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Key areas for targeting innovations to tackle health inequalities in the English NHS

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Dr. Sabrina Germain, Dr. Charitini Stavropoulou and Dr. Alexandra Ziemann

Centre for Healthcare Innovation Research, City, University of London

Summary

- The aim of this report is twofold. First, it seeks to synthesise the main **inequalities acting as barriers to access** NHS services for ethnic minority groups, homeless population, traveller communities, individuals with learning disabilities, individuals with autism and individuals with severe mental illness. Second, it aims to identify **amendable factors within the NHS** that could reduce health inequalities in England.
- It is a **scoping exercise to map and synthesize** the most relevant evidence focusing on reports from key national organizations and main academic literature including a scoping search of the Medline database and Google Scholar, handsearching of references and citation search of included studies. The evidence was synthesized using **a narrative synthesis** of the results.
- Inequalities linked to accessing health services cannot be seen in isolation from the **wider socio-economic inequalities** linked to health, **institutional and structural racism** and more recently **COVID-19**.
- Our report finds that the main access barriers to healthcare are common across all six groups investigated in this report. They include: **medical perceptions, language and communications barriers, cultural barriers and stigma, geographical barriers and lack of support, and legal barriers.**
- The main areas of healthcare, where these barriers are experienced are: **primary care (including vaccination and access to GP services), maternal health services, oral health services, palliative care, cancer care, and mental health services.**
- The report concludes by **suggesting innovative solutions** to rectify inequalities in health that are tailored to a vulnerable group's need, but also account for overlapping, intersecting and converging inequalities.
- Due to limited time and resources, a pragmatic approach was followed to identify overarching themes for the six groups, and hence our searches focused on general terms (e.g. "ethic minority groups") rather than subcategories (e.g. "Black minority" or "Asian minority"). We acknowledge this as one of the report's **limitations**.

I. Introduction & methods

Study aims

The study aims to (i) synthesise main inequalities acting as barriers to access NHS services for ethnic minority groups, homeless population, traveller communities, individuals with learning disabilities, individuals with autism and individuals with severe mental illness, and (ii) identify amendable factors within the NHS that could reduce health inequalities in England.

Research methods

Guided by the NHS England's definition of health inequalities, we performed a scoping exercise to map and synthesize the most relevant evidence on health inequalities in England focusing on reports from key national organizations (NHS England, Health Foundation, King's Fund, Nuffield Trust etc.) and main academic literature including a scoping search of the Medline database and Google Scholar, handsearching of references and citation search of included studies. The evidence was synthesised using a narrative synthesis of the results.

The study was conducted by three members of the Centre for Healthcare Innovation Research (CHIR), Dr Charitini Stavropoulou, CHIR Co-Director, Dr Alexandra Ziemann, CHIR Senior Research Fellow, and Dr Sabrina Germain, Senior Lecturer in the School of Law at City University who specialises in inequalities in healthcare.

Structure of the report

The rest of the report is structured as follows. Section II provides an overview of structural inequalities that are linked to health. Although it is beyond the scope of this report to address these issues, inequalities linked to accessing health services cannot be seen in isolation from this wider context. Section III focuses on inequalities in the NHS, summarising the evidence on access barriers for the groups of interest, namely ethnic minority groups, homeless population, traveller communities, individuals with learning disabilities, individuals with autism and individuals with severe mental illnesses. Section IV makes recommendations and concludes noting the importance of adopting an intersectional approach to tackle inequalities with innovation.

II. Structural inequalities

Health inequalities have been widening over the past decades in the UK (Bennett et al., 2021; Scobie and Morris, 2020). A number of reports from leading think-tanks have called for cross-government action (The Health Foundation, 2021; Snelson and Cattoretti, 2020), emphasising the need for economic development in order to reduce inequalities as 'people's health and the economy cannot be viewed independently (The Health Foundation, 2020; Holmes 2021). Although the focus of this report is on access barriers to healthcare services, it is important to understand the wider context of health inequalities.

Socio-economic inequalities linked to health

Relatively disadvantaged individuals are at higher risk of a range of specific causes of illness (Marmot & Allen, 2020).

