



Inclusion Health: Education and Training for Health Professionals

END of STUDY REPORT



'I didn't used to trust what the doctors were saying about my mental health. I do trust these people now with my life. They made it a lot easier for me to trust them. It is not everything shut at 5pm and doors closed. They are there to help.'

Service user

'Socially excluded service users report that they are often less concerned with their long-term health than in finding a way to overcome their daily circumstances.'

Specialist Community Nurse Practitioner

'Homeless patients can't keep eye drops in a fridge, and can't wash their hands before and after application of the drops.'

Lead Nurse Practitioner

'In the Community Trust that has 65 different settings, that as a bare minimum each of those settings one person has done a day's equality and diversity training and then comes back with competencies and a guide. However, quite often they may not be given the time to cascade the information to colleagues.'

Equality and Diversity GP.

Inclusion Health: Education and Training for Health Professionals

Study commissioned and funded by the Department of Health to inform the work of the National Inclusion Health Board.

INCLUSION HEALTH

The concept of Inclusion Health is founded on the premise that not all UK citizens have access to the highest standards of healthcare. Meeting the health needs of a small group of socially excluded individuals and their communities remains a challenge. This population has poorer predicted health outcomes¹ and a shorter life expectancy than the average population.

The National Inclusion Health programme for England was launched in March 2010 as a cross-government programme led by the Department of Health. It provides a framework for driving improvements in health outcomes for socially excluded groups. The rationale for setting up this framework is to increase the understanding and visibility of the health needs and health outcomes of socially excluded groups. The framework will also ensure that the services which support this population continue to improve, including continuity of care and building capability and capacity. One key activity within the framework is to recognise the achievements of professionals in this field and to build connections across disciplines between health and social care.

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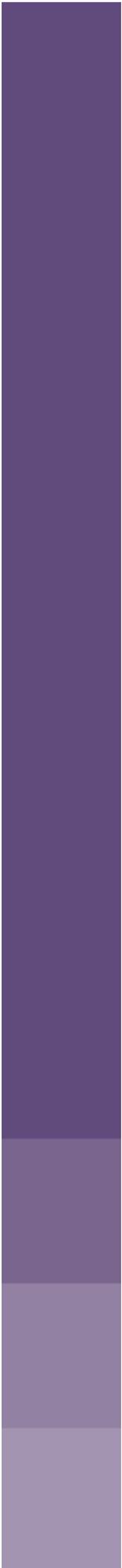
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EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

This report is the output of a study of the education and training that healthcare professionals need, and also receive about Inclusion Health, to enable them to work effectively with vulnerable people who are either homeless, Gypsies and Travellers, Roma, sex workers or vulnerable migrants. The study was commissioned, by the Department of Health, to look at the situation in England and to inform the National Health Inclusion programme. Healthcare professionals are educated and trained in higher education institutions across the United Kingdom. Much of the UK wide healthcare workforce is mobile and during their career many professionals will work in more than one devolved nation. With this in mind the study considered the education and training about Inclusion Health across the devolved administrations.

It has been written to be of interest to the Department of Health and other policy makers, regulatory and professional bodies, the health education sector, education commissioners, public sector service providers that support patients from socially excluded groups, and third sector organisations.

In this Executive Summary we briefly outline the approach we have taken to the study and the contents of each chapter. First, we provide a summary of our key messages, followed by the main limitations to the data and the recommendations for national bodies and education providers.

Key messages

- This study has prompted the education providers to reflect on the extent to which they embed Inclusion Health in their courses. It has also enabled practitioners to express their views about how well the education sector prepares them to care for vulnerable groups and supports them throughout their careers.
- All four devolved administrations recognise the importance of national policy that embeds Inclusion Health in the education and training of healthcare professionals. Each nation has published guidelines to address improvements in health outcomes for national patterns of social exclusion. However, we did not find any evidence of government departments, or national organisations, setting out a plan of work to ensure that healthcare professionals have the appropriate knowledge and skills to care for vulnerable communities.
- Inclusion Health is an area that is generally underdeveloped by healthcare regulatory bodies. The Nursing and Midwifery Council gives the most detailed guidance about Inclusion Health. Some of the regulatory bodies make reference to social determinants or health inequalities, whereas others make no reference at all to Inclusion Health. Without clear regulatory bodies' standards and guidance about Inclusion Health, which in turn enforces the education sector to incorporate this topic in the curricula, there is no guarantee that aspects of Inclusion Health will be taught and assessed.

- The extent to which professional bodies guide their members and the education providers about aspects of Inclusion Health varies enormously. Fewer than half make specific reference to a particular aspect of Inclusion Health. However, The Royal College of General Practitioners has an exemplary resource which is widely available to all healthcare practitioners and the Royal College of Nursing supports an online resource about Inclusion Health for its members.
- The evidence published by organisations, which employ staff to work with vulnerable groups, states that many healthcare practitioners lack the knowledge and skills to effectively support service users from socially excluded communities. The majority of the literature discusses the education and training needs of staff who work with the homeless communities and those who live in insecure accommodation. Nevertheless, many of these needs are considered generalizable to staff who work with Gypsies and Travellers, Roma, sex workers and vulnerable migrants.
- There are stated intentions to improve the knowledge and skills of the staff and to harness the potential that a well-qualified and well-informed healthcare workforce brings to the care of these vulnerable groups. Nevertheless, there is a sizeable gap between what the workforce needs to know, the skills they need to be able to demonstrate, and the readily accessible high quality specialist education and training that will guarantee these achievements.
- This study has consistently highlighted some key areas for study by healthcare professionals who work to support the socially excluded communities (outline in the executive summary and detailed in the full report). Many of these topics could be introduced at pre-registration level and developed for the qualified practitioner.
- The education providers report teaching health inequalities and health risks to the five vulnerable groups and their healthcare needs, nonetheless, there is much less evidence that these topics are assessed. This absence of assessment weakens the knowledge base and the value of studying this subject in the eyes of the student and those providing the service. It also limits the chances of the staff securing essential resources to underpin the provision.
- There is limited academic expertise in the education sector. This situation may be an indicator of the level of commitment of the sector to promote Inclusion Health in the curricula, or the lack of resources available to employ academic staff with the appropriate expertise, or simply that there are insufficient experienced practitioners with expertise in caring for Gypsies and Travellers, Roma or sex workers. We found very little evidence that the education providers involve service users and carers to help deliver the curricula.
- Much of the experience gained by professionals is through ‘learning on the job’ and work experience, rather than through formal education and training. The vast majority of pre-registration/undergraduate students are unlikely to experience placements with socially excluded communities. Although the specialist practitioners report that the practice placement experience with vulnerable groups is one of the strong points of the Specialist Community Nursing courses.

- It is important to reduce the social distance between healthcare professionals and those from vulnerable groups. Appropriate education and training should empower healthcare professionals to reach out to these groups.
- The voluntary sector has a major role in developing and supporting the healthcare professionals. Closer partnership working between the education sector and the third sector would enhance the quality of all education provision.
- Specialist practitioners report difficulty in accessing specialist training programmes to help them develop their clinical and non-clinical knowledge and skills to care for patients from socially excluded groups.

Main limitations to the data

It is important to take care not to conclude that all the findings that apply to one group, such as the homeless, apply equally to the other communities. There is far greater evidence about the health risks and needs of the homeless communities than the other groups. This situation is also mirrored in the data collected as part of this study.

Much of the qualitative data was sourced from interviews, focus groups and surveys and it is possible that such data may be skewed to present either the best or worst impression. The quantitative data was limited to survey data and within the limitations of the study the response rate was sufficiently high to enable some conclusions to be reached and some recommendations to be made.

Much of the data collected refers to nursing and in particular Specialist Community Nurses. This data set reflects the relative proportion of professional engagement in the service and also in the study.

The main recommendations

National policy

1. The government departments of England and national organisations should set out a work programme to ensure that healthcare professionals have appropriate skills, attitudes and understanding of the health issues facing vulnerable groups.

Professional and regulatory bodies

2. Each of the regulatory bodies should make explicit in their standards of education and training the need to embed Inclusion Health in the undergraduate curriculum for all disciplines. Elements of the information from the Nursing and Midwifery Council, with regards to best practice for Inclusion Health, should be shared with the other regulatory bodies.

3. In collaboration with the regulatory bodies the healthcare professional bodies should review their documentation about Inclusion Health and the guidance they give their members about working with socially excluded groups. The professional bodies should encourage their members to use the excellent, mainly online, resources already available.

Education and training

4. All healthcare education providers should review their pre-registration/undergraduate curricula to ensure that Inclusion Health learning outcomes are demonstrated across all their programmes.
5. Higher Education Institutions should ensure that healthcare education programmes are appropriately assessed in relation to aims and learning outcomes of the curriculum that relate specifically to Inclusion Health.
6. Higher Education Institutions need to urgently review their staffing arrangements to ensure that they have sufficient staff with the appropriate knowledge and skills to support the Inclusion Health agenda.
7. Higher Education Institutions must work even more closely and strengthen their links with a broad range of organisations that support socially excluded groups, particularly the voluntary sector, to enable a greater number of students to experience working alongside specialist practitioners, socially excluded service users and their carers.
8. Higher Education Institutions that offer specialist Inclusion Health courses should review how easy it is for the wider multi-professional community, as part of ongoing continuing professional development, to access these courses and develop the appropriate level of knowledge and skills to confidently and competently provide high quality care to vulnerable groups.

Chapter 1. Introduction

‘Inclusion Health: Improving the way we meet primary healthcare needs of the socially excluded’ was published by the Department of Health in 2010¹. In this report it was stated that ‘*many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded*’.

The Department of Health’s National Inclusion Health Board subsequently took forward a programme of work, part of which was to:

- Embed Inclusion Health in undergraduate training for healthcare professionals.
- Influence the primary care post-graduate curriculum.

This study was commissioned and funded by the Department of Health to inform the work of the National Inclusion Health Board with the aim of gaining an in depth understanding about the extent to which pre-registration/undergraduate and post-registration/post-qualifying curricula for health and social care professionals embed Inclusion Health. The Inclusion Health programme identified four priority socially excluded groups with the poorest health: Gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants. The Project Advisory Board suggested that for the study Roma should be considered as a separate vulnerable group as there is less evidence concerning this community.

The study also aimed to capture the education and training needs as identified by those working to support five socially excluded groups:

1. People who are homeless
2. Gypsies and Travellers
3. Roma
4. Sex workers
5. Vulnerable migrants

Chapter 2. Existing evidence

All four nations report the increasing demand on healthcare services by socially excluded groups. Each devolved nation has published guidelines to address improvements in health outcomes for local patterns of social exclusion. Many of these relate specifically to education and training of the healthcare workforce.

Each nation has produced specific guidelines concerning improved health outcomes for the homeless^{2,3,4,5,6}. The Scottish and Welsh Governments have published country specific policies and action plans around developing staff to support the healthcare needs of sex workers and vulnerable migrants. The Welsh Government leads the way in promoting healthcare for Gypsies and Travellers.

¹ Department of Health (2010) Inclusion Health: Improving the way we meet primary healthcare needs of the socially excluded.

² HM Government (2010) Social Exclusion Taskforce. Inclusion Health.

³ Department for Social Development (2007) A Strategy to promote social inclusion of homeless people and those at risk of becoming homeless in Northern Ireland.

⁴ The Scottish Government (2013) Everyone Matters: 2020 Workforce Vision.

⁵ Welsh Government (2008) Refugee Inclusion Strategy.

⁶ Welsh Government (2013) Travelling to a Better Future – A Gypsy and Traveller Framework for action and delivery.

None of the government departments across the four nations promote safeguarding rights to protect the Roma community despite a Directive from the European Commission.

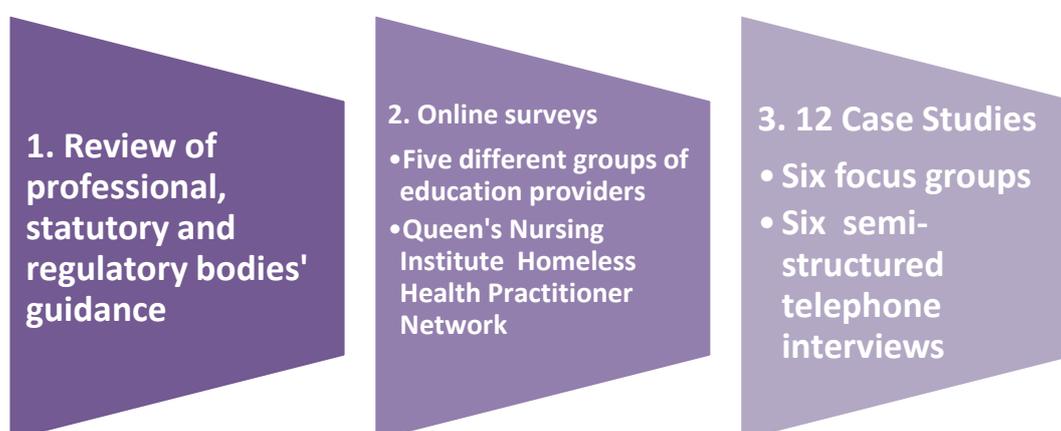
A review of the literature suggests four important conclusions:

- Healthcare professionals often lack the awareness, knowledge and skills to support these vulnerable groups. In addition to enhancing its knowledge and skills, this workforce needs to build its confidence through greater exposure to these communities.
- There are multiple barriers to patients from vulnerable groups accessing health and care services including: direct access to the services, communication difficulties and the behaviour of patients themselves.
- Staff note particular challenges associated with working with vulnerable patients. For example, lack of continuity of care, service users' health beliefs, challenges of engagement, confidence and knowledge of special services.
- The importance of the voluntary sector in supporting service users and education and training of staff.

Chapter 3. Study design and data collection

This study used a combination of data collection methods as illustrated in the figure below.

Data collection methods used in the study



The data collection sources were:

1. An extensive review of the standards and guidance, published by the regulatory and professional bodies that relate specifically to Inclusion Health.
2. Five online surveys, which captured the extent to which aspects of Inclusion Health is embedded in the curricula, were circulated to education providers:

- a. Healthcare education providers that are members of the Council of Deans of Health (55 out of 88 responded).
 - b. Medical schools (14 out of 31 responded).
 - c. Dental schools (8 out of 18 responded).
 - d. Schools of pharmacy (12 out of 27 responded).
 - e. Education providers of healthcare scientist programmes (2 out of 56 responded).
3. Online survey to members of the Queen's Nursing Homeless Health Practitioner Network (106 out of a possible 730 responded).
 4. Focus groups or interviews with staff were held in 12 different organisations that support people from socially excluded communities.

The response rate to the education providers of healthcare scientist courses was very low and this data has not been included in the analysis.

The mixed methods approach enabled a balance of quantitative and qualitative data to be collected. The surveys to the education providers were mostly factual although there were a few questions that sought opinions about how well organisations' teach and assess aspects of health inequalities. The fifth survey included a range of different types of questions: factual questions, knowledge questions, attitudinal questions and preference questions. The data collected from the case study sites was purely qualitative.

Chapter 4. Main findings

This chapter presents the data from four sources: a review of the health and care professional, statutory and regulatory bodies' guidance on Inclusion Health; online surveys to four out of the original five groups of health education providers; an online survey to members of the Queen's Nursing Institute Homeless Health Practitioner Network, and case studies of a sample of organisations which support vulnerable groups.

Professional, statutory and regulatory bodies' guidance on Inclusion Health

Documentation was reviewed for eight out of the nine regulatory bodies. The Nursing and Midwifery Council Standards of Competence⁷ provide the most comprehensive guidance. The General Dental Council; the General Medical Council, and the General Osteopathic Council also make reference to social determinants and or health inequalities. The Health and Care Professions Councils' standards of conduct, performance and ethics⁸ refer to social status, culture and vulnerable adults; there is also reference to Inclusion Health in the standards of proficiency for the 16 professions it regulates. There is no reference to Inclusion Health in the guidance published by the remaining regulatory bodies.

Documentation produced by 37 healthcare professional bodies was reviewed. 16 of them make specific reference to Inclusion Health in their curriculum guidelines. The most comprehensive set of guidelines are produced by the Royal College of General Practitioners⁹. Their vision for general

⁷ Nursing & Midwifery Council (2010) Standards for competence for registered nurses.

⁸ Health and Care Professions Council (2012) Standards of conduct, performance and ethics.

⁹ Royal College of General Practitioners (2012) A core curriculum for learning about health inequalities in UK undergraduate education.

practice¹⁰ highlights that in 2022 the NHS will have ‘a growing intolerance of long standing inequalities in health’, and their vision for the GPs’ role in 2022 includes supporting a reduction in health inequalities and increasing community self-sufficiency. A number of other royal medical colleges have produced guidelines, notably the Royal College of Psychiatrists, which has produced competency based training guidelines¹¹ about mental health and social inclusion.

Other than the Royal College of Nursing¹², that has produced an online resource about social inclusion for its members; the only other non-medical professional associations that guide education providers to cover all aspects of Inclusion Health are those that support social workers¹³.

Education providers’ commitment to Inclusion Health

Data was provided by 196 education providers. All but two reported offering pre-registration courses and 85% offering post-registration/post-graduate courses. In the context of this study the Specialist Community Nursing courses, which are provided by 32% of these responding organisations, are the most important post-registration/post-graduate courses. This is because the highest percentages of practitioners who work with vulnerable groups are Specialist Community Nurses.

Information was provided about whether the institutions teach and assess their pre- students about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs.

The medical schools, dental schools and schools of pharmacy reported that they teach all six aspects of health inequalities¹⁴ to their undergraduate students:

1. Social and economic determinants.
2. Tackling health inequalities.
3. How and why social determinants affect health and wellbeing.
4. How social determinants affect morbidity and mortality.
5. How the effects of social determinants are distributed across society.
6. How and why different groups are more vulnerable and more likely to be excluded.

These topics are also taught on the four fields of pre-registration/undergraduate nursing and social work courses and 60% of the Specialist Community Nursing programmes.

Fewer institutions reported assessing students about health inequalities and those that report to assess these topics were not clear which aspects of health inequalities are assessed. Even on the Specialist Community Nursing courses the level of assessment of health inequalities is relatively low. 53% advised they definitely assess ‘social and economic determinants of health’ but only 38% were

¹⁰ Royal College of General Practitioners (2013) The 2022 GP. A vision for general practice in the future.

¹¹ Royal College of Psychiatrists (2009) Mental Health and Social Inclusion Group Position Statement.

¹² https://www.rcn.org.uk/development/practice/social_inclusion.

¹³ The College of Social Work: (2012) Reforming social work qualifying education: The social work degree http://www.tcsw.org.uk/uploadedFiles/TheCollege/CollegeLibrary/Reform_resources/ReformingSWQualifyingEducation.

¹⁴ University College London Institute of Health Equity (2013) Working for Health Equity: The Role of Health Professionals.

confident they assess the students' knowledge about how 'social determinants are distributed across society'.

Other than the traditional ways of assessing health inequalities the education providers use a number of different innovative approaches such as narratives, actors and outreach projects.

The study found that courses with entire learning outcomes focussed on health inequalities are limited to public health courses and some of the optional modules offered by medical schools. The health visiting and school nursing programmes have a consistently greater focus, than other Specialist Community Nursing programmes, on Inclusion Health learning outcomes for the five vulnerable groups.

The extent to which health risks to vulnerable groups and their healthcare needs are taught varies according to vulnerable group and professional course. For example these topics are mostly taught on social work, adult nursing and mental health nursing pre-registration courses. Although the health risks to Gypsies and Travellers, and Roma, and their healthcare needs, are also reported to be taught on midwifery and children's nursing pre-registration courses. Which vulnerable groups are covered on undergraduate medical programmes is locally determined and dental students learn about oral health risks while on community placement. The schools of pharmacy teach the undergraduate students about the health risks to people who are homeless, sex workers and vulnerable migrants and their healthcare needs.

Specialist Community Nurses are primarily taught about the health risks to people who are homeless, Gypsies and Travellers, and vulnerable migrants, and their healthcare needs. Very few are taught about health risks to Roma and their healthcare needs. Disappointingly nobody reported teaching mental health challenges for people who are homeless.

Far fewer education providers reported assessing students about health risks to vulnerable groups and their healthcare needs.

Medical schools and dental schools support their undergraduate students to gain practice experience with vulnerable groups. For other pre-registration students it is often opportunistic or student led. However, 78% of the organisations that provide Specialist Community Nursing programmes work with the service providers to enable their students to gain the required learning outcomes.

A close partnership between the organisations that support vulnerable groups and the education providers is central to the student learning. Nearly all the medical schools advised that they work with organisations with expertise in supporting people who are homeless, although only one medical school works with an organisation that supports the Roma community.

Just over half of the healthcare education providers reported that they work with organisations with expertise in vulnerable groups to enhance the curricula. Mostly these organisations have expertise in supporting people who are homeless and vulnerable migrants. Half the dental schools work with organisations with expertise in supporting vulnerable groups. However, only one school of pharmacy reported this type of partnership which is with an organisation that specialises in mental health issues and substance misuse within the homeless community.

These specialist organisations support the education providers with teaching; curriculum planning and they also have staff who participate in workshops. Very few healthcare education providers and only one medical school reported either employing or involving service users to help them with the curricula.

The level of commitment of individual Higher Education Institutions to this agenda is evidenced by the pool of academic staff that they employ with specialist expertise in vulnerable groups. Half of the responding healthcare education providers advised they employ academics with specialist knowledge and skills about vulnerable groups. One fifth reported that they have academics that cover all of the five vulnerable groups. The highest level of specialist knowledge amongst the academics is about people who are homeless with very little expertise about the Roma community. This is reflected in the responses from the medical schools, dentals schools and schools of pharmacy.

Views of the members of the Homeless Health Practitioner Network

64 % of the Network (Queen's Nursing Institute Homeless Health Practitioner Network) members who responded are nurses or health visitors. Two-thirds of all the respondents stated they gained much of their knowledge and skills through work experience, 44% had undertaken a Specialist Community Nursing course and 31% reported that they had undertaken other post-registration/ post-qualifying courses. These courses were mostly short courses and the majority of respondents had studied them during the past eight years. Only 10% had studied post-graduate courses.

The Network members reported providing support to vulnerable groups of people, to improve their personal health, through a number of ways:

- Assessment and referral
- Access to healthcare services and other support agencies
- Specialist clinical services
- Specialist support services
- Support and advice
- Outreach
- Listening
- Advocacy
- Health promotion/health education
- Staff education.

However, they reported experiencing considerable difficulties when working with vulnerable groups including the challenges of working directly with people who are homeless, particularly their lack of engagement. They reported difficulties of working with services that are specifically set up to support people who are homeless, notably how well the different services work together and how well the system overall is set up to support this marginalised group. Finally they reported a lack of support for practitioners working in this specialist field of care. Many of them are isolated with 23% of these respondents reporting they are the only healthcare professional in the team.

It is important to note that for many of the respondents a significant period of time has elapsed since they qualified as nurses. However, they did provide a very comprehensive list of topics they would like included in any pre-registration nursing programme. The most frequently mentioned topics were: substance misuse, mental health issues, and the challenges of engaging and supporting those who do not, or do not know how to, connect with the service.

The education and training of healthcare professionals should always reflect the contemporary healthcare service model. The current changes in operationalisation of service delivery can make it really difficult for marginalised groups and those that support them. One of the major challenges for this workforce is the reluctance, by healthcare organisations, to care for these vulnerable groups because of a general lack of knowledge and understanding about the client group.

Findings from the case study sites

The consensus amongst the case study participants is that the level of knowledge and skills of many of the healthcare professionals who work with vulnerable groups should be increased and a greater effort should be made by practitioners to enhance their cultural awareness. They added that all student healthcare practitioners, at the point of registration, should be able to demonstrate a core knowledge and understanding of Inclusion Health and health inequalities, particularly cultural awareness. This would prepare them to support patients from socially excluded communities at any stage in their career.

The participants repeatedly emphasised that healthcare professionals working with vulnerable groups need a combination of both clinical and non-clinical knowledge and skills. Not only is it essential that they have the knowledge of the health risks to these vulnerable groups and their healthcare needs, they also need them to know about current legislation and wider social issues such as finance, benefits and housing.

Clinical placements in the communities provide a valuable learning opportunity for both pre-registration and post-registration students. Unfortunately there is a shortage of suitable placements. Third sector organisations and specialist teams working predominantly with vulnerable groups were identified as playing a major role in developing and supporting healthcare professionals.

The participants at the case study sites frequently made reference to the challenges and difficulties they encounter while working with this client group:

- the fear of saying or doing the wrong thing,
- risking offending the patient or their community members, and
- the potential risk of personal attack.

They also reported problems with what is acceptable behaviour in some of these communities and how the clients do not necessarily comply with social norms, such as attending appointments on time. The situation is exacerbated by the problems within the public sector services for example: lack of flexibility, negative attitudes of some staff towards members of vulnerable communities, and the shortage of suitable written information that is easily understood by the service user and available in a number of different languages. The healthcare system expects these service users to fit the traditional model rather than the service seeking new ways to reach out to the clients.

Successful healthcare for vulnerable groups is dependent on mutual trust between those who provide the service and the service users. It is recognised that building trust will take time and that confidentiality and mutual respect are important for trust to be established.

The support for professionals working in this arena was reported to be very variable. Some healthcare professionals, particularly the loan workers, conveyed that they have little or no support especially

those staff who care for minority socially excluded groups such as the Roma community. Some specialist healthcare networks have been developed and they often provide the only support to staff. Some of the networks are well established e.g. the network to support staff working with people who are homeless, but networks are less well established for those working with other vulnerable communities.

Chapter 5. Education and training institutions

In this short chapter the problems faced by the education and training sector in preparing healthcare professionals, to competently care for socially excluded patients, are outlined. The pre-registration curricula, in particular, are under increasing pressure to include a greater range of learning outcomes.

The evidence from this study is that Inclusion Health is an area that is generally underdeveloped by healthcare regulatory and professional bodies. Unless the regulatory bodies specifically state that Inclusion Health is to be covered in the pre-registration curricula and the professional bodies strengthen their advice on this topic, we will continue to see uneven coverage of this important subject and it will continue to be marginalised by many education providers.

The lack of resources available to the higher education sector means these institutions have to make informed choices about which courses to offer and what expertise they need within their academic workforce. The indication from this study is that although the Higher Education Institutions report a strong commitment to including health inequalities on pre-registration and specialist post-registration courses, few of them invest in a critical mass of staff with expertise in Inclusion Health. Rather they choose to seek innovative ways to support the students to meet learning outcomes associated with caring for vulnerable groups.

This study has highlighted the value of students gaining clinical practice placements in organisations that work in this sector. However, the concerns for the education providers are firstly, how the quality of the learning environment is monitored, and secondly, the value of the time the students spend in such a setting.

Throughout the study reference has been made to the contribution that voluntary and charitable organisations make to the education and training of healthcare professionals working in this specialist field. Particularly in the areas of: cultural awareness training, mental health training, and drug and alcohol addiction awareness.

A number of concerns have been raised about the over reliance on the voluntary sector to support the education and training of healthcare professionals principally:

- Lack of funding to support this aspect of the voluntary sectors' work.
- Much of the education and training provided by the voluntary sector is based on employees past experience of working in the field.
- The education and training provided by the voluntary sector is not quality assured nor is it accredited.
- Online resources made available by the voluntary sector are not supported by specialist educators with up to date knowledge of the sector.

One option to strengthen the learning opportunities about aspects of health inequalities is for the key stakeholders to develop a Local Partnership Alliance with a specific remit for education and training in Inclusion Health. This proposed formal tripartite partnership would be between the publicly funded service providers, the third sector providers and the education providers.

Chapter 6. General discussion and conclusions

In the literature the authors have found clear national guidelines about improving health outcomes for specific vulnerable communities other than Roma. What has not been found, is any evidence of government departments or national organisations setting out a plan of work to ensure that healthcare professionals have the appropriate skills and knowledge to care for vulnerable communities. It is therefore concluded that this omission should be addressed at a national level.

The guidance produced by the regulatory and professional bodies is largely underdeveloped. It is very important that these regulatory bodies urgently review their standards of education and training, and the guidance they publish about Inclusion Health. This situation is unsatisfactory as without the regulatory steer the education providers are not mandated to include health inequalities as part of any curriculum. In the absence of regulation the education providers and practitioners turn to the professional bodies for advice and in many cases these are also underdeveloped. It is recommended that regulatory bodies and professional bodies should work in collaboration to jointly review their published standards and guidance, about Inclusion Health.

Throughout the full report there are examples of the education and training needs of the healthcare workforce that care for these socially excluded groups. There is repeated reference to discriminatory and judgemental behaviour by staff who work in the public healthcare sector. Much of the material available refers to people who are homeless and it is assumed that this information is generalizable to all the communities. However, the practitioners say this is not the case and there needs to be a greater differentiation, on the courses, between the different groups.

For many of these service users their health is not a priority, a fact which sometimes escapes the practitioners. The complex needs of patients from these vulnerable communities and their chaotic lifestyles seldom trigger a differentiated response from the staff. This situation can lead to significant health problems such as poor oral health, respiratory diseases, unmanaged diabetes and infections. Many staff seem unaware of the higher than average mortality rates for patients from socially excluded communities and the poor immunisation status of many of the children from these vulnerable groups.

The education providers should review the learning outcomes of their pre-registration/undergraduate courses and specialist post-registration courses to address these concerns and also the limited academic assessment of health inequalities. This study has found that other than the medical schools the education providers employ relatively few academic staff with specialist knowledge of these communities or engage very few service users or their carers to enhance the students' learning.

Despite the fact that student healthcare professionals benefit enormously from practice learning opportunities it was disappointing to find how significantly different the practice experience is for students working with vulnerable groups. Currently much of the experience gained by professionals is through 'learning on the job' and work experience.

One of the ways to address the regular changes in service delivery and the impact this has on the vulnerable communities is to develop sound partnerships between the stakeholders, particularly between the education providers and the voluntary sector.

Lack of access to specialist courses and online resources continues to be very difficult for many of the practitioners working in this field. The education providers should reflect on how this situation can be improved and how they can help the practitioners develop the skills to deal with the many challenges they face caring for socially excluded patients.

CHAPTER 1

INTRODUCTION

1.0 INTRODUCTION

This study is about the education and training of healthcare professionals for Inclusion and Health and the development of their knowledge and skills to competently support patients from five socially groups. The study was commissioned and funded by the Department of Health (DH) to inform the work of the National Inclusion Health Board.

In this first chapter we describe the background to the study, explain Inclusion Health, outline the study and explain the structure of the report.

1.1 Background to the study

In 2010 the DH highlighted a number of challenges in relation to Inclusion Health² one of which was *'many practitioners (especially in non-specialist settings) lack awareness, skills and training to cope effectively with the most excluded'*.

Sustainable high quality care for all health and care service users should be the ultimate aim of high quality education and training. However, in 2011 a working paper published by Rand Europe³ noted that there is very little evidence of *'a direct association between the quality of healthcare education and training and the quality of care provided to the service users'*.

The achievement of a strong, stable and capable workforce to drive change and make a real difference to the lives and health outcomes of the socially excluded groups prompted the National Inclusion Health Board in England to take forward a work programme with the aim of:

- Embedding Inclusion Health in undergraduate training for healthcare professionals.
- Influencing the primary care post-graduate curriculum.
- Partnering with early adopter universities to develop training for Inclusion Health within undergraduate and post graduate courses.

The Health and Social Care Act (2012)⁴ contains specific legal duties on health inequalities for the Secretary of State, NHS England and Clinical Commissioning Groups with respect to access to services. It identifies three dimensions to quality care that are required for clinical effectiveness:

- Care based on the best evidence.
- Safety which avoids all avoidable harms.
- A positive patient experience.

In order for the above to be realised an appropriate and contemporary approach to the education and training of the workforce is required.

The extent to which Inclusion Health is embedded in the curricula is not well evidenced. Similarly the degree to which regulators require healthcare education providers to demonstrate knowledge about health risks to vulnerable groups and their healthcare needs has not been fully demonstrated. There is some evidence to suggest that those working with vulnerable groups have limited specialist education and training opportunities, however the impact this makes on the quality of service is not well understood.

The background to this study, therefore, identifies the need to further understand and develop the evidence about education and training for Inclusion Health.

1.2 About the study

The study aimed to gain an in-depth understanding about the extent to which pre-registration/undergraduate and post-registration/postgraduate curricula for health and social care professionals embed Inclusion Health. It also aimed to capture the education and training needs as identified by those working to support the socially excluded groups. The Inclusion Health programme identified four priority socially excluded groups with the poorest health: Gypsies, Travellers and Roma; the homeless and rough sleepers; sex workers; and vulnerable migrants.

The Project Advisory Board suggested that for this study Roma should be considered as a separate vulnerable group, because currently there is less evidence concerning this community. Consequently the vulnerable groups under study were:

1. **People who are homeless.** This community includes both those people who are in insecure accommodation and rough sleepers. The former includes people who are living in hostels, night shelters, squats, or in bed and breakfast accommodation. It embraces individuals or families who are covered by the main homelessness duty and are living in temporary accommodation. It also includes 'sofa surfers' or those living temporarily with family and friends. The latter includes people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or "bashes").
2. **Gypsies and Travellers.** These communities are also variously described as Gypsy and Traveller, Gypsy Travellers or Gypsies/Travellers. This includes indigenous travelling people (English Romany Gypsies, Irish Travellers and Scottish Traveller-Gypsies); Fairground and Circus Travellers; New Travellers and Bargees.
3. **Roma.** Romany people from European countries. This group may also include economic migrants who may be vulnerable for reasons associated with poverty, casual work etc.
4. **Sex workers.** This includes commercial 'street-based' and 'parlour based' sex workers.
5. **Vulnerable migrants.** This includes failed asylum seekers; refugees and victims of trafficking.

1.3 About this report

Regarding sources and quotations in this report we have taken every effort to maintain confidentiality.

The report starts with a detailed review of the evidence for the education and training of the healthcare workforce that cares for patients from vulnerable communities (Chapter 2). Chapter 3 sets out the study design and the approaches taken to collect the data. The main findings of the study constitute the body of the report and are set out in chapter 4. There are four parts to this chapter: a review of the health and care professional, statutory and regulatory bodies' guidance on Inclusion Health; data from four online surveys to health education providers; data from an online survey to members of the Queen's Nursing Institute Homeless Health practitioner Network and the data from a sample of organisations which support vulnerable groups. Chapter 5 is a short chapter setting out the problems faced by education and training institutions and possible solutions to address these challenges. The

final chapter (Chapter 6) presents the overall discussion, conclusions and recommendations. Throughout the report there is reference to appendices which are presented in a separate document. A copy of the surveys can be accessed electronically and are embedded in the report in chapter 3.

CHAPTER 2

EXISTING EVIDENCE

2.0 EXISTING EVIDENCE

2.1 Introduction

The health needs of socially excluded groups are very often complex and chaotic and require a sophisticated, coordinated and flexible response from services⁵. A person experiencing one or more dimensions of social exclusion is likely to have multiple contact points with the health and social care system (appendix 1).

It is difficult to capture the health needs of vulnerable groups because of the lack of accurate data in the standard datasets⁶. An indication of the number of vulnerable people in England is provided in table 1. Data available at the time of reviewing the evidence shows there are 20,158 homeless people in Northern Ireland^(footnote 15), 10,000 refugees in Wales^(footnote16) and 2,120 Gypsies/Travellers in Scotland^(footnote17).

Table 1 Estimated number of vulnerable people in England

Vulnerable group	England ^(footnote18)
Homeless	40,500 ^(footnote19)
Sex Workers	80,000
Gypsies and Travellers	300,000
Refugees	300,000
Failed asylum seekers	155,000 – 285,000

Education and training of the healthcare workforce, that supports vulnerable individuals and vulnerable groups, should be considered in the context of how the socially excluded access health and social care services and to whom they turn when they require help from the system.

2.2 Policy context –the four nations

As early as 2008 the DH⁷ recognised that if frontline staff are going to improve the quality of care, provided to those who use the NHS, they need the *'right training and education'*. In 2010 the DH supported the recommendations from the Marmot Report on health inequalities in England⁸. One of these recommendations was to 'ensure healthy standard of living for all'. During the same period the DH also recognised the need to 'improve the health of the poorest fastest' and published a guide to improve primary care services for socially excluded people². Within this publication two key questions were asked of the staff and professionals working with socially excluded people:

¹⁵ Data from The statutory homeless statistics 2004-2011. Housing Executive (2012) Homelessness strategy for Northern Ireland 2012-2017.

¹⁶ 2001 census for Wales.

¹⁷ Data from 2009: Scottish Government Social Research (2010) Gypsies/Travellers in Scotland: The twice yearly count No.16 2009.

¹⁸ The complex overlapping nature of the groups makes it particularly difficult to get data on single groups.

¹⁹ There are estimated to be 40,500 people in England in the hostel system at any one time, and approximately 100,000 individuals' cycle in and out of it in the course of a year.

1. *'Do you have the right information and analysis to be able to achieve the engagement and improvements in health outcomes that local patterns of social exclusion require?'*
2. *'Are you supported within wider training and education networks to deliver care in this arena?'*

It is also noted in this publication that both clinical and non-clinical staff, who work with socially excluded people, face significant challenges every day and that the workforce should be supported to work in this arena. It is suggested that this support can take different forms including:

- *'Supervision and support networks with protected time for reflective practice.'*
- *'Setting up organisations to operate as learning organisations.'*
- *'Training and education programmes that include training rotations, induction, clinical supervision and networking support.'*

In 2011 the charity sector published 'Turning the Tide'⁶. This document was developed in response to the concern that a group of individuals live chaotic lives and face poor life chances, as a result of multiple needs and ineffective contact with services. The authors explained that these vulnerable people often face premature death because of a failure in the system to understand their needs and to work collectively to support them⁹. People who face multiple needs usually look for help to services that are primarily set up to deal with one problem at a time. The health sector is no exception and mainly supports people with single, severe clinical conditions. The result is that professionals providing healthcare may see people with multiple needs as 'hard to reach' or 'not my problem' and for the person seeking help this can make services seem unhelpful and uncaring.

In 2010 the DH published a white paper, *Liberating the NHS: Developing the healthcare workforce*¹⁰ in which it is stated that *'Excellent health and healthcare depends on a highly skilled and educated workforce, working together with compassion and respect for people.'* Also in this paper is the reference to a new framework for developing the healthcare workforce to ensure *'high quality education and training that supports safe, high quality care and greater flexibility'*. In 2011 the DH published a report from the NHS Future Forum discussions about education and training¹¹ in which it was recommended that there should be a greater focus on evidence from education outcomes and that education and training needed to be more flexible and responsive to healthcare demands with a *renewed and strengthened focus on continuing education and development.*

All devolved administrations recognise the growing demand of health inequalities and the importance of the correct knowledge and skills to enable health professionals to address health inequalities for the most vulnerable groups^{1,12, 13,14,15}. Each of the governments of the four nations has taken a country specific approach to raising the awareness of socially excluded groups. The approach taken is determined by which socially excluded groups live in the country and the specific healthcare needs of these communities. For example England and Scotland have produced comprehensive strategies as well as community specific guidelines, Wales has produced a number of strategies designed to support the different communities with a prime focus on Gypsies and Travellers, whereas Northern Ireland has focussed on people who are homeless.

In 'Liberating the NHS: Developing the Healthcare Workforce: from Design to Delivery'¹⁶ the DH set out the policy for planning and commissioning education and training for healthcare and public health workforce. In this document it was proposed that there would be an Education Outcomes Framework¹⁷ (EOF) which would directly link education and learning to improvements in patient

outcomes. In total there are four Outcomes Frameworks for the NHS: NHS (England) Outcomes Framework, The Public Health Outcomes Framework, The Adult Social Care Outcomes Framework and the EOF. These frameworks are closely aligned through a common structure and the EOF underpins the whole system (appendix 2). The NHS Outcomes Framework for 2014/2015¹⁸ includes reviewing how to improve the breadth of the framework to better cover specific areas including those from vulnerable groups and the Public Health Outcomes Framework¹⁹ considers opportunities to reduce health inequalities.

In 2010, as part of the DH Inclusion Health programme, The National Inclusion Health Board¹ for England was established with the remit of:

- Providing cross-sector and interdisciplinary leadership and ownership of the Inclusion Health agenda nationally.
- Championing the needs of vulnerable groups and promoting the principles of the Inclusion Health approach.
- Providing direction, oversight and decision making for the delivery of the Inclusion Health programme.
- Providing evidence-based challenge across health and social care.
- Working in partnership with Government to develop and drive innovative solutions.

The vulnerable groups prioritised by this Board experience some of the poorest health outcomes in England. The Hidden Needs report²⁰ identifies the difficulty of obtaining a comprehensive national or local picture of these health outcomes because of the lack of standardised data for these groups, in the national datasets. The Board established four working groups:

1. Leadership and Workforce established to develop strong, clear national and local leadership for the Inclusion Health agenda and to have a focus on getting Inclusion Health embedded within postgraduate training.
2. Provision, Prevention and Promotion established to develop and promote innovative models of good practice of joined-up, promising, cost-effective and equitable care.
3. Data and Research established 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.
4. Assurance and Accountability established to promote the objectives outlined in the National Inclusion Health strategy.

The Institute for Health Equity²¹ recommended that: *‘a broad and clear understanding of the social determinants of health and how to tackle them is included as a key outcome indicator of workforce training and education’*. This Institute also recommended that good education about the social determinants of health will empower the workforce to successfully tackle health inequalities²². More specifically it advocated that knowledge about the social determinants of health and what works to tackle health inequities should be a ‘mandatory, assessed element of undergraduate and postgraduate education’. Furthermore, it was proposed that ‘student placements in a range of health and non-health organisations, particularly in deprived areas’, should be a core component of every health professional course.

In 2013 the Royal College of General Practitioners published a commissioning guide²³ about the healthcare needs of vulnerable groups. This guide which was primarily written for the English context

provides a very useful introduction to the healthcare needs of these patients. One of the key messages from this work highlights the importance of educating and training the healthcare workforce: *‘Multi-disciplinary working should be encouraged from the beginning of clinical training, by stressing social inclusion aspects in formal education, as well as through secondments or volunteering’*.

As part of Health Education England’s mandate²⁴ under the area of working in partnership a key theme is: *‘Education and training of staff should be with the objective of improving the prevention and care delivered to patients and communities’*. Despite the increased interest in the planning and development of the healthcare workforce in England there is still very little systematic assessment of the quality of the delivery of education and training for Inclusion Health and the impact on the quality of service.

In 2013 NHS Scotland reported that the Scottish Health Service is facing many challenges including the growing demand of health inequalities²⁵. The government pledged to provide wider and more equitable access to healthcare. It made reference to a number of factors associated with poor attendance patterns of patients, from areas of social deprivation, and is taking steps to include this issue in training programmes. One of the priority areas for NHS Education for Scotland is ‘supporting the developing cultural competence of the health and social care workforce and the delivery of person-centred care’.

2.2.1 National policies to support people who are homeless

Each of the four national governments has published country specific guidelines about improving healthcare for people who are homeless.

In 2012 the Department for Communities and Local Government, England, published a report recommending a joint approach to preventing homelessness²⁶. In this report the Government restated its’ priority to tackle health inequalities. It also committed to improving health outcomes for homeless people including those with dual drugs/alcohol and mental health needs.

In 2005²⁷ the Scottish Executive produced The Health and Homelessness Standards in recognition of the critical importance of strong leadership in dealing with health inequalities. Standard 5 addressed the importance of staff training (box 1).

Box 1 Scottish Executive Health and Homeless Standard 5²⁷

‘Staff training is critical to ensuring appropriate service responses, though the content and level of training and awareness raising, should be determined by local circumstances. Such training should include all relevant staff, including reception and administrative personnel.’

Dental care for people who are homeless is a particular focus for the Scottish Government²⁸ which has published two reports about oral health in the homeless community. Both of these reports make reference to the importance of staff training to enable the staff to promote oral health amongst this community.

In 2013 the Welsh Government²⁹ published standards, designed for local health boards, to improve the health and wellbeing of people who are homeless and specific vulnerable groups. Standard 2 is shown in box 2.

Box 2 Welsh Government Standard 2 to improve health and wellbeing of vulnerable groups²⁹

- ‘Evidence of systems for identifying training needs and for joint training between partner agencies.
- A jointly agreed training and development plan for staff working to support and improve health and wellbeing of homeless people.
- Multiagency training (involving past and present service users) to meet this plan is regularly available and its’ impact is evaluated.
- A structured joint approach for identifying the training and development needs of staff and responsibility for delivering targeted training to meet the ongoing development needs of all workers across partner agencies to support best practice.’

Homelessness continues to be a major problem in Northern Ireland and the impact of homelessness affects individual’s lives for years and ‘impedes an individual’s health’. A coordinated multi-agency approach is required to promote health and social inclusion³⁰. In response, The Department for Social Development¹² in Northern Ireland developed a strategy to promote social inclusion of people who are homeless describing sixteen guiding principles. One of these principles is specifically on staff education and training. As part of this strategy the need to promote better educated, better trained and better informed public sector staff about homelessness issues was highlighted. Another guiding principle in this report is to ‘promote the health and mental well-being of the homeless and ensure they have access to quality health and social services when required’.

The Department of Social Development also recommended that the Northern Ireland Housing Executive ensures that staff training includes attitudes to homelessness and substance abuse. It also suggested that organisations that support people who are homeless should include guidelines, in their codes of conduct, about working with people who are homeless and ensure that homelessness training is available to staff within the Health Service.

2.2.2 National policies to support Gypsies and Travellers

In 2013 The Welsh Government published ‘Travelling to a Better Future – A Gypsy and Traveller Framework for action and delivery¹⁵’. This is the first strategic national Gypsy and Traveller policy document developed in the UK. The aim of the framework is to realise the Welsh Government’s commitment to the Gypsy and Traveller community; to ensure equality of opportunity for Gypsies and Travellers in Wales and to think about new ways in which Gypsy and Traveller communities can be enabled to access resources, not always available to them, by ensuring services are flexible enough to respond to their needs.

