healthwatch Croydon

# Health inequalities in Croydon – A public discussion

March 2025

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# Executive Summary

As part of Healthwatch Croydon's Annual Meeting on 6 November 2024 at the Clocktower Café in central Croydon, there was a public discussion, section under the title: ***Your views on health inequalities.*** Residents had the opportunity to share their views on health inequalities in Croydon to help inform the borough's new Health and Care Plan.

This session was focused on hearing experiences as residents and as people and organisations supporting people living in Croydon who are dealing with the impact of health inequalities on their lives, their health (physical and mental) and their wellbeing.

There were ten tables of discussions. Each were given the NHS definition of health inequalities and the core aspects of Croydon's Health and Wellbeing Strategy 2024-2029 to inform the discussion, see Appendix for more details.

Questions included:

- What health inequalities have you or people you know experienced in Croydon?
- Where are the opportunities to overcome these inequalities?

Healthwatch Croydon analysed the varied discussions, and this report shares these findings and opportunities to overcome inequalities along with the detail of how these were derived. A summary version of this insight and opportunities will be presented in the Croydon Health and Care Plan, due to be published in early 2025.

## Findings

Barriers in access to services: Residents have different experiences of accessing services. They said that information needs to be local, relevant and easy to understand. Digital developments like apps and online interactions need to align with residents' access to them, their knowledge needs and abilities. Residents want to see the right person first time.

Systematic and structural issues – system to resident: Residents and the people that support them experience variable levels of care between services and disconnects between different parts of the system. Some experiences are with staff who are not suitably qualified (e.g. not qualified as a prescriber resulting in delayed access to treatment), or do not seem interested enough in the resident. Other concerns included working with processes which do not support them, such as two-ring call backs from GPs that tick a box in responding but do not allow for the time to answer the call. This extends the process causing residents unnecessary stress, when they just wanted to be listened to and helped.

Systematic and structural issues – resident to system: How the system views a resident can impact their approaches to care provided. The focus is on identifying deficits and problems rather than on the whole person. This can create a culture of dependency rather than empowerment. There is with insufficient co-production of individual care plans designed around individual and specific needs.

Life experiences: The recognition of, and response to, residents' life experience is central to building trust in services. Residents have experienced not being seen or heard, as well as being judged and experiencing discrimination that leads to a mistrust in services and systems. Experience of using some services, for example of NHS111 can affect confidence in using this service and therefore

deciding to go to other places such as accident and emergency care. The impact of the social determinants of health such as education, malnourishment, poverty and poverty of opportunity need to be considered as they can make a difference on how people perceive and use services

Support in our communities: The role that communities can have in reducing inequalities. Residents see a distinct role for community groups to empower communities not usually heard and support the need for more communal and collaborative approaches.

Research into policy and practice: Residents are also keen to see resident experience and views used to inform policy and make changes to services. Are there the resources and political will to change services?

## Opportunities

**Learn more about experience around access and build into implementation of changes:** Use resident experience to refine access to pathways and ensure that there is relevant information and support, particularly around digital services.

**Focus on service-user experience to ensure each contact counts:** See the pathway from the service users' perspective rather than the providers and manage expectations to ensure that every contact counts. Ensure measures of quality are aligned to resident experience.

**Empower the person to manage their health:** Focus on the person's potential to manage their condition and develop ways of living well, providing personalised support to enable them to be empowered. Take a coproduction approach to the development of treatment plans and services to facilitate the empowerment.

**Use life experiences to shape services:** Engage with all residents about their experience of service and use this to help shape how services are delivered. Contextualise experience in line with the social determinants of health and protected characteristics to track differences in experiences.

**Apply the power of communities**: Engage and work with specific geographic and ethnic communities to address the communal barriers to services and needs.

**Utilise research both local and beyond to drive change:** Ensure suitable resources are available to engage with populations, analyse the data and translate into practice to make meaningful impact.

