Co-Chair Lord Victor Adebowale (VA) provided the welcome and introduction to the meeting which was held to discuss the role of the National Inclusion Health Board and its work in specific relation to the homeless and Gypsy and Traveller Communities.

Speakers at the meeting were:
- Professor Steve Field, Chair of the National Inclusion Health Board
- Yvonne McNamara, Director at the Irish Traveller Movement in Britain
- Charles Fraser, Chief Executive at St Mungos

**Speakers**

**Professor Steve Field** (SF) started with a presentation outlining the work of the National Inclusion Health Board and its core workstreams.

- The Inclusion Health programme is a DH led, cross-government programme which looks to deliver a step-change in health outcomes for groups that are vulnerable to the poorest health outcomes. This includes the homeless, sex workers, Gypsies and Travellers (GTs) and vulnerable migrants.
- The programme seeks to drive improvements, mainly through system reform and clinical leadership, to ensure everyone gets the care they need, regardless of their needs or circumstances.
- It also strives to ensure policies and programmes across health and the wider social determinants of health consider the needs of those with multiple problems, and result in their equitable access to quality care.
- The key document on Health Inclusion (HI) is The Marmot Review looking at the social determinants of health.
- Areas the HI Board are looking at need investment and more attention to be part of the system.
- Stats given included:
  - GTs are twice as likely to have poor health than the rest of the population.
  - Homeless individuals are 4 times more likely to have musculoskeletal problems, 6 time more likely to have respiratory problems and 25 times more likely to have eye complaints.
  - 68% of women in prostitution meet the criteria for Post Traumatic Stress Disorder in the same range as victims of torture and combat veterans undergoing treatment.
  - Asylum seekers and failed asylum seekers have proportionately high mental health needs: 1 in 10 suffer from PTSD and 1 in 20 suffer from depression.
- This work is very much linked to the Health and Social Care Bill.
- As the NHS Commissioning Board is about to be established, it will be driven by looking at 5 outcome goals of which will need to include excluded groups.
- Measuring is often based on outcomes rather than measuring stories – this doesn’t capture everything.
- The numbers of people in excluded groups are small but outcomes are appalling and costs are high. Economic modelling around the homeless shows that you should invest more in this group as it saves more in the long run.
- The Health and Social Care Bill will ensure the Secretary of State has a legal duty to address inequalities.
- What the Department of Health have been doing is working with colleagues in the Lords to ensure inclusion health is in every part of the Bill. Also trying to encourage JSNAs to include direct targets around homeless, GTs etc.
- People don’t have access to care and the quality of care due to their chaotic lifestyles is very different to others.
- Traveller health has not been cracked by the NHS.
- Neither are we very good across England on homeless healthcare – transport, housing, the economy – we could do better.
- Sex workers care is not that good either.
- When individual need starts moving from physical to mental health the picture is quite shocking.
- GPs will say they never turn patients away; that they always see people quickly and continuity of care is important; yet there are examples of GPs within yards of centres that won’t work with disadvantaged groups.
- The NHS is generally not a bad system but it is not universal.
- ACCESS is one of the things the IHB will be working on. It is also working on a model of 4 working groups including:
  - **Improving leadership and training** – not in all curricular for Royal colleges, nurses and GPs do not have placements in the places where there’s the most disadvantage unless a special study model – many therefore won’t have a clue that these people exist. People aren’t being treated with respect, compassion or care by healthcare professionals – if staff had better training and exposure throughout training they may better understand health needs.
  - **Data and research**
  - **Provision, prevention and promotion**
  - **Assurance and accountability**
- In meetings with David Nicholson Steve was positive that he wants to do something dramatic around health inequalities.
- Discussions with the Secretary of State are exactly the same – Anne Milton wants to come to their meetings, Paul Burstow is very active (lead for the homeless), Opposition also very keen. The outlook is positive.
- As the Bill passes on we’ll hear more about the IH Board’s work.

**Charles Fraser** was our second speaker, talking about what St Mungos are doing to link to Inclusion Health and to look briefly at relevant system reforms and the changes required to ensure people have access to health care.

