FIFTH NATIONAL INCLUSION HEALTH BOARD MEETING NOTES
5 March 2013
Richmond House

Attendees

Board members: Professor Stephen Field (Chair), Cllr. David Rogers, Professor Sir Michael Marmott, and Stephen Morris (Deputising for Duncan Selbie)

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

Guests: Christine Marriot, Professor Waleska Teixeira Caiaffa, Belo Horizonte Observatory for Urban Health, Brazil **[Steve - to provide names of his team attending]**

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

Apologies: Duncan Selbie, Charles Fraser, Sandie Keene, Professor Lindsey Davies, Crystal Oldman, Anna Soubrey MP (Lead Minister)

Introduction: Professor Steve Field (Chair)

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

He welcomed Professor Waleska Ciaiffa from the Belo Horizonte Health Observatory.

The meeting note on the 3rd of December was agreed. This will be placed on the DH website.

DH Update: Martin Gibbs

Martin Gibbs (MG) informed the Board that funding was approved for two new projects.

St. Mungos (£10,000) to identify the additional costs falling on primary care services in meeting the health needs of the homeless, and the Irish Traveller Movement in Britain (£15,000) to provide evidence of the impact of poor living conditions on the health of Gypsies and Travellers. Both projects would report to the Board.

Approval is being sought for funding for the Provision, Promotion and Prevention Working Group to develop the model for community based medical respite centres.

MG said he expected an Inclusion Health programme budget of £200,000 for 2013 / 2014. This would provide uncommitted funding of £100,000 and he asked the Board and working group chairs to consider the most effective ways to invest this.

MG reported on work with DCLG to scope the future work programme for the Ministerial Working Group on Homelessness. DH is keen to get a handle on what is driving the recent significant increases in homelessness. Minister is concerned about the impact on the families with children made homeless and moved to accommodation some way from their home area.

Work to develop the Inclusion Health guide on inclusive JSNAs and JHWSs is progressing well. The guide will be shared with the Board for comments in April. It is essential that the need to better reflect the needs of vulnerable groups in JSNAs and JHWSs is recognised and acted upon.

Action – Circulate draft guide for comment.

Other updates:

Paul Hitchcock (PH) reported on the Leadership and Workforce working group project on curriculum mapping, which would build on work previously undertaken by the Academy of Medical Royal Colleges. This would develop a set of national standards and criteria for professionals working with vulnerable people and map them against the NHS leadership attributes.

MG commented on how important it was to get health inequalities embedded within the NHS Constitution.

Michael Marmot (MM) reported that the Institute of Health Equity (IHE) would publish a report demonstrating the role the NHS workforce can play in reducing health inequalities through action on the social determinants of health. The IHE has the commitment of 19 health workforce and other organisations to an on-going programme of work.

MG said he would see what could be done to make the link between the report and the NHS Constitution Handbook.

Cllr Rogers (DR) said that while local government supports the intention to reduce inequalities, it was important to recognise that local government funding has been cut significantly. He asked whether travelling show people were included within the Gypsy and Traveller group.

SF (Chair) said the remit did not include travelling show people, but that it was an interesting proposition.

Aidan Halligan (AH) said it was critical to have the right relationships with local government and that by working together as a group and integrating our work, we are in a much better position to heighten awareness of health inequalities. We should be questioning the entire configuration of health services if we are really committed to patient care.

SF (Chair) said that as a team we needed to be bonded with LG, PHE and the NHS CB and that we need to get a strong message across that we are going to use the standards which we have agreed at the Board to take things forward.

He went on to update the Board about recruitment to his team at the NHS CB. There would be a lead on Inclusion Health and Health Inequalities who would be looking into, amongst other things, the outcomes framework, different groups (ie cancer patients) and what effect geographical location has on rates of vulnerability.

Stephen Morris (SM) informed the Board that the PHE team would soon be established and he suggested it might be useful to have Kevin Fenton and John Newton come and talk to the Board. He said PHE was an integral part of providing funding to enable local government to deliver. PHE wants to work with the expertise of this group and local government to find service solutions.

He added that as the NHS has protected funding; it needed to tread with great care to avoid creating divisions between itself, public health organisations and local government, all which had seen their budgets reduced.

Action - Invite Kevin Fenton and John Newton to a meeting of the Board.

DR said the disparity between PCT reports on what they had spent on public health, which had influenced the level of funding to local authorities, was an issue for local government.

SF (Chair) informed the Board that the NHS CB had secured a further £100.000 from the medical budget to fund a further four-day event to focus on health inequalities and Inclusion Health. The intention is to discuss such subjects as medical levers to identify vulnerability, and what procedures should be followed to improve the health of vulnerable people.
Amongst others, the events will include invitees from the NHS CB as well as medical commissioners.

Helen Mathie (HM) updated the Board on the work she was doing on barriers to GP registration and models of primary care provision for the homeless and other vulnerable groups. A picture of the current situation is emerging, for example, 85% of homeless people are registered with a GP, however, 35% of vulnerable migrants reported they had been refused services.

There are examples of innovative effective commissioning models around the country. There are, however, concerns about the future commissioning of low volume services such as non-clinical health visitors and advocacy services in the new system.

SF (Chair) said we need an early warning system in place to identify vulnerable groups and commission services for them in a collaborative way.

Bobbie Jacobson (BJ) suggested there wasn't enough evaluation being done on the percentage of the population that needed to be served to make the value worthwhile. PCTs have been using locally enhanced services in order to finance primary care. There needs to be centralised information about whether these specialised services are working.

SF (Chair) said we needed to work with the NHS CB team to make things happen.

Nigel Hewett (NH) reported on the work to revise the standards document as well as work they were doing on modelling medical respite.

(BJ) thought we should be repopulating the "We". If we are all in this together, when we have annual events all four of the working groups should be given equal time as all were trying to keep up their initiatives. She reiterated that there needed to be a place to assimilate shared information, a shared website where information could be uploaded and accessed).

MG reported that work to develop an Inclusion Health website was on hold because of changes being made to government websites.

Presentation from Professor Waleska Ciaffa

Professor Ciaffa (WC) presented the work she has done to develop a vulnerability index, which identified social determinants and inequalities in the urban environment, from both a physical and social point of view.

WC described how they were identifying action-oriented indicators by assembling data from different sources and creating a citywide database of urban indicators. The municipal government now uses the index to inform decision making about population needs, resource allocations, and program guidance.

SF (Chair) thanked Professor Ciaiffa for her presentation and iterated that there were some important parallels for us to consider.

BJ said the Board needed to focus on both the place based index and /or vulnerability index, which would capture healthcare needs. We could not ignore housing needs as they affect the ability of people to register with a GP and can therefore influence healthcare needs.

Health inequalities duties

MG gave a short presentation to introduce the new legal duties as regards to health inequalities duties in the Health and Social Care Act 2012.

Action – to send detailed information on the duties to the Board.