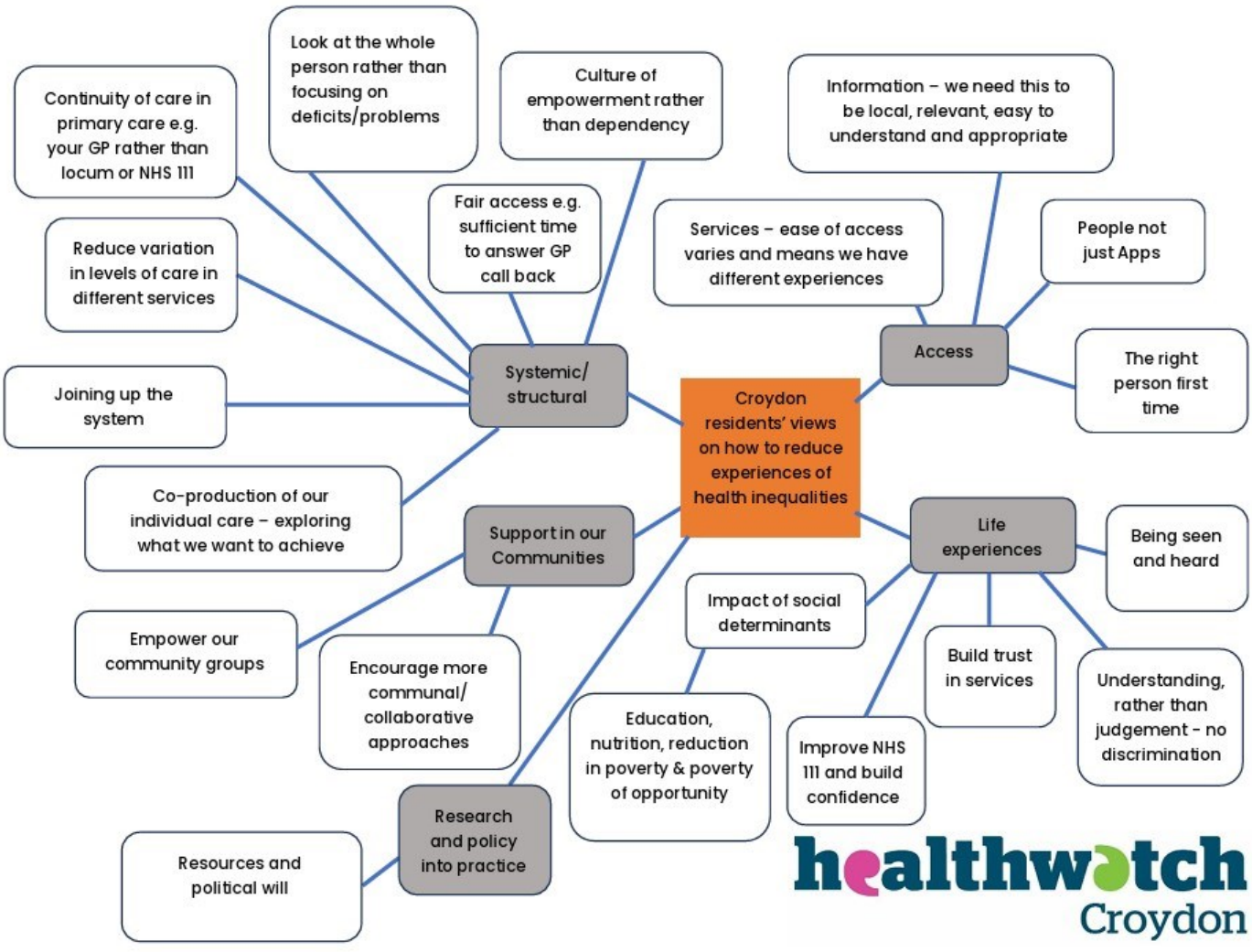
It is noted that much of what was discussed aligned closely the three aspects of health service reform referenced the *Independent investigation of the NHS in England* (Darzi, 2024), and the three shifts the NHS needs to make:

- moving more care from hospitals to communities.
- making better use of technology in health and care.
- focusing on preventing sickness not just treating it.

# Insight

This section presents a more detailed overview of the varied discussions undertaken across ten tables. We took a grounded theory approach (Glaser & Strauss, 1967) to gaining insight by setting questions and building up themes from what was discussed. Some table talked directly about their experiences of specific services while others considered wider systemic issues and the complex interactions affected by the wider social determinants of health.

The aim of this report is to represent the range of experiences and ideas that we heard with some opportunities to support developments in services for Croydon.