- On Inclusion Health Charles stated that they are big fans of it, Charles is on the Board, and St Mungos involved.
- Ministers from other Departments visited and spoke sympathetically about engaging with hard to reach groups.
- Inclusion Health crystallised necessity of going to where people are and taking services to them.
- The Board has only met once but can provide a rallying point across Gov’t.
- DWP launched its Social Justice Strategy and reference IH Project (p56).
• Role of Health and Wellbeing Boards (HWBs) increasingly vital - suggested they should have an inclusion health subject for each HWBs to allow them to assess the needs of excluded people with a line back to a national programme – **DH and Central London councils seem to be keen but need to lobby for this with your contacts!**

• Need good and consistent primary care that covers things like Mental Health treatments and intermediate care acknowledged – exploring a pan London GP service through a community interest company with Great Chapel Street in Soho run by GPs to provide the clinical governance back to the CIC – called homeless health care

• Looking at recovery centre to provide medical care for homeless in the community plus discharge place for the UCL and Royal Free hospitals

• Steve spoke about access but also about usage and some residents do have theoretical access but do not use so do not have good outcomes

• We think some of the goals can be achieved in a round about way – vocational scheme where some have substance misuse dependency and the powerful pull of occupation does help people turn lives around

• Leadership is critical and hope IH has the muscle it needs – the involvement of Anne Milton is welcome and should have this muscle.

• How do we really get traction across the system?

• Measurement: if it's not measured it doesn’t exist. How do we ensure the JSNA includes neglected groups - not disease focused but the needs of those with the worst health needs to be highlighted and fed back into commissioning cycle?

• Health inequalities: the responsibilities for this lies with the NHS Commissioning Board, CCGs, Public Health England, HWBs and in London the Mayor has a strategy – everyone is responsible so who will take responsibility?

• One size fits all-ism – whole population approach in health, employment or housing do not work. Commissioners need to target and recognise specific and segmented groups who may be small need targeted support to address compounded problems – whole population approach marginalises these groups further. Policy makers need to address unequal things unequally.

**Yvonne McNamara** from the Irish Traveller Movement in Britain was our final presenter and provided the perspective from Gypsy and Traveller communities.

• Gypsy and Travellers (GTs) are effectively homeless in this country

• From a health perspective there are a lot of issues for this community – one of the biggest difficulties for their organisation is the lack of recognition and monitoring for this population.

• There is no national data collected on GTs and despite all of the issues within this community they are not one of the 16 ethnic groups monitored. They need to be included otherwise how can we address inequalities if not recognised? They are beginning to feature in some of the policies but only in a small way.

• From a Public Health perspective this should be a priority. Look at life expectancy – 10 years less for men than settled population and 12 for women. Some research in Leeds say life expectancy is now 20 years worse in some areas

• Infant mortality is 3x higher than the national average

• Other issues around poor site location of where GTs are living mean high rates of respiratory conditions

• Lack of access to GPs means there are huge issues for GTs to get healthcare access to things like immunisations so they access A&E instead. It is a catch 22 situation as GP surgeries aren’t working with them, A&E complain…
Social care and mental health is another big issue. There is very little research out there and there is one report by DH (2004) in relation to GTs saying this population is twice as likely to be depressed.

Conditions for GTs are very difficult at the moment.

What can we do?

- Asking the APPG (along with the specific APPG chaired by Andrew George) to bring some pressure around ethnic monitoring
- European Commission called on members last year to develop a national Roma strategy – integration strategies on a number of issues around integration, health etc however we are still not taking action. Members have said no but some policy measures will be introduced – all piece mill, not joined up and still no national strategy
- Nothing has changed for these communities – some situations have actually got worse over the last 50 years
- Red Cross are involved in the Dale Farm site due to living conditions
- No authorised sites being developed at the moment, no fixed abode constantly moving so no access to healthcare
- Need to get to grips with this community – the issues are vast
- Need targeted measures to address the huge gaps in inequality across different areas
- Two key asks are for 1. Ethnic monitoring and 2. A national strategy to address the huge health inequalities faced by this group.

