COMMISSIONING INCLUSIVE SERVICES

Practical steps towards inclusive JSNAs, JHWSs and commissioning for Gypsies, Travellers and Roma, homeless people, sex workers and vulnerable migrants

Introduction

The National Inclusion Health Board commissioned this guide, which was co-produced with organisations that work directly with the people targeted within it. The Board would like to thank those who helped with the drafting of the content and acknowledge the support of all those who provide further resources. The Board recognises their continued commitment to sharing knowledge and setting out practical steps, which practitioners, commissioners and others can use to ensure that better health outcomes are achieved for the most vulnerable in our society.

We aim to update this guide regularly, so it remains a source of current information and good practice. If you have examples of what has worked, sources of information or guidance that would be helpful to others please send to Martin.Gibbs@dh.gsi.gov.uk.

Who is this guide for?

This guide is for all those involved in the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS): from local authorities and clinical commissioning groups (CCGs) that have a joint duty to prepare the JSNA and JHWS, health and wellbeing boards, Healthwatch, representatives of local voluntary and community sector organisations and communities themselves.

Why is it needed?

The *Statutory guidance on Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies* makes it clear that the purpose of JSNAs and JHWSs is to improve the health and wellbeing of local communities and to reduce health inequalities for all ages.

To do this, the JSNA must include those in disadvantaged areas or vulnerable groups who experience health inequalities, such as those who find it difficult to access services and those with complex and multiple needs, when considering the current and future health and social care needs for all the local population.

This can present a challenge: people in the most vulnerable circumstances are often not visible in national datasets or in outcomes frameworks; data and research is often weak; and engagement can need sensitive and appropriate handling. They have needs to be addressed which are often complex and require sophisticated, coordinated and flexible responses from service providers.

The costs of failure are great, not only to individual life chances, but also to the taxpayer, services and the communities who pick up the pieces. It is, therefore, crucial that they are included in both the JSNA and JHWS to inform local commissioning plans.

This guide will help to bring a greater focus on tackling health inequalities, by supporting JSNAs and JHWSs to identify at the needs of the most vulnerable, and set clear priorities for how these can be met. It does not set out to provide all the answers, but to sign post to sources of information and helpful contacts. It has a focus on how to engage with vulnerable, often excluded people and communities, to better understand their needs and how these can be met.

What does this guide cover and how is it structured?

While there are many vulnerable groups, the Inclusion Health programme has identified as an initial priority those with the poorest health, where information on their needs and successful interventions is relatively weak, and crucially where there has been much less focus in JSNAs. These are the focus of this guide: Gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants.

This guide includes a section for each of these groups describing their health needs and barriers they face to accessing services; and with practical advice for developing inclusive JSNAs and JHWSs. Sources of further information are highlighted.

In July 2013, the Department of Health launched a consultation "Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England." The consultation recognises that "the needs and interests of vulnerable or disadvantaged patients including the homeless, travellers and those lawfully resident but may not have documentation should be protected and not be charged." This guide will be updated to reflect any changes in policy following the consultation.

Getting started - how do current JSNAs and JHESs measure up?

Only 32 per cent of those who answered the relevant question in the consultation on JSNA and JHWSs guidance expressed the view that in the past JSNAs have contributed to understanding inequalities in their area. This suggests considerable scope for improvement before JSNAs provide a shared understanding of health inequalities and JHWSs take account of the entire local population, including the most vulnerable and often overlooked.

Like any aspect of a JSNA, information on vulnerable groups should create a holistic and fluid picture of what this means for the community and individuals rather than just a collection of data. It should be evidence-based so that health and wellbeing boards get a strong sense of what the implications are for the local area and what priorities it should be taking forward from this evidence in the JHWS.

There is a clear role for local agencies to be partners in developing and reviewing the JSNA and JHWS from the outset. There are a range of advantages to involving the voluntary and community sectors: they have a detailed understanding about community needs; they have good knowledge about local services and how effective these are; and they can advise on ways to involve more vulnerable groups with complex multiple health and care needs to ensure their voices are captured in the JSNA process.

Some key questions

Does the JSNA:

- Describe the scale of health inequalities in the area?
- Identify the causes?
- Capture and present health inequalities in a way that is understandable and informs the JHWS?
- Identify the most vulnerable and excluded, including Gypsies, Travellers and Roma, the homeless, sex workers and vulnerable migrants?
- Reflect the knowledge and understanding of local voluntary and community groups?