Within the Framework, two of the actions under the objective ‘To make health and social care services more accessible to the Gypsy and Traveller community’ are:

1. Department of Health and Social Services ensure that the staff understands the cultural, access and health needs of the Gypsy and Traveller community, so that national strategic health policy takes this into account at the point of development or review.
2. Local Health Boards ensure that healthcare professionals receive training on the culture, tradition and practices of the Gypsy and Traveller community, to develop a cultural awareness that can be reflected in their interactions with the Gypsy and Traveller community. This should include doctors, nurses, receptionists and health visitors.



2.2.3 National policies to support Roma

In 2013 the European Commission asked all Member States to do more to support the Roma community and to progress their strategic development for integration of this population³¹. Despite this call the UK Governments have done nothing to safeguard the rights of this ethnic group. The Roma have the right to live and work in the UK, but they do not enjoy the same rights as other UK citizens in terms of employment, housing or social benefits³². This leads to increased vulnerability and low health expectations.

2.2.4 National policies to support sex workers

The sexual health and relationships strategy developed for the Scottish Executive³³ stated that staff providing sexual health advice, information and education, should have appropriate skills and attitudes and a common understanding of the issues facing vulnerable groups. Undergraduate and pre-registration training programmes for health, education and social care staff should include a focus on the social model of health and include aspects of sexual health which enable them to support sexual wellbeing. Staff at all levels and in all sectors will need increased knowledge and skills on sex and sexual relationships. It is suggested that this includes those whose remit is not solely sexual and reproductive health (for example, staff working in Accident & Emergency (A&E) departments, general medical departments, staff working in social care as well as parents and carers). It was also recommended that: *'NHS Boards should develop joint training for health and local authority personnel to develop core skills in communication, attitudes and relationships, addressing the wider social and cultural determinants of sexual health'*.

The Welsh Assembly Government produced a Sexual Health and Wellbeing action plan 2010-2015³⁴. It is noted in the plan that some groups such as sex workers need special consideration because they

are at higher risk as they are especially vulnerable, or have particular access to health and care service requirements.

2.2.5 National policies to support vulnerable migrants

The Refugee Inclusion Strategy produced by the Welsh Government in 2008¹⁴ was aimed at supporting and enabling refugees to rebuild their lives in Wales and make a full contribution to society (box 3). The specific objectives within the strategy centred on three areas: services and their delivery, fulfilling potential and community cohesion.

Box 3 Recommendation from the Welsh Government Refugee Inclusion Strategy¹⁴

‘Training is required to help service providers understand how their services can better meet the needs of refugees and asylum seekers and increase their understanding of the diversity of needs and the availability of specialist support.’

It was also identified that access to language skills training is more important for the longer-term aim of achieving refugee inclusion.

In 2009 The Scottish Government published a report of a review of the evidence base of migration into Scotland³⁵. In this report two main areas of interest in relation to migrants and health were highlighted: firstly, the effect of migration on levels of demand for health services; and secondly, public health impacts that arise from migration, for example different health behaviours such as alcohol consumption.

2.3 Education and training needs of the workforce to support Inclusion Health

As all four nations move towards enhancing the education and training of their workforce, to guarantee that healthcare professionals have appropriate skills, attitudes and a common understanding of the health issues facing vulnerable groups, it is important to review the evidence that exists about the education and training needs of these staff.

The review of this evidence is set out under the following headings:

- 2.3.1 Overview of recommended education and training of the health and care workforce who work with vulnerable groups
- 2.3.2 Healthcare professionals’ cultural awareness of vulnerable groups
- 2.3.3 Trust between those from vulnerable groups and healthcare professionals
- 2.3.4 Training in substance misuse, alcohol abuse and mental health for those working with vulnerable groups
- 2.3.5 Barriers to vulnerable groups accessing health services
- 2.3.6 Challenges and concerns for healthcare professionals working with vulnerable groups

2.3.7 Employing specialist staff to work with vulnerable groups

2.3.8 Third sector training provision for healthcare professionals working with vulnerable groups.

The findings from this review have informed the questions asked in the surveys, the focus groups and the telephone interviews.

2.3.1 Overview of recommended education and training of the health and care workforce who work with vulnerable groups

The Social Exclusion Task Force³⁶, the Queen's Nursing Institute³⁷ and St Mungo's³⁸ identified that many healthcare practitioners, particularly in non-specialist settings, lack awareness, skills and training, to cope effectively with vulnerable groups. The literature emphasises that not only does this workforce need greater knowledge and skills; it also needs to build its confidence to deal with the service challenges. Healthcare practitioners can often work in isolation with minimal support and networks and can also be marginalised from mainstream health services.

A review of the evidence highlighted the following areas of development for healthcare professionals working with socially excluded patients:

- Training in human rights, equality and diversity.
- Training in current legislation, particularly in relation to vulnerable migrants³⁹.
- Acquiring a detailed knowledge of the culture of socially excluded groups^{40, 41, 42, 43}.
- Understanding of all the domains of exclusion, with the aim of ensuring competent responses to the most 'obvious' issue, or characteristic of an individual or family⁴⁴.
- Improving having the confidence to ask the right questions to help elicit accurate information from patients from vulnerable groups^{45, 46}.
- Acquiring the ability to set aside all personal reflections, problems and stereotypes⁴⁷.
- Fostering a welcoming non-judgemental approach to clients⁴⁸.
- Ensuring a flexible approach to appointments to include drop in appointments and scheduled consultations⁴⁸.
- Improving the attitude to the client to see them as a whole person and not simply a list of problems that require treatment⁴⁸.

The report by Homeless Link and St Mungo's⁴⁵ recorded a demand from the homelessness sector, for training to include discriminatory attitudes which persist in health settings as illustrated below.

'Ward staff are not adequately trained, I think they're a bit lost with it...a lot of times we get the wards ringing saying 'I don't know what to do with this chap, he's just told me he's homeless, he's got nowhere to go'. Vulnerable Person's lead⁴⁵

'We need to teach them [healthcare providers] to avoid negative stereotypes; we need to change the culture and attitudes of the NHS'. Voluntary sector senior manager⁴⁵

Non-specialist healthcare professionals routinely have little contact with vulnerable groups. Consequently their views about them are often influenced by the media and/or negative experiences in the workplace⁴⁹. Strong leadership, training for staff and promotion of culture change are seen as crucial in healthcare services to overcoming these issues⁴⁶. This is important when considering the education and training of health and care professionals, at both an undergraduate and postgraduate level. The complex needs of vulnerable groups do not generally trigger any differentiated response from service providers. These groups may require a highly specialised response which includes enhanced case management and ‘interprofessional’ education and training to help professionals learn from each other⁵.

A high level service specification developed by the London Pathway⁵⁰ for medical respite care for patients who are homeless, includes reference to medical respite services needing to seek to meet education standards for staff working in homeless health services (box 4).

Box 4 Faculty for Homeless and Inclusion Health Standard for all Homeless Health Services⁵⁰

‘Education and involvement in undergraduate and postgraduate training of medical, nursing, dental, psychological therapy and social work students, and development of links with relevant professional bodies; the staff team could be enhanced and supported by offering opportunities for health and social care training placements, apprenticeships across care and facilities roles, and adult education in-reach from local providers.’

Negative experiences as a result of staff not being equipped to meet the needs of vulnerable groups could be significantly improved through training for health professionals, delivered by specialist staff, homeless organisations, or peer advocates³⁹.

The London Pathway also published findings, from exploratory research, about improving dental services for homeless people⁵¹. The findings suggested the need to work with dental schools to increase the awareness of the needs and perspectives of the next generation of dental practitioners.

The UK Network of Sex Work Projects⁵² identified an initiative which trains medical staff to highlight the need for sensitivity around clinical examinations and information gathering when working with sex workers.

Studies^{53,54,55} have shown that the health of refugees can worsen after reaching the UK, particularly their mental health. It appears that rather than seeing refugees as ordinary people, they are often seen to be intriguing, exciting or even exotic. Sometimes they are seen as ‘scary’, having survived torture, trafficking, rape and other traumas that are outside most people’s experiences, and which are often outside healthcare professionals’ mainstream training⁵⁶. The Tavistock and Portman NHS Foundation Trust⁵⁷ delivers one of the few courses with regards to refugee care.

It is recommended by the social policy and social work subject centre at the University of Southampton⁵⁸ that health inequalities are included at both pre and post qualifying levels. Three examples of approaches to the addition of health inequalities to the curriculum are suggested

including permeation across the whole curriculum, a focussed health module on the topic, or interprofessional modules with other health professionals as well as social workers.

However, despite a commitment to social work supporting a reduction in health inequalities there is evidence that this is not reflected in the social work curricula⁵⁹. It has been suggested that there are three areas where health inequalities can be included in the curricula: human rights, interprofessional education and international social work. It is indicated that the challenge for those educating social work students is to ensure that the students understand and are aware of the essential role they play in the social determinants of health.

2.3.2 Healthcare professional's cultural awareness of vulnerable groups

An overall theme from the literature is that healthcare professionals can lack knowledge, confidence and expertise about the beliefs and culture of vulnerable groups^{15,60,61,62,63,64,65}. One approach to address cultural differences is the development of cultural competence among healthcare professionals. Ideally, this development should start in undergraduate education and be part of the in-service training of healthcare practitioners⁶⁵.

It has also been suggested that the concept of cultural competence should go beyond individual health workers and encompass whole organisations, which need to commit to dealing with diversity⁶⁵.

It has been reported that there is a direct relationship between the level of competence of health care providers and their ability to provide culturally responsive services⁶⁶. The understanding of distinct cultures is essential to improving access to services and to the effectiveness of these services.

The Royal College of Nursing⁶⁷ recommends cultural awareness training for all frontline staff to feel confident in working with these communities. There is very little cultural awareness training provided, much is tacit knowledge. It has been recommended that training should include myth busting, understanding needs and what to do differently to improve service delivery and engagement with vulnerable groups⁶⁸. An example of an organisation that currently



provides dedicated cultural awareness training to NHS staff is the Minority Ethnic Carers of Older People Project (MECOPP)⁶⁹.

One of the pledged actions by the Welsh Government involves cultural training of health staff^{15, 70}. This has been conducted previously in a study with community nurses in England. The researchers found that the staff held perceptions of Gypsies and Travellers that were informed by media

stereotypes. However, the staff involved in the study demonstrated a willingness to be challenged on their views⁷¹.

In a publication about how social determinants of health can be further embedded in postgraduate medical education and training⁷², it is acknowledged that newly qualified doctors tend to have a fairly limited understanding of the ways that social, cultural and environmental factors can influence people's health and illness. It is also suggested that although there are opportunities in the post graduate curricula, to address and develop a greater understanding of these issues, the uptake of these courses is very low. The paper highlights that the benefit to the patient needs to be kept firmly at the centre of any education and it will be important to ensure that this remains the focus.

2.3.3 Trust between vulnerable groups and health and care professionals

One of the strongest messages that came across throughout an inquiry conducted by the Equal Opportunities Committee of the Scottish parliament in 2012⁷³ was the importance of trust. Trust can be undermined not because others are judged untrustworthy, but because their trustworthiness cannot be judged. This is an important consideration for health and care professionals working with vulnerable groups.

There is a long history of mistrust by the Gypsy and Traveller communities towards mainstream services, including health care services. It is recognised that it takes time to establish trust in these communities⁷⁴. Building a trusting relationship between the patient and the team that supports those that are homeless is fundamental to the therapeutic alliance. This is particularly necessary with patients who will be returning to a chaotic hand-to-mouth existence⁷⁵. Trust is important in enabling full disclosure of risk-taking and health needs as well as intimate clinical examinations of sex workers. Sex workers need to feel respected and not judged in order to engage with health services to receive optimum and appropriate healthcare⁷⁶.

Healthcare managers have a significant role and responsibility in supporting the vulnerable groups and the staff who care for them. The Institute of Healthcare Management⁷⁷ sponsors a number of Master classes for healthcare managers. The classes on influencing skills and dealing effectively with conflict could readily be adapted to help them adopt specific skills for working with vulnerable groups.

2.3.4 Training in substance misuse, alcohol abuse and mental health for those working with vulnerable groups

Most of the literature in this area is focussed on the homeless and describes the issues some of them experience with regards to drug and alcohol abuse. Drug and alcohol abuse accounts for about a third of all deaths amongst the homeless population⁷⁸. Many people who are homeless have mental health problems as well as drug and alcohol problems. This has an impact on healthcare professional's capability to manage and support service users.

It has been suggested that there is a need for increased education, information and training on mental health needs, for both health staff and community members themselves, to reduce discrimination and increase support for those working with Gypsies and Travellers⁷⁹. These principles could equally be applied to all vulnerable groups.

It is recommended that staff should take account of cultural backgrounds when delivering drug and alcohol services. This links to the importance of training and education of staff in cultural awareness (section 2.3.1).

Staff involved in a pan London study by the Mental Health Foundation identified reported that acquiring the skills to recognise and respond to the signs and symptoms of mental health problems and drug and alcohol use was important⁶⁴. A quote from this study is illustrated below.

Homeless Housing Team Manager⁶⁴

'... I think a lot of the staff working with the young people don't necessarily have the skilled background to recognise mental health problems... until something becomes a crisis, because the beginnings of mental health problems aren't often recognised by people that work with them.'

It is noted that practice development for staff should include mental health and substance misuse awareness, cultural awareness, and knowledge about current legislation and policy in the housing, mental health and related sectors. Mental health training needs to go further than raising awareness of the mental health problems young homeless people are likely to encounter, it should also include assessment of their need⁶⁴.

A study conducted by Morrison in 2009⁸⁰, in Glasgow, found that homelessness was an independent risk factor and was more hazardous than being in conventional deprived socio-economic circumstances. This study pointed out that although there is some evidence of effective health interventions among people who are homeless the *'health outcomes are often limited to service delivery or reductions in hospitalisation rates'*. It was highlighted in this work that homelessness increased the risk of death from drugs by seven times, chest problems by three times and doubled the risk of death from circulatory problems.

2.3.5 Barriers to accessing healthcare services

The literature refers to the barriers to accessing health services that socially excluded service users' encounter. These barriers have been grouped into three themes: access to services, communication, and behaviour of vulnerable groups. Education and training programmes for health and care staff should include an understanding of these barriers.

Access to services

- GP surgeries are often reluctant to register patients from travelling communities. All those from vulnerable groups have the right to be fully registered with an NHS general practice, unless the list is full or the person resides outside the practice boundary⁸¹. Access to primary NHS health care in the UK is based on residency and not on a permanent postal address⁸².
- Financial disincentives for GPs to register rough sleepers³⁸.
- No or inaccurate postal address results in lost appointment letters⁸³.
- Transport costs to hospitals and health centres³⁸.
- Lack of integration between services that support vulnerable groups, e.g. between primary care and secondary care; between healthcare and other local non-health services³⁸.

- Institutional factors, such as opening times, the way appointments are managed, location and discrimination³⁸.

Communication

- Communication difficulties between health workers and vulnerable groups have been observed and this increases need for cultural awareness³².
- Illiteracy and lack of easily readable information about services³².
- Shortage of advocates to accompany these service users to appointments³⁹.
- Lack of information for service providers about the concerns of the vulnerable groups³³.
- Hostility of reception staff towards socially excluded individuals³³.
- Lack of personal communication skills of NHS staff and the clients³⁸.

Behaviour of vulnerable groups

- Vulnerable groups, in particular Gypsies and Travellers, tend to ‘normalise and accept’ their ill health. Because of the difficulties of access to healthcare they may not pick up the importance of ill health symptoms⁶¹.
- Mistrust of authorities³².
- Gypsy and Traveller groups may have a reduced incentive to partake in screening and immunisation programmes if they see this supposed ‘preventive’ step as futile^{4,84}.

Common themes in providing appropriate services to help overcome these barriers include a flexible approach; longer appointments to enable assessment and investigation of complex healthcare needs; assertive outreach; offering support in a range of settings including street-based support, and a triage approach where different health needs are prioritised and addressed through a structured health programme^{46,85}.

2.3.6 Challenges and concerns for healthcare professionals working with vulnerable groups

There are a number of challenges and concerns highlighted by professionals working with vulnerable groups that should be considered by education institutions when planning the curricula.

One study summarises the concerns expressed by health professionals working with Gypsies and Travellers, Boaters, Showmen and Roma⁸⁶ which included:

- Lack of continuity of care.
- Gypsies and Travellers’ fixed health beliefs.
- Gypsies and Travellers’ illiteracy.

This study also highlighted a number of challenges for health professionals:

- Understanding Gypsies and Travellers’ culture.
- Communicating with multiple family members acting as next of kin.
- Different health beliefs held by Gypsies and Travellers [e.g. belief in herbal or ‘alternative’ medicines].
- Reluctance of some Gypsies and Travellers to engage with some health professionals.
- Potential difficulty with accessing Gypsies and Travellers’ sites.
- Professional’s lack of confidence when visiting Gypsies and Travellers’ sites.
- How to access specialist advice about this community.

Gypsies and Travellers have been said by some healthcare providers to be resistant to services, to be poor attendees and non-compliant with medical interventions. This highlights the need for greater communication and mutual understanding of the constraints faced by both parties in order to avoid hostility⁴⁵.

The literature suggests that service users who are homeless report that they are often less concerned with their long-term health than in finding a way to overcome their daily circumstances⁸⁷. Repeated eviction can also lead to a break in treatment or failure to access screening programmes which could pick up on significant health problems.

Staff awareness training is seen as the most popular option for respondents (particularly favoured by health visitors) to improve working practices. The BANES study⁸⁶ recommended specialist training to help staff address the challenges they face when caring for vulnerable groups.

Continuity of healthcare is frequently disrupted for those from vulnerable groups as services are generally designed to meet the needs of longer-established residents who can establish an ongoing relationship with their health care providers. Best practice for engaging with the diverse and complex health needs of these groups is likely to involve a combination of targeted and opportunistic health interventions which enable individuals to access health services, while in a 'safe' environment which they are already attending⁸⁷.

A study by St Mungo's⁸⁸, highlighted that in 60% of cases the client sought treatment at either A&E or hospital, not from their GP. Clients were asked to tell the interviewers about any negative or positive experiences they had of A&E or hospitalisation. Two-thirds were able to recount a positive experience attending A&E or hospital. 49% however had suffered a negative experience with A&E or hospitalisation. Types of negative experiences include rude or unpleasant staff, discrimination, unacceptable waiting times or poor quality treatment.

2.3.7 Employing specialist staff to work with vulnerable groups

Most organisations have not employed specialist staff to work with vulnerable groups⁴⁵. However, organisations are looking at interim arrangements to fill this gap in knowledge and skills in the workforce.

A community health needs assessment undertaken by Leeds Gate recommended that commissioners support specialist health worker roles as a temporary measure whilst general approaches to care for vulnerable groups are improved⁸⁹. This recommendation implies that education and training for those working with Gypsies and Travellers will be important to realise this outcome.

The London Pathway for Homeless Patients⁹⁰ project has introduced two specialist roles to help them deliver an improved service for the homeless:

1. Homeless Health Practitioners (HHP)—a specialist nurse to coordinate the hospital care and discharge planning of homeless patients with complex needs. They also coordinate a weekly care planning meeting (paper ward round) to include social workers, mental health teams (hospital and community), drug and alcohol workers, discharge liaison teams and representation from Housing Options.
2. Care Navigators – a team of people with an experience of homelessness supporting the HHPs to provide befriending, mentoring, advocacy and long term follow up and support.

2.3.8 Third sector training provision for health and care professionals working with vulnerable groups

Staff in the voluntary sector work more closely with service users, including those from vulnerable groups, than most NHS staff tend to, and therefore understand their needs better⁸⁶.

Table 2 details the number of charities across the UK that support those from the different vulnerable groups⁹¹.

Table 2 Number of UK charities that provide support to vulnerable groups

Vulnerable group	Number of UK charities
Homeless	128 (107 England & Wales, 12 Scotland, 9 Northern Ireland)
Gypsies and Travellers	15
Sex workers	1
Migrants	7 (England and Wales)

Frequently these organisations demonstrate that they do not just provide advocacy and guidance into generalist services, but also deliver specialist services of their own, including outreach, community support and representation, cultural awareness training for public sector staff and others groups that support socially excluded groups²³. Importantly voluntary organisations often maintain credibility where client groups find it hard to form relationships within mainstream public services²⁰.

The voluntary sector provides a significant amount of education, training and development to healthcare professionals working with patients from the vulnerable groups. Education and training related activities provided by the voluntary sector organisations include:

- Mental health training⁶⁴.
- Training for each new intake of junior doctors with regards to working with the homeless and people in insecure accommodation⁸⁵.
- Recruiting socially excluded individuals to support cultural awareness training^{45,20}.
- Training to frontline staff working with sex workers⁹².
- Drug and alcohol addiction awareness sessions for people who are homeless.
- Development of online modules^{37,27} for general use.

2.4 Summary of existing evidence

This chapter has reviewed the literature about governments' policies towards Inclusion Health, the national policies to support the five vulnerable groups included in this study, and the education and training needs of the healthcare workforce that cares for patients from socially excluded communities.

There is a lack of accurate data about the different vulnerable communities so it is very difficult to predict the healthcare services required. However, all four nations report the increasing demand on healthcare services by socially excluded groups. Each country has published guidelines to address improvements in health outcomes for local patterns of social exclusion. Many of these relate specifically to education and training of the healthcare workforce.

All four nations have produced specific guidelines concerning improved health outcomes for the homeless. The Scottish and Welsh Governments have published country specific policies and action plans around developing staff to support the healthcare needs of sex workers and vulnerable migrants. The Welsh Government leads the way in promoting healthcare for Gypsies and Travellers. None of the government departments across the four nations promote safeguarding rights to protect the Roma community despite a Directive from the European Commission.

Healthcare professionals often lack the awareness, knowledge and skills to support these vulnerable groups. In addition to enhancing its knowledge and skills the workforce needs to build its confidence through greater exposure to these communities.

Areas identified from the literature for inclusion in the curricula are:

- Staff attitudes to the socially excluded
- Current legislation
- Domains of exclusion
- Non-judgemental and flexible approach to care
- Cultural awareness
- Trust between service user and healthcare professionals
- Substance misuse and mental health

The importance of embedding cultural awareness tailored to the different vulnerable groups in the education and training of the healthcare workforce is clearly demonstrated. It is notable that a lack of cultural awareness leads to insensitive conversations and a lack of trust between individuals and healthcare professionals.

There are multiple barriers described of the difficulty vulnerable groups have in accessing health and care services: access to services, communication and behaviour of vulnerable groups. It is important that healthcare staff are educated, trained and fully aware of these barriers in order that they can tailor and adapt their approach to working with these vulnerable groups accordingly.

Healthcare professionals have highlighted a number of challenges and concerns associated with working with socially excluded groups. For example: lack of continuity of care, service users' health beliefs, and the challenges of engagement, confidence and knowledge of special services.

Organisations are seldom able to employ specialist staff to work with vulnerable patients. As an interim arrangement large charitable organisations have created innovative posts such as Homeless Health practitioners and Care Navigators.

The literature has revealed the importance of the voluntary sector organisations in supporting service users and staff. The voluntary sector provides specialist services, education and training for staff and maintains credibility with the socially excluded communities.

CHAPTER 3

STUDY DESIGN and DATA COLLECTION

3.0 STUDY DESIGN and DATA COLLECTION

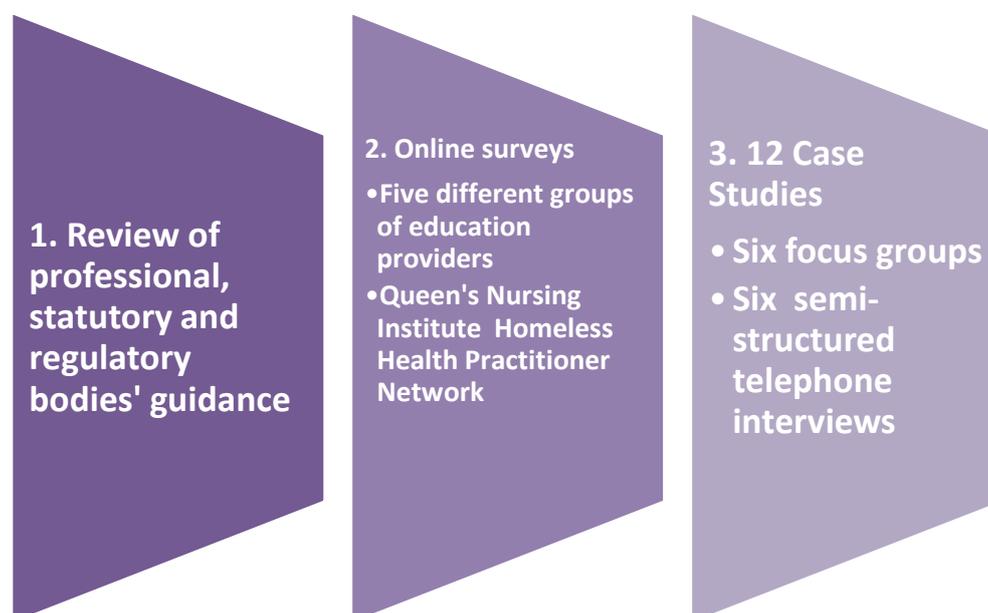
This study aimed to gain a better understanding of the extent to which the education sector embeds Inclusion Health in the curricula. It also aimed to capture the education and training needs of professionals who work with socially excluded groups.

This chapter details the design of the study and the data collection methods used. The approach to collecting the data was pragmatic and based on the premise that, within this limited study, the findings would add to the existing knowledge base rather than develop a comprehensive understanding of the situation.

3.1 Overview of data collection methods

A mixed-method approach to collecting the data was used. This was influenced by time constraints, access to information and the significance of the relative data sources (figure 1).

Figure 1 Data collection methods used in the study



The higher education providers of health and social care programmes are governed by the regulatory bodies which determine the primary qualifications that can be offered. These institutions are also strongly influenced by the professional bodies which support both qualified practitioners and students. Prior to gathering data about the pre-registration and post-registration courses available to healthcare practitioners, a review of the standards and guidance available to education providers was undertaken.

Subsequently an online survey approach was chosen to collect data from the education providers as within one survey it is possible to collect different types of information from the respondents⁹³. The surveys were designed to elicit factual information about the courses provided and the respondents' knowledge and opinion, about the extent to which aspects of Inclusion Health are covered in the curricula. The same approach, but with a different set of questions, was taken to collect data from the UK's largest network of health practitioners that support socially excluded health and care service users.

To gather a localised understanding about the education and training needs of healthcare professionals, who care for service users from the five vulnerable groups: people who are homeless, Gypsies and Travellers, Roma, sex workers and vulnerable migrants, it was decided to collect data through a number of case study sites across the UK. At these sites qualitative data was gathered through one to one interviews or focus groups. Access to the focus group samples ranged from attending an already existing event and capturing the views of attendees, to setting up specific focus group sessions with the explicit intention of gathering data for this study.

3.2 Review of professional, statutory and regulatory bodies' guidance

All health and social care education programmes leading to professional qualification are regulated by statutory bodies which are overseen by the Professional Standards Authority⁹⁴. There are nine health and social care regulatory bodies in the UK. Within this study we reviewed documentation from eight of them:

1. General Dental Council (GDC)
2. General Medical Council (GMC)
3. General Optical Council (GOC)
4. General Osteopathic Council (GOsC)
5. General Pharmaceutical Council (GPC)
6. Health and Care Professions Council (HCPC)
7. Nursing and Midwifery Council (NMC)
8. Pharmaceutical Society of Northern Ireland (PSNI)

The regulatory body that is not included in this study is the General Chiropractic Council as we found no evidence that chiropractors are primary healthcare providers for socially excluded patients.

A review of the documentation provided by these eight regulators was undertaken to identify the extent to which Inclusion Health is included in their standards. Each regulator produces sets of standards.

The documentation that was reviewed varied between regulators and included:

- Standards of Proficiency
- Standards of Practice
- Standards of Education and Training
- Standards of Conduct, Performance and Ethics
- Regulatory codes
- Competencies and learning outcomes

Many health and social care education providers seek advice from professional bodies concerning curriculum content. Documentation provided by 37 different professional associations (box 5) were sourced.

Box 5 Professional bodies and affiliated organisations included in the documentation and resources review	
1. Academy of Medical Royal Colleges	20. Faculty of Public Health (of the Royal Colleges of Physicians)
2. Association of Clinical Scientists	21. Medsin
3. British and Irish Orthoptic Association	22. Royal College of Anaesthetists
4. British Association of Art Therapists	23. Royal College of General Practitioners
5. British Association of Drama Therapists	24. Royal College of Midwives
6. British Association for Music Therapists	25. Royal College of Nursing
7. British Association of Prosthetists and Orthotists	26. Royal College of Obstetricians and Gynaecologists
8. British Association of Social Workers and the College of Social Work	27. Royal College of Ophthalmologists
9. British Dental Association	28. Royal College of Pathologists
10. British Dietetic Association	29. Royal College of Paediatrics and Child Health
11. British Medical Association	30. Royal College of Physicians
12. British Psychological Society	31. Royal College of Psychiatrists
13. Chartered Society of Physiotherapy	32. Royal College of Radiologists
14. College of Emergency Medicine	33. Royal College of Speech and Language Therapists
15. College of Occupational Therapists	34. Royal College of Surgeons
16. College of Optometrists	35. Royal Pharmaceutical Society
17. College of Paramedics	36. Royal Society of Paediatrics and Child Health
18. College of Podiatrists	37. Society and College of Radiographers
19. Faculty of Pharmaceutical Medicine (of the Royal Colleges of Physicians)	

Ten of these organisations do not have readily available information about Inclusion Health. They are:

1. British Association for Music Therapists
2. British Association of Prosthetists and Orthotists
3. British and Irish Orthoptic Society
4. British Psychological Society
5. College of Optometrists
6. College of Podiatrists
7. Royal College of Ophthalmologists
8. Royal College of Surgeons
9. Royal Pharmaceutical Society
10. Royal Society of Paediatrics and Child Health.

The resources available to members of the remaining 27 professional associations include curriculum guidance reports and online support. The findings from this review informed the questions asked in the surveys, the focus groups and the telephone interviews.

3.3 Online surveys

Six surveys were designed specifically for this study and made available via the web-based online survey facility: SurveyMonkey⁹⁵.

Five of the surveys were designed for education providers:

- Survey A for members of the Council of Deans of Health
- Survey B for Medical Schools
- Survey C for Dental Schools
- Survey D for Schools of Pharmacy
- Survey E for institutions that educate and train Healthcare Scientists.

The purpose of these surveys was to capture the extent to which aspects of Inclusion Health are embedded in the curricula.

The sixth survey (survey F) was designed specifically for members of the Queen's Nursing Institute (QNI) Homeless Health Practitioner Network. The purpose of this survey was to ascertain, where possible, what formal education and training, about vulnerable groups, particularly those who are homeless, the members had received and their stated education and training needs to effectively care for people who are homeless.

Distribution of the surveys and response rate

The surveys were distributed via organisational membership networks (table 3).

Survey A [click here](#) was sent to each of the 88 deans of faculties of health who are members of the Council of Deans of Health. There were 55 responses giving a response rate of 64 percent. Many of the responding organisations returned multiple replies to ensure any different approaches by the various professions within each university were captured. There was a maximum of 91 respondents per question.

Of the 78 respondents who identified their role 23 (30%) were Heads or Associate Heads of Faculties/Schools or Departments and 16 (21%) were programme leads or course directors. The remainder had an eclectic mix of roles and responsibilities many of which are organisation specific.

Survey B [click here](#) was distributed through the Medical Schools Council. The survey was considered by the Medical School's Council Executive Committee who gave permission for this survey to be distributed via their network. The survey was distributed to the 31 members and 14 completed the survey, a response rate of 45 percent.

Survey C [click here](#) was distributed to the 18 members of the Dental Schools Council network. Eight member organisations completed the survey, a response rate of 44 percent.

Survey D [click here](#) was distributed to the 27 members of the Pharmacy Schools Council network. 12 members completed the survey, a response rate of 44 percent.

Survey E was distributed to 56 Institutions that provide healthcare science programmes only two organisations responded, a response rate of 3.6 percent. Further responses to this survey were not

sought as these professionals are not frontline clinicians. Neither the responses from the two organisations nor a copy of this survey has been made available as part of this report.

Survey F [click here](#) was distributed via the Queen's Nursing Institute to the 730 members of its Homeless Health Practitioner Network, 106 members responded, a response rate of 14.5 percent. Although the response rate to survey F is low there is sufficient data to warrant inclusion in the study

Table 3 Survey distribution and response rate

Survey name	Survey identification	Number in distribution	Number of responses	Response rate (%)
Council of Deans of Health	A	88	55	63
Medical Schools	B	31	14	45
Dental Schools	C	18	8	44
Schools of Pharmacy	D	27	12	44
Healthcare Science education providers	E	56	2	3.6%
Queen's Nursing Institute Homeless Health Practitioner Network	F	730	106	14.5
Total		950	198	21

Design of the surveys

All the surveys for the education providers had five common sections:

1. An overview of the education provision.
2. Specific information about aspects of Inclusion Health embedded in the pre-registration/undergraduate curricula.
3. Specific information about aspects of Inclusion Health embedded in the post-registration/postgraduate curricula.
4. The extent to which education providers engage the vulnerable groups to enhance the student learning.
5. Academic expertise in the five vulnerable groups.

In addition the survey designed for the healthcare education providers included a section on Specialist Community Nursing education and training, as this is the largest professional group to care for socially excluded patients. The survey designed for the dental schools also included a short section on the dental foundation course.

The questions asked in these surveys were mostly factual although there were a few questions that sought opinions about how well organisations teach and assess aspects of health inequalities. The structure of the surveys enabled separate consideration of each of the five vulnerable groups.

The sixth survey designed specifically for the Queen's Nursing Institute included a range of different types of questions: factual questions, knowledge questions, attitudinal questions and preference questions⁹³.

3.4 Case studies

The purpose of including the case study sites was to gain a greater understanding of the work experience of staff and their recommendations about education and training for those who care for patients from vulnerable groups. A list of potential organisations that care and/or provide support for one or more of the five socially excluded groups was drawn up. Within the scope of the study it was decided that 12 sites should be formally approached to take part in interviews or focus groups; six in England, four in Wales and two in Scotland (table 4).

Of the six organisations that are based in England two support people who are homeless; two support Gypsies and Travellers; one supports the Roma community; one sex workers and

Table 4 Overview of the case study sites and the data collection method used

Organisation	Location	Vulnerable group(s) supported by the organisation	Qualitative data collective method
England			
Birmingham and Solihull Mental Health NHS Foundation Trust, St Matthews Homeless Centre	Birmingham	<ul style="list-style-type: none"> Homeless people 	Focus group
Central and North West London NHS Foundation Trust	London Borough of Hillingdon	<ul style="list-style-type: none"> Roma (polish) Vulnerable migrants: Somali, Asians 	Semi- structured telephone interview
Hope Outside the Prison Environment (HOPE)	Manchester	<ul style="list-style-type: none"> Homeless people 	Focus group
Leeds Gate	Leeds	<ul style="list-style-type: none"> Gypsies and Travellers 	Focus group
Praed Street Project	Central London	<ul style="list-style-type: none"> Sex workers 	Focus group
Refugees in Effective and Active Partnerships (REAP)	London Borough of Hillingdon	<ul style="list-style-type: none"> Vulnerable migrants: Refugees and Asylum Seekers 	Focus group
Scotland			
Drugs Action	Aberdeen	<ul style="list-style-type: none"> Sex workers 	Focus group
NHS Health Glasgow	Glasgow	<ul style="list-style-type: none"> Gypsies and Travellers Roma 	Semi- structured face to face interview
Wales			
Betsi Cadwaladr University Health Board	North	<ul style="list-style-type: none"> Homeless people Gypsies and Travellers 	Semi- structured telephone interview
Cardiff and Vale Health Board	Cardiff	<ul style="list-style-type: none"> Homeless people Gypsies and Travellers Vulnerable migrants: Refugees and Asylum Seekers 	Semi- structured telephone interview
Flying Start, Cardiff and Vale Health Board	Newport	<ul style="list-style-type: none"> Gypsies and Travellers Roma 	Semi-structured interview
Wrexham Borough Council	Wrexham	<ul style="list-style-type: none"> Homeless people Gypsies and Travellers Vulnerable migrants: Refugees and Asylum Seekers 	Semi- structured telephone interview

one supports vulnerable migrants. Five of these organisations took part in focus groups and one in a semi-structured telephone interview.

One of the Scottish organisations supports sex workers and took part in a focus group and the other supports Gypsies and Travellers, and Roma, and two of their staff took part in one semi-structured interview. Staff from four organisations in Wales took part in semi-structured interviews three of which were over the telephone. All four Welsh organisations support Gypsies and Travellers; three support people who are homeless; two vulnerable migrants and one the Roma community.

In total there were six focus groups; two face to face interview sessions and four telephone interviews. The interviews provided rich qualitative data about the opinions and experiences of the individuals. The focus groups also provided data based on opinions and experiences shaped by the group.

Whether the participants took part in face to face interviews, telephone interviews or focus groups was determined by their availability. 34 participants took part in the focus groups including a service user and eight participants took part in the interviews.

A semi-structured questionnaire was used as the basis for the data collection from the case study sites (appendix 3). The questions were clustered around the themes that emerged from the literature search for evidence (chapter 2):

- Healthcare professionals' awareness, knowledge and skills about vulnerable groups.
- Skills and knowledge required of healthcare professionals to deal with those with low health expectations.
- Recommended Inclusion Health learning outcomes.
- Development of knowledge and skills to work with vulnerable groups.
- Challenges and difficulties encountered by healthcare professionals working and supporting these groups.
- Reluctance and lack of confidence of healthcare professionals to take on the care of those in the vulnerable groups.
- Continuity of care for vulnerable groups.
- Support networks for healthcare professionals working with vulnerable groups.
- Trust between healthcare professionals and vulnerable groups.

3.5 Data analysis

The quantitative data from the five surveys was carefully reviewed, cleansed and checked. The qualitative data from the survey responses was collated electronically and analysed thematically.

The qualitative data from the focus groups and semi-structured interviews was tape recorded and transcribed long hand. The data from the transcripts was analysed against the themes explored in the focus groups and interviews.

The main findings are set out in chapter four.

CHAPTER 4

MAIN FINDINGS

4.0 MAIN FINDINGS

4.1 Introduction

In this chapter we present the main findings of the study. The findings are drawn from the four sources as outlined in chapter 3:

1. Review of the health and care professional, statutory and regulatory bodies' guidance on Inclusion Health
2. Four separate online surveys to health education providers
3. Online survey to the Queen's Nursing Institute Homeless Health Practitioner Network
4. Case studies of a sample of organisations which support vulnerable groups.

The chapter is set out according to the sources of data:

- 4.2 Professional, statutory and regulatory bodies' guidance on Inclusion Health
- 4.3 Education providers' commitment to Inclusion Health
- 4.4 Findings from the survey to the Queen's Nursing Institute Homeless Health Practitioner Network
- 4.5 Findings from the case study sites
- 4.6 Overall summary of the main findings

With regards to the online surveys the findings are set out by survey sections.

4.2 Professional, statutory and regulatory bodies' guidance on Inclusion Health

4.2.1 Regulatory bodies' guidance

The job of the regulators is to protect the health and wellbeing of people who use the services of the health and care professionals they register. In order to do this they set and monitor standards including education and training of their registrations.

The review of eight of the nine regulatory bodies' information on Inclusion Health presented a mixed picture (3.2 and appendix 4). There is no standardised approach by the regulatory bodies to documentation of standards and guidance, making it difficult to directly compare the regulators' guidance. Some of the regulatory bodies issue learning outcomes for registration. Whereas, other regulatory bodies set standards of education and training, as well as standards of competence, or standards of proficiency.

The most comprehensive regulatory body guidance on Inclusion Health is provided by the Nursing and Midwifery Council (NMC). The NMC sets standards of competence⁹⁶ (box 6) to enter the register for all four fields of nursing (adult nursing, children's nursing, learning disabilities nursing and mental health nursing). All nurses are also charged with the responsibility of promoting social inclusion.

Box 6 Extract from the NMC's standards for competence to enter the register⁹⁶

'All nurses must practise in a non-judgemental caring and sensitive manner that avoids assumptions, supports social inclusion; recognises and respects individual choice; and acknowledges diversity. Where necessary they must challenge inequality, discrimination and exclusion from access to care.'

The NMC also sets additional competences for specific fields, for example for mental health nursing. It states that *'mental health nurses must use different methods of engaging people, and work in a way that promotes social inclusion, human rights and recovery'*.

The Health and Care Professions Council (HCPC) regulates 16 autonomous professions. This includes the 12 AHP professions, biomedical and clinical scientists, hearing aid dispensers, operating department practitioners and social workers. The HCPC makes no reference to Inclusion Health in the standards of Education and Training. However there is reference in the HCPC's standards of conduct, performance and ethics⁹⁷ (box 7).

Box 7 Extract from the HCPC's standards of conduct, performance and ethics⁹⁷

'You must not allow your views about a service user's sex, age, colour, race, disability, sexuality, social or economic status, lifestyle, culture, religion or beliefs to affect the way you deal with them or the professional advice you give. You must treat service users with respect and dignity.'

You should take appropriate action to protect the rights of children and vulnerable adults if you believe they are at risk, including following national and local policies.'

The HCPC also issues standards of proficiency for each of the professions it regulates (appendix 5). In the context of this study the key HCPC regulated professions that work with vulnerable groups are: occupational therapists, paramedics, physiotherapists, practitioner psychologists, speech and language therapists and social workers. The standards of proficiency for each of these professions are different but all include a reference to one or more aspect of Inclusion Health. The most substantive reference can be found in the standards of proficiency for social workers: *'Be able to reflect on and take account of the impact of inequality, disadvantage and discrimination on those who use social work services and their communities'*.

The General Medical Council, General Dental Council and the General Osteopathic Council include sociological factors relating to health inequalities in the learning outcomes for professional registration.

The documentation from the remaining three regulatory bodies that were incorporated into this review: the General Optical Council, the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland, makes no reference to Inclusion Health.

4.2.2 Professional bodies' guidance

Reference to Inclusion Health and/or social inclusion was found in 27 of the 37 professional associations or representative organisations whose guidelines were reviewed as part of this study (box 5, chapter 3). 16 of these organisations make specific reference to including a particular aspect of Health Inclusion in the curriculum (appendix 5). Some of them mention gaining a theoretical understanding of topics such as cultural, social and ethical issues as they affect the services their members provide, for example the British Association of Drama Therapists and the British Dietetic Association. Others, such as the British Dental Association make reference to gaining practice experience of working with socially excluded groups including people who are homeless.

Guidance produced by some professional associations is detailed and sets out the knowledge, skills and approaches to identifying health determinants and health inequalities. The most comprehensive set of guidelines available to all healthcare professionals have been produced by the Royal College of General Practitioners (RCGP)^{98,99}. It has developed a core curriculum for health inequalities competencies and has developed curriculum statements (appendix 6) which make clear recommendations with regards to Inclusion Health. Online resources and learning material are available which can be accessed by any healthcare professional. Three of the RCGP's curriculum statements that make detailed reference to aspects of Inclusion Health are:

- The GP Consultation in Practice.
- Enhancing Professional Knowledge.
- Healthy People: promoting health and preventing disease.

This exemplary model is readily available and could be used as a template by other professional bodies. In response to the major issue of deprivation and health inequalities in Scotland¹⁰⁰ a recommendation in an RCGP publication in 2010¹⁰¹ stated that '*deprivation and health inequalities should form a prominent vertical strand in all undergraduate curricula, and include opportunities for student selected study modules.*'

The RCGP 2022 vision for general practice¹⁰² highlights that in 2022 the NHS will have '*a growing intolerance of long standing inequalities in health*' and their vision for the GPs' role in 2022 to include supporting a reduction in health inequalities and increasing community self-sufficiency. In addition the RCGP has just published further guidance for GPs working with vulnerable groups¹⁰³.

The Royal College of Nursing (RCN) offers very good support through its online social inclusion resource¹⁰⁴. This resource is available to all nurses and health care assistants in all settings to support practice with excluded people and 'hard-to-reach' communities. This resource covers the social inclusion agenda in each of the four UK countries and highlights issues faced by a number of vulnerable groups. The resource signposts sources of support in the form of agencies, guidance and policies. There are resources available on the RCN website related to inclusive practice, asylum seekers and refugees, Gypsy and Traveller communities, people who are homeless, and sex workers. One of the RCN's key principles of inclusive practice is about nurses challenging inequalities and addressing the causes and effects of exclusion and health inequalities including homelessness, stigma and discrimination.

The Royal College of Pathologists¹⁰⁵ recommends that the curriculum should include: '*the effects of social and cultural issues on access to healthcare, including health issues of migrants and refugees and recognising the effects of exclusion and discrimination on physical and mental health.*' Similarly the Royal College of Psychiatrists¹⁰⁶ has produced a competency based curriculum for specialist

core training in psychiatry in which it is noted that psychiatrists are important in promoting social inclusion and that this is embedded in the curriculum. One of the key position statements issued by the Royal College of Psychiatrists is set out in box 8.

Box 8 Position statement by the Royal College of Psychiatrists¹⁰⁷

‘Socially inclusive practice needs to be built into medical training at all levels, from the undergraduate curriculum to the establishment of competencies for the postgraduate curriculum for psychiatry. Continuing professional development for psychiatrists will be an important tool to promote the cultural change in attitudes and practice required to implement the social inclusion agenda across the profession.’

Other professional associations have curriculum guidelines that draw the members’ attention to Parliamentary reports and Acts. For example the continuing professional development framework developed by the Royal College of Speech and Language Therapy has specific reference to the Mental Capacity Act.

The British Association of Social Workers and the College of Social Work also make extensive reference to covering all aspects of Inclusion Health in education and training programmes. The professional values of social work include the promotion of social justice, inclusion and equality.

A College of Social Work document¹⁰⁸ about reforming social work education highlights that programmes must address the specific needs that may affect all people at different stages of their life experience. There is also the reference to the importance of working effectively through building a relationship with individuals, families, groups and communities as appropriate. These include immigration, especially for refugees and asylum-seekers^{109, 110}.

Key curriculum issues for social work with regards to migration and refugees are:

- ‘A safe environment for an open, honest discussion of views is necessary.
- Asylum seekers and refugees should be included in the planning and delivery of sessions where possible.
- A brief history of British immigration should be provided including ‘push’ and ‘pull’ factors.
- The residual nature of welfare for asylum seekers can be linked to wider debates of neo-liberalism and historically to the poor laws, highlighting the continuities in notions of the ‘deserving’/‘undeserving’, as well as to anti-oppressive and anti-discriminatory practice and international social work perspectives.’

