

Accessing Healthcare in Cambridge

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“There are many amazing individuals providing excellent care yet we are all struggling to provide the best service we can under very difficult circumstances.”

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Moreland

Access to Healthcare in Cambridge

In December 2021, the Department for Levelling Up, Housing and Communities granted £22.5 million to areas with low vaccine uptake. The Cambridge City Council commissioned CCVS to co-design and manage a community engagement scheme to provide neutral and safe spaces for people to discuss their feelings on the vaccines and to make sense of the pandemic. Over the course of this programme, it became more and more apparent that low vaccine uptake was linked to barriers to health access – from needing childcare to attend an appointment to being physically unable to access a vaccination centre. In the final stage of the programme, the City Council commissioned this research to investigate the extent of health inequalities in Cambridge. The aim was to map local communities to understand what the issues were with local access to health services. There is no doubt that the pandemic exacerbated barriers to accessing health care across the United Kingdom. However, the pandemic did not create these health inequalities.

The aim of this research was to “increase opportunities for health equality in Cambridge so that more people enjoy a good quality of life and can access better healthcare choices that are right for them”. Across the roll out of the survey, the CCVS Engagement team and trained CECF Health Champions aimed to provide opportunities for community members to share their experience of access to healthcare in Cambridge. One of the challenges outlined by the Parliamentary Office of Science and Technology (POST) was better representing ethnic minority communities and vulnerable/marginalised groups in research and policymaking to ensure a stronger evidence base on which we measure the extent and effect of health inequalities. We wanted to engage “seldom heard groups” who are often underrepresented in this type of research and less likely to be heard by decision makers. This includes (but is not limited to): particular ethnic minority groups, people with disabilities, refugees and asylum seekers, members of the LGBT+ community, people who are homeless, people with language barriers. Working across the CCVS Engagement Team and the CECF Health Champions network, we used community spaces and buildings to engage seldom heard groups with our research survey. The research may contain similarities and overlaps with other studies collecting health data in the city, such as the comprehensive work of Healthwatch Cambridgeshire on health inequalities in South Cambridgeshire. We will present the key themes from our research and recommendations to improve access for the ICS.

Background information on health inequalities

The King’s Fund defines health inequalities as “avoidable, unfair and systematic differences in health outcomes between different groups of people”. These differences can be observed across various aspects of health, such as life expectancy, access to healthcare services, quality of care, and behavioural risks to health. Health inequalities are caused by a combination of factors, including environmental factors, social and economic determinants (quality of housing), policymaking, and access to and quality/experience of your care (how available the service is to you).

Research has shown that factors such as gender identity, ethnicity, location, age, disability and income can impact someone’s ability to access healthcare services, life expectancy and the chance of experiencing significant health issues during their lifetime. For example, the Institute of Health Equity’s ‘Fuel poverty, cold homes and health inequalities in the UK’ found that with 55% UK households ‘forecast to fall into fuel poverty by January 2023’, households ‘with children ... those on low incomes, living with disabilities, and Black and minority ethnic groups’ would be most at risk from greater damage to their health. These factors can impact every level of access, from

communicating with your GP receptionist to book an appointment to accessing physical buildings to being subjected to institutional biases and discrimination. Therefore, addressing health inequalities and working towards equal access and treatment for all is crucial to promoting health and wellbeing. This requires a comprehensive approach that tackles the root causes of health inequalities, including social, economic, and environmental factors, and ensures that healthcare services are accessible and of high quality for all.

In the '10 Years On' report, the Marmot review found that health inequalities were increasing since their first review in 2010 and that 'the country has been moving in the wrong direction'. In their 10-year review, they recommend engaging the public in the matter of preventing and reducing health inequalities. 2023 is an important time of change for the NHS, with the formation of the new Integrated Care Systems, which came into effect from the 1 July 2022. These systems are 'geographically based partnerships' that work to bring together organisations 'that meet health and care needs, improve population health and reduce inequalities'. The ICS works with VCSE organisation, local authorities, NHS providers and professional bodies to bring organisations closer together and ensure that organisations can communicate with one another. Addressing and reducing these inequalities is a priority for the Cambridgeshire and Peterborough ICS and is 'our core ambition, that will run through everything we do'. Their Health Inequalities strategy promises 'a system-wide approach to addressing health inequalities', 'needs-based commissioning' to address inequalities and to tackle inequalities 'in cardiovascular disease through targeted action on hypertension and diabetes'.