# Findings

## Barriers to access

- Services even when they are in short supply. “We don’t all know how the services work or how to access the ones that we need.”
- Ease of access varies and means we have different experiences, leading to different outcomes for residents from some communities such as
    - Maternity services for Black women.
    - Recognition and treatment of domestic violence as visible signs differ on darker skin.
- Information – ease of access to advice or services can vary depending on what is available that is relevant, easy to understand, available in different languages/translations, and how well information about it is disseminated. We need local information for people about how to access different services such as:
    - young men needing mental health support not knowing where to go.
    - carers of people with differing needs, ease of access to advice or services can vary depending on what is available that is relevant and how well information about it is disseminated.
    - People not just apps – they are great for some but not for all of us. We are expected to use technology such as the NHS app, but many people need training to be able to do this. As a result, there is digital exclusion.

- For residents, seeing a GP is harder than it used to be and being directed to other practitioners who cannot provide the answers can result in delays in access to treatment and return visits to the practice. It would be better to focus on the “right person first time” from the resident perspective.

## Systemic and structural issues:

### System to resident

- Disconnections in the system – some of the structures that have been put in place can isolate people. The experience of using services is that of a very transactional approach, i.e. the practitioner can only help with particular issues, not dealing with the whole person e.g.
    - residents with hearing problems we are repeatedly given telephone appointments.
    - residents given insufficient time to get to the phone to answer GP telephone call backs (2 rings) which then get coded as a ‘missed call’. They then have to call back to book again and their care is delayed as a result.
    - having to attend more than one appointment because a clinician cannot prescribe.
    - concern about having to see locum GPs who do not seem to show interest in the resident instead of "our" GP.
    - GP receptionists can be a barrier and need to listen to us more.

- Experience decisions being made that create complexity and barriers to access.
- occasional problems with referrals as resident live in one borough or ICB area and go to a GP in another ending with discussions about who pays.

**Resident to system:**

- Experiences by residents of a culture of dependency rather than one of empowerment.
- Mindset focuses on needs and labelling our deficits/problems rather than on each of us as a whole person and what we are also able to do
- Insufficient co-production of our individual care with us – exploring what we want to achieve and our passion?
- Distance to services.

## Life experiences

- Not being seen and heard.
- Being judged and experiencing discrimination.
- Mistrust and distrust of services based on experiences during our lives is greater for marginalised groups.
- Experiences with calling NHS 111 and being asked questions by a person that is not medically trained results in less confidence in using the service again.

- The Impact on our lives of social determinants of health on our wellbeing particularly how early disadvantage in education, malnourishment, poverty and poverty of opportunity carries forward in the lives of Croydon residents.

## Support and empower our communities

- Empower our community groups – the places where we go
    - by addressing the unequal and disproportionate access to resources.
    - to have the capacity to build and support us.
    - and give them time to help us.
- Encourage more communal and collaborative approaches.

## Research into practice

- There is much learning that can be collected and analyses but are there the resources and political will to translate insight into policy and practice?

**Case study - Experiencing different levels of care from same provider but at different locations**

Croydon resident can access eye services provided by Moorfields Eye Hospital NHS Foundation Trust which provides services at the hospital's headquarters in Old Street, Islington or in Croydon at Purley War Memorial Hospital. {There is also a service at Croydon University Hospital, but the resident was unaware of}. The resident has used both services and has noticed a difference between them

At Old Street, all the assessments and tests are conducted in one go and completed in two hours, at Croydon these are split over two

appointments, two weeks apart meaning that there is a delay and the need to travel twice.  Also, the consultant they saw in Croydon was not as confident of their responsibilities – the doctor had to keep getting up to get a second opinion. Resident is also not given enough information, or even an explanation why this is happening. There is a sense they are not getting the best consultants. They sense that the other staff are not the same quality. The level of communication is not as good as at Old Street.

There is also an issue with local optician and the link with Moorfields. Their GP and Moorfields don't recognise the local opticians that the resident had been a client of for many years. Therefore, they do not get access to resident records, The resident also does not get letters direct from Moorfields consultants about their care. The letter is only sent to resident only to the GP.  The resident has to go to the GP to get letter and then share with their optician. Resident cannot understand why this cannot be linked directly to their usual optician.

An online consultation was suggested where they send a photograph to their eye, even asking the resident to find a neighbour to take photograph? How is that even possible without sharing personal information? Services should not be reliant on this kind of informal support.