Medsin is a student network and registered charity tackling global and local health inequalities through education, advocacy and community action. Medsin acknowledges the importance of having an understanding of the social determinants of health¹¹¹ and for this to be present in the curriculum. It is suggested that students should have greater exposure to health inequity through placements and that advocacy skills are taught to support students to deal with the social determinants of health²².

Inclusion Health, as a core skill for healthcare professionals, is of such significance that it often warrants a collaborative approach. In 2009 the Health Inequalities Forum of the Academy of Medical Royal Colleges undertook a health inequalities curriculum competency project¹¹². The overall objective of the project was to develop a set of competencies concerning health inequalities that could be used as a resource for Colleges to draw on. The competencies were designed with the intention of

improving patient care; contributing towards combating discrimination and stigma in healthcare and raising awareness among doctors in training, other healthcare students and professionals. These competencies cover three domains: knowledge, skills, attitudes and behaviours.

The Shape of Training review¹¹³ was set up to understand and plan for the future of all medical education and training. The review was jointly sponsored by the Academy of Medical Royal Colleges, the General Medical Council, Medical Education England, the Medical Schools Council, NHS Scotland, NHS Wales and the Northern Ireland Department of Health, Social Services and Public Safety. One of the key messages from this independent review is illustrated in the box 9.

Box 9 Key message from the Shape of Training¹¹³

‘Patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations.’

An e-learning resource has been produced for all healthcare staff by the Department of Health in partnership with Platform 51 on human trafficking¹¹⁴, with guidance from a steering group comprising professional bodies, government agencies, education providers and third sector organisations. This resource has been developed to support staff to recognise the signs that someone has been trafficked and to have the confidence to take the appropriate action.

Midwifery 2020 was a unique UK-wide collaborative programme with the full and active involvement of the four UK Chief Nursing Officers in England, Northern Ireland, Scotland and Wales and carried out in partnership with the Royal Colleges, the Nursing and Midwifery Council (NMC), and with diverse partners and stakeholders in maternity. It is clear that health inequalities affect both women and babies. Midwives have a vital role to play in improving health and social wellbeing for all women and also in reducing health inequalities for their service users. There is increasing social and ethnic diversity, sometimes leading to communication difficulties and other social and clinical challenges in maternity care. One of the key messages in Midwifery 2020¹¹⁵ is about the midwife’s role in public health and working to reduce inequalities (box 10).

Box 10 Key message from Midwifery 2020¹¹⁵

‘Midwives should have a good knowledge of the health and social care needs of the local community; be well networked into the local health and social care system; and be proactive in identifying women at risk, and engaging with the woman, her family and other services as appropriate.’

4.3 The education providers' commitment to Inclusion Health

This section details the responses from the medical and non-medical healthcare education providers' online surveys. It is set out in the order of the contribution that the programmes make to the knowledge and skills of the total workforce that supports the Inclusion Health agenda. The significance of the responses has been reported as a percentage where there are larger numbers of responding organisations and by figures where the numbers of responding organisations are relatively few.

4.3.1 Healthcare education providers (members of the Council of Deans of Health)

4.3.2 Medical schools

4.3.3 Dental schools

4.3.4 Schools of pharmacy

4.3.1 Healthcare education providers (members of the Council of Deans of Health)

The Council of Deans of Health is a UK wide membership organisation comprised of faculties of health and social care. These faculties are responsible for educating and training nurses, midwives, allied health professionals (AHPs), social workers, clinical psychologists and other non-medical healthcare professionals. For the purposes of this study medical, dental and pharmacy education and training has been considered separately and is reported in the subsequent sections 4.3.2-4.3.4.

A survey (survey A, section 3.3) was designed specifically to capture the extent to which the healthcare education providers, who are members of the Council of Deans of Health, embed Inclusion Health learning outcomes for the five vulnerable groups under consideration in this project:

- People who are homeless
- Gypsies and Travellers
- Roma
- Sex workers
- Vulnerable migrants.

The findings from the 88 healthcare education providers who completed the survey are reported under the following headings:

4.3.1.1 Education provision

4.3.1.2 Inclusion Health in the pre-registration healthcare students and trainee support worker courses

4.3.1.3 Inclusion health in the Specialist Community Nursing courses

4.3.1.4 Inclusion Health in the taught post-registration /post-qualifying healthcare courses

4.3.1.5 Vulnerable groups' enhancement of the curricula

4.3.1.6 Service users and carers involvement in the curricula

4.3.1.7 Academic expertise in Inclusion Health

4.3.1.1 Education provision

The healthcare education providers were asked to furnish information about the education and training programmes that they deliver under the following headings:

- Pre-registration education and training
- Specialist Community Nursing education and training
- Post-qualification/post-registration education and training

Pre-registration education and training

The highest percentage of pre-registration education and training programmes delivered by the healthcare education providers is nursing: adult nursing (75%); mental health nursing (67%) and children's nursing (55%). The respondents reported that midwifery (53%), social work (47%) and occupational therapy (40%) together with nursing make up a large percentage of all pre-registration health and care courses. A detailed percentage breakdown of all pre-registration courses provided by the responding Higher Education Institutions (HEIs) is shown in figure 2.

50% (55) of the responding institutions stated that they provide other pre-registration programmes. 18 reported offering a foundation degree in health and social care for support workers and eight offering a pre-registration course leading to practice as an operating department practitioner. The full range of additional pre-registration programmes provided is shown in appendix 7.

Specialist Community Nursing education and training

Specialist Community Nurses have a significant role in supporting vulnerable groups particularly those who are homeless. For this study the collective term Specialist Community Nursing includes sexual health nursing, public health nursing, family health nursing, occupational health nursing, school nursing, health visiting, community children's nursing and district nursing.

32 respondents reported that they provide Specialist Community Nursing (SCN) courses (figure 3), of which 29 provide health visiting courses; 26 school nursing courses, 24 district nursing courses and 18 public health nursing courses. Fewer offer programmes in sexual health nursing, occupational health nursing, community children's nursing and family health nursing.

Post-registration /post-qualifying education and training

88% (77) of the respondents advised that their organisation provides post-registration /post-qualifying programmes (section 4.3.1.4). 38% (21) chose to list the post-graduate/post-registration courses they offer or directed the reader to their website. Four respondents reported that Inclusion Health is integrated into Continuous Personal and Professional Development (CPPD) pathways and modules.

“Our university has available approximately 60 award pathways and around 200 modules. There are none specific to Inclusion Health although it is a feature of some of the modules.”
Senior academic manager

15 organisations reported that they didn't offer any taught post-registration/post-qualifying modules that focussed solely on Inclusion Health.

Figure 2 Percentage of pre-registration courses provided by healthcare education providers

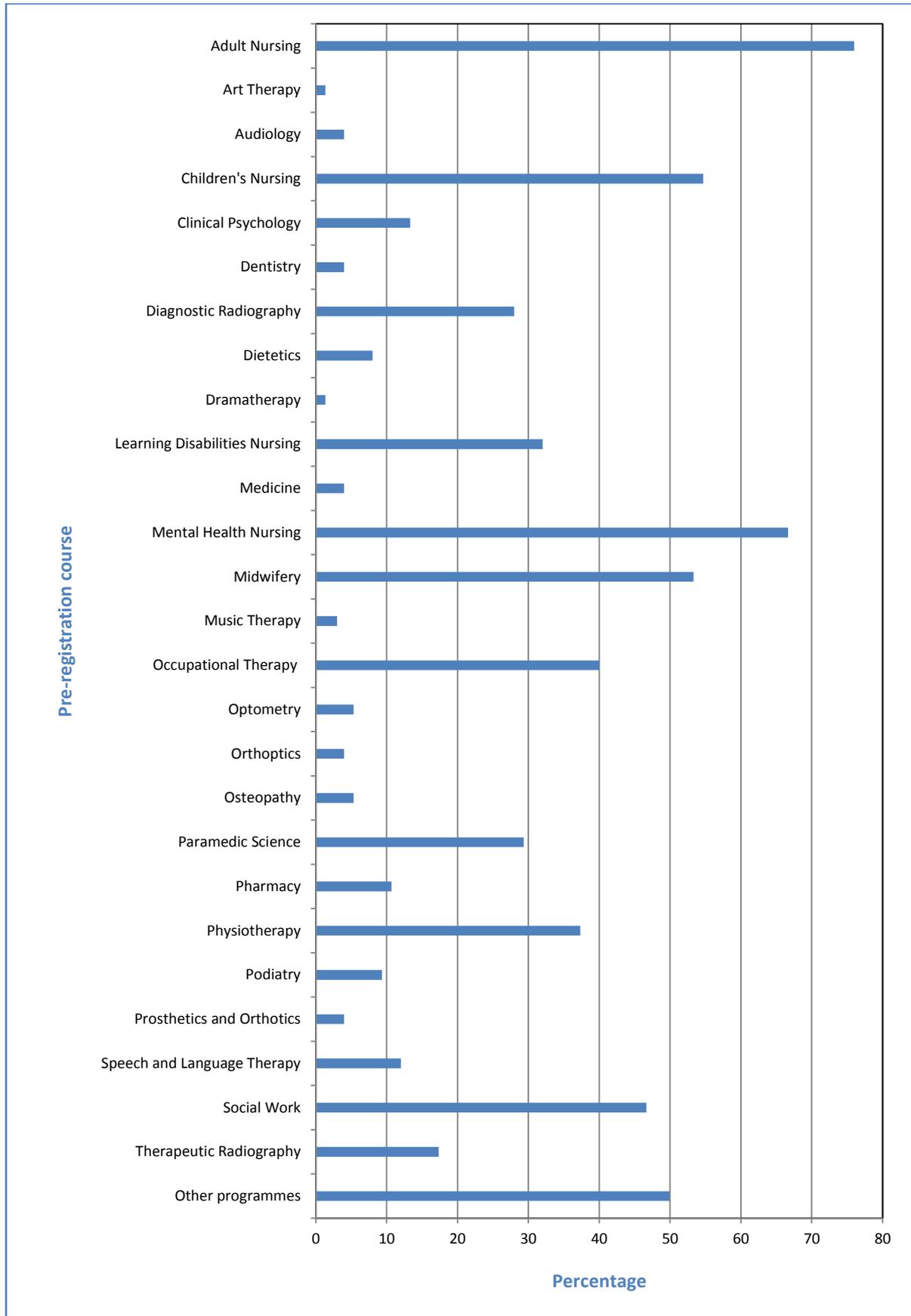
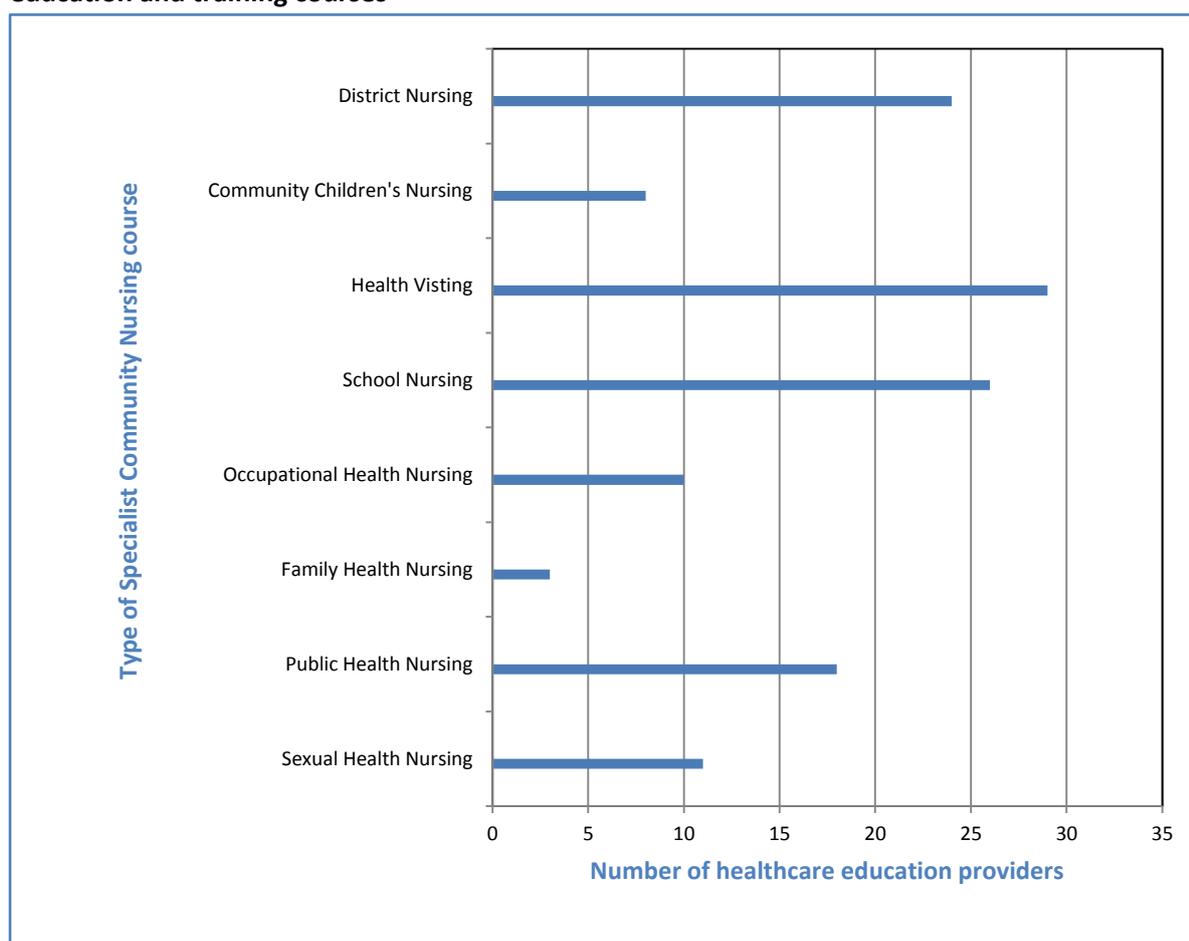


Figure 3 Number of healthcare education providers that offer Specialist Community Nursing education and training courses



4.3.1.2 Inclusion Health in the pre-registration healthcare students and trainee support worker courses

The respondents were asked to provide information about whether their institution taught and assessed their pre-registration students and trainee support workers about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

Health inequalities

The respondents were asked to rank against a five point scale how well, in their opinion; their institution teaches and assesses, as part of pre-registration and support worker education and training, six aspects of health inequalities²²:

1. Social and economic determinants.
2. Tackling health inequalities.
3. How and why social determinants affect health and wellbeing.
4. How social determinants affect morbidity and mortality.
5. How the effects of social determinants are distributed across society.
6. How and why different groups are more vulnerable and more likely to be excluded.

69 respondents answered this question. The majority of the respondents were very clear about what was taught and over 95% reported that they either strongly agreed or agreed that their organisation teaches the six aspects of health inequalities (appendix 8). The respondents were mostly positive about the fact that their organisation assesses all six aspects of health inequalities (appendix 9). Although some of the respondents were undecided as to which aspects they assessed. For example, ten (14%) of the 69 respondents were undecided as to whether they assessed social and economic determinants; how to tackle health inequalities and how the effects of social determinants are distributed across society. Less than five per cent advised that their organisations do not assess the six aspects of health inequalities.

“The six aspects of health inequalities are taught across the curriculum and the department is research active in relation to health inequalities.” Senior Lecturer, Adult Nursing

58 respondents provided data about which pre-registration course content included all six aspects of health inequalities. The responses are shown in figure 4, with the highest percentage of respondents stating that these topics are covered in adult nursing (84% of the respondents), mental health nursing (75%), children’s nursing (64%) and social work (44%) courses. Some of the respondents provided information about other courses in their faculty that also included these six aspects of health inequalities most notably, operating department practitioner courses and the Foundation Degree in Health and Social Care.

HEIs use a range of assessment methods to assess the pre-registration students’ knowledge of vulnerable groups. The relative proportion of different assessment methods are shown in the adjacent pie chart. 90% of the respondents advise that they use a written assignment and 64% it is included in the practice portfolio.

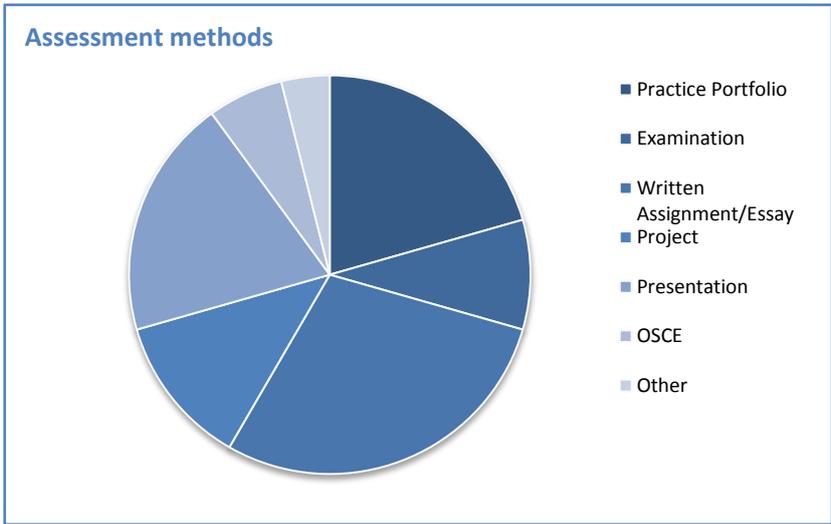
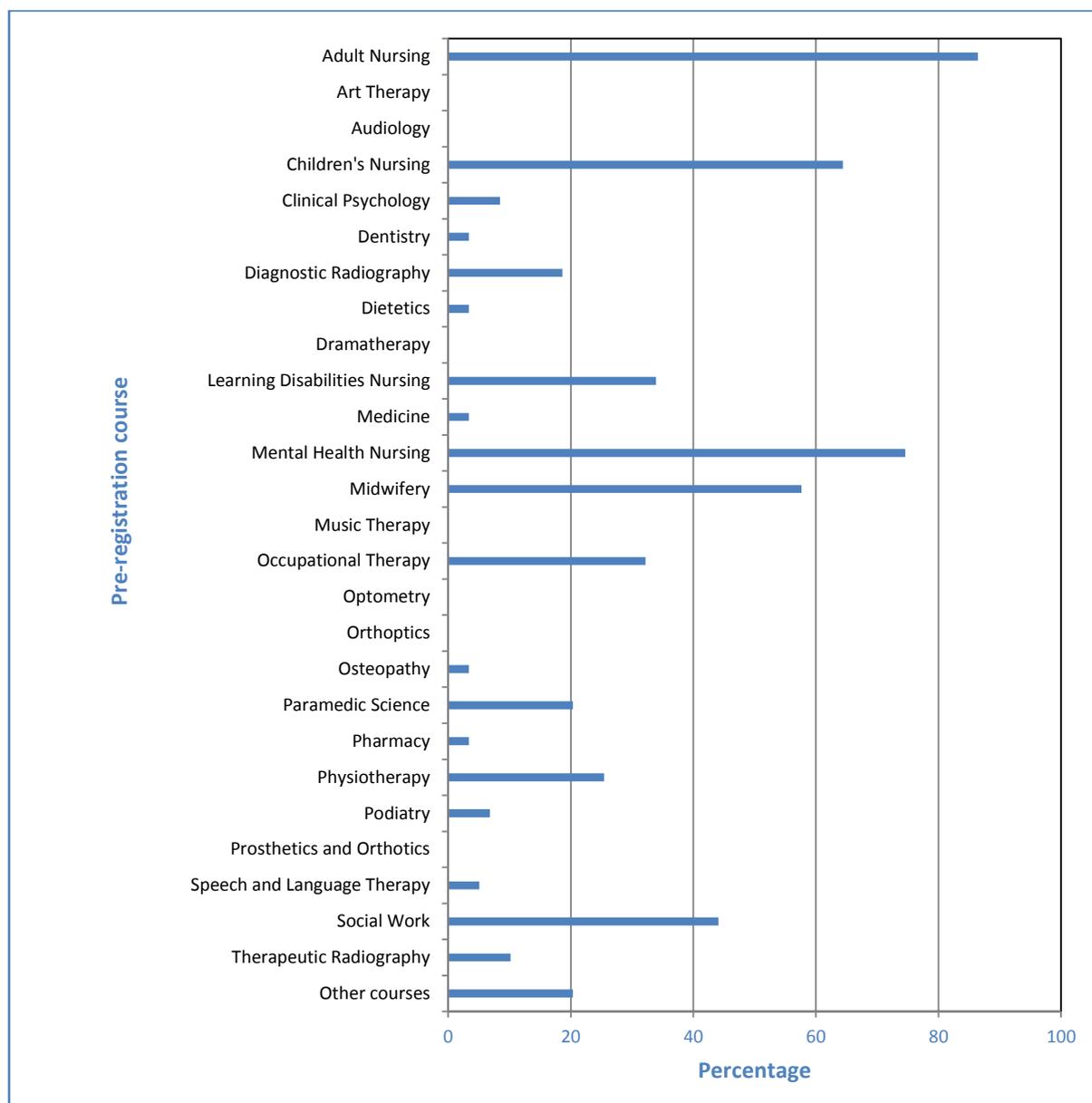


Figure 4 Percentage of organisations that teach all six aspects of health inequalities in pre-registration courses



Other methods that are used to teach and assess, many of which are very innovative, include:

- Service user and carers personal narratives.
- Work in partnership with the organisers and members of a charity or community organisation to develop and carry out a volunteer homeless project.
- Emerging role placements for occupational therapy students based in charities, organisations and services that cater for people with specific needs.
- Scenario based learning.
- Vignettes of service users.
- Actors.
- Outreach projects.

- Health inequalities imagination model and use the characters to assess student understanding.
- Problem based learning using service user examples.
- Emotional learning role play.
- Neighbourhood study.

“Inclusion Health is taught as part of an inter-professional module called Foundations of Practice of Health and Social Care. Social work students study in groups alongside nurses (adult nurses, children’s nurses and mental health nurses) and AHP students (9 different professional groups) to give a presentation on a health inequality.” Undergraduate Course Director

17 respondents reported that their faculty offers pre-registration modules with entire learning outcomes focussed on health inequalities, for example, modules about public health. Many healthcare education providers offer modules in public health for the pre-registration students with learning outcomes focussed on health inequalities.

“Health and health inequalities form a thread throughout the qualification rather than sit as discrete modules.” Assistant Head of Department of Nursing

Health risks to vulnerable groups and their healthcare needs

The respondents were asked separate questions about whether they teach and whether they assess pre-registration students about health risks to the five vulnerable groups and their healthcare. The findings are collated in tables (5 and 6).

This study has found that health risks to vulnerable groups are primarily taught on adult nursing and social work pre-registration courses. Although the number of institutions that reported teaching health risks to vulnerable groups on these courses is low. The number varies between a maximum of 30% that teach health risks to vulnerable migrants on adult nursing pre-registration courses and less than 2% that teach health risks to vulnerable groups for a number of the pre-registration courses. The health risks to people who are homeless and the vulnerable migrants are most frequently covered in the taught content of the pre-registration curricula.

Example of some of the topics taught on a BSc(Hons) Mental Health Nursing course

“Women in prisons, chaotic drug users, asylum seekers and women in refuge.” Dean

Table 5 Number of pre-registration courses with taught components about health risks to vulnerable groups

Course	People who are homeless n=59	Gypsies and Travellers n=60	Roma n=59	Sex workers n=57	Vulnerable migrants n=57	Total
Adult Nursing	13	11	6	10	17	57
Social Work	15	9	8	7	12	51
Mental Health Nursing	12	5	2	5	9	33
Midwifery	5	4	5	8	6	28
Occupational Therapy	7	3	4	1	6	21
Children's Nursing	6	5	1	2	6	20
Clinical Psychology	3	2	1	1	2	9
Healthcare support worker programme	3	1	1	1	1	7
Paramedic Science	3	1	1	-	1	6
Orthoptics	1	1	1	1	1	5
Physiotherapy	3	-	-	1	1	5
Diagnostic Radiography	1	1	1	-	1	4
Operating Department Practice	1	1	1	-	1	4
Learning Disability Nursing	3	-	-	-	-	3
Health Studies	-	-	-	1	1	2
Health Visiting	-	1	-	-	-	1
School Nursing	-	1	-	-	-	1
Number of courses by vulnerable group	73	46	32	38	65	

n- number of respondents

Within the cluster of courses that prepare allied health professionals for registration occupational therapy courses have a greater focus on health risks to vulnerable groups than the other AHP programmes. For example only three faculties reported teaching paramedic students about health risks to people who are homeless and only one faculty reported that this topic is covered in the diagnostic radiography course. This is surprising as once they are qualified practitioners these healthcare professionals are very likely to care for patients who are homeless.

Healthcare needs of vulnerable groups are also primarily taught on adult nursing and social work pre-registration courses (table 6). Although the number of institutions reported to teach healthcare needs on adult nursing courses is higher than the numbers that teach health risks, the overall number of institutions that cover these topics is still low. The number varies between a maximum of 31% that teach healthcare needs of people who are homeless on adult nursing pre-registration courses and less than 2% that teach healthcare needs to vulnerable groups on many pre-registration courses. As with health risks, the healthcare needs of people who are homeless and the vulnerable migrants are most frequently covered in the taught content of the curricula.

Table 6 Number of pre-registration courses with taught components about the healthcare needs of vulnerable groups

Course	People who are homeless n=58	Gypsies and Travellers n=58	Roma n=58	Sex workers n=57	Vulnerable migrants n=59	Total
Adult Nursing	18	14	7	12	18	69
Social Work	15	9	5	5	8	42
Mental Health Nursing	14	6	2	6	8	36
Midwifery	8	6	3	9	7	33
Occupational Therapy	9	4	3	2	8	26
Children's Nursing	9	4	2	3	5	23
Clinical Psychology	3	1	1	1	1	7
Healthcare support worker course	3	2	1	2	1	9
Paramedic Science	2	1	1	-	1	5
Orthoptics	-	1	1	1	1	4
Physiotherapy	3	-	-	1	1	5
Diagnostic Radiography	2	1	1	-	1	5
Operating Department Practice	-	1	1	-	-	2
Learning Disability Nursing	5	1	-	1	2	9
Health Studies	-	-	-	-	-	-
Health Visiting	2	1	-	-	-	3
School Nursing	-	1	-	-	-	1
Public Health	4	-	-	-	-	4
Number of courses by vulnerable group	97	53	28	43	62	

n- number of respondents

Only 24% of the faculties reported teaching healthcare needs of the Roma community compared to 67% who reported teaching healthcare needs of people who are homeless.

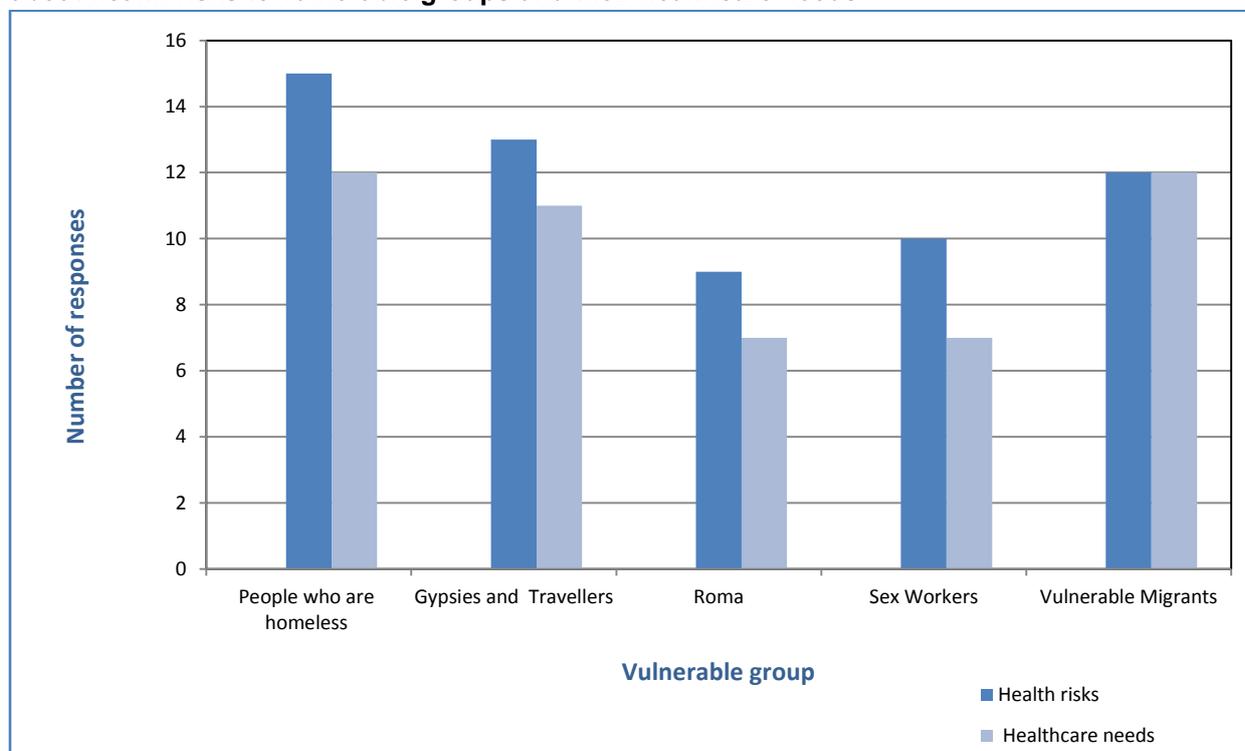
However the study found that there are examples of best practice where faculties enable students to learn about health risks and healthcare needs of vulnerable groups as illustrated in the box below.

"In year 3, adult nursing students, children's nursing students, mental health nursing students, midwifery students, occupational therapy students, diagnostic radiography students, operating department practitioner students, social work students and paramedic science students all study a module together around collaborative working. This module includes discussion around patients/clients who may be homeless or in the travelling community. Midwifery students also study a module called 'public health and the challenges for midwives' which includes vulnerable groups including homeless people." Faculty Director of Quality and Faculty Director of Teaching and Learning

The survey included a question about the extent to which institutions enable pre-registration students to demonstrate their knowledge and understanding of the health risks to vulnerable groups and their healthcare needs. 53 responded to the question about assessing health risks and only 14 responded to the question about assessing healthcare needs. However the responses to these two questions by

vulnerable group were very similar, as shown in figure 5. The numbers of institutions that reportedly assess these topics is very low. We might have expected to find more institutions assessing the pre-registration students about health risks to people who are homeless but this is also relatively low.

Figure 5 Number of respondents that indicated the pre-registration students are assessed about health risks to vulnerable groups and their healthcare needs



Practice placement experience with vulnerable groups

It has been suggested that learning about the healthcare needs of vulnerable migrants is most effective when encountered through practice placements rather than teaching the needs of the specific groups. While this is undoubtedly true the practice learning opportunities are insufficient to ensure that all student groups, who will encounter vulnerable service users and carers during their professional careers, gain this experience and practice learning opportunities are frequently opportunistic.

4.3.1.3 Inclusion Health in the Specialist Community Nursing courses

As mentioned previously, nurses working in the community make a unique contribution to the healthcare of vulnerable groups. This is further evidenced in the survey responses by the QNI Homeless Health Practitioner Network (4.4) and the case studies (4.5).

This section focusses solely on the education and training of the Specialist Community Nurses (SCNs) (district nurses, school nurses, health visitors, community children's nurses, family health nurses, occupational health nurses, public health nurses and sexual health nurses) and their preparedness to support vulnerable groups.

As with pre-registration education and training (4.3.1.2) the respondents were asked to provide information about whether their institution teaches and assesses SCN students about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

Health inequalities

The respondents were asked to rank on a five point scale how well, in their opinion, their institution teaches and assesses SCNs about six aspects of health inequalities (4.3.1.2). The responses are separated into how well the six aspects are taught and how well they are assessed. 30 respondents from 23 HEIs answered this question.

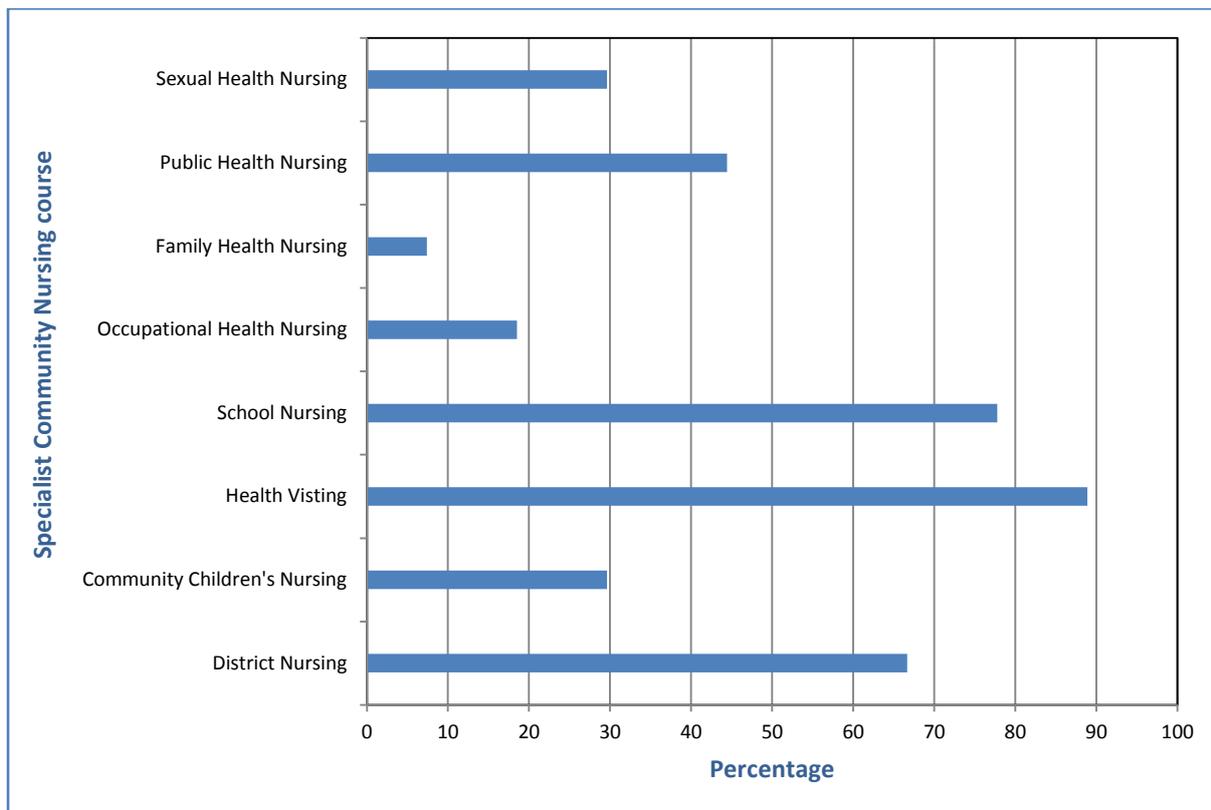
A mean of 59.4% strongly agree that their organisations teach the six aspects of health inequalities. Only one respondent was undecided about one aspect (social determinants affect morbidity and mortality) and another disagreed and advised that their organisation did not teach how to tackle health inequalities. No respondent strongly disagreed with any of the statements. The detail is set out in appendix 10.

The respondents were less clear about assessment. Their opinion as to whether they strongly agreed that they assess aspects of health inequalities ranged from 53% of the respondents who strongly agreed that their organisation assesses the social and economic determinants of health to 38% of the respondents who strongly agreed that they assessed how the effects of social determinants are distributed across society. A mean of 44% and 11% ranked their opinion as agreed and undecided respectively across the six aspects of health inequalities. One reported that they did not assess how to tackle health inequalities (appendix 11).

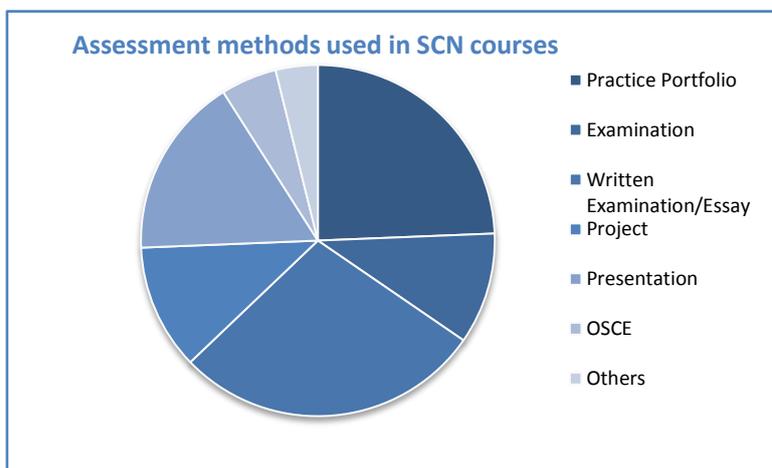
27 respondents provided data about which SCN courses included all six aspects of health inequalities. The responses are shown in figure 6 with the highest percentage of respondents stating that these topics are covered in health visiting courses (89%), school nursing courses (78%) and district nursing courses (67%).

“In our specialist nursing courses we address reducing health inequalities by planning and evaluating community-based projects to improve health.” Acting Head of Professional Practice

Figure 6 Percentage of organisations that teach all six aspects of health inequalities in Specialist Community Nursing courses



25 respondents offered information about the assessment methods used. As with pre-registration assessment methods, the favoured approach, on the SCN courses, is to use a written assignment usually an essay and a portfolio (see adjacent pie chart). Other methods of assessment included a health needs assessment report, professional conversations and dissertations.



20 respondents reported that they offer Specialist Community Nursing modules which have entire learning outcomes focussed on health inequalities (box 11). One of these respondents noted that they were unable to be specific, another that most learning outcomes focus on health inequalities.

Box 11 Example of learning outcomes on a Specialist Community Nursing module

Perspectives of Public Health module, learning outcomes are:

1. Analyse a range of contemporary public health perspectives and their relevance to public health practice, community development and population health and well-being.
2. Evaluate the health needs assessment process from the population, community and individual perspective and identify its use in the development of service provision.
3. Critically examine the relationships between health inequalities, health protection, public health policy and ethical, legal and professional frameworks.
4. Review a range of health promotion models and critically appraise their application to collaborative public health practice across a range of settings.

Health risks to vulnerable groups and their healthcare needs

The extent to which Specialist Community Nursing students are taught about specific health risks to vulnerable groups are set out in the table 7. This study has found that health risks to vulnerable groups are primarily taught on the health visiting and school nursing courses. 37% of the respondents reported that their organisation teaches health visiting students about the health risks to vulnerable migrants. Also on the health visiting courses 36% reported teaching health risks to Gypsies and Travellers and 34% teaching health risks to people who are homeless. In contrast only one organisation reported teaching health risks to four out of the five vulnerable groups on the mental health courses offered to Specialist Community Nurses. Nobody reported that mental health risks to people who are homeless were taught to this group of practitioners. This is disappointing as this study has shown that this workforce would like to learn about mental health challenges for people who are homeless.

Table 7 Number of Specialist Community Nursing courses with taught components about health risks to vulnerable groups

Specialist community nursing course	People who are homeless n= 29	Gypsies and Travellers n= 28	Roma n= 27	Sex workers n= 25	Vulnerable migrants n= 27	Total
Health Visiting	10	10	5	9	10	34
School Nursing	8	7	4	4	10	33
District Nursing	2	3	2	2	3	12
Public Health including Public Health Nursing	4	1	2	2	1	10
Occupational Health Nursing	3	2	1	2	2	10
Sexual Health	3	-	1	4	2	10
Mental Health Nursing		1	1	1	1	4
Number of courses by vulnerable group	30	24	16	24	29	

n- number of respondents

Health risks to sex workers are reported to be taught on a range of Specialist Community Nursing courses many of which use innovative approaches to enabling students to learn about this topic (box 12). Many of the respondents stressed that health risks are a particular focus in practice with access to alternative placements including local housing departments, charities and voluntary sector organisations.

Box 12 Specific examples of how HEIs support the Specialist Community Nursing students to learn about health risks to sex workers

- Practice placement visit.
- Project focused on care and treatment of people who have experienced sexual exploitation.
- Safeguarding runs throughout many modules focused on needs of sex workers.
- Human trafficking.
- People who have personal experience share their narratives with students from local agencies.

Healthcare needs of vulnerable groups are also primarily taught on the health visiting and school nursing Specialist Community Nursing courses and the numbers are very similar between the two sets of courses. As with health risks the numbers of institutions that teach healthcare needs of the Roma community are relatively low although two institutions reported teaching healthcare needs of people who are homeless on the mental health nursing course offered to Specialist Community Nurses.

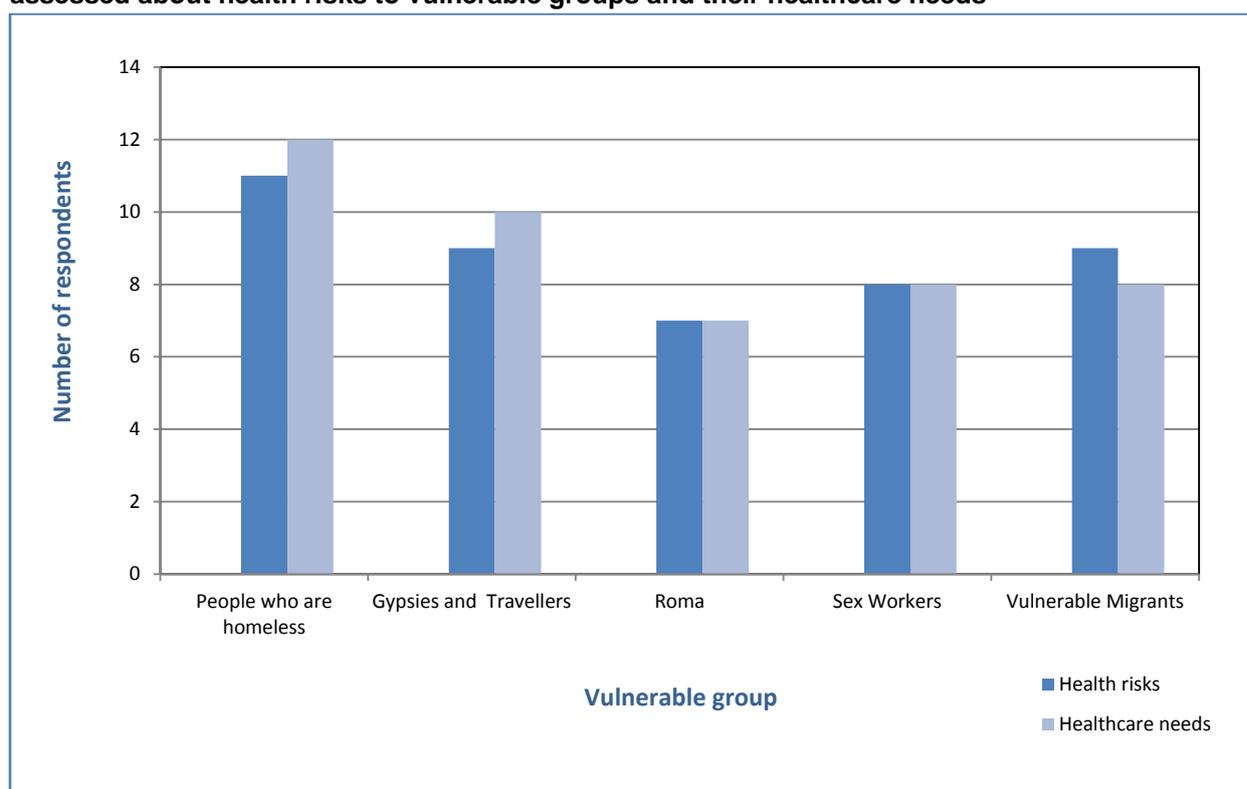
Table 8 Number of Specialist Community Nursing courses with taught components about healthcare needs of vulnerable groups

Specialist community nursing course	People who are homeless n= 26	Gypsies and Travellers n= 25	Roma n= 26	Sex workers n= 27	Vulnerable migrants n= 27	Total
Health Visiting	10	8	4	5	7	34
School Nursing	9	7	3	4	7	30
District Nursing	3	2	1	2	3	11
Public Health including Public Health Nursing	2	2	1	2	1	8
Occupational Health Nursing	2	1	1	2	2	8
Sexual Health	2	1	1	3	1	8
Mental Health Nursing	2	1	1	1	1	6
Community Nursing	-	1	-	-	2	3
Number of courses by vulnerable group	30	23	12	19	24	

n- number of respondents

27 respondents reported that they assess Specialist Community Nursing students about specific health risks to vulnerable groups. 11 of these respondents assess the health risks to people who are homeless; nine the health risks to Gypsies and Travellers and nine the health risks to vulnerable migrants (figure 7). 24 respondents reported a very similar picture about assessing Specialist Community Nursing students on specific healthcare needs of vulnerable groups (figure 7). The responses about assessing healthcare needs of these vulnerable groups were similar to the responses about assessing health risks, although on average slightly higher.

