



**FOURTH NATIONAL INCLUSION HEALTH BOARD MEETING NOTES**  
**3 December 2012**  
**Richmond House**

**Attendees**

**Board members:** Professor Stephen Field (Chair), Professor Lindsey Davies, Charles Fraser, Glyn Jones (Deputising for Sandie Keene), Dr Jessica Allen (Deputising for Professor Sir Michael Marmott), Stephen Morris (Deputising for Duncan Selbie)

**Lead Minister:** Anna Soubry MP

**Working Group Chairs:** Dr Nigel Hewett, Dr. Bobbie Jacobson, Paul Hitchcock, and Professor Aidan Halligan

**Guests:** Dr Paramjit Gill and Adrian Hegenbarth, Royal College General Practitioners (RCGP), and Crystal Oldman from Queens Nursing Institute

**DH staff:** Frances Smethurst, Martin Gibbs, Angharad Evans (Minister's Office), and Karen Murphy (note)

**Apologies:** Duncan Selbie, Cllr. David Rogers

**Introduction: Professor Steve Field (Chair)**

Professor Steve Field (SF (Chair)) welcomed attendees to the fourth meeting of the Board and thanked Board members, working group chairs and guests for taking the time to attend.

SF(Chair) sent his best wishes to Professor Sir Michael Marmott for a speedy recovery from his recent accident.

SF (Chair) welcomed Professor Aidan Halligan, the new Chair of the Assurance and Accountability Working Group to the meeting

SF (Chair) informed the Board that:

- The Minister would be arriving a little later
- The Board would receive presentations from the RCGP and Dr Bobbie Jacobson, Chair of the Data and Research Working Group
- Frances Smethurst would be leaving her role as Branch Head of Health Inequalities to move to the Mental Health, Disability and Equality Division

The meeting note on the 10<sup>th</sup> of September was agreed. This would be placed on the DH website.

### **Presentation from the RCGP**

Dr Paramjit Gill (PG) introduced the work commissioned from the RCGP to develop a health inequalities commissioning toolkit principally for clinical commissioning groups and GPs.

Adrian Hegenbarth (AH) then gave the presentation. He began by talking about the need to produce a toolkit for clinical commissioning groups, local authorities, the NHS Commissioning Board and other agencies which would provide guidance on the principles of best practice, how to meet obligations, and enhance the ability of those hard to reach to access services. The toolkit would be primarily adapted to look at the access to health services for Inclusion Health priority groups: sex workers, Gypsies and Travellers and the homeless.

The toolkit would emphasise the importance of commissioning for hard to reach groups and would uphold the need to follow legal obligations in the 2012 Act, the social justice argument and cost effectiveness.

AH explained how a methodological approach would be used to analyse the information from major data bases using multi-field searches, subject headings, and then peer reviewed. He described how JSNAs, HWBSs and commissioning plans could fit together to agree on shared objectives and pooled budgets when appropriate.

He described the benefits of: sharing data with other agencies as well as local authorities; agreeing on local priorities; planning services to meet local needs; and commissioning the appropriate services, with a view to meeting national outcomes and local indicators

AH stressed the need for extensive consultation with the third sector and local communities to establish priorities, agree on local needs and commission a balanced and effective portfolio; and the importance of establishing what needed to be commissioned and what needed to be decommissioned

Finally, he stressed that we needed to look at what has been addressed and score the result against key indicators such as: peer mentoring schemes; advocacy; capability building and staff awareness; and developing a one stop shop approach. The aim is to get the hard to reach back to a point where they will come back into mainstream services.

**Comments:**

SF (Chair) asked what will the final product look like? He said that in every meeting he goes to with homeless people they say they have been turned away by GPs.

SF (Chair) raised concerns that the counter fraud guidance issued by NHS Protect was being used as a reason to not to register the homeless. The law is clear that proof of address is not a requirement for GP registration.

Martin Gibbs (MG) explained that NHS Protect had responded to a request from DH and withdrawn the guidance. NHS Protect is preparing fresh guidance that will be agreed by DH before issue.

Charles Fraser (CF) described how homeless people have complex needs. He refuted the description of them as hard to reach, as his organisation has no trouble finding them. Service providers find them easy to ignore. Services should be taken to where the homeless congregate. These people are not popular with services and the consensus is that they are all difficult.

CF said that we should determine what our shared objectives are and establish priorities; gather data evidence; and start treatment at an earlier stage. The definition of Statutory Vs Non-Statutory Homeless needs to be defined more clearly.

He added that there must be more analysis on how the budget cuts are affecting local authorities.

Aidan Halligan (AHal) said that we are not doing enough to recognise those GPs who are looking after homeless people. He asked if there is a register of GPs who are committed to looking after homeless people and if there is a way we could help GPs from a local commissioning perspective.

Lindsey Davies (LD) commented that from a GP perspective the three Inclusion Health groups were very different and therefore had different issues. With this in mind, LD thought we should consider whether we needed one or three separate toolkits.

SF (Chair) agreed.

Bobbie Jacobson (BJ) questioned where the evidence was to enable people to take the next step and that we needed to work on that. She also mentioned that there was nothing about sex workers on the presentation slides. The IHE is doing work to identify information on sex workers.