- *Ethnic minority groups*: Residential segregation is a driver of ethnic differences in socioeconomic status and is associated with lower life expectancy, late diagnosis and inferior survival rates in long-term conditions (Landrine et al., 2017; Raleigh and Holmes, 2021; Bambra et al., 2020). Minority ethnic groups also have greater number of coexisting non-communicable diseases (Bambra et al., 2020). Ethnic minority communities are also more likely to report poorer experiences of using health services than their white counterparts.
- *Health inclusion groups - homeless population*: experience higher rates of premature mortality than the rest of the population are recorded for the homeless population (from suicide and unintentional injuries) and an increased prevalence of mental disorders, and substance misuse (Fazel et al., 2014).
- *Health inclusion groups - Traveller community*: low levels of education, poverty and exclusion are factors that significantly lead to poorer health outcomes in the Roma and traveller community in comparison with other White communities (Smith & Newton, 2017; McFadden et al., 2018; Dixon et al., 2021).
- *Learning disabilities*: those with a learning disability are at higher risk of being exposed to social determinants such as poverty, poor housing conditions, unemployment and disconnectedness increasing their risk of mental illness (Emerson and Baines, 2010). Adults with learning disabilities in supported accommodations tend to have an unbalanced diet making them at a greater risk of developing medical conditions (constipation, poor oral health, gastroesophageal reflux disease, diabetes, obesity and others) (Emerson and Baines, 2010).
- *Severe mental illness:* three-quarters of people with depression and/or anxiety have at least one other physical or mental health long term condition (chronic pain is often associated with depression and anxiety) particularly in living areas of higher socioeconomic deprivation. People with depression and/or anxiety living in these areas are also prescribed more medication and tend not to receive as good care as those in least deprived areas. (Hodgson et al., 2020)

Institutional and structural racism/ discrimination

Institutional barriers that hinder equitable access to healthcare services and that do not account for specific characteristics of ethnic minority and disabled groups perpetuate existing disparities in health outcomes (Stone 2002).

- *Ethnic minority groups*: Exposure to racism and discrimination increases the risk of certain chronic conditions (Danso & Danso, 2021). Psychosocial feelings of subordination or inferiority as a result of occupying a low position stimulate physiological stress responses (raised cortisol levels), which, when prolonged can have long-term adverse effect on physical and mental health. (Bartley, 2016.)
- *Learning disabilities*: more at risk to be subject to overt discrimination affecting their health outcomes (Emerson and Baines, 2010).
- *Traveller community*: report regularly experiencing discrimination and exclusion leading them to treat social institutions (including the NHS) with suspicion and apprehension (Smith & Newton, 2017).

COVID-19

Lockdown and social distancing have increased inequalities in exposure to the virus and inequalities in the social determinants of health. The lower people's income the less likely they are to be in jobs where working from home is possible (Marmot & Allen, 2020).

- *Ethnic minority groups:* Public inquiry has shown that racism, discrimination, stigma and distrust are fundamental factors affecting health and risk exposure to COVID-19 (PHE, 2020). Ethnic differences in mortality involving COVID-19 are also strongly associated with demographic and socio-economic factors (ONS, 2020).
- *Learning Disabilities:* Pre-existing health inequalities and poor outcomes for people with learning disabilities have been exacerbated by the pandemic. People with learning disabilities have a death rate from COVID-19 4.1 times higher than the general population (HC Women and Equality Committee, 2020). Individuals with learning disabilities have been affected by the limited availability of public health communication in British Sign language during the first phase of the pandemic (HC Women and Equality Committee, 2020).
- *Autism*: People with autism have welcomed new modes of delivery, with education, therapy and other services delivered into their own homes through video technologies during the lockdown period. However, moving these services online has also removed the needs of the autistic community from plain sight. Advocacy and research groups are less able to draw attention to crucial issues faced by people with autism (Pellicano & Stears, 2020; Spain et al. 2021). People with autism living in institutional residential communities have been more exposed to the virus because of their living conditions in close proximity of others (Pellicano & Stears, 2020). People with autism living alone without extended support networks have also been particularly at risk of having their mental health deteriorate during long periods of lockdown (den Houting, 2020; Spain et al., 2021).
- *Severe mental illness (SMI):* It is estimated that 10 million in England have additional mental health needs as a direct consequence of the pandemic making mental health issues even more prevalent. People with SMI may face longer waiting lists and have more difficulty accessing services due to backlog in the NHS (Hodgson et al., 2020).

III. Inequalities in the NHS

The five tables that follow, show that the main access barriers to healthcare are common across all six groups investigated in this report. They include: medical perceptions (Table 1), language and communications barriers (Table 2), cultural barriers and stigma (Table 3), geographical barriers and lack of support (Table 4), and legal barriers (Table 5).