Does the JHWS:

- Respond to the findings of the JSNA?
- Build on what has been done and what has worked?
- Tackle the problems with evidence-based action to an appropriate scale?
- Identify increased investment towards disadvantaged communities and vulnerable groups?

Gypsies, Travellers and Roma

Health needs and barriers

Romany Gypsies and Irish Travellers are legally recognised as ethnic groups, and protected from discrimination by the Race Relations Act (1976, amended 2000) and the Human Rights Act (1998).

Gypsies and Travellers are a small but significant group who, in terms of health, are amongst the most deprived in England; they continue to suffer from poor health and lower life expectancy. They have some of the worst health outcomes of any ethnic minority group, with studies showing that they have significantly lower life expectancy than the general population. Other health issues, such as high infant mortality rates, high maternal mortality rates, low child immunisations levels, mental health issues, substances misuse issues and diabetes are also seen to be prevalent in the Gypsy and Traveller communities.

Roma often migrate to the UK to find work, to enjoy equal opportunities and a good education for their children and to escape racism and discrimination. They have established significant communities in the north of England, East Midlands, Kent and north and east London, however, some Roma are transient. They share many of the factors and barriers experienced by migrants – see page 14. Contagious diseases, such as tuberculosis, hepatitis, scabies and pediculosis can be found in Roma communities in the UK. Vaccination rates are low among Roma children.

The reasons for such poor health outcomes are numerous and include high levels of illiteracy; lack of good quality health supporting accommodation; lack of knowledge of mainstream services; and a mistrust of authority. Procedures for registering and accessing primary care services is a significant barrier, as well as a lack of cultural awareness and cultural competency amongst health staff which can cause misunderstanding and tension, and can deter some from seeking health care until there is an emergency.

These factors can also be compounded by a sense of fatalism and low expectations about their own health and health services – ill health is seen as normal, an inevitable consequence of adverse social circumstances.

Practical steps to inclusive JSNAs and JHWSs

Dedicate time to establish trust and credibility within the community. The best way to engage their views and involve them is to speak directly to Gypsies, Travellers and Roma. First contact with a community could be established via a trusted organisation; specialist organisations and statutory Traveller teams will be best placed to know how and where to locate them. Work with Roma mediators to communicate with Roma families.

Make efforts to reach the most vulnerable and invisible within these communities, such as those without a secure site or postal address. This should include people living on the roadside, on unauthorised encampments, transit sites and permanent authorised sites (both private and local authority owned).

Men and elderly people from these communities are often omitted from discussions; it is important that they are included as their perspectives are important and may differ from other members of the community. In addition, those living in bricks and mortar accommodation should be included. These may be more difficult to identify, but families living on sites may identify family members who live in housing and schools and GP practices may be able to provide information.

Consider ways of facilitating discussions and supporting people to attend 'official' meetings. Community members may be unfamiliar with formal procedures such as meetings, minutes and agendas. As poor literacy is often a problem, it is important to develop a clear communications strategy to ensure full engagement. Information should be produced in an accessible format, which might mean presenting it in pictorial form, producing audio information (CDs/download), and using multimedia.

Once appropriate engagement has been embedded with Gypsy, Traveller and Roma communities it will then be possible to work through the suggested check-list that is outlined below.

Check-list

1. Population	• What do you know about Gypsies, Travellers and Roma in your local area? *Include those who live in bricks and mortar accommodation and those living on the roadside as well as men and elderly members of the community* • What links do you have with existing national and local strategic Gypsy, Traveller and Roma organisations?
2. Wider social and economic determinants	• What do you know about the sort of work they are involved in? • How does being from a Gypsy, Traveller or Roma community impact on health and wellbeing? • How do the conditions in which they live impact on their health? • What is the impact of their experiences of racism?
3. Lifestyles and health promotion	• How do lifestyles and behaviours impact on the health of Gypsies, Travellers and Roma? • Which services are helping to prevent ill health e.g. voluntary sector support services?
4. Health and wellbeing status	• What mental and physical health and social care needs do Gypsies, Travellers and Roma in your area have? • Is there any information about the causes of mortality among this local population?
5. Service utilisation	• Which services do Gypsies, Travellers and Roma access? Include wide support services which address health and social care needs. What makes these services accessible? • Are there any barriers to using services? • What are the current service gaps and likely future needs of this population? • Do the Gypsies, Travellers and Roma in the area move frequently? *Consider how services can be aligned with other agencies, locally and across counties.*

6. Priorities for action	• How effective is current provision? *Consider whether the services are meeting the needs that Gypsies and Travellers have and how well the existing services are being utilised.* • What are the main causes of poor health that need to be addressed? • How can future investment be better target to meet health and wellbeing needs? • How have local agencies and service users shaped these future priorities?

