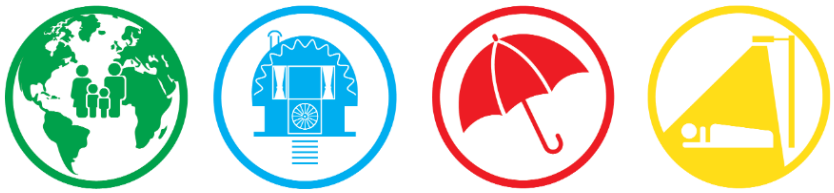


Advancing our Health: Prevention in the 2020s

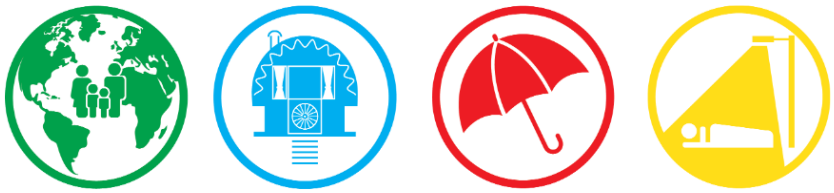
The VCSE Health and Wellbeing Alliance's Inclusion Health Subgroup's Response to the Department of Health and Social Care's Prevention Consultation

About the Health and Wellbeing Alliance

Funded by the Department of Health and Social Care (DHSC), and led by the DHSC, Public Health England and NHS England – together known as the 'system partners' – the VCSE Health and Wellbeing Alliance (HWA) is made up of 20 voluntary sector organisations representing a wide range of groups. The HWA was established to:

- Facilitate integrated working between the voluntary and statutory sectors;
- Support a two-way flow of information between communities, the VCSE sector and policy leads;
- Amplify the voice of the VCSE sector and people with lived experience to inform national policy;
- Facilitate co-produced solutions to promote equality and reduce health inequalities.

This response is from a subgroup of the HWA known as the Inclusion Health Subgroup (IHS). The group has been instrumental in advising system partners on the development of both the Prevention Green Paper and the NHS Long Term Plan. Our role is to highlight the importance of health inequalities as they affect Inclusion Health groups.



VCSE health & wellbeing alliance

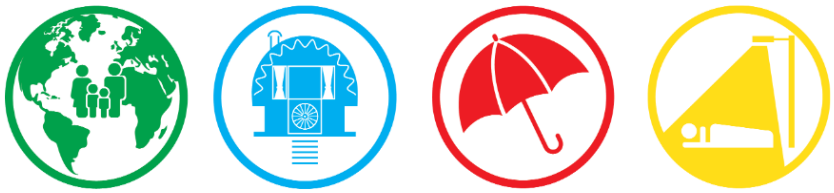
Members of the Inclusion Health Sub Group:

- Homeless Link with a focus on people experiencing homelessness
- Maternity Action with a focus on vulnerable migrants who are also new or expectant mothers
- FaithAction with a focus on vulnerable migrants
- Clinks and Nacro with a focus on people in contact with the criminal justice system
- Friends, Families and Travellers with a focus on Gypsy, Roma and Traveller communities
- CHANGE (as part of the Win Alliance) with a focus on people with learning disabilities
- Stonewall Housing (part of the National LGB&T Partnership) with a focus on homelessness in the LGBT+ community.

Summary of our response

The Green Paper is largely focused on the wider prevention of ill-health in society. Therefore, our response will focus on the first question of the consultation, which is the question that we feel directly impacts the groups that we represent. This submission follows on from the paper that we submitted to influence the Green Paper. Whilst we are pleased that the DHSC gives examples upfront of excluded groups, such as people sleeping rough, people leaving care, ex-offenders, and Gypsy, Traveller and Roma communities, we would have liked to see reference to these, and other, Inclusion Health groups, spread more evenly throughout the Green Paper. Inclusion Health groups are affected just as much by wider public health challenges as the rest of the population.

Inclusion Health groups face multiple disadvantage, and fall through the gaps between services and systems, making it harder for them to address their health issues and to lead fulfilling lives. People experiencing multiple disadvantage tend to be known by everyone but served by no-one, perceived to be "hard to reach" or to be the responsibility of others because, by their very nature, their support needs are complex.



Which health and social care policies should be reviewed to improve the health of: people living in poorer communities, or excluded groups?

