13 October 2026

Baroness Merron
Parliamentary Under-Secretary of State
Department of Health and Social Care

Dear Baroness Merron,

Health Bill targeted amendments to improve health equity, patient safety and accountability

I am writing on behalf of the Traveller Movement, alongside People's Health Trust, Race On The Agenda, Race Equality Foundation, Runnymede and a wider coalition of health and race equality organisations from across the United Kingdom, to seek your support for a small number of targeted amendments to the Health Bill. These proposals have emerged from a shared concern about persistent health inequity across some marginalised communities, and a commitment to improving patient outcomes. Better ethnicity data can help identify population-level inequalities and emerging risks.[1] Collectively, we believe these amendments would strengthen the Bill's ability to improve access to healthcare, reduce health inequalities, and improve accountability across the health system.

Romani (Gypsy), Roma and Irish Traveller people experience exceptionally poor health outcomes and high levels of long-term illness. The 2021 Census found that 'Gypsy or Irish Traveller' people in England and Wales were more than twice as likely as the overall population to describe their health as bad or very bad, at 12.5% compared with 5.2%.[2] The Traveller Movement's research for the National Inclusion Health Board found that two-thirds of Gypsies and Travellers surveyed described their health as bad, very bad or poor, and identified accommodation insecurity, poor living conditions and discrimination as significant contributors to poor health.

These are acute but not isolated experiences for marginalised communities, and yet health data, service design and accountability mechanisms intended to identify,

[1] Office for National Statistics, Mortality by ethnic group following death certification reform, England and Wales: 2025 (2026): https://www.ons.gov.uk/releases/mortalitybyethnicityfollowingdeathcertificationreformenglandandwales2025

[2] Office for National Statistics, Gypsy or Irish Traveller populations, England and Wales: Census 2021 (2023): https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/gypsyoririshtravellerpopulationsenglandandwales/census2021

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address and learn from inequalities often fail to properly recognise them or translate evidence into action. Recent work by Brent Council in partnership with The Traveller Movement similarly identifies the need to understand how Irish Traveller people access health and care, the barriers they encounter, and what action local systems should take to improve their experience.[3]

The proposed changes to these clauses and schedules offer a coherent and proportionate response to these challenges. They would improve the quality of evidence available to decision-makers, strengthen accountability for reducing inequalities, make healthcare more accessible for people facing barriers to engagement, and ensure that patient safety investigations better identify and respond to unequal outcomes.

Clause 51 and Schedule 8: Ensuring accurate ethnicity data within the Single Patient Record

We propose that the 2021 Census ethnicity categories and codes relevant to Romani (Gypsy), Roma and Irish Traveller people be adopted within the Single Patient Record, with NHS bodies and Integrated Care Boards updating their systems accordingly. At present, reliance on older ethnicity classifications frequently absorbs these communities into a broader 'White' category, limiting the NHS's ability to understand and address inequalities across communities. This amendment would give statutory force and consistency to the direction of existing NHS policy. NHS England's Ethnicity Recording Improvement Plan recognises that Gypsy, Roma and Traveller communities are not well reflected in current healthcare data despite experiencing profound inequalities in access, experience and outcomes. It also identifies the continued use of 2001 Census classifications as a barrier to detailed analysis, and states that new data products should use 2021 Census codes.[4]

Accurate and consistent ethnicity recording is essential if inequalities in access, outcomes and patient safety are to be properly understood and addressed. Modernising these classifications would strengthen service planning, population health management and accountability across the NHS, while providing a clearer basis for identifying inequities affecting other ethnic communities where current data are incomplete, inconsistently recorded or insufficiently used.

[3] London Borough of Brent in partnership with The Traveller Movement (2026) Health Needs Assessment of Irish Traveller Communities, https://travellermovement.org.uk/policy-and-publications/health-needs-assessment-of-irish-traveller-communities

[4] NHS England, Ethnicity Recording Improvement Plan (2025): https://www.england.nhs.uk/long-read/ethnicity-recording-improvement-plan/

Clause 4: Strengthening the statutory duty to reduce health inequalities

The current duty requiring the Secretary of State to 'have regard to' health inequalities has not delivered sufficient progress for communities facing entrenched disadvantage. We therefore propose a stronger duty requiring all reasonable steps to be taken to reduce inequalities in access and outcomes, alongside particular consideration of inclusion health groups and communities experiencing racial inequity, and transparent annual reporting on progress and barriers. This would build on established NHS policy. NHS England's Core20PLUS5 approach identifies Gypsy, Roma and Traveller communities as an inclusion-health group and seeks to focus action on people facing the greatest barriers to good health.[5] However, recognition in policy has not consistently translated into clear accountability for measurable progress. Reporting should enable scrutiny of both overall progress and differential outcomes between population groups while recognising that action must be informed by local evidence and community experience.