Further information and guidance

- Joint Strategic Needs Assessments: policy statement (Friends, Families and Travellers, October 2011)
- A response from race equality perspectives to the public health white paper, *Healthy Lives, Healthy People* (Afiya Trust, October 2010)
- How to engage with Gypsies and Travellers as part of your work (Leeds Gate)
- Culturally responsive JSNAs: a review of race equality and JSNA practice (Local Government Improvement and Development, November 2010)
- Bi-annual caravan count (Department for Communities and Local Government)
- The Gypsy Traveller Accommodation Needs Assessment: Guidance (Department of Communities and Local Government, 2007)
- School Level Annual Census (Department for Education)

Examples of inclusive and representative JSNAs

- Cambridgeshire JSNA
- JSNA Chapter: Gypsy, Roma and Travellers (Surrey County Council)
- Health Needs Assessment of the Gypsy and Traveller Community in Bedfordshire (Bedfordshire NHS and Ormiston Trust, 2010)
- Health Needs Assessment: Gypsies and Travellers (Cumbria NHS, 2009)

People who are homeless

Health needs and barriers

People become homeless for a range of different reasons, including poverty, unemployment, relationship breakdown, abuse, and experience of being in care. The term homeless is a broad definition covering rough sleepers, those who are defined as homeless under legislation, living in bread and breakfast including families, and in other temporary accommodation. For information on 'statutory homelessness' and 'rough sleeping' visit the following website: https://www.gov.uk/homelessness-data-notes-and-definitions.

Homeless people have significantly more complex, severe health needs than the rest of the population, and the experience of homelessness often further exacerbates existing health conditions, as well as placing people at severe risk of developing new health problems.

Studies suggest the average age at death of a homeless man is 47 years, compared to 77 for the general population and 43 years for a homeless woman. The homeless often have one or more physical health condition and many have mental health conditions; a considerable proportion have multiple health needs, including one or more mental health problems and a problem with drugs and/or alcohol. Estimates of the prevalence of dual diagnosis among homeless people vary from 10 to 50 per cent.

A high prevalence of communicable diseases such as tuberculosis and hepatitis can be found among those living on the streets or in hostels. There are particular challenges in screening and treating this group for such illnesses. The number of cases of tuberculosis in the UK is rising, with homeless people particularly affected.

The reasons for such poor health outcomes are numerous and include chaotic lifestyles; perception of social stigma; a low awareness of their own personal health needs; barriers to registering with a GP; and accessing health and other services.

There are significant costs involved in not providing appropriate local healthcare services for homeless people, which provide a compelling argument to ensure that homeless people are adequately provided for within a local area.

Practical steps to inclusive JSNAs and JHWSs

Recognise that homelessness is a multi-faceted and complex issue, and in every local area there will be differences in the number of people it affects, the needs they have, and the existing measures in place to respond to this.

Consider the needs and interdependencies both in terms of homelessness as an acute form of housing need and a key determinant of health; and the specific health and wellbeing needs of people who are affected by homelessness.

Engage proactively with homelessness agencies and wider voluntary sector groups throughout the JSNA and JHWS process. It is important to ensure that the full spectrum of homelessness is picked up: people who are statutorily homeless; single homeless people or non-statutory

homelessness, including rough sleeping; and those at risk of homelessness – such as sofa surfers; prison leavers; or those in temporary or overcrowded accommodation

Recognise that homelessness does not exist in isolation and that homeless people are likely to have a range of needs cutting across health and social care, substance use and criminal justice and use the JSNA and JHWS to identify and commission across these interdependencies.

Use the JHWS to take a fresh look at how to integrate services to reduce homelessness, poor health and other areas of multiple needs. Through consideration of housing and other health determinants, it can renew the focus of commissioning on preventing poor health earlier and not just at the more acute end of traditional health and social care spending.