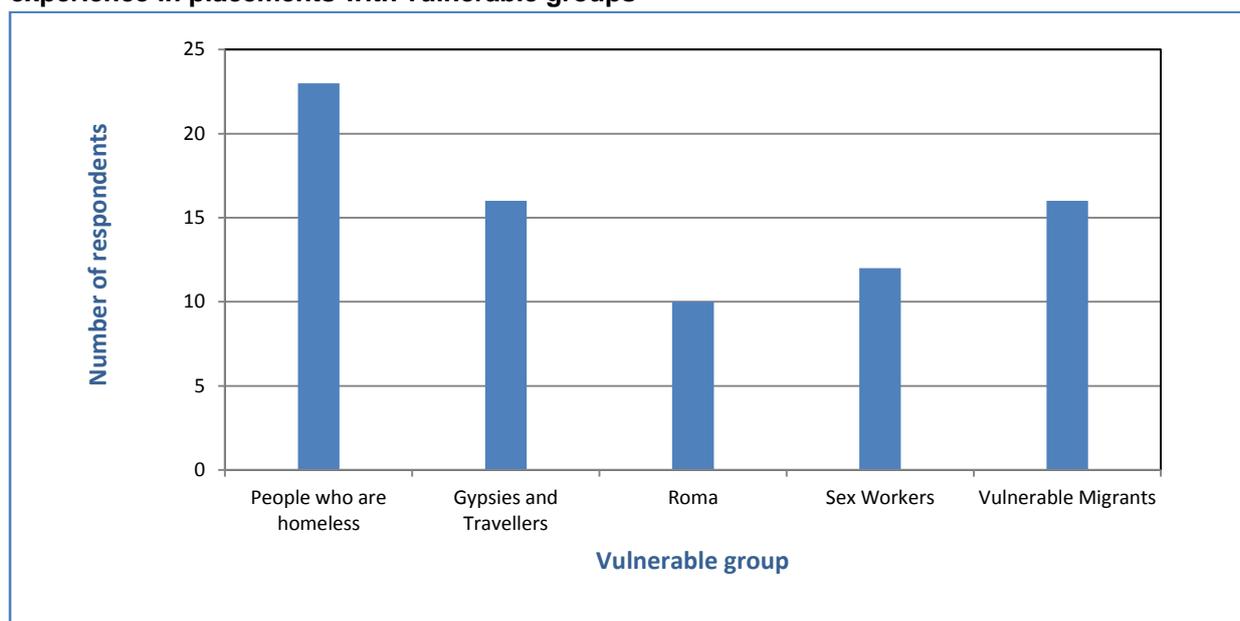
Figure 7 Number of respondents that indicated Specialist Community Nursing students are assessed about health risks to vulnerable groups and their healthcare needs



Practice placement experience with vulnerable groups

The respondents recognised the importance of practice placement learning. In response to the survey question about whether Specialist Community Nursing students have an opportunity to experience practice placements with vulnerable groups, 25 respondents reported that they do enable their students to gain this experience. 23 of them arrange for the students to gain experience with people who are homeless; 16 with Gypsies and Travellers and vulnerable migrants; 12 with sex workers and ten with Roma (figure 8).

Figure 8 Number of respondents that indicated Specialist Community Nursing students gain experience in placements with vulnerable groups



4.3.1.4 Inclusion Health in the taught post- registration /post- qualifying courses

This section sets out the approach that healthcare education providers take to Inclusion Health in their post- registration /post-qualification curricula. Of the 51 respondents, 29 (56.86%) stated they offer post- registration /post-qualification courses/modules with learning outcomes that relate specifically to health inequalities.

Examples of post-qualification/post-registration courses/modules that focus solely on Inclusion Health are:

- MSc in Domestic violence.
- Post-graduate Certificate in Sexual Violence (specifically designed for rape crisis workers).
- Level seven modules in Migration and Public Health.
- Level six modules in Sexual Health.

The faculties reported that the public health modules primarily address this topic as illustrated in box 13.

Box 13 Example of a module that addresses migrant health

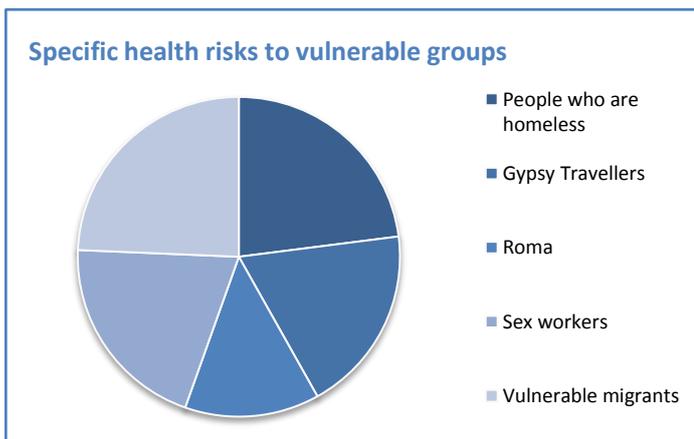
The WHO (2010) Strategic Guidelines for Migration and Health are used to structure the module focusing upon migrant sensitive health systems, policy and legal frameworks, monitoring migrant health and partnerships and networks. The module includes visits to NGOs and services working with migrants in the local area to understand the real life experience of inequity experienced by vulnerable migrants.

The topics that are covered in these modules can be clustered into migration; inequalities; cultural expectations and access to healthcare. For example:

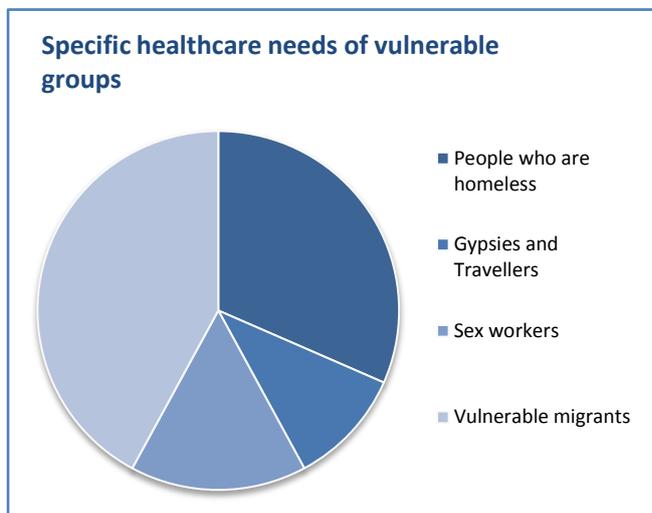
- Migration - the impact of globalisation and migration on health inequalities.
- Inequalities - factors that distinguish different health systems and their impact on patients.
- Cultural expectations - the health needs of vulnerable populations with particular reference to domestic violence, sexual violence.
- Access to healthcare - access to health care and the impact on health outcomes.

Specific health risks to vulnerable groups and their healthcare needs that are covered on taught post-qualifying/post-registration courses.

Only 24 (26%) of all respondents to the survey reported that their post-qualification/post-registration courses/modules cover the specific health risks experienced by vulnerable groups. The healthcare education providers proportionately address the health risks to the vulnerable groups other than the risks to the Roma community which according to the respondents is less frequently considered (see adjacent pie chart).



“A combination of invited expert speakers and internal staff provide holistic coverage of inequalities in general, before specific topics related to health inequality are addressed.” Lecturer



Fewer respondents (19) reported that their post-qualification/post-registration courses/modules cover the specific healthcare needs of vulnerable groups.

The institutions preferentially address the healthcare needs of vulnerable migrants and people who are homeless. According to the respondents their organisations do not consider the healthcare needs of the Roma community at all on the post-qualifying/post-registration courses or modules (see adjacent pie chart).

4.3.1.5 Vulnerable groups' enhancement of the curricula

30 of the 58 respondents stated that they work with organisations that provide services for vulnerable groups to enhance the curricula (example in box 14).

Box 14 Example of how a Scottish university engages with a specialist organisation to effectively support the curricula

The School has established a joint appointment with the Scottish Council for Voluntary Organisations (SCVO) in order to provide an 'independent' voice and co-ordination of best practice engagement with service users and carers within the School. SCVO is the national body representing the third sector in Scotland which works to support people to take voluntary action to help themselves and others, and to bring about social change. The third sector - made up of voluntary organisations, social enterprises and community groups – has two broad roles to play in relation to public service reform and health and care in particular. Its representatives are well placed to make informed and creative input to strategic planning and commissioning; and third sector organisations, either separately or working in collaboration, can play a major role in prevention, the delivery of services and responding to need. The School expects that service users and carers will become more involved with both the design and delivery of health and social care programmes for both education and research. In addition, we recognise the need to develop and embed a strategy that involves a range of stakeholders working in collaborative partnership, to ensure that the School remains at the cutting edge of both education and research now and in the future. The School of Health and Life Sciences aims to provide the highest standard of health and social care education and research, in partnership with service users and carers, in order to enhance the knowledge base and professional practice of Health and Life Sciences. We will strive for an inclusive and meaningful service user and carer involvement that genuinely values the expertise they can bring to support the work of the School. To achieve this we will facilitate and further develop a culture in which the involvement of users and carers is embedded in all School activities.'

A total of 65 different organisations were reported to support the HEIs. About three quarters of these help with teaching; half of them assist with curriculum planning and participating in workshops and approximately one third support recruitment and selection. However, only eleven organisations provide practice placements and four support research or project activity. The details as to how different organisations, that support vulnerable groups, help the HEIs to deliver the curricula are set out in appendices 12-16.

The highest level of assistance is provided by organisations that specialise in supporting people who are homeless and the lowest by organisations that specialise in supporting Gypsies and Travellers, and Roma.

4.3.1.6 Service users and carers involvement in the curricula

Only 15 respondents advised that their organisation engages service users from the five vulnerable groups to enhance the curricula, the detail is shown in figure 9.

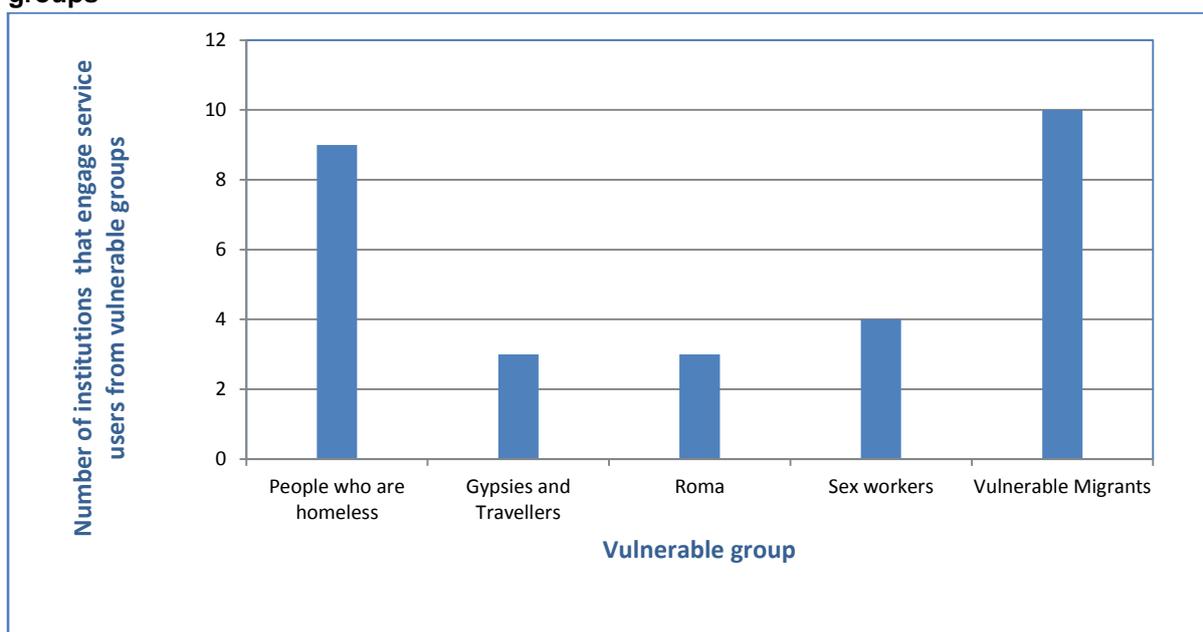
12 of these institutions work with service users to give advice on curriculum planning, to teach on courses and to participate in workshops; eight involve service users in recruitment and selection to courses. Fewer universities (five) reported that they employed service users to help with recruitment and selection of staff. The innovative ways in which the HEIs work with service users include:

- Student open days
- Interviews
- Course and module development and delivery
- Student induction
- Ad hoc teaching
- Video casts
- Group problem based learning
- Capturing personal narratives
- Placement education
- Reflective mentoring
- Assessment of students
- Delivering equality and diversity workshops
- Engagement in research projects
- Consultation
- Working with interpreters

'It is clear that we do engage with people involved in services for the homeless and sex workers but as far as migrants, Roma, Travellers etc. our content and engagement is limited.'

School Learning and Teaching Lead

Figure 9 Number of healthcare education providers that employ service users from vulnerable groups



Five institutions identified that they involve carers to enhance the curricula. All five reported they involve carers that support people who are homeless. Two respondents involve carers that support sex workers and vulnerable migrants and only one respondent that they involve carers that support Gypsies and Travellers, and Roma.

The five organisations that work with carers involve them in curriculum planning, teaching on the course and participating in workshops. Three organisations involve them in recruitment and selection to courses. One noted that the carers support placement education.

4.3.1.7 Academic expertise in Inclusion Health

35 respondents stated that their organisation employs academics with expertise in Inclusion Health. 20 employ staff with expertise in people who are homeless and in vulnerable migrants, 19 employ staff with expertise in sex workers; 11 employ staff with expertise in Gypsies and Travellers, and only six employ staff with expertise in the Roma community. One respondent noted that *“We have visiting lecturers who work with traveller families”*.

28 organisations provided details of the number of academic staff with expertise in Inclusion Health (appendix 17). This study has shown that although the numbers of academics with specialist knowledge about vulnerable groups is relatively low there is a much higher proportion of academics with specialist knowledge about people that are homeless than any other vulnerable group. Only seven providers reported employing staff with specialist knowledge about the Roma community compared to twenty who reported employing staff with expertise in the homeless community and vulnerable migrants. In fact one institution B⁵ (appendix 17) employs more than half the total number of specialists noted in this study.

The highest number of academics in any one education provider, with expertise in vulnerable groups, is reported to be 102 (B⁵) and the lowest one (A³, B³, B⁸, C³). The majority of these staff are engaged in teaching (91%), curriculum planning (83%), research (83%) and assessing students (80%).

4.3.2 Medical schools

There are 31 General Medical Council approved medical schools in the UK. All the medical schools were invited to complete a survey that had been specifically designed to collect data about the extent to which medical schools embed Inclusion Health in the curricula. Representatives from 14 medical schools completed the survey.

The results from the medical schools' survey (Survey B, section 3.3) are reported under the following sections:

- 4.3.2.1 Overview of medical education
- 4.3.2.2 Inclusion Health in the undergraduate medical curricula
- 4.3.2.3 Inclusion Health in the taught postgraduate medical courses
- 4.3.2.4 Vulnerable groups' enhancement of the curricula
- 4.3.2.5 Academic expertise in Inclusion Health

4.3.2.1 Overview of medical education

All 14 responding medical schools run the Bachelor of Medicine and Bachelor of Surgery (M.B.B.S.) programme. Nine schools also offer the intercalated BSc.

11 of the respondents advised that they currently provide postgraduate courses for medical practitioners. Only three institutions provided information about postgraduate courses that have a focus on Inclusion Health. One advised it is currently developing a postgraduate course; one that it had an Inclusion Health CPD day for medical practitioners in June 2014, and one that it supported diversity training for GPs.

4.3.2.2 Inclusion Health in the undergraduate medical curricula

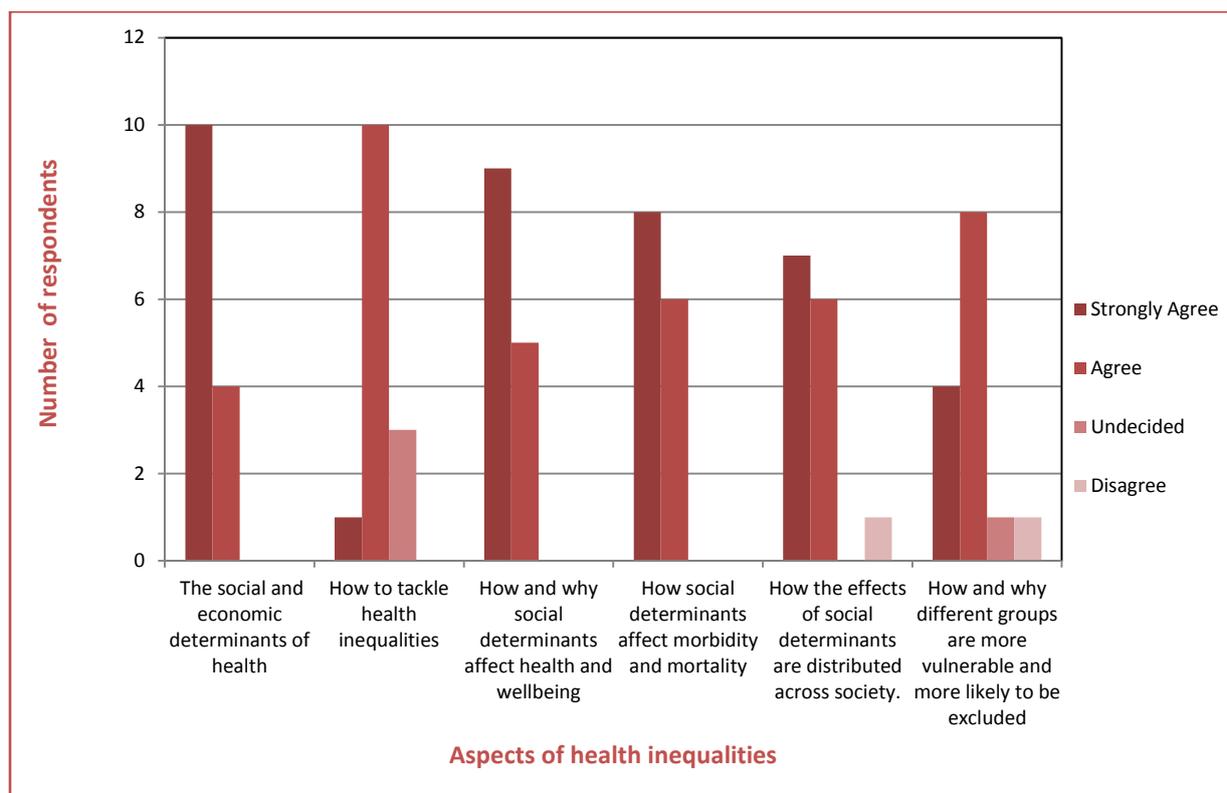
The respondents were asked to provide information about whether their institution teaches and assesses medical students about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

Health inequalities

14 responding medical schools reported that they teach all six aspects of health inequalities on the MBBS whereas only one medical school reported they teach these subjects on the Intercalated BSc. All 14 schools strongly agree (10) or agree (4) that they teach social and economic determinants of health as illustrated in figure 10. There was a similar response about how and why social determinants affect health and wellbeing. Only one school strongly agrees that they teach how to tackle health inequalities and three were undecided, the rest (10) agreed with this statement. All respondents either strongly agree (8) or agree (6) that their organisation teaches how social determinants affect morbidity and mortality. One school reported they do not teach how the effects of social determinants are distributed across society although the other schools strongly agree (7) or agree (6) they do.

Figure 10 Respondents' opinion as to whether their organisation teaches undergraduate medical students about the six aspects of health inequalities



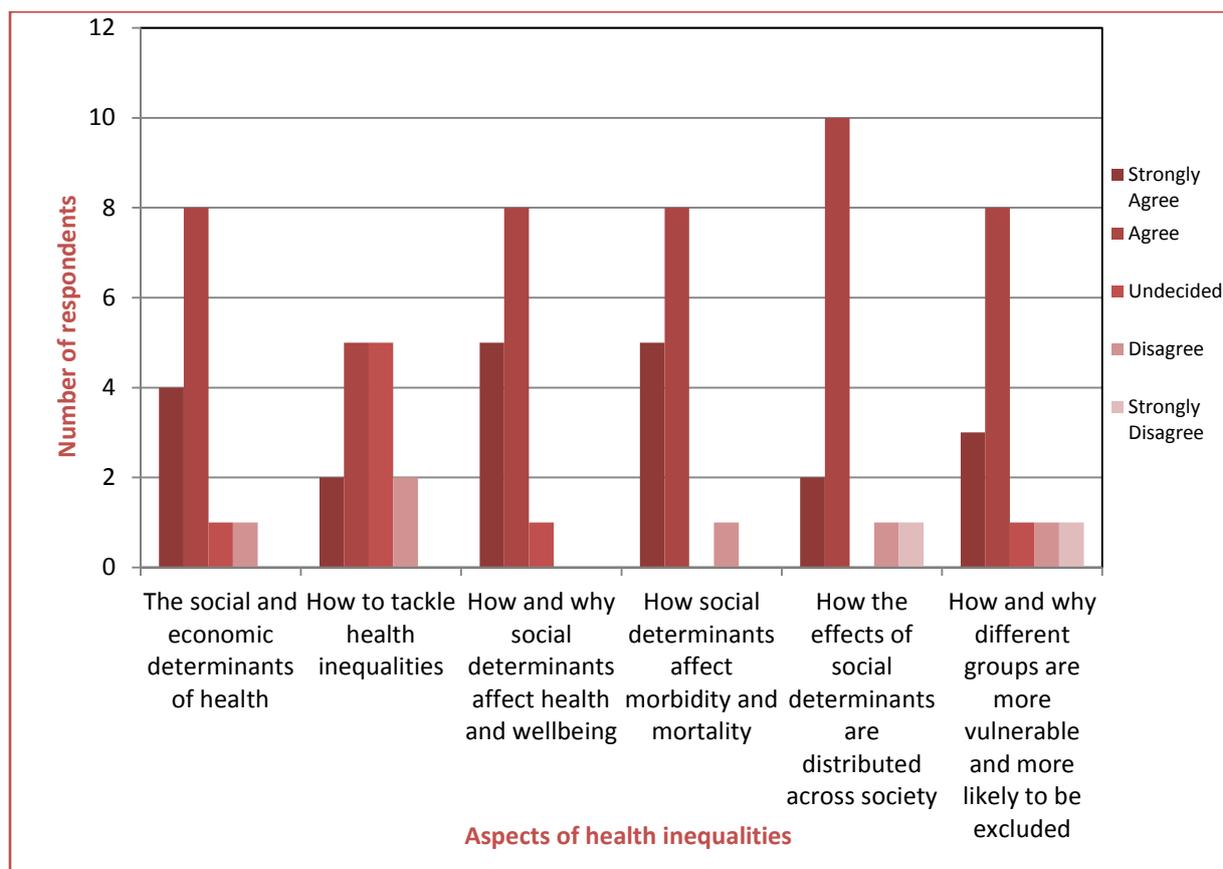
The respondents' views as to whether their schools assess the six aspects of health inequalities were less positive, as shown in figure 11 below, although the majority view was that they agreed they assessed them. However, five institutions were undecided as to whether they assessed how to tackle health inequalities and two stated they did not assess this topic.

11 of the 14 medical schools provided information about how they assess medical students' knowledge of health inequalities (appendix 18). Nine use the written examination as the method to assess. For four of these schools it is the only assessment method. Five schools use the written assignment but only two use the presentation. Two institutions reported using other assessment methods as well as the more traditional approaches and these were:

- Formative assessments related to public health workshops.
- Opportunistic GP and Mental Health placements assessed through a reflective diary.

Only five medical schools reported that they offer undergraduate medical education and training modules which have entire learning outcomes focussed on health inequalities two of which offer them as options. Only one medical school addressed these learning outcomes through all years and all undergraduate medical programmes.

Figure 11 Respondents’ opinion as to whether their organisation assesses undergraduate medical students about the six aspects of health inequalities



Examples as to how the responding medical schools ensure there are learning outcomes focussed on health inequalities are shown in box 15 below:

Box 15 Examples of approaches medical schools take to ensuring learning outcomes are focussed on health inequalities

- Health inequality learning outcomes are identifiable in epidemiology and public health, ethics, health economics, law, professionalism, psychology and sociology themes.
- Patients, Doctors and Society course years 1 and 2.
- Public Health Course year 4.
- Students can self-select to learn about health inequalities through the Selected Components of the course.
- Year 2 Community Module on Access to Healthcare.

Health risks to vulnerable groups and their healthcare needs

Three of the 14 medical schools reported that they teach health risks to the five vulnerable groups and their healthcare needs. However, another three reported that they do not teach either topic. The remaining respondents reported they are influenced by the local population and consequently cover these topics for some groups and not for others. Medical schools based in large homeless communities have the opportunity to use local examples as case studies in their teaching.

Nine medical schools stated they teach their undergraduate medical students about the specific health risks to homeless people and their healthcare needs. Many of the responding organisations have chosen to address this topic during year four.

“Year four students from one medical school examine the experiences of homeless people, for example the impact on their health through social isolation, lack of money, exposure to weather and to violence and life expectancy. This topic is addressed in a fourth year module called Patients, Doctors and Society.” Teaching Fellow

Other medical schools have left this topic to student selected components to enable students with a particular interest in this field to study the topic in more depth (box 16). Only one medical school made reference to students having clinical placements in a health centre for the homeless. Another medical school takes a very different approach and integrates these health risks across all modules to ‘allow students to build an understanding that issues of accommodation occur within many clinical circumstances’ (Senior Lecturer).

Box 16 Example of a student selected component

‘We have a student selected component in ‘general practice in special circumstances’, this includes working with the homeless health service that run a clinic with our local charity working with street sex workers. This is for third year students. The homeless health service doctors teach on this to all second year students, but there is room for improvement here.’

Seven medical schools stated they teach their undergraduate medical students about the specific health risks to Gypsies and Travellers, and six about healthcare needs of this vulnerable group. The comments as to how they address this topic are the same as for people who are homeless.

Four medical schools stated they teach their undergraduate medical students about the specific health risks to Roma and their healthcare needs. One medical school recognises that although there is some opportunity for medical students to learn about Roma there is ‘room for improvement’.

Eight medical schools stated they teach their undergraduate medical students about the specific health risks to sex workers and seven about their healthcare needs. The comments made by the respondents suggest that this subject has greater coverage in the curriculum as it is considered during genitourinary medicine sessions as well as in the public health sessions.

Nine medical schools stated they teach their undergraduate medical students about the specific health risks to vulnerable migrants and eight about their healthcare needs. Some of the responding organisations have fully addressed this topic and offer the medical students a comprehensive spread of learning opportunities.

One medical school provided the following detailed information which sets out their approach, particularly during year three, to health risks to vulnerable migrants.

“In the third year, we have a central teaching day on migrant health. This includes workshops on access to healthcare, housing issues, the asylum system, mental health in migrant communities, and HIV and TB (looking more at the social perspective of these diseases than the biomedical). This covers the issues of destitute asylum seekers and trafficking, and also the issues which Eastern European migrants face. This teaching also includes workshops on working with asylum seekers. These workshops are run by asylum seekers who have been trained as community interpreters, who each bring a friend with limited English, so that the students get an opportunity to practice the skills needed, and also have conversations with the asylum seekers, as this teaching is in second year where their consultation skills are limited.”

GP and Disability, Disadvantage and Diversity (3D) theme lead

In addition third year medical students have the opportunity to spend time in the local primary care services for asylum seekers. Such developments require champions. Some respondents reported that they cover topics such as: barriers to accessing care that asylum seekers and refugees face; problems using interpreters in consultations; working with interpreters; asylum seekers and victims of torture.

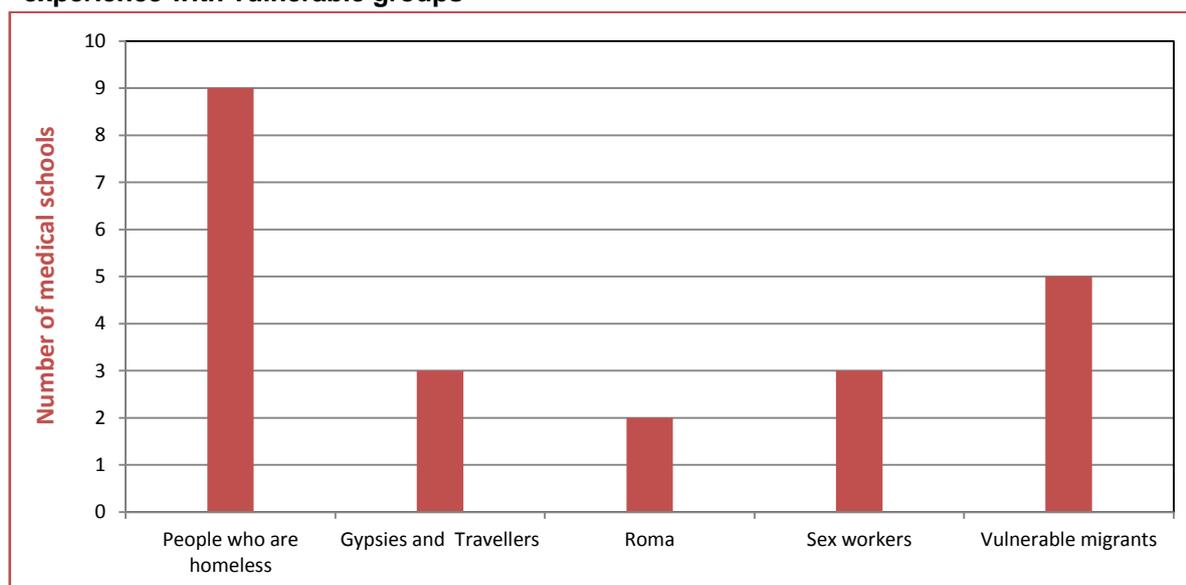
Other medical schools take a less formal approach and recognise that this important topic may be left to chance. As one programme director explained ‘*it is likely to be addressed opportunistically at any point when students encounter migrants*’.

When asked as to whether they assess undergraduate medical students about the specific health risks to vulnerable groups four of the responding medical schools reported that they do. Four assess the health risks to vulnerable migrants; three assess health risks to people who are homeless and only two medical schools reported that they assess the specific health risks of Gypsies and Travellers, Roma and sex workers. With regards to assessing medical students about the healthcare needs of vulnerable groups only two medical schools reported that they do. One of these reported assessing the healthcare needs of all five groups and the other the healthcare needs of vulnerable migrants.

Practice placement experience with vulnerable groups

Nine of the responding medical schools provide opportunities for medical students to gain practice experience with vulnerable adults (figure 12). They all reported that medical students gain practice experience with people who are homeless and only two reported that they gain clinical experience with the Roma community.

Figure 12 Number of responding medical schools that organise practice placement experience with vulnerable groups



4.3.2.3 Inclusion Health in taught postgraduate medical courses

Six medical schools reported that some of their taught postgraduate medical courses/modules have learning outcomes that relate specifically to health inequalities. Examples of such courses (box 17) that are either delivered face to face or self-directed study include:

- Masters courses in Global Health
- Masters courses in Public Health
- Introductory courses to generic masters programmes.

Only three medical schools reported that their postgraduate medical courses/modules address the specific health risks to vulnerable groups. One of these medical schools reported covering the risks to all the vulnerable groups, one the risks to Roma and one the risks to people who are homeless.

Two responding medical schools reported that their postgraduate courses address the healthcare needs of vulnerable groups. Of these one stated that it includes the healthcare needs of people who are homeless and the other the healthcare needs of vulnerable migrants.

Box 17 Example of how one medical school addresses health inequalities in the postgraduate courses

Global Health MSc:

'Social determinants are taught as a theme throughout 1st semester modules in Global Health Principles and Global Disease Burden. Social determinants are assessed as a specific essay question during Global Health Principles module assessment. There is one session on poverty, wealth and health, one session on inequalities and health, and one session on migration and health.'

Public Health MSc: Meeting Challenges of Public Health in Practice

'On successful completion of this module students should be able to: Understand the significance of health inequalities and critically appraise the impact of health policies on inequalities in health.'

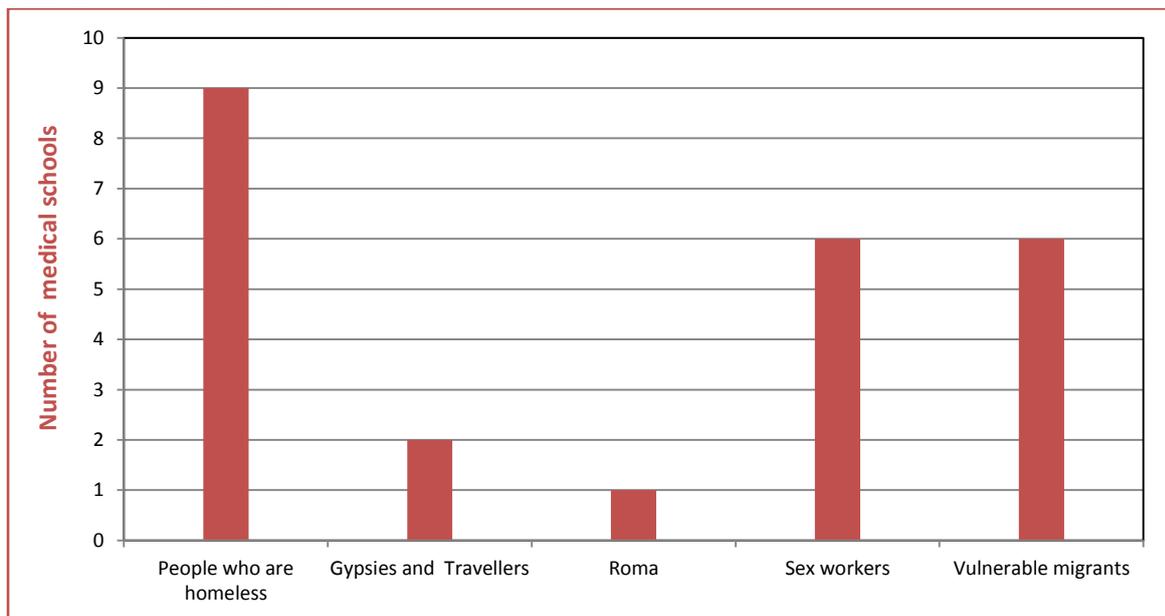
4.3.2.4 Vulnerable groups' enhancement of the curricula

Medical schools report that they take the opportunity to engage local vulnerable communities in teaching the medical students about healthcare needs of these groups. Eleven of the responding medical schools advised that they work with organisations with expertise in supporting vulnerable groups with the aim of enhancing the curricula.

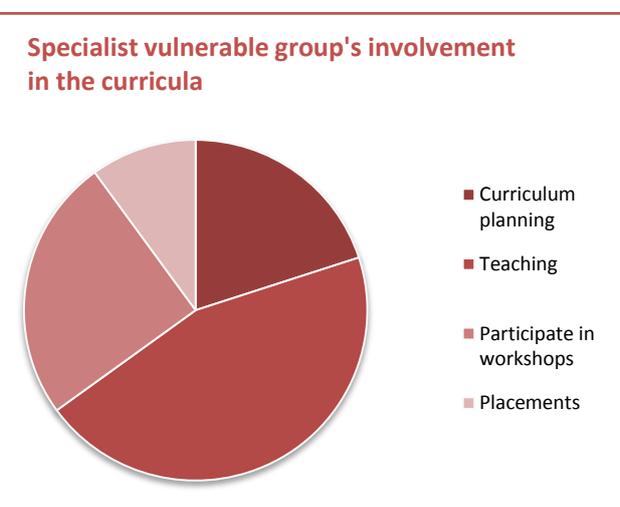
'Asylum seekers should be used in the teaching, rather than just as patients.'

Programme Director

Figure 13 Number of responding medical schools that work with specialist organisations to enhance the curricula



The expertise of these partner organisations is set out in figure 13. Nine of these medical schools work with organisations with expertise in people who are homeless but only one works with organisations with expertise in the Roma community.



These partner organisations work with the medical schools in a number of different ways. Nine of them invite these organisations to send representatives to teach on the course. However, none of them engage these organisations in recruitment and selection (see adjacent pie chart).

In return medical students help the local charities to support local vulnerable adults. Examples of how medical students support these include audits, helping with English language courses, homework clubs and health advocacy for asylum seekers.

Only one medical school employs service users from vulnerable adult groups to enhance the curriculum. Three medical schools reported that they ask service users from vulnerable migrant groups; homeless communities or sex worker groups. They invite them to advise on curriculum planning; to teach on the course and participate in workshops. Examples as to how the medical schools ask service users to enhance the curricula are illustrated below.

“We cannot formally employ asylum seekers who do not yet have their papers but involve them on a freelance basis and can give a cash gift and expenses. We have some refugees who have been through the process, and the experience of being a vulnerable migrant.

We have input into direct teaching from a former sex worker and drug user who experienced abuse and homelessness.” GP and Disability, Disadvantage and Diversity (3D) theme lead

Three medical schools employ carers from the vulnerable groups to enhance the curricula either through teaching, curriculum planning or participating in workshops.

4.3.2.5 Academic expertise in Inclusion Health

Eight of the responding medical schools reported a range of expertise in aspects of Inclusion Health. They all employ academic staff with expertise in people who are homeless; all except one employ academic staff with expertise in sex workers; five employ staff with expertise in vulnerable migrants, three employ staff who have expertise in the Gypsy and Traveller community but only one medical school employs an academic member of staff with expertise in the Roma community. All these academic staff are involved in curriculum planning and teaching the students. Two thirds also assess students and are involved in research.

4.3.3 Dental schools

Nine out of a possible 18 dental schools completed the dental schools survey (Survey C, section 3.3).

The responses are reported under the following sections:

- 4.3.3.1 Overview of dental education
- 4.3.3.2 Inclusion Health in the undergraduate dental curricula
- 4.3.3.3 Dental foundation courses
- 4.3.3.4 Inclusion Health in taught postgraduate dental courses
- 4.3.3.5 Vulnerable groups' enhancement of the curricula
- 4.3.3.6 Academic expertise in Inclusion Health

4.3.3.1 Overview of dental education

Of the nine responding institutions, six offer undergraduate (BSc Dental Surgery) courses, three of these also run a dental foundation course. Seven of these dental schools provide taught post-graduate dental courses and the remaining two are specialist post-graduate dental institutions. Other courses they highlighted include:

- BSc in Dental Therapy
- Diploma in Dental Hygiene and Dental Therapy
- Professional Doctorates in Orthodontics and Endodontics

4.3.3.2 Inclusion Health in undergraduate dental curricula

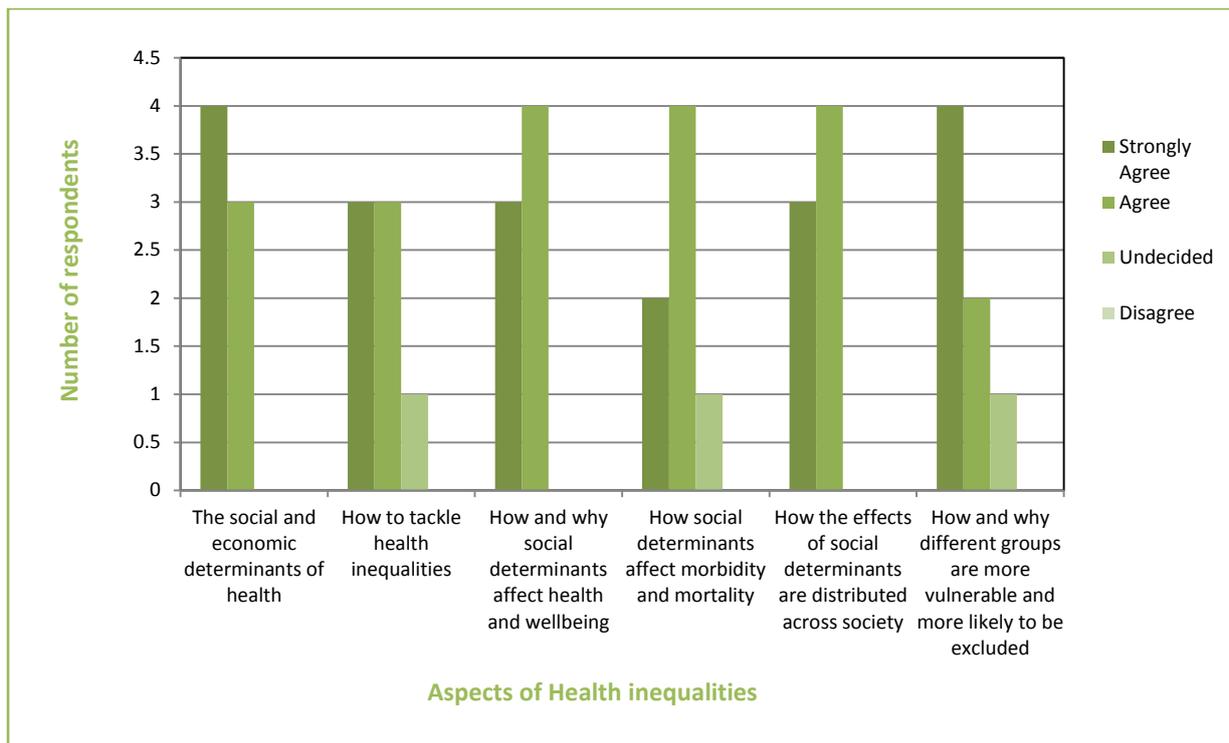
The respondents were asked to provide information about whether their institution teaches and assesses dental students about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

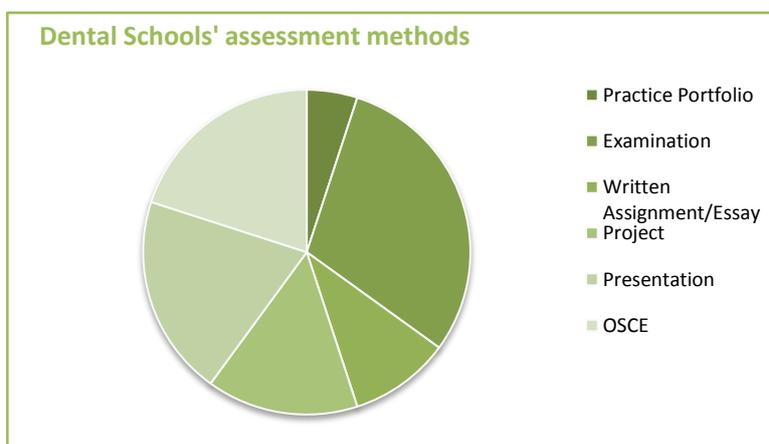
Health inequalities

Three of the seven institutions that provide undergraduate dental education and training reported that they teach all six aspects of health inequalities on their undergraduate dental courses (figure 14). They all strongly agree or agree that they teach the social and economic determinants of health, how and why social determinants affect health, and how the effects of social determinants are distributed across society. Three of the respondents were undecided as to whether they teach how to tackle health inequalities, how social determinants affect morbidity and mortality, and how and why different groups are more vulnerable and more likely to be excluded.

Figure 14 Respondents' opinion as to whether their organisation teaches undergraduate dental students about the six aspects of health inequalities

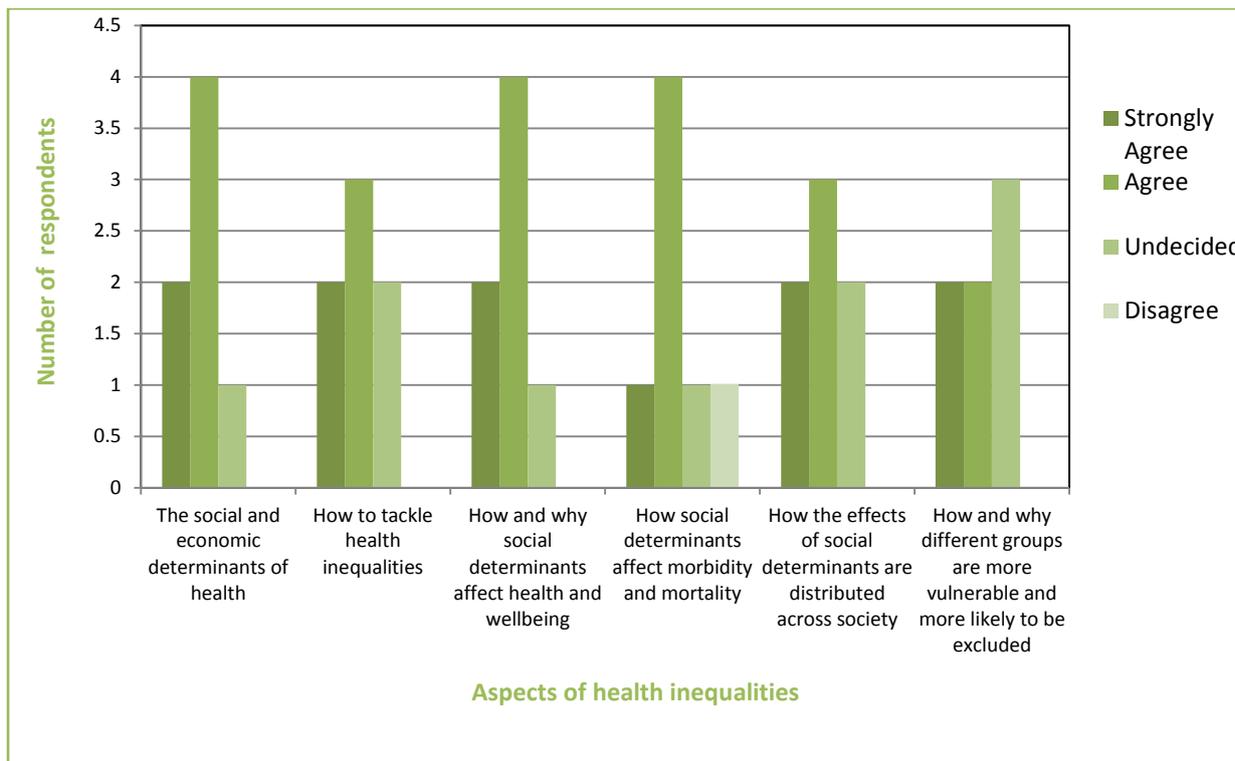


The respondents were more undecided about whether their institution assesses the six aspects of health inequalities (figure 15), particularly whether they assessed, how and why different groups are more vulnerable and more likely to be excluded. Dental Schools preferred method to assess health inequalities is the time constrained examination (see adjacent pie chart).



Only two institutions reported that their undergraduate dental education and training modules have entire learning outcomes focussed on health inequalities. One Professor noted that they ‘*exceed the requirements of the dental education outcomes for social determinants of health and inequalities as set out by the General Dental Council*’. Other dental schools reported that this topic is threaded throughout the curriculum.

Figure 15 Respondents’ opinion as to whether their organisation assesses undergraduate dental students about the six aspects of health inequalities



Health risks to vulnerable groups and their healthcare needs

Health risks to vulnerable groups and their healthcare needs are embedded throughout the dental school’s curricula in the community based modules that are delivered by the community engagement team, for example, a dental public health module or a special care dentistry module.

Four dental schools stated that they teach the undergraduate dental students about the specific health risks to people who are homeless and their healthcare needs as illustrated in box 18. A fifth dental school noted that their focus is oral health and as far as they are aware there are no specific risks to people who are homeless and that this group experience similar risks to other disadvantaged and vulnerable people.