Table 1. Medical perceptions

Individuals from Ethnic minority Groups	*Individuals from health inclusion groups (Homeless Population)*	*Individuals from health inclusion groups (Traveller Community)*	*Individuals with a Learning Disability*	*Individuals with Autism*	*Individuals with Severe Mental Illnesses*
▪ Vulnerability to medical prejudices and racist beliefs (e.g. myth that ethnic minorities have a greater ability to cope with pain or an illness; or that they are genetically more prone to develop co-morbidities and chronic illnesses (Danso & Danso, 2021). ▪ Women from the Black and Asian ethnic minority communities may struggle to voice their healthcare needs and have them adequately addressed (e.g. ethnic minority women have more limited access to	▪ Vulnerability to medical prejudices and pejorative attitudes of healthcare professionals towards individuals who are homeless (e.g. homeless often feel judged, disrespected and stigmatised by support staff and medical professionals discouraging them from seeking treatment or following up on the course of a treatment (Csikar et al, 2019; St Mungo, 2018; Gunner et al., 2019)).	▪ Vulnerability to the prejudiced and pejorative attitudes of healthcare professionals towards members of the traveller community (e.g. reports of **GPs registering** Traveller communities as temporary residents which automatically excluded them from a range of health and social care services (Smith & Newton, 2017; McFadden et al., 2018)). ▪ Previous negative experiences with healthcare professionals and perception of being treated as a lower priority have led to low level of engagement with health	▪ Carers tend to perceive individuals with learning disability they care for to be healthier than suggested by the results of medical examination, late access to healthcare services reduces good health outcomes (Emerson and Baines, 2010). ▪ Disablist attitudes among healthcare staff have had people with learning disabilities sick with **cancer** be less likely to be informed of their diagnosis and prognosis, or given pain relief or to receive **palliative care**	▪ Limited training of **primary care** providers on autism spectrum conditions could lead to undiagnosed or misdiagnosed conditions (e.g. individuals may be wrongly classified as neurodiverse rather than as autistic, even though they are not neurotypical (Simpson, 2020; Bradshaw et al., 2019)). ▪ 'Diagnostic overshadowing' where medical professionals assume that autism is the cause of all behaviours or illness and do not seek to explore other factors impacting the health of	▪ Vulnerability to perceived or real discrimination from medical professionals and support networks such as family and community (Dyer et al., 2020; Arundell et al., 2020). ▪ Inappropriate referrals and referral rejections and lack of holistic approach to individuals' health (Arundel et al., 2020) (e.g. individuals often combine mental health condition with long-term illness, but their conditions are looked at in isolation. Half of people with depression also do not

maternal care. Black women are 4 times more likely and Asian women twice more likely to die in pregnancy than White women (MBRRACE-UK, 2020)). ▪ Individuals from ethnic minority communities are under-represented in medical research and clinical trials making conditions that affect them less likely to be addressed. This issue is significantly more problematic for women (Redwood & Gill, 2013).		outreach programmes (Smith & Newton, 2017; McFadden et al., 2018; McFadden et al., 2021). This also partly explains higher prevalence of anxiety and depression and chronic diseases such as diabetes, asthma, cardiovascular disease and hypertension amongst this community (European commission, 2014.)	(Emerson and Baines, 2010; Osborn et al., 2012). ▪ 'Diagnostic overshadowing' where medical professionals assume that a learning disability is the cause of all behaviours and do not seek to explore other factors impacting the health of an individual (Mencap, 2020; Walker, 2014; Redley, 2012).	an autistic individual (Shankar et al., 2020; Brice et al., 2021). ▪ Previous negative experiences with healthcare professionals that confuse autistic conditions with mental illness have led to low levels of engagement with healthcare services (Bradshaw et al., 2019).	have it recognised in **primary care** (Hodgson et al., 2020)).