Align the JHWS to local homelessness and housing strategies, crime and policing strategies and other local plans.

Check-list

1. Population	• What do you know about the local homeless population? *Think about specific groups who might be experiencing homelessness, such as young people, migrants, women or BME groups* • What trends or changes are there in who is homeless or at risk of homeless- and are their needs identified in the JSNA? • How many people are sleeping rough in your area?
2. Wider social and economic determinants	• What are the levels of housing need? • What do you know about the levels of statutory and non-statutory homelessness? • What is the impact of the local economy and welfare reform on homelessness? • What is available to address the employment needs of the homeless?
3. Lifestyles and health promotion	• How do lifestyles and behaviours, such as drug misuse, smoking and alcohol affect health in homeless people? • Which services are helping to prevent ill health among homeless people – e.g. voluntary services?
4. Health and wellbeing status	• How is homelessness impacting on health and wellbeing? • What mental and physical health needs do homeless people in your area have? • Is there any information about causes of mortality among this population?
5. Service utilisation	• What services are available locally that address the needs of the homeless? • Which services do homeless people access? *Include wide support services (such as homelessness agencies) which address health and social care needs.* • Are there any barriers to using services? *Consider unregistered patients or those who may fall beneath service thresholds*
6. Priorities for action	• How effective is current provision? • How can future investment better be target to meet health and wellbeing needs of homeless people? • How have local agencies and service users shaped future priorities?

Further information and guidance

- [Homelessness and Health: resources to support peer activity](#) (Groundswell and Homeless Link)
- ['Improving the health of the poorest fastest': including single homeless people in your JSNA](#) (Homeless Link, December 2011)
- [Homelessness statistics](#) (Department for Communities and Local Government)

Examples of inclusive and effective JSNAs

- [Southampton Homeless Health Needs Audit](#) (Homeless Link)
- [Cambridgeshire JSNA: People who are homeless or at risk of homelessness](#) (Cambridge)

Sex workers

Health needs and barriers

Historically, sex workers have been one of the most socially excluded groups. Assumptions and stereotypes often override the evidence base necessary to inform delivery of effective health and other services. Sex workers can be categorised into two groups: street workers and off street workers. The health and social needs of the two groups are quite distinct, requiring services tailored to meet these needs, rather than a one size fits all approach.

Most female, and some male, street work is driven by the drug economy. Those who have been trafficked will experience isolation and fear. Chronic addiction is common, resulting in complex and multiple health and care needs, compounded by other socio-economic factors, such as poverty, family breakdown, poor educational attainment, lack of alternative employment opportunities and persistent contact with the criminal justice system.

Female street sex workers report high incidence of violence against them either at the hands of customers, drug dealers, the wider chaotic street fraternity, partners or their traffickers. Homelessness amongst street sex workers is common.

Off street sex workers are part of a hidden economy. In the larger metropolitan areas, many involved in the industry will be migrants, including 'irregular' migrants (those who have overstayed a visa, those who have come into the country on false or irregular paperwork, or those who have been trafficked). They often fear deportation and institutions such as the police. Male off street sex workers often work in isolation. There are significant safety and social implications when this is the case, often pertaining to robbery and blackmail.

The majority of trans sex workers are male to female, either identifying as transsexual, transgendered, or transvestite. Many are pre-op, having undergone some surgery, or hormone therapy whilst retaining male genitalia. Consequently, their clients may have uncertainties about their own sexuality and present with particular issues because of this, including an increased propensity for violence. Many trans sex workers are migrants and report that they are selling sex to pay for gender re-assignment surgery. In addition, some trans sex workers may work as trans but not necessarily identify as such in their everyday lives.

Sex workers experience barriers to accessing healthcare. The criminalisation of sex work leaves sex workers distrustful of statutory services, fearful that information about them will be shared with the police or that they will be deported. This means that they often do not report as sex workers to health services.

Practical steps to inclusive JSNAs & JHWS

Engaging with sex workers is key to assessing their health needs. Services that deliver interventions to sex workers may collect data that can inform the JSNA. Local police and sexual assault referral services may have some information. If there is no data, avoid basing the JSNA on conjecture, hearsay and anecdote, as this would perpetuate existing stigma and stereotypes around sex workers.

Recognise that there are differing drivers and contexts for both the street and off street industry. In addition, these drivers and contexts may be different for male and trans sex workers.