“We focus on oral health. So far as we know there are no specific oral health needs of people in secure accommodation. They experience similarly increased needs and disadvantages of access to care as other disadvantaged and vulnerable people. Most of our students would provide treatment for people in insecure accommodation, for travellers, Roma and sex workers at some stage during their programme with us. We would expect (and assess) students to apply their knowledge of the health needs of disadvantaged people to specific patient groups they treat.”
 Professor and Lecturer

Opportunities to learn about health risks to people who are homeless occur when dental students gain clinical experience in community dental services.

Box 18 Example of how a dental school teaches their undergraduate students about healthcare needs of vulnerable groups

Critical appraisal project focused on special care needs of vulnerable people; these include those who use illicit substances and alcohol as well as those who are homeless. The dental health requirements of this group are considered as part of this project.

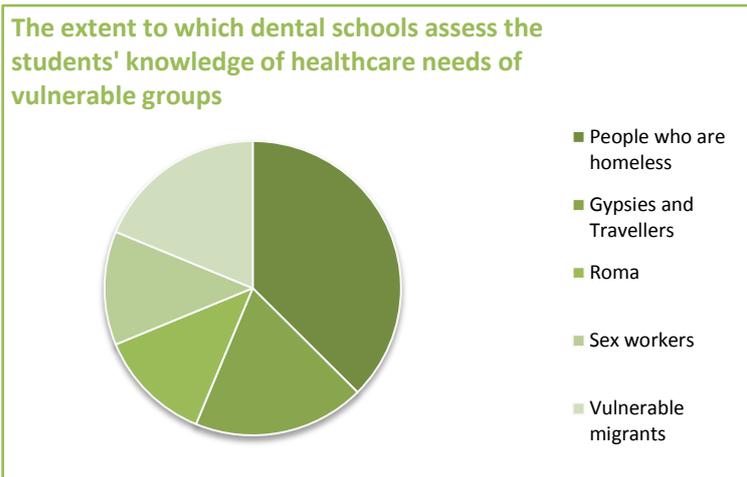
Four dental schools reported that they teach their undergraduate students about specific health risks to Gypsies and Travellers supported by dental service clinical placements. Whereas, three schools reported teaching the healthcare needs of Gypsies and Travellers. Examples of where in the curricula this topic is covered include: Dental Public Health Paediatric Dentistry (child protection) module and in the BSc Oral Health Sciences (Therapists).

Only two of the eight dental schools which completed the survey stated that they teach undergraduate dental students about specific health risks to Roma and their healthcare needs. These institutions reported that these topics are covered in the same part of the curriculum as health risks to people who are homeless and their healthcare needs.

Four dental schools advised that they teach undergraduate dental students about the health risks to sex workers and that this topic is covered under subjects such as the oral manifestations of sexually transmitted diseases as part of the oral medicine course. It is also covered as part of the substance misuse workshop. Three of these dental schools reported they also teach the healthcare needs of sex workers in these sessions.

Three out of the seven dental schools reported that they teach their undergraduate students about specific health risks to vulnerable migrants and their healthcare needs either by organising clinical placements in community dental services or teaching as part of the Dental Public Health programme or the Oral Sciences course.

Four dental schools advised that they assess their undergraduate students about the specific health risks to vulnerable groups. All four schools assess the students about health risks to people who are homeless; two that they assess health risks to Gypsies and Travellers, sex workers and vulnerable migrants, and only one the health risks to the Roma community (see adjacent pie chart).



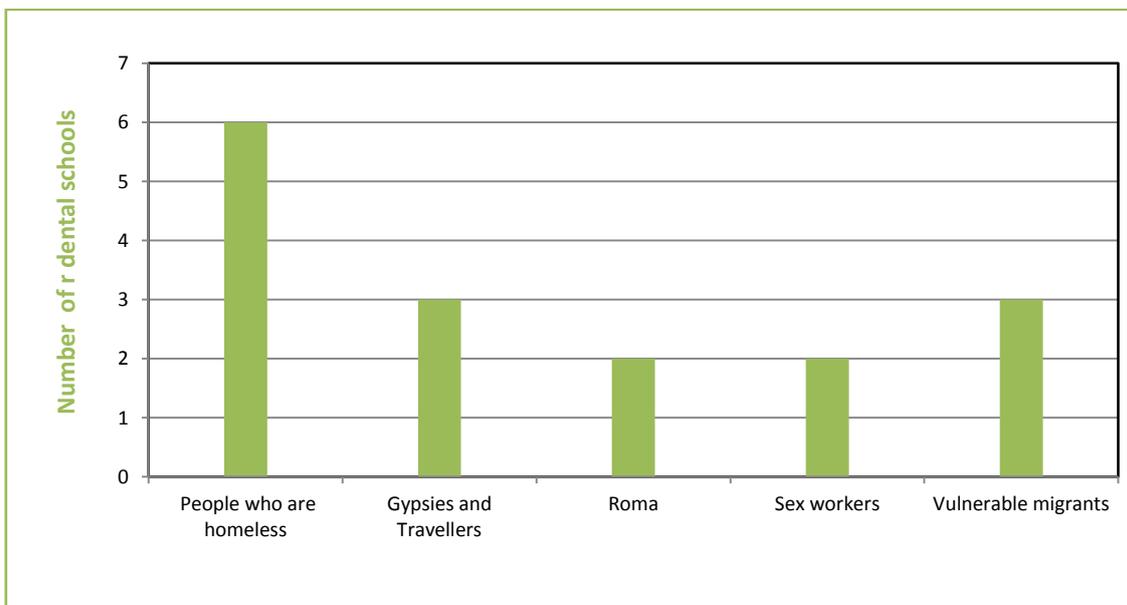
Interestingly, although very few of the responding dental schools teach the specific healthcare needs of the vulnerable groups, six schools reported that they assess the dental students' understanding of

the healthcare needs of people who are homeless; three the healthcare needs of Gypsies and Travellers, and vulnerable migrants, and two the healthcare needs of Roma and sex workers.

Six dental schools reported that their students have the opportunity to experience practice placements with vulnerable adults. All reported that dental students have an opportunity to experience practice placements which include people who are homeless. However, the extent to which dental students gain practice experience with the other vulnerable groups varies as shown in figure 16.

“Students undertake placements in primary care outreach (20 weeks) including community clinics (salaried dental services). During this period they undertake a project exploring the health needs and delivery of care to the local community. Students also undertake an elective period (4 weeks) and over 60% travel abroad. They experience other cultures and healthcare environments. This is assessed as a submitted project assignment”. Dean

Figure 16 Number of responding dental schools that organise practice placement experience with vulnerable groups



4.3.3.3 Dental foundation courses

A dental foundation training course is the first phase of continuing postgraduate education after graduation and is recognised as part of the career pathway in all sections of the dental profession. Of the three responding dental schools that provide dental foundation training programmes none of them have specific health inequalities learning outcomes.

In response to the question about the opportunity for dentists on a dental foundation programme to experience practice placements with vulnerable groups both responding dental schools stated that dentists have a chance to work with people who are homeless and also with vulnerable migrants. One school offers the opportunity for the dentists to gain practice placement experience with Gypsies and Travellers, and Roma. Neither dental school provide practice experience for dentists to work with sex workers.

4.3.3.4 Inclusion Health in taught postgraduate dental courses

Two of the responding institutions only provide postgraduate dental education and training. Four out of the nine responding dental schools advised that some of their taught postgraduate dental courses/modules have learning outcomes that relate specifically to health inequalities. For example: the MSc Health Promotion and the MSc Special Care Dentistry. One Professor of Dental Public Health commented that *‘the dental modules on our Masters in Public Health (dental modules) course will cover health inequalities in depth.’*

These courses are taught primarily through lectures, seminars and discussion groups. They are assessed by formal examinations, essays and in one school by using wikis assessments via wikis. Workplace assessments are also used.

“Each of the modules of the MSc programme has elements that discuss/detail health inequality. The best examples of these are those associated with Paediatric Dentistry, Oral Medicine, Oral and Maxillofacial Surgery.” Institute Director

Only four of the responding dental schools offer taught postgraduate courses/modules that address the specific health risks to vulnerable groups. Three reported that they run taught modules that address the specific health risks to people who are homeless; two the health risks to vulnerable migrants and one the health risks to Gypsies and Travellers, and Roma.

Similarly four of the responding dental schools offer taught postgraduate courses/modules that address the specific healthcare needs of vulnerable groups. All four reported that there are taught postgraduate courses/modules that address the healthcare needs of people who are homeless. The healthcare needs of the other vulnerable groups are not considered.

4.3.3.5 Vulnerable groups’ enhancement of the curricula

Four dental schools reported that they work with organisations with expertise in vulnerable groups to enhance the curricula. All of these four dental schools reported they work with organisations that have expertise in supporting people who are homeless; two work with organisations that have expertise in supporting Gypsies and Travellers, and vulnerable migrants and only one reported working with an organisation that has expertise in supporting Roma and sex workers. The respondents identified the following as some of the organisations they work with:

- Public Health Wales
- Big Issue Homeless organisations
- Local charities
- Special Care Dentistry service within the Public Dental Service for NHS Lothian

“We work with over 40 local organisations around these groups. We have a Community Engagement Team - whose role is to bridge this gap.” Head of School

Three dental schools commented that representatives from organisations that support vulnerable groups teach on the courses and two schools that they help with curriculum planning. Other ways these organisations work with the dental schools include participating in workshops and engaging in research.

None of the responding dental schools employ service users from any of the vulnerable groups to enhance the curricula. However, two of the responding dental schools employ carers from vulnerable groups to enhance the curricula. One of the dental schools employs carers from all four vulnerable groups the other from those who care for people who are homeless. Carers support this dental school by advising on the curriculum; helping with recruitment and selection; teaching the students and taking part in workshops. The carers have honorary contracts as lecturers within the school and also work with the Community Engagement Team.

4.3.3.6 Academic expertise in Inclusion Health

Four of the responding dental schools stated they employ academics with expertise in people who are homeless. All of these dental schools use these academics to give advice on the curriculum design; to teach the students and to assess them. Three of these schools engage the academic staff with expertise in people who are homeless to support the research activity.

None of the responding dental schools reported employing staff with expert knowledge about any of the other vulnerable groups.

One respondent advised that two of their dental public health academic members of staff are involved with NHS Education Scotland in developing an online package in Health Inequalities. The resultant online programme will be used with undergraduate and postgraduate students and available for use by dental team members.

4.3.4 Schools of pharmacy

12 out of a possible 27 schools of pharmacy completed the schools of pharmacy survey (Survey D, section 3.3)

The results from this survey are reported under the following sections:

- 4.3.4.1 Overview of pharmacy education
- 4.3.4.2 Inclusion Health in the undergraduate pharmacy curricula
- 4.3.4.3 Practice placement experience
- 4.3.4.4 Inclusion Health in the taught postgraduate pharmacy courses
- 4.3.4.5 Vulnerable groups' enhancement of the curricula
- 4.3.4.6 Academic expertise in Inclusion Health

4.3.4.1 Overview of pharmacy education

All responding schools of pharmacy reported that they offer the Master of Pharmacy (MPharm) course. This is the only degree that is acceptable as the first step towards a career as a pharmacist. One school also offers a Foundation Degree in Pharmaceutical and Chemical Sciences. Successful completion of the foundation degree permits direct entry into the 2nd year MPharm.

Ten of the 12 schools provide taught postgraduate courses for pharmacists. However, very few offer programmes with a focus on Inclusion Health. Examples of postgraduate pharmacy courses with a focus on Inclusion Health include:

- Overseas Pharmacists Assessment Programme (OSPAP)
- Clinical Pharmacy
- Diploma in Clinical and Health Services Pharmacy
- Advancing Pharmacy Practice
- General Public Health programmes open to pharmacists
- Mental Health

4.3.4.2 Undergraduate pharmacy curricula

The respondents were asked to provide information about whether their institution teaches and assesses pharmacy students about two key aspects of Inclusion Health:

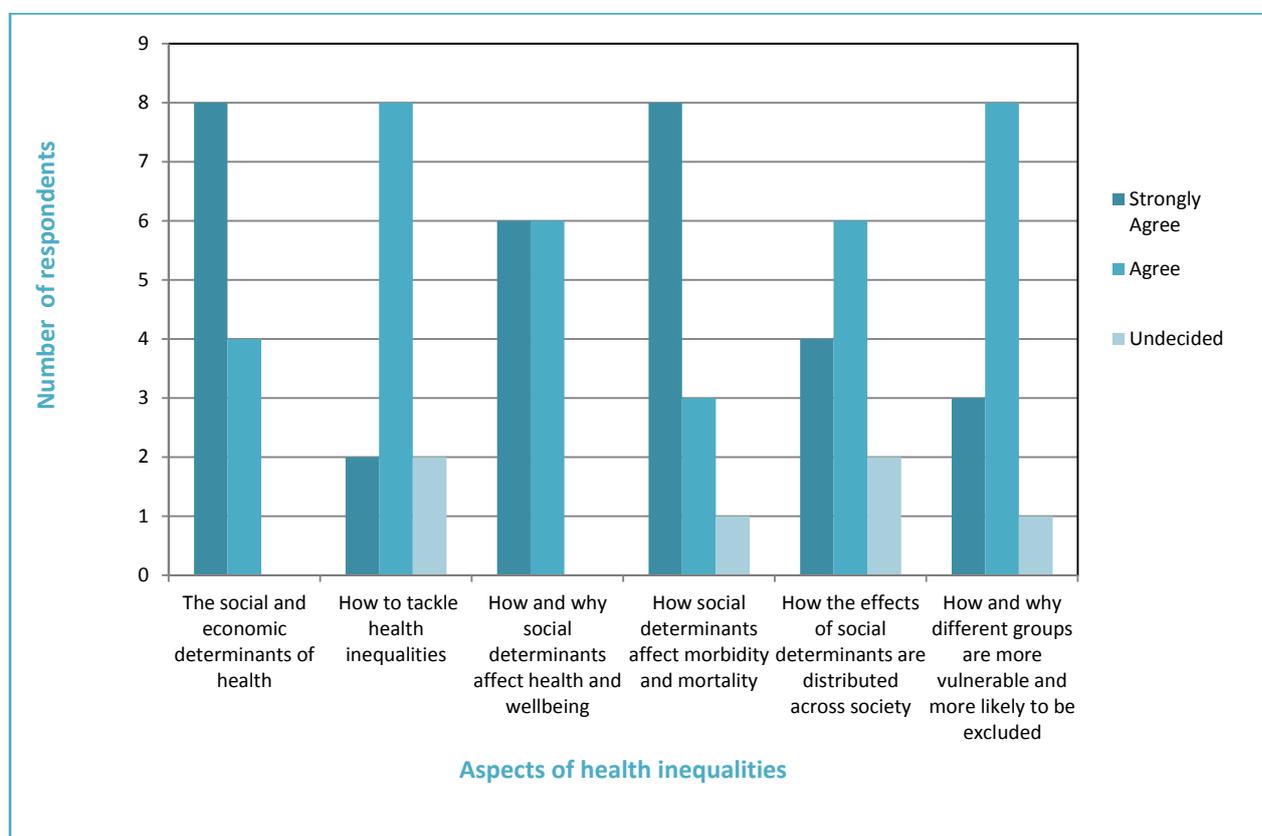
- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

Health inequalities

All 12 schools of pharmacy rated how well their organisation teaches and assesses the six aspects of health inequalities. The pattern of response as to how well their organisation teaches the various aspects of health inequalities differed by the health inequality under consideration (figure 17). The respondents either strongly agree (8) or agree (4) that they teach social and economic determinants of health. There was a similar response, although one respondent was undecided, about how social determinants affect morbidity and mortality. The majority (8) agreed that they teach how to tackle health inequalities but were evenly split as to whether they teach how and why social determinants affect health and wellbeing, six strongly agreed and six agreed. More of the respondents agreed

than strongly agreed that their school teaches how the effects of social determinants are distributed across society and why different groups are more vulnerable and likely to be excluded.

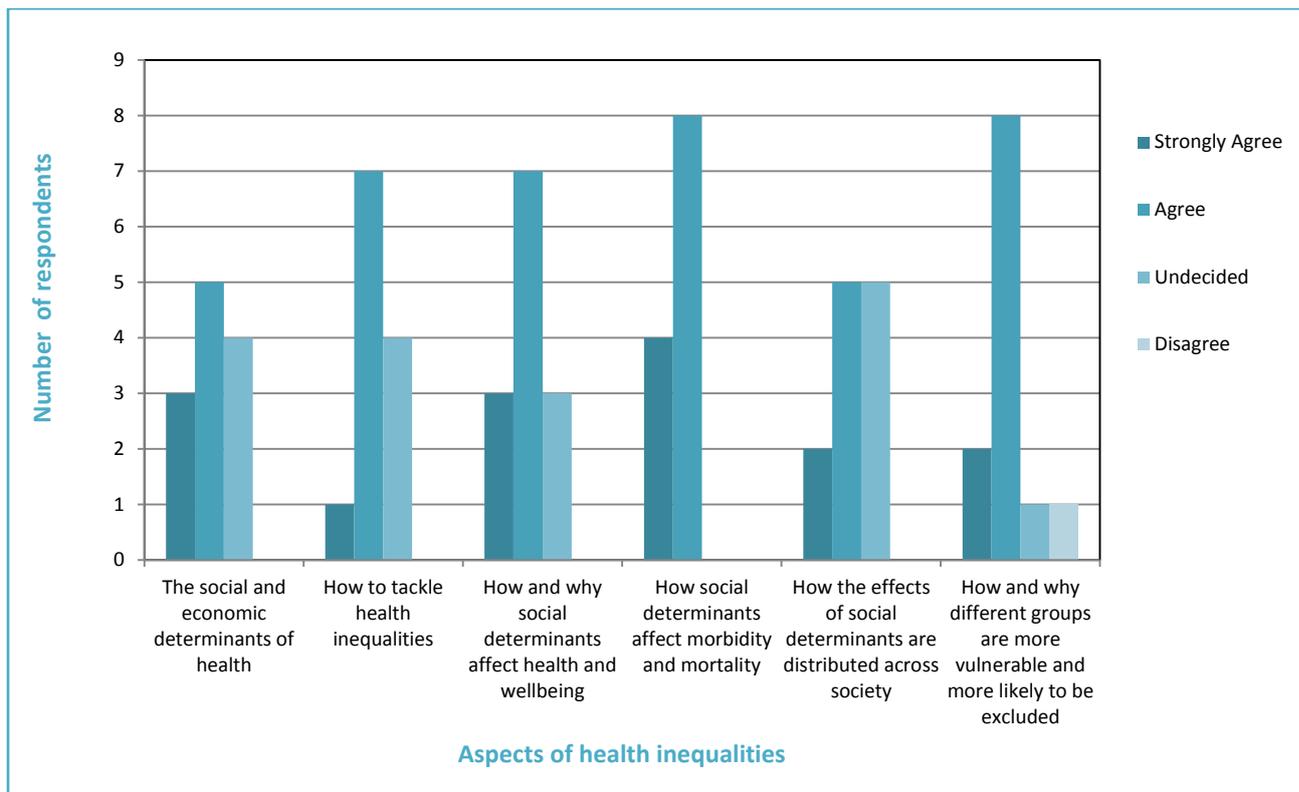
Figure 17 Respondents’ opinion as to whether their organisation teaches pharmacy students about six aspects of health inequalities



The respondents’ views as to whether their school assesses specific aspects of health inequalities were less positive (figure18), although the majority view was that they assess them. However many of the respondents were undecided particularly with regards to whether they assess: how the effects of social determinants are distributed across society, the social and economic determinants of health and how to tackle health inequalities. Eight of the respondents provided details as how they assess health inequalities (appendix 19). The most popular assessment method is the written assignment/essay and the examination.

None of the schools of pharmacy reported that they offer undergraduate pharmacy education and training modules with entire learning outcomes focussed on health inequalities.

Figure 18 Respondents' opinion as to whether their organisation assesses pharmacy students about six aspects of health inequalities



Health risks to vulnerable groups and their healthcare needs

Three of the responding schools teach their undergraduate pharmacy students about the specific health risks to people who are homeless. Five schools of pharmacy stated that they teach undergraduate pharmacy students about the healthcare needs of people who are homeless. Examples of how this topic is covered in the undergraduate pharmacy courses include:

- The public health stream
- Generic aspects of health inequalities
- Infectious diseases
- Social and behavioural pharmacy.

‘Healthcare needs of the homeless are used as an example in teaching about social inequalities’.
Lecturer

A detailed example as to how a school of pharmacy prepares their undergraduate students is shown below.

“This is addressed in The Public Health unit. The difficulty that homeless people who inject drugs intravenously have achieving 'clean' conditions is covered. Students also develop problem solving skills in clinical units by working on case studies which could include homeless people.”
Reader

None of the pharmacy schools reported including health risks to Gypsies and Travellers, and Roma or their healthcare needs in the undergraduate pharmacy curriculum.

Five responding schools of pharmacy reported that they teach their undergraduate pharmacy students about the specific health risks to sex workers. Examples of aspects of undergraduate pharmacy courses that include health risks to sex workers include:

- Sexual health module
- International Public Health
- Public Health module when considering emergency hormonal contraception
- A theme of sexually transmitted disease during symposia day.

Four schools of pharmacy advised that they teach undergraduate pharmacy students about the healthcare needs of sex workers and that this topic is covered in the following ways:

- on modules about sexual health specifically about sexually transmitted diseases
- on modules about public health
- on modules about infectious diseases
- on modules about social and behavioural pharmacy
- alongside emergency hormonal contraception
- as part of risks of IV drug abuse.

Three responding pharmacy schools teach undergraduate pharmacy students about the specific health risks to vulnerable migrants and their healthcare needs. These topics are covered in the Public Health modules, a module on Social and Behavioural Pharmacy, case studies including vulnerable migrants, a lecture on patients suffering from tuberculosis and the risks to vulnerable people.

Five out of the twelve schools of pharmacy reported that they assess undergraduate pharmacy students about the specific health risks to vulnerable groups. Three schools assess the students about health risks to sex workers; two assess the students about health risks to the homeless and vulnerable migrants. Only one respondent stated that their organisation assesses the students about all of these three groups.

Similarly four schools of pharmacy reported that they assess undergraduate pharmacy students about the specific healthcare needs of vulnerable groups. One reported assessing students about healthcare needs of sex workers and vulnerable migrants, the other three reported assessing students about the healthcare needs of people who are homeless, sex workers or vulnerable migrants. No school of pharmacy reported assessing students about the healthcare needs of the Roma community.

4.3.4.3 Practice placement experience

Only two of the responding schools of pharmacy reported that their pre-registration students have the opportunity to experience practice placements which include any of the five vulnerable groups. Both schools enable students to spend time with vulnerable migrants and one with people who are homeless, Gypsies and Travellers, and sex workers. None of the schools of pharmacy reported that their students have access to practice experience with the Roma community.

4.3.4.4 Inclusion Health in taught postgraduate pharmacy courses

Three of the responding schools of pharmacy run taught postgraduate pharmacy courses with learning outcomes that relate specifically to health inequalities. Examples include: OSPAP and Promoting Health through Community Pharmacy; Mental Health; Public Health Pharmacy. These courses address health inequalities through written study guides; face to face lectures or workshops, and online taught sessions. One respondent outlined the approach taken by a school of pharmacy (box 19).

Box 19 Example as to how a school of pharmacy supports postgraduate students to learn about health inequalities

'Within the Promoting Health through Community Pharmacy module we refer to the 1980 Black report identifying health inequalities in 1980 and then the Acheson report 20 years later. The Marmot review is then referred to and a link to the full report given. The public health outcomes framework is also discussed and a link to the full framework given. Specific reading on health inequalities is also given. We provide a link to the NICE local government briefing - Health inequalities and population health. This document defines health inequalities and how to tackle them. In the module we also have a 'think break'..... Think about the services that community pharmacy could provide that would have a positive impact on reducing health inequalities.' Co-director MPharm studies

Two schools of pharmacy reported that they address specific health risks to vulnerable groups and their healthcare needs in their postgraduate pharmacy modules. One of the responding schools of pharmacy addresses the specific health risks to people who are homeless; Gypsies and Travellers, and sex workers. It also addresses the healthcare needs of people who are homeless. The other school reported that it addresses both the health risks to sex workers and vulnerable migrants and their healthcare needs.

4.3.4.5 Vulnerable groups' enhancement of the curricula

Only one of the responding schools of pharmacy reported that they work with organisations with expertise in vulnerable groups to enhance the curricula. The expertise of the partner organisations is in mental health and substance abuse and they support the 'homeless people' component of the curriculum by writing sections of the study guides; teaching on the course; participating in workshops. None of the responding schools of pharmacy reported that they employ service users or carers from any of the vulnerable groups to enhance the curricula, although one school works closely with charities to access service users to participate in workshops.

4.3.4.6 Academic expertise in Inclusion Health

Only one school of pharmacy reported that it employs one academic with expertise in one of the five vulnerable groups. This academic has expertise in people who are homeless and teaches the pharmacy students about their health challenges.

4.4 Findings from the survey to the Queen's Nursing Institute Homeless Health Practitioner Network

4.4.1 Introduction

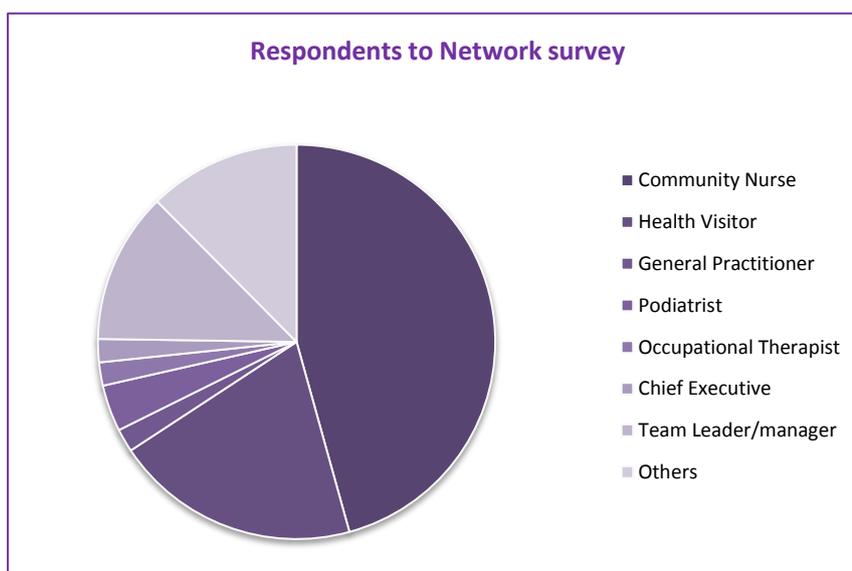
The Queen's Nursing Institute Homeless Health Practitioner Network (subsequently referred to as the Network) has over 730 professionals involved with homeless health³⁷. 98% of this network is comprised of specialist nurses, midwives and health visitors. This composition is reflected in the profile of respondents to the Queen's Nursing Institute Homeless Health Practitioner Network survey (Survey F, section 3.3) as illustrated in 4.4.2 and appendix 20.

The responses are reported under the following sections:

- 4.4.2 Profile of Network respondents and colleagues with whom they work
- 4.4.3 The support Network members offer to vulnerable groups
- 4.4.4 Difficulties of working with vulnerable groups
- 4.4.5 How the Network members develop their knowledge and skills to work with this vulnerable group of clients
- 4.4.6 Pre-registration education and training
- 4.4.7 Specialist Community Nursing education and training
- 4.4.8 Taught post-registration/post-qualifying education and training
- 4.4.9 Core knowledge and skills for healthcare professionals working with vulnerable groups
- 4.4.10 Knowledge and skills required to support vulnerable groups
- 4.4.11 How healthcare organisations care for vulnerable groups of people

4.4.2 Profile of Network respondents and colleagues they work with

106 individuals or 14.5% of the Network completed the questionnaire. Almost half of the respondents are community nurses and a fifth are health visitors. However, a quarter of the respondents did not identify their professional role or are employed in a non-clinical management post. For example: Hostel Manager or Co-ordinator for a Homeless Service in St John Ambulance.



The respondents were asked to explain their role in supporting vulnerable adults which includes single people and families in insecure accommodation and rough sleepers. All of the respondents provided this information and 12 (11%) of them made reference to assessment either clinical (physical health and or mental health) or more general healthcare. These assessments normally result in signposting the individual or families to support services, or refer them directly to a particular service.

13 (12%) reported that they provide a healthcare service and in addition, often refer to other support services. All of the services provided are primary healthcare. An example as to how complicated the networks are for some of the staff who work to support people who are homeless is shown below.

'I am the single point of contact for mental health assessments for homeless and people at risk of homelessness / eviction. I advise GP and refer to appropriate services and ensure that any health issues both physical and mental / psychological are pathways into appropriate service and that they are supported to attend appointments or treatment.'

Specialist practitioner in mental health for homeless

Example of a healthcare practitioner's role in supporting vulnerable adults

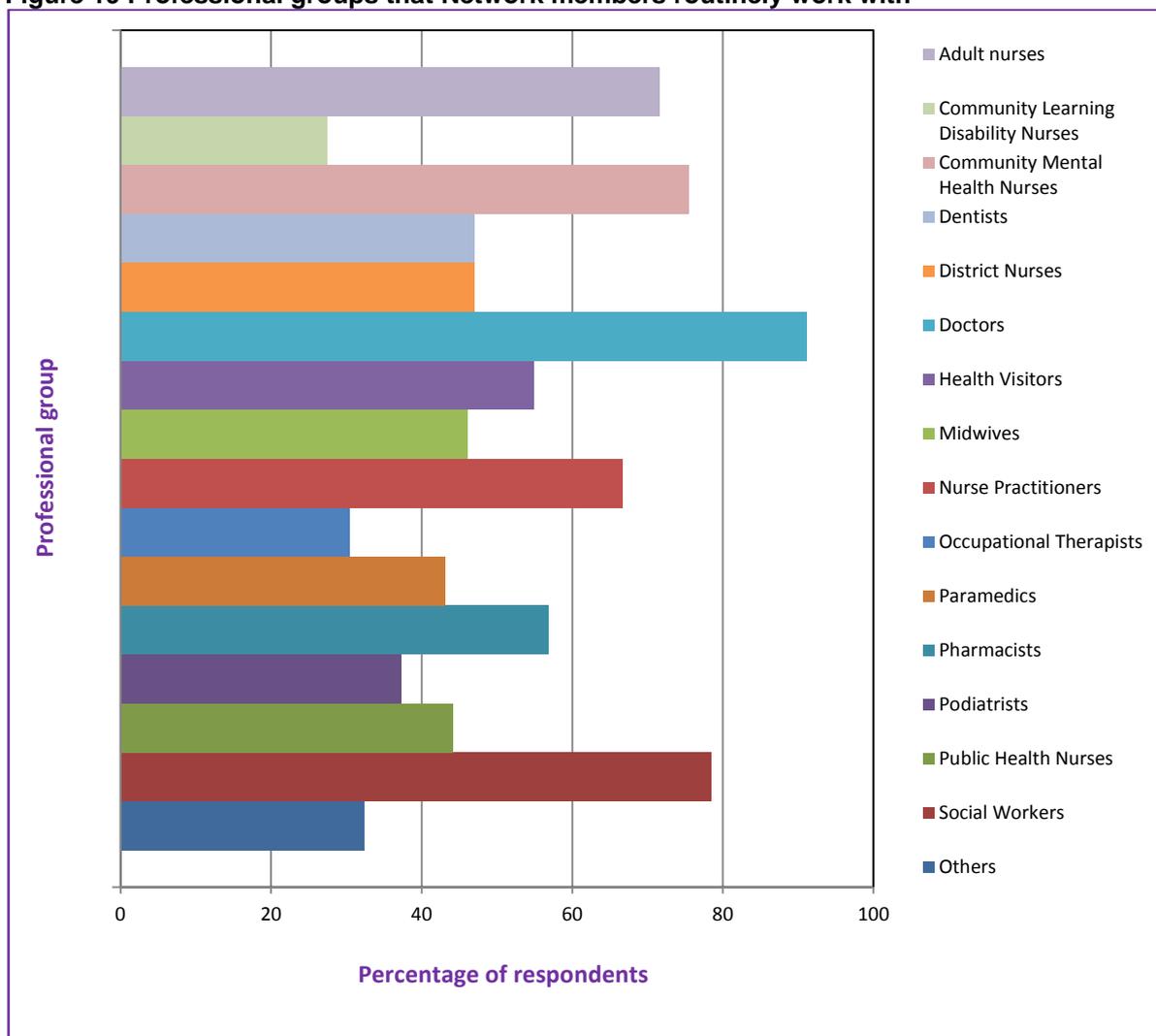
"Providing health care provisions, for this clientele group: health checks, registering with local GP, working closely with the GPs and surgery staff, CPNs, social workers, social inclusion teams, hospital specialists, pharmacists, drug and alcohol workers, hostel staff, churches for London group staff and leaders, age concern. I'm very much used as a communicator between services - link up person." Peripatetic Nurse Practitioner

The Network members work with a range of health and social care practitioners. The key groups are illustrated in figure 19. 91% of the 102 respondents work with doctors, 78% with social workers, 75% with community mental health nurses and 32% listed other professionals.

Of the 'others' group the most frequently noted are:

- Staff in housing/hostel organisations including housing support workers (28)
- Staff in drug and alcohol services (24)
- Police (15)
- Voluntary sector support workers (14)
- Mental Health teams including psychologists and psychiatrists (13).

Figure 19 Professional groups that Network members routinely work with



4.4.3 The support Network members offer to vulnerable groups

68 respondents to the survey explained, many in considerable detail, how they support vulnerable groups of people to improve their personal health. This rich qualitative data has been analysed and the following themes identified:

- Assessment and referral
- Access to healthcare services and other support agencies
- Specialist clinical services
- Specialist support services
- Support and advice
- Outreach
- Listening
- Advocacy
- Health promotion/health education
- Staff education

Assessment and referral

Assessment and referral is a key part of the work of many of the Network respondents. They carry out initial assessments, often in an assertive way, of the vulnerable adults' health status. If successful, they engage in ongoing assessment and monitoring of individual's health and any associated risks. If they work in a clinic they may be able to offer a full health assessment and appropriate testing: screen for blood borne viruses; monitor chronic conditions and carry out diagnostic tests. If the opportunity exists the healthcare practitioner will develop a care plan, implement it and monitor the effects of the planned care.



Mental health assessments are particularly challenging for the Network staff as approved mental health professionals (AMHPs) deem homeless to be a 'lifestyle choice' and not linked to untreated psychotic illness. Some reported providing an ad hoc mental health assessment service to the local housing department for rough sleepers and single adults in temporary accommodation.

Sometimes when the practitioners visit families they undertake an in-depth assessment of the children's health needs as well as those that care for them. They need to work with the family to agree areas of focus, develop a plan which is reviewed, and reassess if necessary.

It is very important that these professionals have a good working knowledge of when and to whom to refer the vulnerable, for treatment and support, following an assessment. They may refer to primary care, secondary care or directly to emergency services. Sometimes they will refer to a local GP and help the individual or family to become registered. They may also refer for mental health assessments or to substance use support service. Those that work with asylum seekers and refugees may also need to refer them to a specific local borough where there is expertise to help them.

Network clinical professionals may receive a referral from outside of their employing organisation. For example families are sometimes referred from a housing association, when housing has become an issue for the vulnerable group, and the Network staff are expected to deal with the problem.

Access to healthcare services and other support agencies

The respondents are often asked or required to help vulnerable adults to access healthcare services, third sector organisations and other support services simply to enable them to meet their basic needs. Consequently these practitioners are expected to know such facts as service availability; opening

hours and appointment systems. Once initial access has been facilitated the clinicians help the vulnerable adults and families to maintain engagement with the services on a regular basis.

One respondent reported that they work very closely with the children's centre staff, social care and education welfare to design services to meet the needs of the clients and this may include facilitating access to health education and health promotion activities.

Specialist Clinical Service

Many of the respondents work for service providers which offer specialist clinical facilities for vulnerable adults. For example, advanced nurse practitioners working in specialist fields such as the homeless and sex workers, will offer clinical sessions with specific screening including sexual health and HIV.

Some GP services have GPs and nurses with specialist clinical knowledge about these groups and they provide screening and immunisation, using both an outreach model and a more traditional venue to improve access and patient choice. These services will include services already mentioned (blood borne viruses and sexual health) and tuberculosis. They will also give advice for long term condition management, nutrition, care plans and if the nurses are appropriately trained, they will also prescribe medications. Some of the Network nurses will treat wounds and manage minor ailments within Patient Group Directives.

Specialist clinical services may well employ or will have access to clinicians with specialist knowledge and clinical skills in substance misuse and foot health. Many of the specialist clinical services support service users with mental health challenges and the clinicians support them by providing brief interventions, cognitive behavioural therapy (CBT) and motivational interviewing.

For many of the service users it is extremely important that the clinicians provide accessible, non-judgemental care and have the option to use interpreters as required. Health visitors often provide services for families who are homeless in their hostel or place of refuge.

Specialist Support Services

Members of the Network are not solely clinicians, working in, or in association with, specialist clinical services, but staff working in wider specialist support services that are central to the wellbeing of vulnerable adults. Included in these services are addiction services; social care services; housing support services; commissioning of healthcare services to support people who are homeless; referral rights and homeless charities.

A team leader for homeless, vulnerable and TB services advised that they '*managed a team of 13 staff providing services addressing health for homeless people in temporary accommodation, rough sleeping, refugees, BME groups, Gypsies and Travellers*'.

'The team runs drop-in clinics in homeless hostels, day centres, refugee day centres, drug and alcohol clinics and initial accommodation hostel for asylum seekers.'

Health visitor

Support and advice

The majority of responses related to the support and advice that so many of the Network members offer. The everyday advice relates to access to healthcare normally provided within GP surgeries. For example, how the vulnerable adult can register with a GP. Often it requires time and care to enable

them to ‘*understand the healthcare system and to have confidence in the advice given*’. It is important that the clinicians assist these service users to identify their own needs and develop their own goals and to encourage them to identify the barriers.

Many of the respondents also provide support to encourage these service users to:

- Attend appointments by often accompanying them.
- Engage with drug and alcohol agencies.
- Comply with medication.

Several of the members reported that they provide advice to healthcare professionals, NHS staff and voluntary agencies and other services to work effectively with these vulnerable groups.

Other examples of support, that the Network members provide, include:

- Facilitating discharge of people who are homeless into accommodation with on-going support.
- Offering developmental checks and immunisations for families who are homeless and find accessing traditional services very difficult.
- One to one specialist palliative care advice.
- Child protection and safeguarding.

Two respondents also advised that they support “moving on” through a multiagency approach. This support enables people who are homeless to ‘*access suitable accommodation with organic re-integration into mainstream society*’. Others work really hard to reach families including those with no recourse to public funds.

Listening and non-judgemental

The repeated message was one of a non-judgemental approach and taking into consideration factors which affect healthcare status. The clinician working in this specialist area must have good listening skills, honesty and openness with no hidden agenda.

It is essential to build trusting relationships where the client feels comfortable and will listen and be prepared to make incremental lifestyle changes.

Advocacy

The Network members often work in an advocacy role, either on behalf of the vulnerable adult or child, or by promoting the service to potential service users. They advocate for chaotic clients with complex issues. In these situations the practitioner must know the local services and communities and be able to act as an advocate for the patients across the agencies.

‘I try to be empathetic as these situations could happen to any of us because of a change in circumstances’.

Volunteer

Members also sit on government and statutory advisory committees and are actively involved in strategic action planning.

Outreach

Outreach approaches to healthcare are very important for these communities. Many of the respondents provide outreach care to hostels, often including informal sessions, at the request of the clients. Families in temporary accommodation are frequently supported by a health visiting service based on an assertive outreach model of practice.

Health promotion/health education

Clinicians working with vulnerable groups use health promotion/health education strategies to help their clients improve their health. They run targeted programmes such as sleep cycle, healthy eating and anger and anxiety management. Health promotion is often part of a nurse-led service at the drop-in clinics and may include safer injecting, smoking cessation, preventing hypothermia, or trench foot.

Staff education

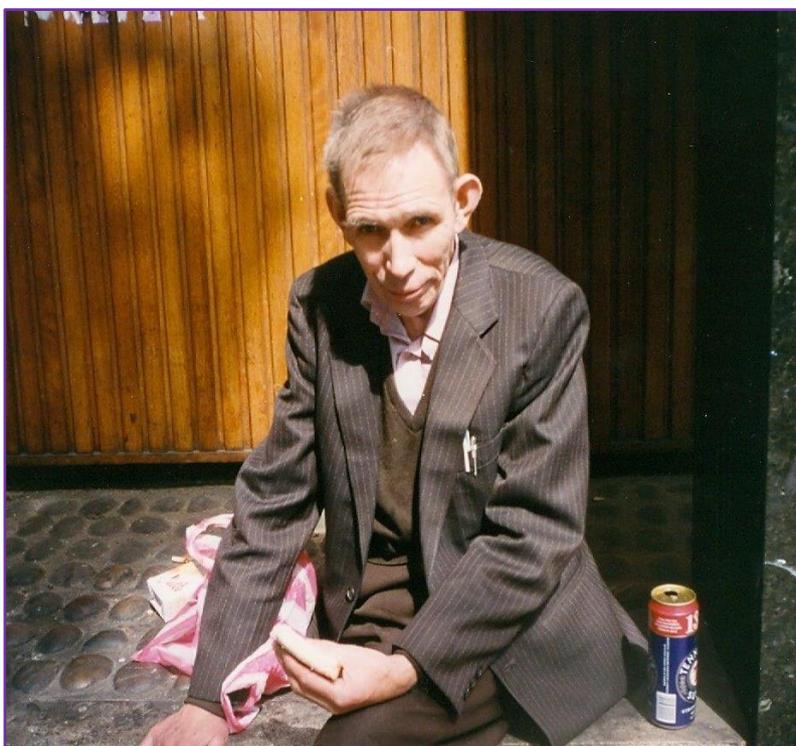
The specialist knowledge and skills that these practitioners have are often shared through formal training programmes, for example, for staff working in A&E departments or for pre-registration students in the university.

The education and development offered by Network members, whether formal or informal, is usually based on local service user scenarios to enable the staff to meet the needs of the local community. Many Network members help health professionals to engage with the vulnerable groups and to deal with consequences, when engagement is not effective.

4.4.4 Difficulties of working with vulnerable groups

66 respondents provided extremely detailed information about the problems they experience in their work with people who are homeless. The evidence they offered is very significant to the main purpose of the project. The in-depth comments have been thematically grouped by aspect of service:

- Working directly with people who are homeless.
- Working with services that are set up to support people who are homeless.
- Lack of support for the practitioners working in this specialist field of care.



Despite the fact that this section in the survey was specifically about problems two respondents chose to report the positive experiences that they have working in their particular location. One described their service where professionals work together with families who are homeless, the hostels are good

and the support staff are well trained. They did point out however, that *'this has taken ten years to achieve'*.

The other example is the situation in Leeds (box 20).

Box 20 Leeds partnership working

'Leeds has an excellent "working in partnership" network within the homeless and asylum specialities. We are privileged to have positive support from our providers and commissioners to work in innovative and creative ways to ensure flexible working and programmes of individual care for our homeless and asylum population. Our challenges are experience of secondary care standards, Home Office restrictions.'

Working directly with people who are homeless

The main theme, from the data about the problems staff experience while working directly with people who are homeless, was lack of engagement. Either the lack of engagement by the clients or the professional's lack of true engagement with this vulnerable group's healthcare needs. Repeatedly the Network members reported a lack of commitment on behalf of the service user to the way the system operates. There is often a disregard for appointment times, for the significance of regular attendance at clinics, and the importance of compliance with treatments. The high frequency with which they fail to attend an appointment can frustrate those providing the services. If this behaviour is not well understood by the practitioners it can lead to discord between those providing the service and the potential service user. The practitioners reported that if the service user has had poor experience of healthcare in particular mental health services, they are very reluctant to re-engage and it is a challenge to persuade them to access services available.

'Some people who have been homeless for a long time just could not cope with 'red tape' and are reluctant to get caught in what for them is a very stressful cycle of anxiety over finances, bills, forms, keeping appointments.'

Community Mental Health Nurse

A major challenge for those working with people who are homeless is the transient nature of the service user. This group is often very mobile and hard to reach, with no address to contact them to follow up treatment. The result is that frequently their course of treatment is not completed, especially during the winter period. Healthcare records are seldom up to date. Consequently there is insufficient health related information from previous interventions, which leads to a perpetuation of their clinical condition. For many of this group, health problems are not a priority until life threatening, they generally leave the situation until it becomes acute rather than take a proactive approach to their care.

The current restructuring in many health and social care services can result in these more vulnerable groups becoming marginalised and *'having to accept second rate care simply because they do not conform'*.

The respondents reported that accessing GP services can be really problematic as practices can make it difficult to register people with no fixed abode, or temporarily in supported accommodation. Many of them have complex appointment systems that are designed around the service user having access to a mobile phone. Inappropriate discharge from hospital to the street with no easy access to a GP service makes continuity of care very testing. In this situation, where they have chaotic lifestyles, the homeless become lost to the system and lost to follow up care.

Many people who are homeless have multifaceted healthcare issues with multiple health problems (physical and mental), which for practitioners can be complex and time consuming. This problem is exacerbated by the complicated needs of this patient group.

The negative attitude of other healthcare professionals can be a big hurdle for specialist clinicians working with these clients. Some staff are very judgemental and can be very discriminating against people who are homeless. This may be because of a lack of knowledge, understanding and skills needed to care for them. It is very important that all staff, including commissioners and managers, try



to be accepting, non-judgemental and appreciate the additional basic requirements. This includes recognising that the needs of families can be quite different from the needs of single adults. A particular issue is the limited understanding of the end of life needs for people who are homeless and the staff acknowledging that this excluded group requires a specialist service, in which they feel accepted, valued and understood. However, so often there is insufficient time to reflect on the care provided to people who are homeless and staff

experience difficulty dealing with anything but the client's basic needs.

Working with services that are set up to support people who are homeless

The Network respondents reported that the main problems they experience, in relation to the services that support people who are homeless, are linked to how well the different services work together and how well the system is set up to support this marginalised group.