Victor thanked out speakers but noted a sense of de ja vu, being back here again talking about these issues again (compared to the 80s when we were talking about this.) Why do reports get written and why do we keep coming back?

- What amongst the moral argument is the driver for change? The moral is not enough so what is the argument here and now that we need to make it clear to Ministers that this has to happen?
- In regards to primary care Victor noted a new medical centre in Earls Court Turning Point are involved in and offered for St Mungos to visit – provides an example of bringing the community into primary care
- On the issue of Commissioning he said it is apparent that population commissioning is essential. There's an attempt to find hard cases/hard to reach but in fact we're discovering there's an and/and approach. Turning Point's Connected Care methodologies, and similar, work provide bespoke approaches to community problems based on understanding of need.
- He was keen not to invite a hierarchy of oppression but there is something about Roma communities that brings it all together – homeless, stigmatised, needs ignored – how we can learn about the treatment of this community and what we're not doing for excluded groups is essential to discuss.

Victor opened up the floor to discussion.

Steve Field

- Inherent institutional racism around Roma – disparate group of backgrounds made worse by portrayal in the press (Dale Farm or reality tv shows)
- Because people aren’t necessarily in an area long enough services don’t get involved
- Homeless services and support does exist – some excellent work – some enthusiastic GPs but constraints around primary care commissioning due to GP boundaries (excuse) – where more successful new services are being commissioned like TP in Earls Court, like in Leicester are where boundaries aren’t such an issue. It is where commissioners look at population need and
commission new services for these groups that go beyond boundaries – London Mayor’s team – if they could work together and have a primary care team covering a large area it would improve things drastically.

- In Birmingham 1.2m people, 1 LA should be able to provide a pan city response to these groups but currently do not.
- Commissioners need more imagination. No Bill needed to act in this way.

**Baroness Meacher**

- Chair of a MH Trust in East London and was on the Marmot Commission
- We don’t have masses of money so need to focus where it is needed
- Interested in these groups and the mental health issues they face – acute and physical. The Commissioning Board could risk being all about physical health – it must include mental health as an equal priority.
- So many people supported by St Mungos have issues linked to MH.
- LTC priority of the Commissioning Board should include reference to MH
- MH is biggest deprivation area of the whole lot and if we address that a lot more will be addressed.

**Steve Field**

- Amendment (Hollins amendment) to add MH to every reference to ‘health’ in the Bill wasn’t taken forward which is unfortunate
- David Nicholson agrees with MH inclusion and setting up Board he is committed to this but our role (the wider group) is to hold the Board to account for this.

**Victor**

- Good point around resource allocation – there is enough in the system but what do we spend it on?
- In Molly’s experience will the new health configuration mitigate towards changing perception or not?

**Baroness Meacher**

- GPs are very aware of areas that are neglected – some bits will improve
- Concern is the privatisation of commissioning work - will KPMG be driving a lot of this and will we lose the plot?

**Steve Field**

- IAPT supported and a good example – it has a strong economic argument behind it
- If you do not measure it you can not know the benefit – particular challenge for GTs
- Move research money into population research because without evidence you can’t convince the Treasury to invest
- How do you get people seen quickly?

**Lynn Emslie (NHS South West)**

- Focus on Early Interventions (EI) and ID people who are in a large case known to services but focus on EI so things don’t escalate to more serious needs
- Early intervention is better for the individual, cheaper, more effective and reduces unnecessary escalation.
- Put interventions in early to try and stop it escalating – politically and economically makes sense

**Victor**
• In regards to prevention there is a stock and flow problem. The people who are persistent are part of the stock, prevention is too late – wonder about the prevention end but wonder about the reality.