Health inequalities in Cambridge

The Vaccine Access Partnership was initiated to address Cambridge's low vaccine uptake of the Covid-19 vaccinations. The Cambs Youth Panel research survey on young people's attitudes towards vaccinations highlighted that there was a lack of accessible information on vaccines available to young people and that young people had difficulties accessing Covid-19 vaccine appointments. This example is a snapshot of the wider problem – young people having difficulty accessing vaccine appointments because of a lack of information available to their age range demonstrates health inequity based on age. Whilst this specific research was on Covid-19 vaccinations, it pertains to wider discourse on health inequalities. It is clear that there are significant disparities in health outcomes across Cambridge depending on a person's socio-economic circumstances, environmental factors and factors of identity. Public Health England's local authority health profile places Cambridge in the worst to 25th percentile for inequality in life expectancy at birth for both female and male populations. The life expectancy is '11.6 years lower for men and 11.6 for women in the most deprived areas of Cambridge than in the least deprived areas'. Healthwatch Cambridgeshire explored the extent of health inequalities across Cambridgeshire and solutions co-designed by local communities. In their latest release, their volunteer Health Champions identified a number of barriers through community focus groups. Barriers identified include poor communication on available health support; the rising cost of living which impacts environmental and socio-economic factors such as housing, diet, transport; digital exclusion which prevents people from using online services; a lack of public transport in rural locations across Cambridgeshire and a lack of suitable housing for those who are homeless or members of the Gypsy/Roma/Traveller community.

Methodology

This work on health inequalities was guided by the founding principles of the Vaccine Access Programme. We designed a broad survey that would allow participants to explore their experience over the past year and bring what they felt comfortable sharing. We wanted to capture how they perceived healthcare services around them and as a part of their day-to-day life. The survey captured positive and negative experiences with healthcare services and tried to gauge how comfortable each person felt with their experience and with accessing healthcare services. The survey gave participants spaces to record any experience with any healthcare service over the past year, with healthcare communication, their experience with any vaccination service and finally, a space for them to share changes that they would like to see/changes that would make services more accessible to them. There are clear similarities to be drawn across research completed by organisations such as Healthwatch and the merits of “listening” and taking community-led approaches are clear. Through engaging communities and voluntary organisations across Cambridge, this research aimed to bring together different yet similar experiences of healthcare to help the new ICS/ICB understand the needs of communities.

Draft versions of the survey were piloted at the Senior’s Winter Fair in December 2022. We used feedback from this event to make changes to the question format and added additional responses to questions on how the general public booked their vaccinations. The draft surveys were also shared with members of the Vaccine Access Partnership for feedback.

We released the survey online at the start of January 2023. To reach “seldom heard groups” The CCVS Engagement team and CECF Health Champions worked with several organisations throughout Cambridge, attending community events and running art and wellbeing workshops to engage these communities with our research. For example, art sessions were held for family groups to begin discussion on what it was like to engage with services across 2021/22. We engaged with a large variety of groups, speaking to those who are homeless, people whose first language is not English and to young people. In total, we received 219 individual responses and 12 responses from Voluntary, Community and Social Enterprise (VCSE) organisations.

Across the wider Vaccine Access Partnership programme, we held 102 engagement opportunities, ranging from community projects, hosted events, pop-up stands and time capsule workshops. We recorded 4050 engagements throughout the project and held 6 training sessions with 96 participants trained in making every contact count, community engagement and cultural awareness.

Our approach was limited by time. We devised our surveys from November to December 2022 and rollout occurred over January to February 2023. Drawing the results together and configuring this report took place over a mere two weeks. Our approach is also limited by its generality needed to suit the many different communities that we wanted to engage. Our survey rollout took place between January 2023 and ended in the middle of February. The results were mostly qualitative and varied – we have identified common themes and trends across the results, separated into responses from residents and responses from organisations. The themes this report discusses are: comfort accessing care; waiting times; continuity of care; the structure of services; minorities and intersectionality; comfort accessing information and vaccinations.

We chose to avoid medical/administrative jargon in the survey but do recognise that this can hinder the level of specificity in response. We sought to remedy this with our participatory approach – our community engagement workers and CECF’s Health Champions used the survey to engage

participants in conversation. The focus was more on building trust across communities, adapting our questioning style to suit the needs of the different groups and people we encountered and to encourage conversations about health and wellbeing. The findings are not rigorous; we have included a recommended reading list at the end of this report if you would like to learn more about ongoing health inequalities research taking place in Cambridgeshire.

It is important to note the crossovers in people's experience – people will experience a different combination of factors depending on their circumstances. Recognising the intersectional nature of experience is important to understanding the level of health inequity for certain communities.