These experiences have resulted in the resident to have a lack of confidence in the quality of service they are supposed to receiving. This makes the choice to travel to Old Street the preferred option, despite the journey, time and cost of travel, as resident can have one appointment and has confidence in the staff. How can the same service be so different?

**Suggested improvements**

- Improve the Croydon service so resident access and experience is the same as Old Street in terms of number of appointments, staff and communication.

- Improve communication between resident, GP and their own optician.

## Opportunities to overcome these inequalities

### Access

- Listen as the people who can't talk don't get as much access.
- Consider health equity rather than health equalities – focusing on equal appropriate access, rather than equal access.
- Easy to understand information.
- Levels of knowledge - support education that supports an individuals' ability to navigate access to care and treatment.
- Recognise that there is digital exclusion and identify ways of addressing this e.g. training and support.
- Broaden time of day of appointments to reflect residents' needs.
- Broaden location of appointments to reflect residents' needs.
- Ensure cultural and language addressed in information leaflets.
- Access needs to be appropriate.
- Ensure annual health checks for people with learning disabilities take place.
- Create quiet spaces for people with autism spectrum disorders.
- Advocacy for carers – practical heal especially with use of the Mental Health Act.

## Systemic/Structural

### System to resident

- Deliver better integration between services to improve the connections between providers and deliver smooth pathways.
- Address impact of GDPR on carers and residents and develop ways that support data sharing that benefits resident experience.
- Increase training to recognise differences in responses by residents e.g. visible signs of domestic violence on darker skin.
- Ensure GP call backs to ring for longer and don't automatically assume the person isn't there.
- Address structural inequalities.
- Train staff in visual awareness and different disabilities.
- Elderly (dementia) care to be part of services not requiring financial measures.

### Resident to system

- Develop a co-production approach to developing our care/treatment plans. This also requires health and social care workers to have the time to work with the whole person.
- Engage and develop participation groups: Learning disabilities and LGBTQ+ community

- Consider different treatment approaches and overcome perceptions that different services are being provided for different communities. For example, 'If you are Black, you are prescribed medication for mental health services before access to other services.'

## Life experiences

- Integrate education and health services, at all ages as education leads to health inequalities – better education supports ability to navigate the system.
- Support for people that cannot buy health produce because they cannot afford it.
- Address social determinants and socioeconomic inequalities that lead to health inequalities, e.g. housing, poverty, travel costs, time off work, fear, distrust, being judged.
- Croydon Council to publish a figure for the number of people who do not have a bed for the night in Croydon and put plans in place to address this.

## Support and empower our communities

- Build on the current hubs in our communities to help residents navigate the way through to getting support when we need it.
- Support self-efficacy through our communities.
- Resourcing of community organisations to meet demand.
- Resourcing support when community tragedy happens.

## Research/policy into practice

- Admit there are inequities and inequalities, explore and be honest about what can be done, funding and different practices – then put them in a plan
- Resourcing organisations effectively to meet demand.
- Future proofing – plan for population increases and impact on demand.
- More partnerships with National Institute for Health research (NIHR)
- More joint research with Croydon Health Services NHS Trust and involve the community more
- There is a new Croydon Carers Strategy which aims to improve access – commitment to supporting it.
- Ensuring that the written information available for carers on the wards at Croydon University Hospital is visible to residents and their visitors.

# References

Darzi. (2024). *Independent invesitgation of the NHS in England.*
Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory.* Aldine Transaction.

# Appendix

Health Inequalities in Croydon Session

Briefing for Facilitators

## Context setting

This session is where we want to hear from you about your experiences as residents and as people and organisations supporting people living in Croydon who are dealing with the impact of health inequalities on their lives, their health (physical and mental) and their wellbeing

As we know from the health and well-being strategy in Croydon, we have some significant health inequalities across the Borough – e.g. life expectancy differences between the most and least deprived areas that we live in (9.2 yrs less for men and 6.5 years less for women - 2018-20 data)

The range of things that affect our health is broad - cost of living, our environment, keeping warm, a roof over our heads, somewhere safe to sleep, etc.

Health inequalities mean different things to each of us - what do they mean to you?

## Questions

- What health inequalities have you or people you know experienced in Croydon?
- Where are the opportunities to overcome these inequalities?