Table 2. Language & communication barriers

Individuals from Ethnic minority Groups	*Individuals from health inclusion groups (Homeless Population)*	*Individuals from health inclusion groups (Traveller Community)*	*Individuals with a Learning Disability*	*Individuals with Autism*
▪ English as a second language (especially in ethnic minority women) leads to misunderstanding, misdiagnosis and incorrect referrals on the part of medical professionals (Szczepura, 2005). ▪ Low literacy particularly the ability to understand health related materials as fewer than one third of Bangladeshi and Pakistani women can read English and fewer than two thirds of older Bangladeshi and Pakistani men can (Szczepura, 2005). ▪ Digital poverty in ethnic minority and migrant communities increases barriers to accessing healthcare remotely (Germain & Yong, 2020). ▪ Migrant women victims of violence face additional barriers because of their unsafe home environment and their abusive partner whom may make it difficult to seek care in privacy	▪ An increased risk of hearing impairment is associated with isolation as well as higher risk of neurocognitive diseases, potentially affecting the ability of people who are homeless to access care or increase their need for healthcare (Batchelor & Kingsman, 2020). ▪ Illiteracy in the homeless population can cause individuals to postpone or cancel their appointments as they are unable to read and sign consent forms (Csikar et al., 2019). ▪ Lack of awareness of available services (e.g. homeless individuals suffering from learning difficulties find it complex to register for primary care services and are sometimes unaware of their availability (Gunner et al, 2019)).	▪ Conventional methods of health promotion (leaflets and letters) are less effective to communicate with Traveller communities because of their high mobility. This may also limit the reach of outreach services leading the traveller community to rely on informal sources of information for treatments and services and reduced awareness of available resources (Smith & Newton, 2017). ▪ Illiteracy and misunderstanding of medical terminology are significant barriers to healthcare services (e.g. inequality in access to palliative care because of a misunderstanding of the process and fear that these services may not be adequate or tailored to travellers' needs (Dixon et al., 2021; McFadden et al., 2021)). ▪ Lack of access to interpreters in primary care settings which extends to booking appointments and delivery of test results (e.g. language	▪ Mask wearing creates a substantial barrier to healthcare services for individuals communicating through lip-read, British sign language or relying on facial expressions (HC Women and Equality Committee, 2020). ▪ Difficulty to verbally communicate discomfort or pain makes appropriate diagnosis and access to adequate care more challenging, particularly for individuals with learning disabilities that tend to be affected with long term health conditions such as epilepsy or diabetes (Mencap, 2020).	▪ Difficulty accessing and using online or telephone services to make appointments coupled with the fact that individuals with autism may have poor organisational skills prevent access to healthcare services (e.g. modes of communications need to be clear and concise to avoid creating anxiety in individuals with autism (Pellicano & Stears, 2020; Simpson, 2020). ▪ Individuals with autism have sensory sensitivities that affect how they access healthcare services. They may choose to avoid healthcare facilities or have adverse reactions in clinical settings because of their condition (e.g. it is important to consider the physical environment used to deliver care in order to avoid triggering anxiety and confusion in individuals (Simpson, 2020; Shankar et al, 2019; Brice et al., 2021; Bradshaw et al., 2019)). ▪ Individuals with autism are sometimes assisted by family members, friends or caregivers during appointments, which can lead medical professional to not directly engage with these individuals and gain medical history

(Robinson and Spilsbury, 2008).		barriers lead to late diagnosis of cancer in traveller community (Condon et al., 2020)).		through a third party (Bradshaw et al., 2019).

Table 3. Cultural barriers & stigma

Individuals from Ethnic minority Groups	*Individuals from health inclusion groups (Homeless Population)*	*Individuals from health inclusion groups (Traveller Community)*	*Individuals with a Learning Disability*	*Individuals with Severe Mental Illnesses*
▪ Cultural and religious believes around health and wellness can have a significant impact on the willingness of some communities to seek healthcare in the NHS rather than using traditional and alternative medicine (Szczepura, 2005). ▪ Stigma associated with certain lifestyles discourages certain groups within ethnic minority communities to seek preventative healthcare services (e.g. prejudice associated with premarital or non-normative sexual activities affects women's access to contraceptive and sexual education services (APPG, 2020)).	▪ Homeless individual's goal in seeking treatment is most often pain relief and appearance which leads homeless individuals not to complete the full course of treatment (e.g. if pain relief is achieved during a first visit it is unlikely that the individual would follow up to complete the **dental treatment** (Batchelor & Kingsman, 2020)). ▪ Competing medical needs and lack of understanding of treatment, examination and procedures causes individuals to delay their medical visit (e.g. homeless individual experience fear and anxiety at the idea of seeking **dental care** and tend to prioritize other medical needs (Csikar et al., 2019)). ▪ Significant barriers accessing **palliative care** because of co-morbidities (e.g.: some homeless	▪ Traditional gender roles impact women and children's ability to access healthcare services (e.g. priority is given to men for transportation, in case of medical emergency women may be unable to access clinics if men are at work (Smith & Newton, 2017)). ▪ Low uptake in **preventative programmes** due to distrust of medical professionals (e.g. Non-compliance with **vaccination programmes** can reflect the community's desire to stand up to the medical profession. (Smith & Newton, 2017; McFadden et al., 2021)). ▪ Health perceptions and beliefs determine compliance with health programmes and treatments (Dixon et al., 2021) (e.g. traveller mothers perceive their children's health	▪ Individuals with learning disabilities tend to learn about sexual health through informal channels and have difficulty accessing appropriate sexual services. This makes them more likely to contract **sexually transmitted diseases** and have a higher rate of unsafe sexual practices. This can also be partly explained because they tend to be under-presented in research in this area. (Emerson and Baines, 2010).	▪ Cultural believes and stigma associated with mental illness in ethnic minority communities can discourage individuals from seeking medical services (e.g. failure to acknowledge non-physical illness as part of health or fear of harassment after a diagnosis deter individuals from seeking an assessment or treatment (Arundell et al., 2020; Dyer et al., 2020)). ▪ According to some studies, Black ethnic minority communities' lack of disease awareness in the area of mental health has individuals delay or avoid healthcare visits (Arundell et al., 2020). ▪ M**istrust of mental health** services due to negative experiences deter individuals