Ethical considerations

Participants were informed of how their data would be used, collected and stored. They were aware that participation in the survey research was voluntary. Research was anonymous and participants were aware that they would not be identified in the research.

Findings from the Survey

The result of the survey has been summarized in two folds; residents' responses and organizations responses.

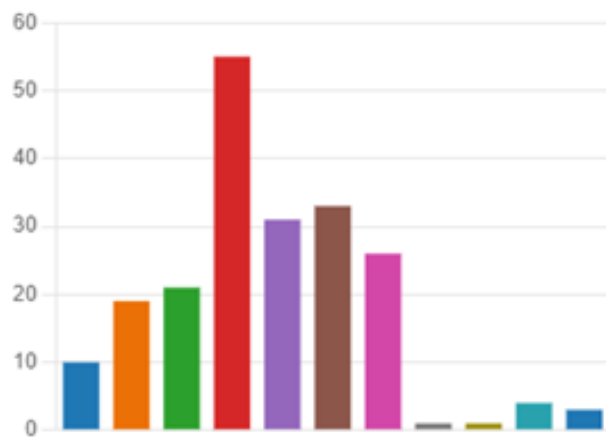
Residents' Responses

The residents survey captured a cross section of demographics including age, ethnic groups, sexual orientation, and disability information. The age range of the respondents is captured in the chart below. Majority of the survey's respondents were middle-aged, and a sizeable number were over 60s.

. What is your age group?

[More Details](#)

Under 18	10
18 to 24	19
25 to 34	21
35 to 44	55
45 to 54	31
55 to 64	33
65 and 74	26
75 and 84	1
85 and over	1
Prefer not to say	4
Other	3



Looking at the distribution of the survey respondents by gender, the survey had 65% respondents who identified as female, 33% as male, and the remaining 2% preferred not to say. However, 3% of the respondents have said that their current gender identity is not the same as the one assigned at birth.

. How do you identify your gender?

[More Details](#)

Male	66
Female	132
Non-binary	1
Other	0
Prefer not to say	4



. Is your gender identity the same as the gender you were assigned at birth?

[More Details](#)

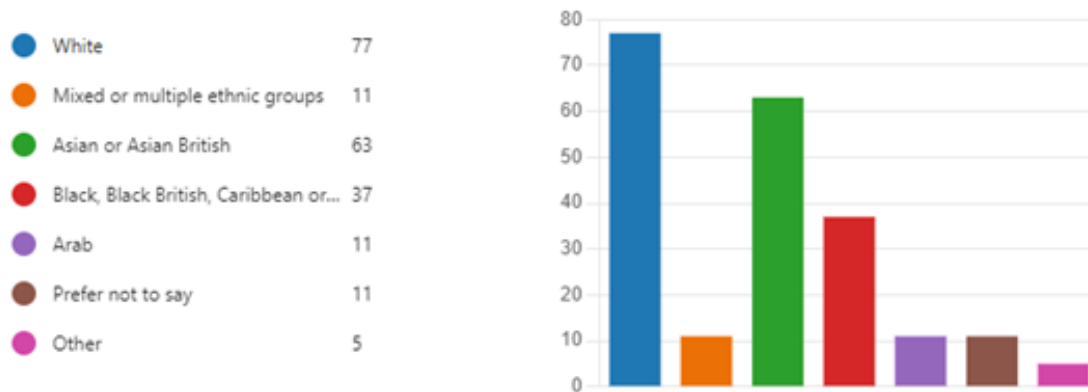
Yes	190
No	6
Prefer not to say	5



The graph below shows the distribution of the survey respondents by ethnic group revealing that there was a mix of ethnicities represented in the survey.

. What is your ethnic group?

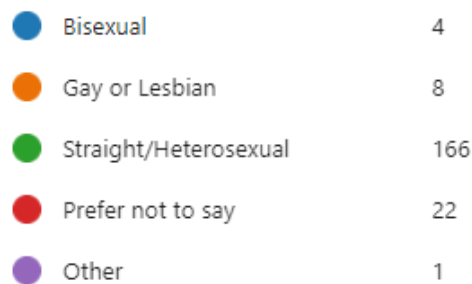
[More Details](#)



When looking at the sexual orientation, 83% of respondents identified as heterosexual whereas 6% identified as LGBTQ+.

. What is your sexuality?

[More Details](#)



Additionally, 18% of the respondents identify as having a disability of some sort, with varying levels of limitations to daily activities and 13% of respondents have caring responsibilities.