Recognise the health and wellbeing of sex workers is an interconnected set of social, emotional, health and wellbeing issues that reflect the complexity of an individual's life and the need for effective and holistic assessment, as well as pathways into appropriate services.

Street sex workers - Be aware that the street sex work scene will vary depending on the part of the country and is constantly evolving – within a short period, demographic changes and styles of working can change beyond recognition. Many operate from known areas (or 'beats') and will be known to local police. Police and court records are a good place to start to identify where beats exist, and the nature and scope of the street economy. Local statutory and voluntary prescribing and generic drug services may also have records of people who are known to transact sex in order to finance their drug use. Local Sexual Assault Referral Centres (SARCs) may have links to other local services that support sex workers. The national Ugly Mugs scheme may also be able to signpost to services.

To conduct a really accurate needs assessment of street sex work undertake at least two to four weeks' worth of night outreach (ideally between 10pm and 6am) so that contact can be made, faces recognised and the scale of the issue quantified within parameters.

Off street sex workers - Often undocumented, part of the hidden economy and difficult to identify. Many will advertise in public spaces, in local papers, online, in local shop windows or telephone boxes. A premises may well use several numbers to advertise and may place numerous different adverts in the same publication, phone box or online.

Touring sex workers - Sex work is a migratory form of work, known as going 'on tour.' Many independent sex workers will travel to emerging new markets in other cities and countries. They will not have permanent links to the local area.

It is important to draw a clear distinction between 'mobile' sex workers, 'migrant' sex workers and 'trafficked' sex workers. Sex workers who go on tour are likely to advertise though various sources; their own personalised web sites and adult websites such as 'Adult Work', 'Viva Street', 'Gaydar', 'Gay Romeo' and 'Eros'.

Trafficked sex workers – Avoid assuming that all migrant sex workers are trafficked, as this is usually not the case. Avoid guessing the numbers of individuals trafficked for sexual exploitation, and consider targeted outreach and effective needs assessment strategies.

Trans sex workers - Be sensitive to their issues, do not make assumptions about gender or genitalia and be aware of double stigma, around both their gender and the work they do.

Check-list

1. Population	• What do you know about sex workers in your local area? *Think about specific groups who might be sex workers: children and young people, migrants, men, transgender.* • What do you know about the sort of work they are involved in? *Consider what sort sex workers they are, i.e. street or off street.*
2. Wider social and economic determinants	• What is the impact of the local economy and welfare reform on the level of sex work in the area? • Is there a link to homelessness? • What support is available to encourage sex workers into other regular employment?
3. Lifestyles and health promotion	• How do lifestyles and behaviours, such as drug misuse, smoking and alcohol affect health and wellbeing in sex workers? • Which services are helping to prevent ill health among sex workers, e.g. voluntary services?
4. Health and wellbeing status	• How is being a sex worker impacting on health and wellbeing? • What mental and physical health and social care needs do sex workers in your area have? • Is there any information about causes of mortality among this population?
5. Service utilisation	• What services are already in place? • Which services do sex workers access? *Include wide support services which address health and social care needs* • Are there any barriers to using services?
6. Priorities for action	• How effective is current provision? • How can future investment be targeted to meet the health and wellbeing needs of sex workers?

Further information and guidance

- A health needs assessment of street-based prostitutes: cross-sectional survey. (Jeal N, Salisbury C (2004). *Journal of Public Health*, 26, pp.147-51.)
- Substance use and health-related needs of migrant sex workers and women trafficked into sexual exploitation in the London Borough of Tower Hamlets and the City of London). (Salvation Army, 2006).
- Ugly Mugs
- Serious crime analysis section (Serious Organised Crime Agency)
- Sex workers and sexual health: projects responding to needs (UKNSWP)
- The different health needs of female sex workers (Royal College of Obstetricians and Gynaecologists)
- Submission to the *Home Office review of local effective practice* (UKNSWP)

Examples of inclusive and effective JSNAs

- Surrey-i JSNA Chapter

Vulnerable migrants

Health needs and barriers

Migration is an ongoing feature of UK demography and migrants form an integral part of every community. Migrants are diverse – they include students, workers, family-joiners, people fleeing persecution – and most of them are young, resilient and self-sufficient. A small proportion faces additional risks and vulnerabilities.