In order to improve the health of people in excluded groups, more specifically Inclusion Health groups, a range of policies should be reviewed. Many of these policies clearly cut across more than one Inclusion Health group, however these are presented below under each group as represented by this partnership:

People experiencing homelessness

People experiencing homelessness often live with multiple disadvantage and health conditions, such as mental ill health, as well as drug and alcohol dependency and related health problems ensuing from this. The Office of National Statistics found that the average age at death for people rough sleeping was 45 for men and 43 for women in 2018; by comparison in the general population of England and Wales, the average age at death was 76 years for men and 81 years for women.[1]

Despite high levels of GP registration, a significant number of people experiencing homelessness are not accessing primary health care services when they need it. Over 17% of respondents to Homeless Link's 2014 Health Needs Audit with mental health issues would like support but are not receiving it. Additionally, 7% of respondents had been refused access to a GP or dentist within the past 12 months. Over a quarter of those receiving some form of support with their physical or mental health problems reported that they would benefit from more help.[2]

As a member of the Making Every Adult Matter (MEAM) coalition, Homeless Link works closely with the Big Lottery funded Fulfilling Lives programme to support people living with multiple disadvantage. A study in one Fulfilling Lives area found that 75% of GPs practices were refusing registration to people who were unable to produce proof of identity. These refusals, which contravene NHS England's own guidance, represent a major barrier to homeless people and other inclusion health groups, many of whom do not own ID or proof of address documentation.

[1] ONS: Deaths of homeless people in England and Wales: 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018 accessed 14/10/19

[2] Homeless Link (2014) The unhealthy state of homelessness https://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

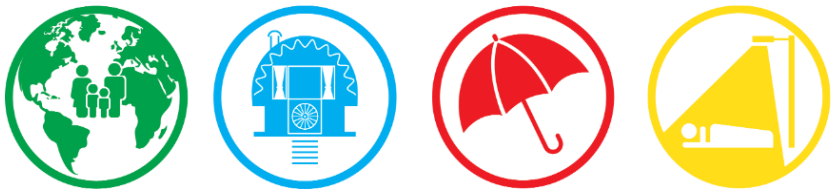
The **NHS Long Term Plan** should be further reviewed to develop policy and practice to improve the outcomes for people experiencing homelessness by:

- Developing social prescribing through local GPs and health and social care staff, including training for staff on the needs of homeless people, and make use of the VCSE sector
- Promoting Psychologically Informed Environments or Trauma-Informed care within housing and health services
- Making primary care services more targeted to the specific needs of homeless patients, and housing and health more joined up as part of the same pathway.
- Make a greater investment in the homelessness sector for approaches known to improve the way homeless people engage with the health system.
- Promote and develop existing homelessness training available for GP reception staff[3] as well as monitoring and accountability mechanisms, to ensure that GP practices do not refuse patient registration because of a lack of documentation or other reasons not permitted under NHS England guidance.
- An integrated housing, health, social care and advice pathway, which links back to the **Homelessness Reduction Act** and the **Rough Sleeping Strategy** can contribute to providing co-ordinated early intervention across services. This could help prevent individuals experiencing deterioration in their condition, and going into crisis.

People from LGBT+ communities

The **NHS Long Term Plan** also needs to be reviewed to ensure a better response to the specific needs of **LGBT communities**. The Plan outlined commitments to reducing health inequalities, but contained just two references to LGBT communities. If significant steps are to be made in eliminating health inequalities faced by LGBT communities, government plans and policy need to contain LGBT-specific evidence based measures. While LGBT specific policy documents, such the LGBT Action Plan 2018 are welcomed, LGBT people need to be mentioned throughout wider policy documents and plans, such as the NHS Long Term Plan.

[3] Pathway: Homelessness training for GP receptionists https://www.pathway.org.uk/4403-2/



Vulnerable migrants

For vulnerable migrants, the Department of Health and Social Care should consider the impact and implication of policies or initiatives on people with low levels of English or BAME communities. For example, Government should consider how the use of new technologies, alongside changes in food labelling, may affect people with limited internet access or for whom language and/or literacy may be a barrier.

Evidence shows that **GP registration** refusals is also a major barrier to vulnerable migrants accessing primary healthcare. Doctors of the World UK research shows that in 2018, a fifth of their 2,189 attempts for register their migrant patients with GP practices were wrongly refused. Lack of proof of ID or address were the most common reasons for refusal (64%) and patient's immigration status was a reason for refusal in 28 cases (7%). Almost one third of the 990 GP practices approached refused at least one registration attempt, demonstrating the widespread nature of the challenge and the need for system change, including better training and oversight.