4. Do you consider yourself to be disabled?

[More Details](#)

● Yes, day to day activities limited ...	10
● Yes, day to day activities limited ...	26
● No	151
● Prefer not to say	11



5. Do you provide unpaid care or support for a family member of friend?

[More Details](#)

● Yes	20
● No	100
● Prefer not to say	30



Access and Challenges

The respondents to this survey reported using health services such as GP services, prescriptions pick up, etc. The word cloud below shows the different services used by the respondents; GP surgeries and hospitals were the most listed in the responses leading to the texts for both words being bolder.



Comfort with Accessing Services

The survey sought to understand the varying challenges that residents faced in accessing healthcare. From the results, 45% of respondents reported experiencing issues while accessing health services in Cambridge.

Have you had any issues with accessing these services?

[More Details](#)

● Yes	94
● No	116



Only 34% of residents felt very comfortable using these services, the rest experienced varying levels of comfort with 24% responding at the lower spectrum of being somewhat uncomfortable and very uncomfortable.

How comfortable did you feel accessing these services?

[More Details](#)

Very comfortable	73
Somewhat comfortable	58
Neither comfortable nor uncom...	31
Somewhat uncomfortable	31
Very uncomfortable	22



Some of the themes that came out under ease of access include waiting times, continuity of care, structure of the service, communication and the intersectionality with minority groups.

Waiting times:

There were varying levels of experiences with using health services, including people who shared that waiting times were too long. This involved how long it took people to get to reception on a phone call, waiting times to get a call back from the doctor, difficulty getting a hospital appointment, and waiting lists for scans. While these seemed to be working smoothly for several respondents depending on their unique circumstances, some respondents reported waiting for long to get access to some of these services.

“GP appointments - rarely get through and appointments are never at convenient times, just told the GP will call in the morning or afternoon (difficult when you work full time and can't take random breaks) and if you miss the call by being in a meeting they don't bother calling back. Once you have spoken to a GP and they are due to follow up, they don't bother. Attending a specific health clinic - adult neurodivergent diagnostic services are basically non-existent. Been waiting 4 years for autism diagnosis referral and 8 months for ADHD diagnosis”.

It was also reported that immigrant population might face harder integration into the healthcare system and difficulty getting medication for diseases that had previously been diagnosed abroad, this is captured by one of the respondents when they said;

“I have prescription from overseas that were urgently prescribed so when I asked for them to be dispatched here, it took very long time and had to go back to my physician / in the UAE to have it prescribed”.

For some patients who have experienced long waiting times, the problem was exacerbated by concurrent risk of misdiagnosis for serious ailments making them lose time to start life-saving treatment, a case study has been reported by a correspondent as captured below;

“Requested an appointment with GP and only telephone appointment offered. Told the GP had palpitations for no reason and shortness of breath when going up the stairs (did not have this problem before). Had blood test and was told everything was normal. 2 months later I was admitted into hospital, after waiting all night at A&E. At hospital I was told I have inflammation of the heart.”

Another respondent reported misdiagnosis of a potential terminal illness and then getting a different diagnosis after a 6-week delay:

“3 months ago, I had stomach pain and went to hospital few times, until I ended up in A&E because of the pain. After some tests, I was told it may be cancer. I am very worried as I am a single mother. I was told the GP would call me in 4 or 5 days with the results. The GP told me to go to the hospital for the results and when I went to the hospital, they said to go the GP for the result. After 6 weeks, I was seen by 2 GPs and was told I don't have cancer, but a cyst, which I'm taking medication for.”

Continuity of Care:

One of the central themes that emerged from the survey was around continuity of care. Several respondents reported having varying levels of disruption in their care for several reasons ranging from moving locations to constant changing of their doctors. A significant number of the survey's respondents commented on the use of locum and part time doctors that kept moving away. Residents have spoken about seeing a different doctor every time they went into the surgery and having to tell the doctor their health issues repeatedly which put a strain on the patient. Two experiences stick out for the responses as quoted below:

“I would like to see my regular doctor more often, I feel that she is always busy and ...I am scared to see locum doctors because they don't know my health properly and they delay process like scans and blood test.”

“Not very good experience. I did not get the help I needed for my mental health problem. I have depression and anxiety and it got worse due to some family events. I had to call my surgery few times in order to get an appointment. I had to go 3 times because of bad side effects of the antidepressants. Every time I went, I saw a different doctor, so I had to explain everything again. There is no continuity of care”

An issue that arises in connection with this is that patients seemed to be losing connections with their health service providers when they made small geographical moves across the city, and a respondent highlighted how this affected continuity of care.