Charles
• The issue of compound or complex trauma amongst rough sleepers in their childhood is well understood and he has been told by colleagues that people can be identified with some accuracy as being prone to homelessness and complex problems in later life
  o Two issues are repairable: that children and adolescent services aren’t that good and should be improved
  o Transitions are hard and should be smoother – compounding barrier
• EI if designed and applied intelligently could have a positively effect
• If public services did their job better upstream, St Mungos would support less people.

Dr Philip Timms (South London and Maudsley NHS Foundation Trust)
• Downstream prevention – psychosis for 10/20 years
• Accessibility and responsibility of a service – tertiary
• Couple of issues: GP registration and cleaning of lists is an engine of social exclusion and several clients have been wiped off lists and it is hard to get them back on. If you’re not on a GP list you can’t be moved on to other services (physical health lists, Community MH services etc)
• Information and data – there are no current databases used by Trusts routinely to collect accommodation data
• The MH minimum dataset has good housing codes that should be used across health and social care – it would give the information we need. This is a real problem at the moment.

Dr Nick Macguire (University of Southampton)
• As an aside to add to mortality issues is murder – 2 homeless people who came through the project were killed and hidden statistics
• Exclusion from psychiatric services is very easy – there are many reasons including substance misuse, homelessness etc
• Data: Revolving Doors coding model for data and how costs can be reduced by interventions is very helpful. People will pay attention to costs and costing models (the RDA model was shared at a previous meeting and can be found here: http://www.revolving-doors.org.uk/documents/financial-analysis-model-an-introduction/)

Steve Field
• We need to measure and evaluate outcomes – people need to be coded so you know they exist
• Within current provision (linear) have to go to the GP, be referred. Under new model, under the Commissioning Board it should be possible to commission services for groups of the population (homeless) including Mental health, Substance Misuse services. If commissioning across health, social care and commissioning in the round, there isn’t a lot in the different models, currently all separate.

Steve posed the question: If you could commission something new what would it look like? In answer he suggested direct access to substance misuse and mental health without the involvement of the GP.

In response to Steve’s question:
• Yvonne McNamara
- There’s scope to look at commissioning for these groups in the whole – the common denominator is that they are transient communities so there is scope to look at how services for these groups are commissioned.
- For GTs there is a lot of mis-information – not all GTs are normadic – the majority are living in houses but for transient and site based gypsiesa lot more is needed.

**Charles Fraser**
- Would like to see commissioning across practice boundaries – social care is difficult due to political control and LA boundaries are less flexible than practice boundaries – health across boundaries and shift between primary and secondary would be fantastic

**Dr Philip Timms**
- Have direct access to MH services for the homeless
- Don’t ignore GPs but more self referral into services

**Anna Page (Revolving Doors Agency)**
- With Commissioning Board responsible for offender health (Diversion at national level) how will this translate to local areas and how will nationally commissioned services relate to locally commissioned services? This could be the same for GTs and Homeless national vs local commissioning.

**Steve Field**
- The Commissioning Board needs to take this seriously
- IHB role is to challenge them
- Useful for IHB to meet with RDA to influence Commissioning Board policy

**Julian Corner (Lankelly Chase)**
- What is the role of rights and equalities in this area? Talking about people’s basic quality of life and it evokes anger because this compromises people’s fundamental right to a good quality of life
- Gets cross when the rationale for change is that it costs less or tidies commissioning – in the midst of this where is the role for defending/extending people’s rights to a basic quality of life?

**Steve Field**
- There is a Future Forum piece of work just starting on the NHS Constitution which is worth looking at and using.
- The NHS Values state in law that individuals have to have access to NICE approved treatment or programmes. We could decide a programme of care for the homeless is access to open access to care
- Pressure on NICE programmes so we should have one for homeless or GTs as there could then be a legal challenge if not met.
- Values include treated with respect and dignity, high quality care, safety and care, compassion, humanity and kindness, everyone counts – all in the constitution for users of the English NHS
- Colleagues say they’ll see anybody but when you meet with individuals there are ways for excluded – often blamed on receptionists – pushed onto A&E.
- Use the constitution!