	individuals are unable to remain in hospice care because of substance abuse issues leading them to have behaviour deemed disruptive by staff. They are therefore unable to receive **end of life treatments** in this setting for conditions such as **cancer** (NHS England, 2018)).	as precarious making them reluctant to cause them further pain with **vaccination** (Smith & Newton, 2017)).		from seeking care (Dyer et al., 2020).

Table 4. Geographical barriers & lack of support

Individuals from Ethnic minority Groups	*Individuals from health inclusion groups (Homeless Population)*	*Individuals from health inclusion groups (Traveller Community)*	*Individuals with a Learning Disability*	*Individuals with Severe Mental Illnesses*
▪ As they are not required by the majority of the population, there is a poor or limited provision of specialised care for diseases affecting ethnic minority groups (e.g. haemoglobinopathies (sickle cell disease)) treatment is limited or not available in certain areas (Szczepura, 2005).	▪ Unpredictable lifestyles, lack of access to transport and not having a fixed address impair ability to engage with **primary care services** (e.g. rough sleepers have the lowest rate of access to GP services (Elwell-Sutton et al., 2016; Gunner et al., 2019)). ▪ Lack of appropriate point of contact (e.g. difficulty locating **NHS dental service**, securing an appointment and making the appointment on time are challenges faced by homeless individuals (Csikar et al., 2019)). ▪ Difficult access to **secondary care services for rough sleepers** (e.g. complex healthcare needs and difficult access to **mental health service** because of comorbidities (mental health	▪ As treatments are not always locally available, high mobility communities may lose access to certain treatments when relocating (Szczepura, 2005). ▪ Health service delivery, services developed for sedentary populations are maladapted to traveller community's needs (e.g. camp site are far removed from **vaccination** clinics (Smith & Newton, 2017).	▪ There are variations across areas of England and NHS Trusts in the expenditure dedicated to services for people with learning disabilities. There are also significantly less resources dedicated to NHS Trusts in **rural areas** (Emerson and Baines, 2010).	▪ Difficulties getting to appointments (e.g. transport barriers, access to buildings and limited availability for appointments) or contacting healthcare providers creates significant barriers to **accessing mental health** services (Arundel et al., 2020).

	issue and substance abuse) (St Mungo, 2018)).			

Table 5. Legal barriers

Individuals from Ethnic minority Groups	*Individuals from health inclusion groups (Homeless Population)*	*Individuals from health inclusion groups (Traveller Community)*	*Individuals with a Learning Disability*
▪ Ethnic minority migrants face legal and financial barriers in accessing the NHS because of the immigration healthcare surcharge imposed on non-residents (Jayaweeera, 2010).	▪ Failure to meet residency requirement to access NHS services and other related services (e.g. absence of a permanent address and other formal requirements impair ability to access services, such as **primary care services, community pharmacy, dental and optical services** which leads homeless individuals to make use of emergency services to receive care (Batchelor and Kingsland, 2020; Elwell-Sutton et al., 2016; Gunner et al., 2019)).	▪ Medical professionals have denied access to care to members of the traveller community on the basis that they did not have a permanent address (e.g. access to dental services) (Smith & Newton, 2017; McFadden et al., 2018). ▪ Legal eviction for unauthorised occupancy of a site disrupts continuous provision of care (e.g. appointments have to be rebooked regularly in different location and may become unavailable (Smith & Newton, 2017)).	▪ Some healthcare institutions fail to comply with equality legislation protecting the rights of individuals with learning disabilities (Mencap, 2007; Ombudsman, 2009; Redley et al., 2012).