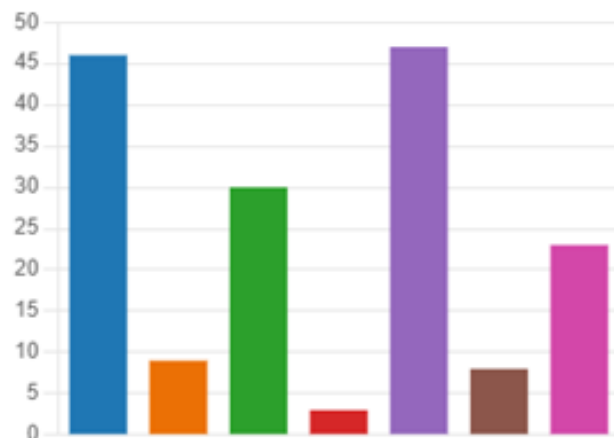
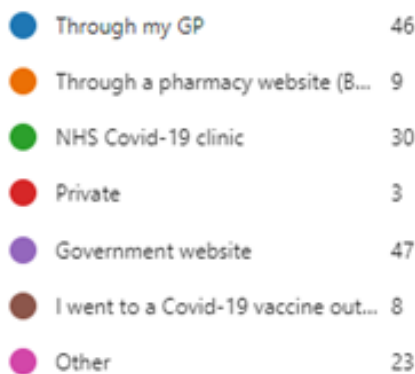
“I moved from one part of Cambridge to another and was taken off my previous surgery because I don't live in the area anymore. The nearest surgery to my house is full, so I have to register further away from home. The new GPs are not as good as my previous one, I have been 3 times and seen 3 different doctors. I feel as I am a nuisance because I have different health problems.”

Structure:

Another important theme that came out of this survey was around the structure of healthcare services and how that related to accessibility. We collected data on vaccinations, and the results show that a lot more people booked their vaccinations through their GP and the government website.

. How did you book your vaccination?

[More Details](#)



The majority of respondents felt the COVID-19 vaccination service was efficient and hitch-free. A number of respondents report being contacted by their GP and offered the vaccine, while others went to a walk-in centre, and yet others booked an appointment on the website. Some access issues identified included the use of face mask by vaccine staff which hindered appropriate communication for hearing-impaired people as reported by this respondent.

“As it was online I was fine. On site, it depends, most people would be willing to take off mask so I could lip read and communicate. One person refused and I acted like I was ok with it but I wasn't”

The use of relay interpreters seemed to have been effective at the start of the lockdown but the service was reported to have dwindled as they lost government funding, compelling deaf users to pay for it themselves if they wanted to keep using the services to call GPs or book hospital appointments. These became expensive if you had to wait long on the phone for the call to be answered.

“So you go to sign live, put your login details, then you put your phone number and you’ll have someone come onto the video and you can sign to them. They will then call the health professional on your behalf and help with the communication so you can book your appointment. You can be 15 minutes in the queue and it’s expensive. The council won’t fund it for me so I have to privately pay, it starts at 60 minutes and you can add to it, it’s something like £45 for 60 minutes, it’s crazy expensive.”

Some deaf patients are left with the option of relying on family and friends to interpret their needs.

“Not a problem but had to bring daughter in-law to interpret for me as I’m deaf. Without the daughter it would be impossible. The nurses were very nice but I have to work hard and be patient to get a good relationship”

An observation was made about the structure of some services being rendered and how they may be set up in ways that deter people from engaging with those services. This was especially seen in the areas of mental health services where a respondent had this to say.

“Although when I tried counselling, I found it too formal. I didn't like the chair facing me straight on. It felt too intense. I find it easier to talk about my feelings in more relaxed environment. I also don’t like that professionals are in a higher chair - like they have more power.”

Communication and the Intersectionality with Minority Groups:

This survey was representative of the diversity that exists in Cambridge as 35% of respondents identified as white and over 50% being from predominantly non-white backgrounds. A theme that came out of this survey was the impact of language barrier on equitable access to healthcare thus implying that current provisions may not be representative of minorities especially those that do not have English as their first language.

Generally, 29% of respondents reported having discomfort with accessing health information while 36% found it easy and there were several ranges of comfort and discomfort levels in between.

How comfortable do you feel accessing communication from healthcare services?