Migrants encounter additional factors that increase their risk of poor physical and mental wellbeing. These fall within the categories of pre-migration experience and country of origin; reason for migration, whether forced or chosen; the migration experience itself; and post migration experience. The compounding impact of these determinants makes some groups of migrants particularly vulnerable, in particular, low paid or unemployed migrant workers, asylum seekers, refused asylum seekers, refugees, unaccompanied asylum seeking children, undocumented migrants and trafficked persons.

Vulnerable migrants have poorer access to employment, income, housing and education, important determinants of health and wellbeing, and face significant barriers to health care. As a result, they have higher morbidity for some conditions and poorer health outcomes. Poor diet, lack of physical activity, discrimination and fear of deportations as well as poor social networks, knowledge of local services and communication problems compound this. Many live in extended families, where overcrowding is a serious issue.

In addition to poor health outcomes, there are a range of barriers that prevent vulnerable migrants accessing healthcare including language barriers; a lack of trust in people outside the migrant community; suspicions of officials and government supported services; and limited availability for appointments for reasons such as shift work or caring responsibilities.

Practical steps to inclusive JSNAs & JHWSs

Recognise that identifying migrants within localities and establishing health and wellbeing needs and assets requires outreach, engagement and partnership. Take time to gain the trust of migrant communities, plan engagement as a long-term commitment. Attend regular activities or events organised by these groups to promote initial dialogue.

Work in partnership with the voluntary sector, community groups and faith-based organisations to facilitate access to the groups they work with. This will help to avoid potential misunderstandings and pitfalls resulting from cultural differences.

Recognise the cultural barriers to migrants' engagement such as a lack of trust in people outside their community. Consider outreach activities in community centres and other informal venues instead of official consultations.

Provide information in the most commonly spoken languages. Avoid written information in areas where numerous foreign languages are spoken, or with communities with low literacy levels, and consider the use of interpreters.

Ensure the JHWS promotes a proactive approach to address the inequalities experienced by vulnerable migrants, based on available evidence (qualitative and quantitative). Prevent the absence of evidence from forestalling action or further research.

Consider the most appropriate models of health care provision to meet the needs of local communities. Identify the potential for joint working and resource-pooling between public health departments, local authorities, voluntary sector, community groups and commissioners of primary care.

Check-list

1. Population	• What do you know about vulnerable migrants in your local area? *Think about those from different groups: children and young people, women, etc*
2. Wider social and economic determinants	• What do you know about the sort of work they are involved in? • In what conditions are they living? • Is there a link to homelessness? • What is the impact of poor education and language skills?
3. Lifestyles and health promotion	• How do lifestyles and behaviours impact on the health of vulnerable migrants? • Which services are helping to prevent ill health among vulnerable migrants?
4. Health and wellbeing status	• How does being a vulnerable migrant impact on health and wellbeing? • What mental and physical health and social care needs do vulnerable in your area have? • Is there any information about causes of mortality among this population?
5. Service utilisation	• Which services do vulnerable migrants? Include wide support services which address health and social care needs. What makes these services accessible? • Are there any barriers to using services? • What are the current service gaps and likely future needs of this population?
6. Priorities for action	• How effective is current provision? • How can future investment better be target to meet health and wellbeing needs of vulnerable migrants? • How have local agencies and service users shaped these future priorities?

Further information and guidance

- [Including Migrant Populations in Joint Strategic Needs Assessment: A Guide](#) (Rose N, Stirling S, Ricketts A, Chappel D., 2011)

- [Understanding the health needs of migrants in the South East region.](#) (HPA et al, 2010)

- [Improving Access to Healthcare for Migrants. A Toolkit.](#) (Ts4sE, 2011)

Examples of inclusive and representative JSNAs

- [Asylum Seekers, Refugees and Migrant Workers](#) (Nottingham City JSNA, 2010)

- [Joint Strategic Needs Assessment for Migrant Workers in Cambridgeshire](#) (Cambridgeshire County Council and NHS Cambridgeshire)

homeless link

St Mungo's
Opening doors for homeless people

EQUALITY

east of england
LOCAL GOVERNMENT
association

LEEDS GATE
— Gypsy and Traveller Exchange —

Travelling
Towards Equality

we seek to end racism and discrimination
against Gypsies and Travellers, whatever
their ethnicity, culture or background,
whether settled or mobile, and to protect
the right to pursue a nomadic way of life

fft
Friends Families and Travellers