IV. Recommendations to tackle inequalities in the NHS

Innovative solutions to rectify inequalities in health should be tailored to a vulnerable group's need, but should also account for overlapping, intersecting and converging inequalities. Interventions to tackle inequalities in health should focus on how ethnicity, gender, sexuality, disability, socio-economic and legal status often work together and interact with each other to influence individuals' health status.

For instance, minority race may aggravate one's vulnerability and ability to access care, and this ability may be even more greatly reduced by gender or disability. Women from ethnic minority backgrounds because of various factors such as domestic violence, social stigma or lack of income may find it harder to access services than their White or male counterparts. People with learning disabilities from minority ethnic communities may also face greater health inequalities than people with learning disabilities from White British communities or ethnic minority individuals that do not have a learning disability (Emerson and Baines, 2010).

Below we suggest a number of areas of healthcare where the literature reviewed for section III suggests may reduce barriers to accessing health care services:

Primary Care (and aspects of Public Health)

Access barriers to primary care were common across all six groups. A few examples where interventions could address these barriers included:

- Developing single appointment for treatment and consultation for homeless population to address complex health issues (i.e. combination of co-morbidities: poor mental health, substance abuse, long term illness) with a more integrated and holistic approach to healthcare (Gunner et al., 2019).
- Outreach programmes that aim to bring services directly to people who are sleeping rough and can provide direct healthcare where possible. Standards published by the Faculty for Homeless and Inclusion Health (2018) state that specialist primary care services should provide street outreach.
- Carefully considering remote consultations, that became increasingly common during COVID-19 as they can pose barriers to ethnic minority and migrant communities who face digital poverty (Germain & Yong, 2020).
- Working with all relevant bodies including faith and community groups to identify effective channels to disseminate information and provide support to local authorities to deliver it on the ground and to improve trust to the medical profession (Szczepura, 2005).
- Improving support to carers of individuals with learning disabilities (Emerson and Baines, 2010).
- Improving GP practice registration of Traveller communities (Smith & Newton, 2017; McFadden et al., 2018) and homeless population (Gunner et al., 2019).
- Improve cancer diagnosis of individuals with learning disabilities at the primary care level (Emerson and Baines, 2020)

Maternity Services and Early Years' Health

- Improving maternity services for ethnic minority groups (MBRRACE UK, 2020), particularly antenatal interventions for BAME pregnant women at high risk of poor birth outcomes where evidence shows there is currently lack of rigorous interventions (Garcia et al., 2015).
- Investing in maternity and early years' health services for traveller communities is key in enhancing their trust to health services more generally (McFadden et al., 2018).
- Targeting immunisation programmes are needed for: traveller communities, who face geographical barriers (Smith & Newton, 2017); ethnic minority groups who may non-comply with vaccination programmes due to mistrust in the medical profession (Smith & Newton, 2017; McFadden et al., 2021) or stigma (APPG, 2020).
    - E.g. Outreach programmes by the same health visitor to travelling community sites has been proven effecting in improving MMR immunisation rates among these communities and building trust (Smith and Newton, 2017).

Oral Health Services

- Deployment of walk in general and dental practices clinic for Traveller communities (including but not limited to traveller community and homeless population) and making it easier to register with dentists (McFadden et al, 2018).

Palliative Care

- Improving traveller bereavement care or advice services that would act as a liaison between healthcare professionals and individuals and families (Dixon et al., 2021).
- Supporting homeless population access palliative care and receive end of life treatment (NHS England, 2018).

Mental Health Services

- Re-establish NHS health checks for people with disabilities (that had been suspended during the pandemic) to better identify and address unrecognised health needs.
- Develop programmes to reduce mistrust of mental health services among individuals with severe mental illness (Arundel et al., 2020).

Limitations

The report is not without limitations, mainly due to a limited timeframe the team had to work on a broad topic. First, this is not a systematic review of the literature, which means that the papers identified are not an exhaustive list of studies on the topic. Second, the focus was narrowed down to barriers to access, as dealing with outcomes and experiences would have required significantly more time and a different search strategy. Yet, and given that outcomes and experiences are ultimately highly related to barriers to access, wherever possible, we highlighted findings relevant to these two areas. Third, certain groups were treated as one when in fact they are not homogenous. This is particularly the case for ethnic minority communities, where different groups within this category, such as Asian and Black communities, have different characteristics and may face different barriers to healthcare access. Due to limited time and resources, a pragmatic approach was followed, that aimed to identify overarching themes. A separate study only on ethnic minority groups would be needed.

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