However, recognition of inclusion health groups currently rests in policy rather than a durable statutory framework. The groups named in policy are therefore vulnerable to being narrowed, redefined or removed through future policy change, despite the persistent and often overlapping barriers they face. The Bill should require particular consideration of inclusion health groups, while allowing local action to be informed by evidence and community experience. Recognition in policy has not consistently translated into clear accountability for measurable progress. Reporting should enable scrutiny of both overall progress and inequalities in outcomes between population groups.

Clause 16 and Schedule 2: Making patient choice genuinely accessible and meaningful

We propose that patient choice arrangements must include accessible information formats, verbal explanations where appropriate, community-language materials, flexible communication methods for people without a fixed address or with insecure contact arrangements, culturally appropriate care pathways, and reasonable adjustments for those with low literacy or limited English, or other barriers to navigating services. The existing NHS Choice Framework recognises that people requiring reasonable adjustments or additional assistance must have these needs taken into account when making choices, and that NHS organisations must meet the Accessible Information Standard.[6] Yet those duties do not fully address barriers faced by people who may have insecure contact arrangements, low literacy, limited

[5] NHS England, Core20PLUS5: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

[6] Department of Health and Social Care, The NHS Choice Framework: https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

digital access or understandable mistrust of services because of experiences of discrimination.

These are practical and proportionate measures that would improve access for many groups facing linguistic, cultural, administrative or practical barriers to healthcare.

Schedule 9: Strengthening patient safety investigations through greater consideration of health inequalities

As investigative functions transfer from the Health Services Safety Investigations Body to the Care Quality Commission, we propose that safety investigations should be required to consider whether incidents or identified risks disproportionately affect inclusion health groups, racialised communities or other populations experiencing inequitable access, treatment or outcomes, and to publish disaggregated findings where data are available, and identify where limitations in data prevent meaningful analysis. NHS England already recognises that some patients are less safe than others in healthcare settings. Its Patient Safety Incident Response Framework requires consideration of health inequalities in incident-response policies, plans and learning processes, while its 2025 Patient Safety Healthcare Inequalities Reduction Framework sets out principles for reducing unequal risks of harm.[7] The proposed amendment would ensure that these important commitments are reflected in statutory investigative functions and subject to transparent public scrutiny.

Requiring such analysis would strengthen the ability of the CQC to identify patterns, target recommendations effectively and ensure that learning from patient safety incidents reflects the experiences of those facing the greatest risks.

Taken together, the proposed changes to Clause 51 and Schedule 8, Clause 4, Clause 16 and Schedule 2, and Schedule 9 would establish a stronger framework for identifying and addressing health inequalities within the NHS. They would improve the visibility of communities currently underrepresented in health data, place greater emphasis on reducing inequalities in outcomes and access, ensure that patient choice arrangements are genuinely accessible, and strengthen the ability of safety investigations to identify patterns of disproportionate harm.

These proposals build on, rather than duplicate, existing NHS policy. NHS England already identifies Gypsy, Roma and Traveller communities as an inclusion-health group, recognises that they are poorly represented in healthcare data, and has issued guidance on reducing patient-safety inequalities.

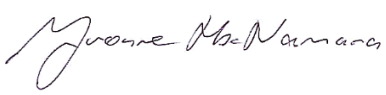
[7] NHS England, Patient Safety Incident Response Framework and Patient Safety Healthcare Inequalities Reduction Framework: https://www.england.nhs.uk/long-read/patient-safety-incident-response-framework/ and https://www.england.nhs.uk/long-read/patient-safety-healthcare-inequalities-reduction-framework/

However, guidance alone cannot ensure consistent recording, analysis, accountability or action across systems. The Bill provides a timely opportunity to give these existing commitments greater clarity and durability.

These proposals are supported by organisations working across the fields of health, public health, inclusion health, race equality and community development throughout the United Kingdom. While informed by longstanding evidence concerning Romani (Gypsy), Roma and Irish Traveller communities, the benefits of these measures would extend far beyond any single community and would contribute to a more equitable, accountable and effective health service for other racialised, marginalised and inclusion health groups. Establishing stronger mechanisms would ensure health systems are better able to see, understand and respond to health inequalities and unequal outcomes wherever they arise.

We therefore urge the Government to adopt, or work constructively to refine and support, these targeted changes to Clause 51 and Schedule 8, Clause 4, Clause 16 and Schedule 2, and Schedule 9. We would welcome the opportunity to discuss the proposals further and to share additional evidence from both community organisations and health experts who support these reforms.

Yours sincerely,



Yvonne McNamara

Chief Executive Officer
The Traveller Movement

cc.
Baroness Taylor of Stevenage
Lord Collins of Highbury
Baroness Whitaker
Baroness Bennett of Manor Castle