[More Details](#)

Very comfortable	76
Somewhat comfortable	63
Neither comfortable nor uncom...	35
Somewhat uncomfortable	19
Very uncomfortable	21



The results have shown that several respondents were happy with emails, text messages and chats because it allowed them to receive information on the go. However, there are several hiccups that have prevented other residents from being able to fully access healthcare information and language barrier contributed to a significant part of this difficulty. Several respondents have reported varying issues related to language barriers while accessing healthcare services. One such issue that stands out is captured in this quote.

“There are times somethings I want to show the GP, and not able to explain in English as English is not my first language”

and this is especially exacerbated in families where there are several non-English speakers or people with varying levels of barriers to accessing health communication apparatus as in the case of a respondent who said:

“Telephone appointments were not suitable for me because my English is not good. I was told to request my medication online, this was difficult because I am not confident with English language and not good at internet. At the hospital, I was told to ask for repeat prescription at the GP and the GP said to do it online. My teen daughter could not do it.”

This language barrier also raises issues of privacy when non-English speakers have to depend on relatives to relay their symptoms to the doctors which means telling relatives about their health issues that they would rather not disclose as a worried respondent says:

“They require phone calls and so I have to ask someone in my family to describe my symptoms or how I feel. I don’t always want to have to share that and sometimes they don’t say exactly what I want to say”.

Whereas some patients with a language barrier are at least able to get some respite by bringing their own interpreters, some others have reported not getting the opportunity to do so.

“My English is not very good and I took my friend with me to a hospital appointment to translate for me. The security officer didn't let my friend in and pushed her away. I insisted that I needed an interpreter and requested a telephone one, but the doctor said no.”

This intersectionality extends to sexuality and how people who identify as LGBTQ+ may experience challenges. A respondent spotlighted how current service offering may affect LGBTQ+ patients.

“Needing a referral from my GP to access gender services is hard because I don't know my practice's attitude towards trans people and don't feel I have a doctor I trust.”

Other areas of intersectional are seen in how existing healthcare structure for service delivery and the way that communication is done through those structures may impact health and wellbeing, especially mental health. There have been conversations raised around long waiting times for phone calls from doctors and how this already creates a pensive atmosphere for patients waiting to speak to a doctor or be scheduled for an appointment. Some of these phone calls come through anonymous numbers and respondents have reported heightened levels of anxiety as seen in the quote below;

“I don't like when they call from anonymous phones. It makes me anxious because I don't know who is calling.”

As mentioned earlier, the hearing impaired have been highly impacted by some of structural issues within healthcare and lack of proper communication had an impact on how people who were deaf and hard of hearing were able to access COVID-19 information and keep themselves safe. A carer for a deaf man reports that he thought COVID-19 was related to a stomach bug and associated with a shortage of toilet paper, so he believed that if he did not experience a stomach ache then he did not have COVID-19 in spite of other symptoms.

Again, the structure of communication has a huge weighting on people of different religious backgrounds as reported by this respondent who identified as Muslim.

“It was a very stressful experience, the GP passed on my application for a ultrasound scans to the hospital but the hospital will not give me an appointment, too busy and wanted to send me to 3rd party scan. But the 3rd party scan department does not have female staff to do the scan they wanted me to go and have a virginal ladies scan with a male technician

scanner. When I requested for a female staff they said there would be a wait for 3 to 4 months for to see a female. I am a Muslim woman I felt very upset this is not acceptable”

This is similar to what has been reported by Healthwatch where people spoke about struggling with getting interpreters and often relying on family and friends to navigate healthcare, and some people not feeling comfortable relaying sensitive issues through interpreters. Other related issues raised there include discriminatory treatment that people whose first language is not English faced within healthcare environments which ranged from being ignored to being treated differently based on pre-existing stereotypes.

Organizations’ Responses

We collected the opinions of organizations providing health services in different capacities within the city. We had responses from 13 organizations including voluntary, community, social enterprise (VCSE) sector and healthcare organizations. We held a focus group with one organisation that supported young people. The results show that the majority of the organizations were concerned about the state of health inequality, with 50% of respondents being “very concerned”. Some of the issues that have been reported by residents were also echoed by these organizations. The structure of current service provisions has left many struggling as summarized by this organization.

“Not enough services (eg maternal mental health, breastfeeding and tongue tie support). Travel to services (not enough localised clinics). Continuity of care not in place. Language barriers to accessing care. Young parents are not always treated respectfully, especially young fathers. Disjointed services. Lack of appropriate 6-week postnatal checkup in some areas. Difficulties in records access between services and Trusts”

The themes of protracted waiting times, language barriers, difficulty for new residents to integrate into the system and receive much needed care came out strongly in the response given by several organizations, one such response is quoted below.