### Introduction to the session (2-3 mins)

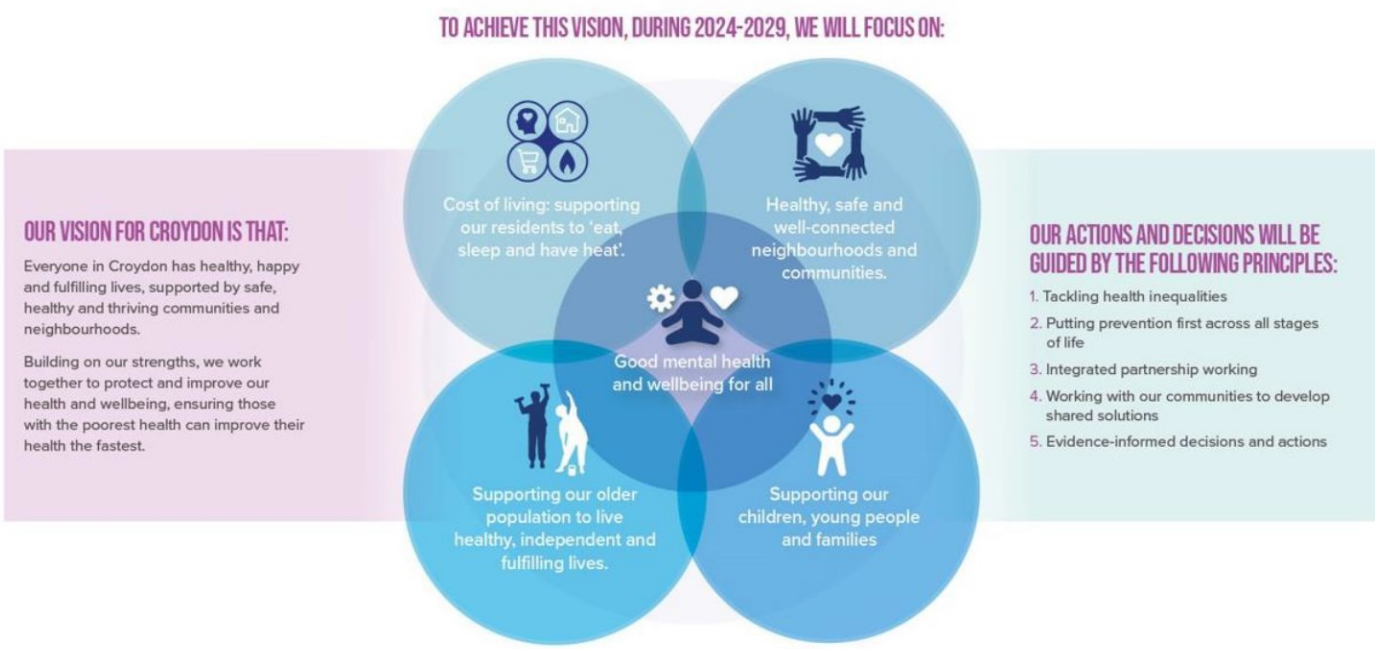
- Context setting/overview of the session – Sandra
- Facilitators at tables – on each table there is a copy of a definition of health inequalities and the 5 areas in the health and wellbeing strategy

### Table discussions (30 mins)

- Each person to spend 3-5 mins noting down their personal responses to the questions on post-its
- Share these on the table and group them on the flipchart paper. This is where it may help to use the 5 areas from the Health and Wellbeing Strategy as a framework.
- Discuss/explore in more detail and capture any examples that are shared for the report

### Whole room (5-10 mins)

- Feedback into the whole room will focus on emerging themes and not cover everything from every table but we will have the post-its and any additional notes to write a report
- Opportunities to share what we've heard from you, e.g. health and social care planning in Croydon, health and wellbeing board, Change: NHS Consultation https://change.nhs.uk/en-GB/ for individuals to share their views and organisations can also do so.




**What are healthcare inequalities? (from the NHS website)**

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider determinants of health.

Wider determinants of health are often interlinked. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food. This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care.

The reasons for this are complex and may include:

•the availability of services in their local area

•service opening times

•access to transport

•access to childcare

•language (spoken and written)

•literacy

•poor experiences in the past

•misinformation

•fear

People living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health group, for example the homeless, are most at risk of experiencing these inequalities.

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