Many of the practitioners noted the lack of joined up working between the numerous services that are involved in this client's care as a result the care is often fragmented, reactive and can be disordered. For example the voluntary and non-statutory services, that support people who are homeless, have different agendas to the public health services in the way they care for the clients.

'The team are dedicated and strive to continue to provide a service.'

Team leader Homeless and Voluntary and TB services

The challenge for the service user, of the lack of integration of services, is that they do not know who to contact. This is because the staff, in these services, lacks the knowledge of wider service provision and the role they play in the overall care and support to the clients. If the services were more integrated and the care was effectively co-ordinated then they would focus on the needs of the vulnerable group rather than an aspect of care.

In order for services to work in an efficient patient focussed way they need to have a greater understanding of other services that also support these clients. The voluntary sector has an extensive knowledge about homelessness issues. However, they do not fully understand the operational policies and procedures of the public sector. A greater understanding of how other services work enables the practitioner to help the client navigate through referral pathways. There are numerous third sector agencies' to liaise with and make caring for patients very complex. Support from a limited number of charitable organisations can be very good, but there is still not enough money to support these people properly, or sufficient joined-up working with statutory services.

Sharing of information between services is particularly important for this group. Secondary mental health services could share information with and collect information from other agencies e.g. social services and the police. This would aid a greater understanding of issues by staff in services that are not directly involved in the client's care.

Families who are homeless experience significant difficulties as they are constantly moved from one borough to another. For example, their children are rarely offered a school place within easy travelling distance, and the GP practice will not register them without utility bills.

Many services that support this vulnerable group are charitable organisations with limited funds and subsequently limited opening times. As a result the clients are left with no option but to use hospitals in what are termed 'frequent inappropriate attendances'.

"Some homeless people have specific views of what services should/ can provide for them. It is not always clear if the person genuinely would accept something that seems unrealistic compared to what others in a similar circumstance would be offered, or whether the person understands full well this won't happen, but helps them avoid having to make a big decision."

Community Mental Health Nurse

The lack of understanding about the healthcare needs of this socially excluded group and the inflexible approach of some mainstream services causes barriers to accessing immediate care. One of the major problems is the inflexibility of mainstream services towards patients who don't or can't keep their appointments. Some of the services expect them to fit certain rules e.g. produce identification, so they can access help to deal with their healthcare needs as a result of a chaotic lifestyle.

The problems with service provision are exacerbated by the lack of funding available and the continued funding cuts. This situation can lead to hostels being closed and cuts to other services resulting in potential discontinuity of care. As there is no recourse to public funds service providers become weary with having funding stopped, resulting in the service users being deprived of the service. An example is where a Community Improvement Plan was introduced that has impacted greatly on the service provision. The outcome was that the team had to look at ways of providing the same service with fewer staff, limited budget and a greater need to advocate for service users. The team were required to demonstrate outcomes to commissioners who have limited or no knowledge of the needs of such groups.

Managing the lack of suitable housing is a significant problem for those that work to support people who are homeless, particularly those discharged from hospital. Private landlords can sometimes exploit these clients. Voluntary organisations, in some areas, have exceeded their capacity to provide accommodation and large families are then inappropriately accommodated in a motel, or bed and breakfast accommodation such as that provided by 'Travelodge'. One particular concern relates to the lack of specialist accommodation or hostel to provide domiciliary care for end of life clients.

An additional pressure for this vulnerable group is the problem they experience accessing benefits. Sometimes the benefits office refuses, or delays, payment to those living on the streets for weeks. The staff in the offices may sanction them if they are a few minutes late, without recognising that many homeless people have no structure to their day and no watch to help them keep to time.

Lack of support for the practitioners working in this specialist field of care

The respondents reported a number of key issues that are worthy of report. Many of them work in isolation, often in a non-medical/non-healthcare environment, for example, health visitors working with housing associations that provide families with temporary accommodation. 23% of these respondents noted they were the only healthcare professional in the team. They reported a fear of lone-working and the personal risk of going into premises without prior knowledge of other residents. There is also the risk of being left stranded in a crisis without peer support.

Lack of regular supervision was mentioned by a number of the Network respondents. They explained that the services vary so much between local boroughs that regular supervision is very difficult to set up. Sometimes the supervision provided is not appropriate and delivered by non-clinical people who do not fully understand the services provided, or the needs of the clients.

Many of the senior managers have no experience of working with the homeless, or an understanding of the workload for the practitioners, or their development needs and think it is '*OK to learn on the job*'.

Support for these specialist healthcare professionals is very important. 36 members of the Network commented on the support available to them. Their comments have been clustered as follows:

- QNI network
- Other networks/support groups
- Clinical supervision
- Support from specialist services
- Support from colleagues

Eight respondents made reference to the support that the QNI Homeless Health Practitioner Network offers both nationally and regionally. Other networks that are available to support them are shown in appendix 21. The most frequently mentioned are the homeless networks for example, Homeless Link and Pathway UCLH.

18 respondents commented on the support they get through clinical supervision. Specific reference was made to local GP support, psychology support and child protection supervision. One respondent commented that they are *'waiting for the NHS restorative clinical supervision programme to commence'*.

Four respondents reported that they are supported by local specialist services and they have regular meetings with the clinicians in those services, for example drug and alcohol services; TB services and child protection services.

Support is often provided by colleagues they work with. This may include the manager especially if the manager has a medical background. Support is also sought from health visitors, colleagues working in educational welfare and those working in the third sector. The support may not be readily available when needed and may only be available through a regular six to eight week meeting.

However five respondents remarked that there is no clinical supervision in place to support them and no access to local networks. This situation can be *'very isolating as service and client do not fit well into generic services'* and the practitioner is left to source the support themselves. An example of how a team provides the support needed is illustrated in the box below.

"Line Manager and all the other homelessness agencies I work with make our loose knit homelessness group. We all know what we have to face and the hard work. We all communicate daily and there is a great feeling of being a family." Lead practitioner specialist community mental health team

4.4.5 How the Network members develop their knowledge and skills to work with this vulnerable group of clients

One of the activities within this study was to ascertain how clinical practitioners acquire their knowledge and skills to work with vulnerable groups. 72 (67%) of the sample of the Network respondents reported that they gained their knowledge and skills through work experience; 22 (20%) by attending specialist short courses; 22 (20%) in-house courses; 18 (17%) reported they learnt from their peers or networking and 11 (10%) by reading around the subject. Only 10 respondents reported that they developed their knowledge and skills by studying a taught post-registration course. Further detail can be found in appendix 22. However, not all healthcare professionals can access education and training as evidenced by a comment from a Homelessness Nurse Co-ordinator, *"I have no academic courses as there are none out there"*.

Many of the comments about where the Network respondents gained their experience included further clarification (see overleaf). Some attended a number of different courses, others a short specialist course and others stated that they learnt all they know from their clients.

Examples of where Network respondents gained their knowledge and skills

“On-going experience in current role 18 years working as a psychiatric nurse within a vast array of clinical settings, all of which identified and worked with the needs of vulnerable individuals within society.” (Specialist Nurse providing Healthcare assessments and signposting to mainstream services)

“From the homeless/rough sleeping population, from years of experience listening to their stories and using research such as: what effects sexual abuse, being in care, problems within a family and the affect that has on an individual that may lead to homelessness.” (Lead Practitioner/Specialist Community Mental Health (RMN) and Homelessness)

“I worked for almost 9 years in a day centre for homeless and vulnerable people including those affected by substance misuse issues and mental health problems. I did a 4 day course entitled Healthcare ‘On the Streets & Off’.” (Co-ordinator Homeless Service St John Ambulance)

“To carry out the enhanced part of my role I attended training, normally by GPs about developmental checks and immunisations. I attended training run by local safeguarding board around working with the Roma and hard to reach families. I also attended courses run by a local migrant charity and many talks given by experienced practitioners to the nurses’ homelessness group. I accompanied experienced practitioners on visits.” (Health Visitor for hard to reach families)

“External training in addiction, alcohol, asylum and attended conferences specifically for homelessness.” (Advanced Nurse Practitioner)

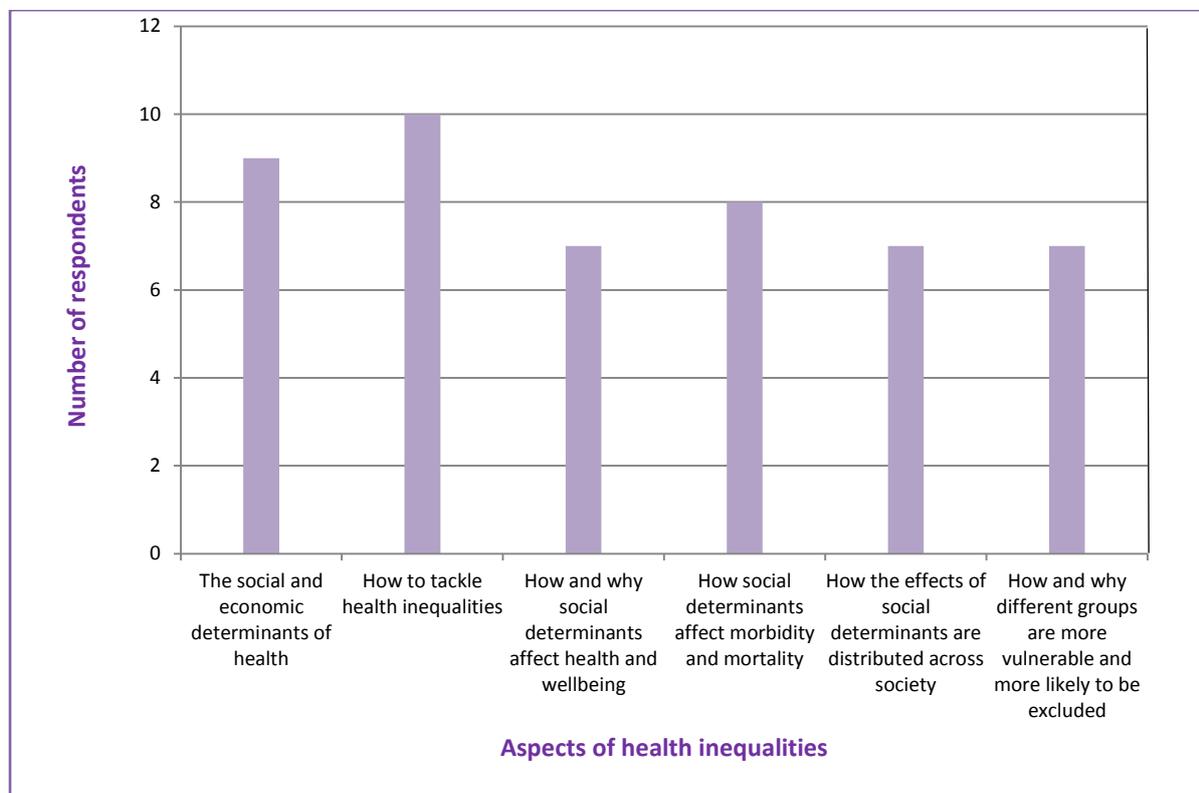
“I worked as an Outreach Worker under the Homeless Mentally Ill Initiative. I worked in a day centre as an advice worker and in hostels for Homeless People. I then worked in a Specialist Multi-disciplinary Mental Health Team for Homeless People.” (Social Worker/Approved mental health professional)

4.4.6 Pre-registration education and training

It is important to note that for many of the respondents a significant period of time has elapsed since they qualified as nurses so the responses to this section are dependent on accurate recall over a period of time.

Only 14 respondents commented as to whether all the six key issues for health inequalities were covered in their pre-registration programmes (figure 20). Half or more of this small sample reported that these topics had been covered in their pre-registration programme.

Figure 20 Key aspects of health inequalities that are covered in the pre-registration curriculum



This same group of respondents commented as to whether they could recall being taught about health risks to the five vulnerable groups and their healthcare needs and only six recounted that they had.

A section of survey F was designed to gather information about pre-registration assessments and evidence as to whether the practitioners had been required to demonstrate learning outcomes about the healthcare needs of people who are homeless. 26% (28) of the sample answered this question and they reported that they were not assessed about the healthcare needs of people who are homeless. One Healthcare Coordinator chose to note, that ‘*although their specialist knowledge and skills to work with the homeless and sex workers was developed experientially, the knowledge and skills learnt throughout her nursing career have all been essential to her current role*’.

Only three of the total sample of the respondents reported, that as part of their pre-registration course, they had been given the opportunity to experience practice placements with vulnerable adults. Furthermore, only one of these three reported that there were defined practice placement learning outcomes that related specifically to caring for vulnerable adults.

67 respondents provided an extensive list (appendix 23) of subjects related to the healthcare needs of vulnerable people that they would have liked to have learnt about as part of their pre-registration course. The most frequently mentioned topics were:

- Substance use/misuse
- Mental health issues
- The challenges of engaging and supporting those who do not want or do not know how to engage with service.

Other topics that were repeatedly mentioned were:

- The specific health risks for these vulnerable groups
- How to tackle health inequalities
- How and why different groups are more vulnerable and more likely to be excluded.
- How social determinants affect morbidity and mortality
- Impact on an individual of disadvantage: emotional trauma; homelessness; abuse; sexual exploitation; debt and asylum.

'Homeless patients can't keep eye drops in a fridge, and can't wash their hands before and after application of drops.'

Lead Nurse Practitioner

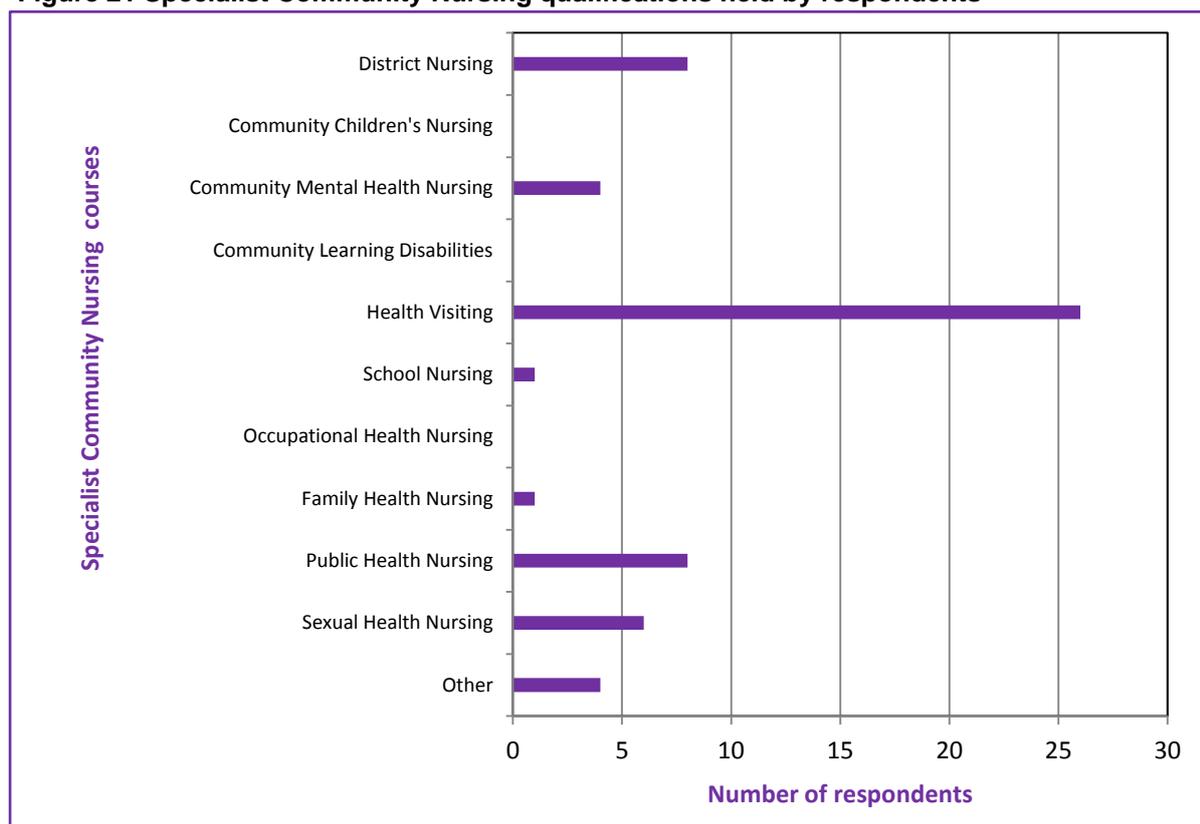
Some of the respondents suggested course module content. A Lead Nurse Practitioner suggested that a pre-registration module content should include long term co-morbidities and clinical conditions that affect the most vulnerable. For example: *particular physical health problems i.e. tissue viability, nutritional status, blood borne viruses, hepatitis C, liver disease and Chronic Obstructive Pulmonary Disease*. A senior nurse and manager in the third sector recommended that such a module should include, *'an understanding as to what constitutes homelessness; what are the specific needs of homeless people; prevalence of tri-morbidity; risk factors in the homeless population; understanding needs/fears/chaotic lifestyle etc.; supporting registration and accessing general practice; reducing inequality'*. An Advanced Nurse Practitioner who works in a GP service pointed out that the pre-registration students should all be aware *'that it isn't always possible to get these patients to follow standard advice'*.

4.4.7 Specialist Community Nursing education and training

42% of the respondents (44) advised they had undertaken an SCN course. The majority (26) of this group had studied a Health Visiting programme; fewer (8) had studied a District Nursing course or Public Health Nursing course (figure 21). None of the respondents reported that they had studied courses in Community Children's Nursing, Community Learning Disabilities Nursing or Occupational Health Nursing.

12 indicated that they had completed their course during the past eight years and noted which key aspects of health inequalities they had studied (table 9). 11 of this group stated the curriculum included the social and economic determinants of health and nine how to tackle health inequalities and how and why social determinants affect health and wellbeing.

Figure 21 Specialist Community Nursing qualifications held by respondents



36 reported that they were not assessed about the healthcare needs of vulnerable groups. Only seven recalled that they were and that they were asked to write an essay.

Table 9 Health inequalities topics covered in the Specialist Community Nursing courses

Topic covered in the curriculum	Number of respondents N=12
The social and economic determinants of health	11
How to tackle health inequalities	9
How and why social determinants affect health and wellbeing	9
How social determinants affect morbidity and mortality	7
How the effects of social determinants are distributed across society	8
How and why different groups are more vulnerable and more likely to be excluded	6
The specific health needs of these vulnerable group of people	6
The specific health risks for these vulnerable groups	7

12 SCNs advised that they were given the opportunity to experience placements with the vulnerable groups. However, only five agreed there were defined learning outcomes that related specifically to caring for these vulnerable groups.

The main topics that the SCNs suggested they would have liked covered as part of their Specialist Community Nursing course were:

- Substance misuse (drugs and alcohol), addictions and related diseases.
- Healthcare needs of people who are homeless and their families.

Other suggested topics can be found in appendix 24.

One nurse practitioner, who works in a Health Inclusion team, referred to current specialist community nursing courses not being relevant to the needs of those working specifically with this group of people, *'I have not completed a specialist community nursing course as there is no course available that is relevant.'*

4.4.8 Taught post-registration/post-qualifying education and training

33 respondents reported that they had undertaken other post-registration/ post-qualifying courses (28 of them during the past eight years) to help them with their work with vulnerable groups, for example:

- Short courses e.g. domestic violence, sex work, refugee health, legislation updates
- Drug and alcohol misuse/abuse
- Mental health issues

Further examples can be found in the appendix 25. Half of these respondents advised that they were assessed, as part of their post-registration/post-qualifying course, about their understanding of the healthcare needs of vulnerable groups of people. The most common form of assessment used was the written assessment (essay) and the formal presentation.

One of the respondents mentioned that their post-registration research was about the healthcare needs of the local homeless population. Another respondent noted that although there was no specific aspect of their post-registration studies that focussed on people who are homeless and other vulnerable groups, because of their personal interest, they ensured that they directed all their assessments to this topic.

Only 13 out of the 48 who commented on whether they were given the chance to gain practice placement experience with vulnerable groups as part of their post-registration studies, reported that they had been given an opportunity. For example: working with men and women who are homeless or working with travelling families.

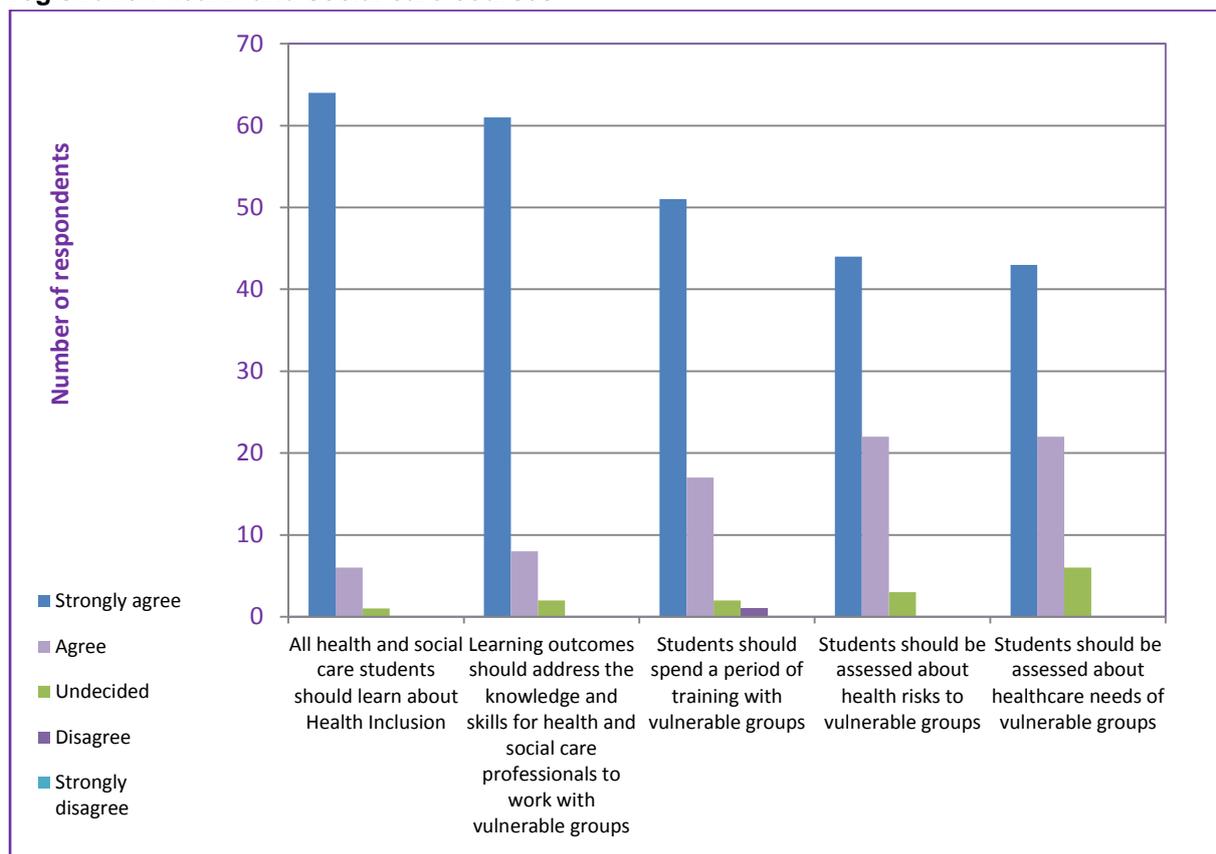
A detailed example of a practice placement experience as part of a post-registration programme is illustrated below.

"I was sent to visit to some travelling families - I was told to take some red books and I would be ok. I remember driving on to the site and big dogs jumping up and snarling and barking at the car door - I sat in the car too afraid to get out until eventually one of the very kind ladies from the caravan closest to me came out and asked what I wanted - I explained who I was and she invited me in and made me a cup of tea to steady my nerves!! The relationship went from there and I was able to help by arranging registration with the local GP and helping a newly married girl to understand how her body worked in order to help her understand how to get pregnant. Three months later they moved off, she was pregnant when she left - scary but successful I think." (Specialist health visitor, homeless families)

4.4.9 Core knowledge and skills for healthcare professionals working with vulnerable groups

The Network respondents were asked to give their opinion about core knowledge and skills for professionals who work with vulnerable groups.

Figure 22 Respondents' opinion about topics that should be in the curricula of all pre-registration health and social care courses



They were asked to rank on a five point scale statements about course content, learning outcomes, practice placement opportunities and assessment for pre-registration, Specialist Community Nursing and post-registration/post-graduate courses.

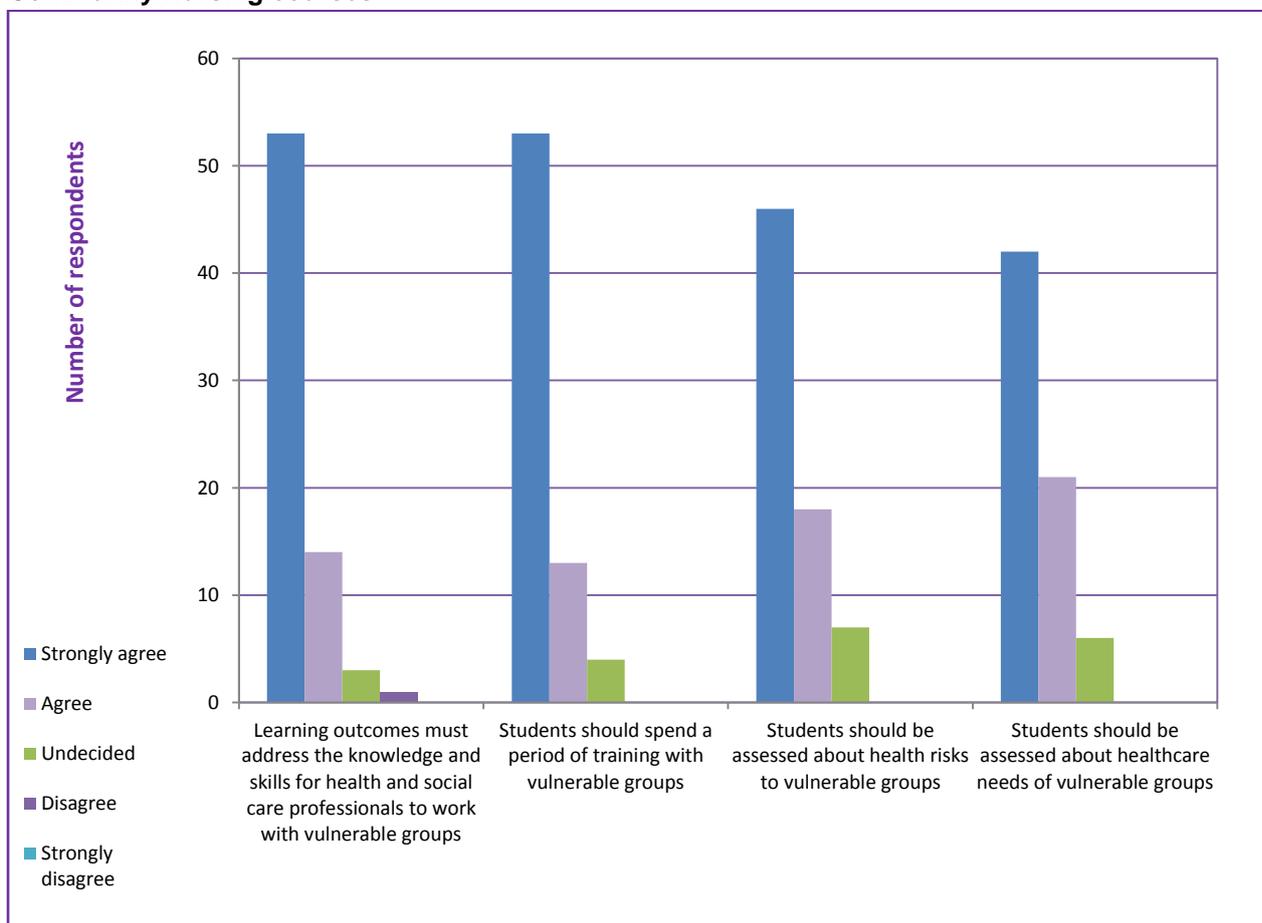
Figure 22 shows the respondents opinion about the extent to which pre-registration health and social care students should learn about aspects of Inclusion Health. 71 respondents (66% of all respondents to this survey) completed this question. 64 strongly agreed or agreed that all pre-registration healthcare students should:

- learn about health inclusion and vulnerable adults;
- spend a period of their training with vulnerable groups; and
- be assessed about the healthcare needs of and the healthcare risks to vulnerable groups of people.

Similarly 64 strongly agreed or agreed that education and training courses for SCNs should prepare the students to work with vulnerable groups by including appropriately assessed learning outcomes and a period of time working with this community (figure 23).

The survey asked the respondents whether post-registration/post-graduate courses should include relevant information about vulnerable groups. 67 (62% of all respondents to this survey) strongly agreed or agreed they should. Only one respondent strongly disagreed.

Figure 23 Respondents’ opinion about topics that should be in the curricula of Specialist Community Nursing courses



4.4.10 Knowledge and skills required to support vulnerable groups

An average of 62 respondents commented on the essential knowledge, understanding and skills that healthcare professionals working with vulnerable groups should have or should develop to support service users effectively. The comments have been analysed by themes and clustered into a) knowledge and understanding and b) skills.

a) Knowledge and Understanding

The respondents recognised that ideally knowledge should be tailored according to the area in which the professional works as some parts of the country have different needs. It was suggested that, if at all possible, the practitioner should gain personal knowledge and experience by working alongside the vulnerable groups that they support, including experience of life on the streets. This approach would help the practitioner gain an insight and a greater understanding of the social structure of which the patient is a part.

“Entrenched problems take a long time to sort out and can be quite scary for the service user. There is usually a reason for each bad decision, which may well make sense to them in context to their background and environment, and there are reasons that problems, however unpleasant, are difficult to sort out. Rejection, failure and history of abuse are commonplace for this client group. It is important for the practitioner not to be part of the cycle but to recognise this. Just because you point out the problem that their behaviour may have on their future, don’t expect it to motivate change. Small changes that have immediate effects are much more likely to motivate change.” Occupational Therapist

The themes about knowledge and understanding that reflect the narrative provided in the comments are listed below in order of number of comments per theme, starting with the highest number of comments:

- Mental health
- Services/resources to support
- Substance misuse
- Homelessness
- Health care needs and beliefs of vulnerable groups
- Legislation
- Health inequalities and the social determinants of health
- Social exclusion
- Motivation to work with vulnerable groups.

Mental health

Many of the Network practitioners encounter service users with mental health challenges. They should understand how mental health impacts on physical and social health. 39% (24) of those who advised about knowledge and skills to work with vulnerable groups highlighted that education and training in mental health and illness was very important. This knowledge would enable them to make more effective assessment of the service users mental health needs. Understanding about the different causes of vulnerability and the link between vulnerability and mental illness would help the practitioners to support the vulnerable adult more effectively, specifically those who are homeless and identify depression and suicidal tendencies.

Practitioners working with people who are homeless with a mental illness, need to be extremely experienced with a good knowledge of the whole range of psychiatric conditions. They need to be able to work autonomously and be very assertive in ensuring that people’s unmet health needs are addressed. Ideally this knowledge and experience would be gained from working in an acute mental health hospital and would help them to better understand how to cope with the problem behaviours they encounter.

Services/resources to support

Respondents reported that the service users often have difficulty accessing local services or they are unaware of the services available. This situation necessitates that the practitioners have a comprehensive knowledge of the local health and social care facilities and resources available, both voluntary and statutory, to support the different vulnerable groups. It is essential that the professionals know why people have difficulty understanding and accessing care and what actions are needed to help them.



Sometimes the vulnerable migrants, Roma and Gypsies and Travellers are not aware of the community facilities and do not fully understand their rights to access the health and social care services. In these circumstances the professional may need to help them to challenge to gain access to the facilities.

Repeatedly the respondents mentioned the importance of knowing about Local Authority housing services; the benefits systems; the pathways to other services that support vulnerable groups and when and how to refer to them, often referred to as care navigation and signposting.

Substance misuse

Vulnerable adults often turn to alcohol and drugs and a history of substance misuse may have led them to becoming vulnerable. The respondents noted that a detailed knowledge of drugs and alcohol and an understanding of substance use and misuse and the impact on physical and mental health is very important.

Healthcare professionals working with the service users should know how to assess for substance misuse needs and the treatments available for individuals who are substance misusers. Service users, who have problems with one or more drugs, including alcohol, sometimes have a dual diagnosis which means that they also have a mental health problem. Respondents noted that a detailed understanding of dual diagnosis is important especially for those working with communities of people who are homeless.

Homelessness

The Network primarily supports people who are homeless. It is unsurprising therefore that many of the respondents' comments related specifically to the knowledge and understanding that they require to support them to work with this vulnerable group. For example, the routes to homelessness; understanding what it means to be homeless; how homelessness impacts on health and mental wellbeing.

People who are homeless may not attend to self-care and so the professionals should understand the common physical conditions that may arise including skin conditions, sexual health problems and difficulties with their feet.

Homelessness may affect families as well as individuals. Those working to support the families should know about the impact of homelessness on all family members and their rights to access housing. This situation is not unique to the UK and professionals can access useful information about housing and homelessness from the European Federation of National Organisations Working with the Homeless (FEANTSA).

Health care needs and beliefs of vulnerable groups

To understand the healthcare needs and beliefs of vulnerable groups the professionals should know about the different vulnerable groups: their culture; their lifestyle and their health beliefs.

Detailed knowledge of health and social risks of vulnerable and marginalised groups will help the professionals to engage with them. Such understanding helps the healthcare practitioner to support them to overcome the barriers to meeting their needs. It is essential that staff working with vulnerable groups can profile their healthcare needs, including knowing about their health determinants, and the public health issues for those living with deprivation and associated early mortality rates. This knowledge will help the clinician to understand the complexity of their health needs and challenge the poor practice and stigma suffered by vulnerable groups.

Legislation

The Network members reported that they need to have knowledge of all legislation that affects the health of their clients. Which acts or laws they need to be familiar with will depend on their specialist area of work. The following acts or laws were identified:

- Child Protection Act
- Community Care Legislation
- Housing Law
- Homelessness Law
- Human Rights Act
- Mental Capacity Act
- Mental Health Act
- Safeguarding Vulnerable Adults Policy.

Other regulations that were noted included the UK Asylum Law and offences related to sex work and drugs.

Knowledge of these laws helps the practitioner assess the clients risk, helps them to plan and consider the possible impact of the legislation.

Health inequalities and the social determinants of health

In 2012 The Royal College of Nursing⁶⁷ published a policy briefing in which it was stated that ‘social determinants are responsible for significant levels of unfair health ‘inequities’’. This briefing noted that ‘social determinants include housing, education, financial security and the built environment as well as the health system’.

Members of the Network who responded to the survey recorded that knowledge of health inequalities and the social determinants of health are essential to help them support their clients. This knowledge helps the professional to understand the level of deprivation and health challenges faced by specific vulnerable groups and individuals within these communities.

Social exclusion

The association between social exclusion and poor health, in particular mental illness, is another area that professionals working with people who are homeless should have knowledge of. An awareness of the causes of social exclusion and the impact of isolation on general well-being should also be better understood.

Motivation to work with vulnerable groups

A very interesting set of comments from the Network respondents related to professional motivation to work with these clients. They asserted that healthcare practitioners really ‘*have to want to work with such groups*’. For example if the practitioner ‘*has issues about working with sex offenders then they shouldn’t be working in an offender healthcare setting*’.

It is essential that staff can accept their clients without any discrimination and be prepared to advocate strongly and work on non-healthcare related problems as they occur.

One respondent summed up the problem as illustrated in the box below.

“This isn’t something you can really teach. You either have it or you don’t. Some people don’t want to / won’t work with such groups of patients. There should be clear and open job roles and healthcare workers should be made aware of these before undertaking such roles - either as students or as substantive staff. Therefore if everything is clear and transparent then staff can’t say once they have started that they can’t / won’t deal with specific groups of patients.”
Advanced Nurse Practitioner

b) Skills

The themes about skills reflected within the narrative data, provided in the comments are listed below in order of number of comments per theme, starting with the highest number of comments:

- Communication skills
- Non-judgemental
- Empathy
- Enhanced skills of caring and compassion
- Assessment skills
- Advocacy
- Motivational interviewing.

Communication skills

40% (25 responders) of the Network who commented on the skills required to work with vulnerable groups mentioned the importance of good communication skills. The respondents particularly emphasised the importance of good active listening skills.

It is very important that communication is as effective as possible and that the skills of the practitioner to communicate with clients, families, and other agencies should be excellent at all levels. Practitioners should develop skills of therapeutic communication and be able to communicate with patients from all backgrounds. A health visitor, for hard to reach families, noted that healthcare practitioners who work with vulnerable groups ‘*must be able to communicate with their clients to understand their issues, which may not be the same priority as that of the professional*’. For example, a health visitor may feel it is vital that the family register with a local GP and have the children immunised. However, the mother has so many issues to deal with living in a hostel that taking a healthy child to the doctor is not a priority’.

Non-judgemental

A recurring theme in the responses was the importance of practitioners being non-judgemental and having a non-judgemental attitude towards the client. It is very important that professionals treat families and individuals with respect and endeavour to really understand the context of their lives.

“Have the right attitude and resilience as this is a very demanding culture with multitude of psycho-social, mental health and physical health issues which all need to be taken into account with the presenting social climate in particular such things as cost of alcohol increasing, benefits going down, what drugs are being sold at that time with the increased use of legal highs.”
Specialist Community Mental Health Nurse

Empathy

Another frequently recurring theme in the responses was that empathy is a desirable skill for professionals working with vulnerable groups. Healthcare practitioners need to have the ability to sense the client's emotions and to imagine what they might be thinking or feeling. An empathetic approach is needed to be able to really support vulnerable groups.

Enhanced caring and compassionate skills

Similarly enhanced caring and compassionate skills are thought to be very important to be able to maintain the standards of care that are needed by vulnerable adults.

It is imperative that clinicians understand that it is not always a personal choice to become homeless; to use drugs or become involved with sex work. It is vital that staff understand the links between mental illness and substance misuse. Other factors include growing up in care and leaving the armed forces.

Assessment skills

Another repeated theme was assessment skills. Assessment skills cover a number of different areas including health needs assessment; risk assessment or more general holistic assessment of needs. One respondent thought this should include diagnostic skills, another that basic assessment skills were insufficient and that practitioners, working with people who are homeless, should develop enhanced assessment skills; and a third that thorough assessment skills alone were not enough and that the practitioner should produce good documentation for others to follow.

Advocacy

Healthcare practitioners working with vulnerable groups often find themselves being the advocate for the individual or group and this requires the clinician to have good advocacy skills. A few respondents noted this key skill and commented that sometimes advocacy alone was not enough and that the client needed the member of staff to be tenacious to achieve the desired outcome for and on behalf of the patient.

Motivational interviewing

Four respondents pointed out that motivational interviewing is a very useful skill for staff working to support vulnerable adults. This skill helps the practitioner to elicit the client's readiness for change and helps the client to strengthen their motivation for change.

4.4.11 How healthcare organisations care for vulnerable groups of people

70 members of the Network commented on the level of commitment by healthcare organisations to care for vulnerable groups. The comments set out in this section are the observations reported by the respondents to the survey. 58 (82.86%) of them stated they experienced a reluctance by healthcare organisations to care for these vulnerable groups.

57 respondents provided explanation as to why healthcare organisations exhibit such reluctance to care for these vulnerable service users: their view is that the overriding problem is a general lack of knowledge and understanding about this client group. Staff employed in healthcare organisations may not know about services and resources that are available to support people who are homeless, the needs of these clients, the challenges they face, the priorities of this group and their entitlements.

This lack of understanding, about people who are homeless may justify why healthcare organisations are reported to be reluctant to care for these patients. The Network respondents reported that staff in service experience difficulty when trying to engage with people who are homeless. Staff in these organisations are reported to complain that such vulnerable people are simply too difficult to manage. One of the major frustrations for the staff is the problem of patients not attending for appointments. This non-attendance is reported to be seen as a waste of time or a waste of an appointment that could be used by others.

The perception of wasting time and resources results in a concern about costing more money to support this community, than other patients, particularly for organisations that operate on a limited budget. Funding has been withdrawn by some healthcare organisations as they are not considered a priority and there is a concern that *'they put huge pressure on services'* because of their complex needs. The respondents reported that staff, in these healthcare services, remark that vulnerable individuals and families are challenging to communicate with and care for. They also reported, that in their view, staff attribute this problem to the chaotic lifestyle which many of them believe is self-inflicted.

'If the healthcare organisations are doing a good job, there would not be the need for charities to be set up for these homeless vulnerable people.'

Volunteer

Many of the comments related to the discriminatory attitude of some staff and the stigma around homelessness that still exists, they observe that they are *'dirty, smelly and unclean'*. The respondents reported certain employees have indicated that they have concerns about their personal safety and are afraid of these vulnerable patients, as they expect them to be violent or abusive.

Another commented that the bureaucratic processes of their organisation prevented the staff from being sufficiently flexible to be able to accommodate the vulnerable service user's needs. An example is the booking system, often clients are required to telephone the service to make an appointment. Many people who are homeless are reported to find this too daunting.

When asked about continuity of care 56 members of the Network commented that they have difficulty providing continuity of care for their patients. One respondent suggested that one way of providing continuity of care for families and vulnerable young people, who are pregnant, is to set up Intensive Multiagency Teams. These teams would have a focus on crisis intervention and they would support

the clients for up to two years. This approach reflects the Family Nurse Practitioner model where continuity is a priority. This approach was also promoted by another respondent who reported they work in a team of GPs, nurses, support workers and health visitors, all of whom work well with multiagency services. Their concern however, is that this work is not always recognised by clinical commissioners and consequently the service may be at risk in the future.

Other comments made by the respondents related to the clinical service. One pointed out that with two staff working a total of 38 hours between them and a caseload of 300 per year they are only able to provide basic care for their clients.

However, one respondent pointed out that *'there are services that are very helpful, non-judgemental and respectful'*. Another respondent noted that they had worked with patients who are homeless for over 20 years and that the service in the hospital where they work has improved following the introduction of a 'specialist homeless team'. The team has fostered excellent links and partnerships with the primary care service, and a local enhanced GP service.

4.5 Findings from the case study sites

In this section we present the findings from the focus groups and semi-structured telephone interviews with staff from the 12 case study sites. Details of the sites; role and number of staff involved in focus groups and interviews are set out in chapter 3. The questions asked are presented in appendix 3 and summarised in chapter 3. The content analysis of the data from the case study sites is discussed under the following headings:

- 4.5.1 Healthcare professionals' awareness, knowledge and skills about vulnerable groups
- 4.5.2 Skills and knowledge required of healthcare professionals to care for those with low health expectations
- 4.5.3 Recommended Inclusion Health learning outcomes
- 4.5.4 Development of knowledge and skills to work with vulnerable groups
- 4.5.5 Challenges and difficulties encountered by healthcare professionals working with vulnerable groups
- 4.5.6 Reluctance and lack of confidence of healthcare professionals to care for those from vulnerable groups
- 4.5.7 Continuity of care
- 4.5.8 Support networks for healthcare professionals working with vulnerable groups
- 4.5.9 Trust between healthcare professionals and vulnerable groups.

4.5.1 Healthcare professionals' awareness, knowledge and skills about vulnerable groups

There was a strongly held view from the participants, at all case study sites, that amongst the healthcare professionals, there is very limited awareness about the five vulnerable groups. Their lack of knowledge and understanding about the communities that they are working with was repeatedly mentioned. For some staff and service users it was a significant cause for concern. There is recognition that healthcare professionals have a job to do, but that the conventional way of working may not fit with the culture and traditions of some of the communities.

The contributors argued that where clinical staff are not in regular contact and working with vulnerable groups, they may miss conditions in these individuals they would otherwise pick up in other patient groups. The participants also maintained that if healthcare professionals are not working in an area where there are a significant number of socially excluded clients, or in a specialist team working with one or several of the vulnerable groups, then they will not gain sufficient experience to acquire the necessary knowledge and skills to competently care for these patients. However, they recognised that the professional's knowledge increases significantly when they work directly with the different vulnerable groups as explained by one doctor who commented that *'my awareness before going into the job (as a doctor) was very poor, but since working in the team my awareness has increased. I have learnt about a world that I didn't know anything about'*.

It was suggested that rather than gaining knowledge and awareness from direct service user experience, the healthcare professionals were informed by the media, which often portrays these groups very negatively. A psychiatric nurse, from a charity that supports Gypsies and Travellers, advised *'we have to remember that the NHS workforce are part of the population and they read what they read in the newspaper'*. An equality and diversity manager from the same organisation suggested *'we need to turn the media off to stop health professionals listening to it'*.

A service user illustrated this prejudgement by commenting on their own personal experience when they were homeless, *‘when I said to the doctors that I smoked cannabis, straight away, they would assume that that was why I was doing certain things rather than looking at the other issues in my life’*. This service user went on to explain that rather than healthcare professionals trying to connect with the individual and understand their previous and current circumstances they would form a perception about the service user, *‘as soon as they found out that you take drugs you get a response “if you stop taking drugs you will feel alright”’*.

Staff observed that they gain general knowledge as part of their training that helps them to do their job. A doctor working with sex workers explained that healthcare professionals learn to adapt this knowledge and *‘then use it in specific circumstances’*. It is not always possible to cover the essential skills in the curriculum and staff learn a lot from the service users. This point was raised by a project leader who works with sex workers: *‘the women teach us so it is not necessarily something you would find in a curriculum’*.

There was a sense from the discussion, at the case study sites, that professionals tend to ‘look down’ on the clients. This in turn prevents the client from speaking up as they would wish to, without the

fear of being judged. The participants recognised that general life experience is particularly important when working with vulnerable groups as it helps the clinicians to *‘be down to earth with people and not judge them’*. One health trainer went on to explain that *‘our role is to guide them and help them in what they need to do. It is difficult for the client as they think they can’t speak to who they need to without being judged or looked down on’*. How the healthcare professionals and their actions are perceived is very important. It is essential that staff clearly explain their role when working with those from vulnerable groups. A member of the community of people who are homeless explained that they had attended a meeting and had been questioned as to why they were there *‘and my answer was so that people like you can understand that I can*

‘Today when a client came in who was suicidal with really bad anxiety attacks the doctor wouldn’t even look at her. She was told to go to A & E. The girl did not want that response; she was in such a state when I phoned the doctor. The explanation was that they are used to seeing her a lot for medication. It is clear to me that they are ignoring her real needs.’