BJ asked why, if this is targeted at commissioning groups, we are looking at individual parties rather than the entire population? Similarly, is this directed at commissioning groups or at the pathway of individuals.

PG pointed out that the toolkit was a work in progress and that they were waiting for data and guidance that has to come from the college and above.

MG explained that he had ministerial go-ahead to look at the issue of GP registration for the homeless and transient populations. The NHS CB may issue fresh guidance for this area. Currently, it is a PCT responsibility to ensure everyone is registered. This responsibility will transfer to the NHS CB from April 2013.

PG commented that GPs and their staff must be made aware that people are entitled to register, that it is not up to the individual practice.

**Action:** PG said that he would arrange to meet with both SF (Chair) and MG to discuss what product they could bring to the next board meeting and he would discuss with MG the feasibility of having 3 separate toolkits.

The Minister joined the meeting.

SF (Chair) welcomed the Minister and following introductions summarised the discussion so far.

Minister (AS) said she recognised the necessity to reduce health inequalities and was committed to do so. She reported on the recent meeting of the

Ministerial Working Group on Homelessness and concern that the numbers of homeless people was increasing.

AS recognised the challenges faced in improving the health of the Inclusion Health groups. She spoke about her legal work with prostitutes and found them to be extremely vulnerable people. She expressed concern about the term sex worker as it indicated choice and did not describe how vulnerable these people are.

AS spoke about the need for good quality data and to share data better. She recognised that sharing data on vulnerable people could be very tricky, as we need to protect patients' privacy and recognise where the barriers were. She has resisted proposals for a duty on the health sector to share data.

BJ commented that one problem is the way data is collected which does not make it easy to share. The issues about confidentiality and confidence are huge. We need an initiative to standardise and rationalise the way we collect data.

#### **Presentation from Dr Bobbie Jacobson**

BJ introduced the presentation which was based on work undertaken by Peter J. Aspinall from the University of Kent, on "Identifying Vulnerable Groups and their health in Routine Data Collections" for the working group.

BJ described how they were working at the blunt end of inclusion/exclusion health. She talked about the triggers that protect people from becoming vulnerable and the fact that it is not clear how complex factors interact, that not everyone is the same and therefore there are different pathways in what is a complex variable field. The spectrum of vulnerability is very different for different groups. For example, economic migrants are not necessarily deemed as vulnerable.

BJ then turned to the issue of data. The analysis had found that some good data is collected and is not being used, that data is collected in an inconsistent way and across the Inclusion Health groups there are many gaps in data availability.

Action needed to be taken with regard to: data collection and reporting; analysis of data; and filling the gaps in research and methodology. The working group made recommendations for improving the data for vulnerable groups, and for standardising the collection and use of data.

BJ asked if the Board could host a meeting with data partners to discuss how data is collected and assimilated. In addition, could we as a Board, commission an annual report on Inclusion Health?

**Action:** SF (Chair) said he would commit to arranging a meeting for BJ and from a reporting point of view, sort out a system wide response.

**Comments:**

AS said that sharing of data should happen more often, but she will continue to resist sharing of information with the Home Office and the police as this could discourage the vulnerable from giving personal information to health professionals.

Stephen Morris (SM) said the fundamental reason for the existence of PHE is to provide coherent knowledge. We need to make information available to politicians and local government officials so they become interested. This is a winning agenda for PHE.

AS commented that while it is important to have the data, we should bear in mind that there will be an inherent prejudice across the board. We must ratchet up the debate on what not doing anything is costing local authorities

Glyn Jones (GJ) said that councils were interested in what is happening in their wards. We need to use information to tap the interest of councillors interest so we can make a difference.

AS said that local authorities should stop being prejudiced and commit themselves to making a difference to peoples' lives. They can't keep booting Gypsies and Travellers off their sites, it is time to confront prejudice.

SF (Chair) congratulated the London Pathway on its success in winning a HSJ award for services to the homeless.

A Hal explained how London Pathway works, how they employ homeless people as care navigators and that by operating in this way are able to buy better care for less money.

He mentioned that there seemed to be an administrative flaw in the way we registered homeless people with GPs as there didn't seem to be an option to classify patients as of No Fixed Address on the registration form.

AS asked how difficult it was to have a No Fixed Address option build into the system of registration?

BJ said that until recently the data collection on ethnicity from the NHS Information Centre had been abysmal.

SF said we needed to standardise and systematise data.

A Hal said that to do this we needed someone to take ownership.

SF (Chair) said that the NHS CB would be meeting with PHE to make this happen.

AS asked if we had identified the increases in homelessness and what were we doing about it?

SF (Chair) said that primary care access needed to be improved to save people going to hospital emergency departments. When things need to be done to improve access the Minister needs to be informed. We need less barriers rather than more to enable people to register

Paul Hitchcock (PH) asked how we can encourage GPs to develop the correct attitudes to want to work with data?

SF (Chair) informed the Board that there would be a Faculty of Homelessness Conference taking place in March and that the Minister had been invited.

LD said that we needed people to work to the new reforms which would enable people to work together more easily.

Jessica Allen (JA) said we have to look at the strengths of the programme so we can look at trajectories of people falling off the radar and then build this view into the pathway

SF (Chair) in ending the meeting, he welcomed thoughts for the agenda for the next NIHB meeting.

CF asked that the Board look into the effects of the changes in the welfare system.