THIRD NATIONAL INCLUSION HEALTH BOARD MEETING NOTES
10 September 2012
Richmond House

Attendees

Board members: Professor Stephen Field (Chair), Sandie Keene, Professor Lindsey Davies, and Jessica Allen (Deputising for Sir Michael Marmott)

Working group Chairs: Dr Nigel Hewett, Helen Mathie (Deputising for Dr. Bobbie Jacobson), and Paul Hitchcock

DH staff: Alison Ismail, Frances Smethurst, Martin Gibbs, Alison Powell and Karen Murphy (note)

Apologies: Jim Easton, Charles Fraser, Duncan Selbie, Adrian Halligan, Cllr. David Rogers and Shaun Gallagher

Introduction: Professor Steve Field (Chair)

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

SF (Chair) informed the Board that:

- Following the recent reshuffle of ministers, there was a new Secretary of State and junior ministers at DH. It was not yet known who would be the new lead minister for Inclusion Health.

- Paul Hitchcock has agreed to chair the Leadership and Workforce working group.

- Professor Aiden Halligan has agreed to chair the Assurance and Accountability working group.

- There will be some staff changes at DH: Frances Smethurst replacing Alison Ismail as Head of the Health Inequalities Unit while Alison is away on maternity leave; and Alison Powell replacing Nerys Cross as Policy Manager of Inclusion Health

SF (Chair) thanked Anne Milton for her support, guidance and commitment to Inclusion Health when lead minister.

The note of the meeting on 2 May was agreed.

Chair updates

SF(Chair) invited each of the working group chairs to introduce their papers on progress and work plans.

Paul Hitchcock (PH) – Chair of Leadership and Workforce Working Group

- The main objective of the working group is to develop strong, clear national and local leadership for the IH agenda, and a dynamic movement for change. To promote the idea of developing a strong, stable and capable workforce to drive change and make a difference to the lives and health outcomes of the most vulnerable.

- PH stressed the importance of establishing training for non-professionals, encouraging an atmosphere of capability and inclusion, involving unions such as TUC in the process and perhaps having them on the working group.

- PH also stressed the importance of capturing information from research done by existing organisations before it is lost during the transition to the new health system.

- PH said it was important to build relationships with other organisations and to expand the membership of the working group to include organisations as such Health Education England.

- PH suggested each of the working groups should be developing their workforces.

Comments:

- Lindsey Davies (LD) commented on how important it will be for health and wellbeing boards to engage in this agenda and develop their understanding of required competencies.

- Sandie Keen (SK) stressed the need to engage with other professionals and is currently involved in talks with health and wellbeing board early implementers.

- LD commented that having DCLG around the Board could be a good plan as it would show genuine joint sponsorship and make it more likely that LGA would take the board more seriously.

- Martin Gibbs (MG) pointed out the intention for the Board to remain independent of central government. He has been in discussion about DCLG having representation on the working groups.

Dr Nigel Hewett (NH) – Chair of Provision, Prevention and Promotion Working Group

- The main objective of the working group is to develop and promote innovative models of joined-up, promising, cost-effective and equitable care. To develop proposals for raising health aspirations, preventing and intervening early.

- NH stressed the adverse consequences of exclusion.

- NH stressed the importance of not losing valuable information on innovative approaches that can be found in the third sector and community organisations, which are currently under threat. There is a deep concern that in 18 months time all knowledge held by existing groups will be gone.

- The Homeless Transition Fund could be a potential model on which to build to ensure the sustainability of voluntary sector organisations engaged in health related activities.

- NH reiterated the need to have a complex integrated response to housing, medicine, etc and that people experiencing health inequalities should be involved in the process of service integration.

- There is a risk that the most vulnerable will fall between gaps in the new commissioning arrangements.

- On a geographical level, NH proposed that the NHS CB should establish a network of local Inclusion Health leads, which could coordinate CCGs commissioning for appropriate provision.

Comments:

- SK commented that we need to be clear on what is central and what is local. We need to know the levels of granularity of who is doing what and pull them together. If we put responsibility lower down the system we are more likely to get something done.

- LD said an Inclusion Health network could be really powerful. Local authorities are good at leading health improvement and we should make the most of that skill. We need local champions of Inclusion Health. They could be a professional nurse, a GP or a health professional. They don't have to be from a particular profession. There could also be a network or Directory of local health professionals.

- SF warned of the potential risk this could become a fragmented system with an inclusion lead for every CCG.

- Duncan Selbie from Public Health England should be involved.

Action – It was agreed that SF, SK, and LD should meet with Duncan Selbie. PH said he is meeting with Duncan Selbie and will propose a round table event.

- SF commented that across the working groups we are light on mental health.

- Jessica Allen (JA) suggested the networks should also focus on prevention.

- Helen Mathie (HM) mentioned the existing networks on Homelessness and that these focus on wider inequalities.

Helen Mathie – representing Dr. Bobbie Jacobson, Chair of Data and Research Working Group

- The main objectives is to improve how the health system identifies vulnerable people; improve the available evidence of good practice in prevention and access to cost-effective health and care interventions; improve how the system measures quality of care for vulnerable groups;

and to work across academic partners to build best practice and research capability.

- The working group held a workshop on understanding and measuring vulnerability on 31 May. This will be followed by further work on vulnerability measures.

- HM explained that data being collected from many different places needs to be pulled together.

- The Group membership would be looked at in light of the work programme.

- It had been noted that some vulnerable groups do not fit onto the slope gradient and we need to find out the best way to get them onto the index of inequality.

Comments:

- JA suggested it may be possible to weight the index to include vulnerable groups.

- SF said we need to make people visible as human beings.

- LD expressed concern at the impact of welfare reforms and this is creating anxiety. The Health Premium could lead to perverse incentives.

- JA reported that the UCL Institute of Health Equity has done a study of the impact of welfare reforms on health inequalities in London.

Action - To send the link to the report to Board members.

- SF asked what are the outcomes we might use for groups at a local level? How do we know what is happening in terms of vulnerable groups?

- NH commented that we need to come up with proposals for the things we need to look at, such as what we should be doing to deliver long-term health improvement.

- NH suggested we could look at developing a guide to setting up an Inclusion health network.
- LD suggested using peer review as a means of developing networks, similar to the peer review used by local government.

- SK suggested we should welcome something that has joint ownership.

- SF said we need to translate the duties on health inequalities to Inclusion Health. The risk is as a group we could drift too much into Health Inequalities and it could become too much.

Steve Field - representing the Assurance and Accountability Working Group

- The working group's main objectives are to take forward the objectives outlined in the Inclusion Health strategy document and work plan through actions that can be undertaken through professional networks and using strong expertise within the groups to forward recommendations to Board on how to deliver the Inclusion Health Programme.

- Mike Kelly has set in train work at NICE to explore the potential for NICE guidance on dual diagnosis and complex needs.

Martin Gibbs – update on Inclusion Health

- Officials will be meeting the new ministers over the coming weeks and when identified, will discuss Inclusion Health with the new lead minister.

- We hope the Minister, Jim Easton and Duncan Selbie will be able to attend the next Board Meeting.

- The DH consultation on JSNAs and JHWBs had been sent to Board members. We will coordinate comments from the Board.

- We need to do more work with DCLG to model how we make integrated services work across health, local government and the voluntary and community sectors.

- SF suggested that the Board meet with St Basil's Youth Reference Group to listen to the concerns of young homeless people.

- HM pointed out that Homeless Link maintain a records of organisations that are seeing their funding reduced or ending.