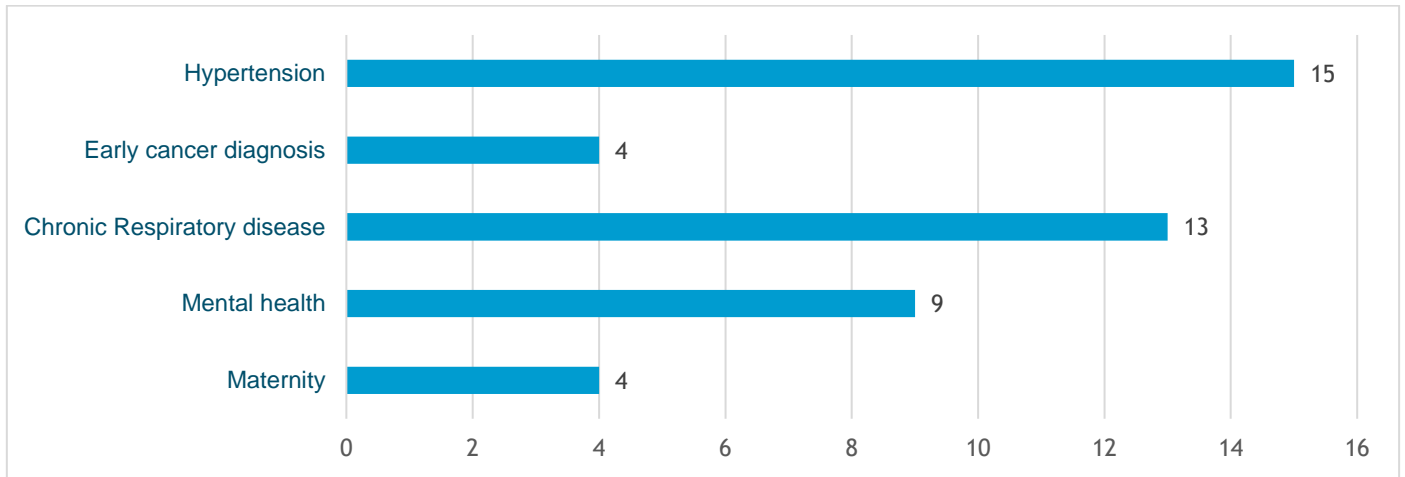
This represents approximately 38% of the sample with 4 people reporting that they had two of the 5 conditions and the rest had one. A lower rate of service use for these conditions in our postcode areas would result in fewer people diagnosed/a later diagnosis. We suspect but have not found local data sources to evidence this is true for people with these conditions.

Graph 4 People's feedback sentiments from those with Core20PLUS5 conditions.
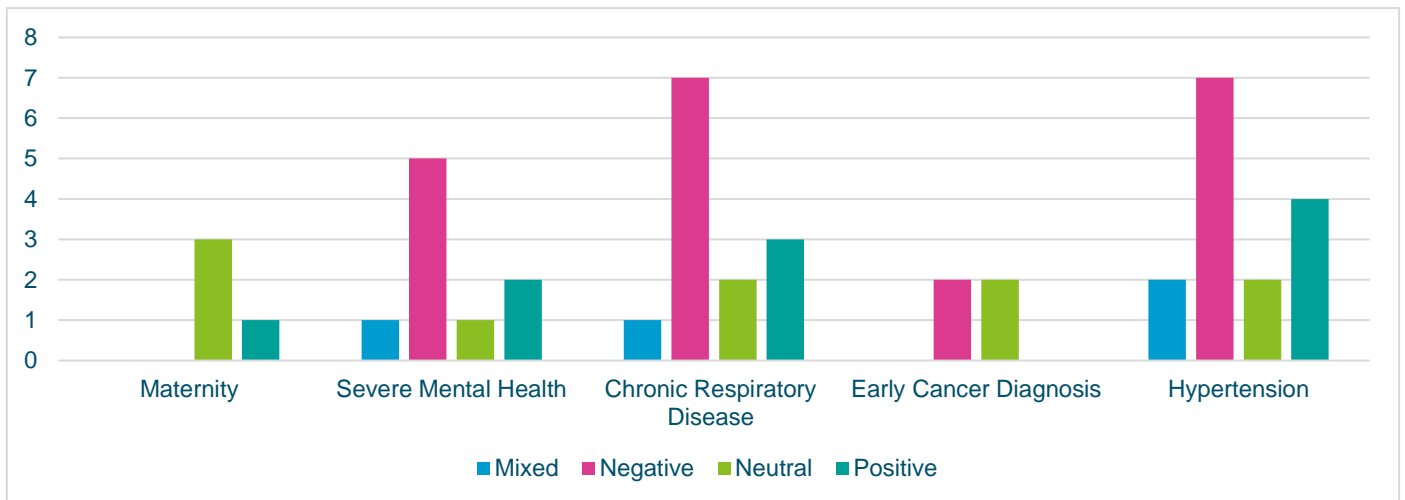
These are similar levels to the rest of the sample except that disproportionately more neutral comments were recorded compared to the rest of the sample. In our small study negative sentiments in particular were not more common than in the rest of the sample.

Considerations for our systems to take forward

Reducing healthcare inequalities requires care tailored to the needs of the individual (personalised care). This includes how individuals access care. Our data suggest that a lack of suitable means to access care is the main issue. This is likely to reduce the opportunity for early diagnosis and timely intervention and suggests significant obstacles to access must be reduced.