In addition, growing evidence indicates that **upfront charging in secondary care** services is preventing many vulnerable migrants from accessing healthcare, including urgent care and treatment they are entitled to under current law.[4] The charging policy has created a deterrent effect for many vulnerable patients, causing them to avoid seeking treatment out of fear. In addition, there have been multiple reports of discriminatory practice in hospitals, whereby urgent or immediately necessary treatment has been delayed or refused.[5] These experiences undermine patient trust and pose a worrying risk to safeguarding, equalities and public health priorities. The policy should be suspended pending review, in accordance with the recommendations of the Academy of Medical Royal Colleges.[6]

For new and expectant mothers who are also **vulnerable migrants**, a number of policy areas require a review:

- Address barriers to accessing primary care services for pregnant women and new mothers associated with insecure housing and lack of identity documents

[4] The BMA (2019). Delayed, deterred, and distressed: The impact of NHS overseas charging regulations on patients and the doctors who care for them. https://www.bma.org.uk/-/media/files/pdfs/employment%20advice/ethics/20190211%20overseas%20charging%20paper.pdf?la=en

[5] Doctors of the World UK (2018) Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances. https://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf

[6] The AoMRC (2019). NHS charges to overseas visitors regulations A statement from the Academy of Medical Royal Colleges. https://www.aomrc.org.uk/wp-content/uploads/2019/03/2019-03-14_NHS_charges_overseas_visitors_regulations.pdf

- Address barriers to accessing welfare benefits arising from GP charges for letters, such as letters to support applications for Sure Start Maternity Grant
- Reduce poverty and disadvantage for pregnant women, new mothers and their families by integrating legal advice on maternity rights at work and social security entitlements into maternity services, building on social prescribing
- Reduce barriers to accessing perinatal mental health services by improving the six-week postnatal check for new mothers to better assess women's mental health as well as the health of their babies
- Improve access to over the counter medicines for women on low incomes, recognising that even low-cost medications can be unaffordable for those on low incomes
- Suspend NHS charges for maternity care for overseas visitors, which deters women from accessing care, increasing the risk of poor outcomes for them and their babies
- Reduce the health inequalities experienced by asylum seeking women through better coordination between health services and the Home Office, including in relation to dispersal (relocation) of asylum-seeking women during pregnancy and new motherhood.

People in contact with the criminal justice system

We welcome the inclusion of **people serving sentences in the community as well as in prisons** within the Green Paper. To improve the health of this large, complex and excluded group of people, justice and health departments must work together to best ensure health and social care policies respond to the specific needs of people in contact with the criminal justice system, including distinctive approaches to those with protected characteristics. **The National Partnership Agreement for Prison Healthcare in England 2018-2021**[7], signed by the Ministry of Justice (MoJ), Her Majesty's Prison and Probation Service (HMPPS), DHSC, Public Health England and NHS England is a positive example of this, and it includes commitments on addressing disparities faced by people with protected characteristics.

- The government should publish a detailed update on its progress in meeting the commitments made in the National Partnership Agreement for Prison Healthcare in England 2018-2021**.**

There are very few studies on the health and care needs of **people serving sentences in the community**, and they rarely feature in JSNAs or HNAs. Those studies that have been done

[7] HM Government/NHS England (2018). National Partnership Agreement for Prison Healthcare in England, 2018-2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767832/6.4289_MoJ_National_health_partnership_A4-L_v10_web.pdf (last accessed 03/10/19).

show levels of health inequalities on par with people in prison and significantly higher than the general population.

- We would like to see people serving sentences in the community and those being released from prison included in JSNAs and a local healthy lifestyle strategy developed with the National Probation Service and community rehabilitation companies.

We welcome the commitment in the **NHS Long Term Plan** to increase the use of community sentence treatment requirements – including Mental Health Treatment Requirement (MHTR), Drug Rehabilitation Requirement (DRR), and Alcohol Treatment Requirement (ATR) – as well as develop a programme of continuity of care through RECONNECT. For each of these initiatives we believe that there are opportunities to embed prevention strategies as part of delivery.