“In common with others arriving in Cambridge, it is virtually impossible for our beneficiaries to access dental care. New arrivals since 2020 have found the situation has substantially worsened and no NHS dentists are accepting new patients. Refugees who have spent years in camps often arrive with acute dental problems, in pain and with impacts on their general health and mental welfare. Their needs are not being met. GP appointments have also become more difficult to access since the end of lockdown, with long wait times. There is rarely any translation service offered for non-English-speaking patients. People we support were advised to wait until their condition was critical and present at A & E.”

These barriers have varying levels of impact on the health of services users.

“We are concerned that some individuals are not being diagnosed at an early stage that may have potentially life-threatening conditions because of the barriers we have listed. Other patients are not following up on appointments or treatments. Some are not able to navigate the system at all and others are being completely excluded.”

Young people also face unique barriers to accessing healthcare services, particularly mental health services. For young carers, they also face the dual responsibility of safeguarding their own health and the health of those they are caring for. Adolescents reported being likely to face infantilisation and fear that they will not be taken seriously by doctors:

“We’ve got young people who are caring for other people, who are caring for young siblings, who’ve got anxieties and worries about other members of their family ... if a teenager goes forward, they’re not seen and they’re not given parity in what they’re bringing”

For young people, it is daunting to continually reach out to doctors and support services to then not feel listened to or heard.

What VCSE organisations are concerned about:

- Support capacity is limited - ‘negative experience then leading to non-attendance in the future’
- “Some clients report that they have simply given up trying to get help
- Growing demand = ‘increased difficulty to access’ - ‘greater investment into prevention and early intervention’
- Limited capacity means hostility will be levelled at those who have done nothing wrong I.e., refugees
- Survivors do not have primary healthcare needs met as they are solely seen as survivors; Overdiagnosis of BPD; experience of women from black and racially minoritized communities – more likely to have physical health symptoms put down to mental health response; medical models can be silencing for survivors; victim blaming as a systematic problem.
- No dentist provision.
- Young people face long waiting times for health services and some report being discharged from children’s services at 16, to then have to wait months to be seen by adult services.

The need for trauma-informed care across all levels of the health service

Two Cambridge-based organisations shared the need to build trauma-informed practice across health services, so that survivors of abuse and/or sexual violence receive proper support. The burden often falls on the voluntary sector to provide specialist support for often complex trauma. Organisation A experienced an 183% increase in the need for their support services during the pandemic. Organisation B, a counselling service for survivors of abuse, have a long waiting list and there is 'little scope for onward referral'. Survivors of sexual violence experienced the impacts of trauma, often heightened by lockdown and isolation and a lack of access to positive coping strategies. Whilst the support services offered by voluntary organisations are excellent, more can be done within the NHS to ensure that survivors receive the best healthcare and to relieve the burden of care from these organisations. B noted that 'many clients report being pushed around a system that is not meeting their needs' when referring to client's experiences through NHS mental health service referrals.

The label of 'survivor' often leads to the gatekeeping of NHS mental health services. Some survivors reported being discharged from IAPT talking therapies if they disclosed that they were a survivor and instead referred to Organisation A, a voluntary service. Whilst Organisation A is a local specialist service, survivors living with trauma should have full access to NHS services. Survivors of abuse and sexual violence will also experience barriers accessing other health services. For example, smear tests and accessing pregnancy clinics can be traumatic for survivors. Reproductive care can feel intrusive for survivors. Offering training to healthcare professionals on trauma-informed care and breaking the silence on supporting survivors could be helpful for ensuring that practices are welcoming towards the needs of survivors. The intersectionality of survivor identities is important to recognise as some survivors will experience a larger number of barriers to support than others – for example, women from black and racially minoritised communities are more likely to have other physical health symptoms related to other health issues put down to a mental health response and their pain is likely to be diminished resulting from institutional racism and racist bias. There is a systemic problem with disbelief and victim blaming which minimises the impacts and realities of abuse and sexual violence for survivors.

There are clear disparities between support available for survivors of very recent sexual violence opposed to the support available for survivors of historic sexual violence. Survivors of very recent sexual violence can access a SARC centre within 72 hours of the abuse occurring. However, SARCs exist to provide forensic and medical exams – therefore there is nothing that a SARC centre could do for a survivor of historic sexual violence. Yet, significant resources are put into SARC centres, meaning that there is a disproportionate distribution of resources available across the broad spectrum of survivors. This is not to mention the long period of time it can take for survivors to feel ready to disclose their experience and that only a small number feel able to access a SARC centre. It must be noted that survivors belonging to marginalised groups may feel even more unable to access a SARC centre.