Health Trainer

‘speak in an intelligible way and you can have a conversation with me’. It is important that staff engage with socially excluded groups to get a greater understanding of their problems rather than being too judgemental.

“Health professionals need to have life experience. I remember a doctor telling me that I was clinically depressed. They were just hidden behind a clipboard. I just wasn’t having it.”

A service user who was previously homeless.

The perceived power imbalance between the professional and the service user is very important for some vulnerable groups. So staff should be fully aware of the impact of their approach. A counsellor

working with ex-offenders explained that wherever possible it was important to *'minimise the power imbalance (between the client and the professional) and try wherever possible to manage this'*. A specialist midwife also explained *'that some of the communities perceive the professional in the uniform as the one with power'*.

Participants commented on the lack of mental health awareness amongst some clinicians. They also pointed out that if they are unaware of both physical and mental health issues they are seldom able to deal with the wider situations that arise when working with vulnerable groups. A health visitor working with the Gypsy and Traveller community went on to explain that *'GPs are concerned with the groups (Gypsies and Travellers) not attending appointments, however health visitor colleagues are more worried about how to culturally engage with the communities'*. A community psychiatric nurse noted that there is a need for persistence and engagement with the homeless clients and that there is an expectation, by other health professionals, that we will deal with all the clients' issues i.e. housing and finance. However, they explained that what they normally do is to *'signpost the client'*.

The overall consensus from the case study sites is that there is very little or no mention of these vulnerable groups in equality and diversity training. According to a policy officer, *'staff who are directly employed by the NHS have equality and diversity training but the Gypsy and Traveller community is rarely mentioned'*. An equality and diversity manager from one of the sites explained that they deliver the corporate induction sessions. During these sessions we *'talk about health inequalities and have a number of students, including doctors on placement, who know nothing about this topic'*. This manager reported that they have to deal with the basics, whereas they should be honing the skills of the specialist professionals.

It is important to note that knowledge works both ways i.e. the healthcare professional requires knowledge of the different vulnerable groups and the communities require knowledge of the health and care system. It is essential that vulnerable groups are identified by the healthcare professionals and their specific needs are understood when they present as patients in the clinical setting. Lack of awareness of what these groups understand about their health needs and the UK healthcare service, can impact on the care they receive. The following example given by a health visitor working with the Roma community in Wales illustrates this point:

"My field is EU Roma and from the community perspective, the GPs, community practitioners, health visitors and staff in the hospitals such as A & E, won't use language line, they won't have awareness that the patients are even EU Roma. The staff won't have had any education on EU Roma and they don't really understand why the EU Roma doesn't understand anything about the service. The community will not understand the service as no one has ever explained it to them. The result is a lack of knowledge on both sides."
Health visitor.

The ability to be courteous towards the different communities is seen as a key skill. Staff behaving in a courteous and respectful way and demonstrating that they have tried to understand the culture of the socially excluded communities is essential. This study highlighted the fact that this is not always the case.

Cultural awareness is particularly important when working with the Gypsy and Traveller community as one member of that community explained, *‘the cultural behaviour in one caravan might be very different to that in an adjacent caravan’*. A midwife noted that although understanding the culture of the different communities is very important, the service user needs to get to know the healthcare professional and the organisation they represent.

‘I find that staff are crying out to understand more about the communities. If you don’t know anything about the culture, then you can’t treat people individually.’

Specialist midwife working with Gypsies and Travellers.

A specialist midwife working with the Gypsy and Traveller community reported that health professionals do intend to be courteous, but may not appear to be because of the *‘pressures on them and their services and the fact they have to get through the workload and deliver a certain amount of care’*. Successful outcomes are dependent on good relationships between the professional and the service user. It is particularly important for the district nurse to be courteous should they need to go back again into the community. It was also pointed out that vulnerable migrants and Gypsies and Travellers need to engage with the services that are offered to them and that many are not accessing support when they can.

The example below typifies the importance of cultural competence among the staff.

“There is something about putting your handbag on the table in a caravan, even if it has only been on the floor of your car. I wonder if I was expecting a baby and a midwife came along and did that, on a scale of 1-10 how much is this going to be a problem to me.”

Community member from the Gypsy and Traveller community.

4.5.2 Skills and knowledge required by healthcare professionals to care for those with low health expectations

Managing patients who have low health expectations and greater immediate priorities, other than their health needs, requires healthcare professionals to be confident in their ability to identify and ask the patients the most appropriate questions. As one project lead working with sex workers explained, *‘often clients expect us to resolve everything not just their health needs’*. A number of those interviewed reported that the main issue for clients and their families are finance, job security and how to pay the bills.

There was a need identified for healthcare professionals to be aware of the prevalence of poor health amongst the different vulnerable groups, particularly the poor immunisation status of many of the children. It is reported²⁹ that average mortality rates in the homeless community are 47 years for women and 43 years for men as compared to UK average mortality rates of 82.5 years for

women and 79.5 years for men. According to the participants, members of this community will not have a healthy diet and may not be aware that they have a health problem because of substance misuse.

Similarly the life expectancy of Gypsy Travellers in Scotland is reported to be 11 years shorter for women and 15 years shorter for men⁸⁰. A policy officer in Scotland commented that *'this is a shocking statistic as their life expectancy is in the 60s'*. The officer went on to explain that NHS Health Glasgow has launched a campaign to understand more about the healthcare needs of Gypsies and Travellers and what can be done to improve their health as they are not accessing support. Within the Gypsy and Traveller community, the male community perceive ill health as normal, as in their working life they have to be strong. To promote accessibility to healthcare services travelling cafés have been set up in Glasgow alongside other facilities normally accessed by this community.

Some socially excluded individuals have low expectations of healthcare communities and there are stories of poor care, particularly around infant feeding. For example, in some communities women do not breast feed. In these situations it is very difficult for the healthcare professional to know how to challenge this behaviour and to have a conversation with the women about the benefits of breast feeding.

'If they are motivated to change then they will take on board the advice given.'

Dietitian

One of the independent organisations that support vulnerable migrants considered the impact of vulnerable migrants' lifestyle on their health. As a consequence of no finance and no housing support, families have to share one room. Often asylum seekers are victims of violence, torture and war related trauma. The effect of these situations on the individuals often leads to significant health problems as shown in box 21. Oral Health, respiratory disease and infections are in the top five health issues for people who are homeless. Foot care and unmanaged diabetes were also cited as one of the big health issues for people who are the homeless.

Box 21 Impact of vulnerable migrants lifestyle on their health

- Mental health issues are a particular problem.
- Long term stress/ anxiety leads to mental health problems and sometimes physical health problems.
- Long term effects of low self- esteem.
- Clinical conditions are undiagnosed, untreated and sometimes long term which can lead to complications.
- Violence has both mental health and physical health implications.
- Access to food can be a problem which can lead to malnutrition.
- Overcrowding can lead to problems with communicable diseases.
- War related trauma for example deafness and intense stress.
- There may be medically unexplained physical symptoms when in fact there may be a mental health issue.

4.5.3 Recommended Inclusion Health learning outcomes

The staff who participated in the focus groups and telephone interviews were asked to give their opinion about course learning outcomes associated with Inclusion Health. They were asked to consider learning outcomes for courses preparing health and care professionals entering a profession and also for those courses that are designed specifically for staff who work more closely with vulnerable groups as part of their daily work.

4.5.3.1 Inclusion Health learning outcomes for healthcare professionals at the point of registration

The overall consensus from the case study participants was that a general awareness of vulnerable groups was seen as important in the undergraduate curriculum for any profession and that *'training needs to keep up with the times'*. A senior manager in a voluntary organisation advised that *'they will come across these communities in their general practice and it is important to find innovative ways of gaining this knowledge without them necessarily coming to a training day i.e. online learning or some other medium'*. Some of the participants commented that if healthcare professionals do not know enough about the communities and the individuals within them their behaviours and attitudes may distance the service user.

It was recognised that Inclusion Health learning outcomes at the point of registration are essential. The universities should help the students develop the values based approach, to enable them to differentiate between something that is generic and something that applies specifically to a vulnerable group. This should enable the new practitioner to effectively balance between stereotyping and individual person centred care. A nurse working with sex workers suggested that *'whatever the model of curriculum it is important to try to get the terminology right'* as use of inappropriate terminology leads to incorrect stereotyping. Cultural awareness should be core learning for all undergraduates as this helps reduce the risk of stereotyping as illustrated below.

'If you are teaching people, it might be worth giving them knowledge about what they should be looking out for and why, rather than telling them that this is a sex worker and this is what they do.'

Doctor working with sex workers.

"Cultural awareness is critical for undergraduates and starting to chip away at the challenging of the stereotypes and discrimination and what baggage that woman is bringing with her."
Specialist midwife working with Gypsies and Travellers.

It was recognised that in many pre-registration courses the curriculum is already overloaded and rather than adding to the curriculum the education providers could consider ways of integrating Inclusion Health into the existing curriculum possibly through *'problem based learning scenarios or using the student group to share experiences with fellow students'*.

'Homelessness we sort of covered it in emergency medicine which included social study modules. This was in the 2nd and 3rd year of medical school where you do health psychology and sociology modules.'

Doctor working with sex workers.

The staff noted that it would be difficult to begin to discuss the detail of each of the different groups and their specific needs at an undergraduate level. It was felt that these topics were often very low on the list of priorities as part of the curriculum. However, respondents were clear that at the point of registration students should be able to demonstrate non-discriminatory, non-judgemental practice.

4.5.3.2 Inclusion Health learning outcomes for healthcare specialists working with vulnerable groups

There are contrasting views between the respondents about Inclusion Health learning outcomes for healthcare specialists working with vulnerable groups. On the one hand, they think it is very important that staff who are working with vulnerable groups fully understand their cultural backgrounds and their different identities. On the other hand, there is the view that this knowledge and skill should have been developed during pre-registration study and that for specialist practitioners they should be further developing these skills.

One dietitian reported that there was nothing in the Trust induction regarding these groups even though this Trust supports vulnerable groups. However, an equality and diversity manager from an organisation that supports Gypsies and Travellers noted that *'in the corporate induction sessions we talk about health inequalities and have a number of students, including doctors on placement, who know nothing about these groups'*.

It was pointed out that many clients from vulnerable groups are complex cases and that the specialist practitioner should know that they can sometimes be chaotic in their behaviour and that some are at risk of self-harm because of the drug and alcohol abuse.

One of the strong recommendations about learning outcomes for qualified practitioners working with vulnerable groups was about enabling healthcare practitioners to develop the skills of asking very pertinent questions to ensure they gain the appropriate knowledge of who the patient is and the care they need. A specialist midwife explained that health professionals of the future need to have the confidence to ask questions covering issues such as the client's home environment and their views on immunisation. One doctor explained that it is *'difficult to know which questions to ask and why you are asking them'*.

Repeatedly the staff mentioned the need for specialist practitioners to reflect on their own behaviour, body language and approach and how they themselves would wish to be treated. Health professionals often expect clients to take risks. However, it was noted by one respondent that *'often professionals won't take a risk on a client'*.

“In the past, having suffered from depression, doctors would prescribe anti-depressants straight away; however they could suggest exercise and lifestyle advice instead. It was good when exercise etc. was advised as this shows that they are thinking outside of the box rather than medicating people all the time.” Health trainer, working with ex-offenders and the homeless.

The view from service users about Inclusion Health learning outcomes is that textbook answers are pointless and that where possible staff working with these socially excluded communities should be required to demonstrate that they have engaged directly with a representative sample, as one service user explained *‘having a lived experience makes all the difference’*. A physiotherapist agreed with this view and explained that in everyday work they find it very difficult, in a general caseload, to identify the different communities, for example which people are homeless and who are Gypsies and Travellers.

4.5.4 Development of knowledge and skills to work with vulnerable groups

Many of the comments made by the members of the focus groups and those who took part in the telephone interviews suggested topics for inclusion in the curriculum and how this development could or should be enabled. The value of training sessions without being tokenistic, particularly in the voluntary sector, is fully recognised.

4.5.4.1 Suggested topics for development

A comprehensive list of topics suggested by the participants included those that are grouped around three themes: the development of greater knowledge about the communities that the vulnerable live in; those that are non-clinical skills based, and those that are specifically about enhancing clinical skills. These suggestions were made with a view to helping the practitioners to better manage the clinical conditions and non-clinical problems that vulnerable groups present with.

The communities in which vulnerable people live

- Knowledge about the communities as a whole.
- The difference between migrants and refugees and the latest rules and regulations about asylum seekers.
- Supporting vulnerable groups to understand their rights, as they may not be aware.
- Language barriers of some of the communities and the subsequent interpreter needs.
- The different cultural barrier e.g. for those from vulnerable groups they may not understand about the partnership between the healthcare professional and the patient.
- Trafficking.

Non-clinical skills to support socially excluded groups

- Unpicking some of the attitudes and prejudices of healthcare professionals towards vulnerable groups.
- Flexible approaches to managing the diversity of these groups.
- Understanding the priorities of the client which may not be health related but rather that they may need to complete and be supported to complete a benefits form.
- Multi-agency working.

Enhancement of clinical skills to support socially excluded groups

- Tolerance, understanding and courtesy through basic communication skills when working with these groups.
- Equality and diversity cultural training.
- Substance misuse and the underlying causes.
- Mental health issues including social stigma.
- Domestic violence and safeguarding.
- Counselling and advocacy skills.
- Enhanced listening skills.
- Children's health issues especially immunisation status.
- Diagnosis and management of specific clinical conditions that are most prevalent across each of the different socially excluded groups.

It was suggested that an understanding of the recovery package¹¹⁶ would help healthcare staff to support vulnerable groups as illustrated by one participant 'all the teams that I have worked with have no idea what recovery means'. The package includes identifying what empathy, congruence and the core conditions are for those with mental health conditions. This package has helped professionals identify the differences between the medical and the social model and understanding that when looking at recovery it is about normalising the situation and life. This was illustrated in comments by a social worker as shown below.

"Staff sometimes do not understand how hard it is for people taking these drugs because as they are prescribed there is a view that they are perfectly legitimate, and they are perfectly safe and of course they are not. The same applies for the over the counter medication. We all read the label and think ok I will be fine.

Clients who do have problems can be very loath to come forward to say for example I am addicted to cough medicine. It is a real problem to those who are addicted. There needs to be more understanding." Social worker who works with sex workers.

4.5.4.2 Delivering development opportunities

Whenever training sessions, about working with vulnerable groups, take place, these are seen as valuable. However, often staff reported having received very limited training and topics such as health inequalities were only covered in wider cultural awareness courses.

What was less evident from the case study sites is how often the training should take place and what it should look like. One senior manager, of a voluntary organisation, pointed out that *'you can't just have a brief mention of these communities'*. Many of the participants suggested that basic awareness training followed by specialist topics being taught as appropriate to different staff groups was a good model. Another suggestion included utilising the human rights framework as a framework for staff development.

The general view was that topics such as equality and diversity cultural training should be delivered on a rolling programme with regular update, rather than the model where one member of staff attends a day's training and is then expected to cascade the information to their colleagues, as this approach doesn't usually work.

One of the key challenges facing those who deliver education and training programmes is the lack of funding. Respondents reported that funding to support formal training, for example, to pre-registration social work students, was no longer available. Unless the training is made mandatory, funding is unlikely to be forthcoming. A possible solution to the lack of funding available is illustrated below.

"If the HEI sector chose to they could fund this development. If one of the recommendations is that this type of education and training should be mandated as an education standard that everybody in training should have a core knowledge for whichever vulnerable group you are working with there would be funding to support this part of the syllabus?." Social worker

It was highlighted that both third sector organisations and specialist teams working predominantly with vulnerable groups play a significant part in supporting and developing healthcare professionals in the local area where they are located and/or nationally. The specialist teams were generally asked to provide training and development at ad hoc sessions to healthcare professionals including doctors, nurses, occupational therapists and social workers in some of the universities. However, this was not seen as formalised. Some of the staff from the voluntary organisations explained that their past experience makes them very good trainers and they know what knowledge and skills healthcare professionals need to support socially excluded groups. One counsellor from a third sector organisation explained that they have developed a toolbox for anybody working with mental health training and part of this toolbox includes *'delivering training on drug and alcohol abuse'*.

Training sessions must be delivered by staff who have in-depth understanding about vulnerable groups. Many of the specialist clinicians recounted that they have delivered some training sessions to uni-professional groups and observed that social workers are more engaged in this topic than other professional groups, some of whom are clearly not engaged and not sure what it has to do with them.

The participants discussed the value of online learning and it was suggested that *'any e-learning package should be supported by someone qualified to help unpick the issues and give participants room to explore the issues'*.

A manager of a charity who was working to support an Ambulance Trust observed that *'equalities training can do more harm than good, as without someone being with them and guiding them when*

watching the video and exploring and unpicking some of the prejudices it becomes just about ticking a box'. Similarly staff commented on the value of guides and written information.

"I think quite often that the 'guides' and the 'how to' can be quite obstructive. I certainly wouldn't ask for a 'what to say' and 'what not to say book' as this pushes people down a certain road." Equality and diversity manager who works with Gypsies and Travellers.

However, there was a sense that innovative ways of gaining knowledge about these groups without staff having to attend face to face training days was important to consider. For example NHS Health Glasgow, in partnership with National Education Scotland, are working on a set presentation which will be a training resource for NHS staff who work in local authorities. A senior manager from a voluntary organisation suggested having *'an interactive event followed by a web page with e-modules as the important message to get out is that this is everyone's business'*.

'Could it be the case that every health and social care professional on their desk top did 20 minutes training would that be enough?. It is like driving a wedge, would this be a starting point?'

CEO of a voluntary organisation

An example was given where family members from the community go into the university and speak to social work students about their experiences of accessing services. It was noted that the students really enjoy this and it is a very popular session. However, not all programmes are well received. One voluntary organisation that supports sex workers runs training programmes for the local acute trust emergency gynaecology team *'and there is often a bit of a 'funny' attitude by the students but we won them over by giving them case studies to consider'*.

4.5.4.3 Student placements

Although the participants recognised that practical experience alongside theory is very beneficial for the learner, the opportunities for students to gain good practice experience with socially excluded groups was reported to be very limited and in some cases not available. A clinical psychologist explained that *'I have completed a psychology degree and you would think that you would get some kind of work experience. There was none over the 3 years of the course'*.

Sometimes practical experience is gained purely by chance as shown below.

"I was on a 4 year pre-registration programme in social work. We had 3 placements during the course. I came to this charity in the 4th year, it was my final placement. The placement was randomly allocated and there was no guarantee that social work students would get clinical experience with vulnerable groups. We could specify an interest in this topic but the university allocated us to a 16 week placement. It is very important to have these placements as it gives you an indication of the people you will be working with. Nobody else from my year came here. It is difficult for the university to prepare you for this if you have never been exposed to it. More placements rather than fewer would be the ideal." Social worker working with sex workers

Staff at the third sector case study sites gave examples of medical students and social work students on placements within some of their organisation for various lengths of time. Some of the students only spent a few hours and others spent a number of weeks. For example, working with Gypsies and Travellers or supporting sex workers. A GP practice manager, of a practice that sees many patients from socially excluded groups, reported that they had agreed to give some medical students a placement and this had resulted in four groups of 10 third year medical students spending just 2 hours with them. They went on to explain that it is difficult to know how valuable this type of experience is. A very experienced health trainer shared this concern and noted that *‘student nurses spent time with them for practice experience and quite often they were put doing the administrative tasks rather than getting hands on experience’*.

Some of the participants recounted that there had been some very good students and they had really relished the opportunities, however, there were others who didn't appear to value the clinical experience. There was an expressed concern that a core skill set that enabled healthcare professionals to work with these vulnerable groups was not valued by either the university sector or the students. For example it was reported that a student had queried, *‘am I going to get my competencies signed off doing this?’*

‘I had to volunteer to know what I knew and through past experiences. If I hadn't done the volunteering I don't think I would be here today.’

Counsellor

There was also a view that confidence was greater amongst mature students on placement in contrast to those entering an undergraduate programme directly from school. It was also suggested that one way to gain a fuller understanding about the healthcare needs of vulnerable groups would be for students to volunteer to work in the third sector organisations. A counsellor, from a voluntary organisation that supports the people who are homeless, explained that they had volunteered during their training otherwise they wouldn't have been able to work with this vulnerable group.

4.5.5 Challenges and difficulties encountered by healthcare professionals working with vulnerable groups

Throughout this chapter there are references to challenges and difficulties that healthcare professionals face working with vulnerable groups. This section brings together some of the key challenges and difficulties that the study participants in the case study sites highlighted.

One key challenge for healthcare professionals is fear either of saying or doing the wrong thing. The participants explained that they are concerned of being seen to be racist or using a phrase that can or cannot be used in the community. As one GP explained in some communities *‘the word “mental” is not used so what are we supposed to say?’*

Some of the participants recounted that they are sometimes frightened by members of the different communities and their animals as shown in box 22.

Box 22 Examples of frightening situations that healthcare professionals may encounter when visiting Gypsy Traveller communities

'I remember myself when I went on site that I was really terrified because a couple of children picked up stones and then mum came out and she said "It's alright, she's the nice lady", and then I relaxed'.

Health visitor working with Gypsies and Travellers.

'Staff are sometimes frightened of dog bites. '

CEO of a third sector organisation that supports Gypsies and Travellers.

Sometimes this fear is justified and organisations have to minimise these risks and so the healthcare practitioner may not be able to go close to a client. On other occasions, it is about perceived fear as highlighted by a specialist midwife working with Gypsies and Travellers. This midwife commented on the fear experienced by many healthcare practitioners: *'Community midwives would make a referral to my team as soon as a woman approaches them. I think that is around fear'.*

Another challenge is about understanding the different communities and what is acceptable to them, in order to be able to develop a treatment plan and provide the support they need. A CEO of a third sector organisation that supports Gypsies and Travellers gave an example of the type of problems that healthcare professionals face: *'A health professional had been in a trailer and washed their hands in the wrong bowl and then there is the feeling of health professionals not being able to get anything right through a lack of knowledge and understanding'.*

A major challenge for the staff is the time constraints in traditional clinic settings which do not allow for the flexibility required when working with these groups. As one nurse who provides healthcare for sex workers explained the staff in the clinic *'want to make the client fit the health service rather than have a service to fit the client'.* The nurse went on to clarify that *'because of the nature of the work that sex workers do they often cannot make an appointment during 9-5. As a consequence they can be extremely hard to engage with'.* Often when the service user does turn up for an appointment they are late, and that then has an impact on the rest of the clinic timings. Lack of time to engage with patients from socially excluded groups is also a significant challenge for doctors working in the community. One doctor explained about the tension between seeing one of these patients for as long as it takes results in limiting the number of patients that can be seen in one session.

Staff repeatedly commented on the difficulties that they experienced as a result of attitudes of some of their colleagues towards these vulnerable communities as one health visitor noted *'nothing will really change until we can target the attitudes of healthcare practitioners such as those of the GPs'.* Nonetheless, there are many staff who work to support vulnerable groups who will do everything possible to help them. As a specialist midwife who works with the Gypsy and Traveller community explained, *'there are community midwives who love looking after Travellers and will hold onto them and be very flexible in how they approach them'.*

In contrast when staff leave, who really enjoy working with vulnerable groups and have made a significant impact on the care of that community, the relationship with that community may falter. The healthcare staff who are left behind then have to start from the beginning again to build up the relationship once more.

Language was often seen as a barrier to working with the communities with examples given of no written information in the patient's own language. A doctor advised that very often when they see vulnerable migrants there will be an interpreter on the telephone. Consequently, although they may have a great deal to explain to the patient, they are anxious not to overload them with too much information. A GP practice manager gave a very good example of a structural barrier such as literacy. They reported that a receptionist sent an Irish Traveller away with a form. They then went on to explain the dilemma for the receptionist, *'do you say to someone "Are you OK with filling this form in?" when there is a big queue of people. Are you going to say this to everybody or just to the people that you think might be in need of some help?'*

'There is a serious lack of written information in the patient's own language and a significant gap between information needed and translated information available'.

Physiotherapist working with Roma, Somali and Asian populations

The participants reported other challenges such as the receptionists acting as a gate keeper to the service. For some potential service users this is a massive barrier. As one counsellor explained even parents calling on behalf of their children to change the appointment may experience a negative attitude from the receptionist.

Some organisations do not think about the effect of the environment on the client's perception of the care they are going to receive. One health trainer pointed out that in some centres *'there is a massive desk, a comfortable chair and a "rubbish chair", this setting does not encourage a vulnerable person to engage in the consultation'*.

4.5.6 Reluctance and lack of confidence of healthcare professionals to care for those from vulnerable groups

Staff reported a lack of interest in these groups and a lack of time to spend with these patients as reasons why some GPs were reluctant to see patients from socially excluded groups. Accident and

'Do they (health professionals) need to stop for a minute and think that this person is disruptive and challenging for a reason? It doesn't happen.'

Health trainer working with ex-offenders and the homeless

Emergency departments are often reluctant to see these patients because of their complex needs and challenging behaviour. Known patients from vulnerable groups can be very unpopular with the staff as they are often considered to be very demanding and difficult to deal with. The participants from an organisation that supports sex workers reported that *'A & E departments dislike the client group intensely because this client group are complex. Known drug users and sex workers are very unpopular across the hospital as they return a lot and are expensive'*. It is not only in A&E where it is difficult to engage the staff, GP practices can also be

are expensive'. It is not only in A&E where it is difficult to engage the staff, GP practices can also be

reluctant to care for vulnerable people. A GP practice manager reported that they had undertaken a training needs assessment in relation to asylum seekers and the interest was very low. Even in GP practices, where vulnerable people are registered, staff are very reluctant to do site visits.

Reluctance to care for patients from vulnerable groups is not solely limited to doctors and nurses as explained by a CEO of a voluntary organisation. They recounted a situation when an ambulance driver put a petition against a Gypsies and Travellers site on a Women's Institute coffee stall. This was challenged through the local ambulance service and the matter has been addressed and the staff are now going to the site.

Perceived reluctance to care for members of some communities may be nothing to do with professional reticence but more to do with organisational protocol. For example some women who have been sexually abused would rather see a paramedic than a police officer. However the guidelines for the paramedics are that they cannot examine the women until the police have seen them.

Sometimes the reluctance to help patients from vulnerable groups can be attributed to a lack of confidence by healthcare professionals as illustrated below.

"If there are 10 people asking you questions in that community because they are so desperate to have answers you are not going to want to go back. It can be overwhelming for professionals who do not have experience of working with this community." Health visitor working with Gypsies and Travellers

There was a mixed view from participants in the study as to the confidence of healthcare professionals to work with vulnerable groups. Some suggested that there is no difference in the confidence required to manage patients from vulnerable groups than there is to manage other patients. Others suggested that healthcare professionals are only confident in their sphere of practice with a way of working that is rigid and inflexible.

4.5.7 Continuity of care

The transient nature of some of the groups means that there may be only one opportunity for the service user to attend a clinic appointment. This situation was generally seen as an issue for staff working with the different communities as it meant continuity of care may be really difficult. A CEO of a voluntary organisation that works with Gypsies and Travellers explained that *'continuity of care may be a problem but also people think it is a problem when in fact it isn't'*.

Staff reported that in the NHS there were perceived barriers to continuity of care for roadside Travellers. For example, a pregnant woman might start a pregnancy in Wales, then move somewhere else and end up in Leeds. Gypsy and Traveller families move around and their health records go astray.

The need for persistence to review clients and their families is important to consider in the education and training of healthcare professionals. There was a view that if you didn't have someone working in the service who could fast track some of the procedures the individual and the community will have moved on before they are seen.

“We have a lady who has a positive HIV diagnosis and the whole team have pursued her on the phone for 18 months. Finally we got through to her the other day but it is about having the persistence, the desire and the time to keep doing that.” Project lead working with sex workers

Providing continuity of care can be very time consuming and the pressures on the service can result in reduced continuity of care as one health visitor explained, *‘their organisation had spent a whole week trying to find where a family had gone in order to provide them with support’*. Health visitors also report spending a great deal of time with the EU Roma community trying to organise their immunisations or help them register with their local GP. As one health visitor explained *‘the EU Roma are some of the most vulnerable families on my caseload’*.

4.5.8 Support networks for healthcare professionals working with vulnerable groups

The issue of support networks for healthcare professionals was discussed with the case study site participants. There was no feeling of isolation expressed where there were colleagues working together as a team to deliver a service. However, there were comments about specialist teams becoming marginalised, by other fellow health professionals, because of the nature of their work. A psychiatric nurse who works with Gypsies and Travellers reported that *‘There was a health visitor that I managed several years ago who said that she felt isolated and marginalised in the health visiting circles because of the nature of her work’*. A situation was reported where a healthcare professional who supports sex workers has been a lone worker for years. The project lead commented that *‘It is hard for her. She does outreach alone and you shouldn’t really do outreach alone. She is very isolated and has no colleagues to discuss things with’*.

The participants observed that networks are very important particularly where there is little or no supervision. The networks to support those working with Gypsies and Travellers are not as robust as those that support staff who work with people who are homeless. Nevertheless, one health visitor, who supports Gypsies and Travellers, reported having *‘brilliant support from the police, education, and the voluntary organisations’*. One senior manager in a voluntary organisation explained that *‘it is very important that there are networks of people who see Gypsies and Travellers so staff and volunteers feel supported. They are looking to set up a network in the north for those who work with Gypsies and Travellers.’*

‘Some teams may become exotic ghettos all on their own and like being specialists’

Chief Executive, voluntary organisation, working with Gypsies and Travellers.

The UK network for Sex Work projects¹¹⁷ was cited as a really important network for support and in particular for those teams who only sporadically work with sex workers. There is also a UK sex workers forum. A project lead for an organisation that supports sex workers reported that *‘the teams meet with a psychologist once a month as part of their clinical supervision to discuss and talk through specific cases’*.

There is very little support for those who work with EU Roma. The study only identified one health visitor in the whole of the UK who is an EU Roma specialist.

The staff recommended that, in order to ensure support for staff, managers of teams should be made fully aware of the caseloads of their clinical teams and the support available to them. A senior manager from a voluntary organisation concurred with this view and stated they are looking at health navigators co-located in the community and acute organisations. They went on to explain that the aim of these navigators is about being a mentor and a buddy to the patient, and a link between services and being a single point of contact.

4.5.9 Trust between healthcare professionals and vulnerable groups

It was clear from the discussions with healthcare professionals that developing trust between them and those from vulnerable groups, who use their services, is very important. Established trust enables healthcare professionals to begin to work effectively with the clients and to help and support them with their needs. It also helps to reduce the social distance between the healthcare professional and the vulnerable groups.

'I didn't used to trust what the doctors were saying about my mental health. I do trust these people now with my life. They made it a lot easier for me to trust them. It is not everything shut at 5pm and doors closed. They are there to help.'

Service user

The staff commented that building up trust between the professional and the client may take time. A counsellor who works with ex-offenders and the homeless asked an important question: *'How can you trust someone when you have only seen them for 10 minutes once a week or once a fortnight?'* Staff advised that for service users who attend the service regularly it makes it so much easier to build up trust.

Staff explained that it is important to take the time required to build trust. A GP practice manager explained *'it takes ages to build those trusting relationships so have to go at that person's pace.'* It can take a very long time for some vulnerable communities such as EU Roma to trust healthcare professionals as illustrated below.

"We need some specialist professionals including health visitors as it takes the EU Roma a very long time to trust you with all the discrimination issues. It would probably take around 6 months for them to trust you. Once you have the trust you can really start to work with them and do something. It is about being empathetic and listening. It is also about helping them with the other issues before you start to talk about the health issues." Health visitor working with the EU Roma community.

It can be very difficult to build trust between healthcare professionals and some vulnerable migrant communities. An example is service users from Afghanistan, where unless there is trust between the healthcare professional and the man, care will not be enabled for the women and children.

Confidentiality is crucial for trust to be established. A breakdown in confidentiality results in lack of trust. Trust is difficult to achieve when there is a perceived judgemental approach by healthcare professionals. Respect for healthcare professionals by those who belong to vulnerable communities is central to building trust as explained by a member of a Gypsy and Traveller community in the quote below.

“They think someone is going to do something to them if someone does come and they are so on edge that they don’t get their job done. However, if you go in relaxed you get the job done and pick up on other issues and then build the trust. Your approach towards someone fuels their behaviour towards you. This will help build relationships and it may require 2-3 visits before they will tell you what the issues are.” Community member from the Gypsy and Traveller community

Establishing trust with sex workers can be particularly difficult, as it is a very hard for them to tell a stranger what they are doing. It is such a secret world. Society is generally very judgemental and the reason they do not trust the staff is that they have had a bad experience, particularly those who are immigrants from countries like Russia. A project lead for an organisation that supports sex workers reported that *‘sex workers from Russia have had a very negative experience of healthcare professionals where they are judged harshly and confidentiality doesn’t exist. Consequently they may not trust us initially’*.

In many countries health and care systems are directed through the Home Office. For vulnerable migrants this is a concern and when healthcare professionals ask them questions relating to payment of the service the service user assumes the questions are related to immigration. One nurse observed that *‘most often the women think that the questions are around immigration status. What we try to get through to them is ‘don’t panic, immigration will not be informed, nobody is coming’*. The concern for the sex workers is that they will be asked to show their passports and papers and half of them do not have these papers so they panic. An interviewee from a charity that supports sex workers explained *‘we need to get the message across to them before a crisis happens’*.

Building trust with vulnerable communities will enable ongoing and continuity of care. As a policy officer explained *‘if you build trust with Gypsies and Travellers they are much more likely to attend GP surgeries more frequently’*. This was a recurring theme from the participants who appreciate that trust is built by the service user having a professional that they recognise care for them. Where possible healthcare professionals will try to identify a champion who has established trust with a community and ask that individual to be the key contact.

4.6 Summary of the main findings

In this chapter all the project findings have been gathered together and arranged by data source: review of the health and care professional, statutory and regulatory bodies' guidance on Inclusion Health: four online surveys to education providers (non-medical healthcare education providers, medical schools, dental schools and schools of pharmacy); an online survey to members of the Queen's Nursing Institute Homeless Health Practitioner Network, and case study sites focus groups and telephone interviews.

In this section the main findings from this large study are summarised. Synopses of the key results that are detailed in the earlier sections of this chapter are set out and the significant and recurring messages that are discussed in more detail in chapter 6 are outlined.

4.6.1 Professional, statutory and regulatory bodies' guidance on Inclusion Health

The evidence from this review is that Inclusion Health is an area that is generally underdeveloped by healthcare regulatory and professional bodies. The approach to Inclusion Health by the eight regulatory bodies reviewed is very varied. The Nursing and Midwifery Council standards of competence provide the most comprehensive guidance about Inclusion Health. It also charges all its registrants to practise in a manner that supports social inclusion and acknowledges diversity. Nurses and Midwives are required, where necessary, to challenge inequality, discrimination and exclusion from access to care.

The standards or learning outcomes as part of the requirements for practitioners to be eligible for professional registration with the General Dental Council, the General Medical Council, and the General Osteopathic Council, also make reference to social determinants and or health inequalities.

There is no reference to Inclusion Health in the Health and Care Professions Council's standards for education and training. Although there is no specific reference to Inclusion Health in this Council's standards of conduct, performance and ethics there is reference in these documents to social status, culture and vulnerable adults. This Council also issues different standards of proficiency for each of the 16 professions that it regulates. The standard of proficiency for social workers is the most detailed in terms of Inclusion Health although all the other standards of proficiency make some reference to this subject.

There is no mention of Inclusion Health within the information reviewed for the remaining three regulatory bodies.

The guidance produced by 16 of the 37 different professional bodies or affiliated organisations that were reviewed, make specific reference to incorporating Inclusion Health in the curricula. The most noteworthy guidelines have been produced by the Royal College of General Practitioners. It has developed a core curriculum for health inequalities competencies and curriculum statements, which make clear recommendations with regards to Inclusion Health. Online resources and learning materials are also available and these can be accessed by any healthcare professional. Other professional bodies that have produced clear guidelines are: the Royal College of Nursing, which also offers support through its online social inclusion resource, and the British Association of Social Workers and the College of Social Work, which make extensive reference to programmes being

required to cover all aspects of Inclusion Health. There is reference to health inequalities in the recent, jointly sponsored, review of medical education and training which supports the recommendation by Medsin that medical students could helpfully offer greater support to vulnerable groups.

4.6.2 Education providers' commitment to Inclusion Health

An extensive range of pre-registration courses are provided by the responding organisations. In total they offer 28 different pre-qualifying courses ranging from Foundation Degrees in Health and Social Care for the support worker, pre-registration nursing, midwifery, social work and AHP courses, Bachelor of Medicine and Bachelor of Surgery, BSc Dental Surgery, to Master's degree in Pharmacy.

The highest percentage of pre-registration education and training programmes offered by the healthcare education providers is nursing, followed by midwifery, social work and occupational therapy. 32% of these HEIs offer a foundation degree in health and social care for support workers.

85% of the education providers that completed the surveys reported they run some type of post-qualifying/post-graduate course. The most important, in the context of this study is the Specialist Community Nursing programme which is provided by 32 (36%) of these organisations. This is because the highest percentage of practitioners who work with vulnerable groups are SCNs.

All the respondents were asked to provide information about whether their institution teaches and assesses their pre-registration students and trainee support workers about two key aspects of Inclusion Health:

- Health inequalities
- Health risks to vulnerable groups and their healthcare needs

Health inequalities

The respondent ranked (in their opinion) how well their organisation teaches and assesses pre-registration/undergraduate students about six key aspects of health inequalities. The majority of medical schools, dental schools and schools of pharmacy reported that as part of their undergraduate/pre-registration programmes they **teach** the six aspects of health inequalities. All the responding healthcare education providers were clear that they teach all six aspects on the undergraduate social work programmes and the four fields of nursing, however, they were less clear about the rest of the provision. These topics are also taught on 60% of the Specialist Community Nursing programmes.

However, the extent to which the education providers **assess** undergraduate/pre-registration students about health inequalities varies. The majority of healthcare education providers were positive about the fact that their organisation assesses health inequalities as part of the undergraduate/pre-registration programmes, although more than 10 percent of the respondents were unclear which aspects they assessed. The medical schools reported assessing all aspects except 'how to tackle health inequalities'. The schools of pharmacy and the dental schools advised that they assess some aspects but the respondents were undecided about which of the six aspects they did assess. The view of those that commented on whether health inequalities are assessed as part of the Specialist Community Nursing course was mixed. The responses ranged from 53% to 38% who strongly agreed that they assess the

‘social and economic determinants of health’ and ‘social determinants are distributed across society’ respectively.

The preferred methods of assessing pre-registration students about health inequalities are written assignments or time constrained examination. Many innovative approaches to teaching and assessing are used by the education providers such as narratives, actors and outreach projects.

Across the healthcare education sector there is an extensive range of undergraduate/pre-registration modules with entire learning outcomes focussed on health inequalities. The highest percentage is the public health based modules. The only other group to comment on modules with entire learning outcomes based on health inequalities was the medical schools, some of which offer the modules as options. The health visiting and school nursing programmes have a consistently greater focus, than other Specialist Community Nursing programmes, on health inclusion learning outcomes for the five vulnerable groups. This is unsurprising as the NMC registered title of the qualifications obtained by Health Visitors and School Nurses is Specialist Community Public Health Nurse. These two groups have a long tradition of public health focus in their work.

Over half of the healthcare education providers run post-qualification/post-registration registration courses/modules, primarily public health, with learning outcomes that relate specifically to health inequalities. Half the dental schools advised that some of their taught postgraduate dental courses/modules have learning outcomes that relate specifically to health inequalities. Postgraduate dental students also have the opportunity to study dental modules on public health masters programmes. Fewer than half the medical schools reported that some of their taught postgraduate medical courses/modules have learning outcomes that relate specifically to health inequalities. Only one of these six medical schools currently provides modules that address the five groups. One quarter of the schools of pharmacy run taught postgraduate pharmacy courses with learning outcomes that relate specifically to health inequalities.

Health risks to vulnerable groups and their healthcare needs

The education providers gave comprehensive information about how they enable their students to learn about the health risks to each vulnerable group and their healthcare needs. For the healthcare education institutions these topics are mainly **taught** in the social work, adult nursing and mental health nursing pre-registration courses. With specific reference to Gypsies and Travellers and the Roma community these topics are also covered in midwifery and children’s nursing courses. From an AHP perspective the occupational therapy courses were the most frequently cited as addressing these groups particularly vulnerable migrants and people who are homeless.

Three medical schools reported that they teach health risks to all vulnerable groups and their healthcare needs. The remaining medical schools cover these topics for some groups and not for others. The decision as to which group to include is often influenced by the local population. Where there are known additional oral health risks to vulnerable groups they are covered in the taught dental undergraduate curricula. Dental students also learn about health risks and healthcare needs while on community placement. The schools of pharmacy teach the undergraduate students about the health risks to people who are homeless, sex workers and vulnerable migrants and their healthcare needs.

This study has found that the extent to which health risks to vulnerable groups and their healthcare needs are taught on the Specialist Community Nursing courses varies according to vulnerable groups and the specialist course. Between one third and one quarter of the education providers teach health visiting students and school nursing students about the health risks to people who are homeless,

Gypsies and Travellers, and vulnerable migrants and their healthcare needs. The number of institutions that teach health risks to the Roma community and their healthcare needs is relatively low. Only one organisation reported teaching health risks to four out of the five vulnerable groups on the mental health courses offered to Specialist Community Nurses. Two institutions reported teaching healthcare needs of people who are homeless on the mental health nursing course offered to Specialist Community Nurses. Although nobody reported that mental health risks to people who are homeless are taught to this group of practitioners. This is disappointing as this study has shown that this workforce would like to learn about mental health challenges for homeless people.

Dental schools primarily include the health risks and healthcare needs of people who are homeless in the post-graduate programmes. Half of the healthcare education providers reported that their post-qualification/post-registration courses/modules address the specific health risks to vulnerable groups. Those that do include health risks consider the homeless group most frequently and the Roma community least frequently. One third reported that their post-qualification/post-registration courses/modules address the specific healthcare needs of vulnerable groups. Similarly half of the schools of pharmacy reported that they address specific health risks to vulnerable groups and their healthcare needs in the postgraduate pharmacy modules. Only three medical schools reported that their postgraduate medical courses/modules address the specific health risks to vulnerable groups and two their healthcare needs. None of the education providers reported offering post-graduate programmes that cover the health risks to and healthcare needs of all five groups.

Far fewer education providers **assess** students about health risks and healthcare needs of vulnerable groups. The schools of pharmacy claimed they assess the undergraduate students about the health risks and the healthcare needs of all vulnerable groups. Three-quarters of the dental schools reported assessing the healthcare needs of the vulnerable groups and half assess the risks to them. Approximately one third of the healthcare education providers advised that pre-registration students are assessed about the health risks and healthcare needs of people who are homeless. Fewer providers assess the health risks and the healthcare needs of Gypsies and Travellers, and vulnerable migrants and only one fifth assess the health risks and the healthcare needs of sex workers and the Roma community. Less than 30% of the medical schools reported assessing undergraduate medical students about the health risks to vulnerable groups and only 14% about the healthcare needs of these groups.

34% of the respondents who provide Specialist Community Nursing (SCN) programmes assess the specific health risks to people who are homeless and their healthcare needs and slightly fewer the health risks to Gypsies and Travellers, and vulnerable migrants and their healthcare needs. Only 22 % reported assessing these students about the health risks to the Roma community and their healthcare needs.

Practice placement experience

The extent to which pre-registration students gain practice experience with vulnerable groups, differs between the professions. For pre-registration students on programmes offered by faculties of health much of the experience is opportunistic or student determined as part of an elective. The majority of medical students and dental students are given an opportunity to gain clinical experience with people who are homeless, but the opportunities these students get to gain practice experience with the other vulnerable groups is much less, particularly with the Roma community. Only one sixth of the schools of pharmacy reported that their pre-registration pharmacy students have the opportunity to experience practice placements with any of the five vulnerable groups.

However, a notable strength of the SCN courses is the practice placement experience with vulnerable groups. 78% of the organisations that provide these SCN courses endorse learning in practice and work with the service providers to enable these students to gain the required learning outcomes.

Many of the respondents stressed that health risks to the service users are a particular focus in practice with access to alternative placements including local housing departments, charities and voluntary sector organisations.

Enhancing inclusion health within the curricula

A close partnership between the organisations that support vulnerable groups and the education providers is central to the student learning. Nearly all the medical schools advised that they work with organisations with expertise in supporting people who are homeless, although only one medical school works with an organisation that supports the Roma community.

Just over half of the healthcare education providers reported that they work with organisations with expertise in vulnerable groups to enhance the curricula. Half of which work with organisations with expertise in the homeless and vulnerable migrants, and about a fifth of them work with organisations that have expertise in the other three vulnerable groups. Half the dental schools work with organisations with expertise in supporting vulnerable groups. However, only one school of pharmacy reported working with an organisation with expertise in vulnerable groups and that this organisation specialises in mental health issues and substance misuse within the homeless community.

These specialist organisations support the education providers with teaching. In return some of the medical students will support the organisations to care for their clients. Many healthcare education providers also get support for curriculum planning and participating in workshops. One school of pharmacy invites their partner organisation to write sections of the study guides. Through the partnerships with these specialist organisations the education providers may also find suitable practice placements for the students.

Very few healthcare education providers, and only one medical school, either employ or involve service users to help them with the curricula. None of the dental schools or schools of pharmacy reported employing service users. The extent to which carers, from these vulnerable groups, are involved in enhancing the curricula is negligible.

Academic expertise

The level of commitment of individual HEIs to this agenda is evidenced by the pool of academic staff that they employ with specialist expertise in vulnerable groups. Half of the responding healthcare education providers advised they employ academics with specialist knowledge and skills about vulnerable groups. One fifth reported that they have academics that cover all of the five vulnerable groups. The highest level of specialist knowledge amongst the academics is in people who are homeless with very little expertise about the Roma community. This is reflected in the responses from the medical schools, dentals schools and schools of pharmacy.