Appointments offered more flexibly without an undue wait or difficulty in requesting them and provided with consideration of when people are able to attend may deter fewer people from attending their GP practice.

Equally, having flexible means of accessing care tailored to local communities combined with person-centred or personalised care tailored to the needs of individuals is likely to encourage more people to attend.

When requesting care, the possibility of speaking to someone who listens compassionately and who seeks to understands them can result in more timely and more appropriate care for these communities [7,8].

1. **Use resources to effectively tackle co-morbidities and complexity**

In the areas we visited people acquire multiple long-term conditions at a younger age than in more affluent areas [1] and have more mental health problems, which can also complicate diagnosis and management of physical health problems. [8, 9] This may act as an additional barrier to accessing healthcare that should also be considered among the barriers we identified in these communities [10].

In addition, the greater need for healthcare resource, especially primary care provision in deprived areas because of earlier onset of long-term conditions and more complex need, is not met because resource provision is less than in more affluent areas [1,9]

Increased resource allocation may counteract the CORE20PLUS5 conditions in these communities and achieve higher diagnosis rates, earlier diagnosis and support.

2. **Make access to GP services more flexible**

Choice of means of access – in person, online, telephone that allows more flexibility for patients to explain their concern in the way they can best manage.

A timely response to all patient-initiated contact and more flexible triage systems.

Flexibility of appointment times and length with a mix of book-ahead appointments and on-the-day or within two days appointments.

Early diagnosis of conditions, such as cancer and hypertension, can prevent serious consequences and save lives. [11] If it was easier to access GP services fewer people might feel reluctant to go until it is unavoidable and they already have significant illness. This may particularly apply to men [12]

A balance between practice needs and patient populations may be achieved through an effective Patient Participation group (PPG), and dialogue to local communities to understand and then co-produce appropriate access and appointment systems.

3. **Improve listening to address patients' concerns**

Improved listening skills and training for receptionists to counteract stigma and sub-conscious prejudice.

Reception staff are caught between the need to limit demand for GP appointments and facilitating access for patients.

4. Enhance provision and make services responsive to local need?

Improved funding for GP practices working in areas of high need/deprivation to increase provision of appointments.

Continued funding for tailored provision to marginalised communities.

More opportunities for patient-controlled access, such as drop-in, with opportunistic screening. People living in the worst socioeconomic circumstances find it harder to access care [13]. Greater resource and enhanced provision in these areas is likely to increase access to healthcare.

Similarly, services tailored to the particular needs of marginalised groups in the community could provide better for their healthcare needs and reduce levels of ill health [14]. Tailored provision provided in the right places or taken to the individual e.g. the Compass centre, open to all who are homeless, and health visitor provision to the Romany community, travellers, and van dwellers, provided to them where they live and based on established relationships of trust, are good examples of ways of addressing this need. We suggest that these services should be supported and extended.

Drop-in services have a role in care provision, although there is often a long wait. This includes in emergency departments where people are generally assured of being seen.

Learning for future projects

Future engagement visits

What worked well?

We used existing processes that Healthwatch practice i.e.:

- Named contacts at community events.
- Sending flyers in advance of visit
- Preparation of resources before visit i.e. clipboard, pens etc.
- Freebie bags, fobs

What worked less well?

- Time taken for engagement visits i.e. each visit up to 4 hours.
- Time taken in entering data and ensuring all feedback is included i.e. form slightly different.
- Following up non-responders
- The need to collect phone numbers of responders to use at a time convenient to them when we may not be in office.

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   Community Graden Knowle
   St Cuthberts Church Tea Club
   Feed the Homeless
   Hartcliffe and Withywood partnership
   Weston-super-Mare Foodbank
3. The Healthwatch staff team
4. Healthwatch Volunteers that supported our visits.
5. Jemma Ballinger, Healthwatch Volunteer who advised on the feedback form we used based on her lived experience of learning disability

Quality Assurance

This project was co-designed using Healthwatch BNSSG methods, delivered by Healthwatch Volunteers Julie Kell and Cindy Mann. Pre-visit checks included a risk assessment, lead volunteer assignment, and a pre-meeting carried out.

As part of the data validation two runs of the data were analysed before the final complete analysis to identify gaps and ensure correct data entry.

Many of the 'quotes' are not verbatim but are paraphrases of what individuals said that volunteers wrote down while interviewing them. Some are written comments from interviewed individuals entered on the engagement forms.

Limitations:

Our visits were all within 3 areas of the highest deprivation (the CORE 20 population), where there was low ethnic diversity, so there were few ethnic minority voices. We did not speak to some groups that might also experience significant barriers to accessing healthcare, such as refugees, street sex workers, and those in culturally defined minority communities who were most likely to be among the PLUS communities. To do so would have required a significant period of time to build contacts, trust, and relationships within the communities, or a broadening of the agreement to sample from the 20% most deprived areas. This was not possible within our time frame or resources.

Strengths:

We worked with organisations within the communities we visited to ensure our visits were not an unwelcome intrusion. We included food banks and also had input from people with learning disabilities. We interviewed the health visitor working with travellers and van dwellers instead of speaking to them directly, which would probably not have been welcomed or possible.

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Appendices

Appendix 1: Patient Feedback Form; Appendix 2: Chart of feedback listed by provider and public sentiment; Appendix 3: Case studies

To view or download the appendices for this report, please visit www.healthwatchbristol.co.uk/investigating-local-health-inequalities-using-core20plus5-approach-april-2024.

If you require this information in an alternative format, email helen@healthwatchbnssg.co.uk or call 03300 553251.