**Charles Fraser**
- There is a sense of de ja vu and a moral argument is convincing but not won. Neither is the economic argument.
- Good point about NICE programmes – legally challengeable
Before the election there were statements around people receiving proper healthcare and a route back in to PCT through World Class Commissioning. The PCTs did not have to give a damn about these groups but did care about their World Class Commissioning score. Need a new hammer that hurts when applied for inaction.

Victor

- How do you hold commissioners to account for inaction? A question for the Commissioning Board.
- If it’s a hanging offence then they’ll do it, if a flogging offence, they’ll take a flogging

Matthew Brindley (Irish Traveller Movement in Britain)

- In regards to the research and data work stream of the IHB – the problem is that there isn’t any recent data on GTs – 2004 is the best that exists.
- There are some in NHS Trusts – Bedfordshire, West Sussex, Surrey have done good needs assessment with these communities but this needs to be put together
- Need to include GTs in the NHS ethnic monitoring nationally and for a data change to include GTs – included in 2011 census but the DH hasn’t caught on.

Nerys Cross (Department of Health, Inclusion Health)

- Part of the workstream is looking at this: issues in terms of number of people in a local area and homelessness and what do we monitor locally to pull together a national picture?
- Need for national level and local level data and clear ways of collecting

Sophie Kydd (Addaction)

- Increasing knowledge within vulnerable groups (substance misuse/homeless/sex workers) – word of mouth within communities is very important to raise health issues, awareness of services etc
- TB is a big problem and Hepatitis C and substance misuse itself and teaching people about it. They tell each other and the news spreads/ help each other recognise issues which can lead to signposting
- All very localised – lack of funding for this kind of work
- Substance misuse = engaged audience once through the doors but need to create places where knowledge of a whole host of issues can be spread.
- Added extras that services provided that helped people have stopped.

Dr Fabian Davies (British Psychological Society)

- Basis of exclusion itself
- Why haven’t we addressed what it is that leads people to being excluded and remain in that cycle? Do they exclude selves? Shunned, goes round and round.
- Need to address something in ourselves (those of us not excluded) to build partnerships with the excluded to build relationships – what are we doing to share aspirations of excluded groups when informed about change and inclusion?

Final comments from the panel

Yvonne McNamara

- Non-excluded not wanting to be involved with excluded groups
- As an organisation they have been making DVDs on maternity care (won the APPG award for innovation). The next will be on mental health, speaking to
the professionals and the community – first steps to engage with psychological therapies and MH orgs delivering services but not targeting these populations
- Dislike the term ‘hard to reach’ – reach is made too hard, no such thing.
- NHS Constitution is of particular interest – is this the lever? Is it a legal challenge to use? Moral argument hasn’t worked and from a business perspective (Roma integration strategy) money sitting in Europe but gov’t are still not engaging

Steve Field
- One of the rights in page 5 of the NHS Constitution – legal right not to be discriminated against = LEVER to use!
- A future APPG meeting on the constitution for excluded groups and a means for delivery post July would be very helpful – when looking at tightening it.
- Get on Health and Wellbeing Boards.

Charles Fraser
- Addaction point around best advertising is word of mouth
- St Mungos use peer mentoring
- Believe that while people are neglected by the system some do neglect their own health – vicious cycle that operates
- What works best is peer engagement and simple services

Victor
- The role of local authorities and HWBs also put duties on local authorities to reduce health inequalities which can be challenged so there are more routes to challenge than ever before, providing the bodies have access to the understanding needed to do it.
- Never about lack of money – lack of know how of how to spend it
- It is possible for these services to be commissioned but patchy

Sophie Haves (Women Institute)
- Reference the WI care not custody campaign
- Tap into hard to reach/hear issue in terms of access being the issue and need to provide services that can be engaged with
- AQP issue through voluntary sector who know how to work with these groups can play a key role in supporting these groups.

Victor in response
- Yes but it depends not on competition but how the market is managed

Victor thanked everyone for their contributions.

The next meeting of the Group is on Wednesday 25 April on the Transition to Public Health. Email appg@turning-point.co.uk for more details.