People with learning disabilities

People with learning disabilities also die earlier that the rest of the population, for women it is 29 years earlier and for men 25 years earlier. Many deaths are preventable; it is estimated that 1,200 people with learning disabilities die avoidable deaths every year.[8]

- One of the most common causes of death as with the rest of the population is cancer[9], due to a lack of easy read screening invitations.
- The cancer journey needs to be reviewed in its entirety using an inclusive, whole system approach that considers the specific needs of people with learning disabilities by providing easy read screening invitations and support at appointments.
- Medical staff, including mental health staff at all levels, ought to be trained by co-trainers who themselves have learning disabilities. The training needs to include awareness raising in order to achieve a change of attitude, better communication skills and the ability to identify people with learning disabilities. There needs to be an easy read journey through the system that explains legislation, the roles of different professionals and different services.
- Smoking cessation and alcohol care teams need training in working inclusively and accessibly and this needs to be backed up with easy read information shared through GP practices.
- More people with learning disabilities are likely to have diabetes than the rest of the population. This means diabetes services need support and training to become

[8] Bristol University (2013) Confidential Inquiry into Premature Deaths of People with Learning Disabilities – Final report https://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf Accessed 14/10/19

[9] Op cit.

more inclusive for the whole of an individual's journey through diagnosis to treatment. This could include peer support schemes and forums.

- Mental health services could be more inclusive as they need to be. There needs to be an easy read journey through the system that explains legislation, the roles of different professionals and different services.

Gypsy, Roma and Traveller communities

For Gypsy, Roma and Traveller communities, the Department for Health and Social Care should seek to address long-standing disadvantage and challenges for Gypsies and Travellers in accessing healthcare and preventative interventions such as immunisations and screening. For example:

- **Access to general practice** - almost half of GPs refuse to register patients from Traveller communities if they cannot provide an address or proof of identification[10]. The Department should seek to improve accountability when GPs fail to register patients.
- **Access to dentistry** - around one third of 100 NHS dentists refused to register a mystery shopper from the Traveller community whilst a further 20 dentists had waiting lists in place which act as a disadvantage to nomadic communities[11]. The Department should seek to improve accountability when Dentists fail to register patients.
- **Waiting lists** – although the Armed Forces Covenant specifically recognises disadvantage on NHS waiting lists when relocating within the country, no positive action has been taken to address this for nomadic communities[12]. As part of the Department's commitments as part of Public Sector Equality Duty, this should be addressed.

We welcome the announcement of a cross-Government national strategy to tackle the inequalities faced by Gypsy, Roma and Traveller communities[13]. It is vital that the Department continues to demonstrate a commitment to this and that adequate resources are allocated to deliver real change, the strategy has clear lines of accountability and is ambitious in tackling the root causes of inequality.

The Home Office recently announced it is to consult on proposals to amend the Criminal Justice and Public Order Act 1994 to increase the use of criminal powers on unauthorised

[10] https://www.gypsy-traveller.org/wp-content/uploads/2019/03/No-room-at-the-inn-findings-from-mystery-shopping-GP-practices.pdf

[11] Research conducted in Summer 2019, findings to be published but can be requested from sarahsweeney@gypsy-traveller.org

[12] https://www.england.nhs.uk/commissioning/armed-forces/

[13] https://www.gov.uk/government/news/new-national-strategy-to-tackle-gypsy-roma-and-traveller-inequalities

encampments[14]. We are deeply concerned that this will further contribute to the health inequalities faced by roadside Gypsy and Traveller communities who already face immense challenges in accessing healthcare, basic water and sanitation and are at high risk of hate crime. The Department should take a 'Health in All Policies' approach to unauthorised encampments and site provision and review the enforcement approach being taken by the Home Office for health inequality considerations.

Looking at a wider solution to improve the health of excluded groups

Inclusion needs to be central to the prevention agenda if the health of excluded groups is to be improved. The type of whole-scale cultural and social change that will make real change for excluded groups will require leadership and change that cuts across departmental responsibilities at all levels of government. Unless government addresses the structural issues and the lack of funding that contributes to the landscape of exclusion and multiple disadvantage, many issues which manifest themselves as poorer health-outcomes will remain unresolved.

14 October 2019

Inclusion Health Sub-Group

Health and Wellbeing Alliance

[14] https://www.gov.uk/government/news/government-announces-plans-to-tackle-illegal-traveller-sites