Recommendations for improving services for survivors of abuse included increasing awareness about the needs of survivors. More resources should be put into the treatment of complex trauma. This could include training for staff members who are likely to encounter those living with the effects of trauma. Survivors should also have the opportunity to shape service delivery. There must be recognition that survivors need support across all healthcare services, rather than just those associated with the abuse and violence that they experienced. More referencing of sexual violence

and abuse and of the need for trauma-focused care when getting a smear test could ensure that survivors have more positive experiences. As noted by Organisation B:

“There are many amazing individuals providing excellent care, yet we are all struggling to provide the best service we can under very difficult circumstances. The under investment in mental health and social care being the most impactful for the client group we work with.”

Recommendations

The responses from this survey had similarities with those gotten from similar community enquiries conducted into health equality in Cambridge city and environs, especially the recent report by Healthwatch on tackling health inequalities which highlighted similar themes of language barriers, lack of trust, structural access barriers, communication limitations, digital exclusion, among others.

Residents filling out this survey were asked what they thought needed to change and some of the things that came out strongly were around improvement in the current healthcare structure.

- A lot of respondents wanted to have more face-to-face GP appointments as they felt less able to describe their symptoms fully over the phone.
- Other suggestions revolved around how to make services more accessible including making GP services available in the evenings and on weekends, having more diverse ways of communication to serve the hearing-impaired and those who suffer panic attacks from phone calls.
- As stated earlier, one of the issues raised in this survey bordered on continuity of care. To mitigate this, respondents suggested having more permanent GP rather than Locum and temporary ones. Whereas having several GPs fill in the time to cover for the ever-growing number of healthcare services has its usefulness, this efficiency seems to be weighing against a very important aspect of the user experience which is comfort. Respondents report having to speak to different GPs each time they attended a hospital appointment for the same or related issue and this exerted significant stress on the user.

“Our doctor has changed and the service is very poor keep getting new doctors. We want the GP to go back to norm like before and more personal service like one to one and were the doctors knows you”.

A large number of respondents reported on the increasing number of locum and temporary doctors being placed in GP surgeries and how that creates a lot of fragmentation in the service that they received. Some patients have reported that there is a growing number of foreign-trained personnel now practicing in the UK and there is a significant shift in cultural practice in the delivery of healthcare that affects doctor-patient interaction, this patient quotes

“I would like to see my regular doctor more often I feel that she is always busy ... I am scared to see locum doctors because they don't know my health properly and they delay process like scans and blood test.”

This implies that there may be a need to support foreign-trained GPs with adaptation into the Cambridge culture to enable them provide care that residents find relatable.

- Respondents requested better customer service from receptionists at GP practices especially when dealing with people from minority ethnic groups who may have language barriers.
- Others wanted the NHS to be better funded to provide more extensive services like those that would shorten waiting times to get a call back, more face-to-face appointments, a return of the NHS out of hours service, more access to interpretation services for individuals of ethnic minority backgrounds, faster access to scans and MRI services, more GPs, dental NHS, etc.
- Respondents particularly wanted more time allocation for seeing patients, whether that would be solved by recruiting more GPs or allocating more time per patient. A resident said they felt rushed during consultations and this had an impact on their wellbeing.

Some important points to call attention to are the numerous issues that have arisen in this survey around the intersectionality of minority groups and healthcare access in Cambridge, whether it be ethnic or religious minorities, LGBTQ+ individuals, or people with a disorder or disability. While a move to digitize processes may have its merits, those processes must be designed with the users in mind as an over-reliance on non-face-to-face communication may disadvantage some groups especially those with language barriers. Services must be crafted in a way that is accessible to every resident of Cambridge city, regardless of whether they are long-time residents or have newly moved in, abled or less abled, or are classified as a majority or minority, and digital inclusion should be at the heart of this design. There should be options for more physical consultations for those who may not be able to or who choose not to use online doctor consultations. Healthcare services must also work in a way that involves partnership and evokes trust.

Summary

The survey was conducted as a community response to health access in Cambridge and is intended to highlight issues that are of importance for optimum healthcare provision. While it highlights a number of salient points, it is by no means exhaustive and there is a lot of room for improvement. The results of this survey may show some overlaps and similarities between this survey and others conducted within the city to collect certain health data such as the survey conducted by Healthwatch which is referenced earlier. It is recommended that all the information be taken together to inform healthcare provision in Cambridge.

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