Some healthcare education providers are currently reviewing their curricula. They have commented that taking part in this survey has prompted them to consider how they might embed Inclusion Health more effectively, rather than relying on opportunistic placement learning and study scenarios where not all students will experience the opportunity. Quite a few respondents observed that their institution addresses health inclusion topics for people who are homeless very well but acknowledged that they could improve their curricula with regards to the other identified vulnerable groups.

Value of the questionnaire

Some of the academics who completed the questionnaires choose to comment on the structure of the survey and the value of engaging in this study. The comments about the structure related to the rather prescriptive nature of the survey and the fact that some of the questions related to specific vulnerable groups rather than a more generic approach, and that this approach did not allow institutions to demonstrate fully how they address the health issues of vulnerable groups. For example a respondent from a dental school helpfully pointed out that the questionnaire was based on the premise that the vulnerable groups had specific health risks and needs and while this may be true for general health it is less so for oral health.

However, a number of respondents recorded that being asked to complete a survey had raised the respondent's awareness about the fact that some of their faculties or schools are doing relatively little to ensure students achieve learning outcomes related to these vulnerable groups. For example a respondent from a medical school observed that this exercise has pointed out that there is room for improvement in the curricula, as while they address the social determinants they are doing very little specifically to target the vulnerable groups. Likewise a representative from a school of pharmacy observed that completing this survey has helped them to consider the inclusion of a broader range of patient groups to go into the school to work with their students.

4.6.3 Views of the members of the Homeless Practitioner Network

Section four of the main findings details the quantitative and qualitative responses of 106 members of the QNI Homeless Health Practitioner Network. 64 percent of the respondents gave their profession as either nurses or health visitors, they often chose to elaborate on their responses and they provided extremely insightful comments. Nearly all of them stated they work with doctors and the majority work with social workers and non-specialist adult nurses.

Two-thirds recounted that they gained their knowledge and skills through work experience with fewer than ten percent through studying a post-registration course. Many of them explained that in their role they provide not only healthcare services, but act in an advisory capacity as well, often referring the clients to other services.

Only 13 percent recalled covering health inequalities, health risks to these vulnerable groups or their healthcare needs in any pre or post qualifying programme. Only three people stated that they had been given the opportunity, while pre-registration students, to gain experience in practice placements with vulnerable adults. None of the respondents to the survey recollect being assessed about the healthcare needs of homeless people.

The topics the Network respondents would have liked to have studied as part of their pre-registration course included substance misuse, mental health issues, and the challenges of engaging and supporting those who do not, or do not know how to, connect with the service.

42 percent of the respondents advised they had undertaken an SCN course with over half of this group noting they had studied a health visiting programme. About a quarter advised that they had studied a Specialist Community Nursing programme during the past eight years. Those who could recall the content of the curriculum stated that it included the social and economic determinants of health; how to tackle health inequalities, and how and why social determinants affect health and wellbeing. Very

few reported being assessed about the healthcare needs of vulnerable groups. 27 percent of those who took the specialist course recounted having the opportunity to experience placements with vulnerable groups.

The Specialist Community Nurses suggested that, substance misuse (drugs and alcohol), addictions and related diseases, and the health needs of the homeless and their families should be included in the curriculum of their specialist courses.

31 percent of all the respondents to the survey reported that they had undertaken other post-registration/ post-qualifying courses and the majority had studied them during the past eight years. Most of the courses were short courses, covering topics such as the issues affecting vulnerable groups, drugs and alcohol misuse, and mental health problems. Less than half of this group recall being assessed about their understanding of the healthcare needs of vulnerable groups as part of the course. Just over a quarter of them stated that, as part of their post-registration course they had been given the opportunity to go on a practice placement with vulnerable groups, although there were no defined learning outcomes associated with the placement.

Two-thirds of all the Network respondents commented on the knowledge and skills of pre-registration students. Nearly all of them agreed that Inclusion Health should be part of the pre-registration curricula for healthcare students. In addition they agreed that the pre-registration courses should have appropriate learning outcomes that would enable them to work with vulnerable groups; a clinical placement with a vulnerable individual or group, and assessment of the health risks to these clients and their healthcare needs. These respondents commented similarly about the Specialist Community Nursing courses and suggested that the post-registration courses should include relevant information about vulnerable groups of people.

The Network members support the vulnerable groups to improve their personal health in a number of different ways including: assessment and referral, enabling access to healthcare services, specialist clinical services and support services, providing outreach services and health promotion.

The respondents commented on the essential knowledge, understanding and skills that healthcare professionals, working with vulnerable groups, should have or should develop to support these service users effectively. They suggested that, in order of importance, the knowledge and understanding component of the course should include: mental health issues, services and resources available to support this group, substance misuse, homelessness, healthcare needs and beliefs of vulnerable groups, relevant legislation, health inequalities and the social determinants of health, social exclusion and the importance of professional motivation to work with vulnerable groups. Similarly for skills development they recommended including: communication skills, non-judgemental and empathy skills, enhanced skills of caring and compassion, assessment skills, advocacy skills and skills associated with motivational interviewing.

One of the main problems that staff experience working with homeless people is the lack of engagement. This is either the lack of engagement by the clients themselves or other professionals' lack of true engagement with this vulnerable group's healthcare needs. The situation is exacerbated by the transient nature of the service user and the fact that health problems are not a priority until life threatening.

The education and training of healthcare professionals should always reflect the contemporary healthcare service model. The current changes in operationalisation of service delivery can make it really difficult for marginalised groups and those that support them. For example, accessing GP

services is often very difficult for these clients. It is particularly important that the different services work together otherwise the service user doesn't know who to contact. Many services that support this vulnerable group have limited funds and subsequently limited opening times. As a result the clients are left with no option but to use hospitals in what is termed frequent inappropriate attendances. Lack of suitable housing and difficulty accessing benefits make an already testing situation much more complicated.

The practitioners who work with homeless people often experience a number of related problems themselves: they may work in isolation; they may have little or no supervision; their managers may have no experience of working in this field and there are very few specialist courses available to them. Support that is available includes that provided by networks, guidance from specialist services, clinical supervision from specialists in the field and colleagues working in similar situations.

The majority of the respondents to this survey reported that they experience reluctance by healthcare organisations to care for these vulnerable groups because of a general lack of knowledge and understanding about this client group.

4.6.4 Findings from the case study sites

This section of the summary highlights the findings from the analysis of the qualitative data collected through focus groups and telephone interviews at 12 different case study sites across England, Scotland and Wales.

The consensus amongst the case study participants is that the level of knowledge and skills of many of the healthcare professionals who work with vulnerable groups should be increased. Part of the perceived problem is the lack of opportunity to have direct contact with socially excluded service users to enable them to develop these skills. Other factors proposed include the broad general pre-registration education and training provided for healthcare professionals with little opportunity to access specialist post-registration courses; the paucity of discussion about vulnerable groups in equality and diversity training; the lack of general life experience to give them the confidence to ask key questions, and the negative influence of the media.

The commonly held view is that greater efforts should be taken by the staff to enhance their cultural awareness and to gain a greater understanding as to how the different socially excluded communities view healthcare and the staff that provide it. Staff could also further develop their knowledge of the impact of the lifestyle of these vulnerable groups on their personal health. For many of these service users healthcare is not a priority even though their life expectancy is less.

All student healthcare practitioners, at the point of registration, should be able to demonstrate a core knowledge and understanding of Inclusion Health and health inequalities, particularly cultural awareness. The rationale being that all practitioners will work with patients from these groups at some stage during their career. Education providers are encouraged to find innovative ways to enable this learning to take place.

The complexity of the health and social care needs of the clients and their chaotic lifestyles present additional challenges for the specialist practitioners. The participants repeatedly emphasised that healthcare professionals working with vulnerable groups need a combination of both clinical and non-clinical knowledge and skills. Not only is it essential that they have the knowledge of the health risks

to vulnerable groups and their healthcare needs, their clients often expect and need them to know about current legislation and wider social issues such as finance, benefits and housing. In order for specialist practitioners to effectively support the patients it was suggested that staff should develop a greater understanding of multi-agency working and prejudices towards these groups, as well as being prepared to use flexible approaches to caring for their service users. The key clinical skills identified for further development included greater understanding of substance misuse, recovery packages, mental health issues, domestic violence, safeguarding and advocacy.

Third sector organisations and specialist teams working predominantly with vulnerable groups were identified as playing a major role in developing and supporting healthcare professionals, even though much of this education and training is based on the employee's past experience of working in this specialist area and is not formalised. Many expressed a concern about online learning and study guides that are not supported by specialist trainers with up to date knowledge and experience. There is a lack of funding to provide development programmes and not all service provider organisations support their staff to attend training sessions.

It was recognised that clinical placements in the communities provide a valuable learning opportunity for both pre-registration and post-registration students. However, there is a shortage of suitable placements and some education providers and students do not fully value this experience.

The participants in the focus groups and telephone interviews frequently made reference to the challenges and difficulties they encounter while working with this client group. For example: the fear of saying or doing the wrong thing, risking offending the patient or their community members and the potential risk for personal attack. Staff often struggle with what is acceptable behaviour in some of these communities and note how the clients do not necessarily comply with social norms, such as attending appointments on time. They also reported a number of problems within the service: lack of flexibility, negative attitudes of some staff towards members of vulnerable communities, and the shortage of suitable written information that is easily understood and available in a number of different languages. The healthcare system expects these service users to fit the traditional model rather than the service seeking new ways to reach out to the clients.

Healthcare professionals who support vulnerable service users, who are socially excluded, described a reluctance and lack of interest, shown by many of their colleagues, in the patients, often coupled with a lack of confidence. It was suggested that this may be because of limited knowledge, rigid protocols, or simply insufficient time to support patients, who by the very nature of their situation, take proportionately more time than many of the other service users.



The transient nature of many of these clients often makes continuity of their care extremely difficult.

The support for professionals working in this arena was reported to be very variable. At best the support is significant, for example, where the members of a specialist team are all working with those from a vulnerable group. However, some healthcare professionals, particularly the loan workers conveyed that they have little or no support especially those staff who care for minority socially excluded groups such as the Roma community. Some specialist healthcare networks have been developed and they often provide the only support to staff. Some of the networks are well established e.g. the network to support staff working with people who are homeless but they are less well established for those working with Gypsies and Travellers. In this situation staff reported getting support from others agencies such as the police and education sector.

Successful healthcare for vulnerable groups is dependent on mutual trust between those who provide the service and the service users. It is recognised that building trust will take time and that confidentiality and mutual respect are important for trust to be established. However, it is important that healthcare teams invest in establishing this mutual trust to ensure continuity of care for socially excluded clients.

CHAPTER 5

EDUCATION AND TRAINING INSTITUTIONS

5.0 Education and Training Institutions

This study is primarily about how the education and training, required to effectively prepare healthcare professionals to competently care for socially excluded patients, is matched to the current provision.

In this short chapter we comment on the problems faced by education and training institutions to address this issue and discuss the salient challenges they may encounter as they seek solutions. Training for staff to equip them with the knowledge and skills to care for the homeless, Gypsies and Travellers, Roma, sex workers and vulnerable migrants is principally provided by higher education institutions, the voluntary sector and charitable organisations.

Traditionally the healthcare needs of these vulnerable groups have not been a priority for the education sector. As the evidence for different approaches to health and care develops, the pre-registration curricula come under increasing pressure to include a greater range of learning outcomes.

So often the perceived solution to weaknesses in the healthcare sector is more and better quality education and training. In the context of this study the scenario translates into tackling health inequalities through better knowledge of the social determinants of health and greater skills to support the socially excluded service users. An example is the report published in 2013 by the Institute for Health Equity²² in which it was recommended that *'what works to tackle health inequities should be included as a mandatory, assessed element of undergraduate and postgraduate education'*.

The provision of education and training leading to pre-registration is the responsibility of the HEIs and approval to deliver these programmes is granted by the regulatory bodies. The evidence from this study is that Inclusion Health is an area that is generally underdeveloped by healthcare regulatory bodies. Unless the regulatory bodies specifically state that Inclusion Health is to be covered in the pre-registration curricula it will continue to be a marginalised topic for many education providers.

HEIs that deliver healthcare programmes seek accreditation from professional bodies that work to support and promote their members' education and practice. It is important for the education institutions that the professional bodies accredit their programmes. The professional bodies publicise lists of programmes that they have accredited which is a good marketing opportunity for the education providers. The majority of professional bodies produce curriculum guidance for programmes of study for students of the profession that they represent. Some professional bodies accredit pre-registration/undergraduate programmes as well as post-registration/post-graduate programmes, whereas others accredit only the post-registration/post-graduate programmes. Professional bodies often declare that they rigorously assess a validation approval event and that the programmes of study meet their quality standards, promote best practice and provide effective education outcomes¹¹⁸. The data from this study has shown that some professional bodies have produced excellent curriculum guidance about Inclusion Health for example the Royal College of General Practitioners and the Royal College of Nursing. However, the advice from the majority of professional bodies on this topic is limited. HEIs have significant competing curricula priorities and unless the regulatory bodies and the professional bodies enforce the inclusion of health inequities in the programmes of study we will continue to see uneven coverage of this important topic.

The lack of resources available to the higher education sector means these institutions have to make informed choices about which courses to offer and what expertise they need within their academic workforce. The indication from this study is that few HEIs invest in a critical mass of staff with expertise in Health Inclusion and they seek innovative ways to support the students to meet learning outcomes associated with caring for vulnerable groups. Nevertheless, in response to the education providers' surveys, the HEIs report a strong commitment to including Health Inequalities on pre-registration and specialist post-registration courses.

When asked how they enable students to learn about health risks to particular vulnerable groups and their healthcare needs the education providers explained that the approach to covering these topics varies across the provision. So for example, courses leading to practice as a professional who is deemed very likely to work closely with socially excluded patients has a greater focus on Inclusion Health than other courses. This results in a large percentage of the healthcare workforce having little or no knowledge about health inequalities or the skills to effectively care for those with chaotic lifestyles. This study has shown that students are most likely to be taught about the



health risks to people who are homeless and their healthcare needs. The extent to which the other four vulnerable groups are included in the curriculum content is determined by the institutions' commitment to health inequalities, the course and the local population.

Even where health inequalities are taught, assessment of this topic is limited, and this results in the relevant subjects and topics seeming less significant. Students' knowledge and skills are demonstrated through assessment. This study has shown that fewer education institutions assess the students' knowledge about health risks to vulnerable groups and their healthcare needs than reportedly teach this topic (chapter 4). The challenge for the education provider is how to balance assessing all the knowledge and skills required for clinical practice against the burden, to the student, of over assessment. We might have expected members of the Network to report being assessed on health inequalities. However, we have found that out of the 106 Homeless Health Practitioners who completed the survey only 7 (0.7%) recalled being assessed about health inequalities.

'Also students make a positive contribution in many of these organisations, sometimes through ongoing links which follow on from the teaching. For example, helping with auditing and service planning at the local healthy living centre, assisting with ESOL for health classes, health advocacy with vulnerable asylum seekers, helping at a homework club for asylum seeker children.'

Disability Disadvantage and Diversity lead,
Medical School

One approach to enable the students to gain a greater understanding of Inclusion Health is for the HEIs to work in close partnership with organisations that have expertise in caring for vulnerable patients. This approach requires a significant time commitment and a willingness from both the service providers and the education providers to establish this arrangement.

The majority of the education providers advised that they work with organisations that support people who are homeless and fewer reported that they support vulnerable migrants and sex workers. The minority recounted that they work in partnership with organisations that support Gypsies and Travellers, and Roma. These specialist organisations support the education

providers with teaching, curriculum planning and participating in workshops. Through the partnerships with these specialist organisations the education providers also find practice placements for the students.

This study has highlighted the value of students gaining clinical practice in institutes that work in this sector. Participants in the study have commented on the importance of the practice setting in enabling students to develop a clear understanding of the health challenges for vulnerable groups. Cultural competence among healthcare professionals has been emphasized as a key skill for healthcare professionals. It has been suggested that this development should start in the pre-registration/undergraduate programmes and be further developed at post-registration/postgraduate level. Ideally these skills should be developed in a practice setting.

The concerns for the education providers are, how the quality of the learning environment is monitored, and the value of the time the students spend in such a setting. The higher education sector is required to demonstrate to the regulatory bodies and the education commissioners how they ensure high quality clinical learning. This includes how the staff, in these settings, are supported to train the students. All education and training providers are expected to ensure that the *'learners have an excellent experience and that all elements of education and training are delivered in a safe environment for patients, staff and learners'*¹⁷. Sustaining robust partnerships between specialist healthcare providers and the education sector is resource intensive for both parties. The location of organisations with expertise in caring for vulnerable groups and their proximity to the education providers is very important in terms of time and travel costs.

Throughout the study reference has been made to the contribution that voluntary and charitable organisations make to the education and training of healthcare professionals working in this specialist field. Often staff, in the voluntary sector, work more closely with service users from socially excluded groups than the public or private healthcare sectors; consequently they have a greater understanding of the healthcare needs of vulnerable groups¹⁹. This sector has been identified, by the practitioners, as having a major role in supporting and developing the practitioners. Particularly in the

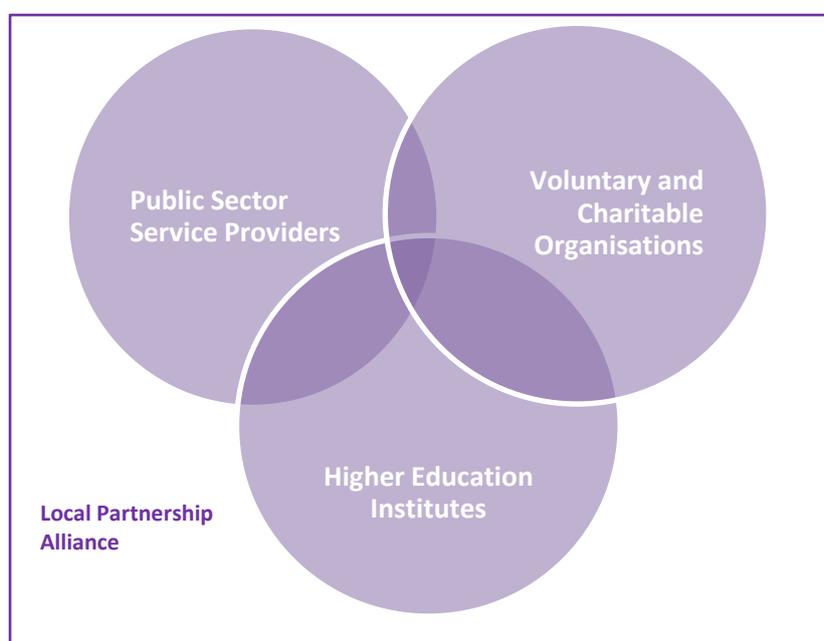
areas of: cultural awareness training, mental health training, and drug and alcohol addiction awareness.

A number of concerns have been raised about the over reliance on the voluntary sector to provide the education, training and development that should be formally provided by the education sector. For example:

- Lack of funding to support this aspect of the voluntary sectors' work.
- Much of the education and training provided by the voluntary sector is based on employees' past experience of working in the field.
- The education and training provided by the voluntary sector is not quality assured nor is it accredited.
- Online resources made available by the voluntary sector are not supported by specialist educators with up to date knowledge of the sector.

Although the voluntary sector has extensive knowledge about many issues that affect socially excluded communities they do not fully understand the operational policies and procedures of the public sector. This situation results in dissonance between the different agencies to the detriment of the care provided to the service user.

Unless there is a stated requirement for the HEIs to evidence that health inequalities are included in the curricula, or there is a local service need, this topic will continue to be a minority component of the majority of HEI courses.



An option to strengthen the learning opportunities about aspects of health inequalities, for students and staff, is for the key stakeholders to develop a Local Partnership Alliance, with a specific remit for education and training in Inclusion Health. The proposed formal tripartite partnership would be between the publicly funded service providers, the third sector providers and the education providers. Which aspect of Inclusion Health or which voluntary group they would

develop expertise in would depend on the needs of the local socially excluded communities.

Such an initiative would promote Centres of Excellence across the UK. The Local Partnership Alliances could share resources, minimise duplication and bid for increased funding to enable high quality online learning materials to be developed. They would also nurture the further development of local high quality practice learning environments.

CHAPTER 6

GENERAL DISCUSSION, CONCLUSIONS and RECOMMENDATIONS

6.0 General Discussion, Conclusions and Recommendations

6.1 Introduction

This study has prompted the education providers to reflect on the extent to which they embed Inclusion Health in their courses. It has also enabled practitioners to express their views about how well the education sector prepares them to care for vulnerable groups and supports them throughout their careers.

Before considering the findings of the study, it is important to consider the limitations of the study itself that are relevant to firstly the conclusions that are drawn, secondly the key messages from the study and thirdly the recommendations.

There was a series of limitations with the study design. For the data collected via the online surveys the conclusions need to be moderated by the potential sample size and the response rates to the questionnaires. The overall response rate to healthcare education providers' survey was good although within survey the response rate to some questions was higher than to others. The response rates to the surveys to the medical schools, the dental schools and the schools of pharmacy were acceptable. The data from these surveys has been included as the findings are of considerable interest and add value to the study. The response rate to the Queen's Nursing Institute Homeless Health Practitioner Network was low but as the number of members of the Network is high and as the data collected was largely qualitative this data set has been included. However, the response rate from the healthcare science education providers was unacceptably low, the data from this survey has not been included in the report. A few of the respondents to the surveys observed that the surveys were '*rather too prescriptive*'. Their view was that this approach did not allow the institutions to fully demonstrate how well they address aspects of Inclusion Health.

Only qualitative data was collected from the case study sites across Great Britain. The findings need to be qualified by the fact that although 12 sites engaged in the study, and therefore a large data set was produced, the spread of case study sites by country and by vulnerable group was not comprehensive. For example, there was no representative site for the homeless or vulnerable migrants in Scotland or sex workers in Wales. The extent to which the case study sites support more than one vulnerable community varies: six support just one community; four support two communities and the remaining two support three out of the five different vulnerable communities.

When considering the extent to which specific groups are supported by the case study sites in the sample the situation is as follows:

- Homeless people are supported by five of the case study sites across England (2) and Wales (3).
- Gypsies and Travellers are supported by six of the sites across all three countries (England 1, Scotland 1, and Wales 4).
- Roma are supported by three sites, one in each country.
- Sex workers are supported by two sites, one in England and one in Scotland.
- Vulnerable migrants are supported by three sites, two in England and one in Wales.

Other than the absence of data from Northern Ireland, these sites gave sufficient access to study participants to inform the outcomes of the project.

Within the limitations of this study the authors have summarised the UK wide policy context for education and training in relation to Inclusion Health. They have reviewed the existing evidence on the education and training of the healthcare workforce to prepare them to support these vulnerable communities. They have undertaken an extensive review of the professional, statutory and regulatory bodies' guidance on aspects of Inclusion Health and identified examples of best practice.

It is important to take care not to conclude that all the findings that apply to one group, such as people who are homeless, apply equally to the other communities. There is far greater evidence about the health risks and needs of the homeless communities than the other groups. Much of the qualitative data was sourced from interviews, focus groups and surveys and it is possible that such data may be skewed to present either the best or worst impression. However, the authors do not think this was the case and are reasonably confident that the participants provided a balanced representation of their knowledge and experience of their organisation's approach to Inclusion Health.

In this chapter the study findings are discussed, the conclusions are identified and the key recommendations are presented.

6.2 Commitment to education and training for Inclusion Health

6.2.1 Government policy

The study was commissioned and funded by the Department of Health, to look at the situation in England and to inform the English National Health Inclusion programme. Healthcare professionals are educated and trained in higher education institutions across the United Kingdom. Much of the UK wide healthcare workforce is mobile and during their career many professionals will work in more than one devolved nation. With this in mind the study considered the education and training about Inclusion Health across the devolved administrations and the findings may be of interest to organisations in Northern Ireland, Scotland and Wales.

From the review of the literature there is evidence, across the UK, that strategic developments have focussed on promoting better informed, better educated and better trained healthcare staff to respond appropriately to the needs of five vulnerable groups: people who are homeless, Gypsies and Travellers, Roma, sex workers and vulnerable migrants.

All four nations report the increasing demand on healthcare services by socially excluded groups. The devolved administrations have responded to this demand slightly differently. Their approach has been determined by national priorities and the percentage of the total population that belongs to one of these five vulnerable groups. Each nation has published guidelines to address improvements in health outcomes for local patterns of social exclusion. Many of these relate specifically to education and training of the healthcare workforce.

There are two organisations that inform English policy concerning education and training for Inclusion Health. One is the National Inclusion Health Board which works with the Government to promote Inclusion Health and the other is the Institute for Health Equity which is supported by the

Department of Health to increase health equality. Both these national organisations advocate for an increased focus on the social determinants of health at both pre and post-registration education and training of healthcare professionals. The National Inclusion Health Board has four work streams each with a specific objective but a shared overall aim of promoting the principles of Inclusion Health for all.

All four nations have produced specific guidelines concerning improved health outcomes for the homeless. The Scottish and Welsh Governments promote cultural competence and awareness and have published country specific policies and action plans around developing staff to support the healthcare needs of sex workers and vulnerable migrants. However, the Welsh Government leads the way in promoting healthcare for Gypsies and Travellers. The study found evidence to suggest that none of the government departments across the four nations promote safeguarding rights to protect the Roma community despite a Directive from the European Commission.

What has not been found, in the literature, is any evidence of government departments or national organisations setting out a plan of work to ensure that healthcare professionals have the appropriate knowledge and skills to care for vulnerable communities, we conclude this omission should be addressed in England at a national level.

Recommendation 1

1. The government departments of England and national organisations should set out a work programme to ensure that healthcare professionals have appropriate skills, attitudes and understanding of the health issues facing vulnerable groups.

6.2.2 Regulatory bodies' standards and guidance

The evidence from this study is that Inclusion Health is an area that is generally underdeveloped by the different healthcare regulatory bodies.

Standards published by eight of the nine healthcare regulatory bodies were scrutinised and only half of them make reference to social determinants or health inequalities and three make no reference to any aspect of Inclusion Health. The eighth, the Nursing and Midwifery Council, has published Standards of Competence that provide the most comprehensive guidance about Inclusion Health. This Council also charges all its registrants to practise in a manner that supports social inclusion and acknowledges diversity. Nurses and Midwives are required, where necessary, to challenge inequality, discrimination and exclusion from access to care.

The Health and Care Professions Council, which regulates 16 professions, includes one or more aspect of Inclusion Health in the profession specific Standards of Proficiency, the most detailed is for social workers in England.

It is very important that these regulatory bodies urgently review their standards of education and training, and the guidance, they publish for the education sector and the registrants about Inclusion Health. Without clear standards and guidance the regulatory bodies are not in a position to guarantee

that, where relevant, aspects of Inclusion Health will be taught and assessed as part of a course. This situation is unsatisfactory as without the regulatory steer the education providers are not mandated to include health inequalities as part of any curriculum.

Recommendation 2

Each of the regulatory bodies should make explicit in their standards of education and training the need to embed Inclusion Health in the undergraduate curriculum for all disciplines. Elements of the information from the Nursing and Midwifery Council, with regards to best practice for Inclusion Health, should be shared with the other regulatory bodies.

6.2.3 Professional bodies' guidelines

Guidelines, published by 37 professional bodies or affiliated organisations, were reviewed as part of this study. The extent to which these professional bodies direct their members and the education providers about aspects of Inclusion Health varies enormously. Fewer than half make specific reference to a particular aspect of Inclusion Health. This is very disappointing particularly in light of the paucity of regulatory standards in this area.

In the absence of regulation, the education providers and practitioners seek advice from the professional bodies. This study has highlighted the exemplary guidelines and resources, about Inclusion Health, that have been produced by the Royal College of General Practitioners, which are readily available to all education providers and health care practitioners. These include vision statements, curriculum guidelines and recent publications which highlight the increasing intolerance towards health inequalities.

The Royal College of Nursing is also to be commended for the support it offers, through its online social inclusion resource, to all nurses and healthcare assistants.

The study has highlighted that, as a core skill for all healthcare professionals, Inclusion Health merits a collaborative approach such as that taken by the Academy of Medical Royal Colleges.

Recommendation 3

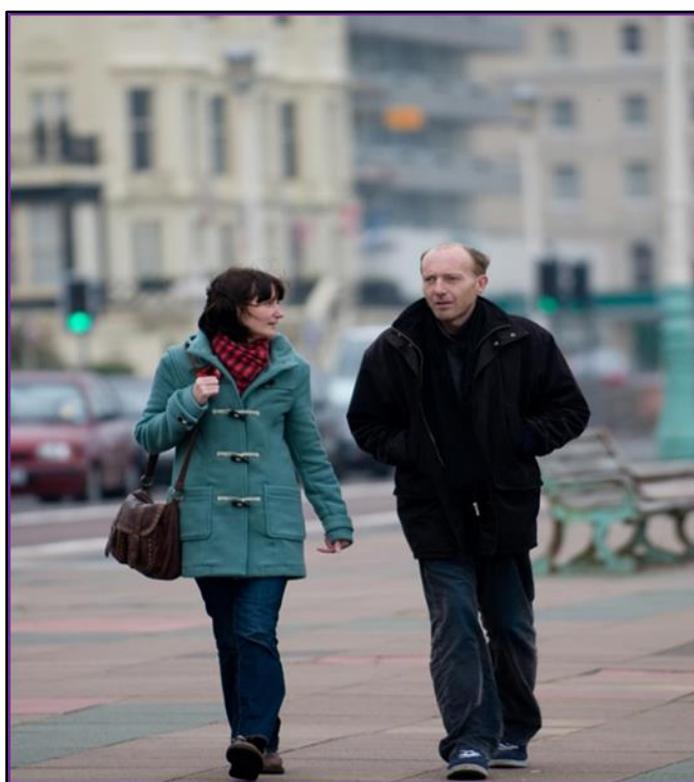
In collaboration with the regulatory bodies the healthcare professional bodies should review their documentation about Inclusion Health and the guidance they give their members about working with socially excluded groups. The professional bodies should encourage their members to use the excellent, mainly online, resources already available.

6.3 Education and training needs of the healthcare workforce that care for socially excluded groups

In this section the existing documentary evidence and the main study findings about the education and training needs of the staff who work with socially excluded communities is discussed. The evidence published by organisations, which employ staff to work with these groups, states that many healthcare practitioners lack the knowledge and skills to effectively support these service users. There is a particular concern about those who work in non-specialist settings, who may be influenced by the media or by negative attitudes demonstrated by their colleagues.

It is very disappointing to see so many references in the literature about the need to tackle the prevailing discriminatory attitude amongst some of the staff who work in this sector. Large organisations that support people who are homeless, for example St Mungo's and Homeless Link continue to entreat the education sector to develop anti-discriminatory approaches in the workforce and to understand the perceived power imbalance between the healthcare practitioner and the service users from socially excluded communities.

The majority of the literature sourced for this study discusses the education and training needs of staff who work with the homeless communities and those who live in insecure accommodation. However, much of these core needs are considered generalizable to staff who work with Gypsies and Travellers, Roma, sex workers and vulnerable migrants. For example education and training in human rights, equality and diversity and fostering a non-judgemental approach. A recurring theme in the literature is the need for staff to be culturally aware and sensitive to the needs of these service users.



In contrast the practitioners caring for these communities stressed the importance of specialist knowledge about the vulnerable groups that they are working with. Some of the respondents noted that the lack of specialist knowledge is a cause for concern.

This study consistently highlighted key topics that all healthcare practitioners working with vulnerable groups should know about, for example: mental health, substance misuse, domestic violence, safeguarding and advocacy, relevant acts and regulations and access to services to support them. References to these recommended subjects were found in the literature and their importance emphasised by the practitioners who contributed to the data. Many of these topics could be introduced during pre-

registration/undergraduate training and further developed at post-registration/postgraduate level.

Core subjects that were repeatedly mentioned, which arguably apply to all pre-registration healthcare courses, but have a particular application in this context are:

- Health inequalities and social determinants of health
- Social exclusion
- Health needs and beliefs of vulnerable groups.

A recurring theme, in the literature reviewed and the qualitative findings from the study, is the need to develop cultural competence within the qualified workforce. There are indications that government departments and professional bodies are starting to address this pressing need. Development of cultural competence would enhance the trust between staff and patients and support the staff to be confident when working in these communities and give them the self-assurance to ask pertinent questions of the patients. The clinicians reported view is that the post-registration curricula should enable the students to explore in greater depth the extent to which the different vulnerable groups access the services, the reasons behind their health and social care choice and the best approach to supporting socially excluded groups. They should also consider ways to ensure continuity of care. Some of the respondents highlighted enhanced skills development for qualified practitioners working with the socially excluded. They stressed the importance of enhanced communication skills: non-judgemental and empathy skills; enhanced skills for caring and compassion; assessment skills; advocacy skills, and skills associated with motivational interviewing.

For many of these service users their health is not a priority, a fact which sometimes eludes the practitioners. The complex needs of patients from these vulnerable communities and their chaotic lifestyles seldom trigger a differentiated response from the staff. The effect of this situation on the individuals often leads to significant health problems such as poor oral health, respiratory diseases, unmanaged diabetes and infections. Many staff seem unaware of the higher than average mortality rates for patients from socially excluded communities and the poor immunisation status of many of the children.

6.4 Education providers commitment to Inclusion Health

Much of this study has focussed on collecting data from healthcare education providers. This section builds on the specific discussion about the education and training institutes in chapters 4 and 5.

The data from the study contains information about the extent to which Inclusion Health is embedded in pre-registration/undergraduate courses; specialist courses e.g. Specialist Community Nursing and post-registration/postgraduate courses. It has been evidenced that there are stated intentions to improve the knowledge and skills of the staff and to harness the potential that a well-qualified and well-informed healthcare workforce brings to the care of these vulnerable groups. However, there is a sizeable gap between what the workforce needs to know, the skills they need to be able to demonstrate and the readily accessible high quality specialist education and training that will guarantee these achievements.

6.4.1 The curricula

The evidence from the study is that the Higher Education providers that responded to the surveys purport to teach all six key aspects of health inequalities on their pre-registration /undergraduate programmes:

1. Social and economic determinants.
2. Tackling health inequalities.
3. How and why social determinants affect health and wellbeing.
4. How social determinants affect morbidity and mortality.
5. How the effects of social determinants are distributed across society.
6. How and why different groups are more vulnerable and more likely to be excluded.

These health inequalities are core to understanding Inclusion Health and an essential component of any health and social care curriculum. The literature⁵⁸ provides three examples of different approaches to the addition of health inequalities to the curriculum: permeation across the whole curriculum; a focussed health module on the topic; interprofessional modules shared with other health professionals.

Unfortunately how well the students understand health inequalities and the essential role they play in the social determinants of health is less clear. The extent to which the HEI sector assesses the students' knowledge about this topic varies, as does the approach taken to ensure appropriate student learning outcomes. The education sector appears, from the evidence collected, to approach some of these core topics differently, often determined by the intended professional career of the students. The risk of this approach is that a large percentage of the clinical workforce is inadequately prepared to care for patients from socially excluded communities.

Health risks to socially excluded groups and the healthcare needs of these service users are considered by practitioners as important topics for inclusion in both pre-registration and post-registration curricula. The study revealed that health risks and healthcare needs are mainly taught on the social work, adult nursing and mental health nursing pre-registration courses. Although these topics are also covered in midwifery and children's nursing courses, in this case it is with specific reference to Gypsies and Travellers, and the Roma community. Each medical school reported covering health risks and healthcare needs, in relation to socially excluded groups, in the undergraduate medical curriculum, in different ways. Dental students have an opportunity to learn about oral health risks to vulnerable groups while on community placement.

Healthcare education providers, service providers and education commissioners should ensure that students and staff have the opportunity to develop the appropriate level of knowledge and skills to enable them to confidently and competently provide high quality care to patients from socially excluded communities.

Recommendation 4

All healthcare education providers should review their pre-registration/undergraduate curricula to ensure that Inclusion Health learning outcomes are demonstrated across all their programmes.

Nearly half of the Network respondents remembered being taught aspects of Inclusion Health as part of their Specialist Community Nursing (SCN) course. The health visiting and school nursing programmes have a consistently greater focus on Inclusion Health learning outcomes for the five vulnerable groups, than the other SCN courses.

Education Institutions are most likely to include Inclusion Health learning outcomes in the curriculum for the public health courses. These courses are normally offered to post-registration/ post-graduate students and primarily by faculties of health and social care. Only limited numbers of medical schools and dental schools post graduate courses/modules have learning outcomes that relate to health inequalities. However, the situation in the post-registration and post-graduate courses is generally more encouraging as the health risks and healthcare needs of vulnerable groups are more uniformly covered at this level of study. Except that none of the education providers reported offering post-graduate programmes that cover the health risks and healthcare needs of all five groups.

6.4.2 Demonstrating learning outcomes

A number of respondents recorded that some of their faculties or schools are doing relatively little to ensure students achieve learning outcomes related to these vulnerable groups. This is supported by the fact that the study team found much less evidence that education providers are assessing the students about health inequalities. This was either direct evidence from the education providers or indirect evidence from the practitioners who were asked to recall whether they had been assessed.

Far fewer education providers assess undergraduate students about health risks to vulnerable groups and their healthcare needs. Although schools of pharmacy claimed they assess the undergraduate students about this topic the other education providers were less positive. The data suggests that students are more likely to be assessed about Inclusion Health on specialist post-registration courses or post-graduate public health courses.

The practitioners advised that specialist post-registration courses should include learning outcomes focussed on Inclusion Health. They explained that students studying these courses should be required to demonstrate their knowledge of this topic as well as a detailed understanding of health risks to socially excluded groups and their healthcare needs. This can only be done through some form of assessment.

Nobody reported that mental health risks to people who are homeless were taught or assessed to members of the Network. This is disappointing as this study has shown that this workforce would like to learn about mental health challenges for homeless people.

Recommendation 5

Higher Education Institutions should ensure that healthcare education programmes are appropriately assessed in relation to aims and learning outcomes of the curriculum that relate specifically to Inclusion Health.

6.4.3 Expertise to support the learning

The medical schools have the best profile of academic staff with expertise to support medical students to learn about the Inclusion Health and the five vulnerable groups. Reassuringly these staff are involved in curriculum planning and teaching the students. Two thirds of them also assess students and are involved in research. However, this situation could be improved as only three reported employing staff with expertise in the Gypsy and Traveller community and one reported employing an academic member of staff with expertise in the Roma community.

Where the healthcare education provider employs specialist academics to support the students learning they preferentially employ staff with expertise in the homeless communities and vulnerable migrants. Only one quarter of these education institutions reported having staff who are knowledgeable about the Roma community. This situation may be an indicator of the level of commitment of the sector to promote Inclusion Health in the curricula, or the lack of resources available to employ academic staff with the appropriate expertise, or simply there are insufficient experienced practitioners with expertise in caring for Gypsies and Travellers, Roma or sex workers.

Employing or at least involving service users and carers to help deliver the curricula is considered to be best practice in education and training for healthcare professionals. Regrettably very few healthcare education providers and only one medical school reported inviting healthcare users from vulnerable groups to help them with the curricula. The extent to which carers to these vulnerable patients are involved in enhancing the curricula is negligible.

Recommendation 6

Higher Education Institutions need to urgently review their staffing arrangements to ensure that they have sufficient staff with the appropriate knowledge and skills to support the Inclusion Health agenda.

6.4.4 Partnership working to enhance Inclusion Health learning opportunities

Despite the fact that student healthcare professionals benefit enormously from practice learning opportunities it was disappointing to find how significantly different the practice experience is for students working with vulnerable groups. Currently much of the experience gained by professionals is through ‘learning on the job’ and work experience.

For some providers the practice learning is opportunistic but for others i.e. medical and dental students they are routinely given the opportunity to gain clinical experience with the homeless but not with other socially excluded groups, however only a small number of pharmacy students are given this chance. This statement was mirrored in the responses by the Network as only very few stated that they had been given the opportunity, while pre-registration students, to gain practice placement experience with vulnerable adults. This situation also concurs with the findings from the case study sites where staff cited overall that the vast majority of students would be unlikely to undertake a placement working with these vulnerable groups. If the education and training of the workforce is to be improved this situation needs to be addressed.

In contrast the education providers reported that a notable strength of the SCN courses is the practice placement experience with vulnerable groups, although, the literature search has underlined the fact that there is a shortage of specialist practitioners with expertise in working with vulnerable groups. Some organisations are looking at interim arrangements to fill the knowledge and skills of the workforce, by introducing new roles such as Homeless Health Practitioners and Care Navigators. This is encouraging as it indicates the clinical service will be able to offer more effective learning environments for a greater number of students. It is also very reassuring for the education sector that has to demonstrate to the regulators that students gain experience in high quality practice settings.

The education and training of healthcare professionals to work with vulnerable groups should always reflect the contemporary healthcare service model, particularly as the changes in service delivery can make it really difficult for marginalised groups and those that support them. It is essential that healthcare education providers work in partnership with organisations that have expertise in supporting socially excluded groups to enhance the curricula. The medical schools are particularly good at working with organisations that support the homeless but less so with organisations that support the other groups. The pattern from the responses is less positive for the other education institutions, particularly for pharmacy where only one school noted that it worked in partnership with an organisation and that institution supports the homeless.

A sound partnership between education providers and the third sector is essential for successful development of the healthcare workforce. The literature emphasises the fact that the third sector delivers specialist services and often provides excellent education and training for the public sector. These organisations normally have a greater understanding of the lifestyles and challenges experienced by those from socially excluded communities and consequently earn greater respect from the service users.

The findings from the study have reinforced this position. The participants at the case study sites repeatedly mentioned that the third sector has a major role in developing and supporting the healthcare professionals who work in this arena. This is an excellent opportunity for healthcare professionals. However, the support is localised and ad hoc depending on geographical location of services. Furthermore it does not enable demonstration of knowledge and skills nor necessarily address the essential education and training requirements. Consequently, there is a question mark over the standard of the courses provided as there is no evidence of any quality assurance processes in place. Closer partnership working between the education sector and the third sector could only enhance the quality of the learning and have the potential to develop more approved practice placements.

Recommendation 7

Higher Education Institutions must work even more closely, and strengthen their links, with a broad range of organisations that support socially excluded groups, particularly the voluntary sector, to enable a greater number of students to experience working alongside specialist practitioners, and socially excluded service users and their carers.

6.4.4 Access to specialist sources of information and guidance

Throughout this study we have found pockets of commendable resources that should be made readily available to those working in Inclusion Health either as educators or practitioners. For example the guidelines provided by some of the professional bodies should be made more easily accessible to the education sector rather than only available to their members. It is recognised that some professional bodies readily make available to all sectors their guidance and resources. However, this is not uniform across the sector.

The same could be argued for programmes of study that are provided by the education and training sector. The SCN courses, particularly the health visiting and school nursing courses, consistently cover Inclusion Health. However clinicians commented that accessing these courses can be difficult. Consequently some of the respondents to the survey reported that they have never had the opportunity to attend a specialist course.

Recommendation 8

Higher Education Institutions that offer specialist Inclusion Health courses should review how easy it is for the wider multi-professional community, as part of ongoing continuing professional development, to access these courses, and develop the appropriate level of knowledge and skills to confidently and competently provide high quality care to vulnerable groups.

6.5 Support for the healthcare workforce to effectively care for socially excluded patients

In this final section the key challenges that practitioners, who work with patients from the socially excluded groups: people who are homeless, Gypsies and Travellers, Roma, sex workers and vulnerable migrants, face are summarised. The support available to them and ways that the education sector could more successfully support them is also considered.

Throughout this study healthcare professionals have described the challenges and difficulties of working with vulnerable groups. The participants repeatedly emphasised that healthcare professionals working with vulnerable groups need a combination of both clinical and non-clinical knowledge and skills. In addition to having the knowledge and skills to provide healthcare for patients who live chaotic lives, and whose health is not a priority (section 6.3), their clients often expect and need them to know about wider social issues such as finance, benefits and housing. The participants in the study suggested that clinical staff would benefit from developing a greater understanding of multi-agency working and the prejudices towards these groups.

One of the biggest challenges for staff working in the NHS is how to sustain a flexible approach to caring for their clients while working in a rigid and inflexible system which is not usually responsive to their patients' social norms. The majority of the respondents to this survey reported that they experience reluctance by healthcare organisations to care for these clients because of a general lack of knowledge and understanding about these patients and their health beliefs.

The practitioners frequently made reference to the challenges and difficulties they regularly face. For example: they are concerned about saying or doing the wrong thing, or they are concerned that something they do may offend the patient or their community members. Some of them also expressed concern about their own personal safety because of the potential risk of personal attack. Staff often struggle with what is acceptable behaviour in some of these communities and how the clients do not necessarily comply with social norms, such as attending appointments on time.

Many of the participants in the study stated that successful healthcare outcomes for patients from vulnerable groups are dependent on mutual trust, between those who provide the service and those

who use the service. It is recognised that building trust will take time and that confidentiality and mutual respect are important for trust to be established. However, healthcare teams should invest in establishing this mutual trust, to ensure continuity of care for socially excluded clients, and to enable the clients to gain confidence in the clinical service and to learn about the help and care that it provides.

The practitioners working with vulnerable groups experience a number of related problems themselves. For example they may work in isolation; they may have little or no supervision; their managers may have no experience of working in this field and there are very few specialist courses available to them. Support that is available to help them includes networks where they can get support, and sometimes clinical supervision, from colleagues also working in the sector. The Queen's Nursing Institute Homeless Health Practitioner Network is reported by the practitioners as being one of the most supportive networks. Practitioners value the help and encouragement that it gives. However, other networks that exist offer varying levels of support for healthcare professionals working with vulnerable groups. Informal networks that the practitioners establish themselves can provide the only help and advice available to some of these specialist practitioners.

Part of the perceived problem is the lack of opportunity for students to have direct contact with socially excluded service users to enable them to develop these skills before taking on a clinical caseload. A close partnership between the organisations that support vulnerable groups and the education providers is central to the student learning. One way of minimising all these challenges, and optimising the opportunities for students, and specialist practitioners, to develop and enhance their knowledge and skills, is to establish Centres of Excellence for education and training in Inclusion Health. These Centres could be developed through Local Partnership Alliances between the education providers, the public sector service providers and the third sector.

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PROJECT ADVISORY BOARD

8.0 The Project Advisory Board

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